

Dentistry – Surgery

IV year

Which sign is not associated with peptic ulcer perforation:

Sudden onset

Cloiberg caps

Positive Blumberg sign

Free air below diaphragm on plain abdominal film

Intolerable abdominal pain

Which ethiological factors causes peptic ulcer disease most oftenly?

Abdominal trauma, alimentary factor

H. pylori, NSAID's

H. pylori, hyperlipidemia

Drugs, toxins

NSAID's, gastrinoma

A 30-year-old male is operated on for peptic ulcer perforation, in 2,5 hours after the beginning of the disease. Which operation will be most efficient (radical operation for peptic ulcer)?

Simple closure and highly selective vagotomy

Simple closure

Simple closure with a Graham patch using omentum

Stomach resection

Antrumectomy

A 42-year-old male, with previous ulcer history and typical clinical picture of peptic ulcer perforation, on examination, in 4 hours after the beginning of the disease, discomfort in right upper quadrant, heart rate - 74/min., mild abdominal wall muscles rigidity, negative Blumberg sign. Free air below diaphragm on X-ray abdominal film. What is you diagnosis?

Peptic ulcer recurrence

Acute cholecystitis

Chronic cholecystitis

Covered peptic ulcer perforation

Acute appendicitis (subhepatic location)

Most oftenly perforated peptic ulcers are located at:

Posterior wall of antrum

Fundus of stomach

Cardiac part of stomach

Posterior wall of duodenal bulb

Anterior wall of duodenal bulb

Penetrated ulcer can cause such complications: 1). Abdominal abscess; 2). Portal pyelophlebitis; 3). Stomach-organ fistula; 4). Acute pancreatitis; 5). Bleeding.

1, 2, 3;

2, 3, 5;

1, 3, 5;

3, 4, 5;

All

A 45-year-old man complains of burning epigastric pain that wakes him up at night. The pain is relieved by eating or using over-the-counter antacids and H2 blockers. Diagnosis is best confirmed by which of the following?

Urea breath test

Serum gastrin levels

Barium meal examination

Upper endoscopy

Upper endoscopy and biopsy

A 44-year-old dentist complains of burning epigastric pain that wakes him up at night caused by a recurrent duodenal ulcer. He has shown considerable improvement following operative treatment by a truncal vagotomy and pyloroplasty, 10 years prior to this incident. Which is TRUE of truncal vagotomy?

It is performed exclusively via the thorax

It can be performed in the neck

If complete, it will result in increased acid secretion

It requires a gastric drainage procedure

It has been abandoned as a method to treat ulcer disease

A 42-year-old executive has refractory chronic duodenal ulcer disease. His physician has suggested several surgical options. The patient has chosen a parietal (highly selective) vagotomy instead of a truncal vagotomy and antrectomy because?

It results in a lower incidence of ulcer recurrence

The complication rate is lower

It reduces acid secretion to a greater extent

It benefits patients with antral ulcers the most

It includes removal of the ulcer

A 63-year-old woman is admitted to the hospital with severe abdominal pain of 3-hour duration. Abdominal examination reveals board-like rigidity, guarding, and rebound tenderness. Her blood pressure is 90/50 mm Hg, pulse 110 bpm (beats per minute), and respiratory rate is 30 breaths per minute. After a thorough history and physical, and initiation of fluid resuscitation, what diagnostic study should be performed?

Supine abdominal x-rays

Upright chest x-ray

Gastrograffin swallow

Computerized axial tomography (CAT) scan of the abdomen

Abdominal sonogram

A frail elderly patient is found to have an anterior perforation of a duodenal ulcer. He has a recent history of nonsteroidal anti-inflammatory drug (NSAID) use and no previous history of peptic ulcer disease. A large amount of bilious fluid is found in the abdomen. What should be the next step?

Lavage and omental patch closure of the ulcer

Lavage of the peritoneal cavity alone

Total gastrectomy

Lavage, vagotomy, and gastroenterostomy

Laser of the ulcer

Name 3 main signs of perforated peptic ulcer?

Abdominal pain, multiple vomiting, distention of abdominal cavity

Increasing abdominal pain, meteorism, peritonitis

Ulcer in past medical history, sudden abdominal pain, board-like rigidity

Ulcer in past medical history, pain in the epigastrium, which gradually increases, peritonitis

Abdominal pain, pale and cold skin, low BP
Abdominal pain, pale and cold skin, low BP

What doesn't predispose to peptic ulcer disease?

Steroid use

Cigarette smoking

Rapid gastric emptying

High gastrin level

H2-blockers intake

What we can find at abdominal examination of patient with perforated peptic ulcer: 1. abdominal wall muscles rigidity; 2. positive Blumberg sign; 3. guarding; 4. tenderness; 5. absence of liver dullness. Choose the best combination.

all are present

1,2,3

1,2,4

1,3,5

2,3,4

Which statement, concerning perforated peptic ulcer, is NOT TRUE?

Patient with a perforated peptic ulcer who has peritoneal signs should undergo laparotomy

Perforated peptic ulcers must be treated nonoperatively

Patients with perforated peptic ulcer usually present with a sudden onset of severe abdominal pain

Free air under the diaphragm confirm the diagnosis of perforated peptic ulcer

Perforation of posterior wall of stomach is seen very rarely

Laboratory studies in patients with perforated ulcer may include: 1. CBC; 2. Serum gastrin level; 3. H. pylori infection testing; 4. Urine analysis; 5. Serum human chorionic gonadotropin levels. Choose correct answer.

1, 2, 3

1, 3, 4

1, 4, 5

2, 3, 5

2, 4, 5

Nonoperative treatment of selected patients with a diagnosis of perforated ulcer includes all the following, EXCEPT:

NSAIDs

Broad-spectrum antibiotics

Proton pump inhibitor

Fluid resuscitation with replacement of fluid and electrolytes

Nasogastric decompression

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1, 4, 5

2, 3, 5

2, 4, 5

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Broad-spectrum antibiotics

Proton pump inhibitor

Fluid resuscitation with replacement of fluid and electrolytes

Nasogastric decompression

The most efficient noninvasive diagnostic method for small bowel obstruction is:

Ultrasound examination.

Irrigography

Colonoscopy

Laparoscopy

Plain abdominal film

Medical therapy will be effective in cases of bowel obstruction caused by: 1.Volvulus; 2.Cancer of colon; 3.Paralytic ileus; 4.Spastic bowel obstruction; 5.Coprostasis.

1, 2, 4

1, 2, 5

3, 4, 5

2, 3, 4

1, 2, 3

The signs of strangulation are: 1.Acute onset of disease; 2.Severe abdominal pain; 3.Slow beginning; 4.Dull pain; 5. Dilated small intestine loops with air/fluid levels on plain abdominal film.

2, 3, 5

1, 2, 5

1, 3, 4

3, 4, 5

4, 5

The signs of obturation are: 1.Acute onset of disease; 2.Severe abdominal pain; 3.Slow beginning; 4.Dull pain; 5. Dilated air-filled colon on plain abdominal film.

3, 4, 5

1, 4, 5

2, 3, 5

1, 2

1, 2, 3

Patient with bowel obstruction is complaining for blood in the stool. What is you diagnosis?

Intussusception

Paralytic ileus

Hernia incarceration

Spastic bowel obstruction

Volvulus

For low large bowel obstruction are characteristic all signs except:

Acute dehydration

Absence of stool

Cloiberg caps on plain abdominal film

Abdominal distension

Slow beginning;

Surgical treatment in case of acute bowel obstruction is indicated in cases: 1. Electrolyte disbalance. 2. Abdominal cramps. 3. Strangulation. 4. Obstruction has not resolved within 24-48 hours of concervative treatment 5. Multiple air-fluid level on plain abdominal film.

2, 3

4, 5

3, 4

3, 5

1, 2

A 42-year-old woman is admitted to the emergency department with severe colicky pain, vomiting, and abdominal distention. She has not passed stools or flatus for 48 hours. X-rays of the abdomen confirm the presence of smallbowel obstruction. What is the most likely cause of small-bowel obstruction in the patients?

Tumors, groin hernia

Gallstones, tumors

Groin hernia incarceration, adhesions

Helminths, tumors

Adhesions, inflammatory diseases

Most oftenly small bowel obstruction is caused by:

Adhesions, inflammatory diseases

Helmints, tumors

Groin hernia incarceration, adhesions

Gallstones, tumors

Tumors, groin hernia.

Surgical treatment in case of acute bowel obstruction is indicated in cases:

1. Electrolyte disbalance. 2. Abdominal cramps. 3. Strangulation. 4. Obstruction has not resolved within 24-48 hours of conservative treatment 5. Multiple air-fluid level on plain abdominal film.

2, 3

4, 5

1, 5

3, 4

1, 2

An elderly nursing home patient is brought to the hospital with recent onset of colicky abdominal pain, distension and obstipation on examination, the abdomen is markedly distended and tympanitic. There is no marked tenderness. Plain abdominal x-ray shows a markedly distended loop located mainly in the right upper quadrant. The likely diagnosis is:

Mesenteric vascular occlusion

Sigmoid volvulus

Gallstone ileus

Chron's disease

Small-bowel obstruction

56-year-old patient admitted to the surgical department with complaints of abdominal pain, repeated vomiting, which does not bring relief. The pain

starts 2 hours before admission, after consumption of large amount of food. Patient anxious, pale skin, acrocyanosis, pulse 120 bpm, BP 90/60 mmHg. Abdomen moderately distended in the epigastric region, in the lower parts - sink in. On palpation: tenderness in the epigastrium. On percussion: tympanic sound in the epigastric region, increased peristalsis. On plain abdominal film dilated small intestinal loops. Make diagnosis?

