

The parents of 12-year-old child noticed that the boy developed thirst after the flu 2 months ago. His state gradually deteriorates and lasts about 2 weeks. Fasting blood glucose - 5.5 mmol/liter. Glutamic acid decarboxylase antibodies are positive. Which stage of type 1 diabetes is in this patient?

Initial immune processes

Active immune processes

Immunological changes with the development of insulinitis

Manifestation of diabetes type 1

Complete destruction of  $\beta$ -cells

Patient R., 45 years old, complains of furunculosis which cannot be managed under treatment. The family doctor prescribed a glucose tolerance test. Results: fasting glucose - 5.4 mmol / l, after 1 hour - 12.1 mmol / l, after 2 hours - 11.7 mmol / l. Which diagnosis is most likely?

Chronic furunculosis without impaired carbohydrate metabolism.

Chronic furunculosis. Impaired glucose tolerance

Type 2 diabetes, first detected

Chronic furunculosis

Type 1 diabetes, first detected

Chronic furunculosis, symptomatic diabetes mellitus.

A 17-year-old boy complains of severe general weakness, lethargy, thirst, increased urination, itchy skin, weight loss. He recently has contracted mumps. The most probable diagnosis?

Asthenic syndrome after viral infection.

Reinfection.

Puberty.

Diabetes mellitus.

Psychogenic polydipsia

A patient with suspected diabetes was appointed with an oral glucose tolerance test: fasting glucose - 5.4 mmol / l, after 1 hour - 12.5 mmol / l, after 2 hours - 8.1 mmol / l. Evaluate the test results.

Normal results

Impaired glucose tolerance

Diabetes.

Results are inaccurate

One more oral glucose tolerance test should be performed

The patient is 39 years old, constantly taking glucocorticoids for bronchial asthma. Recently, he developed thirst, appetite has increased, urination has become more frequent. Glycemia during the day: 8.9; 7.7; 9.1; 7.8; 8.1 mmol/L. Probable diagnosis?

Renal diabetes

Functional disorder of carbohydrate metabolism

Type 1 diabetes.

Type 2 diabetes

Secondary diabetes mellitus.

A 50-year-old woman consulted a cardiologist about high blood pressure, does not take any drugs, over the past six months has increased body weight by 10 kg. Objective: BMI 33.8 kg / m<sup>2</sup>, heart - the boundaries are shifted to the left, heart rate 72 beats / min, blood pressure 155/100 mm. Hg; the abdomen is soft, painless, with traces of itching in the groin. Daily diuresis - 2-2.5 liters.

Laboratory: CBC - Er -  $4.2 \cdot 10^{12}$  / l, Le -  $6.4 \cdot 10^9$  / l, glycemia - 10.9 mmol / l.

What laboratory test will allow to assess the average sugar level for the last 3 months?

Hemoglobin in CBC

Fructosamine

GAD Antibodies

Glycated hemoglobin

Glucose tolerance test

Patient L., 55 years old, was referred for a consultation due to recurrent furunculosis. Laboratory: fasting blood glucose tests: 5.9 - 6.8 mmol / L.

Glucosuria in the night portion of urine - 0. Which of these tests will help to assess the carbohydrate metabolism?

Repeated determination of fasting blood glucose

Glucose tolerance test

Determine postprandial blood glucose levels.

Determine glucose in daily urine

Determine the concentration of C-peptide

Patient H., 39 years old, has been suffering from acromegaly for 7 years.

Recently, he starts complaining about mouth dryness, polyuria, polydipsia

Fasting glycemia - 9.1 mmol / l, glucosuria 1.0%, ketonuria (0). What type of diabetes is in this patient?

Type 1 diabetes.

Type 2 diabetes.

Symptomatic diabetes.

Secondary diabetes of psychogenic (stress) genesis.

Impaired glucose toleranc

In a 28-year-old woman, during the first pregnancy, fasting blood glucose was first detected at 5.5 mmol/l, postprandial - 10.6 mmol/l, glucosuria 1.5%, ketonuria (+). How should this condition be assessed:

Type 1 diabetes.

Type 2 diabetes.

Gestational diabetes.

Symptomatic diabetes.

Diabetes of unspecified genesis.

Patient J., 27 years old, was diagnosed with diabetes. Her doctor prescribed the determination of C-peptide and immunoreactive insulin (IRI) in the bloo What is the purpose of these tests?

To verify diabetes type 2.

Predicting the severity of diabetes type 1.

To determine the dose of insulin

Correction of the insulin therapy schem

Assessment of the functional state of  $\beta$ -cells.

Patient , 41 years old, went to the doctor because of a wound on his arm, which has not healed for about a month. Examination: internal organs without features, within the age norms. Laboratory: standard GTT: fasting glucose - 5.1 mmol / l, after 1 hour - 10.9 mmol / l, after 2 hours - 9.1 mmol / l. Your assessment of the results:

Type 1 diabetes.

Impaired glucose toleranc

Decompensated diabetes.

The test is questionabl

Normal state

The pregnant woman has fasting glucose 7.6 mmol/l and postprandial - 7.8 mmol/l, HbA1c - 6.1%. What is the next step to assess glucose metabolism?

Glucose tolerance test

Glucose in urine

Insulin level in the blood

The concentration of acetone in the urine

Determine the concentration of antibodies to glutamatic acid decarboxylas

A 59-year-old woman is obese. For a long time she complains of itching of the vagina. Treated by a gynecologist because of candidiasis of the vulva. Glucosuria is absent. Fasting blood glucose three times: 4.4; 6.3; 5.1 mmol/L. Which of these examinations can help to make a diagnosis?

To determine the serotype of Candida

To determine the sensitivity of candida to drugs.

Glucose tolerance test

Daily glucosuria

Protein concentration in the urine

Patient S., who has had type 1 diabetes for 10 years, uses basal-bolus insulin therapy. He has height - 178 cm, weight 80 kg, uses Novorapid (Aspart) 8 IU in the morning, 10 IU at noon, 6 IU in the evening and Lantus (Glargin) 36 IU at 22 hours. HbA1c - 8.5%. The patient often has morning hyperglycemia 14-16 mmol/l. He complains of sleep disturbances with frequent restless dreams. Night glycemia was not checked. Your tactics:

Decrease a dose of Lantus

Increase a dose of Lantus

Increase a dose of evening Novorapid

Reduce a dose of evening Novorapid

Change the patient's diet

Patient N., 20 years old, has newly-developed type 1 diabetes. The constitution is asthenic, height 172 cm, weight - 57 kg, BMI - 20.1 kg/m<sup>2</sup>, HbA1c - 9.8%. After coping with ketoacidosis, normalization of laboratory parameters, the patient was prescribed with the basal-bolus regimen of insulin therapy.

Calculate the optimal daily amount of insulin for this patient.

