

Disorders of the menstrual cycle

1 NICE guidelines would recommend the best treatment of a forty-year-old woman with regular, heavy periods who smokes 20 cigarettes a day, has a BMI of 40 and has a normal-size, anteverted uterus on ultrasound scan and who is sexually active.

- a) TAH.
- b) TAH/BSO.
- c) TCRE.
- d) Combined oral contraceptive pill.
- e) Mirena.

Genital infections in gynaecology

2 A patient presents with vulval itching, sore vagina and a profuse, white, curdy discharge with erythema and redness at the introitus. The likely diagnosis is:

- a) Bacterial vaginosis.
- b) Trichomonas vaginalis.
- c) Candida.
- d) Chlamydia.
- e) HPV.

Fertility control, contraception and abortion

3 Choose from below the single best contraceptive method for a forty five-year-old woman with a BMI of 40, smoker with multiple fibroids, who is in a stable relationship, whose family is complete and who has had a peritonitis secondary to appendicitis in the past.

- a) Combined oral contraceptive pill.
- b) Laparoscopic clip sterilization.
- c) Mirena.
- d) Progesterone-only pill.
- e) Hysteroscopic sterilization.

Subfertility

4 The hormone best used as a measurement of ovarian reserve is:

- a) FSH.
- b) Oestradiol.
- c) LH.
- d) Inhibin.
- e) AMH.

Problems in early pregnancy

5 A nineteen year-old-girl is admitted with pelvic pain, a positive pregnancy test and a 3 cm viable ectopic pregnancy seen in the right fallopian tube on ultrasound. She has already had a left salpingectomy for a previous ectopic. The best management would be:

- a) Laparoscopic salpingectomy.

- b) Laparoscopic salpingostomy.
- c) Conservative management with serial $\beta\beta$ HCGs.
- d) Laparotomy.
- e) Methotrexate.

Benign diseases of the uterus and cervix

6 A twenty five-year-old girl presents with mid-cycle pain on a regular monthly basis. She is sexually active and does not take any contraception. The pain quickly resolves after 24 hours. She has a regular 28-day cycle. The likely cause of the pain is:

- a) PID.
- b) Endometriosis.
- c) Mittelschmerz syndrome.
- d) Adenomyosis.
- e) Polycystic ovaries.

Endometriosis and adenomyosis

7 The most suitable treatment for a thirty four-year-old woman with minimal endometriosis on laparoscopy, who has been trying to conceive for two years and has pelvic pain, is:

- a) Laser ablation to endometriosis/excision of the endometriosis.
- b) GnRH analogues.
- c) Danazol.
- d) Progesterone.
- e) Combined oral contraceptive pill.

Diseases of the ovary

8 A seventeen-year-old girl who is not sexually active presents with left iliac fossa pain. An ultrasound scan shows a 5 cm cyst on the left ovary which is complex in nature, with solid, calcified elements and fatty deposits noted on MRI. The likely diagnosis is:

- a) Thecal luteal cyst.
- b) Tubo-ovarian abscess.
- c) Serous cystadenoma.
- d) Fibroma.
- e) Dermoid cyst.

Malignant disease of the uterus

9 The most appropriate treatment option for an eighty-year-old woman with a BMI of 25 presenting with post- menopausal bleeding and found to have Stage 1a endometrial adenocarcinoma on MRI and hysteroscopy is:

- a) Polypectomy and Mirena.
- b) TAH/BSO in a local centre.
- c) TAH/BSO in a cancer centre.
- d) TAH/BSO and radiotherapy.
- e) Radiotherapy alone.

Pre-malignant and malignant disease of the cervix

10 Management of a cervical smear showing moderate dyskaryosis is:

- a) Repeat smear in six months.
- b) HPV vaccination.
- c) Colposcopy and biopsy.
- d) LLETZ procedure.
- e) Wertheim's hysterectomy.

Urogynaecology

11 The management of a thirty eight-year-old woman whose family is complete, with a BMI of 30 and who has urodynamically proven stress incontinence and a 4/5 score on the Oxford Grading Scale, would be:

- a) Pelvic floor exercises.
- b) Bladder neck injections.
- c) Anterior repair.
- d) Colposuspension.
- e) TVT.

Pelvic organ prolapse

12 Management of an eighty nine-year-old woman with ischaemic heart disease who is not sexually active but presents with a procidentia of the uterus is:

- a) Shelf pessary.
- b) Pelvic floor exercises.
- c) Vaginal hysterectomy.
- d) Hysteroscopy.
- e) Total vaginal mesh procedure.

Common gynaecological procedures

13 The procedure most suitable for the investigation of pelvic pain is:

- a) Cystoscopy.
- b) Hysteroscopy.
- c) Hysterosalpingogram.
- d) Laparoscopy.
- e) Hysterectomy.

SBA answers

1 E

As this woman is sexually active and has a raised BMI and has not explored medical management, initially medical management would be advised before embarking on surgery such as a hysterectomy or endometrial resection or ablation. The combined oral contraceptive pill is a recognized medical management for menorrhagia but would be contraindicated in this woman as she has a raised BMI and is a smoker. As she has a normal-size cavity within the uterus, a Mirena would be the best choice. NICE guidelines would recommend

Mirena in the initial management of menorrhagia and as the woman is under the age of forty five and has regular periods, she would not need endometrial sampling before trying the Mirena. See Chapter 5, Gynaecology by Ten Teachers, 19th edition.