Bowel obstruction caused by the tumor of large intestine
Bowel obstruction caused by the tumor of large intestine

Small intestine volvulus

Acute pancreatitis

Groin hernia incarceration

Peptic ulcer perforation

The small intestine receives blood supply from different sources. They are:

1) Superior mesenteric artery (SMA)

2) Inferior mesenteric artery (IMA)

3) Arteries iliaca externae

4) Arteries iliaca internae

5) Celiac axis

Choose correct combination.

2, 3

4, 5

1, 5

3, 4

1, 2

The small bowel wall consists of all of the following layers, EXCEPT:

Subserosa

Mucosa

Submucosa

Muscularis

Serosa

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Urea breath test

Serum gastrin levels

Ultrasound

Barium meal examination

Upper endoscopy and biopsy

A 44-year-old patient has refractory chronic duodenal ulcer disease. His physician has suggested several surgical options. The patient has chosen a parietal (highly selective) vagotomy instead of a truncal vagotomy and antrectomy because?

It results in a lower incidence of ulcer recurrence.

It benefits patients with antral ulcers the most.

It includes stomach resection.

It left the nerve supply to pylorus intact (nerves of Latarjet).

It includes removal of the ulcer.

A frail elderly patient is found to have an anterior perforation of a duodenal ulcer. He has a recent history of nonsteroidal anti-inflammatory drug (NSAID) use and no previous history of peptic ulcer disease. A large amount of bilious fluid is found in the abdomen. What should be the next step?

Lavage and omental patch closure of the ulcer

Lavage of the peritoneal cavity alone

Total gastrectomy

Laser of the ulcer

Lavage, vagotomy, and gastroenterostomy

A 37-year-old man has had recurrent symptoms suggestive of peptic ulcer disease for 4 years. Endoscopy reveals an ulcer located on duodenum bulb. A mucosal biopsy reveals *Helicobacter pylori*. What is TRUE about *H. pylori*?

Active organisms can be discerned by serology.

It is protective against gastric carcinoma.

It is associated with chronic gastritis.

It cannot be detected by the urea breath test.

It causes gastric ulcer but not duodenal ulcer.

A 68-year-old woman has been diagnosed with a benign ulcer on the greater curvature of her stomach, 5 cm proximal to the antrum. After 3 months of standard medical therapy, she continues to have guaiac positive stool, anemia, and abdominal pain with failure of the ulcer to heal. Biopsies of the gastric ulcer have not identified a malignancy. The next step in management is which of the following?

Surgical intervention, including total gastrectomy

Surgical intervention, including partial gastric resection

Admission of the patient for total parenteral nutrition (TPN), treatment of anemia, and endoscopic therapy

Endoscopy and bipolar electrocautery or laser photocoagulation of the gastric ulcer

Treatment of the anemia and repeat all studies in 6 weeks

Over the past 6 months, a 60-year-old woman with long standing duodenal ulcer disease has been complaining of anorexia, nausea, weight loss and repeated vomiting. She recognizes undigested food in the vomitus. Examination and workup reveal dehydration, hypokalemia, and hypochloremic alkalosis. What is the most likely diagnosis?

Anorexia nervosa

ZES (Zollinger Ellison Syndrome)

Penetrating ulcer

Pyloric obstruction due to cicatricial stenosis of the lumen of the duodenum

Carcinoma of the fundus

A 2-cm ulcer on the greater curvature of the stomach is diagnosed in a 70-year-old woman by a barium study. Gastric analysis to maximal acid stimulation shows achlorhydria. What is the next step in management?

Antacids, H₂ blockers, and repeat barium study in 6 to 8 weeks

Proton pump inhibitor (e.g., omeprazole)

Prostaglandin E (misoprostol) and repeat barium study in 6 to 8 weeks

Immediate elective surgery

Upper endoscopy with multiple biopsies (at least 8 or 9) for the ulcer

Which condition does not cause gastric outlet obstruction?

pancreatic pseudocyst

bezoar

sliding esophageal hernia

ingestion of caustics

gastric polyps

Which tumors may cause gastric outlet obstruction? (1) papilla Vateri cancer, (2) duodenal cancer, (3) hepatocellular carcinomas, (4) pancreatic cancer, (5) uterine cancer

All

1, 3, 5

3, 4, 5

2, 3, 5

1, 2, 4

Which steps are indicated for treatment of gastric outlet obstruction? (1) IV rehydration; (2) Immediate blood transfusion; (3) Correction of electrolyte disbalance; (4) Nasogastric tube placement; (5) Endoscopic gastrostomy.

1, 2, 4

2, 3, 5

3, 4, 5

1, 3, 4

1, 2, 5

Which procedure usually is NOT performed for gastric outlet obstruction related to peptic ulcer disease?

vagotomy and antrectomy

vagotomy and pyloroplasty

truncal vagotomy and gastrojejunostomy

pyloroplasty alone

proximal gastric resection

Which statement concerning gastric outlet obstruction is WRONG?

Peptic ulcer disease or carcinoma can cause gastric outlet obstruction

Continuous vomiting may lead to dehydration and electrolyte abnormalities

Barium upper GI tests may demonstrate the obstruction

Plain radiographs can demonstrate the presence of gastric dilatation

The major benign cause of gastric outlet obstruction (GOO) is malnutrition

Clinical presentation of patient with gastric outlet obstruction may include all listed below, EXCEPT:

Nausea and vomiting are the cardinal symptoms of gastric outlet obstruction

Vomiting usually is rich for bile

Vomit contains undigested food particles

Patients may develop significant and progressive gastric dilatation

Patients may develop significant weight loss

A 48-year-old man undergoes surgery for a chronic duodenal ulcer. The procedure is a truncal vagotomy and which of the following?

Gastroenterostomy

Removal of the duodenum

Closure of the esophageal hiatus

Incidental appendectomy

No further procedure

A 35-year-old man underwent an Billroth II resection. Although usually careful with his diet, he ate a large meal during a business lunch. Within 1 hour, he felt lightheaded and developed abdominal cramping and diarrhea. His symptoms may be attributed to:

Anemia

Jejunogastric intussusceptions

Dumping syndrome

Afferent loop syndrome

Alkaline reflux gastritis

A 63-year-old man underwent gastric resection for severe peptic ulcer disease. He had complete relief of his symptoms but developed "dumping syndrome." This patient is most likely to complain of which of the following?

Severe vasomotor symptoms after eating

Repeated vomiting

Anemia

Gastric intussusception

Intestinal obstruction

A 64-year-old man was evaluated for moderate protein deficiency. He underwent a gastrectomy 20 years earlier. He is more likely to show which of the following?

Porphyria

Hemosiderosis

Aplastic anemia

Hemolytic anemia

Iron deficiency anemia

Choose all signs typical for early dumping syndrome: 1. Occurs within 10-30 minutes after meals; 2. Occurs 1-3 hours after a meal; 3. Nausea, bloating, abdominal cramps; 4. Explosive diarrhea; 5. Flushing, dizziness, palpitations; 6. An intense desire to lie down

1, 3, 4

2, 3, 4

2, 4, 5

2, 4, 6

1, 5, 6

Choose all signs typical for late dumping syndrome: 1. Occurs within 10-30 minutes after meals; 2. Occurs 1-3 hours after a meal; 3. Nausea, bloating, abdominal cramps; 4. Explosive diarrhea; 5. Flushing, dizziness, palpitations; 6. An intense desire to lie down

1, 3, 4

2, 3, 4

2, 4, 5

2, 5, 6

1, 5, 6

The following are pathogenetic links of dumping syndrome except:

Immediate dumping of gastric contents into the jejunum

Relative intravascular volume contraction and hemoconcentration occur as a consequence of osmotic shift of fluids from the intravascular compartment i

Release of vasoactive GI hormones responsible for peripheral and splanchnic vasodilatation and vasomotor symptoms such as flushing, tachycardia and di

In response to rapid delivery of a meal to the small intestine, high concentration of carbohydrates is seen in the proximal small bowel followed by ra

Hyperglycemia develops due to insulin deficiency in patients with dumping syndrome

The following are diet recommendations for a patient with dumping syndrome except:

Avoid liquids for at least 30 minutes after a solid meal

Daily food intake should be divided into at least six meals

Carbohydrate intake should be reduced, with preference for complex, rather than simple carbohydrates

Increased intake of milk and dairy is recommended

Supplementation of dietary fibers (bran, citrucel) has been shown to be beneficial in the treatment of late hypoglycemia

The most effective drug for dumping syndrome treatment is:

Acarbose

Octreotide

Tolbutamide

Propranolol

Verapamil

The following statements about surgical treatment of patients with dumping syndrome are true except:

The goal of surgical treatment is to slow down gastric emptying

Surgery is suggested after one year of medical measures (diet, behavioral, drug therapy)

Surgery is highly effective method of dumping syndrome treatment

In patients with Billroth II gastrectomy, a conversion to Billroth I anatomy allows restoration of the gastric content delivery into the duodenum

Excellent results with an interposed jejunal segment has been reported

What hormone produces beta-cells of pancreatic gland:

Somatostatin

Somatotropin

Insulin

Glucagon

Pancreozymin

Which ethiological factors causes acute pancreatitis most oftenly?

