

CERTIFIED OBSTETRIC EMERGENCIES (C-OBE) PRACTICE EXAM (SAMPLE)

STUDY GUIDE



**SAMPLE STUDY GUIDE
WITH LIMITED QUESTIONS**

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THE FULL VERSION STUDY GUIDE**

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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. How is ARDS defined and managed in obstetrics?

- A. $\text{PaO}_2/\text{FiO}_2 < 200$ with unilateral infiltrates; conservative ventilation
- B. $\text{PaO}_2/\text{FiO}_2 < 300$ with bilateral infiltrates not due to cardiac failure; ventilatory support with low tidal volume, manage infection/sepsis
- C. $\text{PaO}_2/\text{FiO}_2 < 100$; high tidal volume ventilation
- D. ARDS is not applicable in obstetrics

2. In severe placental abruption, fibrinogen is often less than what value?

- A. $< 200 \text{ mg/dL}$
- B. $> 400 \text{ mg/dL}$
- C. $300\text{-}400 \text{ mg/dL}$
- D. $200\text{-}400 \text{ mg/dL}$

3. Peripartum cardiomyopathy most commonly presents when?

- A. Last month of pregnancy to 5 months postpartum
- B. During first trimester
- C. Immediately after cesarean section only
- D. In adolescence

4. Which describes the three main breech presentations?

- A. Frank breech: hips flexed, knees extended; Complete breech: hips and knees flexed; Incomplete breech: one or both hips extended; includes footling and kneeling
- B. Frank breech: hips extended, knees flexed; Complete breech: hips and knees extended; Incomplete breech: hips flexed
- C. Frank breech: head first; Complete breech: buttocks first; Incomplete breech: feet first
- D. Frank breech: hips flexed; Complete breech: hips flexed and knees extended; Incomplete breech: both hips extended

5. Organ dysfunction markers in maternal sepsis commonly include which combination?

- A. Elevated creatinine, elevated liver enzymes, and decreased platelets
- B. Elevated creatinine only
- C. Decreased creatinine and normal LFTs
- D. Low lactate and normal platelets

- 6. What is the TXA dosing regimen described for obstetric hemorrhage?**
- A. 1 g IV over 10 minutes; second dose if bleeding persists
 - B. 2 g IV over 30 minutes
 - C. 1 g IV bolus only
 - D. 500 mg IV push
- 7. Placenta accreta spectrum is most strongly associated with which obstetric history factor?**
- A. Prior cesarean deliveries
 - B. First pregnancy
 - C. No prior imaging
 - D. Maternal smoking
- 8. Which description matches Grade I placental abruption?**
- A. Mild bleeding, no fetal distress
 - B. Severe bleeding with painful contractions
 - C. Moderate bleeding with fetal distress
 - D. No bleeding with fetal distress
- 9. After an ischemic stroke in pregnancy, which of the following is typically part of management after the acute event?**
- A. Blood pressure control and antiplatelet therapy
 - B. Immediate initiation of full-dose thrombolysis in all cases
 - C. Avoid any antiplatelets due to bleeding risk
 - D. Immediate surgical intervention to remove clots without medical therapy
- 10. Recurrence risk of uterine rupture in future pregnancies is approximately:**
- A. About 4–19%
 - B. About 50%
 - C. About 1%
 - D. About 90%

Answers

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1. B
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. How is ARDS defined and managed in obstetrics?

- A. $\text{PaO}_2/\text{FiO}_2 < 200$ with unilateral infiltrates; conservative ventilation
- B. $\text{PaO}_2/\text{FiO}_2 < 300$ with bilateral infiltrates not due to cardiac failure; ventilatory support with low tidal volume, manage infection/sepsis**
- C. $\text{PaO}_2/\text{FiO}_2 < 100$; high tidal volume ventilation
- D. ARDS is not applicable in obstetrics

