Common questions

- Pap smear vs biopsy? → Cytology vs histology.
- Pap smear vs colposcopy? → Pap is a screening test; colposcopy is diagnostic assessment with possible biopsy.
- Where is the important sampling area? → Transformation zone.
- Why may screening be inappropriate immediately after menarche? → Cervical maturation and transient HPV changes can make screening less useful; follow the age-based guideline.

STATION 4 — VAGINAL DISCHARGE

Task: Take a focused history and distinguish physiological discharge from common infective causes.

History

- Onset, duration, amount and change from baseline.
- Colour: white/grey/yellow/green/bloody.
- Consistency: thin, thick, curdy/frothy.
- Odour: especially fishy/foul.
- Itching, burning, vulval soreness, dyspareunia, dysuria.
- Pelvic/lower abdominal pain, fever, postcoital bleeding.
- LMP and pregnancy possibility.
- Sexual history: new/multiple partners, condom use, STI history.
- Recent antibiotics, diabetes, immunosuppression and douching/irritants.

Typical patterns

- **Candidiasis:** intense vulval itch/soreness; thick curdy “cottage-cheese” discharge; usually little/no offensive odour.
- **Bacterial vaginosis:** thin, homogeneous grey/white discharge with fishy odour; classically associated with elevated vaginal pH.
- **Trichomoniasis:** frothy yellow-green discharge, irritation and possible strawberry cervix; STI.
- **Cervicitis:** mucopurulent cervical discharge, postcoital bleeding or pelvic symptoms; consider chlamydia/gonorrhoea.

Examination/investigations

- External inspection → speculum examination → assess vagina and cervix.
- Vaginal pH, microscopy/wet mount or appropriate NAAT/swabs according to suspected infection.
- STI testing when indicated.
- Pregnancy test when relevant.

STATION 5 — SPECULUM EXAMINATION

Definition

- Insertion of a speculum into the vagina to separate the vaginal walls and directly visualize the vagina and cervix.

Technique — 5-minute OSCE sequence

- Introduce yourself, confirm identity, explain procedure, obtain consent and offer a chaperone.
- Ask about pain and ensure privacy; position appropriately with adequate exposure.
- Wash hands and use gloves.
- Warm/lubricate appropriately without contaminating samples; use the smallest suitable speculum.
- Separate the labia and insert the closed speculum gently, usually directed posteriorly, then rotate/advance as appropriate.
- Open the blades to visualize the cervix; inspect cervix/vaginal walls for discharge, bleeding, lesions or inflammation.
- Take swabs/Pap sample if indicated.
- Release the lock, close the blades gently and withdraw slowly while inspecting the vaginal walls.
- Dispose of equipment safely, help the patient sit comfortably and explain findings/next steps.

Why speculum before bimanual?

- You can directly see the cervix and vaginal walls and obtain cervical/vaginal samples before manipulation causes bleeding or discharge to be displaced.
- Bimanual examination then assesses uterus/adnexa and pelvic tenderness.

Safety: Do not force the speculum. Stop if significant pain occurs and reassess.

STATION 6 — HYSTEROSCOPY

What is it?

- Endoscopic visualization of the cervical canal and uterine cavity using a hysteroscope.
- Diagnostic hysteroscopy can identify intracavitary pathology; operative hysteroscopy can treat selected lesions.

Indications

- Abnormal uterine bleeding with suspected intracavitary pathology.
- Suspected endometrial polyp or submucosal fibroid.
- Infertility/recurrent pregnancy loss when intrauterine pathology is suspected.
- Removal of selected intracavitary lesions or foreign bodies.

Basic procedure

- Consent, pregnancy exclusion when appropriate, analgesia/anaesthesia depending on procedure.
- Introduce hysteroscope through the cervix and distend the uterine cavity with the appropriate medium.
- Inspect cervical canal and cavity; take biopsy or perform operative treatment if indicated.
- Recover and give post-procedure advice.

Complications

- Uterine perforation, bleeding, infection.
- Cervical trauma.
- Fluid overload/electrolyte disturbance depending on distension medium and procedure.
- Rare anaesthetic complications.