Abdominal trauma, alimentary factor	500-1000 ml
Gallstones, alcohol	700 ml
Hypercalcemia, hyperlipidemia	2500 ml
Drugs, toxins	
ERCP, sphincter of Oddi dysfunction	What instrumental examination should be performed to diagnose necrotizing pancreatitis?
Which thesis is correct according to pathogenesis of acute pancreatitis?	US
Intrapancreatic enzyme's activation	ERCP
Pancreatic gland autolysis	Plain abdominal film
Neutrophils chemoactivation, infiltration and inflammation	Blood gases
SIRS	CT
All are correct	
A 52-year-old male, without alcohol history, admitted to hospital with acute pain in epigastrium, radiating to the back. Amylase level elevated. Which radiological findings will help diagnosing acute pancreatitis?	A 60-year-old alcoholic is admitted to the hospital with a diagnosis of acute pancreatitis. Upon admission, his white blood cell (WBC) count is $21 \times 10^9/l$. His lipase, lactate dehydrogenase and aspartate aminotransferase are elevated, blood glucose is 10 mmol/L. Which of the following is TRUE?
Changes in liver on CT scans	A serum calcium level of 1.7 mmol/L on the second hospital day is a bad prognostic sign
Choledocholithiasis on US	This patient is expected to have a mortality rate of less than 5%
Stomach shifted anteriorly on contrast examination of GIT	The patient's lipase level is not important indication of prognosis
Cloiber cups on plain abdominal film	This patient requires immediate surgery
Air below diaphragm on plain abdominal film	A venous blood gas would be helpful in assessing the severity of illness in this patient
What is the volume of pancreatic juice produced in 24 hours?	
200-500 ml	
100-200 ml	A 40-year-old alcoholic male is admitted with severe epigastric pain

radiating to the back. Serum amylase level is reported as normal (fluoroscopic method), but serum lipase is elevated. The serum is noted to be milky in appearance. A diagnosis of pancreatitis is made. The serum amylase is normal because:

The patient has chronic renal failure

The patient has hyperlipidemia

The patient has alcoholic cirrhosis

The patient has alcoholic hepatitis

The diagnosis of pancreatitis is incorrect

A 57-year-old woman is admitted to the hospital with abdominal pain. She reports that she drinks alcohol only at social occasions. The amylase is elevated to 120 mmol/l. Which following x-ray finding would support a diagnosis of acute pancreatitis?

Hepatic lesion on CT scan

Gas in abdominal cavity

Dilated colon transversum

Large loop of colon in the RUQ

Irregular cutoff of the CBD on cholangiogram

Following a motor vehicle accident a truck driver complains of severe abdominal pain. Serum amylase level is markedly increased to 400 mmol/l. Grey Turner's sign is seen in the flanks. Pancreatic trauma is suspected. Which statement is true of pancreatic trauma?

It is oftenly caused by blunt injuries

It is usually an isolated single-organ injury

It often requires a total pancreatectomy

It may easily diagnosed at operation

It is proved by the mildly elevated amylase level

The severity of pancreatitis can be estimated with:

Ranson Criteria

Alvarado scale

US examination results

SOFA scale

CXR

Clinical staging (Atlanta consensus) of acute pancreatitis consists of the following forms of the disease: 1. Pseudotumorous pancreatitis. 2. Mild acute pancreatitis. 3. Sterile pancreonecrosis. 4. Infected pancreonecrosis. 5. Pseudocyst of the pancreas. Select the correct combination of answers:

2,3,4

1,2,3,5

3,4

2,3,4,5

All correct

Enzyme toxemia in case of pancreonecrosis is caused by: 1. Trypsin. 2. Phospholipase A2. 3. Chymotrypsin. 4. Elastase. 5.

Enterokinase. Select the correct combination of answers:

1,4

2,3,5

1,2,3,4

1,3,4,5

All correct

A 45-year-old male admitted to the surgical department with severe pain in epigastrium with irradiation to the back, which develops after alcohol consumption. Acute pancreatitis was diagnosed. The patient was performed CT scan: pancreatic enlargement. What is the stage of acute pancreatitis according to CT picture?

Grade A

Grade B

Grade C

Grade D

Grade E

Acute pancreatitis is most rarely seen in:

> 60 years old women

21-45 years old men

45-60 years old women

45-60 years old men

Children

How peritoneum covers pancreatic gland?

From all sides

From anterior and posterior sides

From anterior and inferior side

Covers only anterior surface of the gland

Covers anterior and posterior sides only of the head of the gland

For clinical picture of acute pancreatitis are typical all signs except:

Continuous severe pain located in the epigastrium and/or left upper quadrant

The pain irradiates to the back

Multiple vomiting

Paralytic ileus

Absence of liver dullness

In differential diagnosis of acute pancreatitis and acute bowel obstruction will be useful: 1. CBC; 2. Liver enzymes serum levels; 3. Serum amylase and lipase levels; 4. Plain abdominal film; 5. Serum electrolytes. Choose best combination.

1, 2

2, 3

3, 4

1, 5

2, 5

Choose changes in biochemical test typical for patients with acute pancreatitis: 1. Hypertriglyceridemia; 2. Hyperglycemia; 3. Hypercalcemia;

4. Hypotriglyceridemia;
Hypocalcemia.

1, 2, 5

1, 3, 4

2, 3, 4

3, 4, 5

1, 2, 4

Most common cause of death in early acute pancreatitis is?

Renal failure

Cardiac failure

Respiratory failure

Uncontrolled coagulopathy

Sepsis

A 60-year-old female treated in surgical department for acute pancreatitis. On 30 day of treatment in epigastrium appeared mass 10 cm in diameter. CBC: RBC - 3,71012/l, WBC - 10109/l. US examination: fluid collected near the head of the pancreatic gland. What complication of acute pancreatitis developed in this case?

Postnecrotic pseudocyst

Retroperitoneal phlegmone

Enzyme peritonitis

Pancreatic abscess

Cancer of the head of the pancreas

5. A 45-year-old male treated in surgical department for acute pancreatitis during 28 days. He started to complain for the temperature elevation to 39°C, weakness, fatigue. CBC: RBC - 3,51012/l, WBC - 21109/l. CT: 11 cm in diameter fluid collected near the head of the pancreatic gland. What complication of acute pancreatitis developed in this case?

Postnecrotic pseudocyst

Retroperitoneal phlegmone

Enzyme peritonitis

Pancreatic abscess

Cancer of the head of the pancreas

The early complications of acute pancreatitis are all, except:

Pancreatic shock

Acute respiratory distress syndrome

Enzyme peritonitis

Renal failure

Pancreatic fistula

When infection complications of acute pancreatitis develops most oftenly?

On 7-th day of disease

After 2 weeks

On 4-th day of disease

After 6 months

On 2-nd day of disease

Treatment of acute pancreatitis includes all EXCEPT:

Diuretics

Antibiotics

Intravenous hydration

Analgesics

Nothing per os

A 24-year-old college student recovers from a bout of severe pancreatitis. He has mild epigastric discomfort, sensation of bloating, and loss of appetite. Examination reveals an epigastric fullness that on ultrasound is confirmed to be a pseudocyst. The swelling increases in size over a 3-week period of observation to 15 cm in diameter. What should be the next step in management?

Percutaneous drainage of the cyst

Laparotomy and internal drainage of the cyst

Excision of pseudocyst

Total pancreatectomy

Administration of pancreatic enzymes

A 42-year-old woman with a history of chronic alcoholism is admitted to the hospital because of acute pancreatitis. The bilirubin and amylase levels are in the normal range. An ultrasound reveals cholelithiasis (stones in the gallbladder, CBD 6 mm in diameter). The symptoms decreased on the fifth day after admission. What should she be advised?

To start on a low-fat diet at home

To increase the fat content of her diet

To undergo immediate cholecystectomy

To undergo cholecystectomy during the same hospital stay as well as an assessment of her bile ducts

That she will be discharged and should undergo elective cholecystectomy after 3 months

A 26-year-old woman with a known history of chronic alcoholism is admitted to the hospital with severe abdominal pain due to acute pancreatitis. The serum and urinary amylase levels are elevated. On the day following admission to the hospital, there is no improvement, and she has a mild cough and slight dyspnea. What is the most likely complication?

Pulmonary atelectasis

Bronchitis

Pulmonary embolus

Afferent loop syndrome

Pneumonia

The most often cause of death in case of destructive pancreatitis is:

Pulmonary embolism

Mechanical jaundice

Peritonitis

Septic complications

Renal failure

30-year-old man hospitalized with a severe epigastric pain. During examination: hypoxemia, dehydration. Laboratory tests: increased levels of amylase and lipase in the blood. CT confirmed severe acute pancreatitis. Which antibiotic will reduce the risk of infection?

Ampicillin

Erythromycin

Gentamicin

Ceftriaxon

Imipenem/cilastatin

45-year-old man who abused alcohol, admitted to the hospital complaining of abdominal pain, nausea, vomiting. Body temperature 36,8°C. At palpation: defined tumor in the epigastrium. Laboratory tests: pancreatic amylase normal. On the second day in the hospital CT was held: 9 cm pseudocyst of pancreas was found. Which statement regarding this patient is correct?

Pseudocyst can cause compression of stomach and biliary ducts

Spontaneous resorption never met

Pseudocyst can be seen only in case of acute pancreatitis

In this case pseudocyst doesn't need any treatment

Malignant degeneration occurs in 25% of cases, if untreated

Which drug is used to suppress the secretion of the pancreas?

Aprotinin

Octreotide

Papaverine

Imipenem/cilastatin

Acetaminophen

Which drug is used to inhibit proteases?

Aprotinin

Octreotide

Papaverine

Imipenem/cilastatin

Acetaminophen

Which statement concerning medical treatment of patient with acute pancreatitis on early phase (first 3-5 days) is WRONG?

Patients are kept "nothing per os"

Aggressive fluid resuscitation is critically important

Antibiotics should be used in any case of acute pancreatitis

Imipenem/cilastatin is indicated to prevent infection in patients with pancreatic necrosis

Early initiation of enteral nutrition is important in treatment and infection prevention

Name the source of infection in patients with necrotizing pancreatitis?

