

ABOG ORAL BOARDS OBSTETRICS PRACTICE TEST (SAMPLE)

STUDY GUIDE



SAMPLE STUDY GUIDE WITH LIMITED QUESTIONS

VISIT US ONLINE FOR
THE FULL VERSION STUDY GUIDE

<https://abogoralobstetrics.examzify.com>



Copyright © 2026 by Examzify - A Kaluba Technologies Inc. product.

ALL RIGHTS RESERVED.

No part of this book may be reproduced or transferred in any form or by any means, graphic, electronic, or mechanical, including photocopying, recording, web distribution, taping, or by any information storage retrieval system, without the written permission of the author.

Notice: Examzify makes every reasonable effort to obtain accurate, complete, and timely information about this product from reliable sources.

SAMPLE

Table of Contents

Copyright	1
Table of Contents	2
Introduction	3
How to Use This Guide	4
Questions	5
Answers	8
Explanations	10
Next Steps	16

SAMPLE

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

SAMPLE

- 1. How should a pregnant patient with a history of thrombosis be managed in relation to APLAS?**
 - A. Start low-dose aspirin only
 - B. Continue lifelong anticoagulation or start prophylaxis heparin
 - C. Stop anticoagulation therapy entirely
 - D. Use only lifestyle modifications
- 2. Which antibiotic is recommended for wound incision management after a cesarean section in an outpatient setting?**
 - A. Cefazolin
 - B. Clindamycin
 - C. Amoxicillin
 - D. Vancomycin
- 3. What is the main difference between a surrogate and a gestational carrier?**
 - A. Both carry their own genetic offspring
 - B. Surrogate does not have a genetic link to the baby
 - C. Only gestational carriers donate their eggs
 - D. Surrogate is the biological mother; gestational carrier is not
- 4. Which fetal anomalies are associated with pregestational diabetes?**
 - A. Down syndrome and spina bifida
 - B. Sacral agenesis and cardiac anomalies
 - C. Clubfoot and limb reduction defects
 - D. Neural tube defects and cleft lip
- 5. Which of the following is a contraindication for external cephalic version?**
 - A. Fetal growth restriction
 - B. Breech presentation
 - C. Multiple gestation
 - D. Gestational diabetes

- 6. What is a potential fetal benefit of corticosteroid administration in preterm pregnancies?**
- A. Increase in birth weight
 - B. Reduction in respiratory distress syndrome
 - C. Reduction in need for cesarean section
 - D. Decrease in prenatal complications
- 7. How is *Chlamydia trachomatis* typically treated in pregnant women?**
- A. Azithromycin 1 gram orally in a single dose
 - B. Doxycycline 100mg orally twice a day for 7 days
 - C. Erythromycin 500mg orally 4 times a day for 7 days
 - D. Clindamycin 300mg orally 3 times a day for 7 days
- 8. What is the implication of having both copies of a gene on one chromosome with no copies on the other?**
- A. It indicates the absence of a carrier.
 - B. It usually leads to the expression of the disease.
 - C. It can incorrectly suggest a lack of carrier status.
 - D. It has no relevance.
- 9. What is the recommended management for acute urinary retention?**
- A. Immediate decompression through slow catheterization
 - B. Oral diuretics
 - C. Physical therapy
 - D. Increased fluid intake
- 10. What is one common cause of secondary hypertension?**
- A. Pheochromocytoma
 - B. Hypertension in pregnancy
 - C. Essential hypertension
 - D. Obesity

Answers

SAMPLE

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

SAMPLE

Explanations

SAMPLE

1. How should a pregnant patient with a history of thrombosis be managed in relation to APLAS?

- A. Start low-dose aspirin only
- B. Continue lifelong anticoagulation or start prophylaxis heparin**
- C. Stop anticoagulation therapy entirely
- D. Use only lifestyle modifications

