Surgery Collection

Question Bank with Answers & Explanations

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65 Topics • 2053 Questions

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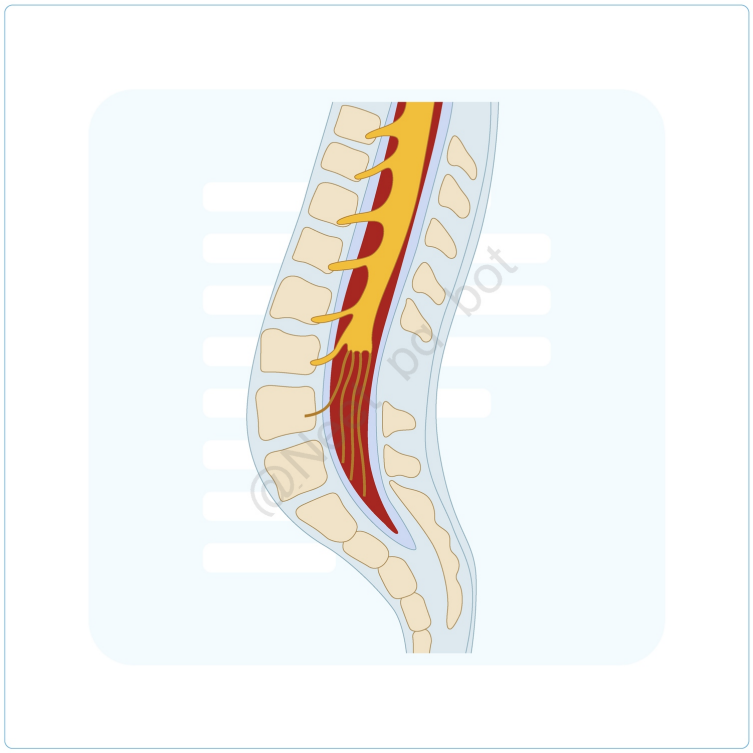
Q1: A 25-year-old asymptomatic patient undergoes a routine lumbar spine X-ray for an unrelated complaint. The radiologist notices an incidental finding on the image. Which of the following findings would be inconsistent with spina bifida occulta? (Q849163)

A. Tuft of hair or dimple over the affected area

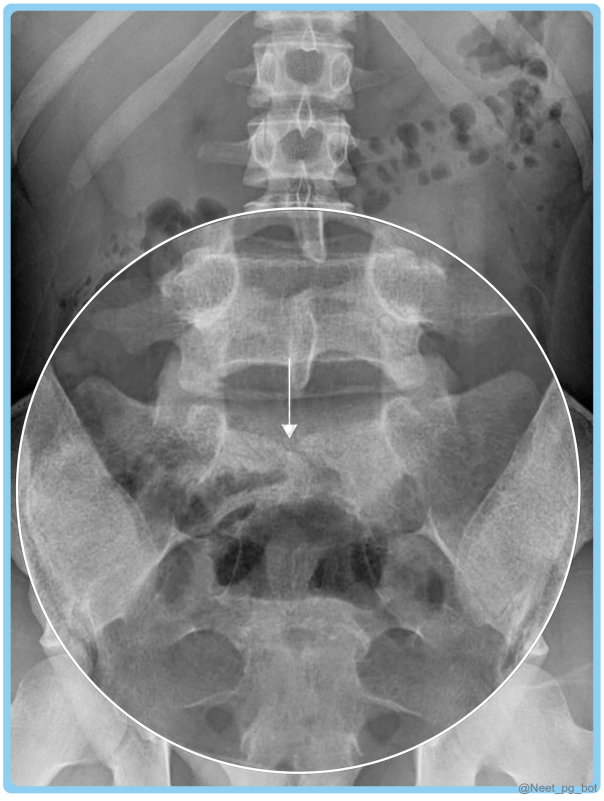
B. Often asymptomatic and found incidentally on imaging

C. Failure of vertebral arches to fuse with intact spinal cord and meninges

D. Visible sac with cerebrospinal fluid and neural elements protruding through a defect



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See Answer in Part B → Q1

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Q2: A 28-year-old pregnant woman at 20 weeks of gestation undergoes a routine ultrasound, which reveals a fluid-filled sac at the lower back of the fetus. Which statement about myelomeningocele is most accurate? (Q849164)

A. Protrusion of meninges through a vertebral defect

B. Sac contains cerebrospinal fluid but no neural elements.

C. Better prognosis than other spina bifida types

D. Includes spinal cord tissue within the protruding sac.

See Answer in Part B → Q2

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Q3: Which of the following medications, when taken during pregnancy, is most strongly associated with an increased risk of myelomeningocele in the developing fetus? (Q849165)

A. Metformin

B. Valproic acid

C. Amoxicillin

D. Levothyroxine

See Answer in Part B → Q3

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Q4: Which of the following is most commonly associated with Arnold-Chiari malformation type II? (Q849166)

A. Syringomyelia

B. Myelomeningocele

C. Adult-onset headaches

D. Scoliosis

See Answer in Part B → Q4

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Q5: Which of the following is NOT part of the classic triad of Dandy-Walker malformation? (Q849167)

A. Cystic dilatation of the fourth ventricle

B. Complete or partial agenesis of the cerebellar vermis

C. Enlarged posterior fossa

D. Hydrocephalus

See Answer in Part B → Q5

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Q6: A 42-year-old male is brought to the emergency department after collapsing at home. His family reports that he suddenly screamed in pain, clutching his head and describing it as the "worst headache of his life," followed by several episodes of vomiting. On examination, he is confused, has significant neck stiffness (nuchal rigidity), and shows marked photophobia. There is no history of recent head trauma. A non-contrast CT scan of the brain is shown below. Which of the following is the most common cause of this patient's condition? (Q849169)

A. Smoking

B. Rupture of a berry aneurysm

C. Severe hypertension

D. Arteriovenous malformation



See Answer in Part B → Q6

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Q7: A 55-year-old patient presents with a sudden severe headache, brief loss of consciousness, nausea, and vomiting. Neurological examination shows decreased consciousness and mild focal deficits. A non-contrast CT scan of the head is provided. What is the most probable diagnosis? (Q849170)

A. Subdural Hematoma (SDH)

B. Extradural Hematoma (EDH)

C. Subarachnoid Hemorrhage

D. Periventricular Hemorrhage



See Answer in Part B → Q7

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Q8: A 52-year-old male with a history of hypertension and smoking presents with sudden onset of nausea, vomiting, and confusion. On examination, he has a decreased level of consciousness and neck stiffness. A non-contrast CT scan reveals subarachnoid haemorrhage. Which of the following statements about Berry aneurysms is not true? (Q849173)

A. Associated with connective tissue disorders like Marfan's syndrome.

B. Absence of smooth muscle and intimal elastic lamina.

C. Most commonly seen at the bifurcation of the vertebrobasilar arteries.

D. Unruptured cases are asymptomatic

See Answer in Part B → Q8

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Q9: A 45-year-old man with a recent dental infection presents with persistent headaches, fever, and confusion. He exhibits focal neurological deficits and seizures. The radiological findings are provided. Given his clinical presentation and imaging, what is the most appropriate next step in the management of this patient? (Q849174)

A. Initiate IV antibiotics and immediate surgical drainage

B. Start oral antibiotics and monitor with CT every 48 hours

C. Administer high-dose corticosteroids and supportive care

D. Begin antiepileptic medications and refer for op follow-up.



See Answer in Part B → Q9

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Q10: A 58-year-old patient presents with a significant right-sided brain tumour. During the neurological examination, the patient exhibits right-sided weakness. Which of the following best accounts for this presentation? (Q849175)

A. Kernohan notch phenomenon

B. Brown-Sequard syndrome

C. Tullio phenomenon

D. Uhthoff's phenomenon

See Answer in Part B → Q10

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Q11: A 62-year-old man is brought to the emergency department after a fall from a ladder. He has a GCS score of 9 (E2V3M4), and his right pupil is dilated and nonreactive. The CT scan shows a large right-sided subdural hematoma with a significant midline shift to the left. BP: 180/100 mmHg, HR: 52 beats/minute with irregular breathing patterns. Which type of brain herniation is most likely occurring in this patient? (Q849177)

A. Subfalcine herniation

B. Tonsillar herniation

C. Upward transtentorial herniation

D. Uncal herniation

See Answer in Part B → Q11

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Q12: A 62-year-old man undergoes emergent decompressive craniectomy for a large right hemispheric infarct with significant mass effect. Post-surgery, he remains comatose and, six hours later, develops pinpoint pupils and irregular breathing. A stat CT scan shows resolution of the midline shift but reveals new bilateral hyperdense lesions in the midbrain. What is the most likely explanation for these new CT findings? (Q849179)

A. Contrast extravasation

B. Hemorrhagic transformation of infarct

C. Duret haemorrhage

D. Hypertensive microbleeds

See Answer in Part B → Q12

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• [01_Neurosurgery] 002 Cns Tumors

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[01_Neurosurgery] 002 Cns Tumors — Quick Jump

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Q1: A 7-year-old child presents with a headache which gets worse in the morning, associated with nausea, vomiting, and vertigo. The radiograph revealed a type of brain tumour in the 4th ventricle. Which of the following is the investigation of choice in this case? (Q849223)

A. MRI

B. Ultrasonography

C. X-ray

D. CT scan

See Answer in Part B → Q1

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Q2: A 40-year-old man presents with symptoms of spinal cord compression, including back pain and weakness in the legs. MRI reveals a spinal tumour. Which of the following statements about spinal tumours is NOT true? (Q849239)

A. Osteoblastic metastases are often associated with prostate cancer

B. Ependymomas are the most common intramedullary tumours in adults

C. The malignant primary tumour usually involves the vertebral body

D. Most common metastases to the spine are from the Lungs

See Answer in Part B → Q2

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Q3: A 55-year-old man with a history of immunosuppression is suspected for Primary CNS lymphoma and evaluated. Which of the following is not accurate about this condition? (Q849238)

A. Often shows a dramatic but short-lived response to steroids.

B. Steroids should be withheld before biopsy.

C. Shows no response to steroids.

D. Diagnosis is confirmed with a stereotactic biopsy.

See Answer in Part B → Q3

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Q4: A 65-year-old patient with a small brain metastasis is being considered for Stereotactic Radiosurgery (SRS). Which statement correctly describes Stereotactic Radiosurgery (SRS)? (Q849237)

A. Delivers broad radiation to treat the entire brain.

B. Delivers a focused dose of radiation to the tumour from multiple angles.

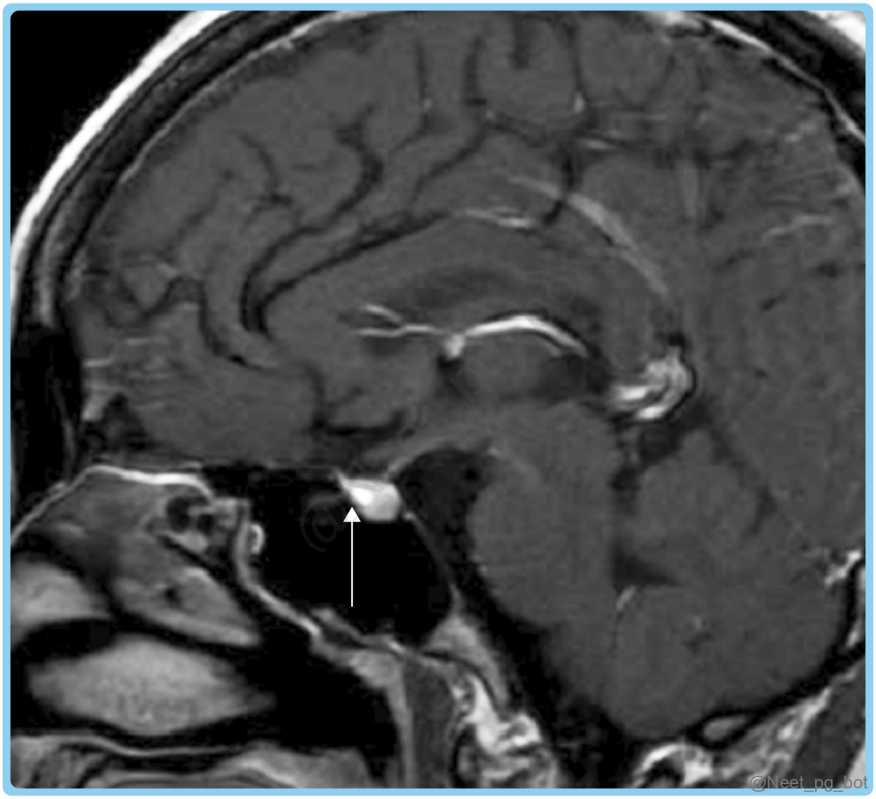
C. Requires prior surgical removal of the tumour.

D. Used for large, invasive tumours needing extensive surgery.

See Answer in Part B → Q4

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Q5: A 32-year-old woman visits your clinic with complaints of missed periods and noticeable visual disturbances over the past few months. She also reports frequent headaches and mild galactorrhea. MRI shows the findings given in the image. What visual defect is most commonly associated with this condition? (Q849236)



See Answer in Part B → Q5

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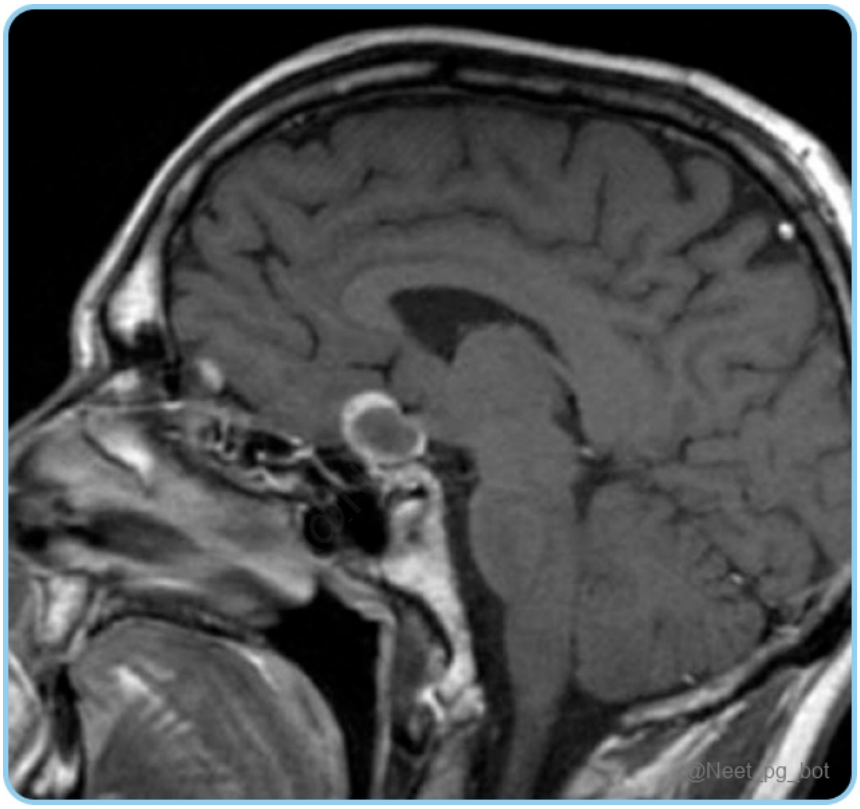
Q6: A 6-year-old child presents with headache, vomiting, blurring of vision, weakness, recent aggression, and weight gain. Examination reveals growth retardation and signs of hypopituitarism. MRI findings are noted. Which of the following is not true regarding this condition? (Q849235)

A. Hypopituitarism is the characteristic feature

B. It is more common in children

C. It is derived from pituitary stalk

D. Growth retardation is also observed



See Answer in Part B → Q6

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Q7: A 52-year-old female patient presents with complaints of difficulty understanding speech and tinnitus. On examination, there is unilateral sensorineural hearing loss, reduced corneal sensitivity, and numbness of the face. Which of the following nerves is most commonly involved in this condition? (Q849234)

A. Inferior vestibular nerve

B. Superior vestibular nerve

C. Cochlear nerve

D. Facial nerve

See Answer in Part B → Q7

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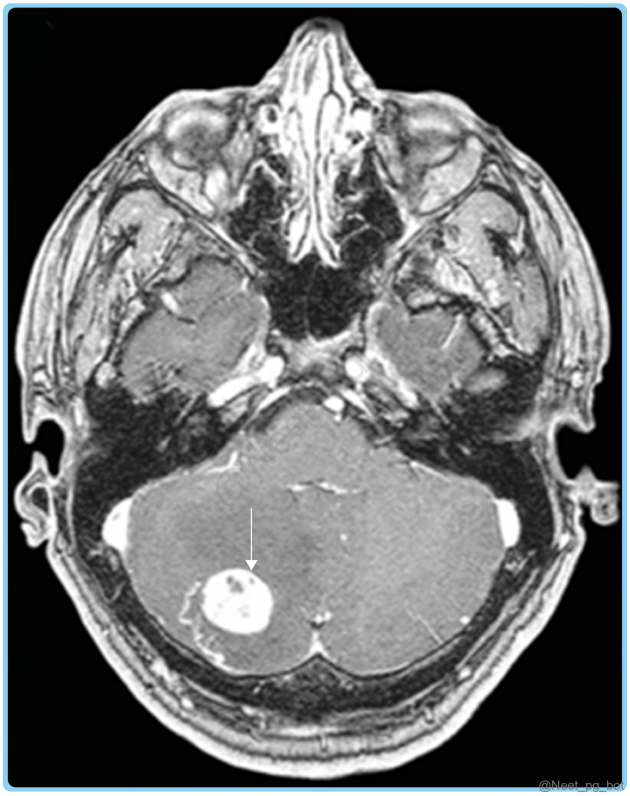
Q8: A 48-year-old male presented with headache, blurring of vision, weakness and loss of balance. His radiological investigations suggested hydrocephalus and pheochromocytoma. A tumour is detected whose radiograph is given below. Which of the following genetic syndromes is most commonly associated with this condition? (Q849233)

A. MEN 1 syndrome

B. VHL syndrome

C. Lynch syndrome

D. Gardner's syndrome



See Answer in Part B → Q8

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Q9: A 3-year-old child presented with complaints of severe morning headache associated with nausea, vomiting and seizure. On examination, the doctor suspected a brain tumour and suggested an MRI, which revealed a tumour at the vermis region.

Which of the following syndromes is associated with this condition? (Q849224)

A. Gorlin syndrome

B. NF1 syndrome

C. VHL syndrome

D. Turcot’s syndrome

See Answer in Part B → Q9

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Q10: A 45-year-old woman presents with worsening headaches, cognitive issues, and personality changes. MRI reveals a large mass in the left frontal lobe with surrounding oedema, likely a primary brain tumour. What is the overall most common type of primary brain tumour in adults? (Q849181)

A. Medulloblastoma

B. Glioblastoma

C. Meningioma

D. Oligodendroglioma

See Answer in Part B → Q10

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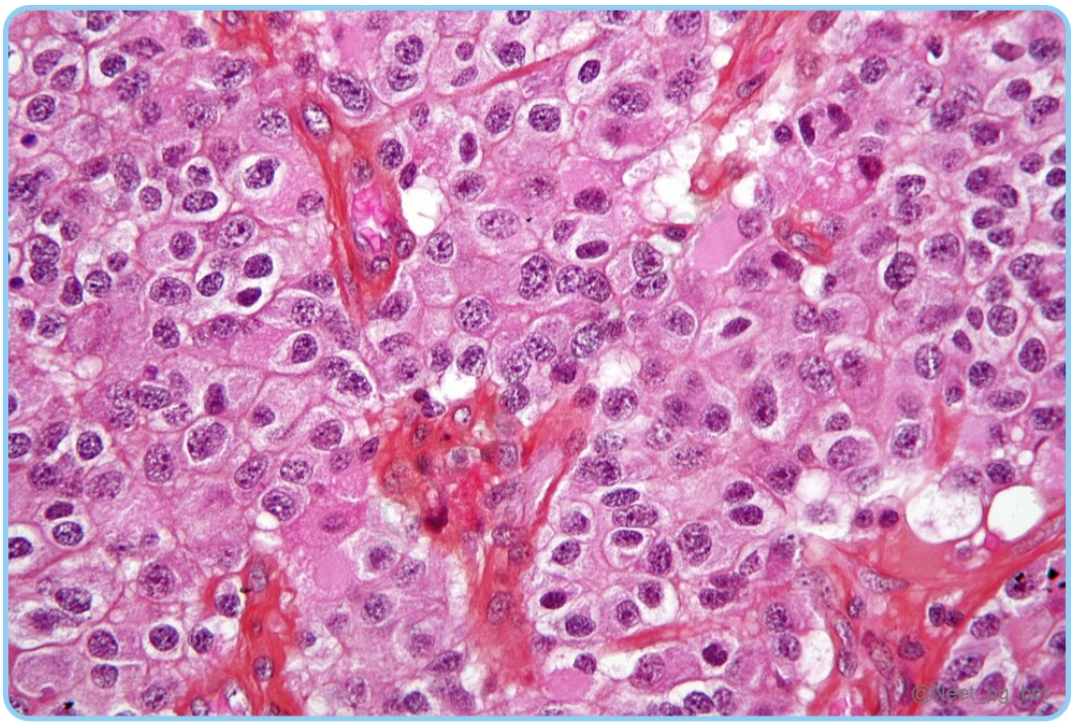
Q11: A 45-year-old male presents with recurrent seizures and headaches. MRI reveals a mass located in the cerebral hemisphere. Histopathological examination of the mass shows cells with a "fried egg" appearance and a chicken-wire capillary pattern. Which of the following is the most likely diagnosis? (Q849222)

A. Meningioma

B. Oligodendroglioma

C. Craniopharyngioma

D. Glioblastoma



See Answer in Part B → Q11

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Q12: A 55-year-old female presents with headaches and visual disturbances. Imaging studies reveal a well-circumscribed mass in the brain. On histopathological examination, the tumour shows calcifications and cells arranged in whorls. Which of the following radiological findings is most characteristic of this tumour type? (Q849221)

A. Calcified mass

B. Ring enhancement

C. Dural tail sign

D. Vasogenic oedema

See Answer in Part B → Q12

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Q13: A 60-year-old patient presents with worsening headaches, focal neurological deficits, and personality changes. MRI imaging reveals a ring-enhancing lesion surrounded by significant oedema. Based on these imaging characteristics, which of the following is the most likely diagnosis and management in recurrent cases? (Q849220)

A. Meningioma, Bevacizumab

B. Glioblastoma Multiforme, Temozolomide

C. Metastatic Brain Tumor, Evacizumab

D. Primary CNS Lymphoma, Doxorubicin



See Answer in Part B → Q13

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Q14: A 45-year-old patient presents with headaches and focal neurological deficits. Imaging reveals a tumour located in the cerebral hemispheres, characterised by

infiltrative growth and low cellularity. Which of the following options best describes the likely diagnosis for this tumour? (Q849195)

A. Pilocytic Astrocytoma

B. Diffuse Astrocytoma

C. Anaplastic Astrocytoma

D. Glioblastoma Multiforme

See Answer in Part B → Q14

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Q15: A 12-year-old child presents with headaches, vomiting, and unsteady gait. Imaging reveals a mass in the posterior fossa. The lesion is surgically resected, and histology reveals a tumour with a low mitotic index. Which of the following best describes the most common location and prognosis of this tumour? (Q849189)

A. Hypothalamus, Poor prognosis

B. Cerebellum, Good prognosis

C. Cerebellum, Poor prognosis

D. Hypothalamus, Good prognosis

See Answer in Part B → Q15

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Q16: Which type of brain tumour is most likely to cause personality changes, impaired judgment, and difficulty with motor planning? (Q849183)

A. Frontal lobe tumors

B. Temporal lobe tumors

C. Occipital lobe tumors

D. Cerebellar tumors

See Answer in Part B → Q16

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Q17: A 62-year-old man with a 40-pack-year smoking history presents with worsening headaches, confusion, ataxia, and right-sided weakness. A CT scan reveals multiple ring-enhancing brain lesions and further imaging identifies a mass in the right upper lobe of the lung. What is the most likely primary source of brain metastases? (Q849182)

A. Colorectal cancer

B. Prostate cancer

C. Lung cancer

D. Melanoma

See Answer in Part B → Q17

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Q1: What is the classification of the head injury of a patient involved in a road traffic accident, based on a GCS score of 10? (Q793536)

A. Moderate traumatic brain injury

B. Severe traumatic brain injury

C. Minor traumatic brain injury

D. Mild traumatic brain injury

See Answer in Part B → Q1

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Q2: Which of the following is most likely to be seen due to the rupture of a saccular aneurysm? (Q855826)

A. Subdural hemorrhage

B. Subarachnoid hemorrhage

C. Intracerebral hemorrhage

D. Hydrocephalus

See Answer in Part B → Q2

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Q3: A cricket player was initially hit on the head with a cricket ball, appearing fine but later collapsing, regaining consciousness to play well, and then found unconscious in the dressing room. What is the probable diagnosis based on the result of the CT scan provided? (Q859882)

A. Extradural hemorrhage

B. Artifact

C. Subdural hemorrhage

D. Subarachnoid hemorrhage



See Answer in Part B → Q3

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Q4: A 27-year-old man came to the clinic with a headache, palpitations, and sweating. As there is a history of renal problems in his brother and father, he requested an abdominal ultrasound, which revealed the presence of multiple renal and pancreatic

cysts. 24-hour urinary metanephrine was sent, which was elevated. What is the most likely diagnosis? (Q859827)

A. Multiple endocrine neoplasia type I

B. Von Hippel-Lindau disease

C. Birt-Hogg-Dube syndrome

D. Tuberous sclerosis

See Answer in Part B → Q4

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Q5: What is the diagnosis for the unconscious patient brought to the casualty department following a road accident, as depicted in the provided CT scan image? (Q859631)

A. Extradural hematoma (EDH)

B. Subdural hematoma (SDH)

C. Intraparenchymal bleed

D. Subarachnoid hemorrhage (SAH)



See Answer in Part B → Q5

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Q6: A 15-year-old boy presents with a slow-growing, rubbery, non-tender swelling on the side of the neck, as shown in the image. Examination shows the presence of freckles and light skin patches over the face and trunk. What is the most likely diagnosis? (Q856736)

A. Cystic hygroma

B. Chemodectoma

C. Neural tumour

D. Lipoma



See Answer in Part B → Q6

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Q7: Calculate the Glasgow Coma Scale (GCS) of a patient admitted after a road traffic accident and receiving mechanical ventilation. The patient demonstrates a response by opening their eyes upon verbal command and exhibits spontaneous movement in all four limbs. (Q856539)

A. Eyes-2, Verbal-1, Motor-5

B. Eyes-2, Verbal-NT, Motor-5

C. Eyes-3, Verbal-1, Motor-6

D. Eyes-3, Verbal-NT, Motor-6

See Answer in Part B → Q7

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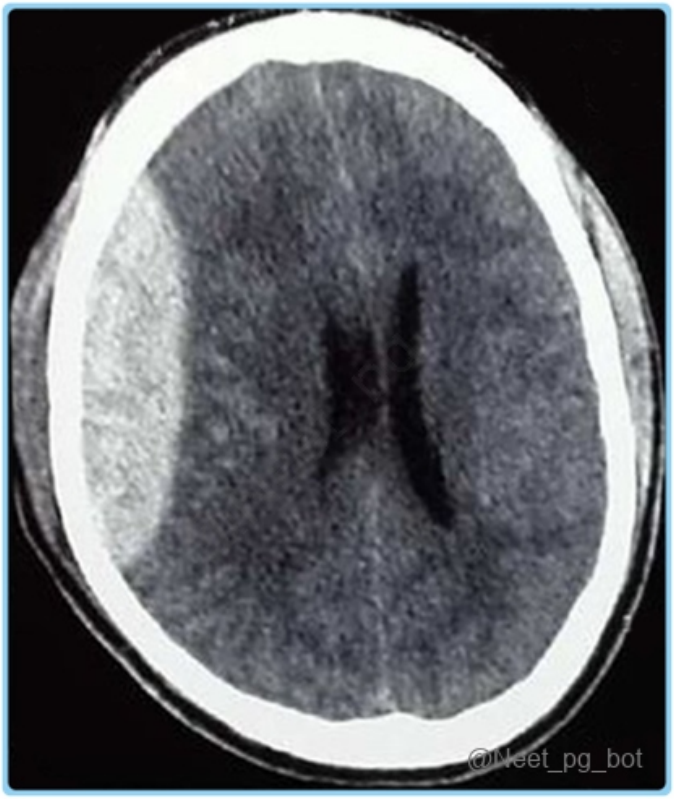
Q8: What potential diagnosis should be considered for a patient admitted to the Emergency department following a road traffic accident exhibiting an altered level of consciousness and a Glasgow Coma Scale (GCS) score of 10, as depicted in the provided CT scan? (Q857436)

A. Subdural hematoma

B. Intracerebral hemorrhage

C. Extradural hematoma

D. Hemorrhagic contusion



See Answer in Part B → Q8

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Q9: An old lady sustained a fall and developed a headache and neurological symptoms a few days later. What is your diagnosis? (Q855261)

A. Multi-infarct dementia

B. Frontal lobe meningioma

C. Korsakoff disease

D. Subdural hematoma

See Answer in Part B → Q9

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Q10: A 34-year-old woman was brought to the AIIMS emergency following a road traffic accident. She was hemodynamically stable, and her GCS score was 3. She was intubated and sent for non-contrast C,T which was found to be normal. What is the most likely diagnosis? (Q855175)

A. Subdural hemorrhage

B. Extradural hemorrhage

C. Diffuse axonal injury

D. Cerebral contusion

See Answer in Part B → Q10

@Neet_pg_bot

Q11: A 30 year male old patient presents to OPD with complaints of recurrent headache and nausea, MRI brain shown. What is the diagnosis? (Q866457)

A. Meningioma

B. Glioma

C. Ependymoma

D. Pilocytic astrocytoma



See Answer in Part B → Q11

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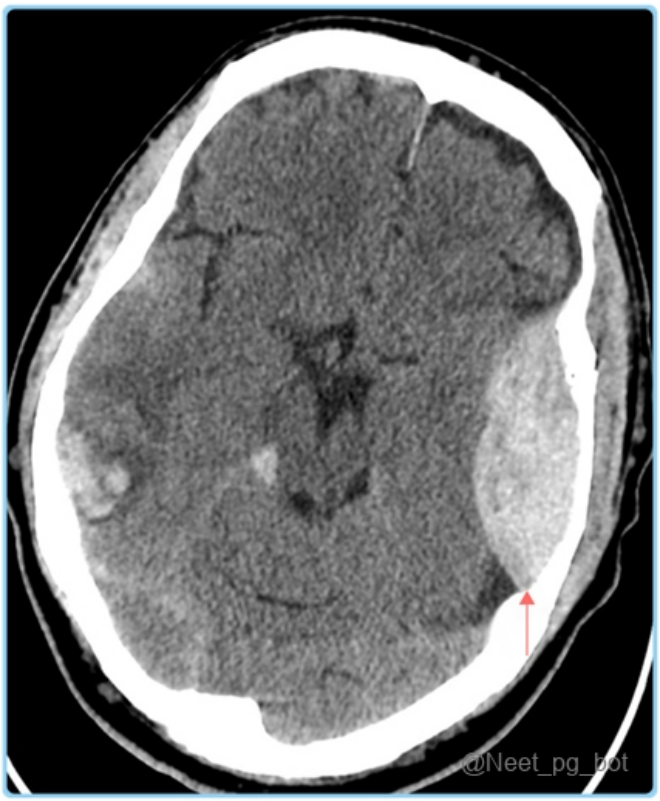
Q12: What is the probable diagnosis for a 30-year-old woman who experienced nausea and vomiting after being involved in a road traffic accident, and was brought to the emergency room unconscious, based on the findings of the NCCT brain? (Q857856)

A. Extradural hemorrhage

B. Subdural hemorrhage

C. Intra-parenchymal hemorrhage

D. Subarachnoid hemorrhage



See Answer in Part B → Q12

@Neet_pg_bot

Q13: What is the most appropriate course of action for the management of a patient who presents to the emergency department with a severe headache and has a blood pressure reading of 160/100 mmHg, along with a CT scan showing evidence of a subarachnoid haemorrhage? (Q855267)

A. Nimodipine

B. Angiography

C. Surgery

D. Fibrinolytic therapy

See Answer in Part B → Q13

@Neet_pg_bot

Q14: A 50-year-old patient presents with confusion and ataxia following trauma one week ago. He has a history of alcohol dependence, with his last intake 2 weeks ago. A CT scan reveals the following findings. What is the most likely diagnosis? (Q855207)

A. Extradural hemorrhage

B. Subdural hemorrhage

C. Intra-parenchymal hemorrhage

D. Subarachnoid hemorrhage



See Answer in Part B → Q14

@Neet_pg_bot

Q15: What is the Glasgow Coma Scale (GCS) score of a patient who was admitted to the emergency room after being involved in a road traffic accident and, on examination, opens his eyes in response to a painful stimulus, speaks inappropriately, and withdraws his limbs in response to a painful stimulus? (Q855182)

A. E2V2M3

B. E3V3M3

C. E2V3M4

D. E3V2M2

See Answer in Part B → Q15

@Neet_pg_bot

Q16: Which of the following conditions is associated with perineural invasion? (Q854781)

A. Adenoid cystic carcinoma

B. Pleomorphic adenoma

C. Mucoepidermoid tumour

D. Pancreatic cancer

See Answer in Part B → Q16

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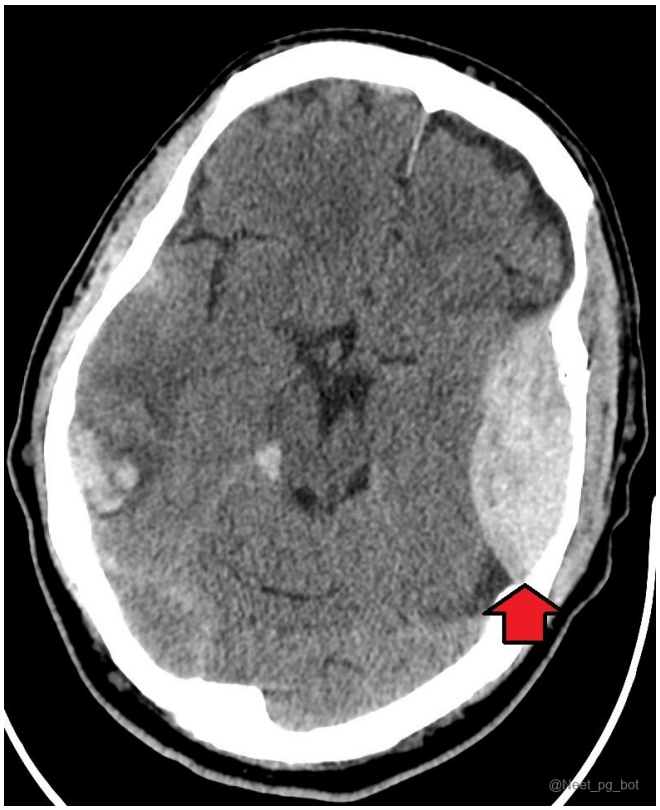
Q17: A 32-year-old patient had a RTA and was brought to the ER. On examination, his GCS was E2M4V2 and his CT scan is given below. Which of the following is the preferred treatment in this condition? (Q820167)

A. Ventilation

B. Craniotomy with evacuation of hematoma

C. Anticoagulants

D. Steroids



See Answer in Part B → Q17

@Neet_pg_bot

Q18: Which type of intracranial hemorrhage is most likely depicted in the image given below? (Q860287)

A. Extradural hemorrhage

B. Subarachnoid hemorrhage

C. Subdural hematoma

D. Intraparenchymal hemorrhage



See Answer in Part B → Q18

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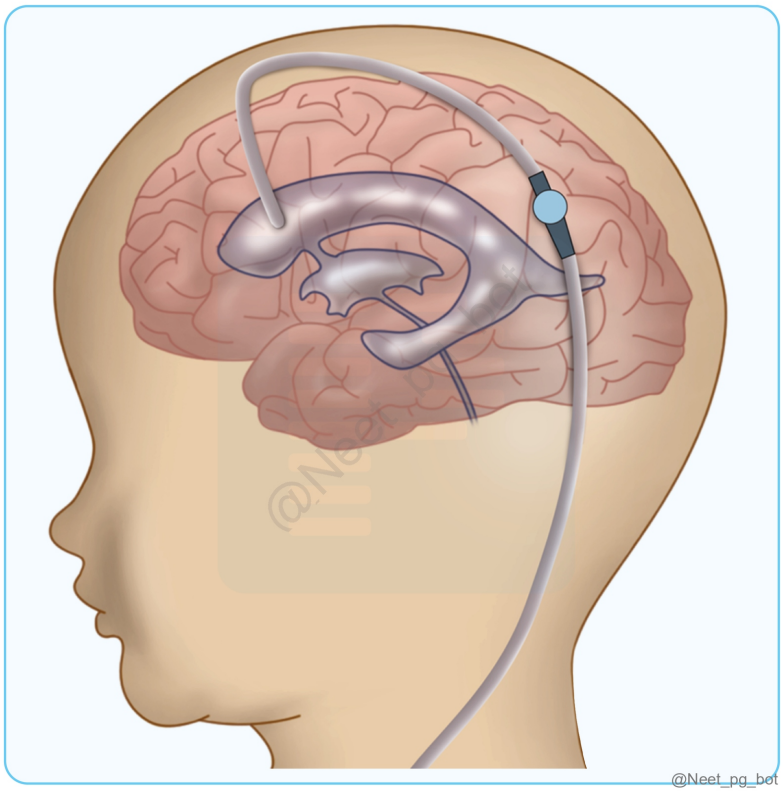
Q19: A 7-year-old boy is brought with complaints of headache, and vomiting for a few days. He had undergone a ventriculoperitoneal (VP) shunt placement for hydrocephalus a year ago. What is the most common cause of shunt malfunction in this patient? (Q860460)

A. Shunt infection

B. Shunt obstruction

C. Shunt tip migration

D. Shunt disconnection



See Answer in Part B → Q19

@Neet_pg_bot

Q20: A 65-year-old patient with a history of thromboembolic stroke, currently taking warfarin and aspirin, presents with a headache and confusion after a fall in the toilet. A non-contrast CT of the head is given in the image. What is the next best step in management? (Q860383)

A. Aspirin + Clopidogrel

B. Vitamin K + FFP + Neurosurgery consultation

C. IV Mannitol

D. Observation



See Answer in Part B → Q20

@Neet_pg_bot

Q21: A 25 year patient had a Road traffic accident was initially conscious but later became unconscious and subsequently died. On postmortem examination, multiple petechial haemorrhages are seen in the corpus callosum, what is the probable diagnosis (Q866463)

A. EDH

B. Diffuse axonal injury

C. Subdural hematoma

D. SAH

See Answer in Part B → Q21

@Neet_pg_bot

Q22: Which of the following is the next step in the management of an old patient who has undergone complete excision of glioblastoma ? (Q793556)

A. Chemotherapy with Bevacizumab

B. No further management

C. Chemoradiation

D. Radiotherapy

See Answer in Part B → Q22

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• [02_Head And Neck] 004 Oral Cavity

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[02_Head And Neck] 004 Oral Cavity — Quick Jump

Q1 (p. 51)	*Q2 (p. 51)*	*Q3 (p. 52)*	*Q4 (p. 52)*	*Q5 (p. 52)*	*Q6 (p. 53)*
Q7 (p. 53)	*Q8 (p. 54)*	*Q9 (p. 54)*	*Q10 (p. 55)*	*Q11 (p. 55)*	*Q12 (p. 56)*
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Q19 (p. 59)	*Q20 (p. 59)*	*Q21 (p. 59)*	*Q22 (p. 60)*	*Q23 (p. 60)*	*Q24 (p. 61)*
Q25 (p. 61)	*Q26 (p. 62)*				

Q1: A 55-year-old male presents with a 2 cm ulcerative lesion located on the lateral border of the anterior portion of the tongue, closer to the tip. During surgical planning, which group of lymph nodes is the most likely initial site of lymphatic drainage for this lesion? (Q849605)

A. Level I

B. Level II

C. Level III

D. Level IV

See Answer in Part B → Q1

@Neet_pg_bot

Q2: A 65-year-old patient presents with metastatic adenocarcinoma, but the primary tumor site remains unidentified. Which of the following is the most appropriate next step in the workup to help locate the primary tumor? (Q849630)

A. Complete blood count

B. PET scan

C. Start chemotherapy

D. Exploratory surgery

See Answer in Part B → Q2

@Neet_pg_bot

Q3: A 58-year-old patient who recently had a neck dissection is experiencing swelling, pain, and fluid accumulation in the surgical area. Which of the following is NOT a typical complication associated with neck dissection? (Q849629)

A. Wound dehiscence

B. Chyle leak

C. Accessory nerve injury

D. Facial nerve paralysis

See Answer in Part B → Q3

@Neet_pg_bot

Q4: A patient undergoes a neck dissection that involves removing lymph nodes from levels I-V, while preserving the spinal accessory nerve, and internal jugular vein. What type of neck dissection was performed? (Q849628)

A. Radical neck dissection

B. Anterolateral Neck Dissection

C. Modified Radical Neck Dissection Type II

D. Modified Radical Neck Dissection Type III

See Answer in Part B → Q4

@Neet_pg_bot

Q5: A 58-year-old male is scheduled for a neck dissection due to metastatic squamous cell carcinoma of the oral cavity. Which incision will the surgeon choose to provide optimal access to all cervical lymph node levels? (Q849619)

A. Macfee incision

B. Modified Schobinger incision

C. Y-shaped incision

D. Modified Macfee incision

See Answer in Part B → Q5

@Neet_pg_bot

Q6: A 60-year-old female diagnosed with oral cavity cancer presents with a non-healing ulcer on her lower lip. Which of the following lymph node levels is most likely involved in this patient? (Q849618)

A. Levels IV and V

B. Levels II, III and IV

C. Levels I, II and III

D. Level VII

See Answer in Part B → Q6

@Neet_pg_bot

Q7: A 35-year-old male presents with a smooth, tender swelling in the right lower jaw in relation to tooth caries. A panoramic radiograph shows a well-defined radiolucency around the roots of the lower right first molar. What is the most likely diagnosis? (Q849612)

A. Dentigerous cyst

B. Dental cyst

C. Ameloblastoma

D. Epulis

See Answer in Part B → Q7

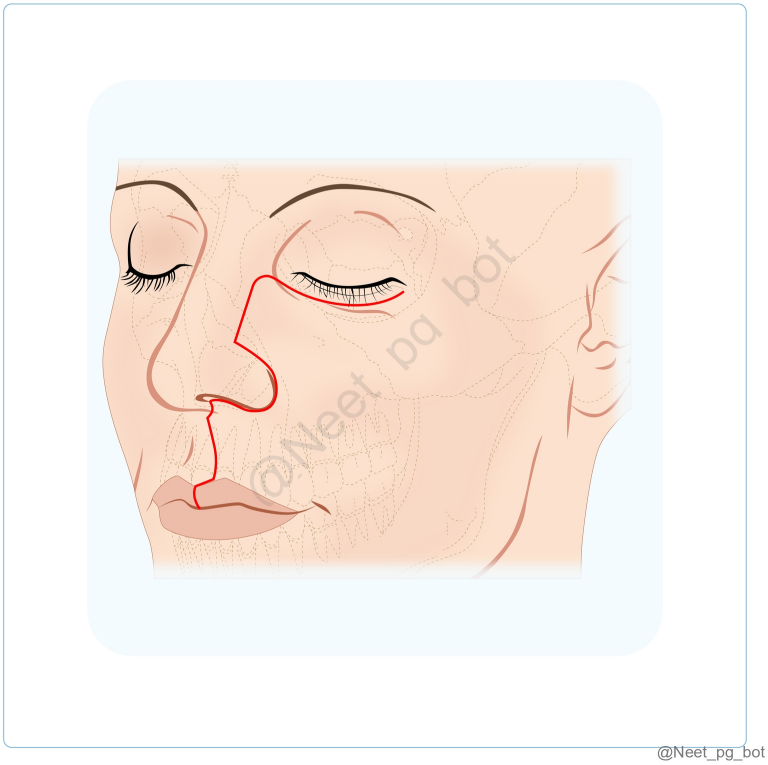
Q8: A 55-year-old male presents with a large tumor involving the floor of the maxillary sinus, causing facial swelling and nasal obstruction. During surgery, the surgical team uses the approach shown in the image. Identify the type of incision used in this procedure. (Q849611)

A. Caldwell-Luc Incision

B. Weber-Fergusson Incision

C. Modified Blair Incision

D. Lateral Rhinotomy Incision



See Answer in Part B → Q8

Q9: A 55-year-old male patient requires mandibular reconstruction following the resection of a tumor. The surgeon is considering different bone graft options. Which of the following bone grafts is not likely to be chosen for bony reconstruction of the mandible? (Q849610)

A. Fibula bone graft

B. Iliac crest bone graft

C. Tibia bone graft

D. Scapula bone graft

See Answer in Part B → Q9

@Neet_pg_bot

Q10: A patient is scheduled for segmental mandibulectomy due to a lower alveolar tumor invading the mandible. Which statement accurately describes this procedure? (Q849609)

A. Preserves mandible continuity.

B. Suitable for tumors not invading the mandible.

C. Removes the entire height of the mandible.

D. Resection of partial thickness of the mandible.

See Answer in Part B → Q10

@Neet_pg_bot

Q11: A 65-year-old male with lower alveolar squamous cell carcinoma presents with an ulcerated mass, extensive cortical bone erosion, invasion beyond the inferior alveolar canal. What is the most appropriate treatment? (Q849608)

A. Radiotherapy

B. Local excision with marginal resection

C. Segmental mandibulectomy

D. Marginal resection, along with block dissection

See Answer in Part B → Q11

@Neet_pg_bot

Q12: A patient presents with 2.5 cm ulceroproliferative adenoid cystic carcinoma on the left side of the hard palate. Imaging shows no evidence of bone invasion or lymph node involvement. Which of the following is the most appropriate management strategy? (Q849607)

A. Wide local excision with frozen section control

B. Partial maxillectomy with ipsilateral neck dissection

C. Partial maxillectomy without neck dissection

D. Radiotherapy alone

See Answer in Part B → Q12

@Neet_pg_bot

Q13: A female who chews betel quid has pale, fibrous oral mucosa and a 2 cm interincisal opening. Biopsy revealed increased collagen deposition in the lamina propria. Which of the following is the most likely complication of this condition if left untreated? (Q849606)

A. Candidiasis

B. Malignant transformation

C. Bilateral submandibular gland hypertrophy

D. Spontaneous remission of fibrosis

See Answer in Part B → Q13

@Neet_pg_bot

Q14: Which of the following statements about the extent of the oral cavity is false? (Q849562)

A. The anterior border of the oral cavity begins at the vermillion border.

B. Superiorly, the oral cavity includes the soft palate up to the uvula.

C. The posterior extent of the oral cavity ends at the circumvallate papillae of the tongue.

D. The tonsils are not a part of the oral cavity.

See Answer in Part B → Q14

@Neet_pg_bot

Q15: A 65-year-old patient presents with a 2.5 cm ulcerative lesion on the right side of his lower lip confirmed as squamous cell carcinoma. Which of the following statements is correct regarding the primary lymphatic drainage and surgical management of this lesion? (Q849594)

A. Drains to submental nodes; level I neck dissection is sufficient.

B. Drains to ipsilateral submandibular nodes; levels I-III neck dissection is recommended.

C. High risk of contralateral metastasis; bilateral neck dissection is needed.

D. Drains to preauricular and parotid nodes; requires superficial parotidectomy.

See Answer in Part B → Q15

@Neet_pg_bot

Q16: A 72-year-old farmer presents with a 3.5 cm exophytic lesion on his lower lip. Biopsy confirms well-differentiated squamous cell carcinoma with 8 mm depth of invasion. There are no palpable lymph nodes. Which of the following is the correct management strategy? (Q849593)

A. Wide local excision with 5 mm margins and neck observation.

B. Wide local excision with 1 cm margins and ipsilateral neck dissection.

C. Wide local excision with 1 cm margins and bilateral neck dissection.

D. Radiotherapy alone.

See Answer in Part B → Q16

@Neet_pg_bot

Q17: A 62-year-old male with recurrent squamous cell carcinoma of the oral cavity is being considered for immunotherapy using pembrolizumab. Which of the following correctly describes the mechanism of action of the drug? (Q849592)

A. Inhibits VEGF to prevent tumor angiogenesis

B. Blocks PD-1 receptor, enhancing T-cell anti-tumor activity

C. Targets EGFR to inhibit tumor cell proliferation

D. Activates NK cells to induce antibody-dependent cellular cytotoxicity

See Answer in Part B → Q17

@Neet_pg_bot

Q18: A 59-year-old male with T2N2bM0 squamous cell carcinoma of the buccal mucosa underwent surgery. The postoperative histopathology report reveals close surgical margin (< 5 mm) and extracapsular extension in two lymph nodes. What is the most appropriate adjuvant treatment for this patient? (Q849591)

A. Radiotherapy alone

B. Chemotherapy alone

C. Concurrent chemoradiotherapy

D. Observation and close follow-up

See Answer in Part B → Q18

@Neet_pg_bot

Q19: A 58-year-old male with a 6 cm x 4 cm defect involving more than 50% of the tongue after excision for a T3N1M0 squamous cell carcinoma needs reconstruction. Which of the following flaps would be most appropriate for reconstruction for this patient? (Q849590)

A. Radial forearm free flap

B. Anterolateral thigh free flap

C. Pectoralis major myocutaneous flap

D. Supraclavicular artery island flap

See Answer in Part B → Q19

@Neet_pg_bot

Q20: A 62-year-old male presents with a T2N1M0 squamous cell carcinoma of the lateral border of the tongue. According to the latest National Comprehensive Cancer Network (NCCN) guidelines, what is the most appropriate initial management for this patient? (Q849589)

A. Wide local excision of the primary tumor only.

B. Definitive radiotherapy with concurrent chemotherapy.

C. Surgery followed by adjuvant radiotherapy.

D. Neoadjuvant chemotherapy followed by surgery.

See Answer in Part B → Q20

@Neet_pg_bot

Q21: A male presents with a painful 2.5 cm ulceroproliferative growth on the right lateral border of the tongue with induration extending to the floor of the mouth and a single, firm, mobile 1.5 cm lymph node palpable in the right submandibular region. The CT scan shows no mandible or extrinsic muscle involvement. What is the correct TNM staging for this patient? (Q849570)

A. T2N1M0

B. T3N1M0

C. T4aN1M0

D. T2N2aM0

See Answer in Part B → Q21

@Neet_pg_bot

Q22: A 55-year-old patient presents with a non-healing ulcer in the oral cavity and is diagnosed with carcinoma oral cavity. Which of the following statements regarding carcinoma oral cavity is most accurate? (Q849569)

A. Distant metastasis is common.

B. Ulcer lasting over 3 weeks is significant.

C. Adenocarcinoma is the most common oral cancer.

D. Oral carcinoma is the least common among head and neck tumors.

See Answer in Part B → Q22

@Neet_pg_bot

Q23: A patient who had developed a buccal squamous cell carcinoma was treated by complete resection and radiation therapy. After his treatment was completed and he had clear margins after the resection, he developed a new tumor in his oral cavity on his tongue. What is the basis of this development of a second primary tumor? (Q849568)

A. Field defect

B. Field effect

C. Field cancerization

D. All of the above

See Answer in Part B → Q23

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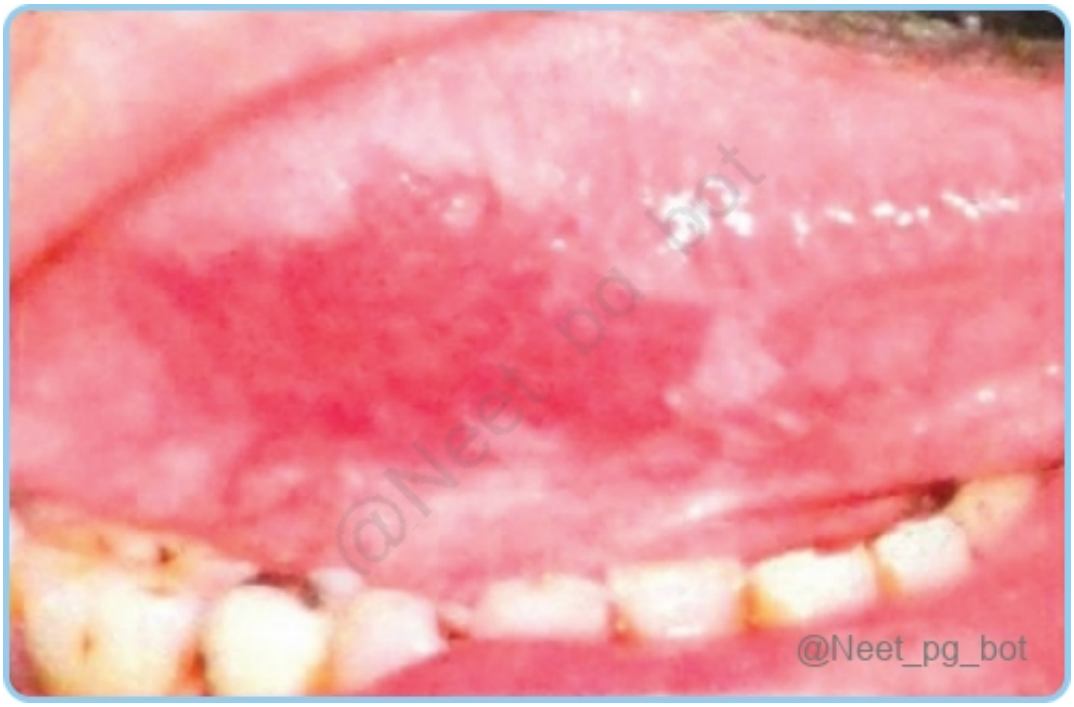
Q24: A 45-year-old female comes to the clinic with a reddish patch on her tongue, as shown in the figure. She gives a history of chewing pan masala for more than 15 years. She has no difficulty in opening her mouth and has no other comorbidities. What is the most probable diagnosis? (Q849565)

A. Oral submucosal fibrosis

B. Erythroplakia

C. Plummer-Vinson syndrome

D. Leukoerythroplakia



See Answer in Part B → Q24

@Neet_pg_bot

Q25: A 50-year-old patient comes to the OPD concerned about a newly developed whitish discolouration in his mouth. On examination, a white plaque-like lesion was

found in his buccal mucosa, which could not be rubbed off. What is the most likely diagnosis? (Q849564)

A. Leukoplakia

B. Erythroplakia

C. Speckled leukoplakia

D. Chronic hyperplastic Candidiasis



See Answer in Part B → Q25

@Neet_pg_bot

Q26: A 45-year-old male comes to the hospital after noticing abnormal growth on the right side of his mouth. He has had a habit of smoking and chewing betel quid for more than 20 years. On further evaluation, he also gives a history of a red lesion present in the same location before the current state. Which of the following, in this case, is not a risk factor for oral carcinoma? (Q849563)

A. Age above 40 years

B. Erythroplakia

C. Smoking

D. Betel quid

See Answer in Part B → Q26

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• [02_Head And Neck] 005 Salivary Glands

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[02_Head And Neck] 005 Salivary Glands — Quick Jump

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Q13 (p. 70) *Q14 (p. 70)* *Q15 (p. 70)* *Q16 (p. 71)* *Q17 (p. 71)* *Q18 (p. 72)*
Q19 (p. 72)

Q1: A 45 y/o woman undergoes a superficial parotidectomy for a pleomorphic adenoma. Which of the following is a known complication associated with this condition or its treatment? (Q849649)

A. Permanent facial nerve paralysis is common after parotidectomy.

B. Pleomorphic adenomas rarely recur after surgical excision.

C. Radiotherapy for pleomorphic adenoma is risk-free and only used as a primary treatment.

D. Frey’s syndrome is characterized by sweating and flushing in the preauricular area during meals.

See Answer in Part B → Q1

@Neet_pg_bot

Q2: A 28-y/o male presents with a painless, soft swelling in the submandibular region that has been gradually enlarging over the past 2 months. On examination, the swelling is dumbbell-shaped, fluctuant, and bidigitally palpable. The overlying mucosa appears thick with a bluish hue. Fine needle aspiration yields a viscous, "egg white-like" fluid with high amylase content, confirming the diagnosis. What is the most appropriate treatment for this patient? (Q849658)

A. Incision and drainage of the cyst

B. Marsupialization (unroofing) of the ranula

C. Surgical excision of the ranula and involved sublingual gland

D. Observation and follow-up

See Answer in Part B → Q2

@Neet_pg_bot

Q3: A 16 y/o female has a painless, soft, fluctuant swelling in the anterior floor of her mouth that has increased in size over a few weeks. There is no history of trauma or infection. What is the most appropriate next step in confirming the diagnosis? (Q849657)

A. Magnetic Resonance Imaging

B. Computed Tomography

C. Incisional biopsy

D. Aspiration of the lesion



See Answer in Part B → Q3

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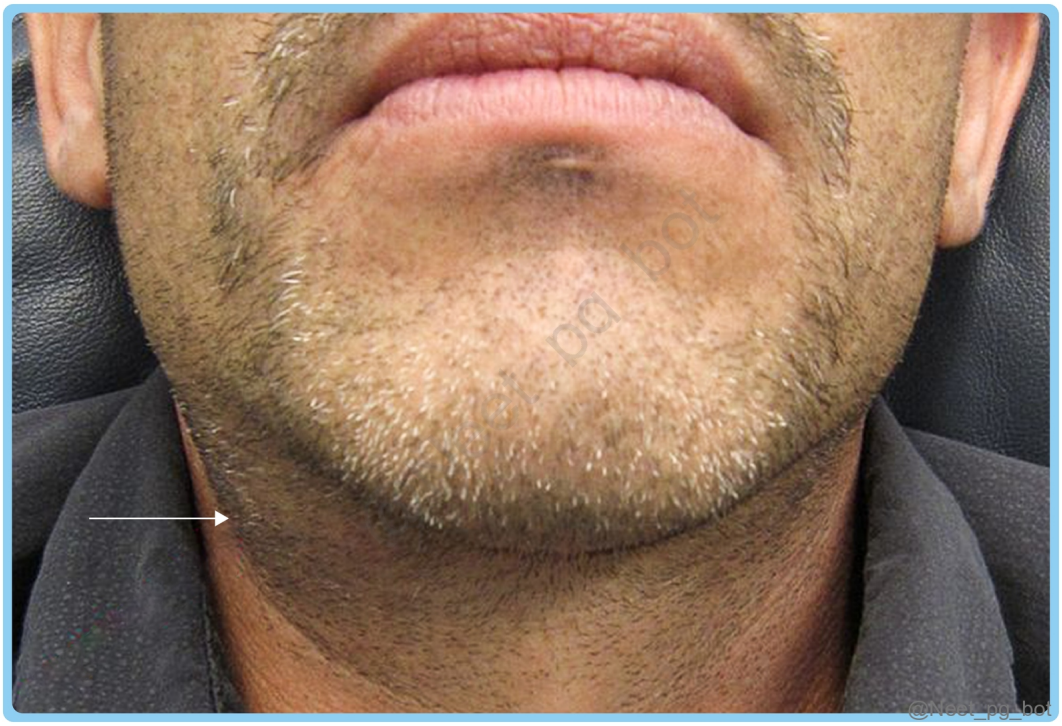
Q4: A 52 y/o male has recurrent pain and swelling in the left lower jaw, worsening over several months. On examination, there is a significant swelling of the right submandibular gland, but no palpable stone. A CT scan shows an 8 mm stone deep within the submandibular gland, inaccessible by sialendoscopy. What is the best next step in management? (Q849656)

A. Endoscopic removal of the stone

B. Ductal slitting for stone extraction

C. External shock wave lithotripsy (ESWL)

D. Gland excision



See Answer in Part B → Q4

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Q5: A 45 y/o woman is undergoing surgery for the removal of a submandibular gland mass. Postoperatively, she complains of numbness and a burning sensation of her tongue. Which nerve is most likely to have been injured during the procedure?

(Q849655)

A. Facial Nerve

B. Lingual Nerve

C. Hypoglossal Nerve

D. Glossopharyngeal Nerve

See Answer in Part B → Q5

@Neet_pg_bot

Q6: A 60 y/o man with a diagnosis of adenoid cystic carcinoma has undergone surgical resection of a tumour located in the palate. Postoperative imaging reveals no residual tumour but shows the involvement of regional lymph nodes. What is the most appropriate additional treatment for this patient? (Q849654)

A. Additional surgical resection

B. External beam radiotherapy

C. Preoperative chemotherapy

D. Observation and regular follow-up

See Answer in Part B → Q6

@Neet_pg_bot

Q7: A 60 y/o man presents with a slow-growing, painless mass in the submandibular region. O/E, the mass is firm and non-tender and biopsy reveals a tumor with a combination of tubular and solid histological patterns. Imaging shows perineural invasion extending towards the base of the skull. Which histopathological type in this carcinoma is associated with the worst prognosis? (Q849653)

A. Cribriform

B. Tubular

C. Solid

D. Papillary

See Answer in Part B → Q7

@Neet_pg_bot

Q8: Which immunohistochemical marker helps to distinguish acinic cell carcinoma from secretory carcinoma? (Q849652)

A. p53

B. Mammaglobin

C. S100

D. Ki-67

See Answer in Part B → Q8

@Neet_pg_bot

Q9: A 45 y/o female has a firm, enlarging swelling below her left ear for 6 months. O/E, the swelling is hard and nodular, with no signs of facial nerve involvement. FNAC shows malignant cells, and imaging reveals a tumour in both lobes of the parotid gland with no distant metastases. What is the most likely diagnosis? (Q849651)

A. Pleomorphic adenoma

B. Mucoepidermoid carcinoma

C. Adenoid cystic carcinoma

D. Warthin’s tumor

See Answer in Part B → Q9

@Neet_pg_bot

Q10: Which of the following statements about Warthin's tumour and its diagnostic features is correct? (Q849650)

A. It is best identified on imaging by its hypoechoic appearance and confirmed with FNAC.

B. A Tc99 pertechnetate scan showing a "hotspot" is indicative of Warthin's tumour.

C. HPE shows mucin-secreting cells

D. Warthin's tumour generally exhibits low uptake on Tc99 pertechnetate scans

See Answer in Part B → Q10

@Neet_pg_bot

Q11: Which of the following salivary glands secretes saliva through Stensen’s duct? (Q849640)

A. Parotid gland

B. Submandibular gland

C. Sublingual gland

D. Minor salivary glands

See Answer in Part B → Q11

@Neet_pg_bot

Q12: A 35 y/o female has a slowly enlarging, painless, well-defined mass in the left parotid gland, present for two years. O/E there is no facial nerve involvement. Ultrasound shows a well-lobulated, hypoechoic lesion, and FNAC suggests a benign neoplasm. What is the most appropriate next step in management? (Q849648)

A. Observation and follow-up

B. Radiotherapy

C. Surgical excision with a margin of normal tissue

D. Enucleation of the tumour

See Answer in Part B → Q12

@Neet_pg_bot

Q13: A 50 y/o female with swelling and pus discharge from the left cheek for two weeks, worsening with eating, recently had a superficial parotidectomy. Examination reveals a small external opening at the parotid region with saliva-like discharge. What is the best initial management? (Q849647)

A. Antibiotics and observation

B. Sialography to evaluate the fistula

C. Surgical exploration and repair

D. Anticholinergic therapy with hyoscine bromide

See Answer in Part B → Q13

@Neet_pg_bot

Q14: A 60 y/o male undergoes a parotidectomy for a benign tumour located in the superficial lobe of the parotid gland. On the second postoperative day, he notices sweating and flushing in the area just in front of his ear when he eats. The patient also reports mild numbness of the earlobe. Which of the following nerves is most commonly affected? (Q849646)

A. Facial nerve

B. Auriculotemporal nerve

C. Great auricular nerve

D. Hypoglossal nerve

See Answer in Part B → Q14

@Neet_pg_bot

Q15: A 45 y/o patient presents with a parotid gland tumour located deep to the facial nerve. The tumour has been identified as malignant and has extended beyond the parotid gland. Given these findings, which surgical approach is most appropriate for this patient? (Q849645)

A. Radical parotidectomy

B. Total conservative parotidectomy

C. Superficial parotidectomy

D. Adequate parotidectomy

See Answer in Part B → Q15

@Neet_pg_bot

Q16: A 62 y/o woman presents with a recurrent adenoid cystic carcinoma of the submandibular gland. The tumour has been surgically resected twice before, and each time, the pathology report showed perineural invasion. What is the most appropriate next step in managing her condition? (Q849644)

A. Repeat surgical excision

B. Radiation therapy

C. Chemotherapy

D. Targeted therapy

See Answer in Part B → Q16

@Neet_pg_bot

Q17: A 45 y/o woman presents with a progressively enlarging mass in her right parotid gland. The mass is non-tender and has been present for 6 months. An ultrasound revealed a well-defined hypoechoic lesion with no evidence of calcification or increased vascularity. Which of the following is the most appropriate next step for this patient? (Q849643)

A. Sialography

B. Positron Emission Tomography (PET-CT)

C. Core Needle Biopsy

D. Fine-needle aspiration Cytology (FNAC)

See Answer in Part B → Q17

@Neet_pg_bot

Q18: Which is the most common salivary gland tumour found in infants and young children? (Q849642)

A. Pleomorphic adenoma

B. Mucoepidermoid carcinoma

C. Hemangioma

D. Adenoid cystic carcinoma

See Answer in Part B → Q18

@Neet_pg_bot

Q19: A 50 y/o male presents with a swelling in his parotid gland, and a biopsy reveals a Warthin's tumour. Which of the following is most likely a contributing risk factor for this patient's condition? (Q849641)

A. Radiation exposure in childhood

B. Chronic inflammation of the salivary glands

C. Smoking history

D. Immunocompromised state

See Answer in Part B → Q19

@Neet_pg_bot

• [02_Head And Neck] 006 Neck Facial Injuries Abnormalities

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[02_Head And Neck] 006 Neck Facial Injuries Abnormalities — Quick Jump

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Q25 (p. 84)					

Q1: A patient is brought to the trauma unit after being assaulted. He presents with severe pain, swelling, and deformity in the lower jaw. Imaging confirms a "bucket handle" fracture of the mandible. What is the most likely nerve to be injured in this type of fracture? (Q849719)

A. Lingual nerve

B. Inferior alveolar nerve

C. Hypoglossal nerve

D. Facial nerve

See Answer in Part B → Q1

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Q2: Match the following LeFort's fracture types: LeFort's types Features 1. LeFort's I a- Craniofacial dislocation 2. LeFort's II b- Horizontal fracture 3. LeFort's III c- Pyramidal fracture d- Tripod fracture (Q849716)

A. 1-b, 2-c, 3-a

B. 1-d, 2-b, 3-a

C. 1-c, 2-d, 3-b

D. 1-a, 2-c, 3-b

See Answer in Part B → Q2

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Q3: A 30-year-old male presents to the emergency department after a motor vehicle accident. On assessment, there is bruising around the left eye, and tenderness over the zygomatic arch. Which of the following imaging views is most appropriate for assessing a suspected zygomatic bone fracture? (Q849715)

A. Caldwell's view

B. Water's view

C. Lateral skull view

D. Towne's view

See Answer in Part B → Q3

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Q4: All of the following are true regarding the clinical presentation of zygomatic bone fracture except? (Q849714)

A. Epistaxis

B. Anesthesia in infra-orbital nerve distribution

C. Flattening of malar prominence

D. Deranged dental occlusion

See Answer in Part B → Q4

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Q5: A 22-year-old male presents with pain in the jaw and difficulty opening his mouth after a fall from a bicycle, landing directly on his chin. On examination, there is tenderness at the left preauricular region with limited mouth opening. CT scan

confirms an undisplaced fracture of the left mandibular condyle. The patient has no other injuries and is otherwise stable. What is the most appropriate management? (Q849708)

A. Open reduction with internal fixation (ORIF)

B. Observation with a soft diet

C. Intermaxillary fixation (IMF)

D. Surgical excision of the condylar head

See Answer in Part B → Q5

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Q6: A 24-year-old male presents to the emergency department after a motorcycle accident. He complains of severe pain in his lower jaw, difficulty closing his mouth properly, and numbness in his lower lip on the right side. Physical examination reveals swelling and tenderness over the right jaw, malocclusion, and a palpable step-off in the premolar region. The paresthesia in the patient's lower lip is most likely due to the involvement of which nerve? (Q849707)

A. Facial nerve

B. Inferior alveolar nerve

C. Mental nerve

D. Lingual nerve

See Answer in Part B → Q6

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Q7: A 3-month-old female infant presents with feeding difficulties and a noticeable facial deformity. On examination, the infant has a unilateral complete cleft involving the left lip, extending through the alveolus and hard palate, with an intact soft palate on the left side. The right side of the lip and palate are completely intact. What is the LAHSHAL classification for this patient's cleft abnormality? (Q849706)

A. 0000HAL

B. LAH0000

C. LAHS000

D. LAHSAL

See Answer in Part B → Q7

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Q8: A mother brings her apparently normal 20-day-old newborn to the pediatric clinic with a complaint of milk coming through the nasal passages of the baby during feeding. Upon examination, you find the following: This condition is due to the failure of which of the following processes during embryonic development? (Q849702)

A. Fusion of the maxillary and medial nasal processes

B. Formation of the lateral palatine processes

C. Fusion of the palatal shelves

D. Formation of the primary palate



See Answer in Part B → Q8

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Q9: A 45-year-old male is diagnosed with a mandibular condyle fracture following an assault. The fracture is associated with malocclusion and facial asymmetry. Which of the following is a common post-surgical complication after open reduction and internal fixation (ORIF) of this fracture? (Q849718)

A. Temporomandibular joint ankylosis

B. Persistent pain and facial contour deformities

C. Complete loss of mandibular function

D. Intraoral hemorrhage

See Answer in Part B → Q9

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Q10: All of the following statements are true regarding the management of midface fractures, except? (Q849717)

A. Interdental or intermaxillary fixation is not mandatory

B. Reestablish the proper dentoskeletal relationship

C. Immobilize the fractured bone

D. Ensure normal postoperative occlusion

See Answer in Part B → Q10

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Q11: A 3-month-old infant presents to the pediatric clinic with feeding difficulties and nasal regurgitation. On examination, the infant has a cleft involving only the soft palate. There are no other abnormalities or syndromic features observed. When should surgery be planned for this infant with a cleft of only the soft palate? (Q849705)

A. At birth

B. At 6 months

C. After 1 year

D. After 5 years

See Answer in Part B → Q11

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Q12: A 2-day-old male infant is born with a unilateral cleft lip and palate. He is the first child of healthy, non-consanguineous parents with no significant family history. On physical examination, the infant has a noticeable cleft lip and palate. No other obvious abnormalities are noted. You suspect a syndromic association. Which of the following is the most common syndrome associated with cleft lip? (Q849704)

A. Van der Woude syndrome

B. Pierre Robin sequence

C. Treacher Collins syndrome

D. DiGeorge syndrome

See Answer in Part B → Q12

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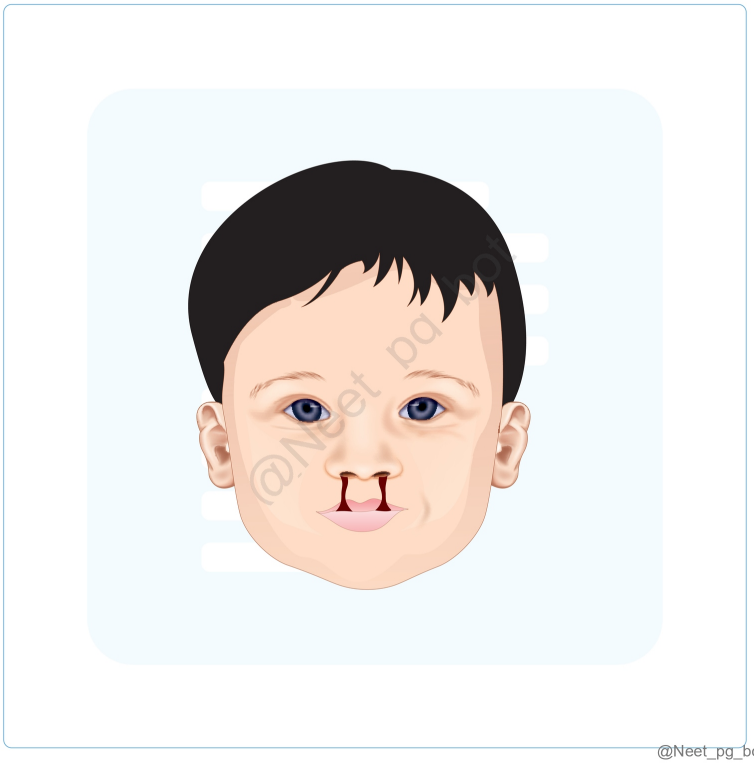
Q13: A 3-day-old male neonate is brought to you by his parents, concerned about the appearance of his face. On examination, the neonate has the appearance as shown in the image. Which of the following embryological events is most likely responsible for this defect? (Q849703)

A. Failure of fusion between the lateral palatine processes and nasal septum.

B. Non-fusion of the maxillary prominences and medial nasal prominences.

C. Incomplete fusion of the mandibular prominences.

D. Non-fusion of the lateral nasal prominences and the medial nasal prominences.



See Answer in Part B → Q13

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Q14: A 60-year-old patient is found to have a carotid body tumor that completely encases the carotid vessels, posing significant surgical challenges. According to the Shamblin classification system, what type of tumor does this describe? (Q849620)

A. Type I

B. Type II

C. Type III

D. Cannot be determined.

See Answer in Part B → Q14

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Q15: The intermaxillary segment gives rise to all of the following structures EXCEPT: (Q849701)

A. Philtrum of the lip

B. Primary palate

C. Secondary palate

D. Four incisor teeth

See Answer in Part B → Q15

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Q16: Match the structures formed in Column II with the corresponding prominence in Column I: Column I Column II A. Lateral Nasal Prominence 1. Lower lip B. Maxillary Prominence 2. Philtrum of upper lip, crest, and tip of nose C. Medial Nasal Prominence 3. Cheeks, lateral portion of upper lip D. Mandibular Prominence 4. Alae

of nose (Q849700)

A. A-2, B-1, C-3, D-2

B. A-4, B-1, C-3, D-2

C. A-2, B-3, C-4, D-1

D. A-4, B-3, C-2, D-1

See Answer in Part B → Q16

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Q17: A 55-year-old male patient with squamous cell carcinoma of the oral cavity undergoes a right radical neck dissection. Three days postoperatively, the patient complains of shoulder weakness and difficulty in lifting his right arm above his shoulder. On physical examination, he has a limited range of motion in the right shoulder and exhibits winging of the scapula on the right side. What is the most likely nerve injured during the neck dissection that could explain this patient's symptoms? (Q849699)

A. Accessory nerve (CN XI)

B. Phrenic nerve

C. Cervical sympathetic chain

D. Hypoglossal nerve (CN XII)

See Answer in Part B → Q17

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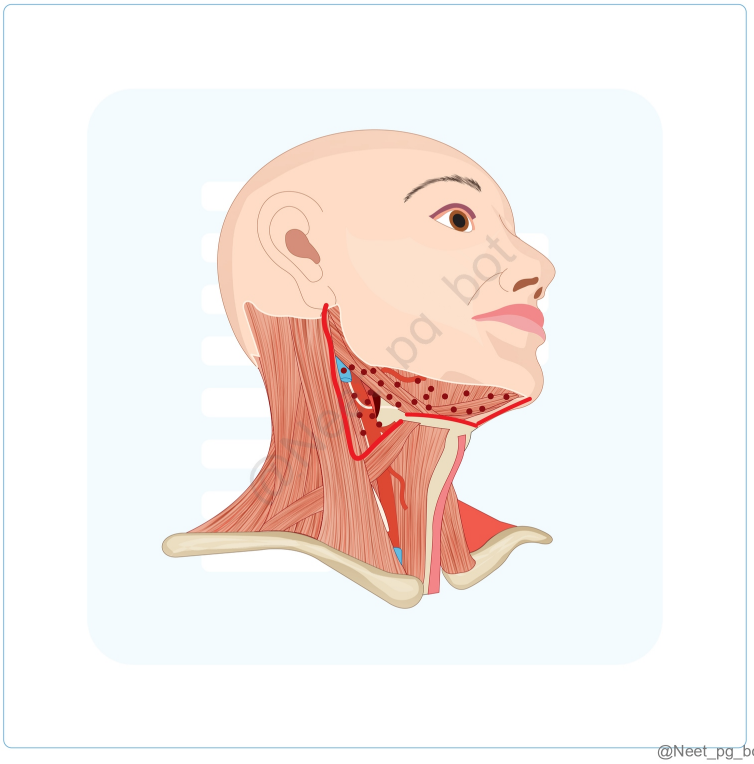
Q18: A 60-year-old male patient presents to the clinic with a non-healing ulcer on the left lateral border of the tongue. Upon examination, the lesion measures 2 cm and has been present for 6 weeks and there is a palpable lymph node in the left submandibular region. After evaluation, the surgeon decides to perform a neck dissection. The image below depicts the lymph nodes to be removed during the procedure. What type of neck dissection is planned for this patient? (Q849698)

A. Radical neck dissection

B. Modified radical neck dissection

C. Supraomohyoid neck dissection

D. Extended supraomohyoid neck dissection



See Answer in Part B → Q18

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Q19: Which lymph node level in the neck is primarily responsible for draining the thyroid gland? (Q849627)

A. Level Ib

B. Level IIa

C. Level VI

D. Level III

See Answer in Part B → Q19

@Neet_pg_bot

Q20: Which of the following nerves is most likely to be injured during surgery in the posterior triangle of the neck, potentially leading to weakness in shoulder elevation? (Q849626)

A. Hypoglossal Nerve (CN XII)

B. Vagus Nerve (CN X)

C. Phrenic Nerve

D. Spinal Accessory Nerve (CN XI)

See Answer in Part B → Q20

@Neet_pg_bot

Q21: Which of the following conditions is most commonly associated with a cervical rib? (Q849625)

A. Rotator Cuff Tear

B. Cervical Spondylosis

C. Thoracic Outlet Syndrome

D. Pancoast’s syndrome

See Answer in Part B → Q21

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Q22: Which branchial cleft remnant typically passes behind the carotid artery? (Q849624)

A. First branchial cleft remnant

B. Second branchial cleft remnant

C. Third branchial cleft remnant

D. Fourth branchial cleft remnant

See Answer in Part B → Q22

@Neet_pg_bot

Q23: A branchial fistula typically presents with which of the following characteristics? (Q849623)

A. A midline neck mass that moves with swallowing

B. A lateral neck opening that drains mucus or saliva

C. A neck swelling that enlarges after a respiratory infection

D. A solid mass in the posterior triangle of the neck

See Answer in Part B → Q23

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Q24: A 38-year-old patient presents with a soft, translucent swelling on the front edge of the sternocleidomastoid muscle. The swelling is non-tender and has not been associated with any infection. It is diagnosed as a branchial cyst. Which of the following is false regarding the given diagnosis? (Q849622)

A. Typical location is the meeting of upper and middle thirds of sternocleidomastoid.

B. It has an onset in late adulthood.

C. Cancerous lymph nodes may have to be ruled out.

D. Complete removal is done, ideally when not infected.

See Answer in Part B → Q24

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Q25: An infant presents with a translucent swelling in the neck that has been expanding over time as shown in the image below The swelling is filled with clear lymph and increases in size when the infant coughs.. Which of the following is false regarding the given condition? (Q849621)

A. Common locations include the cheek, axilla, groin, and mediastinum.

B. It has an unpredictable growth pattern.

C. It is incompressible and cystic in nature.

D. Injection of sclerosing agents can be given to reduce size.



See Answer in Part B → Q25

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• [02_Head And Neck] 007 Previous Year Questions

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[02_Head And Neck] 007 Previous Year Questions — Quick Jump

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Q31 (p. 104)	*Q32 (p. 105)*	*Q33 (p. 105)*	*Q34 (p. 105)*	*Q35 (p. 106)*	

Q1: What is the definition of the Miami criteria regarding intraoperative parathyroid hormone (PTH) measurement among the options listed below? (Q854934)

A. Quarter fall in 5 min

B. Quarter fall in 10 min

C. Half fall in 5 min

D. Half fall in 10 min

See Answer in Part B → Q1

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Q2: A 28-year-old female presents with a bluish translucent extravasation cystic sublingual swelling . The swelling is accompanied by visible veins over the swelling and is transilluminant . What is the most likely diagnosis? (Q820193)

A. Thyroglossal cyst

B. Dermoid cyst

C. Ranula

D. Sublingual tumour

See Answer in Part B → Q2

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Q3: A 6-year-old child presents with a swelling in the subhyoid region of the neck that moves with deglutition and protrusion of the tongue. What is the recommended treatment for this patient? (Q820236)

A. Total thyroidectomy

B. Ramstedt's operation

C. Hemi-thyroidectomy

D. Sistrunk's operation

See Answer in Part B → Q3

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Q4: A 45-year-old female patient undergoes a routine thyroid examination, during which a palpable thyroid nodule is discovered. Fine-needle aspiration cytology confirms the presence of papillary thyroid cancer. All of the following statements are true regarding papillary thyroid cancer Except: (Q820244)

A. It often presents with cervical lymph node metastases.

B. It is the most common type of thyroid cancer.

C. It arises from parafollicular C-cells

D. It is TSH dependent

See Answer in Part B → Q4

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Q5: A patient presents with swelling in the floor of the mouth. Upon examination, the swelling appears as shown in the image. What is the most likely diagnosis? (Q854776)

A. Cystic hygroma

B. Ranula

C. Dermoid

D. Branchial cyst



See Answer in Part B → Q5

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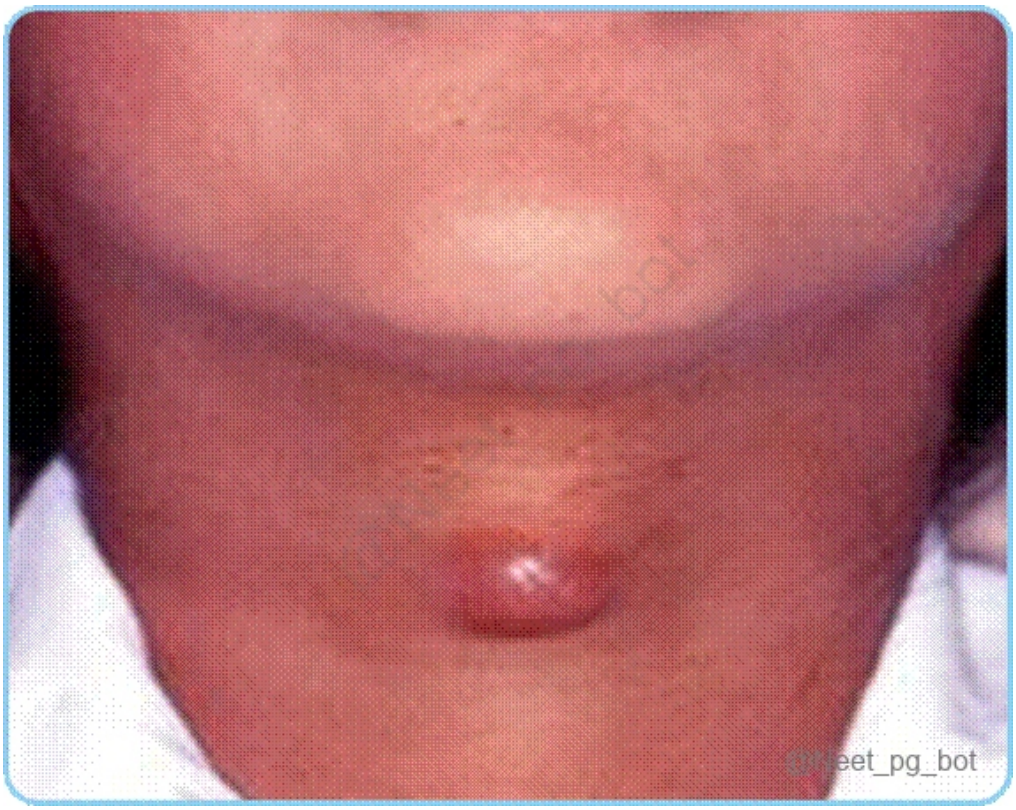
Q6: A 23-year-old male patient presents with a swelling in the midline of his neck that shifts when he swallows or sticks out his tongue. What is the probable diagnosis? (Q855273)

A. Brachial cyst

B. Thyroglossal cyst

C. Plunging ranula

D. Dermoid cyst



See Answer in Part B → Q6

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Q7: A 32-year-old man with a history of chronic tobacco chewing presents with a painless white patch in the gingivobuccal sulcus that has persisted for the past 7 months. The lesion is non-scrapable and there is no restriction of mouth opening. What is the most appropriate next step in management? (Q857858)

A. Local excision and biopsy

B. Advise cessation of tobacco and observe

C. Intralesional steroid injections

D. Sclerotherapy

See Answer in Part B → Q7

@Neet_pg_bot

Q8: The false statement about cystic masses of the neck is: (Q857144)

A. Type 3 branchial fistula has its internal orifice on cricopharynxgeus

B. Cystic hygroma is filled with clear lymph

C. Thyroglossal cyst moves upwards on swallowing, and tongue protrusion

D. Fluctuation is positive in branchial cyst

See Answer in Part B → Q8

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Q9: Which of the following structures is most likely to be injured, leading to lower lip paralysis in a 30-year-old teacher who underwent parotidectomy? (Q856747)

A. Temporal branch of the facial nerve

B. Cervical branch of facial nerve

C. Parotid duct

D. Mandibular branch of facial nerve

See Answer in Part B → Q9

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Q10: Which part of cranial fossa is injured in Raccoon eyes? (Q820177)

A. Anterior cranial fossa

B. Middle cranial fossa

C. Posterior cranial fossa

D. Bone aponeurotic layer

See Answer in Part B → Q10

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Q11: Which statement regarding retrosternal goitre is accurate? (Q855029)

A. Operated in all patients regardless of symptoms

B. Sternal incision is always required to operate

C. It receives blood supply from the thoracodorsal artery

D. Most of the retrosternal goitres can be removed by a neck incision

See Answer in Part B → Q11

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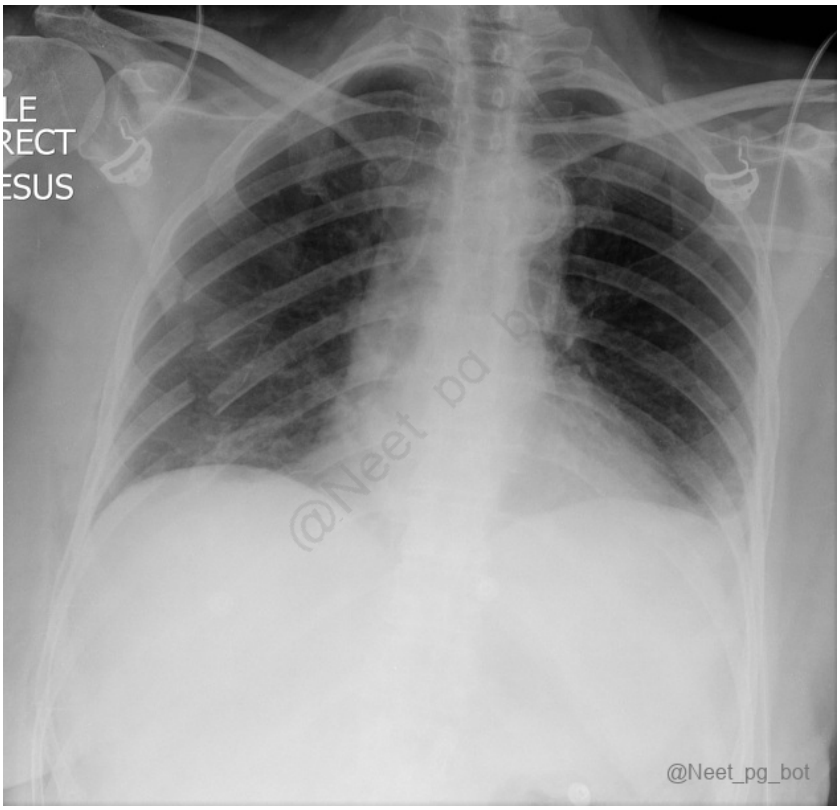
Q12: A car driver was brought into the A & E following a RTA with complaints of breathlessness. On examination, his vitals are PR-112/min, BP-100/70, SpO2-90 %, and there is extensive bruising on his chest. What is the management of this patient? (Q859614)

A. Chest tube drainage

B. 24% oxygen

C. IPPV

D. Internal operative fixation of the fracture’s segments



See Answer in Part B → Q12

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Q13: Which of the following tests would a surgeon advise first in a patient with a large thyroid swelling? (Q859615)

A. Ultrasound of the neck

B. FNAC

C. Biopsy

D. Radioiodine uptake

See Answer in Part B → Q13

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Q14: A 32-year-old patient who is a chronic alcoholic presents with oral ulcers and a burning sensation. A picture of the oral cavity is given below. What is the most likely diagnosis? (Q855770)

A. Leukoplakia

B. Erythroplakia

C. Submucosal fibrosis

D. Malakoplakia



See Answer in Part B → Q14

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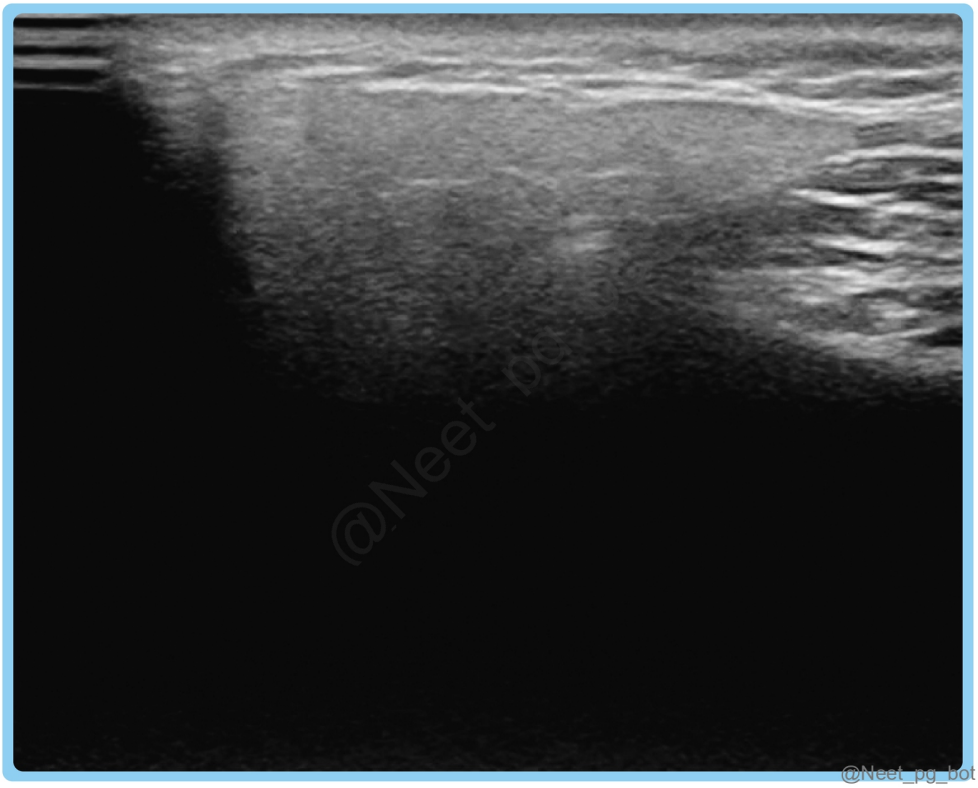
Q15: A 45-year-old patient complained of pain in one side of the neck. She is afraid of eating food as it worsens the pain. Ultrasound imaging of the salivary glands is done and shown below. What is the most likely diagnosis? (Q855805)

A. Sialolithiasis

B. Foreign body

C. Osteoma of the floor of the mouth

D. Cervical lymphadenopathy



See Answer in Part B → Q15

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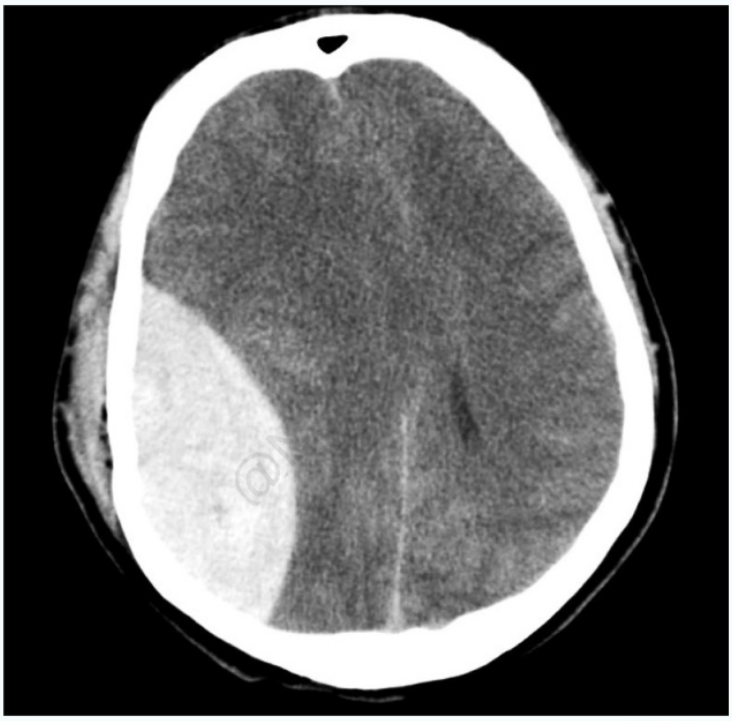
Q16: A 30-year-old patient of RTA was brought to the emergency department. There was a history of vomiting. The patient was initially conscious and oriented, but after a few hours, he became drowsy and then progressed to stupor and coma. This sequence of lucid interval was followed by neurological deterioration. What is the preferred treatment option? (Q879144)

A. Wait for spontaneous resolution

B. Burr hole and evacuation

C. Craniotomy

D. Conservative management with IV mannitol



See Answer in Part B → Q16

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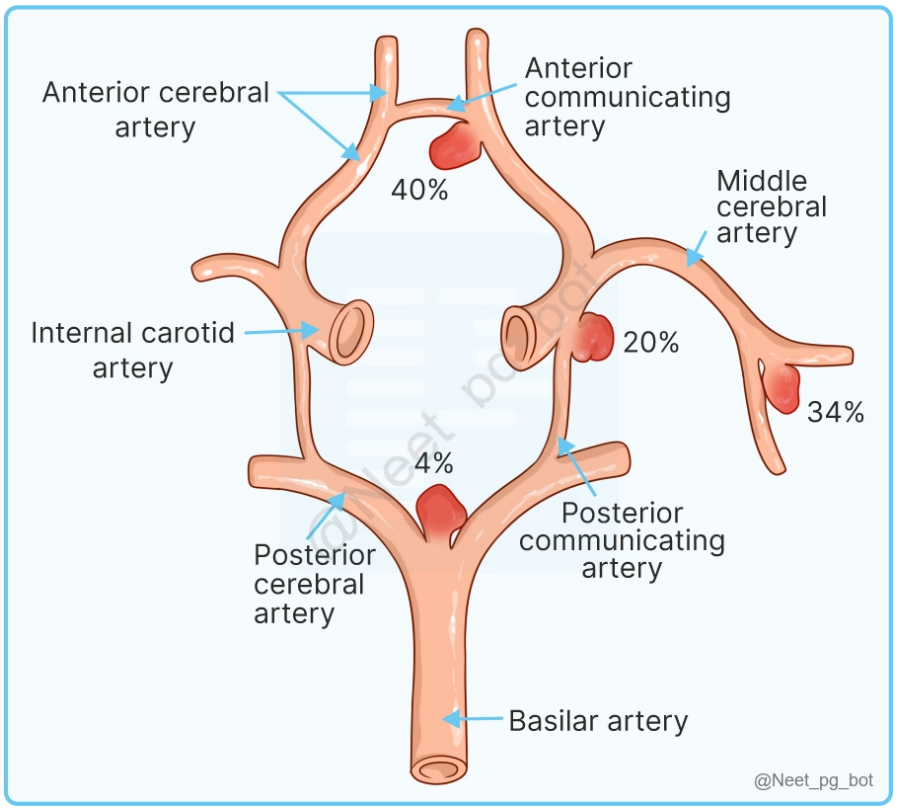
Q17: What is the most common site of a Berry aneurysm in the circle of Willis? (Q879234)

A. Anterior cerebral artery

B. Middle cerebral artery

C. Basilar artery

D. Vertebral artery



See Answer in Part B → Q17

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Q18: In modified radical neck dissection, which of the following structures is NOT preserved? (Q860278)

A. Sternocleidomastoid muscle

B. Internal jugular vein

C. Spinal accessory nerve

D. Submandibular gland

See Answer in Part B → Q18

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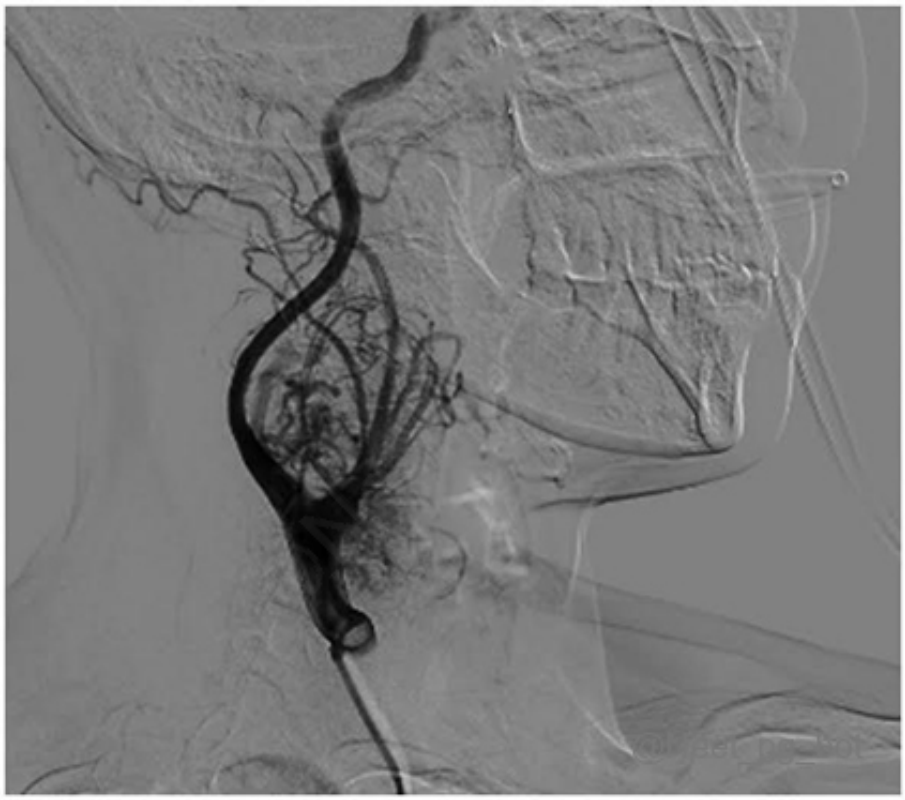
Q19: History of pulsatile mass in the neck. Digital angiography image shown. Not filling on carotid compression. But refilling on releasing pressure. What is the diagnosis? (Q866454)

A. Carotid Aneurysm

B. Carotid Body tumour

C. AV fistula

D. Haemangioma



See Answer in Part B → Q19

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Q20: An elderly male presents with foul-smelling breath and dysphagia. A barium swallow X-ray is provided. What is the most likely diagnosis? (Q853043)

A. ■■■Tracheoesophageal fistula

B. Achalasia cardia

C. Carcinoma esophagus

D. Zenker's diverticulum



See Answer in Part B → Q20

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Q21: A 60 y/o male suddenly experiences an intense headache, described as the worst headache of his life, followed by vomiting and photophobia. O/E he has neck stiffness and a dilated pupil on the right side. A CT scan reveals bleeding in the subarachnoid space. Which of the following is the most common cause of this condition? (Q852704)

A. Hypertension

B. Intracranial aneurysm

C. Arteriovenous malformation (AVM)

D. Brain tumour

See Answer in Part B → Q21

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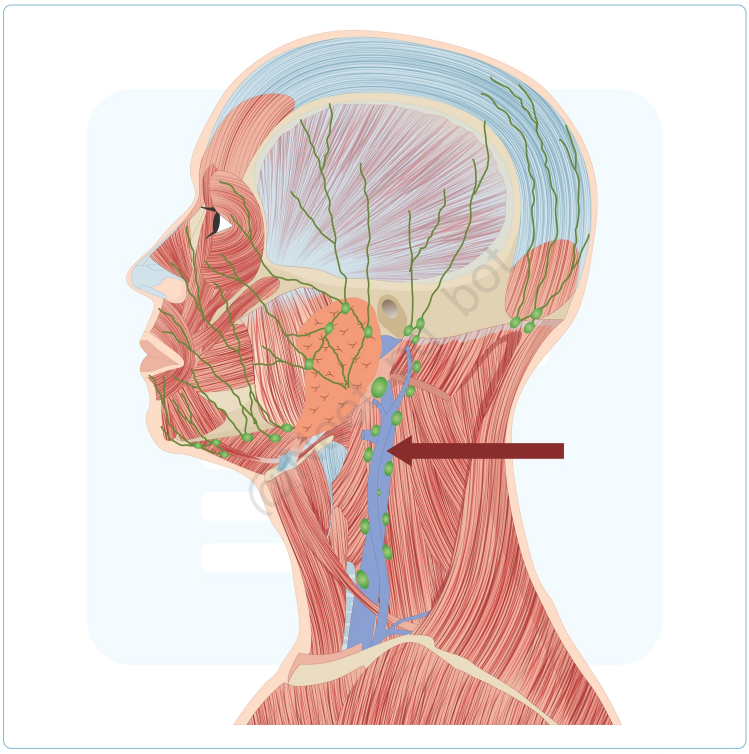
Q22: Identify the level of lymph nodes indicated in the marked region of the neck in the given anatomical image. (Q852717)

A. Level II

B. Level Ia

C. Level Ib

D. Level IV


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See Answer in Part B → Q22

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Q23: Which of the following is an indication for adjuvant radiotherapy in oral malignancy after resection and modified radical neck dissection (MRND)? (Q844310)

A. Extranodal extension

B. Multiple lymph node metastasis

C. T3 tumor

D. Close margin

See Answer in Part B → Q23

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Q24: In the evaluation of squamous cell carcinoma (SCC) of the lip, which biopsy technique is considered most appropriate for obtaining a representative tissue sample for histopathological diagnosis? (Q844291)

A. Superficial shave biopsy of the tumor surface

B. Complete excision of the lesion

C. Incisional biopsy including both tumor and adjacent normal tissue

D. Punch biopsy limited to the ulcerated surface

See Answer in Part B → Q24

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Q25: A 65-year-old smoker presents with ulcerative lesions on his lower lip for the past year. On examination, there is a palpable ipsilateral submental lymph node approximately 5x5 cm. A biopsy from the lesion is suggestive of squamous cell carcinoma. What is the next step in management? (Q860454)

A. Radiotherapy

B. Combined chemoradiotherapy

C. Resection with primary closure alone

D. Resection of primary lesion with lip reconstruction and MRND



See Answer in Part B → Q25

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Q26: A patient arrives at the emergency department following severe maxillofacial trauma sustained in a road traffic accident. The airway is compromised, and immediate intervention is required. What is the most appropriate immediate management? (Q860234)

A. Tracheostomy

B. Orotracheal intubation

C. Cricothyroidotomy

D. Bag mask with jaw thrust

See Answer in Part B → Q26

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Q27: A child presented with the following findings and is planned to undergo surgery, which muscle will be repaired during surgery? (Q865320)

A. Orbicularis oris

B. Orbicularis oculi

C. Zygomaticus major

D. Levator alae nasi



See Answer in Part B → Q27

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Q28: Which among the following is the most common parotid gland tumour? (Q860295)

A. Pleomorphic adenoma

B. Warthin’s tumor

C. Adenoid cystic carcinoma

D. Mucoepidermoid carcinoma

See Answer in Part B → Q28

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Q29: What is the most likely diagnosis for a young patient under 5 years of age presenting with a painless, soft, fluctuating mass on the lateral side of the neck? (Q860298)

A. Thyroglossal cyst

B. Cystic hygroma

C. Cervical lymphadenopathy

D. Ranula



See Answer in Part B → Q29

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Q30: What is the condition depicted in the given image, and what is the next investigation required for management? (Q860313)

A. Erythroplakia and biopsy

B. Erythroplakia and observation

C. Leukoplakia and biopsy

D. Leukoplakia and observation



See Answer in Part B → Q30

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Q31: Match the following features seen due to compression of the following structures in the case of thyroid swelling: Structure Features 1. Trachea a. Hoarseness 2. Esophagus b. Horner syndrome 3. Sympathetic chain c. Dyspnea 4. Recurrent laryngeal nerve d. Dysphagia (Q857298)

A. 1-c, 2-d, 3-b, 4-a

B. 1-d, 2-c, 3-a, 4-b

C. 1-a, 2-d, 3-b, 4-c

D. 1-c, 2-a, 3-d, 4-b

See Answer in Part B → Q31

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Q32: ABCD 2 scoring includes all the following parameters except? (Q820103)

A. Age

B. Hypertension

C. History of stroke

D. Diabetes Mellitus

See Answer in Part B → Q32

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Q33: A 25-year-old patient had a RTA and was brought to the emergency room with bradycardia and a high BP. The GCS of this patient is < 8. What should be the immediate management in this patient? (Q820119)

A. Urgent CT head

B. Intubate and IPPV

C. Thrombolysis

D. Normal saline infusion

See Answer in Part B → Q33

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Q34: What is the Intubation of choice in a Maxillofacial trauma patient? (Q820169)

A. Tracheostomy

B. Laryngeal mask airway

C. Orotracheal intubation

D. Mask ventilation

See Answer in Part B → Q34

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Q35: A 50-year-old male chronic smoker came to OPD with cough, dyspnea, and difficulty swallowing . A palpable lump was present in the neck. Which of the following are smokers most likely to develop? (Q793891)

A. Adenocarcinoma

B. Squamous cell carcinoma

C. Large cell carcinoma

D. Adenoid cystic carcinoma

See Answer in Part B → Q35

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• [03_Cardiothoracic Vascular Surgery] 008 Arterial Disorders - I

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[03_Cardiothoracic Vascular Surgery] 008 Arterial Disorders - I — Quick Jump

Q1 (p. 107)	*Q2 (p. 107)*	*Q3 (p. 108)*	*Q4 (p. 108)*	*Q5 (p. 108)*	*Q6 (p. 109)*
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Q25 (p. 118)					

Q1: A 62-year-old male patient is having complaints of loss of vision in the form of a curtain coming down in front of the right eye. He has a history of 2 episodes of strokes, after which he has left-sided sensory and motor loss limited to the face and neck. Which of the following blood vessels might be stenosed in this case? (Q849435)

A. Left vertebral artery

B. Carotid artery

C. First part of the left subclavian artery

D. Superior mesenteric vein

See Answer in Part B → Q1

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Q2: A 67-year-old male was having complaints of sudden onset of severe chest pain, which was radiating to his back, and suddenly, he went unconscious. He was chronically hypertensive, a drug defaulter, and was having weakness, dizziness and dyspnea for 1 day. His current BP is 90/50 mm Hg, and his Heart Rate is 140 bpm. What is the best investigation of choice in this condition? (Q849415)

A. CT Angiography

B. Aortography

C. Trans Esophageal Echocardiography

D. Chest x-ray

See Answer in Part B → Q2

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Q3: Which of the following signs is seen in Arteriovenous fistula? (Q849404)

A. Murphy’s sign

B. Brudzinski’s sign

C. Hegar’s sign

D. Nicoladoni’s sign

See Answer in Part B → Q3

@Neet_pg_bot

Q4: A 35-year-old female experiences numbness and tingling in her right arm, worsened by arm elevation. During examination, she abducts her arms to 90° with external rotation, flexes her elbows to 90°, and opens and closes her hands for 3 minutes, which reproduces her symptoms. Which test was most likely performed? (Q849407)

A. Adson's Test

B. Roos Test

C. Wright's Test

D. Elvey Test

See Answer in Part B → Q4

@Neet_pg_bot

Q5: A 23-year-old competitive swimmer presents with progressive weakness and tingling in his right hand. On examination, there is wasting of the small muscles of the

hand and sensory loss in the medial side of the hand and forearm. Which of the following nerves is most likely compressed in this patient? (Q849406)

A. Median nerve (C5-T1

B. Ulnar nerve (C8-T1)

C. Radial nerve (C5-T1)

D. Axillary nerve (C5-C6)

See Answer in Part B → Q5

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Q6: Which of the following is the most preferred vascular graft for CABG? (Q849434)

A. Long saphenous vein

B. Dacron

C. Polyurethane

D. Left Internal Mammary Artery

See Answer in Part B → Q6

@Neet_pg_bot

Q7: A 48-year-old male presents with retrosternal chest pain, which was radiation to the left arm and shoulder. He has a previous history of acute myocardial infarction. CABG was advised, but the patient is insisting on using synthetic graft and wants to know more about it. Which of the following is the most preferred synthetic vascular graft for CABG? (Q849433)

A. Polyurethane

B. ePTFE

C. Dacron

D. Long saphenous vein

See Answer in Part B → Q7

@Neet_pg_bot

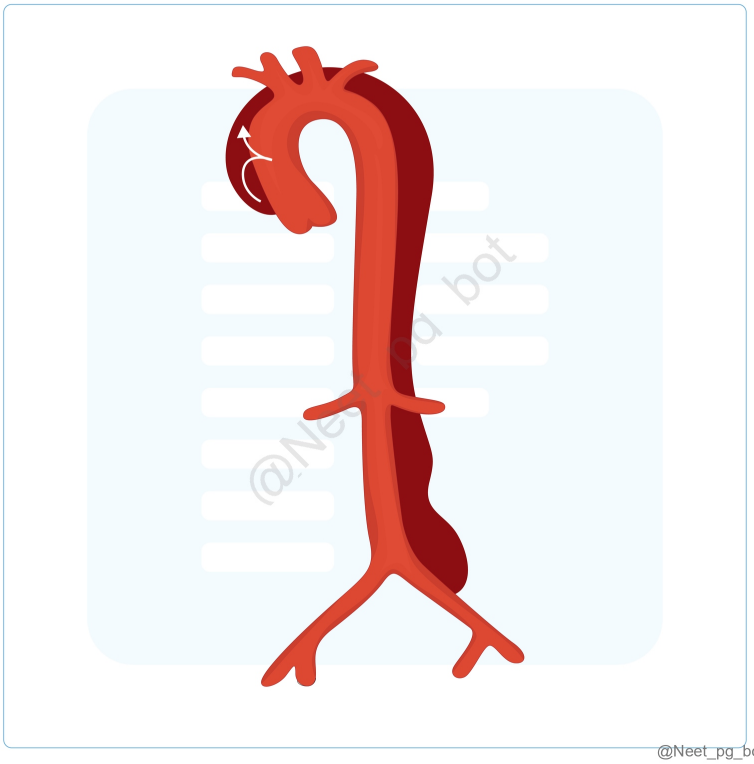
Q8: Based on the Stanford classification, which type of aortic dissection is shown below? (Q849418)

A. Type A

B. Type B

C. Type C

D. Type D



See Answer in Part B → Q8

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Q9: A 72-year-old male with a history of hypertension and smoking presents with back pain, and imaging shows a thoracoabdominal aortic aneurysm starting at the sixth intercostal space and extending to just above the renal arteries. According to the Crawford classification, which type does this aneurysm correspond to? (Q849413)

A. Type I

B. Type II

C. Type III

D. Type V

See Answer in Part B → Q9

@Neet_pg_bot

Q10: A 65-year-old male with a history of hypertension and smoking presents with an abdominal aortic aneurysm measuring 6.0 cm in diameter, detected during routine surveillance. Which of the following is the most appropriate next step in the management of this patient? (Q849412)

A. Regular ultrasound surveillance every 6 months

B. Begin beta-blocker therapy

C. Endovascular aneurysm repair

D. Lifestyle modifications and smoking cessation

See Answer in Part B → Q10

@Neet_pg_bot

Q11: A 45-year-old male with a history of bacterial endocarditis presents with sudden onset of severe headache, nausea, and vomiting. A CT scan of the head is shown below. Which of the following is the most likely cause of the haemorrhage in this patient? (Q849411)

A. Ruptured berry aneurysm

B. Traumatic brain injury

C. Hypertensive intracerebral haemorrhage

D. Ruptured mycotic aneurysm



See Answer in Part B → Q11

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Q12: A 58-year-old male presents with a pulsatile mass in the right groin following recent arterial catheterisation. Doppler ultrasound reveals an aneurysm. Which characteristic best describes this type of aneurysm? (Q849410)

A. Involves all three arterial wall layers

B. Fusiform dilation of the artery.

C. Wall composed of fibrous tissue only

D. Commonly caused by atherosclerosis

See Answer in Part B → Q12

@Neet_pg_bot

Q13: A 65-year-old male with a history of atrial fibrillation presents to the emergency department with sudden, severe abdominal pain that is disproportionate to physical examination findings. He also reports vomiting and the passage of blood in his stool. Given his history and clinical presentation, which artery is most likely involved in this patient's condition? (Q849409)

A. Superior Mesenteric Vein

B. Superior Mesenteric Artery

C. Inferior Mesenteric Artery

D. Inferior Mesenteric Vein

See Answer in Part B → Q13

@Neet_pg_bot

Q14: A 24-year-old woman presents with episodic colour changes in her fingers triggered by cold temperatures and stress. The episodes follow a characteristic sequence. What is the correct sequence of events in the skin colour changes seen in the Raynaud phenomenon? (Q849408)

A. Rubor → Cyanosis → Pallor

B. Cyanosis → Pallor → Rubor

C. Pallor → Cyanosis → Rubor

D. Rubor → Pallor → Cyanosis

See Answer in Part B → Q14

@Neet_pg_bot

Q15: A 58-year-old male presents to the emergency department with a sudden onset of severe pain in his left leg. The leg appears pale and feels cold to the touch, and the

patient is unable to move or feel his toes. On examination, no pulses are detectable below the knee. What is the most likely diagnosis? (Q849347)

A. Deep vein thrombosis

B. Acute limb ischemia

C. Chronic venous insufficiency

D. Cellulitis

See Answer in Part B → Q15

@Neet_pg_bot

Q16: A 65-year-old male presents with a sudden onset of severe pain in his left leg, which has become cold and pale. On examination, there is an absence of distal pulses. Imaging reveals a large saddle embolus at the aortic bifurcation. What is the most appropriate catheter to use for embolectomy in this case? (Q849405)

A. Seldinger catheter

B. Swan-Ganz catheter

C. Fogarty catheter

D. Tenckhoff catheter

See Answer in Part B → Q16

@Neet_pg_bot

Q17: A 60-year-old male with end-stage renal disease is scheduled for the creation of a surgically created arteriovenous (AV) fistula to facilitate long-term hemodialysis. Which of the following is the most commonly used type of AV fistula for this purpose? (Q849401)

A. Cimino-Brescia fistula

B. Blalock-Taussig shunt

C. Snuff box fistula

D. Axillary-axillary loop graf

See Answer in Part B → Q17

@Neet_pg_bot

Q18: A 46-year-old male presents with intense pain in his left leg along with the following lesion. Which of the following is the most probable diagnosis? (Q849399)

A. Neuropathic ulcer

B. Venous ulcer

C. Arterial ulcer

D. Pressure ulcer



See Answer in Part B → Q18

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Q19: A 35-year-old male with a 12-year history of smoking presents with severe rest pain and discoloration of the left lower limb's digits as shown below. He has experienced worsening pain in this limb for the past 2 days, following 3 months of discomfort. What is the appropriate management for this condition? (Q849394)

A. Lumbar sympathectomy

B. Abstinence from smoking

C. Amputation

D. Vasodilators



See Answer in Part B → Q19

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Q20: A 56-year-old male presents with sudden pain and numbness in his right lower limb for 1 day. On examination, the limb is cold and pale and exhibits loss of sensory and mild motor functions. Doppler studies reveal only venous signals. What grade of Rutherford's classification is this case? (Q849393)

A. Grade I

B. Grade IIA

C. Grade IIB

D. Grade III

See Answer in Part B → Q20

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Q21: A 38-year-old chronic smoker presents with lower limb pain during walking for 2 weeks. Examination reveals an ankle-to-brachial systolic pressure ratio of 0.7. What is the correct interpretation of this finding? (Q849392)

A. Critical limb ischemia

B. Intermittent claudication

C. Normal index

D. Calcified vessels

See Answer in Part B → Q21

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Q22: What is the most specific investigation of choice for peripheral arterial disease? (Q849391)

A. Ankle-Brachial Index

B. Duplex ultrasonography

C. CT angiography

D. Magnetic Resonance Angiography

See Answer in Part B → Q22

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Q23: A 65-year-old man presents with pain in his right calf that occurs after walking 200 meters and is relieved by rest. The pain does not occur when he is at rest or when he walks shorter distances. Based on Boyd's classification of intermittent claudication,

which grade best describes this patient's condition? (Q849390)

A. Grade 0

B. Grade I

C. Grade II

D. Grade III

See Answer in Part B → Q23

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Q24: A 40-year-old male presents with pain in his hands and feet, which worsens with cold exposure. He has a history of heavy smoking. On examination, he has ulcers on his fingers and toes. Angiography reveals "corkscrew" collaterals and segmental occlusions. Which of the following conditions is most likely in this patient? (Q849389)

A. Systemic sclerosis

B. Thromboangiitis obliterans

C. Atherosclerosis

D. Frostbite

See Answer in Part B → Q24

@Neet_pg_bot

Q25: A 72-year-old man presents with a sudden onset of severe pain, numbness, and coldness in his left leg. On examination, the left leg appears pale, and no pulse is palpable below the femoral artery. What is the most probable cause of this acute peripheral arterial occlusion? (Q849388)

A. Atherosclerosis

B. Buerger's disease

C. Fibromuscular dysplasia

D. Arterial dissection

See Answer in Part B → Q25

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• [03_Cardiothoracic Vascular Surgery] 009 Venous Disorders - I

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[03_Cardiothoracic Vascular Surgery] 009 Venous Disorders - I — Quick Jump

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Q25 (p. 130)	*Q26 (p. 131)*				

Q1: A 62-year-old male presents with left leg swelling and pain for 5 days and has a positive D-dimer test. Duplex ultrasonography confirms an extensive DVT involving the left popliteal and femoral veins. Which of the following is the most appropriate initial management strategy? (Q849439)

A. Unfractionated heparin followed by warfarin

B. LMWH followed by oral anticoagulant

C. Catheter-directed thrombolysis

D. IVC filter placement

See Answer in Part B → Q1

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Q2: An infant presents with a large, rapidly growing vascular malformation, along with severe thrombocytopenia and microangiopathic hemolytic anemia. What is the most likely diagnosis? (Q849459)

A. Klippel-Trénaunay Syndrome

B. Kasabach-Merritt Syndrome

C. Sturge-Weber Syndrome

D. Capillary Hemangioma

See Answer in Part B → Q2

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Q3: A 50-year-old man presents with prominent varicose veins on his medial thigh and calf. Upon examination, incompetence of the great saphenous vein (GSV) is identified. The surgeon is considering the appropriate surgical intervention. What is the primary indication for performing Saphenofemoral Junction Ligation and GSV Stripping? (Q849455)

A. Varicose veins on the posterolateral calf due to small saphenous vein incompetence

B. Incompetence of the great saphenous vein with varicose veins on the medial thigh and calf

C. Varicose veins on the anterior thigh due to incompetent perforator veins

D. Small varicose veins unsuitable for endovenous ablation

See Answer in Part B → Q3

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Q4: A 55-year-old male with chronic venous insufficiency presents with a venous ulcer on his lower leg. He has a history of prolonged standing at work and reports aching and heaviness in his legs. What is correct regarding compression therapy in this patient? (Q849453)

A. Class 1 compression hosiery exerts 18-24 mmHg of pressure

B. Compression bandaging typically exerts less pressure than compression hosiery

C. Compression bandaging should be avoided in patients with a history of venous ulcers

D. Compression therapy is most effective when it exerts a graduated pressure to promote venous return

See Answer in Part B → Q4

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Q5: Which of the following statements about the pathophysiology of varicose veins is incorrect? (Q849447)

A. Defects in the walls or valves of the veins lead to retrograde blood flow.

B. Inflammatory changes in walls lead to dilatation, elongation and valvular dysfunction.

C. The veins have a low end-diastolic volume.

D. Chronic ambulatory venous hypertension develops.

See Answer in Part B → Q5

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Q6: A patient comes to the surgery OPD complaining of small swellings and a wound on his right lower leg. On clinical evaluation, he is found to have hyperpigmentation in his right leg around the ankle and lower third of the leg. He also has a healed venous ulcer and is symptomatic. According to the CEAP classification, what is the clinical stage of the disease in this case? (Q849449)

A. C5a

B. C5s

C. C3r

D. C6

See Answer in Part B → Q6

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Q7: A 50-year-old woman with inflammatory bowel disease presents with a painful ulcer on her leg. The ulcer has a necrotic edge and a purulent base, with significant surrounding erythema. What type of ulcer is most consistent with this presentation? (Q849461)

A. Neurotrophic ulcer

B. Pyoderma gangrenosum

C. Venous ulcer

D. Arterial ulcer

See Answer in Part B → Q7

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Q8: A 62-year-old man has a chronic ulcer on his leg from a burn injury sustained 12 years ago. Recently, the ulcer has developed indurated, painless, raised edges and surrounding fibrosis. What is the most likely diagnosis? (Q849460)

A. Venous ulcer

B. Pressure ulcer

C. Marjolin’s ulcer

D. Actinic keratosis

See Answer in Part B → Q8

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Q9: A 64-year-old woman is scheduled for the great saphenous vein (GSV) stripping to treat her varicose veins. What is the most likely nerve injury she might experience post-operatively? (Q849458)

A. Sural nerve

B. Common peroneal nerve

C. Saphenous nerve

D. Tibial nerve

See Answer in Part B → Q9

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Q10: A patient with chronic venous insufficiency presents with symptomatic varicose veins. The physician decides to use foam sclerotherapy, specifically the Tessari technique, to treat the affected veins. What is the typical ratio of sclerosant to air used in the Tessari technique for creating the foam? (Q849457)

A. 1:1

B. 1:2

C. 1:3

D. 1:6

See Answer in Part B → Q10

@Neet_pg_bot

Q11: Which of the following statements best describes the difference between Dodd and Cockett surgeries? (Q849456)

A. Dodd: ligation in the thigh; Cockett: ligation in the lower leg

B. Dodd: open surgery; Cockett: endoscopic

C. Dodd: targets superficial veins; Cockett: targets deep veins

D. Dodd: higher risk of nerve injury; Cockett: lower risk

See Answer in Part B → Q11

@Neet_pg_bot

Q12: A 45-year-old woman presents with symptomatic varicose veins. She is interested in learning about the available treatment options and their benefits. Her primary concern is to minimize recovery time and reduce post-operative pain. Which of the following surgical approaches is most appropriate for this patient? (Q849454)

A. Saphenofemoral ligation and great saphenous stripping

B. Saphenopopliteal junction ligation and small saphenous stripping

C. Endovenous laser ablation (EVLA)

D. Phlebectomy as a standalone procedure

See Answer in Part B → Q12

@Neet_pg_bot

Q13: A 45-year-old male presents with chronic leg pain, swelling, and visible varicose veins. A duplex ultrasound is performed to assess venous function. Which of the following statements is TRUE regarding interpreting the duplex scan in this patient? (Q849452)

A. The duplex scan should be performed with the patient in a supine position

B. A reflux time of less than 500 milliseconds is clinically significant

C. Presence of perforator vein with a diameter >3.5 mm is significant

D. The duplex scan is primarily used to locate perforating veins

See Answer in Part B → Q13

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Q14: The following test was conducted in the clinic for a patient suffering from varicose veins. On releasing only tourniquet 3, the filling of blood was observed. What does this signify? (Q849451)

A. Hunterian’s perforator incompetence

B. Boyd’s perforator incompetence

C. Dodd’s perforator incompetence

D. Cockett’s perforator incompetence



See Answer in Part B → Q14

@Neet_pg_bot

Q15: A patient with varicose veins is being examined in the surgical OPD. The Brodie-Trendelenburg I test is done for the patient, and the surgeon notices that blood is filling from above. What does this signify? (Q849450)

A. Valvular incompetence

B. Perforator incompetence

C. Sapheno-femoral incompetence

D. Presence of DVT

See Answer in Part B → Q15

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Q16: A 45-year-old man presents with left leg swelling and pain for 3 days. Duplex ultrasonography reveals a thrombus in the popliteal vein. Which of the following veins is most likely to be involved next in the progression of this DVT? (Q849436)

A. Great saphenous vein

B. Common femoral vein

C. Posterior tibial vein

D. External iliac vein

See Answer in Part B → Q16

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Q17: After noticing small swellings over his legs, a 60-year-old man comes to the surgical OPD. He is a tailor by occupation and works long hours. He explains that he experiences a heaviness and aching in the legs after a long day of work but is relieved once he elevates his legs and rests. Which of the following is not a more severe sign of this disease? (Q849448)

A. Thrombophlebitis

B. Lipodermatosclerosis

C. Ulceration

D. Pedal edema

See Answer in Part B → Q17

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Q18: A 50-year-old woman presents with visible, dilated veins on both legs. She has a history of two pregnancies and works as a retail clerk. On examination, the dilated veins are most prominent along the posterior aspect of her calves. Which of the following describes the classification of her varicose veins based on the involved venous system? (Q849446)

A. Great Saphenous Vein System

B. Small Saphenous Vein System

C. Non-saphenous veins

D. Perforator veins

See Answer in Part B → Q18

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Q19: A 55-year-old woman presents with varicose veins in her left leg. On examination, you notice dilated, tortuous veins along the posterior aspect of her calf and lateral thigh. To accurately map the incompetent veins for potential treatment, which of the following describes the most likely location of the Boyd perforator vein? (Q849445)

A. Medial ankle, posterior to the medial malleolus

B. Medial calf, approximately 10 cm above the medial malleolus

C. Lateral calf, at the junction of the middle and lower thirds

D. Medial knee, approximately 10 cm below the knee joint line

See Answer in Part B → Q19

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Q20: A 55-year-old woman presents with recurrent episodes of tender, erythematous cord-like swellings along different superficial veins of her lower extremities over the past 3 months. Which of the following is most likely to be associated with this presentation? (Q849444)

A. Recent childbirth

B. Thromboangiitis obliterans

C. Pancreatic malignancy

D. Polycythemia vera

See Answer in Part B → Q20

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Q21: A 20-year-old competitive swimmer presents with a 2-day history of left arm pain, swelling, and mild discoloration after intense training. Duplex ultrasound shows a thrombus in the left subclavian vein. What is the most likely diagnosis? (Q849443)

A. Thoracic outlet syndrome

B. Paget-Schrotter syndrome

C. Raynaud's phenomenon

D. Lymphedema

See Answer in Part B → Q21

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Q22: A 30-year-old woman is in the post-operative ward after a cesarean section. She had no complications and gave birth to a healthy baby. Which of the following is a prophylactic step she needs to be advised to prevent deep vein thrombosis? (Q849442)

A. Early mobilization along with compression stockings

B. Low molecular weight heparin

C. Low-dose unfractionated heparin

D. Fondaparinux

See Answer in Part B → Q22

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Q23: A patient came with complaints of discoloration of his left leg as shown in the image. He has a history of deep vein thrombosis and has been inconsistent on medication. What is the possible diagnosis here? (Q849441)

A. Venous gangrene

B. Venous ulcer

C. Atrophic blanche

D. Post-thrombotic leg



See Answer in Part B → Q23

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Q24: A 45-year-old man with metastatic colorectal cancer is diagnosed with an acute DVT of the left leg. He had an episode of upper GI bleed 2 days ago. His lab results show a platelet count of 40,000/μL and an INR of 1.8. Which of the following is the most appropriate management strategy for preventing pulmonary embolism in this patient? (Q849440)

A. Start anticoagulation with LMWH

B. Place a permanent IVC filter

C. Place a retrievable IVC filter

D. Start anticoagulation with UFH

See Answer in Part B → Q24

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Q25: A 45-year-old man with a history of colorectal cancer underwent surgery 3 weeks ago and is now presenting with complaints of left leg swelling and pain for 3

days. His left calf is 4 cm larger than the right. Using Wells' criteria for DVT, what is his pre-test probability score and risk category? (Q849438)

A. 2 points; Moderate risk

B. 5 points; High risk

C. 3 points; Moderate risk

D. 4 points; High risk

See Answer in Part B → Q25

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Q26: A 52-year-old male presents with a swollen, painful left calf that developed over the past two days. He reports no history of trauma, surgery, or prolonged immobility. Physical examination reveals a warm, erythematous, and tender left calf. Which of the following clinical features is most specific for diagnosing deep vein thrombosis? (Q849437)

A. Calf pain on dorsiflexion of the foot

B. Asymmetrical calf swelling

C. Pain that worsens with leg elevation

D. Localized tenderness along the course of the deep veins

See Answer in Part B → Q26

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[03_Cardiothoracic Vascular Surgery] 010 Lymphatic System — Quick Jump

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Q1: A 40-year-old female presents with persistent swelling in her lower legs. Upon physical examination, the swelling is noted to be non-pitting, and the patient has no signs of irreversible skin changes. What is the most appropriate Brunner's classification grade for her condition? (Q849351)

A. Subclinical/latent

B. Grade I

C. Grade II

D. Grade III

See Answer in Part B → Q1

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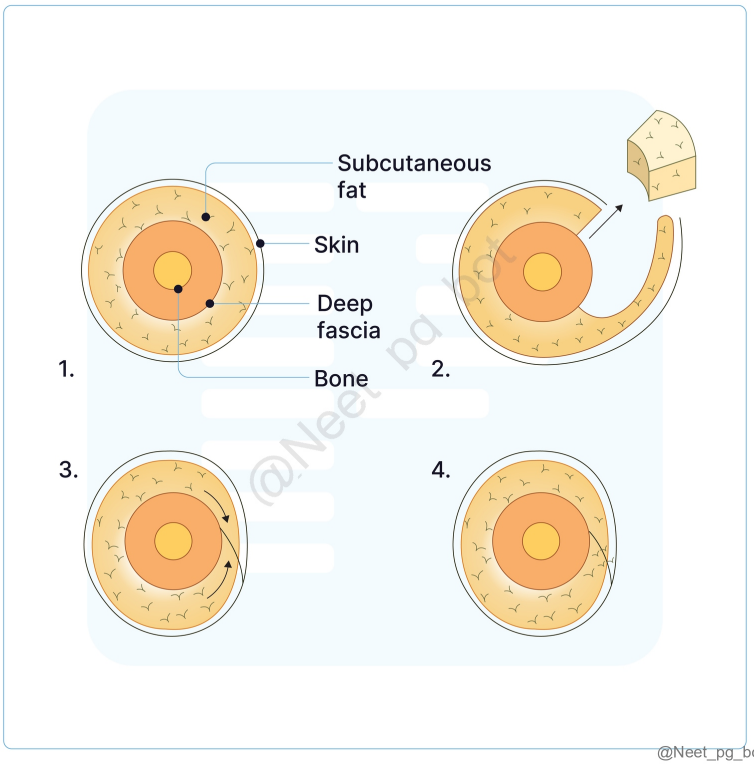
Q2: A 60-year-old female with severe lymphedema of the lower limb, not responding to conservative therapies. Due to persistent swelling and functional impairment, she undergoes surgical intervention. An image of the surgical procedure is shown below. What is the procedure known as? (Q849354)

A. Thompson Procedure

B. Charles Procedure

C. Nielubowicz Operation

D. Kinmonth procedure



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See Answer in Part B → Q2

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Q3: A patient with breast carcinoma after 11 years of Modified radical mastectomy and radiotherapy, now presents with pain, skin nodules and worsening of swelling of left arm as shown in the image below. What is the most probable diagnosis? (Q849356)

A. Lymphangiosarcoma

B. Venous thrombosis

C. Cellulitis

D. Lymphedema



See Answer in Part B → Q3

@Neet_pg_bot

Q4: A patient with chronic lymphedema is being evaluated for surgical management. Which of the following is not a reduction procedure for lymphedema? (Q889676)

A. Liposuction

B. Charles' procedure

C. Homans' procedure

D. Lymphatic–venous shunt

See Answer in Part B → Q4

@Neet_pg_bot

Q5: A 35-year-old man presents to the emergency department with a rapidly spreading reddish streak on his left arm, accompanied by fever and swollen axillary lymph nodes. He reports sustaining a small cut on his hand two days ago while gardening. Physical examination reveals a tender, warm, erythematous streak extending from the hand to the upper arm, with blanching on pressure. What is the next best step in the management of this patient? (Q849348)

A. Immediate surgical incision and drainage of the affected area

B. Oral antihistamines and topical corticosteroids

C. Limb elevation and initiation of intravenous antibiotics like penicillin or cloxacillin

D. Watchful waiting for 48 hours before initiating any treatment

See Answer in Part B → Q5

@Neet_pg_bot

Q6: A patient with chronic lymphedema is advised decongestive lymphatic therapy (DLT). Which of the following is not a component of decongestive lymphatic therapy? (Q889675)

A. Manual lymphatic drainage

B. Compression therapy

C. Regular diuretic therapy

D. Limb elevation

See Answer in Part B → Q6

@Neet_pg_bot

Q7: What is the most common site of mediastinal lymphoma? (Q889673)

A. Anterior mediastinum

B. Middle mediastinum

C. Posterior mediastinum

D. Superior mediastinum

See Answer in Part B → Q7

@Neet_pg_bot

Q8: A 60-year-old woman has had chronic lower-limb lymphedema for 15 years following cancer surgery. She presents for routine follow-up. Which of the following is not a complication of chronic lymphedema? (Q889672)

A. Recurrent cellulitis

B. Stewart-Treves Syndrome

C. Fibrosis

D. Venous ulcer

See Answer in Part B → Q8

@Neet_pg_bot

Q9: Direct contrast lymphangiography is planned in a patient with a suspected lymphatic abnormality. Which of the following statements regarding this procedure is true? (Q889670)

A. It is a noninvasive imaging technique requiring no anaesthesia

B. Contrast is injected rapidly into a peripheral vein

C. Cannulation is usually performed on lymphatic vessels at the dorsum of the foot

D. It is commonly used as a routine diagnostic test for lymphedema

See Answer in Part B → Q9

@Neet_pg_bot

Q10: A newborn is noted to have bilateral, non-pitting swelling of the feet and lower legs present since birth, as shown in the image. Examination shows thickened skin and prominent veins over the dorsum of the feet. The child's father has similar leg swelling. There is no history of surgery, infection, or trauma. Which of the following statements regarding this condition is true? (Q889667)

A. It is most commonly caused by filarial infection

B. It is inherited in an autosomal recessive pattern

C. It is associated with mutations in the FLT4 (VEGFR-3) gene

D. The lymphedema typically resolves spontaneously with age



See Answer in Part B → Q10

@Neet_pg_bot

Q11: A 52-year-old woman with a history of pelvic surgery and radiotherapy presents with long-standing swelling of the left leg.The clinical appearance is shown. Which grade of lymphedema does this most likely represent? (Q889664)

A. Grade 0

B. Grade I

C. Grade II

D. Grade III



See Answer in Part B → Q11

@Neet_pg_bot

Q12: Identify the given condition and choose among the following: {{caption_text}} (Q849357)

A. Stewart - Treves syndrome

B. Lymphedema

C. Cystic hygroma

D. Marjolin’s ulcer



See Answer in Part B → Q12

@Neet_pg_bot

Q13: A 4-month-old baby is brought to the hospital with complaints of swelling in the neck as given in the image and diagnosed as cystic hygroma. Which of the following is true regarding the condition? {{caption_text}} (Q849355)

A. Swelling presents after the age of 1 year

B. It is a benign tumor

C. Laser excision is the treatment of choice

D. The size remains constant throughout the life



See Answer in Part B → Q13

@Neet_pg_bot

Q14: Which of the following is the least preferred treatment option for early management of lymphedema? (Q849353)

A. Use of compression stockings

B. Limb elevation, regular check-up

C. Specialized complex physical therapy

D. Nielubowicz procedure

See Answer in Part B → Q14

@Neet_pg_bot

Q15: A 55-year-old male with chronic leg swelling presents with difficulty pinching the skin over the dorsum of his foot. What is this sign known as? {{caption_text}} (Q849352)

A. Buffalo hump

B. Square toes

C. Stemmer's sign

D. Merkel's sign



See Answer in Part B → Q15

@Neet_pg_bot

Q16: A 25-year-old female presents with swelling in her right calf and foot, which has gradually worsened over the past few years. She reports that the swelling started in her teenage years and has become more pronounced with time. What is the diagnosis in this patient? (Q849350)

A. Congenital lymphedema

B. Lymphedema praecox

C. Lymphedema tarda

D. None of the above

See Answer in Part B → Q16

@Neet_pg_bot

Q17: A 55-year-old woman presents with chronic swelling of her left arm. She has a history of breast cancer treatment 2 years ago. Which of the following is the most common iatrogenic cause of lymphedema in this patient's scenario? (Q849349)

A. Radiotherapy

B. Lymph node dissection

C. Chemotherapy

D. Biologic Targeted Therapy

See Answer in Part B → Q17

@Neet_pg_bot

• [03_Cardiothoracic Vascular Surgery] 011 Thorax And Mediastinum

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[03_Cardiothoracic Vascular Surgery] 011 Thorax And Mediastinum — Quick Jump

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Q1: Which of the following paraneoplastic syndromes is NOT commonly associated with small cell lung carcinoma (SCLC)? (Q849541)

A. Syndrome of Inappropriate Antidiuretic Hormone (SIADH)

B. Eaton-Lambert Syndrome

C. Hypercalcemia

D. Cushing's Syndrome

See Answer in Part B → Q1

@Neet_pg_bot

Q2: A 3-year-old child presents with a history of choking followed by intermittent coughing and wheezing. The X-ray is as follows. What is the most appropriate investigation for diagnosis and intervention? (Q849521)

A. Chest X-ray

B. CT Scan

C. Rigid Bronchoscopy

D. Flexible Bronchoscopy



See Answer in Part B → Q2

@Neet_pg_bot

Q3: A 55 y/o male with a persistent cough and occasional chest discomfort has a chest X-ray showing a 2.5 cm peripheral, sharply demarcated, lobulated mass with a "popcorn" appearance. No smoking history. What is the most likely diagnosis? (Q849522)

A. Pancoast Tumor

B. Pulmonary Hamartoma

C. Lung Abscess

D. Cystic Adenomatoid Malformation

See Answer in Part B → Q3

@Neet_pg_bot

Q4: A 45 y/o male with a 3-month history of cough, hemoptysis, and wheezing has a CXR showing a central mass obstructing the right bronchus. Biopsy reveals a low-grade malignant tumour diagnosed as bronchial adenoma. Which of the following is NOT a type of bronchial adenoma? (Q849528)

A. Adenoid Cystic Carcinoma

B. Carcinoid

C. Small Cell Carcinoma

D. Mucoepidermoid Carcinoma

See Answer in Part B → Q4

@Neet_pg_bot

Q5: A 65-y/o male, who worked for 30 years in shipbuilding, presents with a 6-month h/o progressive shortness of breath, chest pain, and significant weight loss. A CXR reveals a pleural effusion and a subsequent pleural biopsy confirms the diagnosis of malignant mesothelioma. Which subtype of malignant mesothelioma is most likely to be associated with a better prognosis in this patient? (Q849529)

A. Sarcomatoid subtype

B. Epithelial subtype

C. Mixed (biphasic) subtype

D. Both B and C

See Answer in Part B → Q5

@Neet_pg_bot

Q6: A 65 y/o male with a 30-year history in brake pad manufacturing presents with dyspnea, chest discomfort, and cough. Imaging shows pleural thickening and nodules. Biopsy confirms early-stage malignant mesothelioma. Which IHC markers and treatments are most consistent with this diagnosis? (Q849534)

A. Positive CEA, negative vimentin, treated with radiation therapy alone

B. Negative CEA, positive vimentin, treated with Extended Pleurectomy and Decortication (EPD) combined with chemotherapy

C. Positive CEA, negative cytokeratins, treated with chemotherapy only

D. Negative vimentin, positive cytokeratins, treated with Extrapleural Pneumonectomy (EPP) alone

See Answer in Part B → Q6

@Neet_pg_bot

Q7: What is the most common type of lung carcinoma? (Q849535)

A. Small cell lung carcinoma

B. Bronchogenic carcinoma

C. Adenocarcinoma

D. Squamous cell carcinoma

See Answer in Part B → Q7

@Neet_pg_bot

Q8: A 60-year-old male, with a 40-year history of smoking, presents with a persistent cough, hoarseness, and recent onset of facial swelling and distended neck veins. Imaging reveals a mass in the central region of the right lung. Based on the location and clinical features, what is the most likely diagnosis? (Q849538)

A. Adenocarcinoma

B. Squamous Cell Carcinoma (SCC)

C. Large Cell Carcinoma

D. Apical (Pancoast's) Tumor

See Answer in Part B → Q8

@Neet_pg_bot

Q9: What is the most common site of metastasis for lung cancer? (Q849539)

A. Liver

B. Brain

C. Adrenal Glands

D. Bone

See Answer in Part B → Q9

@Neet_pg_bot

Q10: A 65 y/o woman presents to the emergency with a sudden onset of shortness of breath, chest pain, and hypotension. She is diagnosed with a massive pulmonary embolism. Which of the following is the most appropriate initial treatment for this patient? (Q849520)

A. Inferior Vena Cava (IVC) Filter

B. Thrombolytic Therapy

C. Ventilator Support

D. Vitamin K Antagonists

See Answer in Part B → Q10

@Neet_pg_bot

Q11: A 65 y/o male with a 35-pack-year smoking history presents with worsening dyspnea, cough, and weight loss. A CT shows a 6.5 cm right upper lobe mass invading the chest wall, with ipsilateral mediastinal lymph node involvement and liver metastasis as seen on the PET scan. What is the TNM stage of his lung cancer? (Q849543)

A. T2b, N1, M0

B. T3, N2, M1b

C. T4, N2, M1a

D. T3, N3, M1c

See Answer in Part B → Q11

@Neet_pg_bot

Q12: A 65 y/o male with a confirmed diagnosis of stage IIIB non-small cell lung cancer (NSCLC) is being evaluated for treatment options. His disease is localized with significant mediastinal lymph node involvement, and he has a good performance status. Which of the following is the most appropriate initial treatment for this patient? (Q849544)

A. Surgical resection followed by adjuvant chemotherapy

B. Chemoradiation followed by maintenance immunotherapy

C. Systemic therapy with palliative radiation

D. Adjuvant chemotherapy alone

See Answer in Part B → Q12

@Neet_pg_bot

Q13: A 63-year-old man with a history of smoking presents with a central lung mass, weight loss, and a new diagnosis of squamous cell carcinoma (SCC). Which of the following is a common clinical presentation associated with squamous cell carcinoma of the lung due to its typical location? (Q849545)

A. Pleural effusion causing dyspnea

B. Hypercalcemia with renal stones

C. Superior vena cava syndrome

D. Horner's syndrome

See Answer in Part B → Q13

@Neet_pg_bot

Q14: A 62- y/o man with a history of heavy smoking is diagnosed with a central lung mass. He is also noted to have severe hypercalcemia and is receiving chemotherapy and radiation therapy. Which of the following statements is true? (Q849546)

A. SCLC is less aggressive than large cell carcinoma

B. Oat cells are seen in Large cell carcinoma

C. SCLC is strongly linked to smoking and can cause SIADH

D. Large cell carcinoma usually presents in central lung areas

See Answer in Part B → Q14

@Neet_pg_bot

Q15: A 72 y/o woman presents with severe shoulder pain and noticeable ptosis. Imaging reveals a mass at the apex of the lung, involving the upper ribs and vertebrae. Horner's syndrome is observed. Which imaging modalities are most suitable for the evaluation of this condition? (Q849547)

A. Chest X-ray

B. Ultrasound

C. CT scan

D. MRI

See Answer in Part B → Q15

@Neet_pg_bot

Q16: Which of the following statements regarding cardiac tumours is true? (Q849548)

A. Angiosarcomas are the most common benign primary cardiac tumours.

B. Nearly 90% of primary cardiac tumours are malignant.

C. Myxomas are the most common primary cardiac tumours in adults.

D. Cardiac myocytes have high proliferative activity, contributing to the formation of cardiac tumours.

See Answer in Part B → Q16

@Neet_pg_bot

Q17: A 55 y/o female presents with symptoms of shortness of breath, occasional dizziness, and a recent episode of fever and weight loss. Imaging studies reveal a mass in the left atrium and is diagnosed with atrial myxoma. Which of the following is true? (Q849549)

A. The majority of atrial myxomas arise from the right atrium.

B. Atrial myxomas are more common in males, around 3rd decade of life.

C. Atrial myxomas can cause systemic emboli and obstruction of blood flow.

D. The genetic cause of atrial myxomas is always linked to an autosomal recessive pattern.

See Answer in Part B → Q17

@Neet_pg_bot

Q18: A 14 y/o boy presents with a chest wall deformity characterized by a protruding sternum, resulting in a convex appearance of the chest. The patient is otherwise asymptomatic, and his chest wall growth is nearing completion. Which of the following statements about the management of this condition is true? (Q849550)

A. The Nuss procedure is the preferred surgical approach.

B. Non-surgical bracing is effective in correcting pectus carinatum

C. The modified Ravitch procedure is exclusively used for treating the Pigeon chest.

D. Surgical intervention for pectus carinatum is typically recommended for cosmetic reasons.

See Answer in Part B → Q18

@Neet_pg_bot

Q19: The thoracic duct, the largest lymphatic vessel in the body, passes through the posterior mediastinum. Which of the following anatomical triangles is the key area used for locating and managing the thoracic duct? (Q849492)

A. Simon's triangle

B. Lesgaft's triangle

C. The triangle of Petit

D. Poirier’s Triangle

See Answer in Part B → Q19

@Neet_pg_bot

Q20: A 48 y/o female presents with fluctuating muscle weakness, difficulty speaking, and drooping eyelids that worsen with physical activity. Imaging reveals a mass in the anterior mediastinum. Which of the following is the most likely paraneoplastic syndrome associated with her condition? (Q849463)

A. Lambert-Eaton myasthenic syndrome

B. Myasthenia gravis

C. Cushing syndrome

D. Syndrome of inappropriate antidiuretic hormone (SIADH)

See Answer in Part B → Q20

@Neet_pg_bot

Q21: A 55 y/o male presents with a persistent cough and dyspnea on exertion. A chest x-ray reveals an anterior mediastinal mass with tracheal deviation. What is the next best step in evaluating this patient for a potential thymoma? (Q849464)

A. Serum markers

B. Chest X-ray with lateral view

C. Contrast-enhanced CT scan

D. Pulmonary function tests (PFTs)

See Answer in Part B → Q21

@Neet_pg_bot

Q22: A 63 y/o female is diagnosed with a Stage III thymoma and presents with symptoms of myasthenia gravis. The tumour appears to have invaded the superior vena cava and pericardium. What is the most appropriate treatment plan for this patient? (Q849465)

A. Complete surgical resection

B. Radiation therapy alone

C. Observation and periodic follow-up imaging

D. Chemotherapy as a primary treatment without surgery

See Answer in Part B → Q22

@Neet_pg_bot

Q23: A 48 y/o man with a history of pulmonary TB presents with progressive shortness of breath, facial swelling, and difficulty swallowing. His chest X-ray shows an abnormal shadow in the mediastinum. A CT scan reveals extensive fibrotic tissue compressing the SVC and oesophagus. What is the most likely diagnosis? (Q849466)

A. Superior vena cava syndrome

B. Pulmonary embolism

C. Chronic fibrous mediastinitis

D. Thymoma

See Answer in Part B → Q23

@Neet_pg_bot

Q24: A 72-year-old male with COPD presents with sudden severe shortness of breath and right-sided chest pain. On examination, he is cyanotic, in respiratory distress, and has diminished breath sounds on the right side. A CXR shows a large air collection in the right pleural space. What is the most likely diagnosis? (Q849474)

A. Primary Spontaneous Pneumothorax (PSP)

B. Secondary Spontaneous Pneumothorax (SSP)

C. Chylothorax

D. Hemothorax

See Answer in Part B → Q24

@Neet_pg_bot

Q25: A 30-year-old male presents to the emergency department after a stabbing injury to the chest, having respiratory distress, 4 cm wound on the right side. On examination, his breath sounds are decreased on the right side, and he shows signs of hypoxia. His vital signs are stable. What is the most appropriate first step in managing this patient? (Q849479)

A. Perform needle thoracocentesis in the 2nd intercostal space, midclavicular line

B. Insert a chest tube immediately at the site of the injury

C. Apply a sterile occlusive dressing over the wound, taped on three sides

D. Obtain a chest X-ray to assess the injury and confirm the diagnosis

See Answer in Part B → Q25

@Neet_pg_bot

Q26: A 25-year-old male, after a motor vehicle accident, presents with severe respiratory distress, decreased breath sounds on the right, hyper-resonance, and tracheal deviation to the left. His BP is 85/55 mmHg, and jugular veins are distended. What is the most appropriate next step in management? (Q849480)

A. Order an urgent chest X-ray to confirm the diagnosis

B. Perform an immediate needle thoracocentesis in the 5th intercostal space, in anterior axillary line

C. Insert a chest tube into the 5th intercostal space in the anterior axillary line

D. Perform a finger thoracostomy in the safe triangle

See Answer in Part B → Q26

@Neet_pg_bot

Q27: A 70 y/o woman with lung cancer presents with sudden severe chest pain and shortness of breath, 3 weeks post-lobectomy. She is pale, tachypneic, with BP 85/50 mmHg and HR 120 bpm. Examination reveals right-sided dullness and diminished breath sounds. A CXR shows a large pleural effusion, and thoracentesis drains 1000ml of blood. What is the most appropriate next step in management? (Q849481)

A. Observation and follow-up with chest X-ray

B. Administration of antibiotics and bronchodilators only

C. Thoracotomy with evacuation and lung decortication

D. Intercostal chest tube (ICT) placement

See Answer in Part B → Q27

@Neet_pg_bot

Q28: Which of the following is least likely to be found in the posterior mediastinum? (Q849462)

A. Neurofibroma

B. Thymoma

C. Ganglioneuroma

D. Aneurysm of descending aorta

See Answer in Part B → Q28

@Neet_pg_bot

Q29: A 45 y/o male presents with chest pain and dyspnea one week after undergoing oesophagal surgery. A pleural tap reveals milky white fluid with high triglyceride levels. Which of the following is the most appropriate next step in the management of this patient? (Q849493)

A. Oral antibiotics

B. Thoracic duct ligation via thoracoscopy

C. Oral diet with medium-chain triglycerides

D. Immediate pleurodesis with talc

See Answer in Part B → Q29

@Neet_pg_bot

Q30: A 35 y/o male presents with milky urine and abdominal pain after a fatty meal. He reports weight loss and frequent urinary infections. Urinalysis shows chyluria. What is the most likely underlying cause of chyluria in this patient? (Q849494)

A. Renal stone disease

B. Filarial infection

C. Tuberculosis

D. Diabetes mellitus

See Answer in Part B → Q30

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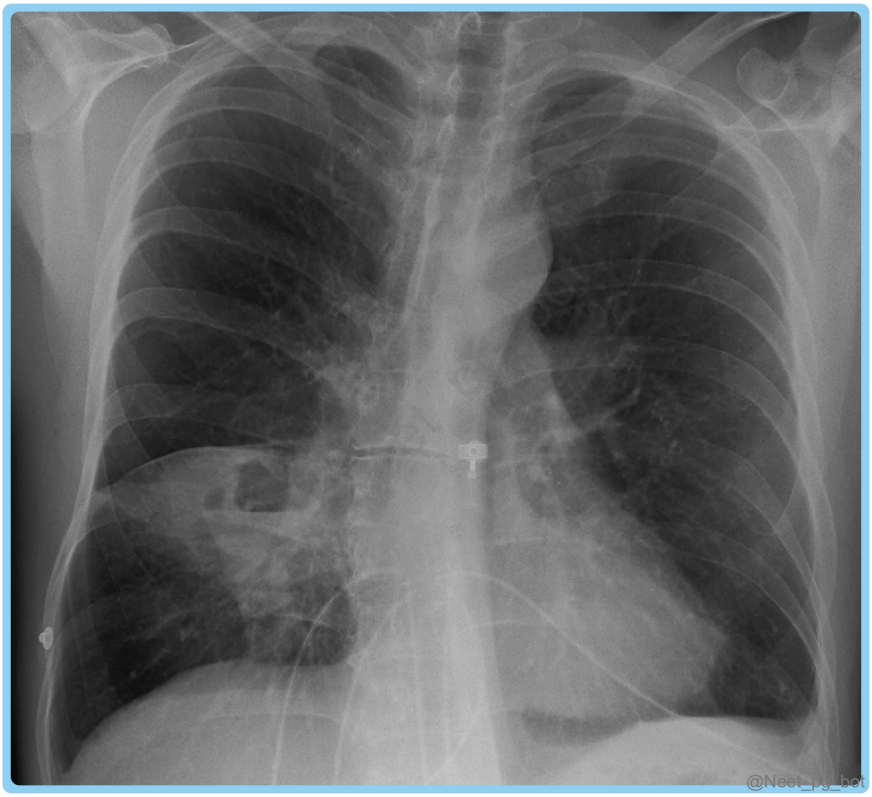
Q31: A 60 y/o male presents with fever, cough, and foul-smelling sputum. A chest X-ray reveals a localized opacity in the apical lower lobe. Sputum culture shows the presence of anaerobic bacteria. Which of the following is the most likely cause? (Q849495)

A. Aspiration of oropharyngeal secretions

B. Hematogenous spread from endocarditis

C. Direct extension from pneumonia

D. Bronchial obstruction due to lung cancer



See Answer in Part B → Q31

@Neet_pg_bot

Q32: A 58 y/o male with a history of chronic kidney disease presents to the clinic with shortness of breath and chest discomfort. A chest X-ray shows a pleural effusion on the right side. Analysis of the pleural fluid reveals the following: Pleural fluid protein

to serum protein ratio: 0.7 Pleural fluid lactate dehydrogenase (LDH) to serum LDH ratio: 0.65 Pleural fluid LDH level: 300 U/L (serum LDH upper limit of normal is 200 U/L) Based on these findings and Light's criteria, which of the following is the most likely cause of this patient's pleural effusion? (Q849496)

A. Congestive heart failure

B. Lung cancer

C. Nephrotic syndrome

D. Cirrhosis

See Answer in Part B → Q32

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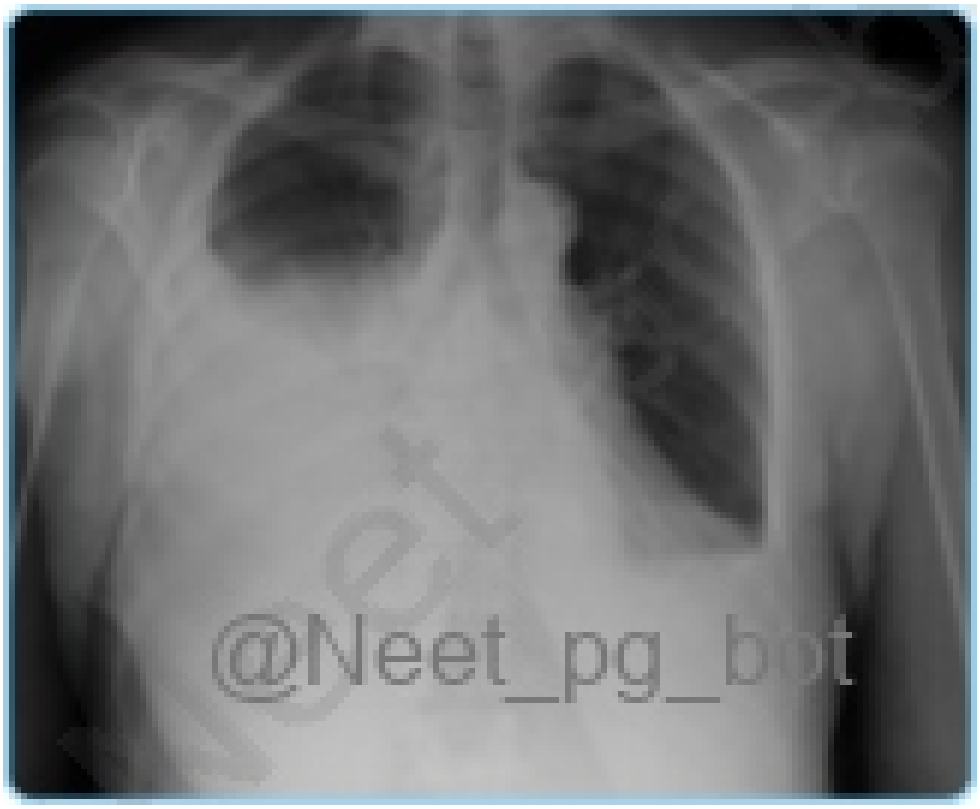
Q33: A 72 y/o male with h/o COPD presents with progressive shortness of breath and chest pain. The chest X-ray findings are shown below. Thoracentesis is performed, and analysis of the pleural fluid reveals high protein & LDH levels. Which of the following is the next best step in managing this patient? (Q849497)

A. Initiate diuretic therapy

B. Perform a pleural biopsy

C. Insert a chest tube for drainage

D. Administer antibiotics



See Answer in Part B → Q33

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Q34: A 50 y/o male patient has been hospitalized following a hip replacement surgery for the past 6 days. He has a history of obesity and smoking. On the sixth day, he suddenly develops shortness of breath, and chest pain, and coughs up blood. Which of the following is the most likely contributing factor to his current condition? (Q849518)

A. Prolonged immobility

B. Dehydration

C. High blood pressure

D. Recent blood transfusion

See Answer in Part B → Q34

@Neet_pg_bot

Q35: Which of the following is the most commonly used gold standard investigation for diagnosing pulmonary embolism in a clinical setting? (Q849519)

A. Doppler Ultrasound

B. Chest X-ray

C. Ventilation-Perfusion (V/Q) Lung Scan

D. CT Pulmonary Angiography (CTPA)

See Answer in Part B → Q35

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• [03_Cardiothoracic Vascular Surgery] 012 Previous Year Questions

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Q1: In a 35-year-old individual with a history of chronic smoking who is experiencing bluish discoloration of the toes and intermittent claudication, what would be the most suitable investigation to conduct next? (Q856763)

A. CT Angiography

B. MR Angiography

C. Digital subtraction angiography

D. Duplex scan

See Answer in Part B → Q1

@Neet_pg_bot

Q2: Identify the type of ulcer? (Q866906)

A. Arterial Ulcer

B. Venous ulcer

C. Diabetic ulcer

D. Neuropathic



See Answer in Part B → Q2

@Neet_pg_bot

Q3: A 50-year-old diabetic man presents with a progressive increase in pain in his calf. He now prefers to sleep in a seated position by hanging his leg to alleviate pain.Pain is more in the distal part like toes and feet. It gets aggravated with movements and pressure. The pain is increased in lying down and elevation of foot; it may be reduced on hanging the foot down. Which of the following is the most likely cause? (Q793482)

A. Rest pain

B. Sciatica

C. Neurological claudication

D. Venous claudication

See Answer in Part B → Q3

@Neet_pg_bot

Q4: Which of the following findings is likely to be seen in this patient? (Q855695)

A. Decreased posterior tibial & dorasalis pedis pulsations

B. Loss of sensation over the foot

C. Positive tredelenberg sign

D. Pain on compression of the calf



See Answer in Part B → Q4

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Q5: A 32-year-old male chronic smoker presents with pain in the fingers for a few months. On examination, gangrenous ulcers were present in the fingers, as shown below. Investigation showed blood glucose and lipid profile within normal limits.

