

INI CET Obstetrics and Gynaecology

Sample Paper – 6

Duration: 14 Minutes

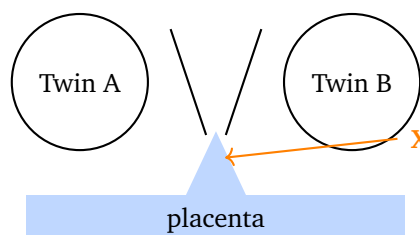
Maximum Marks: 15

Instructions

- This paper contains **15** Multiple Choice Questions (Single Best Response), modelled on the Obstetrics and Gynaecology content of **INI CET** (Institutes of National Importance Combined Entrance Test) conducted by AIIMS New Delhi.
- The **15-question** length matches the number of Obstetrics and Gynaecology items you actually meet in the real 200-question paper.
- Each correct answer carries **+1 mark**. There is **negative marking of one-third (0.33) mark** for every incorrect answer; unattempted questions carry no penalty.
- Every question has **exactly one best answer**. Choose the single most appropriate option, weighing clinical presentation against investigation findings.
- Attempt this practice paper in one timed sitting of about **14 minutes**, the pace the real computer-based test demands.

Obstetrics: Antenatal Care and Physiology

Q1. In the first-trimester ultrasound schematic of a twin pregnancy, the inter-twin membrane meets the placenta as a triangular tongue of placental tissue (the twin-peak or lambda sign, marked X). This finding indicates:



(A) Monochorionic monoamniotic pregnancy



- (B) Monochorionic diamniotic pregnancy
- (C) Dichorionic diamniotic pregnancy
- (D) Conjoined twins

Q2. Twin-twin transfusion syndrome (TTTS), driven by unbalanced flow through placental vascular anastomoses, is seen almost exclusively in which type of twin pregnancy?

- (A) Monochorionic (single shared placenta)
- (B) Dichorionic diamniotic
- (C) Any dizygotic twin pregnancy
- (D) Any twin pregnancy complicated by polyhydramnios

Q3. When the inter-twin membrane meets the placenta at a right angle with no lambda tongue (the T sign of a monochorionic pregnancy), timely counselling depends on early diagnosis. Chorionicity is most reliably determined by ultrasound at:

- (A) 6 to 7 weeks
- (B) 11 to 14 weeks (first trimester)
- (C) 20 weeks
- (D) Only at term

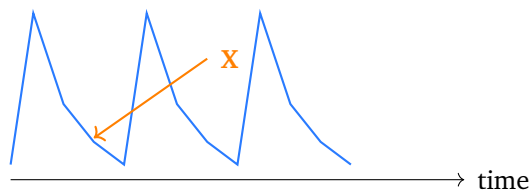
Obstetrics: Complications of Pregnancy

Q4. Asymmetric fetal growth restriction, in which the abdominal circumference lags while head growth is relatively preserved (head-sparing pattern), is most typically caused by:

- (A) A chromosomal abnormality
- (B) Utero-placental insufficiency (e.g. pre-eclampsia)
- (C) First-trimester TORCH infection
- (D) Constitutional (familial) short stature



- Q5.** The umbilical artery Doppler waveform shown (marked X) demonstrates absent and then reversed end-diastolic flow. In a growth-restricted fetus this finding indicates:



- (A) Normal placental blood flow
 - (B) Mild maternal dehydration only
 - (C) Severely raised placental resistance, an ominous sign warranting delivery
 - (D) An isolated finding with no clinical significance
- Q6.** Symmetric (proportionate) growth restriction, in which the head and body are equally small from early pregnancy, is most suggestive of:
- (A) An early insult such as a chromosomal anomaly or congenital infection
 - (B) Late-onset placental insufficiency
 - (C) Well-controlled gestational diabetes
 - (D) A normal post-term pregnancy

Labour and Puerperium

- Q7.** Among the four Ts (Tone, Tissue, Trauma, Thrombin), the single most common cause of primary postpartum haemorrhage is:
- (A) Retained placental tissue
 - (B) Genital tract trauma
 - (C) A coagulation disorder
 - (D) Uterine atony (failure of the uterus to contract)
- Q8.** The single most effective component of active management of the third stage of labour for preventing postpartum haemorrhage is:



- (A) Immediate (early) cord clamping
- (B) Routine episiotomy
- (C) A prophylactic uterotonic (oxytocin) given with delivery of the anterior shoulder
- (D) Bladder catheterisation

Gynaecology: Benign and Endocrine

Q9. Menopause is diagnosed clinically, in retrospect, after:

