Cervical Cytology (1→18)

1) What percentage of cervical cancers are due to Pap screen failure?
   (a) 10%
   (b) 30%
   (c) 50%
   (d) 65%

2) What percentage of HPV 16 infections clear within 36 months?
   (a) 20%
   (b) 50%
   (c) 70%
   (d) 90%

3) A 36 year old has normal Pap cytology. What is her risk of a CIN 3 diagnosis over the next 3 years?
   (a) 1 in 100
   (b) 1 in 200
   (c) 1 in 500
   (d) 1 in 1000

4) A 36 year old has normal cytology and negative HPV. What is her risk of a CIN 3 diagnosis over the next 3 years?
   (a) 1 in 100
   (b) 1 in 200
   (c) 1 in 500
   (d) 1 in 1000

MATCH the risk of CIN2/3 with each Pap result.
5. ASCUS
   (a) 10%
6. ASC-H
   (b) 20%
7. LSIL
   (c) 40%
8. HSIL
   (d) 80%
9) Identify the **FALSE** statement (according to ACOG)
   (a) Begin cervical cytology screening at age 21 for all women
   (b) Screen all 21-29 year old women annually
   (c) Low risk women 30yo and over may have cervical cytology screening every 3 years if they previously had 3 consecutive negative screens
   (d) Women s/p benign hysterectomy with no history of cervical dysplasia no longer need Pap screens.
   (e) Cervical cancer screening could continue beyond age 70 in some cases.

10) Which patient needs annual cervical cytology screening?
    (a) HIV-positive
    (b) history of DES exposure
    (c) history of LEEP for CIN II-III
    (d) s/p renal transplant
    (e) all the above

11) Which patient with absent endocervical / transformation zone cells can follow-up in twelve months for repeat cytology screening?
    (a) 12 wks pregnant
    (b) HIV positive with history of normal paps
    (c) postmenopausal
    (d) all the above
    (e) a and c only

12) A 35yo G2P2 has a Pap result ASCUS, HR HPV positive. Next steps may include:
    (a) Check HPV 16/18 genotype
    (b) Immediate colposcopy
    (c) Repeat Pap and HPV screen in 6 months
    (d) a or b.
    (e) a or b or c

13) Which approach is **NOT** recommended for women with ASCUS with cervical biopsy of CIN1?
    (a) pap at 6 and 12 months
    (b) hpv at 12 months
    (c) pap and hpv at 12 months
    (d) none of the above
14) 21yo G0 presents with an HSIL Pap. Colposcopy with ECC reveals CIN1. Appropriate next steps may include:
   (a) Pap and colpo at 6month
   (b) immediate LEEP
   (c) Pap and HPV at 6 months
   (d) a or b
   (e) all the above

15) An asymptomatic postmenopausal 52 yo G0 with no prior abnormal Paps has LSIL on most recent Pap. You recommend
   (a) immediate colposcopy
   (b) HPV screen
   (c) repeat Pap in 6 months
   (d) any of the above are appropriate

16) 26yo at 26wks GA is noted to have her 1st LSIL pap. Appropriate next steps include:
   (a) colposcopy and biopsy
   (b) f/u colposcopy at 6wks postpartum
   (c) Pap q 3months
   (d) cesarean to avoid HPV infection in the newborn

17) A 34yo non-pregnant G2P2 has a screening pap smear AGC-NOS. Initial evaluation should include
   (a) Repeat Pap smear with HPV screen
   (b) If HPV positive, colposcopy
   (c) Colposcopy with endocervical curettage
   (d) All of the above

18) Indications for diagnostic conization include:
   (a) presence of adenocarcinoma in situ
   (b) a positive endocervical curettage
   (c) a patient with HSIL pap screen, but no obvious cervical or vaginal lesions
   (d) patients with negative ECC but the upper limits of a lesion cannot be easily identified
   (e) ALL of the above
Sterilization (19 → 20)

19) All of the following are contraindications for hysteroscopic sterilization **EXCEPT:**
   - (a) 4 wks postpartum
   - (b) unicornuate uterus
   - (c) copper allergy
   - (d) active pelvic infection
   - (e) prior bilateral tubal ligation

20) Percentage of women younger than 30 yo expressing regret after permanent sterilization?
   - (a) 5%
   - (b) 10%
   - (c) 20%
   - (d) 40%

Congenital uterine anomalies (21 → 25)

21) You are evaluating a 29 y.o. G0 new to your office who would like to get pregnant with husband of 1 year. Her gynecologic history reveals menarche age 12, monthly menses with severe dysmenorrhea, but otherwise normal flow x 5 days. Her medical history is unremarkable. She is quite nervous as she has never had a pelvic exam and has had trouble inserting tampons.