Which of the following is the most likely diagnosis? (Q857126)

A. Buerger’s disease

B. Diabetic ulcers

C. Acute paronychia

D. Raynaud’s phenomenon



See Answer in Part B → Q5

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Q6: What is the probable medical condition for an 80-year-old male who experienced pain and swelling in the calf muscle on the right side after being immobilized due to a fracture in the right inter-trochanteric region? (Q857130)

A. Chronic osteomyelitis

B. Deep vein thrombosis

C. Compartment syndrome

D. Arterial claudication

See Answer in Part B → Q6

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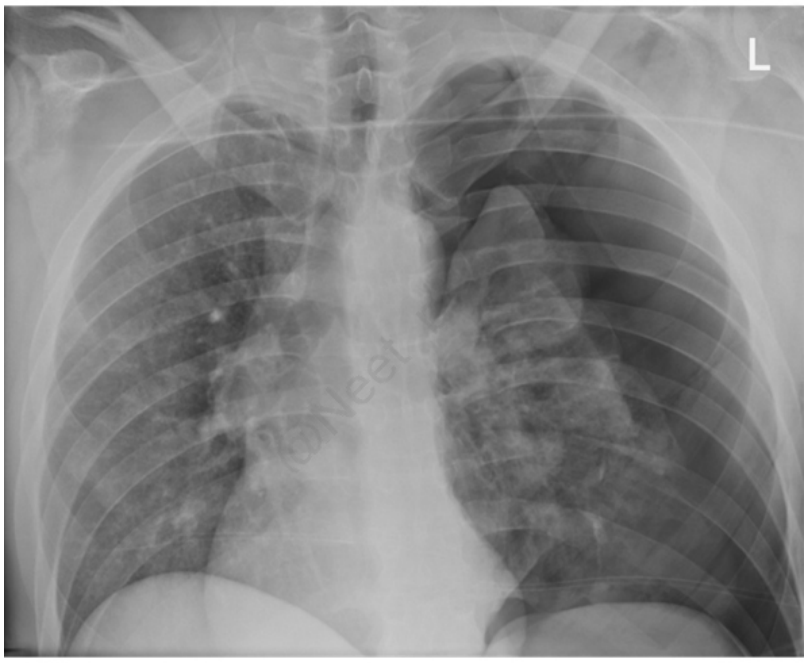
Q7: A 25-year-old male patient involved in a road traffic accident was managed upon arrival at the emergency room, with a respiratory rate of 25 breaths per minute and a blood pressure of 80/45mmHg, and exhibiting hyper-resonance on the left side of the chest, what is the appropriate action based on the findings from the chest x-ray? (Q857456)

A. Wide bore needle insertion in the 2nd ICS

B. Wide bore needle insertion in the 5th ICS followed by an intercostal drain in the 5th ICS

C. Aspiration of the pleural fluid

D. No intervention needed



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See Answer in Part B → Q7

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Q8: A patient underwent surgery, for which she was immobilised. Patient started complaining of leg pain on the 5th postoperative day. On examination , Homan's sign is positive. What is the most probable diagnosis? (Q857539)

A. Deep Venous thrombosis

B. Urinary sepsis

C. Peripheral vascular disease

D. Lymphangitis

See Answer in Part B → Q8

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Q9: How is empyema thoracis treated? (Q857541)

A. Antibiotics alone

B. Chest tube drainage and antibiotics

C. ICD alone

D. Wait and watch

See Answer in Part B → Q9

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Q10: A man presented with a history of stab injury to the arm. On examination, there was a hematoma, and radial and ulnar pulses were not felt. A 3.5cm longitudinal tear is noted in the brachial artery. Which among the following is the best treatment option? (Q858346)

A. Primary repair with end-to-end anastomosis

B. Repair with great saphenous vein graft

C. Repair with prosthetic graft

D. Repair with saphenous vein patch

See Answer in Part B → Q10

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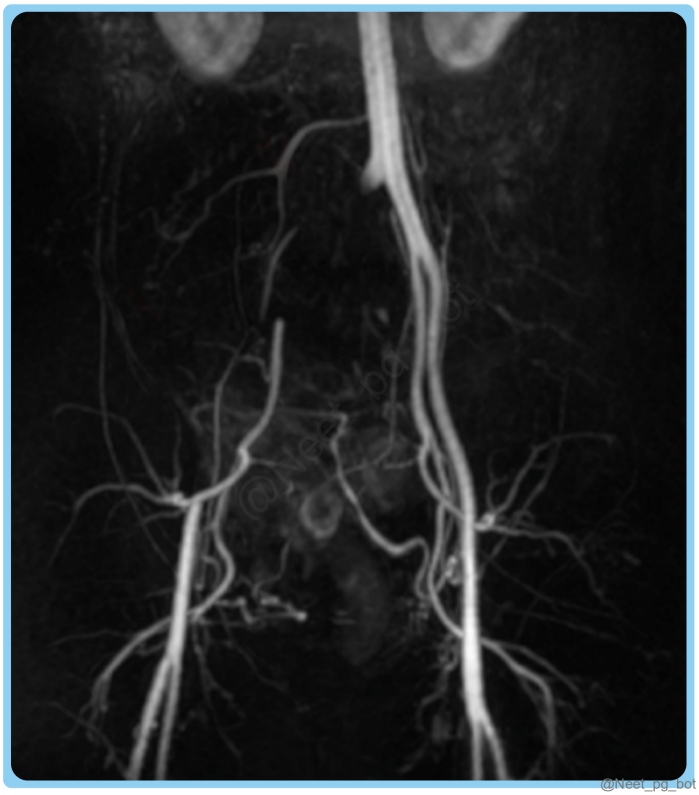
Q11: A 70-year-old female patient presents with pain in the thigh during walking. MRA shows complete long-segment occlusion of the right common iliac artery extending into the proximal external iliac artery, with distal reconstitution through internal iliac collaterals. What is the best surgical management? (Q856200)

A. PTA with stenting

B. Femoroiliac bypass

C. Aortofemoral bypass

D. Aorto-iliac bypass



See Answer in Part B → Q11

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Q12: According to the CEAP classification, What will be the stage in this patient as the patient presents with the same problem again and again? (Q856207)

A. C2

B. C1

C. C4a

D. C5



See Answer in Part B → Q12

@Neet_pg_bot

Q13: What is the appropriate course of action for managing a 25-year-old male patient who was brought to the emergency room following a road traffic accident? The patient has a respiratory rate of 25 breaths per minute and a blood pressure of 80/45 mmHg. During examination, hyper-resonance is detected on the right side of the

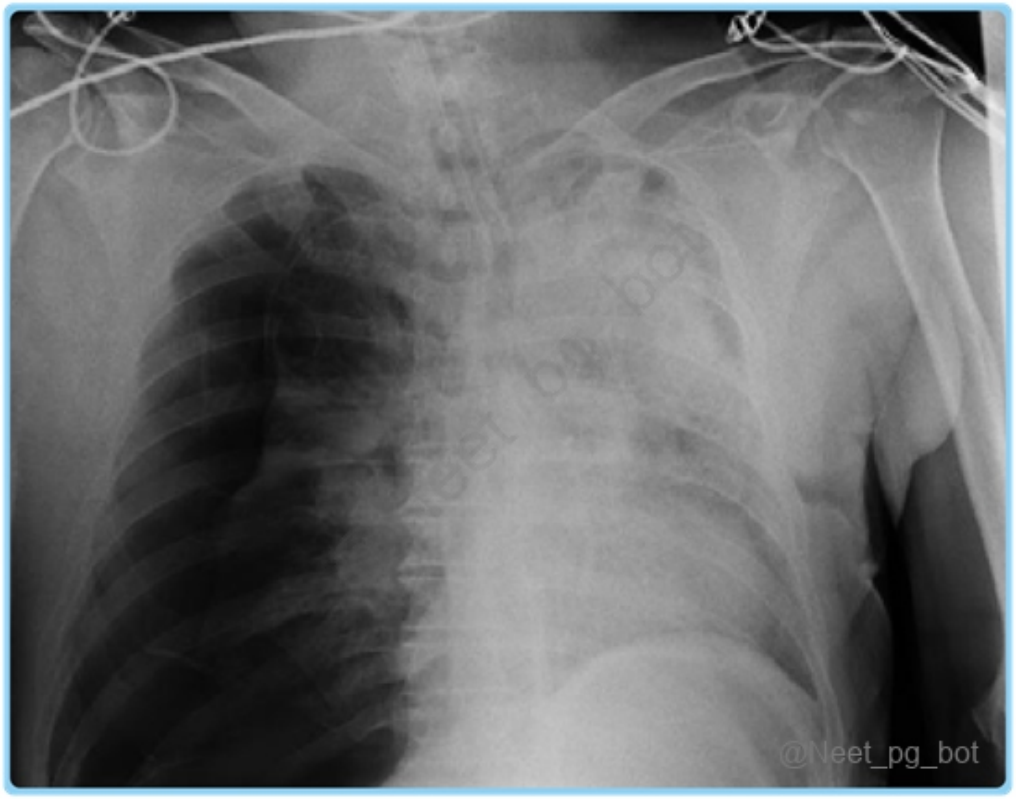
chest. Please refer to the provided chest X-ray for further evaluation. (Q856746)

A. Wide bore needle insertion in the 5th intercostal space (ICS)

B. Wide bore needle insertion in the 5th ICS followed by an intercostal drain in the 5th ICS

C. Aspiration of the pleural fluid

D. No intervention is needed



See Answer in Part B → Q13

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Q14: A bus conductor was diagnosed with varicose veins. On examination, skin eczema and lipodermatosclerosis were noted. According to the CEAP classification system, he would be classified as: (Q856753)

A. C1

B. C2

C. C3

D. C4

See Answer in Part B → Q14

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Q15: A 40-year-old smoker presents with sudden, severe, tearing chest pain radiating to his back, shortness of breath, and mild nausea. His BP is 190/110 mmHg, and heart rate is 105 bpm. What is the initial management? (Q857860)

A. Control blood pressure

B. Urgent surgery

C. Wait and watch

D. Blood transfusion

See Answer in Part B → Q15

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Q16: What is the most likely diagnosis of the lesion shown in the image below? (Q856766)

A. Arterial insufficiency

B. Neuropathic ulcer

C. Venous ulcer

D. Tuberculous ulcer



See Answer in Part B → Q16

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Q17: Which of the following adverse effects is not observed following a massive blood transfusion? (Q856773)

A. Hypocalcemia

B. Hypercalcemia

C. Hypokalemia

D. Hyperkalemia

See Answer in Part B → Q17

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Q18: A 55-year-old man with IHD presents with sudden, severe, generalised abdominal pain and multiple episodes of vomiting. On examination, the pulse rate is 118 bpm, rhythm is irregularly irregular, and BP is 90/60 mmHg. The abdomen appears soft and non-distended, and bowel sounds are absent. Which of the following could be a likely diagnosis in this case? (Q856298)

A. Acute severe pancreatitis

B. Ruptured aortic aneurysm

C. Acute mesenteric ischemia

D. Peptic ulcer perforation

See Answer in Part B → Q18

@Neet_pg_bot

Q19: What is the management approach for a 50-year-old male patient who has a 40 mm abdominal aortic aneurysm detected during his routine annual checkup? (Q854937)

A. Urgent endovascular aneurysm repair

B. Surgery is indicated if the aneurysmal diameter is > 55mm

C. Urgently wheel the patient to OT for surgery

D. Surgery is indicated only if the aneurysm is > 77mm

See Answer in Part B → Q19

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Q20: Which of the following statements regarding intermittent claudication is accurate? (Q854944)

A. Felt at rest

B. Most commonly felt in the calf muscles

C. Day-to-day distance is variable

D. Relieved after getting out of bed

See Answer in Part B → Q20

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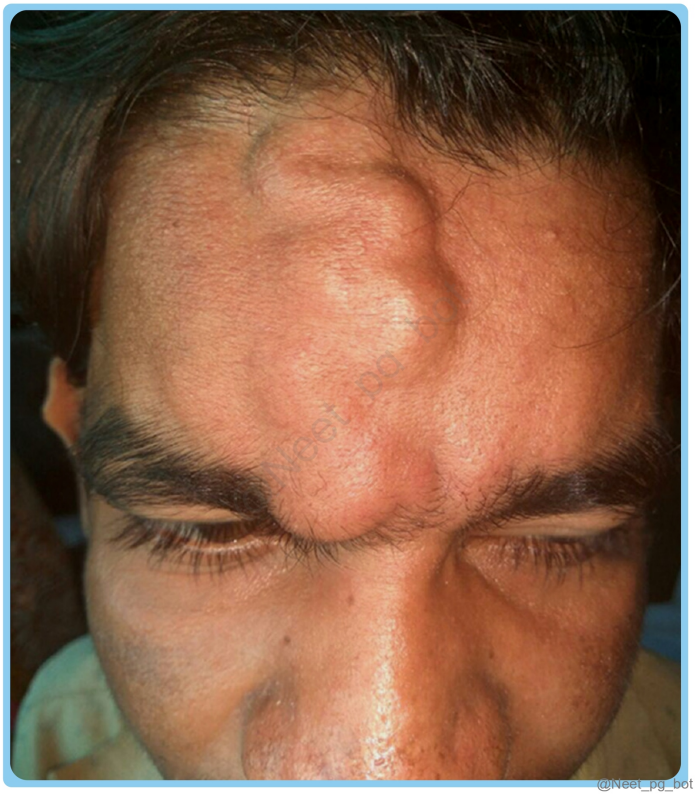
Q21: What is the most probable diagnosis for a 41-year-old female patient who presented with a twisted swelling on the scalp and face, accompanied by a pulsating sensation and a bruit heard during auscultation? (Q854947)

A. Neurofibromatosis

B. Liposarcoma

C. Cirsoid Aneurysm

D. Varicocele



See Answer in Part B → Q21

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Q22: According to the TNM staging, a patient with lung cancer of size 2.5 cm is staged as: (Q854986)

A. T1b

B. T1c

C. T2a

D. T1a

See Answer in Part B → Q22

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Q23: Which of the following is not a component of Thoracoscore? (Q855018)

A. Performance status

B. Complication of surgery

C. ASA grading

D. Priority of surgery

See Answer in Part B → Q23

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Q24: What is the probable diagnosis for a 50-year-old male who is a long-term smoker and experiences pain in both thighs and buttocks while walking approximately 500 meters? (Q858494)

A. Arterial disease involving the superficial femoral artery

B. Arterial disease with aortoiliac involvement

C. Femoral venous insufficiency

D. Arterial disease involving the profunda femoris artery

See Answer in Part B → Q24

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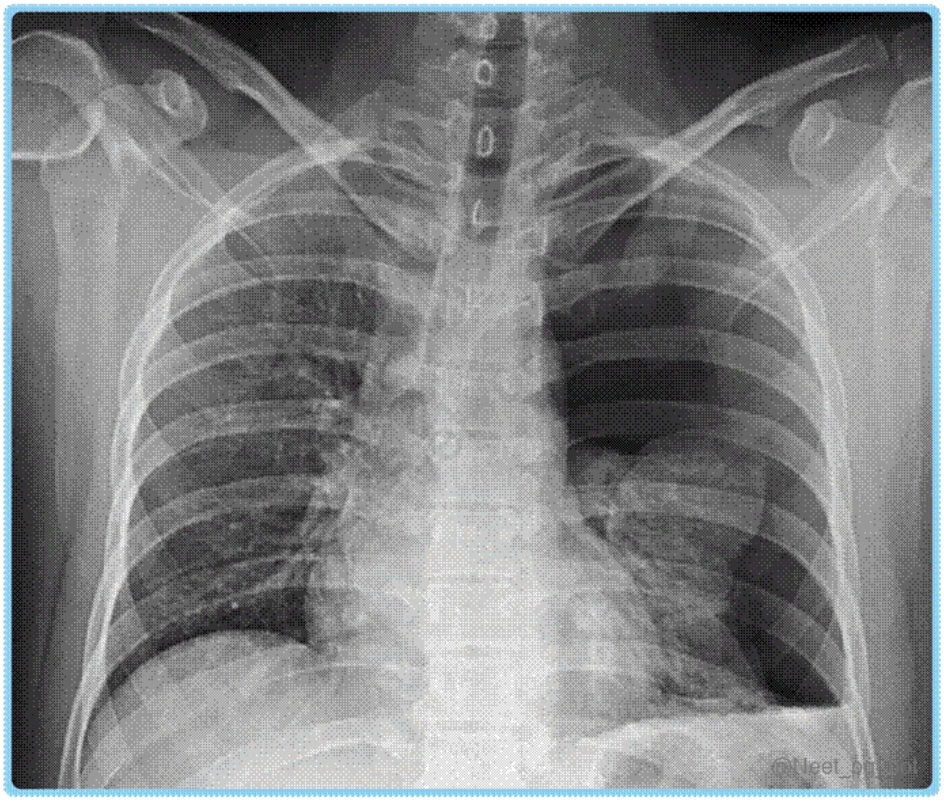
Q25: What would be the appropriate course of action for managing a 25-year-old male patient who was brought to the emergency department after a road traffic accident (RTA)? The patient has a respiratory rate of 25 breaths per minute and a blood pressure of 80/45 mmHg. During examination, hyper-resonance is detected over the left side of the chest. The provided chest x-ray is shown below. (Q859600)

A. Wide bore needle insertion in the right 5th ICS

B. Wide bore needle insertion in the left 5th ICS followed by an intercostal drain

C. Aspiration of the pleural fluid

D. No intervention is needed



See Answer in Part B → Q25

@Neet_pg_bot

Q26: A male patient presents with impotence and absent femoral pulse. The pain in the gluteal region is observed. At which level has the pathology occurred? (Q855764)

A. Bilateral popliteal arteries

B. Bilateral internal iliac arteries

C. Aortoiliac bifurcation

D. Bilateral femoral arteries

See Answer in Part B → Q26

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Q27: A patient presents with a tender pulsatile mass, as shown in the image below. What will be done next for this patient? (Q855769)

A. Ultrasound Doppler

B. Needle aspiration

C. CT angiogram with percutaneous management

D. Intravenous antibiotics for 7 days



See Answer in Part B → Q27

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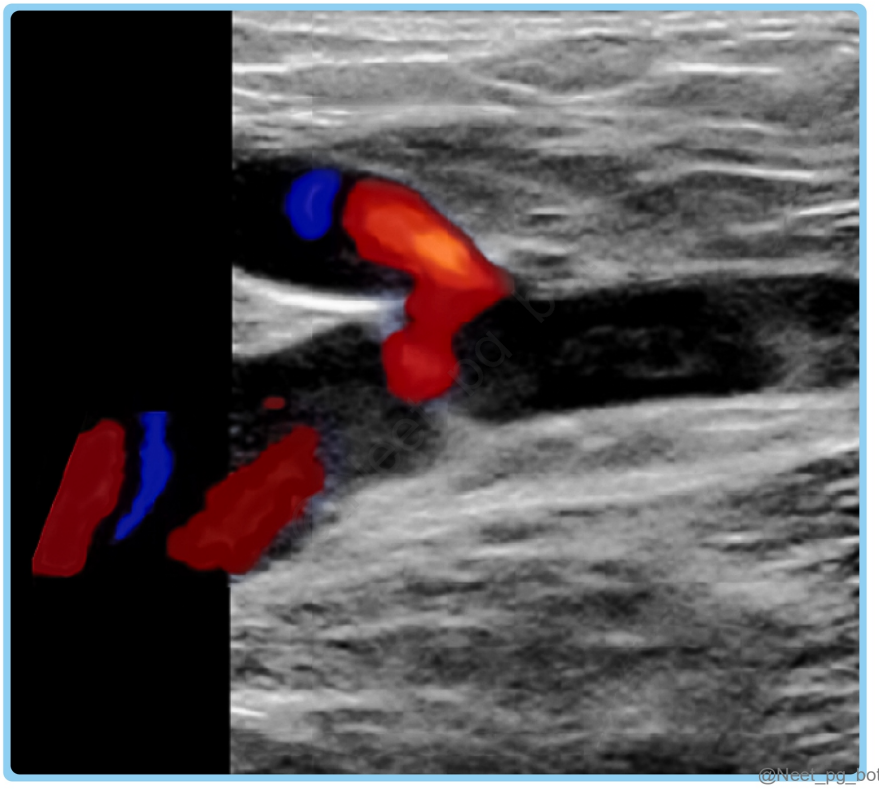
Q28: A patient presents with sudden onset right leg pain. An investigation was done, and the obtained image is shown below. What is the investigation? (Q855821)

A. Digital subtraction angiography

B. Ultrasound Doppler

C. MR angiography

D. Plethysmography



See Answer in Part B → Q28

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Q29: A 39-year-old male who had a road traffic accident and suffered from chest trauma was admitted to the ER. About 1800 ml of blood loss from the chest tube in an hour. What is the next step in management for this condition? (Q820129)

A. Emergency Thoracotomy

B. Conservative for next 6-hours

C. Continue resuscitation

D. Wait & watch

See Answer in Part B → Q29

@Neet_pg_bot

Q30: A 30-year-old male presented to EMT with H/o Penetrating chest trauma. On examination, severe tracheal deviation was present. What is the immediate step of management? (Q866927)

A. Needle decompression

B. Chest X-ray

C. E-FAST

D. O2 support at 100%

See Answer in Part B → Q30

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Q31: In a chronic limb ischemia patient, what is the ABI below which gangrene is imminent: (Q865388)

A. 0.5

B. 0.3

C. 0.9

D. 1

See Answer in Part B → Q31

@Neet_pg_bot

Q32: A 56 years old man presents with the following pathology, which of the following is correct? (Q866445)

A. Sclerotherapy is the best treatment

B. Lipodermatosclerosis/eczema can occurs

C. Telangiectasia is rare

D. No possibility of venous ulcer



See Answer in Part B → Q32

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Q33: A chronic smoker presents with leg pain after walking 100 meters. On examination, there is an absent pulse in the bilateral dorsalis pedis, anterior tibial, and posterior tibial arteries, but no gangrene is noted. Intermittent claudication is suspected. Which of the following statements about this condition is correct? (Q853070)

A. Pain is more at night and sleep

B. Pain aggravated by standing and relieved by bending forward

C. Development of pain on the 1st step of walking

D. Pain develops after walking some distance and is relieved by rest

See Answer in Part B → Q33

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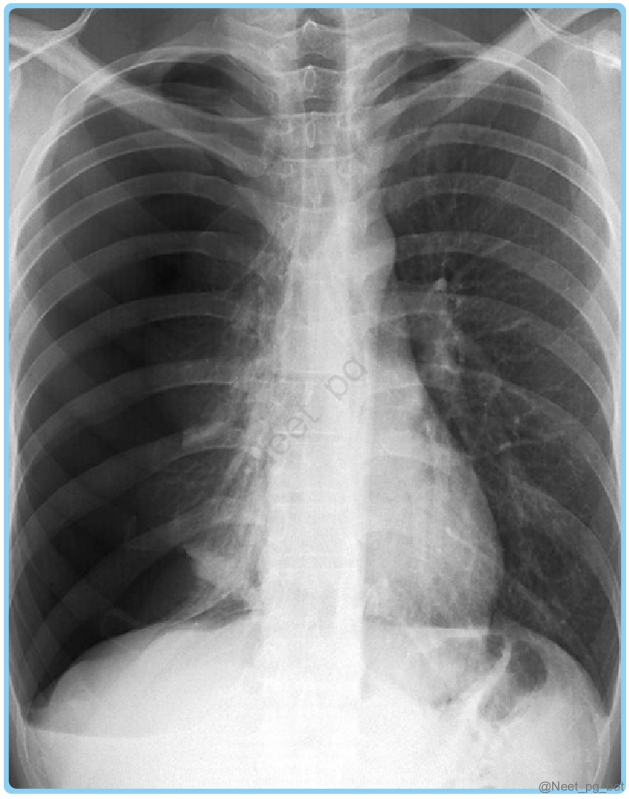
Q34: Following a fight between 2 groups, a boy was brought with severe pain in the chest, distended neck veins, dyspnea, and a BP of 80/50 mmHg. X-ray shows the following findings: What is the diagnosis? (Q852683)

A. Tension pneumothorax

B. Primary Spontaneous Pneumothorax

C. Traumatic Pneumothorax

D. Bilateral Pneumothorax



See Answer in Part B → Q34

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Q35: A 62-year-old male presents with left leg swelling and pain for 5 days and has a positive D-dimer test. Duplex ultrasonography confirms an extensive DVT involving the left popliteal and femoral veins. Which of the following is the most appropriate initial management strategy? (Q852702)

A. Unfractionated heparin followed by warfarin

B. LMWH followed by oral anticoagulant

C. Catheter-directed thrombolysis

D. IVC filter placement

See Answer in Part B → Q35

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Q36: Which type of ulcer is given below? (Q844296)

A. Venous ulcer

B. Arterial ulcer

C. Trophic ulcer

D. Diabetic foot



See Answer in Part B → Q36

@Neet_pg_bot

Q37: What is the appropriate management for a patient presenting with constant chest pain and radiological findings of stanford type A aortic dissection? (Q844300)

A. Surgical management

B. Vasodilator

C. Beta blocker

D. Beta blocker plus vasodilator

See Answer in Part B → Q37

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Q38: A patient presented to the outpatient department with a dilated, tortuous vein in the leg. The patient reported a history of trauma to the same area 10 years prior. Upon examination, a pulsatile vein was also noted. What is the most likely diagnosis? (Q860393)

A. Varicose vein

B. Angiofibroma

C. Hemangioma

D. A-V Fistula

See Answer in Part B → Q38

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Q39: An elderly man with a chronic history of IV drug use presents with progressively increasing swelling in the groin on the right side. The swelling is non-fluctuant but pulsatile on examination. He has diminished pulses distal to the swelling on the same side. What is the next step in the management of this patient? (Q860455)

A. CT angiography followed by surgery

B. Oral antibiotics and observation

C. Compression stocking

D. Incision and drainage

See Answer in Part B → Q39

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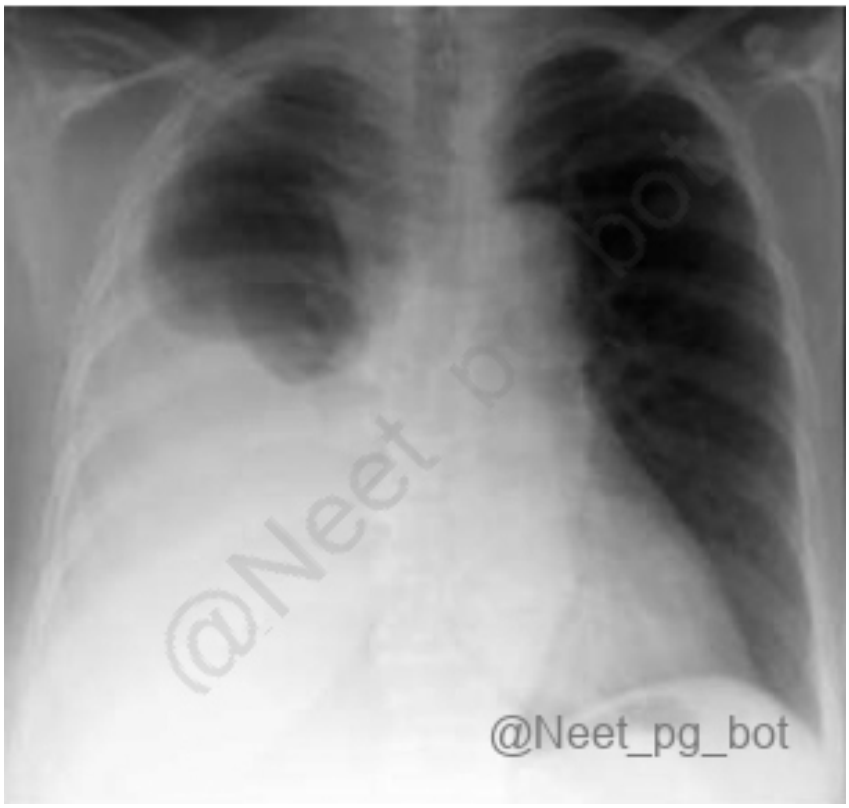
Q40: A 32-year-old male presents to the emergency department after sustaining a stab wound to the right side of his chest. He is in acute distress, with a heart rate of 120 beats per minute, blood pressure of 90/60 mmHg, and respiratory rate of 28 breaths per minute. On physical examination, there are decreased breath sounds on the right side. A chest X-ray is shown below. What is the diagnosis? (Q840044)

A. Pneumothorax

B. Hemothorax

C. Tension Pneumothorax

D. Hydrothorax



See Answer in Part B → Q40

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Q41: A patient presents with calf pain while walking a certain distance. The pain is severe enough that he must stop and rest before continuing. According to Boyd's grading, which of the following grades best describes this condition? (Q860217)

A. Grade 1

B. Grade 2

C. Grade 3

D. Grade 4

See Answer in Part B → Q41

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Q42: A man presented with a history of stab injury over the arm. On examination, there was the presence of hematoma, and radial and ulnar pulses were not felt. A 3.5 cm longitudinal tear is noted in the brachial artery. Which of the following is the best treatment option? (Q857300)

A. Primary repair with end-to-end anastomosis

B. Repair with great saphenous vein graft

C. Repair with prosthetic graft

D. Repair with saphenous vein patch

See Answer in Part B → Q42

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Q43: After undergoing surgery to correct a left-sided varicocele, a 30-year-old male patient inquires about the primary route through which venous drainage occurs following the surgery. How should the surgeon correctly respond to the patient's question? (Q857310)

A. Cremasteric veins

B. Penile veins

C. Ectopic drainage in the iliac fossa

D. Testicular veins

See Answer in Part B → Q43

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Q44: Which is the least commonly used graft for coronary artery bypass graft (CABG)? (Q857806)

A. Long saphenous vein

B. Internal mammary artery

C. Intercostal artery

D. Radial artery

See Answer in Part B → Q44

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Q45: In a patient with aortic dissection, injury to which of the following structure will cause hiccups? (Q820139)

A. Phrenic nerve

B. Abdominal aorta

C. Thoracic aorta

D. Spinal accesory nerve

See Answer in Part B → Q45

@Neet_pg_bot

Q46: A 56-year-old patient presented with varicose veins. What is the investigation of choice for varicose veins? (Q820163)

A. Duplex scan

B. Plethysmography

C. MRI

D. CT

See Answer in Part B → Q46

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Q47: What is the most preferred site for the insertion of the intercostal tube drain? (Q820173)

A. Upper border of lower rib

B. Lower border of upper rib

C. Lower border of lower rib

D. Middle of intercostal space

See Answer in Part B → Q47

@Neet_pg_bot

Q48: A patient presents with dull, aching pain and tortuous veins in both lower limbs. Which test would be appropriate for evaluating superficial femoral vein (SFJ) competence? (Q854740)

A. Fegan's test

B. Homan’s test

C. Modified Perthes test

D. Brodie Trendelenburg test

See Answer in Part B → Q48

@Neet_pg_bot

Q49: A 62-year-old patient presents with pain in the calf muscles while walking. The pain subsides with rest. Which of the following is not typically seen in intermittent claudication? (Q854759)

A. Cramping in the muscles during exercise

B. Pain starting on taking the first step

C. The most common cause is atheroma

D. The level of occlusion cannot be decided based on symptoms

See Answer in Part B → Q49

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Q50: A patient presents with a sudden onset of chest pain shooting to the neck and interscapular region. X-ray shows a widened mediastinum. Blood pressure is 110/90 mmHg in the right upper limb and 160/100 mmHg in the left upper limb. What is the most likely diagnosis? (Q855199)

A. Acute coronary syndrome

B. Acute pulmonary embolism

C. Acute aortic dissection

D. Esophageal rupture

See Answer in Part B → Q50

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Q51: A construction worker presents to the OPD with complaints of white fingers. He has been working in the cement and concrete industry and has spent 20 years using

heavy machinery drills and polishing wood and furniture. What is the most likely etiology for this condition? (Q855246)

A. Candidal infection of the fingers due to continuous exposure to water

B. Exposure to thinners and paints

C. Continuous exposure to cement and concrete

D. Continuous exposure to drills and machines

See Answer in Part B → Q51

@Neet_pg_bot

Q52: Identify the given condition: (Q855253)

A. Venous ulcer

B. Malignant ulcer

C. Arterial ulcer

D. Trophic ulcer



See Answer in Part B → Q52

@Neet_pg_bot

Q53: A patient with varicose veins complains of eczema in the same region. According to the CEAP guidelines, what is the stage of the clinical classification? (Q855257)

A. C2

B. C3

C. C4a

D. C4b

See Answer in Part B → Q53

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Q54: A 17-year-old woman with no comorbidities presents with numbness and paraesthesia of the fingers along with the characteristic finding as shown in the image below. She has no history of smoking or history of other illnesses. She mentions the episodes occur when she is under excess stress or during cold temperatures. What is the most likely diagnosis? (Q857783)

A. Buerger’s disease

B. Atherosclerosis

C. Raynaud’s phenomenon

D. Giant cell arteritis



See Answer in Part B → Q54

@Neet_pg_bot

Q55: All of the following are classic anterior mediastinal masses EXCEPT: (Q857785)

A. Parathyroid adenoma

B. Lymphoma

C. Teratoma

D. Thymoma

See Answer in Part B → Q55

@Neet_pg_bot

Q56: While washing clothes in cold water, a female patient exhibits color changes in her hands from white to red . Which of the following drugs is best suited for this

patient? (Q793884)

A. ACE inhibitors

B. Calcium channel blockers

C. Thiazides

D. Alpha-blockers

See Answer in Part B → Q56

@Neet_pg_bot

Q57: Which of the following provides long-lasting results in a coronary artery bypass graft (CABG) ? (Q793485)

A. Long saphenous vein

B. Internal mammary artery

C. Poly tetra fluoro eythlene (PTFE)

D. Gastroepiploic artery

See Answer in Part B → Q57

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• [04_Hepatobiliary Pancreatic Surgery] 013 Liver Tumors - I

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[04_Hepatobiliary Pancreatic Surgery] 013 Liver Tumors - I — Quick Jump

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Q7 (p. 195) *Q8 (p. 195)* *Q9 (p. 195)* *Q10 (p. 196)* *Q11 (p. 196)* *Q12 (p. 197)*
Q13 (p. 197) *Q14 (p. 198)*

Q1: Which of the following is the most common type of primary liver tumor? (Q848891)

A. Metastasis

B. Hepatocellular carcinoma

C. Hepatoblastoma

D. Hemangioma

See Answer in Part B → Q1

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Q2: A 55-year-old male patient with a history of chronic hepatitis B presents with abdominal discomfort and weight loss. Imaging studies reveal a primary liver tumor with multiple metastatic lesions. Considering the typical metastatic pattern of liver tumors, what is the most likely site of these metastases? (Q848892)

A. Bones

B. Brain

C. Lungs

D. Kidneys

See Answer in Part B → Q2

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Q3: A 45-year-old woman is incidentally found to have a 5 cm hepatic lesion on an ultrasound performed for evaluation of vague abdominal discomfort. A contrast-enhanced MRI shows a lesion with peripheral nodular enhancement and centripetal filling in the delayed phase. What is the most appropriate management for this patient? (Q848893)

A. Immediate surgical resection

B. Percutaneous biopsy

C. Observation with periodic imaging

D. Radiofrequency ablation

See Answer in Part B → Q3

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Q4: During a routine abdominal ultrasound of a 35-year-old female, a liver lesion was noted. imaging with a CECT scan shows a central stellate scar within the lesion. What is the most likely diagnosis? (Q848894)

A. Hepatocellular carcinoma

B. Focal nodular hyperplasia

C. Hepatic adenoma

D. Hemangioma

See Answer in Part B → Q4

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Q5: A 24-year-old woman presents with complaints of right upper quadrant abdominal pain for the past few weeks. She has a history of using oral contraceptive pills for the past 5 years. On examination, the physician palpates a slightly tender, smooth, and well-defined mass in the right upper quadrant. Which of the following is the most likely diagnosis? (Q848895)

A. Hepatocellular carcinoma

B. Hepatic hemangioma

C. Hepatic adenoma

D. Focal nodular hyperplasia

See Answer in Part B → Q5

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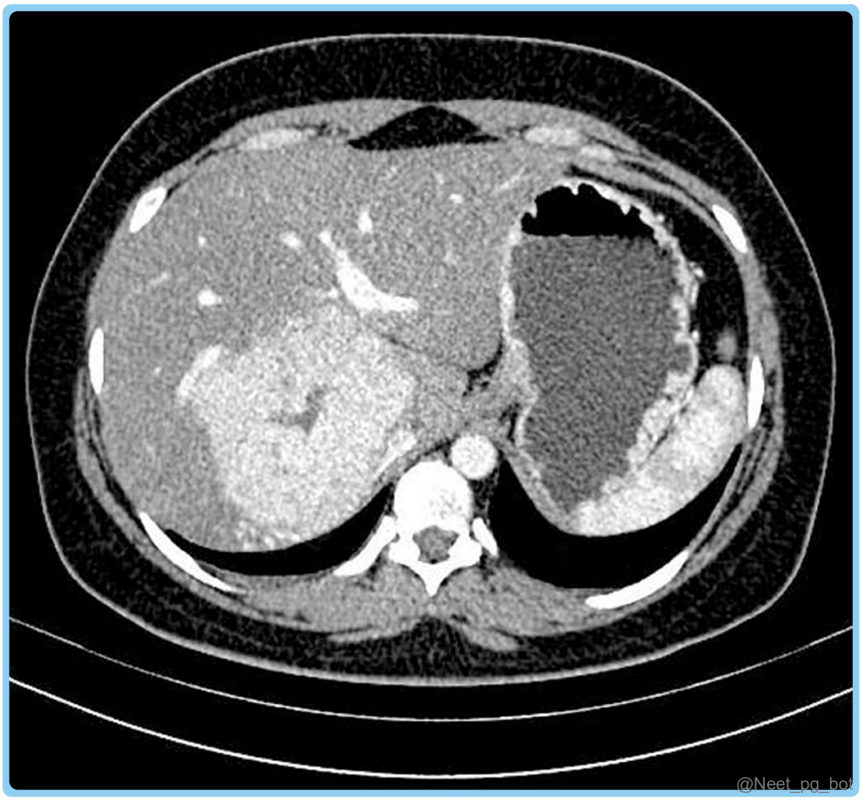
Q6: In which of the following conditions are these CECT findings seen? (Q848896)

A. Focal nodular hyperplasia

B. Serous cystadenoma of the pancreas

C. Renal oncocytoma

D. All of the above



See Answer in Part B → Q6

@Neet_pg_bot

Q7: A 55-year-old male patient presents with persistent abdominal pain and unexplained weight loss He has a history of chronic hepatitis B infection and moderate alcohol consumption. Physical examination reveals mild jaundice and hepatomegaly. Which of the following risk factors is most strongly associated with developing hepatocellular carcinoma (HCC) in this patient? (Q848901)

A. Age

B. Alcohol consumption

C. Hepatitis B infection

D. Male gender

See Answer in Part B → Q7

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Q8: A 55-year-old man with a history of chronic hepatitis C and cirrhosis presents to the clinic with complaints of fatigue, unintentional weight loss, and abdominal discomfort. On physical examination, you note mild ascites and hepatomegaly. The serum alpha-fetoprotein level is elevated. What is the investigation of choice in this patient? (Q848902)

A. MRI with MRCP

B. CECT

C. Triple phase CT

D. Liver biopsy

See Answer in Part B → Q8

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Q9: A 12-year-old boy presents with a history of fatigue, abdominal distension, and jaundice. He has a known diagnosis of liver cirrhosis secondary to chronic hepatitis B infection. Recently, he has developed a palpable liver mass, and imaging studies confirm the presence of hepatocellular carcinoma. Which of the following parameters is not typically used in the prognosis of his condition? (Q848903)

A. Serum bilirubin

B. Serum ammonia

C. Serum albumin

D. Prothrombin time/INR

See Answer in Part B → Q9

@Neet_pg_bot

Q10: A 65-year-old male with a history of chronic hepatitis B presents with increasing fatigue, weight loss, and right upper quadrant pain. Physical examination reveals jaundice and hepatomegaly. Imaging shows multiple lesions with a 4 cm mass in the right lobe and satellite nodules in the left lobe, along with portal vein thrombosis. His LFT shows elevated bilirubin and low albumin levels. The patient is diagnosed with HCC. According to standard protocol, what is the most appropriate treatment option for this patient? (Q848905)

A. Surgical Resection

B. Liver Transplantation

C. Transarterial Chemoembolization (TACE)

D. Sorafenib

See Answer in Part B → Q10

@Neet_pg_bot

Q11: A 24-year-old female from Southeast Asia presents with abdominal pain and a palpable liver mass. She has no history of hepatitis B or C infection, and no signs of

cirrhosis. Imaging studies show a well-circumscribed, non-encapsulated tumor in the liver with a central stellate scar. Laboratory tests reveal normal alpha-fetoprotein levels but elevated neurotensin and B12 binding globulin. What is the most likely diagnosis? (Q848906)

A. Scirrhous Variant of Hepatocellular Carcinoma

B. Fibrolamellar Variant of Hepatocellular Carcinoma

C. Cholangiocarcinoma

D. Metastatic Liver Cancer

See Answer in Part B → Q11

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Q12: A 2-year-old male presents with an asymptomatic palpable abdominal mass detected during a routine physical examination. The child has a history of low birth weight and no history of hepatitis B or C infection. Laboratory tests reveal elevated alpha-fetoprotein levels. Imaging studies show a large intra-abdominal mass. Biopsy confirms hepatoblastoma. Which of the following statements about hepatoblastoma is incorrect? (Q848907)

A. Hepatoblastoma is the most common primary malignancy of the liver in children.

B. The most common route of spread for hepatoblastoma is lymphatic.

C. Hepatoblastoma is not associated with Hepatitis B or C infection.

D. The most characteristic laboratory abnormality is thrombocytosis.

See Answer in Part B → Q12

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Q13: A 55-year-old male with a history of chronic liver disease secondary to hepatitis C presents for evaluation due to worsening ascites, jaundice, and weight loss. He has been diagnosed with hepatocellular carcinoma (HCC). Imaging reveals a single liver lesion measuring 4 cm in diameter with no evidence of vascular invasion or

extrahepatic spread. Laboratory studies show stable liver function tests and AFP levels below 100 ng/mL. Which of the following criteria is the most critical in determining his eligibility for liver transplantation? (Q848908)

A. Tumor size less than or equal to 5 cm

B. Absence of portal vein thrombosis

C. AFP (Alpha-fetoprotein) levels below 400 ng/mL

D. Platelet count greater than 100,000/µL

See Answer in Part B → Q13

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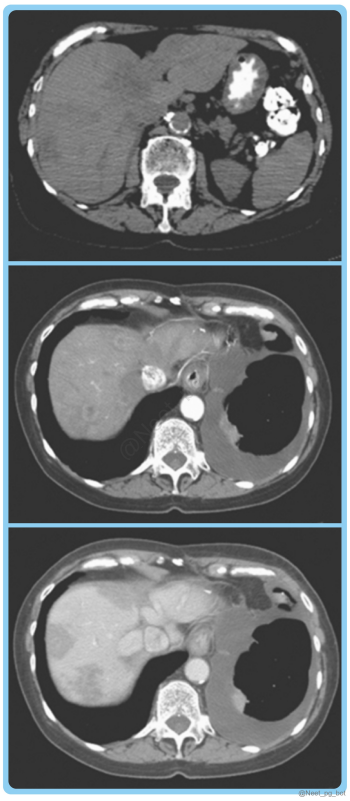
Q14: From the below given triple phase CT scan, which of the following statements is true regarding Liver cancer? (Q848909)

A. Hypodense in arterial phase in HCC

B. Hyperdense in arterial phase in Metastasis liver disease

C. Hyperdense in non-contrast CT in HCC

D. Hypodense in venous phase in Metastasis liver disease



See Answer in Part B → Q14

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• [04_Hepatobiliary Pancreatic Surgery] 014 Portal Hypertension

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[04_Hepatobiliary Pancreatic Surgery] 014 Portal Hypertension — Quick Jump

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Q7 (p. 204) *Q8 (p. 205)* *Q9 (p. 205)* *Q10 (p. 205)* *Q11 (p. 206)* *Q12 (p. 206)*
Q13 (p. 207) *Q14 (p. 207)*

Q1: A 45-year-old female who recently underwent bone marrow transplantation presents with abdominal pain and swelling. The clinical features resonate with hepatic veno-occlusive disease and a transvenous hepatic biopsy confirms the diagnosis. Which of the following symptoms is NOT a part of the clinical triad of hepatic veno-occlusive disease? (Q849016)

A. Tender hepatomegaly

B. Hyperbilirubinemia (jaundice)

C. Retention of fluid (ascites)

D. Portal hypertension

See Answer in Part B → Q1

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Q2: Which of the following is a pre-sinusoidal cause of portal hypertension? (Q849006)

A. Cirrhosis

B. Budd-Chiari syndrome

C. Congestive cardiac failure

D. Schistosomiasis

See Answer in Part B → Q2

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Q3: A 52-year-old man presents to the emergency department with worsening abdominal distension and visible abdominal veins. He has a history of chronic alcohol abuse and has been experiencing increasing fatigue and jaundice. Collaterals are between the paraumbilical vein &.....: Which of the following vessels is involved in this condition? (Q849007)

A. Left gastric vein

B. Superior and inferior epigastric vein

C. Superior mesenteric vein

D. Inferior vena cava



See Answer in Part B → Q3

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Q4: A 55-year-old man with a history of cirrhosis presents to the emergency department with hematemesis and melena. He is hypotensive and tachycardic. Which of the following is the most appropriate initial step in management? (Q849008)

A. Order an urgent upper endoscopy

B. Administer a proton pump inhibitor

C. Request a CT scan of the abdomen

D. Initiate fluid resuscitation

See Answer in Part B → Q4

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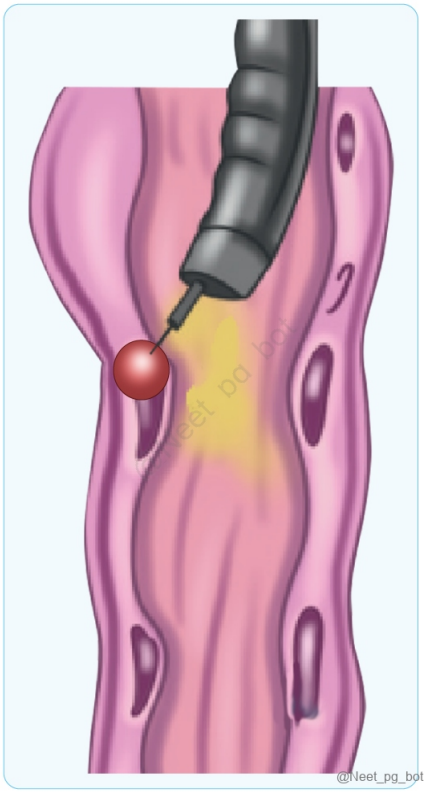
Q5: Which of the following statements is true about the image below? (Q849009)

A. Technically difficult to perform

B. Decreased chances of perforation

C. Always preferred over ligation

D. Lack of depth perception is present



See Answer in Part B → Q5

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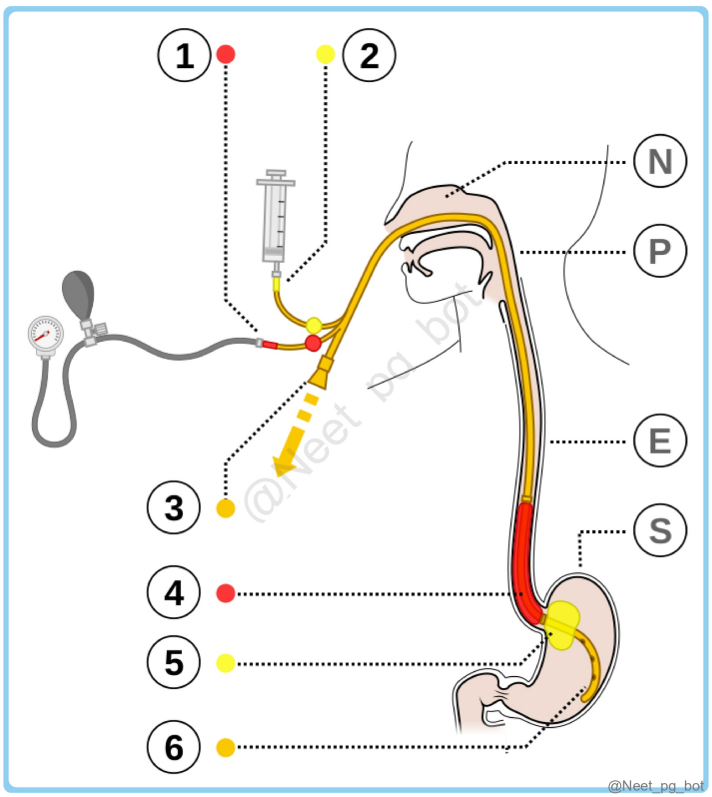
Q6: Identify the tube shown in the following image used in the management of portal hypertension. (Q849010)

A. Sengstaken-Blakemore tube

B. Minnesota tube

C. Linton-Nachlas tube

D. Nasogastric (Ryle's) tube



See Answer in Part B → Q6

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Q7: A 60-year-old patient with refractory ascites secondary to cirrhosis undergoes Transjugular intrahepatic portosystemic shunt placement. Two days post-procedure, the patient develops severe dyspnea, peripheral edema, jugular venous distension, and hypotension. A Doppler ultrasound reveals a patent shunt. Which of the following is the most likely cause of the patient's symptoms? (Q849011)

A. Right heart failure

B. Hepatorenal syndrome

C. Pulmonary hypertension

D. Porto-pulmonary hypertension

See Answer in Part B → Q7

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Q8: Which of the following complications is most likely to occur after the creation of a side-to-side portocaval shunt (SSPCS)? (Q849012)

A. Encephalopathy

B. Renal failure

C. Recurrent variceal bleeding

D. Portal vein thrombosis

See Answer in Part B → Q8

@Neet_pg_bot

Q9: Which selective shunt procedure is associated with the preservation of portal perfusion to the liver while effectively decompressing varices? (Q849013)

A. Distal splenorenal shunt (DSRS)

B. Proximal splenorenal shunt (PSRS)

C. Side-to-side portocaval shunt (SSPCS)

D. Interposition grafts

See Answer in Part B → Q9

@Neet_pg_bot

Q10: In a patient with Budd Chiari Syndrome, which of the following imaging findings is most indicative of chronic disease? (Q849014)

A. Enlarged caudate lobe

B. Ascites

C. Hepatic vein thrombosis

D. Splenomegaly

See Answer in Part B → Q10

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Q11: A 12-year-old boy presents with a history of recurrent episodes of gastrointestinal bleeding. He has no history of liver disease, jaundice, or ascites. Physical examination reveals moderate splenomegaly but no hepatomegaly. Doppler ultrasound of the abdomen shows obstruction at the confluence of the splenic vein and the superior mesenteric vein. What is the most likely diagnosis? (Q849015)

A. Cirrhosis

B. Non-Cirrhotic Portal Fibrosis (NCPF)

C. Extrahepatic Portal Vein Obstruction (EHPVO)

D. Budd-Chiari Syndrome

See Answer in Part B → Q11

@Neet_pg_bot

Q12: A 45-year-old man presents to the emergency department with a 3-day history of left upper quadrant abdominal pain and nausea. He has a history of chronic pancreatitis due to alcohol abuse. Physical examination reveals tenderness in the left upper quadrant and splenomegaly. Abdominal CT scan without contrast shows a thrombus in the splenic vein. What type of varices are likely to be seen on endoscopic examination? (Q849017)

A. Esophageal varices

B. Gastric varices

C. Esophageal and gastric varices, with esophageal predominant

D. Duodenal varices

See Answer in Part B → Q12

@Neet_pg_bot

Q13: A 60-year-old male with a history of cirrhosis presents with recurrent esophageal variceal bleeding that has not responded to endoscopic treatments. The patient is scheduled for a Sugiura procedure. Which of the following components is NOT part of the Sugiura procedure? (Q849018)

A. Splenectomy

B. Esophagogastric devascularization

C. Intraesophageal portacaval shunt

D. Esophageal transection

See Answer in Part B → Q13

@Neet_pg_bot

Q14: A 48-year-old male is diagnosed with portal hypertension. Hepatic venous pressure gradient (HVPG) measurements are taken to assess the severity of his portal hypertension. Based on the prognostic values of HVPG, what are the cut-off HVPG values for clinically significant portal hypertension and increased risk of acute variceal bleeding respectively? (Q849019)

A. ≥6 mm Hg, ≥10mm Hg

B. ≥8 mm Hg, ≥12 mm Hg

C. ≥10 mm Hg, ≥12 mm Hg

D. ≥16 mm Hg, ≥18 mm Hg

See Answer in Part B → Q14

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• [04_Hepatobiliary Pancreatic Surgery] 015 Gall Bladder - I

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[04_Hepatobiliary Pancreatic Surgery] 015 Gall Bladder - I — Quick Jump

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Q1: Which of the following is not a risk factor for gallbladder carcinoma? (Q849000)

A. Smoking

B. Gallstones

C. Porcelain gallbladder

D. Hepatitis B

See Answer in Part B → Q1

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Q2: A 65-year-old female presents with severe right upper quadrant pain, jaundice, and a history of recurrent cholangitis. Imaging reveals a cholecystocholedochal fistula involving up to two-thirds of the circumference of the common bile duct. Which type of Mirizzi syndrome is seen in this patient? (Q848994)

A. Type I

B. Type II

C. Type III

D. Type IV

See Answer in Part B → Q2

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Q3: A 75-year-old male in the ICU with sepsis and multiple organ failure develops sudden right upper quadrant pain and fever. Ultrasound reveals a distended gallbladder with thickened walls and no gallstones. Which of the following is not a predisposing factor for acalculous cholecystitis? (Q848992)

A. Parenteral nutrition

B. Extensive burns

C. Hypertension

D. Diabetes

See Answer in Part B → Q3

@Neet_pg_bot

Q4: A 75-year-old female with a history of cholelithiasis presents with acute abdominal pain, vomiting, and signs of bowel obstruction. O/E, she has abdominal distension and high-pitched bowel sounds. A radiograph shows pneumobilia and a calcified gallstone in the right lower quadrant. CT confirms an abnormal gallbladder with air and fluid accumulation. What is the most appropriate management for this patient? (Q848991)

A. Cholecystectomy and fistula repair

B. Endoscopic removal of the gallstone

C. Enterolithotomy

D. Conservative management with IV fluids and antibiotics

See Answer in Part B → Q4

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Q5: A 65-year-old male with a history of diabetes presents with severe right upper quadrant pain, fever, and jaundice. Imaging reveals gas within the gallbladder wall. Which of the following organisms is most likely to be the causative agent in this patient's condition? (Q848990)

A. Clostridium perfringens

B. Staphylococcus aureus

C. Streptococcus pyogenes

D. Pseudomonas aeruginosa

See Answer in Part B → Q5

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Q6: A 65-year-old female presents with right upper quadrant pain and nausea. An ultrasound reveals a 1.5 cm gallbladder polyp, and a follow-up scan shows an increase in size from the previous scan six months ago. She also has a history of gallstones. Which of the following factors increases the risk of invasive cancer in gallbladder polyps? (Q848996)

A. Age less than 60 years

B. Presence of gallstones

C. Polyp size more than 0.5 cm

D. The same polyp size on repeated scans

See Answer in Part B → Q6

@Neet_pg_bot

Q7: A 70-year-old female presents with vague right upper quadrant discomfort, but she is mostly asymptomatic. An abdominal X-ray reveals extensive calcification of the gallbladder wall. There is bluish appearance and brittle consistency of the gallbladder. What is the most likely diagnosis? (Q848999)

A. Gallbladder carcinoma

B. Cholesterolosis

C. Porcelain gallbladder

D. Acute cholecystitis

See Answer in Part B → Q7

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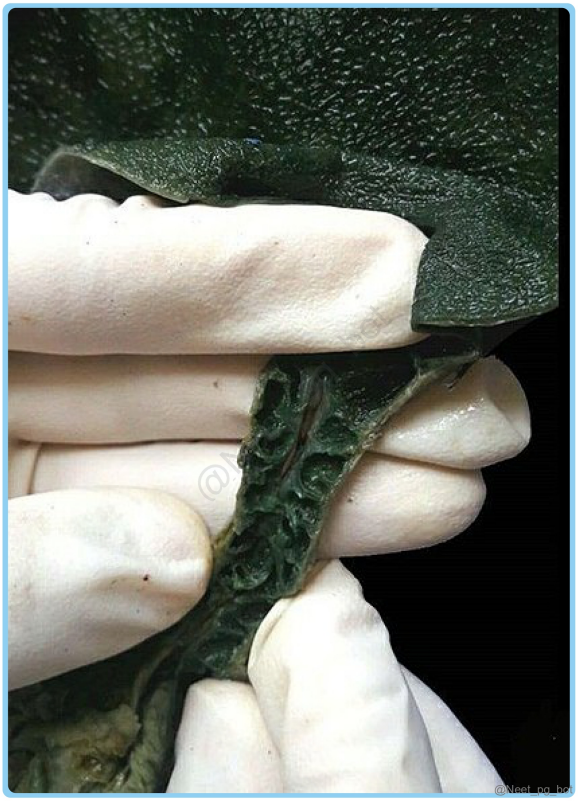
Q8: A 50 y/o woman undergoing laparoscopic cholecystectomy is found to have a structure that appears to have a spiral configuration. What is the most likely anatomical feature being observed? (Q843481)

A. Vasa vasorum

B. Sphincter of Oddi

C. Accessory Pancreatic Duct

D. Valves of Heister



See Answer in Part B → Q8

@Neet_pg_bot

Q9: Which of the following risk factors is associated with both gallbladder cancer and cholangiocarcinoma? (Q849001)

A. Gallstones

B. Porcelain gallbladder

C. Primary sclerosing cholangitis (PSC)

D. Hepatitis C virus infection

See Answer in Part B → Q9

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Q10: A 45 y/o patient presents with recurrent right upper quadrant pain and nausea. Imaging reveals a pathological outpouching in the infundibular region of the gallbladder containing multiple gallstones. What is this feature known as? (Q843479)

A. Phrygian cap

B. Floating gallbladder

C. Hartmann's pouch

D. Gallbladder carcinoma

See Answer in Part B → Q10

@Neet_pg_bot

Q11: Which layer of the gastric wall is considered the strongest? (Q843478)

A. Mucosa

B. Submucosa

C. Muscularis Externa

D. Serosa

See Answer in Part B → Q11

@Neet_pg_bot

Q12: A 65 y/o female presents with a 3-month history of intermittent upper right quadrant pain, weight loss, and loss of appetite. She has jaundice and a palpable mass in the right upper quadrant. Laboratory tests reveal mild anaemia, leukocytosis, and elevated CA19-9 and carcinoembryonic antigen. USG suggests a gallbladder mass and a CT scan confirms the mass without distant metastases. What is the most appropriate next step in management? (Q849002)

A. Immediate laparoscopic cholecystectomy

B. Percutaneous biopsy of the gallbladder mass

C. Referral for palliative chemotherapy

D. Laparoscopic examination for staging

See Answer in Part B → Q12

@Neet_pg_bot

Q13: Which of the following surgeons is correctly matched with their pioneering laparoscopic procedure and year of achievement? (Q849005)

A. Professor Erich Mühe - First video-assisted laparoscopic cholecystectomy in 1987

B. Dr. Philippe Mouret - First laparoscopic cholecystectomy in 1985

C. Dr. Kurt Semm - First laparoscopic appendicectomy in 1983

D. Professor Erich Mühe - First laparoscopic appendicectomy in 1983

See Answer in Part B → Q13

@Neet_pg_bot

Q14: A 62-year-old male presents with intermittent right upper quadrant pain and nausea. An ultrasound shows significant thickening of the gallbladder wall and hyperproliferation of the mucosa. Which of the following is NOT a USG finding in Adenomyomatosis? (Q848998)

A. Diamond ring sign

B. Comet tail artefacts

C. V-shaped artefacts

D. Porcelain appearance

See Answer in Part B → Q14

@Neet_pg_bot

Q15: A 58-year-old male, with past h/o cholesterol stones, presents with intermittent right upper quadrant pain and occasional nausea.USG reveals the gallbladder mucosa has a coarse, granular appearance with small nodules and some larger polypoid formations. On performing laparoscopic cholecystectomy of this patient, the following appearance of the gall bladder was observed. What is the most likely diagnosis? (Q848997)

A. Acute cholecystitis

B. Porcelain gallbladder

C. Cholesterolosis

D. Gallbladder carcinoma



See Answer in Part B → Q15

@Neet_pg_bot

Q16: A 65 y/o presents with jaundice, weight loss, and abdominal pain. O/E a palpable mass is noted in the right upper quadrant. Imaging studies reveal a mass involving the gallbladder, with signs of local invasion but no distant or lymph node metastasis. A biopsy confirms gallbladder carcinoma. Based on the TNM classification, which stage is most likely for this patient's tumour? (Q849003)

A. T1a N0 M0

B. T2b N1 M0

C. T3 N0 M0

D. T4 N2 M1

See Answer in Part B → Q16

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Q17: A 58 y/o presents with jaundice, weight loss, and upper right abdominal pain. Imaging studies including CT and MRI reveal a mass in the gallbladder with local invasion into the liver but no distant metastasis. The patient undergoes a laparoscopic examination confirming the staging. What is the most appropriate treatment approach for this patient? (Q849004)

A. Endoscopic stenting to relieve jaundice

B. Radical en bloc resection of the gallbladder, liver wedge, and regional lymph nodes

C. Palliative chemotherapy

D. No further treatment if the tumor is confined to the mucosa

See Answer in Part B → Q17

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Q18: A 58-year-old male presents with right upper quadrant pain, jaundice, and fever. Imaging reveals a gallstone eroding less than one-third of the circumference of the common bile duct. What is the management? (Q848995)

A. Bilio-enteric anastomosis

B. Percutaneous cholecystostomy

C. Subtotal/Partial cholecystectomy + ERCP stenting

D. Partial cholecystectomy with choledochoplasty

See Answer in Part B → Q18

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Q19: A 45-y/o female presents with symptomatic gallstones and is scheduled for laparoscopic cholecystectomy. During the procedure, the surgeon encounters difficulty due to unexpected anatomical variations. The right hepatic artery appears very tortuous and is located close to the cystic duct. What is the most likely anatomical anomaly encountered in this case? (Q843338)

A. Phrygian cap

B. Moynihan Hump

C. Floating Gallbladder

D. Mirizzi Syndrome

See Answer in Part B → Q19

@Neet_pg_bot

Q20: A 70-year-old critically ill male in the ICU with sepsis and multiple organ failure presents with sudden onset of right upper quadrant pain, fever, and jaundice. Bedside ultrasonography shows a distended gallbladder with thickened walls and pericholecystic fluid but no gallstones. What is the treatment of choice for this patient? (Q848993)

A. Laparoscopic cholecystectomy

B. Oral antibiotics and observation

C. Endoscopic retrograde cholangiopancreatography (ERCP)

D. Percutaneous cholecystostomy

See Answer in Part B → Q20

@Neet_pg_bot

Q21: A 45-year-old woman with asymptomatic gallstones is being evaluated for prophylactic cholecystectomy. Which of the following is NOT typically considered an indication for prophylactic cholecystectomy? (Q848989)

A. Gallstones larger than 3 cm

B. Presence of gallstones in the common bile duct

C. Asymptomatic small gallbladder polyps

D. Undergoing bariatric surgery

See Answer in Part B → Q21

@Neet_pg_bot

Q22: Which of the following is an indication for dissolution therapy in gallstone management? (Q848988)

A. Non-functioning gallbladder

B. Stone larger than 1.5 cm

C. Cholesterol stones which are typically radiolucent

D. Multiple stones

See Answer in Part B → Q22

@Neet_pg_bot

Q23: A 60-year-old patient with a history of diabetes and hypertension presents with right upper quadrant pain, fever, and elevated white blood cell count. According to the Tokyo Guidelines (2013/2018), what is the recommended treatment approach if the patient is diagnosed with Grade II acute cholecystitis and does not respond to antibiotic treatment and supportive care? (Q848987)

A. Early laparoscopic cholecystectomy within 5-7 days.

B. Immediate discharge with oral antibiotics.

C. Early gallbladder drainage followed by delayed/elective cholecystectomy.

D. Delayed cholecystectomy after 6 weeks.

See Answer in Part B → Q23

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Q24: A 45-year-old patient presents with right upper quadrant (RUQ) pain and fever. On examination, the clinician notes localized tenderness over the right

hypochondrium. USG of the abdomen reveals gallbladder wall thickness of about 5mm along with the presence of pericholecystic fluid. According to the Tokyo Guidelines, which combination of findings would confirm a diagnosis of acute cholecystitis? (Q848986)

A. RUQ tenderness, elevated C-reactive protein, gallbladder wall thickening on USG.

B. Murphy's sign, fever, normal gallbladder wall on USG.

C. Palpable RUQ mass, normal white blood cell count, pericholecystic fluid on USG.

D. RUQ pain, elevated C-reactive protein, no imaging finding

See Answer in Part B → Q24

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Q25: An ultrasound image of the gallbladder is consistent with a congenital anatomical variant. What is the most likely diagnosis? (Q843484)

A. Floating gallbladder

B. Accessory gallbladder

C. Phrygian cap

D. Gallbladder septum



See Answer in Part B → Q25

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Q26: A 45 y/o woman presents to the ER with severe right upper quadrant abdominal pain, nausea, and vomiting. She has a history of gallstones and is diagnosed with acute cholecystitis. During laparoscopic cholecystectomy, the surgeon encounters difficulty identifying the cystic artery due to inflammation. Which anatomical landmarks within Calot's triangle would be most helpful in locating the cystic artery? (Q843480)

A. Gallbladder fundus

B. Cystic lymph node

C. Common bile duct

D. Portal vein

See Answer in Part B → Q26

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Q27: A 45 y/o woman presents with severe right upper quadrant pain, fever, and nausea. She has a history of pain after fatty meals. O/E, she has right upper quadrant tenderness and a positive Murphy's sign. Lab tests show elevated alkaline phosphatase, bilirubin, transaminases, and leukocytosis. Which investigation is best to confirm this patient’s diagnosis? (Q843342)

A. USG- Sonographic Murphy's sign positive.

B. Plain X-Ray- Identifies radio-opaque gallstones

C. CT Scan- Pericholecystic fluid, Impacted stones, gallbladder wall thickness

D. HIDA Scan- Non-visualization of the gallbladder

See Answer in Part B → Q27

@Neet_pg_bot

Q28: A 45 y/o woman presents to the ER with severe right upper quadrant pain radiating to her back. She has a h/o gallstones. O/E, she exhibits tenderness in the right upper quadrant. An abdominal CT scan shows a characteristic triradiate pattern of gas within a gallstone. Based on the CT findings, which of the following signs is most likely being described? (Q843341)

A. Murphy sign

B. Mermaid sign

C. Stellate scar sign

D. Mercedes-Benz sign



See Answer in Part B → Q28

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Q29: Which of the following statements accurately describes a characteristic of pigment stones? (Q843340)

A. Black pigment stones are associated with bacterial β-glucuronidase activity in the bile duct.

B. Black pigment stones are associated with hemolysis.

C. Brown pigment stones are associated with excess bilirubin from hemolysis.

D. Black pigment stones are primarily composed of calcium bilirubinate and cholesterol.

See Answer in Part B → Q29

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Q30: A 49-y/o woman presents with intermittent right upper quadrant pain that worsens after fatty meals. She has a history of Sickle cell disease and has been on total parenteral nutrition (TPN) for the past six months due to severe Crohn's disease post-ileal resection. She also gives a h/o OCP usage for 5 years. The patient underwent cholecystectomy which showed the following finding. Which of the following factors is least likely to contribute to the formation of this patient's condition? (Q843339)

A. Total parenteral nutrition

B. Sickle cell disease

C. Ileal resection due to Crohn's disease

D. OCP usage



See Answer in Part B → Q30

@Neet_pg_bot

• [04_Hepatobiliary Pancreatic Surgery] 016 Bile Duct

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Q19 (p. 232)	*Q20 (p. 233)*	*Q21 (p. 234)*	*Q22 (p. 234)*	*Q23 (p. 235)*	

Q1: A 50 year old woman presents with complaints of persistent fatigue, itching, and mild right upper quadrant abdominal pain. On examination, she has jaundice and hepatomegaly. Laboratory tests reveal elevated alkaline phosphatase and positive anti-mitochondrial antibodies. What is the most likely diagnosis? (Q843496)

A. Primary biliary cirrhosis

B. Primary sclerosing cholangitis

C. Autoimmune hepatitis

D. Drug-induced liver disease

See Answer in Part B → Q1

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Q2: A 70 year old male presents with painless obstructive jaundice, significant weight loss, and a palpable, non-tender mass in the right hypochondrium. Imaging reveals a mass at the liver hilum with no evidence of distant metastasis. What is the correct management of this patient? (Q848917)

A. Stenting through PTC or ERCP

B. Portal region clearance with hemihepatectomy

C. Extensive bile duct resection, nodal clearance, caudate lobe removal, and cholecystectomy

D. Chemotherapy with 5-FU and cisplatin

See Answer in Part B → Q2

@Neet_pg_bot

Q3: A 55 year old woman undergoes a cholecystectomy, after which she develops jaundice and abdominal pain. Imaging reveals a bile duct stricture at the confluence of the right and left hepatic ducts, but the ducts themselves are intact. According to the Bismuth classification, what type of stricture does she have? (Q843542)

A. Type I

B. Type II

C. Type III

D. Type IV

See Answer in Part B → Q3

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Q4: A 25-year-old woman presents with persistent right upper quadrant pain for several days, fever, and jaundice. On examination, right upper quadrant tenderness is present. On USG, cystic dilation of the common bile duct is seen. Which of the following malignancies is not associated with this condition? (Q848898)

A. Cholangiocarcinoma

B. Squamous Cell carcinoma

C. Pancreatic Carcinoma

D. Renal cell carcinoma

See Answer in Part B → Q4

@Neet_pg_bot

Q5: A 45-year-old woman presents with worsening abdominal pain, jaundice, and fever. Ultrasound shows a choledochal cyst and bile duct obstruction. What imaging study is most appropriate for the next step in management? (Q848899)

A. CT Scan

B. Magnetic Resonance Cholangiopancreatography

C. Endoscopic Retrograde Cholangiopancreatography

D. Percutaneous Transhepatic Cholangiography

See Answer in Part B → Q5

@Neet_pg_bot

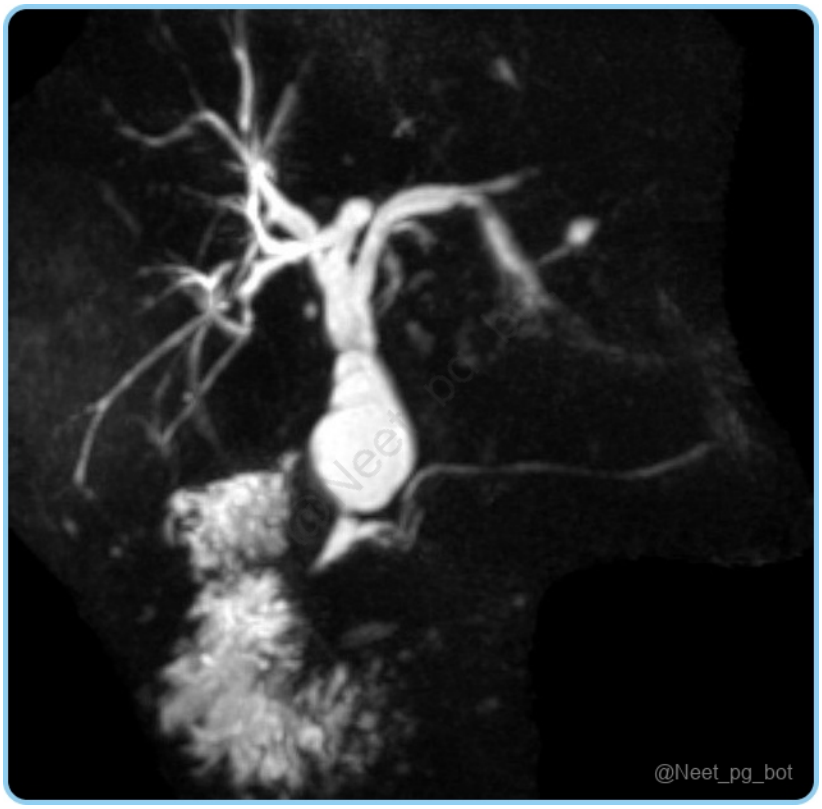
Q6: MRCP imaging studies done for a 35 year old woman who presented with a history of recurrent cholangitis, jaundice, and right upper quadrant pain reveal the following. Based on the Todani classification, what is the most appropriate surgical treatment for this patient? (Q848897)

A. Liver transplantation

B. Transduodenal sphincteroplasty

C. Roux-en-Y hepaticojejunostomy

D. Partial hepatectomy



See Answer in Part B → Q6

@Neet_pg_bot

Q7: During a laparoscopic cholecystectomy, a lateral injury to the Common Bile Duct is identified. What is the most appropriate next step in management? (Q882176)

A. Continue the laparoscopic procedure and place a drain

B. Convert to open procedure with T-tube drainage

C. Ligate the duct proximal to the injury

D. Close the abdomen and refer for ERCP

See Answer in Part B → Q7

@Neet_pg_bot

Q8: According to the Strasberg classification, what type of bile duct injury does this image show? (Q848919)

A. Class A

B. Class B

C. Class C

D. Class D



See Answer in Part B → Q8

@Neet_pg_bot

Q9: A 45-year-old male presents with severe colicky pain in the upper right quadrant, jaundice, and episodes of haematemesis and melaena. He had a history of blunt abdominal trauma a few weeks ago. Which is the investigation of choice for detecting the bleeding site in this patient? (Q848918)

A. Liver Function Tests

B. Ultrasound of the abdomen

C. Selective arteriography

D. Upper GI endoscopy

See Answer in Part B → Q9

@Neet_pg_bot

Q10: A 65 year old female presents with painless jaundice and a palpable, non-tender, globular mass in the right hypochondrium. Imaging suggests an obstructed biliary system. The patient has no history of gallstones. Based on Courvoisier's law, which of the following conditions is not an exception to the rule? (Q848916)

A. Double impacted stone

B. A large stone in Hartmann's pouch

C. Empyema of the gallbladder with a CBD stone

D. Chronic cholecystitis with multiple gallstones

See Answer in Part B → Q10

@Neet_pg_bot

Q11: A 58 year old female presents with painless obstructive jaundice, significant weight loss, and anorexia. Imaging reveals a tumour involving the confluence of the right hepatic duct and left hepatic duct, extending into both ducts. Based on the Bismuth-Corlette classification, which type of perihilar cholangiocarcinoma is most consistent with these findings? (Q848915)

A. Type 1

B. Type 2

C. Type 3A

D. Type 4

See Answer in Part B → Q11

@Neet_pg_bot

Q12: Which of the following is not a risk factor for cholangiocarcinoma? (Q848914)

A. Primary sclerosing cholangitis

B. Hepatitis C

C. Clonorchis sinensis infestation

D. Alcohol consumption

See Answer in Part B → Q12

@Neet_pg_bot

Q13: Which of the following is the classical triad of acute cholangitis? (Q848911)

A. Pain, jaundice, fever

B. Pain, jaundice, shock

C. Fever, jaundice, ↑WBC

D. Pain, ↑WBC, ↑Bilirubin

See Answer in Part B → Q13

@Neet_pg_bot

Q14: A 40 year old patient is experiencing persistent abdominal pain and elevated serum amylase after undergoing ERCP. The pain began shortly after the procedure. Which of the following is the most likely cause of the patient's symptoms? (Q848910)

A. Post-ERCP pancreatitis

B. Post-ERCP duodenal perforation

C. Post-ERCP cholangitis

D. Post-ERCP sphincter stenosis

See Answer in Part B → Q14

@Neet_pg_bot

Q15: A 55 year old male with history of obesity and a low-protein diet presents with intermittent abdominal pain, jaundice, and recurrent episodes of dark urine and light-colored stools. Recently, he developed a fever with chills. Blood tests show elevated WBC count and abnormal liver function tests. MRCP reveals multiple pigmented stones in the common bile duct and intrahepatic ducts. What is the most likely cause of his condition? (Q843489)

A. Primary Choledocholithiasis

B. Secondary Choledocholithiasis

C. Gallstone ileus

D. Chronic Pancreatitis

See Answer in Part B → Q15

@Neet_pg_bot

Q16: How many sphincters make up the Sphincter of Oddi Complex? (Q848889)

A. 12

B. 9

C. 6

D. 4

See Answer in Part B → Q16

@Neet_pg_bot

Q17: During a gallbladder surgery, the surgeon identifies the hepatic artery running medially and carefully avoids injuring a structure located laterally to it. Which of the following is the most likely structure located lateral to the hepatic artery? (Q848888)

A. Common hepatic duct

B. Portal vein

C. Cystic artery

D. Common bile duct

See Answer in Part B → Q17

@Neet_pg_bot

Q18: Which artery primarily supplies the common hepatic duct and the common bile duct? (Q848887)

A. Gastroduodenal artery

B. Pancreaticoduodenal artery

C. Right hepatic artery

D. Left hepatic artery

See Answer in Part B → Q18

@Neet_pg_bot

Q19: A 50 year old man presents with jaundice and abdominal pain one week after a cholecystectomy. Imaging confirms a bile duct injury with a complete transection of the common bile duct. What is the recommended management for this injury at this stage? (Q843544)

A. Immediate surgical repair

B. Conservative management with antibiotics and observation

C. Delay repair for 4-6 weeks and then perform Roux-en-Y choledochojejunostomy

D. Endoscopic stenting and balloon dilation

See Answer in Part B → Q19

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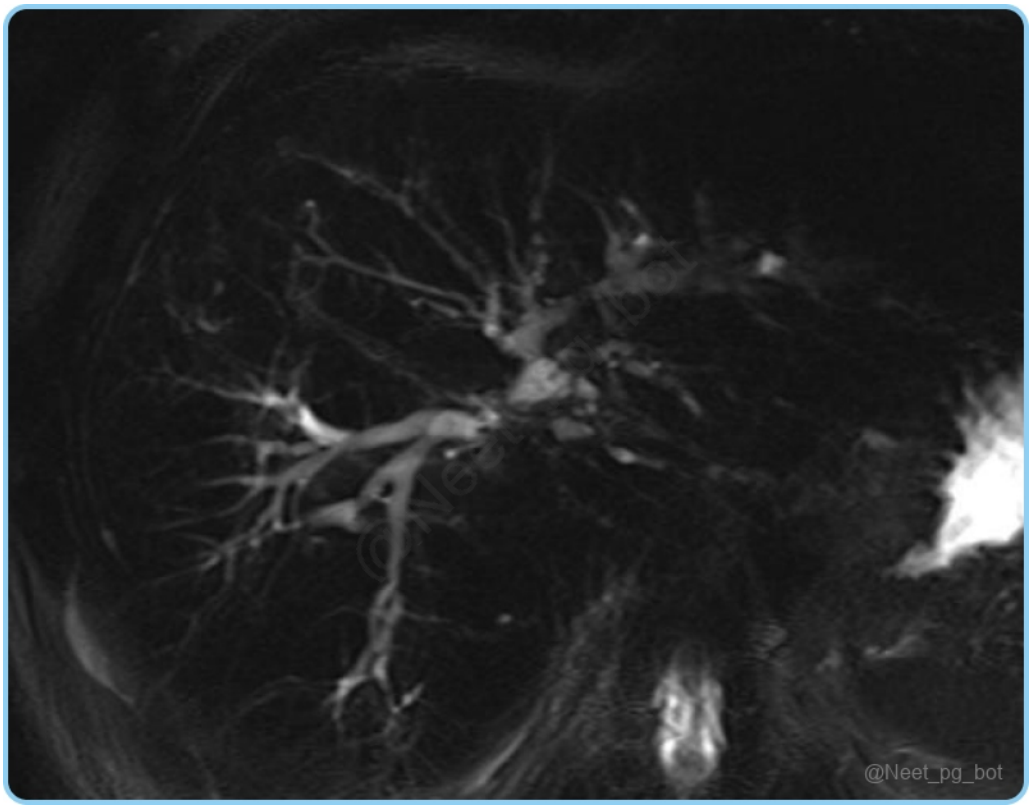
Q20: A 40 year old male with a history of ulcerative colitis presents with fatigue, pruritus, jaundice, elevated ALP, and GGTP. The MRCP and Liver biopsy show the following findings. Despite endoscopic stenting, his symptoms persist, and liver function continues to decline. What is the most definitive treatment option for this patient? (Q843541)

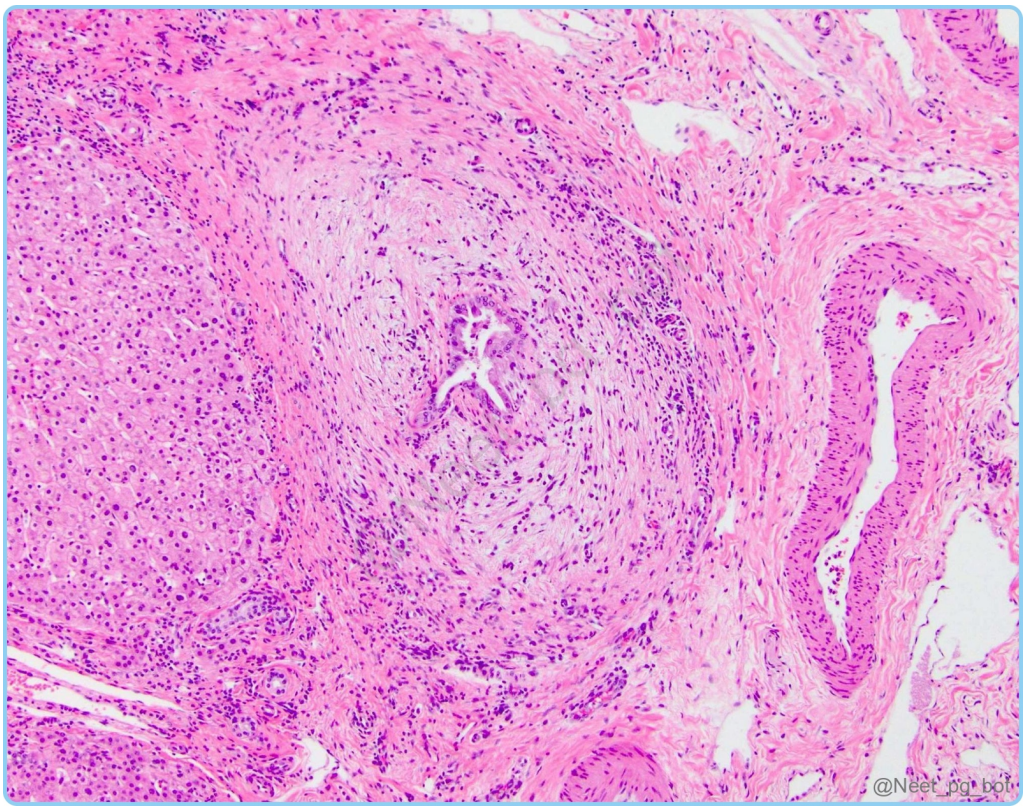
A. Antibiotics and cholestyramine

B. Endoscopic retrograde cholangiopancreatography

C. Liver transplantation

D. Operative resection





See Answer in Part B → Q20

@Neet_pg_bot

Q21: A 45 year old male with a history of ulcerative colitis presents with jaundice, right upper quadrant pain, and intermittent fever. Laboratory tests reveal elevated serum ALP and gamma-glutamyl transpeptidase (GGTP). MRCP shows stricturing and beading of the bile ducts. What is the most likely diagnosis? (Q843540)

A. Primary sclerosing cholangitis

B. Acute cholangitis

C. Choledocholithiasis

D. Hepatocellular carcinoma

See Answer in Part B → Q21

@Neet_pg_bot

Q22: A 70 year old female presents with signs of severe cholangitis. Despite initial treatment with broad-spectrum antibiotics and an unsuccessful ERCP attempt, her condition continues to worsen. An ultrasound shows multiple stones and a severely dilated common bile duct. What is the next best step in management? (Q843495)

A. Repeat ERCP

B. Percutaneous transhepatic cholangiography (PTC)

C. Open biliary decompression

D. Continued observation and supportive care

See Answer in Part B → Q22

@Neet_pg_bot

Q23: A 62 year old male presents with jaundice and severe abdominal pain in the right upper quadrant that started abruptly after a heavy meal. He also reports dark urine, pale stools, and intermittent fever with chills. An ultrasound shows a dilated common bile duct. ERCP is planned for stone removal. What is the maximum size of the stone that can typically be removed by ERCP without additional procedures? (Q843491)

A. 17 mm

B. 15 mm

C. 20 mm

D. 25 mm

See Answer in Part B → Q23

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• [04_Hepatobiliary Pancreatic Surgery] 017 Pancreatic Tumors - I

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[04_Hepatobiliary Pancreatic Surgery] 017 Pancreatic Tumors - I — Quick Jump

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Q19 (p. 243)	*Q20 (p. 243)*	*Q21 (p. 244)*	*Q22 (p. 244)*	*Q23 (p. 245)*	

Q1: Which type of pancreatic neoplasm most commonly arises in the tail of the pancreas? (Q848982)

A. Serous cystadenoma.

B. Mucinous cystadenoma

C. VIPOMA

D. Adenocarcinoma pancreas

See Answer in Part B → Q1

@Neet_pg_bot

Q2: A 60-year-old male presents with recurrent episodes of abdominal pain and is found to have jaundice. An ERCP is performed, revealing thick mucus extruding through the ampulla of Vater. Which of the following is the most likely diagnosis? (Q848974)

A. Pseudocyst

B. Main duct IPMN

C. Chronic pancreatitis

D. Pancreatic adenocarcinoma

See Answer in Part B → Q2

@Neet_pg_bot

Q3: What is the most common complication and common cause of death in a patient post pancreaticoduodenectomy? (Q848927)

A. Delayed gastric emptying, Pulmonary complication

B. Anastomosis leak, Pulmonary complication

C. Delayed gastric emptying, Perforated bowel obstruction

D. Anastomosis leak, Perforated bowel obstruction

See Answer in Part B → Q3

@Neet_pg_bot

Q4: A 48-year-old perimenopausal woman presents with abdominal discomfort. Imaging reveals a multilocular cyst with thick walls located in the pancreatic tail. Fine-needle aspiration of the cyst fluid shows high carcinoembryonic antigen levels exceeding 400 ng/mL, with normal amylase levels. What is the most likely diagnosis? (Q848965)

A. Pancreatic pseudocyst

B. Serous cystadenoma

C. Mucinous cystic neoplasm

D. Adenoma of the Ampulla of Vater

See Answer in Part B → Q4

@Neet_pg_bot

Q5: A 45-year-old male has a history of recurrent peptic ulcers and severe abdominal pain. Despite the use of proton pump inhibitors, his symptoms persist. Endoscopic examination reveals small nodules in the medial wall of the duodenum. His family history is significant for multiple endocrine neoplasia type I. Which of the following

statements is most likely true regarding his condition? (Q848952)

A. The tumors are most commonly found in the tail of the pancreas.

B. The condition is curable with surgical removal of the primary tumor.

C. The patient's gastrinoma is likely located within the gastrinoma triangle.

D. The use of proton pump inhibitors has made diagnosis of this condition easier

See Answer in Part B → Q5

@Neet_pg_bot

Q6: A 70-year-old female patient is evaluated for a pancreatic cystic mass. The CT scan shows a lobular, hypodense lesion with multiple small cysts, a central hyperdense scar, and scattered "sunburst" calcifications. Based on these findings, what is the most likely diagnosis? (Q848962)

A. Mucinous cystic neoplasm

B. Pancreatic pseudocyst

C. Serous cystadenoma

D. Intraductal papillary mucinous neoplasm

See Answer in Part B → Q6

@Neet_pg_bot

Q7: What is the most common site of gastrinoma in patients with Zollinger–Ellison syndrome (Q848953)

A. Stomach

B. Pancreas

C. Duodenum

D. Liver

See Answer in Part B → Q7

@Neet_pg_bot

Q8: Among the following, which option correctly describes the most common location of origin of insulinoma in the pancreas? (Q848984)

A. Head > Body > Tail

B. Body = Tail > Head

C. Tail > Body > Head

D. Head = Body = Tail

See Answer in Part B → Q8

@Neet_pg_bot

Q9: Which type of pancreatic neoplasm most commonly arises in the body and tail of the pancreas? (Q848978)

A. Serous cystadenom

B. Mucinous cystadenoma

C. Intraductal papillary mucinous neoplasm

D. Adenocarcinoma pancreas

See Answer in Part B → Q9

@Neet_pg_bot

Q10: A 55-year-old male presents with jaundice, weight loss, and epigastric pain. Imaging reveals a mass in the head of the pancreas. Which of the following conditions is most likely responsible for these symptoms? (Q848976)

A. Chronic Pancreatitis

B. Ductal Adenocarcinoma

C. Solid Pseudopapillary Neoplasm

D. Intraductal Papillary Mucinous Neoplasm

See Answer in Part B → Q10

@Neet_pg_bot

Q11: A patient with a suspected intraductal papillary mucinous neoplasm (IPMN) has elevated serum CA 19-9 levels. What does this finding most likely suggest? (Q848971)

A. The IPMN is benign and does not require surgical intervention

B. The IPMN is likely malignant or has high-grade dysplasia

C. The IPMN is a branch duct type and requires conservative management

D. The IPMN is likely malignant and surgery is contraindicated

See Answer in Part B → Q11

@Neet_pg_bot

Q12: In a patient with a pancreatic cyst, peripheral eggshell calcification on CT is: (Q848967)

A. Common in benign cysts and easily detected.

B. Easily detected and a definitive marker of malignancy.

C. Difficult to detect but highly indicative of malignancy in mucinous cystic neoplasms.

D. Exclusively associated with pancreatic pseudocysts, not with malignancy.

See Answer in Part B → Q12

@Neet_pg_bot

Q13: A 45-year-old patient presents with chronic watery diarrhea. Laboratory tests reveal elevated levels of vasoactive intestinal peptide (VIP) > 150 pg/ml, achlorhydria, and hypokalemia. Imaging studies show a solitary mass in the body of the pancreas. What is the treatment of choice in this condition? (Q848960)

A. Initiate high-dose corticosteroid therapy with Prednisolone

B. Start treatment with Octreotide

C. Perform a distal pancreatectomy

D. Begin broad-spectrum antibiotic therapy

See Answer in Part B → Q13

@Neet_pg_bot

Q14: A 58-year-old female presents with diarrhea, weight loss, and itchy lesions around the mouth and vagina. Physical examination reveals a rash as shown in the image below. On evaluation, she has diabetes, and imaging studies indicate a large pancreatic mass. Which of the following is the most likely diagnosis? (Q848956)

A. Gastrinoma

B. Insulinoma

C. Glucagonoma

D. VIPoma



See Answer in Part B → Q14

@Neet_pg_bot

Q15: A 45-year-old woman with a family history of cancer presents for a routine check-up. Her mother and maternal aunt both had pancreatic cancer. Genetic testing reveals a gain-of-function mutation in the PRSS1 gene. Which of the following factors contributes the most to her increased risk of developing pancreatic cancer? (Q848920)

A. Chronic pancreatitis

B. Germline BRCA2 mutation

C. Lynch syndrome

D. Hereditary pancreatitis

See Answer in Part B → Q15

@Neet_pg_bot

Q16: Which diagnostic finding is most indicative of an insulinoma? (Q848951)

A. Elevated serum glucose levels

B. Low C-peptide levels

C. Elevated serum insulin levels during hypoglycemia

D. Hyperinsulinemic response to oral glucose tolerance test

See Answer in Part B → Q16

@Neet_pg_bot

Q17: Which of the following statements is true regarding neuroendocrine tumors of the pancreas? (Q848928)

A. The most common non-functional neuroendocrine tumor of the pancreas is insulinoma

B. Somatostatin receptor scintigraphy is used for the localization of NETs

C. The most common site of metastasis is the lungs

D. Functional NETs are diagnosed at a later stage and have poor prognosis

See Answer in Part B → Q17

@Neet_pg_bot

Q18: Which surgical procedure is characterized by the resection of the pancreatic head while preserving the stomach and pylorus? (Q848926)

A. Whipple procedure

B. Distal pancreatectomy

C. Longmire Traverso procedure

D. Total pancreatectomy

See Answer in Part B → Q18

@Neet_pg_bot

Q19: A patient is scheduled to undergo a Whipple procedure for the treatment of pancreatic cancer. The surgeon needs to perform anastomosis to reconstruct the digestive tract after removing the affected tissues. In which sequence are the anastomoses typically performed during a Whipple procedure? (Q848925)

A. Hepaticojejunostomy → Pancreaticojejunostomy → Gastrojejunostomy

B. Pancreaticojejunostomy → Hepaticojejunostomy → Gastrojejunostomy

C. Gastrojejunostomy → Pancreaticojejunostomy → Hepaticojejunostomy

D. Pancreaticojejunostomy → Gastrojejunostomy → Hepaticojejunostomy

See Answer in Part B → Q19

@Neet_pg_bot

Q20: A 65-year-old male presents with jaundice, dark urine, and weight loss over the past two months. Courvoisier's Sign is positive on physical examination. What is the

next best step in the management of this patient to both visualize pancreatic and biliary ducts, and tissue sampling? (Q848924)

A. Computed Tomography

B. Endoscopic Ultrasonography

C. Endoscopic Retrograde Cholangiopancreatography

D. Diagnostic Laparoscopy

See Answer in Part B → Q20

@Neet_pg_bot

Q21: A 55-year-old man with no history of obesity or a family history of diabetes is recently diagnosed with diabetes mellitus. He also reports vague upper abdominal discomfort, significant weight loss, and mild jaundice. Which of the following findings on physical examination would most likely suggest a diagnosis of pancreatic cancer? (Q848923)

A. Tender and enlarged gallbladder

B. Hepatomegaly with jaundice

C. Courvoisier's sign

D. Murphy’s sign

See Answer in Part B → Q21

@Neet_pg_bot

Q22: A 56-year-old patient with pancreatic cancer has completed initial treatment. To monitor for potential recurrence, the oncologist decides to check a tumor marker. Which of the following tumor markers is commonly used for establishing a baseline and monitoring for recurrence in pancreatic cancer? (Q848922)

A. Alpha-fetoprotein

B. Carbohydrate Antigen 19-9

C. Carcinoembryonic Antigen

D. Human Chorionic Gonadotropin

See Answer in Part B → Q22

@Neet_pg_bot

Q23: A 65-year-old man presents with symptoms of jaundice and abdominal pain. Imaging studies reveal a solid mass in the pancreatic head. Histological examination shows a dense fibrous stroma with neoplastic tubular glands. The tumor is characterized by local spread along nerves, lymphatics, and blood vessels, and has metastasized to the liver. What is the most likely diagnosis? (Q848921)

A. Serous cystadenoma

B. Mucinous cystic neoplasm

C. Ductal adenocarcinoma

D. Solid pseudopapillary neoplasm

See Answer in Part B → Q23

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• [04_Hepatobiliary Pancreatic Surgery] 018 Previous Year Questions

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Q31 (p. 263)	*Q32 (p. 263)*	*Q33 (p. 264)*	*Q34 (p. 265)*	*Q35 (p. 265)*	*Q36 (p. 266)*
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Q43 (p. 270)	*Q44 (p. 270)*	*Q45 (p. 270)*	*Q46 (p. 271)*	*Q47 (p. 271)*	*Q48 (p. 272)*
Q49 (p. 273)	*Q50 (p. 273)*	*Q51 (p. 274)*	*Q52 (p. 274)*	*Q53 (p. 275)*	*Q54 (p. 275)*
Q55 (p. 276)	*Q56 (p. 277)*	*Q57 (p. 277)*	*Q58 (p. 277)*	*Q59 (p. 278)*	*Q60 (p. 278)*
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Q67 (p. 282)	*Q68 (p. 283)*	*Q69 (p. 284)*	*Q70 (p. 285)*	*Q71 (p. 286)*	*Q72 (p. 287)*
Q73 (p. 287)					

Q1: What is the most probable diagnosis for a 42-year-old woman who came with symptoms of fever, vomiting, and right hypochondriac pain, which radiates to the neck? She has experienced similar episodes in the past, and a positive Murphy's sign was observed during the examination. (Q857521)

A. Acute cholecystitis

B. Carcinoma gallbladder

C. Peptic ulcer

D. Acute appendicitis

See Answer in Part B → Q1

@Neet_pg_bot

Q2: ERCP is least useful in the diagnosis of: (Q856781)

A. Recurrent pancreatitis

B. Unexplained jaundice

C. Periampullary mass

D. Acute Pancreatitis without choledocholithiasis

See Answer in Part B → Q2

@Neet_pg_bot

Q3: A 54-year-old female patient presents with abdominal pain and bilious vomiting. She had a history of abdominal hysterectomy 2 years back. On examination, abdomen auscultation revealed high-pitched bowel sounds. Investigations showed air within the biliary tree. What is the most likely diagnosis? (Q856242)

A. Gallstone ileus

B. Adhesive intestinal obstruction

C. Ischemic enterocolitis

D. Diverticulitis

See Answer in Part B → Q3

@Neet_pg_bot

Q4: An alcoholic patient presented with severe abdominal pain. Pancreatitis was suspected, and a CT scan revealed lesions with fluid collected near the body of the pancreas. Which of the following enzymes is most likely to be elevated? (Q856230)

A. Serum GGT

B. CEA

C. Serum lipase

D. Serum bilirubin

See Answer in Part B → Q4

@Neet_pg_bot

Q5: A patient underwent cholecystectomy for gallstones 2.5 years ago. She now presents with symptoms of obstructive jaundice. Investigation reveals a stone in the common bile duct. What is the stone most likely to be? (Q856204)

A. Primary

B. Secondary

C. Tertiary

D. Recurrent

See Answer in Part B → Q5

@Neet_pg_bot

Q6: What should be the subsequent course of action in the management of a female patient who experienced abdominal pain and increased heart rate three days after cholecystectomy? Her white blood cell count is 11000 cells / mm^3, and an ultrasound examination revealed a 5x5 cm accumulation of fluid in the sub-hepatic space on the right side. (Q856532)

A. Antibiotics and send home

B. USG-guided pigtail catheter drainage

C. Laparoscopy and re-exploration

D. ERCP and T-tube placement

See Answer in Part B → Q6

@Neet_pg_bot

Q7: A 16-year-old female with recurrent jaundice and abdominal pain is found to have a fusiform cystic dilatation of the common bile duct on ultrasound. Which investigation is best to fully delineate the biliary anatomy and confirm the diagnosis before surgery? (Q858369)

A. Magnetic Resonance Cholangiopancreatography

B. Endoscopic ultrasound

C. Percutaneous transhepatic cholangiography

D. Endoscopic retrograde cholangiopancreatography

See Answer in Part B → Q7

@Neet_pg_bot

Q8: Which of the following statements about hepatocellular carcinoma (HCC) is/are correct? 1. TACE(Transarterial chemoembolization) is used for multinodular lesions 2. Lenvatinib is used for lesions less than 3 cm 3. The incidence of HCC is increasing 4. NASH and NAFLD are risk factors for HCC (Q858368)

A. 1, 2, 3

B. 2, 3, 4

C. 1, 3, 4

D. 1 and 2

See Answer in Part B → Q8

@Neet_pg_bot

Q9: A 40 year old woman presented with jaundice, fever, and abdominal pain. She is suspected to have cholangitis. Which of the following apart from abdominal pain makes up Reynold pentad? 1. Fever 2. Jaundice 3. Hypotension 4. Altered sensorium 5. Hematemesis 6. Melena (Q858359)

A. 1, 2, 3, 4

B. 2, 3, 4, 5

C. 1, 3, 4, 5

D. 1, 2, 4, 5

See Answer in Part B → Q9

@Neet_pg_bot

Q10: What is the most appropriate next step in the management of a female patient who has abdominal pain, multiple gallstones with no thickening of the gallbladder wall as seen on ultrasound, a common bile duct diameter of 12mm, serum bilirubin level of 0.8, alkaline phosphatase level of 380, and a 5-fold increase in GGT? (Q858345)

A. MRCP

B. ERCP

C. Endoscopic ultrasound

D. Laparoscopic cholecystectomy

See Answer in Part B → Q10

@Neet_pg_bot

Q11: A patient presents with pain in the right upper quadrant on the second postoperative day following a cholecystectomy. Evaluation reveals a collection in the subhepatic space. A bile leak is suspected. What is the best next step in management? (Q856233)

A. MRCP

B. ERCP

C. HIDA

D. CECT

See Answer in Part B → Q11

@Neet_pg_bot

Q12: A 36-year-old man presents with dull aching epigastric pain. He gives a history of acute abdominal pain following a binge of alcohol 5 weeks back, which was managed conservatively. On examination, he appeared icteric, and a firm mass was palpable in the epigastrium. His CT scan is given below. Which of the following is the most likely diagnosis? (Q857497)

A. Pancreatic pseudocyst

B. Large choledochal cyst

C. Gastric duplication cyst

D. Mesenteric cyst

See Answer in Part B → Q12

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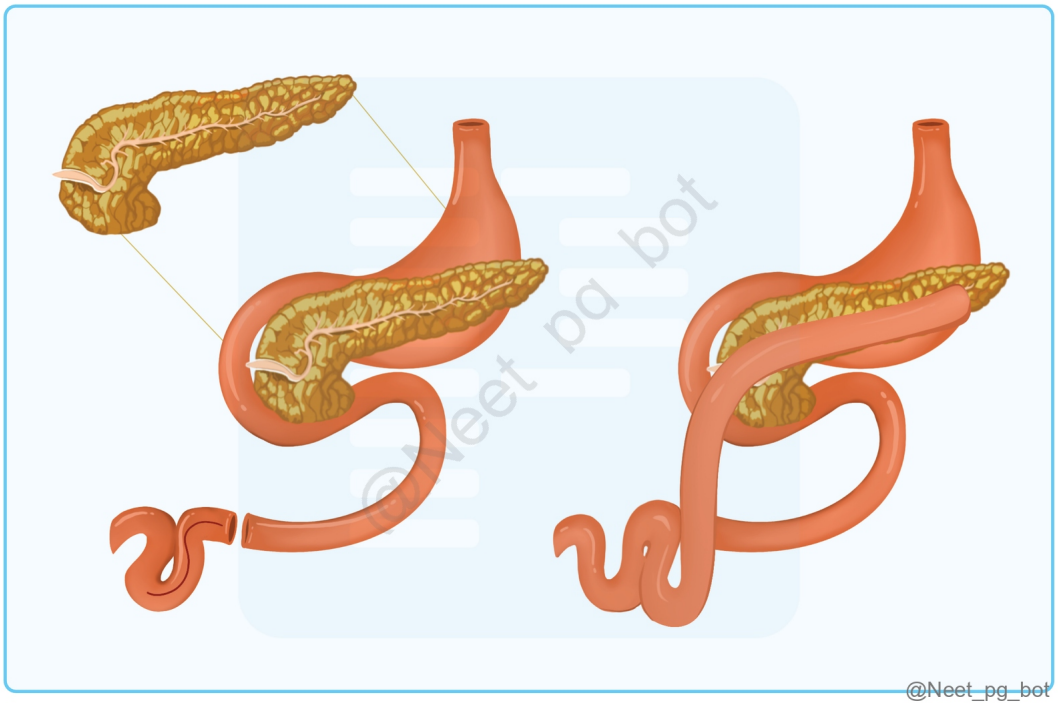
Q13: Identify the procedure shown in the image below. (Q857478)

A. Gastrojejunostomy

B. Pancreaticojejunostomy

C. Pancreatic Ileostomy

D. Duodenojejunostomy



See Answer in Part B → Q13

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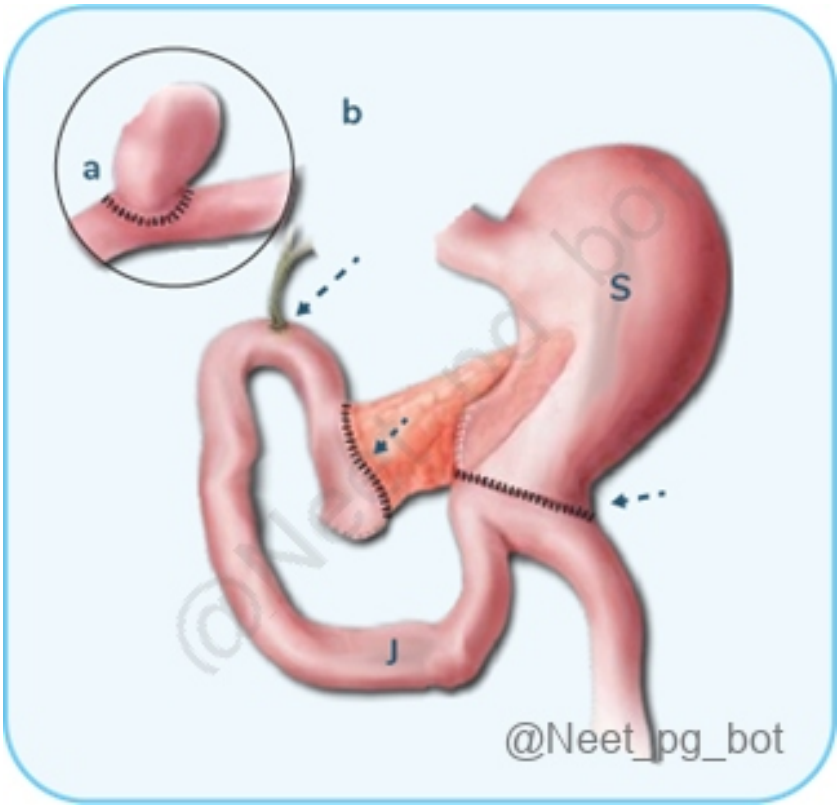
Q14: Identify the procedure shown in the image: (Q857473)

A. Beger’s procedure

B. Whipple’s procedure

C. Frey’s procedure

D. Pancreatic redivision



See Answer in Part B → Q14

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Q15: A 40-year-old man is brought to the casualty with severe abdominal pain radiating to the back for the past 1 day and has had 3 episodes of vomiting. The pain radiates to the back and is slightly relieved in the sitting forward position. The following signs are seen on examination and lab investigations reveal elevated lipase and amylase. Which of the following is the most likely diagnosis? (Q857470)

A. Acute appendicitis

B. Acute cholecystitis

C. Acute pancreatitis

D. Acute ischemic colitis



See Answer in Part B → Q15

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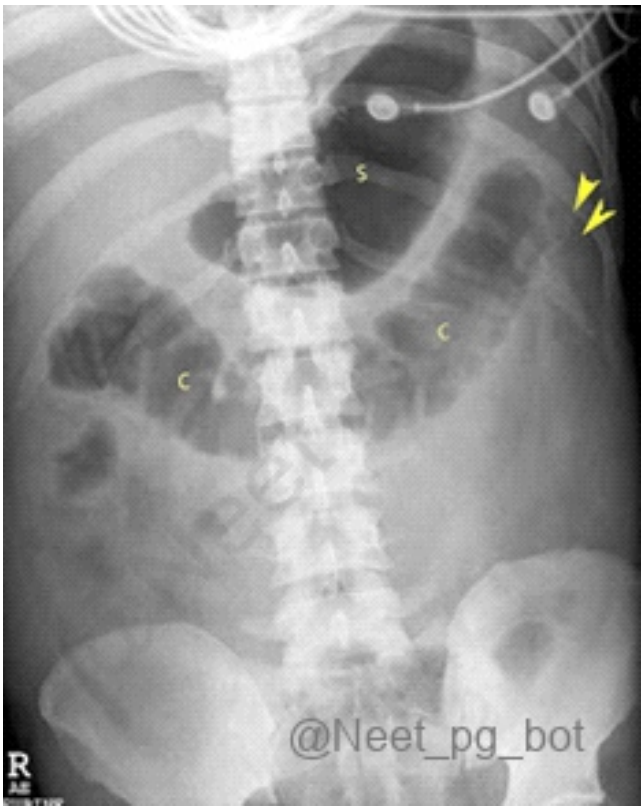
Q16: A young man presents to the emergency department with complaints of severe abdominal pain and 3 episodes of vomiting in the past 9 hours. He says that the pain radiates to the back and is partially relieved by bending forwards. The abdominal radiograph of the patient is given below which shows a 'colon cut-off sign '. What is the most likely diagnosis? (Q857194)

A. Acute hepatitis

B. Acute pancreatitis

C. Acute colitis

D. Intestinal obstruction



See Answer in Part B → Q16

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Q17: Which of the following is the most common side effect of cholecystectomy? (Q857190)

A. Acute kidney injury

B. Osteoporosis

C. Steatorrhea

D. Colorectal cancer

See Answer in Part B → Q17

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Q18: What would be your approach in managing a patient who is a 40-year-old woman with a 5 mm gallbladder polyp detected on abdominal ultrasound, but no gallbladder stones? The patient is overall healthy and shows no symptoms. (Q857186)

A. Regular follow-up every 2 months

B. Polypectomy

C. Laparoscopic cholecystectomy

D. Open cholecystectomy

See Answer in Part B → Q18

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Q19: A patient underwent laparoscopic cholecystectomy and was discharged after removing the drain tube on the first postoperative day. On day two, the patient came back to the hospital with complaints of increasing abdominal pain with tachycardia and was febrile on examination. On ultrasound examination, there was a 5 x 5 cm collection in the subhepatic space. What is the most likely cause of this condition? (Q857185)

A. Infection

B. Surgical site pain

C. Bile leak

D. Retained gallstones

See Answer in Part B → Q19

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Q20: What is the term for a stone obstructing the cystic duct, causing dilation of the common hepatic duct, resulting in CBD obstruction and jaundice? (Q859850)

A. Acute cholecystitis

B. Porcelain gallbladder

C. Cholesterolosis

D. Mirizzi’s syndrome

See Answer in Part B → Q20

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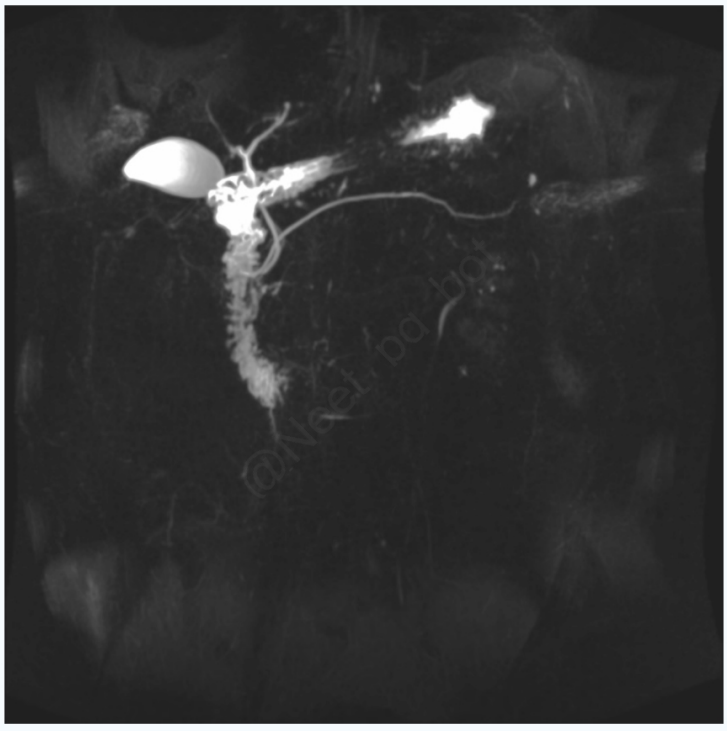
Q21: A 17-year-old boy presents with recurrent episodes of abdominal pain. Serum amylase and lipase are elevated on two occasions, but exocrine pancreatic function is normal. An MRCP image is shown below. Which of the following is the most likely diagnosis? (Q879143)

A. Annular pancreas

B. Chronic pancreatitis

C. Pancreas divisum

D. Choledochal cyst



See Answer in Part B → Q21

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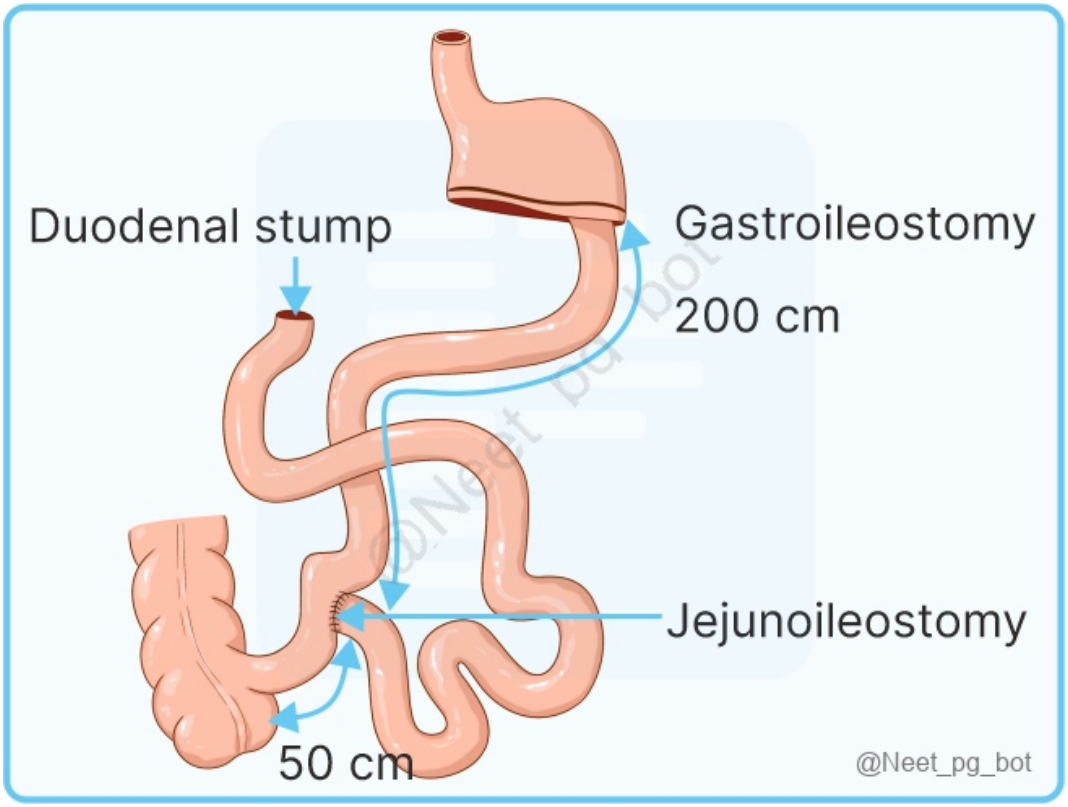
Q22: Identify the procedure: (Q879138)

A. Biliopancreatic diversion

B. Roux -en Y procedure

C. Sleeve gastrectomy

D. Duodenal switch



See Answer in Part B → Q22

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Q23: TIGARO classification is used for? (Q879133)

A. Acute pancreatitis

B. Chronic pancreatitis

C. Acute cholecystitis

D. Pancreatic cancer

See Answer in Part B → Q23

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Q24: A patient has undergone a laparoscopic cholecystectomy. A drain was inserted because of a difficult gallbladder dissection. Day 7 drain output is 300 ml. The patient is afebrile, and MRCP shows cystic duct stump leak. What is the next best management? (Q879124)

A. ERCP with or without a stent

B. USG-guided pigtail catheter insertion

C. Re – do laparoscopic ligation of the bile stump

D. Follow up as it will heal on its own

See Answer in Part B → Q24

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Q25: Arrange the following steps of surgery in order: A. Creating pneumoperitoneum B. Dissection of hepatocystic triangle C. Ligation of cystic duct and artery D. Separation of the gallbladder from the liver bed (Q879106)

A. A-B-C-D

B. A-C-B-D

C. B-A-C-D

D. D-A-B-C

See Answer in Part B → Q25

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Q26: On day 3 after laparoscopic cholecystectomy, a stable patient develops worsening RUQ pain and low-grade fever. Imaging shows a 6-cm biloma and a small cystic duct stump leak. Symptoms persist despite antibiotics and observation. What is the next best step in management? (Q879097)

A. Observation

B. IV antibiotics

C. Image-guided pigtail drainage

D. ERCP with stenting

See Answer in Part B → Q26

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Q27: What is the most frequently occurring location for an intraperitoneal abscess to develop? (Q855584)

A. Suprahepatic

B. Subhepatic

C. Left lobe of the liver

D. Left side below diaphragm

See Answer in Part B → Q27

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Q28: A 70-year-old woman had her routine follow-up, and her USG is shown below. She is asymptomatic at present but has a history of mild right hypochondriac pain, which is relieved by taking analgesics. What is the most likely diagnosis? (Q859867)

A. Gallstones

B. Amoebic liver abscess

C. Hydatid cyst

D. Acute cholecystitis



See Answer in Part B → Q28

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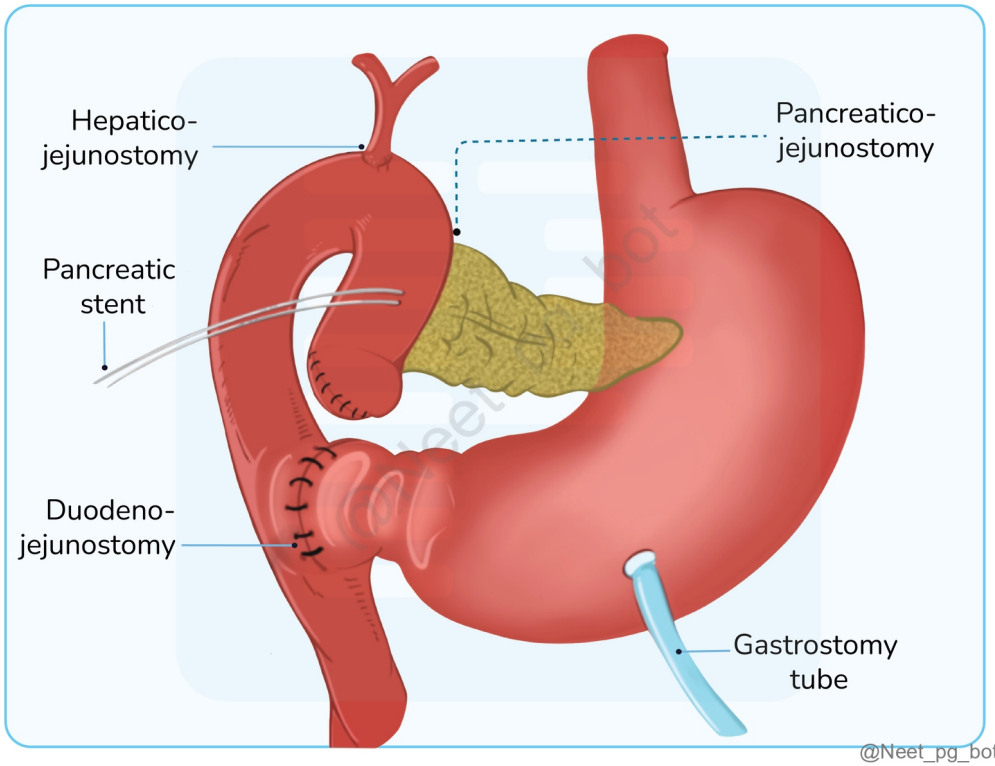
Q29: The following procedure is performed for the management of? (Q855692)

A. Advanced gastric carcinoma

B. Gallbladder carcinoma

C. Distal cholangiocarinoma

D. Chronic calcific pancreatitis



See Answer in Part B → Q29

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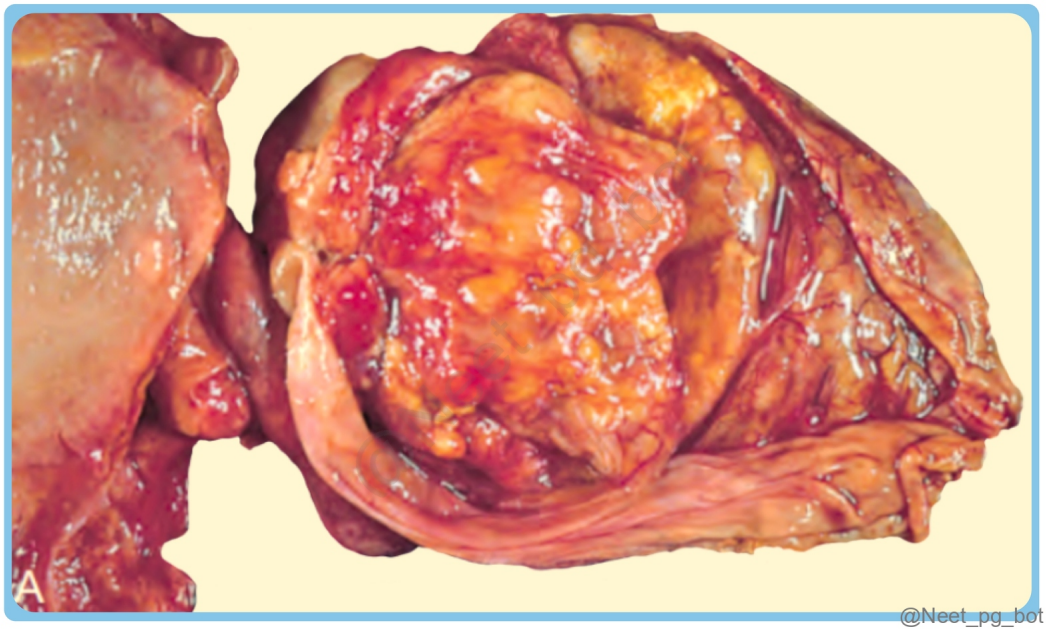
Q30: A patient underwent a laparoscopic cholecystectomy for cholelithiasis. A picture of the resected gall bladder is shown below. What is the diagnosis? (Q859620)

A. Gall bladder carcinoma

B. Mixed stone in gallbladder

C. Cholecystitis

D. Choledocholithiasis



See Answer in Part B → Q30

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Q31: Which of the following is a tumour marker of pancreatic cancer? (Q859616)

A. NSE

B. Alpha-Fetoprotein

C. Ca 15-3

D. CA 19-9

See Answer in Part B → Q31

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Q32: A young sheep farmer presents to the OPD with pain in the right upper part of the abdomen. Upon examination, there was tenderness and enlargement of the liver. Blood investigations show eosinophilia, elevated liver enzymes, and abdominal ultrasound, as shown below. Which of the following is the most likely diagnosis? (Q859613)

A. Amoebic liver abscess

B. Hydatid cyst

C. Pyogenic liver abscess

D. Hepatocellular carcinoma



See Answer in Part B → Q32

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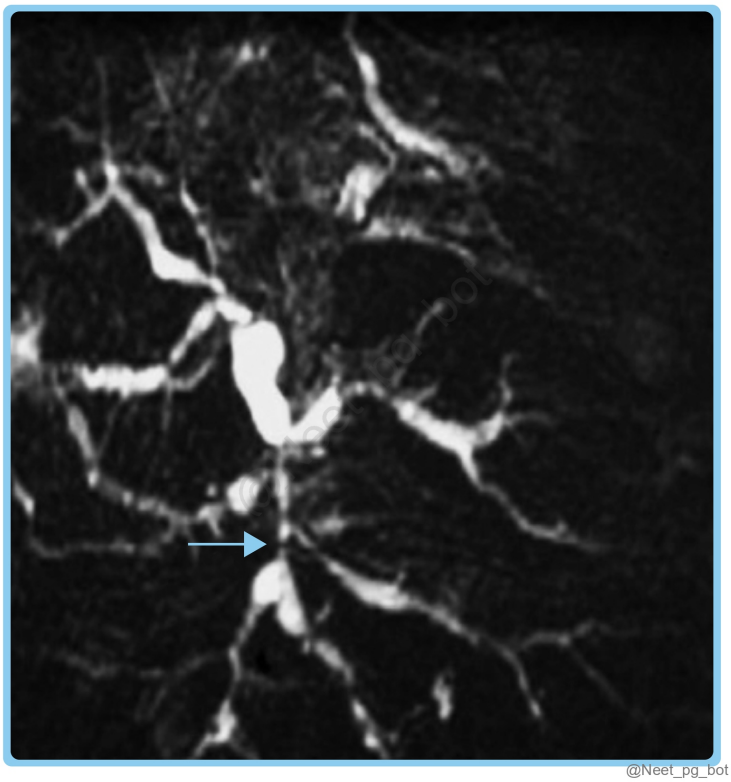
Q33: A 35-year-old man presented with recurrent episodes of fever with chills. The MRCP image is shown below. What is the most likely diagnosis? (Q858489)

A. Primary sclerosing cholangitis

B. Caroli disease

C. Oriental cholangitis

D. Primary biliary carcinoma



See Answer in Part B → Q33

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Q34: An 80-year-old woman presented with fatigue. Imaging revealed a scleroatrophic gallbladder with impacted stones and a large stone in the common bile duct, causing dilation of the biliary tree. What is the next step in management? (Q855020)

A. Immediately take up the patient for cholecystectomy

B. Endoscopic retrograde cholangiopancreatography

C. Wait and watch

D. CT scan

See Answer in Part B → Q34

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Q35: A 5-year-old child with Wilson's disease is being considered for liver transplantation. Which of the following is not a parameter in the selection criteria for transplantation? (Q855014)

A. Age < 10 years

B. Bilirubin > 300µmol/L

C. AST > 300 IU/L

D. PT > 100 s

See Answer in Part B → Q35

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Q36: A patient with recurrent pain in the right hypochondrium, nausea, and vomiting is diagnosed with biliary dyskinesia. Which of the following is least useful in the diagnosis of this condition? (Q856301)

A. CT scan

B. HIDA scan

C. ERCP

D. Endoscopy

See Answer in Part B → Q36

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Q37: According to Strasberg's classification of bile duct injuries, a bile leak from the cystic duct stump or a minor duct in the gallbladder fossa with continuity to the common bile duct is classified as: (Q856250)

A. Type A

B. Type B

C. Type C

D. Type D



See Answer in Part B → Q37

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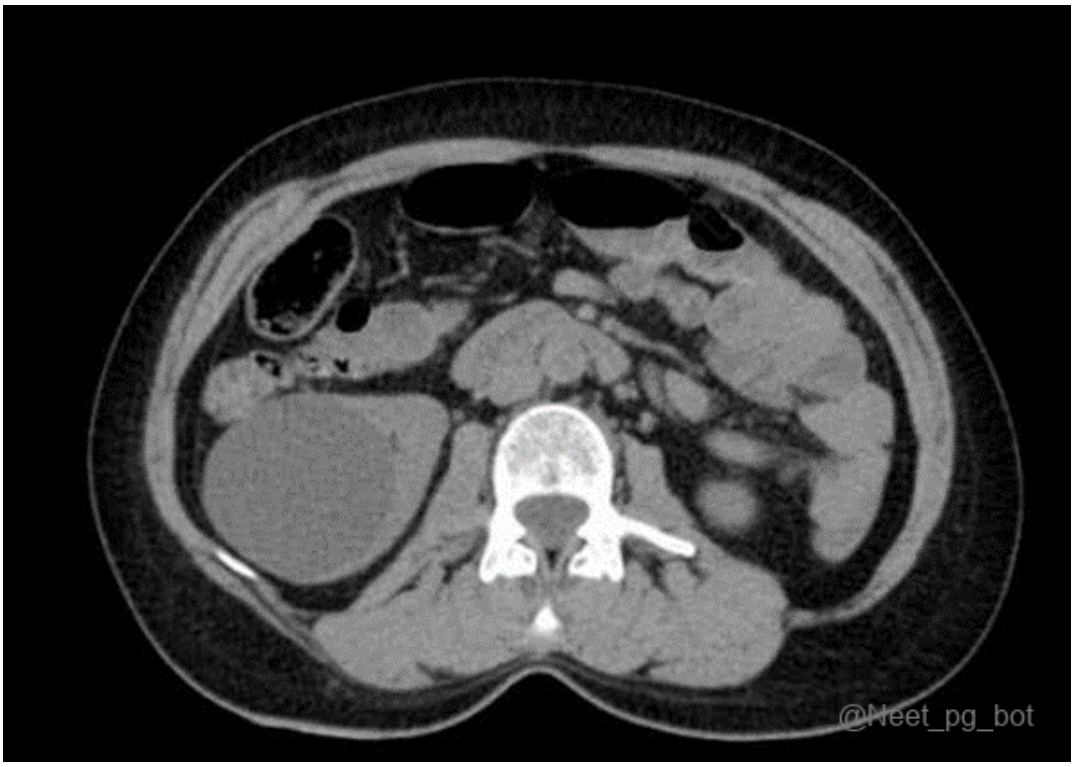
Q38: A 62-year-old female undergoes a contrast-enhanced abdominal CT scan for unrelated mild abdominal discomfort. The scan reveals a solitary, 4 cm, round, dark, fluid-filled lesion in the right kidney as shown in the image. The lesion does not change in appearance or become brighter after the administration of intravenous contrast. Based on these findings, what is the most likely diagnosis? (Q844294)

A. Renal cyst

B. Renal tumor

C. ADPKD

D. Hydatid cyst



See Answer in Part B → Q38

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Q39: A patient underwent cholecystectomy, and the histopathology reveals carcinoma with invasion into the muscular layer. What is the next best step? (Q857249)

A. Radiotherapy

B. Chemotherapy

C. Excision of the stump

D. Extended Cholecystectomy

See Answer in Part B → Q39

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Q40: Which classification system is used for bile duct injury, taking location, injury to the duct, and vessel involvement into account? (Q857247)

A. Bismuth

B. Strasberg

C. Stewart Way

D. Hannover

See Answer in Part B → Q40

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Q41: Which of the following is not a risk factor for gallbladder cancer? (Q857241)

A. Porcelain Gall Bladder

B. Primary Sclerosing Cholangitis

C. Polyp <10 mm

D. Gallstone >3 cm

See Answer in Part B → Q41

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Q42: A 45-year-old male presents to the emergency department with severe abdominal pain radiating to the back. Laboratory investigations reveal elevated serum amylase and lipase levels. Which of the following should be avoided in the management of the given condition? (Q860175)

A. Nil per oral

B. Administration of 5% dextrose

C. Parenteral nutrition

D. Early initiation of oral feedings

See Answer in Part B → Q42

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Q43: What is the most common complication of ERCP? (Q860172)

A. Duodenal perforation

B. Cholangitis

C. Hemorrhage

D. Pancreatitis

See Answer in Part B → Q43

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Q44: A newborn presents with jaundice. Biliary atresia is suspected when jaundice is persistent and exceeds? (Q860450)

A. 2 days

B. 2 weeks

C. 2 months

D. 2 years

See Answer in Part B → Q44

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Q45: A 45-year-old alcoholic patient presents to the ER with severe abdominal pain radiating to the back. Blood investigations reveal increased serum amylase and lipase levels. What is the most likely diagnosis? (Q860443)

A. Peptic ulcer disease

B. Acute pancreatitis

C. Acute cholecystitis

D. Pyogenic liver abscess

See Answer in Part B → Q45

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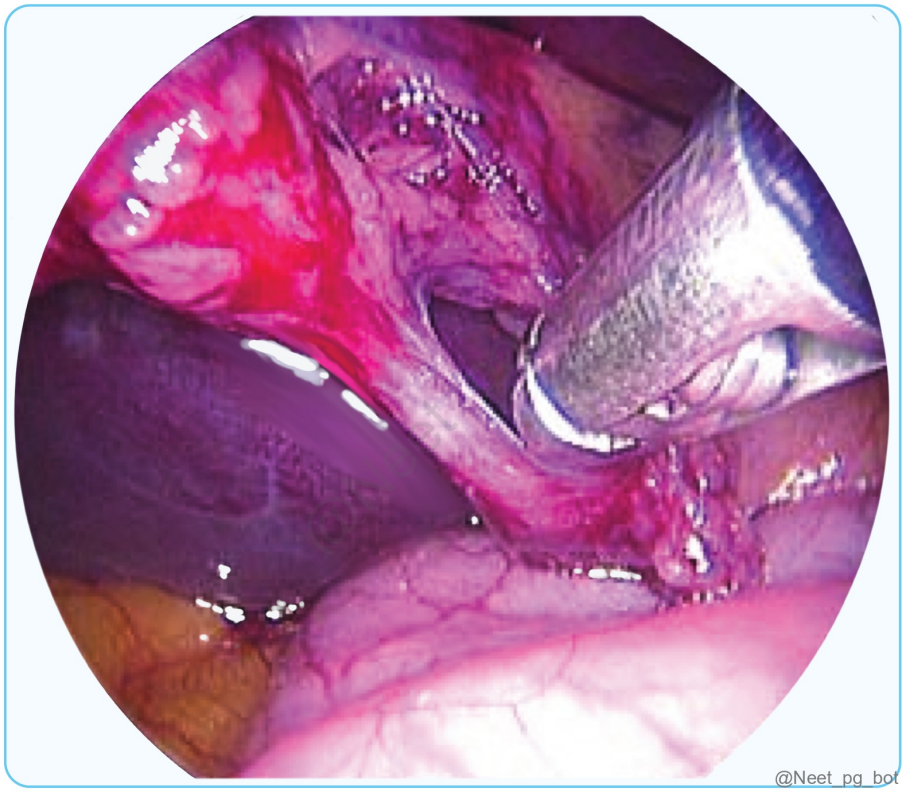
Q46: A patient underwent laparoscopic cholecystectomy. Identify the marked structure in the image. (Q860420)

A. Cystic artery

B. Cystic duct

C. Right hepatic artery

D. Hepatic duct



See Answer in Part B → Q46

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Q47: Which of the following statements about Choledochal Cyst is incorrect? (Q857250)

A. Increased risk of cholangiocarcinoma

B. The cyst can be opened directly and drained

C. Todani classification is used for grading

D. Associated with abnormal Bilio-Pancreatic Junction

See Answer in Part B → Q47

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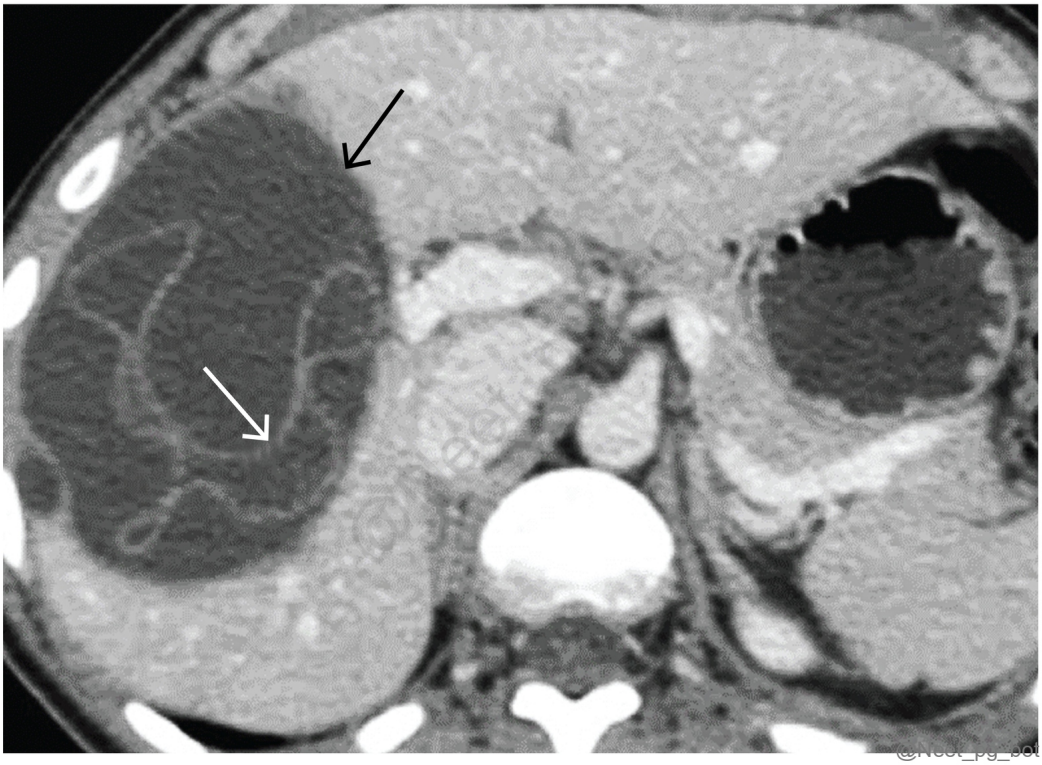
Q48: Identify the stage of disease given in the image. (Q844272)

A. Type 1

B. Type 2

C. Type 3

D. Type 4



See Answer in Part B → Q48

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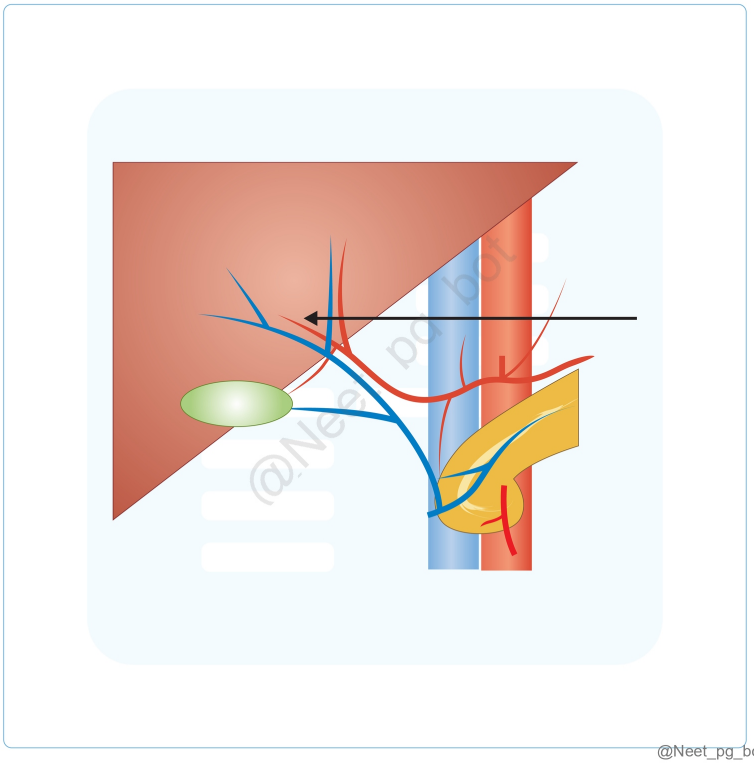
Q49: Identify the marked structure? (Q852723)

A. Cystic artery

B. Right Hepatic artery

C. Hepatic duct

D. Cystic duct


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See Answer in Part B → Q49

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Q50: Which of the following is the classical triad of acute cholangitis? (Q852707)

A. Pain, jaundice, fever

B. Pain, jaundice, shock

C. Fever, jaundice, ↑WBC

D. Pain, ↑WBC, ↑Bilirubin

See Answer in Part B → Q50

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Q51: A 20-year-old male presents with acute epigastric pain and fever. He has a history of cholelithiasis. On examination, abdominal guarding and rigidity are noted. Laboratory results show elevated serum amylase and lipase levels, along with leukocytosis. What is the most likely diagnosis for his condition? (Q853061)

A. Serum amylase remains elevated even after 30 days of resolution of acute pancreatitis

B. ■■■> 75 per cent of patients present with hypercalcemia

C. Serum lipase is more specific than serum amylase

D. Increase in the level of serum lipase is directly proportional to the severity

See Answer in Part B → Q51

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Q52: A patient presents with a 2-year history of anorexia, epigastric pain, jaundice, and itching (pruritis). On examination, the gallbladder is palpable. What is the most likely diagnosis? (Q866482)

A. Gallbladder carcinoma

B. Hepatocellular carcinoma (HCC)

C. Cholelithiasis (gallstones)

D. Ca of the head of the pancreas

See Answer in Part B → Q52

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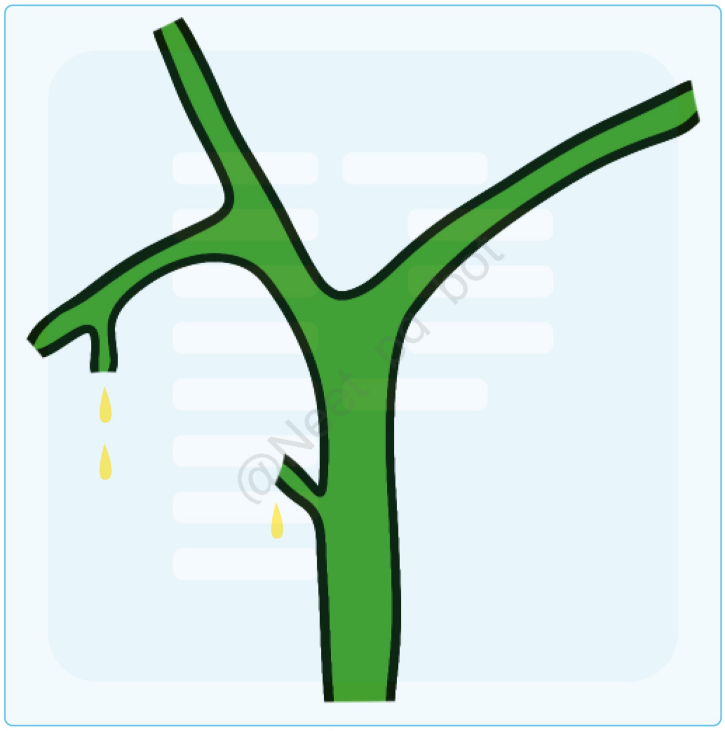
Q53: Based on the given image, which type of injury is shown according to the Bismuth-Strasberg classification: (Q866466)

A. Type A

B. Type B

C. Type C

D. Type D



See Answer in Part B → Q53

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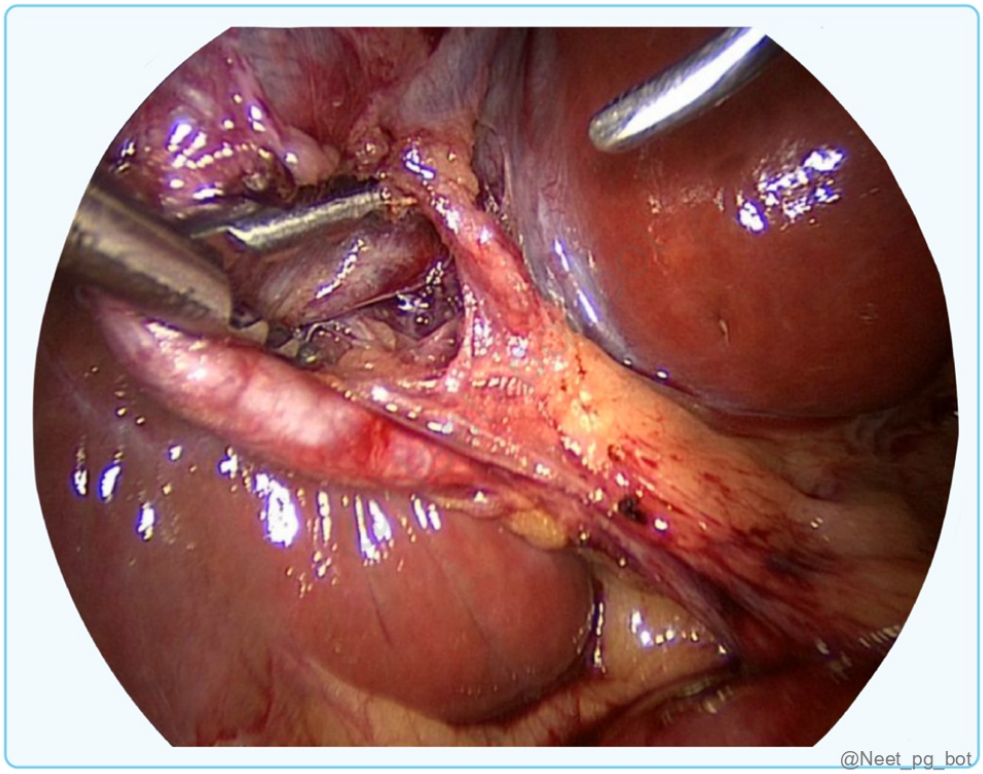
Q54: During a laparoscopic cholecystectomy, the surgeon carefully identifies the boundaries of the hepatocystic triangle to avoid injury to important structures. Which of the following is not a boundary of the hepatocystic triangle? (Q865336)

A. Cystic duct

B. Common hepatic duct

C. Inferior border of the liver

D. Cystic artery



See Answer in Part B → Q54

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Q55: A 30-year-old female presented with pain in the right upper quadrant of the abdomen after 4 days of cholecystectomy. On USG, it showed a significant collection in RUQ. What will you do further? (Q866916)

A. Re-explore laparoscopically

B. Higher antibiotics

C. MRCP

D. USG guided aspiration of content

See Answer in Part B → Q55

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Q56: A 55-year-old alcoholic patient presents with sudden and unintentional weight loss. Lab investigations revealed serum alkaline phosphatase (ALP) of 240 IU/L, alpha-fetoprotein (AFP) of 600 ng/ml, and normal serum AST and ALT levels. What is the most likely diagnosis? (Q855185)

A. Hepatic adenoma

B. Cholangiocarcinoma

C. Hepatocellular carcinoma

D. Alcoholic hepatitis

See Answer in Part B → Q56

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Q57: A 50-year-old alcoholic patient presents with a history of waxing and waning jaundice for the past 2 months. His CT examination reveals dilatation of the common bile duct and pancreatic duct. What is the most probable diagnosis in the patient? (Q855691)

A. Cholangiocarcinoma

B. Periampullary carcinoma

C. Common bile duct stone

D. Head of the pancreas carcinoma

See Answer in Part B → Q57

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Q58: A chronic-alcoholic presents to the emergency room with acute pain in the abdomen in the epigastric region radiating to the back with nausea, anorexia, and occasional vomiting. Investigations showed elevated amylase levels (3 times) and total

count. Likely diagnosis is: (Q857788)

A. Acute hepatitis

B. Acute pancreatitis

C. Acute cholecystitis

D. Acute appendicitis

See Answer in Part B → Q58

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Q59: Which of the following is the best preferred investigation for Neuroendocrine Tumors (NETs)? (Q857777)

A. USG

B. SRS

C. MRI

D. PET

See Answer in Part B → Q59

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Q60: A patient arrives with pain in the right upper abdomen. One week ago, the patient experienced a bout of diarrhoea. Abdominal CT scan results indicate the presence of a liver abscess measuring approximately 25 cubic centimetres. What should be the subsequent course of action in treating this patient? (Q855205)

A. PAIR

B. Surgery

C. Medical therapy

D. Percutaneous drainage

See Answer in Part B → Q60

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Q61: A patient presents with features of chronic pancreatitis, including recurrent attacks, and has a 10 mm dilatation of the pancreatic duct with intraductal calculi present. Which of the following is the surgery of choice? (Q855189)

A. Pancreaticoduodenectomy

B. Longitudinal pancreaticojejunostomy

C. ERCP and sphincterotomy

D. Coring of the pancreas head

See Answer in Part B → Q61

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Q62: A 46 year male had a tumor in his left lobe of liver, so left sided hemi hepatectomy was planned, which of the following lobes of liver will be resected in this procedure? (Q866907)

A. 2,3 and 4

B. 1,2 & 3

C. 5, 6, 7 & 8

D. 2, 3, 4 & 5

See Answer in Part B → Q62

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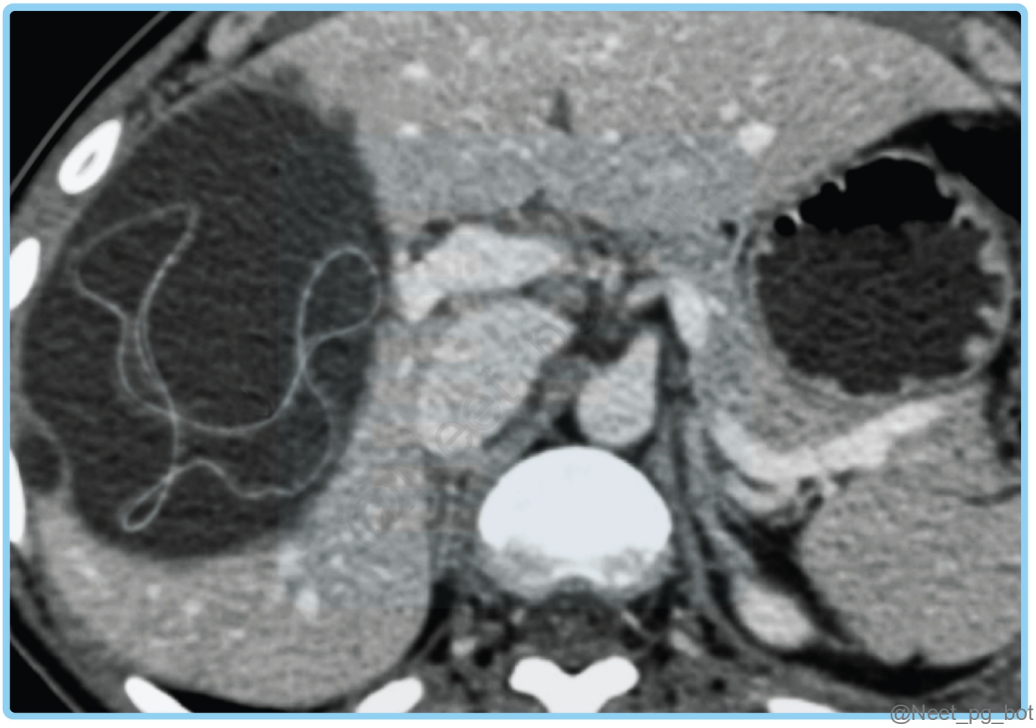
Q63: A patient presents with fever, abdominal pain, and jaundice. Investigations show the given findings. Which of the following statements is true regarding this condition? (Q855184)

