

Certified Obstetric Emergencies (C-OBE) Practice Exam (Sample)

Study Guide



Everything you need from our exam experts!

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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. Early warning signs of maternal decompensation include which combination?**
 - A. Tachycardia, tachypnea, mild hypotension, cool extremities**
 - B. Hypertension and tachycardia**
 - C. Fever and leukocytosis**
 - D. Hyperglycemia**

- 2. What empiric antibiotic combination is commonly used for chorioamnionitis?**
 - A. Ampicillin + Gentamicin (add Clindamycin if C-section)**
 - B. Penicillin alone**
 - C. Amoxicillin + Metronidazole**
 - D. Vancomycin + Gentamicin**

- 3. Tissue plasminogen activator (tPA) may be considered in pregnancy in which circumstances?**
 - A. Life-threatening PE or stroke**
 - B. Routine DVT prophylaxis**
 - C. Mild preeclampsia**
 - D. Normal postpartum period**

- 4. Which set of medications is listed as uterotonics in postpartum hemorrhage management?**
 - A. Pitocin (Oxytocin), Cytotec (Misoprostol), Tranexamic Acid**
 - B. Magnesium sulfate, Labetalol, Hydralazine**
 - C. Cefazolin, Ampicillin, Gentamicin**
 - D. Furosemide, Spironolactone, Hydrochlorothiazide**

- 5. Why is early fibrinogen replacement emphasized in obstetric hemorrhage?**
 - A. Pregnant patients have higher baseline fibrinogen, and a drop below 200 mg/dL is linked to severe PPH; early cryoprecipitate or fibrinogen concentrate helps prevent DIC.**
 - B. Fibrinogen levels are always low in pregnancy; replacement prevents anemia.**
 - C. Fibrinogen does not influence bleeding risk in obstetrics.**
 - D. Fibrinogen only matters after DIC develops.**

- 6. Management of a stable patient with an unruptured ectopic pregnancy includes which option?**
- A. Methotrexate (has no contraindications)**
 - B. Immediate cesarean section**
 - C. Expectant management only**
 - D. Ultrasound-guided aspiration only**
- 7. Which scoring system is specifically used for obstetric early warning in pregnancy?**
- A. MEOWS**
 - B. SOFA**
 - C. APACHE II**
 - D. ACLS score**
- 8. What is an appropriate first-line treatment for hypotension caused by high spinal anesthesia?**
- A. Administer a vasopressor**
 - B. Administer a diuretic**
 - C. Administer a bronchodilator**
 - D. Place patient in Trendelenburg plus oxygen**
- 9. In abruption-related DIC, which laboratory finding is typically elevated?**
- A. D-dimer**
 - B. Fibrinogen**
 - C. Platelet count**
 - D. Hemoglobin**
- 10. Which factors increase the risk for placenta accreta spectrum?**
- A. Prior cesarean deliveries and placenta previa**
 - B. Young age and lack of prior pregnancies**
 - C. Gestational diabetes only**
 - D. Hyperemesis gravidarum**

Answers

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

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Explanations

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1. Early warning signs of maternal decompensation include which combination?

- A. Tachycardia, tachypnea, mild hypotension, cool extremities**
- B. Hypertension and tachycardia**
- C. Fever and leukocytosis**
- D. Hyperglycemia**

Recognizing early decompensation relies on signs that perfusion is failing and the body is compensating to maintain oxygen delivery. Tachycardia, tachypnea, mild hypotension, and cool, clammy extremities together reflect the body's response to reduced circulating volume or cardiac output and the onset of poor tissue perfusion. In pregnancy, tachycardia can be normal, but when it occurs with rapid breathing, even a modest drop in blood pressure, and cool skin, it signals evolving shock or decompensation. The other patterns don't fit this scenario as tightly. Hypertension with tachycardia is more suggestive of preeclampsia, not decompensation from shock. Fever and leukocytosis point toward infection, which is important but not the immediate perfusion failure pattern. Hyperglycemia is a nonspecific stress response and not by itself a hallmark of decompensation.

