

ABOG ORAL BOARDS OBSTETRICS PRACTICE TEST (SAMPLE)

STUDY GUIDE



Prepare with structure. Pass with confidence



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Introduction

Preparing for a certification exam can feel overwhelming, but with the right tools, it becomes an opportunity to build confidence, sharpen your skills, and move one step closer to your goals. At Examzify, we believe that effective exam preparation isn't just about memorization, it's about understanding the material, identifying knowledge gaps, and building the test-taking strategies that lead to success.

This guide was designed to help you do exactly that.

Whether you're preparing for a licensing exam, professional certification, or entry-level qualification, this book offers structured practice to reinforce key concepts. You'll find a wide range of multiple-choice questions, each followed by clear explanations to help you understand not just the right answer, but why it's correct.

The content in this guide is based on real-world exam objectives and aligned with the types of questions and topics commonly found on official tests. It's ideal for learners who want to:

- Practice answering questions under realistic conditions,
- Improve accuracy and speed,
- Review explanations to strengthen weak areas, and
- Approach the exam with greater confidence.

We recommend using this book not as a stand-alone study tool, but alongside other resources like flashcards, textbooks, or hands-on training. For best results, we recommend working through each question, reflecting on the explanation provided, and revisiting the topics that challenge you most.

Remember: successful test preparation isn't about getting every question right the first time, it's about learning from your mistakes and improving over time. Stay focused, trust the process, and know that every page you turn brings you closer to success.

Let's begin.

How to Use This Guide

This guide is designed to help you study more effectively and approach your exam with confidence. Whether you're reviewing for the first time or doing a final refresh, here's how to get the most out of your Examzify study guide:

1. Start with a Diagnostic Review

Skim through the questions to get a sense of what you know and what you need to focus on. Your goal is to identify knowledge gaps early.

2. Study in Short, Focused Sessions

Break your study time into manageable blocks (e.g. 30 – 45 minutes). Review a handful of questions, reflect on the explanations.

3. Learn from the Explanations

After answering a question, always read the explanation, even if you got it right. It reinforces key points, corrects misunderstandings, and teaches subtle distinctions between similar answers.

4. Track Your Progress

Use bookmarks or notes (if reading digitally) to mark difficult questions. Revisit these regularly and track improvements over time.

5. Simulate the Real Exam

Once you're comfortable, try taking a full set of questions without pausing. Set a timer and simulate test-day conditions to build confidence and time management skills.

6. Repeat and Review

Don't just study once, repetition builds retention. Re-attempt questions after a few days and revisit explanations to reinforce learning. Pair this guide with other Examzify tools like flashcards, and digital practice tests to strengthen your preparation across formats.

There's no single right way to study, but consistent, thoughtful effort always wins. Use this guide flexibly, adapt the tips above to fit your pace and learning style. You've got this!

Questions

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- 1. What should be done if the placenta remains undelivered after 4 hours following a second-trimester loss?**
 - A. Administer more oxytocin
 - B. Perform surgical removal
 - C. Wait for natural expulsion
 - D. Use misoprostol again
- 2. What is the recommendation for delivery in suboptimally dated pregnancies?**
 - A. Elective delivery is recommended
 - B. Amniocentesis should be performed prior to delivery
 - C. Consider interval ultrasound every 3-4 weeks
 - D. Immediate delivery should occur at 38 weeks
- 3. What complication can occur due to uterine tachysystole during labor?**
 - A. Labor continuation
 - B. Cardiac arrest
 - C. Uterine rupture
 - D. Increased maternal comfort
- 4. What is the fasting blood glucose threshold for diagnosing gestational diabetes?**
 - A. Less than 100 mg/dL
 - B. Less than 90 mg/dL
 - C. Less than 95 mg/dL
 - D. Less than 85 mg/dL
- 5. Which of the following is NOT a requirement for elective induction?**
 - A. Must be greater than 39 weeks
 - B. Positive serum pregnancy test for 36 weeks or greater
 - C. Fetal heart tones detected after 20 weeks
 - D. FLM established before 39 weeks