20-26 IU of insulin per day

30-36 IU of insulin per day

40-45 IU of insulin per day

45-50 IU of insulin per day

55-60 IU of insulin per day

Patient , 31 years old, complains of recurrent hypoglycemic conditions not related to physical activity or eating disorders, which periodically occur 2 hours after dinner. The patient uses insulin therapy: Actrapid NM 12 IU and Protafan NM 20 IU in the morning, Actrapid NM 8 IU at noon, Actrapid NM 12 IU and Protafan NM 14 IU in the evening. HbA1c - 7.6%, glycemic profile: 8<sup>00</sup>- 7.4 mmol/l; 11<sup>00</sup> - 8.3 mmol/l; 13<sup>00</sup>-6.8 mmol/l; 16<sup>00</sup>-7.3 mmol/L; 21<sup>00</sup> - 3.6 mmol/l; 3<sup>00</sup> - 8.2 mmol/l. Your treatment tactics?

Reduce the amount of calories of dinner

Increase the amount of calories of dinner

Increase the dose of Actrapid NM in the evening

Reduce the dose of Actrapid NM in the evening

Reduce the dose of Protafan NM in the evening

Patient J., 32 years old, has had type 1 diabetes for 5 years, is on base-bolus insulin therapy. He set off to a business trip and forgot insulin, which he has not been injecting for 3 days. Objectively: the skin is dry, cold, blood pressure 115/70 mm Hg, pulse - 94 beats per minut HbA1c - 7.6%. Glycemic profile: 8<sup>00</sup>-16.4 mmol/l; 11<sup>00</sup> - 18.3 mmol/l; 13<sup>00</sup> - 15.8 mmol/l; 16<sup>00</sup>-17.5 mmol/l; 21<sup>00</sup> - 16.6 mmol/l; 3<sup>00</sup> - 14.5 mmol/l. Urine glucose - 2.5%, acetone +. Your treatment tactics?

To improve diet

Resume insulin therapy at previous doses

Increase the doses of insiluns by 6-8 IU

Start intensive insulin therapy

Reduce the previous insulin doses by 6-8 IU

Patient V., 23 years old, recently developed type 1 diabetes. In the hospital she was prescribed insulin therapy: Pharmasulin H 30/70 at a dose of 30 IU (18 IU in the morning and 12 IU in the evening). The constitution is normosthenic, height 165 cm, weight - 64 kg, BMI - 22.9 kg/m<sup>2</sup>, HbA1c - 8.6%. Glycemic profile 8<sup>00</sup>- 8.4 mmol/l; 11<sup>00</sup> - 13.1 mmol/l; 13<sup>00</sup>-11.8 mmol/l; 16<sup>00</sup>-16.2 mmol/l; 21<sup>00</sup> - 6.6 mmol/l; 3<sup>00</sup> - 10.5 mmol/l. Your treatment tactics.

To improve the diet

Apply the basal-bolus insulin therapy

Increase the morning dose of insulin Pharmasulin H 30/70

Increase the evening dose of insulin Pharmasulin H 30/70

Increase morning and evening doses of insulin Pharmasulin H 30/70

Patient P., 44 years old, has had type 1 diabetes for 12 years. 3 years ago he was diagnosed with chronic kidney disease, microalbuminuria, and he wants to set off to resort. HbA1c - 7.1%, self-control of blood-glucose is satisfactory. Is it recommended for him to go to resort rehabilitation?

Contraindicate

Not recommended due to the threat of diabetes decompensation

Possible, but without the use of mineral waters at the resort

There are no contraindications

Possible deterioration because of chronic kidney disease

Patients with newly diagnosed type 1 diabetes should calculate a diet at the school for diabetics. Which ratio of macronutrients is correct?

Carbohydrates 50-60%, fats 20-30%, proteins 15-20%

Carbohydrates 40-50%, fats 15-25%, proteins 25-30%

Carbohydrates 50-60%, fats 30-40%, proteins 10-20%

Carbohydrates 60-70%, fats 10-20%, proteins 15-20%

Carbohydrates 40-50%, fats 20-30%, proteins 20-30%

Patient O., 46 years old, has had type 1 diabetes for 18 years. He is on the basis -bolus-insulin therapy. He injects Novorapid (Aspart) 3 times a day 10-12-8 IU and Toujeo (Glargin 300) 24 IU at 22.00. HbA1c - 7.9%, glycemic profile 8<sup>00</sup>-13.4 mmol/l; 11<sup>00</sup> - 6.7 mmol/l; 13<sup>00</sup>-10.9 mmol/l; 16<sup>00</sup>-8.1 mmol/l; 21<sup>00</sup> - 7.9 mmol/l; 3<sup>00</sup> - 10.8 mmol/l. Choose treatment tactics.

Insulin therapy does not need any changes

Improve the diet

Reduce the dose of Toujeo

Increase the dose of Toujeo

Reduce the dose of Novorapid

Patient M., 30 years old, a taxi driver, complains of weight loss (14-16 kg in the last 2 months), polyuria, polydipsi Fasting blood glucose - 17.6 mmol/l, glucosuria - 3.0%, ketone bodies (++) . Your treatment tactics?

Diet.

Diet and biguanides.

Diet Pevzner and sulfonylureas derivatives.

Diet and insulin therapy.

Diet and Soliqua (Glargin + Lixisenatide)

In a 62-year-old patient the examination revealed glycemia - 8.9 mmol/l and glucosuria -15 g/l. HbA1c - 8.7%, C-peptide - 0.92 (references range - 0.9-3.0)  $\mu$ Od/dL, insulin 2.6 (references range - 2-25) ng/dL, He does not have any complaints. Glutamic acid dextran antibodies - 324.3 (references range - up to 10). Your treatment tactics:

Diet.

Diet and biguanides.

Diet and sulfonylureas derivatives.

Diet and SGLT-2-inhibitors.

Diet and insulin therapy

Patient , 25 years old, has been suffering from hypoglycemia in the first half of the day for 2 weeks. It is not related to physical activity or the diet violation.

He uses insulin therapy: Pharmasulin H 14 IU and Pharmasulin HNP 26 IU (at 8<sup>30</sup>), at lunch - Pharmasulin H 10 IU (at 13<sup>30</sup>), in the evening - Pharmasulin H 10 IU and Pharmasulin HNP 14 IU (18<sup>30</sup>). HbA1c - 9.1%. Glycemic profile: 8<sup>00</sup>- 7.1 mmol/l; 11<sup>00</sup> - 3.7 mmol/l; 13<sup>00</sup>-3.2 mmol/l; 16<sup>00</sup>-14.3 mmol/l; 21<sup>00</sup> - 7.8 mmol/l; 3<sup>00</sup> - 5.4 mmol/l. Urine glucoser - 0.5%, ketones (0). Your tactics?

Increase calories consumption in the afternoon

Decrease calories consumption in the afternoon

Reduce the dose of evening Pharmasulin HNP

Reduce the dose of morning Pharmasulin HNP

Reduce the dose of morning Pharmasulin H and Pharmasulin HNP

Indications for the appointment of recombinant insulin analogues are, except:

Frequent unexplained nocturnal hypoglycemia

Low vision (Vis 0.4 / 0.4 uncorrected)

Diabetic autonomic neuropathy

Severe labile type 1 diabetes

Morning hyperglycemic preprandial conditions

Patient K., 21 years old, was newly diagnosed with glycemia 13 mmol/l, daily glucosuria 40 g/l. The last two weeks she has been experiencing an increased appetite, but lost 5-6 kg; thirst, frequent urination, weakness. The constitution

is hypersthenic, height 175 cm, weight 75 kg, BMI - 25.1 kg/m<sup>2</sup>. C-peptide 0.9 (range: 0.9-3.0) µOd/dl, HbA1c - 8.3%. Your tactics.