On speculum exam, you notice a thin mucosal tissue septum from the anterior to posterior wall extending along the entire vaginal length. You suspect a Mullerian fusion defect and remember from your CREOG review that all of the following are true about Mullerian anomalies **EXCEPT:**

   a. The overall incidence of Mullerian anomalies is 5%
   b. Patients usually have normal female karyotype
   c. Ovaries are also abnormal and patient may have premature ovarian failure
   d. Renal anomalies are often associated

22) As you continue your exam, you feel confident this a longitudinal vaginal septum as a result of a vertical fusion or canalization of the mullerian ducts and urogenital sinus. Other vertical fusion defects include:

   a. Cervical agenesis
   b. Unicornuate uterus
   c. Cribiform hymen
   d. Transverse septum
23) You complete your speculum exam and are sure there is only one normal appearing cervix. You tell the patient your findings and tell her you need to order more tests to determine her anatomy. You advise initially:
   a. Hysteroscopy, D&C
   b. Diagnostic laparoscopy
   c. CT scan
   d. Pelvic ultrasound

24) You order a pelvic ultrasound and the results show normal ovaries and kidneys but possible septate versus bicornuate uterus. To confirm the diagnosis you recommend:
   a. HSG
   b. Sonohysterogram
   c. MRI
   d. None of the above-no further imaging needed

25) You order an MRI and results show an intercornual diameter <2cm and a fibrous septum extending ¾ of the uterine length. The cervix and endometrium appear normal. The vaginal septum is confirmed. You counsel the patient on the following EXCEPT:
   a. Septate uterus is the most common mullerian anomaly
   b. She is unlikely to have associated obstetrical complications
   c. Hysteroscopic metroplasty improves pregnancy outcomes
   d. Jones and Tompkins metroplasty are performed transabdominally

**Uterine fibroids, adenomyosis, adnexal issues (26 → 30)**

26) 35 y.o. G2P2 African American woman is consults you for symptomatic uterine fibroids. She complains of heavy irregular bleeding and pelvic pressure. She would like to have one more child. You counsel her on all of the following regarding fibroids EXCEPT:
   a. large or fast growing fibroids should be removed because of high risk of leiomyosarcoma
   b. associated adverse pregnancy outcomes include abruption, malpresentation and dysfunctional labor
   c. Hereditary leiomyomatosis and renal cell cancer syndrome is caused by a mutation in the Fumarate Hydratase gene
   d. fibroids decrease in size during menopause
27) You review her recent pelvic ultrasound confirming several large intramural fundal fibroids, 5-7cm that greatly distorts the endometrium. After much discussion, you agree with your patient that abdominal myomectomy is her best option. The most likely outcome of her operation is:

   a. You will have to convert to hysterectomy intraoperatively
   b. Her irregular or heavy bleeding will resolve
   c. She will never have fibroids in future
   d. Minimal post-op adhesions will form

28) (PROLOG question) 40 yo woman with a history of endometriosis and pelvic pain has a complex adnexal mass on transvaginal ultrasonography. You inform her that the ultrasonographic characteristic most predictive of malignancy is :

   a. Free fluid in the cul-de-sac
   b. Papillary areas inside cyst
   c. Septations
   d. Size greater than 6cm
   e. Wall thickness of 2mm

29) A 16 yo G0 presents complaining of mild pelvic pain for the past several weeks. On exam you feel a 5cm fullness in the left adnexa. Pelvic ultrasound confirms a thin walled, 5 cm, unilocular left ovarian cyst. You recommend:

   a. Repeat US in 8 weeks
   b. Pelvic MRI
   c. CA-125
   d. Diagnostic laparoscopy