A. Surgery is mandatory

B. Fine-needle aspiration cytology is diagnostic

C. Angioembolization is the treatment of choice

D. Echinococcus species is involved in etiology



See Answer in Part B → Q63

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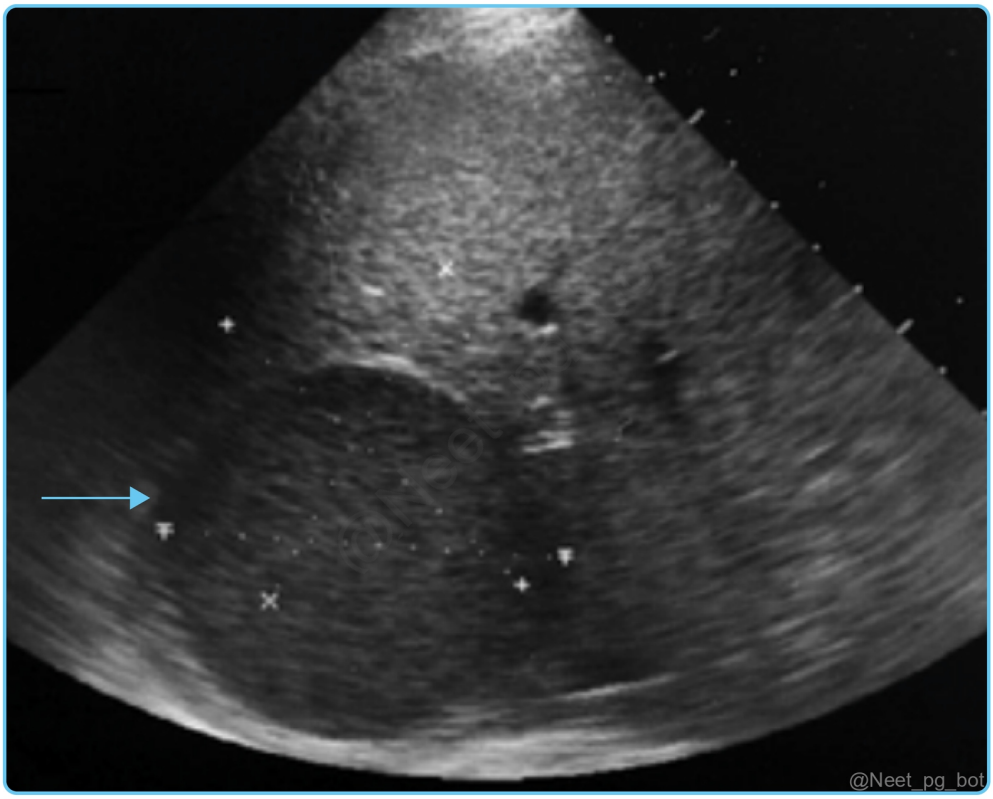
Q64: A 35-year-old patient with a history of dysentery for 6 weeks complains of pain in the right upper abdomen. On ultrasound, a hypoechoic hyperdense lesion is seen in the liver. Based on the given image, identify the condition. (Q854784)

A. Amoebic liver abscess

B. Pyogenic liver abscess

C. Hydatid cyst

D. Hemangioma



See Answer in Part B → Q64

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Q65: After laparoscopic cholecystectomy, what should the expected urine output be in a patient with normal renal function? (Q854780)

A. 500 ml/day

B. 0.5 ml/min

C. 0.5-1.5 ml/kg/hour

D. 1 ml/kg/min

See Answer in Part B → Q65

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Q66: What is the sign of the gallbladder seen in this USG? (Q854768)

A. Phrygian cap sign

B. Murphy sign

C. Claw sign

D. Omega sign



See Answer in Part B → Q66

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Q67: Which condition is most likely based on the image findings? {{caption_text}} (Q854742)

A. Stricture

B. Choledocholithiasis

C. Cholecystitis

D. Cholangiocarcinoma



See Answer in Part B → Q67

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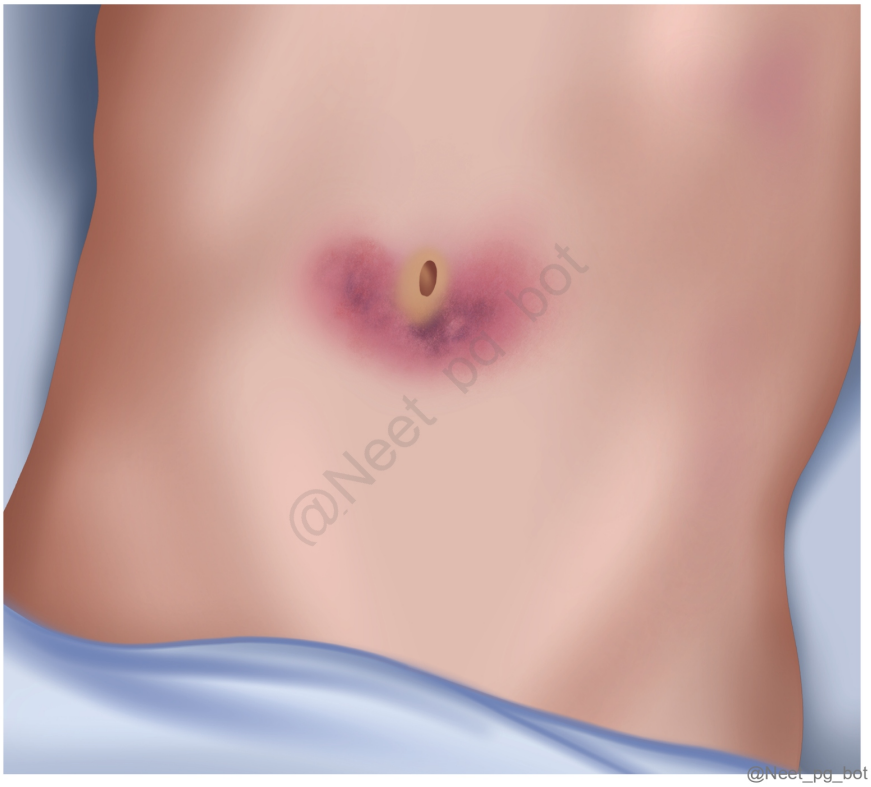
Q68: A 45-year-old male presents with abdominal pain in the emergency room. . On examination, there is blackish discoloration involving the periumbilical skin . What is the most likely diagnosis for this presentation? (Q820153)

A. Acute pancreatitis

B. Necrotizing fasciitis

C. Chronic pancreatitis

D. Traumatic fat necrosis



See Answer in Part B → Q68

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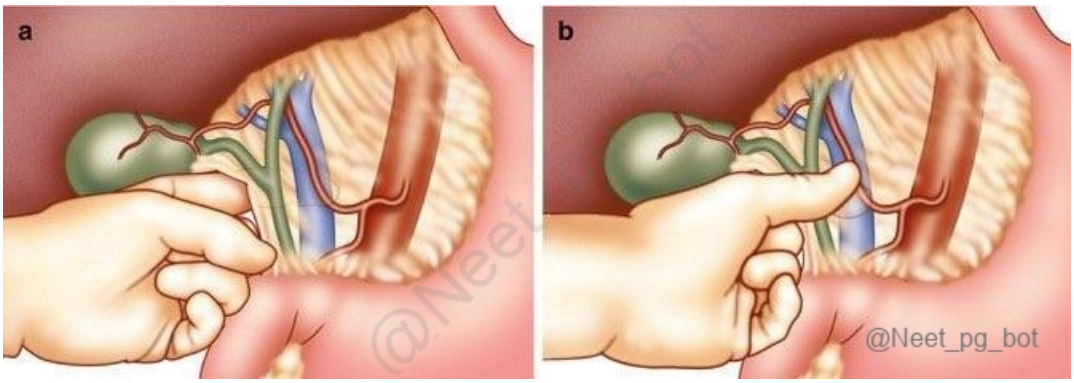
Q69: A 39-year-old patient presented with RTA and is brought to ER with a pulse rate of 120/min, and SBP of <80mmHg. Despite intravenous fluid resuscitation and BT, the patient's condition deteriorates with ongoing profuse bleeding from the liver . Identify the procedure shown in the image done to control massive liver bleed. (Q820112)

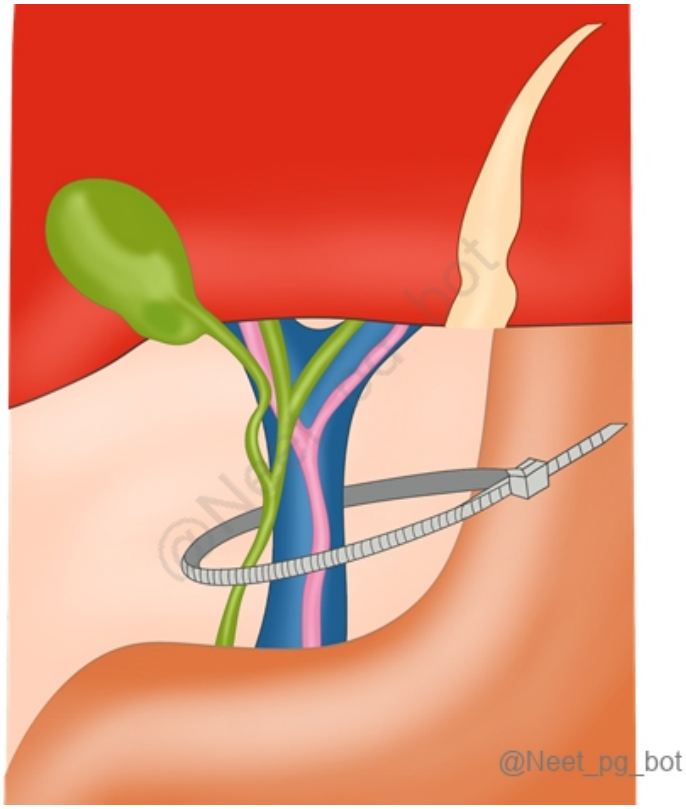
A. Kocher maneuver

B. Pringle’s maneuver

C. Cattell-Braasch maneuver

D. Mattox maneuver





See Answer in Part B → Q69

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Q70: What is the optimal management approach for a patient presenting with fever and abdominal pain five days after experiencing a common bile duct injury resulting in a leak ? (Q793377)

A. Ultrasound–guided aspiration

B. ERCP and stenting

C. Re-exploration and hepaticojejunostomy

D. Re-exploration and primary repair

See Answer in Part B → Q70

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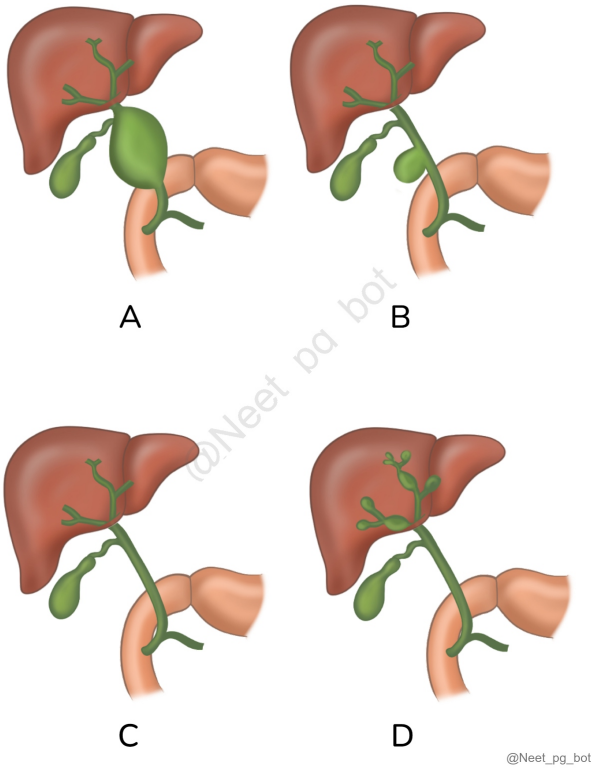
Q71: Which of the following represents a type III choledochal cyst from the given image ? (Q793411)

A. A

B. B

C. C

D. D



See Answer in Part B → Q71

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Q72: Which neuroendocrine tumor of the pancreas is commonly linked with necrolytic erythema migrans ? (Q793855)

A. Insulinoma

B. Glucagonoma

C. Somatostatinoma

D. VIPoma

See Answer in Part B → Q72

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Q73: A 40-year-old man is brought to the casualty with severe abdominal pain radiating to the back for the past 1 day and has had 3 episodes of vomiting. The pain radiates to the back and is slightly relieved in the sitting forward position . The following signs are seen on examination and lab investigations reveal elevated lipase and amylase . Which of the following is the most likely diagnosis? (Q805008)

A. Acute appendicitis

B. Acute cholecystitis

C. Acute pancreatitis

D. Acute ischemic colitis



See Answer in Part B → Q73

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• [05_Gastrointestinal Surgery] 019 Esophagus - I

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[05_Gastrointestinal Surgery] 019 Esophagus - I — Quick Jump

Q1 (p. 289)	*Q2 (p. 289)*	*Q3 (p. 290)*	*Q4 (p. 290)*	*Q5 (p. 290)*	*Q6 (p. 291)*
Q7 (p. 291)	*Q8 (p. 294)*	*Q9 (p. 294)*	*Q10 (p. 295)*	*Q11 (p. 296)*	*Q12 (p. 296)*
Q13 (p. 296)	*Q14 (p. 297)*	*Q15 (p. 297)*	*Q16 (p. 298)*	*Q17 (p. 299)*	*Q18 (p. 299)*
Q19 (p. 299)	*Q20 (p. 300)*	*Q21 (p. 300)*	*Q22 (p. 300)*	*Q23 (p. 301)*	*Q24 (p. 302)*
Q25 (p. 302)					

Q1: A 45-year-old male presents to the emergency department with severe chest pain following forceful vomiting. Physical examination reveals subcutaneous emphysema. What is the most likely diagnosis? (Q849134)

A. Myocardial Infarction

B. Boerhaave's Syndrome

C. Acute Pancreatitis

D. Gastric Ulcer Perforation

See Answer in Part B → Q1

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Q2: A 45-year-old woman presents with fatigue, difficulty swallowing and pale skin. Investigation reveals a cervical esophageal web. Which of the following conditions is most likely? (Q849131)

A. Achalasia

B. Barrett’s Esophagus

C. Plummer-Vinson Syndrome

D. Esophageal Carcinoma

See Answer in Part B → Q2

@Neet_pg_bot

Q3: A 70-year-old male with a history of smoking presents with progressive dysphagia and weight loss. Endoscopy reveals a mass in the mid-esophagus. Biopsy confirms squamous cell carcinoma. Imaging shows the tumor invading the muscularis propria and metastasis to three regional lymph nodes. What is the TNM classification for this patient? (Q849128)

A. T2 N1 M0

B. T2 N2 M0

C. T3 N2 M0

D. T2 N3 M1

See Answer in Part B → Q3

@Neet_pg_bot

Q4: A 45-year-old man presents with progressive dysphagia for both solids and liquids over the past year. He also reports occasional chest pain, especially after eating. Manometry is performed and analyzed using the Chicago Classification. The results show spastic contractions in the distal esophagus. Based on these findings, what type of achalasia is most likely? (Q849117)

A. Type I Achalasia

B. Type II Achalasia

C. Type III Achalasia

D. Diffuse Esophageal Spasm

See Answer in Part B → Q4

@Neet_pg_bot

Q5: A 40-year-old man complains of a burning sensation in his chest and regurgitation after meals. Symptoms improve with antacids and have no significant weight loss. What is the most likely diagnosis? (Q849123)

A. Peptic ulcer disease

B. Gastroesophageal reflux disease (GERD)

C. Gastritis

D. Esophageal spasm

See Answer in Part B → Q5

@Neet_pg_bot

Q6: Which of the following findings are diagnostic of nutcracker esophagus? Distal esophageal contraction amplitude > 180 mmHg Distal esophageal contraction amplitude > 45 mmHg Distal esophageal peristaltic wave duration > 6 cm Distal esophageal contraction amplitude < 30 mmHg Distal esophageal contraction duration > 6 seconds Multiple simultaneous contractions with an amplitude of > 30 mmHg. (Q849125)

A. 1 and 5

B. 2 and 3

C. 1, 3, and 5

D. 2 and 6

See Answer in Part B → Q6

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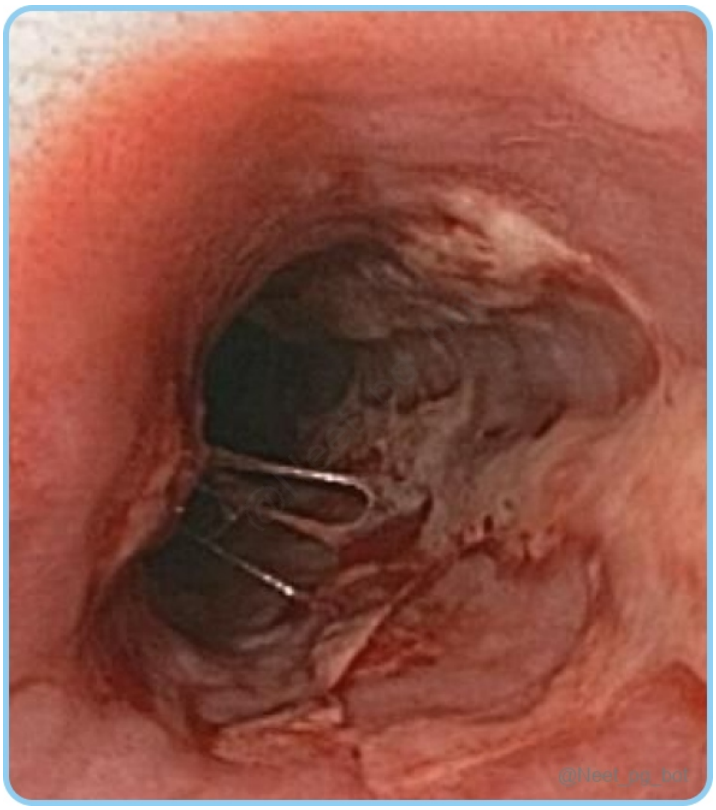
Q7: Match the following conditions with its endoscopy images A) Esophageal candidiasis 1) B) Feline esophagitis 2) C)Herpes simplex esophagitis 3) D)CMV esophagitis 4) (Q849135)

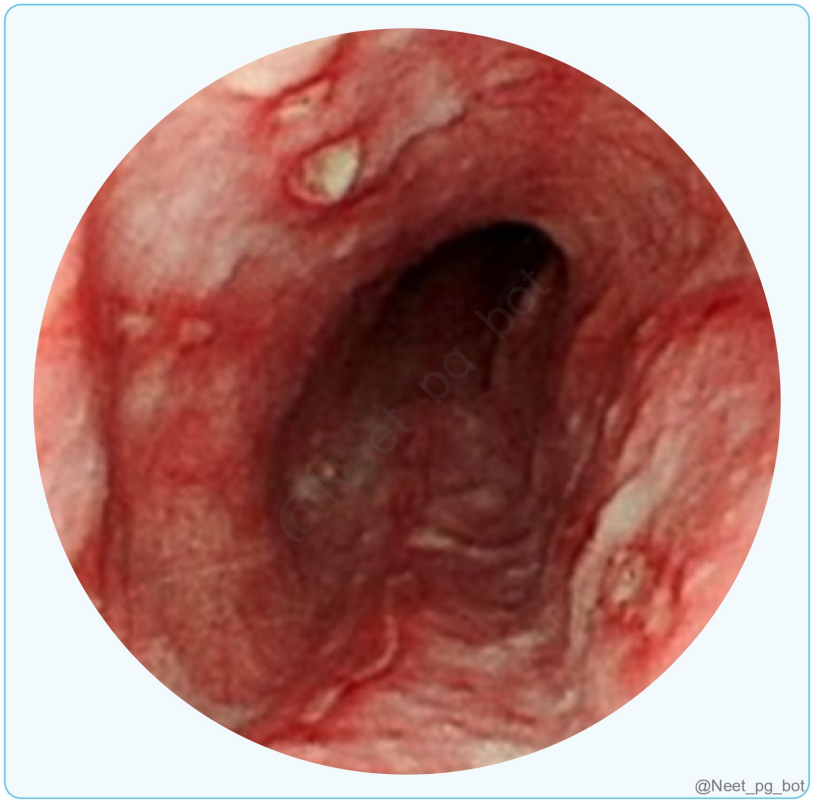
A. A-2, B-4, C-1, D-3

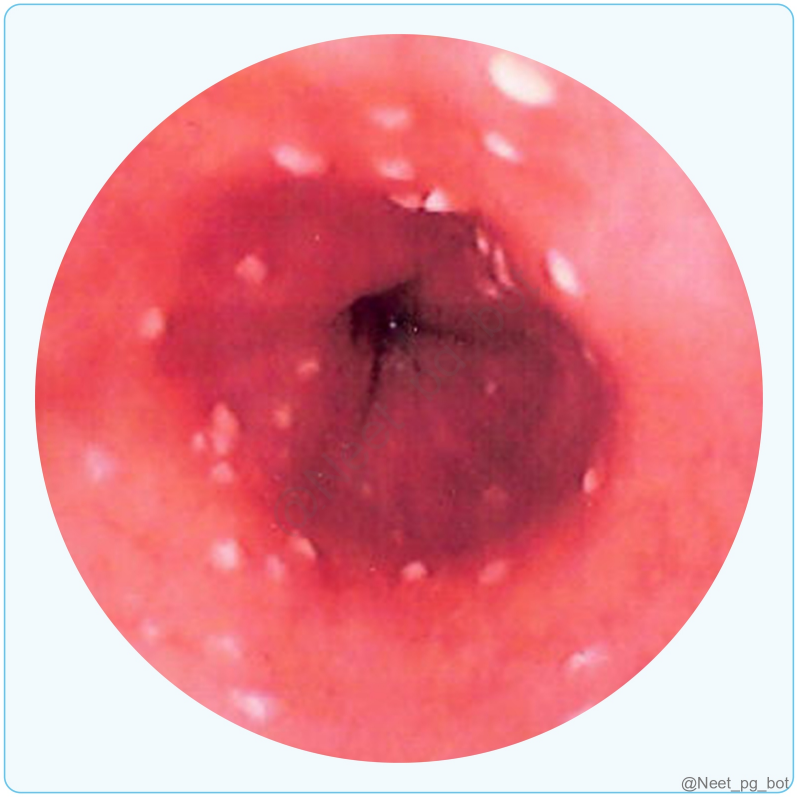
B. A-3, B-4, C-1, D-2

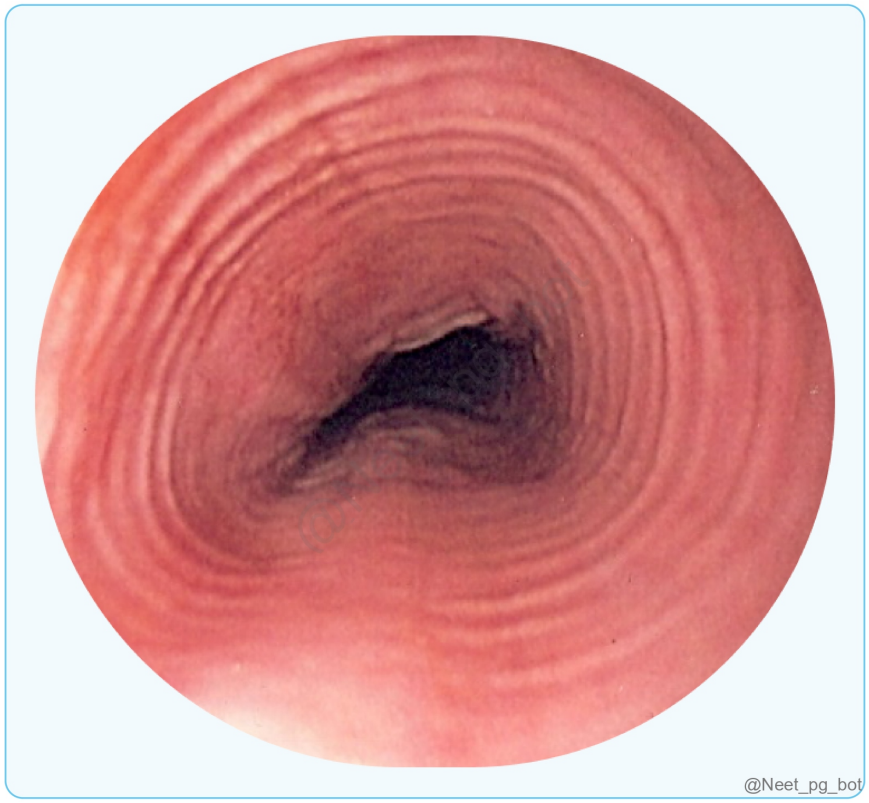
C. A-4, B-3, C-2, D-1

D. A-1, B-4, C-2, D-3




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See Answer in Part B → Q7

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Q8: Which of the following is true regarding the esophagus? (Q849108)

A. The upper esophageal sphincter is composed of the thyropharyngeus and cricopharyngeus muscles

B. The lower esophageal sphincter is a physiological entity

C. The cervical esophagus is supplied by the inferior thyroid artery

D. All are true

See Answer in Part B → Q8

@Neet_pg_bot

Q9: A 60-year-old male patient complains of intermittent dysphagia and episodes of food obstruction. Endoscopy reveals a fibrous band at the gastroesophageal junction.

Which of the following is the most likely diagnosis? (Q849133)

A. Esophageal Web

B. Zenker's Diverticulum

C. Barrett's Esophagus

D. Schatzki Ring

See Answer in Part B → Q9

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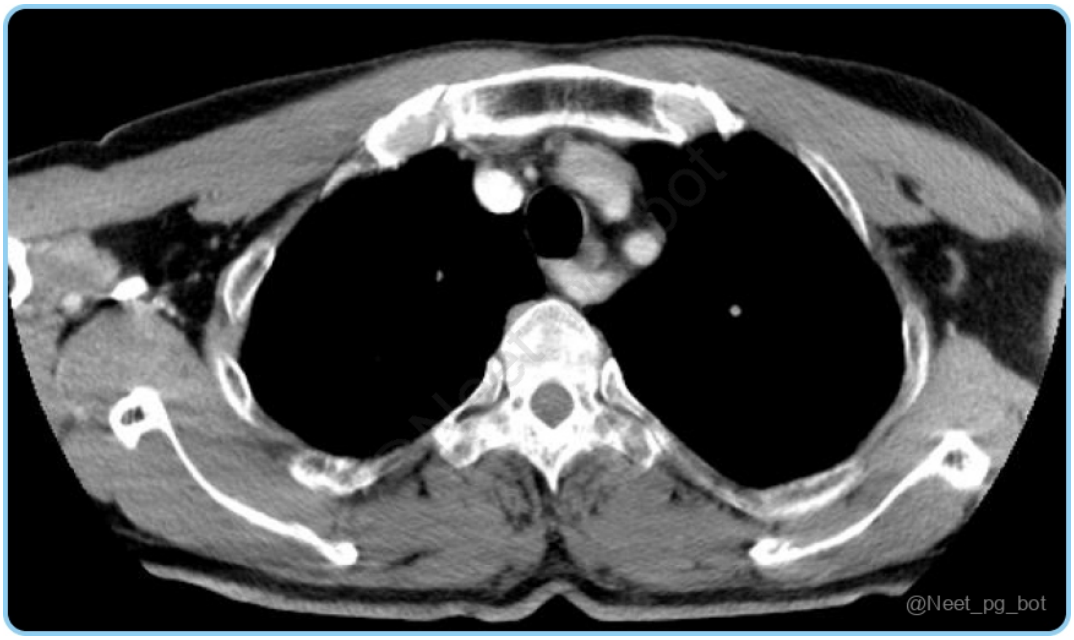
Q10: A 60-year-old patient presents with late-onset difficulty swallowing and significant weight loss. Imaging reveals an aberrant right subclavian artery compressing the esophagus. What is the most likely diagnosis? (Q849132)

A. Achalasia

B. Esophageal Cancer

C. Dysphagia Lusoria

D. Schatzki's Ring



See Answer in Part B → Q10

@Neet_pg_bot

Q11: A 45-year-old man undergoes an endoscopy for evaluation of dysphagia and an incidental mass is discovered in the esophagus. An endoscopic ultrasound (EUS) shows a hypoechoic mass originating from the muscularis propria. Which of the following statements regarding the esophageal lesion is most accurate? (Q849130)

A. Immediate biopsy and fine-needle aspiration (FNA) should be performed to confirm the diagnosis.

B. If the lesion is asymptomatic and small, it can be observed without biopsy.

C. The preferred treatment for small, symptomatic lesions is chemotherapy.

D. Large lesions (>5 cm) are best managed with radiofrequency ablation (RFA)

See Answer in Part B → Q11

@Neet_pg_bot

Q12: A 62-year-old male presents with progressive dysphagia and weight loss over the past 3 months. An endoscopy reveals a tumor in the lower third of the esophagus. Biopsy confirms adenocarcinoma. Further investigation reveals, the tumor has invaded the muscularis propria but no distant metastasis is detected. Which treatment option is most appropriate for this patient? (Q849129)

A. Endoscopic Mucosal Resection (EMR)

B. Endoscopic Submucosal Dissection (ESD)

C. Esophagectomy

D. Radiofrequency Ablation (RFA)

See Answer in Part B → Q12

@Neet_pg_bot

Q13: A 55-year-old male with a history of smoking and heavy alcohol consumption presents with progressive dysphagia and significant weight loss. Endoscopy reveals an

ulcerated lesion in the mid-esophagus, and biopsies confirm squamous cell carcinoma. What is the most appropriate initial diagnostic step to assess the extent of the disease? (Q849127)

A. Chromoendoscopy

B. Barium contrast study

C. Endoscopic Ultrasound (EUS)

D. FDG-PET scan

See Answer in Part B → Q13

@Neet_pg_bot

Q14: A 60-year-old man with chronic GERD undergoes endoscopy, which shows a 3 cm segment of salmon-colored mucosa above the gastroesophageal junction. Biopsy confirms intestinal metaplasia without dysplasia, and no nodularity or ulceration is seen.What is the most appropriate next step in management? (Q849126)

A. Annual surveillance endoscopy

B. Immediate endoscopic mucosal resection (EMR)

C. High-dose proton pump inhibitor (PPI) therapy and aspirin

D. Endoscopic ablation with radiofrequency ablation (RFA)

See Answer in Part B → Q14

@Neet_pg_bot

Q15: A 55-year-old man presents with intermittent chest pain and difficulty swallowing for the past few months. The chest pain is often severe and mimics angina but is not related to exertion. His symptoms often occur at night. Barium swallow reveals a typical finding given below. Which of the following disorders is most likely responsible for these findings? (Q849124)

A. Achalasia cardia

B. Gastroesophageal reflux disease (GERD)

C. Esophageal stricture

D. Diffuse esophageal spasm



See Answer in Part B → Q15

@Neet_pg_bot

Q16: Which of the following is considered a minimally invasive procedure for treating achalasia cardia? (Q849119)

A. Laparoscopic Heller's Cardiomyotomy

B. Partial Fundoplication

C. Per-Oral Endoscopic Myotomy (POEM)

D. Esophagectomy

See Answer in Part B → Q16

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Q17: A 42-year-old man presents with progressive dysphagia for liquids more than solids for over six months, regurgitation of undigested food, nocturnal cough, and unintentional weight loss. The bird beak sign is seen on a barium swallow. Which investigation is the gold standard for diagnosing his condition? (Q849118)

A. Upper gastrointestinal endoscopy

B. High-resolution manometry

C. Barium swallow study

D. Chest X-ray

See Answer in Part B → Q17

@Neet_pg_bot

Q18: Which of the following statements is true about the Zenker's diverticulum? (Q849116)

A. An enlarged diverticulum always results in desynchronization.

B. Halitosis is a symptom of an enlarged diverticulum.

C. Protrudes posteriorly below the cricopharyngeal sphincter.

D. Absence of a suture line increases the chance of a postoperative leak.

See Answer in Part B → Q18

@Neet_pg_bot

Q19: A 55-year-old woman with persistent GERD symptoms despite optimal medical therapy is considered for surgery. What is the most appropriate surgical procedure for her condition? (Q849115)

A. Nissen fundoplication

B. Fontan procedure

C. Hartmann procedure

D. Heineke–Mikulicz pyloroplasty

See Answer in Part B → Q19

@Neet_pg_bot

Q20: Which hormone is known to decrease LES pressure? (Q849114)

A. Gastrin

B. Cholecystokinin

C. Progesterone

D. Motilin

See Answer in Part B → Q20

@Neet_pg_bot

Q21: A 55-year-old man presented with difficulty swallowing and chest discomfort after meals, which improved after forceful belching. On physical examination, he appeared pale. Chest X-ray revealed a gas-filled structure within the thoracic cavity. Which of the following is the most likely diagnosis? (Q849113)

A. Peptic ulcer disease

B. Hiatus hernia

C. Esophageal cancer

D. Gastritis

See Answer in Part B → Q21

@Neet_pg_bot

Q22: A newborn male presents with severe respiratory distress and a scaphoid abdomen. Chest X-ray reveals bowel loops in the left thoracic cavity. Immediate surgical intervention is planned to repair the diaphragmatic defect. Which of the following is the most likely diagnosis? (Q849112)

A. Bochdalek hernia

B. Morgagni hernia

C. Rolling hiatus hernia

D. Sliding hiatus hernia



See Answer in Part B → Q22

@Neet_pg_bot

Q23: A newborn male, 1 day old, presents with persistent regurgitation of feeds and continuous drooling of saliva from the mouth. The baby exhibits frequent coughing and cyanosis, prompting an investigation that reveals a tracheoesophageal fistula. Which type is the most likely to be seen? (Q849111)

A. Type A

B. Type B

C. Type C

D. Type E

See Answer in Part B → Q23

@Neet_pg_bot

Q24: A 35-year-old man ingests a household cleaner and sustains a corrosive injury to esophagus. Which of the following is false in this case? (Q849110)

A. Neutralization with vinegar/citrus for alkali; antacids/milk/egg whites for acid

B. Early endoscopy is not preferred

C. Avoid emetics and sodium bicarbonate to prevent perforation

D. All are false

See Answer in Part B → Q24

@Neet_pg_bot

Q25: A 5-year-old boy swallowed a disk battery and an x-ray revealed that it was lodged in the esophagus. What is the next step in the management of this patient? (Q849109)

A. Observe

B. Immediate endoscopic removal

C. Endoscopic removal after 1 day of observation

D. Endoscopic removal after 2 days of observation

See Answer in Part B → Q25

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• [05_Gastrointestinal Surgery] 020 Stomach-I

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[05_Gastrointestinal Surgery] 020 Stomach-I — Quick Jump

Q1 (p. 303)	*Q2 (p. 303)*	*Q3 (p. 304)*	*Q4 (p. 304)*	*Q5 (p. 305)*	*Q6 (p. 305)*
Q7 (p. 306)	*Q8 (p. 306)*	*Q9 (p. 307)*	*Q10 (p. 307)*	*Q11 (p. 308)*	*Q12 (p. 308)*
Q13 (p. 309)	*Q14 (p. 309)*	*Q15 (p. 310)*	*Q16 (p. 310)*	*Q17 (p. 311)*	*Q18 (p. 312)*
Q19 (p. 312)	*Q20 (p. 312)*	*Q21 (p. 313)*	*Q22 (p. 313)*	*Q23 (p. 314)*	*Q24 (p. 314)*
Q25 (p. 315)	*Q26 (p. 315)*	*Q27 (p. 315)*	*Q28 (p. 316)*	*Q29 (p. 316)*	*Q30 (p. 317)*

Q1: A 58-year-old woman visits her primary care physician complaining of persistent upper abdominal pain that worsens after meals. She also reports experiencing nausea and occasional vomiting. After a thorough clinical evaluation, the physician suspects a gastric ulcer. What investigation should be done multiple times as a must in case of a gastric ulcer? (Q849029)

A. Endoscopy

B. Endoscopy with biopsy

C. Assessment for H pylori

D. Ultrasonography

See Answer in Part B → Q1

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Q2: A patient with suspected gastric carcinoma undergoes an upper GI endoscopy. A large, malignant-appearing ulcer is noted. While there is a central crater, the endoscopist notes that its margins are ill-defined and blend into the surrounding gastric wall, causing localized rigidity. These findings are most characteristic of which Borrmann classification type? (Q849092)

A. Type I

B. Type II

C. Type III

D. Type IV

See Answer in Part B → Q2

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Q3: A male patient comes to the clinic due to abdominal pain. He is a chronic smoker and has never been consistent with a healthy diet. An endoscopy and biopsy of the lesion in his stomach confirm gastric cancer. Which of the following statements regarding risk factors of gastric carcinoma is false? (Q849091)

A. High-salt foods like salted or smoked meat increase the risk of gastric carcinoma

B. H-pylori is the most common infectious cause of gastric carcinoma

C. Adenomatous polyps carry a risk of turning cancerous

D. Proton pump inhibitors have a protective effect against gastric cancer

See Answer in Part B → Q3

@Neet_pg_bot

Q4: A 50-year-old male comes to the OPD for a follow-up of peptic ulcer disease. He has had an upper gastrointestinal bleed in the recent past and was endoscopically and medically managed. A repeat endoscopy is done to assess his risk of rebleed and a flat pigmented spot is viewed in the duodenum. According to the Forrest classification system, what is the classification of the ulcer and risk of rebleed observed here? (Q849090)

A. IA, high risk

B. IIB, high risk

C. III, low risk

D. IIC, low risk

See Answer in Part B → Q4

@Neet_pg_bot

Q5: A 40-year-old patient is brought to the emergency department with melena and dizziness. Her BP is 100/ 80 mmHg, and her pulse rate is 100 bpm. Her lab investigations reveal Hb of 8 gm/dL and a blood urea nitrogen (BUN) of 25 mg/dL. Based on the Blatchford score, which of the following findings would most significantly increase her risk stratification score? a. Systolic blood pressure less than 100 mm of Hg b. High blood urea nitrogen level (> 25) c. Diagnosis of Mallory Weiss syndrome d. Heart rate more than 100 bpm (Q849089)

A. a and b only

B. a, b and c

C. a, c and d

D. a, b and d

See Answer in Part B → Q5

@Neet_pg_bot

Q6: A 60-year-old patient presents with sudden, massive hematemesis. An upper endoscopy identifies a small mucosal defect surrounded by normal gastric mucosa. Angiography reveals a large, tortuous artery in the left gastric artery distribution. What is the underlying pathophysiological mechanism of bleeding in Dieulafoy's lesion? (Q849088)

A. Erosion of the mucosa due to excessive acid secretion

B. Rupture of varices caused by portal hypertension

C. Erosion of mucosa due to pulsations from a large submucosal artery

D. Ulceration of the gastric mucosa due to chronic use of NSAIDs

See Answer in Part B → Q6

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Q7: A 62-year-old female with a history of liver cirrhosis presents with symptoms of chronic gastrointestinal bleeding, including anaemia and fatigue. Upper endoscopy is shown below. Which of the following is the most appropriate initial treatment for this condition? (Q849087)

A. Radiofrequency ablation

B. Hormonal therapy

C. Argon plasma coagulation

D. Reducing portal pressure



See Answer in Part B → Q7

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Q8: A 56-year-old man arrives in the emergency department with severe upper gastrointestinal bleeding. On examination, he is pale, hypotensive, and has a rapid pulse. Which of the following is the initial priority in managing this patient?

(Q849093)

A. Immediate endoscopy to identify the bleeding source

B. Assessment of airway, breathing, and circulation (ABCs) with intravenous access establishment

C. Administration of terlipressin for suspected variceal bleeding

D. Blood transfusion to raise hemoglobin above 10 g/dL

See Answer in Part B → Q8

@Neet_pg_bot

Q9: In patients with AIDS, which of the following organisms is a recognised cause of gastritis? (Q890664)

A. Histoplasmosis

B. Cryptosporidiosis

C. Cytomegalovirus

D. Isospora belli

See Answer in Part B → Q9

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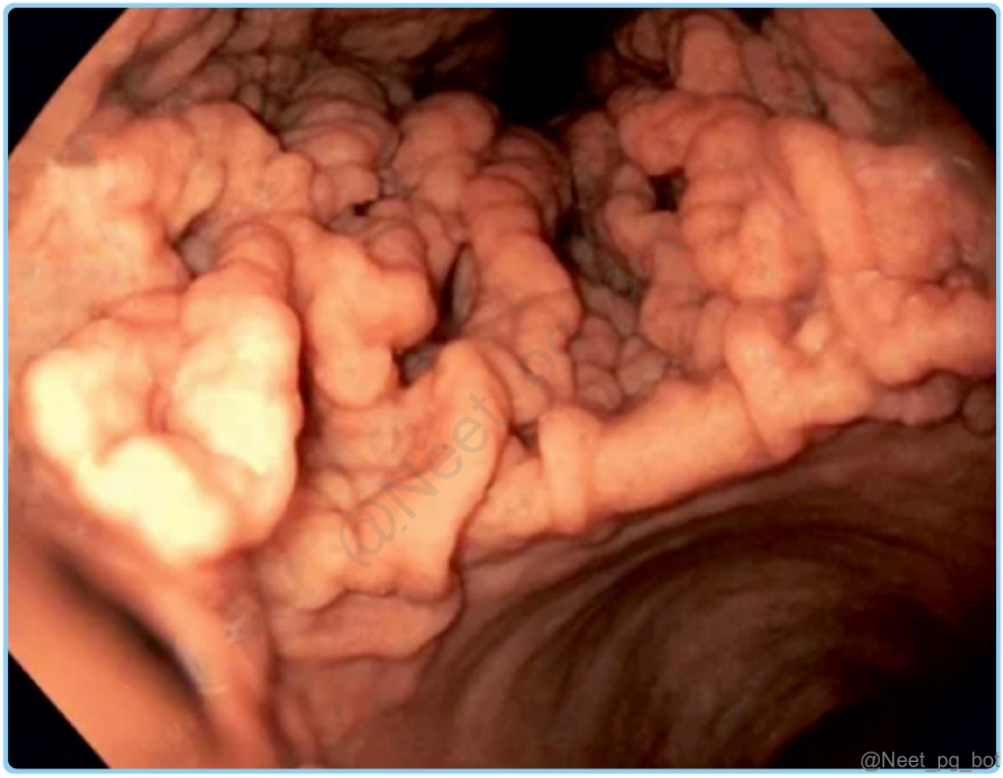
Q10: A 48-year-old man presents with progressive weight loss, early satiety, and bilateral pedal edema. Laboratory evaluation reveals hypoalbuminemia with normal liver function tests. Upper GI endoscopy shows the following appearance . Biopsy reveals foveolar hyperplasia with reduced parietal cells. Which of the following is the most likely underlying mechanism? (Q890677)

A. Autoimmune destruction of parietal cells leading to intrinsic factor deficiency

B. Overexpression of transforming growth factor-α causing mucous cell proliferation and reduced acid secretion

C. Increased gastrin secretion causing parietal cell hyperplasia and hyperchlorhydria

D. Chronic Helicobacter pylori infection causing antral-predominant inflammation



See Answer in Part B → Q10

@Neet_pg_bot

Q11: A 26-year-old male presents with persistent dyspepsia despite a 1-month course of PPIs. A urea breath test is positive. What is the most likely diagnosis? (Q890663)

A. Type A gastritis

B. Type B gastritis

C. Reflux gastritis

D. Erosive gastritis

See Answer in Part B → Q11

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Q12: In hypovolemic shock, which part of the gastrointestinal tract is most vulnerable to ischemia due to poor collateral blood supply? (Q890660)

A. Griffith’s point

B. Sudeck’s point

C. Terminal ileum

D. Stomach

See Answer in Part B → Q12

@Neet_pg_bot

Q13: A patient with severe burn injuries develops an upper gastrointestinal bleed. Endoscopy reveals multiple acute ulcers predominantly involving which part of the stomach? (Q890666)

A. Fundus and body

B. Antrum

C. Lesser curvature

D. Pyloric canal

See Answer in Part B → Q13

@Neet_pg_bot

Q14: Which of the following surgical procedures is specifically indicated for a Type IV proximal gastric ulcer? (Q890668)

A. Maki’s pylorus-preserving gastrectomy

B. De Miguel’s antrectomy

C. Kelling-Madlener procedure

D. Highly selective vagotomy with ulcer excision

See Answer in Part B → Q14

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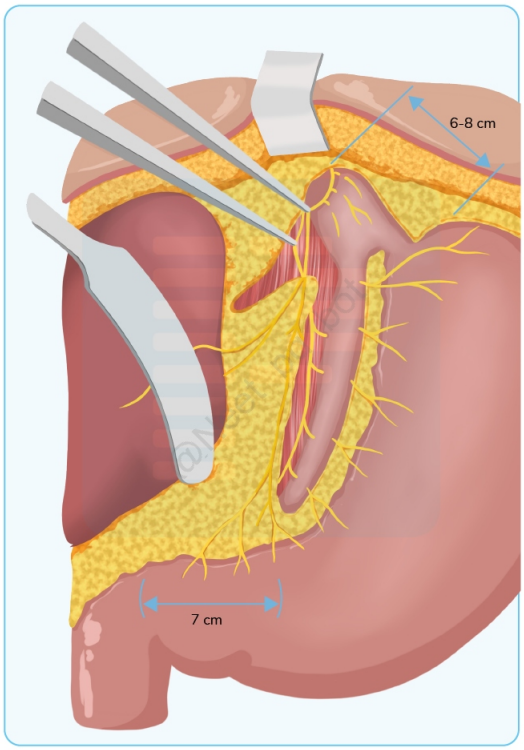
Q15: Which of the following statements is incorrect regarding the image shown below? (Q890670)

A. Ulcer recurrence rate is highest

B. Acid reduction is maximum

C. Nerve of Latarjet is spared

D. Postoperative complications are minimal



See Answer in Part B → Q15

@Neet_pg_bot

Q16: A 40-year-old man presents with sudden onset severe abdominal pain. On examination, he is tachycardic, hypotensive, and has board-like abdominal rigidity.

An erect chest X-ray reveals the following finding. What is the most appropriate immediate management? Ultrasound abdomen Intravenous fluid resuscitation Exploratory laparotomy Elective surgery Conservative management (Q890672)

A. 2, 3

B. 1, 4

C. 3, 4, 5

D. 1, 2, 5



See Answer in Part B → Q16

@Neet_pg_bot

Q17: A patient develops sweating, tachycardia, colicky abdominal pain, and diarrhea within 30-40 minutes of meals following gastric surgery. Which of the following best explains the underlying mechanism? (Q890673)

A. Excess insulin secretion leading to hypoglycemia

B. Rapid entry of hyperosmolar chyme causing fluid shift into the intestinal lumen

C. Increased gastric acid secretion due to vagal overactivity

D. Delayed gastric emptying causing gastric distension

See Answer in Part B → Q17

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Q18: Which of the following statements best describes organoaxial gastric volvulus? (Q890675)

A. Rotation occurs along the transverse (short) axis of the stomach

B. It is less common and usually not associated with diaphragmatic defects

C. It occurs along the longitudinal axis between the cardia and pylorus and is commonly associated with paraoesophageal hernia

D. It rarely requires surgical management

See Answer in Part B → Q18

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Q19: During a Billroth II procedure, the surgeon carefully dissects the pyloric region. Which of the following statements about this area's anatomy is most accurate? (Q849020)

A. The right gastric artery originates directly from the celiac trunk

B. The vagus nerve forms a single identifiable trunk in this region

C. Lymph nodes here drain exclusively into the pancreaticolienal group

D. The gastroduodenal artery passes posterior to the first part of the duodenum

See Answer in Part B → Q19

@Neet_pg_bot

Q20: A 45-year-old male with a history of chronic alcoholism presents to the emergency department after a night of intense vomiting following a drinking binge. He complains of severe upper abdominal pain and is found to have hematemesis. An urgent upper GI endoscopy is performed, revealing a mucosal laceration near the GE junction. Which of the following is not a management option for the above condition? (Q849086)

A. Multipolar electrocoagulation

B. Epinephrine injection

C. Endoscopic band ligation

D. Balloon tamponade

See Answer in Part B → Q20

@Neet_pg_bot

Q21: Which of the following is NOT a cause of upper gastrointestinal bleeding? (Q849085)

A. Peptic Ulcer Disease

B. Esophageal Varices

C. Mallory-Weiss Tear

D. Angiodysplasia

See Answer in Part B → Q21

@Neet_pg_bot

Q22: A patient presents with early satiety, weight loss, nausea, and vomiting. An upper endoscopy reveals a narrowing of the pylorus due to inflammation and scarring from peptic ulcer disease. What is the most appropriate initial step in managing this patient's gastric outlet obstruction? (Q849084)

A. Surgical antrectomy with reconstruction and vagotomy

B. Endoscopic dilation with stent placement

C. Placement of a nasogastric tube and correction of fluid/electrolyte imbalances

D. Immediate initiation of H. pylori eradication therapy

See Answer in Part B → Q22

@Neet_pg_bot

Q23: A 65-year-old man presents with severe epigastric pain and black, tarry stools. He has a history of chronic gastritis and NSAID use for osteoarthritis. Upper GI endoscopy reveals a gastric ulcer and a biopsy is taken for histological analysis. According to the modified Johnson's criteria, what type of ulcer is most likely? (Q849028)

A. Type I

B. Type IV

C. Type III

D. Type V

See Answer in Part B → Q23

@Neet_pg_bot

Q24: A 60-year-old male with a long-standing history of duodenal ulcer on treatment with proton pump inhibitors presents to the clinic with sudden severe epigastric pain, rebound tenderness, and air under the diaphragm. Based on this history, what is the complication? (Q849027)

A. Perforated duodenal ulcer

B. Pyloric stenosis

C. Gastric outlet obstruction

D. Hourglass deformity of stomach

See Answer in Part B → Q24

@Neet_pg_bot

Q25: A 35-year-old man comes to the clinic with pain in the epigastrium and uneasiness for 2 months, which is temporarily relieved by antacids. He has a history of smoking and takes nonsteroidal anti-inflammatory drugs (NSAIDs) occasionally for back pain. An upper gastrointestinal endoscopy reveals a duodenal ulcer. What would be the best line of treatment in this case? (Q849026)

A. H. pylori eradication

B. Proton pump inhibitors

C. Antacids like aluminium hydroxide

D. Highly selective vagotomy

See Answer in Part B → Q25

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Q26: A 50-year-old woman with a history of gastric carcinoma comes to the OPD with abdominal pain, early satiety, diarrhoea, and bloating. On examination, she is tachycardic and has palpitations. She also complains of headaches. She has undergone partial gastrectomy and Billroth type II reconstruction. What is the diagnosis here? (Q849025)

A. Recurrence of gastric carcinoma

B. Dumping syndrome

C. Gastric ulcer, Type V

D. Irritable bowel syndrome

See Answer in Part B → Q26

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Q27: A 60-year-old male with a history of peptic ulcer disease underwent partial gastrectomy with Roux-en-Y reconstruction five years ago. He presents with symptoms of severe diarrhoea, foul breath, and significant weight loss over the past few months. Which of the following is the most likely complication he is experiencing? (Q849024)

A. Gastrocolic fistula

B. Postvagotomy diarrhoea

C. Bilious vomiting

D. Nutritional deficiency

See Answer in Part B → Q27

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Q28: A 62-year-old woman is diagnosed with a T3N1M0 gastric adenocarcinoma located in the proximal third of the stomach, extending to the gastroesophageal junction. Which of the following gastrectomy procedures is most appropriate for curative intent? (Q849023)

A. Distal gastrectomy

B. Proximal gastrectomy

C. Total gastrectomy

D. Sleeve gastrectomy

See Answer in Part B → Q28

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Q29: A 55-year-old man undergoes a distal gastrectomy for gastric cancer. The surgeon wants to restore gastrointestinal continuity with a method that minimizes bile reflux gastritis. Which of the following reconstruction techniques is most appropriate? (Q849022)

A. Billroth I

B. Billroth II

C. Roux-en-Y gastrojejunostomy

D. Jejunal interposition

See Answer in Part B → Q29

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Q30: A 45-year-old man with refractory peptic ulcer disease is being considered for surgical intervention. Which of the following procedures will most likely preserve the vagal innervation of the gastric antrum and pylorus while reducing acid secretion? (Q849021)

A. Truncal vagotomy

B. Selective vagotomy

C. Truncal vagotomy with antrectomy

D. Highly selective vagotomy

See Answer in Part B → Q30

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• [05_Gastrointestinal Surgery] 021 Stomach-Ii

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[05_Gastrointestinal Surgery] 021 Stomach-Ii — Quick Jump

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Q31 (p. 332)	*Q32 (p. 332)*				

Q1: A 58 year old man is diagnosed with an adenocarcinoma located 4 cm below the gastroesophageal junction. According to the Siewert classification system, what type of tumour does he have, and how should it be treated if it does not extend into the GE junction? (Q849095)

A. Type I; treated as esophageal adenocarcinoma

B. Type II; treated as gastric adenocarcinoma

C. Type III; treated as gastric adenocarcinoma

D. Type III; treated as esophageal adenocarcinoma

See Answer in Part B → Q1

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Q2: A 60 year old woman presents with fatigue, loss of appetite, and a palpable mass in the upper abdomen. Endoscopic examination and biopsy confirmed diffuse large B-cell lymphoma of the stomach. What is the most appropriate treatment regimen for this patient? (Q849122)

A. H. pylori eradication therapy

B. Radiation therapy alone

C. Chemotherapy with R-CHOP

D. Immunotherapy with checkpoint inhibitors

See Answer in Part B → Q2

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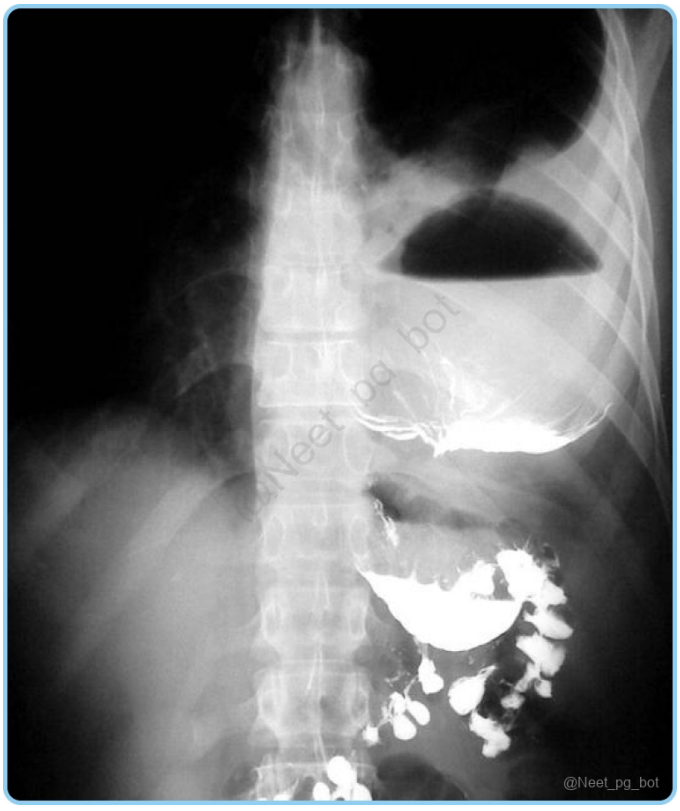
Q3: Match the following conditions with their corresponding X-ray findings: i) Teapot stomach a) ii) Hourglass stomach b) iii) Congenital Hypertrophic Pyloric Stenosis c) iv) Leather bottle stomach d) (Q849121)

A. i-a, ii-d, iii-c, iv-b

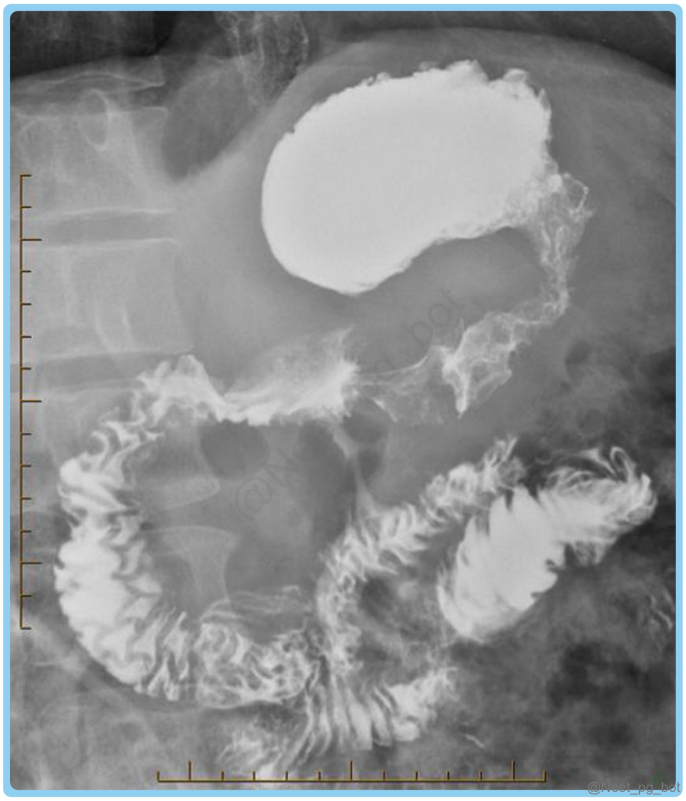
B. i-d, ii-a, iii-c, iv-b

C. i-d, ii-a, iii-b, iv-c

D. i-c, ii-b, iii-a, iv-d




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See Answer in Part B → Q3

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Q4: A 45 year old male presents with severe epigastric pain and inability to vomit despite repeated attempts. On examination, he has significant abdominal distention, and attempts to pass a nasogastric tube were unsuccessful. Which of the following best describes the condition represented by this clinical presentation? (Q849120)

A. Gastric cancer

B. Acute gastric volvulus

C. Peptic ulcer disease

D. Intestinal obstruction

See Answer in Part B → Q4

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Q5: A 17 year old girl with a history of depression presents with complaints of epigastric pain, early satiety, and vomiting of blood. She elicited a history of eating her hair due to stress. On examination, a palpable epigastric mass is noted. A CT scan of the abdomen reveals a large mass in the stomach. What is the most likely diagnosis? (Q849107)

A. Phytobezoar

B. Trichobezoar

C. Gastric carcinoma

D. Intestinal obstruction

See Answer in Part B → Q5

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Q6: A 2-week-old infant presents with vomiting, dehydration, and poor feeding. An abdominal X-ray shows a "double bubble" sign. Which of the following statements correctly differentiates Congenital Hypertrophic Pyloric Stenosis from Duodenal Atresia? (Q849106)

A. CHPS typically presents with bilious vomiting, while Duodenal Atresia presents with non-bilious vomiting.

B. In CHPS, infants are often hungry after vomiting, whereas in Duodenal Atresia, infants have no desire to feed.

C. Both conditions present with projectile vomiting, but CHPS is diagnosed by X-ray showing the "double bubble" sign.

D. Duodenal Atresia is commonly treated with Ramstedt's pyloromyotomy, whereas CHPS requires surgical correction of the duodenum.

See Answer in Part B → Q6

@Neet_pg_bot

Q7: A 3-week-old infant is diagnosed with Congenital Hypertrophic Pyloric Stenosis after presenting with projectile vomiting and signs of dehydration. The surgical team

plans to perform Ramstedt's pyloromyotomy. Which of the following statements about this condition and its management is true? (Q849105)

A. The incision during Ramstedt's pyloromyotomy should only involve the mucosal layer to avoid complications.

B. Infants with CHPS typically do not exhibit hunger after vomiting.

C. Postoperative intravenous fluids are administered until the infant can resume feeding, which usually occurs within 24 hours.

D. Persistent vomiting after surgery is primarily due to incomplete myotomy

See Answer in Part B → Q7

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Q8: A 3-week-old infant presents with persistent projectile non-bilious vomiting, dehydration, and weight loss. The physical examination reveals a palpable mass in the right upper quadrant. An abdominal ultrasound shows a thickened pylorus. Which of the following electrolyte imbalances is most likely to be seen in this patient? (Q849104)

A. Hyperkalemia

B. Hypernatremia

C. Hypokalemia

D. Hypocalcemia

See Answer in Part B → Q8

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Q9: A 65 year old male presents with complaints of persistent abdominal pain and weight loss. After evaluation, he is diagnosed with resectable gastric cancer. Based on the information provided, which of the following treatment options would likely offer the best median overall survival for this patient? (Q849103)

A. ECF (epirubicin, cisplatin, 5-fluorouracil) regimen

B. FLOT (fluorouracil, leucovorin, oxaliplatin, docetaxel) regimen

C. Palliative chemotherapy

D. Total gastrectomy without prior chemotherapy

See Answer in Part B → Q9

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Q10: A 55-year-old woman presents with abdominal pain and a palpable epigastric mass. CT shows a well-defined stomach mass. Biopsy confirms a gastrointestinal stromal tumor, with CD117 and DOG1 positivity. Which statement is most accurate about this patient? (Q849101)

A. CD117 positivity confirms the diagnosis of GIST, and DOG1 is not relevant

B. The primary treatment for GISTs is chemotherapy

C. Surgery is the mainstay of treatment for localized GISTs

D. GISTs most commonly occur in the small intestine and are rarely found in the stomach

See Answer in Part B → Q10

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Q11: A 52-year-old man presents with epigastric pain, weight loss, and early satiety for three months. On examination, mild epigastric tenderness is seen. Upper GI endoscopy reveals an ulcerated mass in the stomach antrum, confirmed as adenocarcinoma. Staging shows no distant metastases but involves perigastric lymph nodes. What is the next step in management? (Q849100)

A. Neoadjuvant chemotherapy followed by total gastrectomy

B. Subtotal gastrectomy with D1 lymph node dissection

C. Subtotal gastrectomy with D2 lymph node dissection

D. Palliative chemotherapy

See Answer in Part B → Q11

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Q12: A 55 year old patient is diagnosed with gastric cancer and is preparing for surgical treatment. The surgical team is reviewing the guidelines for lymph node resection to ensure optimal patient outcomes. According to current recommendations, what is the minimum number of lymph nodes that should be removed and examined during the surgery for gastric cancer? (Q849099)

A. 4 lymph nodes

B. 12 lymph nodes

C. 16 lymph nodes

D. 20 lymph nodes

See Answer in Part B → Q12

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Q13: A 62 year old male undergoes an endoscopic biopsy for a gastric mass. The pathology report reveals that the tumour invades the muscularis propria but does not extend into the subserosal connective tissue. What is the appropriate T classification for this tumour? (Q849098)

A. T1b

B. T2

C. T3

D. T4a

See Answer in Part B → Q13

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Q14: A 55 year old female presents with a palpable nodule in her umbilicus. She also has a history of weight loss and abdominal discomfort. Imaging reveals metastatic

spread of gastric cancer. Which of the following is the term for this clinical finding, and what is its typical route of spread? (Q849097)

A. Krukenberg tumor; hematogenous spread

B. Blumer shelf; transperitoneal spread

C. Sister Mary Joseph's nodule; transperitoneal spread

D. Virchow's node; retrograde lymphatic spread

See Answer in Part B → Q14

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Q15: A 28 year old man presents with recurrent abdominal pain and gastrointestinal bleeding. Imaging studies reveal the presence of multiple gastrointestinal stromal tumors (GISTs) in his stomach. His medical history includes a diagnosis of paragangliomas, and his mother has a history of lung tumors. What is the most likely genetic syndrome associated with this patient's findings? (Q849102)

A. Neurofibromatosis type 1

B. Carney’s Triad

C. Familial adenomatous polyposis

D. Peutz-Jeghers syndrome

See Answer in Part B → Q15

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Q16: A 65 year old male presents with vague epigastric discomfort and constant, non-radiating pain that is not related to food intake. He has a history of iron deficiency anaemia. Considering the regional differences in the prevalence of stomach cancer sites, what is the most likely location of his cancer if he resides in the West? (Q849094)

A. Distal stomach

B. Proximal stomach

C. Antrum of the stomach

D. Body of the stomach

See Answer in Part B → Q16

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Q17: A patient with advanced gastric adenocarcinoma is found to have HER2/neu overexpression. Which targeted therapy is the drug of choice in this setting? (Q888695)

A. Bevacizumab

B. Cetuximab

C. Trastuzumab

D. Pembrolizumab

See Answer in Part B → Q17

@Neet_pg_bot

Q18: A patient with a high-risk gastric gastrointestinal stromal tumour (GIST) undergoes complete surgical resection. What is the most appropriate next step in management? (Q888694)

A. Adjuvant external beam radiotherapy

B. Adjuvant chemotherapy with 5-fluorouracil

C. Adjuvant therapy with imatinib

D. Routine surveillance only

See Answer in Part B → Q18

@Neet_pg_bot

Q19: What is the most common metabolic complication observed in patients after a gastrectomy? (Q888693)

A. Vitamin B12 deficiency

B. Osteoporosis

C. Iron deficiency anaemia

D. Calcium deficiency

See Answer in Part B → Q19

@Neet_pg_bot

Q20: For which of the following clinical scenarios is surgery most appropriately indicated in a patient with gastric lymphoma? (Q888692)

A. Intractable pain without other complications

B. Asymptomatic, incidentally discovered gastric wall thickening

C. First-line chemotherapy failure with persistent symptomatic disease

D. Mild H. pylori-positive gastritis without lymphoma progression

See Answer in Part B → Q20

@Neet_pg_bot

Q21: What is the most common histological subtype of primary gastric non-Hodgkin lymphoma? (Q888691)

A. Gastric MALT lymphoma

B. Burkitt lymphoma

C. Diffuse large B-cell lymphoma

D. Follicular lymphoma

See Answer in Part B → Q21

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Q22: During curative surgical resection for gastric adenocarcinoma, what is the recommended minimum proximal and distal gross negative margin from the tumour edge? (Q888690)

A. 1 cm

B. 2 cm

C. 5 cm

D. 10 cm

See Answer in Part B → Q22

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Q23: According to the Japanese Gastric Cancer Association (JGCA) classification, suprapyloric lymph nodes correspond to which nodal station? (Q888689)

A. Station 1

B. Station 3

C. Station 5

D. Station 7

See Answer in Part B → Q23

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Q24: According to standard criteria, which of the following is an absolute contraindication for endoscopic mucosal resection (EMR) in early gastric cancer? (Q888686)

A. Tumour size 1.5 cm

B. Well-differentiated histology

C. Presence of ulceration

D. Tumour confined to the mucosa

See Answer in Part B → Q24

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Q25: Troisier's sign, characterised by enlargement of the left supraclavicular lymph node (Virchow's node), is most indicative of metastasis from which primary cancer site? (Q888662)

A. Breast

B. Lung

C. Stomach

D. Colon

See Answer in Part B → Q25

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Q26: According to the Japanese classification, early gastric cancer is defined by tumour invasion limited to which layers of the gastric wall? (Q888661)

A. Mucosa and submucosa only

B. Muscularis propria

C. Serosa

D. Adjacent organs

See Answer in Part B → Q26

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Q27: A patient presents with gastric outlet obstruction caused by a diffusely infiltrating gastric carcinoma. This presentation is classic for which condition, and how is it classified in the Bormann system? (Q888657)

A. Linitis plastica; Type III (Ulcerating)

B. Linitis plastica; Type IV (Diffuse infiltrating)

C. Krukenberg tumour; Type II (Ulcerofungating)

D. Gastric adenoma; Type I (Polypoid)

See Answer in Part B → Q27

@Neet_pg_bot

Q28: Which molecular alteration is characteristic of the intestinal type of gastric adenocarcinoma according to Lauren's classification? (Q888652)

A. Mutation of E-cadherin

B. Loss of heterozygosity in the APC gene

C. Inactivation of p53 only

D. KRAS mutation

See Answer in Part B → Q28

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Q29: According to Lauren's classification, which type of gastric adenocarcinoma is primarily associated with hematogenous spread? (Q888650)

A. Type II (Diffuse type)

B. Mixed type

C. Type I (Intestinal type)

D. Indeterminate type

See Answer in Part B → Q29

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Q30: A patient with Helicobacter pylori infection is found to have gastric polyps. Which type of gastric polyp is most commonly associated with H. pylori and typically regresses after eradication therapy? (Q888648)

A. Adenoma

B. Fundic gland polyp

C. Hyperplastic polyp

D. Hamartomatous polyp

See Answer in Part B → Q30

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Q31: Which of the following is the most common location of gastric adenocarcinoma in Asian populations, and why? (Q888645)

A. Proximal stomach, due to the high prevalence of GERD

B. Antrum, due to the higher prevalence of H. pylori infections

C. Cardia, due to obesity-related factors

D. Fundus, due to autoimmune gastritis

See Answer in Part B → Q31

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Q32: A 35 year old male presents with severe weight loss and loss of appetite. Endoscopic examination reveals a thickened, rigid stomach with a "mother of pearl" appearance. Biopsy shows poorly differentiated cells with signet ring cells. What is the most appropriate treatment for his condition? (Q849096)

A. Partial gastrectomy

B. Chemotherapy alone

C. Total gastrectomy with oesophagojejunal anastomosis

D. Proton pump inhibitors and antibiotics

See Answer in Part B → Q32

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• [05_Gastrointestinal Surgery] 022 Peritoneum

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[05_Gastrointestinal Surgery] 022 Peritoneum — Quick Jump

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Q1: A 35-year-old female presents with painless swelling in the umbilical region. On physical examination, the swelling is found to be soft, smooth, and freely mobile in a direction perpendicular to the line of the mesentery. Imaging studies confirm the presence of a mesenteric cyst. Which of the following is not a component of Tillaux's triad? (Q849228)

A. Soft, smooth swelling in the umbilical region

B. Freely mobile in a direction perpendicular to mesentery

C. Presence of tenderness

D. Zone of resonance all around

See Answer in Part B → Q1

@Neet_pg_bot

Q2: A 52-year-old woman presents with abdominal distension, colicky pain that worsens after meals, and a gradual decline in her overall health. On examination, she has multiple hernias and ascites that do not demonstrate shifting dullness. Imaging reveals a jelly-like substance throughout the peritoneal cavity and mesentery. What is the most likely diagnosis for this patient? (Q849229)

A. Ovarian cystic tumor

B. Pseudomyxoma peritonei

C. Ascitic fluid due to liver cirrhosis

D. Colorectal carcinoma

See Answer in Part B → Q2

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Q3: A CT scan reveals periaortic soft tissue mass encasing both ureters. Regarding retroperitoneal fibrosis, which of the following statements is false? (Q849231)

A. Methysergide use is a recognized etiology in some cases.

B. Bilateral ureteric obstruction is best managed initially with bilateral nephrostomies.

C. Tamoxifen is contraindicated in the medical management of this condition.

D. Laparoscopic ureterolysis with omental wrapping is a surgical option for persistent cases.

See Answer in Part B → Q3

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Q4: A 55-year-old male with a history of liver cirrhosis and ascites presents to the emergency department with fever, abdominal pain, and tenderness. Paracentesis is performed, and the ascitic fluid analysis shows an elevated white blood cell count. Which of the following organisms is the most common cause of spontaneous bacterial peritonitis in patients with ascites along with its source of infection? (Q849176)

A. Escherichia coli, Extraperitoneal source

B. Staphylococcus, Extraperitoneal source

C. Escherichia coli, Intraperitoneal source

D. Streptococcus pneumonia, Intraperitoneal source

See Answer in Part B → Q4

@Neet_pg_bot

Q5: Which of the following statements is false regarding spontaneous bacterial peritonitis (Q849178)

A. Translocation of bacteria from the gut causes SBP

B. Neutrophil count >250/mm is present in SBP

C. Cefotaxime is the first-line treatment for SBP

D. SBP is a polymicrobial infection of ascitic fluid

See Answer in Part B → Q5

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Q6: What is the most common anaerobe responsible for Secondary Bacterial Peritonitis? (Q849180)

A. E. coli

B. Bacteroides fragilis

C. Klebsiella

D. Clostridium difficile

See Answer in Part B → Q6

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Q7: Which of the following statements about continuous ambulatory peritoneal dialysis are true? (Q849225)

A. The most common organism causing peritonitis in CAPD is Staphylococcus saprophyticus

B. Treatment involves intraperitoneal instillation of first-generation cephalosporin via catheter for treating CAPD peritonitis

C. Recurrent attacks of peritonitis in CAPD should not be considered hemodialysis

D. None of the above

See Answer in Part B → Q7

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Q8: A 55-year-old woman presents with a 3-day history of worsening lower abdominal pain, fever, and diarrhea with mucus. She reports a feeling of pressure in her pelvis and says that even sitting is excruciating. Her medical history is significant for diverticulitis, which was treated conservatively 6 weeks ago. Tenderness to palpation in the lower abdomen, and a rectal examination are present. What is the most likely diagnosis? (Q849226)

A. Acute appendicitis

B. Diverticulitis flare-up

C. Pelvic inflammatory disease

D. Pelvic abscess

See Answer in Part B → Q8

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Q9: Which of the following statements are true about mesenteric cyst? (Q849227)

A. Enterogenous cyst has an independent vascular supply

B. Walls of chylolymphatic cysts are thicker than enterogenous cysts

C. Treatment of chylolymphatic cyst is resection and anastomosis

D. Fluid in enterogenous cyst is produced by goblet cells of viscera

See Answer in Part B → Q9

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Q10: A male presents with bilateral flank pain, lower extremity edema, and elevated serum creatinine. CT scan reveals a retroperitoneal mass encasing both ureters. Biopsy shows dense fibrocollagenous tissue with chronic inflammation. Which of the following is the most likely etiology of this patient's condition? (Q849230)

A. IgG4-related disease

B. Metastatic prostate cancer

C. Methysergide use

D. Erdheim-Chester disease

See Answer in Part B → Q10

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• [05_Gastrointestinal Surgery] 023 Small Intestine - I

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[05_Gastrointestinal Surgery] 023 Small Intestine - I — Quick Jump

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Q1: A 3-year-old child with short bowel syndrome presents with severe malabsorption. Which surgical procedure involves stapling a dilated bowel into V shapes on alternating sides, decreasing the width and increasing the bowel length to improve nutrient absorption? (Q849162)

A. Bianchi procedure

B. Whipple Procedure

C. Billroth I and II Procedures

D. STEP procedure

See Answer in Part B → Q1

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Q2: A 6-year-old child with a history of extensive small bowel resection due to necrotizing enterocolitis is diagnosed with short bowel syndrome. Which among the following surgical procedures can help increase the bowel length and potentially reduce the dependency on parenteral nutrition? (Q849161)

A. Bianchi procedure

B. Whipple Procedure

C. Billroth I and II Procedures

D. Ileostomy

See Answer in Part B → Q2

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Q3: A 45-year-old male presents with severe malnutrition and liver dysfunction even after subclavian parenteral nutrition for extensive small bowel resection. Which of the following is the most definitive treatment for his condition? (Q849160)

A. Jugular Parenteral Nutrition (TPN)

B. Small bowel transplantation

C. Serial transverse enteroplasty

D. Ileostomy

See Answer in Part B → Q3

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Q4: A 52-year-old male patient who underwent extensive resection of the small intestine for Crohn's disease presents with persistent diarrhea and worsening malnutrition. Despite following a strict dietary regimen, he is unable to maintain adequate nutritional status or fluid balance without intravenous support. What is the most appropriate management strategy for this patient? (Q849159)

A. Oral rehydration therapy

B. Enteral nutrition

C. Parenteral nutrition

D. Antidiarrheal medications

See Answer in Part B → Q4

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Q5: A 60-year-old woman with a history of extensive small bowel resection presents with persistent diarrhea, significant weight loss, and signs of malnutrition. She is unable to maintain adequate fluid and nutritional balance despite dietary modifications. what condition is she most likely experiencing? (Q849158)

A. Intestinal obstruction

B. Short bowel syndrome

C. Celiac disease

D. Crohn's disease

See Answer in Part B → Q5

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Q6: A 55-year-old patient with radiation enteritis undergoes bowel resection and develops short bowel syndrome. Which statement about bowel function is correct? (Q849157)

A. The jejunum compensates well for the loss of the ileum.

B. The ileum can compensate for a resected jejunum due to better absorption.

C. Short bowel syndrome is less severe with distal bowel loss.

D. The ileum's compensation is reduced due to looser junctions.

See Answer in Part B → Q6

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Q7: A 60-year-old man presents with complaints of fatigue, shortness of breath, and swelling in his legs. He has had a history of intermittent facial flushing and diarrhea for the past several years. Physical examination reveals a new heart murmur. Which of the following is the most likely diagnosis? (Q849155)

A. Aortic stenosis

B. Mitral regurgitation

C. Carcinoid heart disease

D. Pulmonary embolism

See Answer in Part B → Q7

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Q8: Which of the following diagnostic steps is most appropriate to establish a definitive diagnosis of abdominal TB in this patient? (Q849150)

A. Serum-ascites albumin gradient (SAAG) measurement

B. Computed tomography (CT) with enterography protocol

C. Peritoneal fluid adenosine deaminase (ADA) level

D. Biopsy of the involved site with mycobacterial culture and nucleic acid amplification test (NAAT)

See Answer in Part B → Q8

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Q9: A 65-year-old male presents with sudden onset severe abdominal pain that started 30 minutes after his last meal. He is tachycardic and hypotensive and laboratory investigations reveal leukocytosis and elevated chromogranin A levels. A CT scan shows bowel wall enhancement and free fluid in the abdomen. Which of the following is the most preferred treatment? (Q849156)

A. Segmental resection + En-bloc lymphadenectomy

B. Chemotherapy regimen

C. Somatostatin analogue therapy

D. Total bowel resection

See Answer in Part B → Q9

@Neet_pg_bot

Q10: A 48-year-old woman presents with episodes of flushing, diarrhea, and abdominal pain over the past six months. She also reports intermittent wheezing and feels her symptoms worsen after consuming certain foods. On physical examination, she exhibits a rash on her face and neck. Imaging studies reveal a tumor in the ileum of the small intestine. What is the initial investigation of choice for localisation in this patient? (Q849154)

A. Contrast-enhanced CT abdomen

B. DOPA-PET

C. Urinary detention of 5-HIAA

D. Somatostatin receptor scintigraphy (SRS)

See Answer in Part B → Q10

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Q11: What is the most peculiar feature of gastric carcinoid tumor? (Q849153)

A. Abdominal pain

B. Abdominal distension

C. Bowel obstruction

D. Bright red patchy flushing of skin

See Answer in Part B → Q11

@Neet_pg_bot

Q12: A 55 y/o male presents with flushing, diarrhea, and recurrent episodes of bronchospasm. Imaging reveals multiple masses in the ileum. Laboratory tests show elevated serotonin levels. What is the most likely type of tumor responsible for his symptoms? (Q849152)

A. Foregut Carcinoid Tumor

B. Midgut Carcinoid Tumor

C. Hindgut Carcinoid Tumor

D. Non-Syndromic Neuroendocrine Tumor

See Answer in Part B → Q12

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Q13: Which of the following statements is correct? (Q849151)

A. The most common small bowel tumor in adults is carcinoid tumor.

B. The most common small bowel tumor in children is a neuroendocrine tumor.

C. The most common primary malignant small bowel tumor is adenocarcinoma.

D. The most common small bowel tumor in adults is lymphoma.

See Answer in Part B → Q13

@Neet_pg_bot

Q14: A 65 y/o male presents with chronic abdominal discomfort and bloating. Imaging shows multiple jejunal diverticula. The physician suspects these are due to increased intraluminal pressure. What is the most likely etiology of these diverticula? (Q849138)

A. Congenital origin due to incomplete recanalization of the duodenum

B. Acquired origin due to smooth muscle motor dysfunction

C. Remnant of the omphalomesenteric duct

D. Protrusion of the entire intestinal wall layers

See Answer in Part B → Q14

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Q15: A 28-year-old patient with gastrointestinal tuberculosis presents with abdominal pain and intermittent diarrhea. Imaging studies reveal a long, narrow filling defect in the terminal ileum. What is the most likely diagnosis based on these findings? (Q849149)

A. Ulcerative tuberculosis with subacute obstruction and perforation

B. Crohn’s disease with a narrowed segment and proximal distension

C. Hyperplastic tuberculosis with a filling defect in the terminal ileum and lymphadenopathy

D. Appendicitis with mass in the right iliac fossa

See Answer in Part B → Q15

@Neet_pg_bot

Q16: A patient with pulmonary tuberculosis is diagnosed with ulcers in the terminal ileum. Which form of gastrointestinal tuberculosis is characterized by this presentation? (Q849148)

A. Hyperplastic tuberculosis with intestinal wall thickening.

B. Ulcerative tuberculosis with transverse ulcers and serosal thickening.

C. Crohn’s disease with abscesses and fistulas.

D. Hyperplastic tuberculosis with abscesses and fistulas.

See Answer in Part B → Q16

@Neet_pg_bot

Q17: A 35-year-old male presents with symptoms of abdominal pain and weight loss. He has a history of pulmonary tuberculosis. On examination, his abdomen is tender in the right iliac fossa. A barium follow-through study reveals a long, narrow filling defect in the terminal ileum. Which of the following is the most likely diagnosis? (Q849147)

A. Crohn's disease

B. Hyperplastic tuberculosis

C. Appendicitis

D. Carcinoma of the ileum

See Answer in Part B → Q17

@Neet_pg_bot

Q18: A 25-year-old female with a history of weight loss presents with intermittent abdominal pain, nausea, and vomiting. Imaging shows compression of the third portion of the duodenum between the aorta and the superior mesenteric artery. Conservative dietary management has failed. What is the next best step in management? (Q849146)

A. Laparoscopic duodenojejunostomy

B. Open duodenal bypass surgery

C. Continued conservative management

D. Open duodenojejunostomy

See Answer in Part B → Q18

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Q19: A 30 y/o male with a history of rapid weight loss presents with severe postprandial abdominal pain and vomiting. The physician suspects Superior Mesenteric Artery (SMA) syndrome. Which imaging technique is most suitable for visualizing the compression of the duodenum by the SMA and accurately measuring the aortomesenteric angle? (Q849145)

A. Endoscopy

B. Computed Tomography (CT) Scan

C. Barium X-ray Study

D. Abdominal Ultrasound

See Answer in Part B → Q19

@Neet_pg_bot

Q20: Which of the following is NOT TRUE regarding superior mesenteric artery syndrome? (Q849144)

A. Early satiety and postprandial epigastric pain are present.

B. The knee to the chest or left lateral decubitus position alleviates symptoms.

C. Presentation is always acute, needing emergency intervention.

D. All of the above.

See Answer in Part B → Q20

@Neet_pg_bot

Q21: Which part of the duodenum is compressed in superior mesenteric artery syndrome? (Q849143)

A. First

B. Second

C. Third

D. Fourth

See Answer in Part B → Q21

@Neet_pg_bot

Q22: A 6-year-old boy is diagnosed with symptomatic Meckel's diverticulum after presenting with painless rectal bleeding. The diverticulum is found to be inflamed and with ulcers in the base. Which of the following surgical procedures is most appropriate for this patient? (Q849142)

A. Amputation at base and invagination.

B. Resection of small bowel with diverticulum.

C. Ileostomy.

D. Diverticulectomy.

See Answer in Part B → Q22

@Neet_pg_bot

Q23: A 7-year-old boy presents with intermittent episodes of blood in his stools without pain. On examination, there are no signs of acute abdomen. Blood investigations reveal he is anemic. Which is the investigation of choice in this case for Meckel's diverticulum? (Q849141)

A. USG abdomen

B. Colonoscopy

C. Tc-pertechnetate scan

D. CT abdomen

See Answer in Part B → Q23

@Neet_pg_bot

Q24: A 2-year-old boy presents with painless rectal bleeding. CT scans show a diverticulum 2 inches long located around 2 feet proximal to the ileocaecal valve. A Technetium-99m pertechnetate scan shows an area of increased uptake in the right lower quadrant. What is the most likely type of ectopic mucosal tissue found in the diverticulum that can explain these findings? (Q849140)

A. Gastric

B. Pancreatic

C. Colonic

D. Jejunal

See Answer in Part B → Q24

@Neet_pg_bot

Q25: Which of the following characteristics is true regarding Meckel's diverticulum? (Q849139)

A. Located approximately 30 cm from the ileocecal valve.

B. Always lined with ectopic pancreatic tissue

C. Arises from the mesenteric border of the ileum.

D. Contains all the layers of the bowel wall.

See Answer in Part B → Q25

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• [05_Gastrointestinal Surgery] 024 Intestinal Obstruction

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[05_Gastrointestinal Surgery] 024 Intestinal Obstruction — Quick Jump

Q1 (p. 350) *Q2 (p. 350)* *Q3 (p. 351)* *Q4 (p. 351)* *Q5 (p. 351)* *Q6 (p. 352)*
Q7 (p. 353) *Q8 (p. 353)* *Q9 (p. 354)* *Q10 (p. 354)* *Q11 (p. 355)*

Q1: Which of the following statements regarding intraoperative findings for treatment of large bowel obstruction is incorrect? (Q849076)

A. A distended caecum during laparotomy indicates a large bowel obstruction.

B. Emergency caecostomy can be done to stabilize the patient.

C. A collapsed caecum during laparotomy suggests a large bowel obstruction.

D. Resection and anastomosis are appropriate treatments for Crohn's disease

See Answer in Part B → Q1

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Q2: A 45-year-old patient with a history of previous abdominal surgeries presents with severe abdominal pain that initially started as crampy but has become constant and steady. The patient has a temperature of 102 degrees, 128 beats per minute heart rate, and elevated white blood cell count. Which diagnostic test is most appropriate for confirming in this patient? (Q849077)

A. Abdominal X-ray

B. CECT

C. USG abdomen

D. MRI abdomen

See Answer in Part B → Q2

@Neet_pg_bot

Q3: A 55-year-old female patient presents with a history of abdominal surgery performed 3 days ago. She reports worsening abdominal distension and has not passed stool since the surgery. On examination her abdomen is distended, and bowel sounds are absent. Which of the following statements is correct regarding this condition? (Q849078)

A. Caused by increased peristaltic activity.

B. Surgery is the first-line treatment.

C. X-ray shows dilated bowel loops and air-fluid levels

D. Associated with hyperkalemia.

See Answer in Part B → Q3

@Neet_pg_bot

Q4: A 4-year-old boy is brought with intermittent episodes of severe abdominal pain, during which he pulls his knees to his chest and cries inconsolably. He passed a small amount of "red, jelly-like" stool. On examination, the child appears pale, lethargic, and mildly dehydrated. What is the most likely abdominal CT finding seen in this condition? (Q849079)

A. Target sign

B. Claw sign

C. Coiled spring sign

D. Coffee bean sign

See Answer in Part B → Q4

@Neet_pg_bot

Q5: A 75-year-old male patient, bedridden after hip surgery, presents with a 4-day history of progressive abdominal distension, nausea, and constipation. On physical examination, his abdomen is distended but non-tender, with decreased bowel sounds.

An abdominal X-ray shows dilated loops of colon, particularly in the cecum, but no air-fluid levels or evidence of mechanical obstruction. His vital signs are stable, and there is no fever. Which of the following drugs is commonly used in pharmacologic treatment of this condition? (Q849080)

A. Loperamide

B. Neostigmine

C. Stimulant laxatives

D. Osmotic laxatives

See Answer in Part B → Q5

@Neet_pg_bot

Q6: A 72-year-old male presents with a 2-day history of progressive abdominal distension, constipation, and colicky pain. He has a history of chronic constipation and has been bedridden for the past few months due to a hip fracture. On examination, his abdomen is distended and tympanic, with mild tenderness. Abdominal guarding and rigidity not observed. X-ray of the abdomen is shown below. Which of the following factors does not predispose to this condition? (Q849081)

A. Chronic constipation with laxative abuse

B. Anticholinergic drugs

C. Mentally-retarded individuals

D. Short pelvic mesocolon



See Answer in Part B → Q6

@Neet_pg_bot

Q7: Which of the following options is not true regarding caecal volvulus? (Q849082)

A. Rotation is more commonly seen in clockwise direction

B. Caecal volvulus involves the terminal ileum and the right colon

C. In caecal bascule, there is axial twisting

D. Clinically, it may manifest as small bowel obstruction

See Answer in Part B → Q7

@Neet_pg_bot

Q8: Which of the following is/are components of Hartmann’s procedure? (Q849083)

A. Sigmoidectomy

B. Closure of rectal stump

C. Descending colostomy

D. All of the above

See Answer in Part B → Q8

@Neet_pg_bot

Q9: A 45-year-old man with a history of abdominal surgery presents with severe crampy abdominal pain and bilious vomiting. On examination, his abdomen is distended, and he has not had a bowel movement for three days. Which of the following is the most likely cause of his obstruction? (Q849073)

A. Pelvic Adhesions

B. Colorectal Cancer

C. Inguinal Hernia

D. Crohn's Disease

See Answer in Part B → Q9

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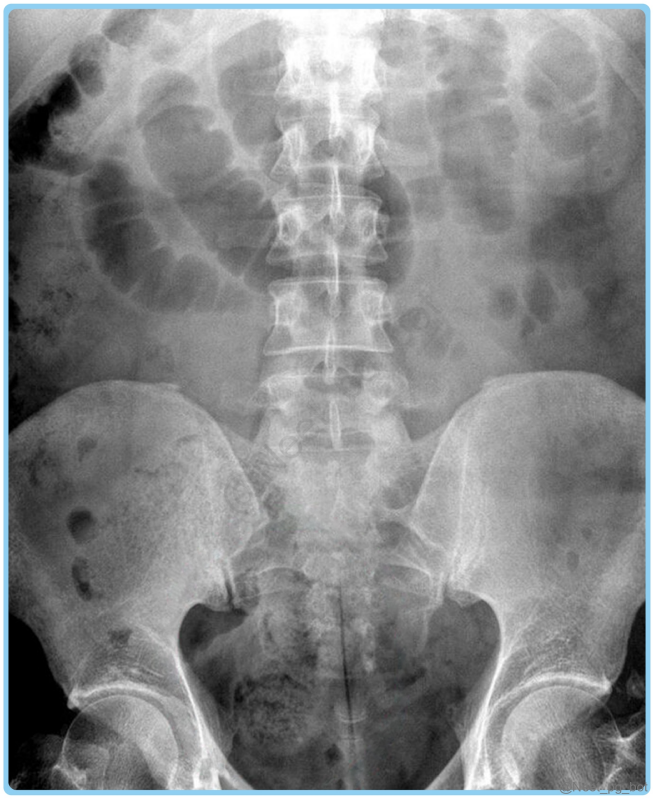
Q10: A 50-year-old man presents with acute abdominal pain, and bilious vomiting. Physical examination reveals a distended abdomen, and he has not had a bowel movement for three days. An abdominal X-ray is shown below. What is the most appropriate next step in management ? (Q849074)

A. Administer oral laxatives

B. Start IV fluids (RL)

C. Exploratory laparotomy

D. IV Prokinetics



See Answer in Part B → Q10

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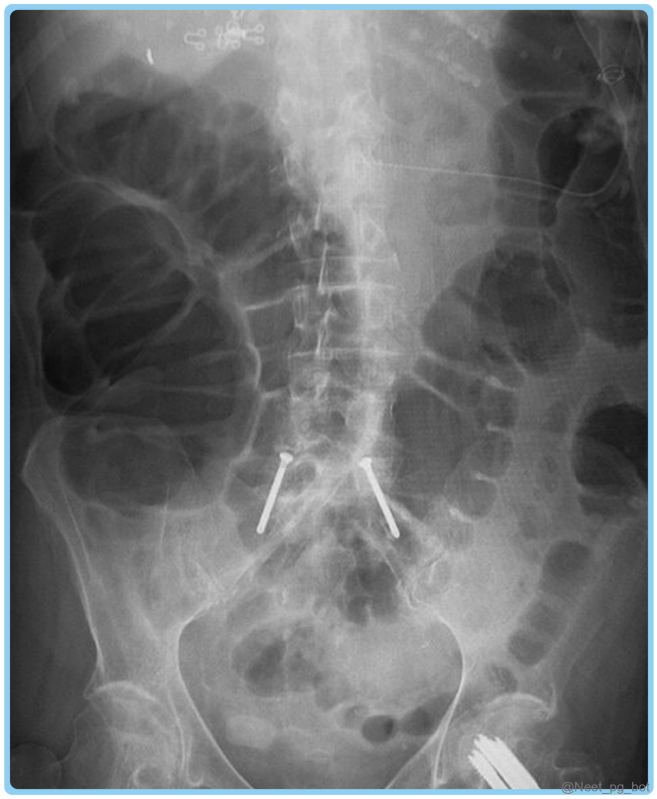
Q11: Based on the findings visible in the X-ray, all of the following are true, except: (Q849075)

A. Haustral folds are irregularly spaced and do not span the full lumen

B. Dilated bowel loops are typically peripheral in location on a supine film

C. Haustral markings do not form complete mucosal rings across the bowel

D. Presence of centrally located featureless loops without haustra is typical of large bowel obstruction



See Answer in Part B → Q11

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• [05_Gastrointestinal Surgery] 025 Large Intestine-I

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[05_Gastrointestinal Surgery] 025 Large Intestine-I — Quick Jump

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Q25 (p. 370)	*Q26 (p. 370)*	*Q27 (p. 370)*			

Q1: Which of the following statements about diverticulitis is incorrect? Diverticulitis often presents with abdominal pain localized to the lower left side. A barium enema is a preferred imaging method for diagnosing diverticulitis. Colostomy is often performed as a first-line treatment. Stage Ib of the Modified Hinchey Classification refers to a pericolic abscess. Complications of diverticulitis may include fistula formation, such as colovesical fistula. (Q849048)

A. 1 and 5

B. 2 and 4

C. 4 and 5

D. 2 and 3

See Answer in Part B → Q1

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Q2: Which variant of Familial Adenomatous Polyposis is associated with both colorectal cancer and brain tumors? (Q849052)

A. Classic FAP

B. Attenuated FAP

C. Gardner's Syndrome

D. Turcot Syndrome

See Answer in Part B → Q2

@Neet_pg_bot

Q3: A 45-year-old woman presents with a history of recurrent colorectal cancer. Her family history reveals that her mother was diagnosed with endometrial cancer at age 50, and her aunt had ovarian cancer. Genetic testing is recommended. What is the most likely diagnosis? (Q849053)

A. Cowden Syndrome

B. Lynch Syndrome

C. Peutz-Jeghers Syndrome

D. MUTYH-Associated Polyposis (MAP)

See Answer in Part B → Q3

@Neet_pg_bot

Q4: A 35-year-old woman presents with multiple oral papillomas, facial trichilemmomas, and a history of thyroid nodules. She also reports that her mother had breast cancer at a young age. On examination, multiple small, wart-like growths on her hands is noted. What is the most likely diagnosis? (Q849054)

A. Neurofibromatosis

B. Cowden disease

C. Peutz-Jeghers syndrome

D. Gardner syndrome

See Answer in Part B → Q4

@Neet_pg_bot

Q5: Which of the following endoscopic findings is considered the earliest and most characteristic lesion seen in Crohn's disease? (Q883976)

A. Cobblestoning mucosa

B. Deep serpiginous ulcers

C. Aphthous ulcers

D. Pseudopolyps

See Answer in Part B → Q5

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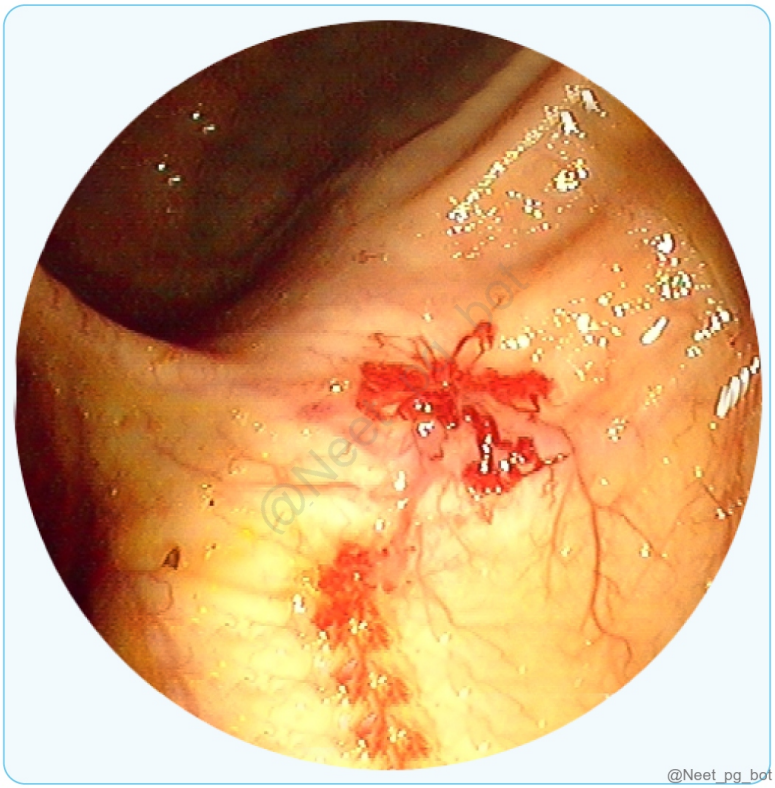
Q6: A 75-year-old patient presents with recurrent episodes of painless lower gastrointestinal bleeding. Colonoscopy is performed, and the image above is obtained. What is the most likely diagnosis? (Q883989)

A. Diverticular bleeding

B. Colonic carcinoma

C. Angiodysplasia

D. Ulcerative colitis



See Answer in Part B → Q6

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Q7: Which colonic region is most vulnerable to ischemic colitis due to its watershed vascular supply? (Q883988)

A. Cecum

B. Hepatic flexure

C. Rectum

D. Splenic flexure

See Answer in Part B → Q7

@Neet_pg_bot

Q8: The radiographic finding of "thumbprinting" on a plain abdominal X-ray is most indicative of which pathological process? (Q883987)

A. Intraluminal faecal impaction

B. Colonic submucosal oedema or haemorrhage

C. Extrinsic compression by an abdominal mass

D. Pneumatosis intestinalis

See Answer in Part B → Q8

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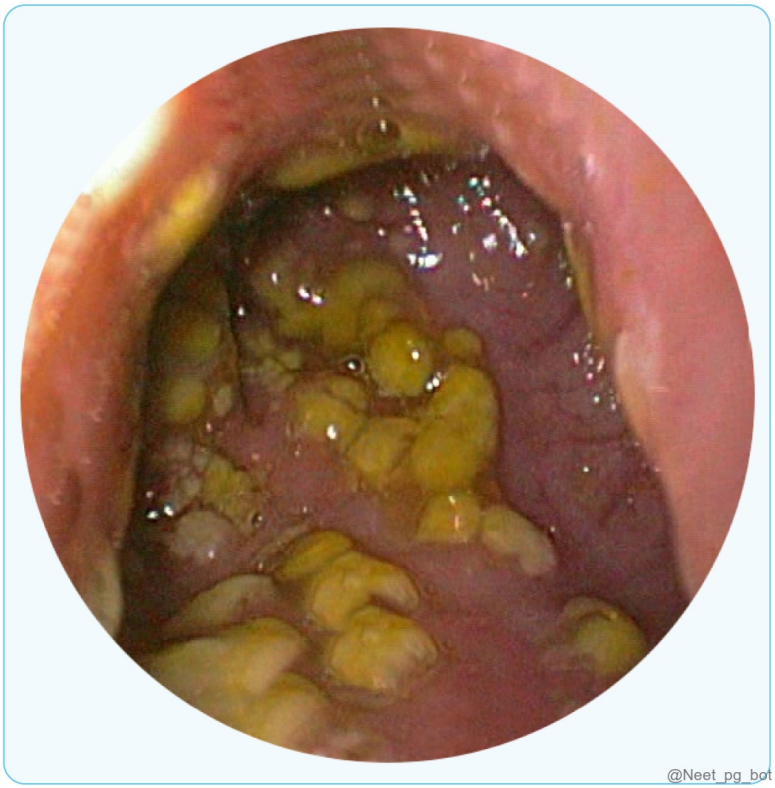
Q9: A 64-year-old woman was recently treated for antibiotic-associated diarrhea and initially improved. Two weeks later, she returns with recurrent abdominal cramps and foul-smelling watery diarrhea. Stool toxin assay is positive for Clostridioides difficile. Sigmoidoscopy findings are shown above. What is the preferred antibiotic for management at this stage? (Q883986)

A. Oral metronidazole

B. Intravenous vancomycin

C. Oral fidaxomicin

D. Oral ciprofloxacin



See Answer in Part B → Q9

@Neet_pg_bot

Q10: In which patient population is a colovesical fistula due to diverticulitis most commonly seen? (Q883985)

A. Young women

B. Men and women equally

C. Women who have had a hysterectomy

D. Men

See Answer in Part B → Q10

@Neet_pg_bot

Q11: A patient with multiple episodes of diverticulitis develops UTIs and says the urine sometimes contains air and particles resembling stool. What is the likely complication? (Q883984)

A. Emphysematous cystitis

B. Colovesical fistula

C. Pericolic abscess

D. Diverticular bleeding

See Answer in Part B → Q11

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Q12: A patient presents with generalised peritonitis due to perforated sigmoid diverticulitis with faecal contamination. Which surgical procedure is most appropriate in this emergency setting? (Q883983)

A. Primary anastomosis without diversion

B. Loop ileostomy

C. Hartmann’s procedure

D. Total colectomy with ileorectal anastomosis

See Answer in Part B → Q12

@Neet_pg_bot

Q13: An elderly patient with multiple comorbidities presents with acute complicated diverticulitis and a pericolic abscess measuring 7 cm on CT scan. What is the most appropriate initial intervention? (Q883982)

A. Immediate surgical resection

B. CT-guided percutaneous drainage and intravenous antibiotics

C. Outpatient oral antibiotics and liquid diet

D. Colonoscopic drainage

See Answer in Part B → Q13

@Neet_pg_bot

Q14: According to the Hinchey classification of acute diverticulitis, which stage is characterised by faecal peritonitis? (Q883981)

A. Stage I

B. Stage II

C. Stage III

D. Stage IV

See Answer in Part B → Q14

@Neet_pg_bot

Q15: What is currently the preferred initial imaging modality for evaluating suspected acute diverticulitis? (Q883980)

A. Barium enema

B. Plain abdominal radiography

C. Computed tomography

D. Colonoscopy

See Answer in Part B → Q15

@Neet_pg_bot

Q16: A 62-year-old man presents with intermittent lower abdominal discomfort and altered bowel habits. A contrast radiographic study of the colon is performed, and the image is shown above. The outpouchings seen in this condition are best described as which of the following? (Q883979)

A. True diverticula involve all bowel layers

B. False diverticula involving mucosa and submucosa only

C. Congenital outpouchings are most common in the cecum

D. Inflammatory pseudopolyps associated with ulcerative colitis



See Answer in Part B → Q16

@Neet_pg_bot

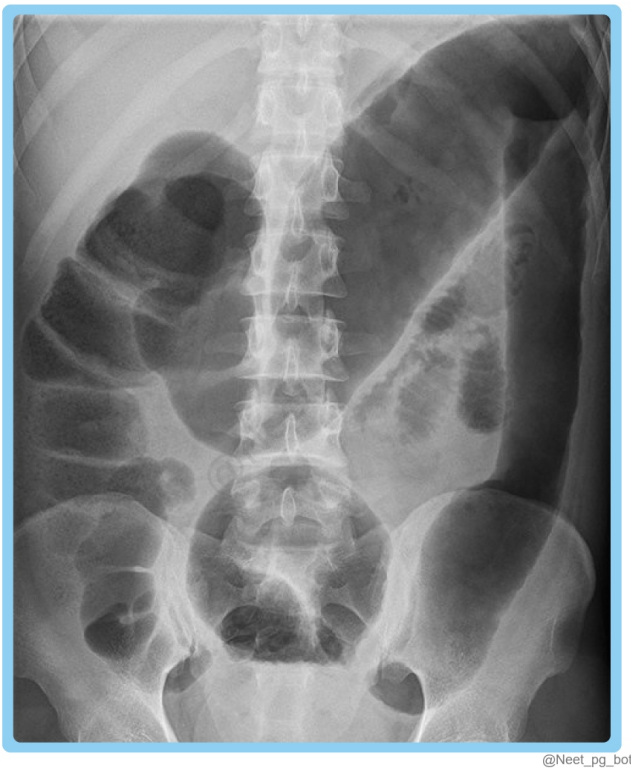
Q17: A patient with severe ulcerative colitis presents with high fever, abdominal distension, and tenderness. An abdominal X-ray shows the following findings. What is the most likely diagnosis? (Q883978)

A. Sigmoid volvulus

B. Crohn's disease flare

C. Toxic megacolon

D. Ogilvie's syndrome



See Answer in Part B → Q17

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Q18: Which of the following statements is TRUE regarding the postoperative recurrence of Crohn's disease? (Q883977)

A. The risk of relapse is highest immediately after surgery and decreases over time.

B. The presence of active disease at the resection margins guarantees early recurrence.

C. The probability of symptomatic relapse increases with time since resection

D. Surgery is curative in the majority of patients with ileocecal Crohn's disease

See Answer in Part B → Q18

@Neet_pg_bot

Q19: A 45-year-old male presents with severe abdominal pain, vomiting, and abdominal distension along with tenderness. X-ray shows dilated bowel loops with air-fluid levels. The patient is taken for exploratory laparotomy. Which of the following structures is most likely to be visualized first to differentiate between small intestine and large intestine obstruction? (Q849042)

A. Cecum

B. Ileum

C. Ascending Colon

D. Sigmoid Colon

See Answer in Part B → Q19

@Neet_pg_bot

Q20: A 16-year-old boy is brought to the clinic by his mother due to rectal bleeding. His father died of colon cancer at age 40. Colonoscopy reveals hundreds of polyps throughout the colon. Which of the following is the most likely diagnosis? (Q849051)

A. Crohn's disease

B. Familial adenomatous polyposis (FAP)

C. Lynch syndrome

D. Juvenile polyposis syndrome

See Answer in Part B → Q20

@Neet_pg_bot

Q21: A 16-year-old girl presents with intermittent abdominal pain, occasional rectal bleeding, and pigmented macules on her lips, buccal mucosa, and digits. Her mother had similar pigmented spots. What is the most likely diagnosis? (Q849050)

A. Familial Adenomatous Polyposis (FAP)

B. Lynch Syndrome

C. Peutz-Jeghers Syndrome

D. Cowden Syndrome

See Answer in Part B → Q21

@Neet_pg_bot

Q22: Which of the following correctly identifies a type of non-neoplastic polyp? (Q849049)

A. Tubular adenomatous polyp

B. Sessile serrated polyp

C. Juvenile polyp

D. Villous adenomatous polyp

See Answer in Part B → Q22

@Neet_pg_bot

Q23: A 55-year-old patient presents with symptoms of abdominal pain and changes in bowel habits. A barium enema is performed, which reveals a characteristic finding on imaging given below. Which of the following is the most likely diagnosis? (Q849047)

A. Diverticulosis

B. Colon Cancer

C. Pseudomembranous Colitis

D. Ischemic colitis



See Answer in Part B → Q23

@Neet_pg_bot

Q24: A 55-year-old male presents to the clinic with complaints of intermittent chest pain and difficulty swallowing. He gives a history of gastrointestinal discomfort and was recently diagnosed with both hiatal hernia and diverticulosis during a routine endoscopic examination. Given his current history, what is the other condition that has the highest probability for which he should be evaluated? (Q849046)

A. Gallstones

B. Peptic ulcer disease

C. Inflammatory bowel disease

D. Chronic pancreatitis

See Answer in Part B → Q24

@Neet_pg_bot

Q25: A 2-day-old neonate presents with abdominal distension, vomiting, and failure to pass meconium within the first 48 hours of life. On physical examination, the abdomen is distended, and a digital rectal examination reveals a tight anal sphincter with an explosive discharge of stool upon withdrawal of the finger. What is the best step of investigation to confirm the exact pathology? (Q849045)

A. Abdominal X-ray

B. Barium enema

C. Rectal biopsy

D. Anorectal manometry

See Answer in Part B → Q25

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Q26: Assertion: The colon plays a significant role in the production of short-chain fatty acids (SCFAs) from dietary fibers. Reason: Fermentation of dietary fibers by gut bacteria in the colon produces SCFAs like butyrate, acetate, and propionate, which serve as metabolic fuel for colon cells. (Q849044)

A. Both Assertion and Reason are true, and the Reason is the correct explanation for the Assertion.

B. Both Assertion and Reason are true, but the Reason is not the correct explanation for the Assertion.

C. The Assertion is true, but the Reason is false.

D. Both Assertion and Reason are false

See Answer in Part B → Q26

@Neet_pg_bot

Q27: A 60-year-old male presents with severe abdominal pain, distension, and constipation. A CT scan reveals a large intestinal obstruction at the level of the descending colon. Which of the following arteries is primarily responsible for providing collateral circulation in this situation? (Q849043)

A. Superior Mesenteric Artery

B. Inferior Mesenteric Artery

C. Marginal Artery of Drummond

D. Arc of Riolan

See Answer in Part B → Q27

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• [05_Gastrointestinal Surgery] 026 Large Intestine-Ii

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[05_Gastrointestinal Surgery] 026 Large Intestine-Ii — Quick Jump

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Q13 (p. 377)	*Q14 (p. 377)*	*Q15 (p. 378)*	*Q16 (p. 378)*	*Q17 (p. 378)*	*Q18 (p. 379)*
Q19 (p. 379)	*Q20 (p. 380)*	*Q21 (p. 380)*	*Q22 (p. 380)*	*Q23 (p. 381)*	*Q24 (p. 381)*
Q25 (p. 381)	*Q26 (p. 382)*	*Q27 (p. 382)*	*Q28 (p. 383)*		

Q1: Which of the following is the most accurate screening method for colon cancer? (Q849056)

A. Flexible sigmoidoscopy

B. Colonoscopy

C. Fecal Occult Blood Test

D. Virtual Colonoscopy

See Answer in Part B → Q1

@Neet_pg_bot

Q2: A 15-year-old patient is diagnosed with juvenile polyposis syndrome (JPS). Which of the following statements accurately describes the management and characteristics of JPS? (Q849072)

A. The initial colonoscopy screening should be started by age 10

B. JPS is caused by mutations in the SMAD4 or BMPR1A genes

C. Prophylactic colectomy is indicated only when iron-deficiency anemia is present

D. Best managed with immediate total colectomy regardless of the number of polyps

See Answer in Part B → Q2

@Neet_pg_bot

Q3: A 65-year-old male presents with acute lower gastrointestinal bleeding. He is hemodynamically stable but has a significant amount of blood in his stool. What is the next best step in management? (Q849071)

A. Outpatient colonoscopy

B. Immediate surgery

C. CT angiogram

D. Inpatient colonoscopy

See Answer in Part B → Q3

@Neet_pg_bot

Q4: A 65-year-old woman presents to the emergency department with a sudden onset of severe abdominal pain, bloody diarrhea, and low-grade fever. Her medical history includes hypertension and a recent episode of congestive heart failure. An abdominal CT scan reveals signs of bowel ischemia. Which of the following is the most likely diagnosis? (Q849070)

A. Acute mesenteric ischemia

B. Ischemic colitis

C. Diverticulitis

D. Crohn's disease

See Answer in Part B → Q4

@Neet_pg_bot

Q5: A 65-year-old male presents with a 5-day history of watery diarrhea, abdominal cramping, and low-grade fever. He was recently treated with cephalosporins for a respiratory infection. Upon examination, the patient is dehydrated but stable.

Endoscopy reveals raised yellowish-white plaques on the colonic mucosa. What is the most likely diagnosis? (Q849069)

A. Ulcerative colitis

B. Crohn’s disease

C. Pseudomembranous colitis

D. Ischemic colitis

See Answer in Part B → Q5

@Neet_pg_bot

Q6: A 45-year-old woman, recently diagnosed with colon and bladder cancer, presents with a notable family history; her mother also had both cancers and succumbed to them. Additionally, she has a history of sebaceous adenomas. Which other malignancy should she be evaluated for, considering the potential hereditary cancer syndrome? (Q849068)

A. Thyroid cancer

B. Liver cancer

C. Breast carcinoma

D. Pancreatic cancer

See Answer in Part B → Q6

@Neet_pg_bot

Q7: Which of the following statements regarding the therapy for colon carcinoma are correct? Statements: 1. Chemotherapy is often used in the adjuvant setting after surgery to reduce the risk of recurrence in patients with Stage III colon cancer 2. Immunotherapy is typically used as a first-line treatment for patients with colon cancer who have microsatellite instability-high (MSI-H) or mismatch repair deficiency 3. Chemotherapy with FOLFOX (5-Fluorouracil, Leucovorin, and Oxaliplatin) is commonly used for Stage IV colon cancer to achieve a cure 4. Checkpoint inhibitors

like Pembrolizumab are effective in colon cancer patients with microsatellite instability-high (MSI-H) or mismatch repair deficiency 5. Radiotherapy is not preferred for colon cancer due to its limited benefit in local control (Q849067)

A. 1, 2, and 4

B. 2, 4, and 5

C. 1, 4, and 5

D. 3, 4, and 5

See Answer in Part B → Q7

@Neet_pg_bot

Q8: A 62-year-old male underwent a right hemicolectomy for carcinoma of the colon. On the fourth postoperative day, he developed severe abdominal pain, fever, tachycardia, and hypotension. On physical examination, his abdomen is distended and diffusely tender with guarding and rigidity. Laboratory results show elevated white blood cell count. A CT scan of the abdomen reveals free fluid and air in the peritoneal cavity. Considering the clinical presentation and imaging findings, what is the most likely cause of his current condition? (Q849066)

A. Surgical site infection

B. Anastomotic leak

C. Bowel obstruction

D. Ileus

See Answer in Part B → Q8

@Neet_pg_bot

Q9: A 55-year-old male presents with fatigue, weight loss, and intermittent abdominal pain. He has a history of occasional rectal bleeding. On examination, he has mild pallor, and there is a palpable mass in the right upper quadrant. A colonoscopy is performed, revealing a large ulcerative mass at the hepatic flexure of the colon. Biopsy

confirms the diagnosis of adenocarcinoma. What is the most appropriate next step in the management of this patient? (Q849065)

A. Segmental resection of the hepatic flexure

B. Right hemicolectomy

C. Extended right hemicolectomy

D. Total colectomy

See Answer in Part B → Q9

@Neet_pg_bot

Q10: Which chemotherapy regimen is standard for adjuvant treatment in a patient with stage III colon cancer? (Q849063)

A. Capecitabine

B. FOLFOX

C. FOLFIRI

D. Bevacizumab

See Answer in Part B → Q10

@Neet_pg_bot

Q11: A 72-year-old female is found to have a 3 cm mass in the ascending colon during colonoscopy. A CT scan of the abdomen and pelvis shows no evidence of lymph node involvement or distant metastases. What is the most appropriate management for this patient? (Q849062)

A. Perform a right hemicolectomy with en-bloc lymph node dissection.

B. Recommend adjuvant chemotherapy following the surgical resection.

C. Proceed with endoscopic mucosal resection of the tumor.

D. Recommend Endoscopic polypectomy

See Answer in Part B → Q11

@Neet_pg_bot

Q12: Which of the following is a possible description of a T3 colon tumour? (Q849061)

A. Tumour invades submucosa

B. Tumour invades subserosa

C. Tumour invades adjacent organs or structures

D. Tumour confined to the mucosa

See Answer in Part B → Q12

@Neet_pg_bot

Q13: Which of the following best describes the Modified Dukes' Staging System for colorectal cancer? (Q849060)

A. Dukes A: Tumour invades the muscularis propria but no lymph node involvement

B. Dukes B: Tumour penetrates through the muscularis propria with positive lymph nodes

C. Dukes C: Tumour invades beyond the bowel wall, no lymph node involvement

D. Dukes D: Tumour has distant metastasis regardless of lymph node status

See Answer in Part B → Q13

@Neet_pg_bot

Q14: On barium enema investigation of a 54-year-old male with colon cancer an apple core lesion was found. What is the location of the carcinoma? (Q849059)

A. Left

B. Right

C. Transverse colon

D. Any of the above

See Answer in Part B → Q14

@Neet_pg_bot

Q15: Arrange the steps in the pathogenesis of colon cancer Dysplasia Intermediate adenoma DNA methylation 18q loss DCC (Q849058)

A. 1,3,2,4

B. 1,2,3,4

C. 4,3,2,1

D. 3,2,1,4

See Answer in Part B → Q15

@Neet_pg_bot

Q16: A 62-year-old male with a history of long-standing ulcerative colitis presents with rectal bleeding, unintentional weight loss, and altered bowel habits. A colonoscopy reveals a large, ulcerated mass in the sigmoid colon, and a biopsy confirms adenocarcinoma. Which of these factors in his history would not have served as risk factors for developing colon cancer? (Q849057)

A. Long-standing ulcerative colitis

B. Smoking

C. Use of NSAIDs

D. Red meat in the diet

See Answer in Part B → Q16

@Neet_pg_bot

Q17: A 54-year-old female with intractable diarrhea and pigmentation was diagnosed with Cronkhite-Canada syndrome. Which of the following statements regarding the disease are true? Hamartomatous polyp of colon Seen only in females Polyps can be present in the stomach and duodenum as well 15% can turn malignant (Q849055)

A. 1,4

B. 2,3,4

C. 1,2

D. 1,2,3,4

See Answer in Part B → Q17

@Neet_pg_bot

Q18: A 62-year-old patient is diagnosed with a large, invasive adenocarcinoma of the splenic flexure of the colon. The colorectal surgeon recommends surgical resection. Which of the following colectomy procedures would be most appropriate for this patient? (Q849064)

A. Left hemicolectomy

B. Extended left hemicolectomy

C. Subtotal colectomy

D. Total proctocolectomy

See Answer in Part B → Q18

@Neet_pg_bot

Q19: Which diagnostic modality can detect active gastrointestinal bleeding at the lowest rate of blood loss? (Q883999)

A. CT angiography

B. Selective mesenteric angiography

C. 99m Tc-labelled red blood cell scintigraphy

D. Colonoscopy

See Answer in Part B → Q19

@Neet_pg_bot

Q20: A guaiac-based faecal occult blood test (gFOBT) is most sensitive for detecting bleeding originating from which part of the gastrointestinal tract? (Q883998)

A. Upper GI tract (e.g., stomach)

B. Small intestine

C. Oesophagus

D. Colon

See Answer in Part B → Q20

@Neet_pg_bot

Q21: In a hemodynamically stable patient presenting with acute hematochezia, what is the appropriate initial diagnostic step? (Q883997)

A. Immediate angiography

B. Urgent exploratory laparotomy

C. Colonoscopy after bowel preparation

D. Upper endoscopy (EGD)

See Answer in Part B → Q21

@Neet_pg_bot

Q22: Along which anatomical structure are the paracolic lymph nodes primarily located? (Q883996)

A. Superior mesenteric artery

B. Marginal artery of Drummond

C. Inferior mesenteric vein

D. Middle colic artery

See Answer in Part B → Q22

@Neet_pg_bot

Q23: A flexible sigmoidoscope is typically designed to visualise the colon up to what approximate length from the anal verge? (Q883995)

A. 25 cm

B. 40 cm

C. 60 cm

D. 100 cm

See Answer in Part B → Q23

@Neet_pg_bot

Q24: A 2-year-old boy undergoes a pull-through procedure for Hirschsprung disease. What is the most common postoperative complication overall? (Q883994)

A. Enterocolitis

B. Faecal incontinence

C. Constipation

D. Anastomotic leak

See Answer in Part B → Q24

@Neet_pg_bot

Q25: A 3-month-old infant presents with chronic constipation, abdominal distension, and failure to pass meconium within the first 48 hours of life. A rectal biopsy confirms aganglionosis of the distal colon, consistent with Hirschsprung disease. Which surgical procedure is considered a definitive treatment for this condition? (Q883993)

A. Duhamel pull-through

B. Nissen fundoplication

C. Heineke-Mikulicz pyloroplasty

D. Whipple procedure

See Answer in Part B → Q25

@Neet_pg_bot

Q26: When performing a rectal biopsy to diagnose Hirschsprung disease, at what distance above the dentate line should the sample ideally be taken to avoid a false-positive result? (Q883992)

A. 0.5 cm

B. 1.0 cm

C. 2.0 cm

D. 5.0 cm

See Answer in Part B → Q26

@Neet_pg_bot

Q27: Hirschsprung disease is most frequently associated with mutations in which gene? (Q883991)

A. APC

B. RET

C. BRCA1

D. CFTR

See Answer in Part B → Q27

@Neet_pg_bot

Q28: What combination of clinical features is typically seen in Heyde’s syndrome? (Q883990)

A. Aortic stenosis, colonic diverticulosis, and iron deficiency anaemia

B. Mitral stenosis, angiodysplasia, acquired von Willebrand disease

C. Aortic stenosis, angiodysplasia, acquired von Willebrand disease

D. Aortic regurgitation, peptic ulcer disease, thrombocytopenia

See Answer in Part B → Q28

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• [05_Gastrointestinal Surgery] 027 Ileostomy Colostomy And Ibd

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[05_Gastrointestinal Surgery] 027 Ileostomy Colostomy And Ibd — Quick Jump

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Q19 (p. 393)	*Q20 (p. 394)*	*Q21 (p. 395)*	*Q22 (p. 395)*	*Q23 (p. 396)*	*Q24 (p. 396)*

Q1: Which of the following macroscopic features is most characteristic of Crohn's disease compared to ulcerative colitis? (Q849290)

A. Continuous inflammation from the rectum extending proximally

B. Erythematous, granular mucosa with superficial ulcerations

C. Transmural inflammation in UC

D. Thickened bowel wall and mesenteric fat wrapping

See Answer in Part B → Q1

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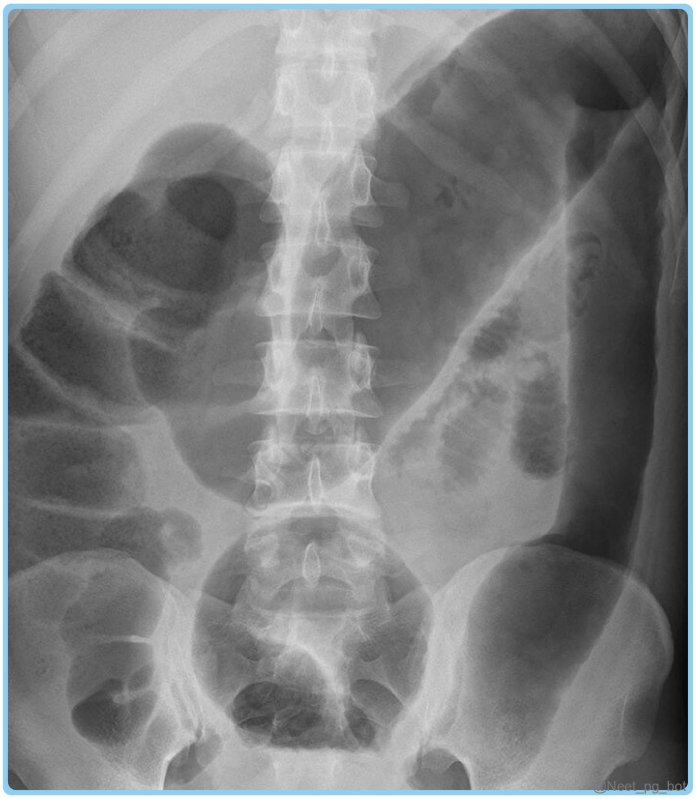
Q2: A 52-year-old male with a history of ulcerative colitis presents with severe abdominal pain and distention, fever, and tachycardia. He appears ill and is in significant discomfort. Lab tests show leukocytosis and electrolyte imbalances. An X-ray of the abdomen is taken. Which of the following surgical procedures is the most appropriate for this patient? {{caption_text}} (Q849289)

A. Segmental Colectomy

B. Total Abdominal Colectomy with End Ileostomy

C. Diverting Loop Ileostomy with Colonic Lavage

D. Laparoscopic Colonic Decompression



See Answer in Part B → Q2

@Neet_pg_bot

Q3: A 38-year-old male presents with severe abdominal distension and diarrhea. His vitals show a heart rate of 125 beats/min, fever of 38.9°C, and a white blood cell count of 13,800/microL. A radiograph reveals colonic dilation of 7 cm. Which of the following additional findings would not confirm the diagnosis of toxic megacolon? (Q849288)

A. Anemia

B. Altered sensorium

C. Hypotension

D. Electrolyte disturbances

See Answer in Part B → Q3

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Q4: A 32-year-old patient diagnosed with mild Crohn's disease affecting the ileocecal region presents to your clinic. The patient has mild symptoms with no significant systemic involvement. What is the most appropriate first-line drug to prescribe for this patient to induce remission in mild Crohn's disease? (Q849267)

A. Prednisone

B. Azathioprine

C. Infliximab

D. Budesonide

See Answer in Part B → Q4

@Neet_pg_bot

Q5: A patient with chronic ulcerative colitis who had undergone total proctocolectomy with ileal pouch-anal anastomosis has come to the department complaining of diarrhoea, abdominal pain, fever and malaise. On examination, hematochezia is noted. What is the first line of treatment here? (Q849287)

A. Antibiotic therapy

B. Biologic agents

C. Probiotics

D. Pouch excision

See Answer in Part B → Q5

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Q6: A 45-year-old male with a long-standing history of chronic inflammatory bowel disease presents for routine follow-up. He undergoes a colonoscopy, during which suspicious lesions are identified. A biopsy confirms the presence of malignancy. Which of the following types of cancer is more commonly associated with Crohn's disease than with ulcerative colitis? (Q849280)

A. Colon carcinoma

B. Small intestine carcinoma

C. Cholangiocarcinoma

D. Gastric cancer

See Answer in Part B → Q6

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Q7: Which of the following would be a differentiating feature of Colitis-associated colon carcinoma (CAC) from sporadic colon cancer? (Q849279)

A. Sporadic colon cancer develops due to chronic inflammation and dysplasia

B. CAC has a lower mortality

C. CAC is more common after the age of 30

D. Sporadic colon cancer is associated with young individuals

See Answer in Part B → Q7

@Neet_pg_bot

Q8: A 58-year-old male comes to the hospital complaining of intermittent pain in the anal region and intermittent diarrhea for 6 months. On examination, he was found to have complex perianal fistulas bilaterally, with skin tags, as shown in the image. His blood investigations reveal anemia. What could be the possible diagnosis leading to this? {{caption_text}} (Q849278)

A. Crohn’s disease of anorectum

B. Ulcerative colitis

C. Carcinoma rectum

D. Hemorrhoids



See Answer in Part B → Q8

@Neet_pg_bot

Q9: A patient with a history of ulcerative colitis (UC) has undergone a total proctocolectomy with ileal pouch-anal anastomosis (TPA + IPAA) as part of their treatment. Which of the following is not a possible complication of the procedure? (Q849277)

A. Anastomotic leak

B. Pouchitis

C. Pelvic sepsis

D. Peritonitis

See Answer in Part B → Q9

@Neet_pg_bot

Q10: Which of the following procedures is the definitive management of Ulcerative colitis? (Q849276)

A. Total Proctocolectomy with End Ileostomy(TPA+EI)

B. Total Proctocolectomy with Ileal Pouch-Anal Anastomosis (TPA+IPAA)

C. Total Proctocolectomy with mucosectomy with hand-sewn IPAA

D. Total abdominal colectomy with very low Hartmann closure with end ileostomy

See Answer in Part B → Q10

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Q11: A 45-year-old patient presents with a history of chronic abdominal pain, frequent bloody diarrhea, and an urgent need to defecate. Colonoscopy reveals continuous inflammation starting from the rectum and extending through the colon. Despite receiving the highest doses of medical therapy, the symptoms have worsened. Which of the following would not be considered an indication for surgery in this patient? (Q849269)

A. Failure of maximum medical therapy

B. Multiple bowel movements

C. Fulminant colitis

D. Enteroenteric fistula

See Answer in Part B → Q11

@Neet_pg_bot

Q12: A 35-year-old patient with moderate to severe ulcerative colitis has achieved clinical remission with a biologic agent. Which of the following drugs is used in the maintenance therapy for moderate to severe ulcerative colitis? (Q849268)

A. Mesalamine

B. Adalimumab

C. Sulfasalazine

D. Hydrocortisone

See Answer in Part B → Q12

@Neet_pg_bot

Q13: A 55-year-old male patient presents with a low rectal tumor and requires bowel diversion. The surgeon is considering the type of stoma to be created. Which of the following indications best matches the need for an ileostomy rather than a colostomy? (Q849254)

A. To relieve bowel obstruction when resection is not feasible.

B. To protect a distal anastomosis after low anterior resection.

C. To manage inflammatory diseases with severe perianal disease.

D. Permanent fecal diversion following total colectomy

See Answer in Part B → Q13

@Neet_pg_bot

Q14: A 39-year-old male with a 12-year history of ulcerative colitis presents with worsening symptoms despite maximum medical therapy. He experiences >10 bowel movements per day, urgency, tenesmus, and significant weight loss. Biopsies show high-grade dysplasia. The surgical team plans a total proctocolectomy with ileal pouch-anal anastomosis (IPAA). What is the primary goal of the planned surgery for this patient? (Q849266)

A. Palliative

B. Curative

C. Remission

D. Maintenance

See Answer in Part B → Q14

@Neet_pg_bot

Q15: Which of the following statements regarding ulcerative colitis is correct? (Q849265)

A. Backwash ileitis, where there is secondary inflammation in the terminal ileum, is a common finding in all patients with ulcerative colitis.

B. Extraintestinal manifestations such as arthritis are more likely to occur in patients with proctitis alone.

C. 8 bloody stools per day and associated joint pain are classified as moderate ulcerative colitis.

D. Fulminant ulcerative colitis is characterized by >10 bowel movements daily, continuous bleeding, and evidence of systemic toxicity.

See Answer in Part B → Q15

@Neet_pg_bot

Q16: A 38-year-old patient with a history of chronic diarrhea and rectal bleeding undergoes a barium enema for evaluation. The radiological image shows changes in the colonic mucosa. Based on the findings of the barium enema, which of the following radiological features is most indicative of Ulcerative colitis (UC)? {{caption_text}} (Q849264)

A. Narrowed, constricted colon with a "hose pipe" appearance

B. Multiple deep ulcers with surrounding inflammation

C. Discontinuous patches of inflammation with normal segments in between

D. Presence of pseudopolyps



See Answer in Part B → Q16

@Neet_pg_bot

Q17: A 30-year-old patient presents with persistent and worsening chronic diarrhea, rectal bleeding, and abdominal pain for the past several months. An endoscopic examination reveals continuous mucosal inflammation starting at the rectum and extending proximally. Which of the following findings is most characteristic of ulcerative colitis (UC) and helps differentiate it from Crohn's disease? (Q849263)

A. Patchy inflammation with skip lesions

B. Continuous inflammation starting from the rectum

C. Transmural inflammation with cobblestone appearance

D. Presence of granulomas in the mucosal layer

See Answer in Part B → Q17

@Neet_pg_bot

Q18: Which extraintestinal manifestation is most commonly associated with Crohn's disease? (Q849262)

A. Uveitis

B. Pyoderma gangrenosum

C. Erythema nodosum

D. Nephrotic syndrome

See Answer in Part B → Q18

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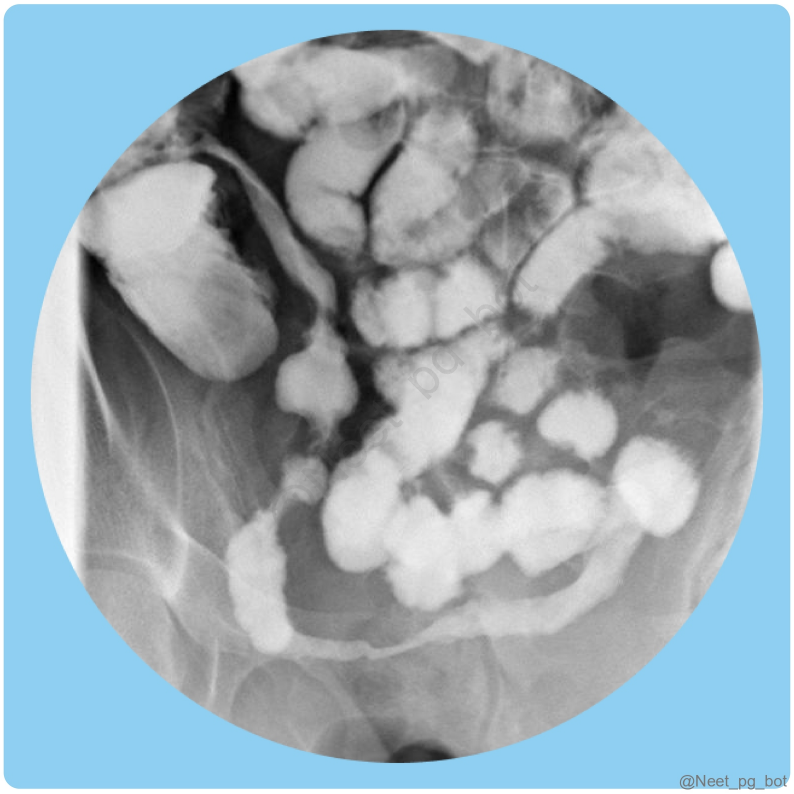
Q19: A 45-year-old patient with a history of long-standing Crohn's disease presents for a follow-up examination. An abdominal X-ray with barium contrast is performed to evaluate the current state of the small bowel. Based on the barium radiographic image provided, which of the following signs is depicted below? {{caption_text}} (Q849261)

A. String Sign of Kantor

B. Apple-Core Sign

C. Lead-Pipe Appearance

D. Bird-Beak Sign



See Answer in Part B → Q19

@Neet_pg_bot

Q20: A 34-year-old female with a known diagnosis of Crohn's disease presents with symptoms of abdominal pain, weight loss, and intermittent diarrhea. Imaging studies reveal significant inflammation and strictures in the gastrointestinal tract. Which part of the gastrointestinal tract is most commonly affected by Crohn's disease, leading to ulcers and strictures? (Q849260)

A. Duodenum

B. Jejunum

C. Ileum

D. Colon

See Answer in Part B → Q20

@Neet_pg_bot

Q21: A 35-year-old patient presents with chronic diarrhea, abdominal pain, and weight loss. A resection of the terminal ileum is performed, and the findings are shown in the image below. Which of the following findings is most characteristic of this disease? {{caption_text}} (Q849258)

A. Continuous mucosal lesions and crypt abscesses

B. Cobblestone appearance and transmural inflammation

C. Superficial ulceration and loss of haustrations

D. Pseudopolyps and mucosal inflammation



See Answer in Part B → Q21

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Q22: A 40-year-old male presents with chronic diarrhea, abdominal pain, and recent weight loss. On examination, there is tenderness in the right lower quadrant, and a colonoscopy revealed patchy inflammation in the terminal ileum with skip lesions.

Which of the following combinations of risk factors and etiological factors is most consistent with the diagnosis? (Q849257)

A. NOD2/CARD15 gene mutation, smoking

B. HLA-DR2 association, appendectomy

C. Autoimmune etiology, non-smoker

D. Milk allergy, personality disorders

See Answer in Part B → Q22

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Q23: A 65-year-old woman undergoes an emergency ileostomy following bowel obstruction. Two weeks postoperatively, she presents with increased pain and swelling around the stoma site. On examination, a bulge is noted adjacent to the stoma. The stoma itself appears healthy, with no signs of necrosis or ischemia. What is the most likely diagnosis? (Q849256)

A. Stoma Stenosis

B. Stoma Retraction

C. Parastomal Hernia

D. Stoma Prolapse

See Answer in Part B → Q23

@Neet_pg_bot

Q24: A 55-year-old male patient undergoes emergency abdominal surgery for a perforated sigmoid diverticulitis with peritonitis. The surgeon decides to create a stoma as part of the management plan. Which of the following stomas is most appropriate for diverting fecal content and allowing distal bowel healing while planning for potential future reconnection? (Q849255)

A. End colostomy

B. Loop ileostomy

C. Double-barrel colostomy

D. Permanent ileostomy

See Answer in Part B → Q24

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• [05_Gastrointestinal Surgery] 028 Appendix

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[05_Gastrointestinal Surgery] 028 Appendix — Quick Jump

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Q25 (p. 408)	*Q26 (p. 409)*	*Q27 (p. 409)*	*Q28 (p. 410)*	*Q29 (p. 410)*	*Q30 (p. 411)*

Q1: A 34-year-old male undergoes an open appendectomy for acute appendicitis. The choice of incision was McBurney's incision. Postoperatively, after a few days, he presents with pain and bulging in the right lower quadrant, which is diagnosed as an indirect inguinal hernia. Which nerve injury during the appendectomy is most likely responsible for this complication? (Q849041)

A. Ilioinguinal nerve

B. Femoral nerve

C. Genitofemoral nerve

D. Pudendal nerve

See Answer in Part B → Q1

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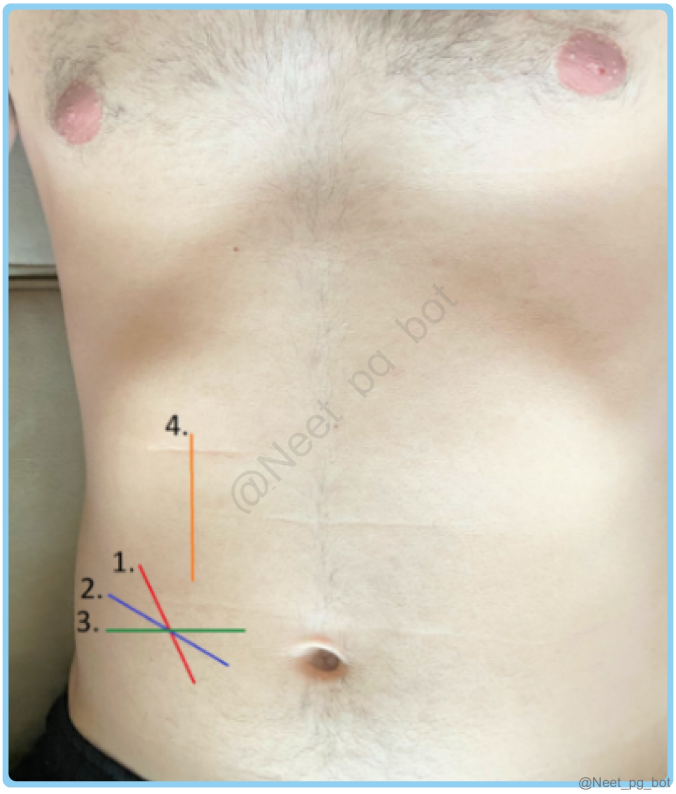
Q2: A 25-year-old male presents with right lower quadrant abdominal pain and is diagnosed with acute appendicitis. The surgical team plans to perform an appendectomy. Which of the following correctly represents the type of Incision used in appendicectomy? a-Rutherford Morrison b-Lanz c-McBurney’s d-Battle (Q849039)

A. 1-a, 2-c, 3-b, 4-d

B. 1-a, 2-b, 3-c, 4-d

C. 1-c, 2-b, 3-a, 4-d

D. 1-c, 2-a, 3-b, 4-d



See Answer in Part B → Q2

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Q3: A 25-year-old male presents with right lower quadrant abdominal pain and is diagnosed with acute appendicitis. He undergoes an open appendectomy. Which of the following statements regarding the steps of an open appendectomy is incorrect? (Q849040)

A. The incision is made at McBurney's point and extended down to the external oblique aponeurosis.

B. Cecum is identified with the help of taenia coli and ileocecal junction.

C. Mesoappendix and appendicular artery are ligated to prevent bleeding.

D. A lock-stitch suture is placed around the base of the appendix which is used to bury the stump after excision of the appendix.

See Answer in Part B → Q3

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Q4: A 24-year-old man presents with acute onset of right lower abdominal pain, fever, and nausea. During physical examination, the manoeuvre shown in the image is performed, which elicits pain in the right lower quadrant. This clinical finding is known as: (Q884006)

A. Obturator sign

B. Rovsing's sign

C. Psoas sign

D. Murphy's sign



See Answer in Part B → Q4

@Neet_pg_bot

Q5: What is the typical initial location and character of abdominal pain at the onset of acute appendicitis? (Q884004)

A. Right lower quadrant, sharp and constant

B. Epigastric, burning

C. Periumbilical, colicky and poorly localised

D. Diffuse, crampy

See Answer in Part B → Q5

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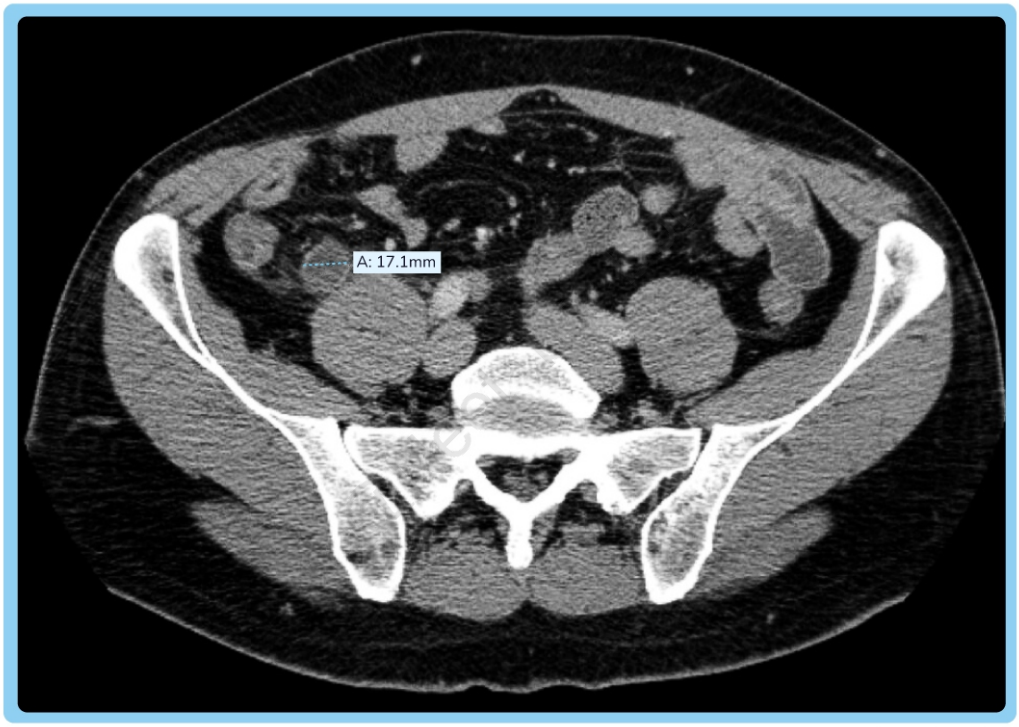
Q6: A 26-year-old patient presents with acute right lower quadrant abdominal pain, nausea, and low-grade fever. A contrast-enhanced CT scan of the abdomen is obtained and is shown above. Which of the following physical examination findings is not typically associated with this condition? (Q884007)

A. Psoas sign

B. Rovsing's sign

C. Ballance sign

D. McBurney's sign



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See Answer in Part B → Q6

@Neet_pg_bot

Q7: In a pediatric patient with suspected acute appendicitis, what is the preferred initial imaging modality to avoid radiation exposure? (Q884008)

A. Plain abdominal X-ray

B. CT scan of the abdomen and pelvis

C. Ultrasound of the abdomen

D. MRI of the abdomen

See Answer in Part B → Q7

@Neet_pg_bot

Q8: A 28-year-old man presents with fever, right lower quadrant pain, and signs of peritonitis. Exploratory laparotomy reveals a perforated appendix with purulent peritoneal fluid. Cultures are obtained. Which anaerobic organism is most commonly isolated in this scenario? (Q884009)

A. Escherichia coli

B. Bacteroides fragilis

C. Clostridium perfringens

D. Klebsiella pneumoniae

See Answer in Part B → Q8

@Neet_pg_bot

Q9: A patient with a palpable, tender right lower quadrant mass and a history of abdominal pain for 5 days is diagnosed with an appendiceal mass. The patient is hemodynamically stable. What is the most appropriate initial management?