Diet.

Diet and biguanides

Diet and Soliqua (Glargin + Lixisenatide)

Diet and Victoza (Liraglutide)

Diet and insulin therapy

The patient is in the intensive care unit with a diagnosis: "Diabetes type 1, severe form, brittle, decompensate Diabetic (ketoacidotic) coma ". The skin is dry, turgor is reduced, the tonus of the eyeballs is reduced, blood pressure - 90/60 mm Hg, heart rate - 130 beats/min. Glycemia - 23 mmol/l, pH - 7.1. The content of ketone bodies (++++). What is the initial tactics?

Administration of 5% glucose solution 500 ml.

Administration of 4% sodium bicarbonate 2.5 ml/kg.

Administration of short-acting insulin 10-20 units in bolus, and then - 0.1 IU/kg/h to eliminate ketoacidosis.

Administration of intermediate-acting insulin 10-20 units in bolus, and then - 0,05 IU/kg/h before elimination of ketoacidosis.

Administration of 0.9% sodium chloride 500 ml IV.

The unconsciousness patient was transported by ambulance to the intensive care unit. A card of a patient with diabetes was found. Breathing with rales, Kussmaul type, the smell of acetone from the mouth, dry skin, turgor is reduced, periosteal reflexes are negative, the tonus of the eyeballs is reduced. The content of lactic acid in the blood is 1.2 mmol/l (normal ranges - 0.62-1.3 mmol/l), glycemia is 29 mmol/l. Which emergency can be suspected?

Lactic acidosis.

Hyperosmolar com

Hypoglycemic com

Diabetic ketoacidosis.

Uremic com

The patient has been suffering from type 1 diabetes for six years. Constantly uses the basal-bolus regimen of insulin therapy. During the last week there is a fever, general weakness, nausea in the morning, elevated blood glucose levels in the morning. Urine acetones - positive (+). Specify the diet for this patient.



Exclude fats, allow sugars  
Exclude fats and sugars  
Exclude fats and proteins  
Exclude proteins and allow sugars  
No special dietary recommendations

The boy, 12 years old, was admitted to the surgical department with complaints of severe abdominal pain, nausea and vomiting. He has been sick for 2 weeks after SARS, since when thirst, dry mouth, polyuria began to increase

Objectively: consciousness is darkened, the tonus of the eyeballs is reduced, deep breathing with rales, blood pressure is 100/55 mm Hg, pulse is 136 beats/min. Abdominal muscle tension. Glycemia - 21 mmol/l, acetonuria, plasma osmolarity - 200 mosm/l. Make the correct diagnosis.

Diabetic ketoacidosis, abdominal typ

Diabetic ketoacidosis, colaptoid typ

Diabetic ketoacidosis, encephalopathic typ

Hyperosmolar com

Acute peritonitis.

The 78-year-old patient has type 2 diabetes and uses a combination of metformin 1000 mg twice/day and dapagliflozin 10 mg/day. In the morning, according to relatives, he complained of nausea, general weakness, diarrhea and calf pain. Due to the progressive deterioration of his condition, he was transported to the hospital, where he lost consciousness. Make a preliminary diagnosis and the treatment.

Type 2 diabetes, decompensate Lactic acidosis. Treatment: control of hypoxia, anti-shock measures, insulin therapy.

Type 2 diabetes, decompensate Diabetic Diabetic ketoacidosis. Treatment: rehydration, insulin therapy, electrolyte correction.

Type 2 diabetes, decompensate Hyperosmolar com Treatment: rehydration, insulin therapy, thrombosis prevention.

Type 2 diabetes, decompensate Lactic acidosis. Treatment: rehydration, anti-shock measures, insulin therapy.

Type 2 diabetes, decompensate Hyperosmolar com Treatment: rehydration, insulin therapy, electrolyte correction.

A 40-year-old patient with severe type 1 diabetes developed decompensation of the disease, which was accompanied by the development of ketoacidosis. Small

doses of short-acting insulin and isotonic sodium chloride solution were performed. An hour later, the patient developed a headache, sweating, and heart failure. Blood sugar - 2.8 mmol / l, sodium content - 140 mmol / l. What caused this condition?

Hyperhydration.

Hypokalemia

Ketoadipic intoxication.

Hyponatremia

Hypoglycemia

All the causes lead to the development of hypoglycemic coma, except:

Insulin overdose

Heavy physical exercises.

Alcohol consumption.

Eating fatty food

Skip meals.

The girl, 18-year-old, has been suffering from diabetes for 5 years. The daily dose of insulin is 36 IU. During pneumonia, the condition sharply deteriorated: significantly increased thirst, abdominal pain, nausea, vomiting, drowsiness. The patient refused to eat in the evening, skipped the insulin injection, and lost consciousness in the morning. Objectively: the skin is dry, turgor is reduced. The tongue is dry. Breathing is deep, with rales, smell of acetone from the mouth. Body temperature - 36.6° C, pulse - 100 beats/min, weak filling and tension, blood pressure - 90/50 mm Hg. In urine - a positive reaction to acetone. Blood glucose - 33 mmol/ liter. What is the previous diagnosis?

Ketosis

Hyperosmolar coma

Diabetic ketoacidosis

Hepatic coma

Cerebral coma

The 52-year-old patient was taken unconscious to the hospital. Objectively: facial features are pointed, eyeballs are soft, skin and mucous membranes are dry, subfebrile body temperature, muscle tone is reduced. Heart rate 110 beats/min, blood pressure 70/40 mm Hg. Periodically occur convulsions. Laboratory: glucose - 20.7 mmol/l, sodium - 148 mmol/l, glucosuria, ketonemia. Make a preliminary diagnosis.

Hyperosmolar coma  
Hyperacidotic coma  
Hyperlactacidemic coma  
Hyperketonemic coma  
Uremic coma

A 27-year-old woman was found unconscious. Objectively: the skin is dry, the tongue is dry, the smell of acetone, shortness of breath, deep breathing, with rales. Heart rate 120 beats/min, blood pressure 80/50 mm Hg. Muscle tension of the anterior abdominal wall, palpation of the abdomen is painless.

Laboratory: leukocytes -  $17.0 \times 10^9/l$ , glucose - 21 mmol/l, creatinine 84  $\mu\text{mol/l}$ , pH - 7.2. Urone reaction with sodium nitroprusside ++++. Choose the most appropriate treatment in the prehospital stage

Short-acting insulin at a dose of 10-12 IU IV  
Short-acting insulin at a dose of 100 IU IV  
Intermediate-acting insulin at a dose of 10-12 IU  
4% sodium bicarbonate solution - 400.0 ml  
Glucagon 1.0 mg i/m

Woman, 26-year-old, has bronchopneumonia, developed com Objectively: the skin is dry, turgor is reduce Breathing is deep, with rales. Smell of aceton Heart rate - 122 beats/min, extrasystoles, blood pressure - 90/50 mm Hg. Liver + 3 cm. Glycemia - 32 mmol / l, blood pH - 6.8. What medication should be included in the treatment of this patient?

