

FExNet 2026

Collated SAQs: Obstetrics & Gynaecology

ANSWER BOOKLET

Model answers for the 22 O&G; SAQs. References cited at the foot of each question. Items marked [core] are required for full marks. Drug doses current to 2025 — confirm with current eTG / RANZCOG / SOMANZ before clinical application.

22 questions • 251 marks

ACEM-aligned format. Sub-questions labelled a) b) c). Mark allocations indicative; references cited in the Answer Booklet. Question and answer indexes are clickable.

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Click any entry to jump to its answer. Marks shown right.

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Question 1 | Pre-eclampsia, HELLP and Eclampsia (16 marks)

A 26-year-old woman, G1P0, presents at 32 weeks gestation with epigastric pain and headache. Vitals: HR 110, BP 165/110, RR 26, SpO₂ 95% RA. Bloods show Hb 80 g/L, platelets $65 \times 10^9/L$, AST 380 U/L, LDH 1100 U/L, urate elevated, urinalysis 3+ protein.

a) List the 4 key diagnostic criteria for HELLP syndrome. (4 marks)

- Haemolysis — schistocytes on film, LDH >600 U/L, low haptoglobin, raised bilirubin [core]
- Elevated Liver enzymes — AST/ALT >2× upper limit [core]
- Low Platelets — $<100 \times 10^9/L$ [core]
- Occurs in the context of pre-eclampsia (hypertension and/or proteinuria) at >20 weeks gestation [core]

b) List 4 life-threatening complications of pre-eclampsia / HELLP. (4 marks)

- Eclampsia (generalised tonic-clonic seizure) [core]
- Intracranial haemorrhage / posterior reversible encephalopathy syndrome (PRES) [core]
- Hepatic rupture / subcapsular haematoma [core]
- Acute pulmonary oedema (capillary leak + cardiac dysfunction) [core]
- Disseminated intravascular coagulation
- Acute kidney injury / cortical necrosis
- Placental abruption
- Stillbirth / IUGR / fetal demise

c) The patient has a generalised tonic-clonic seizure. State 4 specific management steps with drug, dose, and end-point. (4 marks)

- Magnesium sulfate 4 g IV over 5-10 min loading, then 1-2 g/h infusion. End-point: seizure termination; monitor reflexes (loss = toxicity), RR >12, urine output >30 mL/h [core]
- Position left-lateral; high-flow O₂; protect airway (jaw thrust, suction); IV access [core]
- If continuing seizure after MgSO₄: additional 2 g IV bolus or midazolam 5-10 mg IV (avoid prolonged benzodiazepines if possible) [core]
- Calcium gluconate 10% 10 mL IV available for MgSO₄ toxicity [core]
- Continuous CTG monitoring once seizure controlled

d) BP is now 180/115. State 4 ongoing management priorities. (4 marks)

- Antihypertensive therapy — labetalol 20 mg IV bolus (repeat or infuse) OR hydralazine 5-10 mg IV OR oral nifedipine 10 mg. Target BP 140-160 / 90-100 mmHg (avoid rapid drop — placental hypoperfusion) [core]
- Continue magnesium sulfate infusion for seizure prophylaxis (target 24 h post-delivery) [core]
- Definitive treatment is delivery — urgent obstetric review for delivery decision; corticosteroids (betamethasone 11.4 mg IM) if <34/40 [core]
- Strict fluid balance — avoid overload (pulmonary oedema risk); IDC; hourly observations [core]
- Cross-match blood and platelets if HELLP severe
- Senior anaesthetic review (avoid neuraxial if platelets <75)
- Notify NICU, paediatrics, theatre, blood bank

References: SOMANZ Hypertensive Disorders of Pregnancy Guideline 2014 • RANZCOG Statement (current) • eTG (Therapeutic Guidelines, current) • Tintinalli's Emergency Medicine 9e Ch 100 • ACEM clinical policies and statements

Question 2 | Pelvic Inflammatory Disease (12 marks)

A 22-year-old woman presents with left lower quadrant pain, fever 38.5°C, and PV discharge. Sexually active, negative β -hCG.

a) List 4 historical features that raise suspicion for PID over appendicitis. (4 marks)

- Multiple sexual partners, new partner within 3 months, unprotected intercourse [core]
- Bilateral or non-localised lower abdominal pain (appendicitis tends to be RLQ) [core]
- Vaginal discharge, intermenstrual or post-coital bleeding [core]
- Deep dyspareunia [core]
- Recent IUD insertion (within 3 weeks)
- Previous STI / PID episode
- Symptom onset around or after menses

b) List 4 investigations to perform AND state the relevant finding for each. (4 marks)

- **Urine PCR or endocervical swabs** — chlamydia, gonorrhoea, mycoplasma genitalium, trichomonas [core]
- **Urine β -hCG** — exclude ectopic / pregnancy [core]
- **Pelvic ultrasound (TVS)** — tubo-ovarian abscess, hydrosalpinx, free fluid [core]
- FBC + CRP — leucocytosis, raised inflammatory markers [core]
- MSU — exclude UTI
- HIV / syphilis screen
- Speculum exam — cervical motion tenderness, mucopurulent discharge, friability

c) State 4 components of management for confirmed PID per current eTG. (4 marks)

- **Empirical IV antibiotics if severe / TOA / septic:** ceftriaxone 2 g IV daily + azithromycin 1 g PO + metronidazole 500 mg IV q12h (per eTG / RANZCOG) [core]
- **Outpatient regimen** if mild and tolerating: ceftriaxone 500 mg IM stat + doxycycline 100 mg PO BD for 14 days + metronidazole 400 mg PO BD for 14 days [core]
- Partner notification and treatment (last 60 days) [core]
- Review at 72 hours; surgical drainage if TOA fails antibiotics; remove IUD if no response in 48-72 h [core]
- Counsel re: future fertility, ectopic, chronic pelvic pain risk; STI prevention
- Notification of chlamydia/gonorrhoea per state public health regulations

References: eTG (Therapeutic Guidelines, current) • RANZCOG Statement (current) • Tintinalli's Emergency Medicine 9e Ch 102 • Australian STI Management Guidelines

Question 3 | Ectopic Pregnancy (12 marks)

A 28-year-old G2P1 woman presents with 6 hours of right lower quadrant pain and PV bleeding. LMP 7 weeks ago. β -hCG 4500 IU/L. HR 115, BP 90/55.

a) List 3 historical risk factors for ectopic pregnancy. (3 marks)

