

American Board of Obstetrics & Gynecology (ABOG) Qualifying Practice Exam (Sample)

Study Guide



Everything you need from our exam experts!

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SAMPLE

Questions

SAMPLE

- 1. Which hemoglobinopathy is known to cause fetal hydrops?**
 - A. Beta thalassemia major**
 - B. Alpha thalassemia major**
 - C. Sickle cell disease**
 - D. Hemoglobin SC disease**
- 2. Which of the following is not a clinical criterion for diagnosing antiphospholipid syndrome?**
 - A. Severe preeclampsia requiring early delivery**
 - B. Vascular thrombosis**
 - C. Single fetal loss before 10 weeks**
 - D. Two or more preterm births**
- 3. In cases of FGR requiring delivery due to maternal comorbid conditions, when is delivery recommended?**
 - A. At 30-32 weeks**
 - B. At 34-38 weeks**
 - C. At 37 weeks**
 - D. At 39 weeks**
- 4. Which of the following is NOT a criterion for inpatient management of PID?**
 - A. Severe clinical illness**
 - B. Adnexal abscesses**
 - C. Lack of response to oral medications**
 - D. Stable condition**
- 5. Which of the following is a commonly tested contraindication for the use of combined oral contraceptives (COCs)?**
 - A. Age >40**
 - B. Smoking at age 35 or older**
 - C. History of dysmenorrhea**
 - D. Having a family history of hypertension**

- 6. According to AHA recommendations, how much exercise should adults aim for weekly?**
- A. 75 minutes**
 - B. 150 minutes**
 - C. 200 minutes**
 - D. 300 minutes**
- 7. Which of the following is NOT a type of decidua during pregnancy?**
- A. Decidua basalis**
 - B. Decidua capsularis**
 - C. Decidua parietalis**
 - D. Decidua myometrium**
- 8. What should women with vitamin D deficiency in pregnancy take daily?**
- A. 400 IU**
 - B. 800 IU**
 - C. 1000 IU**
 - D. 1-2,000 IU**
- 9. What pressure is ideal for intra-abdominal pressure during laparoscopic surgery to minimize risks?**
- A. 4-6 mmHg**
 - B. 8-12 mmHg**
 - C. 15-20 mmHg**
 - D. 25-30 mmHg**
- 10. What is a key effect of crystalloid fluid resuscitation in hypovolemic shock?**
- A. Immediate hemostatic effect**
 - B. Rapid correction of hypokalemia**
 - C. Support for inadequate urine output**
 - D. Improvement of acid-base status**

Answers

SAMPLE

- 1. B**
- 2. D**
- 3. B**
- 4. D**
- 5. B**
- 6. B**
- 7. D**
- 8. D**
- 9. B**
- 10. D**

SAMPLE

Explanations

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1. Which hemoglobinopathy is known to cause fetal hydrops?

- A. Beta thalassemia major
- B. Alpha thalassemia major**
- C. Sick cell disease
- D. Hemoglobin SC disease

Alpha thalassemia major is known to cause fetal hydrops due to its severe impact on fetal development. In alpha thalassemia, there is a deficiency in the production of alpha globin chains, which can lead to a serious condition called Hydrops Fetalis, particularly when the fetus inherits a severe form of the disease from both parents. This condition results in significant anemia, heart failure, and various complications leading to the accumulation of fluid in the fetal compartments, thus causing hydrops. Alpha thalassemia major results from the deletion of all four alpha globin genes, causing severe hemolytic anemia in utero and triggering the body's compensatory mechanisms, which contribute to the pathophysiology of hydrops. The severity of this manifestation is due to the resultant erythroblastosis and other complications that can severely hinder the fetus's health. Therefore, alpha thalassemia major is the hemoglobinopathy associated with fetal hydrops in a significant clinical context.

2. Which of the following is not a clinical criterion for diagnosing antiphospholipid syndrome?

- A. Severe preeclampsia requiring early delivery
- B. Vascular thrombosis
- C. Single fetal loss before 10 weeks
- D. Two or more preterm births**

Antiphospholipid syndrome (APS) is characterized by the presence of persistent antiphospholipid antibodies along with specific clinical criteria, primarily involving thrombosis and pregnancy complications. Among these criteria, vascular thrombosis is a well-established feature of APS, seen in various forms such as venous or arterial clots. In terms of pregnancy outcomes associated with APS, the clinical criteria include specific types of pregnancy loss. A single fetal loss before 10 weeks of gestation associated with the presence of antiphospholipid antibodies serves as a noted criterion. However, preterm births in the absence of other risk factors or complications are not sufficient on their own to diagnose APS. The condition specifically outlines that there needs to be two or more pregnancy losses or particular complications, such as severe preeclampsia or fetal loss after 10 weeks, to qualify under its diagnostic criteria. Thus, while two or more preterm births due to any reason can occur in a pregnant individual with APS, they do not meet the stringent criteria required for diagnosing the syndrome itself, distinguishing them from the more direct implications of conditions like severe preeclampsia or vascular thrombosis that are part of APS.

