Best Practice & Research Clinical Obstetrics and Gynaecology
Vol. 20, No. 2, pp. A9–A19, 2006
doi:10.1016/j.bpobgyn.2005.12.003
available online at http://www.sciencedirect.com

Gynaecological Surgery: Techniques, Training, Skills and Assessment
Answers to Multiple Choice Questions For Vol. 20, No. 1

1. (a) F (b) T (c) F (d) T (e) T

It is irrelevant as the superior margin of the upper pole of the kidney lies at the level of T10-L2. The abdominal ureters descend almost straight down to the pelvic brim, resting on the fascia of the psoas muscle, which separates it from the tips of the transverse processes of the lumbar vertebra. The ureter enters the pelvis by crossing the bifurcation of the iliac artery in front of the sacroiliac joint. It then runs down the lateral wall of the pelvis to the region of the ischial spine and turns forward to enter the lateral angle of the bladder.

2. (a) T (b) F (c) F (d) F (e) T

The nerve supply to the bladder is from the inferior hypogastric plexuses. The sympathetic outflow is from the first and second lumbar segments of the spinal cord and descend to the bladder via hypogastric plexus. The parasympathetic preganglionic fibres arise as the pelvic splanchnic nerves from the second, third and fourth sacral nerves. The sympathetic nerves to the detrusor muscle are now thought to have little or no action on the smooth muscle of the bladder wall and are distributed mainly to the blood vessels. Micturition is a reflex action that, in the toilet-trained individual, is controlled by higher centres in the brain. The reflex is initiated when the volume of urine reaches about 300 mL, stretch receptors in the bladder wall are stimulated and transmit impulses to the central nervous system, and the individual has a conscious desire to micturate. The Sacral segments of the spinal cord are situated in the upper part of the lumbar region of the vertebral column. The bladder is without any external reflex control. The bladder is flaccid, and the capacity of the bladder is greatly increased. It merely fills to capacity and overflows.

3. (a) T (b) T (c) F (d) T (e) T

The lymph vessels from the body of the uterus and cervix drain into the internal and external iliac nodes. The lymph vessels from the upper third of the vagina drain to the

1521-6934/$ - see front matter

external and internal iliac nodes, from the middle third to the internal iliac nodes, and from the lower third to the superficial inguinal nodes. The lymph vessels from the fundus of the uterus and of the ovary accompany the ovarian artery and drain into para-aortic nodes at the level of the first lumbar vertebra.

The lymph vessels from the uterine tube follow the uterine and ovarian arteries and drain into the internal iliac and para-aortic nodes.

4. (a) F (b) F (c) F (d) T (e) F

Observed exercise tolerance is relatively reproducible when limited by cardiac disease. When exercise tolerance is primarily limited by respiratory disease, it is somewhat more sensitive to patient motivation/effort, but remains a very useful subjective assessment of physiological reserve. Echocardiography is most useful in examining valvular disease. It may give some indication of ventricular contractility and ejection fraction, but this must be interpreted carefully, with consideration of the overall clinical picture. Simple spirometry is useful to assess treatment of airflow limitation. Comprehensive pulmonary function testing is unlikely to be useful in assessing most patients preoperatively.

Asymptomatic ischaemic heart disease is common. Patients should be investigated based on both symptoms and risk factors gathered from the patient history. The most important assessment of diabetics is the presence (or absence) of complications due to their diabetes. Current stability of control (indicated by HbA1c) is important, but less so than identified complications.

5. (a) F (b) F (c) T (d) T (e) F

Antihypertensives should not be withheld on the day of surgery, nor post-operatively. Perioperative withdrawal of beta-blockade is particularly dangerous. There is no clear 'best' regime for the management of diabetes. Choice of regime must consider the logistic feasibility of the technique in the setting where it is to be used. Prophylactic antibiotics should be given before commencement of surgery. Delay beyond 30 minutes after commencement decreases prophylactic efficacy. Venous thromboembolism is one of the greatest causes of readily-preventable peri-operative death. All patients should be considered and assessed for DVT risk. (Prophylaxis in low-risk patients is based on early mobilisation only). Preoperative time in hospital increases surgical wound infection rates in both emergency and elective patients and is of no proven benefit in terms of general peri-operative safety.

6. (a) F (b) F (c) T (d) F (e) F

On a population basis, Pethidine is no better than morphine with regard to postoperative nausea & vomiting. Pethidine has no clear advantages over morphine, and is associated with accumulation of nor-pethidine, a pro-convulsive metabolite. Most postoperative respiratory complications are due to atelectasis, which may then become a site of infection. In major orthopaedic surgery, 10% of postoperative deaths have been attributed to venous thromboembolism.

Postoperative delirium may be a manifestation of another complication such as infection, cardiovascular decompensation, electrolyte disturbance, or hypoxaemia. Acute and reversible causes should be excluded before attribution to 'dementia'. Postoperative myocardial infarctions are often silent and may cause obscure symptoms. Mortality is, however, higher than 'usual' infarcts.