Common viva

- Hysteroscopy vs D&C;: hysteroscopy gives direct visualization and targeted treatment/biopsy; blind curettage does not directly visualize the cavity.

STATION 7 — HYSTERECTOMY

Types

- **Total hysterectomy:** uterus + cervix removed.
- **Subtotal/supracervical:** uterine body removed, cervix retained.
- **Total hysterectomy + BSO:** uterus/cervix plus both tubes and ovaries removed.
- **Radical hysterectomy:** uterus/cervix plus parametrial and upper vaginal tissues with pelvic nodal assessment as appropriate, classically for selected cervical cancer.

Approaches

- Abdominal, vaginal, laparoscopic or robotic depending on indication, anatomy, disease and expertise.

Common indications

- Symptomatic fibroids refractory to conservative treatment.
- Abnormal uterine bleeding from benign disease when definitive treatment is appropriate.
- Uterine prolapse in selected patients.
- Endometrial/cervical/other gynecologic malignancy with the appropriate oncologic procedure.

Complications

- Bleeding/transfusion, infection, venous thromboembolism.
- Bladder/ureter/bowel injury.
- Anaesthetic complications.
- Vaginal cuff complications and possible effects on pelvic floor/sexual function.

OSCE point: If ovaries are being removed, discuss surgical menopause in a premenopausal woman and the implications for fertility and hormones.

STATION 8 — OVARIAN HYPERSTIMULATION SYNDROME (OHSS)

When to suspect it

- Usually after ovarian stimulation for assisted reproduction.
- Symptoms: abdominal distension/pain, nausea/vomiting, rapid weight gain, reduced urine output, shortness of breath.

Mechanism

- Increased ovarian vascular permeability leads to fluid shift from intravascular space into the third space → ascites, haemoconcentration and potentially thrombosis.

Risk factors

- Young age, PCOS, high ovarian response/many follicles, high estradiol and multiple developing follicles; prior OHSS increases concern.

Assessment

- Vitals, weight, abdominal examination, urine output and hydration status.
- CBC/haematocrit, electrolytes, renal and liver function as clinically indicated.
- Ultrasound for enlarged ovaries and ascites; assess for complications.

Complications

- Haemoconcentration, thromboembolism, acute kidney injury, electrolyte disturbance, ascites/pleural effusion and respiratory compromise.
- Pregnancy can worsen/prolong OHSS.

Management principles

- Mild cases: outpatient monitoring, oral fluids and symptom control when safe.
- Moderate/severe: hospital assessment, careful fluid/electrolyte management, thrombosis prevention and treatment of complications.
- Avoid excessive IV fluid; monitor urine output, weight, abdominal symptoms and laboratory trends.

STATION 9 — THYROID DISEASE IN PREGNANCY

History

- Symptoms of hypothyroidism: fatigue, cold intolerance, constipation, weight gain, dry skin, bradycardia.
- Symptoms of hyperthyroidism: heat intolerance, tremor, palpitations, weight loss, anxiety, sweating.
- Previous thyroid disease/surgery, thyroid antibodies, medications and adherence.
- Obstetric history: miscarriage, preterm birth, fetal growth concerns, hypertension.

Investigations

- TSH and free T4 are the key thyroid function tests; interpret using pregnancy-appropriate reference ranges.
- Consider thyroid antibodies and ultrasound when clinically indicated.

Why it matters

- Untreated thyroid disease can contribute to maternal and fetal complications including hypertensive disease, pregnancy loss, growth problems and preterm birth.

Common viva

- Why is TSH useful? → It is a sensitive marker of thyroid axis status, but pregnancy changes thyroid physiology and laboratory interpretation.
- Do not stop established thyroid treatment without medical advice.

STATION 10 — EPILEPSY IN PREGNANCY

History

- Type of seizure, age at diagnosis, frequency, date of last seizure and triggers.
- Current antiseizure medication(s), dose, adherence and recent changes.
- Previous status epilepticus/injury and seizure-related complications.
- Obstetric history and fetal concerns.
- Folic-acid use, contraception and pregnancy planning.