30) A 45 yo G3P2012 complains of menorrhagia and dysmenorrhea unrelieved by COC’s. Physical exam reveals a boggy 12-week sized uterus. EMBX and pelvic ultrasound prove normal. She wants a hysterectomy for adenomyosis. You counsel her on all of the following regarding adenomyosis **EXCEPT**: 

   a. Pelvic ultrasound best detects adenomyosis
   b. Histopathology of adenomyosis shows irregular endomyometrial junction with endometrial glands and stroma present in the myometrium at variable distances.
   c. UAE can help treat bleeding and pain
   d. Hysterectomy is most effective treatment
GYN Surgery (31 \( \rightarrow \) 40)

31) Of the following gynecologic procedures, which one does NOT require preoperative antibiotic prophylaxis?
   a) induced abortion
   b) total abdominal hysterectomy
   c) open abdominal myomectomy
   d) anterior colporrhaphy

32) A 35 year old undergoes abdominal multiple myomectomy. What is her risk of undergoing another fibroid-related surgery in the future (either hysterectomy or repeat myomectomy)?
   a) 5%
   b) 10%
   c) 25%
   d) 40%

33) Your post-operative patient has symptomatic anemia and you are consenting her for blood transfusion. She is at greatest risk for:
   a) Hepatitis B acquisition
   b) Hepatitis C acquisition
   c) HIV acquisition
   d) RBC allosensitization

34) In patients with well-documented penicillin allergy undergoing hysterectomy, the recommended antibiotic prophylaxis is:
   a) clindamycin
   b) metronidazole
   c) vancomycin
   d) clindamycin plus gentamicin

35) During a suction curettage procedure, you notice omentum in the suction tubing. Management should include all of the following EXCEPT:
   a) immediate abdominal exploration
   b) discontinuation of procedure
   c) completion of procedure under ultrasound-guidance
   d) monitoring for active uterine bleeding

36) The most common time of ureteral injury in gynecologic surgery:
   a) division of the uterine artery
   b) division of the infundibulopelvic ligament
   c) mobilization of the bladder
   d) closure of the vaginal cuff
37) You just performed a hysteroscopic myomectomy with glycine deficit 1200 mL. The earliest sign/symptom of hyponatremia for this patient would be:
   a) confusion
   b) seizures
   c) nausea
   d) blurry vision

38) While performing a diagnostic laparoscopy with closed entry technique, a Veress needle injury is noted in the small bowel. The next step in management would be:
   a) conversion to laparotomy
   b) suture reapproximation of the puncture site
   c) close observation
   d) bowel resection

39) Optimal placement of lateral trocars for laparoscopic surgeries is:
   a) 8 cm superior to pubic symphysis and 5 cm lateral to midline,
   b) 5 cm superior to pubic symphysis and 8 cm lateral to midline
   c) 4 cm superior to pubic symphysis and 5 cm lateral to midline
   d) 5 cm superior to pubic symphysis and 10 cm lateral to midline

40) When counseling a patient regarding global endometrial ablation, you inform her that patient satisfaction rates range from:
   a) 50-60%
   b) 60-70%
   c) 70-80%
   d) 80-90%

**GYN Surgery (41 - 50)**

41. A patient had a long vaginal hysterectomy for prolapse and menorrhagia. Vaginal access was challenging during the case. Although the case was long, the procedure was done successfully. POD#1 she is unable to lift her left knee and cannot extend her left leg. She also cannot feel anything along the anterior portion of her left thigh. What is the patient's diagnosis?
   a) left lower extremity thrombosis
   b) left ilio-inguinal nerve transection
   c) left lateral peroneal nerve palsy
   d) left femoral nerve palsy
42. A 75 year old postmenopausal female with hypertension, hypercholesterolemia, obesity, diabetes, and emphysema reports 1 episode of postmenopausal bleeding. PUS reveals a thin homogeneous endometrium of 5mm and a 5 cm simple right adnexal cyst. The patient is asymptomatic from the cyst, but continues to have intermittent spotting ~2-3 times per year for the past 2 years. How would you approach the postmenopausal bleeding evaluation?
   a) expectant management
   b) pelvic ultrasound surveillance
   c) endometrial sampling
   d) hysterectomy

