# Obstetrics and Gynecology

Text Tests

1. What is determined by the first Leopold maneuver in breech presentation?
   1. position of fetus;
   2. the lie and position of fetus;
   3. presenting part of fetus;
   4. \*head of the fetus;
   5. breech end of fetus.
2. What is the first moment of biomehanism of labor in breech presentations?
   1. flexion of head;
   2. \*internal rotation of breech;
   3. flexion of trunk;
   4. internal rotation of shoulders and external rotation of trunk;
   5. internal rotation of head.
3. What term of pregnancy is possible to conduct the prophylactic rotation of fetus on a head in breech presentations?
   1. in 28-32 weeks;
   2. \*in 34-36 weeks;
   3. in 36-38 weeks;
   4. in 32-38 weeks;
   5. without limitation of term.
4. What is contraindication for the external rotation of fetus in breech presentations?
   1. early gestosis;
   2. contracted pelvis I degree;
   3. kidney disease of pregnant woman;
   4. \*scar on the uterus;
   5. all of the above
5. Which aid is given in the labor at frank breech presentation?
   1. classic manual aid;
   2. \*Tsovianov’ I manual aid;
   3. caesarean section;
   4. perineum protective maneuvers;
   5. the Muller’ maneuver is used.
6. What the aim of the Tsovyanov’ manual aid at frank breech presentation consists in?
   1. in providing of slow and gradual advancement of fetus;
   2. in perineum protection from injures;
   3. in the safe delivery of shoulders of fetus;
   4. in the safe delivery of fetal head;
   5. \*in the saving of correct fetal attitude.
7. What is the aim of the classic manual aid?
   1. perineum protective maneuvers from injures;
   2. providing of slow and gradual advancement of fetus;
   3. \*delivery of the fetal arms and head;
   4. delivery of fetal breech;
   5. saving of correct fetal attitude.
8. How often the breech presentations are there?
   1. in 10%
   2. \*in 3-4%
   3. in 1-2%
   4. in 12-14%
   5. in 6-8%
9. To the reasons, which caused the breech presentations belong all, except for:
   1. polyhydramnion
   2. olighydramnion
   3. anomalies of development of uterus
   4. the decreased uterine tonus
   5. \*fetal hypoxia
10. By the third Leopold’ maneuver in breech presentations is palpated:
    1. the posterior of fetus
    2. \*the breech of the fetus
    3. head of the fetus
    4. the level of uterine fundus
    5. position of fetus
11. By the second Leopold’ maneuver in breech presentations is palpated:
    1. fetal extremities
    2. breech of fetus
    3. head of fetus
    4. legs and buttocks of the fetus
    5. \*position of fetus
12. At ІІ position of breech presentation the fetal heart is listened at:
    1. on the left at the level of umbilicus
    2. right side below than umbilicus
    3. on the left below than umbilicus
    4. on the left higher than umbilicus
    5. \*right side higher than umbilicus
13. At the internal obstetric examination the doctor palpates above the pelvic inlet only the breech of fetus. What is the type of breech presentation?
    1. complete breech;
    2. knee;
    3. incomplete breech
    4. \*frank breech;
    5. transversal.
14. During the labor at internal obstetric examination the doctor palpates above the pelvic inlet only one foot of the fetus. What is the type of breech presentation?
    1. complete breech;
    2. knee;
    3. \*incomplete footling
    4. frank breech;
    5. complete footling.
15. What is the circumference of breech with legs in frank breech presentation?
    1. \*32 cm
    2. 34 cm
    3. 36 cm
    4. 38 cm
    5. 40 cm
16. What is the circumference of breech in complete breech presentation?
    1. 32 cm
    2. \*34 cm
    3. 36 cm
    4. 38 cm
    5. 40 cm
17. What complications occur in the first stage of labor in breech presentation more frequent?
    1. \*early gash of amniotic fluid
    2. preeclampsia
    3. bleeding
    4. arrested fetal shoulders
    5. strong uterine contractions
18. Which cervical dilation indicates 6 cm contractile ring station above the symphysis?
    1. 2 cm
    2. 3 cm
    3. 4 cm
    4. \*6 cm
    5. 5 cm
19. What is the reason of the early gash of amniotic fluid in breech presentation?
    1. the large presenting part
    2. \*absence of the girdle of contact
    3. lost tonus of lower segment
    4. the abnormal tonus of uterus
    5. arrested fetal shoulders
20. During the labor in breech presentation all complications are possible, except for:
    1. fetal hypoxia
    2. \*deflexed presentation
    3. early gash of amniotic fluid
    4. weakness of uterine contractions
    5. arrested fetal shoulders
21. What is the third moment of biomehanizm of labor in breech presentation?
    1. flexion of head;
    2. internal rotation of breech;
    3. flexion of trunk;
    4. \*internal rotation of shoulders and external rotation of trunk;
    5. internal rotation of head.
22. What is the last moment of biomehanizm of labor in breech presentation?
    1. \*flexion of head;
    2. internal rotation of breech;
    3. flexion of trunk;
    4. internal rotation of head.
    5. internal rotation of shoulders and external rotation of trunk;
23. In relation to labor in frank breech presentation all assertions are correct, except for:
    1. the legs of fetus lies along a trunk
    2. the fetal arms are crossed on a chest
    3. circumference of the fetal thorax together with arms and legs is more than head
    4. \*labor in frank breech presentation is more favourable, than in cephalic
    5. manual aid by Tsov’yanov is given
24. All of the below are indications for cesarean section in breech presentation EXEPT:
    1. \*Probable fetal weight less 3000 g
    2. Breech presentation of the first fetus in multiple pregnancy
    3. Breech presentation and infertility
    4. Foot link presentation
    5. Probable fetal weight more 3700g
25. What is the aim of the Moriso-Leuvret maneuver?
    1. the delivery of the fetal breech
    2. the more rapid rotation of fetus
    3. \*maneuver helps to flex of the fetal head
    4. delivery of the fetal shoulders
    5. acceleration of labor of fetus
26. What is the first moment of classic manual aid?
    1. the transferring of the anterior arm in the areas of sacrum
    2. \*delivery of posterior arm
    3. delivery of anterior arm
    4. delivery of head of fetus
    5. delivery of breech
27. What is the feature of the first moment of classic manual aid?
    1. an obstetrician always delivers the anterior arm of fetus
    2. \*an obstetrician always delivers the posterior arm of fetus
    3. an obstetrician delivers the head of fetus, flexing it
    4. an obstetrician delivers the head of fetus, deflexing it
    5. an obstetrician helps for labor of breech
28. What is the feature of the IV moment of classic manual aid?
    1. an obstetrician always delivers the posterior arm of fetus
    2. an obstetrician always delivers the anterior arm of fetus
    3. \*an obstetrician delivers the head of fetus, flexing it
    4. an obstetrician delivers the head of fetus, deflexing it
    5. an obstetrician helps for labor of breech
29. What the purpose of the manual aid by Tsovianov’II method in footling presentation consists in?
    1. in perineum protective maneuvers from injuring;
    2. in providing of slow and gradual advancement of fetus;
    3. in delivery of shoulders of fetus;
    4. \*to transform the footling presentation to the incomplete breech;
    5. in saving of correct fetal attitude.
30. Which type of presentation appear as a result of correct applying of the Tsov”yanov’ method in footling presentation?
    1. \*incomplete breech
    2. frank
    3. incomplete footling
    4. complete footling
    5. complete breech
31. Which method of delivery in breech presentations is the best for minimizing of the infant mortality?
    1. \*cesarean section
    2. obstetric forceps
    3. Tsovyanov’ method
    4. classic manual aid
    5. breech extraction
32. What the type of presentation is if the fetal buttocks are palpable:
    1. \*Frank breech presentation;
    2. Complete breech;
    3. Incomplete breech presentation;
    4. Footling ;
    5. Kneeling presentation.
33. What the estimated weight of the fetus in breech presentation in which fetus considered to be large?
    1. 2500 g;
    2. 3000 g;
    3. \*3700 g and more;
    4. 4000 g.
    5. 3800 g
34. What type of the manual aids need the patients with a footling presentation?
    1. Manual aid by Tsovyanov I;
    2. \*Manual aid by Tsovyanov II;
    3. Classic manual aid;
    4. Breech extraction.
    5. All of the above
35. What type of the manual aids need the patients with a frank breech presentation?
    1. \*Manual aid by Tsovyanov I.
    2. Manual aid by Tsovyanov II;
    3. Classic manual aid;
    4. Breech extraction.
    5. All of the above
36. All of the following are the indications to the cesarean section, except:
    1. Breech presentation and the fetal weight 3800 g
    2. Breech presentation and any degree of contracted pelvis
    3. Breech presentation and uterine dysfunction
    4. \*Sinciput vertex presentation and probable fetal weight 3000g
    5. Breech presentation and fetal distress
37. All of the following are the indications to the breech extraction, except:
    1. \*Breech presentation and the fetal weight 3800 g
    2. Breech presentation and maternal preeclampsia severe degree
    3. Breech presentation and uterine dysfunction
    4. Breech presentation and maternal heart or respiratory diseases
    5. Breech presentation and fetal distress
38. All of the following are the conditions to the breech extraction, except:
    1. complete dilation of cervix
    2. \*intact amniotic membrane
    3. the normal fetopelvic proportions
    4. the rupture of membranes
    5. adequate anesthesia.
39. The contraindication to the breech extraction is:
    1. \*fetopelvic disproportion
    2. fetal hypoxia
    3. the rupture of membranes
    4. breech presentation and maternal preeclampsia
    5. breech presentation and uterine dysfunction
40. What is the presentation when the fetal neck is extended and the back and occiput are in contact?
    1. Vertex anterior
    2. \*Face
    3. Brow
    4. Sinciput
    5. Vertex posterior
41. What is the presentation when the fetal head is partially deflexed and a large anterior fontanel is presenting?
    1. Occipital
    2. Face
    3. Brow
    4. \*Sinciput vertex
    5. Vertex posterior
42. What is the circumference of the large segment of the fetal head in the face posterior presentation?
    1. 34 cm.
    2. 36 cm
    3. \*32 cm
    4. 38 cm
    5. 41 cm
43. Spontaneous vaginal delivery is possible in all types of presentations EXCEPT ?
    1. Occipital Anterior
    2. Face
    3. Vertex
    4. Occipital Posterior
    5. \*Brow
44. During which cardinal movement of labor is the face linear of the fetal head is located in oblique diameter of the pelvic inlet?
    1. Internal rotation
    2. \*Extension
    3. External rotation
    4. Expulsion
    5. Flexion
45. The base of the os hyoideus is brought into contact with the inferior margin of the symphysis during which cardinal movement of labor in fase presentation ?
    1. Extension
    2. Expulsion
    3. Descent
    4. \*Flexion
    5. Internal rotation of the fetal head
46. Cesarean section is performed in all below situations EXCEPT ?
    1. \*Sinciput vertex presentation
    2. Face auterior presentation
    3. Brow presentation
    4. Oblique lie
    5. Transverse lie
47. What is the presentation when the fetal head is extended and a chin is presenting?
    1. Vertex Anterior
    2. \*Face
    3. Brow
    4. Sinciput
    5. Vertex posterior
48. What is the first moment in the biomechanism of labor in the face presentation?
    1. Fetal head flexion
    2. Additional flexion of the fetal head
    3. Internal rotation of the fetal head
    4. \*Fetal head extension
    5. External rotation of the fetal head and external rotation of the fetal body
49. What is the circumference of the large segment of the fetal head in the brow presentation?
    1. 32 cm.
    2. 34 cm
    3. 36 cm
    4. 28 cm
    5. \*39-41 cm
50. In which plane of true pelvis internal rotation of the fetal head in the occipital presentation is finished?
    1. Pelvic inlet
    2. \*Pelvic outlet
    3. Plane of the greatest diameter
    4. Plane of the least diameter
    5. Correct answer is absent
51. What is edematous swelling of the fetal scalp during labor?
    1. Molding
    2. \*Caput succedaneum
    3. Subdural hematoma
    4. Erythema nodusum
    5. Epidural hematoma
52. What are the reasons of deflexed presentation:
    1. contracted pelvis
    2. relaxation of perineum mussels
    3. small or large sizes of fetus head
    4. thyroids tumor of fetus
    5. \*all answers are correct
53. How can we diagnose the brow presentation:
    1. Ultrasound examination
    2. Leopold’ manuvers
    3. \*Vaginal examination
    4. X-ray examination
    5. Pelvic examination
54. During vaginal examination fetal chin and nose was diagnosed. What is the presentation?
    1. deflexed vertex
    2. brow
    3. \*face
    4. anterior variety of vertex presentation
    5. posterior variety of vertex presentation
55. During vaginal examination large fontanel, glabella of the fetus was palpated. What is the fetal presentation?
    1. deflexed vertex
    2. \*brow
    3. face
    4. anterior variety of vertex presentation
    5. postirior variety of vertex presentation
56. During vaginal examination large fontanel, which is located below small fontanel was palpated. What is the type of presentation?
    1. \*sinciput vertex
    2. brow
    3. face
    4. anterior variety of occiput presentation
    5. posterior variety of occiput presentation
57. The fetal head is delivered with its vertical size. What is the presentation?
    1. deflexed vertex
    2. brow
    3. \*face
    4. anterior variety of vertex presentation
    5. posterior variety of vertex presentation
58. What is the management of delivery in case of sinciput vertex presentation?
    1. caesarian section
    2. vacuum extraction
    3. fetus destroying operation
    4. \*vaginal delivery
    5. Poro’ section
59. The characteristics of caput succedenum include all of the following except:
    1. Crosses midline
    2. Crosses the suture line
    3. \*It does not disappear within 2-3 days
    4. It is a diffuse edematous swelling of the soft tissues of the scalp
    5. none
60. During vaginal examination the leading point was midline of the frontal suture. What is the presentation?
    1. deflexed vertex
    2. \*brow
    3. face
    4. anterior variety of vertex presentation
    5. postirior variety of vertex presentation
61. What size of obstetvic conjugate indicate true pelvic contraction?
    1. <10 cm
    2. <9 cm
    3. \*<11 cm
    4. <12 cm
    5. <13 cm
62. What is the diagonal conjugate in women with normal pelvis?
    1. 8.0 cm
    2. 9.5 cm
    3. 11.5 cm
    4. \*13.0 cm
    5. 15 cm
63. What is the true conjugate in women with diagonal conjugate 13 cm?
    1. \*11 cm
    2. 9.0 cm
    3. 12.0 cm
    4. 10.0 cm
    5. 15 cm
64. What is the true conjugate in women with external conjugate 20 cm?
    1. \*11 cm
    2. 9.0 cm
    3. 12.0 cm
    4. 10.0 cm
    5. 15 cm
65. What is the average biparietal diameter of term infants?
    1. 8.5 cm
    2. 9.0 cm
    3. \*9.5 cm
    4. 10.0 cm
    5. 11.0 cm
66. The anatomically contracted pelvis is associated with:
    1. \*true conjugate 9 cm
    2. internal conjugate 11.5 cm
    3. external conjugate 20.5 cm
    4. diagonal conjugate 13.5 cm
    5. fetopelvic disproportion
67. The clinically contracted pelvis is associated with:
    1. true conjugate 9 cm
    2. true conjugate 11.5 cm
    3. true conjugate 12.5 cm
    4. true conjugate 13.5 cm
    5. \*fetopelvic disproportion
68. In a nullipara at term the diagonal conjugate is10.5 cm. What is true from the listed below?
    1. The pelvis is contracted.
    2. Oxytocin is contraindicate.
    3. Cesarean section is probably necessary.
    4. Fetaopelvic disproportion is common in labor
    5. \*Al of the above is true
69. What is the main cause of fetopelvic disproportion?
    1. rachitis
    2. \*fetal macrosomia
    3. preterm labor
    4. twins
    5. fetal distress
70. What may be a result of excessive compression of birth canal’ soft tissues?
    1. uterine rupture
    2. cervical rupture
    3. \*vesicovaginal fistules
    4. perineal rupture
    5. Vaginal rupture
71. What may be a result of labor in patients with fetopelvic disproportion?
    1. \*uterine rupture
    2. cervical rupture
    3. vesicovaginal fistules
    4. perineal rupture
    5. Vaginal rupture
72. The pathological contractile ring is a sign of:
    1. anatomically contracted pelvis
    2. fetal distress
    3. fetal macrosomia
    4. \*danger of uterine rupture
    5. all of above
73. What is the management in the case of the clinically contracted pelvis?
    1. normal vaginal delivery
    2. \*cesarean section
    3. obstetrical version
    4. fetal destroying operation
    5. External cephalic version
74. The pelvic formula of the patient is 25 – 28 – 31 – 20 cm. What is the pelvic type?
    1. \*normal pelvis
    2. generally contracted pelvis
    3. flat pelvis
    4. flat rachitic pelvis
    5. Transverse contracted flat pelvis
75. The pelvic sizes of the patient is 23 – 26 – 29 – 17 cm. What is the pelvic type?
    1. normal pelvis
    2. transverse contracted pelvis
    3. flat pelvis
    4. flat rachitic pelvis
    5. \*generally contracted pelvis
76. The pelvic formula of the patient is 23 – 26 – 29 – 18 cm. What is the pelvic type?
    1. normal pelvis
    2. \*generally contracted pelvis
    3. flat pelvis
    4. flat rachitic pelvis
    5. transverse contracted pelvis
77. The pelvic formula of the patient is 25 – 28 – 31 – 18 cm. What is the pelvic type?
    1. normal pelvis
    2. generally contracted pelvis
    3. \*simple flat pelvis
    4. flat rachitic pelvis
    5. transverse contracted pelvis
78. The pelvic formula of the patient is 26 – 26 – 31 – 17 cm. What is the pelvic type?
    1. normal pelvis
    2. generally contracted pelvis
    3. flat pelvis
    4. \*flat rachitic pelvis
    5. transverse contracted flat pelvis
79. What is the difference between the diagonal conjugate and the obstetrical conjugate?
    1. 1 to 2 cm longer
    2. 3 to 4 cm longer
    3. \*1 to 2 cm shorter
    4. both the same size
    5. 3 to 4 cm shorter
80. Generally contracted pelvis is characterized by:
    1. \*diminution of all pelvic diameters
    2. diminution of all pelvic anteroposterior diameters
    3. diminution of all pelvic transversal diameters
    4. diminution of true conjugate and increasing of the pelvic outlet
    5. combination of generally contracted and flat pelvis
81. Simple flat pelvis is characterized by:
    1. diminution of all pelvic diameters
    2. \*diminution of all pelvic anteroposterior diameters
    3. diminution of all pelvic transversal diameters
    4. diminution of true conjugate and increasing of the pelvic outlet
    5. combination of generally contracted and flat pelvis
82. Flat rachitic pelvis is characterized by:
    1. diminution of all pelvic diameters
    2. diminution of all pelvic anteroposterior diameters
    3. diminution of all pelvic transversal diameters
    4. \*diminution of true conjugate and increasing of the pelvic outlet
    5. combination of generally contracted and flat pelvis
83. What is the cause of fetopelvic disproportion?
    1. \*face presentation anterior
    2. face presentation posterior
    3. pretrm labor
    4. twins
    5. fetal distress
84. Transversally contracted pelvis is characterized by:
    1. diminution of all pelvic diameters
    2. diminution of all pelvic anteroposterior diameters
    3. \*diminution of all pelvic transversal diameters
    4. diminution of true conjugate and increasing of the pelvic outlet
    5. combination of generally contracted and flat pelvis
85. The true conjugate of the flat pelvis is 9.5 cm. What is the degree of pelvic contraction?
    1. \*I degree
    2. II degree
    3. III degree
    4. IV degree
    5. V degree
86. The true conjugate of the flat pelvis is 8.5 cm. What is the degree of pelvic contraction?
    1. I degree
    2. \*II degree
    3. III degree
    4. IV degree
    5. V degree
87. The true conjugate of the flat pelvis is 8.0 cm. What is the degree of pelvic contraction?
    1. I degree
    2. \*II degree
    3. III degree
    4. IV degree
    5. V degree
88. The true conjugate of the generally contracted pelvis is 7.0 cm. What is the degree of pelvic contraction?
    1. I degree
    2. II degree
    3. \*III degree
    4. IV degree
    5. V degree
89. The true conjugate of the generally contracted pelvis is 6.5 cm. What is the degree of pelvic contraction?
    1. I degree
    2. II degree
    3. \*III degree
    4. IV degree
    5. V degree
90. The true conjugate of the generally contracted pelvis is 5.0 cm. What is the degree of pelvic contraction?
    1. I degree
    2. II degree
    3. III degree
    4. \*IV degree
    5. V degree
91. What type of pelvis does belong to rare occurred?
    1. \*osteomalatic pelvis
    2. generally contracted pelvis
    3. flat pelvis
    4. flat rachitic pelvis
    5. generally contracted pelvis
92. What management is possible for the patients with I degree of pelvic contraction?
    1. vaginal delivery
    2. cesarean section only
    3. \*vaginal delivery or cesarean section
    4. fetal destroying operation
    5. Labor preparing operation
93. What management is possible for the patients with II degree contracted pelvis?
    1. vaginal delivery
    2. cesarean section only
    3. \*vaginal delivery or cesarean section
    4. fetal destroying operation
    5. Labor preparing operation
94. What management is possible for the patients with III degree contracted pelvis?
    1. vaginal delivery
    2. \*cesarean section only
    3. vaginal delivery or cesarean section
    4. fetal destroying operation
    5. Labor preparing operation
95. What management is possible for the patients with IV degree contracted pelvis?
    1. vaginal delivery
    2. \*cesarean section only
    3. vaginal delivery or cesarean section
    4. fetal destroying operation
    5. correct answer is absent
96. How is macrosomia defined?
    1. \*Birthweight > 4000 g
    2. Birthweight > 4100 g
    3. Birthweight > 4500 g
    4. Birthweight > 5000 g
    5. Birthweight > 5100 g
97. Which of the following is a risk factor for macrosomia?
    1. \*Diabetes
    2. Pregnancy induced hypertension
    3. Maternal anemia
    4. Gestational age > 42 weeks
    5. Preterm labor
98. What is the cause of fetopelvic disproportion?
    1. \*sinciput vertex presentation and large fetus
    2. face presentation posterior
    3. occiput presentation
    4. foot-link presentation
    5. knee-link presentation
99. What is the cause of fetopelvic disproportion?
    1. frank breech presentation
    2. \*sinciput vertex presentatio and III degree of pelvic contraction
    3. occiput presentation
    4. foot-link presentation
    5. knee-link presentation
100. Which cervical dilation indicates 5 cm contractile ring station above the symphysis?
     1. 1 cm
     2. 2 cm
     3. \*5 cm
     4. 3 cm
     5. 4 cm
101. Cesarean section undergo all types of multiple pregnancies EXCEPT:
     1. Breech – breech presentation
     2. Breech – transverse presentation
     3. \*cephalic – cephalic presentation
     4. breech– cephalic presentation
     5. Transverse – transverse
102. How is fetus giant defined?
     1. Birthweight > 4000 g
     2. Birthweight > 4100 g
     3. Birthweight > 4500 g
     4. \*Birthweight > 5000 g
     5. Birthweight > 5100 g
103. Which of the following is NOT a complication of macrosomia?
     1. \*placenta abruption
     2. Brachial plexus injury
     3. Shoulder dystocia
     4. Cephalopelvic disproportion
     5. Uterine rupture
104. Which of the following is suggestive of dichorionic diamnionic twin pregnancy?
     1. Discordance
     2. Sonographic measurement of the dividing membranes thinner than 1 mm
     3. \*Two separate placentae
     4. none of the above
     5. all of the above
105. With twins, which of the following is NOT true?
     1. Pregnancy hypervolemia approximates 50 to 60%.
     2. Cardiac output is increased.
     3. \*Pulse rate is decreased.
     4. Stroke volume is increased
     5. The body weight increased
106. Which of the following is NOT a specific complication of monoamnionic twins?
     1. Cord entanglement
     2. Discordancy
     3. Conjoined twins
     4. Preterm labor
     5. \*Postdate labor
107. Spantaneous vaginal delivery undergoes all types of clinical situations EXCEPT:
     1. Cephalic –cephalic presentation
     2. Cephalic –breech presentation
     3. \*Breech – cephalic presentation
     4. Cephalic – transverse presentation
     5. All of the above
108. How is macrosomia in breech presentation defined?
     1. Birthweight > 4000 g
     2. Birthweight > 4100 g
     3. Birthweight > 3500 g
     4. \*Birthweight > 3700 g
     5. Birthweight > 5100 g
109. What is the best management of labor in breech – breech presentation?
     1. vaginal delivery
     2. \*cesarean section
     3. vacuum extraction
     4. forceps application
     5. breech extraction
110. What is the best management of labor in breech –cephalic presentation?
     1. vaginal delivery
     2. \*cesarean section
     3. vacuum ectraction
     4. forceps application
     5. breech extraction
111. What is the best management of labor in cephalic – breech presentation?
     1. \*vaginal delivery
     2. cesarean section
     3. vacuum extraction
     4. forceps application
     5. breech extraction
112. What is the best management of labor in cephalic – cephalic presentation?
     1. \*vaginal delivery
     2. cesarean section
     3. vacuum extraction
     4. forceps application
     5. breech extraction
113. What is the best management of labor in breech – transverse presentation?
     1. vaginal delivery
     2. \*cesarean section
     3. vacuum extraction
     4. forceps application
     5. breech extraction
114. A twin fetus is at risk for each of the following complications EXCEPT:
     1. stillbirth
     2. anomalies
     3. \*macrosomia
     4. malpresentation
     5. umbilical cord entanglement
115. All of the below are patients at risk for macrosomic fetus EXCEPT:
     1. endocrine disorders
     2. \*multiple pregnancy
     3. obesity
     4. diabetes mellitus
     5. excessive nutrition
116. Which of the following is associated with meconium-stained amniotic fluid?
     1. fetal macrosomia
     2. vaginal delivery
     3. alkalemia
     4. chorioamnionitis
     5. \*fetal distress
117. What is present as compounds in the amnionic fluid only?
     1. \*vernix and ectodermal fetal cells
     2. mononuclear cells and macrophages
     3. lymphocytes and polymorphonucleocytes
     4. eosinophils and vernix
     5. erytyhrocytes
118. What congenital anomaly is associated with polyhydramnion?
     1. ventral septal defect
     2. \*spina bifida
     3. omphalocele
     4. hypoplastic kidneys
     5. fetal anemia
119. At what point in normal gestation the amnionic fluid volume is approximately 1-1,5 mL?
     1. 16 weeks
     2. 28 weeks
     3. \*36 weeks
     4. 40 weeks
     5. 42 weeks
120. Polyhydramnios defines as increasing of amniotic fluid more than:
     1. 1000 mL
     2. 1400 mL
     3. 1600 mL
     4. 1800 mL
     5. \*2000 mL
121. Which of the following anomalies are not associated with polyhydramnios?
     1. central nervous system abnormalities
     2. duodenal atresia
     3. esophageal atresia
     4. \*renal agenesis
     5. immune hydrops
122. What is the major source of amnionic fluid?
     1. \*amnionic epithelium
     2. fetal urination
     3. fetal swallowing
     4. fetal inspiration
     5. placental production
123. What is the most likely cause of polyhydramnion?
     1. maternal anemia
     2. maternal cardiac diseases
     3. decreasing of maternal urination
     4. increased blood pressure
     5. \*maternal infections
124. Which of the following maternal symptom is NOT associated with acute hydramnios?
     1. edema
     2. respiratory distress
     3. enlarged abdomen
     4. preterm labor
     5. \*normal maternal condition
125. What is a frequent maternal complication of hydramnios?
     1. preeclampsia
     2. hypertonic uterine activity
     3. \*placental abruption
     4. postterm pregnancy
     5. anemia
126. Which contractile ring station above the symphysis indicates 4cm cervical dilation?
     1. 1 cm
     2. 2 cm
     3. 8 cm
     4. 6 cm
     5. \*4 cm
127. What is the most common cause of oligohydramnios?
     1. renal anomalies
     2. fetal growth retardation
     3. twin–twin transfusion
     4. \*premature rupture of fetal membranes
     5. Diabetus mellitus
128. What is recommended for labor’ induction in patients with polyhydramnion?
     1. stimulation of uterine contractions
     2. episiotomy
     3. cesarean section
     4. \*early amniotomy
     5. obstetrics forceps
129. Polyhydramnion is a risk factor of :
     1. postpartum infections
     2. \*early postpartum bleeding
     3. fetal macrosomia
     4. fetal malformations
     5. Pregnancy induced hypertension
130. Which complication is typical for I stage of labor in patients with polyhydramnion?
     1. placenta previa
     2. bleeding
     3. maternal infection
     4. fetal distress
     5. \*hypotonic uterine contractions
131. What is the normal average baseline fetal heart rate at term?
     1. 100 to 140 bpm
     2. 110 to 150 bpm
     3. \*110 to 170 bpm
     4. 120 to 140 bpm
     5. 160-179 bpm
132. What is bradycardia?
     1. baseline fetal heart rate < 130 for > 5 min
     2. baseline fetal heart rate < 140 for > 15 min
     3. baseline fetal heart rate < 120 for > 5 min
     4. \*baseline fetal heart rate < 110 for > 15 min
     5. baseline fetal heart rate < 120 for > 3 min
133. Which of the following is NOT associated with fetal bradycardia?
     1. head compression
     2. congenital heart block
     3. fetal distress
     4. \*gestational pyelonephritis
     5. placental abruption
134. How are accelerations defined?
     1. increase in fetal heart rate of 10 bpm for 10 sec
     2. increase in fetal heart rate of 15 bpm for 10 sec
     3. increase in fetal heart rate of 10 bpm for 15 sec
     4. \*increase in fetal heart rate of 15 bpm for 15 sec
     5. increase in fetal heart rate of 5 bpm for 15 sec
135. What is a gradual, smooth descent of the fetal heart rate 30 sec after the contraction called?
     1. early deceleration
     2. \*late deceleration
     3. variable deceleration
     4. acceleration
     5. accomodation
136. What is the most common deceleration pattern encountered during labor?
     1. late decelerations
     2. early decelerations
     3. \*variable decelerations
     4. mixed decelerations
     5. long decelerations
137. What is the definition of asphyxia?
     1. fetal distress
     2. \*hypoxia leading to acidemia
     3. acidemia alone
     4. severe variable decelerations
     5. absence of breath
138. Direct electro fetal heart rate monitoring is made:
     1. during pregnancy
     2. in labor
     3. during pregnancy and un the first stage of labor
     4. in the second stage of labor
     5. \*after releasing of amniotic fluid
139. All of the below take into account during electronic fetal heart rate minitoring EXCEPT:
     1. baseline rhythm
     2. fetal heart rate variability
     3. presence of accelerations
     4. \*ratio between amplitude and rhythm of oscillations
     5. presence of decelerations
140. Which method is the best for evaluation of fetal well-being:
     1. amnioscopy
     2. ultrasonography
     3. fetal heart rate monitoring
     4. \*biophysical profile
     5. determination of a-fetoprotein in amniotic fluid
141. How many minutes do you need for fetal heart rate monitoring?
     1. 10
     2. 20
     3. \*30
     4. 40
     5. 50
142. Nonstress test – is:
     1. amount of amniotic fluid
     2. \*response of the fetal heart rate to the fetal movement
     3. response of the fetal heart rate to physical irritation
     4. response of the fetal heart rate to contractile drugs
     5. response of the fetal heart rate to spasmolytics
143. Reactive nonstress test is:
     1. \*increasing of fetal heart rate at least 15 bpm over a period 15 seconds following a fetal movement
     2. increasing of fetal heart rate at least 1 bpm over a period 1 seconds following a fetal movement
     3. decreasing of fetal heart rate at least 15 bpm over a period 15 seconds following a fetal movement
     4. decreasing of fetal heart rate at least 15 bpm over a period 15 seconds following a fetal movement
     5. absence of accelerations in response of fetal movement
144. Nonreactive nonstress test is:
     1. increasing of fetal heart rate at least 15 bpm over a period 15 seconds following a fetal movement
     2. increasing of fetal heart rate at least 1 bpm over a period 1 seconds following a fetal movement
     3. decreasing of fetal heart rate at least 15 bpm over a period 15 seconds following a fetal movement
     4. decreasing of fetal heart rate at least 15 bpm over a period 15 seconds following a fetal movement
     5. \*absence of accelerations in response of fetal movement
145. How many parameters of fetal well being are presented in determination of biophysical profile?
     1. 2
     2. 3
     3. 4
     4. \*5
     5. 6
146. All of the below are the parameters of biophysical profile EXCEPT:
     1. amount of amniotic fluid
     2. fetal tone
     3. reactive nonstress test
     4. \*fetal urine output
     5. fetal breathing movements
147. How can you estimate of the biophysical profile?
     1. during fetal heart rate monitoring
     2. \*in ultrasonography
     3. in cordocentesis
     4. in amnioscopy
     5. in amniocentesis
148. How many points of biophysical profile is considered to be normal?
     1. 1-2
     2. 3-4
     3. 5-6
     4. 7- 8
     5. \*8 - 10
149. What are the characteristics of normal fetal breathing movements which corresponds with 2 points in biophysical profile?
     1. at least 5 FBM at least 5 seconds duration in 10 minutes
     2. \*at least 1 FBM of at least 30 seconds duration in 30 minutes
     3. at least 1 FBM of at least 20 seconds duration in 30 minutes
     4. at least 1 FBM of at least 15 seconds duration in 15 minutes
     5. at least 2 FBM of at least 30 seconds duration in 30 minutes
150. What are the characteristics of normal fetal tone which correspond with 2 points in biophysical profile?
     1. at least 2 episodes of active extension with return to flexion of fetal limbs/trunk during 30 minutes
     2. at least 3 episode of active extension with return to flexion of fetal limbs/trunk in 15 minutes
     3. \*at least 1 episode of active extension with return to flexion of fetal limbs/trunk in 30 minutes
     4. at least 2 episodes of active extension with return to flexion of fetal limbs/trunk during 10 minutes
     5. at least 1 episode of active extension without return to flexion of fetal limbs/trunk during 10 minutes
151. A reactive nonstress test (NST) is characterized by a fetal heart rate increase of how many beats per minute:
     1. \*15
     2. 25
     3. 50
     4. 5
     5. 55
152. A biophysical profile in which there is one or more episodes of fetal breathing in 30 minutes, three or more discrete movements in 30 minutes, opening / closing of the fetal hand, a nonreactive nonstress test (NST), and no pockets of amniotic fluid greater than 1 cm would have a total score of:
     1. 2
     2. 4
     3. \*6
     4. 8
     5. 10
153. In which gestational age does the second ultrasonography is recommended?
     1. 12-14 weeks
     2. \*16 – 21 weeks
     3. 22-23 weeks
     4. 24-26 weeks
     5. 26-28 weeks
154. All of the below complications should be present during amniocentesis EXCEPT:
     1. maternal trauma
     2. fetal trauma
     3. infection
     4. abortion
     5. \*placenta previa
155. All of below are the main indications for cordocentesis EXCEPT:
     1. fetal distress
     2. fetal isoimmunization
     3. metabolic fetal disorders
     4. \*maternal pregnancy induced hypertension
     5. fetal karyotyping
156. Cordocentesis – is:
     1. puncture of amniotic sac
     2. \*percutaneous umbilical blood sampling
     3. skin sample
     4. chorionic villus sampling
     5. fetoscopy
157. Which size of pelvis is normally 20-21 cm?:
     1. distancia spinarum
     2. \*external conjugate
     3. distancia trochanterica
     4. distancia cristarum
     5. true conjuagete
158. Decrease in fetal heart rate above baseline is called as:
     1. feceleration
     2. acceleration
     3. doceleration
     4. perceleration
     5. \*deceleration
159. Variable decelerations are closely connected with:
     1. \*umbilical cord occlusion
     2. placental abruption
     3. placental previa
     4. diabetes mellitus
     5. pregnancy induced hypertension
160. What is the normal perception of fetal movement by pregnant woman?
     1. \*more than 10 movements during 12 hours
     2. 2 movements for 2 hours
     3. 3 movements in 1 hour
     4. 5 movements in 30 minutes
     5. 1 movement for 24 hours
161. What are the characteristics of normal amount of amniotic fluid volume in the biophysical profile?
     1. \*at least 1 pocket of amniotic fluid at least 1 cm in two perpendicular planes during 30 minutes
     2. at least 2 pockets of amniotic fluid at least 1 cm in two perpendicular planes during 30 minutes
     3. at least 1 pocket of amniotic fluid at least 1 cm in two perpendicular planes during 15 minutes
     4. at least 3 pockets of amniotic fluid at least 1 cm in two perpendicular planes during 20 minutes
     5. at least 1 pocket of amniotic fluid at least 1 cm in two perpendicular planes during 50 minutes
162. How many minutes do you need for estimation of biophysical profile?
     1. 15
     2. 20
     3. 25
     4. \*30
     5. 40
163. All of the below are the complications which should be present during cordocentesis EXCEPT:
     1. \*oligohydramnios
     2. fetal trauma
     3. fever
     4. abortion
     5. placenta abruption
164. How many points does the woman receive on biophysical profile for one fetal breath movement of at least 30 seconds duration in 30 minutes?
     1. 0
     2. 1
     3. \*2
     4. 3
     5. 4
165. How many points does the woman receive on biophysical profile for absence of active extension with return to flexion of fetal limb/trunk?
     1. \*0
     2. 1
     3. 2
     4. 3
     5. 4
166. Biophysical profile of the fetus determines from:
     1. \*28 week of gestation
     2. 16 week of gestation
     3. 12 week of gestation
     4. 40 week of gestation
     5. 34 week of gestation
167. Physiological fetus heart rate is:
     1. 120-140 per min.
     2. \*110-170 per min.
     3. 140-160 per min.
     4. 120-160 per min.
     5. 110-160 per min
168. According with the biophysical fetus profile, doubtful fetus condition is in case:
     1. 4 points and lower
     2. \*5-6 points
     3. 7-10 points
     4. 3-6 points
     5. 5-10 points
169. According with the biophysical fetus profile, pathological fetus condition is in case:
     1. \*4 points and lower
     2. 5-6 points
     3. 7-10 points
     4. 3-6 points
     5. 5-10 points
170. In case of pathological result of biophysical fetus condition:
     1. \*We decide to deliver this patient immediately
     2. To continue observation
     3. To stop delivery stimulation
     4. To perform ultrasonography
     5. Not necessary to do anything
171. To diagnose fetus distress condition during labor we use all exept:
     1. Fetal heart rate assessment by obstetric stetoskope
     2. Electronic Fetal heart rate asessment
     3. Presence of meconium in amniotic fluid
     4. \*Assessment of the labor activity
     5. There is no correct Answer:
172. In case of fetus distress condition in labor we undergo all below prescriptions EXEPT:
     1. Avoid supine position of the patient
     2. Stop oxytocin dropping
     3. Vacuum extraction
     4. Forceps delivery
     5. \*Continue oxytocin dropping
173. In case of fetal distress we:
     1. Avoid supine position of the patient
     2. Stop oxitocin dropping
     3. Avoid prone position
     4. Allow patient to stay in supine position
     5. \*Answer:s A and B
174. In case of fetal distress within the first period of labor:
     1. \*Perform Cesarean section immediately
     2. To continue observation
     3. Continue oxitocin dropping
     4. Continue labor through the natural passway
     5. There is no correct Answer:
175. Which cervical delation indicates 2cm contractile ring station above the symphysis:
     1. 5 fingers
     2. \*1 finger
     3. 4 fingers
     4. 3 fingers
     5. 2 fingers
176. In case of fetal distress within the second period of labor in breach presentation:
     1. Perform Cesarean section immediately
     2. \*To perform breech extraction of the fetus
     3. Continue oxitocin dropping
     4. Continue labor through the natural passway
     5. There is no correct Answer:
177. There are … degrees of fetus retardation:
     1. 2
     2. \*3
     3. 4
     4. 5
     5. 6
178. The first degree of fetus retardation matches with:
     1. \*2 weeks retardations
     2. 3 weeks retardations
     3. 4 weeks retardations
     4. 5 weeks retardations
     5. 1 weeks retardations
179. The second degree of fetus retardation matches with:
     1. 2 weeks retardations
     2. 6 weeks retardations
     3. \*3-4 weeks retardations
     4. 5 weeks retardations
     5. 1 weeks retardations
180. The third degree of fetus retardation matches with:
     1. 2 weeks retardations
     2. 3 weeks retardations
     3. 4 weeks retardations
     4. 1 week retardations
     5. \*more than 4 weeks
181. The first degree hypotrophy of the newborn is:
     1. \*15-20% weight deficit of normal.
     2. 21-30% weight deficit of normal
     3. 31% and more weight deficit of normal
     4. 41% and more weight deficit of normal
     5. 5-10% weight deficit of normal
182. The second degree hypotrophy of the newborn is:
     1. 15-20% weight deficit of normal.
     2. \*21-30% weight deficit of normal
     3. 31% and more weight deficit of normal
     4. 41% and more weight deficit of normal
     5. 5-10% weight deficit of normal
183. The 3 degree hypotrophy of the newborn is:
     1. 15-20% weight deficit of normal.
     2. 21-30% weight deficit of normal
     3. \*31% and more weight deficit of normal
     4. 41% and more weight deficit of normal
     5. 5-10% weight deficit of normal
184. Matured newborn has:
     1. \*47 cm height and 2500 g weight and more
     2. 45 cm height and 2300 g weight
     3. 46 cm height 2450 g weight
     4. 40 cm height and 2000 g weight
     5. 45 cm height and 2450 g weight
185. Nonmatured newborn has:
     1. \*45 cm height and 2499 g weight and less
     2. 45 cm height and 2600 g weight and less
     3. 46 cm height 2700 g weight
     4. 47 cm height and 2600 g weight
     5. 45 cm height and 2650 g weight
186. Feto-placental insufficiency is:
     1. \*acute and chronic
     2. acute, chronic and hidden
     3. light and severe
     4. light, severe and moderate
     5. Moderate and severe
187. In case of normal pregnancy width of the placenta on the 28th week of gestation is:
     1. \*28 mm
     2. 31 mm
     3. 26 mm
     4. 25 mm
     5. 35 mm
188. There are ….. degrees of placental maturity:
     1. 3
     2. \*4
     3. 5
     4. 2
     5. 1
189. We perform auscultation of the fetus heart rate from the:
     1. 20th week of pregnancy
     2. 15th week of pregnancy
     3. \*23-24th week of pregnancy
     4. 28th week of pregnancy
     5. 30th week of pregnancy
190. We perform the first ultrasonography of the fetus in the:
     1. \*11th week of pregnancy
     2. 5th week of pregnancy
     3. 8th week of pregnancy
     4. 20th week of pregnancy
     5. 24th week of pregnancy
191. In case of normal pregnancy width of the placenta on the 31th week of gestation is:
     1. 28 mm
     2. \*31 mm
     3. 26 mm
     4. 25 mm
     5. 40mm
192. In case of normal pregnancy width of the placenta on the 36th week of gestation is:
     1. 28 mm
     2. 31 mm
     3. 26 mm
     4. \*36 mm
     5. 40mm
193. We are talking about feto-placental insufficiency in case of:
     1. \*placenta becoming thinner than 20 mm and thicker than 50 mm
     2. placenta becoming thinner than 25 mm and thicker than 50 mm
     3. placenta becoming thinner than 20 mm and thicker than 40 mm
     4. placenta becoming thinner than 30 mm and thicker than 40 mm
     5. placenta becoming thinner than 30 mm and thicker than 55 mm
194. We perform ultrasonography of the fetus in case of normal pregnancy:
     1. 3 times
     2. \*2 times
     3. 4 times
     4. 5 times
     5. 6 times
195. We perform ultrasonography of fetus in case of normal pregnancy:
     1. on the 16-18th week and 36th week of gestation
     2. \*on the 9 - 11th week and 16 - 18th week of gestation
     3. on the 21th week and 36th week of gestation
     4. on the 16-18th week and 26th week of gestation
     5. on the 24-28th week and 30th week of gestation
196. Fetal heart beating and movement we can see on ultrasonography starting from the:
     1. 10-11th week
     2. 17-18th week
     3. \*7-8th week
     4. 4-5th week
     5. 15-16th week
197. Puncture of the fetal cord vessels is:
     1. Amnioscopy
     2. Fetoscopy
     3. \*Cordocentesis
     4. Amniocentesis
     5. Culdocentesis
198. Fetal visualisation in the intrauterus space is called:
     1. Amnioscopy
     2. \*Fetoscopy
     3. Cordocentesis
     4. Amniocentesis
     5. Hysteroscopy
199. Assessment of the lower part of the fetal sac is called:
     1. \*Amnioscopy
     2. Fetoscopy
     3. Cordocentesis
     4. Amniocentesis
     5. Hysteroscopy
200. Assessment of the lower part of the fetal sac is called:
     1. Amniography
     2. Fetoscopy
     3. Cordocentesis
     4. Amniocentesis
     5. \*There is no correct Answer
201. What is the average of transverse diameter of the pelvic inlet?
     1. 11.0 cm
     2. 10.0 cm
     3. 10.5 cm
     4. \*13.0 cm
     5. 12.0 cm
202. All of the below are the indications to hospitalization to pathologic pregnancy department EXEPT:
     1. Pregnancy induced hypertension;
     2. Anemia;
     3. Placental dysfunction
     4. \*Syphilis;
     5. Pyelonephritis
203. The obstetric-gynecological center consists of:
     1. obstetric hospital, female dispensary.
     2. female dispensary, gynecological department.
     3. \*obstetric hospital, female dispensary, gynecological department.
     4. surgical department.
     5. obstetric hospital, female dispensary, department of new-born.
204. What basic function of admitting office?
     1. medical help to the patient in the case of necessity.
     2. general inspection of the patient.
     3. measuring of temperature.
     4. filling of passport part of history of labor.
     5. \*all of the above.
205. All of the below are the indications to hospitalization to pathologic pregnancy department EXEPT:
     1. Pregnancy induced hypertension;
     2. Anemia
     3. Glomerulonephtitis
     4. \*Tuberculosis
     5. Diabetus mellitus
206. What of the following is not an indication for hospitalization to the second obstetric department?
     1. the death of fetus.
     2. rise of temperature of body..
     3. tuberculosis.
     4. \*diabetes.
     5. syphilis.
207. What of the following is an indication for hospitalization to the second obstetric department?
     1. \*antenatal death of fetus.
     2. preeclampsia of III degree.
     3. bleeding.
     4. diabetes.
     5. fetal malpresentation
208. Which of the following is NOT a component of the bony pelvis?
     1. coccyx
     2. sacrum
     3. ischium
     4. \*femoral head
     5. lumbal part of vertebrae
209. Which of the following is NOT a part of the superior boundary of the true pelvis?
     1. linea terminalis
     2. \*linea interspinalis
     3. promontory of the sacrum
     4. pubic bones
     5. no correct answer:
210. The true pelvis is bounded below by which of the following structures?
     1. sacral promontory
     2. alae of sacral
     3. \*pelvic outlet
     4. upper margins of pelvic bone
     5. linea interspinalis
211. What is the average of transverse diameter of the pelvic outlet?
     1. \*11.0 cm
     2. 10.0 cm
     3. 10.5 cm
     4. 11.5 cm
     5. 12 cm
212. What is the average of interspinous diameter?
     1. 8.0 cm
     2. 10.0 cm
     3. \*10.5 cm
     4. 12.0 cm
     5. 9.0 cm
213. Which of the following is distantia spinarum?
     1. \*the distance between anterior superior iliac spines from the both sides
     2. the distance between iliac crista from the both sides
     3. the distance between iliac spines
     4. the distance between trochanter major from the both sides
     5. the distance between ishiadic spines
214. Which of the following is distantia cristarum?
     1. the distance between anterior superior iliac spines from the both sides
     2. \*the distance between iliac crista from the both sides
     3. the distance between iliac spines
     4. the distance between trochanter major from the both sides
     5. the distance between ishiadic spines
215. Which of the following is distantia trochanterica?
     1. the distance between anterior superior iliac spines from the both sides
     2. the distance between iliac crista from the both sides
     3. the distance between iliac spines to the crista ilii
     4. \*the distance between trochanter major from the both sides
     5. the distance between trochanter minor from the both sides
216. Which size of pelvis have normally 25-26 cm?
     1. true conjugate
     2. \*distantia spinarum
     3. distantia cristarum
     4. distantia trochanterica
     5. external conjugate
217. Which size of pelvis have normally 28-29 cm?
     1. true conjugate
     2. distantia spinarum
     3. \*distantia cristarum
     4. distantia trochanteric
     5. external conjugate
218. Which external size of pelvis have 30-31 cm?
     1. true conjugate
     2. distantia spinarum
     3. distantia cristarum
     4. \*distantia trochanterica
     5. external conjugate
219. Which size of pelvis have normally 20-21 cm?
     1. obstetric conjugate
     2. distantia spinarum
     3. distantia cristarum
     4. distantia trochanterica
     5. \*external conjugate
220. What is the average diameter of the obstetrical conjugate?
     1. 8.0 cm
     2. 9.0 cm
     3. 10 cm
     4. 12.0 cm
     5. \*11 cm
221. How is the obstetric conjugate determined?
     1. add 1.5 cm to the diagonal conjugate
     2. subtract 1.5 cm from the external conjugate
     3. the diagonal and true conjugate are equal
     4. add 1.5-2 cm to the true conjugate
     5. \*subtract 1.5-2 cm from the diagonal conjugate
222. What is the average of Solovjov’ index?
     1. 10-12 cm
     2. 12-14 cm
     3. \*14-16 cm
     4. 16-18 cm
     5. 17-19 cm
223. Which is the obstetric conjugate in patient with conjugate externa 21 and Solovjov’ index 15 cm?
     1. \*12 cm
     2. 11 cm
     3. 10 cm
     4. 9 cm
     5. 8 cm
224. Which of the following is NOT a part of the urogenital diaphragm?
     1. urethral sphincter
     2. \*m. transverses perinei profundus
     3. middle perineal fascia
     4. superficial perineal fascia
     5. sphincter ani
225. What is the shortest diameter of the pelvic cavity?
     1. transverse diameter of the pelvic inlet
     2. obstetric conjugate
     3. true conjugate
     4. diagonal conjugate
     5. \*interspinosus
226. Between which bones does sagittal suture is located?
     1. two frontal
     2. two occipital
     3. \*two parietal
     4. two temporal
     5. no correct answer:
227. Which suture is the most important for the recognition of the fetal position during labor?
     1. frontal
     2. coronal
     3. lambdoid
     4. \*sagittal
     5. transversal.
228. Which is the average of suboccipitobregmatic diameter?
     1. \*9.5
     2. 10.0
     3. 10.5
     4. 11.0
     5. 11.5
229. The anterior fontanel is bounded by following bones EXCEPT?
     1. \*occipital
     2. frontal
     3. left parietal
     4. right parietal
     5. no correct answer
230. In the fetus or neonate, what are the two sutures between the frontal and parietal bones?
     1. frontal
     2. sagittal
     3. lambdoid
     4. \*coronal
     5. occipital.
231. The posterior fontanel is bounded by following bones, EXCEPT?
     1. occipital
     2. \*frontal
     3. left parietal
     4. right parietal
     5. no correct answer
232. Which is the diameter of fetal shoulders?
     1. 9 cm
     2. 10 cm
     3. 11 cm
     4. \*12 cm
     5. 13 cm
233. Which of the following diameters is the greatest?
     1. occipitofrontal
     2. biparietal
     3. \*occipitomental
     4. suboccipitobregmatic
     5. suboccipitomental
234. Which suture is NOT composed the anterior fontanel?
     1. coronal
     2. \*lambdoid
     3. sagittal
     4. frontal
     5. all of the above
235. Which is the diameter of fetal pelvic part?
     1. 8.5 cm
     2. 9 cm
     3. \*9.5 cm
     4. 10.5 cm
     5. 11 cm
236. Which size of the pelvis is normally 25-26 cm?
     1. \*spinarum
     2. external conjugate
     3. true conjugate
     4. trochanterica
     5. cristarum
237. Which from the following diameters represents the smallest circumference of the head?
     1. occipitofrontal
     2. suboccipitofrontal.
     3. bitemporal
     4. biparietal
     5. \*suboccipitobregmatic
238. When the production of amniotic fluids begin?
     1. \*from a 12 day of pregnancy
     2. from the 24th day of pregnancy
     3. from 12 weeks of pregnancy
     4. from 20 weeks of pregnancy
     5. from 24 weeks of pregnancy
239. When the fertilized ovum is called “conceptus”?
     1. 1 week after fertilization;
     2. \*2 weeks after fertilization;
     3. during all pregnancy.
     4. 3 weeks after fertilization;
     5. 5 weeks after fertilization.
240. What is the „cortical reaction”?
     1. capacity of spermatozoon for the ovum penetration;
     2. result of spermatozoa capacity;
     3. \*impenetrability of shell of ovum after fertilization for other spermatozoa;
     4. release of ovum from an corona radiata.
     5. the moment of fertilization
241. What stage of development does an embryo get on in an uterus?
     1. 2 blastomers;
     2. 4 blastomers;
     3. morula;
     4. \*blastocyst.
     5. embryo.
242. What length is the fetus on the 6 th month of pregnancy?
     1. 16 cm;
     2. 25 cm;
     3. 30 cm;
     4. \*35 cm;
     5. 40 cm.
243. What week of fetal development transition to placental circulation of blood is completed on?
     1. \*on a 12-14 week;
     2. on a 10-12 week;
     3. on a 8-10 week;
     4. on a 6-8 week;
     5. on a 4-6 week.
244. During what time of development the result of conception is named an embryo?
     1. from the moment of fertilization to the moment of placentation;
     2. from the 2nd week of development to 12-14th week;
     3. \*from the 3rd week of development to 10th one;
     4. from a 4th week to 8th one.
     5. from the moment of implantation to the 12th week.
245. What composition of amniotic fluids from composition of plasma of the maternal blood differs by?
     1. by the higher level of proteins
     2. \*by lower level of proteins
     3. by the higher level of estrogens
     4. by more low level of estrogens
     5. by the higher level of progesteron
246. What parts of the feto-placental complex stay in uterus after the fetal birth?
     1. \*placenta, membranes, umbilical cord, decidua;
     2. placenta, amniotic fluids, umbilical cord;
     3. placenta, decidua, umbilical cord;
     4. placenta, amnion and chorion membranes,
     5. all of the above
247. On which day after fertilization implantation occur?
     1. on 3-4th day;
     2. on 5-6 day;
     3. \*on 7-8 day
     4. on 9-10 day.
     5. on 10-12 day
248. What is the acrosomic reaction?
     1. increasing of high motive activity of spermatozoa;
     2. process of capacity;
     3. process of confluence of gamete nucleus;
     4. \*possibility to the penetration membranes of ovum
     5. loss of motive activity.
249. The amniotic fluid execute such functions EXCEPT:
     1. an umbilical cord is protected from the compression;
     2. fluid are created conditions for development and motions of fetus;
     3. aiding to dilatation of cervix;
     4. \*the feeding of the fetus is provided;
     5. a fetus is protected from the mechanical damage,
250. Name the fetal membranes, beginning from uterus:
     1. \*decidua, chorion, amnion;
     2. decidua, amnion, chorion;
     3. amnion, decidua, chorion;
     4. amnion, chorion, decidua;
     5. chorion, decidua, amnion.
251. What quantity of amniotic fluids is considered normal on the 38th week of pregnancy?
     1. less than 0,5;
     2. 0,5-0,8 l;
     3. 0,5-1,0 l;
     4. \*1,0-1,5 l;
     5. 1,5-2,5 l.
252. What process is typical for the nervous system at pregnant?
     1. depression
     2. emotional instability
     3. the dominant of pregnancy is formed
     4. the changes of the taste
     5. \*all answers are correct
253. What process is typical for adaptation of the cardiac system to pregnancy?
     1. reduction of blood volume
     2. \*increase of volume of blood on 30-50%
     3. reduction of plasma volume
     4. increase of blood volume on 10-20%
     5. increase of blood volume on 60-70%
254. What level of gaemoglobin is considered normal for pregnant?
     1. 130-140 g/l
     2. 120-130 g/l
     3. \*110-140 g/l
     4. 100-110 g/l
     5. 120-160 g/l
255. What amount of leucocytes is considered as a normal in pregnant?
     1. 5-7,5х109
     2. 7,2-10,6х109
     3. 4-8,8х109
     4. \*5,0-12х109
     5. 7,7-15,6х109
256. If at pregnant at the protracted position on the back there are bradycardia, decreasing of BP, dizziness, it testifies to:
     1. cardiac pathology
     2. organic heart disease
     3. decompensation of cardiac activity
     4. \*syndrome of lower hollow vein
     5. disorders of placental circulation
257. Which cervical dilation indicates 5 cm contractile ring station above the symphysis?
     1. 1 cm
     2. 2 cm
     3. \*5 cm
     4. 3 cm
     5. 4 cm
258. What blood changes arise up at pregnant before the labor?
     1. the level of leucocytes rises
     2. \*coagulative properties of blood rise
     3. the level of red blood cells rises
     4. the volume of circulatory blood goes down
     5. hypovolemia increases
259. What is the reason of heartburn at pregnant?
     1. rise of gastric juice acidity
     2. \*decreasing of tone of cardial sphincter of stomach
     3. rise of stomach activity
     4. violation of diet
     5. disease of stomach
260. Which contractile ring station above the symphysis indicates to 2cm cervical dilation?
     1. \*2 cm above the symphysis
     2. 1 cm above the symphysis
     3. 5 cm above the symphysis
     4. 3 cm above the symphysis
     5. 4 cm above the symphysys
261. What factors assist to frequent development of pyelonephritis at pregnant?
     1. shortening of ureters
     2. \*vezico-ureteral reflux
     3. frequent urination
     4. all answers are correct
     5. the correct answer is not present
262. What hormone provides the “muscular relax” of uterus?
     1. estrogens
     2. \*progesteron
     3. prolactin
     4. oxytocin
     5. placental lactogen
263. What is the weight of uterus at the end of pregnancy?
     1. 400-500 g
     2. 500-800 g
     3. 800-1000 g
     4. \*1000-1500 g
     5. 1500-2000 g
264. What hormone stimulates the appetite at pregnant?
     1. progesteron
     2. estrogens
     3. \*insulin
     4. prolactin
     5. lactogen
265. What is the normal weight gain in pregnant?
     1. on 5-7 kg
     2. on 7-8 kg
     3. \*on 8-12 kg
     4. on 10-16 kg
     5. individually
266. Which sources of calcium are the best for pregnant’ diet?
     1. garden fruits
     2. \*cheese and milk
     3. fish
     4. bread
     5. meat and liver
267. Which sources of iron are the best for pregnant’ diet?
     1. \*meat and liver
     2. apricots
     3. the baked potatoes
     4. milk
     5. all of the above
268. What quantity of liquid is used by pregnant in the second half of pregnancy?
     1. as few as possible
     2. 0,8-1 l
     3. \*1-1,2 l
     4. 1,5-2 l
     5. without limitations
269. What period a fetus is the most sensible to the harmful factors?
     1. in a 1-7 day after the implantation
     2. \*from 3th to the 8th week of pregnancy
     3. from 5 to a 16 week of pregnancy
     4. from 32th to the 36th week of pregnancy
     5. during all pregnancy
270. What is important during conducting of test on pregnancy in early terms?
     1. \*to use morning portion of urine
     2. sterility of urine
     3. to collect urine after the careful hygiene of external genitalia
     4. before conducting of test a woman must not use fat food
     5. all answers are correct
271. Standard urine pregnancy test is positive arproximately
     1. 1-2 week after last menstrual period
     2. 12 day after last menstrual period
     3. 3 weeks after last menstrual period
     4. \*4 weeks after last menstrual period
     5. 16 days after last menstrual period
272. From what week by means the ultrasound it is possible to expose cardiac activity of fetus?
     1. on a 2-3 day after the implantation
     2. on 2 weeks of pregnancy
     3. on 3 weeks of pregnancy
     4. on 4 weeks of pregnancy
     5. \*on a 8 week of pregnancy
273. What information about the menstrual function of woman will help to set the term of pregnancy?
     1. age of beginning of menstruations
     2. regularity of menstruations
     3. duration of menstrual cycle
     4. \*date of the first day of the last menstruation
     5. all the above
274. What question is more important only at collection of anamnesis on a genital function?
     1. quantity of pregnancies
     2. quantity of labors
     3. quantity of abortions
     4. presence of complications during previous pregnancies
     5. \*all the above
275. What term of pregnancy does a multipara feel the first motions of fetus?
     1. in 17 weeks of pregnancy
     2. \*in 18 weeks of pregnancy
     3. in 20 weeks of pregnancy
     4. at 22 weeks of pregnancy
     5. at 24 weeks of pregnancy
276. What form of external cervical os at a nulliparous woman?
     1. \*round
     2. transversal
     3. irregular form
     4. a right answer is not present
     5. right answers B also C
277. It is exposed at bimanual examination, that the isthmus of uterus is softened; the ends of fingers are easily touch together. Who described this sign?
     1. Genter;
     2. Goubarev;
     3. Piscachec;
     4. Snegirov;
     5. \*neither of the above authors.
278. During bimanual research a doctor exposed considerable softening the uterine isthmus. What scientist described this sign?
     1. \*Gegar;
     2. Genter;
     3. Piscachek;
     4. Snegirov;
     5. neither of above
279. Sign Gorvits-Gegar – this:
     1. easy displacement of uterus
     2. \*softening of isthmus of uterus
     3. appearance of asymmetry of uterus
     4. appearance of the thickness on the front surface of uterus
     5. easy changeability of consistency of uterus
280. The Gegar’ sign becomes manifest at:
     1. in 4-5 weeks of pregnancy
     2. \*in 5-6 weeks of pregnancy
     3. in 6-8 weeks of pregnancy
     4. in 8-10 weeks of pregnancy
     5. in 12 weeks of pregnancy
281. What functions are executed by a placenta?
     1. interchange of gases;
     2. trophic;
     3. excretic;
     4. protects an umbilical cord from the compression;
     5. \*all the above
282. What sign of pregnancy belongs to probable?
     1. nausea, vomiting;
     2. palpation of fetal parts in uterus;
     3. \*uterine enlargement;
     4. changes of taste;
     5. all the above
283. What sign of pregnancy does not belong to presumptive?
     1. \*auscultation to fetal heart rate ;
     2. nausea, vomits in the morning;
     3. change of taste;
     4. fatigue;
     5. all the above.
284. What sign of pregnancy belongs to positive?
     1. change of taste;
     2. stopping of menstruations;
     3. cyanosis of uterine cervix;
     4. uterine enlargement;
     5. \*neither of above.
285. What sign of pregnancy does not belong to positive?
     1. palpation of fetal parts ;
     2. \*stopping of menstruations;
     3. auscultation to fetal heart rate ;
     4. presence of motions of fetus;
     5. all the above
286. What sign of pregnancy does not belong to positive?
     1. palpation of fetal parts in an uterus;
     2. auscultation to fetal heart rate ;
     3. results of ultrasonic examination;
     4. \*stopping of menstruations;
     5. all the above.
287. What sign of pregnancy belongs to positive?
     1. increase of abdomen;
     2. stopping of menstruations;
     3. \*auscultation to fetal heart rate;
     4. uterine enlargement;
     5. all the above;
288. Term "longitudinal" lie of fetus in uterus is called as?
     1. habitus flexus
     2. \*situs longitudinalis
     3. situs obliqus
     4. presentatio cerhalica
     5. positio I
289. What term “oblique lie” of fetus in uterus is determined by?
     1. habitus obliqus
     2. situs longitudinalis
     3. \*situs obliqus
     4. presentatio obliqua
     5. positio obliqua
290. A fetus is situated in the first position, if:
     1. \*its back is to the left wall of uterus;
     2. its back is to the right wall of uterus;
     3. its back is to the front wall of uterus;
     4. its back is to the back wall of uterus.
     5. no correct answer
291. The fetal attitude:
     1. \*relation of head and extremities of fetus to its trunk
     2. attitude of vertical axis of fetus toward the axis of uterus
     3. attitude of axis of fetus toward the axis of pelvis
     4. attitude of the back of fetus toward the lateral walls of uterus
     5. attitude of head toward the entrance in a pelvis
292. If the axis of fetus and uterus are perpendicular, head to the right, this is:
     1. longitudinal lie
     2. oblique lie, I position
     3. oblique lie, ІІ position
     4. transversal lie, I position
     5. \*transversal lie, ІІ position
293. Where is the best place for auscultation of the fetal heart rate at longitudinal lie, cephalic presentation, ІІ position, anterior variety?
     1. right side, higher than umbilicus;
     2. on the left, higher than umbilicus;
     3. on the left, below than umbilicus;
     4. \*right side, below than umbilicus.
     5. at the level of umbilicus, on the left
294. Where is the best place for auscultation of the fetal heart rate at longitudinal lie, breech presentation, I position, anterior variety?
     1. right side, higher than umbilicus;
     2. \*on the left, higher than umbilicus;
     3. on the left, below than umbilicus;
     4. right side, below than umbilicus.
     5. at the level of umbilicus, on the left
295. Where is the best place for auscultation of the fetal heart rate at longitudinal lie, breech presentation, ІІ position, anterior variety?
     1. \*right side, higher than umbilicus;
     2. on the left, higher than umbilicus;
     3. on the left, below than umbilicus;
     4. right side, below than umbilicus.
     5. at the level of umbilicus, on the left
296. All of the below can determine by the second Leopold’ maneuver EXEPT:
     1. \*height of standing of uterine fundus
     2. variety of the fetus
     3. position of fetus
     4. Fetal movements
     5. quantity of amniotic fluid.
297. Where is the best place for auscultation of the fetal heart rate at transversal lie, I position, anterior variety?
     1. right side, higher than umbilicus;
     2. on the left, higher than umbilicus;
     3. on the left, below than umbilicus;
     4. right side, below than umbilicus.
     5. \*at the level of umbilicus, on the left
298. What we determine by the third Leopold’ maneuver?
     1. height of standing of uterine fundus;
     2. \*presenting part;
     3. variety and position of fetus;
     4. attitude of fetus toward the entrance in a pelvis.
     5. quantity of amniotic fluid.
299. What we determine by the fourth Leopold’ maneuver?
     1. height of standing of uterine fundus;
     2. presenting part;
     3. variety and position of fetus;
     4. \*attitude of fetus toward the entrance in a pelvis.
     5. quantity of amniotic fluid.
300. Which in a norm the frequency of fetal heart rate?
     1. \*110-170 in 1 min.
     2. 110-190 in 1 min.
     3. 100-140 in 1 min.
     4. 100-120 in 1 min.
     5. 120-180 in 1 min.
301. What reference points the abdominal circumference in pregnant is measured at?
     1. at the level of spina iliaca posterior-inferior and umbilicus
     2. at the level of spina iliaca anterior-superior and umbilicus
     3. \*at the level of spina iliaca posterior-superior and umbilicus
     4. at the level of middle spina iliaca and umbilicus
     5. at the level of the back sacrum os and umbilicus
302. What term of pregnancy, if the uterine fundus is found at the level of umbilicus?
     1. 16 weeks;
     2. \*24 weeks;
     3. 28 weeks;
     4. 30 weeks.
     5. 36 weeks
303. What term of pregnancy, if the uterine fundus is found at the level of pubis?
     1. \*12 weeks;
     2. 14 weeks;
     3. 16 weeks;
     4. 18 weeks.
     5. 20 weeks
304. Indicate term of pregnancy when uterine fundus is found at the level of umbilicus?
     1. 16 weeks;
     2. \*24 weeks;
     3. 28 weeks;
     4. 30 weeks.
     5. 36 weeks
305. In Which Leopold’ maneuver the presenting part of fetus is determined?
     1. first;
     2. second;
     3. \*third;
     4. fourth.
     5. any
306. In which Leopold’ maneuver the level of uterine fundus is determined?
     1. \*first;
     2. second;
     3. third;
     4. fourth.
     5. any
307. The last menstruation at a woman was 12.07. 2012. Define the date of the expected labor, using a formula Negele.
     1. \*19.04.13
     2. 19.03.13
     3. 5.04.13
     4. 12 04.13
     5. 5.10.13
308. What percentages of fetuses are born in the occiput presentation at term?
     1. 80
     2. 85
     3. 90
     4. \*95
     5. 99
309. What is the most common presentation of the fetus?
     1. posterior occiput
     2. breech
     3. face
     4. brow
     5. \*anterior occiput
310. Which of the following is characteristic of synclitism?
     1. Sagittal suture is not parallel to the transverse axis of the inlet.
     2. \*Sagittal suture lies midway between the symphysis and sacral promontory.
     3. Sagittal suture, although parallel to the transverse axis of the inlet, does not lie exactly midway between the symphysis and sacral promontory.
     4. Sagittal suture rotates 45 degrees from the sacral spines.
     5. Sagittal suture lies closer to symphysis
311. Which of the following is characteristic of posterior asynclitism?
     1. \*Sagittal suture lies closer to symphysis.
     2. Sagittal suture lies midway between the symphysis and sacral promontory.
     3. Sagittal suture, although parallel to the transverse axis of the inlet, does not lie exactly midway between the symphysis and sacral promontory and lies closer to promontory.
     4. Sagittal suture rotates 45 degrees from the sacral spines.
     5. None of the above.
312. During which cardinal movement of labor the fetal head delivered in anterior occiput presentation?
     1. \*extension
     2. internal rotation
     3. external rotation
     4. expulsion
     5. flexion
313. When the internal rotation of the fetal head does begin?
     1. in the plane of pelvic inlet
     2. in the greatest pelvic dimension
     3. in the plane of the least pelvic dimension
     4. \*when the head descents from the plane of the greatest pelvic dimension to the plane of the least pelvic dimension
     5. on the pelvic floor
314. Where the internal rotation of the fetal head is complete?
     1. in the plane of pelvic inlet
     2. in the greatest pelvic dimension
     3. in the plane of the least pelvic dimension
     4. when the head descents from the plane of the greatest pelvic dimension to the plane of the least pelvic dimension
     5. \*on the pelvic floor
315. In the result of the internal rotation of the fetal head the sagittal suture is
     1. in the transversal size of pelvic inlet
     2. in the oblique size of the greatest pelvic dimension
     3. in the anterior-posterior size of the greatest pelvic dimension
     4. in the anterior-posterior size of the least pelvic dimension
     5. \*in the anterior-posterior size of the pelvic outlet
316. The anterior shoulder appears under the symphysis during which cardinal movement of labor?
     1. extension
     2. expulsion
     3. \*external head rotation
     4. descent
     5. internal head rotation
317. The base of the occiput is brought into contact with the inferior margin of the symphysis during which cardinal movement of labor?
     1. \*extension
     2. expulsion
     3. descent
     4. flexion
     5. external rotation
318. What is the leading point in the anterior occiput presentation?
     1. fossa occipitalis
     2. tuber occipitalis
     3. the area of the border of the hair part
     4. the midpoint of sagittal suture
     5. \*small fontanel
319. What is the leading point in the posterior occiput presentation?
     1. fossa occipitalis
     2. tuber occipitalis
     3. the area of the border of the hair part
     4. \*the midpoint of sagittal suture
     5. small fontanel
320. How much centimetres does the suboccipitobregmaticus diameter have?
     1. 14 cm
     2. \*9,5 cm
     3. 12 cm
     4. 11 cm
     5. 10 cm
321. What is the first fixing point in the posterior occiput presentation?
     1. small fontanel
     2. tuber occipitalis
     3. \*the area of the border of the hair part
     4. the midpoint of sagittal suture
     5. fossa suboccipitalis
322. Which diameter of the fetal head presents in the anterior occiput presentation?
     1. fronto-occipitalis
     2. \*suboccipitobregmatic
     3. biparietal
     4. sagittal suture
     5. bitemporal
323. What is the presentation if Leopold maneuvers reveal the following: (1) breech in fundus, (2) resistant plane palpated through mother’s right flank, (3) head movable, (4) cephalic prominence on maternal left?
     1. breech presentation, I position
     2. breech presentation, II position
     3. occiput presentation, I position
     4. \*occiput presentation, II position
     5. transversal presentation
324. What are the cardinal movements of labor in anterior occiput presentation (in order)?
     1. descent, flexion, internal rotation, extension, expulsion
     2. flexion, engagement, internal rotation, external rotation
     3. \*flexion, internal rotation, extension, external rotation of the head, internal rotation of the body
     4. flexion, descent, internal rotation, extension, expulsion
     5. internal rotation, extension, external rotation, flexion
325. What are the cardinal movements of labor in posterior occiput presentation (in order)?
     1. descent, flexion, internal rotation, extension, expulsion
     2. flexion, engagement, internal rotation, external rotation
     3. flexion, internal rotation, extension, external rotation
     4. \*flexion, internal rotation, additional flexion. extension, expulsion
     5. additional flexion, internal rotation, extension, additional extension, external rotation
326. Which circumference the fetal head is delivered in anterior occiput presentation?
     1. \*32 cm
     2. 33 cm
     3. 34 cm
     4. 36 cm
     5. 38 cm
327. Which circumference the fetal head is delivered in posterior occiput presentation?
     1. 32 cm
     2. \*33 cm
     3. 34 cm
     4. 36 cm
     5. 38 cm
328. Which of the following is essential for the generation of uterine contractions?
     1. prostaglandins
     2. calcium
     3. estrogen
     4. oxytocin
     5. \*all of the above
329. Where is oxytocin primarily synthesized?
     1. adrenal gland
     2. placenta
     3. anterior pituitary
     4. ovary
     5. \*posterior pituitary
330. All processes play the part in the labor initialization EXEPT
     1. \*progesterone increases
     2. prostaglandins increase
     3. oxytocin increases
     4. estrogens increases
     5. serotonin increases
331. The basic elements involved in the uterine contractile system, EXEPT
     1. actin
     2. myosin
     3. adenosine triphospate
     4. calcium
     5. \*estrogens
332. What is the most important in the characteristic of the uterine contractions?
     1. strong
     2. \*regular
     3. moderate
     4. painful
     5. strenght
333. Which labor forces are present in I stage of labor?
     1. false uterine contractions
     2. \*true uterine contractions
     3. uterine contractions and pushing
     4. pushing
     5. all of the above
334. Which labor forces are present in II stage of labor?
     1. false uterine contractions
     2. true uterine contractions
     3. \*uterine contractions and pushing
     4. pushing
     5. all of the above
335. Which labor forces are present in III stage of labor?
     1. false uterine contractions
     2. true uterine contractions
     3. \*uterine contractions and pushing
     4. pushing
     5. all of the above
336. Which moment is the beginning of I stage of labor?
     1. \*onset of regular uterine contractions
     2. complete dilatation of cervix
     3. rupture of amniotic sac
     4. onset of pushing
     5. delivery of the fetus
337. Which moment is the end of II stage of labor?
     1. onset of uterine contractions
     2. complete dilatation of cervix
     3. rupture of amniotic sac
     4. complete cervical effacement
     5. \*delivery of the fetus
338. Which moment is the beginning of III stage of labor?
     1. \*separation of placenta
     2. complete dilatation of cervix
     3. rupture of amniotic sac
     4. complete cervical effacement
     5. delivery of the fetus.
339. Which moment is the end of 3 stage of labor?
     1. onset of pushing
     2. complete dilatation of cervix
     3. separation of placenta
     4. \*expulsion of placenta
     5. delivery of the fetus
340. Which of the following is NOT associated with II stage of labor?
     1. uterine contractions
     2. \*placental separation
     3. fetal expulsion
     4. pushing
     5. fetal internal rotation
341. Which of the following is NOT associated with III stage of labor?
     1. uterine contractions
     2. placental expulsion
     3. placental separation
     4. pushing
     5. \*fetal internal rotation
342. Which of the following characterizes I stage of labor?
     1. myometrial relaxation
     2. uterine awakening
     3. fetal expulsion
     4. pushing
     5. \*cervical dilatation
343. Which contraction duration (sec) characterizes active labor?
     1. 20
     2. 30
     3. \*60
     4. 90
     5. 100
344. What is the minimal dilatation during the first stage of labor in multiparous?
     1. 0,5-0,8 cm/hour
     2. 0,8-1.0 cm/hour
     3. 1.0-1.2 cm/hour
     4. \*1.2-1.5 cm/hour
     5. 2.0-2.5 cm/hour
345. What is the most important measure of labor progression?
     1. contraction frequency
     2. contraction intensity
     3. contraction duration
     4. \*cervical dilatation
     5. cervical effacement
346. Which of the following characterizes phase 2 of labor?
     1. \*fetal expulsion
     2. uterine awakening
     3. cervical effacement
     4. cervical dilatation
     5. placental separation
347. Which of the following characterizes III stage of labor?
     1. myometrial tranquility
     2. fetal expulsion
     3. cervical effacement
     4. cervical dilatation
     5. \*placental separation
348. Where are prostaglandins synthesized?
     1. adrenal gland
     2. placenta
     3. posterior pituitary
     4. ovary
     5. \*decidua
349. Which of the following is characteristic the I stage of true labor?
     1. irregular contractions
     2. discomfort in lower abdomen
     3. \*cervical dilatation
     4. discomfort relieved by sedation
     5. fetal expulsion
350. How often should the fetal heart rate be auscultated during the second stage of labor?
     1. 5 min
     2. 10 min
     3. 15 min
     4. 30 min
     5. \*after every uterine contraction
351. What is the maximal duration of the second stage of labor in primiparas?
     1. 5 min
     2. 20 min
     3. 50 min
     4. 100 min
     5. \*120 min
352. What is the station where the presenting part is at the level of the ischial spines?
     1. -2
     2. -1
     3. \*0
     4. +1
     5. +2
353. What is the station where the presenting part is at the level of the pelvic inlet?
     1. \*-2
     2. -1
     3. 0
     4. +1
     5. +2
354. When the cervix and vagina should be inspected for lacerations?
     1. after first signs of placental separation
     2. after fetal delivery
     3. \*after placental delivery
     4. after suturing of the lacerations of vagina
     5. 2 hours after delivery
355. Which is the first of perineal protective maneuver?
     1. the decreasing of perineal tension
     2. the delivery of the fetal head out of the pushing
     3. delivery of the shoulders
     4. \*prevention of preterm fetal extension
     5. regulation of maternal efforts
356. Which is the second of perineal protective maneuver?
     1. the decreasing of perineal tension
     2. \*the delivery of the fetal head out of the pushing
     3. delivery of the shoulders
     4. prevention of preterm fetal extension
     5. regulation of maternal efforts
357. Which is the third of perineal protective maneuver?
     1. \*the decreasing of perineal tension by borrowing tissues
     2. the delivery of the fetal head out of the pushing
     3. delivery of the shoulders
     4. prevention of preterm fetal extension
     5. regulation of maternal efforts
358. Which is the fourth of perineal protective maneuver?
     1. the decreasing of perineal tension
     2. the delivery of the fetal head out of the pushing
     3. delivery of the shoulders
     4. prevention of preterm fetal extension
     5. \*regulation of maternal efforts
359. Which is the fifth of perineal protective maneuver?
     1. the decreasing of perineal tension
     2. the delivery of the fetal head out of the pushing
     3. \*delivery of the shoulders
     4. prevention of preterm fetal extension
     5. regulation of maternal efforts
360. What is the most reliable indicator of rupture of the fetal membranes?
     1. fluid per cervical os
     2. positive nitrazine test
     3. positive ferning test
     4. membranes are not palpated
     5. \*all of the above
361. Which moment of the fetal membranes rupture is considered as a normal?
     1. before the beginning of uterine contraction
     2. at the beginning of I stage of labor
     3. at the end of I stage of labor
     4. at the beginning of II stage of labor
     5. \*all of the above
362. What is the maximal duration of the third stage of labor?
     1. 5 min
     2. 20 min
     3. \*30 min
     4. 50 min
     5. 120 min
363. How often during the first stage of labor should the fetal heart rate be auscultated in a low-risk pregnancy?
     1. every 5 min before a contraction
     2. \*every 15 min after a contraction
     3. every 40 min before a contraction
     4. every 45 min after a contraction
     5. after every uterine contraction
364. The pregnant woman at term complaints on the irregular lower abdomen pains. The cervix is not effaced, close. What is the diagnosis?
     1. second stage of labor
     2. the beginning of the first stage of labor
     3. the end of the first stage of labor
     4. \*the false labor
     5. third stage of labor
365. The pregnant woman at term complaints on the regular lower abdomen pains. The cervix is effaced, dilated on 2-3 cm. What is the diagnosis?
     1. second stage of labor
     2. \*latent phase of first stage of labor
     3. the end of the first stage of labor
     4. the false labor
     5. third stage of labor
366. The baby was born 5 min ago. The signs of placental separation are negative. The bleeding begins. The blood lost is 450 ml. What is the doctor’s tactic?
     1. to continue the observation
     2. \*to perform the manual placental separation
     3. to propose the patient to push
     4. to pull on the umbilical cord
     5. to perform the massage of the uterus
367. What factor is determining the forming of pain intensity during labor?
     1. level of oxytocin in the organism;
     2. \*level of pain sensitiveness;
     3. force of cerebral impulses;
     4. force of uterine contractions;
     5. patient’s behavior.
368. What is the aim of conducting of psychoprophylaxis classes?
     1. to remove the emotional component of labor pain;
     2. to remove the sense of fear;
     3. to form the positive dominant of labor;
     4. to acquaint with duration of labor act;
     5. \*all transferred.
369. What is the aim of a I psychoprophylaxis class?
     1. \*to acquaint the patient with an anatomy and physiology of female genitalia and processes, that take place in an organism during labor;
     2. to teach patient to behave correctly in I period of labor, to use the methods of anaesthetizing;
     3. to teach the patient to push correctly;
     4. to teach the patient to breathe between pushing correctly;
     5. to acquaint pregnant with physiology duration of puerperium and to take care of new-born.
370. What is the aim of ІІ psychoprophylaxis class?
     1. to acquaint patient with an anatomy and physiology of female genitalia and processes, that take place in an organism during labor;
     2. \*to teach patient to behave correctly in I period of labor, to use the methods of anaesthetizing;
     3. to teach the patient to push correctly;
     4. to teach the patient to breathe between pushing correctly;
     5. to acquaint pregnant with physiology duration of puerperium and to take care of new-born.
371. What is an obligatory condition for the beginning of the medicinal anaesthetizing of labor?
     1. the fluid gash;
     2. normal feto-pelvic proportions;
     3. physiology duration of labor;
     4. \*presence of regular uterine contractions and opening of uterine cervix on 3-4 cm;
     5. primapara.
372. What condition is obligatory for the beginning of the medicinal anaesthetizing of labor?
     1. \*opening of uterine cervix on 3-4 cm;
     2. normal feto-pelvic proportions;
     3. physiology duration of labor;
     4. the fluid gash;
     5. primapara.
373. What side effect of promedol limits the term of its introduction in labor?
     1. \*depresses the respiratory center of fetus;
     2. causes bradicardia at a mother;
     3. causes a somnolence;
     4. causes tachicardia at a mother;
     5. causes the allergic reactions.
374. What is the peculiarity of introduction of promedol for anaesthetizing of labor?
     1. \*should be given at least 2 hours to the birth of fetus;
     2. should be given only in the ІІ period of labor;
     3. should be given only one time;
     4. should be given only intravenously;
     5. should be given in combination with spasmolytics.
375. What requirement is obligatory for medicines, which are used for the medicinal anaesthetizing?
     1. to decrease the uterine contractions;
     2. to improve the state of fetus;
     3. \*do not depress the contractive activity of uterus;
     4. not to cause a somnolence;
     5. to have short time of action.
376. What medicine is used for the protracted operations with uterine relaxation?
     1. trilen;
     2. viadril;
     3. promedol;
     4. nitrous oxide;
     5. \*phtorotan.
377. The second stage of labor at patient is finished by obstetric forceps applying. What anaesthetizing is the best?
     1. inhalation anesthesia;
     2. epidural anesthesia;
     3. \*intravenous anesthesia;
     4. local anaesthetizing;
     5. it is possible to perform without any anesthesia.
378. Which of the follows is the most effective for cervical dilation in the I stage of labor?
     1. analgin in pills;
     2. no-shpa in pills;
     3. novocaine 0,25%;
     4. \*baralgin 5 ml intravenously;
     5. papaverin 2% 2 ml i/m.
379. What method of anaesthetizing is used in I and ІІ stage of preterm labor?
     1. \*epidural anesthesia;
     2. inhalation anesthesia;
     3. intravenous anesthesia;
     4. local anaesthetizing;
     5. spazmolitics.
380. What middle weight of uterus at once after labor?
     1. 100-200 g;
     2. 300-400 g;
     3. 500-600 g;
     4. 700-800 g;
     5. \*900-1000 g.
381. How long is the early puerperium?
     1. 30 min;
     2. 3 days
     3. 12 days;
     4. \*2 hours
     5. 6-8 weeks.
382. Lochia rubra consist of all the following, EXEPT
     1. blood
     2. shreds of the membranes
     3. \*parts of placenta
     4. decidual membrane
     5. erythrocytes.
383. Lochia alba consist of all the following, EXEPT
     1. \*blood
     2. mucus
     3. leucocytes
     4. decidual cells
     5. erythrocytes.
384. What level the fundus of uterus on the 1 day after labor is found at?
     1. \*on a 1 transversal finger below than umbilicus;
     2. on 2 transversal fingers below than umbilicus;
     3. on 2 transversal fingers higher than pubis;
     4. on a middle between a umbilicus and pubis;
     5. at the level of pubis.
385. What level the fundus of uterus on a 4th day after labor is found at?
     1. on a 1 transversal finger below than umbilicus;
     2. on 2 transversal fingers below than umbilicus;
     3. \*on a middle between an umbilicus and pubis;
     4. on 2 transversal fingers higher than pubis;
     5. at the level of pubis.
386. What character does lochia in first 3 days after labor have?
     1. \*bloody;
     2. bloody-serosal;
     3. serosal-bloody;
     4. serosal;
     5. mucousal.
387. What character does lochia on a 7-9 day after labor have ?
     1. bloody;
     2. bloody-serosal;
     3. serosal;
     4. \*serosal-bloody;
     5. mucous.
388. What character does lochia on a 10 day after labor have?
     1. bloody;
     2. bloody-serosal;
     3. serosal-bloody;
     4. \*serosal;
     5. mucous.
389. What affirmation in relation to the state of cervix just after labor is correct?
     1. the cervix is closed;
     2. the cervix admits a 1 transversal finger;
     3. the cervix admits 3-4 transversal fingers;
     4. the cervix is formed.
     5. \*the cervix admits a hand;
390. What assertion in relation to the state of cervix on a 9 day after labor is correct?
     1. the cervix is closed;
     2. \*the cervix admits a 1 transversal finger;
     3. the cervix admits 3-4 transversal fingers;
     4. the cervix admits a hand;
     5. the cervix is formed.
391. What hormone response for proliferation of secretory tissue of breast ?
     1. prolactin;
     2. lyoteinizied hormone;
     3. \*estrogens;
     4. prostaglandins;
     5. corticosteroids.
392. What factor can be negatively reflected on the gemodinamic parameters of puerperal woman at first hours of puerperium?
     1. fatigue after the labor;
     2. beginning of lactation;
     3. contraction of uterus;
     4. perineal ruptures;
     5. \*stopping of functioning of utero-placental circle of blood circulation and related to it redistribution of blood.
393. What complications can develop due to the incorrect suturing of cervical rupture in a future?
     1. \*cervical ectropion;
     2. violation of function of pelvic muscles;
     3. prolaps of uterus;
     4. endometritis;
     5. bleeding.
394. Physiological blood lost of puerperal woman by mass 76 kg is:
     1. 260 ml;
     2. \*380 ml;
     3. 320 ml;
     4. 240 ml;
     5. 450 ml.
395. What assertion is wrong in relation to a colostrum?
     1. the producing started on 2nd day after labor;
     2. is the yellow liquid;
     3. \*the producing started on 4-5th day after labor;
     4. contains the high quantity of fats;
     5. contains albumens and antibodies.
396. For a valuable lactation there are the necessary following factors, except for:
     1. early applying of child to the breasts;
     2. correct technique of applying the baby to the breasts;
     3. rational feeding of the mother;
     4. feeding of child “on call”;
     5. \*feeding of child exactly on hours.
397. The physiologycal blood lost of puerperal woman by mass 64 kg is:
     1. 260 ml;
     2. 380 ml;
     3. \*320 ml;
     4. 240 ml;
     5. 450 ml.
398. What hormone is produced by a pituitary gland under the act of nipple compression at feeding of child?
     1. oxythocin;
     2. vasopressin;
     3. progesteron;
     4. \*prolactin;
     5. estradiol.
399. What is contra-indication for mother and child staying togetherin postnatal wards?
     1. perineal rupture 1st;
     2. cervical rupture;
     3. uterine subinvolution;
     4. the birth trauma of child;
     5. \*preeclampsia ІІІ st.
400. All of below is recommended for the diet of lactating woman, except:
     1. \*plenty of fluids;
     2. adequate amount of protein
     3. plenty of vitamins, fat, minerals
     4. limitation of the use of liquid;
     5. high calories.
401. What is excluded from the diet of lactating woman?
     1. plenty of fluids;
     2. adequate amount of protein
     3. \*chocolate
     4. milk;
     5. meat.
402. What the uterine subinvolution is?
     1. \*deceleration of process of uterine involution;
     2. speed-up of the uterine involution;
     3. delay of lochia in the uterine cavity;
     4. initial stage of endometritis;
     5. slow closing of cervix.
403. At which time of puerperium does milk become mature?
     1. on 2-3;
     2. \*on 5-6;
     3. on 8-10;
     4. on 10-12;
     5. on 15-16.
404. Whant is the maximal physiologycal blood lost in labor?
     1. 0,1 % from body weight
     2. 0,3 % from body weight
     3. \*0,5 % from body weight
     4. 0,7 % from body weight
     5. 1 % from body weight
405. Physiologycal blood lost of puerperal woman by mass 68 kg is:
     1. 260 ml;
     2. 380 ml;
     3. 360 ml;
     4. \*340 ml;
     5. 420 ml.
406. What hormone initiates lactogenesis?
     1. \*prolactin;
     2. progesteron;
     3. estradiol;
     4. oxytocin;
     5. luteotropin.
407. When a baby is at the first time put to the mother’ breasts?
     1. 2 hours after birth;
     2. \*during the first 30 minutes after birth;
     3. after 2 days after birth;
     4. after adjusting of lactation at a mother;
     5. in 2-3 days after birth.
408. What is contraindicated at the breasts feeding of baby?
     1. \*the use of baby's dummy;
     2. feeding “on call of” baby;
     3. frequent feeding of child;
     4. early beginning of the breasts-feeding.
     5. rational feed of mother.
409. Which of the following is characteristic of true labor?
     1. Irregular contractions
     2. Discomfort in lower abdomen
     3. \*Cervical dilatation
     4. Discomfort relieved by sedation
     5. Passage of the blood-tinged
410. When should the fetal heart rate be auscultated during observation for labor in the II stage?
     1. Before the contraction
     2. During the contraction
     3. \*At the end and immediately after a contraction
     4. Any time
     5. After delivery
411. What is the station where the fetal head is visible at the introitus?
     1. +2
     2. \*+3
     3. +4
     4. +5
     5. 0
412. What is the most reliable indicator of rupture of the fetal membranes?
     1. Fluid per cervical os
     2. Positive nitrazine test
     3. \*Positive ferning
     4. Positive oncofetal fibronectin
     5. Bloody discharge
413. What is the station where the presenting part is at the level of the ischial spines?
     1. -2
     2. -1
     3. \*0
     4. +1
     5. +2
414. During the third stage of labor, which of the following is NOT a sign of placenta separation?
     1. A gush of blood
     2. Uterus rises in the abdomen
     3. Umbilical cord protrudes out of the vagina
     4. \*A sudden, sharp, unrelenting contraction
     5. Cessation of umbilical vessels pulsation
415. What is the primary mechanism of placental site hemostasis?
     1. Vasoconstriction by contracted myometrium
     2. Oxytocin
     3. \*Ergonovine maleate
     4. Methylergonovine
     5. Prostaglandines
416. Level of contractile ring above the symphysis 3 fingers suggests about:
     1. 4 cm cervical dilation
     2. 2 cm cervical dilation
     3. \*6 cm cervical dilation
     4. Amniotic fluid gush
     5. Complete cervical dilation
417. What is edematous swelling of the fetal scalp during labor?
     1. \*Molding
     2. Caput succedaneum
     3. Subdural hematoma
     4. Erythema nodusum
     5. Epidural hematoma
418. What is the minimal physiologic blood loss in labor?
     1. 100 ml
     2. \*250 ml
     3. 300 ml
     4. 350 ml
     5. 450 ml
419. Level of contractile ring above the symphysis 2 fingers suggests about:
     1. \*4 cm cervical dilation
     2. 2 cm cervical dilation
     3. 6 cm cervical dilation
     4. Amniotic fluid gush
     5. Complete cervical dilation
420. Level of contractile ring above the symphysis 1 finger suggests about:
     1. 4 cm cervical dilation
     2. \*2 cm cervical dilation
     3. 6 cm cervical dilation
     4. Amniotic fluid gush
     5. Complete cervical dilation
421. Level of contractile ring above the symphysis 5 fingers suggests about:
     1. 4 cm cervical dilation
     2. 2 cm cervical dilation
     3. 6 cm cervical dilation
     4. Amniotic fluid gush
     5. \*Complete cervical dilation
422. Which uterine contractions in the beginning of the first stage of labor are called as regular:
     1. \*1- 2 uterine contractions every 10-15 minutes by duration 15-20 seconds
     2. 1 uterine contraction every 10-15 minutes by duration 10 seconds
     3. 2- 3 uterine contractions every 5-6 minutes by duration 15-20 seconds
     4. 2 uterine contractions every 25-30 minutes by duration 5-10 seconds
     5. 4 uterine contractions every 10 minutes by duration 5-10 seconds
423. In which cervical dilation of normal labor releasing of amniotic fluid gush is presented:
     1. 4 cm cervical dilation
     2. 2 cm cervical dilation
     3. 6 cm cervical dilation
     4. 7 cm cervical dilation
     5. \*8-10 cm cervical dilation
424. Where does the fetal head is located in full cervical dilation?
     1. 2 station
     2. 1 station
     3. \*0 station
     4. +1 station
     5. +2 station
425. Positive Alfeld’ sign in the placental stage of labor is:
     1. \*Lenghtening of the umbilical cord
     2. A gush of blood
     3. Uterus rises in the abdomen
     4. A sudden, sharp, unrelenting contraction
     5. Cessation of umbilical vessels pulsation
426. Positive Shreder’ sign in the placental stage of labor is:
     1. Lengthening of the umbilical cord
     2. A gush of blood
     3. \*Uterus rises in the abdomen
     4. A sudden, sharp, unrelenting contraction
     5. Cessation of umbilical vessels pulsation
427. Positive Strasman’ sign in the placental stage of labor is:
     1. Lengthening of the umbilical cord
     2. A gush of blood
     3. Uterus rises in the abdomen
     4. A sudden, sharp, unrelenting contraction
     5. \*Cessation of umbilical vessels pulsation
428. Positive Chukalov -Kustner’ sign in the placental stage of labor is:
     1. \*umbilical cord doesn’t change its length in pressing by palm above the symphysis
     2. A gush of blood
     3. Uterus rises in the abdomen
     4. Painful uterine contraction
     5. Cessation of umbilical vessels pulsation
429. How do you called the sign in the placental stage of labor if umbilical cord doesn’t change its length in pressing by palm above the symphysis
     1. \*Positive Chukalov -Kustner’ sign
     2. Negative Chukalov -Kustner’ sign
     3. Positive Strasman’ sign
     4. Positive Shreder’ sign
     5. Positive Alfeld’ sign
430. Cessation of umbilical vessels pulsation in the placental stage of labor is:
     1. Positive Chukalov -Kustner’ sign:
     2. Positive Vasten sign
     3. \*Positive Strasman’ sign
     4. Positive Shreder’ sign
     5. Positive Alfeld’ sign
431. Uterus rises in the abdomen in the placental stage of labor is:
     1. Positive Chukalov -Kustner’ sign
     2. Positive Vasten sign
     3. Positive Strasman’ sign
     4. \*Positive Shreder’ sign
     5. Positive Alfeld’ sign
432. Lengthening of the umbilical cord in the placental stage of labor is:
     1. Positive Chukalov -Kustner’ sign
     2. Positive Vasten sign
     3. Positive Strasman’ sign
     4. Positive Shreder’ sign
     5. \*Positive Alfeld’ sign
433. Cervical effacement - is:
     1. A gush of blood
     2. \*Thinning of the cervix
     3. Braxton- Hicks contractions
     4. Passage of the blood-tinged mucus
     5. Increasing of the cervix
434. How many stages does the placental stage of labor have?
     1. \*2
     2. 3
     3. 4
     4. 5
     5. 1
435. What is the average duration of the second stage of labor in nulliparous women?
     1. \*20 min- 2 hours
     2. 2 hours
     3. 15 – 20 minutes
     4. < 15 minutes
     5. 2- 3 hours
436. What is the average duration of the placental stage of labor in nulliparous women?
     1. \*5- 20 minutes
     2. < 5- 20 minutes
     3. 5- 20 minutes
     4. 2-3 minutes
     5. 1 hour
437. All of the below are the main compounds of pushing efforts EXCEPT:
     1. uterine contractions
     2. contractions of prelum abdominale
     3. pelvic floor muscles contractions
     4. contractions of the diaphragm
     5. \*contractions of the pharynx
438. Where does the fetal head is located in the beginning of the pushing efforts?
     1. in the pelvic inlet
     2. in the plane of the greatest dimension
     3. in the mid pelvisleast plane +4
     4. \*in the outlet
     5. above the pelvic inlet
439. Cervical stage of labor starts from:
     1. regular uterine contractions till 4 cm dilation of the cervix
     2. irregular uterine contractions till 6 cm dilation of the cervix
     3. \*regular uterine contractions till 10 cm dilation of the cervix
     4. regular uterine contractions till 6 cm dilation of the cervix
     5. regular uterine contractions till releasing of the amniotic fluid
440. Fetal stage of labor starts from:
     1. regular uterine contractions till 4 cm dilation of the cervix
     2. \*full dilation of the cervix till delivery of the fetus
     3. full dilation of the cervix till delivery of the placenta
     4. 6 cm dilation of the cervix till delivery of the placenta
     5. regular uterine contractions till releasing of the amniotic fluid
441. Placental stage of labor starts from:
     1. delivery of the placenta till 2 hours
     2. full dilation of the cervix till delivery of the fetus
     3. full dilation of the cervix till delivery of the placenta
     4. \*delivery of the fetus till delivery of the placenta
     5. regular uterine contractions till releasing of the amniotic fluid
442. How often during the first stage of labor the vaginal examination should the performed in the case of normal duration of labor?
     1. Every 30 min
     2. Every 45 minutes
     3. Every 2 hours
     4. \*Every 4 hours
     5. Once in a hour
443. Latent phase of the first stage of labor starts from:
     1. \*regular uterine contractions till 3-4 cm dilation of the cervix
     2. irregular uterine contractions till 6 cm dilation of the cervix
     3. regular uterine contractions till 10 cm dilation of the cervix
     4. regular uterine contractions till 6 cm dilation of the cervix
     5. regular uterine contractions till releasing of the amniotic fluid
444. Active phase of the first stage of labor starts from:
     1. regular uterine contractions till 3-4 cm dilation of the cervix
     2. regular uterine contractions till 6 cm dilation of the cervix
     3. regular uterine contractions till 10 cm dilation of the cervix
     4. regular uterine contractions till 6 cm dilation of the cervix
     5. \*3-4 cm dilation of the cervix till full cervical dilation
445. How do you called the peripheral way of the placenta separation from the uterine wall?
     1. Abuladze
     2. Henter’s
     3. Krede- Lazarevich
     4. \*Dunkan
     5. Shultse
446. How do you called the central way of the placenta separation from the uterine wall?
     1. Abuladze
     2. Henter’s
     3. Krede- Lazarevich
     4. Dunkan
     5. \*Shultse
447. How do you called the method of separated placental removal: “The uterus is situated in the midline position. The abdominal wall is grasped by the fingers in the longitudinal fold an asked the woman to push”.
     1. \*Abuladze
     2. Henter’s
     3. Krede- Lazarevich
     4. Dunkan
     5. Shultse
448. How do you called the method of separated placental removal: “The uterus is situated in the midline position. Two firsts are located in the uterine fundus and a doctor …………”.
     1. \*Abuladze
     2. Henter’s
     3. Krede- Lazarevich
     4. Dunkan
     5. Shultse
449. How do you called the method of separated placental removal: “The uterus is situated in the midline position. Catheherization of urinary bladder is performed. Large finger is located in the anterior uterine wall, the rests – on the posterior one. The uterus is grasped in the anterior-posterior direction.
     1. Abuladze
     2. \*Henter’s
     3. Krede- Lazarevich
     4. Dunkan
     5. Shultse
450. Which method of manual removal of the sepatared placenta is the least traumatic?
     1. \*Abuladze
     2. Henter’s
     3. Krede- Lazarevich
     4. Dunkan
     5. Shultse
451. Which operation does belong to the birth preparing operations?
     1. obstetric forceps
     2. cesarean section
     3. \*amniotomy
     4. craniotomy
     5. cervical cerclage
452. Choose indication for cervical cerclage:
     1. threatened abortion
     2. inevitable abortion
     3. incomplete abortion
     4. placenta previa
     5. \*cervical incompetence
453. What is the normal duration of false labor?
     1. >1 hr
     2. >2 hr
     3. >3 hr
     4. 4 hr
     5. \*≤ 6 hr
454. All of the above are the indications for forceps application, exept:
     1. fetal distress
     2. primary uterine inertia
     3. \*contracted pelvis
     4. placenta abruption in the second stage of labor
     5. secondary uterine inertia
455. What is the indication for the operation of applying obstetric forceps?
     1. placenta previa
     2. placenta abruption
     3. \*hypotonic uterine contractions
     4. contracted pelvis
     5. high direct standing of the fetal head
456. Which of the following is true of blindness in conjunction of pregnancy induced hypertension?
     1. \*occur in severe preeclampsia
     2. occur in moderate preeclampsia
     3. occur in mild preeclampsia
     4. is not present in pregnancy induced hypertension
     5. there is no correct answer
457. Which of the following is NOT a sign of severe pregnancy-induced hypertension?
     1. upper abdominal pain
     2. oliguria
     3. \*polyuria
     4. fetal growth retardation
     5. visual disturbances
458. Which sign suggest about magnesium toxicity?
     1. \*decreasing of patellar reflex
     2. Depression
     3. increasing of breathing
     4. polyuria
     5. there is no correct answer
459. Which sign suggest about magnesium toxicity?
     1. \*oliguria
     2. increasing of breathing
     3. polyuria
     4. insomnia
     5. there is no correct answer
460. All drugs should be prescribed in Hyperemesis gravidarum EXEPT?
     1. infusion therapy
     2. antiemetic
     3. intravenous droperidol-diphenhydramine
     4. metoclopramide parenterally
     5. \*intravenous prostaglandyns
461. Which operation is performed for reduction of fetal shoulders in labor?
     1. amniotomy;
     2. embriotomy;
     3. craniotomy;
     4. \*cleidotomy;
     5. cranioklazia
462. What type of cesarean section is more frequent performed in obstetric?
     1. corporal
     2. \*transverse lower segment
     3. vertical lower segment
     4. extraperitoneal
     5. intraperitoneal
463. Choose the contraindications for cesarean section
     1. anatomic contracted pelvis
     2. \*endometritis in labor
     3. cefaloopelvic disproportion
     4. deflexed position of the fetal head
     5. breech presentation
464. What is contraindication for performing of operation of external version of the fetus?
     1. premature fetus
     2. \*multifetal pregnancy
     3. breech presentation
     4. transverse fetal lie
     5. oblique fetal lie
465. Choose the indication episiotomy in labor?
     1. danger for perineal rupture
     2. \*fetal distress
     3. large fetus
     4. brow presentation
     5. deflexed vertex presentation
466. Chose the indication for episiotomy?
     1. \*breech presentation
     2. uterine inertia
     3. placental abruption
     4. placenta previa
     5. diabetus mellitus in pregnancy
467. Choose the indication for episiotomy?
     1. \*scar in the perineal region
     2. placental dysfunction
     3. transverse fetal lie
     4. oblique fetal lie
     5. multifetal pregnancy
468. Choose indications to corporal cesarean section:
     1. \*adhesions in the lower uterine segment
     2. breech presentation
     3. oblique fetal lie
     4. deflexed fetal presentation
     5. scar insufficiency in the uterus
469. Choose indications to corporal cesarean section:
     1. breech presentation
     2. \*large intramural node in the lower uterine segment
     3. oblique fetal lie
     4. scar insufficiency in the uterus
     5. placental abruption
470. What index in the general blood analysis indicate the severity of pregnancy induced hypertetnsion ?
     1. \*thrombocytes
     2. leukocytes
     3. hemoglobin
     4. basophiles
     5. neutrophiles
471. Indications to planned cesarean section in diabetus mellitus and pregnancy?
     1. \*”fresh” hemorrhages in retinae
     2. placenta abruption
     3. placenta previa
     4. cervical incompetence
     5. probable fetal weight 3700 g
472. In regard to preeclampsia, proteinuria is defined as how much urinary excretion?
     1. 100 mg/24 hr
     2. 200 mg/24 hr
     3. \*300 mg/24 hr
     4. 500 mg/24 hr
     5. 600 mg/24 hr
473. Which of the following is NOT diagnostic of moderate preeclampsia?
     1. serum creatinine from 75 – 120 mkmol/L
     2. <0,3 – 5 g proteinuria in 24 hour collection
     3. 39 - 42 hematocrit
     4. \*diastolic blood pressure 110 mm. Hg
     5. 180-150.000 thrombocytes
474. What is the significance of maternal thrombocytopenia in a patient with preeclampsia?
     1. is a fetal indication for cesarean section
     2. \*indicates severity of disease
     3. requires therapy with platelets
     4. is a contraindication to scalp pH determination
     5. there is no correct answer
475. Chronic hypertension defined as:
     1. \*hypertension present before the 12 week of gestation or beyond 6 weeks' postpartum.
     2. hypertension present before the 22 week of gestation or beyond 6 weeks' postpartum
     3. hypertension present before the 24 week of gestation or beyond 8 weeks' postpartum
     4. hypertension present before the 34 week of gestation or beyond 10 weeks' postpartum
     5. hypertension present before the 4 week of gestation or beyond 12 weeks' postpartum
476. Hypertension in pregnancy defined as:
     1. diastolic blood pressure of 80 mm Hg or greater, as a systolic blood pressure at or above 140 mm Hg at one estimation with the interval 2 hours
     2. diastolic blood pressure of 85 mm Hg or greater, as a systolic blood pressure at or above 140 mm Hg at three estimations with the interval 1 hour
     3. diastolic blood pressure of 90 mm Hg or greater, as a systolic blood pressure at or above 135 mm Hg at two estimations with the interval 4 hours
     4. \*diastolic blood pressure of 90 mm Hg or greater, as a systolic blood pressure at or above 140 mm Hg at two estimations with the interval 4 hours.
     5. diastolic blood pressure of 90 mm Hg or greater, as a systolic blood pressure at or above 145 mm Hg at two estimations with the interval 3 hours
477. The level of proteinuria in 24 hour collection is 0.2 g. For which degree of pregnancy induced hypertension does it characterized?
     1. pregestosis
     2. \*mild preeclampsia
     3. moderate preeclampsia
     4. severe preeclampsia
     5. eclampsia
478. What is the scheme of methyldopha prescription in the treatment of moderate preeclampsia?
     1. \*0.25 – 0.5 g 3-4 times a day
     2. 0.5 – 1.5g 3-4 times a day
     3. 0.25 g once a day
     4. 0,1 g once a day
     5. 0,5 g once a day
479. To which group does atenolol belong to?
     1. central alpha2 adrenoagonists
     2. \*adrenoblockers
     3. vasodilators
     4. anticonvulsant
     5. calcium channel blocker
480. What is the initial dose of magnesium sulfate in the treatment of moderate preeclampsia?
     1. \*4 g
     2. 6 mg
     3. 6 g
     4. 8 g
     5. 10g
481. With preeclampsia, what is the significance of severe, right upper-quadrant pain?
     1. cholecystitis
     2. pancreatitis
     3. \*tension on Glisson’s capsule
     4. Teitze syndrome
     5. Terner’s syndrome
482. When is eclampsia least likely to occur?
     1. antepartum
     2. intrapartum
     3. immediately postpartum
     4. \*after 48 hr postpartum
     5. after 2 hours postpartum
483. Which of the following is true of blindness in conjunction with severe preeclampsia?
     1. \*likely central in origin
     2. often permanent
     3. usually unilateral
     4. common
     5. there is no correct answer
484. Which of the following is NOT a sign of severe pregnancy-induced hypertension?
     1. upper abdominal pain
     2. oliguria
     3. \*convulsions
     4. fetal growth retardation
     5. visual disturbances
485. How is magnesium toxicity treated?
     1. calcium chloride intravenously
     2. calcium phosphate orally
     3. \*calcium gluconate and discontinue magnesium
     4. dialysis
     5. there is no correct answer
486. Which of the complications are NOT true about preeclampsia?
     1. placental abruption
     2. cerebral hemorrhage
     3. renal insufficiency
     4. intranatal fetal death
     5. \*anaphylactic shock
487. Which of the following is considered an abnormal 24-hour urinary protein in women with severe preeclampsia?
     1. 300 mg in 24 hr
     2. 1 g in 24 hr
     3. 2 g in 24 hr
     4. 3 g in 24 hr
     5. \*>5 g in 24 hr
488. How is the pathophysiology of preeclampsia characterized?
     1. vasodilatation
     2. \*vasospasm
     3. hemodilution
     4. hypervolemia
     5. there is no correct answer
489. With eclampsia, which of the following is NOT true?
     1. Cerebral edema is present.
     2. Electroencephalogram abnormalities are frequent.
     3. Petechial hemorrhage is common.
     4. \*Cerebral blood flow is normal.
     5. convulsions are present
490. Of the following, which is NOT considered to be a predisposing factor to preeclampsia?
     1. family history of preeclampsia
     2. multiple fetuses
     3. renal transplantation
     4. \*multiparity
     5. hypertensive disorders
491. The main characteristic signs of superimposed pregnancy induced hypertension are all of the below EXCEPT:
     1. early beginning;
     2. severe duration;
     3. isolated proteinuria, edema, or hypertension
     4. \*atypical clinical findings such as paresthesia, insomnia, hypersalivation
     5. combined proteinuria, edema, or hypertension
492. Gestational hypertension defines as:
     1. occurs after 30 weeks of pregnancy and doesn’t accompanies with proteinuria
     2. \*occurs after 20 weeks of pregnancy and doesn’t accompanies with proteinuria
     3. occurs after 12 weeks of pregnancy and accompanies with proteinuria
     4. occurs after 20 weeks of pregnancy and accompanies with proteinuria
     5. occurs after 12 weeks of pregnancy and doesn’t accompanies with proteinuria
493. Which of the following is NOT diagnostic of severe preeclampsia?
     1. increased serum creatinine more than 1200 mkmol/L
     2. 5 g proteinuria in 24 hour collection
     3. 45 hematocrit
     4. elevated liver enzymes
     5. \*180.000 thrombocytes
494. Which of the following is NOT diagnostic of severe preeclampsia?
     1. increased serum creatinine more than 120 mkmol/L
     2. >5 g proteinuria in 24 hour collection
     3. 42 hematocrit
     4. diastolic pressurE. 110 mm Hg
     5. \*300.000 thrombocytes
495. All drugs should be prescribed in Hyperemesis gravidarum EXEPT?
     1. regydration
     2. antiemetic
     3. intravenous droperidol-diphenhydramine
     4. metoclopramide parenterally
     5. \*intravenous oxytocin
496. Which of the following is true in 24-hour urinary protein in women with mild preeclampsia?
     1. \*<300 mg in 24 hr
     2. <700 mg in 24 hr
     3. 2 g in 24 hr
     4. 3 g in 24 hr
     5. 1 g in 24 hr
497. What is the normal duration of treatment in the case of moderate preeclampsia?
     1. 1-2 days
     2. \*7-10 days
     3. 24 hours
     4. 12-14 days
     5. 5-6 hours
498. All of the following are the main indications for cesarean section in preeclampsia EXCEPT:
     1. HELLP-syndrome;
     2. eclampsia;
     3. pulmonary edema;
     4. cerebral symptoms;
     5. \*anemia
499. What is the normal duration of treatment in the case of eclamptic seizure?
     1. 1-2 days
     2. 7-10 days
     3. 24 hours
     4. 12-14 days
     5. \*5-6 hours
500. What is the normal duration of treatment in the case of mild preeclampsia?
     1. 1-2 days
     2. \*7-10 days
     3. 24 hours
     4. 12-14 days
     5. 5-6 hours
501. What is the normal duration of treatment in the case of severe preeclampsia?
     1. 1-2 days
     2. 7-10 days
     3. \*24 hours
     4. 12-14 days
     5. 5-6 hours
502. What is the level of diastolic blood pressure in the mild preeclampsia?
     1. 80-89 mmHg
     2. \*90 – 99 mm Hg
     3. 100 – 109 mm Hg
     4. 110 – 120 mm Hg
     5. 120 mm Hg
503. What is the level of diastolic blood pressure in the moderate preeclampsia?
     1. 80-89 mmHg
     2. 90 – 99 mm Hg
     3. \*100 – 109 mm Hg
     4. 110 – 120 mm Hg
     5. 120 mm Hg
504. What is the level of diastolic blood pressure in the severe preeclampsia?
     1. 80-89 mmHg
     2. 90 – 99 mm Hg
     3. 100 – 109 mm Hg
     4. \*> 110 mm Hg
     5. 120 mm Hg
505. The level of diastolic blood pressure is 95 mm Hg. For which degree of pregnancy induced hypertension does it characterized ?
     1. pregestosis
     2. \*mild preeclampsia
     3. moderate preeclampsia
     4. severe preeclampsia
     5. eclampsia
506. The level of diastolic blood pressure is 105mm Hg. For which degree of pregnancy induced hypertension does it characterized?
     1. pregestosis
     2. mild preeclampsia
     3. \*moderate preeclampsia
     4. severe preeclampsia
     5. eclampsia
507. The level of diastolic blood pressure is 115mm Hg. For which degree of pregnancy induced hypertension does it characterized ?
     1. pregestosis
     2. mild preeclampsia
     3. moderate preeclampsia
     4. \*severe preeclampsia
     5. eclampsia
508. The level of proteinuria in 24 hour collection is 0.1 g. For which degree of pregnancy induced hypertension does it characterized?
     1. pregestosis
     2. \*mild preeclampsia
     3. moderate preeclampsia
     4. severe preeclampsia
     5. eclampsia
509. The level of proteinuria in 24 hour collection is 0.3 g. For which degree of pregnancy induced hypertension does it characterized?
     1. pregestosis
     2. mild preeclampsia
     3. \*moderate preeclampsia
     4. severe preeclampsia
     5. eclampsia
510. The level of proteinuria in 24 hour collection is 0.5 g. For which degree of pregnancy induced hypertension does it characterized?
