

INI CET Obstetrics and Gynaecology

Sample Paper – 7

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.
- Attempt this practice paper in one timed sitting of about **14 minutes**, the pace the real computer-based test demands.

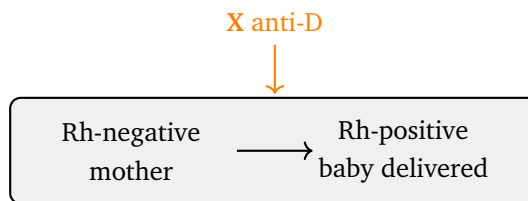
Obstetrics: Antenatal Care and Physiology

- Q1.** In the antenatal work-up of an Rh-negative pregnant woman, the test used to detect free maternal antibodies circulating against fetal Rh-positive red cells is the:
- (A) Direct Coombs test on maternal cells
(B) Kleihauer-Betke acid elution test
(C) Indirect Coombs test
(D) Rosette screening test on the newborn
- Q2.** In an Rh-negative, unsensitised woman with a negative antibody screen, routine antenatal (prophylactic) anti-D immunoglobulin is administered at:



- (A) 12 weeks of gestation
- (B) 28 weeks of gestation
- (C) 20 weeks of gestation
- (D) 6 weeks of gestation

Q3. The box below summarises postpartum anti-D prophylaxis. After an Rh-negative mother delivers an Rh-positive baby, the anti-D immunoglobulin (marked X) should be given within:



- (A) 6 hours of delivery
- (B) 48 hours of delivery
- (C) 96 hours of delivery
- (D) 72 hours of delivery

Obstetrics: Complications of Pregnancy

Q4. A pregnancy is correctly defined as post-term (prolonged) when it continues beyond:

- (A) 40 completed weeks
- (B) 42 completed weeks
- (C) 41 completed weeks
- (D) 44 completed weeks

Q5. The earliest and most reliable ultrasound finding that confirms intrauterine fetal death is:

- (A) Spalding sign (overlapping skull bones)
- (B) Robert sign (gas in the fetal heart and great vessels)
- (C) Reduced liquor volume



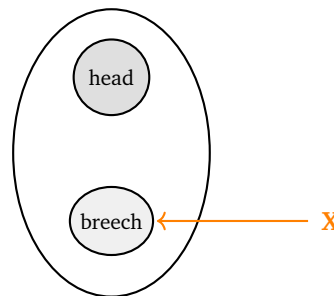
(D) Absent fetal cardiac activity on real-time scanning

Q6. Prolonged retention of a dead fetus in the uterus, especially beyond four weeks, most characteristically predisposes the mother to:

- (A) Gestational diabetes mellitus
- (B) Disseminated intravascular coagulation (DIC)
- (C) Rh isoimmunisation
- (D) Placenta praevia

Labour and Puerperium

Q7. The schematic shows a fetus lying with its head at the fundus and the buttocks presenting at the pelvic inlet (marked X). The commonest variety of breech presentation is:



- (A) Footling breech
- (B) Complete (flexed) breech
- (C) Frank (extended) breech
- (D) Kneeling breech

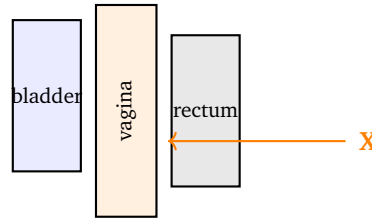
Q8. Which malpresentation carries the highest risk of umbilical cord prolapse during labour?

- (A) Footling (incomplete) breech
- (B) Frank breech
- (C) Occipito-anterior vertex
- (D) Face presentation, mento-anterior



Gynaecology: Benign and Endocrine

- Q9.** In the sagittal diagram of the pelvic compartments, the posterior compartment defect (marked X) in which the rectum bulges forward into the vagina is called a:



- (A) Cystocele
 - (B) Enterocele
 - (C) Urethrocele
 - (D) Rectocele
- Q10.** In the POP-Q (Pelvic Organ Prolapse Quantification) system, the fixed reference point relative to which all prolapse measurements are recorded is the:
- (A) Ischial spine
 - (B) Hymen
 - (C) Introital skin margin
 - (D) External cervical os
- Q11.** For a postmenopausal woman with symptomatic third-degree uterine prolapse who has completed her family and does not wish to preserve the uterus, the definitive treatment is:
- (A) Vaginal hysterectomy with pelvic floor repair
 - (B) A ring pessary alone
 - (C) Kegel (pelvic floor) exercises
 - (D) Reassurance and observation

Gynaecological Oncology

- Q12.** The most common malignant ovarian germ cell tumour, characteristically radiosensitive and associated with a raised serum lactate dehydrogenase (LDH), is:
- (A) Yolk sac (endodermal sinus) tumour
 - (B) Immature teratoma
 - (C) Dysgerminoma
 - (D) Choriocarcinoma
- Q13.** Granulosa cell tumour of the ovary characteristically shows small micro-follicular spaces containing eosinophilic material and degenerate nuclei. These structures are called:
- (A) Call-Exner bodies
 - (B) Schiller-Duval bodies
 - (C) Psammoma bodies
 - (D) Reinke crystals

