



# OBSTETRICS

medpgnotes

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## KEY TO THIS DOCUMENT

Text in normal font – Must read point.  
Asked in any previous medical entrance  
examinations

**Text in bold font** – Point from Harrison's  
text book of internal medicine 18<sup>th</sup>  
edition

*Text in italic font* – Can be read if  
you are thorough with above two.

## OBSTETRIC ANATOMY

## ANATOMY IN OBSTETRICS

Motor Nerve supply of detrusor	S2,S3,S4
Weight of normal uterus	45 – 60 gm
Cholinergic fibres of uterus travel via	S2,S3,S4
Nerve root blocked in pudendal nerve block	S2,S3,S4
Uterine blood flow at term	500 – 750 ml/min
Motile spermatozoa found in wet mount of vaginal secretion are indicative of intercourse within past	24 hours
Thickness of endometrium at the time of implantation	5-6 mm
Fetal circulation is first established and separated from maternal circulation at the age of	21 days
<i>Oxygen content of blood sent to upper body during fetal life is higher than that sent to lower body</i>	<i>Oxygenated blood passes through foramen ovale to left ventricle</i>
<i>Persistence of fetal circulation (persistent pulmonary hypertension)</i>	<i>Presence of cyanosis, common in babies having meconium staining of liquor, <math>paO_2</math> in right radial artery is often higher than lower limb arteries</i>
How many days after ovulation placental circulation is established	18 – 21 days
Trophoblast give rise to	Placenta, Chorion, Amnion
Syncytiotrophoblast and cytotrophoblast differentiate on	8 days
Separate fetal blood from syncytiotrophoblast	Fetal capillary membrane, Mesenchyme of intervillous blood space, Cytotrophoblast
Does NOT separate fetal blood from syncytiotrophoblast	Decidua parietalis
Umbilical cord is covered by	Amnion
Oxygenated blood from placenta to heart in utero by	Umbilical vein, IVC
Do NOT carry deoxygenated blood in fetal circulation	Umbilical vein
<i>Fetal blood is returned to umbilical arteries and placenta through</i>	<i>Two hypogastric arteries</i>
Single umbilical artery on examination of umbilical cord after delivery	Indicator of considerably increased incidence of major malformation of fetus
<i>Umbilical artery catheter is removed only if</i>	<i><math>PiO_2 &gt; 0.4</math></i>
Folds of Hoboken are found in	Umbilical cord
No of vessels in cut section of umbilical cord	3
Umbilical cord usually fall after	5-10 days
Placenta has	2 arteries and 1 vein
Weight of placenta at term	500 gm
Placenta is formed by	Decidua basalis, Chorion frondosum
Blood flow in intervillous space at term	500 ml
Bleeding into decidua basalis leads to	Separation of placenta
Fetal blood loss in abnormal cord insertion is seen in	Vasa previa
Marginal insertion of cord into placenta	Battledore placenta

<i>Succenturiate placenta is commonly associated with</i>	<i>Retained placenta</i>
Amniotic membrane	AVASCULAR, Provides maximum tensile strength, Develops after 2-7 days of gestation, Fetal ectoderm
Fetal membranes include	Amnion, chorion, decidua capsularis
NOT a fetal membrane	Yolk sac
Internal organs in fetus develops at	6 weeks
Insulin secreted by fetal pancreas by	12 weeks
Urine formation in intrauterine life starts at	3 months
Lanugo hair appears at	4 months
After 28 weeks of gestation	Alive, >1000 gm, Phosphatidyl glycerol present
Phosphatidyl glycerol appears in amniotic fluid at	35 weeks

## OBSTETRIC DIAMETERS

True pelvis refer to	Lower part of pelvis
<i>Sacral promontory</i>	<i>Anterior margin of first sacral vertebra</i>
Smallest diameter of true pelvis	Interspinous diameter
Most important diameter of pelvis during labor	Interspinous diameter of outlet
Shortest anteroposterior diameter of pelvic inlet	Obstetric conjugate
Obstetric conjugate definition	Distance between promontory of sacrum to point above pubic symphysis
Obstetric conjugate	10 cm
Critical obstetric conjugate for trial of labor	10 cm
Diagonal conjugate is defined as distance between	Lower border of symphysis pubis and the sacral promontory
Obstetric conjugate is computed by separating 1.5 to 2 cm from	Diagonal conjugate
Can be assessed directly	Diagonal conjugate
Diagonal conjugate	12 cm
Maximum diameter of pelvic inlet	Transverse diameter
Shortest diameter of pelvic outlet	Posterior sagittal diameter
Shortest diameter of fetal head	Bitemporal diameter
Most important plane in obstructed labor	Plane of least pelvic dimension