Pregnancy considerations

- Seizure control is important because maternal generalized seizures can harm mother and fetus.
- Antiseizure drugs have different fetal risks; treatment should be individualized and abrupt withdrawal should be avoided.
- Medication adherence and specialist follow-up are important.
- Discuss folic acid and preconception counselling.

If seizure occurs in pregnancy

- Protect from injury, place in lateral position when possible, maintain airway and assess maternal/fetal status.
- Treat prolonged/generalized seizures urgently according to emergency protocol.
- Always consider eclampsia in a pregnant patient with a new seizure, especially with hypertension or other preeclampsia features.

STATION 11 — MANAGEMENT OF CARDIAC DISEASE IN PREGNANCY

History

- Known cardiac diagnosis, previous surgery/interventions and functional status.
- Dyspnoea, orthopnoea, PND, chest pain, palpitations, syncope, cyanosis and exercise tolerance.
- Previous pregnancy complications and thromboembolism.
- Current cardiac medications and anticoagulation.

Examination

- BP, pulse, oxygen saturation, JVP, heart sounds/murmurs, signs of heart failure and peripheral oedema.
- Assess respiratory status and fetal wellbeing.

Investigations

- ECG and echocardiography are key; additional tests depend on the lesion and symptoms.
- Routine antenatal fetal surveillance as indicated.

Management principles

- Multidisciplinary care for significant disease.
- Risk-stratify maternal cardiovascular risk and plan delivery in advance.
- Treat heart failure/arrhythmia according to pregnancy-safe protocols.
- Anticoagulation decisions require individualized assessment of thrombotic and bleeding risk.

Viva: Ask the examiner what lesion is present before giving a specific drug or delivery plan—the management differs markedly between lesions.

STATION 12 — PRETERM LABOUR / PRETERM BIRTH

This is the high-priority station. The following is based directly on the uploaded university lecture PTL-2.pdf. Page references below correspond to the uploaded 48-page lecture. ■filecite■turn0file0■

A. Definition — say this first

• Preterm labour: regular uterine contractions associated with cervical changes (dilatation and effacement) after the age of viability and before 37 completed weeks from the LMP.

• Threatened preterm labour: regular uterine contractions but no evidence of cervical change.

• WHO definition of preterm birth: birth before 37 weeks of gestation.

• Lecture categories: moderately preterm 33–36 weeks; very preterm <32 weeks; extremely preterm <28 weeks. (Slides 3–4)

B. Classification / causes

• **Spontaneous:** idiopathic; birth follows spontaneous preterm labour; risk factors include obstetric history, social factors and lifestyle.

• **PPROM:** preterm premature rupture of membranes before labour and before 37 weeks; infection is highlighted as a major cause.

• **Iatrogenic/medically indicated:** maternal complications such as severe hypertension or abruption, or endangered fetus such as IUGR/fetal distress. (Slide 5)

C. Risk factors — examiner loves these

• **Maternal:** age extremes, low maternal weight, smoking, alcohol and coitus; the lecture notes increased risk with very low weight and age extremes.

• **Previous reproductive history:** previous preterm birth, second-trimester abortions, uterine abnormalities and previous pregnancy bleeding.

• **Current pregnancy:** uterine overdistension, multiple pregnancy, fetal congenital abnormalities, APH/threatened abortion, maternal illness, retained IUCD, IUFD, PROM and genital-tract infection.

• **Other factors in the slides:** periodontal infection, second-trimester bleeding, psychiatric disorder, smoking, diabetes, thyroid disease, asthma, hypertension, psychological stress and depression.

• **Major single risk factor highlighted:** multiple pregnancy. (Slides 6–15)

D. History station — ask in this order

• **Opening:** “I understand you are having symptoms suggesting early labour. I would like to ask about the contractions, fluid loss, bleeding, fetal movements and risk factors.”

• **Contractions:** onset, frequency, duration, regularity, increasing intensity.

• **Fluid:** gush or continuous leakage, colour, smell, time of onset → suspect PPROM.

• **Bleeding:** amount, colour, clots, pain → consider APH/abruption.

• **Fetal movements:** normal/reduced/absent.

• **Infection symptoms:** fever, dysuria, abnormal/foul discharge, pelvic/uterine pain.