     1. pregestosis
     2. mild preeclampsia
     3. \*moderate preeclampsia
     4. severe preeclampsia
     5. eclampsia
511. The level of proteinuria in 24 hour collection is 1.0. g. For which degree of pregnancy induced hypertension does it characterized?
     1. pregestosis
     2. mild preeclampsia
     3. \*moderate preeclampsia
     4. severe preeclampsia
     5. eclampsia
512. The level of proteinuria in 24 hour collection is 6.0. g. For which degree of pregnancy induced hypertension does it characterized?
     1. pregestosis
     2. mild preeclampsia
     3. moderate preeclampsia
     4. \*severe preeclampsia
     5. eclampsia
513. The level of thrombocytes is > 150 x 109. For which degree of pregnancy induced hypertension does it characterized?
     1. pregestosis
     2. \*mild preeclampsia
     3. moderate preeclampsia
     4. severe preeclampsia
     5. eclampsia
514. The level of thrombocytes is > 80 – 150 x 109. For which degree of pregnancy induced hypertension does it characterized?
     1. pregestosis
     2. mild preeclampsia
     3. \*moderate preeclampsia
     4. severe preeclampsia
     5. eclampsia
515. The level of thrombocytes is < 80 x 109. For which degree of pregnancy induced hypertension does it characterized?
     1. pregestosis
     2. mild preeclampsia
     3. moderate preeclampsia
     4. \*severe preeclampsia
     5. eclampsia
516. The level of proteinuria is < 0,3 g/L. For which degree of pregnancy induced hypertension does it characterized?
     1. pregestosis
     2. \*mild preeclampsia
     3. moderate preeclampsia
     4. severe preeclampsia
     5. eclampsia
517. The level of protein is 3 g/L. For which degree of pregnancy induced hypertension does it characterized?
     1. pregestosis
     2. mild preeclampsia
     3. \*moderate preeclampsia
     4. severe preeclampsia
     5. eclampsia
518. The level of creatinine is > 120 mkmol/L. For which degree of pregnancy induced hypertension does it characterized?
     1. pregestosis
     2. mild preeclampsia
     3. moderate preeclampsia
     4. \*severe preeclampsia
     5. eclampsia
519. What is the adequate management of mild preeclampsia?
     1. sedative
     2. \*expectant management
     3. hypotensive
     4. anticonvulsants
     5. spasmolytics
520. Indications to hospitalization in mild preeclampsia are all of the below EXCEPT:
     1. gestational age more than 37 weeks
     2. presence of any sign of moderate preeclampsia
     3. fetoplacental insufficiency
     4. \*high temperature
     5. there is no correct answer
521. What is the dose of acetylsalicylic acid for prevention of pregnancy induced hypertension?
     1. 20 mg a day
     2. 40 mg a day
     3. \*60 - 100 mg a day
     4. 110 – 120 mg a day
     5. 120 mg a day
522. What is the dose of calcium for prevention of pregnancy induced hypertension?
     1. \*2 g a day
     2. 4 mg a day
     3. 6 mg a day
     4. 8 g a day
     5. 10 mg a day
523. From which gestational age acetylsalicylic acid is prescribed for prevention of pregnancy induced hypertension?
     1. 8 weeks
     2. 10 weeks
     3. 16 weeks
     4. \*20 weeks
     5. 22 weeks
524. From which gestational age calcium is prescribed for prevention of pregnancy induced hypertension?
     1. 8 weeks
     2. 10 weeks
     3. \*16 weeks
     4. 20 weeks
     5. 22 weeks
525. What is the maximal dose of methyldopa in the treatment of moderate preeclampsia ?
     1. 1g in a day
     2. 2 g in a day
     3. \*3 g in a day
     4. 4 g in a day
     5. 5 g in a day
526. What is the maximal dose of niphedipine in the treatment of moderate preeclampsia?
     1. \*100 mg in a day
     2. 200 mg in a day
     3. 300 mg in a day
     4. 400 mg in a day
     5. 500 mg in a day
527. What is the scheme of niphedipine prescription in the treatment of moderate preeclampsia?
     1. \*10 mg 3-4 times a day
     2. 10 mg 2-3 times a day
     3. 20 mg once a day
     4. 40 mg a day
     5. 5 g once a day
528. To which group does methyldopa belong to?
     1. \*central alpha2 adrenoagonists
     2. adrenoblockers
     3. spasmolytic
     4. anticonvulsant
     5. calcium channel blocker
529. To which group does niphedipine belong to?
     1. central alpha2 adrenoagonists
     2. adrenoblockers
     3. vasodilator
     4. anticonvulsant
     5. \*calcium channel blocker
530. To which group does hydralasin belong to?
     1. central alpha2 adrenoagonists
     2. adrenoblockers
     3. \*peripheral vasodilators
     4. anticonvulsant
     5. calcium channel blocker
531. To which group does metoprolol belong to?
     1. central alpha2 adrenoagonists
     2. \*adrenoblockers
     3. vasodilators
     4. anticonvulsant
     5. calcium channel blocker
532. What is the level of diastolic blood pressure in which magnesium sulfate is prescribed?
     1. < 100 mm Hg
     2. \*> 110 mm Hg
     3. 120 mm Hg
     4. < 90 mm Hg
     5. 130 mm Hg
533. What is the maximal dose of labetolol in the treatment of severe preeclampsia ?
     1. \*300 mg a day
     2. 400 mg a day
     3. 500 mg a day
     4. 700 mg in a day
     5. 800 mg in a day
534. What is the initial dose of hydralasin in the treatment of moderate preeclampsia ?
     1. \*20 mg
     2. 40 mg
     3. 50 mg
     4. 70 mg
     5. 80 mg
535. Contraindications to magnesial therapy in the pregnancy induced hypertension include all of the below EXCEPT:
     1. decreasing level of calcium
     2. depression of centre of breathing
     3. arterial hypotension
     4. kachexia
     5. \*anemia
536. Which should be normal diuresis in infusion therapy in pregnancy induced hypertension ?
     1. \*60 ml per hour
     2. 80 ml per hour
     3. 100 ml per hour
     4. 40 ml per hour
     5. 20 ml per hour
537. What is the general volume of infusion therapy in pregnancy induced hypertension?
     1. 10- 15ml /kg
     2. 15 – 20 ml/kg
     3. 20 – 25 ml/kg
     4. \*30 – 35 ml/kg
     5. 40 – 45 ml/kg
538. What is the normal duration of magnesial therapy in pregnancy induced hypertension?
     1. 12 hours after delivery
     2. 18 hours after delivery
     3. 20 hours after delivery
     4. \*24-48 hours after delivery
     5. 48-56 hours after delivery
539. All of the below should be checked during prescription magnesial therapy EXCEPT:
     1. diuresis per hour
     2. patellar reflex
     3. respirations
     4. fetal heart rate monitoring
     5. \*fetal movement
540. All of the below prescribed for decreasing of blood pressure in pregnancy induced hypertension EXCEPT:
     1. central alpha2 adrenoagonists
     2. adrenoblockers
     3. vasodilators
     4. \*magnesium sulfate
     5. calcium channel blockers
541. All of the below prescribed for decreasing of blood pressure in pregnancy induced hypertension EXCEPT:
     1. calcium channel blocker
     2. adrenoblockers
     3. vasodilators
     4. central alpha2 adrenoagonists
     5. \*angiotensin-converting-enzyme (ACE) inhibitors
542. To major predisposing factors of pregnancy induced hypertension are all of the below EXCEPT:
     1. nulliparity
     2. familial history of preeclampsia–eclampsia
     3. multiple fetuses
     4. \*anemia
     5. diabetes
543. To major predisposing factors of pregnancy induced hypertension are all of the below EXCEPT:
     1. chronic vascular disease
     2. hydatidiform mole
     3. fetal hydrops
     4. \*early maternal age
     5. familial history of preeclampsia–eclampsia
544. All of the below are the main steps in treatment of eclampsia EXCEPT:
     1. control of convulsions
     2. correction of hypoxia and acidosis
     3. \*correction of weight gain
     4. blood pressure control
     5. delivery after control of convulsions.
545. All of the following below prescribed for decreasing of blood pressure in pregnancy induced hypertension EXCEPT:
     1. calcium channel blocker
     2. adrenoblockers
     3. \*diuretics
     4. central alpha2 adrenoagonists
     5. central alpha2 adrenoagonists
546. The patient with moderate preeclampsia undergoes to pass urine analysis:
     1. \*once a day
     2. twice a day
     3. once a week
     4. twice a week
     5. once a month
547. The patient with moderate preeclampsia undergoes to pass blood analysis for thrombocytes:
     1. once a day
     2. twice a day
     3. \*once a 3 days
     4. once a week
     5. once a month
548. The patient with moderate preeclampsia undergoes to pass blood analysis for creatinin:
     1. once a day
     2. twice a day
     3. \*once a 3 days
     4. once a week
     5. once a month
549. The patient with severe preeclampsia undergoes to pass urine analysis:
     1. once a day
     2. twice a day
     3. \*every 4 hours
     4. every 12 hours
     5. every 6 hours
550. All of the below are the main forms of gestosis in early terns of pregnancy EXCEPT:
     1. hypersalivation
     2. mild vomiting
     3. \*severe anemia
     4. moderate vomiting
     5. severe vomiting
551. All of the below belong to rare forms of gestosis during pregnancy EXCEPT:
     1. \*hyperemesis gravidarum
     2. acute fatty liver
     3. dermatosis of pregnancy
     4. tetania of pregnancy
     5. osteomalacia of pregnancy
552. How many times a day the patient with mild vomiting complaints of vomiting?
     1. \*2-4 times a day
     2. 4-6 times a day
     3. 6-8 times in 3 days
     4. 8-10 times a day
     5. every 12 hours
553. How many times a day the patient with moderate vomiting complaints of vomiting?
     1. 2-4 times a day
     2. 4-6 times a day
     3. 6-8 times in 3 days
     4. \*8-10 times a day
     5. more than 10 times a day
554. How many times a day the patient with severe vomiting complaints of vomiting?
     1. 2-4 times a day
     2. 4-6 times a day
     3. 6-8 times in 3 days
     4. 8-10 times a day
     5. \*more than 10 times a day
555. All of the below are the main signs of mild vomiting EXCEPT:
     1. tachycardia
     2. \*edema
     3. normal diuresis
     4. normal blood pressure
     5. general weakness
556. All of the below are the main signs of moderate vomiting EXCEPT:
     1. tachycardia
     2. increasing of the temperature
     3. \*normal diuresis
     4. acetonuria
     5. weight loss
557. All of the below are the main signs of severe vomiting EXCEPT:
     1. \*bradycardia
     2. increasing of the temperature
     3. decreasing of diuresis
     4. ketonuria
     5. weight loss
558. Which form of early gestosis of pregnancy is called as hyperemesis gravidarum?
     1. hypersalivation
     2. mild vomiting
     3. severe anemia
     4. moderate vomiting
     5. \*severe vomiting
559. With all of the above diseases should you differentiate hyperemesis gravidarum EXCEPT?
     1. gastroenteritis
     2. hepatitis
     3. fatty liver of pregnancy
     4. \*bronchial asthma
     5. peptic ulcer
560. What is the leading cause of hyperemesis gravidarum?
     1. increasing of progesterone
     2. decreasing b-subunits of chorionic gonadotropin
     3. increasing of b-subunits of chorionic gonadotropin
     4. decreasing of progesterone
     5. \*decreasing of estrogens
561. All of the below are the main signs of hyperemesis gravidarum EXCEPT:
     1. weight loss
     2. dehydration
     3. acidosis from starvation
     4. alkalosis from loss of hydrochloric acid in vomitus
     5. \*hyperkalemia
562. All of the following belong to the anti-emetics drugs which have been used in early gestosis EXCEPT:
     1. promethazine
     2. prochlorperazine
     3. \*niphedipine
     4. metoclopramide
     5. droperidol-diphenhydramine
563. Which of the following is a mechanism of parenteral metoclopramide efficiency?
     1. \*stimulation of the upper intestinal tract motility
     2. stimulatiion gastric secretions
     3. stimulation biliary function
     4. depression of pancreatic secretion
     5. depression of gastric secretions
564. Metoclopramide’ anti-emetic properties apparently result from:
     1. increasing of estrogenes
     2. increasing of chorionic gonatotropine hormone
     3. decreasing of chorionic gonatotropine hormone
     4. \*central antagonism of dopamine receptors
     5. decreasing of estrogenes
565. All of the below are the main laboratory findings in hyperemesis gravidarum EXCEPT:
     1. ketonuria
     2. increasing of hemoglonin
     3. increasing of erythrocytes
     4. hypokalemia
     5. \*decreasing of hemoglobin
566. All of the below drugs should be prescribed in hyperemesis gravidarum EXCEPT:
     1. sedative
     2. \*hypotensive
     3. anti-emetic
     4. infusion therapy
     5. vitamins
567. Which drug should prescribed for decreasing of hypersalivation?
     1. \*atropine sulfatis
     2. natrii benzoates
     3. niphedipine
     4. sodium chloride
     5. etaperazine
568. The patient with severe vomiting should pass all of the below laboratory analysis EXCEPT:
     1. urine
     2. level of thrombocytes
     3. hematocrite
     4. electrolytes
     5. \*feces
569. What is the best management of pregnancy in the case of acute fatty liver?
     1. infusion therapy
     2. \*pregnancy interrupting
     3. vitamins
     4. sedative drugs
     5. spasmolytics drugs
570. What is the best management of pregnancy in the case of osteomalacia of pregnancy?
     1. infusion therapy
     2. \*pregnancy interrupting
     3. vitamins
     4. sedative drugs
     5. calcium containing drugs
571. All of the below should be prescribed in infusion therapy in pregnancy induced hypertension EXCEPT:
     1. fresh frozen plasma
     2. \*5 % glucose
     3. isotonic solution
     4. refortan
     5. stabisol
572. Which type of anesthesia is recommended in labor in patients with moderate pregnancy induced hypertension?
     1. pudendal
     2. \*epidural
     3. general
     4. paracervical
     5. infiltrative
573. Presence of convulsions characterizes which degree of pregnancy induced hypertension?
     1. pregestosis
     2. mild preeclampsia
     3. moderate preeclampsia
     4. severe preeclampsia
     5. \*eclampsia
574. All of the below are the main rare forms of gestosis during pregnancy EXCEPT:
     1. \*hyperemesis gravidarum
     2. acute fatty liver
     3. dermatosis of pregnancy
     4. tetania of pregnancy
     5. osteomalacia of pregnancy
575. How many times a day the patient with mild vomiting complaints of vomiting?
     1. 4-6 times a day
     2. \*2-4 times a day
     3. 6-8 times in 3 days
     4. 8-10 times a day
     5. every 12 hours
576. How many times a day the patient with moderate vomiting complaints of vomiting?
     1. 2-3 times a day
     2. 4-5 times a day
     3. 5-6 times in 3 days
     4. \*8-9 times a day
     5. more than 10 times a day
577. How many times a day the patient with severe vomiting complaints of vomiting?
     1. 2-4 times a day
     2. \*more than 10 times a day
     3. 6-8 times in 3 days
     4. 8-10 times a day
     5. 4-6 times a day
578. All of the below are the main signs of mild vomiting EXCEPT:
     1. tachycardia
     2. \*diarrhea
     3. normal diuresis
     4. normal blood pressure
     5. general weakness
579. All of the below are the main signs of moderate vomiting EXCEPT:
     1. tachycardia
     2. increasing of the temperature
     3. \*polyuria
     4. acetonuria
     5. weight loss
580. All of the below are the main signs of severe vomiting EXCEPT:
     1. \*diarrhea
     2. increasing of the temperature
     3. decreasing of diuresis
     4. ketonuria
     5. weight loss
581. Which form of early gestosis of pregnancy is severe vomiting: as hyperemesis gravidarum?
     1. hypersalivation
     2. mild vomiting
     3. severe anemia
     4. moderate vomiting
     5. \*hyperemesis gravidarum
582. With all of the above diseases should you differentiate hyperemesis gravidarum EXCEPT?
     1. gastroenteritis
     2. hepatitis
     3. fatty liver of pregnancy
     4. \*hypersalivation
     5. peptic ulcer
583. What is the leading cause of hyperemesis gravidarum?
     1. increasing of progesterone
     2. low level b-subunits of chorionic gonadotropin
     3. increasing of b-subunits of chorionic gonadotropin
     4. low level of progesterone
     5. \*low level of estrogens
584. All of the below are the main signs of hyperemesis gravidarum EXCEPT:
     1. weight loss
     2. dehydration
     3. acidosis from starvation
     4. alkalosis from loss of hydrochloric acid in vomitus
     5. \*hypercalcemia
585. All of the following belong to the anti-emetics drugs which have been used in early gestosis EXCEPT:
     1. promethazine
     2. prochlorperazine
     3. \*labetalol
     4. metoclopramide
     5. droperidol-diphenhydramine
586. Which of the following is a mechanism of parenteral metoclopramide efficiency?
     1. \*dophamin receptor block
     2. stimulatiion gastric secretions
     3. stimulation biliary function
     4. depression of pancreatic secretion
     5. depression of gastric secretions
587. Promethazine’ anti-emetic properties apparently result from:
     1. increasing of estrogenes
     2. increasing of chorionic gonatotropine hormone
     3. decreasing of chorionic gonatotropine hormone
     4. \*H-1 histamin receptor block, anticholinergic effects
     5. decreasing of estrogenes
588. All of the below are the main laboratory findings in hyperemesis gravidarum EXCEPT:
     1. ketonuria
     2. increasing of hemoglonin
     3. increasing of erythrocytes
     4. hypokalemia
     5. \*decreasing of leukocytes
589. All of the below drugs should be prescribed in hyperemesis gravidarum EXCEPT:
     1. sedative
     2. \*antianemic
     3. anti-emetic
     4. infusion therapy
     5. vitamins
590. Which should be recommended for decreasing of hypersalivation?
     1. \*salvia decoction
     2. natrii benzoates
     3. niphedipine
     4. sodium chloride
     5. etaperazine
591. The patient with severe vomiting should pass all of the below laboratory analysis EXCEPT:
     1. urine
     2. level of thrombocytes
     3. hematocrite
     4. \*Zimnitsky test
     5. electrolytes
592. What is the best management of pregnancy in the case of acute fatty liver?
     1. infusion therapy
     2. \*symptomatic treatment and pregnancy interrupting
     3. vitamins
     4. antyhistamin drugs
     5. spasmolytics drugs
593. What is the management of pregnancy in the case of HELLP -syndrom?
     1. infusion therapy
     2. \*pregnancy interrupting
     3. vitamins
     4. sedative drugs
     5. calcium containing drugs
594. All of the below should be prescribed in infusion therapy in pregnancy induced hypertension EXCEPT:
     1. fresh frozen plasma
     2. \*blood transfusion
     3. isotonic solution
     4. refortan
     5. stabisol
595. Which type of anesthesia is Not recommended in labor in patients with moderate pregnancy induced hypertension?
     1. \*pudendal
     2. epidural
     3. general
     4. all abovel
     5. nothing above
596. Which degree of pregnancy induced hypertension characterizes presence of convulsions?
     1. pregestosis
     2. mild preeclampsia
     3. moderate preeclampsia
     4. severe preeclampsia
     5. \*eclampsia
597. What is the World Health Organization definition of a premature infant?
     1. <2500 g
     2. 38 weeks or less
     3. \*37 weeks or less
     4. 36 weeks or less
     5. < 2000 g
598. In days, how is a postterm pregnancy defined?
     1. >280 days
     2. >287 days
     3. \*>294 days
     4. >300 days
     5. 310 days
599. In a woman with a favourable cervix and an estimated fetal weight of 3850 g, what is the appropriate management at a certain 42 weeks’ gestation?
     1. expectant management
     2. start fetal surveillance
     3. \*induce labor
     4. schedule cesarean section
     5. there is no correct answer
600. At what gestational age does the incidence of complications due to prematurity equal that of term infants?
     1. 25 to 26 weeks
     2. 28 to 30 weeks
     3. \*32 to 34 weeks
     4. 36 weeks or more
     5. 22-24 weeks
601. What is the preferred management of preterm rupture of membranes on the 36 week of gestation?
     1. antibiotics
     2. tocolytics
     3. steroids
     4. \*expectant
     5. spasmolitics
602. How is postterm pregnancy defined?
     1. beyond 37 weeks
     2. beyond 40 weeks
     3. \*beyond 42 weeks
     4. beyond 44 weeks
     5. beyond 46 weeks
603. In a woman with an unfavorable cervix and an estimated fetal weight of 3800 g, what is the appropriate management at a certain 42 weeks’ gestation?
     1. labor induction
     2. cesarean section
     3. fetal surveillance plus hospitalization
     4. \*cervical ripening
     5. there is no correct answer
604. How is preterm labor defined?
     1. \*from 22 to 36 weeks
     2. from 24 to 38 weeks
     3. from 28 to 37 weeks
     4. from 28 to 38 weeks
     5. from 22 to 38 weeks
605. Which of the following is NOT true concerning indomethacin?
     1. is used to treat preterm labor
     2. is a prostaglandin synthetase inhibitor
     3. may cause premature closure of the fetal ductus arteriosus
     4. \*decreases neonatal intracranial hemorrhage
     5. there is no correct answer
606. Which of the following vaginal infections is positively associated with preterm birth?
     1. \*bacterial vaginosis
     2. trichomonal vaginalis
     3. candida vaginalis
     4. herpes simplex infections
     5. gardnerella vaginalis
607. What is the mechanism of action of b-adrenergic agents?
     1. blocks thymidine kinase
     2. \*activates adenylcyclase
     3. blocks conversion of ATP to cyclic AMP
     4. increases intracellular calcium
     5. there is no correct answer
608. Which of the following is NOT a description associated with the postterm infant?
     1. \*smooth skin
     2. patchy peeling skin
     3. long, thin body
     4. worried looking face
     5. there is no correct answer
609. What is the management of the preterm labor in the case breech presentation?
     1. expectant management
     2. start fetal surveillance
     3. induce labor
     4. \*cesarean section
     5. there is no correct answer
610. All of the below are prescribes in the case of danger of preterm labor EXCEPT:
     1. spasmolytics
     2. \*contractil drugs
     3. sedative drugs
     4. Prostaglandines’ synthesis inhibitors
     5. b-adrenomimetic drugs
611. According to Friedman, what is prolongation of the latent phase of labor in a primigravida?
     1. 14 hr
     2. \*20 hr
     3. 24 hr
     4. 48 hr
     5. 52 hr
612. What is the duration of active-phase labor in nulliparous women?
     1. <3 hr
     2. \*4 to 5 hr
     3. 6 to 8 hr
     4. ~12 hr
     5. there is no correct answer
613. Which prostaglandin has been used for cervical ripening?
     1. F2a
     2. \*E2
     3. F10
     4. М1
     5. A2
614. What is the mean half-life of oxytocin in plasma?
     1. \*5 min
     2. 10 min
     3. 15 min
     4. 20 min
     5. there is no correct answer
615. All of the following are the main signs of false labor EXCEPT:
     1. Irregular intervals and duration
     2. Painful uterine contractions
     3. \*Presence cervical dilation
     4. Increased uterine tone
     5. Unchanged intensity of uterine contractions
616. In the parous woman, how is the prolonged latent phase defined?
     1. >6 hr
     2. \*>14 hr
     3. >20 hr
     4. >24 hr
     5. there is no correct answer
617. Where in the myometrium uterine contractions of normal labor begin and last longest?
     1. \*fundus
     2. lower uterine segment
     3. cervix
     4. laterally in miduterus
     5. there is no correct answer
618. How long does it take oxytocin to reach steady state levels in the plasma?
     1. 5 min
     2. 10 min
     3. 20 min
     4. \*40 min
     5. there is no correct answer
619. All of the below are prescribes in the case of false labor EXCEPT:
     1. Therapeutic rest
     2. \*contractiles drugs
     3. sedative drugs
     4. Prostaglandines’ synthesis inhibitors
     5. beta-adrenomimetic drugs
620. Management of the uterine inertia in the second stage of labor includes all of the following EXCEPT:
     1. Augmentation of labor
     2. \*Spasmolytics
     3. Forceps application
     4. Vacuum application
     5. Cesarean section
621. According to Friedman, what are the phases of cervical dilatation?
     1. preparatory–active
     2. preparatory–latent
     3. \*latent- active
     4. active pelvic
     5. there is no correct answer
622. Which factor likely contributes to the prolongation of the latent phase?
     1. excessive sedation
     2. conduction analgesia
     3. \*uneffaced and undilated cervix
     4. all of the above
     5. there is no correct answer
623. In a multiparous woman, secondary arrest of dilatation is defined as no cervical dilatation for how long?
     1. >1 hr
     2. \*>2 hr
     3. >3 hr
     4. >14 hr
     5. 15 hr
624. In a nulliparous woman, how long is the prolonged deceleration phase?
     1. >1 hr
     2. >2 hr
     3. \*>3 hr
     4. >20 hr
     5. 22 hr
625. All of the below are prescribes in the case of excessive uterine activity EXCEPT:
     1. Therapeutic rest
     2. \*contractiles drugs
     3. sedative drugs
     4. Prostaglandines’ synthesis inhibitors
     5. beta-adrenomimetic drugs
626. In a primigravida, what is the minimum rate of dilation of the cervix in the active phase of labor?
     1. 0.5 cm/hr
     2. \*1.2 cm/hr
     3. 1.5 cm/hr
     4. 2.0 cm/hr
     5. there is no correct answer
627. What is the preferred treatment for a nulliparous patient with prolonged deceleration phase and no signs of cephalopelvic disproportion?
     1. sedation
     2. \*oxytocin
     3. cesarean section
     4. increased hydration
     5. there is no correct answer
628. Which of the following is NOT true of hypertonic dysfunction?
     1. may be associated with placental abruption
     2. painful contraction
     3. ineffective cervical dilation
     4. \*occurs usually after 4 cm
     5. there is no correct answer
629. All of the following belong the signs of uterine inertia EXCEPT
     1. Inadequate uterine activity
     2. Lack of the progressive cervical effacement
     3. Station of presenting part in the pelvic inlet (- 3, -2 station) for a long period of time and slowly descent of the fetus in the case of “cephalopelvic disproportion” absence
     4. \*adequate cervical dilation
     5. Increased duration of labor
630. All of the below are prescribes in the case of discoordinative uterine activity EXCEPT:
     1. \*contractile drugs
     2. Therapeutic rest
     3. sedative drugs
     4. Prostaglandines’ synthesis inhibitors
     5. beta-adrenomimetic drugs
631. All of the below are prescribes in the case of false labor EXCEPT:
     1. Therapeutic rest
     2. \*contractiles drugs
     3. sedative drugs
     4. Prostaglandines’ synthesis inhibitors
     5. beta-adrenomimetic drugs
632. All of the below are the types of abnormal labour EXCEPT:
     1. False labor
     2. primary uterine inertia
     3. secondary uterine inertia
     4. Incoordinative uterine activity
     5. \*danger of uterine inertia
633. All of the below are the types of incoordinative uterine activity EXCEPT:
     1. dyscoordination
     2. \*primary uterine inertia
     3. hyperactivity of lower uterine segment
     4. uterine tetania
     5. circulative dystocia
634. All of the below are the signs of false labor EXCEPT:
     1. Painful uterine contractions
     2. Irregular intervals and duration of uterine contractions
     3. \*Painless uterine contractions
     4. No cervical dilation
     5. Relief from sedation
635. All of the below are the signs of false labor EXCEPT:
     1. Painful uterine contractions
     2. Irregular intervals and duration of uterine contractions
     3. uterine contractions don’t increased with physical activity
     4. \*cervical effacement, dilation
     5. Relief from sedation
636. All of the below are the signs of false labor EXCEPT:
     1. Increased uterine tone
     2. \*Regular intervals and duration of uterine contractions
     3. uterine contractions don’t increased with physical activity
     4. absence of cervical dilation
     5. lasts more than 6 hours
637. All of the below are prescribes in the case of false labor EXCEPT:
     1. spasmolytics
     2. \*oxytocin
     3. sedative
     4. indomethacine
     5. partusisten
638. All of the below are the main causes of uterine contractions abnormality EXCEPT:
     1. maternal exhaustion
     2. pathological changes of uterine cervix and uterus
     3. Cephalopelvic disproportion
     4. postdate pregnancy
     5. \*placental abruption
639. All of the below are the main causes of uterine contractions abnormality EXCEPT:
     1. polyhydramnion
     2. multiple pregnancy
     3. administration of excess anesthesia
     4. \*placental previa
     5. there is no correct answer
640. Which type of uterine inertia is called as primary?
     1. occurs from the 2cm cervical dilation till the end of labor
     2. occurs from the 4 cm cervical dilation till the end of labor
     3. \*occurs from the early onset of labor and lasts until the end of labor.
     4. occurs from the 6 cm cervical dilation till 8 cm dilation
     5. occurs in the second stage of labor
641. All of the below are the main signs of uterine inertia EXCEPT:
     1. Inadequate uterine activity
     2. Lack of the progressive cervical effacement and dilation
     3. Increased duration of labor
     4. -2 station of the fetal head for a long period of time
     5. \*0- station of the fetal head for 30 minutes
642. What firstly should you prescribe for uterine inertia treatment?
     1. \*Therapeutic rest in the case of maternal exhaustion.
     2. amniotomy
     3. induction of labor by oxytocin
     4. induction of labor by prostaglandins
     5. spasmolytics
643. All of the below are prescribed for therapeutic rest in the case of uterine inertia EXCEPT:
     1. Promedol
     2. Atropin Sulfatis
     3. \*Enzaprost
     4. Droperidol
     5. Natrii Oxybuturatis
644. Which dose of oxytocin is recommended for induction of labor in the case of uterine inertia?
     1. \*5 units
     2. 10 units
     3. 15 units
     4. 20 units
     5. 25 units
645. In treatment of urinary tract infection (UTI) in the third trimester, the antibiotic of choice should be:
     1. \*Cephalosporin
     2. Tetracycline
     3. Sulfonamide
     4. Nitrofurans
     5. There is no correct answer
646. What causes the majority of heart disease in pregnancy?
     1. idiopathic cardiomyopathy
     2. constrictive pericarditis
     3. hypertension
     4. \*congenital heart lesions
     5. There is no correct answer
647. Which of the following symptoms in pregnancy is suggestive of heart disease?
     1. tachycardia
     2. tachypnea
     3. \*syncope with exertion
     4. peripheral edema
     5. There is no correct answer
648. A 27 – year - old woman at 32 weeks’ gestation presents complaining of cough, fever, chest pain, and dyspnoea. Which of the following tests would be most helpful in making a diagnosis?
     1. complete blood cell count
     2. mycoplasma-specific immunoglobulin G
     3. urinalysis for pneumococcal antigen
     4. \*chest x-ray
     5. There is no correct answer
649. Which of the following factors is NOT an indication for hospitalization of a woman with pneumonia?
     1. altered mental status
     2. Diastolic blood pressure 110 mm Hg
     3. t0 38,50C
     4. \*respiratory rate 20 / min
     5. Dispnea
650. What is the etiology of reflux esophagitis in pregnancy?
     1. constriction of upper esophageal sphincter
     2. relaxation of upper esophageal sphincter
     3. constriction of lower esophageal sphincter
     4. \*relaxation of lower esophageal sphincter
     5. There is no correct answer
651. Which of the following is NOT a risk factor for gestational diabetes?
     1. age > 30 years
     2. prior macrosomic infant
     3. prior stillborn infant
     4. \*sister with gestational diabetes
     5. There is no correct answer
652. In diabetes, which fetal organ is unaffected by fetal macrosomia?
     1. heart
     2. kidney
     3. liver
     4. \*brain
     5. There is no correct answer
653. Which of the following complications is NOT increased in pregnant women with hypothyroidism?
     1. preeclampsia
     2. placental abruption
     3. low birthweight
     4. \*placenta previa
     5. There is no correct answer
654. Which of the following is the most sensitive method to diagnose maternal primary CMV infection?
     1. culture of cervix
     2. cytomegalovirus IgG titer
     3. \*cytomegalovirus IgM titer
     4. 2-fold increase in IgG titer
     5. There is no correct answer
655. Antepartum syphilis is NOT associated with which of the following?
     1. fetal death
     2. preterm labor
     3. neonatal infection
     4. \*abruptio placenta
     5. There is no correct answer
656. What is the most common presenting symptom in women with thrombotic thrombocytopenic syndrome?
     1. fever
     2. fatigue
     3. \*haemorrhage
     4. neurological abnormalities
     5. there is no correct answer
657. What is the risk of transmission of HIV to the newborn from breastfeeding?
     1. \*increased
     2. decreased
     3. remains the same
     4. unknown
     5. There is no correct answer
658. Which of the following is NOT associated with cytomegalic inclusion disease?
     1. microcephaly
     2. chorioretinitis
     3. \*hydrops
     4. thrombocytopenic purpura
     5. There is no correct answer
659. What is the initial drug of choice for the treatment of pyelonephritis in pregnancy?
     1. doxyciclini
     2. cephalosporin
     3. \*ampicillin
     4. empirical
     5. There is no correct answer
660. Transient diabetes insipidus is most likely encountered in pregnant women with which of the following complications?
     1. \*acute fatty liver
     2. severe preeclampsia
     3. HELLP syndrome
     4. hemolytic uremic syndrome
     5. There is no correct answer
661. Management of a labour in woman with mitral stenosis should NOT include which of the following?
     1. epidural analgesia
     2. endocarditic prophylaxis
     3. beta-blockers to slow heart rate
     4. \*elective caesarean section
     5. There is no correct answer
662. Which treatment is of choice for early onset influenza in pregnancy?
     1. retrovir
     2. \*Amantadine
     3. Acyclovir
     4. ganciclovir
     5. There is no correct answer
663. What is the most likely diagnosis in a woman with frequency, urgency, pyuria, dysuria, and a sterile urine culture?
     1. E. coli cystitis
     2. group B streptococcus cystitis
     3. \*Chlamydia trachomatis urethritis
     4. N. gonorrhoeae urethritis
     5. There is no correct answer
664. An 18 – year - old nulliparous black woman has been on antibiotics for 4 days for pyelonephritis. She continues to have fever ranging from 38.9 to 39.6 ° C. Workup reveals a right urethral obstruction secondary to calculi. What is the next most appropriate step in her management?
     1. Change her antibiotics.
     2. Continue the present antibiotics for at least 7 days.
     3. \*Pass a double-J urethral stent.
     4. Perform a percutaneous nephrostomy
     5. There is no correct answer
665. Which of the following is associated with congenital toxoplasmosis infection?
     1. limb defects
     2. cardiac defects
     3. \*hepatosplenomegaly
     4. renal defects
     5. There is no correct answer
666. What is the most common presenting symptom of renal stones in pregnant women?
     1. flank pain
     2. abdominal pain
     3. hematuria
     4. \*infection
     5. There is no correct answer
667. What is the most common serious medical complication of pregnancy?
     1. cystitis
     2. pneumonia
     3. pancreatitis
     4. \*pyelonephritis
     5. There is no correct answer
668. During pregnancy, what happens to regurgitation associated with the mitral valve?
     1. \*decreases
     2. remains the same
     3. increases mildly
     4. increases significantly
     5. There is no correct answer
669. How should a woman with deep venous thrombosis in a previous pregnancy be managed in a current pregnancy?
     1. careful observation
     2. \*minidose subcutaneous heparin
     3. full prophylactic subcutaneous heparin
     4. low-dose aspirin
     5. There is no correct answer
670. How should a pregnant woman who is tuberculin-positive but x-ray negative be managed?
     1. rifampin 10 mg / kg daily for 12 months
     2. isoniazid 300 mg daily for 12 months
     3. ethambutol for 12 months
     4. \*observation and treatment after delivery
     5. There is no correct answer
671. Which of the following complications is associated with ruptured appendix and peritonitis?
     1. fetal growth restriction
     2. oligohydramnios
     3. chorioamnionitis
     4. \*preterm birth
     5. There is no correct answer
672. We have 28 - year patient with mitral stenosis and impaired cardial function for pre-pregnancy counseling. Your recommendation about next pregnancy:
     1. pregnancy is recommended
     2. \*pregnancy is not recommended
     3. pregnancy is allowed in three months
     4. pregnancy is allowed in five months
     5. There is no correct answer
673. In case of mitral incompetence in pregnant patient blood during systole goes to the:
     1. aorta
     2. lung artery
     3. \*aorta and left atrium
     4. aorta and right atrium
     5. there is no correct answer
674. Mitral disease is:
     1. \*combined stenosis of mitral foramen and mitral valves incompetence
     2. stenosis of mitral foramen
     3. mitral incompetence
     4. mitral incompetence and heart failure
     5. there is no correct answer
675. Von Willebrand disease is:
     1. \*the most common hereditary coagulation abnormality
     2. the least common hereditary coagulation abnormality
     3. the most common hereditary metabolism abnormality
     4. the least common hereditary metabolism abnormality
     5. There is no correct answer
676. In case of Von Willebrand disease we prescribe:
     1. indirect anticoagulant
     2. direct anticoagulant
     3. \*blood factor – VIII
     4. blood factor – VI
     5. Blood factor VII
677. Contraindication for pregnancy is:
     1. mitral stenosis
     2. mitral incompetence
     3. obesity
     4. sole kidney
     5. \*mitral stenosis with heart failure
678. Contraindication for pregnancy is not:
     1. mitral stenosis with active rheumatic disease
     2. mitral incompetence with lung edema
     3. there is no correct answer
     4. \*sole kidney
     5. mitral stenosis with heart failure
679. What is the management of the total placenta percreta?
     1. \*total hysterectomy
     2. manual separation and removal of the placenta
     3. hysterotomy
     4. subtotal hysterectomy
     5. ligation of the vessels
680. What is the management of the partial placenta percreta?
     1. \*total hysterectomy
     2. manual separation and removal of the placenta
     3. hysterotomy
     4. subtotal hysterectomy
     5. ligation of the vessels
681. What is the management of the focal placenta percreta?
     1. \*total hysterectomy
     2. manual separation and removal of the placenta
     3. hysterotomy
     4. subtotal hysterectomy
     5. ligation of the vessels
682. What is the highest dose of oxytocin is prescribed in the uterine atony?
     1. 5 units
     2. 10 units
     3. 15 units
     4. \*20 units
     5. 25 units
683. Which dose of prostaglandin Enzaprost is prescribed in the uterine atony?
     1. 1 mg
     2. 2 mg
     3. \*5 mg
     4. 10 mg
     5. 15 mg
684. Which dose of misoprostol is prescribed in the uterine atony?
     1. \*800 mkg
     2. 600 mkg
     3. 400 mkg
     4. 200 mkg
     5. 100 mkg
685. All of the below are the predisposing factors to genital tract trauma EXCEPT:
     1. complicated vaginal delivery
     2. forceps application
     3. vacuum application
     4. \*multiple pregnancy
     5. breech extraction.
686. Couvelaire’ uterus is the complication of which pathology?
     1. \*placental abruption
     2. placental adherence
     3. placental accreta
     4. placental percreta
     5. uterine hypotony
687. What is the best method of diagnosis of genital tract trauma?
     1. vaginal examination
     2. \*speculum inspection
     3. patients complaints
     4. female history
     5. ultrasonography
688. Which of the following is the most ideal method of delivery for severe abruption in the second stage of labor in breech presentation?
     1. forceps delivery
     2. immediate cesarean section
     3. cesarean section after blood replacement
     4. \*breech extraction
     5. vacuum application
689. What is the best management of the mild form of placental abruption ?
     1. forceps delivery
     2. immediate cesarean section
     3. cesarean section after blood replacement
     4. \*observation
     5. vacuum application
690. Which of the following is NOT characteristic of early hypovolemic shock?
     1. decreased mean arterial pressure
     2. decreased stroke volume
     3. increased arteriovenous oxygen content difference
     4. \*increased central venous pressure
     5. there is no correct answer
691. Which of the following is characteristic of the secondary phase of amniotic fluid embolism?
     1. pulmonary hypertension
     2. decreased systemic vascular resistance
     3. decreased left ventricular stroke index
     4. \*lung injury and coagulopathy
     5. there is no correct answer
692. How many stages of hemorrhagic shock severity have been distinguished?
     1. 1
     2. 2
     3. 3
     4. \*4
     5. 5
693. What is the blood loss in the first stage of hemorrhagic shock severity?
     1. \*10 – 20 % from circulating blood volume
     2. 20 – 30 % from circulating blood volume
     3. 30 – 40 % from circulating blood volume
     4. 40 % from circulating blood volume
     5. 50 % from circulating blood volume
694. What is the blood loss in the second stage of hemorrhagic shock severity?
     1. 10 – 20 % from circulating blood volume
     2. \*20 – 30 % from circulating blood volume
     3. 30 – 40 % from circulating blood volume
     4. 40 % from circulating blood volume
     5. 50 % from circulating blood volume
695. What is the blood loss in the third stage of hemorrhagic shock severity?
     1. 10 – 20 % from circulating blood volume
     2. 20 – 30 % from circulating blood volume
     3. \*30 – 40 % from circulating blood volume
     4. 40 % from circulating blood volume
     5. 50 % from circulating blood volume
696. What is the blood loss in the fourth stage of hemorrhagic shock severity?
     1. 10 – 20 % from circulating blood volume
     2. 20 – 30 % from circulating blood volume
     3. 30 – 40 % from circulating blood volume
     4. \*> 40 % from circulating blood volume
     5. 50 % from circulating blood volume
697. Which level of blood loss is indication to hysterectomy in the case of hemorrhagic shock?
     1. 250 ml
     2. \*1, 5 % from body weight
     3. 400 ml
     4. 0, 5 % from body weight
     5. 1 % from body weight
698. All of the above are the main causes of disseminated intravascular clotting (DIC) syndrome EXCEPT:
     1. Placenta abruption
     2. Embolic fluid embolism
     3. \*Chronic bronchitis
     4. pregnansy induced hypertension
     5. Hypotonic bleeding
699. What is the volume of infusion therapy in the mild degree of hemorrhagic shock severity?
     1. 500 ml
     2. 1000 ml
     3. 1500 ml
     4. 2000 ml
     5. \*2500 ml
700. Which dose of colloids is recommended in the mild degree of hemorrhagic shock severity?
     1. 5 ml / kg
     2. \*10 ml / kg
     3. 15 ml / kg
     4. 20 ml / kg
     5. 25 ml/kg
701. All of the above belong to the colloids which are widely used in obstetrics EXCEPT:
     1. Refortan
     2. Gelofusin
     3. \*Ringer-Lokka
     4. Stabisol
     5. Fresh-frozen plasma
702. What is the volume of infusion therapy in the moderate degree of hemorrhagic shock severity?
     1. 1000 ml
     2. 1500 ml
     3. 2000 ml
     4. 2500 ml
     5. \*3000 ml
703. What is the volume of infusion therapy in the severe degree of hemorrhagic shock severity?
     1. 1500 ml
     2. 2000 ml
     3. 2500 ml
     4. \*3500 ml
     5. 4000 ml
704. What is the first stage of Disseminated Intravascular Clotting (DIC) syndrome?
     1. hypocoagulation without generalizing fibrinolysis activation
     2. \*hypercoagulation
     3. hypocoagulation with generalizing fibrinolysis activation
     4. total fibrinolysis
     5. there is no correct answer
705. What is the second stage of Disseminated Intravascular Clotting (DIC) syndrome?
     1. \*hypocoagulation without generalizing fibrinolysis activation
     2. hypercoagulation
     3. hypocoagulation with generalizing fibrinolysis activation
     4. total fibrinolysis
     5. there is no correct answer
706. What is the third stage of Disseminated Intravascular Clotting (DIC) syndrome ?
     1. hypocoagulation without generalizing fibrinolysis activation
     2. hypercoagulation
     3. \*hypocoagulation with generalizing fibrinolysis activation
     4. total fibrinolysis
     5. there is no correct answer
707. What is the fourth stage of Disseminated Intravascular Clotting (DIC) syndrome ?
     1. hypocoagulation without generalizing fibrinolysis activation
     2. hypercoagulation
     3. hypocoagulation with generalizing fibrinolysis activation
     4. \*total fibrinolysis
     5. there is no correct answer
708. All of the below are the main signs of Disseminated Intravascular Clotting (DIC) syndrome EXCEPT:
     1. Hemorrhages into skin and mucous membranes
     2. Hemorrhages from the places of injections, incisions, uterus
     3. Necrosis of some areas of skin and mucous membranes
     4. \*Hypertension
     5. Central nervous system impairment, acute renal, liver, pulmonary insufficiency.
709. Which of the following is contraindicated in all stages of Disseminated Intravascular Clotting (DIC) syndrome?
     1. \*Heparin
     2. Fresh frozen plasma
     3. Contrical
     4. Transamacha acid
     5. Gordox
710. Which of the following is contraindicated in all stage of Disseminated Intravascular Clotting (DIC) syndrome?
     1. Fresh frozen plasma
     2. \*Fibrinogen
     3. Etamsilat
     4. Transamic acid
     5. Proteolyric enzymes inhibitors
711. All of the below are the main signs of Cardiorespiratory collapse in amniotic fluid embolism EXCEPT:
     1. Severe pain in the chest
     2. Cough
     3. Feeling of the death, cyanosis
     4. \*Hypertension
     5. Sudden dyspnea, hypotension
712. In which level of hemoglobin transfusion of erythromassa is indicated?
     1. < 120 g/l
     2. < 110 g/l
     3. < 100 g/l
     4. < 80 g/l
     5. \*< 70 g/l
713. What is the amount of blood loss if Algover’s index is 0.8 ?
     1. \*10 % from circulating blood
     2. 20 % from circulating blood
     3. 30 % from circulating blood
     4. 40 % from circulating blood
     5. 50 % from circulating blood
714. What is the amount of blood loss if Algover’s index is 0.9 – 1.2?
     1. 10 % from circulating blood
     2. \*20 % from circulating blood
     3. 30 % from circulating blood
     4. 40 % from circulating blood
     5. 50 % from circulating blood
715. What is the amount of blood loss if Algover’s index is 1.3 – 1.4?
     1. 10 % from circulating blood
     2. 20 % from circulating blood
     3. \*30 % from circulating blood
     4. 40 % from circulating blood
     5. 50 % from circulating blood
716. What is the amount of blood loss if Algover’s index is 1.5 ?
     1. 10 % from circulating blood
     2. 20 % from circulating blood
     3. 30 % from circulating blood
     4. \*40 % from circulating blood
     5. 50 % from circulating blood
717. All of the above are risk factors for amniotic fluid embolism EXCEPT:
     1. excessive labor contractions
     2. manual removal of placenta
     3. placenta abruption
     4. \*chronic pyelonephritis
     5. hemorrhagic shock
718. All of the above are risk factors for septic shock EXCEPT:
     1. \*Placenta abruption
     2. Septic abortion
     3. Chorionamnionitis
     4. Pyelonephritis
     5. Endometritis
719. Which dose of colloids is recommended in the moderate degree of hemorrhagic shock severity?
     1. 5 ml / kg
     2. \*10 ml / kg
     3. 15 ml / kg
     4. 20 ml / kg
     5. 25 ml/kg
720. Which dose of fresh-frozen plasma is recommended in the moderate degree of hemorrhagic shock severity?
     1. \*5 - 10 ml / kg
     2. 10 - 15 ml / kg
     3. 15 - 20 ml / kg
     4. 20 - 25ml / kg
     5. 25 - 30ml/kg
721. Which dose of erythromassa is recommended in the moderate degree of hemorrhagic shock severity?
     1. \*5 ml / kg
     2. 15 ml / kg
     3. 10 ml / kg
     4. 20 ml / kg
     5. 25 ml/kg
722. Which dose of colloids is recommended in the severe degree of hemorrhagic shock severity?
     1. \*7 ml / kg
     2. 10 ml / kg
     3. 15 ml / kg
     4. 20 ml / kg
     5. 25 ml/kg
723. Which dose of crystalloids is recommended in the severe degree of hemorrhagic shock severity?
     1. \*7 ml / kg
     2. 10 ml / kg
     3. 15 - 20 ml / kg
     4. 20 - 25ml / kg
     5. 25 - 30ml/kg
724. Which dose of fresh-frozen plasma is recommended in the severe degree of hemorrhagic shock severity?
     1. 5 - 10 ml / kg
     2. \*10 - 15 ml / kg
     3. 15 - 20 ml / kg
     4. 20 - 25ml / kg
     5. 25 - 30ml/kg
725. Which dose of erythromass is recommended in the III degree of hemorrhagic shock severity?
     1. 5-10 ml / kg
     2. \*10- 20 ml / kg
     3. 20- 25 ml / kg
     4. 25 - 30 ml / kg
     5. 30 ml/kg
726. All of the above are indicated in the infusion therapy in the hemorrhagic shock EXCEPT:
     1. \*Reopoliglucin
     2. Isotonic solution
     3. Refortan
     4. Gelofusin
     5. Erythromass
727. All of the above are indicated in the infusion therapy in the hemorrhagic shock EXCEPT:
     1. Isotonic solution
     2. \*5 % glucose
     3. Stabisol
     4. Gelofusin
     5. Erythromass
728. Which dose of erythromass is recommended in the IV degree of hemorrhagic shock severity?
     1. 5-10 ml / kg
     2. 10- 20 ml / kg
     3. 20- 25 ml / kg
     4. 25 - 30 ml / kg
     5. \*30 ml/kg
729. Which dose of colloids is recommended in the IV degree of hemorrhagic shock severity?
     1. 7 ml / kg
     2. \*10 ml / kg
     3. 15 ml / kg
     4. 20 ml / kg
     5. 25 ml/kg
730. What is the initial rate of infusion therapy in the case of hemorrhagic shock and low arterial blood pressure?
     1. 50 ml per minute
     2. 100 ml per minute
     3. \*200 ml per minute
     4. 150 ml per minute
     5. 250 ml per minute
731. What is the heart rate in the mild degree of hemorrhagic shock?
     1. 70-80 beats per min
     2. \*90 -100 beats per min
     3. 120 beats per min
     4. 140 beats per min
     5. 160 beats per min
732. What is the heart rate in the moderate degree of hemorrhagic shock?
     1. 70-80 beats per min
     2. 90 -100 beats per min
     3. \*120 beats per min
     4. 140 beats per min
     5. 160 beats per min
733. What is the heart rate in the severe degree of hemorrhagic shock?
     1. 70-80 beats per min
     2. 90 -100 beats per min
     3. 120 beats per min
     4. \*140 beats per min
     5. 160 beats per min
734. What is the level of systolic blood pressure in the mild degree of hemorrhagic shock severity?
     1. 120 mm Hg
     2. \*90-100 mm Hg
     3. 70 – 90 mm Hg
     4. 50- 70 mm Hg
     5. < 50 mm Hg
735. What is the level of systolic blood pressure in the moderate degree of hemorrhagic shock severity?
     1. 120 mm Hg
     2. 90-100 mm Hg
     3. \*70 – 90 mm Hg
     4. 50- 70 mm Hg
     5. < 50 mm Hg
736. What is the level of systolic blood pressure in the severe degree of hemorrhagic shock severity?
     1. 20 mm Hg
     2. 90-100 mm Hg
     3. 70 – 90 mm Hg
     4. \*50- 70 mm Hg
     5. < 50 mm Hg
737. What is the level of systolic blood pressure in the considerable degree of hemorrhagic shock severity?
     1. 120 mm Hg
     2. 90-100 mm Hg
     3. 70 – 90 mm Hg
     4. 50- 70 mm Hg
     5. \*< 50 mm Hg
738. What is the level of hematocrit in the mild degree of hemorrhagic shock severity?
     1. \*0,30 – 0,38
     2. 0,20- 0,25
     3. 0,38 – 0,42
     4. 0, 25 – 0, 30
     5. < 0,20
739. What is the level of hematocrit in the moderate degree of hemorrhagic shock severity?
     1. 0,30 – 0,38
     2. 0,20- 0,25
     3. 0,38 – 0,42
     4. \*0, 25 – 0, 30
     5. < 0,20
740. What is the level of hematocrit in the severe degree of hemorrhagic shock severity?
     1. 0,30 – 0,38
     2. \*0,20- 0,25
     3. 0,38 – 0,42
     4. 0, 25 – 0, 30
     5. < 0,20
741. What is the level of hematocrit in the considerable degree of hemorrhagic shock severity?
     1. 0,30 – 0,38
     2. 0,20- 0,25
     3. < 0, 25
     4. 0, 25 – 0, 30
     5. \*< 0,20
742. What is the diuresis in hour in the mild degree of hemorrhagic shock severity?
     1. 50 ml
     2. \*30- 50 ml
     3. 25 – 30 ml
     4. 5 – 15 ml
     5. 5 ml
743. What is the diuresis in hour in the moderate degree of hemorrhagic shock severity?
     1. 50 ml
     2. 30- 50 ml
     3. \*25 – 30 ml
     4. 5 – 15 ml
     5. 5 ml
744. What is the diuresis in hour in the severe degree of hemorrhagic shock severity?
     1. 50 ml
     2. 30- 50 ml
     3. 25 – 30 ml
     4. \*5 – 15 ml
     5. 5 ml
745. What is the diuresis in hour in the IV degree of hemorrhagic shock severity?
     1. 50 ml
     2. 30- 50 ml
     3. 25 – 30 ml
     4. 5 – 15 ml
     5. \*0- 5 ml
746. All of the below are the factors in which predomination of amniotic pressure over venous is presented in Amniotic fluid embolism EXCEPT:
     1. excessive labor contractions
     2. \*preterm labor
     3. placenta abruption
     4. uterine cervix dystocia
     5. multiple pregnancy
747. All of the below are the factors in which trauma of venous uterine vessels is presented in Amniotic fluid embolism EXCEPT:
     1. placenta abruption
     2. puerperal hypotonic hemorrhage
     3. cesarean section
     4. manual removal of placenta
     5. \*postdate pregnancy
748. Differential diagnosis of Amniotic fluid embolism is performed with all of the below diseases EXCEPT:
     1. Myocardial infarction
     2. Thrombembolia of pulmonary artery
     3. \*Pneumonia
     4. Embolia by the air
     5. Mendelson’ syndrome
749. What is the blood loss in the mild degree of hemorrhagic shock severity?
     1. \*750 – 1000 ml
     2. 250 – 300 ml
     3. 400 – 450 ml
     4. 500 – 700 ml
     5. 1500 ml
750. What is the blood loss in the moderate degree of hemorrhagic shock severity?
     1. 750 – 1000 ml
     2. \*1000 – 1500 ml
     3. 450 – 550 ml
     4. 500 – 700 ml
     5. 1500 - 2000 ml
751. What is the blood loss in the severe degree of hemorrhagic shock severity?
     1. 750 – 1000 ml
     2. 1000 – 1500 ml
     3. 2500 – 3000 ml
     4. 1500 – 1000 ml
     5. \*1500 - 2500 ml
752. What is the blood loss in the minimal severe degree of hemorrhagic shock severity?
     1. 1000 ml
     2. 1500 ml
     3. \*> 2500 ml
     4. >3000 ml
     5. 3500 ml
753. The first stage of spreading postpartum infection:
     1. adjacent organs
     2. \*limited area of postpartum wounds
     3. localized in one organ
     4. generalized infection
     5. no correct answers
754. The second stage of postpartum infection spreading:
     1. adjacent organs
     2. limited area of postpartum wounds
     3. \*localized in one organ
     4. generalized infection
     5. no correct answers
755. The third stage of postpartum infection spreading:
     1. \*adjacent organs
     2. limited area of postpartum wounds
     3. localized in one organ
     4. generalized infection
     5. no correct answers
756. Fourth stage of postpartum infection spreading:
     1. adjacent organs
     2. limited area of postpartum wounds
     3. localized in one organ
     4. \*generalized infection
     5. no correct answers
757. The most common septic complications after delivery are:
     1. \*wound infection, endomyometritis
     2. thrombophlebitis
     3. metroflebitis
     4. mastitis
     5. peritonitis
758. Postpatum infection spreads:
     1. only by hematogenous
     2. only by rising
     3. by lymphogenous
     4. nothing above
     5. \*all answers are correct.
759. In the case of episiotomy wound infection:
     1. using of antibacterial therapy without cleaning of wound
     2. \*remove sutures, clean the wound, drainage
     3. draining wound without removing of sutures
     4. applying tampons without removing of sutures
     5. removing of sutures, applying oinment tampons
760. Diagnosis of postpartum endomyometritis is based on:
     1. the character of lochia
     2. the size and consistency of the uterus
     3. the results of blood analysis
     4. evidence of intoxication
     5. \*all answers are correct.
761. Treatment of parametritis with fluctuation includes all except:
     1. Colpotomy
     2. draining of wound
     3. cleaning of wound
     4. \*laparoscopy
     5. anti-bacterial therapy
762. The main clinical manifestation of postpartum peritonitis are:
     1. intestinal paresis
     2. abdominal pain
     3. increasing intoxication
     4. nausea, vomiting
     5. \*all answers are correct.
763. In what case the clinical signs of postpartum peritonitis appear the latest?
     1. in case of chorioamnionitis
     2. in case of postoperative intestinal paresis
     3. \*in case of suturing incompetence on the uterus
     4. all versions of the same
     5. no correct answers
764. The main signs of puerperal sepsis are:
     1. severe fever, intoxication
     2. presents of primary purulent focus, intoxication
     3. \*presents of primary purulent focus, severe fever, the selection of the bacterial agent from blood
     4. presents of primary purulent focus, severe fever
     5. presents of primary purulent focus, changes in white blood
765. Treatment of postpartum sepsis includes:
     1. \*removal of infected organ, complex intensive treatment
     2. intensive therapy: antibacterial, antitoxic
     3. in intensive care: antibacterial, immunomodulatory
     4. antibacterial, vitamin therapy
     5. elimination of foci of infection, vitamin therapy
766. On what day after Cesarean section peritonitis due to violation of the barrier function of intestine occurs?
     1. 1 - 2
     2. 9 - 10
     3. \*2 - 3
     4. 4 - 5
     5. 6 - 7
767. What among the proposed methods is the most important for the treatment of postpartum endometritis?
     1. bacteriological research on the flora and sensitivity to antibiotics
     2. intensive infusion therapy
     3. \*Removal of the delay parts of concepts products
     4. Irrigation wall cavity of the uterus antiseptic solutions
     5. desensibilizational therapy
768. On 10 day after delivery patient complains on increased body temperature till 38 0 C, pain in the left mammary gland. During palpation are determined painful infiltrations with softening in the center, hyperemia of the skin. Previous diagnosis:
     1. Laktostasis
     2. \*purulent mastitis
     3. serous mastitis
     4. fibroadenoma of mammalian gland
     5. diffuse mastopathia
769. Which stage of spreading septic process the infectious-toxic shock belongs to?
     1. First
     2. Second
     3. Third
     4. \*Fourth
     5. Fifth.
770. On what day after Cesarean section peritonitis due to insufficiency of uterus scar begins?
     1. 1 - 2
     2. 2 - 3
     3. \*4 - 5
     4. 6 - 7
     5. 9 - 10
771. What disease belong to the II stage of spreading septic process:
     1. Postpartum ulcer
     2. \*Pelvioperitonitis
     3. Endometritis
     4. Peritonitis
     5. Infection-toxic shock.
772. Which stage of spreading septic process phlebitis pelvic veins belongs to?
     1. First
     2. Second
     3. \*Third
     4. Fourth
     5. Fifth
773. How should qualified postpartum psychosis?
     1. \*As a manifestation of postpartum infection
     2. As a sign of organic brain damage
     3. As epilepsy
     4. As vasoneurosis
     5. As schizophrenia
774. Treatment of mastitis, which started includes all these except:
     1. Retromammarian Novocain blockage
     2. Dehydratation therapy
     3. Emptying of the breast
     4. \*Warm compresses on the mammalian gland
     5. All above
775. The vagina lacerations are repaired with:
     1. interrupted catgut suture from upper angle
     2. interrupted catgut suture starting from the upper corner, with 1-st suture on 1 cm above the end of the wound
     3. interrupted catgut suture starting from deep layer
     4. no interrupted catgut suture from the upper angle
     5. \*all methods are possible
776. Perineum ruptures of second degree are repaired:
     1. \*firstly perineum muscles and vaginal mucous with catgut, after the skin with silk or lavsan
     2. firstly commissural posterior, skin, vaginal mucous
     3. firstly skin, perineum muscles, vaginal mucus
     4. firstly vaginal mucous is sutured, starting from the upper corner, then on the skin silk or lavsan sutures
     5. all answers are correct
777. Vaginal lacerations are classified into:
     1. complete rupture of vagina
     2. incomplete rupture of vagina
     3. 3 degrees
     4. 2 degrees
     5. \*spontaneous, traumatic
778. Perineum lacerations are divided into:
     1. complete perineum rupture
     2. incomplete perineum rupture
     3. \*3 degrees
     4. 2 degrees
     5. 4 degrees
779. Indications to planned cesarean section in diabetus mellitus and pregnancy:
     1. uterine myoma and pregnancy
     2. placenta abruption
     3. polyhydramnios
     4. cervical incompetence
     5. \*probable fetal weight more than 4000 g
780. Sign of diabetic fetopathy in pregnancy:
     1. \*double contour of the fetal head
     2. oligohydramnion
     3. fetal growth retardation
     4. fetal distress
     5. placental dysfunction
781. To the methods of functional diagnostics does not belong:
     1. measuring basal temperature.
     2. symtom “pupillus”.
     3. symptom of “fern”.
     4. exfoliative vaginal cytology
     5. \*colposcopy.
782. What does belong to methods of functional diagnostics:
     1. measuring basal temperature.
     2. symtom “pupillus”.
     3. symptom of “fern”.
     4. exfoliative vaginal cytology.
     5. \*all above.
783. What is not an indication for administration the hysterosalpingography?
     1. tube infertility.
     2. infertility of endocrine genesis.
     3. infertility of uterine genesis.
     4. \*inflammatory diseases of uterus and tubes.
     5. a method is obligatory at the inspection of all patients with infertility.
784. When is not used the uterine sounding?
     1. for determination of permeability of cervical canal.
     2. for determination straight of cervical canal.
     3. for determination of length of uterine cavity.
     4. for the exposure of tumors in the uterine cavity.
     5. \*for the exposure of tumors of ovaries.
785. The uterus is supported by:
     1. the uterosacral ligaments .
     2. the cardinal ligaments .
     3. the round ligaments .
     4. the broad ligaments.
     5. \*all above
786. The examination of gynecological patient begins from?
     1. from the life history taking.
     2. from the illness history taking.
     3. from an external inspection.
     4. from gynecological examination.
     5. \*from getting a passport data.
787. What quantity of blood is lost by a woman during normal menstruation?
     1. less than 50 ml.
     2. 50-100 ml.
     3. \*50-150 ml.
     4. 150-200 ml.
     5. 200-250 ml.
788. The two main anatomic divisions of the uterus are:
     1. corpus and fundus.
     2. cornu and fundus.
     3. \*corpus and cervix.
     4. cervix and isthmus .
     5. cervix and fundus .
789. Which of the following doesn’t supply the uterus?
     1. uterine artery.
     2. ovarian artery.
     3. \*vaginal artery.
     4. all above.
     5. nothing above.
790. Before puberty, the ratio of the length of the body of the uterus to the length of the cervix is approximately:
     1. \*1:1.
     2. 2:1.
     3. 3:1.
     4. 4:1.
     5. nothing above.
791. What part of the ovary comes to contain the developing follicles?
     1. medulla.
     2. \*cortex.
     3. inner par .
     4. membrane.
     5. nothing above.
792. The fallopian tubes consist of:
     1. isthmus.
     2. ampulla.
     3. infundibulum.
     4. \*all above.
     5. ampulla and infundibulum
793. The wall of the uterus consists of:
     1. serous membrane and myometrium.
     2. endometrium and myometrium .
     3. endometrium and perimetrium .
     4. \*perimetrium, myometrium, endometrium.
     5. perimetrium and myometrium
794. What is the narrowest part of uterine tube?
     1. \*isthmus.
     2. ampulla.
     3. infundibulum.
     4. all above.
     5. ampulla and infundibulum
795. Duration of proliferation phase in uterine cycle is:
     1. from 1 to 5 day .
     2. \*from 5 to 14 day.
     3. from 14 to 28day .
     4. from 10 to 14 day.
     5. from 15 to 20 day
796. Duration of secretion phase in uterine cycle is:
     1. from 1 to 5 day .
     2. from 5 to 14 day.
     3. \*from 14 to 28day .
     4. from 10 to 14 day.
     5. from 15 to 20 day
797. The blood supply of the fallopian tubes is from:
     1. the ovarian arteries
     2. the uterine arteries
     3. \*the ovarian and uterine arteries
     4. the tubal arteries
     5. the rectum arteries
798. Which one of the following are external genital organ:
     1. major labia
     2. minior labia
     3. bartholin glands
     4. clitoris
     5. \*all answers are correct
799. Which method of gynacological examination does belong to basic?
     1. \*inspection of external genitalia.
     2. taking of smear on a flora.
     3. taking of smear on oncocytology.
     4. ultrasonic examination.
     5. biopsy.
800. Which process represents the IIb type of smear at oncocytological examination?
     1. the unchanged epithelium.
     2. proliferation.
     3. \*metaplasia.
     4. inflammatory process.
     5. malignisation.
801. The change of basal temperature is based on?
     1. \*on influence of progesteron on hypothalamus.
     2. on influence of estrogens on hypothalamus.
     3. on influence of estrogens on a hypophysis.
     4. on influence of progesteron on a hypophysis.
     5. on influence of progesteron on an uterus.
802. What is the cariopicnotic index?
     1. correlation of cells with picnotic nuclears to the eozinofil cells.
     2. correlation of cells with picnotic nuclears to the intermediate cells.
     3. correlation of cells with picnotic nuclears to the superficial cells.
     4. \*correlation of cells with picnotic nuclears to all cells in a smear.
     5. correlation of cells with picnotic nuclears to the basal cells.
803. What is an indications for conducting of ultrasonography?
     1. suspicion on the cancer of uterine cervix.
     2. chronic colpitis.
     3. \*uterine myoma.
     4. pregnancy of early terms.
     5. all transferred.
804. What appearance of the first menstruation in 14 years can testify about?
     1. about the presence of inflammatory disease of uterus.
     2. about the presence of inflammatory disease of adnexa.
     3. about the presence of abnormal position of uterus.
     4. about the presence of of genius infantilism.
     5. \*about normal development of organism of girl.
805. Which method does belongs to endoscopic?
     1. \*colposcopy.
     2. hysterosalpingography.
     3. culdocentesis.
     4. ultrasonic examination.
     5. cytologycal.
806. Which process represents the I type of smear of oncocytological examination?
     1. \*the unchanged epithelium.
     2. proliferation.
     3. metaplasia.
     4. inflammatory process.
     5. malignisation.
807. Pap smear test detected moderate dysplasia on a background of unchanged epithelium. Which is the type of smear?
     1. IIa.
     2. IIb.
     3. \*IIIa.
     4. IIIb.
     5. IIIс.
808. The Shiller’s test is based on:
     1. \*on power of iodine to unite with glycogen.
     2. on discoloration of the pathologically changed areas.
     3. on the short term edema of tissue.
     4. on coloring by the iodine of areas of displasia.
     5. on coloring by the iodine of areas of inflammation.
809. What is contraindication for conducting of the diagnostic curettage of uterine cavity?
     1. presence of bleeding from an uterus.
     2. suspicion on the polyps of mucus membrane of uterus.
     3. suspicion on the cancer of endometrium.
     4. presence of polyps of cervical canal.
     5. \*presence of endometritis.
810. How to start a survey of gynecological patients?
     1. from the life history taking.
     2. from the disease history taking.
     3. from allergic anamnesis.
     4. from professional anamnesis.
     5. \*complaints of patient.
811. Which localization of pain is typical for the inflammatory diseases of adnexa?
     1. in lower part of abdomen above a pubis.
     2. in a right hypogastric area.
     3. \*in lateral quadrants of lower part of abdomen.
     4. in epigastrium.
     5. in sacrum and lumbal region.
812. Which question during questioning of a patient is the first about the menstrual function?
     1. \*When menarhe came?
     2. When did menstruation become regular?
     3. When the last menstruation begun?
     4. How many days the menstruation proceeds?
     5. How many blood is lost during menstruation?
813. Which smear is obligatory at routine gynecological examination?
     1. on hormonal cytology.
     2. on microflora.
     3. on the degree of cleanness.
     4. on a “hormonal mirror”.
     5. \*on oncocytology.
814. Which process represents the IIIa type of smear at oncocytological examination?
     1. the unchanged epithelium.
     2. \*mild or moderate dysplasia.
     3. cancer.
     4. inflammatory process.
     5. suspicion on malignisation.
815. What a diphasic basal temperature testifies about?
     1. about the presence of normal menstrual cycle.
     2. about the presence of ovulation.
     3. about the presence of lutein phase.
     4. about the presence of diphasic menstrual cycle.
     5. \*all above.
816. Which possibilities does hysteroscopy have?
     1. it is possible to examine mucus of the uterus.
     2. it is possible to expose the pathological changes of endometrium.
     3. it is possible to delete the polyps of endometrium.
     4. it is possible to delete a intraepithelial contraceptive.
     5. \*all above.
817. For diagnosis which disease a biopsy used?
     1. \*cancer of uterine cervix.
     2. cancer of uterus.
     3. uterine myoma.
     4. cancer of ovaries.
     5. all above.
818. What appearance of the first menstruation in 16 years can testify about?
     1. about the presence of inflammatory disease of uterus.
     2. about the presence of inflammatory disease of adnexa.
     3. about the presence of abnormal position of uterus.
     4. \*about the presence of genital infantilism.
     5. about normal development of organism of girl.
819. Which localization of pain is typical for the diseases of uterus?
     1. \*in lower part of abdomen above a pubis.
     2. in a right hypogastric area.
     3. in the left hypogastric area.
     4. in epigastrium.
     5. in sacrum and lumbal region.
820. At bimanual examination a normal uterine tube are palpated as:
     1. elastic structures.
     2. dense structures.
     3. pelvic mass.
     4. thin elastic unpainful structures.
     5. \*not are palpated.
821. Which process represents the IIIb type of smear at oncocytological examination?
     1. the unchanged epithelium.
     2. mild dysplasia.
     3. moderate dysplasia on a background malignant regeneration.
     4. \*severe dysplasia on the background of high quality processes.
     5. suspicion on malignisation.
822. What does the presence of positive symptom “pupillus”during all menstrual cycle testify about?
     1. \*about the high saturation of organism of estrogens.
     2. about estrogen insufficiency.
     3. about the presence of ovulation.
     4. about the presence of lutein phase.
     5. about the presence of early follicular phase.
823. Preparation of patient for conducting ultrasound assessment of the female genitalia?
     1. emptying the urinary bladder.
     2. \*to drink several glasses of water or other liquid one to two hours before the procedure
     3. being on diet during 3 days before examination.
     4. examination is conducted on a hungry stomach.
     5. examination is conducted after the inspection of uterine cervix in speculum.
824. A pelvic ultrasound may be used to diagnose and assist in the treatment of the following conditions:
     1. abnormalities in the anatomic structure of the uterus.
     2. fibroid tumors.
     3. presence and position of an intrauterine contraceptive device (IUD)
     4. monitoring of ovarian follicle size for infertility evaluation
     5. \*all above
825. What is the average age of menarche?
     1. 8-9 years.
     2. 9-10 years.
     3. 10-11 years.
     4. \*12 year.
     5. 16 year.
826. What instruments are used for a Pap Smear?
     1. Cuscoe’ speculum.
     2. Sims’ speculum.
     3. \*cytobrush.
     4. pincers.
     5. cornzang.
827. When in a norm the “pupil” symptom is most positive?
     1. after menstruation.
     2. in an early follicular phase.
     3. \*in time of ovulation.
     4. in an early lutein phase.
     5. during the menstruation.
828. What does the index of ripening 0/20/80 testifie about?
     1. an early follicular phase.
     2. \*the phase of ovulation.
     3. a lutein phase.
     4. hormonal insufficiency.
     5. insufficiency of estrogens.
829. What method enables to define permeability of uterine tubes?
     1. colposcopy.
     2. hysteroscopy.
     3. rentgenopelvigraphy.
     4. \*hysterosalpingography.
     5. ultrasound examination.
830. Bartholin gland of vagina are located:
     1. in the basis of minor labia.
     2. in thickness of mid- layers of major labia.
     3. in a groove between the bottom thirds of minor and major labia.
     4. \*in thick back parts of major labia.
     5. in uterus.
831. Excretions from a vagina “cheese-like” arise up at:
     1. \*vaginal candidosis.
     2. genital trichomoniasis.
     3. malignant tumors.
     4. erosions of uterine cervix.
     5. non-specific colpitis.
832. Which question belongs to questioning of a sexual function of a patient?
     1. \*When did you start the sexual life?
     2. Did you have any abortion?
     3. The first day of your last menstruation?
     4. Did the character of menstruation change lately?
     5. How many abortions were?
833. Which artery supplies most of the pelvis?
     1. The internal pudendal artery
     2. The common carotid arteries
     3. The femoral artery
     4. \*The internal iliac (hypogastric) artery
     5. The middle cerebral artery
834. Which disease does permanent dull pain have?
     1. at the diseases of vagina.
     2. \*at chronic inflammatory processes.
     3. at the rupture of uterine tube.
     4. at a tubal abortion.
     5. at algomenorrhea.
835. Symptoms of Stein-Leventhal syndrome:
     1. obesity
     2. irregular or no menstruation
     3. acne
     4. excess hair growth
     5. \*All of the above
836. What is a Pap Smear?
     1. \*is a screening test for cervical cancer.
     2. is a screening test for fertility.
     3. the analysis the microbial flora.
     4. the determination of vaginal pH.
     5. determination of correlation of cells on different types of ripening
837. Appearance of “fern symptom” is based on:
     1. on the change of type of uterine cervix.
     2. on diameter of cervical canal.
     3. on the rise of viscidity of cervical mucus.
     4. \*on power of mucus to crystallize at drying.
     5. on hyperthermic influence of progesteron on hypothalamus.
838. What is used for extended colposcopy?
     1. a 3% solution of boric acid.
     2. \*a 3% solution of vinegar acid.
     3. a 3% solution of NaCl.
     4. a 10% solution of chloride of sodium.
     5. a 10% Lugol solution.
839. Which basal temperature in the first phase of menstrual cycle must be?
     1. 36,0.
     2. 36,2-36,5.
     3. 37,0.
     4. \*36,6-36,8.
     5. 37,1-37,4.
840. Excretions from a vagina "foamy" character arise up at:
     1. vaginal candidosis.
     2. \*genital trichomoniasis.
     3. malignant tumors.
     4. erosions of uterine cervix.
     5. non-specific colpitis.
841. Aim of bacterioscopic examination?
     1. for the revealing atypical cells.
     2. for determination of correlation of cells with a different stage of development.
     3. for determination of correlation of cells on different types of ripening.
     4. \*for the analysis the microbial flora.
     5. for determination of vaginal pH.
842. A doctor will take sample cells for Pap Smear from:
     1. from the lateral fornix of vagina and cervical canal.
     2. from vaginal part of uterine cervix.
     3. from the back fornix of vagina and cervical canal.
     4. from a cervical canal.
     5. \*from vaginal part of uterine cervix and cervical canal.
843. What process represents the V type of smear at oncocytological examination?
     1. the unchanged epithelium.
     2. mild or moderate dysplasia.
     3. \*cancer.
     4. inflammatory process.
     5. suspicion on malignisation.
844. When in a norm the “fern” symptom is most positive?
     1. at once after menstruation.
     2. in the early follicular phase.
     3. \*in time of ovulation.
     4. in the early lutein phase.
     5. in end of menstruation.
845. Which basal temperature in the second phase of menstrual cycle must be?
     1. 36,0.
     2. 36,2-36,5.
     3. 37,0.
     4. 36,6-36,8.
     5. \*37,1-37,4.
846. The upper border of the frontal vaginal wall contacts with:
     1. \*urenary bladder
     2. urethra
     3. ureter
     4. rectum
     5. all are wrong
847. Haw many degrees of uterus displacement?
     1. 1 .
     2. \*3.
     3. 2.
     4. 4.
     5. 5.
848. Normal position of uterus is:
     1. anteflexio, retroposition .
     2. retroflexio, retroposition.
     3. \*anteversio, anteflexio .
     4. anteflexio, retroversio.
     5. retrodeviation.
849. What is uterine retrodeviation?
     1. combination of anteflexioand retroposition .
     2. \*combination of retroflexion and retroversion.
     3. combination of anteversio and anteflexio .
     4. combination of anteflexio andretroversio.
     5. nothing above
850. What can leed to uterus prolaps?
     1. vaginal and perineum injuries during previous delivery .
     2. multiple deliveries.
     3. constipations .
     4. hard work.
     5. \*all above.
851. Hypomenstrual syndrome includes:
     1. \*Oligomenorrhea, opsomenorrhea, hypo menorrhea
     2. Opsomenorrhea, polimenorrhea
     3. Proyomenorrhea, hypomenorrhea
     4. Oligomenorrhea, hypermenorrhea
     5. All of the above
852. Indicate factor which doesn't lead to menstrual dysfunction:
     1. Chronic intoxication
     2. Sexual infantilism
     3. Long-term chronic infection
     4. Abnormal development of genital organs
     5. \*none of the above
853. Amenorrhea - is:
     1. Absence of menstruation during 1year
     2. \*Absence of menstruation for 6 months
     3. Duration of menstruation more than 7 days
     4. Duration of menstruation less than 2 days
     5. none of the above
854. Which type of amenorrhea does not exist?
     1. Secondary
     2. False
     3. \*Combined
     4. Physiological
     5. Pathological
855. Which the hormonal imbalance underlies the galactorrhea syndrome?
     1. Increasing of all gonadotropins hormones
     2. \*Hyperprolactinemia
     3. Increasing secretion of Tireotropin hormone
     4. Increased level of progesterone
     5. Decreased production of 17 - ketosteroids
856. Which types of dysfunctional uterine bleeding are presented below?
     1. Ovulatory
     2. Anovulatory
     3. Cyclic
     4. Acyclic
     5. \*All of the above
857. Characteristic of anovulatory uterine bleeding:
     1. Monophasic basal temperature below 37 degrees
     2. Absence of s "fern" and "pupil" symptoms in the middle of the menstrual cycle
     3. Absence of secretory transformation of the endometrium
     4. \*All of the above
     5. None of the above
858. Which of the following diseases displays abnormal rhythm of menstruation?
     1. Spaniamenorrhea
     2. Opsomenorrhea
     3. Tahimenorhea
     4. \*All of the above
     5. None of the above
859. Indicate changes which are presented during the follicular persistence:
     1. Absence of ovulation
     2. Absence of the corpus luteum and progesterone production
     3. Absence of endometrial secretory transformation
     4. None of the above
     5. \*all the above
860. Tests of functional diagnostics include:
     1. investigation of cervical mucous layer
     2. changes of basal temperature
     3. colpocytology
     4. \*all answers are correct
     5. all are incorrect
861. The lower border of the frontal vaginal wall contacts with:
     1. urethra
     2. urenary bladder
     3. \*ureter
     4. rectum
     5. all are wrong
862. The upper border of back wall of vagina consists of:
     1. rectum
     2. \*douglus pouch
     3. cervix of the urinary bladder
     4. urethra
     5. all are wrong
863. The uterine form of amenorrhea can result from all specified below diseases, except:
     1. Frequent curettage of the uterine cavity
     2. Genital infantilism
     3. Chronic inflammation nonspecific etiology
     4. Tuberculosis of endometrium
     5. \*None of the below
864. What is not used for diagnosis of disorders of the menstrual cycle?
     1. Tests of functional diagnostics
     2. Investigation of the hormone levels in the blood
     3. X-ray of sella turcica
     4. Determining the level of TTH
     5. \*Use all of the above
865. Spaniomenorrhoea - is:
     1. Shortening of the menstrual cycle less than 21 days
     2. Absence of menstruation for 6 months
     3. Painful menstruation
     4. Excess loss of blood during menstruation
     5. \*None of the above
866. What is characteristic for uterine form of amenorrhea?
     1. Decresed basal temperature in the second phase of the cycle
     2. \*Normal basal body temperature chart
     3. Raising the temperature in the I phase of the cycle
     4. Monophasic basal body temperature chart
     5. None of the above
867. The complication of false amenorrhea:
     1. Hypotrophy of the mammary glands
     2. \*Hematocolpos
     3. Anovulation
     4. opsomenorrhoea
     5. All listed
868. Proyomenorrhea is:
     1. \*Shortening of the menstrual cycle less than 21 days
     2. Increased of the menstrual cycle to 3 - 6 months (2 - 4 times per year)
     3. Length of menstrual cycle 6 - 8 weeks
     4. Decreased of the duration of menstruation up to 2 days
     5. None of the above
869. The internal genital organs are represented by the following organs except for:
     1. \*bartholin gland
     2. uterus
     3. fallopian tube
     4. ovary
     5. None of the above
870. For the clinical manifestations of dysmenorrhoea are not typical:
     1. Headache
     2. Nausea
     3. \*Excessive blood loss
     4. Abdominal pain
     5. Irritability
871. Which of the following method is used to diagnose uterine form of amenorrhea?
     1. \*Hysteroscopy
     2. Tests of functional diagnostics
     3. Hysterosalpingography
     4. None of the above
     5. All listed
872. Duration of menstruation less than 2 days is called:
     1. \*Oligomenorrhea
     2. Opsomenorhea
     3. Hypomenorhea
     4. Hypermenorrhea
     5. All listed
873. Which of the following is the cause of ovarian form of amenorrhea?
     1. congenital gonades’ dysgenesia
     2. the Shereshevsky-Terner’s syndrome
     3. the Shtein-Levental syndrome
     4. \*All of the above
     5. None of the above
874. the Shereshevsky-Terner’s syndrome is the result of:
     1. \*a complex of genetic defects, connected with chromosomes anomaly
     2. Presence of double uterus
     3. Absence of ovaries
     4. Vaginal atresia
     5. Polycystic ovarian syndrome
875. Hypomenorhea - is:
     1. \*reduced amount of blood, less than 50 ml
     2. an excessive amount of blood, more than 100-150 ml
     3. The absence of menstruation for 6 months
     4. Duration of menstruation more than 12 days
     5. None of the above
876. Stein - Leventhal syndrome is characterized by:
     1. \*Ovarian amenorrhea
     2. Uterine amenorrhea
     3. Hypothalamic amenorrhea
     4. Cryptomenorrhea
     5. None of the above
877. Stein - Leventhal syndrome is characterized by:
     1. Presence of cystic changes in ovaries
     2. Cryptomenorrhea
     3. Hirsutism
     4. Infertility
     5. \*All listed
878. What from listed methods is not used in the inspection of virgin girls?
     1. Examination of the Breast
     2. \*Speculum inspection
     3. Inspection of the external genitalia
     4. None of the above
     5. All listed
879. Tests of functional diagnostics allow to detect the following except:
     1. cario-picnotic index
     2. symtom “pupillus”
     3. measurement of basal temperature
     4. \*gestagen testing
     5. fern symptom
880. Prepuberty - is:
     1. \*a period of two years immediately prior to the onset of puberty when growth and changes leading to sexual maturity occur
     2. Age of menarche
     3. The first year after the onset of menarche
     4. Age from 5 to 8 years
     5. None of the above
881. Puberty finished:
     1. Establishment of normal ovulatory menstrual cycle
     2. The appearance of secondary sexual characteristics
     3. In 16 years
     4. \*Since the beginning of the first menstruation
     5. None of the above
882. Gestagens possess the following action:
     1. decrease amount of cholesterole in the blood
     2. determine development of primary and secondary sex characters
     3. increase uterine contractility
     4. all answers are correct
     5. \*all are wrong
883. Tests of functional diagnostics allow to detect:
     1. two-phase nature of menstrual cycle
     2. level of estrogen saturation of an organism
     3. presence of ovulation
     4. full value of luteinising cycle
     5. \*all are correct
884. Treatment of juvenile uterine bleeding provides all of the above, except:
     1. stopping Haemorrhage
     2. Normalization of menstrual function
     3. \*Stimulation of Ovulation with clomifene
     4. Antianaemia therapy
     5. All of above
885. Which of the following is not recommended for the treatment of juvenile bleeding?
     1. Hormone
     2. Hemostatic agents
     3. vitamins
     4. Antianaemia drugs
     5. \*All of the above are indicated
886. In premature sexual maturation secondary sexual signs and menarche appeared:
     1. \*In 9 years
     2. In 11 years
     3. In 13 years
     4. None of these cases
     5. In all these cases
887. Which of the following unusual for premature puberty?
     1. Delayed intellectual development
     2. Accelerated physical development during maturation, with subsequent delay
     3. Early ossification
     4. \*Typically all of the above
     5. None of the above
888. Which of the following is not typical for the delay of sexual development by ovarian origin?
     1. \*The presence of ovulation once for 45 days
     2. Rudimentary ovaries
     3. Maldevelopmentation of secondary sexual characteristics
     4. Can attend all of the above
     5. None of the above
889. What agents most frequently caused inflammatory diseases in the girls?
     1. Pale treponema
     2. Gonococcus
     3. Chlamydia
     4. \*Staphylococcus
     5. All of the below
890. Which ovarian cyst are most common in the girls?
     1. Hormone active tumors
     2. \*Retention cyst
     3. Malignant tumors
     4. Dermoid cyst
     5. All of the above
891. Estrogen possess the following action:
     1. promotes peristalsis in uterus and tube
     2. promotes processes of ossification
     3. stimulates activity of cellular immunity
     4. \*all answers are correct
     5. all are wrong
892. Treatment of juvenile bleeding can not start from:
     1. \*Fractional curettage of the endometrial cavity
     2. Hormone
     3. Hemostatic agents
     4. All methods are used
     5. None of the above
893. In the children's gynaecology do not use:
     1. \*Hysteroscopy
     2. Test of functional diagnostic
     3. Ultrasound sonography
     4. Bakterioscopy
     5. All of the above
894. The pelvic exam in virgin is indicated in:
     1. \*In suspecting of a foreign body in vagina
     2. In the case of juvenile bleeding
     3. In inflammatory processes of the vulva
     4. In all these cases
     5. None of the above
895. The young woman 20 years old, whose delivered a year ago, Shihan' syndrome was the diagnosis of the doctor. What you need for confirmation of the diagnosis?
     1. \*Research level of gonadotropic hormones, pituitary tomography
     2. Hysteroscopy
     3. Culdoscopy
     4. Laparoscopy
     5. All of the above
896. 12 years old girl complains of bleeding from the genital tract, which first appeared 3 days ago. Physically well developed secondary sexual characteristics are expressed. External genitalia developed properly. What is the most reliable cause bleeding?
     1. Dysfunctional uterine bleeding
     2. \*Menarche
     3. Endometrial cancer
     4. Hormonone active ovarian tumor
     5. Hemophilia
897. 15 years old female patient was admitted to the gynaecology department, complaining of spotting that began 10 days ago. The first menstrual period was 3 months ago, after it was delayed for 2 - 5 months. Sexual life does not live through the rectum is defined by a reduced body of the uterus, the relations between the body and neck of 1:1. Extras are not determined. Coagulogram normal, complete blood count - a slight decrease in haemoglobin level. What is the most likely diagnosis?
     1. threatened miscarriage
     2. \*Juvenile bleeding
     3. Idiopathic thrombocytopenic purpura
     4. All above
     5. Notning above
898. 26 years old woman 6 months ago have delivered. A child is on breast feeding. Came to the survey because of absence of menses, they do not appear after birth once. When bimanual examination the uterus is not enlarged, dense, andexa are not determined. What is the most likely diagnosis?
     1. Psevdoamenorrhea
     2. \*Lactated amenorrhea
     3. Sheehan's syndrome
     4. Chiari - Frommelya syndrome
     5. 3 - 5 weeks of Pregnancy
899. What kind of endometriosis belongs to internal?
     1. endometriosis of uterine cervix
     2. endometriosis of vagine
     3. \*endometriosis of uterus
     4. All above
     5. Nothing above
900. Which of medicines should not be used for treatment of endometriosis?
     1. danasol
     2. \*sinestrol
     3. dufaston
     4. zoladex
     5. danogen
901. Lately menstruations at patient gained character hyperpolimenorrhea. She complains on brown excretions and a few days after, menstruations are painful. In history – 3 artificial abortions. Bimanual examination: the uterus is insignificaly enlarged. A hysterosalpingography – infiltration of contrast inside the uterine wall. Previous diagnosis?
     1. \*endometriosis of uterus body
     2. cancer of uterus body
     3. myoma
     4. endometriosis of uterus cervix
     5. horiocarcinima
902. How is the state named, when less than 2 days proceed to menstruation?
     1. spaniomenorrhea
     2. hypomenorrhea
     3. proyomenorrhea
     4. \*oligomenorrhea
     5. opsomenorrhea
903. What menorrhagia is?
     1. bleeding unconnected with a menstrual cycle
     2. more than 150ml blood during menstruation
     3. \*duration of menstruation over 12 days
     4. duration of menstruation 5-10 days
     5. duration of menstruation 7-12 days
904. What changes develop in the organism of patients after removing of ovaries?
     1. hirsutism.
     2. prolaps uterus
     3. inflammatory diseases
     4. obesity
     5. \*osteoporosis
905. What is the highest level of menstrual regulation?
     1. \*brain cortex
     2. hypothalamus
     3. ovaries
     4. uterus
     5. all above
906. To hypothalamic amenorrhea does not belong:
     1. psychogenic amenorrhea
     2. \*amenorrhea at a syndrome Shikhane
     3. amenorrhea at false pregnancy
     4. amenorrhea at adipozogenital dystrophy
     5. amenorrhea at a syndrome Kiary-Frommel
907. How the acyclic, not connected with menstrual cycle uterine bleeding are named?
     1. polymenorrhea
     2. bradimenorrhea
     3. menorrhagia
     4. \*metrorrhagia
     5. metropatia
908. Physiology amenorrhea is caused by such states of organism, exept for:
     1. lactation
     2. pregnancy
     3. menopause
     4. puberty age
     5. \*endocrine disease
909. Ovarian amenorrhea is at:
     1. Itsenco-Kushing syndrome
     2. false pregnancy
     3. \*Shtein-Levental syndrome
     4. syndrome Shikhane
     5. all above
910. Which from transferred syndromes does not belong to neuroendocrine?
     1. \*Shershevscy-Terner
     2. Shtain-Levental syndrome
     3. climacteric
     4. postovarioectomy
     5. all above
911. At what age climacteric period start “in time”?
     1. in 40-45 years
     2. in 42-44 years
     3. \*in 49-50 years
     4. In 55-57 years
     5. when menstruations are halted, age not important
912. Name the sequence of levels of adjusting of menstrual function
     1. \*brain cortex-hypothalamus-hypophysis-ovaries-uterus
     2. hypothalamus-hypophysis-ovaries-uterus
     3. hypophysis-ovaries-uterus
     4. hypothalamus-hypophysis -uterus -ovaries
     5. brain cortex-hypothalamus-hypophysis –uterus –ovaries
913. Diagnostics of virile syndrome must include:
     1. \*determination of 17-ketosteroids level
     2. curettage of walls
     3. colposcopy
     4. culdocentesis
     5. biopsy
914. Pathogenesis of this disease is connected with necrosis of pituitary gland:
     1. Shershevscy-Terner syndrome
     2. \*Shikhane's syndrome
     3. adrenogenital syndrome
     4. Shtain-Levental syndrome
     5. nothing above
915. In climacteric age the medical treatment of dysfunctional uterine bleeding begin with:
     1. setting of estrogens
     2. \*diagnostic curettage of uterine cavity
     3. colposcopy
     4. setting of androgens
     5. setting of gestagens
916. Where are prostaglandins synthesized?
     1. in hypophysis
     2. in ovaries
     3. in adrenal glands
     4. in a pancreas
     5. \*in all tissues of organism
917. What symptome is leading in the clinical manifestation of pathological climacteric period?
     1. \*neurovegetative
     2. endocrine
     3. cerebral
     4. asteno-neurotic
     5. atrphy
918. The postcastrative syndrome develops after:
     1. the carried of endocrine diseases
     2. \*removing of ovaries
     3. removing of uterus
     4. introduction of large doses of hormons
     5. violation of pituitary function
919. Which hormone provides lactation process:
     1. estrogen
     2. cortizol
     3. insulin
     4. \*prolactin
     5. all are correct
920. What is spaniomenorrhea?
     1. menstruations come in 6-8 weeks
     2. \*menstruations come 1 time per 4-6 monthes
     3. menstruations are absent
     4. quantity of menstrual blood less than 50ml
     5. duration of menstruation 1-2 days
921. What changes of multilayer squamosus epithelium is common for true erosion?
     1. Proliferation
     2. desquamation
     3. Ectopia
     4. \*Metaplasia
     5. Reganeration
922. True erosion is diagnosed with:
     1. \*Colposkopy
     2. Bimanual assessment
     3. ultrasonography
     4. Smear bacterioskopy
     5. CTG
923. Healing of true erosion is going with:
     1. connective tissue
     2. \*single-layered cylindricum epithelium
     3. multilayer pavement epithelium
     4. Growth of secretory glands
     5. all are wrong
924. True erosion is healing within:
     1. up to one month
     2. up to 6 months
     3. \*up to 2-3 weeks
     4. up to 1 year
     5. there is no self-healing
925. For the treatment of true cervical erosion we use:
     1. Dexamethazone
     2. Myramistin ointment
     3. Lugol solution
     4. Iodine solution
     5. \*Solkovagin
926. Etiological factors of psudoerosin is all except:
     1. Dyshormonal disturbances
     2. Changes of humoral immunity
     3. Autoimmune process
     4. \*Alimentary factor
     5. Inflammatory process
927. Ectopy of cylindricum epithelium we divede into:
     1. Premenopausal, menopausal, postmenopausal
     2. mild, moderate, severe
     3. \*congenital, posttraumatic, dyshormonal
     4. cervical, vaginal and vulval
     5. all are wrong
928. The test for measurement of basal temperature is based on hyperthermal effect of:
     1. estradiol
     2. prostaglandin
     3. \*progesterone
     4. LTH
     5. FH
929. For polyp treatment we use all except:
     1. polyp twisting
     2. Coagulation
     3. endocervical curettage
     4. \*conization of cervix
     5. cryodestruction
930. HPV-infection is more common for:
     1. parturiant women with septical cmplications
     2. women with pathological menopause
     3. women with frequent respiratory diseases
     4. women with menstrual dysfunction
     5. \*sexually active women
931. HPV cervical lesions can be all except:
     1. Condyloma acuminata
     2. condyloma latum
     3. Inverted condyloma
     4. \*Cervical polyp
     5. cervical cancer
932. Action of estrogen on the organism:
     1. blocks receptor of uterus
     2. weaken proliferative process of endrometrium
     3. causes secretory transformation of endometrium
     4. all answers are correct
     5. \*all are wrong
933. The most exact method for the diagnosis of the reason of the uterine bleeding:
     1. colposcopy
     2. \*laparoscopy
     3. USG
     4. hysteroscopy
     5. cystoscopy
934. In diagnistic of cervical leucoplacia we use all except:
     1. biopsy
     2. colposcopy
     3. cytology
     4. Speculum assessment
     5. \*culdoscopy
935. To the benign cervical condition belong all except:
     1. dysplasia
     2. leukoplakia
     3. erythroplasia
     4. Endometriosis
     5. \*adenomatosis
936. To the risk factors for dysplasia belong all except:
     1. Early sexual activity
     2. A lot of sexual partner
     3. cervical trauma during delivery and abortion
     4. hyperestrogenemia
     5. \*hyperprogesteronemia
937. In diagnostic of cervical dysplasia we use all except:
     1. cytological examination
     2. histochemical examination
     3. cytogenetic examination
     4. \*metrosalpingography
     5. colposcopy
938. The indication for hysterosalpingography is:
     1. suspicion on fallopian tube sterility
     2. suspicion on internal endometriosis
     3. presence of intrauterine pathology
     4. \*all answers are correct
     5. all answers are incorrect
939. Cervical adenomatosis is:
     1. \*Atypical glandular hyperplasia
     2. Glandular-cystical hyperplasia
     3. multilayer pavement epithelium hyperplasia
     4. Metaplasia of cylindrical epithelium
     5. none above
940. In treatment of benign process we use all except:
     1. electrocauterizing conization
     2. electrocauterizing excision
     3. cryoablation
     4. laser destruction
     5. \*coagulation with solkovagin
941. In what type of ovarion tumour we have endometrium hyperplasia?
     1. yellow body cyst
     2. ovarian cancer
     3. \*follicle cyst
     4. paraovarian cyst
     5. papillary cystoma
942. What is typical for proliferative myoma?
     1. presence of atypia
     2. \*increased mitotic activity
     3. node calcification
     4. multiple nodes
     5. atypical localization
943. What ovarian tumour belongs to estrogenproductive tumour and might cause development of hyperplasticprocess in uterine?
     1. fibroma
     2. androblastoma
     3. \*thecoma
     4. pseudomyxoma
     5. pseudomucinous cystoma
944. Node consistency of uterine fibromyoma depends from:
     1. \*correlation of parenchyma and stroma
     2. vessels' amount
     3. presence of endometrioid tissues
     4. fatty tissue amount
     5. node size
945. What sign is not typical for proliferative myoma?
     1. \*Atypical growth
     2. plenty of plasmatic cells
     3. plenty of lymphoid cells
     4. fast growth
     5. increased mitotic activity
946. Subserouse fibromyoma node is localizes in:
     1. \*under peritoneum
     2. under uterine mucous layer
     3. in myometrium
     4. behind cervix
     5. between broad ligament layers
947. Submucous myoma node is localized:
     1. under peritoneum
     2. \*under uterine mucous layer
     3. in myometrium
     4. behind cervix
     5. between broad ligament layers
948. Intramural myoma node is localized:
     1. under peritoneum
     2. under uterine mucous layer
     3. \*in myometrium
     4. behind cervix
     5. between broad ligament layers
949. Interstitial myoma node is localized:
     1. under peritoneum
     2. under uterine mucous layer
     3. \*in myometrium
     4. behind cervix
     5. between broad ligament layers
950. Intraligamentary myoma node is localized:
     1. under peritoneum
     2. under uterine mucous layer
     3. in myometrium
     4. behind cervix
     5. \*between broad ligament layers
951. Retrocervical myoma node is localized:
     1. under peritoneum
     2. under uterine mucous layer
     3. in myometrium
     4. \*behind cervix
     5. between broad ligament layers
952. What is typical for hormonal status of patient with fibromyoma?
     1. high level of chorionic gonadotropin
     2. high level of prgesteron
     3. high level of androgens
     4. high level of pituitary gland hormons
     5. \*high level of estrogens
953. What sign is typical for subserous myoma?
     1. hyperpolymenorrhea
     2. infertility
     3. metrorrhagia
     4. all above
     5. \*symptomless
954. What sign is typical for submucous myoma?
     1. \*hyperpolymenorrhea
     2. amenorrhea
     3. foamy vaginal discharge
     4. tumour destruction
     5. symptomless
955. What sign is typical for retrocervical myoma?
     1. hyperpolymenorrhea
     2. infertility
     3. foamy vaginal discharge
     4. amenorrhea
     5. \*rectum dysfunction
956. What method should be used for diagnostic subserous myoma?
     1. hysterosalpingography
     2. uterine probing
     3. \*ultrasonography
     4. curettage of uterine cavity
     5. hysterography
957. What method should be used for diagnostic submucous myoma?
     1. laparoscopy
     2. \*hysteroscopy
     3. Doppler assessment
     4. biopsy
     5. puncture of abdominal cavity through posterior vaginal fornix
958. What method should be used for diagnostic interstitial myoma?
     1. hysterosalpingography
     2. uterine probing
     3. \*ultrasonography
     4. curettage of uterine cavity
     5. hysteroscopy
959. At what form of uterine fibromyoma we have such complication as node twisting?
     1. \*subserous
     2. submucous
     3. intraligamentous
     4. interstitial
     5. retrocervical
960. At what form of uterine fibromyoma we have such complication as node delivering?
     1. subserous
     2. \*submucous
     3. intraligamentous
     4. interstitial
     5. retrocervical
961. At what form of uterine fibromyoma we have such complication as inversion of uterus?
     1. subserous
     2. \*submucous
     3. intraligamentous
     4. interstitial
     5. retrocervical
962. What size of uterus in case of fibromyoma is indication for surgical treatment?
     1. as 6 weeks of gestation.
     2. as 8 weeks of gestation
     3. as 10 weeks of gestation
     4. \*as 12 weeks of gestation
     5. as 16 weeks of gestation
963. What endometrium conditions belong to the background disease?
     1. \*glandular-cystic hyperplasia
     2. adenomatosis
     3. endometriosis
     4. uterine fibromyoma
     5. endometritis
964. What endometrium conditions belong to the premalignant disease?
     1. glandular-cystic hyperplasia
     2. glandular hyperplasia
     3. endometriosis
     4. \*polyposis of endometrium
     5. endometritis
965. What is typical for hormonal status of patient with hyperplasia of endometrium?
     1. high level of chorionic gonadotropin
     2. high level of prgesteron
     3. high level of androgens
     4. high level of pituitary gland hormons
     5. \*high level of estrogens
966. What medication we use for treatment hyperplastic process of endometrium?
     1. femoston
     2. \*oxiprogesteron capronat
     3. novinet
     4. folliculin
     5. synestrol
967. What is indication for surgical treatment of patiene with hyperplastis process of endometrium?
     1. prolonged bleeding, without reaction on to medical treatment
     2. postmenopausal period
     3. hormonotherapy intolerance
     4. \*all above
     5. there is no correct answer
968. Which method of diagnosis is not obligatory for confirmation myoma of the uterus:
     1. USG of the organs of lower pelvis
     2. \*рelviography
     3. separate diagnostic currettage of the mucous membrane from the uterus & its cervix
     4. hysteroscopy
     5. laparoscopy
969. What drugs we use for treatment of uterine fibromyoma?
     1. progesteron
     2. releasing-factor antagonists
     3. androgens
     4. \*all above
     5. there is no correct answer
970. What pregnancy complication might be in case of uterine fibromyoma?
     1. fetus malpresentation
     2. treat of abortion or preterm labour
     3. hypotonic bleeding in the third period of labor
     4. \*all above
     5. there is no correct answer
971. What influence of lactation process onto fibromyoma in puerperium?
     1. \*possible complete or partial resolving of nodes or their regression
     2. promote fast growth of fibromyoma
     3. promote fibromyoma malignization
     4. promote necrosis and suppuration of node
     5. there is no correct answer
972. How pregnancy influences on to fibromyoma growth?
     1. \*promote fast growth of fibromyoma
     2. promote necrosis of node
     3. promote fibromyoma malignization
     4. all above
     5. there is no correct answer
973. What substance is in IUD for fibromyoma treatment?
     1. \*levonorgestrel
     2. synestrol
     3. 17-oxiprogesteroni capronat
     4. all above
     5. there is no correct answer
974. Choose the most exact method for determination of pathological reason for uterine bleeding in women from 30-40 years:
     1. measurement of the basal temperature of the body
     2. \*diagnostic currettage of the mucous membrane of the uterus
     3. hysteroscopy
     4. measurement of the concentration of estrogens in the blood serum.
     5. measurement of the concentration of progesterone in the blood serum.
975. At appearance of acyclic hemorrhagic discharges, the following is conducted:
     1. \*hysterosalphyngography
     2. determination of LH
     3. USG
     4. diagnostic currettage
     5. all of the above
976. What cause uterine bleeding in case of fibromyoma?
     1. pathological transformation of uterus with increasing of her cavity and endometrium square
     2. disturbances of uterus contractility in consequence of presence of sumucose nodes or big polype of endometrium
     3. irregularity of morfofunctional endometrium changes and disturbances of its position that lead to its preterm separation
     4. \*all above
     5. there is no correct answer
977. What cause uterine bleeding in case of fibromyoma?
     1. pathological transformation of uterus with increasing of her cavity and endometrium square
     2. disturbances of uterus contractility in consequence of presence of sumucose nodes or big polype of endometrium
     3. disturbances of ovary finction
     4. \*all above
     5. there is no correct answer
978. What adjacent pathology should be treated as first step of fibromyoma treatment?
     1. thyroid gland pathology
     2. inflammatory process of genitalia
     3. to correct body weight
     4. \*all above
     5. there is no correct answer
979. What alternative surgical intervantion in case of sumcouse fibromyoma we can perform if patient wants to save uterus?
     1. hysteroscopic myomectomy
     2. endometrium ablation
     3. endometrium resection
     4. \*all above
     5. there is no correct answer
980. What method is effective alternative for myomectomy or hysterectomy?
     1. \*embolization of uterine vessels
     2. physiotherapy
     3. homeopathic treatment
     4. all above
     5. there is no correct answer
981. What growth speed of fibromyoma is "fast" and is indication for surgical treatment?
     1. \*on 4 - 5 weeks per year and more
     2. on 1 - 2 weeks per year
     3. on 2 - 3 weeks per year
     4. all above
     5. there is no correct answer
982. To epithelial ovarian tumour belongs:
     1. \*serous cystoma
     2. Androblastoma
     3. Chorioepithelioma
     4. Teratoma
     5. tuboovarian tumour
983. What tumour does not belong to epithelial tumour?
     1. papillary cystoma
     2. follicular cyst
     3. Brenner tumour
     4. Carcinoma
     5. \*androblastoma
984. What type of ovarian tumour does endometrium hyperpasia develop?
     1. yellow body cyst
     2. ovarian cancer
     3. \*follicular cyst
     4. paraovarian cyst
     5. papillary cystoma
985. What ovarian tumour has such symptom as menorrhagia?
     1. yellow body cyst
     2. ovarian cancer
     3. \*follicular cyst
     4. paraovarian cyst
     5. papillary cystoma
986. What tumour belongs to retentional ovarian cyst, mostly bilateral and observed with hydatidiform mole and chorioepithelioma?
     1. paraovarian cyst
     2. follicular cyst
     3. chocolate cyst
     4. \*thecalutein cyst
     5. dermoid cyst
987. What type of ovarian tumour is obligatory precancer condition?
     1. yellow body cyst
     2. ovarian cancer
     3. follicular cyst
     4. paraovarian cyst
     5. \*papillary cystoma
988. What tumor produced male hormones?
     1. papillary cystoma
     2. teratoid tumor
     3. chorioepithelioma
     4. \*androblastoma
     5. Dysgerminoma
989. What tumour belongs to the germinomogenic?
     1. \*chorioepithelioma
     2. Androblastoma
     3. Gynandroblastoma
     4. Carcinoma
     5. Brenner tumour
990. What tumour belongs to the estrogenproductive?
     1. Fibroma
     2. Androblastoma
     3. \*thecoma
     4. Pseudomyxoma
     5. pseudomucinous cystoma
991. Which microorganism cause non-specific inflammatory diseases of the female genitalia?
     1. Mycoplasma
     2. \*staphylococcus
     3. Gonococcus
     4. Chlamydia
     5. Trichomonads
992. What process underlies the development of bacterial vaginosis?
     1. \*violation of vaginal flora
     2. excessive development of the lactobacilli
     3. Vaginal candidiasis
     4. Trichomonas colpitis
     5. Gonorrhea
993. Which form of Chlamydia provides transmission?
     1. \*elementary bodies
     2. reticular calf
     3. vegetative calf
     4. L - form
     5. key cell
994. The patient complains of feeling itchy, burning, pain in the vagina, and large amount of discharges. On examination: vaginal mucous membrane swelling flushed accumulation of white layers, similar to the chees.Select drugs for patients.
     1. cifran
     2. Doxycycline
     3. \*Diflucan
     4. Ceftriaxone
     5. levamisole
995. The causative genital warts are:
     1. Adenovirus
     2. herpes virus
     3. cytomegalovirus
     4. kondilovirus
     5. \*papilomavirus
996. What diagnostic methods should be applied to determine the etiology of colpitis?
     1. colposcopy
     2. culdoscope
     3. hysteroscopy
     4. cytology
     5. \*bakterioscopic examination
997. In which disease in the vaginal smear is "a key cell"?
     1. Healthy women
     2. \*bacterial vaginosis
     3. Trichomonas colpitis
     4. cancer of the vagina
     5. vaginal candidiasis
998. Hypothalamus secretes the following hormones excluding:
     1. releasing factor FSH
     2. releasing factor LH
     3. \*gonadotropine
     4. no one is correct
     5. all are correct
999. When encouraged to take swabs for detection of gonococci?
     1. in the 1 st day of menstruation
     2. \*2 - 4 day of menstruation
     3. immediately after menstruation
     4. the day of ovulation
     5. before menstruation
1000. What medication used to treat Trichomonas colpitis in pregnant?
      1. metronidazole
      2. \*klion – D
      3. tinidazole
      4. all listed
      5. none listed
1001. What is the primary form of the disease in chlamydiosis?
      1. bartholinitis
      2. urethritis
      3. colpitis
      4. \*endocervicitis
      5. salpingitis
1002. The patient complains of feeling of itching, pain in the vagina, large selection of white disharge. On examination: vaginal mucosa edematous flushed, in the lateral fornices - the accumulation of white layers, similar to the chees. What is the previous diagnosis?
      1. Trichomonas coleitis
      2. coleitis chlamydial
      3. urogenital mycoplasmosis
      4. bacterial vaginosis
      5. \*candidiasis vaginitis
1003. For treatment of genital warts external genital use:
      1. \*solkoderm
      2. Solcoseryl
      3. solkotrihovak
      4. solkovagin
      5. ointment from solkoserilom
1004. What cells characterize bacterial vaginosis?
      1. "Owl eye"
      2. \*"Key cell"
      3. elementary bodies
      4. segmental body
      5. distention body
1005. What is the pH content of vaginal bacterial vaginosis?
      1. 2,2 - 3,4
      2. 3,8 - 4,2
      3. \*5,0 - 7,5
      4. 7,6 - 8,5
      5. 8,6 - 9,5
1006. What reagent is used for amino test?
      1. \*10% solution of potassium hydroxide
      2. 10% solution of sodium hydroxide
      3. 10% solution of potassium permanganate
      4. 1% solution of potassium tetra borate
      5. 1% solution of silver hydroxide
1007. Which drug is used for drug provocation gonorrhea?
      1. Aloe
      2. piratseram
      3. ciprofloxacin
      4. \*pirogenal
      5. Tiberal
1008. When first obtaining smear to determine the effectiveness of treatment of gonorrhea?
      1. 2 - 3 days after treatment with antibiotics
      2. 4 - 7 days after the treatment with antibiotics
      3. \*7 - 10 days after the treatment with antibiotics
      4. 10 - 15 days after the treatment with antibiotics
      5. 16 - 20 days after the treatment with antibiotics
1009. The patient was diagnosed Trichomonas colpitis. Select a product for the treatment of this patient
      1. \*tinidozol
      2. ciprofloxacin
      3. ampicillin
      4. Biseptol
      5. Diflucan
1010. If any discharge from the vagina disease has an unpleasant fishy smell?
      1. gonorrhea
      2. \*dysbacteriosis of vagina
      3. trichomoniasis
      4. Vaginal candidiasis
      5. laktobakterioz of vagina
1011. Which drugs are used in suspected the presence of anaerobic microflora?
      1. klatsid
      2. \*metronidazole
      3. unazin
      4. tsifran
      5. Doxycycline
1012. For diseases that are transmitted sexually, do not belong:
      1. \*bacterial vaginosis
      2. Chlamydia
      3. trichomoniasis
      4. genital herpes
      5. cytomegalovirus infection
1013. Which of the antibiotics used to treat gonorrhea in pregnant?
      1. \*Ceftriaxon
      2. Doxycycline
      3. ciprofloxacin
      4. metronidazole
      5. trobitsin
1014. How to perform postcoital prevention of gonorrhea?
      1. \*0,05 % chlorhexidine
      2. 0,5 % silver nitrate
      3. 1 % Lugol's iodine solution
      4. gonovaccine
      5. rekutan solution
1015. The incubation period of gonorrhea usually lasts:
      1. 1 month
      2. \*3 - 7 days
      3. 21 days
      4. no incubation period
      5. 15 - 20 days
1016. Patient complains of the appearance of discharge from genital tract, itching sensation in the area of the external genitalia and vagina. In objective examination mucous membrane of the vagina edematous, hyperemic, allocation frothy nature, in large numbers. Diagnosis?
      1. purulent colitis
      2. \*Trichomonas colpitis
      3. urogenital chlamydial
      4. bacterial vaginosis
      5. gonorrheal colpitis
1017. Which group of antibiotics commonly used for the treatment of urogenital chlamydia?
      1. \*macrolides
      2. aminoglycosides.