## FETAL DIAMETERS AND PRESENTATION

Normal fetal heart rate at 37 – 40 weeks of pregnancy	120 – 160 per minute
Longest diameter of fetal skull	Mentovertical > Submentovertical Occipitofrontal
Diameter in face presentation	Submentobregmatic, Submentovertical
Shortest diameter of fetal skull	Submentobregmatic
Fully extended face	Submentobregmatic
Bitemporal diameter of fetus	8 cm
Shortest diameter of fetal skull	Bitemporal
Fetal weight can be assessed by	Biparietal diameter
Commonest diameter of engagement	Suboccipitofrontal
Suboccipitofrontal diameter	10 cm



Largest Fetal Diameter corresponding to Pelvis	Occipitofrontal
Engaging diameter in deflexed head is	Occipitofrontal diameter
Fetal diameter NOT measuring 9.5 cm	Occipitofrontal
When vertex is well flexed, presentation is	Vertex
Commonest type of presentation	Vertex
MC type of vertex presentation	Left occipitotransverse
Abnormal attitude	Face presentation
NOT a USG fetal growth diameter	Transcerebellar diameter

## PHYSIOLOGY OF OBSTETRICS

### HCG AND HPL

Human placenta	Haemochorial
Placenta develops from	Chorion frondosum & Decidua basalis
Decidua at site of implantation	Decidua basalis
Placental hormone	hCS is diabetogenic, hCG rise leads to nausea luteal placental shift at 8 – 10 weeks
NOT true about placental hormone	Progesterone production require fetal steroidogenic tissue
Insulin like growth factor is secreted by	Trophoblast
Role of human placental lactogen	Growth of fetus
Hormones secreted by placenta exclusively	HCG, HPL
Schwangerschaft protein	Pregnancy specific beta 1 glycoprotein
NOT secreted by placenta	Prolactin
Chemical pregnancy	Positive beta HCG and absent gestational sac
HCG	Non specific alpha and specific beta subunit
HCG is secreted by	Placenta
Hcg is secreted by	Syncytiotrophoblast
HCG	Alpha subunit is identical to LH, FSH and TSH, Maximum level is seen at 60 – 70 days of gestation
Doubling time of hcg	1.4 – 2 days
In early pregnancy, doubling time of hcg concentration in plasma is	48 hours
Highest hCG levels seen in	60 – 70 days
Peak level of HCG in pregnancy at	Early gestation
<i>NOT a function of HCG</i>	<i>Inhibition of relaxin</i>
At what level of beta HCG, normal pregnancy can be detected by Transvaginal ultrasound	1000 IU/ml
Earliest diagnostic test of pregnancy	Beta Hcg
Minimum level of beta HCG detected by radioimmunoassay	0.001 IU/ml
Most sensitive method of quantitative measurement of hcg	Radioimmunoassay
<i>Positive pregnancy test with serum progesterone level of less than 5 ng/ml</i>	<i>Non viable pregnancy</i>

