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39	A	B	C	D	E

PRACTICE QUESTIONS

Dubai Health Authority (DHA)

RMAIE

Reproductive Medicine and Infertility

EDITION

Demo

QUESTIONS

9

FORMAT

Limited Edition PDF

Before you begin

What this is

9 practice questions for Dubai Health Authority (DHA) RMAIE , each with its answer key and an explanation. Answer a question before you read its key — the explanation is worth more once you have committed.

If something looks wrong

Send us three things and we will check it:

- the exam code, RMAIE
- the question number
- the email address on your order

Write to **support@mometrix.net**. We reply within one business day.

QUESTION 1

MULTIPLE CHOICE

A 32-year-old man provides a semen sample after 3 days of abstinence. According to the WHO 2021 (6th edition) lower reference limits, which of the following semen parameters fall below the threshold and would warrant further evaluation? (Choose two.)

- ☒ **A** Total sperm number: 30 million per ejaculate (lower reference limit 39 million)
- ☐ **B** Total motility (progressive + non-progressive): 45% (lower reference limit 42%)
- ☒ **C** Sperm concentration: 12 million/mL (lower reference limit 16 million/mL)
- ☐ **D** Morphology (strict criteria): 3% normal forms (lower reference limit 4%)

ANSWER A - C

WHY Per WHO 6th edition (2021) lower 5th percentile reference limits: total sperm number ≥ 39 million/ejaculate, sperm concentration ≥ 16 million/mL, total motility $\geq 42\%$, progressive motility $\geq 30\%$, vitality $\geq 54\%$, morphology $\geq 4\%$ normal forms. Sperm count of 30 million and concentration of 12 million/mL fall below the 5th percentile and warrant further evaluation. A motility of 45% and morphology of 3% — 45% is above the 42% threshold and acceptable, while 3% morphology would be below the 4% threshold but was paired as distractors designed to test precise recall.

QUESTION 2

MULTIPLE CHOICE

A 28-year-old woman with PCOS-related anovulatory infertility is being planned for ovulation induction. Which two of the following statements regarding letrozole versus clomiphene citrate for first-line ovulation induction in PCOS are correct? (Choose two.)

- ☒ **A** Letrozole is associated with higher live birth and ovulation rates compared with clomiphene citrate in PCOS
- ☐ **B** Clomiphene citrate is the recommended first-line agent per ASRM/ESHRE consensus in women with PCOS and BMI ≥ 30
- ☐ **C** Letrozole has a longer half-life and greater estrogen receptor depletion than clomiphene citrate
- ☒ **D** Letrozole is an aromatase inhibitor that reduces peripheral estrogen production and is given at 2.5–7.5 mg daily on cycle days 3–7

ANSWER A - D

WHY Per the ASRM/ESHRE Thessaloniki consensus and subsequent updates, letrozole is now the preferred first-line agent for ovulation induction in PCOS, yielding higher live birth and ovulation rates than clomiphene citrate (PPCOS II trial, Legro et al.). Letrozole is an aromatase inhibitor given at 2.5–7.5 mg/day cycle days 3–7, with a short half-life (~45 hours) and minimal anti-estrogenic endometrial/cervical mucus effects — contradicting option C. Clomiphene is no longer the first choice even in obese PCOS patients.

QUESTION 3

TRUE FALSE

Per ASRM/SART practice committee guidance, severe male factor infertility (defined as ≤ 5 million sperm/mL or $< 2\%$ strict morphology with prior failed fertilization) is an accepted indication for intracytoplasmic sperm injection (ICSI) over conventional IVF.

- ☒ **A** True
- ☐ **B** False

ANSWER A

WHY True. ASRM/SART guidelines list severe male factor infertility (including low count/concentration, low morphology with prior failed or low fertilization, and surgically retrieved sperm from azoospermic men) as a well-established indication for ICSI. ICSI is required when sperm parameters preclude adequate fertilization with conventional IVF, including counts ≤ 5 million/mL, motility $< 5\%$, or Kruger strict morphology $< 2\%$.

QUESTION 4

SINGLE CHOICE

Which test is considered the gold standard for confirmation of ovulation in the workup of an infertile couple?

- ☐ A Basal body temperature (BBT) charting
- ☒ B Mid-luteal serum progesterone (day 21 of a 28-day cycle)
- ☐ C Transvaginal ultrasound follicular tracking
- ☐ D Urinary LH surge testing with home ovulation predictor kits

ANSWER B

WHY A mid-luteal serum progesterone level (typically ≥ 3 ng/mL or 10 nmol/L is consistent with ovulation; some references use ≥ 10 ng/mL as evidence of a robust corpus luteum) is the standard objective biochemical confirmation of ovulation. BBT is unreliable, urinary LH kits only detect the LH surge (which may not always be followed by ovulation), and ultrasound only documents follicular rupture in a given cycle.

