# Mother in Labour MCQs Template

## 1. Identifying True Labour

Question 1:

Which of the following findings confirms true labour in a primigravida at 38 weeks?

A. Contractions that become regular but no cervical change

B. [✔] Regular painful contractions accompanied by progressive cervical dilation

C. Contractions that intensify with walking but cervix remains closed

D. Occasional tightening in the abdomen relieved by rest

Indication:

True labour is confirmed by progressive cervical change (dilation and/or effacement) in the presence of regular contractions.

High-Yield Summary Points:

* - Definition of True vs. False Labour:
* • True labour: Regular, painful contractions with progressive cervical dilation.
* • False (Braxton Hicks): Irregular contractions without cervical change, often relieved by rest or position change.
* - Key Signs:
* • Cervical effacement and dilation
* • Contractions increase in frequency, duration, and intensity
* • Show (blood-tinged mucus) and rupture of membranes may follow
* - Other Options Explained:
* 1. Regular contractions without cervical change → False labour
* 2. Intensification with walking but no dilation → Braxton Hicks
* 3. Occasional tightness relieved by rest → Braxton Hicks pattern
* - Why Cervical Change Matters: Cervical effacement (thinning) and dilation indicate the uterus and cervix are responding to labour hormones.

Mnemonic for True Labour Assessment:

“C’CONTRACTION”

* - Cervical change
* - Contractions regular, painful
* - Opening (dilation)
* - Not relieved by rest
* - Timing increases
* - Regular pattern
* - Amniotic membranes may rupture
* - Change in effacement
* - Toward delivery
* - Intensity increases
* - Observe for show
* - Notatory (noticeable) pain

Predictive Questions:

1. Which hormone primarily causes cervical ripening at term?

2. A 40 weeks woman has irregular low back pain but no effacement or dilation—what is the most likely diagnosis?

3. What is “lightening,” and when does it typically occur?

## 2. Stages of Labour and Cervical Dilation

Question 2:

During the first stage of labour, cervical dilation from 4 cm to 10 cm corresponds to which phase?

A. Latent phase

B. [✔] Active phase

C. Transition phase

D. Second stage

Indication:

The active phase (4–10 cm dilation) is characterized by more rapid cervical dilatation.

High-Yield Summary Points:

* - Phases of First Stage:
* 1. Latent phase: 0–3 cm dilation, mild irregular contractions
* 2. Active phase: 4–10 cm dilation, contractions become stronger, longer, and closer (often 3–5 min apart)
* 3. Transition phase: 8–10 cm (sometimes considered part of active), very intense contractions
* - Second Stage: Full dilation → delivery of fetus
* - Why Not Other Choices:
* 1. Latent phase: Up to 3 cm dilation, typically slower progress
* 2. Transition phase: Last part of active, often 8–10 cm with very strong contractions—clinically considered part of active for many guidelines but sometimes distinguished
* 3. Second stage: Begins after full dilation (10 cm) until delivery
* - Clinical Relevance:
* • Identify when to call obstetrician for augmentation (e.g., oxytocin) if dilation <1 cm/hour in active phase.
* • Monitor maternal vitals and fetal heart rate more closely in active phase due to stress.

Mnemonic for Stages of Labour:

“LET’S PUSH”

* - Latent (0–3 cm)
* - Early Active (4–6 cm)
* - Transition (8–10 cm)
* - Second stage (10 cm → birth)
* - Placental stage (delivery of placenta)
* - Uterine contraction continues
* - Suturing/repair
* - Homeostasis (monitor bleeding)

Predictive Questions:

1. In the latent phase, average rate of cervical dilation per hour is:

* - A. 1 cm/hr
* - B. 0.5 cm/hr
* - C. 2 cm/hr
* - D. 3 cm/hr

2. A labouring woman’s dilation stalls at 5 cm for 3 hours with moderate contractions—what is the next best step?

3. Define the normal duration of the active phase in a multiparous woman.

## 3. Cardinal Movements of Labour

Question 3:

Which of the following is the correct order of the cardinal movements of labour for a vertex presentation?