• **Past obstetric history:** previous preterm birth, PROM, second-trimester loss, cervical procedures/uterine abnormalities.

• **Current pregnancy:** gestational age, singleton/twins, scans, cervical length, complications such as hypertension/diabetes/IUGR.

• **Risk factors:** smoking, low BMI, interpregnancy interval, infection, stress/psychiatric disease, retained IUCD and recent procedures.

E. Diagnosis — memorize the numbers from the lecture

• Regular uterine contractions: **4 in 20 minutes**.

• Cervical changes: **dilatation ≥2 cm** and **effacement >80%**. (Slide 32)

• Initial evaluation: history, examination and MSU. (Slide 33)

F. Examination

• Maternal vital signs, temperature and general condition.

• Abdominal examination: uterine tenderness, contractions, fundal height, lie/presentation and fetal heart.

• Assess for infection, bleeding and uterine activity.

• Speculum examination is particularly important if PPROM is suspected: look for fluid, cord prolapse, cervical dilatation and obtain HVS when indicated.

• Avoid unnecessary digital vaginal examination if PPROM is suspected because it may increase infection risk.

G. Investigations / prediction

• **Fetal fibronectin (fFN):** cervicovaginal marker; disruption of the chorio-decidual interface can occur with infection, stress and haemorrhage. A positive test increases risk and may help with decisions about admission, in-utero transfer and steroids. (Slides 16–18)

• **TVUS cervical length:** important predictor, especially in symptomatic patients. The lecture notes routine assessment around 22–24 weeks and that a cervical length ≤1.5 cm is associated with increased early preterm birth risk. (Slides 19–22)

• The lecture emphasizes that cervical length and fFN together provide the most accurate prediction.

H. Prevention — know these headings

• Cervical cerclage.

• Progesterone.

• Detection and treatment of vaginal/intrauterine infection.

• The lecture also lists non-steroidal anti-inflammatory drugs under prevention. (Slide 23)

• For short cervix, the lecture presents vaginal progesterone 200 mg daily and cites reduced delivery before 34 weeks in the study shown; memorize the university slide wording for your exam. (Slides 24–25)

I. Management — first question: can I safely inhibit labour?

• **Initial:** history + examination + MSU.

• **Absolute contraindications to inhibiting labour:** fetal death; congenital anomalies incompatible with life; chorioamnionitis; fetal indication for immediate delivery; maternal indication for immediate delivery. (Slide 33)

• **Relative contraindications:** IUGR, pre-eclampsia, vaginal bleeding and cervical dilatation >4 cm. (Slide 34)

J. Tocolytics — know the classes + key adverse effects

• **β-adrenergic agonists:** adverse effects include palpitations, arrhythmias, myocardial ischaemia, pulmonary oedema, hypotension, glucose intolerance, hypokalaemia and paralytic ileus. Absolute contraindications listed in the lecture include cardiac disease, anaemia, hyperthyroidism and MAO inhibitors. Fetal/neonatal effects include fetal tachycardia and neonatal hypoglycaemia. (Slides 35–37)

• **Magnesium sulfate:** lecture notes inhibition of contractions at 5–8 mg/dL; side effects include flushing, dizziness, decreased temperature and respiratory depression; contraindicated in myasthenia gravis and renal failure; antidote = calcium gluconate. (Slide 38)

• **Magnesium sulfate for neuroprotection:** lecture states it reduces cerebral palsy, including moderate/severe cases, without increasing death. (Slide 39)

• **Prostaglandin synthetase inhibitor:** indomethacin; adverse effects include GI complications, premature closure of ductus arteriosus and oligohydramnios. (Slide 40)

• **Oxytocin antagonist:** atosiban. **Calcium-channel blockers** are also listed as tocolytic agents. (Slide 35)

K. Corticosteroids — extremely high yield

• Promote surfactant release from type II pneumocytes and increase phosphatidylcholine synthesis.

• Lecture: beneficial <34 weeks; recommended 24–36 weeks; effect lasts about one week.

• Betamethasone **12 mg IM, repeated after 24 hours**. (Slide 41)

• When asked “why steroids?” → accelerate fetal lung maturation and reduce neonatal respiratory complications.