      3. imidazole
      4. penicillins
      5. cephalosporins
1018. How many days should continue antibiotic therapy at ureaplasmosis?
      1. Chance of acute administration of high doses of antibiotics
      2. No less than 5 days
      3. 7 days
      4. \*10 - 14 days
      5. 21 days
1019. The average incubation period of syphilis is:
      1. 2 months
      2. \*3 - 4 weeks
      3. 21 days
      4. no incubation period
      5. 15 - 20 days
1020. Which tissue usually injuries by gonococcus?
      1. \*cylindrical epithelium
      2. multilayered epithelium
      3. to the basal membrane
      4. with all this
      5. to any of the listed
1021. What disharge are typical for acute gonococcal endocervicitis?
      1. \*purulent, yellow-green
      2. white curdled
      3. transparent, colorless
      4. all listed
      5. none listed
1022. What are the most frequent and threatening complication of gonococcal infection?
      1. \*pelvioperitonitis
      2. irregular menstrual
      3. discomfort during sexual
      4. all listed
      5. none listed
1023. Which feature of modern gonococcal infection?
      1. \*reducing the sensitivity of gonococci to penisilin antibiotics
      2. improving the sensitivity of gonococci to penicillin antibiotics
      3. fewer oligosymptomatic form
      4. all listed
      5. none listed
1024. Which feature of modern gonococcal infection?
      1. \*growth rate oligosymptomatic and torpid forms
      2. improving the sensitivity of gonococci to penicillin antibiotics
      3. fewer oligosymptomatic form
      4. all listed
      5. none listed
1025. Which feature of modern gonococcal infection?
      1. \*dominated mixed infection (Trichomonas, gonococci, chlamydia)
      2. improving the sensitivity of gonococci to penicillin antibiotics
      3. predominates monoinfection (gonococcus rarely occur together with other pathogens)
      4. all listed
      5. none listed
1026. What is the best prevention of gonococcal infection?
      1. \*condom use and availability of one partner
      2. condom use and availability of many partners
      3. chlorhexidine digluconate prophylaxis after sexual intercourse with a new partner
      4. all listed
      5. none listed
1027. Treatment of the sexual partner in the case of gonococcal infection include:
      1. \*drugs prescribed venerologist and / or a urologist, which similar drugs, appointed a woman
      2. partner not need to treat
      3. penicillin orally 5 days
      4. all of these options correct
      5. none listed
1028. Which factor triggers the appearance of endometritis and pelvioperitonitis caused by Trichomonas vaginalis?
      1. \*introduction of intrauterine contraceptive devices in the absence of control for trichomoniasis
      2. bath
      3. presence of concomitant candidiasis
      4. all of these options correct
      5. no right answer
1029. Vaginal trichomonads on the environment:
      1. \*unstable, the parasite only in the human
      2. resistant, because transmitted mainly by domestic
      3. resistant, is transmitted by dog or house cat
      4. all of these options correct
      5. no right answer
1030. Clinically diagnosed chlamydial infection:
      1. There are specific features in the form of yellow foaming secretions
      2. \*no specific signs, on examination there are signs of inflammation of genital organs, often - miscarriages or ectopic pregnancies in history
      3. There are specific features in the form of white cheesy discharge
      4. all of these options correct
      5. no right answer
1031. Hypothalamus secretes the following hormones:
      1. gonadotropine
      2. estrogen
      3. gestagen
      4. \*releasing-hormone
      5. no right answer
1032. What are the pathogens most often lead to an ectopic pregnancy?
      1. Candida albikans
      2. \*gonococcus and chlamydia
      3. pale treponema
      4. all of these options correct
      5. no right answer
1033. Which disease is characterized by erosion of the cervix as a result endocevicitis?
      1. Candida albikans
      2. \*gonococcus
      3. pale treponema
      4. all of these options correct
      5. no right answer
1034. Which disease is characterized by erosion of the cervix as a result endocervicitis?
      1. Candida albikans
      2. \*chlamydia
      3. pale treponema
      4. all of these options correct
      5. no right answer
1035. Which disease is characterized by erosion of the cervix as a result endocervicitis?
      1. Candida albikans
      2. \*trichomonads
      3. pale treponema
      4. all of these options correct
      5. no right answer
1036. What tumour has masculinization property?
      1. fibroma
      2. \*androblastoma
      3. thecoma
      4. pseudomyxoma
      5. all above
1037. What tumour rise from ovarian adnexa?
      1. yellow body cyst
      2. follicular cyst
      3. lutein cyst
      4. dermoid cyst
      5. \*paraovarian cyst
1038. What tumour of external genitalia develops from connective tissue?
      1. \*fibroma
      2. lipoma
      3. myxoma
      4. hemangioma
      5. papilloma
1039. What tumour of external genitalia develops from fatty and connective tissue?
      1. fibroma
      2. \*lipoma
      3. myxoma
      4. hemangioma
      5. papilloma
1040. What tumour of external genitalia develops from mesenchyma remains?
      1. fibroma
      2. \*lipoma
      3. myxoma
      4. hemangioma
      5. papilloma
1041. What tumour of external genitalia develops from congenital defect of skin vessels and mucous?
      1. fibroma
      2. lipoma
      3. myxoma
      4. \*hemangioma
      5. papilloma
1042. What tumour of external genitalia develops from epithelial tissue and has fibroepithelial structure?
      1. fibroma
      2. lipoma
      3. myxoma
      4. hemangioma
      5. \*papilloma
1043. What promotes formation of bartholin gland' cyst?
      1. \*obstruction of excretory duct
      2. forms from epithelium after its trauma
      3. disorders at time of embryogenesis
      4. all above
      5. no correct answer
1044. What is a risk factor for follicle cyst development?
      1. \*inflammatory process
      2. menopause
      3. childhood
      4. all above
      5. no correct answer
1045. What is predisposition for development of benign mammary gland condition?
      1. \*hormonal disturbance
      2. cervical dysplasia
      3. multiparity
      4. all above
      5. no correct answer
1046. What is common for papillary ovarian cystoma?
      1. has short pedicle
      2. has serouse or bloody content
      3. papilla might be present inside and outside
      4. \*all above
      5. no correct answer
1047. What is common for ovarian pseudomyxoma?
      1. \*multicamerate, thin-walled, might be ruptured spontaneously
      2. has serouse or bloody content
      3. papilla might be present inside and outside
      4. all above
      5. no correct answer
1048. Common for ovarian pseudomyxoma is:
      1. \*has sticky jellylike mass, non absosrbed in peritoneum cavity
      2. has serouse or bloody content
      3. papilla might be present inside and outside
      4. all above
      5. there isn’tcorrect answer
1049. Ovarian tumour on thin pedicle, thin-walled, fullfiled with fatty content, has hair:
      1. fibroma
      2. androblastoma
      3. \*dermoid cyst
      4. pseudomyxoma
      5. pseudomucinous cystoma
1050. What treatment should be prescribes for patient with dermoid cyst?
      1. point puncture with content suction
      2. substitutive hormonal therapy
      3. \*cystectomy
      4. antibacterial therapy
      5. Zoladex
1051. Which diseases characterized by the development of tubal infertility as a result of adhesions and / or the formation of pyosalpinx?
      1. candidiasis
      2. \*gonococcal infection
      3. Syphilis
      4. all of these options are correct
      5. no right answer
1052. Which diseases characterized by the development of tubal infertility as a result of adhesions and / or the formation pyosalpinx?
      1. candidiasis
      2. \*chlamydial infection
      3. Syphilis
      4. all of these options correct
      5. no right answer
1053. The combination, which is of particular pathogens resistant to traditional therapy of candidiasis?
      1. cytomegalovirus and candidiasis
      2. \*papilloma virus infection and candidiasis
      3. syphilis and candidiasis
      4. all of these options correct
      5. no right answer
1054. In identifying the patient gynecological complications of chlamydial infection treatment is carried out:
      1. \*gynecologist in the hospital
      2. dermatovenerologist in the appropriate patient with a gynecologist
      3. dermatologist
      4. all of these options correct
      5. no right answer
1055. For diagnosis of endocrine infertility need to:
      1. \*measure rectal temperature
      2. Perform colposcopy
      3. Perform hysterosalpingography
      4. Perform hysterectomy
      5. Perform laparoscopy
1056. As the operation is called liberation of uterine tube from adhesions?
      1. Salpingotomy
      2. \*Salpingolisis
      3. Salpingostomatoplastic
      4. Salpingoanastomos
      5. salpingoectomy
1057. Which spermogram considered normal?
      1. If motile sperm are more than 20%
      2. If motile sperm over 30%
      3. If motile sperm over 40%
      4. \*If motile sperm over 50%
      5. If motile sperm to 10%
1058. What is capacitation?
      1. accumulation of sperm in epididimise
      2. increase in the size of sperm
      3. \*acquisition fertilised properties
      4. loss of sperm motility
      5. large number of abnormal forms of sperm
1059. What substance is used for uterotubography?
      1. chlorhexidine digluconate 0.05%
      2. dimexide
      3. \*verografin
      4. methylene blue
      5. fenolsulfoftalein
1060. Chronic salpingooophoritis constitutes a violation of the Fallopian tubes, their congestion, peritubal adhesions, knotted salpingitis. It can be found at:
      1. metrorosalpingography
      2. \*laparoscopy
      3. colposcopy
      4. hysteroscopy
      5. Ultrasonography
1061. What is the main cause of primary female infertility?
      1. \*genital infantilism.
      2. colpitis
      3. pseudo-cervix
      4. deferred abortion
      5. Rhesus - conflict
1062. From which place the material for the Shuvarsky sample is taken?
      1. urethra
      2. uterus
      3. anterior vaginal vault
      4. \*posterior vaginal vault
      5. cervical canal
1063. When there is an absolute sterility?
      1. in inflammatory processes in the fallopian tube
      2. with genital infantilism
      3. \*after removal of the uterus
      4. after ectopic pregnancy
      5. in endocrine pathology
1064. Marriage is considered infertile if pregnancy does not occur during:
      1. 6 months of regular sexual life
      2. \*12 months of regular sexual life
      3. 18 months of regular sexual life
      4. 24 months of regular sexual life
      5. 28 months of regular sexual life
1065. What is the volume of ejaculate can be considered normal?
      1. 1 to 2 ml
      2. 2 to 3 ml
      3. \*from 2 to 5 ml
      4. from 1 to 10 ml
      5. from 10 to 15 ml
1066. Which form of pathological changes of spermatozoa is called azoospermia?
      1. \*absence of sperm
      2. reducing the number of sperm
      3. immobile sperm
      4. prevalence of pathologically altered forms of sperm
      5. fewer ejaculate
1067. Which form of pathological changes of spermatozoa is called necrospermia?
      1. absence of sperm
      2. reducing the number of sperm
      3. \*dead sperm
      4. prevalence of pathologically altered forms of sperm
      5. fewer ejaculate
1068. Which form of pathological changes of spermatozoa is called teratozoospermia?
      1. absence of sperm
      2. reducing the number of sperm
      3. immobile sperm
      4. \*prevalence of pathologically altered forms of sperm
      5. fewer ejaculate
1069. Which form of pathological changes in sperm is oligospermia?
      1. absence of sperm
      2. \*reducing the number of sperm
      3. immobile sperm
      4. prevalence of pathologically altered forms of sperm
      5. fewer ejaculate
1070. What is the basis of endocrine sterility?
      1. violation of the Fallopian tubes
      2. \*violation ovogenesis and ovulation
      3. oligomenorrhea
      4. pathological changes of the endometrium
      5. algomenorrhea
1071. What is the main cause of the uterine form of inferfility?
      1. opsomenorrea
      2. spaniomenorrea
      3. proyomenorrea
      4. \*Intrauterine adhesions
      5. hypomenorrea
1072. What is the main cause of tubal sterility?
      1. endocervicitis
      2. \*adnexitis
      3. bartholinitis
      4. Human papilloma virus infection
      5. colpitis
1073. Reason peritoneal forms of inferfility?
      1. endocervicitis
      2. \*pelvioperitonitis
      3. bartholinitis
      4. Human papilloma virus infection
      5. colpitis
1074. What is not included in the complex examination of patients with endocrine form of infertility?
      1. \*definition of the Fallopian tubes
      2. basal body temperature
      3. determine the level of hormones in the blood
      4. smears on the "hormonal mirror"
      5. ultrasound control the growth of follicles during the menstrual cycle
1075. What drug stimulates ovulation patients with endocrine form of infertility?
      1. progesterone
      2. \*Clomiphene Citrate
      3. androkur
      4. femoston
      5. dufaston
1076. In which form of infertility it is necessary to perform Shuvarsky test?
      1. endocrine
      2. uterine
      3. peritoneal
      4. pipe
      5. \*cervical
1077. The most exact method for the diagnosis of pathology in uterine bleeding:
      1. colposcopy
      2. laparoscopy
      3. USG
      4. \*hysteroscopy
      5. Pap test
1078. How called test for contact of sperm with cervical mucus?
      1. Heat test
      2. Sample Aburela
      3. Sample Stein
      4. \*Sample Shuvarsky
      5. Sample Hoffmann
1079. In what form of infertility ovulation stimulation is recommended?
      1. \*endocrine
      2. uterine
      3. peritoneal
      4. pipe
      5. cervical
1080. In what form of the infertility you want to assign such a complex treatment: a course hydrotubation, antiinflammatory, resolving therapy?
      1. endocrine
      2. uterine
      3. infantilism
      4. \*tubal
      5. cervical
1081. In what form of infertility salpingolisis is recommended?
      1. endocrine
      2. uterine
      3. \*peritoneal
      4. infantilism
      5. cervical
1082. When insemination with sperm donor is indicated?
      1. after menstruation
      2. During menstruation
      3. \*in periovulatory period
      4. the day before the expected menstruation
      5. Time does not matter (any day of the menstrual cycle)
1083. On what day you complete a transfer of the embryo in the uterus during fertilization in vitro?
      1. 10 - 11 days after fertilization
      2. \*2 - 3 days after fertilization
      3. 13 - 14 days after fertilization
      4. 15 - 16 days after fertilization
      5. 18 - 19 days after fertilization
1084. What is the most reliable method of determining ovulation?
      1. basal body temperature
      2. determine the level of estrogen in the blood
      3. \*detecting the LH surge
      4. determine the level of progesterone in the blood
      5. determine the level of FSH in the blood
1085. Desquamation of functional layer of endometrium occurs owing to:
      1. peak output of luteotropine
      2. decreased amount of prolactin in the blood
      3. increased amount of estradiol in the blood
      4. \*decreased amount of estrogen and progesterone in the blood
      5. peak output of follitropine
1086. Absence of which anatomical organs is an indication for in vitro fertilization?
      1. Uterus
      2. One ovary
      3. One of uterine tube
      4. Both ovaries
      5. \*Both Fallopian tubes
1087. Absence of a what anatomical organs is an indication for surrogate motherhood?
      1. \*Uterus
      2. One ovary
      3. One of uterine tube
      4. Both ovaries
      5. Both Fallopian tubes
1088. Which factor is an indication for insemination with sperm donor?
      1. absence of one ovary
      2. the absence of both ovaries
      3. the absence of both fallopian tubes
      4. absence of the uterus
      5. \*azoospermia
1089. The women with dysfunctional uterine bleeding form the risk group:
      1. on spontaneous abortion or preterm delivery
      2. on development of birth abnormalities
      3. on development of the genital tumors
      4. on development of the tumors of the mammary glands
      5. \*all answers are correct
1090. To perform the semen analysis is necessary to investigate the sperm no later than:
      1. 10 min after ejaculation
      2. \*through 1 - 1,5 hours after ejaculation
      3. 5 hours after ejaculation
      4. after 3 - 4 hours after ejaculation
      5. 10 - 12 hours after ejaculation
1091. Which days the 28-day menstrual cycle, ovulation induction is performed by the introduction of Clomiphene Citrate?
      1. from 15 to 20 days of the menstrual cycle
      2. 5 to 9 days of the menstrual cycle
      3. 3 to 8 days of the menstrual cycle
      4. \*from 1 to 5 days of the menstrual cycle
      5. from 7 to 12 day menstrual cycle
1092. Which of the following is a common cause of tubal infertility?
      1. transferred candida infection
      2. \*transferred gonococcal infection
      3. parotitis in childhood
      4. all of the above
      5. none of these
1093. Which of the following is a common cause of tubal infertility?
      1. transferred candida infection
      2. \*transferred chlamydial infection
      3. parotitis in childhood
      4. all of the above
      5. none of these
1094. Which of the following may lead to endocrine infertility?
      1. transferred candida infection
      2. \*hyperprolactinaemia
      3. parotitis in childhood
      4. all of the above
      5. none of these
1095. Which of the following is the drug for the treatment of infertility caused by endometriosis?
      1. Fluconazole
      2. \*danazol
      3. bromkriptin
      4. all of the above
      5. none of these
1096. Which of the following is the drug for the treatment of infertility caused by endometriosis?
      1. Fluconazole
      2. \*Zoladex
      3. bromkriptin
      4. all listed
      5. none of these
1097. How long does the conservative therapy have to be continued for the resumption of the Fallopian tube?
      1. rate hydrotubation, with no pregnancy occurs within 6 months - surgical treatment
      2. \*with proven blocked tubes operative treatment is carried out immediately
      3. rate hydrotubation, with no pregnancy occurs within 12 months - surgical treatment
      4. all of the above is true
      5. none of these
1098. Diagnostic value of laparoscopy in gynecology is particularly high under all enumerated conditions, except:
      1. ectopic pregnancy
      2. \*uterine pregnancy
      3. tumors of the ovaries
      4. myoma of the uterus
      5. all of the above
1099. What treatments are carried out by women, infertility is due to the presence of uterine fibroids?
      1. supravaginal cancer and hormone replacement therapy
      2. \*if possible - conservative myomectomy or conservative therapy using agonists URNG releasing - hormone (zolodeks, Diferelin), progestogen
      3. first step is the use of Clomiphene - citrate is stimulation of ovulation
      4. all of the above is true
      5. none of these
1100. What in violation of the immune system of the cervix result in immunological infertility?
      1. genital infection
      2. IUD insertion
      3. operation scraping the uterus
      4. \*all of the above
      5. none of these
1101. What is the leading symptom of uterine sarcoma?
      1. \*Recurrent uterine bleeding
      2. Opsomenorrhea
      3. Spaniomenorrhea
      4. Oligomenorrhea
      5. Pronounced hirsutism
1102. What is a risk factor for the development of sarcoma?
      1. Presence of candidal colpitis
      2. Large number of parity
      3. \*The presence of fibroids in the pre-and post – menopausal period
      4. Presence of rheumatism
      5. All the above listed
1103. The patient's ovarian tumor is confined to one ovary; there are not any metastasis to distant organs and lymph nodes. Which is stage of the process?
      1. \*I A
      2. I B
      3. 1 C
      4. II A
      5. II B
1104. For the luteinising phase of the menstruation cycle is not characteristic:
      1. secretory transformation of the endometrium
      2. corpus leuteum is present in ovarium
      3. continues about 13 days
      4. \*the level of estrogen in blood is increasing
      5. All the above listed
1105. Which nature of growth is the most common in cancer of the uterine body?
      1. Endophytic
      2. Ulcered
      3. Infiltrative
      4. Ulcered-infiltrative
      5. \*Exophytic
1106. Which benign ovarian tumor does often degenerate into malignant tumor?
      1. Dermoid
      2. Mucinous
      3. \*Epitelialial and papillary
      4. Mucinous and dermoid
      5. Nothing of the above listed
1107. What is the substratum of primary ovarian cancer?
      1. Pseudo-mucinous cystoma
      2. Dermoid cysts
      3. Papillary cystoma
      4. \*Surface epithelium
      5. Metastases of breast cancer
1108. What can be considered as a risk factor for developing malignant tumors of the ovaries in girls?
      1. Girls with asthenic physique
      2. Girls with atopic dermatitis
      3. \*Early puberty
      4. Girls with rheumatic disease
      5. Girls with vulvovaginitis
1109. Preinvasive cervical cancer - is:
      1. dysplasia on a background of pseudo erosion
      2. \*process, limited only by the epithelium
      3. growing of the process in the stroma to a depth of 0.5 cm
      4. growing of the process in the stroma to a depth of 1.0 cm
      5. Nothing above
1110. What is the most likely cause of cervical cancer nowadays?
      1. Pseudo erosion
      2. Candidiasis
      3. \*Human papillomavirus
      4. Bartholinitis
      5. Large number of parity
1111. The major risk factor for cervical cancer includes:
      1. Initiation of sexual activity at an early age
      2. Multiple sexual partners
      3. Infection with human papilloma virus 16
      4. Cigarette smoking
      5. \*All the above listed
1112. How often should a woman of reproductive age have a Pap smear?
      1. \*once a year
      2. once a 5 years
      3. once a 10 years
      4. depends on woman’s willing
      5. during every pregnancy
1113. Follicular phase of menstruation cycle is characterised by:
      1. desquamation of functional layer of endometrium
      2. \*growth of ovarian follicle
      3. development of yellow body in ovary
      4. the decrease of endrogen in blood circulation
      5. All the above listed
1114. Metrorrhagia:
      1. changes in menstruation rhythm
      2. increased amount of the blood loss during menstruation cycle
      3. increased duration of menstruation cycle
      4. \*acyclic uterine bleeding
      5. Nothing above
1115. Which changes are present in the I type smear for oncocytology?
      1. Light or moderate dysplasia
      2. \*Unchanged epithelium
      3. Cancer
      4. Inflammatory process
      5. Suspected malignancy
1116. Which changes are present in the III type smear for oncocytology?
      1. Proliferation, metaplasia, hyperkeratosis
      2. Cancer
      3. \*Light or moderate dysplasia
      4. Inflammatory process
      5. Suspected malignancy
1117. Which changes are present in the VI type smear for oncocytology?
      1. Proliferation, metaplasia, hyperkeratosis
      2. \*Uninformative smear
      3. Cancer
      4. Light or moderate dysplasia
      5. Suspected malignancy
1118. Entophytic form of cervical cancer is characterized by:
      1. Growing tumor into the vagina
      2. Growing tumor in the cervical canal
      3. Growing tumor in parametrical tissue
      4. \*Growing tumor in the muscle layer of the cervix
      5. Growing tumor in vaginal wall
1119. Exophytic form of cervical cancer is characterized by:
      1. \*Growing tumor into the vagina like "cauliflower"
      2. Growing tumor in the cervical canal
      3. Growing tumor in parametrical tissue
      4. Growing tumor in vaginal wall
      5. Growing tumor in the muscle layer of the cervix
1120. Which method is a method of early diagnosis of cervical cancer?
      1. An ultrasound scan
      2. Nuclear magnetic resonance imaging
      3. Radioisotope stsintiografiya
      4. \*Pap smear
      5. Computed Tomography
1121. Reason for performing simple and advanced colposcopy in women with suspected cancer of the cervix:
      1. To determine the depth of invasion process
      2. The colposcopy is the first treatment step
      3. To definite the diagnosis of malignant neoplasm
      4. \*To identify the most pathologically altered plot for the capture of target biopsy
      5. Such patients is are not necessary to conduct a survey
1122. Menorrhagia is:
      1. acyclic uterine bleeding
      2. \*cyclic uterine bleeding in connection with menstruation cycle
      3. painfull and abundant menstruation
      4. pre- & post menstruation bloody allocation
      5. short period of menstruation cycle
1123. The final diagnosis of cervical cancer is made:
      1. On the basis of biochemical analysis of blood
      2. On the basis of simple and advanced colposcopy
      3. On the basis of ultrasound
      4. \*On the basis of histological examination
      5. On the basis of cytological examination
1124. Which disease should the doctor predispose if contact bleeding reveals in speculum examination?
      1. Candidiasis
      2. Blood disease
      3. Bacterial vaginosis
      4. Preeclampsia
      5. \*Cervical cancer
1125. Which women are at high risk for uterine cancer?
      1. With genital infantilism history
      2. With a history of amenorrhea
      3. \*With obesity and diabetes
      4. Infertility patients
      5. Multiparity
1126. What method of diagnosis is the best for confirmation the uterine cancer diagnosis?
      1. \*Histological study material fractional curettage
      2. Laparoscopy
      3. An ultrasound scan
      4. Colposcopy
      5. Hysteroscopy
1127. Which additional diagnostic methods should be applied for diagnosis of uterine cancer?
      1. Puncture of the posterior arch cus
      2. \*Fractional curettage of the uterus
      3. Biopsy
      4. Colposcopy
      5. Laparoscopy
1128. Which diagnostic methods should be applied for diagnosis the depth of tumor of uterine cancer?
      1. Cytology aspirate from the cavity of the uterus
      2. Curettage of the uterus
      3. An ultrasound scan
      4. \*Uterography and gas pelvigraphy
      5. Colposcopy
1129. Oligomenorrhoea is:
      1. rare and poor menstruation
      2. rare and painfull menstruation
      3. \*decreased amount of the blood loss during menstruation
      4. intermenstrual bloody allocation
      5. short menstruation cycle
1130. Ovaries are vasculated by:
      1. uterine artery
      2. ovarian artery
      3. illolumbar artery
      4. \*both uterine and ovarian artery
      5. both internal genital and ovarian artery
1131. Which changes are present in the II type smear for oncocytology?
      1. Light or moderate dysplasia
      2. Unchanged epithelium
      3. Cancer
      4. \*Inflammatory process
      5. Suspected malignancy
1132. What is the best method of treatment for unruptured ectopic pregnancy if diameter of the pelvic mass on ultrasound less than 3,5 cm?
      1. Duphastone prescription
      2. \*Methotrexat injection
      3. Estrogens’ prescription
      4. Hysterectomy
      5. Salpingoectomy
1133. What is the most common complication of the ectopic pregnancy which is located in the isthmic part of tube?
      1. Uterine rupture
      2. \*Rupture of the fallopian tube
      3. Tubal abortion
      4. Ovarian apoplexy
      5. Necrosis of fallopian tube
1134. Papilloma virus infection 16, 18 type contributes to:
      1. True erosion of the cervix
      2. Folce erosion of the cervix
      3. \*Cervical dysplasia
      4. all of the above
      5. none of the above
1135. Which are the etiological factors contribute to ectropion?
      1. \*gap cervix during childbirth
      2. hysteroscopy
      3. hydrotubation
      4. endocervicitis
      5. none of these
1136. Which colposcopic picture is typical for patients with leukoplakia?
      1. multilayer flat epithelium
      2. \*Iodine negative area
      3. cylindrical epithelium
      4. atypical transformation zone
      5. squamous metaplasia
1137. Which type of cells found in cytological smears in patients with leukoplakia?
      1. "Owl eye"
      2. "Key cell"
      3. proliferative cell
      4. poligonia
      5. \*diskeratosis
1138. Which term is not synonymous with dysplasia?
      1. atypical hyperplasia
      2. basal hyperplasia
      3. \*adenomatosis
      4. cervical intraepithelial neoplasia
      5. atypia
1139. What are the signs detected in cytologic smears of dysplasia?
      1. hyperkeratosis
      2. Dyskeratosis
      3. diskarioz
      4. leukoplakia
      5. \*all of the above
1140. Which pathological process manifests by thinning and keratinization of the mucous of the cervix?
      1. True erosion of the cervix
      2. False cervical erosion
      3. \*leukoplakia
      4. ectropion
      5. eritroplakia
1141. Which process does IІ type of Pap-Smear?
      1. unchanged epithelium
      2. \*proliferation
      3. dysplasia
      4. inflammatory
      5. malignancy
1142. Which process does І type of Pap-Smear**?** 
      1. \*unchanged epithelium
      2. moderate dysplasia
      3. invasive cervical cancer
      4. inflammation process
      5. suspected malignancy
1143. In identifying the patient type I smear on oncocytologist of the cervix a woman must come to re-examine to a local obstetrician - gynecologist by:
      1. \*1 year for baseline medical examination
      2. 1 month to confirm the effectiveness of treatment
      3. sent to the oncology inpatient
      4. 6 months for the baseline medical examination
      5. There isn’t correct answer
1144. In identifying the patient type II A smear from the cervix woman must come to re-examine to a local obstetrician - gynecologist by:
      1. 1 year for baseline medical examination
      2. \*1 month to confirm the effectiveness of treatment
      3. sent to the oncology inpatient
      4. 6 months for the baseline medical examination
      5. There isn’t correct answer
1145. In the II B type of cytological cervical smear a woman must come to the district obstetrician - gynecologist by:
      1. 1 year for baseline medical examination
      2. \*controlling examination (colposcopy, cytology, bacterioscopy) carried out after the next menstrual
      3. sent to the oncology inpatient
      4. 6 months for the baseline medical examination
      5. There isn’t correct answer
1146. In the II B type of Pap smear from the cervix of the second control inspections carried out through:
      1. 1 year
      2. controlling examination (colposcopy, cytology, bacterioscopy) carried out after the next menstrual
      3. \*3 months from the time of coagulation
      4. 2 years from the time of coagulation
      5. There isn’t correct answer
1147. In III A type of Pap smear of the cervix first control examination carried out through:
      1. 1 year for baseline medical examination
      2. \*controlling examination (colposcopy, cytology, bacterioscopy) carried out after the next menstrual
      3. immediately sent to the oncology inpatient
      4. 6 months for the baseline medical examination
      5. There isn’t correct answer
1148. Which treatment is performed with mild dysplasia:
      1. \*diatermokonization of cervix
      2. diathermocoagulation of cervix
      3. laser
      4. treatment by solkovagin
      5. treatment of sea buckthorn oil
1149. What treatment is carried out at moderate dysplasia with lesions of the cervical canal?
      1. Diatermokonization of the cervix
      2. Cervical diathermocoagulation
      3. laser
      4. treatment by solkovagin
      5. \*hysterectomy
1150. Which treatment is followed by a 40 years patient with cervical dysplasia with the deformation of the cervical canal:
      1. diatermokonization of cervix
      2. diathermocoagulation of cervical
      3. laser
      4. treatment by solkovagin
      5. \*hysterectomy without appendages
1151. Which treatment is followed by a 48 years patient with severe cervical dysplasia and ovarian cyst:
      1. diatermokonization of cervix
      2. diathermocoagulation of cervix
      3. \*hysterectomy with appendages
      4. treatment by solkovagin
      5. hysterectomy without appendages
1152. How long does it take for a woman to outpatient observation after treatment, which had a V type cervical smear?
      1. 1 year for baseline medical examination
      2. controlling examination (colposcopy, cytology, bacterioscopy) is conducted after each of the next menstruation
      3. 2 months from the time of coagulation
      4. within 1 year after hysterectomy
      5. \*There isn’t correct answer
1153. Cytological feature - metaplastic epithelium, histological - proliferating. Which will be colposcopic picture?
      1. Ectopia cylindrical epithelium
      2. \*Benign unfinished transformation zone (zone of benign metaplasia)
      3. Benign completed the transformation zone (zone of benign metaplasia) Ov. Nabothi
      4. Inflammatory processes of the cervix (exo-, endocervicitis)
      5. There isn’t correct answer
1154. Colposcopic sign - ectopia cylindrical epithelium. What will happen when cytological and histological study?
      1. \*Unchanged cylindrical epithelium. Simple endotservikosis
      2. Metaplazirovanny epithelium. Proliferating endotservikosis
      3. Multilayered squamous epithelium. Stationary endotservikosis
      4. The epithelium of all segments with degenerative changes, leukocytes. Layers of squamous and cylindrical epithelium, connective tissue infiltration of small cell
      5. There isn’t correct answer
1155. Colposcopic sign - benign unfinished transformation zone (zone of benign metaplasia). What will happen when cytological and histological study?
      1. Unchanged cylindrical epithelium. Simple endotservikosis
      2. \*Epithelium metaplaziya. Proliferating endotservikosis
      3. Multilayered squamous epithelium. Stationary endotservikosis
      4. The epithelium of all segments with degenerative changes, leukocytes. Layers of squamous and cylindrical epithelium, small cell infiltration of the connective tissue
      5. There isn’t correct answer
1156. Colposcopic sign - benign completed the transformation zone (zone of benign metaplasia) Ov. Nabothi. What will happen when cytological and histological study?
      1. Unchanged cylindrical epithelium. Simple endotservikoz
      2. Metaplazirovanny epithelium. Proliferating endotservikoz
      3. \*Multilayered squamous epithelium. Stationary endotservikoz
      4. The epithelium of all segments with degenerative changes, leukocytes. Layers of squamous and cylindrical epithelium, small cell infiltration of the connective tissue
      5. There isn’t correct answer
1157. Colposcopic sign - inflammation of the cervix (exo-, endocervicitis). What will happen when cytological and histological study?
      1. Unchanged cylindrical epithelium. Simple endotservikosis
      2. Metaplazirovanny epithelium. Proliferating endotservikosis
      3. Multilayered squamous epithelium. Stationary endotservikosis
      4. \*The epithelium of all segments with degenerative changes, leukocytes. Layers of squamous and cylindrical epithelium, small cell infiltration of the connective tissue
      5. There isn’t correct answer
1158. Colposcopic sign - warts. What will happen when cytological and histological study?
      1. Proliferation of glandular epithelium with a slight increase in the nuclei. Glandular or epidermialny polyp
      2. \*Nuclear-free surface cells with hyperkeratosis. Signs of keratinization squamous epithelium
      3. Squamous epithelium of the different layers with koylotsitarnoy atypia (CIN I) Marked proliferation of connective tissue papillae proliferation of squamous epithelium with hyper .- diskeriozom
      4. The epithelium of all segments with degenerative changes, leukocytes. Layers of squamous and cylindrical epithelium, small cell infiltration of the connective tissue
      5. There isn’t correct answer
1159. Colposcopic sign - precancerous polyps. What will happen when cytological and histological study?
      1. Proliferation of glandular epithelium with a slight increase in the nuclei. Glandular or epidermizovanny polyp
      2. Nuclear-free surface cells with hyperkeratosis. Signs of keratinization squamous epithelium
      3. \*Proliferation of glandular or squamous epithelium with diskariozom (CIN I-III). Proliferation of connective tissue papillae with dysplastic altered glandular or squamous epithelium
      4. The epithelium of all segments with degenerative changes, leukocytes. Layers of squamous and cylindrical epithelium, small cell infiltration of the connective tissue
      5. There isn’t correct answer
1160. What are symptoms of cancer of the vulva?
      1. the presence of tumor
      2. bleeding
      3. pus discharge from the ulcerated surface
      4. \*all listed
      5. None of the above
1161. Name the forms of cancer of the vulva?
      1. exophytic
      2. endophytic
      3. ulcer
      4. infiltrative-edematous
      5. \*alllisted
1162. A special feature of the development of cancer of the vulva, localized in the clitoris, is?
      1. rapid growth
      2. bleeding of tissue
      3. Early metastasis
      4. \*all listed
      5. None of the above
1163. Advanced cancer of the vulva are usually linked?
      1. Delayed patient’s treatment to the doctor
      2. with error diagnostics
      3. the lack of alertness of cancer doctor
      4. \*with all the above
      5. None of the above
1164. In which lymph nodes are distributed metastases in cancer of the vulva?
      1. inguinal
      2. femoral
      3. iliac
      4. sacral
      5. \*true A, B, C
1165. Name the factors influencing metastasis of cancer of the vulva?
      1. The histological structure of tumor
      2. the size of the tumor
      3. localization of the tumor
      4. depth of invasion
      5. \*all listed
1166. The most common site of cancer of the vulva?
      1. Labia minora
      2. clitoris
      3. posterior commissure
      4. \*true A, B
      5. all listed
1167. Methods of radical treatment of patients with cancer of the vulva?
      1. Surgical
      2. combined
      3. radiation
      4. cryodestruction
      5. \*true A, B, C
1168. Hyperplastic processes and endometrial cancer develops most often in the background?
      1. anovulation
      2. obesity
      3. diabetes
      4. \*all listed
      5. true A, B
1169. Name the background diseases of the endometrium by the WHO classification?
      1. endometrial polyp
      2. atypical hyperplasia
      3. hyperplasia
      4. all listed
      5. \*true A, C
1170. Histological forms of endometrial cancer?
      1. low-differentiated cancer
      2. adenocarcinoma
      3. clear cell carcinoma
      4. \*all listed
      5. None of the above
1171. What applies to the precancerous of endometrium?
      1. adenomatous polyp
      2. atypical hyperplasia
      3. atrophic endometrium
      4. \*true A, B
      5. true A, C
1172. The main symptoms of endometrial cancer?
      1. bleeding from the genital tract during menopause.
      2. acyclic bleeding in the reproductive age.
      3. pain in lower abdomen.
      4. \*true A, B.
      5. all listed
1173. Factors contributing to tubal sterility with chronic salpingo-oophoritis are?
      1. narrowing or complete obliteration of the lumen of the fallopian tubes
      2. damage to the ciliated epithelium of the mucosa of uterine tube
      3. Local hyperthermia
      4. \*true A, B
      5. true A, B, C
1174. The most frequent causes of tubal infertility are?
      1. nonspecific recurrent inflammatory disease of adnexa uteri
      2. specific inflammatory diseases of adnexa uteri
      3. congenital malformations of fallopian tubes
      4. None of the above
      5. \*true A, B
1175. To restore the generative function with dysgenesis of the gonads necessary?
      1. long-term cyclic therapy sex hormones
      2. Consuming calcium gluconate
      3. \*Regenerative function is usually hopeless
      4. stimulation of ovulation
      5. resection of ovaries
1176. Causes of infertility for women in marriage?
      1. inflammatory diseases of genital organs
      2. infantilism
      3. genital hypoplasia
      4. \*all these reasons
      5. None of the above
1177. Tubal sterility may be due to?
      1. the sclerotic changes in the muscular wall of the fallopian tube
      2. violation of the reception in the Fallopian tube
      3. infantilism
      4. \*all these reasons
      5. None of the above
1178. Syndrome of ovarian hypofunction is characterized?
      1. cessation of menstruation
      2. infertility
      3. the monophasic basal temperature curve (below 37 ° C)
      4. negative test with progesterone
      5. \*all listed
1179. In the treatment of infertility in patients with hypothyroidism are usually used?
      1. thyroidin
      2. Clostilbegyt
      3. calcium gluconate and discontinue magnesium
      4. \*true A, B
      5. all of the above
1180. Hyperandrogenic of ovarian origin is often accompanied by?
      1. LH hypersecretion
      2. increasing the index of LH / FSH
      3. moderate hyperprolactinemia
      4. \*all listed
      5. None of the above
1181. Commonest site of endometriosis:
      1. Vagina,
      2. \*uterus.
      3. urinary bladder,
      4. Peritoneal cavity.
      5. Umbilicus
1182. Treatment of a case of endometriosis at a younger age group:
      1. Progestins
      2. \*Danazol
      3. Hysterectomy with oophorectomy
      4. All above
      5. Nothing above
1183. What is the lymphatic drainage of the vulva?
      1. \*Inguinal lymphnodes,
      2. Iliac lymphnodes,
      3. Para aortic lymphnodes,
      4. Mediastinal nodes,
      5. Nothing above
1184. Carcinoma of cervix is caused by:
      1. Herpes simplex type I
      2. \*Human papillomavirus
      3. Ebstein barr virus
      4. Adenovirus
      5. Nothing above
1185. Carcinoma of cervix is associated with all, except:
      1. Multiparity,
      2. Herpes simples virus,
      3. Early coitus.
      4. \*Diabetes mellitus,
      5. Multiple sex partners
1186. Oral conceptives are contraindicated in case of:
      1. Hypertension
      2. Uterine Fibroids
      3. Thrombolism
      4. \*All of the above
      5. Nothing above
1187. Laparoscopic sterilisation is contraindicated in:
      1. Postpartum period,
      2. \*Gynaecology tumours
      3. Following MTP,
      4. If the patient has more than 3 children
      5. Nothing above
1188. The cause of secondary amenorrhea could be:
      1. \*Stein-Leventhal syndrome
      2. Ovarian dysgenesie
      3. Imperforate hymen,
      4. All of the above
      5. Nothing above
1189. The signs of pelvic tuberculosis are:
      1. Amenorrhea,
      2. Infertility,
      3. Foul smelling discharge,
      4. \*All of the above
      5. Nothing above
1190. The commonest of ovarian tumour is:
      1. \*Pseudomucinous cystadenoma
      2. Mucinous cystadenoma
      3. Dermoid
      4. Papillary cystadenoma
      5. Nothing above
1191. The source of HCG is the:
      1. \*Syncitiotrophoblast,
      2. Cytotrophoblast
      3. langhans layer
      4. Chorionic villi
      5. Nothing above
1192. The uncommon change in a myoma is:
      1. Calcification,
      2. Red degeneration,
      3. \*Malignant change
      4. Hyaline change
      5. Nothing above
1193. The best method to confirm the diagnosis of cervix carcinoma is:
      1. Physical examination,
      2. Pap smear,
      3. \*Cervical biopsy
      4. Curettage
      5. Nothing above
1194. The best method to prevent pregnancy after unprotected intercose is:
      1. High Estrogen pills
      2. Curettage
      3. \*the Morning-After Pill
      4. Menstrual regulation
      5. Nothing above
1195. Danazol is used in all cases, except:
      1. Hirsulism
      2. Endometriosis
      3. Dysfunctional Uterine bleeding
      4. \*Fibroid
      5. Nothing above
1196. Which of the following is not used for the diagnosis of reasons of uterine bleeding:
      1. colposcopy
      2. \*laparoscopy
      3. USG
      4. separate currettage of the mucous membrane of the uterus & its cervix
      5. hysteroscopy
1197. The main method for the diagnosis of the cancer of the uterine body:
      1. cytological study of the aspirate from the uterine cavity
      2. \*hystologic study of the endometrium
      3. transvaginal echography
      4. hysteroscopy
      5. radiologically monitored hysterosalphingography
1198. Urinary incontinence in utero vaginal prolapse is mostly due to:
      1. \*Detrusor instability
      2. Stress incontinence
      3. Urge incontinence
      4. True incontinence
      5. Nothing above
1199. Systemic metastasis is commonest in:
      1. Ovarian Carcinoma
      2. Endometrial carcinoma
      3. \*Choriocarcinoma
      4. Carcinoma cervix
      5. Nothing above
1200. Commonest Site for fibroid is:
      1. Submucous
      2. \*Intramural
      3. Subserous
      4. Cervical
      5. Nothing above
1201. Contraceptive of choice for newly married women is:
      1. Norplant
      2. IUCD
      3. Condom
      4. \*OCP(oral contraceptive pill)
      5. Nothing above
1202. Gestational trophoblastic tumours occur most commonly after:
      1. Cesearean section
      2. \*Spontaneous abortion
      3. Preterm delivery
      4. Full term delivery
      5. Nothing above
1203. Red degeneration of fibroid occurs commonly in:
      1. Post partum
      2. \*3rd Trimester
      3. 2nd Trimester
      4. 1 st Trimester
      5. Nothing above
1204. Methods of the diagnostics of the endometrial cancer are the following, except:
      1. \*laparoscopy
      2. separate diagnostic currettage ofr the mucous membrane from the uterine cervix & its body
      3. USG
      4. Hysteroscopy
      5. Nothing above
1205. Post menopausal women has a 4x4 cm ovarian mass. The correct line of management is:
      1. Wait and watch
      2. \*Surgical exploration
      3. Progesterone pills
      4. Clomiphene therapy
      5. Nothing above
1206. Best method for cancer cervix screening is:
      1. \*Pap smear
      2. Colposcopy
      3. Biopsy
      4. Colpomicroscopy
      5. Nothing above
1207. Chocolate cyst of the ovaries arise:
      1. Denovo in the ovary
      2. From the corpus luteum
      3. From the Graafian follicle
      4. \*As a result of endometriosis
      5. nothing above
1208. Deficiency of which hormone presents in case of dysfunctional uterine bleeding
      1. Oestrogen
      2. \*Progesterone
      3. Thyroxin
      4. A.C.T.H.
      5. Cortisol
1209. Sexual infantilism is associated with:
      1. Pituitary tumours
      2. Gonadal aplasia
      3. Dwarfism
      4. \*all of the above
      5. nothing above
1210. Theca-lutein cysts are the ovarian response to excess:
      1. FSH
      2. LH
      3. Estrogen
      4. \*HCG
      5. nothing above
1211. Shoulder pain during ectopic pregnancy indicates:
      1. Tubal abortion
      2. Development of tubal mole
      3. Development of broad ligament haematoma
      4. \*Severe internal bleeding
      5. nothing above
1212. What is not a complication of prolapsed uterus?
      1. \*Carcinoma cervix
      2. Elongation of cervix
      3. Cystocele
      4. Decubitus ulcer
      5. Nothing above
1213. Palpation of uterus per rectum is performed in:
      1. Primigravida
      2. \*Virgins
      3. Grand multi paras
      4. Placenta previa
      5. Nothing above
1214. If a patient, who had received radiations for carcinoma cervix, started bleeding per vaginally but parametrium is free. Treatment is:
      1. \*Wertheims operation
      2. Radical hysterectomy
      3. Total hysterectomy
      4. Exanteration
      5. Nothing above
1215. The ovarian tumour diagnosed after delivery should be removed:
      1. Immediately after the 3rd stage
      2. \*Within 48 hours of delivery
      3. After one week
      4. Only after 6 weeks
      5. Nothing above
1216. A 65-year-old with bleeding P/V. On examination senile vaginitis. Patient requires immediate:
      1. Cytology and colposcopy
      2. Oestrogen therapy and colposcopy
      3. \*Cytology and fractional curettage
      4. Fractional curettage
      5. Nothing above
1217. Best proof of ovulation is by:
      1. Basal body Temperature chart
      2. Study of cervical mucus
      3. Vaginal cytology
      4. \*Endometrial biopsy
      5. Nothing above
1218. Risk factor for breast cancer include:
      1. \*Family history
      2. History of HPV infection
      3. Early menopause
      4. Low-fat diet
      5. All of the above
1219. Ovarian cancer is:
      1. Early to detect with the Pap smear
      2. Likely to carry a good prognosis once it is detected
      3. \*Frequently detected late in its course
      4. All of the above
      5. None of the above
1220. The following statements are true regarding osteoporosis expect;
      1. It affects one-third to one-half of postmenopausal women
      2. It increases as women age
      3. It puts women at high risk for hip fractures
      4. \*It occurs as a result of arthritis
      5. All of the above
1221. Depression in women:
      1. Occurs less frequently than in men
      2. Tends to be treated in only about 75% of women with this condition
      3. \*It twice as likely to occur in women than in men
      4. It is easy to treat with psychotropic drugs developed in research on women
      5. All of the above
1222. Risk factors for osteoporosis?
      1. Premature menopause
      2. Excessive caffeine intake
      3. Regular alcohol use
      4. Excess salt intake
      5. \*All of the above
1223. Risk factors for osteoporosis?
      1. Postmenopause
      2. Insufficient dietary calcium
      3. Smoking
      4. Family history of osteoporosis
      5. \*All of the above
1224. What causes dysfunctional uterine bleeding during adolescence?
      1. Abnormal periods
      2. \*Anovulatory cycles
      3. Poor diet
      4. Poor grades
      5. All of the above
1225. What is the most visible sign of puberty?
      1. Social withdrawal
      2. Weight gain
      3. \*Enlargement of the breast bud
      4. Anger
      5. All of the above
1226. How can the Tanner Stages be defined
      1. Emotional changes of the aging woman
      2. Thelarche
      3. \*Stages of adolescent physical development
      4. Menarche
      5. All of the above
1227. What is the second phase of the normal menstrual cycle?
      1. Ovulation
      2. \*Secretory-luteal phase
      3. Menstruation
      4. Proliferative –follicular phase
      5. All of the above
1228. The corpus luteum regresses with decreases in estrogen and progestin, resulting in menstruation, when what does not occur?
      1. Ovulation
      2. Cysts
      3. Menarche
      4. \*Implantation
      5. All of the above
1229. Risk factors for uterine cancer include those factors that expose the endometrium to estrogen, including:
      1. Early menarche (before 12)
      2. Never having children
      3. Late menopause(after age 55)
      4. History of failure to ovulate
      5. \*All of the above
1230. Risk factors for uterine cancer include those factors that expose the endometrium to estrogen, including:
      1. Infertility
      2. Diabetes
      3. Gallbladder disease
      4. Hypertension
      5. \*All of the above
1231. Risk factors for uterine cancer include those factors that expose the endometrium to estrogen, including:
      1. Infertility
      2. Gallbladder disease
      3. Hypertension
      4. Obesity
      5. \*All of the above
1232. What is correct about amniocentesis?
      1. Intrauterine diagnosis
      2. Withdrawl of allatonic fluid from pregnant women
      3. Chemical analysisof fluids of pregnant women
      4. \*Culturing amniotic cells and study of metaphasic chromosomes to identify chromosomal abnormality
      5. All of the above
1233. What is correct about test tube baby?
      1. Fertilization inside female genital tract and grown in test tube
      2. Rearing of prematuraly born in incubator
      3. \*Fertilization outside and gestation inside womb of mother
      4. Both fertilization and development are effected outside the genital tract.
      5. All of the above
1234. Contraceptive oral pills help in birth control by
      1. Killing of ova
      2. \*Preventing ovulation
      3. Killing of sperms
      4. Forming barrier between sperms and ova
      5. All of the above
1235. Most important component of oral contraceptive agents is
      1. Thyroxine
      2. LH
      3. \*Progestrone
      4. GH
      5. All of the above
1236. Copper-T/ loop prevents
      1. Ovulation
      2. \*Fertilization
      3. Zygote formation
      4. Cleavage
      5. All of the above
1237. Which of the following is a mechanical barrier used in birth control?
      1. Copper-T
      2. \*Diaphragm
      3. Loop
      4. Dalcon shield
      5. All of the above
1238. Which of the following represents a condition where the motility of sperms is highly reduced?
      1. Azospermia
      2. Polyspermy
      3. Oligospermia
      4. \*Asthenospermia
      5. All of the above
1239. Chancroid is a sexually transmitted disease caused by
      1. Treponima
      2. \*Haemophilus
      3. Neisseria
      4. Trichomonas
      5. All of the above
1240. Oral contraceptive pills function by inhibiting
      1. Fertilization
      2. \*Ovulation
      3. Reproduction
      4. Implantation
      5. All of the above
1241. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ is found positive during fertlity period of menstrual cycle, in which cervical mucus is slippery and can be drawn into a thread when stretched between two fingers.
      1. \*Spinnbarkeit test
      2. Shick test
      3. Ballottement test
      4. Pyroglobulin test
      5. All of the above
1242. Failure of testis to descend into the scrotum is called
      1. Paedogenesis
      2. Castration
      3. \*Cryptorchidism
      4. Impotency
      5. All of the above
1243. At suspicion on endometrial cancer, hysteroscopy allows to diagnose (define) all enumerated, except:
      1. presence of any pathological process
      2. superficial spreading of process
      3. \*the depth of invasion
      4. result of biopsy
      5. All of the above
1244. After a sperm has entered on ovum, entry of other sperm is prevented by
      1. Condensation of the yolk
      2. Formation of pigment coat
      3. Development of viteline membrane
      4. \*Development of fertilization membrane
      5. All of the above
1245. Umbulical cord contains
      1. Umbulicus
      2. Placenta
      3. Discus proligerus
      4. \*Allantoic artery and vein
      5. All of the above
1246. The site of fertilization in human is
      1. Ovary
      2. Uterus
      3. Vagina
      4. \*Fallopian tube
      5. All of the above
1247. Freshly released human egg has
      1. One Y-chromosome
      2. \*One X-chromosome
      3. Two X-chromosome
      4. One X-chromosome and one Y-chromosome
      5. All of the above
1248. In 28 day human ovarian cycle, ovulation occures on
      1. Day 1
      2. Day 5
      3. \*Day 14
      4. Day 28
      5. None of the above
1249. Corpus luteum develops from
      1. Oocyte
      2. Nephrostome
      3. \*Graffian follicle
      4. None of the above
      5. All of the above
1250. Corpus luteum secretes
      1. LH
      2. Estrogen
      3. Progestrone
      4. \*FSH
      5. All of the above
1251. Preparation of sperm before penetrating ovum is:
      1. Spermation
      2. Coition
      3. Insemination
      4. \*Capacitation
      5. None of the above
1252. Villi of human placenta develops from
      1. \*Chorion
      2. Allantois
      3. Yolk salk
      4. Both A and B
      5. None of the above
1253. Fertilized ovum is implanted in uterus after
      1. 1 day
      2. \*7 days
      3. 8 days
      4. 10 days
      5. None of the above
1254. Secretion of progestrone by corpus luteum is initiated by
      1. MSH
      2. \*LH
      3. Testosterone
      4. FSH
      5. None of the above
1255. Correct sequance of hormone secretion from the beginning of menstuation is
      1. FSH, progesterone, estrogen
      2. Estrogen, FSH, progesterone
      3. \*FSH, estrogen, progesterone
      4. Estrogen, progesterone, FSH
      5. None of the above
1256. Ovulation or release of ovum occure on the day of menstrual cycle
      1. 8-10
      2. \*12-14
      3. 14-18
      4. Last two days of mensrtual cycle
      5. None of the above
1257. Antrum is cavity of
      1. Ovary
      2. \*Graffian follicle
      3. Blastula
      4. Gastrula
      5. None of the above
1258. Hormone responsible for ovulation and development of corpus luteum is
      1. FSH
      2. \*LH
      3. ADH
      4. ICSH
      5. None of the above
1259. Which is the more unusual sexually transmitted infection?
      1. Syphilis
      2. \*Hepatitis C
      3. Gonorrhea
      4. Yeast Infection
      5. Hepatitis B
1260. Menopause is defined as:
      1. 2 or more irregular periods after age 40
      2. The start of hot flashes
      3. \*No menstrual period for 12 consecutive months
      4. An increase in mood swings
      5. All of the above
1261. The average age of menopause is:
      1. \*51
      2. 60
      3. 55
      4. 49
      5. 35
1262. The most characteristic symptom of menopause is
      1. Hot flashes
      2. \*It varies from woman to woman
      3. Mood swings
      4. Vaginal dryness
      5. Painful intercourse
1263. Menopause increases health risks like:
      1. Heart Disease
      2. Sexually transmitted diseases
      3. Osteoporosis
      4. \*A and C
      5. All of the above
1264. Women who are going through menopause should take:
      1. Hormone therapy
      2. \*It depends on the woman, her symptoms, and her medical history
      3. Bioidentical hormone therapy
      4. Estrogen therapy
      5. All of the above
1265. The most accurate test to determine if a woman is in peri-menopausal is:
      1. Follicle stimulating hormone (FSH) blood test
      2. Complete blood count (CBC)
      3. Urinalysis
      4. \*None of the above
      5. All of the above
1266. Which of the following are proven alternative therapies for menopause symptoms:
      1. Black cohosh
      2. Plant estrogens
      3. Herbals
      4. \*None of the above
      5. All of the above
1267. During perimenopause, some doctors may prescribe which treatment?
      1. Hormone therapies (HT)
      2. Birth control pills
      3. Benzodiazepines
      4. \*A or B
      5. All of the above
1268. Which is NOT a usual symptom of menopause?
      1. Night sweats
      2. \*Back pain
      3. Headaches
      4. Anxiety
      5. Vaginal dryness
1269. If menopause occurs in a woman younger than \_\_\_ years, it is considered to be premature.
      1. \*40
      2. 45
      3. 50
      4. 30
      5. 60
1270. Which factors can affect the timing of menopause?
      1. Surgical removal of the ovaries
      2. Chemotherapy
      3. Radiation
      4. \*All of the above
      5. None of the above
1271. Nausea and vomiting or "morning sickness" may be due to elevations in levels of:
      1. Human chorionic gonadotropin (hCG)
      2. Progesterone
      3. \*Estrogens
      4. Prostaglandins
      5. All of the above
1272. Fatigue and tiredness, symptoms of pregnancy are believed to be related to the rising levels of:
      1. Estrogens
      2. Prostaglandins
      3. \*Progesterone
      4. Human chorionic gonadotropin (hCG)
      5. All of the above
1273. The "mask of pregnancy" is also referred to as:
      1. Vitiligo
      2. Keratosis pilaris
      3. \*Melasma
      4. Tinea versicolor
      5. All of the above
1274. Feelings of breast swelling, tenderness, or pain can begin in some women:
      1. \*Two weeks after conception
      2. One month after conception
      3. Two months after conception
      4. Three months after conception
      5. Eight months after conception
1275. The following are also common symptoms of early pregnancy:
      1. Abdominal pain
      2. Dizziness
      3. Vaginal dryness
      4. Bleeding
      5. \*None of the above
1276. Fetal movement may typically be perceived after \_\_\_\_ weeks for new mothers.
      1. 8 weeks
      2. 10 weeks
      3. 15 weeks
      4. \*20 weeks
      5. 30 weeks
1277. \_\_\_\_\_\_\_\_\_\_\_\_\_ is a major factor for infertility in women.
      1. Age
      2. Weight
      3. Anovulation
      4. \*All of the above
      5. None of the above
1278. Women who are trying to conceive should boost their intake of \_\_\_\_\_\_\_\_\_\_\_\_\_\_.
      1. Nickel
      2. Lycopene
      3. Potassium
      4. \*Folic acid
      5. Estrogen
1279. Which sexually transmitted disease can result in infertility in women?
      1. Human papillomavirus (HPV)
      2. Genital herpes
      3. \*Chlamydiosis
      4. Yeast Infection
      5. All of the above
1280. If a couple is infertile, this means the couple...
      1. Will never be able to have children
      2. \*Could not conceive after 12 months of unprotected sex
      3. Should look into adoption
      4. All of the above
      5. None of the above
1281. A 35-year-old woman is considered infertile after \_\_\_\_ of trying to conceive.
      1. 1 month
      2. 2 months
      3. 4 months
      4. \*6 months
      5. Two years
1282. The most common symptom of a vaginal yeast infection is:
      1. Bleeding
      2. Discharge
      3. Fever
      4. \*Itching
      5. Inferility
1283. What causes yeast infections?
      1. Overgrowth of vaginal yeast
      2. Lack of protective vaginal bacteria
      3. Low Immunity
      4. Antibiotics
      5. \*All of the above
1284. Which of the following is a possible symptom of an STD?
      1. Bumps, sores, or warts near the mouth, anus, or vagina
      2. Painful urination
      3. Painful sex
      4. \*All of the above
      5. None of the above
1285. The bacterium Chlamydia trachomatis can cause:
      1. Lymphogranuloma venereum (LGV) and orchitis
      2. Epididymitis and urethritis
      3. Chlamydia
      4. \*All of the above
      5. None of the above
1286. What is the first phase of the normal menstrual cycle?
      1. Ovulation
      2. Secretory-luteal phase
      3. Menstruation
      4. \*Proliferative –follicular phase
      5. All of the above
1287. Indicate the compounds of the obstetric-gynecological structure:
      1. Maternity home, female dispensary
      2. Female dispensary, gynecological departments.
      3. \* Maternity home, female dispensary, gynecological departments.,
      4. Maternity home, female dispensary, surgical departments
      5. Maternity home, female dispensary, infants department
1288. Ambulatory obstetric care applies at:
      1. Departments of pregnancy pathology.
      2. \*Female dispensaries
      3. Departments of extragenital pathologies of pregnancy
      4. Gynecological departments.
      5. Infants department.
1289. How many women does one female unit service?ї?
      1. 1200
      2. 2100.
      3. 3000.
      4. \*3300.
      5. 5000.
1290. Till how many weeks of pregnancy the pregnant woman should be at first visit the female dispensary?
      1. Till 8-weeks of pregnancy
      2. \*Till 12- weeks of pregnancy
      3. Till 16 weeks of pregnancy
      4. Till 30- weeks of pregnancy
      5. in any gestational week
1291. All of the below methods of investigations should the doctor perform in female dispensary at first visit of the pregnant woman till 12 week EXEPT:
      1. Pelvis investigation
      2. Speculum examination
      3. Bimanual examination
      4. Weighting of the woman
      5. \*Determination of uterine height and circumference
1292. All of the below methods of investigations should the doctor prescribe in female dispensary for pregnant woman EXEPT:
      1. Vaginal smear
      2. ABO and RhD blood type
      3. General urine analysis
      4. General blood count
      5. \*X-ray examination of chest
1293. Consultations of which doctors are recommended by doctor in female dispensary for pregnant woman?
      1. Therapeutic
      2. Therapeutic, Surgeon, Otorinolaryngologist, Dentist
      3. \*Therapeutic, Surgeon, Dentist
      4. Therapeutic, Surgeon, Otorinolaryngologist, Dermatologist
      5. Therapeutic, Surgeon, Cardiologist, Dentist
1294. How often the pregnant woman should visit the doctor in the first half of pregnancy?
      1. Once a week
      2. Twice a week
      3. \*Once a 4 weeks
      4. Once in 10 days
      5. Once a two months
1295. How often the pregnant woman should visit the doctor in the second half of pregnancy?
      1. Once a week
      2. Twice a week
      3. Once a 4 weeks
      4. \*Once in 2 weeks
      5. Once a two months
1296. Which examination the pregnant woman should pass obligatory in the second half of pregnancy in visit to the doctor?
      1. \*Determination of blood pressure
      2. Speculum examination
      3. Bimanual examination
      4. Pelvis examination
      5. Vaginal smear
1297. Which examination the pregnant woman should not pass in the second half of pregnancy in every visit to the doctor?
      1. Determination of blood pressure
      2. \*Speculum examination
      3. Uterine height determination
      4. Circumference of the abdomen determination
      5. Weighting
1298. Which examination the pregnant woman should not pass in the second half of pregnancy in every visit to the doctor?
      1. Determination of blood pressure
      2. \*Determination of pelvic sizes
      3. Uterine height determination
      4. Circumference of the abdomen determination
      5. Weighting
1299. How often does pregnant woman should pass urine analysis in the second half of pregnancy?
      1. Once a month
      2. \*Once in a two weeks
      3. Twice in three months
      4. 5 times during all period of monitoring under the woman
      5. 2 times during all period of monitoring under the woman
1300. Which parameter in general urine analysis is the most informative during monitoring of pregnant woman?
      1. Level of epithelial cells
      2. \*Proteinuria
      3. Amount of sugar
      4. Amount of leukocytes
      5. Transparency
1301. What is the peculiarity of arterial blood pressure in pregnant woman?
      1. Estimated at forearm
      2. \*Estimated in the both hands
      3. Estimated after physical activity
      4. Estimated in sitting position
      5. Estimated at standing position
1302. At which gestational age does the pregnant woman receive vacation before delivery?
      1. 22 week of pregnancy
      2. \*30 weeks of pregnancy
      3. 24 week of pregnancy
      4. 32 week of pregnancy
      5. 35week of pregnancy
1303. For how many days does the pregnant woman receive vacation for pregnancy and delivery?
      1. 120
      2. \*126
      3. 140
      4. 155
      5. 180
1304. What is the high of obstetric perineum in the most of women?
      1. 1-2 cm
      2. \*3-4 cm
      3. 5-6 cm
      4. 0,5-1cm
      5. 8cm
1305. Where do the bartholins’ glands openings are located?
      1. \*Between labia minor and hymen
      2. Between labia major and labia minor
      3. In lower part of labia major
      4. In the area of clitors
      5. In the area of posterior commissure
1306. What is the length of urethra in the women?
      1. \*3-4 cm
      2. 1-2 cm
      3. 5-6 cm
      4. 7-8 cm
      5. 8-9cm
1307. Where the external opening of the urethra is located?
      1. \*2-3 cm below clitoris
      2. 1-2 cm above clitoris
      3. 1-2 cm above vaginal opening
      4. 2-3 cm above vaginal opening
      5. 3-4 cm below clitoris
1308. Which epithelium covers the vagina?
      1. \*multilayer squamosus epithelium
      2. multilayer columnar epithelium
      3. single layer columnar epithelium
      4. single layer squamosus epithelium
      5. ciliated epithelium
1309. Which glands are presented in the vaginal mucous membrane?
      1. \*mucous membrane of the vagina doesn’t contain glands
      2. tubular
      3. sinuous
      4. glands which produce lactic acid
      5. glands which produce mucous
1310. What is the normal length of uterine tubes?
      1. \*8-12cm
      2. 3-4 cm
      3. 5-7 cm
      4. 12-15cm
      5. 1-2 cm
1311. Which epithelium cover the fallopian tube?
      1. multilayer squamosus epithelium
      2. multilayer columnar epithelium
      3. single layer columnar epithelium
      4. single layer squamosus epithelium
      5. columnar ciliated epithelium
1312. How do you called lig. suspensorii ovarica?
      1. Lig. Ovarii proprii
      2. \*Lig. infundibulopelvicum
      3. Lig. teres uteri
      4. Lig. teres ovarii.
      5. Lig. latum ovarii.
1313. What is the upper border of uterine isthmus?
      1. External cervical os
      2. \*Place of dense attachment of peritoneum
      3. Histological internal cervical os
      4. Place of fallopian tubes attachmement
      5. Place of round ligaments attachment
1314. From which structures in labor does the lower uterine segment of the uterus consist of?
      1. Uterine body
      2. \*Uterine cervix and isthmus
      3. Uterine body and ishtmus
      4. Uterine cervix
      5. Uterine cervix
1315. Uterine artery is a branch of:
      1. Internal pudendal artery
      2. \*Arteria iliaca interna
      3. Arteria iliaca externa
      4. Aorta
      5. Arteria illiaca communis
1316. Obstetric perineum is:
      1. \*Distance between posterior comissura and anus
      2. Distance between clitoris and posterior comissura
      3. Distance between external orifice of urethra and clitoris
      4. Distance between external orifice of urethra and posterior comissura
      5. Distance between external orifice of urethra and anus
1317. How many degrees does the angle between uterine body and uterine cervix have?
      1. 50
      2. 90
      3. \*120
      4. 160
      5. 70
1318. At which day at 28 day of menstrual cycle ovulation take place?
      1. At 10-12
      2. At 12-13
      3. \*At 14-15
      4. At 16-17
      5. At 19-20
1319. Which hormone is produced by luteal body?
      1. Foliculin
      2. Estriol
      3. \*Progesteron
      4. Lutropin
      5. Prolactin
1320. Under influence of which hormone uterine endometrium transform into decidua membrane?
      1. Foliculin
      2. Estriol
      3. \*Progesteron
      4. Lutropin
      5. Prolactin
1321. Where the prostaglandins are synthesized?
      1. In pituitary gland
      2. In ovaries
      3. In adrenal glands
      4. In pancreas
      5. \*In all tissues of organism
1322. Female pelvis consist of:
      1. 2 iliac bones, 2 ishial bones, 2 pubis
      2. Sacrum, 2 terminalis bones
      3. Sacrum, 2 terminalis bones, 2 iliac bones, 2 ishial bones
      4. \*sacrum, 2 pelvic bones, coccyx
      5. 2 pelvic bones, 2 iliac bones, 2 ishial bones, 2 pubis, coccyx, sacral bone
1323. Female pelvis consist of:
      1. 2 bones
      2. 1 bone
      3. 5 bones
      4. \*4 bones
      5. 3 bones
1324. What is the normal length of umbilical cord:
      1. \*30-70cm
      2. 10 cm
      3. 20cm
      4. 25cm
      5. 30cm
1325. Which vessels are present inside the umbilical cord?
      1. \*1 vein, 2 arteries
      2. 2 veins, 2 arteries
      3. 2 arteries, 3 veins
      4. 3 arteries, one vein
      5. 1 artery, 1 vein
1326. At which gestational age of pregnancy the amount of amniotic fluid is maximum?
      1. At 22 week of pregnancy
      2. At 28 week of pregnancy
      3. At 32 week of pregnancy
      4. At 34 week of pregnancy
      5. \*At 38 week of pregnancy
1327. What is the fetal weight at 22 week of gestation?
      1. 300 gram
      2. 400 gram
      3. \*500 gram
      4. 600 gram
      5. 700 gram
1328. What is the fetal weight from 37 week of gestation?
      1. 1300 gram
      2. 2400 gram
      3. \*from 2500 gram and more
      4. 1600 gram
      5. 1700 gram
1329. What is the fetal length from 37 week of gestation?
      1. 20cm
      2. 25cm
      3. \*47 cm and more
      4. 30 cm
      5. 32 cm
1330. From gestational age fetus is viable?
      1. From 12 week
      2. From 20 week
      3. \*From 22 week
      4. From 30 week
      5. From 28 week
1331. What is the normal duration of physiological pregnancy?
      1. 250 days
      2. 260 days
      3. 270 days
      4. \*280 days
      5. 300 days
1332. At which gestational age of prenatal development placentation start?
      1. \*At 12-14 week
      2. At 10 week of pregnancy
      3. At 8-10 week of pregnancy
      4. At 4-6 week of pregnancy
      5. At 6-8 week of pregnancy
1333. Uterine fundus located 4 cm above symphysis. Which gestational age corresponds with such enlargement?
      1. 18 week
      2. 12 week of pregnancy
      3. 10 week of pregnancy
      4. 6 week of pregnancy
      5. \*16week of pregnancy
1334. Uterine fundus located 4 cm below umbilicus. Which gestational age corresponds with such enlargement?
      1. 18 week
      2. 12 week of pregnancy
      3. 10 week of pregnancy
      4. \*20 week of pregnancy
      5. 16week of pregnancy
1335. Uterine fundus located at the level of umbilicus. Which gestational age corresponds with such enlargement?
      1. 18 week
      2. \*24week of pregnancy
      3. 10 week of pregnancy
      4. 20 week of pregnancy
      5. 16week of pregnancy
1336. Uterine fundus located 4cm above the umbilicus. Which gestational age corresponds with such enlargement?
      1. \*28 week o pregnancy
      2. 22 week of pregnancy
      3. 12 week of pregnancy
      4. 24 week of pregnancy
      5. 16week of pregnancy
1337. Uterine fundus located at the level of procesus xyphoideus. Which gestational age corresponds with such enlargement?
      1. 28 week o pregnancy
      2. 22 week of pregnancy
      3. 12 week of pregnancy
      4. 24 week of pregnancy
      5. \*36week of pregnancy
1338. Which external pelvic size determine between both iliac spines?
      1. \*distantia spinarum
      2. distantia cristarum
      3. distantia trochantericа.
      4. distantia interspinalis
      5. distantia spinosum
1339. Which external pelvic size determine between both iliac crists?
      1. distantia spinarum
      2. \*distantia cristarum
      3. distantia trochantericа.
      4. distantia interspinalis
      5. distantia spinosum
1340. Which external pelvic size determine between both trochanter major of femoral bones?
      1. distantia spinarum
      2. distantia cristarum
      3. distantia trochantericа.
      4. distantia interspinalis
      5. distantia spinosum
1341. External conjugate is the distance between:
      1. \*Fossa suprasacralis and upper midpoint at external surface of symphysis
      2. Fossa suprasacralis and promontorium
      3. Promontorium and internal midpoint of upper part of symphysis
      4. Promontorium and lower part of symphysis
      5. Promontorium and middle internal part of symphysis
1342. How much centimeters you should subtract from external conjugate if Solovjov index is 15 cm?
      1. 10cm
      2. 11 cm
      3. 8 cm
      4. \*9cm
      5. 13 cm
1343. Which diameter doesn’t belong to anteroposterior diameters of true pelvis?
      1. Obstetric conjugate
      2. Anatomical conjugate
      3. Diagonal conjugate
      4. \*Oblique conjugate
      5. True conjugate
1344. At which condition you can determine the diagonal conjugate?
      1. At external examination
      2. Only at dislocated pelvis
      3. \*In contracted pelvis
      4. If pelvic sizes are normal
      5. There is no correct answer
1345. How do you called the distance fro lower part of sympysis to promontorium?
      1. Obstetric conjugate
      2. Anatomical conjugate
      3. \*Diagonal conjugate
      4. Oblique conjugate
      5. True conjugate
1346. Where does the upper angle of Michaelis Rhomb is located?
      1. In the region of first sacral vertebrae
      2. In the area of second sacral vertebrae
      3. \*In the fossa suprasacralis
      4. In the region of fifth lumbar vertebrae
      5. In the region of the fourth lumbar vertebrae
1347. How many degrees does pubis angle have?
      1. 60-70
      2. 70-80
      3. \*90-100
      4. 110-120
      5. 120-130
1348. How many centimeters does the vertical of Michaelis Rhomb have?
      1. 7
      2. 8
      3. 9
      4. \*10-11
      5. 12-13
1349. How many centimeters do lateral conjugates have?
      1. 17
      2. 18
      3. 20
      4. \*15-16
      5. 21-22
1350. What is the function of perineal muscles?
      1. \*To keep correct position of sexual organs
      2. To provide defecation
      3. To provide urination
      4. To provide uterine contractions
      5. To keep normal position of kidneys
1351. Which structure is not a compound of urogenital diaphragm?
      1. Urethral spincter
      2. m. transversus perinei profundus
      3. \*m. transversus perinei superficialis
      4. sphincter ani
      5. There is no correct answer
1352. Which muscle narrow the vaginal entrance?
      1. m. ischiocavernosus.
      2. m. transversus perinei profundus
      3. m. transversus perinei superficialis
      4. \*m. bulbocavernosus
      5. m. levator ani.
1353. Which layer of muscles called as urogenital diaphragm?
      1. Superficialis
      2. \*Medium
      3. Upper
      4. Deep
      5. Pelvic floor
1354. Which muscle is a part of deep layer of perineal muscles?
      1. m. ischiocavernosus.
      2. m. transversus perinei profundus
      3. m. transversus perinei superficialis
      4. m. bulbocavernosus
      5. \*m. levator ani.
1355. Which layer of muscles called as pelvic diaphragm?
      1. Superficialis
      2. Medium
      3. Upper
      4. \*Deep
      5. Pelvic floor
1356. Which diameter of fetal head estimated between chin and occiput?
      1. Sublingvo-bregmaticus
      2. Fronto-occipitalis
      3. Suboccipito-bregmaticus
      4. \*Mento-occipitalis
      5. Suboccipito-frontalis
1357. Which bones does the posterior fontanel form?
      1. Two frontal and two parietal
      2. \*Two parietal and occipital
      3. Two parietal and temporal
      4. Two parietal and two occipital
      5. Two frontal and two temporal
1358. Which diameter of fetal head estimated between fossa suboccipitalis and the border of the hair in the forehead?
      1. Sublingvo-bregmaticus
      2. Fronto-occipitalis
      3. Suboccipito-bregmaticus
      4. Mento-occipitalis
      5. \*Suboccipito-frontalis
1359. Which bones does the sagittal suture join?
      1. Two frontal
      2. \*Two parietal
      3. Two parietal and occipital
      4. Two parietal and temporal
      5. Two frontal and two temporal
1360. Which bones does the lambdoid suture join?
      1. Two frontal
      2. Two parietal
      3. \*Two parietal and occipital
      4. Two parietal and temporal
      5. Two frontal and two temporal
1361. Which bones does the frontal suture join?
      1. \*Two frontal
      2. Two parietal
      3. Two parietal and occipital
      4. Two parietal and temporal
      5. Two frontal and two temporal
1362. Which bones does the coronar suture join?
      1. Two frontal
      2. Two parietal
      3. \*Two parietal and occipital
      4. Two parietal and temporal
      5. Two frontal and two parietal
1363. From how many bones does the fetal head consist of?
      1. 4
      2. 5
      3. 6
      4. \*7
      5. 8
1364. Which fetal membrane formed from trophoblast?
      1. Amnion
      2. Decidua
      3. Placental
      4. \*Chorion
      5. Implantative
1365. Which fetal membrane belongs to maternal?
      1. Amnion
      2. \*Decidua
      3. Placental
      4. Chorion
      5. Implantative
1366. Which hormone the trophoblast start to produce after implantation?
      1. Estriol
      2. \*Chorionic gonadotropin hormone
      3. Progesteron
      4. Relaxin
      5. Placental lactogen
1367. During which period of prenatal development product of the conceptus are called as embrion?
      1. From the moment of fertilization till placentation
      2. \*From the 3-d till 8 week of pregnancy
      3. From the 2-nd till 12-14 week of gestation
      4. From implantation till 12 week of gestation
      5. From implantation till 10 week of gestation
1368. Which speed of sperm in the female sexual organs?
      1. 1-2 mm per hour
      2. \*2-3 mm per hour
      3. 3-5 mm per min
      4. 2-3 mm per min
      5. 5-7 mm per minute
1369. At which stage of development fertilized ovum enter the uterus?
      1. 2 blasmomeres
      2. 4 blastomeres
      3. \*morula
      4. blastocyst
      5. embrion
1370. How do you called by another words chorionic membrane of fetus?
      1. Amnion
      2. Trophoblast
      3. \*Amnion
      4. Embryotroph
      5. Corticotroph
1371. What is the origin of decidual membrane?
      1. Villi of chorion
      2. Villi of trophoblast
      3. \*As a result of pregnancy hyperplastic endometrium
      4. Amniotic layer of the cells
      5. Endothelial cells
1372. What are the compounds of afterbirth?
      1. Placenta, amniotic fluid, umbilical cord
      2. Placenta, decidua membrane, umbilical cord
      3. \*Placenta, membranes, umbilical cord
      4. Placenta, amnion and chorion
      5. Amnion, chorion, deciadua
1373. What is the type of human placentation?
      1. Chorion-amniotic
      2. Hemoamniotic
      3. \*Hemochorioebdothelial
      4. Hemoplacental
      5. Hemoallantois
1374. Called the membranes in the direction from fetus to uterine wall?
      1. \*Amnion, Chorion, Decidual
      2. Chorion, Amnion, Decidual
      3. Decidual, Amnion, Chorion
      4. Decidual, Chorion, Amnion
      5. Chorion, Decidual, Amnion
1375. What is the average weight of placenta in the end of pregnancy?
      1. 100-200 gramm
      2. 200-300 gramm
      3. 300-400 gramm
      4. \*500- 600 gramm
      5. 1000-1200 gramm
1376. Thanks to which placental function fetus receive the nutrients?
      1. Excretory
      2. Endocrine
      3. Hormonal
      4. \*Trophic
      5. Gas exchange
1377. Thanks to which placental function fetal metabolic products are excreted?
      1. \*Excretory
      2. Endocrine
      3. Hormonal
      4. Trophic
      5. Gas exchange
1378. Where do the estrogens are synthesized during pregnancy?
      1. \*Placenta and adrenal glands
      2. Placenta
      3. Adrenal glands
      4. Amniotic membrane
      5. Placenta and amnion
1379. What is the difference between the composition of amniotic fluid and composition of maternal plasma?
      1. \*Lower level of proteins in amniotic fluid
      2. Higher level of proteins in amniotic fluid
      3. Higher level of estrogens in amniotic fluid
      4. Lower level of estrogens in amniotic fluid
      5. Higher level of progesterone in amniotic fluid
1380. When does the production of amniotic fluid starts during pregnancy?
      1. \*From 12 day of pregnancy
      2. From 24 day of pregnancy
      3. From 12 week of pregnancy
      4. From 20 week of pregnancy
      5. From 24 week of pregnancy
1381. All of the below are the functions of amniotic fluid EXEPT?
      1. Protection of umbilical cord from compression
      2. \*Trophic function
      3. To create the conditions for fetal movements
      4. To contribute normal duration of the first stage of labor
      5. To protect fetus from mechanical trauma
1382. Which amount of amniotic fluid consider to be normal in the end of pregnancy?
      1. Less than 0,5 L
      2. 0,5- 0,8 L
      3. 0,5-1,0 L
      4. \*1,0- 1,5 L
      5. 1,5-2,5 L
1383. Chorionic gonadotropin hormone is synthesized by:
      1. Amniotic fluid
      2. Placenta
      3. Decidua
      4. Amnion
      5. \*Chorion
1384. To which substances does chorionic gonadotropin belong to?
      1. Phospholipids hormones
      2. Phospholipids’ enzymes
      3. Protein’ enzymes
      4. Carbohydrates’ Enzymes
      5. \*Protein hormones
1385. What is the base of immunological tests of pregnancy?
      1. To determine the level of estrogens in urine
      2. To determine progesterone in urine
      3. \*To determine chorionic gonadotropin hormone in urine
      4. To estimate prolactin in blood
      5. To determine luteinizing hormone in urine
1386. What it is important to follow in determination of urine test for pregnancy?
      1. \*To use the early portion of urine
      2. To collect the urine after careful toilet of external sexual organs
      3. To keep urine sterility
      4. Before collecting of urine the woman doesn’t take acute food
      5. Before collecting the urine the doesn’t take alcohol
1387. When in urine of pregnant woman b-unit of Chorionic gonadotropin hormone is revealed?
      1. On 2-3 day after ovulation
      2. \*At 7-8 day after ovulation
      3. At 9-10 day after ovulation
      4. At 3 week after fertilization
      5. In 2 weeks after fertilization
1388. When the amount of Chorionic gonadotropin hormone in pregnant’ blood reach maximum levels?
      1. On 10-12 day of pregnancy
      2. \*On 60-70 day of pregnancy
      3. On 20-30 day of pregnancy
      4. On 30-40 day of pregnancy
      5. On 80-90 day of pregnancy
1389. From which week of pregnancy does Ultrasonography can reveal fetal heart contractions?
      1. On 2-3 day after fertilization
      2. On 2 week of pregnancy
      3. On 3 week of pregnancy
      4. \*On 4 week of pregnancy
      5. On 5 week of pregnancy
1390. From which week of pregnancy does Ultrasonography can reveal fetal movements?
      1. On 2-3 day after fertilization
      2. On 2 week of pregnancy
      3. On 3 week of pregnancy
      4. On 4 week of pregnancy
      5. \*On 8 week of pregnancy
1391. Which disease transferred in childhood cab cause the pelvic deformation?
      1. \*Rachitis
      2. Rubella
      3. Diabetes Mellitus
      4. Varicella
      5. Measles
1392. Which information about menstrual function can help to determine gestational age of pregnancy?
      1. \*First day of the last menstrual period
      2. Regularity of menstruation
      3. Duration of menstruation
      4. Age of menstrual cycle beginning
      5. All of the above
1393. Which question is the most important in taking the history about childbearing function?
      1. Amounts of pregnancies
      2. Amounts of labors
      3. Amounts of abortions
      4. Presence of complications in previous labors
      5. \*All of the above
1394. To determine the amounts of pregnancies in the woman we take into account?
      1. Amounts of labors + induced abortions
      2. Amounts of labors
      3. Amounts of labors+ induced abortions+ spontaneous abortions
      4. Amounts of labors + spontaneous abortions
      5. \*Amounts of labors+ induced abortions+ spontaneous abortions+ectopic pregnancies
1395. What is the aim of taking the history about secretory function??
      1. To determine the level of gonadotropin hormones in the blood
      2. To determine ovarian hormones in the blood
      3. To determine the level of gastric secretion
      4. To determine level of placental secretion
      5. \*To determine the character of discharges from sexual organs
1396. Which shape of external cervical os in primapara woman?
      1. Longitudinal
      2. Transverse
      3. Oval
      4. Cylindrical
      5. \*Round
1397. Which shape of external cervical os in multipara woman?
      1. Longitudinal
      2. \*Transverse
      3. Oval
      4. Cylindrical
      5. Round
1398. In bimanual examination was diagnosed that uterus is asymmetrical form, its right horn largest than left one. How do you called this sign?
      1. Snegurjov
      2. \*Piskachek
      3. Henter
      4. Hehar
      5. Michaelis
1399. In speculum examination blue color of the cervix and lateral vaginal walls have been observed. How do you called this sign?
      1. Snegurjov
      2. Piskachek
      3. Henter
      4. Hehar
      5. \*Chedvik
1400. In bimanual examination the uterus becomes contracted and more firm. How do you called this sign?
      1. \*Snegurjov
      2. Piskachek
      3. Henter
      4. Hehar
      5. Michaelis
1401. In bimanual examination the uterus is more anteflexed as a result of softening of its isthmus. How do you called this sign?
      1. Snegurjov
      2. Piskachek
      3. Henter
      4. \*Hehar
      5. Michaelis
1402. In bimanual examination there is the crista at the anterior surface of the uterus. How do you called this sign?
      1. Snegurjov
      2. Piskachek
      3. \*Henter
      4. Hehar
      5. Michaelis
1403. Horvits-Hehar sign in early terms of pregnancy is:
      1. Light dislocation of uterus
      2. Uterine assymetria
      3. \*Softening of uterine isthmus
      4. Crista on the anterior surface of uterus
      5. Blue color of the uterine cervix in speculum examination
1404. Henter sign in early terms of pregnancy is:
      1. Light dislocation of uterus
      2. Uterine assymetria
      3. Softening of uterine isthmus
      4. \*Crista on the anterior surface of uterus
      5. Blue color of the uterine cervix in speculum examination
1405. Snegirjov sign in early terms of pregnancy is:
      1. Changing of uterine tone in bimanual examination
      2. Uterine assymetria
      3. Softening of uterine isthmus
      4. Crista on the anterior surface of uterus
      5. Blue color of the uterine cervix in speculum examination
1406. Piskachek sign in early terms of pregnancy is:
      1. Light dislocation of uterus
      2. \*Uterine assymetria
      3. Softening of uterine isthmus
      4. Crista on the anterior surface of uterus
      5. Blue color of the uterine cervix in speculum examination
1407. From which place does the doctor take material for cytological examination:
      1. Endocervical canal
      2. \*Anterior-lateral fornix and endocervix
      3. Posterior fornix
      4. Anterior fornix and urethra
      5. Vagina
1408. From which place does the doctor take material for purity of the vagina?
      1. Endocervical canal
      2. Anterior-lateral fornix and endocervix
      3. \*Posterior fornix
      4. Anterior fornix and urethra
      5. Vagina
1409. From which place does the doctor take material for gonorrhea?
      1. Endocervical canal
      2. Anterior-lateral fornix and endocervix
      3. \*Urethra, endocervix, rectum
      4. Anterior fornix and urethra
      5. Vagina
1410. From which place does the doctor take material for hormonal mirror?
      1. Endocervical canal
      2. Anterior-lateral fornix and endocervix
      3. \*Upper third part of lateral fornices
      4. Anterior fornix and urethra
      5. Vagina
1411. Determination of a-fetoprotein have an important role for:
      1. Determination gestational age of pregnancy
      2. Determination fetal maturity
      3. \*Determination of fetal abnormal development
      4. Determination of fetal sex
      5. Determination of fetal sizes
1412. The a-fetoprotein is produced in:
      1. Placenta
      2. \*Fetal liver and gastro-intestinal tract
      3. Decidual membrane
      4. Fetal kidneys
      5. Fetal brain
1413. High level of a-fetoprotein is prented in fetal abnormal development of:
      1. Cardiovascular system
      2. \*Nervous system
      3. Fetal kidneys
      4. Gastrointestinal tract
      5. Fetal limbs
1414. Diagnosis of pregnancy is made if basal temperature:
      1. 36,7-36,9 during 2 and more weeks
      2. 36,2-36,6 during 2and more weeks
      3. 38,2-38,6 during 2 and more weeks
      4. \*37,2-37,9 during 7 and more days
      5. Below 36,7 during 7 and more days
1415. Decreasing of basal temperature in pregnant woman indicate into:
      1. Normal duration of pregnancy
      2. Insufficiency of estrogens
      3. Insufficiency of progesterone
      4. \*Danger of pregnancy interrupting
      5. Insufficiency of oxytocin
1416. Which functions below to placental:
      1. Trophic
      2. Gas exchange
      3. Excretory
      4. Endocrine
      5. \*All mentioned
1417. How do you called the smallest part of the placenta?
      1. Placentitis
      2. Curunkul
      3. Carbunkul
      4. Placenton
      5. \*Cotyledon
1418. Which sign of pregnancy belong to probable?
      1. Nausea
      2. Vomiting
      3. \*Enlargement of uterus
      4. Perception of fetal movements
      5. Palpation of small parts of the fetus in the uterus
1419. Which sign of pregnancy doesn’t belong to probable?
      1. \*Nausea, vomiting
      2. Stopping of menses
      3. Enlargement of uterus
      4. Cervical cyanosis
      5. Softening of uterine ishtmus
1420. Which sign of pregnancy belong to presumptive?
      1. \*Nausea, vomiting
      2. Stopping of menses
      3. Enlargement of uterus
      4. Cervical cyanosis
      5. Softening of uterine isthmus
1421. Which sign of pregnancy doesn’t belong to presumptive?
      1. Nausea
      2. Vomiting
      3. Emotional lability
      4. Changing of smell
      5. \*Fetal heart rate auscultation
1422. Which sign of pregnancy belong to positive?
      1. Nausea
      2. Vomiting
      3. Emotional lability
      4. Changing of smell
      5. \*Nothing above
1423. Which sign of pregnancy doesn’t belong to positive?
      1. Ultrasound scanning of the fetus
      2. Palpation of the entire fetus
      3. Presence of fetal movements
      4. Fetal heart sounds
      5. \*Delay of menses
1424. Which sign of pregnancy belong to positive?
      1. Enlargement of the abdomen
      2. Delay of menses
      3. Enlargement of uterus
      4. \*Fetal heart sounds auscultation
      5. Delay of menses
1425. Positive signs of pregnancy suggest about:
      1. Physiological duration of pregnancy
      2. Changes in sexual organs of pregnant women
      3. Enlargement of uterus
      4. \*Presence of fetus in the uterus
      5. Delay of menses
1426. Which term indicate normal fetal attitude?
      1. \*Habitus flexus
      2. Situs longitudinalis
      3. Situs obliqus
      4. Presentatio cephalica
      5. Positio I
1427. Which term indicate longitudinal fetal lie?
      1. Habitus flexus
      2. \*Situs longitudinalis
      3. Situs obliqus
      4. Presentatio cephalica
      5. Positio I
1428. Which term indicate transverse fetal lie?
      1. Habitus flexus
      2. Situs longitudinalis
      3. Situs obliqus
      4. Presentatio cephalica
      5. \*Situs transversus
1429. Which term indicate oblique fetal lie?
      1. Habitus flexus
      2. Situs longitudinalis
      3. \*Situs obliqus
      4. Presentatio cephalica
      5. Positio I
1430. Fetus is presented in the first position if:
      1. \*Fetal back is presented to the left uterine wall
      2. Fetal back is presented to the right uterine wall
      3. Fetal back is presented to the anterior uterine wall
      4. Fetal back is presented to the posterior uterine wall
      5. Fetal back is presented to the uterine fundus
1431. Fetus is presented in the right position if:
      1. Fetal back is presented to the left uterine wall
      2. \*Fetal back is presented to the right uterine wall
      3. Fetal back is presented to the anterior uterine wall
      4. Fetal back is presented to the posterior uterine wall
      5. Fetal back is presented to the uterine fundus
1432. Fetus is presented in the anterior variety if:
      1. Fetal back is presented to the left uterine wall
      2. Fetal back is presented to the right uterine wall
      3. \*Fetal back is presented to the anterior uterine wall
      4. Fetal back is presented to the posterior uterine wall
      5. Fetal back is presented to the uterine fundus
1433. Fetus is presented in the posterior variety if:
      1. Fetal back is presented to the left uterine wall
      2. Fetal back is presented to the right uterine wall
      3. Fetal back is presented to the anterior uterine wall
      4. \*Fetal back is presented to the posterior uterine wall
      5. Fetal back is presented to the uterine fundus
1434. Fetal lie is:
      1. Relation of small parts of the fetus to its body
      2. \*Relation of vertical fetal axis to uterine axis
      3. Relation of fetal axis to pelvic axis
      4. Relation of fetal back to lateral uterine walls
      5. Relation fetal head to the pelvic inlet
1435. Fetal attitude is:
      1. \*Relation of small parts of the fetus to its body
      2. Relation of vertical fetal axis to uterine axis
      3. Relation of fetal axis to pelvic axis
      4. Relation of fetal back to lateral uterine walls
      5. Relation fetal head to the pelvic inlet
1436. If fetal axis crosses uterine axis under 900, this is:
      1. Habitus flexus
      2. Situs longitudinalis
      3. Situs obliqus
      4. Presentatio cephalica
      5. \*Situs transversus
1437. If fetal axis crosses uterine axis under 900, fetal head is from the right side this is:
      1. \*Transverse lie, second position
      2. Oblique lie, second position
      3. Oblique lie, first position
      4. Transverse lie, first position
      5. Longitudinal lie, second position
1438. If fetal axis crosses uterine axis under 900, fetal head is from the left side this is:
      1. Transverse lie, second position
      2. Oblique lie, second position
      3. Oblique lie, first position
      4. \*Transverse lie, first position
      5. Longitudinal lie, second position
1439. Indicate the best place for fetal heart rate auscultation for longitudinal lie, cephalic presentation, first position, anterior variety:
      1. From the right, above umbilicus
      2. From the left, above umbilicus
      3. \*From the left, below umbilicus
      4. From the right, below umbilicus
      5. On the level of umbilicus, from the right
1440. Indicate the best place for fetal heart rate auscultation for longitudinal lie, cephalic presentation, second position, anterior variety:
      1. From the right, above umbilicus
      2. From the left, above umbilicus
      3. From the left, below umbilicus
      4. \*From the right, below umbilicus
      5. On the level of umbilicus, from the right
1441. Indicate the best place for fetal heart rate auscultation for longitudinal lie, breech presentation, first position, anterior variety:
      1. \*From the right, above umbilicus
      2. From the left, above umbilicus
      3. From the left, below umbilicus
      4. From the right, below umbilicus
      5. On the level of umbilicus, from the right
1442. Indicate the best place for fetal heart rate auscultation for longitudinal lie, breech presentation, second position, anterior variety:
      1. From the right, above umbilicus
      2. \*From the left, above umbilicus
      3. From the left, below umbilicus
      4. From the right, below umbilicus
      5. On the level of umbilicus, from the right
1443. Indicate the best place for fetal heart rate auscultation for transverse lie, first position, anterior variety:
      1. From the right, above umbilicus
      2. From the left, above umbilicus
      3. From the left, below umbilicus
      4. From the right, below umbilicus
      5. \*On the level of umbilicus, from the left
1444. Indicate the best place for fetal heart rate auscultation for transverse lie, second position, anterior variety:
      1. From the right, above umbilicus
      2. From the left, above umbilicus
      3. From the left, below umbilicus
      4. From the right, below umbilicus
      5. \*On the level of umbilicus, from the right
1445. In pelvic examination the uterus is enlarged till sizes of chicken egg. How many weeks of pregnancy does the pregnant woman have:
      1. 2 weeks
      2. \*4 weeks
      3. 8 weeks
      4. 10 weeks
      5. 12 weeks
1446. In pelvic examination the uterus is enlarged till sizes of goose egg. How many weeks of pregnancy does the pregnant woman have:
      1. 2 weeks
      2. 4 weeks
      3. \*8 weeks
      4. 10 weeks
      5. 12 weeks
1447. In pelvic examination the uterus is enlarged till sizes of male fist. How many weeks of pregnancy does the pregnant woman have:
      1. 2 weeks
      2. 4 weeks
      3. \*8 weeks
      4. 10 weeks
      5. \*12 weeks
1448. In pelvic examination the uterus is enlarged till sizes of female fist. How many weeks of pregnancy does the pregnant woman have:
      1. 2 weeks
      2. 4 weeks
      3. \*8 weeks
      4. 10 weeks
      5. 12 weeks
1449. In pelvic examination the uterus is enlarged till sizes of interm infant head. How many weeks of pregnancy does the pregnant woman have:
      1. 2 weeks
      2. 4 weeks
      3. 8 weeks
      4. 10 weeks
      5. \*12 weeks
1450. The fundus of uterus in pregnant woman is palpated two fingers above symphysis. How many weeks of pregnancy does the pregnant woman have:
      1. 12 weeks
      2. \*16 weeks
      3. 18 weeks
      4. 20 weeks
      5. 26 weeks
1451. The fundus of uterus in pregnant woman is palpated two fingers below umbilicus. How many weeks of pregnancy does the pregnant woman have:
      1. \*20 weeks
      2. 24 weeks
      3. 28 weeks
      4. 32 weeks
      5. 36 weeks
1452. The fundus of uterus in pregnant woman is palpated two fingers above umbilicus. How many weeks of pregnancy does the pregnant woman have:
      1. \*28 weeks
      2. 32 weeks
      3. 36 weeks
      4. 40 weeks
      5. 22 weeks
1453. The fundus of uterus in pregnant woman is palpated in the midway between umbilicus and xyphoid process. How many weeks of pregnancy does the pregnant woman have:
      1. 24 weeks
      2. 28 weeks
      3. \*32 weeks
      4. 36 weeks
      5. 40 weeks
1454. The fundus of uterus in pregnant woman is palpated in the midway between umbilicus and xyphoid process. How many weeks of pregnancy does the pregnant woman have:
      1. 24 weeks
      2. 28 weeks
      3. 32 weeks
      4. \*36 weeks
      5. 40 weeks
1455. Which process is the typical for cardiovascular system adaptation in pregnant woman?
      1. Decreasing of blood circulating volume
      2. \*Increasing of blood circulating volume into 30-50 %
      3. Decreasing of plasma circulating plasma
      4. Increasing of blood circulating volume into 10-20%
      5. Increasing of blood circulating volume into 60-70 %
1456. Why during pregnancy physiologic hemodilution occur?
      1. Decreasing of erythrocytes
      2. \*Increasing of blood circulating plasma
      3. Increasing of erythrocytes
      4. Decreasing of plasma volume
      5. There is no correct answer
1457. Which hematocrit is characterized for pregnant women?
      1. 42-45
      2. 40-42
      3. 36-42
      4. 35-38
      5. \*33-34
1458. Which amount of erythrocytes is characterized for pregnant women?
      1. 130-140g/l
      2. 120-130g/l
      3. \*110-120g/l
      4. 100-110g/l
      5. 120-160g/l
1459. Which amount of erythrocytes is characterized for pregnant women?
      1. 5-7,5 x 109
      2. 7,2-10,5 x 109
      3. 4-8,8 x 109
      4. \*5,0-12x109
      5. 7,7-15,6x109
1460. Which amount of erythrocytes sedimentation rate is characterized for pregnant women?
      1. 5-12 mm/hour
      2. 10-16mm/hour
      3. 2-15mm/hour
      4. 20-35mm/hour
      5. \*40-50mm/hour
1461. There is bradycardia, hypotension, and loss of consciousness in the pregnant woman on the back position. How do you call this syndrome?
      1. Placental dysfunction
      2. Attack of bronchial asthma
      3. Acute pyelonephritis
      4. Congenital heart disease
      5. \*Supine hypotensive syndrome
1462. Doctors’ tactics in the case of supine hypotensive syndrome in pregnant woman:
      1. To call emergency team
      2. To inject for women cardiac drugs
      3. \*To put the pregnant woman into lateral position
      4. To hang one’s head
      5. To raise foot end of bad
1463. Which changes occur in pregnant woman in the blood before delivery?
      1. Increasing of leukocytes amount
      2. Increasing of erythrocytes
      3. \*Increasing of coagulation
      4. Decreasing of blood circulating volume
      5. Severing of hypovolemia
1464. What is the reason of heartburn in pregnant women?
      1. Increasing of gastric acid in stomach
      2. \*Decreasing tonus of cardiac’ stomach sphincter
      3. Increasing of stomach motility
      4. Impairment in diet
      5. Gastro-intestinal tract diseases
1465. What is the reason of constipation in pregnant women?
      1. \*Decreasing of large bowel motility
      2. Decreasing of tonus of cardiac’ stomach sphincter
      3. Increasing of stomach motility
      4. Impairment in diet
      5. Gastro-intestinal tract diseases
1466. What is the reason of decreasing of large bowel motility in pregnant women?
      1. Decreasing of cellular tissue in the food
      2. \*Effect of progesterone into large bowel
      3. Compression of large bowel by pregnant uterus
      4. Increasing of cellular tissue in the food
      5. Gastro-intestinal tract diseases
1467. What is the reason of nausea in late terms of pregnancy in women?
      1. Increasing of gastric acid in stomach
      2. \*Decreasing tonus of cardiac’ stomach sphincter
      3. Increasing of stomach motility
      4. Impairment in diet
      5. \*Prolonged of emptying time
1468. Which reasons provoke often pyelonephritus in pregnant women?
      1. Decreasing of urethra during pregnancy
      2. Decreasing of urethra sphincter tonus
      3. Increasing of urethral motility
      4. Impairment in diet
      5. \*Vesico-urethral reflex
1469. What is the reason of frequent urination in pregnant women?
      1. Inflammatory process in kidneys
      2. \*Enlarge uterus compress the urinary bladder
      3. Increasing of kidneys’ function
      4. Impairment in diet
      5. Dilation of ureters
1470. Which changes in spinal column are physiological during pregnancy?
      1. Lumbar kyphosis
      2. \*Lumbar lordosis
      3. Thoracic kyphosis
      4. Temporary skoliosis
      5. Physiologic osteochondrosis
1471. In pituitary gland in the first weeks of pregnancy there are too much cells which produce:
      1. Foliculostimulating hormone
      2. \*Prolactin
      3. Oxytocin
      4. Vasopressin
      5. Progesteron
1472. Which hormone support “muscle” relaxation in pregnancy?
      1. Estrogen
      2. Prolactin
      3. Oxytocin
      4. Vasopressin
      5. \*Progesteron
1473. What is the uterine weight in the end of pregnancy?
      1. 400-500g
      2. 500-800g
      3. 800-1000g
      4. \*1000-1500g
      5. 1500-2000g
1474. What is the main substratum for supporting of energy’ needs for fetus?
      1. Proteins
      2. Carbohydrates
      3. Lipids
      4. Microelements
      5. \*Glucose
1475. Which mechanism support glucose transportation to the fetus through placenta?
      1. Difusion
      2. Perfusion
      3. \*Facilitated diffusion
      4. Filtration
      5. Ultrafiltration
1476. Which hormone cause increasing of appetite in pregnant women?
      1. Estrogen
      2. \*Insulin
      3. Prolactin
      4. Lactogen
      5. Progesteron
1477. Which mechanism support of storage in the pregnant’ organism lipids and glycogens for increasing of body weight?
      1. Metabolic effect of androgens
      2. \*Anabolic effect of insulin
      3. Metabolic effect of progesterone
      4. Anabolic effect of estrogens
      5. Increasing of appetite and food consumption
1478. How much increase pregnant women weight during normal duration of pregnancy?
      1. 5-7 kg
      2. 7-8 kg
      3. \*8-12 kg
      4. 10-16 kg
      5. 20 kg
1479. Which mechanism support physiological gestational immunosupresion?
      1. Activation of cellular immunity
      2. \*Decreasing of cellular immunity
      3. Increasing of tissue link of immunity
      4. Decreasing of tissue link of immunity
      5. Suppression of all links of immunity
1480. Which tissue support decreasing of immunological incompatibility between mother and fetus?
      1. Placenta
      2. Chorion
      3. Amnion
      4. \*Decidua
      5. All fetal membranes
1481. Which caloric intake in the first half of pregnancy should be present in pregnant woman?
      1. 1500-1700kkal
      2. 1600-2000kkal
      3. 2000-2400kkal
      4. \*2400-2700kkal
      5. 2700-3000kkal
1482. Which caloric intake in the second half of pregnancy should be present in pregnant woman?
      1. 1500-1700kkal
      2. 1600-2000kkal
      3. 2000-2400kkal
      4. 2400-2700kkal
      5. \*2700-3000kkal
1483. Which amount of liquid for day should the pregnant woman consume in the second half of pregnancy?
      1. 200ml
      2. 400ml
      3. 800ml
      4. \*1000-1200ml
      5. 1500-2000ml
1484. What is the normal duration of physiological pregnancy?
      1. \*280days
      2. 300days
      3. 320days
      4. 350days
      5. 400days
1485. When as a rule the normal labor start?
      1. \*In the night
      2. In the morning
      3. In the evening
      4. In the afternoon
      5. There is no correct answer
1486. What is the stimulus to the beginning of labor?
      1. Increasing of prolactin amount
      2. \*Removal of “progesterone” block
      3. Decreasing of estrogens
      4. Increasing of amniotic fluid
      5. Increasing of androgens
1487. The main fertility indicators are:
      1. Basal temperature
      2. cervical secretions (cervical mucus)
      3. the length of the menstrual cycle.
      4. all are wrong
      5. \*all answers are correct.
1488. How long does the fertile time last?
      1. for around 8–9 days of each menstrual cycle.
      2. for 20 days of each menstrual cycle.
      3. for around 2–3 days of each menstrual cycle.
      4. all are wrong
      5. \*all answers are correct.
1489. What are the advantages of natural family planning?
      1. can help to plan a pregnancy
      2. It does not involve using any chemicals or physical devices.
      3. There are no physical side effects.
      4. can help to avoid a pregnancy.
      5. \*all answers are correct.
1490. What are the disadvantages of natural family planning?
      1. It takes 3–6 menstrual cycles to learn effectively.
      2. Woman has to keep daily records.
      3. Woman needs to avoid sex or use male or female condoms during the fertile time.
      4. Natural methods don't protect woman against sexually transmitted infections (STIs).
      5. \*all answers are correct.
1491. What does belong to emergency contraception:
      1. the emergency contraceptive pill, Postinor
      2. the emergency contraceptive pill, ellaOne
      3. the emergency intrauterine device (IUD).
      4. all are wrong
      5. \*all answers are correct.
1492. What are the disadvantages of sterilisation?
      1. The tubes may rejoin and woman will be fertile again.
      2. Sterilisation cannot be easily reversed.
      3. Sterilisation does not protect woman against sexually transmitted infections.
      4. It takes between four weeks to at least three months for sterilisation to be effective.
      5. \*all answers are correct.
1493. The most common methods of endometrial sampling are:
      1. Endometrial biopsy
      2. Dilatation and curettage (D&C)
      3. Hysteroscopy
      4. all are wrong
      5. \*all answers are correct.
1494. Non-surgical treatment options for vaginal prolapse
      1. Kegel Exercises
      2. Pelvic Floor Therapy
      3. Vaginal Pessary
      4. all are wrong
      5. \*all answers are correct.
1495. Surgical treatment options for vaginal prolapse
      1. Anterior Colporrhaphy
      2. Paravaginal Defect Repair
      3. Posterior Colporrhaphy
      4. Perineorrhaphy
      5. \*all answers are correct.
1496. Surgical treatment options for vaginal prolapse
      1. Vaginal Vault Suspension
      2. Hysterectomy
      3. Prolift™
      4. all are wrong
      5. \*all answers are correct.
1497. Risk factors for the development of vaginal prolapse are:
      1. pregnancy,
      2. vaginal delivery,
      3. hysterectomy,
      4. obesity,
      5. \*all answers are correct.
1498. Risk factors for the development of vaginal prolapse are:
      1. chronic cough,
      2. chronic constipation,
      3. repetitive heavy lifting,
      4. \*all answers are correct.
      5. all are wrong
1499. Risk factors for the development of vaginal prolapse are:
      1. menopause,
      2. and genetic connective tissue weakness.
      3. chronic constipation,
      4. \*all answers are correct.
      5. all are wrong
1500. Synonym of an anterior vaginal wall prolapse
      1. \*cystocele
      2. enterocele
      3. Rectocele
      4. all answers are correct.
      5. all are wrong
1501. Synonym of a posterior vaginal wall prolapse
      1. cystocele
      2. enterocele
      3. \*Rectocele
      4. all answers are correct.
      5. all are wrong
1502. Complications of surgical abortion may include:
      1. Heavy Bleeding
      2. Incomplete Abortion
      3. Sepsis
      4. Damage to the Cervix
      5. \*all answers are correct.
1503. Complications of surgical abortion may include:
      1. Scarring of the Uterine Lining
      2. Perforation of the Uterus
      3. Damage to Internal Organs
      4. Death
      5. \*all answers are correct.
1504. Possible reasons for abnormal uterine bleeding include:
      1. Endometrial polyps.
      2. Uterine fibroids.
      3. Endometrial hyperplasia
      4. \*all answers are correct.
      5. all are wrong
1505. Possible reasons for abnormal uterine bleeding include:
      1. Hormonal imbalance.
      2. Cancer.
      3. Miscarriage
      4. \*all answers are correct.
      5. all are wrong
1506. Reasons for surgical removing of polyps:
      1. To establish the diagnosis
      2. To rule out malignant cancer
      3. To cure irregular bleeding , by removing the polyp.
      4. \*all answers are correct.
      5. all are wrong
1507. What is the inflammation of the serous layer of the uterus
      1. \*Perymetritis.
      2. parametritis.
      3. endometritis.
      4. Metroendometritis.
      5. Sepsis
1508. Definition of perimetritis
      1. inflammation or irritation of the the endometrium of the uterus.
      2. \*Inflammation of the uterus involving the perimetrial covering.
      3. inflammation of the muscular layers of the uterus.
      4. inflammation of the mucosal layers of the uterus.
      5. Inflammation of the vagina.
1509. Definition of endometritis
1510. inflammation or irritation of the the endometrium of the uterus.
      1. Inflammation of the uterus involving the perimetrial covering.
      2. inflammation of the muscular layers of the uterus.
      3. Inflammation of the vagina.
      4. inflammation of the mucosal layers of the uterus.
1511. Definition of Vaginitis
      1. Inflammation or irritation of the the endometrium of the uterus.
      2. Inflammation of the uterus involving the perimetrial covering.
      3. inflammation of the muscular layers of the uterus.
      4. \*Inflammation of the vagina.
      5. inflammation of the mucosal layers of the uterus.
1512. Hormonal treatments of endometriosis may include:
      1. Progesterone pills
      2. Progesterone injections
      3. Gonadotropin-agonist medications
      4. \*all answers are correct.
      5. all are wrong
1513. Symptoms of endometritis may include:
      1. Abdominal distention or swelling
      2. Abnormal vaginal bleeding
      3. Abnormal vaginal discharge
      4. Discomfort with bowel movement (constipation may occur)
      5. \*all answers are correct.
1514. Symptoms of endometritis may include:
      1. Fever
      2. General discomfort
      3. Lower abdominal or pelvic pain (uterine pain)
      4. \*all answers are correct.
      5. all are wrong
1515. Possible Complications of endometritis
      1. Infertility
      2. Pelvic peritonitis (generalized pelvic infection)
      3. Pelvic or uterine abscess formation
      4. \*all answers are correct.
      5. all are wrong
1516. Possible Complications of endometritis
      1. Septicemia
      2. Septic shock
      3. Pelvic or uterine abscess formation
      4. \*all answers are correct.
      5. all are wrong
1517. The main symptom of endometriosis is.
      1. \*Pain
      2. uterine abscess formation
      3. Heavy Bleeding
      4. Hormonal imbalance.
      5. Fever
1518. The main symptom of endometriosis is.
      1. uterine abscess formation
      2. Heavy Bleeding
      3. Hormonal imbalance.
      4. Fever
      5. \*all are wrong
1519. A woman with endometriosis may have:
      1. Painful periods
      2. Pain in the lower abdomen before and during menstruation
      3. Cramps for a week or two before menstruation
      4. Cramps during menstruation;
      5. \*all answers are correct.
1520. A woman with endometriosis may have:
      1. Pain during or following sexual intercourse
      2. Pain with bowel movements
      3. Pelvic or low back pain that may occur at any time during the menstrual cycle
      4. \*all answers are correct.
      5. all are wrong
1521. What is endometrial ablation?
      1. \*the surgical destruction of the endometrium.
      2. Perforation of the Uterus
      3. the hormonal destruction of the endometrium.
      4. all answers are correct.
      5. all are wrong
1522. Menopause is defined as:
      1. 2 or more irregular periods after age 40
      2. The start of hot flashes
      3. \*No menstrual period for 12 consecutive monts
      4. An increase in mood swings
      5. all are wrong
1523. Endometriosis occurs deep inside the uterus.
      1. True
      2. \*False
      3. Depends on age
      4. After 50 years
      5. After 30 years
1524. Endometriosis is a common gynecological disease.
      1. \*True
      2. False
      3. After 50 years
      4. After 30 years
      5. After 40 years
1525. When are endometrial cells shed?
      1. Daily
      2. weekly
      3. Shedding is unpredictable
      4. \*during menstruation
      5. all are wrong
1526. What is one of the most common symptoms of endometriosis.
      1. Bloating
      2. Pelvic muscle spasm
      3. Diarrhea
      4. \*Infertility
      5. all are wrong
1527. Women with endometriosis have a higher risk of ovarian cancer.
1528. True
      1. False
      2. Depends on age
      3. After 50 years
      4. After 30 years
1529. Most women with endometriosis will not be able to conceive.
      1. True
1530. False
      1. Depends on age
      2. After 50 years
      3. After 30 years
1531. Why does endometriosis cause pain in some women?
      1. Endometriosis tissues cannot leave the body
      2. Endometriosis areas make chemicals that irritate pelvic tissues
      3. Endometriosis produces chemicals that are known to cause pain
      4. \*All of the above
      5. all are wrong
1532. How often is recommended breast self-exams?
      1. Once per day
      2. Once per week
      3. \*Once per month
      4. Twice per year
      5. all are wrong
1533. Which is NOT a term describing a normal part of the breast?
      1. Ducts
      2. Lymph nodes
      3. Fat
      4. \*Mastalgia
      5. all are wrong
1534. Abnormal cells that do not function like the body's normal cells are called...
      1. Stem cells
      2. Muscle cells
      3. \*Cancerous cells
      4. Mitochondrial cells
      5. all are wrong
1535. What causes breast cancer?
      1. \*No one knows
      2. Living near highly industrialized cities
      3. Low levels of bodily hormones
      4. Vaccines
      5. all are wrong
1536. Which is the most common form of breast cancer?
      1. \*Invasive ductal carcinoma
      2. Ductal carcinoma in situ
      3. Infiltrating lobular carcinoma
      4. invasive lobular carcinoma
      5. None of the above
1537. The medical term for the spread of cancer is called.
      1. Mammary embolism
      2. \*Metastasis
      3. Suffusion
      4. Diffusion
      5. None of the above
1538. What are breast cancer risk factors for women?
      1. Childbearing later in life
      2. Having never had children
      3. Being overweight after menopause
      4. \*All of the above
      5. None of the above
1539. Recommendation for a woman who has found a lump in the breast
      1. \*Make an appointment with a doctor
      2. Do nothing
      3. Go immediately to the nearest emergency room
      4. Apply ice packs to the breast to reduce swelling
      5. None of the above
1540. Of eight women who live to be 85, how many are expected to develop breast cancer?
      1. \*One
      2. Two
      3. Three
      4. Four
      5. None of the above
1541. The first sign of pregnancy is most often:
      1. Food cravings
      2. Fatigue and tiredness
      3. Mood swings and stress
      4. \*Missed menstrual period
      5. None of the above
1542. HIV is an abbreviation for:
      1. Human immune virus
      2. \*Human immunodeficiency virus
      3. Humanoid immunodeficiency virus
      4. Humanus immunocompromisation virus
      5. None of the above
1543. Which is NOT considered a common method of transmission for HIV?
      1. Blood
      2. Genital secretions
      3. Breast milk
      4. \*Urine
      5. None of the above
1544. About one-fourth of all people with HIV/AIDS are:
      1. Homosexual men
      2. Living in southern U.S. states
      3. \*Over the age of 50
      4. Bisexual women
      5. None of the above
1545. People with HIV and AIDS are largely prone to...
      1. Systemic infections.
      2. Superficial infections.
      3. \*Opportunistic infections.
      4. Hospital-acquired infections.
      5. None of the above
1546. Which of the following is NOT a characteristic, AIDS-related physical change?
      1. Lipodystrophy
      2. Loss of subcutaneous fat
      3. Wasting syndrome
      4. \*hyperpigmentation
      5. None of the above
1547. What is a major factor for infertility in women.
      1. Age
      2. Weight
      3. Anovulation
      4. \*All of the above
      5. None of the above
1548. Which sexually transmitted disease can result in infertility in women?
      1. Human papillomavirus (HPV)
      2. Genital herpes
      3. \*Pelvic inflammatory disease
      4. All of the above
      5. None of the above
1549. A 35-year-old woman is considered infertile after \_\_\_\_ of trying to conceive.
      1. 1 month
      2. 2 months
      3. 4 months
      4. \*6 months
      5. None of the above
1550. Where does ovarian cancer occur?
      1. On tissue within the ovary
      2. On the surface of the ovary
      3. In egg-forming germ cells within the ovary
      4. \*Any of the above
      5. None of the above
1551. Who is most at risk for developing ovarian cancer?
      1. A woman who has had multiple children
      2. A woman who is underweight
      3. \*A woman over the age of 60
      4. Any of the above
      5. None of the above
1552. Ovarian cancer is classified into \_ stages, depending upon the extent of spread.
      1. 2
      2. 3
      3. \*4
      4. 5
      5. None of the above
1553. Usually, the first treatment for ovarian cancer is...
      1. \*Surgery
      2. Chemotherapy
      3. Radiation
      4. Any of the above
      5. None of the above
1554. Subserosal fibroids are located :
      1. \*beneath the serosa
      2. inside the uterine cavity
      3. beneath the lining of the uterus
      4. within the muscular wall of the uterus.
      5. None of the above
1555. Submucosal fibroids are located:
      1. beneath the serosa
      2. inside the uterine cavity
      3. inside the fallopian tubes
      4. \*beneath the lining of the uterus within the muscular wall of the uterus.
      5. None of the above
1556. Intramural fibroids are located:
      1. \*beneath the serosa
      2. inside the uterine cavity
      3. beneath the lining of the uterus
      4. \*within the muscular wall of the uterus.
      5. None of the above
1557. The most common symptom of submucous uterine fibroid is:
      1. \*abnormal uterine bleeding.
      2. pelvic pain
      3. pressure on the bladder with frequent or even obstructed urination
      4. pressure on the rectum with pain during defecation.
      5. None of the above
1558. Large uterine fibroids can cause:
      1. pressure
      2. pelvic pain,
      3. pressure on the bladder with frequent or even obstructed urination
      4. pressure on the rectum with pain during defecation.
      5. \*All of the above
1559. What is the treatment for uterine fibroids?
      1. hysterectomy
      2. myomectomy
      3. cryosurgery
      4. uterine artery embolization
      5. \*All of the above
1560. Medical treatments of uterine fibroids include:
      1. danazol
      2. raloxifene
      3. low dose formulations of oral contraceptives.