A. Engagement → Extension → Internal rotation → Descent → Expulsion → External rotation

B. Engagement → Descent → Flexion → Internal rotation → Extension → External rotation

C. [✔] Engagement → Descent → Flexion → Internal rotation → Extension → External rotation

D. Flexion → Engagement → Extension → Internal rotation → Descent → External rotation

Indication:

The classic sequence is engagement → descent → flexion → internal rotation → extension → external rotation.

High-Yield Summary Points:

* - Definition of Cardinal Movements (Vertex):
* 1. Engagement: Head enters pelvic inlet, biparietal diameter at pelvic brim
* 2. Descent: Continued downward movement through pelvis
* 3. Flexion: Chin to chest so smallest suboccipito–bregmatic diameter presents
* 4. Internal rotation: Occiput rotates anteriorly (toward pubic symphysis)
* 5. Extension: Head extends under pubic symphysis as it emerges
* 6. External rotation (Restitution): After head emerges, rotates to align with shoulders
* 7. Expulsion: Body follows head
* - Other Options Explained:
* 1. Option 1 omitted “Flexion” and mis-ordered “Internal rotation” vs. “Descent.”
* 2. Option 4 places flexion after engagement, but flexion actually occurs during descent phase.

Mnemonic for Cardinal Movements:

“Every Day Favors In Eager Expectant Exits”

* - Engagement
* - Descent
* - Flexion
* - Internal rotation
* - Extension
* - External rotation
* - Expulsion

Predictive Questions:

1. During internal rotation, the fetal occiput moves from which position to which position?

2. Which cardinal movement corresponds with the fetal head passing under the pubic symphysis?

3. How does an OP (occiput posterior) presentation alter the typical sequence of cardinal movements?

## 4. Monitoring Fetal Heart Rate Patterns

Question 4:

A labouring mother's electronic fetal monitor shows recurrent, late decelerations with contractions. What is the most appropriate immediate intervention?

A. Continue routine monitoring—this is normal in active labour

B. [✔] Reposition the mother to left lateral and administer oxygen

C. Increase oxytocin infusion rate

D. Prepare for immediate forceps delivery

Indication:

Late decelerations indicate uteroplacental insufficiency. First response is maternal repositioning (to improve uterine perfusion) and oxygen.

High-Yield Summary Points:

* - FHR Decelerations:
* - Early decelerations: Mirror contractions, due to fetal head compression—benign
* - Variable decelerations: Vary in timing, due to cord compression—if severe/prolonged, intervene
* - Late decelerations: Begin after contraction peak, return after contraction ends—indicate uteroplacental insufficiency, fetal hypoxia risk
* - Management of Late Decelerations:
* 1. Reposition mother (left lateral) to relieve aortocaval compression
* 2. Administer oxygen via face mask (8–10 L/min)
* 3. Stop oxytocin if being infused (to lessen uterine hyperstimulation)
* 4. Notify obstetrician, consider tocolysis (e.g., terbutaline) if hyperstimulation
* 5. Prepare for intrauterine resuscitation measures or expedite delivery if persistent
* - Why Not Other Choices:
* 1. Normal routine monitoring is inappropriate—late decels are ominous
* 2. Increasing oxytocin could worsen uterine hyperstimulation and exacerbate late decels
* 3. Forceps delivery is premature without first attempting intrauterine resuscitation

Mnemonic for Late Decelerations Management:

“LION — L”

* - Lateral (reposition mother)
* - Increase IV fluids (bolus)
* - Oxygen (maternal)
* - Notify provider and Notify tocolysis/stop oxytocin

Predictive Questions:

1. What cut-off interval between deceleration nadir and contraction peak defines a “late” deceleration?

2. Describe the primary cause of variable decelerations and first-line management.

3. If a mother on oxytocin has late decelerations, what is the correct adjustment of oxytocin infusion?

## 5. Pain Relief in Labour

Question 5:

Which of the following is a contraindication to epidural analgesia in a mother in active labour?