Contraception, Infertility and Infections

- Q14.** Recurrent pregnancy loss, the entity that warrants a full etiological evaluation, is conventionally defined as:
- (A) Two or more consecutive clinical pregnancy losses
 - (B) A single early pregnancy loss
 - (C) Five or more pregnancy losses
 - (D) Any one ectopic pregnancy
- Q15.** The most important treatable, thrombosis-mediated cause of recurrent (often second-trimester) pregnancy loss, for which anticoagulant therapy improves outcome, is:
- (A) Balanced parental chromosomal translocation
 - (B) Bicornuate uterus
 - (C) Antiphospholipid antibody syndrome
 - (D) Luteal phase deficiency



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

Concept – detecting Rh antibodies: The Coombs (antiglobulin) test comes in two forms.

Step 1 – what the question asks: It asks for the test that detects **free antibodies circulating in maternal serum**.

Step 2 – name the test: The **indirect Coombs test** incubates maternal serum with Rh-positive test cells, then adds antiglobulin to detect bound antibody. A rising titre signals sensitisation.

Why the other options are wrong:

- A, direct Coombs: detects antibody already coating the newborn's red cells, not free maternal antibody.
- B, Kleihauer-Betke: quantifies fetal cells in maternal blood to size the fetomaternal bleed.
- D, rosette test: a qualitative screen for fetomaternal haemorrhage, not maternal antibody.

Final Answer: Indirect Coombs test $\Rightarrow$ C

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

Q2.**Solution**

Concept – routine antenatal anti-D: Prophylaxis is timed to cover silent third-trimester bleeds.

Step 1 – identify the woman: She is Rh-negative, unsensitised, with a negative antibody screen.

Step 2 – give the timing: Routine antenatal anti-D is given at **28 weeks** (with a further dose at delivery if the baby is Rh-positive).

Why the other options are wrong:

- A and C, 12 and 20 weeks: too early; the main risk of transplacental passage rises later.
- D, 6 weeks: not a prophylaxis time point.



Final Answer: 28 weeks of gestation $\Rightarrow$

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

Q3.

Solution

Concept – postpartum anti-D window: The dose must be given before the mother mounts an immune response.

Step 1 – read the box: An Rh-positive baby has been delivered to an Rh-negative mother, so postpartum anti-D is indicated.

Step 2 – give the window: Anti-D immunoglobulin should be given within **72 hours** of delivery to neutralise fetal cells before sensitisation.

Why the other options are wrong:

- A and B, 6 and 48 hours: earlier than needed; 72 hours is the accepted limit.
- C, 96 hours: beyond the window, so protection is less reliable.

Final Answer: Within 72 hours of delivery $\Rightarrow$

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

Q4.

Solution

Concept – defining post-term pregnancy: The cut-off is set by completed weeks of gestation.

Step 1 – recall the definition: Post-term (prolonged) pregnancy is one continuing beyond **42 completed weeks** (294 days).

Step 2 – clinical relevance: Beyond this, placental function may decline, raising perinatal risk.

Why the other options are wrong:

- A and C, 40 and 41 weeks: term or late-term, not post-term.
- D, 44 weeks: incorrect; the threshold is 42 weeks.

Final Answer: Beyond 42 completed weeks $\Rightarrow$

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



Q5.

Solution

Concept – confirming fetal death: Real-time ultrasound gives the definitive sign.

Step 1 – name the sign: **Absent fetal cardiac activity** on real-time scanning is the earliest and most reliable confirmation of intrauterine fetal death.

Step 2 – contrast with radiology: The older X-ray signs appear only days later.

Why the other options are wrong:

- A, Spalding sign: overlapping skull bones, a late (days) radiological change.
- B, Robert sign: gas in fetal vessels, also late.
- C, reduced liquor: non-specific and inconstant.

Final Answer: Absent fetal cardiac activity ⇒ **D**

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

Q6.

Solution

Concept – retained dead fetus: Thromboplastins from the dead fetus enter the maternal circulation.

Step 1 – name the risk: Prolonged retention, especially beyond four weeks, can cause **disseminated intravascular coagulation**.

Step 2 – mechanism: Released tissue thromboplastin consumes fibrinogen and clotting factors, causing bleeding.

Why the other options are wrong:

- A, gestational diabetes: unrelated to fetal death.
- C, Rh isoimmunisation: driven by Rh incompatibility, not retention itself.
- D, placenta praevia: an implantation problem, not a consequence of retained fetus.

Final Answer: Disseminated intravascular coagulation ⇒ **B**

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



Q7.

Solution

Concept – types of breech: Breech varieties differ by the position of the fetal legs.

Step 1 – read the schematic: The head is at the fundus and the buttocks present at the inlet (marked X), confirming a breech lie.

Step 2 – name the commonest: The **frank (extended) breech**, with hips flexed and knees extended, is the most common variety, especially in primigravidae.

Why the other options are wrong:

- A, footling: less common and carries higher cord-prolapse risk.
- B, complete breech: hips and knees both flexed; less common than frank.
- D, kneeling breech: rare.

