

INI CET Obstetrics and Gynaecology

Sample Paper – 9

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 for each clinical scenario.
- 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.** Under the national antenatal programme, the recommended daily dose of elemental iron with folic acid given to a pregnant woman for prophylaxis of anaemia is:
- (A) 60 mg elemental iron with 500 mcg folic acid
(B) 100 mg elemental iron with 5 mg folic acid
(C) 20 mg elemental iron with 100 mcg folic acid
(D) 200 mg elemental iron with 1 mg folic acid
- Q2.** For a woman entering pregnancy with a normal body mass index, the recommended total gestational weight gain across the whole pregnancy is approximately:



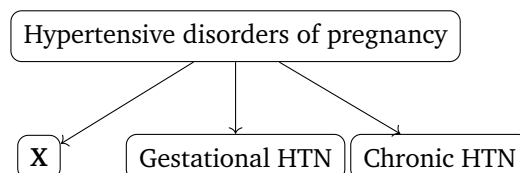
- (A) 1 to 3 kg
- (B) 5 to 8 kg
- (C) 28 to 40 kg
- (D) 11 to 16 kg

Q3. According to the World Health Organization, anaemia in pregnancy is diagnosed when the haemoglobin concentration falls below:

- (A) 13 g/dL
- (B) 12 g/dL
- (C) 11 g/dL
- (D) 7 g/dL

Obstetrics: Complications of Pregnancy

Q4. The chart classifies the hypertensive disorders of pregnancy. The category marked X, defined as new-onset hypertension appearing after 20 weeks of gestation together with significant proteinuria, is:



- (A) Preeclampsia
- (B) Gestational hypertension
- (C) Chronic hypertension
- (D) White-coat hypertension

Q5. Chronic hypertension complicating pregnancy is best defined as hypertension that is:

- (A) Newly detected only after 20 weeks and resolving after delivery
- (B) Present before conception or diagnosed before 20 weeks of gestation
- (C) Present only during the second stage of labour



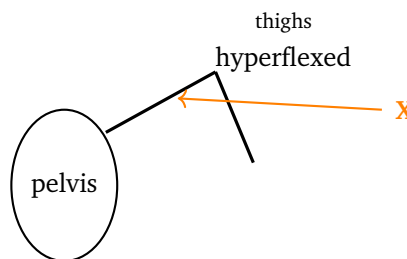
(D) Confined to the first 12 weeks and disappearing thereafter

Q6. The drug of choice for the prevention and control of convulsions in a woman with eclampsia is:

- (A) Magnesium sulphate
- (B) Diazepam
- (C) Phenytoin
- (D) Nifedipine

Labour and Puerperium

Q7. The schematic (marked **X**) shows the first-line manoeuvre for shoulder dystocia, in which the maternal hips are sharply hyperflexed onto the abdomen to straighten the sacrum and free the impacted anterior shoulder. This manoeuvre is the:



- (A) Wood's corkscrew manoeuvre
- (B) McRoberts manoeuvre
- (C) Zavanelli manoeuvre
- (D) Lovset manoeuvre

Q8. Umbilical cord prolapse is diagnosed in a woman with a live fetus who is not yet fully dilated. The single most important immediate step is to:

- (A) Start oxytocin to speed up labour
- (B) Await spontaneous vaginal delivery
- (C) Elevate the presenting part off the cord and arrange immediate caesarean section

(D) Give an oxytocic and observe

Gynaecology: Benign and Endocrine

Q9. Precocious puberty in a girl is conventionally defined as the onset of secondary sexual characteristics before the age of:

- (A) 8 years
- (B) 10 years
- (C) 12 years
- (D) 14 years

Q10. The commonest cause of abnormal uterine bleeding in an adolescent girl within the first two years of menarche is:

- (A) Endometrial carcinoma
- (B) Uterine leiomyoma
- (C) Anovulatory cycles from an immature hypothalamic-pituitary-ovarian axis
- (D) Cervical polyp

Q11. A young woman presents with oligomenorrhoea, hirsutism and polycystic ovaries on ultrasound. Diagnosed by the Rotterdam criteria, the most likely condition is:

- (A) Cushing syndrome
- (B) Congenital adrenal hyperplasia
- (C) Hyperprolactinaemia
- (D) Polycystic ovary syndrome

Gynaecological Oncology

Q12. In contrast to the traditionally clinical staging of carcinoma cervix, endometrial and ovarian carcinomas are staged by:

- (A) Clinical pelvic examination alone



- (B) Tumour size measured on ultrasound only
- (C) The Bethesda cytology system
- (D) Surgico-pathological FIGO staging

Q13. The tumour marker most useful for monitoring the response to treatment and detecting recurrence in epithelial ovarian carcinoma is:

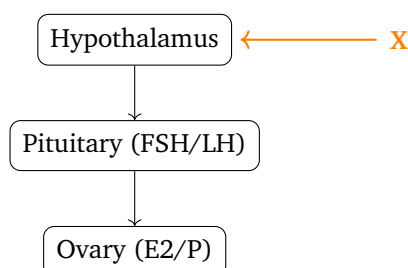
- (A) Alpha-fetoprotein (AFP)
- (B) CA-125
- (C) Beta-hCG
- (D) Carcinoembryonic antigen (CEA)

Contraception, Infertility and Infections

Q14. In a woman with anovulatory infertility due to polycystic ovary syndrome, the oral agent now recommended as first-line for ovulation induction, having shown higher live-birth rates than clomiphene, is:

- (A) Clomiphene citrate
- (B) Letrozole
- (C) Tamoxifen
- (D) Bromocriptine

Q15. In the diagram of the hypothalamic-pituitary-ovarian axis, the hormone released at the point marked X, which acts on the anterior pituitary to trigger the secretion of FSH and LH, is:



- (A) Estradiol
- (B) Progesterone



- (C) Gonadotropin-releasing hormone (GnRH)
- (D) Inhibin



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

Concept – antenatal iron and folic acid prophylaxis: Routine supplementation prevents iron deficiency anaemia in pregnancy.

Step 1 – recall the programme dose: The national antenatal schedule gives **60 mg of elemental iron with 500 mcg of folic acid** once daily for at least 180 days in pregnancy.

Step 2 – note the therapeutic dose: If anaemia is already present, the treatment dose is higher (two tablets daily), but the prophylactic dose asked here is one tablet.

Why the other options are wrong:

- B, 100 mg iron with 5 mg folic acid: an overstated dose, not the routine prophylaxis.
- C, 20 mg iron with 100 mcg folic acid: too low to prevent anaemia.
- D, 200 mg iron with 1 mg folic acid: an unsafe, excessive elemental iron dose.

Final Answer: 60 mg elemental iron with 500 mcg folic acid $\Rightarrow$ A

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

Q2.**Solution**

Concept – gestational weight gain: Recommended weight gain depends on the pre-pregnancy body mass index.

Step 1 – match the normal BMI woman: For a normal BMI (18.5 to 24.9), the recommended total gain is **11 to 16 kg** over the whole pregnancy.

Step 2 – reason: This range supports fetal growth, placenta and maternal stores without excessive gain.

Why the other options are wrong:

- A, 1 to 3 kg: far too little, risking a low-birth-weight baby.
- B, 5 to 8 kg: below the recommended range for a normal BMI.
- C, 28 to 40 kg: excessive and linked to complications.



Final Answer: 11 to 16 kg $\Rightarrow$

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

Q3.

Solution

Concept – WHO cut-off for anaemia in pregnancy: Physiological haemodilution lowers the diagnostic threshold in pregnancy.

Step 1 – recall the value: The World Health Organization defines anaemia in pregnancy as haemoglobin **below 11 g/dL**.

Step 2 – grade it: Mild is 10 to 10.9, moderate is 7 to 9.9, and severe is below 7 g/dL.

Why the other options are wrong:

- A, 13 g/dL: the cut-off for adult men, not pregnancy.
- B, 12 g/dL: the cut-off for non-pregnant women.
- D, 7 g/dL: this marks severe anaemia, not the diagnostic threshold.

Final Answer: Below 11 g/dL $\Rightarrow$

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

Q4.

Solution

Concept – classifying hypertensive disorders of pregnancy: The label depends on timing of onset and the presence of proteinuria.