Management of a pregnant patient with a history of thrombosis, particularly in relation to Antiphospholipid Syndrome (APS), often necessitates more than just conservative measures or lifestyle modifications. Patients with APS are at a significantly increased risk for both venous and arterial thrombotic events, especially during pregnancy. Starting lifelong anticoagulation or initiating prophylaxis with heparin is crucial in managing these patients. Heparin, particularly low molecular weight heparin (LMWH), is the treatment of choice during pregnancy as it effectively reduces the risk of thrombosis while being safe for the developing fetus. The use of heparin is preferred over other anticoagulants due to its ability to prevent placental insufficiency and other complications associated with APS, such as recurrent miscarriages or severe preeclampsia. In cases where a woman has had a previous thrombotic event, maintaining anticoagulation helps mitigate the potential for further incident occurrences during the pregnancy. Thus, the correct approach in managing a pregnant individual with a history of thrombosis related to APS is to either continue lifelong anticoagulation or start prophylaxis with heparin to ensure both maternal and fetal wellbeing.

2. Which antibiotic is recommended for wound incision management after a cesarean section in an outpatient setting?

- A. Cefazolin
- B. Clindamycin**
- C. Amoxicillin
- D. Vancomycin

The recommended antibiotic for wound incision management after a cesarean section in an outpatient setting is clindamycin, particularly in cases where there is a concern for penicillin allergy or when a broader coverage for skin flora, including anaerobes, is needed. Clindamycin is effective against staphylococci and streptococci, which are common pathogens involved in post-surgical infections. It also provides coverage for anaerobic bacteria, which can be particularly relevant for surgical wounds. In outpatient settings, it is crucial to prevent infections and facilitate healing, and clindamycin's bactericidal action makes it a suitable choice, especially in patients who may not tolerate other antibiotics. Additionally, it is administered orally, making it convenient for outpatient management. Cefazolin is commonly used as a prophylactic antibiotic during surgery and for inpatient management rather than for outpatient wound care due to its intravenous formulation. While amoxicillin has good coverage, it may not be sufficient against certain resistant strains. Vancomycin is generally reserved for more serious infections or situations where MRSA coverage is specifically indicated, making it less suitable for outpatient incision management in the absence of high-risk factors for resistant organisms.

3. What is the main difference between a surrogate and a gestational carrier?

- A. Both carry their own genetic offspring
- B. Surrogate does not have a genetic link to the baby
- C. Only gestational carriers donate their eggs
- D. Surrogate is the biological mother; gestational carrier is not**

The main difference between a surrogate and a gestational carrier hinges on the genetic relationship to the child they carry. A surrogate is traditionally someone who becomes pregnant with her own egg, often through artificial insemination, and therefore is the biological mother of the baby she carries. This arrangement means the surrogate has a genetic link to the child, as the child is conceived using the surrogate's ovum. On the other hand, a gestational carrier has no genetic connection to the child she carries. In this arrangement, embryos are created using the eggs and sperm of the intended parents or donors through in vitro fertilization, and then these embryos are implanted into the gestational carrier. Thus, while the gestational carrier carries the baby to term, she is not genetically related to the child. This distinction is crucial in understanding the different roles and biological relationships involved in the surrogacy process. The roles of surrogates and gestational carriers are legally and ethically significant in the context of family planning and reproductive technology.

4. Which fetal anomalies are associated with pregestational diabetes?

- A. Down syndrome and spina bifida
- B. Sacral agenesis and cardiac anomalies**
- C. Clubfoot and limb reduction defects
- D. Neural tube defects and cleft lip