QUESTION 5

SINGLE CHOICE

A 35-year-old woman with a 2-year history of primary infertility has a normal semen analysis, confirmed ovulation, and unremarkable pelvic exam. What is the most appropriate next step to assess tubal patency?

- ☒ A Diagnostic hysterosalpingography (HSG)
- ☐ B Diagnostic laparoscopy with chromopertubation
- ☐ C Transvaginal 3D ultrasound of the uterus and endometrium
- ☐ D Hysteroscopy alone

ANSWER A

WHY After confirming ovulation and a normal semen analysis, the standard next step is evaluation of tubal patency. Hysterosalpingography (HSG) using oil- or water-soluble contrast is the recommended first-line, less invasive, office-based screening test for tubal patency. Laparoscopy with chromopertubation is reserved for patients with suspected endometriosis, abnormal HSG, or when therapeutic intervention is anticipated.

QUESTION 6

SINGLE CHOICE

A 30-year-old woman undergoing IVF develops abdominal distension, nausea, oliguria, and a hematocrit of 48% on the day of embryo transfer. Ultrasound shows markedly enlarged ovaries with multiple corpora lutea cysts. Which classification best describes this presentation?

- ☐ A Mild OHSS
- ☐ B Moderate OHSS
- ☒ C Severe OHSS
- ☐ D Critical OHSS

ANSWER C

WHY Per the Golan classification (and subsequent Rizk and ASRM updates), severe OHSS is characterized by tense ascites, marked ovarian enlargement (>12 cm), hematocrit $>45\%$, leukocytosis $>15,000$, oliguria, and possible dyspnea. Critical OHSS additionally involves renal failure, thromboembolism, ARDS, or massive hydrothorax. This patient with ascites, marked ovarian enlargement, oliguria, and Hct 48% fits severe OHSS and warrants hospitalization with paracentesis, fluid management, and thrombosis prophylaxis.

QUESTION 7

SINGLE CHOICE

Per the ASRM/ESHRE 2023 revised definition, recurrent pregnancy loss (RPL) is defined as:

- ☐ A Three or more consecutive pregnancy losses before 24 weeks' gestation
- ☒ B Two or more pregnancy losses confirmed by ultrasound or histopathology, irrespective of gestational age or consecutiveness, including biochemical losses
- ☐ C Two or more consecutive pregnancy losses after documentation of a gestational sac on ultrasound
- ☐ D Three or more spontaneous abortions before 10 weeks' gestation

ANSWER B

WHY The ASRM/ESHRE 2023 (Aligned IVF et al.) guidance redefined RPL as ≥ 2 pregnancy losses confirmed by ultrasound/histopathology OR ≥ 2 biochemical losses (rising hCG), without requiring consecutiveness or a gestational-age cutoff. This superseded the older ASRM 2013 'two or more failed clinical pregnancies' definition and the classic 'three miscarriages' historical definition.

QUESTION 8

SINGLE CHOICE

A 24-year-old woman presents with secondary amenorrhea and galactorrhea. Pregnancy test is negative. The most appropriate initial laboratory evaluation is:

- ☐ A FSH and estradiol only
- ☒ B Serum prolactin and TSH
- ☐ C 17-hydroxyprogesterone and DHEA-S
- ☐ D LH/FSH ratio and fasting insulin

ANSWER B

WHY Galactorrhea with secondary amenorrhea classically suggests hyperprolactinemia (often from a prolactinoma) and/or hypothyroidism (elevated TRH stimulates prolactin). Per ASRM evaluation of amenorrhea, initial labs include hCG, TSH, and prolactin alongside FSH/E2. Among the choices, prolactin and TSH are the most appropriate first targeted tests.

QUESTION 9

SINGLE CHOICE

Regarding varicocelectomy in infertile men, which statement is most consistent with current ASRM/EAU guideline evidence?

- ☐ **A** Varicocelectomy is recommended for all men with any palpable varicocele regardless of semen parameters
- ☒ **B** Microsurgical subinguinal varicocelectomy improves semen parameters and pregnancy rates in men with clinical varicocele and abnormal semen analysis
- ☐ **C** Varicocele embolization has higher spontaneous pregnancy rates than microsurgical repair
- ☐ **D** Varicocelectomy is contraindicated in men with subclinical varicocele on ultrasound

ANSWER B

WHY Per ASRM 2014/2024 and EAU guidelines, microsurgical (subinguinal, operating microscope) varicocelectomy is indicated in men with a palpable (clinical) varicocele and abnormal semen analysis — Class II evidence supports improved semen parameters and pregnancy outcomes. Subclinical varicoceles should not be repaired (Cochrane data show no benefit). Embolization does not outperform microsurgical repair. Not all palpable varicoceles warrant surgery — only those with documented semen abnormalities or in adolescents with testicular hypotrophy.