3. In cases of FGR requiring delivery due to maternal comorbid conditions, when is delivery recommended?

- A. At 30-32 weeks
- B. At 34-38 weeks**
- C. At 37 weeks
- D. At 39 weeks

Delivery in cases of fetal growth restriction (FGR) due to maternal comorbid conditions is recommended primarily between 34 to 38 weeks of gestation to optimize neonatal outcomes while balancing the risks associated with preterm birth. After 34 weeks, the lungs and other vital organs of the fetus are sufficiently developed, allowing for a better chance of a successful transition to life outside the womb. Additionally, in the presence of maternal comorbidities such as hypertension, diabetes, or any conditions that can compromise placental function, earlier delivery can mitigate risks to both the mother and the fetus. Timing delivery closer to 38 weeks can further enhance respiratory maturity and reduce the chances of neonatal complications. However, this range is particularly tailored to the status of both maternal and fetal health at the time of assessment. Delivering at earlier times, such as at 30-32 weeks, can pose risks associated with significant prematurity, including respiratory distress syndrome and other complications. Aiming for delivery before 34 weeks may not provide sufficient time for fetal development, while waiting until 39 weeks may pose additional maternal risks and may not be justified if the fetal condition is unstable. Therefore, aiming for delivery within this 34 to 38-week window strikes

4. Which of the following is NOT a criterion for inpatient management of PID?

- A. Severe clinical illness
- B. Adnexal abscesses
- C. Lack of response to oral medications
- D. Stable condition**

Inpatient management of pelvic inflammatory disease (PID) is indicated based on specific clinical criteria that highlight the severity and complications of the illness. The criteria typically include severe clinical illness, the presence of adnexal abscesses, and lack of response to oral medications, all of which suggest that the patient may require more intensive treatment and monitoring that can only be provided in a hospital setting. When a patient is described as being in a stable condition, it implies that they do not exhibit the severe symptoms or complications typically associated with PID that would warrant inpatient care. Stability in a patient's condition often indicates that they can be treated safely and effectively with outpatient therapies. Thus, "stable condition" does not meet the criteria for requiring inpatient management, making it the correct answer for the question regarding what does not qualify for hospitalization in PID cases.

5. Which of the following is a commonly tested contraindication for the use of combined oral contraceptives (COCs)?

A. Age >40

B. Smoking at age 35 or older

C. History of dysmenorrhea

D. Having a family history of hypertension

The use of combined oral contraceptives (COCs) is contraindicated for women who smoke and are 35 years of age or older because smoking significantly increases the risk of cardiovascular complications associated with estrogen-containing contraceptives. The risk of thromboembolic events—such as deep vein thrombosis and pulmonary embolism—escalates in this population, leading to serious health concerns. Therefore, guidelines for prescribing COCs recommend careful assessment and often advise against their use in these individuals. Age greater than 40, history of dysmenorrhea, and having a family history of hypertension do not carry the same level of contraindication related to COC use. Women over 40 can often safely use COCs if they are otherwise healthy and do not have additional risk factors. Dysmenorrhea is not a contraindication and could actually be treated effectively with COCs. While a family history of hypertension may indicate a need for closer monitoring, it does not automatically contraindicate the use of COCs unless the woman has developed hypertension herself or has additional risk factors.

6. According to AHA recommendations, how much exercise should adults aim for weekly?

A. 75 minutes

B. 150 minutes

C. 200 minutes

D. 300 minutes

The American Heart Association (AHA) recommends that adults engage in at least 150 minutes of moderate-intensity aerobic exercise each week to achieve substantial health benefits. This recommendation is based on extensive research indicating that such a level of physical activity is effective in reducing the risk of various chronic diseases, managing weight, and improving mental health. Moderate-intensity exercise might include activities such as brisk walking, cycling on a flat surface, or gardening, where you are working hard enough to raise your heart rate and break a sweat but can still talk. Alternatively, adults can also aim for 75 minutes of vigorous-intensity exercise, such as running or swimming laps, but the recommendation of 150 minutes strikes a balance for most individuals, promoting sufficient cardiovascular health and overall fitness without being overly burdensome. Achieving 150 minutes can be broken down into manageable segments throughout the week, such as 30 minutes a day, five days a week, making it accessible for most people. This approach emphasizes the importance of consistency and incorporating exercise as a regular part of one's lifestyle for better long-term health outcomes.