4.2% sodium bicarbonate solution  
5% glucose solution  
40% glucose solution  
long-acting insulin  
1 ml of 0.1% adrenaline solution

A 64-year-old woman has had type 2 diabetes for 21 years, including 6 years of basal-bolus insulin. Adheres to the diet, calculates carbohydrate calories, HbA1c - 6.0%. Was diagnosed with CKD IV, GFR (CKD-EPI) - 19 ml/min/1.73 m<sup>2</sup>, microalbumin/creatinine ratio - 7.6 mg/mmol. This does not include:

Macroalbuminuria  
Hypertension.  
Increased daily insulin dos

Reduced of daily insulin dos

Edem

The patient, 42 years old, has had type 2 diabetes for 10 months, follows the diet. Objectively: fasting blood glucose - 5.5 mmol/L, postprandial - 7.6 mmol/L, HbA1c - 6.8%, glucosuria 0%. Blood pressure - 125/80 mm Hg. There are no complications of diabetes. Make the correct diagnosis.

Type 1 diabetes mellitus, moderate severity, compensate Honeymoon phase

Type 2 diabetes mellitus, moderate severity, compensate

Type 2 diabetes, first detected, subcompensate

Diabetes mellitus type 1, mild form, compensate

Type 2 diabetes, mild form, compensate

A 65-year-old woman has been suffering from type 2 diabetes for 10 years. She takes metformin at a dose of 2000 mg per day and gliclazide at a dose of 120 mg per day. She has developed numbness and freezing of the feet for the last 6 months. Examination: BMI - 34 kg/m<sup>2</sup>, blood pressure 160/100 mm Hg, glycated hemoglobin level 8.3%. Choose the appropriate therapy.

Increase the dose of both drugs to the maximum doses.

Add meglitinides to the therapy

Instead of gliclazide prescribe a DPP-4 inhibitor

Prescribe a GPP-1 agonist instead of metformin

Add SGLT-2 inhibitor to the therapy

Which of the following antidiabetic drugs increases the risk of acute pancreatitis?

Metformin.

Glimepirid

Nateglinid

Gliclazid

Dulaglutide

Patient A, who has type 2 diabetes and takes metformin at a dose of 2000 mg/d, developed finger gangren Laboratory: glycated hemoglobin - 7,5% Which therapy should be applied in this case?

Replace metformin with gliclazide at the maximum therapeutic dos

Combine metformin with gliclazide at a medium therapeutic dos

Combine metformin with intermediate-acting insulin in 2 injections per day.

Switch the patient to exenatide in combination with a DPP-4 inhibitor.

Prescribe insulin therapy with short-acting insulin in 4 injections per day.

What is the main mechanism of action of biguanides?

Stimulation of glucagon production.

Stimulation of insulin exocytosis from  $\beta$ -cells of the islets of the pancreas.

Enhancement of insulin action at receptor and postreceptor levels in insulin-dependent tissues.

Inhibition of sodium-glucose linked transporter type 2 in distal nephron tubules

Inhibition of *dipeptidyl peptidase-4*.

What is the main mechanism of action of GPP-1 agonists?

Stimulation of glucagon-like peptide 1.

Stimulation of insulin exocytosis from  $\beta$ -cells of the islets of the pancreas.

Enhanced insulin action at receptor and postreceptor levels in insulin-dependent tissues.

Inhibition of sodium-glucose linked transporter type 2 in distal nephron tubules

Inhibition of *dipeptidyl peptidase-4*.

What is the main mechanism of action of sulfonylurea derivatives?

Stimulation of glucagon production.

Stimulation of insulin exocytosis from  $\beta$ -cells of the pancreatic islets.

Enhanced insulin action at receptor and postreceptor levels in insulin-dependent tissues.

Inhibition of sodium-glucose linked transporter type 2 in distal nephron tubules

Inhibition of *dipeptidyl peptidase-4*.

What is the main mechanism of action of saxagliptin?

Stimulation of glucagon production.

Stimulation of insulin exocytosis from pancreatic islet beta cells.

Enhanced insulin action at receptor and postreceptor levels in insulin-dependent tissues.

Inhibition of sodium-glucose linked transporter type 2 in distal nephron tubules

Inhibition of *dipeptidyl peptidase-4*.

A patient with type 2 diabetes had to undergo surgery (appendectomy). He takes metformin at a dose of 2000 mg / day, gliclazide (diabetes MR) 60 mg / day and saxagliptin at a dose of 5 mg / day. Fasting blood glucose - 6.2 mmol/L,

postprandial - 7.6 mmol/L, the level of glycated hemoglobin - 7.3%. What should be the tactics of hypoglycemic therapy?

Switch to 4 injections of short-acting insulin.

Do not change this therapy.

Continue metformin and prescribe intermediate-acting insulin in 2 injections.

Discontinue drugs and recommend strict diet therapy during surgery.

Prescribe GPP-1 agonist (liraglutide)

All statements regarding biguanides are correct, except:

Decreased gastrointestinal glucose absorption.

Inhibition of gluconeogenesis in the liver.

Increased tissue sensitivity to insulin at the periphery.

Decrease the level of cholesterol, triglycerides.

Activation of  $\beta$ -cell proliferation and inhibition of its apoptosis.

A woman with type 2 diabetes is worried about being overweight. She consulted a doctor about recommendations for weight loss. Which of the tips would you choose for her?

Do not change her eating habits, but only reduce the amount of salt consumed.

Do not change her eating habits, but eliminate alcohol consumption.

Do unloading days three times a week.

Do not change eating habits, but introduce 2 unloading days a week.

None of them

Indications for insulin therapy for type 2 diabetes are all except:

Diabetic ketoacidosis.

Diabetic foot syndrome

Dilated cardiomyopathy.

Pregnancy and lactation.

Surgery

Non-calorie sugar substitute is:

Sorbitol.

Maltodextrin

Aspartam

Fructose

Xylitol.

Female 26 years of age, taking daily levothyroxine 50 mcg / day due to hypothyroidism on the basis of chronic autoimmune thyroiditis. In the control examination: no complaints, objectively - without pathological abnormalities, IMT 58 kg; TSH 7.2 mIU / l, FT4 1.26 ng / dL, FT3 3.08 ng / dL. Your suggestion for therapeutic tactics at the moment:

No correction is require

Reduce the dose to 25 mcg / day.

Increase the dose to 75 mcg / day.

Leave dose, add selenium preparation.

Correction after determination of lipidogram.

Patient V., 3 years old, was admitted to hospital for congenital hypothyroidism. Which of the following drugs should be prescribed?