      4. \*All of the above
      5. None of the above
1561. Which contraceptive can be used for emergency contraception.

Marvelon.

Novinet.

Ovidon.

Regulon.

1. Postinor.
2. Intrauterine system"Mirena" is introduced to:
   1. Women with endometriosis.
   2. 2. Women with a fibroid uterus.
   3. 3. Women with a syndrome Ashermana.
   4. 4. Women with infertility.
   5. 5. \* All of the above.
3. A hormonal IUD should NOT be used by women who:
   1. Have abnormal vaginal bleeding that has not been explained
   2. Have untreated cervical cancer
   3. Have untreated uterine cancer
   4. Have certain abnormalities of the uterus
   5. 5. \* All of the above.
4. A hormonal IUD should NOT be used by women who:
   1. Have had pelvic inflammatory disease within the past 3 months
   2. Have had an STI such as chlamydia or gonorrhea within the past 3 months
   3. Have severe liver disease
   4. None of the above
5. All of the above.
6. Advantages of using hormonal IUD
   1. Is one of the most effective forms of reversible birth control
   2. It can be used while breastfeeding
   3. No preparations needed before sex to ensure it works
   4. Ability to become pregnant returns quickly when removed
7. All of the above.
8. Advantages of using hormonal IUD
   1. Fewer menstrual cramps
   2. Lighter periods
   3. Effective for five years
9. All of the above.
   1. None of the above
10. What is Indication for Hormonal IUD using:
    1. birth control,
    2. Menorrhagia
    3. Endometriosis
    4. chronic pelvic pain
11. All of the above.
12. Indication for Hormonal IUD using:
    1. Endometriosis
    2. Adenomyosis
    3. Dysmenorrhea
13. All of the above.
    1. None of the above
14. Side effects of hormonal IUD
    1. \*Expulsion
    2. Fewer menstrual cramps
    3. Menorrhagia
    4. All of the above.
    5. None of the above
15. What is the main complaint in patients with mastopathy?
    1. \*Pain.
    2. Disorders of the menstrual cycle.
    3. Increased body temperature
    4. Increased libido.
    5. Increasing of breast size.
16. Which method is the most effective in detecting early breast cancer?
    1. Inspection.
    2. Palpation.
    3. Thermography.
    4. Cytological examination of discharge from the nipple.
    5. \*Mammography.
17. Major role in the regulation of growth and development of breast play all hormones EXCEPT:
    1. Progesterone.
    2. Prolactin.
    3. \*FSH
    4. Estradiol.
    5. None of the above
18. What hormonal disorders lead to premature puberty in adrenogenital syndrome?
    1. Hypoestrogenemia
    2. \*Hyperandrogenism
    3. Hyperestrogenism
    4. None of the above
    5. All of the above.
19. Polycystic ovary syndrome (PCOS) is a condition characterized by:
    1. the accumulation of numerous cysts on the ovaries associated with high male hormone levels
    2. chronic anovulation
    3. metabolic disturbances
    4. None of the above
    5. \*All of the above.
20. Classic symptoms of Polycystic ovary syndrome include:
    1. excess facial and body hair
    2. acne
    3. obesity
    4. None of the above
    5. \*All of the above.
21. What do classic symptoms of Polycystic ovary syndrome include?
    1. irregular menstrual cycles
    2. infertility
    3. excess facial hair
    4. excess body hair
    5. \*All of the above.
22. What is Follicle stimulating hormone ?
    1. \*A hormone that stimulates the growth and maturation of mature eggs in the ovary.
    2. Hormone produced by the ovaries
    3. Hormone produced by the adrenal glands
    4. Hormone produced by the testes
    5. None of the above
23. Estrogens is—
    1. Hormones produced by the adrenal glands
    2. \*Hormones produced by the ovaries
    3. Hormones produced by the pancreas
    4. Hormones produced by the hypophysis
    5. Hormones produced by the hypothalamus gland
24. The general functions of the hypothalamus are:
    1. pituitary gland regulation
    2. blood pressure regulation
    3. body temperature regulation
    4. regulation of ovarian function
    5. \*All of the above
25. Tests of functional diagnostics include:
    1. investigation of cervical mucous layer;
    2. changes of basal temperature;
    3. colpocytology;
    4. \*all answers are correct;
    5. all are incorrect.
26. Physiological аmenorrhoea is typical for:
    1. childhood period;
    2. postmenopause;
    3. period of lactation;
    4. to pregnancy;
    5. \*all answers are correct.
27. Which of these is not common for ovarian polycystic syndrome:
    1. amenorrhoea;
    2. hirsutism;
    3. \*ovulatory menstrual cycles;
    4. obesity;
    5. infertility.
28. Causes of primary algomenorrhoea:
    1. infantilism;
    2. retrodeviation of uterus;
    3. high production of prostaglandins;
    4. \*all the above factors.
    5. none of the above
29. Associated syndromes with hypergonadotropic amenoroea are:
    1. ovary depletion syndrome;
    2. resistant ovary syndrome;
    3. Shereshevski-Turner syndrome;
    4. \*all of the above.
    5. none of the above
30. Secondary аmenorrhoea can result from:
    1. psychic stress;
    2. massive blood loss during labour;
    3. expressed deficiency of the body mass;
    4. genital tuberculosis;
    5. \*all of the above.
31. What quantity of blood is lost by a woman during normal menstruation?
    1. less than 50 ml.
    2. 50-100 ml.
    3. \*50-150 ml.
    4. 150-200 ml.
    5. 200-250 ml.
32. Duration of proliferation phase in uterine cycle is:
    1. from 1 to 5 day .
    2. \*from 5 to 14 day.
    3. from 14 to 28day .
    4. from 10 to 14 day.
    5. from 15 to 20 day
33. Select a disease which is a violation of the rhythm of menstruation.
    1. \*Tachimenoreya
    2. Amenorrhea
    3. Polymenorrhea
    4. Oligomenorrhea
    5. none of the above
34. Physiological аmenorrhoea is the absence of menstruations:
    1. in girls of 10-12 years;
    2. during pregnancy;
    3. during period of lactation;
    4. at senile age;
    5. \*all of the above
35. If menopause occurs in a woman younger than \_\_\_ years, it is considered to be premature.
    1. \*40
    2. 45
    3. 50
    4. 30
    5. 60
36. Characteristic of anovulatory uterine bleeding:
    1. Monophasic basal temperature below 37 degrees
    2. Absence of s "fern" and "pupil" symptoms in the middle of the menstrual cycle
    3. Absence of secretory transformation of the endometrium
    4. \*All of the above
    5. None of the above
37. Duration of secretion phase in uterine cycle is:
    1. from 1 to 5 day .
    2. from 5 to 14 day.
    3. \*from 14 to 28day .
    4. from 10 to 14 day.
    5. from 15 to 20 day
38. Which method of gynacological examination does belong to basic?
    1. \*inspection of external genitalia.
    2. taking of smear on a flora.
    3. taking of smear on oncocytology.
    4. ultrasonic examination.
    5. biopsy.
39. Which of the following is the cause of ovarian form of amenorrhea?
    1. congenital gonades’ dysgenesia
    2. the Shereshevsky-Terner’s syndrome
    3. the Shtein-Levental syndrome
    4. \*All of the above
    5. None of the above
40. Prepuberty - is:
    1. \*a period of two years immediately prior to the onset of puberty when growth and changes leading to sexual maturity occur
    2. Age of menarche
    3. The first year after the onset of menarche
    4. Age from 5 to 8 years
    5. None of the above
41. Treatment of juvenile uterine bleeding provides all of the above, except:
    1. stopping Haemorrhage
    2. Normalization of menstrual function
    3. \*Stimulation of Ovulation with clomifene
    4. Antianaemia therapy
    5. All of above
42. Which of medicines should NOT BE USED for treatment of endometriosis?
    1. danasol
    2. \*sinestrol
    3. dufaston
    4. zoladex
    5. danogen
43. How is the state named, when less than 2 days proceed to menstruation?
    1. spaniomenorrhea
    2. hypomenorrhea
    3. proyomenorrhea
    4. \*oligomenorrhea
    5. opsomenorrhea
44. What is the highest level of menstrual regulation?
    1. \* brain cortex
    2. hypothalamus
    3. ovaries
    4. uterus
    5. all above
45. Ovarian amenorrhea is at:
    1. Itsenco-Kushing syndrome
    2. false pregnancy
    3. \* Shtein-Levental syndrome
    4. syndrome Shikhane
    5. all above
46. In climacteric age the medical treatment of dysfunctional uterine bleeding begin with:
    1. setting of estrogens
    2. \*diagnostic curettage of uterine cavity
    3. colposcopy
    4. setting of androgens
    5. setting of gestagens
47. What is spaniomenorrhea?
    1. menstruations come in 6-8 weeks
    2. \*menstruations come 1 time per 4-6 monthes
    3. menstruations are absent
    4. quantity of menstrual blood less than 50ml
    5. duration of menstruation 1-2 days
48. Menorrhagia is:
    1. acyclic uterine bleeding
    2. \*cyclic uterine bleeding in connection with menstruation cycle
    3. painfull and abundant menstruation
    4. pre- & post menstruation bloody allocation
    5. short period of menstruation cycle
49. The change of basal temperature is based on?
    1. \*on influence of progesteron on hypothalamus.
    2. on influence of estrogens on hypothalamus.
    3. on influence of estrogens on a hypophysis.
    4. on influence of progesteron on a hypophysis.
    5. on influence of progesteron on an uterus.
50. The cause of secondary amenorrhea could be:
    1. \*Stein-Leventhal syndrome
    2. Ovarian dysgenesie
    3. Imperforate hymen,
    4. All of the above
    5. Nothing above
51. How to start a survey of gynecological patients?
    1. from the life history taking.
    2. from the disease history taking.
    3. from allergic anamnesis.
    4. from professional anamnesis.
    5. \*complaints of patient.
52. What does the presence of positive symptom “pupillus”during all menstrual cycle testify about?
    1. \*about the high saturation of organism of estrogens.
    2. about estrogen insufficiency.
    3. about the presence of ovulation.
    4. about the presence of lutein phase.
    5. about the presence of early follicular phase.
53. Symptoms of Stein-Leventhal syndrome:
    1. obesity
    2. irregular or no menstruation
    3. acne
    4. excess hair growth
    5. \*All of the above
54. When in a norm the “fern” symptom is most positive?
    1. at once after menstruation.
    2. in the early follicular phase.
    3. \*in time of ovulation.
    4. in the early lutein phase.
    5. in end of menstruation.
55. Treatment of juvenile bleeding can not start from:
    1. \*Fractional curettage of the endometrial cavity
    2. Hormone
    3. Hemostatic agents
    4. All methods are used
    5. None of the above
56. To hypothalamic amenorrhea does not belong:
    1. psychogenic amenorrhea
    2. \*amenorrhea at a syndrome Shikhane
    3. amenorrhea at false pregnancy
    4. amenorrhea at adipozogenital dystrophy
    5. amenorrhea at a syndrome Kiary-Frommel
57. Which hormone provides lactation process:
    1. estrogen
    2. cortizol
    3. insulin
    4. \*prolactin
    5. all are correct
58. Commonest site of endometriosis:
    1. Vagina,
    2. \*uterus.
    3. urinary bladder,
    4. Peritoneal cavity.
    5. Umbilicus
59. Danazol is used in all cases, except:
    1. Hirsulism
    2. Endometriosis
    3. Dysfunctional Uterine bleeding
    4. \*Fibroid
    5. Nothing above
60. The following statements are true regarding osteoporosis expect;
    1. It affects one-third to one-half of postmenopausal women
    2. It increases as women age
    3. It puts women at high risk for hip fractures
    4. \*It occurs as a result of arthritis
    5. All of the above
61. What appearance of the first menstruation in 14 years can testify about?
    1. about the presence of inflammatory disease of uterus.
    2. about the presence of inflammatory disease of adnexa.
    3. about the presence of abnormal position of uterus.
    4. about the presence of of genius infantilism.
    5. \*about normal development of organism of girl.
62. What is the average age of menarche?
    1. 8-9 years.
    2. 9-10 years.
    3. 10-11 years.
    4. \*12 year.
    5. 16 year.
63. When in a norm the “pupil” symptom is most positive?
    1. after menstruation.
    2. in an early follicular phase.
    3. \*in time of ovulation.
    4. in an early lutein phase.
    5. during the menstruation.
64. Hypomenstrual syndrome includes:
    1. \*Oligomenorrhea, opsomenorrhea, hypo menorrhea
    2. Opsomenorrhea, polimenorrhea
    3. Proyomenorrhea, hypomenorrhea
    4. Oligomenorrhea, hypermenorrhea
    5. All of the above
65. Which types of dysfunctional uterine bleeding are presented below, exist?
    1. Ovulatory
    2. Anovulatory
    3. Cyclic
    4. Acyclic
    5. \*All of the above
66. The complication of false amenorrhea:
    1. Hypotrophy of the mammary glands
    2. \*Hematocolpos
    3. Anovulation
    4. opsomenorrhoea
    5. All listed
67. The Shereshevsky-Terner’s syndrome is the result of:
    1. \*a complex of genetic defects, connected with chromosomes anomaly
    2. Presence of double uterus
    3. Absence of ovaries
    4. Vaginal atresia
    5. Polycystic ovarian syndrome
68. In premature sexual maturation secondary sexual signs and menarche appeared:
    1. \*In 9 years
    2. In 11 years
    3. In 13 years
    4. None of these cases
    5. In all these cases
69. Estrogen possess the following action:
    1. promotes peristalsis in uterus and tube
    2. promotes processes of ossification
    3. stimulates activity of cellular immunity
    4. \*all answers are correct
    5. all are wrong
70. What kind of endometriosis belongs to internal?
    1. endometriosis of uterine cervix
    2. endometriosis of vagine
    3. \*endometriosis of uterus
    4. All above
    5. Nothing above
71. Which from transferred syndromes DOES NOT BELONG to neuroendocrine?
    1. \*Shershevscy-Terner
    2. Shtain-Levental syndrome
    3. climacteric
    4. postovarioectomy
    5. all above
72. Deficiency of which hormone presents in case of dysfunctional uterine bleeding
    1. Oestrogen
    2. \*Progesterone
    3. Thyroxin
    4. A.C.T.H.
    5. Cortisol
73. What appearance of the first menstruation in 16 years can testify about?
    1. about the presence of inflammatory disease of uterus.
    2. about the presence of inflammatory disease of adnexa.
    3. about the presence of abnormal position of uterus.
    4. \*about the presence of genital infantilism.
    5. about normal development of organism of girl.
74. Appearance of “fern symptom” is based on:
    1. on the change of type of uterine cervix.
    2. on diameter of cervical canal.
    3. on the rise of viscidity of cervical mucus.
    4. \*on power of mucus to crystallize at drying.
    5. on hyperthermic influence of progesteron on hypothalamus.
75. Indicate factor which doesn't lead to menstrual dysfunction:
    1. Chronic intoxication
    2. Sexual infantilism
    3. Long-term chronic infection
    4. Abnormal development of genital organs
    5. \*none of the above
76. Which type of amenorrhea DOES NOT EXIST?
    1. Secondary
    2. False
    3. \*Combined
    4. Physiological
    5. Pathological
77. What operation is one of those that prepare birth ways for childbirth?
78. Amniotomy
79. Obstetric forceps
80. C-section
81. Craniotomy
82. Cervical circlage
83. What are the indications for applying suture to the cervix?
84. The threat of miscarriage
85. Initial abortion
86. Incomplete abortion
87. \* Istmiko-cervical insufficiency
88. Presentation of placenta
89. Which term termination of pregnancy can be at the request of the woman?
90. Up to 8 weeks
91. To 10 weeks
92. \* To12 weeks
93. To14 weeks
94. To28 weeks
95. What can be specified with the indications for applying obstetrical forceps?
96. Presentation of placenta
97. \* Placental abraption
98. Dyskoordynovana impaired activity
99. Contracted pelvis
100. High standing straight head
101. Which term should be external version of the fetus by Archangelsky?
102. By 28 weeks
103. At 30 weeks
104. \*At 32-36 weeks
105. At 36-38 weeks
106. At 40 weeks of pregnancy
107. Patient with active uterus activity at the time of head crowning on perineum appeared small cracks, pale skin of perineum. What should I do?
108. Hysterotomy
109. \*Epiziotomy
110. Peryneotomy
111. Impose obstetric forceps
112. Amniotomy
113. Which type of obstetric forceps are used in modern obstetric practice?
114. Lazarević
115. Nägeli
116. Bush
117. \*Fenomenova-Simpson
118. Sims
119. What of the following is a condition for Ceserian section?
120. Transverse position of fetus
121. Long without amniotic fluid period
122. Endometritis in childbirth
123. \*Living fetus
124. Cephalopelvic disproportion
125. Which tool is used for fixation of the cervix?
126. Hehar’s dilators
127. Curette
128. Uterine sound
129. Forceps
130. \*Tenaculum
131. Contraindications to the operation of external rotation of the fetus is:
132. Premature pregnancy
133. \*Maltyfetal pregnancy
134. Pelvic fetal presentation
135. Transverse position of fetus
136. Oblique fetal position
137. To which group operations include the imposition of obstetrical forceps operation?
138. That correct position of the fetus
139. Those that save pregnancy
140. That prepare birth canal
141. \*That help to delivery fetus
142. Fetal destroying operation
143. In assessing the knowledge of a pregestational woman with type 1 diabetes concerning changing insulin needs during pregnancy, the doctor recognizes that further teaching is warranted when the client states:
144. \* “I will need to increase my insulin dosage during the first 3 months of pregnancy.”
145. “Insulin dosage will likely need to be increased during the second and third trimesters.”
146. “Episodes of hypoglycemia are more likely to occur during the first 3 months.”
147. “Insulin needs should return to normal within 7 to 10 days after birth if I am bottle feeding.”
148. All variants are possible
149. Preconception counseling is critical to the outcome of diabetic pregnancy because poor glycemic control before and during early pregnancy is associated with:
150. Frequent episodes of maternal hypoglycemia
151. \*Congenital anomalies in the fetus
152. Polyhydramnios
153. Hyperemesis gravidarum
154. All above
155. In planning for the care of a 30-year-old woman with pregestational diabetes, the doctor recognizes that the most important factor affecting pregnancy outcome is the:
156. Mother's age
157. Number of years since diabetes was diagnosed
158. Amount of insulin required prenatally
159. \*Degree of glycemic control during pregnancy
160. All above
161. A serious but uncommon complication of undiagnosed or partially treated hyperthyroidism is thyroid storm, which may occur is response to stress such as infection, birth, or surgery. Symptoms of this emergency disorder include which of the following?
162. Hypothermia
163. \* Restlessness
164. Bradycardia
165. Hypertension
166. All above
167. During a prenatal visit, the doctor is explaining dietary management to a woman with pregestational diabetes. The doctor evaluates that teaching has been effective when the woman states:
168. “I will need to eat 600 more calories per day since I am pregnant.”
169. “I can continue with the same diet as before pregnancy, as long as it is well-balance”
170. \*“Diet and insulin needs change during pregnancy.”
171. “I will plan my diet based on results of urine glucose testing.”
172. All above
173. In teaching the woman with pregestational diabetes about desired glucose levels, the doctor explains that a normal fasting glucose level, such as before breakfast, is in the range of:
174. \*60 to 100 mg/dl
175. 90 to 120 mg/dl
176. 120 to 150 mg/dl
177. 150 to 180 mg/dl
178. Nothing above
179. Screening at 24 weeks’ reveals that a pregnant woman has gestational diabetes mellitus (GDM). In planning her care, the doctor and the woman mutually agree that an expected outcome is to prevent injury to the fetus as a result of GDM. The doctor identifies that the fetus is at greatest risk for:
180. \*Macrosomia
181. Congenital anomalies of the central nervous system
182. Preterm birth
183. Low birth weight
184. All above
185. A 26-year-old primigravida has come to the clinic for her regular prenatal visit at 12 weeks. She appears thin and somewhat nervous. She reports that she eats a well-balanced diet, although her weight is less than it was at her last visit. The results of laboratory studies confirm that she has a hyperthyroid condition. Based on the available data, the doctor formulates a plan of care. Which of the following problem is most appropriate for the woman at this time?
186. Deficient fluid volume
187. \*Imbalanced nutrition: less than body requirements
188. Imbalanced nutrition: more than body requirements
189. Disturbed sleep pattern
190. All above
191. In terms of the incidence and classification of diabetes, maternity doctors should know that:
192. Type 1 diabetes is most common.
193. \*Type 2 diabetes often goes undiagnose
194. Gestational diabetes mellitus (GDM) means that the woman will be receiving insulin treatment until 6 weeks after birth.
195. Type 1 diabetes may become type 2 during pregnancy.
196. All above
197. Metabolic changes throughout pregnancy that affect glucose and insulin in the mother and the fetus are complicated but important to understand Doctors should know that:
198. Insulin crosses the placenta to the fetus only in the first trimester, after which the fetus secretes its own.
199. Women with insulin-dependent diabetes are prone to hyperglycemia during the first trimester because they are consuming more sugar.
200. \* During the second and third trimesters, pregnancy exerts a diabetogenic effect that ensures an abundant supply of glucose for the fetus.
201. Maternal insulin requirements steadily decline during pregnancy.
202. All above
203. With regard to the association of maternal diabetes and other risk situations affecting mother and fetus, doctors should be aware that:
204. \*Diabetic ketoacidosis (DKA) can lead to fetal death at any time during pregnancy.
205. Hydramnios occurs approximately twice as often in diabetic pregnancies.
206. Infections occur about as often and are considered about as serious in diabetic and nondiabetic pregnancies.
207. Even mild-to-moderate hypoglycemic episodes can have significant effects on fetal well-being.
208. All above
209. The doctor providing care for a woman with gestational diabetes understands that a laboratory test for glycosylated hemoglobin Alc:
210. Is now done for all pregnant women, not just those with or likely to have diabetes.
211. Is a snapshot of glucose control at the moment.
212. \* Would be considered evidence of good diabetes control with a result of 2.5% to 5.9%.
213. Is done on the patient’s urine, not her blood
214. All above
215. A serious but uncommon complication of undiagnosed or partially treated hyperthyroidism is thyroid storm, which may occur is response to stress such as infection, birth, or surgery. Symptoms of this emergency disorder include which of the following?
216. \* Fever
217. Hypothermia
218. Bradycardia
219. Hypertension
220. All above
221. Achieving and maintaining constant \_\_\_\_ with blood glucose levels in the range of 60 to 120 mg/dl is the primary goal of medical therapy for the pregnant women with diabetes. This is achieved through a combination of diet, insulin, exercise, and blood glucose monitoring.
222. \*euglycemia
223. hyperglycemia
224. hypoglycemia
225. euglycosemia
226. All above
227. Which factor is most important in diminishing maternal/fetal/neonatal complications in a pregnant woman with diabetes?
228. The woman’s stable emotional and psychological status
229. Evaluation of retinopathy by an ophthalmologist
230. Total protein excretion and creatinine clearance within normal limits
231. \* Degree of glycemic control before and during the pregnancy
232. All above
233. Which major neonatal complication is carefully monitored after the birth of the infant of a diabetic mother?
234. \*Hypoglycemia
235. Hypercalcemia
236. Hypobilirubinemia
237. Hypoinsulinemia
238. All above
239. Which factor is known to increase the risk of gestational diabetes mellitus?
240. Underweight prior to pregnancy
241. Maternal age less than 25 years
242. \*Previous birth of large infant
243. Previous diagnosis of type 2 diabetes mellitus
244. All above
245. Which disease process improves during pregnancy?
246. Bell’s palsy
247. Epilepsy
248. Systemic lupus erythematosus (SLE)
249. \*Rheumatoid arthritis
250. All above
251. Glucose metabolism is profoundly affected during pregnancy because:
252. pancreatic function in the islets of Langerhans is affected by pregnancy.
253. a pregnant woman uses glucose at a more rapid rate than a nonpregnant woman.
254. a pregnant woman increases her dietary intake significantly.
255. \*placental hormones are antagonistic to insulin, resulting in insulin resistance.
256. All above
257. When a pregnant diabetic experiences hypoglycemia while hospitalized, the doctor should have the client:
258. \* eat six saltine crackers or drink 8 oz of milk.
259. drink 8 oz of orange juice with 2 teaspoons of sugar adde
260. drink 4 oz of orange juice followed by 8 oz of milk.
261. eat a candy bar.
262. All above
263. Intervention for pregnant women with diabetes is based on the knowledge that the need for insulin:
264. increases throughout pregnancy and the postpartum perio
265. decreases throughout pregnancy and the postpartum perio
266. \* varies depending on the stage of gestation.
267. should not change because the fetus produces its own insulin.
268. Nothing above
269. The best evaluation for the client’s goal of accurate insulin use is that she will
270. repeat the taught steps of the techniques
271. \*accurately withdraw, mix, and inject the insulin
272. have normal fasting and postprandial glucose levels
273. state that she understands the teaching given
274. Nothing above
275. . Which is a risk for a mother with gestation diabetes?
276. PIH
277. Increase risk for infection
278. Difficult delivery
279. \* All of the above
280. Nothing above
281. Which patient is not at risk for gestational diabetes mellitus?
282. patient with chronic hypertension
283. patient how has had previous unexplained fetal deaths
284. \* patient who feels fatigued by the end of the day
285. patient who’s maternal age is older than 25yrs.
286. Nothing above
287. In her 36th week of gestation, a client with type 1 diabetes has a 9-pound, 10-ounce infant by cesarean birth. When caring for an infant of a diabetic mother (IDM), the doctor should monitor for signs of:
288. Meconium ileus
289. Physiologic jaundice
290. Increased intracranial pressure
291. \*Respiratory distress syndrome
292. Nothing above
293. A mother asks the neonatal doctor why her infant must be monitored for hypoglycemia when her type 1 diabetes was in excellent control during her pregnancy. The best response by the doctor is:
294. "Newborns' glucose levels drop after birth, so we are especially cautious with your baby because of your diabetes."
295. "Newborns' pancreases produce increased amounts of insulin during the first day of birth so we are checking to see if hypoglycemia has occurre"
296. "Babies of mothers with diabetes do not have a large supply of glucose stores at birth, so it is difficult for them to maintain their blood glucose levels within an acceptable range."
297. \* "Babies of mothers with diabetes have a higher than average insulin level because of the glucose received from their mothers during pregnancy, so their glucose level may drop."
298. Nothing above
299. The doctor teaching a prenatal class is asked why babies of mothers with diabetes are larger than those who do not have diabetes. The doctor should respond that these mothers:
300. Take exogenous insulin, which stimulates fetal growth
301. \* Have extra circulating glucose that causes fatty deposits in the fetus
302. Consume extra calories to cover the insulin manufactured by the fetus
303. Are usually overweight, with some of the calories being utilized by the fetus
304. Nothing above
305. In her 37th week of gestation, a client with type 1 diabetes has an amniocentesis to determine fetal lung maturity. The L/S ratio is 2:1, phosphatidylglycerol is present, and creatinine is 2 mg/dL. Based on this information the doctor assesses that:
306. A cesarean birth will be scheduled
307. A birth must be scheduled immediately
308. There is no need for further fetal monitoring
309. \*The newborn should be free from respiratory problems
310. Nothing above
311. A client at 6 weeks' gestation who has type 1 diabetes is attending the prenatal clinic for the first time. The doctor explains that during the first trimester insulin requirements may decrease because:
312. Body metabolism is sluggish in the first trimester
313. \*Morning sickness may lead to decreased food intake
314. Fetal requirements of glucose in this period are minimal
315. Hormones of pregnancy decrease the body's need for insulin
316. Nothing above
317. When caring for a client with type 1 diabetes on the first postpartum day, the doctor expects her insulin requirements to:
318. Slowly decrease
319. Quickly increase
320. \*Suddenly decrease
321. Remain unchanged
322. Nothing above
323. A client with pregestational type 1 diabetes is being counseled on what to expect during her recently confirmed pregnancy. The statement that indicates the client needs further education is:
324. \*"I can expect that my baby will be larger than average."
325. "My blood glucose levels may be lower during my first trimester."
326. "Additional insulin may be needed in the second half of my pregnancy."
327. "Drinking more water will decrease my risk of getting a urinary tract infection."
328. Nothing above
329. A primagravida with pregestational type 1 diabetes is at her first prenatal visit. When discussing changes in insulin needs during pregnancy and after birth, the doctor explains that based on her blood glucose levels she should expect to increase her insulin dosage between the:
330. 10th and 12th weeks of gestation
331. 18th and 22nd weeks of gestation
332. \* 24th and 28th weeks of gestation
333. 36th week of gestation and the time of birth
334. Nothing above
335. A primigravid client who was successfully treated for preterm labor at 30 weeks' gestation had a history of mild hyperthyroidism before becoming pregnant. The doctor should instruct the client to do which of the following?
336. \*Continue taking low-dose oral propylthiouracil (PTU) as ordere
337. Discontinue taking the methimazole (Tapazole) until after delivery.
338. Consider breast-feeding the neonate after the de­livery.
339. Contact the physician if bradycardia occurs.
340. Nothing above
341. A multigravid client at 39 weeks' gestation diagnosed with insulin-dependent diabetes is admitted for induction of labor with oxytocin . Which of the following should the doctor include in the teaching plan as a possible disadvantage of this procedure?
342. Urinary frequency
343. Maternal hypoglycemi
344. Preterm birth.
345. \*Neonatal jaundice.
346. Nothing above
347. Which of the following nursing diagnoses would be the priority for a multigravid diabetic client at 38 weeks' gestation who is scheduled for labor induction with oxytocin?
348. Risk for deficient fluid volume related to oxytocin infusion.
349. Pain related to prolonged labor and uterine ischemi
350. Fear related to possible need for cesarean delivery.
351. \* Risk for injury, maternal or fetal, related to potential uterine hyper stimulation.
352. Nothing above
353. Which of the following statements about a fetal biophysical profile would be incorporated into the teaching plan for a primigravid client with insulin-dependent diabetes?
354. It determines fetal lung maturity.
355. \* It is noninvasive using real-time ultrasound
356. It will correlate with the newborn's Apgar score.
357. It requires the client to have an empty bladder.
358. Nothing above
359. A 30-year-old multigravid client at 8 weeks' gestation has a history of insulin-dependent diabetes since age 18. When explaining about the importance of blood glucose control during pregnancy, which of the following should the doctor expect to occur regarding the client's insulin needs during the first trimester?
360. They will increase.
361. \*They will decrease.
362. They will remain constant.
363. They will be unpredictable.
364. Nothing above
365. When developing a teaching plan for a primigravid client with insulin-dependent diabetes about monitoring blood glucose control and insulin dosages at home, which of the following would the doctor expect to include as a desired target range for blood glucose levels?
366. 40 to 60 mg/dl between 2:00 and 4:00 pm.
367. \*60 to 100 mg/dl before meals and bedtime snacks
368. 110 to 140 mg/dl before meals and bedtime snacks
369. 140 to 160 mg/dl 1 hour after meals.
370. Nothing above
371. When teaching a primigravid client with diabetes about common causes of hyperglycemia during pregnancy, which of the following would the doctor include?
372. Fetal macrosomi
373. Obesity before conception.
374. \* Maternal infection.
375. Pregnancy-induced hypertension.
376. Nothing above
377. . After teaching a diabetic primigravida about symptoms of hyperglycemia and hypoglycemia, the doctor determines that the client understands the instruction when she says that hyperglycemia may be manifested by which of the following?
378. \*Dehydration.
379. Pallor.
380. Sweating.
381. Nervousness
382. Nothing above
383. At 38 weeks' gestation, a primigravid client with poorly controlled diabetes and severe preeclampsia is admitted for a cesarean delivery. The doctor explains to the client that delivery helps to prevent which of the following?
384. Neonatal hyperbilirubinemia
385. Congenital anomalies.
386. Perinatal asphyxi
387. \*Stillbirth.
388. Nothing above
389. A primigravid client with diabetes at 39 weeks' gestation is seen in the high-risk clini The physician estimates that the fetus weighs at least 4,500 g (10 lb). The client asks, "What causes the baby to be so large?" The doctor's response is based on the understanding that fetal macrosomia is usually related to which of the following?
390. Family history of large infants.
391. Fetal anomalies
392. \*Maternal hyperglycemi
393. Maternal hypertension.
394. Nothing above
395. With plans to breast-feed her neonate, a pregnant client with insulin-dependent diabetes asks the doctor about insulin needs during the postpartum perio Which of the following statements about postpartal insulin requirements for breastfeeding mothers would the doctor include in the explanation?
396. \* They fall significantly in the immediate postpartum perio
397. They remain the same as during the labor process.
398. They usually increase in the immediate postpartum perio
399. They need constant adjustment during the first 24 hours.
400. Nothing above
401. A client with gestational diabetes who is entering her third trimester is learning how to monitor her fetus's movements. After teaching the client about the kick count, the doctor should know the client needs further instruction if she makes which of the following statements?
402. "The baby may be more active at different times of the day."
403. "How I feel my baby move is different than my frien"
404. \*"The baby should be moving less than 10 times in 3 hours."
405. "The baby may not move at times because it is asleep."
406. Nothing above
407. A 27-year-old primigravid client with insulin-dependent diabetes at 34 weeks' gestation undergoes a nonstress test, the results of which are documented as reactive. The doctor tells the client that the test results indicat which of the following?
408. A contraction stress test is necessary.
409. The nonstress test should be repeated
410. Chorionic villus sampling is necessary.
411. \*There is evidence of fetal well-being.
412. Nothing above
413. A primigravid client with insulin-dependent diabetes tells the doctor that the contraction stress test performed earlier in the day was suspicious. The doctor interprets this test result as indicating that the fetal heart rate pattern showed which of the following?
414. Frequent late decelerations
415. Decreased fetal movement
416. \*Inconsistent late decelerations
417. Lack of fetal movement.
418. Nothing above
419. A woman seeking prenatal care relates a history of macrosomic infants, two stillbirths, and polyhydramnios with each pregnancy. The doctor recognizes that these factors are highly suggestive of:
420. Toxoplasmosis
421. Abruptio placentae
422. Hydatidiform mole
423. \* Diabetes mellitus
424. Nothing above
425. The doctor explains that pregnancy affects glucose metabolism because:
426. \*Placental hormones increase the resistance of cells to insulin
427. Insulin cells cannot meet the body’s demands as the woman’s weight increases
428. There is a decreased production of insulin during pregnancy
429. The speed of insulin breakdown is decreased during pregnancy
430. All above
431. The doctor explains that a woman who uses oral hypoglycemic agents to control diabetes mellitus will need to take insulin during pregnancy because:
432. Insulin can cross the placental barrier to the fetus
433. \* Insulin does not cross the placental barrier to the fetus
434. Oral agents do not cross the placenta
435. Oral agents are not sufficient to meet maternal insulin needs
436. Nothing above
437. Which major neonatal complication is carefully monitored after the birth of the infant of a diabetic mother?
438. \*Hypoglycemia
439. Hypercalcemia
440. Hypobilirubinemia
441. Hypoinsulinemia
442. Nothing above
443. Which factor is known to increase the risk of gestational diabetes mellitus?
444. Underweight prior to pregnancy
445. Maternal age less than 25 years
446. \* Previous birth of large infant
447. Previous diagnosis of type 2 diabetes mellitus
448. All above
449. Glucose metabolism is profoundly affected during pregnancy because:
450. pancreatic function in the islets of Langerhans is affected by pregnancy.
451. a pregnant woman uses glucose at a more rapid rate than a nonpregnant woman.
452. a pregnant woman increases her dietary intake significantly.
453. \* placental hormones are antagonistic to insulin, resulting in insulin resistance.
454. All above
455. When a pregnant diabetic experiences hypoglycemia while hospitalized, the doctor should have the client:
456. \*eat six saltine crackers or drink 8 oz of milk.
457. drink 8 oz of orange juice with 2 teaspoons of sugar adde
458. drink 4 oz of orange juice followed by 8 oz of milk.
459. eat a candy bar.
460. All above
461. Intervention for pregnant women with diabetes is based on the knowledge that the need for insulin:
462. increases throughout pregnancy and the postpartum perio
463. decreases throughout pregnancy and the postpartum perio
464. \*varies depending on the stage of gestation.
465. should not change because the fetus produces its own insulin.
466. All above
467. A pregestational diabetic woman at 20 weeks' gestation exhibits the following: thirst, nausea and vomiting, abdominal pain, drowsiness, and increased urination. Her skin is flushed and dry and her breathing is rapid with a fruity odor. A priority action when caring for this woman would be to:
468. Provide the woman with a simple carbohydrate immediately
469. Request an order for an antiemetic
470. Assist the woman into a lateral position to rest
471. \*Administer insulin according to the woman's blood glucose level
472. All above
473. During her pregnancy, a woman with pregestational diabetes has been monitoring her blood glucose level several times a day. Which of the following levels would require further assessment?
474. 85 mg/dl—prior to breakfast
475. 90 mg/dl—prior to lunch
476. \* 135 mg/dl—two hours after supper
477. 100 mg/dl—at bedtime
478. All above
479. Specific guidelines should be followed when planning a diet with a pregestational diabetic woman to ensure a euglycemic state. An appropriate diet would reflect:
480. 40 calories per kg of prepregnancy weight daily
481. \*A caloric distribution among three meals and at least two snacks
482. A minimum of 350 mg of carbohydrate daily
483. A protein intake of at least 30% of the total kcal in a day
484. All above
485. An obese pregnant woman with gestational diabetes is learning self-injection of insulin. While evaluating the woman's technique for self-injection, the doctor would recognize that the woman understood the instructions when she:
486. Washes her hands and puts on a pair of clean gloves
487. Shakes the NPH insulin vial vigorously to fully mix the insulin
488. Draws the NPH insulin into her syringe first
489. \*Spreads her skin taut and punctures the skin at a 90-degree angle
490. All above
491. A woman has just been admitted with a diagnosis of hyperemesis gravidarum. She has been unable to retain any oral intake and as a result has lost weight and is exhibiting signs of dehydration with electrolyte imbalance and acetonuri The care management of this woman would include:
492. \*Administering diphenhydramine (Benadryl) to control nausea and vomiting
493. Keeping the woman on nothing-by-mouth status (NPO) for a maximum of 24 hours after intravenous fluids are started
494. Avoiding oral hygiene until the woman is able to tolerate oral fluids
495. Providing small frequent meals of bland foods and warm fluids once the woman begins to respond to treatment
496. All above
497. A woman seeking prenatal care relates a history of macrosomic infants, two stillbirths, and polyhydramnios with each pregnancy. The doctor recognizes that these factors are highly suggestive of:
498. Toxoplasmosis
499. Abruptio placentae
500. Hydatidiform mole
501. \*Diabetes mellitus
502. All above
503. The doctor explains that pregnancy affects glucose metabolism because:
504. \*Placental hormones increase the resistance of cells to insulin
505. Insulin cells cannot meet the body’s demands as the woman’s weight increases
506. There is a decreased production of insulin during pregnancy
507. The speed of insulin breakdown is decreased during pregnancy
508. All above
509. The doctor explains that a woman who uses oral hypoglycemic agents to control diabetes mellitus will need to take insulin during pregnancy because:
510. Insulin can cross the placental barrier to the fetus
511. \*Insulin does not cross the placental barrier to the fetus
512. Oral agents do not cross the placenta
513. Oral agents are not sufficient to meet maternal insulin needs
514. All above
515. When caring for a pregnant woman with cardiac problems, the doctor must be alert for signs and symptoms of cardiac decompensation, which are:
516. regular heart rate and hypertension
517. An increased urinary output, tachycardia, and dry cough
518. Shortness of breath, bradycardia, and hypertension
519. \*Dyspnea, crackles, and an irregular, weak pulse
520. All above
521. Prophylaxis of subacute bacterial endocarditis (SBE) is given before and after birth when a pregnant woman has:
522. \*Valvular disease
523. Congestive heart disease
524. Arrhythmias
525. Postmyocardial infarction
526. All above
527. Postpartum care of the woman with cardiac disease:
528. Is the same for that of any pregnant woman.
529. \*Includes rest, stool softeners, and monitoring the effect of activity.
530. Includes ambulating frequently, alternating with active range of motion.
531. Includes limiting visits with the infant to once per day.
532. Nothing above
533. A woman was anemic during her pregnancy. She had been taking iron for 3 months before the birth. She gave birth by cesarean 2 days ago and has been having problems with constipation. After assisting her back to bed from the bathroom, the doctor notes that the woman's stools are dark (greenish black). The doctor would:
534. Perform a guaiac test and record the results
535. Recognize the finding as abnormal and report it to the primary health care provider
536. \*Recognize the finding as normal as a result of iron therapy
537. Check the woman's next stool to validate the observation
538. Nothing above
539. In caring for a pregnant woman with sickle cell anemia with increased blood viscosity, the doctor is concerned about the development of a thromboembolism. The care would include:
540. Monitoring the client for a negative Homan sign
541. Massaging calves when the woman complains of pain
542. \*Applying anti-embolic stockings
543. Maintaining a restriction on fluid intake
544. Nothing above
545. When assessing a pregnant woman at 28 week’s gestation that is diagnosed with rheumatic heart disease, it is important that the doctor be alert for sign indicating cardiac decompensation. A sign of cardiac decompensation would be:
546. Dry skin, hacking cough
547. Supine hypotension
548. Wheezing with inspiration and expiration
549. \*Rapid pulse that is irregular and weak
550. Nothing above
551. A woman at 30 week’s gestation with class II cardiac disorders calls her primary health care provider’s office and speaks to the doctor practitioner. She tell the doctor that she has been experiencing a frequent, moist cough for the past few days. In addition, she has been feeling more tired and is having difficulty completing her routine activities of some difficulty with breathing. The doctor’s best response would be:
552. \*Have some bring you to the office so we can assess your cardiac status
553. Try to get more rest during the day because this is a difficult time for your heart
554. Take an extra diuretic tonight before you go to bed because you may developing some fluid in your lung
555. Ask your family to come over and do your housework fort he next few days so you can rest
556. Nothing above
557. A pregnant woman with cardiac disorder will begin anticoagulant therapy to prevent clot formation. In preparing this woman for this treatment measure the doctor would expect to teach the woman about self-administration of which of the following medication
558. Furosemid
559. Propranolol
560. \*Heparin
561. Warfarin
562. Nothing above
563. At previous antepartal visit, the doctor taught a pregnant woman diagnosed with class II cardiac disorder about measures to use to lower her risk for cardiac decompensation. The woman would demonstrate need for further instruction if she
564. Increased roughage in her diet
565. Remains on bed rest only getting out of bed go to the bathroom
566. \*Sleep 10 hours every night and rests after meals
567. States she will call the doctor immediately if she experiences any pain or swelling in her legs
568. Nothing above
569. Which type of anesthesia is generally or more effective method of pain relief for the labour of a woman with cardiac problem
570. \*Epidural anestesia
571. Narcotics
572. Breathing techniques
573. All pain relief methods are contraindicated
574. Nothing above
575. \_\_\_\_ anemia is the most common type of anemia during pregnancy
576. \*Iron deficiency
577. Folic acid deficiency
578. Sickle cell hemoglobinopathy
579. Thalassemia
580. Nothing above
581. The pregnant woman is considered anemic when her hemoglobin level is less than
582. \*11 g/dl
583. 120 g/dl
584. 33 g/dl
585. 55 g/dl
586. Nothing above
587. The pregnant woman is considered anemic when her hematocrit is less than
588. 22 %
589. \*33 %
590. 35 %
591. 25 %
592. Nothing above
593. During pregnancy a woman requires a daily intake of
594. \*600 mcg of folic acid
595. 600 mcg of ascorbinicy acid
596. 60 mcg of folic acid
597. 60 mcg of ascorbinicy acid
598. Nothing above
599. Physiologic stress on the heart is the greatest between the \_\_ and\_\_ weeks of gestation because cardiac output is at peak
600. 18-22
601. 38-40
602. 18-32
603. \*28-32
604. Nothing above
605. Risk for cardiac decompensation is also higher during \_\_\_\_
606. Childbirth and first 24-48 weeks after birth
607. Childbirth and first 24-48 days after birth
608. \*Childbirth and first 24-48 hours after birth
609. Childbirth and first 24-48 months after birth
610. Nothing above
611. According to the classification of cardiovascular disorders developed by New York Heart Association Class I implies
612. symptomatic with increased activity
613. symptomatic at rest
614. symptomatic with ordinary activity
615. \*asymptomatic at normal level of activity
616. Nothing above
617. According to the classification of cardiovascular disorders developed by New York Heart Association Class II implies
618. asymptomatic at normal level of activity
619. symptomatic with ordinary activity
620. \*symptomatic with increased activity
621. symptomatic at rest
622. Nothing above
623. According to the classification of cardiovascular disorders developed by New York Heart Association Class III implies
624. \*symptomatic with ordinary activity
625. asymptomatic at normal level of activity
626. symptomatic at rest
627. symptomatic with increased activity
628. Nothing above
629. According to the classification of cardiovascular disorders developed by New York Heart Association Class IV implies
630. asymptomatic at normal level of activity
631. symptomatic with ordinary activity
632. symptomatic with increased activity
633. \*symptomatic at rest
634. Nothing above
635. What is congestive heart failure with cardiomyopathy founding the last month of pregnancy or with the first 5 month postpartum, lack of another cause for heart failure and absence of heart disease prior to the last month of pregnancy
636. Eisenmenger Syndrome
637. Marfan’s Syndrome
638. \*Peripartum cariomyopathy
639. Aortic Stenosis
640. Nothing above
641. Which disease refers the damage of the heart valves and the chordae tendineae cordis as a result of an infection originating from an inadequately group β-hemolitic streptococcal infection of the throat
642. \*Rheumatic heart disease
643. Systemic lupus erythematosus
644. Eisenmenger Syndrome
645. Marfan’s Syndrome
646. Nothing above
647. Narrowing of the opening of the valve between the left atrium and the left ventricle of the heart by stiffening of the valve leaflets, which obstructs blood flow from the atrium to the ventricles is
648. Aortic Stenosis
649. \*Mitral Stenosis
650. Stenosis of right ventricular outflow
651. pulmonary artery stenosis
652. Nothing above
653. An inflammation of the innermost lining of the heart caused by invasion of microorganisms leads to development of
654. \*Infective endocarditis
655. Mitral Stenosis
656. Aortic Stenosis
657. Infective endocardimyopathy
658. Nothing above
659. Complication related to maternal cardiovascular problems is:
660. \*Preterm labour
661. Postterm labour
662. Oligohydroamnios
663. Macrosomia
664. Nothing above
665. Complication related to maternal cardiovascular problems is:
666. Postterm labour
667. PROM
668. Prolonged I stage of labour
669. \*Miscarriage
670. All above
671. Complication related to maternal cardiovascular problems is:
672. Macrosomia
673. \*Stillbirth
674. Low birth weight newborn
675. PROM
676. All above
677. Which changes occur during normal pregnancy and affect the woman with cardiac disease
678. Decrease cardiac output
679. Hg concentration rise
680. \*Increase intravascular volume
681. Systemic blood pressure falls during the third trimester
682. All above
683. Pregnancy is contraindicated for a woman who has had
684. Heart transplantantation
685. Ventricular septal defect
686. \*Pulmonary hypertension
687. Atrial septal defect
688. All above
689. Pregnancy is contrindicated for a woman who has had
690. Patent ductus arteriosus
691. \*Shunt lesions associated with Eisenmenger syndrome
692. Artificial heart valves
693. Atrial septal defect
694. All above
695. Folic acid deficiency during conception and early pregnancy increase risk of
696. \*Neural tube defects
697. Low birth weight newborn
698. Heart failure
699. Gastroshisis
700. All above
701. Folic acid deficiency during conception and early pregnancy increase risk of
702. \*Cleft lip
703. Chloasma
704. striae gravidarum
705. Cleft nose
706. All above
707. The doctor would include in a teaching plan for the pregnant patient who has iron deficiency anemia and who has been placed on iron supplement that:
708. \*Citrus fruits enhance absorption of iron.
709. Bran products support iron deficiency.
710. Milk will disguise the taste of the iron.
711. Folic acid decrease absorption of iron
712. All above
713. The doctor would include in a teaching plan for the pregnant patient who has iron deficiency anemia and who has been placed on iron supplement that:
714. The folic acid therapy will continue for about 3 years
715. Bran products support iron deficiency.
716. Milk will disguise the taste of the iron.
717. \*The iron therapy will continue for about 3 months.
718. All above
719. Which of the following forms of heart disease in women of childbearing years usually has a benign effect on pregnancy?
720. Cardiomyopathy
721. Rheumatic heart disease
722. Congenital heart disease
723. \*Mitral valve prolapse
724. All above
725. When teaching a pregnant woman with class II heart disease, the doctor should:
726. advises her to gain at least 30 pounds.
727. explains the importance of a diet high in calcium.
728. \*instructs her to avoid strenuous activity.
729. informs her of the need to limit fluid intake.
730. All above
731. Which instructions are most important to include in a teaching plan for a client in early pregnancy that has class I heart disease?
732. She must report any nausea or vomiting.
733. She may experience mild fatigue in early pregnancy.
734. \*She must report any chest discomfort or productive cough.
735. She should plan to increase her daily exercise gradually throughout pregnancy.
736. All above
737. Anti-infective prophylaxis is indicated for a pregnant woman with a history of mitral valve stenosis related to rheumatic heart disease because the woman is at risk of developing:
738. hypertension
739. upper respiratory infections
740. postpartum infection
741. \*bacterial endocarditis
742. All above
743. Which of the following should the doctor include when planning intrapartum care for a client with heart disease?
744. Take vital signs according to standard protocols.
745. \*Continuously monitor cardiac rhythm with telemetry.
746. Massage the uterus to hasten delivery of the placent
747. Maintain infusion of intravenous fluids to avoid dehydration.
748. All above
749. The doctor is teaching a new prenatal client about her iron deficiency anemia during pregnancy. Which state­ment indicates that the client needs further instruction about her anemia?
750. "I will need to take iron supplements now."
751. \*"I may have anemia because my family is of Asian descent."
752. "I am considered anemic if my hemoglobin is below 11 g/dl."
753. "The workload on my heart is increased when there is not enough oxygen in my system."
754. All above
755. A client asks the doctor why taking folic acid is so important before and during pregnancy. Which of the fol­lowing would be the doctor's best response?
756. \*"Folic acid is important in preventing neural tube defects in newborns and preventing anemia in mothers."
757. "Eating foods with moderate amounts of folic acid helps regulate blood glucose levels."
758. "Folic acid consumption helps with the absorption of iron during pregnancy."
759. "Folic acid is needed to promote blood clotting and collagen formation in the newborn."
760. All above
761. A client with a past medical history of ventricular septal defect repaired in infancy is seen at the prenatal clini She is complaining of dyspnea with exertion and being very tire Her vital signs are 98, 80, 20, BP 116/72. She has + 2 pedal edema and clear breath sounds. As the doctor plans this client's care, which of the following is her cardiac classification according to the New York Heart Association Cardiac Disease classification?
762. Class I
763. \*Class II
764. Class III
765. Class IV
766. All above
767. After instruction of a primigravid client at 8 weeks' gestation diagnosed with class I heart disease about self-care during pregnancy, which of the following client statements would indicate the need for additional teaching?
768. “I should avoid being near people who have a col"
769. "I may be given antibiotics during my pregnancy."
770. \*"I should reduce my intake of protein in my diet."
771. "1 should limit my salt intake at meals."
772. All above
773. While caring for a primigravid client with class II heart disease at 28 weeks' gestation, the doctor would instruct the client to contact her physician immediately if the client experiences which of the following?
774. Mild ankle edem
775. Emotional stress on the job
776. Weight gain of 1 lb in 1 week.
777. \*Increased dyspnea at rest.
778. All above
779. When developing the collaborative plan of care for a multigravid client at 10 weeks' gestation with a history of cardiac disease who was being treated with digitalis therapy before this pregnancy, which of the following would the doctor anticipate happening with the client's drug therapy regimen?
780. Need for an increased dosage.
781. \*Continuation of the same dosage
782. Switching to a different medication.
783. Addition of a diuretic to the regimen.
784. All above
785. Which of the following anticoagulants would the doctor expect to administer when caring for a primigravid client at 12 weeks' gestation who has class II cardiac disease due to mitral valve stenosis?
786. \*Heparin.
787. Warfarin (Coumadin).
788. Enoxaparin(Lovenox)
789. Ardeparin (Normiflo).
790. All above
791. A primigravid client with class II heart disease who is visiting the clinic at 8 weeks' gestation tells the doctor that she has been maintaining a low-sodium, 1,800-calorie diet. Which of the following instructions should the doctor give the client?
792. Avoid folic acid supplements to prevent megaloblastic anemi
793. Severely restrict sodium intake throughout the pregnancy.
794. \*Take iron supplements with milk to enhance absorption.
795. Increase caloric intake to 2,200 calories daily to promote fetal growth.
796. All above
797. A 39-year-old multigravid client at 39 weeks' gestation admitted to the hospital in active labor has been diagnosed with class II heart disease. To ensure cardiac emptying, and adequate oxygenation during labor, the doctor plans to encourage the client to do which of the following?
798. Breathe slowly after each contraction.
799. Avoid the use of analgesics for the labor pain.
800. \*Remain in a side-lying position with the head ele­vate
801. Request local anesthesia for vaginal delivery.
802. All above
803. When developing the plan of care for a multigravid client with class III heart disease, which of the following areas should the doctor expect to assess frequently?
804. Dehydration.
805. Nausea and vomiting.
806. Iron-deficiency anemi
807. \*Tachycardi
808. All above
809. A multigravid client in active labor has been diagnosed with class II heart disease and has had a prosthetic valve replacement. When developing the plan of care for this client, the doctor should anticipate that the physician most likely will order which of the following medications?
810. Anticoagulants.
811. \*Antibiotics.
812. Diuretics.
813. Folic acid supplements.
814. All above
815. The primary fetal risk when the mother has any type of anemia is for
816. neonatal anemia
817. elevated bilirubin
818. limited infection defenses
819. \*reduced oxygen delivery
820. All above
821. The preferred manner of delivering the baby in a gravido-cardiac is vaginal delivery assisted by forceps under epidural anesthesi The main rationale for this is:
822. To allow atraumatic delivery of the baby
823. To allow a gradual shifting of the blood into the maternal circulation
824. \*To make the delivery effort free and the mother does not need to push with contractions
825. To prevent perineal laceration with the expulsion of the fetal head
826. All above
827. In a gravido-cardiac mother, the first 2 hours postpartum (4th stage of labor and delivery) particularly in a cesarean section is a critical period because at this stage
828. \*There is a fluid shift from the placental circulation to the maternal circulation which can overload the compromised heart.
829. The maternal heart is already weak and the mother can die
830. The delivery process is strenuous to the mother
831. The mother is tired and weak which can distress the heart
832. All above
833. A gravido-cardiac mother is advised to observe bed rest primarily to
834. Allow the fetus to achieve normal intrauterine growth
835. \*Minimize oxygen consumption which can aggravate the condition of the compromised heart of the mother
836. Prevent perinatal infection
837. Reduce incidence of premature labor
838. All above
839. \_\_\_\_\_\_ is a classification system for cardiovascular disorders developed by the New York Heart Classification
840. organic classification of functional heart disease
841. \*functional classification of organic heart disease
842. organic classification of organic heart disease
843. functional classification of functional heart disease
844. All above
845. Class I of cardiovascular disorders, developed by the NYHA implies:
846. symptomatic at rest
847. symptomatic with ordinary activity
848. symptomatic with increased activity
849. \*asymptomatic at normal levels of activity
850. All above
851. Class II of cardiovascular disorders, developed by the NYHA implies:
852. symptomatic with ordinary activity
853. \*symptomatic with increased activity
854. asymptomatic at normal levels of activity
855. symptomatic at rest
856. All above
857. Class III of cardiovascular disorders, developed by the NYHA implies:
858. symptomatic with increased activity
859. symptomatic at rest
860. \*symptomatic with ordinary activity
861. asymptomatic at normal levels of activity
862. All above
863. Class IV of cardiovascular disorders, developed by the NYHA implies:
864. \*symptomatic at rest
865. symptomatic with increased activity
866. asymptomatic at normal levels of activity
867. symptomatic with ordinary activity
868. All above
869. On her first visit to the prenatal clinic a client with rheumatic heart disease asks the doctor if she will have special nutritional needs. The doctor should respond that in addition to the regular pregnancy diet she probably will need supplemental:
870. Vitamins C and D
871. \*Iron and folic acid
872. Vitamins B2 and B12
873. Calcium and magnesium
874. All above
875. The action that has the highest priority for a client with class I heart disease during the postpartum period should be:
876. Promotion of aggressive ambulation
877. \*Observation for signs of cardiac decompensation
878. Assessment of the mother's reaction to the birth
879. Advisement about activity levels during the postpartum period
880. All above
881. A client, at 28 weeks' gestation, with previously diagnosed mitral valve stenosis is being evaluated in the clini The sign or symptom that would indicate the client is experiencing difficulty related to her heart disease is:
882. Heart palpitations
883. \*Syncope on exertion
884. A displaced apical pulse
885. A grade 2 systolic murmur
886. All above
887. The position that the doctor should encourage a client with cardiac disease to assume during labor is:
888. Supine
889. High-Fowler's
890. \*Semi-Fowler's
891. Trendelenburg
892. All above
893. Dietary counseling for a pregnant client with sickle cell anemia should include supplemental folic aci The doctor recognizes that this is important because it:
894. Prevents sickle cell crises
895. Decreases the sickling of RBCs
896. Lessens the oxygen needs of cells
897. \*Compensates for a rapid turnover of RBCs
898. All above
899. Which is not a type of cardiovascular disease?
900. Varicose veins
901. High blood pressure
902. \*Cellulitis
903. Stroke
904. All above
905. A patient asks a doctor, “My doctor recommended I increase my intake of folic acid What type of foods contain the highest concentration of folic acids?”
906. \*Green vegetables and liver
907. Yellow vegetables and red meat
908. Carrots
909. Milk
910. All above
911. Rheumatic heart disease is usually preceded by which infection?
912. \*streptococcal pharyngitis
913. syphilis
914. pneumococcal pneumonia
915. chlamydial vaginitis
916. All above
917. Intrapartum nursing care for a woman who has sickle cell disease focuses on
918. \*maintaining oxygenation and preventing dehydration
919. controlling pain and avoiding unnecessary movement
920. preventing excess exertion and limiting visitors
921. increasing calorie intake and avoiding internal monitoring
922. All above
923. Which is not a risk for a fetus whose mother has anemia?
924. low birth weight
925. \*prematurity
926. still birth
927. fetal tachycardia
928. All above
929. A client in sickle cell crisis has been hospitalized during her pregnancy. Discharge instructions have been given in preparation for her return home. The doctor knows the client needs further teaching when she states which of the following?
930. "I will need more frequent appointments during the remainder of the pregnancy."
931. "Signs of any type of infection must be reported immediately."
932. \*"At the earliest signs of a crisis, I need to seek treatment."
933. "I have this disease because I don't eat enough food with iron."
934. All above
935. A pregnant woman has been diagnosed with cholelitthiasis. An important component of her treatment regiment will be dietary modification. The doctor would help this woman to plan a diet that:
936. Reduces dietary fat to approximately 60 g per day
937. limits protein to 30% of total calories
938. \*Chooses foods so that most calories come from carbohydrates
939. Avoid spicy food
940. All above
941. In providing nutritional counseling for the pregnant woman experiencing cholecystitis, the doctor would:
942. Assess the woman’s dietary history for adequate calories and proteins
943. Instruct the woman that the bulk of calories should come from proteins
944. \*Instruct the woman to eat a low-fat diet and avoid fried foods
945. Instruct the woman to eat a low-cholesterol, low-salt diet
946. All above
947. Which factor can complicate diagnosis and surgical treatment for abdominal problems during pregnancy?
948. \*displacement of internal organs
949. present of the fetus
950. retro deviation of uterine body
951. constipations related pregnancy
952. All above
953. Surgery may be necessary in woman with cholecystitis if she has:
954. One attacks of biliary colic
955. Chronic cholecystitis
956. \*Obstructive jaundice
957. Chronic pancreatitis
958. All above
959. A new antenatal client is being seen for the first time. She has had asthma since she was a child and it is under control when the client takes her medication correctly and consistently. Which of the following client state­ments concerning asthma during pregnancy indicates the need for further instruction?
960. "I need to continue taking my asthma medication as prescribe"
961. "It is my goal to prevent or limit asthma attacks."
962. "During an asthma attack, oxygen needs continue to be high for mother and fetus."
963. \*"Bronchodilators should be used only when necessary because of the risk they present to the fetus."
964. All above
965. The woman usually return to the her prepregnancy asthma status after
966. \*3 month after giving birth
967. 3 weeks after giving birth
968. 3 years after giving birth
969. 3 hours after giving birth
970. All above
971. A woman with asthma is experiencing a postpartum hemorrhage. Which drug would not be used to treat her bleeding because it may exacerbate her asthma?
972. Pitocin
973. Nonsteroidal anti-inflammatory drugs (NSAIDs)
974. \*Hemabate
975. Fentanyl
976. All above
977. The severity of asthma symptoms usually peaks between
978. 6 and 16 week’s gestation
979. 16 and 26 week’s gestation
980. 26 and 36 day’s after birth
981. \*26 and 36 week’s gestation
982. All above
983. Since the gene for cystic fibrosis was identified in 1989, data can be collected for the purposes of genetic counseling for couples regarding carrier status. What percentage of infants born to mothers with cystic fibrosis will be carriers of the gene?
984. 10%
985. 25%
986. 50%
987. \*100%
988. All above
989. A primigravid client admitted to the labor area in early labor tells the doctor that her brother was born with cystic fibrosis. When teaching the client about this disorder, the doctor understands that this disorder is considered as which of the following?
990. X-linked recessive.
991. X-linked dominant.
992. \*Autosomal recessive.
993. Autosomal dominant.
994. All above
995. Congenital anomalies can occur with the use of antiepileptic drugs including which of the following?
996. \*Cleft lip
997. Omphalocele
998. Inguinal hernia
999. Congenital lung disease
1000. All above
1001. Congenital anomalies can occur with the use of antiepileptic drugs including which of the following?
1002. Gastroschisis
1003. \*Congenital heart disease
1004. Femoral hernia
1005. Anal displasia
1006. All above
1007. Congenital anomalies can occur with the use of antiepileptic drugs including which of the following?
1008. Gallbladder stones
1009. Facial paralisis
1010. Diaphragmatic hernia
1011. \*Neural tube defects
1012. All above
1013. Appendicitis is more difficult to diagnose during pregnancy because the appendix is:
1014. Covered by the uterus
1015. Displaced to the left
1016. Low and to the right
1017. \*High and to the right
1018. All above
1019. Postoperative care of the pregnant woman who requires abdominal surgery for appendicitis includes which additional assessment?
1020. Intake and output, intravenous site
1021. Signs and symptoms of infection
1022. Vital signs and incision
1023. \*Fetal heart rate and uterine activity
1024. All above
1025. Treatment of inflammatory Bowel disease for the pregnant woman include
1026. \*Sulfasalazin
1027. Sulfate Magnesium
1028. Streptomycin
1029. Sandostatin
1030. All above
1031. Joan has a history of drug use and is screened for hepatitis B during the first trimester. Which of the following actions is appropriate?
1032. Anticipate administering the vaccination for hepatitis B as soon as possible.
1033. \*Plan for retesting during the third trimester.
1034. Discuss the recommendation to bottle feed her baby.
1035. Practice respiratory isolation.
1036. All above
1037. \_\_\_\_ is a disorder of the brain causing recurrent seizures; it is the most common neurologic disorder accompanied pregnancy
1038. Pregnancy induce hypertension
1039. ectopic pregnancy
1040. eclampsia
1041. \*epilepsy
1042. All above
1043. Preoperative care of a pregnant woman differs from that for a nonpregnant woman in one significant aspect, namely the presence of the
1044. \*fetus
1045. pregnant uterus
1046. hormonal changes
1047. organs displacement
1048. All above
1049. General preoperative observation and ongoing care are the same as for any surgery, with addition of continuous \_\_\_ monitoring if the fetus is considered to be viable.
1050. fetal position
1051. \*FHR
1052. fetal movement
1053. fetal circulation
1054. All above
1055. General preoperative observation and ongoing care are the same as for any surgery, with addition of continuous \_\_\_ monitoring if the fetus is considered to be viable.
1056. uterine size
1057. uterine consistency
1058. \*uterine contractions
1059. uterine relaxations
1060. All above
1061. Intrapartally feta oxygenation is improved by placing the woman on an operating table with a \_\_\_ to avoid maternal vena cava compression
1062. Trendelenburg’s position
1063. longitudinal position
1064. lithotomy position
1065. \*lateral tilt
1066. All above
1067. Intrapartally feta oxygenation is improved by placing the woman on an operating table with a lateral tilt to avoid \_\_\_\_
1068. maternal malabsorbtion
1069. maternal aspiration of gastric masses
1070. \*maternal vena cava compression
1071. maternal aorta compression
1072. All above
1073. Surgery there is an increase for the onset of \_\_\_
1074. postterm labour
1075. \*preterm labour
1076. stillbirth
1077. IUGR
1078. All above
1079. The doctor would suspect pyelonephritis when a pregnant woman reports:
1080. Frequency and urgency of urination
1081. Nausea and weight loss
1082. Burning sensation when voiding
1083. \*Tenderness in the flank area
1084. All above
1085. The doctor would include in a teaching plan for the pregnant patient who has iron deficiency anemia and who has been placed on iron supplement that:
1086. Folic acid should be avoided while taking iron
1087. Milk will disguise the taste of the iron.
1088. \*Citrus fruits enhance absorption of iron
1089. Bran products support iron deficiency
1090. All above
1091. The doctor would include in a teaching plan for the pregnant patient who has iron deficiency anemia and who has been placed on iron supplement that:
1092. . Bran products support iron deficiency.
1093. Folic acid should be avoided while taking iron
1094. \*The iron therapy will continue for about 3 months.
1095. Milk will disguise the taste of the iron
1096. All above
1097. Operation epiziotomy is performed in all cases, except:
1098. Threatening of perineum rupture
1099. Applaying obstetrical forceps
1100. Breech presentation of fetus
1101. All above
1102. \*Nothing above
1103. What examination before a planned operation does not require c-section?
1104. Research vaginal microflora
1105. Fetal ultrasound
1106. Biochemical analysis of blood
1107. Koagulogramma
1108. \*Nothing above
1109. What anesthesia is considered optimal for c-section?
1110. Intravenous anesthesia
1111. \*Epiduralna anesthesia
1112. Spinal anesthesia
1113. Endotracheal anesthesia
1114. All above
1115. Eclampsia is necessary to differentiate
1116. with epilepsy
1117. with hypertension
1118. with a brain tumor
1119. \*With all of the above
1120. Nothing above
1121. The specific gravity of urine in gestational pyelonephritis usually
1122. increased
1123. Reduced
1124. \*Not changed
1125. All above are possible
1126. Nothing above
1127. Microscopic haematuria is most common
1128. for late preeclampsia
1129. for pyelonephritis
1130. \*for glomerulonephritis
1131. All above
1132. Nothing above
1133. Cylindruria most typical
1134. for late preeclampsia
1135. for pyelonephritis
1136. \*For glomerulonephritis
1137. for nephrolithiasis
1138. All above
1139. Glomerular filtration in the kidneys preeclampsia severity III
1140. is not changed
1141. \*Reduced
1142. Increased
1143. All above are possible
1144. Nothing above
1145. Kidney glomerular filtration chronic glomerulonephritis in pregnant women, as a rule
1146. is not changed
1147. \*reduced
1148. increased
1149. All above are possible
1150. Nothing above
1151. Pronounced changes in the eye fundus are most common
1152. \*For hypertension
1153. for edema in pregnant
1154. nephrolithiasis
1155. All above
1156. Nothing above
1157. Treatment of severe preeclampsia aimed on
1158. normalization of microcirculation
1159. normalization of hemodynamic
1160. the elimination of hypovolemia
1161. the elimination of hypoproteinemia
1162. \*On all of the above
1163. Renal blood flow in severe preeclampsia, usually
1164. not changed
1165. \*Reduced
1166. Increased
1167. All above are possible
1168. Nothing above
1169. Early delivery is indicated in the presence of
1170. eclamptic coma
1171. anurii
1172. pre-eclampsia
1173. \*All of the above
1174. None of the above
1175. In case of severe pre-eclampsia should be
1176. \* urgent delivery
1177. urgently make transfusion
1178. can immediately plasmapheresis
1179. prepare for delivery in 2-3 days
1180. prepare for delivery within 5-7 days
1181. For acute fatty liver is characterized by all of the above, except
1182. \*a sharp increase in the content of transaminase levels (ALT, AST)
1183. gipoproteinemii
1184. hyperbilirubinemia
1185. severe heartburn
1186. jaundice
1187. Acute hepatic steatosis in pregnancy is often the result of
1188. acute cholecystitis
1189. acute Pancreatitis
1190. \*severe preeclampsia
1191. all of the above
1192. Nothing above
1193. When hypotonic uterine bleeding starts:
1194. on cervical stage
1195. on the expulsive stage
1196. after the delivery of the fetus
1197. \*After the placental separation
1198. Non above
1199. The cause of uterine bleeding in the postpartum period is Not
1200. Birth canal trauma
1201. violation of the contractile activity of the uterus
1202. Abnormal clotting of blood
1203. \* Hypertonic disease
1204. All above
1205. Bleeding in the uterus hypotonic is characterizes:
1206. Bleeding from birth canal continuous like a stream
1207. \*Bleeding with clots
1208. Bleeding with the formation of light clots
1209. Bleeding without clots
1210. All are possible
1211. Bleeding in case of parts of the placenta staying in the uterus is characterized by:
1212. \*Appearance after the delivery of defective placenta particles l
1213. after the placental separation there is no bleeding
1214. bleeding without clots
1215. All are possible
1216. Nothing above
1217. Characteristics of uterine hypotonic and atonic bleeding are:
1218. Uterus is firm, its fundus at the level of or below the navel
1219. After emptying and massage is firm
1220. \*Relaxed, soft, light or no reaction after stimulation
1221. Uterus fundus turns aside to the left part of the abdomen
1222. All are possible
1223. When the bleeding at the early postpartum period it is necessary to:
1224. \*Review and suturing of birth canal injuries
1225. Kolposkopy
1226. Hysterotokografy
1227. Laparoskopy
1228. Nothing above
1229. First aid in case of early postpartum bleeding includes:
1230. \*Use of uterotonik
1231. Application diuretyks
1232. Use of vikasol
1233. Using of mezaton becose low blood pressure
1234. Nothing above
1235. Postpartum hemostasis is provide with following factors:
1236. Retraction of myometrium and body temperature
1237. blood clots in the vessels of the placental sections and hematocrit levels
1238. hyperkoahulation and number of platelets
1239. \* Retraction myometrium and local hemostatic factors
1240. Nothing above
1241. Delay of additional part of the placenta in uterus is diagnosed by
1242. Abnormal shape of the placenta
1243. Delay of amniotic membranes
1244. \* Broken vessels in the placenta
1245. thin platsenta
1246. Nothing above
1247. In later postpartum period the delay of placental tissue in uterus can be diagnosed during
1248. palpation of the uterus
1249. \*ultrasound examination
1250. X ray examination
1251. Vaginal examination
1252. Nothing above
1253. Bleeding in early postpartum period usually
1254. stops without treatment
1255. does not lead to serious consequences
1256. \* If not treated can lead to lethal exit
1257. belongs to the rarely labor complications
1258. Nothing above
1259. After examination of birth canal and bleeding in early postpartum period it is necessary to
1260. To perform external massage of the uterus and blood transfusion
1261. examination, suturing of injuries of birth canal and blood transfusion
1262. manual examination of the uterus and massage, blood transfusion
1263. \* The external uterine massage, an examination of birth canal, manual examination of the uterus, massage
1264. Nothing above
1265. When bleeding on 6 day of postpartum period it is necessary to
1266. manual examination of the uterus cavity
1267. \*Curettage of the uterus cavity
1268. Pudendal block
1269. puncture of the duglas spase
1270. Nothing above
1271. Measures to stop bleeding in the early postpartum period usually begin when bloodlost
1272. more than 1000 ml
1273. \* More than 250 ml
1274. more than 400 ml
1275. more than 100 ml
1276. Nothing above
1277. For prophylaxis of bleeding in late postpartum period is necessary to appoint
1278. vikasol
1279. \* Ultrasonic investigation of uterus
1280. General blood test
1281. General urine test
1282. Oxytocin
1283. Which term termination of pregnancy can be in case of medical indication?
1284. Up to 10 weeks
1285. To 12 weeks
1286. To 14 weeks
1287. Up to 8 weeks
1288. \*To 22 weeks

Situational Tasks

1. 30-years-old woman, primapara at 34 weeks of gestation arrives in active labor. Uterine contractions occur every 3-4 minutes. Per vaginum: the uterine cervix dilatation is 6 cm. The amniotic sac is intact. Fetal buttocks are presented. Management of labor?
   1. Manual aid by Tsovianov II
   2. \*Cesarean section
   3. Subtotal breech extraction
   4. Classic manual aid
   5. Total breech extraction
2. Woman with in-time pregnancy. Bears down during 40-45 seconds with intervals 1-2 minutes. The rupture of the membrane has occurred 10 minutes ago. Vaginal examination: fetal head is on the pelvic floor. Saggital suture is in anterior-posterior diameter of pelvic outlet. Amniotic sac is absent. What is the stage of labor?
   1. Cervical
   2. \*Pelvic
   3. Cranial
   4. Early postpartum
   5. Placental
3. Primapara. At vaginal examination: opening of cervix is 8 cm, sagittal suture in a transversal size of the pelvic inlet, small fontanel is palpated as a leading point. For which type of presentation is it typical?
   1. The brow presentation
   2. The vertex presentation.
   3. The face presentation
   4. \*The anterior occiput presentation.
   5. The posterior occiput presentation
4. At pregnant 28 years with pregnancy 24 weeks transverse lie of the fetus is found. Head is on the left. Fetal heart rate is clear, 138 in 1 min. Pregnancy is first, passed without complications. Sizes of pelvis: 25-29-31-20 cm. What is the doctor’ tactic now?
   1. To hospitalize and to perform the external obstetric version
   2. \*The supervision
   3. To hospitalize in the term of pregnancy 38-39 weeks for performing the external obstetric version
   4. To do the classic obstetric version of fetus
   5. To appoint a corregate gymnastics
5. Primapara. At vaginal examination: opening of cervix is 8 cm, sagittal suture in a oblique size of the pelvic inlet, the large fontanel is palpated as a leading point. For which type of presentation is it typical?
   1. The brow presentation
   2. \*The sinciput vertex presentation.
   3. The face presentation
   4. The anterior occiput presentation.
   5. The posterior occiput presentation
6. Postpartum patient. A girl was born by mass 3800 g. In pressing above the symphysis umbulical cord doesn't change it lenght. How do you called this sign of placenta separation?
   1. Positive Shreder sign
   2. Positive Alfelda sign
   3. Positive Vasten sign
   4. Positive Chukalov-Kustner sign
   5. \*Negative Chukalov-Kustner sign
7. A woman 28 years admitted to female dispensary with complaints about the delay of menstruation during 5 days. At vaginal examination: uterine cervix of conical shape, without pathology. The body of uterus is insignificantly increased, dense, mobile. The uterine adnexa are unpainful, not enlarged. Excretions mucous. What methods of examination for determination of pregnancy will be most effective?
   1. \*Test on pregnancy
   2. Ultrasonic examination
   3. Bimanual examination
   4. X- ray examination
   5. Biological method
8. In time of the vaginal examination of a pregnant women cervix is effaced, dilatation is 5 cm, the fetal head is in the pelvic inlet. A sagittal suture is in the right oblique size, a small fontanel is left close to a sacral bone. Determine the position and the variety of the fetus.
   1. \*The 2nd position, the posterior variety
   2. The 1st position, the anterior variety
   3. The 1st position, the posterior variety
   4. The 2nd position, the anterior variety
   5. The high-riding sagittal suture
9. Pregnant D. admitted to the maternity hospital with pregnancy at term and regular uterine contractions during 6 hours. This pregnancy is first. Pelvic sizes: 25-26-31-20 cm. Fetal heart rate 136 in 1 min. What is the doctor’ conclusion about the pelvic sizes?
   1. Normal pelvis
   2. The true conjugate decreased
   3. The external conjugate decreased
   4. \*Distantia cristarum decreased
   5. Distantia spinarum decreased
10. The doctor is measuring the patient’ pelvic size between the anterior spines of the os ileum. Which size is measuring by the doctor?
    1. Distantia cristnarum
    2. \*Distantia spinarum
    3. Distantia trochanterica
    4. Conjugata externa
    5. Conjugata vera
11. The last menstrual period in patient was 22.12. 2011 What is the exposed term of labor on the Negele’ formula?
    1. 15.09.12
    2. 29.08.12
    3. \*29.09.12
    4. 22.09.12
    5. 22.10.12
12. The pregnant C. was admitted in the pathology’pregnancy department. Pregnancy ІІ, 39 weeks. Circumference of abdomen – 110 cm, height of the uterine fundus – 36 cm. The fetal lie is longitudinal, cephalic presentation. What is the exposed fetal weight by Volskov’ method?
    1. 3700 g
    2. \*3960 g
    3. 4200 g
    4. 2880 g
    5. 3270 g
13. The neonatologist is measuring the sizes of the newborn head. The baby is at term, weight 3200 g. One of the fetal head size is 9.5 cm, circumference 32 cm. Which size is measured?
    1. \*Small obligue (suboccipitobregmatic)
    2. Middle obligue (suboccipitofrontal)
    3. Large obligue (occipitomental)
    4. Biparietal
    5. Bitemporal
14. The external conjugate of patient is 21 cm. Solovjov’s index 15cm. What is the average of the true conjugate?
    1. 11 cm
    2. 10 cm
    3. \*12 cm
    4. 13 cm
    5. 9 cm
15. The pregnant 24 years is admitted to the admitting office of the maternity hospital with pregnancy 38-39 weeks and regular uterine contractions. At the examination: body temperature is 38.5. In which department patient have to be admitted?
    1. Pathology of pregnancy
    2. Extragenital pathology
    3. First obstetric department
    4. \*Second obstetric department
    5. Admitting office
16. Pregnant A. admitted to the maternity hospital. The uterine fundus is palpated on the umbilical level. What is the doctor’ conclusion about the term of pregnancy?
    1. 12 weeks of pregnancy
    2. 20 weeks of pregnancy
    3. \*24 weeks of pregnancy
    4. 28 weeks of pregnancy
    5. 36 weeks of pregnancy
17. Patient N., II labor. The patient’ condition is satisfactory. Uterine contractions are active. On the left of umbilicus the head of fetus is palpated in uterus, presenting part is not determined. Heart rate is 150 in 1 min, is auscultated at the umbilical level. Your diagnosis?
    1. \*Transversal lie of fetus, I position.
    2. Transversal presentation of fetus.
    3. Breech presentation of fetus.
    4. Transversal lie of fetus, II position.
    5. Transversal position.
18. Pregnant, 25 weeks of pregnancy. During the last 2 months complains of weakness, violation of taste, the promoted fragility of hair and nails. At laboratory examination: the rate of red blood cells 2,8x1012, Hb 98 g/l. To appoint medical treatment.
    1. \*Contained iron medicines
    2. Vitamins
    3. Transfusion of red blood cells mass
    4. Medical diet
    5. Immunocorrection
19. Pregnant D. admitted to the maternity hospital with pregnancy at term and regular uterine contractions during 6 hours. This pregnancy is first. Pelvic sizes: 25-28-32-18 cm. Fetal heart rate 136 in 1 min. What is the doctor’ conclusion about the pelvic sizes?
    1. Normal pelvis
    2. The true conjugate increased
    3. \*The external conjugate decreased
    4. The internal conjugate is normal
    5. Distantia spinarum decreased
20. In a maternity hall patient is delivered 6 hours ago. The head of the fetus is in the pelvic inlet. The fetal lie is longitudinal, the fetal back to the left. Fetal heart rate is clear, rhythmic, 136 in 1min. At vaginal examination: opening of cervix is 7 cm, sagittal suture in a right oblique size, small fontanel is below large one, located to the left near the sacrum. To define position and visus.
    1. The first position, anterior visus.
    2. The second position is and anterior visus.
    3. \*The first position, posterior visus.
    4. The second position, posterior visus.
    5. Occiput presentation, anterior visus.
21. The pregnant 26 years is admitted to the admitting office of the maternity hospital with pregnancy 40 weeks and regular uterine contractions. At the examination: body temperature is 36.5o. In anamnesis – tuberculosis. Which department the patient have to be admitted in?
    1. Pathology of pregnancy
    2. Extragenital pathology
    3. First obstetric department
    4. \*Second obstetric department
    5. Gynecological department
22. The pregnant 18 years is admitted to the admitting office of the maternity hospital with pregnancy 32 weeks. At the examination: body temperature is 36.6o, cough is present. In anamnesis – diabetes mellitus. In which department patient have to be admitted?
    1. Pathology of pregnancy
    2. \*Extragenital pathology
    3. First obstetric department
    4. Second obstetric department
    5. Gynecological department
23. A woman 28 years visited the doctor of female dispensary with complaints about the delay of menstruation during 2 months. At vaginal examination: uterine cervix of conic shape, without pathology. The uterine body is enlarged to female fist. The uterine adnexa are unpainful, not enlarged. What is the gestational age of the pregnancy?
    1. 16 weeks
    2. 12 weeks
    3. \*8 weeks
    4. 2 weeks
    5. 4 weeks
24. Patient D, labor II, at term. The boy by mass 3200 g was born. The signs of separation of placenta are absent during 30 min, bleeding is absent. What must be done by doctor?
    1. Extraction of placenta for the umbilical cord.
    2. To apply method Abuladze.
    3. To apply a method Krede.
    4. Deleting of placenta for Genter.
    5. \*Manual separation of placenta.
25. Patient S., labor first, at term. Uterine contractions on 45-50 sec, every 2-3 min. Fetal heart rate is rhythmic, 144 bpm, a head is in the pelvic inlet. Vaginally: cervix is effaced, opening 7 cm, amniotic membrane is absent. What is period of labor?
    1. \*First.
    2. Second.
    3. Preliminary.
    4. Finishing.
    5. Third.
26. Pregnant 24 years, the first pregnancy, I labor. Regular uterine contractions. At vaginal examination: the cervical opening is 4 cm, an amniotic sac is whole, the fetal head is fixed in the pelvic inlet. Sagittal suture is in a transversal size, the small fontanel is in the center of pelvis to the left. What is the moment of the labor biomechanism?
    1. The V moment of the labor biomechanism
    2. The ІІ moment of the labor biomechanism
    3. The ІІІ moment of the labor biomechanism
    4. The IV moment of the labor biomechanism
    5. \*I moment of the labor biomechanism
27. In primapara entered department of pathology in 2 weeks after the supposed term of labor. Abdominal circumference 98 cm, diminished on 2 cm during the last week. From nipples at pressing milk is selected. Position of fetus is longitudinal, a head is in the pelvic inlet. Fetal heart rate is clear, rhythmic to 140 bpm. Diagnosis?
    1. Pregnancy at term
    2. Preterm pregnancy
    3. \*Postterm pregnancy
    4. Retardation of the fetus
    5. Multifetal pregnancy
28. Postpartum patient 25 years, at 7th day after labor. The patient’ condition is satisfactory, woman has no complaints. Temperature is 36,60С, pulse 76 in 1 min. Breasts are soft, nipples are unpainful. Uterus is dense, unpainful, fundus on 2 cm above the pubis. Lochia mucous, insignificant. What is the best doctor’ advice in relation to the hygiene of genitalia?
    1. Cleanse of vagina by iodine
    2. Cleanse of vagina by soap
    3. Cleanse of vagina by vaginal tampons
    4. \*Cleanse of external genitalia by water with soap
    5. Cleanse of external genitalia by alcohol
29. Patient F., 18 years. Labor I, at term. The body weight is 80 kg. What volume of blood lost is physiological for the patient?
    1. To 500 ml.
    2. To 600 ml.
    3. To 300 ml.
    4. To 200 ml.
    5. \*To 400 ml.
30. Postpartum patient is examined by the doctor of puerperal department. Uterine fundus is 8cm below the umbilicus; lochia are bloody-serous; milk glands are enlarged, the milk from nipples is selected. For what time of puerperal period these changes are typical?
    1. \*4 day
    2. 10 day
    3. 9 day
    4. 1 day
    5. 12 day
31. Neonatologist at the examination of newborn girl on a 3rd day after labor exposed the bloody excretion from her vagina, heaping of milk glands up with the excretion of colostrum. Action of what hormones affects such changes at a girl?
    1. \*Maternal estrogens
    2. Maternal prolactin
    3. Maternal androgens
    4. Maternal progesteron
    5. The Gonadotropic hormones of girl
32. Primapara T., 19 years, I labor, II stage of labor. At vaginal examination: sagittal suture in the direct size of plane of pelvic outlet, small fontanel under a pubis, the fetal head is on the pelvic floor. What moment of perineal protective maneuvers is performed?
    1. The regulation of pushing
    2. The delivery of the fetal head out of the pushing
    3. Decreasing of perineal tension
    4. \*Prevention of preterm fetal head extension
    5. The delivery of shoulders
33. At patient on the 5th day of postpartum period suddenly there was an increasing of the temperature. The body temperature is 38,5oС, mammary glands are normal, lactation is satisfied. Signs of perotoneal irritation are abcent. In pelvic examination purulent excretions from the uterus are present, uterus is soft in painfull in palpation. The uterus is increased, soft, painful in palpation.What is the most probable diagnosis?
    1. \*Endometritis
    2. Mastitis
    3. Lochiometra
    4. Pelvioperitonitis
    5. Peritonitis
34. The first delivery, II period. The fetal lie is longitudinal. The head presents, that it can't be determinate by external maneuvers. In internal examination: the uterine cervix is effaced, dilatation is full, membranes are absent. The sagittal suture is in a direct size, small fontanel is under the pubis. In the pushing the fetal head appears from a vulva. What area of pelvis a fetal head occupies?
    1. Pelvic inlet
    2. That is pressed to pelvic inlet plane
    3. \*The area of pelvic outlet
    4. The area of wide part of a cavity of a small pelvis
    5. The area of narrow part of a cavity of a small pelvis
35. Patient S., labor first, at term. Uterine contractions on 45-50 sec, after 2-3 min.. Fetal heart rate is rhythmic, 144 in 1 min, a head is in the pelvic inlet. Vaginally: cervix is effaced, dilating is full, amniotic membrane is absent. What is period of labor?
    1. First.
    2. \*Second.
    3. Preliminary.
    4. Finishing.
    5. Third.
36. Primapara N., 20 years, II pregnancy, I labor. The fetal lie is longitudinal, the fetal back is anteriorly. The fetal heart rate is clear, rhythmic. Vaginal examination: the cervix is effaced, opening is full, an amniotic sac is absent. Head of fetus in the plane of pelvic outlet. Sagittal suture is in a direct size, small fontanel is under the pubis. What moment of the labor biomechanism at the anterior type of occipital presentation is ended?
    1. The І moment of the labor biomechanism
    2. \*II moment of the labor biomechanism
    3. The ІІІ moment of the labor biomechanism
    4. The IV moment of the labor biomechanism
    5. The V moment of the labor biomechanism
37. The patient is admitted to delivery department. In examination longitudinal lie, I position, posterior variety of the fetus is exposed. What is the leading point at the posterior type of occipital presentation?
    1. Small fontanel
    2. \*The middle of sagittal suture
    3. Large fontanel
    4. Chin
    5. Subtongue bone
38. Multipara 32 years. 30 minutes passed after delivery of the fetus. The signs of placental separation are negative. Bleeding began – blood lost is 450 ml. What must be done?
    1. Uterine curettage.
    2. Introduction of uterotonics.
    3. To apply the method of Crede-Lazarevich.
    4. Expecting tactic to 1 hour.
    5. \*Manual separation of placenta.
39. Postpartum patient, 22 years. On the 3rd day after the first labor complains on pains in milk glands, on its increasing, body T - 36,6o. What hormones do regulate the process of milk producing?
    1. \*Luteotropin, prolactin
    2. Corticotropin, lyoteotropin
    3. Tireotropin, prolactin
    4. Follitropin, prolactin
    5. Somatotropin, follitropin
40. Primapara, 20 years, I labor. Regular pushing. The fetal lie is longitudinal. The fetal heart rate is clear, rhythmic, 130 in 1 min. At vaginal examination sagittal suture in the direct size of pelvic outlet, small fontanel is under a pubis. The fetal head is extending. What moment of perineal protective maneuvers is performing now?
    1. Prevention of preterm fetal head extention
    2. \*Decreasing of perineal tension and regulation of pushing
    3. The regulation of pushing
    4. The delivery of shoulders
    5. The delivery of the fetal head out of the pushing
41. Patient II, labor first, at term. The patient’ condition is satisfactory. The new-born is just delivered. The umbilical cord hangs down from a vagina and increses in its lenths. Bleeding is not present. Uterus is in normal tonus. How do you called this positive sign of placenta separation?
    1. Dovshenko sign
    2. \*Alfelda sign
    3. Shreder' sign
    4. Kutsenko sign
    5. Hehar sign
42. Postpartum patient, 26 years, after the third physiological labor, discharged out from hospital to home on a sixth day. What method of contraception to her is the best?
    1. \*Amenorrea due to lactation
    2. Hormonal contraception
    3. Mechanical contraception
    4. The interrupted sexual intercourse
    5. Barrier methods
43. Patient 30 years, labor at term. A girl with the Apgar score 8 was born. The umbilical vessels do not pulsate, the cord is clammed. Bloody excretions from the vagina are absent. What period of labor this patient is found in?
    1. Cervical
    2. Pelvic
    3. \*Placental
    4. Puerperal period
    5. Preliminary period
44. Pregnant N., 25 years is delivered in the maternity department with complaints about periodic pains in lower part of abdomen and lumbal region during 7 hours. Amniotic fluid did not released. Fetal heart rate is 136 in 1min. Vaginal examination: the cervix is effaced, opening 10 cm, the amniotic membrane is whole. What is the doctor’ tactic?
    1. \*Amniotomy
    2. Cesarean section
    3. Stimulation of labor
    4. Obstetric forceps
    5. Conservative conducting of labor
45. Pregnant at term is admitted to the maternity home . Uterine contractions are not present. Position of the fetus is longitudinal, presentation is cephalic. Fetal heart rate 136 in 1 min, clear, rhythmic. Amniotic fluid are not released. What is the reason of prolonged pregnancy?
    1. High level of oxytocin
    2. High level of estrogens
    3. Low level of progesteron
    4. \*Low level of oxytocin
    5. High level of prostaglandins
46. Multipara 32 years. 10 minutes passed after fetus delivery. The signs of placenta separation are negative. Bleeding began – blood lost is 550 ml. What must to be done?
    1. Expecting tactic.
    2. Introduction of uterotonics.
    3. To apply the method of Crede-Lazarevich.
    4. \*Manual separation of placenta.
    5. Massage of uterus.
47. At patient on the 7th day of puerperal period suddenly there was a hallucinatory syndrome: patient is not oriented in space and time, does not recognize neighbors. The temperature of body rose to 38,5oС, purulent excretions from the uterus appeared. At vaginal examination: the uterus is increased, soft, painful at palpation, the uterine cervix freely skips 1 finger. What reason of psychical violations, that arose up at postpartum patient?
    1. Psychical diseases in anamnesis
    2. Negative emotional influence of labor on patient
    3. Astenic-vegetative syndrome
    4. \*Puerperal infection
    5. Manifestation of schizophrenia
48. Postpartum patient C. on 4th day after labor complains about the rise of body temperature, general weakness, pains in lower part of abdomen. Preterm rupture of amniotic fluid was happaned. 72 hours without amniotic fluid. Uterus is on 4 cm below umbilicus, soft. On ultrasound the signs of endometritis are found. What is the reason of complication?
    1. \*The protracted amniotic fluidless period.
    2. Premature labor.
    3. Hypotonic uterine contractions.
    4. Epiziotomy.
    5. The infection of organism
49. Patient in III stage of labor undergo the operation of manual separation of placenta. Which blood loss is indication for this operation?
    1. 50 ml and more
    2. 100ml and more
    3. 150 ml and more
    4. 200 ml and more
    5. \*More 250 ml
50. In the 30years old primapara intensive uterine contractions with an interval of 1-2 min, duration 50 sec have begun. In time of the fetal head delivery the patient complaints on severe pain in the perineum. The perineum is 5 cm, its skin become pale. What is it necessary to perform:
    1. \*Perineotomy
    2. Episiotomy.
    3. Protection of the perineum.
    4. Vacuum - extraction of the fetus.
    5. Waiting tactics.
51. Patient with pregnancy at term, the first stage of labor proceeded 10 hours, second stage – 30 minutes. In 15 minutes after the fetal delivery the signs of placental separation appeared. The blood lost is now 200 ml. What must be done?
    1. To wait 30 min.
    2. Manual separation of placenta
    3. \*External maneuvers of placenta delivery.
    4. Introduction of uterotonics.
    5. Introduction of spasmolitics.
52. At pregnant 28 years at the visit of female dispensary with pregnancy 35-36 weeks transversal position of the fetus is found. Head is on the left. Fetal heart rate is clear, 138 in 1 min. Pregnancy is first, passed without complications. What is the tactic?
    1. The supervision
    2. \*To hospitalize and to perform the external obstetric version
    3. To hospitalize in the term of pregnancy 38-39 weeks for external obstetric version
    4. To do the classic obstetric version of fetus
    5. To appoint a corregate gymnastics
53. In vaginal examination of a multipara the cervix is effaced, dilatation is 5 cm, the fetal buttocks are palpated in the level of pelvic inlet. The intertrochanteric diameter is in the right oblique size, the fetal sacrum is anteriorly. What is the diagnosis?
    1. The 2nd position, posterior variety
    2. The 1st position, anterior variety
    3. The 1st position, posterior variety
    4. \*The 2nd position, anterior variety
    5. The transversal position
54. Patient in the term of pregnancy 39-40 weeks. Position of fetus is longitudinal. I stage of labor. At vaginal examination: the uterine cervix dilatation is 10 cm. Amniotic membrane is absent. Buttocks and feet of the fetus are palpated. What is the diagnosis?
    1. \*Complete breech presentation
    2. Incomplete breech presentation
    3. Complete footling presentation
    4. Incomplete footling presentation
    5. Knee presentation
55. Patient 32 years, labor first. Pregnancy 40 weeks. Sizes of pelvis - 25-28-30-19 cm. probable fetal weight is 4100 g. Position is longitudinal, breech presentation. Fetal heart rate 140 in 1 min. Vaginally: the cervix is dilated on 2 cm. Amniotic membrane is whole. What is the tactic of conduct of labor?
    1. Cesarean section after full dilatation
    2. Labor stimulation
    3. Obstetric version of the fetus
    4. Amniotomy
    5. \*Cesarean section immediately
56. Primapara C., 20 years, uterine contractions proceeds 13 hours. Amniotic fluid with meconium has released. The pushing efforts are 40 sec every 5 min. The fetal lie is longitudinal, breech presentation. The fetal heart rate is 70 in 1 min. with each pushing gets worse. Complete dilation of cervix is present in vaginal examination. An amniotic sac is absent. The buttocks are in the plane of the greatest dimension of the pelvis. What to do?
    1. To stimulate uterine contractions
    2. Cesarean section
    3. \*To conduct fetal breech extraction
    4. To conduct medicinal medical treatment.
    5. To conduct labor on Tsovianov’ method
57. Primapara is admitted to the delivery department. The transversal position of the fetus is found. Fetal heart rate is clear, 138 in 1 min. Vaginally: the uterine cervix is dilated for 8 cm, amniotic membrane is absent. The fetal back and umbilical cord is palpated. What is the doctor’ tactic?
    1. Wait to the full cervical dilation and perform the internal obstetric version
    2. To perform the external obstetric version
    3. The supervision
    4. \*Cesarean section immediately
    5. Cesarean section after full cervical dilation
58. Patient N., II labor. The patient’ condition is satisfactory. Uterine contractions are active. On the left of umbilicus the fetal head is palpated in uterus, presenting part is not determined. Heart rate is 150 in 1 min. Vaginally: the uterine cervix is dilated for 3 cm, amniotic membrane is absent, light amniotic fluid are releasing. Your diagnosis?
    1. Transversal lie of fetus, II position.
    2. \*Transversal lie of fetus, I position.
    3. Breech presentation, I position.
    4. Breech presentation, II position
    5. The second period of labor.
59. The patient is delivered in a hospital with amniotic fluid released and regular uterine contractions which began 8 hours ago. The head of the fetus is in the pelvic inlet. At vaginal examination cervical dilation is 8 cm, sagittal suture in a right oblique size, large fontanel is below small one, small fontanel is to the left under the pubis. To define presentation, position and variety.
    1. The brow presentation, first position, anterior variety.
    2. \*The vertex presentation, I position, anterior variety.
    3. The face presentation, I position, posterior variety.
    4. The occiput presentation, second position, posterior variety.
    5. Occiput presentation, I position, anterior variety.
60. I labor, II stage. Longitudinal fetal lie, complete breech presentation. The doctor begins the classic manual aid. The Mauriceau-Levre maneuver is used for:
    1. Breech extraction
    2. Cesarean section
    3. \*Fetal head extraction
    4. Tsovyanov I manual aid
    5. Tsovyanov II manual aid
61. The primapara 23 years entered maternity hospital with regular uterine contractions, position of fetus is longitudinal, presentation is cephalic. External sizes of pelvis: 26-29-31-20, circumference of abdomen - 96 cm, level of uterine fundus - 38 cm above pubis. At vaginal examination uterine cervix is 10 cm, amniotic membrane is absent, the head of fetus is in the pelvic inlet. The fetal eyes are determined, the nose, brow, anterior corner of large fontanel. Diagnosis and the tactic of doctor?
    1. \*The brow presentation of fetus, labor by cesarean section
    2. The generally contracted pelvis, conservative labor
    3. The deflexed vertex presentation of fetus, conservative labor
    4. Clinically contracted pelvis, labor by cesarean section
    5. Face presentation of fetus, labor by cesarean section
62. Patient in the term of pregnancy 39-40 weeks. Position of fetus is longitudinal. I stage of labor. At vaginal examination: the uterine cervix is effaced, dilatation is 10 cm. Amniotic membrane is absent. Buttocks of the fetus are palpated. What is the diagnosis?
    1. Complete breech presentation
    2. \*Frank breech presentation
    3. Complete footling presentation
    4. Incomplete footling presentation
    5. Knee presentation
63. In vaginal examination of a multipara it was determined: the cervix is effaced, dilatation is 5 cm, the fetal buttocks are palpated in the level of pelvic inlet. The intertrochanteric diameter is in the right oblique size, the fetal sacrum is posteriorly. What is the diagnosis?
    1. \*The 2nd position, posterior variety
    2. The 1st position, anterior variety
    3. The 1st position, posterior variety
    4. The 2nd position, anterior variety
    5. The transversal position
64. The primapara 24 years admitted to the maternity hospital with regular uterine contractions. Sizes of pelvis: 25-28-30-20 cm. Abdominal circumference is 100 cm, level of uterine fundus - 28 cm, presenting part is absent. Right side the fetal head is palpated, left – the breech, fetal heart rate - 144 in 1 min. Vaginal examination: the uterine cervix is effaced, dilated for 4 cm, amniotic membrane is whole. What is the tactic of labor conducting?
    1. \*Cesarean section
    2. Supervision
    3. External version of the fetus on a head
    4. Stimulation of uterine contractions
    5. Classic obstetric version of the fetus
65. Primapara S., 27 years, admitted maternity hospital at 40 weeks of gestation. The fetal lie is longitudinal, I position, anterior variety, breech presentation. At vaginal examination: the complete opening of cervix, amniotic sac is absent, the fetal buttocks in the plane of least dimension. What to do?
    1. Breech extraction.
    2. Cesarean section.
    3. To stimulate uterine contractions
    4. To conduct medical treatment of eclampsia
    5. \*To conduct labor on Tsovianov’ method
66. Patient with active uterine contractions admitted in a maternity block. Abdomen circumference – 100 cm, the level of uterine fundus – 39 cm. Sizes of pelvis 26-29-32-20 cm. Lie of fetus is longitudinal, 1st position, in the uterine fundus great dense part of fetus is determined. At internal examination: uterine cervix is effaced, opening 4 cm, amniotic membrane is whole, fetal feet are presented. Tactic conduct of labor?
    1. Classic manual aid.
    2. Conservative conduct of labor by Tsovyanov.
    3. Labor stimulation
    4. Amniotomy.
    5. \*Cesarean section.
67. The patient is delivered in a hospital with amniotic fluid gash and uterine contractions which began 8 hours ago. The head of the fetus is in the pelvic inlet. Fetal heart rate is clear, rhythmic, 136 in 1min. At vaginal examination: opening of cervix is 8 cm, frontal suture in a right oblique size, the root of nose is palpated. What is the fetal presentation?
    1. \*The brow presentation, first position, anterior variety.
    2. The vertex presentation, I position, anterior variety.
    3. The face presentation, I position, posterior variety.
    4. The occiput presentation, second position, posterior variety.
    5. Occiput presentation, I position, anterior variety.
68. Primapara is admitted to the delivery department in the I stage of labor. The transverse position of the fetus is found. Head is on the left. Fetal heart rate is 180 in 1 min. Vaginally: the uterine cervix is dilated for 8 cm, amniotic membrane is absent. The fetal arm is palpated in vagina. What is the doctor’ tactic?
    1. To perform the external obstetric version
    2. Wait to the full cervical dilation and perform the internal obstetric version
    3. The supervision
    4. \*Cesarean section immediately
    5. Cesarean section after full cervical dilation
69. Patient in the term of pregnancy 39-40 weeks. Position of fetus is longitudinal. I stage of labor. At vaginal examination: the uterine cervix is effaced, dilatation is 8 cm. Amniotic membrane is absent. Both feet of the fetus are palpated in vagina. What is the diagnosis?
    1. Complete breech presentation
    2. Incomplete breech presentation
    3. \*Complete footling presentation
    4. Incomplete footling presentation
    5. Knee presentation
70. Primapara C., 19 years, labor began 10 hours ago, just have came out the amniotic fluid with meconium and the foot of fetus fell out, the pushing efforts on 45 sec every 2-3 min, regular, sufficient force and intensity. The fetal heart rate is 90 in 1 min. At vaginal examination: complete opening of cervix, an amniotic sac is absent, a foot is palpated in vagina. What to do?
    1. To conduct labor conservative on a method of Tsovyanov II
    2. Cesarean section
    3. To stimulate uterine contractions
    4. To conduct medicinal therapy of fetal distress.
    5. \*To conduct the fetal extraction on one leg
71. Pregnant C., 26 years, entered maternity department with regular uterine contractions. Term of pregnancy 39 weeks. Abdominal circumference - 126 cm, uterine fundus height – 41 cm. The fetal lie is longitudinal, breech presentation. Uterus in normal tonus. The fetal heart rate is 130 in 1 min, rhythmic. Vaginally: cervical dilatation is full, vagina is filled by an amniotic sac. During examination about 5 L of amniotic fluid came out, buttocks are in the pelvic cavity. Diagnosis?
    1. Large fetus. Breech presentation
    2. Multifetal pregnancy. Incomplete presentation of the I fetus
    3. \*Franc breech presentation. Polyhydramnion
    4. Polyhydramnion. Complete breech presentation
    5. Polyhydramnion
72. Primapara. At vaginal examination: opening of cervix is 8 cm, the frontal suture in a transversal size of the pelvic inlet, the middle of frontal suture is palpated as a leading point. For which type of presentation is it typical?
    1. \*The brow presentation
    2. The vertex presentation.
    3. The face presentation
    4. The anterior occiput presentation.
    5. The posterior occiput presentation
73. At pregnant 28 years at the visit of female dispensary with pregnancy 38 weeks transversal position of the fetus is found. Abdominal circumference 116 cm, the uterine fundus height – 32 cm. Head is on the left. Fetal heart rate is clear, 138 in 1 min. Sizes of pelvis: 25-29-31-20 cm. What is the doctor’ tactic?
    1. To hospitalize and to perform the external obstetric version
    2. \*To hospitalize and perform cesarean section at term
    3. The supervision
    4. To do the classic obstetric version of fetus in labor
    5. To appoint a corregate gymnastics
74. Patient with active uterine contractions admitted in a maternity block. Pregnancy 1st. Abdomen circumference – 100 cm, the level of uterine fundus – 39 cm. Sizes of pelvis 26-29-32-20 cm. Lie of fetus is longitudinal, in the uterine fundus great dense part of fetus is determined. At internal examination: uterine cervix is effaced, opening 4 cm, amniotic membrane is whole, fetal feet are presented. Tactic conduct of labor?
    1. \*Cesarean section.
    2. Labor stimulation
    3. Conservative conduct of labor by Tsovyanov.
    4. Amniotomy.
    5. Classic manual aim.
75. The patient is delivered in a hospital with amniotic fluid released and regular uterine contractions which began 8 hours ago. The head of the fetus is in the pelvic inlet. Fetal heart rate is clear, rhythmic, 136 in 1min. At vaginal examination: opening of cervix is 8 cm, the fetal chin, cheeks and nose are palpated. To define the fetal presentation.
    1. The brow presentation.
    2. The vertex presentation.
    3. \*The face presentation..
    4. Occiput presentation, anterior variety.
    5. The occiput presentation, posterior variety.
76. The primapara 24 is admitted in observative department due to high body temperature – 38,7o, 1 stage of labor, regular uterine contractions. Sizes of pelvis: 25-28-30-20 cm. Abdominal circumference is 100 cm, level of uterine fundus 28 cm, presenting part is absent. Right side the fetal head is palpated, left – the breech, fetal heart sounds are absent. Vaginal examination: the uterine cervix is fully dilated, amniotic membrane is whole. What is the tactic of labor conducting?
    1. Cesarean section after full dilatation
    2. Cesarean section immediately
    3. External version of the fetus on a head
    4. Stimulation of uterine contractions
    5. \*Classic obstetric version of the fetus
77. The pregnant woman visited the doctor. External sizes of her pelvis: 21-24-27-16 cm, Solovyov’ index – 15 cm. What is the degree of pelvic contraction?
    1. I
    2. II
    3. \*III
    4. IV
    5. Normal pelvis
78. In a maternity block the pregnant woman is admitted. Pregnancy is ІІ, the first pregnancy ended by stillbirth by mass 3800 g with a hemorrhage in a brain. Height of the woman is 160 cm, external sizes of pelvis: 26-28-30-17 cm, Solovyov’ index – 16 cm, sizes of rhomb Mihaelis: 9 x 10 cm, circumference of abdomen 110 cm, level of uterine fundus - 41 cm above pubis. Diagnosis? Plan of conduct of labor?
    1. \*Simple flat pelvis, labor by cesarean section
    2. Generally contracted pelvis, labor by cesarean section
    3. Simple flat pelvis, conservative labor
    4. The rachitic pelvis, labor by cesarean section
    5. The Generally contracted pelvis, conservative labor
79. The primapara 23 years is admitted in maternity hospital with regular uterine contractions, position of fetus is longitudinal, presentation is cephalic. External sizes of pelvis: 26-29-31-20 cm, circumference of abdomen - 106 cm, level of uterine fundus - 42 cm above pubis. Pushing are active. Patient complains about permanent acute pain in the lower uterine segment, can not have normal urination, Vasten’ sign is positive. Vaginal examination: opening of uterine cervix is 10 cm, amniotic membrane is absent, the fetal head is in the plane of pelvic inlet. Diagnosis?
    1. Generally contracted pelvis
    2. Flat pelvis
    3. Fetal macrosomia
    4. \*Clinically contracted pelvis
    5. Deflexed presentation of fetus
80. The pregnant woman is visited the doctor. External sizes of her pelvis: 25-28-31-21 cm, Solovyov’ index – 15 cm. Diagnosis?
    1. Generally contracted pelvis
    2. Simple flat pelvis
    3. Transversally contracted pelvis
    4. The rachitic pelvis
    5. \*Normal pelvis
81. In the pregnant the generally contracted pelvis I degree was diagnosed. What is the pelvic formula of that patient?
    1. 25-26-32-18 cm
    2. 25-28-31-20 cm
    3. \*24-27-30-19 cm
    4. 22-25-28-17 cm
    5. 25-28-31-18 cm
82. The infant with mass 2800 g was born with dolichocephalic shape of his head, the caput succedaneum is in the area of posterior fontanel. The duration of II stage of labor was 2 hours. Which type of contracted pelvis his mother has?
    1. Normal pelvis
    2. Simple flat pelvis
    3. \*Generally contracted pelvis
    4. Transversally contracted pelvis
    5. The rachitic pelvis
83. In patient 25 years, labor III. The pelvic sizes: 24-27-30-19 cm. After stormy uterine contractions and pushing at a highly standing fetal head and positive Vasten’ sign uterine contractions was stopped suddenly, bloody excretions from a vagina appeared, fetal heart rate is not listened. The condition of patient suddenly became worse, blood pressure went down to 70 mm Hg, pulse 140 in a 1 minute, the skin is pale. Reason of the shock condition?
    1. \*Uterine rupture
    2. Threatened rupture of uterus
    3. Abruption placentae
    4. Syndrome of squeezing of lower hollow vein
    5. Placenta previa
84. A patient in a term 37 weeks of pregnancy was admitted to female dispensary. Patient feels the fetal motions in all abdomen. Abdomen is increased due to a pregnant uterus. Circumference of abdomen - 122 cm, level of uterine fundus - 40 cm. 2 round and firm parts of the fetus is palpated [to the right at the level of umbilicus and in the uterine fundus]. Presenting part is mobile above the pelvic inlet. Fetal heart rate is listened to in many points, 140 in 1 min, rhythmic. What is most probable diagnosis?
    1. \*Multifetal pregnancy
    2. Hydramnion
    3. Pregnancy and myoma of uterus
    4. Molar pregnancy
    5. Large fetus
85. Pregnant visited the doctor with complaints about the sharp increase of volume of abdomen after the acute infection. Abdominal circumference – 98 cm, uterine fundus height 36 cm. Fetal lie is longitudinal, the fetal head as in 32 weeks of pregnancy, above the pelvic inlet, mobile. The fetal heart rate 120 in 1 min. What medical treatment is conducted?
    1. \*Medical treatment by antibiotics
    2. Medical treatment by diuretics
    3. Medical treatment is contraindicated
    4. Medical treatment cardiac drugs
    5. Medical treatment by hypotensive drugs
86. In external examination the doctor palpated above the pubis the prominent pole of the fetal head. Which sign was found?
    1. Positive Piskatcek’ sign
    2. Positive Zangemeister’ sign
    3. Negative Vasten’ sign
    4. Negative Negele’ sign
    5. \*Positive Vasten’ sign
87. Patient N., 27 years. Labor are second, at term. Mass of the fetus is 4000 gr. The head of fetus was born. It is diagnosed tight loops of umbilical cord round a cervix, attempts to weaken loops were uneffective. Pushing are active. A fetus is arrested in pelvic outlet, heart rate is 160 in 1 min. What to do?
    1. \*To cut the loop of umbilical cord in clamps.
    2. To do fetal extraction with the head by hands
    3. Craniotomia.
    4. Obstetric forceps.
    5. To cut a perineum.
88. Pregnant, 25 weeks of pregnancy. During the last 2 months complains on a weakness, violation of taste, the promoted fragility of hair and nails. At laboratory examination: the rate of red blood cells 2,8x1012, Hb 98 g/l. Which complication can develop in fetus?
    1. Macrosomia
    2. Avitaminosis
    3. Izoimmunisation
    4. Asphyxia
    5. \*Fetal growth retardation
89. At the end of the first period of physiological labor the clear amniotic fluids outcome. The patient’ blood pressure is 140/90 mm Hg. Contractions are 35-40 sec every 4-5 min. Heart rate of the fetus is 100 beats per minute. Diagnosis.
    1. Preterm labor.
    2. \*Acute fetal distress.
    3. Placental abruption.
    4. Posterior occipital presentation
    5. Hydramnion
90. Pregnant C., 26 years, entered department of pathology of pregnant with complaints about dizziness, weakness, shortness of breath, increase of frequency of moving of the fetus. Pregnancy 36 weeks. At the examination: Abdomen circumference – 92 cm, the level of uterine fundus – 29 cm. Body of uterus in normal tonus, heart rate of the fetus is160 in 1 min, rhythmic. The woman is pale, skin is dry. In the blood test: Hb – 80 g/l, red blood cells rate – 2,2x1012/l, L – 4,5h109/l, Tr. – 220h109/l, Fe – 8,31 mmol/l. How does this disease of woman influence on the fetal condition?
    1. \*Fetal growth reytardation, fetal distress
    2. High amniotic fluid-level
    3. Daun disease
    4. The lacks of the fetus develop
    5. Hemolytic disease develops
91. Pregnant D. appealed to the doctor of female dispensary with complaints about the abnormal enlargement of abdomen at pregnancy 20 weeks. The patient’ condition is satisfactory. BP 120/60 mm Hg. Abdominal circumference – 110 cm, uterine fundus level - 26 cm. The fetal heart rate is clear, rhythmic 130 in 1 min. At ultrasound: the fetal head is absent. Diagnosis?
    1. \*Anencephaly
    2. Microcephaly
    3. Hydrocephaly
    4. Cerebral fistula
    5. Dawn’ disease
92. Primapara P., 18 years is delivered in the maternity department with complaints about the bad feeling of fetal movements at pregnancy 38 weeks, AT 120/60 mm Hg. The fetal lie is longitudinal, I position, the fetal head is above the pelvic inlet, fetal movements are weak, fetal heart rate 180 bpm. Uterine contractions are absent. Amniotic fluid with meconium were revealed at amnioscopy. Diagnosis?
    1. Polyhydramnion
    2. Olygohydramnion
    3. \*Fetal distress
    4. The normal state of fetus
    5. Hemolytic disease of the fetus
93. Pregnant W, 20 years, complaints about the weak fetal movements. Pregnancy 40 weeks. Uterine contractions are absent. The fetal lie is longitudinal, cephalic presentation. At ultrasound: during 20 minutes one respiratory motion of fetus (which proceeded 30 sec.) happened, three motions of trunk and extremities (from flexed position in the deflexed and rapid returning in the previous state) in reply to these motions happened increase of frequency of heart beating in fetus (proceeded more than 15 sec), quantity of amniotic liquid 3 cm. Estimate the biophysical profile of the fetus.
    1. 4 marks
    2. 8 marks
    3. 6 marks
    4. \*10 marks
    5. 2 marks
94. Pregnant B, 20 years, complaints about the weak fetal movements. Pregnancy 40 weeks. Uterine contractions are absent. The estimation of the biophysical profile of the fetus is 8 marks. What is the doctor’s tactic?
    1. To hospitalize patient for fetal distress therapy
    2. Cesarean section immediately
    3. Repeat the biophysical profile of the fetus
    4. To perform amniocentesis
    5. \*Supervision
95. Primapara D, 34 years visited the doctor of female dispensary the first time. No complaints. Pregnancy 18 weeks. The fetal heart rate is 130 bpm. What of the following should be administrated?