Pulmonary infection

Bacterial translocation from gut

Skin infection

Urinary infection

Nosocomial infection

A 44-year-old woman is admitted to the hospital because of acute pancreatitis. Biochemical test: bilirubin - 45 $\mu\text{mol/l}$. An ultrasound reveals stones in gallbladder and CBD 14 mm in diameter. MRCP: 8 mm stone in the distal part of CBD, which is dilated to 14 mm. What should be the first step in the treatment of patient?

Whipple procedure

Distal resection of the pancreas

Sphincterotomy and stone extraction

Only medical treatment

Urgent cholecystectomy

A 47-year-old man with a known history of chronic alcoholism is admitted to the hospital with severe abdominal pain due to acute pancreatitis. His general condition worsens in first 48 hours. CBC: RBC - 4,410,12/l, WBC - 11,2109/l. On second series of CT scans rapid increase in retroperitoneal fluid accumulation was found. Which complication of necrotizing pancreatitis develops in this case?

Enzyme peritonitis

Retroperitoneal bleeding

Pancreatic duct disruption

Retroperitoneal phlegmon

Pancreatic abscess

Choose the WRONG statement concerning pseudocyst definition:

Peripancreatic fluid collection persisting for more than 4 weeks

Pseudocyst lack an epithelial layer

Most of them are filled with necrotic debris

Intervention (minimally invasive or conventional) should be performed in case of pseudocyst complications development

In all cases pseudocysts should be treated with conventional surgery

Which sign is characterized by rebound tenderness over the site of abnormality in patients with peritonitis?

Kocher's sign

Blumberg's sign

Murphy's sign

Pasternatski's sign

Cullen's sign

What is the leading etiological factor causing spontaneous bacterial peritonitis?

Candida albicans

Streptococcus pyogenes;

Staphylococcus aureus

Escherichia Coli

Pseudomonas aeruginosa

Name the scoring system which helps surgeon to make the prognosis in case of peritonitis?

Manheim index

APACHE II

ONTARIO Score

EuroSCORE

SOFA

A 68-year-old woman is admitted with an acute surgical abdomen. After resuscitation with IV crystalloids fluids and administration of antibiotics, she is taken for an immediate laparotomy. Perforated diverticulitis of the sigmoid colon is found. The sigmoid colon is inflamed but mobile and the mesentery contains a perforated abscess. The best operation for this patient would be:

Insertion of a drain in the abscess

Sigmoid resection including the abscess and primary colon-to-colon anastomosis

Sigmoid loop colostomy

Left hemicolectomy

Sigmoid resection and end sigmoid colostomy and oversew the rectum (Hartmann procedure)

Which statement is WRONG concerning primary microbial peritonitis?

Occurs without perforation of a hollow viscus

Occurs with perforation of a hollow viscus

Caused by direct seeding of microorganisms

Seeding of microorganisms via bacterial translocation from the gut

Seeding of microorganisms via hematogenous dissemination

Which statement is wrong concerning secondary microbial peritonitis?

Occurs subsequent to perforation of a hollow viscus

Endogenous microbes spill out into the peritoneal cavity

Even after timely surgical intervention and preemptive antibiotic therapy, about 15-30% of patients demonstrate ongoing infection consisting of rec

Perforation of the colon is associated with lower infection rates

Patients who develop secondary microbial peritonitis should undergo surgery to alleviate the source of ongoing peritoneal soilage

Which examination would be most efficient in finding the cause for secondary bacterial peritonitis?

Laparoscopy

Plain abdominal film

Ultrasound

CT scan

Level of CRP

One of the listed below diseases didn't cause secondary peritonitis

Acute cholecystitis

Destructive appendicitis

Acute cholangitis

Bowel obstruction

Intestinal infarction

Choose the clinical sign, not typical for acute peritonitis:

Tachycardia

Positive Blumberg sign

Muscles rigidity

Paralytic ileus

Positive Ortner sign

Select the method of instrumental examination, which is not suitable for localization of intra-abdominal abscesses:

US

Colonoscopy

CT

MRI

Laparoscopy

Specify the main microorganisms, which are identified in the abdominal

cavity of patients with purulent peritonitis:

Monomicrobial

Gram-positive microorganisms domination

Gram-negative microorganisms domination

Staphylococcus

Streptococcus

Choose a reason for the use of metronidazole as a component of antibacterial therapy of patients with diffuse peritonitis?

Elimination of anaerobic bacteria

Elimination of gram-positive flora

Elimination of gram-negative flora

Elimination of fungal infections

Antiprotozoal antibiotic

For the clinical course of acute peritonitis three stages are typical. Choose the correct combination: 1. Subclinical; 2. Reactive; 3. Toxic; 4. Septic; 5. Terminal:

1, 2, 3

2, 3, 4

1, 2, 5

3, 4, 5

2, 3, 5

For clinical picture of subdiaphragmatic abscess is typical everything except:

Reduction of pulmonary respiratory excursions

Elevation of diaphragm dome

Reactive pleural effusion

Leukocytosis

Hematemesis

A 40-year-old patient, operated at 36 hours after onset of the disease, patient was performed median laparotomy. On visual inspection of abdominal cavity during operation: redness and swelling of the peritoneum in the lower parts of abdominal cavity, peritoneum covered with fibrin, purulent exudate in the peritoneal cavity of the pelvis. Appendix is thickened, tense, dark purple color with perforations that exudes pus. Choose the best method of treatment:

Appendectomy, sanitation and drainage of the abdominal cavity by installing drains

Appendectomy

Appendectomy and sanitation of the abdominal cavity

Appendectomy and sanitation of the abdominal cavity, ileostomy

Appendectomy and laparostomy

A 60-year-old patient with coronary heart disease, was hospitalized after 48 hours of onset of acute severe epigastric pain, which extended

throughout the abdomen, vomiting. The patient's condition is severe. On examination: confused consciousness, pale skin, swelling of both legs, breathing - 26 per minute, heart rate - 120 bpm, BP - 90/60 mmHg, dry tongue, anterior abdominal wall in the act of breathing is not involved, abdominal cavity is painful in all departments, positive Blumberg sign, absence of bowel sounds on auscultation, daily urine output - 800 ml/24 hours, CBC - WBC - $15 \times 10^9 / l$, HMG - 131 g/l, serum amylase - 200 U/l (N=60-180 U/l). Plain abdominal film revealed free gas under the diaphragm. Make the diagnosis:

Peptic ulcer perforation, peritonitis, reactive stage

Peptic ulcer perforation, peritonitis, toxic stage

Peptic ulcer perforation, peritonitis, terminal stage

Acute pancreatitis

Acute appendicitis, peritonitis, toxic stage

A 60-year-old patient with coronary heart disease, was hospitalized after 48 hours of onset of acute severe epigastric pain, which extended throughout the abdomen, vomiting. The patient's condition is severe. On examination: confused consciousness, pale skin, swelling of both legs, breathing - 26 per minute, heart rate - 120 bpm, BP - 90/60 mmHg, dry tongue, anterior abdominal wall in the act of breathing is not involved,

abdominal cavity is painful in all departments, positive Blumberg sign, absence of bowel sounds on auscultation, daily urine output - 800 ml/24 hours, CBC: WBC - 21×10^9 / l, HMG - 131 g/l, serum amylase - 200 U/l (N=60-180 U/l). Plain abdominal film revealed free gas under the diaphragm. Choose optimal strategy of patient's management:

Laparoscopy to make the diagnosis

Infusion and cardiac therapy for 1-2 hours followed by surgery

Emergency surgery without preparation

Ultrasound examination of the abdominal cavity in order to confirm the diagnosis and choose surgical approach

Infusion and cardiac therapy for 1-2 hours followed by upper GI endoscopy

In differential diagnosis between intraperitoneal bleeding and peritonitis, choose the right combination of the following clinical symptoms pathognomonic for peritonitis: 1). RBC - $2,0 \times 10^9$ /l, hemoglobin - 70 g/l; 2). Arterial hypotension; 3). Blumberg sign; 4). Paralytic ileus; 5). Severe persistent abdominal pain. Choose correct combination:

1,2,5

1,2,3

1,2,4

2,3,4

3,4,5

The main factors determining the outcome in patients with peritonitis are: 1). The prevalence of abdominal contamination. 2). Virulence of pathogens. 3). Source of peritonitis. 4). Disease duration. 5). The age of the patient. Choose the best combination of answers:

1,2,3

1,4,5

1,2,3,5

2,3,4,5

All are true

The severity of endogenous intoxication in patients with peritonitis is caused by: 1). Metabolic disorders; 2). Hypovolemia; 3). Impaired microcirculation; 4). Paresis of the intestine; 5). Condition of cellular immunity. Choose the best combination of answers:

1,4,5

1,2,3

1,2,3,5

2,3,4,5

All are true

The most efficient noninvasive diagnostic method for small bowel obstruction is:

Ultrasound examination.

Irrigography

Colonoscopy

Laparoscopy

1, 2

Plain abdominal film

1, 2, 3

Medical therapy will be effective in cases of bowel obstruction caused by:
1.Volvulus; 2.Cancer of colon;
3.Paralytic ileus; 4.Spastic bowel obstruction; 5.Coprostasis.

Patient with bowel obstruction is complaining for blood in the stool. What is your diagnosis?

1, 2, 4

Intussusception

1, 2, 5

Paralytic ileus

3, 4, 5

Hernia incarceration

2, 3, 4

Spastic bowel obstruction

1, 2, 3

Volvulus

The signs of strangulation are: 1.Acute onset of disease; 2.Severe abdominal pain; 3.Slow beginning; 4.Dull pain; 5. Dilated small intestine loops with air/fluid levels on plain abdominal film.

For low large bowel obstruction are characteristic all signs except:

2, 3, 5

Acute dehydration

1, 2, 5

Absence of stool

1, 3, 4

Cloiberg caps on plain abdominal film

3, 4, 5

Abdominal distension

4, 5

Slow beginning;

The signs of obturation are: 1.Acute onset of disease; 2.Severe abdominal pain; 3.Slow beginning; 4.Dull pain; 5. Dilated air-filled colon on plain abdominal film.