- (A) 3 months of amenorrhoea
- (B) 12 consecutive months of amenorrhoea with no other cause
- (C) The first hot flush
- (D) A single raised FSH value

Q10. The characteristic hormonal profile of the postmenopausal woman is:

- (A) High FSH and LH with low oestradiol
- (B) Low FSH with high oestradiol
- (C) High oestradiol with low LH
- (D) Normal levels of all reproductive hormones

Q11. In a woman with an intact uterus, oestrogen-only hormone replacement therapy is avoided because unopposed oestrogen increases the risk of:

- (A) A benign ovarian cyst
- (B) Cervical carcinoma
- (C) Osteoporotic fracture
- (D) Endometrial hyperplasia and carcinoma

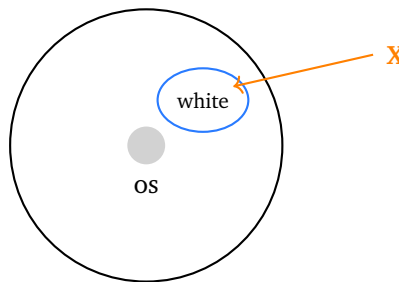
Gynaecological Oncology

Q12. The Pap (cervical cytology) smear is a screening test whose main value is that it detects:



- (A) Only frankly invasive cervical cancer
- (B) Ovarian carcinoma
- (C) Pre-invasive cervical intraepithelial neoplasia (dysplasia)
- (D) Endometrial carcinoma

Q13. The colposcopy schematic shows the cervix after application of 5% acetic acid; the abnormal high-grade CIN area marked **X** turns dense and opaque white. This colposcopic change is called:



- (A) Leukoplakia
- (B) Mosaicism
- (C) Punctation
- (D) Acetowhite change

Contraception, Infertility and Infections

Q14. A thin, grey, homogeneous vaginal discharge with a fishy odour, a vaginal pH above 4.5, and clue cells on microscopy is characteristic of:

- (A) Vulvovaginal candidiasis
- (B) Bacterial vaginosis
- (C) Trichomoniasis
- (D) Physiological (normal) discharge

Q15. A thick, white, curdy (cottage-cheese) discharge with intense vulval itching, a normal vaginal pH, and pseudohyphae on microscopy is caused by:

- (A) Candida albicans (vulvovaginal candidiasis)
- (B) Gardnerella vaginalis

- (C) *Trichomonas vaginalis*
- (D) *Neisseria gonorrhoeae*



Detailed Solutions**Q1.****Solution**

Concept – determining chorionicity: The shape where the membrane meets the placenta tells the chorionicity.

Step 1 – read the sign: A triangular wedge of placental tissue pushing up between the membranes is the **lambda (twin-peak) sign**.

Step 2 – interpret: This wedge means two fused placentas, so the pregnancy is **dichorionic diamniotic**.

Why the other options are wrong:

- A, monochorionic monoamniotic: a single sac with no dividing membrane.
- B, monochorionic diamniotic: shows a thin T sign, not a lambda.
- D, conjoined twins: fused fetuses, a different and rare picture.

Final Answer: Dichorionic diamniotic pregnancy $\Rightarrow$ **C**

Answer: (C) [Go Back to Q1](#)

Q2.**Solution**

Concept – TTTS and placentation: Twin-twin transfusion needs a shared vascular bed.

Step 1 – name the requirement: TTTS arises only when twins share **one monochorionic placenta** with connecting anastomoses.

Step 2 – mechanism: Net flow from a donor twin to a recipient twin causes donor oligohydramnios and recipient polyhydramnios.

Why the other options are wrong:

- B, dichorionic: two separate placentas, so no shared vessels.
- C, dizygotic: always dichorionic, hence not at risk.
- D, polyhydramnios: a possible sign of TTTS, not the type of pregnancy that permits it.

Final Answer: Monochorionic (single shared placenta) $\Rightarrow$ **A**

Answer: (A) [Go Back to Q2](#)



Q3.

Solution

Concept – timing of chorionicity assessment: The membrane signs are clearest early.

Step 1 – name the window: Chorionicity is best assigned at **11 to 14 weeks**, when the lambda and T signs and membrane thickness are most reliable.

Step 2 – why early: As pregnancy advances the lambda sign regresses, so late scans become unreliable.

Why the other options are wrong:

- A, 6 to 7 weeks: sac counting is possible but membrane signs are not yet clear.
- C, 20 weeks: the lambda sign may have faded, reducing accuracy.
- D, at term: far too late for counselling or surveillance planning.