A. Platelet count of 100,000 /mm³ without coagulopathy

B. [✔] Sepsis with bacteremia

C. History of lumbar spine surgery 10 years ago

D. Controlled hypertension on labetalol

Indication:

Sepsis with bacteremia is a contraindication to epidural due to risk of introducing pathogens into the epidural space.

High-Yield Summary Points:

* - Epidural Analgesia:
* - Provides effective pain relief from active labour through second stage
* - Involves injection of local anesthetic ± opioid into the epidural space
* - Absolute Contraindications:
* - Maternal refusal
* - Infection at injection site or systemic (bacteremia/sepsis)
* - Uncorrected hypovolemia
* - Coagulopathy (e.g., INR >1.5, platelets <80,000 if risk factors)
* - Increased intracranial pressure (mass lesion)
* - Relative Contraindications (risk vs. benefit):
* - Prior spine surgery → may decrease efficacy or increase technical difficulty, but not absolute if evaluated by anesthetist
* - Controlled hypertension → monitor blood pressure after epidural
* - Why Not Other Choices:
* 1. Platelet 100,000 /mm³ alone is borderline but often acceptable if no other coagulopathy (some guidelines allow ≥75,000–100,000)
* 2. Lumbar surgery may make placement more difficult, but not an absolute contraindication—discuss with anesthetist
* 3. Controlled hypertension is an indication for careful monitoring, not a contraindication

Mnemonic for Epidural Contraindications:

“SICU CO”

* - Sepsis (systemic infection)
* - Infection at site of needle insertion
* - Coagulopathy
* - Uncorrected hypovolemia
* - Communication/refusal by patient
* - Other (increased ICP)

Predictive Questions:

1. A labouring woman with von Willebrand disease (Type 1) desires an epidural—what pre-procedure labs and interventions are needed?

2. How should you manage sudden maternal hypotension after epidural placement?

3. List three benefits and two risks of epidural analgesia during labour.

## 6. Use of Partograph in Labour Monitoring

Question 6:

On a partograph, if the woman's cervical dilation remains at 5 cm for 3 hours in the active phase, what action is recommended?

A. Allow continuation of labour; check again in 2 hours

B. [✔] Consider augmentation with oxytocin

C. Prepare for immediate cesarean section

D. Encourage mother to ambulate and drink ice-cold water

Indication:

Lack of cervical change >2 hours in active phase suggests “failure to progress”—augment with oxytocin.

High-Yield Summary Points:

* - Partograph Alert and Action Lines:
* - Alert line: 1 cm dilation per hour (begin at 4 cm).
* - Action line: Typically 2 hours to right of alert line; if crossed, consider intervention.
* - Active Phase Arrest Criteria:
* - No cervical change for ≥2 hours with adequate contractions, OR
* - Contraction frequency/duration inadequate—first rule out inadequate uterine activity
* - Management Steps:
* 1. Assess contractions (frequency, duration, intensity).
* 2. If inadequate—amniotomy ± oxytocin augmentation.
* 3. If adequate but no progress—evaluate for cephalopelvic disproportion or malposition; consider operative delivery if needed.
* - Why Not Other Choices:
* 1. Waiting without intervention risks prolonged labour and maternal/fetal complications
* 2. Immediate cesarean is premature unless other indications present (eg, fetal distress, CPD)
* 3. Ambulation and hydration are good for latent phase but not sufficient in active arrest

Mnemonic for Partograph Intervention:

“2-2-1 RULE”

* - 2 hours no change in active phase → consider augmentation
* - 2 cm per hour is expected, but alert line starts at 4 cm
* - 1 intervention: amniotomy, then oxytocin

Predictive Questions:

1. What is the normal rate of descent of the fetal head during the active phase?

2. How often should fetal heart rate and maternal vitals be recorded on the partograph?

3. Name two maternal complications of prolonged labour if augmentation is delayed.

## 7. Assessing Rupture of Membranes

Question 7:

A labouring mother reports a sudden gush of fluid at home. Upon examination, the fluid is clear and pooling in the vagina; nitrazine test is blue. What is the most reliable next step to confirm rupture of membranes (ROM)?