2. What empiric antibiotic combination is commonly used for chorioamnionitis?

- A. Ampicillin + Gentamicin (add Clindamycin if C-section)**
- B. Penicillin alone**
- C. Amoxicillin + Metronidazole**
- D. Vancomycin + Gentamicin**

Chorioamnionitis needs rapid, broad-spectrum coverage of the organisms commonly ascending from the genital tract, including GBS, E. coli, and anaerobes. The combination of ampicillin and gentamicin provides that spectrum: ampicillin targets gram-positive cocci such as GBS and Listeria, while gentamicin adds strong gram-negative coverage, giving a reliable, effective early treatment while cultures and delivery are arranged. If cesarean delivery is anticipated or performed, adding clindamycin extends anaerobic coverage and helps prevent uterine infection after surgery, addressing the higher risk of anaerobic pathogens in the surgical setting. Other regimens are less ideal for initial empiric therapy: penicillin alone misses adequate gram-negative coverage; amoxicillin plus metronidazole isn't the standard IV inpatient regimen and can leave gaps in gram-negative coverage; vancomycin plus gentamicin focuses on resistant gram-positives and gram-negatives but doesn't optimally cover anaerobes and isn't the preferred first-line approach for routine chorioamnionitis.

3. Tissue plasminogen activator (tPA) may be considered in pregnancy in which circumstances?

- A. Life-threatening PE or stroke**
- B. Routine DVT prophylaxis**
- C. Mild preeclampsia**
- D. Normal postpartum period**

The situation where tissue plasminogen activator is considered in pregnancy is a life-saving, emergency use to rapidly dissolve a dangerous clot. Thrombolysis can be lifesaving for a massive pulmonary embolism or a large acute ischemic stroke when the mother's condition is unstable and the benefits outweigh the risk of serious bleeding. In these dire cases, the goal is to restore perfusion quickly to prevent collapse or irreversible brain injury, even though this treatment carries bleeding risks for both mother and fetus. Routine DVT prophylaxis is not treated with tPA; it relies on anticoagulants like heparin or LMWH to prevent clot formation rather than dissolve existing clots. Mild preeclampsia is managed with blood pressure control, seizure prophylaxis, and delivery planning rather than clot-busting therapy. A normal postpartum period is not an indication for thrombolysis, since there's no emergent clotting event to address. So, the best fit is using tPA only in a life-threatening thrombotic emergency, where rapid clot dissolution could save the mother's life and the clinical team has weighed the bleeding risks against the potential benefit.

4. Which set of medications is listed as uterotonics in postpartum hemorrhage management?

- A. Pitocin (Oxytocin), Cytotec (Misoprostol), Tranexamic Acid**
- B. Magnesium sulfate, Labetalol, Hydralazine**
- C. Cefazolin, Ampicillin, Gentamicin**
- D. Furosemide, Spironolactone, Hydrochlorothiazide**

Uterotonics are drugs that make the uterus contract to stop postpartum bleeding. The two key uterotonic medications widely used are oxytocin (Pitocin) and misoprostol (Cytotec). They actively stimulate uterine contractions to compress bleeding vessels. Tranexamic acid, while very helpful in reducing bleeding by stabilizing clots, does not cause uterine contractions. It's an adjunct in postpartum hemorrhage management to reduce blood loss, but it isn't a uterotonic. The other options contain drugs that are for blood pressure control, infection prevention, or diuretic use, none of which are uterotonics. So the set that includes Pitocin and Cytotec centers on the actual uterotonic agents used to induce uterine contractions, with tranexamic acid as an important adjunct in PPH care.

5. Why is early fibrinogen replacement emphasized in obstetric hemorrhage?

- A. Pregnant patients have higher baseline fibrinogen, and a drop below 200 mg/dL is linked to severe PPH; early cryoprecipitate or fibrinogen concentrate helps prevent DIC.**
- B. Fibrinogen levels are always low in pregnancy; replacement prevents anemia.**
- C. Fibrinogen does not influence bleeding risk in obstetrics.**
- D. Fibrinogen only matters after DIC develops.**

In obstetric hemorrhage, fibrinogen is a key determinant of how well a clot forms and stays intact. Although pregnant women start with higher fibrinogen levels, during a severe bleed those levels can plummet quickly due to blood loss and dilution from IV fluids. When fibrinogen falls below about 200 mg/dL, the clot becomes weak and bleeding worsens, which is a strong indicator that the patient is at high risk for progressing to severe hemorrhage and disseminated intravascular coagulation. Replacing fibrinogen early—using cryoprecipitate or a fibrinogen concentrate—helps restore the clot's strength before bleeding spirals out of control. This approach targets the underlying coagulopathy and supports hemostasis, rather than waiting for more obvious signs of trouble to appear. The other statements mischaracterize the situation: fibrinogen levels aren't always low in pregnancy; the concern isn't simply anemia, and fibrinogen directly influences bleeding risk in obstetrics. Waiting until DIC develops means treating a established crisis rather than preventing it.