L. PPROM — separate it from spontaneous PTL

• Definition in lecture: rupture of membranes before 37 completed weeks.

• History: gush of fluid from vagina.

• Speculum: diagnosis, check for cord prolapse and dilatation; HVS.

• Nitrazine paper: pH 7–7.5 changes yellow → blue.

• Ferning/arborization test may support diagnosis.

• Ultrasound: reduced amniotic-fluid index is supportive, not the sole diagnostic test.

• Lecture also lists alpha-fetoprotein among diagnostic tests. (Slide 45)

M. PPROM — chorioamnionitis screen

• Fever.

• Maternal and fetal tachycardia.

• Uterine tenderness.

• Uterine contractions.

• Foul-smelling vaginal discharge.

• Raised WBC. (Slide 46)

N. PPROM management — memorize the framework

• Hospitalization and monitoring.

• Vital signs; fetal heart and NST.

• WBC and C-reactive protein.

• Antibiotics.

• Corticosteroids.

• Tocolytic agents may be used in selected circumstances.

• **Lecture threshold:** <34 weeks → expectant management; >34 weeks → delivery. (Slide 48)

• The lecture emphasizes that the major perinatal mortality is due to prematurity rather than sepsis, while infection risk rises as the latent period increases. (Slide 47)

O. Common examiner viva questions

• Define preterm labour.

• Differentiate threatened PTL from established PTL.

• What is PPROM?

• What are the three broad categories of preterm birth?

• Name the biggest single risk factor in the lecture → multiple pregnancy.

• What are the diagnostic contraction/cervical criteria? → 4/20 min + dilatation ≥2 cm + effacement >80%.

• What tests predict spontaneous PTB? → TVUS cervical length and cervicovaginal fFN.

• What cervical length is highlighted as high risk? → ≤1.5 cm in the lecture.

• When should you NOT give a tocolytic? → absolute contraindications such as chorioamnionitis, fetal death, lethal anomaly or an indication for immediate delivery.

• Name tocolytics.

• Main important adverse effect of indomethacin? → premature ductal closure and oligohydramnios.

• Magnesium sulfate antidote? → calcium gluconate.

• Why give antenatal corticosteroids? → fetal lung maturation.

• Betamethasone dose in the lecture? → 12 mg IM, repeat in 24 h.

• How do you diagnose PPROM? → history + sterile speculum assessment + supportive tests such as nitrazine/ferning; ultrasound is supportive.

• How do you look for chorioamnionitis? → fever, maternal/fetal tachycardia, uterine tenderness, contractions, foul discharge, raised WBC.

Preterm OSCE closing statement: “I would assess maternal and fetal wellbeing, establish whether this is true preterm labour or PPROM, look for infection/bleeding/indications for immediate delivery, assess cervical status and gestational age, then involve the obstetric/neonatal team and give appropriate steroids, tocolysis and/or magnesium sulfate according to the clinical situation and contraindications.”

University source: PTL-2.pdf, 48 pages. The above preterm section follows the uploaded lecture, including its stated numerical thresholds and treatment doses. ■filecite■turn0file0■

LAST 5-MINUTE OSCE — UNIVERSAL CHECKLIST

If the station is HISTORY

- Introduce yourself → confirm identity → consent → privacy/chaperone.
- Open question → clarify presenting complaint → relevant obstetric/gynecologic history.
- Always ask LMP/gestational age when pregnancy is possible.
- Ask red flags: pain, bleeding, fever, discharge, urinary symptoms, reduced fetal movements where relevant.
- Past obstetric history + medical/surgical history + medications/allergies.
- Finish with social/sexual history where relevant, then summarize and offer plan.

If the station is an ORAL / instrument station

- Start with definition.
- Give 3–5 indications.
- Give the basic steps/technique.
- Give major complications.
- Know the key differentiating point from similar procedures.
- If management is asked: stabilize → identify contraindications → investigations → definitive/medical treatment → follow-up.

High-yield distinction: Pap smear = cervical cytology; cervical biopsy = histology; colposcopy = magnified cervical assessment ± biopsy; endometrial biopsy/D&C; = endometrial tissue.

End of pack.