Surgical treatment in case of acute bowel obstruction is indicated in cases:
1. Electrolyte disbalance. 2. Abdominal cramps. 3. Strangulation. 4. Obstruction has not resolved within 24-48 hours of conservative treatment 5. Multiple air-fluid level on plain abdominal film.

3, 4, 5

2, 3

1, 4, 5

4, 5

2, 3, 5

3, 4

3, 5

1, 2

A 42-year-old woman is admitted to the emergency department with severe colicky pain, vomiting, and abdominal distention. She has not passed stools or flatus for 48 hours. X-rays of the abdomen confirm the presence of smallbowel obstruction. What is the most likely cause of small-bowel obstruction in the patients?

Tumors, groin hernia

Gallstones, tumors

Groin hernia incarceration, adhesions

Helminths, tumors

Adhesions, inflammatory diseases

Most oftenly small bowel obstruction is caused by:

Adhesions, inflammatory diseases

Helminths, tumors

Groin hernia incarceration, adhesions

Gallstones, tumors

Tumors, groin hernia.

Surgical treatment in case of acute bowel obstruction is indicated in cases:

1. Electrolyte disbalance. 2. Abdominal cramps. 3. Strangulation. 4. Obstruction has not resolved within 24-48 hours of conservative treatment 5. Multiple air-fluid level on plain abdominal film.

2, 3

4, 5

1, 5

3, 4

1, 2

An elderly nursing home patient is brought to the hospital with recent onset of colicky abdominal pain, distension and obstipation on examination, the abdomen is markedly distended and tympanitic. There is no marked tenderness. Plain abdominal x-ray shows a markedly distended loop located mainly in the right upper quadrant. The likely diagnosis is:

Mesenteric vascular occlusion

Sigmoid volvulus

Gallstone ileus

Chron's disease

Small-bowel obstruction

56-year-old patient admitted to the surgical department with complaints of abdominal pain, repeated vomiting, which does not bring relief. The pain starts 2 hours before admission, after consumption of large amount of food. Patient anxious, pale skin, acrocyanosis, pulse 120 bpm, BP 90/60 mmHg. Abdomen moderately distended in the epigastric region, in the lower parts - sink in. On palpation: tenderness in the epigastrium. On percussion: tympanic sound in the epigastric region, increased peristalsis. On plain abdominal film dilated small intestinal loops. Make diagnosis?

Bowel obstruction caused by the tumor of large intestine
Bowel obstruction caused by the tumor of large intestine

Small intestine volvulus

Acute pancreatitis

Groin hernia incarceration

Peptic ulcer perforation

The small intestine receives blood supply from different sources. They are:

1) Superior mesenteric artery (SMA)

2) Inferior mesenteric artery (IMA)

3) Arteries iliaca externae

4) Arteries iliaca internae

5) Celiac axis

Choose correct combination.

2, 3

4, 5

1, 5

3, 4

1, 2

The small bowel wall consists of all of the following layers, EXCEPT:

Subserosa

Mucosa

Submucosa

Muscularis

Serosa

Perirectal abscess fistulous disease is most oftenly:

Associated with a specific systemic disease

Associated with specific infection disease

Cryptoglandular in origin

Associated with hemorrhoids

Etiology is not known

According to their location perirectal abscesses are classified to (one answer is not correct):

Perianal

Superficial

Supralevator

Ischiorectal

Intersphincteric

The typical complications of perirectal abscess are all, except:

Hemorrhoids

Sphincter injury

Perineal sepsis

Chronic fistula

Internal fistula

What imaging study is necessary to make diagnosis uncomplicated perirectal abscess fistula disease?

Sinogram

Transrectal US

CT

No imaging study

MRI

The most effective treatment, which is successful in healing 90% of anal fissures, includes: 1. Stool softeners; 2. Laxatives; 3. Antibiotics; 4. NSAIDs; 5. Sitz bath.

1, 2, 3

1, 4, 5

2, 3, 4

3, 4, 5

1, 2, 5

Uncomplicated internal hemorrhoids typically are associated with:

Anorectal pain

Pain after defecation

Thrombosis

Perirectal abscesses

Bright-red bleeding per rectum

Internal and external hemorrhoids can develop all complications except:

Incarceration

Necrosis

Perianal condylomas

Thrombosis

Bleeding

Proctoscopy reveals nonbleeding grade I hemorrhoids. Indications for surgical treatment are all except:

III-IV grade hemorrhoids

Severe bleeding

Thrombosis

I-II grade hemorrhoids

Necrosis

Why during hemorrhoidal bleeding the blood is bright-red?

Hemorrhoidal veins have lots of shunts with rectal arteries

Hemorrhoids never bleed

Hemorrhoids develop from arteries

Bleeding is associated with coagulopathy

Most often the upper parts of colon are bleeding, which are richly vascularized

A 44-year-old man has recurrent hemorrhoids. What treatment modality is not indicated in case of recurrence?

Decreasing time spent on the toilet

Increasing dietary fiber

Decreasing constipating foods

Minimally invasive treatment

Conventional surgery

It is suspected that a 34 year old patient has an abscess of Douglas pouches. What diagnostic method is to be chosen?

Digital examination of rectum

Rectoromanoscopy

Laparoscopy

R-scopy of abdominal cavity

Percussion and auscultation of stomach

A patient complains about evaginations in the region of anus that appear during defecation and need to be replaced. Examination with anoscope revealed 1x1 cm large evaginations of mucosa above the pectineal line. What is the most probable diagnosis?

Acute proctitis

Anal fissure

External hemorrhoids

Internal hemorrhoids

All statements concerning Crohn's disease are true, except?

Nonspecific inflammation

Etiology is not known

Ileocolic region affected most oftenly

Affects all parts of GI (from the oropharynx to the anus)

Superficial (mucosal) inflammation

All statements concerning Ulcerative colitis (UC) are true, except?

Smokers are in the risk group for UC

Etiology is not known

20-30% of patients with UC have another family member with the disease

Transmural inflammation

Affects colon and rectum

The typical complications of Crohn's disease are all, except:

Sclerosing cholangitis

Hemorrhage

Intestinal obstruction caused by strictures

Internal fistula

Abdominal abscesses

A 26-year-old man is present with mild clinical signs of Crohn's colitis. What primary treatment this patient should be recommended:

Medical treatment with aminosalicylates

Total colectomy

Treatment of anemia

Left hemicolectomy

Right hemicolectomy

A 43-year-old woman undergoes investigation for colitis. In her history, it is noted that 20 years earlier she underwent a surgical procedure on the large intestine. Is the diagnosis more likely to be ulcerative colitis rather than Crohn's disease because at the previous operation?

The serosa appeared normal on inspection, but the colon mucosa was extensively involved

There was evidence of fistula formation

All layers of the bowel wall were involved

Skip lesions were noted

The preoperative GI series showed a narrowing string like stricture in the ileum (string sign)

A 35-year-old man has known ulcerative colitis. Which of the following is an indication for total proctocolectomy?

Occasional bouts of colic and diarrhea

Sclerosing cholangitis

Toxic megacolon

Arthritides

Iron deficiency anemia

A 54-year-old man with diarrhea is found to have ulcerative colitis. Colectomy should be advised in patients with ulcerative colitis who have symptoms that persist for more than which of the following?

10-20 years

More than 25 years

1 month

6 months

1 year

A 48-year-old woman develops colon cancer. She is known to have a long history of ulcerative colitis. In ulcerative colitis, which of the following is a characteristic of colon cancer?

Has an excellent prognosis because of physician awareness.

Has a synchronous carcinoma in 4-5% of cases.

Occurs equally in the right and left side.

Occurs more frequently than in the rest of the population.

Is more likely to occur when the ulcerative disease is confined to the left colon.

A 40-year-old man with a long history of bloody diarrhea presents with increased abdominal pain, vomiting, and fever. On examination, he is found to be dehydrated and shows tachycardia and hypotension. The abdomen is markedly tender with guarding and rigidity. What is the most likely cause?

Acute perforated diverticulitis

Volvulus of the sigmoid colon

Perforated carcinoma of the sigmoid colon

Toxic megacolon in ulcerative colitis

Small-bowel perforation from regional enteritis

A 25-year-old man has recurrent, indolent fistula in ano. He also complains of weight loss, recurrent attacks of diarrhea with blood mixed in the stool, and tenesmus. Proctoscopy revealed a healthy, normal-appearing rectum. What is the most likely diagnosis?

Crohn's colitis

Fever

Ischemic colitis

Amoebic colitis

Patient, who suffered on Crohn's disease, is admitted to the hospital. Physical examination can evaluate FOLLOWING features: (1) nutritional status, (2) presence of abdominal tenderness or a mass, (3) perianal and rectal disorders, (4) intestinal fistulisation, (5) colon ulceration.

Ulcerative colitis

Colitis associated with acquired immunodeficiency syndrome (AIDS)

1,4,5

Risk factors for Crohn's disease may include all, EXCEPT:

2,3,5

Nonsteroidal anti-inflammatory drugs (NSAIDs)

1,2,5

Family history

2,3,4

Ethnicity

1,2,3

Age of 20 and 30

Cigarette smoking

Laboratory study findings in the evaluation of Crohn's disease may indicate all disorders, EXCEPT:

The characteristic presentation of Crohn disease may be all(EXCLUDE wrong point):

Anemia

Abdominal pain

Leukocytosis

Diarrhea

Hypoalbuminemia

Tenesmus

Increased erythrocyte sedimentation rate (ESR)

Obstruction

Thrombocytopenia

Intestinal fistulization

Patient with Crohn's disease is going to undergo X ray procedure. Barium contrast studies can evaluate features such as (1) adhesions, (2)pseudodiverticula, (3) fistulization, (4) submucosal edema, (5) malnutrition.