- 6. Which classification describes gestational diabetes that is diet controlled?**
- A. A1DM
 - B. A2DM
 - C. Type 1 Diabetes
 - D. Type 2 Diabetes
- 7. What is a potential obstetric outcome associated with untreated major depression?**
- A. Increased risk of hypertensive disorders
 - B. Increased incidence of low birth weight
 - C. Higher rates of primary cesarean delivery
 - D. Lower risk of gestational diabetes
- 8. Which condition is a contraindication for using Prostaglandin E1?**
- A. Previous low-risk cesarean delivery
 - B. High blood pressure
 - C. Prior cesarean delivery or major uterine surgery
 - D. Single gestation
- 9. How soon after delivery should Rhlg (Rhogam) be administered?**
- A. Within 48 hours
 - B. Within 72 hours
 - C. Within 24 hours
 - D. Within 96 hours
- 10. Which gestational age corresponds to an expected fetal weight of around 2000 grams?**
- A. 28 weeks
 - B. 32 weeks
 - C. 34 weeks
 - D. 36 weeks

Answers

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1. B
2. C
3. C
4. C
5. C
6. A
7. B
8. C
9. B
10. C

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Explanations

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1. What should be done if the placenta remains undelivered after 4 hours following a second-trimester loss?

- A. Administer more oxytocin
- B. Perform surgical removal**
- C. Wait for natural expulsion
- D. Use misoprostol again

When the placenta remains undelivered for more than 4 hours after a second-trimester loss, it is critical to intervene to prevent complications such as infection or hemorrhage. Surgical removal, typically through dilation and curettage (D&C), is the appropriate management in this scenario. Given the time elapsed, the likelihood of spontaneous expulsion decreases, and the risks associated with retaining placental tissue increase. Surgical intervention not only ensures that all placental remnants are removed, thus reducing the risk of postpartum complications, but it can also provide a quicker resolution for the patient, allowing her to begin the healing process both physically and emotionally. While administering more oxytocin or using misoprostol could be considered options in some cases to promote uterine contractions, their effectiveness may be diminished given the duration of retention, which can lead healthcare providers to favor surgical intervention instead. Waiting for natural expulsion is typically not advised in this scenario, as the prolonged retention of the placenta poses significant risks.

2. What is the recommendation for delivery in suboptimally dated pregnancies?

- A. Elective delivery is recommended
- B. Amniocentesis should be performed prior to delivery
- C. Consider interval ultrasound every 3-4 weeks**
- D. Immediate delivery should occur at 38 weeks

In the context of suboptimally dated pregnancies, it is essential to ensure accurate gestational age assessment to optimize delivery timing and minimize risks for both the mother and fetus. Regular interval ultrasounds every 3-4 weeks are recommended in such cases. The reasoning behind this recommendation lies in the need for dynamic monitoring of fetal growth and development, which allows for adjustments to be made in the management plan based on the most current information. By conducting ultrasounds at these intervals, clinicians can evaluate fetal size, assess amniotic fluid levels, and determine placental function. This ongoing assessment helps in making timely decisions regarding the appropriateness of delivery, considering that suboptimally dated pregnancies might be at risk for various complications, including preterm delivery or intrauterine growth restriction. In contrast, the other options may not align with best practices for managing pregnancies with an uncertain due date. For instance, immediate delivery at a set gestational age, such as 38 weeks, may not be suitable without appropriate clinical indicators or evidence of fetoplacental compromise. Similarly, elective delivery and pre-delivery amniocentesis might not be standard recommendations in the absence of specific indications or complications that necessitate earlier intervention. Regular monitoring through ultrasound provides a more

3. What complication can occur due to uterine tachysystole during labor?

- A. Labor continuation
- B. Cardiac arrest
- C. Uterine rupture**
- D. Increased maternal comfort

Uterine tachysystole is defined as excessive uterine activity, typically characterized by more than five contractions in a ten-minute period. This condition can lead to several complications during labor, particularly impacting the tone and integrity of uterine muscle and the fetal condition. Uterine rupture is a particularly severe complication that can arise as a result of tachysystole. During tachysystole, the excessive frequency of contractions can lead to prolonged and intense pressure on the uterine wall. If the contractions are too frequent or too strong, they can result in a breach in the uterine wall, especially in cases where there is a pre-existing scar (such as from a previous cesarean section). This rupture can lead to significant maternal and fetal morbidity and mortality, requiring immediate medical intervention. The other options do not represent complications associated with uterine tachysystole. For instance, continuous labor is expected in the context of tachysystole, cardiac arrest is not a direct consequence of this condition, and increased maternal comfort would be unlikely given the stress and potential pain associated with excessively frequent contractions. Thus, uterine rupture distinctly exemplifies a serious complication that can ensue from unmanaged uterine tachysystole during labor.