Pregestational diabetes has been associated with a specific range of fetal anomalies, most notably sacral agenesis and cardiac anomalies. Sacral agenesis is characterized by the partial or complete absence of the sacrum, leading to a spectrum of musculoskeletal and neurological deficits. This condition is particularly linked to maternal diabetes due to the teratogenic effects of hyperglycemia, especially in the early weeks of gestation. Cardiac anomalies are also more prevalent in infants born to mothers with pregestational diabetes. Studies indicate that this condition can lead to various structural heart defects, including outflow tract obstructions and septal defects. The exact mechanism by which diabetes leads to these cardiac anomalies is complex and is thought to involve metabolic derangements caused by poorly controlled blood sugar levels during critical periods of fetal development. This association emphasizes the importance of proper management of blood glucose levels before and throughout pregnancy to minimize the risk of these serious congenital defects. In contrast, while other options list conditions related to maternal diabetes, they do not represent the most common or significant fetal anomalies linked specifically to pregestational diabetes.

5. Which of the following is a contraindication for external cephalic version?

- A. Fetal growth restriction
- B. Breech presentation**
- C. Multiple gestation
- D. Gestational diabetes

The practice of external cephalic version (ECV) is often considered for a fetus that is in a breech presentation, as the procedure aims to turn the fetus into a head-down position before delivery. However, there are specific contraindications for performing ECV that are important to recognize. Breech presentation itself is not a contraindication; rather, it is the primary indication for considering ECV. The procedure's goal is to correct the breech presentation, and therefore, it is essential to differentiate between what constitutes a contraindication and what indicates the need for the procedure. In the context of contraindications, certain factors may pose a risk to either the mother or the fetus if they undergo the ECV procedure. For example, conditions like fetal growth restriction, multiple gestation, or certain maternal complications may make it unsafe to attempt the procedure. Fetal growth restriction, for instance, introduces concerns about the health and well-being of the fetus during the manipulation involved in ECV. Similarly, multiple gestations can complicate the procedure, as the presence of more than one fetus increases the potential for adverse outcomes. In summary, while breech presentation is the scenario that typically prompts consideration for ECV, it is not a contraindication. The

6. What is a potential fetal benefit of corticosteroid administration in preterm pregnancies?

- A. Increase in birth weight
- B. Reduction in respiratory distress syndrome**
- C. Reduction in need for cesarean section
- D. Decrease in prenatal complications

Corticosteroid administration in preterm pregnancies is primarily aimed at accelerating fetal lung maturity. These medications promote the production of surfactant in the fetal lungs, which is crucial for reducing the risk of respiratory distress syndrome (RDS), a condition that results from inadequate surfactant levels leading to alveolar collapse and impaired gas exchange after birth. By ensuring that the lungs are better developed and more capable of functioning upon delivery, corticosteroids significantly lower the incidence of RDS, thus improving neonatal outcomes and reducing complications associated with prematurity. While other factors may improve with corticosteroid use, such as potential reductions in cesarean sections or prenatal complications, the most direct and clinically significant fetal benefit from these medications is the reduction in respiratory distress syndrome. This underscores the critical role that effective lung maturity plays in preterm infants' immediate postnatal health and survival.

7. How is Chlamydia trachomatis typically treated in pregnant women?

- A. Azithromycin 1 gram orally in a single dose**
- B. Doxycycline 100mg orally twice a day for 7 days
- C. Erythromycin 500mg orally 4 times a day for 7 days
- D. Clindamycin 300mg orally 3 times a day for 7 days

Chlamydia trachomatis is a common sexually transmitted infection that can pose risks during pregnancy, including complications such as preterm labor, low birth weight, and transmission to the neonate. The recommended treatment for Chlamydia in pregnant women is azithromycin 1 gram orally in a single dose. Azithromycin is preferred because it is effective, well-tolerated, and can be administered as a single dose, which enhances adherence to the treatment. This is especially important in a pregnant population where maintaining treatment compliance is critical to ensuring both maternal and fetal health. Other antibiotic options, though effective for chlamydial infections in general, are not recommended during pregnancy due to potential side effects or lack of sufficient research supporting their safety in pregnant women. For example, doxycycline is contraindicated in pregnancy because it can affect fetal bone and tooth development, while erythromycin, although sometimes used, has a higher frequency of gastrointestinal side effects and may not be as effective in this context as azithromycin. Clindamycin, while effective for certain infections, is not indicated as a first-line treatment for chlamydia in pregnant women. Thus, the guideline to treat pregnant women with a single dose of azithromycin reflects safety,

8. What is the implication of having both copies of a gene on one chromosome with no copies on the other?

- A. It indicates the absence of a carrier.
- B. It usually leads to the expression of the disease.
- C. It can incorrectly suggest a lack of carrier status.**
- D. It has no relevance.