Levothyroxine \*

Somatotropic

Potassium iodide

Thiamazole

Prednison

Patient V., 2 years old, was admitted to the hospital for delayed physical and mental development. Objectively: height 52 cm, body weight 13 kg. Expressed skin dryness, hair thin and brittle. The skull is large, the crown is not close. The tongue protrudes from the oral cavity. Heart rate 55 beats / min. Heart tones are mute. The thyroid gland is not enlarged. Mental and physical development lags behind the passport. Make a preliminary diagnosis.

Subacute thyroiditis

Congenital hypothyroidism \*

Autoimmune thyroidin, hypothyroid phas

Endemic goiter

Sporadic goiter.

From anamnesis of the patient M., 45 years old, it is known about chronic thyroiditis. Recently, she has been worried about frostbite, drowsiness, constipation, memory loss. Objectively: the skin is pale, dry, cold and swollen, the loss of eyebrows and hair on the temples. BELL 100/70 mm Hg. bradycardi. What is the most likely diagnosis?

Endemic goiter, euthyroid condition

Chronic fibrous thyroiditis

Autoimmune thyroiditis, euthyroid condition  
Secondary hypothyroidism  
Autoimmune thyroiditis, hypothyroidism. \*

The patient is diagnosed with acute purulent thyroiditis at the stage of abscession.  
Which of the following treatments is appropriate?

Surgical treatment \*  
Thiamazole  
Radioiodine therapy  
Prednisone  
Potassium iodid

In the complex treatment of thyrotoxic crisis, the following drugs are prescribed,  
except:

Anaprilin  
The Lugol solution  
Adrenaline \*  
Cordyamine  
40% glucose solution.

Patient L., 39 years old Operated for the diffuse toxic goiter of the third century. A  
month after surgery, the patient had convulsive contractions of the muscles of the  
extremities. Objectively: Pulse 76 beats / min., Blood pressure 136/80, symptoms  
of Chvostek, Trusso positiv What is the most likely diagnosis?

Postoperative hypothyroidism  
Recurrence of goiter  
Vegetative-vascular dystonia  
Postoperative hypoparathyroidism \*  
None of the above

The boy is 11 days, sluggish, motionless, constantly drowsy, suffering from  
constipation. He rarely screams, his voice rough. Objectively: the tongue is  
large; the skin is dry, yellowish in color, cold Bradycardia, hypotension. The  
thyroid gland is not palpable Karyotype 46XY. Establish a probable diagnosis.

Down disease  
Congenital hypothyroidism \*  
Hemolytic disease of the newborn  
Iron deficiency anemia



Endemic goiter.

A woman has 32 years of complaints of frostbite, adynamia, inhibition, drowsiness. Objectively: the skin is pale, dry, cold and swollen, the loss of eyebrows and hair on the temples. BELL 100/70 mm Hg. bradycardia, fluid in the pericardium cavity. On ECG bradycardia, the low voltage of the QRS complexes and the teeth of P and T. The thyroid gland is not enlarged Which diagnosis is most likely?

Autoimmune thyroiditis, euthyroid state

Endemic goiter

Subacute thyroiditis

Hypothyroidism \*

Cardiovascular failure

Patient S., 38, complains of emotional lability, tachycardia during agitation, hyperhidrosis of the palms. Thyroid enlarged to IV century, moderately compacted and heterogeneous, lobe surface Ultrasound: echogenicity of the gland is reduced, the structure is heterogeneous. TSH - 2.1 mIU / l, free T4 - 13.6 pmol / l. What is the most likely diagnosis?

Primary hypothyroidism

Secondary hypothyroidism

Primary hyperthyroidism

Secondary hyperthyroidism

Autoimmune thyroiditis, euthyroid state

Patient 29 years old complained of weight gain, frostbite, dry skin, drowsiness, difficulty concentrating. Objectively: height 165 cm, weight 78 kg, female phenotype, t 35,8C, HR 58 / min, blood pressure 105/60 mm Hg Other internal organs unchanged Thyroid 1 st., Diffusely compacted The galactorrhea of the 1st century Laboratory study found an increase in TSH and prolactin levels, a decrease in T4. What is the probable cause of the galactorrhea?

Primary hypothyroidism.

Secondary hypothyroidism.

Tertiary hypothyroidism.

Hypopituitarism.

Prolactinoma

Patient hospitalized after influenza. From anamnesis (according to relatives) it is known about hypothyroidism, the last 6 months have not been treated. On examination, consciousness is absent, tendon reflexes are lowered, body temperature is 35.50 C, breathing 10 per 1 min, superficial. BELL 80/50 mm Hg. Art. Pulse 48 beats / min, fluid in the cavity of the pericardium. ECG low voltage QRS complexes and teeth P and T. What is the most likely diagnosis?

Acute disorders of cerebral circulation

Myocardial infarction.

Acute cardiovascular failure

Hypothyroid coma

Chronic adrenal insufficiency.

In a patient of 26 years with postoperative hypothyroidism who received L - thyroxine 100 µg twice a day, tachycardia, sweating, irritability, and sleep disorders appear. Determine the tactics of further treatment.

Reduce the dose of thyroxine

Add thiamazole

Assign beta blockers

Increase the dose of thyroxine

Prescribe sedatives.

In the patient K., 46 years, six months after subtotal resection of the thyroid gland appeared general weakness, apathy, drowsiness, hair loss, dry skin, constipation. Pulse 60 beats / min., Blood pressure 130/80 mm Hg. Art. What is the most likely diagnosis?

Iodine deficiency state

Subacute thyroiditis, hypothyroid stage

Autoimmune thyroiditis

Postoperative hypothyroidism

Hyperthyroidism.

Patient S., 25, has no complaints. The examination revealed an increase in the thyroid gland. He resides in the Skole district. Objectively: the thyroid gland enlarged to the 2nd century., Of uniform consistency, elastic, not painful. Total T4 - 80 mmol / l, T3 - 2.3 mmol / l, TSH - 3.6 mmO / l.

Diffuse toxic goiter

Subacute thyroiditis

Autoimmune thyroiditis, euthyroid state

Endemic goiter, euthyroid state  
Endemic goiter, hypothyroidism.

Patient K., age 52, complains of weight gain, weakness, discomfort in the neck. Objectively: dry skin, moderate swelling of the face and extremities. Pulse rate of 60 beats / min. The thyroid gland enlarged to the second century, is heterogeneous, not painful. Antibodies against thyroid peroxidase 300 IU / ml. Hormone levels: total T4 - 40 nmol / l, T3 - 0.68 nmol / l, TSH - 12.4 mIU / l.

What is your diagnosis?

Endemic goiter  
Subacute thyroiditis  
Autoimmune thyroiditis, hypothyroidism  
Autoimmune thyroiditis, euthyroid state  
Fibrous thyroiditis.