(Q884010)

A. Immediate appendectomy

B. Ochsner-Sherren regimen

C. Percutaneous drainage of the mass

D. Laparoscopic exploration

See Answer in Part B → Q9

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Q10: When converting a gridiron (McBurney) incision to a Rutherford Morison incision during an appendectomy, which of the following muscle layers are divided? (Q884011)

A. Only the external oblique muscle

B. External oblique, internal oblique, and transversus abdominis muscles

C. Rectus abdominis muscle only

D. External oblique and transversus abdominis muscles only

See Answer in Part B → Q10

@Neet_pg_bot

Q11: A surgeon performing an appendectomy ensures that only a very short appendiceal stump is left behind to avoid stump appendicitis. What is the recommended maximum length of the residual appendiceal stump? (Q884012)

A. 1 mm

B. 3 mm

C. 5 mm

D. 10 mm

See Answer in Part B → Q11

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Q12: During an open appendectomy, which instrument is specifically designed for atraumatic grasping of delicate structures like the appendix or fallopian tube? (Q884013)

See Answer in Part B → Q12

@Neet_pg_bot

Q13: What is the most common site within the appendix for a carcinoid tumour to arise? (Q884014)

A. Base of the appendix

B. Mid-appendix

C. Tip (distal third) of the appendix

D. Appendiceal orifice

See Answer in Part B → Q13

@Neet_pg_bot

Q14: A 1.8 cm carcinoid tumour is found at the tip of the appendix on histopathology after an appendectomy. There is no invasion of the mesoappendix, and margins are clear. What is the most appropriate next step in management? (Q884015)

A. Observation only

B. Completion of right hemicolectomy

C. Chemotherapy

D. Repeat appendectomy with wider margins

See Answer in Part B → Q14

@Neet_pg_bot

Q15: An incidental 0.5 cm carcinoid tumour at the tip of the appendix with clear margins and no high-risk features is discovered after an appendectomy. What is the appropriate management? (Q884016)

A. Completion of right hemicolectomy

B. Adjuvant chemotherapy

C. Observation only

D. Radiation therapy

See Answer in Part B → Q15

@Neet_pg_bot

Q16: Which pathogen is classically associated with mesenteric lymph node enlargement producing symptoms similar to acute appendicitis? (Q884017)

A. Salmonella typhi

B. Campylobacter jejuni

C. Mycobacterium tuberculosis

D. Yersinia enterocolitica

See Answer in Part B → Q16

@Neet_pg_bot

Q17: Pseudomyxoma peritonei most commonly arises from rupture or leakage of which type of tumour? (Q884018)

A. Colonic adenocarcinoma

B. Appendiceal mucinous cystadenoma

C. Ovarian serous cystadenocarcinoma

D. Gastric signet ring carcinoma

See Answer in Part B → Q17

@Neet_pg_bot

Q18: Which physical examination manoeuvre, when performed in the left lower quadrant, elicits pain in the right lower quadrant and is suggestive of acute appendicitis? (Q884005)

A. Psoas sign

B. Obturator sign

C. Murphy's sign

D. Rovsing's sign

See Answer in Part B → Q18

@Neet_pg_bot

Q19: A 28-year-old woman presented with a 3-day history of vague lower abdominal pain, low-grade fever, and urinary frequency. Initial pelvic examination and urinalysis were inconclusive. CT scan revealed acute appendicitis with an inflamed appendix located in the pelvis. The delayed diagnosis in this case was most likely due to: (Q849031)

A. The appendix's pelvic location masking classic right lower quadrant signs

B. Misinterpretation of urinary symptoms as a primary urological issue

C. Lack of characteristic migration of pain from periumbilical to right iliac fossa

D. Absence of typical anorexia and vomiting in early appendicitis

See Answer in Part B → Q19

@Neet_pg_bot

Q20: Which pathological process marks the starting point in the evolution of acute appendicitis? (Q884003)

A. Luminal obstruction

B. Ischemic injury due to arterial embolism

C. Bacterial translocation from the colon

D. Autoimmune inflammation

See Answer in Part B → Q20

@Neet_pg_bot

Q21: Which anatomical structure serves as a surgical landmark to identify the ileocecal junction during appendectomy? (Q884002)

A. Jackson membrane

B. Gerlach valve

C. Fold of Treves

D. Mesoappendix

See Answer in Part B → Q21

@Neet_pg_bot

Q22: A patient undergoes an appendectomy. While separating the mesoappendix, the operating surgeon cauterises and ligates the vessel within it. Which artery is this? (Q884001)

A. Ileocolic artery

B. Right colic artery

C. Appendicular artery

D. Middle colic artery

See Answer in Part B → Q22

@Neet_pg_bot

Q23: A surgeon performing an appendectomy notes the appendix in its typical location. Which anatomical position is this most likely to be? (Q884000)

A. Pelvic

B. Retrocaeal

C. Subcaecal

D. Pre-ileal

See Answer in Part B → Q23

@Neet_pg_bot

Q24: A 30-year-old female presents with right lower quadrant abdominal pain and is diagnosed with acute appendicitis. During surgery, a small mass is found at the tip of the appendix, which is subsequently identified as a carcinoid tumour. Which of the following statements about carcinoid tumours in the appendix is correct? (Q849038)

A. They are most commonly found at the base of the appendix.

B. They typically produce excessive amounts of insulin.

C. For carcinoid tumors >2cm, right hemicolectomy is the preferred modality of treatment

D. They are associated with a high risk of metastasis.

See Answer in Part B → Q24

@Neet_pg_bot

Q25: A 55-year-old male with a history of appendicitis presents with severe right lower quadrant pain, fever, tachycardia, and tenderness. An ultrasound shows an

appendix mass. Despite conservative treatment, his condition worsens. Which sign or symptom indicates the need for surgical intervention? (Q849037)

A. Increased white blood cell count with stable abdominal findings

B. Rising pulse rate with increasing size of the appendix mass

C. Localized right iliac fossa pain with no change in pulse rate

D. Generalized abdominal pain with no fever

See Answer in Part B → Q25

@Neet_pg_bot

Q26: A 45-year-old male presents with a 3-day history of right lower quadrant pain, fever, and anorexia. His examination is significant for a palpable mass in the right lower quadrant with guarding and rebound. A CT scan demonstrates an appendiceal mass. He was admitted to the hospital and started on intravenous antibiotics. After 48 hours, his fever has resolved, and his abdominal pain has significantly improved. What is the most appropriate next step in management? (Q849036)

A. Discharge home on oral antibiotics

B. Continue IV antibiotics and observe

C. Laparoscopic appendectomy

D. Colonoscopy

See Answer in Part B → Q26

@Neet_pg_bot

Q27: Which of the following statements is true about acute appendicitis? (Q849035)

A. Diagnosis in children can be done by clinical signs only

B. Diagnosis in adults requires additional imaging modalities

C. The gold standard test is the USG abdomen

D. A shift to the left in the leukocyte count is seen

See Answer in Part B → Q27

@Neet_pg_bot

Q28: A 16-year-old male presents to the emergency department with a 12-hour history of abdominal pain. The pain was initially periumbilical and colicky in nature but has since localized to the right iliac fossa. He has also experienced one episode of vomiting and has no appetite. His Alvarado score is 5. What is the inference of this score? (Q849034)

A. Negative for acute appendicitis

B. Diagnosis for acute appendicitis is confirmed

C. CECT is indicated in this patient

D. None of the above

See Answer in Part B → Q28

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Q29: A 22-year-old male presents with right lower quadrant pain for the past 24 hours. On examination, the surgeon demonstrates cutaneous hyperesthesia in an area bounded by a line joining the anterior superior iliac spine, the umbilicus, and the pubic symphysis. Which of the following statements is most accurate regarding this clinical sign? (Q849033)

A. This sign is known as Sherren's triangle and is specific to retro-cecal appendicitis

B. The hyperesthesia is due to irritation of the T10-L1 nerve roots by the inflamed appendix

C. This sign is highly specific for appendicitis and rules out other causes of right lower quadrant pain

D. The presence of this sign contraindicates the use of laparoscopy for appendectomy

See Answer in Part B → Q29

@Neet_pg_bot

Q30: A 28-year-old male presents with right lower quadrant pain, nausea, and low-grade fever. Upon examination, he exhibits rebound tenderness at McBurney's point. Which of the following is the most likely initial event in the pathogenesis of this patient's condition? (Q849032)

A. Bacterial invasion of the appendiceal wall

B. Obstruction of the appendiceal lumen

C. Thrombosis of appendiceal vessels

D. Perforation of the appendix

See Answer in Part B → Q30

@Neet_pg_bot

• [05_Gastrointestinal Surgery] 029 Rectum And Anal Canal - I

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[05_Gastrointestinal Surgery] 029 Rectum And Anal Canal - I — Quick Jump

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Q25 (p. 422)	*Q26 (p. 422)*				

Q1: A 28 y/o female presents with a history of chronic constipation, rectal pain, and bleeding. On examination, an ulcer is found on the anterior wall of the rectum, 7 cm from the anal verge. Proctography reveals rectal intussusception. Which is the most appropriate treatment for this patient's condition? (Q849210)

A. STARR Procedure

B. Abdominal Rectopexy

C. Histology

D. Colostomy

See Answer in Part B → Q1

@Neet_pg_bot

Q2: A 55 y/o male presents with rectal bleeding and pain during defecation. O/E, a firm mass is palpable in the anal canal. A biopsy confirms carcinoma of the anal canal. Imaging shows no distant metastasis, but inguinal nodes are enlarged. Which of the following is the most appropriate initial treatment for this patient? (Q849209)

A. Abdominoperineal Resection (APR) with Colostomy

B. Chemoradiation

C. Radiotherapy alone

D. Neoadjuvant Chemotherapy followed by surgery

See Answer in Part B → Q2

@Neet_pg_bot

Q3: A 60 y/o patient is diagnosed with anal canal cancer. A tumour of size 3cm invades through the muscularis propria into the perirectal tissue, involving 4-6 regional lymph nodes without distant metastasis. Which of the following stages correctly describes this condition? (Q849208)

A. Stage I (T1-T2, N0, M0)

B. Stage II (T1-T2, N1, M0)

C. Stage III (T1-T4, N2, M0)

D. Stage IV (T1-T4, N1-N3, M1)

See Answer in Part B → Q3

@Neet_pg_bot

Q4: A 58 y/o woman presents with anal pain, bleeding during bowel movements, and the presence of a palpable mass. She has a history of multiple sexual partners and was recently diagnosed with human papillomavirus (HPV) infection. Which of the following risk factors is most strongly associated with the development of anal canal cancer in this patient? (Q849207)

A. HPV infection leads to anal condylomata.

B. Immunosuppression due to a recent organ transplant.

C. History of vulvar intraepithelial neoplasia (VIN).

D. Chronic constipation resulting in haemorrhoids.

See Answer in Part B → Q4

@Neet_pg_bot

Q5: .A 78-year-old woman with a history of chronic constipation and faecal incontinence presents with a complaint of a mass that protrudes circumferentially from her anus, which she can manually reduce. She also reports occasional bleeding and difficulty with bowel movements. Which of the following is the most appropriate management for this patient's rectal prolapse? (Q849192)

A. Perineal rectopexy

B. Rubber band ligation

C. Abdominal rectopexy

D. Infrared photocoagulation

See Answer in Part B → Q5

@Neet_pg_bot

Q6: A 58 y/o man presents with bright red blood in his stool, tenesmus, and intermittent abdominal pain for one month. A digital rectal exam reveals a hard mass 5 cm from the anal verge. Rigid sigmoidoscopy confirms a neoplasm. What is the next step to evaluate the extent of his disease? (Q849205)

A. Perform a CT scan of the abdomen and pelvis.

B. Schedule a colonoscopy.

C. Obtain a biopsy of the rectal mass.

D. Surgical intervention

See Answer in Part B → Q6

@Neet_pg_bot

Q7: A 35-year-old woman experiencing severe pain during bowel movements, bright red blood on toilet paper, and chronic anal fissures has not improved with conservative treatment and is being referred for surgery. Which surgical procedure is aimed at reducing anal sphincter tone to promote healing of the fissure while

maintaining continence? (Q849202)

A. Fissurectomy

B. Lateral Internal Sphincterotomy

C. Anal Advancement Flap

D. Botulinum toxin injection

See Answer in Part B → Q7

@Neet_pg_bot

Q8: A 35-year-old woman with a recurrent anal abscess has developed an anal fistula. She is concerned about continence after surgery. Which surgical option is best to treat her condition while minimizing incontinence risk? (Q849199)

A. Fistulotomy

B. Fistulectomy

C. Setons

D. Ligation of the Intersphincteric Fistula Tract (LIFT)

See Answer in Part B → Q8

@Neet_pg_bot

Q9: A 1-week-old girl with a newly diagnosed rectovestibular fistula is undergoing evaluation. Which of the following is the most appropriate initial treatment for a newborn with a rectovestibular fistula? (Q849211)

A. Single-stage anoplasty

B. Initial colostomy followed by definitive pull-through operation

C. Wangenstein's Invertogram to determine the level of the rectal pouch

D. Aspiration of meconium and dye injection for fistula assessment

See Answer in Part B → Q9

@Neet_pg_bot

Q10: A 62 y/o woman diagnosed with rectal carcinoma is being evaluated for treatment options. Which of the following statements regarding the treatment strategies for rectal carcinoma is true? (Q849206)

A. Total mesorectal excision (TME) is a method of palliative care in patients with advanced rectal cancer.

B. Neoadjuvant chemoradiotherapy is used after surgical resection to minimize the risk of local recurrence.

C. Local excision is indicated for early-stage rectal cancers with good prognostic factors.

D. Abdominoperineal excision (APR) is the preferred surgical approach for all cases of rectal carcinoma.

See Answer in Part B → Q10

@Neet_pg_bot

Q11: A 60-year-old male presents with bright red, painless rectal bleeding and a feeling of incomplete evacuation. Digital rectal examination (DRE) reveals a firm, irregular, palpable mass located 6 cm from the anal verge. Which statement about the clinical features of rectal carcinoma is most accurate? (Q849204)

A. Tenesmus is a late symptom.

B. Rectal carcinoma typically presents without any changes in bowel habits.

C. Rectal carcinoma is most common in patients under 55 years of age.

D. The presence of a hard mass within 7-8 cm of the anal verge.

See Answer in Part B → Q11

@Neet_pg_bot

Q12: A 24-year-old male presents with recurrent painful swelling and discharge at the natal cleft. He has coarse hair and reports worsening after prolonged sitting. On examination, a tender fluctuant swelling with a midline pit is noted.What is the most appropriate initial management? (Q849203)

A. Complete surgical excision of the sinus

B. Cauterization using silver nitrate

C. Drainage through a midline incision

D. Lateral internal sphincterotomy

See Answer in Part B → Q12

@Neet_pg_bot

Q13: A 32 y/o woman presents with severe pain during bowel movements and bright red blood on toilet paper for 2 weeks. She describes the pain as excruciating and sharp, akin to "passing glass." Based on this clinical scenario, which of the following statements is correct? (Q849201)

A. It mainly presents with anal itching & discharge

B. The hallmark symptom is severe pain during defecation that usually subsides after bowel movements.

C. This condition is characterized by a thickened anal papilla and a skin tag.

D. The majority of cases occur in the anterior midline in women due to childbirth.

See Answer in Part B → Q13

@Neet_pg_bot

Q14: A 35 y/o woman presents with severe pain during bowel movements and bright red blood on toilet tissue. Upon examination, the physician suspects an anal fissure. Which of the following characteristics is most likely associated with a chronic anal fissure? (Q849200)

A. Presence of bright red blood only after bowel movements.

B. Severe sharp pain during bowel movements that subside afterwards.

C. Thickened anal papilla and skin tag are present at the fissure site.

D. Extensive oedema and inflammation

See Answer in Part B → Q14

@Neet_pg_bot

Q15: During a detailed anatomical study, a researcher examines the fascia layers associated with the rectum. Which of the following structures separates the rectum from the prostate in males? (Q849184)

A. Presacral fascia

B. Fascia propria

C. Denonvilliers' fascia

D. Waldeyer's fascia

See Answer in Part B → Q15

@Neet_pg_bot

Q16: A 32 y/o male presents with intermittent discharge of pus from an external opening near the anus, accompanied by discomfort and occasional blood in the discharge. He has a history of anorectal abscess treated six months ago and reports pain during bowel movements. Which of the following is the investigation of choice in this case? (Q849198)

A. Fistulography (X-ray)

B. Endoscopic Ultrasound

C. Anoscopy

D. MRI

See Answer in Part B → Q16

@Neet_pg_bot

Q17: A 45 y/o male presents to the clinic with a persistent anal discharge and discomfort. He has a history of recurrent perianal abscesses over the past year. O/E an external opening is noted near the anal margin. Which of the following is the most likely cause of the anal fistula in this patient? (Q849197)

A. Crohn's disease

B. Tuberculosis

C. Actinomycosis

D. Cryptoglandular infection

See Answer in Part B → Q17

@Neet_pg_bot

Q18: A 38-year-old man presents with severe anal pain and a tender, indurated lump at the anal margin. He reports a two-day history of progressively localized pain but has no systemic symptoms such as fever or malaise. What is the next best step in managing this patient? (Q849196)

A. Immediate antibiotic therapy

B. Surgical drainage under anaesthesia

C. Observation and follow-up in 48 hours

D. Imaging studies to confirm diagnosis

See Answer in Part B → Q18

@Neet_pg_bot

Q19: A 45-year-old diabetic male reports deep, intense pain "inside" the anal area that worsens with coughing or sneezing. The examination shows minimal external swelling, but the significant discomfort prevents a complete digital rectal exam. Given this clinical picture, which type of anorectal abscess is most likely present in this patient? (Q849194)

A. Perianal Abscess

B. Ischiorectal Abscess

C. Intersphincteric Abscess

D. Supralevator Abscess

See Answer in Part B → Q19

@Neet_pg_bot

Q20: A 55-year-old man presents with difficulty urinating and lower abdominal discomfort. The doctor advises a digital rectal examination (DRE) to assess for potential prostate enlargement or other rectal abnormalities. Which of the following is not an external inspection finding? (Q849193)

A. Anal fissures

B. Rectal polyps

C. Pilonidal sinus

D. External hemorrhoids

See Answer in Part B → Q20

@Neet_pg_bot

Q21: A 72-year-old multiparous woman presents with a painless mass protruding from her anus along with occasional bleeding and fecal incontinence. O/E the mass is circumferential, red in colour, and reducible. Which of the following is the most likely type of rectal prolapse? (Q849191)

A. Partial prolapse

B. Mucosal prolapse

C. Complete prolapse

D. Internal haemorrhoids

See Answer in Part B → Q21

@Neet_pg_bot

Q22: A 45-year-old man presents with persistent bleeding from haemorrhoids despite dietary changes and non-operative treatments. Examination reveals third-degree internal haemorrhoids. Which of the following is not an indication of hemorrhoidectomy? (Q849190)

A. Third-degree haemorrhoids

B. Second-degree haemorrhoids

C. 'Mixed' haemorrhoids with a well-defined external component

D. Fourth-degree haemorrhoids

See Answer in Part B → Q22

@Neet_pg_bot

Q23: A 50-year-old woman presents with bright red bleeding during defecation and a prolapsed haemorrhoid that cannot be reduced manually. What is the most suitable management for this patient? (Q849188)

A. Dietary and lifestyle changes

B. Rubber band ligation

C. Sclerotherapy

D. Hemorrhoidectomy

See Answer in Part B → Q23

@Neet_pg_bot

Q24: A 45-year-old man reports experiencing bright red bleeding during bowel movements and a mass that protrudes from his anus, which he can manually reduce but does not reduce spontaneously. On examination, no thrombosed haemorrhoids are observed. Which degree of internal haemorrhoids is this patient most likely suffering from? (Q849187)

A. First degree

B. Second degree

C. Third degree

D. Fourth degree

See Answer in Part B → Q24

@Neet_pg_bot

Q25: A 55 y/o woman presents with complaints of rectal bleeding and discomfort during bowel movements. She mentions experiencing chronic constipation and frequent straining. Which pathophysiological mechanism is most likely contributing to her haemorrhoids? (Q849186)

A. High-fiber diet

B. Well-supported suspensory tissues

C. Excess venous drainage

D. Increased intra-abdominal pressure

See Answer in Part B → Q25

@Neet_pg_bot

Q26: A 58 y/o male presents with rectal cancer located just distal to the dentate line. During his evaluation for metastatic spread, which lymph nodes are most likely to be

involved given the location of his cancer? (Q849185)

A. Internal iliac lymph nodes

B. Inferior mesenteric lymph nodes

C. Para-aortic lymph nodes

D. Inguinal lymph nodes

See Answer in Part B → Q26

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• [05_Gastrointestinal Surgery] 030 Hernia - I

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[05_Gastrointestinal Surgery] 030 Hernia - I — Quick Jump

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Q25 (p. 436)	*Q26 (p. 436)*				

Q1: A 65-year-old male presents with a painful, irreducible groin hernia, severe colicky pain, bilious vomiting, and absence of faeces or flatus for 24 hours. The hernia is tense and extremely tender, with reddish-blue skin discolouration and no cough impulse. What is the immediate next step in management? (Q849330)

A. Administer IV antibiotics and fluids and proceed with surgery

B. Immediate surgical repair with synthetic mesh

C. Apply cold compresses to the hernia to reduce swelling

D. Start oral antibiotics and monitor the hernia for changes



See Answer in Part B → Q1

@Neet_pg_bot

Q2: A patient presents with an incisional hernia located just above the umbilicus in the midline of the abdomen. According to the EHS classification, how is this hernia classified? (Q849338)

A. M1

B. M2

C. M3

D. L2

See Answer in Part B → Q2

@Neet_pg_bot

Q3: Which of the following is NOT typically considered an indication for surgical repair of an umbilical hernia in adults? (Q849337)

A. Incarceration or strangulation of hernia contents

B. Hernia size >2 cm in diameter

C. Symptomatic hernia causing pain or discomfort

D. Hernia in a patient with a BMI of 32

See Answer in Part B → Q3

@Neet_pg_bot

Q4: A 75-year-old thin woman presents with intermittent pain and paresthesia along the medial aspect of her right thigh. She reports nausea and vomiting over the past few days. On examination, hip flexion and external rotation exacerbate her thigh pain. Which of the following signs is most specific for the likely diagnosis? (Q849335)

A. Cough impulse

B. Howship-Romberg sign

C. Carnett's sign

D. Murphy's sign

See Answer in Part B → Q4

@Neet_pg_bot

Q5: A 55-year-old woman presents with a painful lump in her lower right abdomen, lateral to the rectus muscle. The swelling becomes more prominent when she stands or coughs. CT scan shows a defect in the transversus abdominis aponeurosis. What is the most likely diagnosis? (Q849334)

A. Epigastric hernia

B. Umbilical hernia

C. Spigelian hernia

D. Incisional hernia

See Answer in Part B → Q5

@Neet_pg_bot

Q6: A 60-year-old male patient presents with right lower abdominal swelling and is diagnosed with a sliding hernia. After discussing the risks, his surgery is planned for hernia repair. Which of the following statements regarding sliding hernia is true? (Q849333)

A. More common in females than males

B. Anterior wall of the sac is formed by the viscera

C. There is an increased risk of bowel injury during management.

D. Most common content is the appendix.

See Answer in Part B → Q6

@Neet_pg_bot

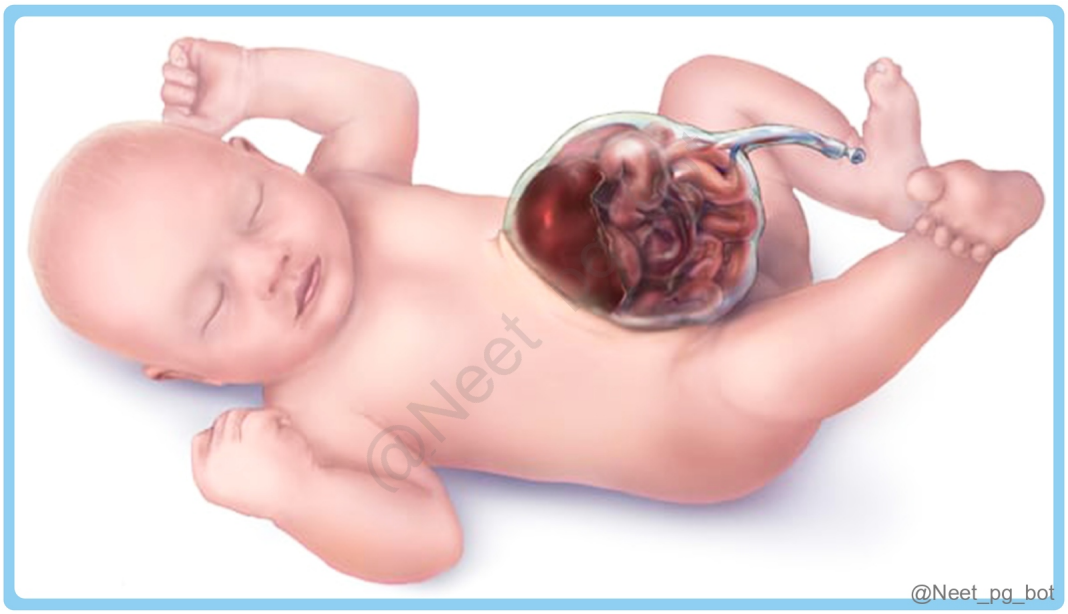
Q7: Which of the following is NOT a feature associated with the image shown below? (Q849340)

A. Covered by amnion and peritoneum layers

B. Higher incidence of associated chromosomal abnormalities like Trisomy 13, 18, and 21

C. The defect is usually located to the right of the umbilical cord insertion

D. Can be associated with Beckwith-Wiedemann Syndrome



See Answer in Part B → Q7

@Neet_pg_bot

Q8: A 45-year-old woman presents with a reducible swelling in the left groin below the inguinal ligament, suggesting a femoral hernia. The surgeon opts for a low approach to access the femoral canal directly without entering the inguinal canal. Which technique is most appropriate for this approach? (Q849331)

A. Lockwood's technique

B. McEvedy's technique

C. Lotheissen's technique

D. McVay repair

See Answer in Part B → Q8

@Neet_pg_bot

Q9: During laparoscopic inguinal hernia repair, which critical structure should the surgeon avoid to prevent significant bleeding? (Q849329)

A. Obturator Artery

B. Accessory Obturator Artery

C. Corona Mortis artery

D. Superficial Epigastric Artery

See Answer in Part B → Q9

@Neet_pg_bot

Q10: A 42-year-old woman with a history of Gardner's syndrome presents with persistent abdominal pain and a palpable mass in the left lower quadrant. She has previously undergone an open proctocolectomy. Imaging studies reveal an infiltrative mass in the mesentery. What is the most appropriate management strategy for her recurrent intra-abdominal mass? (Q849341)

A. Immediate systemic chemotherapy without further surgical intervention.

B. Wide local excision with a 2 cm margin, potentially followed by radiotherapy.

C. Hormonal therapy to manage the tumor.

D. Laparoscopic surgery to remove the tumor, given its lower risk of recurrence.

See Answer in Part B → Q10

@Neet_pg_bot

Q11: A 55-year-old woman with sudden groin pain and diarrhoea is found to have a small bulge in the right groin. She describes the pain as colicky and has symptoms resembling acute gastroenteritis. Which type of hernia is most likely associated with these symptoms? (Q849342)

A. Littre's hernia

B. Amyand's hernia

C. Maydl's hernia

D. Richter's hernia

See Answer in Part B → Q11

@Neet_pg_bot

Q12: A 62-year-old male has a right groin bulge that worsens with standing and reduces when lying down. The bulge is medial to the inferior epigastric vessels. Based on the Nyhus classification, which type of hernia does this patient have? (Q849215)

A. Type I

B. Type II

C. Type III A

D. Type III B

See Answer in Part B → Q12

@Neet_pg_bot

Q13: A newborn is diagnosed with a congenital diaphragmatic hernia (CDH) and presents with severe respiratory distress. Physical examination revealed a scaphoid abdomen and a chest X-ray showed bowel loops in the thoracic cavity and a mediastinal shift. What is the most appropriate initial intervention to stabilise the infant before surgical repair? (Q849345)

A. Bag-mask ventilation to ensure adequate oxygenation.

B. Placement of an Orogastric tube to decompress the stomach

C. IV Antibiotics to prevent infection in the herniated bowel.

D. Immediate surgery, irrespective of the status

See Answer in Part B → Q13

@Neet_pg_bot

Q14: A 12-year-old girl presents with abdominal pain and intermittent nausea. Physical examination reveals a large, non-tender abdominal mass in the left lower quadrant, contiguous with the small intestine in the mesentery. Based on the findings, which type of mesenteric cyst is most likely, and what is the preferred management approach? (Q849346)

A. Enterogenous cyst; Resection and anastomosis

B. Chylolymphatic cyst; Enucleation

C. Hydatid cyst; Anti-parasitic therapy

D. Traumatic cyst; Observation

See Answer in Part B → Q14

@Neet_pg_bot

Q15: Match the following hernias with their respective defects. Hernia Defect 1. Berger's Hernia a) Defect in the conjoint tendon 2. Beclard's Hernia b) Hernia into the pouch of Douglas 3. Ogilvie's Hernia c) Hernia behind the Roux limb 4. Stammer's Hernia d) Through the saphenous opening 5. Peterson Hernia e) Through transverse mesocolon after retro colic gastro-jejunostomy (Q849343)

A. 1-b, 2-d, 3-a, 4-e, 5-c

B. 1-b, 2-c, 3-d, 4-a, 5-e

C. 1-d, 2-a, 3-e, 4-b, 5-c

D. 1-a, 2-d, 3-c, 4-e, 5-b

See Answer in Part B → Q15

@Neet_pg_bot

Q16: A day-old preterm infant is admitted with severe respiratory distress. Physical examination shows a scaphoid abdomen and chest X-rays reveal bowel loops in the thorax and a mediastinal shift. Despite intensive care, the infant's condition deteriorates rapidly and leads to death. Which of the following accurately describes a

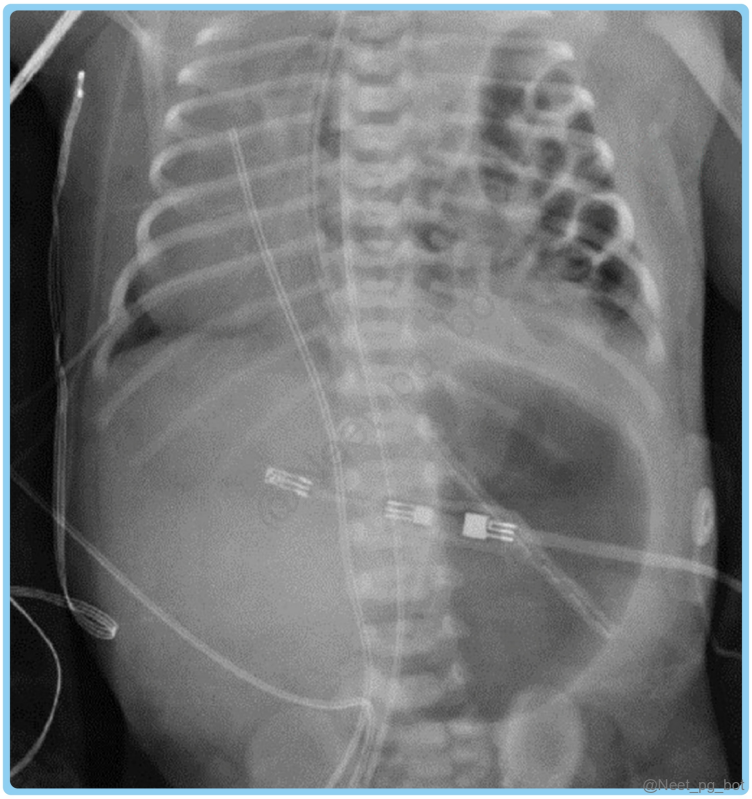
characteristic feature of the most common type of this condition? (Q849344)

A. Left-sided posteromedial defect with herniation of small intestine

B. Right-sided anterolateral defect associated with herniation of the liver

C. Defective central tendon of the diaphragm

D. Persistence of the pleuroperitoneal canal



See Answer in Part B → Q16

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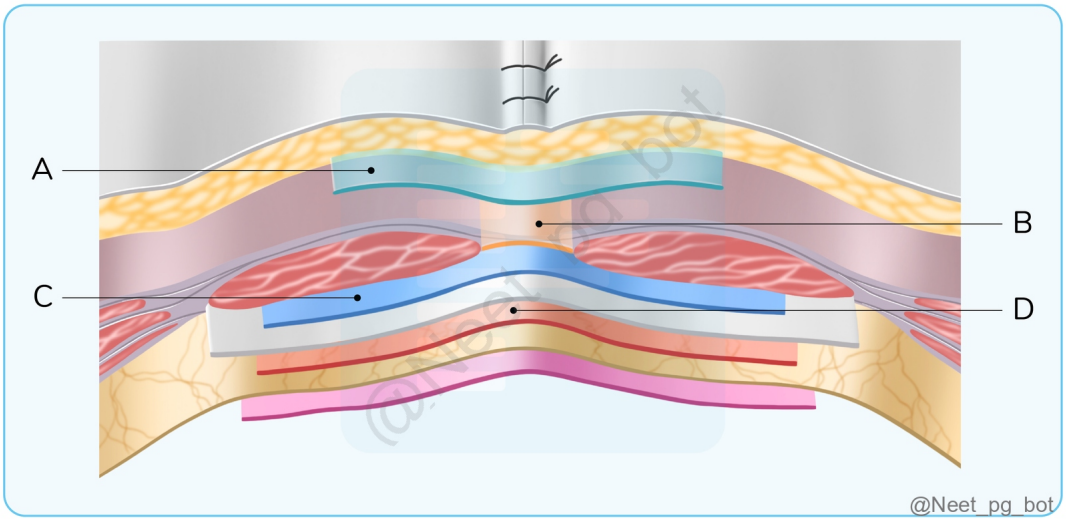
Q17: Which technique of incisional hernia is done at point B? (Q849339)

A. Onlay

B. Inlay

C. Retromuscular

D. Preperitoneal



See Answer in Part B → Q17

@Neet_pg_bot

Q18: A 58-year-old male with chronic bronchitis, smoking history, and recent steroid use presents with a lower abdominal bulge that worsens with prolonged standing and heavy weight lifting. Which of these factors contributes to the risk of his condition? Chronic bronchitis Heavy weight lifting Smoking Steroid use (Q849212)

A. 1, 2, 3

B. 1, 3, 4

C. 2, 3, 4

D. 1, 2, 3, 4

See Answer in Part B → Q18

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Q19: Which type of lumbar hernia is characterized by a protrusion just below the 12th rib? (Q849336)

A. Petit's lumbar hernia

B. Grynfeltt-Lesshaft hernia

C. Gibbon's hernia

D. Pantaloon hernia

See Answer in Part B → Q19

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Q20: A 55-year-old woman presents with a small, reducible swelling in her right groin area. Upon examination, you noticed that the swelling was located lateral to the femoral vessels. Which variant of femoral hernia is this most likely to be? (Q849332)

A. Narath's hernia

B. Cloquet's hernia

C. Velpeau's hernia

D. Laugier's hernia

See Answer in Part B → Q20

@Neet_pg_bot

Q21: A 55-year-old man undergoes emergency inguinal hernia surgery. Postoperatively, he experiences persistent groin pain, raising concerns about nerve injury. Which nerve is most commonly injured during open inguinal hernia surgery? (Q849328)

A. Iliohypogastric nerve

B. Ilioinguinal nerve

C. Genitofemoral nerve

D. Femoral nerve

See Answer in Part B → Q21

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Q22: A laparoscopic surgeon is repairing an inguinal hernia and wants to avoid using electrocautery in certain areas to prevent injury. Which anatomical region should the surgeon avoid? (Q849327)

A. Triangle of Doom

B. Triangle of Pain

C. Triangle of Hesselbach

D. Triangle of Scarpa

See Answer in Part B → Q22

@Neet_pg_bot

Q23: A 62-year-old male presents with a progressively worsening right groin bulge over 6 months, causing discomfort during lifting or prolonged standing. The hernia is reducible, and he is scheduled for elective repair. What is the gold standard surgical technique for his inguinal hernia repair? (Q849217)

A. Shouldice Repair

B. Lichtenstein Repair

C. Herniotomy

D. Stoppa Repair

See Answer in Part B → Q23

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Q24: A 72-year-old female presents with a non-reducible right groin bulge below the inguinal ligament, confirmed by ultrasound to extend into the femoral canal. According to the Gilbert classification, which type best describes this condition? (Q849216)

A. Type 1

B. Type 3

C. Type 6

D. Type 7

See Answer in Part B → Q24

@Neet_pg_bot

Q25: A 67-year-old male presents with a gradually increasing bulge in his right groin, which becomes more prominent when standing and straining and can be reduced when lying down. The bulge is medial to the inferior epigastric vessels. Which statement best describes this inguinal condition? (Q849214)

A. Direct hernia, passing through a defect in the abdominal wall.

B. Indirect hernia, passing through the deep inguinal ring into the scrotum.

C. Direct hernia, passing through the deep inguinal ring.

D. Indirect hernia, passing through a defect in the abdominal wall.

See Answer in Part B → Q25

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Q26: A 72-year-old man presents with a bulge in his lower abdomen that worsens with heavy lifting or coughing. Physical examination reveals a direct inguinal hernia. Which of the following correctly describes the boundaries of the involved anatomical triangle? (Q849213)

A. Lateral: Inferior epigastric vessels; Medial: Rectus abdominis; Inferior: Inguinal ligament

B. Lateral: Rectus abdominis; Medial: Inguinal ligament; Inferior: Femoral vessels

C. Lateral: Femoral vessels; Medial: Rectus abdominis; Inferior: Superior epigastric vessels

D. Lateral: Inguinal ligament; Medial: Femoral vessels; Inferior: Rectus abdominis

See Answer in Part B → Q26

• [05_Gastrointestinal Surgery] 031 Spleen

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[05_Gastrointestinal Surgery] 031 Spleen — Quick Jump

Q1 (p. 438) *Q2 (p. 438)* *Q3 (p. 438)* *Q4 (p. 439)* *Q5 (p. 439)* *Q6 (p. 440)*
Q7 (p. 440) *Q8 (p. 440)* *Q9 (p. 441)* *Q10 (p. 441)*

Q1: Which of the following statements about the spleen is not true? (Q849317)

A. Normal adult spleen weights 75–250 g.

B. The long axis lies along the 10th rib.

C. It develops from the mesenchymal cells of the ventral mesogastrium.

D. It is an intraperitoneal organ

See Answer in Part B → Q1

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Q2: What is the most common indication for a splenectomy? (Q849318)

A. Hereditary spherocytosis

B. Idiopathic thrombocytopenic purpura (ITP)

C. Trauma

D. Abscess

See Answer in Part B → Q2

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Q3: A 45-year-old male is planned for an elective splenectomy due to hereditary spherocytosis. Which of the following vaccination strategies is most appropriate to prevent infections post-splenectomy? (Q849319)

A. 10-12 weeks before surgery

B. Only if the patient shows signs of infection

C. Delay all vaccinations until 6 months after surgery

D. 1 week before the surgery

See Answer in Part B → Q3

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Q4: An elderly male undergoes an open splenectomy due to splenic rupture following a car accident. In the postoperative room, he complains of shortness of breath and chest discomfort. What is the MOST common immediate complication after a splenectomy? (Q849320)

A. Pulmonary embolism

B. Left basal atelectasis

C. Pleural effusion

D. Pneumonia

See Answer in Part B → Q4

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Q5: A 25-year-old woman with thalassemia major undergoes an elective splenectomy. She is informed about potential complications and the need for vaccinations. When is the most common Fatal late complication of splenectomy most likely to occur? (Q849321)

A. Within the first 6 months

B. 1-2 years post-splenectomy

C. 2-5 years post-splenectomy

D. 5-10 years post-splenectomy

See Answer in Part B → Q5

@Neet_pg_bot

Q6: A 4-year-old boy is brought to the clinic with a history of sudden onset of petechial hemorrhages and purpuric patches on the skin. The mother also reports episodes of spontaneous epistaxis over the past few days. He had a flu-like illness a few weeks ago. Laboratory investigations show isolated thrombocytopenia. Which of the following statements is most accurate about the disease? (Q849322)

A. Equal incidence in both males and females

B. Predominantly seen in females aged 15-50

C. Associated with renal dysfunction

D. Associated with hemolytic anemia and jaundice

See Answer in Part B → Q6

@Neet_pg_bot

Q7: A 45-year-old patient presents with persistent petechiae, frequent nosebleeds, and heavy menstrual bleeding over the past 7 months. She is being considered for splenectomy. Which statement accurately reflects the current approach to this treatment? (Q849323)

A. Laparoscopic splenectomy is preferred.

B. Long-term steroid therapy is the primary approach.

C. Approximately 50% of patients will achieve complete remission post-splenectomy.

D. All patients receive pre-splenectomy transfusions immediately

See Answer in Part B → Q7

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Q8: A 45-year-old patient undergoes a splenectomy for an incidental finding. Histological examination of the spleen reveals a vascular tumor. Which of the following is the most likely type of tumor identified? (Q849325)

A. Histiocytic Lymphoma

B. Hemangioendothelioma

C. Non-Hodgkin's Lymphoma

D. Plasmacytoma

See Answer in Part B → Q8

@Neet_pg_bot

Q9: A 45-year-old patient presents with a one-week history of persistent left upper abdominal pain. The patient exhibits fever, left upper quadrant tenderness, and leukocytosis. Which of the following is the investigation of choice for confirming the diagnosis? (Q849326)

A. Chest X-ray

B. Abdominal Ultrasound

C. Computed Tomography (CT)

D. Radioisotope Scanning

See Answer in Part B → Q9

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Q10: A 30-year-old patient presents with an abdominal mass. Imaging studies reveal a cystic structure in the spleen. Based on the imaging characteristics and the absence of an epithelial lining, which of the following is the most likely diagnosis? (Q849324)

A. Cystic hemangioma

B. Mesenchymal Inclusion Cyst

C. Secondary cyst

D. Dermoid cyst

See Answer in Part B → Q10

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• [05_Gastrointestinal Surgery] 032 Previous Year Questions

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[05_Gastrointestinal Surgery] 032 Previous Year Questions — Quick Jump

Q1 (p. 444)	*Q2 (p. 444)*	*Q3 (p. 444)*	*Q4 (p. 445)*	*Q5 (p. 445)*	*Q6 (p. 445)*
Q7 (p. 446)	*Q8 (p. 447)*	*Q9 (p. 447)*	*Q10 (p. 447)*	*Q11 (p. 448)*	*Q12 (p. 449)*
Q13 (p. 450)	*Q14 (p. 450)*	*Q15 (p. 451)*	*Q16 (p. 451)*	*Q17 (p. 452)*	*Q18 (p. 452)*
Q19 (p. 453)	*Q20 (p. 453)*	*Q21 (p. 454)*	*Q22 (p. 455)*	*Q23 (p. 455)*	*Q24 (p. 456)*
Q25 (p. 457)	*Q26 (p. 457)*	*Q27 (p. 458)*	*Q28 (p. 459)*	*Q29 (p. 460)*	*Q30 (p. 461)*
Q31 (p. 462)	*Q32 (p. 462)*	*Q33 (p. 463)*	*Q34 (p. 464)*	*Q35 (p. 464)*	*Q36 (p. 464)*
Q37 (p. 465)	*Q38 (p. 465)*	*Q39 (p. 466)*	*Q40 (p. 466)*	*Q41 (p. 467)*	*Q42 (p. 467)*
Q43 (p. 468)	*Q44 (p. 468)*	*Q45 (p. 469)*	*Q46 (p. 470)*	*Q47 (p. 470)*	*Q48 (p. 471)*
Q49 (p. 472)	*Q50 (p. 472)*	*Q51 (p. 473)*	*Q52 (p. 474)*	*Q53 (p. 474)*	*Q54 (p. 475)*
Q55 (p. 476)	*Q56 (p. 476)*	*Q57 (p. 476)*	*Q58 (p. 477)*	*Q59 (p. 477)*	*Q60 (p. 478)*
Q61 (p. 479)	*Q62 (p. 479)*	*Q63 (p. 480)*	*Q64 (p. 480)*	*Q65 (p. 481)*	*Q66 (p. 481)*
Q67 (p. 482)	*Q68 (p. 482)*	*Q69 (p. 483)*	*Q70 (p. 483)*	*Q71 (p. 484)*	*Q72 (p. 485)*
Q73 (p. 485)	*Q74 (p. 485)*	*Q75 (p. 486)*	*Q76 (p. 486)*	*Q77 (p. 486)*	*Q78 (p. 487)*
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Q91 (p. 492)	*Q92 (p. 493)*	*Q93 (p. 493)*	*Q94 (p. 494)*	*Q95 (p. 494)*	*Q96 (p. 495)*
Q97 (p. 495)	*Q98 (p. 496)*	*Q99 (p. 496)*	*Q100 (p. 496)*	*Q101 (p. 497)*	*Q102 (p. 498)*
Q103 (p. 498)	*Q104 (p. 498)*	*Q105 (p. 499)*	*Q106 (p. 500)*	*Q107 (p. 500)*	*Q108 (p. 500)*
Q109 (p. 501)	*Q110 (p. 501)*	*Q111 (p. 502)*	*Q112 (p. 502)*	*Q113 (p. 502)*	*Q114 (p. 503)*
Q115 (p. 504)	*Q116 (p. 505)*	*Q117 (p. 506)*	*Q118 (p. 506)*	*Q119 (p. 507)*	*Q120 (p. 508)*
Q121 (p. 508)	*Q122 (p. 509)*	*Q123 (p. 509)*	*Q124 (p. 509)*	*Q125 (p. 510)*	*Q126 (p. 510)*
Q127 (p. 510)	*Q128 (p. 511)*	*Q129 (p. 511)*	*Q130 (p. 512)*	*Q131 (p. 512)*	*Q132 (p. 513)*
Q133 (p. 513)	*Q134 (p. 514)*	*Q135 (p. 514)*	*Q136 (p. 515)*	*Q137 (p. 516)*	*Q138 (p. 517)*
Q139 (p. 517)	*Q140 (p. 518)*	*Q141 (p. 518)*	*Q142 (p. 519)*	*Q143 (p. 519)*	*Q144 (p. 519)*
Q145 (p. 520)	*Q146 (p. 520)*	*Q147 (p. 521)*	*Q148 (p. 521)*	*Q149 (p. 522)*	*Q150 (p. 523)*
Q151 (p. 524)	*Q152 (p. 524)*	*Q153 (p. 525)*	*Q154 (p. 525)*	*Q155 (p. 526)*	*Q156 (p. 526)*
Q157 (p. 527)	*Q158 (p. 527)*	*Q159 (p. 528)*	*Q160 (p. 529)*	*Q161 (p. 530)*	*Q162 (p. 531)*
Q163 (p. 531)	*Q164 (p. 532)*	*Q165 (p. 533)*	*Q166 (p. 534)*	*Q167 (p. 534)*	*Q168 (p. 535)*
Q169 (p. 536)	*Q170 (p. 536)*	*Q171 (p. 537)*	*Q172 (p. 538)*	*Q173 (p. 538)*	*Q174 (p. 538)*
Q175 (p. 539)	*Q176 (p. 540)*	*Q177 (p. 541)*	*Q178 (p. 541)*	*Q179 (p. 541)*	*Q180 (p. 542)*
Q181 (p. 542)	*Q182 (p. 543)*	*Q183 (p. 543)*	*Q184 (p. 544)*	*Q185 (p. 544)*	*Q186 (p. 545)*
Q187 (p. 546)	*Q188 (p. 546)*	*Q189 (p. 547)*	*Q190 (p. 548)*	*Q191 (p. 548)*	*Q192 (p. 549)*

Q193 (p. 550) *Q194 (p. 550)* *Q195 (p. 551)* *Q196 (p. 551)*

Q1: A 2-month-old male infant presents with a scrotal swelling that has been present since birth. Now, the swelling has become suddenly painful, red, and irreducible. What is the most likely diagnosis? (Q866898)

A. Acute epididymo-orchitis

B. Testicular torsion

C. Strangulated inguinal hernia

D. Incarcerated inguinal hernia

See Answer in Part B → Q1

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Q2: Which of the following is a recommended treatment for esophageal varices? (Q866901)

A. Endoscopic ligation

B. Transjugular intrahepatic portosystemic shunt (TIPS)

C. Intravenous labetalol

D. Oral amoxicillin

See Answer in Part B → Q2

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Q3: What is the most appropriate treatment for an 8cm chylolymphatic mesenteric cyst? (Q866911)

A. Aspiration

B. Enucleation

C. Resection of the cyst along with the adjacent bowel

D. Conservative

See Answer in Part B → Q3

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Q4: A follow-up patient of GERD on endoscopy was having a nodule in the 2nd part of the duodenum, which hormone are you suspecting to be raised? (Q866920)

A. Gastrin

B. Inulin

C. VIP

D. Glucagon

See Answer in Part B → Q4

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Q5: A neonate has intestines protruding from the abdomen without any covering. Initial management is done. If the viscera cannot be reduced into the abdomen, what is the appropriate next step in management? (Q866922)

A. Surgical correction

B. Conservative management with higher antibiotics

C. Silo placement → Serial reduction → Operative fascial closureCover the content with a Silo bag and wait

D. Cover with NS-soaked gauze

See Answer in Part B → Q5

@Neet_pg_bot

Q6: A 16-year-old boy presents with multiple episodes of abdominal pain and a history of passing blood in his stools. On examination, he has darkly pigmented spots on his lips and oral mucosa. Endoscopy reveals multiple hamartomatous polyps in the small intestine. What is the most likely diagnosis? (Q866926)

A. Familial Adenomatous Polyposis

B. Peutz-Jeghers Syndrome

C. Juvenile Polyposis Syndrome

D. Cronkhite-Canada Syndrome

See Answer in Part B → Q6

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Q7: Identify the pathology in the child. (Q866930)

A. Umbilical Hernia

B. Spigelian Hernia

C. Inguinal Hernia

D. Femoral Hernia



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See Answer in Part B → Q7

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Q8: Which of the following veins are involved in the formation of esophageal varices? (Q866934)

A. Left gastric vein

B. Right gastric vein

C. Left gastroepiploic vein

D. Right gastroepiploic vein

See Answer in Part B → Q8

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Q9: A 22-year-old male presents to the emergency department with a 12-hour history of abdominal pain that started around the umbilicus and has now localised to the right lower quadrant. He also reports nausea and loss of appetite. On examination, he has tenderness in the right iliac fossa with rebound tenderness. His temperature is 38.2°C. Laboratory investigations reveal a white blood cell count of 14,000/mm 3 with a left shift. What is his pain score? (Q865323)

A. 5

B. 7

C. 8

D. 10

See Answer in Part B → Q9

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Q10: A 65-year-old patient undergoes colonoscopy for evaluation oc altered bowel habits. A 6cm colonic mass is identified and biopsied. Histopathology confirms adenocarcinoma that is confined to the mucosal layer, with no evidence of invasion into the submucosa or beyond. Imaging studies show no lymph node involvement or distant metastasis. Based on this information, what is the most appropriate TNM stage of this tumour? (Q865328)

A. Stage I

B. Stage IIA

C. Stage IIB

D. Stage 0

See Answer in Part B → Q10

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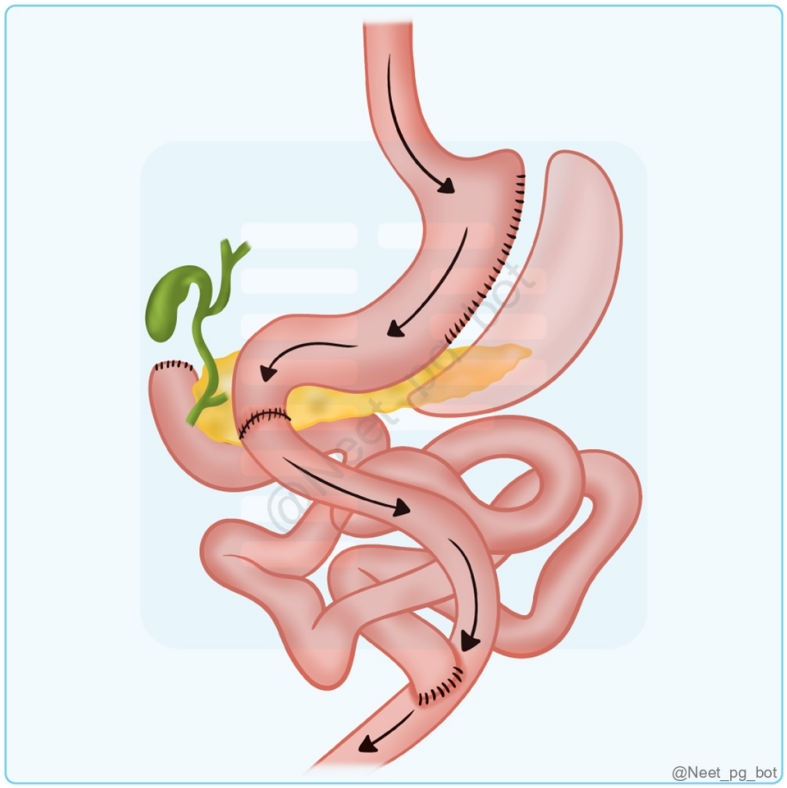
Q11: Identify the procedure done? (Q865332)

A. Single Anastamosis Duodenal-Ileal Bypass with Gastrectomy

B. Gastric bypass

C. Sleeve Gastrectomy

D. Adjustable gastric banding



See Answer in Part B → Q11

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Q12: A 35-year-old patient presents with a history of diarrhea associated with blood in stool for several weeks. On examination, the patient is febrile and has abdominal distension and tenderness. A CT scan (coronal view) shows a grossly dilated colon with loss of haustrations. Laboratory investigations reveal leukocytosis and elevated inflammatory markers. Based on the clinical and radiological findings, what is the most likely diagnosis? (Q865369)

A. Ulcerative colitis

B. Crohn's disease

C. Colonic carcinoma

D. Intestinal tuberculosis

See Answer in Part B → Q12

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Q13: Which of the following is incorrectly matched with its corresponding scoring or classification system? (Q865384)

A. Pancreatitis -Atlanta classification

B. Achalasia - Los Angeles Score

C. Colonoscopy - Boston Score

D. Parathyroid - Miami criteria

See Answer in Part B → Q13

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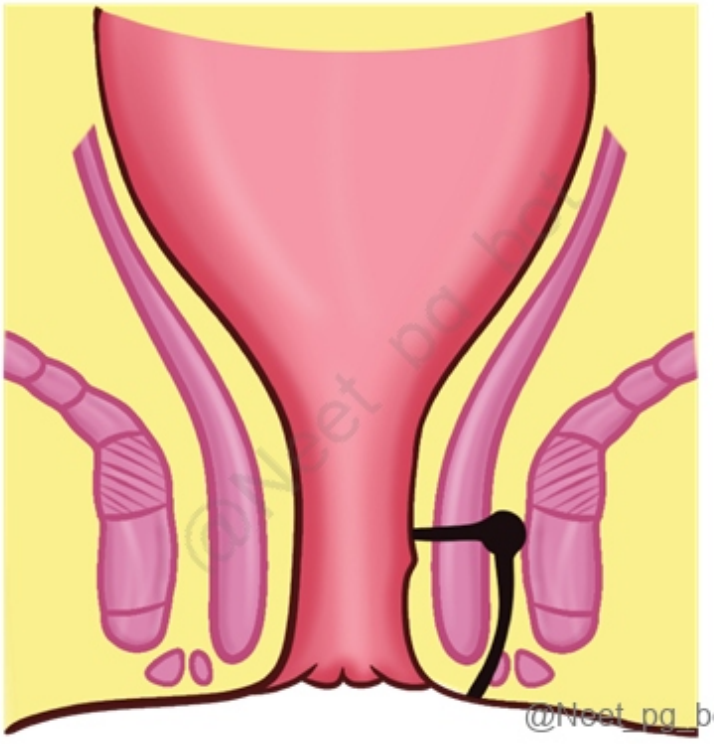
Q14: Identify the fistula according to park's classification? (Q866417)

A. Intersphincteric

B. Supra-sphincteric

C. Extra-sphincteric

D. Trans-sphincteric high



See Answer in Part B → Q14

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Q15: During ward rounds, you encounter a patient who has been admitted with esophageal carcinoma. What is the most likely presentation for this patient? (Q853041)

A. Dysphagia of liquids followed by solids

B. Dysphagia of solids followed by liquids

C. Chest pain

D. Neck mass

See Answer in Part B → Q15

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Q16: A 30-year-old patient with peptic ulcer disease presents with persistent abdominal pain despite treatment at multiple hospitals. He has ulcers in the jejunum and ileum. His gastric pH is <2, and after discontinuing PPIs, his gastrin levels are 10 times higher than normal. What is the likely lesion, and what are the boundaries of the triangle containing it? (Q853042)

A. Insulinoma; triangle formed

B. ■■■Insulinoma; triangle formed by cystic duct, junction of D2-D3, neck and body of pancreas

C. Gastrinoma; triangle formed by cystic duct, junction of D2-D3, neck and body of pancreas

D. Gastrinoma; triangle formed by only common bile duct, junction of D2-D3, neck and body of pancreas

See Answer in Part B → Q16

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Q17: An intern assists in laparoscopic surgery, and the resident explains the instruments and operating ports. The surgeon then asks, "What is the angle between the camera port and the working port called?" (Q853044)

A. Azimuth's angle

B. ■■■Elevation angle

C. Crossing angle

D. Manipulation angle

See Answer in Part B → Q17

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Q18: What is the Truelove and Witts classification used for? (Q853059)

A. ■■■Acute severe ulcerative colitis

B. ARDS

C. Acute encephalitis

D. Acute pancreatitis

See Answer in Part B → Q18

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Q19: Match the following diseases with their respective gene mutation: A. Familial adenomatous polyposis i. SMAD4 B. Juvenile polyposis ii. STK11 C. Tuberous sclerosis iii. APC gene D. Peutz-Jeghers syndrome iv. TSC1 (Q853060)

A. A-i, B-ii, C-iii, D-iv

B. A-ii, B-iii, C-i, D-iv

C. A-iii, B-i, C-iv, D-ii

D. A-iv, B-ii, C-iii, D-i

See Answer in Part B → Q19

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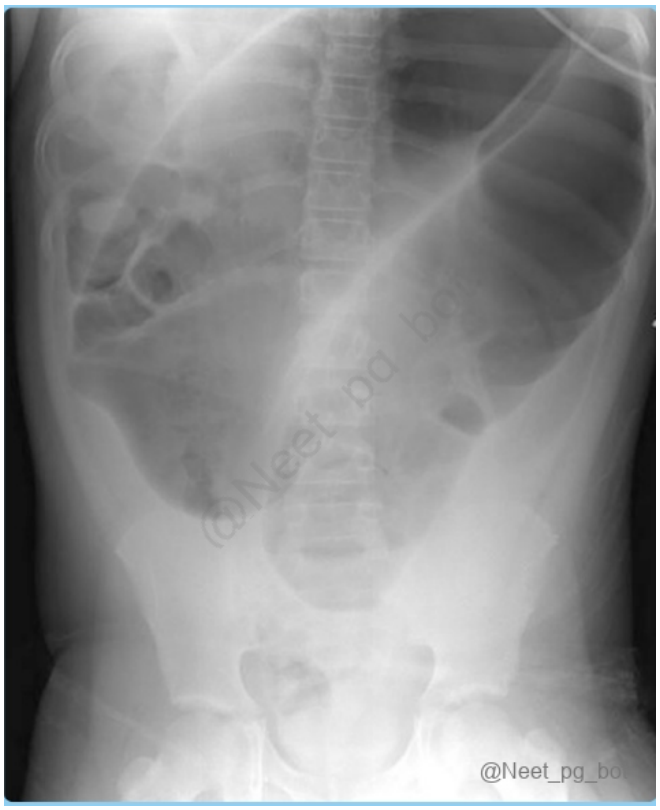
Q20: A 33-year-old male presents with sudden onset acute abdominal pain, constipation for 1 day, persistent hiccups, and occasional vomiting. An abdominal X-ray was performed. Identify the pathology. (Q852686)

A. Sigmoid volvulus

B. Caecal volvulus

C. Intussusception

D. Dynamic obstruction



See Answer in Part B → Q20

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Q21: A 34-year-old male undergoes an open appendectomy for acute appendicitis. The choice of incision was McBurney's incision. Postoperatively, after a few days, he presents with pain and bulging in the right lower quadrant, which is diagnosed as an indirect inguinal hernia. Which nerve injury during the appendectomy is most likely responsible for this complication? (Q852703)

A. Ilioinguinal nerve

B. Femoral nerve

C. Genitofemoral nerve

D. Pudendal nerve

See Answer in Part B → Q21

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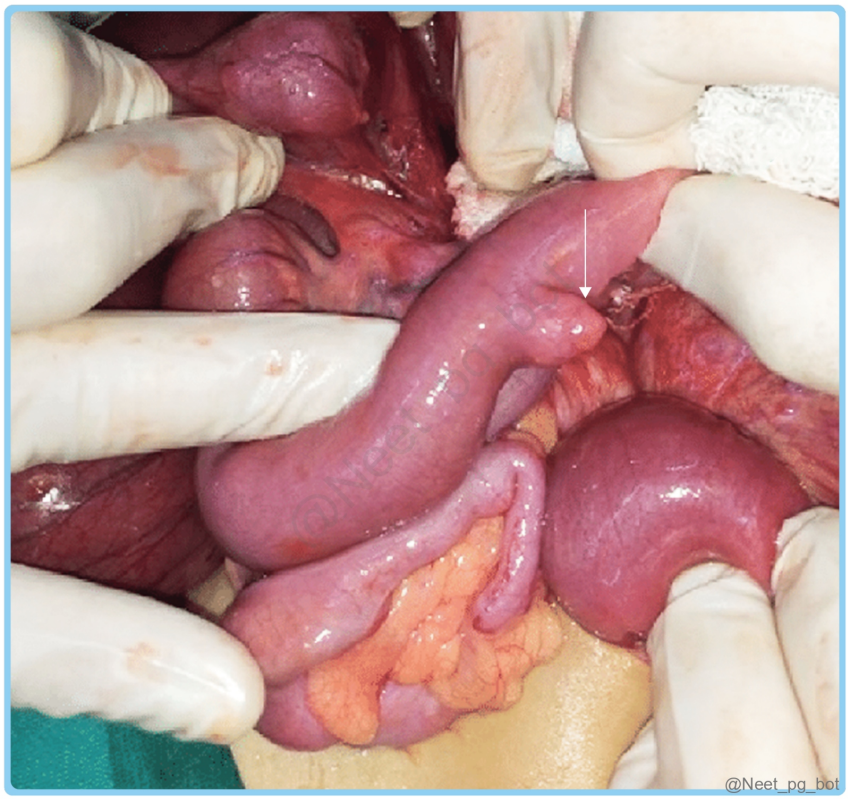
Q22: A 4-year-old boy was brought to the emergency department with complaints of melena that contains gastric mucosa and acute intermittent pain in the right iliac region. On surgical exploration, the following structure was found, what is the diagnosis? (Q852679)

A. Meckel's diverticulum

B. Appendicular lump

C. Carcinoid

D. Obstructed bowel loops



See Answer in Part B → Q22

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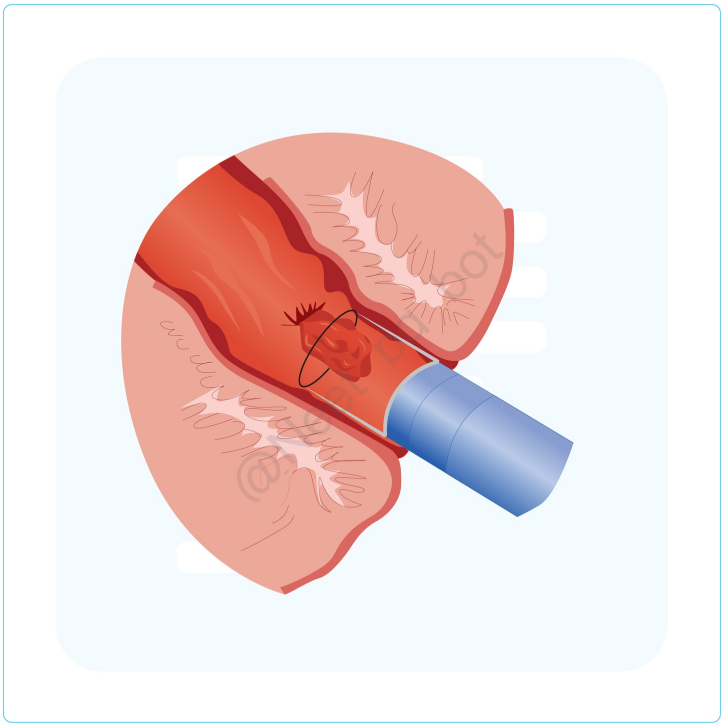
Q23: A patient with grade 4 hemorrhoids underwent surgery, identify the instrument. (Q852681)

A. Haemorrhoids resection kit

B. Stapler kit

C. Haemorrhoids band kit

D. CO2 laser



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See Answer in Part B → Q23

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Q24: What is the most likely cause of lower right abdominal pain and rebound tenderness in a patient with Meckel's diverticulum? (Q852725)

A. Perforation

B. Intestinal obstruction

C. Appendicitis

D. Cholecystitis

See Answer in Part B → Q24

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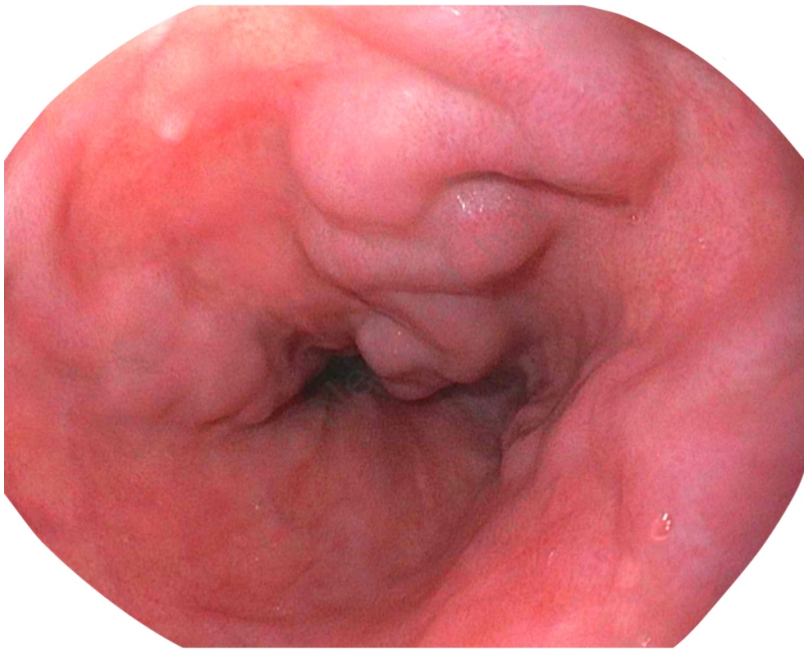
Q25: The endoscopic image shows the following finding. What is the diagnosis? (Q844309)

A. Barretts esophagus

B. Esophageal varices

C. Gastric erosion

D. Chronic GERD



See Answer in Part B → Q25

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Q26: A patient presents with an umbilical hernia that was previously reducible but has now become irreducible. Which of the following is the most appropriate management option? (Q844312)

A. Umblical excision

B. Umbilical excision with mesh hernioplasty

C. Mesh hernioplasty

D. Conservative management



See Answer in Part B → Q26

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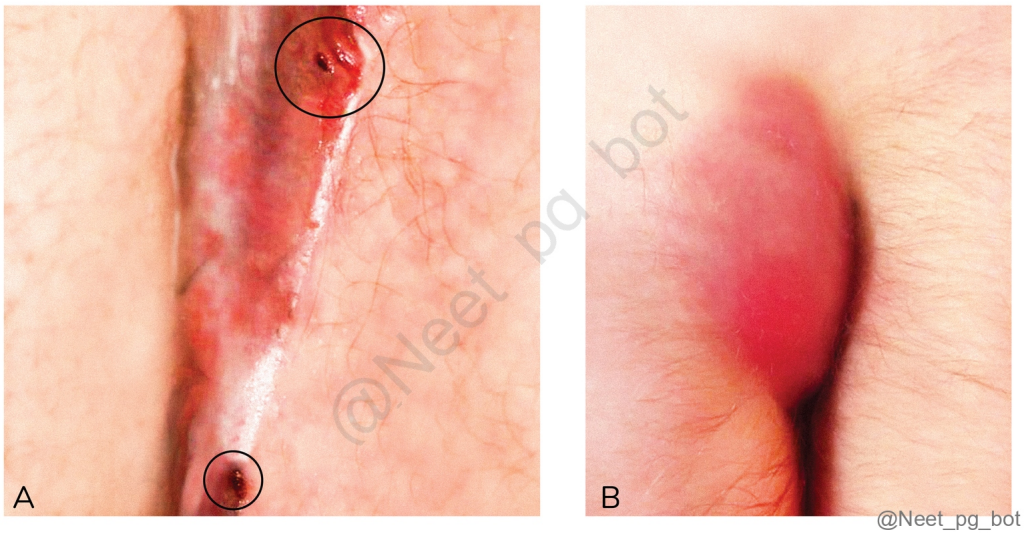
Q27: A jeep driver presented with pain in the gluteal region along with swelling. What is the most likely diagnosis? (Q844317)

A. Pilonidal sinus

B. Fistula in ano

C. Fissure in ano

D. Gluteal abscess



See Answer in Part B → Q27

@Neet_pg_bot

Q28: A patient presents to the outpatient department (OPD) with recurrent diarrhea, abdominal pain, and foul-smelling stools. Following finding was observed on colonoscopy. what is the diagnosis? (Q844298)

A. Pseudomembranous colitis

B. FAP

C. Ulcerative colitis

D. Acute gastritis



See Answer in Part B → Q28

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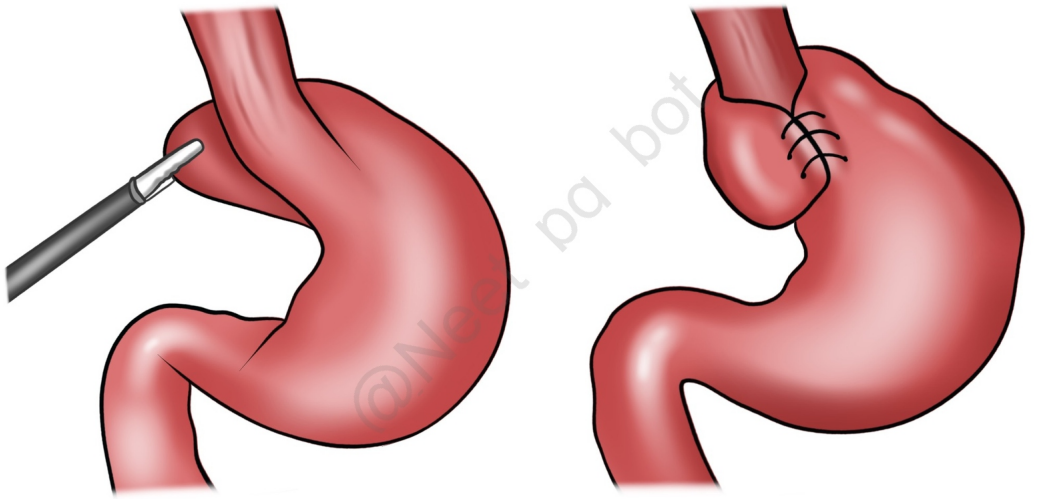
Q29: Identify the procedure commonly performed in patients with recurrent gastroesophageal reflux disease (GERD): (Q844301)

A. 360-degree Nissen fundoplication

B. Partial gastrectomy

C. Esophageal banding

D. 270-degree Nissen fundoplication



See Answer in Part B → Q29

@Neet_pg_bot

Q30: A child with recurrent vomiting undergoes an x-ray, as shown below. What is the most likely electrolyte imbalance in this patient? (Q860358)

A. Hypokalemia

B. Hyperkalemia

C. Hyponatremia

D. Hypernatremia



See Answer in Part B → Q30

@Neet_pg_bot

Q31: Which nerve is most commonly injured during indirect inguinal hernia surgery? (Q860378)

A. Femoral nerve

B. Genitofemoral nerve

C. Obturator nerve

D. Ilioinguinal nerve

See Answer in Part B → Q31

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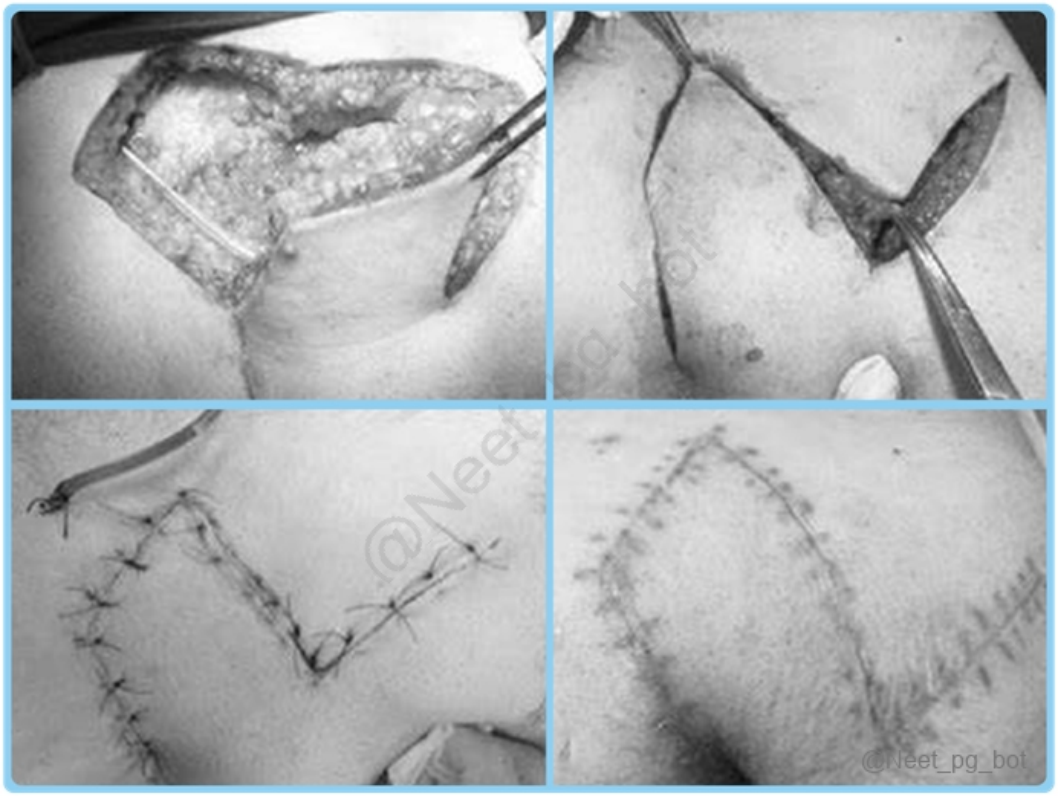
Q32: A patient underwent surgery for pilonidal sinus, which type of flap is used in this surgery? (Q860379)

A. Rhomboid flap

B. Advanced flap

C. Rotational flap

D. Free flap



See Answer in Part B → Q32

@Neet_pg_bot

Q33: Which incision is most commonly used for an appendectomy? (Q860386)

A. McBurney incision

B. Kocher's incision

C. Midline incision

D. Battle incision

See Answer in Part B → Q33

@Neet_pg_bot

Q34: A 54-year-old male with a history of multiple episodes of vomiting, binge drinking, and heavy meals presents to the emergency department with sudden onset of severe left-sided chest pain radiating to the left shoulder. Pneumoperitoneum is noted on X-ray. What is the most likely diagnosis? (Q860410)

A. Mediastinal air leak

B. Esophageal perforation

C. Pneumoperitoneum

D. Peptic ulcer

See Answer in Part B → Q34

@Neet_pg_bot

Q35: Which of the following is not an indication for splenectomy? (Q860413)

A. Iatrogenic splenic trauma

B. Thrombocytopenia

C. Hairy cell leukemia

D. Bone marrow failure

See Answer in Part B → Q35

@Neet_pg_bot

Q36: A 60-year-old male patient presents with a left groin swelling for a few years, which increases in size on standing and decreases when lying down. On examination, the swelling shows a positive cough impulse. What is the appropriate management?

(Q860416)

A. Incision and drainage

B. Herniotomy

C. Herniorrhaphy

D. Reduction of contents, repair defects and reinforcement with mesh

See Answer in Part B → Q36

@Neet_pg_bot

Q37: Which of the following structures does not form the boundary of Hesselbach's triangle? (Q860425)

A. Inferior epigastric artery

B. Vas deferens

C. Rectus abdominis

D. Inguinal ligament

See Answer in Part B → Q37

@Neet_pg_bot

Q38: What is the type of hernia in which the internal organ forms a portion of the wall of the hernia sac? (Q860428)

A. Lumbar hernia

B. Sliding hernia

C. Spigelian hernia

D. Richter hernia

See Answer in Part B → Q38

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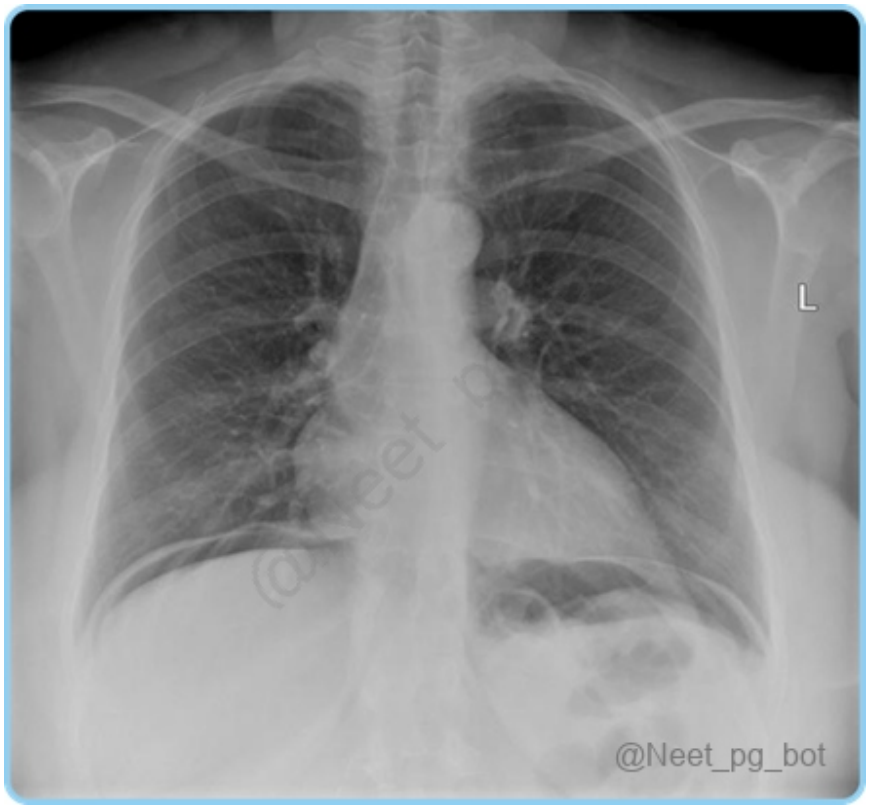
Q39: A 35-year-old male presents to the ER with complaints of epigastric pain for 1 day. On examination, his heart rate is 120/min, and blood pressure is 100/60 mmHg. There is tenderness, guarding, and rigidity on palpation. Based on the clinical presentation and the X-ray findings, what is the most likely cause of this patient's condition? (Q860453)

A. Acute cholecystitis

B. Hollow viscus perforation

C. Sigmoid volvulus

D. Small bowel obstruction



See Answer in Part B → Q39

@Neet_pg_bot

Q40: During laparoscopic surgery, while inserting the trocar, which of the following is most prone to injury? (Q860456)

A. Abdominal aorta

B. Superior epigastric artery

C. Both superior and inferior epigastric arteries

D. Inferior epigastric artery

See Answer in Part B → Q40

@Neet_pg_bot

Q41: A 40-year-old male presents with diffuse abdominal pain. Physical examination reveals rigidity and guarding. Abdominal X-ray shows air under the diaphragm. The patient is taken up for surgery, and an ileal perforation is noted intraoperatively with gross contamination of the abdomen with enteric and purulent content. What is the appropriate management of this patient? (Q860486)

A. Resection and anastomosis

B. Primary repair

C. Urgent surgical exploration with ileostomy

D. Omental patch closure

See Answer in Part B → Q41

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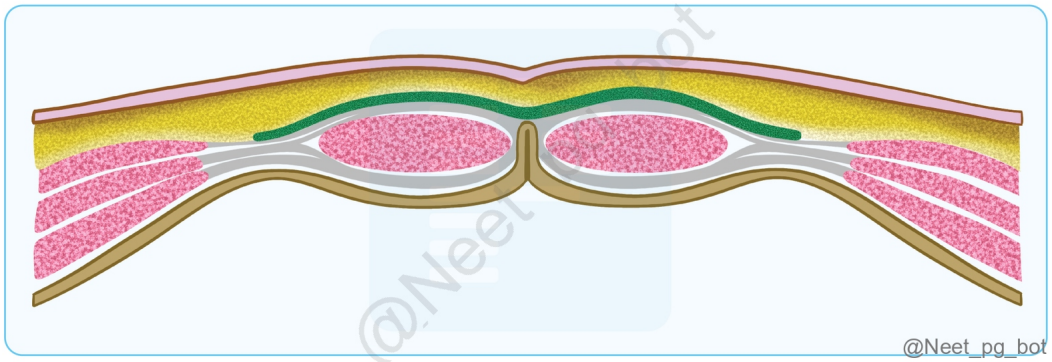
Q42: A 60-year-old female presents with a gradually progressive swelling over the abdomen for 1.5 years. She has a history of midline surgery. On examination, the swelling is 4 cm and is reducible with a palpable cough impulse. She is planning to undergo fascial closure with mesh repair. What is the most likely location of the mesh shown in the image? (Q860489)

A. Inlay

B. Sublay

C. Onlay

D. Intraperitoneal repair



See Answer in Part B → Q42

@Neet_pg_bot

Q43: Which of the following is the most common hernia in females? (Q840009)

A. Direct Inguinal hernia

B. Indirect inguinal hernia

C. Femoral hernia

D. Obturator hernia

See Answer in Part B → Q43

@Neet_pg_bot

Q44: A 45-year-old patient presents to the clinic with complaints of food regurgitation and weight loss over the past several months. A barium swallow test is performed. What is the diagnosis? (Q840035)

A. Achalasia cardia

B. Esophageal carcinoma

C. Zenker's diverticulum

D. Diffuse esophageal spasm



See Answer in Part B → Q44

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Q45: Which of the following are risk factors for cholangiocarcinoma? Hepatitis B PSC Caroli's disease Opisthorchis viverrini (Q840038)

A. 1, and 2 only

B. 2, 3, and 4 only

C. 4 only

D. 1, 2, 3, and 4

See Answer in Part B → Q45

@Neet_pg_bot

Q46: A 20-year-old chronic alcoholic presents with severe hematemesis. USG shows distention of the portal vein and the liver appears hyperechoic. Pantoprazole has been initiated. What is the next appropriate step in management? (Q840054)

A. Initiate a course of broad-spectrum antibiotics

B. Order a liver biopsy to assess for fibrosis

C. Administer intravenous fluids and electrolyte replacement

D. Perform an endoscopy to look for varices

See Answer in Part B → Q46

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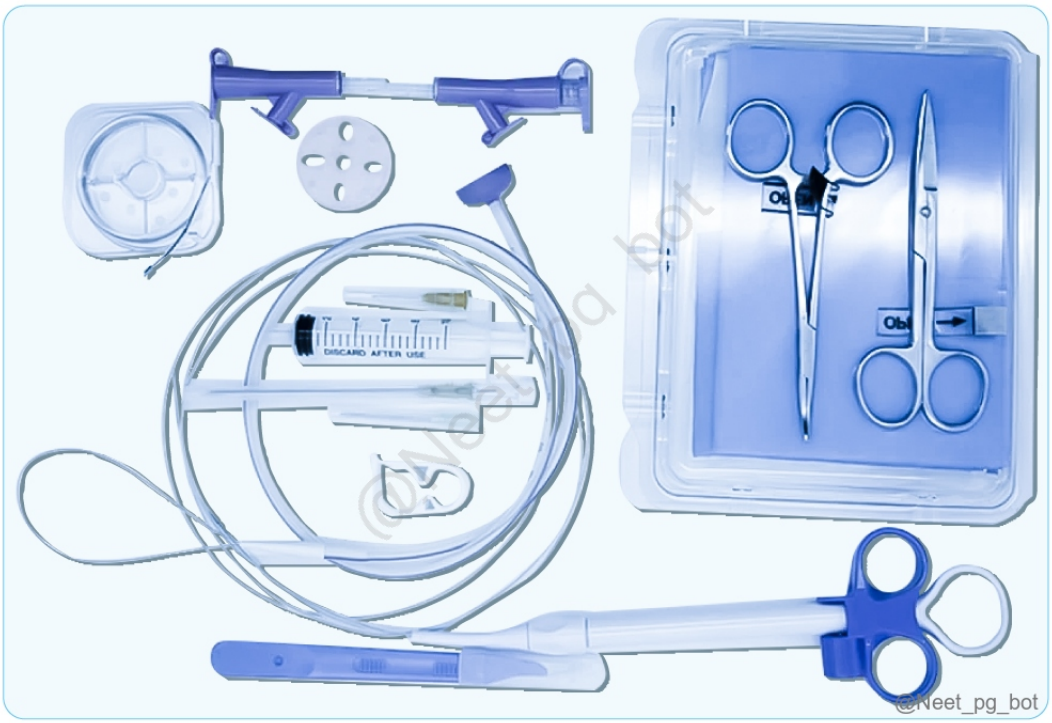
Q47: Identify the image given below? (Q840055)

A. PEG tube

B. Central line

C. Orogastric tube insertion

D. ICD



See Answer in Part B → Q47

@Neet_pg_bot

Q48: A 28-year-old pregnant woman presents with a history of decreased fetal movements and respiratory distress in her newborn. On examination, the neonate appeared cyanotic, with increased breathing work. Auscultation reveals bowel sounds in the left hemithorax. A chest x-ray is given in the image. Which of the following congenital anomalies is most likely responsible for these findings? (Q860177)

A. Congenital diaphragmatic hernia

B. Tetralogy of Fallot

C. Transposition of the Great Vessels

D. Tracheoesophageal fistula



See Answer in Part B → Q48

@Neet_pg_bot

Q49: During an endoscopy, a man is found to have the squamocolumnar junction located more proximally than normal. Which of the following conditions is most likely responsible for this finding? (Q860181)

A. Achalasia cardia

B. Sliding hernia

C. Rolling hernia

D. Gastroesophageal reflux disease

See Answer in Part B → Q49

@Neet_pg_bot

Q50: Which appendicular carcinoma is most commonly associated with pseudomyxoma peritonei? (Q860183)

A. Mucinous cystadenocarcinoma

B. Adenocarcinoma

C. Carcinoid tumour

D. Serous cystadenoma

See Answer in Part B → Q50

@Neet_pg_bot

Q51: Which of the following is the treatment of choice in a pregnant woman with an anal wart, as shown in the image given below? (Q860185)

A. Trichloroacetic acid application

B. Excision

C. Cryotherapy with liquid nitrogen

D. Oral acyclovir



See Answer in Part B → Q51

@Neet_pg_bot

Q52: A 70-year-old male patient who underwent gastrointestinal surgery one month ago, presents with a palpable abdominal bulge at the surgical site. Physical examination reveals a reducible 12 cm incisional hernia. What is the most appropriate next step in the management of this patient? (Q860195)

A. Schedule for laparoscopic mesh repair

B. Prescribe an abdominal belt for daily use

C. Advise observation and reassessment in six months

D. Laparoscopic closure without mesh

See Answer in Part B → Q52

@Neet_pg_bot

Q53: A neonate is diagnosed with gastroschisis. What is the most appropriate management strategy for this condition? (Q860202)

A. Surgical wall repair

B. Wait and watch

C. Slowly putting it inside

D. Surgical excision

See Answer in Part B → Q53

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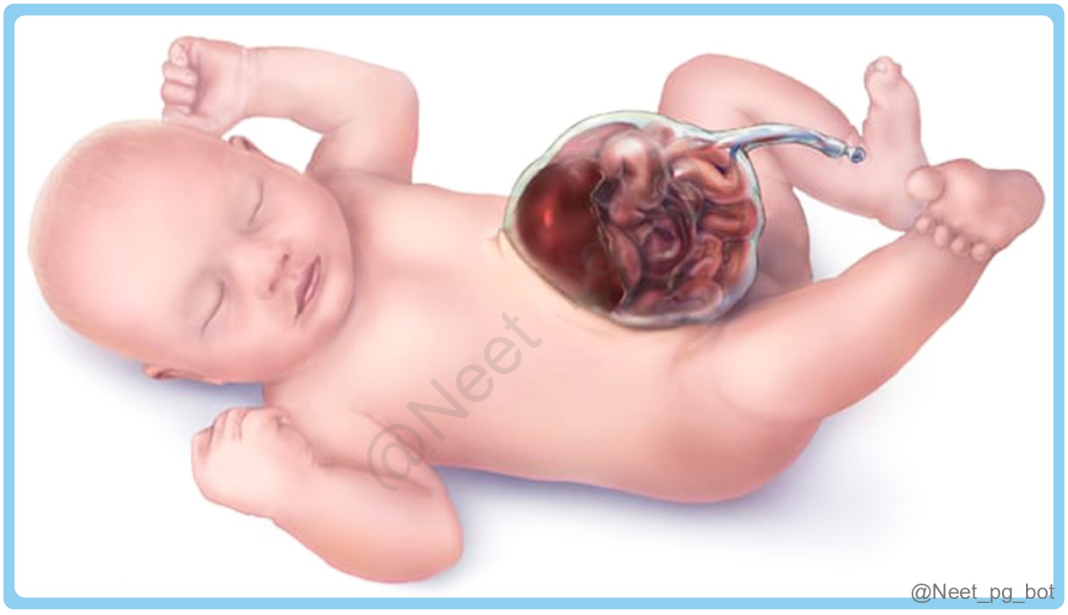
Q54: Identify the image: (Q860206)

A. Omphalocele

B. Urachal cyst

C. Umbilical hernia

D. Umbilical adenoma



See Answer in Part B → Q54

@Neet_pg_bot

Q55: In a seat belt injury, which of the following organs is most commonly affected? (Q860228)

A. Liver

B. Spleen

C. Pancreas

D. Hollow viscus

See Answer in Part B → Q55

@Neet_pg_bot

Q56: A young patient in the first decade of life presents with grade II splenic injury with no active bleeding. What is the management? (Q860297)

A. Splenectomy

B. Splenorrhaphy

C. Embolization

D. Conservative

See Answer in Part B → Q56

@Neet_pg_bot

Q57: What is the most likely diagnosis for an adult male patient with a history of intermittent purulent discharge with a slight blood tinge from an external opening located in the perianal region? (Q860300)

A. Hemorrhoids

B. Pilonidal sinus

C. Perianal abscess

D. Fistula in ano

See Answer in Part B → Q57

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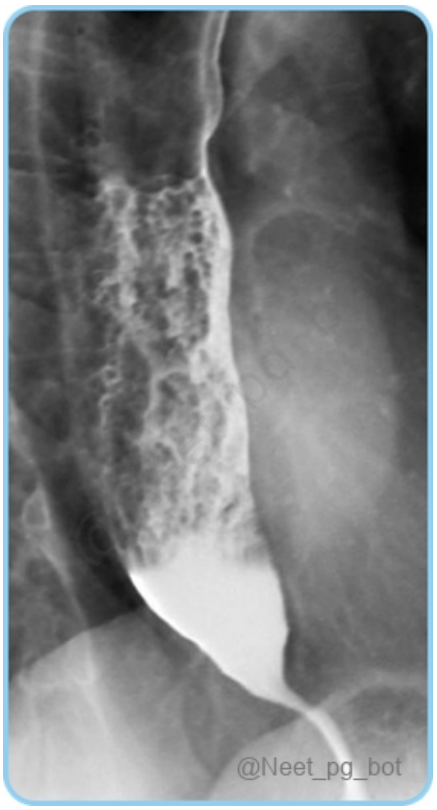
Q58: A barium swallow radiographic image of a woman with dysphagia is given below. What is the diagnosis? (Q860304)

A. Achalasia

B. Distal esophageal spasm

C. Jackhammer esophagus

D. None of the above



See Answer in Part B → Q58

@Neet_pg_bot

Q59: A patient underwent bronchoscopy, during the procedure a perforation occurred at 25 cm. Which structure is most likely to be damaged? (Q860306)

A. Diaphragm

B. Arch of aorta

C. Pharyngoesophageal junction

D. T10

See Answer in Part B → Q59

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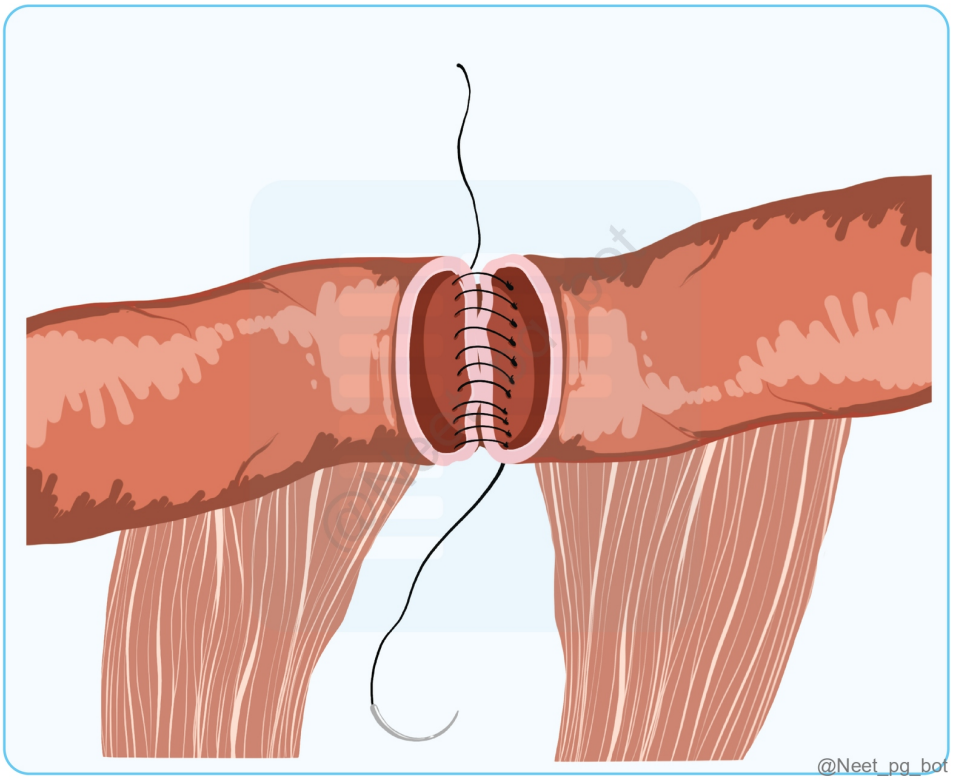
Q60: Identify the operative procedure shown in the image. (Q860308)

A. Primary closure of perforation

B. Resection and Anastomosis

C. Ileostomy

D. Resection alone



See Answer in Part B → Q60

@Neet_pg_bot

Q61: A young female presents with pain and vomiting in the ER. Clinical examination reveals a swelling lateral and below the pubic tubercle. X-ray shows intestinal obstruction. What is the most probable diagnosis? (Q857243)

A. Adhesions

B. Strangulated Inguinal Hernia

C. Strangulated Femoral Hernia

D. Appendicular mass

See Answer in Part B → Q61

@Neet_pg_bot

Q62: A 55-year-old male presents with complaints of dysphagia, halitosis, and regurgitation . Radiological imaging shows a blind pouch at the level of the pharynx. What is the likely diagnosis ? (Q820101)

A. Pulsion diverticula

B. Achalasia cardia

C. CA Esophagus

D. GERD

See Answer in Part B → Q62

@Neet_pg_bot

Q63: A 60-year-old man, a smoker, presented to the OPD with complaints of fatigue. He is known to be anemic and his sister had a history of endometrial cancer. The physician is considering appropriate colorectal cancer screening methods for this patient. Which screening method should be recommended for colorectal malignancy in this patient? (Q820105)

A. Barium enema

B. Colonoscopy every 10 years

C. Check for occult blood in stool

D. Flexible sigmoidoscopy yearly

See Answer in Part B → Q63

@Neet_pg_bot

Q64: What type of material is in the mesh used in Lichtenstein hernioplasty? (Q820106)

A. Polypropylene

B. Polyglactin

C. Polydioxanone

D. Polyacrilamide

See Answer in Part B → Q64

@Neet_pg_bot

Q65: A 20-year-old male presents with a 5-day history of abdominal pain, fever and vomiting . On examination, there is a palpable mass in right iliac fossa with leukocytosis . What is the management plan for this condition? (Q820127)

A. Ochsner-Sherren regime

B. Alvarado scoring

C. Laparoscopic appendectomy

D. Cholecystectomy

See Answer in Part B → Q65

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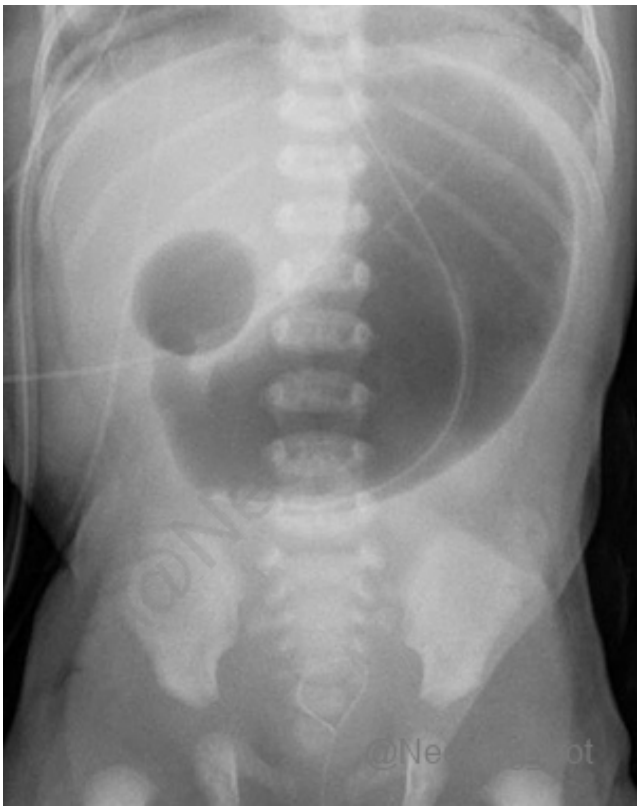
Q66: A newborn baby presents with bilious vomiting and abdominal distension within 2 days of birth . An X-ray abdomen was performed which is shown below. What is the most probable diagnosis? (Q820131)

A. Duodenal atresia

B. Pyloric stenosis

C. Esophageal atresia

D. Gas in bowel



See Answer in Part B → Q66

@Neet_pg_bot

Q67: A 70-year-old male patient presents with progressive dysphagia to solids and liquids and the manometry findings include uncoordinated or absent peristalsis with increased LES resting pressure . What is the most likely diagnosis for this patient? (Q820145)

A. Stomach cancer

B. Cancer esophagus

C. GERD

D. Achalasia cardia

See Answer in Part B → Q67

@Neet_pg_bot

Q68: A 45-year-old patient presents after undergoing a Billroth II gastrectomy operation and complains of symptoms suggestive of dumping syndrome , including vomiting and diarrhea occurring approximately 20 minutes after meals. What should be the initial management for this patient's condition? (Q820171)

A. Low fat diet

B. Small frequent meals

C. Insulin and protein

D. Reverse Billroth II to Billroth I

See Answer in Part B → Q68

@Neet_pg_bot

Q69: A 35-year-old patient is scheduled to undergo laparoscopic surgery. The surgical team plans to create a pneumoperitoneum to facilitate the procedure. Which gas is commonly used for creating the pneumoperitoneum in laparoscopic surgeries? (Q820240)

A. Helium

B. Oxygen

C. Nitrogen

D. Carbon dioxide

See Answer in Part B → Q69

@Neet_pg_bot

Q70: A male patient complains of loss of appetite and dysphagia, with a weight loss of approximately 6 kg over the last three months. He had a previous diagnosis of esophageal cancer and underwent treatment. What might be the cause of his current symptoms? (Q830818)

A. Esophageal cancer recurrence

B. Fibrosis

C. Achalasia cardia

D. GERD

See Answer in Part B → Q70

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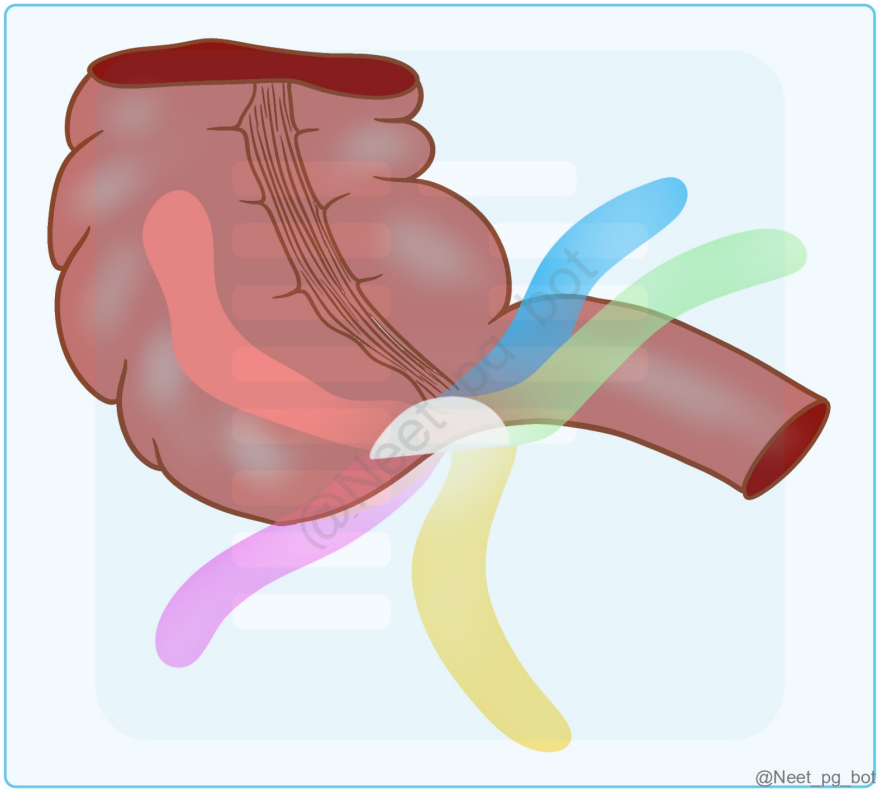
Q71: What is the position of the appendix marked in red colour? (Q854748)

A. Retrocecal

B. Preileal

C. Subcecal

D. Pelvic



See Answer in Part B → Q71

@Neet_pg_bot

Q72: A surgeon examines a case of hernia and is able to retract the hernial sac but not its contents. Based on this examination, which type of hernia is most likely? (Q854750)

A. Incarcerated hernia

B. Reduction en masse

C. Sliding hernia

D. Maydl's hernia

See Answer in Part B → Q72

@Neet_pg_bot

Q73: A 53-year-old patient presents with a complaint of per rectal bleeding. The surgeon suspects a possible colorectal pathology and wants to determine the most appropriate investigation for this patient. Which of the following options would be the best choice? (Q854758)

A. Colonoscopy

B. CEA levels

C. CA-19-9 levels

D. CECT

See Answer in Part B → Q73

@Neet_pg_bot

Q74: Which of the following is not a perineal approach for rectal prolapse? (Q854766)

A. Altemeir

B. Frykman and Goldberg's

C. Thiersch

D. Delorme

See Answer in Part B → Q74

@Neet_pg_bot

Q75: Which of the following is the most common complication following ligation of the first vessel during abdominoperineal resection for rectal carcinoma? (Q855169)

A. Parasympathetic - bladder dysfunction and retrograde ejaculation

B. Sympathetic - bladder dysfunction and impotence

C. Sympathetic - retrograde ejaculation and bladder dysfunction

D. Sympathetic - impotence and loss of cutaneous sensation in the perineal region

See Answer in Part B → Q75

@Neet_pg_bot

Q76: A 45-year-old male presents with right thigh pain after undergoing bilateral laparoscopic hernia repair for an inguinal hernia. Which nerve entrapment is most likely responsible for this symptom? (Q855178)

A. Ilioinguinal nerve

B. Iliohypogastric nerve

C. Femoral nerve

D. Lateral cutaneous nerve of thigh

See Answer in Part B → Q76

@Neet_pg_bot

Q77: A patient presents with swelling in the groin region, diagnosed as a direct inguinal hernia . Weakness in which of the following structures is most likely to cause this condition? (Q855239)

A. Pectineal ligament

B. Conjoint tendon

C. Reflected part of inguinal ligament

D. Lacunar ligament

See Answer in Part B → Q77

@Neet_pg_bot

Q78: A 4-year-old child presents with a rectal polyp and painless rectal bleeding. Histopathological examination reveals enlarged and inflamed glands filled with mucin. The child is diagnosed with a juvenile rectal polyp. Which of the following best describes the polyp in this case? (Q855247)

A. Adenoma

B. Choristoma

C. Hamartoma

D. Carcinoma

See Answer in Part B → Q78

@Neet_pg_bot

Q79: A 20-year-old female patient consumed a cleaning product containing 90% sodium hydroxide. She is having complete dysphagia. What is the best step in management? (Q855272)

A. Esophagojejunostomy

B. Stent placement

C. Feeding jejunostomy

D. Gastrojejunostomy

See Answer in Part B → Q79

@Neet_pg_bot

Q80: Which of the following is not true about Congenital Hypertrophic Pyloric Stenosis? (Q857791)

A. Presents with non-bilious vomiting

B. Caused by hypertrophy of longitudinal muscles

C. USG is the gold standard investigation for this condition

D. Hypokalemic metabolic alkalosis seen

See Answer in Part B → Q80

@Neet_pg_bot

Q81: Which of the following is the most common type of anorectal fistula? (Q857797)

A. Intersphincteric

B. Trans-sphincteric

C. Suprasphincteric

D. Extrasphincteric

See Answer in Part B → Q81

@Neet_pg_bot

Q82: During an endoscopy, when a constriction is detected at the esophageal junction approximately 25 cm from the incisor, what is the likely cause? (Q857827)

A. Inferior vena cava

B. Arch of aorta

C. Right bronchus

D. Diaphragmatic opening

See Answer in Part B → Q82

@Neet_pg_bot

Q83: A homosexual man presents with painful defecation and a protruding mass from the anal canal. Biopsy confirms squamous cell carcinoma of the anus. What is the appropriate course of action for managing this patient? (Q857833)

A. Chemotherapy

B. Abdominoperineal repair

C. Combined chemoradiation

D. Wide local excision

See Answer in Part B → Q83

@Neet_pg_bot

Q84: A man came with complaints of recurrent discharge and pain due to lesions around the anus for 3 years. A diagnosis of fistula-in-ano is made. What is the gold standard investigation for this condition? (Q857874)

A. Fistulography

B. USG

C. CECT

D. MRI

See Answer in Part B → Q84

@Neet_pg_bot

Q85: Which of the following procedures has the highest risk of causing the recurrence of duodenal ulcers? (Q857899)

A. Selective Vagotomy

B. Highly selective vagotomy

C. Truncal vagotomy

D. Truncal Vagotomy with Antrectomy

See Answer in Part B → Q85

@Neet_pg_bot

Q86: An elderly woman underwent surgical resection of her bowel; after a few months, she presents with easy fatigability and tiredness. Blood smear evaluation shows macrocytic anaemia. Resection of all of the following can cause this, except: (Q855654)

A. Jejunum

B. Duodenum

C. Ileum

D. Stomach

See Answer in Part B → Q86

@Neet_pg_bot

Q87: Which of the following statements regarding acute cholecystitis is false? (Q855683)

A. Gall bladder thickness >3 mm on USG

B. Murphy’s sign positive

C. Leukocytosis

D. Gold standard investigation is CT scan

See Answer in Part B → Q87

@Neet_pg_bot

Q88: Which of the following is not a perineal approach for the condition shown in the image? (Q855689)

A. Rip stein's procedure

B. Delorme’s operation

C. Thiersch operation

D. Altemeier’s procedure



See Answer in Part B → Q88

@Neet_pg_bot

Q89: A patient who had grade 3 splenic trauma was managed conservatively in the ICU. Which of the following signs on day 2 would indicate a need for surgery? (Q855694)

A. Hemoglobin falls from 12 mg/dL to 10 mg/dL

B. Extraperitoneal bladder rupture

C. Pneumoperitoneum

D. Air in gallbladder

See Answer in Part B → Q89

@Neet_pg_bot

Q90: A female patient was diagnosed with gastric cancer. On immunohistopathology, the biopsy sample was positive for CD117 and negative for LCA, cytokeratin, and S100. What is the diagnosis? LCA - Leucocyte common antigen GIST - Gastrointestinal stromal tumors SCC - Squamous cell carcinoma (Q855697)

A. GIST

B. Adenocarcinoma

C. Hodgkin’s lymphoma

D. SCC

See Answer in Part B → Q90

@Neet_pg_bot

Q91: A female patient is planned for cholecystectomy. Which of the following is not an advantage of laparoscopic surgery? (Q855698)

A. Lesser post-operative pain

B. Cosmetically better

C. Earlier return to normal physiological function

D. Longer duration of stay in hospital

See Answer in Part B → Q91

@Neet_pg_bot

Q92: Severe, intractable pain in advanced rectum cancers is due to: (Q855699)

A. Anterior infiltration in prostate

B. Anterior infiltration in the bladder

C. Posterior infiltration in sacral plexus

D. All of the above

See Answer in Part B → Q92

@Neet_pg_bot

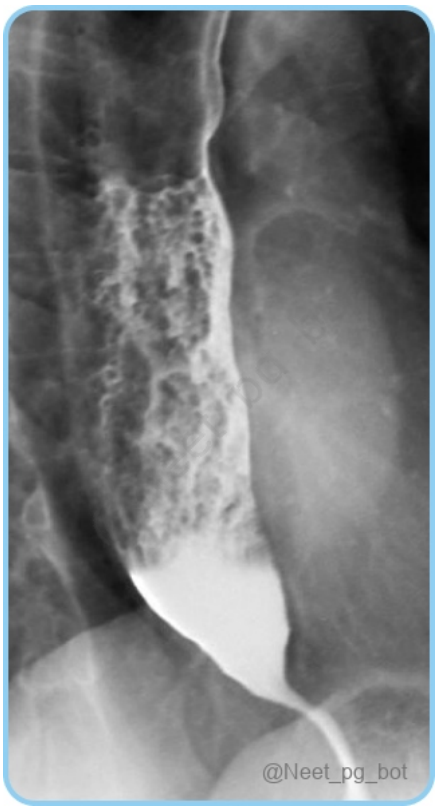
Q93: Which investigation is not necessary for the following condition? (Q855153)

A. Timed barium study

B. Endoscopy

C. Esophageal manometry

D. 24-hour pH monitoring



See Answer in Part B → Q93

@Neet_pg_bot

Q94: Which of the following causes maximum malnutrition? (Q855159)

A. Pancreatic fistula

B. Duodenal fistula

C. Distal ileal fistula

D. Colonic fistula

See Answer in Part B → Q94

@Neet_pg_bot

Q95: Which of the following nerves would be involved if a patient experiences a loss of sensations over the root of the penis after undergoing open hernia surgery? (Q855162)

A. Iliohypogastric nerve

B. Ilioinguinal nerve

C. Genitofemoral nerve

D. Medial cutaneous nerve to thigh

See Answer in Part B → Q95

@Neet_pg_bot

Q96: A 10-year-old child with hereditary spherocytosis and hypersplenism presents to the hospital. A splenectomy is planned for this child. All the following vaccines are recommended before splenectomy except? (Q855165)

A. Pneumococcal vaccine

B. Typhoid vaccine

C. Haemophilus influenza B vaccine

D. Meningococcal vaccine

See Answer in Part B → Q96

@Neet_pg_bot

Q97: Which of the following statements about psoas abscess are true? Fluctuant swelling in the hip Cold abscess can develop from Pott's abscess Pain on the passive extension of the hip joint is seen It develops more commonly through the hematogenous route in immunocompromised patients and elderly. (Q855170)

A. 1 and 2

B. 1, 3 and 4

C. 1, 2, 3 and 4

D. 2, 3 and 4

See Answer in Part B → Q97

@Neet_pg_bot

Q98: Which of the following would be the most commonly encountered ectopic tissue in Meckel’s diverticulum? (Q855203)

A. Gastric and pancreatic

B. Colonic and pancreatic

C. Gastric and colonic

D. Thyroid and lung

See Answer in Part B → Q98

@Neet_pg_bot

Q99: What is true about gall bladder carcinoma? (Q855210)

A. Palpable abdominal lump is the earliest sign

B. Earliest sign is jaundice

C. Gallstones and gallbladder cancer are easily distinguished clinically

D. Median survival is less than 6 months

See Answer in Part B → Q99

@Neet_pg_bot

Q100: A patient who had undergone appendectomy 2 days ago presents with severe abdominal pain. On exploration, there is a collection of blood in the abdomen. Which of the following arteries should have been ligated during surgery? (Q855212)

A. Ileocolic artery

B. Right colic artery

C. Superior rectal artery

D. Superior mesenteric artery

See Answer in Part B → Q100

@Neet_pg_bot

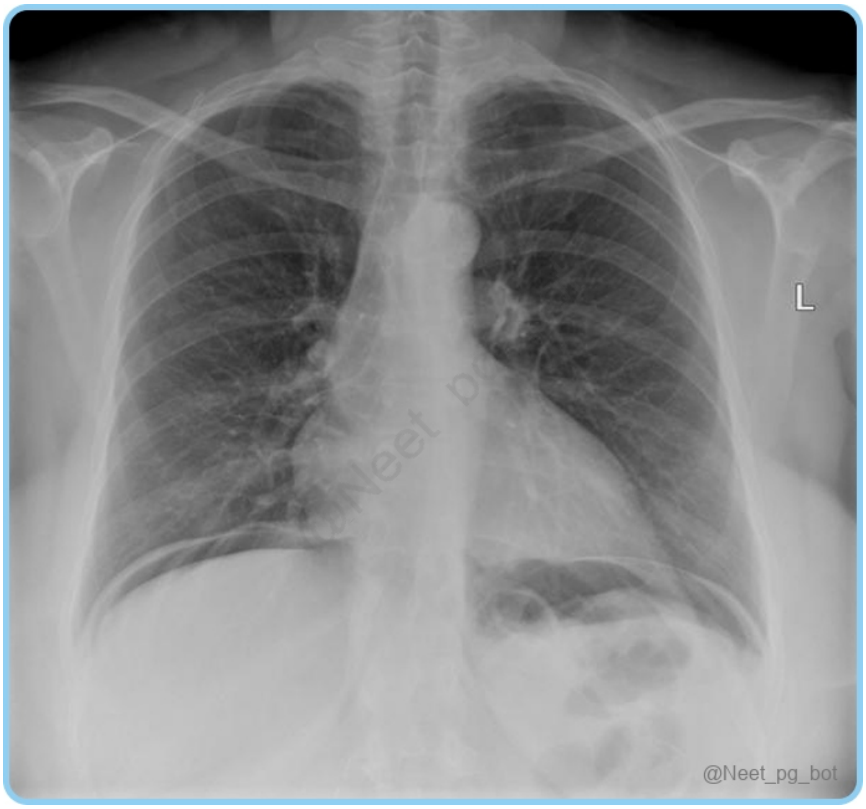
Q101: What should be the subsequent step in managing a 32-year-old male patient who comes to the surgical emergency department with a 2-day history of peptic ulcer disease, experiencing abdominal pain, bloating, and difficulty passing stools? IV fluids CECT abdomen Exploratory laparotomy Upper GI endoscopy Below is the provided X-ray film image (Q855215)

A. 1 and 2

B. 1 and 3

C. 1 and 4

D. 1, 2 and 3



See Answer in Part B → Q101

@Neet_pg_bot

Q102: Identify the correct statement regarding gastric carcinoma: It is mostly hereditary E-cadherin adhesion defect is seen in diffuse types of gastric CA. Wnt signaling pathway defect is seen in intestinal-type gastric CA. Depth of cancer has no role in prognosis. (Q855250)

A. A, C, D

B. B, C

C. B, C, D

D. A, D

See Answer in Part B → Q102

@Neet_pg_bot

Q103: A patient presented with large intra-abdominal fluid accumulation and was found to have pancreatic necrosis. Which of the following are included in the management of the condition? Antibiotics IV IV fluids Culture MRI Assisted drainage Laparotomy (Q855349)

A. 1, 2, 3, 4 and 5

B. 2, 4, 5 and 6

C. 1, 2, 3, 5 and 6

D. 1, 2, 3, 4, 5 and 6

See Answer in Part B → Q103

@Neet_pg_bot

Q104: What is the most prevalent condition that leads to the occurrence of heartburn and chest pain in a patient? (Q857174)

A. Barrett's esophagus

B. Pneumonia

C. Myocardial infarction

D. Esophagitis

See Answer in Part B → Q104

@Neet_pg_bot

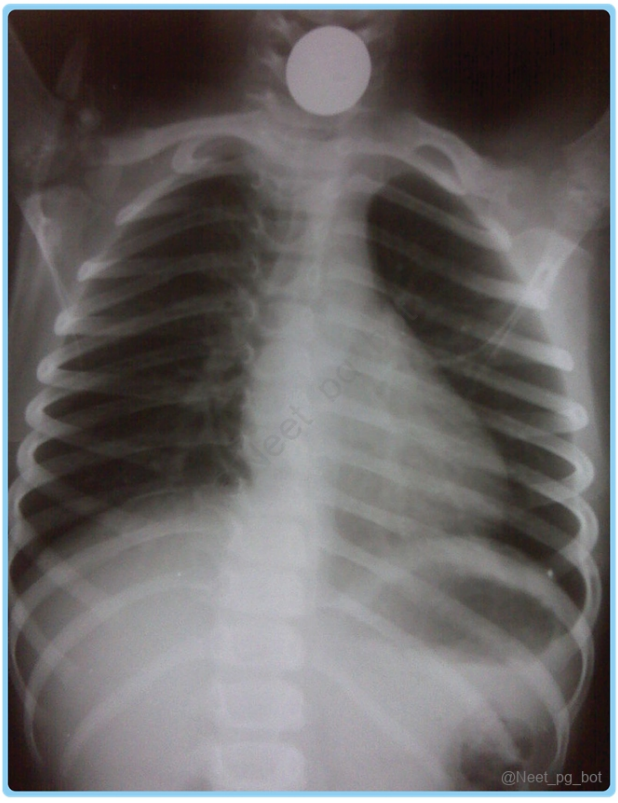
Q105: A baby playing unsupervised was brought with complaints of difficulty in swallowing for the last few hours. The x-ray image is given below. What is the diagnosis? (Q857178)

A. Foreign body in the trachea

B. Foreign body in the esophagus

C. Foreign body in lungs

D. Foreign body in pleura



See Answer in Part B → Q105

@Neet_pg_bot

Q106: What is the most appropriate next course of action in managing a male patient, aged 40, who presents with widespread abdominal pain and has a confirmed history of Crohn's disease, as well as rigidity and guarding observed during a physical examination, with ileal perforation being detected on imaging? (Q857216)

A. Antibiotics and NPO

B. Upper GI endoscopy

C. Urgent surgical exploration with ileostomy

D. CT abdomen

See Answer in Part B → Q106

@Neet_pg_bot

Q107: A 34-year-old male presented with a painless mass in the right inguinal region. On examination, there is a cough impulse on the index finger. The swelling reaches the scrotum and is reduced completely by pressing it through the deep inguinal ring with a gurgling sound. What is the likely diagnosis? (Q857238)

A. Femoral hernia

B. Direct inguinal hernia

C. Indirect inguinal hernia

D. Umbilical hernia

See Answer in Part B → Q107

@Neet_pg_bot

Q108: What is the likely diagnosis for a 40-year-old patient who has experienced the passage of mucus and blood in their stool, with inflammation predominantly observed in the rectum during sigmoidoscopy, and the presence of crypt abscess detected during biopsy? (Q857240)

A. Ulcerative colitis

B. Irritable bowel syndrome

C. Crohn disease

D. Pseudomembranous colitis

See Answer in Part B → Q108

@Neet_pg_bot

Q109: An elderly male patient presented with purulent discharge from an opening located in the perianal region. The patient is put in a lithotomy position, and the opening is located at the 11 o'clock position, 2 cm from the anal margin. What will be the likely position of the internal opening, and where does the internal opening start? (Q857258)

A. 12 o'clock and at the external anal sphincter

B. 11 o'clock and at the internal anal sphincter

C. 9 o'clock and at anal verge

D. 6 o'clock and crypt of the dentate line

See Answer in Part B → Q109

@Neet_pg_bot

Q110: What is the most probable outcome for the patient after undergoing gastrectomy? (Q857271)

A. Folic acid deficiency

B. Vitamin B12 deficiency

C. Gastric ulcer

D. Constipation

See Answer in Part B → Q110

@Neet_pg_bot

Q111: What is the diagnosis for a patient who exhibits symptoms of dysphagia, experiencing pain behind the breastbone, and regurgitation accompanied by coughing following meals? (Q857274)

A. Brown Patterson Kelly syndrome

B. Achalasia

C. Esophageal diverticula

D. Reflux esophagitis

See Answer in Part B → Q111

@Neet_pg_bot

Q112: In a patient with ascites visiting your clinic for diagnostic paracentesis, you opt for a midline approach to remove the fluid. Which of the following size needles is used during this procedure? (Q857276)

A. 14 gauge

B. 16 gauge

C. 17 gauge

D. 22 gauge

See Answer in Part B → Q112

@Neet_pg_bot

Q113: A patient presented with retrosternal chest pain radiating to the jaw and dysphagia. A barium swallow was performed, and the following image was shown. Which of the following is the most likely diagnosis? (Q857438)

A. Infectious esophagitis

B. Diffuse esophageal spasm

C. Barrette's esophagus

D. Esophageal stricture



See Answer in Part B → Q113

@Neet_pg_bot

Q114: The provided barium swallow indicates (Q857453)

A. Achalasia cardia

B. Diffuse esophageal spasm

C. Nutcracker oesophagus

D. Hypertensive lower esophageal sphincter



See Answer in Part B → Q114

@Neet_pg_bot

Q115: Which of the following conditions has a barium enema as shown in the picture below? (Q857454)

A. Multiple colonic polyps

B. Ulcerative colitis

C. Diverticulosis

D. Irritable bowel syndrome



See Answer in Part B → Q115

@Neet_pg_bot

Q116: A gross specimen of the colon obtained from a 14-year-old boy is shown below. Which of the following is the most likely diagnosis? (Q857499)

A. Crohn's disease

B. Familial adenomatous polyposis (FAP)

C. Lynch syndrome

D. Juvenile polyposis syndrome



See Answer in Part B → Q116

@Neet_pg_bot

Q117: During a routine check-up, an elderly male was discovered to have a rectal mass during a digital rectal examination, indicating the possibility of rectal carcinoma. Despite normal bowel habits, the next course of action for managing this patient should be: (Q857519)

A. CT scan of the abdomen

B. Rigid sigmoidoscopy and biopsy

C. Full colonoscopy and biopsy

D. Barium enema

See Answer in Part B → Q117

@Neet_pg_bot

Q118: A 30-year-old female presented with a low-grade fever of 1-week duration associated with loss of appetite and weight loss. Barium meal follow-through image of the patient is given below. What is the probable diagnosis? (Q857520)

A. Ileocaecal TB

B. Ulcerative colitis

C. Crohn's disease

D. Carcinoma caecum



See Answer in Part B → Q118

@Neet_pg_bot

Q119: A 35-year-old man arrives at the emergency department with a concern of vomiting blood. He mentions a recent pattern of excessive alcohol consumption. Upon examination, his vital signs are steady, and he has a pale appearance. There are no indications of ongoing bleeding. The results of his liver function tests are within the normal range. To further assess the situation, an upper gastrointestinal endoscopy is

scheduled. What is the most probable diagnosis? (Q857523)

A. Esophageal varices

B. Gastric ulcer

C. Mallory-Weiss tear

D. Alcoholic gastritis

See Answer in Part B → Q119

@Neet_pg_bot

Q120: Which of the following accurately represents Bormann's classification for gastric carcinoma? (Q857524)

A. Type I: Polypoid tumor with a small ulcerated component

B. Type II: Ulcerated tumor with infiltrative margins

C. Type III: Diffusely infiltrative tumor with linitis plastica appearance

D. Type IV: Mucinous carcinoma with extensive peritoneal metastases

See Answer in Part B → Q120

@Neet_pg_bot

Q121: A 60-year-old male presents to the emergency department with abdominal pain and vomiting. He reports a 2-day history of constipation and bloating. On examination, he appears uncomfortable, and his abdomen is distended with high-pitched bowel sounds. X-ray reveals dilated loops of the small bowel. What is the most likely cause of his symptoms? (Q857525)

A. Colonic malignancy

B. Small bowel obstruction

C. Acute pancreatitis

D. Gastric ulcer

See Answer in Part B → Q121

@Neet_pg_bot

Q122: Which of the following findings of colonoscopy is highly malignant? (Q857526)

A. Multiple flat polyps about 100

B. Single pedunculated polyp

C. Multiple pedunculated polyps

D. Solitary flat polyp

See Answer in Part B → Q122

@Neet_pg_bot

Q123: Which of the following statements accurately describes McBurney's point in cases of acute appendicitis? (Q857527)

A. McBurney point is located in the left lower quadrant of the abdomen.

B. McBurney point corresponds to the site of maximal tenderness in acute appendicitis.

C. McBurney point is used to assess rebound tenderness in acute appendicitis.

D. McBurney point is located at the umbilicus in acute appendicitis.

See Answer in Part B → Q123

@Neet_pg_bot

Q124: What is the likely diagnosis for a patient who has been experiencing fever and pain in the lower right abdomen for the past 5 days, with the presence of a tender mass in the right iliac fossa and an elevated leukocyte count? (Q857528)

A. Appendicitis

B. Hydronephrosis

C. Tuberculosis

D. Carcinoma colon

See Answer in Part B → Q124

@Neet_pg_bot

Q125: What is the diagnosis of a female patient who presents with a mass in the inguinal area that can be reduced from the deep inguinal ring accompanied by a gurgling sound? (Q857530)

A. Direct inguinal hernia

B. Indirect inguinal hernia

C. Femoral hernia

D. Pantaloon hernia

See Answer in Part B → Q125

@Neet_pg_bot

Q126: All of the following are true about Crohn’s disease except (Q857554)

A. Rectum is involved

B. Serpiginous ulcers are formed

C. Transmural involvement

D. Recurrence is more common

See Answer in Part B → Q126

@Neet_pg_bot

Q127: Which of the following statements are true about colon cancer? 1. Right and left colon cancers can behave differently 2. Colon cancers can be hereditary 3. Colon

cancer risk can be reduced by metformin 4. Colon cancers frequently metastasize to the liver (Q858355)

A. 1, 2 and 3 only

B. 2, 3 and 4 only

C. 2 and 4 only

D. 1, 2, 3 and 4

See Answer in Part B → Q127

@Neet_pg_bot

Q128: Nonclinical question: Match the following: 1. Hirschsprung's disease A. MRCP 2. Posterior urethral valve B. CT scan 3. Choledochal cyst C. Rectal biopsy 4. Intussusception D. Micturating cystourethrogram (Q856527)

A. 1-C, 2-D, 3-B, 4-A

B. 1-A, 2-D, 3-B, 4-C

C. 1-C, 2-D, 3-A, 4-B

D. 1-D, 2-C, 3-A, 4-B

See Answer in Part B → Q128

@Neet_pg_bot

Q129: Which of the following structures are incised by a surgeon during an appendectomy performed initially with a gridiron incision? 1. External oblique 2. Internal oblique 3. Transversus abdominis 4. Rectus abdominis (Q856574)

A. 1, 3, 4

B. 2, 3, 4

C. 1, 2, 3

D. 1, 2, 4

See Answer in Part B → Q129

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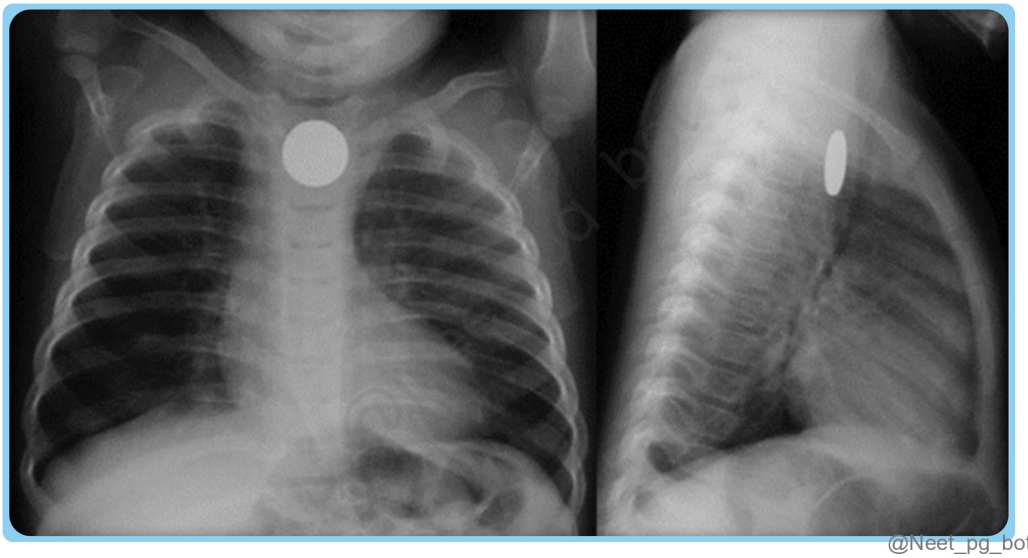
Q130: A baby playing unsupervised was brought with complaints of difficulty in swallowing for the last few hours. The x-ray image is given below. What is the diagnosis? (Q856208)

A. Foreign body in the trachea

B. Foreign body in the esophagus

C. Artifact

D. Soft tissue calcification in the neck



See Answer in Part B → Q130

@Neet_pg_bot

Q131: A patient was found to have a mass arising from the antrum of the stomach, which involves the head of the pancreas and metastasis to the right lobe of the liver. How will you manage this patient? (Q856238)

A. Palliative gastrojejunostomy followed by chemotherapy

B. Radical gastrectomy

C. Whipple's procedure

D. Gastrectomy with right hepatectomy

See Answer in Part B → Q131

@Neet_pg_bot

Q132: A patient presents with a hernia medial to the inferior epigastric artery. What is the most likely diagnosis and appropriate management for the same? (Q856248)

A. Direct hernia and Bassini repair

B. Direct hernia and Lichtenstein mesh repair

C. Indirect hernia and Bassini repair

D. Indirect hernia and Lichtenstein mesh repair

See Answer in Part B → Q132

@Neet_pg_bot

Q133: A patient with rectal prolapse underwent surgery. The postoperative image is given below. Identify the Procedure. (Q856252)

A. Stapled hemorrhoidopexy

B. Well’s procedure

C. Thiersch wiring

D. Altemeier repair



See Answer in Part B → Q133

@Neet_pg_bot

Q134: Which of the following statements regarding Peutz-Jeghers syndrome is correct? 1. Autosomal dominant disease 2. Defect in the STK11 gene 3. Melanin spots on digits and perianal skin 4. Autosomal recessive 5. Congenital hypertrophy of retinal pigment epithelium is seen (Q856731)

A. 2, 4 and 5

B. 1, 2 and 3

C. 1, 3 and 4

D. 2, 3 and 5

See Answer in Part B → Q134

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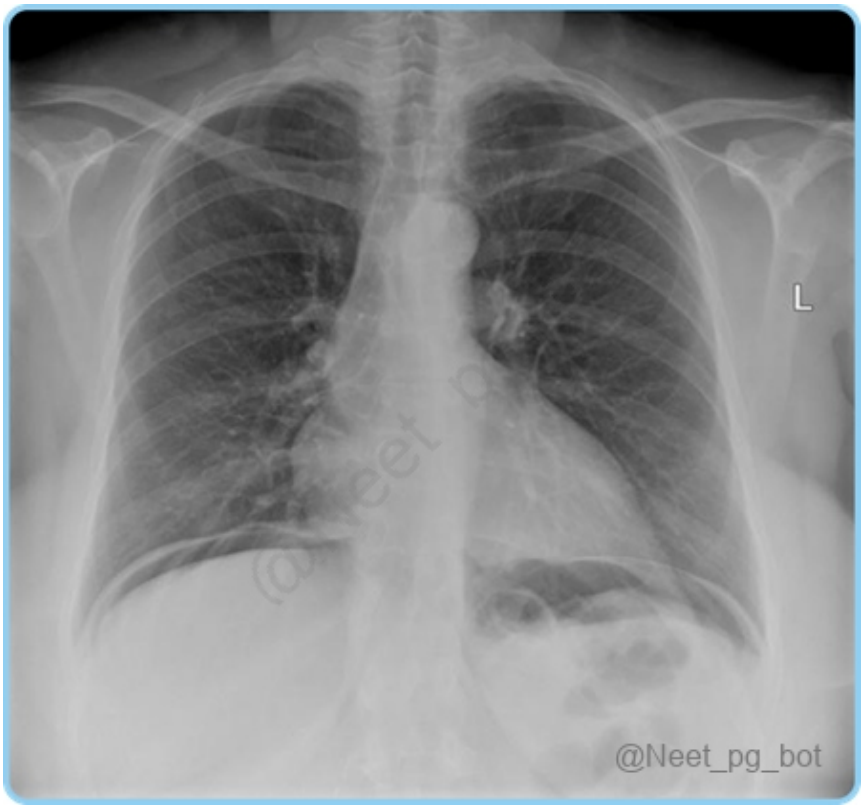
Q135: A 40-year-old man presents to the ER with severe abdominal pain. On examination, his HR is 110 bpm, BP-88/60 mmHg. Guarding is present on per abdomen examination. Erect abdominal X-ray is shown below. Which of the following would you proceed with for the management of this case? A. USG abdomen B. IV fluids C. Exploratory laparotomy D. Elective surgery E. Conservative management (Q856732)

A. B & C

B. B & D

C. A, B & C

D. A, B & E



See Answer in Part B → Q135

@Neet_pg_bot

Q136: Identify the following correctly. (Q856734)

A. CA bladder

B. Right inguinal hernia

C. Left inguinal hernia

D. None of the above



See Answer in Part B → Q136

@Neet_pg_bot

Q137: A man in his middle age arrives with a gradual onset of challenges while swallowing both solid and liquid substances over the course of 8 months. The results of a barium swallow test conducted are provided below. What additional examinations should be conducted for this individual? (Q856737)

A. Upper GI endoscopy & Manometry

B. Upper GI endoscopy & PET scan

C. Upper GI endoscopy & CECT

D. Upper GI endoscopy & 24-hour pH monitoring



See Answer in Part B → Q137

@Neet_pg_bot

Q138: A child is diagnosed with congenital hypertrophic pyloric stenosis. Which among the following can be seen in this child? A. Bilious vomiting B. Visible peristalsis from left to right C. Hypochloremia and hypokalemia D. Metabolic alkalosis (Q856748)

A. B, C and D

B. A and D only

C. A, B and D

D. A, B, C and D

See Answer in Part B → Q138

@Neet_pg_bot

Q139: Which of the following statements accurately describes the Tillaux sign? (Q856752)

A. Mass is felt in the periumbilical region

B. Mass is brilliantly transilluminate

C. Mass is mobile perpendicular to the mesentery attachment line

D. Fluctuation is positive

See Answer in Part B → Q139

@Neet_pg_bot

Q140: Which of the options accurately represents a valid statement concerning retroperitoneal trauma? (Q856775)

A. All zone 1 injury to be treated conservatively

B. Zone 3 injury, whether blunt or penetrative, should always be explored

C. Zone 2 injury with expanding hematoma should be treated surgically

D. Mattox maneuver is when the ascending colon is mobilized to the right to visualise the Aorta

See Answer in Part B → Q140

@Neet_pg_bot

Q141: Which of the following is the most appropriate mesh for use in hernioplasty? (Q856253)

A. Heavyweight with small pores

B. Heavyweight mesh with large pores

C. Lightweight mesh with small pores

D. Lightweight mesh with large pores

See Answer in Part B → Q141

@Neet_pg_bot

Q142: According to the European Hernia Society classification, M3 incisional hernia refers to: (Q856259)

A. Epigastric

B. Infraumbilical

C. Umbilical

D. Suprapubic

See Answer in Part B → Q142

@Neet_pg_bot

Q143: A 32-year-old male was diagnosed with achalasia cardia. High-resolution manometry revealed massive, simultaneous, high-pressure contractions of the distal oesophagus. According to the Chicago classification, which type of achalasia does the patient have? (Q855003)

A. Type II

B. Type I

C. Type IV

D. Type III

See Answer in Part B → Q143

@Neet_pg_bot

Q144: What is the likely diagnosis for a middle-aged man who comes to the emergency department with upper abdominal pain following a large meal? During clinical examination, there is tenderness in the upper abdomen, and a chest X-ray reveals a widening of the mediastinum and pneumomediastinum. (Q855009)

A. Spontaneous perforation of esophagus

B. Perforation of peptic ulcer

C. Foreign body in esophagus

D. Rupture of emphysematous bulla of the lung

See Answer in Part B → Q144

@Neet_pg_bot

Q145: What is the most frequently encountered neuroendocrine tumour in the pancreas? (Q855011)

A. Gastrinoma

B. Somatostatinoma

C. Insulinoma

D. VIPoma

See Answer in Part B → Q145

@Neet_pg_bot

Q146: What stage of Hinchey's classification is indicated when a patient with clinical features suggestive of peritonitis presents with diverticular perforation and faecal peritonitis during surgery? (Q855025)

A. Stage 1

B. Stage 2

C. Stage 3

D. Stage 4

See Answer in Part B → Q146

@Neet_pg_bot

Q147: In MEN 1 syndrome, where is the most frequent occurrence of gastrinoma observed? (Q855032)

A. Jejunum

B. Ileum

C. Duodenum

D. Stomach

See Answer in Part B → Q147

@Neet_pg_bot

Q148: What does the given barium swallow film show? (Q858476)

A. Aortic aneurysm

B. Pharyngeal pouch

C. Carotid body tumour

D. Esophageal carcinoma



See Answer in Part B → Q148

@Neet_pg_bot

Q149: A middle-aged man presents with a gradual onset of swallowing difficulties for both solid and liquid foods, persisting for 8 months. The barium swallow test results are presented below. The patient undergoes upper gastrointestinal endoscopy and manometry. Which of the following statements is not true regarding this condition? (Q859597)

A. Loss of lower esophageal sphincter pressure causing reflux

B. <75% relaxation of the lower esophageal sphincter

C. It is a primary motility disorder

D. Esophageal peristalsis is absent



See Answer in Part B → Q149

@Neet_pg_bot

Q150: What would be the subsequent course of action for managing a 35-year-old woman who has been experiencing swelling in her right groin for the past six months, as determined during her arrival at the emergency department? Upon examination, a reducible hernia is observed in the right groin without any signs of strangulation. (Q859599)

A. Exploratory laparotomy

B. Reduce the swelling and later observe

C. Reduce the swelling and do elective surgery

D. Do a CT abdomen

See Answer in Part B → Q150

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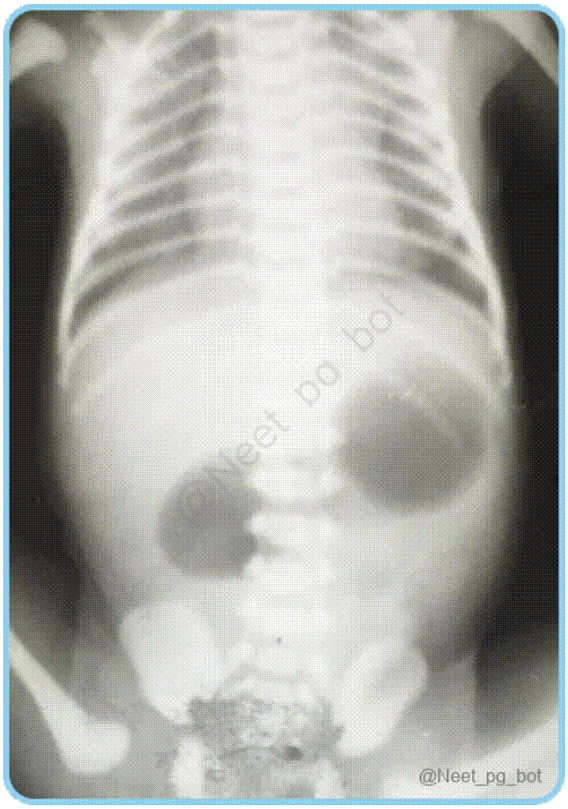
Q151: The likely diagnosis for a newborn infant presenting with signs of intestinal obstruction, as indicated by the x-ray image and CT abdomen showing an annular pancreas, is: (Q859607)

A. Jejunoileal atresia

B. Esophageal atresia

C. Duodenal atresia

D. Colonic atresia



See Answer in Part B → Q151

@Neet_pg_bot

Q152: A patient who underwent Nissen's fundoplication was seen in the ward during evening rounds. He is asymptomatic at present and has stable vitals. What is the next line of management for this patient? (Q859609)

A. Nasogastric tube to prevent gas bloat syndrome

B. Insert chest tube to prevent pneumothorax

C. Monitor vitals

D. Imaging to rule out perforation

See Answer in Part B → Q152

@Neet_pg_bot

Q153: Which of the following do not require instruments to examine? (Q859610)

A. Acute anal fissure

B. Carcinoma rectum

C. Hemorrhoids

D. Rectal polyp

See Answer in Part B → Q153

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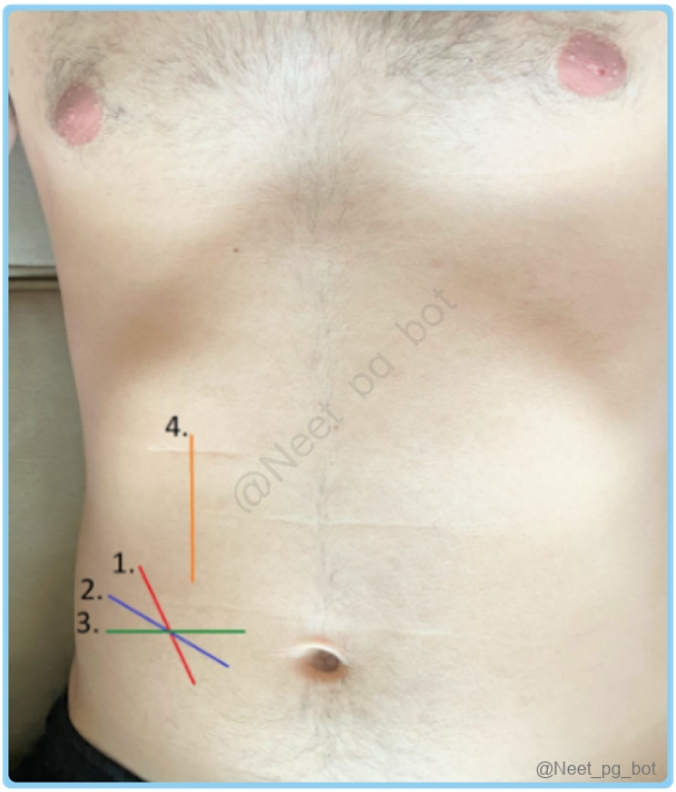
Q154: Identify the incision marked as 4. (Q859611)

A. Gridiron incision

B. Lanz incision

C. Rutherford - Morison incision

D. Paramedian incision



See Answer in Part B → Q154

@Neet_pg_bot

Q155: Which of the following statements about carcinoid tumours in the appendix is false? (Q859612)

A. Size appears to be the best predictor of malignant behaviour and metastatic potential

B. Arise from Kulchitsky cells of the crypts of Leiberkuhn

C. Most common location is the base of the appendix

D. Most common tumor of the appendix

See Answer in Part B → Q155

@Neet_pg_bot

Q156: The most common type of gastric sarcoma: (Q859623)

A. GIST

B. Liposarcoma

C. Leiomyosarcoma

D. Epithelioid sarcoma

See Answer in Part B → Q156

@Neet_pg_bot

Q157: What structures are contained within the anterior pararenal space? Head, neck, and body of the pancreas Adrenal gland, kidney, ureters Aorta, inferior vena cava Ascending and descending colon (Q859825)

A. 1,4

B. 3,4

C. 2,3

D. 1,2

See Answer in Part B → Q157

@Neet_pg_bot

Q158: What electrolyte imbalance is commonly observed in patients with this postoperative condition, as depicted in the provided x-ray? (Q859829)

A. Hypocalcemia

B. Hypokalemia

C. Hyperkalemia

D. Hypercalcemia



See Answer in Part B → Q158

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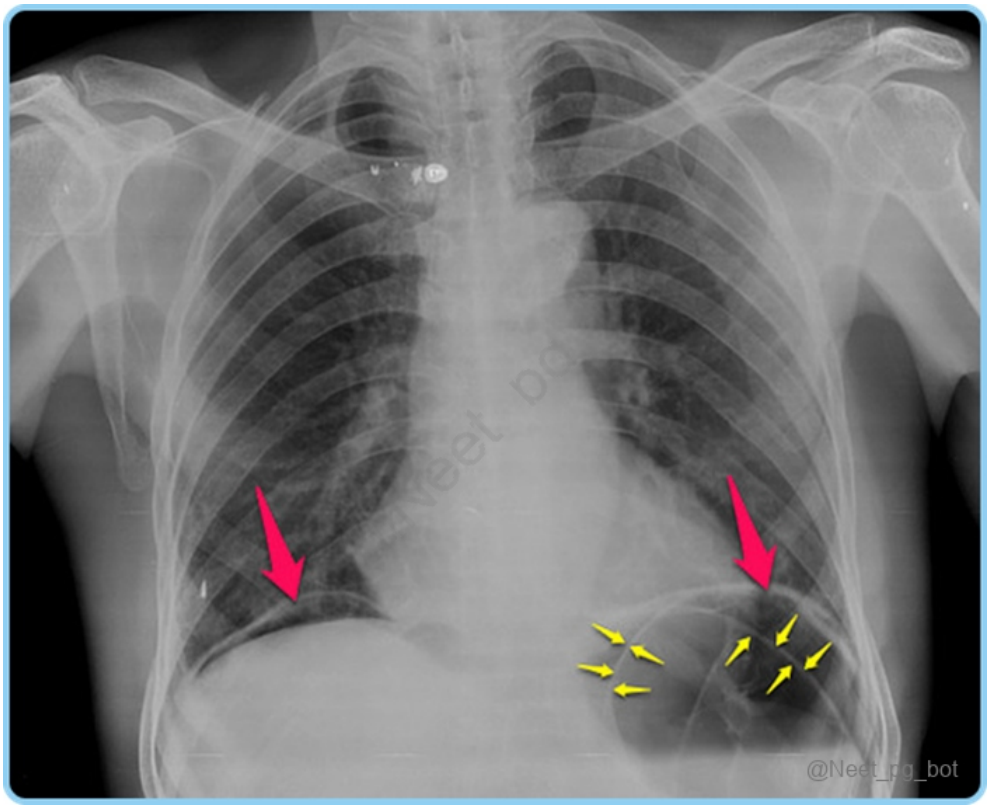
Q159: A 40-year-old male presents with diffuse abdominal pain. He has a past history of peptic ulcer disease. Physical examination reveals rigidity. An X-ray of the abdomen is shown below. What is the next best step in the management of this patient? (Q859831)

A. Antibiotics and NPO (nothing by mouth)

B. Upper GI endoscopy

C. Urgent surgical exploration

D. CT abdomen



See Answer in Part B → Q159

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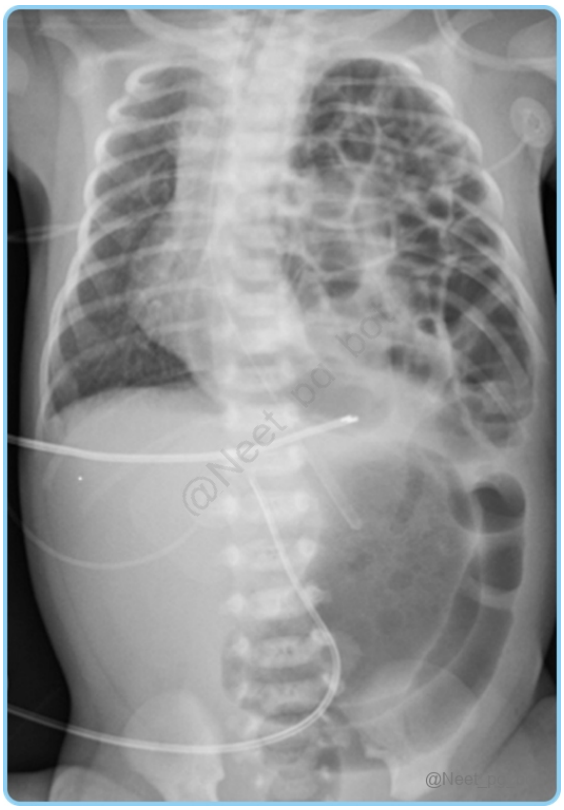
Q160: A neonate presented with mild intermittent upper abdominal pain. On examination, the infant has a scaphoid abdomen and breath sounds are decreased on both sides. The X-ray is given below. What is the diagnosis? (Q859848)

A. Bochdalek hernia

B. Pneumonia

C. Gastric volvulus

D. Eventration of diaphragm



See Answer in Part B → Q160

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Q161: What is the diagnosis of a neonate who is brought to the hospital with complaints of forceful vomiting that is not accompanied by bile after feeding? The child appears lethargic and dehydrated, and abdominal examination shows visible movements of the stomach. A barium meal was conducted, and the image provided is shown below. (Q859853)

A. Hirschsprung’s disease

B. Congenital hypertrophic pyloric stenosis

C. Jejunal atresia

D. Duodenal atresia



See Answer in Part B → Q161

@Neet_pg_bot

Q162: What is the probable diagnosis for a 5-year-old child with abdominal swelling, mild discomfort, no pain or vomiting, and a fluctuant soft swelling that moves freely in a plane perpendicular to the mesentery attachment, as seen in the outpatient department? (Q859866)

A. Peritoneal cyst

B. Lipoma

C. Chylolymphatic cyst

D. Pseudocyst

See Answer in Part B → Q162

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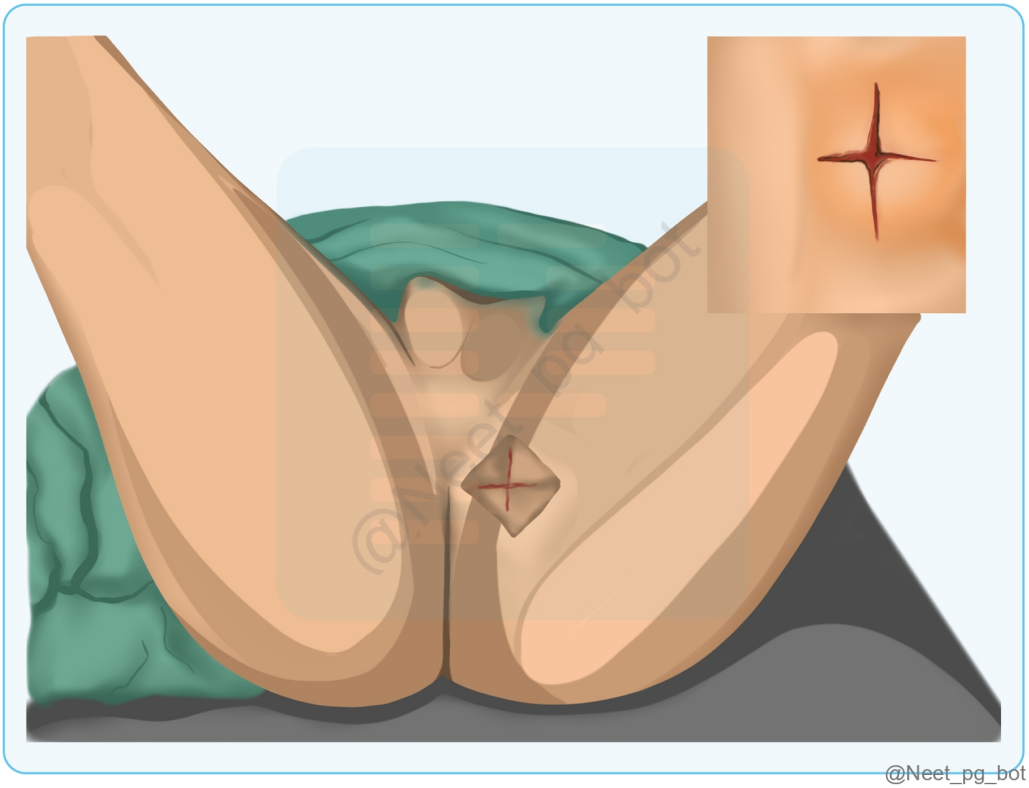
Q163: The image below shows an image of the anus. What is the most likely diagnosis, and it occurs when one of your anus glands becomes clogged and infected? Pus and fluid accumulate in the anal gland, resulting in an excruciatingly painful abscess around your anus? (Q859870)

A. Hemorrhoids

B. Pelvirectal abscess

C. Perianal abscess

D. Pilonidal sinus



See Answer in Part B → Q163

@Neet_pg_bot

Q164: Which of the following is the most probable diagnosis for a 38-year-old male patient who visited the surgery OPD with a history of occasional discharge of pus with a slight presence of blood from an external opening in the perianal region, despite multiple attempts at drainage? The examination of the perianal region is depicted

below. (Q859872)

A. Pilonidal sinus

B. Perianal abscess

C. Hemorrhoids

D. Fistula-in-ano



See Answer in Part B → Q164

@Neet_pg_bot

Q165: An infant of 12 weeks presented with the following defect in the umbilical area. Identify the condition. (Q859875)

A. Omphalocele

B. Gastroschisis

C. Umbilical hernia

D. Paraumbilical hernia



See Answer in Part B → Q165

@Neet_pg_bot

Q166: A patient, after heavy drinking of alcohol presents with multiple episodes of vomiting and hematemesis. The most likely diagnosis is: (Q859898)

A. Mallory-Weiss syndrome

B. Esophageal carcinoma

C. Achalasia cardia

D. Boerhaave's syndrome

See Answer in Part B → Q166

@Neet_pg_bot

Q167: The treatment of choice for inguinal hernia in infants is: (Q859899)

A. Herniotomy

B. Herniorrhaphy

C. TRUSS

D. Hernioplasty

See Answer in Part B → Q167

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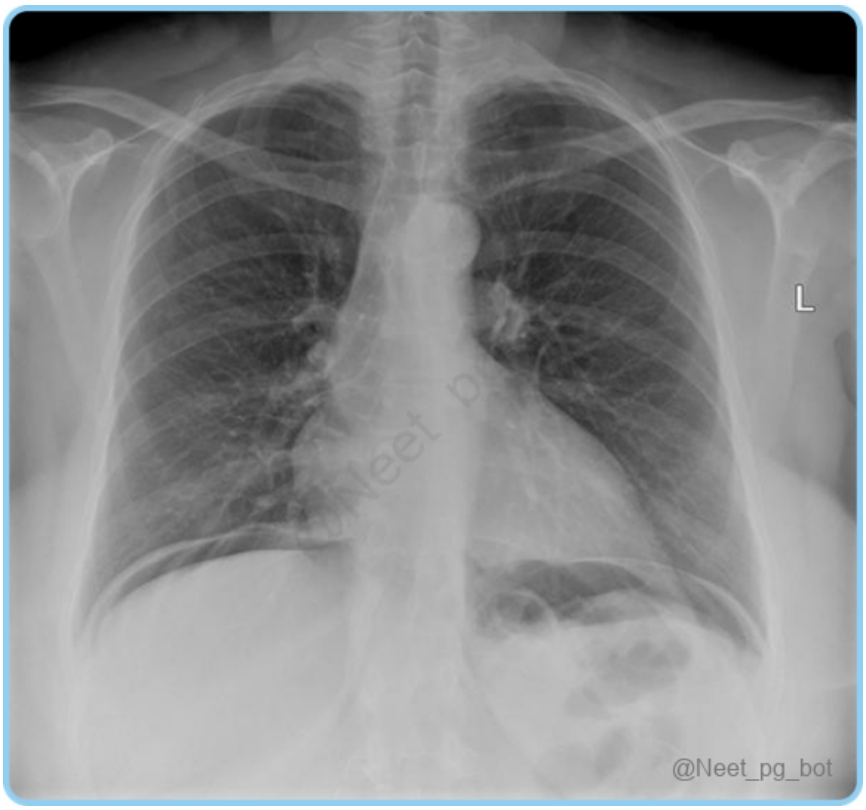
Q168: A patient presents with acute-onset, severe abdominal pain. He is hemodynamically stable. A chest X-ray is shown below. What is the next step in management? (Q855778)

A. Gastric lavage

B. Chest tube insertion

C. Tracheostomy

D. Resuscitation and laparotomy



See Answer in Part B → Q168

@Neet_pg_bot

Q169: A 1.5-month-old male infant presents to the outpatient department with vomiting after feeding and failure to thrive . On examination, a firm, olive-shaped mass is palpated in the upper abdomen . What is the most likely diagnosis? (Q852714)

A. Subacute Intestinal Obstruction

B. Pyloric Stenosis

C. GERD

D. Esophageal Atresia

See Answer in Part B → Q169

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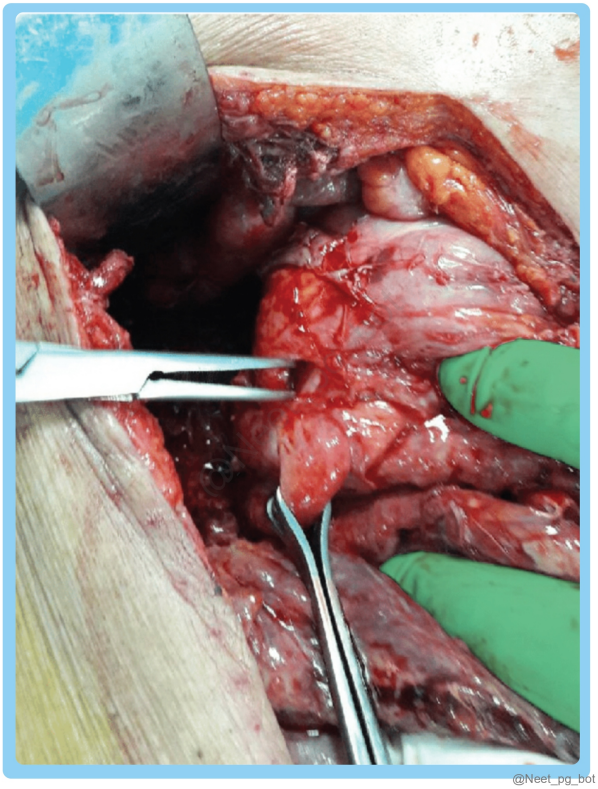
Q170: An alcoholic male patient diagnosed with hollow viscus perforation is taken up for laparotomy. Intraoperatively, a 2 cm perforation is seen in the duodenal region, as shown below. How can this patient be managed? (Q860458)

A. Primary closure of the defect

B. Omental pedicle repair

C. Billroth I

D. Billroth II



See Answer in Part B → Q170

@Neet_pg_bot

Q171: Which of the following is/are complications associated with GERD? Asthma Laryngitis Pulmonary Fibrosis Chronic cough (Q839982)

A. 1,2

B. 1,2,4

C. 1,2,3

D. 1,2,3,4

See Answer in Part B → Q171

@Neet_pg_bot

Q172: Which of the following is not a layer of esophagus? (Q820123)

A. Mucosa

B. Submucosa

C. Serosa

D. Muscularis

See Answer in Part B → Q172

@Neet_pg_bot

Q173: Which of the following gene mutations are involved in carcinoma of the colon? (Q856243)

A. APC, BRCA, k-ras

B. APC, k-ras, p53

C. MYh, K-RAS, APC

D. MYH, p53, DCC

See Answer in Part B → Q173

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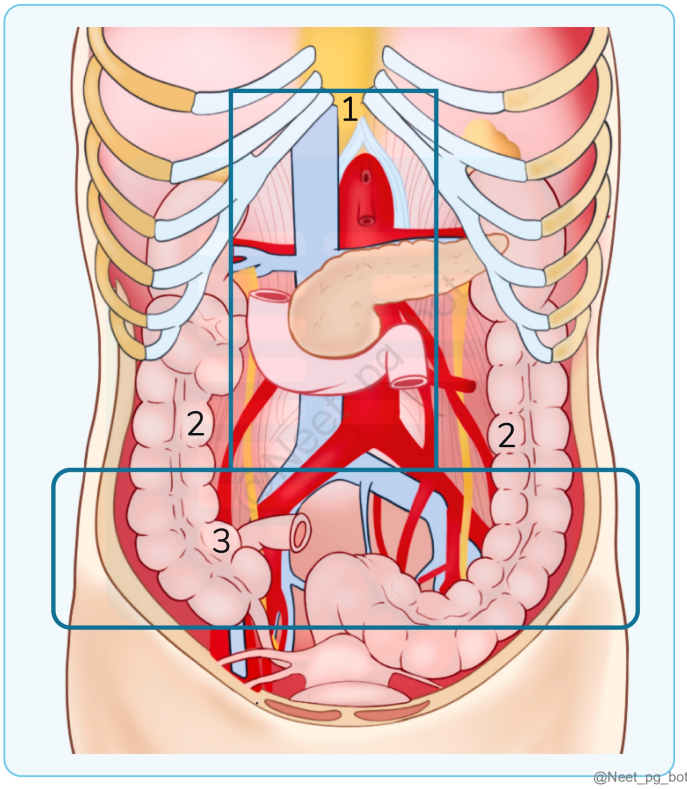
Q174: Mandatory exploration is required in the injuries. Which zones of retroperitoneum are required? (Q859819)

A. 1

B. 2

C. 3

D. 1 & 3



See Answer in Part B → Q174

@Neet_pg_bot

Q175: A 45-year-old man complained of recurrent discharge and pain due to lesions around the anus for 3 years. What is the diagnosis? (Q855580)

A. Pilonidal sinus

B. Carbuncle

C. Boil

D. Fistula in ano



See Answer in Part B → Q175

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Q176: A 35-year-old man with a history of ulcerative colitis presents with fatigue and pruritus. Laboratory investigations show a cholestatic liver function test pattern. MRCP reveals multifocal strictures and beading of intrahepatic and extrahepatic bile ducts. Liver biopsy demonstrates concentric "onion-skin" fibrosis around bile ducts. What is the most likely diagnosis? (Q879028)

A. Primary biliary cholangitis

B. Primary sclerosing cholangitis

C. Autoimmune hepatitis

D. Secondary biliary cirrhosis

See Answer in Part B → Q176

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Q177: The angle between two working ports in laparoscopic surgery? (Q879104)

A. Azimuth angle

B. Elevation angle

C. Manipulation angle

D. Extreme angle

See Answer in Part B → Q177

@Neet_pg_bot

Q178: All of the following statements about stomas are true except? (Q879107)

A. Patients with a colostomy are at a higher risk of fluid and electrolyte imbalance

B. Ileostomy stoma is spouted

C. Temporary stomas are fashioned as a loop

D. Colostomy stoma is everted and flushed

See Answer in Part B → Q178

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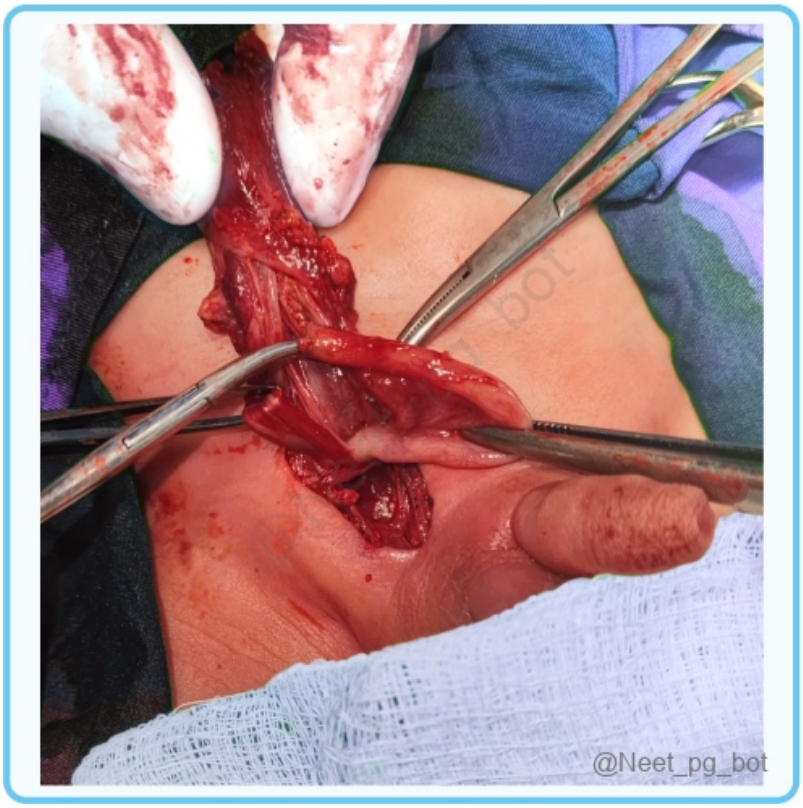
Q179: During surgery for an inguinal hernia, the appendix is found inside the hernia sac. What type of hernia is this? (Q879118)

A. Litter’s hernia

B. Amyand’s hernia

C. Gibbons hernia

D. Richter’s hernia



See Answer in Part B → Q179

@Neet_pg_bot

Q180: A patient with recurrent history of gastric ulcers presented with severe pain abdomen on evaluation a small mass is found on the anterior wall of duodenum. Which investigation will help in the diagnosis? (Q879137)

A. Insulin levels

B. Gastrin level

C. Urea breath test

D. 24 hr PH monitoring

See Answer in Part B → Q180

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Q181: Arrange the steps of hernioplasty: 1. Skin incision 2. Identify the sac and reduce the content 3. Place the mesh 4. Close the wound (Q879145)

A. 1 → 2 → 3 → 4

B. 1 → 3 → 2 → 4

C. 2 → 1 → 3 → 4

D. 1 → 2 → 4 → 3

See Answer in Part B → Q181

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Q182: A 20-year-old male presents with pain in the right iliac fossa for 4 days, associated with fever and vomiting. On examination, a tender, palpable mass is felt in the right iliac fossa. He is diagnosed with an appendicular lump. Which of the following statements is incorrect regarding this condition? (Q879226)