Final Answer: 11 to 14 weeks (first trimester) ⇒ **B**

Answer: (B) [Go Back to Q3](#)

Q4.

Solution

Concept – symmetric vs asymmetric FGR: The pattern points to the timing and cause of the insult.

Step 1 – read the pattern: Head-sparing with a lagging abdominal circumference is **asymmetric** growth restriction.

Step 2 – name the cause: It results from late **utero-placental insufficiency**, as in pre-eclampsia, which spares brain growth by preferential blood redistribution.

Why the other options are wrong:

- A, chromosomal abnormality: usually causes symmetric restriction.
- C, first-trimester TORCH infection: an early insult, giving symmetric restriction.
- D, familial short stature: a constitutionally small but healthy fetus, not true restriction.

Final Answer: Utero-placental insufficiency ⇒ **B**

Answer: (B) [Go Back to Q4](#)



Q5.

Solution

Concept – umbilical artery Doppler: Diastolic flow reflects placental resistance.

Step 1 – read the waveform: Loss of forward flow in diastole, then flow reversal (marked X), signals **very high placental resistance**.

Step 2 – act on it: Absent or reversed end-diastolic flow is an ominous sign of fetal compromise and usually warrants delivery after steroid cover.

Why the other options are wrong:

- A, normal flow: normal umbilical arteries keep positive forward diastolic flow.
- B, dehydration: does not abolish umbilical diastolic flow.
- D, no significance: this is one of the most serious Doppler findings.

Final Answer: Severely raised placental resistance warranting delivery ⇒ **C**

Answer: (C) [Go Back to Q5](#)

Q6.

Solution

Concept – symmetric growth restriction: Equal smallness from early pregnancy implies an early cause.

Step 1 – read the pattern: Head and body equally small from the outset is **symmetric** restriction.

Step 2 – name the cause: It reflects an **early insult**, such as a chromosomal anomaly or a congenital (TORCH) infection, that limits total cell number.

Why the other options are wrong:

- B, late placental insufficiency: gives asymmetric, not symmetric, restriction.
- C, gestational diabetes: tends to cause a large (macrosomic) fetus.
- D, post-term pregnancy: not a cause of proportionate smallness.

Final Answer: An early chromosomal or infective insult ⇒ **A**

Answer: (A) [Go Back to Q6](#)



Q7.

Solution

Concept – causes of primary PPH: The four Ts rank the causes.

Step 1 – name the commonest: Uterine atony (Tone) accounts for about 70 to 80% of primary postpartum haemorrhage.

Step 2 – mechanism: A relaxed uterus fails to compress the open placental-bed vessels, so bleeding continues.

Why the other options are wrong:

- A, retained tissue: an important but less common cause.
- B, trauma: lacerations cause bleeding despite a well-contracted uterus, but are less frequent.
- C, coagulation disorder (Thrombin): the least common of the four Ts.

Final Answer: Uterine atony ⇒

Answer: (D) [Go Back to Q7](#)

Q8.

Solution

Concept – active management of the third stage: One measure prevents most atonic PPH.

Step 1 – name it: A **prophylactic uterotonic**, oxytocin given with delivery of the anterior shoulder, is the key step.

Step 2 – effect: It makes the uterus contract promptly and cuts the risk of PPH by roughly half, alongside controlled cord traction.

Why the other options are wrong:

- A, early cord clamping: no longer routine and does not prevent PPH.
- B, episiotomy: not protective and may itself cause bleeding.
- D, bladder catheterisation: helpful adjunct but not the main preventive measure.

Final Answer: Prophylactic oxytocin ⇒

Answer: (C) [Go Back to Q8](#)



Q9.

Solution

Concept – clinical definition of menopause: Menopause is defined retrospectively.

Step 1 – state the rule: It is diagnosed after **12 consecutive months of amenorrhoea** with no other cause.

Step 2 – context: The average age is around 51 years and the diagnosis is clinical, not biochemical.

Why the other options are wrong:

- A, 3 months: too short; this may just be a skipped cycle.
- C, first hot flush: a symptom of the perimenopause, not the definition.
- D, single FSH value: FSH fluctuates and is not needed to diagnose typical menopause.

Final Answer: 12 consecutive months of amenorrhoea ⇒ **B**

Answer: (B) [Go Back to Q9](#)

Q10.

Solution

Concept – postmenopausal hormones: Ovarian failure changes the feedback loop.

Step 1 – name the profile: Falling oestradiol removes negative feedback, so **FSH and LH rise while oestradiol falls**.

