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Operative vaginal delivery – Multiple choice questions Vol. 56

1. Which of the following is true/false with regards to the impact of operative vaginal birth training?

a) Randomised controlled trials have investigated the impact of training on maternal and neonatal outcomes.
b) Training has demonstrated a reduction in third and fourth degree tear rates.
c) Targeted training has been shown to influence local instrumental delivery rates.
d) Hypoxic-ischaemic encephalopathy rates have been reduced as a result of training.
e) Qualitative studies have validated the importance of teaching non-technical skills in training for operative vaginal birth.

2. Which of the following is true/false with regards to the success of emergency skills training?

a) Systematic reviews have demonstrated the utility of obstetric emergency skills training on maternal and neonatal outcomes.
b) Studies have demonstrated that multi-disciplinary simulation training can have a direct link to the reduction in neonatal injury from shoulder dystocia.
c) Studies have demonstrated that multi-disciplinary skills training has a direct link to the reduction in episiotomy rates.
d) Studies have demonstrated that multi-disciplinary skills training has a direct link to improved maternal satisfaction and birth experience.
e) Studies have demonstrated that multi-disciplinary skills training has a direct link to improved neonatal outcome following cord prolapse.

3. Which of the following is true/false with regards to operative vaginal birth training?

a) Evidence suggests that training should be only for obstetricians.
b) Evidence suggests that training should only monitor trainee satisfaction.
c) Evidence suggests that training should have an aspect of continued competence assessment.
d) Evidence suggests that local training is likely to be more efficacious than national training.
e) Kirkpatrick's model of programme evaluation level 4 should not be sought after when creating a training programme.

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4. Which of the following is true/false with regards to simulation training?

a) Evidence suggests that high fidelity training can improve learning.
b) Evidence suggests that team training is vital in simulation training for obstetric emergencies.
c) Evidence suggests that distance training in a simulation centre is better for simulation training as it allows participants to learn in a safe environment.
d) Simulation training does not improve participants' knowledge.
e) Simulation training should only be used for obstetric emergencies.

5. The reasons cited for not performing OVD include which of the following?

a) Inadequate training
b) Equipment shortages
c) Cultural beliefs
d) Policies failing to support the use of OVD
e) Maternal fear

6. Which of the following is/are true with respect to second-stage caesarean delivery outcomes for the mother and baby when compared to OVD?

a) Studies comparing perinatal outcomes after second stage caesarean deliveries and OVD show similar outcomes
b) Mothers have longer hospital stays with second-stage caesarean delivery
c) Mothers have more haemorrhage with second-stage caesarean delivery
d) Mothers have more perineal damage with second-stage caesarean delivery
e) Mothers have more puerperal sepsis with second-stage caesarean delivery

7. Which of the following is/are true regarding blood-borne viral infections of the mother and performing OVD?

a) Blood-borne viral infections of the mother are a contra-indication to OVD
b) A Cochrane review supports RCOG guidance on this
c) Scalp trauma should be avoided
d) In UK and Ireland the rate of OVD in HIV positive women was between 10 and 15%
e) The rate of HIV-positivity in babies born by OVD in UK and Ireland is approximately 3%

8. The following is/are appropriate Indications for performing an OVD?

a) Maternal request
b) Delay in the second stage
c) Shoulder dystocia
d) Transverse lie
e) Maternal medical conditions

9. In women undergoing operative vaginal delivery:

a) Group A streptococcal infection is the most severe infective cause.
b) There is a higher risk of UTI compared to women who have an unassisted vaginal delivery
c) The majority of infections occur within 24 hours of birth
d) Episiotomy is associated with a lower risk of postpartum infection.
e) Vacuum delivery has a lower risk of infection than forceps.