- Previous ectopic pregnancy (10-25% recurrence risk) [core]
- Previous pelvic / tubal surgery (sterilisation, salpingectomy, ectopic excision) [core]
- Previous PID / chlamydia / gonorrhoea infection [core]
- IUD in situ (failed contraception → ectopic over IUP)
- Assisted reproduction (IVF/ICSI) — also raises heterotopic risk
- Smoking
- Endometriosis

b) List 3 sonographic findings concerning for ectopic on TVS. (3 marks)

- Empty uterus with β -hCG above the discriminatory zone (>1500-2000 IU/L for TVS) [core]
- Adnexal mass separate from the ovary (tubal ring or 'bagel' sign, complex mass) [core]
- Free fluid in the pouch of Douglas (significant haemoperitoneum if echogenic) [core]
- Live extrauterine pregnancy (cardiac activity outside uterus — pathognomonic)
- 'Ring of fire' on colour Doppler
- Pseudosac in uterus (centrally placed, lacks double decidual sign / yolk sac)

c) State 6 immediate management priorities for this haemodynamically unstable patient. (6 marks)

- Activate massive transfusion / O-negative blood until crossmatched [core]
- Two large-bore IV access; FBC, group & crossmatch (4 units), coagulation, β -hCG, U&E; [core]
- Urgent O&G; consultation — direct to theatre for laparoscopy / laparotomy $\pm$ salpingectomy [core]
- Anti-D 250 IU IM if Rh-negative and <12/40, or 625 IU IM if >12/40 [core]
- Permissive hypotension during resuscitation (target SBP 80-90); avoid large-volume crystalloid [core]
- Analgesia (morphine titrated), anti-emetics, consent for surgery, IDC [core]
- Notify theatre, blood bank, anaesthetics simultaneously
- Continuous monitoring; arterial line if persistently shocked

References: RANZCOG Statement (current) • ASUM / RANZCR Early Pregnancy Imaging Guidelines • eTG (Therapeutic Guidelines, current) • Tintinalli's Emergency Medicine 9e Ch 100 • Cameron's Textbook of Adult Emergency Medicine 5e

Question 4 | First-Trimester Bleeding — Miscarriage (11 marks)

A 29-year-old G1P0 woman, 8 weeks by LMP, presents with PV bleeding (2 pads in 6 h) and mild abdominal cramping. Stable vitals. β -hCG 6440. TVS shows intrauterine sac with mean sac diameter 26 mm and no fetal pole identified.

a) State the diagnosis and the diagnostic criteria. (2 marks)

- **Missed miscarriage (early pregnancy loss) [core]**
- Per ASUM/RANZCOG criteria — mean sac diameter ≥ 25 mm without visible embryo OR embryo crown-rump length ≥ 7 mm without cardiac activity (TVS, single confirming scan) [core]

b) Complete the table — for each type of miscarriage, state the cervical os finding AND whether products have passed. (5 marks)

- **Threatened** — cervical os CLOSED; no products passed; viable IUP [core]
- **Inevitable** — cervical os OPEN; no/some products passed; bleeding ongoing [core]
- **Incomplete** — cervical os OPEN; some products passed; retained products on USS [core]
- **Complete** — cervical os CLOSED; all products passed; empty uterus on USS [core]
- **Missed (delayed)** — cervical os CLOSED; no products passed; non-viable IUP on USS [core]

c) List the 3 management options for missed miscarriage. (3 marks)

- **Expectant** — watchful waiting up to 2 weeks; reassess; success ~50% in missed miscarriage [core]
- **Medical** — misoprostol 800 μ g PV (per RANZCOG), repeat at 24-48 h if needed; success ~80% [core]
- **Surgical** — suction curettage / D&C; indicated if heavy bleeding, sepsis, patient preference, or failure of conservative measures [core]

d) State the dose and route of anti-D for this Rh-negative patient at <12 weeks. (1 mark)

- Anti-D 250 IU IM (single dose), within 72 h of the bleeding event (per Australian Red Cross Blood Service guidelines) [core]

References: RANZCOG Statement (current) • ASUM / RANZCR Early Pregnancy Imaging Guidelines • eTG (Therapeutic Guidelines, current) • Australian Red Cross Anti-D

Question 5 | Hyperemesis Gravidarum (10 marks)

A 24-year-old G2P1 woman at 10 weeks gestation presents with 3 days of severe vomiting, poor oral intake. She has lost 4 kg since pregnancy started. She appears dehydrated. K 2.9, Na 132, ketones 4+ on urinalysis.

a) State the 3 diagnostic criteria for hyperemesis gravidarum. (3 marks)

- Persistent vomiting in pregnancy not related to other causes [core]
- Acute starvation — large ketonuria [core]
- Weight loss >5% of pre-pregnancy body weight [core]
- Often associated with electrolyte disturbance (hypoK, hypoNa, alkalosis), dehydration

b) List 3 differential diagnoses for vomiting in early pregnancy. (3 marks)

- Molar pregnancy (very high β -hCG drives vomiting) [core]
- Gastroenteritis / food poisoning
- Urinary tract infection / pyelonephritis
- Acute appendicitis or cholecystitis
- Thyrotoxicosis (β -hCG cross-reactivity)
- DKA (in known/new diabetic)
- Drug-related (iron, opioids)

c) State 4 components of management with drug, dose, route. (4 marks)

- **IV rehydration** — Hartmann's 1-2 L stat, continue until ketonuria clears; do NOT use dextrose-only solutions (Wernicke risk) [core]
- **Thiamine 100 mg IV daily** for 3 days BEFORE any IV dextrose (Wernicke prophylaxis) [core]
- **Antiemetic ladder:** pyridoxine 25-50 mg PO TDS + doxylamine 25 mg PO; if inadequate add metoclopramide 10 mg IV / ondansetron 4-8 mg IV (after 10 weeks) $\pm$ prochlorperazine; corticosteroids reserved for refractory cases [core]
- Replace electrolytes — potassium 40 mmol IV in 1 L over 4 h if K <3.0 [core]
- VTE prophylaxis if admitted
- Reassurance, antenatal review, dietary advice; consider TVS to confirm viable IUP and exclude molar pregnancy

References: RANZCOG Statement (current) • eTG (Therapeutic Guidelines, current) • Tintinalli's Emergency Medicine 9e Ch 100

Question 6 | Antepartum Haemorrhage (12 marks)

A 30-year-old G2P1 at 30 weeks gestation presents with PV bleeding for 6 hours. HR 110, BP 100/50, RR 24. Bleeding is bright red and continuing.