Step 1 – identify X: New-onset hypertension after 20 weeks *with* significant proteinuria (or other organ involvement) defines **preeclampsia**.

Step 2 – contrast with the neighbours: Gestational hypertension has the same timing but no proteinuria; chronic hypertension predates 20 weeks.

Why the other options are wrong:

- B, gestational hypertension: new hypertension after 20 weeks but without proteinuria.
- C, chronic hypertension: present before pregnancy or before 20 weeks.
- D, white-coat hypertension: raised readings only in the clinic setting.

Final Answer: Preeclampsia $\Rightarrow$



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

Q5.

Solution

Concept – defining chronic hypertension in pregnancy: Timing separates chronic from pregnancy-induced hypertension.

Step 1 – state the definition: Chronic hypertension is that which is **present before conception or diagnosed before 20 weeks** of gestation.

Step 2 – clinical relevance: It persists beyond 12 weeks postpartum, unlike gestational hypertension which resolves.

Why the other options are wrong:

- A, detected only after 20 weeks and resolving: this describes gestational hypertension.
- C, confined to the second stage of labour: not a recognised category.
- D, confined to the first 12 weeks: not how chronic hypertension is defined.

Final Answer: Present before conception or before 20 weeks ⇒ **B**

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

Q6.

Solution

Concept – controlling eclamptic convulsions: One drug is the established standard for eclampsia.

Step 1 – name the drug: **Magnesium sulphate** is the drug of choice to prevent and control eclamptic seizures.

Step 2 – monitoring: Watch the knee-jerk reflex, respiratory rate and urine output; calcium gluconate is the antidote for toxicity.

Why the other options are wrong:

- B, diazepam: a second-line anticonvulsant with more respiratory depression.
- C, phenytoin: less effective than magnesium in eclampsia.
- D, nifedipine: an antihypertensive, not an anticonvulsant.

Final Answer: Magnesium sulphate ⇒ **A**

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



Q7.

Solution

Concept – first manoeuvre for shoulder dystocia: The initial step needs no vaginal manipulation.

Step 1 – identify X: Sharp hyperflexion of the maternal hips onto the abdomen is the **McRoberts manoeuvre**, the recommended first response.

Step 2 – why it works: It flattens the sacral promontory and rotates the pubic symphysis, freeing the anterior shoulder, often with suprapubic pressure.

Why the other options are wrong:

- A, Wood's corkscrew: an internal rotational manoeuvre used if McRoberts fails.
- C, Zavanelli: cephalic replacement, a last resort.
- D, Lovset: used for the arms in breech delivery, not shoulder dystocia.

Final Answer: McRoberts manoeuvre ⇒ **B**

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

Q8.

Solution

Concept – managing umbilical cord prolapse: Cord compression threatens the fetus, so speed matters.

Step 1 – name the immediate step: Elevate the presenting part off the cord and arrange immediate caesarean section when the fetus is alive and full dilatation is not present.

Step 2 – supporting measures: Knee-chest or head-down position, and stopping any oxytocin, reduce cord compression while preparing for delivery.

Why the other options are wrong:

- A, start oxytocin: worsens compression and is contraindicated.
- B, await spontaneous delivery: risks fetal death from cord compression.
- D, give an oxytocic and observe: delays the needed operative delivery.

Final Answer: Elevate presenting part and deliver by caesarean ⇒ **C**

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



Q9.

Solution

Concept – defining precocious puberty: An age threshold separates normal from precocious development.

Step 1 – state the age: In girls, precocious puberty is the appearance of secondary sexual characteristics before **8 years** of age.

Step 2 – note the boys' figure: For boys the cut-off is 9 years; the commonest form in girls is idiopathic central precocious puberty.

Why the other options are wrong:

- B, 10 years: within the normal age of pubertal onset.
- C, 12 years: a typical age for menarche, not precocious.
- D, 14 years: development after this age would instead be assessed for delay.

Final Answer: Before 8 years ⇒

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

Q10.

Solution

Concept – adolescent abnormal uterine bleeding: The immature reproductive axis explains most cases.

Step 1 – name the cause: Anovulatory cycles from an immature hypothalamic-pituitary-ovarian axis are the commonest cause soon after menarche.