43. What are your next recommendations for the patient above regarding the incidental right adnexal cyst?
   a) no further testing or treatment warranted since this is an incidental finding and she is asymptomatic
   b) surgical removal since this is a postmenopausal mass
   c) ultrasound surveillance
   d) US guided cyst aspiration and assessment of CA-125 level for more diagnostic information

44. A 35 yo requests routine GYN annual examination. She has no complaints. On review of her family history, she informs you that her maternal uncle was diagnosed with breast cancer. She is of Ashkenazi Jewish descent. What would you recommend next?
   a) self breast exams every 6 months
   b) annual mammograms starting at age 35yrs
   c) genetic counseling
   d) risk reducing prophylactic BSO

45. What would you recommend for the same patient above if she is of non-Ashkenazi Jewish heritage?
   a) self breast exams every 6 months
   b) annual mammograms starting at age 35yrs
   c) genetic counseling
   d) risk reducing prophylactic BSO

46. A 30yo requests contraception. She recently met a partner and would like to become sexually active. She has well-controlled hypertension and migraine headaches without aura. She would like to conceive in 3 months after she completes her nursing degree. Which contraceptive option would you advise?
   a) levonorgestrel Intrauterine System
   b) depot medroxyprogesterone acetate
   c) combined oral contraception
   d) progestin only oral contraception
47. A 35 yo patient with a family history of ovarian cancer undergoes genetic testing and is found to carry a BRCA-1 mutation. She opts to undergo prophylactic risk-reducing BSO.

What are her chances of an occult ovarian neoplasm at time of risk-reducing BSO?
  a) 1%
  b) 10%
  c) 20%
  d) 30%

48. What is her ovarian cancer risk reduction?
  a) 20-30%
  b) 50-60%
  c) 80-90%
  d) 100%

49. What is her breast cancer risk reduction?
  a) 20-30%
  b) 50-60%
  c) 80-90%
  d) 100%

50. What is her residual risk of primary peritoneal cancer?
  a) 1%
  b) 10%
  c) 25%
  d) 50%

**Urogynecology (51 → 58)**

51. Vaginal estrogen can help menopausal patients with all of the following **EXCEPT**:
   (a) frequent urinary tract infections
   (b) urinary stress incontinence
   (c) urinary urgency
   (d) urinary frequency

52. Kegel exercises can help patients with all of the following **EXCEPT**:
   (a) urinary stress incontinence
   (b) urinary frequency
   (c) urinary urgency
   (d) frequent urinary tract infections
53. Bladder irritants include:
   (a) alcoholic beverages
   (b) carbonated drinks
   (c) caffeinated drinks
   (d) spicy foods
   (e) fruit juices
   (f) all of the above

54. Unindicated treatment for aggravating nocturia once a night would be:
   (a) decreased evening fluids
   (b) decreased bladder irritants
   (c) bladder training
   (d) oxybutynin
   (e) mild sedatives

55. Side effects of oxybutynin and similar medications include:
   (a) dry mouth
   (b) urinary retention
   (c) dental cavities
   (d) heartburn
   (e) both (a) and (b)
   (f) all of (a) and (b) and (c) and (d)

56. Constipation can worsen which of the following?
   (a) urinary frequency
   (b) urinary urgency
   (c) urinary stress incontinence
   (d) overflow incontinence
   (e) both (a) and (b)
   (f) Both (a) and (c)
   (g) Both (c) and (d)

57. LEAST likely to help nocturia five times a night (small volumes)?
   (a) decreased bladder irritants
   (b) bladder training
   (c) decreased evening fluids
   (d) oxybutynin
   (e)

58. First line treatment for mixed incontinence includes all of the following EXCEPT:
   (a) estrogen
   (b) oxybutynin
   (c) pessaries
   (d) bladder training

Quizmasters: Doctors Lucy Chie, Hye-Chun Hur, Rebekah Viloria, Paul Winig, and Linda Yang
Survey:

59. How long did this quiz take you to complete at home?

(a) I didn’t have time to try it before January 6th at 9 am 
(b) 15 minutes 
(c) 1 hour 
(d) 2 hours 
(e) 3 hours 
(f) I’m not sure of the total time

60. How do you feel about this format of take-home quiz + audience response slideshow? Please try to be honest – you will not hurt anyone’s feelings if your impression is (a).

(a) Negative 
(b) Neutral 
(c) Positive 
(d) Very Positive