A. Ochsner– Sherren regimen is the initial treatment

B. Ultrasonography is useful in evaluation

C. Interval appendectomy is mandatory in all cases

D. Appendicular lump is a complication of acute appendicitis

See Answer in Part B → Q182

@Neet_pg_bot

Q183: What type of hernia is a funicular hernia ? (Q32236)

A. Direct inguinal hernia

B. Indirect inguinal hernia

C. Femoral hernia

D. Umbilical hernia

See Answer in Part B → Q183

@Neet_pg_bot

Q184: Which of the following is the most common type of anorectal fistula ? (Q513252)

A. Intersphincteric

B. Trans-sphincteric

C. Suprasphincteric

D. Extrasphincteric

See Answer in Part B → Q184

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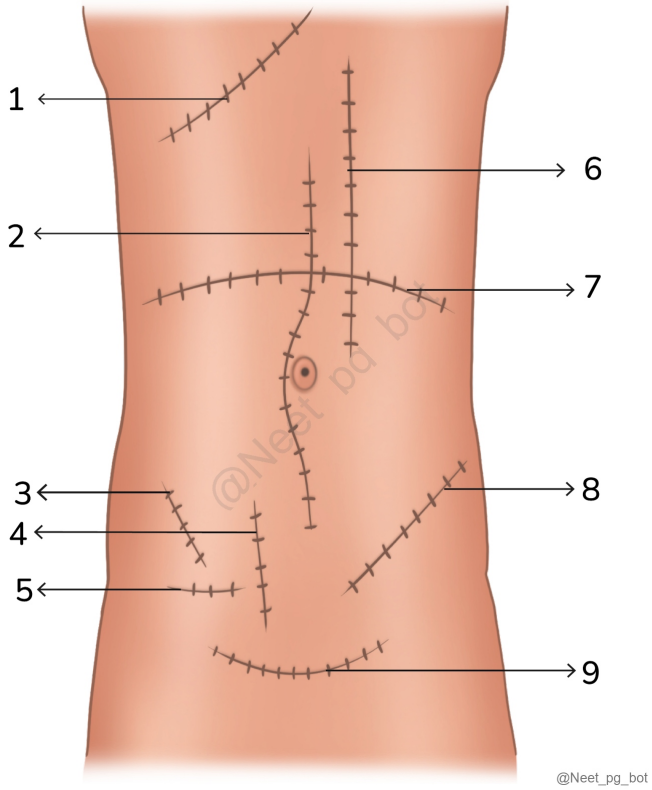
Q185: A 23-year-old male had acute appendicitis 3 days ago and presented to the surgery department with abdominal pain and tenderness . Which of the following incisions would be appropriate for this condition? (Q793366)

A. 1

B. 2

C. 3

D. 5



See Answer in Part B → Q185

@Neet_pg_bot

Q186: A 45-year-old alcoholic with a history of binge drinking presents with an episode of vomiting bright red blood . His vitals are stable. An endoscopy was performed, an image of which is given below; what is the probable diagnosis here? (Q793397)

A. Tension pneumothorax

B. Boerhaave syndrome

C. Mallory Weiss Tear

D. Gastric ulcer perforation



See Answer in Part B → Q186

@Neet_pg_bot

Q187: What is the most probable cause of massive, sudden onset hematemesis in a 50-year-old patient with a history of chronic liver disease and chronic alcoholism, who has arrived at the emergency department? (Q793399)

A. Mallory Weiss tear

B. Bleeding esophageal varices

C. Boerhaave's syndrome

D. Perforated ulcer

See Answer in Part B → Q187

@Neet_pg_bot

Q188: A 3-day old neonat e presents abdominal distension and bilious vomiting . Among the following, which is the most appropriate investigation to diagnose the condition? (Q793487)

A. Barium swallow

B. Barium meal

C. Barium meal follow through

D. CECT abdomen

See Answer in Part B → Q188

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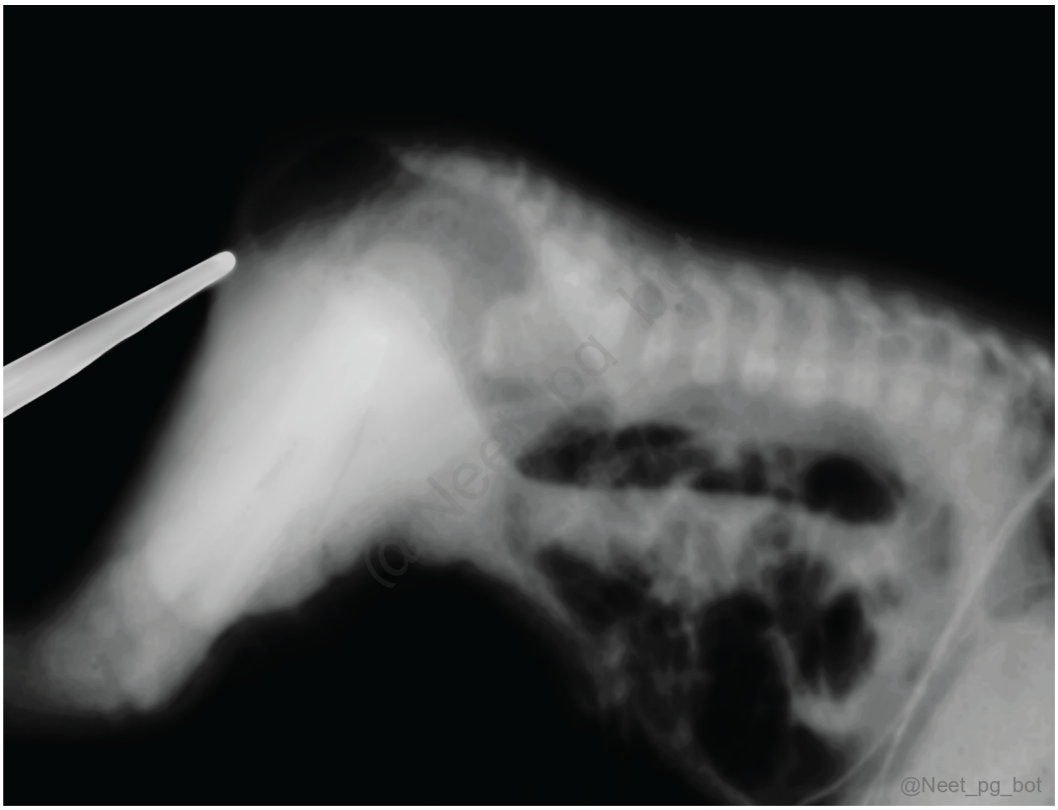
Q189: Identify the pathology in the given radiograph of a newborn .: (Q793490)

A. Meningocele

B. Imperforate anus

C. Congenital megacolon

D. Pyloric stenosis



See Answer in Part B → Q189

@Neet_pg_bot

Q190: Which of the following is the best investigation to establish a diagnosis of GERD ? (Q793499)

A. 24 hours ambulatory pH monitoring

B. Upper GI endoscopy

C. CECT

D. MRI

See Answer in Part B → Q190

@Neet_pg_bot

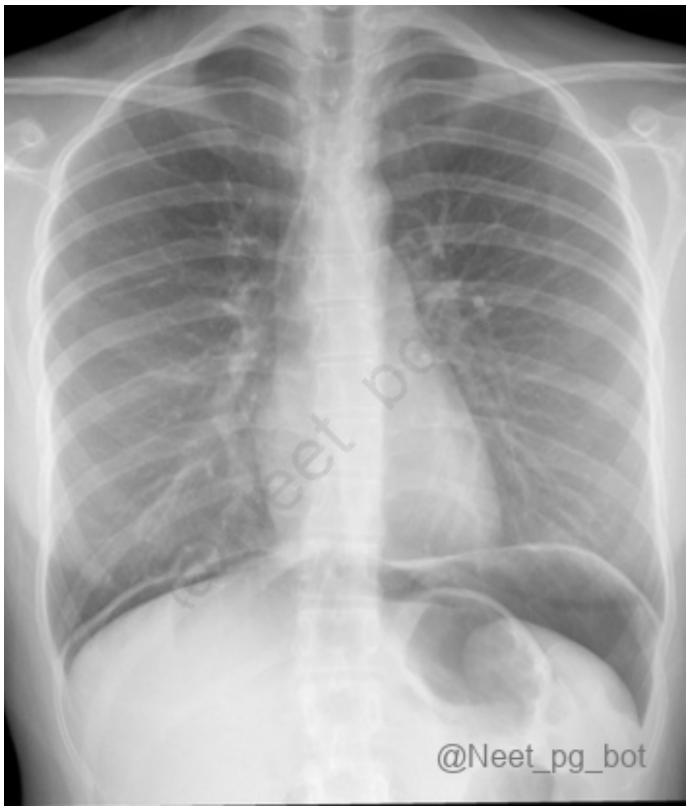
Q191: A 42-year-old alcoholic and a chronic smoker presented with bouts of vomiting and stabbing pain in the epigastrium . He was binge drinking shortly before the symptoms started. He is febrile and tachycardic . The given findings were seen on bedside radiological imaging. Which among the following is a likely cause of this? (Q793502)

A. Tension pneumothorax

B. Peptic ulcer perforation

C. Boerhaave syndrome

D. Mallory Weiss tear



See Answer in Part B → Q191

@Neet_pg_bot

Q192: Which of the following is the most common deficiency observed after gastric bypass /bariatric surgery ? (Q793518)

A. Iron

B. Copper

C. Zinc

D. Calcium

See Answer in Part B → Q192

@Neet_pg_bot

Q193: An elderly man underwent Roux-en-Y gastric bypass surgery for obesity . He now presents to his physician with complaints of dizziness, fatigue, and tremors 2 hours after the ingestion of a carbohydrate-rich meal . His symptoms occur mainly due to 1. Hypoglycemia 2. Small volume of food intake 3. High osmotic load of food 4. Increased release of insulin 5. Increased release of glucagon (Q793528)

A. 1, 2 and 5

B. 1, 3 and 5

C. 1 and 4

D. 3 and 5

See Answer in Part B → Q193

@Neet_pg_bot

Q194: A young adult with gastric outlet obstruction presents with vomiting . Which of the following fluids is preferred in this patient for initial resuscitation ? (Q793531)

A. Normal saline

B. Ringer lactate

C. 5% dextrose in water

D. 20% dextrose in water

See Answer in Part B → Q194

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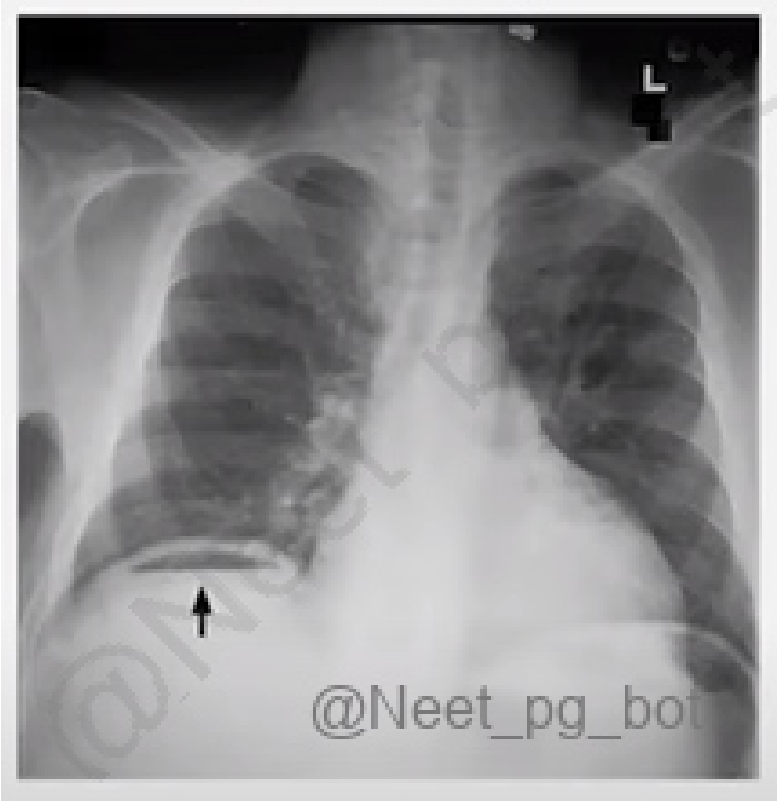
Q195: A 34 years old female with a history of alcohol intake was taking NSAIDs for abdominal pain . She developed severe pain in the whole abdomen . A radiograph is given below. What is the diagnosis? (Q793857)

A. Rupture of ectopic pregnancy

B. Acute pancreatitis

C. Perforated liver abscess

D. Hollow viscus perforation



See Answer in Part B → Q195

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Q196: What is the diagnosis of a patient who had a bronchospasm history, and was found to have a tumor in their ileum along with elevated levels of 5-hydroxy

indoleacetic acid in their urine? (Q793867)

A. Carcinoid tumor

B. Neuroblastoma

C. Leiomyoma

D. Chromaffinoma

See Answer in Part B → Q196

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• [05_Gastrointestinal Surgery] 033 Previous Year Questions

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[05_Gastrointestinal Surgery] 033 Previous Year Questions — Quick Jump

Q1 (p. 553) *Q2 (p. 553)* *Q3 (p. 553)* *Q4 (p. 554)* *Q5 (p. 555)* *Q6 (p. 555)*
Q7 (p. 556)

Q1: Which of the following is not a layer of esophagus? (Q820123)

A. Mucosa

B. Submucosa

C. Serosa

D. Muscularis

See Answer in Part B → Q1

@Neet_pg_bot

Q2: Which of the following is/are complications associated with GERD? Asthma Laryngitis Pulmonary Fibrosis Chronic cough (Q839982)

A. 1,2

B. 1,2,4

C. 1,2,3

D. 1,2,3,4

See Answer in Part B → Q2

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Q3: A 1.5-month-old male infant presents to the outpatient department with vomiting after feeding and failure to thrive . On examination, a firm, olive-shaped mass is

palpated in the upper abdomen . What is the most likely diagnosis? (Q852714)

A. Subacute Intestinal Obstruction

B. Pyloric Stenosis

C. GERD

D. Esophageal Atresia

See Answer in Part B → Q3

@Neet_pg_bot

Q4: A 45-year-old man complained of recurrent discharge and pain due to lesions around the anus for 3 years. What is the diagnosis? (Q855580)

A. Pilonidal sinus

B. Carbuncle

C. Boil

D. Fistula in ano



See Answer in Part B → Q4

@Neet_pg_bot

Q5: Which of the following gene mutations are involved in carcinoma of the colon? (Q856243)

A. APC, BRCA, k-ras

B. APC, k-ras, p53

C. MYh, K-RAS, APC

D. MYH, p53, DCC

See Answer in Part B → Q5

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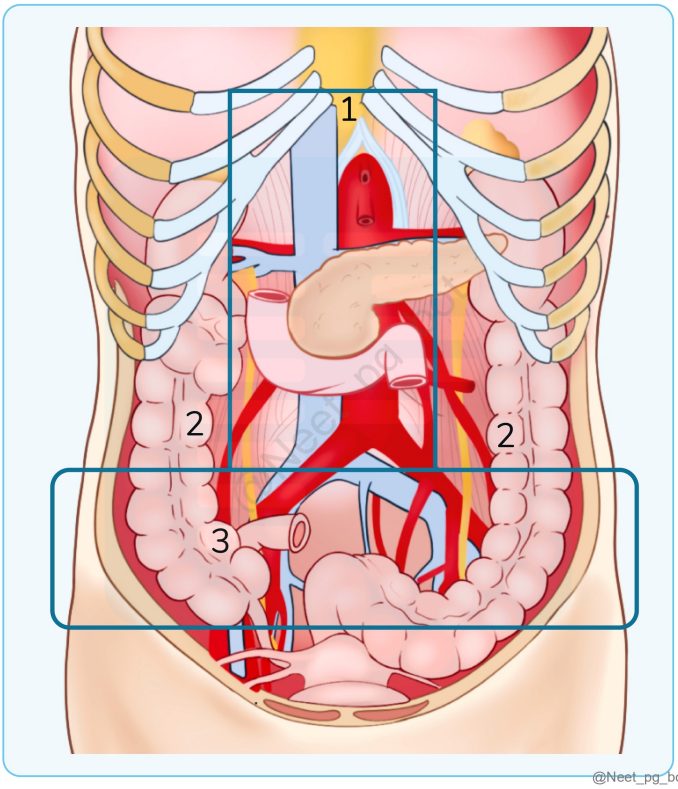
Q6: Mandatory exploration is required in the injuries. Which zones of retroperitoneum are required? (Q859819)

A. 1

B. 2

C. 3

D. 1 & 3



See Answer in Part B → Q6

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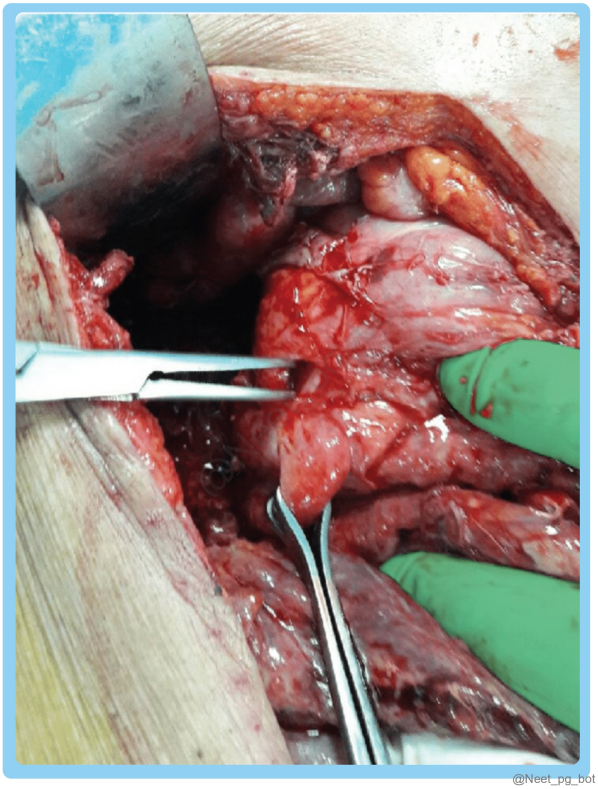
Q7: An alcoholic male patient diagnosed with hollow viscus perforation is taken up for laparotomy. Intraoperatively, a 2 cm perforation is seen in the duodenal region, as shown below. How can this patient be managed? (Q860458)

A. Primary closure of the defect

B. Omental pedicle repair

C. Billroth I

D. Billroth II



See Answer in Part B → Q7

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• [06_Urology] 034 Renal Stones Infections Disorders Of Kidney Hydronephrosis And Genitourinary Tuberculosis

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[06_Urology] 034 Renal Stones Infections Disorders Of Kidney Hydronephrosis And Genitourinary Tuberculosis — Quick Jump

Q1 (p. 558)	*Q2 (p. 558)*	*Q3 (p. 559)*	*Q4 (p. 559)*	*Q5 (p. 559)*	*Q6 (p. 560)*
Q7 (p. 561)	*Q8 (p. 561)*	*Q9 (p. 562)*	*Q10 (p. 562)*	*Q11 (p. 562)*	*Q12 (p. 563)*
Q13 (p. 563)	*Q14 (p. 564)*	*Q15 (p. 564)*	*Q16 (p. 564)*	*Q17 (p. 565)*	*Q18 (p. 566)*

Q1: A urologist is teaching medical students about the causes of hydronephrosis. When discussing bilateral hydronephrosis, which of the following conditions is not typically associated with this presentation? (Q849270)

A. Bladder neck stenosis

B. Benign prostatic hyperplasia

C. Posterior urethral valve

D. Retrocaval ureter

See Answer in Part B → Q1

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Q2: A male presents with a 3 cm stone in the middle calyx of the left kidney. Which of the following statements regarding the use of percutaneous nephrolithotomy (PCNL) in the management of this patient is correct? (Q849250)

A. PCNL involves creating a large flank incision to directly access the renal pelvis and remove the stone

B. PCNL is indicated for the treatment of renal stones larger than 2 cm in diameter or stones resistant to ESWL

C. PCNL is performed under general anesthesia, and the patient is required to remain immobilized for several days postoperatively

D. PCNL is contraindicated in patients with severe hydronephrosis or anatomical abnormalities of the urinary tract

See Answer in Part B → Q2

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Q3: In a 55-year-old male with sterile pyuria, flank pain, and a "moth-eaten" renal calyx appearance on CT, which test is the gold standard for confirming genitourinary tuberculosis? (Q849274)

A. Retrograde Pyelogram

B. Urine Culture & Sensitivity

C. Intravenous Pyelogram

D. Contrast-Enhanced CT

See Answer in Part B → Q3

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Q4: A 45-year-old man with a history of renal tuberculosis presents with increased urinary frequency and lower abdominal discomfort that has gradually worsened over the past few months. Imaging studies reveal significant fibrosis and a reduced bladder size. Which of the following features is present in the advanced stage, where the bladder is contracted? (Q849273)

A. Golf hole around the ureteric orifice

B. Calcification of bladder wall

C. The beaded appearance of the distal ureter

D. None of the above

See Answer in Part B → Q4

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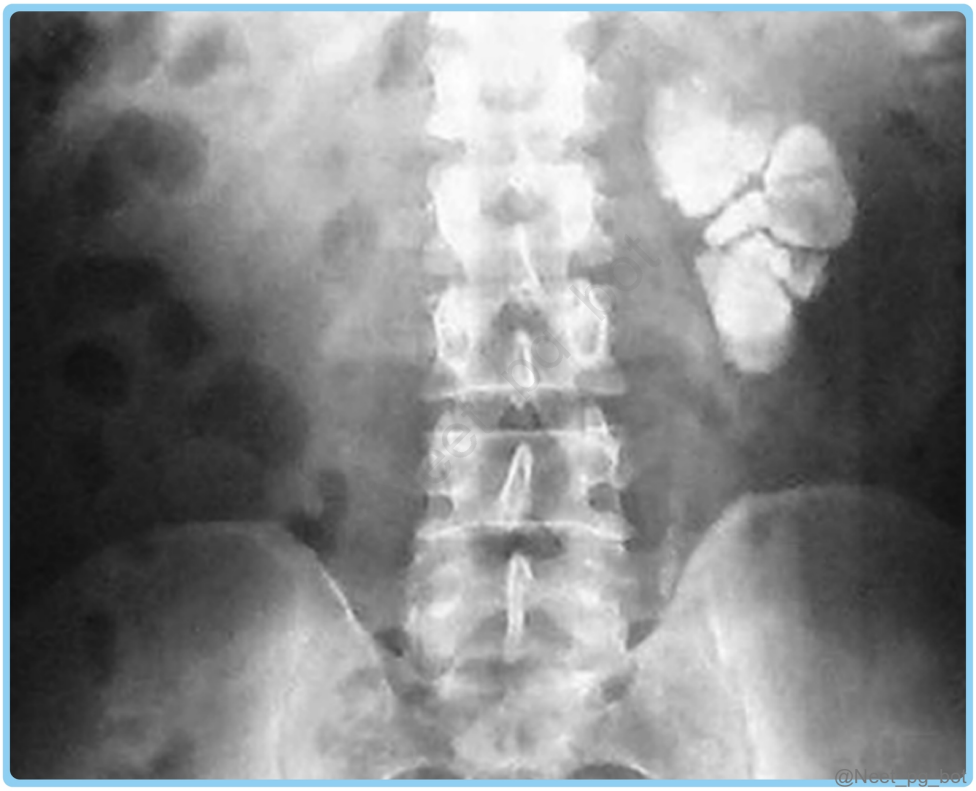
Q5: A 38-year-old male with a history of untreated pulmonary tuberculosis presents with symptoms of dysuria, hematuria, and flank pain, and noticed a gradual worsening of his symptoms. His laboratory tests are consistent with renal impairment. Which of the following features are seen in this condition? (Q849272)

A. Caseous necrosis and tissue destruction

B. Dystrophic calcification

C. Ureteric strictures and obstruction

D. All of the above



See Answer in Part B → Q5

@Neet_pg_bot

Q6: A 35-year-old man presents with intermittent right flank pain and a palpable mass in his right loin. His urinalysis shows microscopic hematuria. Imaging reveals the presence of unilateral hydronephrosis. Which of the following correctly describes the condition known as Dietl's crisis? (Q849271)

A. Sudden onset of flank pain accompanied by fever and pyuria

B. Intermittent flank pain with a palpable abdominal mass that resolves after voiding large volume of urine

C. Constant dull ache in the loin with progressive renal failure

D. Acute anuria associated with bilateral ureteric obstruction

See Answer in Part B → Q6

@Neet_pg_bot

Q7: A 62-year-old diabetic man presents with fever, flank pain, and a palpable mass in his left loin. Initial ultrasound reveals a fluid collection associated with the left kidney. Which of the following statements is incorrect with respect to the probable diagnosis of this patient? (Q849259)

A. Pyonephrosis is commonly seen in patients with hydronephrosis due to renal obstruction

B. Pyonephrosis can spread by cortical extension & hematogenous route

C. Pyonephrosis involves the collection of pus inside the kidney

D. Percutaneous nephrostomy is the treatment of choice for elderly and diabetic patients

See Answer in Part B → Q7

@Neet_pg_bot

Q8: A 55-year-old female with poorly controlled diabetes presents with fever, flank pain, and vomiting. Initial investigations reveal a kidney infection. Which of the following findings is likely to be seen in Emphysematous Pyelonephritis but not in Xanthogranulomatous Pyelonephritis? (Q849252)

A. Presence of Proteus as the causative organism

B. Air within the kidney or perinephric region on imaging

C. Association with struvite stones

D. Foamy lipid-laden histiocytes in renal parenchyma

See Answer in Part B → Q8

@Neet_pg_bot

Q9: A 60-year-old patient with a history of recurrent renal stones is scheduled for laser-based intracorporeal lithotripsy to treat a 2 cm stone in the renal pelvis. Which of the following lasers is most commonly used for intracorporeal lithotripsy procedures? (Q849251)

A. Carbon dioxide laser

B. Neodymium: YAG laser

C. Holmium: YAG laser

D. Helium laser

See Answer in Part B → Q9

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Q10: Which of the following is the most common type of radiolucent renal stone? (Q849241)

A. Calcium Oxalate Stones

B. Uric Acid Stones

C. Cystine Stones

D. Xanthine Stones

See Answer in Part B → Q10

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Q11: A male underwent ESWL for a 2 cm renal stone 4 weeks ago. Imaging now reveals multiple small stone fragments (street of stone) in the ureter. Which of the

following statements regarding the management of this condition is correct? (Q849249)

A. Urgent ureteroscopy should be performed to remove the obstructing stone fragments

B. Conservative management with alpha-blocker therapy is the first-line approach

C. Repeat ESWL is the preferred option to further fragment the retained stone pieces

D. Percutaneous nephrolithotomy is the treatment of choice to clear the Steinstrasse

See Answer in Part B → Q11

@Neet_pg_bot

Q12: A male presents with a 10 mm stone in the lower pole of the left kidney. Regarding the use of extracorporeal shock wave lithotripsy (ESWL) for this patient, which of the following statements is false? (Q849248)

A. ESWL works by generating focused shock waves that pass through the body and fragment the stone

B. ESWL is contraindicated in patients with significant skeletal deformities or obesity

C. ESWL can be performed on stones less than 2 cm in diameter for optimal fragmentation

D. Post-ESWL, the patient is encouraged to ambulate soon after the procedure to facilitate stone passage

See Answer in Part B → Q12

@Neet_pg_bot

Q13: A male presents with a 5 mm lower-ureteric stone and no hydronephrosis. Which of the following is the most appropriate initial management strategy for this patient? (Q849247)

A. Urgent ureteroscopic stone extraction

B. Extracorporeal shock wave lithotripsy

C. Percutaneous nephrostomy tube placement

D. Trial of conservative management with medical expulsive therapy

See Answer in Part B → Q13

@Neet_pg_bot

Q14: A 30 years old male presents with recurrent episodes of right flank pain and hematuria. Ultrasonography and plain abdominal radiography are inconclusive for renal stones. Which of the following statements regarding the use of radionuclide scans in the evaluation of this patient is correct? (Q849246)

A. Technetium-99m dimercaptosuccinic acid (DMSA) scan is the preferred modality to diagnose renal stones

B. Gallium-67 citrate scan has higher sensitivity and specificity than DMSA scan for detecting renal stones

C. Radionuclide scans are exclusively reserved for patients with impaired renal function

D. Radionuclide scans can distinguish between obstructing and non-obstructing renal stones

See Answer in Part B → Q14

@Neet_pg_bot

Q15: Which of the following investigations is considered the gold standard for diagnosing renal stones and can identify both radiopaque and radiolucent stones? (Q849245)

A. Kidney, Ureter, and Bladder X-ray

B. Ultrasound

C. Non-contrast computed tomography

D. Intravenous urogram

See Answer in Part B → Q15

@Neet_pg_bot

Q16: A 35-year-old woman presents with recurrent urinary tract infections (UTIs), persistent back pain, and hematuria. Imaging reveals a large, branched stone occupying a significant portion of her right kidney. Urinalysis shows alkaline pH, the presence of bacteria, and crystals as shown below. Which of the following is the most likely composition of this stone? (Q849244)

A. Calcium oxalate

B. Uric acid

C. Struvite

D. Cystine



See Answer in Part B → Q16

@Neet_pg_bot

Q17: A 42-year-old male presents to the emergency department with severe abdominal pain. Imaging reveals that he has a renal stone lodged in the middle third of his ureter. He describes the pain as radiating to his hypogastrium. Which nerve is

responsible for the radiation of pain to the hypogastrium? (Q849243)

A. Ilioinguinal Nerve

B. Iliohypogastric Nerve

C. Genitofemoral Nerve

D. Femoral Nerve

See Answer in Part B → Q17

@Neet_pg_bot

Q18: A 50-year-old man with a history of HIV, on ART, presents to the emergency department with severe flank pain, hematuria, and difficulty urinating. Recent imaging studies reveal the presence of renal stones. Which of the following ART drugs is commonly associated with the development of renal stones? (Q849242)

A. Indinavir

B. Efavirenz

C. Nevirapine

D. None of the above

See Answer in Part B → Q18

@Neet_pg_bot

• [06_Urology] 035 Renal Tumors And Renal Congenital Abnormalities

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[06_Urology] 035 Renal Tumors And Renal Congenital Abnormalities — Quick Jump

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Q7 (p. 569)	*Q8 (p. 570)*	*Q9 (p. 571)*	*Q10 (p. 571)*	*Q11 (p. 572)*	*Q12 (p. 572)*
Q13 (p. 573)	*Q14 (p. 573)*	*Q15 (p. 574)*	*Q16 (p. 575)*	*Q17 (p. 575)*	*Q18 (p. 575)*
Q19 (p. 576)	*Q20 (p. 576)*				

Q1: A 55-year-old male presents with painless hematuria and weight loss over the past six months. CECT reveals a 9 cm enhancing mass in the right kidney, with evidence of invasion into the renal vein. Histopathology shows cells with clear cytoplasm and a delicate network of vasculature. Which of the following is the most likely variant of renal cell carcinoma? (Q849283)

A. Chromophobe renal cell carcinoma

B. Papillary renal cell carcinoma

C. Clear cell renal cell carcinoma

D. Collecting duct carcinoma

See Answer in Part B → Q1

@Neet_pg_bot

Q2: A 70-year-old male with a history of hypertension is diagnosed with renal cell carcinoma (RCC) after a CT scan reveals a 5 cm tumor confined to the right kidney. His renal function is normal, and there is no evidence of metastasis. What is the most appropriate initial treatment for this patient? (Q849286)

A. Partial Nephrectomy

B. Radical Nephrectomy

C. Radiofrequency Ablation

D. Targeted Therapy

See Answer in Part B → Q2

@Neet_pg_bot

Q3: A 28-year-old woman is incidentally found to have a horseshoe kidney during an abdominal CT scan. She has no symptoms. Which of the following complications is she at highest risk for developing? (Q849300)

A. Pelviureteric junction obstruction

B. Renal cell carcinoma

C. Renal artery stenosis

D. Nephroptosis

See Answer in Part B → Q3

@Neet_pg_bot

Q4: A newborn presents with abdominal distension and respiratory distress. Ultrasound reveals bilaterally enlarged kidneys with multiple small cysts. Which of the following statements regarding the diagnosis is incorrect? (Q849296)

A. It follows an autosomal recessive pattern of inheritance

B. The gene involved is the PKHD1 gene on chromosome 7

C. USG shows enlarged, echogenic kidneys, with poor corticomedullary differentiation

D. Hepatic fibrosis is the cause of death

See Answer in Part B → Q4

@Neet_pg_bot

Q5: Which of the following statements is incorrect regarding the investigations and treatment of Autosomal Dominant Polycystic Kidney Disease? (Q849295)

A. CECT is the investigation of choice for ADPKD

B. IVP may show a "spider leg" or "bell-shaped" appearance in ADPKD

C. Rovsing's operation is the gold standard for management which involves the opening and evacuation of fluid from cysts in ADPKD

D. Treatment is only done when cysts are overdistended causing pain, hemorrhage & infection

See Answer in Part B → Q5

@Neet_pg_bot

Q6: A 6-month-old child undergoes a micturating cystourethrogram for suspected vesicoureteric reflux. The radiologist notes reflux into the renal pelvis with mild distention of the collecting system. Which grade of vesicoureteric reflux does this finding represent? (Q849304)

A. Grade IV

B. Grade II

C. Grade III

D. Grade I

See Answer in Part B → Q6

@Neet_pg_bot

Q7: A 4-year-old boy presents with recurrent urinary tract infections and a palpable kidney mass in the loin region. Further, the patient is diagnosed with vesicoureteric reflux on both sides. Which of the following is an incorrect statement regarding the management of this condition? (Q849303)

A. Most cases resolve spontaneously without treatment

B. The investigation of choice is Intravenous Pyelogram

C. Symptomatic cases require surgical correction via ureteric reimplantation

D. Severe cases may require nephrectomy and renal transplantation

See Answer in Part B → Q7

@Neet_pg_bot

Q8: A 5-year-old girl is brought to the pediatric urology clinic by her mother, who reports that the child has "never been dry" since birth. The mother notes that urine dribbles continuously via the vagina, but the child can also pass urine normally. An intravenous urogram is performed which is attached below. Which of the following is the most likely diagnosis? (Q849302)

A. Vesicoureteral reflux

B. Posterior urethral valves

C. Ectopic ureter from duplicated collecting system

D. Ureterocele



See Answer in Part B → Q8

@Neet_pg_bot

Q9: A 6-year-old boy presents with recurrent urinary tract infections and a palpable abdominal mass. Imaging reveals a cystic dilation near the ureteral orifice within the bladder. Which of the following best describes the underlying condition? (Q849301)

A. Ureterocele

B. Bladder diverticulum

C. Ectopic ureter

D. Vesicoureteral reflux

See Answer in Part B → Q9

@Neet_pg_bot

Q10: A 40-year-old male presents with right-sided flank pain and persistent hematuria. An intravenous urogram is done and given below. What is the definitive management of this condition? (Q849299)

A. Observation with serial imaging

B. Ureteric stent placement

C. Surgical repositioning of the ureter

D. Percutaneous nephrostomy



See Answer in Part B → Q10

@Neet_pg_bot

Q11: A 35-year-old woman presents with intermittent left flank pain and episodes of gross hematuria. Imaging reveals a dilated renal pelvis with a narrowed ureteropelvic junction. Which of the following is the most appropriate long-term management? (Q849298)

A. Percutaneous nephrostomy

B. Watchful waiting with regular monitoring

C. Pyeloplasty

D. Ureteric balloon dilatation

See Answer in Part B → Q11

@Neet_pg_bot

Q12: A 20-year-old pregnant woman undergoes an ultrasound at 22 weeks' gestation. The scan reveals severe oligohydramnios and the fetal kidneys are not visualized. Which of the following additional findings is most likely to be present in the fetus? (Q849297)

A. Pulmonary hypoplasia

B. Normal lung development

C. Medullary sponge kidney

D. Enlarged fetal bladder

See Answer in Part B → Q12

@Neet_pg_bot

Q13: A 45-year-old woman with a history of tuberous sclerosis complex with angiomyolipoma (AML) presents with a sudden onset of severe left flank pain. On examination, she is hypotensive and has a tender left flank. Imaging reveals a large hemorrhage in the left kidney extending into the perirenal space. Which of the following is the most likely diagnosis? (Q849281)

A. Pyelonephritis

B. Renal cell carcinoma

C. Wunderlich syndrome

D. Acute appendicitis

See Answer in Part B → Q13

@Neet_pg_bot

Q14: Which of the following statements is incorrect regarding Autosomal Dominant Polycystic Kidney Disease? (Q849294)

A. The disease involves a mutation in the PKD1 and PKD2 genes on chromosomes 4 and 16 respectively

B. Hypertension is the most common manifestation

C. Cysts can be seen in the organs such as the ovary, and pancreas in patients with ADPKD

D. The most common extrarenal manifestation is polycystic liver disease

See Answer in Part B → Q14

@Neet_pg_bot

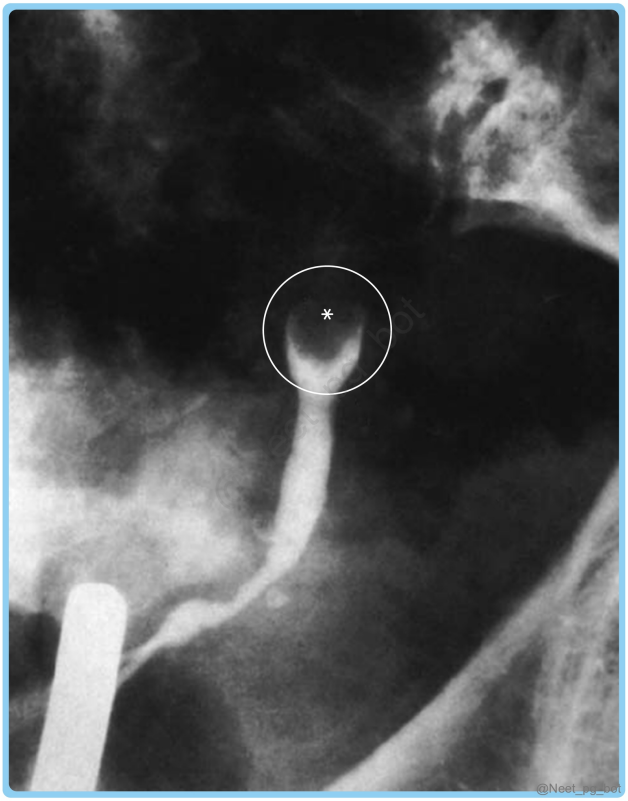
Q15: A 65-year-old man with a history of working in a dye factory for 30 years presents with flank pain and gross hematuria. Urinalysis confirms the presence of blood, and cytology shows atypical cells. A retrograde urogram was done given in the image below. He was diagnosed with carcinoma of the renal pelvis. Which of the following statements is incorrect regarding the diagnosis? (Q849293)

A. The radiographic image shows the Goblet sign.

B. Patients most commonly present with flank pain

C. CT urography is the investigation of choice for diagnosis

D. The most common histological type is transitional cell carcinoma



See Answer in Part B → Q15

@Neet_pg_bot

Q16: A 4-year-old girl is brought to the pediatrician with a palpable abdominal mass. Imaging studies reveal a large renal tumor and a biopsy confirms the diagnosis of Wilms tumor. Which of the following statements regarding Wilms tumor is correct? (Q849292)

A. Chemotherapy is contraindicated in Wilms tumor due to the young age of the patients

B. The most common site of metastasis in patients with Wilms tumor is the Liver.

C. A multimodal approach including surgery, chemotherapy, and radiation is typically used.

D. The route of spread is mostly lymphatic for metastasis of tumor foci.

See Answer in Part B → Q16

@Neet_pg_bot

Q17: A 2-year-old male child presents with severe proteinuria, ambiguous genitalia, and hypertension. His karyotype is 46XY, and genetic testing reveals a missense mutation in the WT1 gene. Imaging studies show a unilateral renal mass. Which of the following is the most likely explanation for the patient's clinical presentation? (Q849291)

A. Beckwith-Wiedemann syndrome with Wilms' tumor

B. Denys-Drash syndrome with gonadal dysgenesis

C. Frasier syndrome with gonadoblastoma

D. Perlman syndrome with nephroblastomatosis

See Answer in Part B → Q17

@Neet_pg_bot

Q18: A 55-year-old man presents with painless hematuria and a palpable mass in the left flank. Imaging studies reveal a renal mass measuring 8 cm with evidence of invasion into the renal vein but no involvement of surrounding lymph nodes or distant metastasis. According to the TNM staging system, what is the most appropriate stage of this renal cell carcinoma? (Q849285)

A. Stage I

B. Stage II

C. Stage III

D. Stage IV

See Answer in Part B → Q18

@Neet_pg_bot

Q19: A 62-year-old woman with a history of smoking presents with a sudden onset of headaches and visual disturbances. A CT scan shows a 5 cm mass in the left kidney. Which of the following is most likely associated with her condition? (Q849284)

A. Addison's disease

B. Hypocalcemia

C. Hypotension

D. Polycythemia

See Answer in Part B → Q19

@Neet_pg_bot

Q20: A 65-year-old male presents with an incidental finding of a renal mass on imaging. The mass shows an enhancing appearance on cross-sectional imaging with a central stellate scar. A biopsy is inconclusive, and the mass is surgically removed. Histopathological examination reveals granular, eosinophilic cytoplasm within the tumor cells, negative for cytokeratin 7. What is the most likely diagnosis? (Q849282)

A. Clear Cell Renal Cell Carcinoma

B. Renal Oncocytoma

C. Chromophobe Renal Cell Carcinoma

D. Papillary Renal Cell Carcinoma

See Answer in Part B → Q20

@Neet_pg_bot

• [06_Urology] 036 Urinary Bladder

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[06_Urology] 036 Urinary Bladder — Quick Jump

Q1 (p. 578)	*Q2 (p. 578)*	*Q3 (p. 579)*	*Q4 (p. 579)*	*Q5 (p. 579)*	*Q6 (p. 580)*
Q7 (p. 580)	*Q8 (p. 580)*	*Q9 (p. 581)*	*Q10 (p. 581)*	*Q11 (p. 582)*	*Q12 (p. 582)*
Q13 (p. 582)	*Q14 (p. 583)*	*Q15 (p. 585)*	*Q16 (p. 585)*	*Q17 (p. 586)*	*Q18 (p. 587)*
Q19 (p. 588)	*Q20 (p. 588)*				

Q1: A 74-year-old man was diagnosed with squamous cell carcinoma of the bladder. Which of the following is the most likely risk factor for this type of bladder cancer? (Q849368)

A. History of schistosomiasis.

B. Previous bladder augmentation surgery.

C. Occupational exposure to aromatic hydrocarbons.

D. Use of drugs like cyclophosphamide

See Answer in Part B → Q1

@Neet_pg_bot

Q2: A patient who had undergone cystectomy and urinary diversion with an ileal conduit after being diagnosed with muscle-invasive bladder cancer comes for follow-up. His blood investigations revealed an electrolyte imbalance. Which of the following is not a possible imbalance in this condition? (Q849377)

A. Hypokalemia

B. Hyponatremia

C. Hypocalcemia

D. Hypomagnesemia

See Answer in Part B → Q2

@Neet_pg_bot

Q3: A new mother comes to the outpatient department with her neonate as she notices intermittent fluid leaking from the umbilicus of the baby. On examination, the umbilicus is inflamed, enlarged, and there is delayed healing of the cord stump. What is the diagnosis? (Q849376)

A. Patent urachus

B. Urachal cyst

C. Umbilical-urachal sinus

D. Vesico-urachal diverticulum

See Answer in Part B → Q3

@Neet_pg_bot

Q4: A 55-year-old male with non-muscle invasive bladder carcinoma is advised TURBT and BCG immunotherapy due to a high risk of recurrence. Which condition is not a contraindication for BCG therapy? (Q849375)

A. Immunocompromised

B. Immediately after TURBT

C. Total urinary incontinence

D. Previous history of tuberculosis

See Answer in Part B → Q4

@Neet_pg_bot

Q5: During a radical cystectomy for bladder cancer in males, which of the following structures is typically spared and not removed? (Q849374)

A. Seminal Vesicles

B. Prostate

C. Urethra

D. Testes

See Answer in Part B → Q5

@Neet_pg_bot

Q6: Which of the following is the preferred initial therapy for a patient with carcinoma in situ (Tis) urinary bladder cancer after TURBT? (Q849373)

A. Intravesical Gemcitabine (single instillation)

B. Intravesical Mitomycin (single instillation)

C. Intravesical BCG therapy

D. Immediate Cystectomy

See Answer in Part B → Q6

@Neet_pg_bot

Q7: Which of the following is not a tumor marker for urinary bladder cancer? (Q849372)

A. Hyaluronidase (HYAL-1)

B. Nuclear Matrix Protein 22

C. Bladder Tumor Antigen

D. Alpha-fetoprotein

See Answer in Part B → Q7

@Neet_pg_bot

Q8: A 62-year-old male with a bladder tumor invading the muscle layer is classified as which TNM stage? (Q849371)

A. Ta

B. T1

C. T2

D. T3

See Answer in Part B → Q8

@Neet_pg_bot

Q9: A 62-year-old patient with muscle-invasive bladder cancer is undergoing evaluation for metastasis. What is the most common lymphatic node involved in bladder cancer metastasis? (Q849370)

A. Supraclavicular nodes

B. Pelvic Nodes

C. Retroperitoneal Nodes

D. Intrathoracic Nodes

See Answer in Part B → Q9

@Neet_pg_bot

Q10: A 65-year-old male with a history of smoking presents with frequent urination and microscopic hematuria. Cystoscopy reveals a flat, high-grade lesion confined to the bladder epithelium. What is the most likely diagnosis? (Q849369)

A. Papillary tumor

B. Carcinoma in situ

C. Stage T1 urothelial carcinoma

D. Squamous cell carcinoma of bladder

See Answer in Part B → Q10

@Neet_pg_bot

Q11: A 7-year-old boy with recurrent urinary tract infections (UTIs) is brought with a few episodes of hematuria and bladder discomfort. Imaging shows a diverticulum near the ureteric orifice. Which of the following statements is most accurate based on the clinical scenario? (Q849367)

A. Congenital diverticulum due to its location and UTIs.

B. Occurs secondary to high intravesical pressure.

C. Immediate surgery is needed regardless of symptoms.

D. Thick-walled bladder with multiple diverticula.

See Answer in Part B → Q11

@Neet_pg_bot

Q12: A 34-year-old male presents with severe abdominal pain and inability to urinate after a car accident. On examination, he has diffuse abdominal tenderness with guarding and rigidity. A cystogram reveals urine leakage into the peritoneal cavity. What is the next best step in management? (Q849366)

A. Foley’s catheterisation and observation

B. Emergency laparotomy

C. IV antibiotics and close monitoring

D. Delayed surgical repair

See Answer in Part B → Q12

@Neet_pg_bot

Q13: A 48-year-old female presents with chronic pelvic pain, urinary urgency, and frequency. On cystoscopy, a characteristic bladder lesion with a small capacity and visible mucosal breaks is noted. What is the most likely diagnosis? (Q849364)

A. Bladder Cancer

B. Radiation Cystitis

C. Interstitial Cystitis with Hunner’s Lesion

D. Urinary Tract Infection

See Answer in Part B → Q13

@Neet_pg_bot

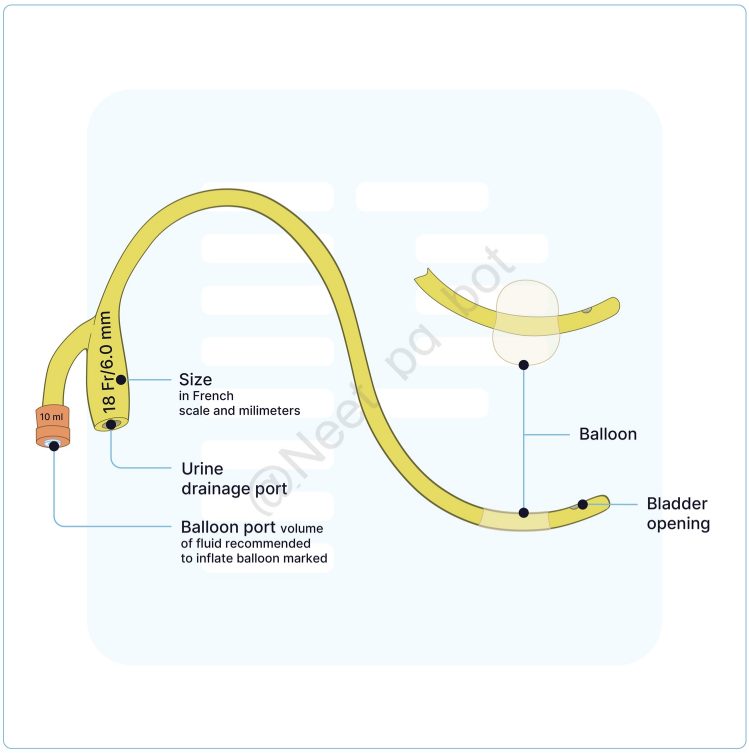
Q14: Based on the images provided, where would each of the shown catheters be used? Image 1: Image 2: (Q849358)

A. Image 1:Used for patients with acute urinary retention; Image 2:Used only in neurogenic bladder

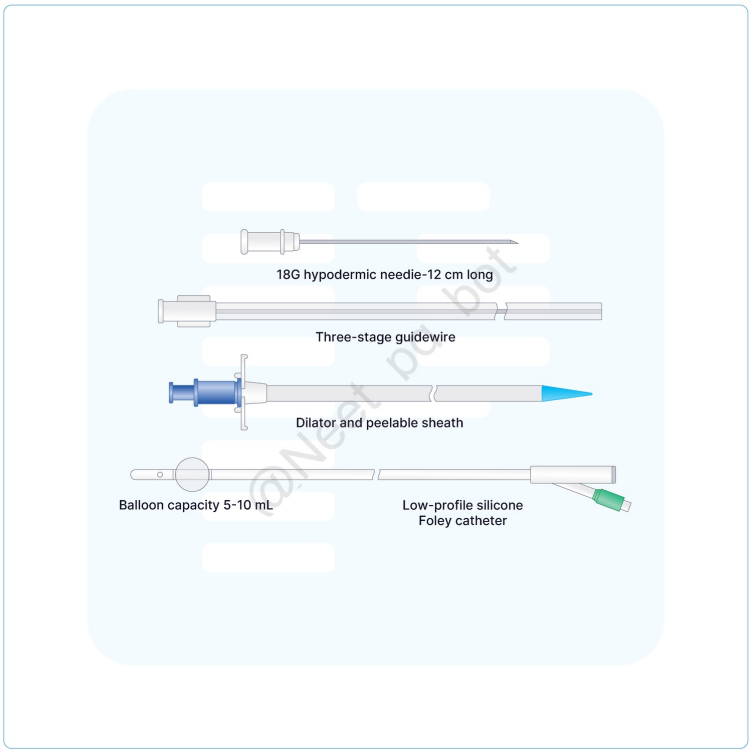
B. Image 1: Used for patients with an enlarged prostate causing retention; Image 2: Used in cases of urethral stricture or trauma

C. Image 1: Used for short-term postoperative bladder drainage; Image 2:Used only when Foley's catheterization is contraindicated

D. Image 1: Used for patients with acute urinary retention; Image 2:Used for continuous bladder irrigation



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See Answer in Part B → Q14

@Neet_pg_bot

Q15: A 35-year-old male presents to the emergency department after a motor vehicle accident with a pelvic fracture and gross hematuria. The CT cystogram showed the following characteristic findings. Which of the following statements regarding the diagnosis of this patient is incorrect? {{caption_text}} (Q849365)

A. Retrograde cystography demonstrates extravasation of contrast limited to the perivesical space.

B. Catheter drainage for 10-14 days is the treatment of choice for uncomplicated cases.

C. Immediate surgical repair in cases of bladder neck injury.

D. Both urethral and suprapubic catheters are recommended in all cases.



See Answer in Part B → Q15

@Neet_pg_bot

Q16: A 60-year-old female with recurrent UTIs and a history of chronic immunosuppression after a renal transplant presents with non-tender abdominal

nodules. The biopsy shows histiocytes with basophilic inclusions staining positive for PAS and von Kossa stains. Which of the following is the most accurate statement regarding the diagnosis? (Q849363)

A. Commonly associated with Gram-negative bacteria like E. coli

B. Characteristic histological feature is Langhans giant cells

C. Treated primarily with high-dose corticosteroids

D. Usually self-limiting and resolves without treatment

See Answer in Part B → Q16

@Neet_pg_bot

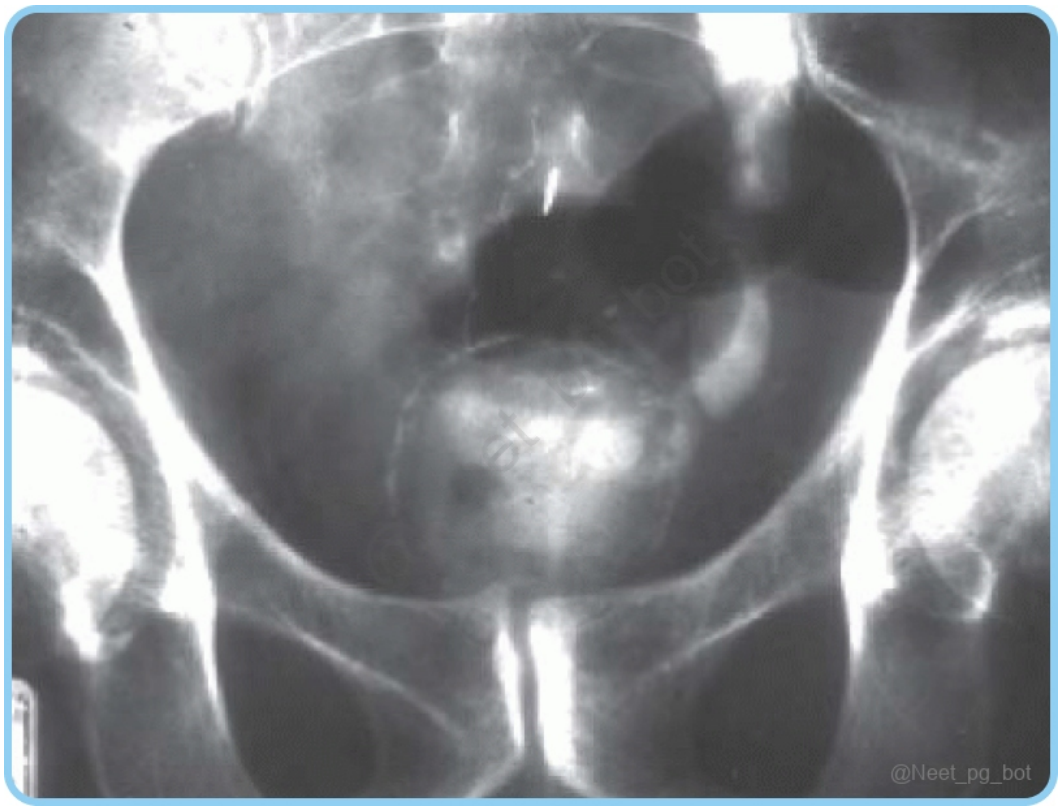
Q17: A 45-year-old male tourist from rural Egypt presents with recurrent hematuria and lower abdominal pain. A pelvic radiograph shows a circular calcification resembling a fetal head in the pelvis with associated faint calcification of the distal right ureter. What is the most likely diagnosis and appropriate next step? (Q849362)

A. Bladder stones; perform cystoscopy

B. Chronic schistosomiasis; obtain urine microscopy for ova

C. Pelvic tuberculosis; order interferon-gamma release assay

D. Calcified bladder tumor; schedule CT urography



See Answer in Part B → Q17

@Neet_pg_bot

Q18: A 9-year-old boy from a rural area presents with suprapubic pain, increased urinary frequency, and occasional hematuria, with no incontinence or systemic symptoms. He appears thin, has normal external genitalia, and has no significant medical history. Imaging shows multiple small, smooth bladder stones. What is the most likely cause? (Q849361)

A. Bladder outlet obstruction leading to urinary stasis

B. Infection with urease-producing bacteria

C. Nutritional deficiency

D. Foreign body presence in the bladder

See Answer in Part B → Q18

@Neet_pg_bot

Q19: Which of the following statements about ectopia vesicae is correct? (Q849360)

A. More common in females than males

B. Presents with normal urinary continence

C. Increased risk of urinary bladder adenocarcinoma

D. Resolves on its own without surgery

See Answer in Part B → Q19

@Neet_pg_bot

Q20: A 70-year-old male with diabetes and Parkinson's disease presents with a 6-month history of difficulty urinating, incomplete bladder emptying, and frequent nighttime urination. A post-void residual volume test shows significant urine retention. Which of the following conditions is least likely the primary cause of his chronic urinary retention? (Q849359)

A. Parkinson's disease

B. Diabetic neuropathy

C. Benign Prostatic Hyperplasia (BPH)

D. Overactive Bladder

See Answer in Part B → Q20

@Neet_pg_bot

• [06_Urology] 037 Prostate And Seminal Vesicles

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[06_Urology] 037 Prostate And Seminal Vesicles — Quick Jump

Q1 (p. 589) *Q2 (p. 589)* *Q3 (p. 590)* *Q4 (p. 590)* *Q5 (p. 590)* *Q6 (p. 591)*
Q7 (p. 591) *Q8 (p. 592)* *Q9 (p. 592)* *Q10 (p. 592)* *Q11 (p. 593)* *Q12 (p. 593)*

Q1: An elderly male is identified to have a well-circumscribed lesion within the prostate suspicious of cancer. Based on the McNeal classification, in which prostatic zone is the lesion most likely to be located? (Q849305)

A. Transitional Zone

B. Peripheral Zone

C. Central Zone

D. Anterior Fibromuscular Stroma

See Answer in Part B → Q1

@Neet_pg_bot

Q2: A 75-year-old man presents with difficulty in urination, weak stream, and increased frequency. On digital rectal examination, his prostate is found to be enlarged, and his PSA levels are mildly elevated. Which enzyme converts testosterone to dihydrotestosterone, a hormone responsible for the pathogenesis of his condition? (Q849306)

A. Aromatase

B. 17-β Hydroxysteroid dehydrogenase

C. 5 ■ reductase

D. 21-Hydroxylase

See Answer in Part B → Q2

@Neet_pg_bot

Q3: A 68-year-old male presents with complaints of urinary frequency, nocturia, and a weak urinary stream. The International Prostate Symptom Score (IPSS) assessment reveals a score of 22. Which of the following best describes the severity of his symptoms according to the IPSS? (Q849307)

A. Mild

B. Moderate

C. Severe

D. Asymptomatic

See Answer in Part B → Q3

@Neet_pg_bot

Q4: A 65-year-old male presents with urinary frequency, nocturia, and a weak urinary stream for 6 months. His prostate is symmetrically enlarged, prostate-specific antigen (PSA) is slightly elevated and Qmax (Uroflowmetry) is 7 ml/sec. Which of the following is the most appropriate initial management for this patient? (Q849308)

A. Transurethral resection of the prostate

B. Tamsulosin

C. Immediate catheterization

D. Finasteride

See Answer in Part B → Q4

@Neet_pg_bot

Q5: Which of the following is the most common complication of TURP (Trans urethral resection of prostate)? (Q849309)

A. Retrograde ejaculation

B. TURP syndrome

C. Incontinence

D. Erectile dysfunction

See Answer in Part B → Q5

@Neet_pg_bot

Q6: A 70-year-old man is undergoing transurethral resection of the prostate (TURP) for benign prostatic hyperplasia. Postoperatively, he gets agitated and complains of severe headache, nausea, and blurred vision. His lab results show a serum sodium level of 118 mEq/L. Which of the following is the most appropriate initial management? (Q849310)

A. Administer intravenous hypertonic saline

B. Start oral furosemide

C. Administer intravenous normal saline

D. Oral fluid restriction

See Answer in Part B → Q6

@Neet_pg_bot

Q7: A 65-year-old male is undergoing surgery for Benign Prostatic Hyperplasia with distressing LUTS (lower urinary tract symptoms). Prostate gland is significantly enlarged, measuring over 100 grams. Which among the following surgical approach is most appropriate? (Q849311)

A. Transurethral incision of prostate

B. Open prostatectomy

C. Frayer’s suprapubic prostatectomy

D. Young’s perineal prostatectomy

See Answer in Part B → Q7

@Neet_pg_bot

Q8: A 55-year-old male, known diabetic presents to the emergency department with a high-grade fever, perineal pain, and difficulty urinating. He has a history of acute bacterial prostatitis, treated two weeks ago with antibiotics. On examination, the prostate is tender and swollen. What is the most likely diagnosis and investigation to confirm the same? (Q849312)

A. Prostatic abscess and Transrectal ultrasound

B. Chronic prostatitis and urine culture

C. Acute prostatitis and urine microscopy

D. Benign prostatic hyperplasia and PSA levels

See Answer in Part B → Q8

@Neet_pg_bot

Q9: A 60-year-old male undergoes evaluation for a urinary tract infection. Imaging studies reveal multiple small stones within the prostate gland. Laboratory analysis of these prostatic calculi will most likely show which of the following compositions? (Q849313)

A. Uric acid

B. Struvite

C. Calcium oxalate

D. Calcium phosphate

See Answer in Part B → Q9

@Neet_pg_bot

Q10: An elderly male presents with urinary hesitancy, weak stream, nocturia, weight loss, and back pain. DRE reveals a hard, irregular prostate. Which of the following is the common genetic alteration observed in his condition? (Q849314)

A. Mutation of the BRCA1 gene

B. Hypermethylation of GSTP1

C. Overexpression of HER2

D. Mutation of the RB1 gene

See Answer in Part B → Q10

@Neet_pg_bot

Q11: A 70-year-old male presents with an elevated PSA level of 12 ng/mL. A transrectal ultrasound-guided biopsy reveals a Gleason score of 9 (4 + 5). Which of the following is the most appropriate initial management approach for this patient? (Q849315)

A. Active surveillance with regular PSA monitoring and repeat biopsies

B. Radical prostatectomy

C. Hormone therapy and possibly radiation

D. Observation with no immediate treatment

See Answer in Part B → Q11

@Neet_pg_bot

Q12: A 65-year-old male patient undergoes a transurethral resection of the prostate (TURP) for benign prostatic hyperplasia. During the procedure, a tumor is discovered, which involves less than 5% of the resected tissue and is well-differentiated. The tumor was an incidental finding and was not palpable during a digital rectal examination. Based on the TNM staging system for prostate cancer, what is the most appropriate stage for this tumor? (Q849316)

A. T1a

B. T1b

C. T2a

D. T3a

See Answer in Part B → Q12

@Neet_pg_bot

• [06_Urology] 038 Urethra And Penis

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[06_Urology] 038 Urethra And Penis — Quick Jump

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Q7 (p. 597)	*Q8 (p. 598)*	*Q9 (p. 598)*	*Q10 (p. 598)*	*Q11 (p. 599)*	*Q12 (p. 599)*
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Q19 (p. 602)	*Q20 (p. 602)*				

Q1: A 28-year-old male was involved in a high-speed road traffic accident. He reports severe pelvic pain and difficulty in passing urine. On examination, there is blood at the urethral meatus, and the patient complains of suprapubic tenderness. The bladder appears to be distended, and there is a high-riding prostate on a digital rectal examination. Which of the following investigations is the most appropriate to confirm the suspected injury of this patient? (Q849422)

A. Retrograde Urethrography (RGU)

B. Cystoscopy

C. Voiding Cystourethrography

D. Intravenous Pyelography (IVP)

See Answer in Part B → Q1

@Neet_pg_bot

Q2: Which of the following statements are true regarding urethral carcinoma? (Q849431)

A. Bloody discharge present without infection

B. Prostatic urethral tumor is treated with laser ablation

C. Squamous carcinoma has a poor prognosis

D. All are true

See Answer in Part B → Q2

@Neet_pg_bot

Q3: A 45-year-old male presents with a carcinoma penis. After discussing treatment options, he is informed that his management plan may include partial penectomy. What is the nature of his cancer? (Q849430)

A. Localized tumor of glans

B. Proximal penile tumor

C. T1 stage

D. T2 stage

See Answer in Part B → Q3

@Neet_pg_bot

Q4: A 45-year-old male presents with a noninvasive, localized squamous cell carcinoma on the glans penis. The lesion is well-demarcated and has not invaded deeper tissues. What is the TNM stage of his cancer? (Q849429)

A. T1

B. T2

C. T3

D. Ta

See Answer in Part B → Q4

@Neet_pg_bot

Q5: A 52-year-old male presents with a large, dry, verrucae-like growth on the penis. Biopsy confirms it as a Buschke-Lowenstein tumor. Which of the following is the wrong statement regarding the disease? (Q849428)

A. Caused by HPV

B. Radiotherapy is contraindicated

C. Can spread through blood

D. It is curable

See Answer in Part B → Q5

@Neet_pg_bot

Q6: Bowen's disease, erythroplasia of Queyrat, and bowenoid papulosis are examples of: (Q849427)

A. Premalignant penile lesions

B. Benign tumors of the penise

C. Penile malignancies

D. None of the above

See Answer in Part B → Q6

@Neet_pg_bot

Q7: Which of the following statements are correct regarding Peyronie's Disease? Is characterized by fibrous plaques in the tunica albuginea of the penis. The plaques are typically found on the ventral aspect of the penis. Can be associated with Dupuytren's contracture. Oral medications like pentoxifylline and vitamin E are used in medical management. The primary treatment involves immediate surgical intervention (Nesbit Operation). (Q849426)

A. 1, 2, and 4 are correct

B. 2, 3, and 5 are correct

C. 1, 3, and 4 are correct

D. 2, 4, and 5 are correct

See Answer in Part B → Q7

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Q8: A 45-year-old man presents with symptoms of urinary obstruction, including difficulty in starting urination, weak urinary stream, and frequent urinary tract infections. On physical examination, he has a history of trauma to the pelvic region. A retrograde urethrogram (RGU) reveals a stricture in the anterior urethra measuring more than 2 cm. Which of the following is the most appropriate management option for this patient? (Q849425)

A. Urethral Dilatation

B. Optical Internal Urethrotomy

C. Excision and reconstruction with buccal mucosa

D. Urethral Stenting

See Answer in Part B → Q8

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Q9: Assertion: Eggplant deformity is a clinical manifestation observed in penile fracture cases. Reason: It is caused by a tear in the corpus spongiosum layer of the penis. (Q849424)

A. Both Assertion and Reason are correct, and the Reason is the correct explanation for the Assertion

B. Both Assertion and Reason are correct, but the Reason is not the correct explanation for the Assertion

C. The Assertion is correct, but the Reason is incorrect

D. The Assertion is incorrect, but the Reason is correct

See Answer in Part B → Q9

@Neet_pg_bot

Q10: A 28-year-old male was involved in a high-speed motor vehicle accident. On examination, he has a high-riding prostate on rectal exam, and blood is noted at the urethral meatus. He complains of difficulty in urination, and imaging reveals a pelvic fracture. Retrograde urethrography confirms a complete disruption of the posterior urethra. After initial stabilization, Which of the following is the most definitive method of management for this patient? (Q849423)

A. Immediate Surgical Repair of the Urethra

B. Suprapubic Catheter Placement Alone

C. Delayed Urethroplasty 3 months post-injury

D. Long-term Foley Catheterization

See Answer in Part B → Q10

@Neet_pg_bot

Q11: Which of the following is the least dilatable part of the male urethra? (Q849378)

A. Prostatic urethra

B. Membranous urethra

C. Penile (spongy) urethra

D. Urethral meatus

See Answer in Part B → Q11

@Neet_pg_bot

Q12: A 35-year-old male presents with an erection lasting over 6 hours and initial aspiration fails to resolve the condition. What is the next appropriate step in the management of this patient? (Q849387)

A. Oral phosphodiesterase inhibitors

B. Observation

C. Intracavernosal phenylephrine injection

D. Penile prosthesis placement

See Answer in Part B → Q12

@Neet_pg_bot

Q13: A 30 year old male presents with a painless erection following a penile trauma. Doppler ultrasound confirms the presence of blood flow and blood gas analysis shows arterial blood characteristics. What is the most likely type of priapism? (Q849386)

A. Ischaemic priapism

B. Non-ischaemic priapism

C. Neurogenic priapism

D. Recurrent priapism

See Answer in Part B → Q13

@Neet_pg_bot

Q14: A 60-year-old male presents to the emergency department with severe pain and swelling of the glans penis after retracting his foreskin for catheterization. The foreskin is stuck behind the glans with visible constriction. What is the most appropriate initial management? (Q849385)

A. Circumcision

B. Manual reduction using compression methods

C. Topical corticosteroid application

D. Oral antibiotics

See Answer in Part B → Q14

@Neet_pg_bot

Q15: A 5 year old boy presents with a non-retractable foreskin that has a fibrotic ring around the preputial orifice. His parents report that he experiences pain and irritation during urination. What is the most likely diagnosis? (Q849384)

A. Physiologic phimosis

B. Paraphimosis

C. Pathologic phimosis

D. Balanitis

See Answer in Part B → Q15

@Neet_pg_bot

Q16: A newborn male presents with urinary retention, lethargy and a distended bladder. Antenatal ultrasound showed a "keyhole sign" with a thickened bladder wall. Which of the following is the most likely diagnosis? (Q849383)

A. Hypospadias

B. Vesicoureteral reflux

C. Posterior urethral valves

D. Neurogenic bladder

See Answer in Part B → Q16

@Neet_pg_bot

Q17: A 4-year-old boy presents with complaints of recurrent UTI and difficulty urinating as mentioned by their parents.Upon examination, the physician notes that the urethral opening is located on the dorsal (top) aspect of the penis rather than at the tip. What is the most likely diagnosis? (Q849382)

A. Hypospadias

B. Peyronie’s disease

C. Epispadias

D. Phimosis

See Answer in Part B → Q17

@Neet_pg_bot

Q18: A 4-year-old boy presents with recurrent urinary tract infections and a history of abnormal urination. Physical examination reveals an abnormal opening on the perineum instead of the tip of the penis. What is the most likely diagnosis? (Q849381)

A. Hypospadias

B. Epispadias

C. Ectopic vesicae

D. Phimosis

See Answer in Part B → Q18

@Neet_pg_bot

Q19: What is the correct sequence of steps for hypospadias repair? (Q849380)

A. Degloving, orthoplasty, urethroplasty, and glanuloplasty

B. Orthoplasty, degloving, urethroplasty, and glanuloplasty

C. Degloving, urethroplasty, orthoplasty, and glanuloplasty

D. Degloving, urethroplasty, glanuloplasty, and orthoplasty

See Answer in Part B → Q19

@Neet_pg_bot

Q20: What is the most common type of hypospadias? (Q849379)

A. Scrotal hypospadias

B. Glanular hypospadias

C. Penoscrotal hypospadias

D. Perineal hypospadias

See Answer in Part B → Q20

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• [06_Urology] 039 Testis And Scrotum

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[06_Urology] 039 Testis And Scrotum — Quick Jump

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Q19 (p. 611)	*Q20 (p. 611)*				

Q1: A 45-year-old man presents with bilateral scrotal swelling. On examination, tense clusters that feel like bunches of grapes are palpable posterior to the testis and positive transillumination seen. Which of the following is the most appropriate management option if the patient reports discomfort? (Q849482)

A. Aspiration of the cysts

B. Total epididymectomy

C. Ultrasound-guided drainage

D. Excision of the cysts

See Answer in Part B → Q1

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Q2: A 35-year-old man presents with a painless, firm scrotal mass. Serum alpha-fetoprotein (AFP) and human chorionic gonadotropin (hCG) levels are elevated. What is the most likely diagnosis? (Q849491)

A. Epididymal cyst

B. Orchitis

C. Chimney sweep cancer

D. Hydrocele

See Answer in Part B → Q2

@Neet_pg_bot

Q3: For a patient with Stage I seminoma, which of the following is the most appropriate treatment? (Q849490)

A. Radical Orchidectomy followed by adjuvant chemotherapy

B. Radical Orchidectomy followed by adjuvant radiotherapy

C. High-dose chemotherapy

D. Radical Orchidectomy alone

See Answer in Part B → Q3

@Neet_pg_bot

Q4: Match the tumor markers with their associated testicular tumor types: Tumor Markers Tumor Types 1. AFP (Alpha-fetoprotein) a. Seminoma 2. HCG (Human Chorionic Gonadotropin) b. Yolk Sac Tumor 3. LDH (Lactate Dehydrogenase) c. Choriocarcinoma 4. CA-125 d. Ovarian cancer (Q849489)

A. 1-b,2-c,3-a,4-d

B. 1-d,2-b,3-c,4-a

C. 1-a,2-d,3-b,4-c

D. 1-c,2-a,3-d,4-b

See Answer in Part B → Q4

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Q5: A 25 years old man presents with a painless testicular mass. On examination, non-tender 3 cm mass in the right testicle is found.Ultrasound reveals a homogeneous, hypoechoic intratesticular mass. Serum tumor markers show elevated beta-hCG and LDH but normal AFP. Which of the following is the most likely diagnosis? (Q849488)

A. Leydig cell tumor

B. Embryonal carcinoma

C. Seminoma

D. Teratoma

See Answer in Part B → Q5

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Q6: A 28-year-old man undergoes a radical orchiectomy for a painless,enlarging testicular mass. Histopathology reveals neoplastic cells confined to the seminiferous tubules without stromal invasion.Serum tumor markers are within normal limits.Which of the following is the most likely diagnosis? (Q849487)

A. Seminoma

B. Yolk sac tumor

C. Leydig cell tumor

D. Intratubular germ cell neoplasm (ITGCN)

See Answer in Part B → Q6

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Q7: Match the following WHO classification of tumors with its corresponding tumor :- 1. Germ cell tumors derived from germ cell neoplasia in situ A. Gonadoblastoma 2. Germ cell tumors unrelated to germ cell neoplasia in situ B. Prepubertal-type teratoma 3. Sex cord-stromal tumors C. Sertoli cell tumor 4.Nonseminomatous germ cell tumors D. Choriocarcinoma (Q849486)

A. 1 - A; 2 - B; 3 - C; 4 - D

B. 1 - B; 2 - A; 3 - C; 4 - D

C. 2 - B; 1 - C; 3 - D; 4 - A

D. 4 - A; 3 - B; 2 - C; 1 - D

See Answer in Part B → Q7

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Q8: A 30-year-old male presents with a painless testicular mass. On physical examination, a solid intratesticular mass is palpable, and there is difficulty in palpating the epididymis. Which of the following associated findings would most likely be present in this patient? (Q849485)

A. Cough and dyspnea

B. Gynecomastia

C. Lower extremity swelling

D. Lumbar back pain

See Answer in Part B → Q8

@Neet_pg_bot

Q9: A 28-year-old man presents for a routine physical exam. He has a history of cryptorchidism corrected by orchidopexy in childhood. What is his relative risk of developing testicular cancer compared to the general population? (Q849484)

A. No increased risk

B. 1.5 to 3.5 times higher

C. 2 times higher

D. 3.7 to 7.5 times higher

See Answer in Part B → Q9

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Q10: A 60-year-old male with a history of diabetes presents with intense pain, swelling, and erythema of the scrotum. Physical examination reveals dusky skin and

subcutaneous crepitation. What is the most appropriate initial management? (Q849483)

A. Oral antibiotics

B. Immediate surgical debridement

C. Observation and pain management

D. Aspiration of the affected area

See Answer in Part B → Q10

@Neet_pg_bot

Q11: A 35-year-old man presented with a swelling of the scrotum, which was diagnosed as a spermatocele. Which of the following features of the swelling would have led to this diagnosis? (Q849478)

A. Location of the swelling at the head of the epididymis, above and behind the body of the testis

B. Soft, cystic, and transilluminant

C. Barley water-like fluid with spermatozoa on aspiration cytology

D. All of the above

See Answer in Part B → Q11

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Q12: A 25-year-old tall, thin male presents with a dull, aching pain in his left groin and scrotum, describing a "bag of worms" sensation on palpation. He was suggested to undergo Palomo's Operation. Which of the following describes the procedure? (Q849477)

A. Suprainguinal extraperitoneal ligation of the testicular vein

B. Extraperitoneal excision of testicular vein

C. Excision of pampiniform plexus

D. None of the above

See Answer in Part B → Q12

@Neet_pg_bot

Q13: Which of the following statements on hydrocele is false? (Q849476)

A. Fluid is collected between the two layers of the tunica vaginalis

B. Primary vaginal hydrocele is common in middle-aged men

C. Lord's plication is done for large hydrocele

D. Congenital hydrocele is reduced on lying down

See Answer in Part B → Q13

@Neet_pg_bot

Q14: A 15-year-old boy presented with a sudden onset of pain in the scrotum, groin, and lower abdomen. On examination of the scrotum, he is showing Deming's sign. What is Deming's sign? (Q849475)

A. The affected testis is positioned high

B. The affected testis lies horizontally

C. Opposite testis is placed horizontally

D. The affected testis is positioned low

See Answer in Part B → Q14

@Neet_pg_bot

Q15: A 27-year-old male is presented with a swollen, red, and painful epididymis. On examination, his vas deferens has a beaded texture and epididymis is craggy. A diagnosis of epididymo-orchitis was made. What is the most likely causative organism? (Q849473)

A. Mumps

B. Filaria

C. Tuberculosis

D. Gonococci

See Answer in Part B → Q15

@Neet_pg_bot

Q16: A 4-year-old boy has a right testis that intermittently moves between the scrotum and the groin, especially during physical activity. The testis is retractable but can be brought down into the scrotum upon gentle manipulation, while the left testis is normally positioned. What is the most likely physiological explanation for this intermittent movement of the testis? (Q849472)

A. Patent processus vaginalis

B. Undescended testis

C. Overactive dartos muscle

D. Increased tone of the cremasteric muscle

See Answer in Part B → Q16

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Q17: A 2 year old boy underwent surgery for an ectopic testis, followed by an orchidopexy. Several weeks later, he presents with symptoms including swelling and pain in the scrotum, along with fever. On examination, the scrotum is tender, and the affected testis appears to be positioned higher than normal. What is the most likely cause for these symptoms? (Q849471)

A. Abscess formation

B. Scrotal hematoma

C. Testicular atrophy

D. Testicular torsion

See Answer in Part B → Q17

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Q18: An 8 months old infant is undergoing surgical exploration for an undescended testis. The surgeon follows the standard approach and examines the inguinal canal but does not find the testis in the usual tract. Which location should the surgeon check next? (Q849470)

A. Superficial inguinal pouch

B. Perineum

C. Femoral canal

D. Retroperitoneum

See Answer in Part B → Q18

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Q19: All are true regarding undescended testis, except? (Q849469)

A. Seminoma is the most common tumor associated with undescended testis

B. Elevated abdominal temperature impairs sperm production

C. Orchidopexy is typically performed between 6-18 months of age.

D. Undescended testis causes loss of secondary sexual characteristics due to Leydig cell impairment.

See Answer in Part B → Q19

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Q20: Which of the following factors are responsible for testicular descent? Testosterone Gubernaculum Intra-abdominal Pressure CGRP (Calcitonin Gene-Related Peptide) INSL3 (Insulin-like 3) Processus Vaginalis (Q849468)

A. 1, 2, and 3

B. 1, 2, and 6

C. 1, 3, 4, and 6

D. 1,2,3,4,5,6

See Answer in Part B → Q20

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Q19 (p. 626)	*Q20 (p. 626)*	*Q21 (p. 627)*	*Q22 (p. 628)*	*Q23 (p. 629)*	*Q24 (p. 629)*
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Q43 (p. 643)	*Q44 (p. 643)*	*Q45 (p. 644)*	*Q46 (p. 644)*	*Q47 (p. 645)*	*Q48 (p. 646)*
Q49 (p. 646)	*Q50 (p. 646)*	*Q51 (p. 647)*	*Q52 (p. 647)*	*Q53 (p. 648)*	*Q54 (p. 648)*
Q55 (p. 648)	*Q56 (p. 649)*	*Q57 (p. 649)*	*Q58 (p. 650)*	*Q59 (p. 650)*	*Q60 (p. 650)*
Q61 (p. 651)	*Q62 (p. 652)*	*Q63 (p. 652)*	*Q64 (p. 652)*	*Q65 (p. 653)*	*Q66 (p. 653)*
Q67 (p. 654)	*Q68 (p. 654)*	*Q69 (p. 655)*	*Q70 (p. 656)*	*Q71 (p. 656)*	*Q72 (p. 657)*
Q73 (p. 657)	*Q74 (p. 658)*	*Q75 (p. 658)*	*Q76 (p. 659)*	*Q77 (p. 659)*	*Q78 (p. 660)*
Q79 (p. 661)	*Q80 (p. 661)*	*Q81 (p. 662)*	*Q82 (p. 663)*	*Q83 (p. 663)*	*Q84 (p. 664)*
Q85 (p. 664)	*Q86 (p. 665)*	*Q87 (p. 666)*	*Q88 (p. 666)*	*Q89 (p. 667)*	*Q90 (p. 668)*
Q91 (p. 668)	*Q92 (p. 669)*	*Q93 (p. 670)*	*Q94 (p. 671)*	*Q95 (p. 672)*	*Q96 (p. 672)*
Q97 (p. 673)	*Q98 (p. 674)*	*Q99 (p. 675)*	*Q100 (p. 675)*	*Q101 (p. 676)*	*Q102 (p. 677)*
Q103 (p. 678)	*Q104 (p. 678)*	*Q105 (p. 679)*			

Q1: A 13-year-old boy presents to the OPD with sudden onset severe pain in the right testis 2 hours after being hit by a cricket ball. On examination: Severe tenderness of the right testis, absent cremasteric reflex & testis is high-riding. What is the next best step in management? (Q866925)

A. USG Arterial Doppler

B. NSAIDS

C. USG Venous Doppler

D. Surgical exploration

See Answer in Part B → Q1

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Q2: Which of the following is not a recognised cause of recurrent renal stone formation? (Q865361)

A. Hyperoxaluria

B. Hypercalciuria

C. Hypercitraturia

D. Hyperuricosuria

See Answer in Part B → Q2

@Neet_pg_bot

Q3: A 3 year old child was brought to OPD with complain of dysuria and ballooning on micturition and examination as given below, what is the diagnosis? (Q866452)

A. Balanitis xerotica obliterans

B. True phimosis

C. Recurrent balanoposthitis

D. Recurrent urinary tract infections



See Answer in Part B → Q3

@Neet_pg_bot

Q4: A middle-aged woman presents with flank pain and dysuria. The pain was temporarily relieved by intravenous analgesics administered at a nearby primary healthcare center. She is diagnosed with ureteric colic secondary to ureteric calculi. What is the most appropriate diagnostic modality in this case? (Q853039)

A. NCCT KUB

B. ■■■■■■■

C. USG KUB

D. ■■■Ureteroscopy

See Answer in Part B → Q4

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Q5: Identify the structure on prostate biopsy: (Q853040)

A. Psammoma bodies

B. Corpora arenacea

C. ■■■Amyloid

D. Corpora amylacea



See Answer in Part B → Q5

@Neet_pg_bot

Q6: A newborn male presents with urinary retention, lethargy and a distended bladder. Antenatal ultrasound showed a "keyhole sign" with a thickened bladder wall. Which of the following is the most likely diagnosis? (Q852715)

A. Hypospadias

B. Vesicoureteral reflux

C. Posterior urethral valves

D. Neurogenic bladder

See Answer in Part B → Q6

@Neet_pg_bot

Q7: A 22-year-old male presents to the emergency department with a strong urge to urinate but is unable to do so. He has a history of perineal trauma. On examination, blood is noted at the external urethral meatus. Which structure is most likely injured? (Q852718)

A. Bulbar urethra

B. Posterior urethral valve

C. Intraperitoneal Bladder rupture

D. Membranous urethra

See Answer in Part B → Q7

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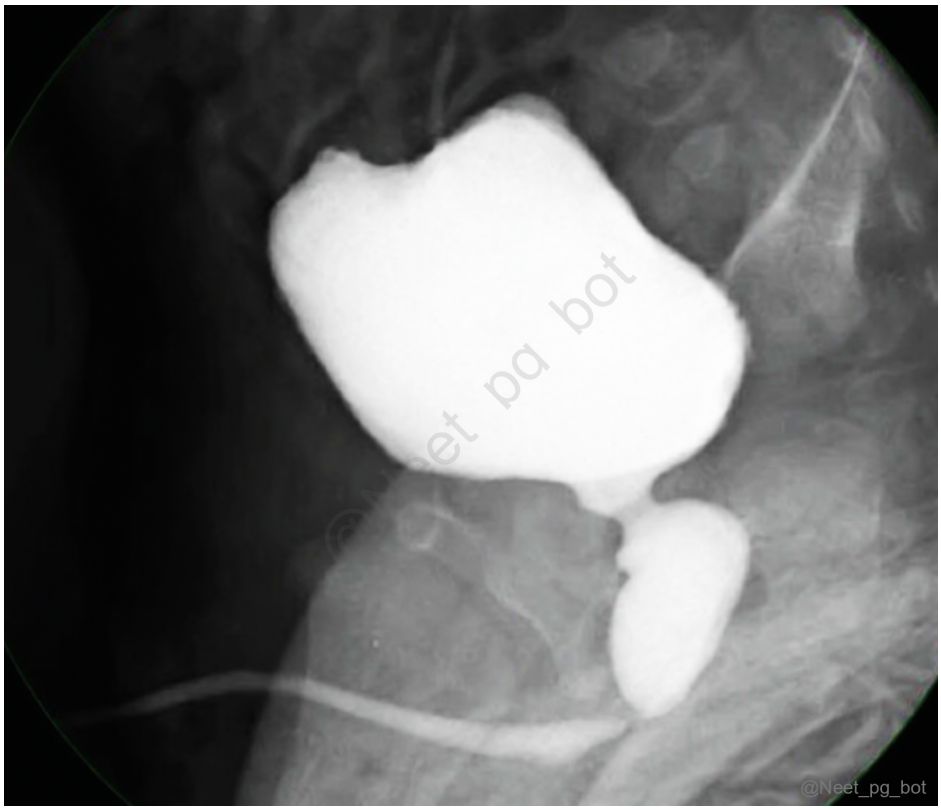
Q8: A child presents to the outpatient department (OPD) with a radiological image as given. What is the most appropriate management for this condition? (Q844289)

A. Endoscopic ablation

B. Dilation of urethra

C. Dilation of urethra and bladder

D. Conservative



See Answer in Part B → Q8

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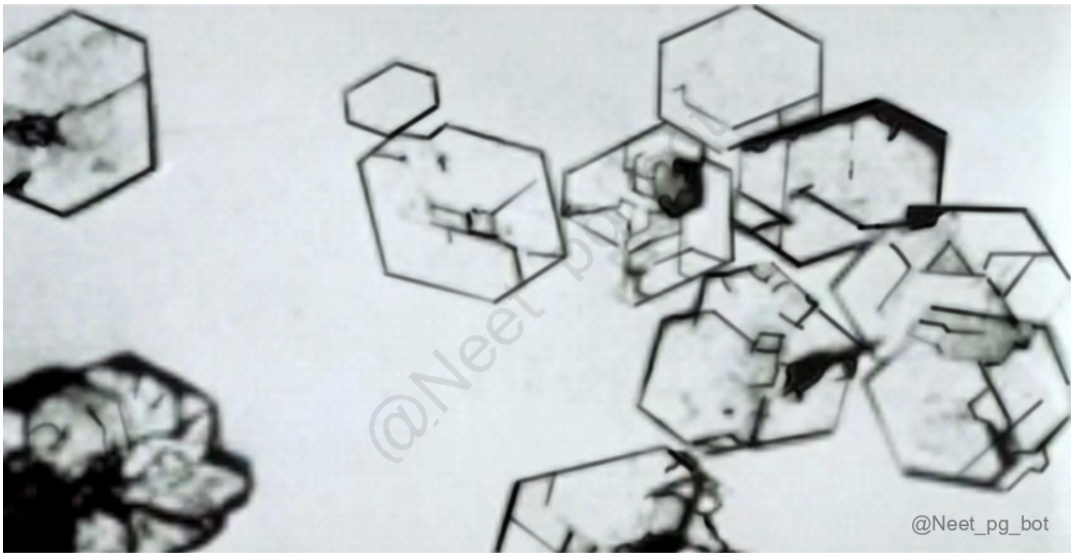
Q9: A young patient presents to the outpatient department (OPD) with recurrent colicky abdominal pain. Urine examination reveals the presence of red blood cells (RBCs). What is the most likely diagnosis? (Q844290)

A. Glomerulonephritis

B. Oxalate stone

C. Polycystic kidney disease

D. Cystine stone



See Answer in Part B → Q9

@Neet_pg_bot

Q10: A 12-year-old child presents to the outpatient department (OPD) with a complaint of scrotal pain, with a history of trauma 6 hours prior. Upon surgical exploration, the findings suggest significant damage. What is the most likely diagnosis? (Q844297)

A. Testicular torsion with gangrene

B. Torsion of testicular appendages with gangrene

C. Gangrene

D. Hematoma



See Answer in Part B → Q10

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Q11: What instrument is used to insert this tube? (Q844311)

A. Nephroscope

B. Cysto urethroscope

C. Ureteroscope

D. Endoscope



See Answer in Part B → Q11

@Neet_pg_bot

Q12: A patient was brought to the emergency department with a history of fall and head injury. What is the diagnosis? (Q844292)

A. EDH

B. SDH

C. SAH

D. Contusion



See Answer in Part B → Q12

@Neet_pg_bot

Q13: Identify the procedure done. (Q844299)

A. Orchidectomy

B. Total penectomy

C. Partial penectomy

D. None of the above



See Answer in Part B → Q13

@Neet_pg_bot

Q14: A patient presents with a growth over the penis that is classified as a T3 lesion, with no enlarged inguinal lymph nodes detected. What is the best method of management? (Q844305)

A. Penectomy

B. Penectomy with orchidectomy

C. Penectomy with superficial / modified inguinal lymph node dissection

D. Penectomy with deep inguinal lymph node dissection

See Answer in Part B → Q14

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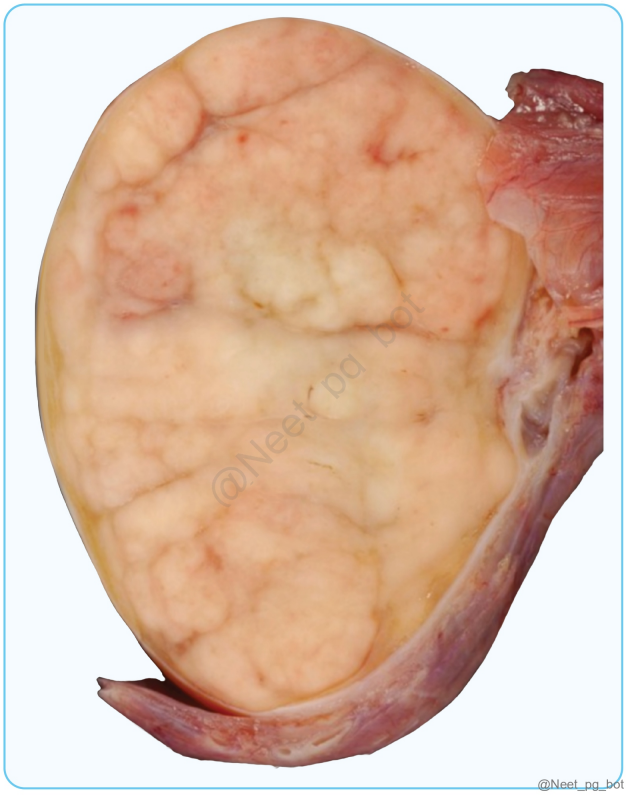
Q15: A 35-year-old male presents with a bulky scrotal swelling. On evaluation, malignancy is suspected, and an orchidectomy is performed. The gross section of the testicular mass is shown in the image. What is the most likely diagnosis? (Q860402)

A. Seminoma

B. Teratoma

C. Yolk sac tumour

D. Endodermal sinus tumor



See Answer in Part B → Q15

@Neet_pg_bot

Q16: An adult male presents to the outpatient department with a painful scrotal swelling accompanied by fever. The swelling is associated with the tunica vaginalis and is characterized by fluid accumulation. What is the likely diagnosis? (Q860406)

A. Varicocele

B. Hydrocele

C. Cystocele

D. Torsion testis

See Answer in Part B → Q16

@Neet_pg_bot

Q17: A 40-year-old man presents with gynecomastia. Ultrasound reveals a 1 cm solid mass within the body of the testis. Serum testosterone is 600 ng/dL, and estradiol is 35 pg/mL. What is the most likely diagnosis? (Q860423)

A. Spermatocytic tumor

B. Sertoli cell tumor

C. Granulosa cell tumor

D. Leydig cell tumor

See Answer in Part B → Q17

@Neet_pg_bot

Q18: A 55-year-old man presents with abdominal pain. A CECT (Contrast Enhanced CT) abdomen was done. What is the likely source of pain? (Q860459)

A. Gall bladder

B. Spleen

C. Kidney

D. Liver



See Answer in Part B → Q18

@Neet_pg_bot

Q19: All of the following statements regarding Wilms tumor are true, except? (Q840019)

A. Presents as an abdominal mass

B. Most commonly seen <5yrs of age

C. Majority patients recover due to chemotherapy and radiotherapy

D. Lung involvement in uncommon and occurs late

See Answer in Part B → Q19

@Neet_pg_bot

Q20: 45-year-old female presents with recurrent episodes of right flank pain, hematuria, and a history of urinary tract infections. Urine analysis shows alkaline

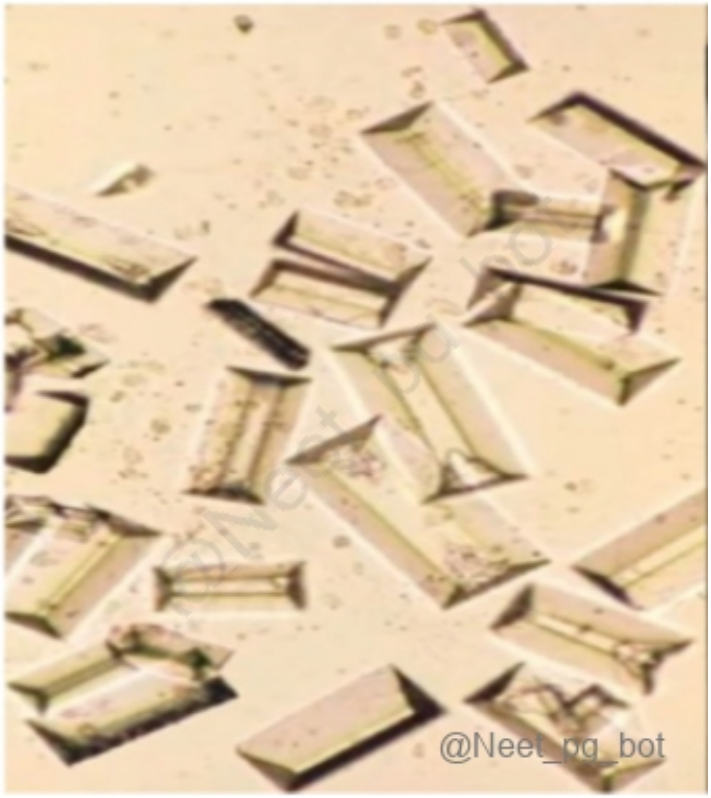
urine with a pH of 8.0. Microscopy revealed the following finding. Which of the following is the most likely underlying cause of this patient's condition? (Q840022)

A. Triple phosphate stone

B. Ca Oxalate Stones

C. Uric Acid Stones

D. Cystine Stones



See Answer in Part B → Q20

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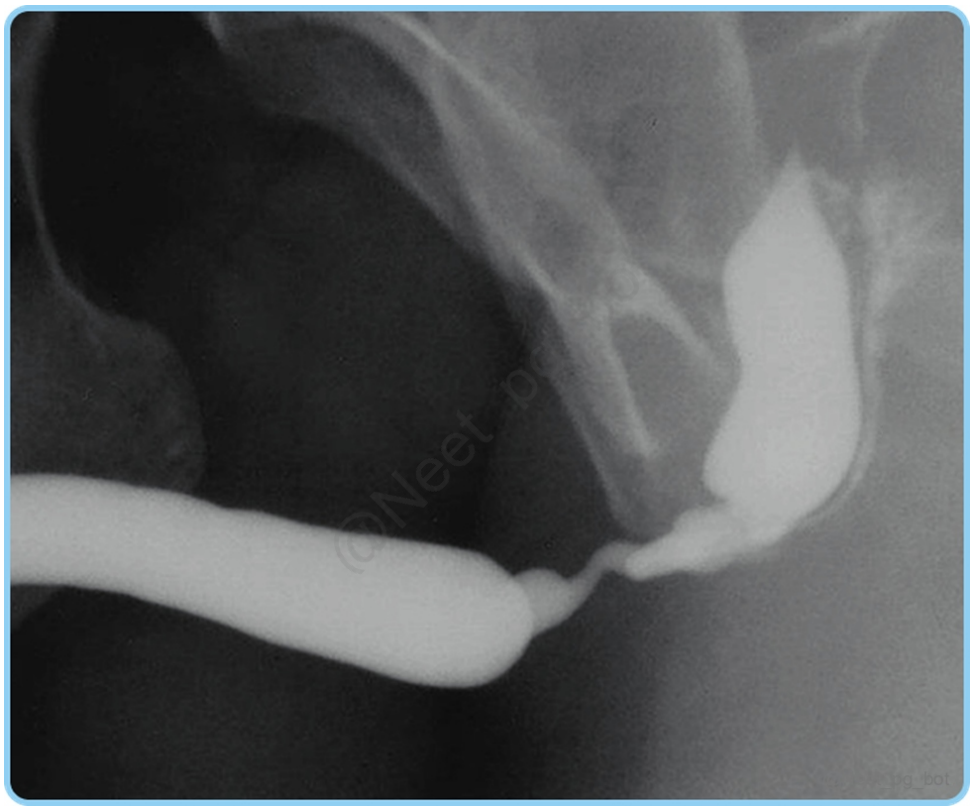
Q21: Identify the condition in the image: (Q860209)

A. Bulbar urethral stricture

B. Membranous urethral injury

C. Urethral tear

D. Prostate hyperplasia



See Answer in Part B → Q21

@Neet_pg_bot

Q22: A patient develops a severe infection and necrosis in the scrotal region after 5 days of catheterization. Based on the clinical presentation, what is the most likely diagnosis? (Q860214)

A. Fournier’s gangrene

B. Gas gangrene

C. Wet gangrene

D. Scrotal hematoma



See Answer in Part B → Q22

@Neet_pg_bot

Q23: A 35-year-old male presents with a painless testicular mass. After orchidectomy, histopathological examination reveals the presence of Reinke's crystals within the tumor cells. What is the most likely diagnosis? (Q860215)

A. Sertoli cell tumor

B. Leydig cell tumor

C. Seminoma

D. Yolk sac tumor

See Answer in Part B → Q23

@Neet_pg_bot

Q24: Post-orchidectomy, the specimen shows Reinke's Crystals. What is the diagnosis? (Q857248)

A. Seminoma

B. Leydig Cell Tumor

C. Metastasis

D. Yolk sac tumour

See Answer in Part B → Q24

@Neet_pg_bot

Q25: A 45 year old patient with a history of kidney stones that were surgically removed 2 years ago presents with complaints of fever and flank pain. Imaging done is shown here. What would be the most appropriate next step in the management of this patient? (Q820137)

A. Laparotomy to remove the stones

B. Lithotripsy to remove recurrent stone

C. Leave the foreign body inside

D. Cystoscopic retrieval of foreign Body



See Answer in Part B → Q25

@Neet_pg_bot

Q26: A 65-year-old male patient presents with urinary complaints. He has a history of working in a dye factory in the past. On USG examination, his bladder walls are found to be thickened and irregular. What is the most appropriate management for this patient? (Q820175)

A. Instillation of BCG

B. Cystoscopy with tumor removal

C. Intravesical mitomycin C

D. Radical cystectomy



See Answer in Part B → Q26

@Neet_pg_bot

Q27: What is the best investigation to assess renal perfusion? (Q820191)

A. DTPA scan

B. DMSA scan

C. RGU

D. CT urogram

See Answer in Part B → Q27

@Neet_pg_bot

Q28: A 4-year-old child is brought to the emergency department with a painless abdominal swelling noticed by the parents. On examination, a large, firm, mobile

abdominal mass is noted. The mass is unilateral and does not cross the midline. There is no associated hematuria, fever, or weight loss. What is the most probable diagnosis? (Q830828)

A. Neuroblastoma

B. Angiomyolipoma

C. Renal cell carcinoma

D. Wilm’s tumor

See Answer in Part B → Q28

@Neet_pg_bot

Q29: A 45-year-old patient presents with complaints of dysuria and intermittent back pain. On examination, there are no palpable abdominal masses or tenderness. An X-ray image of the abdomen is shown. What is the most likely diagnosis? (Q854769)

A. PTH adenoma

B. Wilm's tumour

C. Renal cell carcinoma

D. Lipoma



See Answer in Part B → Q29

@Neet_pg_bot

Q30: A 55-year-old male presented with verrucous carcinoma around the glans of the penis. Examination reveals that the inguinal lymph nodes are not enlarged. What is the appropriate management for this patient? (Q855147)

A. Total penectomy

B. CO2 laser excision

C. Topical 5-fluorouracil

D. Partial penectomy

See Answer in Part B → Q30

@Neet_pg_bot

Q31: A diabetic patient presents with sudden-onset perineal pain. On examination, foul-smelling discharge and necrotic tissue, as seen in the image, are noted. Which of the following is true about the given condition? (Q855167)

A. Anti-gas gangrene serum is indicated for all cases

B. Urinary diversion is the next step

C. A bilateral orchidectomy must be done

D. Mixed aerobic and anaerobic infection



See Answer in Part B → Q31

@Neet_pg_bot

Q32: Which of the following statements is not true regarding the provided medical condition? (Q855208)

A. Repeated radical surgery every 24 hours may be required to adequately manage this condition

B. This is a case of Meleney's gangrene

C. The condition is caused by β-hemolytic streptococcus and may sometimes be polymicrobial

D. Hyperbaric oxygen has no role in the treatment of this condition.



See Answer in Part B → Q32

@Neet_pg_bot

Q33: A 55-year-old male patient presents with hematuria and a neovascular mass in the left kidney on a CT scan, as shown below. What is the diagnosis? (Q857778)

A. Renal cell carcinoma

B. Renal oncocytoma

C. Renal angiomyolipoma

D. Renal cyst



See Answer in Part B → Q33

@Neet_pg_bot

Q34: Which lymph node is most commonly involved in prostate cancer? (Q857794)

A. Deep inguinal

B. Retroperitoneal

C. Superficial inguinal

D. Pelvic

See Answer in Part B → Q34

@Neet_pg_bot

Q35: Which of the following statements is false about the following image? (Q857795)

A. Staphylococcus aureus is the causative organism

B. Common in diabetic patients

C. High mortality

D. The testes remain unaffected



See Answer in Part B → Q35

@Neet_pg_bot

Q36: What type of hernia is a funicular hernia? (Q857796)

A. Direct inguinal hernia

B. Indirect inguinal hernia

C. Femoral hernia

D. Umbilical hernia

See Answer in Part B → Q36

@Neet_pg_bot

Q37: A 50-year-old male patient came to the outpatient department with complaints of hematuria. A 2x2 cm bladder mass is seen which is low-grade transitional cell carcinoma. Which among the following is the ideal management? (Q857799)

A. Transurethral resection of the tumor

B. Resection with ileal conduit

C. Partial cystectomy with bladder reconstruction

D. Neoadjuvant chemotherapy



See Answer in Part B → Q37

@Neet_pg_bot

Q38: Which of the following will have unilateral hydronephrosis? (Q857801)

A. Urethral atresia

B. Posterior urethral valves

C. Benign Prostatic Hyperplasia

D. Retrocaval ureter

See Answer in Part B → Q38

@Neet_pg_bot

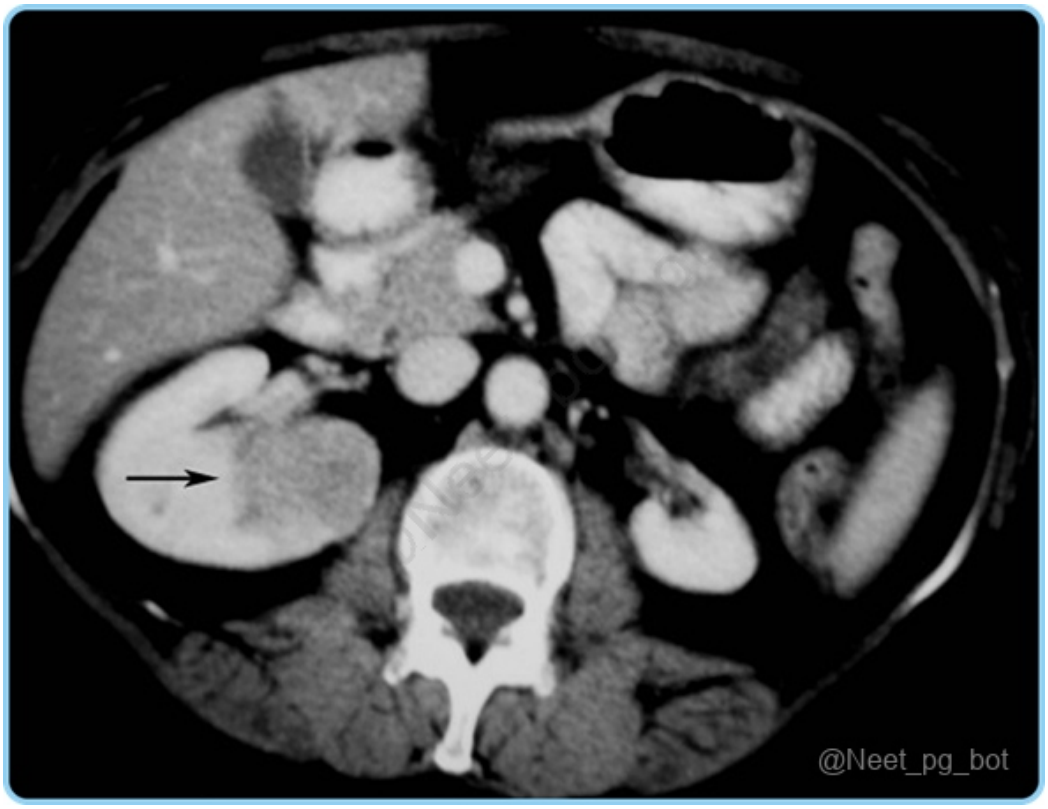
Q39: A 44-year-old female presents with an incidentally discovered 4 cm solid, hyper-enhancing mass in the lower pole of the right kidney on CT imaging. The contralateral kidney is normal, and there is no evidence of lymphadenopathy or distant metastasis. What is the most appropriate management for this patient? (Q857802)

A. Partial nephrectomy

B. Partial nephrectomy + Neoadjuvant chemotherapy

C. Radical nephrectomy

D. Radical nephrectomy + Postoperative radiotherapy



See Answer in Part B → Q39

@Neet_pg_bot

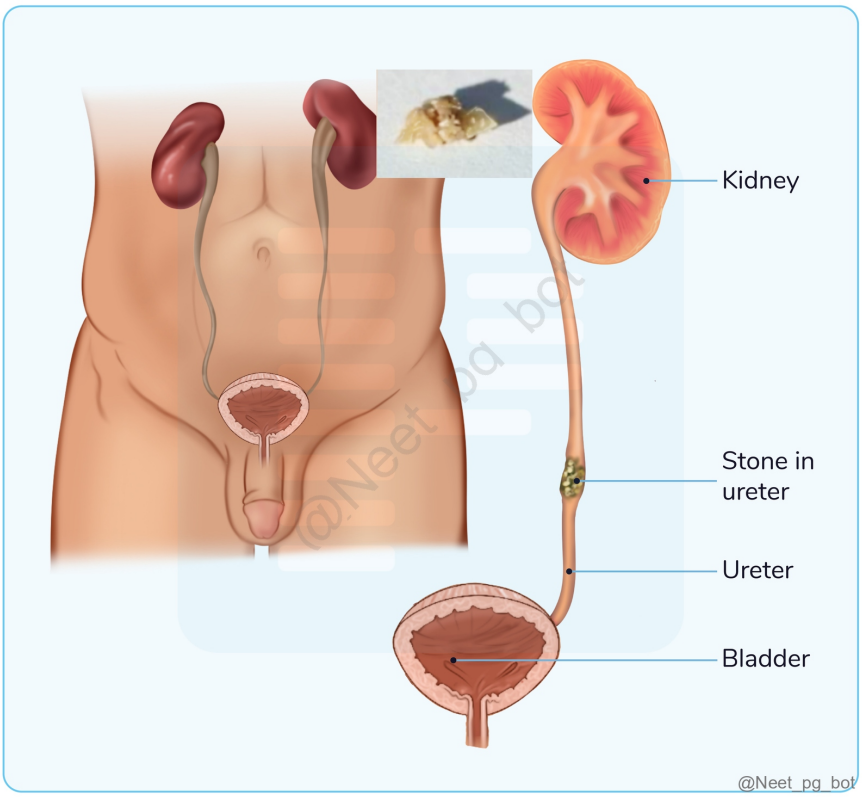
Q40: Which of the following is the recommended treatment for the condition shown in the image, where the size of the stone is 1.5 cm? (Q857820)

A. Percutaneous nephrolithotomy

B. Ureteroscopy

C. ESWL

D. Wait and watch



See Answer in Part B → Q40

@Neet_pg_bot

Q41: What is the initial management approach for urinary symptoms in a patient with benign prostatic hyperplasia (BPH)? (Q857822)

A. TURP: Transurethral resection of prostate

B. Tamsulosin

C. Finasteride

D. Observation

See Answer in Part B → Q41

@Neet_pg_bot

Q42: Which of the following are true about nephroblastoma except: (Q857825)

A. Treatment is chemotherapy followed by surgery

B. Lung metastasis is common

C. Hematogenous spread

D. Most common intra-abdominal malignancy in children

See Answer in Part B → Q42

@Neet_pg_bot

Q43: A 25-year-old patient presents to the surgical OPD with a painless left inguinal reducible mass. On examination cough impulse is positive. After further investigations, the patient is diagnosed with an inguinal hernia. What is the surgical management of this patient? (Q857831)

A. Herniotomy

B. Hernioplasty

C. Wait and watch

D. Emergency laparotomy

See Answer in Part B → Q43

@Neet_pg_bot

Q44: A male patient presented with complaints of hematuria and recurrent urinary tract infection. You notice the following finding in his CT. What is the likely condition indicated by the arrow in the image? (Q857867)

A. Polycystic kidney disease

B. Horseshoe kidney

C. Hydronephrosis

D. Pancake kidney



See Answer in Part B → Q44

@Neet_pg_bot

Q45: Which is the correct sequence for the correction of hypospadias? Urethroplasty Penile de-gloving Orthoplasty Glanuloplasty (Q855696)

A. 1,3,2,4

B. 2,3,1,4

C. 3,1,4,2

D. 1,3,4,2

See Answer in Part B → Q45

@Neet_pg_bot

Q46: A 30-year-old male patient presents with a pelvic fracture following blunt abdominal trauma. No blood is seen at the meatus. Catheterisation does not produce significant urine output. The radiological image is given below. What is the next step in management? (Q855183)

A. Suprapubic cystostomy

B. Per Urethral catheterisation

C. Laparotomy

D. Pelvic packing along with B/L percutaneous nephrostomy



See Answer in Part B → Q46

@Neet_pg_bot

Q47: What is the most likely diagnosis for a young girl who presents with continuous dribbling of urine despite voiding normally, as reported by her parents, who mention her never being completely dry since birth? (Q857151)

A. Ectopic ureter

B. Ureterocele

C. Congenital megaureter

D. Vesicoureteric reflux

See Answer in Part B → Q47

@Neet_pg_bot

Q48: A 1-month-old child is brought to the OPD for consultation regarding an empty scrotal sac. On examination B/L inguinal masses are palpable. What is the next step of management for this child? (Q857163)

A. Perform karyotyping

B. Surgical exploration within the next 2 weeks

C. Perform orchidopexy now

D. Wait and watch for spontaneous descent within the next 6 months.

See Answer in Part B → Q48

@Neet_pg_bot

Q49: Which of the following is the most common type of radiolucent renal stone? (Q857202)

A. Calcium Oxalate Stones

B. Uric Acid Stones

C. Cystine Stones

D. Xanthine Stones

See Answer in Part B → Q49

@Neet_pg_bot

Q50: For which of the following conditions is the Whitaker test recommended? (Q857211)

A. Hydronephrosis

B. Posterior urethral valve

C. Urethral atresia

D. Urethral stricture

See Answer in Part B → Q50

@Neet_pg_bot

Q51: A 33-year-old man was referred to the surgery OPD from the infertility clinic. On palpation, a bag of worms sensation was felt with dilated veins. What is the most likely diagnosis? (Q857251)

A. Hydrocele

B. Varicocele

C. Testicular torsion

D. Epididymo Orchitis

See Answer in Part B → Q51

@Neet_pg_bot

Q52: What would be the best treatment option for a patient who has been diagnosed with renal cell carcinoma and has a tumour measuring 10 cm in size, located at the lower part of the kidney, and has negative regional lymph nodes? (Q857266)

A. Radical nephrectomy

B. Partial nephrectomy

C. Radiotherapy

D. Chemotherapy

See Answer in Part B → Q52

@Neet_pg_bot

Q53: What is the most likely diagnosis for a patient who has a scrotal mass on the left side that is hard in texture, has uneven edges, does not decrease in size when lying down or manipulated, does not have a cough impulse, but shows enlargement in the para-aortic lymph nodes? (Q857268)

A. Hydrocele

B. Direct inguinal hernia

C. Indirect inguinal hernia

D. Metastasising testicular tumor

See Answer in Part B → Q53

@Neet_pg_bot

Q54: A 10-month-old male baby presented with an empty scrotum. Ultrasonography revealed that the right testis was found in the right inguinal canal, while the left testis was found in the perineum. Comment on the diagnosis of this baby. (Q857500)

A. Bilateral undescended testis

B. Bilateral ectopic testis

C. Right-side undescended testis and left-sided ectopic testis

D. Right side ectopic testis and left side undescended testis

See Answer in Part B → Q54

@Neet_pg_bot

Q55: What is the most probable diagnosis for a 14-year-old boy who is experiencing sudden scrotal pain, where physical examination reveals a swollen and red scrotum

with the right testes being retracted, absent cremasteric reflex, and negative Prehn's sign? (Q857504)

A. Right-sided hydrocele

B. Strangulated inguinal hernia

C. Right testicular torsion

D. Right epididymo orchitis

See Answer in Part B → Q55

@Neet_pg_bot

Q56: What is the likely diagnosis for an elderly male patient who has come to the hospital with lower back pain, a movable mass in the lower back that becomes more prominent when breathing in and a general feeling of weakness? The lab tests show the presence of red blood cells in the urine, with no sign of pus cells. (Q857531)

A. Polycystic kidney disease

B. Hydronephrosis

C. Renal cell carcinoma

D. Chronic pyelonephritis

See Answer in Part B → Q56

@Neet_pg_bot

Q57: What is the likely diagnosis for a 60-year-old male who is experiencing lower back pain and has sclerotic lesions in the vertebrae? (Q857532)

A. Carcinoma prostate

B. Tuberculosis

C. Renal cell carcinoma

D. Carcinoma colon

See Answer in Part B → Q57

@Neet_pg_bot

Q58: A patient with a history of trauma has a ruptured bulbar urethra. What is the location for the accumulation of urine? (Q857534)

A. Superficial pouch

B. Deep pouch

C. Rectouterine pouch

D. Uterovesical pouch

See Answer in Part B → Q58

@Neet_pg_bot

Q59: In a newborn male with an undeveloped scrotum, the testis was observed to be located near the peritoneum. Which of the following factors aids in the descent of the testis into the scrotum? (Q857536)

A. GnRH Analogues

B. Testosterone

C. Cold Compressions

D. Manually bring the testis down to the bottom of scrotum.

See Answer in Part B → Q59

@Neet_pg_bot

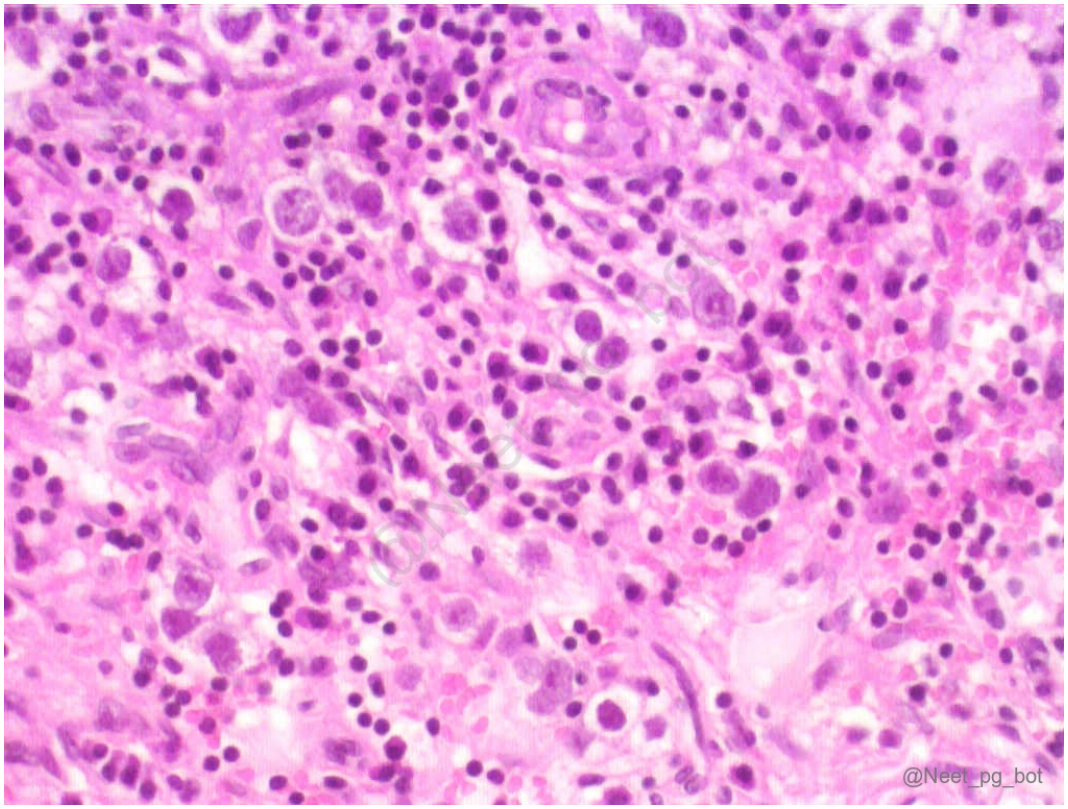
Q60: A 35-year-old man presents with scrotal enlargement. His LDH levels are notably elevated, while HCG and alpha-fetoprotein levels remain within normal ranges. Upon histopathological examination, the findings are as shown below. What is the most probable diagnosis? (Q857537)

A. Leydig cell tumor

B. Embryonal carcinoma

C. Seminoma

D. Teratoma



See Answer in Part B → Q60

@Neet_pg_bot

Q61: A young male underwent lumbar sympathectomy, and bilateral L1 ganglions were removed. What will be the most common side effect? (Q857538)

A. Impotence

B. Retrograde ejaculation

C. Bladder dysfunction

D. Incontinence

See Answer in Part B → Q61

@Neet_pg_bot

Q62: All the following are features of polycystic disease of kidneys except: (Q857543)

A. Hematuria

B. Hypertension

C. Renal failure

D. Erythrocytosis

See Answer in Part B → Q62

@Neet_pg_bot

Q63: A 26 year old male presented with a painless large round firm right testicular swelling, with a dragging sensation. The left testis was normal. AFP was around 3000U. What is the next best step in the management? (Q858337)

A. FNAC

B. Scrotal true cut biopsy

C. High inguinal orchidectomy

D. Repeat tumor markers

See Answer in Part B → Q63

@Neet_pg_bot

Q64: A 20-year-old was brought to the ER after falling off his bicycle. His vitals were stable, but he had a bruise over the perineum, and he had not passed urine yet. Blood was seen at the meatus and the bladder was not palpable. How do you manage him? (Q858339)

A. Wait and send him home

B. Immediate insertion of a Foley catheter

C. Suprapubic aspiration of urine

D. Wait for bladder to fill and urge to urinate

See Answer in Part B → Q64

@Neet_pg_bot

Q65: What is the primary reason for bladder outlet obstruction in male children? (Q858352)

A. Posterior urethral valve

B. Urethral atresia

C. Anterior urethral valve

D. Ureterocele

See Answer in Part B → Q65

@Neet_pg_bot

Q66: A 3-year-old boy is brought by his mother with right-sided abdominal swelling noticed during bathing. He had a history of hematuria 2 weeks ago, which resolved spontaneously. On examination, a right-sided reniform, ballotable mass is palpable. What is the investigation of choice for confirming the diagnosis? (Q856530)

A. CECT abdomen

B. PET-CT

C. 24-hour urinary VMA

D. FNAC

See Answer in Part B → Q66

@Neet_pg_bot

Q67: A 50-year-old male patient came to the outpatient department with complaints of hematuria. A 2x2 cm bladder mass is seen which is low grade transitional cell carcinoma. Which among the following is the ideal management? (Q856567)

A. Transurethral resection of the tumor

B. Resection with ileal conduit

C. Partial cystectomy with bladder reconstruction

D. Neoadjuvant chemotherapy

See Answer in Part B → Q67

@Neet_pg_bot

Q68: Which of the following statements is true regarding the condition mentioned below? {{caption_text}} (Q856203)

A. Patient must be started on anti-gas gangrene serum therapy

B. It is a mixed flora aerobic and anaerobic infection

C. Bilateral orchiectomy is generally performed

D. Compulsory urinary diversion is performed



See Answer in Part B → Q68

@Neet_pg_bot

Q69: In a patient with abdominal pain and sterile pyuria, what is the finding shown in the image given? (Q856205)

A. Putty kidney

B. Nephrocalcinosis

C. Staghorn calculus

D. Psoas calcification



See Answer in Part B → Q69

@Neet_pg_bot

Q70: A 75-year-old man with prostate carcinoma presents to you with a PSA of 9 ng/mL with a small tumour focus. His Gleason score is 6. What will be your most likely management? (Q856232)

A. Radical prostatectomy

B. External beam radiation

C. Brachytherapy

D. Active surveillance

See Answer in Part B → Q70

@Neet_pg_bot

Q71: A patient arrives after being involved in a motorcycle road traffic accident. The patient does not report any pain or injury. Upon examination, there is evidence of blood at the urethral meatus. What would be your subsequent course of action in terms of managing this patient? (Q856251)

A. Foley's catheterization

B. Wait and watch

C. Nephrogram

D. Suprapubic cystostomy

See Answer in Part B → Q71

@Neet_pg_bot

Q72: What is the probable diagnosis for a girl who has experienced continuous urinary dribbling and persistent bladder fullness since birth? (Q856227)

A. Stress incontinence

B. Ureterocele

C. Ectopic ureter

D. Vesicovaginal fistula

See Answer in Part B → Q72

@Neet_pg_bot

Q73: Identify the investigation and the lesion depicted in the image given below: (Q854923)

A. Retrograde cystourethrogram with membranous urethra stricture

B. Retrograde cystourethrogram with penile urethral stricture

C. Micturating cystourethrography with bulbar stricture

D. Micturating cystourethrography with prostatic urethra stricture



See Answer in Part B → Q73

@Neet_pg_bot

Q74: A male patient was brought to the emergency department following a fall into a manhole, resulting in injury to his perineum. He experiences a strong urge to urinate but is unable to do so. During examination, blood is observed at the opening of the urethra, and there is swelling of the penis and scrotum. Which specific area is affected by the injury? (Q854961)

A. Membranous urethra rupture

B. Bulbar urethra injury

C. Prostatic urethra injury

D. Urinary bladder rupture

See Answer in Part B → Q74

@Neet_pg_bot

Q75: Which of the following should be the treatment of choice for renal cell carcinoma with a tumour less than 4 cm in size? (Q854970)

A. Partial nephrectomy

B. Partial nephrectomy + Neoadjuvant chemotherapy

C. Radical nephrectomy

D. Radical nephrectomy + Postoperative radiotherapy

See Answer in Part B → Q75

@Neet_pg_bot

Q76: A 65-year-old man presented to his primary care physician with a 3-month history of increasing urinary frequency without burning and nocturia four times each day. He has limited his fluid consumption and caffeine intake in the evening without much benefit. On prostate examination, the swelling was palpated with a smooth surface, and a firm, non-tender rubber-like consistency was found. The physician thinks of benign prostate hypertrophy. All are characteristic features of benign prostate hypertrophy except: (Q859601)

A. Increased trabeculations in the bladder

B. J-shaped/ fish hook proximal ureter

C. J-shaped/ fish hook distal ureters

D. Bilateral hydronephrosis

See Answer in Part B → Q76

@Neet_pg_bot

Q77: A 68-year-old man presents to OPD with a low backache. His PSA level is 100 ng/ml. Which of the following drugs is indicated for treatment? (Q859617)

A. Somatostatin

B. Terlipressin

C. Goserelin

D. Testosterone

See Answer in Part B → Q77

@Neet_pg_bot

Q78: A 25-year-old morbidly obese male patient presented with complaints of severe abdominal pain and urinary disturbances. His urine microscopy shows the following type of crystals, and an ultrasound of the kidney revealed a renal stone of size 2.5 cm. What is the treatment of choice? (Q859621)

A. Extracorporeal shockwave lithotripsy (ESWL)

B. Percutaneous nephrolithotomy (PCNL

C. Open surgery

D. Ureteroscopy-assisted removal



See Answer in Part B → Q78

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Q79: According to Weigert Meyer's rule of duplication of the ureter, the lower pole ureter in the urinary bladder is: (Q859624)

A. Lateral and cephalad to the upper pole ureter

B. Lateral and caudal to the upper pole ureter

C. Medial and cephalad to the upper pole ureter

D. Medial and caudal to the upper pole ureter

See Answer in Part B → Q79

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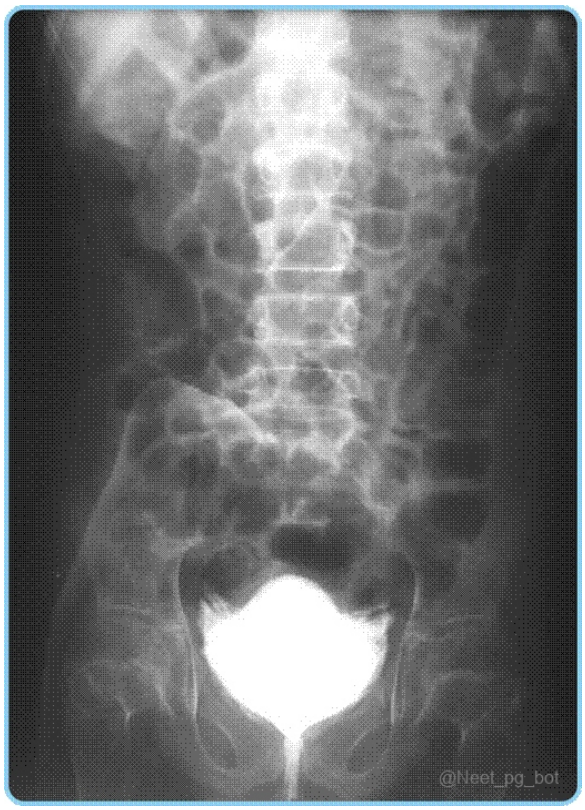
Q80: A 35-year-old male presents to the emergency department after a motor vehicle accident with a pelvic fracture and gross hematuria. The CT cystogram showed the following characteristic findings. Which of the following statements regarding the diagnosis of this patient is incorrect? (Q859625)

A. Retrograde cystography demonstrates extravasation of contrast limited to the perivesical space.

B. Catheter drainage for 10-14 days is the treatment of choice for uncomplicated cases.

C. Immediate surgical repair in cases of bladder neck injury.

D. Both urethral and suprapubic catheters are recommended in all cases.



See Answer in Part B → Q80

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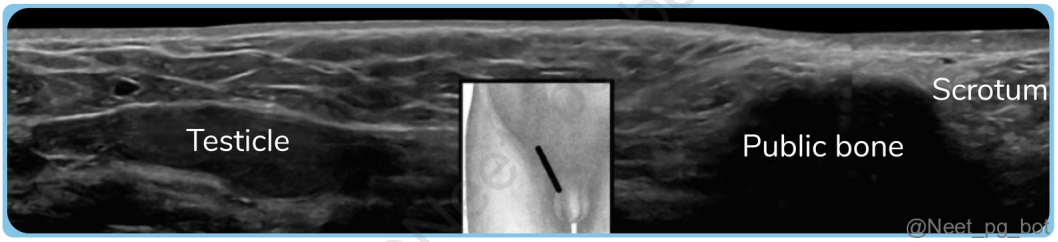
Q81: An 11-month-old boy had a recent urinary tract infection that was resolved with antibiotics. Vital signs are within normal limits. Physical examination revealed an empty scrotum on the right side with normal left testis. However, a mass was palpable on the right inguinal canal. The USG revealed the right testicle under the subcutaneous fat near the right inguinal canal, as shown in the image below. What is the next best step in management? (Q859626)

A. Observation

B. Hormonal therapy with hCG

C. Orchidopexy

D. Diagnostic laparoscopy



See Answer in Part B → Q81

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Q82: A 65-year-old male presents with a low backache and weight loss. He has progressive difficulty in urination and had an episode of urinary retention two days back, which was relieved by catheterisation. PSA was done, which was 5.2 ng/ml, and an x-ray of the LS spine showed osteoblastic changes. What is the clinical diagnosis? (Q859832)

A. Benign prostatic hypertrophy

B. Carcinoma bladder

C. Prostate cancer

D. Renal cell cancer

See Answer in Part B → Q82

@Neet_pg_bot

Q83: What should be the initial course of action for a patient who has presented with a pelvic fracture and a rupture in the membranous urethra? (Q859840)

A. A suprapubic catheter should be inserted as soon as possible

B. IVP should be done

C. Immediate urethroplasty

D. MCU should be done

See Answer in Part B → Q83

@Neet_pg_bot

Q84: What is the cause of the following appearance in IVP? (Q859841)

A. Horseshoe kidney

B. Ureterocoele

C. Bladder tumour

D. Posterior urethral valve



See Answer in Part B → Q84

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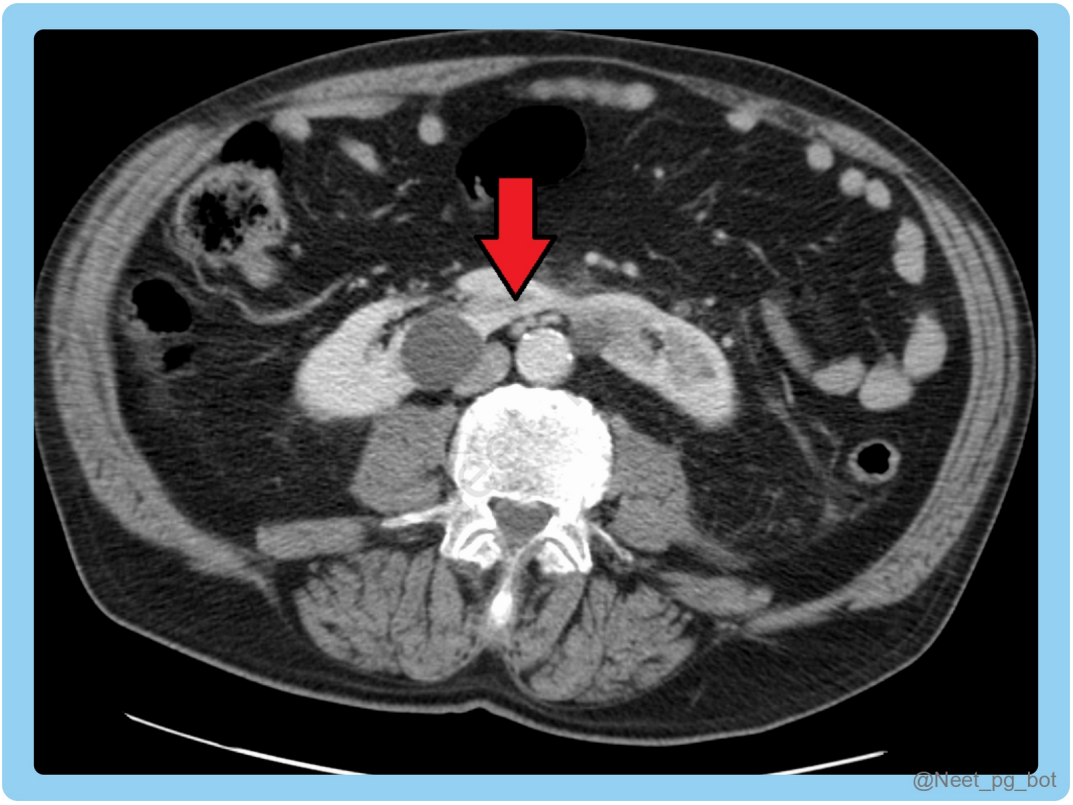
Q85: A 30-year-old man developed abdominal pain for which he was being evaluated. You notice the following in his CECT. What is the likely condition indicated by the arrow in the image? (Q859842)

A. Appendicitis

B. Horseshoe kidney

C. Wilms tumor

D. Abdominal aortic aneurysm



See Answer in Part B → Q85

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Q86: What is the likely diagnosis for a patient who visited the outpatient department (OPD) experiencing intense pain during erection and a deviated penis for the past half-year? (Q859845)

A. Peyronie’s disease

B. Priapism

C. Marion’s disease

D. Erectile dysfunction

See Answer in Part B → Q86

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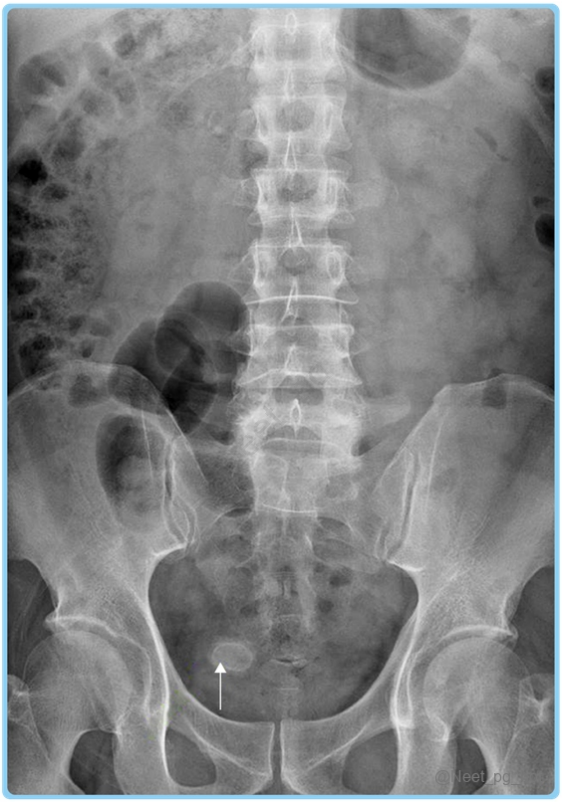
Q87: What is the diagnosis based on the X-ray given below? {{caption_text}} (Q859858)

A. Renal calculi

B. Bladder calculi

C. Schistosomiasis

D. Ureteric calculi



See Answer in Part B → Q87

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Q88: A 60-year-old patient undergoes TURP, and after 3 days, the patient develops altered sensitiveness and drowsiness. The most probable diagnosis is: (Q859864)

A. Hypernatremia

B. Hyponatremia

C. Stroke

D. Meningitis due to spinal anaesthesia

See Answer in Part B → Q88

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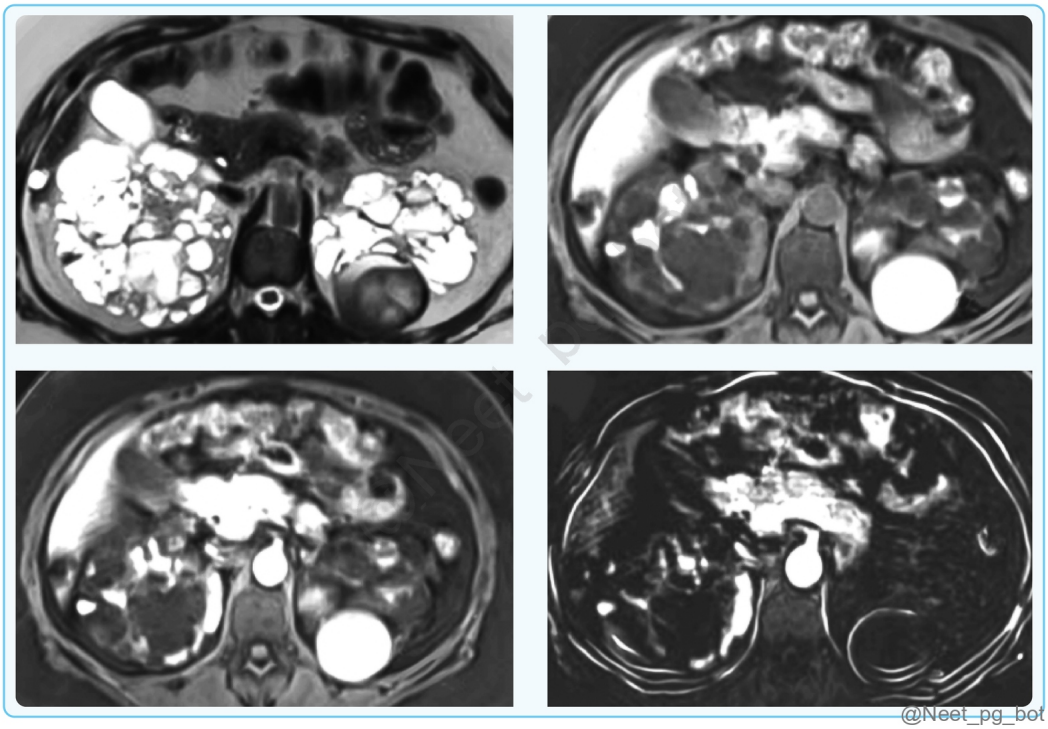
Q89: A 40-year-old man with a known case of hypertension presented with multiple episodes of hematuria and loin pain. His elder brother passed away due to a stroke at the age of 40. The CT abdomen is shown below. What is the probable diagnosis? (Q855565)

A. Renal cell carcinoma

B. Autosomal dominant polycystic kidney disease

C. Tuberculosis of the kidney

D. Autosomal recessive polycystic kidney disease



See Answer in Part B → Q89

@Neet_pg_bot

Q90: What is the probable diagnosis for an elderly male patient who experienced scrotal pain and discharge, as indicated in the provided image? (Q855763)

A. Torsion of testis

B. Acute epididymo-orchitis

C. Scrotal carcinoma

D. Fournier’s gangrene



See Answer in Part B → Q90

@Neet_pg_bot

Q91: A patient presents with prostate carcinoma, which has now spread to the vertebra. What is the route of spread to the lumbar vertebra? (Q855766)

A. Batson's plexus

B. Transcoelomic spread

C. Inferior vesical vein

D. Internal iliac vein

See Answer in Part B → Q91

@Neet_pg_bot

Q92: A 6-year-old boy came with a history of recurrent urinary tract infections. Imaging was done and is shown below. What is the diagnosis? (Q855781)

A. Vesicoureteric reflux

B. Urinary bladder diverticulum

C. Urinary bladder hernia

D. Vesicocolic fistula



See Answer in Part B → Q92

@Neet_pg_bot

Q93: A young male patient with a history of a motor vehicle accident cannot pass urine. Blood is seen at the meatus. What is the most likely site of urethral injury? (Q855797)

A. Bulbar urethra

B. Spongy urethra

C. Membranous urethra

D. Penile urethra



See Answer in Part B → Q93

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Q94: A delayed intravenous urogram of a patient is given below. What is the likely diagnosis? (Q855803)

A. Pelviureteric junction obstruction

B. Putty kidney

C. Staghorn calculus

D. Cystic kidney



See Answer in Part B → Q94

@Neet_pg_bot

Q95: What is the initial management approach for urinary symptoms in a patient with benign prostatic hyperplasia (BPH) ? (Q794786)

A. TURP: Transurethral resection of prostate

B. Tamsulosin

C. Finasteride

D. Observation

See Answer in Part B → Q95

@Neet_pg_bot

Q96: A 50-year-old male patient came to the outpatient department with complaints of hematuria . A 2x2 cm bladder mass is seen which is low grade transitional cell carcinoma . Which among the following is the ideal management? (Q802848)

A. Transurethral resection of the tumor

B. Resection with ileal conduit

C. Partial cystectomy with bladder reconstruction

D. Neoadjuvant chemotherapy



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See Answer in Part B → Q96

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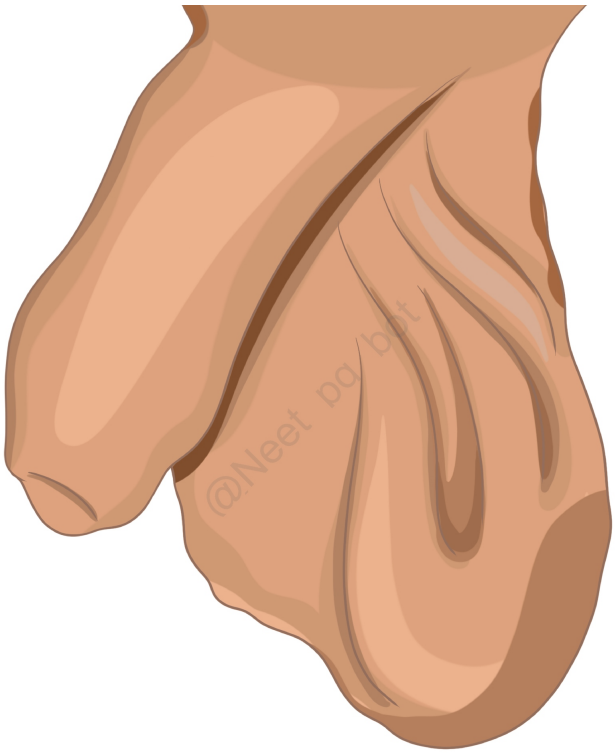
Q97: A 33-year-old man was referred to the surgery OPD from the infertility clinic . On inspection, the scrotum appeared as in the image. On palpation, a bag of worm sensation was felt . What is the most likely diagnosis? (Q793368)

A. Hydrocele

B. Varicocele

C. Testicular torsion

D. Epididymo Orchitis



See Answer in Part B → Q97

@Neet_pg_bot

Q98: Which of the following are s torage symptoms of benign prostatic hyperplasia ? 1. Urgency 2. Enuresis 3. Hesitancy 4. Frequency 5. Dribbling (Q793417)

A. 1, 3, 4

B. 2 and 5

C. 1, 2, 4, 5

D. 1, 2, 4

See Answer in Part B → Q98

@Neet_pg_bot

Q99: What diagnosis would you suggest for a 10-month-old male baby who presented with an empty scrotum , wherein ultrasonography showed the right testis located in the right inguinal canal and the left testis located in the perineum? (Q793435)

A. Bilateral undescended testis

B. Bilateral ectopic testis

C. Right side undescended testis and left sided ectopic testis

D. Right side ectopic testis and left side undescended testis

See Answer in Part B → Q99

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Q100: Identify the investigation and the lesion depicted in the image given below. (Q793492)

A. Retrograde cystourethrogram with membranous urethra stricture

B. Retrograde cystourethrogram with penile urethral stricture

C. Micturating cystourethrography with bulbar stricture

D. Micturating cystourethrography with psoriatic urethra stricture



See Answer in Part B → Q100

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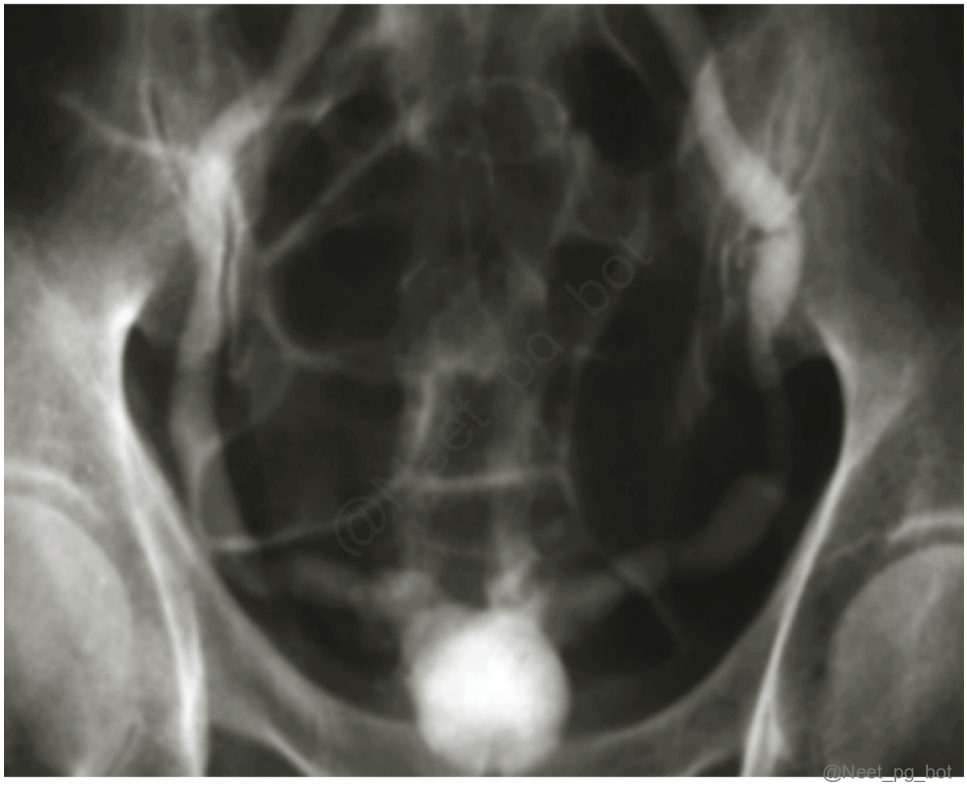
Q101: A patient presented to the hospital with a history of increased frequency of micturition . On cystoscopy, a pale ureteric orifice was seen. The patient's KUB x-ray is given below. What is the most probable diagnosis? (Q793507)

A. Bladder carcinoma

B. Schistosomiasis

C. Bladder tuberculosis

D. Papilloma of urinary bladder



See Answer in Part B → Q101

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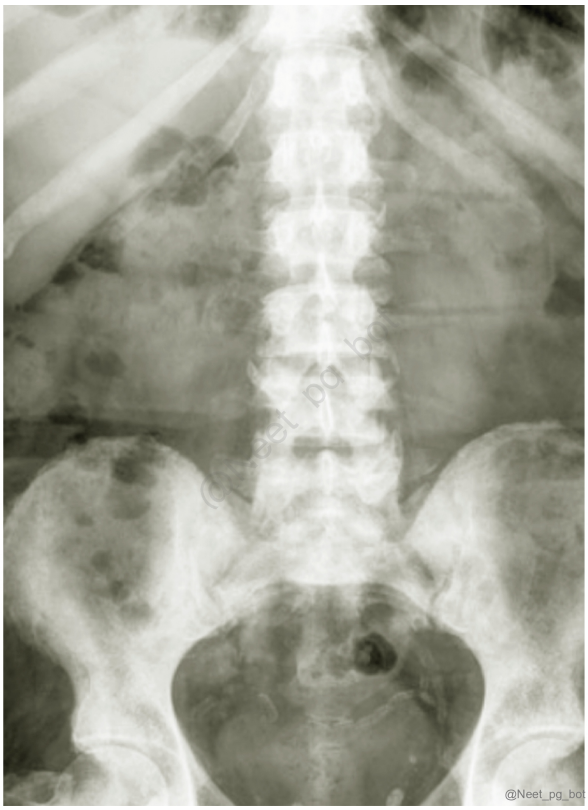
Q102: A 77-year-old man presented with worsening hip and back pain . He also reports weight loss and loss of appetite . His PSA levels are elevated. What is the most likely diagnosis here? (Q793512)

A. Ankylosing spondylitis

B. Osteosarcoma

C. Osteoclastoma

D. Prostate cancer



See Answer in Part B → Q102

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Q103: A 50-year-old male patient presents with palpitations, episodic headaches , and sweating episodes . Workup shows a small left-sided suprarenal mass . Which of the following would be done for confirmation? (Q793850)

A. Urinary vanillyl mandelic acid levels

B. Blood 5-HIAA levels

C. Urine myoglobin

D. Stool trypsin levels

See Answer in Part B → Q103

@Neet_pg_bot

Q104: If radiotherapy is administered along with chemotherapy for bladder cancer, which drug's dosage should be decreased? (Q793872)

A. Cisplatin

B. Gemcitabine

C. Paclitaxel

D. Ifosfamide

See Answer in Part B → Q104

@Neet_pg_bot

Q105: Which of the following is used for prostate cancer ? (Q793878)

A. Gleason score

B. Bethesda score

C. Alvarado score

D. Nottingham score

See Answer in Part B → Q105

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• [07_Endocrine Surgery] 041 Breast-I

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[07_Endocrine Surgery] 041 Breast-I — Quick Jump

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Q7 (p. 682)	*Q8 (p. 683)*	*Q9 (p. 683)*	*Q10 (p. 683)*	*Q11 (p. 684)*	*Q12 (p. 684)*
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Q25 (p. 689)	*Q26 (p. 689)*	*Q27 (p. 690)*	*Q28 (p. 690)*	*Q29 (p. 691)*	*Q30 (p. 691)*
Q31 (p. 692)	*Q32 (p. 692)*	*Q33 (p. 693)*	*Q34 (p. 693)*		

Q1: A 45-year-old woman has a painless, firm breast lump and enlarged lymph nodes in the armpit. Which imaging technique is most sensitive for detecting cancer, especially in dense breast tissue? (Q880445)

A. 2D mammography

B. Digital mammography

C. Tomosynthesis with conventional mammography

D. Full-field digital mammography

See Answer in Part B → Q1

@Neet_pg_bot

Q2: During the luteal phase of the menstrual cycle, which hormone is mainly responsible for promoting lobular and alveolar development of the mammary glands? (Q880421)

A. Estrogen

B. Progesterone

C. Both A and B

D. Prolactin

See Answer in Part B → Q2

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Q3: During a routine third-trimester checkup, a pregnant woman is found to have additional nipples along the embryonic milk line. What is the proper medical term for this condition? (Q880423)

A. Polymastia

B. Polythelia

C. Accessory mammary tissue

D. Mammary hypertrophy

See Answer in Part B → Q3

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Q4: A 28-year-old woman is noted to have extra glandular tissue in her axilla that becomes tender during her menstrual cycle. Regarding accessory breast tissue, which of the following statements is incorrect? (Q880425)

A. It can respond to hormonal changes such as menstruation or pregnancy

B. It is synonymous with supernumerary nipples

C. It can rarely be found along the chest wall or abdomen

D. Surgical removal may be considered for cosmetic or symptomatic reasons

See Answer in Part B → Q4

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Q5: Congenital absence of the breast (amazia) is most commonly associated with which syndrome? (Q880427)

A. Turner syndrome

B. Poland’s syndrome

C. Klinefelter syndrome

D. Marfan syndrome

See Answer in Part B → Q5

@Neet_pg_bot

Q6: Which of the following is a typical clinical feature of Poland syndrome? (Q880430)

A. Absence of the sternal portion of pectoralis major

B. Short, webbed fingers (symbrachydactyly)

C. Unilateral breast hypoplasia or aplasia

D. All of the above

See Answer in Part B → Q6

@Neet_pg_bot

Q7: A 41-year-old woman presents with a painful, cord-like structure on the anterior chest wall extending over her breast. She denies trauma, infection, or fever. On examination, a tender, subcutaneous cord is palpable, fixed to the overlying skin. When she raises her arm, a narrow groove alongside the cord becomes visible. What is the most likely diagnosis? (Q880431)

A. Mastitis

B. Mondor’s disease

C. Inflammatory breast carcinoma

D. Lymphangitis

See Answer in Part B → Q7

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Q8: A 48-year-old woman with mammary duct ectasia presents with persistent periareolar swelling, recurrent nipple discharge, and discomfort despite conservative management and antibiotics. Which surgical procedure is most appropriate in this scenario? (Q880432)

A. Microdochectomy

B. Hadfield's procedure

C. Axillary lymph node dissection

D. Excision of breast tissue related to the affected duct

See Answer in Part B → Q8

@Neet_pg_bot

Q9: A 42-year-old woman presents with a single-duct, bloody nipple discharge from her right breast. She has no palpable lumps, and her mammogram and ultrasound are normal. She is concerned about the possibility of cancer. Which of the following is the most appropriate next step in management? (Q880433)

A. Simple reassurance and annual imaging follow-up

B. Microdochectomy of the affected duct

C. Hadfield’s major mammary duct excision

D. Start empirical antibiotics and observe

See Answer in Part B → Q9

@Neet_pg_bot

Q10: At what age is routine screening mammography generally recommended for asymptomatic women without high-risk factors? (Q880441)

A. After 30 years

B. After 35 years

C. After 40 years

D. After 50 years

See Answer in Part B → Q10

@Neet_pg_bot

Q11: Which of the following is correct regarding screening mammography? (Q880442)

A. Performed in symptomatic women and requires only a single view of each breast

B. Two standard views, mediolateral oblique and craniocaudal, are obtained for each breast in asymptomatic women

C. Not performed in women older than 40 years

D. Diagnostic mammography and screening mammography are identical in technique and timing

See Answer in Part B → Q11

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Q12: A 65-year-old patient undergoes a screening mammogram. The radiologist identifies a cluster of calcifications and a discrete mass. Which of the following radiological descriptors in the mammography report would be the least concerning for malignancy? (Q880443)

A. Irregular mass

B. Wide halo

C. Macrocalcification

D. Spiculated margins

See Answer in Part B → Q12

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Q13: Match the following findings with the associated condition: Type of calcification Disease A. Popcorn calcification i) Fibrocystic disease B. Lead-pipe calcification ii) Duct ectasia C. Broken needle calcification iii) Traumatic fat necrosis D. Tea cup calcification iv) Fibroadenoma (Q880444)

A. A-iii, B-ii, C-i, D-iv

B. A-iv, B-iii, C-ii, D-i

C. A-i, B-iii, C-ii, D-iv

D. A-ii, B-iv, C-iii, D-i

See Answer in Part B → Q13

@Neet_pg_bot

Q14: Which of the following describes the basal type of breast malignancy? (Q848861)

A. ER +, PR -, and HER2 +

B. ER -, PR -, and HER2 -

C. ER +, PR +, and HER2 +

D. ER -, PR -, and HER2 +

See Answer in Part B → Q14

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Q15: A 45-year-old woman diagnosed with early-stage breast cancer opts for surgery that involves the removal of the entire breast, including the nipple and areola, but not the axillary lymph nodes. Which type of mastectomy is she likely undergoing? (Q848864)

A. Total (Simple) Mastectomy

B. Modified Radical Mastectomy

C. Radical Mastectomy

D. Extended Mastectomy

See Answer in Part B → Q15

@Neet_pg_bot

Q16: Which of the following conditions is not an absolute contraindication for breast-conserving surgery (BCS)? (Q848863)

A. Prior radiation therapy to the chest wall or breast

B. Diffuse malignant microcalcifications

C. Stage IIB breast cancer

D. Pregnancy

See Answer in Part B → Q16

@Neet_pg_bot

Q17: Which of the following are components of the Van Nuys Prognostic Index (VNPI) for DCIS? Tumor size Margin status Histological grade Patient age (Q848862)

A. 1 & 2

B. 1 & 3

C. 1, 2 & 3

D. 1, 2, 3 & 4

See Answer in Part B → Q17

@Neet_pg_bot

Q18: Arrange the following in decreasing order of frequency of metastasis in breast cancer (Q848853)

A. Lumbar vertebrae> femur> thoracic vertebrae> ribs> skull

B. Lumbar vertebrae> thoracic vertebrae> ribs> skull> femur

C. Thoracic vertebrae>lumbar vertebrae> ribs> skull> femur

D. Thoracic vertebrae> femur> lumbar vertebrae> ribs> skull

See Answer in Part B → Q18

@Neet_pg_bot

Q19: What is the primary arterial supply to the superior part of the breast? (Q848845)

A. Internal thoracic artery

B. Lateral thoracic artery

C. Thoracoacromial artery

D. Intercostal artery

See Answer in Part B → Q19

@Neet_pg_bot

Q20: Which of the following is the most common cause of bloody nipple discharge? (Q848846)

A. Breast cancer

B. Fibroadenoma

C. Intraductal papilloma

D. Duct Ectasia

See Answer in Part B → Q20

@Neet_pg_bot

Q21: Which of the following statements about breast cancer risk factors is true? (Q848847)

A. The median age of breast cancer presentation is 60 years in India

B. The relative risk of Papillomatosis is 8-10

C. Relative Risk for breast cancer in 1st-degree relative is 3

D. Early onset of menstruation increases breast cancer risk.

See Answer in Part B → Q21

@Neet_pg_bot

Q22: Which of the following is the most common model used for breast cancer risk assessment? (Q848848)

A. Gail Model

B. Framingham Risk Score

C. ASCVD Risk Estimator

D. QRISK3

See Answer in Part B → Q22

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Q23: All of the following are invasive carcinomas except: (Q848849)

A. Ductal carcinoma

B. Lobular carcinoma

C. Tubular carcinoma

D. Fibroadenoma

See Answer in Part B → Q23

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Q24: A 52-year-old woman undergoes a routine mammogram, which reveals clustered calcifications in her left breast. Further investigation confirms the diagnosis of ductal carcinoma in situ (DCIS). The lesion is small, low-grade, and has clear margins. The patient expresses a strong desire to preserve her breast if possible. What is the most appropriate initial treatment approach? (Q848850)

A. Hormonal therapy alone

B. Lumpectomy with radiation therapy

C. Lumpectomy alone

D. Systemic chemotherapy

See Answer in Part B → Q24

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Q25: A 38-year-old premenopausal woman is diagnosed with Lobular Carcinoma In Situ (LCIS) after a breast biopsy. She opts for chemoprevention as her management strategy. Her doctor discusses various medication options with her. Which of the following statements about chemoprevention for LCIS is correct? (Q848851)

A. Chemoprevention eliminates the risk of developing breast cancer

B. Tamoxifen reduces breast cancer risk by 25% over 5 years

C. Chemoprevention is only effective for the ipsilateral breast

D. Tamoxifen reduces breast cancer risk by 56% over 5 years

See Answer in Part B → Q25

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Q26: A 55-year-old woman is diagnosed with breast cancer. The pathology report shows a 2.5 cm tumor with positive lymph nodes. The tumor is ER-positive, PR-positive, and HER2-negative. Which of the following statements is most accurate

regarding her prognosis and treatment? (Q848852)

A. The tumor size and lymph node status suggest a favorable prognosis

B. The hormone receptor status indicates the tumor will not respond to endocrine therapy

C. The absence of HER2 overexpression means targeted therapies are the primary treatment option

D. The ER-positive status suggests a better prognosis and responsiveness to endocrine therapy

See Answer in Part B → Q26

@Neet_pg_bot

Q27: Which of the following statements about lymphatic drainage of the breast is true? (Q848844)

A. Level III lymph nodes are located lateral to the pectoralis minor muscle.

B. Lymphatic drainage from the breast is directed to the subclavian lymph nodes.

C. Level I lymph nodes are also known as Rotter’s nodes.

D. Level II lymph nodes are located posterior to the pectoralis major

See Answer in Part B → Q27

@Neet_pg_bot

Q28: A 52-year-old female presents with a two-month history of persistent itching, redness, and scaling of the right nipple, unresponsive to moisturizing creams. Physical examination reveals erythema and crusting of the nipple and areola without palpable breast lumps. The image of her right breast is given below. What is the most probable diagnosis? {{caption_text}} (Q848854)

A. Paget disease of the nipple

B. Scirrhous tumor

C. Ductal papilloma

D. Inflammatory carcinoma



See Answer in Part B → Q28

@Neet_pg_bot

Q29: A 45-year-old female presents with a painless lump in her right breast, noticed during a self-examination two weeks ago. Which of the following tests has the maximum accuracy? (Q848855)

A. FNAC

B. Core biopsy

C. Mammography

D. Triple assessment

See Answer in Part B → Q29

@Neet_pg_bot

Q30: A lesion was found in a routine mammogram of a 52-year-old asymptomatic woman. Which of the following statements regarding mammogram findings is false? (Q848856)

A. If the density of the lesion is high, it is mostly malignant

B. Architectural distortion is usually present in benign lesions

C. Calcification in benign lesions is diffuse

D. Margins are well-circumscribed in benign lesions

See Answer in Part B → Q30

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Q31: A 48-year-old female underwent a lumpectomy for a 2 cm invasive ductal carcinoma in her right breast. Post-surgery pathology revealed positive margins, indicating residual cancerous tissue. Which of the following investigations is most suitable to check for residual cancer tissues? (Q848857)

A. MRI

B. USG

C. Mammography

D. Repeat the biopsy

See Answer in Part B → Q31

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Q32: Match the following: Biopsy Feature 1. FNAC a. Evaluation of cellular fibroadenoma 2. Core-needle biopsy b. Assessment of suspicious lymph nodes 3. Excisional biopsy c. Sampling solid masses, calcifications, and densities identified on imaging (Q848858)

A. 1-b,2-c,3-a

B. 1-a,2-b,3-c

C. 1-c,2-b,3-a

D. 1-b,2-a,3-c

See Answer in Part B → Q32

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Q33: A 45-year-old woman presents for her routine mammogram. She has no family history of breast cancer and no previous history of breast issues. A mammogram reveals a well-circumscribed, homogeneous lesion with characteristic benign features, such as a simple cyst with no suspicious calcifications or architectural distortions. Based on these findings, What is the appropriate BI-RADS category for this lesion? (Q848859)

A. BI-RADS 1

B. BI-RADS 2

C. BI-RADS 3

D. BI-RADS 4

See Answer in Part B → Q33

@Neet_pg_bot

Q34: A 55-year-old woman presents with a palpable breast lump. After imaging studies and a biopsy, the results show a tumor measuring 3.5 cm in the breast. The patient also has involvement of ipsilateral internal mammary lymph nodes, but no distant metastases are detected. Based on the TNM staging system, what is the appropriate stage for this breast cancer? (Q848860)

A. T1 N2

B. T2 N1

C. T2 N2

D. T3 N1

See Answer in Part B → Q34

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• [07_Endocrine Surgery] 042 Breast-Ii

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[07_Endocrine Surgery] 042 Breast-Ii — Quick Jump

Q1 (p. 695)	*Q2 (p. 695)*	*Q3 (p. 696)*	*Q4 (p. 696)*	*Q5 (p. 696)*	*Q6 (p. 697)*
Q7 (p. 697)	*Q8 (p. 698)*	*Q9 (p. 698)*	*Q10 (p. 698)*	*Q11 (p. 699)*	*Q12 (p. 700)*
Q13 (p. 700)	*Q14 (p. 700)*	*Q15 (p. 701)*	*Q16 (p. 701)*	*Q17 (p. 702)*	*Q18 (p. 702)*
Q19 (p. 703)	*Q20 (p. 703)*	*Q21 (p. 704)*	*Q22 (p. 704)*	*Q23 (p. 704)*	*Q24 (p. 705)*
Q25 (p. 705)	*Q26 (p. 706)*	*Q27 (p. 706)*			

Q1: What is the approximate risk of malignancy associated with a lesion classified as BI-RADS 4A? (Q880446)

A. 2–10%

B. 10–50%

C. 50–95%

D. ≥95%

See Answer in Part B → Q1

@Neet_pg_bot

Q2: A 38-year-old woman presents with localized, non-cyclical medial breast pain. Examination and imaging are normal. Pain is maximal at a specific point, and musculoskeletal causes have been excluded. Which of the following is the most appropriate management? (Q880439)

A. Reassurance only

B. Oral NSAIDs for 1 week

C. Local injection of corticosteroid plus lidocaine

D. Empirical antibiotics

See Answer in Part B → Q2

@Neet_pg_bot

Q3: Which of the following are indications for adjuvant chemotherapy in breast cancer? Post-surgery eradication of microscopic residual disease in high-risk patients Inflammatory breast cancer. HER2-positive breast cancer in combination with HER2-targeted therapy Triple-negative breast cancer Enabling breast-conserving surgery by reducing tumor size. (Q848826)

A. 1, 3, and 5 are correct

B. 2, 3, and 5 are correct

C. 2, 4, and 5 are correct

D. 1, 3, and 4 are correct

See Answer in Part B → Q3

@Neet_pg_bot

Q4: Physiological gynecomastia is not typically seen in which of the following age groups? (Q880438)

A. Neonates

B. Pubertal boys

C. Men over 50 years

D. Men aged 30–40 years

See Answer in Part B → Q4

@Neet_pg_bot

Q5: Which of the following statements regarding phyllodes tumours is true? (Q880437)

A. Most commonly seen in women aged 15–25 years

B. True mixed neoplasms comprising both epithelial and mesenchymal elements

C. Rarely require wide local excision due to low recurrence risk

D. Frequently infiltrate the skin early in their course

See Answer in Part B → Q5

@Neet_pg_bot

Q6: A 16-year-old girl presents with a rapidly enlarging breast lump. On examination, the lump is firm, well-circumscribed, and measures more than 5 cm in diameter. Which of the following terms best describes this fibroadenoma? (Q880436)

A. Simple fibroadenoma

B. Giant fibroadenoma

C. Complex fibroadenoma

D. Phyllodes tumor

See Answer in Part B → Q6

@Neet_pg_bot

Q7: Regarding breast carcinoma, which of the following statements is incorrect? (Q880435)

A. Inflammatory carcinoma produces cutaneous oedema due to obstruction of subdermal lymphatics by tumour cells

B. Mucinous carcinomas are typically hormone receptor–negative

C. Ductal carcinoma in situ often shows associated calcifications

D. Lobular carcinoma in situ tends to be multicentric and bilateral

See Answer in Part B → Q7

@Neet_pg_bot

Q8: A 22-year-old woman presents with a firm, mobile, well-circumscribed breast lump measuring 2.5 cm. Ultrasound confirms a typical fibroadenoma. She has no family history of breast cancer. Which of the following best describes the underlying pathological process in fibroadenoma? (Q880434)

A. Hyperplasia of a breast lobule

B. Malignant transformation of ductal epithelium

C. Cystic degeneration of breast stroma

D. Inflammatory infiltration of breast tissue

See Answer in Part B → Q8

@Neet_pg_bot

Q9: A 28-year-old lactating mother presents with fever, breast pain, swelling, and a tender, erythematous area on her left breast. Ultrasonography confirms the presence of a pus-filled cavity. What would be the initial treatment in this scenario? (Q848841)

A. Close Observation

B. Antibiotics and breast emptying

C. Hormonal therapy

D. Surgical excision

See Answer in Part B → Q9

@Neet_pg_bot

Q10: A 55-year-old menopausal woman presents with a unilateral, scaly, and erythematous lesion on her nipple, initially resembling eczema but without itching. She was diagnosed with Paget's disease of the nipple. Which of the following cancers is most commonly associated with Paget's disease? {{caption_text}} (Q848836)

A. Invasive ductal carcinoma

B. Invasive lobular carcinoma

C. Ductal carcinoma in situ

D. Lobular carcinoma in situ



See Answer in Part B → Q10

@Neet_pg_bot

Q11: A 45-year-old woman with a family history of breast cancer undergoes genetic testing and is found to have a BRCA1 mutation. What are the implications of this mutation regarding the cancer risks and potential associated cancers? (Q848843)

A. Increased risk of breast cancer with well-differentiated hormone receptor-positive tumors.

B. Increased risk of breast cancer, typically high-grade and triple-negative, along with higher risks of colon and ovarian cancers.