a) Name the 2 most common causes of significant antepartum haemorrhage after 20 weeks. (2 marks)

- Placental abruption (premature separation of normally implanted placenta) **[core]**
- Placenta praevia (placenta covering or encroaching on internal os) **[core]**

b) List 4 clinical features distinguishing abruption from praevia. (4 marks)

- **Pain:** abruption = constant, severe; praevia = painless **[core]**
- **Uterus:** abruption = tender, 'wood-hard' / 'tetanic'; praevia = soft, non-tender **[core]**
- **Fetal distress / loss:** common in abruption; less common with praevia (unless massive bleed) **[core]**
- **Bleeding visible vs concealed:** praevia = always revealed; abruption may be CONCEALED (retroplacental clot) **[core]**
- **Coagulopathy / DIC:** more common in abruption (thromboplastin release)
- **Risk factors:** abruption = trauma, hypertension, cocaine, smoking; praevia = previous CS, multiparity, advanced maternal age

c) Name the examination that MUST be avoided AND state why. (2 marks)

- **Digital vaginal examination** must be AVOIDED until placenta praevia has been excluded by ultrasound **[core]**
- Reason: digital exam can disrupt a low-lying placenta and precipitate catastrophic haemorrhage **[core]**
- Speculum may be performed cautiously by experienced clinician; if active bleeding, defer until after USS

d) List 4 immediate management priorities. (4 marks)

- Resuscitate — left lateral tilt 15-30°, two large-bore IV, IV fluid bolus, O₂ **[core]**
- Activate MTP / order O-negative blood; bloods include FBC, coags, fibrinogen, group and crossmatch (4 units), Kleihauer **[core]**
- **Urgent O&G; review** for bedside USS to locate placenta and consider delivery **[core]**
- Continuous CTG monitoring of fetal wellbeing **[core]**
- Anti-D 625 IU IM if Rh-negative
- Corticosteroids — betamethasone 11.4 mg IM if <34/40 and delivery anticipated
- Analgesia and anti-emetics
- Notify theatre, anaesthetics, NICU

References: RANZCOG Statement (current) • RCOG Green-top Guideline (current) • Tintinalli's Emergency Medicine 9e Ch 100 • ATLS 10th edition

Question 7 | Postpartum Haemorrhage (14 marks)

A 32-year-old G5P5 woman has just delivered a 4.2 kg baby in her car en route to your ED. She has heavy ongoing PV bleeding. HR 130, BP 80/50. Estimated blood loss 1500 mL.

a) List the 4 most common causes of post-partum haemorrhage (the '4 Ts'). (4 marks)

- **Tone** — uterine atony (~70% — most common) [core]
- **Trauma** — vaginal / cervical / perineal lacerations, uterine rupture [core]
- **Tissue** — retained products of conception, retained placenta [core]
- **Thrombin** — coagulopathy (DIC, congenital, anticoagulation) [core]

b) State 6 immediate management steps with rationale. (6 marks)

- **Bimanual uterine compression** — fist in anterior fornix, abdominal hand compresses uterus from above; mechanical control while awaiting uterotonic effect [core]
- **Two large-bore IV; activate MTP**; O-negative initially; balanced 1:1:1 transfusion [core]
- **Oxytocin 10 IU IM stat AND 40 IU in 1 L Hartmann's IV at 250 mL/h** — first-line uterotonic [core]
- **Ergometrine 250 µg IM** (avoid in hypertensive disease) AND **misoprostol 800 µg PR** if no response [core]
- **Tranexamic acid 1 g IV over 10 min** (repeat at 30 min if continuing) — WOMAN trial evidence [core]
- **Carboprost 250 µg IM** ($\text{PGF}_{2\alpha}$) — avoid in asthma; can repeat q15 min to max 2 mg [core]
- Examine and repair perineal/vaginal/cervical lacerations
- IDC to monitor urine output; warm patient (avoid hypothermia coagulopathy)
- Empty bladder (reduces uterine displacement)
- Manual removal of retained placenta (under anaesthesia)

c) List 4 second-line / surgical interventions for uncontrolled PPH. (4 marks)

- **Intrauterine balloon tamponade** (Bakri / Rusch) — 500 mL saline; first-line surgical adjunct [core]
- **Examination under anaesthesia** — repair lacerations, evacuate retained products [core]
- **Compression sutures** (B-Lynch) at laparotomy [core]
- Internal iliac / uterine artery ligation; interventional radiology embolisation [core]
- Hysterectomy as last resort
- Recombinant Factor VIIa for refractory coagulopathy (off-label)

References: RANZCOG Statement (current) • RCOG Green-top Guideline (current) • eTG (Therapeutic Guidelines, current)
• Tintinalli's Emergency Medicine 9e Ch 100 • WOMAN trial (Lancet 2017)

Question 8 | Umbilical Cord Prolapse (8 marks)

A 28-year-old G2P1 at 38 weeks gestation presents in early labour with ruptured membranes. On speculum exam you see a loop of umbilical cord protruding through the cervix. Maternity ward is in another building.

a) State the 2 immediate clinical priorities. (2 marks)

- **Relieve cord compression** — manually elevate the presenting part off the cord with a gloved hand in the vagina; do NOT replace cord into uterus; keep cord moist and warm **[core]**
- **Position** — knee-chest or steep Trendelenburg with left lateral tilt to reduce compression **[core]**

b) List 3 risk factors for cord prolapse. (3 marks)

- Malpresentation (breech, transverse, oblique) **[core]**
- Polyhydramnios **[core]**
- Preterm or premature rupture of membranes; artificial rupture of membranes **[core]**
- Multiparity
- Long umbilical cord
- Multiple pregnancy (especially second twin)

c) State 3 ongoing management steps while awaiting definitive delivery. (3 marks)

- Urgent obstetric / theatre activation — emergency Caesarean section is definitive treatment if cervix not fully dilated and delivery not imminent **[core]**
- Tocolysis — terbutaline 250 µg SC or salbutamol 100 µg IV — to reduce contractions during transfer **[core]**
- Continuous CTG monitoring; bladder filling with 500-700 mL saline via IDC may further reduce compression during transfer **[core]**
- Two large-bore IV; group and crossmatch; high-flow O₂
- Maintain operator's hand in vagina until baby is delivered, ideally by Caesarean

References: RANZCOG Statement (current) • RCOG Green-top Guideline (current) • Tintinalli's Emergency Medicine 9e Ch 100 • Cameron's Textbook of Adult Emergency Medicine 5e