## SIGNS OF PREGNANCY

Minimum number of antenatal visits	3
<i>Minimum three antenatal visits</i>	<i>20, 32, 36 weeks</i>
Ideal number of antenatal visits	12-14
Antenatal visits after 36 weeks should be made	Once a week
Position used for bimanual examination in OPD	Dorsal position with thighs flexed
Per rectal palpation of uterus in	Virgins
Associated with increased risk of normal pregnancy	Increased production of clotting factors by liver
Vagina in normal pregnancy	Increased number of lactobacilli
Short statured primigravida has height less than	140 cm
Urine collected in pregnant female by	Early morning sample
Wied test is used to differentiate	Cytohormonal study to differentiate perimenopause from pregnancy
Placental localization is done by	Placentography
USG of umbilical artery is to know about	Heart beat
Uterine soufflé	Due to increase in blood flow through dilated uterine vessels
Radiological investigation in a female of reproductive age should be restricted to	First 10 days of menstrual cycle
Clinical feature of Pseudocyesis	Quickening, amenorrhea, false labor
NOT a feature of Pseudocyesis	Enlargement of UTERUS
Most diagnostic sign of pregnancy	Fetal heart sounds
Positive sign of pregnancy	Detection of fetal parts in USG/X-ray
Most striking symptom of pregnancy	Cessation of Menstruation
Pathognomic sign in abdominal pregnancy	Weinberg sign
NOT a definite sign of pregnancy	Amenorrhea
Changes that occur in second trimester of pregnancy	Braxton Hick's contraction, Quickening
Braxton hick contraction	Occurs during most months of pregnancy
<i>Braxton hick contraction</i>	<i>Painless, rules out abdominal pregnancy, seen in hematometra</i>
<i>NOT true about Braxton hick contraction</i>	<i>They aid in cervical dilatation during first stage of labor</i>
Braxton hick's contractions are absent in	Abdominal pregnancy
Pregnancy is confirmed by	Fetal heart activity, Fetal movement by examiner, Fetal sac in USG
Quickening felt at	16 – 20 weeks
Internal ballotment	16 <sup>th</sup> week to 28 <sup>th</sup> week
<i>External ballotment</i>	<i>20 weeks</i>
Carunculae Myrtiformes is diagnostic of	Previous child birth
Test done for routine pregnancies	Syphilis
Absolute diagnosis of pregnancy	Fetal heart rate, Fetal movements, fetal skeleton in X ray
NOT used for establishing antenatal diagnosis	Deciduas
NOT a presumptive sign of pregnancy	Fetal movement perception by examiner
Signs positive in early pregnancy	Hegar sign, Palmer sign, Goodell sign, Osiander sign
In early pregnancy, clinical signs of feeling cervix and body of bulky uterus separated because of softened isthmus at 6-10 weeks of gestation	Hegar sign

Hegar sign of pregnancy is	Softening of isthmus
Hegar sign elicited in	Early pregnancy
Hegar sign elicited by	8 weeks
<i>Triad of enlarged upper part of uterus, soft middle part of uterus, firm cervix</i>	<i>Hegar sign</i>
Softening of cervix with lateral implantation (one half is more firm than other half)	Piskacek sign
Chadwick sign	Bluish discolouration of vagina
Jacquier sign	Bluish hue of vagina
Osiander sign	Pulsation in lateral vaginal fornix
Palmer sign elicit	Intermittent uterine contraction
Palmer sign in pregnancy related to	Rhythmic contractions of uterus
<i>Laden sign</i>	<i>Central part of isthmus is soft</i>
<i>Von Fernvard sign</i>	<i>Fundus is soft</i>
NOT an early sign of pregnancy	Cullen sign, Lemon sign
Best investigation to diagnose fetal age	Serial ultrasound
Earliest sign of gestation evidenced by decidual thickness by USG	29 – 35 days
20 weeks pregnancy diagnosed by	USG
Earliest detection of pregnancy by USG is by	Gestational sac
Manual appreciation of fetal parts and fetal movements by examination is earliest possible by	20 weeks
Study of fetal parts in first trimester with least radiation hazard	Ultrasound
Fetal heart can be detected earliest with transvaginal sonography at (from last menstrual period)	46 days
Transvaginal USG can detect fetal cardiac activity in	6 weeks
In transvaginal USG, earliest detection of gestational sac by	14 days after ovulation
Finding seen earliest in USG	Yolk sac
Earliest ultrasound sign of pregnancy in a transabdominal ultrasound scan is	Fundal endometrial thickening
Transabdominal USG can detect fetal cardiac activity in	8 weeks
USG done at 18-20 weeks mainly to	Detect fetal anomaly
Antenatal Doppler	In normal pregnancy, placental resistance is low. Reduction in end diastolic flow is associated with poor outcome, Reduction in EDF is associated with IUGR, S/D ratio is high in IUGR, Flow velocities and S/D ratio are useful to evaluate high risk pregnancies
Earliest sign of fetal life is detected by	Real time USG
6 weeks of pregnancy, safest method to confirm pregnancy	Doppler for fetal cardiac activity
32 weeks of gestation, Decreased uterus size, Fetal Movements Diminished, Investigation of Choice	USG Doppler
Doppler finding in USG in IUGR associated with worst prognosis	Reversal of diastolic flow
Most reliable indicator for measurement of gestational age in first trimester	Crown rump length
Normal crown rump length at birth	38 – 50 cm
Crown rump length 120 mm	14 weeks
Best parameter for estimation of fetal age by USG in	Femur length