    1. To hospitalize patient for NST and fetal distress therapy
    2. Biophysical profile of the fetus
    3. \*Alpha-fetoprotein test
    4. To perform amniocentesis
    5. Cordocentesis
96. A child was born in time. On the second day at a child jaundice of skin and mucus membranes appeared. Indirect bilirubin is 136 mcmol/l. At a mother blood type 0[І]Rh-, at a child - A[ІІ]Rh+. What is the mechanism of icterus?
    1. \*Hemolisis of red blood cells
    2. Holestasis
    3. Hepatitis
    4. Violation of bile outflow
    5. Violation of exchange of bilirubin
97. Patient with Rh negative type of blood on 16 week of pregnancy presents the history of isoimmunisation. Which test is the most informative in this case?
    1. Fetal heart rate
    2. Determination of the father’s Rh status
    3. Alpha-fetoprotein test
    4. \*Test for antibodies
    5. Amnioscopy
98. Pregnant 25 years, labor first. Pregnancy 40 weeks, cephalic presentation, I period of labor. Uterine contractions proceeds 12 hours, uterine contractions through 5-6 min, duration is 45-50 sec. Fetal heart rate is 90 in 1 min. At vaginal examination: the uterine cervix is effaced, opening 6 cm. What diagnosis is most probable?
    1. Chronic fetal distress
    2. \*Acute fetal distress
    3. Hemolitic disease of the fetus
    4. Hypotrophy of the fetus
    5. Fetal-placental insufficiency
99. The patient on 36 week of pregnancy complaints of the abnormal fetal movements. Fetal heart rate monitoring was performed. Basal rhythm is 120-130 bpm, some accelerations and variable decelerations presents. Indicate the sign of fetal distress:
    1. \*Presence of significant variable decelerations.
    2. Basal rhythm 120-160 bpm.
    3. Two and more accelerations in 10 min.
    4. Registration of intensive fetal movements.
    5. All of the above.
100. Primapara S. Pregnancy 40 weeks. Edema on lower extremities. The fetal lie is longitudinal, I position, head is in the pelvic inlet. Fetal movements are very weak. The fetal heart rate is 110 bpm. Uterine contractions are absent. Amnioscopy performed: the amniotic fluid is green color. Diagnosis?
     1. Polyhydramnion
     2. Olygohydramnion
     3. \*Fetal distress
     4. The normal state of fetus
     5. Fetal asphyxia
101. Pregnant D., 30 years. Pregnancy 40 weeks. Uterine contractions are regular. The fetal lie is longitudinal, cephalic presentation. In pelvic examination - cervix is dilated for 5 cm, sagittal suture in left oblique size, small fontanell is under the symphysis. Estimate the position and variety of the fetus.
     1. medium anterior
     2. right occipital anterior
     3. right occipital posterior
     4. left occipital posterior
     5. \*left occipital anterior
102. Pregnant N., 26 years is delivered in the maternity department in I stage of labor with complaints about headache, noise in ears, dizziness. Pregnancy ІІ, 38 weeks. At the examination: AT 170/120 mm Hg, edema. Uterine contractions every 5 minutes, with each contraction there are late decelerations on fetal monitoring. Meconial amniotic fluid released. Indicate fetal changes.
     1. Increase of pH
     2. \*Decreasing of oxygen level in the fetal blood
     3. Decreasing of milk acid in the fetal blood
     4. Increase CO2
     5. Increase of oxygen level in the fetal blood
103. Pregnancy A, multiple, 15-16 weeks of gestation. The table of contents of alpha-fetoprotein in the blood of pregnant exceeds a norm. How to interpret the anomalous level of alpha-fetoprotein in this case?
     1. Violation of osteogenesis.
     2. Defect of the fetal neural tube.
     3. Fetal anomalies.
     4. Necrosis of liver.
     5. \*The sign of multifetal pregnancy
104. Pregnant B, 20 years, complaints about the weak fetal movements. Pregnancy 38 weeks. Uterine contractions are absent. The fetal heart rate is 170 bpm. The estimation of the biophysical profile of the fetus is 6 marks. What is the best doctor’s tactic?
     1. Fetal distress therapy
     2. Cesarean section immediately
     3. \*To hospitalize patient and repeat the biophysical profile of the fetus in 2- 3 days
     4. To perform amniocentesis
     5. Supervision
105. Primapara D, 39 years visited the doctor of female dispensary the first time. No complaints. Pregnancy 18 weeks. The fetal heart rate is 130 bpm. The alfafetoprotein test is administrated. What was the indication for that test?
     1. Term of pregnancy
     2. Fetal heart rate
     3. \*Age of mother
     4. The first pregnancy
     5. All of the above
106. Pregnant D. visited the doctor of female dispensary with complaints about the abnormal enlargement of abdomen at pregnancy 11 weeks. The patient’ condition is satisfactory. Arterial blood pressure is 120/60 mm Hg. At ultrasound anencephaly was established. What is the doctor’s tactic?
     1. Ultrasound examination
     2. Alpha-fetoprotein test
     3. Cesarean section
     4. Amnioscopy
     5. \*To perform induced abortion
107. Primapara C., labor began 10 hours ago, just have came out the amniotic fluid with the meconium and the foot of fetus fell out, the pushing efforts on 45 sec every 2-3 min, regular. BP 130/90 mm Hg. The fetal position is longitudinal, incomplete footling presentation. The fetal heart rate is 90 in 1 min. Complete dilation of cervix, amniotic sac is absent, a foot is palpated at vaginal examination. What is the indication to breech extraction in that patient?
     1. High blood pressure
     2. Hypotonic uterine contractions
     3. Intensive contractions
     4. \*Acute fetal distress.
     5. No indications
108. Patient C., 26 years, 18 hours are found in labor: pushing appeared hour ago – on 30 sec. in 3-4 minutes. Fetal heart rate is arhythmical to 80 in 1 min. Fetal head is presented in plane of least dimension of true pelvis. Your subsequent obstetric tactic?
     1. The cardiomonitoring supervision
     2. \*Obstetrical forceps
     3. To conduct labor conservative
     4. To execute perineotomia.
     5. Cesarean section.
109. Pregnant B, 20 years, complaints about the weak fetal movements. Pregnancy 38 weeks. Uterine contractions are absent. The fetal heart rate is 100 bpm. The estimation of the biophysical profile of the fetus is 4 marks. What is the best doctor’s tactic?
     1. To hospitalize patient for NST and fetal distress therapy
     2. \*Cesarean section immediately
     3. Repeat the biophysical profile of the fetus
     4. To perform amniocentesis
     5. Supervision
110. Patient 25 years. Pregnancy I, 40 weeks, the fetal lie is longitudinal, cephalic presentation, I period of labor. Uterine contractions proceeds 12 hours, duration 45-50 sec., every 5-6 min. The fetal heart rate was 140 bpm, now is 90 bpm. Cervical dilation is 6 cm. Diagnosis?
     1. Feto-placental insufficiency
     2. Chronic fetal distress
     3. Hemolytic disease of fetus
     4. Fetal growth retardation
     5. \*Acute fetal distress
111. At a woman 28 years at the second labor a 3 400 g girl was born with anemia and increasing icterus. Blood type at a woman B (ІІІ) Rh-, at the father of new-born B (ІІІ) Rh+, at new-born B(ІІІ) Rh+. What is the most credible diagnosis?
     1. \*Rh-izoimmunization.
     2. Conflict on an antigen A.
     3. Conflict on an antigen In.
     4. Conflict on an antigen AV.
     5. Infection
112. Patient at term presents the history of fetal distress in 36 weeks of pregnancy. Now the fetal heart rate is 120 bpm. Which test is the most informative in this case?
     1. \*Fetal biophysical profile.
     2. Ultrasound examination
     3. Alpha-fetoprotein test
     4. Test for antibodies
     5. Amnioscopy
113. Pregnant B, 20 years, complaints about the weak fetal movements. Pregnancy 38 weeks. Uterine contractions are absent. The fetal heart rate is 90 bpm. The estimation of the biophysical profile of the fetus is 2 marks. What is the best doctor’s tactic?
     1. To hospitalize patient for NST and fetal distress therapy
     2. \*Cesarean section immediately
     3. Repeat the biophysical profile of the fetus
     4. To perform amniocentesis
     5. Alpha-fetoprotein test
114. Pregnant D. visited the doctor of female dispensary with complaints about the abnormal enlargement of abdomen at pregnancy 20 weeks. Abdominal circumference – 110 cm, uterine fundus level - 26 cm. The fetal heart rate is clear, rhythmic 130 in 1 min. At ultrasound: the fetal head is abnormally large, the brain ventricles are significantly enlarge. Diagnosis?
     1. Cerebral fistula
     2. Anencephaly. Polyhydramnion
     3. Macrocephaly. Macrosomia
     4. \*Hydrocephaly. Polyhydramnion
     5. Dawn’ disease
115. The pregnant S. was admitted in pathologic of pregnant department. Pregnancy ІІ, 37 weeks. Complaints about the gradual enlargement of abdominal sizes after viral infection. Circumference of abdomen – 110 cm, uterine height – 36 cm. The fetal lie is longitudinal, cephalic presentation, head of the rounded shape, dense, above the pelvic inlet. The fetal heart rate is clear, rhythmic 130 in 1 min. The diagnosis: chronic polyhydramnion. Which antibiotics of the first line used for medical treatment?
     1. Doxycecline
     2. \*Erythromycin
     3. Amoxill
     4. Gentamycin
     5. Clyndamycin
116. Patient in 37 weeks of pregnancy was presented in female dispensary. An abdomen is enlarged due to a pregnant uterus. Abdominal circumference - 122 cm, uterine height - 40 cm. Two great parts of fetus are palpated to the right and to the left at the level of umbilicus. Presenting part is not determined. The fetal heart rate is auscultating in many points at the level of umbilicus, 140 and 130 in 1 min, rhythmic. What is the diagnosis?
     1. Fetal macrosomia
     2. Polyhydramnion
     3. Pregnancy and uterine fibromioma
     4. Molar pregnancy
     5. \*Multifetal pregnancy
117. 28 years old pregnant was admitted to the maternity home. External sizes of her pelvis: 24-27-30- 18 cm, conjugata diagonalis is 10,5 cm. What is the degree of pelvic contraction?
     1. I
     2. \*II
     3. III
     4. IV
     5. Normal pelvis
118. In a maternity block the pregnant woman was admitted. External sizes of her pelvis: 26-26-32-17 cm, Solovyov’ index – 15 cm. Abdominal circumference is 100 cm, level of uterine fundus - 36 cm. Diagnosis?
     1. Simple flat pelvis
     2. Generally contracted pelvis
     3. Transversally contracted pelvis
     4. \*The flat rachitic pelvis
     5. Generally contracted pelvis,
119. In the pregnant the generally contracted pelvis II degree was diagnosed. What is the pelvic formula of that patient?
     1. 25-28-31-20 cm
     2. 25-26-32-18 cm
     3. 24-27-30-19 cm
     4. \*22-25-28-17 cm
     5. 25-28-31-18 cm
120. 2800 g infant was born after the prolong labor. The anterior asynclitism was presented, the head was slightly extended, caput succedaneum is in the area of large fontanel. Which type of contracted pelvis his mother has?
     1. Normal pelvis
     2. \*Simple flat pelvis
     3. Generally contracted pelvis
     4. Transversally contracted pelvis
     5. The rachitic pelvis
121. Primapara of 32 years old. The pelvic sizes: 26-27-30-18 cm. Beginning of the ІІ stage of labor. Uterine contractions are severe, almost without intervals. Acute pain in the lower segment of uterus. The uterus took shape of “sand-glass”. Fetal heart rate is 140 in 1min, rhythmic. The lie of the fetus is longitudinal, the head presentation. Probable fetal weight is 4600 gr. Diagnosis?
     1. \*Threatened uterine rupture.
     2. Uterine rupture.
     3. Discoordinate uterine contractions.
     4. Abruptio placentae.
     5. Normal labor
122. The pregnant Х. in 32 weeks of pregnancy visited the doctor of female dispensary with complaints about the increasing of abdominal volume after the acute infection a week ago. The patient’ condition is satisfactory, the edema are absent. The abdominal circumference is 98 cm, uterine fundus level – 36 cm. The fetal lie is longitudinal, the fetal head as in 32 weeks of pregnancy, above the pelvic inlet, mobile. The fetal heart rate 120 in 1 min. What pathology is presented?
     1. Multifetal pregnancy
     2. Chronic polyhydramnion
     3. Breech position of fetus
     4. Transversal position of fetus
     5. \*Acute polyhydramnion
123. G., 20 eyars old, multimapara. Full term of pregnancy. The labor started 6 hours ago. The membranes are intact. Pelvic sizes: 25,28,31,20 cm. Uterine contractions occur every 4-5 minutes. Fetal head rate is 140 per minute with satisfactory characteristics. Probable fetal weight by Volskov – 4200g. Per vaginum: the cervix is 8cm dilated. The amniotic sac is present. Fetal buttocks are palpated in the plane of inlet. Bitrochanter diameter is in the oblique diameter of pelvic inlet. Which type of breech presentation is presented?
     1. Complete breech
     2. Incomplete footling
     3. \*Frank breech
     4. Complete footling
     5. Incomplete knee-ling
124. G., 20 eyars old, multimapara. Full term of pregnancy. The labor started 6 hours ago. The membranes are intact. Pelvic sizes: 25,28,31,20 cm. Uterine contractions occur every 4-5 minutes Fetal head rate 140 per minute with satisfactory characteristics. Probable fetal weight by Volskov is 4200g. Per vaginum: the cervix is 8cm dilated. The amniotic sac isintact. Fetal buttocks are palpated in the plane of inlet. Bitrochanter diameter is in the oblique diameter of pelvic inlet. What is the management of labor?
     1. Manual aid by Tsovianov II
     2. Classic manual aid
     3. Manual aid by Tsovianov III
     4. Manual aid by Tsovianov I
     5. \*Cesarean section
125. A., 22 years old, primapara. Full term of pregnancy. The labor started 12 hours ago. The membranes ruptured 15 minutes ago. Pelvic sizes: 25,28,31,20 cm. Fetal head rate 140 per minute with satisfactory characteristics. Per vaginum: the cervix is completely dilated. The amniotic sac is absent. Fetal buttocks and fetal feet are palpated in the 0 station. Bitrochanter diameter is in the oblique diameter of pelvic inlet. Which type of breech presentation is presented?
     1. \*Complete breech
     2. Incomplete foot-ling
     3. Frank breech
     4. Complete foot-ling
     5. Incomplete knee-ling
126. A., 22 years old, multipara. Full term of pregnancy. The labor started 12 hours ago. The membranes ruptured 15 minutes ago. Pelvic sizes: 25,28,31,20 cm. Fetal head rate 140 per minute with satisfactory characteristics. Per vaginum: the cervix is completely dilated. The amniotic sac is absent. Fetal buttocks and fetal feet are palpated in the 0 station. Bitrochanter diameter is in the oblique diameter of pelvic inlet. What is the management of labor?
     1. Manual aid by Tsovianov II
     2. \*Classic manual aid
     3. Manual aid by Tsovianov III
     4. Manual aid by Tsovianov I
     5. Cesarean section
127. Primipara M., 23 years old. Pregnancy at term. The labor started 4 hours ago. The membranes ruptured 1 hour ago. Pelvic sizes: 25,28,10,20 cm. Fetal head rate 140 per minute with satisfactory characteristics. Uterine contractions occur every 4-5 minutes. Per vaginum: the uterine cervix dilatation is 4 cm. The amniotic sac is absent. Fetal feet are presented. Buttocks are in the pelvic inlet. Which type of breech presentation is presented?
     1. Complete breech
     2. Incomplete foot-ling
     3. Frank breech
     4. \*Complete foot-ling
     5. Incomplete knee-ling
128. Primipara M., 23 years old. Pregnancy at term. The labor started 4 hours ago. The membranes ruptured 1 hour ago. Pelvic sizes: 25,28,10,20 cm. Fetal head rate 140 per minute with satisfactory characteristics. Uterine contractions occur every 4-5 minutes. Per vaginum: the uterine cervix dilatation is 4 cm. The amniotic sac is absent. Fetal feet are presented. Buttocks are in the pelvic inlet. Management of labor?
     1. Manual aid by Tsovianov II
     2. Classic manual aid
     3. Manual aid by Tsovianov III
     4. Manual aid by Tsovianov I
     5. \*Cesarean section
129. Primipara D., 24 years old. Pregnancy at term. The labor started 4 hours ago. The membranes are intact. Pelvic sizes: 25,28,31,20 cm. Fetal head rate 140 per minute with satisfactory characteristics. Uterine contractions occur every 4-5 minutes. Per vaginum: the uterine cervix dilatation is 6 cm. The amniotic sac is intact. Fetal knees are presented and fetal knees are lower than the buttocks. Which type of breech presentation is presented?
     1. Complete breech
     2. Incomplete foot-ling
     3. Frank breech
     4. Complete foot-ling
     5. \*Complete knee-ling
130. Primipara D., 24 years old. Pregnancy at term. The labor started 4 hours ago. The membranes are intact. Pelvic sizes: 25,28,31,20 cm. Fetal head rate 140 per minute with satisfactory characteristics. Uterine contractions occur every 4-5 minutes. Per vaginum: the uterine cervix dilatation is 6 cm. The amniotic sac is intact. Fetal knees are presented and fetal knees are lower than the buttocks. Management of labor?
     1. Manual aid by Tsovianov II
     2. \*Cesarean section
     3. Manual aid by Tsovianov I
     4. Classic manual aid
     5. Manual aid by Tsovianov III
131. 36-years-old women at term arrive in active labor, full dilated with a presenting part at the pelvic floor. She has had no prenatal care and four previous vaginal deliveries of four boys all weighing 3000 to 3200 g. Artificial rupture of membranes is performed, at which time the patient is found to have a frank breech presentation. Contractions are strong, occurring every 3 minutes. The fetal heart rate is 100 beat in minute. Which would be the best management?
     1. Manual aid by Tsovianov II
     2. Cesarean section
     3. Manual aid by Tsovianov I
     4. Classic manual aid
     5. \*Total breech extraction
132. 33-years-old women, primapara at term arrives in active labor, full dilated with a presenting part at the pelvic floor. The membranes ruptured 15 minutes ago. Pelvic sizes: 25,28,31,20 cm. Pushing efforts are weak and occur every 6-7 minutes Fetal heart rate 100 per minute and is not clear. Per vaginum: the fetus is delivered till the level of anterior scapulae. Which would be the best management?
     1. Manual aid by Tsovianov II
     2. Cesarean section
     3. \*Subtotal breech extraction
     4. Classic manual aid
     5. Total breech extraction
133. Primipara F., 24 years old. Multiply pregnancy at term. The labor started 6 hours ago. The membranes are intact. Pelvic sizes: 25,28,31,21 cm. In Leopolds maneuvers – longitudinal lie of both fetuses, breech presentation of the first fetus and cephalic – of the second one. Fetal heart rates 140 per minute with satisfactory characteristics. Uterine contractions occur every 7-8 minutes. Per vaginum: the uterine cervix dilatation is 5 cm. The amniotic sac is absent. Buttocks of the first fetus is presented. Which type of breech presentation is presented?
     1. \*Multiply pregnancy. The frank breech presentation of the first fetus.
     2. Multiply pregnancy. Complete breech presentation of the first fetus.
     3. Multiply pregnancy. Complete foot-ling presentation of the first fetus.
     4. Multiply pregnancy. Incomplete foot-ling presentation of the first fetus.
     5. Multiply pregnancy. Knee-ling presentation of the first fetus.
134. Primipara F., 24 years old. Multiply pregnancy at term. The labor started 6 hours ago. The membranes are intact. Pelvic sizes: 25,28,31,21 cm. In Leopolds Maneuvers – longitudinal lie of both fetuses, breech presentation of the first fetus and cephalic – of the second one. Fetal heart rates 140 per minute with satisfactory characteristics. Uterine contractions occur every 7-8 minutes. Per vaginum: the uterine cervix dilatation is 5 cm. The amniotic sac is absent. Buttocks of the first fetus is presented. What is the management of labor?
     1. Manual aid by Tsovianov II
     2. \*Cesarean section
     3. Subtotal breech extraction
     4. Classic manual aid
     5. Total breech extraction
135. 30-years-old women, primapara at 34 weeks of gestation arrives in active labor. Uterine contractions occur every 3-4 minutes. Per vaginum: the uterine cervix dilatation is 6 cm. The amniotic sac is intact. Fetal buttocks are presented. Which type of breech presentation is presented?
     1. Complete breech
     2. Incomplete foot-ling
     3. \*Frank breech
     4. Complete foot-ling
     5. Complete knee-ling
136. Woman with in-time pregnancy. Uterine contractions occur every 4-5 minutes and lasts 30-35 seconds. Vaginal examination: cervix is totally effaced, dilation to 4 cm, fetal head is on -2 station. Saggital suture is in right oblique diameter of the pelvic inlet, posterior fontanel under the symphysis. Amniotic sac is present. Diagnosis?
     1. \*Longitudinal lie, cephalic presentation, I position, anterior. First stage of labor
     2. Longitudinal lie, cephalic presentation, I position, posterior. First stage of labor
     3. Longitudinal lie, cephalic presentation, II position, anterior. First stage of labor
     4. Longitudinal lie, cephalic presentation, II position, anterior. Second stage of labor
     5. Longitudinal lie, cephalic presentation, I position, anterior. Second stage of labor
137. N., 21 years old, primapara. Full term of pregnancy. The labor started 8 hours ago. The membranes ruptured 15 minutes ago. Pelvic sizes: 25,28,31,20 cm. Fetal head rate 140 per minute with satisfactory characteristics. Per vaginum: the cervix is completely dilated. The amniotic sac is absent. Fetal buttocks are palpated in outlet plane of pelvic. Bitrochanter diameter is in the anteroposteror diameter of pelvic outlet. Which type of breech presentation is presented?
     1. Complete breech
     2. Incomplete footling
     3. \*Frank breech
     4. Complete footling
     5. Incomplete knee-ling
138. M., 28 years old, primapara. Full term of pregnancy. The labor started 8 hours ago. The membranes ruptured 15 minutes ago. Pelvic sizes: 23,25,29,18 cm. Fetal head rate 140 per minute with satisfactory characteristics. Per vaginum: the uterine cervix dilatation is 5 cm. The amniotic sac is absent. One fetal foot is palpated in the vagina. Buttocks are in the pelvic inlet. Management of labor?
     1. Manual aid by Tsovianov II
     2. Classic manual aid
     3. Manual aid by Tsovianov III
     4. Manual aid by Tsovianov I
     5. \*Cesarean section
139. N., 21 eyars old, primapara. Full term of pregnancy. The labor started 8 hours ago. The membranes ruptured 15 minutes ago. Pelvic sizes: 25,28,31,20 cm. Fetal head rate 140 per minute with satisfactory characteristics. Per vaginum: the cervix is completely dilated. The amniotic sac is absent. Fetal buttocks are palpated in outlet plane of pelvic. Bitrochanter diameter is in the anteroposteror diameter of pelvic outlet. Management of labor?
     1. Manual aid by Tsovianov II
     2. Classic manual aid
     3. Manual aid by Tsovianov III
     4. \*Manual aid by Tsovianov I
     5. Cesarean section
140. Woman with in-time pregnancy. Uterine contractions occur every 4-5 minutes and lasts 30-35 seconds. Vaginal examination: cervix is totally effaced, dilation to 5 cm, fetal head is on -2 station. Saggital suture is in left oblique diameter of the pelvic inlet, posterior fontanel under the symphysis. Amniotic sac is present. Diagnosis?
     1. Longitudinal lie, cephalic presentation, I position, anterior. First stage of labor
     2. Longitudinal lie, cephalic presentation, I position, posterior. First stage of labor
     3. \*Longitudinal lie, cephalic presentation, II position, anterior. First stage of labor
     4. Longitudinal lie, cephalic presentation, II position, anterior. Second stage of labor
     5. Longitudinal lie, cephalic presentation, I position, anterior. Second stage of labor
141. Woman with in-time pregnancy. Uterine contractions occur every 3-4 minutes and lasts 30-35 seconds. Vaginal examination: cervix is totally effaced, dilation to 6 cm, fetal head is on -2 station. Saggital suture is in right oblique diameter of the pelvic inlet, posterior fontanel near sacral region. Amniotic sac is present. Diagnosis?
     1. Longitudinal lie, cephalic presentation, I position, anterior. First stage of labour
     2. \*Longitudinal lie, cephalic presentation, II position, posterior. First stage of labour
     3. Longitudinal lie, cephalic presentation, II position, anterior. First stage of labour
     4. Longitudinal lie, cephalic presentation, II position, anterior. Second stage of labour
     5. Longitudinal lie, cephalic presentation, I position, anterior. Second stage of labour
142. Woman with in-time pregnancy. Uterine contractions occur every 4-5 minutes and lasts 30-35 seconds. Vaginal examination: cervix is totally effaced, dilation to 4 cm, fetus head is on -2 station. Saggital suture is in left oblique diameter of the pelvic inlet, posterior fontanel near sacral region. Amniotic sac is present. Diagnosis?
     1. Longitudinal lie, cephalic presentation, I position, anterior. First stage of labour
     2. Longitudinal lie, cephalic presentation, II position, posterior. First stage of labour
     3. Longitudinal lie, cephalic presentation, II position, anterior. First stage of labour
     4. Longitudinal lie, cephalic presentation, II position, anterior. Second stage of labour
     5. \*Longitudinal lie, cephalic presentation, I position, posterior. First stage of labour
143. M., 28 years old, para 2. Full term of pregnancy. Initiation of labor was 8 hours ago. Uterine contractions are every 3 minutes and lasts 35-40 seconds. The membranes ruptured 20 minutes ago. Pelvic sizes: 25,28,31,20. Fetal head rate 132 per minute with satisfactory characteristics. Probable fetal weight is 3000 g. Vaginal results: the cervix is completely dilated. The amniotic sac is absent. Fetal head is in 0 station. Sagittal suture is in the right oblique diameter of pelvic inlet. Anterior fontanel is located to the right side anteriorly and posterior fontanel is near sacral region to the left side. What is the diagnosis?
     1. \*Labour 2, at term, II period of labour. Longitudinal lie, Sinciput vertex presentation, II position, posterior visus
     2. Labour 2, at term, II period of labour. Longitudinal lie, Sinciput vertex presentation, II position, anterior visus
     3. Labour 2, at term, I period of labour. Longitudinal lie, Sinciput vertex presentation, II position, anterior visus
     4. Labour 2, at term, I period of labour. Longitudinal lie, Sinciput vertex presentation, II position, anterior visus
     5. Labour 2, at term, II period of labour. Longitudinal lie, Sinciput vertex presentation, II position, posterior visus.
144. M., 28 years old, para 2. Full term of pregnancy. Initiation of labor was 8 hours ago. Uterine contractions are every 3 minutes and lasts 35-40 seconds. The membranes ruptured 20 minutes ago. Pelvic sizes: 25,28,31,20. Fetal head rate 132 per minute with satisfactory characteristics. Probable fetal weight is 3000 g. Vaginal results: the cervix is completely dilated. The amniotic sac is absent. Fetal head is in 0 station. Sagittal suture is in the left oblique diameter of pelvic inlet. Anterior fontanel is located to the left side anteriorly and posterior fontanel is near sacral region to the right side. What is the diagnosis?
     1. Labour 2, at term, II period of labour. Longitudinal lie, Sinciput vertex presentation, II position, anterior visus
     2. Labour 2, at term, I period of labour. Longitudinal lie, Sinciput vertex presentation, II position, anterior visus
     3. Labour 2, at term, I period of labour. Longitudinal lie, Sinciput vertex presentation, II position, anterior visus
     4. Labour 2, at term, II period of labour. Longitudinal lie, Sinciput vertex presentation, I position, posterior visus
     5. \*Labour 2, at term, II period of labour. Longitudinal lie, Sinciput vertex presentation, I position, posterior visus.
145. Primipara N., 25 years old. Delivery at term. Initiation of labor was 8 hours ago. The amniotic sac is ruptured. Pelvic sizes: 25,28,31,20. Fetal heart rate is 136 per minute with satisfactory characteristics. Uterine contractions are occurring every 3 minutes and lasts 30-35 seconds. Vaginal results: the uterine cervix dilatation is 6 sm. The amniotic sac is absent. Fetal head fixed to the inlet of pelvis. Face line is in the right oblique size. Chin is located anteriorly. What is the diagnosis?
     1. Longitudinal lie, vertex presentation. I position, posterior visus.
     2. \*Longitudinal lie, face presentation. I position, posterior visus.
     3. Longitudinal lie, face presentation. II position, posterior visus.
     4. Longitudinal lie, face presentation. I position, anterior visus.
     5. Longitudinal lie, sinciput vertex presentation. I position, posterior visus.
146. Primipara N., 25 years old. Delivery at term. Initiation of labor was 8 hours ago. The amniotic sac is ruptured. Pelvic sizes: 25,28,31,20. Fetal heart rate is 136 per minute with satisfactory characteristics. Uterine contractions are occurring every 3 minutes and lasts 30-35 seconds. Vaginally: uterine cervix dilatation is 6 cm. The amniotic sac is absent. Fetal head in the 0 station. Face line is in the right oblique size. Chin is located anteriorly. What is the management of labor?
     1. Cesarean section
     2. Classic manual aid
     3. \*Vaginal delivery
     4. Tsovianov I
     5. Tsovianov II
147. Primipara N., 25 years old. Delivery at term. Initiation of labor was 8 hours ago. The amniotic sac is ruptured. Pelvic sizes: 25,28,31,20. Fetal heart rate is 136 per minute with satisfactory characteristics. Uterine contractions are occurring every 3 minutes and lasts 30-35 seconds. Vaginal results: the uterine cervix dilatation is 10 sm. The amniotic sac is absent. Fetal head is in -1 station. Face line is in the right oblique size. Chin is located posteriorly. What is the diagnosis?
     1. Longitudinal lie, vertex presentation. I position, posterior visus.
     2. Longitudinal lie, face presentation. I position, posterior visus.
     3. \*Longitudinal lie, face presentation. II position, anterior visus.
     4. Longitudinal lie, face presentation. I position, anterior visus.
     5. Longitudinal lie, sinciput vertex presentation. I position, posterior visus
148. Primipara N., 25 years old. Delivery at term. Initiation of labor was 8 hours ago. The amniotic sac is ruptured. Pelvic sizes: 25,28,31,20. Fetal heart rate is 136 per minute with satisfactory characteristics. Uterine contractions are occurring every 3 minutes and lasts 30-35 seconds. Vaginal results: the uterine cervix dilatation is 10 sm. The amniotic sac is absent. Fetal head is in -1 station. Face line is in the right oblique size. Chin is located posteriorly. What is the management of labor?
     1. \*Cesarean section
     2. Classic manual aid
     3. Vaginal delivery
     4. Tsovianov I
     5. Tsovianov II
149. M., 28 years old, para 2. Full term of pregnancy. Initiation of labor was 8 hours ago. The membranes ruptured 20 minutes ago. Pelvic sizes: 25,28,31,20 cm. Fetal heart rate is 132 per minute with satisfactory characteristics. Per vaginum: the cervix is completely dilated. The amniotic sac is absent. Fetal head is in outlet plane of pelvic. The chin is palpated under the symphysis. Diagnosis?
     1. Labor 2, at term, 1 period of labor. Longitudinal lie, face presentation, anterior visus.
     2. Labor 2, at term, 1 period of labor. Longitudinal lie, vertex presentation, anterior visus.
     3. Labor 2, at term, 1 period of labor. Longitudinal lie, sinciput vertex presentation, anterior visus.
     4. Labor 2, at term, 1 period of labor. Longitudinal lie, brow presentetion, posterior visus.
     5. \*Labor 2, at term, 2 period of labor. Longitudinal lie, face presentation, posterior visus.
150. M., 28 years old, para 2. Full term of pregnancy. Initiation of labor was 8 hours ago. The membranes ruptured 20 minutes ago. Pelvic sizes: 25,28,31,20 cm. Fetal heart rate is 132 per minute with satisfactory characteristics. Per vaginum: the cervix is completely dilated. The amniotic sac is absent. Fetal head is in outlet plane of pelvic. The chin is palpated under the symphysis. What is the moment of labor biomechanism?
     1. \*Flexion of the fetal head
     2. Extension of the felt head
     3. Additional flexion of the fetal head
     4. Extension of the fetal head
     5. Internal rotation of the fetal head
151. N., 28 eyars old, primapara. Full term of pregnancy. The labor started 8 hours ago. The membranes ruptured 15 minutes ago. Pelvic sizes: 23,25,29,18 cm. Fetal head rate 140 per minute with satisfactory characteristics. Per vaginum: the uterine cervix dilatation is 5 cm. The amniotic sac is absent. One fetal foot is palpated in the vagina. Buttocks are in the pelvic inlet. Which type of breech presentation is presented?
     1. Complete breech
     2. \*Incomplete foot-ling
     3. Frank breech
     4. Complete foot-ling
     5. Incomplete knee-ling
152. M., 28 years old, para 2. Full term of pregnancy. Initiation of labor was 8 hours ago. The membranes ruptured 20 minutes ago. Pelvic sizes: 25,28,31,20 cm. Fetal heart rate is 132 per minute with satisfactory characteristics. Per vaginum: the cervix is completely dilated. The amniotic sac is absent. Fetal head is in outlet plane of pelvic. The chin is palpated under the symphysis. Managemant of labor?
     1. Tsovianov II
     2. \*Normal vaginal delivery
     3. Leopold care
     4. Cesarean section
     5. Tsovianov I
153. Primipara N., 19 years old. Delivery at term. The labor started 7 hours ago. The membranes are intact. Pelvic sizes: 25,28,31,20 cm. Fetal heart rate 140 per minute with satisfactory characteristics. Uterine contractions are occurring every 3-4 minutes. Per vaginum: the uterine cervix dilatation is 7 cm. The amniotic sac is present. Fetal head is fixated to the pelvic inlet. Frontal suture is in the left oblique size. Large fontanel, orbital ridges, eyes, and root of the nose are palpated. The nose and mouth can not be palpable. The large fontanel is under the symphysis. Diagnosis?
     1. \*Labour 1, at term 1 stage of labour. Longitudinal lie, brow presentation, left sided, posterior.
     2. Labour 1, at term 2 stage of labour. Longitudinal lie, face presentation, right sided, posterior.
     3. Labour 1, at term 1 stage of labour. Longitudinal lie, vertex presentation, left sided, posterior.
     4. Labour 1, at term 2 stage of labour. Longitudinal lie, brow presentation, right sided, posterior.
     5. Labour 1, at term 2 stage of labour. Longitudinal lie, brow presentation, right sided, anterior
154. Primipara N., 19 years old. Delivery at term. The labor started 7 hours ago. The membranes are intact. Pelvic sizes: 25,28,31,20 cm. Fetal heart rate 140 per minute with satisfactory characteristics. Uterine contractions are occurring every 3-4 minutes. Per vaginum: the uterine cervix dilatation is 7 cm. The amniotic sac is present. Fetal head is fixated to the pelvic inlet. Frontal suture is in the right oblique size. Large fontanel, orbital ridges, eyes, and root of the nose are palpated. The nose and mouth can not be palpable. The large fontanel is under the symphysis. Diagnosis?
     1. \*Labour 1, at term 1 stage of labour. Longitudinal lie, brow presentation, right sided, posterior.
     2. Labour 1, at term 2 stage of labour. Longitudinal lie, face presentation, right sided, posterior.
     3. Labour 1, at term 1 stage of labour. Longitudinal lie, vertex presentation, left sided, posterior.
     4. Labour 1, at term 2 stage of labour. Longitudinal lie, brow presentation, left sided, posterior.
     5. Labour 1, at term 2 stage of labour. Longitudinal lie, brow presentation, right sided, anterior
155. Primipara N., 19 years old. Delivery at term. The labor started 7 hours ago. The membranes are intact. Pelvic sizes: 25,28,31,20 cm. Fetal heart rate 140 per minute with satisfactory characteristics. Uterine contractions are occurring every 3-4 minutes. Per vaginum: the uterine cervix dilatation is 7 cm. The amniotic sac is present. Fetal head is fixated to the pelvic inlet. Frontal suture is in the left oblique size. Large fontanel, orbital ridges, eyes, and root of the nose are palpated. The nose and mouth can not be palpable. The large fontanel is under the symphysis. What is the best management of labor?
     1. \*Cesarean section
     2. Tsovianov I
     3. Tsovianov II
     4. Normal vaginal delivery
     5. Leopold care
156. Primipara N., 19 years old. Delivery at term. The labor started 7 hours ago. The membranes are intact. Pelvic sizes: 25,28,31,20 cm. Fetal heart rate 140 per minute with satisfactory characteristics. Uterine contractions are occurring every 3-4 minutes. Per vaginum: the uterine cervix dilatation is 7 cm. The amniotic sac is present. Fetal head is fixated to the pelvic inlet. Frontal suture is in the right oblique size. Large fontanel, orbital ridges, eyes, and root of the nose are palpated. The nose and mouth can not be palpable. The large fontanel is under the symphysis. What is the best management of labor?
     1. \*Cesarean section
     2. Tsovianov I
     3. Tsovianov II
     4. Normal vaginal delivery
     5. Leopold care
157. Primipara N., 22 years old. Delivery at term. The labor started 3 hours ago. The membranes are intact. Pelvic sizes: 21,24,27,16 cm. Fetal heart rate 140 per minute with satisfactory characteristics. Uterine contractions occur every 10-12 minutes. Per vaginum: the uterine cervix dilatation is 3 cm. The amniotic sac is present. Fetal head fixed to the inlet of pelvis. Sagittal suture is in the left oblique size. Small and large fontanels are palpated. The large fontanel is under the symphysis. Diagnosis?
     1. Longitudinal lie, the deflexed vertex presentation, left sided, posterior. General contracted pelvis of the I degree.
     2. \*Longitudinal lie, the deflexed vertex presentation, left sided, posterior. General contracted pelvis of the III degree.
     3. Longitudinal lie, the deflexed vertex presentation, left sided, posterior. General contracted pelvis of the IV degree.
     4. Longitudinal lie, the deflexed vertex presentation, left sided, posterior.
     5. Longitudinal lie, the deflexed vertex presentation, left sided, posterior. General contracted pelvis of the II degree.
158. Primipara N., 22 years old. Delivery at term. The labor started 3 hours ago. The membranes are intact. Pelvic sizes: 21,24,27,16 cm. Fetal heart rate 140 per minute with satisfactory characteristics. Uterine contractions occur every 10-12 minutes. Per vaginum: the uterine cervix dilatation is 3 cm. The amniotic sac is present. Fetal head fixed to the inlet of pelvis. Sagittal suture is in the left oblique size. Small and large fontanels are palpated. The large fontanel is under the symphysis. Management of labor?
     1. \*Cesarean section
     2. Tsovianov I
     3. Tsovianov II
     4. Normal vaginal delivery
     5. Leopold care
159. Primipara N., 22 years old. Delivery at term. The labor started 3 hours ago. The membranes are intact. Pelvic sizes: 21,24,27,16 cm. Fetal heart rate 140 per minute with satisfactory characteristics. Uterine contractions occur every 10-12 minutes. Per vaginum: the uterine cervix dilatation is 3 cm. The amniotic sac is present. Fetal head fixed to the inlet of pelvis. Sagittal suture is in the right oblique size. Small and large fontanels are palpated. The large fontanel is under the symphysis. Diagnosis?
     1. Longitudinal lie, the deflexed vertex presentation, right sided, posterior. General contracted pelvis of the I degree.
     2. Longitudinal lie, the deflexed vertex presentation, left sided, posterior. General contracted pelvis of the III degree.
     3. Longitudinal lie, the deflexed vertex presentation, left sided, posterior. General contracted pelvis of the IV degree.
     4. Longitudinal lie, the deflexed vertex presentation, left sided, posterior.
     5. \*Longitudinal lie, the deflexed vertex presentation, right sided, posterior. General contracted pelvis of the II degree.
160. Primipara N., 22 years old. Delivery at term. The labor started 3 hours ago. The membranes are intact. Pelvic sizes: 21,24,27,16 cm. Fetal heart rate 140 per minute with satisfactory characteristics. Uterine contractions occur every 10-12 minutes. Per vaginum: the uterine cervix dilatation is 3 cm. The amniotic sac is present. Fetal head fixed to the inlet of pelvis. Sagittal suture is in the right oblique size. Small and large fontanels are palpated. The large fontanel is under the symphysis. Management of labor?
     1. \*Cesarean section
     2. Tsovianov I
     3. Tsovianov II
     4. Normal vaginal delivery
     5. Leopold care
161. Primapara R., 21 eyars old, primapara. Full term of pregnancy. The labor started 8 hours ago. The membranes ruptured 15 minutes ago. Pelvic sizes: 25,28,31,20 cm. Fetal head rate 140 per minute with satisfactory characteristics. Per vaginum: the cervix is dilated to 5 cm. The amniotic sac is absent. Fetal head is palpated in plane of pelvic inlet. Which stage of labor?
     1. Third
     2. Second
     3. Latent stage of first
     4. \*Active stage of first
     5. Fourth
162. L., 27 eyars old, primapara. Full term of pregnancy. The labor started 9 hours ago. The membranes ruptured 15 minutes ago. Pelvic sizes: 25,28,31,20 cm. Fetal head rate 140 per minute with satisfactory characteristics. Per vaginum: the cervix is dilated to 5 cm. The amniotic sac is absent. Fetal buttocks are palpated in outlet plane of pelvic. Bitrochanter diameter is in the anteroposteror diameter of pelvic outlet. Which type of breech presentation is present?
     1. \*Frank breech presentation
     2. Incomplete footling presentation.
     3. Complete footling presentation.
     4. Complete breech presentation
     5. Incomplete knee-ling presentation
163. L., 27 eyars old, primapara. Full term of pregnancy. The labor started 9 hours ago. The membranes ruptured 15 minutes ago. Pelvic sizes: 25,28,31,20 cm. Fetal head rate 140 per minute with satisfactory characteristics. Per vaginum: the cervix is dilated to 5 cm. The amniotic sac is absent. Fetal buttocks are palpated in outlet plane of pelvic. Bitrochanter diameter is in the anteroposteror diameter of pelvic outlet.
     1. The manual aid by Tsovyanov II
     2. \*The manual aid by Tsovyanov II
     3. Cesarean section
     4. Classic manual aid
     5. Michaelis’ care
164. Primipara F., 25 years old. Pregnancy at term. The labor started 6 hours ago. The membranes ruptured one hour ago. Pelvic sizes: 23,25,29,18 cm. Fetal head rate 140 per minute with satisfactory characteristics. Uterine contractions occur every 7-8 minutes. Per vaginum: the uterine cervix dilatation is 2 cm. The amniotic sac is absent. One fetal foot is palpated in the vagina. Buttocks are in the pelvic inlet. Which stage of labor?
     1. \*Latent stage of first stage
     2. Active stage of first stage
     3. Second stage
     4. Third
     5. Fourth
165. Primipara F., 25 years old. Pregnancy at term. The labor started 6 hours ago. The membranes ruptured 1 hour ago. Pelvic sizes: 23,25,29,18 cm. Fetal head rate 140 per minute with satisfactory characteristics. Uterine contractions occur every 7-8 minutes. Per vaginum: the uterine cervix dilatation is 2 cm. The amniotic sac is absent. One fetal foot is palpated in the vagina. Buttocks are in the pelvic inlet. Which type of presentation is present?
     1. Frank breech
     2. \*Incomplete footling
     3. Complete footling
     4. Complete breech presentation
     5. Incomplete knee-ling presentation
166. Primapara 30 years old. Pregnancy at term. The labor started 6 hours ago. The membranes ruptured 1 hour ago. Pelvic sizes: 23,25,29,18 cm. Fetal head rate 140 per minute with satisfactory characteristics. Uterine contractions occur every 7-8 minutes. Per vaginum: the uterine cervix dilatation is 5 cm. The amniotic sac is absent. One fetal foot is palpated in the vagina. What is the best management of labor?
     1. The manual aid by Tsovyanov II
     2. The manual aid by Tsovyanov I
     3. \*Cesarean section
     4. Classic manual aid
     5. Michaelis care
167. Primipara M., 23 years old. Pregnancy at term. The labor started 4 hours ago. The membranes ruptured 1 hour ago. Pelvic sizes: 25,28,10,20 cm. Fetal head rate 140 per minute with satisfactory characteristics. Uterine contractions occur every 4-5 minutes. Per vaginum: the uterine cervix dilatation is 4 cm. The amniotic sac is absent. Fetal feet are presented. Buttocks are in the pelvic inlet. Diagnosis?
     1. Frank breech
     2. Incomplete footling
     3. \*Complete footling
     4. Complete breech presentation
     5. Incomplete knee-ling presentation
168. Primipara M., 23 years old. Pregnancy at term. The labor started 4 hours ago. The membranes ruptured 1 hour ago. Pelvic sizes: 25,28,10,20 cm. Fetal head rate 140 per minute with satisfactory characteristics. Uterine contractions occur every 4-5 minutes. Per vaginum: the uterine cervix dilatation is 4 cm. The amniotic sac is absent. Fetal feet are presented. Buttocks are in the pelvic inlet. Management?
     1. The manual aid by Tsovyanov II
     2. The manual aid by Tsovyanov I
     3. \*Cesarean section
     4. Classic manual aid
     5. Michaelis care
169. Primipara M., 23 years old. Pregnancy at term. The labor started 4 hours ago. The membranes ruptured 1 hour ago. Pelvic sizes: 25,28,10,20 cm. Fetal head rate 140 per minute with satisfactory characteristics. Uterine contractions occur every 2-3 minutes. Per vaginum: the uterine cervix dilatation is 10cm. The amniotic sac is absent. Fetal feet are presented. Buttocks are in the mid pelvis. Management?
     1. \*The manual aid by Tsovyanov II
     2. The manual aid by Tsovyanov I
     3. Cesarean section
     4. Classic manual aid
     5. Michaelis care
170. M., 37 eyars old, multimapara. Full term of pregnancy. The labor started 7 hours ago. The membranes are intact. Probable fetal weght is 4200. Pelvic sizes: 25,28,31,20 cm. Fetal head rate 140 per minute with satisfactory characteristics. Per vaginum: the cervix is dilated to 5 cm. Fetal buttocks are palpated in plane of pelvic inlet. Which type of breech presentation is present?
     1. \*Frank breech presentation
     2. Incomplete footling presentation.
     3. Complete footling presentation.
     4. Complete breech presentation
     5. Incomplete knee-ling presentation
171. M., 37 eyars old, multimapara. Full term of pregnancy. The labor started 7 hours ago. The membranes are intact. Probable fetal weght is 4200. Pelvic sizes: 25,28,31,20 cm. Fetal head rate 140 per minute with satisfactory characteristics. Per vaginum: the cervix is dilated to 5 cm. Fetal buttocks are palpated in plane of pelvic inlet. Management?
     1. The manual aid by Tsovyanov II
     2. The manual aid by Tsovyanov I
     3. \*Cesarean section
     4. Classic manual aid
     5. Michaelis care
172. A., 22 eyars old, primapara. Full term of pregnancy. The labor started 12 hours ago. The membranes ruptured 15 minutes ago. Pelvic sizes: 25,28,31,20 cm. Fetal head rate 140 per minute with satisfactory characteristics. Per vaginum: the cervix is completely dilated. The amniotic sac is absent. Fetal buttocks and fetal feet are palpated in the 0 station. Bitrochanter diameter is in the oblique diameter of pelvic inlet. Diagnosis?
     1. Frank breech presentation
     2. Incomplete footling presentation.
     3. Complete footling presentation.
     4. \*Complete breech presentation
     5. Incomplete knee-ling presentation
173. A., 22 eyars old, primapara. Full term of pregnancy. The labor started 12 hours ago. The membranes ruptured 15 minutes ago. Pelvic sizes: 25,28,31,20 cm. Fetal head rate 140 per minute with satisfactory characteristics. Per vaginum: the cervix is completely dilated. The amniotic sac is absent. Fetal buttocks and fetal feet are palpated in the 0 station. Bitrochanter diameter is in the oblique diameter of pelvic inlet.Management?
     1. The manual aid by Tsovyanov II
     2. The manual aid by Tsovyanov I
     3. Cesarean section
     4. \*Classic manual aid
     5. Michaelis care
174. A., 22 eyars old, primapara. Full term of pregnancy. The labor started 12 hours ago. The membranes ruptured 15 minutes ago. Pelvic sizes: 25,28,31,20 cm. Fetal head rate 140 per minute with satisfactory characteristics. Per vaginum: the cervix is dilated to 6 cm. The amniotic sac is absent. Fetal knees are palpated in the -1station. Diagnosis?
     1. Frank breech presentation
     2. Incomplete footling presentation.
     3. \*Complete footling presentation.
     4. Complete breech presentation
     5. Complete knee-ling presentation
175. A., 22 eyars old, primapara. Full term of pregnancy. The labor started 12 hours ago. The membranes ruptured 15 minutes ago. Pelvic sizes: 25,28,31,20 cm. Fetal head rate 140 per minute with satisfactory characteristics. Per vaginum: the cervix is dilated to 6 cm. The amniotic sac is absent. Fetal knees are palpated in the -1station.Management?
     1. The manual aid by Tsovyanov II
     2. The manual aid by Tsovyanov I
     3. \*Cesarean section
     4. Classic manual aid
     5. Michaelis care
176. Primipara N., 22 years old. Delivery at term. The labor started 6 hours ago. The membranes are intact. Pelvic sizes: 21,24,27,16 cm. Fetal heart rate 100 per minute with satisfactory characteristics. Uterine contractions occurr every 10-12 minutes. Per vaginum: the uterine cervix dilatation is 3 cm. The amniotic sac is present. Fetal head fixed to the inlet of pelvis. Sagittal suture is in the left oblique size. Small and large fontanels are palpated. The large fontanel is under the symphysis. Management
     1. The manual aid by Tsovyanov II
     2. The manual aid by Tsovyanov I
     3. \*Cesarean section
     4. Classic manual aid
     5. Michaelis care
177. Primipara N., 22 years old. Delivery at term. The labor started 6 hours ago. The membranes are intact. Pelvic sizes: 21,24,27,16 cm. Probable fetal weight 4300g. Fetal heart rate 100 per minute with satisfactory characteristics. Uterine contractions occurr every 10-12 minutes. Per vaginum: the uterine cervix dilatation is 4 cm. The amniotic sac is present. Fetal head fixed to the inlet of pelvis. Sagittal suture is in the left oblique size. Small and large fontanels are palpated. The large fontanel is under the symphysis. Management of labor.
     1. The manual aid by Tsovyanov II
     2. The manual aid by Tsovyanov I
     3. \*Cesarean section
     4. Classic manual aid
     5. Michaelis care
178. Primipara N., 22 years old. Delivery at term. The labor started 6 hours ago. The membranes are intact. Pelvic sizes: 21,24,27,16 cm. Probable fetal weight 4300g. Fetal heart rate 100 per minute with satisfactory characteristics. Uterine contractions occurr every 10-12 minutes. Per vaginum: the uterine cervix dilatation is 4 cm. The amniotic sac is present. Fetal head fixed to the inlet of pelvis. Sagittal suture is in the left oblique size. Small and large fontanels are palpated. The large fontanel is under the symphysis. Choose the correct diagnosis.
     1. Longitudinal lie, brow presentation, anterior visus
     2. Longitudinal lie, sinciput vertex presentation, anterior visus
     3. \*Longitudinal lie, sinciput vertex presentation, posterior visus
     4. Longitudinal lie, face presentation, anterior visus.
     5. Longitudinal lie, face presentation, posterior visus.
179. Multipara N., 18 years old. Delivery at term. The labor started 8 hours ago. The membranes are ruptured 20 minutes ago. Pelvic sizes: 25,28,31,20 cm. Fetal heart rate 140 per minute with satisfactory characteristics. Uterine contractions are occurring every 2-3 minutes. Per vaginum: the uterine cervix dilatation is 8 cm. The amniotic sac is absent. Fetal head is fixated to the pelvic inlet. Frontal suture is in the right oblique size. Large fontanel, orbital ridges, eyes, and root of the nose are palpated. The nose and mouth can not be palpable. The large fontanel is under the symphysis. What is the management of labor?
     1. The manual aid by Tsovyanov II
     2. The manual aid by Tsovyanov I
     3. \*Cesarean section
     4. Classic manual aid
     5. Michaelis care
180. Multipara N., 18 years old. Delivery at term. The labor started 8 hours ago. The membranes are ruptured 20 minutes ago. Pelvic sizes: 25,28,31,20 cm. Fetal heart rate 140 per minute with satisfactory characteristics. Uterine contractions are occurring every 2-3 minutes. Per vaginum: the uterine cervix dilatation is 8 cm. The amniotic sac is absent. Fetal head is fixated to the pelvic inlet. Frontal suture is in the right oblique size. Large fontanel, orbital ridges, eyes, and root of the nose are palpated. The nose and mouth can not be palpable. The large fontanel is under the symphysis. Diagnosis?
     1. \*Longitudinal lie, brow presentation, anterior visus.
     2. Longitudinal lie, sinciput vertex presentation, anterior visus.
     3. Longitudinal lie, sinciput vertex presentation, posterior visus.
     4. Longitudinal lie, face presentation, anterior visus.
     5. Longitudinal lie, face presentation, posterior visus.
181. Multipara N., 18 years old. Delivery at term. The labor started 8 hours ago. The membranes are ruptured 20 minutes ago. Pelvic sizes: 25,28,31,20 cm. Fetal heart rate 140 per minute with satisfactory characteristics. Uterine contractions are occurring every 2-3 minutes. Per vaginum: the uterine cervix dilatation is 8 cm. The amniotic sac is absent. Fetal head is fixated to the pelvic inlet. Frontal suture is in the right oblique size. Large fontanel, orbital ridges, eyes, and root of the nose are palpated. The nose and mouth can not be palpable. The large fontanel is under the symphysis. Which management of labor?
     1. The manual aid by Tsovyanov II
     2. The manual aid by Tsovyanov I
     3. \*Cesarean section
     4. Classic manual aid
     5. Michaelis care
182. Primipara N., 18 years old. Delivery at term. The labor started 8 hours ago. The membranes ruptured 1 hour ago. Pelvic sizes: 25,28,31,20 cm. Fetal heart rate 150 per minute with satisfactory characteristics. Uterine contractions occurr every 3-4 minutes. Per vaginum: the uterine cervix dilatation is 7 cm. The amniotic sac is absent. Fetal head is fixated to the pelvic inlet. Sagittal suture is in the left oblique size. Small and large fontanels are palpated. The large fontanel is under the symphysis. What is the management of labor?
     1. The manual aid by Tsovyanov II
     2. The manual aid by Tsovyanov I
     3. Cesarean section
     4. Classic manual aid
     5. \*Vaginal delivery
183. S., 25 years old, nullipara. Full term of pregnancy. Initiation of labor was 5 hours ago. The membranes are intact. Pelvic sizes: 25,28,31,20 cm. Fetal heart rate is 140 per minute with satisfactory characteristics. Per vaginum: the cervix is 5 cm dilated. The amniotic sac is persent. Fetal head is in the plane of inlet. Face line is in the left oblique size, the chin is palpated near sacral region of the symphysis. What is the management of labor?
     1. The manual aid by Tsovyanov II
     2. The manual aid by Tsovyanov I
     3. \*Cesarean section
     4. Classic manual aid
     5. Vaginal delivery
184. M., 22 years old, nullipara. Full term of pregnancy. Initiation of labor was 4 hours ago. The membranes ruptured are intact. Pelvic sizes: 25,28,31,20 cm. Fetal heart rate is 140 per minute with satisfactory characteristics. Per vaginum: the cervix is 4 cm dilated. The amniotic sac is persent. Fetal head is in the plane of inlet. Face line is in the right oblique size, the chin is palpated near sacral region of the symphysis. What is the management of labor?
     1. The manual aid by Tsovyanov II
     2. The manual aid by Tsovyanov I
     3. \*Cesarean section
     4. Classic manual aid
     5. Vaginal delivery
185. M., 25 years old, multipara. Full term of pregnancy. Initiation of labor was 7 hours ago. The membranes ruptured 40 minutes ago. Pelvic sizes: 25,28,31,20 cm. Fetal heart rate is 132 per minute with satisfactory characteristics. Per vaginum: the cervix is completely dilated. The amniotic sac is absent. Fetal head is in the plane of the greatest diameter of the true pelvis. The face line is in the right oblique size. The chin is palpated under the symphysis. What is the moment of labor biomechanism?
     1. First
     2. \*Second
     3. Third
     4. Fourth
     5. Fifth
186. M., 25 years old, multipara. Full term of pregnancy. Initiation of labor was 7 hours ago. The membranes ruptured 40 minutes ago. Pelvic sizes: 25,28,31,20 cm. Fetal heart rate is 132 per minute with satisfactory characteristics. Per vaginum: the cervix is completely dilated. The amniotic sac is absent. Fetal head is in the plane of the greatest diameter of the true pelvis. The face line is in the right oblique size. The chin is palpated under the symphysis. What is the management of labor?
     1. The manual aid by Tsovyanov II
     2. The manual aid by Tsovyanov I
     3. Cesarean section
     4. Classic manual aid
     5. \*Vaginal delivery
187. Primipara N., 25 years old. Delivery at term. The labor started 6 hours ago. The membranes ruptured 1 hour ago. Pelvic sizes: 25,28,31,20 cm. Fetal heart rate 140 per minute with satisfactory characteristics. Uterine contractions occur every 7-8 minutes. Per vaginum: the uterine cervix dilatation is 6 cm. The amniotic sac is absent. Fetal head fixed to the inlet of pelvis. Sagittal suture is in the right oblique size. Small fontanel is palpated. What is the management of labor?
     1. The manual aid by Tsovyanov II
     2. The manual aid by Tsovyanov I
     3. Cesarean section
     4. Classic manual aid
     5. \*Vaginal delivery
188. Primipara N., 25 years old. Delivery at term. The labor started 6 hours ago. The membranes ruptured 1 hour ago. Pelvic sizes: 25,28,31,20 cm. Fetal heart rate 140 per minute with satisfactory characteristics. Uterine contractions occur every 7-8 minutes. Per vaginum: the uterine cervix dilatation is 6 cm. The amniotic sac is absent. Fetal head fixed to the inlet of pelvis. Sagittal suture is in the right oblique size. Small and large fontanels are palpated. The large fontanel is under the symphysis. Diagnosis?
     1. Longitudinal lie, brow presentation, anterior visus
     2. Longitudinal lie, sinciput vertex presentation, anterior visus.
     3. \*Longitudinal lie, sinciput vertex presentation, posterior visus.
     4. Longitudinal lie, face presentation, anterior visus.
     5. Longitudinal lie, face presentation, posterior visus.
189. M., 28 years old, para 2. Full term of pregnancy. Initiation of labor was 8 hours ago. The membranes ruptured 20 minutes ago. Pelvic sizes: 25,28,31,20 cm. Fetal heart rate is 132 per minute with satisfactory characteristics. Per vaginum: the cervix is completely dilated. The amniotic sac is absent. Fetal head is in outlet plane of pelvic. The chin is palpated under the symphysis. What is the management?
     1. The manual aid by Tsovyanov II
     2. The manual aid by Tsovyanov I
     3. Cesarean section
     4. Classic manual aid
     5. \*Vaginal delivery
190. M., 28 years old, para 2. Full term of pregnancy. Initiation of labor was 8 hours ago. The membranes ruptured 20 minutes ago. Pelvic sizes: 25,28,31,20 cm. Fetal heart rate is 132 per minute with satisfactory characteristics. Per vaginum: the cervix is completely dilated. Fetal head is in outlet plane of pelvic. The chin is palpated under the symphysis. Which moment of biomechanism?
     1. First
     2. Second
     3. \*Third
     4. Fourth
     5. Fifth
191. M., 28 years old, para 2. Full term of pregnancy. Initiation of labor was 8 hours ago. The membranes ruptured 20 minutes ago. Pelvic sizes: 25,28,31,20 cm. Fetal heart rate is 132 per minute with satisfactory characteristics. Per vaginum: the cervix is completely dilated. The amniotic sac is absent. Fetal head is in outlet plane of pelvic. The chin is palpated under the symphysis. Diagnosis?
     1. Longitudinal lie, brow presentation, anterior visus
     2. Longitudinal lie, sinciput vertex presentation, anterior visus.
     3. Longitudinal lie, sinciput vertex presentation, posterior visus.
     4. Longitudinal lie, face presentation, anterior visus.
     5. \*Longitudinal lie, face presentation, posterior visus.
192. 30-years-old women, primapara at 39 weeks of gestation arrives in active labor. Uterine contractions occur every 3-4 minutes. Per vaginum: the uterine cervix dilatation is 6 cm. The amniotic sac is intact. Fetal buttocks are presented. What is the management of labor?
     1. The manual aid by Tsovyanov II
     2. \*The manual aid by Tsovyanov I
     3. Cesarean section
     4. Classic manual aid
     5. Shreder’ care
193. 33-years-old women, primapara at 40 weeks of gestation arrives in active labor. Uterine contractions occur every 4 - minutes. Per vaginum: the uterine cervix dilatation is 5 cm. The amniotic sac is intact. Fetal foot are presented. What is the management of labor?
     1. The manual aid by Tsovyanov II
     2. The manual aid by Tsovyanov I
     3. \*Cesarean section
     4. Classic manual aid
     5. Shreder’ care
194. 38-years-old woman at term arrives in active labor, full dilated with a presenting part - buttocks at the pelvic floor. Probable fetal weight of the fetus is 3200g. Artificial rupture of membranes is performed. Contractions are strong, occurring every 3 minutes. The fetal heart rate is 136 beat in minute. Which would be the best management?
     1. The manual aid by Tsovyanov II
     2. \*The manual aid by Tsovyanov I
     3. Cesarean section
     4. Classic manual aid
     5. Shreder’ care
195. 32-years-old women, primapara at 39 weeks of gestation arrives in active labor. Uterine contractions occur every 3-4 minutes. Per vaginum: the uterine cervix dilatation is 7 cm. The amniotic sac is intact. Fetal knees are presented. What is the management of labor?
     1. The manual aid by Tsovyanov II
     2. The manual aid by Tsovyanov I
     3. \*Cesarean section
     4. Classic manual aid
     5. Shreder’ care
196. F., 28 years old, para 2. Full term of pregnancy. Initiation of labor was 6 hours ago. The membranes ruptured 30 minutes ago. Pelvic sizes: 25, 28, 31, 20 cm. Fetal heart rate is 132 per minute with satisfactory characteristics. Per vaginum: the cervix is completely dilated. The amniotic sac is absent. Fetal head is in outlet plane of pelvic. The chin is palpated under the symphysis. Which circumference of the fetal head is passed thought the birth canal?
     1. \*Hyobregmaticus
     2. Suboccipitofrontalis
     3. Frontooccipitalis
     4. Mentooccipitalis
     5. Suboccipitofrontalis
197. M., 22 years old. According to gestational age 40 weeks of gestation. Complaints of regular uterine contractions for 5 hours. Fetal heart rate is 140 per minute with satisfactory characteristics. Per vaginum: the cervix is dilated for 4 cm. The amniotic sac is presented. Fetal head is in plane of pelvic inlet. Sagital suture and small fontanel is palpated. Indicate stage of labor.
     1. \*Active phase of cervical stage
     2. Latent phase of cervical stage
     3. Passive stage
     4. Active phase of pelvic stage
     5. Latent phase of pelvic stage
198. M., 22 years old. According to gestational age 40 weeks of gestation. Complaints of regular uterine contractions for 3 hours. Fetal heart rate is 140 per minute with satisfactory characteristics. Per vaginum: the cervix is dilated for 2 cm. The amniotic sac is presented. Fetal head is in plane of pelvic inlet. Sagital suture and small fontanel is palpated. Indicate stage of labor.
     1. Active phase of cervical stage
     2. \*Latent phase of cervical stage
     3. Passive stage
     4. Active phase of pelvic stage
     5. Latent phase of pelvic stage
199. Just after delivery of placenta in 60 kg woman 35years old woman after delivery 4000g boy 400ml blood appeared from the vagina. After uterine palpation through abdominal wall softness of uterus was revealed. What is the physiological blood loss for this patient?
     1. 250 ml
     2. \*300 ml
     3. 600ml
     4. 400 ml
     5. 200 ml
200. Just after delivery of placenta in 80 kg woman 40 years old woman after delivery 4200g boy 400ml blood appeared from the vagina. What is the physiological blood loss for this patient?
     1. 250 ml
     2. 300 ml
     3. 600ml
     4. \*400 ml
     5. 200 ml
201. The pregnant woman of 29 years old has been suffering from urolithiasis, secondary-chronic pyelonephritis during 8 years. What group of risk that patient belong to?
     1. \*Threat of gestosis development
     2. Threat of traumatism
     3. Threat of bleeding
     4. Threat of hypotonic uterine contractions
     5. Threat of isosensibilisation
202. Primapara C., 35 years, term of pregnancy 39-40 weeks, appealed with complaints about nausea, pain in epigastrium, edema on lower extremities. Pregnancy 1st, was complicated by early gestosis, with 26 weeks the edema on lower extremities appeared, did not treat oneself. A week ago the edema were become generalized, nausea appeared. Objective: on the lower extremities and abdominal wall edema present. BP – 180/110 mm Hg, 160/100 mm Hg, pulse – 90 in 1 min. Position of the fetus is longitudinal, head presentation. Fetal heart rate is 142 in 1min, clear, rhythmic. The sizes of pelvis are normal, uterine contractions are absent. The expected weight of the fetus – 4000 g. The uterine cervix is shortened, opening 2 cm. Amniotic membrane is intact. A head is above the pelvic inlet. Promontorium is not palpated. Tactic?
     1. \*Cesarean section
     2. Conducting of preparation to labor
     3. Medical treatment of gestosis, examination in a dynamics
     4. Immediately amniotomy, stimulation of uterine contractions
     5. Introduction of spasmolytic
203. Patient 18 years entered maternity department at the beginning of the ІІ stage of labor with complaints about headache, visual disoders, pain in epigastrium. The attack of convulsions with the lost of consciousness happened 3 minutes ago. The patient’ condition is severe. A skin is pale, edema of the face, extremities, anterior abdominal wall. BP – 180/130 mm Hg, 150/110 mm Hg, heart tones at auscultation are arhythmic. Position of the fetus is longitudinal, head presentation, fetal head is in the cavity of small pelvis. Fetal heart rate is 176 in 1min. Vaginal examination: opening of uterine cervix is complete. Amniotic membrane is absent. Head in narrow part of small pelvis. Promontorium is not palpated. Doctor’ tactic?
     1. \*Immediate anesthesia and applying of obstetric forceps
     2. Cesarean section
     3. Stimulation of uterine contractions
     4. Fetal destroying operation
     5. Perineotomy, vacuum-extraction of fetus
204. A woman 24 years is delivered with complaints about headache, appearance of “spots” before eyes, moderate bloody excretions from the vagina. Objectively: BP-200/130 and 200/130 mm Hg, pulse 120 in 1 min, general edema. Fetal heart rate is not listened to. Uterine fundus on 3 transversal fingers above umbilicus, uterus in a condition of hypertonus. A woman considers that at her 32 weeks pregnancies, did not visit female dispensary, not inspected. Tactic of the doctor ?
     1. Medical treatment in the department of intensive therapy
     2. Vaginal labor after previous preparation
     3. Peridural anesthesia
     4. \*Cesarean section immediately.
     5. Conultation of surgeon and internist
205. Primapara admitted to the maternity hospital with complaints about headache, pain in epigastral area, somnolence, general edema. BP - 180/120 mm Hg, position of the fetus is longitudinal, cephalic presentation, Fetal heart rate is - 130 in 1 min, rhythmic. In urine protein is present – 3,3 g/l. Diagnosis?
     1. \*Preeclampsia severe degree
     2. Preeclamsia mild degree
     3. Eclampsia
     4. Hypertensive crizis
     5. Edema of pregnant
206. Pregnant 27 years, in the term of pregnancy 38-39 weeks, delivered in a maternity hospital with complaints about abdomen pain, bloody excretions from vagina. Pregnancy ran on a background of late gestosis, but patient did not treat. The condition is severe, pulse - 90 in 1 min, BP - 110/70 mm Hg. The uterus is tense, painful. Fetal heart rate is 100 in 1 min, arhytmical. At ultrasound the abruptio placentae is set. What must be conducted for prophylaxis of this complication?
     1. \*Medical treatment of late gestosis
     2. Exception of the physical activity
     3. Setting of tocoferol acetate
     4. Setting of gestagen
     5. Setting of estrogen
207. At pregnant 29 years the nausea, vomits, appeared on receiving rest, blinking of “spots” before eyes. BP on both hands 170/100 mm Hg, the general edema are determined. To set a correct diagnosis.
     1. eclampsia
     2. \*preeclampsia of severe degree
     3. separation of eye retina
     4. threat of hemorrhage in a brain
     5. preeclampsia mild degree
208. By the machine of first-aid in a maternity hospital in the grave condition the pregnant 42 years is delivered. Term of pregnancy is 37 weeks. Objectively: consciousness is absent. BP on both hands 180/110 mm Hg, Ps 110 in 1 min, general edema, albumen in urine 5 g/l. At the vaginal examination the structural changes of cervix are absent. What is the management?
     1. Vaginal labor
     2. \*Cesarean section
     3. The fetal destroying operation
     4. Obstetric forceps
     5. Operation of vacuum-extraction of the fetus
209. Patient 28 years with the severe edema is in a maternity hall, in the ІІ period of labor. Head of fetus is in narrow part of small pelvis. Head pains began, twinkling of “spots” before eyes, contractions of muscles of the face. BP - 170/110 mm Hg. What is tactic of conduct of labor?
     1. Cesarean section
     2. Conservative conduct of labor
     3. \*Obstetric forceps
     4. The Vacuum-extraction of the fetus
     5. Labor stimulation
210. Pregnant, complains about headache, twinkling of “spots” before eyes. Pregnancy 32 weeks. Edema of body and face. BP - 190/110 mm Hg. At boiling of urine - considerable sediment. What is the diagnosis?
     1. \*Preeclamsia severe degree
     2. Preeclampsia mild degree
     3. Hypertensive disease
     4. Eclampsia
     5. The Preclampsia moderate degree
211. Primapara appeared in female dispensary in 37 weeks of pregnancy. Complaints are not present. For the last 2 weeks the body weight increased on 2 kg. There is edema of feet. BP – 120/70 mm Hg. Protein in urine – 0,03gr/l. A diagnosis is preeclamsia mild degree. What is the medical tactic?
     1. Ambulatory medical treatment
     2. Labor at term
     3. \*Expectant management
     4. Prolongation of pregnancy
     5. Cesarean section
212. A woman in the term of pregnancy 38 weeks entered maternity hospital with complaints about headache, somnolence, general edema. BP – 180/120 mm Hg. The lie of fetus longitudinal, head presentation, fetal heart rate is 130 in 1 min, rhythmic. In the analysis of urine the level of protein is 3,3 g/l. What complication of pregnancy appear?
     1. Preeclampsia 1 degree
     2. \*Preeclampsia 3 degree
     3. Hypertensive disorder.
     4. Eclampsia.
     5. Preeclampsia 2 degree
213. Patient 28 years at the admitting to the maternity hospital complains about headache, visual disorders. Arterial pressure 200/110 mm Hg. The expressed edema of feet, anterior abdominal wall. Head of fetus in the cavity of small pelvis. Fetal heart rate is clear, rhythmic 190 in 1 min. At vaginal examination: dilation of uterine cervix is full, head of fetus in the cavity of small pelvis. What is the management of labor?
     1. \*Obstetric forceps.
     2. Cesarean section
     3. The fetal destroying operation
     4. Conservative conducting of labor with epiziotomy
     5. Stimulation of uterine contractions
214. Pregnant P. in a term of 32 weeks had the attack of eclampsia at home. Entered intensive therapy department of perinatal center. At the admitting: edema of the face and hands, BP 180/110 mm Hg, albumen in urine 0,128 g/l, cervix is closed. Intensive complex therapy is begun. What is subsequent tactic?
     1. \*Operation of cesarean section immediately.
     2. To prolong pregnancy on 1-2 weeks with medical treatment.
     3. To prolong pregnancy on 3-4 weeks with intensive medical treatment.
     4. To begin labor stimulation by intravenous introduction of oxytocin
     5. To begin labor stimulation by intravenous introduction of prostaglandin.
215. Patient O. 27 years. Pregnancy ІІ, 37-38 weeks, labor ІІ, ІІ period of labor. The attack of eclampsia began. At the vaginal examination: the head of the fetus is in pelvic cavity, sagittal suture in a direct size of pelvic outlet, small fontanella turned to pubis. Which tactic of labor?
     1. \*Obstetric forceps.
     2. To conduct labor conservative with medical treatment of gestosis
     3. Fetal destroying operation
     4. Cesarean section
     5. Vacuum-extraction of the fetus.
216. In primapara, 38 years, at pregnancy 24 weeks headache, dizziness appeared. BP – 190/100 mm Hg. Before pregnancy the BP was normal. At the examination a kidney function is normal. What is the reason of blood pressure increasing?
     1. \*Arterial hypertension of pregnant
     2. Preeclampsia
     3. Secondary arterial hypertension
     4. Distonia on a hypertensive type
     5. Chronic glomerulonephritis
217. A 32-year-old multigravida visits the clinic for a routine prenatal examination at 36 weeks' gestation. She had a prior pregnancy with pregnancy induced hypertension. The assessments during this visit include BP 140/90, Ps 80, and edema of the ankles and feet. Based on the client's past history and current assessment, what further information should the doctor obtain to determine the preeclampsia?
     1. \*Proteinuria
     2. Respiratory rate
     3. Blood glucose level
     4. Edema in lower extremities
     5. Temperature
218. 40-year-old multigravida patient was visited the doctor in the female dispensary with signs of mild preeclampsia. What will be the management of such patient?
     1. \*Expectant management
     2. Prescription of magnesium sulfate
     3. Hospitalization
     4. Prescription of hypotensive drug
     5. Nothing of the above
219. When reviewing the prenatal record of a 16-year-old primigravid client at 37 week’s gestation diagnosed with severe preeclampsia, the doctor would interpret which of the following as most indicative of the client’s diagnosis?
     1. \*Severe blurring of vision
     2. Blood pressure of 138/94 mm Hg
     3. Less than 2 g of protein in a 24-hour sample
     4. Weight gain of 0.5 lb in 1 week
     5. Edema on lower extremities
220. A 28-year-old multigravida woman at 37 weeks' gestation arrives at the emergency department with a blood pressure 160/104 mm Hg. The client, who is diagnosed with severe preeclampsia, aks the doctor, "What is the treatment for my high blood pressure?" Which of the following would the doctor identify as the primary treatment?
     1. \*Vaginal or cesarean delivery of the fetus.
     2. Administration of glucocorticoids
     3. Sedation with phenytoin
     4. Special diet
     5. Reduction of fluid retention with thiazide diuretics
221. Which of the following would the doctor identify as the priority to achieve when plan the care for a primigravida client at 38 weeks' gestation who is hospitalized with severe preeclampsia and receiving intravenous magnesium sulfate?
     1. \*Absence of any seizure activity during the first 48 hours.
     2. Sedation
     3. Decreased generalized edema within 8 hours
     4. Decreased urinary output during the first 24 hours
     5. Decreased reflex excitability within 48 hours
222. When administering intravenous magnesium sulfate as ordered for a client at 34 weeks' gestation with severe preeclampsia, the doctor would explain to the client and her family that this drug acts as which of the following?
     1. \*Central nervous system depressant
     2. Peripheral vasodilator
     3. Antihypertensive
     4. Sedative-hypnotic
     5. Antidepressant
223. Soon after admission of a primigravid client at 38 weeks' gestation with severe preeclampsia, the physician orders a continuous intravenous infusion of 5% dextrose in Ringer's solution and 4 g of magnesium sulfate . While the medication is being administered, which of the following assessment findings should the doctor report immediately?
     1. \*Respiratory rate of 12 breaths /minute
     2. Patellar reflex of+2
     3. Blood pressure of 160/88 mm Hg
     4. Urinary output exceeding intake
     5. Temperature of 36,9C
224. A 16-year-old unmarried primigravid client at 37 weeks' gestation with severe preeclampsia is in early active labor. Her mother is at the bedside. The client's blood pressure is 164/110 mm Hg. Which of the following would alert the doctor that the client may be about to experience a seizure?
     1. \*Epigastric pain
     2. Decreased contraction intensity
     3. Decreased temperature
     4. Hyporeflexia
     5. Increased urinary output
225. An obese 36-year-old multigravid client at 12 weeks' gestation has a history of chronic hypertension. She was treated with methyldopa before becoming pregnant. When counseling the client about diet during pregnancy the doctor realizes that the client needs additional instruction when she states which of the following?
     1. \*I need to reduce my salt intake per day
     2. I need to consume more fluids each day
     3. A regular diet is recommended during pregnancy
     4. I should eat more frequent meals if I get heart- burn
     5. I need to consume more fiber each day
226. The 34-years old woman on the 10-th week of gestation (the second pregnancy) is consulted by the doctor of female consultation to be taken on the dispensary record. In the previous pregnancy there took place hydramnion, the child was born with mass of the body of 4100 g. What method of investigation is necessary to use for patient’ conducting first of all?
     1. \*The test for tolerance to glucose
     2. Determination of the contents of alfa-fetoproteinum
     3. Bacteriological investigation of discharge from the vagina
     4. A cardiophonography of fetus
     5. US of the fetus
227. Woman 22 years with pregnancy 30 weeks. Complaints of pain in lower part of abdomen, more in right side, which appeared 5 hours ago, nausea, single vomit. AP 120/80 mm Hg, pulse - 90 in 1 min, rhythmic. At palpation of abdomen pain in a right hypogastric area is marked, positive symptom Schotkin-Blumberg. Uterus in normal tone. Head of the fetus is mobile above the pelvic inlet. Fetal heart rate 140 in 1 min, clear. Excretions from a vagina mucous. In the blood test: leucocytes 15x109//l. Analysis of urine without deviations from a norm. What is the most probable diagnosis?
     1. \*Appendicitis and pregnancy
     2. Threat of abortion
     3. Abruptio placentae
     4. Kidney colic and pregnancy
     5. Acute pyelonephritis
228. The pregnant appeared in female dispensary with complaints of the delay of menstruation of to 2 months, thirst, general weakness, worsening of sight. From anamnesis it is found out, that a woman with 15 years is ill on diabetes mellitus of severe form. After the conclusion of oculist of violation of sight it is connected with diabetes. Patient had two pregnancies which ended stillborn. The sugar level in the blood – 15 mmol/l. At bimanual examination: uterus increased to 7 weeks. Diagnosis: ІІІ pregnancy, 7 weeks. Diabetes mellitus I type, severe form. Diabetic retinopathia. What is the doctor’ tactic?
     1. \*Termination of pregnancy.
     2. Protective hormonal therapy.
     3. Insulin therapy.
     4. Pregnancies in the conditions of permanent doctor’ supervision.
     5. Correction of glycemia by medicines.
229. The pregnant 40 years entered in the department of pathology of pregnancy with complaints of cephalic pain, dizziness. Term of pregnancy is 25-26 weeks. In anamnesis: 3 labor, 2 abortions, 3 years is found on the ginecologist’ clinical supervision due to leyomyoma of uterus and at an internist – with hypertension IIA. At the admitting BP 200/100 mm Hg, edema on feet and anterior abdominal wall, protein in urina – 2 g/l. What is the most rational tactic of conduct of pregnant?
     1. Operation by Porro
     2. Termination of pregnancy by the operation of small cesarean section
     3. There is no correct answer
     4. Termination of pregnancy by intraamnial introduction of gramicidin
     5. \*To conduct medical treatment of hypertensive disease and qestosis
230. In the gynecological department from therapeutic the pregnant 37 years with a diagnosis hypertensive disease of 2B stage is transferred. Complains on the head pains. BP – 180/110 mm Hg. At a gynecological examination the pregnancy 10 weeks is found. Your tactic?
     1. \*Medical abortion
     2. Prolongation of pregnancy
     3. Intraamninal introduction of gramicidin.
     4. Amniotomy.
     5. Introduction of oxytocin.
231. Primapara 26 years entered maternity hospital with pregnancy of 38 weeks and complaints of profuse bloody discharge. Fetal heart rate is 100 beats per min, arhythmic. Vaginal examination was performed in operating room and revealed cervical effacement and dilation to 4 cm. Placenta tissue is palpated. Blood loss is 700ml. What is the management of this situation?
     1. \*Cesarean section
     2. Expectant management
     3. Forceps application
     4. Uterine curretage
     5. Vacuum-extraction of fetus.
232. At primapara 30 years, which has suffered of rheumatism, having the combined the mitral valve failure, insufficiency of blood circulation IIA, in term of pregnancy 37 weeks appeared suddenly: cyanosis, difficulty of breath. The moist rales in the distance are hearkened, a plenty of foamy sputum discharges at cough. BP 180/110 mm Hg, pulse 140 for a minute. Tones of heart are not listened due to the presence of the loud breathing and wheezes in lungs. Which is the diagnosis?
     1. \*Edema of lungs
     2. Heart attack
     3. Acute pneumonia
     4. Heart attack
     5. Spontaneous pneumothorax
233. Pregnant S., 38 years, appeared to female dispensary concerning of progressing desired pregnancy in a term 18-19 gestation. In anamnesis the heart disease – the opened arterial canal with a syndrome Eyzenmenger. Which method of the artificial interrupting of this pregnancy is most optimum in such term?
     1. \*Intraamnial introduction of gramicidin
     2. A small trance abdominal cesarean section
     3. Small transvaginal cesarean section
     4. Extraamnial introduction of hypertensive solution
     5. Intravenous infusion of enzaprost
234. Pregnant D. admitted to the maternity hospital with pregnancy at term and regular uterine contractions during 6 hours. This pregnancy is first, in anamnesis – heart disease – the opened arterial canal without the signs of insufficiency of circulation of blood. Fetal heart rate 136. What is the tactic of conduct of labor?
     1. \*Vaginal delivery
     2. To finish by the operation of cesarean section
     3. To apply obstetric forceps
     4. To eliminate a pushing efforts by applying of obstetric forceps
     5. To perform the fetal destroying operation
235. An expectant mother in the term of pregnancy 34 weeks after a motor-car catastrophe admitted in the maternity department. A skin is pale, a pulse a speed-up, BP 80/30 mm of Hg, stupor. Uterus with clear contours, in normal tonus, heart rate of the fetus is 164 in 1 min. The closed fracture of thigh-bone takes place. blood lost is 250 ml. What is the reason of this severe condition of pregnant?
     1. \*traumatic shock
     2. Placenta previa
     3. the placental abruptio
     4. the rupture of uterus
     5. Gestosis of pregnant
236. Pregnant, 25 weeks of pregnancy. During the last 2 months complains of a weakness, violation of taste, the promoted fragility of hair and nails. At laboratory examination: the rate of red blood cells 2,8x1012, Hb 98 g/l. What is medical treatment.
     1. \*Iron contained medicines
     2. Vitamins
     3. Transfusion of red blood cells mass
     4. Medical diet
     5. Immunostimulation
237. The pregnant, 24 years, admitted with complaints of a general weakness, stuffiness, palpitation at the physical activity. In anamnesis 2 labor, this pregnancy is third, by a term 36 weeks. Objectively skin is pale, BP 110/70 mm Hg, pl 90, rhythmic, is auscultated the sistolic murmur an apex, a liver and spleen are not increased. Laboratory examinations: Hb – 80g/l, red blood cells rate - 2,6x1012/l, reticulocytes - 5 ‰, color index - 0,8, gematocrit - 0,3, poykilocytosis, anizocytosis, iron – 9 mcmol/l. Diagnosis?
     1. \*Iron deficiency anemia
     2. mitral valve insufficiency
     3. Distonia on a hypotonic blood pressure type
     4. Hemolitic anaemia
     5. Hemoglobinopatia
238. Under the supervision in female dispensary the pregnant 9 weeks. In anamnesis 2 years ago surgical correction of mitral stenosis of rheumatic genesis. On this time the condition of pregnant is satisfactory. Indicate subsequent tactic of management of the pregnant.
     1. \*Hospitalization in 12, 30 and 36 weeks of pregnancy
     2. Obligatory hospitalization in 12, 34, 38 weeks of pregnancy
     3. Hospitalization in a 10, 28 and 34 week of pregnancy
     4. Hospitalization is case complaint presence only
     5. The supervision of doctor of female dispensary only
239. To pregnant, 25 years, with mitral vulve stenosis of the of ІІІ degree is offered to perform surgical correction of stenosis during the pregnancy. On this time there is the term of pregnancy 10 weeks. Indicate the most expedient terms of conducting of operation.
     1. Surgical correction during pregnancy is contraindicated
     2. Surgical correction of mitral stenosis is possible only to 14 weeks of pregnancy
     3. \*Surgical correction of mitral stenosis is possible at pregnancy in a term 16-30 weeks
     4. Surgical correction can be performed after 32 weeks of pregnancy
     5. At mitral stenosis there is only conservative medical treatment
240. In female dispensary the pregnant 19 years appeared with pregnancy 8 weeks. In 15 years had the rheumatic attack. It is found on the internist supervision with a diagnosis: Rheumatism, non active phase. Mitral valve insufficiency . Which tactic of doctor must be?
     1. Steroid hormones treatment
     2. To register and conduct the clinical supervision
     3. \*Hospitalisation for the complete examination for possibility of pregnancy progressing
     4. medical treatment of rheumatism
     5. heart glycosides
241. Pregnant, 26 years, has diabetes I type within 15 years. Consulted by an oculist, diagnosed angiopathy of the retinal vessels. The term of pregnancy is 36-37 weeks, pelvic presentation of fetus, tendency to macrosomia, fetoplacental insufficiency. What is the doctor’ tactic for prevention possible complications?
     1. Vaginal labor in 40 weeks
     2. Vaginal labor in 36-37 weeks
     3. Cesarean section at term pregnancy in 40 weeks
     4. \*The operation of cesarean section in a term 36-37 weeks
     5. Obstetric forceps at term pregnancy
242. Primigravida, 18 years old, came to the outpatient department because of 8 week pregnancy. Within assessment internist made diagnosis – rheumatism, nonactive phase, insufficiency of mitral valve. Your tactic?
     1. \*To prolonge pregnancy
     2. To interrupt pregnancy
     3. To continue assessment in specialized department
     4. Immediate hospitalization into pathology department
     5. Pregnant patient does not need observation
243. Pregnant patient at 32 weeks of gestation has temperature 38,9?С, feels chill, dull pain at right lumbar region, anorexia, nausea, vomiting. She had scarlatina in childhood. What pathology do you suspect?
     1. \*Acute gestational pyelonephritis
     2. Acute appendicitis
     3. flue
     4. salpingitis
     5. Amniochorionitis
244. Primigravida, 24 years old has rheumatism. After assessment together with internist, diagnosis is: pregnancy, 8 weeks, rheumatism, active phase, mitral disease with prevalence of left atrioventricular stenosis, insufficiency of blood circulation II-b stage. Your tactic?
     1. \*Abortion
     2. Surgical correction of problem with pregnancy prolongation
     3. To prolonge pregnancy with dynamic observation in outpatient department
     4. To prolonge pregnancy with following preterm delivery
     5. To prolonge pregnancy with treatment of cardiovascular insufficiency
245. Pregnant patient with hypertonic disease, I stage, at term 35 weeks of gestation, has edema of both legs and anterior abdomen wall, proteinuria – 3 g/l, BP – 170/120, headache and worth vision. Intensive care next 4 hours was useless. Your tactic?
     1. Observation
     2. to induce labour
     3. \*Immediate cesarean section
     4. to prolonge intensive treatment
     5. conservative treatment
246. To the outpatient department came female patient, 24 years old, because of 12-13 weeks pregnancy. Primigravida. 4 years ago she had tuberculosis of lungs, has been hospitalized and treated, her condition has been improved. General condition is satisfactory, no complains. Individual chart of pregnancy was filled. Your following tactic?
     1. To inform tbc dispensary
     2. \*To inform tbc dispensary and planned hospitalization 3 times with appropriate treatment
     3. Interruption of pregnancy
     4. No correct answer
     5. All answers are correct
247. Primigravida, 22 years old, came to the outpatient department with next complaints: weakness, bad appetite, hyperhidrosis, temperature - 37,5° in the evening, productive cough, feels bad last 2 weeks. During assessment – skin and visible mucous – clean, pink, normal hemodynamic signs, bubbling and dry rales over lungs. Uterus is ovoid, normotonic, longitudinal position of the fetus, cephalic presentation, heart beating is clear, rhythmic, 130/min. No edema, no vaginal discharge. Your tactic?
     1. \*hospitalization of patient to the conservative department with complete assessment and treatment
     2. Immediate cesarean section
     3. Stimulation of labour activity
     4. Hospitalization to the physiological labour department
     5. No correct answer
248. Primigravida, 24 years old, 28 weeks of pregnancy. She had scarlet fever in childhood, complicated with pyelonephritis. 2 years ago she has been treated for pyelonephritis at the hospital. At admition to the out-patient department were found – proteinuria (2,95g/l), BP – 160/90, edema of low extremities. Longitudinal fetus position, heart rate – 130/min. Your tactic?
     1. \*hospitalization of patient to the conservative department with complete assessment and treatment
     2. Immediate cesarean section
     3. Stimulation of labour activity
     4. Hospitalization to the physiological labour department
     5. No correct answer
249. 38 years old parturient woman has been taken by ambulance to the hospital. 4th pregnancy, 3rd labour. Previous pregnancy was complicated with edema and increased BP up to 150/100. Has hypertonic disease – selftreatment. She visited outpatient department 2 times within pregnancy. Weight gain for pregnancy- 20 kg. Labour activity – last 4 hours. Amniotic fluid gushed at ambulance car – light. 30 min before coming to the hospital she’s got headache and visual disturbance. Edema of low extremities and anterior abdomen wall. BP – 180/100. Ps – 92/min. After urine boiling – precipitate takes half a test tube. Vaginal assessment – complete dilation, no amnion sac, head is present in true pelvic cavity, sagittate suture of skull in left oblique size, more close to the direct size, small fontanel – to the right below pubic. Sciatic bones are not palpable. 2/3 of hollow of the sacrum and whole surface of symphysis is fulfilled with head. Your tactic?
     1. outbound obstetrical forceps
     2. \*obstetrical forceps
     3. Vacuum-extraction
     4. Cesarean section
     5. Stimulation of labour activity
250. Primigravida, 27 years old, 28-29 weeks of pregnancy, came to the outpatient department with complains for pain at lumbar region, more to the right, chill, temperature – 39-39° C. Uterus is normotonic, longitudinal position of fetus, cephalic presentation, fetus heartbeating – 136/min. No vaginal discharge. Pasternatsky symptom – positive at the right side. No edema. BP – 120/80. A lot of leucocytes in urine. Diagnosis?
     1. Chronic pyelonephritis
     2. \*Acute pyelonephritis
     3. urolithiasis
     4. Glomerulonephritis
     5. appendicitis
251. A 27-year-old woman at 30 weeks of gestation complaints of pain in the lower abdomen, urinary frequency, and sensation of pelvic pressure. The patient is found to have a long, closed cervix and irregular uterine contractions. What is the most probable diagnosis?
     1. Initial preterm labor
     2. Inevitable preterm labor
     3. Placenta abruption
     4. Placenta previa
     5. \*Threatened preterm labor
252. A 21-year-old woman at 31 weeks of gestation woman presents with complaints of pain in the lower abdomen, urinary frequency, and sensation of pelvic pressure. The patient is found to have 100 % effaced cervix for 1 cm dilated and irregular uterine contractions. What is the most probable diagnosis?
     1. \*Initial preterm labor
     2. Inevitable preterm labor
     3. Placenta abruption
     4. Placenta previa
     5. Threatened preterm labor
253. A 28-year-old woman at 35 weeks of gestation woman presents with complaints of pain in the lower abdomen, urinary frequency, and sensation of pelvic pressure. The patient is found to have 100 % effaced cervix for 3 cm dilated and irregular uterine contractions. What is the most probable diagnosis?
     1. Initial preterm labor
     2. \*Inevitable preterm labor
     3. Placenta abruption
     4. Placenta previa
     5. Threatened preterm labor
254. 24-year-old woman at 32 weeks of gestation woman presents with complaints of pain in the lower abdomen, urinary frequency, and sensation of pelvic pressure. The patient is found to have a long, closed cervix and irregular uterine contractions. From which therapy prescription a doctor should start?
     1. \*b – 2 adrenomimetics
     2. Spasmolytics
     3. Sedatives
     4. Magnesium sulfate
     5. Dexamethazone
255. 25 years old woman is in preterm labor on the 33 weeks of gestation. Bears down efforts occur during 40-45 seconds with intervals 1-2 minutes. The rupture of the membrane has occurred 10 minutes ago. Vaginal examination: fetus head is on the pelvic floor. Which anesthesia is recommended?
     1. Spinal
     2. Paracervical
     3. \*Pudendal block
     4. Epidural
     5. Intravenous
256. 22-year – old woman in 35 week of gestational age is present in the labor unit in the second stage of the first pre-term labor in cephalic presentation. Which method of anesthesia should be administrated?
     1. Paracervical
     2. Spinal
     3. \*Pudendal block
     4. Epidural
     5. Intravenous
257. 28-year-old woman at 33 week of gestation woman presents with complaints of pain in the lower abdomen, urinary frequency, and sensation of pelvic pressure. The patient is found to have an effaced cervix for 2 cm, and irregular uterine contractions. Which drug have you prescribed for prevention of respiratory distress syndrome?
     1. Ginipral
     2. Magnesium sulfate
     3. Prednisolone
     4. \*Dexamethazone
     5. Hydrocortizone
258. 21 year-old woman at 33 week of gestation woman presents with complaints of pain in the lower abdomen, urinary frequency, and sensation of pelvic pressure. The patient is found to have an effaced cervix for 2 cm, and irregular uterine contractions. Which dose of dexamethazone is recommended for prevention of respiratory distress syndrome?
     1. \*24 mg
     2. 12 mg
     3. 34 mg
     4. 44 mg
     5. 20 mg
259. 19 year-old woman at 32 week of gestation woman presents with complaints of regular uterine contractions. The patient is found to have an effaced cervix for 2 cm. What is the most probable diagnosis?
     1. \*Initial preterm labor
     2. Inevitable preterm labor
     3. Placenta abruption
     4. Placenta previa
     5. Threatened preterm labor
260. 22 year-old woman at 33 week of gestation woman presents with complaints of regular uterine contractions. The patient is found to have an effaced cervix for 7 cm. What is the most probable diagnosis?
     1. Initial preterm labor
     2. \*Inevitable preterm labor
     3. Placenta abruption
     4. Placenta previa
     5. Threatened preterm labor
261. A 28-year-old woman at 35 weeks of gestation woman presents with complaints of pain in the lower abdomen, urinary frequency, and sensation of pelvic pressure. The patient is found to have 100 % effaced cervix for 5 cm dilated and regular uterine contractions. What is the most probable diagnosis?
     1. Initial preterm labor
     2. \*Inevitable preterm labor
     3. Placenta abruption
     4. Placenta previa
     5. Threatened preterm labor
262. 18 year-old woman at 33 week of gestation woman presents with complaints of regular uterine contractions every 2 minutes for 25 seconds. The patient is found to have an effaced cervix for 4 cm. What is the most probable diagnosis?
     1. Initial preterm labor
     2. \*Inevitable preterm labor
     3. Placenta abruption
     4. Placenta previa
     5. Threatened preterm labor
263. 32 year-old woman at 35 week of gestation woman presents with complaints of releasing of amniotic fluid and irregular uterine contractions. The patient is found to have closed long cervix, dilation is absent. What is the most probable diagnosis?
     1. \*Initial preterm labor
     2. Inevitable preterm labor
     3. Placenta abruption
     4. Placenta previa
     5. Danger of preterm labor
264. 34 year-old woman at 36 week of gestation woman presents with complaints of releasing of amniotic fluid and irregular uterine contractions. The patient is found to have closed long cervix, dilation is absent. What is the most appropriate management of such patient?
     1. Prescription of antibacterial drugs
     2. \*Expectant management
     3. Prescription of corticosteroids
     4. Oxytocin prescription
     5. Prostaglandins prescription
265. 31 year-old woman at 35 week of gestation woman presents with complaints of releasing of amniotic fluid and irregular uterine contractions. The patient is found to have closed long cervix, dilation is absent. What is the most appropriate management of such patient?
     1. Prescription of antibacterial drugs
     2. Prescription of b-2 adrenomimetics
     3. Prescription of dexamethasone
     4. Blood analysis, vaginal smear
     5. \*All of the above is recommended
266. 22 year-old woman at 35 week of gestation woman presents with complaints of regular uterine contractions every 1-2 minutes for 35 – 40 seconds. The patient is found to have an effaced cervix for 5 cm. What is the doctor’s management?
     1. b – 2 adrenomimetics
     2. Spasmolytics
     3. \*Prepare for vaginal delivery
     4. Magnesium sulfate
     5. Dexamethazone
267. N., 21 years old, primapara, 34 weeks of pregnancy. The labor started 5 hours ago. The membranes ruptured 2 hours ago. Pelvic sizes: 22,24,29,19 cm. Fetal head rate 140 per minute with satisfactory characteristics. The cervix is 5 cm dilated in vaginal examination. The amniotic sac is absent. Fetal buttocks are palpated in the plane of greatest diameter. Bitrochanter diameter is in the oblique size. What is the presentation ?
     1. Kneeling
     2. Footling
     3. Face
     4. Sinciput
     5. \*Frank breech presentation
268. N., 21 years old, primapara, 34 weeks of pregnancy. The labor started 5 hours ago. The membranes ruptured 2 hours ago. Pelvic sizes: 22,24,29,19 cm. Fetal head rate 140 per minute with satisfactory characteristics. Per vaginum: the cervix is 6 cm dilated. The amniotic sac is absent. Fetal buttocks are palpated in the pelvic inlet. What is the management of patient?
     1. \*Cesarean section
     2. Vaginal delivery
     3. Tsovianov I
     4. Tsovianov II
     5. Total breech extraction
269. Primipara F., 25 years old. 34 weeks of pregnancy. The labor started 6 hours ago. The membranes ruptured 1 hour ago. Pelvic sizes: 25,28,31,20 cm. Fetal heart rate 140 per minute with satisfactory characteristics. Uterine contractions are occurring every 3-4 minutes. Per vaginum: the uterine cervix dilatation is 5 cm. The amniotic sac is absent. Fetal head is presented. Diagnosis?
     1. Initial preterm labor
     2. \*Inevitable preterm labor
     3. Placenta abruption
     4. Placenta previa
     5. Threatened preterm labor
270. Multipara N., 31 years old. 33 weeks of pregnancy complaints of regular uterine contractions every 5 minutes with duration 10-15 seconds. The membranes are intact. Fetal head rate 140 per minute with satisfactory characteristics. Per vaginum: the uterine cervix is dilated to 2 cm. The amniotic sac is present. Fetal head is presented. Diagnosis?
     1. \*Initial preterm labor
     2. Inevitable preterm labor
     3. Placenta abruption
     4. Placenta previa
     5. Threatened preterm labor
271. Which gestational age of pregnancy corresponds with such characteristic signs of infant: wrinkled, patchy peeling skin, a long, thin body suggesting wasting, and advanced maturity because the infant is open-eyed, unusually alert, old and worried-looking? Skin wrinkling can be particularly prominent on the palms and soles. The nails are typically quite long.
     1. Deep preterm fetus
     2. Preterm fetus
     3. \*Postterm fetus
     4. Immature fetus
     5. Mature fetus
272. P., 22 years old, primapara, 33 weeks of pregnancy complaints of dull pain in the sacral region. The membranes ruptured 2 hours ago. Fetal head rate 140 per minute with satisfactory characteristics. Per vaginum: the cervix is closed, length 1,5 cm. The amniotic fluid released. Diagnosis?
     1. \*Initial preterm labor
     2. Inevitable preterm labor
     3. Placenta abruption
     4. Placenta previa
     5. Threatened preterm labor
273. F., 23 years old, primapara, 32 weeks of pregnancy complaints of pain in the sacral region. The membranes ruptured 3 hours ago. Fetal head rate 140 per minute with satisfactory characteristics. Per vaginum: the cervix is closed. The amniotic fluid released. From which therapy prescription a doctor should start?
     1. \*b – 2 adrenomimetics
     2. Spasmolytics
     3. Sedatives
     4. Magnesium sulfate
     5. Dexamethazone
274. M., 21 years old, multipara, 16 weeks of pregnancy complaints of dull pain in the sacral region. Per vaginum: the cervix is dilated for one finger. The amniotic sac is intact. The diameter of internal cervical os on the ultrasonography is 15 mm. Diagnosis?
     1. Initial preterm labor
     2. Inevitable preterm labor
     3. \*Cervical incompetence
     4. Early initial abortion
     5. Threatened preterm labor
275. T., 23 years old, multipara, 17 weeks of pregnancy complaints of pain in the sacral region. Per vaginum: the cervix is dilated for one finger. The amniotic sac is intact. The diameter of internal cervical os on the ultrasonography is 17 mm ? What is most appropriate management of such patient?
     1. b – 2 adrenomimetics
     2. Spasmolytics
     3. \*Cervical cerclage
     4. Magnesium sulfate
     5. Dexamethazone
276. In the department of pathology pregnant woman was hospitalized with second pregnancy 38 weeks. The first ended in c-section as a result of clinically contracted pelvis. Probabe fetal weight is 3200.What is the way of delivery?
     1. Spontaneous early delivery, vacuum extraction of fetus
     2. \*Planned C-section
     3. Wait for spontaneous early delivery, apply forceps delivery to avoid pushing efforts
     4. Firstly you should know the size of the pelvis
     5. Nothing above
277. In primapara pelvic size 24, 26, 29, 18. In the second stage of labor there are signs of clinically contracted pelvis. What is the management?
     1. Conduct stimulation of uterus activity
     2. Obstetric forceps
     3. \*C-section
     4. Vacuum extraction of fetus
     5. Continue epidural anesthesia during childbirth
278. Multipara, the second stage of delivery, fetal head is in the pelvic cavity. Contractions last for 60 seconds in 2 minutes. Fetal heart beat slowed to 100 per min. What is the management?
     1. \*Applying obstetric forceps
     2. Oxytocin stimulation of uterus activity
     3. Perform a classic podalic version
     4. C-section
     5. nothing above
279. The woman is admitted to the maternity home with discontinued uterine contractions and slight bloody discharges from the vagina. The condition is severe, the skin is pale, consciousness is confused. BP – 80/40 mm Hg. The heart rate of the fetus is not determined. In anamnesis there was a cesarean section a year ago. Establish the diagnosis:
     1. Placental presentation
     2. Placental presentation
     3. \*Uterine rupture.
     4. Premature expultion of the amniotic fluids
     5. Nothing above
280. In the woman of the first day after labor the rise of temperature up to 39oС was registered. The rupture of the fetal membranes has taken place 36 hours prior to labor. The investigation of the bacterial flora of cervix of the uterus revealed – hemolytic streptococcus of a group A. The uterine body is soft, tender. Discharges are bloody, with a pus. Establish the most probable postnatal complication.
     1. Thrombophlebitis of veins of the pelvis
     2. \*Metroendometritisis
     3. Infected hematoma
     4. Infective contamination of the urinary system
     5. Endometritisis
281. In the primapara, 30 years, intensive uterine contractions with an interval of 1-2 min, duration 50 sec have begun. In vaginal examination cervical dilation is complete. Amniotic sac is intact. Fetal head is present in 0 station. What is it necessary to perform:
     1. Vacuum - extraction of the fetus.
     2. Protection of the perineum.
     3. Episiotomy.
     4. \*Amniotomy
     5. Nothing
282. A pregnant woman (35 weeks), aged 25, was admitted to the hospital because of bleeding discharge. In anamnesis there were two artificial abortions. In a period of 28-32 weeks there was noted the onset of hemorrhage and US showed a placenta previa. The uterus was in normal tonus, the fetus position was transversal (Ist position). The fetal heartbeats are clear, rhythmical, 140b/min. What is the best tactics of management of the pregnant woman.
     1. The drugs increasing blood coagulation and continue observation
     2. To perform the hemotransfusion and to prolong the pregnancy
     3. To perform the stimulation of delivery by intravenous introduction of oxytocin
     4. \*Cesarean section.
     5. To perform the observation for the intensity of hemorrhage and at the moment of stopping the bleeding to prolong the pregnancy
283. The 3rd full-time pregnancy, the 2nd delivery. The anamnesis showed a spontaneous abortion complicated by metroendometritis. Following 26 weeks some bloody discharge was noted which was estimated as a threat of abortion. The beginning of delivery labor caused some bleeding. The position of fetus is longitudinal, the fetal head is slightly bent to the pelvic inlet. The fetal heartbeats are clear and rhythmical 140 b/min. At the time of internal examination bleeding increased, common blood lost is 300 ml. The diagnosis that was made: partial placenta previa. Choose the most rational treatment.
     1. To perform amniotomy
     2. \*Cesarean operation
     3. To perform amniotomy with the following applications of skin-headed forceps
     4. Accelerate a delivery by intravenous introduction of oxytocin
     5. Perform an observation of character of delivery activity
284. Postpartum patient., 26 years, transferred from the department of physiological obstetrics in observative on a 4 day of puerperal period. Labor are second, coursed normally. Perineal rupture of the ІІ degree sutured by cetgut and silk stitches. A postnatal period during the first two days was without complications. At the end of the third day the body temperature increased to 37,30С, head ache appeares, pain in the area of perineum and vagina. Breasts are not tense, hyperemia is not present. Abdomen is soft, uterine fundus on 3 transversal fingers below the umbilicus, an uterus is firm, unpainful. Lochia rubra, in normal amount. Stitches on a perineum are covered by a purulent discharges, surrounding tissue are edematic, hyperemia present, painful at palpation. What is the complication of puerperal period ?
     1. Puerperal parametritis
     2. Puerperal endometritis
     3. Trombophlebitis of veins of pelvis
     4. \*Postpartum ulcer
     5. Mastitis
285. Pregnant N., 25 years is delivered in the maternity department with complaints of periodic pains in lower part of abdomen and lumbal region, during 7 hours and bloody excretions from a vagina, which appeared 1 hour ago. Amniotic fluid are present. Pregnancy 4, labor is first, previous 3 pregnancies ended by artificial abortion. Fetal heart rate is 136 in 1min. At vaginal examination: the uterine cervix is effaced, opening 6-7 cm, from one side soft spongy tissue is palpated before the presenting head, the amniotic membrane is whole. Blood loss is 50 ml. What is the doctor’ tactic?
     1. Stimulation of labor
     2. \*Amniotomy
     3. Obstetric forceps
     4. The fetal destroying operation
     5. Cesarean section
286. Primapara C., 35 years, term of pregnancy 39-40 weeks, appeared with complaints of nausea, pain in epigastrium, edema on lower extremities. Pregnancy 1st, was complicated by early gestosis, with 26 weeks the edema on lower extremities appeared, did not treat oneself. A week ago the edema were become generalized, nausea appeared. Objective: on the lower extremities and abdominal wall edema present. BP – 180/110 mm Hg, 160/100 mm Hg, pulse – 90 in 1 min. Position of the fetus is longitudinal, head presentation. Fetal heart rate is 142 in 1min, clear, rhythmic. The sizes of pelvis are normal, uterine contractions are absent. The expected weight of the fetus – 4000 g. The uterine cervix is shortened, opening 2 cm. Amniotic membrane is intact. A head is above the pelvic inlet. Promontorium is not palpated. Tactic?
     1. Medical treatment of gestosis, examination in a dynamics
     2. Conducting of preparation to labor
     3. \*Cesarean section
     4. Introduction of spasmolytic
     5. Immediately amniotomy, stimulation of uterine contractions
287. Patient 18 years entered maternity department at the beginning of the ІІ stage of labor with complaints of headache, visual disoders, pains in epigastrium. The attack of convulsions with the lost of consciousness happened 3 minutes ago. The patient’ condition is severe. A skin is pale, edema of the face, extremities, anterior abdominal wall. BP – 180/130 mm Hg, 150\110 mm Hg, heart tones at auscultation are arhythmic. Position of the fetus is longitudinal, head presentation, fetal head is in the cavity of small pelvis. Fetal heart rate is 176 in 1min. Vaginal examination: opening of uterine cervix is complete. Amniotic membrane is absent. Head in narrow part of small pelvis. Promontorium is not palpated. Doctor’ tactic?
     1. \*Immediate anesthesia and applying of obstetric forceps
     2. Stimulation of uterine contractions
     3. Cesarean section
     4. Fetal destroying operation
     5. Fetal destroying operation
288. On a 4 day after the first labor by a fetus with a mass 4200 g postpartum patient complaints of pain in the area of vagina, T-36,9oC, AT – 115/70 mm Hg. At examination: in lower third of right lateral wall of vagina the wound surface to 2 cm in a diameter is exposed, covered by a purulent discharge. A wound bleeds, in surrounded tissue edema and erythema are present. Diagnosis?
     1. Puerperal endometritis
     2. \*Puerperal ulcer of vagina
     3. Haematoma of vagina
     4. Parametritis
     5. Puerperal ulcer of perineum
289. Labor are at term, first, amniotic membrane ruptured before beginning of the uterine contractions 12 hours ago. Duration of labor 10 hours. On the 4th day after labor a temperature increased to 38-39oC, tahicardiya, chill appeared. Pulse is 96 in 1 min, rhythmic. BT 105-70 mm Hg. Skin is pinky color. Breasts without pathology. Uterine body on 2 cm below the umbilicus, soft consistency, painful at palpation. Lochia rubra with an odor. Diagnosis?
     1. Parametritis
     2. Metrotrombophlebitis
     3. Pelvioperitonitis
     4. Postpartum ulcer of perineum
     5. \*Acute puerperal endometritis
290. Primapara, labor proceed 16 hours. Amniotic membranes ruptured 2 hours ago. Cephalic presentation, Fetal heart rate is 168, rhythmic. Opening of uterine cervix is full, head in pelvic outlet. Sagittal suture is in a direct size, small fontanel near a pubis. What is doctor’ tactic?
     1. The conservative tactic
     2. Cesarean section
     3. Medicinal sleep
     4. \*Obstetric forceps
     5. To appoint oxytocin for stimulation
291. Multipara, 31 years, is admitted to labor at 14 o'clock. The uterine contractions began at 6 o'clock. 2 hours before to labor amniotic membrane ruptured. Abdomen has the form of transversal oval, fetal head is on the left. Fetal heart tones are absent. Vaginally: the uterine cervix is dilated on 7 cm, in vagina the left fetal arm is visible, its hand is cyanotic. What is doctor’ tactic?
     1. To conduct of labor conservative
     2. The classic obstetric version of the fetus on a leg
     3. Obstetric forceps
     4. \*Fetal destroying operation
     5. Cesarean section
292. Patient 23 years. Pregnancy 39-40 weeks, position the fetus is longitudinal, cephalic presentation. Sizes of pelvis: 24-25-29-18 cm. The uterine contractions proceed 10 hours, at last 2 hours very painful, patient behaves very uneasily. Amniotic fluid released 2 hours ago. At the external examination a contractile ring is palpated on 2 fingers higher than umbilicus, Vasten’ sign is positive. Fetal heart rate 160 in 1 min. At internal examination: amniotic membrane is absent, opening of uterine cervix 8 cm, head presentation, large fontanel is palpated. The fetal head is in the plane of the pelvic inlet. What is the probable diagnosis?
     1. The rupture of uterus is completed
     2. \*Threatening rupture of uterus
     3. Dyscoordinate uterine contractions
     4. Placental abruption
     5. Tetanus of uterus
293. Primapara in I period of labor acute pain in the region of uterine fundus appeared suddenly, insignificant bloody excretions from a vagina. Uterus in hypertonus. Fetal heart rate – 175. In anamnesis: acutening of chronic pyelonephritis during pregnancy. At vaginal examination: the uterine cervix is effaced, opening of uterine cervix 4 cm. Amniotomy is conducted. Amniotic fluid released with blood. What is the doctor’ tactic?
     1. Stimulation of labor.
     2. Treatment of fetal hypoxia
     3. \*Cesarean section immediately.
     4. To appoint tocolitics
     5. To appoint coagulants
294. Patient C., 26 years, 18 hours are found in labor: pushing appeared hour ago – on 30 sec. in 3-4 minutes. Fetal heart rate is arhythmical, to 100 in 1 min. It is definite at vaginal examination, that a head is found in narrow part of cavity of small pelvis. Your subsequent obstetric tactic?
     1. \*Obstetrical forceps
     2. The cardiomonitoring supervision
     3. Cesarean section.
     4. To execute perineotomia.
     5. To conduct labor conservative
295. Patient N., 33 years, labor I, term gestation 42 weeks. Position of the fetus is longitudinal, cephalic presentation. Amniotic fluid released, were colored by meconium. Auscultation: fetal heart rate arhythmical, to 170 in 1 min. Uterine contractions on 20-25 sec. after 4-5 min. At vaginal examination: cervix is immature. What tactic of conduct of labor?
     1. Obstetric forceps
     2. The cardiomonitoring supervision
     3. \*Cesarean section.
     4. To execute perineotomia.
     5. To conduct labor conservative
296. Patient 28 years with the expressed edema is found in a maternity hall, in the ІІ period of labor. Head of fetus in narrow part of small pelvis. Head pains began, twinkling of “spots” before eyes, contractions of muscles of the face. BP - 170/110 mm Hg. What is tactic of conduct of labor?
     1. \*Obstetric forceps
     2. Conservative conduct of labor
     3. The Vacuum-extraction of the fetus
     4. Labor stimulation
     5. Cesarean section
297. In patient 25 years (labor III) after excessive uterine contractions and pushing at a highly standing head and positive signs Vasten, Zangemeyster. Uterine contractions was stopped suddenly, bloody excretions from a vagina appeared, fetal heart rate is not listened. The condition of patient suddenly became worse, BP went down to 70 mm Hg, pulse 140 in a 1 minute, a skin is pale-grey. Reason of the shock condition?
     1. Threatened rupture of uterus
     2. Abruptio placentae
     3. \*Uterine rupture
     4. Syndrome of squeezing of lower hollow vein
     5. Placenta previa
298. At postpartum patient on the 7th day of puerperal period suddenly there was a hallucinatory syndrome: patient is not oriented in space and time, does not recognize neighbours. The temperature of body rose to 38,5oС, purulent-bloody excretions from the uterus appeared. At vaginal examination: the uterus is increased to 10-11 weeks of pregnancy, soft consistency, painful at palpation, the uterine cervix dilated to1 finger. What reason of psychical violations, that arose up at postpartum patient?
     1. Negative emotional influence of labor on patient
     2. Astenic-vegetative syndrome
     3. Psychical diseases in anamnesis
     4. Manifestation of schizophrenia
     5. \*Puerperal infection
299. Postpartum patient 25 years, V day of puerperal period. Labor I, delivered by the operation of cesarean section, indication – clinically contracted pelvis. At the examination a tongue is dry, fever – body temperature is 38,5oC, Ps – 120, BP – 100/50 mm Hg. Breathing is speed-up, superficial. Abdomen is acutely painful, bloating. Shchotcin’ symptom is positive. Vomiting. Gases are not depart. Excretion from vagina are purulent with an unpleasant smell. What diagnosis is most credible?