Question 9 | Shoulder Dystocia (10 marks)

A 35-year-old G5P4 woman presents in late labour and delivers the head precipitously. The head retracts against the perineum (turtle sign) and you cannot deliver the anterior shoulder with gentle axial traction.

a) Name the condition AND state the time within which delivery should occur to avoid serious fetal hypoxia. (2 marks)

- **Shoulder dystocia** — failure of the anterior shoulder to pass under the symphysis pubis after head delivery **[core]**
- Aim for delivery within **5 minutes** of head delivery to minimise risk of hypoxic-ischaemic encephalopathy; risk of brachial plexus injury, fracture, fetal death rises beyond this **[core]**

b) Describe 6 manoeuvres to assist delivery (HELPER or equivalent stepwise approach). (6 marks)

- **Call for help** — additional midwifery, O&G, anaesthetics, paediatrics **[core]**
- **McRoberts manoeuvre** — hyperflex maternal hips onto abdomen; flattens lumbar lordosis, rotates symphysis cephalad **[core]**
- **Suprapubic pressure** (Rubin I) — by assistant; downward and lateral pressure to disimpact anterior shoulder **[core]**
- **Episiotomy** if needed — gives access for internal manoeuvres **[core]**
- **Internal rotation** — Rubin II (push anterior shoulder posteriorly into oblique) or Wood's screw (rotate posterior shoulder anteriorly) **[core]**
- **Deliver posterior arm** — sweep posterior arm across baby's chest and out **[core]**
- **Roll onto all fours** (Gaskin manoeuvre) — repeats manoeuvres in this position
- Last resorts: cleidotomy, symphysiotomy, Zavanelli (replacement and Caesarean)

c) List 2 maternal AND 2 fetal complications of shoulder dystocia. (2 marks)

- **Maternal:** 3rd/4th degree perineal tear; PPH; bladder/urethral injury; symphyseal diastasis **[core]**
- **Fetal:** brachial plexus injury (Erb's palsy, ~2-16% of SD); clavicle/humerus fracture; hypoxic brain injury; fetal death **[core]**

References: RANZCOG Statement (current) • RCOG Green-top Guideline (current) • Tintinalli's Emergency Medicine 9e Ch 100

Question 10 | Precipitate Delivery in the ED (12 marks)

A 24-year-old female presents to your urban ED in precipitate labour with no antenatal care. Gestational age unknown. The baby is crowning.

a) List 4 immediate actions. (4 marks)

- Call for help — O&G, midwifery, NICU/paediatrics, additional ED nursing **[core]**
- Move to resus cubicle with delivery pack and neonatal resuscitaire prepared **[core]**
- Position — left lateral tilt or McRoberts; IV access; CTG / fetal heart auscultation **[core]**
- Universal precautions; warm environment; prepare for newborn resuscitation **[core]**
- Quick history — gestation, parity, previous deliveries, complications, drugs

b) Complete the table — for each equipment category, list 2 essential items needed for precipitate delivery and neonatal resuscitation. (4 marks)

- **Delivery:** sterile delivery pack (cord clamps, scissors, drapes); episiotomy scissors; warm towels; bulb syringe **[core]**
- **Neonatal resuscitation — general:** resuscitaire with overhead heater and timer; stethoscope; pulse oximeter (right hand); ECG monitoring **[core]**
- **Neonatal airway:** T-piece resuscitator with PEEP; correct-sized face masks; suction with Yankauer + 10/12 Fr suction catheters; ETT 2.5-4.0; laryngoscope with size 0-1 blades **[core]**
- **Drugs/fluids:** adrenaline 1:10 000 (0.01-0.03 mg/kg IV); 0.9% saline 10 mL/kg bolus; naloxone 0.1 mg/kg IM; 10% dextrose 2 mL/kg for hypoglycaemia **[core]**

c) After delivery the placenta has not yet been delivered and there is heavy PV bleeding. State 4 management steps. (4 marks)

- **Active management of 3rd stage:** oxytocin 10 IU IM with delivery of anterior shoulder; controlled cord traction with counter-pressure on uterus **[core]**
- Uterine massage post-delivery; bimanual compression if continuing bleeding **[core]**
- If placenta retained >30 min: IV access, uterotonics, prepare for manual removal under anaesthesia **[core]**
- Bloods: FBC, group and crossmatch, coagulation; TXA 1 g IV; activate MTP if class 3+ shock **[core]**
- Anti-D 625 IU IM if Rh-negative
- Postpartum monitoring — vital signs, lochia, fundal height, uterine tone

References: RANZCOG Statement (current) • ANZCOR Guideline 13 — Neonatal Life Support (current) • Tintinalli's Emergency Medicine 9e Ch 100

Question 11 | Neonatal Resuscitation (12 marks)

Following a precipitate delivery in your ED, the term neonate is delivered apnoeic, cyanosed, and floppy. Initial APGAR 2 at 1 minute.

a) State 4 initial steps within the first 30 seconds per ANZCOR neonatal life support algorithm. (4 marks)

- Place under radiant warmer; dry and stimulate; remove wet linen [core]
- Position head in neutral position; clear airway ONLY if obstructed (avoid routine suctioning) [core]
- Reassess at 30 s — heart rate, breathing, tone, colour [core]
- Pulse oximetry on RIGHT hand (pre-ductal); start ECG monitoring [core]
- Document time of birth on Apgar timer

b) Complete the table — newborn HR thresholds and responses. (4 marks)

- **HR <60/min** — commence chest compressions (3:1 ratio compressions:ventilations, 120 events/min), continue PPV with 100% FiO₂; obtain umbilical venous access and give adrenaline 10-30 µg/kg IV (1:10 000) [core]
- **HR 60-100/min** — continue effective PPV at 40-60 breaths/min, ensure chest rise; reassess every 30 s; escalate FiO₂ as needed [core]
- **HR >100/min and breathing adequately** — monitor; routine care with mother (skin-to-skin) if stable; ongoing observation [core]
- Initial PPV with air (21% O₂) for term babies; 30% for <32 weeks; titrate to pre-ductal SpO₂ targets

c) State the role of therapeutic hypothermia in this neonate. (2 marks)

- Yes — therapeutic hypothermia (33-34°C for 72 h) indicated if >36 weeks gestation AND moderate to severe HIE (Apgar <5 at 10 min, pH <7.0, base deficit ≥16, abnormal neuro exam) [core]
- Must commence within 6 hours of birth; delivered in NICU; transfer urgently to tertiary centre [core]

d) State the ETT size and depth for this term neonate. (2 marks)

