# UNIVERSITY OF SWAZILAND

## FACULTY OF HEALTH SCIENCES

**TITLE OF PAPER: ABNORMAL MIDWIFERY 11 (SEMESTER 2)**

**COURSE CODE:** MID 121

**FINAL EXAMINATION:** MAY, 2009

**TIME ALLOWED:** 2 HOURS

**TOTAL MARKS:** 75

**INSTRUCTIONS:**

1. ANSWER ALL QUESTIONS
2. FIGURES IN BRACKETS INDICATE MARKS ALLOCATED TO EACH OR PART OF A QUESTION.
3. ANSWER EACH QUESTION ON A NEW PAGE.
4. DO NOT CHEAT, IF YOU CHEAT YOU WILL BE PENALISED

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**QUESTION 1 MULTIPLE CHOICE QUESTIONS: SELECT THE MOST APPROPRIATE RESPONSE WRITE THE NUMBER AND LETTER CORRESPONDING TO THE CORRECT RESPONSE**

1. One of the contra-indications for induction of labour is:

(a) A previous induction of labour
(b) A previous Caesarian section
(c) Malpresentation
(d) Reliable estimated date of delivery

2. A pre-induction pelvic scoring system is called the:

(a) Apgar csore
(b) Bishop's score
(c) Dubowitz score
(d) Pelvic score

3. Uterine contractions that are very strong and frequent from onset of labour and result in abnormally rapid progress ~~to as~~ of labour is refered to as:

(a) Prolonged labour
(b) Abnormal labour
(c) Precipitate labour
(d) Dysfunctional labour

4. The excessive use of oxytocic drugs to stimulate uterine contractions may lead to:
(a) Inco-ordinate contractions
(b) Tonic contractions
(c) Titanic contractions
(d) Normal contractions

5. Prolonged second stage of labour may be a result of:

(a) Hypotonic uterine contractions
(b) Hypertonic contractions
(c) Normal contractions
(d) Foetal distress

6. Midwives are in a better position to prevent the occurrence of prolonged labour by:

(a) Perfoming pelvic assessment at 36 weeks gestation
(b) Inducing labour at 38 weeks gestation

(c) Conducting a trial of labour at 36 weeks
(d) Using a partogram to monitor progress of labour

7. An early sign of obstructed labour is the presence of:

(a) Cephalhaomatoma may be felt
(b) Cervix hangs like an empty sleeve
(c) The vagina is hot and moist
(d) Apresenting part that is well applied to the cervix

8. A late sign of obstructed labour is the presence of:

(a) Bandl's ring
(b) Physiologic ring
(c) Amniotic band ring
(d) Cervical ring

9. The engaging diameter of a persistent occipito posterior position is the:

(a) Mentovertical
(b) Occipitobregmantic
(c) Occipitofrontal
(d) Bitrochanteric

10. During delivery of the head of a foetus presenting with persistent occipito posterior position, the midwife will initially:

(a) Flex the occiput to allow smaller diameters to escape
(b) Flex the sinciput to allow the occiput to sweep the perineum
(c) Extend the occiput to allow the entire sinciput to be delivered
(d) Extend the sinciput to allow the occiput to be delivered

11. A midwife will accurately diagnose face presentation by a vaginal examination which will detect:

(a) A soft mass around the cervix
(b) Orbital ridges
(c) Meconium stained liquior
(d) Lanugo on the examining gloved hand

12. The diameter which sweeps the perineum on a face presentation is:

(a) Submentobregmatic
(b) Submentovertical

(c) Mentovertical
(d) Mentofrontal

13. The method of delivering the after-coming head on a breech presentation whereby the baby is grasped by the feet and held on a stretch is called the:

(a) Lovset manoeuvre
(b) Breech extraction
(c) Burns Marshall method
(d) Maurice-Smellie-Veit manoeuvre

14. The ideal position to place a woman who has cord prolapse is:

(a) Left lateral
(b) Fowlers
(c) Recumbent
(d) Sims

15. Silent uterine rupture usually occurs:

(a) During the antenatal period
(b) During labour
(c) As a consequence of incorrect use of oxytocic drugs
(d) Due to obstructed labour

16. In shoulder dystocia, the shoulders:

(a) Lie in the anterior posterior position of the outlet
(b) Fail to rotate and be delivered normally
(c) Rotate easily to allow for mechanism of labour to progress normally
(d) One shoulder is delivered but the other is retained

17. Post partum haemorrhage may be defined as:

(a) Bleeding exceeding 300 ml immediately after delivery
(b) Bleeding which occurs during pueperium irrespective of the amount
(c) Bleeding which is accompanied by pain and involution of the uterus
(d) Bleeding at any stage of pueperium which undermines maternal health

18. Morbid adherence of the placenta is called:

(a) Placenta accrete
(b) Placenta percreta
(c) Placenta succenturia
(d) Velamentous placenta

19. One of the causes of acute inversion of the placenta is:

(a) Previous Caesarian section delivery
(b) Prolonged labour
(c) Mismanagement of third stage of labour
(d) Disordered uterine contractions

20. In order to prevent the occurrence of pueperal infection, the midwife should:

(a) Re-inforce principles of personal hygiene
(b) Keep clients well hydrated during labour
(c) Ensure that products of conception are completely expelled.
(d) Dispose contaminated utensils appropriately

21. The most common organism causing puerperal mastitis is:

(a) Diplococci
(b) Esherichia coli
(c) Haemolytic streptococci
(d) Staphylococcus aureus

22. Puerperal infection may be caused by infection that comes from sources outside the body, these are referred to as:

(a) Endogenous organism
(b) Exogenous organism
(c) Entogenous organism
(d) Ectogenous organism

23. Deep vein thrombosis may be diagnosed by a positive:

(a) Homan's sign
(b) Apgar sign
(c) Bandy's sign
(d) Wang's sign

24. A client diagnosed with post natal depression is usually:

(a) Awake in the morning and feels tired as the day proceeds
(b) Feels tired in the morning and improve as the day goes on
(c) Sleepy most of the time
(d) Awake all the time

25. The best care for a baby whose mother is suffering from puerperal psychosis is to:

(a) Allow the mother to take total care of her/him
(b) Remove him/her from mother to ensure safety
(c) Admit him/her in a nursery
(d) Allow him/her to be taken care of by the midwife

**QUESTION 2**

Mrs Bila, a gravida 1 para 0 is admitted in active labour at 8 am, on the 5th January 2009; she reports that she has been in labour since 2am on the same day. She is 24 years old, height is 151cm, she is at term gestation, lie longitudinal, cephalic presentation, LOA, presenting part 3/5 above the brim; uterine contractions are very strong, urinary bladder distended, catheterised on admission and 60 mls urine drained. Cervix 100% effaced, 6 cm dilated, moulding 3+, meconium stained liquor draining since 4 am on the 5 th January 2009. Vital signs: B/P 130/90, pulse rate 132, respirations 20, foetal heart rate 150 clear but irregular.

(a) Comment about Mrs Bilas' progress of labour.

**15 Marks**

(b) Describe how a midwife would diagnose an occipito posterior position during labour

**10 Marks**

**QUESTION 3**

Mrs Jozi has just delivered a live female infant. While the midwife was conducting the fourth stage of labour she noted that Mrs Jozis' blood pressure was 100/60, pulse rate 88 beats per minute, temperature 36.3 degrees Celsius. Blood loss was amounting to 520 mls.

(a) Discuss in detail how a midwife should manage Mrs Jozi for the next 24 hours.

**25 Marks**