     1. Puerperal pelvioperitonitis
     2. \*The puerperal peritonitis
     3. Septic shock
     4. Puerperal thrombophlebitis
     5. Septicemia
300. Postpartum patient 28 years. A girl was born by mass 3800 g., by length 52 cm. Placenta was delivered in 15 minutes and 300 ml of blood was discharged. Bleeding proceeds. At the review of cervix and vagina the traumas of them are not found. At the review of placenta – vessels pass to the edge of placenta on membranes and are ruptured. What is the subsequent tactic?
     1. \*To perform the manual examination of uterus cavity
     2. Total hysterectomy.
     3. Uterotonics
     4. To conduct the external massage of uterus.
     5. To conduct to tamponada of body of uterus
301. Patient F., 18 years. Labor are first, at term. Mass of body is 100 kg. What volume of blood lost is possible and physiological?
     1. To 600 ml
     2. \*To 500 ml
     3. To 300 ml
     4. To 200 ml.
     5. To 1000 ml
302. Patient 25 years entered maternity hospital on a 38 week of pregnancy with regular uterine contractions and bloody excretions from vagina. The uterine cervix is effaced, opening of canal 4 cm and is blocked by spongy tissue of soft consistency. At a bimanual review bleeding was increased. What is the reason of increasing of bleeding?
     1. Abruptio placentae.
     2. Bleeding from the rupture of uterine cervix
     3. Premature removing of the normally placed placenta
     4. \*Complete placenta previa
     5. The coagulopathic bleeding
303. Before female dispensary the pregnant 22 years appealed, with complaints about pain in lower part of abdomen and in lumbal region, bloody excretion from vagina. Pregnancy is 3rd, last menstruation was approximately 3 months ago. In anamnesis there are two artificial abortions. At vaginal examination: uterine cervix by length 1 cm, external cervical os is slightly opened, cervical canal is closed. The uterus is increased to 11-12 weeks of pregnancy, soft. Excretion from the vagina are bloody, insignificant. Diagnosis?
     1. \*Initial abortion
     2. Molar pregnancy
     3. Threatening abortion.
     4. Pregnancy, that does not develop
     5. Placenta previa
304. Patient is delivered by the ambulance with complaints of acute pains in lower part of abdomen, which appeared suddenly after falling, dizziness, bloody excretions from a vagina; term of pregnancy – 39 weeks. The uterine contractions are regular, in 5 minutes on 40 seconds, amniotic fluid did not released. Objectively: skin and visible mucus membranes are pale, BP 80/50 mm Hg, pl 126. Uterus is tense, on the left near a fundus infiltrat is determined, this area is painful at palpation. Fetal heart rate – 170, arhytmic. At vaginal examination: the uterine cervix is effaced, opening of uterine cervix 5 cm, amniotic membrane is present, parts of placenta are not determined, head of the fetus is above the pelvic inlet. Excretion of bloody, cloys are not present. Test of Lee-White is 15 min. Diagnosed premature separation of normally located placenta. What is the most credible complication?
     1. Uterine rupture
     2. \*Development of DIC-syndrome
     3. Dyscoordinated uterine contractions
     4. Hypotonic uterine contraction
     5. The uterine tetanus
305. Multipara. Uterine contractions of 4-5 hours. bloody excretions began at once after appearance of contractions. Fetal heart rate 100-110 in min. Vaginal examination: the uterine cervix is effaced, edges 0,3 cm, soft. The cervical canal is opened on 6 cm. In the cervix placental tissue is determined. Diagnosis?
     1. Threatening rupture of uterus.
     2. Threatening rupture of uterus.
     3. Partial placenta previa.
     4. \*Central placenta previa.
     5. Abruptio placentae
306. Multipara 32 years. 30 minutes passed after labor of the fetus. The signs of placenta separation are negative. Bleeding began – blood lost is 450 ml. What must to be done?
     1. Introduction of uterotonics.
     2. \*Manual separation of placenta.
     3. To apply the method of Crede-Lazarevich.
     4. Expecting tactic
     5. All above
307. The 26-year old woman had the second for the last 2 years labor with oxytocin application. The child’s weight - 4080 g. After the placental birth there was a severe bleeding, signs of hemorrhagic shock. Despite the introduction of contractive agents, good contraction of the uterus and absence of any uterus cervix and the vagina injuries, the bleeding proceeds. Choose the most probable cause of bleeding.
     1. \*Atony of the uterus.
     2. Uterine rupture.
     3. Injuries of cervix of the uterus
     4. Delay of the part of placenta
     5. Hypotonia of the uterus
308. A parturient woman aged 32. After 3d fullterm delivery (the fetal weigh is 4,3 kg) in early postpartum period there appeared bleeding. To stop it, the external massage of uterus, introduction of uterotonics, manual examination of uterine cavity walls and a massage, an ester tampon into the posterior fornix of vagina were performed. The result was absent, bleeding continued, hemorrhage ran up to 1300 ml. Patient’s condition is severe: she is pale, heartbeat reached 140b/min, BP 80/40 mm Hg. What is the method of bleeding termination in this case.
     1. To perform the tamponada of uterus
     2. To repeat massage of the uterus
     3. \*To perform the laparotomy with the hysterectomy of the uterus without adnexa
     4. To perform the clampation of the parametriums by Henkel-Tickinadze
     5. To introduct the methylergometrin intravenously
309. A pregnant woman (35 weeks), aged 25, was admitted to the hospital because of vaginal bleeding. In anamnesis there were two artificial abortions. In a period of 33 weeks there was noted the onset of hemorrhage and US showed a placenta previa. The uterus was in normal tonus, the fetus position was transversal. The fetal heartbeats are clear, rhythmical, 160b/min. What is the best tactics of management of the pregnant woman.
     1. To perform the observation for the intensity of hemorrhage and at the moment of stopping the bleeding to prolong the pregnancy
     2. \*Cesarean section.
     3. To perform the stimulation of delivery by intravenous introduction of oxytocin
     4. To perform the hemotransfusion and to prolong the pregnancy
     5. To hospitalized and continue observation
310. Pregnant in a term 8 – 9 weeks complains about aching pain above a pubis, that disturbs the last 2 days. Insignificant bloody excretions from vagina appeared some hours ago. At vaginal examination: the uterine cervix is shortened, closed. The body of uterus of dense consistency, as 8–9 weeks of pregnancy, is mobile, painless. Adnexa - without pathology. Excretions from the cervical canal are bloody, moderate. Diagnosis:
     1. Threatened abortion
     2. Abortion inevitable
     3. \*Initial abortion
     4. Incomplete abortion
     5. Metrorragia
311. Patient is delivered in a clinic with complaints about abdomen-ache, brief loss of consciousness. Term of pregnancy 40 weeks. BP – 80/60 mm Hg, pulse 126 in 1 min, weak. Skin is pale. Uterus is tense, protruding in right its half is marked out, near the uterine fundus. At palpation this area is painful. Fetal heart rate is 160 in 1 min, arhythmical. From a vagina a blood in a small amount is discharged. Uterine contractions are moderate, amniotic membranes are intact. At vaginal examination: the opening of uterine cervix is 5-6 cm. Tissue of placenta is not palpated. Diagnosis?
     1. \*placental abruption
     2. Preeclampsia
     3. Placenta previa
     4. Bleeding from the varicosis extended veins of vagina
     5. Uterine rupture
312. Postpartum patient 28 years, pregnancy is sixth (4 abortions, 2 complicated with endometritis). Labor is second, first stage of labor coursed without complications, mass of fetus was 4500 g. Placenta separated and delivered through 7 min. after delivery of the fetus, with all cotyledons. Blood lost was 350 ml. Through 5 min. bloody excretions increased, after external massage the uterus contracts on the short time and again lost the tonus and become soft, bleeding proceeds. Diagnosis?
     1. Placental abruption
     2. Atonic bleeding
     3. Uterine rupture
     4. \*Hypotonic bleeding
     5. Rupture of the cervix of uterus ІІІ degree
313. Pregnant first, 22 years. Pregnancy 35-36 weeks. Sizes of pelvis: 25-26-31-20. Without uterine contractions, at night bleeding appeared from vagina in a quantity 80-100 ml. Fetal heart rate is clear, rhythmic, 136 in 1 min. At internal examination: the uterine cervix is shortened, a cervix pass over a 1 finger. In the cervix soft tissue is palpated. Head of the fetus is mobile above the pelvic inlet. During examination, bleeding increased. Define the volume of obstetric help.
     1. Bed rest
     2. \*Cesarean section
     3. Amniotomy
     4. The strict bed rest and hemostatic therapy
     5. The strict bed rest and tocolitic therapy
314. A 32-years-old woman has the massive bleeding after labor of twins. Placenta, vagina and perineum are whole. Uterine fundus is higher than umbilicus, uterus at palpation is soft. Tone of uterus does not change after introduction of oxytocin. What reason of bleeding is most credible?
     1. Hypotonic uterine contractions
     2. Uterine rupture
     3. \*Atony of uterus
     4. Coagulopathy syndrome
     5. Hypocoagulationof blood
315. Patient is delivered with pregnancy at term and active uterine contractions. During hospitalization the condition is satisfactory, pulse - 84 in 1 min, BP - 150/90 and 160/90 mm of Hg. Suddenly patient complained on severe pain in abdomen, a general weakness, dizziness, face and lips became pale. Pulse - 120 in 1 min, AT - 80/40 and 90/45 mm of Hg. Uterus is tense, very painful. Fetal heart rate is not listened to. At vaginal examination: the uterine cervix is effaced, opening 5 cm. Amniotic membrane is whole, tense. The head is in the pelvic inlet. Insignificant bloody excretions appeared from a vagina. What is the most credible diagnosis?
     1. Uterine rupture
     2. \*Placental abruption
     3. Amniotic fluid embolism
     4. Molar pregnancy
     5. Placenta previa
316. At a woman in 26 week of pregnancy considerable bloody excretions from genital tract appeared suddenly. At ultrasound examination the central placenta previa is diagnosed. General blood lost is 500 ml, bleeding proceeds. What is the doctor’ tactic?
     1. To appoint tocolitics.
     2. To impose a stitch on the uterine cervix
     3. \*Small cesarean section immediately.
     4. To appoint hemostatics
     5. Vaginal delivery
317. Multipara N. is in III stage of labor. The baby weight is 4500 g, length 56 cm. Through 15 min. after the fetal delivery the bleeding began. General blood lost is now 1,5% from the woman’ body weight. What is the doctor’ tactic?
     1. To do the repeated manual revision of cavity of uterus.
     2. To do the tamponade of uterine cavity.
     3. To impose a stitch on the uterine cervix
     4. \*Total hysterectomy.
     5. Subtotal hysterectomy
318. At woman D. labor begins in 39 weeks of pregnancy. In anamnesis there is artificial abortion, which was complicated by endometritis. During 40 min. the signs of placental separation are not present. The signs of the external and internal bleeding are absent. Considerable bloody excretions appeared at an attempt to do the manual separation of placenta. The blood lost is 400 ml. The manual separation of placenta from the uterus was not succeeded. What is the doctor’ tactic?
     1. \*Subtotal hysterectomy
     2. To conduct curettage of walls of uterine
     3. To continue the manual separation of placenta
     4. To conduct total hysterectomy
     5. To appoint uterotonics
319. At postpartum patient 30 years at the manual removal of placenta and examination of uterus the rupture of uterine cervix is exposed in the right side with transition on a lower segment. Blood lost is arrives at 1300 ml and proceeds. Tactic of doctor?
     1. Subtotal hysterectomy
     2. Tamponada of the uterus
     3. Tampon with ether in a posterior fornix
     4. Clamps on Bacsheev or Ticinadze
     5. \*Total hysterectomy
320. Labor were completed by delivery of alive boy by mass 4500 g. In 10 minutes after labor of child the uterine bleeding began . Placenta is separated manualy, the massage of uterus is conducted, oxytocin is entered intravenously. In 15 minutes, bleeding repeated again. The conservative methods of increasing of uterus contraction are not effective. The blood lost for 40 min of the bleeding treatment is over 1200 ml. What must be the tactic?
     1. Repeated introduction of solution of oxytocin
     2. Curettage of uterus
     3. \*Surgical stop of bleeding
     4. Imposition of stitches on the cervix of uterus
     5. External massage of uterus
321. At postpartum patient the massive hypotonic uterine bleeding began after labor by dead child. The blood lost is attained 1600 ml. From the uterus a liquid blood flows out. A blood from a vein does not coagulate. Quantity of trombocytes 80x109/l. The places of injections bleed. What stage of DIC-syndrome has developed at postpartum patient?
     1. I
     2. \*III
     3. II
     4. V
     5. IV
322. Patient N., the patient’ condition is satisfactory. The girl by mass 3100g was born. The signs of separation of placenta and bloody excretions from vagina are absent. 30 minutes passed. What probable pathology of placental attachment?
     1. Hypertonus of uterus.
     2. Placenta previa.
     3. \*Placenta accreta.
     4. Uterine rupture
     5. Atony of uterus.
323. During cesarean section which was performed as a result of placenta abruption widespread extravasation of blood into the uterine wall was revealed. The uterus is soft, hypotonic and should produce severe postpartum hemorrhage. The uterus has a purplish or bluish appearance, owing to such extravasation of blood. Diagnosis? What is the best management of such condition ?
     1. \*Couveler’s uterus. Hysterectomy should be performed.
     2. Placenta previa To perform the hemotransfusion
     3. Atony of uterus. To perform subtotal hysterectomy
     4. Curettage of uterus. To perform the hemotransfusion
     5. Nothing above
324. A 30 years old patient undergoes spontaneous delivery of a 3900 g boy. After 10 minutes without spontaneous placental delivery, traction is applied to the umbilical cord. Placental tissue is expelled wit the umbilical cord, but vaginal hemorrhage begins immediately thereafter. The placenta is clearly not intact. What are appropriate immediate interventions in this situation?
     1. Curettage of uterus
     2. \*Oxytocin administration, manual exploration of the uterine cavity with the uterine massage
     3. Imposition of stitches on the cervix of uterus
     4. Tamponada of the uterus
     5. Nothing above
325. A 22 -year old woman comes to physician with cessation of menses during last 2 weeks, morning sickness, profuse bloody vaginal discharge. During pelvic examination: the uterus is enlarged, cervix is dilated to one finger, profuse vaganl bleeding is present. What would be the most appropriate diagnosis?
     1. Molar pregnancy
     2. Initial abortion
     3. Incomplete abortion
     4. Metrorragia
     5. \*Inevitable abortion in 4 weeks of pregnancy
326. Primapara C., 39 years, term of pregnancy 39-40 weeks, appeared with complaints of regular uterine contractions every 2- 3minutes by 45 seconds. , Position of the fetus is longitudinal, cephalic presentation. Vasten’ sign is positive. Fetal heart rate is 142 in 1min, clear, rhythmic. The sizes of pelvis are normal. The expected weight of the fetus – 4200 g. The uterine cervix is dilated till 7 cm, edematous. Amniotic membrane is absent. Fetal head is above the pelvic inlet. Promontorium is not palpated. What is the adequate management of labor?
     1. \*Immediate cesarean section
     2. Fetal destroying operation
     3. Medical treatment
     4. Immediately stimulation of uterine contractions
     5. Introduction of spasmolytic
327. Patient 22 years entered maternity department at the beginning of the ІІ stage of labor with complaints of headache, visal disturbances , pain in epigastrium. The attack of convulsions with the lost of consciousness happened 5 minutes ago. A skin is pale, edema of the face, extremities, anterior abdominal wall. BP – 200/120 mm Hg, 180/115 mm Hg, heart tones at auscultation are arhythmic. Position of the fetus is longitudinal, cephalic presentation. In vaginal examination: uterine cervix is complete dilated. Amniotic membrane is absent. Fetal head is in pelvic outlet. What is the adequate management of labor?
     1. \*Immediate anesthesia and applying of obstetric forceps
     2. Cesarean section
     3. Stimulation of uterine contractions
     4. Fetal destroying operation
     5. Perineotomy, vacuum-extraction of fetus
328. Primapara admitted to the maternity hospital with complaints of headache, pain in epigastral area, somnolence, general edema. BP - 210/110 mm Hg, position of the fetus is longitudinal, cephalic presentation, Fetal heart rate is - 130 in 1 min, rhythmic. In urine protein is present – 5,8 g/l. Diagnosis?
     1. \*Preeclampsia severe degree
     2. Preeclamsia mild degree
     3. Eclampsia
     4. Hypertensive stroke
     5. Edema of pregnant
329. 42 years old patient is admitted to the maternity hospital in 38 weeks of gestation. Objectively: consciousness is absent. BP on both hands 190/110 mm Hg, Ps 110 in 1 min, general edema, proteinuria 7 g/l. At the vaginal examination: the uterine cervix is closed. What is the adequate management of labor?
     1. Conduct of labor through natural ways
     2. \*Cesarean section
     3. The fetal destroying operation
     4. Applying of obstetric forceps
     5. To conduct the operation of vacuum-extraction of the fetus
330. Patient 30 years with the expressed edema is admitted to the hospital in the second stage of labor. Fetal head in the plane of outlet. Attack of headache appears, twinkling of “spots” before eyes, contractions of muscles of the face. Diastolic blood pressure 115 mm Hg. What is the adequate management of labor?
     1. Cesarean section
     2. Conservative conduct of labor
     3. \*Obstetric forceps
     4. The Vacuum-extraction of the fetus
     5. Labor stimulation
331. In the patient with severe pregnancy induced hypertension during the intravenous infusion of magnesium sulfate such signs have been appeared as decreasing of urine flow till 50 mL during the previous 4 hours, decreasing of patellar reflex, and respiratory depression. How do you explain these signs?
     1. \*Magnesium toxicity
     2. Anaphylactic shock
     3. Acute renal failure
     4. Pulmonry dysfunction
     5. Eclampsia
332. In the patient with severe pregnancy induced hypertension during the intravenous infusion of magnesium sulfate such signs have been appeared as decreasing of urine flow till 50 mL during the previous 4 hours, decreasing of patellar reflex, and respiratory depression What is the management of this patient
     1. Intravenous prescription of 10 mg calcium chloride
     2. Intravenous prescription of 5 mg calcium gluconate
     3. \*Intravenous prescription of 10 mg calcium gluconate
     4. Intravenous prescription of 10 mg calium gluconate
     5. Prescription of dexamethazone
333. A 23-year-old pregnant woman is seen at 8 week’s gestational age for obstetric care. She complains of sickness, and says that has increasing of arterial blood pressure from childhood. Ophtalmologic conclusion is retinopathy. She has two pregnancies, one of them was interrupted for medical indications. The level of arterial blood pressure is 150/100 mmHg. What would be the most appropriate diagnosis?
     1. Preeclampsia 1 degree
     2. \*Chronic hypertension
     3. Hypertensive stroke.
     4. Eclampsia.
     5. Preeclampsia 2 degree
334. A 33-year-old pregnant woman came at 32 week’s gestational age for obstetric care. She complains of sickness, presence of edema on the legs and face. She has had one normal delivery in anamnesis. The level of arterial blood pressure is 145/95 mmHg. Proteinurua in 24 hours collection is 0,3 g. Level of thrombocytes is 180.000 x 10 What would be the most appropriate diagnosis?
     1. \*Mild preecmampsia .
     2. Moderate preeclampsia.
     3. Severe preeclampsia.
     4. Eclampsia
     5. Chronic hypertension
335. A 30-year-old pregnant came at 30 week’s gestational age for obstetric care. She has no complaints. She has had one normal delivery in the past. The level of arterial blood pressure is 140/95 mmHg. Proteinurua in 24 hours collection is 0,2 g. Level of thrombocytes is 180.000 x 10 What would be the most appropriate management?
     1. \*Expectant management.
     2. Prescription of diuretics
     3. Prescription of hypotensives
     4. Induction of labor
     5. Small secarean section
336. A 30-year-old pregnant woman comes at 30 week’s gestational age for obstetric care. She has no complaints. She has had one normal delivery in the anamnesis. The level of arterial blood pressure is 130/95 mmHg. Proteinurua in 24 hours collection is 0,3 g. Level of thrombocytes is 180.000 x 10 What would be the most appropriate diagnosis?
     1. Chronic arterial hypertension
     2. \*Mild preeclampsia
     3. Secondary arterial hypertension
     4. Moderate preeclampsia
     5. Chronic glomerulonephritis
337. A 37-year-old pregnant woman came at 36 week’s gestational age for obstetric care. She complains of epigastrial pain. Edema are present on the legs and face. The level of arterial blood pressure is 160/110 mmHg. Proteinurua in 24 hours collection is 6 g. Level of thrombocytes is 70.000 x 10 What would be the most appropriate diagnosis?
     1. \*Severe preeclampsia
     2. Mild preeclampsia
     3. Moderate preeclampsia
     4. Edema in pregnancy
     5. Eclampsia
338. A 37-year-old pregnant woman came at 36 week’s gestational age for obstetric care. She complains of epigastrial pain. Edema are present on the legs and face. The level of arterial blood pressure is 160/110 mmHg. Proteinurua in 24 hours collection is 6 g. Level of thrombocytes is 70.000 x 10 Prescribe adequate scheme of magnesium sulfate in this situation?
     1. \*7, 5 g (30 ml 25 %) twice a day
     2. 7, 5 g (30 ml 25 %) once a day
     3. 15 g (60 ml 25 %) once a day
     4. 15 g (60 ml 25 %) twice a day
     5. 4 g ( 16 ml 25 % solution) once a day
339. A 37-year-old pregnant woman came 36 week’s gestational age for obstetric care. She complains on epigastrial pain. Edema are present on the legs and face. The level of arterial blood pressure is 160/110 mmHg. Proteinurua in 24 hours collection is 6 g. Level of thrombocytes is 75.000 x 10 What is the leading importance of magnesium sulfate prescription?
     1. \*To arrest and prevent convulsions due to eclampsia
     2. Spasmolytic effect
     3. Increasing of diuresis
     4. Hypotensive effect
     5. Decreasing of diuresis
340. A 28-year-old multigravid client at 37 weeks' gestation arrives at the emergency department with a blood pressure of 160/104 mm Hg and +3 fetal head station. The client, who is diagnosed with severe preeclampsia, asks the doctor, "What is the cure for my high blood pressure?" Which of the following would the doctor identify as the primary cure?
     1. \*Vaginal delivery of the fetus.
     2. Administration of glucocorticoids
     3. Sedation with phenytoin
     4. Special diet
     5. Reduction of fluid retention with thiazide diuretics
341. A 25-year-old pregnant woman came at 33 week’s gestational age for obstetric care. She complains of sickness, presence of edema on the legs. She has had one normal delivery in the past. The level of arterial blood pressure is 150/100 mmHg. Proteinurua in 24 hours collection is 2 g. Level of thrombocytes is 90.000 x 10 What would be the most appropriate diagnosis?
     1. \*Moderate preeclampsia
     2. Mild preeclampsia
     3. Severe preeclampsia
     4. Chronic hypertension
     5. Eclampsia
342. A 31-year-old pregnant woman came at 34 week’s gestational age for obstetric care. She complains of headache, epigastrial pain, visual disturbances. General edema if present. The level of arterial blood pressure is 160/110 mmHg. Proteinurua in 24 hours collection is 6 g. Level of thrombocytes is 70.000 x 10 What would be the most appropriate diagnosis ?
     1. \*Severe preeclampsia
     2. Moderate preeclampsia
     3. Mild preeclampsia
     4. Eclampsia
     5. Chronic hypertension
343. A 35-year-old pregnant woman comes at 36 week’s gestational age for obstetric care. She complains of headache, epigastrial pain, visual disturbances, and convulsions 1 hour ago. General edema is present. The level of arterial blood pressure is 165/115 mmHg. Proteinurua in 24 hours collection is 6 g. Level of thrombocytes is 70.000 x 10 What would be the most appropriate diagnosis ?
     1. \*Eclampsia
     2. Moderate preeclampsia
     3. Mild preeclampsia
     4. Severe preeclampsia
     5. Chronic hypertensio
344. A 35-year-old pregnant woman came at 36 week’s gestational age for obstetric care. She complains on headache, epigastrial pain, visual disturbances, and convulsions. Edema on legs , hands and face is present. The level of arterial blood pressure is 160/110 mmHg. Proteinurua in 24 hours collection is 6 g. Level of thrombocytes is 70.000 x 10 All of the below belong to the links of treatment of this state EXCEPT:
     1. Delivery in 5-6 hours
     2. Prescription of magnesium sulfate
     3. Prescription of hypotensives drugs
     4. Adequate magnesium therapy
     5. \*Prolongation of pregnancy
345. A 28-year-old pregnant patient came at 35 week’s gestational age for obstetric care. She complains of headache, epigastrial pain. Edema are present on the legs and face. In the past one pregnancy was interrupted by uterine curettage. . The level of arterial blood pressure is 155/110 mmHg. Proteinurua in 24 hours collection is 6 g. Level of thrombocytes is 50.000 x 10 What would be the most appropriate diagnosis?
     1. Moderate preeclampsia.
     2. \*Severe preeclampsia
     3. Mild preeclampsia.
     4. Eclampsia
     5. Chronic hypertension
346. A 26-year-old pregnant woman came at 34 week’s gestational age for obstetric care. She complains of headache, epigastrial pain. Edema are present on the legs and face. The level of arterial blood pressure is 155/110 mmHg. Proteinurua in 24 hours collection is 5 g. Level of thrombocytes is 50.000 x 10 All of the below hypotensives agents are recommended in this case EXCEPT:
     1. a – methyldopha
     2. Labetolol
     3. Metoprolol
     4. Niphedipine
     5. \*Kaptopress
347. The bleeding began right after childbirth. The blood loss is 300 ml. There aren’t the signs of the placental separation. What is the most probable diagnosis?
     1. \*Subtotal placenta adherens
     2. Total placenta adherens
     3. Couveler’s uterus
     4. Placenat previa
     5. Placenta abruption
348. The bleeding began right after childbirth. The blood loss is 350 ml. Signs of the placental separation are negarive. What is the most appropriate management?
     1. \*Manual separation of placenta and exploration of the uterine cavity
     2. Prescription of contractile drugs
     3. Total hysterectomy
     4. Uterine curretage.
     5. Uterine artery ligation.
349. On the 6 day of the postpartum period a 26 years-old woman complaints of profuse bleeding from vagina. Pelvic examination reveals 23-24 weeks increased uterus with clots inside. During examination bloody discharge increases. Diagnosis?
     1. Total placenta adherens
     2. Subtotal placenta adherens
     3. Couveler’s uterus
     4. \*Late postpartum hemorrhage
     5. Placenat previa
350. In the 6 day of the postpartum period a 26 years-old woman complaints of profuse bleeding from vagina. Pelvic examination reveals 22-23 weeks increased uterus with clots inside. During examination bloody discharge increases. What is the most appropriate management of this situation?
     1. \*Uterine curretage
     2. Uterine artery ligation.
     3. Total hysterectomy
     4. Manual exploration of the uterine cavity
     5. Prescription of contractile drugs
351. Patient In., 27 years, appealed to female dispensary with complaints on pain in lower parts of an abdomen, which appear a few days before the menstruation, and with its beginning some diminish. Passed the course of antiinflammatory therapy and physiotherapy, but medical treatment was without a positive effect. At ultrasonography in the middle of menstrual cycle, pathology is not exposed. With a previous diagnosis – an adenomyosis woman was hospitalized in the gynecological department for confirmation of diagnosis and medical treatment. What investigation needs to be done for confirmation of diagnosis?
     1. Diagnostic curettage of uterine cavity .
     2. \*Hysteroscopy.
     3. Colposcopy .
     4. Biopsy.
     5. all of the above.
352. The patient 46 years is delivered in the gynecological department with complaints about uterine bleeding during the last 2 days, weakness. At vaginal examination: the uterus is firm, unpainful, enlarged to 9 weeks of pregnancy. What is the doctor tactic?
     1. \*curettage of uterine cavity .
     2. hysteroscopy.
     3. colposcopy .
     4. biopsy.
     5. all above
353. Patient 23 years. Menstruations with 13 years, on 5—6 days, in 28 days, moderate, unpainful. The last menstruation ended 5 days ago. Married three years, did not prevent pregnancy, but pregnancy were not present. Appealed for advice. What it is necessary to begin the inspection from?
     1. \*To conduct vaginal examination and take smears for microflora
     2. To take smear for colpocytology
     3. To appoint to the spermogramm of husband
     4. ultrasonography
     5. To define concentration of sexual hormones in a dynamics
354. Patient 64 years complains about frequent urination, pains in lower parts of abdomen. In anamnesis: 4 labors, 2 last ended by applying of obstetric forceps with episiotomia. Objectively: the perineum is changed due to old perineal rupture. Tumor-like formation of rose color, elastic consistency appears from a sexual cleft, the uterine cervix goes out from a vagina. On the uterine cervix ulcer is visible. What is the most reliable diagnosis?
     1. Inversion of uterus
     2. \*Complete uterine prolapse, decubital ulcer
     3. The protruding fibroid
     4. cancer of cervix of uterus
     5. prolapsus of front wall of uterus.
355. The patient 20 years appealed to the doctor of female dispensary with complaints about impossibility of sexual life, absence of menstruations. At an external review: the second sexual signs answer age. External genital organs developed correctly, a vagina is absent. At the rectoabdominal inspection: uterus is not palpated, transversal membrane is palpated in its place. The adnexa of uterus are not changed. At US-examination - uterus is absent, ovaries of normal sizes. Cariotype – 46XX. What is diagnosis?
     1. Aplasia of ovaries
     2. Testiculary feminisation
     3. \*Aplasia of vagina and uterus
     4. Gonad dysgenesia
     5. Atresia of hymen
356. At a gynecological review at patient C. 28 years, the exposed erosion of uterine cervix which easily bleeds at the touch. From anamnesis the presence of the contact bleeding is set. What inspection must be conducted to patient?
     1. \*Extended colposcopy and taking of biopsy
     2. Cytological examination of secret of cervical canal and uterine cervix
     3. Simple and extended colposcopy
     4. Roentgenologic examination of organs of small pelvis
     5. Rectovaginal and rectoabdominal examination
357. At patient 70 years, bloody excretions from sexual ways appeared in a postmenopaouzal period. At a gynecological review – bloody discharges from a cervical canal. Uterus and adnexa without features. What method of inspection will allow to specify a diagnosis?
     1. Colposcopy
     2. \*Diagnostic curettage with the histological inspection
     3. Roentgenological inspection of organs of small pelvis
     4. Cytological examination
     5. Ultrasonic inspection of organs of small pelvis
358. The patient 49 years is delivered in the gynecological department with complaints about uterine bleeding during the last 4 days, weakness. At vaginal examination: the uterus is firm, unpainful, enlarged to 7 weeks of pregnancy. What is the doctor tactic?
     1. Colposcopy
     2. \*Curettage of the uterine cavity
     3. Laparoscopy
     4. Hysteroscopy
     5. nothing above
359. A woman 32 years appealed to the doctor with complaints about abundant and protracted menstruations, which proceed already during 6 months, general weakness. A skin is pale. At vaginal examination: uterus is enlarged in sizes as to 9-10 weeks of pregnancy, irregular shape, unpainful, mobile, adnexa are not palpated. The diagnosis of uterine myoma was set. What is the best tactic of conducting patient?
     1. \*Diagnostic curettage of uterine cavity
     2. Miomectomy
     3. Setting of hormonal preparations
     4. Hysterectomy
     5. Nothing above
360. Patient 23 years. Menstruations with 13 years, on 5—6 days, in 28 days, moderate, unpainful. The last menstruation ended 5 days ago. Married three years, did not prevent pregnancy, but pregnancy were not present. Appealed for advice. What it is necessary to begin the inspection from?
     1. To appoint to the spermogramm of husband
     2. \*To conduct vaginal examination and take smears for microflora
     3. To take smear for colpocytology
     4. To Conduct ultrasonography
     5. all above
361. At a gynecological review at patient L. 29 years, the exposed erosion of uterine cervix which easily bleeds at the touch. From anamnesis the presence of the contact bleeding is set. What examination must be conducted to patient?
     1. Simple and extended colposcopy
     2. Cytological examination of secret of cervical canal and uterine cervix
     3. Rectovaginal and rectoabdominal examination
     4. Roentgenologic examination of organs of small pelvis
     5. \*Extended colposcopy and taking of biopsy
362. Patient I., 28 years, appealed to female dispensary with complaints on pain in lower parts of an abdomen, blood discharges. Menstruation was 6 weeks ago. What investigation needs to be done for confirmation of diagnosis?
     1. Diagnostic curettage of uterine cavity .
     2. Hysteroscopy.
     3. Colposcopy .
     4. Biopsy.
     5. \*Ultrasonography.
363. The patient 39 years is delivered in the gynecological department with complaints about uterine bleeding during the last 5 days, weakness. At vaginal examination: the uterus is firm, unpainful, enlarged to 7 weeks of pregnancy. What is the doctor tactic?
     1. \*Curettage of uterine cavity .
     2. Hysteroscopy.
     3. Colposcopy .
     4. Biopsy.
     5. Culdocentesis
364. Patient 26 years. Menstruations with 16 years, on 5—6 days, in 28 days, moderate, unpainful. The last menstruation ended 5 days ago. Married three years, did not prevent pregnancy, but pregnancy were not present. What it is necessary to begin the inspection from?
     1. \*To conduct vaginal examination and take smears for microflora
     2. To take smear for colpocytology
     3. Hysteroscopy
     4. ultrasonography
     5. To define concentration of sexual hormones in a dynamics
365. Patient 66 years complains about frequent urination, pains in lower parts of abdomen. In anamnesis: 3 labors. Objectively: the perineum is changed due to old perineal rupture. Tumor-like formation of rose color, elastic consistency appears from a sexual cleft, the uterine cervix goes out from a vagina. What is the most reliable diagnosis?
     1. Inversion of uterus
     2. \*Complete uterine prolapse
     3. The protruding fibroid
     4. Cancer of cervix of uterus
     5. Prolapsus of front wall of uterus.
366. The patient 20 years appealed to the doctor of female dispensary with complaints of absence of menstruations. At an external review: the second sexual signs answer age. External genital organs developed correctly. At the rectoabdominal inspection: uterus is small. The adnexa of uterus are not changed. What is the doctor tactic?
     1. Hysteroscopy
     2. Colposcopy
     3. \*Ultrasonography
     4. To take smear for colpocytology
     5. To define concentration of sexual hormones in a dynamics
367. At a gynecological examination t patient C. 25 years, the exposed erosion of uterine cervix which easily bleeds at the touch. From anamnesis the presence of the contact bleeding is set. What inspection must be conducted to patient?
     1. Cytological examination of secret of cervical canal and uterine cervix
     2. \*Extended colposcopy and taking of biopsy
     3. Simple and extended colposcopy
     4. Hysteroscopy
     5. Rectovaginal and rectoabdominal examination
368. At patient 67 years, bloody excretions from genital tract appeared . At a gynecological examination – bloody discharges from a cervical canal. Uterus and adnexa without features. What method of inspection will allow to specify a diagnosis?
     1. Colposcopy
     2. Ultrasonic inspection of organs of small pelvis
     3. Roentgenological inspection of organs of small pelvis
     4. Cytological examination
     5. \*diagnostic curettage with the histological inspection
369. The patient 46 years is delivered in the gynecological department with complaints about uterine bleeding during the last 3 days, weakness. At vaginal examination: the uterus is firm, unpainful, enlarged to 10 weeks of pregnancy. What is the doctor tactic?
     1. Colposcopy
     2. Culdocentesis
     3. Laparoscopy
     4. Hysteroscopy
     5. \*Curettage of the uterine cavity
370. A woman 32 years appealed to the doctor with complaints of prolonged menstruations, which proceed already during 6 months, general weakness. A skin is pale. At vaginal examination: uterus is enlarged in sizes as to 8-9 weeks of pregnancy, irregular shape, unpainful, mobile, adnexa are not palpated. The diagnosis of uterine myoma was set. What is the best tactic of conducting patient?
     1. Hysterectomy
     2. Miomectomy
     3. Setting of hormonal preparations
     4. \*Diagnostic curettage of uterine cavity
     5. Nothing above
371. At a gynecological examination of patient C. 30 years, the exposed erosion of uterine cervix which easily bleeds at the touch. From anamnesis the presence of the contact bleeding is set. What examination must be conducted to patient?
     1. Simple colposcopy
     2. Cytological examination of secret of cervical canal and uterine cervix
     3. Rectoabdominal examination
     4. X-ray examination of organs of small pelvis
     5. \*Extended colposcopy and taking of biopsy
372. In the gynecology department patient of 26 years with complaints of bleeding from the genital tract, after a delay of menstruation within 6 days, weakness, dizziness. Objective: pale skin, tachycardia, BP - 100/60. In the analysis of blood Hb = 100 g / liter. Doctor’s tactics?
     1. Laparoscopy
     2. Measurement of basal temperature
     3. \*Culdocentesis
     4. Colposcopy
     5. Hysteroscopy
373. A woman aged 42 was diagnosed submucous uterine fibroids. Which method should be used to diagnose this form of uterine fibroids?
     1. Laparoscopy
     2. \*Hysteroscopy
     3. Doppler
     4. Biopsy
     5. Culdocentesis
374. The patient 28years old at the time of cytological examination revealed type I of Pap smear from the cervix. When a woman must come to re-examination to gynecologist:
     1. \*in 1 year for medical examination
     2. after 1 month to confirm the effectiveness of treatment
     3. sent to the oncology clinic
     4. in 6 months for the medical examination
     5. non above
375. The patient 27 years was found type II A of Pap smear from the cervix. When a woman has come to re-examine to gynecologist in:
     1. 1 year for medical examination
     2. \*1 month to confirm the effectiveness of treatment
     3. sent to the oncology clinic
     4. 6 months for medical examination
     5. no correct answer
376. A woman 33 years was diagnosed II B type of Pap smear. How long does an obstetrician-gynecologist will appoint next examination:
     1. 1 year for medical examination
     2. \*Control examination (colposcopy, cytologic study, bacterioscopy) after the next menstruation
     3. sent to the oncology clinic
     4. 6 months for the medical examination
     5. non correct answer
377. The woman at the time of medical examination revealed III A type of Pap smear of the cervix. When the next check inspection:
     1. 1 year for medical examination
     2. \*Control examination (colposcopy, cytologic study, bacterioscopy) conducted after the next menstruation
     3. immediately sent to the oncology clinic
     4. 6 months for the medical examination
     5. non correct answer
378. At a gynecological examination patient C. 30 years old with menstrual disfunction. From anamnesis infertility for 5 years. What examination must be conducted to patient?
     1. To conduct vaginal examination and take smears for microflora
     2. To take smear for colpocytology
     3. To appoint to the spermogramm of husband
     4. Ultrasonography
     5. \*All above
379. The patient 17 years appealed to the gynecologist with complaints about a tearfulness, depressed mood, aggressiveness, pain in the breasts which are marked at her 3-4 days before the menstruation and after the beginning of it disappeared. In anamnesis: labors-0, abortions-0. Menarhe in 13 years, menstruations every 31 days, during 4-5 days, are regular, unpainful, not abundant. At vaginal examination: pathology of genital organs are not exposed. What is the most credible diagnosis?
     1. Algodismenorrea
     2. The endometriosis
     3. \*Premenstrual syndrome
     4. Thireotoxycosis
     5. nothing above
380. Patient to a 21 year, complains about that menstruations which appeared in 16 years, there were the irregular, in a few amount, and the last two years are absent. At examination: the uterine cervix is conical, clean, the body of uterus is small, hypoplastic, mobile, not painful. The adnexa of uterus are not determined, parametrium are free. Colpocytological investigation: the maturity index 70/30/0, cariopicnotic index 40%, rectal temperature is monotonous, below a 37o C. What is most reliable diagnosis?
     1. \*Secondary amenorrea as a result of genital infantilism
     2. primary amenorrhea
     3. secondary amenorrea on a background anovulatory syndrome
     4. pregnancy
     5. Shikhan’ syndrome
381. A woman 49 years complains about bloody excretions from a vagina during 2 weeks which appeared after the delay of menstruation on 3 months. Menstruations the last year irregular. Blood test: Hb - 90 g/l, red blood cells - 2,0х1012 /л, leucocytes - 5,6х109 /л. At vaginal examination: uterus of normal sizes, adnexa are not palpated. What diagnosis is most credible?
     1. Polyps of endometrium
     2. \*Climacteric bleeding
     3. Cancer of endometrium
     4. Violation of blood coagulation
     5. Incomplete abortion
382. Patient 24, entered gynecological department with complaints about considerable bloody excretions. Menarhe with 16 years. At ultrasonography of organs of small pelvis: symmetric bilateral increase of ovaries, bulge of capsule, presence of a plenty of atresia of follicles as cysts by a diameter 0,5-2,5 sm. Previous diagnosis?
     1. \*Syndrome Stein-Levental
     2. Syndrome Terner
     3. Syndrome Asherman
     4. Adrenogenital syndrome
     5. Syndrome Cushing
383. A woman of 54 years complains about the bloody discharges from a vagina and dispareunia. Menopauza during 3 years. At ultrasonic examination the endometrium atrophy exposed. At a speculum examination – mucosal membrane of vagina pale, dry, ulcers on mucousal membrane are marked. Choose the most suitable medical treatment or procedure.
     1. Setting of oxyprogesteron-acetate
     2. Successive therapy of estrogens and progesteron
     3. \*Application of estrogen cream
     4. Biopsy to endometrium
     5. all above
384. The patient complains about acute pains in lower parts of abdomen, which irradiate in rectum. Pains of cyclic character, acutely increase during defecation, physical activity. In intermenstrual period insignificant, and during menstruation severe. Is ill 2 years. Before the menstruations were normal. There were 2 labors, 1 abortion 5 years ago. The inflammatory diseases of genital organs were not present. Pulse -76 in 1 min, AP 120/80 mm Hg. Abdomen is soft, unpainful. Uterus of normal size, adnexa - without changes. Hard, painful infiltrat with an unequal surface is palpated behind the cervix. Infiltrat growth to posterior fornix, it is exposed at rectal examination. Blood test of ESR-16-16 mm/hr, leucocytes-8х109/л. Diagnosis?
     1. Chronic bilateral adnexitis in the stage of acutening
     2. \*External genital endometriosis, retrocervical localization
     3. Ectopic pregnancy
     4. Tumor of rectum
     5. nothing above
385. In female dispensary the patient 28 years appealed with complaints about infertility. By the sexual life 4 years live in marriage, does not prevent pregnancy. Pregnancy were not present. It is set at the inspection of woman: the condition of genital organs without deviations from a norm. Uterine tubes permeability is normal. Bazal temperature during 3 menstrual cycles is monophase. What is the most credible reason of infertility?
     1. \*Anovulatory menstrual cycle
     2. Immunological infertility
     3. Genital endometriosis
     4. Chronic salpingoophoritis
     5. nothing above
386. A 24 y.o. patient 13 months after the first labour consulted a doctor about amenorrhea. Pregnancy has concluded by a Cesarean section concerning to a premature detachment of normally posed placenta hemorrhage has made low fidelity 2000 ml owing to breakdown of coagulability of blood. Choose the most suitable investigation:
     1. Determination of the level of Progesteron
     2. Ultrasonography of pelvis
     3. \*Determination of the level of Gonadotropins
     4. Computer tomography of the head
     5. Determination of the contents of Testosteron-Depotum in Serum of blood
387. A girl 13 y.o. consulted the school doctor on account of moderate bloody discharge from the genital tracts, which appeared 2 days ago. Secondary sexual characters are developed. What is the most probable cause of bloody discharge?
     1. \*Menarche
     2. Haemophilia
     3. Juvenile hemorrhage
     4. Endometrium cancer
     5. Werlhof's disease
388. In female dispensary appealed patient 32 years with complaints on dismenorrea, dispareunia, rectal pain, prementsrual spotting, pain in the back during menstruation. At vaginal examination: sacrum-uterine ligaments are sensible, is marked them induration. The uterus of normal sizes, fixed, is firm. Adnexa are not palpated. At laparoscopy there are small violet tumors on the peritoneal surface of external part of uterus. What diagnosis is most credible?
     1. Internal genital endometriosis
     2. \*External genital endometriosis
     3. Chronic adnexitis
     4. Adenocarcinoma
     5. nothing above
389. A patient was admitted to the hospital with complaints of periodical pain in the lower part of abdomen that gets worse during menses, weakness, malaise, nervousness, dark bloody smears from vagina directly before and after menses. Bimanual examination revealed that uterus body is enlarged, appendages cannot be palpated, posterior fornix has tuberous surface. Laparoscopy revealed: ovaries, peritoneum of rectouterine pouch and pararectal fat have "cyanotic eyes". What is the most probable diagnosis?
     1. \*Disseminated form of endometriosis
     2. Tuberculosis of genital organs
     3. Ovarian cystoma
     4. Chronic salpingitis
     5. Polycystic ovaries
390. A 20 y.o. patient complains of amenorrhea. Objectively: hirsutism, obesity with fat tissue prevailing on the face, neck, upper part of body. On the face there are acne vulgaris, on the skin - striae cutis distense. Psychological and intellectual development is normal. Gynecological condition: external genitals are moderately hairy, acute vaginal and uterine hypoplasia. What diagnosis is the most probable?
     1. Turner's syndrome
     2. \*Itsenko-Cushing syndrome
     3. Shichan's syndrome
     4. Babinski-Froehlich syndrome
     5. Stein-Levental's syndrome
391. Growth of patient is 130 cm, tubby thorax, short neck with wing-like folds, cross-eyes, ptozis, absent secondary sexual sings, amenorrhea. What is the diagnosis?
     1. Syndrome Itsenco-Kushing
     2. \*Shershevsky- Terner’s syndrome
     3. Shtein-Levental syndrome
     4. Pituitary nanizm
     5. Syndrome Pehrants-Babinscy-Frelich
392. A 14 y.o. girl complains of profuse bloody discharges from genital tracts during 10 days after suppresion of menses for 1,5 month. Similiar bleedings recur since 12 years on the background of disordered menstrual cycle. On rectal examination: no pathology of the internal genitalia. In blood: Нb- 70 g/L, RBC- 2,3\*1012/L, Ht- 20. What is the most probable diagnosis?
     1. \*Juvenile bleeding, posthemorrhagic anemia
     2. Noncomplete spontaneous abortion
     3. Polycyst ovarian syndrome
     4. Werlholf's disease
     5. Hormonoproductive ovary tumor
393. A woman 26 years 6 months ago had delivery. A child on the breast nutrition. She came to doctor because of absence of menstruation, they did not appear after childbirth. When bimanual examination the uterus is not enlarged, firm, appendages are not defined. What is the most likely diagnosis?
     1. Psevdoamenoreya
     2. \*Lactational amenorrhea
     3. Sheehan syndrome
     4. Chiari - Frommelya Syndrome
     5. Pregnancy 3 - 5 weeks
394. The patient is 59 years came to the gynecologist with a complaint of vaginal bleeding from the vagina. Postmenopause 12 years. Genitals in a state of involution, uterine cervix is clean, from the cervical canal minor spotting. The uterus is not enlarged, the fornices are deep, not painful. What additional diagnostic tests is needed to clarify the diagnosis?
     1. \*Diagnostic curretage
     2. Culdoscopy
     3. Puncture of the abdominal cavity through the posterior fornix
     4. Hysterosalpingography
     5. All above.
395. Female 19 years old is complaining of the absence of menstruation after childbirth for 8 months. She does not fed, since there was no milk immediately after birth, which complicated with massive bleeding. Recently lost weight, began to crumble hair. Bimanual examination: the uterus less in sizes, appendages are not defined. What is the most likely diagnosis?
     1. Galaktorei - amenorrhea syndrome
     2. \*Sheehan's syndrome
     3. Physiological amenorrhea
     4. Suspicion of ectopic pregnancy
     5. Syndrome Stein - Leventhal
396. A young woman 20 years old, whose birth a year ago have complicated by massive bleeding, the doctor diagnosed Sheshan’s syndrome. Which of the following can confirm the diagnosis?
     1. \*Investigation of the level of gonadotropic hormones, pituitary tomography
     2. Hysteroscopy
     3. Culdoscopy
     4. Laparoscopy
     5. All of above
397. A woman 25 years has Sheehan’s syndrome. A year ago, had birth complications. Which of these complications could lead to the development of this syndrome, and why?
     1. The weakness of labor, stimulation of it. Hormonal disorders
     2. Contracted pelvis, cesarean section. Structural changes in the myometrium and endometrium
     3. Endometritis. Changes in the endometrium
     4. \*Massive blood loss. Necrotic changes in the pituitary
     5. All of these conditions can cause Sheehan’s syndrome
398. Female 12 years came to doctor complaining of vaginal bleeding from the genital tract, which first appeared 3 days ago. Physically well developed secondary sexual characteristics are expressed. The external genitalia developed properly. What is the cause of bleeding?
     1. Dysfunctional uterine bleeding
     2. \*Menarche
     3. Endometrial cancer
     4. Hormone-producing tumors of the ovary
     5. Hemophilia
399. Patient 15 years was admitted to the gynecological hospital complaining of vaginal bleeding, which began 10 days ago. The first menstrual period was 3 months ago, then was delayed for 2 - 5 months. Rectal examination reveled reduced uterine body, the relations between the body and cervix of 1:1. The appendages of the uterus is not defined. Koagulograme normal, general blood test - a slight decrease in hemoglobin levels. What is the most likely diagnosis?
     1. Menarche
     2. \*Juvenile bleeding
     3. Idiopathic thrombocytopenic purpura
     4. Abortion
     5. Hormone-producing tumor
400. Patient 23 years old complains of delay menstruation for 4 months, the last year significantly increased body weight. Objectively : the growth of hair on male pattern. The uterus is normal size. The ovaries are enlarged, dense, not painful at examination. Basal temperature monophase. What is the most likely diagnosis?
     1. Itsenko - Cushing Syndrome
     2. \*Syndrome Stein - Leventhal
     3. Dysgenesis of the gonads
     4. Adrenogenital syndrome
     5. Premenstrual Syndrome
401. A young woman who complains of a delay menstruation 4 months, the physician put a preliminary diagnosis of polycystic ovary syndrome and appointed an additional examination. Which methods are not useful for diagnosis of this disease?
     1. Laparoscopy
     2. Hormonal level
     3. Measurement of basal temperature
     4. \*Colposcopy
     5. Informative all these methods
402. The patient is 39 years old complains of menstrual bleeding that last usually for 12 - 14 days. Last menstrual period began 3 weeks ago and lasts until that time. Bimanual examination doesn’t found changes in the uterus and appendages. What is the pathology?
     1. Polimenoreya
     2. Menorrhagia
     3. \*Disfunctional uterine bleeding
     4. Metrorrhagia
     5. Gynecologic hemorrhagic syndrome.
403. A woman 39 years after delay menstrualtion the uterus bleeding started, which lasts 12 days. The uterus and appendages are normal. What should be the tactics of a doctor?
     1. \*Uterus curretage
     2. Start a transfusion of plasma or other blood products
     3. Hysterectomy
     4. Gestagens therapy
     5. Nothing above
404. A woman 44 years with dysfunctional uterine bleeding, held fractional curettage of the uterus. Anatomical changes in the uterus and appendages are not found. Bleeding appeared for the first time, after a delay of menstruation for 2 months before a normal menstrual cycle. Conclusion of histological examination - endometrial hyperplasia. Which of the following methods most appropriate to use?
     1. Androgens in the cyclic mode
     2. \*Gestagens therapy
     3. Chorionic gonadotropin therapy
     4. Haemostatic therapy
     5. Hysterectomy
405. To the family doctor came the patient S, 25 years complained of the menstruation absence during last 6 months. The patient had 1 delivery 6 years ago, 2 artificial abortion. The last was complicated because of the bleeding, twice held the uterus curretage. After the second d&c was endometritis, which was treated in hospital for 15 days. Menstruation after this disappeared. On gynecological examination the uterus and appendages were normal. What is the preliminary diagnosis?
     1. Uterine pregnancy in the early period
     2. Ovarian amenorrhea
     3. Hypothalamic amenorrhea
     4. Chiari – Frommelya Syndrome
     5. \*Uterine amenorrhea
406. The patient is 48 years with a complaint of violation of the menstrual cycle – menstruation lasts for 7 - 9 days, the excess over the last six months. Notes heat waves, insomnia, irritability, headache. Skin normal colors. Blood pressure 130 / 190 mm., pulse 80 - 90 beats / min, regular. The abdomen was soft and painless. Bimanually: uterus is not enlarged, appendages are not palpable. Fornices are free. What is the most likely diagnosis? Assign treatment.
     1. Climacteric syndrome, treatment is not necessary
     2. \*Climacteric syndrome, treatment of sedatives, hormone replacement therapy estrogen
     3. Postcastration syndrome, hormone replacement therapy
     4. Sheehan's syndrome, treatment is not necessary
     5. Esentsial hypertension, antihypertensiv drugs
407. A woman 32 years appealed to the doctor with complaints about abundant and protracted menstruations, which proceed already during 6 months, general weakness. A skin is pale. At vaginal examination: uterus is enlarged in sizes as to 9-10 weeks of pregnancy, irregular shape, unpainful, mobile, adnexa are not palpated. The diagnosis of uterine myoma was set. What is the best tactic of conducting patient?
     1. \*Diagnostic curettage of uterine cavity
     2. Miomectomy
     3. Hysterectomy
     4. Setting of hormonal preparations
     5. Setting of preparations of iron
408. Patient delivered in the gynecological department by the emergency. Two hours ago suddenly the acute pain in an abdomen, nausea, vomits began. The last menstruation was two weeks ago. Patient is pale, pulse 116, soft, AP 70/40 mm Hg. An abdomen does not take part in breathing. Vaginally: the posterior fornix of vagina is painful, uterus of normal sizes, mobile, painful at palpation. Adnexa can not be palpated through the tension of abdominal wall. Blood test: leucocytes 8x109/l. A pregnancy test is negative. Diagnosis?
     1. \*Apoplexy of ovary
     2. Acute appendicitis
     3. The ruptured ectopic pregnancy
     4. Necrosis of subserosal fibroid
     5. Acute bilateral adnexitis
409. Patient 38 years, 5 years are observed concerning uterine myoma (size of tumor - to 10 weeks of pregnancy), complains about the abundant protracted menstruations at which the quantity of hemoglobin goes down to 80 g\l. At the admission: the time of menstruation, 8th day, excretions are abundant, is patient pale. What is the first step of treatment?
     1. \*The uterine curettage
     2. Hemostatic therapy
     3. Hemostimulated therapy
     4. Antibacterial therapy
     5. Hormonal medical treatment
410. Patient 34 years. The uterine myoma is exposed 2 years ago. Growth is not present. There is pain in lower parts of abdomen. Leucocytosis 17х109 /л. The symptoms of irritation of peritoneum are positive. At vaginal examination: the uterus is enlarged to 10 weeks of pregnancy, one of fibroids is mobile, painful. Excretions are mucous. Diagnosis?
     1. \*fibroid’ torsion
     2. Cyst of ovary
     3. Acute adnexitis
     4. Rupture of pyosalpinx
     5. Acute appendicitis
411. The patient 46 years is delivered in the gynecological department with complaints about severe uterine bleeding during the last 2 days, weakness. At vaginal examination: the uterus is firm, unpainful, enlarged to 9 weeks of pregnancy. What is the doctor tactic?
     1. \*Curettage of the uterine cavity
     2. Colposcopy
     3. Hysteroscopy
     4. Laparoscopy
     5. Pelvic X-ray examination
412. The patient complains about acute pains in lower parts of abdomen, which irradiate in rectum. Pains of cyclic character, acutely increase during defecation, physical activity. In intermenstrual period insignificant, and during menstruation severe. Is ill 2 years. Before the menstruations were normal. There were 2 labors, 1 abortion 5 years ago. The inflammatory diseases of genital organs were not present. Pulse -76 in 1 min, AP 120/80 mm Hg. Abdomen is soft, unpainful. Uterus of normal size, adnexa - without changes. Hard, painful infiltrat with an unequal surface is palpated behind the cervix. Infiltrat growth to posterior fornix, it is exposed at rectal examination. Blood test of ESR-16-16 mm/hr, leucocytes-8х109/л. Diagnosis?
     1. \*External genital endometriosis, retrocervical localization
     2. Chronic bilateral adnexitis in the stage of acutening
     3. Ectopic pregnancy
     4. The Fibromyoma uteruses with untypical localization
     5. Tumor of rectum
413. Patient, 32 years appealed to the gynecologist with complaints about abundant, protracted menstruations during 3 years, aching pain in lumbal area. Did not visit a gynecologist 2 years. The last menstruation 2 a week ago, in time. In anamnesis: menarhe at 13 years, menstruations during 7 days, every 28 days; Labors-0, abortions-3. At vaginal examination: the uterine cervix is clean, the uterus is enlarged to 9 weeks of pregnancy, firm, mobile, not painful, in anteflexio. Adnexa on either side are not enlarged. Excretions are mucous. What is to be carried out the first of all?
     1. \*Diagnostic curettage of the uterine cavity
     2. Surgical medical treatment
     3. Hormonal therapy 17-OPC
     4. Diagnostic laparoscopy
     5. Supervision after sick
414. Patient 43 years appealed to female dispensary with complaints in the presence of cervical erosion which was exposed at routine medical examination by the midwife. In anamnesis: labors-4, abortions-5. Меnarche at 12 years, menstruations every 28 days, during 3 days, are regular, unpainful. Sexual life with 17 years. At colposcopy: on the uterine cervix the area of transformation is found out. The biopsy is carried out and the diagnosis of displasia is confirmed. At cytological examination there is IIIB type of Pap’ smear. To define the necessary volume of treatment of the patient:
     1. \*Cervical diatermoconisation
     2. The diatermocoagulation of the cervix
     3. The total hysterectomy without adnexa
     4. The criodestruction of the cervix
     5. Subtotal hysterectomy of cervix
415. Patient In., 27 years, appealed to female dispensary with complaints on pain in lower parts of an abdomen, which appear a few days before the menstruation, and with its beginning some diminish. Passed the course of antiinflammatory therapy and physiotherapy, but medical treatment was without a positive effect. At ultrasonography in the middle of menstrual cycle, pathology is not exposed. With a previous diagnosis – an adenomyosis woman was hospitalized in the gynecological department for confirmation of diagnosis and medical treatment. What investigation needs to be done for confirmation of diagnosis?
     1. \*Hysteroscopy
     2. Fractious diagnostic curettage of uterine cavity
     3. X- ray examination of small pelvis and abdominal region
     4. Colposcopy
     5. Biopsy
416. Patient 23 years is delivered in the gynecological department in the severe condition with complaints about acute permanent pain in the area of right labia pudenda majora, impossibility of movement. Objectively: temperature of body 38,7. At a review: right labia pudenda majora is slightly swollen, skin above it and lower part of vagina is swollen, hyperhemia is present. At palpation the pain become severe. Inguinal lymphatic nodes are enlarged, especially to the right. Laboratory: high leucocytosis, rise ESR to 27 mm\hr. Diagnosis:
     1. \*The true abscess of bartolin gland
     2. False abscess of bartolin gland
     3. Cyst of bartolin gland
     4. An abscess is steam of ouretralnih glands
     5. Vestibulit
417. Patient 22 years. Complains about pain in a right labia pudenda majora, rise of body temperature to 38.0 °C. At the review of genital organs the considerable increasing of right large sexual lip definites, especially in the lower third. Erythema, edema, at palpation acutely painful, fluctuation is determined. To conduct vaginal examination due to acute pain is impossible. Blood test: Leucocytes — 10,0 x 109 per cu mm, Rod-nuclear — 10%.What method is main?
     1. \*The dissection and drainage of abscess
     2. To withdraw a bartolin gland within the limits of healthy tissue
     3. To appoint physical therapy procedures
     4. To appoint compresses with liniment
     5. To expect a spontaneous regeneration of abscess
418. Patient A.complains for discharge from vagine, genital itching. Objectives: vaginal mucous is edematous, hyperemic, foamy discharge. Diagnose?
     1. Purulent colpitis
     2. \*Trichomonal colpitis
     3. Urogenital clamidiosis
     4. Bacterial colpitis
     5. Gonorrheal colpitis
419. Female patient, 33 years old, has IIA type of PAP-smear. When she should visit obstetritian-gynecologist next time?
     1. In 1 year
     2. \*In 1 month to confirm effectiveness of treatment
     3. Should be directed to the oncological hospital
     4. In 6 months
     5. There is no correct answer
420. Female patient, 35 years old, has IIB type of PAP-smear. When she should visit obstetritian-gynecologist next time?
     1. in 1 year
     2. \*control assessment (colposcopy, cytological test, bacterioscopy) should be performed after next menstruation
     3. should be directed to the oncological hospital
     4. in 6 months
     5. there is no correct answer
421. Patient 25 years, complains about considerable foamy discharge from the vagina, pain at sexual intercourse, itching in vagina. Menstrual function is normal. There were 1 labor and one abortion. She is ill about a week. At examination: vaginal walls with edema, erythema, dischage are yellow and foamy. What is most reliable diagnosis?
     1. \*Trichomoniasis.
     2. Acute gonorrhea
     3. Candidosis
     4. Bacterial vaginosis
     5. Chlamidiasis
422. The patient 36 years complains on pain in lower parts of abdomen, rise of body temperature to 37,7 – 38oC, purulent-bloody excretions from a vagina. 3 days ago artificial abortion was done at pregnancy 8-9 weeks. Objectively: external genital organs without pathology, uterine cervix with the signs of endocervicitis. The uterine body is enlarged to 5-6 weeks of pregnancy, the mobile is limited, soft, not painful. Adnexa are not determined, a region of them is unpainful. Parametrium are free. Excretions festering. Blood test: hemoglobin — 100 g/l, leucocytes — 12x109 /l. What agent is the most reliable cause of endometritis?
     1. \*Gonococcus
     2. Gardnerella
     3. Trichomonas
     4. Fungus flora
     5. Doderleyn’ bacilli
423. Patient 29 years, delivered by the emergency, complains about acute pains in lower parts of an abdomen. Pains arose up suddenly, at getting up of weight. The last menstruation was 10 days ago, in the term. Labors — 2, abortions — 2. The last time visited gynecologist half-year ago, ovarian cyst was definite. Pulse - 100 in a minute, rhythmic, breathing 22 in a minute. Abdomen is tense, acutely painful, especially on the left. Objectively: the uterine cervix is cylinder, deformed by old post-natal ruptures, clean. The uterine body is not determined due to tension of abdominal wall. Right adnexa not palpated. A tumor without clear contours is palpated in the region of the left adnexa, elastic consistency, the mobile is limited, painful. Parametriums are free. What most reliable diagnosis?
     1. \*Torsion of pedicle of ovarian cyst
     2. The ruptured ectopic pregnancy
     3. Apoplexy of ovary
     4. Rupture the cysts of ovary
     5. Rupture the cysts of ovary
424. The patient 36 years complains on pain in lower parts of abdomen on the left side, which arose up suddenly. Objectively: external genital organs without pathology, the uterine cervix is cylindric, clean. The body of uterus is enlarged to 12—13 weeks of pregnancy, the mobile is limited. One of fibroids on the left near a fundus acutely painful. Adnexa are not determined, its region is unpainful. Parametriums are free. Excretions serous. Blood test: Haemoglobin — 120 g/l, leucocytes — 12x109 /л. What is the most reliable diagnosis?
     1. \*Necrosis of fibroid
     2. Spontaneous rupture of pregnant uterus
     3. Chorionepithelioma
     4. The interrupted pregnancy in the interstitsial region of fallopian tube
     5. Destructive form of the molar pregnancy
425. The patient 48 years complains about abundant menstruations. Menstruations to this time were without deviations from a norm. Labors — 2, abortions — 2. The last 2 years not visited gynecologist. Objectively: external genital organs without pathology, the uterine cervix is cylinder, clean. The uterus is enlarged to 14-15 weeks of pregnancy, unequal surface, mobile, not painful. Adnexa are not determined, its region is unpainful. Parametriums are free. Excretions mucous. What most reliable diagnosis?
     1. \*Uterine myoma
     2. Sarcoma of uterus
     3. Pregnancy 14-15 weeks
     4. Chorionepitelioma
     5. Cancer to endometrium
426. Patient 48 years complains on the very abundant menstruation for the last 8-9 months. During 2 years is observed by a gynecologist concerning uterine myoma. Objectively: the uterine cervix is clean, external os is closed. The uterus in normal position, enlarged to 9-10 weeks of pregnancy, unequal surface, firm, mobile, not painful. Adnexa of both sides are not determined. Parametrium free. Excretions mucous. What is the most reliable diagnosis?
     1. \*Subserosal uterine myoma
     2. Cancer to endometrium
     3. Interstitial uterine myoma
     4. Endometriosis
     5. pregnancy
427. The patient 36 years appealed to female dispensary with complaints about pain in lower parts of abdomen. The patient found a tumor in abdominal region. Menstruations to this time were without deviations from a norm, but became more abundant. The last menstruation 10 days ago. Labors — 2, abortions — 2. Objectively: external genital organs without pathology, the uterine cervix is clean. The uterus is enlarged to 22-23 weeks of pregnancy, unequal surface, mobile, not painful. Adnexa are not determined, a region is them unpainful. Parametrium free. What is the most reliable diagnosis?
     1. \*The Uterine myoma
     2. Sarcoma of body of uterus
     3. Pregnancy 14-15 weeks
     4. Chorionepithelioma
     5. Cancer of endometrium
428. The patient 36 years complains about pain in lower parts of abdomen, that reminds the labor contractions, weakness. The menstruations last 2 years are more abundant, of long duration. The last menstruation began 2 days ago. Objectively: A skin and mucous membranes are pale, pulse 88 in 1 min. Abdomen is soft, unpainful. Gynecological status: external genital organs without pathology, the uterine cervix is cylinder, a canal freely skips 2 fingers. From a cervix a tumor 3x6 cm hangs down to the vagina, pedicle by thickness to 1 cm enters to the cavity of uterus. The tumor is a dark-purple color, at contact bleeds. The body of uterus is enlarged to 7-8 weeks of pregnancy, unequal surface, mobile, not painful. Adnexa are not determined. What is the most reliable diagnosis?
     1. \*The protruding fibroid
     2. Endophytic growth of cancer of uterine cervix
     3. Chorionepithelioma, metastasis in the uterine cervix
     4. Inevitable abortion in 7-8 weeks of pregnancy
     5. Exophytic growth of cancer of uterine cervix
429. In the gynecological department a woman 25 years appealed with complaints about the rise of temperature of body to 38,60С, pain in lower parts of abdomen, dyzuria. Became ill 3 days to that, when the indicated complaints appeared after artificial abortion. At gynecological examination: the uterine cervix is cylinder, external os is closed. Body of uterus a few enlarged, painful, soft. The adnexa of uterus are not palpated. Excretions festering-bloody. In the blood test leycocytosis with displacement of formula of blood to the left, speed-up ESR. What diagnosis is most credible?
     1. \*Acute endometritis
     2. Acute endocervicitis
     3. Acute salpingoophoritis
     4. Acute cystitis
     5. Piosalpinx
430. In female dispensary appealed patient 32 years with complaints on dismenorrea, dispareunia, rectal pain, prementsrual spotting, pain in the back during menstruation. At vaginal examination: sacrum-uterine ligaments are sensible, is marked them induration. The uterus of normal sizes, fixed, is firm. Adnexa are not palpated. At laparoscopy there are small violet tumors on the peritoneal surface of external part of uterus. What diagnosis is most credible?
     1. \*External genital endometriosis
     2. Internal genital endometriosis
     3. Adenocarcinoma
     4. Chronic adnexitis
     5. Ectopic pregnancy
431. The patient 49 years complains about the protracted and abundant menstruations during 2th years. At vaginal examination: the uterine cervix is cylinder, a cervicaliy canal skips one finger, higher than level of internal os a hard tumor is felt by a diameter to 4 sm. An uterus is enlarged to 10 weeks of pregnancy, firm, unpainful. Adnexa are not palpated. What most credible diagnosis?
     1. \*Submucous uterine myoma
     2. Inevitable abortion
     3. Polyps of uterine cervix
     4. Molar pregnancy
     5. Anomaly of uterine development
432. At a gynecological review at patient C. 28 years, the exposed erosion of uterine cervix which easily bleeds at the touch. From anamnesis the presence of the contact bleeding is set. What inspection must be conducted to patient?
     1. \*Extended colposcopy and taking of biopsy
     2. Simple and extended colposcopy
     3. Cytological examination of secret of cervical canal and uterine cervix
     4. Rectovaginal and rectoabdominal examination
     5. X-ray examination of organs of small pelvis
433. The patient 40 years entered gynecological department for surgical medical treatment in connection with the presence of submucous uterine myoma. At colposcopy uterine cervix dysplasia is exposed. What volume of operative interference is optimum?
     1. \*Total hysterectomy without adnexa
     2. Subtotal hysterectomy of uterus without adnexa
     3. Subtotal hysterectomy of uterus with adnexa
     4. Conservative myomectomy
     5. Defundation of uterus
434. Patient C. 21р., complains about insignificant excretions from sexual ways itch of external genital organs, which appeared after sexual intercourse. In marriage is not found. At a review there is hyperemia of vault of vagina and cervix . In the area of posterior fornix of vagina of accumulation of liquid, greyish-yellow, foamy excretions. Previous diagnosis?
     1. \*Acute trihomoniasis
     2. Acute gonorrhoea
     3. Urogenital chlamidiosis
     4. Micoplasmosis
     5. Ureaplasmosis
435. Female patient, 28 years old, has IIB type of PAP-smear. She has been treated by coagulation. When she should visit obstetritian-gynecologist next time?
     1. in 1 year
     2. control assessment (colposcopy, cytological test, bacterioscopy) should be performed after next menstruation
     3. \*in 3 months after coagulation
     4. in 2 years after coagulation
     5. there is no correct answer
436. Female patient, 25 years old, has IIIA type of PAP-smear. When she should visit obstetritian-gynecologist next time?
     1. in 1 year
     2. \*control assessment (colposcopy, cytological test, bacterioscopy) should be performed after next menstruation
     3. should be directed to the oncological hospital
     4. in 6 months
     5. there is no correct answer
437. What treatment should be prescribed to the 48-year old female patient with severe cervical dysplasia with involved cervical canal and ovarian cyst?
     1. electroconization of cervix uteri
     2. electrocoagulation of cervix uteri
     3. \*Total hysterectomy with adnexa uteri
     4. solcovagin treatment
     5. Total hysterectomy without adnexa uteri
438. Female patient, 33 year old, complains for genital itching, pain in vagina, white discharge. During assessment: mucous – edematous, hyperemic, in folders – whitish cheeslike dischurge. Primary diagnose?
     1. trichomonal colpitis
     2. clamidia colpitis
     3. urogenital mycoplasmosis
     4. bacterial colpitis
     5. \*candidiasis colpitis
439. Female patient, 34 year old, complains for genital itching, pain in vagina, white discharge. During assessment: mucous – edematous, hyperemic, in folders – whitish cheeslike dischurge. Choose appropriate medication..
     1. cifran
     2. Flagil
     3. \*Dyflucan
     4. Trichopol
     5. Levamisole
440. Female patient, 50 year old. Menopause – 1 year. No complains. During assessment: cervix is clean, uterus body is increased up to the 7 weeks of pregnancy. Uterine adnexa are not palpable. US – intramural node, 2 cm. What is appropriate treatment ?
     1. \*Conservative
     2. Supracervical hysterectomy without adnexa
     3. Total hysterectomy with adnexa
     4. Supracervical hysterectomy with adnexa
     5. Myomectomy
441. Female patient, 30 years old. Complains at considerable bloody discharge during each menstruation. Menstruation lasts 7 - 10 days. Gynecologiacal status: cervix is clean, uterus inlarged up to the 14 weeks of pregnancy. Adnexa uteri are not palpable. US – submucouse, subserouse and several interstitial nodes from 2 to 5 cm. Prescribe appropriate treatment
     1. Conservative
     2. \*Supracervical hysterectomy without adnexa
     3. Total hysterectomy with adnexa
     4. Supracervical hysterectomy with adnexa
     5. Myomectomy
442. Female patient, 51 years old. Complains at considerable bloody discharge during each menstruation. Menstruation lasts 10 - 12 days. Gynecologiacal status: cervix has dysplasia, uterus inlarged up to the 12 weeks of pregnancy. Adnexa uteri are inlarged. US intramural node 3,5 cm and 4 subserouse nodes from 1 to 2,5 cm. Both ovaries have cysts. Prescribe appropriate treatment?
     1. Conservative
     2. Supracervical hysterectomy without adnexa
     3. \*Total hysterectomy with adnexa
     4. Supracervical hysterectomy with adnexa
     5. Myomectomy
443. In 32 year old female patient during assessment we found near the uterus not painful elastic tumourlike formation with smooth surface, mobile. There are no complains. US – unicameral, homogeneous echogenicity, diameter – 16 cm. Diagnose?
     1. \*Serous ovarian cystoma
     2. Pseudomucinous ovarian cystoma
     3. Papillary ovarian cystoma
     4. Adnexitis
     5. Endometrioid cyst
444. During surgical intervention we found in female patient multicameral ovarian tumour, covered papillary growth from outside and inside. Diagnose?
     1. Adnexitis
     2. Yellow body cyst
     3. Pseudomucinous ovarian cystoma
     4. Serous ovarian cystoma
     5. \*Papillary ovarian cystoma
445. During surgical intervention we found in female patient multicamerate ovatian tumour, filled with dense jellylike yellow content. Diagnose?
     1. Adnexitis
     2. Yellow body cyst
     3. \*Pseudomucinous ovarian cystoma
     4. Serous ovarian cystoma
     5. Papillary ovarian cystoma
446. Female patient, 35 years old. Complains at considerable bloody discharge during each menstruation. Menstruation lasts 5-7 days. Gynecologiacal status: cervix is clean, uterus inlarged up to the 8 weeks of pregnancy. Adnexa uteri are not palpable. US – submucouse and 3 interstitial nodes from 1 to 3 cm. Prescribe appropriate treatment..
     1. \*Zoladex-depo
     2. Androgens
     3. Estrogens
     4. Total hysterectomy with adnexa
     5. Myomectomy
447. Female patient, 35 years old, year ago masculinization signs appeared: hair on the mammory gland and face, voice timbre has changed, menstruation ceased. Before: menstruation was regular, in anamnesis – 1 delivery and 2 artificial abortion. Gynecological assessment: atrophy of mammory glands, uterus hypoplasia, tumour near the uterus – 7 cm in diameter with glandular surface. Diagnosis?
     1. Policystic syndrom
     2. Genital infantilism
     3. False female hermafroditism
     4. ndrogenital syndrom
     5. \*Androblastoma
448. Female patient, 52 year old complains for bloody discharge from uterus, like menstruation, but her last menses finished 3 years ago. Her libido has increased, and mammary glands have inlarged. During gynecological assessment: uterus – without atrophic changes (as common for menopause). To the side from uterus – tumour, 10 cm in diameter. Primary diagnosis?
     1. Androblastoma
     2. Yellow body cyst
     3. Thecoma
     4. Ovarian fibroma
     5. \*Dysgerminoma
449. During surgical intervation we found in female patient unicamerate ovatian tumour, with smooth surface, filled with dense fatty yellow content. In tumour – hair, bone formation. Diagnose?
     1. Thecoma
     2. Folliculoma
     3. \*Dermoid cyst
     4. Ovarian canser
     5. Pseudomucinous ovarian cystoma
450. Female patient, 55 years old, menopausal period – 5 years, follicular cyst has been found. Prescribe appropriate treatment.
     1. puncture with content aspiration
     2. replacement hormonal therapy
     3. \*hysterectomy with adnexa
     4. antiinflammatory, antibacterial therapy
     5. cystectomy and resection of avary
451. Female patient, 45 year old. Ovarian cystoma has been found. What special treatment should be recomended to this patient?
     1. puncture with content aspiration
     2. replacement hormonal therapy
     3. hysterectomy with adnexa
     4. antiinflammatory, antibacterial therapy as a basic treatment
     5. \*adnexectomy
452. Female patient, 29 year old, complains for low abdomen pain, frequent menses (cycle – 20 days), lasts – 7-9 days. 4 years ago she had adnexitis. Had not delivery. During gynecological assessment: to the left side – smooth, elastic formation, 7 cm in diameter, sensitive during palpation, grows to the abdomen cavity direction. Primary diagnosis.
     1. \*follicular cyst
     2. yellow body cyst
     3. cancer of left ovary
     4. all answer are correct
     5. There is no correct answer
453. After antibacterial treatment, as a basic therapy of asymtomatic paraovarian cyst, 3 cm in diameter, in female patient, 25 year old, in 2 months we found that cyst did not change its size. What next treatment is recomended?
     1. cystectomy
     2. replacement hormonal therapy
     3. hysterectomy with adnexa
     4. anti-inflammatory, antibacterial therapy again
     5. \*cystectomy and ovarian resection
454. Female patient, 25 year old. During anual gynecological assesment we found paraovarian cyst, 3 cm in diameter. What treatment should be prescribed?
     1. puncture with content aspiration
     2. replacement hormonal therapy
     3. hysterectomy with adnexa
     4. \*antiinflammatory, antibacterial therapy as a basic treatment
     5. cystectomy and ovarian resection
455. During surgical intervention in female patient due to ovarian tumour pseudomixoma has been found. It was ruptured and all content was pour out into abdominal cavity. What should be done next?
     1. puncture with content aspiration
     2. replacement hormonal therapy
     3. \*chemotherapy in postoperative period
     4. antiinflammatory, antibacterial therapy as a basic treatment
     5. Zoladex in postoperative period
456. Female patient, younger 35 years. During mammory gland palpation we found volumetric formation. What special assessment method can we recommend to decrease ray load for this patient?
     1. MRI
     2. CTG
     3. X-ray
     4. \*Ultrasongraphy
     5. all above
457. Female patient 34 year old complains for irregular menstrual cycle, weight gain, hirsutism, infertility. During bimanual assessment: uterus body is less than physiologicaly, at the both side – hard mobile ovaries, 4 х 5 х 4 cm, painless. What pathology can we suspect?
     1. \*policystic ovarian syndrome
     2. chronic adnexitis
     3. tuberculosis of uterus adnexa
     4. bilateral ovarian tumours
     5. ovarian endometriosis
458. Female patient, 30 years old, came to the gynecologist for regular annual assessment. No complains. Delivery – 1, abortion – 0. Regular menstruation. Objectively: cervics – cylindrical, uterus body – normal size, firm, mobile, painless. In uterus – tumours has been found during palpation (8 х 10 cm left, 10 х 12 cm right) elastic consistence, with smooth surface, mobile, painless, parametrium – free. No liquid in abdominal cavity. Primary diagnosis?
     1. \*Bilateral ovarian cystomas
     2. Ovarian endometriosis
     3. Crucenberg cancer
     4. Peritoneum pregnancy
     5. Fibroid node on pedicle
459. 43 years old patient complains of contact bleeding in the last 6 months. Bimanual: Cervix increased in size, limited in mobility. In the speculum - the cervix looks like cauliflower. Schiller tests are positive. What is the most likely diagnosis?
     1. Fibroids
     2. Cervical polyp
     3. Cervical pregnancy
     4. \*Cervical cancer
     5. Leukoplakia
460. Woman 30 years, came to the gynecologist on the medical examination. No complaints. In anamnesis delivery - 1, abortion - 1. Menstruation is regular. Objectively: the cervix is cylindrical, uterus body of normal size, firm, mobile, painless. On both sides of the uterus palpable tumor (8 x 10 cm on the left, 10 x 12 cm on the right) tight elastic consistency, with a smooth surface, mobile, painless. The fluid in the abdominal cavity has not defined. What is the most likely diagnosis?
     1. Ovarian Endometriosis
     2. \*Bilateral cysts
     3. Krukenberg’ Canser
     4. Abdominal pregnancy
     5. Fibromatosis of the uterus
461. Patient 58 years old complaints of bloody discharge from the genital tract. Menopause has been for 8 years. Gynecological examination: Uterus somewhat enlarged, firm, is limited in mobility, appendages of the uterus is not defined, the parameters are free. After fractional curettage of the uterus, it’s obtained considerable tissue scraping. What is the most likely diagnosis?
     1. Cervical cancer
     2. Adenomyosis
     3. Chorionepithelioma
     4. \*Hysterocarcinoma
     5. Hormone-producing ovarian tumor
462. Patient 60years old was admitted to the gynecology department with complaints of a slight bloody discharge from the genital tract, which appeared after 4 years of menopause. During bimanual examination: cervix cylindrical epithelium non injuried. Uterus in anteflexioversio, slightly increased in size, mobile. Adnexes are not define. After diagnostic curettage of the uterus,has received special-shaped scraping. What is the most likely diagnosis?
     1. Menopausal bleeding
     2. \*Hysterocarcinoma
     3. Fibroids of the uterus
     4. Ovarian dysfunction
     5. Adenomyosis of the uterus
463. Patient 64 years admitted to the Department with uterine bleeding and anemia. After 12-years of absence of menstruation, 7-8 months ago had appeared firstly serous, watery then bloody-serous, such as "meat slops" discharge from the vagina and abdominal pain. Which pathology is most likely?
     1. Incomplete abortion
     2. \*Cancer of the uterus
     3. Molar pregnancy
     4. Chorionepithelioma
     5. Internal genital endometriosis
464. Patient 56, complains of general weakness, dull abdominal pain, increased abdomen. Menopause for 5 years. On examination, marked ascites. During bimanual examination: size of the uterus is small , shifted to the right, left and posteriorly is palpable firm, nodular, nonmoveable tumor formation, 10 x 12 cm in size .Wich is the most likely diagnosis?
     1. Colon tumor
     2. Subserous hysteromyoma
     3. \*Ovarian cancer
     4. tubo-ovarian abscess
     5. Genital endometriosis
465. Patient 48 years complained of dull pain, gravity in the lower regions of the abdomen, a significant increase in the abdomen for the last 4 months. Menses were normal. Gynecological examination revealed: cervix is normal, the uterus of normal size, painless, mobile on both sides of the uterus palpable tumor size of 10 - 12 cm, dense texture, uneven surface, motionless. In the abdominal cavity is defined by a significant amount of free fluid. What is the most likely diagnosis?
     1. Cirrhosis
     2. \*Ovarian Cancer
     3. Benign ovarian tumors
     4. tubo-ovarian abscess
     5. Genital endometriosis
466. Patient aged 47 complained of heavy menstrual flow. Last menstrual period was 10 days ago. Gynecological study: the cervix is cylindrical, deformed old scars , the anterior lip leukoplakia. The body of the uterus enlarged to 14 - 15 weeks of pregnancy, with a rough surface, solid, mobile, painless. Appendages are not palpable. The vaults are deep. Highlight mucous. Which treatment should you choose?
     1. Conservative myomectomy
     2. hormone therapy
     3. antiinflammatory, antibacterial therapy
     4. haemostatic therapy
     5. \*Hysterectomy
467. Patient age 47 suffer from uterine cancer 8 years, not being treated over the past year, the tumor grew to the size of 15-week pregnancy. What is the plan of surgical treatment?
     1. \*Total hysterectomy with appendages
     2. Enucleation of myoma nodes
     3. Supravaginal hysterectomy without adnexal
     4. Supravaginal hysterectomy with appendages
     5. Total hysterectomy without appendages
468. Patient 45 years old complains of contact bleeding during past 5 months. In the speculum: cervix enlarged, looks like cauliflower, bleeds when touched by the probe. In bimanual examination uterus thick consistency. The body of the uterus is not enlarged, reduced mobility. Appendages are not palpable, the parameters of free. The vaults are deep. A possible diagnosis?
     1. Polyposis of the cervix
     2. Hysterocarcinoma
     3. Protruded myoma
     4. Cervical pregnancy
     5. \*Cervical cancer
469. The patient 58 years after 10 years of menopause had heavy uterine bleeding. Bimanual and speculum examination cause heavy bleeding, other pathologies haven’t been identified. A possible diagnosis?
     1. Incomplete abortion
     2. Hemorrhagic metropatiya Schroeder
     3. \*Hysterocarcinoma
     4. Myoma
     5. Violation of the menstrual cycle, climacteric nature
470. The patient, aged 42, complained of dull abdominal pain, weakness, appetite loss, weight loss for the last 3 months to 18 kg, an increase in the abdomen. Examination revealed: Ascites, on the side of right adnexa palpated dense, nodular, limited mobility of the tumor. In the clinical analysis of blood - increased ESR to 50 mm / h. A possible diagnosis?
     1. Cyst
     2. Ectopic pregnancy
     3. Fibroids of the uterus
     4. \*Ovarian cancer
     5. Right-hand adnexitis
471. The patient O., 58 years old, complains on dull pain in left lower quadrant for last few months. Examination revealed: the patient's ovarian tumor is confined to one ovary, there are not any metastasis to distant organs and lymph nodes. Which stage of the process?
     1. \*I A
     2. I B
     3. 1 C
     4. II A
     5. II B
472. The patient K, 62 years old, complains on dull pain in lower quadrants for last few months. Examination revealed: the patient's ovarian tumor is limited to both ovaries, there are not any metastasis to distant organs and lymph nodes. Which stage of the process?
     1. I A
     2. \*I B
     3. 1 С
     4. II А
     5. II B
473. The patient C, 60 years old, complains on dull pain in left lower quadrant for last few months. Examination revealed: the patient's ovarian tumor is confined to one ovary with germination in the capsule, there are not any metastasis to distant organs and lymph nodes. Which stage of the process?
     1. I A
     2. I B
     3. \*1 С
     4. II А
     5. II B
474. The patient A, 65 years old, complains on dull pain in lower quadrants for last year. Examination revealed: the patient's ovarian tumor captures one ovary, extends to the uterus and tubes, there are not any metastasis to distant organs and lymph nodes. Which stage of the process?
     1. I A
     2. I B
     3. 1 С
     4. \*II А
     5. II B
475. The patient D, 65 years old, complains on dull pain in lower quadrants for last 2years. Examination revealed: the patient's ovarian tumor captures both the ovary, fallopian tube and uterus, germinates in the parameters, but does not reach the pelvic wall, there are not any metastasis to distant organs and lymph nodes. Which stage of the process?
     1. I A
     2. I B
     3. 1 С
     4. II А
     5. \*II B
476. The patient B, 70 years old, complains on dull pain in lower quadrants for last 2years. Examination revealed: the patient's ovarian tumor captures both the ovary, fallopian tube and uterus, germinates in the parameters, but does not reach the the walls of the pelvis, there are metastasis to the lungs and lymph nodes, ascites presents. Which stage of the process?
     1. III A
     2. III B
     3. III C
     4. \*IV
     5. IV B
477. The patient F, 57 years old, complains on dull pain in lower quadrants for last 1,5 years. Examination revealed: the patient's ovarian tumor captures both the ovary, fallopian tube and uterus, germinates in the parameter reaches the walls of the pelvis, there are not any metastasis to distant organs and lymph nodes. Which stage of the process?
     1. III A
     2. III B
     3. \*III b
     4. IV
     5. IV B
478. The patient T, 42 years old, complains on dull abdominal pain, weakness, loss of appetite and weight loss for the last 3 months, increasing of the abdomen. Examination revealed: cancer of the body of the uterus with local growth and localization at the bottom of the uterus, without deep invasion, there are not any metastasis to distant organs and lymph nodes. Which is the optimal surgery?
     1. \*Radical Wertheim Hysterectomy
     2. Hysterectomy without appendages
     3. Hysterectomy with appendages
     4. Supracervical hysterectomy
     5. Can be restricted by radiotherapy and chemotherapy.
479. An antenatal G 2, T 1, P 0, Ab 0, L I client is dis\_cussing her postpartum plans for birth control with her health care provider. In analyzing the available choices, which of the following factors has the greatest impact on her birth control options?
     1. Satisfaction with prior methods.
     2. Preference of sexual partner.
     3. \*Breast-or bottle-feeding plan.
     4. History of clotting disease.
     5. Nothing of the above
480. Assessment of a 16-year-old nulligravid client who visits the clinic and asks for information on contraceptives, reveals a menstrual cycle of 28 days. The doctor understand that girl has deficient knowledge related to ovulation and fertility management. Which of the following would be important to include in the teaching plan for the client?
     1. The ovum survives for 96 hours after ovulation, making conception possible during this time.
     2. The basal body temperature falls at least 0.2° F after ovulation has occurred.
     3. \*Ovulation usually occurs on day 14, plus or minus 2 days, before the onset of the next menstrual cycle.
     4. Most women can tell they have ovulated because of severe pain and thick, scant cervical mucus.
     5. Nothing of the above
481. Which of the following instructions about activities during menstruation would the doctor include when counseling an adolescent who has just begun to menstruate?
     1. \*Take a mild analgesic if needed for menstrual pain.
     2. Avoid cold foods if menstrual pain persists.
     3. Stop exercise while menstruating.
     4. Avoid sexual intercourse while menstruating.
     5. All of the above
482. After conducting a class for female adolescents about human reproduction, which of the following statements indicates that the school doctor's teaching has been effective?
     1. \*"Under ideal conditions, sperm can reach the ovum in 15 to 30 minutes, resulting in pregnancy."
     2. "I won't become pregnant if I abstain from intercourse during the last 14 days of my menstrual cycle."
     3. "Sperm from a healthy male usually remain viable in the female reproductive tract for 96 hours."
     4. "After an ovum is fertilized by a sperm, the ovum then contains 21 pairs of chromosomes."
     5. Nothing of the above
483. Before advising a 24-year-old client desiring oral contraceptives for family planning, the doctor would assess the client for signs and symptoms of which of the following?
     1. Anemia.
     2. \*Hypertension.
     3. Dysmenorrhea.
     4. Acne vulgaris.
     5. Nothing of the above
484. After instructing a 20-year-old nulligravid client about adverse effects of oral contraceptives, the doctor determines that further instruction is needed when the client states which of the following as an adverse effect?
     1. Weight gain.
     2. Nausea.
     3. Headache.
     4. \*Ovarian cancer.
     5. Nothing of the above
485. While discussing reproductive health with a group of female adolescents, one of the adolescents asks the doctor, "Where is the ovum fertilized?" The doctor responds by stating that fertilization normally occurs at which of the following sites?
     1. Uterus.
     2. Vagina.
     3. \*Fallopian tube.
     4. Cervix.
     5. Ovary
486. A 22-year-old nulligravid client tells the doctor that she and her husband have been considering using condoms for family planning. Which of the following instructions would the doctor include about the use of condoms as a method for family planning?
     1. \*Using a spermicide with the condom offers added protection against pregnancy.
     2. Natural skin condoms protect against sexually transmitted diseases.
     3. The typical failure rate for couples using condoms is about 25%.
     4. Condom users commonly report penile gland sensitivity.
     5. All of the above
487. Which of the following would the doctor include in the teaching plan for a 32-year-old female client requesting information about using a diaphragm for family planning?
     1. Douching with an acidic solution after intercourse is recommended.
     2. \*Diaphragms should not be used if the client develops acute cervicitis.
     3. The diaphragm should be washed in a weak solution of bleach and water.
     4. The diaphragm should be left in place for 2 hours after intercourse.
     5. The diaphragm should be used if the client has true erosion.
488. After being examined and fitted for a diaphragm, a 24-year-old client receives instructions about its use. Which of the following client’ statements indicates a need for further teaching?
     1. "I can continue to use the diaphragm for about 2 to 3 years if 1 keep it protected in the case."
     2. "If I get pregnant, I will have to be refitted for another diaphragm after the delivery."
     3. "Before inserting the diaphragm I should coat the rim with contraceptive jelly."
     4. \*"If I gain or lose 20 lb, I can still use the same diaphragm."
     5. " I have to go to an OBG doctor for Pap smear examination every year"
489. A 22-year-old client tells the doctor that she and her husband are trying to conceive a baby. When teaching the client about reducing the incidence of neural tube defects in newborns, the doctor would emphasize the need for in take of which of the following nutrients?
     1. Iron.
     2. \*Folic acid.
     3. Calcium.
     4. Magnesium.
     5. Zink
490. 39-year-old multigravid client asks the doctor for information about female sterilization with a tubal ligation. Which of the following client statements indicates effective teaching?
     1. \*"My fallopian tubes will be tied off through a small abdominal incision."
     2. "Reversal of a tubal ligation is easily done, with a pregnancy success rate of 80%."
     3. "After this procedure, I must abstain from intercourse for at least 3 weeks."
     4. "Both of my ovaries will be removed during the tubal ligation procedure."
     5. "The uterus will be removed during the tubal ligation procedure."
491. 25-year-old patient notes the absence of pregnancy within 5 years. Operations were performed twice at the tubal pregnancy. What method can solve the question of the generative function in this woman?
     1. \*In Vitro Fertilization (IVF) and embryo transplantation
     2. Intrauterine artificial insemination
     3. Intracervical artificial insemination
     4. Correction factors of ovarian
     5. Insemination sperm donor
492. When discussing sexual arousal and orgasm with a 25-year-old nulliparous client, which of the following would the doctor include as the primary anatomic female structure involved?
     1. Vaginal wall.
     2. \*Clitoris.
     3. Mons pubis.
     4. Vulvovaginal glands.
     5. Uterus.
493. A 23-year-old nulliparous client visiting the clinic for a routine examination tells the doctor that she desires to use the basal body temperature method for family planning. The doctor should instruct the client to do which of the following?
     1. Check the cervical mucus to see if it is thick and sparse.
     2. \*Take her temperature at the same time every morning before getting out of bed.
     3. Document ovulation when her temperature decreases at least 1°F.
     4. Avoid coitus for 10 days after a slight rise in temperature.
     5. Take her temperature at the different time every day.
494. A couple visiting the infertility clinic for the first time asks the doctor, "What causes infertility in a woman?"Which of the following would the doctor include in the response as one of the most common factors?
     1. Absence of uterus.
     2. Overproduction of prolactin.
     3. \*Anovulation.
     4. Immunologic factors.
     5. Genetic factors.
495. A couple visiting the infertility clinic for the first time states that they have been trying to conceive for the past 2 years without success. After a history and physical examination of both partners, the doctor determines that an appropriate outcome for the couple would be to accomplish which of the following by the end of this visit?
     1. Choose an appropriate infertility treatment method.
     2. Acknowledge that only 50% of infertile couples achieve a pregnancy.
     3. Discuss alternative methods of having a family, such as adoption.
     4. \*Describe each of the potential causes and possible treatment modalities.
     5. Nothing of the above
496. A client is scheduled to have in vitro fertilization (IVF) as an infertility treatment. Which of the following client statements about IVF indicates that the client understands this procedure?
     1. "IVF requires supplemental estrogen to enhance the implantation process."
     2. "The pregnancy rate with IVF is higher than that with gamete intrafallopian transfer."
     3. \*"IVF involves bypassing the blocked or absent fallopian tubes."
     4. "Both ova and sperm are instilled into the openened of a fallopian tube."
     5. Nothing of the above
497. A multigravid client will be using medroxyproges\_terone acetate (Depo-Provera) as a family planning method. After the doctor instructs the client about this method, which of the following client’s statement indicates effective teaching?
     1. "This method of family planning requires monthly injections."
     2. "1 should have my first injection during my men\_strual cycle."
     3. \*"One possible adverse effect is absence of a menstrual period."
     4. "This drug will be given by subcutaneous injections."
     5. Nothing of the above
498. Which of the following instructions should the doctor expect to include in the teaching plan for a 30-year-old multiparous client who will be using an intrauterine device (IUD) for family planning?
     1. Amenorrhea is a common adverse effect of IUDs.
     2. The client needs to use additional protection for conception.
     3. IUDs are more costly than other forms of contraception.
     4. \*Severe cramping may occur when the IUD is inserted.
     5. Nothing of the above
499. After counseling a 35-year-old client about breast self-examination and mammography, the doctor determines that the client has understood the instructions when the client states which of the following?
     1. \*"I should have a mammogram every year once I'm 40."
     2. "I should schedule a mammography examination during my menstrual period."
     3. "Mammography screening is inexpensive."
     4. "Mammography is an extremely painful procedure."
     5. "I shouldn’t have a mammogram till 60 year old"
500. A married woman aged 35, having one sexual partner, chronic thrombophlebitis of lower extremities. Which method of contraception should be recommended?
     1. Oral contraceptives
     2. Surgical sterilization husband
     3. Mechanical contraception
     4. \*Intrauterine contraception
     5. Coitus interrupts
501. The woman, suffering from infertility came to the gynecologist with complain of delayed menstruation. Which pregnancy test will be the most reliable in the early stages?
     1. \*Measurement of human chorionic gonadotropin in the blood
     2. Immune hemagglutination inhibition test.
     3. Reaction Galey Maynini
     4. Measurement of the concentration of estrogen in the blood
     5. Measurement of concentration of progesterone in the blood
502. A female patient, aged 25, suffers endocrine form of infertility for 5 years. What should be included in investigations of this patient?
     1. Ultrasonic monitoring of growth of follicles during the menstrual cycle.
     2. Measuring basal temperature.
     3. Determine the level of hormones in the blood.
     4. Smears on the "hormonal mirror."
     5. \*All answers are correct.
503. A couple is visiting the clinic because they have been unable to conceive a baby after 3 years of frequent coitus. After discussing the various causes of male infertility, the doctor determines that the male partner needs further instruction when he states which of the following as a cause?
     1. \*Seminal fluid with an alkaline pH.
     2. Frequent exposure to heat sources.
     3. Abnormal hormonal stimulation.
     4. Immunologic factors.
     5. Sexually transmitted diseases.
504. 25-year-old patient notes the absence of pregnancy within 5 years. Operations were performed twice at the tubal pregnancy. Which method can solve the problem?
     1. \*In Vitro Fertilization (IVF) and embryo transplantation
     2. Intrauterine artificial insemination
     3. Intracervical artificial insemination
     4. Correction ovarian function
     5. Insemination of sperm of a donor
505. The patient 29 years old, complains of infertility. Sexual life has been leading in marriage for 4 years, has’n been preventing pregnancy. She didn’t have any pregnancy yet. An examination of women is established: the development of genital organs were normal; The fallopian tubes are passable. Basal [rectal] temperature for three menstrual cycles had single phase. The most probable cause of infertility?
     1. \*Anovulatory menstrual cycle
     2. Chronic adnexitis
     3. Anomalies of genital organs
     4. Immunological infertility
     5. Genital endometrioses
506. 43 years old patient complains of contact bleeding in the last 6 months. Bimanual: Cervix increased in size, limited in mobility. In the speculum - the cervix looks like cauliflower. Schiller test is positive. What is the most likely diagnosis?
     1. Fibromyoma
     2. Cervical polyp
     3. Cervical pregnancy
     4. \*Cervical cancer
     5. Leukoplakia
507. Woman 30 years, came to the gynecologist on the medical examination. No complaints. In anamnesis delivery - 1, abortion - 1. Menstruation is regular. Objectively: the cervix is cylindrical, uterus body of normal size, firm, mobile, painless. On both sides of the uterus palpable tumor (8 x 10 cm on the left, 10 x 12 cm on the right) tight elastic consistency, with a smooth surface, mobile, painless. The fluid in the abdominal cavity has not defined. What is the most likely diagnosis?
     1. Ovarian Endometriosis
     2. \*Bilateral cysts
     3. Krukenberg’ Canser
     4. Abdominal pregnancy
     5. Fibromyoma
508. Patient 58 years old complaints of bloody discharge from the genital tract. Menopause has been for 8 years. Gynecological examination: Uterus somewhat enlarged, firm, is limited in mobility, appendages of the uterus is not defined, the parameters are free. After fractional curettage of the uterus, it’s obtained considerable tissue scraping. What is the most likely diagnosis?
     1. Cervical cancer
     2. Adenomyosis
     3. Chorionepithelioma
     4. \*Hysterocarcinoma
     5. Hormone-producing ovarian tumor
509. Patient 60years old was admitted to the gynecology department with complaints of a slight bloody discharge from the genital tract, which appeared after 4 years of menopause. During bimanual examination: cervix cylindrical epithelium non injuried. Uterus in anteflexioversio, slightly increased in size, mobile. Adnexes are not define. After diagnostic curettage of the uterus,has received special-shaped scraping. What is the most likely diagnosis?
     1. Menopausal bleeding
     2. \*Hysterocarcinoma
     3. Fibromyoma
     4. Ovarian dysfunction
     5. Adenomyosis of the uterus
510. Patient 64 years admitted to the Department with uterine bleeding and anemia. After 12-years of absence of menstruation, 7-8 months ago had appeared firstly serous, watery then bloody-serous, such as "meat slops" discharge from the vagina and abdominal pain. Which pathology is most likely?
     1. Incomplete abortion
     2. \*Cancer of the uterus
     3. Molar pregnancy
     4. Chorionepithelioma
     5. Internal genital endometriosis
511. Patient 56, complains of general weakness, dull abdominal pain, increased abdomen. Menopause for 5 years. On examination, marked ascites. During bimanual examination: size of the uterus is small , shifted to the right, left and posteriorly is palpable firm, nodular, nonmoveable tumor formation, 10 x 12 cm in size. Wich is the most likely diagnosis?
     1. Colon tumor
     2. Subserous hysteromyoma
     3. \*Ovarian canser
     4. Tubovarian abscess
     5. Genital endometriosis
512. Patient 48 years complained of dull pain, gravity in the lower regions of the abdomen, a significant increase in the abdomen for the last 4 months. Menses were normal. Gynecological examination revealed: cervix is normal, the uterus of normal size, painless, mobile on both sides of the uterus palpable tumor size of 10 - 12 cm, dense texture, uneven surface, motionless. In the abdominal cavity is defined by a significant amount of free fluid. What is the most likely diagnosis?
     1. Fibromyoma
     2. \*Ovarian Cancer
     3. Benign ovarian tumors
     4. Tubovarian abscess
     5. Genital endometriosis
513. Patient aged 47 complained of heavy menstrual flow. Last menstrual period was 10 days ago. Gynecological study: the cervix is cylindrical, deformed with old scars , the anterior lip has leukoplakia. The body of the uterus enlarged to 14 - 15 weeks of pregnancy, with a rough surface, solid, mobile, painless. Appendages are not palpable. The vaults are deep. Highlight mucous. Which treatment should you choose?
     1. Conservative myomectomy
     2. Hormonal therapy
     3. Herbal therapy
     4. Haemostatic therapy
     5. \*Hysterectomy
514. Patient 45 years old complains of contact bleeding during past 5 months. In the speculum: cervix enlarged, looks like cauliflower, bleeds when touched by the probe. In bimanual examination uterus has thick consistency. The body of the uterus is not enlarged, reduced mobility. Appendages are not palpable, the parameters of free. The vaults are deep. What is the most likely diagnosis?
     1. Polyposis of the cervix
     2. Hysterocarcinoma
     3. Birth of fibromatous node
     4. Cervical pregnancy
     5. \*Cervical cancer
515. Patient age 47 suffer from uterine cancer 8 years, not being treated over the past year, the tumor grew to the size of 15-week pregnancy. What is the plan of surgical treatment?
     1. \*Total hysterectomy with appendages
     2. Enucleation of myoma nodes
     3. Supra-vaginal hysterectomy without appendages
     4. Supravaginal hysterectomy with appendages
     5. Hysterectomy without appendages
516. The patient 58 years after 10 years of menopause had heavy uterine bleeding. Bimanual and speculum examination cause heavy bleeding, other pathologies haven't been identified. A possible diagnosis?
     1. Incomplete abortion
     2. Hemorrhagic metropatiya
     3. \*Hysterocarcinoma
     4. Myoma
     5. Violation of the menstrual cycle, climacteric nature
517. The patient, aged 42, complained of dull abdominal pain, weakness, appetite loss, weight loss for the last 3 months to 18 kg, an increase in the abdomen. Examination revealed: Ascites, on the side of right adnexa palpated dense, nodular, limited mobility of the tumor. In the clinical analysis of blood - increased ESR to 50 mm / h. A possible diagnosis?
     1. Cyst
     2. Ectopic pregnancy
     3. Fibroids of the uterus
     4. \*Ovarian cancer
     5. Right-hand adnexitis
518. The patient O, 58 years old, complains on dull pain in left lower quadrant for last few months. Examination revealed: the patient's ovarian tumor is confined to one ovary, there are not any metastasis to distant organs and lymph nodes. Which stage of the process?
     1. \*I A
     2. I B
     3. 1 C
     4. II A
     5. II B
519. The patient K, 62 years old, complains on dull pain in lower quadrants for last few months. Examination revealed: the patient's ovarian tumor is limited to both ovaries, there are not any metastasis to distant organs and lymph nodes. Which stage of the process?
     1. I A
     2. \*I B
     3. 1 С
     4. II А
     5. II B
520. The patient C, 60 years old, complains on dull pain in left lower quadrant for last few months. Examination revealed: the patient's ovarian tumor is confined to one ovary with germination in the capsule, there are not any metastasis to distant organs and lymph nodes. Which stage of the process?
     1. I A
     2. I B
     3. \*1 С
     4. II А
     5. II B
521. The patient A, 65 years old, complains on dull pain in lower quadrants for last year. Examination revealed: the patient's ovarian tumor captures one ovary, extends to the uterus and tubes, there are not any metastasis to distant organs and lymph nodes. Which stage of the process?
     1. I A
     2. I B
     3. 1 С
     4. \*II А
     5. II B
522. The patient D, 65 years old, complains on dull pain in lower quadrants for last 2years. Examination revealed: the patient's ovarian tumor captures both the ovary, fallopian tube and uterus, germinates in the parameters, but does not reach the pelvic wall, there are not any metastasis to distant organs and lymph nodes. Which stage of the process?
     1. I A
     2. I B
     3. 1 С
     4. II А
     5. \*II B
523. The patient B, 70 years old, complains on dull pain in lower quadrants for last 2years. Examination revealed: the patient's ovarian tumor captures both the ovary, fallopian tube and uterus, germinates in the parameters, but does not reach the the walls of the pelvis, there are metastasis to the lungs and lymph nodes, ascites presents. Which stage of the process?
     1. III A
     2. III B
     3. III C
     4. \*IV
     5. IV B
524. The patient F, 57 years old, complains on dull pain in lower quadrants for last 1,5 years. Examination revealed: the patient's ovarian tumor captures both the ovary, fallopian tube and uterus, germinates in the parameter reaches the walls of the pelvis, there are not any metastasis to distant organs and lymph nodes. Which stage of the process?
     1. III A
     2. III B
     3. \*III b
     4. IV
     5. IV B
525. The patient T, 42 years old, complains on dull abdominal pain, weakness, loss of appetite and weight loss for the last 3 months, increasing of the abdomen. Examination revealed: cancer of the body of the uterus with local growth and localization at the bottom of the uterus, without deep invasion, there are not any metastasis to distant organs and lymph nodes. Which is the optimal surgery?
     1. \*Total Hysterectomy with lymph nodes near the tumor
     2. Hysterectomy without appendages
     3. Hysterectomy with appendages
     4. Supravaginal uterine amputation
     5. Can be restricted by radiotherapy and chemotherapy.
526. The patient K, 48 years old, came for regular check-up. Which process the type I does reflect in Pap smear test?
     1. \*Normal epithelium.
     2. Moderate dysplasia.
     3. Cancer.
     4. Inflammation.
     5. Suspicion of malignization.
527. The patient C, 45 years old, complains on dull abdominal pain, weakness, loss of appetite and weight loss for the last 5 months. Which process does the type V reflect in Pap smear test?
     1. Normal epithelium
     2. Moderate dysplasia.
     3. \*Cancer.
     4. Inflammation.
     5. Suspicion of malignization
528. The patient C, 38 years old, complains on excessive with odor discharge from the vagina lately. Which process does the type IIA reflect in Pap smear test?
     1. Normal epithelium.
     2. Moderate dysplasia.
     3. Cancer.
     4. \*Inflammation.
     5. Suspicion of malignization.
529. The patient C, 55 years old, complains on dull abdominal pain, weakness, bloody-serous, such as "meat slops" discharge from the vagina. Which additional diagnostic methods should be applied to refine the diagnosis of cancer of uterine body?
     1. An ultrasound scan.
     2. \*Biopsy of endometrium.
     3. Colposcopy.
     4. Laparoscopy.
     5. Pap smear test
530. A woman of 54 years complains about the bloody discharges from a vagina and dispareunia. menopause during 3 years. At ultrasonic examination the endometrium atrophy exposed. At a speculum examination – mucosal membrane of vagina pale, dry, ulcers on mucousal membrane are marked. Choose the most suitable medical treatment or procedure.
     1. \*Application of estrogen cream
     2. Setting of oxyprogesteron-acetate
     3. Successive therapy of estrogens and progesteron
     4. Biopsy of endometrium
     5. Factious diagnostic scraping of cavity of uterus off
531. A woman 32 years appealed to the doctor with complaints about abundant and protracted menstruations, which proceed already during 6 months, general weakness. A skin is pale. At vaginal examination: uterus is enlarged in sizes as to 9-10 weeks of pregnancy, irregular shape, unpainful, mobile, adnexa are not palpated. The diagnosis of uterine myoma was set. What is the best tactic of conducting patient?
     1. Miomectomy
     2. Hysterectomy
     3. \*Diagnostic curettage of uterine cavity
     4. Setting of hormonal preparations
     5. Setting of preparations of iron
532. Patient delivered in the gynecological department by the emergency. Two hours ago suddenly the acute pain in an abdomen, nausea, vomits began. The last menstruation was two weeks ago. Patient is pale, pulse 116, soft, AP 70/40 mm Hg. An abdomen does not take part in breathing. Vaginally: the posterior fornix of vagina is painful, uterus of normal sizes, mobile, painful at palpation. Adnexa can not be palpated through the tension of abdominal wall. Blood test: leucocytes 8x109/l. A pregnancy test is negative. Diagnosis?
     1. Acute appendicitis
     2. The ruptured ectopic pregnancy
     3. Necrosis of subserosal fibroid
     4. \*Ovarian apoplexy
     5. Acute bilateral adnexitis
533. The patient complains about infertility. Menstruations started at 16 years, are not regular, 5-6 days after 28-35 days, to marriage - painful. Sexual life during 4 years. Did not use contraceptives, become not pregnant. In childhood was ill on a measles, scarlet fever. Vaginally: the uterus is of normal size, mobile, unpainful, adnexa are not palpated. In speculum: the uterine cervix is normal. Analysis of sperm of husband - 55 mln of spermatozoa in 1 ml, 75% of them are mobile. Shuvarscy test is positive. A basal temperature during 2 cycles is monotonous. Diagnosis?
     1. Infertility I, tubal genesis
     2. Infertility I, tubal-peritoneal genesis
     3. \*Infertility I, anovulatory cycles
     4. Infertility I, masculine genesis
     5. Infertility I, anomaly of development of privy parts
534. A woman complains about periodic pains and feeling of weight in lower parts of an abdomen. Sometimes each evening there is a subfebril temperature. Menstruations are normal. Sexual life with 20 years. Two normal labors were. The patient’ condition is satisfactory. Pulse -76 on a minute, BP 120/70 mm Hg. Vaginally: bilateral tumors of adnexa are palpated, tumors are immobile, a small pelvis is filled by tumors, on the lower pole of tumors the painful growths are palpated. Blood test of ESR- 60 mm/hr, moderate lymphopenia, insignificant eozinophylia. Diagnosis?
     1. Bilateral tubo-ovarian tumors of inflammatory genesis
     2. Bilateral cystomas of ovaries
     3. Stage IIIOvarian Cancer
     4. Stage I Ovarian Cancer
     5. \*Stage II Ovarian Cancer
535. The patient complains about acute pains in lower parts of abdomen, which irradiate in rectum. Pains of cyclic character, acutely increase during defecation, physical activity. In intermenstrual period insignificant, and during menstruation severe. Is ill 2 years. Before the menstruations were normal. There were 2 labors, 1 abortion 5 years ago. The inflammatory diseases of genital organs were not present. Pulse -76 in 1 min, AP 120/80 mm Hg. Abdomen is soft, unpainful. Uterus of normal size, adnexa - without changes. Hard, painful infiltrat with an unequal surface is palpated behind the cervix. Infiltrat growth to posterior fornix, it is exposed at rectal examination. Blood test of ESR-16-16 mm/hr, leucocytes-8х109/л. Diagnosis?
     1. \*External genital endometriosis, retrocervical localization
     2. Chronic bilateral adnexitis in the stage of acutening
     3. Ectopic pregnancy
     4. The Fibromyoma uteruses with untypical localization
     5. Tumor of rectum
536. Patient D., 30 years, delivered with complaints about pain in lower parts of abdomen of periodic character which arose up suddenly, irradiate in sacrum and anus, and also on spotting bloody excretions. The last menstruation - 6 weeks ago. In anamnesis there are 1 labor, 2 abortions. After the last abortion - acute bilateral adnexitis. Objectively: the patient’ condition is satisfactory, t-36,8o. The symptoms of irritation of peritoneum are not exposed. Vaginal examination: uterine cervix of cyanotic, the uterus is enlarged in sizes, sensible at palpation; right adnexa - without changes. In the projection of the left adnexa – tumor which mobile is limited, consistency elastic, shape egg-like by sizes 4х4х5 cm, acutely painful at palpation; discharges are bloody, moderate. Diagnosis?
     1. Cyst of the left ovary with violation of blood supply
     2. \*The ruptured left-side ectopic pregnancy
     3. Acute left-side adnexitis
     4. Subserosal fibromyoma with violation of blood supply
     5. Apoplexy of the left ovary
537. A woman, 26 years, appealed to the doctor of female dispensary with complaints about absence of menstruation (delay on 26 days) and feeling of nausea, mostly in the morning. A test on pregnancy is positive. Earlier a menstrual cycle was regular. Pregnancies were not present before. It is set at the objective inspection: mucous membrane the cervix are cyanotic, uterine consistency is soft, some enlarged in uterine sizes is present. Ultrasonography – a fetal sac in the uterine cavity is not exposed. The most credible diagnosis?
     1. Violation of menstrual cycle
     2. Uterine pregnancy
     3. \*Suspicion on unruptured ectopic pregnancy
     4. The broken extra-uterine pregnancy
     5. Ovarian insufficiency
538. At patient with molar pregnancy curettage of walls of uterine cavity is conducted. Remoted maintenance is sent to hystological examination. Bleeding was stopped. In 2 days patient discharged out under the supervision of doctor-gynecologist of female dispensary. What obligatory examination must be conducted?
     1. \*Estimation of level of chorionic gonadotropin
     2. Determination of level hemoglobin and quantity of red blood cells
     3. To conduct ultrasonography after 2 weeks
     4. Determination of levels FSG and LG
     5. Determination of level of progesteron
539. Patient 38 years-old, 5 years are observed concerning uterine myoma (size of tumor - to 10 weeks of pregnancy), complains of the abundant protracted menstruations at which the quantity of hemoglobin goes down to 80 g\l. At the admission: the time of menstruation, 8th day, discharge are abundant, patient is pale. What is the first step of treatment?