10. The following factors put women at higher risk of maternal sepsis:

a) Lower socioeconomic status
b) Medical co-morbidities
c) Delay in antibiotic prescribing
d) Belonging to a black or other ethnic minority group
e) Previous prescription of antibiotics

11. Group A streptococcal sepsis is an important cause of infectious morbidity in women who deliver vaginally. The following are features of GAS infection:

a) It occurs principally through direct spread from the normal flora of the female genital tract.
b) GAS infection can present rapidly in the postpartum period
c) Treatment should include antibiotics given within one hour of suspected diagnosis, avid resuscitation and source control if necessary.
d) Necrosis with gas formation is common in the tissues when GAS infection is severe
e) Clinical features may be non-specific

12. The following is/are important to prevent infection after OVD:

a) Basic sterile technique
b) Covering of perineal wounds
c) Antibiotic prophylaxis before delivery
d) Antibiotic prophylaxis after delivery
e) Avoidance of episiotomy

13. Obstetric anal sphincter injury:

a) Is classified as 3a if <50% of the external anal sphincter is torn
b) Occurs only if an operative vaginal delivery is performed
c) Occurs consistently in <5% of operative vaginal deliveries
d) Occurs more frequently during 'out-of-hours' deliveries
e) Occurs more frequently with rotational forceps delivery compared to manual rotation followed by direct forceps delivery

14. Mediolateral episiotomy:

a) Should be performed in preference to a midline episiotomy for OASIS prevention
b) Is defined as an episiotomy that is directed at least 45° away from the midline
c) Reduces the risk of OASIS during operative vaginal delivery
d) Should be performed routinely rather than selectively during operative vaginal delivery
e) Should be performed routinely rather than selectively during operative vaginal delivery in a woman with a prior history of OASIS

15. In terms of long-term pelvic floor problems following operative vaginal delivery:

a) OASIS is associated with faecal incontinence
b) OVD is more likely to result in faecal incontinence if the delivery was operative rather than spontaneous
c) OVD has similar rates of dyspareunia compared to spontaneous vaginal delivery
d) OVD results in poorer sexual functioning compared to spontaneous vaginal delivery
e) OVD results in delayed resumption of sexual intercourse compared to spontaneous vaginal delivery

16. Nontechnical skills are implicated in the following situations:

a) 20% of errors in surgical units
b) 30% of intrapartum stillbirths, neonatal deaths or severe brain injury within seven days of birth
c) The development of PTSD in women following delivery
d) The development of second victim syndrome
e) Increased incident reporting

17. An attempt to perform a rotational operative vaginal delivery is associated with greater risk than primary caesarean section in the setting of which of the following?

a) Abnormal/non-reassuring fetal heart rate
b) Meconium-stained liquor
c) Small for gestational age
d) High maternal BMI
e) Advanced maternal age

18. According to RCOG guidelines, the following should be present before an any attempt at an rOVD is made:

a) Operator experienced in rotational deliveries is present
b) Woman is in a setting where cesarean section is available
c) Fetal head is not palpable per abdomen
d) Bladder is empty
e) The woman has effective regional analgesia in place

19. Manual rotation may be a superior method of rOVD compared to rotational ventouse or rotational forceps because:

a) Junior obstetricians require less training in its use
b) It is safer for mothers
c) It is safer for babies
d) It is more successful
e) Other maternity professionals prefer it

20. Operative vaginal delivery (OVD) is performed when delivery needs to be expedited. Which of the following is/are pre-requisites for OVD?

a) Fetal head engagement 0/5th palpable on abdominal examination
b) Cervical dilatation 9cm
c) Known fetal head position e.g. occipito-posterior (OP) position
d) Operator grade – junior doctor with one year experience in obstetrics
e) Verbal consent

21. The following is/are risk factors for failed OVD:

a) Incorrect diagnosis of a fetal head malposition such as occipito-posterior (OP) position incorrectly diagnosed as occipito-anterior (OA)
b) Missing cephalopelvic disproportion on examination
c) Maternal obesity
d) Previous caesarean section
e) Pathological CTG