- ETT size 3.0-3.5 mm (3.0 if <28/40, 3.5 for term) [core]
- Depth at lip = (weight in kg + 6) cm — typically 9-10 cm at lip for term [core]

References: ANZCOR Guideline 13 — Neonatal Life Support (current) • Royal Children's Hospital Melbourne — Clinical Practice Guideline • Tintinalli's Emergency Medicine 9e Ch 109

Question 12 | Maternal Cardiac Arrest (13 marks)

Ambulance is bringing a 30-year-old woman, 38 weeks pregnant, with CPR in progress, ETA 10 minutes. No further history available.

a) List 5 specific preparation steps prior to arrival. (5 marks)

- Activate maternal collapse code — O&G, anaesthetics, NICU/paediatrics, theatre [core]
- Prepare resus bay — left lateral uterine displacement device (or designate person); tilt board [core]
- Open MTP / activate blood bank for O-negative blood [core]
- Prepare perimortem Caesarean tray — scalpel #10, scissors, clamps, suction, light source [core]
- Prepare neonatal resuscitaire with warmer, ETT, umbilical lines [core]
- Difficult airway trolley (pregnancy-related changes)
- Identify designated leader, recorder, time-keeper

b) List 4 modifications to ALS for a pregnant patient at this gestation. (4 marks)

- **Manual left uterine displacement** — displace uterus to left to relieve aortocaval compression (preferred over tilting which compromises CPR quality) [core]
- Hand position for compressions slightly higher on sternum (gravid uterus elevates diaphragm) [core]
- Early intubation by experienced operator — small ETT (6.0-6.5), expect difficult airway (oedematous tissues, full stomach risk) [core]
- **Resuscitative hysterotomy if no ROSC by 4 minutes**, aiming for delivery by 5 minutes [core]
- Standard drugs and energies (no dose modification for pregnancy)
- Consider reversible causes specific to pregnancy: amniotic fluid embolism, eclampsia, magnesium toxicity, haemorrhage, LAST

c) State the 2 indications for resuscitative hysterotomy. (2 marks)

- Maternal cardiac arrest with no ROSC by 4 minutes of effective CPR [core]
- Gestation ≥ 20 -24 weeks (uterus at or above umbilicus); aims to relieve aortocaval compression and improve maternal CPR — fetal survival is secondary [core]

d) State 2 key procedural steps of resuscitative hysterotomy. (2 marks)

- Vertical midline skin incision from xiphoid to pubis; vertical midline incision in lower segment of uterus; deliver baby; clamp and cut cord [core]
- Continue maternal CPR throughout; do not delay for asepsis, anaesthesia, or transfer; performed in resus bay [core]
- After delivery — clamp uterine vessels, leave uterus open until O&G/surgical assistance arrives
- Resuscitate baby on resuscitaire if signs of life

References: ANZCOR Guideline 11.10 — Resuscitation in Special Circumstances (Pregnancy) • RCOG Green-top Guideline (current) • Tintinalli's Emergency Medicine 9e Ch 100 • ATLS 10th edition

Question 13 | Trauma in Pregnancy (12 marks)

A 28-year-old woman at 30 weeks gestation is brought to your trauma bay after a high-speed MVC. HR 120, BP 100/80, SpO₂ 95% RA, GCS 15. Seatbelt mark across abdomen, LUQ tender.

a) List 3 cardiovascular AND 3 respiratory physiological changes of pregnancy that complicate trauma assessment. (6 marks)

- **CV:** blood volume ↑ 40-50% — patient may lose 30-35% before showing hypotension **[core]**
- **CV:** HR ↑ 15-20 bpm baseline — tachycardia less specific for shock **[core]**
- **CV:** aortocaval compression supine — spurious hypotension; manage with left lateral tilt or manual displacement **[core]**
- **CV:** physiological systolic murmur and 'flow' diastolic findings
- **Resp:** tidal volume ↑ 40%; FRC ↓ 20% — rapid desaturation with apnoea; pre-oxygenate fully **[core]**
- **Resp:** chronic respiratory alkalosis (PaCO₂ ~30); 'normal' PaCO₂ = relative respiratory failure **[core]**
- **Resp:** diaphragm elevated — chest drain insertion 1 intercostal space higher than usual (4th ICS rather than 5th) **[core]**

b) List 3 imaging modalities for the abdomen with justification. (3 marks)

- **FAST USS** — bedside, no radiation; first-line for haemoperitoneum **[core]**
- **CT abdo/pelvis with contrast** — definitive for solid organ injury, retroperitoneal bleed; fetal dose 10-25 mGy (below deterministic threshold of 100 mGy) **[core]**
- **Formal obstetric ultrasound** — placental abruption, fetal heart, gestation, amniotic fluid **[core]**
- **MRI** — for spinal trauma without radiation; not first-line in unstable patient

c) State the role of the Kleihauer-Betke test in this Rh-negative patient. (1 mark)

- Quantifies fetomaternal haemorrhage; guides additional anti-D dosing beyond the standard 625 IU IM for Rh-negative women after >12/40 trauma; result >6 mL fetal blood requires additional anti-D **[core]**

d) List 2 examination findings that suggest placental abruption. (2 marks)

- Vaginal bleeding (may be concealed — absence doesn't exclude) **[core]**
- Tense, tender uterus ('woody' uterus) with increased uterine tone or contractions **[core]**
- Fetal distress on CTG (late decelerations, bradycardia)
- Maternal hypotension or DIC out of proportion to visible bleeding

References: ATLS 10th edition • RANZCOG Statement (current) • Royal Children's Hospital Melbourne — Clinical Practice Guideline • Tintinalli's Emergency Medicine 9e Ch 254

Question 14 | Preterm Labour (12 marks)

A 34-year-old G1P0 at 30 weeks gestation presents with regular painful contractions every 3 minutes for 1 hour and SROM 30 minutes ago. She has the urge to push. Your hospital has no obstetric or neonatal service; tertiary centre is 220 km away.

a) List 4 management priorities for this patient. (4 marks)