Patient , 41 years old, found an increase in thyroid gland of II., Painful on palpation, pain radiates into the lower jaw, body temperature 37-38 ° C, a week ago suffered angin Most likely that the patient:

Diffuse toxic goiter  
Toxic thyroid adenoma  
Subacute thyroiditis  
Autoimmune thyroiditis  
Riedel's goiter

Patient S., 24, has no complaints. The examination revealed an increase in the thyroid gland He resides in the Skole district. Objectively: thyroid gland enlarged to the 2nd century., Of uniform consistency, elastic, not painful, sensitive to palpation. Total T4 - 80 nmol / l, TSH - 1,8 mIU / l. Assign therapy.

L-thyroxine  
Thiamazole  
Potassium iodide  
Combination of L-thyroxine and potassium iodide  
None of the following.

The main reason for thyroid enlargement in Hashimoto thyroiditis is:

Thyocyte hyperplasi  
Formation of fibrous tissu  
TSH stimulation.

Lymphoid infiltration of the gland  
Influence of antimicrosomal antibodies.

An "accumulation defect" on a thyroid scan may be a sign of:

Subacute thyroiditis.

Malignant tumor.

Riddle's thyroiditis.

Acute purulent thyroiditis.

Any underlying pathology

A resident of the mountain district of Ivano-Frankivsk region, 23 years old, complains of miscarriage (in history - 2 miscarriages). Palpatory thyroid gland I., Soft, homogeneous; on ultrasound - without pathological changes. There are no clinical signs of thyroid dysfunction. Laboratory: TSH 6.2 mIU / L, BT4 1.46 ng / dL, anti-TPO 20 IU / ml. What is the probable cause of this situation?

Hashimoto thyroiditis.

Iodine deficiency subclinical hypothyroidism.

Thyrotoxicosis.

Manifest hypothyroidism.

Stressful condition.

Clinical manifestations of Riddle thyroiditis may be:

Bradycardi

Tachycardi

Leukocytosis.

Weight loss.

Swallowing disorders.

A 45-year-old man was diagnosed with nodular goiter. On scintigraphy - "hot zone" in the projection of the nod T3 and T4 levels are elevated Your diagnosis?

Diffuse toxic goiter

Thyroid cancer

Autoimmune thyroiditis

Toxic thyroid adenoma

Subacute thyroiditis.

Patient 29 years old with postoperative hypothyroidism, who receives 150 mcg of Levothyroxine 2 times a day, developed tachycardia, sweating, sleep disturbances. Determine the tactics of further treatment:

Prescribe sedatives.

Prescribe beta-blockers.

Replace L-thyroxine with another similar drug.

Increase the dose of the hormone

Reduce the dose of the hormone

In a 28-year-old woman, palpation of the thyroid gland in the left lobe revealed a nodule, an oval nodule measuring 3.2x2.5 cm, dense in consistency, limited mobility, not painful. Heredity is burdened, from the history of the patient it is known about cancer in the family. Which of the following thyroid cancers are familial (inherited cancer)?

Papillary cancer.

Follicular cancer.

Medullary cancer

Anaplastic cancer .

Adenoma of the thyroid gland

A 40-year-old woman has a nodule in her thyroid gland. Heredity is burdened. From the anamnesis of the patient it is known about cancer in the family. Suspected medullary thyroid cancer. Which diagnostic method is effective for detecting medullary thyroid cancer?

Hypocalcemia

Increased levels of calcitonin in the blood

Hypercalcemia

Thyroglobulin level.

TSH level

To diagnose medullary cancer, thyroid FNAB (fine-needle biopsy) was performed. What morphological features are characteristic of this disease?

Presence of multinucleated giant cells in the punctate

Presence of bacteria in the punctate

Presence of neutrophilic leukocytes in the punctate

Presence of erythrocytes in the punctate

A 28-year-old woman has a nodule in her thyroid gland. Scintigraphy from I131 showed that it was "cold". From the anamnesis it was found out that at the age of 10 she underwent a course of radiotherapy for chronic tonsillitis. Treatment tactics?

Thyroid hormones.

Glucocorticoids.

Prescribe iodine preparations.

Surgical treatment.

Dynamic observation.

In a 40-year-old woman, palpation of the thyroid gland in the left lobe revealed a nodule, dense, moderately painful. Ultrasound revealed reduced echogenicity, containing calcinates. What additional tests should be performed to confirm the diagnosis?

ECG.

Scintigraphy.

Aspiration fine-needle biopsy.

Determination of urinary iodine excretion.

Thyroglobulin

A 29-year-old man consulted an endocrinologist due to the presence of a nodule in the thyroid gland. There are no other complaints. The node was found accidentally during a preventive examination. Heredity is not burdensome. History - without features. The general condition is satisfactory. In the left lobe of the thyroid gland is palpated a node 4 cm in diameter, hard, painless, mobile. Cervical lymph nodes are not enlarged. The level of thyroxine in the blood is 120 nmol / l. Preliminary diagnosis?

Toxic thyroid adenoma

Simple non-toxic nodular goiter.

Anaplastic thyroid cancer

Papillary thyroid cancer.

Subacute de Quervain's thyroiditis.

The patient complains of lethargy, drowsiness and convulsions. From the anamnesis it was established that a calcium preparation with vitamin D3 was used for the treatment of osteoporosis. Which of the following drugs reduces the entry of Ca ions into the tissues?

Sodium fluoride

Amiodarone  
Procainamide  
Verapamil  
Aimalin

Patient, 48 years old. Complains of weakness, intermittent pain in the heart, palpitations, drowsiness, irritability. Ill for 3 years. She was treated without effect by a cardiologist and a neurologist. Objectively: height 166 cm, body weight 70 kg. Skin of normal color, moist. The thyroid gland is diffusely enlarged to the II degree, elastic-elastic consistency, with a smooth surface, mobile. Pulse 96 per minute, blood pressure 140/70 mm Hg. Art. Heart tones are sonorous, systolic murmur over the apex. Additional data: general analysis of blood and urine without pathology. The level of thyroid hormones is moderately elevated. Ultrasound: evenly reduced echogenicity. Make a preliminary diagnosis:

Diffuse toxic goiter of the II degree, manifest thyrotoxicosis.

Autoimmune thyroiditis.

Thyroid cancer.

Riedel's goiter.

Diffuse euthyroid goiter of II degree

A 32-year-old woman went to an endocrinologist for a nodule in her thyroid. There are no other complaints. Which diagnostic method is most effective for determining medullary thyroid cancer?

Ultrasound of the thyroid gland

Blood calcitonin level.

Thyroglobulin level.

Radiograph of soft tissues of the gland

Thyroid scan.

The patient has complaints of irritability, sweating, hand tremors, palpitations, weight loss with preserved appetite. The thyroid gland is enlarged to the second degree, elastic, not painful. These symptoms are most consistent with:

Diffuse toxic goiter

Neurasthenia

Autoimmune thyroiditis

Hypothyroidism

Hypoparathyroidism.

Patient , 37 years ol Complains of irritability, palpitations, sweating, general weakness, shortness of breath. She lost 7 kg. Objective: height 168 cm, body weight 58 kg. The skin is moist. The thyroid gland is enlarged due to all departments. There is a gleam in the eyes, a slight bilateral exophthalmos, tremor of the fingers. Pulse 120 for 1 min., Blood pressure 150/60 mm Hg. Art. What is the previous diagnosis?