Step 2 – marker: A persistently high FSH is the classic laboratory hallmark of the menopause.

Why the other options are wrong:

- B, low FSH with high oestradiol: the reverse of the true pattern.
- C, high oestradiol with low LH: describes the reproductive years, not menopause.
- D, all normal: incorrect, since the axis is markedly altered.

Final Answer: High FSH and LH with low oestradiol ⇒ **A**

Answer: (A) [Go Back to Q10](#)



Q11.

Solution

Concept – unopposed oestrogen and the endometrium: Oestrogen drives endometrial growth.

Step 1 – name the risk: In a woman with a uterus, unopposed oestrogen causes endometrial hyperplasia and carcinoma.

Step 2 – prevention: Adding a progestogen opposes this proliferation, so combined HRT is used when the uterus is intact.

Why the other options are wrong:

- A, ovarian cyst: not the recognised hazard of oestrogen-only HRT.
- B, cervical cancer: driven by HPV, not by HRT.
- C, osteoporotic fracture: oestrogen actually protects bone.

Final Answer: Endometrial hyperplasia and carcinoma ⇒ D

Answer: (D) [Go Back to Q11](#)

Q12.

Solution

Concept – purpose of the Pap smear: Cervical screening targets pre-cancer.

Step 1 – state the value: The Pap smear detects **pre-invasive cervical intraepithelial neoplasia (dysplasia)** before it becomes cancer.

Step 2 – benefit: Treating CIN at this stage prevents progression to invasive cervical carcinoma.

Why the other options are wrong:

- A, invasive cancer only: screening aims to catch disease before invasion.
- B, ovarian carcinoma: not detected by a cervical smear.
- D, endometrial carcinoma: the Pap smear is not a reliable test for it.

Final Answer: Pre-invasive cervical intraepithelial neoplasia ⇒ C

Answer: (C) [Go Back to Q12](#)



Q13.

Solution

Concept – colposcopic findings after acetic acid: Acetic acid highlights abnormal epithelium.

Step 1 – identify X: The dense opaque white area appearing after 5% acetic acid is **acetowhite change**, the marker of high-grade CIN.

Step 2 – basis: Acetic acid coagulates the high nuclear protein of dysplastic cells, so they reflect white light.

Why the other options are wrong:

- A, leukoplakia: white plaque visible before acetic acid (hyperkeratosis).
- B, mosaicism: a tile-like vascular pattern, not the white change itself.
- C, punctation: stippled vessels, a separate vascular sign.

Final Answer: Acetowhite change $\Rightarrow$ **D**

Answer: (D) [Go Back to Q13](#)

Q14.

Solution

Concept – causes of abnormal vaginal discharge: Discharge features point to the organism.

Step 1 – read the clues: A thin grey discharge, fishy odour, pH above 4.5, and clue cells define **bacterial vaginosis**.

Step 2 – mechanism: Loss of lactobacilli and overgrowth of Gardnerella and anaerobes raise the pH and produce amines.

Why the other options are wrong:

- A, candidiasis: thick white curdy discharge with itching and a normal pH.
- C, trichomoniasis: frothy yellow-green discharge with motile trichomonads and a strawberry cervix.
- D, physiological discharge: clear or white, odourless, with a normal pH.

Final Answer: Bacterial vaginosis $\Rightarrow$ **B**

Answer: (B) [Go Back to Q14](#)



Q15.

Solution

Concept – vulvovaginal candidiasis: A curdy discharge with itching is a hall-mark.

Step 1 – name the organism: A thick white cottage-cheese discharge with intense itching, a normal pH, and pseudohyphae is caused by **Candida albicans**.

Step 2 – confirm: Microscopy in potassium hydroxide shows budding yeasts and pseudohyphae; treatment is an azole antifungal.

Why the other options are wrong:

- B, *Gardnerella vaginalis*: causes bacterial vaginosis with a raised pH, not curdy discharge.
- C, *Trichomonas vaginalis*: gives a frothy green discharge with a high pH.
- D, *Neisseria gonorrhoeae*: causes cervicitis and purulent discharge, not curdy discharge with pseudohyphae.

Final Answer: *Candida albicans* ⇒ A

Answer: (A) [Go Back to Q15](#)



Answer Key

Q	Ans	Q	Ans	Q	Ans	Q	Ans	Q	Ans
1	C	2	A	3	B	4	B	5	C
6	A	7	D	8	C	9	B	10	A
11	D	12	C	13	D	14	B	15	A