- Tocolysis to suppress contractions — nifedipine 20 mg PO loading, then 10-20 mg PO q4-6h (first-line in Australasia); alternative salbutamol IV **[core]**
- **Antenatal corticosteroids** — betamethasone 11.4 mg IM x 2 doses 24 h apart (or dexamethasone) — reduces neonatal RDS, IVH, mortality if given <34/40 **[core]**
- **Magnesium sulfate 4 g IV over 20 min, then 1 g/h** for fetal neuroprotection if <30 weeks (or up to 32/40) **[core]**
- **GBS prophylaxis** — benzylpenicillin 3 g IV stat (or cephazolin / clindamycin if allergic) **[core]**
- Continuous CTG monitoring
- Liaise with retrieval service / tertiary centre; arrange neonatal transfer if delivery imminent

b) List 4 medications to prepare for management of the patient AND 4 pieces of equipment for delivery. (4 marks)

- **Medications:** oxytocin 10 IU (PPH prophylaxis); MgSO₄ (neuroprotection); betamethasone (RDS prevention); benzylpenicillin (GBS); nifedipine (tocolysis); TXA 1 g IV (PPH); naloxone (neonatal); 0.9% saline IV **[core]**
- **Equipment:** delivery pack with cord clamps; neonatal resuscitaire with overhead warmer; T-piece resuscitator and small face masks; ETT 2.5-3.0 mm; pulse oximeter; suction with size 6-8 Fr catheters; warm towels; plastic bag for preterm thermal care **[core]**

c) List 4 measures for the immediate post-delivery period for a preterm neonate. (4 marks)

- Plastic bag / wrap (without drying) for thermal stabilisation — <32/40 babies **[core]**
- Delayed cord clamping >60 s if vigorous (reduces transfusion needs, IVH) **[core]**
- PPV with T-piece if apnoeic — start with FiO₂ 30% for <32 weeks; titrate to pre-ductal SpO₂ targets **[core]**
- Surfactant administration via INSURE technique if RDS develops and intubation required **[core]**
- Continuous monitoring of HR, SpO₂, temperature, blood glucose
- Early urgent transfer to tertiary NICU

References: RANZCOG Statement (current) • ANZCOR Guideline 13 — Neonatal Life Support (current) • eTG (Therapeutic Guidelines, current) • Tintinalli's Emergency Medicine 9e Ch 100

Question 15 | Post-Partum Sepsis (13 marks)

A 35-year-old female presents 7 days post-vaginal delivery of a healthy term baby with fevers and rigors for 12 hours, mild headache. T 39.5, HR 130, BP 75/45, RR 20, SpO₂ 98% on 2 L NP.

a) List 5 differential diagnoses for post-partum fever / sepsis. (5 marks)

- **Endometritis** — most common; ascending infection of uterine cavity (often polymicrobial) [core]
- Wound infection — perineal tear, episiotomy, or Caesarean wound [core]
- Mastitis / breast abscess — Staph aureus most common [core]
- Urinary tract infection / pyelonephritis (catheterisation risk) [core]
- Septic pelvic thrombophlebitis / VTE / pulmonary embolism [core]
- Pneumonia (aspiration, atelectasis post-anaesthesia)
- Retained products of conception with infection
- Group A streptococcal sepsis (consider in fulminant cases)
- Toxic shock syndrome

b) List 4 specific delivery details to obtain AND state their significance. (4 marks)

- Mode of delivery (vaginal vs Caesarean) — Caesarean ↑ risk of wound and intra-abdominal infection [core]
- Duration of labour, prolonged ROM >18 h — ↑ chorioamnionitis / endometritis risk [core]
- Manual removal of placenta or retained products — ↑ endometritis risk [core]
- GBS status and intrapartum antibiotic prophylaxis received [core]
- Perineal trauma (3rd/4th degree tear) — wound infection risk
- Catheterisation duration — UTI risk

c) State 4 immediate management priorities (post-arrival). (4 marks)

- **Sepsis Six within 1 hour:** blood and appropriate cultures; serum lactate; high-flow O₂; IV crystalloid 30 mL/kg; empirical broad-spectrum antibiotics; IDC for urine output [core]
- **Empirical antibiotics:** piperacillin-tazobactam 4.5 g IV q8h + clindamycin 600 mg IV q8h (cover Group A strep and toxin production), OR per local antibiogram and severity [core]
- Fluid resuscitation; vasopressors (noradrenaline) if persistent hypotension after 30 mL/kg [core]
- Imaging — pelvic USS for retained products / abscess; CT abdo if not pelvic source [core]
- Urgent O&G; consultation — surgical drainage / evacuation if retained products or abscess
- ICU referral; consider VTE prophylaxis once haemodynamically stable
- Notify infectious diseases if Group A strep suspected; infection-control precautions

References: RANZCOG Statement (current) • eTG (Therapeutic Guidelines, current) • ACEM clinical policies and statements • Surviving Sepsis Campaign 2021

Question 16 | Hypertensive Emergency in Pregnancy (10 marks)

A 39-year-old G1P0 at 36 weeks gestation presents with a headache. T 36.7, HR 90, BP 165/110, SpO₂ 99% RA. She has visual aura. No history of essential hypertension.

a) List 4 differential diagnoses for headache in this patient. (4 marks)

- Pre-eclampsia / impending eclampsia [core]
- Posterior reversible encephalopathy syndrome (PRES) [core]
- Cerebral venous sinus thrombosis (hypercoagulable state of pregnancy) [core]
- Intracranial haemorrhage (aneurysmal SAH, ICH from severe hypertension) [core]
- Migraine (may worsen in pregnancy)
- Meningitis / encephalitis
- Carotid or vertebral artery dissection (rare; post-partum predisposition)

b) Complete the table — for each examination AND each investigation, state one finding that supports severe pre-eclampsia (4 total: 2 exam + 2 invs). (4 marks)

- **Exam:** BP $\geq 160/110$ on 2 readings, hyperreflexia / clonus, right upper quadrant tenderness (HELLP), papilloedema [core]
- **Exam:** pitting peripheral oedema (face, hands), $\downarrow$ urine output, visual disturbance / scotoma [core]
- **Inv:** urinalysis $\geq 2+$ proteinuria; urine PCR >30 mg/mmol [core]
- **Inv:** thrombocytopenia <100 ; AST/ALT $>2\times$ normal; creatinine >90 ; raised urate; haemolysis on film [core]

c) State 2 antihypertensive options with dose, route, and BP target. (2 marks)

- Labetalol 20 mg IV bolus (repeat q10 min, max 300 mg) OR infusion 20-160 mg/h [core]
- Hydralazine 5-10 mg IV bolus q20 min OR nifedipine 10 mg PO repeated. Target BP 140-160 / 90-100 mmHg (avoid rapid drop $\rightarrow$ placental hypoperfusion) [core]
- AVOID ACE-i / ARB, atenolol, sodium nitroprusside in pregnancy