2 C

Bacterial vaginosis has a fishy, malodorous vaginal discharge and a creamy or greyish/white discharge without any itching or pain. Chlamydia is usually asymptomatic but may present with post-coital bleeding or a mild, mucopurulent cervical discharge. Trichomonas vaginalis presents with vulval sores.

“““““ a foul-smelling vaginal discharge which is often frothy and yellowy/green. HPV presents with genital warts.

See Chapter 6, Gynaecology by Ten Teachers, 19th edition.

3 D

The combined oral contraceptive pill would be contraindicated if the woman has a BMI of 40. A Mirena is unlikely to fit within the uterine cavity as this woman has multiple fibroids. Sterilization is less attractive as she has had a previous laparotomy. The progesterone-only pill is as effective as the oral contraceptive pill in women over the age of forty. Hysteroscopic sterilization would be difficult in view of the multiple fibroids.

See Chapter 7, Gynaecology by Ten Teachers, 19th edition.

4 E

Anti-Mullerian hormone (AMH) levels can be measured in blood and are shown to be proportional to the number of small antral follicles. Serum AMH levels decrease with age and are undetectable in the post-menopausal period. AMH levels represent the quantity of the ovarian follicle pool and are a useful marker of ovarian reserve.

See Chapter 8, Gynaecology by Ten Teachers, 19th edition.

5 B

RCOG guidelines recommend laparoscopic salpingostomy in patients who have had a previous salpingectomy. This would at least retain some chance of subsequent fertility without the need for IVF. Conservative management and methotrexate are contraindicated as the pregnancy is too large and is viable on ultrasound scan. Laparotomy may be necessary but usually this can be treated with a laparoscopic approach.

See Chapter 9, Gynaecology by Ten Teachers, 19th edition.

6 C

As the pain is regular and occurs mid-cycle, this is most likely due to ovulation rather than endometriosis, which causes pre-menstrual pain and dyspareunia. Adenomyosis causes dysmenorrhoea. Polycystic ovary syndrome does not cause pelvic pain.

See Chapter 10, Gynaecology by Ten Teachers, 19th edition.

7 A

It has been recognized that subsequent fertility rates increase in patients with minimal endometriosis if this is excised or ablated using laser laparoscopy. The combined pill and GnRH analogues and danazol would

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all inhibit ovulation and therefore preclude the chances of pregnancy. Progesterone has not been shown to improve subsequent pregnancy rates.

See Chapter 11, Gynaecology by Ten Teachers, 19th edition.

8 E

Thecal luteal cysts are often complex in nature and have blood clots noted but no solid elements. The fibromas are solid elements but no calcified deposits. Tubo-ovarian abscesses usually have a mucopurulent complex nature. The fact that this cyst has calcified elements and fatty deposits on MRI is pathognomonic of a dermoid cyst.

See Chapter 12, Gynaecology by Ten Teachers, 19th edition.

9 B

If the adenocarcinoma is confined to the uterus and does not extend beyond 50 per cent of the myometrium, it is appropriate just to have a total abdominal hysterectomy and bilateral salpingo-oophorectomy with no subsequent radiotherapy. This can be performed in a local centre under current guidelines.

See Chapter 13, Gynaecology by Ten Teachers, 19th edition.

10 C

The smear test is a screening test and not a diagnostic test. As the smear shows moderate dyskaryosis, surveillance is no longer recommended and the patient requires colposcopic assessment. If, at colposcopic assessment, the colposcopic appearances are suggestive of CIN2, one could take a biopsy or perform a 'see and treat' LLETZ procedure. However, colposcopic assessment is mandatory before embarking straight for a LLETZ procedure.

See Chapter 14, Gynaecology by Ten Teachers, 19th edition.

11 E

As this patient has a 4/5 score on the Oxford Grading Scale, she has excellent pelvic floor contraction already and therefore would warrant surgical intervention. Anterior repair is not recognized as a suitable treatment for stress incontinence, only anterior compartment prolapse. Bladder neck injections can be useful but in a thirty eight year old, the longevity is very short lived. Colposuspension requires a laparotomy and has now been superseded by the tension-free vaginal tape procedure, which is recommended as gold standard under NICE guidelines.

See Chapter 16, Gynaecology by Ten Teachers, 19th edition.

12 A

As this lady is not sexually active and has numerous risk factors for surgery, a shelf pessary would be recommended in the first instance. Vaginal hysterectomy may be considered as a second-line treatment, but if she copes well with the pessary, this would negate the risk of surgery and anaesthesia. Total vaginal mesh is currently not recommended under NICE guidelines as first-line treatment for prolapse. Pelvic floor exercises have no role in Grade 2 or more prolapse.

See Chapter 17, Gynaecology by Ten Teachers, 19th edition.

13 D

Cystoscopy is useful for looking for conditions within the bladder. Hysteroscopy is the procedure to assess the uterine cavity for fibroids, investigation or post-menopausal bleeding, menorrhagia or fibroids.

Hysterosalpingogram is useful to assess tubal patency in the investigation of the infertile couple. Hysterectomy would be a treatment rather than an investigative exploratory procedure.

See Appendix 1, Gynaecology by Ten Teachers, 19th edition.

SBA answers