A. Perform a speculum exam to visualize pooling

B. [✔] Use a sterile speculum to inspect for amniotic fluid leakage and perform a fern test

C. Check nitrazine pH strip only

D. Palpate the fundus to see if uterus is softer

Indication:

Fern test under sterile speculum is highly reliable; nitrazine alone can yield false positives.

High-Yield Summary Points:

* - ROM Confirmation Tests:
* 1. Speculum exam + pooling: Direct visualization of fluid in posterior fornix
* 2. Fern test: Dried fluid on slide shows arborizing pattern if amniotic fluid
* 3. Nitrazine (pH) test: Amniotic fluid is alkaline (pH >6.5) → blue; but false positive if blood, semen, or infections present
* 4. Amnisure / Actim tests (if available): Detect placental α-microglobulin-1—very accurate
* - Why Not Other Choices:
* 1. Nitrazine alone → false positives (blood, meconium, infections)
* 2. Palpation of uterus softness is nonspecific—fundus tone changes with contractions
* 3. Pooling on speculum must be corroborated by fern test or Amnisure for certainty
* - Implications of ROM:
* - If ≤34 weeks: risk of preterm birth, need latency antibiotics/corticosteroids
* - If ≥37 weeks: induce labour if not in labour—reduce infection risk
* - Must monitor for chorioamnionitis: maternal fever, tachycardia, foul-smelling fluid

Mnemonic for ROM Diagnosis:

“P-FAN”

* - Pooling on speculum
* - Fern test (microscopic)
* - Amniture test (Amnisure) if available
* - Nitrazine pH strip

Predictive Questions:

1. In a woman at 36 weeks with PROM (premature ROM), what is the single best next step?

2. Name two criteria that define “prolonged ROM.”

3. What antibiotic regimen is recommended to prevent infection after PROM?

## 8. Management of Third Stage (Placental Delivery)

Question 8:

Which of the following is part of the active management of the third stage of labour to prevent postpartum hemorrhage (PPH)?

A. Wait for spontaneous placental separation without intervention

B. Leave the cord clamped for 10 minutes before cutting

C. [✔] Administer 10 units of oxytocin IM after delivery of the anterior shoulder

D. Encourage mother to push until placenta delivers

Indication:

In active management, giving oxytocin immediately after birth of baby (often after anterior shoulder or head) reduces PPH risk.

High-Yield Summary Points:

* - Active Management (AMTSL) Components:
* 1. Uterotonic drug (oxytocin 10 units IM/IV) immediately after birth of baby
* 2. Controlled cord traction (CCT): Apply gentle downward traction with counter-pressure on uterus once signs of placental separation appear
* 3. Uterine massage after placenta to maintain contraction
* - Benefits:
* - Decreases risk of atonic PPH by up to 60%
* - Shortens third stage by promoting uterine contraction & placental detachment
* - Why Not Other Choices:
* 1. Expectant (physiologic) management: higher risk of PPH
* 2. Delaying cord clamping is recommended (30–60 seconds), but waiting 10 minutes is harmful—risk neonatal anemia
* 3. Encouraging pushing for placental delivery can lead to uterine inversion if done improperly; instead, controlled cord traction is used
* - When Not to Use Oxytocin Immediately:
* - If mother has hypertensive emergency with risk of water intoxication—choose ergometrine carefully
* - Avoid ergometrine in hypertension, but oxytocin is generally safe

Mnemonic for AMTSL:

“OCC”

* - Oxytocin (IM/IV)
* - Cord traction (controlled)
* - Compression (uterine massage)

Predictive Questions:

1. What signs indicate placental separation before applying controlled cord traction?

2. Name two alternate uterotonics if oxytocin is unavailable.

3. What is the main risk of giving ergometrine to a hypertensive mother?

## 9. Detecting Fetal Malposition

Question 9:

On vaginal examination during active labour, the presenting part of the fetus is felt over the sacral promontory with the sagittal suture lying transversely. This indicates which presentation?