third trimester	
Parameters used to estimate gestational age in last trimester	Abdominal circumference, BPD, Femur length

## PHYSIOLOGICAL CHANGES IN PREGNANCY

Total duration of Pregnancy	280 days/40 weeks/10 lunar months
Term delivery	40 weeks
<b>Pregnant woman not allowed for international travel after</b>	<b>32 weeks</b>
Overdistended uterus in 2 <sup>nd</sup> trimester	Wrong date, Hydramnios, Distended bladder, Twins, Fibromyoma
Average weight gain during pregnancy in poor Indian woman	6.5 kg
Net weight gain in pregnancy	10-12 kg
Net weight gain in pregnancy	24 lb (24 pounds)
Weight gain in pregnancy NOT related to	Smoking
Best method for assessing fetal well being at term by serial estimation of	Estriol
Prolactin levels highest during	Pregnancy and falls during lactation
Alpha and beta subunits NOT seen in	Prolactin
Intermediate cell predominance on vaginal cytology	Pregnancy
Character of vagina in normal pregnancy	Increase in number of lactobacilli
Oxytocin sensitivity during delivery	Increase
Decidual reaction and Arias stella reaction	Progesterone
Hormone essential for maintaining pregnancy	Progesterone
Arias stella reaction	Loss of polarity of nucleus, Presence of hyperchromatic nucleus, Specific to ectopic pregnancy
Aris stella reaction seen in	Ovarian pregnancy, Molar pregnancy, Interstitial pregnancy
Arias stella reaction NOT seen in	Salpingitis isthmica noda
During pregnancy, increased respiratory sensitivity to CO <sub>2</sub> due to higher circulatory levels of	Progesterone
Changes during pregnancy	Hyperplasia of thyroid and parathyroid, Increased pigmentation, Increased insulin
Changes during pregnancy	Increased cardiac output, Increased tidal volume, Decreased plasma protein concentration, Decreased residual volume, Decreased hematocrit
Truly physiological in pregnancy	Mild pedal edema, Increased GFR
Features of Pregnancy	Serum potassium decreased and sodium retention, Insulin level increase, Increased BMR
During fetal life, maximum growth is caused by	Insulin
Insulin resistance in pregnancy because of	Human placental lactogen, Progesterone, Estrogen
Characteristic lesion of pregnancy	Chloasma
<i>Dissection of which artery is common in pregnancy</i>	<i>Aorta</i>
<i>Blood cells increasing in pregnancy</i>	<i>WBC</i>
<i>Clotting factors increasing in pregnancy</i>	<i>All clotting factors except 11 and 13</i>
<i>Renal changes increasing in pregnancy</i>	<i>GFR and renal blood flow</i>
<i>Respiratory changes increasing in</i>	<i>Tidal volume, minute volume, airway</i>