C. Increased risk of breast cancer and higher risk of endometrial cancer.

D. Increased risk of ovarian cancer with no significant increase in breast cancer risk.

See Answer in Part B → Q11

@Neet_pg_bot

Q12: A 35-year-old woman presents with cyclical breast pain and palpable lumps in her breasts. She reports that the pain increases just before her menstrual period. Physical examination reveals dense breast tissue without any nipple discharge or skin involvement. What is the most likely diagnosis? (Q848842)

A. Mucinous carcinoma

B. Fibrocystic Changes

C. Medullary Carcinoma

D. Ductal carcinoma

See Answer in Part B → Q12

@Neet_pg_bot

Q13: A 35-year-old woman presents with a tender, thrombosed subcutaneous cord on her right breast, which becomes more pronounced when she raises her arm. She reports no recent trauma or infections. What is the most likely diagnosis? (Q848839)

A. Ductal carcinoma in situ

B. Mondor's Disease

C. Mastitis

D. Fibrocystic Changes

See Answer in Part B → Q13

@Neet_pg_bot

Q14: A 20-year-old woman presents with a painless, firm, mobile lump in her breast. On physical examination, the lump is approximately 1 cm in diameter, firm,

well-circumscribed, and freely mobile. Ultrasound confirms a well-defined, solid, homogeneous mass with smooth margins and no signs of calcifications. What is the most likely diagnosis and management plan? (Q848838)

A. Cyst; surgical excision.

B. Fibroadenoma; conservative management with regular monitoring.

C. Giant fibroadenoma; immediate surgical removal.

D. Inflammatory carcinoma; urgent biopsy and treatment.

See Answer in Part B → Q14

@Neet_pg_bot

Q15: Which of the following statements regarding phyllodes tumor are correct? Statements: Tumors of mixed connective tissue and epithelium Classified as benign, intermediate, and malignant Discrete structure with cystic spaces in USG Excisional biopsy is the definitive diagnostic method (Q848837)

A. 1,3

B. 4

C. 3,4

D. 1,2,3,4

See Answer in Part B → Q15

@Neet_pg_bot

Q16: A 45-year-old woman presents with a palpable mass in her left breast. On examination, the mass is 3 cm in diameter, and there is no evidence of skin or chest wall involvement. An ultrasound reveals a single enlarged axillary lymph node. Biopsy confirms invasive ductal carcinoma, ER/PR positive, HER2 negative, shows no distant metastasis. What is the most appropriate management approach? (Q848823)

A. Total mastectomy with sentinel lymph node biopsy (SLNB)

B. Breast-conserving surgery (BCS) with SLNB followed by radiotherapy (RT)

C. Neoadjuvant chemotherapy followed by mastectomy

D. BCS with axillary lymph node dissection (ALND) without radiotherapy

See Answer in Part B → Q16

@Neet_pg_bot

Q17: A 65-year-old man presents with a hard, unilateral breast lump and nipple retraction. Clinical examination reveals skin dimpling and axillary lymphadenopathy. A biopsy confirms breast cancer. Which of the following is wrong about his diagnosis? (Q848835)

A. Associated with BRCA2 mutation

B. Most common in 4th decade of life

C. Poorer prognosis compared to carcinoma breast in females

D. Infiltrating duct carcinoma is the most common type

See Answer in Part B → Q17

@Neet_pg_bot

Q18: A 25-year-old was diagnosed with invasive ductal carcinoma in her 5th week of gestation. Her axillary lymph node biopsy has come back positive. What is the most appropriate management along with modified radical mastectomy? (Q848834)

A. Termination of pregnancy

B. Chemotherapy

C. Radiation therapy

D. Termination of pregnancy and chemotherapy

See Answer in Part B → Q18

@Neet_pg_bot

Q19: A 35-year-old lactating woman presents with a rapidly progressing, painful, and warm swelling involving her entire left breast. She was diagnosed with inflammatory breast cancer. Which of the following statements are correct regarding her condition? {{caption_text}} (Q848833)

A. The prognosis is bad

B. Stage III B carcinoma (T4d)

C. Can be mistaken for acute mastitis

D. All are true



See Answer in Part B → Q19

@Neet_pg_bot

Q20: What is the primary purpose of a sentinel lymph node biopsy in the management of cancer, and how does it help guide treatment decisions? (Q848832)

A. To determine the exact stage of the cancer by identifying all affected lymph nodes.

B. To assess whether cancer has spread to the lymph nodes.

C. To completely remove all lymph nodes to prevent cancer recurrence.

D. To evaluate the effectiveness of chemotherapy before surgery.

See Answer in Part B → Q20

@Neet_pg_bot

Q21: Which of the following components is not evaluated in the Bloom-Richardson grading system? (Q848831)

A. Tubule formation

B. Nuclear pleomorphism

C. Mitotic count

D. Tumor size

See Answer in Part B → Q21

@Neet_pg_bot

Q22: Which of the following statements about the TRAM flap is true? (Q848830)

A. The TRAM flap uses only skin and fat from the abdomen, preserving the abdominal muscle.

B. The TRAM flap relies on tissue from the back, including skin and muscle, for reconstruction.

C. The TRAM flap involves using tissue from the abdomen, including both skin and muscle, for breast reconstruction.

D. The TRAM flap uses tissue from the thigh, including skin and fat, to reconstruct the breast.

See Answer in Part B → Q22

@Neet_pg_bot

Q23: A patient develops a painful, swollen area in the axillary region two weeks after mastectomy. What is the most likely diagnosis? (Q848829)

A. Seroma

B. Lymphedema

C. Hematoma

D. Axillary lymphadenopathy

See Answer in Part B → Q23

@Neet_pg_bot

Q24: Match the following hormonal therapy drugs with their primary use: 1.Tamoxifen a. Pre-menopausal hormone receptor-positive breast cancer 2.Anastrozole b. Post-menopausal hormone receptor-positive breast cancer 3.Fulvestrant c. HER2-positive breast cancer 4.Trastuzumab d. Hormone receptor-positive metastatic breast cancer (Q848828)

A. 1-a, 2-b, 3-d, 4-c

B. 1-b, 2-c, 3-d, 4-a

C. 1-a, 2,d, 3-b, 4-c

D. 1-c, 2-a, 3-b, 4-d

See Answer in Part B → Q24

@Neet_pg_bot

Q25: Which of the following types of breast carcinoma is most likely to respond best to radiation therapy? (Q848827)

A. Invasive ductal carcinoma

B. Inflammatory breast cancer

C. Ductal carcinoma in situ (DCIS)

D. Triple-negative breast cancer

See Answer in Part B → Q25

@Neet_pg_bot

Q26: A 55-year-old woman with Stage IV HER2-positive metastatic breast cancer presents with fungation of the breast, multiple metastases to the liver and bones. Which of the following treatment strategies is most appropriate for her condition? (Q848825)

A. Trastuzumab + Chemotherapy + Palliative mastectomy

B. Tamoxifen + Radiation Therapy + Bone-targeted therapy

C. Hormonal Therapy alone

D. Surgical Resection of Metastases + Radiotherapy

See Answer in Part B → Q26

@Neet_pg_bot

Q27: A 52-year-old woman presents with Stage III B breast cancer. Her diagnostic workup includes imaging studies and biopsy, revealing a locally advanced tumor with involvement of regional lymph nodes. The tumor is hormone receptor-positive and HER2-positive. What would be the most appropriate management approach for this patient? (Q848824)

A. Neoadjuvant chemotherapy followed by modified radical mastectomy and adjuvant radiotherapy

B. Immediate modified radical mastectomy followed by adjuvant chemotherapy and endocrine therapy

C. Primary endocrine therapy followed by adjuvant chemotherapy and radiotherapy

D. Neoadjuvant chemotherapy followed by lumpectomy and adjuvant radiotherapy

See Answer in Part B → Q27

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• [07_Endocrine Surgery] 043 Thyroid-I

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[07_Endocrine Surgery] 043 Thyroid-I — Quick Jump

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Q7 (p. 710) *Q8 (p. 710)* *Q9 (p. 711)* *Q10 (p. 711)* *Q11 (p. 712)* *Q12 (p. 712)*
Q13 (p. 713) *Q14 (p. 714)* *Q15 (p. 714)* *Q16 (p. 714)* *Q17 (p. 715)* *Q18 (p. 715)*
Q19 (p. 716) *Q20 (p. 716)* *Q21 (p. 719)*

Q1: A 12-year-old child presents with congenital sensorineural hearing loss, recurrent episodes of vertigo, and a palpable thyroid gland. The child's mother has a similar history. What is the most likely diagnosis? (Q848948)

A. Alport syndrome

B. Pendred syndrome

C. Usher syndrome

D. Perrault syndrome

See Answer in Part B → Q1

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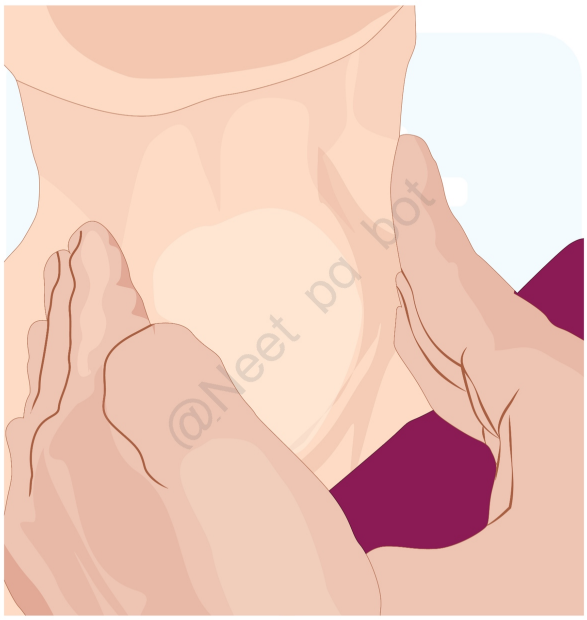
Q2: Identify the below technique used during the examination of the thyroid gland. (Q848947)

A. Kocher's method

B. Lahey’s method

C. Crile’s method

D. Pizillo’s method



See Answer in Part B → Q2

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Q3: A 44-year-old woman presents with a solitary thyroid swelling. On examination, a 3 cm non-tender thyroid nodule is noted, and her thyroid function tests are normal. What is the next step in the investigation of this thyroid swelling? (Q848935)

A. Fine Needle Aspiration Cytology

B. USG of thyroid

C. Core biopsy

D. CT neck

See Answer in Part B → Q3

@Neet_pg_bot

Q4: Which of the following conditions is a contraindication for radioactive iodine therapy? (Q848945)

A. Medullary thyroid carcinoma

B. Papillary thyroid carcinoma

C. Hurthle cell carcinoma

D. Tumor size > 2cm + distant metastasis

See Answer in Part B → Q4

@Neet_pg_bot

Q5: A 27-year-old female presents with symptoms of weight loss, palpitations and eye protrusion. Lab tests reveal ■ TSH and ■ T3, T4 values. What is the most likely diagnosis and the primary target of this condition? (Q848938)

A. Toxic multinodular goiter,TSH receptor

B. Graves disease, TSH receptor

C. Hashimoto's Thyroiditis, TPO

D. Subacute Thyroiditis, Thyroglobulin

See Answer in Part B → Q5

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Q6: A 50-year-old woman with Graves disease has been receiving medical management for 6 months but continues to have significant symptoms and persistent ophthalmopathy. The goitre remains large. Considering her ongoing symptoms, what is the most appropriate next step in her treatment? (Q848940)

A. Thyroidectomy

B. Radioactive iodine ablation

C. Antithyroid medications and beta-blockers.

D. External beam radiotherapy

See Answer in Part B → Q6

@Neet_pg_bot

Q7: A 45-year-old man presents with neck pain, fever, and fatigue. His physical examination shows a tender, swollen thyroid gland. Lab reports revealed elevated inflammatory markers and low radioactive iodine uptake, and he is HLA B35 positive. What is the most appropriate initial treatment step for this patient? (Q848942)

A. NSAIDs

B. Start Levothyroxine and continue throughout

C. Start antithyroid drugs

D. Thyroidectomy

See Answer in Part B → Q7

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Q8: A 40-year-old woman with a known history of Graves' disease presents with signs of thyroid storm i.e., fever, delirium, tachycardia, and restlessness. In addition to beta-blockers and antithyroid drugs, she is started on glucocorticoids. What is the primary rationale for administering glucocorticoids in the management of thyroid storm? (Q848950)

A. To block the conversion of T4 to T3

B. To suppress the synthesis of thyroid hormones

C. To reduce the effects of catecholamines

D. To block the release of T4 and T3

See Answer in Part B → Q8

@Neet_pg_bot

Q9: A 20-year-old male presents with a painless midline neck swelling that has been present since childhood and has gradually increased in size. The swelling moves upward on protrusion of the tongue. Ultrasound shows a cystic midline lesion .Which of the following is the correct statement regarding this condition? (Q848929)

A. High risk of developing squamous cell carcinoma

B. Removal of the cyst along with the tract and part of the hyoid bone is done

C. Most commonly seen in the suprahyoid region

D. Incision and Drainage are the preferred management



See Answer in Part B → Q9

@Neet_pg_bot

Q10: A 64-year-old man with multinodular goitre is being treated with a large dose of iodine. Subsequently, his thyroid function tests show significantly elevated TSH and low free T4 levels, but he is asymptomatic. What is the most likely finding? (Q848949)

A. Jod- Basedow effect

B. Wolff-Chaikoff effect

C. Amiodarone- induced thyrotoxicosis

D. Thyroid storm

See Answer in Part B → Q10

@Neet_pg_bot

Q11: A 31-year-old female with Graves' disease who underwent total thyroidectomy now presents with hoarseness of voice and stridor due to recurrent laryngeal nerve injury. What is the most common site of injury to the recurrent laryngeal nerve? (Q848946)

A. Through the carotid sheath

B. At the level of the zuckerkandl tubercle

C. At the level of the cricothyroid muscle

D. Near the inferior thyroid artery

See Answer in Part B → Q11

@Neet_pg_bot

Q12: A 60-year-old man presents with worsening shortness of breath and difficulty swallowing. On physical examination, a large, firm, and non-tender neck swelling is noted. The lower limit of the swelling cannot be palpated, and raising his arms above his head results in the finding shown in the image. Given these clinical findings, which of the following is the Investigation of choice? (Q848944)

A. Ultrasound of the Neck

B. CT Scan of the Neck and Chest

C. MRI of the Neck

D. Radioactive Iodine Uptake Test



See Answer in Part B → Q12

@Neet_pg_bot

Q13: A 60-year-old woman with a large multinodular goitre is scheduled for a total thyroidectomy. To prepare her for the surgery and reduce the risk of complications, her endocrinologist prescribed Lugol's iodine. Which of the following statements are true regarding Lugol's iodine? It is used to reduce thyroid vascularity before thyroid surgery It works by inhibiting the synthesis of thyroid hormones in the thyroid gland It increases the uptake of radioactive iodine It is not commonly indicated in the management of toxic multinodular goiter It is not indicated in case of a thyroid storm (Q848943)

A. 1,2,5

B. 2,3,4

C. 3,4,5

D. 1,2,4

See Answer in Part B → Q13

@Neet_pg_bot

Q14: A 55-year-old woman presents with an enlarging, hard, and fixed thyroid mass, neck discomfort, and difficulty swallowing. On examination, the thyroid gland feels rock-hard with no tenderness. Ultrasound of the thyroid shows extensive fibrosis. What is the most likely diagnosis? (Q848941)

A. Riedel's Thyroiditis

B. Hashimoto's Thyroiditis

C. De Quervain's Thyroiditis

D. Silent Thyroiditis

See Answer in Part B → Q14

@Neet_pg_bot

Q15: A 30-year-old pregnant woman in her first trimester is diagnosed with Graves disease. What is the most appropriate first-line treatment for her condition? (Q848939)

A. Propylthiouracil

B. Methimazole

C. Levothyroxine

D. Propranolol

See Answer in Part B → Q15

@Neet_pg_bot

Q16: A 23-year-old female visited the clinician with a solitary thyroid nodule and was advised for thyroid function tests where Tsh level is 27.3mU/L, T3 is 1.24 ng/ml, and T4 is 4.87 microgram/ml. Which of the following manifestations is true regarding the condition? (Q848937)

A. Heat intolerance

B. Tachycardia

C. Diarrhea

D. Weight gain

See Answer in Part B → Q16

@Neet_pg_bot

Q17: A 36-year-old woman presents with a solid, hypoechoic thyroid nodule. She undergoes Fine Needle Aspiration Cytology (FNAC), which confirms the nodule is benign. What is the most appropriate Bethesda classification and its management for this benign thyroid nodule? (Q848936)

A. Bethesda I; Repeat FNA

B. Bethesda II; Clinical and sonographic follow-up

C. Bethesda III; Near total thyroidectomy

D. Bethesda VI; Repeat FNA, molecular testing or lobectomy

See Answer in Part B → Q17

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Q18: A 65-year-old woman presents with a thyroid mass and normal thyroid function tests. Fine Needle Aspiration Cytology (FNAC) is planned to evaluate the mass. Which of the following conditions is FNAC effective in diagnosing? (Q848934)

A. Follicular Neoplasm

B. Riedel’s Thyroiditis

C. Thyroid Lymphoma

D. Solitary Thyroid Nodule

See Answer in Part B → Q18

@Neet_pg_bot

Q19: A 45-year-old patient with a history of multinodular goitre is being considered for thyroid surgery. The surgical team decides to perform a procedure that removes the majority of the thyroid gland, leaving a small amount of tissue in one of the lobes and removing the isthmus. Which of the following best describes this procedure? (Q848932)

A. Total Thyroidectomy

B. Lobectomy

C. Dunhill Procedure

D. Subtotal Thyroidectomy

See Answer in Part B → Q19

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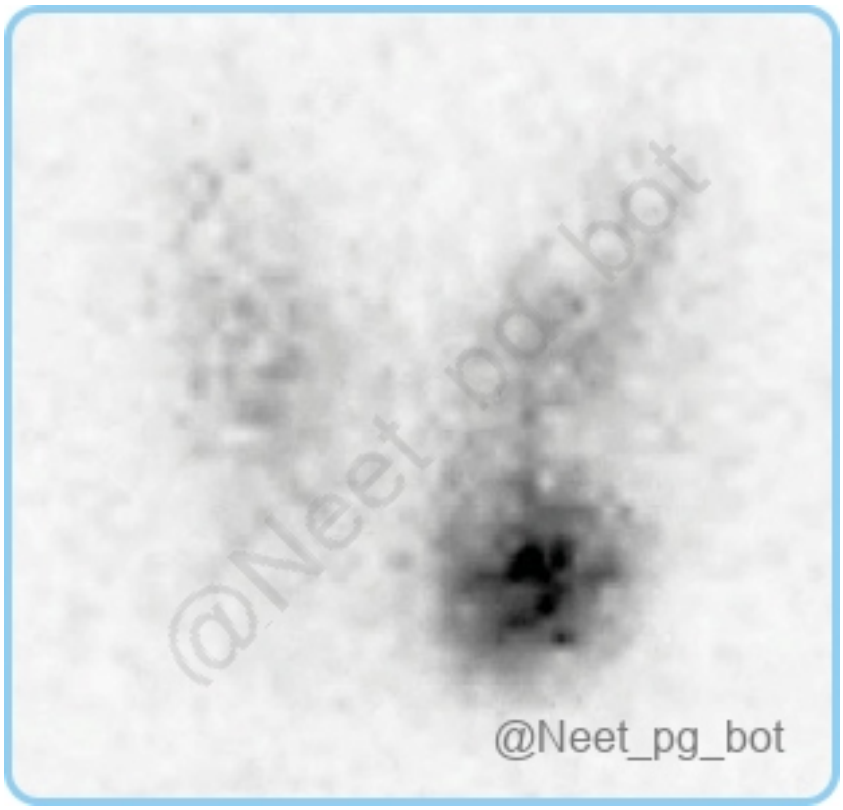
Q20: Match the following Thyroid scan images with respective conditions: 1. A. Graves Disease 2. B. Cold nodule 3. C. Hot Nodule 4. D. Toxic Multinodular Goiter (Q848931)

A. 1-C, 2-A, 3-D, 4-B

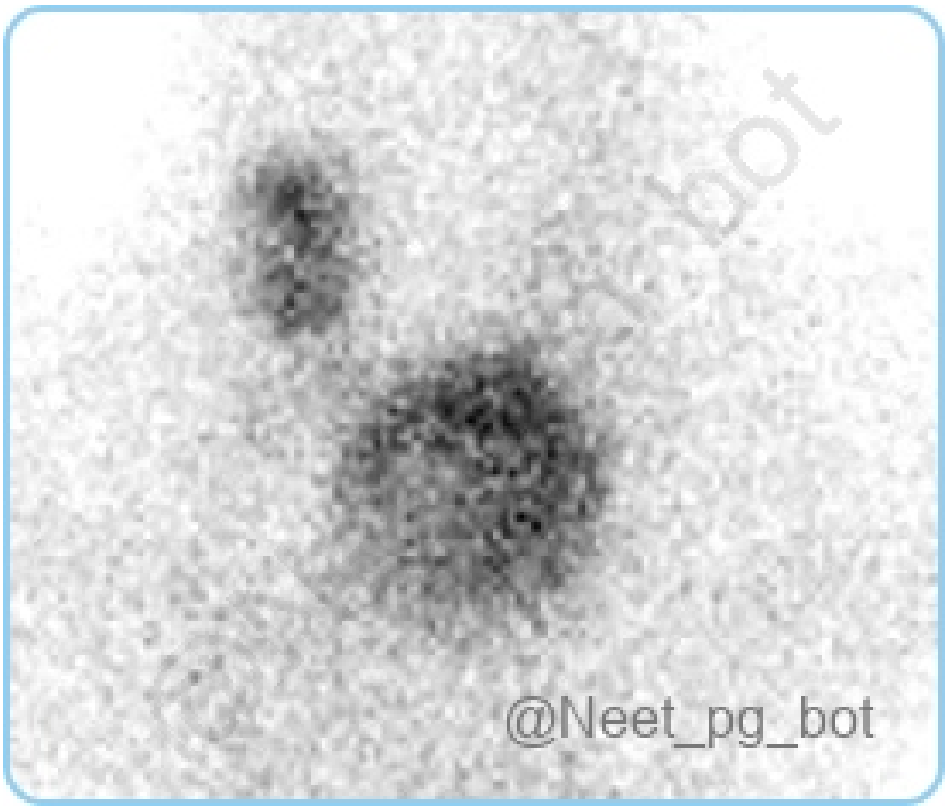
B. 1-A, 2-C, 3-B, 4-D

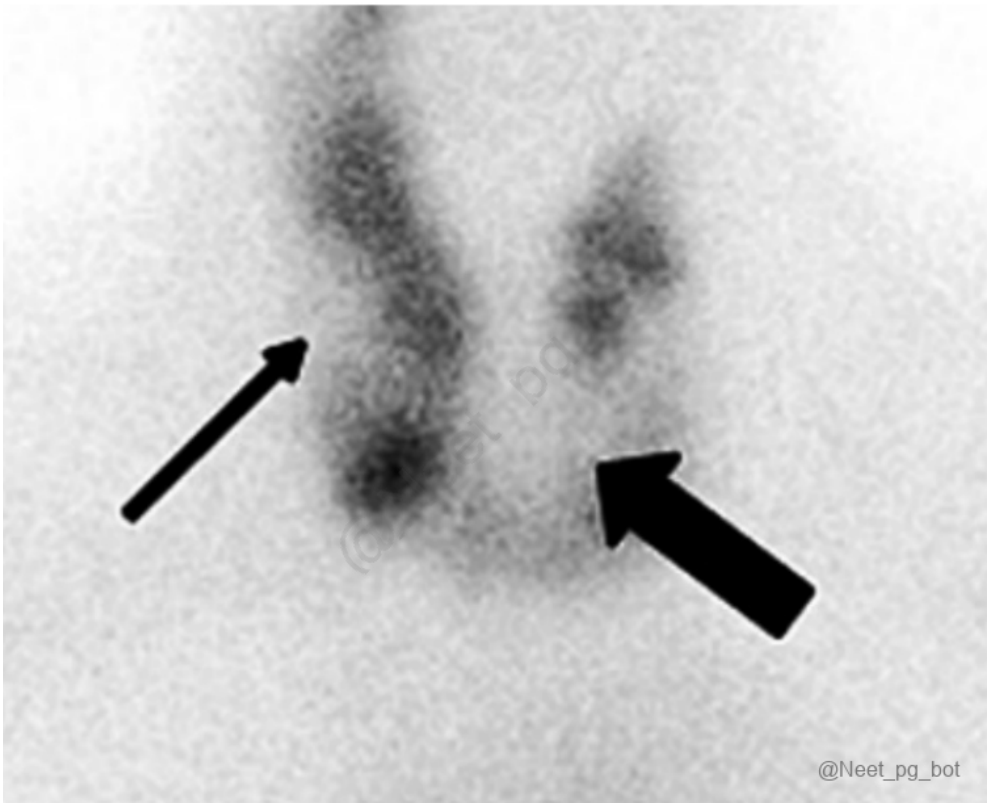
C. 1-B, 2-D, 3-A, 4-C

D. 1-C, 2-D, 3-A, 4-B


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See Answer in Part B → Q20

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Q21: A 45-year-old woman with differentiated thyroid cancer has undergone a total thyroidectomy. To target any residual thyroid tissue or cancer cells, she is scheduled for radioactive iodine ablation therapy. Which of the following isotopes of iodine is used for this therapeutic procedure? (Q848930)

A. Iodine-123 (I-123)

B. Iodine-125 (I-125)

C. Iodine-131 (I-131)

D. Iodine-132 (I-132)

See Answer in Part B → Q21

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• [07_Endocrine Surgery] 044 Thyroid-Ii

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[07_Endocrine Surgery] 044 Thyroid-Ii — Quick Jump

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Q7 (p. 723)	*Q8 (p. 724)*	*Q9 (p. 724)*	*Q10 (p. 725)*	*Q11 (p. 725)*	*Q12 (p. 726)*
Q13 (p. 727)	*Q14 (p. 727)*	*Q15 (p. 728)*	*Q16 (p. 729)*	*Q17 (p. 729)*	*Q18 (p. 730)*
Q19 (p. 730)	*Q20 (p. 731)*	*Q21 (p. 731)*			

Q1: What is the best investigation to check for extra thyroid spread of thyroid gland neoplasm ? (Q882181)

A. USG

B. MRI

C. PET scan

D. Iodine scan

See Answer in Part B → Q1

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Q2: A 30-year-old patient presents with hypertension, sweating, and frequent headaches. Imaging reveals a thyroid nodule, and tests show elevated serum calcitonin. The family history includes similar early-onset cases. What condition is most likely associated with these findings? (Q848961)

A. MEN 1

B. MEN 2A

C. Cowden syndrome

D. Familial medullary thyroid carcinoma

See Answer in Part B → Q2

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Q3: A 72-year-old male presents with a rapidly growing thyroid mass accompanied by severe pain and hoarseness of voice. Imaging shows the direct invasion of surrounding structures, including the trachea and oesophagus. The diagnosis of anaplastic thyroid carcinoma is confirmed. In managing this condition, which of the following is not typically included? (Q848972)

A. Radioactive iodine

B. Tumor debulking

C. Doxorubicin

D. Trametinib

See Answer in Part B → Q3

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Q4: A 45-year-old female recently underwent total thyroidectomy for papillary thyroid carcinoma. Which of the following is not part of her post-surgical management? (Q848970)

A. Immediately start high-dose thyroxine (T4) to prevent hypothyroidism.

B. Stop thyroxine (T4) for 6 weeks before a whole-body scan.

C. Administer recombinant TSH if stopping thyroxine (T4) is intolerable.

D. PET scan if thyroglobulin rises despite normal neck USG and chest X-ray.

See Answer in Part B → Q4

@Neet_pg_bot

Q5: A 45-year-old patient undergoes a total thyroidectomy for a large multinodular goitre. Postoperatively, the patient is monitored for complications. Which of the following is least likely to occur? (Q848969)

A. Tension Hematoma

B. Horner's syndrome

C. RLN Palsy

D. Hypercalcemia

See Answer in Part B → Q5

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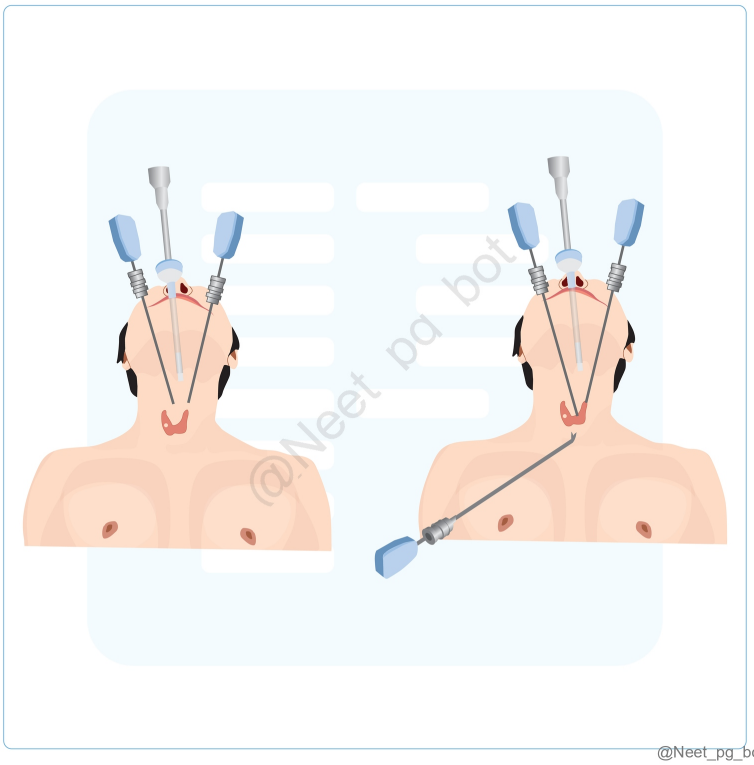
Q6: A 45-year-old woman with a thyroid pathology is being considered for the procedure shown in the image. Which of the following conditions is a contraindication for this procedure? (Q848983)

A. Hashimoto's thyroiditis

B. Benign thyroid nodule 2 cm

C. T1 Papillary carcinoma

D. Thyroid adenoma 2.5 cm



See Answer in Part B → Q6

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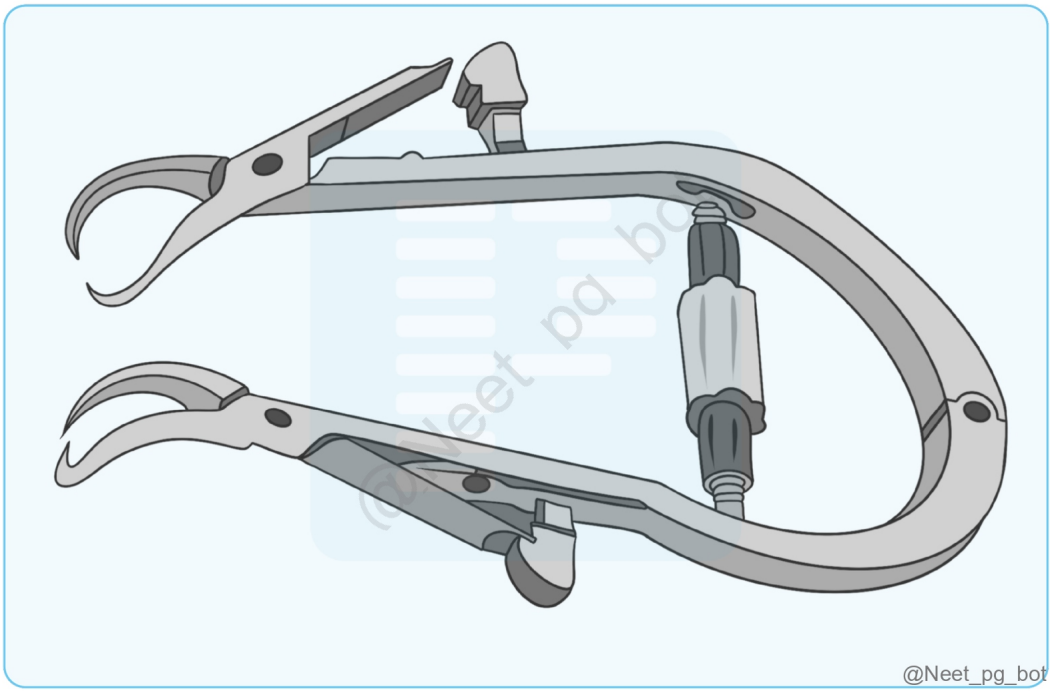
Q7: A 55-year-old patient is undergoing a thyroidectomy, and the surgical team uses a specialized retractor to improve exposure and facilitate the operation. Identify the retractor. (Q848981)

A. Deaver’s retractor

B. Joll’s retractor

C. Richardson retractor

D. Volkmann retractor



See Answer in Part B → Q7

@Neet_pg_bot

Q8: A 60-year-old woman presents with symptoms of hyperthyroidism, including weight loss, palpitations, and tremors. A large thyroid nodule is noted on examination, and laboratory tests reveal elevated thyroid hormones with suppressed thyroid-stimulating hormone (TSH) levels. An ultrasound shows multiple nodules in the thyroid gland. Which of the following management strategies is most appropriate for this patient? (Q848980)

A. Antithyroid drugs followed by total thyroidectomy

B. Radioactive iodine therapy

C. Thyroid hormone replacement therapy

D. Treat with lugol iodine followed by surgery

See Answer in Part B → Q8

@Neet_pg_bot

Q9: A 72-year-old woman with a history of Hashimoto's thyroiditis presents with a rapidly growing thyroid mass, dysphagia, dyspnea, and hoarseness. Biopsy confirms diffuse large B-cell lymphoma. Which of the following is most appropriate for treating this patient? (Q848979)

A. Surgical resection alone

B. External beam radiotherapy combined with chemotherapy

C. Expectant management with hormone replacement

D. Chemotherapy followed by thyroidectomy

See Answer in Part B → Q9

@Neet_pg_bot

Q10: A 62-year-old woman has recently undergone surgery for papillary thyroid carcinoma (PTC). Postoperative pathology reports indicate: Tumour Size: 3.8 cm Extrathyroidal Invasion: Present No lymph node involvement No distant metastases Complete surgical resection Which of the following scoring systems is specifically used to assess the prognosis in the postoperative setting? (Q848977)

A. AGES Scoring System

B. AMES Scoring System

C. MACIS Scoring System

D. TNM Staging System

See Answer in Part B → Q10

@Neet_pg_bot

Q11: A 40-year-old patient presents with midline neck swelling, persistent diarrhoea, and elevated serum calcitonin. Imaging shows the tumour confined to the thyroid without lymph node involvement. Histopathology reveals amyloid stroma. Which of the following is most appropriate for managing this condition? (Q848975)

A. Radioactive iodine therapy

B. Total thyroidectomy with modified radical neck dissection

C. Tyrosine kinase inhibitors and radiotherapy

D. Total thyroidectomy with central neck dissection

See Answer in Part B → Q11

@Neet_pg_bot

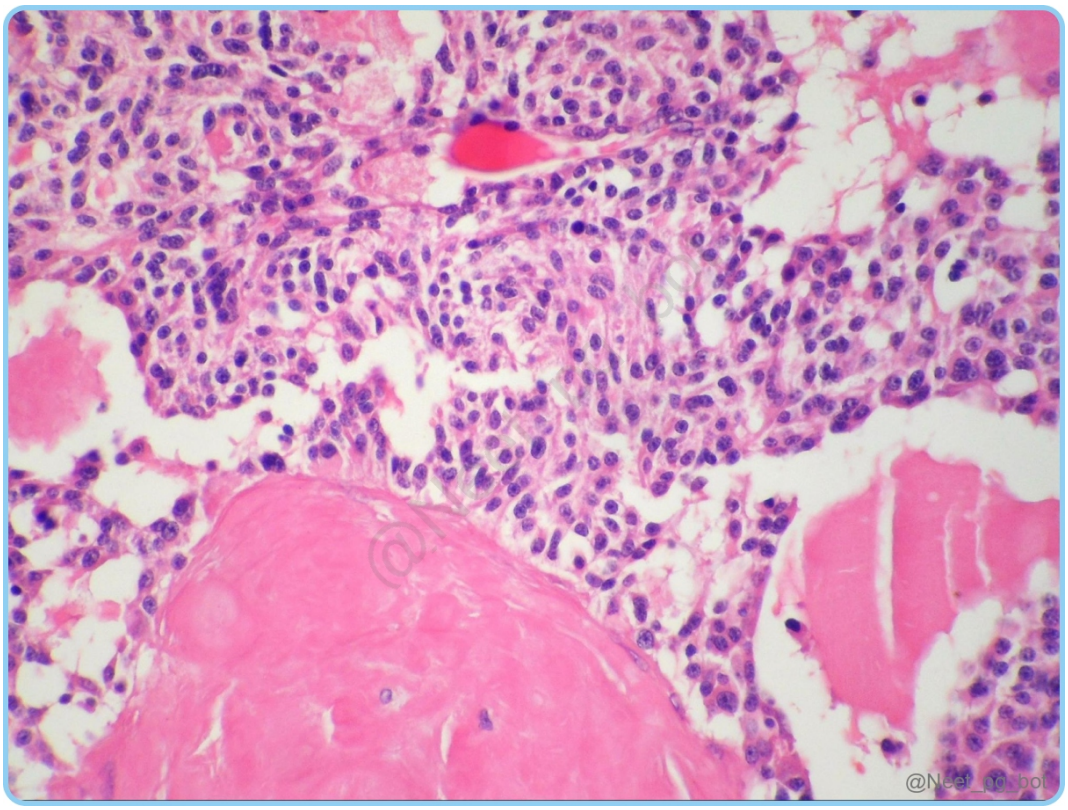
Q12: A 45-year-old with midline neck swelling and persistent diarrhoea has an enlarged thyroid gland. The family history includes pheochromocytoma and hyperparathyroidism. The image shows a histopathological examination of the thyroid. Which marker is most valuable for monitoring this condition? (Q848973)

A. Serum TSH

B. Serum Calcitonin

C. Serum Thyroglobulin

D. Serum PTH



See Answer in Part B → Q12

@Neet_pg_bot

Q13: A 48-year-old female presents with a midline neck swelling which moves upwards when she swallows. On examination, the swelling is suspected to be related to the thyroid gland. What is the most likely anatomical structure responsible for this movement, and what is the clinical significance of this feature? (Q848954)

A. Prevertebral fascia - distinguishing thyroid masses from parathyroid masses

B. Pretracheal fascia - causes thyroid masses to move with swallowing

C. Investing layer of the deep cervical fascia - encloses both the thyroid and trachea

D. Superficial fascia - supports the thyroid gland’s position in the neck

See Answer in Part B → Q13

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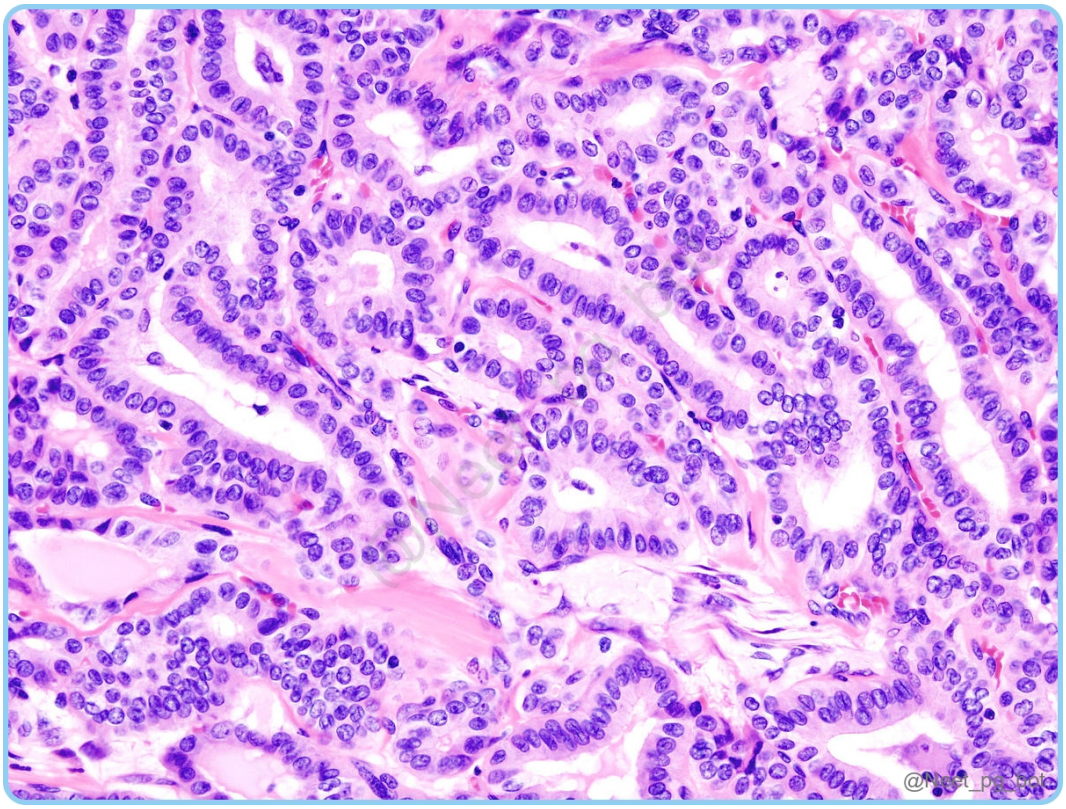
Q14: A 32 year old female patient presented with complaints of midline swelling in neck without any palpable lymph nodes. FNAC and biopsy revealed the image below. Which of the following should be the management of this condition ? (Q848968)

A. Thyroidectomy + Removal of enlarged lymph nodes

B. Thyroidectomy + Removal of enlarged lymph nodes + MRND

C. MRND

D. Thyroidectomy



See Answer in Part B → Q14

@Neet_pg_bot

Q15: Which type of incision is typically used for thyroidectomy? (Q848966)

A. Killian's incision

B. Gridiron incision

C. Lanz crease incision

D. Kocher’s collar incision

See Answer in Part B → Q15

@Neet_pg_bot

Q16: A 56-year-old female patient with a history of long-standing goiter, presented with complaints of sudden, painless increase in the size of swelling of the neck. Biopsy revealed the presence of follicles suggestive of carcinoma. What is the most common site and route of metastasis in this condition? (Q848964)

A. Lungs, lymphatic

B. Liver, lymphatic

C. Bones, hematogenous

D. Liver, hematogenous

See Answer in Part B → Q16

@Neet_pg_bot

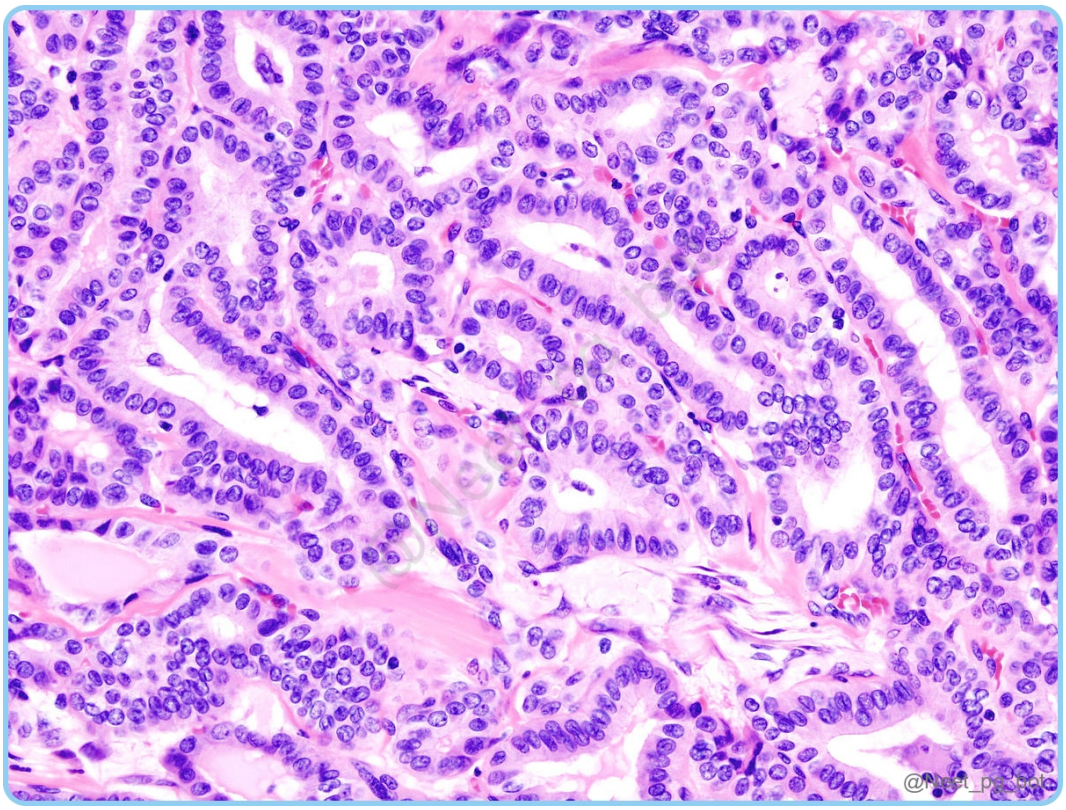
Q17: A 34-year-old female presents with neck swelling and a history of childhood neck irradiation for Hodgkin’s lymphoma. On examination, a hard mass is found in the neck. FNAC confirms thyroid carcinoma with HPE image given below, what is the most likely diagnosis? (Q848963)

A. Follicular thyroid carcinoma

B. Medullary thyroid carcinoma

C. Anaplastic thyroid carcinoma

D. Papillary thyroid carcinoma



See Answer in Part B → Q17

@Neet_pg_bot

Q18: A 58-year-old woman has a 5 cm thyroid tumour with extrathyroidal extension, cervical lymphadenopathy, and no distant metastasis. Based on the TNM staging system, what is the most accurate classification for this patient? (Q848959)

A. T3b N1 M0

B. T4 N1 M1

C. T4 N1 M0

D. T2 N0 M0

See Answer in Part B → Q18

@Neet_pg_bot

Q19: All the following forms the boundaries of Beahrs' triangle except? (Q848958)

A. Common Carotid Artery

B. Inferior Thyroid Artery

C. Recurrent Laryngeal Nerve

D. Superior Thyroid Artery

See Answer in Part B → Q19

@Neet_pg_bot

Q20: A 60-year-old male undergoes a total thyroidectomy for a large multinodular goitre. Postoperatively, he experiences hoarseness and difficulty speaking. Which anatomical site is most commonly associated with this nerve injury during thyroidectomy? (Q848957)

A. Right subclavian artery

B. Arch of the aorta

C. Berry’s ligament

D. Tubercle of Zuckerkandl

See Answer in Part B → Q20

@Neet_pg_bot

Q21: During thyroid surgery on a patient, significant bleeding occurs near the superior pole of the thyroid gland. Which vessel branches from the artery supplying this region? (Q848955)

A. Common carotid artery

B. Subclavian artery

C. External carotid artery

D. Brachiocephalic trunk

See Answer in Part B → Q21

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• [07_Endocrine Surgery] 045 Parathyroid And Adrenal Glands - I

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[07_Endocrine Surgery] 045 Parathyroid And Adrenal Glands - I — Quick Jump

Q1 (p. 733)	*Q2 (p. 733)*	*Q3 (p. 734)*	*Q4 (p. 734)*	*Q5 (p. 734)*	*Q6 (p. 735)*
Q7 (p. 735)	*Q8 (p. 736)*	*Q9 (p. 736)*	*Q10 (p. 737)*	*Q11 (p. 737)*	*Q12 (p. 737)*
Q13 (p. 738)	*Q14 (p. 738)*	*Q15 (p. 739)*	*Q16 (p. 739)*	*Q17 (p. 739)*	*Q18 (p. 740)*
Q19 (p. 740)	*Q20 (p. 741)*	*Q21 (p. 741)*			

Q1: A 45-year-old woman presents with a large adrenal mass discovered incidentally on imaging. The tumor measures 12 cm and shows irregular borders with central necrosis. She exhibits symptoms of Cushing syndrome. What is the most likely diagnosis for this adrenal mass? (Q848874)

A. Benign Cortical Adenoma

B. Adrenal Myelolipoma

C. Adrenocortical Carcinoma

D. Aldosterone-Producing Adenoma

See Answer in Part B → Q1

@Neet_pg_bot

Q2: Which of the following is not an indication for surgery in an asymptomatic patient with primary hyperparathyroidism? (Q848886)

A. Serum calcium level 0.25 mmol/L above the upper limit of normal

B. DEXA T score of -2.5 at the lumbar spine

C. Creatinine clearance <60 mL/min

D. Age >60 years

See Answer in Part B → Q2

@Neet_pg_bot

Q3: Which of the following statements is TRUE regarding olfactory neuroblastoma? (Q848885)

A. Benign tumor arising from the squamous epithelium of the nasal cavity.

B. Presents as a bilateral mass in the lower nasal cavity.

C. Causes anosmia and nasal obstruction due to a unilateral polypoidal mass.

D. Treated with chemotherapy alone, with no surgical excision.

See Answer in Part B → Q3

@Neet_pg_bot

Q4: A mother brought her 2-year-old child as she noticed he is unable to completely open his eyes and that there is a limp in his walk. On examination, there is a mass in the abdomen and miosis and anhidrosis in the eyes. A biopsy confirms neuroblastoma. What would be the laboratory findings in this case? (Q848884)

A. Raised 24 hr urinary catecholamines

B. Low serum LDH

C. Low neuron specific enolase

D. Thrombocytopenia

See Answer in Part B → Q4

@Neet_pg_bot

Q5: A child of 2 years is brought to the hospital with an abdominal mass that has grown from the right to the center of the abdomen for a few months. The child has urinary symptoms and bluish-purple discoloration around the eyes. What is the most probable diagnosis? (Q848883)

A. Pheochromocytoma

B. Adrenocortical carcinoma

C. Paraganglioma

D. Neuroblastoma

See Answer in Part B → Q5

@Neet_pg_bot

Q6: A 55-year-old patient is diagnosed with malignant pheochromocytoma after presenting with persistent hypertension and elevated plasma metanephrines. Imaging reveals metastasis to various sites. Which of the following is not a common site for metastasis? (Q848881)

A. Liver

B. Brain

C. Lungs

D. Kidney

See Answer in Part B → Q6

@Neet_pg_bot

Q7: A 30-year-old woman in her 24th week of pregnancy presents with severe headaches, palpitations, and paroxysmal hypertension. Laboratory investigations reveal elevated plasma metanephrines, and imaging confirms the presence of a pheochromocytoma. Which of the following is the most appropriate management strategy for this patient? (Q848880)

A. Use phenoxybenzamine and plan laparoscopic adrenalectomy in the second trimester.

B. Wait until the third trimester, use Labetalol to control BP, and perform a C-section followed by adrenalectomy.

C. Use calcium channel blockers and plan for surgical resection postpartum.

D. Perform immediate open adrenalectomy.

See Answer in Part B → Q7

@Neet_pg_bot

Q8: A 33-year-old man presents with a history of paroxysmal hypertension, palpitations, headaches, and sweating. Initial plasma-free metanephrine testing returns positive results. What is the most appropriate next step in the investigation of this patient's condition to confirm the diagnosis? (Q848878)

A. Performing an MIBG (metaiodobenzylguanidine) scan

B. Performing a 24-hour urine collection for metanephrines

C. Conducting a clonidine suppression test

D. Ordering a CT/MRI scan of the abdomen

See Answer in Part B → Q8

@Neet_pg_bot

Q9: A 35-year-old woman presents with episodes of severe headaches, palpitations, and sweating. Imaging reveals a large adrenal mass and biochemical tests confirm elevated plasma metanephrines. Further genetic testing shows a mutation in the SDHB gene. Which of the following genetic syndromes is most likely associated with her condition? (Q848877)

A. MEN 2 Syndrome

B. Hereditary Paraganglioma-Pheochromocytoma Syndrome (HPPS)

C. Von Hippel–Lindau Disease (VHL)

D. Neurofibromatosis Type 1 (NF1)

See Answer in Part B → Q9

@Neet_pg_bot

Q10: A 52-year-old patient presents with intermittent episodes of hypertension, headache, and sweating. After conducting a series of tests, the diagnosis points toward an extra-adrenal pheochromocytoma. What is the most common site for an extra-adrenal pheochromocytoma? (Q848876)

A. Adrenal medulla

B. Organ of Zuckerkandl

C. Parotid gland

D. Pancreas

See Answer in Part B → Q10

@Neet_pg_bot

Q11: A 48-year-old man presents with episodic symptoms of severe headache, palpitations, and profuse sweating. His laboratory tests reveal elevated plasma metanephrines, and a CT scan identifies a vascular adrenal mass. Which of the following statements accurately describes the nature of this adrenal mass? (Q848875)

A. Primarily secretes ACTH, causing continuous hypertension.

B. It intermittently releases catecholamines, leading to episodes of headache, palpitations, and sweating.

C. Presents with chronic, steady symptoms without significant paroxysms.

D. Usually non-vascular and causes minimal clinical symptoms.

See Answer in Part B → Q11

@Neet_pg_bot

Q12: A 45-year-old patient with h/o chronic kidney disease is found to have elevated serum calcium levels. Which of the following actions of parathyroid hormone (PTH) is most directly responsible for increasing serum calcium levels? (Q848840)

A. Inhibition of calcium reabsorption in the kidneys.

B. Stimulation of 1,25-dihydroxyvitamin D production.

C. Decreased intestinal calcium absorption.

D. Promotion of bone mineralization.

See Answer in Part B → Q12

@Neet_pg_bot

Q13: A 55-year-old woman undergoes a routine abdominal CT scan for an unrelated issue. The scan reveals a 2.5 cm mass in the left adrenal gland. The patient has no history of adrenal disorders but reports occasional episodes of sweating and palpitations. Her blood pressure is elevated. Based on these findings, what condition should be primarily ruled out in the diagnostic workup? (Q848873)

A. Subclinical Cushing syndrome

B. Adrenocortical carcinoma

C. Pheochromocytoma

D. Aldosteronoma

See Answer in Part B → Q13

@Neet_pg_bot

Q14: A 50-year-old patient presents with elevated serum calcium levels and a neck mass. After further evaluation, the diagnosis of parathyroid carcinoma is confirmed. The patient is scheduled for surgery. What is the standard surgical treatment for this case to minimize the risk of local recurrence? (Q848872)

A. Total thyroidectomy

B. En bloc resection

C. Lymph node dissection

D. Total parathyroidectomy

See Answer in Part B → Q14

@Neet_pg_bot

Q15: A 45-year-old woman undergoes a total thyroidectomy for the treatment of Graves' disease. Two days postoperatively, she presents with numbness and tingling around her mouth and in her fingers. She also complains of muscle cramps and mild weakness. Laboratory tests reveal decreased serum calcium levels. What is the most likely cause of her symptoms following the surgery? (Q848871)

A. Postoperative hypophosphatemia

B. Hypocalcemia due to damage to the parathyroid glands

C. Infection at the surgical site

D. Postoperative bleeding leading to hypovolemia

See Answer in Part B → Q15

@Neet_pg_bot

Q16: A 62-year-old woman with a history of tertiary hyperparathyroidism undergoes total parathyroidectomy. Three days later, she presents with carpopedal spasms and numbness around her mouth. Her serum calcium level is 6.9 mg/dL. What is the most likely diagnosis? (Q848870)

A. Pseudohypoparathyroidism

B. Hungry bone syndrome

C. Persistent hyperparathyroidism

D. Recurrent hyperparathyroidism

See Answer in Part B → Q16

@Neet_pg_bot

Q17: A 57-year-old patient with chronic renal failure is found to have elevated parathyroid hormone levels, but his serum calcium level is in the normal range. What is the diagnosis? (Q848869)

A. Primary hyperparathyroidism

B. Tertiary hyperparathyroidism

C. Secondary hyperparathyroidism

D. Calciphylaxis

See Answer in Part B → Q17

@Neet_pg_bot

Q18: A 40-year-old lady comes to the emergency department with muscle weakness, fatigue, and abdominal pain, and on evaluation, has some memory loss. Her lab reports show elevated serum calcium levels (13mg%), and she is diagnosed with primary hyperparathyroidism. Which of the following is the preferred treatment in this scenario? (Q848868)

A. Selective estrogen receptor modulators

B. Bisphosphonates

C. Parathyroidectomy

D. Calcimimetic drugs

See Answer in Part B → Q18

@Neet_pg_bot

Q19: Which of the following is the most accurate investigation to localize the lesion in a case of primary hyperparathyroidism? (Q848867)

A. Ultrasonography

B. Sestamibi scan

C. 4D computed tomography

D. MRI

See Answer in Part B → Q19

@Neet_pg_bot

Q20: A 55-year-old postmenopausal woman presents with a fracture of the radius. She is found to have some mild memory impairment on questioning and her X-ray shows osteoporosis. On further evaluation, her serum calcium levels are elevated. Which of the following is not a common manifestation of this condition? (Q848866)

A. Nephrolithiasis

B. Salt and pepper skull

C. Neck mass

D. Brown tumors

See Answer in Part B → Q20

@Neet_pg_bot

Q21: A 45-year-old woman presents with recurrent kidney stones. Lab tests showed elevated calcium and parathyroid hormone levels. Imaging reveals pituitary adenoma and pancreatic neuroendocrine tumors. Her father had similar issues. What is the most likely diagnosis? (Q848865)

A. Wermer syndrome

B. Werner syndrome

C. MEN 4

D. Sipple syndrome

See Answer in Part B → Q21

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• [07_Endocrine Surgery] 046 Previous Year Questions

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[07_Endocrine Surgery] 046 Previous Year Questions — Quick Jump

Q1 (p. 742)	*Q2 (p. 742)*	*Q3 (p. 743)*	*Q4 (p. 743)*	*Q5 (p. 744)*	*Q6 (p. 744)*
Q7 (p. 745)	*Q8 (p. 746)*	*Q9 (p. 746)*	*Q10 (p. 746)*	*Q11 (p. 747)*	*Q12 (p. 747)*
Q13 (p. 747)	*Q14 (p. 748)*	*Q15 (p. 748)*	*Q16 (p. 749)*	*Q17 (p. 749)*	*Q18 (p. 749)*
Q19 (p. 750)	*Q20 (p. 751)*	*Q21 (p. 751)*	*Q22 (p. 752)*	*Q23 (p. 753)*	*Q24 (p. 753)*
Q25 (p. 754)	*Q26 (p. 754)*	*Q27 (p. 754)*	*Q28 (p. 755)*	*Q29 (p. 755)*	*Q30 (p. 756)*
Q31 (p. 756)	*Q32 (p. 757)*	*Q33 (p. 757)*	*Q34 (p. 757)*	*Q35 (p. 758)*	*Q36 (p. 759)*
Q37 (p. 759)	*Q38 (p. 760)*	*Q39 (p. 761)*	*Q40 (p. 761)*	*Q41 (p. 762)*	*Q42 (p. 763)*
Q43 (p. 763)	*Q44 (p. 764)*	*Q45 (p. 764)*	*Q46 (p. 765)*	*Q47 (p. 765)*	*Q48 (p. 766)*
Q49 (p. 766)	*Q50 (p. 766)*	*Q51 (p. 767)*	*Q52 (p. 767)*	*Q53 (p. 768)*	*Q54 (p. 768)*
Q55 (p. 769)	*Q56 (p. 769)*	*Q57 (p. 770)*	*Q58 (p. 770)*	*Q59 (p. 770)*	*Q60 (p. 771)*
Q61 (p. 771)	*Q62 (p. 772)*	*Q63 (p. 772)*	*Q64 (p. 773)*	*Q65 (p. 773)*	*Q66 (p. 774)*
Q67 (p. 774)	*Q68 (p. 775)*	*Q69 (p. 775)*	*Q70 (p. 775)*	*Q71 (p. 776)*	

Q1: A 30-year-old lactating mother presents with pain in her left breast and a fever. On examination of the affected side, there is localized erythema, warmth, and point tenderness, the fluctuation test is positive. There is mild axillary lymphadenopathy on the affected side and the contralateral breast is normal. Repeated aspirations under antibiotic cover were unsuccessful. A USG done showed fluid collection. What is the management plan for this patient? (Q857135)

A. Incision and drainage

B. Broad spectrum antibiotics only

C. Breast conservation surgery

D. Punch biopsy

See Answer in Part B → Q1

@Neet_pg_bot

Q2: Fluorescence in-situ hybridization (FISH) is required in which of the following interpretations of HER2/NEU? (Q856565)

A. 1+

B. 2+

C. 3+

D. All of the above

See Answer in Part B → Q2

@Neet_pg_bot

Q3: What would be the appropriate next step in the management of a 55-year-old female patient who has a 4x3 cm lump in the right upper outer quadrant, with no involvement of axillary lymph nodes, and a BIRADS 4b staging on mammography? The patient underwent breast conservation surgery, and the final histopathology examination (HPE) report indicated high nuclear-grade ductal carcinoma in situ (DCIS) with necrosis and a 10mm margin clearance. (Q856541)

A. Adjuvant radiotherapy

B. Adjuvant chemotherapy

C. Follow up 6 monthly for 2 years and then yearly follow up

D. Trastuzumab therapy

See Answer in Part B → Q3

@Neet_pg_bot

Q4: In the surgical procedure for breast carcinoma, a frozen section was performed. This technique has benefits for all individuals, with the exception of: (Q858358)

A. To assess sentinel lymph node

B. To know margin positivity

C. To know metastasis

D. To confirm definitive diagnosis immediately in all cases

See Answer in Part B → Q4

@Neet_pg_bot

Q5: Which patient has better prognosis in breast cancer? (Q857556)

A. Her2+

B. Triple negative

C. Luminal B

D. Luminal A

See Answer in Part B → Q5

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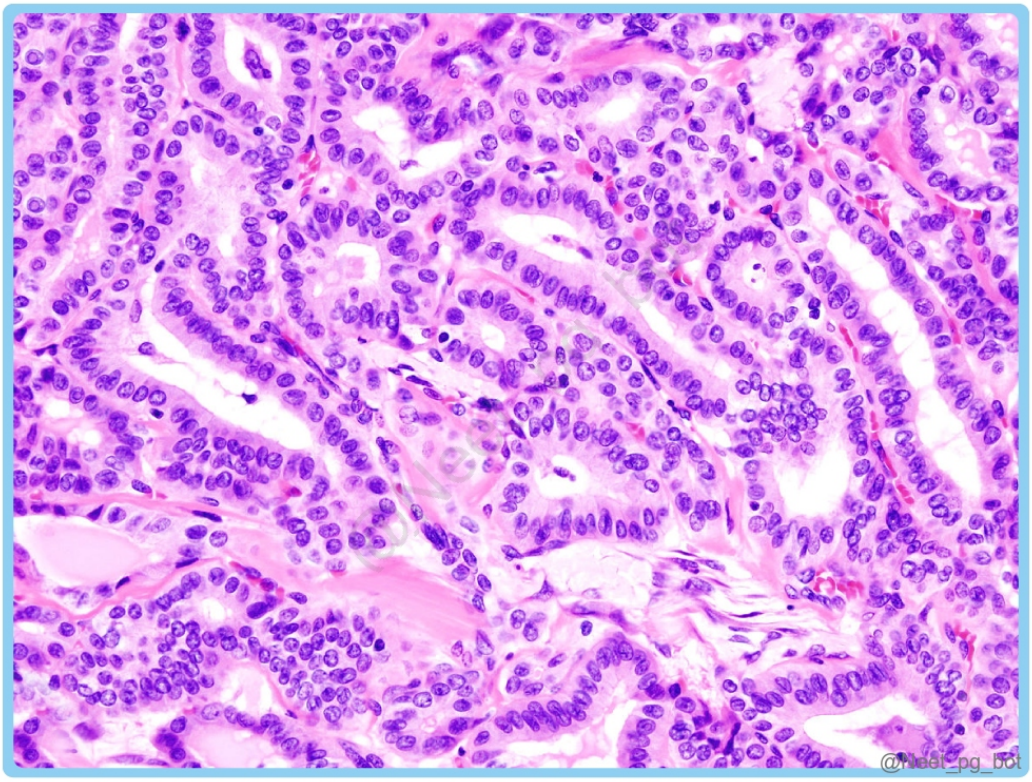
Q6: A 45-year-old lady presented with a swelling in her neck. She had an exposure to radiation in the past. Identify the type of disease, image of FNAC is given below: (Q857495)

A. Papillary carcinoma

B. Follicular carcinoma

C. Medullary carcinoma

D. Anaplastic carcinoma



See Answer in Part B → Q6

@Neet_pg_bot

Q7: A 30-year-old lactating mother presents with pain in her left breast and a fever. On examination of the affected side, there is localised erythema, warmth, and point tenderness, and the fluctuation test is positive. Mild axillary lymphadenopathy is on the affected side, and the contralateral breast is normal. What is the most likely diagnosis for this patient? (Q857494)

A. Lactational mastitis

B. Breast carcinoma

C. Breast abscess

D. Fibroadenoma

See Answer in Part B → Q7

@Neet_pg_bot

Q8: Best prognosis among the following breast cancer subtypes is for: (Q857269)

A. Luminal A

B. Luminal B

C. ER negative

D. Basal like

See Answer in Part B → Q8

@Neet_pg_bot

Q9: A 23-year-old woman presents to the surgery out-patient with a left-sided breast lump, which she noticed on a self-breast examination 3 weeks ago. She has no other complaints. On palpation, the lump seems to be mobile and firm. FNAC is characterized by stromal and epithelial elements with no signs of malignancy. What is the best next step in management? (Q857141)

A. Mammography

B. Reassurance and follow-up

C. Surgical excision

D. Start Tamoxifen

See Answer in Part B → Q9

@Neet_pg_bot

Q10: Which of the following statements are true? 1. Due to increasing mammography there occurs over diagnosis of breast carcinoma 2. Colon cancer screening is done by digital rectal examination 3. Oral cancer screening is done by visual inspection 4. Cervix cancer screening is done by a pap smear (Q856570)

A. 2, 3, 4

B. 1, 2, 3, 4

C. 4 only

D. 1, 3, 4

See Answer in Part B → Q10

@Neet_pg_bot

Q11: For a patient presenting with a new breast lump, which of the following investigations is the LEAST appropriate for the initial diagnosis? (Q855288)

A. Radiological investigations

B. PET scan

C. Clinical examination

D. Histology and cytology

See Answer in Part B → Q11

@Neet_pg_bot

Q12: A 25-year-old woman presents with a breast lump, no skin changes, and no indurations. In histology, fibroadenoma appeared. Which of the following categories does it fall under? (Q855202)

A. BI-RADS 1

B. BI-RADS 2

C. BI-RADS 3

D. BI-RADS 4

See Answer in Part B → Q12

@Neet_pg_bot

Q13: What is the appropriate next step in managing a 37-year-old unmarried woman who has never given birth, is sexually active, and is currently taking oral contraceptive pills, considering that her mother was diagnosed with breast cancer at the age of 60 and her older sister was diagnosed with ovarian cancer at 40? (Q855690)

A. Genetic counseling and screening for BRCA

B. Routine mammography

C. Stop taking oral and contraceptive pills

D. Prophylactic surgery

See Answer in Part B → Q13

@Neet_pg_bot

Q14: Which of the following is not a relative contraindication for breast conservative surgery? (Q855688)

A. Tumor size <4 cm

B. Li-Fraumeni Syndrome

C. Prior radiation to the chest

D. Genetic Predisposition to Breast Cancer

See Answer in Part B → Q14

@Neet_pg_bot

Q15: A 49-year-old female presents with a breast lump. Which of the following findings is in accordance with basal cell type breast cancer? (Q855676)

A. ER +ve, PR +ve, HER2 -ve

B. ER +ve, PR -ve, HER2 -ve

C. ER -ve, PR -ve, HER2 -ve

D. ER -ve, PR -ve, HER2 +ve

See Answer in Part B → Q15

@Neet_pg_bot

Q16: What preoperative intervention can be administered to minimise intraoperative bleeding in a 32-year-old female patient diagnosed with Grave's disease, presenting with eye symptoms and an enlarged thyroid, who is scheduled to undergo a total thyroidectomy? (Q855665)

A. Potassium iodide

B. Propranolol

C. Propylthiouracil

D. Betamethasone

See Answer in Part B → Q16

@Neet_pg_bot

Q17: What is the probable diagnosis for a 30-year-old woman who complains of a painless mass in her left breast that can be felt? The mass is highly movable, measures 3 x 3 cm, and has a rubbery texture. (Q793449)

A. Breast abscess

B. Phyllodes tumor

C. Fibroadenoma

D. Invasive ductal carcinoma

See Answer in Part B → Q17

@Neet_pg_bot

Q18: Which of the following carries the lowest risk of developing invasive ductal carcinoma? (Q793425)

A. Florid epithelial hyperplasia

B. Papilloma with fibrovascular core

C. Atypical hyperplasia

D. Squamous metaplasia

See Answer in Part B → Q18

@Neet_pg_bot

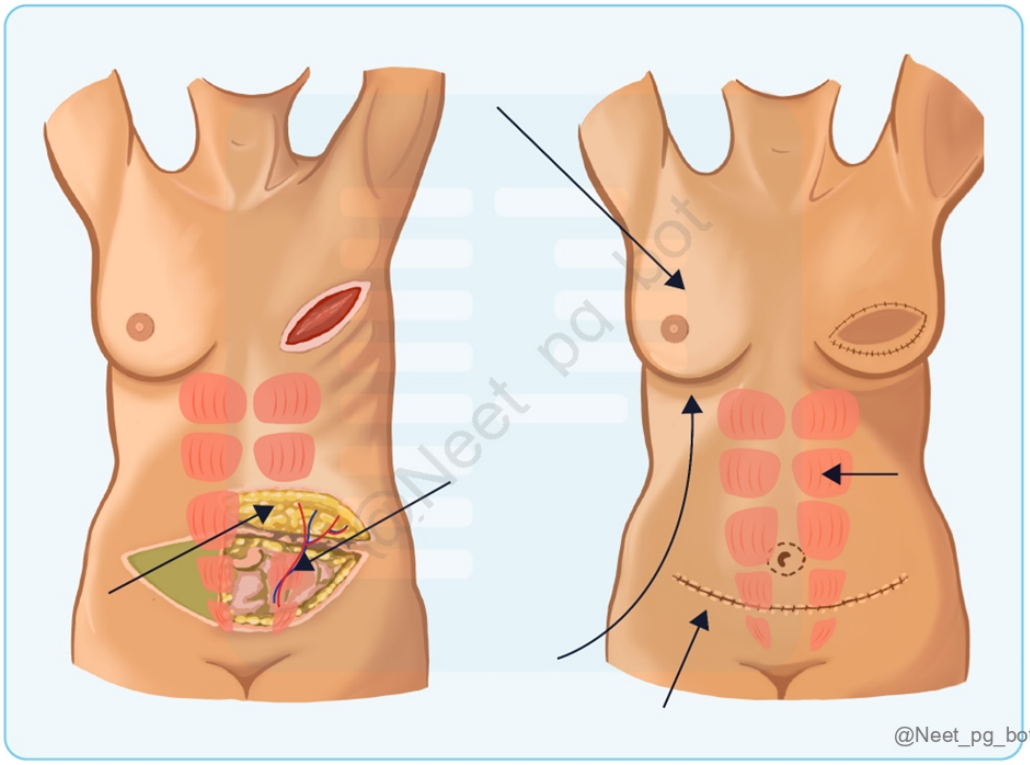
Q19: Which of the following is true about the flap given in the image? (Q858485)

A. Pedicled TRAM based on superior epigastric artery

B. Free TRAM based on superior and inferior epigastric artery

C. DIEP based on deep inferior epigastric artery

D. Lower abdominal fat-based inferior epigastric vessels



See Answer in Part B → Q19

@Neet_pg_bot

Q20: A woman presented with the following findings in the left breast for 3 months and pain for 2 months. What is the management plan for the following? (Q879127)

A. Simple mastectomy followed by management of complications

B. Neoadjuvant chemotherapy followed by radical mastectomy

C. Radical mastectomy with Axillary Lymph node dissection

D. Neoadjuvant chemotherapy followed by MRM and RT



See Answer in Part B → Q20

@Neet_pg_bot

Q21: Identify the wrong statement about late dumping syndrome from the following? (Q879109)

A. Symptoms start after 2 hours of food intake

B. Symptoms worsen with physical activity

C. Symptoms are relieved on lying down

D. Clinical features include tremors, dizziness and palpitations

See Answer in Part B → Q21

@Neet_pg_bot

Q22: A 59-year-old lady presents with a progressive, painless lump in the breast. What is the cause for the following skin change? (Q855834)

A. Infiltration of subdermal lymphatics

B. Infiltration of the lactiferous duct

C. Involvement of Cooper’s ligament

D. Spread of the tumour to the anterior chest wall



See Answer in Part B → Q22

@Neet_pg_bot

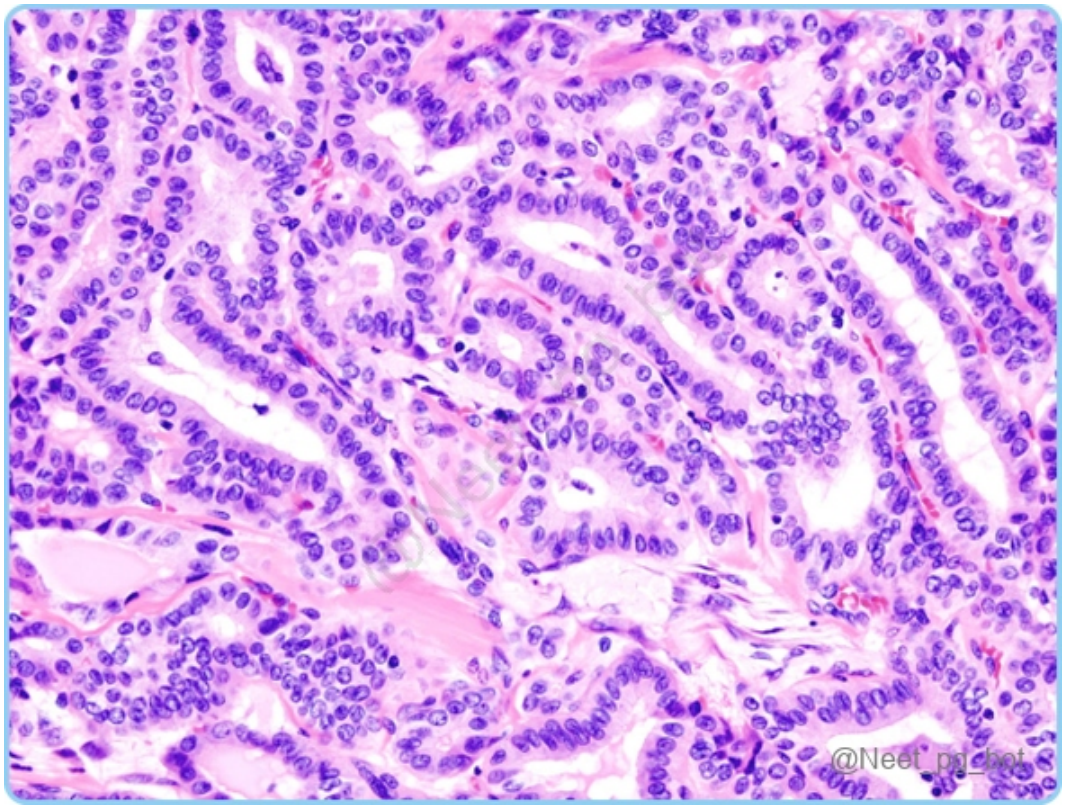
Q23: A male patient presented with midline neck swelling. He later developed cervical node enlargement. The histopathology of the lesion is shown below. Which of the following statements is false about this condition? (Q855784)

A. Excellent prognosis is associated with this condition

B. It spreads quickly via lymphatics

C. Nuclear characteristics are used for the identification

D. Fine needle aspiration cytology (FNAC) is not diagnostic



See Answer in Part B → Q23

@Neet_pg_bot

Q24: Grey-Turner's sign is seen in: (Q859891)

A. Acute appendicitis

B. Acute pancreatitis

C. Acute cholecystitis

D. Acute hepatitis

See Answer in Part B → Q24

@Neet_pg_bot

Q25: Best way to localise extra-adrenal pheochromocytoma: (Q859889)

A. X-ray

B. Nucleotide scan

C. VMA excretion

D. Clinical examination

See Answer in Part B → Q25

@Neet_pg_bot

Q26: What kind of thyroid cancer is frequently linked to prior radiation exposure, elevated RET/PTC rearrangements, and BRAF mutations? (Q859619)

A. Follicular carcinoma

B. Papillary carcinoma

C. Anaplastic carcinoma

D. Medullary carcinoma

See Answer in Part B → Q26

@Neet_pg_bot

Q27: A 15-year-old boy undergoes bilateral adrenalectomy for phaeochromocytoma. On the third postoperative day, the boy feels lethargic and tired. Blood pressure is 80/60 mm Hg; there is no sign of bleeding. What could be the cause of this? (Q858492)

A. Addisonian crisis

B. SIADH

C. Diabetes insipidus

D. Cerebral salt wasting disease

See Answer in Part B → Q27

@Neet_pg_bot

Q28: A 28-year-old lactating mother presents with pain in her left breast. Which of the following is the most likely cause of acute mastitis? (Q857792)

A. Breast engorgement

B. Hormonal influence

C. Absence of lactation

D. Crack in the nipple

See Answer in Part B → Q28

@Neet_pg_bot

Q29: Which of the following nerves is least injured during thyroid surgery? (Q856287)

A. Recurrent laryngeal nerve

B. Cervical sympathetic trunk

C. External laryngeal nerve

D. Marginal mandibular nerve

See Answer in Part B → Q29

@Neet_pg_bot

Q30: A 40-year-old woman presents with complaints of swelling of the right breast over the past 15 days. On examination, there was a local rise in temperature, and the lump was mobile over the chest wall. What is the likely diagnosis? (Q856239)

A. Inflammatory carcinoma

B. Giant fibroadenoma

C. Phyllodes tumour

D. Galactocele



See Answer in Part B → Q30

@Neet_pg_bot

Q31: What will be the most likely associated condition with increased TSH and low T4 levels? (Q856211)

A. Hypoparathyroidism

B. Pituitary Adenoma

C. Grave's disease

D. Hashimoto's thyroiditis

See Answer in Part B → Q31

@Neet_pg_bot

Q32: What risks are associated with the initiation of tamoxifen in a patient diagnosed with unilateral breast cancer? (Q856774)

A. Ovarian cancer

B. Endometrial cancer

C. Breast cancer, on the other side

D. Cervical cancer

See Answer in Part B → Q32

@Neet_pg_bot

Q33: Which of the following statements is correct regarding adequate thyroid FNAC sampling? (Q856768)

A. 6 follicular clusters each with 10 cells each

B. 3 follicular clusters with 10-15 cells each

C. 10 follicular cell clusters with 6-8 cells each

D. 12 follicular cell clusters with 10-12 cells each

See Answer in Part B → Q33

@Neet_pg_bot

Q34: A 50-year-old female presents with a 4 x 3 cm irregular mass in the upper outer quadrant of the right breast, which is not fixed to the skin or the chest wall. A 2 cm lymph node is palpated in the right axilla. No mass is noted in the opposite breast. Which of the following investigations would you perform in this patient? Bilateral Mammography PET Scan Biopsy of the breast mass USG guided biopsy of the lymph node (Q856729)

A. 1, 2, 3 & 4

B. 1, 2 & 3

C. 1, 3 & 4

D. 1 & 3

See Answer in Part B → Q34

@Neet_pg_bot

Q35: A patient underwent surgery for breast carcinoma. She now presents with painless swelling involving the arm, as shown in the image below. What is the most likely diagnosis? (Q856226)

A. Lymphedema

B. Lymphangiosarcoma

C. Venous thrombosis

D. Cellulitis



See Answer in Part B → Q35

@Neet_pg_bot

Q36: Which of the following is the most common cause of bloody nipple discharge? (Q852700)

A. Breast cancer

B. Fibroadenoma

C. Intraductal papilloma

D. Duct Ectasia

See Answer in Part B → Q36

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Q37: A patient presents with polyuria, polydipsia, lethargy, and abdominal pain. She also has a history of mood disorders and recurrent kidney stones. Which of the following investigations would not be useful in arriving at the diagnosis? (Q860481)

A. Nuclear sestamibi scan

B. USG neck

C. Dual-energy radiographic absorptiometry (DEXA)

D. Angiography of renal arteries

See Answer in Part B → Q37

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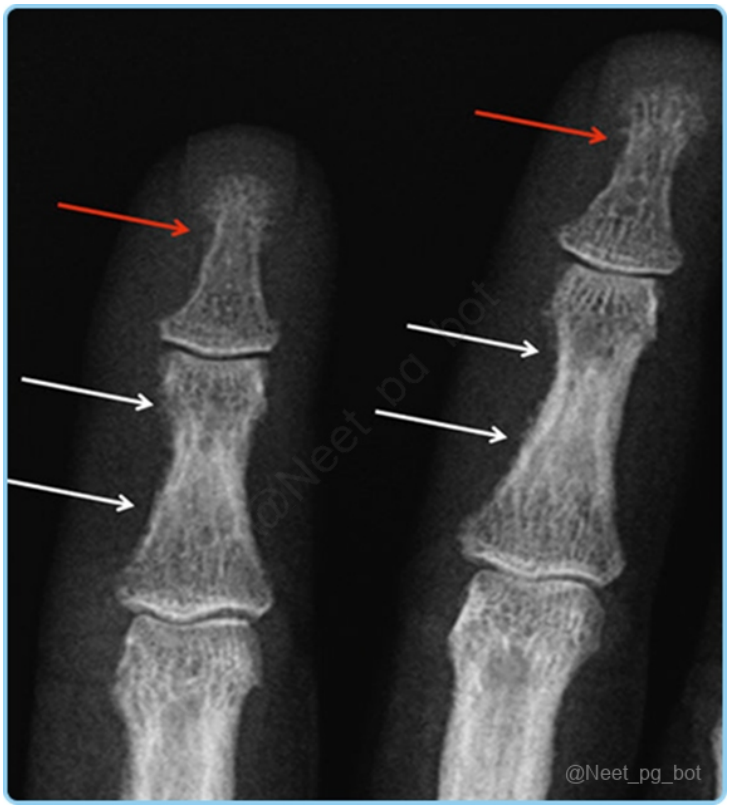
Q38: A middle-aged man with a history of renal calculi presents with bone pain and abdominal cramps. X-ray shows subperiosteal resorption of the 2nd and 3rd metacarpals and phalanges. Serum calcium and PTH are raised, and phosphate levels are decreased. Which of the following investigations will help localise the pathology? (Q860470)

A. 99Tc radiolabelled sestamibi scan

B. MRI scan

C. USG

D. CT scan



See Answer in Part B → Q38

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Q39: Which of the following is not an indication for parathyroidectomy in a patient with primary hyperparathyroidism? (Q860451)

A. Serum calcium > 1 mg/dL above the upper limit of normal

B. 24-hour urine calcium > 400 mg/d

C. Age < 50 years

D. Creatinine clearance < 90 mL/min

See Answer in Part B → Q39

@Neet_pg_bot

Q40: A patient presents with a swelling in the thyroid region that moves with deglutination and protrusion of the tongue. The swelling has ruptured, resulting in pus discharge. What is the preferred treatment? (Q860404)

A. Sistrunk procedure

B. Antibiotics

C. Incision and drainage

D. None of the above



See Answer in Part B → Q40

@Neet_pg_bot

Q41: A female presented with 1x 1 cm thyroid swelling. What is next best step in management? (Q844302)

A. I 131

B. TSH

C. TSH and T4

D. T3 and T4

See Answer in Part B → Q41

@Neet_pg_bot

Q42: A patient presents to the outpatient department with an ulcerated breast tumor and liver metastasis. What is the appropriate management? (Q844324)

A. Simple mastectomy

B. Modified Radical Mastectomy (MRM)

C. Radical mastectomy

D. Neoadjuvant chemotherapy followed by surgery

See Answer in Part B → Q42

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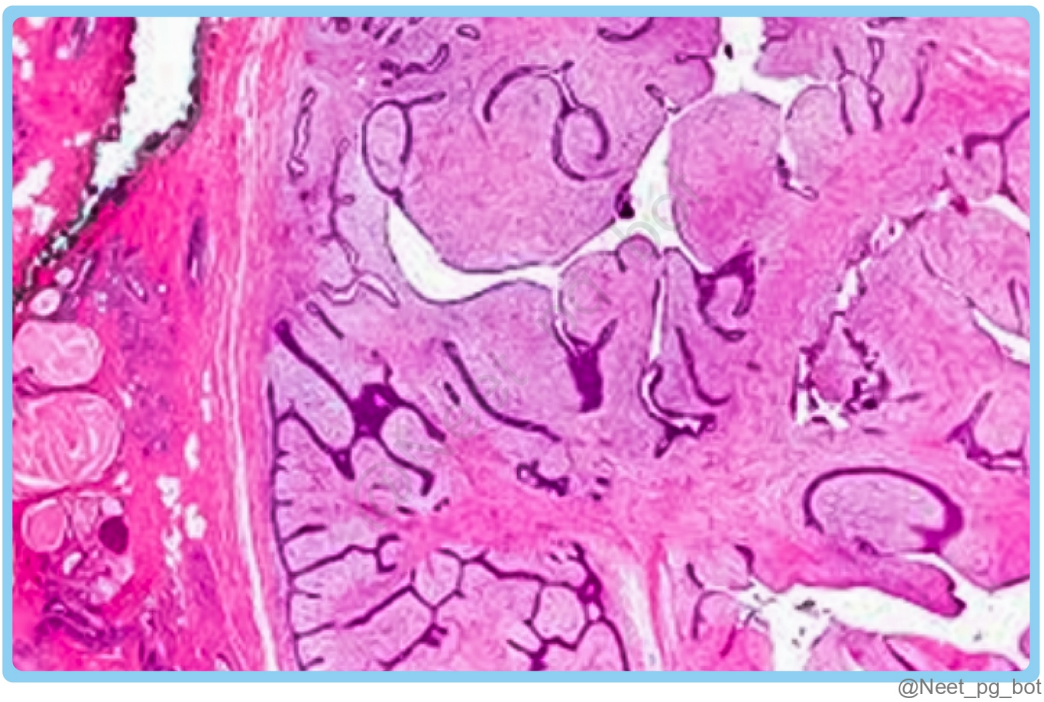
Q43: A 40-year-old female presents with an irregular 5 x 6 cm mass in the right breast. Histopathological examination reveals findings consistent with which of the following diagnoses? (Q844306)

A. Phyllodes tumor

B. Fibroadenoma

C. Mastitis

D. Grade 2 breast tumor



See Answer in Part B → Q43

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Q44: A 23-year-old female visited the clinician with a solitary thyroid nodule and was advised for thyroid function tests where Tsh level is 27.3mU/L, T3 is 1.24 ng/ml, and T4 is 4.87 microgram/ml. Which of the following manifestations is true regarding the condition? (Q852701)

A. Heat intolerance

B. Tachycardia

C. Diarrhea

D. Weight gain

See Answer in Part B → Q44

@Neet_pg_bot

Q45: What is the preferred treatment for a benign tumour of the superficial parathyroid gland? (Q860494)

A. Enucleation

B. Surgical resection

C. Chemotherapy

D. Radiation therapy

See Answer in Part B → Q45

@Neet_pg_bot

Q46: Which is the most lethal nerve injury during thyroid surgery? (Q853037)

A. U/L RLN (partial)

B. B/L RLN (partial)

C. U/L RLN (complete)

D. B/L RLN (complete)

See Answer in Part B → Q46

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Q47: A 20-year-old male presents with occasional palpitations, high blood pressure, and headache. He is diagnosed with pheochromocytoma. What is the preferred initial investigation? (Q853036)

A. USG-abdomen

B. MRI - abdomen

C. MIBG

D. 24 hours urine metanephrines

See Answer in Part B → Q47

@Neet_pg_bot

Q48: Which of the following is not a component of MEN2B syndrome? (Q853035)

A. Medullary thyroid carcinoma

B. Mucosal ganglioneuromatosis

C. Marfanoid habitus

D. Parathyroid hyperplasia

See Answer in Part B → Q48

@Neet_pg_bot

Q49: A 40-year-old patient with a history of Hodgkin's lymphoma and prior radiation therapy presents with a right-sided thyroid swelling. Fine needle aspiration cytology (FNAC) confirms papillary carcinoma with no evidence of lymph node involvement. What is the next step in management? (Q853034)

A. Hemi-thyroidectomy with modified radical neck dissection

B. Total thyroidectomy

C. Total thyroidectomy with modified radical neck dissection

D. Hemi-thyroidectomy

See Answer in Part B → Q49

@Neet_pg_bot

Q50: A 34-year-old male presents with a serum calcium level of 12.8 mg/dL (normal range: 8.5–10.25 mg/dL) along with elevated parathyroid hormone (PTH) levels. Ultrasound imaging reveals a 1.5 x 1.5 cm mass in the right lower lobe of the thyroid gland. Which of the following statements is correct regarding this condition? (Q853033)

A. MIBI followed by focussed parathyroidectomy to be done

B. Normal DEXA scan rules out the need for surgery

C. Only observation, no need for surgery

D. Creatinine clearance > 80 ml/min mandates the surgery

See Answer in Part B → Q50

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Q51: A neonate is diagnosed with congenital hypothyroidism. Thyroid ultrasound shows normal gland in-situ, but radioiodine uptake scan shows no uptake. What is the diagnosis? (Q866458)

A. Absent thyroid gland

B. Thyroid dyshormogenesis

C. lodine deficiency

D. Defective thyroid uptake

See Answer in Part B → Q51

@Neet_pg_bot

Q52: A 43 year old female present to OPD due changes in breast changes in breast and a lump in breast as given below, what is the diagnosis? (Q866420)

A. T4d

B. T4a

C. T1c

D. T3



See Answer in Part B → Q52

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Q53: A 45-year-old woman with a history of multinodular goitre undergoes a CT angiogram with iodinated contrast for suspected pulmonary embolism. Two weeks later, she presents with palpitations, heat intolerance, and weight loss. Her thyroid function tests show suppressed TSH and elevated T3 and T4. Which of the following best explains this patient's current condition? (Q865430)

A. Wolff-Chaikoff effect

B. Jod-Basedow effect

C. Thyroid storm

D. Hashitoxicosis

See Answer in Part B → Q53

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Q54: A 52-year-old female patient presents with HER-2-positive breast cancer that has become resistant to trastuzumab treatment. The oncologist is considering the next

line of treatment. Which of the following options would be the most appropriate choice? (Q854756)

A. Lapatinib

B. Sorafenib

C. Vemurafenib

D. Erlotinib

See Answer in Part B → Q54

@Neet_pg_bot

Q55: A 50-year-old woman after thyroidectomy comes to you for a 2 nd opinion for further treatment of papillary thyroid cancer. What would you recommend for this patient? (Q857779)

A. Radiotherapy

B. Chemotherapy

C. Radioiodine scan

D. Wait and watch

See Answer in Part B → Q55

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Q56: Genetic testing for BRCA 1/BRCA 2 is indicated for all of the following except: (Q857771)

A. Breast cancer diagnosed in a postmenopausal female >50 years of age

B. Male breast cancer

C. Two breast cancer primaries

D. TNBC diagnosed age 60 years

See Answer in Part B → Q56

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Q57: A 51-year-old woman is evaluated for a right breast mass. Physical examination reveals a 6 cm firm tumor. Palpable, mobile lymph nodes are also noted in the right axilla. A core biopsy confirms invasive ductal carcinoma, and a subsequent workup for distant disease is negative. According to the AJCC TNM staging system, what is the clinical stage of her cancer? (Q857767)

A. cT3N1M0

B. cT4N0M0

C. cT4N1M0

D. cT3N0M0

See Answer in Part B → Q57

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Q58: A woman presents with a BIRADS-5 breast lesion. Which of the following is a good prognostic factor for this lesion? (Q855191)

A. BRCA-1 positive

B. p53 positive

C. ER positive

D. High Ki-67

See Answer in Part B → Q58

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Q59: What is the primary prognostic factor that significantly influences the outcome of breast cancer? (Q854789)

A. Lymph node

B. Distant metastasis

C. Size

D. Hormone receptors

See Answer in Part B → Q59

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Q60: A 55-year-old female presents with a breast lump and is seeking medical evaluation. On examination, a palpable mass is detected in the breast. Which of the following conditions is not associated with the development of breast cancer? (Q854764)

A. Alcohol intake

B. Late menopause

C. Hormone replacement therapy

D. Multiparity

See Answer in Part B → Q60

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Q61: Which of the following are typically done in breast conservation therapy? Wide local excision Axillary node dissection Frozen section during surgery Optional: Post-operative radiotherapy (Q854762)

A. 1, 2, 3

B. 1, 3, 4

C. 1, 2

D. 2, 3

See Answer in Part B → Q61

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Q62: A 50-year-old woman presents with a slowly enlarging, painless thyroid nodule. She has no history of radiation exposure. On examination, the nodule is firm and mobile. Thyroid function tests are within normal limits. Ultrasound shows a solitary, solid lesion in the right lobe of the thyroid. Fine-needle aspiration cytology (FNAC) is performed, but is inconclusive. A hemithyroidectomy is done, and histopathology reveals capsular and vascular invasion. What is the most likely diagnosis? (Q865363)

A. Papillary thyroid carcinoma

B. Follicular adenoma

C. Follicular thyroid carcinoma

D. Medullary thyroid carcinoma

See Answer in Part B → Q62

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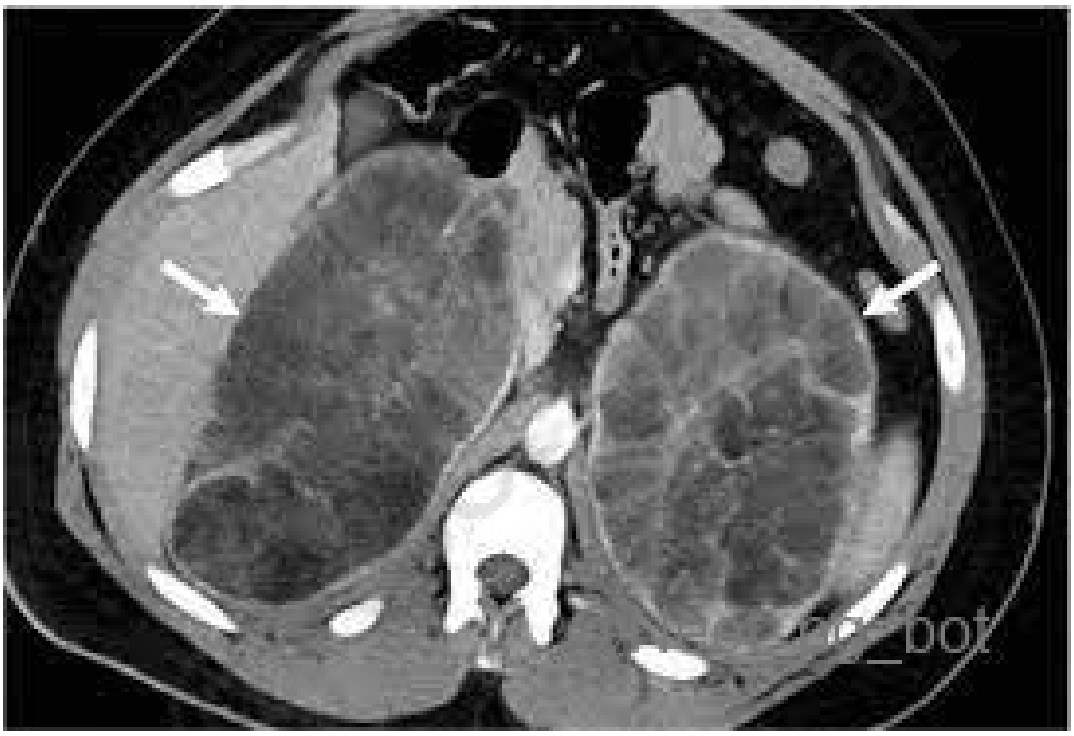
Q63: Which of the following condition is depicted in the given CT image ? (Q820159)

A. Cirrhosis

B. HCC

C. Congenital Adrenal Hyperplasia

D. Hepatitis



See Answer in Part B → Q63

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Q64: A patient with a known history of rheumatoid arthritis is brought to the ER due to dizziness. Her blood pressure is 90/60 mmHg. She stopped taking a medication prescribed by her local doctor. Her blood sugar is low, and serum potassium is 6 mEq/L. Which of the following drugs should be given to her next? (Q857303)

A. IV Saline

B. Hydrocortisone

C. Dopamine infusion

D. Sodium bicarbonate

See Answer in Part B → Q64

@Neet_pg_bot

Q65: Which of the following is the best method to conclusively localize a parathyroid adenoma? (Q857302)

A. SPECT Sestamibi

B. Tc99 Sestamibi Scan

C. USG Neck

D. MRI

See Answer in Part B → Q65

@Neet_pg_bot

Q66: Which of the following drugs are not used for thyrotoxic crisis management? (Q857301)

A. Acetaminophen

B. Aspirin

C. Lugol's iodine

D. Propranolol

See Answer in Part B → Q66

@Neet_pg_bot

Q67: Identify the most common pancreatic islet tumor associated with MEN-1 syndrome. (Q860303)

A. VIPoma

B. Gastrinoma

C. Insulinoma

D. Lipoma

See Answer in Part B → Q67

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Q68: Which of the following will not result in hoarseness of voice after a thyroid surgery? (Q840046)

A. Dissecting/retracting strap muscles

B. Exploring Beahrs triangle

C. Tubercle of zuckerkandl dissection

D. Ligating inferior thyroid vessels

See Answer in Part B → Q68

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Q69: A 52-year-old woman is diagnosed with invasive ductal carcinoma of the left breast. On examination, there is skin ulceration overlying the tumor, localized edema and redness, but no diffuse inflammatory changes. Nipple retraction is present. No axillary lymphadenopathy is noted, and imaging shows no distant metastasis. What is the T-stage of this tumor? (Q840029)

A. T2

B. T3

C. T4a

D. T4b

See Answer in Part B → Q69

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Q70: ER positivity is used as which of the following in the context of breast carcinoma? (Q840015)

A. Diagnostic marker

B. Prognostic marker

C. Surrogate molecular marker

D. Treatment

See Answer in Part B → Q70

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Q71: What is the term used to describe the signs and symptoms caused by hormones released from tumor tissue, which cannot be explained by the tumor's anatomical distribution? (Q793543)

A. Pretumor syndrome

B. Paraneoplastic syndrome

C. Paratumour syndrome

D. Autocrine phenomenon

See Answer in Part B → Q71

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• [08_Plastic Surgery] 047 Burns

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[08_Plastic Surgery] 047 Burns — Quick Jump

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Q19 (p. 785)	*Q20 (p. 785)*				

Q1: A 35 year old industrial worker presents to the ED with severe pain and burns on his right hand after exposure to hydrofluoric acid. The burns are superficial, with erythema and blistering. What is the most appropriate initial management step? (Q849515)

A. Immediate surgical debridement

B. Topical application of calcium gluconate gel

C. Intravenous calcium gluconate

D. Bier's block with calcium gluconate 10%

See Answer in Part B → Q1

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Q2: A 40-year-old man suffered burns from a wildfire affecting his entire right upper limb and the front of his torso. What is the total percentage of body surface area that has been burned? (Q849512)

A. 27%

B. 18%

C. 36%

D. 32%

See Answer in Part B → Q2

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Q3: A 29-year-old woman sustained severe burns following a spillage of boiling water in the kitchen by accident. She requires colloid resuscitation after the first 24 hours of crystalloid resuscitation. Which of the following can be used to calculate colloid fluid volume? (Q849510)

A. Parkland formula

B. Muir and Barclay regime

C. Evan's formula

D. Galveston regime

See Answer in Part B → Q3

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Q4: A 24-year-old boy sustained burns in an accident. He has 20% burns and is of 60 kg. What is the total fluid requirement for a day according to the Parkland regime? (Q849508)

A. 4800 mL

B. 5000 mL

C. 4000 mL

D. 3800 mL

See Answer in Part B → Q4

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Q5: A 25-year-old female is brought to the emergency department after being found unconscious during a thunderstorm. On examination, she has fern-like marks on his neck (as shown in the image below). After regaining consciousness, she complains of weakness and numbness in her lower limbs. What is the most likely diagnosis of her

condition? (Q849517)

A. Compartment syndrome

B. Keraunoparalysis

C. Hypokalemic periodic paralysis

D. Transient ischemic attack



See Answer in Part B → Q5

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Q6: A 35-year-old electrician is brought to the emergency department after sustaining an electrical injury while working on a faulty high-voltage switchboard. On examination, he is noted to have an entry wound on his left hand and an exit wound on his right foot and dark urine in the Foley catheter bag. Laboratory tests show the following results: Serum creatinine: 2.5 mg/dL Potassium: 5.8 mEq/L Creatine kinase (CK): 25,000 U/L What is the most appropriate next step in the management of this patient? (Q849516)

A. Initiate intravenous fluid resuscitation and monitor urine output

B. Immediate surgical debridement of the entry and exit wounds

C. Administer calcium gluconate for hyperkalemia

D. Start hemodialysis immediately

See Answer in Part B → Q6

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Q7: A 32 year old male arrives at the emergency department with severe facial burns after being involved in a car accident. The patient's facial burns are extensive, covering the entire face and neck region, and have caused significant swelling. He is conscious and in pain, but his airway is patent. Which method of dressing should be chosen for this patient's facial burns, and why? (Q849514)

A. Exposure Method – To allow continuous monitoring of the facial burns and prevent airway compromise.

B. Closed Method – To reduce the risk of infection by providing a protective barrier over the burned area.

C. Exposure Method – To facilitate a moist environment that promotes healing in the facial area.

D. Closed Method – To minimize fluid loss from the burned area and aid in preventing dehydration.

See Answer in Part B → Q7

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Q8: A 36 year old male is admitted to the hospital with severe second and third-degree burns. On the fourth day, the patient develops a fever, increased pain in the burned area, and a malodorous discharge from the wound. The burn wound appears to have significant eschar formation. Wound cultures reveal heavy growth of Pseudomonas aeruginosa. Which of the following topical agents would be most appropriate for this patient? (Q849513)

A. Silver sulfadiazine (1%)

B. Sulfamylon (Mafenide acetate) (5%/11%)

C. Silver nitrate (0.5%)

D. Povidone iodine (5%)

See Answer in Part B → Q8

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Q9: A 24-year-old burns patient is receiving fluid resuscitation and is being closely monitored. What should his ideal urine output be? (Q849511)

A. 1 mL/kg/hr

B. 3 mL/kg/hr

C. 5 mL/kg/hr

D. 2 mL/kg/hr

See Answer in Part B → Q9

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Q10: A 10-year-old boy contracted burns and is in need of fluid resuscitation. Which of the following formulas can be used to measure the fluid volume? (Q849509)

A. Parkland formula

B. Modified Brooke formula

C. Evan’s formula

D. Galveston formula

See Answer in Part B → Q10

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Q11: A 70-year-old woman presents to the emergency department after a house fire. She has burns involving parts of her face, neck, and both hands. The total body surface area (TBSA) affected is approximately 12%. After emergency management using ATLS guidelines, What is the most appropriate next step in management? (Q849498)

A. Discharge with outpatient follow-up for wound care and pain management

B. Admit to the general medical floor for observation and supportive care

C. Refer to a burn center for specialized treatment

D. Manage in the emergency department with fluids and dressings, then discharge

See Answer in Part B → Q11

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Q12: What is the most commonly used fluid for initial resuscitation in burn patients? (Q849507)

A. Hypertonic saline

B. Ringer lactate

C. 5% Dextrose

D. Albumin

See Answer in Part B → Q12

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Q13: Which of the following complications in a patient with an airway burn most at risk? (Q849506)

A. Chronic bronchitis

B. Pulmonary embolism

C. Acute airway obstruction

D. Pleural effusion

See Answer in Part B → Q13

@Neet_pg_bot

Q14: What is the most common cause of death in the first 24 hours after sustaining severe burns? (Q849505)

A. Septicemia

B. Hypovolemic shock

C. Acute respiratory distress syndrome (ARDS)

D. Renal failure

See Answer in Part B → Q14

@Neet_pg_bot

Q15: A 35-year-old male presents to the emergency department with complaints of extensive burns on his back, chest, and legs. On examination, the affected areas are dry, leathery, and charred black with no blister formation.What is the most likely type of burn? (Q849504)

A. Second-degree burn

B. First-degree burn

C. Third-degree burn

D. Fourth-degree burn

See Answer in Part B → Q15

@Neet_pg_bot

Q16: Match the type of burn with its corresponding characteristic: Type of Burn Characteristics 1. First-degree burn A. Blistering, partial-thickness damage 2.

Second-degree burn B. Charring, full-thickness skin damage 3. Third-degree burn C. Redness, Epidermal burn 4. Fourth-degree burn D. Involvement of muscles and bones (Q849503)

A. 1-C, 2-A, 3-B, 4-D

B. 1-A, 2-B, 3-D, 4-C

C. 1-C, 2-B, 3-A, 4-D

D. 1-D, 2-C, 3-A, 4-B

See Answer in Part B → Q16

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Q17: Which of the following best differentiates deep partial-thickness burns from superficial partial-thickness burns? (Q849502)

A. Involvement of the epidermis and papillary dermis with visible capillary refill.

B. Blistering and loss of epidermis with pink and moist dermis.

C. Healing within 2 weeks without scarring.

D. Reduced sensation, fixed capillary staining and no blanching with pressure.

See Answer in Part B → Q17

@Neet_pg_bot

Q18: In burn injuries, which zone is characterized by necrotic tissue and irreversible cell damage at the time of injury? (Q849501)

A. Zone of Hyperemia

B. Zone of Stasis

C. Zone of Coagulation

D. Zone of Inflammation

See Answer in Part B → Q18

@Neet_pg_bot

Q19: A 55-year-old male with a history of a recent traumatic brain injury presents with sudden epigastric pain, vomiting of blood, and black stools. He is diagnosed with a Cushing ulcer. Despite initial management with IV fluids and proton pump inhibitors (PPIs), the patient continues to bleed. What is the most appropriate next step in management? (Q849500)

A. Increase the dose of IV PPIs and observe for improvement.

B. Perform an urgent endoscopy to control the bleeding.

C. Schedule the patient for a planned surgical vagotomy and pyloroplasty.

D. Refer the patient for immediate angiography with embolization.

See Answer in Part B → Q19

@Neet_pg_bot

Q20: Which among the following statements about the body responses to severe burns are true? A) Hypermetabolism after a burn increases oxygen consumption and leads to muscle wasting. B) The zone of coagulation is a reversible area of tissue damage in burns. C) Cardiopulmonary effects in severe burns can result in reduced cardiac output. D) Immune suppression following a burn increases the risk of infection. E) Inflammation and edema in burn injuries cause increased vascular permeability and fluid loss. (Q849499)

A. All except A and C

B. All except A and B

C. All except B

D. All are correct

See Answer in Part B → Q20

@Neet_pg_bot

• [08_Plastic Surgery] 048 Plastic Surgery And Skin Lesions

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[08_Plastic Surgery] 048 Plastic Surgery And Skin Lesions — Quick Jump

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Q25 (p. 800)	*Q26 (p. 800)*	*Q27 (p. 801)*	*Q28 (p. 801)*	*Q29 (p. 801)*	*Q30 (p. 802)*

Q1: The following are good prognostic factors for melanoma except (Q849574)

A. No or very few mitoses (<1 per mm sq)

B. Lack of ulceration

C. Absence of Regression

D. Thinner tumor growth

See Answer in Part B → Q1

@Neet_pg_bot

Q2: After a skin graft procedure in a burn patient, regeneration of the epidermis occurs from resident stem cells in the basal layer. These regenerative cells belong to which category of stem cell potency? (Q882386)

A. Multipotent

B. Pluripotent

C. Totipotent

D. Unipotent

See Answer in Part B → Q2

@Neet_pg_bot

Q3: Which of the following is true regarding basal cell carcinoma? (Q849639)

A. Superficial BCC typically appears with a thin pearly border

B. Nodular is the least common type of BCC

C. Morpheaform variant is the most common type of BCC

D. The prognosis is very poor for all cases

See Answer in Part B → Q3

@Neet_pg_bot

Q4: All of these are used for flap monitoring except: (Q849638)

A. Clinical assessment

B. Color Doppler sonography

C. Microdialysis

D. None of the above

See Answer in Part B → Q4

@Neet_pg_bot

Q5: Which of the following types do osteomyocutaneous flaps belong to? (Q849637)

A. Conjoined flaps

B. Chimeric flaps

C. Composite flaps

D. None of the above

See Answer in Part B → Q5

@Neet_pg_bot

Q6: Which of the following is an example of a free flap? (Q849636)

A. Z-Plasty

B. Pectoralis major myocutaneous flap

C. Radial artery forearm flap

D. Deltopectoral flap

See Answer in Part B → Q6

@Neet_pg_bot

Q7: A 45-year-old man presents with a large soft tissue defect on his lower leg following a motorcycle accident. The wound measures 10 cm x 15 cm and involves exposure of the tibia. The plastic surgeon is considering an axial flap for reconstruction. Which of the following statements is incorrect regarding the usage of an axial flap? (Q849635)

A. Axial pattern flaps derive their blood supply directly from a fasciocutaneous artery that runs beneath the flap's longitudinal axis.

B. It allows for a larger flap design compared to random pattern flaps and delivers better cosmetic results

C. Deltopectoral flap is a type of axial flap

D. Due to larger size, axial flaps require a high complexity, multi-step method for reconstruction of defects

See Answer in Part B → Q7

@Neet_pg_bot

Q8: Regarding the use of random flaps in grafting, which of the following statements is incorrect? (Q849634)

A. V-Y Plasty is a random flap used for fingertips and extremities

B. Random flaps rely on perfusion from the subdermal vascular plexus which is a low-pressure system

C. Z-Plasty is used for lengthening of tissue and scars.

D. Due to the tenuous blood supply, a minimum length-width ratio of 3:1 is required

See Answer in Part B → Q8

@Neet_pg_bot

Q9: A 48-year-old man presents with a progressively enlarging, painless mass in his groin. A biopsy confirms a diagnosis of soft tissue sarcoma. Which of the following characteristics would most likely increase the probability of lymph node involvement in this patient? (Q849633)

A. Tumor Size >5 cm

B. High-grade histology

C. Rhabdomyosarcoma histotype

D. Deep location relative to fascia

See Answer in Part B → Q9

@Neet_pg_bot

Q10: A 35-year-old woman with a family history of multiple cancers presents with a soft tissue mass. Genetic testing reveals a TP53 mutation. Which of the following is the most likely clinical course associated with her condition? (Q849632)

A. Development of multiple benign lipomas

B. Increased risk of developing gastrointestinal stromal tumors (GIST)

C. High likelihood of developing soft tissue sarcomas, breast cancer, and brain tumors

D. Predominantly risk of osteosarcoma and leukemia

See Answer in Part B → Q10

@Neet_pg_bot

Q11: A 5-year-old boy is brought to the OPD by his mother with complaints of swelling on her nape. On examination, a hard, freely mobile, and slow-growing mass is seen. A photograph of the lesion is shown below. Which of the following is the most appropriate clinical diagnosis for this patient? (Q849631)

A. Cock's Peculiar Tumor

B. Pott's Puffy Tumor

C. Pilomatrixoma

D. Cylindroma



See Answer in Part B → Q11

@Neet_pg_bot

Q12: All of the following conditions resolve spontaneously in an infant except (Q849578)

A. Port wine stain

B. Strawberry angioma

C. Salmon patch

D. Cock’s peculiar tumor

See Answer in Part B → Q12

@Neet_pg_bot

Q13: A 28-year-old female patient came to OPD complaining of swelling on the side of her face. On examination, the swelling was painless, smooth, soft, and non-tender. A CT scan was done to rule out dural attachment and a diagnosis of angular dermoid was made. How will you manage the case? (Q849577)

A. Surgical excision

B. Wait and watch

C. Wide local excision with a 2 cm margin

D. Laser ablation



See Answer in Part B → Q13

@Neet_pg_bot

Q14: A 64-year-old male patient came to the OPD with complaints of swelling on the back of the neck. O/E the swelling is soft and doughy to the touch and non-tender. A diagnosis of lipoma is made. What is the definitive management of this condition? (Q849576)

A. Surgical excision

B. Wide local excision with sentinel node biopsy

C. Excision of the cyst with the wall

D. Incision and drainage followed by excision



See Answer in Part B → Q14

@Neet_pg_bot

Q15: A patient came with complaints of a painful swelling present on the trunk. On examination, tenderness and pus discharge present with a black-colored punctum seen. A provisional diagnosis of an infected sebaceous cyst is made. Identify the incorrect statement about this condition. (Q849575)

A. It contains sebum.

B. It is a type of retention cyst

C. Black colored punctum is present on the cyst

D. There is the proliferation of epidermal cells



See Answer in Part B → Q15

@Neet_pg_bot

Q16: A patient with a skin graft is experiencing mild swelling and oozing at the graft site 24 hours after surgery. Which phase of graft take is most likely occurring? (Q849551)

A. Imbibition

B. Inflammation

C. Revascularization

D. Maturation

See Answer in Part B → Q16

@Neet_pg_bot

Q17: Which of the following Clark levels indicates that malignant melanoma has invaded the subcutaneous tissue? (Q849573)

A. Level II

B. Level III

C. Level IV

D. Level V

See Answer in Part B → Q17

@Neet_pg_bot

Q18: Which of the following statements is true about malignant melanoma? (Q849572)

A. CK-20 is a positive marker for malignant melanoma

B. Lentigo Maligna is the most malignant type of malignant melanoma

C. Lymphatic spread is the common route of metastasis

D. Most common site of metastasis is the Lymph Node

See Answer in Part B → Q18

@Neet_pg_bot

Q19: A 70-year-old male presents with a large, aggressive squamous cell carcinoma on his lower lip. After initial treatment attempts, the tumor remains persistent. Which of the following treatment options is most appropriate to ensure complete removal of the tumor while minimizing damage to surrounding healthy tissue? (Q849571)

A. Cryotherapy

B. Electrodesiccation and Curettage

C. Wide Local Excision

D. Mohs Micrographic Surgery

See Answer in Part B → Q19

@Neet_pg_bot

Q20: A 65-year-old farmer presents with a persistent, scaly lesion on his ear. The lesion has irregular, everted edges and has been gradually growing as shown below. Which of the following is the most common causative factor for his condition? (Q849567)

A. Tobacco Use

B. Arsenic Exposure

C. Sunlight Exposure

D. Radiation Exposure



See Answer in Part B → Q20

@Neet_pg_bot

Q21: A 62-year-old male presents with a slow-growing, pearly nodule on his nose. The lesion shows telangiectatic vessels on its surface and has a central depression. Which of the following is the most appropriate diagnostic method to confirm the diagnosis of this skin lesion? (Q849566)

A. Punch Biopsy

B. Wedge Biopsy

C. Excisional Biopsy

D. None of the above

See Answer in Part B → Q21

@Neet_pg_bot

Q22: A 65-year-old man presents with a non-healing ulcer on the popliteal surface of his leg that has been present for several months. The ulcer developed at the site of a burn scar he sustained 30 years ago. On examination, the ulcer is painless, slow-growing, and has irregular borders as shown in the image? What is the most appropriate initial management for this patient? (Q849560)

A. Cryotherapy and regular dressing changes

B. Wide local excision followed by flap cover

C. Wide local excision followed by flap cover and radiotherapy

D. Observation and follow-up in 6 months



See Answer in Part B → Q22

@Neet_pg_bot

Q23: A 55-year-old man with a history of diabetes presents with a chronic wound on his lower leg. On examination, you observe a well-defined lesion with the following characteristics: The deepest part of the lesion shows exposed muscle tissue. The exposed surface appears red and moist with some granulation tissue. There is a distinct boundary between healthy skin and the wound. A narrow area surrounds the wound where the skin appears different from both the healthy skin and the wound itself. Based on this clinical scenario, which of the following correctly matches the described features with the parts of an ulcer? (Q849558)

A. Exposed muscle - Floor; Red, moist surface with granulation - Base; Boundary of healthy skin - Edge; Narrow surrounding area - Margin

B. Exposed muscle - Base; Red, moist surface with granulation - Floor; Boundary of healthy skin - Margin; Narrow surrounding area - Edge

C. Exposed muscle - Floor; Red, moist surface with granulation - Base; Boundary of healthy skin - Margin; Narrow surrounding area - Edge

D. Exposed muscle - Base; Red, moist surface with granulation - Edge; Boundary of healthy skin - Floor; Narrow surrounding area - Margin

See Answer in Part B → Q23

@Neet_pg_bot

Q24: Which of the following is not a type of fasciocutaneous flap? (Q849557)

A. Radial forearm flap

B. Groin flap

C. Tensor fascia lata flap

D. Scapular flap

See Answer in Part B → Q24

@Neet_pg_bot

Q25: Which of the following is not an absolute indication for flap surgery? (Q849556)

A. Post-burn contractures

B. Exposed bony prominences in the joint area

C. Radiated vessel

D. Stage III bedsores

See Answer in Part B → Q25

@Neet_pg_bot

Q26: A 30-year-old patient with extensive third-degree burns requires skin grafting. The surgical team opts for a meshed split-thickness skin graft (STSG). Which of the following is a key benefit of using a meshed skin graft in this scenario? (Q849555)

A. Enhanced cosmetic appearance

B. Coverage of a large area with minimal donor skin

C. Reduced risk of secondary contraction

D. Decreased need for vascularization

See Answer in Part B → Q26

@Neet_pg_bot

Q27: A 45-year-old male undergoes a split-thickness skin graft for a large wound on his leg. Three days postoperatively, the graft appears swollen with fluid accumulating underneath it. Which of the following complications is most likely? (Q849554)

A. Graft failure

B. Hematoma or seroma formation

C. Infection

D. Poor cosmetic outcome

See Answer in Part B → Q27

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Q28: A patient needs a graft to cover a small, non-weight-bearing area that is prone to contraction. Which type of graft would be most appropriate to minimize the risk of contraction? (Q849553)

A. Thiersch graft, due to its minimal contraction

B. Wolfe graft, due to its full-thickness nature

C. Split-thickness graft, because it can cover larger areas

D. Composite graft, because it includes skin and underlying tissue

See Answer in Part B → Q28

@Neet_pg_bot

Q29: During a skin grafting procedure, the surgeon opts for a tool that can precisely control the thickness of the graft to ensure uniformity. Which of the following instruments is most appropriate for this task? (Q849552)

A. Surgical scissors

B. Dermabrader

C. Ferris-Smith forceps

D. Electric dermatome

See Answer in Part B → Q29

@Neet_pg_bot

Q30: Match the following types of ulcers with their characteristic edge appearance: Conditions Edges 1. Healing Ulcer a. Punched-out edges 2. Ischaemic Ulcer b. Undermined edges 3. Tubercular Ulcer c. Sloping edges 4. Basal Cell Carcinoma d. Everted edges 5. Squamous Cell Carcinoma e. Rolled or Pearly white edges (Q849559)

A. 1-c, 2-a, 3-b, 4-d, 5-e

B. 1-b, 2-c, 3-a, 4-d, 5-e

C. 1-c, 2-a, 3-b, 4-e, 5-d

D. 1-b, 2-c, 3-a, 4-e, 5-d

See Answer in Part B → Q30

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• [08_Plastic Surgery] 049 Wound Healing

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[08_Plastic Surgery] 049 Wound Healing — Quick Jump

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Q7 (p. 805) *Q8 (p. 806)* *Q9 (p. 806)* *Q10 (p. 807)* *Q11 (p. 808)* *Q12 (p. 808)*
Q13 (p. 809)

Q1: A 75-year-old bedridden patient is admitted to the hospital with pneumonia. During routine care, the nurse notices an area of redness and tissue breakdown over the patient's sacrum. The patient has been immobile for several days due to weakness. Which of the following statements is incorrect regarding pressure sores? (Q849533)

A. Pressure sores occur when external pressure exceeds capillary occlusive pressure of 30 mm Hg

B. Malnutrition and neurological deficits are contributing factors to pressure sore development

C. The most common site for pressure sores is the greater trochanter

D. In case of pressure sores on Malleolus, lateral is more commonly affected than medial

See Answer in Part B → Q1

@Neet_pg_bot

Q2: A 75-year-old bedridden patient in a long-term care facility is found to have a pressure sore on his sacral area during a routine skin assessment. Upon examination, the nurse notices a deep, crater-like wound extending through the dermis into the subcutaneous tissue. The base of the wound appears red, and there is no visible bone, tendon, or muscle. Based on the staging system for pressure sores, how would this be classified? (Q849536)

A. Stage IV

B. Stage II

C. Stage III

D. Stage I

See Answer in Part B → Q2

@Neet_pg_bot

Q3: A 25-year-old woman presents with a raised, firm, reddish-purple lesion extending beyond the margins of a surgical scar on her chest. The scar is from a surgery performed 8 months ago. The lesion is pruritic and occasionally painful. Which of the following is the most likely diagnosis? (Q849542)

A. Hypertrophic scar

B. Keloid

C. Dermatofibroma

D. Malignant transformation of the scar

See Answer in Part B → Q3

@Neet_pg_bot

Q4: Which of the following best describes the proliferative phase of wound healing? (Q849523)

A. Vasoconstriction and thrombus formation

B. Fibroblast activity and collagen production

C. Maturation of collagen

D. Recruitment of neutrophils and macrophages

See Answer in Part B → Q4

@Neet_pg_bot

Q5: Which of the following factors is most likely to adversely affect wound healing? (Q849524)

A. Proper oxygenation

B. Vitamin A supplementation

C. Ionizing radiation

D. Normal body temperature

See Answer in Part B → Q5

@Neet_pg_bot

Q6: A 50-year-old woman undergoes an elective cholecystectomy. How would you classify this surgical wound? (Q849525)

A. Class I

B. Class II

C. Class III

D. Class IV

See Answer in Part B → Q6

@Neet_pg_bot

Q7: All of the following measures help prevent surgical site infections except: (Q849526)

A. Minimizing postoperative hospital stay

B. Proper hand hygiene and surgical scrubbing

C. Prolonged use of postoperative drains

D. Administering pre-operative antibiotics at induction

See Answer in Part B → Q7

@Neet_pg_bot

Q8: A patient presents with a large, open wound on the lower leg that has been left to heal naturally without surgical closure. This type of healing is best described as: (Q849527)

A. Healing by primary intention

B. Healing by secondary intention

C. Healing by tertiary intention

D. Delayed primary closure

See Answer in Part B → Q8

@Neet_pg_bot

Q9: A 68-year-old diabetic patient presents with a non-healing ulcer on their heel that has persisted for 4 months despite regular dressing changes and offloading. The image showing the wound is given below. Based on this clinical scenario, which of the following statements is incorrect? (Q849530)

A. Chronic wound is a wound that persists beyond 4-12 weeks from its first appearance

B. Delay in healing most commonly occurs due to prolonged inflammatory phase

C. Pain is initially severe, but disappears with time due to nociceptor damage

D. Examples of chronic wounds include vascular ulcers, diabetic ulcers, and pressure sores



See Answer in Part B → Q9

@Neet_pg_bot

Q10: A 35-year-old factory worker presents to the emergency department with a severe injury to his right forearm after it was caught in a machine, as shown in the picture below. Which of the following statements is incorrect with respect to the injury? (Q849531)

A. It occurs due to shearing force between tissue planes, usually between subcutaneous tissue and deep fascia or between muscle and bone.