7. Which of the following is NOT a type of decidua during pregnancy?

- A. Decidua basalis**
- B. Decidua capsularis**
- C. Decidua parietalis**
- D. Decidua myometrium**

Decidua is the term used to describe the modified mucosal lining of the uterus during pregnancy. It plays a crucial role in supporting the developing embryo and later, the fetus. The types of decidua include: - Decidua basalis, which is the area of the decidua that lies beneath the implanted embryo and contributes to the placenta. - Decidua capsularis, which surrounds the gestational sac and eventually becomes part of the placental membrane as the embryo grows. - Decidua parietalis, which refers to the remaining portion of the decidua lining the uterine cavity that does not come into direct contact with the placenta. The other option, decidua myometrium, is not a recognized type of decidua. The myometrium is the muscular layer of the uterus, distinct from the decidual tissue, and does not function in the same capacity during pregnancy. Therefore, identifying decidua myometrium as not being a type aligns with the understanding of decidua in the context of pregnancy and uterine anatomy.

8. What should women with vitamin D deficiency in pregnancy take daily?

- A. 400 IU**
- B. 800 IU**
- C. 1000 IU**
- D. 1-2,000 IU**

Women with vitamin D deficiency in pregnancy should take a daily supplement of 1,000 to 2,000 IU. This dosage is supported by research indicating that higher levels of vitamin D can be beneficial for both maternal and fetal health. During pregnancy, adequate vitamin D levels are important for calcium metabolism and bone health, which are critical for the developing fetus as well as for the mother's bone integrity. The recommended amount of vitamin D can vary based on individual needs and current vitamin D levels in the body, but it is widely accepted that 1,000 to 2,000 IU is a safe and effective range for those who are deficient. Vitamin D is not only important for bone health but also plays a role in immune function and has been linked to lower risks of certain pregnancy complications. Additionally, the other options tend to represent lower daily recommendations that may not be sufficient for women already identified with deficiency. Lower doses, such as 400 IU or 800 IU, may be adequate for maintenance once sufficient levels of vitamin D are reached, but they are typically not enough to correct a deficiency effectively during pregnancy. Thus, for women diagnosed with vitamin D deficiency, a higher supplementation of 1,000 to 2,000 IU is the recommended approach to

9. What pressure is ideal for intra-abdominal pressure during laparoscopic surgery to minimize risks?

- A. 4-6 mmHg
- B. 8-12 mmHg**
- C. 15-20 mmHg
- D. 25-30 mmHg

The ideal intra-abdominal pressure during laparoscopic surgery is typically maintained at a level between 8 and 12 mmHg. This range is established to create sufficient working space for the surgeon without compromising hemodynamics or causing excessive pressure on the diaphragm, which can lead to respiratory complications. Maintaining intra-abdominal pressure within this range is crucial for several reasons. First, it facilitates adequate visualization of the surgical field while also allowing for optimal organ displacement and mobility. Second, pressures above 12 mmHg can start to provoke adverse physiological responses, such as decreased venous return and impaired respiratory function. In particular, at pressures higher than 12 mmHg, there is a risk of significant cardiovascular and pulmonary changes, which can lead to complications during and after the surgery. Furthermore, pressures significantly lower than 8 mmHg may not provide enough pneumoperitoneum to safely and effectively manipulate the instruments and visualize the operative field. Therefore, the target pressure of 8-12 mmHg exemplifies a balance between providing ample operational space and minimizing potential risks associated with higher pressures.

10. What is a key effect of crystalloid fluid resuscitation in hypovolemic shock?

- A. Immediate hemostatic effect
- B. Rapid correction of hypokalemia
- C. Support for inadequate urine output
- D. Improvement of acid-base status**

In hypovolemic shock, the administration of crystalloid fluids plays a critical role in restoring intravascular volume and enhancing hemodynamic stability. One of the key effects of crystalloid fluid resuscitation is the improvement of acid-base status. When a patient is hypovolemic, perfusion to tissues is compromised, which can result in lactic acidosis due to anaerobic metabolism. By adequately resuscitating with crystalloids, the blood volume is increased, leading to improved tissue perfusion and oxygen delivery. This process helps to clear metabolic byproducts, including lactic acid, thus facilitating the correction of acidosis. As the circulating volume is restored and perfusion improves, the acid-base balance begins to normalize, which is essential in managing patients in shock. Other potential benefits of crystalloid resuscitation may not directly align with the primary effects observed; for instance, the immediate hemostatic effect is more associated with blood products rather than crystalloids. Furthermore, while crystalloid fluids can support urine output, they don't specifically address the direct cause of inadequate output. Rapid correction of hypokalemia is also not a main focus of crystalloid therapy, as the primary aim is fluid replacement rather than electrolyte correction. Therefore, enhancing