Step 2 – mechanism: Without ovulation there is unopposed oestrogen and no progesterone, so the endometrium sheds irregularly.

Why the other options are wrong:

- A, endometrial carcinoma: virtually never seen at this age.
- B, leiomyoma: a cause in older women, rare in adolescents.
- D, cervical polyp: an uncommon cause of adolescent bleeding.

Final Answer: Anovulatory cycles ⇒

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



Q11.

Solution

Concept – Rotterdam criteria: Two of three features establish this diagnosis.

Step 1 – match the picture: Oligomenorrhoea, clinical hyperandrogenism (hirsutism) and polycystic ovaries fit **polycystic ovary syndrome**, needing any two of the three after exclusion.

Step 2 – exclusion: Other causes of androgen excess must first be ruled out.

Why the other options are wrong:

- A, Cushing syndrome: would show striae, central obesity and hypertension.
- B, congenital adrenal hyperplasia: raised 17-hydroxyprogesterone, usually earlier onset.
- C, hyperprolactinaemia: causes galactorrhoea and amenorrhoea, not this triad.

Final Answer: Polycystic ovary syndrome ⇒ D

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

Q12.

Solution

Concept – FIGO staging methods: Different genital cancers use different staging approaches.

Step 1 – identify the method: Endometrial and ovarian carcinomas are staged by **surgico-pathological FIGO staging**, based on operative and histological findings.

Step 2 – contrast: Carcinoma cervix has traditionally been staged clinically, though the FIGO 2018 revision now allows imaging and pathology.

Why the other options are wrong:

- A, clinical examination alone: this is the older cervical approach, not for endometrium or ovary.
- B, tumour size on ultrasound: size alone does not define these stages.
- C, Bethesda system: a cervical cytology reporting system, not a staging tool.

Final Answer: Surgico-pathological FIGO staging ⇒ D

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



Q13.

Solution

Concept – tumour markers in gynaecological oncology: Each malignancy has a characteristic marker.

Step 1 – match ovarian carcinoma: CA-125 is used to monitor treatment response and detect recurrence in epithelial ovarian carcinoma.

Step 2 – caution: It is not a good screening test, as it rises in benign conditions like endometriosis and pelvic inflammatory disease.

Why the other options are wrong:

- A, AFP: raised in yolk sac (endodermal sinus) germ cell tumours.
- C, beta-hCG: marker of gestational trophoblastic disease and choriocarcinoma.
- D, CEA: associated with colorectal and mucinous tumours, not the standard ovarian monitor.

Final Answer: CA-125 $\Rightarrow$ **B**

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

Q14.

Solution

Concept – first-line ovulation induction in PCOS: Recent evidence has shifted the preferred oral agent.

Step 1 – name the agent: Letrozole, an aromatase inhibitor, is now first-line for ovulation induction in anovulatory PCOS, with higher live-birth rates than clomiphene.

Step 2 – mechanism: It lowers oestrogen, releasing the pituitary to raise FSH and recruit a follicle.

Why the other options are wrong:

- A, clomiphene citrate: an effective older agent, now second to letrozole in PCOS.
- C, tamoxifen: a selective oestrogen receptor modulator used occasionally, not first-line.
- D, bromocriptine: used for ovulation only when hyperprolactinaemia is the cause.



Final Answer: Letrozole $\Rightarrow$ B

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

Q15.

Solution

Concept – the hypothalamic-pituitary-ovarian axis: The axis runs top-down from hypothalamus to ovary.

Step 1 – identify X: The hypothalamus releases **gonadotropin-releasing hormone (GnRH)**, which acts on the anterior pituitary to secrete FSH and LH.

Step 2 – downstream: FSH and LH then drive ovarian follicle growth and the secretion of estradiol and progesterone.

Why the other options are wrong:

- A, estradiol: an ovarian hormone that feeds back on the axis, not the hypothalamic signal.
- B, progesterone: secreted by the corpus luteum, downstream of X.
- D, inhibin: an ovarian hormone that selectively suppresses FSH, not the releasing hormone.

Final Answer: Gonadotropin-releasing hormone (GnRH) $\Rightarrow$ C

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



Answer Key

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