People with severe Crohn's disease as usual experience following symptoms, EXCEPT:

2,3,5

Skin disorders

RDS syndrom

Arthritis

Fatigue

1,4,5

1,2,5

2,3,4

1,2,3

Computed tomography (CT) scanning, in case of Crohn's disease, is helpful in the assessment of:

Abscesses

Adhesions

Enteral insufficiency

Extraintestinal complications

All are correct

For patients with moderate or severe Crohn's disease therapy may include:

Aminosalicylates(1), Antibiotic(2),
Vitamin B12(3), Steroids(4),
Octreotide(5).

1,2,4

2,3,4

1,2,5

1,3,5

2,3,5

The three classic indications for surgery, in patients with Crohn's disease, are: (1)stricture, (2)weight loss, (3)bleeding, (4)fistulisation, (5)perforation.

2,3,5

1,2,4

2,3,4

1,2,5

1,3,5

Which statement, concerning Crohn's disease, is NOT true?

The primary treatment of Crohn's disease is medical. Surgery is indicated for complications of the disease process.

Severe hemorrhage is usual in patients with Crohn disease.

Patients with Crohn disease most commonly present with symptoms related to a chronic inflammatory process involving the ileocolic region

Perianal fissures or fistulae are common in case of Crohn disease.

Transmural involvement on histological examination is a feature of Crohn disease

Etiologic factors contributing to ulcerative colitis are the following, EXCEPT:

Low-fiber diet

Nonsteroidal anti-inflammatory drug (NSAID) use

Consumption of milk products

Immune system reactions

Genetic factors

Toxic megacolon is a condition, which may result in: (1) colonic dysmotility, (2) intestinal fistulisation, (3) colonic dilation, (4) infarction and perforation, (5) multiple perianal fissures.

3,4,5

2,4,5

1,2,5

1,2,3

1,3,4

Ulcerative colitis is associated with various extracolonic manifestations. These include which of the following? (1) pyoderma gangrenosum, (2) erythema nodosum, (3) ankylosing gastritis, (4) chronic pyelonephritis, (5) uveitis.

2,4,5

3,4,5

1,2,5

1,3,4

1,2,3

Patients with severe case of ulcerative colitis can have signs of volume depletion and toxicity. Which of the following is true?

All are correct

Weight loss

Fever

Tachycardia

Significant abdominal tenderness

The inflammation is uniform, without intervening areas of normal mucosa

Contact bleeding may also be observed

Abnormal erythematous mucosa, with or without ulceration

Extending from the rectum to part or all of the colon

In case of Ulcerative colitis, findings on CBC count may include which of the following:

(1)Hyperhemoglobinemia (ie, hemoglobin > 16 g/dL in males and > 14 g/dL in females)

(2)Anemia (ie, hemoglobin < 14 g/dL in males and < 12 g/dL in females)

(3)Thrombocytosis (ie, platelet count >350,000/ μ L)

(4)Thrombocytopenia (ie, platelet count <160,000/ μ L)

(5)Leucocytosis (ie, total count >10,000/ μ L)

(6)Leucocytopenia (ie, total count <4,000/ μ L)

2,4,5

1,3,6

2,4,6

2,3,5

1,3,5

Endoscopically, ulcerative colitis is characterized by:

All are correct

The extent of Ulcerative colitis is defined by the following:

(1)Right-sided disease - Ulcerative colitis present in the ascending colon up to, but not distal to, the splenic

(2)Extensive disease - Evidence of ulcerative colitis proximal to the splenic flexure

(3)Left-sided disease - Ulcerative colitis present in the descending colon up to, but not proximal to, the splenic flexure

(4)Proctosigmoiditis - Disease limited to the rectum with or without sigmoid involvement

(5)Terminal ileitis - Disease limited to the ileum without colonic involvement

1,2,3

2,3,4

1,2,5

1,4,5

3,4,5

Which statement, concerning Ulcerative colitis, is NOT true?

The surgical treatment of ulcerative colitis involves removing the colon and, in most cases, the rectum.

Histologically, most of the pathology is limited to the mucosa and submucosa

Ulcerative colitis extends proximally from the anal verge in an uninterrupted pattern to involve part or the entire colon

Double-contrast barium enema examination is a useless technique for diagnosing ulcerative colitis

Ulcerative colitis is an idiopathic chronic inflammatory disorder limited to the colon

Which diagnostic procedure should be performed at first in a hemodynamically unstable patient with blunt abdominal trauma?

Ultrasound (Focused abdominal sonography for trauma)

Triple contrast CT

Diagnostic peritoneal lavage

Laparoscopy

Plain abdominal film

Which diagnostic procedure should be performed at secondly in a hemodynamically unstable patient with blunt abdominal trauma?

Ultrasound (Focused abdominal sonography for trauma)

Triple contrast CT

Diagnostic peritoneal lavage

Laparoscopy

Plain abdominal film

The indications for laparotomy in patient with penetrating abdominal trauma are: 1). Hemodynamic instability; 2). Positive peritoneal signs; 3). Evisceration; 4). Grade IV liver injury; 5). Grade V spleen injury. Choose the best combination.

1, 2, 3

1, 3, 4

1, 4, 5

2, 3, 5

All conditions are indications for laparotomy

Which diagnostic procedure should be performed at first in a hemodynamically stable patient with penetrating abdominal trauma?

Ultrasound (Focused abdominal sonography for trauma)

CT

Laparoscopy

Local wound exploration

Diagnostic peritoneal lavage

Which diagnostic procedure should be performed secondly in a hemodynamically stable patient with penetrating abdominal trauma?

Ultrasound (Focused abdominal sonography for trauma)

CT

Laparoscopy

Local wound exploration

Diagnostic peritoneal lavage

Which organs are injured most oftenly in patients with blunt abdominal trauma: 1). Stomach; 2). Duodenum; 3). Liver; 4). Spleen; 5). Small intestine; 6). Large intestine.

1, 2

2, 5

3, 4

5, 6

1, 6

A 7-year-old boy was involved in a motorcycle crash while seated in the back of a minivan without restraints. His vital signs in the emergency room are stable but he is complaining of left upper quadrant abdominal pain. The FAST scan shows scanty fluid around in the left colic gutter. An abdominal and pelvic CT scan with iv and po contrast is performed and the radiologist suggests a "blush" (arterial extravasation) in the splenic parenchyma. The spleen itself sustained a deep parenchymal tear and is classified as a grade III injury. The child remains hemodynamically stable. What is recommended next?

Continuous hemodynamic monitoring, celiac angiogram, and angio embolisation of splenic artery.

Immediate exploration in the operation room

If hemodynamic instability develops, aggressive fluid resuscitation including a repeated bolus of 20 mL/kg lactated Ringer's solution followed by a li

Monitoring only

Pneumovax and elective splenectomy in 6 weeks

Laparoscopy in abdominal trauma may be indicated in which of the following?

To exclude diaphragmatic injury

In patients with multiple previous abdominal operations

If there is limited cardiovascular reserve

If severe diffuse peritonitis exists

In hemodynamically unstable patients

A 30-year-old restrained driver was involved in a motor-vehicle crash. He is hemodynamically stable and has a large seat belt sign on the abdomen. His abdomen is tender to palpation. In this patient one should be most concerned about:

Liver and spleen injury

Transection of the head of the pancreas

Renal pedicle avulsion

Hollow-viscus injuries

Pelvic fracture

A 20-year-old unrestrained driver was involved in a motor-vehicle crash. A computed tomography (CT) of the abdomen revealed a large hematoma in the second portion of duodenum. The rest of the abdomen is normal. The initial management of this duodenal hematoma should be:

Operative evacuation

Nasogastric decompression, intravenous fluids, and gradual resumption of oral diet

Endoscopic retrograde cholangiopancreatogram (ERCP)

Laparotomy, pyloric exclusion, and gastrojejunostomy

Octreotide

In a patient who had a motor-cycle crash, a CT of the abdomen revealed a peripancreatic hematoma and indistinct pancreatic border. The most definitive test for a pancreatic injury requiring operative intervention is:

ERCP

Ultrasonography

CT scanning

Operative exploration

Amylase test of lavage fluid

A 25-year-old man fell down from his bicycle and hit a concrete wall on his left side. An ultrasound examination showed free fluid in the abdomen. A CT scan confirmed a grade III splenic injury. The most important contraindication for a nonoperative management of the splenic injury is:

Hemodynamic instability

Active bleeding on CT scan

Adult patient

Lack of availability of blood for transfusion

Extensive associated injuries

A 17-year-old girl presents to the emergency department with a stab wound to the abdomen and a blow to the head that left her groggy. Her blood pressure is 80/0 mm Hg, pulse is 120 bpm, and respiration rate is 28 breaths per minute. Her abdomen has a stab

wound in the anterior axillary line at the right costal margin. Two large-bore intravenous lines, a nasogastric tube, and a Foley catheter are inserted. The blood pressure rises to 85 mm Hg after 2 L of Ringer's lactate. The appropriate management is which of the following?

Peritoneal lavage

Ultrasound of the abdomen

Laparoscopic assessment of the peritoneal cavity

Exploratory laparotomy

CT of the head

A 22-year-old woman presents to the emergency department with a chief complaint of severe left upper quadrant (LUQ) pain after being punched by her husband. Her blood pressure is 110/70 mm Hg, pulse is 100 bpm, and respiration rate is 24 breaths per minute. The best means to establish a diagnosis is which of the following?

FAST

Physical examination

CT of the abdomen

Peritoneal lavage

Upper gastrointestinal (GI) series

A 60-year-old man is attacked with a baseball bat and sustains multiple blows to the abdomen. He presents to the emergency department in shock and is brought to the operating room (OR), where a laparotomy reveals massive hemoperitoneum and a stellate fracture of the right and left lobes of the liver.