The situation described, where both copies of a gene are on one chromosome with no copies on the other chromosome, typically indicates a form of chromosomal alteration, such as uniparental disomy or deletion on the homologous chromosome. This arrangement can lead to misleading interpretations regarding carrier status. When a gene is duplicated on one chromosome but absent on its homolog, it can create the false impression that an individual is not a carrier of a recessive trait. If a person carries a recessive mutation on one chromosome, and the second chromosome lacks that gene entirely, it can prevent detection of the carrier status during standard genetic testing. This phenomenon may lead to the conclusion that the individual does not carry a genetic predisposition to certain conditions, when in fact they may carry a pathogenic variant but are simply presenting with the duplication rather than the typical heterozygous state. This understanding is crucial in genetic counseling and testing since identifying carriers accurately is important for assessing risks for offspring and providing appropriate counseling to affected families.

9. What is the recommended management for acute urinary retention?

A. Immediate decompression through slow catheterization

B. Oral diuretics

C. Physical therapy

D. Increased fluid intake

The recommended management for acute urinary retention is immediate decompression through slow catheterization. This approach is critical because acute urinary retention typically presents as a sudden inability to void, often accompanied by significant discomfort or pain. In this situation, the immediate goal is to relieve the pressure and pain caused by the distended bladder. Catheterization allows for the prompt drainage of urine, alleviating the acute symptoms and preventing potential complications, such as bladder overdistension, infection, or bladder damage. Slow catheterization is particularly important in this context because it reduces the risk of causing further trauma to the bladder and urinary tract, which can occur with more rapid decompression. Other management strategies, such as oral diuretics, physical therapy, or increased fluid intake, do not address the immediate needs presented by acute urinary retention. Diuretics may exacerbate retention by further decreasing urine output without providing any relief. Physical therapy is not a direct treatment for urinary retention and typically focuses on strengthening relevant pelvic floor muscles, which is more appropriate for chronic bladder dysfunction rather than acute retention. Increased fluid intake may also worsen the situation by adding to an already full bladder without offering a means of relieving the retention. Therefore, the most appropriate and immediate intervention for acute urinary retention is catheterization

10. What is one common cause of secondary hypertension?

A. Pheochromocytoma

B. Hypertension in pregnancy

C. Essential hypertension

D. Obesity

Pheochromocytoma is a common cause of secondary hypertension due to its role as an adrenal tumor that produces excess catecholamines (such as epinephrine and norepinephrine). These hormones lead to increased heart rate and vascular resistance, resulting in elevated blood pressure. This condition is characterized by paroxysmal hypertension, often accompanied by symptoms like palpitations, sweating, and headaches. The diagnosis typically involves imaging studies and measurements of catecholamines in the plasma or urine, distinguishing it from primary hypertension, which lacks a specific identifiable cause. In contrast, other conditions listed may contribute to hypertension but do not directly function as common causes of secondary hypertension in the same manner. Hypertension in pregnancy, while a significant clinical issue, typically presents as either gestational hypertension or preeclampsia in a specific population rather than a broad cause of secondary hypertension. Essential hypertension refers to a primary form of high blood pressure without a clear underlying cause. Obesity is a significant risk factor for developing hypertension, but it typically leads to essential hypertension rather than functioning as a direct cause of secondary hypertension like pheochromocytoma.

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!

SAMPLE