6. Management of a stable patient with an unruptured ectopic pregnancy includes which option?

- A. Methotrexate (has no contraindications)**
- B. Immediate cesarean section**
- C. Expectant management only**
- D. Ultrasound-guided aspiration only**

For a stable patient with an unruptured ectopic pregnancy, medical management with methotrexate is an appropriate option when there are no contraindications. Methotrexate blocks the growth of rapidly dividing trophoblastic tissue, allowing the ectopic pregnancy to resolve without surgery. This approach is chosen to preserve fertility and avoid operative risks, provided the patient can be reliably followed. Key criteria include hemodynamic stability, no rupture, a relatively small ectopic mass (often under about 3.5 cm), no fetal cardiac activity, and a β -hCG level within the protocol's range. There must also be no contraindications to methotrexate, such as significant renal or hepatic disease, hematologic disorders, active peptic ulcer disease, immunodeficiency, or inability to comply with serial follow-up. After administration, serial β -hCG measurements are used to confirm a decreasing trend, with surgery considered if there is treatment failure. Immediate cesarean section is not indicated in this stable, unruptured scenario, and expectant management or ultrasound-guided aspiration alone are not the standard first-line choices in most cases.

7. Which scoring system is specifically used for obstetric early warning in pregnancy?

- A. MEOWS**
- B. SOFA**
- C. APACHE II**
- D. ACLS score**

Early recognition of deterioration in pregnancy relies on a tool that accounts for how obstetric physiology shifts normal vital signs. The MEOWS, or Modified Early Obstetric Warning Score, does exactly that by using obstetric-specific thresholds and signs. Pregnancy naturally alters heart rate, blood pressure, and other parameters, so a scoring system built for general patients can miss subtle problems. MEOWS adjusts these thresholds to reflect pregnancy, allowing a rising score to promptly trigger escalation to the obstetric team. This enables timely interventions for common obstetric emergencies such as hemorrhage, infection, or preeclampsia. The other scores are general critical-care tools not designed for obstetric physiology, so they don't provide the pregnancy-specific escalation cues needed.

8. What is an appropriate first-line treatment for hypotension caused by high spinal anesthesia?

- A. Administer a vasopressor**
- B. Administer a diuretic**
- C. Administer a bronchodilator**
- D. Place patient in Trendelenburg plus oxygen**

High spinal anesthesia blocks sympathetic nerves, causing widespread vasodilation and a drop in systemic vascular resistance and venous return. The immediate goal is to restore vascular tone and raise the mean arterial pressure so organs, including the uterus and fetus, continue to be perfused. A vasopressor directly counteracts the vasodilation by constricting blood vessels, thereby quickly increasing systemic vascular resistance and improving pressure. This makes a vasopressor the best first-line treatment in this scenario. Repositioning the patient in Trendelenburg with oxygen might provide a small, temporary boost in venous return, but it does not address the underlying loss of vascular tone as effectively. A diuretic would reduce circulating volume and worsen hypotension, and a bronchodilator isn't relevant to this circulatory issue.

9. In abruption-related DIC, which laboratory finding is typically elevated?

- A. D-dimer**
- B. Fibrinogen**
- C. Platelet count**
- D. Hemoglobin**

When placental abruption triggers disseminated intravascular coagulation, there's widespread clot formation followed by breakdown of those clots. This increases fibrinolysis, leading to elevated fibrin degradation products. D-dimer is a specific fragment released when crosslinked fibrin is degraded, so its level rises in abruption-related DIC. That makes D-dimer the typical elevated lab finding. Conversely, fibrinogen is usually consumed and decreases, platelets drop due to consumption, and hemoglobin is not elevated and may fall from bleeding.

10. Which factors increase the risk for placenta accreta spectrum?

- A. Prior cesarean deliveries and placenta previa**
- B. Young age and lack of prior pregnancies**
- C. Gestational diabetes only**
- D. Hyperemesis gravidarum**

The key concept is that placenta accreta spectrum is strongly linked to placental bed abnormalities from previous uterine surgery, especially when placenta previa is present. When a uterus has scar tissue from prior cesarean deliveries, the normal decidual layer at the placental interface can be disrupted, allowing placental villi to invade into the myometrium (accreta, increta, or percreta). Placenta previa places the placenta over the cervix, often overlapping scar tissue, which further increases the likelihood of abnormal placentation. The risk climbs with the number of prior cesarean sections. Other factors listed—younger age with no prior pregnancies, gestational diabetes alone, or hyperemesis gravidarum—do not have the same strong association with PAS.

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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://cobe.examzify.com>

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

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