22. The following statement(s) is/are true about ultrasound prior to OVD:

a) It increases correct diagnosis of the fetal head position
b) It delays the decision to delivery interval
c) It reduces the risk of failed OVD
d) It is unobtrusive to the mother
e) It is a difficult skill to learn

23. Forced-assisted delivery is contraindicated in the following circumstances:

a) Suspected osteogenesis imperfecta in the fetus
b) Deflexed occipito-posterior position with station zero
c) Cardiotocography (CTG) showing fetal tachycardia with late decelerations.
d) Fetal bradycardia in a preterm infant at station +2cm.
e) Maternal hypertension with blood pressure recording 200/120 mm Hg.

24. Forceps-assisted delivery is associated with the following complications:

a) A four-fold increased risk of OASI compared with ventouse.
b) An increased risk of urinary incontinence compared with second stage Caesarean section that is still apparent 1 year following the birth.
c) A reduced incidence of subsequent vaginal birth compared with second stage Caesarean section.
d) A higher incidence of neonatal traumatic injury compared with second stage Caesarean section.
e) Psychological sequelae that may result in a woman requesting an elective Caesarean section in a future pregnancy.

25. In relation to fetal head impaction:

a) It occurs exclusively following failed attempt at forceps-assisted delivery.
b) Manoeuvres that relieve it include reverse breech extraction at Caesarean section.
c) Traumatic injuries occur as a result of the impaction and not the manoeuvres used to relieve it.
d) The occurrence of this complication warrants completion of a clinical incident form.
e) The nature of the delivery complication should be highlighted to the attending neonatologist

26. In terms of the medico-legal aspects of operative vaginal delivery:

a) Most medical negligence cases are tried in civil courts before a judge and jury.
b) A criminal conviction for manslaughter is likely where an obstetrician deviates from clinical practice guidelines and the baby develops cerebral palsy.
c) The Montgomery ruling supported the view that patients with diabetes and a large baby should be informed of the increased risk of shoulder dystocia and that caesarean section is protective.
d) Obstetricians should withhold their concerns about sub-standard care in the context of an adverse birth-related event, pending legal advice.
e) The consent process for OVD should be part of an ongoing dialogue commencing with antenatal education, continuing through labour up until the point of delivery, as required.

27. In relation to obstetric litigation:

a) CTG interpretation is open to inter- and intra-observer variation and is particularly challenging in the second stage of labour.
b) Contemporaneous CTG interpretation by the health professionals caring for a patient is usually consistent with the interpretation of experts when reviewed after an adverse birth-related event.
c) Clinical practice guidelines are designed to limit variation in clinical practice and restrict individualised decision-making by clinicians.
d) Errors of judgement are acceptable if the doctor was acting in good faith within the limits of their abilities and under appropriate supervision.
e) Adverse outcomes such as cerebral palsy are likely to result in very large compensatory claims of as much as 10–12 million pounds (UK).

28. In legal terms:

a) Causation refers to the direct relationship between breach of duty and the adverse outcome resulting in litigation.
b) A woman who experiences vaginal prolapse following a forceps delivery has 3 years from the birth in which to raise a claim of negligence.
c) In the case of children, the 3-year limit in which to start a legal claim doesn't start to apply until their 18th birthday.
d) No fault compensation implies that the medical staff provided sub-standard care.
e) Witnesses to fact are instructed to provide independent expert opinions for the court.

29. Regarding Situational awareness which of the following is/are true?

a) Situational awareness is the assessment of the environment and the detection of any changes within it
b) Perception is considered the first part of it
c) The second step is projection
d) Projection involves thinking ahead to the variables that could occur in the situation
e) Situational awareness involves evaluating the clinical situation continuously and adjusting actions accordingly

30. The following is/are associated with loss of situational awareness:

a) Cognitive overload
b) Distractions
c) High risk situations
d) Multiple emergencies co-existing
e) Lack of training in situational awareness