ARDS in obstetrics is defined by acute onset hypoxemic respiratory failure with a $\text{PaO}_2/\text{FiO}_2$ ratio ≤ 300 , accompanied by bilateral infiltrates on imaging that are not fully explained by cardiac failure or fluid overload. In pregnancy, the goal is to support oxygenation while protecting the lungs from further injury, since maternal oxygen delivery directly affects fetal well-being. The best approach matches this definition and management: a $\text{PaO}_2/\text{FiO}_2$ ratio under 300 with bilateral infiltrates not due to cardiac failure, plus ventilatory support using low tidal volumes to minimize volutrauma and adjust PEEP as needed, along with treating any underlying infection or sepsis. The other options don't fit: unilateral infiltrates contradict the bilateral edema pattern of ARDS, a very low $\text{PaO}_2/\text{FiO}_2$ with high tidal volumes promotes lung injury, and ARDS can and does occur in pregnancy, so saying it's not applicable is incorrect.

2. In severe placental abruption, fibrinogen is often less than what value?

- A. < 200 mg/dL**
- B. > 400 mg/dL
- C. 300–400 mg/dL
- D. 200–400 mg/dL

In severe placental abruption, tissue factor release can trigger intravascular coagulation that consumes clotting factors, especially fibrinogen. As fibrinogen is used up faster than it's produced, its level drops, and this hypofibrinogenemia signals a significant coagulopathy and ongoing bleeding risk. Normal fibrinogen is about 200–400 mg/dL, so when it falls below 200 mg/dL in this scenario, it most strongly indicates severe consumption coagulopathy and guides urgent management (including fibrinogen replacement). The other ranges described are not as characteristic of the dramatic fibrinogen depletion seen with severe abruption-related DIC.

3. Peripartum cardiomyopathy most commonly presents when?

- A. Last month of pregnancy to 5 months postpartum**
- B. During first trimester
- C. Immediately after cesarean section only
- D. In adolescence

Peripartum cardiomyopathy is a dilated cardiomyopathy that presents with heart failure symptoms during the peripartum period. It most commonly emerges from the last month of pregnancy through about five months after delivery because this window captures the peak hemodynamic and hormonal shifts: the substantial increase in blood volume and cardiac output late in pregnancy followed by postpartum changes that can unmask or precipitate ventricular dysfunction. This timing helps distinguish it from conditions that would present in early pregnancy (first trimester), only in the immediate postoperative period, or unrelated to pregnancy timing such as adolescence.

4. Which describes the three main breech presentations?

- A. Frank breech: hips flexed, knees extended; Complete breech: hips and knees flexed; Incomplete breech: one or both hips extended; includes footling and kneeling**
- B. Frank breech: hips extended, knees flexed; Complete breech: hips and knees extended; Incomplete breech: hips flexed
- C. Frank breech: head first; Complete breech: buttocks first; Incomplete breech: feet first
- D. Frank breech: hips flexed; Complete breech: hips flexed and knees extended; Incomplete breech: both hips extended

Breech presentations are classified by how the hips and knees are positioned, which determines which part presents first. In frank breech, the hips are flexed and the knees are extended, so the buttocks present first with the legs extended upward toward the head. In complete breech, both the hips and knees are flexed, so the buttocks present with the legs folded and the feet closer to the face. In incomplete breech, the hips are extended, so the presenting part can be a foot or a knee rather than the buttocks, and this includes subtypes where feet (footling) or knees (kneeling) present first. This description lines up with the statement that the three main breech presentations are frank (hips flexed, knees extended), complete (hips and knees flexed), and incomplete (hips extended, with footling or kneeling variants).

5. Organ dysfunction markers in maternal sepsis commonly include which combination?

- A. Elevated creatinine, elevated liver enzymes, and decreased platelets**
- B. Elevated creatinine only
- C. Decreased creatinine and normal LFTs
- D. Low lactate and normal platelets

In maternal sepsis, organ dysfunction is reflected by involvement of multiple organ systems, and the lab markers that signal this dysfunction typically include the kidneys, liver, and blood-forming/coagulation systems. Elevated creatinine indicates kidney injury, which is a common and serious complication in sepsis. Elevated liver enzymes point to hepatic dysfunction, another frequent organ insult during septic processes. A decreased platelet count signals hematologic/coagulation abnormalities, which can arise from sepsis-related disseminated intravascular coagulation or liver-related effects on platelets. Together, these markers show multi-system involvement, which is characteristic of severe sepsis. The other options don't fit as well because they either focus on a single abnormality, propose a counterintuitive change (like decreased creatinine), or rely on lactate levels with normal platelets, which doesn't capture organ dysfunction across multiple systems.