References: SOMANZ Hypertensive Disorders of Pregnancy Guideline 2014 • RANZCOG Statement (current) • eTG (Therapeutic Guidelines, current) • Tintinalli's Emergency Medicine 9e Ch 100

Question 17 | Heavy Vaginal Bleeding (Non-Pregnant) (12 marks)

A 42-year-old woman presents with heavy PV bleeding for 5 days. β -hCG negative. HR 105, BP 105/65, Hb 78 g/L.

a) List 5 differential diagnoses AND for each one feature that would support that diagnosis. (5 marks)

- **Fibroids (leiomyoma)** — palpable bulky irregular uterus on bimanual; supported by pelvic USS **[core]**
- **Anovulatory dysfunctional uterine bleeding** — irregular cycles, often perimenopausal age **[core]**
- **Endometrial / cervical malignancy** — intermenstrual / post-coital bleeding, irregular cervix on speculum, age >40 risk factor **[core]**
- **Coagulopathy** (von Willebrand, anticoagulant use, thrombocytopaenia) — bruising, family history, abnormal coags **[core]**
- **Endometrial polyp** — irregular bleeding, supported by USS / hysteroscopy **[core]**
- Thyroid disease (hypothyroidism causes menorrhagia)
- PID / endometritis
- Adenomyosis (tender bulky uterus)

b) List 4 immediate management steps in the ED for this haemodynamically borderline patient. (4 marks)

- Two large-bore IV; bloods including FBC, group and crossmatch, coagulation, β -hCG, TFTs **[core]**
- Crystalloid resuscitation; transfuse if Hb <70 or symptomatic / haemodynamically unstable **[core]**
- **Tranexamic acid 1 g IV** (or 1 g PO TDS) — reduces bleeding by ~50% **[core]**
- **High-dose progestogen** — norethisterone 5 mg PO TDS until bleeding controlled, OR medroxyprogesterone; alternative: combined OCP if no contraindications **[core]**
- Iron supplementation (oral or IV ferric carboxymaltose if severe)
- Speculum exam, bimanual exam, cervical screening if not current

c) List 3 specialist referral pathways or interventions. (3 marks)

- Outpatient gynaecology referral for pelvic USS / TVS, hysteroscopy and biopsy if >45 years or risk factors for endometrial Ca **[core]**
- Mirena (LNG-IUS) — first-line long-term medical management for menorrhagia **[core]**
- Endometrial ablation, uterine artery embolisation, myomectomy, or hysterectomy as definitive options **[core]**
- Haematology referral if coagulopathy

References: RANZCOG Statement (current) • eTG (Therapeutic Guidelines, current) • Tintinalli's Emergency Medicine 9e Ch 102

Question 18 | Ovarian Torsion (10 marks)

A 26-year-old woman, 8 weeks pregnant by IVF, presents with sudden-onset severe right iliac fossa pain, vomiting. Ovarian hyperstimulation noted on recent USS with 6 cm right cyst.

a) List 3 historical features supporting ovarian torsion. (3 marks)

- Sudden-onset severe unilateral pelvic / iliac fossa pain, often associated with movement / exercise **[core]**
- Nausea and vomiting (autonomic response, 60-70%) **[core]**
- Pre-existing ovarian cyst, pregnancy, IVF / ovarian hyperstimulation, or ovarian mass **[core]**
- Intermittent / recurrent pain (partial / detorting ovary)

b) List 3 sonographic features of ovarian torsion. (3 marks)

- Enlarged ovary (>4 cm, peripherally displaced follicles — 'string of pearls') **[core]**
- Reduced or absent venous and arterial Doppler flow (specific but late finding) **[core]**
- Free fluid in pelvis
- 'Whirlpool sign' — twisted vascular pedicle on Doppler
- Adnexal mass or cyst with the torted ovary

c) State 4 management steps. (4 marks)

- **Urgent O&G; consultation — laparoscopy / laparotomy with detorsion** within 6-8 hours to preserve ovarian function **[core]**
- IV access, fluids, analgesia (morphine titrated), anti-emetics, NBM **[core]**
- Bloods — FBC, group and save, β -hCG (to confirm pregnancy and viability) **[core]**
- Confirm pregnancy and assess for IUP / complications of OHSS prior to surgery **[core]**
- Avoid delay — necrotic ovary loses function within hours; preservation is the goal even with non-viable appearance intraoperatively

References: RANZCOG Statement (current) • Tintinalli's Emergency Medicine 9e Ch 102 • Cameron's Textbook of Adult Emergency Medicine 5e

Question 19 | Sexual Assault — Acute ED Management (12 marks)

A 22-year-old woman presents to your ED 4 hours after an alleged sexual assault. She is distressed but haemodynamically stable. She wishes to discuss medical options.

a) List 4 principles guiding initial ED care. (4 marks)

- Trauma-informed, patient-centred care — privacy, same-gender clinician where possible, written/verbal consent at every step **[core]**
- Rapid involvement of **specialised sexual assault service** (state-specific — e.g. SAS in NSW, CASA in Vic, FAMSAC etc.) for forensic examination **[core]**
- Address medical needs first — injuries, haemodynamic stability, mental health crisis **[core]**
- Avoid contamination of forensic evidence — patient should not shower, change clothes, eat/drink before exam if possible (within 120 hours) **[core]**
- Mandatory reporting if minor or vulnerable adult per state legislation
- Ongoing safety assessment; offer accommodation / refuge support

b) List 4 medical interventions that should be offered. (4 marks)

- **Emergency contraception** — levonorgestrel 1.5 mg PO if <72 h; ulipristal 30 mg PO up to 120 h; copper IUD up to 5 days (most effective) **[core]**
- **HIV post-exposure prophylaxis (PEP)** if <72 h — tenofovir-emtricitabine + dolutegravir (per state protocol); 28-day course **[core]**
- **STI prophylaxis** — empirical ceftriaxone 500 mg IM + azithromycin 1 g PO + metronidazole 2 g PO; treat partner risk **[core]**
- **Hepatitis B post-exposure** — vaccine ± HBIG depending on serostatus **[core]**
- Tetanus booster if injuries warrant
- Pregnancy and STI follow-up testing at 2 weeks, 6 weeks, and 3 months

c) State 4 mandatory documentation and disclosure considerations. (4 marks)