Toxic thyroid adenoma

Diffuse toxic goiter

Chronic fibrous thyroiditis

Autoimmune thyroiditis, euthyroid state

Neurastheni

Patient G., 48 years ol Has been suffering from diffuse toxic goiter for 7 years.

Which of the prescribed drugs has an antithyroid effect?

Prednisolone

Thiamazole

B-vitamin complex

Phytosedative complex

Anaprilin.

A 24-year-old woman who has recently had hypertension has serum potassium level of 2.7 mEq / l, plasma aldosterone (AP) level is 55 ng% (norm 1-6). The following studies revealed: AP after saline infusion - 54 ng% (norm 1-8), after a 4-hour walk - 32 ng% (norm 4-31); serum 18-hydroxycorticosterone level is 108 ng% (norm <30). What is the most likely diagnosis?

Primary hyperaldosteronism (Conn syndrome)

Corticosteroma

Androsteroma

Pheochromocytoma

Corticosterom

Which statement will be incorrect about congenital adrenal cortex hyperplasia

The disease develops as a result of birth defects in the enzyme 21 hydroxylase

The disease develops as a result of birth defects in the enzyme 3 $\beta$  dehydrogenase

The disease develops as a result of birth defects in the enzyme 11  $\beta$  hydroxylase

The disease develops as a result of birth defects of the enzyme 17 $\alpha$  hydroxylase

The disease develops as a result of birth defects in the enzyme lactate dehydrogenase



Which hormone is produced in the zona of the adrenal cortex?

Cortisone

Adrenaline

Testosterone

Corticosterone

Norepinephrine

Which of the diagnostic criteria is uncharacteristic of pheochromocytoma?

Increased urinary excretion of vanillylmandelic acid

Decreases in blood catecholamines

Increase in ESR

Leukocytosis, eosinophilia, erythrocytosis

Conduction disorders and left ventricular hypertrophy on the ECG

Which statement will be true for Itsen-Cushing's syndrome?

Cortisol and ACTH levels are elevated

Cortisol and ACTH levels are reduced

Cortisol levels are elevated, ACTH is lowered

Cortisol levels are elevated, ACTH is lowered

Cortisol levels unchanged, ACTH elevated

Which of the antihypertensive drugs is the drug of choice for treating hypertension with pheochromocytoma?

Alpha blockers

Beta blockers

Clonidine

ACE inhibitors

Receptor antagonists for angiotensin II

Which statement would be incorrect for acute adrenal insufficiency?

Develops in pathology of the adrenal glands

May accompany severe violations of other organs and systems

It is accompanied by hypertension

It is accompanied by collapse and hypotension

It is accompanied by a decrease in cortisol, corticosterone, aldosterone

Which statement will be true for adipogenital dystrophy?

Cortisol, ACTH, testosterone, progesterone levels are elevated  
ACTH cortisol, testosterone, and progesterone levels decreased  
Cortisol levels increased, ACTH, testosterone, progesterone reduced  
ACTH cortisol levels increased, testosterone lowered, progesterone lowered  
Cortisol levels unchanged, ACTH of testosterone, progesterone elevated

Patient K., aged 51, complained of severe headache, heartache, severe general muscle weakness, seizures, thirst, rapid urination in large portions. Laboratory studies: ZAK - without features, urine test - alkaline reaction, proteinuria, isohypostenuria, biochemical analysis of urine - hyperkaliuria, hyponatriuria, increased daily excretion of aldosterone. What is your diagnosis?

Hyperaldosteronism  
Hypoparathyroidism  
Diabetes mellitus  
Addison's Disease  
Chronic renal failure

Konin's disease was suspected in a patient of 46 years. What blood test should you do to confirm your diagnosis?

Blood tests for aldosterone  
Blood tests for cortisone  
Blood tests for calcium content  
Research on cholesterol  
General blood test

A man, 17 years old, last 3 weeks, feeling tired, muscular weakness, dizziness. He left the house early and lost consciousness. AO 95/60 mmHg, Ps 115 beats / min. The skin is cool, dry, dark. Laboratory data: hematocrit 36%, glucose 62 mg / dL, Na 120 lv / l, K 6.7, creatinine 1.4 mg%. Which endocrine disease should be suspected?

Adrenogenital syndrom  
Corticosterom  
Waterhouse-Friederick syndrom  
Sheehan Syndrom  
Addison's diseas

Which statement will be true for secondary chronic adrenal insufficiency?

Cortisol levels, ACTH elevated

Cortisol levels, ACTH reduced

Cortisol levels are lowered, ACTH increased

Cortisol levels are elevated, ACTH is lowered

Cortisol levels unchanged, ACTH elevated

Which statement will be true for changes in blood in chronic adrenal insufficiency?

Hypernatremia, hypercholesterolemia, hyperkalemia

Hyponatremia, hypercholesterolemia, hypokalemia

Hyponatremia, hypocholesterolemia, hypokalemia

Hyponatremia, hypercholesterolemia, hyperkalemia

Hypernatremia, hypocholesterolemia, hypokalemia

Patient, 58, was admitted to the endocrinology department with headaches, general weakness, increased blood pressure, which is bad for correction, dry mouth, thirst, weight loss, dry cough. Hypertensive disease is more than 10 years. On examination: thin, pale skin, dry, in the lungs - vesicular breathing, heart rhythmic tones, heart rate - 88 beats per minute, blood pressure 180/110 mm Hg. Laboratory data: blood sugar - 7.8 mmol / l, ZAK and ZAS without features. Adrenal ultrasound - enlarged left adrenal gland, CT of the adrenal gland - volume formation of the left adrenal gland. What is your healing tactic?

Adrenalectomy unilateral

Phentolamine in / in to stabilization of blood pressure

Adrenalectomy bilateral

$\beta$ -blockers

Seduxen

Which of the hormones is produced in the glomerular zone of the adrenal cortex?

Cortisone

Adrenaline

Testosterone

Aldosterone

Estrogens

The causes of hyperaldosteronism may be all of the following except:

Hormone-active tumor of the adrenal gland (aldosteroma)

Bilateral hyperplasia of the glomerular zone of the adrenal glands

Bilateral hyperplasia of the retinal mesh

Long-term use of medicines (diuretics, contraceptives)

May develop in some kidney diseases

The patient 37 years after the stressful situation had an attack, accompanied by pain in the chest and head, a sense of fear of death, internal chills. HELL - 180/100 mmHg, heart rate - 100 per min. The attack ended with the release of a large amount of light urine. What is the disease you suspect?

Sympatho-adrenal crisis

Weight-insular crisis

Epileptic seizure

Neurasthenia

Migraine attack

Patient, 26, complains of severe weakness, lack of appetite, nausea, weight loss (by 10 kg for 3 months). He was treated in the gastroenterology department, but the disease is progressing. On examination: hyperpigmentation occurs on the skin and gums against the background of reduced nutrition. In the lungs - unchanged heart tones - deaf, heart rate - 80 beats per minute. Pain on palpation of the abdomen is observed. Emptying - 3-4 times a day. What is the most likely diagnosis?