6. What is the TXA dosing regimen described for obstetric hemorrhage?

- A. 1 g IV over 10 minutes; second dose if bleeding persists**
- B. 2 g IV over 30 minutes
- C. 1 g IV bolus only
- D. 500 mg IV push

The key idea here is how tranexamic acid is used to control obstetric hemorrhage. The standard regimen is a 1-gram intravenous dose given over about 10 minutes, with a second 1-gram dose if the bleeding persists. This approach, backed by obstetric hemorrhage guidelines and trials, emphasizes early administration to reduce mortality from bleeding. The second dose is only given if bleeding continues, so the total dose can be up to 2 grams but not given all at once in a single large infusion.

7. Placenta accreta spectrum is most strongly associated with which obstetric history factor?

A. Prior cesarean deliveries

B. First pregnancy

C. No prior imaging

D. Maternal smoking

Placenta accreta spectrum arises when placental tissue attaches to or invades the uterine wall because the normal decidual layer is disrupted. Uterine scarring from prior cesarean deliveries creates areas where the decidua basalis is deficient, allowing placental villi to adhere to or invade the myometrium more deeply than normal. The presence and number of prior cesarean sections are the strongest history-linked risk factors, and the risk rises with each additional cesarean. While other factors like placenta previa can amplify the risk, a history of prior cesarean deliveries alone is the most influential predictor. In contrast, being in the first pregnancy, having no prior imaging, or maternal smoking do not carry the same strong association with PAS.

8. Which description matches Grade I placental abruption?

A. Mild bleeding, no fetal distress

B. Severe bleeding with painful contractions

C. Moderate bleeding with fetal distress

D. No bleeding with fetal distress

Grade I placental abruption is characterized by a mild separation of the placenta with minimal clinical impact. The hallmark is light vaginal bleeding and a reassuring fetus with no fetal distress, while the mother remains hemodynamically stable and the uterus is not markedly tender or hypertonic. This milder presentation distinguishes it from higher-grade abruptions, which show heavier bleeding, uterine tenderness or contractions, and fetal distress or maternal instability. Therefore, mild bleeding with no fetal distress aligns best with Grade I.

9. After an ischemic stroke in pregnancy, which of the following is typically part of management after the acute event?

A. Blood pressure control and antiplatelet therapy

B. Immediate initiation of full-dose thrombolysis in all cases

C. Avoid any antiplatelets due to bleeding risk

D. Immediate surgical intervention to remove clots without medical therapy

After an ischemic stroke in pregnancy, the goal is to stabilize the mother and prevent new injury while minimizing bleeding risk for both mother and fetus. The typical post-acute approach focuses on careful blood pressure control to reduce the chance of hemorrhagic transformation and to maintain adequate placental perfusion, along with antiplatelet therapy to lower the risk of early recurrent stroke. Low-dose aspirin is commonly used in pregnancy when an antithrombotic is indicated because it has a favorable safety profile for both mother and baby. Full-dose thrombolysis is not automatically given in every case; it carries bleeding risks and requires strict timing and evaluation, which makes it unsuitable as the default management for all patients. Immediate surgical removal of clots without medical therapy isn't standard; procedures like mechanical thrombectomy are considered in specific scenarios (such as large-vessel occlusion) and are not a universal replacement for medical therapy.

10. Recurrence risk of uterine rupture in future pregnancies is approximately:

A. About 4–19%

B. About 50%

C. About 1%

D. About 90%

A prior uterine rupture means the uterus has a scar that can be a weak point in future pregnancies, so recurrence risk is real but not deterministically high. In studies of women with this history, the chance of another rupture in a subsequent pregnancy falls in a broad range, commonly cited as about 4–19%. This variability comes from differences in how rupture is defined, the type and extent of the scar, interpregnancy interval, and how labor is managed. The risk is clearly higher than in the general population, but it is not near certainty, so the estimate A best reflects the typical range reported in the literature.

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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:

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

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