A. Right occipito-anterior (ROA)

B. Left occipito-anterior (LOA)

C. [✔] Occipito-posterior (OP)

D. Transverse lie

Indication:

Feeling the sagittal suture transverse and occiput near sacrum indicates OP (the head is facing maternal spine).

High-Yield Summary Points:

* - Fetal Lie vs. Attitude vs. Presentation:
* - Lie: Relation of fetal long axis to maternal: longitudinal, transverse, or oblique
* - Attitude: Degree of flexion or extension of fetal head
* - Presentation: Which part is at the cervix: vertex (occiput), breech (sacrum), shoulder, face
* - Determining Occipito-Posterior (OP):
* - Occiput palpated posteriorly (near sacrum)
* - Spine of fetus is aligned with maternal belly (sagittal suture transverse)
* - Back pain is common complaint (“back labour”)
* - Why Not Other Choices:
* 1. ROA/LOA: Occiput felt anteriorly near pubic symphysis with sagittal suture A-P orientation
* 2. Transverse lie: No head in pelvis—shoulder/breech felt in transverse orientation
* - Clinical Implications:
* - OP often leads to longer labour, more back pain, may need maternal positioning (hands-and-knees), rotational forceps, or cesarean if labour dystocia
* - Check partograph for slow progress

Mnemonic for Fetal Position Palpation:

“SPA”

* - Sacrum (occiput) palpated at maternal sacrum → OP
* - Pubis palpated (occiput) → OA
* - Anterior (sagittal suture) felt long A–P → OA/OP depending on where occiput is

Predictive Questions:

1. Which maternal position can help rotate an OP fetus to OA?

2. How does OP presentation affect the shape of the maternal abdomen?

3. What is the expected fetal heart rate auscultation site in LOA?

## 10. Distinguishing True Labour Signs from False

Question 10:

A 39 weeks primigravida calls the unit complaining of “tightening” every 20 minutes for the last 3 hours, relieved by changing position. On exam, cervix is 1 cm dilated and 20% effaced. What is the most likely diagnosis?

A. Early active phase

B. [✔] Braxton Hicks contractions (false labour)

C. Transition phase

D. Preterm labour

Indication:

Contractions that are infrequent, relieved by position change, with minimal cervical change point to false labour.

High-Yield Summary Points:

* - Braxton Hicks (False Labour):
* - Irregular contractions, usually painless or mildly uncomfortable
* - Do not progress in frequency/duration/intensity
* - Often relieved by hydration, rest, or position change
* - Cervix remains minimally effaced (≤20–30%), minimal dilation (<2–3 cm)
* - True Labour:
* - Regular contractions that gradually increase in frequency (every 3–5 min) and intensity
* - Progressive cervical dilation/effacement
* - Contractions not relieved by rest/hydration
* - Why Not Other Choices:
* 1. Early active phase: Regular contractions with progressive dilation (≥3 cm)
* 2. Transition: 8–10 cm, very intense—unlikely at 1 cm dilation
* 3. Preterm labour: Occurs <37 weeks—this patient is term (39 weeks)
* - Clinical Tip:
* - Encourage hydration and ambulation; Braxton Hicks can be more frequent with dehydration or after intercourse.

Mnemonic for False Labour:

“F.R.E.S.H.”

* - Frequency irregular
* - Relieved by rest/hydration
* - Effacement/dilation minimal
* - Short duration (<30 sec)
* - Head not descending

Predictive Questions:

1. How do you counsel a woman experiencing frequent Braxton Hicks at 36 weeks?

2. What red-flag symptom suggests preterm labour rather than Braxton Hicks?

3. At what dilation does the latent phase end and active phase begin in primigravida?