

# Advanced Life Support in Obstetrics (ALSO) Practice Test (Sample)

## Study Guide



**Everything you need from our exam experts!**

**Copyright © 2025 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 from reliable sources accurate, complete, and timely information about this product.**

**SAMPLE**

## **Questions**

SAMPLE

- 1. What is a crucial aspect of patient education during prenatal visits in advanced life support in obstetrics?**
  - A. Providing a detailed birth plan**
  - B. Discussing warning signs during pregnancy and labor**
  - C. Advising on diet during pregnancy**
  - D. Scheduling routine postpartum check-ups**
- 2. What is the definitive diagnosis of eclampsia?**
  - A. Onset of elevated blood pressure**
  - B. Onset of seizures**
  - C. Onset of renal failure**
  - D. Onset of proteinuria**
- 3. Which is a medical management option for ectopic pregnancy?**
  - A. Methotrexate**
  - B. Insulin**
  - C. Ibuprofen**
  - D. Corticosteroids**
- 4. When should a physician consider emergency cesarean delivery?**
  - A. When fetal movement is noted**
  - B. In the presence of fetal distress, uterine rupture, or severe maternal condition**
  - C. Only during scheduled deliveries**
  - D. When the patient requests it**
- 5. What is the rationale behind performing a fundal massage after delivery?**
  - A. To promote uterine contraction and prevent postpartum hemorrhage**
  - B. To assess the fundal height**
  - C. To facilitate the expulsion of the placenta**
  - D. To increase maternal comfort**

- 6. In cases of maternal seizure during labor, what is the first step?**
- A. Administering sedatives**
  - B. Protecting the airway and administering oxygen**
  - C. Calling for surgical intervention**
  - D. Placing the patient in a prone position**
- 7. Describe the approach to care for a patient with significant vaginal bleeding in the third trimester.**
- A. Immediate stabilization, secure IV access, fluid resuscitation, and urgent assessment**
  - B. Waiting for the patient to stabilize before approaching treatment**
  - C. Performing an ultrasound before any intervention**
  - D. Starting a medication to slow down contractions**
- 8. When should heparin be discontinued before a scheduled induction or cesarean section?**
- A. 12 hours before**
  - B. 24 hours before**
  - C. 48 hours before**
  - D. At the onset of labor**
- 9. What clinical findings suggest the presence of gestational hypertension?**
- A. Bloating and loss of appetite**
  - B. Blood pressure greater than 140/90 mmHg after 20 weeks of gestation**
  - C. Fetal heart rate variability**
  - D. Increased white blood cell count**
- 10. What is the recommended first-line treatment for a patient experiencing pre-eclampsia?**
- A. Administer antihypertensive medication**
  - B. Provide IV fluids and monitor closely**
  - C. Administer magnesium sulfate to prevent seizures**
  - D. Initiate immediate labor induction**

## **Answers**

SAMPLE

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

SAMPLE

## **Explanations**

SAMPLE



**1. What is a crucial aspect of patient education during prenatal visits in advanced life support in obstetrics?**

- A. Providing a detailed birth plan**
- B. Discussing warning signs during pregnancy and labor**
- C. Advising on diet during pregnancy**
- D. Scheduling routine postpartum check-ups**

A crucial aspect of patient education during prenatal visits in the context of advanced life support in obstetrics is discussing warning signs during pregnancy and labor. Educating expectant mothers about potential warning signs empowers them to recognize when they may need immediate medical attention. This knowledge is vital to ensuring both maternal and fetal safety, as early identification of complications can significantly affect outcomes. For instance, patients should be informed about symptoms such as severe abdominal pain, heavy bleeding, or changes in fetal movement, which may indicate complications like placental abruption or preeclampsia. Understanding these warning signs helps pregnant individuals and their support systems react promptly, ensuring timely intervention. While other aspects of prenatal education, such as developing a birth plan, dietary advice, and scheduling postpartum check-ups, are important, they do not carry the same immediate relevance to potentially life-threatening situations that may arise during pregnancy and labor. Thus, the focus on recognizing warning signs is essential for enhancing patient safety and the overall quality of obstetric care.

**2. What is the definitive diagnosis of eclampsia?**

- A. Onset of elevated blood pressure**
- B. Onset of seizures**
- C. Onset of renal failure**
- D. Onset of proteinuria**

The definitive diagnosis of eclampsia is determined by the onset of seizures. Eclampsia is a serious condition associated with severe preeclampsia, characterized by new-onset seizures in a pregnant woman who has previously been diagnosed with preeclampsia or presents with symptoms of hypertension and edema. The presence of seizures is what distinguishes eclampsia from other hypertensive disorders in pregnancy, making it a critical factor in its diagnosis. While elevated blood pressure is a common finding in both preeclampsia and eclampsia, it is not exclusive to eclampsia and can also occur in other conditions. Similarly, renal failure and proteinuria may occur in preeclampsia, but neither of these are definitive indicators of eclampsia. Therefore, the onset of seizures is the key clinical criterion that confirms the diagnosis of eclampsia, emphasizing the need for immediate medical intervention to protect both the mother and the fetus.