Which of the following techniques should be used immediately?

Pringle's maneuver

Packing the liver

Suture ligation

Ligation of the right hepatic artery

Ligation of the proper hepatic artery

A 23-year-old man is shot with a handgun and found to have a through-and-through injury to the right transverse colon. There is little fecal contamination and no bowel devascularization. At operation, what does he require?

Right hemicolectomy with ileotransverse colon anastomosis

Right hemicolectomy with ileostomy and mucous fistula

Debridement and closure of wounds with exteriorization of colon

Debridement and closure of wounds

Segmental resection with primary anastomosis

A 20-year-old woman presents to the emergency department with a stab wound to the abdomen. There is minimal abdominal tenderness. Local wound exploration indicates that the knife penetrated the peritoneum. What is the ideal use of antibiotic administration?

Preoperatively

Intraoperatively, if a colon injury is found

Postoperatively, if the patient develops fever

Postoperatively, based on culture and sensitivity of fecal contamination found at the time of surgery

Intraoperatively, if any hollow viscus is found to be injured

A 70-year-old woman is hit by a car and injures her midabdomen. The best way to rule out a rupture of the second part of the duodenum is by which mode?

Repeated physical examinations

Ultrasound

Repeated amylase levels

CT with oral and intravenous contrast

Peritoneal lavage

A 15-year-old girl had an injury to the right retroperitoneum with duodenal contusion. What is the test required to exclude a rupture of the duodenum?

Serum amylase

Dimethyliminodiacetic acid (HIDA) scan

Gastrografin study

Upper GI with barium

ERCP

A 33-year-old man presents to the emergency department with a gunshot injury to the abdomen. At laparotomy, a deep laceration is found in the pancreas just to the left of the vertebral

column with severance of the pancreatic duct. What is the next step in management?

Intraoperative cholangiogram

Debridement and drainage of defect

Distal pancreatectomy

Closure of abdomen with J-P drains

Vagotomy

In case of abdominal trauma, we can divide abdomen into few parts. They are all, EXCEPT:

intrathoracic abdomen

pelvic abdomen

retroperitoneal abdomen

true abdomen

lateral abdomen

Blunt force injuries to the abdomen can generally be explained by a few mechanisms. They are 1) deceleration; 2) penetration; 3) crushing; 4) compression; 5) acceleration. Choose the correct combination.

1, 2, 3

1, 3, 4

1, 4, 5

2, 4, 5

2, 3, 5

What is the most common reason of blunt abdominal trauma in the civilian population?

Vehicular trauma

Recreational accidents

Industrial accidents

Trauma during cardiopulmonary resuscitation

Heimlich maneuver

The most reliable signs and symptoms in patients after blunt abdominal trauma are all of the following, EXCEPT:

Pain

External hemorrhage

Hypervolemia

Peritoneal irritation

Internal hemorrhage

Blunt abdominal trauma may lead to intra abdominal bleeding. Concerning this condition, which statement is NOT true?

Large amounts of blood can accumulate in the peritoneal and pelvic cavities

Lap belt marks have been correlated with an increased incidence of other intra-abdominal injuries

Intraperitoneal bleeding never causes hypovolemia

Bradycardia may indicate the presence of free intraperitoneal blood

Ecchymosis involving the flanks (Grey Turner sign) or the umbilicus (Cullen sign) indicates retroperitoneal hemorrhage

Which, laboratory evaluation of abdominal trauma patients is useless in consideration of management?

complete blood count (CBC)

serum electrolytes

serum amylase

urinalysis

coagulation studies

blood typing and cross-matching

arterial blood gases (ABGs)

In case of blunt abdominal trauma, you should perform all listed bellow, EXCEPT:

Nasogastric tube should be placed routinely

Foley catheter should be placed

All patients should undergo tetanus immunization

The most important initial concern is an assessment of hemodynamic stability

Obtain pregnancy test on all females of childbearing age

The FAST examination protocol in trauma patient, consists of 4 acoustic windows (known as the 4 P's) with the patient supine. These windows are all, EXCEPT:

Pericardiac

Perihepatic

Perisplenic

Pelvic

Peritoneal

Contraindications to DPL(diagnostic peritoneal lavage) are all the following, EXCEPT:

need for laparotomy

morbid obesity

history of multiple abdominal surgeries

pregnancy

evidence of thoracic injury

Complications of DPL(diagnostic peritoneal lavage) may include:

Bleeding from catheter insertion

Wound or peritoneal infection

Injury to intra-abdominal structures

All are wrong

All are correct

Indications for laparotomy in a patient with blunt abdominal injury include the following:

Signs of peritonitis

Shock within admission

Suspicion on hepatic laceration

Negative FAST(focused assessment with sonography for trauma)

All are correct

Blunt chest trauma can be caused most oftenly by: 1. Motor vehicle crashe; 2.

Stab wound; 3. Height falls; 4. Airplane crashe; 5. Bullet wound:

1, 3, 4

2, 3, 5

3, 4, 5

2, 3, 4

1, 2, 3

Name the most common thoracic injury in blunt trauma?

Pericardial tamponade

Sternal fracture

Rib fracture

Flail chest

Hemothorax

A 45-year-old man skidded from the road at high speed and hit a tree. Examples of deceleration injuries in this patient include:

Rib fracture

Hemothorax

Posterior dislocation of shoulder

Aortic arch rupture

Aortic valve rupture

Choose life-threatening injuries, which should be identified immediately: 1. Esophageal rupture; 2. Tension pneumothorax; 3. Massive hemothorax; 4. Cardiac tamponade; 5. Pulmonary contusion.

2, 3, 5

1, 4, 5

1, 3, 5

1, 2, 3

2, 3, 4

A 70-year-old man is brought into the emergency department following his injury as a passenger in a car crash. He complains of right side chest pain. Physical examination reveals a respiratory rate of 42 breaths per minute and multiple broken ribs of a segment of the chest wall that moves paradoxically with respiration. At thoracentesis signs of tension pneumothorax absent. Make the diagnosis?

Aorta rupture

Esophageal injury

Flail chest

Sternal fracture

Hemothorax

A 70-year-old man is brought into the emergency department following his injury as a passenger in a car crash. He complains of right side chest pain. Physical examination reveals a respiratory rate of 42 breaths per minute and multiple broken ribs of a segment of the chest wall that moves paradoxically with respiration. At thoracentesis signs of tension pneumothorax absent. What should the next step be?

Intercostal nerve blocks

Endotracheal intubation

Insertion of a nasogastric tube

Tracheostomy

Tube thoracostomy

An 18-year-old man is brought to the emergency department with a stab wound just to the right of the sternum in the sixth intercostal space. His blood pressure is 80 mm Hg. Faint heart sounds and pulsus paradoxus are noted. Auscultation of the right chest reveals markedly decreased breath sounds. The initial management of this patient should be which of the following?

Insertion of central venous access line

Pericardial window

Echocardiogram

Analgesics

Aspiration of the right chest cavity

An 18-year-old man presents to the emergency department with a gunshot wound to the left chest in the anterior axillary line in the sixth intercostal space. His blood pressure is 120/70 mm Hg, pulse - 78 bpm. A sucking sound is audible during inspiration. Immediate management is which of the following?

Insertion of central venous access line

Closure of the hole with sterile dressing

Pleurocentesis

Exploratory thoracotomy

Exploratory laparotomy

While landing at the end of flight a young man develops shortness of breath and rightsided pressure chest pain. He is tall and thin. He has not previously consulted a doctor. A chest film is likely to show?

Cardiomegaly

Hemothorax

Dilated stomach

Spontaneous pneumothorax

Left pleural effusion

While landing at the end of flight a young man develops shortness of breath and rightsided pressure chest pain. He is tall and thin. He has not previously consulted a doctor. The treatment is:

Thoracoscopy

Insertion of a nasogastric tube

Thoracocentesis

Immediate cardiology consult

Insertion of a chest tube

A 26-year-old man is stabbed in the right intercostal space in the midclavicular line and presents to the emergency department. On examination, subcutaneous emphysema of the right chest wall, absent breath sounds, and a trachea shifted to the left are noted. What is the most likely serious diagnosis?

Chest wall laceration

Hemopneumothorax

Massive hemothorax

Tension pneumothorax

Pneumothorax

A 31-year-old man is shot in the back of the left chest, and the bullet exits the left anterior chest. The patient's blood pressure is 130/90 mm Hg, respiration rate is 28 breaths per minute, and pulse is 110 bpm. A chest x-ray reveals hemothorax. A chest tube is inserted and yields 800 mL of blood; the first and second hour drainage is 200 mL/h and 240 mL/h, respectively. What is the next step in management?

Perform a left thoracotomy

Insert a Swan-Ganz catheter

Transfuse and observe drainage for another hour

Collect the blood for autotransfusion

Place a second chest tube

A 31-year-old man is shot in the back of the left chest, and the bullet exits the left anterior chest. The patient's blood pressure is 130/90 mm Hg, respiration rate is 28 breaths per minute, and pulse is 110 bpm. A chest x-ray reveals hemothorax. A chest tube is inserted and yields 800 mL of blood; the first and second hour drainage is 200 mL/h and 240 mL/h, respectively.

In the patient described above the most likely cause of the bleeding in the patient is injury to which of the following?

Left atrium

Pulmonary vein

1, 2, 3

Internal thoracic or intercostals arteries

Lung parenchyma

Pulmonary artery

Which statement is wrong concerning sternal fracture?

Is associated with high rate of myocardial contusion and cardiac tamponade

Which statement concerning 1st and 2nd ribs fractures is wrong?

