Obstetrics Simulation Workshop- Pre- and Post-test ANSWERS

1. What is the definition of labour and how does it differ from "false labour"?
   True labour refers to uterine contractions producing cervical changes. False labour (i.e., Braxton Hicks contractions) refers to irregular uterine contractions that do not result in any cervical dilation or effacement.

2. List 3 ways in which ruptured membranes can be confirmed.
   a. Observation of fluid leaking from the cervix
   b. Nitrazine paper pH testing
   c. Microscopic examination of secretions from posterior vaginal fornix or cervix and observation of ferning due to crystallization of NaCl
   d. Ultrasound showing oligohdramnios
   e. Amniocentesis with instillation of dye and subsequent detection of dye in vagina

3. List 3 indications for cesarean section (Hacker & Moore, 2010, p226).
   a. Maternal preference
   b. Dystocia
   c. Repeat cesarean delivery
   d. Breech presentation
   e. Fetal distress
   f. Placenta previa

4. What are 2 ways in which labour can be induced and/or augmented?
   a. Prostaglandins (Cervidil/Cytotec)
   b. Intrauterine placement of ateters or use of osmotic dilators
   c. Artificial rupture of membranes
   d. Oxytocin infusion

5. List three features of a normal fetal heart rate tracing.
   a. Variability
   b. Rate (110-160)
   c. Accelerations, no decelerations

6. Name two blood tests you would order for a patient with suspected pre-eclampsia.
   a. Liver panel
   b. CBC (platelets)

7. List three things you might consider to manage shoulder dystocia.
   a. Suprapubic pressure
   b. McRoberts' maneuver
   c. Corkscrew/Woods maneuver
   d. Fracture of one or both clavicles
   e. Change maternal position to on all fours
   f. Zavanelli maneuver followed by caesarian section

8. List three methods of pain control that can be used during labour.
   a. Non-pharmacologic (e.g., support person, Jacuzzi, birthing ball)
   b. Non-epidural pharmacologic (e.g., narcotics, nitrous oxide)
   c. Epidural pharmacologic

9. What is the definition of dystocia in the first stage of labour?
   After 3-4 cm dilation, cervical dilation <1.2 cm/hour (nulliparous) or <1.5 cm/hour (multiparous)

10. What are 3 prerequisites for an assisted vaginal delivery (Hacker & Moore, 2010, p.223)?
    a. Prolonged second stage of labour
    b. Suspicion of immediate or impending fetal compromise
    c. Stabilization the aftercoming head during a breech delivery
    d. To shorten second stage of labour for maternal benefit (e.g., HTN, cardiac disorders, pulmonary disease).

11. What are three things you could do to manage post-partum hemorrhage?
    a. Manual tamponade + fundal pressure
    b. Uterotonic agents
    c. Curettage
    d. Interventional radiology to inject thrombogenic factors into uterine arteries
    e. Ligation of uterine arteries
    f. Hysterectomy

12. List two complications of artificial rupture of the membranes.
    a. Increased risk of postpartum infection
    b. Increased risk of cord prolapse

13. What are three risk factors for post-partum hemorrhage?
    a. Overdistention of the uterus
        i. Multigestation pregnancy
        ii. Polyhydramnios
        iii. Fetal macrosomia
        iv. Grand multiparity (>5)
    b. Prolonged labour
    c. Precipitous labour (<3 hours)
    d. Oxytocin augmentation
    e. Magnesium sulphate treatment for preeclampsia
    f. Chorioamnionitis
    g. Halogenated anesthetics

14. List three factors that may predispose to ~~shoulder~~ dystocia.
    a. Powers (ineffective uterine contractions, epidural anesthetic)
    b. Passenger (abnormal fetal lie, malpresentation, malposition, fetal anatomic defects)
    c. Passage (maternal bony pelvic contractures)