Final Answer: Frank (extended) breech ⇒

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

Q8.

Solution

Concept – cord prolapse risk: A poorly fitting presenting part lets the cord slip past.

Step 1 – name the malpresentation: **Footling (incomplete) breech** carries the highest risk of cord prolapse because the irregular presenting part does not fill the pelvic inlet.

Step 2 – consequence: The cord can descend alongside the feet, causing acute fetal compromise.

Why the other options are wrong:

- B, frank breech: the buttocks fit the inlet better, lower risk.
- C, occipito-anterior vertex: a well-applied head, lowest risk.
- D, face mento-anterior: a malpresentation but not the highest cord-prolapse risk.

Final Answer: Footling (incomplete) breech ⇒

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



Q9.

Solution

Concept – pelvic compartment defects: Each vaginal wall defect is named by the organ that herniates.

Step 1 – read the diagram: X points to the posterior compartment, where the rectum bulges forward into the vagina.

Step 2 – name it: A forward bulge of the rectum into the posterior vaginal wall is a rectocele.

Why the other options are wrong:

- A, cystocele: the bladder bulging into the anterior wall.
- B, enterocele: small bowel herniating into the upper posterior wall (pouch of Douglas).
- C, urethrocele: urethral bulge into the lower anterior wall.

Final Answer: Rectocele $\Rightarrow$

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

Q10.

Solution

Concept – POP-Q reference point: Prolapse is measured against a fixed anatomical landmark.

Step 1 – name the reference: In POP-Q, all points are measured relative to the hymen, defined as zero.

Step 2 – convention: Points above the hymen are negative, points below are positive.

Why the other options are wrong:

- A, ischial spine: a landmark for station in labour, not POP-Q.
- C, introital margin: not the defined zero point.
- D, external cervical os: a measured point (point C/D), not the reference.

Final Answer: Hymen $\Rightarrow$

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



Q11.

Solution

Concept – definitive prolapse surgery: Choice depends on parity and wish to keep the uterus.

Step 1 – match the patient: She is postmenopausal, has completed her family and does not wish to preserve the uterus.

Step 2 – name the treatment: Vaginal hysterectomy with pelvic floor repair is the definitive procedure for symptomatic uterine prolapse in such a woman.

Why the other options are wrong:

- B, ring pessary: a conservative measure for those unfit or unwilling to have surgery.
- C, Kegel exercises: help mild prolapse only, not third-degree.
- D, observation: inappropriate for symptomatic third-degree prolapse.

Final Answer: Vaginal hysterectomy with pelvic floor repair ⇒ A

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

Q12.

Solution

Concept – ovarian germ cell tumours: Markers and radiosensitivity separate them.

Step 1 – name the tumour: Dysgerminoma is the commonest malignant ovarian germ cell tumour, is radiosensitive, and raises serum LDH.

Step 2 – clinical note: It is the ovarian counterpart of the testicular seminoma.

Why the other options are wrong:

- A, yolk sac tumour: raises AFP, not the commonest.
- B, immature teratoma: graded by neural tissue, not LDH-linked.
- D, choriocarcinoma: raises beta-hCG, rare.

Final Answer: Dysgerminoma ⇒ C

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



Q13.

Solution

Concept – granulosa cell histology: Sex cord stromal tumours have signature structures.

Step 1 – name the structure: The microfollicular spaces with eosinophilic material and degenerate nuclei are **Call-Exner bodies**, characteristic of granulosa cell tumour.

Step 2 – clinical link: These oestrogen-secreting tumours can cause precocious puberty or postmenopausal bleeding, and secrete inhibin.

Why the other options are wrong:

- B, Schiller-Duval bodies: seen in yolk sac tumours.
- C, psammoma bodies: seen in serous tumours and papillary thyroid cancer.
- D, Reinke crystals: seen in Leydig (hilus) cell tumours.

Final Answer: Call-Exner bodies ⇒ A

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

Q14.

Solution

Concept – defining recurrent pregnancy loss: The definition sets when to start evaluation.

Step 1 – state the definition: Recurrent pregnancy loss is conventionally **two or more consecutive clinical pregnancy losses**.

Step 2 – implication: This threshold prompts a full etiological work-up.

Why the other options are wrong:

- B, a single loss: common and usually needs no work-up.
- C, five or more: far above the accepted threshold.
- D, one ectopic pregnancy: not a definition of recurrent loss.

Final Answer: Two or more consecutive losses ⇒ A

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



Q15.

Solution

Concept – treatable cause of recurrent loss: One cause is both common and correctable.

Step 1 – name the cause: Antiphospholipid antibody syndrome is the most important treatable, thrombosis-mediated cause of recurrent (often second-trimester) loss.

Step 2 – management: Low-dose aspirin with heparin improves live-birth rates.

Why the other options are wrong:

- A, balanced translocation: a genetic cause, not thrombosis-mediated and not easily treated.
- B, bicornuate uterus: an anatomical cause, corrected surgically, not by anti-coagulants.
- D, luteal phase deficiency: a debated hormonal cause, not thrombotic.

Final Answer: Antiphospholipid antibody syndrome $\Rightarrow$

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



Answer Key

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