Is caused by direct blow to front of the chest

Causes pulsus paradoxicus

Needs large traumatic force

May injure subclavian artery/vein

Is very uncommon injury

Frequently have injury to bronchi

Is seen in 60% of patients with blunt trauma

Frequently have injury to aorta

Require high force

Most oftenly fracture of 11th or 12th ribs are associated with:

A 25-year-old man is shot in the left lateral chest. In the emergency department, his blood pressure is 120/90 mm Hg, pulse rate is 104 beats per minute (bpm), and respiration rate is 36 breaths per minute. Chest x-ray shows air and fluid in the left pleural cavity. Nasogastric aspiration reveals blood-stained fluid. What is the best step to rule out esophageal injury?

Pneumothorax

Peritoneal lavage

Injury to bronchi

Esophagoscopy

Injury to aorta

Esophagogram with gastrograffin

Damage to underlying abdominal solid organs (liver, spleen, kidney)

Insertion of nasogastric tube

Flail chest

Insertion of chest tube

In what cases patients with rib fractures should be treated immediately or monitored carefully: 1. Elderly patients; 2. Patients with concomitant heart diseases; 3. Patients with COPD; 4. Patients with multiple rib fractures; 5. Patients with flail chest.

Because of his involvement in a motor vehicle accident, a 23-year-old football player has a chest wall injury. The only abnormal findings on clinical and radiologic examination are a fracture of the left fifth to seventh ribs and a small

1, 4, 5

1, 2, 4

3, 4, 5

2, 4, 5

hemothorax. What should treatment include?

Administration of cortisone to prevent callus formation

Administration of analgesic medication

Insertion of a metal plate to fix the fracture

Thoracotomy to treat a small hemothorax in the left base

Insertion of an intercostal drain to avoid pneumothorax

A 25-year-old woman was stabbed by her boyfriend in the left chest. On examination, she has a 1-cm stab wound just inferior to her left breast in the mid-clavicular line. There is jugular venous distension and breath sounds are completely absent on the left side. She is becoming extremely dyspneic and hypoxic. Make the diagnosis.

Rupture diaphragm

Flail chest

Massive hemothorax

Tension pneumothorax

Cardiac tamponade

A 45-year-old man was a passenger in a car when he was T-boned by a truck at a high speed. He is short in breath, complains of severe pain in the chest, and is hypoxic on the pulse oximeter. The breath sounds are diminished on the left and the percussion note is completely dull. He rapidly becomes tachycardic and hypotensive.

Massive hemothorax

Flail chest

Open pneumothorax

Tension pneumothorax

Cardiac tamponade

A 40-year-old woman is brought to the emergency department following a car crash in which she was the driver. In the emergency department, her blood pressure is 80/60 mm Hg, pulse is 128 bpm, and respiratory rate is 36 breaths per minute. She complains of right lower chest wall and severe right upper quadrant (RUQ) tenderness. Her breath sounds are questionably diminished. The immediate priority is to perform which of the following?

Endotracheal intubation

Thoracentesis with an 18-gauge needle

CT scan of chest and abdomen

Chest x-ray

Peritoneal lavage

In the case of isolated pneumothorax the tube should be placed in the:

Fifth intercostal space, mid axillary line

Fifth intercostal space, midclavicular line

Second intercostal space, mid axillary line

Second intercostal space, midclavicular line

Second intercostal space, anterior axillary line

In the case of hemothorax the tube should be placed in the:

Fifth intercostal space, mid axillary line

Fifth intercostal space, midclavicular line

Second intercostal space, mid axillary line

Second intercostal space, midclavicular line

Second intercostal space, anterior axillary line

A 55-year-old man involved in an automobile accident is unresponsive and is intubated at the scene. On arrival in the emergency department, he responds to painful stimulation. His systolic BP is 60 mm Hg, his HR is 140 bpm, his neck veins are distended, and his breath sounds are absent on the left side. Immediate management should involve which of the following?

CT scan of head

Peritoneal lavage

Pericardiocentesis

Insertion of an 18-gauge needle in the left second intercostal space

Insertion of a central venous line on the right side

During a car crash a young man suffers bilateral multiple fracture ribs. He is alert and presents shortness of breath. His blood pressure is 100/60 mm Hg

and chest is unstable. Treatment for this is:

Temporary extracorporeal circulation to allow fractures to heal.

Avoid intubation, control pain, and perform aggressive bronchial toilette.

Fracture stabilization, with towel clips on ribs and attached to weights (external fixation).

Once the patient is stable, open rib fracture reduction and stabilization with plates.

Prolonged intubation and ventilatory support until rib fractures heal along with aggressive bronchial toilette.

A 31-year-old man is brought to the emergency room following an automobile accident in which his chest struck the steering wheel. Examination reveals stable vital signs, but the patient exhibits palpable 7 rib fractures from the right side and paradoxical movement of the right side of the chest. Chest x-ray shows no evidence of pneumothorax or hemothorax, but a large pulmonary contusion is developing. Proper treatment would consist of which of the following?

No treatment unless signs of respiratory distress develop

Immediate operative stabilization

Stabilization with towel clips

Stabilization of the chest wall with sandbags

Tracheostomy, mechanical ventilation, and positive end-expiratory pressure

Select the proper intervention for a life-threatening injury of the chest:
LARYNGEAL OBSTRUCTION

- Occlusive dressing
- Tube thoracostomy
- Subxiphoid window
- Cricothyroidotomy
- Endotracheal intubation

Select the proper intervention for a life-threatening injury of the chest: **OPEN PNEUMOTHORAX**

- Occlusive dressing
- Tube thoracostomy
- Subxiphoid window
- Cricothyroidotomy
- Endotracheal intubation

Select the proper intervention for a life-threatening injury of the chest: **FLAIL CHEST**

- Tube thoracostomy
- Occlusive dressing
- Subxiphoid window
- Cricothyroidotomy
- Endotracheal intubation

Select the proper intervention for a life-threatening injury of the chest: **TENSION PNEUMOTHORAX**

- Occlusive dressing

Subxiphoid window

Tube thoracostomy

Cricothyroidotomy

Endotracheal intubation

Select the proper intervention for a life-threatening injury of the chest: **PERICARDIAL TAMPONADE**

Occlusive dressing

Tube thoracostomy

Subxiphoid window

Cricothyroidotomy

Endotracheal intubation

Name please indications for immediate surgery in patients with chest trauma:
1. Traumatic disruption with loss of chest wall integrity; 2. A chronic clotted hemothorax; 3. Atelectasis associated with ribs fracture; 4. A massive air leak following chest tube insertion; 5. High rate of blood loss via the chest tube (>200 ml/h).

2,3,4

2,4,5

1,4,5

1,3,5

1,2,3

Name indications for immediate surgery in patients after chest trauma:
1. Traumatic disruption with loss of chest wall integrity; 2. Cardiac tamponade; 3. Tracheoesophageal

fistula; 4. A persistent thoracic duct fistula/chylothorax; 5. Large vessel injury.

2, 3, 4

2, 4, 5

1, 3, 5

1, 2, 5

1, 3, 4

What is the cornerstone in management of patients with rib fractures?

Diagnostic thoracotomy

Ipsilateral chest tube placement

Endotracheal intubation

Immediate surgery

Pain control

Concerning thoracic trauma which statement IS NOT true?

Isolated first and second rib fractures require surgical therapy

First and second rib fractures are caused by excessive energy force

Cardiac tamponade is an indications for immediate surgery

Flail chest is associated with paradoxical motion of the flail segment

Rib fractures do not require surgery

What is the obvious sign of diaphragmatic disruption on chest radiographs?

Evidence of ipsilateral pneumothorax

Mediastinum dislocation to the contralateral side

Distended shade of the mediastinum

Absence of complete expansion of the lung

Abdominal visceral herniation into the chest

Which statement IS NOT true concerning thoracic trauma?

Large, clotted hemothoraces may require an operation

Tension pneumothoraces are always life-threatening states

Treatment for an open pneumothorax consists of placing a 3-way occlusive dressing over the wound

Open pneumothorax is caused by lung tissue defect that is larger than the cross-sectional area of the larynx

All patients with pneumothorax due to trauma need a tube thoracostomy

What are the primary therapies for pulmonary contusions? 1. Surgical debridement; 2. Pain control, iv fluid restriction; 3. Immobilization with a figure-of-eight dressing; 4. Pulmonary toilet; 5. supplemental oxygen.

2,3,4

2,4,5

1,2,5

1,3,5

1,3,4

All conditions belong to blunt cardiac injuries, except:

Atrioventricular stenosis

Cardiac tamponade

Cardiac chamber rupture

Rupture of interventricular septum

Rupture of the valves,

Which condition CAN NOT occur in patients with chest trauma?

Main bronchial disruption

Heart contusion

Esophageal ahalasia

Esophageal rupture

Pericardial tamponade

Trauma is the leading cause of death, morbidity, hospitalization, and disability in Americans in the age:

More than 65y

45 - 65y

10 - 45y

1 - 10y

0 - 1y

What injury DOES NOT compromise ventilation?

Acute cardiac tamponade

Flail chest

Painfull ribs fracture

Open pneumothorax

Lung contusion

Measurement of serum creatine kinase isoenzyme (creatine kinase-MB) levels is frequently performed in patients with possible:

Tension pneumothorax

Flail chest developing

Traumatic asphyxia

Multiple ribs fracture

Blunt myocardial injury

What is the initial study of choice in patients with thoracic blunt trauma, suspicious on pneumothorax?

Ventilation test

CT scanning

Echocardiography

12-lead ECG

The chest radiogram

Ultrasound examinations of thoracic cavities can be performed to confirm the diagnosis:

Multiple atelectasis

Main bronchi disruption

Multiple ribs fracture

Open pneumothorax

Acute cardiac tamponade