B. Skin viability is assessed using Fluorescein injection under anesthesia

C. Characteristic Morel-Lavallée lesion can be seen due to edema of surrounding viable tissue around the wound

D. Treatment primarily involves a multidisciplinary approach which may require amputation



See Answer in Part B → Q10

@Neet_pg_bot

Q11: A 25-year-old man is brought to the emergency department following a motorcycle accident. He has a closed fracture of the right tibia and complains of severe pain in his right lower leg. On examination, there is pain on passive stretching of the affected limb and distal sensory disturbances are noted. The emergency physician suspects compartment syndrome. Which of the following is the most applicable next step in an ideal clinical setting in the management of the patient? (Q849532)

A. Immediate fasciotomy without further investigation

B. Measurement of compartment pressure

C. Application of a compression bandage to reduce swelling

D. Administration of intravenous antibiotics

See Answer in Part B → Q11

@Neet_pg_bot

Q12: A 65-year-old bedridden patient presents with a stage III pressure sore on the sacrum. Which of the following is the most appropriate initial management approach? (Q849537)

A. Immediate surgical debridement

B. Application of hydrocolloid dressing

C. Negative pressure wound therapy

D. Flap reconstruction

See Answer in Part B → Q12

@Neet_pg_bot

Q13: What is the maximum tensile strength that a mature scar can achieve compared to normal skin? (Q849540)

A. 20-30%

B. 40-50%

C. 70-80%

D. 90-100%

See Answer in Part B → Q13

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• [08_Plastic Surgery] 050 Previous Year Questions

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[08_Plastic Surgery] 050 Previous Year Questions — Quick Jump

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Q19 (p. 820)	*Q20 (p. 821)*	*Q21 (p. 822)*	*Q22 (p. 822)*	*Q23 (p. 823)*	*Q24 (p. 824)*

Q1: A 7-year-old boy is brought to the emergency department 6 hours after sustaining burns involving 22% of total body surface area (TBSA). On examination, he has cool extremities, blood pressure 92/50 mmHg, pulse rate 56/min, and urine output <0.5 mL/kg/hour since the burn. What is the most appropriate next step in management? (Q866923)

A. Administer a crystalloid bolus of 10–20 mL/kg (Ringer’s lactate)

B. Start colloid infusion for volume expansion

C. Proceed with surgical intervention for burn wound management

D. Initiate fluid resuscitation at 30 mL/kg/hour

See Answer in Part B → Q1

@Neet_pg_bot

Q2: A patient presented with a 0.3 cm nodule on the left nasolabial fold. It was excised, and a pathological examination was done. What is the diagnosis? (Q855808)

A. Basal cell carcinoma

B. Melanoma

C. Squamous cell carcinoma

D. Nevus



See Answer in Part B → Q2

@Neet_pg_bot

Q3: A 4-year-old child presents with burn injuries after accidental contact with a hot metal surface. Examination shows burns involving the entire posterior trunk, the upper half of the anterior trunk, and the anterior and posterior surfaces of both arms. Using the pediatric Lund and Browder chart, estimate the total body surface area (TBSA) burned. (Q855773)

A. 15-20%

B. 25-30%

C. 35-40%

D. 10-15%

See Answer in Part B → Q3

@Neet_pg_bot

Q4: The image below shows a pressure sore. Which stage does this belong to? (Q855758)

A. Stage 1

B. Stage 2

C. Stage 3

D. Stage 4



See Answer in Part B → Q4

@Neet_pg_bot

Q5: What is the preferred management of the condition in the image below? (Q859868)

A. Surgical excision

B. Radiotherapy

C. Antibiotics

D. Intralesional steroids



See Answer in Part B → Q5

@Neet_pg_bot

Q6: What is the probable diagnosis for the lesion developed by a patient after 6 months of undergoing a surgery, as depicted below? (Q859844)

A. Hypertrophic scar

B. Atrophic scar

C. Keloid scar

D. Contracture



See Answer in Part B → Q6

@Neet_pg_bot

Q7: A 23-year-old man presented with a burn injury. He is covered with burns on his head & neck, both upper limbs, front and back of the chest. Calculate the percentage of burns. (Q856257)

A. 27%

B. 36%

C. 45%

D. 18%

See Answer in Part B → Q7

@Neet_pg_bot

Q8: Which of the following statements regarding Marjolin's ulcer is not true? (Q857471)

A. It is seen in sites of chronic wounds or scars

B. It rapidly progresses to malignancy

C. It can progress to squamous cell carcinoma

D. It is radioresistant due to avascularity

See Answer in Part B → Q8

@Neet_pg_bot

Q9: A 65-year-old man who has the following lesion over the face. He complains of bleeding while itching. The most likely diagnosis is (Q857457)

A. Dermatofibrosarcoma

B. Marjolin’s ulcer

C. Basal cell carcinoma

D. Naevus



See Answer in Part B → Q9

@Neet_pg_bot

Q10: Pressure greater than __ mm of Hg causes pressure sores.: (Q857264)

A. 33

B. 45

C. 54

D. 67

See Answer in Part B → Q10

@Neet_pg_bot

Q11: A patient who underwent surgery for a lipoma 5 weeks ago now presents with a scar at the incision site that is limited to the original wound boundaries. What is the most likely diagnosis? (Q857170)

A. Keloid

B. Exuberant granulation

C. Hypertrophic scar

D. Granulation tissue

See Answer in Part B → Q11

@Neet_pg_bot

Q12: What is the preferred management of angular dermoid cyst? (Q857146)

A. Surgical excision

B. Wait and watch

C. Wide local excision with a 2 cm margin

D. Laser ablation

See Answer in Part B → Q12

@Neet_pg_bot

Q13: In the case of a woman who has suffered third and fourth degree burns on her back, what would be the appropriate sequence of steps in her treatment? (Q793406)

A. Resuscitation – reconstruction – debridement

B. Resuscitation – debridement – allograft or autograft

C. Debridement – resuscitation – autograft

D. Debridement – reconstruction – resuscitation

See Answer in Part B → Q13

@Neet_pg_bot

Q14: What type of graft is used when a patient undergoes skin grafting following a road traffic accident in which the graft is harvested from the patient's own body? (Q857870)

A. Autograft

B. Xenograft

C. Allograft

D. Isograft



See Answer in Part B → Q14

@Neet_pg_bot

Q15: A 56-year-old female was treated for a burn wound in the lower limb 5 years ago. Now she has developed an ulcer in the burn scar as shown in the image below. What is the most probable diagnosis ? (Q820097)

A. Marjolin’s ulcer

B. Venous ulcer

C. Arterial ulcer

D. Cellulitis



See Answer in Part B → Q15

@Neet_pg_bot

Q16: Estimate the extent of injury for a patient with burns involving front of the chest & abdomen, right upper limb, and right thigh(Anterior). (Q857246)

A. 45%

B. 27%

C. 36%

D. 31.5%

See Answer in Part B → Q16

@Neet_pg_bot

Q17: How does the graft get nutrition on day 3? (Q844293)

A. Imbibition

B. Inosculation

C. Neovascularization

D. None

See Answer in Part B → Q17

@Neet_pg_bot

Q18: What type of dressing is used to cover this post burn wound? (Q844314)

A. Split thickness skin graft

B. Full thickness skin graft

C. VAC dressing

D. Normal sumag dressing



See Answer in Part B → Q18

@Neet_pg_bot

Q19: A 30 year old female was brought to EMR after fire on examination of lower limb full-thickness burns and deep partial-thickness burns were present involving it Circumferentially, procedure was performed as given below, identify the procedure? (Q866414)

A. Escharotomy

B. Debridement

C. Excised to healthy tissue fat/fascia

D. Early skin grafting



See Answer in Part B → Q19

@Neet_pg_bot

Q20: Which of the following is correct regarding nerve grafts: Nerve graft is used for peripheral nerves It is used for surgical repair of facial nerve palsy Most common nerve grafts are saphenous nerve and anterior interosseous nerve Nerve graft can be reconstructed only with fibrin glue (Q865378)

A. 2, 3

B. 1, 3, 4

C. 1, 2

D. 1, 2, 3

See Answer in Part B → Q20

@Neet_pg_bot

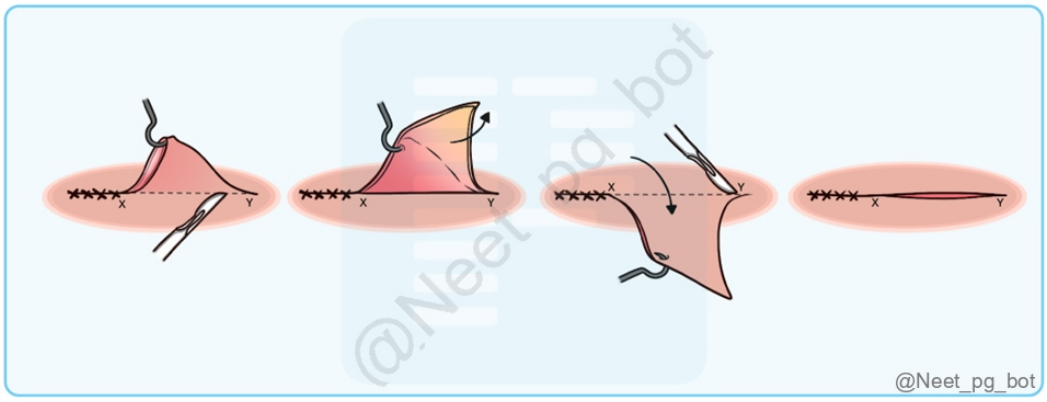
Q21: The following approach is used in: (Q865375)

A. Keloid excision

B. Abscess Drainage

C. Correcting Dog ear

D. Split thickness skin graft



See Answer in Part B → Q21

@Neet_pg_bot

Q22: Identify the procedure given below in the image? (Q865299)

A. Transposition flap is used for scar revision

B. Split-thickness skin grafting

C. Repositioning flap without transposition

D. Tissue transplantation



See Answer in Part B → Q22

@Neet_pg_bot

Q23: A patient underwent split-thickness skin grafting for a burn injury on the arm. On post-operative day 6, he develops stiffness of the arm during physiotherapy. What is the most appropriate next step in management? (Q866899)

A. Surgical excision of contracture

B. Passive extension of the joint under direct visualization of the graft

C. Continue physiotherapy without intervention

D. Remove the graft and regraft the area

See Answer in Part B → Q23

@Neet_pg_bot

Q24: What does the inclusion of a split-thickness skin graft in wound closure on the thigh entail? (Q793440)

A. Epidermis and full dermis

B. Epidermis and variable part of the dermis

C. Epidermis, dermis and fat

D. Epidermis only

See Answer in Part B → Q24

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• [09_Oncology] 051 Oncology

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[09_Oncology] 051 Oncology — Quick Jump

Q1 (p. 825) *Q2 (p. 825)* *Q3 (p. 826)* *Q4 (p. 826)* *Q5 (p. 826)* *Q6 (p. 827)*
Q7 (p. 827) *Q8 (p. 828)* *Q9 (p. 828)* *Q10 (p. 829)* *Q11 (p. 829)* *Q12 (p. 830)*
Q13 (p. 830)

Q1: Which of the following is the most common type of soft tissue sarcoma in adults? (Q849395)

A. Leiomyosarcoma

B. Liposarcoma

C. Rhabdomyosarcoma

D. Angiosarcoma

See Answer in Part B → Q1

@Neet_pg_bot

Q2: A 60-year-old male presents with a rapidly enlarging mass in the retroperitoneal area. Imaging reveals a large, heterogeneous mass with areas of necrosis. A biopsy confirms the diagnosis of dedifferentiated liposarcoma . What is the most common cause of death in patients with this condition? (Q849396)

A. Hemorrhage due to tumour rupture

B. Metastasis to lungs

C. Infection secondary to immunosuppression

D. Local recurrence leading to organ failure

See Answer in Part B → Q2

@Neet_pg_bot

Q3: Which of the following malignant tumours is known for spreading through both hematogenous and lymphatic routes? (Q849397)

A. Liposarcoma

B. Leiomyosarcoma

C. Angiosarcoma

D. Rhabdomyosarcoma

See Answer in Part B → Q3

@Neet_pg_bot

Q4: A 45-year-old male presents with a rapidly enlarging, painless mass in his right thigh, which has been growing over a few months. The mass is firm, deep-seated, and non-tender on examination. Which of the following is the most appropriate next step to establish a definitive diagnosis? (Q849398)

A. Contrast-Enhanced CT (CECT)

B. MRI

C. Tru-cut biopsy

D. PET-CT

See Answer in Part B → Q4

@Neet_pg_bot

Q5: A 60-year-old male presents with a rapidly growing, painless mass in the upper arm. Imaging shows that the mass is located deep in the fascia, and biopsy results indicate poorly differentiated pleomorphic cells with high mitotic activity. What is the most important prognostic factor for this patient's soft tissue sarcoma? (Q849400)

A. Tumor Size

B. Presence of Necrosis

C. Depth of Tumor

D. Histological Grade

See Answer in Part B → Q5

@Neet_pg_bot

Q6: In the surgical management of soft tissue sarcoma, which of the following criteria is most appropriate for achieving optimal outcomes? (Q849402)

A. Wide local excision with a 1 cm margin

B. Radical excision with removal of adjacent muscle groups

C. Wide local excision with a 2 cm margin

D. Radical excision with lymph node removal

See Answer in Part B → Q6

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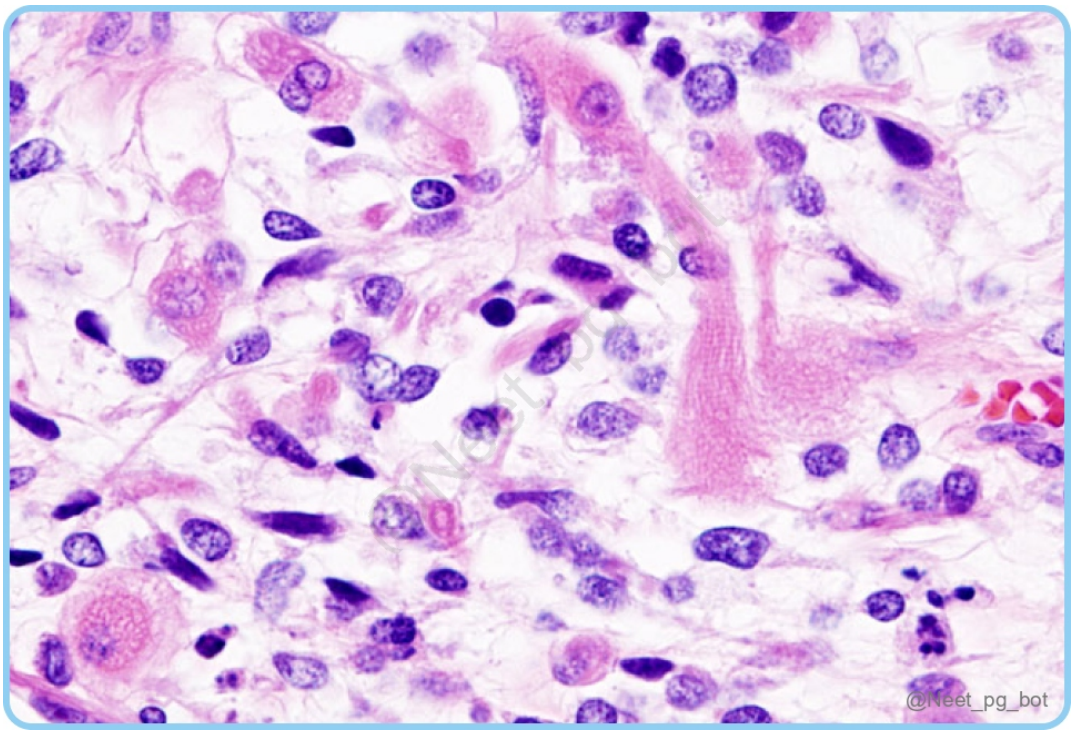
Q7: A 6-year-old boy has a rapidly growing 3 cm mass in his right cheek. Biopsy shows small round blue cells, alveolar patterns, eosinophilic cytoplasm with cross-striations, and positive immunochemistry for desmin and myogenin. What is the most likely diagnosis? (Q849403)

A. Ewing sarcoma

B. Neuroblastoma

C. Rhabdomyosarcoma

D. Lymphoma



See Answer in Part B → Q7

@Neet_pg_bot

Q8: A 58-year-old woman is diagnosed with a high-grade retroperitoneal liposarcoma. After treatment, her oncologist monitors for metastases. What's the most common site of metastasis for retroperitoneal sarcomas? (Q849414)

A. Lungs

B. Liver

C. Bone

D. Brain

See Answer in Part B → Q8

@Neet_pg_bot

Q9: In unresectable or metastatic Dermatofibrosarcoma Protuberans (DFSP), which targeted therapy is considered the drug of choice? (Q849416)

A. Vemurafenib

B. Imatinib

C. Pembrolizumab

D. Dabrafenib

See Answer in Part B → Q9

@Neet_pg_bot

Q10: Which of the following is NOT a critical metabolic derangement typically observed in tumour lysis syndrome? (Q849417)

A. Hyperkalemia

B. Hyperuricemia

C. Hypercalcemia

D. Hyperphosphatemia

See Answer in Part B → Q10

@Neet_pg_bot

Q11: A 50-year-old male who has been taking chemotherapy for chronic leukaemia for 2 years was having shortness of breath, dizziness, and flank pain for 3 days. His investigations revealed elevated serum uric acid, phosphate and potassium levels and decreased calcium levels. Which of the following is not the management of this condition? (Q849419)

A. Aggressive hydration

B. Allopurinol

C. Bisphosphonates

D. Hemodialysis

See Answer in Part B → Q11

@Neet_pg_bot

Q12: A 48-year-old male with small cell carcinoma of the lung presents with cyanosis of the neck and face, epistaxis, headache, dizziness and swelling over the face, neck and upper chest. He is irregular regarding chemotherapy sessions. Chest x-ray revealed a widening of the superior mediastinum. What is the investigation of choice in this condition? (Q849420)

A. Chest x-ray

B. MRI

C. Ultrasound

D. CT scan

See Answer in Part B → Q12

@Neet_pg_bot

Q13: Which of the following statements regarding desmoid tumours is NOT true? (Q849421)

A. It is often associated with FAP (familial adenomatous polyposis)

B. It arises in musculoaponeurotic structures

C. It is more common in females than males

D. Estrogen inhibits its growth

See Answer in Part B → Q13

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• [09_Oncology] 052 Previous Year Questions

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[09_Oncology] 052 Previous Year Questions — Quick Jump

Q1 (p. 831)	*Q2 (p. 832)*	*Q3 (p. 832)*	*Q4 (p. 833)*	*Q5 (p. 834)*	*Q6 (p. 834)*
Q7 (p. 835)	*Q8 (p. 835)*	*Q9 (p. 836)*	*Q10 (p. 836)*	*Q11 (p. 836)*	*Q12 (p. 837)*
Q13 (p. 837)	*Q14 (p. 838)*	*Q15 (p. 838)*	*Q16 (p. 838)*	*Q17 (p. 839)*	

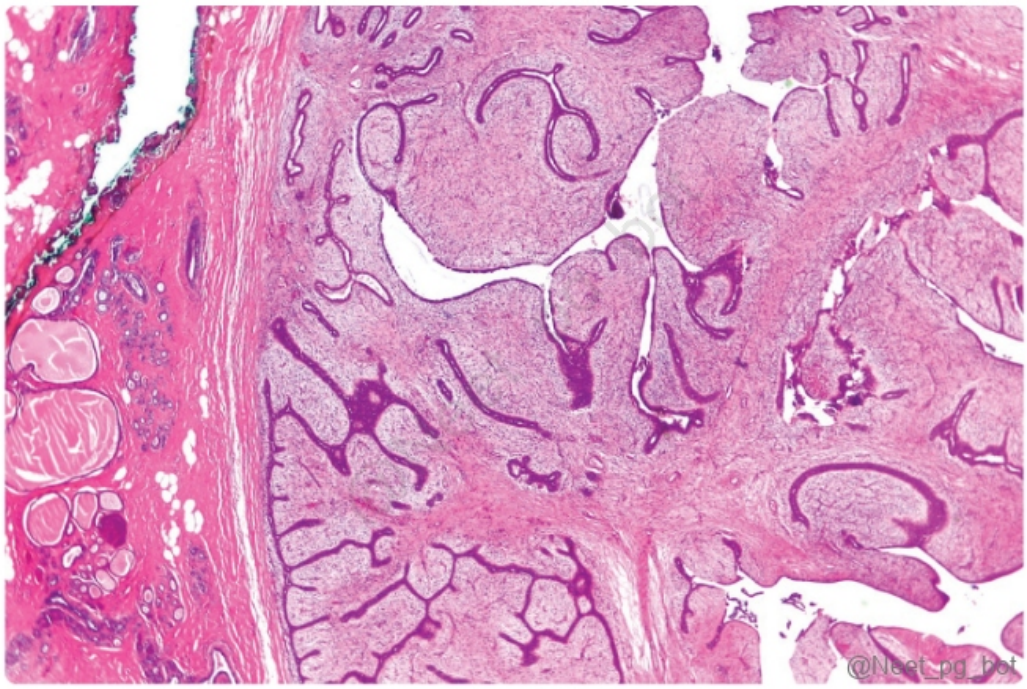
Q1: A 30-year-old female presents to the OPD with a 3 cm breast lump in the upper medial quadrant . The lump has an uneven, bosselated surface , and the overlying skin is mildly ulcerated . Microscopic examination reveals the given findings. What is the most likely diagnosis? (Q852716)

A. Phyllodes tumor

B. Galactocele

C. Fibroadenoma

D. Paget's disease



See Answer in Part B → Q1

@Neet_pg_bot

Q2: A patient present with abdominal pain on evaluation patient has raised mucin and CEA levels and normal amylase what might be the diagnosis? (Q879136)

A. Serous cystadenoma of pancreas

B. Pseudocyst of pancreas

C. Mucinous cystic neoplasm of pancreas

D. Intraductal papilloma of pancreas

See Answer in Part B → Q2

@Neet_pg_bot

Q3: A 40-year-old man presents with a lesion over his left ear. It slowly grew in size over the past 3 months, and he is a chronic smoker with 20 pack years. Vitals are within normal limits, and his physical examination is otherwise unremarkable. The histopathologic evaluation shows keratin pearls. What is the most likely diagnosis for this patient? (Q859628)

A. Nodular melanoma

B. Basal cell carcinoma

C. Squamous cell carcinoma

D. Malignant melanom



See Answer in Part B → Q3

@Neet_pg_bot

Q4: A 50-year-old lady presented with a 1.5 cm pigmented lesion on her face that was growing rapidly in size and associated with itching. The lesion is shown below. Which of the following is likely the diagnosis? (Q859627)

A. Dysplastic nevus

B. Congenital melanocytic nevus

C. Acquired melanocytic nevus

D. Malignant melanoma



See Answer in Part B → Q4

@Neet_pg_bot

Q5: Most common primary source of metastasis to the brain is: (Q859618)

A. Thyroid

B. Lung

C. Liver

D. Breast

See Answer in Part B → Q5

@Neet_pg_bot

Q6: A factory worker working in a plastic pipe factory presented to the OPD with weight loss and right upper quadrant abdominal pain for 6 months duration. He had hepatomegaly. Further investigation revealed that most of the liver was replaced by a

hemorrhagic tumour with extensive necrosis. What can be the likely diagnosis in this case? (Q859608)

A. Cavernous hemangioma

B. Metastatic carcinoma of the liver

C. Angiosarcoma of the liver

D. Primary hepatocellular carcinoma

See Answer in Part B → Q6

@Neet_pg_bot

Q7: Which of the following is the most commonly seen tumour in the retroperitoneal space? (Q856278)

A. Liposarcoma

B. Rhabdomyosarcoma

C. Synovial sarcoma

D. Neurofibroma

See Answer in Part B → Q7

@Neet_pg_bot

Q8: What is the most likely primary site of origin for metastatic liver adenocarcinoma with CK 7 (-), CK 20 (+), and CDX-1 (+) IHC markers? (Q856231)

A. Colon carcinoma

B. Breast carcinoma

C. Pancreatic carcinoma

D. Ovarian carcinoma

See Answer in Part B → Q8

@Neet_pg_bot

Q9: Match the following: A. Marjolin ulcer over the dorsum of foot measuring 3cm x 2cm 1. Excision biopsy B. 1.5 cm cervical lymph node in the neck 2. Core needle biopsy C. Soft tissue sarcoma over mid-thigh 3. USG guided FNAC D. Solitary thyroid nodule 4. Wedge biopsy (Q855301)

A. A-1, B-2, C-3, D-4

B. A-4, B-1, C-2, D-3

C. A-3, B-2, C-1, D-4

D. A-4, B-3, C-2, D-1

See Answer in Part B → Q9

@Neet_pg_bot

Q10: What is the meaning of neoadjuvant chemotherapy in the context of a 54-year-old woman diagnosed with stage 2A cervical cancer? (Q855282)

A. Chemotherapy is given along with radiation.

B. Chemotherapy is given during surgery.

C. Chemotherapy is given before radical surgery to reduce the bulk of the tumour.

D. Chemotherapy is given after radical surgery for micrometastases.

See Answer in Part B → Q10

@Neet_pg_bot

Q11: A patient with a known case of HTN came in with complaints of headaches for five days. All classical signs, increased metanephrine levels, and other investigations indicate pheochromocytoma. What is the best imaging modality for this patient? (Q820147)

A. CECT Chest and Abdomen

B. Sestamibi scan

C. MIBG

D. USG

See Answer in Part B → Q11

@Neet_pg_bot

Q12: A 45-year-old female presents with redness and a Peau d'orange appearance involving more than 2/3 of her breast, without any palpable lump in the breast. On further evaluation, it is found that the skin involvement extends to the chest wall and is suggestive of inflammatory carcinoma . What is the appropriate TNM staging for this patient? (Q820110)

A. T4a

B. T4b

C. T3

D. T4d

See Answer in Part B → Q12

@Neet_pg_bot

Q13: A female presents with a non-palpable lump in the breast. The biopsy and IHC results reveal Luminal A. What characteristics are included under Luminal A? (Q857277)

A. ER positive, PR positive, Her2 neu positive

B. ER positive, PR positive, Her2 neu negative with low proliferation

C. ER positive, PR positive, Her2 neu negative with high proliferation

D. Triple-negative

See Answer in Part B → Q13

@Neet_pg_bot

Q14: Spread of prostate cancer to lumbar vertebra is via? (Q852720)

A. Arterial spread

B. Local spread

C. Lymphatic spread

D. Venous spread

See Answer in Part B → Q14

@Neet_pg_bot

Q15: In a follow-up case of prostate cancer, what do we need to check? (Q852724)

A. Alkaline phosphatase

B. PSA

C. Testosterone

D. Acid phosphatase

See Answer in Part B → Q15

@Neet_pg_bot

Q16: What is the T stage for this tumour in the oral cavity? (Q853071)

A. T3

B. ■■■T4a

C. T2

D. ■■■T4b



See Answer in Part B → Q16

@Neet_pg_bot

Q17: Which of the following drugs is preferred for lowering uric acid to prevent renal damage in tumor lysis syndrome ? (Q793897)

A. Furosemide

B. Rasburicase

C. Corticosteroids

D. Febuxostat

See Answer in Part B → Q17

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• [10_Others] 053 Previous Year Questions

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[10_Others] 053 Previous Year Questions — Quick Jump

Q1 (p. 840)	*Q2 (p. 841)*	*Q3 (p. 841)*	*Q4 (p. 842)*	*Q5 (p. 843)*	*Q6 (p. 843)*
Q7 (p. 844)	*Q8 (p. 845)*	*Q9 (p. 845)*	*Q10 (p. 846)*	*Q11 (p. 846)*	*Q12 (p. 847)*
Q13 (p. 847)	*Q14 (p. 848)*	*Q15 (p. 848)*	*Q16 (p. 848)*	*Q17 (p. 849)*	*Q18 (p. 850)*
Q19 (p. 851)	*Q20 (p. 851)*	*Q21 (p. 852)*	*Q22 (p. 853)*	*Q23 (p. 853)*	*Q24 (p. 854)*
Q25 (p. 854)	*Q26 (p. 854)*	*Q27 (p. 855)*	*Q28 (p. 855)*	*Q29 (p. 856)*	*Q30 (p. 856)*
Q31 (p. 857)	*Q32 (p. 857)*	*Q33 (p. 858)*	*Q34 (p. 858)*	*Q35 (p. 859)*	*Q36 (p. 859)*
Q37 (p. 859)	*Q38 (p. 860)*	*Q39 (p. 860)*	*Q40 (p. 861)*	*Q41 (p. 861)*	*Q42 (p. 862)*
Q43 (p. 862)	*Q44 (p. 863)*	*Q45 (p. 863)*	*Q46 (p. 864)*	*Q47 (p. 865)*	*Q48 (p. 865)*
Q49 (p. 866)	*Q50 (p. 866)*	*Q51 (p. 867)*	*Q52 (p. 867)*	*Q53 (p. 867)*	*Q54 (p. 868)*
Q55 (p. 869)	*Q56 (p. 869)*	*Q57 (p. 870)*	*Q58 (p. 870)*	*Q59 (p. 871)*	*Q60 (p. 871)*
Q61 (p. 871)	*Q62 (p. 872)*	*Q63 (p. 872)*	*Q64 (p. 873)*	*Q65 (p. 873)*	*Q66 (p. 873)*
Q67 (p. 874)	*Q68 (p. 875)*	*Q69 (p. 875)*	*Q70 (p. 875)*	*Q71 (p. 876)*	*Q72 (p. 876)*
Q73 (p. 877)					

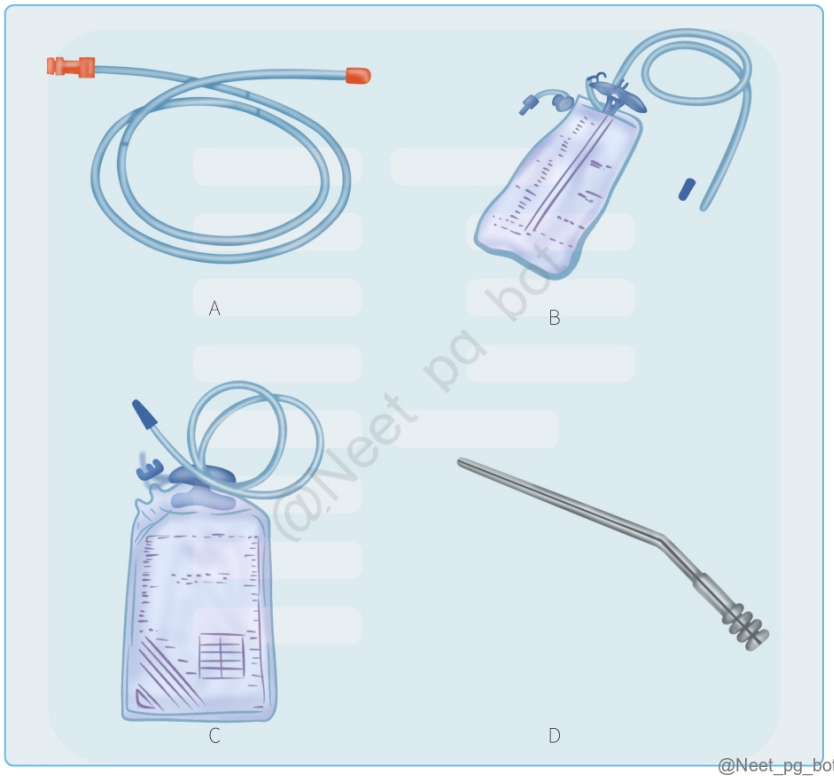
Q1: Match the following 1. Urine Bag 2. Nasogastric Tube 3. Underwater seal bag 4. Suction cannula (Q856303)

A. 1-D, 2-C, 3-A, 4-B

B. 1-C, 2-A, 3-B, 4-D

C. 1-D, 2-A, 3-C, 4-B

D. 1-B, 2-A, 3-C, 4-D



See Answer in Part B → Q1

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Q2: What steps should be taken to manage the case of a 24-year-old male who was hit by a motorbike while crossing the road, leading to abdominal injuries and bruising, with a blood pressure of 88/60 and IV fluids already administered, along with a positive FAST examination? (Q857115)

A. Abdominal CT scan

B. Abdominal MRI scan

C. Exploratory laparotomy

D. Diagnostic peritoneal lavage

See Answer in Part B → Q2

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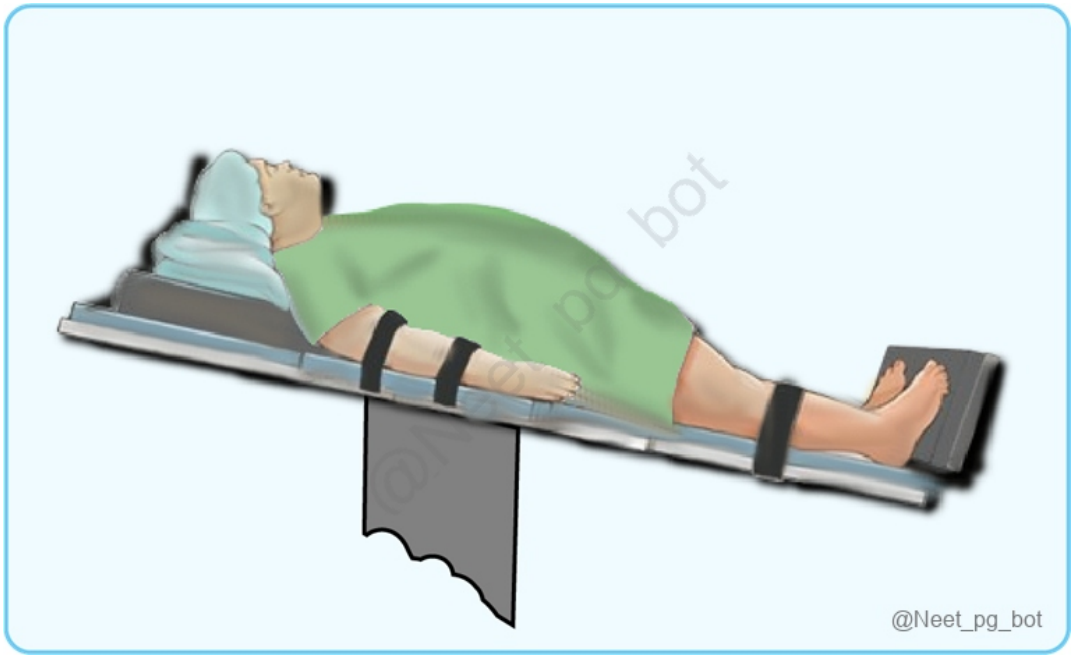
Q3: The position of the patient in the image shown below is known as: (Q856730)

A. Lloyd Davis position

B. Jack knife position

C. Trendelenburg position

D. Reverse Trendelenburg position



See Answer in Part B → Q3

@Neet_pg_bot

Q4: Which of the following methods is accurate for measuring the nasogastric tube? (Q856572)

A. Tip of nose to ear lobule to xiphisternum

B. Angle of mouth to tragus to xiphisternum

C. Ala of nose to angle of mandible to xiphisternum

D. Angle of mouth to ear lobule to umbilicus

See Answer in Part B → Q4

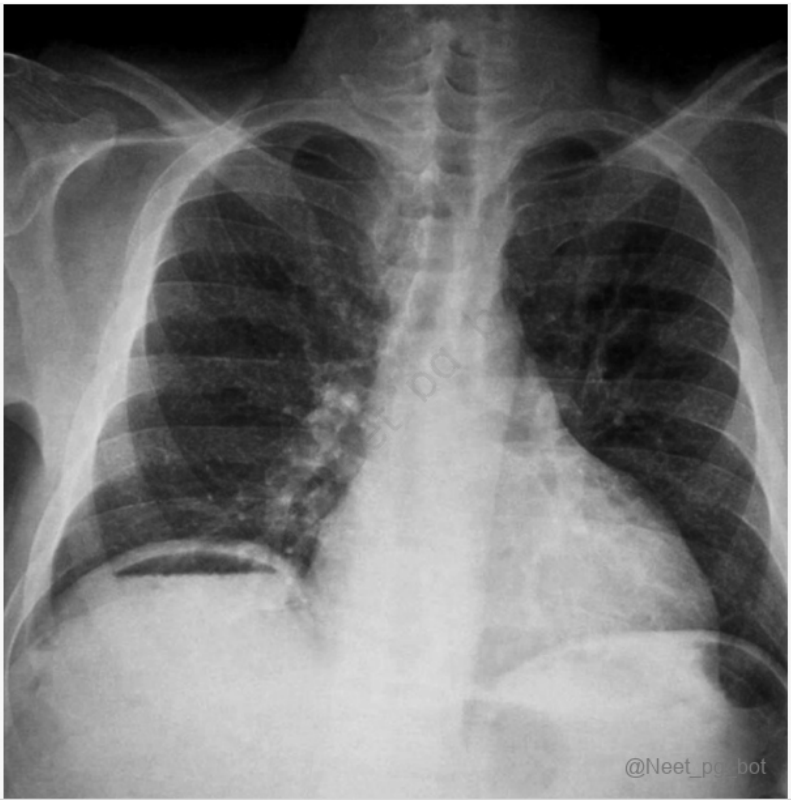
Q5: What might you suspect as the diagnosis for a 26-year-old male patient who arrives at the emergency department complaining of abdominal pain and constipation persisting for the last three days? The patient recalls being struck in the abdomen by a bull three days ago. Could yo u examine the provided X-ray to aid in your assessment? (Q856561)

A. Hemothorax

B. Hollow viscus perforation

C. Pneumothorax

D. Intestinal obstruction



See Answer in Part B → Q5

Q6: What is the needle placement angle when using the interrupted suturing technique to suture a laceration in the ER? (Q856559)

A. 60 degrees

B. 70 degrees

C. 80 degrees

D. 90 degrees

See Answer in Part B → Q6

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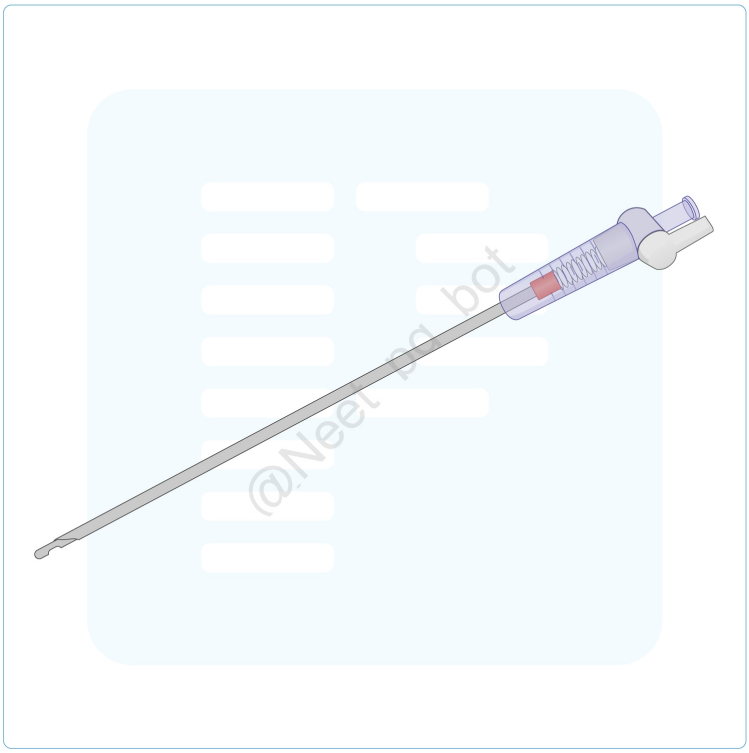
Q7: What is the name of the instrument depicted below, which is utilized for the creation of a pneumoperitoneum? (Q856535)

A. Veress needle

B. Morris' needle

C. Yankauer suction tip

D. Von Graefe needle



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See Answer in Part B → Q7

@Neet_pg_bot

Q8: What is triage for? (Q856526)

A. To prepare for a disaster

B. To assess the impact of a disaster

C. To classify the priority of treatment

D. To rehabilitate following a disaster

See Answer in Part B → Q8

@Neet_pg_bot

Q9: Match the correct answer related to the nerve injuries in various surgeries: A. Breast surgery 1. External Laryngeal nerve B. Thyroid surgery 2. Hypoglossal nerve

C. Submandibular excision 3. Phrenic nerve D. Thymectomy 4. Long Thoracic Nerve (Q856314)

A. A-1, B-2, C-3, D-4

B. A-2, B-3, C-4, D-1

C. A-3, B-4, C-1, D-2

D. A-4, B-1, C-2, D-3

See Answer in Part B → Q9

@Neet_pg_bot

Q10: The components of qSOFA scoring include: A. Mental status B. Blood pressure C. Respiratory rate D. Heart rate (Q856309)

A. A & B

B. C & D

C. A, B & C

D. A, B, C & D

See Answer in Part B → Q10

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Q11: In a patient with liver cirrhosis, what is the primary cause of mortality when esophageal varices are present? (Q857119)

A. Hypovolemic shock

B. Cardiogenic shock

C. Obstructive shock

D. Distributive shock

See Answer in Part B → Q11

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Q12: A 32-year-old woman has been declared brain dead, and her family has chosen to donate her organs. Who would be the most suitable recipient of her organs? (Q856294)

A. 14-year-old child with multi-organ dysfunction syndrome

B. 50-year alcoholic man with liver cirrhosis with 1 month abstinence

C. 70-year-old woman with end-stage renal disease

D. 32-year-old woman with renal failure

See Answer in Part B → Q12

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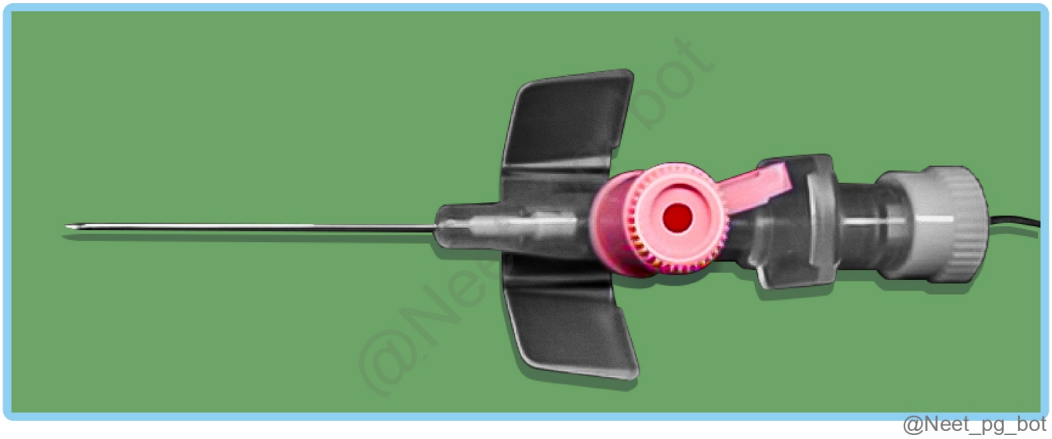
Q13: What is the size of the cannula shown in the below image? (Q856292)

A. 16 G

B. 18 G

C. 20 G

D. 22 G



See Answer in Part B → Q13

@Neet_pg_bot

Q14: FAST stands for (Q856255)

A. First assessment with sonography in trauma

B. Focussed assessment with sonography in trauma

C. First abdominal sonography in trauma

D. Focussed abdominal sonography in trauma

See Answer in Part B → Q14

@Neet_pg_bot

Q15: A patient, after a road traffic accident, presented with pain in the abdomen. The resident examined the child and found that vitals were stable, and tenderness was present in the left lumbar region. Which is the best investigation of choice? (Q856254)

A. Contrast-enhanced CT scan

B. Retrograde urethrogram

C. Wait and watch

D. Emergency laparotomy

See Answer in Part B → Q15

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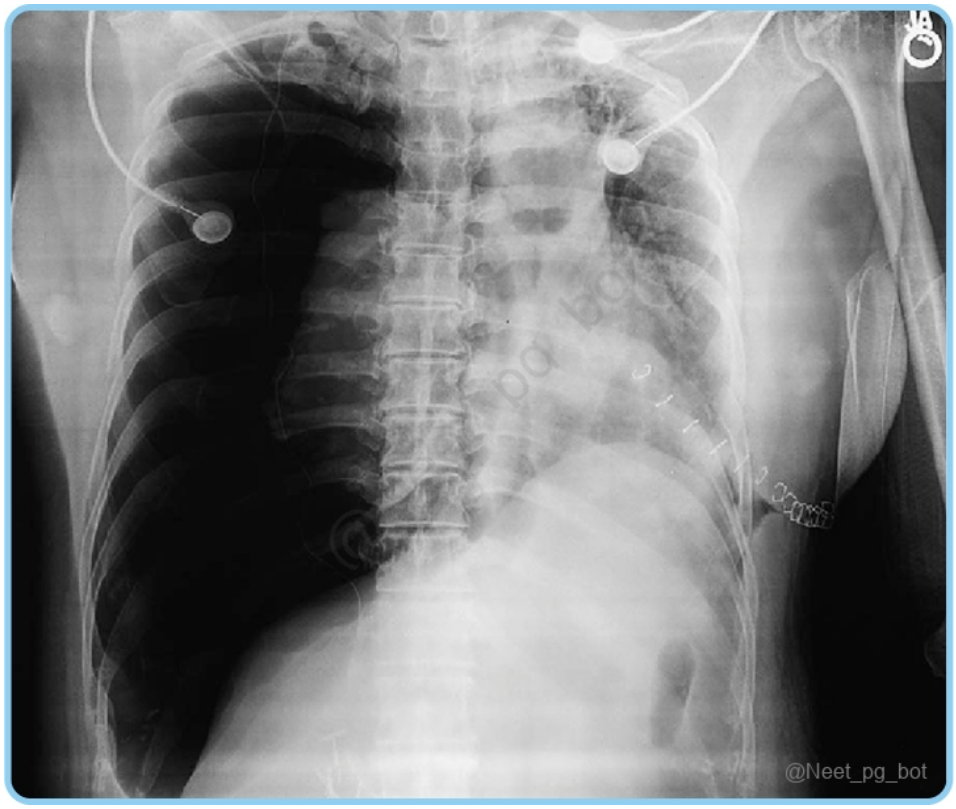
Q16: A patient following a road traffic accident presented with subcutaneous emphysema. On auscultation, there was no air entry on the right side. Vitals were unstable. What will be your immediate management? (Q856246)

A. Insertion of wide bore needle in the 2nd intercostal space

B. Wide bore needle decompression and IV fluids

C. Intubation and positive pressure ventilation

D. e-FAST



See Answer in Part B → Q16

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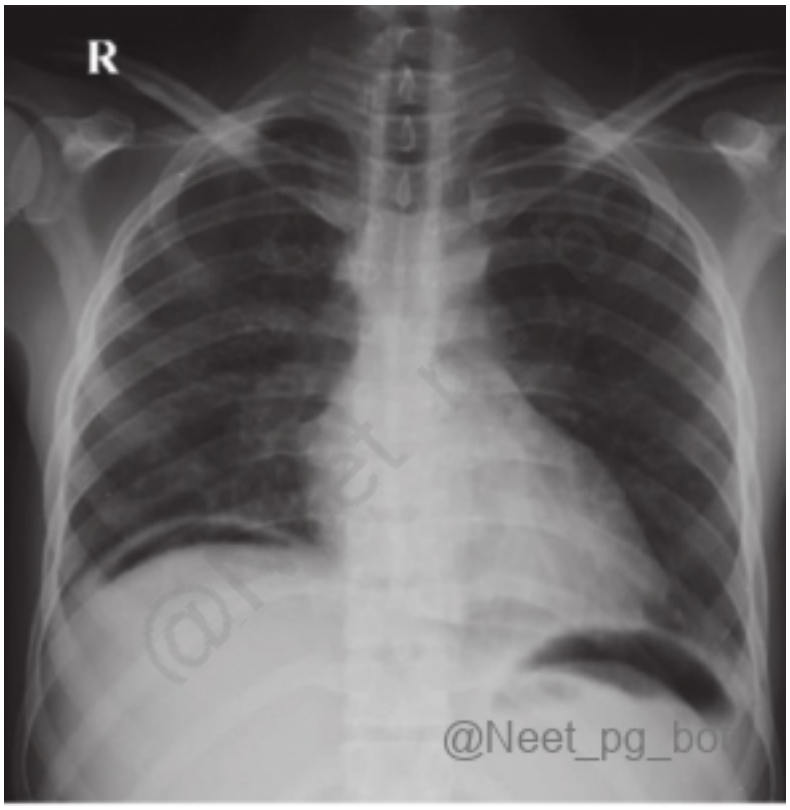
Q17: What is the most probable diagnosis for a 25-year-old patient who has been experiencing abdominal pain and fever for the past three days, based on the provided chest X-ray taken in an upright position? (Q856206)

A. Hollow viscus perforation

B. Gastric volvulus

C. Liver abscess

D. Empyema thoracis



See Answer in Part B → Q17

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Q18: A patient presented with blunt trauma to the abdomen. On evaluation, liver injury was noted, for which primary repair was done. Coagulation function was monitored intraoperatively using the method shown below. What is the method used? (Q855836)

A. Thromboelastography

B. Plethysmography

C. Sonography

D. Elastography



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See Answer in Part B → Q18

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Q19: A patient with an incident of being stabbed in the front part of the abdomen is brought to the emergency. The patient's vital signs are stable. What will be the next step in managing this case? (Q855832)

A. Emergency laparotomy

B. Observation

C. Intravenous hydration

D. Further investigation

See Answer in Part B → Q19

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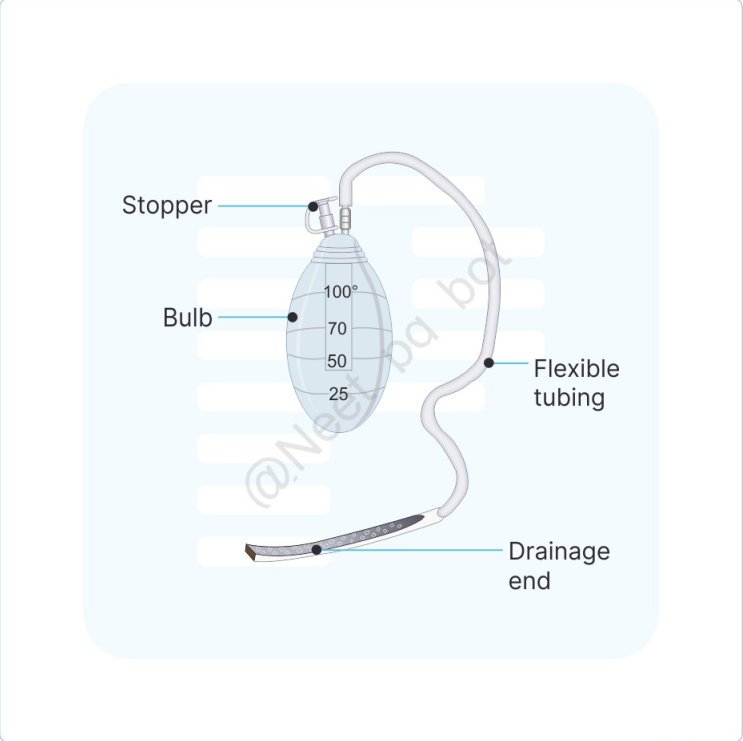
Q20: A 45-year-old patient undergoes a mastectomy for breast cancer. Post-operatively, the surgeon decides to use a closed suction drain. Which of the following drain types is shown in the image below? (Q858365)

A. Penrose drain

B. Jackson Pratt drain

C. Romovac suction drain

D. Hemovac drain



See Answer in Part B → Q20

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Q21: Which among the following are incorrect about tension pneumothorax? Occurs due to improper dressing of open wound Blunt trauma with simple pneumothorax can never convert to tension pneumothorax Most common cause is due to positive pressure in mechanical ventilation Can be caused due to spinal injury (Q865398)

A. 1, 4

B. 2,3,4

C. 1,2,4

D. 2,3

See Answer in Part B → Q21

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Q22: All of the following is a contraindication to Breast Conservation surgery except ? (Q865393)

A. Previous history of radiation to the chest

B. Tumor involving single quadrant

C. Scleroderma

D. Persistent positive margins even after resection

See Answer in Part B → Q22

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Q23: A 40-year-old male presents to the emergency department with severe respiratory distress, BP: 70/59 mmHg, tracheal deviation to the right, distended neck veins, and absent breath sounds on the left side. These findings are suggestive of a tension pneumothorax. What is the most appropriate immediate next step in management? (Q865354)

A. Perform needle thoracostomy immediately

B. CT Chest

C. Airway, breathing, and circulation (ABC) assessment

D. Chest tube insertion

See Answer in Part B → Q23

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Q24: A 65-year-old patient is on mechanical ventilation for acute respiratory distress syndrome (ARDS). Suddenly, the patient becomes hypotensive, tachycardic, and shows absent breath sounds on the left side with tracheal deviation to the right. What is the most common cause of this in patients receiving mechanical ventilation? (Q865348)

A. High tidal volume

B. Barotrauma due to high airway pressure

C. Endotracheal tube malposition

D. Oxygen toxicity

See Answer in Part B → Q24

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Q25: A patient presents with a breast lump, and imaging (X-ray mammography) along with histopathology confirms a diagnosis of breast cancer. She has a family history of breast cancer involving two relatives and has a 29-year-old daughter. Which gene should be tested to assess hereditary breast cancer risk in this patient? (Q865316)

A. BRCA1

B. TP53

C. BRCA2

D. STK11

See Answer in Part B → Q25

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Q26: Which of the following is not a component of TNM stage T4b breast cancer? (Q865312)

A. Ulceration

B. Peau d’orange

C. Inflammatory carcinoma

D. Ipsilateral macroscopic satellite nodules

See Answer in Part B → Q26

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Q27: A 38-year-old man was brought to the emergency department after sustaining an RTA and injury to the lower chest. On presentation, the patient is stable, and vitals are normal. Chest radiography showed clear lung fields. What is the next step in management? (Q858483)

A. eFAST

B. Tube thoracostomy

C. CECT chest

D. CECT abdomen

See Answer in Part B → Q27

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Q28: What could be the most likely reason for a patient presenting with chronic non-pitting edema in the lower extremities? (Q858480)

A. Lymphedema

B. Arterial Disorders

C. Venous Disorders

D. Coronary heart disease

See Answer in Part B → Q28

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Q29: Identify the fluid shown below on the basis of composition: Sodium (Na+) 131 millimoles per liter Chloride (Cl-) 111 millimoles per liter Lactate 29 millimoles per liter Potassium (K+) 5 millimoles per liter Calcium (Ca2+) 2 millimoles per liter Total osmolarity 279 millimoles per liter (Q855761)

A. Haemaccel

B. Ringer lactate

C. Isolyte

D. Isolyte M

See Answer in Part B → Q29

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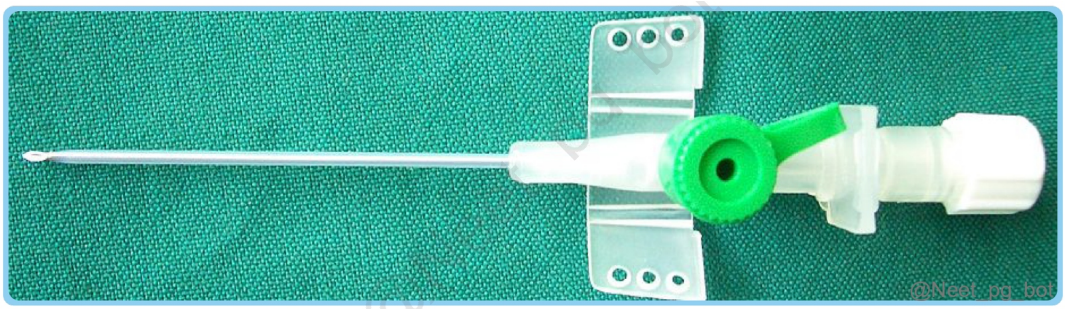
Q30: A patient was received in the casualty following a road traffic accident. His BP was 90/60 mmHg and his pulse rate was 120/min. The emergency room physician asked you to replace the fluid loss in this patient. What is the flow rate of fluid with the IV cannula given in the image? (Q858350)

A. 86ml/min

B. 96ml/min

C. 90 ml/min

D. 63ml/min



See Answer in Part B → Q30

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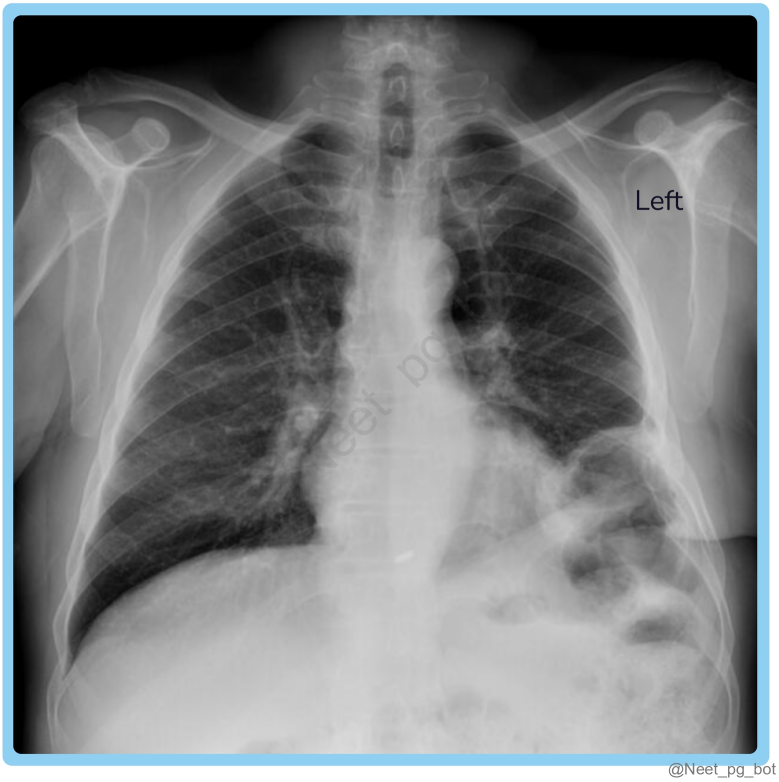
Q31: A 24-year-old male patient was brought to the emergency department following a road traffic accident. His heart rate was 100/min, respiratory rate was 24/min, and his chest X ray is given below. Which of the following is contraindicated in him? (Q858348)

A. Nasogastric tube insertion

B. Chest tube insertion

C. Log roll

D. Epidural anaesthesia



See Answer in Part B → Q31

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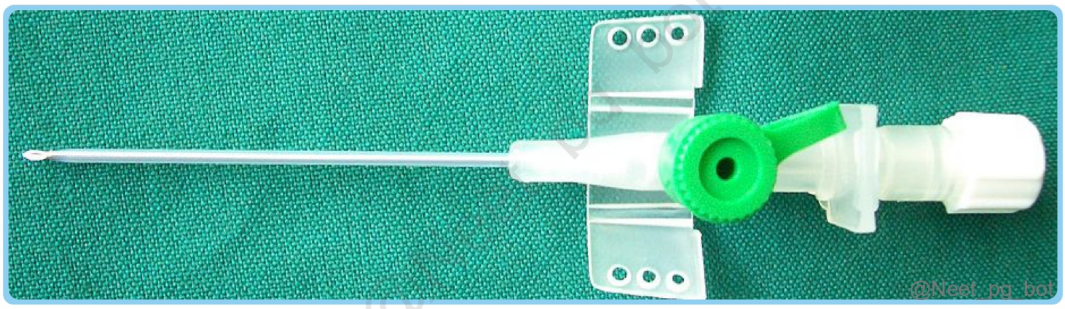
Q32: What is the size of the cannula gauge used in this picture? (Q858341)

A. 14

B. 16

C. 18

D. 20



See Answer in Part B → Q32

@Neet_pg_bot

Q33: In all types of shock, which of the following is observed? (Q857889)

A. Reduced tissue perfusion

B. Increased peripheral resistance

C. Decreased respiratory rate

D. Cold clammy skin

See Answer in Part B → Q33

@Neet_pg_bot

Q34: Among the options provided, which pairing correctly matches the trauma patients brought to the casualty? (Q857835)

A. Extradural hemorrhage (EDH) - Pin point pupil

B. Penetrating injury to eustachian tube - CSF otorrhea

C. Penetrating injury to eye - Battle sign

D. Gaze palsy - Mid brain lesion

See Answer in Part B → Q34

@Neet_pg_bot

Q35: Which of the following is not included in the qSOFA score components? (Q857805)

A. Respiratory rate >22

B. Lactate dehydrogenase

C. Altered mental status

D. Systolic blood pressure <100 mmHg

See Answer in Part B → Q35

@Neet_pg_bot

Q36: A 38-year-old man was brought to the emergency department after sustaining an RTA and injury to the lower chest. On presentation, the patient is stable, and vitals are normal. Chest radiography showed clear lung fields. What is the next step in management? (Q857798)

A. eFAST

B. Tube thoracostomy

C. CECT chest

D. CECT abdomen

See Answer in Part B → Q36

@Neet_pg_bot

Q37: Which class of hypovolemic shock, according to Advanced Trauma Life Support (ATLS) guidelines, is characterised by the absence of urine output? (Q857765)

A. Class I

B. Class II

C. Class III

D. Class IV

See Answer in Part B → Q37

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Q38: Among the options provided, which one is NOT acknowledged as a potential complication resulting from a significant blood transfusion? (Q854760)

A. Hypocalcemia

B. Hypokalemia

C. Hypothermia

D. Hypernatremia

See Answer in Part B → Q38

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Q39: A patient arrives at the emergency department after being involved in a car accident. The patient is experiencing difficulty breathing and their neck veins appear dilated. The x-ray reveals a significant amount of air on the left side. What is the most appropriate course of action for treatment? (Q793363)

A. Wide bore needle insertion in the 5th intercostal space

B. Endotracheal intubation

C. Tracheostomy

D. Pericardiocentesis



See Answer in Part B → Q39

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Q40: A patient sustained a crush injury on their right arm. He was taken to the hospital and on examination, his arm was pulseless, swollen, and dark red. What would be the best way to manage this case? (Q793385)

A. Intraosseous administration of fluids

B. Acidification of urine

C. Fasciotomy

D. Hemodialysis

See Answer in Part B → Q40

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Q41: During a complicated delivery, a mother died. Which of the following is the most common Direct cause of maternal death? (Q820108)

A. Embolism

B. Heart Disease

C. Hemorrhage

D. Anemia

See Answer in Part B → Q41

@Neet_pg_bot

Q42: Which fluid is administered most commonly during intraoperative blood loss? (Q820149)

A. Isolyte P

B. Crystalloids

C. Blood

D. Colloids

See Answer in Part B → Q42

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Q43: A 39-year-old female presented in the OPD with bloody discharge from the nipple . On examination, it was found to be from a single lactiferous duct . What is the treatment for bloody nipple discharge with single duct involvement? (Q820183)

A. Microdochectomy

B. Hadfield’s procedure

C. Microdiscectomy

D. IV antibiotics + Incision

See Answer in Part B → Q43

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Q44: Which of the following is not correct for the device depicted below: (Q820185)

A. Based on infrared emitted from RBCs

B. Localizes calcified plaque

C. Checks blood flow

D. Checks thickness of artery and vein



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See Answer in Part B → Q44

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Q45: A 35-year-old male sustained a head injury following a motorcycle accident. He experienced a brief loss of consciousness at the scene. Upon regaining consciousness, he developed a severe headache and began to feel drowsy. A CT scan of the head is

performed. Which of the following should be the management for this patient? (Q840033)

A. Anticoagulants

B. Immediate surgical decompression

C. Observation in ICU

D. Mannitol administration



See Answer in Part B → Q45

@Neet_pg_bot

Q46: Which of the following is not done in the primary survey of trauma? (Q840042)

A. NCCT head

B. CXR

C. Intubation

D. ICD drainage

See Answer in Part B → Q46

@Neet_pg_bot

Q47: Mount fuji sign on CT is seen in which of the following? (Q840051)

A. Pneumocephalus

B. Pneumoperitoneum

C. Pneumomediastinum

D. Pneumothorax

See Answer in Part B → Q47

@Neet_pg_bot

Q48: Which of the following is a complication usually associated with the procedure shown in the image below? (Q854753)

A. Aspiration

B. Torticollis

C. Pneumothorax

D. Recurrent laryngeal nerve paralysis



See Answer in Part B → Q48

@Neet_pg_bot

Q49: For the purpose of preventing surgical site infection, what is the recommended technique and optimal timing for hair removal prior to surgery? (Q793358)

A. On the OT table with electric hair clippers

B. With a razor 24 hours before surgery

C. With a hair removal cream on the previous day

D. On the OT table with a razor

See Answer in Part B → Q49

@Neet_pg_bot

Q50: What is the minimum platelet count necessary for most surgical procedures? (Q854782)

A. 20,000 (10^9/L)

B. 30,000 (10^9/L)

C. 40,000 (10^9/L)

D. 50,000 (10^9/L)

See Answer in Part B → Q50

@Neet_pg_bot

Q51: Which one of the following is excluded from the primary survey? (Q854940)

A. Measuring blood pressure

B. Removing clothes to inspect for wounds

C. Taking CT scan of the patient

D. Checking airway patency

See Answer in Part B → Q51

@Neet_pg_bot

Q52: Which of the following is not taken into consideration in ASEPSIS wound scoring? (Q854951)

A. Wound swab from the site

B. Serous discharge

C. Erythema

D. Induration

See Answer in Part B → Q52

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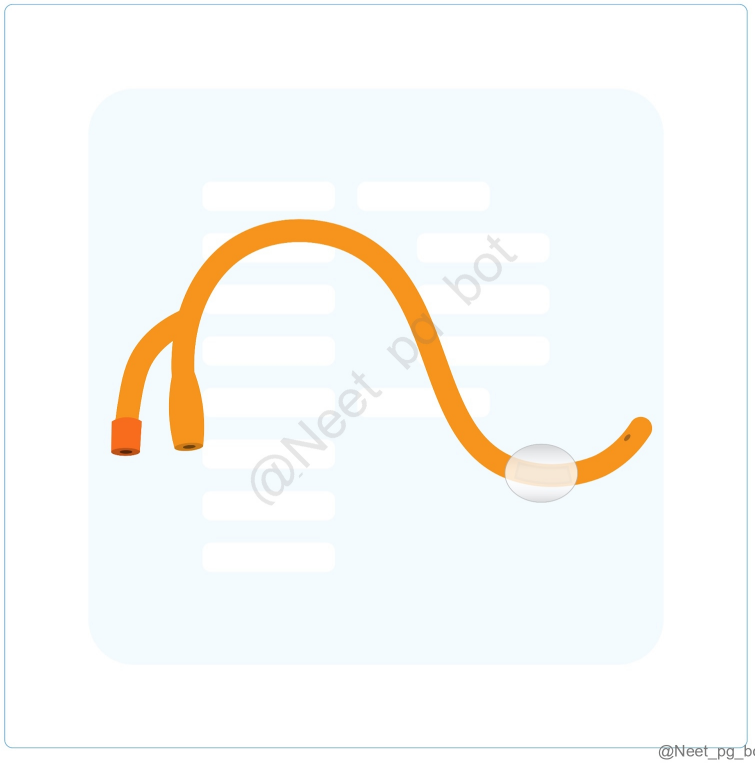
Q53: What does the number (14Fr) marked on the Foley catheter correspond to? (Q855673)

A. Inner lumen diameter

B. Length of the tube

C. Outer tube diameter

D. Bulb size



See Answer in Part B → Q53

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Q54: Which of the following statements are true regarding central venous access and peripheral venous access? Phlebitis is the most common complication in peripheral venous access. Isotonic saline and heparin are flushed to retain patency If an arteriovenous fistula is present in a limb, avoid peripheral venous access in the same limb. Vasopressors for septic shock are given in the central line to avoid limb ischemia. (Q855686)

A. 1, 3, 4

B. 2, 3, 4

C. 1, 2, 3, 4

D. 1, 2, 3

See Answer in Part B → Q54

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Q55: Which of the following statements is accurate concerning split-thickness and full-thickness skin grafts? Primary contractures are more in split skin grafts Secondary contractures are more in split skin grafts Primary contractures are more in full-thickness grafts Secondary contractures are more in full-thickness grafts (Q855680)

A. 2 and 3

B. 2 and 4

C. 1 and 3

D. 1 and 4

See Answer in Part B → Q55

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Q56: Which of the following options does not represent one of the boundaries of the triangle of safety for the insertion of an ICD in a patient with a chest x-ray showing pneumothorax? (Q855678)

A. Lateral edge of the pectoralis major

B. Mid-clavicular line

C. 5th intercostal space

D. Lateral border of latissimus dorsi

See Answer in Part B → Q56

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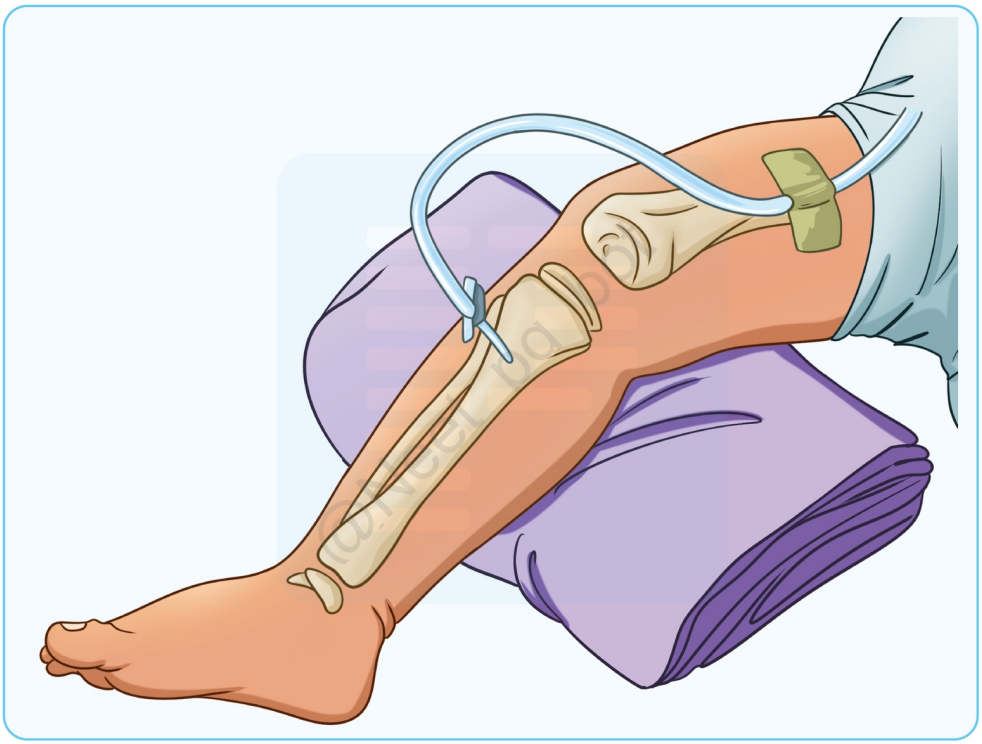
Q57: Identify the procedure being performed in the image given below. (Q855166)

A. Intraosseous cannula for pain relief

B. Bone marrow aspiration

C. Intraosseous route access for giving IV fluids

D. Bone marrow biopsy



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See Answer in Part B → Q57

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Q58: In the case of a patient arriving at the emergency department with a road traffic accident (RTA), what is the appropriate order of steps in their management? Cervial spine stabilisation Intubation IV cannulation CECT (Q855671)

A. 1, 3, 2, 4

B. 1, 2, 3, 4

C. 2, 1, 3, 4

D. 2, 1, 4, 3

See Answer in Part B → Q58

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Q59: Hand rub can be utilised in accordance with the standard hand hygiene protocol in all locations listed below, with the exception of: (Q855667)

A. If the hands are visibly soiled

B. While moving from a contaminated site to a clean site during patient care

C. After removing sterile gloves

D. During direct patient contact

See Answer in Part B → Q59

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Q60: Which of these is the most life-threatening injury that can be identified by assessing the breathing component of the patient? (Q855661)

A. Cervical spine injury

B. Tension pneumothorax

C. Blunt cardiac injury

D. Laryngotracheal injury

See Answer in Part B → Q60

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Q61: According to triage, which of the following categories of patients comes under green? (Q855552)

A. Ambulatory patients

B. Moderate priority

C. High Priority

D. Dead patients

See Answer in Part B → Q61

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Q62: A patient presents with multiple stab injuries to the chest. On examination, there is reduced chest movement on the right side and tracheal deviation to the left side. Additionally, the neck veins are distended. What is the next best step in the management of this patient? (Q855325)

A. Resuscitative thoracotomy

B. ICD placement

C. Needle thoracocentesis

D. Finger thoracotomy

See Answer in Part B → Q62

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Q63: Which of the following is true regarding shock? (Q855318)

A. Anaerobic respiration produces carbon dioxide

B. Hypovolaemic shock—most common type

C. Stage of compensatory shock is also called stage 2 of shock

D. Anaphylactic shock—is due to a Type 2 hypersensitivity reaction

See Answer in Part B → Q63

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Q64: Which one of the options listed below does not belong to the category of damage control surgery? (Q855279)

A. Control of hemorrhage

B. Resuscitation

C. Decontamination

D. Vascular anastomosis

See Answer in Part B → Q64

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Q65: A young patient presents with a 5-day fever history and signs of hypotension, tachycardia, tachypnea, and altered mental status. Lab results show elevated white blood cell count, neutrophil proportion, and serum creatinine. The intern doctor plans to assess the quick Sequential Organ Failure Assessment (qSOFA) score for prognosis prediction and hospitalisation duration. Which elements are part of the qSOFA score? (Q855275)

A. BP, RR, and CBC

B. Creatinine, PR, and BP

C. RR, Body temperature, and PR

D. SBP, RR, and GCS score

See Answer in Part B → Q65

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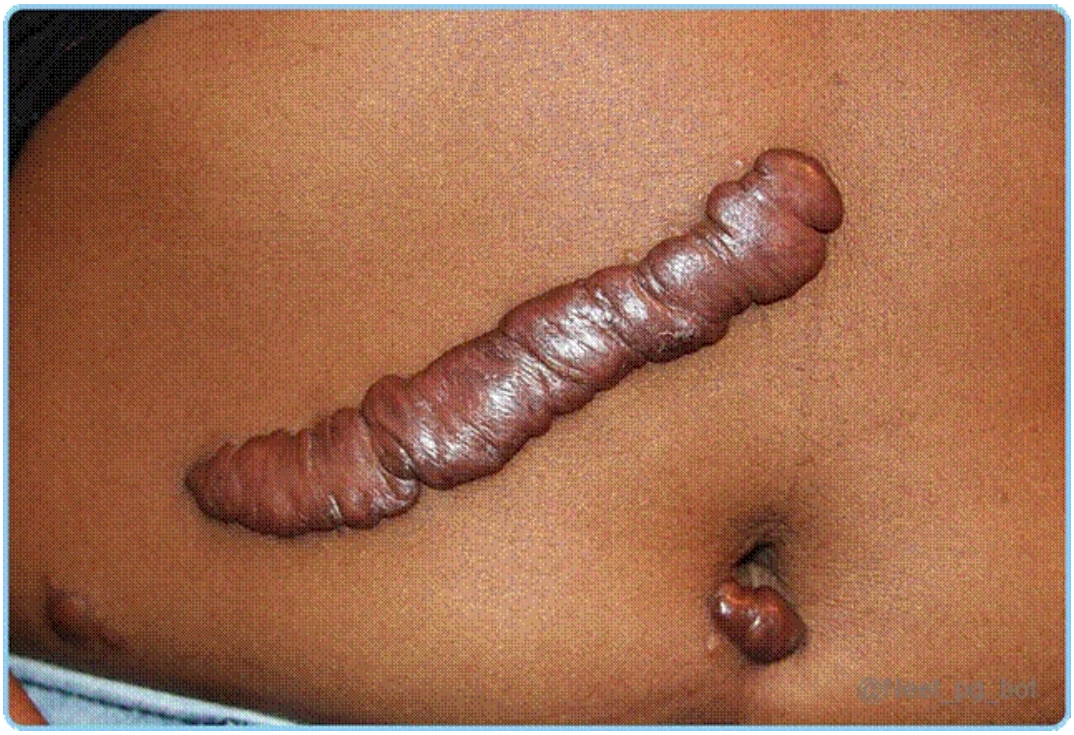
Q66: A patient presents to the clinic with a lesion as shown in the image. He had a traumatic injury to the chest one year ago, and the scar has grown beyond the boundary of the initial injury. What is the most likely diagnosis? (Q855177)

A. Hemangioma

B. Hypertrophic scar

C. Keloid

D. Neurofibroma



See Answer in Part B → Q66

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Q67: A 38-year-old man was brought to the emergency department after sustaining an RTA and injury to the lower chest. On presentation, the patient is stable, and vitals are normal . Chest radiography showed clear lung fields. What is the next step in management? (Q801160)

A. eFAST

B. Tube thoracostomy

C. CECT chest

D. CECT abdomen

See Answer in Part B → Q67

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Q68: Which of the following tests is not conducted before a blood transfusion for a person with RTA, when a family member is volunteering for blood donation? (Q793932)

A. Hepatitis A

B. Hepatitis B

C. Hepatitis C

D. HIV 1 & 2

See Answer in Part B → Q68

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Q69: What guidance would you provide to the female patient prior to undergoing laparoscopic surgery? (Q793926)

A. Eat full before surgery.

B. Drink plenty of water before surgery.

C. Enema on the night before surgery

D. NPO for specific hours before surgery

See Answer in Part B → Q69

@Neet_pg_bot

Q70: Which of the following is not included in the AAST grading system for splenic trauma? (Q793921)

A. Parenchymal destruction

B. Vascular involvement

C. Adjacent organ involvement

D. Hematoma

See Answer in Part B → Q70

@Neet_pg_bot

Q71: What is the likely reason behind the occurrence of surgical emphysema in the patient following an emergency tracheostomy performed outside of the hospital? (Q793917)

A. Puncture of posterior wall

B. High tracheostomy

C. Blockage of the tube

D. Tight suture

See Answer in Part B → Q71

@Neet_pg_bot

Q72: What would be the subsequent course of action for this injury depicted in the image after a three-day period following a Road Traffic Accident (RTA)? (Q793911)

A. Debridement of necrotic tissue with primary closure

B. Debridement of necrotic tissue and hyperbaric oxygen

C. Amputation

D. Clean and close with rotation flap



See Answer in Part B → Q72

@Neet_pg_bot

Q73: Which of the following CT findings is not an indication to perform angiography in a splenic trauma patient under conservative management? (Q793370)

A. Subcapsular hematoma covering 40% surface area.

B. Significant hemoperitoneum

C. Presence of pseudoaneurysm

D. Contrast extravasation

See Answer in Part B → Q73

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• [11_General Surgery] 054 Previous Year Questions

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[11_General Surgery] 054 Previous Year Questions — Quick Jump

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Q7 (p. 881)	*Q8 (p. 882)*	*Q9 (p. 882)*	*Q10 (p. 882)*	*Q11 (p. 883)*	*Q12 (p. 883)*
Q13 (p. 884)	*Q14 (p. 884)*	*Q15 (p. 885)*	*Q16 (p. 886)*	*Q17 (p. 887)*	*Q18 (p. 888)*
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Q49 (p. 904)	*Q50 (p. 905)*				

Q1: Identify the type of ulcer shown in the image below: (Q860399)

A. Venous ulcer

B. Malignant ulcer

C. Arterial ulcer

D. Trophic ulcer



See Answer in Part B → Q1

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Q2: A 35-year-old woman, 10 years after mastectomy, notices gradual swelling and heaviness in her right upper limb without pain. On examination, bluish nodules on the skin with no infections are noted. What is the most likely cause of her symptoms? (Q860167)

A. Lymphangiosarcoma

B. Thoracic outlet syndrome

C. Chronic venous insufficiency

D. Recurrent breast cancer

See Answer in Part B → Q2

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Q3: A patient presents to the emergency room after a road traffic accident with shock and hypotension. The extended focused assessment with sonography for trauma (eFAST) is negative, the X-ray is normal, and the ECG shows bradycardia. The patient's SpO2 is 93%, blood pressure is 80/60 mmHg, and pulse rate is 40/min. Based on this information, what type of shock is most likely? (Q860219)

A. Septic shock

B. Hemorrhagic shock

C. Cardiogenic shock

D. Neurogenic shock

See Answer in Part B → Q3

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Q4: In patients at risk of refeeding syndrome, which of the following electrolyte imbalances is typically not associated with this condition? (Q860221)

A. Hypokalemia

B. Hyperkalemia

C. Hypocalcemia

D. Hypophosphatemia

See Answer in Part B → Q4

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Q5: Identify the edges of the lesion given in the image: (Q860254)

A. Everted

B. Rolled out

C. Sloping

D. Punched out



See Answer in Part B → Q5

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Q6: A patient following a road traffic accident (RTA) with a crush injury presents with crepitus and a reddish-brown wound within 3 days after amputation. What is the most likely condition? (Q860260)

A. Gas gangrene

B. Impetigo

C. Tetanus

D. Cellulitis

See Answer in Part B → Q6

@Neet_pg_bot

Q7: Arrange the stages of wound healing in the correct sequence: (Q860267)

A. Proliferation, hemostasis, inflammation, remodeling

B. Inflammation, remodeling, hemostasis, proliferation

C. Hemostasis, inflammation, proliferation, remodeling

D. Remodeling, proliferation, hemostasis, inflammation

See Answer in Part B → Q7

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Q8: Which of the following is considered a “sure sign” of abdominal wound dehiscence in a post-operative hypotensive patient? (Q860272)

A. Increased bowel sounds

B. Persistent abdominal pain

C. Serosanguinous drainage from the wound

D. Widening of the abdominal scar with palpable edges

See Answer in Part B → Q8

@Neet_pg_bot

Q9: An elderly chronic smoker male is diagnosed with squamous cell carcinoma of the lower lip with no lymph node involvement. What is the treatment of choice? (Q860276)

A. Radiotherapy

B. Combined chemoradiotherapy

C. Wide local excision with negative borders

D. Wide local excision with frozen section

See Answer in Part B → Q9

@Neet_pg_bot

Q10: In a triage setting, which of the following categories requires the highest priority intervention? (Q860294)

A. Red

B. Yellow

C. Green

D. Black

See Answer in Part B → Q10

@Neet_pg_bot

Q11: What type of skin graft is used in the image shown? (Q860305)

A. Split thickness

B. Full thickness

C. Wolfe graft

D. Local flap



See Answer in Part B → Q11

@Neet_pg_bot

Q12: A female patient presents to the outpatient department 10 days postpartum with complaints of a fluctuant breast mass with tenderness, high-grade fever, and cracked nipples. What is the most probable diagnosis? (Q860324)

A. Breast engorgement

B. Breast abscess

C. Acute mastitis

D. Fibroadenoma

See Answer in Part B → Q12

@Neet_pg_bot

Q13: Which of the following is characteristic of hypovolemic shock? (Q860374)

A. Increase in cardiac output

B. High vascular resistance

C. Increase in venous pressure

D. Increased mixed venous saturation

See Answer in Part B → Q13

@Neet_pg_bot

Q14: What is the diagnosis based on the image below? (Q859893)

A. Botryomycosis

B. Erysipelas

C. Ecthyma

D. Carbuncle



See Answer in Part B → Q14

@Neet_pg_bot

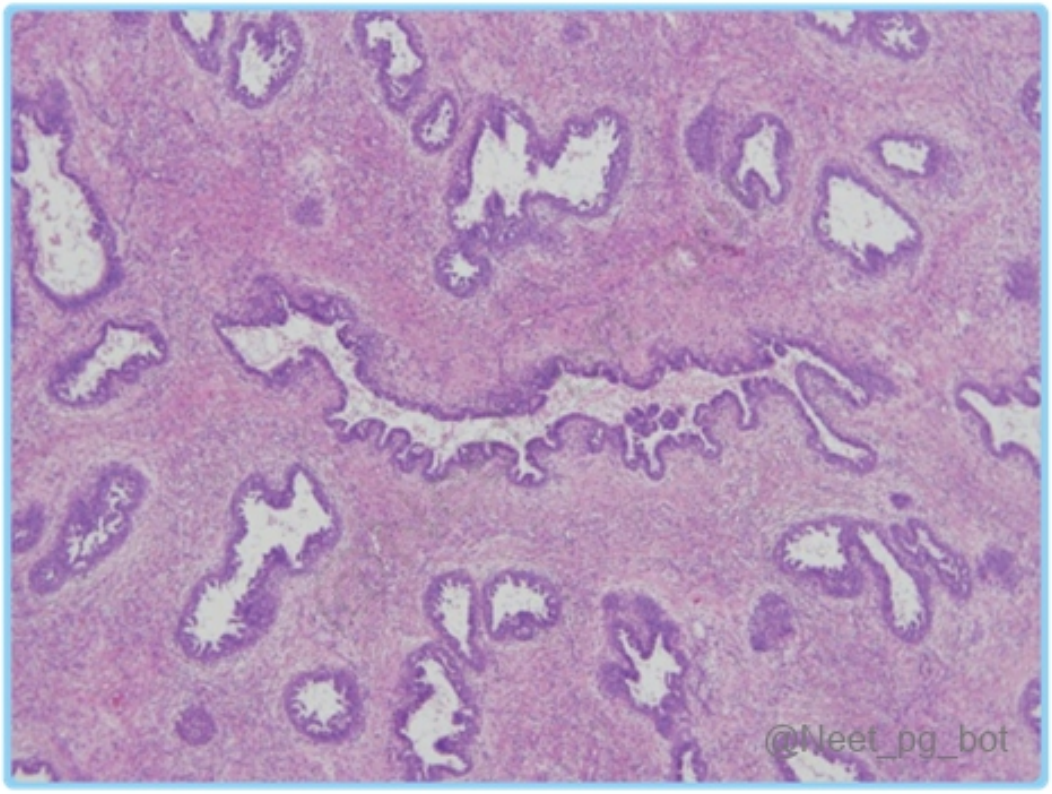
Q15: A 30-year-old female who is receiving cyclosporine A following renal transplantation develops multiple and bilateral breast lumps that regress after cessation of the treatment. Biopsy image is given below. What is the most likely diagnosis? (Q860452)

A. Fat necrosis

B. Phyllodes tumour

C. Fibroadenoma

D. Carcinoma breast



See Answer in Part B → Q15

@Neet_pg_bot

Q16: A 65-year-old male presents to the outpatient department with a swelling in the back of his neck that has been present for almost a year. The swelling has not increased in size. On examination, it is non-pulsatile, and the slip sign is positive, with the swelling measuring 3x3 cm. Which of the following statements is most likely true? (Q860457)

A. High chances of malignant transformation

B. FNAC necessary for diagnosis

C. PET scan necessary for staging

D. Excision can be done if the patient requests it



See Answer in Part B → Q16

@Neet_pg_bot

Q17: A 47-year-old man presents with a chronic non-healing painless ulcer over his scalp for 8 years. He has a history of electric burns to the scalp 8 years ago. The examination findings are shown below. Which of the following statements is true? (Q860461)

A. Radiotherapy is useful

B. It can progress to squamous cell carcinoma

C. No lymphatic spread

D. Long-duration antibiotics will improve the condition.



See Answer in Part B → Q17

@Neet_pg_bot

Q18: A 25-year-old woman presents with severe pain and swelling in her right hand, which is increasing in size and severity. She had a prick injury in the garden 5 days ago. On examination, she cries out in pain when her hand is extended and when the palmar aspect is palpated passively. Which of the following statements is true about the condition? (Q860463)

A. More common in the dorsal aspect of the hand

B. X-ray imaging will aid in the location of the foreign body in all patients

C. It requires incision and drainage

D. Oral analgesics are the mainstay of treatment



See Answer in Part B → Q18

@Neet_pg_bot

Q19: A patient fell from a train onto the railway track and injured both his legs severely. He was urgently taken to the hospital, and the following procedure was performed (image shown below). What is the rationale for performing this procedure? (Q860466)

A. Better fit for prosthesis

B. Life-saving procedure

C. Reduces risk of cancer

D. Good cosmetic outcomes



See Answer in Part B → Q19

@Neet_pg_bot

Q20: In solid organ transplantation, which of the following organs is associated with a higher incidence of rejection? (Q860491)

A. Lungs

B. Intestine

C. Kidney

D. Liver

See Answer in Part B → Q20

@Neet_pg_bot

Q21: A 55-year-old female patient with chronic pancreatitis undergoes a Puestow procedure. What is the most preferred route for supplementary nutrition in this patient? (Q860504)

A. TPN (Total Parenteral Nutrition)

B. Oral feeding

C. Feeding gastrostomy

D. Feeding jejunostomy

See Answer in Part B → Q21

@Neet_pg_bot

Q22: A 30-year-old female presents to the emergency department with burn injuries sustained from a stove explosion. She has burns involving the face with singeing of eyelashes, both upper limbs entirely, and the anterior chest. The burns are partial-thickness, involving the epidermis and part of the dermis. Based on the rule of Nines, what is the approximate total body surface area (TBSA) affected by burns? (Q865330)

A. 33-36%

B. 40-45%

C. 25-28%

D. 50-55%

See Answer in Part B → Q22

@Neet_pg_bot

Q23: Which of the following is incorrect regarding the following dressing? (Q865340)

A. Redressing is done after 4 - 7 days

B. Negative pressure 10-20 mmHg

C. Increase proliferation and protein matrix synthesis

D. Can be continuous & intermittent



See Answer in Part B → Q23

@Neet_pg_bot

Q24: Which of the following cancers is NOT related to obesity? (Q865421)

A. Meningioma

B. Gastric carcinoma

C. Pancreatic carcinoma

D. Multiple myeloma

See Answer in Part B → Q24

@Neet_pg_bot

Q25: A 30-year-old lactating mother presents with pain in her left breast and a fever. On examination, the left breast appears as shown in the image below. There is mild axillary lymphadenopathy on the affected side and the contralateral breast is normal.

Repeated aspirations under antibiotic cover were unsuccessful. A USG done showed fluid collection. What is the next best step in the management of this patient? (Q865425)

A. Incision and drainage

B. Broad-spectrum antibiotics only

C. Breast conservation surgery

D. Punch biopsy



See Answer in Part B → Q25

@Neet_pg_bot

Q26: An 84-year-old man who had a stroke 2 years ago and has been on extended bed rest, develops a pressure ulcer with partial skin thickness loss and a clean base. What is the grade of his pressure sore? (Q853066)

A. 1

B. 2

C. 3

D. 4

See Answer in Part B → Q26

@Neet_pg_bot

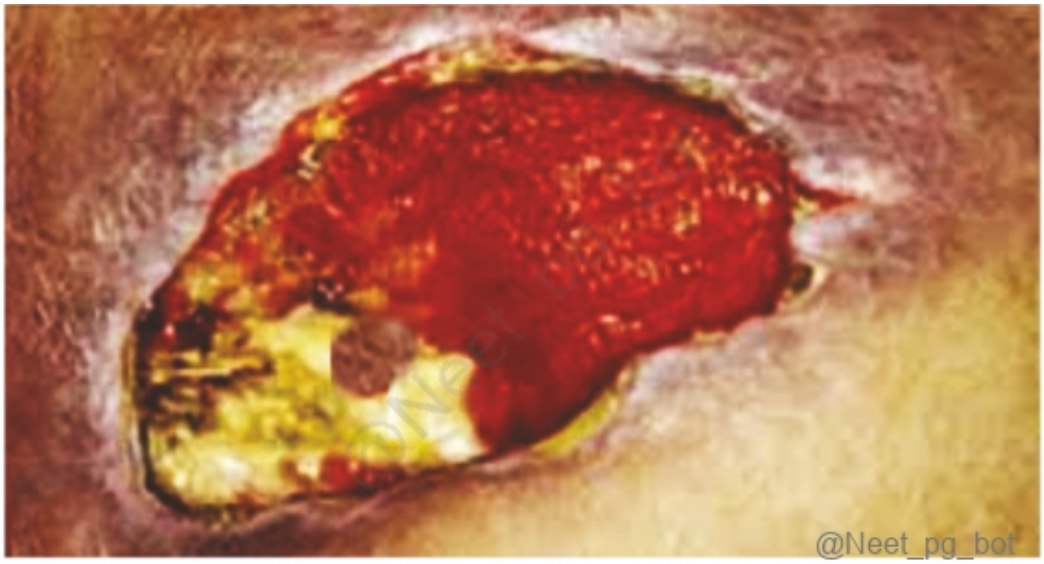
Q27: Identify the grade of the condition given in the image below ? (Q844279)

A. Grade 1

B. Grade 2

C. Grade 3

D. Grade 4



See Answer in Part B → Q27

@Neet_pg_bot

Q28: A 20-year-old chronic alcoholic presents with severe hematemesis. An ultrasound (USG) shows distention of the portal vein, and the liver appears hyperechoic. Pantoprazole has been administered. What is the next appropriate step

in management? (Q844303)

A. Initiate a course of broad-spectrum antibiotics

B. Order a liver biopsy to assess for fibrosis

C. Administer intravenous fluids and electrolyte replacement

D. Perform an endoscopy to look for varices

See Answer in Part B → Q28

@Neet_pg_bot

Q29: Which of the following is a complication of Total Parenteral Nutrition (TPN) in a sepsis patient in the ICU? (Q844304)

A. Hyperlipidemia

B. Hyperglycemia

C. Hyperglyceridemia

D. Hypoglycemia

See Answer in Part B → Q29

@Neet_pg_bot

Q30: What is the ideal pressure setting for vacuum-assisted closure (VAC) therapy? (Q844308)

A. -125 mm Hg

B. 60 to 80 mm Hg

C. 130 mm Hg

D. 80 to 100 mm Hg

See Answer in Part B → Q30

@Neet_pg_bot

Q31: During laparoscopic port placement, injury to which abdominal wall vessels must be avoided while inserting the trocar?During laparoscopic surgery, where shouldn't the trocar be inserted? (Q852687)

A. Superior epigastric artery

B. Inferior epigastric artery

C. Abdominal aorta

D. Both A and B

See Answer in Part B → Q31

@Neet_pg_bot

Q32: A 45-year-old male patient was brought to the emergency department following a road traffic accident.O/E, he had multiple injuries all over his body and was found to be in class III hemorrhagic shock. The percentage of blood loss would be between: (Q852705)

A. 5-15%

B. 30-40%

C. >40%

D. 15-30%

See Answer in Part B → Q32

@Neet_pg_bot

Q33: A 45-year-old man is found unconscious after a fall from a ladder. In the emergency department, his eyes do not open even in response to pain; he is making incomprehensible sounds, and he exhibits abnormal flexion in response to painful stimuli. What is his Glasgow Coma Scale (GCS) score? (Q852706)

A. 5

B. 6

C. 7

D. 8

See Answer in Part B → Q33

@Neet_pg_bot

Q34: A 20-year-old male presents to the outpatient department with a swelling on his wrist. He reports fluctuation in size , mild numbness in the hand , and occasional pain . What is the most likely diagnosis? (Q852713)

A. Lipoma

B. Ganglion cyst

C. Dermoid cyst

D. Hematoma



See Answer in Part B → Q34

@Neet_pg_bot

Q35: A woman, a few weeks after delivery, complains of bloody discharge from nipple and fever. On examination, diffuse lump under areola. What is the diagnosis? (Q852719)

A. Galactocele

B. Lactational mastitis

C. Mondor disease

D. Fibrocystic disease

See Answer in Part B → Q35

@Neet_pg_bot

Q36: A patient with dilated tortuous veins of the leg presented to the OPD and is diagnosed with varicose vein of grade C4a. What is the best preferred treatment? (Q852721)

A. Compression

B. Endothermal ablation

C. Non endothermal non tumescent ablation

D. Open surgery

See Answer in Part B → Q36

@Neet_pg_bot

Q37: The ureter is safe in which type of hysterectomy? (Q852722)

A. Open laparotomy

B. Laparoscopy

C. Robotic

D. Vaginal

See Answer in Part B → Q37

@Neet_pg_bot

Q38: A 25-year-old male with a history of a road traffic accident presents to the emergency department. His GCS is 8/15, oxygen saturation is 85%, blood pressure is 100/60 mmHg and heart rate is 60 beats per minute. On examination, breath sounds are absent on the right side. What is the next step in management? (Q853038)

A. Start IV fluids, give atropine and secure airway

B. Secure airway, give oxygen, insert ICD, secure IV line

C. Evaluate for head injury and do CT-head

D. ■■■Administer IV dextrose followed by NCCT head

See Answer in Part B → Q38

@Neet_pg_bot

Q39: What should be the next course of action in the management of a 30-year-old breastfeeding mother who is experiencing pain and fever in her left breast? The left breast appears abnormal as depicted in the provided image. There is slight swelling of the lymph nodes in the armpit on the affected side, while the opposite breast appears normal. Despite multiple attempts at draining the fluid with the use of antibiotics, it was unsuccessful. An ultrasound examination revealed the presence of fluid collection. (Q793402)

A. Incision an drainage

B. Broad spectrum antibiotics only

C. Breast conservation surgery

D. Punch biopsy



See Answer in Part B → Q39

@Neet_pg_bot

Q40: A 35-year-old male had surgery for an ileal perforation. Due to significant contamination, only the sheath was sutured, leaving the wound open. Daily wound irrigation was carried out, and the wound was closed on postoperative day 5. What type of wound-healing mechanism is occurring in this scenario? (Q853067)

A. Primary intention

B. Secondary intention

C. Tertiary intention

D. Quaternary intention

See Answer in Part B → Q40

@Neet_pg_bot

Q41: A friend of yours is teaching you about enhanced recovery after surgery. Which of the following statements he makes is inaccurate? (Q853068)

A. ■■■Prolonged fasting is necessary

B. Epidural anaesthesia recommended in laparoscopic surgery for pain control

C. Reduction of hospital stay by 2-3 weeks

D. Beta-blockers are given after major surgery done under general anaesthesia to improve the outcome

See Answer in Part B → Q41

@Neet_pg_bot

Q42: What kind of wound is an open cardiac massage? (Q857262)

A. Clean

B. Contaminated

C. Dirty

D. Clean Contaminated

See Answer in Part B → Q42

@Neet_pg_bot

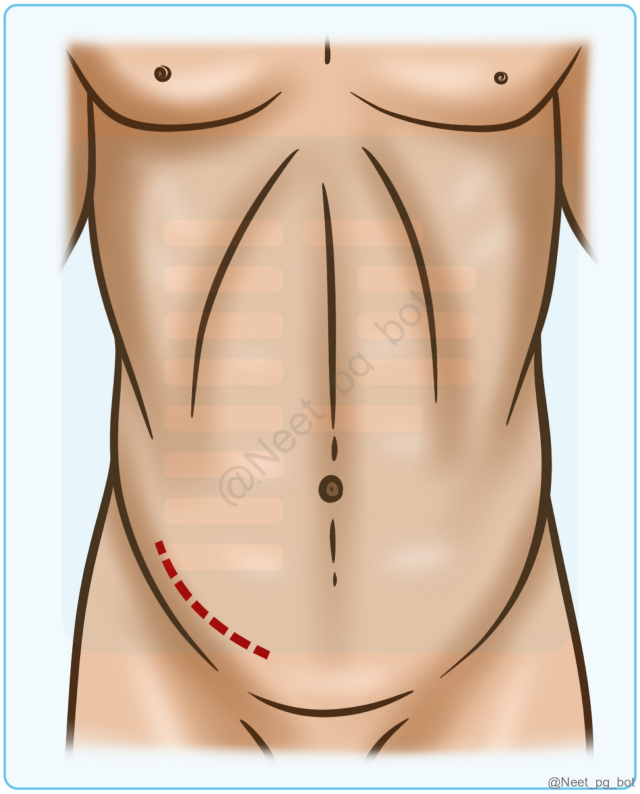
Q43: Identify the incision made and marked in the image. (Q857292)

A. Robson

B. Maylard

C. Gibson Abernathy

D. Kocher's



See Answer in Part B → Q43

@Neet_pg_bot

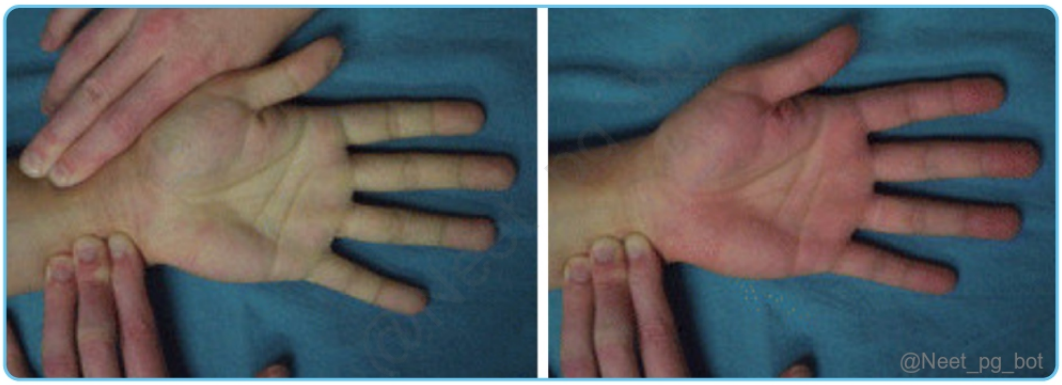
Q44: Identify the test provided in the image below. (Q857294)

A. Allen’s test

B. Adson’s test

C. Elevated arm stress test

D. Nicoladoni’s test



See Answer in Part B → Q44

@Neet_pg_bot

Q45: Smoking increases the risk of which of the following diseases? Duct ectasia Fibroadenoma Mondor disease Breast carcinoma (Q857295)

A. 2, 3

B. 1, 4

C. 2, 3, 4

D. 1, 3, 4

See Answer in Part B → Q45

@Neet_pg_bot

Q46: A 25-year-old male patient is brought to the casualty after a road traffic accident (RTA) with suspected pelvic fractures. On examination, he is found to be in hypovolemic shock. What is the earliest treatment for control of haemorrhage in this case? (Q857297)

A. Immediate internal fixation

B. Multiple blood transfusions

C. Use bedsheets to compress the pelvis

D. Emergency external fixation

See Answer in Part B → Q46

@Neet_pg_bot

Q47: A soldier arrives at a referral hospital 24 hours after experiencing a shrapnel injury to his right thigh caused by a high-speed projectile. He expresses significant discomfort at the site of the wound. Upon examination, there is evidence of crepitus. Which of the following microorganisms is the probable culprit behind his current state? (Q857804)

A. Clostridium septicum

B. Clostridium difficile

C. Clostridium novyi

D. Clostridium perfringens

See Answer in Part B → Q47

@Neet_pg_bot

Q48: A 32-year-old female undergoes emergency laparotomy for perforation peritonitis. Which of the following is the surest sign of wound dehiscence? (Q857853)

A. Copious sero-sanguinous discharge

B. Rebound tenderness

C. Hemorrhage

D. Hypotension

See Answer in Part B → Q48

@Neet_pg_bot

Q49: A barber aged 42 years presented with a healed ulcer as below, over the lower medial aspect of the right leg. On examination, he has varicose veins on both his legs.

What is the most likely type of ulcer he had? (Q859836)

A. Neuropathic ulcer

B. Arterial ulcer

C. Venous ulcer

D. Tubercular ulcer



See Answer in Part B → Q49

@Neet_pg_bot

Q50: False regarding deep second-degree burns: (Q859883)

A. Heal by scar deposition

B. No blanching

C. Damage to the deeper dermis

D. Completely painless

See Answer in Part B → Q50

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• [12_Miscellaneous] 055 Trauma Atls Protocol

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[12_Miscellaneous] 055 Trauma Atls Protocol — Quick Jump

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Q7 (p. 909)	*Q8 (p. 910)*	*Q9 (p. 910)*	*Q10 (p. 910)*	*Q11 (p. 911)*	*Q12 (p. 911)*
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Q19 (p. 914)	*Q20 (p. 914)*	*Q21 (p. 915)*	*Q22 (p. 915)*	*Q23 (p. 915)*	*Q24 (p. 916)*
Q25 (p. 917)	*Q26 (p. 917)*	*Q27 (p. 917)*			

Q1: A 35-year-old male arrives in the emergency department after a motor vehicle collision with unstable vitals and multiple injuries. Which trauma severity score is most appropriate for predicting his likelihood of survival? (Q849616)

A. Injury Severity Score (ISS)

B. Revised Trauma Score (RTS)

C. Trauma and Injury Severity Score (TRISS)

D. Mangled Extremity Severity Score (MESS)

See Answer in Part B → Q1

@Neet_pg_bot

Q2: In the context of severely injured trauma patients, which of the following is not classically included in the “lethal triad” that worsens outcomes? (Q880420)

A. Hypothermia

B. Shock

C. Acidosis

D. Coagulopathy

See Answer in Part B → Q2

@Neet_pg_bot

Q3: Which of the following best describes the principle of balanced resuscitation in trauma patients? (Q880418)

A. Maintaining airway, breathing, and circulation

B. Allowing permissive hypotension

C. Maintaining pH by correcting acid–base balance

D. Fluid resuscitation with both colloids and crystalloids

See Answer in Part B → Q3

@Neet_pg_bot

Q4: A 28-year-old man with head trauma is on mechanical ventilation. On examination, he opens his eyes spontaneously and shows purposeful movements in all four limbs. What is his GCS? (Q880417)

A. Eyes – 4, Verbal – 1, Motor – 5

B. Eyes – 4, Verbal – NT, Motor – 5

C. Eyes – 4, Verbal – 1, Motor – 6

D. Eyes – 4, Verbal – NT, Motor – 6

See Answer in Part B → Q4

@Neet_pg_bot

Q5: A 40-year-old comatose patient on ventilatory support is being assessed for brainstem death. Which of the following findings may falsely suggest preserved brainstem activity, and therefore should not be taken as evidence of brainstem function? 1. Babinski reflex 2. Decorticate/decerebrate posturing 3. Tachycardia 4. Normal systolic BP >100 mmHg 5. Presence of oculocephalic reflex (Q880416)

A. 2, 4, and 5

B. 1, 2, and 3

C. 2, 3 and 5

D. 1, 3 and 4

See Answer in Part B → Q5

@Neet_pg_bot

Q6: A young male presents with a severely mangled lower limb following a road traffic accident. The surgeon plans to calculate the Mangled Extremity Severity Score (MESS) to guide the decision on amputation versus salvage. Which one of the following factors is not a component of the MESS scoring system? (Q880410)

A. Age of the patient

B. Ischemia

C. Neurogenic injury

D. Energy of injury

See Answer in Part B → Q6

@Neet_pg_bot

Q7: Which of the following parameters are included in calculating the Revised Trauma Score (RTS)? 1. Glasgow Coma Scale 2. Respiratory rate 3. Pulse rate 4. Systolic blood pressure 5. Mechanism of injury (Q880409)

A. 2, 4, and 5

B. 1, 3, and 5

C. 2, 3, and 4

D. 1, 2, and 4

See Answer in Part B → Q7

@Neet_pg_bot

Q8: In a disaster scenario, assign the appropriate triage color code to the following patients: Patient Triage Color Code 1. An unconscious patient with massive head trauma and no spontaneous respiration A. Black 2. A patient with an open femur fracture and active bleeding B. Red 3. A patient with stable vitals but multiple rib fractures C. Yellow 4. A patient with a sprained ankle is walking around D. Green (Q880405)

A. 1-A, 2-B, 3-C, 4-D

B. 1-B, 2-A, 3-D, 4-C

C. 1-C, 2-A, 3-D, 4-B

D. 1-D, 2-C, 3-B, 4-A

See Answer in Part B → Q8

@Neet_pg_bot

Q9: Which of the following does not typically rise as part of the acute neuroendocrine response to surgical stress or trauma? (Q880404)

A. ACTH

B. TNF-α

C. Growth hormone

D. Insulin

See Answer in Part B → Q9

@Neet_pg_bot

Q10: A 60-year-old man taking medication to prevent blood clots suddenly suffers severe bleeding after an accident. Which treatment option is most effective for quickly reversing the blood-thinning effects and controlling the bleeding? (Q880268)

A. Cryoprecipitate

B. Prothrombin complex concentrate

C. Fresh-frozen plasma

D. Platelets

See Answer in Part B → Q10

@Neet_pg_bot

Q11: A person experiencing significant internal bleeding needs to have their blood levels restored to a safe range. Experts recommend not aiming too high to avoid complications. Based on current best practices, which of the following target values is considered appropriate for restoring blood levels in such a situation? (Q880266)

A. 12 g/dL

B. 6 g/dL

C. 10 g/dL

D. 8 g/dL

See Answer in Part B → Q11

@Neet_pg_bot

Q12: Based on the shelf life of the various blood components, which should be utilized first to minimize the risk of wastage due to expiry? (Q880256)

A. Packed RBCs

B. Fresh frozen plasma

C. Cryoprecipitate

D. Platelets

See Answer in Part B → Q12

@Neet_pg_bot

Q13: With respect to the Enhanced Recovery After Surgery (ERAS) protocol, which of the following statements is incorrect? (Q880233)

A. Early initiation of physiotherapy and mobilisation is recommended

B. ERAS protocols are applicable in colorectal surgical procedures

C. Oral feeding is delayed for one week postoperatively

D. Discharge planning begins before hospital admission

See Answer in Part B → Q13

@Neet_pg_bot

Q14: A 40-year-old male is admitted to the hospital after a major traumatic injury. On the third day post-trauma, his oxygen consumption and metabolic rate have increased significantly, and he exhibits elevated catecholamine levels. Which phase of the metabolic response is this patient most likely in? (Q849617)

A. Ebb phase

B. Flow phase

C. Anabolic phase

D. Recovery phase

See Answer in Part B → Q14

@Neet_pg_bot

Q15: A road traffic accident has occurred, and the first response team has arrived at the scene. Which of the following is not a key priority in prehospital care? (Q849595)

A. Evaluate the scene

B. Perform an initial assessment

C. Make triage-transport decision

D. Transport immediately and delay interventions

See Answer in Part B → Q15

@Neet_pg_bot

Q16: A 30-year-old woman with mid-facial trauma from a car accident is stabilized and the secondary survey begins. Which of the following is not an appropriate step in the secondary survey? (Q849615)

A. Obtaining a detailed history

B. Digital rectal examination for spinal injury

C. Nasogastric tube in a patient with mid-facial fractures

D. Repeat FAST examination for abdominal injury

See Answer in Part B → Q16

@Neet_pg_bot

Q17: A 25-year-old male involved in a high-speed motor vehicle accident is brought to the emergency department. After completing the primary survey and stabilizing the patient, the trauma team begins the secondary survey. Which of the following steps is not a part of the secondary survey? (Q849614)

A. Identifying external hemorrhage

B. Full neurological examination

C. Thorough head-to-toe examination

D. Obtaining a detailed patient history

See Answer in Part B → Q17

@Neet_pg_bot

Q18: A 45-year-old man is found unconscious after a fall from a ladder. In the emergency department, his eyes do not open even in response to pain; he is making incomprehensible sounds, and he exhibits abnormal flexion in response to painful stimuli. What is his Glasgow Coma Scale (GCS) score? (Q849613)

A. 5

B. 6

C. 7

D. 8

See Answer in Part B → Q18

@Neet_pg_bot

Q19: During the primary survey of a trauma patient in the emergency department, which of the following injuries is not classified as life-threatening under the category of "breathing" problems? (Q849604)

A. Flail chest

B. Hemothorax

C. Bronchial rupture

D. Expanding hematoma

See Answer in Part B → Q19

@Neet_pg_bot

Q20: Which of the following statements is true regarding the CRASH-2 trial in trauma? (TXA= Tranexamic acid) (Q849603)

A. TXA is more effective when given after 3 hours of trauma.

B. TXA reduced all-cause mortality versus placebo.

C. TXA in children worsens pulmonary and neurological outcomes.

D. CRASH-2 showed TXA is ineffective in trauma.

See Answer in Part B → Q20

@Neet_pg_bot

Q21: A 35-year-old male is brought in after a fall from height and is found to be in hypovolemic shock. According to ATLS protocol, which of the following investigations is not recommended during the primary survey to identify the cause of the life-threatening bleed? (Q849602)

A. FAST scan

B. Chest X-Ray

C. Pelvic radiograph

D. CT scan

See Answer in Part B → Q21

@Neet_pg_bot

Q22: A road accident patient, stabilized with no severe external injuries, suddenly develops tachycardia, weak pulses, hypotension, and tachypnoea. Which ATLS primary assessment component is most likely causing these symptoms? (Q849601)

A. Airway

B. Circulation

C. Neurological

D. Hypothermia

See Answer in Part B → Q22

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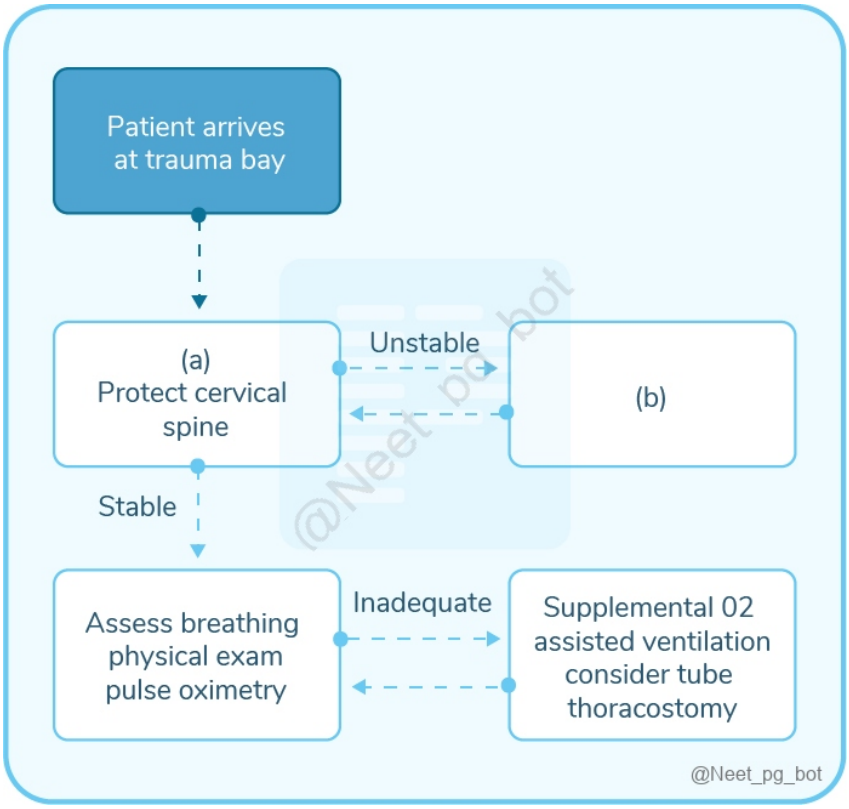
Q23: A critically injured patient is brought to the emergency department. The primary assessment is started. In the following algorithm identify the missing step (a) and action (b). (Q849600)

A. a- Assess airway, b- Establish stable airway

B. a- Assess circulation, b- Prevent shock

C. a- Establish airway, b- Assess circulation

D. a- Assess airway, b- Assess circulation



See Answer in Part B → Q23

@Neet_pg_bot

Q24: A 34-year-old patient arrives at the emergency department after a motor vehicle collision. The ED physician is assessing whether to order spinal imaging. Which of the following findings does not indicate that spinal imaging is necessary? (Q849599)

A. No focal neurological deficit

B. Patient is intoxicated

C. Altered level of consciousness

D. Presence of midline spinal tenderness

See Answer in Part B → Q24

@Neet_pg_bot

Q25: In an emergency situation in the casualty, the ATLS protocol is followed after a patient who was in a road traffic accident is brought to the hospital. Which of the following is not a component in the primary evaluation of the patient? (Q849598)

A. Detailed history of the patient

B. Airway assessment

C. Rule out shock

D. Check for neurological disability

See Answer in Part B → Q25

@Neet_pg_bot

Q26: After a major earthquake, a patient presents with a compound fracture and spinal injuries. Considering the severity of these injuries and the urgency of treatment, which triage color code is most appropriate for this patient? (Q849597)

A. Black

B. Red

C. Green

D. Yellow

See Answer in Part B → Q26

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Q27: After a high-speed road traffic accident, a trauma team arrives to find multiple critically injured patients. According to the trimodal mortality model, which statement is correct? (Q849596)

A. Immediate deaths occur days after the injury

B. Early deaths occur within hours of reaching the hospital

C. Majority of deaths are due to cardiac causes

D. Late deaths are mostly due to internal hemorrhage

See Answer in Part B → Q27

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• [12_Miscellaneous] 056 General Surgery Robotic Laparoscopic And Bariatric Surgeries

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[12_Miscellaneous] 056 General Surgery Robotic Laparoscopic And Bariatric Surgeries — Quick Jump

Q1 (p. 919)	*Q2 (p. 919)*	*Q3 (p. 920)*	*Q4 (p. 920)*	*Q5 (p. 920)*	*Q6 (p. 921)*
Q7 (p. 921)	*Q8 (p. 922)*	*Q9 (p. 922)*	*Q10 (p. 922)*	*Q11 (p. 923)*	*Q12 (p. 923)*
Q13 (p. 923)	*Q14 (p. 924)*	*Q15 (p. 924)*	*Q16 (p. 925)*	*Q17 (p. 925)*	*Q18 (p. 926)*
Q19 (p. 926)	*Q20 (p. 926)*	*Q21 (p. 927)*	*Q22 (p. 927)*	*Q23 (p. 928)*	*Q24 (p. 928)*
Q25 (p. 928)	*Q26 (p. 929)*	*Q27 (p. 929)*	*Q28 (p. 930)*	*Q29 (p. 930)*	*Q30 (p. 930)*

Q1: During a laparoscopic intra-abdominal surgery, the surgeon has to insufflate the peritoneal cavity. Which of the following statements is true regarding the Veress needle technique? (Q849681)

A. It is an open technique for creating pneumoperitoneum

B. The positioning of the needle is confirmed by a laparoscopic camera

C. Veress needle is a spring-loaded needle

D. It has a sharp inner stylet that deploys in the peritoneal cavity

See Answer in Part B → Q1

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Q2: A patient who has undergone gastric banding is being advised on postoperative nutritional guidelines. Which of the following supplements is specifically recommended for this patient to prevent deficiency? (Q849695)

A. Selenium

B. Folic acid

C. Zinc

D. Vitamin D

See Answer in Part B → Q2

@Neet_pg_bot

Q3: A 45-year-old patient undergoes bariatric surgery and is at risk for postoperative complications. What is the most common cause of 30-day mortality following bariatric surgery? (Q849694)

A. Cardiac failure

B. Pulmonary embolism

C. Anastomotic leak

D. Respiratory failure

See Answer in Part B → Q3

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Q4: A 45-year-old patient with a BMI of 38 kg/m² is considering weight loss surgery. The surgeon suggests a procedure that involves placing a band around the stomach just below the cardia to create a small gastric pouch. Which procedure is being recommended? (Q849693)

A. Sleeve gastrectomy

B. Roux-en-Y gastric bypass

C. Intragastric balloon placement

D. Laparoscopic adjustable gastric banding

See Answer in Part B → Q4

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Q5: A 38-year-old woman with a BMI of 40 kg/m² undergoes sleeve gastrectomy. Post-surgery, she asks how the procedure helps her lose weight. What is the primary mechanism by which sleeve gastrectomy leads to weight loss? (Q849692)

A. Reduced stomach size and hormonal changes.

B. Complete removal of the stomach.

C. Reduced appetite with no hormonal impact.

D. Nutrient malabsorption due to intestinal bypass.

See Answer in Part B → Q5

@Neet_pg_bot

Q6: A 52-year-old woman is recovering from a recent Roux-en-Y gastric bypass surgery. She has been informed about the possible complications that can arise post-surgery. Which of the following is least likely to be a complication of her bypass surgery? (Q849691)

A. Anastomotic leak

B. Internal hernia

C. Pancreatitis

D. Deep vein thrombosis

See Answer in Part B → Q6

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Q7: A 40-year-old obese male visits the surgical OPD. He is advised to undergo a biliopancreatic diversion and duodenal switch (BPD-DS) surgery. What would not be a possible indication for BPD-DS? (Q849690)

A. Higher BMIs

B. Failed another operation for weight loss

C. Failed surgery for metabolic control

D. Preexisting iron deficiency

See Answer in Part B → Q7

@Neet_pg_bot

Q8: In the preoperative assessment for obesity surgery, which of the following factors does NOT contribute to the obesity surgery mortality risk score? (Q849689)

A. BMI >50 kg/m²

B. Female gender

C. Age >45 years

D. Hypertension

See Answer in Part B → Q8

@Neet_pg_bot

Q9: A patient is evaluated for obesity in the hospital for bariatric surgery. Which of the following would not be an indication for the surgery? (Q849688)

A. BMI ≥ 40kg/m2 with no comorbidities

B. BMI ≥ 35kg/m2 with no comorbidities

C. Failure of previous nonsurgical attempts

D. BMI ≥ 37.5kg/m2 in Asian population with/without comorbidities

See Answer in Part B → Q9

@Neet_pg_bot

Q10: In which of the following situations is robotic surgery not suitable? (Q849687)

A. Limited space/visualization

B. Surgeon suffers from tremors in hands

C. Gynecological operations

D. Low-budget surgical setup

See Answer in Part B → Q10

@Neet_pg_bot

Q11: Which of the following statements about per-oral endoscopic myotomy is false? (Q849686)

A. It is a modification of NOTES surgery

B. A flexible endoscope is used to create a submucosal tunnel

C. It is a good surgical technique for achalasia cardia

D. The procedure involves the division of longitudinal muscles

See Answer in Part B → Q11

@Neet_pg_bot

Q12: A 20-year-old female comes to the OPD for an elective abdominal surgery. She is worried about developing a scar and enquires about a scarless procedure. Which among the following surgical procedures gives a scarless result? (Q849685)

A. Laparoscopic abdominal surgery

B. Laparotomy

C. Natural orifice transluminal endoscopic surgery

D. Hand-assisted laparoscopic surgery

See Answer in Part B → Q12

@Neet_pg_bot

Q13: A 25-year-old female who underwent a simple mastectomy was admitted in the hospital and discharged on the same day after the procedure. What type of surgery is this? (Q849684)

A. Daycare surgery

B. Fast track surgery

C. Overnight stay surgery

D. Short stay surgery

See Answer in Part B → Q13

@Neet_pg_bot

Q14: A laparoscopic surgery was done on a patient for cholecystitis, and he later complained of shoulder pain. What would be the most possible cause for this? (Q849683)

A. Intrabdominal abscess

B. Mesenteric bleeding

C. Perforation of esophagus

D. Splenic trauma

See Answer in Part B → Q14

@Neet_pg_bot

Q15: A 45-year-old patient is about to undergo a cholecystectomy. He has no other comorbidities and wants a minimally invasive surgery; hence, the surgeon suggests a laparoscopic cholecystectomy. Which of the following gases is most widely used for creating a pneumoperitoneum? (Q849682)

A. Room air

B. O2 (oxygen)

C. CO2 (carbon dioxide)

D. He (helium)

See Answer in Part B → Q15

@Neet_pg_bot

Q16: A diabetic patient with severe sepsis develops a persistent urinary tract infection (UTI) despite antibiotic treatment. The infection control team suspects a multidrug-resistant pathogen. Which of the following is true about nosocomial infections? (Q849664)

A. Staphylococcus aureus is the most common cause of hospital-acquired respiratory infections.

B. Klebsiella is a frequent cause of drug-resistant hospital-acquired UTIs.

C. Nosocomial infections are not typically transmitted between patients.

D. Patients with artificial prostheses are less prone to nosocomial infections than those with indwelling devices.

See Answer in Part B → Q16

@Neet_pg_bot

Q17: A 55-year-old woman, 4 days post-abdominal surgery, reports a sudden feeling of popping at her surgical site followed by the drainage of pinkish fluid. On examination, there is partial wound dehiscence with no visible bowel protrusion. What is the next best step in management? (Q849680)

A. Prompt reclosure of the fascia

B. Apply a wound vacuum system and monitor

C. Prescribe oral antibiotics and discharge

D. Place an abdominal binder and observe

See Answer in Part B → Q17

@Neet_pg_bot

Q18: A 68-year-old man develops a fever of 101.5°F on postoperative day 5 after total hip replacement. He also has localized pain and swelling in his left calf. The chest X-ray is normal, and there are no respiratory symptoms. What is the most likely cause of his fever? (Q849679)

A. Pulmonary embolism

B. Thrombophlebitis

C. Deep infections

D. Gas gangrene of wound

See Answer in Part B → Q18

@Neet_pg_bot

Q19: In the operating room, the surgical team is completing the WHO Surgical Safety Checklist. They are focused on final checks before closing the incision. Which of the following is not a standard checklist item at this stage? (Q849678)

A. Confirm patient identity.

B. Verify surgical team roles.

C. Reviewing anesthesia concerns.

D. Checking the patient's COVID-19 status.

See Answer in Part B → Q19

@Neet_pg_bot

Q20: A 50-year-old man develops sudden respiratory distress, altered consciousness and hypotension during a craniotomy surgery. The anesthesiologist hears a mill-wheel murmur and suspects an air embolism. What is the most appropriate immediate action? (Q849677)

A. Administer a diuretic.

B. Perform CPR.

C. Place in Trendelenburg position.

D. Administer epinephrine.

See Answer in Part B → Q20

@Neet_pg_bot

Q21: A 55-year-old female patient is scheduled for lateral thoracotomy. The surgical team prepares to position her on the operating table. Which position should the patient be placed in for optimal access to the thorax? (Q849676)

A. Jackknife Position

B. Lateral Decubitus Position

C. Lithotomy Position

D. Trendelenburg Position

See Answer in Part B → Q21

@Neet_pg_bot

Q22: A patient's wound, evaluated on postoperative day 7, shows signs of erythema, pain and swelling with no discharge and deep tissue involvement. What is the likely Southampton wound grading? (Q849675)

A. Grade I

B. Grade II

C. Grade III

D. Grade IV

See Answer in Part B → Q22

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Q23: Which of the following correctly matches the zone in an OT (Operating Theatre) complex with its primary function? (Q849673)

A. Protective zone: Includes the sterile operation rooms.

B. Clean zone: Primarily contains the change rooms for medical and paramedical staff.

C. Aseptic zone: Contains the sterile operating rooms.

D. Disposal zone: Connected directly to the aseptic zone and contains the patient transfer bay.

See Answer in Part B → Q23

@Neet_pg_bot

Q24: Which of the following strategies is most effective in preventing surgical site infections (SSIs) during an operation? (Q849672)

A. Administering prophylactic antibiotics before the first incision and maintaining positive pressure in the operating room (OR).

B. Using concentric circles for antisepsis application and maintaining the OR temperature at 18 ± 3°C.

C. Administering antibiotics after the operation and maintaining a negative pressure differential in the OR.

D. Avoiding alcohol-based antiseptic solutions and using antibiotics with a short tissue half-life.

See Answer in Part B → Q24

@Neet_pg_bot

Q25: A 62-year-old man with hypovolemic shock requires rapid fluid resuscitation. Which of the following IV catheters would be most appropriate for this situation? (Q849671)

A. 22G yellow catheter

B. 18G green catheter

C. 14G orange catheter

D. 24G blue catheter

See Answer in Part B → Q25

@Neet_pg_bot

Q26: A 28-year-old man from a resource-poor area presents with a 3-week history of fever, abdominal pain, and altered bowel habits. Abdominal examination reveals a doughy feel and a mass in the right iliac fossa. Which finding would most likely distinguish intestinal tuberculosis from typhoid fever in this patient? (Q849670)

A. Evening rise in temperature

B. Positive blood culture for Salmonella Typhi

C. Multiple longitudinal ulcers in the terminal ileum

D. Caseating granulomas on intestinal biopsy

See Answer in Part B → Q26

@Neet_pg_bot

Q27: A 48-year-old male immigrant presents with a painless, fluctuating mass in the neck that has been gradually enlarging over 2 months, along with an evening rise in temperature and weight loss. On examination, there is a 3 cm soft, non-tender swelling in the left posterior triangle of the neck without signs of inflammation. Which of the following is the most appropriate next step in management? (Q849669)

A. Incision and drainage

B. Fine needle aspiration cytology

C. Excisional biopsy

D. Empiric antitubercular therapy

See Answer in Part B → Q27

@Neet_pg_bot

Q28: A 56-year-old diabetic male presents with severe leg pain, swelling, dusky discoloration, and bullae, 24 hours after a minor cut. The leg is edematous with crepitus, and the patient is febrile and tachycardic, showing signs of septic shock. What is the most appropriate next step? (Q849668)

A. Monitor and observe

B. Immediate surgical debridement

C. IV fluids and pain management

D. Oral antibiotics

See Answer in Part B → Q28

@Neet_pg_bot

Q29: A 45-year-old man presents with severe muscle pain and swelling in his leg following a gunshot wound. The wound has a foul-smelling, brown discharge and shows signs of crepitus. X-rays reveal gas in the soft tissues. What is the most likely diagnosis? (Q849667)

A. Hidradenitis Suppurativa

B. Fournier’s Gangrene

C. Gas Gangrene

D. Cellulitis

See Answer in Part B → Q29

@Neet_pg_bot

Q30: A 55-year-old diabetic male presents with a 2-day history of increasing redness, warmth, and swelling in his left leg and also has fever and chills. The erythema is rapidly expanding, with no clear demarcation. What is the most likely diagnosis? (Q849666)

A. Carbuncle

B. Cellulitis

C. Erysipelas

D. Necrotizing fasciitis

See Answer in Part B → Q30

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• [12_Miscellaneous] 057 Injuries To The Head Neck And Thorax

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[12_Miscellaneous] 057 Injuries To The Head Neck And Thorax — Quick Jump

Q1 (p. 932)	*Q2 (p. 932)*	*Q3 (p. 933)*	*Q4 (p. 934)*	*Q5 (p. 934)*	*Q6 (p. 934)*
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Q31 (p. 946)	*Q32 (p. 946)*	*Q33 (p. 947)*			

Q1: A 45 y/o male is brought to the emergency room after a car accident with a penetrating injury to the left chest. An eFAST reveals fluid accumulation in the pericardial sac. Which of the following is not a component of Beck's triad, a classic finding in pericardial tamponade? (Q849790)

A. Hypotension

B. Jugular venous distension

C. Bradycardia

D. Muffled heart sounds

See Answer in Part B → Q1

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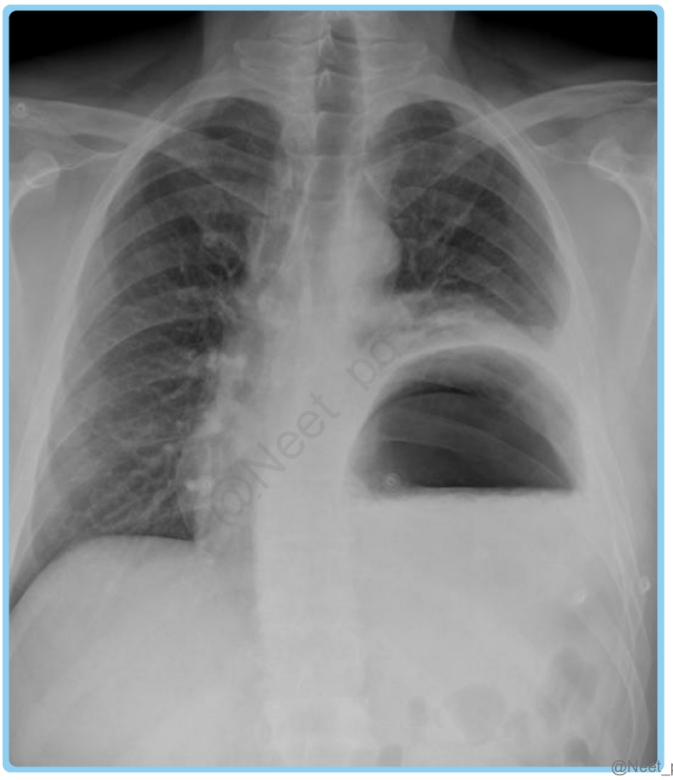
Q2: An elderly lady presents to the trauma care center following a motor vehicle collision. She complains of chest pain and abdominal pain. On examination, breath sounds are decreased on the left side. X-ray chest shows loops of bowel in the left hemithorax. Which of the following statements is false regarding the management of this patient's likely condition? (Q880429)

A. The most accurate evaluation of the condition in stable patients may be achieved by a CT scan

B. Operative repair is indicated in all symptomatic or diagnosed cases to prevent delayed complications

C. In the setting of an acute penetrating injury, repair can often be achieved via a thoracic incision

D. The defect is typically closed with non-absorbable sutures, such as polypropylene, placed in an interrupted fashion



See Answer in Part B → Q2

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Q3: A 35-year-old man presents to the casualty after being stabbed in the precordial region. He is in shock, with elevated jugular venous pressure and muffled heart sounds. Which of the following statements is incorrect? (Q880389)

A. Cardiac tamponade is the most likely diagnosis

B. If an open pneumothorax is suspected, the chest wound should be sealed completely on all four sides with an occlusive dressing

C. eFAST can identify fluid around the heart

D. Needle pericardiocentesis is not routinely recommended

See Answer in Part B → Q3

@Neet_pg_bot

Q4: A patient with blunt chest trauma undergoes tube thoracostomy. Which of the following best confirms that the intercostal drain is functioning properly? (Q880388)

A. Continuous air bubbles in the underwater seal

B. Oscillation of the water column in the tube

C. Chest X-ray

D. Auscultation

See Answer in Part B → Q4

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Q5: A 10-year-old child is brought to the emergency department after a road traffic accident. He is in severe respiratory distress with hypotension, tracheal deviation to the left, and absent breath sounds on the right side. What is the first-line management? (Q880387)

A. Insert a wide-bore needle in the 5th ICS anterior to the mid-axillary line

B. Insert a wide-bore needle in the 5th ICS in the mid-clavicular line

C. Insert a wide-bore needle in the 2nd ICS in the mid-axillary line

D. Insert a wide-bore needle in the 2nd ICS in the mid-clavicular line

See Answer in Part B → Q5

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Q6: A 28-year-old man presents with pain and tenderness over the right upper chest after a fall from a motorcycle. Chest X-ray reveals a fracture of the right 3rd rib. Which of the following is not recommended in the management of an isolated rib fracture? (Q880386)

A. Provide opioid analgesia

B. Advise deep breathing

C. Advise frequent coughing

D. Strapping over the affected rib

See Answer in Part B → Q6

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Q7: A 35-year-old man suffers severe blunt chest trauma in a high-speed motorcycle accident. On arrival, he is tachycardic and hypotensive with unequal blood pressures in both upper limbs. Chest X-ray demonstrates mediastinal widening without evidence of lung injury. Which investigation is the most appropriate to confirm the diagnosis? (Q880383)

A. Transoesophageal echocardiography

B. CT angiography

C. MR angiography

D. Transthoracic echocardiography

See Answer in Part B → Q7

@Neet_pg_bot

Q8: A 38-year-old man arrives in the emergency department after sustaining a stab injury to the lower chest. He is bradycardic and hypotensive, not improving with IV fluids. Chest X-ray shows clear lung fields. What is the most appropriate next step in management? (Q880382)

A. eFAST

B. Tube thoracostomy

C. CECT chest

D. CECT abdomen

See Answer in Part B → Q8

@Neet_pg_bot

Q9: A 32-year-old male arrives at the trauma bay with multiple penetrating injuries to the anterior and lateral neck following an assault. Which of the following would not warrant immediate surgical exploration? (Q880378)

A. Pulsatile bleeding

B. Respiratory distress

C. Fluid-responsive hemorrhagic shock

D. Air bubbling from penetrating injury

See Answer in Part B → Q9

@Neet_pg_bot

Q10: Which of the following regarding acute spinal cord injury is incorrect? (Q880376)

A. Hypotension occurs due to loss of parasympathetic tone

B. Immediate respiratory compromise may result from phrenic nerve involvement

C. The Canadian C-Spine rule and NEXUS are used to assess the need for cervical spine imaging

D. Patients with neurological deficits should be shifted off the backboard as early as possible

See Answer in Part B → Q10

@Neet_pg_bot

Q11: A 30-year-old man is rescued after a road traffic accident with suspected cervical spine injury. The team decides to log roll him for safe transfer. According to ATLS guidelines, what is the minimum number of people required for this maneuver? (Q880375)

A. 3

B. 4

C. 5

D. 6

See Answer in Part B → Q11

@Neet_pg_bot

Q12: While transferring a conscious patient with multiple injuries following a road accident, which of the following methods of transport is inappropriate? (Q880371)

A. Securing the thorax, abdomen, and lower limbs with straps on a stretcher

B. Positioning the patient prone to reduce aspiration risk

C. Shifting the patient in the lateral position for immediate transfer

D. Rolling the patient carefully onto a rigid spine board

See Answer in Part B → Q12

@Neet_pg_bot

Q13: A 45-year-old male with a large right-sided pneumothorax and decreased breath sounds requires an intercostal chest drain (ICD). What is the most appropriate insertion site for the ICD? (Q849794)

A. 5th intercostal space, midclavicular line

B. 2nd intercostal space, midaxillary line

C. 5th intercostal space, anterior axillary line

D. 2nd intercostal space, posterior axillary line

See Answer in Part B → Q13

@Neet_pg_bot

Q14: A 25 y/o male is brought to the ED after an explosion at a construction site. He was close to the blast and submerged in water. He has severe abdominal pain, difficulty hearing, shortness of breath, unstable vitals, and ruptured tympanic membranes on examination. Which organ is most severely damaged in this scenario? (Q849793)

A. Lungs

B. Limbs

C. Gastrointestinal tract

D. Brain

See Answer in Part B → Q14

@Neet_pg_bot

Q15: A 32 y/o male presents after a car accident with severe chest and abdominal pain. O/E there are decreased breath sounds on the left side and abdominal tenderness. Chest X-ray reveals bowel gas patterns in the left thoracic cavity. A nasogastric tube is placed, and its tip is seen in the thoracic cavity. What is the most appropriate next step in management? (Q849792)

A. Initiate conservative management and observe the patient.

B. Emergency laparotomy.

C. Order a CT scan of the chest and abdomen for further evaluation.

D. Schedule an elective surgery.

See Answer in Part B → Q15

@Neet_pg_bot

Q16: A 45 y/o male presents to the emergency department after a motor vehicle accident. He is tachypneic, has severe chest pain, and paradoxical chest wall movement is noted on physical examination. His oxygen saturation is 85% on room

air. A chest X-ray shows multiple rib fractures on the left side. What is the most appropriate initial management for this patient? (Q849791)

A. Tracheostomy

B. Intercostal tube drainage

C. Positive pressure ventilation

D. Thoracotomy

See Answer in Part B → Q16

@Neet_pg_bot

Q17: In a patient with raised intracranial pressure (ICP) that remains elevated despite initial management, which of the following strategies is considered a second-tier therapy for refractory cases? (Q849783)

A. Elevate the head end of the bed to 30°.

B. Administer mannitol to maintain serum osmolality < 320 mOsm/kg.

C. Perform a decompressive craniectomy.

D. Start therapeutic hyperventilation.

See Answer in Part B → Q17

@Neet_pg_bot

Q18: A 35 y/o man with a head injury, scalp laceration, headache, skull depression, and CT showing an intracranial hematoma and frontal sinus involvement presents to the emergency department. What is the most appropriate management? (Q849775)

A. Monitor and allow spontaneous healing with no immediate intervention.

B. Order a follow-up CT scan in 24 hours to reassess the extent of the injuries.

C. Perform operative debridement and repair the scalp, and consider craniotomy

D. Administer antibiotics and provide supportive care without any surgical intervention.

See Answer in Part B → Q18

@Neet_pg_bot

Q19: A 25 y/o male presents to the emergency department after being struck on the head by a small, high-velocity object. He is conscious but reports a severe headache. A CT scan reveals a depressed skull fracture with evidence of intracranial air. Which of the following is the most appropriate next step in management? (Q849776)

A. Conservative management with observation.

B. Surgical exploration and elevation of the depressed fracture.

C. Intravenous antibiotics without surgery.

D. Application of a pressure dressing to the fracture site.

See Answer in Part B → Q19

@Neet_pg_bot

Q20: A 32 y/o male presents to the emergency department after a high-impact motor vehicle accident. He complains of a severe headache, difficulty smelling, and clear fluid dripping from his nose. O/E, there is no external evidence of trauma, but the patient has a subconjunctival haemorrhage in the right eye. What is the most likely location of his skull fracture? (Q849777)

A. Anterior cranial fossa

B. Middle cranial fossa

C. Posterior cranial fossa

D. Occipital bone

See Answer in Part B → Q20

@Neet_pg_bot

Q21: A 68 y/o male on warfarin therapy presents to the emergency department after a fall from a ladder. He is fully conscious with a Glasgow Coma Scale (GCS) score of 15. He reports no loss of consciousness but is unable to recall events that happened before the fall. According to NICE guidelines, what is the most appropriate timing for a CT head scan in this patient? (Q849778)

A. Immediate CT scan within 1 hour

B. CT scan within 8 hours

C. CT scan within 24 hours

D. No need for a CT scan; observation only

See Answer in Part B → Q21

@Neet_pg_bot

Q22: A 20 y/o male footballer sustains a blow to the head during a match. He did not lose consciousness but appeared confused and had difficulty recalling events before the impact. O/E, he is slow to respond and exhibits slight incoordination while walking. It is determined that he has suffered a concussion. Which of the following statements is most appropriate regarding his management? (Q849779)

A. He should be allowed to return to play if he feels better after 15 minutes.

B. An immediate CT scan is required to rule out a cerebral contusion.

C. He should be monitored for second-impact syndrome if he returns to play prematurely.

D. A diagnosis of concussion is unlikely since there was no loss of consciousness.

See Answer in Part B → Q22

@Neet_pg_bot

Q23: A 45 y/o male presents to the ED after a head injury sustained in a motor vehicle accident. He briefly lost consciousness at the scene but was alert and oriented upon arrival. A few hours later, he becomes progressively drowsy, and his right pupil is dilated. A CT scan shows the following findings. What is the most likely diagnosis?

(Q849780)

A. Subdural Hematoma (SDH)

B. Epidural Hematoma (EDH)

C. Intracerebral Haemorrhage (ICH)

D. Cerebral Contusion



See Answer in Part B → Q23

@Neet_pg_bot

Q24: A 60 y/o male suddenly experiences an intense headache, described as the worst headache of his life, followed by vomiting and photophobia. O/E he has neck stiffness and a dilated pupil on the right side. A CT scan reveals bleeding in the subarachnoid space. Which of the following is the most common cause of this condition? (Q849781)

A. Hypertension

B. Intracranial aneurysm

C. Arteriovenous malformation (AVM)

D. Brain tumour

See Answer in Part B → Q24

@Neet_pg_bot

Q25: A 35-year-old male in a high-speed crash presents with sudden loss of consciousness and remains comatose with neurological deficits, despite normal CT findings. What is the most likely diagnosis? (Q849782)

A. Contusion

B. Subdural hematoma

C. Diffuse axonal injury (DAI)

D. Epidural hematoma

See Answer in Part B → Q25

@Neet_pg_bot

Q26: Match each description with the correct layer of the scalp: 1. Pericranium a) Richly vascularized 2. Aponeurosis b) Periosteum 3. Skin c) Danger zone 4. Connective Tissue d) Connects scalp muscles 5. Loose Areolar Connective Tissue e) Sebaceous glands (Q849665)

A. 1-d, 2-e, 3-c, 4-b, 5-a

B. 1-c, 2-d, 3-b, 4-d, 5-a

C. 1-e, 2-b, 3-a, 4-d, 5-c

D. 1-b, 2-d, 3-e, 4-a, 5-c

See Answer in Part B → Q26

@Neet_pg_bot

Q27: A 30 y/o woman sustains a stab wound in the neck that is located just above the cricoid cartilage but below the angle of the mandible. The injury is causing severe bleeding, and there is concern about the potential involvement of vital neck structures. Which neck zone is most relevant for assessing potential injury to major blood vessels and the trachea in this patient? (Q849784)

A. Zone I

B. Zone II

C. Zone III

D. Zone IV

See Answer in Part B → Q27

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Q28: A 67 y/o man collapses and requires cardiopulmonary resuscitation (CPR) in the emergency department. After successful resuscitation, imaging reveals a rib fracture. Which rib is most commonly fractured during CPR? (Q849785)

A. 1st rib

B. 2nd rib

C. 5th rib

D. 11th rib

See Answer in Part B → Q28

@Neet_pg_bot

Q29: A 55 y/o female was involved in a motor vehicle collision and now complains of severe anterior chest pain. O/E, she has point tenderness over the sternum and visible ecchymosis. What is the most likely associated injury that should be evaluated in a patient with a sternal fracture? (Q849786)

A. Rib fractures

B. Pulmonary contusion

C. Myocardial contusion

D. Pneumothorax

See Answer in Part B → Q29

@Neet_pg_bot

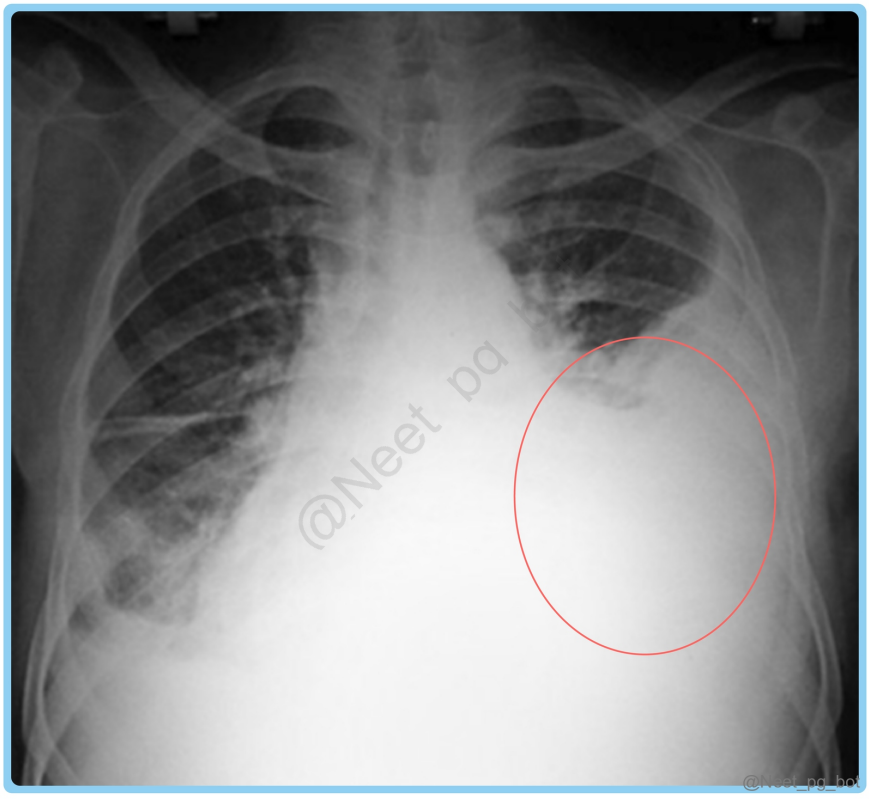
Q30: A 34 y/o male presents to the ER after a high-speed car collision. He complains of severe shortness of breath, and physical examination reveals absent breath sounds on the lower left side with a dull note on percussion. The chest X-ray is given below. Which of the following is the most appropriate next step in management? (Q849787)

A. Needle thoracostomy

B. ICD (Intercostal Drain) insertion

C. Immediate thoracotomy

D. Observation and serial chest X-rays



See Answer in Part B → Q30

@Neet_pg_bot

Q31: A 45 y/o male presents with severe chest trauma following a motor vehicle accident. After inserting a chest tube, the initial drainage is 1600 ml of blood, and he continues to drain over 200 ml/hour for the next three hours despite stabilization efforts. What is the most appropriate next step in management? (Q849788)

A. Increase the suction on the chest tube

B. Administer intravenous fluids and continue observation

C. Perform an urgent thoracotomy

D. Insert a second chest tube

See Answer in Part B → Q31

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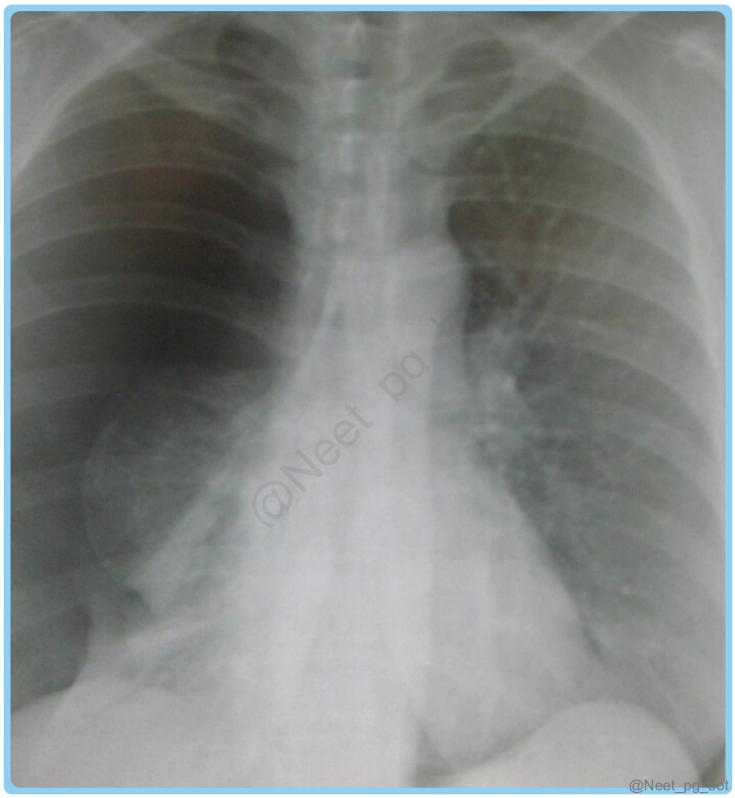
Q32: A 45 y/o man presents to the ED after a fall from a height. He is in severe respiratory distress, with rapid breathing. An x-ray film was taken of the chest which revealed the following. His blood pressure is rapidly dropping. Which of the following findings is least likely to be associated with this patient's condition? (Q849789)

A. Hyper-resonance on the affected side

B. Tracheal deviation towards the opposite side

C. Bilateral equal breath sounds

D. Distended neck veins



See Answer in Part B → Q32

@Neet_pg_bot

Q33: A 30-year-old male is brought in after a road traffic accident. He has quadriplegia, urinary retention, and cervical spine tenderness on examination. What is the most appropriate advice regarding radiographic evaluation in this patient? (Q880374)

A. Patient should not be moved; obtain a portable X-ray after stabilizing the neck

B. Ask the radiographer to take cervical and chest X-rays

C. Obtain AP and lateral cervical X-rays without cervical support

D. Order a cervical X-ray and allow the patient to shift himself from the trolley

See Answer in Part B → Q33

@Neet_pg_bot

• [12_Miscellaneous] 058 Abdominal Trauma

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[12_Miscellaneous] 058 Abdominal Trauma — Quick Jump

Q1 (p. 948)	*Q2 (p. 948)*	*Q3 (p. 949)*	*Q4 (p. 949)*	*Q5 (p. 949)*	*Q6 (p. 950)*
Q7 (p. 950)	*Q8 (p. 951)*	*Q9 (p. 951)*	*Q10 (p. 951)*	*Q11 (p. 952)*	*Q12 (p. 952)*
Q13 (p. 953)	*Q14 (p. 953)*	*Q15 (p. 954)*	*Q16 (p. 954)*	*Q17 (p. 955)*	*Q18 (p. 955)*
Q19 (p. 955)	*Q20 (p. 956)*	*Q21 (p. 956)*	*Q22 (p. 957)*	*Q23 (p. 957)*	*Q24 (p. 958)*
Q25 (p. 958)	*Q26 (p. 958)*				

Q1: Which of the following statements about abdominal trauma is true? (Q880392)

A. The most commonly injured organ in blunt trauma is the liver

B. The spleen is the most commonly injured organ in penetrating trauma

C. In gunshot injuries, the stomach is the most commonly injured organ

D. The jejunum is the most commonly injured part of the bowel in blunt trauma

See Answer in Part B → Q1

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Q2: A 19-year-old male is brought to the emergency department after a high-speed car crash. He is hypotensive (SBP 65 mmHg), and a FAST scan is positive. At laparotomy, heavy bleeding is noted from the area behind the liver along with a hollow-viscus perforation. A Pringle manoeuvre does not control the bleeding. Laparotomy packs are placed, slowing the haemorrhage. Despite resuscitation, his blood pressure remains low. Arterial pH is 7.05, and core temperature is 34°C. What is the next best step in management? (Q880428)

A. Ligation of the hepatic arteries

B. Hepatectomy

C. Hepatic artery embolization

D. Shift the patient to ICU for resuscitation

See Answer in Part B → Q2

@Neet_pg_bot

Q3: A 10-year-old boy is brought to the emergency department after a bicycle handlebar injury to the abdomen. Ultrasound reveals a Grade II splenic laceration. The child is hemodynamically stable with no signs of ongoing bleeding. What is the most appropriate management in this case? (Q880426)

A. Conservative management

B. Splenectomy

C. Embolization

D. Splenorrhaphy

See Answer in Part B → Q3

@Neet_pg_bot

Q4: During an emergency laparotomy for a patient with blunt abdominal trauma, the surgeon encounters a perirenal hematoma around the left kidney. The patient remains hemodynamically unstable.What is the next best step in management? (Q880424)

A. Single-shot intravenous pyelography

B. Contrast-enhanced computed tomography

C. Ultrasonography of the abdomen

D. Direct renal exploration

See Answer in Part B → Q4

@Neet_pg_bot

Q5: A young man sustains a renal injury following a road traffic accident and is initially managed conservatively. A few days later, he develops a flank swelling and imaging reveals a urinoma. What is the next best step in management? (Q880422)

A. Ureteral stenting

B. Surgical repair and exploration

C. Observation

D. Percutaneous drainage

See Answer in Part B → Q5

@Neet_pg_bot

Q6: A 25-year-old male presents after a high-velocity road traffic accident. He is hypotensive (BP 85/60 mmHg) and tachycardic (HR 100/min). Imaging suggests a pelvic fracture with retroperitoneal bleeding. Regarding the principles of damage control surgery (DCS), which of the following statements is correct? (Q880419)

A. Coagulopathy is corrected in Phase II of DCS

B. Definitive repair of injuries is done 12–24 hours after Phase III

C. Internal iliac artery ligation is done in Phase II

D. Hypothermia and acidosis are corrected in Phase I

See Answer in Part B → Q6

@Neet_pg_bot

Q7: A trauma patient is undergoing diagnostic peritoneal lavage (DPL) to evaluate for intra-abdominal bleeding. Which one of the following statements regarding the interpretation of DPL results is incorrect? (Q880415)

A. More than 100,000 red blood cells per mm^3 is considered positive

B. More than 200 white blood cells per mm^3 is considered positive

C. Aspiration of 10 mL or more of gross blood is an indication for laparotomy

D. Amylase level greater than 175 units/dL is considered positive

See Answer in Part B → Q7

@Neet_pg_bot

Q8: A 12-year-old boy presents after a fall from a height with abdominal pain. He is hemodynamically stable on examination, with tenderness in the left flank region. Urinalysis reveals 50 RBC/hpf.What is the investigation of choice for this patient? (Q880400)

A. Contrast-enhanced CT scan

B. Retrograde urethrogram

C. Wait and watch

D. Emergency laparotomy

See Answer in Part B → Q8

@Neet_pg_bot

Q9: A 40-year-old man is admitted to the ICU following blunt abdominal trauma. On monitoring, his intra-abdominal pressure is measured as 24 mmHg.What is the grade of intra-abdominal hypertension in this patient? (Q880399)

A. Grade I

B. Grade II

C. Grade III

D. Grade IV

See Answer in Part B → Q9

@Neet_pg_bot

Q10: A 35-year-old woman with 35% total body surface area (TBSA) deep burns over the abdomen and lower limbs is admitted to the burns ICU. She had received 9 litres of Ringer's lactate at a peripheral hospital. On arrival, she is hypotensive (BP 86/52 mmHg), tachycardic (HR 120 bpm), and her urine output has been less than 15 mL over the past 2 hours. On examination, there are tight circumferential eschars over the abdomen. The ventilator shows peak airway pressures of 40 cm H■O. What is the most appropriate next step? (Q880396)

A. Administration of dobutamine

B. Measurement of bladder pressure

C. Diuresis with furosemide

D. Increase PEEP

See Answer in Part B → Q10

@Neet_pg_bot

Q11: A critically ill patient on mechanical ventilation develops rising airway pressures, hypotension, and oliguria. Abdominal compartment syndrome is suspected. Which of the following statements is false regarding this condition? (Q880395)

A. Hypercarbia and respiratory acidosis

B. Hypoxia due to increased peak inspiratory pressure

C. Hypotension due to a decrease in venous return

D. Oliguria due to ureter obstruction

See Answer in Part B → Q11

@Neet_pg_bot

Q12: A 35-year-old man sustained a penetrating abdominal injury during a street altercation. At laparotomy, the cecum was found to be extensively damaged and non-salvageable. What is the most appropriate management for this patient? (Q880394)

A. Catheter tube cecostomy

B. Right hemicolectomy with ileocolostomy

C. Transverse colostomy

D. End loop sigmoid colostomy

See Answer in Part B → Q12

@Neet_pg_bot

Q13: Regarding abdominal trauma, which of the following is correct? 1. The mesentery is the most commonly injured structure in seat belt injuries. 2. The first investigation in blunt abdominal trauma is CT scan. 3. FAST (Focused Assessment with Sonography for Trauma) is the initial investigation of choice. 4. CECT is the investigation of choice in a hemodynamically stable patient. (Q880393)

A. 1,3,4

B. 1,2,3

C. 2,3,4

D. 2,4

See Answer in Part B → Q13

@Neet_pg_bot

Q14: Which of the following statements is true? The most commonly injured organ in blunt trauma to the abdomen is the liver. The liver is the most commonly injured organ in penetrating abdominal trauma. In gunshot injuries to the abdomen, the stomach is the most commonly injured organ. The jejunum is the most commonly injured part of the bowel in blunt trauma to the abdomen. The mesentery is the most commonly injured structure in seat belt injuries. The first investigation done on a patient with blunt abdominal trauma is a CT scan. CECT is the investigation of choice for a stable patient with blunt abdominal trauma. (Q849659)

A. 1, 2, 3, 6, 7

B. 3, 4, 5, 6

C. 2, 4, 5, 7

D. 1, 2, 5, 7

See Answer in Part B → Q14

@Neet_pg_bot

Q15: A 35 y/o male presents to the ER after a high-speed motor vehicle accident. He is hemodynamically stable but complains of left-sided abdominal pain. He has hematuria & his CECT shows a 3 cm laceration extending into the renal cortex and medulla without involvement of the collecting system. No evidence of vascular injury is noted. What is the most appropriate grade of renal trauma based on the findings? (Q849746)

A. Grade I Renal Trauma

B. Grade II Renal Trauma

C. Grade III Renal Trauma

D. Grade IV Renal Trauma

See Answer in Part B → Q15

@Neet_pg_bot

Q16: A 40 y/o male presents to the ER after being involved in a motorcycle collision. His vital signs are stable, and a CT scan reveals an expanding hematoma confined to the lateral retroperitoneum with no active bleeding. What is the most appropriate management approach for this patient? (Q849738)

A. Immediate surgical exploration

B. Extraperitoneal packing

C. Diagnostic peritoneal lavage (DPL)

D. Angioembolization

See Answer in Part B → Q16

@Neet_pg_bot

Q17: A 45 y/o male patient presents with abdominal distension, decreased urine output, and difficulty breathing following abdominal surgery. His intra-abdominal pressure (IAP) is measured at 28 cm H■O. Which of the following is the most appropriate next step in management? (Q849734)

A. Close monitoring in the ICU

B. Aggressive fluid resuscitation

C. Surgical decompression

D. Administration of diuretics

See Answer in Part B → Q17

@Neet_pg_bot

Q18: A 45 y/o male is undergoing damage control surgery after sustaining severe abdominal injuries in a construction accident. After rapid haemorrhage control, he is moved to the ICU for further resuscitation. What is the main focus during the ICU stage of damage control surgery? (Q849733)

A. Definitive Closure of the Abdomen

B. Ongoing Resuscitation and Stabilization

C. Repair of Organ Injuries

D. Selection of the Next Surgical Procedure

See Answer in Part B → Q18

@Neet_pg_bot

Q19: A 29 y/o male presents to the emergency following a high-speed car crash. He was wearing a seat belt and had a clear seat belt sign across his lower abdomen. He reports increasing abdominal pain and tenderness. Which structure is commonly injured in this scenario? (Q849732)

A. Mesentery

B. Liver

C. Spleen

D. Bladder

See Answer in Part B → Q19

@Neet_pg_bot

Q20: A 28 y/o male suffers a stab wound to the abdomen. During surgery, an injury to the head of the pancreas is discovered, with the involvement of both the main pancreatic duct and the intrapancreatic bile duct. Which surgical procedure is most appropriate for this injury? (Q849731)

A. Distal pancreatectomy

B. Whipple procedure

C. External drainage alone

D. Repair of the pancreatic duct without resection

See Answer in Part B → Q20

@Neet_pg_bot

Q21: A 40 y/o male presents to the emergency after a high-speed motorcycle collision. He is hemodynamically stable but reports severe, diffuse abdominal pain. On examination, there is significant tenderness in the upper abdomen, but no guarding or rebound tenderness is noted. Which of the following findings on the CT scan would most strongly suggest a duodenal injury? (Q849730)

A. Free air in the retroperitoneum

B. Liver laceration with intra-abdominal free fluid

C. Large splenic hematoma with peri splenic fluid collection

D. Moderate free fluid in the pelvis without solid organ injury

See Answer in Part B → Q21

@Neet_pg_bot

Q22: During liver trauma surgery, the Pringle manoeuvre is performed to control bleeding. Which of the following structures is occluded during this manoeuvre? (Q849674)

A. Hepatic artery

B. Portal vein

C. Both the hepatic artery and portal vein

D. Bile duct

See Answer in Part B → Q22

@Neet_pg_bot

Q23: A 35 y/o male presents to the emergency following a motor vehicle accident. He is hemodynamically stable with left upper quadrant tenderness. A FAST exam reveals free fluid in the abdomen. The CT scan shows a minor splenic injury. What is the most appropriate next step in management? (Q849663)

A. Immediate splenectomy

B. Non-operative management with close monitoring in ICU

C. Exploratory laparotomy

D. Angiography with embolization

See Answer in Part B → Q23

@Neet_pg_bot

Q24: A 34 y/o man presents with a gunshot wound to the abdomen. He is hemodynamically unstable with a blood pressure of 90/60 mmHg and a heart rate of 130 bpm. On examination, there is significant abdominal tenderness with guarding and rigidity. What is the best initial management step? (Q849662)

A. Perform a FAST scan

B. Start fluid resuscitation and obtain an abdominal X-ray

C. Urgent exploratory laparotomy

D. Obtain a CT scan with IV contrast

See Answer in Part B → Q24

@Neet_pg_bot

Q25: Which of the following is the most accurate diagnostic tool for evaluating blunt abdominal trauma in a hemodynamically stable patient? (Q849661)

A. FAST (Focused Assessment with Sonography for Trauma)

B. Diagnostic Peritoneal Lavage (DPL)

C. CT scan with IV contrast

D. Plain abdominal X-ray

See Answer in Part B → Q25

@Neet_pg_bot

Q26: A 30 y/o male is admitted after a motorcycle accident with abdominal trauma. The doctor decides to perform initial imaging tests. Which statement about FAST, eFAST, and DPL is incorrect? (Q849660)

A. eFAST can detect >100 mL of free blood in the abdomen and thoracic cavities.

B. FAST is reliable for assessing retroperitoneum and detecting injuries to hollow viscus.

C. DPL is valuable in resource-limited settings and detects blood or contaminants in the abdomen.

D. FAST and eFAST do not determine the specific nature or extent of injuries.

See Answer in Part B → Q26

@Neet_pg_bot

• [12_Miscellaneous] 059 Transplantation

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[12_Miscellaneous] 059 Transplantation — Quick Jump

Q1 (p. 960)	*Q2 (p. 960)*	*Q3 (p. 961)*	*Q4 (p. 961)*	*Q5 (p. 961)*	*Q6 (p. 962)*
Q7 (p. 962)	*Q8 (p. 963)*	*Q9 (p. 963)*	*Q10 (p. 964)*	*Q11 (p. 964)*	*Q12 (p. 964)*
Q13 (p. 965)	*Q14 (p. 965)*	*Q15 (p. 966)*	*Q16 (p. 966)*	*Q17 (p. 966)*	*Q18 (p. 967)*
Q19 (p. 967)	*Q20 (p. 968)*	*Q21 (p. 968)*	*Q22 (p. 968)*	*Q23 (p. 969)*	*Q24 (p. 969)*
Q25 (p. 969)	*Q26 (p. 970)*	*Q27 (p. 970)*	*Q28 (p. 971)*		

Q1: An elderly man with diabetes presents with progressive weight loss and poor appetite. You decide to assess his nutritional status using the Malnutrition Universal Screening Tool (MUST) . Which of the following factors are included in this assessment? 1. Body Mass Index (BMI) 2. Age 3. Recent weight loss 4. Current nutritional intake 5. Acute illness (Q880220)

A. 1,3,4,5

B. 1,2,3,4

C. 2,3,4,5

D. 1,2,3,5

See Answer in Part B → Q1

@Neet_pg_bot

Q2: A patient with long-standing Crohn’s disease is found to have several skip lesions in the small intestine. If surgical excision includes the segment primarily responsible for bile salt absorption, the patient is most likely to develop steatorrhea. Which segment is this? (Q880219)

A. Duodenum

B. Ileum

C. Jejunum

D. Caecum

See Answer in Part B → Q2

@Neet_pg_bot

Q3: Following an emergency laparotomy for a penetrating abdominal injury, a patient is left with less than 100 cm of jejunum and a jejunostomy is created. Which of the following statements regarding management of this condition is incorrect? (Q880218)

A. The patient behaves as a net secretor

B. Oral water intake should be restricted to less than 1 L per day

C. Resuscitation is best achieved with hypotonic intravenous fluids

D. Use of antisecretory agents is recommended

See Answer in Part B → Q3

@Neet_pg_bot

Q4: Which of the following parameters is NOT included in the MELD (Model for End-Stage Liver Disease) score? (Q849882)

A. Bilirubin

B. Creatinine

C. International Normalized Ratio (INR)

D. Albumin

See Answer in Part B → Q4

@Neet_pg_bot

Q5: A 55 y/o male with advanced idiopathic pulmonary fibrosis (IPF) is evaluated for lung transplantation. He has significant dyspnea on minimal exertion, and his forced vital capacity (FVC) is 42% of the predicted value. His pre-transplant workup is

normal, and he is listed for a single lung transplant. Which of the following conditions is most likely to benefit from single lung transplantation? (Q849892)

A. Cystic fibrosis

B. Pulmonary arterial hypertension

C. Idiopathic pulmonary fibrosis

D. Bronchiectasis

See Answer in Part B → Q5

@Neet_pg_bot

Q6: A 55 y/o male who underwent heart transplantation 10 years ago presents with exertional dyspnea and fatigue for a few weeks. His initial post-transplant course was uneventful, and he has been compliant with his immunosuppressive regimen. What is the most common cause of late mortality in heart transplant recipients that should be considered in this patient? (Q849891)

A. Graft rejection

B. Infection

C. Cardiac allograft vasculopathy (CAV)

D. Renal failure

See Answer in Part B → Q6

@Neet_pg_bot

Q7: A 45-year-old male with end-stage heart failure secondary to ischemic cardiomyopathy is being evaluated for orthotopic heart transplantation. After confirming the indications for transplantation, the surgical team begins the procedure. Which of the following represents the correct sequence of anastomoses typically performed? (Q849890)

A. Pulmonary artery → Left atrium → Aorta → Right atrium

B. Left atrium → Right atrium → Pulmonary artery → Aorta

C. Aorta → Pulmonary artery → Left atrium → Right atrium

D. Right atrium → Aorta → Pulmonary artery → Left atrium

See Answer in Part B → Q7

@Neet_pg_bot

Q8: In isolated intestine transplantation, the venous outflow from the allograft is typically established by anastomosis of which of the following? (Q849889)

A. Donor SMV to the recipient superior vena cava

B. Donor SMV to the recipient portal vein or inferior vena cava

C. Donor SMA to the recipient portal vein

D. Donor SMV to the recipient splenic vein

See Answer in Part B → Q8

@Neet_pg_bot

Q9: A transplant team is evaluating potential cadaveric donors for a small bowel transplant. Criteria for donor selection include compatible blood type, size of the donor relative to the recipient, and viral serologic testing. Which of the following is NOT a criterion for donor selection in small bowel transplantation? (Q849888)

A. Blood type compatibility

B. Donor body weight 50% to 75% of the recipient’s weight

C. Maximum cold ischemia time of 10 to 12 hours

D. Donor's minimal vasopressor requirement

See Answer in Part B → Q9

@Neet_pg_bot

Q10: A 50-year-old female with a history of type 1 diabetes mellitus presents with recurrent severe hypoglycemia with decreased awareness. He is scheduled for islet cell transplantation. Which immunosuppressive regimen is most commonly used to prevent immune rejection of the transplanted islet cells? (Q849887)

A. Cyclosporine + azathioprine + prednisolone

B. Methotrexate + mycophenolate mofetil + hydrocortisone

C. Cyclophosphamide + etanercept + rituximab

D. Daclizumab + sirolimus + tacrolimus

See Answer in Part B → Q10

@Neet_pg_bot

Q11: A 45-year-old male with a history of type 1 diabetes mellitus undergoes a pancreas transplantation. On postoperative day 3, he develops sudden-onset severe abdominal pain, and doppler ultrasound reveals no blood flow to the pancreas graft. What is the most common cause of pancreatic graft failure in this scenario? (Q849886)

A. Vascular thrombosis

B. Anastomotic leak

C. Pancreatitis

D. Bleeding

See Answer in Part B → Q11

@Neet_pg_bot

Q12: Which of the following statements is/are true regarding pancreas transplantation? Type-2 DM with clear c-peptide deficiency is not an indication for pancreas transplantation. End-to-end anastomosis is done between the internal iliac artery and splenic artery Systemic venous drainage is preferred over portal venous drainage Enteric drainage of endocrine secretion is preferred (Q849885)

A. Only 2

B. 1, 2, and 4

C. 2 and 3

D. All of the above

See Answer in Part B → Q12

@Neet_pg_bot

Q13: Which of the following statements is NOT true regarding contraindications and complications of renal transplantation? (Q849884)

A. Renal vein thrombosis post-surgery is managed conservatively with anticoagulants

B. Active IV drug abuse is a contraindication for the transplant

C. Lymphocele can cause ureteric obstruction

D. Renal artery stenosis post-transplant is best treated by angioplasty

See Answer in Part B → Q13

@Neet_pg_bot

Q14: A 45-year-old male with end-stage renal disease due to polycystic kidney disease is scheduled for a renal transplant, with his brother serving as the donor. During the transplant procedure, where is the donor kidney typically placed, and to which vessel is its renal artery anastomosed? (Q849883)

A. Right hypochondrium and aorta

B. Left hypochondrium and external iliac artery

C. Iliac fossa and Internal iliac artery

D. Lumbar region and Inferior vena cava

See Answer in Part B → Q14

@Neet_pg_bot

Q15: Which of the following best describes the definition of a "deceased person" according to the Transplantation of Human Organs Act? (Q849795)

A. A person who has been unconscious for more than 24 hours.

B. A person who has a permanent cessation of all evidence of life.

C. A person who has been declared clinically dead but with potential for revival.

D. A person who has undergone a major surgery with no sign of life for 6 hours.

See Answer in Part B → Q15

@Neet_pg_bot

Q16: A 55-year-old patient with end-stage liver disease receives a liver from a donor with familial amyloid polyneuropathy (FAP) as part of a domino liver transplantation. Which of the following statements is incorrect? (Q849881)

A. It can use a liver from a patient with familial amyloid polyneuropathy (FAP).

B. FAP symptoms appear immediately after transplantation.

C. If the recipient later develops FAP symptoms, they can undergo a retransplantation without risk of malignancy recurrence.