Addison's disease

Hypothyroid coma

Hyperlactacidemic coma

Hyperosmolar coma

Acute insufficiency of adrenal cortex

Patient H 26 years old, complains of thirst (drinks more than 8 liters of fluid during the day), polyuria. Examination revealed hyposthenuria. Which drug should be prescribed?

Cabergoline 0.5 mg once a week

Minirin 1 tablet 1-3 times a day

Dexamethasone 0.5 mg once a day 1 Bromocriptine 2.5 mg once daily

Diacarb 0.25 once daily

Patient O., 25 years old, complained of menstrual irregularities (amenorrhea) for 3 months), intermittent headache. On examination, the constitution is normosthenic, nutrition is satisfactory, the skin is clean, moderately moist, when pressed from the

breasts, a whitish fluid is released. The thyroid gland is not palpable. Pregnancy is excluded. What additional examination should be prescribed in the first place?

Determine the level of thyrotropic hormone, free T4

Determine the level of thyroid-stimulating hormone, free T4, prolactin, MRI of the pituitary gland

Determine the level of prolactin

Determine the level of female sex hormones

MRI of the pituitary gland, ultrasound of the ovaries

A 28-year-old woman is being examined for primary infertility. Diagnosed with pituitary macroadenoma (suprasellar growth) without impaired visual function. The prolactin content is 104.6 ng / ml (norm 4.79-23.3 ng / ml).

Bromocriptine 5 mg three times a day

Cabergoline 0.5 mg once a week

Cabergoline 0.5 mg once a day

Transphenoidal removal of pituitary macroadenoma

Octreotide 0.05 mg p / w twice a day

Patient M. 32, examined for hypercorticism. In order to differentially diagnose the source of hypercortisolemia, it was decided to conduct a large dexamethasone test. Specify the correct schedule of dexamethasone for this purpose?

0.5 mg 4 times a day for 2 days

1.0 mg 4 times a day for 2 days

2.0 mg 4 times per day for 2 days

0.5 mg 6 times a day for 2 days

A 22-year-old woman is being examined for obesity and periodic high blood pressure. The family doctor referred the patient to an endocrinologist, who suggested a small dexamethasone test. Specify the correct schedule of dexamethasone for this purpose.

Dexamethasone 0.5 mg every 6 hours for 48 hours

Dexamethasone 1.0 mg every 6 hours for 48 hours

Dexamethasone 0.5 mg every 6 hours for 72 hours

Dexamethasone 0.5 mg every 4 hours for 48 hours

Dexamethasone 1.5 mg every 6 hours for 48 hours 2.0 mg 6 times a day for 2 days

The patient, P 38, complains of frequent headaches, fatigue, loss of ability to work. An increase in intracranial pressure, secondary hypothyroidism was noted. On

X-ray of a skull: expansion of a Turkish saddle, double-contour of a bottom with presellar pneumatization. On MRI: cerebrospinal fluid in the intracellular area, the sickle-shaped pituitary gland Diagnose:

Tertiary hypothyroidism

Parkinson's syndrome

Pituitary cyst

"Empty" Turkish saddle syndrome

Picture of transcranial adenectomy

The patient, A 30 years old, complains of an increase in the size of the jaw, hands, feet, palpitations, menstrual irregularities such as oligomenorrhea The examination diagnosed dyslipoproteinemia, elevated prolactin and somatotrophic hormone MRI revealed a cystic pituitary adenoma of 9 mm. Choose the correct diagnosis.

Acromegaly

Gigantism

Macroprolactinoma

Craniopharyngioma

Prolactotrophic hyperplasia

A 28-year-old woman complained of being overweight. From the anamnesis it is known that overweight from adolescence, but began to gain weight after childbirth. On examination: the skin is clean, moderately moist. Excess of adipose tissue, the distribution is uniform. Height 172 cm, weight 96.3 kg, BMI 32.53 kg / m<sup>2</sup>. Set the degree of obesity.

Normal body weight.

Overweight.

Grade I

Grade II

Grade III

A 21-year-old girl complains of disproportionate obesity (upper type), menstrual irregularities, and hair growth in androgen-dependent areas. The examination revealed an increase in cortisol, ACTH. MRI revealed an 11 mm pituitary adenoma Itsenko-Cushing's disease was diagnose Choose a false statement for this disease

Patients have a "moon-shaped" face

Hypertension.

Dysplastic obesity.

Development of osteoporosis.

Frequent hypoglycemic conditions .

Patient H, 42 years old, complains of severe polydipsia and polyuria. During the day he drinks more than 8 liters of fluid. He associates the disease with a recent psycho-emotional trauma. The additional examination revealed hyposthenuria of the urine, a decrease in antidiuretic hormone. What functional tests are performed to diagnose diabetes insipidus?:

With clonidine

With verospirone

With fluid restriction

With dexamethasone

With starvation

The patient complains of progressive obesity with a predominant deposition of subcutaneous fat in the shoulder girdle, mammary glands, abdomen, buttocks and thighs. Consulted by a gynecologist, confirmed the underdevelopment of the genitals. At additional inspection decrease in levels of FSH, LH, estrogens is diagnosed. Make the correct diagnosis.

Pehkrantz-Babinski-Frelich syndrome

Alimentary-constitutional obesity

Itsenko-Cushing's disease

Shereshevsky-Turner syndrome

Lawrence-Moon-Bardet syndrome -For

Patient O., 28 years old, is being examined for infertility. According to the results of instrumental and laboratory examinations, polycystic ovary disease was diagnosed. Which statement is wrong for this disease?

Ovarian-menstrual cycle disorders

Anovulatory cycles

Female phenotype

Overweight

Thyroid enlargement

The patient, K 22 years old, complains of short stature and overweight. Low growth rate since childhood, growth retardation was more than 3 sigma deviations. Pituitary dwarfism was diagnosed. What height is the criterion for this disease in patients?

Less than 100 cm

Less than 110 cm

Less than 120 cm

Less than 130 cm 1 Less than 140 cm

The patient, 36 years old, complained of a sharp increase in weight (22 kg during the year), periodic headache, decreased potency. Objective: height 170 cm, body weight 114 kg. Fat deposits mainly on the chest, abdomen. On the shoulders, abdomen and thighs stretch crimson-cyanotic color. Heart tones are deaf, blood pressure 170/100 mm of mercury. Art. External and internal genitals are well developed. Fasting blood glucose 7.6 mmol / L

Alimentary-constitutional obesity

Hypothyroid obesity

Hypoovarian obesity

Itsenko-Cushing's disease

Lipomatosis

The parents of a 13-year-old girl went to the doctor with complaints about her child's short stature and overweight. Objectively: proportional growth retardation, excess body weight with uniform deposition of subcutaneous fat, delayed sexual development. The doctor suspected pituitary dwarfism. Which criterion is considered correct to confirm the diagnosis?

Height less than 120 cm

Growth lag of 3 or more sigmoid deviations

Height less than 130 cm

Lag growth by 2 sigma deviations

Growth lag by 1 sigma deviation