**3. Which is a medical management option for ectopic pregnancy?**

**A. Methotrexate**

**B. Insulin**

**C. Ibuprofen**

**D. Corticosteroids**

Methotrexate is a medical management option for ectopic pregnancy due to its ability to inhibit cell division and effectively terminate the growth of the ectopic tissue. This medication works by targeting rapidly dividing cells, such as those found in certain types of pregnancy complications, thereby preventing the continuation of an ectopic pregnancy that could lead to serious complications like rupture and internal bleeding. In cases where early diagnosis is made and the ectopic pregnancy is unruptured, methotrexate can be administered to help dissolve the ectopic mass and allow the body to reabsorb the tissue. This non-invasive approach can preserve fertility and minimize the need for surgical intervention, making it a valuable option in specific scenarios. Other treatments listed, such as insulin, ibuprofen, and corticosteroids, do not have a therapeutic role in managing ectopic pregnancies. Insulin is primarily used for managing diabetes, ibuprofen is used for pain relief and inflammation, and corticosteroids have various anti-inflammatory applications but do not address the underlying problem of ectopic tissue growth.

**4. When should a physician consider emergency cesarean delivery?**

**A. When fetal movement is noted**

**B. In the presence of fetal distress, uterine rupture, or severe maternal condition**

**C. Only during scheduled deliveries**

**D. When the patient requests it**

Emergency cesarean delivery is indicated in situations where the health and safety of both the mother and the fetus are at significant risk. The presence of fetal distress—such as insufficient oxygen supply leading to signs of fetal compromise—demands swift action to prevent injury or death. Similarly, a uterine rupture can pose an immediate threat to maternal and fetal well-being, necessitating quick surgical intervention. Additionally, severe maternal conditions, like a significant hemorrhage or severe hypertension, also warrant an emergency cesarean to avoid further complications. In contrast, fetal movement is a normal occurrence and does not indicate an emergency situation. Scheduled deliveries lack the immediate urgency that necessitates an emergency procedure. While a patient's request should be considered in an ongoing clinical context, the decision for an emergency cesarean must be based on medical necessity rather than personal desire. Therefore, the correct choice highlights the critical conditions that clearly necessitate the urgent intervention of an emergency cesarean delivery.

**5. What is the rationale behind performing a fundal massage after delivery?**

**A. To promote uterine contraction and prevent postpartum hemorrhage**

**B. To assess the fundal height**

**C. To facilitate the expulsion of the placenta**

**D. To increase maternal comfort**

Performing a fundal massage after delivery is primarily aimed at promoting uterine contraction and preventing postpartum hemorrhage. After childbirth, the uterus needs to contract effectively to reduce the risk of excessive bleeding due to the separation of the placenta from the uterine wall. Fundal massage stimulates the uterine muscle, encouraging it to tighten and thus minimize the potential for hemorrhage, which is a leading cause of maternal morbidity and mortality. The action of massaging the fundus (the top part of the uterus) helps to ensure that the uterus is firm and contracted. A well-contracted uterus reduces the likelihood of atony, where the uterus fails to contract adequately, leading to excessive bleeding. Although fundal height assessment and facilitating the expulsion of the placenta are part of post-delivery care, they are not the primary rationale for performing a fundal massage. Additionally, while comfort for the mother may be a secondary benefit, it is not the main purpose of this intervention. Thus, the correct answer focuses on the critical role that fundal massage plays in uterine contraction to prevent complications related to postpartum hemorrhage.

**6. In cases of maternal seizure during labor, what is the first step?**

**A. Administering sedatives**

**B. Protecting the airway and administering oxygen**

**C. Calling for surgical intervention**

**D. Placing the patient in a prone position**

In cases of maternal seizure during labor, the priority is to protect the airway and ensure adequate oxygenation. During a seizure, there is a risk of aspiration and compromising the airway, which can lead to severe complications for both the mother and the fetus. Thus, maintaining a clear airway is paramount. Administering oxygen is also critical because the seizure can cause hypoxia, which can affect the fetus and the mother. Ensuring that the mother receives oxygen as soon as possible helps to provide the necessary support to maintain both maternal and fetal well-being. Other options, while they may have their place in overall seizure management or patient care, do not address the immediate threat to airway security and oxygenation that is essential in this acute situation.