     1. Hemostatic therapy
     2. Hemostimulated therapy
     3. Antibacterial therapy
     4. Hormonal medical treatment
     5. \*dilatation and curettage procedure
540. Patient 34 years. The uterine myoma is exposed 2 years ago. Growth is not present. There is pain in lower parts of abdomen. Leucocytosis 17х109 /л. The symptoms of irritation of peritoneum are positive. At vaginal examination: the uterus is enlarged to 10 weeks of pregnancy, one of fibroids is mobile, painful. Excretions are mucous. Diagnosis?
     1. Cyst of ovary
     2. \*fibroid’ torsion
     3. Acute adnexitis
     4. Rupture of piosalpinx
     5. Acute appendicitis
541. Patient, 32 years appealed to the gynecologist with complaints about abundant, protracted menstruations during 3 years, aching pain in lumbal area. Did not visit a gynecologist 2 years. The last menstruation 2 a week ago, in time. In anamnesis: menarhe at 13 years, menstruations during 7 days, every 28 days; Labors-0, abortions-3. At vaginal examination: the uterine cervix is clean, the uterus is enlarged to 9 weeks of pregnancy, firm, mobile, not painful, in anteflexio. Adnexa on either side are not enlarged. Excretions are mucous. What is to be carried out the first of all?
     1. \*diagnostic curettage of the uterine cavity
     2. Surgical medical treatment
     3. Hormonal therapy 17-OPC
     4. Diagnostic laparoscopy
     5. Supervision after sick
542. Patient 43 years appealed to female dispensary with complaints in the presence of cervical erosion which was exposed at routine medical examination by the midwife. In anamnesis: labors-4, abortions-5. Меnarche at 12 years, menstruations every 28 days, during 3 days, are regular, unpainful. Sexual life with 17 years. At colposcopy: on the uterine cervix the area of transformation is found out. The biopsy is carried out and the diagnosis of displasia is confirmed. At cytological examination there is IIIB type of Pap’ smear. To define the necessary volume of treatment of the patient:
     1. The diatermocoagulation of the cervix
     2. \*cervical diatermoconisation
     3. The total hysterectomy without adnexa
     4. The criodestruction of the cervix
     5. Subtotal hysterectomy of cervix
543. The patient 17 years appealed to the gynecologist with complaints about a tearfulness, depressed mood, aggressiveness, pain in the breasts which are marked at her 3-4 days before the menstruation and after the beginning of it disappeared. In anamnesis: labors-0, abortions-0. Menarhe in 13 years, menstruations every 31 days, during 4-5 days, are regular, unpainful, not abundant. At vaginal examination: pathology of genital organs are not exposed. What is the most credible diagnosis:
     1. Fibrous-cystic mastopatia
     2. Algodismenorrea
     3. \*Premenstrual syndrome
     4. The endometriosis
     5. Thyrotoxicosis
544. Patient In., 27 years, appealed to female dispensary with complaints on pain in lower parts of an abdomen, which appear a few days before the menstruation, and with its beginning some diminish. Passed the course of antiinflammatory therapy and physiotherapy, but medical treatment was without a positive effect. At ultrasonography in the middle of menstrual cycle, pathology is not exposed. With a previous diagnosis – an adenomyosis woman was hospitalized in the gynecological department for confirmation of diagnosis and medical treatment. What investigation needs to be done for confirmation of diagnosis?
     1. Factious diagnostic curettage of uterine cavity
     2. Sciagraphy of organs of small pelvis and abdominal region
     3. Colposcopy
     4. \*Hysteroscopy
     5. Biopsy
545. The patient 46 years is delivered in the gynecological department with complaints about uterine bleeding during the last 2 days, weakness. At vaginal examination: the uterus is firm, unpainful, enlarged to 9 weeks of pregnancy. What is the doctor tactic?
     1. \*Curettage of the uterine cavity
     2. Colposcopy
     3. Hysteroscopy
     4. Laparoscopy
     5. Pelvic sciagraphy
546. Patient 23 years is delivered in the gynecological department in the severe condition with complaints about acute permanent pain in the area of right labia pudenda majora, impossibility of movement. Objectively: temperature of body 38,7. At a review: right labia pudenda majora is slightly swollen, skin above it and lower part of vagina is swollen, hyperhemia is present. At palpation the pain become severe. Inguinal lymphatic nodes are enlarged, especially to the right. Laboratory: high leucocytosis, rise ESR to 27 mm\hr. Diagnosis:
     1. False abscess of Bartholin's gland
     2. \*The true abscess of Bartholin's gland
     3. Cyst of Bartholin's gland
     4. An abscess of steam of urethral glands
     5. Vestibulite
547. Patient 23 years. Menstruations with 13 years, on 5—6 days, in 28 days, moderate, unpainful. The last menstruation ended 5 days ago. Married three years, did not prevent pregnancy, but pregnancy were not present. Appealed for advice. What it is necessary to begin the inspection from?
     1. To take smear for colpocytology
     2. To appoint to the spermogramm of husband
     3. \*To conduct vaginal examination and take smears for microflora
     4. To Conduct ultrasonography
     5. To define concentration of sexual hormones in a dynamics
548. Patient to a 21 year, complains about that menstruations which appeared in 16 years, there were the irregular, in a few amount, and the last two years are absent. At examination: the uterine cervix is conical, clean, the body of uterus is small, hypoplastic, mobile, not painful. The adnexa of uterus are not determined, parametrium are free. Colpocytological investigation: the maturity index 70/30/0, cariopicnotic index 40%, rectal temperature is monotonous, below a 37o C. What is most reliable diagnosis?
     1. Primary amenorrhea
     2. Secondary amenorrhea on a background anovulatory syndrome.
     3. Pregnancy
     4. \*Secondary amenorrhea as a result of genital infantilism
     5. Sheehan’ syndrome
549. Patient 22 years. Complains about pain in a right labia pudenda majora, rise of body temperature to 38 degrees. At the review of genital organs the considerable increasing of right large sexual lip definites, especially in the lower third. Erythema, edema, at palpation acutely painful, fluctuation is determined. To conduct vaginal examination due to acute pain is impossible. Blood test: ESR — 35 mm/hr, leucocytes — 10,0 x 109/l What method is main?
     1. \*The dissection and drainage of abscess
     2. To withdraw a bartolin gland within the limits of healthy tissue
     3. To appoint physical therapy procedures
     4. To appoint compresses with liniment
     5. To expect a spontaneous regeneration of abscess
550. Patient 25 years, complains about considerable foamy excretions from the vagina, pain at sexual intercourse, itching in vagina. Menstrual function is normal. There were 1 labors and one abortion. Is ill about a week. At examination: vaginal mucous with edema, erythema, excretions are yellow and foamy. What is most reliable diagnosis?
     1. Acute gonorrhea
     2. \*Trichomoniasis.
     3. Candidosis
     4. Bacterial vaginosis
     5. Chlamidiasis
551. The patient 36 years complains on pain in lower parts of abdomen, rise of body temperature to 37,7 – 38oC, purulent-bloody excretions from a vagina. 3 days ago artificial abortion was done at pregnancy 8-9 weeks. Objectively: external genital organs without pathology, uterine cervix with the signs of endocervicitis. The uterine body is enlarged to 5-6 weeks of pregnancy, the mobile is limited, soft, not painful. Adnexa are not determined, a region of them is unpainful. Parametrium are free. Excretions festering. Blood test: hemoglobin — 100 g/l, leucocytes — 12x109 /l. What agent is the most reliable cause of endometritis?
     1. Gardnerella
     2. Trichomonas
     3. Fungus flora
     4. Doderlein's bacillus
     5. \*Gonococcus
552. Patient 43 years complains about bloody excretions from genital organs after the sexual contact or weight lifting. Bloody excretions are unconnected with a menstrual cycle. At a speculum examination: cervix is cylindric, exernal os is closed, on a front part of the cervix a lot of the nipple excrescences are visible, cervix is covered by festering excretions and easily bleed at contact. Body of uterus and adnexa on either side without pathology. Parametriums are free. What is the most reliable diagnosis?
     1. \*Cancer of uterine cervix
     2. The true erosion.
     3. Simple pseudo erosion
     4. The endometriosis
     5. papillary pseudo erosion
553. Patient 29 years, delivered by the emergency, complains about acute pains in lower parts of an abdomen. Pains arose up suddenly, at getting up of weight. The last menstruation was 10 days ago, in the term. Labors — 2, abortions — 2. The last time visited gynecologist half-year ago, ovarian cyst was definite. Pulse - 100 in a minute, rhythmic, breathing 22 in a minute. Abdomen is tense, acutely painful, especially on the left. Objectively: the uterine cervix is cylinder, deformed by old post-natal ruptures, clean. The uterine body is not determined due to tension of abdominal wall. Right adnexa not palpated. A tumor without clear contours is palpated in the region of the left adnexa, elastic consistency, the mobile is limited, painful. Parametriums are free. What most reliable diagnosis?
     1. The ruptured ectopic pregnancy
     2. Apoplexy of ovary
     3. Rupture the cysts of ovary
     4. \*Torsion of pedicle of ovarian cyst
     5. Rupture the cysts of ovary
554. The patient 36 years complains on pain in lower parts of abdomen on the left side, which arose up suddenly. Objectively: external genital organs without pathology, the uterine cervix is cylindric, clean. The body of uterus is enlarged to 12—13 weeks of pregnancy, the mobile is limited. One of fibroids on the left near a fundus acutely painful. Adnexa are not determined, its region is unpainful. Parametriums are free. Excretions serous. Blood test: Haemoglobin — 120 g/l, leucocytes — 12x109 /л. What is the most reliable diagnosis?
     1. \*Necrosis of fibroid
     2. Miscarriage
     3. Uterine Chorionepithelioma
     4. The Molar pregnancy
     5. Cancer of body of uterus
555. Patient 23 years complains about absence of menstruation 3 months. Menstruations from 13 years, to this time without deviations. Objectively: external genital organs without pathology, uterine cervix is cyanotic. The uterine body is enlarged to 10—11 weeks of pregnancy. Right side from the uterus is determined tumor 8x10 cm, elastic consistency, smooth surface, the mobile is limited. Adnexa are not determined on the left. Parametriums are free. Excretions mucous. What is the most reliable diagnosis?
     1. Uterine Chorionepithelioma
     2. The Molar pregnancy
     3. The subserosal Fibromyomas
     4. \*Pregnancy is 10-11 weeks, cyst of right ovary
     5. Cancer of body of uterus with metastases in right addition of uterus
556. Patient 64 years complains about frequent urination, pains in lower parts of abdomen. In anamnesis: 4 labors, 2 last ended by applying of obstetric forceps with episiotomia. Objectively: the perineum is changed due to old perineal rupture. Tumor-like formation of rose color, elastic consistency appears from a sexual cleft, the uterine cervix goes out from a vagina. On the uterine cervix ulcer is visible. What is the most reliable diagnosis?
     1. \*Complete uterine prolapse, decubital ulcer
     2. Inversion of uterus
     3. The protruding fibroid
     4. Cancer of cervix of uterus
     5. Cystocele
557. The patient 48 years complains about abundant menstruations. Menstruations to this time were without deviations from a norm. Labors — 2, abortions — 2. The last 2 years not visited gynecologist. Objectively: external genital organs without pathology, the uterine cervix is cylinder, clean. The uterus is enlarged to 14-15 weeks of pregnancy, unequal surface, mobile, not painful. Adnexa are not determined, its region is unpainful. Parametriums are free. Excretions mucous. What most reliable diagnosis?
     1. \*Uterine myoma
     2. Sarcoma of uterus
     3. Pregnancy 14-15 weeks
     4. Uterine Chorionepithelioma
     5. Cancer of endometrium
558. Patient 22 years, complains about absence of pregnancy during 5 years of marriage. For the last 3 years conducted medical and resort treatment. Two months ago metrosalpingography was done — tubes’ permeability is normal. The last menstruation was with the delay on 2 weeks, painful. 2 days ago bloody excretions in a small amount and pain in lower parts of abdomen appeared again. Objectively: the uterine cervix is cyanotic, external os is closed. The uterus in normal position, enlarged to 5 weeks of pregnancy, is soft, mobile. Right adnexa are not determined. The left adnexa are enlarged in sizes to 6x3 cm, painful at palpation. Parametriums are free. Excretions are bloody, in a little quantity. Blood test: Haemoglobin — 90g/l, red cells — 3,0 h 10 /l, leucocytes— 8,6 h 10 /l. What is the most reliable diagnosis?
     1. Pregnancy 6-5 weeks. Abortion, that began. Cyst of the left ovary.
     2. Pyosalpinx after metrosalpingography
     3. The molar pregnancy
     4. Violation of menstrual cycle
     5. \*Ectopic pregnancy, that was ruptured on the type of tube abortion
559. The patient 36 years appealed to female dispensary with complaints about pain in lower parts of abdomen. The patient found a tumor in abdominal region. Menstruations to this time were without deviations from a norm, but became more abundant. The last menstruation 10 days ago. Labors — 2, abortions — 2. Objectively: external genital organs without pathology, the uterine cervix is clean. The uterus is enlarged to 22-23 weeks of pregnancy, unequal surface, mobile, not painful. Adnexa are not determined, a region is them unpainful. Parametrium free. What is the most reliable diagnosis?
     1. Sarcoma of body of uterus
     2. \*The Uterine myoma
     3. Pregnancy 14-15 weeks
     4. Chorionepitelioma
     5. Cancer of endometrium
560. Patient 48 years complains on the very abundant menstruation for the last 8-9 months. During 2 years is observed by a gynecologist concerning uterine myoma. Objectively: the uterine cervix is clean, external os is closed. The uterus in normal position, enlarged to 9-10 weeks of pregnancy, unequal surface, firm, mobile, not painful. Adnexa of both sides are not determined. Parametrium free. Excretions mucous. What is the most reliable diagnosis?
     1. Cancer of endometrium
     2. Interstitial uterine myoma
     3. \*Subserosal uterine myoma
     4. Endometriosis with the overwhelming defeat of body of uterus
     5. The myoma of uterus and pregnancy
561. The patient 36 years complains about pain in lower parts of abdomen, that reminds the labor contractions, weakness. The menstruations last 2 years are more abundant, of long duration. The last menstruation began 2 days ago. Objectively: A skin and mucous membranes are pale, pulse 88 in 1 min. Abdomen is soft, unpainful. Gynecological status: external genital organs without pathology, the uterine cervix is cylinder, a canal freely skips 2 fingers. From a cervix a tumor 3x6 cm hangs down to the vagina, pedicle by thickness to 1 cm enters to the cavity of uterus. The tumor is a dark-purple color, at contact bleeds. The body of uterus is enlarged to 7-8 weeks of pregnancy, unequal surface, mobile, not painful. Adnexa are not determined. What is the most reliable diagnosis?
     1. \*The protruding fibroid
     2. Endophytic growth of cancer of uterine cervix
     3. Chorionepithelioma, metastasis in the uterine cervix
     4. Miscarriage at 7-8 weeks of pregnancy
     5. Exophytic growth of cancer of cervix of uterus
562. You are counseling a premenopausal client regarding prevention of osteoporosis. You recommend that she increase her dietary intake of which of the following?
     1. Milk and iron
     2. \*Calcium and vitamin D
     3. Magnesium and vitamin C
     4. Magnesium and phosphorus
     5. All of the above
563. You are completing the chief complaint interview for a 17-year-old with dysmenorrhea. You will assess for which of the following symptoms?
     1. Food cravings
     2. Heart palpitations
     3. Abnormal bleeding
     4. \*Duration of her pain
     5. All of the above
564. In cancer prevention program for women you would include all of the following except:
     1. Smoking cessation
     2. Periodic screening
     3. \*Bone density index measurement
     4. Elimination of unopposed estrogen use for menopause
     5. All of the above
565. You are explaining the intervention strategies for PMS to a 28-year-old client. You recommend that during the latter part of her cycle she limit which of the following?
     1. Exercise
     2. Fluid intake
     3. Fruits and vegetables
     4. \*Salt and caffeine intake
     5. All of the above
566. You are counseling a 40-year-old client who has come to the clinic because she fund a “lump” in her breast last night. She is frantic because she believes she has cancer. The clinical breast examination reveals firm, smooth, discrete masses in both breast. You reinforce the physicisn’s impression that she is feeling is most likely a noncancerous “lump” and that she should have which of the following evaluation procedures first?
     1. Lumpectomy
     2. \*Mammogram
     3. Excisional biopsy
     4. Stereotactic biopsy
     5. All of the above
567. You are collecting data from a 37-year-old client who you suspect may have fibroid tumors. You expect her subjective data to include which of the following symptoms?
     1. Urinary urgency
     2. Difficult defecation
     3. Cyclic migraine headaches
     4. \*Deep pelvic dyspareunia(painful sexual intercourse)
     5. All of the above
568. You are completing the chief complaint interview with a client who states that she has a continuous dysmenorrhea. Based on her subjective data, you suspect which of the following medical diagnoses?
     1. \*Cervical cancer
     2. Hypermenorrhea
     3. Pelvic relaxation
     4. Polycystic ovary disease
     5. All of the above
569. The chief complaint interview on a client reveals vaginal discharge with itching and burning. The client also reveals she experiences dyspareunia. If her diagnosis is monilial vulvovaginitis, you would expect the wet mount slide to contain which of the following?
     1. Bacteria
     2. Clue cells
     3. Trichomonads
     4. \*Candida albicans
     5. All of the above
570. Patient 49 years old, who had three normal deliveries and 2 artificial abortion without complications in history, during the last year had been having irregular menses delayed up to 2-3 months. About three weeks ago, there were spotting in moderation, continuing to the present. Gynecological examination revealed no pathology. Probable diagnosis:
     1. adenomyosis
     2. \*dysfunctional bleeding
     3. endometrial cancer
     4. submucous uterine fibroids
     5. cervical cancer
571. Female 38 years old complains on painful menstruation in the past six months, especially during the first 2 days. In the history she had two normal deliveries and two medical abortion without complications, the last one - a year ago. The menstrual cycle is regular. The last menstrual period ended 5 days ago. On examination: the abdomen is painless, cervix and vagina without pathology, the body of the uterus a few more than normal, dense, uterine appendages are not palpable. Probable diagnosis:
     1. Chorionepithelioma
     2. uterine pregnancy
     3. endometrial polyps
     4. \*adenomyosis
     5. placental polyp
572. A patient 30 years old has bilateral piosalpings. Which surgery would you recommend:
     1. subtotal hysterectomy with appendages
     2. total hysterectomy with appendages
     3. supracervical amputation with the uterine tubes
     4. \*Removal of both fallopian tubes
     5. removal of both appendages
573. At 35 years old patient it’s revealed intraepithelial cervical cancer. Which intervention would you recommend:
     1. hysterectomy with appendages
     2. hysterectomy without adnexa
     3. cryolysis
     4. \*Electro-conization of the cervix uteri
     5. none of the above
574. At the vaginal examination, at the patient with suspected ectopic pregnancy revealed: external os of cervix was slightly open with the red bloody discharge from the cervix, the uterus was enlarged to 8 weeks of pregnancy, the appendages were not defined, the vaginal vaults are free. Diagnosis:
     1. tubal abortion
     2. \*miscarriage
     3. ovarian apoplexy
     4. inflammation of the appendages of the uterus
     5. all wrong
575. Girl 16 years old has been bleeding from the genital tract for 8 days after 2-month delay. The first menstruation appeared 4 months ago for 2 days at 28 days, moderate, painless. She denies sexual life. Her development is normal, physically well-built. Rektoabdominal examination had revealed no pathology. Hb - 80 g / l. Probable diagnosis:
     1. hormone producing ovarian tumor
     2. cervical cancer
     3. cervical polyp
     4. \*juvenile uterine bleeding
     5. endometrial polyps
576. Patient 38 years old complains on abdominal pain. Pain appeared 3 hours ago. The menstrual cycle is normal. Palpation: painful in the lower regionof abdomen, slightly positive peritoneal signs. The temperature - 38.2 by C, leukocytosis - 12h/109g / l. At gynecological examination: the uterus was enlarged respectively to 8 weeks of pregnancy, nodular, painful at palpation, appendages are not palpable, discharge was mucous. Probable diagnosis:
     1. inflammation of the appendages
     2. endometrial polyps
     3. endometritis
     4. \*necrosis of one of the nodes of uterine
     5. adenomyosis
577. 28 year old married woman, having one sexual partner, suffering from chronic venous thrombophlebitis of the lower limbs, the mother of one child should be advised to:
     1. oral contraceptives
     2. surgical sterilization
     3. \*intrauterine contraception
     4. Surgical sterilization of husband
     5. none of the above
578. 67 year old patient complains on spotting from the genital tract after 15-year postmenopausal period. The patient is treated by a therapist about hypertension. Blood pressure rises to 200/100 mm Hg At the time of the inspection - 160/90 mm ??Hg . Her Height is 162 cm and Weight is 96 kg. At gynecological examination: cervix is not changed, spotting, infiltrates in the pelvis does not. Probable diagnosis:
     1. adenomyosis
     2. dysfunctional uterine bleeding
     3. cervical cancer
     4. \*endometrial cancer
     5. hysteromyoma
579. At the vaginal examination of the patient you revealed the following : the exernal os of cervix is closed, the uterus is slightly enlarged, soft, the right of the appendages is soft and painful. There is pain with movement of the cervix. Possible diagnosis:
     1. \*progressive tubal pregnancy
     2. apoplexy of the right ovary
     3. chronic inflammation of the right adnexa
     4. correct answers to "A" and "D"
     5. All answers are correct
580. In 29 year patient you revealed endometrioid ovarian cysts. What would you recommend?
     1. excretory urography
     2. barium enema
     3. sigmoidoscopy
     4. all listed
     5. \*none of the above
581. 26 years old patient has formed formation of purulent inflammation of the appendages of the uterus. What would you recommend?
     1. puncture through the posterior vaginal vault, draining pus cavity and the introduction of antibiotics into it
     2. \*surgery
     3. pirogenal therapy
     4. electrophoresis of zinc
     5. Nothing above
582. In 27 years old woman you suspect tubal abortion (without significant intra-abdominal bleeding). With which diseases you would differentiate:
     1. a miscarriage of small time
     2. acuta salpingoophoritis
     3. dysfunctional uterine bleeding
     4. \*the correct answers «A» and «C»
     5. All answers are correct
583. You counsel an infertile couple. Which exam would you recommend to pass at first:
     1. hysterosalpingography
     2. cytology of vaginal smears
     3. determination of basal body temperature
     4. endometrial biopsy
     5. \*spermogram
584. After examination of 55 years old patient, you suspect a malignant ovarian lesion. What would you recommend:
     1. salpingo-oophorectomy on the affected side
     2. supracervical amputation of the uterus with appendages
     3. \*total hysterectomy with appendages, and resection of the omentum
     4. removal of the uterus with appendages on both sides
     5. supracervical amputation of the uterus without appendages
585. Women, 39 year admitted to the gynecology department with complaints of severe abdominal pain, occurring after physiological activity. In bimanual examination found sharply painful swelling in the pelvis, the positive symptoms of peritoneal irritation on the side of the tumor. Your diagnosis?
     1. \*torsion of ovary cancer stem
     2. spontaneous miscarriage
     3. salpingoophoritis acuta
     4. dysfunctional uterine bleeding
     5. none of the above
586. In the gynecology department admitted a woman 23 year with complaints of sudden onset of pain in one of the iliac regions, radiating pain in the shoulder, nausea, and vomiting, delayed menstruation for 3 weeks. Pregnancy test is positive. Your diagnosis?
     1. \*an ectopic pregnancy, the type of rupture of the uterine tube
     2. torsion of ovary cancer stem
     3. spontaneous miscarriage
     4. salpingoophoritis acuta
     5. dysfunctional uterine bleeding
587. By the end of the 1st period of physiological labor clear amniotic fluid came off. Contractions lasted 35-40 sec every 4-5min. Heartbeat of the fetus was 100 bpm. The BP was 140/90 mm Hg. What is the most probable diagnosis?
     1. \*Acute hypoxia of the fetus
     2. Premature labor
     3. Premature detachment of normally posed placenta
     4. Back occipital presentation
     5. Hydramnion
588. Which gestational age gives the most accurate estimation of weeks of pregnancy by uterine size?
     1. \*Less that 12 weeks
     2. Between 12 and 20 weeks
     3. Between 21 and 30 weeks
     4. Between 31 and 40 weeks
     5. Over 40 weeks
589. A 20-year-old woman is having timed labor continued for 4 hours. Light amniotic fluid came off. The fetus head is pressed to the orifice in the small pelvis. The anticipated fetus mass is 4000,0 g. Heartbeat of the fetus is normal. In vaginal examination- cervix is dilated to 4 cm, the fetal membranes are not present. The head is in 1-st plane of the pelvis, a sagittal suture is in the left slanting dimension.What is the purpose of glucose-calcium-hormone - vitaminized background conduction?
     1. \*Prophylaxes of weakness of labor activity
     2. Labor stimulation
     3. Fetus hypoxia prophylaxes
     4. Antenatal preparation
     5. Treatment of weakness of labor activity.
590. A woman in her 39th week of pregnancy, the second labour, has regular birth activity. Uterine contractions take place every 3 minutes. What criteria describe the beginning of the II labor stage the most precisely?
     1. \*Cervical dilatation by no less than 4 cm
     2. Cervical effacement over 90%
     3. Duration of uterine contractions over 30 seconds
     4. Presenting part is in the lower region of small pelvis
     5. Rupture of fetal bladder
591. A 24 years old primipara was hospitalised with complaints about discharge of the amniotic waters. The uterus is tonic on palpation. The position of the fetus is longitudinal, it is pressed with the head to pelvic outlet. Palpitation of the fetus is rhythmical, 140 bpm, auscultated on the left below the navel. Internal examination: cervix of the uterus is 2,5 cm long, dense, the external os is closed, light amniotic waters out of it. Point a correct component of the diagnosis:
     1. \*Antenatal discharge of the amniotic waters
     2. Early discharge of the amniotic waters
     3. The beginning of the 1st stage of labour
     4. The end of the 1st stage of labour
     5. Pathological preterm labour
592. A 34-year-old woman with 10-week pregnancy (the second pregnancy) has consulted gynaecologist to make a record in patient chart. There was a hydramnion previous pregnancy; the birth weight of a child was 4086 g. What tests are necessary first of all?
     1. .\*The test for tolerance to glucose
     2. Determination of the contents of alpha fetoprotein
     3. Bacteriological test of discharge from the vagina
     4. Fetus cardiophonography
     5. Ultrasound of the fetus
593. A 36 year old woman in the 9th week of gestation (the second pregnancy) consulted a doctor of antenatal clinic in order to be registered there. In the previous pregnancy hydramnion was observed, the child's birth weight was 5000 g. What examination method should be applied in the first place?
     1. \*The test for tolerance to glucose
     2. Determination of the PAPP - protein
     3. Bacteriological examination of discharges from vagina
     4. .Determination of chorionic gonatotropin hormone
     5. US of fetus
594. At term of a gestation of 40 weeks height of standing of a uterine fundus is less then assumed for the given term. The woman has given birth to the child in weight of 2500 g, a length of a body 53 cm, with an assessment on a scale of Apgar of 4-6 points. Labor were fast. The cause of such state of the child was:
     1. \*Chronic fetoplacental insufficiency
     2. Delay of fetal growingan
     3. Placental detachment
     4. Infection of a fetus
     5. Prematurity
595. A woman, aged 40, primigravida, with infertility in the medical history, on the 42-43 week of pregnancy. Labour activity is weak. Longitudinal presentation of the fetus, I position, anterior position. The head of the fetus is engaged to pelvic inlet. Fetus heart rate is 140 bmp, rhythmic, muffled. Cervix dilation is 4 cm. On amnioscopy: greenish color of amniotic fluid and fetal membranes. Cranial bones are dense, cranial sutures and small fontanels are diminished. What should be tactics of delivery?
     1. \*Caesarean section
     2. Amniotomy, labour stimulation, fetal hypoxia treatment
     3. Fetal hypoxia treatment, in the ІІ period - forceps delivery
     4. Fetal hypoxia treatment, conservative delivery
     5. Medication sleep, amniotomy, labour stimulation
596. A pregnant woman (35 weeks), aged 25, was admitted to the hospital because of bloody discharges. In her medical history there were two artificial abortions. In a period of 28-32 weeks there was noted the onset of hemorrhage and USD showed a placental presentation. The uterus is in normotonus, the fetus position is transversal (Ist position). The heartbeats is clear, rhythmical, 140 bpm. What is the further tactics of the pregnant woman care?
     1. .\*To perform a delivery by means of Cesarean section
     2. To perform the hemotransfusion and to prolong the pregnancy
     3. To introduct the drugs to increase the blood coagulation and continue observation
     4. Stimulate the delivery by intravenous introduction of oxytocin

E To keep the intensity of hemorrhage under observation and after the bleeding is controlled to prolong the pregnancy

1. A woman, primagravida, consults a gynecologist on 10.04.2013. Last menstruation was on 10.01.2013. When does an expectant day of delivery according ovulation method?
   1. 8 August
   2. 25 July
   3. \*24 August
   4. 11 July
   5. 5 September
2. Condition of a parturient woman has been good for 2 hours after live birth: uterus is thick, globe-shaped, its bottom is at the level of umbilicus, bleeding is absent. The clamp put on the umbilical cord remains at the same level, when the woman takes a deep breath or she is being pressed over the symphysis with the verge of hand, the umbilical cord drows into the vagina. Bloody discharges from the sexual tracts are absent. What is the doctor's further tactics?
   1. \*To do manual removal of afterbirth
   2. To apply Abduladze method
   3. To apply Crede's method
   4. To do curettage of uterine cavity
   5. To introduct oxitocine intravenously
3. A 28 year old woman had the second labor and born a girl with manifestations of anemia and progressing jaundice. The child's weight was 3 400 g, the length was 52 cm. The woman's blood group is B(III) Rh- negative, the father's blood group is A(III)Rh positive, the child's blood group is B(III)Rh positive. What is the cause of anemia?
   1. \*Rhesus incompatibility
   2. Antigen A. incompatibility
   3. Antigen B incompatibility
   4. Antigen AB incompatibility
   5. Intrauterine infection
4. Examination of a just born placenta reveals defect 2x3 cm large. Hemorrhage is absent. What tactic is the most reasonable?
   1. \*Manual uretus cavity revision
   2. Prescription of uterotonic medicines
   3. External uterus massage
   4. Parturient supervision
   5. Instrumental uterus cavity revision
5. A newborn's head is of dolichocephalic shape, that is front-to-back elongated. Examination of the occipital region of head revealed a labour tumour located in the middle between the prefontanel and posterior fontanel. The delivery took place with the following type of fetus head presentation:
   1. \*Posterior vertex presentation
   2. Anterior vertex presentation
   3. Presentation of the bregma
   4. Brow presentation
   5. Face presentation
6. A woman consulted a doctor on the 14th day after labour about sudden pain, hyperemy and induration of the left mammary gland, body temperature rise up to 39oC, headache, indisposition. Objectively: fissure of nipple, enlargement of the left mammary gland, pain on palpation. What pathology would you think about in this case?
   1. \*Lactational mastitis
   2. Lacteal cyst with suppuration
   3. Fibrous adenoma of the left mammary gland
   4. Breast cancer
   5. Phlegmon of mammary gland
7. In 10 min after childbirth by a 22-year-old woman, the placenta was spontaneousely delivered and 100 ml of blood came out. Woman weight - 80 kg, infant weight - 4100 g, length - 53 cm.The uterus contracted. In 10 minutes the hemorrhage renewed and the amount of blood constitued 300 ml. What amount of blood loss is permissible for this woman?
   1. \*400 ml
   2. 1000 ml
   3. 500 ml
   4. 650 ml
   5. 300 ml
8. A pregnant woman was registered in a maternity welfare clinic in her 11th week of pregnancy. She was being under observation during the whole term, the pregnancy course was normal. What document must the doctor give the pregnant woman to authorize her hospitalization in maternity hospital?
   1. \*Exchange card
   2. Appointment card for hospitalization
   3. Individual prenatal record
   4. Medical certificate
   5. Sanitary certificate
9. Immediately after delivery a woman had hemorrhage, blood loss exceeded postpartum hemorrhage rate and was progressing. There were no symptoms of placenta detachment. What tactics should be chosen?
   1. \*Manual removal of placenta and afterbirth
   2. Uterus tamponade
   3. Instrumental revision of uterine cavity walls
   4. Removal of afterbirth by Crede's method
   5. Intravenous injection of methylergometrine with glucose
10. A primapara with pelvis size 25-28-31-20 cm has active labor activity. Waters poured out, clear. Fetus weight is 4500 g, the head is engaged to the small pelvis inlet. Vasten's sign as positive. Cervix of uterus is fully dilated. Amniotic sac is absent. The fetus heartbeat is clear, rhythmic, 136 bpm. What is the labor tactics?
    1. \*Caesarean section
    2. Vacuum extraction of the fetus
    3. Obstetrical forseps
    4. Conservative tactics of labor
    5. Stimulation of the labor activity
11. Multimapara with pelvis size 25-28-31-20 cm has active labor activity. Leaking of clear amniotic fluid was presented. Probable fetal weight is 4#00 g, the head is engaged to the small pelvis inlet. Vasten's sign as positive. Cervix of uterus is fully dilated. Amniotic sac is absent. The fetus heartbeat is clear, rhythmic, 136 bpm. What is the management?
    1. \*Caesarean section
    2. Vacuum extraction of the fetus
    3. Obstetrical forseps
    4. Conservative tactics of labor
    5. Stimulation of the labor activity
12. Internal obstetric examination of a parturient woman revealed that the sacrum hollow was totally occupied with fetus head, ischiadic spines couldn't be detected. Sagittal suture is in the straight diameter, occipital fontanel is directed towards symphysis. In what plane of small pelvis is the presenting part of the fetus?
    1. \*Plane of pelvic outlet
    2. Wide pelvic plane
    3. Narrow pelvic plane
    4. Plane of pelvic inlet
    5. Over the pelvic inlet
13. A 30 years old woman has the 2-nd labour that has been lasting for 14 hours. Hearbeat of fetus is muffled, arrhythmic, 100/min. Vaginal examination: cervix of uterus is completely opened, fetus head is level with outlet from small pelvis. Saggital suture is in the straight diameter, small crown is near symphysis. What is the further tactics of handling the delivery?
    1. \*Use of obstetrical forceps
    2. Stimulation of labour activity by oxytocin
    3. Cesarean section
    4. Cranio-cutaneous (Ivanov's) forceps
    5. Use of cavity forceps
14. Vaginal inspection of a parturient woman revealed: cervix dilation is up to 2 cm, fetal bladder is intact. Sacral cavity is free, sacral promontory is reachable only with a bent finger, the inner surface of the sacrococcygeal joint is accessible for examination. The fetus has cephalic presentation. Sagittal suture occupies the transverse diameter of pelvic inlet, the small fontanel to the left, on the side. What labor stage is this?
    1. \*Cervix dilatation stage
    2. Preliminary stage
    3. Prodromal stage
    4. Stage of fetus expulsion
    5. Placental stage
15. 10 minutes after delivery a woman discharged placenta with a tissue defect 5х6 cm large. Discharges from the genital tracts were profuse and bloody. Uterus tonus was low, fundus of uterus was located below the navel. Examination of genital tracts revealed that the uterine cervix, vaginal walls, perineum were intact. There was uterine bleeding with following blood coagulation. Your actions to stop the bleeding:
    1. \*To make manual examination of uterine cavity
    2. To apply hemostatic forceps upon the uterine cervix
    3. To introduce an ether-soaked tampon into the posterior fornix
    4. To put an ice pack on the lower abdomen
    5. To administer uterotonics
16. A parturient woman is 23 years old. Vaginal obstetric examination reveals full cervical dilatation. There is no fetal bladder. Fetal head is in the plane of pelvic outlet. Sagittal suture is in mesatipellic pelvis, anterior fontanel is closer to pubes. The fetal head diameter in such presentation will be:
    1. \*Suboccipito-bregmaticus
    2. Fronto-occipitalis recta
    3. Biparietal
    4. Suboccipitio-frontalis
    5. Mento-occipitalis
17. After delivery and revision of placenta there was found the defect of placental lobule. General condition of woman is normal, uterus is firm, and there is moderate bloody discharge. Speculum inspection of birth canal shows absence of lacerations and raptures. What action is necessary?
    1. \*Manual exploration of the uterine cavity
    2. External massage of uterus
    3. Introduction of uterine contracting agents
    4. Urine drainage, cold on the lower abdomen
    5. Introduction of hemostatic medications
18. A parturient woman is 27 year old, it was her second labour, delivery was at term, normal course. On the 3rd day of postpartum period body temperature is 36,8oC, Ps - 72/min, AP - 120/80 mm Hg. Mammary glands are moderately swollen, nipples are clean. Abdomen is soft and painless. Fundus of uterus is 3 fingers below the umbilicus. Lochia are bloody, moderate. What is the most probable diagnosis?
    1. \*Physiological course of postpartum period
    2. Subinvolution of uterus
    3. Postpartum metroendometritis
    4. Remnants of placental tissue after labour
    5. Lactostasis
19. A parturient woman is 25 years old, it is her second day of postpartum period. It was her first full-term uncomplicated labour. The lochia should be:
    1. \*Bloody
    2. Sanguino-serous
    3. Mucous
    4. Purulent
    5. Serous
20. A woman is 34 years old, it is her tenth labor at full term. It is known from the anamnesis that the labor started 11 hours ago, labor was active, painful contractions started after discharge of waters and became continuous. Suddenly the parturient got knife-like pain in the lower abdomen and labor activity stopped. Examination revealed positive symptoms of peritoneum irritation, ill-defined uterus outlines. Fetus was easily palpable, movable. Fetal heartbeats weren’t auscultable. What is the most probable diagnosis?
    1. \*Rupture of uterus
    2. Uterine inertia
    3. Discoordinated labor activity
    4. Risk of uterus rupture
    5. II labor period
21. Examination of placenta revealed a defect. An obstetrician performed manual investigation of uterine cavity, uterine massage. Prophylaxis of endometritis in the postpartum period should involve following actions:
    1. \*Antibacterial therapy
    2. Instrumental revision of uterine cavity
    3. Haemostatic therapy
    4. Contracting agents
    5. Intrauterine instillation of dioxine
22. A primigravida is 22 years old. She has Rh(-), her husband has Rh(+). Antibodies to Rh weren't found at 32 weeks of pregnancy. Redetermination of antibodies to Rh didn't reveal them at 35 weeks of pregnancy as well. How often should the antibodies be determined hereafter?
    1. \*Once a week
    2. Once in two weeks
    3. Once in three weeks
    4. Monthly
    5. There is no need in further checks
23. In the end of the fist period of physiological labor clear amniotic fluid .released. Contractions lasted 35-40 sec every 4-5min. Heartbeat of the fetus was 80 bpm. The BP was 140/90 mm Hg. What is the most probable diagnosis?
    1. \*Acute fetal distress
    2. Premature labor
    3. Premature separation of normally localized placenta
    4. Chronic fetal distress
    5. Hydramnion
24. At which gestational age does multipara feel first fetal movements?
    1. Less that 12 weeks
    2. At 20 week
    3. \*At 18 week
    4. At 23 week
    5. At 30 week
25. A 22-year-old woman is having interm labor continued for 5 hours. Light amniotic fluid came off. The fetus head is fixed to the orifice in the small pelvis. The probable fetal weight is 4000,0 g. Heartbeat of the fetus is normal. In vaginal examination – cervix is dilated to 1 cm, the fetal membranes are not present. The head is in 2-st plane of the pelvis. In which stage of labor does the woman present?
    1. \*First, latent phase
    2. First, active phase
    3. First, spontaneous phase
    4. Second, active phase
    5. Third, latent phase
26. A woman in her 40th week of pregnancy, the second labour, has regular birth activity. Uterine contractions take place every 3 minutes. What criteria describe the beginning of the II labor stage the most objective?
    1. Cervical dilatation by no less than 4 cm
    2. \*Cervical dilation to 10 cm
    3. Duration of uterine contractions over 30 seconds
    4. Presenting part is in the lower region of small pelvis
    5. Rupture of fetal bladder
27. A woman in her 39-th week of pregnancy, the second labor, has regular birth activity. Uterine contractions take place every 3 minutes. All of the below indicate the beginning of the II stage of labor EXEPT:
    1. \*Cervical dilatation to .4 cm
    2. Cervical dilation to 9-10 cm
    3. Duration of uterine contractions more than 30 seconds
    4. Presenting part is in 0 station
    5. Rupture of membranes
28. A 24 years old primipara was hospitalised with complaints about discharge of the amniotic waters. The uterus is tonic on palpation. The position of the fetus is longitudinal, it is pressed with the head to pelvic outlet. Palpitation of the fetus is rhythmical, 140 bpm, auscultated on the left below the navel. Internal examination: cervix of the uterus is 2,5 cm long, dense, the external os is closed, light amniotic waters out of it. Point a correct component of the diagnosis:
    1. \*Antenatal discharge of the amniotic waters
    2. Early discharge of the amniotic waters
    3. The beginning of the 1st stage of labour
    4. The end of the 1st stage of labour
    5. Pathological preterm labour
29. A 36-year-old woman with 11-week pregnancy has consulted gynaecologist to make a record in patient chart. All of the below investigations the woman should pass EXEPT:
    1. The blood sugar
    2. Determination of the contents of PAPP-protein
    3. Bacteriological test of discharge from the vagina
    4. \*Fetal cardiotachography
    5. Ultrasound of the fetus
30. A 32 year old woman in the 12th week of gestation (the second pregnancy) consulted a doctor of antenatal clinic in order to be registered there. In the previous pregnancy hydramnion was observed, the child's birth weight was 5000 g. What examination method should be applied in the first place?
    1. \*The test for tolerance to glucose
    2. Determination of the contents of fetoproteinum
    3. Bacteriological examination of discharges from vagina
    4. A cardiophonography of fetus
    5. US of fetus
31. At term of a gestation of 40 weeks height of standing of a uterine fundus is less then assumed for the given term. The woman has given birth to the child in weight of 2500 g, length of a body 53 cm, with an assessment on Apgar score of 4-6 points. Labor were fast. The cause of such state of the child was:
    1. \*Placental dysfunction
    2. Acute fetal distress
    3. Placental detachment
    4. Infection of a fetus
    5. Prematurity
32. 41 years old woman, primigravida, with infertility in the medical history, on the 42-43 week of pregnancy. Labour activity is weak. Longitudinal lie of the fetus, I position, anterior variety. The head of the fetus is engaged to pelvic inlet. Fetus heart rate is 140 bmp,rhythmic. Cervix dilation is .6 cm. One hour before green colored amniotic fluid released. Cranial bones are dense, cranial sutures and small fontanels are diminished. What should be management delivery?
    1. \*Caesarean section
    2. Amniotomy, labour stimulation, fetal hypoxia treatment
    3. Fetal hypoxia treatment, in the ІІ period - forceps delivery
    4. Fetal hypoxia treatment, conservative delivery
    5. Medication sleep, amniotomy, labour stimulation
33. A woman, primagravida, consults a gynecologist on 05.03.2013. A week ago she felt the fetus movements for the first time. Last menstruation was on 10.01.2013. When should be the day of delivery according Neegle rule?
    1. \*17 October
    2. .25 July
    3. 22 August
    4. 11 July
    5. 5 September
34. 33 years old woman, multipara, consults a gynecologist on 25.02.2013. A week ago she felt the fetus movements for the first time. Last menstruation was on 11.12.2012. When should be the day of delivery according Neegle rule?
    1. 17 October
    2. .25 July
    3. 22 August
    4. \*18 September
    5. 5 September
35. 25 years old woman, primapara , consults a gynecologist on 25.01.2013. A week ago she felt the fetus movements for the first time. Last menstruation was on 11.10.2012. When should be the day of delivery according Neegle rule?
    1. \*18 July
    2. 25 July
    3. 22 August
    4. 18 September
    5. 5 September
36. Just after 2 hours after delivery condition of the postpartum woman is good. The uterus is thick, globe-shaped, its fundus at the umbilicus, bleeding is absent. The clamp put on the umbilical cord remains at the same level and doesn’t change it length during pressing above the symphysis. Bloody discharges from the vagina are absent. What is the adequate management?
    1. \*To do manual separation and removal of .placenta
    2. To apply Abduladze method
    3. To apply Crede's method
    4. To do curettage of uterine cavity
    5. To introduct oxitocine intravenously
37. A 38 year old woman had the second labour and born a girl with manifestations of anemia and progressing jaundice. The child's weight was 3 200 g, the length was 50 cm. The woman's blood group is B(III) Rh-., the father's blood group is A.(III)Rh+, the child's blood group is B(III)Rh+. What is the cause of anemia?
    1. \*Rhesus incompatibility
    2. Diabetes mellitus
    3. Placenta dysfunction
    4. Fetal growth retardation
    5. Intrauterine infection
38. Examination of a placenta after delivery reveals defect 3x5 cm large. Hemorrhage is absent. What management is the most appropriate?
    1. \*Manual exploration of uterine cavity
    2. Prescription of uterotonic medicines
    3. External uterus massage
    4. Observation for the patient
    5. Uterine curretage
39. Examination of the infant’ head after delivery reveals tumor located in area of the forehead. The delivery took place with the following type of fetus head presentation:
    1. Posterior vertex presentation
    2. Anterior vertex presentation
    3. Sinciput vertex presentation
    4. \*Brow presentation
    5. Face presentation
40. Examination of the infant’ head after delivery reveals tumor located in area of the face. The delivery took place with the following type of fetal head presentation:
    1. Posterior vertex presentation
    2. Anterior vertex presentation
    3. Presentation of the bregma
    4. Brow presentation
    5. \*Face presentation
41. A woman consulted a doctor on the 10th day after labor about discharge from vagina. Objectively body temperature is normal. Pulse rate is 72 beats per minute, blood pressure 120/60mm.Hg. What character of the discharge should be normally at this day of postpartum period?
    1. Bloody
    2. Purulent
    3. Bloody-serous
    4. \*Serous
    5. Serous-bloody
42. A woman consulted a doctor on the 5th day after labor about discharge from vagina. Objectively body temperature is normal. Pulse rate is 72 beats per minute, blood pressure 120/60mm.Hg. What character of the discharge should be normally at this day of postpartum period?
    1. Bloody
    2. Purulent
    3. \*Bloody-serous
    4. Serous
    5. Serous-bloody
43. A woman consulted a doctor on the 21th day after labor about discharge from vagina. Objectively body temperature is normal. Pulse rate is 72 beats per minute, blood pressure 120/60mm.Hg. What character of the discharge should be normally at this day of postpartum period?
    1. Bloody
    2. Purulent
    3. Bloody-serous
    4. \*Serous
    5. Serous-bloody
44. A woman consulted a doctor on the 18th day after labor about discharge from vagina. Objectively body temperature is normal. Pulse rate is 72 beats per minute, blood pressure 120/60mm.Hg. What character of the discharge should be normally at this day of postpartum period?
    1. Bloody
    2. Purulent
    3. Bloody-serous
    4. \*Serous
    5. Serous-bloody
45. 21 years old woman consulted a doctor on the 2 day after labor about the examinations which she should pass at postpartum period. Objectively body temperature is normal. Pulse rate is 72 beats per minute, blood pressure is 120/60mm.Hg. All of the below examination the woman should pass before discharge from hospital EXEPT:
    1. Genaral blood analysis
    2. General urine analysis
    3. Bacterioscopic examionation of the vaginal discarge
    4. \*Analysis of the feces
    5. Ultrasonography of the uterus
46. 22 years old woman consulted after delivery about the examinations which she should pass at postpartum period. Objectively body temperature is normal. Pulse rate is 84 beats per minute, blood pressure is 110/60mm.Hg. All of the below examination the woman should pass before discharge from hospital EXEPT:
    1. Genaral blood analysis
    2. General urine analysis
    3. \*ECG
    4. X-ray examination of chest
    5. Ultrasonography of the uterus
47. In 10 min after .delivery by a 32-year-old woman, the placenta was spontaneousely delivered and 150 ml of blood came out. Woman weight is 90kg, infant weight - 3800 g, length - 52 cm. The uterus contracted. In 10 minutes the hemorrhage renewed and the total amount of blood loss is 350 ml. What amount of blood loss is physiologic for this woman?
    1. 400 ml
    2. 1000 ml
    3. \*450 ml
    4. 650 ml
    5. 300 ml
48. In 14 min after .delivery by a 22-year-old woman, the placenta was spontaneousely delivered and 50 ml of blood came out. Woman weight is 60kg, infant weight - 3100g, length - 52 cm. The uterus contracted. In 15 minutes the hemorrhage renewed and the total amount of blood loss is 250 ml. What amount of blood loss is physiologic for this woman?
    1. 400 ml
    2. 1000 ml
    3. 450 ml
    4. 650 ml
    5. \*300 ml
49. In 18 min after .delivery by a 28-year-old woman, the placenta was spontaneousely delivered and 80 ml of blood came out. Woman weight is 64kg, infant weight - 03100g, length - 50 cm. The uterus contracted. In 10 minutes the hemorrhage renewed and the total amount of blood loss is 300 ml. What amount of blood loss is physiologic for this woman?
    1. 400 ml
    2. \*320 ml
    3. 450 ml
    4. 650 ml
    5. 300 ml
50. In 20 min after .delivery by a 19-year-old woman, the placenta was spontaneousely delivered and 60 ml of blood came out. Woman weight is 76kg, infant weight - 3500g, length - 50 cm. The uterus contracted. In 15 minutes the hemorrhage renewed and the total amount of blood loss is 250 ml. What amount of blood loss is physiologic for this woman?
    1. 400 ml
    2. \*380 ml
    3. 450 ml
    4. 650 ml
    5. 300 ml
51. A pregnant woman was registered in a maternity clinic in her 10th week of pregnancy. She was being under observation during the whole term, the pregnancy course was normal. Choose the document which the doctor should give to the pregnant woman to authorize her hospitalization in maternity hospital?
    1. \*Exchange card
    2. Appointment card for hospitalization
    3. Individual prenatal record
    4. Medical certificate
    5. Sanitary certificate
52. Immediately after delivery hemorrhage occurs in 23 years old patient, blood loss exceeded physiological and was progressing. There were no symptoms of placenta separation. What tactics should be chosen?
    1. \*Manual removal of placenta and afterbirth
    2. Uterus tamponade
    3. Instrumental revision of uterine cavity walls
    4. Removal of afterbirth by Crede's method
    5. Intravenous injection of methylergometrine with glucose
53. A 26 years old primapara with pelvis size 23-26-18-18 cm has active labor activity. Amniotic fluid gush occurs in full cervical dilation. Probable fetal weight is is 4200 g, the head is engaged to the small pelvis inlet. Vasten's sign is positive. Cervix of uterus is fully dilated. Amniotic sac is absent. The fetus heartbeat is clear, rhythmic, 136 bpm. Which complication occur in labor?
    1. \*Clinical contracted pelvis
    2. Acute fetal distress
    3. Chronic fetal distress
    4. Preterm releasing of amniotic fluid
    5. Uterine inertia
54. A 26 years old primapara with pelvis size 23-26-18-18 cm has active labor activity. Amniotic fluid gush occurs in full cervical dilation. Probable fetal weight is is 4100g, the head is engaged to the small pelvis inlet. Vasten's sign is positive. Cervix of uterus is fully dilated. Amniotic sac is absent. The fetus heartbeat is clear, rhythmic, 136 bpm. Which complication occur in labor?
    1. \*Cephalopelvic disproportion
    2. Acute fetal distress
    3. Chronic fetal distress
    4. Preterm releasing of amniotic fluid
    5. Uterine inertia
55. Multimapara with pelvis size 25-28-31-20 cm has active labor activity. Leaking of clear amniotic fluid was presented. Probable fetal weight is 4000 g, the head is engaged to the small pelvis inlet. Vasten sign is negative. Cervix of uterus is fully dilated. Amniotic sac is absent. The fetus heartbeat is green colored, arhythmic, 80 bpm. What is the management?
    1. \*Caesarean section
    2. Vacuum extraction of the fetus
    3. Obstetrical forceps
    4. Conservative tactics of labor
    5. Stimulation of the labor activity
56. Multimapara with pelvis size 25-28-31-20 cm has active labor activity. Leaking of clear amniotic fluid was presented. Probable fetal weight is 4000 g, the head is engaged to the small pelvis inlet. Vasten sign is negative. Cervix of uterus is fully dilated. Amniotic sac is absent. The fetus heartbeat is green colored,arhythmic, 80 bpm. Which complication occur in labor?
    1. \*Acute fetal distress
    2. Chronic fetal distress
    3. Uterine rupture
    4. Cephalopelvic disproportion
    5. False labor
57. Multimapara with pelvis size 25-28-31-20 cm has active labor activity. Leaking of clear amniotic fluid was presented. Probable fetal weight is 4000 g, the head is in +2 station. Cervix of uterus is fully dilated. Amniotic sac is absent. The fetus heartbeat is green colored, arhythmic, 80 bpm. What is the best management of this situation?
    1. Caesarean section
    2. Vacuum extraction of the fetus
    3. \*Obstetric forceps
    4. Conservative tactics of labor
    5. Stimulation of the labor activity
58. 25 years old multipara woman is in the second labor for 12hours. Fetal lie is longitudinal, breech presentation is presented. Heartbeat of fetus is arrhythmic, 80beats per min. In vaginal examination: cervix of uterus is completely dilated, fetal buttocks are on the pelvic floor. What is the best management of such obstetric situation?
    1. Use of obstetrical forceps
    2. Stimulation of labour activity by oxytocin
    3. Cesarean section
    4. Cranio-cutaneous (Ivanov's) forceps
    5. \*Breech extraction
59. In 10 minutes after delivery at placental inspection tissue defect 5х6 cm is revealed. Discharges from the genital tracts were profuse and bloody. Uterus tonus was absent. Examination of genital tracts revealed that the uterine cervix, vaginal walls, perineum were intact. There was uterine bleeding with following blood coagulation what is an appropriate management?
    1. \*To make manual examination of uterine cavity
    2. To apply hemostatic forceps upon the uterine cervix
    3. To introduce an ether-soaked tampon into the posterior fornix
    4. To put an ice pack on the lower abdomen
    5. To administer uterotonics
60. Woman in labor has 23 years old. Vaginal obstetric examination reveals full cervical dilatation. There is no amniotic bladder. Fetal head is in the plane of mid pelvis. Sagittal suture is in right oblique diameter, posterior fontanel closed to pubes. The fetal head diameter in such presentation will be:
    1. \*Suboccipito-bregmaticus
    2. Fronto-occipitalis
    3. Biparietal
    4. Suboccipitio-frontalis
    5. Mento-occipitalis
61. Multipara woman in labor has 33 years old. In vaginal obstetric examination 8 cm cervical dilatation is present. There is no amniotic bladder. Fetal head is in the -station. Sagittal suture is in left oblique diameter, anterior and posterior fontanels are on the same level, anterior fontanel is closed to the symphysis. The fetal head diameter in such presentation will be:
    1. Suboccipito-bregmaticus
    2. \*Fronto-occipitalis
    3. Biparietal
    4. Suboccipitio-frontalis
    5. Mento-occipitalis
62. Multipara woman in labor has 33 years old. In vaginal obstetric examination 8 cm cervical dilatation is present. There is no amniotic bladder. Fetal head is in the -1 station. Sagittal suture is in left oblique diameter, anterior and posterior fontanels are on the same level, anterior fontanel is closed to the symphysis. Which type of presentation is presented in this situation:
    1. Vertex anterior
    2. \*Sinciput vertex
    3. Face
    4. Brow
    5. Vertex posterior
63. Woman in labor has 21 years old. Vaginal obstetric examination reveals full cervical dilatation. There is no amniotic bladder. Fetal head is in – 1 station. Sagittal suture is in right oblique diameter, posterior fontanel closed to pubis. Which type of presentation is presented in this situation?
    1. \*Vertex anterior
    2. Vertex posterior
    3. Sinciput vertex
    4. Brow
    5. Face
64. Multipara woman in labor has 35 years old. In vaginal obstetric examination 9 cm cervical dilatation is present. There is no amniotic bladder. Fetal head is in the – 1 station. Frontal suture is in left oblique diameter, anterior fontanel near sacral region, ridge of the nose near symphysis. Which type of presentation is presented in this situation?
    1. Vertex anterior
    2. Vertex posterior
    3. Sinciput vertex
    4. \*Brow
    5. Face
65. Multipara woman in labor has 40 years old. In vaginal obstetric examination 9 cm cervical dilatation is present. There is no amniotic bladder. Fetal head is in the – 1 station. Face line is in left oblique diameter, chin under the symphysis. Which type of presentation is presented in this situation?
    1. Vertex anterior
    2. Vertex posterior
    3. Sinciput vertex
    4. Brow
    5. \*Face posterior
66. Multipara woman in labor has 40 years old. In vaginal obstetric examination 9 cm cervical dilatation is present. There is no amniotic bladder. Fetal head is in the – 1 station. Face line is in left oblique diameter, chin near sacral region. Which type of presentation is presented in this situation?
    1. Vertex anterior
    2. Vertex posterior
    3. Sinciput vertex
    4. Brow
    5. \*Face anterior
67. Multipara woman in labor has 40 years old. Fetal heart rate is 140 beats per minute, clear. In vaginal obstetric examination 9 cm cervical dilatation is present. There is no amniotic bladder. Fetal head is in the – 1 station. Face line is in left oblique diameter, chin near sacral region. What is the management of this situation?
    1. \*Cesarean section
    2. Fetal destroying operation
    3. Induction of labor
    4. Obstetric forceps
    5. Vacuum application
68. Multipara woman in labor has 40 years old. Fetal heart rate is 140 beats per minute, clear. In vaginal obstetric examination 9 cm cervical dilatation is present. There is no amniotic bladder. Fetal head is in the – 1 station. Face line is in left oblique diameter, chin near sacral region. Which complication is the most common as the result of such presentation?
    1. \*Cephalopelvic disproportion
    2. Fetal fistress
    3. Uterine inertia
    4. Placenta previa
    5. Placenta abruption
69. Multipara woman in labor has 35 years old. In vaginal obstetric examination 9 cm cervical dilatation is present. There is no amniotic bladder. Fetal head is in the – 1 station. Frontal suture is in left oblique diameter, anterior fontanel near sacral region, ridge of the nose near symphysis. The fetal head diameter in such presentation will be:
    1. Suboccipito-bregmaticus
    2. Fronto-occipitalis
    3. Biparietal
    4. Suboccipitio-frontalis
    5. \*Mento-occipitalis
70. Multipara woman in labor has 35 years old. In vaginal obstetric examination 9 cm cervical dilatation is present. There is no amniotic bladder. Fetal heart rate is 136 beats per minute, clear. Fetal head is in the – 1 station. Frontal suture is in left oblique diameter, anterior fontanel near sacral region, ridge of the nose near symphysis. What is the management of delivery in this situation?
    1. \*Cesarean section
    2. Fetal destroying operation
    3. Induction of labor
    4. Obstetric forceps
    5. Vacuum application
71. Multipara woman in labor has 40 years old. In vaginal obstetric examination 9 cm cervical dilatation is present. There is no amniotic bladder. Fetal head is in the – 1 station. Face line is in left oblique diameter, chin near sacral region. The fetal head diameter in such presentation will be:
    1. Suboccipito-bregmaticus
    2. Fronto-occipitalis
    3. \*Hyo-bregmaticus (vertical)
    4. Suboccipitio-frontalis
    5. Mento-occipitalis
72. Multipara woman in labor has 40 years old. In vaginal obstetric examination 9 cm cervical dilatation is present. There is no amniotic bladder. Fetal head is in the – 1 station. Face line is in left oblique diameter, chin near sacral region. What is the management of delivery in this situation?
    1. \*Cesarean section
    2. Fetal destroying operation
    3. Induction of labor
    4. Obstetric forceps
    5. Vaginal delivery
73. After delivery at placental inspection there was found the defect of placental lobule. General condition of woman is normal, uterus is firm, there is moderate bloody discharge. Speculum inspection of birth canal shows absence of lacerations and ruptures. What is the management of this situation is the first?
    1. \*Manual exploration of the uterine cavity
    2. Internal massage of uterus
    3. Introduction of Oxytocine
    4. Precription of Pabal
    5. Prescription of Trenexamic acid
74. 24 years old woman is presented after normal interm delivery. At objective examination her temperature is 36,8oC, Ps - 72/min, AP - 120/80 mm Hg. Mammary glands are moderately swollen, nipples are clean, without fissure. Character of the lactation - colostrum. Abdomen is soft and painless. Uterine fundus - 3 fingers below the umbilicus. Lochia are bloody, moderate. Which day of postpartum period does these objective signs corresponds with?
    1. \*3 day
    2. 2 day
    3. 1 day
    4. 5 day
    5. 4 day
75. 28 years old woman is presented after normal interm second delivery. At objective examination her temperature is 36,8oC, Ps - 84/min, AP - 120/80 mm Hg. Mammary glands are moderately swollen, nipples are clean, without fissure. Character of the lactation – immature milk. Abdomen is soft and painless. Uterine fundus – 3in the mid way between symphysis and umbilicus. Lochia are bloody-serous, moderate. Which day of postpartum period does these objective signs corresponds with?
    1. 3 day
    2. 2 day
    3. 1 day
    4. \*5 day
    5. 4 day
76. 22 years old woman is presented after normal interm delivery. At objective examination her temperature is 36,7oC, Ps - 72/min, AP - 110/70 mm Hg. Mammary glands are moderately swollen, nipples are clean, without fissure. Character of the lactation - colostrum. Abdomen is soft and painless. Uterine fundus - 2 fingers below the umbilicus. Lochia are bloody, moderate. Which day of postpartum period does these objective signs corresponds with?
    1. 3 day
    2. \*2 day
    3. 1 day
    4. 5 day
    5. 4 day
77. A parturient woman is 25 years old, it is her sixth day of postpartum period. It was her first full-term uncomplicated labour. The lochia should be:
    1. Bloody
    2. \*Bloody-serous
    3. Mucous
    4. Purulent
    5. Serous
78. A parturient woman is 25 years old, it is her sixth day of postpartum period. It was her first full-term uncomplicated labour. The lochia should be:
    1. Bloody
    2. \*Bloody-serous
    3. Mucous
    4. Purulent
    5. Serous
79. A woman was hospitalised with full-term pregnancy. Examination: the uterus is tender, the abdomen is tense, cardiac tones of the fetus are not auscultated. What is the most probable complication of pregnancy?
    1. \*Placental abraption
    2. Premature labor
    3. Back occipital presentation
    4. Acute hypoxia of a fetus
    5. Hydramnion
80. A pregnant woman in her 40th week of pregnancy undergoes obstetric examination: the cervix of uterus is undeveloped. The oxytocin test is negative. Examination at 32 weeks revealed: AP 140/90 mm Hg, proteinuria 1 g/l, peripheral edemata. Reflexes are normal. Choose the most correct tactics:
    1. \*Labour stimulation after preparation
    2. Absolute bed rest for 1 month
    3. Complex therapy of gestosis for 2 days
    4. Caesarian section immediately
    5. Complex therapy of gestosis for 7 days
81. A 26 year old woman had the second labour within the last 2 years with oxytocin application. The child's weight is 4080 g. After the placent birth there were massive bleeding, signs of hemorrhagic shock. Despite the injection of contractive agents, good contraction of the uterus and absence of any cervical and vaginal disorders, the bleeding proceeds. Choose the most probable cause of bleeding:
    1. \*Atony of the uterus
    2. Injury of cervix of the uterus
    3. Hysterorrhexis
    4. Delay of the part of placenta
    5. Hypotonia of the uterus
82. A woman is admitted to maternity home with discontinued labor activity and slight bloody discharges from vagina. The condition is severe, the skin is pale, consciousness is confused. BP is 80/40 mm Hg. Heartbeat of the fetus is not heard. There was a Cesarian section a year ago. Determine the diagnosis?
    1. Cord presentation
    2. \*Uterus rupture
    3. Placental presentation
    4. Expulsion of the mucous plug from cervix uteri
    5. Premature expulsion of amniotic fluid
83. Rise in temperature up to 39̊̊С was registered the next day after a woman had labor. Fetal membranes rupture took place 36 hours prior to labors. The examination of the bacterial flora of cervix uteri revealed the following: haemolytic streptococcus of group A. The uterus tissue is soft, tender. Discharges are bloody, with mixing of pus. Establish the most probable postnatal complication.
    1. Infective contamination of the urinary system
    2. Thrombophlebitis of veins of the pelvis
    3. Infected hematoma
    4. \*Metroendometritis
    5. Apostatis of stitches after the episiotomy
84. On the first day after labour a woman had the rise of temperature up to 39̊C. Rupture of fetal membranes took place 36 hours before labour. Examination of the bacterial flora of cervix of the uterus revealed hemocatheretic streptococcus of A group. The uterus body is soft, tender. Discharges are bloody, with admixtures of pus. Specify the most probable postnatal complication:
    1. Thrombophlebitis of veins of the pelvis
    2. \*Metroendometritis
    3. Infectious hematoma
    4. Infective contamination of the urinary system
    5. Apostasis of sutures after the episiotomy
85. A woman of a high-risk group (chronic pyelonephritis in anamnesis) had vaginal delivery. The day after labour she complained of fever and loin pains, frequent urodynia. Specify the most probable complication:
    1. \*Infectious contamination of the urinary system
    2. Thrombophlebitis of veins of the pelvis
    3. Infectious hematoma
    4. Endometritis
    5. Apostasis of sutures after episiotomy
86. In 8 months after the first labor a 24-year-old woman complains of amenorrhea. Cesarian section was conducted as a result of premature detachment of normally posed placenta. Hemorrhage has made low fidelity of 2000 ml due to breakdown of coagulation of blood. Choose the most suitable investigation.
    1. \*Determination of the level of gonadotropin
    2. Ultrasound of organs of a small pelvis
    3. Progesteron test
    4. Computer tomography of the head
    5. Determination of the contents of testosteron-depotum in blood serum.
87. A 34 y.o. woman in her 29-th week of pregnancy, that is her 4-th labor to come, was admitted to the obstetric department with complaints of sudden and painful bloody discharges from vagina that appeared 2 hours ago. The discharges are profuse and contain grumes. Cardiac funnction of the fetus is rhytmic, 150 strokes in the minute, uterus tone is normal. The most probable provisional diagnosis will be:
    1. \*Placental presentation
    2. Detachment of normally located placenta
    3. Vasa previa
    4. Bloody discharges
    5. Disseminated intravascular coagulation syndrome
88. A 34-year-old woman with 10-week pregnancy (the second pregnancy) has consulted gynaecologist to make a record in patient chart. There was a hydramnion previous pregnancy, the birth weight of a child was 4086 g. What tests are necessary first of all?
    1. \*The test for tolerance to glucose
    2. Determination of the contents of \alpha fetoprotein
    3. Bacteriological test of discharge from the vagina
    4. Fetus cardiophonography
    5. Ultrasound of the fetus
89. A primagravida with pregnancy of 37-38 weeks complains of headache, nausea, pain in epigastrium. Objective: the skin is acyanotic. Face is hydropic, there is short fibrillar twitching of blepharons, muscles of the face and the inferior extremities. The look is fixed. AP- 200/110 mm Hg; sphygmus of 92 bpm, intense. Respiration rate is 32/min. Heart activity is rhythmical. Appreciable edemata of the inferior extremities are present. Urine is cloudy. What medication should be administered?
    1. \*Droperidolum of 0,25% - 2,0 ml
    2. Dibazolum of 1% - 6,0 ml
    3. Papaverine hydrochloride of 2% - 4,0 ml
    4. Hexenalum of 1% - 2,0 ml
    5. Pentaminum of 5% - 4,0 ml
90. An onset of severe preeclampsia at 16 weeks gestation might be caused by:
    1. \*Hydatidiform mole
    2. Anencephaly
    3. Twin gestation
    4. Maternal renal disease
    5. Interventricular defect of the fetus
91. A woman had the rise of temperature up to 38,5̊С on the first day after labour. The rupture of fetal membranes took place 36 hours before labour. The investigation of the bacterial flora of cervix of the uterus revealed hemocatheretic streptococcus of group A. The uterus body is soft, tender. Discharges are bloody, mixed with pus. Specify the most probable postnatal complication:
    1. Apostatis of junctures after the episiotomy
    2. Thrombophlebitis of pelvic veins
    3. Infected hematoma
    4. Infection of the urinary system
    5. Metroendometritis
92. A pregnant woman may be diagnosed with hepatitis if it is confirmed by the presence of elevated:
    1. \*SGOT (ALT)
    2. Sedimentation rates
    3. WBCs
    4. Alkaline phosphatase
    5. BUN
93. A pregnant woman (35 weeks), aged 25, was admitted to the hospital because of bloody discharges. In her medical history there were two artificial abortions. In a period of 28-32 weeks there was noted the onset of hemorrhage and USD showed a placental presentation. The uterus is in normotonus, the fetus position is transversal (Ist position). The heartbeats is clear, rhythmical, 140 bpm. What is the further tactics of the pregnant woman care?
    1. \*To perform a delivery by means of Cesarean section
    2. To perform the hemotransfusion and to prolong the pregnancy
    3. To introduct the drugs to increase the blood coagulation and continue observation
    4. Stimulate the delivery by intravenous introduction of oxytocin
    5. To keep the intensity of hemorrhage under observation and after the bleeding is controlled to prolong the pregnancy
94. Condition of a parturient woman has been good for 2 hours after live birth: uterus is thick, globe-shaped, its bottom is at the level of umbilicus, bleeding is absent. The clamp put on the umbilical cord remains at the same level, when the woman takes a deep breath or she is being pressed over the symphysis with the verge of hand, the umbilical cord drows into the vagina. Bloody discharges from the sexual tracts are absent. What is the doctor's further tactics?
    1. \*To do manual removal of afterbirth
    2. To apply Abduladze method
    3. To apply Crede's method
    4. To do curettage of uterine cavity
    5. To introduct oxitocine intravenously
95. The woman who has delivered twins has early postnatal hypotonic uterine bleeding reached 1,5% of her bodyweight. The bleeding is going on. Conservative methods to arrest the bleeding have been found ineffective. The conditions of patient are pale skin, acrocyanosis, oliguria. The woman is confused. The pulse is 130 bpm, BP– 75/50 mm Hg. What is the further treatment?
    1. \*Uterine extirpation
    2. Supravaginal uterine amputation
    3. Uterine vessels ligation
    4. Inner glomal artery ligation
    5. Putting clamps on the uterine cervix
96. A 37 y.o. primigravida woman has been having labor activity for 10 hours. Labor pains last for 20-25 seconds every 6-7 minutes. The fetus lies in longitude, presentation is cephalic, head is pressed upon the entrance to the small pelvis. Vaginal examination results: cervix of uterus is up to 1 cm long, lets 2 transverse fingers in. Fetal bladder is absent. What is the most probable diagnosis?
    1. \*Primary uterine inertia
    2. Secondary uterine inertia
    3. Normal labor activity
    4. Discoordinated labor activity
    5. Pathological preliminary period
97. A 26 y.o. woman complains of a mild bloody discharge from the vagina and pain in the lower abdomen. She has had the last menstruation 3,5 months ago. The pulse is 80 bpm. The blood pressure (BP) is 110/60 mm Hg and body temperature is 36,6^0C. The abdomen is tender in the lower parts. The uterus is enlarged up to 12 weeks of gestation. What is your diagnosis?
    1. \*Inevitable abortion
    2. Incipient abortion
    3. Incomplete abortion
    4. Complete abortion
    5. Disfunctional bleeding
98. A 20 y.o. pregnant woman with 36 weeks of gestation was admitted to the obstetrical hospital with complains of pain in the lower abdomen and bloody vaginal discharge. The general condition of the patient is good. Her blood pressure is 120/80 mm Hg. The heart rate of the fetus is 140 bpm, rhythmic. Vaginal examination: the cervix of the uterus is formed and closed. The discharge from vagina is bloody up to 200 ml per day. The head of the fetus is located high above the pelvis inlet. A soft formation was defined through the anterior fornix of the vagina. What is the probable diagnosis?
    1. Premature placental separation
    2. Uterine rupture
    3. Threatened premature labor
    4. \*Placental presentation
    5. Incipient abortion
99. A 28-year-old parturient complains about headache, vision impairment, psychic inhibition. Objectively: AP- 200/110 mm Hg, evident edemata of legs and anterior abdominal wall. Fetus head is in the area of small pelvis. Fetal heartbeats is clear, rhythmic, 190/min. Internal examination revealed complete cervical dilatation, fetus head was in the area of small pelvis. What tactics of labor management should be chosen?
    1. \*Forceps operation
    2. Cesarean
    3. Embryotomy
    4. Conservative labor management with episiotomy
    5. Stimulation of labor activity
100. A 25 year old woman had the third labour and born a girl with manifestations of anemia and progressing jaundice. The child's weight was 3 600 g, the length was 51 cm. The woman's blood group is B (III) Rh-, the father's blood group is A (III) Rh+, the child's blood group is B (III) Rh+. What is the cause of anemia?
     1. \*Rhesus incompatibility
     2. Antigen A incompatibility
     3. Antigen B incompatibility
     4. Antigen AB incompatibility
     5. Intrauterine infection
101. A parturient complains about pain in the mammary gland. Palpation revealed a 3х4 cm large infiltration, soft in the centre. Body temperature is 38,5^oC. What is the most probable diagnosis?
     1. \*Acute purulent mastitis
     2. Pneumonia
     3. Pleuritis
     4. Retention of milk
     5. Birth trauma
102. A secundipara has regular birth activity. Three years ago she had cesarean section for the reason of acute intrauterine hypoxia. During labor she complains of extended pain in the area of postsurgical scar. Objectively: fetus pulse is rhythmic - 140 bpm. Vaginal examination shows 5 cm cervical dilatation. Fetal bladder is intact. What is the tactics of choice?
     1. \*Cesarean section
     2. Augmentation of labour
     3. Obstetrical forceps
     4. Waiting tactics of labor management
     5. Vaginal delivery
103. A primagravida in her 20th week of gestation complains about pain in her lower abdomen, blood smears from the genital tracts. The uterus has an increased tonus, the patient feels the fetus movements. Bimanual examination revealed that the uterus size corresponded the term of gestation, the uterine cervix was contracted down to 0,5 cm, the external orifice was open by 2 cm. The discharges were bloody and smeary. What is the most likely diagnosis?
     1. \*Incipient abortion
     2. Risk of abortion
     3. Abortion in progress
     4. Incomplete abortion
     5. Missed miscarriage
104. A woman consulted a doctor on the 14th day after labour about sudden pain, hyperemy and induration of the left mammary gland, body temperature rise up to 39oC, headache, indisposition. Objectively: fissure of nipple, enlargement of the left mammary gland, pain on palpation. What pathology would you think about in this case?
     1. \*Lactational mastitis
     2. Lacteal cyst with suppuration
     3. Fibrous adenoma of the left mammary gland
     4. Breast cancer
     5. Phlegmon of mammary gland
105. A young woman applied to gynecologist due to her pregnancy of 4-5 weeks. The pregnancy is desirable. Anamnesis stated that she had rheumatism in the childhood. Now she has combined mitral heart disease with the priority of mitral valve deficiency. When will she need the inpatient treatment (what periods of pregnancy)?
     1. \*8-12 weeks, 28–32 weeks, 37 weeks
     2. 6-7weeks, 16 weeks, 38 weeks
     3. 16 weeks, 34 weeks, 39-40 weeks
     4. 10-12 weeks, 24 weeks, 37-38 weeks
     5. 12-16 weeks, 27-28 weeks, 37-38 weeks
106. A woman in the first half of pregnancy was brought to clinic by an ambulance. Term of pregnancy is 36 weeks. She complains of intensive pain in the epigastrium, had vomiting for 2 times. Pain started after the patient had eaten vinaigrette. Swelling of lower extremities. BP - 140/100 mm Hg. Urine became curd after boiling. What is the most probable diagnosis?
     1. \*Preeclampsia
     2. Nephropathy of the 3rd degree
     3. Food toxicoinfection
     4. Dropsy of pregnant women
     5. Exacerbation of pyelonephritis
107. Immediately after delivery a woman had haemorrhage, blood loss exceeded postpartum haemorrhage rate and was progressing. There were no symptoms of placenta detachment. What tactics should be chosen?
     1. \*Manual removal of placenta and afterbirth
     2. Uterus tamponade
     3. Instrumental revision of uterine cavity walls
     4. Removal of afterbirth by Crede's method
     5. Intravenous injection of methylergometrine with glucose
108. A 30-year-old gravida consulted a gynecologist about bright red bloody discharges from the vagina in the 32 week of gestation. She was hospitalized with a suspicion of placental presentation. Under what conditions is it rational to conduct the internal examination in order to make a diagnosis?
     1. \*In the operating room prepared for the operation
     2. In the examination room of antenatal clinic
     3. In the admission ward of maternity hospital
     4. In the delivery room keeping to all the aseptics regulations
     5. The examination is not to be conducted because of risk of profuse haemorrhage
109. A 30 y.o. woman has the 2-nd labour that has been lasting for 14 hours. Hearbeat of fetus is muffled, arrhythmic, 100/min. Vaginal examination: cervix of uterus is completely opened, fetus head is level with outlet from small pelvis. Saggital suture is in the straight diameter, small crown is near symphysis. What is the further tactics of handling the delivery?
     1. \*Use of obstetrical forceps
     2. Stimulation of labour activity by oxytocin
     3. Cesarean section
     4. Cranio-cutaneous (Ivanov's) forceps
     5. Use of cavity forceps
110. In10 minutes after delivery a woman discharged placenta with a tissue defect 5х6 cm large. Discharges from the genital tracts were bloody profuse. Uterus tonus was low, fundus of uterus was located below the navel. Examination of genital tracts revealed that the uterine cervix, vaginal walls, perineum were intact. There was uterine bleeding with following blood coagulation. Your actions to stop the bleeding:
     1. \*To make manual examination of uterine cavity
     2. To apply hemostatic forceps upon the uterine cervix
     3. To introduce an ether-soaked tampon into the posterior fornix
     4. To put an ice pack on the lower abdomen
     5. To administer uterotonics
111. On the 5th day after labor body temperature of a 24-year-old parturient suddenly rose up to 38,7̊̊C. She complains about weakness, headache, abdominal pain, irritability. Objectively: AP- 120/70 mm Hg, Ps- 92 bpm, t- 38,7̊C. Bimanual examination revealed that the uterus was enlarged up to 12 weeks of pregnancy, it was dense, slightly painful on palpation. Cervical canal lets in 2 transverse fingers, discharges are moderate, turbid, with foul smell. In blood: skeocytosis, lymphopenia, ESR - 30 mm/h. What is the most likely diagnosis?
     1. \*Endometritis
     2. Parametritis
     3. Pelviperitonitis
     4. Metrophlebitis
     5. Lochiometra
112. A 27 y.o. gravida with 17 weeks of gestation was admitted to the hospital. There was a history of 2 spontaneous miscarriages. On bimanual examination: uterus is enlarged to 17 weeks of gestation, uterus cervix is shortened, isthmus allows to pass the finger tip. The diagnosis is isthmico-cervical insufficiency. What is the doctor's tactics?
     1. \*To place suture on the uterus cervix
     2. To administer tocolytic therapy
     3. To interrupt pregnancy
     4. To administer hormonal treatment
     5. To perform amniocentesis
113. Examination of a just born placenta reveals defect 2x3 cm large. Hemorrhage is absent. What tactic is the most reasonable?
     1. \*Manual uretus cavity revision
     2. Prescription of uterotonic medicines
     3. External uterus massage
     4. Parturient supervision
     5. Instrumental uterus cavity revision
114. A 27 y.o. woman suffers from pyelonephritits of the only kidney. She presents to the maternity welfare centre because of suppresion of menses for 2,5 months. On examination pregnancy 11 weeks of gestation was revealed. In urine: albumine 3,3 g/L, leucocytes cover the field of vision. What is doctor's tactics in this case?
     1. \*Immediate pregancy interruption
     2. Pregnancy interruption after urine normalization
     3. Maintenance of pregnancy till 36 weeks
     4. Pregnancy interruption at 24-25 weeks
     5. Maintenance of pregnancy till delivery term
115. On the tenth day after discharge from the maternity house a 2-year-old patient consulted a doctor about body temperature rise up to 39̊C, pain in the right breast. Objectively: the mammary gland is enlarged, there is a hyperemized area in the upper external quadrant, in the same place there is an ill-defined induration, lactostasis, fluctuation is absent. Lymph nodes of the right axillary region are enlarged and painful. What is the most likely diagnosis?
     1. \*Lactational mastitis
     2. Abscess
     3. Erysipelas
     4. Dermatitis
     5. Tumour
116. A 28-years-old woman complains of nausea and vomiting about 10 times per day. She has been found to have body weight loss and xerodermia. The pulse is 100 bpm. Body temperature is 37,2̊C. Diuresis is low. USI shows 5-6 weeks of pregnancy. What is the most likely diagnosis?
     1. \*Moderate vomiting of pregnancy
     2. Mild vomiting of pregnancy
     3. I degree preeclampsia
     4. Premature abortion
     5. Food poisoning
117. A 25 y.o. patient complains of body temperature rise up to 37̊С, pain at the bottom of her abdomen and vaginal discharges. Three days ago, when she was in her 11th week of pregnancy, she had an artificial abortion. Objectibely: cervix of uterus is clean, uterus is a little bit enlarged in size, painful. Appendages cannot be determined. Fornixes are deep, painless. Vaginal discharges are sanguinopurulent. What is the most probable diagnosis?
     1. \*Postabortion endometritis
     2. Hematometra
     3. Pelvic peritonitis
     4. Postabortion uterus perforation
     5. Parametritis
118. A 25 y.o. pregnant woman in her 34th week was taken to the maternity house in grave condition. She complains of headache, visual impairment, nausea. Objectively: solid edemata, AP- 170/130 mm Hg. Suddenly there appeared fibrillary tremor of face muscles, tonic and clonic convulsions, breathing came to a stop. After 1,5 minute the breathing recovered, there appeared some bloody spume from her mouth. In urine: protein - 3,5 g/L. What is the most probable diagnosis?
     1. \*Eclampsia
     2. Epilepsy
     3. Cerebral hemorrhage
     4. Cerebral edema
     5. Stomach ulcer
119. A 30 y.o. parturient woman was taken to the maternity house with complaints of having acute, regular labour pains that last 25-30 seconds every 1,5-2 minutes. Labour activity began 6 hours ago. Uterus is in higher tonus, head of the fetus is above the opening into the small pelvis. Fetal heartbeat is 136/min. P.V: cervical dilatation is 4 cm, uterine fauces is spasming at a height of parodynia. Head is level with opening into the small pelvis, it is being pushed off. What is the most probable diagnosis?
     1. \*Discoordinated labour activity
     2. Secondary powerless labour activity
     3. Pathological preliminary period
     4. Primary powerless labour activity
     5. Normal labour activity
120. A primigravida woman appealed to the antenatal clinic on the 22.03.09 with complaints of boring pain in the lower part of abdomen. Anamnesis registered that her last menstruation was on the 4.01.03. Bimanual examination revealed that uterine servix is intact, external os is closed, uterus is enlarged up to the 9-th week of pregnancy, movable, painless. What complication can be suspected?
     1. \*Risk of abortion in the 9-th week of pregnancy
     2. Initial in the 9-th week of pregnancy
     3. Hysteromyoma
     4. Vesicular mole
     5. Pathological preliminary period
121. A 32-year-old gravida complains of episodes of unconsciousness, spontaneous syncopes that are quickly over after a change of body position. A syncope can be accompanied by quickly elapsing bradycardia. There are no other complications of gestation. What is the most likely reason for such condition?
     1. \*Postcava compresseion by the gravid uterus
     2. Pressure rise in the veins of extremities
     3. Pressure fall in the veins of extremities
     4. Vegetative-vascular dystonia (cardiac type)
     5. Psychosomatic disorders
122. An ambulance delivered a 21-year-old woman to the gynaecological department with complaints of colicky abdominal pain and bloody discharges from the genital tracts. Bimanual examination revealed that uterus was soft, enlarged to the size of 6 weeks of gestation, a gestational sac was palpated in the cervical canal. Uterine appendages weren't palpable. Fornices are free, deep and painless. Discharges from the genital tracts are bloody and profuse. What is the most likely diagnosis?
     1. \*Abortion in progress
     2. Cervical pregnancy
     3. Threat of abortion
     4. Incipient abortion
     5. Interrupted fallopian pregnancy
123. A woman is 34 years old, it is her tenth labor at full term. It is known from the anamnesis that the labor started 11 hours ago, labor was active, painful contractions started after discharge of waters and became continuous. Suddenly the parturient got knife-like pain in the lower abdomen and labor activity stopped. Examination revealed positive symptoms of peritoneum irritation, ill-defined uterus outlines. Fetus was easily palpable, movable. Fetal heartbeats wasn't auscultable. What is the most probable diagnosis?
     1. \*Rupture of uterus
     2. Uterine inertia
     3. Discoordinated labor activity
     4. Risk of uterus rupture
     5. II labor period
124. Examination of placenta revealed a defect. An obstetrician performed manual investigation of uterine cavity, uterine massage. Prophylaxis of endometritis in the postpartum period should involve following actions:
     1. \*Antibacterial therapy
     2. Instrumental revision of uterine cavity
     3. Haemostatic therapy
     4. Contracting agents
     5. Intrauterine instillation of dioxine
125. A pregnant woman was delivered to the gynecological unit with complaints of pain in the lower abdomen and insignificant bloody discharges from the genital tracts for 3 hours. Last menstruation was 3 months ago. Vaginal examination showed that body of womb was in the 10th week of gestation, a fingertip could be inserted into the external orifice of uterus, bloody discharges were insignificant. USI showed small vesicles in the uterine cavity. What is the most likely diagnosis?
     1. \*Molar pregnancy
     2. Abortion in progress
     3. Incipient abortion
     4. Threat of spontaneous abortion
     5. Incomplete abortion
126. A 28 y.o. primagravida, pregnancy is 15-16 weaks of gestation, presents to the maternity clinics with dull pain in the lower part of the abdomen and in lumbar area. On vaginal examination: uterus cervix is 2,5 cm, external isthmus allows to pass the finger tip. Uterus body is enlarged according to the pregnancy term. Genital discharges are mucous, mild. What is the diagnosis?
     1. \*Threatened spontaneous abortion
     2. Spontaneous abortion which has begun
     3. Stopped pregnancy
     4. Hydatid molar pregnancy
     5. Placenta presentation
127. A maternity house has admitted a primagravida complaining of irregular, intense labour pains that have been lasting for 36 hours. The woman is tired, failed to fall asleep at night. The fetus is in longitudinal lie, with cephalic presentation. The fetus heartbeat is clear and rhythmic, 145/min. Vaginal examination revealed that the uterine cervix was up to 3 cm long, dense, with retroflexion; the external orifice was closed; the discharges were of mucous nature. What is the most likely diagnosis?
     1. \*Pathological preliminary period
     2. Uterine cervix dystocia
     3. Primary uterine inertia
     4. Physiological preliminary period
     5. Secondary uterine inertia
128. In the department of pathology of the pregnant woman was hospitalized with second 38 weeks pregnancy. The first ended in cesarean section due to cephalopelvic disproportion. The estimated fetal weight - 3200. What method of delivery will choose?
     1. Expect spontaneous onset of labor to make a vacuum - the extraction of the fetus
     2. \*Elective caesarean section
     3. Excitation of labor at 38 weeks, delivery lead conservative
     4. Expect spontaneous onset of labor, eliminate attempts by forceps
     5. Plan the delivery can only know the size of the pelvis
129. Patient’s pelvis size are 24, 26, 29, 18. In the 2 stage of labor showed signs of clinical disproportion between the size of the pelvis and the hea What to do?
     1. Conduct induction of labor
     2. Apply forceps
     3. \*Make a c-section
     4. Make a vacuum - the extraction of the fetus
     5. Continue to labor under epidural anesthesia
130. Patient 23 years old has II labor, II period, the head of the fetus in the pelvic cavity. Pushing efforts are every 2 minutes 60 seconds. Fetal heartbeat slowed down to 100 / min. What to do?
     1. \* Apply forceps
     2. Conduct induction of labor with oxytocin
     3. Hold vacuum induction of labor
     4. Conduct a classic version on the leg, followed by extraction of the fetus
     5. Finish cesarian section
131. At 38 years old pregnant woman with vaginal examination in the lower segment of the uterus myoma detected nod Third delivery. Pelvis normal. What is the most practical method of delivery?
     1. Extraperitoneal cesarean section
     2. \* Caesarean section followed hysterectomy without appendages
     3. Classical cesarean
     4. Caesarean section and remove node
     5. Apply forceps
132. In the third stage of labor started to blee Clamp on the umbilical cord remains at the previous level, by pressing on the side of doctor’s hand drawn umbilical pubis. What to do?
     1. Make a hysterectomy without adnexa
     2. Vacuum - aspiration of the placenta
     3. Delivery the placenta by the method Crede- Lazarević
     4. \* Manual removal of placenta and exploration of the uterus
     5. Removal of the placenta by curette
133. Pregnancy is the first, full-term, breech presentation. Pelvic dimensions 26, 26, 30, 17cm. What method of delivery?
     1. Preventive version on the head of the fetus and delivery through the birth canal
     2. \* Cesarean section
     3. First period - expectant, and then - depending on the descending of breech
     4. The extraction of the fetus by inguinal part
     5. First period - expectant, and then apply a forceps
134. At vaginal examination in the first stage of labor found that sagittal suture is in anterior-posterior size of pelvic inlet. What to do?
     1. \* Cesarean section
     2. Childbirth till full dilatation, and then – forceps
     3. Make amniotomy and podalic version followed by extraction
     4. Vacuum - extraction of the fetus
     5. All are possible
135. In women with twins the first fetus is in footling presentation, the second - in the transverse lay. Which is the method of delivery?
     1. Vaginal
     2. Extraction of the first fetus of the foot, make a classic version, followed by extraction of the second fetus
     3. \* Cesarean section
     4. Wait for the birth of I fetus and make a classic version to the following extraction of the second fetus
     5. Wait for the birth of I fetus and make cesarean section for the second fetus
136. Parturient has started vaginal bleeding. Labor process is activ Vaginal examination: 3 cm cervical dilatation, amniotic mambrane is present, the edge of the placenta is palpable, cephalic presentation. What to do?
     1. \*Amniotomy
     2. Amniotomy and oxytocin
     3. Make a c-section
     4. Apply forceps
     5. Tactics of waiting
137. Primapara, 25 years old, breech presentation, II stage of labor. The pelvis is of normal siz Estimated fetal weight 3800. Make a plan of delivery.
     1. Forceps delivery
     2. Extraction of the first fetus of the foot
     3. To provide obstetric care, depending on the type of breech presentation
     4. Preventive version and delivery in cephalic presentation
     5. \*Immediately cesarean section
138. Woman in labor was admitted to the hospital for the first delivery, complaining of significant vaginal bleeding. Labor forces are weak, head fixated to the pelvic inlet. Diagnosed central placenta previ What to do?
     1. Amniotomy
     2. \*Cesarean section
     3. Oxytocin augmentation
     4. Amniotomy and oxytocin
     5. Apply forceps
139. In woman with moderate preeclampsia in the I stage of labor came with sharp pain in the abdomen, the uterus does not relax between contractions in the uterus defined painful are The head of the fetus is in the pelvic inlet. Fetal heart arrhythmic, 90 bpm. / Min. What to do?
     1. Immediately vacuum - extraction of the fetus
     2. Apply forceps
     3. \*Immediate cesarean section
     4. Induction of labor
     5. Give obstetric anesthesia
140. Delivery in incomplete breech presentation prolaps of pulsating umbilical cord loops was diagnose The cervix delitation is 8 cm, size of the pelvis: 26, 27, 31, 17. Fetal heart rate 120 / min. What is the tactic?
     1. Extraction of the fetus on breech end
     2. \*Urgent cesarean section
     3. Continue the conservative management of labor
     4. Make a external profilaxy versionl
     5. Vaginal deliveryr , to do only when there is fetus distress
141. Ultrasound at 38 weeks pregnant P. diagnosed transverse position of the fetus. Choose the proper tactics Recommend admission to the hospital with the beginning of labor, after full dilatation of the cervix - the extraction of the fetus
     1. Hospitalization, to prepare the cervix with prostaglandins, amniotomy and stimulation of labor
     2. Hospitalization and immediately perform cesarean
     3. Hospitalization, to perform preventive cephalic version
     4. \*Hospitalization and perform plan
     5. Caesarean section
142. Patient K. 24 years II delayed delivery, II period lasts 2 hours. Fetal head is fixated to the pelvic inlet. Pelvic dimensions 24, 26, 29, 18. Half an hour ago, fetal heartbeat disappeared . Tactics of the doctor?
     1. Immediate cesarean
     2. \*Fetal destroying operation
     3. Apply forceps
     4. Conduct induction of labor
     5. Make podalic version
143. In women with pelvic contraction II degree diagnosed transverse fetus lie and fetal death. Doctor decided to perform fetal destroying operation. Which of these operations is carried out in such situation?
     1. \*Decapitation
     2. Kleydotomiya
     3. Craniotomy
     4. Kranioklaziya
     5. Perforation of subsequent head
144. While visiting the doctor pregnant at 34 week was diagnosed breech presentation. Second pregnancy, previous over 2 years ago was normal childbirth. Pelvis is normal size. Tactics of the doctor?
     1. Up to 38 weeks of observation, hospitalization
     2. Hospitalization, after 38 weeks - Cesarean section
     3. \* Archangelsky prophylaxis external version of fetus
     4. Combined version
     5. Choice on the woman's request
145. When the suture is removed, in case of cervical incompetence circlage in patients 25 y.o. with habital abortion ?
     1. In 37 - 38 weeks
     2. Amniotic fluid gash
     3. With the onset of preterm labor
     4. \* In all cases
     5. In 39-40 weeks
146. In which of the cases with contracted pelvis surgical delivery is indicated?
     1. Brow presentation, regardless of the fetus size
     2. Cephalopelvic disproportion
     3. Asinklitic engagment
     4. 3 degreeof contraction
     5. \*In all these cases
147. Admitted to the hospital a woman in labor with a dead fetus. A week ago had flu. Vaginal examination revealed cephalic presentation, palpabable the eyebrows, a large fontanell Labors activ Pelvis normal. Management of delivery?
     1. Vaginal delivery without intervention
     2. Immediate cesarean section
     3. \* Fetal destroying operation
     4. Vacuum - extraction of the fetus
     5. Podalic version, followed by extraction of the fetus
148. Which of these deliveries are not finished surgically?
     1. Brow presentation
     2. Asinclitic engagment
     3. Face presentation
     4. Footling presentation
     5. \*In all of these cases
149. The woman at the age of 22 has first interm delivery, active labor. Pelvis size are 24 - 26 - 28 - 18 cm, breech presentation. Estimated fetal weight 4000 g. Your tactics?
     1. Stimulation of uterus activity
     2. Apply forceps
     3. Conservative management
     4. Fetal destroying operation
     5. \* Make a c-section
150. What doctor’s tactic if, after extraction of the fetus by the leg there is a suspicion of uterine rupture?
     1. \* Perform a manual exploration of the uterus
     2. If the general condition does not suffer longer supervision in the delivery room after the birth
     3. Immediately perform a laparotomy
     4. Confirm the diagnosis by ultrasound
     5. Uterus curettage
151. The operation of the classical rotation of the fetus with two hands. Where the second hand during the execution actually turn?
     1. In section promenevo-carpal joint arm, which makes a turn
     2. In the uterus
     3. Covers the lower leg calf fetus
     4. \* In the uterus of the fetal head
     5. How convenient doctor
152. In the delivery room of a woman in labor, the II stage of labor. On her feet swelling, AT - 170/110 mm Hg. In the analysis of urine protein 3.0 g / l. Fetal head is on the pelvic floor. Fetal heart rate 152 beats. / Min, rhythmical. Your tactics:
     1. Vacuum - extraction of the fetus
     2. Cesarean section
     3. Conservative management of labor
     4. \*Apply outlet forceps
     5. Fetal destroying operation
153. Patient in labor 6 hours, active labor. Fetal heart rate 146 beats. / Min. rhythmical. Vaginal examination - the dilatation of the cervix 6 cm, amnionic mambrane is absent. Defined nose, eye holes, the mouth of the fetus. Expected fetal weight 3700 g. What is your tactics?
     1. Conservative management of labor
     2. Apply forceps
     3. Fetal destroying operation
     4. Vacuum - extraction of the fetus
     5. \*Cesarean section
154. Term births, with a partial placenta previa and breech presentation, lasted 4 hours. Vaginal examinaion - dilatation of the cervix 4 cm, fetal membrane is present. Estimated fetal weight 4100 g Your tactics of delivery?
     1. Make amniotomy and stimulate labor
     2. Make amniotomy and spazmolitics
     3. Conservative management of labor
     4. The extraction of the fetus by pelvic end
     5. \* Cesarean section
155. Among these, select the condition for external cephalic preventive Arhangelsky version:
     1. For 30 - 32 weeks of pregnancy
     2. Full opening of the cervix
     3. Only incase of multiple pregnancies
     4. \*The satisfactory condition of the fetus
     5. Active labor
156. III stage of labor lasts for 30 minutes. separation of the placenta did not happen. Was an attempt manual removal of placent The attempt is not successful and increased bleeding. Your tactics:
     1. Introduction of oxytocini
     2. \*Hysterectomy
     3. Waiting tactic
     4. Massage the uterus on the fist
     5. Ice on the lower abdomen
157. For caesarean section for severe forms of placental abruption identified Kyuveler’s uterus. What is the tactic?
     1. To drain abdominal cavity
     2. Hysterectomy with adnexa
     3. Stitching the uterus
     4. Make a hysterectomy without adnexa
     5. Tactics depend on the degree of blood loss
158. Due to the presence of a dead fetus and clinically contracted pelvis was decided to perform the fetal destroying operation. Breech presentation. Which of the following operations can be applied?
     1. Kleydotomiya
     2. \*Perforation of following head
     3. Decapitation
     4. Evisceration
     5. Vacuum extraction
159. A woman with an intense labor activity began to complain of a severe headache and vision disorders. AT - 170/100 mm. Hg., expressed general edem Fetal heart rate 158 beats / min. clear, rhythmical. The head of the fetus in the pelvic cavity. The dilatation of the cervix is full, amniotic membrane is present. How to finish the delivery?
     1. Immediate cesarean
     2. \* Apply forceps
     3. Fetal destroying operation
     4. Vacuum - extraction of the fetus
     5. Induction of labor by prostaglandins
160. Due to the threat of uterine rupture and dead fetus was performed fetal destroying operation. Haw to finish the delivery?
     1. Hysterectomy
     2. Forceps applying
     3. \* Manual exploration of the uterus cavity
     4. Instrumental exploration of the uterine cavity
     5. Vacuum extraction of the fetus
161. Patient has a first delivery. Pelvis size 23 - 26 - 29 - 18 cm, true conjugate is 7.5 cm. Fetal heartbeat 160 beats / min. Which method of delivery?
     1. The use obstetrics forceps
     2. Vaginal delivery
     3. \* Cesarean section
     4. Vacuum - extraction of the fetus
     5. Waiting tactics of clinically contracted pelvis signs
162. The first birth in women 26 years, footling presentation, and 38 weeks of pregnancy. Pelvis normal size. Estimated fetal weight of 3800. Make a plan of delivery.
     1. Vaginal delivery
     2. he period of expectant, in the second-extraction of the fetus at the end of the pelvic
     3. the period of expectant, in the second - to provide emergency obstetric care, depending on the variety of pelvic presentation
     4. Obstetric forceps
     5. \*C-section
163. Patient in hospital on the first delivery of the major complaints of bloody discharge from the vagina. Uterus activity is weak head to the door to oppression pelvis. Diagnosed with central presentation placenta. Make a plan of delivery
     1. Amniotomy
     2. .\*C-section
     3. Stimulation of patrimonial activity
     4. Amniotomiyu and stimulation of patrimonial activity
     5. Impose obstetric forceps
164. Pregnant with moderate preeclampsia in periods of labor appeared sharp pain in the abdomen, uterus is relaxed between contractions in the bottom section of the uterus is determined painful protrusion. Fetal head over the entrance to the pelvis. Arrhythmic heartbeat of the fetus, 90 per. Min. What to do?
     1. Immediately vacuum extraction of fetus
     2. Impose obstetric forceps
     3. \*Immediately hysterotomy
     4. Conduct stimulation patrimonial activity
     5. Dates obstetric anesthesia
165. At birth in the mixed breech presentation fell pulsing umbilical cord loops. Dilatation of cervical os 8cm. Pelvic dimensions: 26.27 31, 17.Fetus heart rate is120/min. Make a plan of delivery
     1. Immediate extraction of the fetus at the end of the pelvic
     2. \*Urgent C-section
     3. Continue conservative management of labor
     4. Make a version method after Archangelsky
     5. Keep labor conservative, intervene only when there will be fetal distress
166. Ultrasound at 38 weeks pregnant P. diagnosed transverse position of the fetus. Choose the right tactics:
     1. Recommend admition to the maternity home with the beginning of labor activity after full dilatation of cervix and - extraction of the fetus
     2. Hospitalization, prepare to amniotomy and stimulation of theuterus activity
     3. Hospitalization and immediately perform hysterotomy
     4. Hospitalization, to make cephalic version
     5. \*Hospitalization and perform plan C-section
167. In patient K. 24 years II delayed delivery, the second period lasts 2 hours. Fetal head fixed to the pelvis inlet. Pelvic size 24, 26, 29, 18. Half an hour ago ceased heartbeat of the fetus. Tactics of doctor?
     1. Immediately hysterotomy
     2. \*Fetal destroying operation
     3. Applay obstetric forceps
     4. Conduct stimulation uterus activity
     5. Make podalic version and extraction of the leg
168. At the next doctor visit pregnant K. 34 weeks were found fetal pelvic presentation. Second pregnancy, previus finished 2 years ago, normal childbirth. Normal pelvic dimensions. Tactics doctor?
     1. . Observations up to 38 weeks in hospital
     2. Admission, after 38 weeks - hysterotomy
     3. \*Prophylactic external version of the fetus after Archangelsky
     4. Combined version
     5. Select the request woman
169. Before female dispensary the pregnant 25 years appealed, with complaints about pain in lower part of abdomen and in lumbal region, bloody excretion from vagina. Pregnancy is 3rd, last menstruation was approximately 3 months ago. In anamnesis there are three artificial abortions. At vaginal examination: uterine cervix by length 0,5 cm, external cervical os is slightly opened, cervical canal is closed. The uterus is increased to 10-11 weeks of pregnancy, soft. Excretion from the vagina are bloody, insignificant. Diagnosis?
     1. . Placenta previa
     2. Molar pregnancy
     3. Threatening abortion.
     4. Pregnancy, that does not develop
     5. \*Initial abortion
170. Multipara. Uterine contractions of 4-5 hours. bloody excretions began at once after appearance of contractions. Fetal heart rate 90-100 in min. Vaginal examination: the uterine cervix is effaced, edges 0,4 cm, soft. The cervical canal is opened on 5 cm. In the cervix placental tissue is determined. Diagnosis?
     1. Threatening rupture of uterus.
     2. Threatening rupture of uterus.
     3. Partial placenta previa.
     4. \*Central placenta previa.
     5. Abruptio placentae
171. Multipara 34 years. 30 minutes passed after labor of the fetus. The signs of placenta separation are negative. Bleeding began – blood lost is 380 ml. What must to be done?
     1. Introduction of uterotonics.
     2. \*Manual separation of placenta.
     3. To apply the method of Crede-Lazarevich.
     4. Expecting tactic
     5. All above
172. A 52-year-old woman suffering from obesity, complains of bloody discharges from sexual paths during 4 days. Last normal menses were 2 years ago. Histological investigation of biopsy of the endometrium has revealed adenomatous hyperplasia. What reason from the mentioned below caused the development of disease?
     1. Supersecretion of androgens by the cortex of paranephroses
     2. Hypersecretion of estrogens by tissues of the organism.
     3. Poor aromatization of preandrogens due to hypothyroidism
     4. The increased contents of follicle-stimulating hormone
     5. \*Excessive transformation of preandrogens from adipose tissues.
173. A 40-year-old woman complains of colic pains in the lower part of abdomen and abundant bloody discharges from genital tract. Last 2 years she had menses for 15-16 days, abundant, with clots, painful. Had 2 medical abortions. In bimanual investigation: from the canal of the cervix uteri - a fibromatous node, 3 cm in diameter, on the thin stem. Discharges are bloody, moderate.Choose the correct tactics.
     1. Hormonal hemostasis
     2. \*Operation: untwisting of born node
     3. Phase by phase vitamin therapy
     4. Supravaginal ablation of the uterus without ovaries
     5. Hysterectomy without ovaries
174. A 40-year-old woman complains of yellow color discharges from the vagina. Bimanual examination: no pathological changes. Smear test: Trichomonas vaginalis and mixed flora. Colposcopy: two hazy fields on the front labium, with a negative Iodum probing. What is your tactics?
     1. Specific treatment of Trichomonas colpitis
     2. Diathermocoagulation of the cervix uteri
     3. \*Treatment of specific colpitis with the subsequent biopsy
     4. Cervix ectomy
     5. Cryolysis of cervix uteri
175. A 32 y.o. woman consulted a gynecologist about having abundant long menses within 3 months. Bimanual investigation: the body of the uterus is enlarged according to about 12 weeks of pregnancy, distorted, tuberous, of dense consistence. Appendages are not palpated. Histological test of the uterus body mucosa: adenocystous hyperplasia of endometrium. Optimal medical tactics:
     1. Radial therapy
     2. Hormonetherapy
     3. Phytotherapy
     4. \*Surgical treatment
     5. Phase by phase vitamin therapy
176. A woman complains of having slight dark bloody discharges and mild pains in the lower part of abdomen for several days. Last menses were 7 weeks ago. The pregnancy test is positive. Bimanual investigation: the body of the uterus indicates for about 5-6 weeks of pregnancy, it is soft, painless. In the left appendage there is a retort-like formation, 7х5 cm large, mobile, painless. What examination is necessary for detection of fetus localization?
     1. Cystoscopy
     2. Hysteroscopy
     3. Hromohydrotubation
     4. Colposcopy
     5. Ultrasound
177. In 13 months after the first labor a 24-year-old woman complains of amenorrhea. Cesarian section was conducted as a result of premature detachment of normally posed placenta.Hemorrhage has made low fidelity of 2000 ml due to breakdown of coagulation of blood.Choose the most suitable investigation.
     1. \*Determination of the level of gonadotropin
     2. Ultrasound of organs of a small pelvis
     3. Progesteron test
     4. Computer tomography of the head
     5. Determination of the contents of testosteron-depotum in blood serum.
178. 12 months after the first labor a 24-year-old patient complained of amenorrhea. Pregnancy ended in Caesarian section because of premature detachment of normally positioned placenta which resulted in blood loss at the rate of 2000 ml owing to disturbance of blood clotting. Choose the most suitable investigation:
     1. Progesteron test
     2. USI of small pelvis organs
     3. \*Estimation of gonadotropin rate
     4. Computer tomography of head
     5. Estimation of testosteron rate in blood serum
179. In the woman of 24 years about earlier normal menstrual function, cycles became irregular, according to tests of function diagnostics - anovulatory. The contents of prolactin in blood is boosted. Choose the most suitable investigation:
     1. \*Computer tomography of the head
     2. Determination of the level of gonadotropins
     3. USI of organs of small pelvis
     4. Progesterone assay
     5. Determination of the contents of testosteron-depotum in blood serum
180. A 29 year old patient underwent surgical treatment because of the benign serous epithelial tumour of an ovary. The postoperative period has elapsed without complications. What is it necessary to prescribe for the rehabilitational period:
     1. Antibacterial therapy and adaptogens
     2. \*Hormonotherapy and proteolytic enzymes
     3. Lasertherapy and enzymotherapy
     4. Magnitotherapy and vitamin therapy
     5. The patient does not require further care
181. A 26 y.o. woman complains of sudden pains in the bottom of abdomen irradiating to the anus, nausea, giddiness, bloody dark discharges from sexual tracts for one week, the delay of menses for 4 weeks. Signs of the peritoneum irritation are positive. Bimanual examination: borders of the uterus body and its appendages are not determined because of sharp painfullness. The diverticulum and painfullness of the back and dextral fornixes of the vagina are evident. What is the most probable diagnosis?
     1. \*Ruptured tubal pregnancy
     2. Apoplexy of the ovary
     3. Acute right-side adnexitis
     4. Torsion of the crus of the ovary tumour
     5. Acute appendicitis
182. At the gynaecological department there is a patient of 32 years with the diagnosis: "acute bartholinitis".Body temperature is $38,2^0C, leucocytes count 10,4\*10^9/L, the ESR is 24 mm/hour. In the area of big gland of the vestibulum - the dermahemia, the sign of the fluctuation, sharp tenderness (pain). What is the most correct tactics of the doctor?
     1. Antibiotic therapy
     2. Antibiotics, Sulfanilamidums
     3. Surgical dissection, drainage of the abscess of the gland
     4. \*Surgical dissecting, a drainage of an abscess of the gland, antibiotics
     5. Antibiotics, detoxication and biostimulants.
183. An onset of severe preeclampsia at 16 weeks gestation might be caused by:
     1. \*Hydatidiform mole
     2. Anencephaly
     3. Twin gestation
     4. Maternal renal disease
     5. Interventricular defect of the fetus
184. An endometrial adenocarcinoma that has extended to the uterine serosa would be classified as stage:
     1. IC
     2. IIIA
     3. IIA
     4. IIB
     5. IVAB
185. Which of the methods of examination is the most informative in the diagnostics of a tube infertility?
     1. \*Laparoscopy with chromosalpingoscopy
     2. Pertubation
     3. Hysterosalpingography
     4. Transvaginal echography
     5. Bicontrast pelviography
186. A 26 y.o. woman complains of a mild bloody discharge from the vagina and pain in the lower abdomen. She has had the last menstruation 3,5 months ago. The pulse is 80 bpm. The blood pressure (BP) is 110/60 mm Hg and body temperature is $36,6^0C$. The abdomen is tender in the lower parts. The uterus is enlarged up to 12 weeks of gestation. What is your diagnosis?
     1. Complete abortion
     2. Incipient abortion
     3. Incomplete abortion
     4. \*Inevitable abortion
     5. Disfunctional bleeding
187. A18 y.o. woman complains of pain in the lower abdomen. Some minutes before she has suddenly appeared unconscious at home. The patient had no menses within last 3 months.On examination: pale skin, the pulse- 110 bpm, BP- 80/60 mm Hg. The Schyotkin's sign is positive. Hb- 76 g/L. The vaginal examination: the uterus is a little bit enlarged, its displacement is painful. There is also any lateral swelling of indistinct size. The posterior fornix of the vagina is tendern and overhangs inside. What is the most probable diagnosis?
     1. \*Impaired extrauterine pregnancy
     2. Ovarian apoplexy
     3. Twist of cystoma of right uterine adnexa
     4. Acute salpingoophoritis
     5. Acute appendicitis
188. In the gynecologic office a 28 y.o. woman complains of sterility within three years. The menstrual function is not impaired. There were one artificial abortion and chronic salpingo-oophoritis in her case history. Oral contraceptives were not used. Her husband's analysis of semen is without pathology. What diagnostic method will you start from the workup in this case of sterility?
     1. \*Hysterosalpingography
     2. Hormone investigation
     3. Ultra sound investigation
     4. Diagnostic scraping out of the uterine cavity
     5. Hysteroscopia
189. A 28-year-old patient underwent endometrectomy as a result of incomplete abortion. Blood loss was at the rate of 900 ml. It was necessary to start hemotransfusion. After transfusion of 60 ml of erythrocytic mass the patient presented with lumbar pain and fever which resulted in hemotransfusion stoppage. 20 minutes later the patient's condition got worse: she developed adynamia, apparent skin pallor, acrocyanosis, profuse perspiration. $t^o$- $38,5^oC$, Ps- 110/min, AP- 70/40 mm Hg. What is the most likely diagnosis?
     1. Septic shock
     2. Hemorrhagic shock
     3. \*Hemotransfusion shock
     4. Anaphylactic shock
     5. DIC syndrome
190. A 58-year-old female patient came to the antenatal clinic with complaints of bloody light-reddischarges from the genital tracts. Menopause is 12 years. Gynaecological examination found externalia and vagina to have age involution; uterine cervix was unchanged, there were scant bloody discharges from uterine cervix, uterus was of normal size; uterine appendages were not palpable; parametria were free. What is the most likely diagnosis?
     1. \*Uterine carcinoma
     2. Atrophic colpitis
     3. Abnormalities of menstrual cycle with climacteric character
     4. Cervical carcinoma
     5. Granulosa cell tumor of ovary
191. The results of a separate diagnostic curettage of the mucous of the uterus' cervix and body made up in connection with bleeding in a postmenopausal period: the scrape of the mucous of the cervical canal revealed no pathology, in endometrium - the highly differentiated adenocarcinoma was found. Metastases are not found. What method of treatment is the most correct?
     1. Surgical treatment and chemotherapy
     2. \*Surgical treatment and hormonotherapy
     3. Surgical treatment and radial therapy
     4. Radial therapy
     5. all are wrong
192. A 27 y.o. woman complains of having the disoders of menstrual function for 3 months, irregular pains in abdomen. On bimanual examination: in the dextral appendage range of uterus there is an elastic spherical formation, painless, 7 cm in diameter. USI: in the right ovary - a fluid formation, 4 cm in diameter, unicameral, smooth. What method of treatment is the most preferable?
     1. \*Prescription of an estrogen-gestogen complex for 3 months with repeated examination
     2. Operative treatment
     3. Dispensary observation of the patient
     4. Anti-inflammatory therapy
     5. Chemotherapeutic treatment
193. A 40 year old patient complains of yellowish discharges from the vagina. Bimanual examination revealed no pathological changes. The smear contains Trichomonas vaginalis and blended flora. Colposcopy revealed two hazy fields on the frontal labium, with a negative Iodine test. Your tactics:
     1. biopsy Diathermocoagulation of the cervix of the uterus
     2. \*Treatment of specific colpitis and subsequent
     3. Specific treatment of Trichomonas colpitis
     4. Cervix ectomy
     5. Cryolysis of cervix of the uterus
194. A 48 year old female patient complains about contact haemorrhage. Speculum examination revealed hypertrophy of uterus cervix. It resembles of cauliflower, it is dense and can be easily injured. Bimanual examination revealed that fornices were shortened, uterine body was nonmobile. What is the most probable diagnosis?
     1. \*Cervical carcinoma
     2. Metrofibroma
     3. Endometriosis
     4. Cervical pregnancy
     5. Cervical papillomatosis
195. Laparotomy was performed to a 54 y.o. woman on account of big formation in pelvis that turned out to be one-sided ovarian tumor along with considerable omental metastases. The most appropriate intraoperative tactics involves:
     1. Biopsy of omentum
     2. \*Ablation of omentum, uterus and both ovaries with tubes
     3. Biopsy of an ovary
     4. Ablation of an ovary and omental metastases
     5. Ablation of omentum and both ovaries with tubes
196. A parturient complains about pain in the mammary gland. Palpation revealed a 3х4 cm large infiltration, soft in the centre. Body temperature is $38,5^oC$. What is the most probable diagnosis?