- Detailed contemporaneous history in patient's own words (using quotation marks); avoid leading questions **[core]**
- Document all injuries with diagrams or photographs (with consent), exact dimensions and locations **[core]**
- Police involvement is the patient's choice (unless mandatory reporter applies); document decision and informed-consent discussion **[core]**
- Mandatory reporting: if patient is a minor or vulnerable adult — to police, child protection / elder abuse services per state legislation **[core]**
- Psychological support — refer to sexual assault counselling, mental health crisis team if needed; consider admission if safety concerns
- Confidentiality — discuss with whom information will be shared (treating team, sexual assault service, forensics)

References: ACEM clinical policies and statements • ACEM Sexual Assault Policy • ASHM PEP Guidelines (current)

Question 20 | Tubo-Ovarian Abscess (9 marks)

A 26-year-old woman presents with 4 days of progressive lower abdominal pain, fever 38.8, vaginal discharge. β -hCG negative. WCC 18, CRP 240. TVS shows a 7 cm complex adnexal mass with thick walls.

a) List 3 sonographic features supporting tubo-ovarian abscess. (3 marks)

- Complex adnexal mass with thickened irregular walls and internal echoes (debris) **[core]**
- Hyperaemia on colour Doppler around abscess **[core]**
- Free fluid in pouch of Douglas
- Loss of normal ovarian architecture; tubular fluid-filled structure (hydrosalpinx → pyosalpinx)

b) State 3 management priorities. (3 marks)

- **Inpatient IV antibiotics** — ceftriaxone 2 g IV daily + metronidazole 500 mg IV q12h + doxycycline 100 mg PO BD (per RANZCOG / eTG); minimum 14 days total course **[core]**
- Urgent O&G; review — surgical drainage / interventional radiology drainage if >7 cm, no response in 48-72 h, ruptured, or septic **[core]**
- Sepsis Six if septic — fluid resuscitation, lactate, blood cultures, IDC, MTP if shocked **[core]**
- STI screening — chlamydia, gonorrhoea, mycoplasma; partner notification

c) List 3 long-term complications. (3 marks)

- Tubal infertility (10-20% per episode) **[core]**
- Increased risk of ectopic pregnancy (7-10× baseline) **[core]**
- Chronic pelvic pain **[core]**
- Recurrent PID
- Fitz-Hugh-Curtis syndrome (perihepatitis)

References: RANZCOG Statement (current) • eTG (Therapeutic Guidelines, current) • Tintinalli's Emergency Medicine 9e Ch 102

Question 21 | Bedside POCUS in Suspected Ruptured Ectopic (9 marks)

A 28-year-old female presents collapsed in the street, pale, diaphoretic, abdominal pain. GCS 15, HR 110, BP 90/60, RR 22, LIF tenderness with peritonism. β -hCG positive. You perform bedside USS.

a) List 3 differential diagnoses for this presentation. (3 marks)

- **Ruptured ectopic pregnancy [core]**
- Ruptured haemorrhagic ovarian cyst [core]
- Ovarian torsion [core]
- PID / tubo-ovarian abscess
- Appendicitis with peritonism
- Heterotopic pregnancy (especially post-IVF)

b) List 3 key bedside POCUS findings to assess for in this patient. (3 marks)

- Free fluid in pouch of Douglas (haemoperitoneum) — echogenic suggests blood [core]
- Adnexal mass / tubal ring or live extrauterine pregnancy [core]
- Empty uterus despite positive β -hCG (or pseudosac) [core]
- Free fluid in Morison's pouch (Morison's positive = significant haemoperitoneum / large bleed)
- Collapsed IVC / hyperdynamic LV (volume depletion on RUSH)

c) List 3 inclusion/exclusion criteria for a local bedside-USS protocol in early pregnancy. (3 marks)

- **Inclusion:** pregnant patient (positive β -hCG); credentialled clinician; bleeding or pain in early pregnancy; β -hCG above discriminatory zone [core]
- **Exclusion:** non-credentialled operator; haemodynamic instability requiring immediate theatre (do not delay surgery for confirmatory POCUS) [core]
- **Adjunct, not replacement:** formal TVS required where POCUS is non-diagnostic; suspected ectopic always needs formal TVS confirmation [core]

References: ASUM / RANZCR Early Pregnancy Imaging Guidelines • RANZCOG Statement (current) • ACEP / ACEM ED Ultrasound Guidelines

Question 22 | Peripartum Cardiomyopathy (10 marks)

A 34-year-old woman, 4 weeks post-delivery of her second child, presents with progressive dyspnoea, orthopnoea, and bilateral leg swelling. HR 115, BP 100/65, SpO₂ 91% RA, RR 28. Lung crackles bilaterally.

a) State the 3 diagnostic criteria for peripartum cardiomyopathy. (3 marks)

- Heart failure developing in last month of pregnancy or within 5 months post-partum **[core]**
- LVEF <45% on echocardiography (with or without LV dilatation) **[core]**
- Absence of identifiable other cause of heart failure (no pre-existing cardiac disease) **[core]**

b) List 4 differential diagnoses. (4 marks)

- Pulmonary embolism (post-partum hypercoagulable state) **[core]**
- Severe pre-eclampsia with pulmonary oedema **[core]**
- Amniotic fluid embolism **[core]**
- Pre-existing cardiomyopathy (dilated, hypertrophic) unmasked by pregnancy **[core]**
- Acute coronary syndrome / SCAD (spontaneous coronary artery dissection)
- Severe valvular disease (especially mitral stenosis)
- Sepsis with cardiac dysfunction

c) State 3 management priorities specific to peripartum cardiomyopathy. (3 marks)

- Standard heart-failure therapy WITH pregnancy/lactation considerations: furosemide IV; β -blocker (metoprolol or carvedilol); ACEi/ARB ONLY post-partum (teratogenic); spironolactone post-partum **[core]**
- **Anticoagulation** — VTE risk markedly elevated (combination of low EF + post-partum hypercoagulability); LMWH or warfarin **[core]**
- **Bromocriptine 2.5 mg BD** for 1 week then OD for 6 weeks may improve recovery (per ESC guideline) — used with anticoagulation due to VTE risk; cessation of breastfeeding required **[core]**
- ICU / coronary care; consider mechanical support (IABP, ECMO) for severe LV dysfunction
- Counsel against future pregnancy until LVEF recovered (40% recurrence risk)

References: ESC Guidelines on Cardiovascular Diseases in Pregnancy (current) • RANZCOG Statement (current) • Tintinalli's Emergency Medicine 9e Ch 100