**7. Describe the approach to care for a patient with significant vaginal bleeding in the third trimester.**

**A. Immediate stabilization, secure IV access, fluid resuscitation, and urgent assessment**

**B. Waiting for the patient to stabilize before approaching treatment**

**C. Performing an ultrasound before any intervention**

**D. Starting a medication to slow down contractions**

The approach to care for a patient with significant vaginal bleeding in the third trimester involves immediate stabilization, securing intravenous access, initiating fluid resuscitation, and conducting an urgent assessment. This protocol is crucial because significant bleeding can lead to rapid maternal and fetal compromise due to potential conditions such as placental abruption, previa, or even uterine rupture. Immediate stabilization is essential to prevent hypovolemic shock and stabilize maternal vital signs. Securing IV access allows for prompt fluid resuscitation, which is critical in managing the potential cardiovascular instability that can occur with significant blood loss. Fluid resuscitation helps to maintain perfusion to vital organs and the fetus. Furthermore, an urgent assessment is necessary to identify the cause of the bleeding, which can inform subsequent management strategies. This approach prioritizes the safety and health of both the mother and the fetus, recognizing that timely intervention is critical in obstetric emergencies. In contrast, delaying treatment to wait for stabilization, performing an ultrasound beforehand, or starting medications to slow contractions would not address the immediate risks associated with significant bleeding and could potentially worsen outcomes for both the mother and the fetus.

**8. When should heparin be discontinued before a scheduled induction or cesarean section?**

**A. 12 hours before**

**B. 24 hours before**

**C. 48 hours before**

**D. At the onset of labor**

Heparin, an anticoagulant medication, is important in preventing thromboembolic events, especially in certain populations during pregnancy. However, when planning for a scheduled induction or cesarean section, the risk of bleeding during and after the procedure increases when anticoagulants are present in the system. The appropriate timing for discontinuation of heparin is 24 hours before the scheduled procedure. This interval allows sufficient time for the anticoagulant effects of heparin to diminish safely, thus reducing the risk of excessive bleeding during surgical interventions. The pharmacokinetics of heparin indicate that, after this period, the majority of its anticoagulation effect will have waned, minimizing complications related to its use. In contrast, the other timings suggested do not provide an adequate window for the heparin's effects to be sufficiently reduced before the surgical or induction process. For instance, discontinuing heparin 12 hours prior may not be enough time for the drug to clear from the system, leaving a potential risk for increased bleeding. Similarly, stopping heparin 48 hours before may be unnecessarily cautious in many cases, which could lead to a higher risk of thromboembolic events if the heparin is needed for

**9. What clinical findings suggest the presence of gestational hypertension?**

- A. Bloating and loss of appetite**
- B. Blood pressure greater than 140/90 mmHg after 20 weeks of gestation**
- C. Fetal heart rate variability**
- D. Increased white blood cell count**

Gestational hypertension is characterized primarily by elevated blood pressure that occurs after 20 weeks of gestation. In this context, a blood pressure reading greater than 140/90 mmHg is a key clinical finding. This elevation in blood pressure is significant because it can lead to complications for both the mother and the fetus if not managed appropriately. The criteria for diagnosing gestational hypertension emphasize the importance of monitoring blood pressure during prenatal visits. This allows healthcare providers to identify potential issues early and intervene as necessary to ensure the health and safety of both the mother and the developing baby. Other options presented do not specifically indicate gestational hypertension. For instance, bloating and loss of appetite can be associated with various conditions during pregnancy but are not diagnostic criteria for this specific hypertension. Fetal heart rate variability is a normal finding that can indicate the well-being of the fetus rather than hypertension in the mother. An increased white blood cell count may suggest infection or another unrelated issue, but it does not directly correlate with the diagnosis of gestational hypertension. Thus, the blood pressure threshold established after 20 weeks of gestation remains the most definitive clinical finding for this condition.

**10. What is the recommended first-line treatment for a patient experiencing pre-eclampsia?**

- A. Administer antihypertensive medication**
- B. Provide IV fluids and monitor closely**
- C. Administer magnesium sulfate to prevent seizures**
- D. Initiate immediate labor induction**

Administering magnesium sulfate is the recommended first-line treatment for a patient experiencing pre-eclampsia, especially when there is a risk of progression to severe pre-eclampsia or eclampsia (seizures). Magnesium sulfate acts as a neuroprotective agent to help prevent seizures, which accompany severe forms of pre-eclampsia. The administration of magnesium sulfate has been shown to effectively reduce the incidence of seizures in these patients, making it a critical intervention in the management of pre-eclampsia. While controlling hypertension is also important in the management of pre-eclampsia, the immediate focus should be on seizure prevention, which magnesium sulfate directly addresses. Other supportive measures, like providing IV fluids or initiating labor induction, may be necessary depending on the clinical scenario, but they do not target the risk of seizures as effectively as magnesium sulfate does. Therefore, in the context of managing pre-eclampsia, the priority established by clinical guidelines is the prevention of seizures with magnesium sulfate.