     1. \*Acute purulent mastitis
     2. Pneumonia
     3. Pleuritis
     4. Retention of milk
     5. Birth trauma
197. A 43 y.o. patient complains of formation and pain in the right mammary gland, rise of temperature up to $37,2^0C$ during the last 3 months. Condition worsens before the menstruation. On examination: edema of the right breast, hyperemia, retracted nipple. Unclear painful infiltration is palpated in the lower quadrants. What is the most probable diagnosis?
     1. Premenstrual syndrome
     2. Right-side acute mastitis
     3. Right-side chronic mastitis
     4. \*Cancer of the right mammary gland
     5. Tuberculosis of the right mammary gland
198. A 14 year old girl complains of profuse bloody discharges from genital tracts during 10 days after suppresion of menses for 1,5 month. Similiar bleedings recur since 12 years on the background of disordered menstrual cycle. On rectal examination: no pathology of the internal genitalia. In blood: Нb - 70 g/l, RBC- 2,3\cdot10^{12}/l, Ht - 20. What is the most probable diagnosis?
     1. \*Juvenile bleeding, posthemorrhagic anemia
     2. Werlholf's disease
     3. Polycyst ovarian syndrome
     4. Hormonoproductive ovary tumor
     5. Incomplete spontaneous abortion
199. A 33-year-old woman was urgently brought to clinic with complaints of the pain in the lower part of the abdomen, mostly on the right, irradiating to rectum, she also felt dizzy. The above mentioned complaints developed acutely at night. Last menses were 2 weeks ago. On physical exam: the skin is pale, Ps - 92 bpm, t- $36,6^OC$, BP- 100/60 mm Hg. The abdomen is tense, slightly tender in lower parts, peritoneal symptoms are slightly positive. Hb- 98 g/L. What is the most probable diagnosis?
     1. Renal colic
     2. Acute appendicitis
     3. Intestinal obstruction
     4. Abdominal pregnancy
     5. \*Apoplexy of the ovary
200. A 54-year-old female patient consulted a doctor about bloody discharges from the genital tracts after 2 years of amenorrhea. USI and bimanual examination revealed no genital pathology. What is the tactics of choice?
     1. \*Fractional biopsy of lining of uterus and uterine mucous membranes
     2. Styptic drugs
     3. Contracting drugs
     4. Estrogenic haemostasia
     5. Hysterectomy
201. A 27 y.o. gravida with 17 weeks of gestation was admitted to the hospital. There was a history of 2 spontaneous miscarriages. On bimanual examination: uterus is enlarged to 17 weeks of gestation, uterus cervix is shortened, isthmus allows to pass the finger tip. The diagnosis is isthmico-cervical insufficiency. What is the doctor's tactics?
     1. To interrupt pregnancy
     2. To administer tocolytic therapy
     3. \*To place suture on the uterus cervix
     4. To administer hormonal treatment
     5. To perform amniocentesis
202. A 27 y.o. woman turns to the maternity welfare centre because of infertility. She has had sexual life in marriage for 4 years, doesn't use contraceptives. She didn't get pregnant. On examination: genital development is without pathology, uterus tubes are passable, basal (rectal) temperature is one-phase during last 3 menstrual cycles. What is the infertility cause?
     1. Immunologic infertility
     2. Chronic adnexitis
     3. Abnormalities in genital development
     4. \*Anovular menstrual cycle
     5. Genital endometriosis
203. A 43 y.o. woman complains of contact hemorrhages during the last 6 months. Bimanual examination: cervix of the uterus is enlarged, its mobility is reduced. Mirrors showed the following: cervix of the uterus is in the form of cauliflower. Chrobak and Schiller tests are positive. What is the most probable diagnosis?
     1. Cervical pregnancy
     2. Polypus of the cervis of the uterus
     3. \*Cancer of cervix of the uterus
     4. Nascent fibroid
     5. Leukoplakia
204. A 26-year-old woman gave birth to a child 6 months ago. She applied to gynecologist complaining of menstruation absence. The child is breast-fed. Vagina exam: uterus is of normal form, dense consistence. What is the most probable diagnosis?
     1. Pseudoamenorrhea
     2. \*Physiological amenorrhea
     3. Gestation
     4. Asherman's syndrome
     5. Sheehan's syndrome
205. A primagravida in her 20th week of gestation complains about pain in her lower abdomen,blood smears from the genital tracts. The uterus has an increased tonus, the patient feels the fetus movements. Bimanual examination revealed that the uterus size corresponded the term of gestation, the uterine cervix was contracted down to 0,5 cm, the external orifice was open by 2 cm. The discharges were bloody and smeary. What is the most likely diagnosis?
     1. \*Incipient abortion
     2. Risk of abortion
     3. Abortion in progress
     4. Incomplete abortion
     5. Missed miscarriage
206. A patient was admitted to the hospital with complaints of periodical pain in the lower part of abdomen that gets worse during menses, weakness, malaise, nervousness, dark bloody smears from vagina directly before and after menses. Bimanual examination revealed that uterus body is enlarged, appendages cannot be palpated, posterior fornix has tuberous surface. Laparoscopy revealed: ovaries, peritoneum of rectouterine pouch and pararectal fat have "cyanotic eyes". What is the most probable diagnosis?
     1. Polycystic ovaries
     2. \*Disseminated form of endometriosis
     3. Chronic salpingitis
     4. Tuberculosis of genital organs
     5. Ovarian cystoma
207. A gravida with 7 weeks of gestation is referred for the artificial abortion. On operation while dilating cervical canal with Hegar dilator №8 a doctor suspected uterus perforation. What is immediate doctors tactics to confirm the diagnosis?
     1. \*Probing of uterus cavity
     2. Bimanual examination
     3. Ultrasound examination
     4. Laparoscopy
     5. Metrosalpingography
208. A pregnant woman in her 8th week was admitted to the hospital for artificial abortion. In course of operation during dilatation of cervical canal of uterus by means of Hegar's dilator № 8 the doctor suspected uterus perforation. What is the immediate tactics for confirmation of this diagnosis?
     1. Laparoscopy
     2. Bimanual examination
     3. US examination
     4. \*Uterine probing
     5. Metrosalpingography
209. A 59 year old female patient applied to a maternity clinic and complained about bloody discharges from the genital tracts. Postmenopause is 12 years. Vaginal examination revealed that external genital organs had signs of age involution, uterus cervix was not erosive, small amount of bloody discharges came from the cervical canal. Uterus was of normal size, uterine appendages were unpalpable. Fornices were deep and painless. What method should be applied for the diagnosis specification?
     1. \*Separated diagnosic curretage
     2. Laparoscopy
     3. Puncture of abdominal cavity through posterior vaginal fornix
     4. Extensive colposcopy
     5. Culdoscopy
210. A 25-year-old woman complains of profuse foamy vaginal discharges, foul, burning and itching in genitalia region. She has been ill for a week. Extramarital sexual life. On examination: hyperemia of vaginal mucous, bleeding on touching, foamy leucorrhea in the urethral area. What is the most probable diagnosis?
     1. Chlamydiosis
     2. Gonorrhea
     3. \*Trichomonas colpitic
     4. Vagina candidomicosis
     5. Bacterial vaginosis
211. A 26 year old woman who delivered a child 7 months ago has been suffering from nausea,morning vomiting, sleepiness for the last 2 weeks. She suckles the child, menstruation is absent. She hasn't applied any contraceptives. What method should be applied in order to specify her diagnosis?
     1. \*Ultrasonic examination
     2. Rentgenography of small pelvis organs
     3. Palpation of mammary glands and pressing-out of colostrum
     4. Bimanual vaginal examination
     5. Speculum examination
212. A 13 year old girl consulted the school doctor on account of moderate bloody discharge from the genital tracts, which appeared 2 days ago. Secondary sexual characters are developed.What is the most probable cause of bloody discharge?
     1. Juvenile hemorrhage
     2. \*Menarche
     3. Haemophilia
     4. Endometrium cancer
     5. Werlhof's disease
213. After examination a 46-year-old patient was diagnosed with left breast cancer T2N2M0, cl. gr.II-a. What will be the treatment plan for this patient?
     1. Operation + radiation therapy
     2. Operation only
     3. \*Radiation therapy + operation + chemotherapy
     4. Radiation therapy only
     5. Chemotherapy only
214. A 28 y.o. primagravida, pregnancy is 15-16 weaks of gestation, presents to the maternity clinics with dull pain in the lower part of the abdomen and in lumbar area. On vaginal examination: uterus cervix is 2,5 cm, external isthmus allows to pass the finger tip. Uterus body is enlarged according to the pregnancy term. Genital discharges are mucous, mild. What is the diagnosis?
     1. Hydatid molar pregnancy
     2. Spontaneous abortion which has begun
     3. Stopped pregnancy
     4. \*Threatened spontaneous abortion
     5. Placenta presentation
215. During examination of a patient, masses in the form of condyloma on a broad basis are found in the area of the perineum. What is the tactics of the doctor?
     1. Antiviral treatment
     2. Cryodestruction of condyloms
     3. Surgical ablation of condyloms
     4. Chemical coagulator treatment
     5. \*To send a woman into dermatological and venerological centre
216. A 28 year old woman has bursting pain in the lower abdomen during menstruation; chocolate-like discharges from vagina. It is known from the anamnesis that the patient suffers from chronic adnexitis. Bimanual examination revealed a tumour-like formation of heterogenous consistency 7х7 cm large to the left from the uterus. The formation is restrictedly movable, painful when moved. What is the most probable diagnosis?
     1. \*Endometrioid cyst of the left ovary
     2. Follicular cyst of the left ovary
     3. Fibromatous node
     4. Exacerbation of chronic adnexitis
     5. Tumour of sigmoid colon
217. A 68-year-old patient consulted a doctor about a tumour in her left mammary gland.Objectively: in the upper internal quadrant of the left mammary gland there is a neoplasm up to 2,5 cm in diameter, dense, uneven, painless on palpation. Regional lymph nodes are not enlarged. What is the most likely diagnosis?
     1. Cyst
     2. \*Cancer
     3. Fibroadenoma
     4. Mastopathy
     5. Lipoma
218. A 40-year-old female patient has been observing profuse menses accompanied by spasmodic pain in the lower abdomen for a year. Bimanual examination performed during menstruation revealed a dense formation up to 5 cm in diameter in the cervical canal. Uterus is enlarged up to 5-6 weeks of pregnancy, movable, painful, of normal consistency. Appendages are not palpable. Bloody discharges are profuse. What is the most likely diagnosis?
     1. \*Nascent submucous fibromatous node
     2. Abortion in progress
     3. Cervical carcinoma
     4. Cervical myoma
     5. Algodismenorrhea
219. A 29-year-old patient complains of sterility. Sexual life is for 4 years being married, does not use contraception. There was no pregnancy before. On physical examination, genitals are developed normally. Uterine tubes are passable. Rectal temperature during three menstrual cycles is monophase. What is the most probable reason for sterility?
     1. Anomalies of genitals development
     2. Chronic adnexitis
     3. \*Anovulatory menstrual cycle
     4. Immunologic sterility
     5. Genital endometriosis
220. A 45 y.o. woman complains of contact bleedings during 5 months. On speculum examination: hyperemia of uterus cervix, looks like cauliflower, bleeds on probing. On bimanual examination: cervix is of densed consistensy, uterus body isn't enlarged, mobile, nonpalpable adnexa, parametrium is free, deep fornixes. What is the most likely diagnosis?
     1. Cervical pregnancy
     2. Cancer of body of uterus
     3. Fibromatous node which is being born
     4. \*Cancer of cervix of uterus
     5. Polypose of cervix of uterus
221. A 20 y.o. patient complains of amenorrhea. Objectively: hirsutism, obesity with fat tissue prevailing on the face, neck, upper part of body. On the face there are acne vulgaris, on the skin - striae cutis distense. Psychological and intellectual development is normal. Gynecological condition: external genitals are moderately hairy, acute vaginal and uterine hypoplasia. What diagnosis is the most probable?
     1. \*Itsenko-Cushing syndrome
     2. Turner's syndrome
     3. Stein-Levental's syndrome
     4. Shichan's syndrome
     5. Babinski-Froehlich syndrome
222. A 27 y.o. woman suffers from pyelonephritits of the only kidney. She presents to the maternity centre because of suppresion of menses for 2,5 months. On examination pregnancy 11 weeks of gestation was revealed. In urine: albumine 3,3 g/L, leucocytes cover the field of vision. What is doctor's tactics in this case?
     1. Pregnancy interruption at 24-25 weeks
     2. Pregnancy interruption after urine normalization
     3. Maintenance of pregnancy till 36 weeks
     4. \*Immediate pregancy interruption
     5. Maintenance of pregnancy till delivery term
223. A 24-year-old female patient complains of acute pain in the lower abdomen that turned up after a physical stress. She presents with nausea, vomiting, dry mouth and body temperature 36,6^oC. She has a right ovarian cyst in history. Bimanual examination reveals that uterus is dense, painless, of normal size. The left fornix is deep, uterine appendages aren't palpable, the right fornix is contracted. There is a painful formation on the right of uterus. It's round, elastic and mobile. It is 7х8 cm large. In blood: leukocytosis with the left shit. What is the most likely diagnosis?
     1. Extrauterine pregnancy
     2. Right-sided pyosalpinx
     3. Subserous fibromyoma of uterus
     4. Acute metritis
     5. \*Ovarian cyst with pedicle torsion

Picture Tests

1. Indicate the number of endometrium in the Fig.2?
   1. \*1
   2. 2
   3. 3
   4. 5
   5. 4
2. Indicate the number of fetus in the Fig.2?
   1. 1
   2. \*2
   3. 3
   4. 5
   5. 4
3. What is demonstrated as № 1 in the Fig.7?
   1. \*Zone osculation
   2. Contractile ring
   3. Alfeld’ sign
   4. Adjacent organ
   5. Communication zone
4. What is demonstrated as № 2 in the Fig.7?
   1. Zone osculation
   2. Contractile ring
   3. \*Anterior amniotic fluid
   4. Adjacent organ
   5. Posterior amniotic fluid
5. What is demonstrated as № 3 in the Fig.7?
   1. Zone osculation
   2. Contractile ring
   3. Anterior amniotic fluid
   4. Adjacent organ
   5. \*Posterior amniotic fluid
6. How do you called the instrument which is present on the Fig. 40?
   1. Retractor
   2. Cusco’ speculum
   3. Sims’ speculum
   4. Perforator
   5. \*Forceps
7. What type of placenta is shown on the Fig.41, 2?
   1. \*Partial placenta previa
   2. Complete placenta previa
   3. Marginal placenta previa
   4. Normal position of placenta
   5. Low lying placenta
8. What type of placenta is shown on the Fig.41, 3?
   1. Low lying placenta
   2. Complete placenta previa
   3. \*Marginal placenta previa
   4. Normal position of placenta
   5. Total placenta previa
9. What type of placenta is shown on the Fig.41, 4?
   1. Partial placenta previa
   2. Complete placenta previa
   3. Marginal placenta previa
   4. Normal position of placenta
   5. \*Low lying placenta
10. Which of the following is least likely to result in a patient having placenta previa in the Fig. 41, 1?
    1. \*Primiparity
    2. Previous cesarean section
    3. Multiparity
    4. Advancing maternal age
    5. Infection
11. What is the most common characteristic symptom in women with placenta previa which is present in the Fig. 41, 2?
    1. Abnormal fetal heart rate tracing
    2. Painful bleeding
    3. \*Painless bleeding
    4. Coagulopathy
    5. Headache
12. Which type of spontaneous abortion is present on the Fig. 42, 1?
    1. Threatened
    2. \*Initial
    3. Inevitable
    4. Complete
    5. Incomplete
13. What is the most common method for diagnosis of placenta previa in the Fig.41,1?
    1. Abdominal x-ray
    2. Arteriography
    3. \*Ultrasound
    4. Computed tomographic scanning
    5. Estimation of biophysical profile
14. What is the best management of placenta previa which is present in the Fig.41, 1 in labor?
    1. \*cesarean section
    2. amniotomy
    3. contractiles drugs
    4. amniotomy, contractiles drugs
    5. vacuum extraction
15. What is the best management of placenta previa which is present in the Fig. 41, 2 in labor when the amount of blood loss is till 250ml ?
    1. cesarean section
    2. amniotomy
    3. contractiles drugs
    4. \*amniotomy, contractiles drugs
    5. vacuum extraction
16. What is the best management of placenta previa which is present in the Fig. 41,3 in labor when the amount of blood loss is till 250ml ?
    1. cesarean section
    2. amniotomy
    3. contractiles drugs
    4. \*amniotomy, contractiles drugs
    5. vacuum extraction
17. What is the best management of placenta previa which is present in the Fig. 41, 2 in labor when the amount of blood loss is more than 250ml ?
    1. \*cesarean section
    2. amniotomy
    3. contractiles drugs
    4. amniotomy, contractiles drugs
    5. vacuum extraction
18. What is the best management of placenta previa which is present in the Fig. 41,4 in labor when the amount of blood loss is more than 250ml ?
    1. \*cesarean section
    2. amniotomy
    3. contractiles drugs
    4. amniotomy, contractiles drugs
    5. vacuum extraction
19. What is the best management of placenta previa which is present in the Fig. 41,4 in labor when the amount of blood loss is till 250ml ?
    1. cesarean section
    2. amniotomy
    3. contractiles drugs
    4. \*amniotomy, contractiles drugs
    5. vacuum extraction
20. What is the best management of placenta previa which is present in the Fig. 41,2 in labor when the amount of blood loss is more than 250ml ?
    1. \*cesarean section
    2. amniotomy
    3. contractiles drugs
    4. amniotomy, contractiles drugs
    5. vacuum extraction
21. Which type of spontaneous abortion is present on the Fig. 42, 2?
    1. Threatened
    2. Initial
    3. \*Inevitable
    4. Complete
    5. Incomplete
22. Which type of spontaneous abortion is present on the Fig. 42, 3?
    1. Threatened
    2. Initial
    3. Inevitable
    4. Complete
    5. \*Incomplete
23. Which type of spontaneous abortion is present on the Fig. 42, 4?
    1. Threatened
    2. \*Missed
    3. Inevitable
    4. Complete
    5. Incomplete
24. What is the best management of the spontaneous abortion which is present on the Fig. 42, 1?
    1. \*Conservative
    2. Uterine curettage
    3. Vacuum suction
    4. Total hysterectomy
    5. Subtotal hysterectomy
25. What is the best management of the spontaneous abortion which is present on the Fig. 42, 2?
    1. Conservative
    2. \*Uterine curettage
    3. Vacuum suction
    4. Total hysterectomy
    5. Subtotal hysterectomy
26. Which pathology is present on the Fig. 54?
    1. Vaginal atresia
    2. Uterine aplasia
    3. Atresia of vagina
    4. \*Atresia of hymen
    5. Vaginal aplasia
27. What is the best management of the pathology which is present on the Fig. 43?
    1. Conservative
    2. Uterine curettage
    3. Conservative
    4. \*Total hysterectomy
    5. Subtotal hysterectomy
28. How do you called the pathology which is present on the Fig. 43?
    1. \*Couvelere uterus
    2. Uterine atony
    3. Ectopic pregnancy
    4. Molar pregnancy
    5. Ovarian apoplexy
29. What is the most often reason of pathology which is present on the Fig. 43?
    1. Placenta previa
    2. \*Placenta abruption
    3. Ectopic pregnancy
    4. Molar pregnancy
    5. Ovarian apoplexy
30. Which pathology is described of the Fig. 44?
    1. Ovarian apoplexy
    2. Uterine myoma
    3. \*Ectopic pregnancy
    4. Uterine prolapse
    5. Ovarian cystoma
31. Which type of ectopic pregnancy is present on the Fig.44,2?
    1. Pregnancy in the rudimentary horn
    2. Abdominal
    3. \*Tubal rupture
    4. Cervical
    5. Intraligamentary
32. Which type of ectopic pregnancy is present on the Fig.44,3?
    1. Pregnancy in the rudimentary horn
    2. Abdominal
    3. \*Tubal abortion
    4. Cervical
    5. Intraligamentar
33. What is the best method of treatment for ectopic pregnancy on the Fig.44,2?
    1. Ovarian resection
    2. Vacuum suction
    3. Oophorectomy
    4. Hysterectomy
    5. \*Salpingectomy
34. What is the best method of treatment for ectopic pregnancy on the Fig.44,3?
    1. Ovarian resection
    2. Vacuum suction
    3. Oophorectomy
    4. Hysterectomy
    5. \*Salpingectomy
35. How do you called type of ectopic pregnancy in the Fig.44, 5?
    1. Abdominal
    2. Intraligamentary
    3. Ampullar
    4. \*Unruptured tubal
    5. Interstitial
36. What is the best method of ectopic pregnancy diagnosis in the Fig.44, 2?
    1. \*Culdocentesis
    2. General blood amount
    3. Urine analysis
    4. Ultrasonography
    5. X-ray examination
37. What is the best method of treatment for ectopic pregnancy on the Fig.44,5?
    1. \*Methotrexate prescription
    2. Vacuum suction
    3. Oophorectomy
    4. Hysterectomy
    5. Salpingectomy
38. What is the best method of treatment for unruptured ectopic pregnancy on the Fig.44,5 if diameter of the pelvic mass on ultrasound less than 3,5 cm?
    1. Duphastone prescription
    2. \*Methotreksat injection
    3. Estrogens’ prescription
    4. Hysterectomy
    5. Salpingectomy
39. All of the below are indicated for the type of spontaneous abortion which present on the Fig. 64, 1 EXCEPT:
    1. Sedative drugs
    2. No-spani
    3. Papaverine hydrochloride
    4. Duphastone
    5. \*Uterine curettage
40. What is the most common complication of the ectopic pregnancy duration on the Fig.44,5?
    1. Uterine rupture
    2. \*Rupture of the fallopian tube
    3. Tubal abortion
    4. Ovarian apoplexy
    5. Necrosis of fallopian tube
41. All of the below are indicated for the type of spontaneous abortion which present on the Fig. 42, 1 EXCEPT:
    1. Sedative drugs
    2. No-spani
    3. Papaverine hydrochloride
    4. \*Uterine suction
    5. Progesterone
42. What is the management of spontaneous abortion which is present on the Fig.42, 3?
    1. \*Uterine curettage
    2. No-spani
    3. Papaverine hydrochloride
    4. Duphastone
    5. Uthrogestane
43. What is the management of spontaneous abortion which is present on the Fig.42, 4?
    1. No-spani
    2. \*Uterine curettage
    3. Papaverine hydrochloride
    4. Duphastone
    5. Utrogestane
44. Which type of suture is applied in the cervical incompetence on the Fig.50?
    1. \*Mac-Donald
    2. Shirodkar
    3. Pelau
    4. Phannenstiel
    5. Joel-Cohen
45. What is the best method for diagnosis of cervical incompetence which is presented on the Fig.50?
    1. \*Ultrasound
    2. X-ray examination
    3. Colposcopy
    4. Pelvic examination
    5. Speculum examination
46. What is the best method for treatment of cervical incompetence should present on the Fig.50?
    1. Shturmdorf’ operation
    2. Cesarean section
    3. \*Cervical cerclage
    4. Cervical curettage
    5. Cervical hysterectomy
47. Which suture is applied for cervical incompetence treatment on the Fig. 50?
    1. \*Silk
    2. Vikril
    3. Catgut
    4. Capron
    5. Lavsan
48. Indicate the number of superficial layer of squamous vaginal epithelium in the Fig.51?
    1. \*1
    2. 2
    3. 3
    4. 4
    5. 5
49. In which gestational age the doctor should apply the suture on the cervix in the case of cervical incompetence which is present in the Fig. 50?
    1. 8 weeks
    2. 12 weeks
    3. 14 weeks
    4. \*16 weeks
    5. 22 weeks
50. In which gestational age the doctor should apply the suture on the cervix in the case of cervical incompetence which is present in the Fig. 50?
    1. \*18 weeks
    2. 22 weeks
    3. 24 weeks
    4. 28 weeks
    5. 30 weeks
51. In which gestational age the doctor should remove the suture from the cervix in the case of cervical incompetence which is present in the Fig. 50?
    1. 26 weeks
    2. 28 weeks
    3. 34 weeks
    4. \*38 weeks
    5. 40 weeks
52. Indicate the number of intraepithelium layer of squamous vaginal epithelium in the Fig.51?
    1. 1
    2. \*2
    3. 3
    4. 4
    5. 5
53. Indicate the number of intermediate layer of squamous vaginal epithelium in the Fig.51?
    1. 1
    2. 2
    3. \*3
    4. 4
    5. 5
54. Indicate the number of parabasal layer of squamous vaginal epithelium in the Fig.51?
    1. 1
    2. 2
    3. 3
    4. \*4
    5. 5
55. Indicate the number of basal layer of squamous vaginal epithelium in the Fig.51?
    1. 1
    2. 2
    3. 3
    4. 4
    5. \*5
56. Which layer of squamous vaginal epithelium is present on the Fig.51, 1?
    1. Intraepithelium
    2. \*Superficial
    3. Parabasal
    4. Intermediate
    5. Basal
57. Which layer of squamous vaginal epithelium is present on the Fig.51, 2?
    1. \*Intraepithelium
    2. Superficial
    3. Parabasal
    4. Intermediate
    5. Basal
58. Which layer of squamous vaginal epithelium is present on the Fig.51, 3?
    1. Intraepithelium
    2. Superficial
    3. Parabasal
    4. \*Intermediate
    5. Basal
59. Which layer of squamous vaginal epithelium is present on the Fig.51, 4?
    1. Intraepithelium
    2. Superficial
    3. \*Parabasal
    4. Intermediate
    5. Basal
60. Which layer of squamous vaginal epithelium is present on the Fig.51, 5?
    1. Intraepithelium
    2. Superficial
    3. Parabasal
    4. Intermediate
    5. \*Basal
61. Which abnormal development of internal sexual organs is present on the Fig. 52, 1?
    1. Complete double uterus, cervix
    2. \*Complete double uterus, cervix and vagina
    3. Bifid uterus with single vagina
    4. Saddle like uterus
    5. Uterine gynatresia
62. Which abnormal development of internal sexual organs is present on the Fig.52, 2?
    1. \*Complete double uterus, cervix
    2. Complete double uterus, cervix and vagina
    3. Bifid uterus with single vagina
    4. Saddle like uterus
    5. Uterine gynatresia
63. Which abnormal development of internal sexual organs is present on the Fig. 52, 3?
    1. Complete double uterus, cervix
    2. Complete double uterus, cervix and vagina
    3. \*Bifid uterus with single vagina
    4. Saddle like uterus
    5. Uterine gynatresia
64. Which abnormal development of internal sexual organs is present on the Fig. 52, 4?
    1. Complete double uterus, cervix
    2. Complete double uterus, cervix and vagina
    3. Bifid uterus with single vagina
    4. \*Saddle like uterus
    5. Uterine gynatresia
65. Which pathology is present on the Fig. 53?
    1. Aplasia of vagina
    2. Atresia of gymen
    3. Cervical ectropion
    4. \*Cervical erosion
    5. Cervical leukoplakia
66. Which method of diagnosis is shown on the Fig. 53?
    1. Laparoscopy
    2. \*Simple colposcopy
    3. Broadened colposcopy
    4. Hysteroscopy
    5. Metrosalpingography
67. Choose the drug for chemical destruction of pathological process which is present on the Fig. 53:
    1. Rigevidon
    2. \*Solcovagyn
    3. Duphastone
    4. Etamsilat
    5. Oxytocin
68. Choose the drug for chemical destruction of pathological process which is present on the Fig. 53:
    1. Rigevidon
    2. Dicinone
    3. Utrogestan
    4. \*Vagotyle
    5. Oxytocin
69. Choose the method of treatment for pathological process which is present on the Fig. 53:
    1. \*Electrocoagulation
    2. Prescription of duphastone
    3. Prescription of vitamin E
    4. Total hysterectomy
    5. Subtotal hysterectomy
70. What is the best method of treatment for pathology which is present on the Fig. 54?
    1. Suturing of labia major
    2. Suturing of labia minor
    3. \*Surgical incision of hymen
    4. Application of anesthetics
    5. Application of antibacterial drugs
71. Which complication is the most common as a result of pathology which is present on the Fig. 54?
    1. Vagihal atresia
    2. Vaginal aplasia
    3. Labia major adhesion
    4. Labia minor adhesion
    5. \*Hematocolpos
72. Which pathology is described on the Fig.55?
    1. \*Cervical carcinoma
    2. Ovarian carcinoma
    3. Uterine carcinoma
    4. Vaginal cancer
    5. Pedjetta’ disease
73. Which stage of cervical carcinoma is described on the Fig. 55, 1?
    1. \*Ia
    2. Ib
    3. Iia
    4. Iib
    5. III
74. Which stage of cervical carcinoma is described on the Fig. 55, 2?
    1. Ia
    2. \*Ib
    3. Iia
    4. Iib
    5. III
75. What type of placenta is shown on the Fig.41, 1?
    1. Partial placenta previa
    2. Low lying placenta previa
    3. Marginal placenta previa
    4. Normal position of placenta
    5. \*Total placenta previa
76. What is demonstrated as № 1 in the Fig.2?
    1. Amnion
    2. Chorion lave
    3. Amniotic fluid
    4. \*Endometrium
    5. Chorion frondosum
77. What is demonstrated as № 2 in the Fig.2?
    1. Amnion
    2. Chorion lave
    3. Amniotic fluid
    4. \*Fetus
    5. Chorion frondosum
78. What is demonstrated as № 3 in the Fig.2?
    1. Amnion
    2. Chorion lave
    3. Amniotic fluid
    4. Fetus
    5. \*Chorion frondosum
79. What is demonstrated as № 4 in the Fig.2?
    1. Chorion lave
    2. \*Decidual membrane
    3. Fetus
    4. Chorion frondosum
    5. Amnion
80. What is demonstrated as № 5 in the Fig.2?
    1. \*Amnion
    2. Chorion lave
    3. Decidual membrane
    4. Fetus
    5. Chorion frondosum
81. What is demonstrated as № 6 in the Fig.2?
    1. Amnion
    2. \*Chorion lave
    3. Decidual membrane
    4. Fetus
    5. Chorion frondosum
82. Indicate the number of amnion in the Fig.2?
    1. 1
    2. 2
    3. 3
    4. 4
    5. \*5
83. Indicate the number of chorion lave in the Fig.2?
    1. 1
    2. 2
    3. 3
    4. 5
    5. \*6
84. Indicate the number of chorion frondosum in the Fig.2?
    1. 1
    2. 2
    3. \*3
    4. 5
    5. 6
85. Indicate the number of decidual membrane in the Fig.2?
    1. 1
    2. 2
    3. 3
    4. 5
    5. \*4
86. Which stage of cervical carcinoma is described on the Fig. 55, 3?
    1. I
    2. II
    3. \*III
    4. IV
    5. V
87. Choose the most common sign of pathology which is present on the Fig.55:
    1. Lover abdominal pain
    2. Dizziness
    3. Lymphorrhea
    4. \*Contact bleeding
    5. Constipation
88. Which symptom is present on the Fig.56?
    1. “Fern” symptom
    2. “Pupil” symptom
    3. Mucus tension symptom
    4. Caryopicnotic symptom
    5. “Figo” symptom
89. What is the importance of symptom which is present on the Fig.56?
    1. \*To diagnose ovarian functional state
    2. To diagnose uterine function
    3. To diagnose vaginal properties
    4. To diagnose ovulation
    5. To diagnose hypothalamic function
90. Which pathology is described of the Fig. 57?
    1. Ovarian apoplexy
    2. Uterine myoma
    3. \*Ectopic pregnancy
    4. Uterine prolapse
    5. Ovarian cystoma
91. Which type of ectopic pregnancy is present on the Fig.57?
    1. \*Pregnancy in the rudimentary horn
    2. Abdominal
    3. Ovarian
    4. Cervical
    5. Intraligamentar
92. Which pathology is present on the Fig. 58?
    1. \*Cervical erosion
    2. Atresia of gymen
    3. Cervical ectropion
    4. Aplasia of vagina
    5. Cervical leukoplakia
93. What is the first step in the treatment of situation which is present on the Fig.58?
    1. Electrocoagulation
    2. \*Removal of intrauterine device
    3. Chemical destruction
    4. Laser destruction
    5. Application of antibacterial drugs
94. Which pathology is present on the Fig.59?
    1. Vaginal cyst
    2. \*Abscess of Bartholins’ gland
    3. Gartner’ duct cyst
    4. Muller’ duct cyst
    5. Leopold’ cyst
95. What is the best method of treatment of pathology which is present on the Fig.59?
    1. Antiseptic application
    2. Antibacterial drugs
    3. \*Marsupialization
    4. Hormone therapy
    5. Physiotherapy
96. Which pathology is present on the Fig.60?
    1. Vaginal cyst
    2. Abscess of Bartholins’ gland
    3. Vaginitis
    4. \*Vulvar leukoplakia
    5. Vulvitis
97. Which microorganisms are described on the Fig. 61?
    1. Gardnerella vaginalis
    2. \*Candida albicans
    3. Gonococcus
    4. Trichomonas vaginalis
    5. Staphylococcus
98. Which microorganisms are described on the Fig. 62, 2?
    1. Gardnerella vaginalis
    2. Candida albicans
    3. Gonococcus
    4. \*Trichomonas vaginalis
    5. Staphylococcus
99. What is the Shiller’s test is based on in the Fig. 71?
    1. \*on power of iodine to unite with glycogen.
    2. on discoloration of the pathologically changed areas.
    3. on the short term edema of tissue.
    4. on coloring by the iodine of areas of displasia.
    5. on coloring by the iodine of areas of inflammation.
100. Which test is shown in the Fig. 71?
     1. \*Shiller’s test
     2. Alfelda’ test
     3. Kustner’ test
     4. Mychajlov’ test
     5. Danford test
101. What method enables to define pathology which is shown in the Fig. 71?
     1. \*colposcopy.
     2. hysteroscopy.
     3. rentgenopelvigraphy.
     4. hysterosalpingography.
     5. ultrasound examination.
102. What method enables to define pathology which is shown in the Fig. 71?
     1. hysteroscopy.
     2. \*speculum examination
     3. rentgenopelvigraphy.
     4. hysterosalpingography.
     5. ultrasound examination.
103. For diagnosis of which pathology Shiller’s which is used in the Fig. 71 used?
     1. \*Cervical
     2. Ovarian
     3. Uterine
     4. Abdominal
     5. Mammary
104. Which a basal temperature in the first phase of menstrual cycle in the Fig. 3 must be?
     1. 36 0.
     2. 36,2-36,50.
     3. 370.
     4. \*36,6-36,80.
     5. 37,1-37,40.
105. Which a basal temperature in the second phase of menstrual cycle in the Fig. 3 must be?
     1. 36 0.
     2. 36,2-36,50.
     3. 370.
     4. 36,6-36,80.
     5. \*37,1-37,40.
106. How do you called the uterine phase which is present on the Fig.3 and lasts from the 1 to 5 day?
     1. \*Desquamation
     2. Proliferation
     3. Regeneration
     4. Secretion
     5. Ovulation
107. How do you called the uterine phase which is present on the Fig.3 and occur on the 5-6 day?
     1. Desquamation
     2. Proliferation
     3. \*Regeneration
     4. Secretion
     5. Ovulation
108. How do you called the uterine phase which is present on the Fig.3 and occur from 7th to 14th day?
     1. Desquamation
     2. \*Proliferation
     3. Regeneration
     4. Secretion
     5. Ovulation
109. How do you called the uterine phase which is present on the Fig.3 and occur from 15th to 28th day?
     1. Desquamation
     2. Proliferation
     3. Regeneration
     4. \*Secretion
     5. Ovulation
110. Which events occur on the ovarian level on the Fig.3, 1-2 ?
     1. Proliferation
     2. Regeneration
     3. Formation of luteal body
     4. Ovulation
     5. \*Follicular maturation
111. Which events occur on the ovarian level on the Fig.3, 3?
     1. Proliferation
     2. Regeneration
     3. Secretion
     4. \*Ovulation
     5. Follicular maturation
112. Which events occur on the ovarian level on the Fig.3, 4?
     1. Proliferation
     2. \*Formation of luteal body
     3. Secretion
     4. Ovulation
     5. Follicular maturation
113. Which hormones are produced by follicular cells during follicular maturation on the Fig. 3, 1-2?
     1. \*Estrogens
     2. Progesterone
     3. Prostaglandins
     4. Cytokines
     5. Enzymes
114. Which hormones are produced by structure on the Fig. 3,4?
     1. Estrogens
     2. \*Progesterone
     3. Prostaglandins
     4. Cytokines
     5. Enzymes
115. How do you called type of ectopic pregnancy on the Fig.63, 1?
     1. \*Abdominal
     2. Intraligamentary
     3. Ampullar
     4. Isthmic
     5. Interstitial
116. How do you called type of ectopic pregnancy on the Fig.63, 2a?
     1. Abdominal
     2. Intraligamentary
     3. Ampullar
     4. Isthmic
     5. \*Interstitial
117. How do you called type of ectopic pregnancy on the Fig.63, 2б?
     1. Abdominal
     2. Intraligamentary
     3. Ampullar
     4. \*Isthmic
     5. Interstitial
118. How do you called type of ectopic pregnancy on the Fig.63, 2в?
     1. Abdominal
     2. Intraligamentary
     3. \*Ampullar
     4. Isthmic
     5. Interstitial
119. How do you called type of ectopic pregnancy on the Fig.63, 3б?
     1. Abdominal
     2. Intraligamentary
     3. Ampullar
     4. \*Ovarian
     5. Interstitial
120. How do you called type of ectopic pregnancy on the Fig.63, 4?
     1. Abdominal
     2. \*Intraligamentary
     3. Ampullar
     4. Ovarian
     5. Interstitial
121. How do you called type of ectopic pregnancy on the Fig.63, 5?
     1. Abdominal
     2. Intraligamentary
     3. Ampullar
     4. \*Cervical
     5. Interstitial
122. What is the best method of treatment for ectopic pregnancy on the Fig.63,5?
     1. Uterine curettage
     2. Vacuum suction
     3. \*Total hysterectomy
     4. Subtotal hysterectomy
     5. Cone cervical resection
123. What is the best method of treatment for ectopic pregnancy on the Fig.63,2б?
     1. Uterine curettage
     2. Vacuum suction
     3. Total hysterectomy
     4. Subtotal hysterectomy
     5. \*Salpingectomy
124. What is the best method of treatment for ectopic pregnancy on the Fig.63,2в?
     1. Uterine curettage
     2. Vacuum suction
     3. Total hysterectomy
     4. Subtotal hysterectomy
     5. \*Salpingectomy
125. What is the best method of treatment for ectopic pregnancy on the Fig.63,2а?
     1. Uterine curettage
     2. Vacuum suction
     3. Ovarian resection
     4. Hysterectomy
     5. \*Salpingectomy
126. What is the best method of treatment for ectopic pregnancy on the Fig.63,3а?
     1. \*Ovarian resection
     2. Vacuum suction
     3. Oophorectomy
     4. Hysterectomy
     5. Salpingectomy
127. What is the best method of treatment for ectopic pregnancy on the Fig.63,3б?
     1. \*Ovarian resection
     2. Vacuum suction
     3. Oophorectomy
     4. Hysterectomy
     5. Salpingectomy
128. What is the best method of treatment for unruptured ectopic pregnancy on the Fig.63,2б if diameter of the pelvic mass on ultrasound less than 3,5 cm?
     1. Duphastone prescription
     2. \*Methotreksat injection
     3. Estrogens’ prescription
     4. Hysterectomy
     5. Salpingectomy
129. What pathology is shown on the Fig.72?
     1. Uterine myoma
     2. Molar pregnancy
     3. \*Ovarian cystoma
     4. Ectopic pregnancy
     5. Ovarian apoplexy
130. What is the most common complication of the ectopic pregnancy duration on the Fig.63,2a?
     1. Uterine rupture
     2. \*Rupture of the fallopian tube
     3. Tubal abortion
     4. Ovarian apoplexy
     5. Necrosis of fallopian tube
131. What is the most common complication of the ectopic pregnancy duration on the Fig.63,2в?
     1. Uterine rupture
     2. Rupture of the fallopian tube
     3. \*Tubal abortion
     4. Ovarian apoplexy
     5. Necrosis of fallopian tube
132. Which type of spontaneous abortion is present on the Fig. 64, a?
     1. \*Threatened
     2. Initial
     3. Inevitable
     4. Complete
     5. Incomplete
133. Which type of spontaneous abortion is present on the Fig. 64, б?
     1. Threatened
     2. \*Initial
     3. Inevitable
     4. Complete
     5. Incomplete
134. Which type of spontaneous abortion is present on the Fig. 64, в?
     1. Threatened
     2. Initial
     3. \*Inevitable
     4. Complete
     5. Incomplete
135. Which type of spontaneous abortion is present on the Fig. 64, г?
     1. Threatened
     2. Initial
     3. Inevitable
     4. Complete
     5. \*Incomplete
136. What is the best management of the spontaneous abortion which is present on the Fig. 64, a?
     1. \*Conservative
     2. Uterine curettage
     3. Vacuum suction
     4. Total hysterectomy
     5. Subtotal hysterectomy
137. What is the best management of the spontaneous abortion which is present on the Fig. 64, б?
     1. \*Conservative
     2. Uterine curettage
     3. Vacuum suction
     4. Total hysterectomy
     5. Subtotal hysterectomy
138. All of the below are indicated for the type of spontaneous abortion which present on the Fig. 64, a EXCEPT:
     1. Sedative drugs
     2. No-spani
     3. Papaverine hydrochloride
     4. Duphastone
     5. \*Uterine curettage
139. All of the below are indicated for the type of spontaneous abortion which present on the Fig. 64, б EXCEPT:
     1. Sedative drugs
     2. No-spani
     3. Papaverine hydrochloride
     4. Duphastone
     5. \*Uterine curettage
140. All of the below are indicated for the type of spontaneous abortion which present on the Fig. 64, a EXCEPT:
     1. Sedative drugs
     2. No-spani
     3. Papaverine hydrochloride
     4. \*Uterine suction
     5. Progesterone
141. All of the below are indicated for the type of spontaneous abortion which present on the Fig. 64, б EXCEPT:
     1. \*Uterine suction
     2. No-spani
     3. Papaverine hydrochloride
     4. Duphastone
     5. Utrogestane
142. What is the management of spontaneous abortion which is present on the Fig.64, в?
     1. \*Uterine curettage
     2. No-spani
     3. Papaverine hydrochloride
     4. Duphastone
     5. Utrogestane
143. What is the management of spontaneous abortion which is present on the Fig.64, г?
     1. No-spani
     2. \*Uterine curettage
     3. Papaverine hydrochloride
     4. Duphastone
     5. Utrogestane
144. Which type of uterine fibroid is present on the Fig. 65, 1?
     1. Subserosal
     2. \*Intramural
     3. Submucous
     4. Intracervical
     5. Protruded
145. Which type of uterine fibroid is present on the Fig. 65, 2?
     1. \*Subserosal
     2. Intramural
     3. Submucous
     4. Intracervical
     5. Protruded
146. Which type of uterine fibroid is present on the Fig. 65, 2a?
     1. \*Subserosal twisted
     2. Intramural
     3. Submucous
     4. Intracervical
     5. Protruded
147. Which type of uterine fibroid is present on the Fig. 65, 3?
     1. Subserosal twisted
     2. Intramural
     3. \*Submucous
     4. Intracervical
     5. Protruded
148. Which type of uterine fibroid is present on the Fig. 65, 4?
     1. Subserosal twisted
     2. Intramural
     3. Submucous
     4. \*Intracervical
     5. Protruded
149. Which type of uterine fibroid is present on the Fig. 65, 5?
     1. Subserosal twisted
     2. Intramural
     3. Submucous
     4. Intracervical
     5. \*Intraligamentory
150. Which type of uterine fibroid is present on the Fig. 65, 6?
     1. \*Protruded
     2. Intramural
     3. Submucous
     4. Intracervical
     5. Intraligamentory
151. Which type of uterine fibroid is submucous on the Fig. 65?
     1. 1
     2. 2
     3. 2a
     4. \*3
     5. 4
152. Which type of uterine fibroid is subserous on the Fig. 65?
     1. 1
     2. \*2
     3. 3
     4. 4
     5. 5
153. Which type of uterine fibroid is subserous twisted on the Fig. 65?
     1. 1
     2. 2
     3. \*2a
     4. 3
     5. 4
154. Which type of uterine fibroid is intramural on the Fig. 65?
     1. \*1
     2. 2
     3. 3
     4. 4
     5. 5
155. Which type of uterine fibroid is intracervical on the Fig. 65?
     1. 1
     2. 2
     3. 3
     4. \*4
     5. 5
156. Which type of uterine fibroid is intraligamentary on the Fig. 65?
     1. 1
     2. 2
     3. 3
     4. 4
     5. \*5
157. Which type of uterine fibroid is protruded on the Fig. 65?
     1. 2
     2. 4
     3. 3
     4. 5
     5. \*6
158. What is the best management of the fibroid on the Fig. 65,2a in reproductive patients?
     1. Uterine curettage
     2. Progesterone injection
     3. \*Conservative myomectomy
     4. Total hysterectomy
     5. Ovarian resection
159. What is the best management of the fibroid on the Fig. 65, 3?
     1. Uterine curettage
     2. Progesterone injection
     3. Conservative myomectomy
     4. \*Hysterectomy
     5. Progesterone injections
160. What is the leading symptom of fibroid which is present on the Fig. 65, 3?
     1. Cramp pain
     2. \*Bleeding
     3. Dizziness
     4. Constipation
     5. Nausea
161. What is the leading complication of fibroid which is present on the Fig. 65, 2a?
     1. Bleeding
     2. Ovarian apoplexy
     3. Rupture of fibroid
     4. \*Torsion of fibroid
     5. Ectopic pregnancy
162. What is the leading complication of fibroid which is present on the Fig. 65, 2a?
     1. Bleeding
     2. Ovarian apoplexy
     3. Rupture of fibroid
     4. Ectopic pregnancy
     5. \*Necrosis of fibroid
163. All of the below methods can reveal fibroid which is present on the Fig. 65, 3 EXCEPT:
     1. Uterine sounding
     2. Hysteroscopy
     3. Ultrasonography
     4. Hysterography
     5. \*Laparoscopy
164. All of the below methods can reveal fibroid which is present on the Fig. 65, 2a EXCEPT:
     1. \*Uterine sounding
     2. Bimanual examination
     3. Ultrasonography
     4. Laparotomy
     5. Laparoscopy
165. All of the below methods can reveal fibroid which is present on the Fig. 65, 3 EXCEPT:
     1. \*Colposcopy
     2. Hysteroscopy
     3. Ultrasonography
     4. Hysterography
     5. Uterine curettage
166. What is the best management of the fibroid on the Fig. 65, 6?
     1. Spasmolytics injection
     2. Progesterone injection
     3. \*Myomectomy and uterine curettage
     4. Hysterectomy
     5. Subtotal hysterectomy
167. Subserouse fibromyoma node in the Fig. 65 localized in:
     1. \*under peritoneum
     2. under uterine mucous layer
     3. in myometrium
     4. behind cervix
     5. between broad ligament layers
168. Submucous myoma node in the Fig. 65 localized:
     1. under peritoneum
     2. \*under uterine mucous layer
     3. in myometrium
     4. behind cervix
     5. between broad ligament layers
169. Intramural myoma node in the Fig. 65 localized:
     1. under peritoneum
     2. under uterine mucous layer
     3. \*in myometrium
     4. behind cervix
     5. between broad ligament layers
170. Interstitial myoma node in the Fig. 65 localized:
     1. under peritoneum
     2. under uterine mucous layer
     3. \*in myometrium
     4. behind cervix
     5. between broad ligament layers
171. Intraligamentary myoma node in the Fig. 65 localized:
     1. under peritoneum
     2. under uterine mucous layer
     3. in myometrium
     4. behind cervix
     5. \*between broad ligament layers
172. Retrocervical myoma node in the Fig. 65 localized:
     1. under peritoneum
     2. under uterine mucous layer
     3. in myometrium
     4. \*behind cervix
     5. between broad ligament layers
173. What is typical for hormonal status of patient with fibromyoma which is presented in the Fig. 65?
     1. high level of chorionic gonadotropin
     2. high level of prgesteron
     3. high level of androgens
     4. high level of pituitary gland hormons
     5. \*high level of estrogens
174. What sign is typical for subserous myoma in the Fig. 65, 2a?
     1. hyperpolymenorrhea
     2. infertility
     3. metrorrhagia
     4. all above
     5. \*symptomless
175. What sign is typical for submucous myoma in the Fig. 65, 3?
     1. \*hyperpolymenorrhea
     2. amenorrhea
     3. foamy vaginal discharge
     4. tumour destruction
     5. symptomless
176. What sign is typical for retrocervical myoma in the Fig. 65, 5?
     1. hyperpolymenorrhea
     2. infertility
     3. foamy vaginal discharge
     4. amenorrhea
     5. \*rectum dysfunction
177. What method should be used for diagnostic subserous myoma in the Fig. 65, 2a?
     1. hysterosalpingography
     2. uterine probing
     3. \*Ultrasonography
     4. curettage of uterine cavity
     5. hysterography
178. What method should be used for diagnostic submucous myoma in the Fig. 65, 3?
     1. laparoscopy
     2. \*hysteroscopy
     3. Doppler assessment
     4. Biopsy
     5. puncture of abdominal cavity through posterior vaginal fornix
179. What method should be used for diagnostic interstitial myoma in the Fig. 65, 1?
     1. hysterosalpingography
     2. uterine probing
     3. \*Ultrasonography
     4. curettage of uterine cavity
     5. hysteroscopy
180. At what form of uterine fibromyoma we have such complication as node twisting in the Fig. 65?
     1. \*subserous
     2. submucous
     3. intraligamentous
     4. interstitial
     5. retrocervical
181. At what form of uterine fibromyoma we have such complication as node protruding in the Fig. 65?
     1. Subserous
     2. \*submucous
     3. intraligamentous
     4. interstitial
     5. retrocervical
182. At what form of uterine fibromyoma we have such complication as inversion of uterus in the Fig. 65?
     1. Subserous
     2. \*submucous
     3. intraligamentous
     4. interstitial
     5. retrocervical
183. What size of uterus in case of fibromyoma in the Fig. 65 is indication for surgical treatment?
     1. as 6 weeks of gestation.
     2. as 8 weeks of gestation
     3. as 10 weeks of gestation
     4. \*as 12 weeks of gestation
     5. as 16 weeks of gestation
184. Which pathology is present on the Fig.27?
     1. Ectopic pregnancy
     2. Ovarian apoplexy
     3. \*Molar pregnancy
     4. Uterine sarcoma
     5. Uterine fibroid
185. What is the best management for pathology which is present on the Fig. 27?
     1. Conservative
     2. Uterine curettage
     3. \*Vacuum suction
     4. Total hysterectomy
     5. Subtotal hysterectomy
186. All of the below are clinical signs for pathology which is present on the Fig.27 EXCEPT:
     1. Uterine enlargement greater than expected for gestational dates
     2. “Snowstorm” appearance on ultrasound
     3. Bilateral theca lutein cysts
     4. Painless spotting
     5. \*Uterine sizes less than expected for gestational dates
187. All of the below are clinical signs for pathology which is present on the Fig.27 EXCEPT:
     1. Uterine enlargement greater than expected for gestational dates
     2. “Snowstorm” appearance on ultrasound
     3. Bilateral theca lutein cysts
     4. Painless spotting
     5. \*Low level of ChGT hormone in urine
188. Which obstetric operation is presented on the Fig. 32?
     1. Craniotomy
     2. Vacuum extraction
     3. Forceps application
     4. Cleidotomy
     5. \*Amniotomy
189. Which method of anesthesia is recommended for operation in the Fig. 32?
     1. Epidural
     2. \*No anesthesia
     3. Pudendal
     4. Intravenous
     5. Intramuscular
190. Which obstetric operation is presented on the Fig. 33?
     1. Craniotomy
     2. Vacuum extraction
     3. \*Forceps application
     4. Cleidotomy
     5. Decapitation
191. Which stage of forceps application is present on the Fig. 33?
     1. Insertion of the left blade
     2. Insertion of the right blade
     3. Locking of the blades
     4. \*Traction
     5. Removal of the blades
192. Which types of forceps are applied on the fetal head on the Fig. 33?
     1. \*Outlet forceps
     2. Low forceps
     3. Mid forceps
     4. High forceps
     5. Medium forceps
193. Which instrument is applied on the fetal head during fetal destroying operation on the Fig. 33?
     1. Retractor
     2. Kranioklast
     3. Hook
     4. Perforator
     5. \*Obstetric forceps
194. Which type of anterior wall incision is present in the Fig.36, 1?
     1. High Vertical
     2. \*Phannenstiel
     3. Stark
     4. Low vertical
     5. Joel-Cohen
195. All of the below are the disadvantages for the Phannenstiel incision in the Fig.36, 1 EXCEPT:
     1. Formation of hematoma
     2. \*Cosmetic effect
     3. Denervation of abdominal wall
     4. Experienced surgeon
     5. More time for entering into the abdominal cavity
196. Which types of stitches are applied into the uterus on the Fig. 36,4?
     1. Interrupted vicryl
     2. Interrupted catgut
     3. \*Continuous vicryl
     4. Interrupted catgut
     5. Continuous silk
197. Which stage of cesarean section is shown on the Fig.36,3?
     1. Incision of abdominal wall
     2. Incision of uterine cavity
     3. \*Delivery of the fetus
     4. Suturing of the peritoneum
     5. Suturing of the abdominal cavity
198. Which obstetric operation is presented on the Fig. 36?
     1. Craniotomy
     2. Vacuum extraction
     3. Forceps application
     4. Cleidotomy
     5. \*Cesarean section
199. Incision of which structure is present in the Fig. 36,2 ?
     1. Abdominal wall
     2. Transverse fascia
     3. Aponeurosis
     4. Peritoneum
     5. \*Muscles
200. Which type of cesarean section is present in the Fig. 36,2?
     1. Classic (corporal)
     2. \*Transverse in the lower uterine segment
     3. Low vertical in the lower uterine segment
     4. High in the fundus
     5. Low in the fundus
201. All of the below are the indications for cesarean section in the Fig. 36 EXEPT:
     1. Brow presentation
     2. \*Vertex presentation
     3. Foot-link presentation
     4. Pregnancy as a result of assisted reproductive technologies
     5. Eclampsia
202. Which obstetric operation is presented on the Fig. 39?
     1. Craniotomy
     2. \*Vacuum extraction
     3. Forceps application
     4. Leucotomy
     5. Perineotomy
203. How do you called the instrument which is present on the fetal head in the Fig. 39?
     1. Retractor
     2. Cusco’ speculum
     3. Sims’ speculum
     4. Perforator
     5. \*Vacuum
204. Which pathology is present on the Fig. 66?
     1. Uterine myoma
     2. \*Complete uterine prolapse
     3. Incomplete uterine prolapse
     4. Uterine sarcoma
     5. Ectopic pregnancy
205. What is the best management for pathology which is present on the Fig. 66?
     1. Conservative
     2. Uterine curettage
     3. Anterior colporraphy
     4. \*Vaginal hysterectomy
     5. Posterior colporraphy
206. Which complication is the most common for pathology which is present on the Fig.66?
     1. Abdominal sharp pain
     2. Profuse bleeding
     3. Constipation
     4. \*Urine incontinence
     5. Dizziness
207. Which complication is the most common for pathology which is present on the Fig.66?
     1. Abdominal sharp pain
     2. Dizziness
     3. Constipation
     4. Profuse bleeding
     5. \*Decubital ulcer
208. Which method of diagnosis is present on the Fig. 67?
     1. Hysteroscopy
     2. \*Culdocentesis
     3. Hysterography
     4. Colposcopy
     5. Laparoscopy
209. Which method of diagnosis is present on the Fig. 36?
     1. Hysteroscopy
     2. Culdocentesis
     3. Hysterography
     4. Colposcopy
     5. \*Laparoscopy
210. Which pathology is present on the Fig. 69?
     1. Cervical ectropion
     2. Cervical erosion
     3. Cervical endometriosis
     4. Submucous myoma
     5. \*Cervical leukoplakia
211. For which pathology is characterized sign which present on the Fig. 27?
     1. Ectopic pregnancy
     2. Ovarian apoplexy
     3. \*Molar pregnancy
     4. Uterine sarcoma
     5. Uterine myoma
212. How do you called the sign which present on the Fig. 27?
     1. \*”Snowstorm” appearance
     2. “Mulberry” appearance
     3. “Apple-like” appearance
     4. “Grape-like” appearance
     5. “Raspberry” appearance
213. Which pathology is present on the Fig. 73?
     1. Cervical ectropion
     2. Cervical dysplasia
     3. Cervical endometriosis
     4. \*Cervical polyp
     5. Cervical erosion
214. What is shown as № 1 in the Fig.74?
     1. \*Normal epithelium
     2. Mild dysplasia
     3. Moderate dysplasia
     4. Severe dysplasia
     5. Cancer in situ
215. What is shown as № 2 in the Fig.74?
     1. Normal epithelium
     2. \*Mild dysplasia
     3. Moderate dysplasia
     4. Severe dysplasia
     5. Cancer in situ
216. What is shown as № 3 in the Fig.74?
     1. Normal epithelium
     2. Mild dysplasia
     3. \*Moderate dysplasia
     4. Severe dysplasia
     5. Cancer in situ
217. What is shown as № 4 in the Fig.74?
     1. Normal epithelium
     2. Mild dysplasia
     3. Moderate dysplasia
     4. \*Severe dysplasia
     5. Cancer in situ
218. What is shown as № 5 in the Fig.74?
     1. Normal epithelium
     2. Mild dysplasia
     3. Moderate dysplasia
     4. Severe dysplasia
     5. \*Cancer in situ
219. Choose mild dysplasia, on which hyperplasia and basal cell atypia occupies 1/3 of epithelium layer on the Fig.74:
     1. 1
     2. \*2
     3. 3
     4. 4
     5. 5
220. Choose moderate dysplasia, on which hyperplasia and basal cell atypia occupies 1/2 of epithelium layer on the Fig.74:
     1. 1
     2. 2
     3. \*3
     4. 4
     5. 5
221. Choose severe dysplasia, on which hyperplasia and basal cell atypia occupies more than 2/3 of epithelium layer on the Fig.74:
     1. 1
     2. 2
     3. 3
     4. \*4
     5. 5
222. Indicate cancer in situ on the Fig.74:
     1. 1
     2. 2
     3. 3
     4. 4
     5. \*5
223. Which pathology is present on the Fig. 75?
     1. Ovarian apoplexy
     2. Ovarian cystoma
     3. \*Torsion of ovarian cystoma
     4. Ectopic pregnancy
     5. Molar pregnancy
224. What is the best management for pathology which is present on the Fig. 75?
     1. Oophorectomy
     2. Ovarian resection
     3. Total hysterectomy
     4. Subtotal hysterectomy
     5. \*Salpingooophorectomy
225. All of the below are the main signs of pathology which is present in the Fig. 75 EXEPT:
     1. Lower abdominal pain
     2. Signs of peritoneal irritation
     3. High temperature
     4. \*Increasing of blood pressure
     5. Vomiting
226. All of the below are the main compounds of surgical pedicle of pathology which is present in the Fig. 75 EXEPT:
     1. Fallopian tube
     2. Mesosalpinx
     3. Mesoovarium
     4. \*Sacrouterine ligament
     5. Ovarian ligament
227. Why the doctor should put the clamp during operation of pathology which is present in the Fig. 75 below surgical pedicle:
     1. \*To prevent thrombembolism
     2. To prevent infection
     3. To prevent shock
     4. To prevent hypertension
     5. To prevent hypotension
228. How do you called the distance 2 which is present on the Fig.8?
     1. Anatomical conjugate
     2. \*Obstetric conjugate
     3. Anteroposterior diameter of the plane of greatest dimension
     4. Anteroposterior diameter of the midpelvis
     5. Anteroposterior diameter of the pelvic outlet
229. How do you called the distance 4 which is present on the Fig.8?
     1. Anatomical conjugate
     2. Obstetric conjugate
     3. \*Diagonal conjugate
     4. Anteroposterior diameter of the midpelvis
     5. Anteroposterior diameter of the pelvic outlet
230. How do you called the distance 3 which is present on the Fig.8?
     1. Anteroposterior diameter of the plane of greatest dimension
     2. Obstetric conjugate
     3. Diagonal conjugate
     4. Anteroposterior diameter of the midpelvis
     5. \*Anteroposterior diameter of the pelvic outlet
231. How much centimeters in normal pelvis doest the distance 2 which is present on the Fig.8 have?
     1. 9cm
     2. 10cm
     3. \*11cm
     4. 12,5 – 13cm
     5. 13, 5- 14cm
232. How much centimeters in normal pelvis doest the distance 4 which is present on the Fig.8 have?
     1. 9cm
     2. 10cm
     3. 11cm
     4. \*12,5 – 13cm
     5. 13, 5- 14cm
233. How much centimeters in normal pelvis doest the distance 3 which is present on the Fig.8 have?
     1. 9cm
     2. 10cm
     3. \*11cm
     4. 12,5cm
     5. 13, 5cm
234. Which structure 1 of the fetal head is present on the Fig.1?
     1. Anterior fontanel
     2. Posterior fontanel
     3. Sagital suture
     4. Frontal suture
     5. \*Lambdoid suture
235. Which structure 2 of the fetal head is present on the Fig.1?
     1. Anterior fontanel
     2. \*Posterior fontanel
     3. Sagital suture
     4. Frontal suture
     5. Lambdoid suture
236. Which structure 3 of the fetal head is present on the Fig. 1?
     1. Anterior fontanel
     2. Posterior fontanel
     3. \*Sagital suture
     4. Frontal suture
     5. Lambdoid suture
237. Which structure 4 of the fetal head is present on the Fig. 1?
     1. Anterior fontanel
     2. \*Coronal suture
     3. Sagital suture
     4. Frontal suture
     5. Lambdoid suture
238. Which structure 5 of the fetal head is present on the Fig.1?
     1. Anterior fontanel
     2. Coronal suture
     3. Sagital suture
     4. \*Frontal suture
     5. Lambdoid suture
239. Which structure 6 of the fetal head is present on the Fig. 1?
     1. \*Anterior fontanel
     2. Coronal suture
     3. Sagital suture
     4. Posterior fontanel
     5. Lambdoid suture
240. Which diameter 7 of the fetal head is present on the Fig. 1?
     1. Bitemporal
     2. Coronar suture
     3. Sagital suture
     4. \*Biparietal
     5. Lambdoid suture
241. Which diameter 8 of the fetal head is present on the Fig. 1?
     1. \*Bitemporal
     2. Coronar suture
     3. Sagital suture
     4. Biparietal
     5. Lambdoid suture
242. How much centimeters doest the diameter 7 which is present on the Fig.1 have?
     1. \*9 - 9,5cm
     2. 10cm
     3. 11cm
     4. 12,5 – 13cm
     5. 13, 5- 14cm
243. How much centimeters doest the diameter 8 which is present on the Fig.1 have?
     1. 9 - 9,5cm
     2. 10cm
     3. 11cm
     4. \*8cm
     5. 13, 5- 14cm
244. How do you called the Vasten sign which is present on the Fig.25,1?
     1. \*Positive
     2. At the same level
     3. Negative
     4. Probable
     5. 0 station
245. How do you called the Vasten sign which is present on the Fig.25,2?
     1. Positive
     2. \*At the same level
     3. Negative
     4. Probable
     5. 0 station
246. How do you called the Vasten sign which is present on the Fig.25,3?
     1. Positive
     2. At the same level
     3. \*Negative
     4. Probable
     5. 0 station
247. Choose the correct diagnosis on the Fig. 7:
     1. Transverse lie, left position, anterior variety
     2. Transverse lie, right position, anterior variety
     3. \*Longitudinal lie, left position, anterior variety
     4. Oblique lie, right position, anterior variety
     5. Oblique lie, left position, anterior variety
248. Choose the correct diagnosis on the Fig. 13, 3:
     1. Transverse lie, left position, anterior variety
     2. Transverse lie, right position, posterior variety
     3. Longitudinal lie, left position, anterior variety
     4. \*Longitudinal lie, right position, posterior variety
     5. Transverse lie, left position, posterior variety
249. Choose the correct diagnosis on the Fig. 13, 4:
     1. Longitudinal lie, left position, anterior variety
     2. Longitudinal lie, right position, anterior variety
     3. \*Longitudinal lie, left position, posterior variety
     4. Longitudinal lie, right position, posterior variety
     5. Transverse lie, left position, posterior variety
250. Choose the correct diagnosis on the Fig. 13, 5:
     1. Longitudinal lie, left position, anterior variety
     2. Longitudinal lie, right position, anterior variety
     3. \*Persistent transverse lie, right position, anterior variety
     4. Longitudinal lie, right position, posterior variety
     5. Transverse lie, left position, posterior variety
251. What can you determine in obstetric examination on the Fig. 13, 1?
     1. \*Face presentation anterior
     2. Face presentation posterior
     3. Sinciput vertex presentation
     4. Brow anterior
     5. Brow posterior
252. What can you determine in obstetric examination on the Fig. 13, 2?
     1. Face presentation anterior
     2. Face presentation posterior
     3. \*Sinciput vertex presentation
     4. Brow anterior
     5. Brow posterior
253. Choose the diagnosis for the best fetal heart rate auscultation on the Fig.14, 1:
     1. \*Longitudinal lie, cephalic presentation, left sided anterior
     2. Longitudinal lie, cephalic presentation, right sided anterior
     3. Longitudinal lie, cephalic presentation, left sided posterior
     4. Longitudinal lie, breech presentation, left sided posterior
     5. Longitudinal lie, breech presentation, left sided anterior
254. Choose the diagnosis for the best fetal heart rate auscultation on the Fig.14, 2:
     1. Longitudinal lie, cephalic presentation, left sided anterior
     2. Longitudinal lie, cephalic presentation, right sided anterior
     3. \*Longitudinal lie, cephalic presentation, left sided posterior
     4. Longitudinal lie, breech presentation, left sided posterior
     5. Longitudinal lie, breech presentation, left sided anterior
255. Choose the diagnosis for the best fetal heart rate auscultation on the Fig.14, 3:
     1. Longitudinal lie, cephalic presentation, left sided anterior
     2. \*Longitudinal lie, cephalic presentation, right sided anterior
     3. Longitudinal lie, cephalic presentation, left sided posterior
     4. Longitudinal lie, breech presentation, left sided posterior
     5. Longitudinal lie, breech presentation, left sided anterior
256. Choose the diagnosis for the best fetal heart rate auscultation on the Fig.14, 4:
     1. \*Longitudinal lie, cephalic presentation, right sided posterior
     2. Longitudinal lie, cephalic presentation, right sided anterior
     3. Longitudinal lie, cephalic presentation, left sided posterior
     4. Longitudinal lie, breech presentation, left sided posterior
     5. Longitudinal lie, breech presentation, right sided anterior
257. Choose the diagnosis for the best fetal heart rate auscultation on the Fig.14, 5:
     1. \*Longitudinal lie, breech presentation, left sided anterior
     2. Longitudinal lie, cephalic presentation, right sided anterior
     3. Longitudinal lie, cephalic presentation, left sided posterior
     4. Longitudinal lie, breech presentation, left sided posterior
     5. Longitudinal lie, breech presentation, right sided anterior
258. Choose the diagnosis for the best fetal heart rate auscultation on the Fig.14, 6:
     1. Longitudinal lie, breech presentation, left sided anterior
     2. Longitudinal lie, cephalic presentation, right sided anterior
     3. Longitudinal lie, cephalic presentation, left sided posterior
     4. \*Longitudinal lie, breech presentation, left sided posterior
     5. Longitudinal lie, breech presentation, right sided anterior
259. Choose the diagnosis for the best fetal heart rate auscultation on the Fig.14, 7:
     1. Longitudinal lie, breech presentation, left sided anterior
     2. Longitudinal lie, cephalic presentation, right sided anterior
     3. Longitudinal lie, cephalic presentation, left sided posterior
     4. Longitudinal lie, breech presentation, left sided posterior
     5. \*Longitudinal lie, breech presentation, right sided anterior
260. Choose the diagnosis for the best fetal heart rate auscultation on the Fig.14, 8:
     1. Longitudinal lie, breech presentation, left sided anterior
     2. \*Longitudinal lie, breech presentation, right sided posterior
     3. Longitudinal lie, cephalic presentation, left sided posterior
     4. Longitudinal lie, breech presentation, left sided posterior
     5. Longitudinal lie, breech presentation, right sided anterior
261. Which structure is present on the Fig. 15, 1?
     1. \*Uterus
     2. Fetus
     3. Amnion
     4. Umbilical cord
     5. Placenta
262. Which structure is present on the Fig. 15, 2?
     1. Uterus
     2. Fetus
     3. Amnion
     4. Umbilical cord
     5. \*Placenta
263. Which structure is present on the Fig. 15, 3?
     1. Uterus
     2. Fetus
     3. Amnion
     4. \*Umbilical cord
     5. Placenta
264. Which structure is present on the Fig. 15, 4?
     1. Uterus
     2. Fetus
     3. \*Amnion
     4. Umbilical cord
     5. Placenta
265. Which structure is present on the Fig. 15, 5?
     1. Uterus
     2. \*Amniotic fluid
     3. Amnion
     4. Umbilical cord
     5. Placenta
266. How do you called the method of checking placenta separation which is present on the Fig. 24?
     1. Abuladse
     2. Henter
     3. Crede-Lazarevich
     4. Snegurov’
     5. \*Chukalov-Kustner’
267. Which moment of biomechanism of labor is shown on the Fig.10?
     1. Flexion of the fetal head
     2. Internal rotation of the fetal head
     3. \*Extension of the fetal head
     4. External rotation of the fetal head and internal rotation of the fetal body
     5. Additional flexion of the fetal head
268. Which moment of biomechanism of labor is shown on the Fig.11?
     1. Flexion of the fetal head
     2. Internal rotation of the fetal head
     3. Extension of the fetal head
     4. \*External rotation of the fetal head and internal rotation of the fetal body
     5. Additional flexion of the fetal head
269. Which perineal protective maneuver is recommended in situation which is present on the Fig.11?
     1. Prevention of the preterm fetal head extension
     2. Increasing of the vaginal opening
     3. Regulation of the pushing efforts
     4. Delivery of the fetal head
     5. \*Delivery of the shoulders
270. In which diameter the true pelvis does the sagittal suture of the fetal fetal head is located in the Fig.10?
     1. Right oblique size of the pelvic inlet
     2. Left oblique size of the pelvic inlet
     3. Anteroposterior diameter of the pelvis inlet
     4. \*Anteroposterior diameter of the pelvis outlet
     5. Transverse diameter of the pelvis inlet
271. Which operation is shown in the Fig. 12?
     1. Cesarean section
     2. \*Manual separation of the placenta
     3. Uterine curretage
     4. Hysteresctomy
     5. Shturmdorf’ operation
272. How many minutes the doctor should wait for starting of the operation which is present in the Fig. 12 in low risk patients in the case of absence of bleeding?
     1. 5 minutes
     2. 10 minutes
     3. 15 minutes
     4. 25 minutes
     5. \*30 minutes
273. How many minutes the doctor should wait for starting of the operation which is present in the Fig. 12 in high risk patients in the case of absence of bleeding?
     1. 5 minutes
     2. 10 minutes
     3. \*15 minutes
     4. 25 minutes
     5. 30 minutes
274. How many minutes the doctor should wait for starting of the operation which is present in the Fig. 12 in low risk patients in the case of bleeding?
     1. 5 minutes
     2. 10 minutes
     3. 15 minutes
     4. 25 minutes
     5. \*starts immediately
275. How many minutes the doctor should wait for starting of the operation which is present in the Fig. 12 in high risk patients in the case of bleeding?
     1. 5 minutes
     2. 10 minutes
     3. 15 minutes
     4. 25 minutes
     5. \*starts immediately
276. Which perineal protective maneuver is present on the Fig.22?
     1. Prevention of the preterm fetal head extension
     2. Increasing of the vaginal opening
     3. Regulation of the pushing efforts
     4. Delivery of the fetal head
     5. \*Delivery of the shoulders
277. Which perineal protective maneuver is present on the Fig.20?
     1. \*Prevention of the preterm fetal head extension
     2. Increasing of the vaginal opening
     3. Regulation of the pushing efforts
     4. Delivery of the fetal head
     5. Delivery of the shoulders
278. Delivery at which presentation is present on the Fig. 10?
     1. \*Vertex presentation
     2. Brow presentation
     3. Face presentation anterior
     4. Sinciput vertex
     5. Face presentation posterior
279. Which perineal protective maneuver is present on the Fig.20?
     1. \*There is no correct answer
     2. Increasing of the vaginal opening
     3. Regulation of the pushing efforts
     4. Delivery of the fetal head
     5. Delivery of the shoulders
280. Which perineal protective maneuver is shown on the Fig.21 and performed by right hand?
     1. Prevention of the preterm fetal head extension
     2. \*Increasing of the vaginal opening
     3. Regulation of the pushing efforts
     4. Delivery of the fetal head
     5. Decreasing of perineal tension
281. Which perineal protective maneuver is shown on the Fig.23 and performed by right hand?
     1. Prevention of the preterm fetal head extension
     2. Increasing of the vaginal opening
     3. Regulation of the pushing efforts
     4. Delivery of the fetal head
     5. \*Decreasing of perineal tension
282. In which type of breech presentation manual care which is present on the Fig. 5 is applied for?
     1. Complete
     2. \*Frank
     3. Complete knee-link
     4. Incomplete foot-link
     5. Complete foot-link
283. What is the importance of manual care which is present on Fig. 5 and applied in breech presentation?
     1. To prevent preterm fetal head extension
     2. \*To support normal fetal attitude
     3. For shoulders’ delivery
     4. For fetal head delivery
     5. For foot delivery
284. Which care is applied for the fetus on the Fig. 5?
     1. \*Tsovianov I
     2. Tsovianov II
     3. Classic manual aid
     4. Breech extraction
     5. Subtotal breech extraction
285. What is the best method for delivery is recommended for the situation which is present on the Fig.16?
     1. \*Cesarean section
     2. Vaginal delivery
     3. Internal podalic version
     4. External version
     5. Manual extraction
286. What is the best method for delivery is recommended for the situation which is present on the Fig.17?
     1. Cesarean section
     2. \*Vaginal delivery
     3. Internal podalic version
     4. External version
     5. Manual extraction
287. What is the fetal shoulders circumference in complete breech presentation in the Fig. 16?
     1. 32cm
     2. 33cm
     3. 34cm
     4. 38cm
     5. \*35cm
288. What is the fetal head circumference in complete breech presentation in the Fig. 16?
     1. \*32cm
     2. 33cm
     3. 34cm
     4. 38cm
     5. 35cm
289. What is the fetal buttocks circumference in complete breech presentation in the Fig. 16?
     1. 32cm
     2. 33cm
     3. \*34cm
     4. 38cm
     5. 35cm
290. What is the fetal buttocks circumference in frank breech presentation in the Fig. 17?
     1. \*32cm
     2. 33cm
     3. 34cm
     4. 38cm
     5. 35cm
291. What is the fetal shoulders circumference in frank breech presentation in the Fig. 17?
     1. 32cm
     2. 33cm
     3. 34cm
     4. \*39cm
     5. 35cm
292. What is the fetal head circumference in frank breech presentation in the Fig. 17?
     1. \*32cm
     2. 33cm
     3. 34cm
     4. 38cm
     5. 35cm
293. What is the fetal buttocks circumference in footling presentation in the Fig. 18?
     1. 32cm
     2. 33cm
     3. 34cm
     4. \*28cm
     5. 35cm
294. What is the fetal shoulders circumference in footling presentation in the Fig. 18?
     1. 32cm
     2. 33cm
     3. \*34cm
     4. 39cm
     5. 35cm
295. What is the fetal head circumference in footling presentation in the Fig. 18?
     1. \*32cm
     2. 33cm
     3. 34cm
     4. 38cm
     5. 35cm
296. What is demonstrated as № 1 in the Fig.19,a?
     1. \*Internal cervical os
     2. Mid cervical os
     3. External cervical os
     4. Contractile ring
     5. Lower uterine segment
297. What is demonstrated as № 2 in the Fig.19,a?
     1. Internal cervical os
     2. Mid cervical os
     3. \*External cervical os
     4. Contractile ring
     5. Lower uterine segment
298. What is demonstrated as № 3 in the Fig.19,a?
     1. Internal cervical os
     2. Mid cervical os
     3. External cervical os
     4. Contractile ring
     5. \*Endocervical chanel
299. What is demonstrated as № 1 in the Fig.19,б?
     1. Internal cervical os
     2. Mid cervical os
     3. External cervical os
     4. \*Contractile ring
     5. Endocervical chanel
300. What is demonstrated as № 1 in the Fig.19,в?
     1. Internal cervical os
     2. Mid cervical os
     3. External cervical os
     4. \*Contractile ring
     5. Endocervical chanel
301. Which level above the symphysis of structure №1station in the Fig.19,г if dilation of the cervix is 1 cm?
     1. \*1 cm
     2. 2 cm
     3. 3 cm
     4. 4 cm
     5. 6 cm
302. Which level above the symphysis of structure №1station in the Fig.19,г if dilation of the cervix is 2 cm?
     1. 1 cm
     2. \*2 cm
     3. 3 cm
     4. 4 cm
     5. 6 cm
303. Which level above the symphysis of structure №1station in the Fig.19,г if dilation of the cervix is 3 cm?
     1. 1 cm
     2. 2 cm
     3. \*3 cm
     4. 4 cm
     5. 6 cm
304. Which level above the symphysis of structure №1station in the Fig.19,г if dilation of the cervix is 4 cm?
     1. 1 cm
     2. 2 cm
     3. \*4 cm
     4. 6 cm
     5. 8 cm
305. Which level above the symphysis of structure №1station in the Fig.19,г if dilation of the cervix is 5 cm?
     1. 1 cm
     2. 2 cm
     3. 4 cm
     4. \*5 cm
     5. 8 cm
306. Which level above the symphysis of structure №1station in the Fig.19,г if dilation of the cervix is 6 cm?
     1. 1 cm
     2. 2 cm
     3. 4 cm
     4. 5 cm
     5. \*6 cm
307. Which level above the symphysis of structure №1station in the Fig.19,г if dilation of the cervix is 8 cm?
     1. 2 cm
     2. 4 cm
     3. 6 cm
     4. \*8 cm
     5. 10 cm
308. Which level above the symphysis of structure №1station in the Fig.19,г if dilation of the cervix is 10 cm?
     1. 2 cm
     2. 4 cm
     3. 6 cm
     4. 8 cm
     5. \*10 cm
309. Which level above the symphysis of structure №1station in the Fig.19,г if dilation of the cervix is 7 cm?
     1. 2 cm
     2. 4 cm
     3. 6 cm
     4. \*7 cm
     5. 10 cm
310. Which level above the symphysis of structure №1station in the Fig.19,г if dilation of the cervix is 9 cm?
     1. 2 cm
     2. 5 cm
     3. 6 cm
     4. 9 cm
     5. 10 cm
311. Which level above the symphysis of structure №1station in the Fig.19,г if dilation of the cervix is one finger?
     1. \*2 cm
     2. 4 cm
     3. 6 cm
     4. 8 cm
     5. 10 cm
312. Which level above the symphysis of structure №1station in the Fig.19,г if dilation of the cervix is two fingers?
     1. 2 cm
     2. \*4 cm
     3. 6 cm
     4. 8 cm
     5. 10 cm
313. Which level above the symphysis of structure №1station in the Fig.19,г if dilation of the cervix is three fingers?
     1. 2 cm
     2. 4 cm
     3. \*6 cm
     4. 8 cm
     5. 10 cm
314. Which level above the symphysis of structure №1station in the Fig.19,г if dilation of the cervix is four fingers?
     1. 2 cm
     2. 4 cm
     3. 6 cm
     4. \*8 cm
     5. 10 cm
315. Which level above the symphysis of structure №1station in the Fig.19,г if dilation of the cervix is five fingers?
     1. 2 cm
     2. 4 cm
     3. 6 cm
     4. 8 cm
     5. \*10 cm
316. How do you called the distance 4 which is present on the Fig.4?
     1. Anteroposterior diameter of the plane of greatest dimension
     2. \*Obstetric conjugate
     3. Diagonal conjugate
     4. Anteroposterior diameter of the midpelvis
     5. Anteroposterior diameter of the pelvic outlet
317. How do you called the distance 5 which is present on the Fig.4?
     1. Anteroposterior diameter of the plane of greatest dimension
     2. Obstetric conjugate
     3. Diagonal conjugate
     4. Right oblique size of the pelvic inlet
     5. \*Left oblique size of the pelvic inlet
318. How do you called the distance 6 which is present on the Fig.4?
     1. Anteroposterior diameter of the plane of greatest dimension
     2. Obstetric conjugate
     3. Diagonal conjugate
     4. \*Right oblique size of the pelvic inlet
     5. Left oblique size of the pelvic inlet
319. How much centimeters in normal pelvis doest the distance 5 which is present on the Fig.4 have?
     1. 9cm
     2. 10cm
     3. 11cm
     4. \*12 – 12,5cm
     5. 13, 5- 14cm
320. How much centimeters in normal pelvis doest the distance 6 which is present on the Fig.4 have?
     1. 9cm
     2. 10cm
     3. 11cm
     4. \*12 – 12, 5cm
     5. 13- 13, 5cm
321. What is the best method for delivery is recommended for the situation which is present on the Fig.18?
     1. \*Cesarean section
     2. Vaginal delivery
     3. Internal podalic version
     4. External version
     5. Manual extraction
322. How do you called the version which is present on the Fig. 49?
     1. Classic manual care
     2. Internal podalic version
     3. \*External cephalic version
     4. Internal cephalic version
     5. Tsovianov version
323. In which term of pregnancy the doctor perform the version which is present on the Fig. 49?
     1. 24 weeks
     2. 26 weeks
     3. 28 weeks
     4. 30 weeks
     5. \*32-36 weeks
324. All of the below are contraindications for version which present on the Fig.49 EXCEPT:
     1. Polyhydramnios
     2. Multiple pregnancy
     3. Placenta previa
     4. Danger of preterm labor
     5. \*Maternal anemia
325. In which diameter of the true pelvis does the sagittal suture of the fetal fetal head is located in the Fig. 15, 1?
     1. \*Right oblique size of the pelvic inlet
     2. Left oblique size of the pelvic inlet
     3. Anteroposterior diameter of the pelvis inlet
     4. Right oblique size of the midpelvis
     5. Transverse diameter of the pelvis inlet
326. In which diameter of the true pelvis does the sagittal suture of the fetal fetal head is located in the Fig. 15, 2?
     1. Right oblique size of the pelvic inlet
     2. \*Left oblique size of the pelvic inlet
     3. Anteroposterior diameter of the pelvis inlet
     4. Right oblique size of the midpelvis
     5. Transverse diameter of the pelvis inlet
327. In which diameter of the true pelvis does the sagittal suture of the fetal fetal head is located in the Fig. 15, 3?
     1. Right oblique size of the pelvic inlet
     2. \*Left oblique size of the pelvic inlet
     3. Anteroposterior diameter of the pelvis inlet
     4. Right oblique size of the midpelvis
     5. Transverse diameter of the pelvis inlet
328. In which diameter of the true pelvis does the sagittal suture of the fetal fetal head is located in the Fig. 15, 4?
     1. \*Right oblique size of the pelvic inlet
     2. Left oblique size of the pelvic inlet
     3. Anteroposterior diameter of the pelvis inlet
     4. Right obligue size of the midpelvis
     5. Transverse diameter of the pelvis inlet
329. How much centimeters in first degree of pelvic contraction doest the distance 2 which is present on the Fig.8 have?
     1. 13-14cm
     2. 12-13cm
     3. 11-12cm
     4. \*10-9cm
     5. 8-7,5cm
330. How much centimeters in second degree of pelvic contraction doest the distance 2 which is present on the Fig.8 have?
     1. 13-14cm
     2. 12-13cm
     3. 11-12cm
     4. 10-9cm
     5. \*8-7, 5cm
331. How much centimeters in third degree of pelvic contraction doest the distance 2 which is present on the Fig.8 have?
     1. 11-12cm
     2. 10-9cm
     3. 8-7, 5cm
     4. \*7- 5, 5
     5. <5, 5
332. How much centimeters in fourth degree of pelvic contraction doest the distance 2 which is present on the Fig.8 have?
     1. 11-12cm
     2. 10-9cm
     3. 8-7, 5cm
     4. 7- 5, 5
     5. \*<5, 5
333. Choose the number of place for the best fetal heart rate auscultation for longitudinal lie, cephalic presentation, left sided anterior on the Fig.6:
     1. \*1
     2. 2
     3. 3
     4. 5
     5. 6
334. Choose the number of place for the best fetal heart rate auscultation for longitudinal lie, cephalic presentation, right sided anterior on the Fig.6:
     1. 1
     2. \*3
     3. 4
     4. 7
     5. 8
335. Choose the number of place for the best fetal heart rate auscultation for longitudinal lie, breech presentation, right sided anterior on the Fig.6:
     1. 1
     2. 3
     3. 4
     4. \*7
     5. 8
336. Choose the number of place for the best fetal heart rate auscultation for longitudinal lie, breech presentation, left sided anterior on the Fig.6:
     1. 1
     2. 2
     3. 3
     4. \*5
     5. 6
337. Choose the number of place for the best fetal heart rate auscultation for longitudinal lie, cephalic presentation, left sided posterior on the Fig.6:
     1. 1
     2. \*2
     3. 3
     4. 5
     5. 6
338. Choose the number of place for the best fetal heart rate auscultation for longitudinal lie, cephalic presentation, right sided posterior on the Fig.6:
     1. 1
     2. 3
     3. \*4
     4. 7
     5. 8
339. Choose the number of place for the best fetal heart rate auscultation for longitudinal lie, breech presentation, right sided posterior on the Fig.6:
     1. 1
     2. 3
     3. 4
     4. 7
     5. \*8
340. Choose the number of place for the best fetal heart rate auscultation for longitudinal lie, breech presentation, left sided posterior on the Fig.6:
     1. 1
     2. 2
     3. 3
     4. 5
     5. \*6
341. How do you called the sign which is present on the Fig. 25?
     1. Piskachek
     2. \*Vasten
     3. Henter
     4. Leopolod
     5. Hehar
342. In all of the below conditions the sign which is present on the Fig. 25,1 is positive EXCEPT:
     1. \*Vertex presentation
     2. Brow presentation
     3. Face presentation anterior
     4. Sinciput vertex and large fetus
     5. Sinciput vertex and pelvic contraction
343. In all of the below conditions the sign which is present on the Fig. 25,3 is negative EXCEPT:
     1. Vertex presentation anterior
     2. \*Brow presentation
     3. Face presentation posterior
     4. Sinciput vertex posterior
     5. Vertex presentation posterior
344. The conjugate 4 which is present on the Fig.8 has 12 cm. To which degree of pelvis contraction does the pelvis belong to?
     1. \*I
     2. II
     3. III
     4. IV
     5. V
345. The conjugate 4which is present on the Fig.8 has 10 cm. To which degree of pelvis contraction does the pelvis belong to?
     1. I
     2. \*II
     3. III
     4. IV
     5. V
346. Which type of breech presentation is present in the Fig. 16?
     1. \*Complete
     2. Frank
     3. Complete knee-link
     4. Incomplete foot-link
     5. Complete foot-link
347. Which type of breech presentation is present in the Fig. 17?
     1. Complete
     2. \*Frank
     3. Complete knee-link
     4. Incomplete foot-link
     5. Complete foot-link
348. Which type of breech presentation is present in the Fig. 18?
     1. Complete
     2. Frank
     3. Complete knee-link
     4. \*Incomplete foot-link
     5. Complete foot-link
349. Which care is applied for the fetus in the Fig. 16?
     1. Tsovianov I
     2. Tsovianov II
     3. \*Classic manual aid
     4. Breech extraction
     5. Subtotal breech extraction
350. What is the management of labor in the situation which is present in the Fig. 18?
     1. Tsovianov I
     2. Tsovianov II
     3. Classic manual aid
     4. \*Cesarean section
     5. Subtotal breech extraction
351. Which care is applied for the fetus on the Fig. 17?
     1. \*Tsovianov I
     2. Tsovianov II
     3. Classic manual aid
     4. Breech extraction
     5. Subtotal breech extraction
352. In which type of breech presentation manual care which is present on the Fig. 5 is applied for?
     1. Complete
     2. \*Frank
     3. Complete knee-link
     4. Incomplete knee-link
     5. Complete foot-link
353. What is the importance of manual care which is present on Fig. 5 and applied in breech presentation?
     1. To prevent preterm delivery of fetal foot
     2. \*To support normal fetal attitude
     3. For shoulders’ delivery
     4. For fetal head delivery
     5. For foot delivery
354. What methods of assessment is presented on the Fig.34?
     1. US
     2. ECG
     3. MRI
     4. there is no correct answer
     5. \*CTG
355. From what term of gestation do we start to use presented method of assessment at Fig.34?
     1. 10 weeks
     2. 15 weeks
     3. \*28 weeks
     4. 35 weeks
     5. 37 weeks
356. Which two curves are presented at Fig.34?
     1. red and black
     2. \*fetus hart rate and uterus activity
     3. fetus hart rate
     4. uterus activity
     5. there is no correct answer
357. What shows us the upper curve at Fig.34?
     1. \*fetus hart rate
     2. uterus activity
     3. there is no correct answer
     4. ECG
     5. MRI
358. What shows us the black curve at Fig.34?
     1. fetus hart rate
     2. \*uterus activity
     3. there is no correct answer
     4. ECG
     5. MRI
359. What is the normal range for fetal hart rate, presented at Fig.34 by red line?
     1. 60-90
     2. \*110-170
     3. 120-160
     4. 100-150
     5. 155-175
360. The presented assessment at Fig.34 is a part of:
     1. \*Biophysical fetus profile
     2. ECG
     3. MRI
     4. Amnioscopy
     5. there is no correct answer
361. What parameters do we assess during procedure shown at Fig.34?
     1. basal rhythm
     2. variability of the fetus hart rate
     3. periodical changes in fetus hart rate
     4. \*all of them
     5. none of them
362. How long do we perform assessment shown at Fig.34?
     1. 10 min
     2. 20 min
     3. 30 min
     4. \*40-60 min
     5. 15-30 min
363. How do we call test of fetus hart rate in response at fetus motions performed during procedure shown at Fig.34?
     1. stress test
     2. \*non-stress test
     3. US
     4. Biophysical fetus profile
     5. MRI
364. Which points can we get for non-stress test during performing assessment presented at Fig.34?
     1. 0, 1
     2. 1, 2
     3. \*0, 1, 2
     4. 2, 3
     5. 8-10
365. What scale do we use during interpretation of results obtained during assessment shown at Fig.34?
     1. Abuladze
     2. \*Fisher
     3. Monro
     4. Levre
     5. Shreder
366. What does it mean if we get from 8 to 10 points during assessment shown at Fig.34?
     1. fetal distress
     2. \*normal condition
     3. satisfactory condition
     4. unreliable condition
     5. there is no correct answer
367. What does it mean if we get 5-7 points during assessment shown at Fig.34?
     1. fetal distress
     2. normal condition
     3. \*satisfactory condition
     4. unreliable condition
     5. there is no correct answer
368. What does it mean if we get up to 4 points during assessment shown at Fig.34?
     1. \*fetal distress
     2. normal condition
     3. satisfactory condition
     4. unreliable condition
     5. there is no correct answer
369. What should we do if we get from 8 to 10 points during assessment shown at Fig.34?
     1. cesarean section
     2. repeat assessment in one week
     3. \*its normal condition
     4. to deliver patient
     5. there is no correct answer
370. What should we do if we get 5-7 points during assessment shown at Fig.34?
     1. cesarean section
     2. \*to repeat assessment in one week
     3. its normal condition
     4. to deliver patient
     5. there is no correct answer
371. What should we do if we get up to 4 points during assessment shown at Fig.34?
     1. \*cesarean section
     2. repeat assessment in one week
     3. its normal condition
     4. to deliver patient
     5. there is no correct answer
372. What condition is shown at Fig.46?
     1. \*patient after convulsion with eclampsia
     2. hypertonic disease
     3. neurological condition
     4. preeclampsia
     5. there is no correct answer
373. What is seen at the patient’s tongue at Fig.46?
     1. \*tongue has been bitten
     2. edema
     3. laceration
     4. ulcer
     5. there is no correct answer
374. What stages has the condition presented at Fig.46?
     1. \*first, second, third and eclampsia
     2. first and second
     3. 5
     4. 6
     5. 1
375. What main features do we assess in patient with condition shown at Fig.46?
     1. \*BP, proteinuria, oedema
     2. blood test and urine test
     3. blood test
     4. urine test
     5. there is no correct answer
376. What is the BP upper level for the first stage of condition shown at Fig.46?
     1. 120/80
     2. 130/90
     3. 140/100
     4. \*160/100
     5. 170/110
377. What is the BP upper level for the second stage of condition shown at Fig.46?
     1. 120/80
     2. 130/90
     3. 140/100
     4. 150/90
     5. \*170/110
378. What is the BP upper level for the third stage of condition shown at Fig.46?
     1. 120/80
     2. 130/90
     3. 140/100
     4. 150/90
     5. \*there is no correct answer
379. What is the additional sign for the last stage of condition shown at Fig.46?
     1. hematuria
     2. leucouria
     3. unconscious
     4. \*convulsion
     5. there is no correct answer
380. How many MgSo4 will you give to the patient with condition shown at Fig.46 in bolus method firstly?
     1. 10 g
     2. 7 g
     3. 1 g
     4. \*4 g
     5. 20 g
381. The first help when convulsions have started in patient with condition shown at Fig.46 is:
     1. to give the patient anticonvulsive drugs
     2. \*to place the patient on to the smooth surface
     3. to fix the patient mandible
     4. to start magnesium therapy
     5. there is no correct answer
382. What is shown at Fig.47.1?
     1. \*checking BP
     2. weighting the patient
     3. testing the urine
     4. checking the presence of oedema
     5. there is no correct answer
383. What is shown at Fig.47.2?
     1. checking BP
     2. \*weighting the patient
     3. testing the urine
     4. checking the presence of oedema
     5. there is no correct answer
384. What is shown at Fig.47.3?
     1. checking BP
     2. weighting the patient
     3. \*testing the urine
     4. checking the presence of edema
     5. there is no correct answer
385. What is shown at Fig.47.4?
     1. checking BP
     2. weighting the patient
     3. testing the urine
     4. checking the presence of edema
     5. \*there is no correct answer
386. What is shown at Fig.47.5?
     1. checking BP
     2. weighting the patient
     3. testing the urine
     4. \*checking the presence of edema
     5. there is no correct answer
387. What is shown at Fig.47.6?
     1. checking BP
     2. weighting the patient
     3. testing the urine
     4. checking the presence of edema
     5. \*there is no correct answer
388. What pathologic condition is shown at Fig. 47 (1-6)?
     1. preeclampsia
     2. eclampsia
     3. \*preeclampsia and eclampsia
     4. Hypertonic disease
     5. there is no correct answer
389. What period of pregnancy is condition shown at Fig.46 common for?
     1. there is no correct answer
     2. first trimester
     3. second trimester
     4. \*last trimester
     5. first part of pregnancy
390. Name the stages of condition shown at Fig.47.6
     1. first
     2. second
     3. third
     4. eclapsia
     5. there is no correct answer
391. What is the BP upper level for the first stage of condition shown at Fig.47?
     1. 120/80
     2. 130/90
     3. 140/100
     4. \*150/90
     5. 170/110
392. What is the BP upper level for the second stage of condition shown at Fig.47?
     1. 120/80
     2. 130/90
     3. 140/100
     4. 150/90
     5. \*170/110
393. What is the BP upper level for the third stage of condition shown at Fig.47?
     1. 120/80
     2. 130/90
     3. 140/100
     4. 150/90
     5. \*over 170/110
394. What is the proteinuria upper level for the first stage of condition shown at Fig.47?
     1. 0,5 g
     2. \*1 g
     3. 2 g
     4. 3 g
     5. 4 g
395. What is the proteinuria upper level for the second stage of condition shown at Fig.47?
     1. 0,5 g
     2. 1 g
     3. 2 g
     4. \*3 g
     5. 4 g
396. What is the proteinuria level for the third stage of condition shown at Fig.47?
     1. 0,5 g
     2. 1 g
     3. 2 g
     4. 3 g
     5. \*over 3 g
397. At the second stage of condition shown at Fig. 47 BP should be taken:
     1. \*3 times during the first day after admission and then – twice a day
     2. 3 times per day
     3. each 6 hours
     4. each 4 hours
     5. there is no correct answer
398. At the second stage of condition shown at Fig. 47 auscultation of the fetus hart rate should be taken:
     1. \*each 8 hours
     2. each 6 hours
     3. each 4 hours
     4. there is no correct answer
     5. each hour
399. At the second stage of condition shown at Fig. 47 urine test should be taken:
     1. each hour
     2. \*each day
     3. twice a day
     4. each week
     5. each month
400. At the second stage of condition shown at Fig. 47 24-hour proteinuria should be taken;
     1. each hour
     2. \*each day
     3. twice a day
     4. each week
     5. each month
401. At the second stage of condition shown at Fig. 47 blood test should be taken:
     1. \*one time per 3 days
     2. twice a day
     3. each week
     4. each month
     5. each hour
402. What methods of assessment is presented on the Fig.35?
     1. US
     2. ECG
     3. MRI
     4. there is no correct answer
     5. \*CTG
403. From what term of gestation do we start to use presented method of assessment at Fig. 35?
     1. 10 weeks
     2. 15 weeks
     3. 28 weeks
     4. 35 weeks
     5. 37 weeks
404. Which two curves are presented at Fig. 35?
     1. red and black
     2. \*fetus hart rate and uterus activity
     3. fetus hart rate
     4. uterus activity
     5. there is no correct answer
405. What shows us the red curve at Fig. 35?
     1. \*fetus hart rate
     2. uterus activity
     3. there is no correct answer
     4. ECG
     5. MRI
406. What shows us the black curve at Fig. 35?
     1. fetus hart rate
     2. \*uterus activity
     3. there is no correct answer
     4. ECG
     5. MRI
407. What is the normal range for fetal hart rate, presented at Fig. 35by red line?
     1. 60-90
     2. \*110-170
     3. 120-160
     4. 100-150
     5. 155-175
408. The presented assessment at Fig. 35is a part of:
     1. \*Biophysical fetus profile
     2. ECG
     3. MRI
     4. Amnioscopy
     5. there is no correct answer
409. What parameters do we assess during procedure shown at Fig. 35?
     1. basal rhythm
     2. variability of the fetus hart rate
     3. periodical changes in fetus hart rate
     4. \*all of them
     5. none of them
410. How long do we perform assessment shown at Fig. 35?
     1. 10 min
     2. 20 min
     3. 30 min
     4. \*40-60 min
     5. 15-30 min
411. How do we call test of fetus hart rate in response at fetus motions performed during procedure shown at Fig. 35?
     1. stress test
     2. \*non-stress test
     3. US
     4. Biophysical fetus profile
     5. MRI
412. Which points can we get for non-stress test during performing assessment presented at Fig. 35?
     1. 0, 1
     2. 1, 2
     3. \*0, 1, 2
     4. 2, 3
     5. 8-10
413. What scale do we use during interpretation of results obtained during assessment shown at Fig. 35?
     1. Abuladze
     2. \*Fisher
     3. Monro
     4. Levre
     5. Shreder
414. What does it mean if we get from 8 to 10 points during assessment shown at Fig. 35?
     1. fetal distress
     2. \*normal condition
     3. satisfactory condition
     4. unreliable condition
     5. there is no correct answer
415. What does it mean if we get 5-7 points during assessment shown at Fig. 35?
     1. fetal distress
     2. normal condition
     3. \*satisfactory condition
     4. unreliable condition
     5. there is no correct answer
416. What does it mean if we get up to 4 points during assessment shown at Fig. 35?
     1. \*fetal distress
     2. normal condition
     3. satisfactory condition
     4. unreliable condition
     5. there is no correct answer
417. What should we do if we get from 8 to 10 points during assessment shown at Fig. 35?
     1. cesarean section
     2. repeat assessment in one week
     3. \*its normal condition
     4. to deliver patient
     5. there is no correct answer
418. What should we do if we get 5-7 points during assessment shown at Fig. 35?
     1. cesarean section
     2. \*to repeat assessment in one week
     3. its normal condition
     4. to deliver patient
     5. there is no correct answer
419. What should we do if we get up to 4 points during assessment shown at Fig. 35?
     1. \*cesarean section
     2. repeat assessment in one week
     3. its normal condition
     4. to deliver patient
     5. there is no correct answer
420. Complication of what stage of the delivery can be the situation in the Fig. 48?
     1. 1 stage
     2. 2 stage
     3. \*3 stage
     4. 4 stage
     5. non of the above
421. What is the main etiology factor of uterine inversion in Fig. 48?
     1. Uterus hypotony
     2. \*Uterus atony
     3. Uterus hypertony
     4. Excessive uterus activity
     5. all of the above
422. What action of the doctor may lead to the situation in Fig. 48?
     1. Vacuum exraction
     2. Forceps applying
     3. \*Pulling on the umbilical cord before placental separation
     4. Pulling the umbilical cord after placental separation
     5. All of the above
423. Treatment of the situation on the Fig.48 includes:
     1. Antishock measures
     2. General anastesia
     3. Uterus reposition
     4. Antibiotics
     5. \*All of the above
424. What degree of perineum rupture in Fig.30?
     1. 1st degree
     2. \*2 degree
     3. 3 degree
     4. 3 degree incomplete
     5. 3 degree complete
425. What degree of perineum rupture in Fig.31?
     1. 1st degree
     2. 2 degree
     3. 3 degree
     4. 3 degree incomplete
     5. \*3 degree complete
426. Perineum rupture in the fig 30 includes:
     1. over tension tissues and perineum fissures
     2. \*damage of perineum skin and muscles
     3. laceration of commissural posterior, a small area of skin, vaginal mucous
     4. the rupture of perineum muscles and sphincter any
     5. all above
427. Perineum rupture in the fig 31 includes:
     1. over tension tissues and perineum fissures
     2. damage of perineum skin and muscles
     3. laceration of commissural posterior, a small area of skin, vaginal mucous
     4. \*the rupture of perineum muscles and sphincter any
     5. all above
428. Third degree of complete perineum rupture in Fig. 31 means injuries of:
     1. Perineum muscles
     2. Coinsurer posterior, a small area of skin, vaginal mucous
     3. \*Perineum muscles, external sphincter and rectal mucous
     4. Perineum muscles and sphincter any
     5. Non of the above
429. Perineum ruptures in Fig. 30 are repaired:
     1. \*Firstly perineum muscles and vaginal mucous with catgut, after the skin with silk or lavsan
     2. Firstly commissural posterior, skin, vaginal mucous
     3. Firstly skin, perineum muscles, vaginal mucus
     4. Firstly vaginal mucous is sutured, starting from the upper corner, then on the skin silk or lavsan sutures
     5. All answers are correct
430. How is sutured the perineum rupture in Fig. 31?
     1. Firstly muscles and mucous of vagina, after sphincter any
     2. Firstly commissural posterior, skin, vaginal mucous then sphincter any
     3. \*Firstly mucous of rectal then sphincter any, perineum muscles, vagina mucous with catgut, after skin with lavsan or silk sutures
     4. Firstly vaginal mucous with catgut suture, starting from the upper corner, then on the skin lavsan or silk sutures
     5. Firstly vaginal mucous, mucous of sphincter any then perinea muscles with catgut, then the skin with lavsan or silk sutures
431. What is shown in the Fig.30?
     1. \*Perineum rupture 2 stage
     2. Perineum rupture 1 stage
     3. Comlete perineum rupture
     4. Incomlete perineum rupture
     5. Perineum rupture 3 stage
432. What is shown in the Fig.31?
     1. Perineum rupture 2 stage
     2. Perineum rupture 1 stage
     3. \*Comlete perineum rupture 3 stage
     4. Incomlete perineum rupture 3 stage
     5. Perineum rupture 3 stage
433. What is shown in the Fig.48?
     1. Uterus prolaps 1 stage
     2. Uterus prolaps 2 stage
     3. Uterus prolaps 3 stage
     4. \*Uterus inversion
     5. Complete perineum rupture 3 stage
434. What is shown in the Fig.12?
     1. Manual exploration of the uterus cavity
     2. \*Manual separation of the placenta
     3. Delivery of the placenta
     4. Abuladze method
     5. Krede-Lazerevich method
435. During what stage of labor the operation shown in the Fig.12 is performed?
     1. 1 stage
     2. 2 stage
     3. \*3 stage
     4. Early postpartum period
     5. Late postpartum period
436. What are the indications for performing the operation shown in the Fig.12?
     1. \*Blood lost more than 300 ml and absence of placenta separation signs
     2. Absence of placenta separation signs
     3. Blood lost more than 200 ml
     4. Blood lost more than 250 ml
     5. Blood lost less than 300ml
437. What are the indications for performing the operation shown in the Fig.12?
     1. Blood lost more than 300 ml and presence of placenta separation signs
     2. \*Absence of placenta separation signs and blood lost more than 300 ml
     3. Blood lost more than 200 ml and absence of placenta separation signs
     4. Blood lost more than 250 ml and absence of placenta separation signs
     5. Blood lost less than 300ml and presence of placenta separation signs
438. What are the indications for performing the operation shown in the Fig.12?
     1. Forceps delivery
     2. Absence of placenta separation signs and blood lost more than 300 ml
     3. Absence of placenta separation signs more than 30 min
     4. After fetal destroying operation
     5. \*All are correct
439. What are the contraindications for performing the operation shown in the Fig.12?
     1. Forceps delivery
     2. Absence of placenta separation signs and blood lost more than 300 ml
     3. Absence of placenta separation signs more than 30 min
     4. After fetal destroying operation
     5. \*Nothing above
440. What are the contraindications for performing the operation shown in the Fig.12?
     1. Forceps delivery
     2. Absence of placenta separation signs and blood lost more than 300 ml
     3. After fetal destroying operation
     4. \*Blood lost less than 300ml and presence of placenta separation signs
     5. Absence of placenta separation signs more than 30 min
441. Which instrument is present on the Fig.85, 2?
     1. Tenaculum
     2. Sim’s speculum
     3. \*Uterine sound
     4. Retractor
     5. Bivalve Cusko’ speculum
442. Which instruments are on the Fig.26, 3?
     1. Sim’s speculum
     2. Retractor
     3. \*Uterine curettes
     4. Tenaculums
     5. Hehar’ dilator
443. Which pathology is present on the Fig.27?
     1. Choriocarcinoma
     2. \*Hydatidiform mole
     3. Endometrial adhesions
     4. Uterine sarcoma
     5. Uterine fibroid
444. What is the treatment of pathology which is present on the Fig. 27?
     1. Cutting of adhesions
     2. Uterine curettage
     3. \*Removal of intrauterine contents
     4. Total hysterectomy
     5. Subtotal hysterectomy
445. All of the below are clinical signs for pathology which is present on the Fig.27 EXCEPT:
     1. Uterine enlargement greater than expected for gestational dates
     2. “Snowstorm” appearance on ultrasound
     3. Bilateral theca lutein cysts
     4. Painless spotting
     5. \*Acute sharp pain in lower abdomen
446. All of the below are clinical signs for pathology which is present on the Fig.27 EXCEPT:
     1. Uterine enlargement greater than expected for gestational dates
     2. “Snowstorm” appearance on ultrasound
     3. Bilateral theca lutein cysts
     4. Painless spotting
     5. \*Unilateral ovarian cyst
447. Which pathology is present on the Fig. 28?
     1. Cervical incompetence
     2. Choriocarcinoma
     3. Vaginal wall prolapse
     4. \*Complete uterine prolapse
     5. Cervical pregnancy
448. What is the treatment for pathology which is present on the Fig. 28?
     1. Cervical cerclage
     2. Uterine curettage
     3. Anterior colporraphy
     4. \*Vaginal hysterectomy
     5. Posterior colporraphy
449. All of the below are complication for pathology which is present on the Fig.28 EXCEPT:
     1. Cystitis
     2. Urine incontinence
     3. Bacteriuria
     4. \*Anemia
     5. Trophic ulcer
450. All of the below are complication for pathology which is present on the Fig.28 EXCEPT:
     1. \*Abdominal sharp pain
     2. Urine incontinence
     3. Bacteriuria
     4. Cystitis
     5. Trophic ulcer
451. Which pathology is on the Fig. 29?
     1. Choriocarcinoma
     2. Parovarian cyst
     3. Incomplete uterine prolapse
     4. Ovarian dermoid cyst
     5. \*Polycystic ovarian disease
452. What is the treatment for pathology which is present on the Fig. 29?
     1. Unilateral oophorectomy
     2. \*Wedge-shape ovarian resection
     3. Total hysterectomy
     4. Subtotal hysterectomy
     5. Salpingooophorectomy
453. All of the below are clinical signs for pathology which is present on the Fig.29 EXCEPT:
     1. Infertility
     2. Obesity
     3. Hypomenstrual syndrome
     4. Hairriness
     5. \*Anemia
454. All of the below are clinical signs for pathology which is present on the Fig.29 EXCEPT:
     1. Infertility
     2. \*Algodysmenorrhea
     3. Amenorrhea
     4. Hairriness
     5. Obesity
455. Which method of diagnosis is shown for revealing pathology which is present on the Fig. 30?
     1. Colpomicroscopy
     2. Hysteroscopy
     3. Culdoscopy
     4. \*Simply colposcopy
     5. Laparoscopy
456. Which method of diagnosis is using for revealing pathology which is present on the Fig. 31?
     1. Ultrasound
     2. Colposcopy
     3. Culdoscopy
     4. \*Hysteroscopy
     5. Colpomicroscopy
457. Which pathology is present on the Fig. 31?
     1. Intramural fibroid
     2. \*Submucous fibroid
     3. Cervical endometriosis
     4. Cervical erosion
     5. Subserous fibroid
458. Which instrumental method of examination is present on the Fig. 32?
     1. Hysteroscopy
     2. \*Puncture of abdominal cavity
     3. Hysterography
     4. Hysterosalpingography
     5. Laparoscopy
459. Which pathology can be diagnosed by method using on the Fig. 33?
     1. Uterus fibroid
     2. Hematoureters
     3. \*Ectopic pregnancy
     4. Hematocolpos
     5. All above
460. For which diseases method of diagnosis which is present on the Fig.34 is recommended?
     1. Subserous myoma
     2. Ovarian apoplexy
     3. \*Uterus polips
     4. Tubal occlusion
     5. Ectopic pregnancy
461. Which possible causes of pathology which is shown on the Fig. 23?
     1. Chromosome problems
     2. Drug and alcohol abuse
     3. Exposure to environmental toxins
     4. Hormone problems
     5. \*All of the above
462. Which possible causes of pathology which is shown on the Fig. 23?
     1. Obesity
     2. Physical problems with the mother's reproductive organs
     3. Problem with the body's immune response
     4. Serious systemic diseases in the mother
     5. \*All of the above
463. Which possible symptoms of pathology which is shown on the Fig. 23?
     1. Low back pain or abdominal pain that is dull, sharp, or cramping
     2. Tissue or clot-like material that passes from the vagina
     3. Vaginal bleeding, with or without abdominal
     4. All of the above
     5. None of the above
464. Which tests have to be done for a woman with pathology which is shown on the Fig. 27?
     1. A pelvic examination
     2. ultrasound
     3. HCG blood test
     4. Chest x-ray
     5. \*All of the above
465. Which recommendations have to be done for a woman after treatment pathology which is shown on the Fig. 27?
     1. serum HCG levels will be followed
     2. avoid pregnancy for 6 - 12 months
     3. use a reliable contraceptive for 6 - 12 months
     4. \*All of the above
     5. None of the above
466. Which stage of Uterine prolapse is shown on the Fig. 28?
     1. Stage 0
     2. StageI
     3. StageII
     4. StageIII
     5. \*StageIV
467. Which possible causes of pathology which is shown on the Fig. 28?
     1. Pregnancy and childbirth
     2. The physical trauma of labor
     3. Aging and menopause
     4. Obesity
     5. \*All of the above
468. What is the main cause of pathology which is shown on the Fig. 28?
     1. \*Pregnancy and childbirth
     2. Chronic coughing
     3. Chronic constipation
     4. Chronic straining
     5. None of the above
469. The risk of pathology which is shown on the Fig. 28 with age:
     1. \*Increases
     2. Decreases
     3. Stay the same
     4. Depends on woman
     5. None of the above
470. Prevention program of pathology which is shown on the Fig. 28 has to include:
     1. good antenatal care in pregnancy
     2. proper management and timely intervention during delivery
     3. good postnatal care with proper rest
     4. correct diet and appropriate exercise so as to strengthen the pelvic musculature
     5. \*All of the above.
471. Prevention program of pathology which is shown on the Fig. 28 has to include everything, except:
     1. good antenatal care in pregnancy
     2. \*repeated deliveries and stressful manual work
     3. good postnatal care with proper rest
     4. correct diet and appropriate exercise so as to strengthen the pelvic musculature
     5. proper management and timely intervention during delivery.
472. Which possible symptoms of pathology which is shown on the Fig. 47?
     1. Menorrhagia
     2. Abnormal vaginal bleeding
     3. Leukorrhea
     4. Polyps may not cause symptoms.
     5. \*All of the above
473. Which possible causes of pathology which is shown on the Fig. 47?
     1. An abnormal response to increased levels of estrogen
     2. Chronic inflammation
     3. Clogged blood vessels in the cervix
     4. \*All of the above
     5. None of the above
474. What is the best management for pathology which is shown on the Fig. 47?
     1. \*Polypectomy
     2. Total hysterectomy
     3. Subtotal hysterectomy
     4. Radical hysterectomy
     5. None of the above
475. With which pathology is it necessary to differentiate the pathology which is shown on the Fig. 47?
     1. Cancerous growths
     2. Cervical warts
     3. Endometrial polyps
     4. Myomas
     5. \*All of the above
476. Which stage of cervical cancer is shown on the Fig. 48, 5?
     1. \*Stage 0
     2. StageI
     3. StageII
     4. StageIII
     5. StageIV
477. What is the best management for pathology which is shown on the Fig. 48, 5?
     1. Radiation therapy
     2. Chemotherapy
     3. radical hysterectomy
     4. \*cold knife cone biopsy
     5. None of the above
478. Which management for pathology which is shown on the Fig. 48, 5?
     1. cold knife cone biopsy
     2. cryosurgery
     3. cauterization or diathermy
     4. laser surgery
     5. \*All of the above
479. Which management for pathology which is shown on the Fig. 48, 5, EXCEPT?
     1. cold knife cone biopsy
     2. cryosurgery
     3. cauterization or diathermy
     4. laser surgery
     5. \*Chemotherapy
480. What is the main cause of pathology which is shown on the Fig. 48, 5?
     1. Pregnancy
     2. \*Infection with the common human papillomavirus (HPV)
     3. Childbirth
     4. Obesity
     5. None of the above