<i>pregnancy</i>	<i>conductance</i>
<i>Protein changes in pregnancy</i>	<i>Total plasma protein, globulin, fibrinogen</i>
<i>Iron related parameters increasing in pregnancy</i>	<i>Serum transferrin, TIBC</i>
Cardiovascular change in last trimester of pregnancy	Shift of apical impulse lateral and upwards in left 4th intercostal space
Aggravated by pregnancy	Carditis
Maximum increase in cardiac output by which stage of pregnancy	32 weeks
Maximum cardiac output in pregnancy	Immediate postpartum period
During uterine contraction of labor, uterine blood flow	Decreases
Normal changes during pregnancy	Increased stroke volume, Increased intravascular volume
During pregnancy, maternal blood volume increased by	50%
Peripheral vascular resistance in pregnancy	Decreased
Abnormal CVS change in pregnancy	Right axis deviation, Early diastolic murmur
Abnormal finding in pregnancy	Supraclavicular murmur
Cardiovascular change in last trimester of pregnancy	Shift of apical impulse laterally and upwards in left 4 <sup>th</sup> intercostal space
Last to occur in pregnancy	Uterine snuffle
Uterine snuffle is due to	Increase in blood flow through dilated uterine vessels
<i>Changes in respiratory system in pregnancy</i>	<i>Tidal volume increases</i>
<i>Level of hormone unchanged in pregnancy</i>	<i>Vasopressin</i>
Supine hypotension is characteristic of	3 <sup>rd</sup> trimester
Supine hypertension syndrome	Compression of aorta and vena cava by gravid uterus when lying supine
Least likely physiological change in pregnancy	Increase in peripheral vascular resistance
Treatment for edema in pregnancy	Bed rest
Plasma fibrinogen in pregnancy	Increases
Increased pregnancy	Globulin, Fibrinogen, Leucocytes, Transferrin
Cause of increased risk of thromboembolism in pregnancy	Increased production of clotting factor by liver
Increase in blood volume by	40%
Increase in RBC volume	20%
Maximum plasma volume increase	50%
NOT increased in pregnancy	Vital capacity
NOT increased in pregnancy	Plasma osmolality
NOT increasing in pregnancy	Platelets
Clotting factor NOT increased in pregnancy	11
Clotting factor decreased in pregnancy	13
MC cause of decreased platelet in pregnancy	Benign gestational
Changes NOT occurring in pregnancy	Increase in blood viscosity
Urinary system during pregnancy	Increased GFR, Increased Renal blood flow, Hypertrophy of bladder musculature, Decreased activity of ureter
Urinary retention in pregnancy as early as	10 – 16 weeks
GFR in pregnancy increased by	50%
Normally present in urine of pregnant woman in third trimester	Glucose

<i>Pregnancy is associated with reduced risk of</i>	<i>Relapse of multiple sclerosis</i>
<i>Couvade syndrome</i>	<i>Partner experiences some of the symptoms of pregnant woman</i>

## NUTRITION AND PREGNANCY

Daily calorie requirement in pregnancy	2500 Kcal
Iron supplementation in pregnant women for	3 months
Calcium requirement per day during third trimester of pregnancy	1000 mg
Folic acid supplement reduces risk of	Neural tube defects
Folic acid initiated	Before conception
Demand NOT increased in pregnancy	Vitamin B12
NOT a criteria for fetal growth	Maternal weight gain

## GESTATIONAL TROPHOBLASTIC DISEASES

### FEATURES OF GESTATIONAL TROPHOBLASTIC DISEASES

Highest incidence of gestational trophoblastic disease	Asia
Gestational trophoblastic disease is of high risk, if it follows	Normal pregnancy
<i>MC cause of persistent trophoblastic disease after evacuation of hydatidiform mole evacuation</i>	<i>Residual mole</i>
Condition associated with H.mole	Hyperthyroidism
NOT associated with H.mole	Gestational diabetes
<i>Uterine height more than corresponding gestational age with complains of vomiting and per vaginal bleeding favors the diagnosis of</i>	<i>Hydatidiform mole</i>
Hydatidiform mole is due to	Degeneration of Chorionic villi
Hydatidiform mole	Trophoblastic proliferation, Hydropic degeneration
Chromosome number of H.mole	46XX
Luteal cysts	Molar pregnancy
<i>Doughy feel of uterus is associated with</i>	<i>Gestational trophoblastic diseases</i>
H.mole	Hysterectomy in selected cases, Thyrotoxicosis rare
In hydatidiform mole, blood cells do not develop because of defect in	Mesoderm
MC complication of molar pregnancy	Hemorrhage
<i>Sequale of vesicular mole</i>	<i>Chorioadenoma destruens (invasive mole)</i>
Abortion in H.mole often occurs at	4-6 months
Conversion of complete hydatidiform mole to invasive mole is indicated by	Plateau hcg, enlarged uterine size, persistence of theca lutein cyst
MC GTD following H.mole	Invasive mole