4. What is the fasting blood glucose threshold for diagnosing gestational diabetes?

- A. Less than 100 mg/dL
- B. Less than 90 mg/dL
- C. Less than 95 mg/dL**
- D. Less than 85 mg/dL

The correct threshold for diagnosing gestational diabetes based on fasting blood glucose levels is less than 95 mg/dL. This standard is established by guidelines from organizations such as the American Diabetes Association and the International Association of Diabetes and Pregnancy Study Groups. When a pregnant individual has a fasting blood glucose level of 95 mg/dL or higher, it indicates that their body is struggling to maintain normal glucose levels during pregnancy, pointing towards an impairment in glucose metabolism that is characteristic of gestational diabetes. This threshold is crucial for early identification and management of gestational diabetes, which can help prevent complications for both the mother and the baby. Other fasting thresholds are used for different conditions but do not apply to gestational diabetes diagnoses in this context, highlighting the importance of understanding specific diagnostic criteria for different types of diabetes.

5. Which of the following is NOT a requirement for elective induction?

- A. Must be greater than 39 weeks
- B. Positive serum pregnancy test for 36 weeks or greater
- C. Fetal heart tones detected after 20 weeks**
- D. FLM established before 39 weeks

The requirement for elective induction generally includes specific conditions meant to ensure the safety of both the mother and the fetus. One of these conditions is that the pregnancy must be at least 39 weeks gestation, which is necessary to reduce risks associated with premature birth. Additionally, it is important that fetal lung maturity is established, which typically means the fetus should not be induced before 39 weeks unless there are compelling medical indications. Another significant requirement is that there must be positive serum pregnancy tests at 36 weeks or greater. This ensures that the pregnancy is progressing normally and that the fetus is developed enough to withstand the stress of labor. The detection of fetal heart tones is indeed a standard part of monitoring fetal well-being, but it is not specifically listed as a requirement for elective induction. While fetal heart activity should be confirmed before labor begins, the essential criteria for elective induction focus more on gestational age, the established lung maturity of the fetus, and confirmation of adequate pregnancy status. Thus, the presence of fetal heart tones after 20 weeks does not directly relate to the criteria for elective induction.

6. Which classification describes gestational diabetes that is diet controlled?

- A. A1DM**
- B. A2DM
- C. Type 1 Diabetes
- D. Type 2 Diabetes

Gestational diabetes that is diet-controlled is classified as A1DM. This classification is part of the Gestational Diabetes Mellitus (GDM) classification system, where A1DM specifically refers to cases of gestational diabetes that can be managed through dietary modifications alone. In this scenario, the pregnant individual has elevated blood glucose levels that do not require insulin or oral hypoglycemic agents; rather, these levels can be maintained within normal range solely through dietary management. A1DM typically indicates a less severe form of gestational diabetes that is often associated with a favorable pregnancy outcome when appropriately managed. A2DM, in contrast, refers to cases of gestational diabetes where medication, such as insulin or oral hypoglycemic agents, is necessary to control blood glucose levels. This distinction is crucial in managing care and interventions during pregnancy. Type 1 and Type 2 diabetes are not classifications of gestational diabetes but rather chronic forms of diabetes that predate pregnancy. Type 1 diabetes is characterized by absolute insulin deficiency due to autoimmune destruction of insulin-producing beta cells, while Type 2 diabetes is marked by insulin resistance and relative insulin deficiency. Neither of these classifications applies to gestational diabetes specifically.

7. What is a potential obstetric outcome associated with untreated major depression?

- A. Increased risk of hypertensive disorders
- B. Increased incidence of low birth weight**
- C. Higher rates of primary cesarean delivery
- D. Lower risk of gestational diabetes

Untreated major depression during pregnancy can significantly affect a mother and her baby's health. One of the potential outcomes linked to untreated major depression is an increased incidence of low birth weight. This association arises because depression can lead to factors such as poor nutrition, inadequate prenatal care, and increased stress levels, all of which can impair fetal growth and development. Low birth weight is defined as a birth weight of less than 2500 grams (5 pounds, 8 ounces), and it can increase the risk of various health complications for the infant, including respiratory issues, infections, and long-term developmental delays. Maternal depression can disrupt normal physiological processes during pregnancy, which can lead to adverse outcomes for the fetus. In contrast, while untreated major depression can be associated with other complications, such as hypertensive disorders or cesarean deliveries, the direct and clear connection to low birth weight is particularly well-established in the literature around maternal mental health and its impact on pregnancy outcomes. The absence of a risk related to gestational diabetes indicates that untreated major depression does not correlate with a lower risk of this condition, further emphasizing the focus on the relationship between depression and low birth weight.

8. Which condition is a contraindication for using Prostaglandin E1?

- A. Previous low-risk cesarean delivery
- B. High blood pressure
- C. Prior cesarean delivery or major uterine surgery**
- D. Single gestation

Prostaglandin E1 (misoprostol) is commonly used in obstetrics for various indications, including induction of labor. However, its use is contraindicated in certain situations, particularly in patients who have had prior uterine surgery, such as a cesarean delivery. This is primarily due to the increased risk of uterine rupture when the uterus has been previously scarred or weakened. In cases of prior cesarean delivery or major uterine surgery, the integrity of the uterus is compromised, and the use of prostaglandins can increase uterine contractility. This heightened activity can lead to the potential for the scar tissue from the previous surgery to tear, resulting in serious complications for both the mother and the fetus. In contrast, having a previous low-risk cesarean delivery, high blood pressure, or a single gestation does not inherently pose the same level of risk for uterine rupture and therefore does not serve as a classified contraindication for the use of Prostaglandin E1. Thus, the choice relating to prior cesarean delivery or major uterine surgery is the correct and most clinically relevant concern when considering the use of prostaglandin E1.

9. How soon after delivery should Rhlg (Rhogam) be administered?

- A. Within 48 hours
- B. Within 72 hours**
- C. Within 24 hours
- D. Within 96 hours

Rh immunoglobulin (often referred to as Rhogam) is administered to Rh-negative women who deliver an Rh-positive infant. This is crucial in preventing Rh immunization, which can lead to hemolytic disease of the newborn in future pregnancies. The correct timing for administering Rhlg is within 72 hours postpartum. This timing is essential because the earlier the treatment is given, the more effective it is at neutralizing any Rh-positive fetal red blood cells that may have entered the maternal circulation during delivery. Administering Rhlg within this timeframe helps to prevent the mother's immune system from producing antibodies against Rh-positive blood, which is vital for the health of any future pregnancies. Although Rhlg can be given up to 72 hours after delivery, giving it any later would risk the chance that sensitization has already occurred, making timely intervention critical. This guideline is supported by professional organizations, including the American College of Obstetricians and Gynecologists (ACOG), which recommends that Rhlg administration should happen as soon as possible within this window, but preferably within the first 48 hours to optimize outcomes.

10. Which gestational age corresponds to an expected fetal weight of around 2000 grams?

- A. 28 weeks
- B. 32 weeks
- C. 34 weeks**
- D. 36 weeks

The expected fetal weight of around 2000 grams typically corresponds to a gestational age of 34 weeks. At this point in pregnancy, fetal growth accelerates significantly, with the fetus usually reaching this weight as it continues to develop and gain fat stores in preparation for birth. By 34 weeks, the fetus has a more developed body composition and is approaching viability, which makes this weight a common benchmark at this stage. In the context of fetal development, at 28 weeks, the expected weight is typically lower, as major organ systems are still maturing and overall growth is not as pronounced. By 32 weeks, while the fetus continues to grow, it generally weighs less than 2000 grams on average. At 36 weeks, the average fetal weight is usually above 2000 grams, as the fetus is nearing full term and experiencing rapid weight gain in the last weeks of pregnancy. Therefore, 34 weeks is recognized as the gestational age when a fetal weight of approximately 2000 grams is expected.

Next Steps

Congratulations on reaching the final section of this guide. You've taken a meaningful step toward passing your certification exam and advancing your career.

As you continue preparing, remember that consistent practice, review, and self-reflection are key to success. Make time to revisit difficult topics, simulate exam conditions, and track your progress along the way.

If you need help, have suggestions, or want to share feedback, we'd love to hear from you. Reach out to our team at hello@examzify.com.

Or visit your dedicated course page for more study tools and resources:

<https://abogoralobstetrics.examzify.com>

We wish you the very best on your exam journey. You've got this!

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