D. The recipient is less likely to develop or be significantly affected by the metabolic syndrome

See Answer in Part B → Q16

@Neet_pg_bot

Q17: A 52-year-old woman, who underwent a liver transplant 2 months ago, presents with jaundice and bile leakage from the surgical site. Imaging studies suggest narrowing of the bile ducts. What is the most likely complication she is experiencing, and what could be the potential need for management? (Q849880)

A. Acute cellular rejection- Increase immunosuppressants

B. Chronic rejection- Continue monitoring

C. Ischemic-type biliary lesion (ITBL)- Consider retransplantation

D. Hepatic artery thrombosis- Start anticoagulation therapy

See Answer in Part B → Q17

@Neet_pg_bot

Q18: A 40-year-old male with end-stage liver disease due to chronic hepatitis C is being evaluated for a liver transplant. During the evaluation, it was noted that his 38-year-old sister is willing to donate a portion of her liver. Which of the following liver transplant options is most appropriate for this patient? (Q849879)

A. Deceased Donor Liver Transplantation (DDLT)

B. Domino Liver Transplantation

C. Living Donor Liver Transplantation (LDLT)

D. Split Liver Transplantation

See Answer in Part B → Q18

@Neet_pg_bot

Q19: Which of the following methods is currently considered the gold standard for preserving the pancreas before transplantation? (Q849878)

A. Hypothermic machine perfusion (HMP)

B. Normothermic machine perfusion (NMP)

C. Static cold storage (SCS) with University of Wisconsin (UW) solution

D. Normothermic regional perfusion (NRP)

See Answer in Part B → Q19

@Neet_pg_bot

Q20: A 45-year-old male is declared legally dead due to irreversible brainstem function loss following a severe head injury. He is considered for organ donation. Which of the following statements is true regarding Donation After Brainstem Death (DBD)? (Q849877)

A. In DBD complications like graft dysfunction, especially with the liver and pancreas, are expected.

B. A 5-minute "no-touch" period is observed in the case of DBD.

C. In DBD, organs are perfused with oxygenated blood at the time of procurement.

D. Warm ischemia is seen in DBD.

See Answer in Part B → Q20

@Neet_pg_bot

Q21: A 52-year-old female who received a multi-visceral transplant presents with unexplained fever, night sweats, and significant weight loss. Her laboratory results show persistent Epstein–Barr virus (EBV) viremia. Which of the following transplant recipients is at the highest risk of developing post-transplant lymphoproliferative disorder (PTLD)? (Q849803)

A. Kidney transplant recipient

B. Liver transplant recipient

C. Intestinal transplant recipient

D. Heart transplant recipient

See Answer in Part B → Q21

@Neet_pg_bot

Q22: In transplant recipients, which of the following is the most common cause of viral infection within the first 6 months post-transplant? (Q849802)

A. Herpes Simplex Virus (HSV)

B. Cytomegalovirus (CMV)

C. Epstein-Barr Virus (EBV)

D. BK Virus

See Answer in Part B → Q22

@Neet_pg_bot

Q23: Which intervention has been shown to reduce the risk of graft loss in kidney transplant recipients with BK virus nephropathy? (Q849801)

A. Increasing the dosage of calcineurin inhibitors

B. Administering antiviral therapy as a first-line treatment

C. Timely reduction of immunosuppressive therapy

D. Routine use of corticosteroids

See Answer in Part B → Q23

@Neet_pg_bot

Q24: Which of the following is the most common malignancy in transplant recipients? (Q849800)

A. Kaposi Sarcoma

B. Post-transplant lymphoproliferative Disorder (PTLD)

C. Squamous Cell Carcinoma

D. Cytomegalovirus-Associated Tumors

See Answer in Part B → Q24

@Neet_pg_bot

Q25: Which of the following drugs works by inhibiting T-cell activation through the blockage of calcineurin, ultimately reducing IL-2 production? (Q849799)

A. Azathioprine

B. Prednisone

C. Tacrolimus

D. Sirolimus

See Answer in Part B → Q25

@Neet_pg_bot

Q26: Which type of graft involves tissue transplantation between genetically identical individuals, such as identical twins? (Q849798)

A. Autograft

B. Allograft

C. Isograft

D. Xenograft

See Answer in Part B → Q26

@Neet_pg_bot

Q27: A 45-year-old patient requires a kidney transplant. Which statement about HLA matching is most accurate for this transplant? (Q849797)

A. Mismatches at the HLA-B locus have a more significant impact on transplant outcomes than mismatches at the HLA-DR locus.

B. HLA typing is typically performed using DNA sequencing to assess compatibility.

C. HLA Class I molecules are categorized into HLA-DP, HLA-DQ, and HLA-DR.

D. Tissue typing in transplantation includes HLA-B, HLA-C, and HLA-DP loci.

See Answer in Part B → Q27

@Neet_pg_bot

Q28: A 45-year-old male patient undergoes a kidney transplant. Shortly after the procedure, he experiences a rapid onset of graft dysfunction characterized by the destruction of the graft's vascularization. Which type of rejection does this patient most likely have? (Q849796)

A. Hyperacute Rejection

B. Acute Cellular Rejection

C. Acute Humoral Rejection

D. Chronic Rejection

See Answer in Part B → Q28

@Neet_pg_bot

• [12_Miscellaneous] 060 Nutrition Sutures And Anastomosis

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[12_Miscellaneous] 060 Nutrition Sutures And Anastomosis — Quick Jump

Q1 (p. 972) *Q2 (p. 972)* *Q3 (p. 973)* *Q4 (p. 973)* *Q5 (p. 973)* *Q6 (p. 974)*
Q7 (p. 974) *Q8 (p. 974)* *Q9 (p. 975)* *Q10 (p. 975)* *Q11 (p. 976)* *Q12 (p. 976)*
Q13 (p. 977) *Q14 (p. 977)* *Q15 (p. 977)* *Q16 (p. 978)* *Q17 (p. 978)* *Q18 (p. 979)*
Q19 (p. 979) *Q20 (p. 980)* *Q21 (p. 980)* *Q22 (p. 980)* *Q23 (p. 981)* *Q24 (p. 981)*
Q25 (p. 982)

Q1: Which of the following is the recommended knot for securing the final stitch in a continuous suture technique during surgery? (Q849771)

A. Reef knot

B. Aberdeen knot

C. Surgeon’s knot

D. Buried knot

See Answer in Part B → Q1

@Neet_pg_bot

Q2: In a patient suffering from acute pancreatitis, which electrolyte disturbance is most commonly observed? (Q880229)

A. Hypercalcemia

B. Hypocalcemia

C. Hypernatremia

D. Hyperkalemia

See Answer in Part B → Q2

@Neet_pg_bot

Q3: All of the following are recognised causes of hypokalemia except: (Q880228)

A. Hyperaldosteronism

B. Diarrhoea

C. High nasogastric output

D. Metabolic acidosis

See Answer in Part B → Q3

@Neet_pg_bot

Q4: In a post-surgical patient, which of the following is typically the first clinical indication of fluid overload? (Q880227)

A. Distended neck veins

B. Peripheral edema

C. Weight gain

D. Increased cardiac output

See Answer in Part B → Q4

@Neet_pg_bot

Q5: Long-term dependence on total parenteral nutrition without adequate supplementation can most commonly lead to deficiency of which of the following? (Q880226)

A. Vitamin B12

B. Folic acid

C. Amino acids

D. Zinc

See Answer in Part B → Q5

@Neet_pg_bot

Q6: A patient has been receiving total parenteral nutrition (TPN) through a central venous line for more than a month. Which of the following is not routinely recommended as part of monitoring during TPN therapy? (Q880225)

A. Regular assessment for new-onset glucose intolerance

B. Checking serum electrolytes every 2–3 days

C. Weekly monitoring of liver function tests and blood urea nitrogen

D. Scheduled replacement of the central venous catheter every two weeks

See Answer in Part B → Q6

@Neet_pg_bot

Q7: A patient is started on total parenteral nutrition through a peripherally inserted central catheter. After placement, a chest radiograph is obtained to confirm the line's position. The catheter tip should ideally terminate in which vessel? (Q880223)

A. Subclavian vein

B. Internal jugular vein

C. Superior vena cava

D. Inferior vena cava

See Answer in Part B → Q7

@Neet_pg_bot

Q8: While inserting a Ryle's tube in a conscious patient, which position is considered most appropriate to facilitate the smooth passage of the tube? (Q880221)

A. Supine with neck flexion

B. Supine with neck extension

C. Sitting with neck flexion

D. Sitting with neck extension

See Answer in Part B → Q8

@Neet_pg_bot

Q9: Which of the following contributes to the generation of endogenous water within the body? (Q880217)

A. Ingested fluids

B. Breakdown of solid food

C. Oxidation of solid foodstuffs

D. Both A and C

See Answer in Part B → Q9

@Neet_pg_bot

Q10: During morning rounds, an intern is asked how to recognise inadequate perfusion in a burns patient receiving fluid therapy. The resident explains that a fluid bolus of 10 mL/kg should be given if certain warning signs appear. Which of the following is not an indication for administering a fluid bolus?: (Q880215)

A. Tachycardia

B. Low hematocrit

C. Restlessness

D. Cool peripheries

See Answer in Part B → Q10

@Neet_pg_bot

Q11: A 60-year-old patient is undergoing ileostomy closure and the surgeon opts for a hand-sewn anastomosis technique. Which of the following accurately describes the single-layer hand-sewn anastomosis technique? (Q849774)

A. It includes an inner continuous suture layer and an outer layer of interrupted sutures.

B. It uses a continuous suture line through all layers of the bowel wall, except the mucosa.

C. It uses a continuous suture line through all layers of the bowel wall.

D. It involves placing a purse-string suture on the distal stump and stapling the anastomosis.

See Answer in Part B → Q11

@Neet_pg_bot

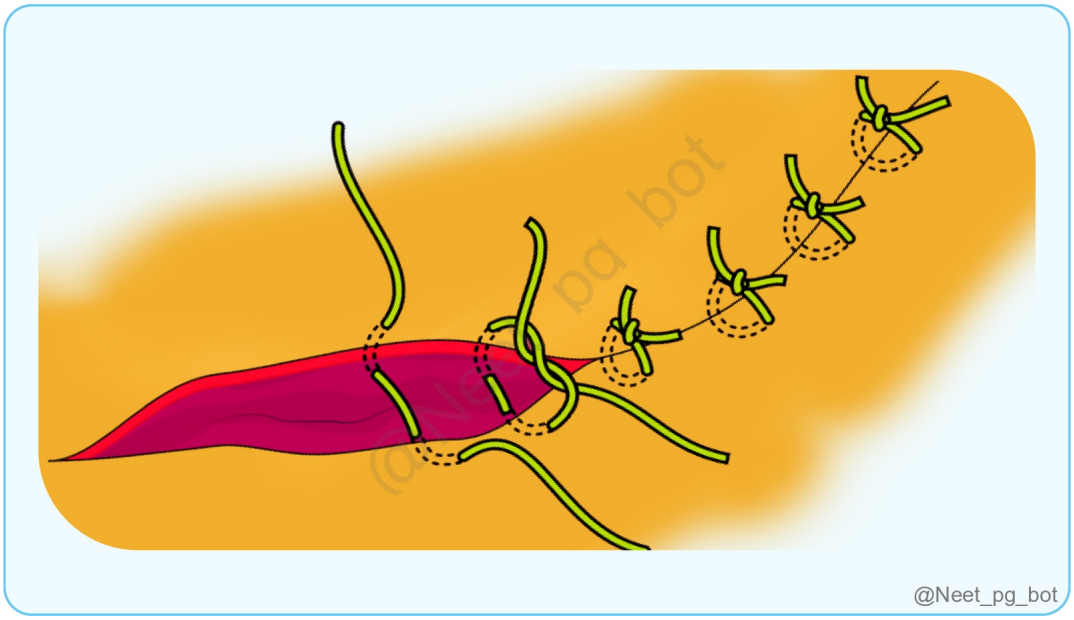
Q12: Identify the type of suturing technique used in the image given below. (Q849773)

A. Interrupted sutures

B. Continuous sutures

C. Mattress sutures

D. Subcuticular sutures



See Answer in Part B → Q12

@Neet_pg_bot

Q13: Which of the following types of surgical needles is most appropriate for suturing tough or dense tissue such as skin and fascia? (Q849772)

A. Round-bodied needle

B. Triangular needle

C. Blunt-ended needle

D. J-shaped needle

See Answer in Part B → Q13

@Neet_pg_bot

Q14: A 45 y/o male patient is admitted to the ICU following a major road traffic accident, resulting in multiple fractures and abdominal injuries. The patient is currently unable to take oral nutrition. He is expected to require enteral feeding for more than 3 weeks. Imaging studies reveal delayed gastric emptying and significant gastric distension. What is the most appropriate route for enteral nutrition in this patient? (Q849754)

A. Nasogastric tube

B. Ryles tube

C. Feeding gastrostomy

D. Feeding jejunostomy

See Answer in Part B → Q14

@Neet_pg_bot

Q15: Which of the following best describes Jenkins's rule in the context of abdominal wound closure? (Q849770)

A. Use of interrupted sutures with bites 2 cm apart to reduce wound tension.

B. Continuous suturing with bites 1 cm apart, avoiding suture locking to create a "spring coil" effect.

C. Continuous suturing with locking sutures, with bites placed 1 cm from the wound edge

D. Use of mattress sutures to maximize the tension across the wound during healing

See Answer in Part B → Q15

@Neet_pg_bot

Q16: A 60-year-old woman with a history of peripheral artery disease presents with critical limb ischemia. She is scheduled for a femoral-popliteal bypass surgery to restore blood flow to her lower extremity. Which suture is preferred for vascular anastomosis? (Q849769)

A. Prolene

B. Silk

C. Vicryl

D. Nylon

See Answer in Part B → Q16

@Neet_pg_bot

Q17: A 45-year-old female undergoes an abdominal hysterectomy. The surgeon chooses to close the rectus sheath using PDS (polydioxanone) sutures due to their prolonged tensile strength. What is the expected time frame for the complete absorption of the polydioxanone sutures in this patient? (Q849763)

A. 60 - 90 days

B. 180 days

C. 90 - 120 days

D. 7 - 10 days

See Answer in Part B → Q17

@Neet_pg_bot

Q18: A 28-year-old male undergoes repair of a laceration on his forearm following a minor accident. The surgeon chooses monocryl for the subcutaneous layer and polyglycolic acid sutures for the deep dermal layer. Which of the following statements is/are true regarding these sutures in this case? Poliglecaprone is not preferred for subcuticular suturing Monocryl is a polymer of glycolide and caprolactone Polyglycolic acid exhibits highest affinity for adherence to E.coli and staph. aureus Patient is informed that monocryl will be completely absorbed in 180 days (Q849762)

A. Only 2

B. 2 and 3

C. 1, 2 and 4

D. All the statements

See Answer in Part B → Q18

@Neet_pg_bot

Q19: A 30-year-old female undergoes an elective laparoscopic cholecystectomy, during which the surgeon uses Vicryl sutures to close the internal fascial layers. Postoperatively, the patient expresses concern about how long the sutures will remain in her body before being fully absorbed. What is the expected time frame for complete absorption of the Vicryl sutures in this case? (Q849761)

A. 60 - 90 days

B. 180 days

C. 90 - 120 days

D. 7 - 10 days

See Answer in Part B → Q19

@Neet_pg_bot

Q20: A 30-year-old man undergoes an open appendectomy, and plain catgut sutures are used for closing the muscle layer. Which of the following statements regarding these sutures is most accurate? (Q849760)

A. Non-absorbable and provide long-term tensile strength

B. Made from synthetic materials and are highly resistant to enzymatic degradation

C. Primarily absorbed by enzymatic proteolysis and has variable tensile strength

D. Causes minimal tissue reaction and are preferred for patients with suture allergies

See Answer in Part B → Q20

@Neet_pg_bot

Q21: A 30-year-old male undergoes abdominal surgery, and the surgeon plans to use a non-absorbable monofilament suture for skin closure to minimize tissue reaction and ensure long-term wound support. Which of the following sutures should be selected? (Q849759)

A. Polyglactin 910 (Vicryl)

B. Polydioxanone (PDS)

C. Nylon

D. Polyglycolic acid (Dexon)

See Answer in Part B → Q21

@Neet_pg_bot

Q22: A 45 year old male severely malnourished patient with a history of chronic alcoholism and recent weight loss is admitted in the hospital. After stabilization, he is

started on a high-calorie enteral feeding regimen to address his nutritional deficiencies. Within 48 hours of initiating feeding, he begins to have muscle weakness, difficulty in breathing and is confused. Which of the following electrolyte abnormalities in the blood is least likely to be associated with his current condition? (Q849758)

A. Hypophosphatemia

B. Hypokalemia

C. Hypomagnesemia

D. Hypernatremia

See Answer in Part B → Q22

@Neet_pg_bot

Q23: A 72-year-old male with severe pancreatitis is initiated on total parenteral nutrition (TPN) due to his inability to tolerate enteral feeding. Shortly after the central venous catheter is inserted, he complains of sudden onset shortness of breath and pleuritic chest pain. On examination, his breath sounds are decreased on the same side of the catheter insertion. What is the most likely complication that has occurred? (Q849757)

A. Catheter-related sepsis

B. Catheter related thrombosis

C. Dyselectrolytemia

D. Pneumothorax

See Answer in Part B → Q23

@Neet_pg_bot

Q24: A 45-year-old male recovering from gastrointestinal surgery is on total parenteral nutrition (TPN). Initially, he was receiving a 2-in-1 TPN formulation. Due to ongoing nutritional needs, the medical team switches him to a 3-in-1 TPN

formulation. Which component is newly included in the 3-in-1 formulation that was not in the 2-in-1? (Q849756)

A. Amino acids

B. Dextrose

C. Lipids

D. Fiber

See Answer in Part B → Q24

@Neet_pg_bot

Q25: A 38-year-old male involved in a motor vehicle accident has been in the ICU for several days with multiple injuries including head and abdominal trauma. The ICU team is considering starting enteral feeding. Which of the following findings would most likely contraindicate the initiation of enteral nutrition in this patient? (Q849755)

A. Inflammatory bowel disease

B. Distal low-output enterocutaneous fistula

C. Proximal small intestinal fistula

D. Constipation

See Answer in Part B → Q25

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• [12_Miscellaneous] 061 Shock

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[12_Miscellaneous] 061 Shock — Quick Jump

Q1 (p. 983)	*Q2 (p. 983)*	*Q3 (p. 984)*	*Q4 (p. 984)*	*Q5 (p. 984)*	*Q6 (p. 985)*
Q7 (p. 985)	*Q8 (p. 986)*	*Q9 (p. 986)*	*Q10 (p. 987)*	*Q11 (p. 987)*	*Q12 (p. 987)*
Q13 (p. 988)	*Q14 (p. 988)*	*Q15 (p. 989)*	*Q16 (p. 989)*		

Q1: A 56-year-old man is brought to the emergency department after a road traffic accident. He is confused, has a heart rate of 132/min, blood pressure 78/50 mmHg, cool clammy extremities, and a capillary refill time of >4 seconds. Arterial blood gas shows metabolic acidosis with elevated lactate.Which statement best explains the underlying pathophysiology in this patient's condition? (Q849579)

A. Decreased tissue perfusion leading to impaired oxygen delivery and utilization at the cellular level.

B. Low arterial pressure alone, irrespective of oxygen delivery.

C. Fluid loss without impact on cellular respiration.

D. Inflammatory cytokine release causing organ failure in all patients with trauma.

See Answer in Part B → Q1

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Q2: A 25-year-old male patient was brought with multiple injuries on his body following a road traffic accident. O/E patient was drowsy and confused, extremities were cold and clammy, weak thready pulse noted. On auscultation, tachypnoea and tachycardia observed. Identify the type of shock seen in this patient. (Q849580)

A. Hypovolemic shock

B. Distributive shock

C. Neurogenic shock

D. Cardiogenic shock

See Answer in Part B → Q2

@Neet_pg_bot

Q3: A 45-year-old male patient was brought to the emergency department following a road traffic accident. O/E, he had multiple injuries all over his body and was found to be in class III hemorrhagic shock. The percentage of blood loss would be between: (Q849581)

A. 5-15%

B. 30-40%

C. >40%

D. 15-30%

See Answer in Part B → Q3

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Q4: Following a road traffic accident, a 23-year-old man presents with multiple injuries on his body and the percentage of blood loss is <15%. Identify which class of ATLS classification it belongs to. (Q849582)

A. Class 1

B. Class 2

C. Class 3

D. Class 4

See Answer in Part B → Q4

@Neet_pg_bot

Q5: A 62-year-old male with a history of hypertension and type 2 diabetes presents with chest pain. His ECG shows ST-segment elevation in the anterior leads. Despite

initial treatment, his condition deteriorates with low blood pressure, rapid heart rate, and difficulty breathing. Examination reveals elevated jugular venous pressure (JVP) and crackles on lung auscultation. What type of shock is this patient most likely experiencing? (Q849583)

A. Cardiogenic shock

B. Obstructive shock

C. Hypovolemic shock

D. Septic shock

See Answer in Part B → Q5

@Neet_pg_bot

Q6: A patient admitted to the hospital with a urinary tract infection develops oliguria and lightheadedness on the third day of admission. His peripheries are warm, capillary refill is brisk, and his blood pressure is noted to be 86/56 mmHg despite fluid resuscitation. What type of shock is this patient likely experiencing? (Q849584)

A. Hypovolemic shock

B. Septic shock

C. Obstructive shock

D. Cardiogenic shock

See Answer in Part B → Q6

@Neet_pg_bot

Q7: A 42-year-old man is brought after a high-impact motor vehicle accident. On examination, he has a spinal cord injury at the level of T6 with flaccid paralysis of the lower extremities. His vital signs show hypotension, bradycardia, and warm, flushed skin. Which of the following is the most likely underlying pathophysiologic mechanism for his shock state? (Q849585)

A. Decreased cardiac output

B. Decreased blood volume

C. Increased vascular permeability

D. Decreased peripheral vascular resistance

See Answer in Part B → Q7

@Neet_pg_bot

Q8: A 28-year-old male presents with a sudden onset of severe fatigue, weakness, nausea, vomiting, and abdominal pain. On examination, he is hypotensive (BP 75/45 mmHg), tachycardic (HR 115 bpm), and has noticeable diffuse skin hyperpigmentation, especially in sun-exposed areas and palmar creases. Laboratory results reveal: Sodium: 128 mEq/L Potassium: 5.8 mEq/L Glucose: 58 mg/dL What is the most likely diagnosis? (Q849586)

A. Diabetic ketoacidosis

B. Septic shock

C. Addison's disease

D. Panhypopituitarism

See Answer in Part B → Q8

@Neet_pg_bot

Q9: A 55-year-old patient is brought to the emergency department with severe abdominal pain, tachycardia, and hypotension. Examination reveals pale, cool, and clammy skin with delayed capillary refill. The patient has oliguria. Which of the following hemodynamic profiles is most characteristic of this patient's condition? (Q849587)

A. SVR - ↓ ; CO - ↑ ; CVP - Normal or ↑

B. SVR - ↑ ; CO - ↓ ; CVP - ↓

C. SVR - ↓ ; CO - ↓ ; CVP - ↑

D. SVR - ↑ ; CO - ↑ ; CVP - ↑

See Answer in Part B → Q9

@Neet_pg_bot

Q10: A 65-year-old patient presents with sudden onset of shortness of breath, tachycardia, and hypotension. Examination reveals cool, clammy skin, and delayed capillary refill. The most appropriate initial management strategy for this patient's condition would be : (Q849588)

A. Fluid resuscitation with normal saline and initiation of norepinephrine

B. Fluid resuscitation with Ringer's lactate and initiation of dobutamine

C. Fluid resuscitation with normal saline and initiation of dopamine

D. Fluid resuscitation with Ringer's lactate and initiation of epinephrine

See Answer in Part B → Q10

@Neet_pg_bot

Q11: Among the different types of shock, which one is most common? (Q880237)

A. Hypovolemic

B. Cardiogenic

C. Obstructive

D. Distributive

See Answer in Part B → Q11

@Neet_pg_bot

Q12: A 24-year-old man is brought to the emergency department after sustaining multiple injuries in a motorcycle crash. He is hypotensive and tachycardic, and

physical examination shows cool extremities and delayed capillary refill. His body initiates compensatory mechanisms to maintain perfusion to vital organs. Which of the following tissues is least likely to maintain adequate blood flow during this compensatory response? (Q880242)

A. Brain

B. Heart

C. Kidneys

D. GI tract

See Answer in Part B → Q12

@Neet_pg_bot

Q13: Which type of shock is associated with cardiac tamponade? (Q880246)

A. Hypovolemic shock

B. Cardiogenic shock

C. Obstructive shock

D. Distributive shock

See Answer in Part B → Q13

@Neet_pg_bot

Q14: Which of the following equations correctly represents the calculation of the modified shock index? (Q880252)

A. Heart Rate divided by Systolic Blood Pressure (HR/SBP)

B. Heart Rate divided by Diastolic Blood Pressure (HR/DBP)

C. Heart Rate divided by Mean Arterial Pressure (HR/MAP)

D. Pulse Rate divided by Systolic Blood Pressure (PR/SBP)

See Answer in Part B → Q14

@Neet_pg_bot

Q15: Which of the following are included in the quick Sequential Organ Failure Assessment (qSOFA) criteria? 1. Respiratory rate ≥ 22 breaths per minute 2. Systolic blood pressure ≤ 100 mmHg 3. Altered mental status (Glasgow Coma Scale < 15) 4. Heart rate ≥ 120 beats per minute 5. Fever ≥ 38°C (Q880270)

A. 1, 2, 3

B. 2, 3, 4

C. 3, 4, 5

D. 1, 2, 4

See Answer in Part B → Q15

@Neet_pg_bot

Q16: Which of the following are not included in the Systemic Inflammatory Response Syndrome (SIRS) criteria? 1. Body temperature > 38°C or < 36°C 2. Heart rate > 90 beats per minute 3. Respiratory rate > 20 breaths per minute or PaCO■ < 32 mmHg 4. White blood cell count > 12,000/mm³ or < 4,000/mm³ or > 10% immature forms (bands) 5. Systolic blood pressure < 90 mmHg (Q880272)

A. 1 only

B. 2 and 3

C. 5 only

D. 1 and 4

See Answer in Part B → Q16

@Neet_pg_bot

• [12_Miscellaneous] 062 Tubes Catheters And Drains

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[12_Miscellaneous] 062 Tubes Catheters And Drains — Quick Jump

Q1 (p. 990) *Q2 (p. 991)* *Q3 (p. 991)* *Q4 (p. 992)* *Q5 (p. 993)* *Q6 (p. 994)*
Q7 (p. 995) *Q8 (p. 995)* *Q9 (p. 998)* *Q10 (p. 998)* *Q11 (p. 999)*

Q1: A 45-year-old patient undergoes a mastectomy for breast cancer. Post-operatively, the surgeon decides to use a closed suction drain. Which of the following drain types is shown in the image below? (Q849748)

A. Penrose drain

B. Jackson Pratt drain

C. Romovac suction drain

D. Hemovac drain



See Answer in Part B → Q1

@Neet_pg_bot

Q2: A 6-month-old infant is admitted with severe vomiting and requires placement of a gastric tube. The nurse sets up the feeding equipment as shown in the image. Which of the following tubes is correctly depicted in the image? (Q849749)

A. Nasogastric tube

B. Infant feeding tube

C. Orogastric tube

D. Jejunal feeding tube



See Answer in Part B → Q2

@Neet_pg_bot

Q3: A 45-year-old patient undergoes a choledochotomy for the removal of common bile duct stones. The surgeon decides to use the given tube during the procedure.

Which of the following statements best describes its correct use and function in this scenario? (Q849750)

A. It is inserted to provide long-term biliary drainage and should be left in place for several months.

B. It acts as a stent and is retained for 4-6 weeks in the distal filling defect.

C. It is used to create a biliary-enteric anastomosis and is removed immediately after surgery.

D. It is placed to perform intraoperative cholangiography and is removed before closing the incision.



See Answer in Part B → Q3

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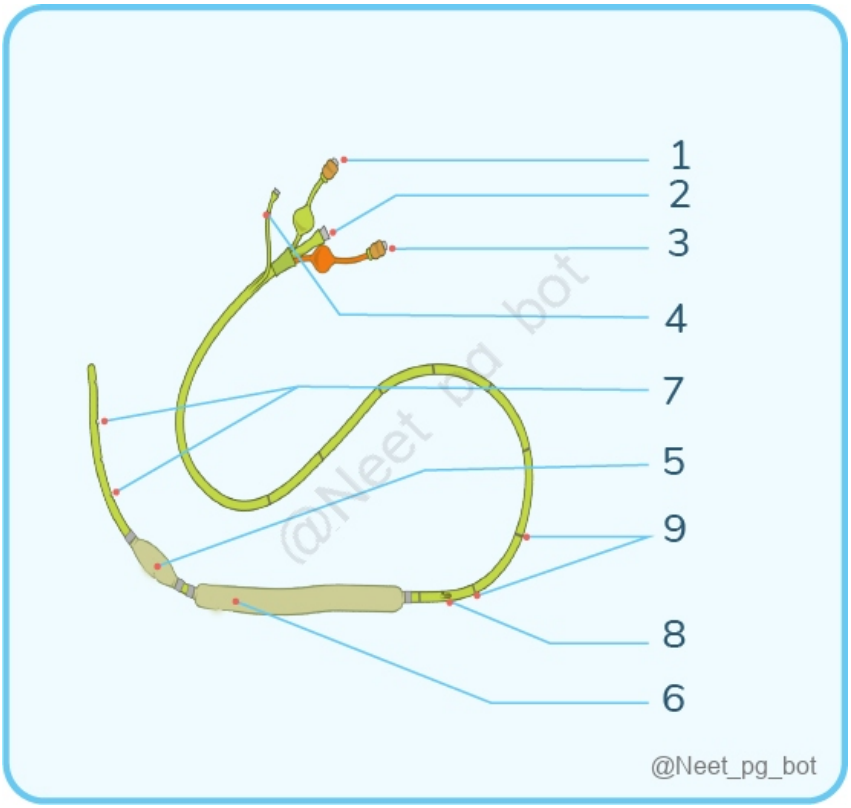
Q4: A 45-year-old patient with a history of cirrhosis presents to the emergency department with massive hematemesis. The physician uses an instrument given in the picture below. Which of the following statements is correct with respect to use of this device? (Q849751)

A. This instrument is commonly used if variceal bleeding does not stop by banding/sclerotherapy/gluing.

B. The esophageal balloon is inflated first with 30-40 mmHg pressure, followed by gastric balloon inflation with 400 mL of air.

C. It is a definitive treatment and does not require further procedures like banding or sclerotherapy.

D. The most common complication associated with its use is pressure necrosis of esophageal mucosa.



See Answer in Part B → Q4

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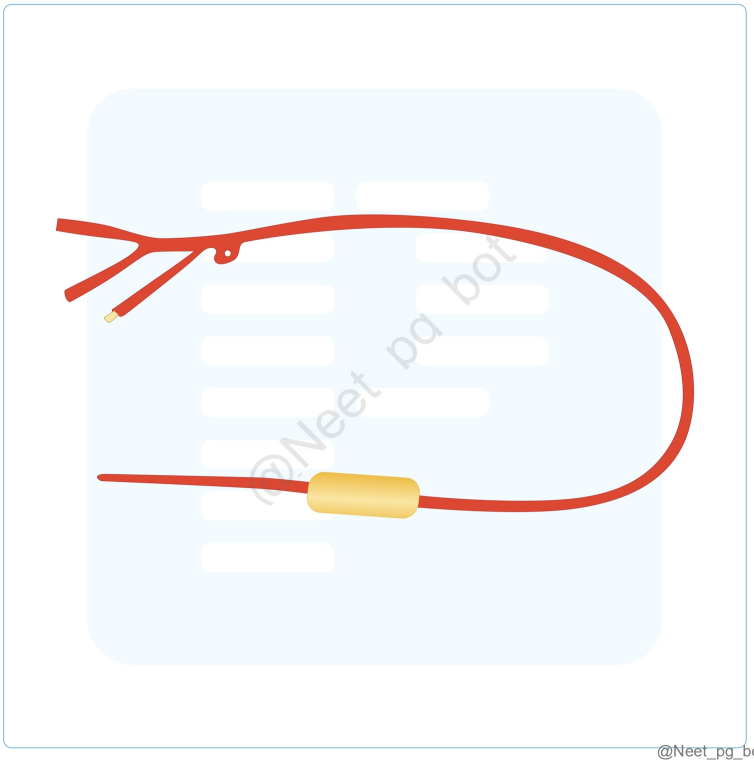
Q5: A 60-year-old man with a history of alcoholic cirrhosis presents to the emergency department with massive hematemesis. After initial stabilization, the decision is made to use the following device, as given in the picture below, for temporary management of suspected bleeding gastric varices. Which of the following statements about the device is INCORRECT? (Q849752)

A. The device shown in the picture is Sengstaken-Blakemore tube

B. It contains three lumens consisting of Esophageal and gastric aspiration port, and a port for balloon inflation

C. It has a single gastric balloon with capacity 500-600cc

D. It is used for temporary management of bleeding gastric varices



See Answer in Part B → Q5

@Neet_pg_bot

Q6: Which of the following statements about the following instrument in the image is incorrect? (Q849753)

A. The catheter is coated with silicone to minimize irritation during prolonged use.

B. For self-retaining purposes, the balloon is inflated with 20-30 ml of saline.

C. It can be used for administration of intravesical chemotherapy

D. 2-way foley’s catheter can be used for bladder irrigation following TURP



See Answer in Part B → Q6

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Q7: A 58-year-old patient is rushed to the emergency department with symptoms of acute limb ischemia. The vascular surgeon diagnoses an arterial embolism and decides to perform an embolectomy. Which of the following catheters is specifically designed and most appropriate for this procedure? (Q849764)

A. Swan-Ganz catheter

B. Fogarty Catheter

C. De-Pezzer Catheter

D. Malecot’s Catheter

See Answer in Part B → Q7

@Neet_pg_bot

Q8: Match the following: a. Foley’s catheter 1. b. Nelaton’s catheter 2. c. Malecot’s catheter 3. d. Red-rubber catheter 4. (Q849765)

A. a-3, b-4, c-1,d-2

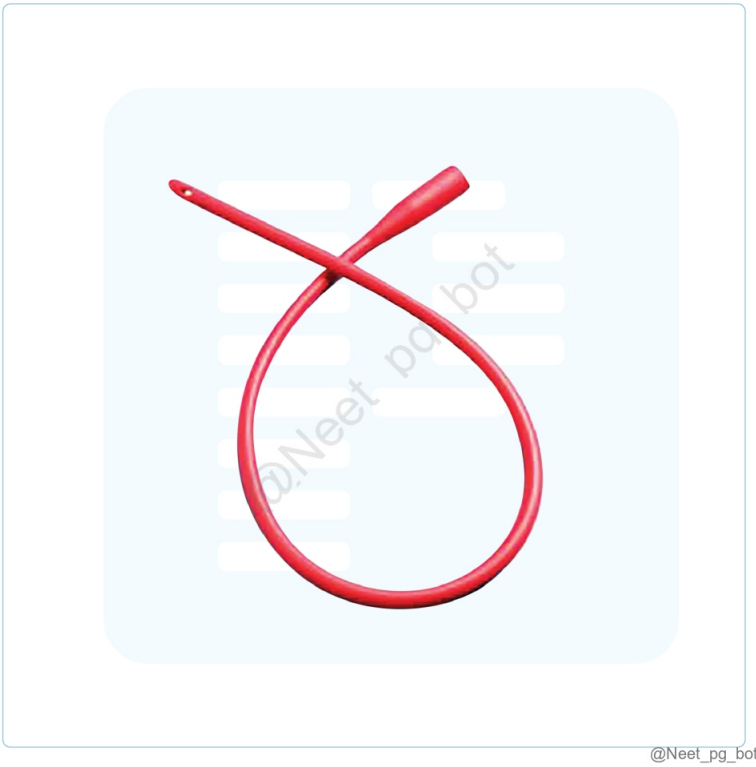
B. a-4, b-3, c-2, d-1

C. a-1, b-2, c-3, d-4

D. a-2, b-1, c-4, d-3



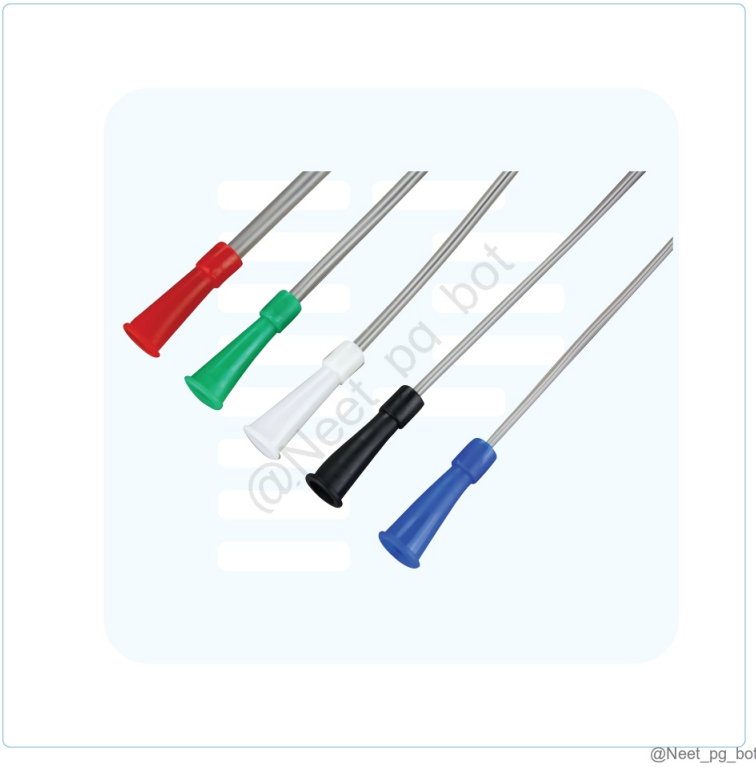
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See Answer in Part B → Q8

@Neet_pg_bot

Q9: All of the following are true statements regarding central venous catheters except- (Q849766)

A. The tip of the catheter is situated in the inferior vena cava

B. The most dangerous complication is pneumothorax

C. Inside OT, the Internal jugular vein is the preferred vein

D. In acutely injured, critically ill patients Femoral vein is the preferred vein

See Answer in Part B → Q9

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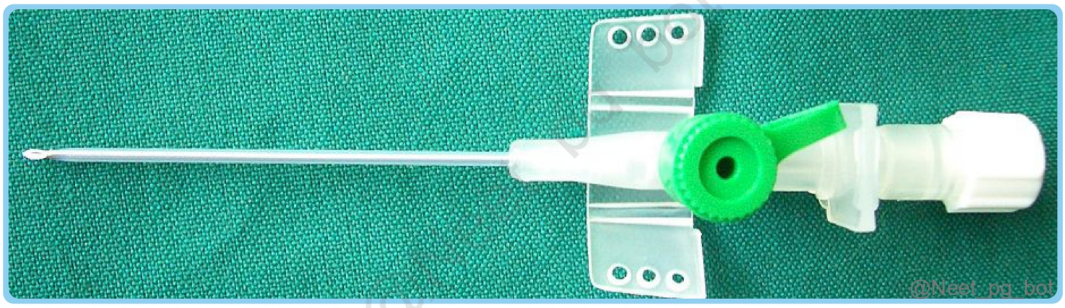
Q10: What is the size of the cannula shown in the below image? (Q849767)

A. 18G

B. 20G

C. 24G

D. 26G



See Answer in Part B → Q10

@Neet_pg_bot

Q11: All of the following about chemo-port is true, except (Q849768)

A. Retained for 5 years

B. Used for chemotherapy administration

C. The catheter is placed beneath the skin

D. The veins used are the internal jugular and subclavian veins.

See Answer in Part B → Q11

@Neet_pg_bot

• [12_Miscellaneous] 063 Instruments

« Back to Folder Directory

[12_Miscellaneous] 063 Instruments — Quick Jump

Q1 (p. 1000)	*Q2 (p. 1001)*	*Q3 (p. 1001)*	*Q4 (p. 1001)*	*Q5 (p. 1002)*	*Q6 (p. 1003)*
Q7 (p. 1003)	*Q8 (p. 1004)*	*Q9 (p. 1005)*	*Q10 (p. 1005)*	*Q11 (p. 1006)*	*Q12 (p. 1007)*
Q13 (p. 1007)	*Q14 (p. 1007)*	*Q15 (p. 1008)*	*Q16 (p. 1008)*	*Q17 (p. 1009)*	*Q18 (p. 1010)*
Q19 (p. 1011)	*Q20 (p. 1011)*	*Q21 (p. 1012)*	*Q22 (p. 1013)*	*Q23 (p. 1013)*	*Q24 (p. 1013)*
Q25 (p. 1014)	*Q26 (p. 1015)*	*Q27 (p. 1015)*	*Q28 (p. 1017)*	*Q29 (p. 1017)*	*Q30 (p. 1018)*
Q31 (p. 1020)	*Q32 (p. 1021)*				

Q1: The surgical instrument displayed in the image is not typically used for which of the following purposes? (Q880283)

A. Blunt dissection of soft tissues in pelvic surgery

B. Deep tissue dissection during vagotomy

C. Cutting sutures on the skin surface

D. Dissection during laparoscopic cholecystectomy



See Answer in Part B → Q1

@Neet_pg_bot

Q2: Which of the following is an advantage of robotic-assisted surgery over conventional laparoscopy? (Q880402)

A. Completely eliminates the need for trained surgical assistance

B. Offers fully autonomous operation without surgeon input

C. Provides motion scaling and tremor suppression for enhanced precision

D. Has lower cost compared to laparoscopic surgery

See Answer in Part B → Q2

@Neet_pg_bot

Q3: Flexible sigmoidoscopy is a diagnostic procedure commonly used to evaluate the lower gastrointestinal tract. Up to which part of the colon can a flexible sigmoidoscope typically reach? (Q880401)

A. Ascending colon

B. Hepatic flexure

C. Splenic flexure

D. Sigmoid colon

See Answer in Part B → Q3

@Neet_pg_bot

Q4: Which of the following best explains the mechanism of action of the wound management technique shown in the image? (Q880398)

A. Application of negative pressure to promote wound healing

B. Application of positive pressure to increase tissue perfusion

C. Use of foam dressing to provide antimicrobial action

D. Use of sponge material to mechanically debride the wound



See Answer in Part B → Q4

@Neet_pg_bot

Q5: Which of the following statements about the device shown in the image is true? (Q880397)

A. The electrical current passes between two closely placed electrodes on the surgical site

B. It does not require a grounding pad since the circuit is closed within the instrument

C. Unipolar cautery has a lower risk of electrical burns compared to bipolar cautery

D. The current enters the patient through the active electrode and exits via a dispersive electrode



See Answer in Part B → Q5

@Neet_pg_bot

Q6: Which of the following features is most characteristic of coagulation mode in electrosurgical diathermy? (Q880391)

A. Continuous low-voltage current with rapid heating and tissue vaporization

B. Energy concentrated over a small area with minimal lateral thermal spread

C. Intermittent high-voltage current causing tissue dehydration and protein denaturation

D. Generation of sparks used primarily for precise tissue dissection

See Answer in Part B → Q6

@Neet_pg_bot

Q7: What is the primary use of the instrument shown in the image below? (Q880390)

A. Measuring oral temperature

B. Measuring rectal temperature

C. Measuring tympanic temperature

D. Measuring axillary temperature



See Answer in Part B → Q7

@Neet_pg_bot

Q8: In adult males, which Foley catheter size is generally preferred to minimize urethral trauma while ensuring adequate drainage? (Q880385)

A. 8 French

B. 12 French

C. 16 French

D. 20 French

See Answer in Part B → Q8

@Neet_pg_bot

Q9: Identify the medical device shown in the image below: (Q880384)

A. Central venous catheter

B. Pigtail catheter

C. Foley catheter

D. Nasogastric tube



See Answer in Part B → Q9

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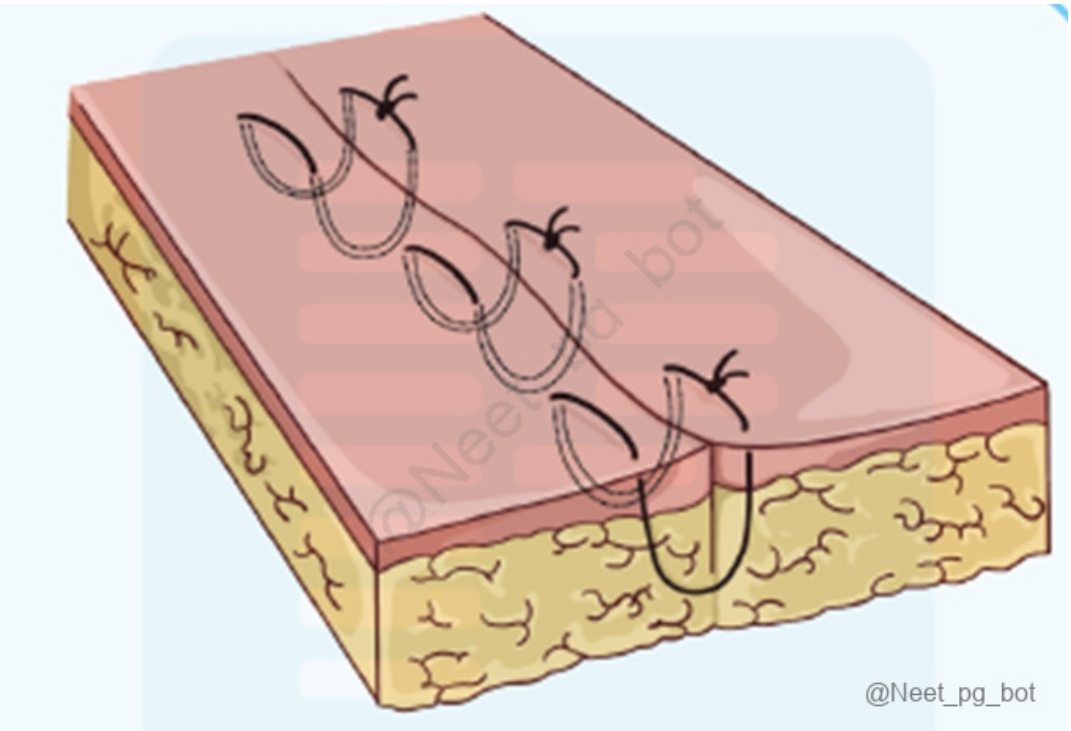
Q10: Identify the suturing technique demonstrated in the accompanying image. (Q880381)

A. Interrupted sutures

B. Continuous sutures

C. Mattress sutures

D. Subcuticular sutures



See Answer in Part B → Q10

@Neet_pg_bot

Q11: Which of the following statements about surgical knots is correct? (Q880380)

A. A square knot provides more security than a granny knot due to equal tension in both throws

B. A granny knot is preferred over a square knot for ligating blood vessels because it tightens more securely

C. A surgeon's knot involves a single throw followed by multiple throws to reduce slippage in high-tension areas

D. The slip knot is used to permanently secure sutures as it does not loosen over time.

See Answer in Part B → Q11

@Neet_pg_bot

Q12: The eye present at the tip of Kocher’s thyroid dissector is used for: (Q880379)

A. Passing ligatures through it to tie the superior pedicle

B. Fixation to the thyroid capsule

C. Holding the inferior thyroid artery

D. Injecting local anesthetic

See Answer in Part B → Q12

@Neet_pg_bot

Q13: A surgeon is performing an inguinal hernia repair and needs an instrument to retract the skin, fascia, and muscle superficially. Which retractor is most appropriate for this purpose? (Q880377)

A. Deaver retractor

B. Langenbeck retractor

C. Kocher’s intestinal clamp

D. Lahey’s thyroid tenaculum

See Answer in Part B → Q13

@Neet_pg_bot

Q14: The primary function of the instrument depicted is to, (Q880373)

A. Retracting the abdominal wall and deep viscera like liver and spleen

B. Levering tissues atraumatically to provide adequate surgical exposure

C. Clamping and holding intestinal tissue firmly during bowel surgery

D. Assisting in major abdominal surgeries such as cholecystectomy



See Answer in Part B → Q14

@Neet_pg_bot

Q15: Which of the following statements correctly describes the Morris retractor? (Q880372)

A. Self-retaining, used in oral surgery

B. Flat curved blade with blunt ridge

C. Sharp hooks for thyroid tissue

D. Toothed clamp for intestines

See Answer in Part B → Q15

@Neet_pg_bot

Q16: Which surgical instrument is depicted in the image provided below? (Q880288)

A. Langenbeck retractor

B. Kocher’s intestinal clamp

C. Doyen’s mouth gag

D. Lahey’s thyroid tenaculum



See Answer in Part B → Q16

@Neet_pg_bot

Q17: Which of the given instrument's tip resembles the given image? (Q849835)

A. Mayo's Towel Clip

B. Rampley's Sponge Holding Forceps

C. Moynihan's Tetra-Towel Clip

D. Doyen's Towel Clip



See Answer in Part B → Q17

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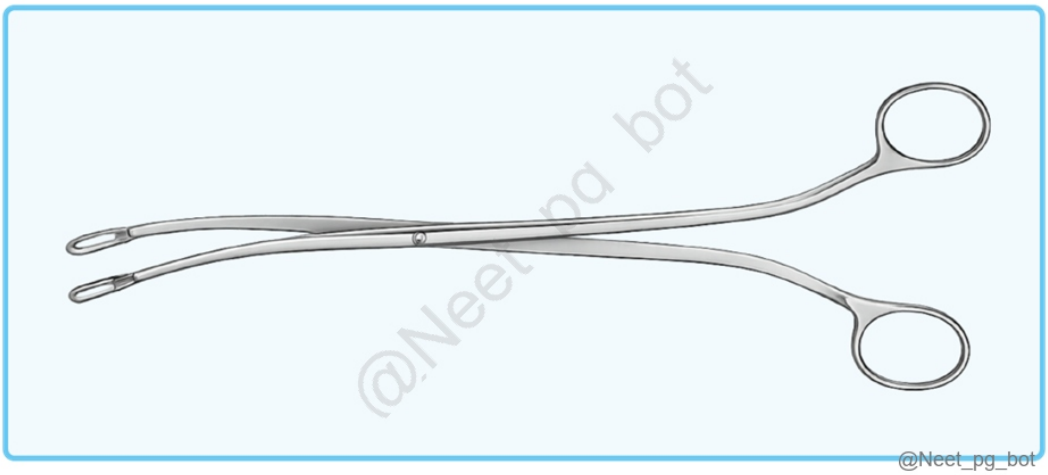
Q18: What is the name of the instrument shown below that is used for gallstone removal? (Q880278)

A. Sponge holding forceps

B. Desjardin’s choledocholithotomy forceps

C. Blakemore’s gallstone forceps

D. Tischler forceps



See Answer in Part B → Q18

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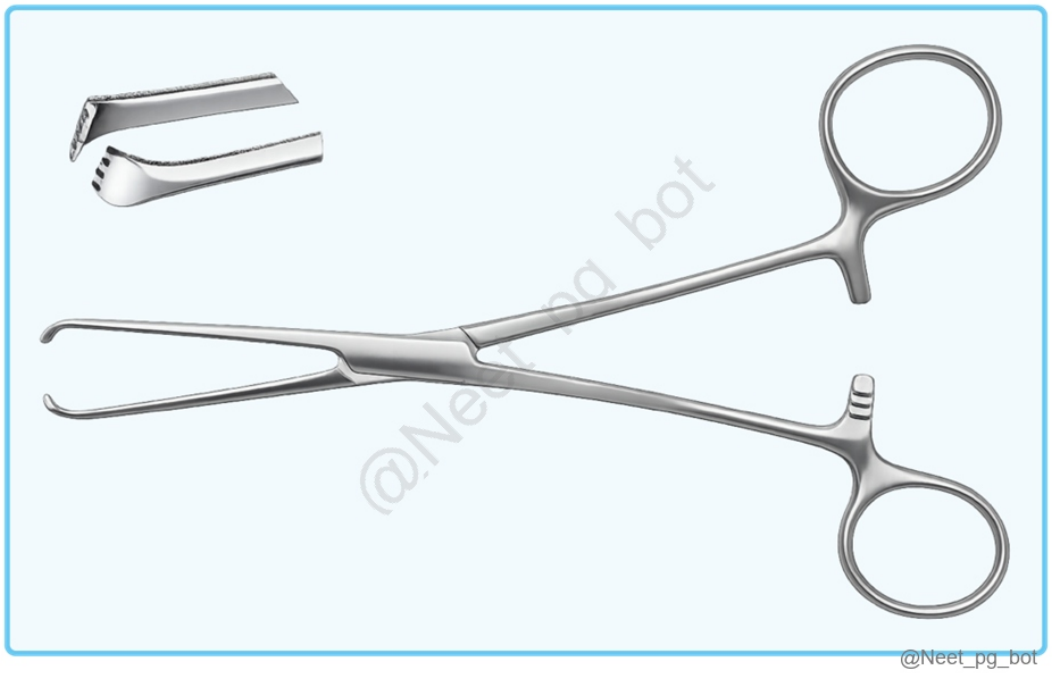
Q19: Which of the following is not a typical application of the instrument shown in the image below? (Q880275)

A. Holding the margins of vaginal flaps during a colporrhaphy operation

B. Grasping the rectus sheath during abdominal wall repair

C. Retracting bowel loops during a laparotomy

D. Holding the anterior lip of the cervix during a D&C procedure



See Answer in Part B → Q19

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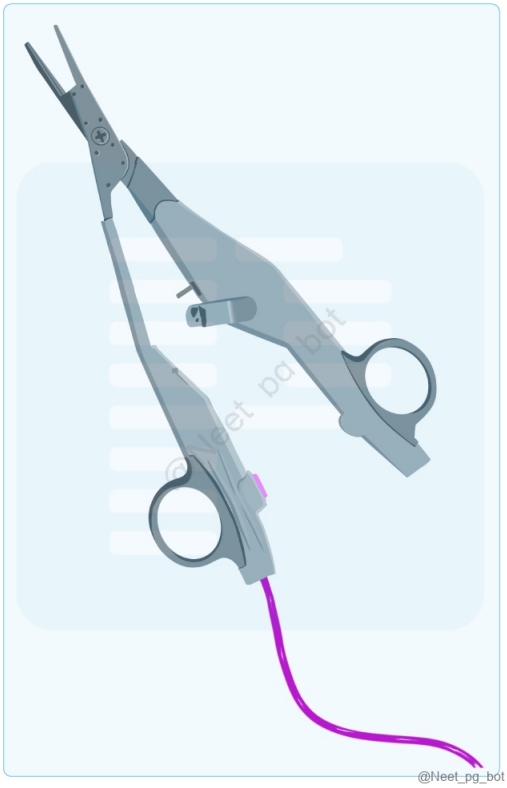
Q20: Which of the following statements is false regarding the given instrument? (Q849848)

A. Uses pressure and continuous bipolar energy for vessel sealing.

B. Achieves burst pressures over three times the normal systolic blood pressure.

C. Sealing time is 8-10 seconds.

D. Denatures collagen and elastin in vessel walls, forming a solid tissue seal.



See Answer in Part B → Q20

@Neet_pg_bot

Q21: Which of the following best describes the safety protocols for electrosurgery using diathermy? (Q849847)

A. Always use the maximum current setting to ensure effectiveness and minimize burns.

B. Bipolar diathermy is preferred in patients with implants.

C. Monopolar diathermy is preferred near vital & sensitive structures.

D. There is no need to use smoke extractors as the risk of exposure to surgical smoke is minimal.

See Answer in Part B → Q21

@Neet_pg_bot

Q22: Which laparoscopic instrument is used to establish pneumoperitoneum in the closed approach? (Q849846)

A. Hasson Cannula/Trocar

B. Veress Needle

C. Laparoscopic Camera

D. Secondary Trocar

See Answer in Part B → Q22

@Neet_pg_bot

Q23: Which of the following instruments is used to assess the patency of CBD? (Q849845)

A. Bakes Dilator

B. Tracheal Dilator

C. Urethral Dilator

D. Filiform Bougies

See Answer in Part B → Q23

@Neet_pg_bot

Q24: Which of the following statements correctly differentiates Mayo scissors from Metzenbaum scissors? (Q849844)

A. Mayo scissors are designed for delicate dissection while Metzenbaum scissors are sturdy and suited for cutting dense tissues.

B. Mayo scissors are sturdy and suitable for cutting dense tissues, while Metzenbaum scissors are ideal for blunt dissection and fine tissue work.

C. Metzenbaum scissors are used for cutting dense tissues, while Mayo scissors are for blunt dissection in thoracic surgeries.

D. Metzenbaum scissors are suitable for cutting sutures and are sturdy, whereas Mayo scissors are delicate and used for blunt dissection

See Answer in Part B → Q24

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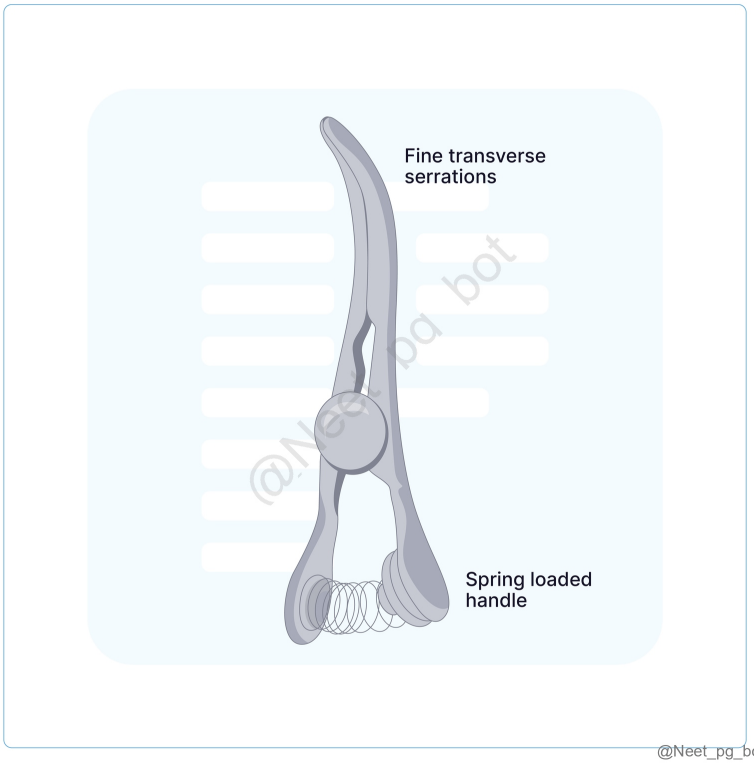
Q25: Identify the following instrument: (Q849843)

A. Payr’s gastric occlusion clamp

B. Potts bulldog clamp

C. Doyens intestinal occlusion clamp

D. Lights bulldog clamp



See Answer in Part B → Q25

@Neet_pg_bot

Q26: Which of the following is used to retract the scapula during thoracotomy? (Q849842)

See Answer in Part B → Q26

@Neet_pg_bot

Q27: Match the following instruments with their respective images: 1. Kocher’s forceps A) 2. Mosquito forceps B) 3. Allis forceps C) 4. Babcock’s forceps D) (Q849841)

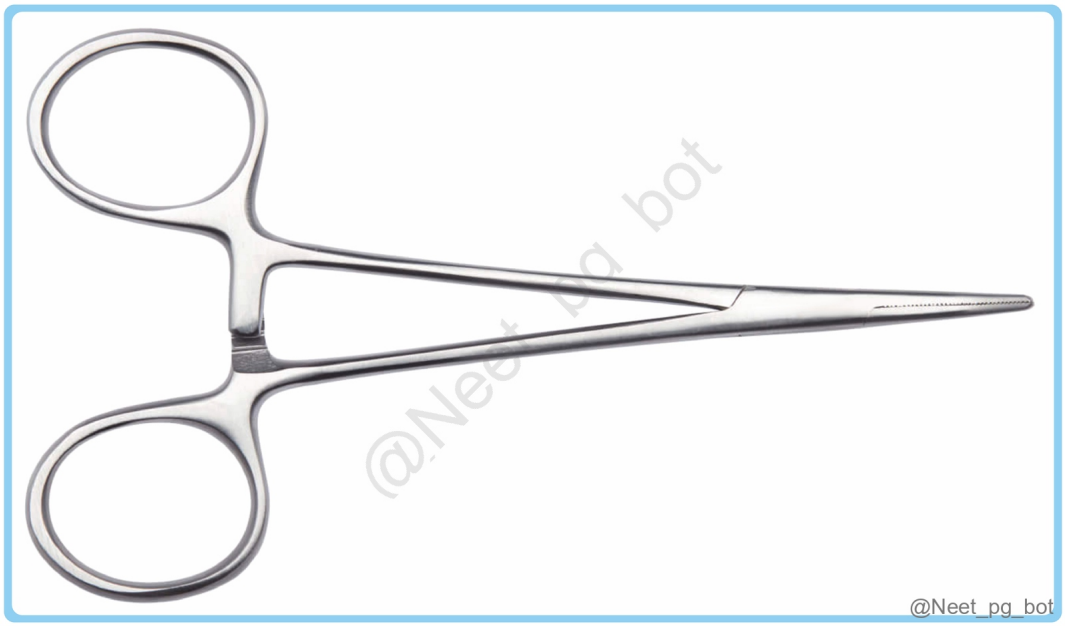
A. 1-A,2-B,3-C,4-D

B. 1-B,2-C,3-A,4-D

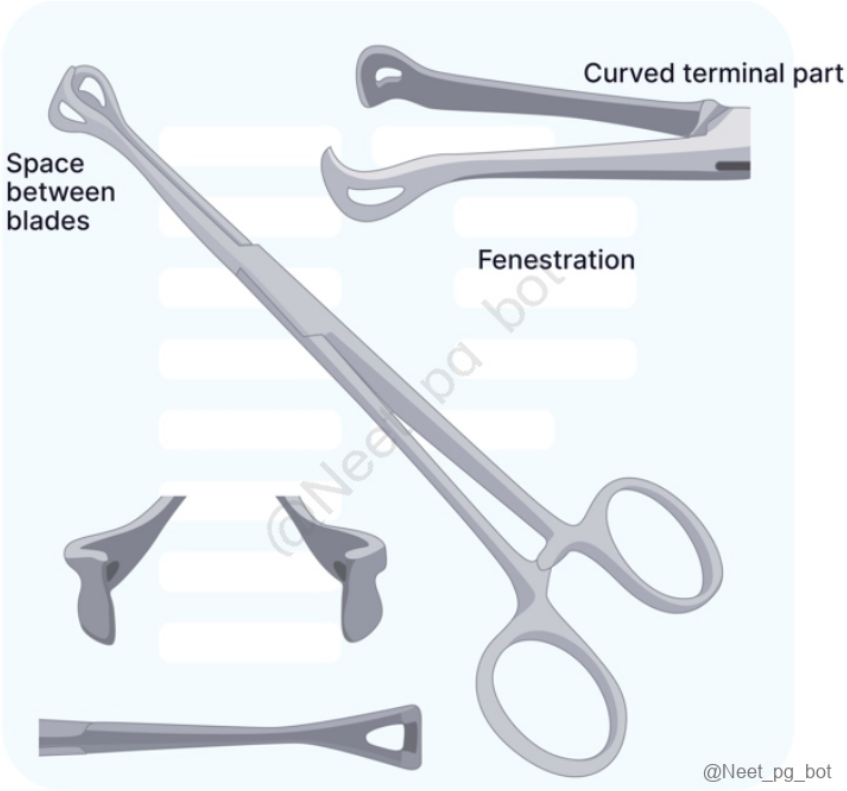
C. 1-C,2-B,3-1,4-D

D. 1-D,2-A,3-B,4-C




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See Answer in Part B → Q27

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Q28: A 45 year old woman undergoes surgery for varicose veins involving the stripping of the long saphenous vein using a Mayo vein stripper. Post-operatively, she complains of pain and tingling along the medial aspect of her leg. Which nerve is most commonly damaged during the stripping of the long saphenous vein? (Q849840)

A. Sciatic nerve

B. Tibial nerve

C. Saphenous nerve

D. Femoral nerve

See Answer in Part B → Q28

@Neet_pg_bot

Q29: A 60 year old male presents with rectal bleeding and a history of hemorrhoids. His physician decides to perform a proctoscopy using Kelly's rectal speculum to assess the cause of the bleeding. Which of the following is NOT an indication of the use of Kelly's rectal speculum? (Q849839)

A. Diagnosing piles

B. Treating partial rectal prolapse

C. Treating acute anal fissure

D. Assessing rectal carcinoma

See Answer in Part B → Q29

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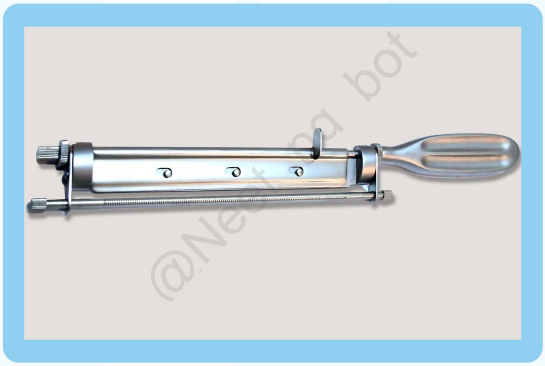
Q30: Match the following instruments with their corresponding images: 1) a) Bone nibbler 2) b) Humby’s Knife 3) c) Rib Shear 4) d) Bone Cutter (Q849838)

A. 1-a. 2-d, 3-c, 4-b

B. 1-b, 2-c, 3-d, 4-a

C. 1-b, 2-a, 3-d, 4-c

D. 1-c, 2-a, 3-d, 4-b



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See Answer in Part B → Q30

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Q31: Which of the following statements is FALSE? (Q849837)

A. The needle holder is sterilized by an autoclave.

B. Toothed dissecting forceps are used to hold delicate structures like nerves and vessels.

C. Curved needle holders provide better maneuverability in deep areas like the pelvis.

D. Plain non-toothed dissecting forceps are used to hold friable structures like peritoneum and tendons.

See Answer in Part B → Q31

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Q32: Match the following Blade numbers with their uses given. 1. No. 11 a) Skin incisions in major surgeries 2. No. 12 b) Used in plastic surgery 3. No. 15 c) Incision and drainage of abscesses 4. No. 22 d) Used for tonsillectomy (Q849836)

A. 1-d, 2-c, 3-a, 4-b

B. 1-a, 2-b, 3-d, 4-c

C. 1-c, 2-a, 3-b, 4-d

D. 1-c, 2-d, 3-b, 4-a

See Answer in Part B → Q32

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• [12_Miscellaneous] 064 Pediatric Surgery

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[12_Miscellaneous] 064 Pediatric Surgery — Quick Jump

Q1 (p. 1022) *Q2 (p. 1022)* *Q3 (p. 1023)* *Q4 (p. 1023)* *Q5 (p. 1024)* *Q6 (p. 1025)*
Q7 (p. 1025) *Q8 (p. 1026)* *Q9 (p. 1027)* *Q10 (p. 1027)* *Q11 (p. 1027)* *Q12 (p. 1028)*
Q13 (p. 1028) *Q14 (p. 1029)* *Q15 (p. 1029)* *Q16 (p. 1029)* *Q17 (p. 1030)* *Q18 (p. 1031)*
Q19 (p. 1031) *Q20 (p. 1032)* *Q21 (p. 1032)* *Q22 (p. 1033)* *Q23 (p. 1033)* *Q24 (p. 1034)*
Q25 (p. 1034)

Q1: At 2 days of life, a male newborn becomes irritable and inconsolable. He is noted to have abdominal distension. He failed to pass meconium since being born. A follow-up barium enema shows microcolon and terminal ileum with meconium. What is the most probable diagnosis? (Q849737)

A. Sigmoid volvulus

B. Hirschsprung disease

C. Duodenal atresia

D. Meconium ileus

See Answer in Part B → Q1

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Q2: A 14-year-old boy presents with pain in the right lower abdomen and lower back. On clinical examination, there is discomfort in the right hip during passive extension, along with a palpable swelling in the right lumbar area extending towards the groin. What is the most likely diagnosis? (Q880413)

A. Pyelonephritis

B. Psoas abscess

C. Appendicitis

D. Torsion of the right undescended testis

See Answer in Part B → Q2

@Neet_pg_bot

Q3: Which of the following is the most frequently encountered extracranial solid malignancy in the pediatric age group? (Q880412)

A. Neuroblastoma

B. Nephroblastoma

C. Medulloblastoma

D. Rhabdomyosarcoma

See Answer in Part B → Q3

@Neet_pg_bot

Q4: A pediatric surgery resident evaluates a newborn presenting with an abdominal wall malformation. Which of the following statements about this condition is incorrect? (Q880408)

A. The central abdominal wall defect can exceed 4 cm in size

B. This malformation typically occurs without any associated congenital anomalies

C. The covering sac consists of amnion and peritoneum

D. This defect forms part of Cantrell’s pentalogy



See Answer in Part B → Q4

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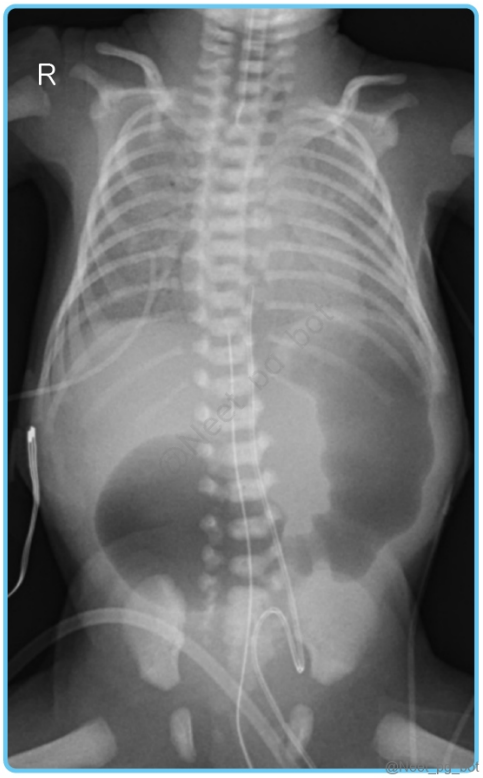
Q5: A newborn, 3 days old, has repeated episodes of bilious vomiting. The erect abdominal X-ray is shown. What should be the immediate next step in management? (Q880407)

A. CT scan of the abdomen

B. Gastrografin follow-through

C. Abdominal ultrasound

D. Exploratory laparotomy



See Answer in Part B → Q5

@Neet_pg_bot

Q6: Among all the types of gastrointestinal atresias, which one occurs most frequently? (Q880406)

A. Duodenal atresia

B. Colonic atresia

C. Ileal atresia

D. Jejunal atresia

See Answer in Part B → Q6

@Neet_pg_bot

Q7: A 10-day-old female baby was brought to the OPD with the following findings as shown in the image given below. On examination there is no cough impulse in the swelling. X-ray examination shows the erosion of the coccyx. The most likely clinical diagnosis would be: (Q849745)

A. Spina bifida

B. Myelomeningocele

C. Sacrococcygeal teratoma

D. Sacral agenesis



See Answer in Part B → Q7

@Neet_pg_bot

Q8: How will you manage a case of anorectal malformation with no visible fistula in a female patient with cross-table lateral X-ray showing rectum below the coccyx? (Q849744)

A. Protective colostomy followed by posterior sagittal anorectoplasty

B. Anoplasty

C. Colostomy

D. None of the above

See Answer in Part B → Q8

@Neet_pg_bot

Q9: Which of the following diagnostic methods is used to differentiate between a high and low lesion in anorectal malformation, and how does it determine the location of the rectum? (Q849743)

A. Abdominal ultrasound; identifies the rectal location by imaging the entire pelvic cavity.

B. MRI of the pelvis; differentiates based on the presence of anatomical anomalies in the pelvic floor

C. Invertogram; assesses the rectal termination by the rise of gas in relation to the pelvic floor.

D. X-ray of the pelvis; determines rectal termination based on bone structures and distance from the pelvic floor.

See Answer in Part B → Q9

@Neet_pg_bot

Q10: Which of the following accurately describes a component and a step involved in the LADD's operation for managing intestinal malrotation? (Q849742)

A. Appendectomy; Division of LADD’s bands near the medial aspect of the duodenum

B. Reduction of volvulus; Widening of the mesenteric base by mobilizing the duodenum

C. Bowel repositioning; Resection of viable bowel wrapped in warm, moist sponges

D. Division of LADD’s bands; Placement of the duodenum and proximal jejunum on the left side of the abdomen

See Answer in Part B → Q10

@Neet_pg_bot

Q11: A 3-week-old infant presents with sudden-onset bilious vomiting and lethargy. The baby has been experiencing intermittent abdominal pain and has not been gaining

weight as expected. On examination, the infant shows signs of poor perfusion and decreased urine output. Which of the following is the most likely diagnosis, and what should be the primary investigation to confirm it? (Q849741)

A. Intestinal Malrotation with Midgut Volvulus; Upper GI Contrast Study

B. Pyloric Stenosis; Upper GI Contrast Study

C. Intestinal Malrotation with Midgut Volvulus; Barium Swallow Study

D. Pyloric Stenosis; Barium Swallow Study

See Answer in Part B → Q11

@Neet_pg_bot

Q12: Which of the following statements is true about hyper-rotation of intestines? (Q849740)

A. The cecum is located in the left hypochondrium

B. The cecum is in the midline inferior to the pylorus

C. Arrested counter-clockwise rotation around 180°

D. The presence of Ladd's bands is noticed

See Answer in Part B → Q12

@Neet_pg_bot

Q13: A 3-day-old male baby is brought with complaints of irritable crying. Mother gave the history of not passing meconium in the first 48 hours of life. On examination, abdominal distension was seen with rebound tenderness and reduced bowel sounds. Identify the condition. (Q849739)

A. Complicated meconium ileus

B. Sigmoid volvulus

C. Duodenal atresia

D. Midgut volvulus

See Answer in Part B → Q13

@Neet_pg_bot

Q14: A 35-year-old man presents with recurrent chest infections and dyspnea. Chest CT reveals a 5 cm, well-defined, fluid-filled cystic lesion in the right paratracheal region. What is the most likely diagnosis? (Q849720)

A. Pulmonary sequestration

B. Bronchogenic cyst

C. Pericardial cyst

D. Hydatid cyst

See Answer in Part B → Q14

@Neet_pg_bot

Q15: Which of the following statements about the meconium plug are false? (Q849736)

A. Associated with hypothyroidism and cystic fibrosis

B. X-ray of the abdomen shows the corkscrew's appearance

C. Water-soluble contrast enema is used for diagnosis and therapeutic purposes.

D. It is mostly seen in preterm infants.

See Answer in Part B → Q15

@Neet_pg_bot

Q16: All of the following are true about small bowel duplication except? (Q849735)

A. These are submucosa-lined structures in continuity with the GI tract

B. The most common site is the ileum

C. Cystic duplication is the most common type

D. Located along the mesenteric border

See Answer in Part B → Q16

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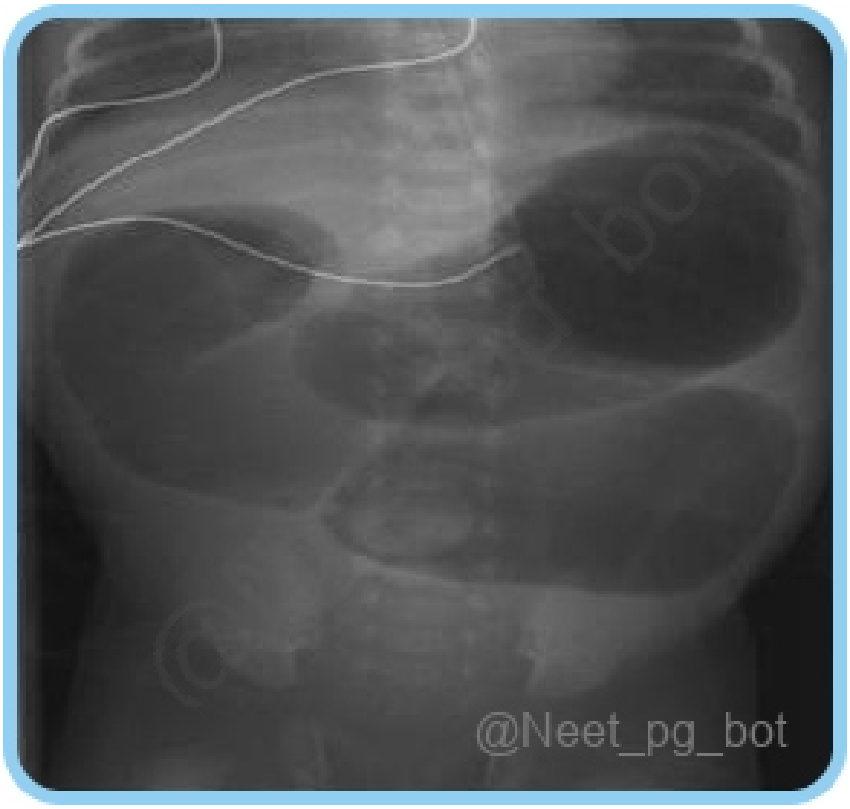
Q17: A 3-day-old neonate presents with abdominal distension and bilious vomiting. An erect X-ray of the abdomen is done, as shown below. What is the most probable diagnosis you suspect? (Q849729)

A. Jejunoileal atresia

B. Congenital diaphragmatic hernia

C. Sigmoid volvulus

D. Duodenal atresia



See Answer in Part B → Q17

@Neet_pg_bot

Q18: On observing the following finding in the X-ray of a baby with a history of Down's syndrome, what is the most likely diagnosis you would suspect? (Q849728)

A. Duodenal atresia

B. Ileal atresia

C. Jejunal atresia

D. Congenital hypertrophic pyloric stenosis



See Answer in Part B → Q18

@Neet_pg_bot

Q19: An 8-week-old infant is diagnosed with type 3 biliary atresia. The surgical team is planning the most appropriate intervention for this patient. Which of the following describes the preferred surgical approach for this patient? (Q849727)

A. Liver transplantation

B. Kasai porto-enterostomy

C. Choledochoenterostomy

D. Conservative management with ursodeoxycholic acid

See Answer in Part B → Q19

@Neet_pg_bot

Q20: A 3-week-old infant is brought to the pediatrician with persistent jaundice and pale, clay-colored stools. The parents report that the baby is not gaining weight as expected. On physical examination, the infant appears jaundiced and the liver is palpable 2 cm below the right costal margin. Which of the following diagnostic tests would be most specific for confirming the suspected diagnosis? (Q849726)

A. Abdominal ultrasound

B. CECT

C. Hepatobiliary scintigraphy

D. Intraoperative cholangiogram

See Answer in Part B → Q20

@Neet_pg_bot

Q21: A 6-week-old infant presents with persistent jaundice and acholic stools. After initial workup, a congenital hepatobiliary disorder is suspected. Intraoperative cholangiography reveals complete obliteration of the common bile duct, cystic duct, and hepatic duct up to the porta hepatis. Based on the Kasai Classification, which type of this condition does this infant have? (Q849725)

A. Type 1

B. Type 2A

C. Type 2B

D. Type 3

See Answer in Part B → Q21

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Q22: A newborn is diagnosed with Type A Tracheoesophageal fistula (TEF). The surgical team is discussing treatment options based on the gap between the proximal and distal ends of the esophagus. On further investigations, the gap is considerably larger. Which of the following will be the correct management for this patient? (Q849724)

A. Tension-free Esophago-Esophagostomy

B. Feeding gastrostomy followed by tension free Esophago-Esophagostomy

C. Excision of fistula tract + Tension-free esophago-esophagostomy.

D. Excision of fistula tract + repair of the defect.

See Answer in Part B → Q22

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Q23: A newborn male presents with continuous drooling of saliva from the mouth and regurgitation of feeds given orally. When attempting to pass a nasogastric tube, the physician notices that it coils in the esophagus and cannot be passed into the stomach. X-ray reveals the presence of gas in the gastrointestinal tract below the diaphragm. Further evaluation reports the presence of cardiovascular abnormality. Which of the following cardiac abnormalities is most likely to be seen? (Q849723)

A. Ventricular septal defect (VSD)

B. Patent ductus arteriosus (PDA)

C. Tetralogy of Fallot (TOF)

D. Atrial septal defect (ASD)

See Answer in Part B → Q23

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Q24: A 45-year-old man presents with progressive dyspnea on exertion. Chest X-ray shows an elevated left hemidiaphragm. Further imaging reveals thinning and upward displacement of the left hemidiaphragm without any defect. What is the most appropriate management? (Q849722)

A. Observation and follow-up

B. Plication of the diaphragm

C. Mesh repair

D. Pneumoperitoneum induction

See Answer in Part B → Q24

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Q25: A 20-year-old female presents with recurrent hemoptysis. CT angiography reveals a dense lesion in the left lower lobe with arterial supply from the descending thoracic aorta. Which of the following is the most likely diagnosis? (Q849721)

A. Intralobar pulmonary sequestration

B. Extralobar pulmonary sequestration

C. Bronchogenic cyst

D. Congenital cystic adenomatoid malformation

See Answer in Part B → Q25

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• [12_Miscellaneous] 065 Previous Year Questions

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[12_Miscellaneous] 065 Previous Year Questions — Quick Jump

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Q7 (p. 1039)	*Q8 (p. 1039)*	*Q9 (p. 1040)*	*Q10 (p. 1040)*	*Q11 (p. 1041)*	*Q12 (p. 1041)*
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Q43 (p. 1057)	*Q44 (p. 1058)*	*Q45 (p. 1058)*	*Q46 (p. 1059)*	*Q47 (p. 1059)*	*Q48 (p. 1060)*
Q49 (p. 1060)	*Q50 (p. 1061)*	*Q51 (p. 1061)*	*Q52 (p. 1061)*	*Q53 (p. 1062)*	*Q54 (p. 1062)*
Q55 (p. 1063)	*Q56 (p. 1063)*	*Q57 (p. 1064)*	*Q58 (p. 1065)*	*Q59 (p. 1066)*	*Q60 (p. 1066)*
Q61 (p. 1067)	*Q62 (p. 1068)*	*Q63 (p. 1069)*	*Q64 (p. 1069)*	*Q65 (p. 1070)*	*Q66 (p. 1071)*
Q67 (p. 1071)	*Q68 (p. 1072)*	*Q69 (p. 1073)*	*Q70 (p. 1073)*	*Q71 (p. 1074)*	*Q72 (p. 1074)*
Q73 (p. 1075)	*Q74 (p. 1075)*	*Q75 (p. 1075)*	*Q76 (p. 1076)*	*Q77 (p. 1076)*	*Q78 (p. 1077)*
Q79 (p. 1077)	*Q80 (p. 1077)*	*Q81 (p. 1078)*	*Q82 (p. 1079)*	*Q83 (p. 1080)*	*Q84 (p. 1080)*
Q85 (p. 1081)	*Q86 (p. 1082)*	*Q87 (p. 1082)*	*Q88 (p. 1083)*	*Q89 (p. 1084)*	*Q90 (p. 1084)*
Q91 (p. 1085)	*Q92 (p. 1085)*	*Q93 (p. 1086)*	*Q94 (p. 1086)*	*Q95 (p. 1087)*	*Q96 (p. 1088)*
Q97 (p. 1088)	*Q98 (p. 1089)*	*Q99 (p. 1089)*	*Q100 (p. 1089)*	*Q101 (p. 1090)*	*Q102 (p. 1091)*
Q103 (p. 1091)	*Q104 (p. 1091)*	*Q105 (p. 1092)*	*Q106 (p. 1092)*	*Q107 (p. 1093)*	*Q108 (p. 1093)*
Q109 (p. 1094)	*Q110 (p. 1094)*	*Q111 (p. 1094)*	*Q112 (p. 1095)*	*Q113 (p. 1096)*	*Q114 (p. 1097)*
Q115 (p. 1098)	*Q116 (p. 1099)*	*Q117 (p. 1100)*	*Q118 (p. 1100)*	*Q119 (p. 1101)*	*Q120 (p. 1101)*
Q121 (p. 1102)	*Q122 (p. 1102)*	*Q123 (p. 1103)*	*Q124 (p. 1103)*	*Q125 (p. 1104)*	*Q126 (p. 1104)*
Q127 (p. 1104)	*Q128 (p. 1105)*	*Q129 (p. 1105)*	*Q130 (p. 1106)*	*Q131 (p. 1106)*	*Q132 (p. 1107)*
Q133 (p. 1108)	*Q134 (p. 1108)*	*Q135 (p. 1109)*	*Q136 (p. 1109)*	*Q137 (p. 1109)*	*Q138 (p. 1110)*
Q139 (p. 1111)	*Q140 (p. 1112)*	*Q141 (p. 1112)*	*Q142 (p. 1113)*	*Q143 (p. 1114)*	*Q144 (p. 1116)*
Q145 (p. 1116)	*Q146 (p. 1117)*	*Q147 (p. 1117)*	*Q148 (p. 1118)*	*Q149 (p. 1118)*	*Q150 (p. 1119)*

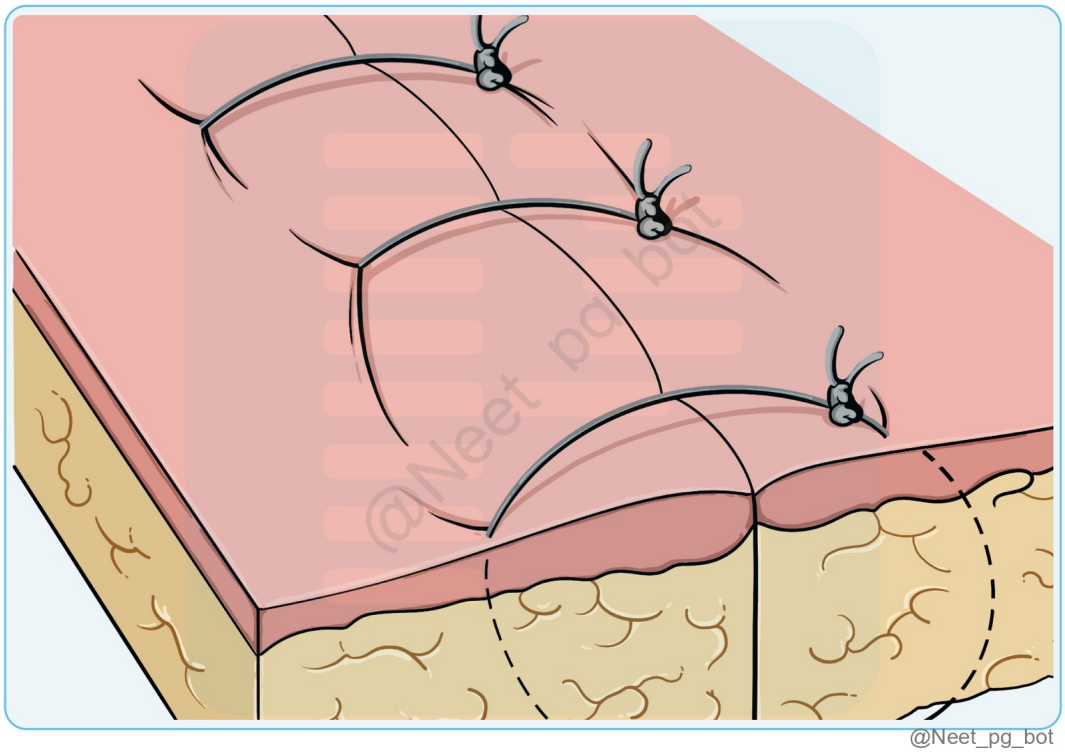
Q1: Identify the types of sutures? (Q866904)

A. Vertical Mattress

B. Horizontal mattress

C. Subcuticular suture

D. Simple Interrupted suture



See Answer in Part B → Q1

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Q2: Given below what is the correct sequence of Damage control surgery? 1. Patient selection 2. Primary exploration 3. ICU care 4. Secondary exploration (Q866908)

A. 1,2,3,4

B. 2,1,4,3

C. 3,1,2,4

D. 1,3,2,4

See Answer in Part B → Q2

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Q3: After an RTA patient has severe Maxillofacial trauma with SpO2 80% at room air, and the patient cannot be intubated or ventilated, what should be your immediate step for this? (Q866924)

A. Cricothyrotomy

B. Tracheostomy

C. ICD insertion

D. Do suction and again try intubation

See Answer in Part B → Q3

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Q4: A child comes after a train accident with stable vitals but a big laceration on the leg. Which triage category does the patient come under? (Q866932)

A. Red

B. Yellow

C. Green

D. Black

See Answer in Part B → Q4

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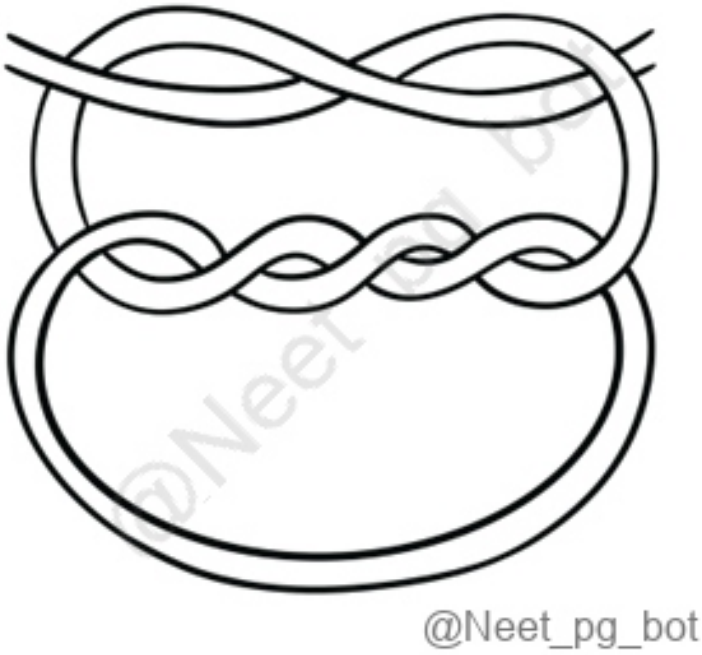
Q5: Identify the knot? (Q866418)

A. Granny’s knot

B. Reef knot

C. Double Knot

D. Surgeons knot



See Answer in Part B → Q5

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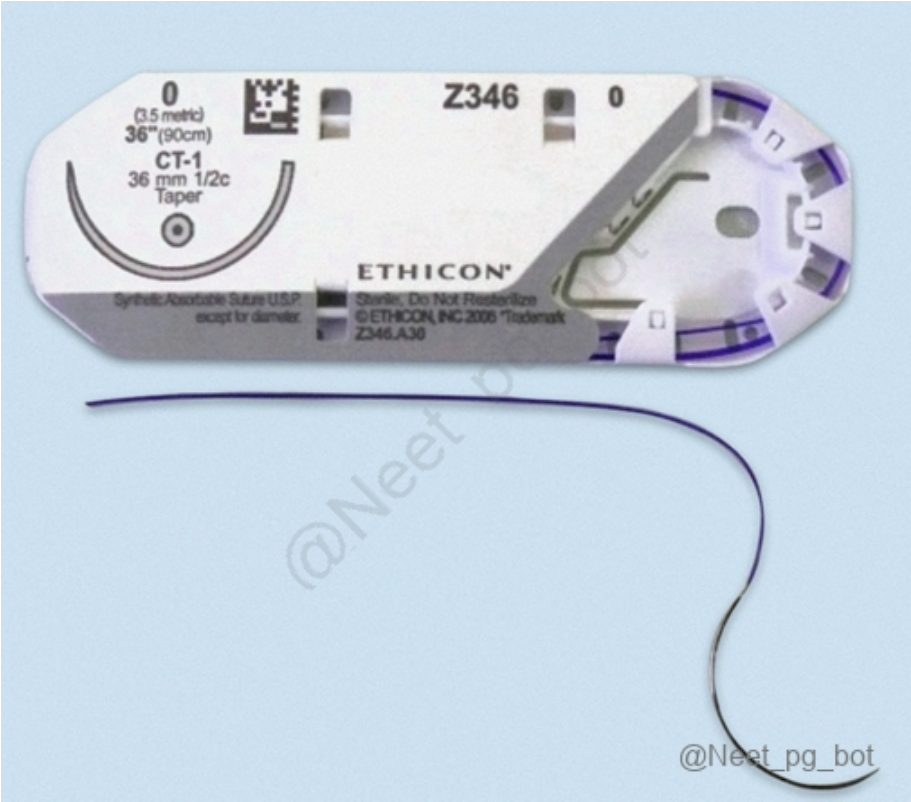
Q6: What is correct regarding this suture ? (Q866449)

A. Non absorbable

B. Monofilament

C. Braided multiflament

D. Collagen derived



See Answer in Part B → Q6

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Q7: A patient arrives at the emergency room with a penetrating injury and low blood pressure (hypotension). What is the most appropriate next step in managing this patient? (Q866481)

A. Emergency laparotomy

B. Computed Tomography (CT) scan

C. Diagnostic Peritoneal Lavage (DPL)

D. Ultrasonography (USG) of the abdomen

See Answer in Part B → Q7

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Q8: Apart from the abdominal cavity, which body part is included in e-FAST? (Q856756)

A. Pelvic Cavity

B. Peripheral vessels

C. Thoracic cavity

D. Dural and subdural spaces

See Answer in Part B → Q8

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Q9: According to GCS, a verbal score of 1 indicates: (Q859598)

A. No Verbal response

B. Inappropriate words

C. Incomprehensible sounds

D. Oriented response

See Answer in Part B → Q9

@Neet_pg_bot

Q10: Most common site of peripheral aneurysm? (Q859603)

A. Brachial artery

B. Popliteal artery

C. Radial artery

D. Femoral artery

See Answer in Part B → Q10

@Neet_pg_bot

Q11: Which one of the following is absent in cases of massive blood transfusion? (Q859604)

A. DIC

B. Febrile transfusion reaction

C. Hypercalcemia

D. Thrombocytopenia

See Answer in Part B → Q11

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Q12: Which of the following statements about ranula is FALSE? (Q859629)

A. Mucus extravasation cyst

B. Arises from submandibular salivary gland

C. Bluish, translucent cystic swelling on the floor of the mouth

D. Marsupialization or excision is the treatment

See Answer in Part B → Q12

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Q13: What is the probable diagnosis for a patient who is taking steroids for psoriasis and is experiencing a low-grade fever only at night, weight loss, and an ulcer on her neck with undermined edges, as depicted in the provided image? (Q859630)

A. Psoriasis flare-up

B. Tubercular lymphadenitis

C. Lymphosarcoma

D. Syphilis



See Answer in Part B → Q13

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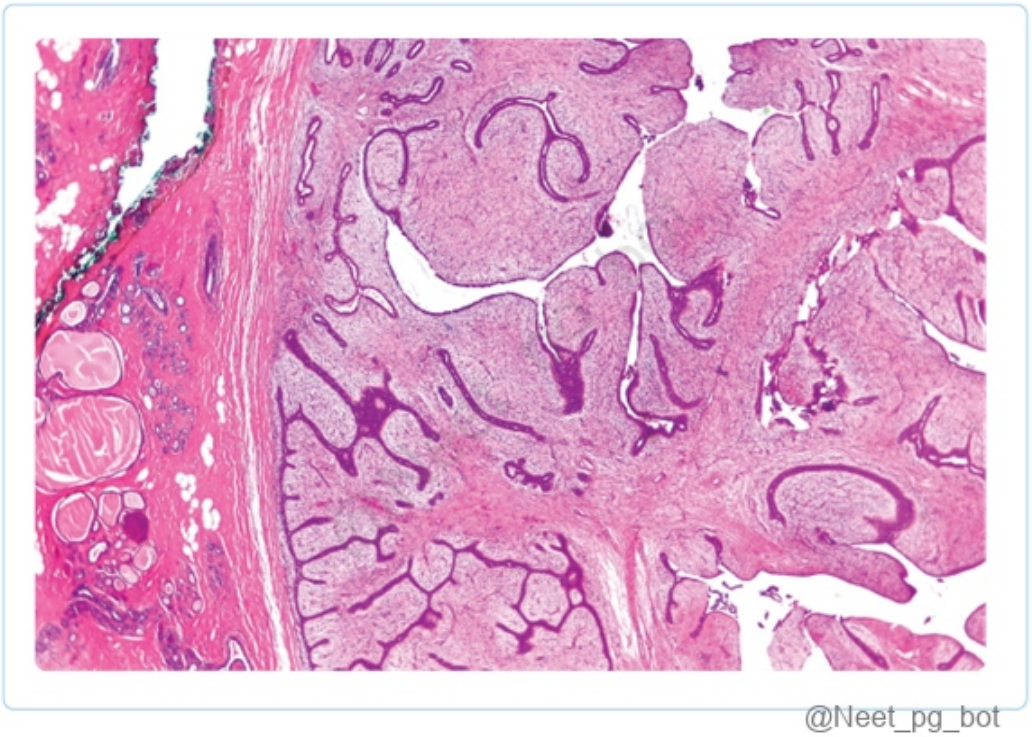
Q14: A 45-year-old woman comes to the OPD with a history of a lump in the left breast. On clinical examination, the size of the lump in the left breast is 9x10 cm with the following appearance and no axillary lymphadenopathy. The histopathology of the biopsy from the lump shows increased stromal cellularity and typical leaflike architecture. What is your likely diagnosis? (Q859852)

A. Phyllodes tumour

B. Giant fibroadenoma

C. Inflammatory carcinoma

D. Ductal carcinoma



See Answer in Part B → Q14

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Q15: What is the diagnosis from the given abdominal x-ray? (Q859880)

A. Ureterocoele

B. Pelvic bone fracture

C. Rectal foreign body

D. Bladder stone



See Answer in Part B → Q15

@Neet_pg_bot

Q16: Which of the following is not a component of TNM stage T4b breast cancer? (Q865312)

A. Ulceration

B. Peau d’orange

C. Inflammatory carcinoma

D. Ipsilateral macroscopic satellite nodules

See Answer in Part B → Q16

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Q17: A patient presents with a breast lump, and imaging (X-ray mammography) along with histopathology confirms a diagnosis of breast cancer. She has a family history of breast cancer involving two relatives and has a 29-year-old daughter. Which gene should be tested to assess hereditary breast cancer risk in this patient? (Q865316)

A. BRCA1

B. TP53

C. BRCA2

D. STK11

See Answer in Part B → Q17

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Q18: A 65-year-old patient is on mechanical ventilation for acute respiratory distress syndrome (ARDS). Suddenly, the patient becomes hypotensive, tachycardic, and shows absent breath sounds on the left side with tracheal deviation to the right. What is the most common cause of this in patients receiving mechanical ventilation? (Q865348)

A. High tidal volume

B. Barotrauma due to high airway pressure

C. Endotracheal tube malposition

D. Oxygen toxicity

See Answer in Part B → Q18

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Q19: A 40-year-old male presents to the emergency department with severe respiratory distress, BP: 70/59 mmHg, tracheal deviation to the right, distended neck veins, and absent breath sounds on the left side. These findings are suggestive of a tension pneumothorax. What is the most appropriate immediate next step in management? (Q865354)

A. Perform needle thoracostomy immediately

B. CT Chest

C. Airway, breathing, and circulation (ABC) assessment

D. Chest tube insertion

See Answer in Part B → Q19

@Neet_pg_bot

Q20: All of the following is a contraindication to Breast Conservation surgery except ? (Q865393)

A. Previous history of radiation to the chest

B. Tumor involving single quadrant

C. Scleroderma

D. Persistent positive margins even after resection

See Answer in Part B → Q20

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Q21: Which among the following are incorrect about tension pneumothorax? Occurs due to improper dressing of open wound Blunt trauma with simple pneumothorax can never convert to tension pneumothorax Most common cause is due to positive pressure in mechanical ventilation Can be caused due to spinal injury (Q865398)

A. 1, 4

B. 2,3,4

C. 1,2,4

D. 2,3

See Answer in Part B → Q21

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Q22: A 35-year-old male sustained a head injury following a motorcycle accident. He experienced a brief loss of consciousness at the scene. Upon regaining consciousness, he developed a severe headache and began to feel drowsy. A CT scan of the head is performed. Which of the following should be the management for this patient? (Q840033)

A. Anticoagulants

B. Immediate surgical decompression

C. Observation in ICU

D. Mannitol administration



See Answer in Part B → Q22

@Neet_pg_bot

Q23: Which of the following is not done in the primary survey of trauma? (Q840042)

A. NCCT head

B. CXR

C. Intubation

D. ICD drainage

See Answer in Part B → Q23

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Q24: Mount fuji sign on CT is seen in which of the following? (Q840051)

A. Pneumocephalus

B. Pneumoperitoneum

C. Pneumomediastinum

D. Pneumothorax

See Answer in Part B → Q24

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Q25: During a complicated delivery, a mother died. Which of the following is the most common Direct cause of maternal death? (Q820108)

A. Embolism

B. Heart Disease

C. Hemorrhage

D. Anemia

See Answer in Part B → Q25

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Q26: Which fluid is administered most commonly during intraoperative blood loss? (Q820149)

A. Isolyte P

B. Crystalloids

C. Blood

D. Colloids

See Answer in Part B → Q26

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Q27: A 39-year-old female presented in the OPD with bloody discharge from the nipple . On examination, it was found to be from a single lactiferous duct . What is the treatment for bloody nipple discharge with single duct involvement? (Q820183)

A. Microdochectomy

B. Hadfield’s procedure

C. Microdiscectomy

D. IV antibiotics + Incision

See Answer in Part B → Q27

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Q28: Which of the following is not correct for the device depicted below: (Q820185)

A. Based on infrared emitted from RBCs

B. Localizes calcified plaque

C. Checks blood flow

D. Checks thickness of artery and vein



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See Answer in Part B → Q28

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Q29: Which of the following is a complication usually associated with the procedure shown in the image below? (Q854753)

A. Aspiration

B. Torticollis

C. Pneumothorax

D. Recurrent laryngeal nerve paralysis



See Answer in Part B → Q29

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Q30: Among the options provided, which one is NOT acknowledged as a potential complication resulting from a significant blood transfusion? (Q854760)

A. Hypocalcemia

B. Hypokalemia

C. Hypothermia

D. Hypernatremia

See Answer in Part B → Q30

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Q31: What is the minimum platelet count necessary for most surgical procedures? (Q854782)

A. 20,000 (10^9/L)

B. 30,000 (10^9/L)

C. 40,000 (10^9/L)

D. 50,000 (10^9/L)

See Answer in Part B → Q31

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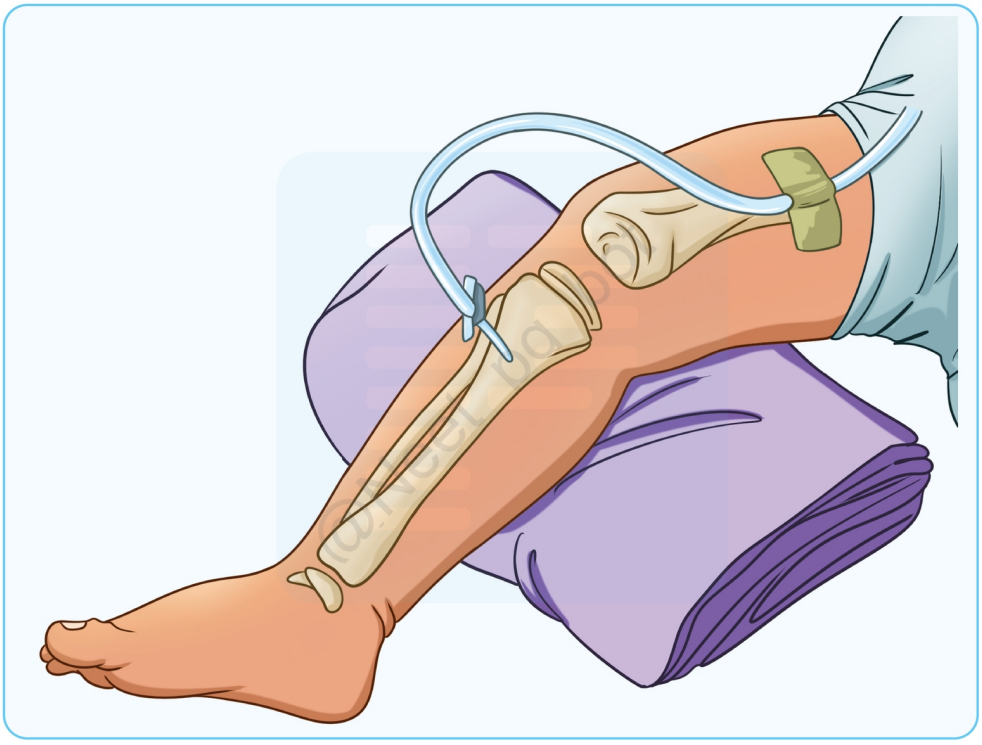
Q32: Identify the procedure being performed in the image given below. (Q855166)

A. Intraosseous cannula for pain relief

B. Bone marrow aspiration

C. Intraosseous route access for giving IV fluids

D. Bone marrow biopsy



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See Answer in Part B → Q32

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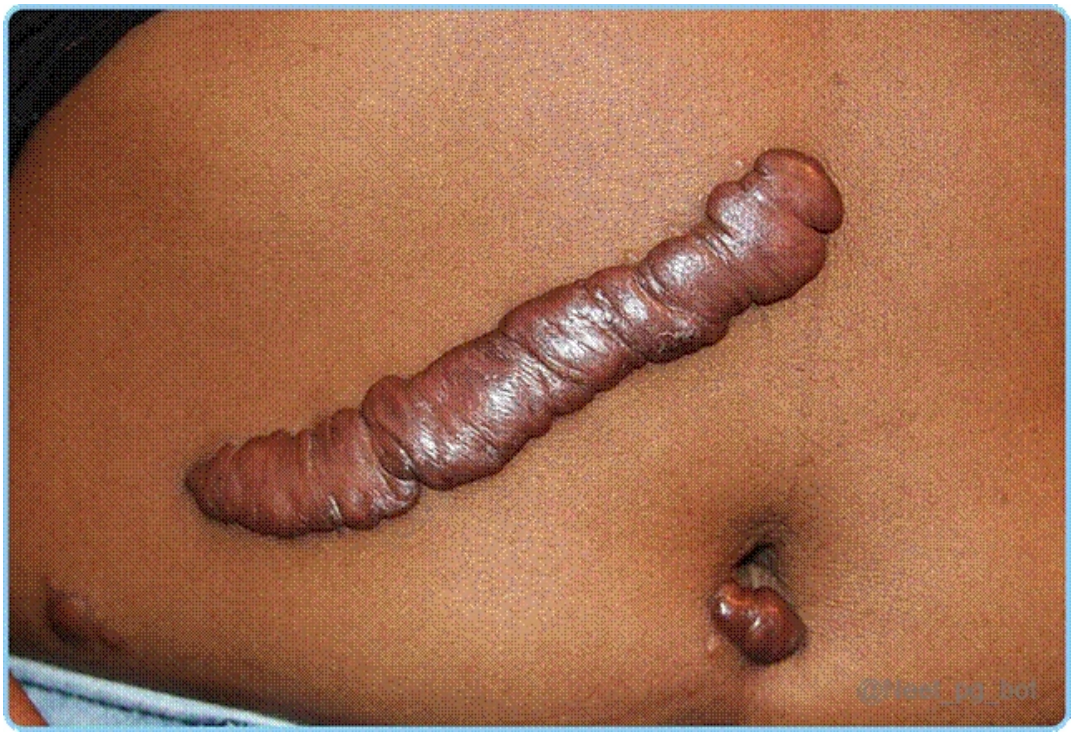
Q33: A patient presents to the clinic with a lesion as shown in the image. He had a traumatic injury to the chest one year ago, and the scar has grown beyond the boundary of the initial injury. What is the most likely diagnosis? (Q855177)

A. Hemangioma

B. Hypertrophic scar

C. Keloid

D. Neurofibroma



See Answer in Part B → Q33

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Q34: A young patient presents with a 5-day fever history and signs of hypotension, tachycardia, tachypnea, and altered mental status. Lab results show elevated white blood cell count, neutrophil proportion, and serum creatinine. The intern doctor plans to assess the quick Sequential Organ Failure Assessment (qSOFA) score for prognosis

prediction and hospitalisation duration. Which elements are part of the qSOFA score? (Q855275)

A. BP, RR, and CBC

B. Creatinine, PR, and BP

C. RR, Body temperature, and PR

D. SBP, RR, and GCS score

See Answer in Part B → Q34

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Q35: Which class of hypovolemic shock, according to Advanced Trauma Life Support (ATLS) guidelines, is characterised by the absence of urine output? (Q857765)

A. Class I

B. Class II

C. Class III

D. Class IV

See Answer in Part B → Q35

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Q36: A 38-year-old man was brought to the emergency department after sustaining an RTA and injury to the lower chest. On presentation, the patient is stable, and vitals are normal. Chest radiography showed clear lung fields. What is the next step in management? (Q857798)

A. eFAST

B. Tube thoracostomy

C. CECT chest

D. CECT abdomen

See Answer in Part B → Q36

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Q37: Which of the following is not included in the qSOFA score components? (Q857805)

A. Respiratory rate >22

B. Lactate dehydrogenase

C. Altered mental status

D. Systolic blood pressure <100 mmHg

See Answer in Part B → Q37

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Q38: Among the options provided, which pairing correctly matches the trauma patients brought to the casualty? (Q857835)

A. Extradural hemorrhage (EDH) - Pin point pupil

B. Penetrating injury to eustachian tube - CSF otorrhea

C. Penetrating injury to eye - Battle sign

D. Gaze palsy - Mid brain lesion

See Answer in Part B → Q38

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Q39: In all types of shock, which of the following is observed? (Q857889)

A. Reduced tissue perfusion

B. Increased peripheral resistance

C. Decreased respiratory rate

D. Cold clammy skin

See Answer in Part B → Q39

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Q40: For the purpose of preventing surgical site infection, what is the recommended technique and optimal timing for hair removal prior to surgery? (Q793358)

A. On the OT table with electric hair clippers

B. With a razor 24 hours before surgery

C. With a hair removal cream on the previous day

D. On the OT table with a razor

See Answer in Part B → Q40

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Q41: A patient arrives at the emergency department after being involved in a car accident. The patient is experiencing difficulty breathing and their neck veins appear dilated. The x-ray reveals a significant amount of air on the left side. What is the most appropriate course of action for treatment? (Q793363)

A. Wide bore needle insertion in the 5th intercostal space

B. Endotracheal intubation

C. Tracheostomy

D. Pericardiocentesis



See Answer in Part B → Q41

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Q42: A patient sustained a crush injury on their right arm. He was taken to the hospital and on examination, his arm was pulseless, swollen, and dark red. What would be the best way to manage this case? (Q793385)

A. Intraosseous administration of fluids

B. Acidification of urine

C. Fasciotomy

D. Hemodialysis

See Answer in Part B → Q42

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Q43: Which of these is the most life-threatening injury that can be identified by assessing the breathing component of the patient? (Q855661)

A. Cervical spine injury

B. Tension pneumothorax

C. Blunt cardiac injury

D. Laryngotracheal injury

See Answer in Part B → Q43

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Q44: Hand rub can be utilised in accordance with the standard hand hygiene protocol in all locations listed below, with the exception of: (Q855667)

A. If the hands are visibly soiled

B. While moving from a contaminated site to a clean site during patient care

C. After removing sterile gloves

D. During direct patient contact

See Answer in Part B → Q44

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Q45: In the case of a patient arriving at the emergency department with a road traffic accident (RTA), what is the appropriate order of steps in their management? Cervial spine stabilisation Intubation IV cannulation CECT (Q855671)

A. 1, 3, 2, 4

B. 1, 2, 3, 4

C. 2, 1, 3, 4

D. 2, 1, 4, 3

See Answer in Part B → Q45

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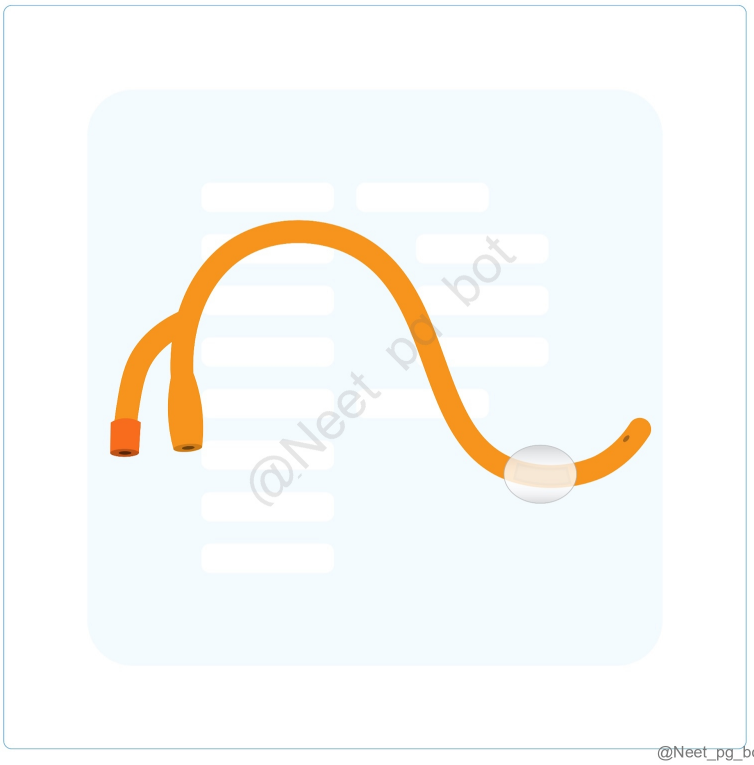
Q46: What does the number (14Fr) marked on the Foley catheter correspond to? (Q855673)

A. Inner lumen diameter

B. Length of the tube

C. Outer tube diameter

D. Bulb size



See Answer in Part B → Q46

@Neet_pg_bot

Q47: Which of the following options does not represent one of the boundaries of the triangle of safety for the insertion of an ICD in a patient with a chest x-ray showing

pneumothorax? (Q855678)

A. Lateral edge of the pectoralis major

B. Mid-clavicular line

C. 5th intercostal space

D. Lateral border of latissimus dorsi

See Answer in Part B → Q47

@Neet_pg_bot

Q48: Which of the following statements is accurate concerning split-thickness and full-thickness skin grafts? Primary contractures are more in split skin grafts Secondary contractures are more in split skin grafts Primary contractures are more in full-thickness grafts Secondary contractures are more in full-thickness grafts (Q855680)

A. 2 and 3

B. 2 and 4

C. 1 and 3

D. 1 and 4

See Answer in Part B → Q48

@Neet_pg_bot

Q49: Which of the following statements are true regarding central venous access and peripheral venous access? Phlebitis is the most common complication in peripheral venous access. Isotonic saline and heparin are flushed to retain patency If an arteriovenous fistula is present in a limb, avoid peripheral venous access in the same limb. Vasopressors for septic shock are given in the central line to avoid limb ischemia. (Q855686)

A. 1, 3, 4

B. 2, 3, 4

C. 1, 2, 3, 4

D. 1, 2, 3

See Answer in Part B → Q49

@Neet_pg_bot

Q50: Which one of the options listed below does not belong to the category of damage control surgery? (Q855279)

A. Control of hemorrhage

B. Resuscitation

C. Decontamination

D. Vascular anastomosis

See Answer in Part B → Q50

@Neet_pg_bot

Q51: Which of the following is true regarding shock? (Q855318)

A. Anaerobic respiration produces carbon dioxide

B. Hypovolaemic shock—most common type

C. Stage of compensatory shock is also called stage 2 of shock

D. Anaphylactic shock—is due to a Type 2 hypersensitivity reaction

See Answer in Part B → Q51

@Neet_pg_bot

Q52: A patient presents with multiple stab injuries to the chest. On examination, there is reduced chest movement on the right side and tracheal deviation to the left side.

Additionally, the neck veins are distended. What is the next best step in the management of this patient? (Q855325)

A. Resuscitative thoracotomy

B. ICD placement

C. Needle thoracocentesis

D. Finger thoracotomy

See Answer in Part B → Q52

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Q53: What steps should be taken to manage the case of a 24-year-old male who was hit by a motorbike while crossing the road, leading to abdominal injuries and bruising, with a blood pressure of 88/60 and IV fluids already administered, along with a positive FAST examination? (Q857115)

A. Abdominal CT scan

B. Abdominal MRI scan

C. Exploratory laparotomy

D. Diagnostic peritoneal lavage

See Answer in Part B → Q53

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Q54: In a patient with liver cirrhosis, what is the primary cause of mortality when esophageal varices are present? (Q857119)

A. Hypovolemic shock

B. Cardiogenic shock

C. Obstructive shock

D. Distributive shock

See Answer in Part B → Q54

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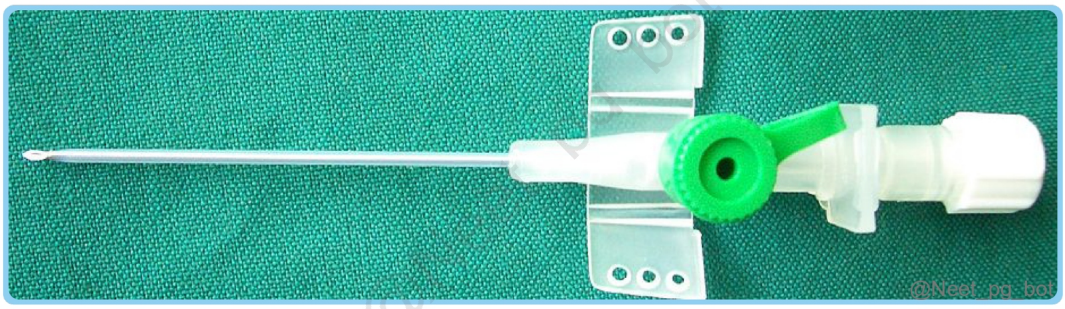
Q55: What is the size of the cannula gauge used in this picture? (Q858341)

A. 14

B. 16

C. 18

D. 20



See Answer in Part B → Q55

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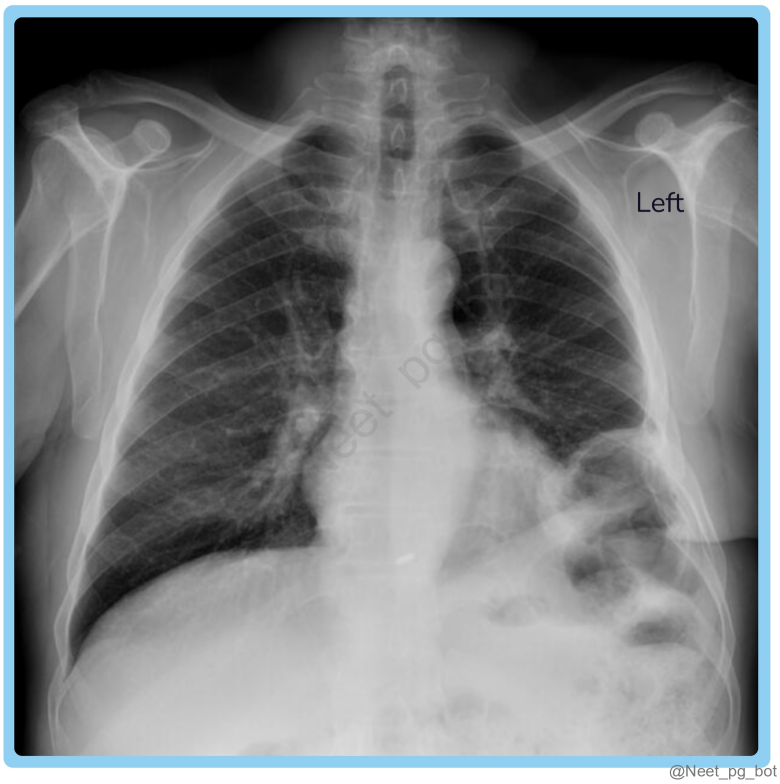
Q56: A 24-year-old male patient was brought to the emergency department following a road traffic accident. His heart rate was 100/min, respiratory rate was 24/min, and his chest X ray is given below. Which of the following is contraindicated in him? (Q858348)

A. Nasogastric tube insertion

B. Chest tube insertion

C. Log roll

D. Epidural anaesthesia



See Answer in Part B → Q56

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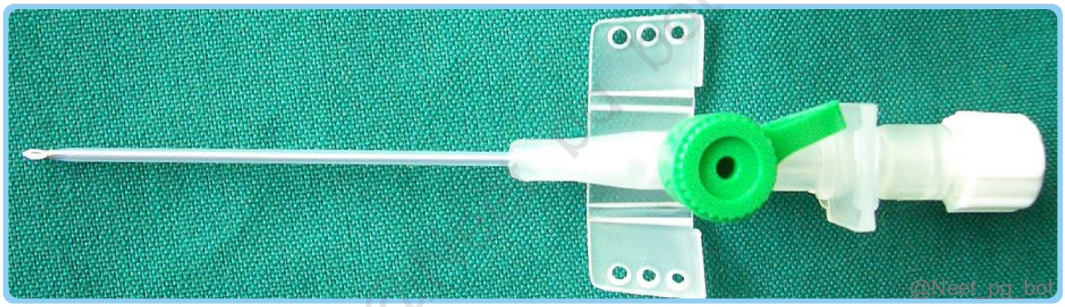
Q57: A patient was received in the casualty following a road traffic accident. His BP was 90/60 mmHg and his pulse rate was 120/min. The emergency room physician asked you to replace the fluid loss in this patient. What is the flow rate of fluid with the IV cannula given in the image? (Q858350)

A. 86ml/min

B. 96ml/min

C. 90 ml/min

D. 63ml/min



See Answer in Part B → Q57

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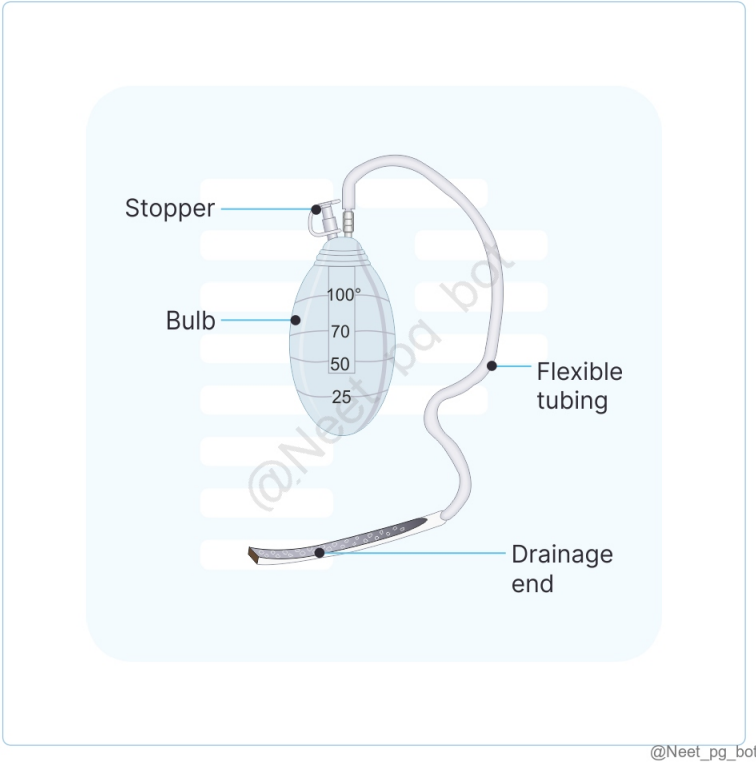
Q58: A 45-year-old patient undergoes a mastectomy for breast cancer. Post-operatively, the surgeon decides to use a closed suction drain. Which of the following drain types is shown in the image below? (Q858365)

A. Penrose drain

B. Jackson Pratt drain

C. Romovac suction drain

D. Hemovac drain



See Answer in Part B → Q58

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Q59: What is triage for? (Q856526)

A. To prepare for a disaster

B. To assess the impact of a disaster

C. To classify the priority of treatment

D. To rehabilitate following a disaster

See Answer in Part B → Q59

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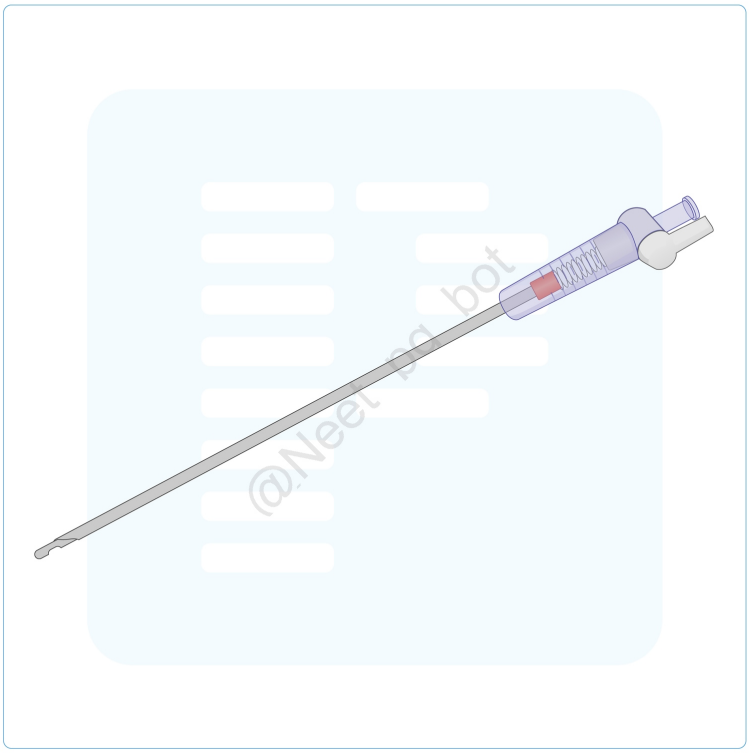
Q60: What is the name of the instrument depicted below, which is utilized for the creation of a pneumoperitoneum? (Q856535)

A. Veress needle

B. Morris' needle

C. Yankauer suction tip

D. Von Graefe needle



See Answer in Part B → Q60

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Q61: What is the needle placement angle when using the interrupted suturing technique to suture a laceration in the ER? (Q856559)

A. 60 degrees

B. 70 degrees

C. 80 degrees

D. 90 degrees

See Answer in Part B → Q61

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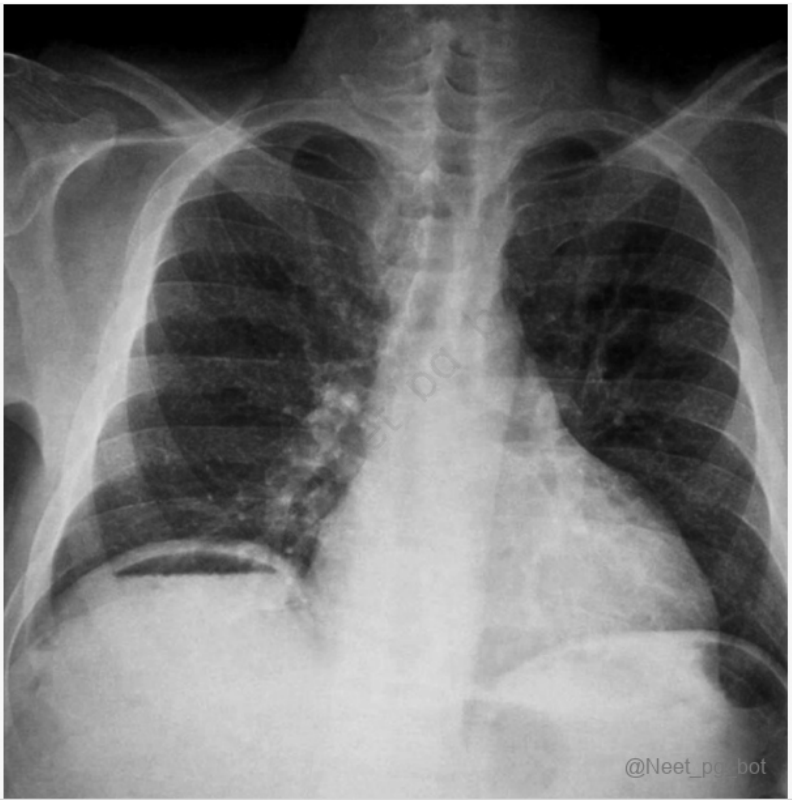
Q62: What might you suspect as the diagnosis for a 26-year-old male patient who arrives at the emergency department complaining of abdominal pain and constipation persisting for the last three days? The patient recalls being struck in the abdomen by a bull three days ago. Could yo u examine the provided X-ray to aid in your assessment? (Q856561)

A. Hemothorax

B. Hollow viscus perforation

C. Pneumothorax

D. Intestinal obstruction



See Answer in Part B → Q62

@Neet_pg_bot

Q63: Which of the following methods is accurate for measuring the nasogastric tube? (Q856572)

A. Tip of nose to ear lobule to xiphisternum

B. Angle of mouth to tragus to xiphisternum

C. Ala of nose to angle of mandible to xiphisternum

D. Angle of mouth to ear lobule to umbilicus

See Answer in Part B → Q63

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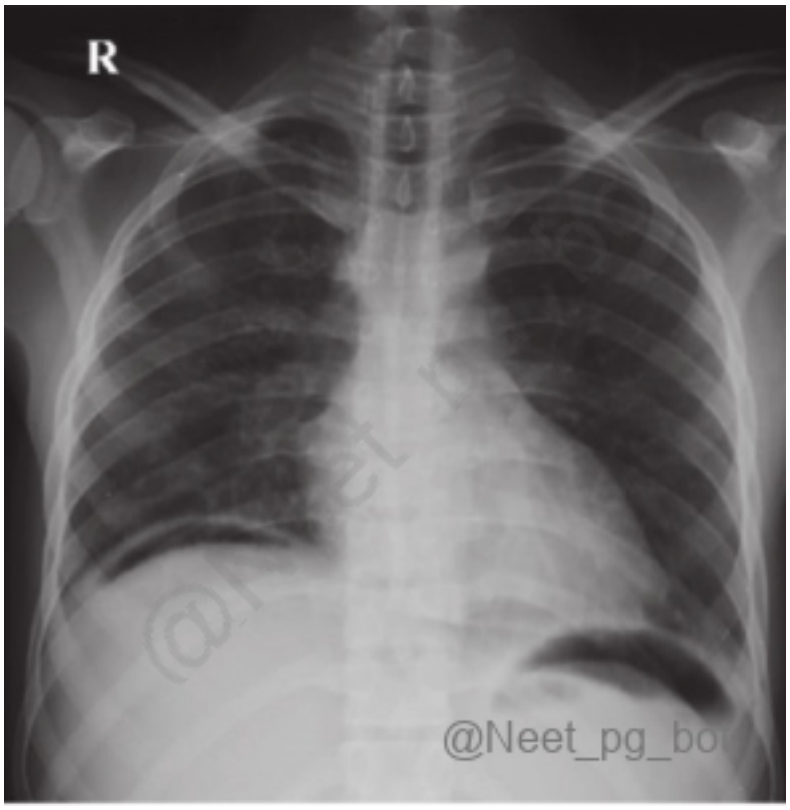
Q64: What is the most probable diagnosis for a 25-year-old patient who has been experiencing abdominal pain and fever for the past three days, based on the provided chest X-ray taken in an upright position? (Q856206)

A. Hollow viscus perforation

B. Gastric volvulus

C. Liver abscess

D. Empyema thoracis



See Answer in Part B → Q64

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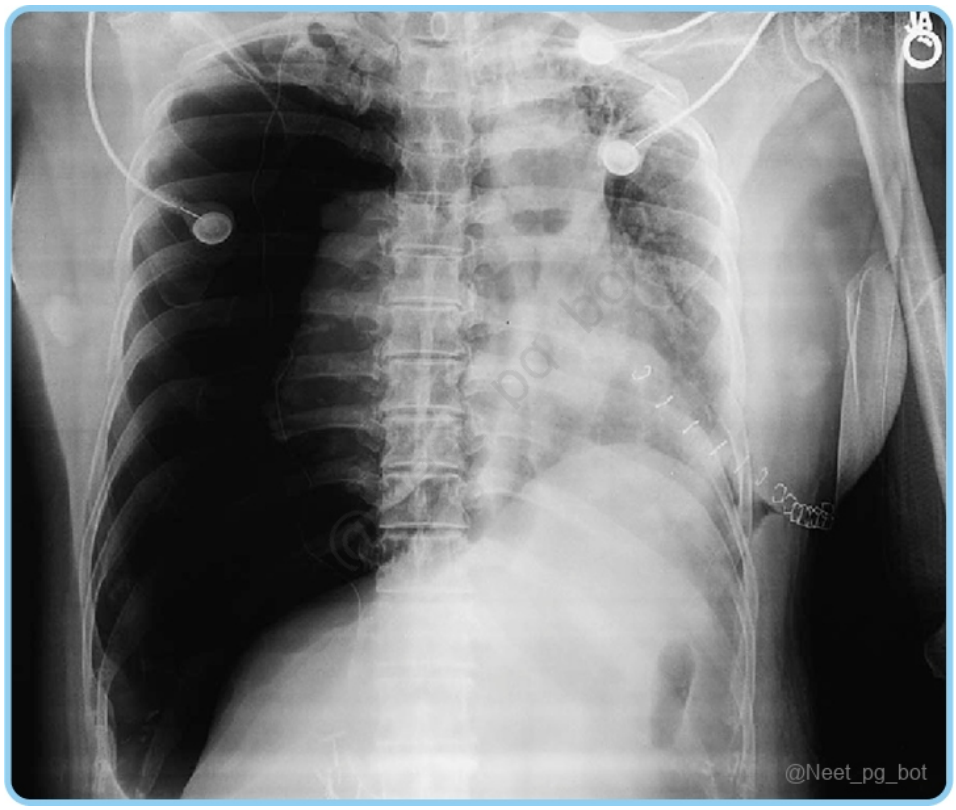
Q65: A patient following a road traffic accident presented with subcutaneous emphysema. On auscultation, there was no air entry on the right side. Vitals were unstable. What will be your immediate management? (Q856246)

A. Insertion of wide bore needle in the 2nd intercostal space

B. Wide bore needle decompression and IV fluids

C. Intubation and positive pressure ventilation

D. e-FAST



See Answer in Part B → Q65

@Neet_pg_bot

Q66: A patient, after a road traffic accident, presented with pain in the abdomen. The resident examined the child and found that vitals were stable, and tenderness was present in the left lumbar region. Which is the best investigation of choice? (Q856254)

A. Contrast-enhanced CT scan

B. Retrograde urethrogram

C. Wait and watch

D. Emergency laparotomy

See Answer in Part B → Q66

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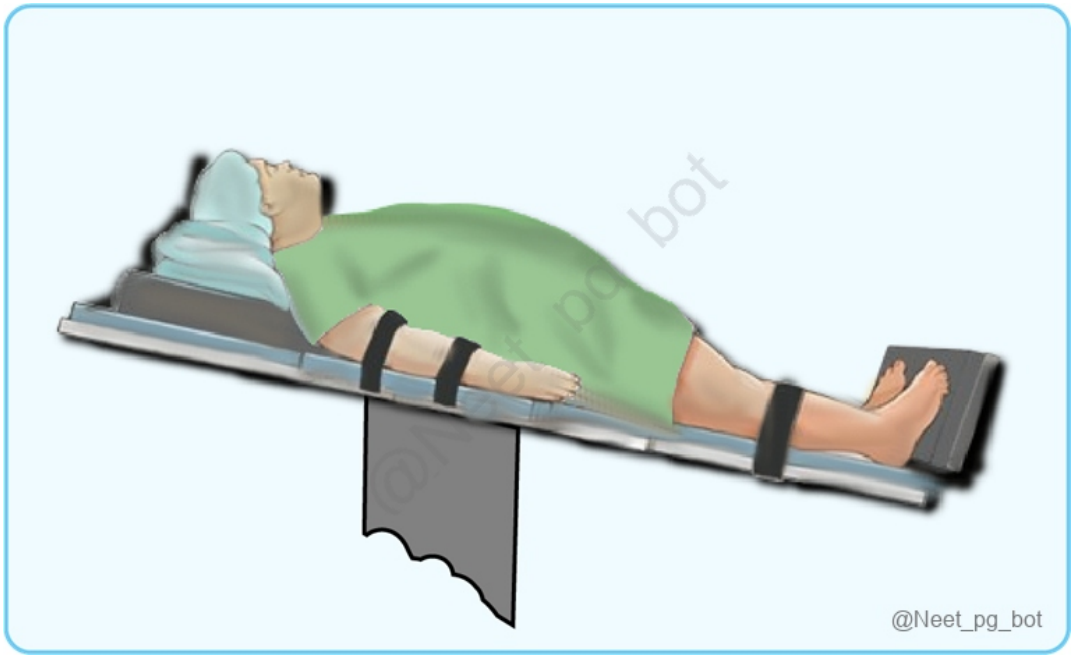
Q67: The position of the patient in the image shown below is known as: (Q856730)

A. Lloyd Davis position

B. Jack knife position

C. Trendelenburg position

D. Reverse Trendelenburg position



See Answer in Part B → Q67

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Q68: FAST stands for (Q856255)

A. First assessment with sonography in trauma

B. Focussed assessment with sonography in trauma

C. First abdominal sonography in trauma

D. Focussed abdominal sonography in trauma

See Answer in Part B → Q68

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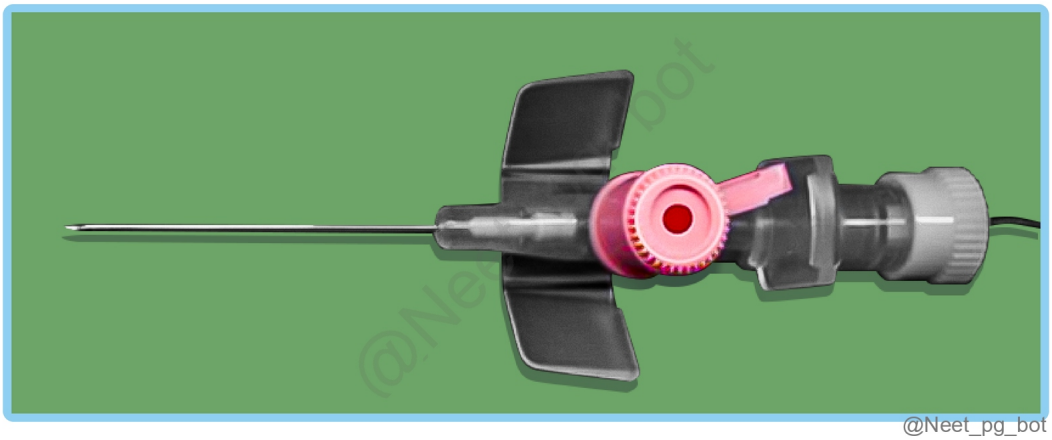
Q69: What is the size of the cannula shown in the below image? (Q856292)

A. 16 G

B. 18 G

C. 20 G

D. 22 G



See Answer in Part B → Q69

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Q70: A 32-year-old woman has been declared brain dead, and her family has chosen to donate her organs. Who would be the most suitable recipient of her organs? (Q856294)

A. 14-year-old child with multi-organ dysfunction syndrome

B. 50-year alcoholic man with liver cirrhosis with 1 month abstinence

C. 70-year-old woman with end-stage renal disease

D. 32-year-old woman with renal failure

See Answer in Part B → Q70

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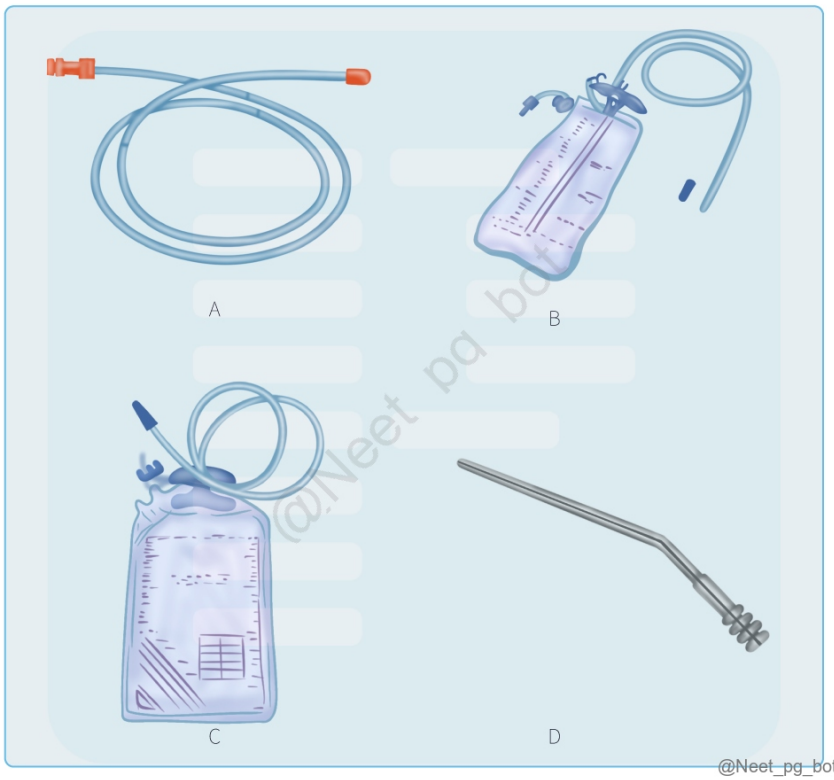
Q71: Match the following 1. Urine Bag 2. Nasogastric Tube 3. Underwater seal bag 4. Suction cannula (Q856303)

A. 1-D, 2-C, 3-A, 4-B

B. 1-C, 2-A, 3-B, 4-D

C. 1-D, 2-A, 3-C, 4-B

D. 1-B, 2-A, 3-C, 4-D



See Answer in Part B → Q71

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Q72: The components of qSOFA scoring include: A. Mental status B. Blood pressure C. Respiratory rate D. Heart rate (Q856309)

A. A & B

B. C & D

C. A, B & C

D. A, B, C & D

See Answer in Part B → Q72

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Q73: Match the correct answer related to the nerve injuries in various surgeries: A. Breast surgery 1. External Laryngeal nerve B. Thyroid surgery 2. Hypoglossal nerve C. Submandibular excision 3. Phrenic nerve D. Thymectomy 4. Long Thoracic Nerve (Q856314)

A. A-1, B-2, C-3, D-4

B. A-2, B-3, C-4, D-1

C. A-3, B-4, C-1, D-2

D. A-4, B-1, C-2, D-3

See Answer in Part B → Q73

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Q74: Which one of the following is excluded from the primary survey? (Q854940)

A. Measuring blood pressure

B. Removing clothes to inspect for wounds

C. Taking CT scan of the patient

D. Checking airway patency

See Answer in Part B → Q74

@Neet_pg_bot

Q75: Which of the following is not taken into consideration in ASEPSIS wound scoring? (Q854951)

A. Wound swab from the site

B. Serous discharge

C. Erythema

D. Induration

See Answer in Part B → Q75

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Q76: What could be the most likely reason for a patient presenting with chronic non-pitting edema in the lower extremities? (Q858480)

A. Lymphedema

B. Arterial Disorders

C. Venous Disorders

D. Coronary heart disease

See Answer in Part B → Q76

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Q77: A 38-year-old man was brought to the emergency department after sustaining an RTA and injury to the lower chest. On presentation, the patient is stable, and vitals are normal. Chest radiography showed clear lung fields. What is the next step in management? (Q858483)

A. eFAST

B. Tube thoracostomy

C. CECT chest

D. CECT abdomen

See Answer in Part B → Q77

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Q78: According to triage, which of the following categories of patients comes under green? (Q855552)

A. Ambulatory patients

B. Moderate priority

C. High Priority

D. Dead patients

See Answer in Part B → Q78

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Q79: Identify the fluid shown below on the basis of composition: Sodium (Na+) 131 millimoles per liter Chloride (Cl-) 111 millimoles per liter Lactate 29 millimoles per liter Potassium (K+) 5 millimoles per liter Calcium (Ca2+) 2 millimoles per liter Total osmolarity 279 millimoles per liter (Q855761)

A. Haemaccel

B. Ringer lactate

C. Isolyte

D. Isolyte M

See Answer in Part B → Q79

@Neet_pg_bot

Q80: A patient with an incident of being stabbed in the front part of the abdomen is brought to the emergency. The patient's vital signs are stable. What will be the next step in managing this case? (Q855832)

A. Emergency laparotomy

B. Observation

C. Intravenous hydration

D. Further investigation

See Answer in Part B → Q80

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Q81: A patient presented with blunt trauma to the abdomen. On evaluation, liver injury was noted, for which primary repair was done. Coagulation function was monitored intraoperatively using the method shown below. What is the method used? (Q855836)

A. Thromboelastography

B. Plethysmography

C. Sonography

D. Elastography



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See Answer in Part B → Q81

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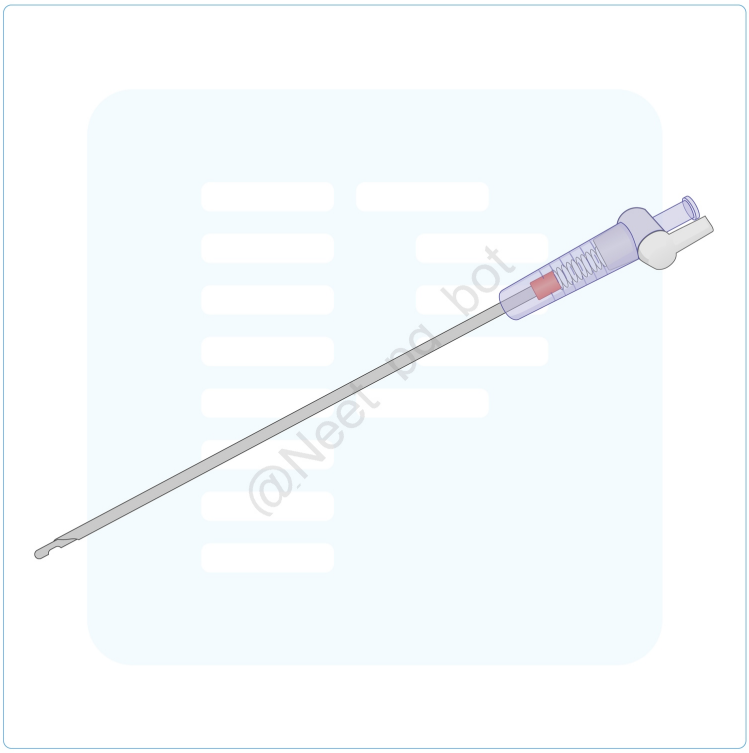
Q82: Identify the given instrument. (Q852678)

A. Veress needle

B. Hasson's cannula

C. Jamshidi needle

D. 3 mm Trocar



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See Answer in Part B → Q82

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Q83: A patient presents with burn injuries involving the anterior and posterior torso, both upper limbs, and the perineum. The face and lower limbs are spared. According to the Rule of Nines, what is the total body surface area (TBSA) burned? (Q852680)

A. 5-10%

B. 20-30%

C. 10-15%

D. 40-50%

See Answer in Part B → Q83

@Neet_pg_bot

Q84: Identify the procedure? (Q852684)

A. Retrograde pyelogram

B. Combined Retrograde Pyelogram and Ureteroscopy

C. Intravenous Pyelogram

D. Antegrade pyelography



See Answer in Part B → Q84

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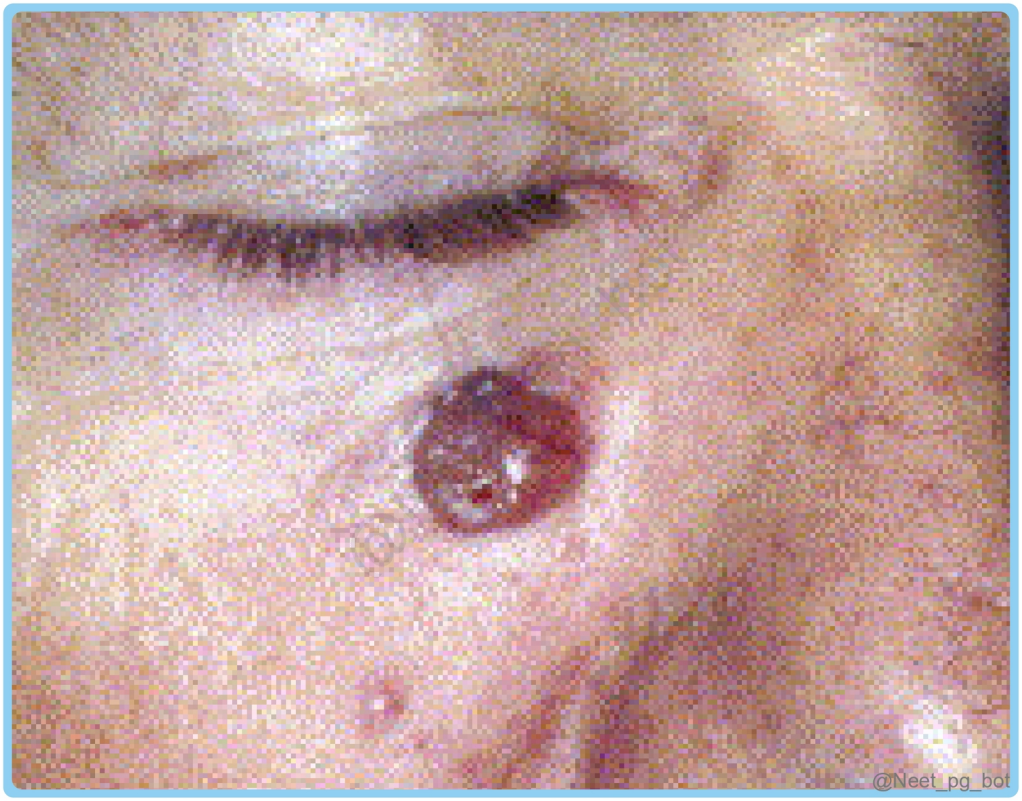
Q85: Which of the following is not related to disease progression? (Q852689)

A. Duration

B. Depth

C. Site

D. Stage of Cancer



See Answer in Part B → Q85

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Q86: A patient with diffuse severely contaminated peritonitis underwent laparotomy and was left open after surgery. Which of the following might help? (Q852688)

A. VAC

B. Normal saline soaked gauze

C. Prefer closure after laparotomy

D. Antibiotic soaked gauze

See Answer in Part B → Q86

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Q87: A patient presents to the emergency department with confusion. On examination, he opens his eyes to pain, shows abnormal flexion to pain, and is disoriented in speech. What is his Glasgow Coma Scale (GCS) score? (Q852690)

A. 11

B. 12

C. 10

D. 9

See Answer in Part B → Q87

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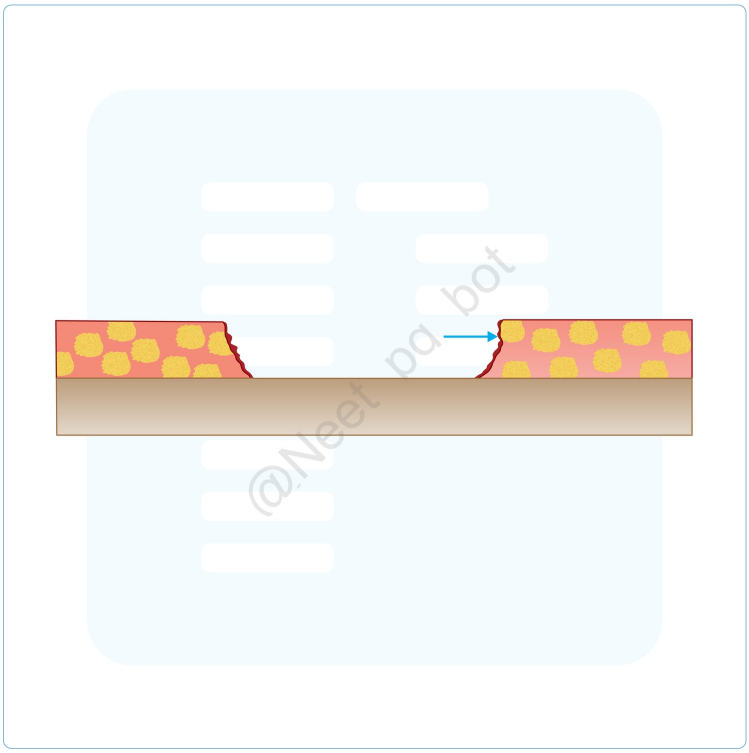
Q88: The given image is of an ulcer, identify the marked structure? (Q852682)

A. Margin

B. Edge

C. Floor

D. Base



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See Answer in Part B → Q88

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Q89: In a patient experiencing excessive bleeding, with limbs displaying low temperature and reduced central venous pressure (CVP), what type of shock is observed? (Q859602)

A. Cardiogenic shock

B. Hypovolemic shock

C. Obstructive shock

D. Hypo adrenal shock

See Answer in Part B → Q89

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Q90: In a hypotensive patient with a head injury, which of the subsequent fluids should be avoided? (Q859606)

A. 0.9% NS

B. 5% Dextrose

C. Ringer lactate

D. 3% saline

See Answer in Part B → Q90

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Q91: A 30-year-old female presents to the emergency department with burn injuries sustained from a stove explosion. She has burns involving the face with singeing of eyelashes, both upper limbs entirely, and the anterior chest. The burns are partial-thickness, involving the epidermis and part of the dermis. Based on the rule of Nines, what is the approximate total body surface area (TBSA) affected by burns? (Q865330)

A. 33-36%

B. 40-45%

C. 25-28%

D. 50-55%

See Answer in Part B → Q91

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Q92: Which of the following is incorrect regarding the following dressing? (Q865340)

A. Redressing is done after 4 - 7 days

B. Negative pressure 10-20 mmHg

C. Increase proliferation and protein matrix synthesis

D. Can be continuous & intermittent



See Answer in Part B → Q92

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Q93: Which of the following cancers is NOT related to obesity? (Q865421)

A. Meningioma

B. Gastric carcinoma

C. Pancreatic carcinoma

D. Multiple myeloma

See Answer in Part B → Q93

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Q94: A 30-year-old lactating mother presents with pain in her left breast and a fever. On examination, the left breast appears as shown in the image below. There is mild axillary lymphadenopathy on the affected side and the contralateral breast is normal. Repeated aspirations under antibiotic cover were unsuccessful. A USG done showed

fluid collection. What is the next best step in the management of this patient? (Q865425)

A. Incision and drainage

B. Broad-spectrum antibiotics only

C. Breast conservation surgery

D. Punch biopsy



See Answer in Part B → Q94

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Q95: A 25-year-old male with a history of a road traffic accident presents to the emergency department. His GCS is 8/15, oxygen saturation is 85%, blood pressure is 100/60 mmHg and heart rate is 60 beats per minute. On examination, breath sounds are absent on the right side. What is the next step in management? (Q853038)

A. Start IV fluids, give atropine and secure airway

B. Secure airway, give oxygen, insert ICD, secure IV line

C. Evaluate for head injury and do CT-head

D. ■■■Administer IV dextrose followed by NCCT head

See Answer in Part B → Q95

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Q96: An 84-year-old man who had a stroke 2 years ago and has been on extended bed rest, develops a pressure ulcer with partial skin thickness loss and a clean base. What is the grade of his pressure sore? (Q853066)

A. 1

B. 2

C. 3

D. 4

See Answer in Part B → Q96

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Q97: A 35-year-old male had surgery for an ileal perforation. Due to significant contamination, only the sheath was sutured, leaving the wound open. Daily wound irrigation was carried out, and the wound was closed on postoperative day 5. What type of wound-healing mechanism is occurring in this scenario? (Q853067)

A. Primary intention

B. Secondary intention

C. Tertiary intention

D. Quaternary intention

See Answer in Part B → Q97

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Q98: A friend of yours is teaching you about enhanced recovery after surgery. Which of the following statements he makes is inaccurate? (Q853068)

A. ■■■Prolonged fasting is necessary

B. Epidural anaesthesia recommended in laparoscopic surgery for pain control

C. Reduction of hospital stay by 2-3 weeks

D. Beta-blockers are given after major surgery done under general anaesthesia to improve the outcome

See Answer in Part B → Q98

@Neet_pg_bot

Q99: During laparoscopic port placement, injury to which abdominal wall vessels must be avoided while inserting the trocar?During laparoscopic surgery, where shouldn't the trocar be inserted? (Q852687)

A. Superior epigastric artery

B. Inferior epigastric artery

C. Abdominal aorta

D. Both A and B

See Answer in Part B → Q99

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Q100: A 45-year-old male patient was brought to the emergency department following a road traffic accident.O/E, he had multiple injuries all over his body and was found to be in class III hemorrhagic shock. The percentage of blood loss would be between: (Q852705)

A. 5-15%

B. 30-40%

C. >40%

D. 15-30%

See Answer in Part B → Q100

@Neet_pg_bot

Q101: A 20-year-old male presents to the outpatient department with a swelling on his wrist. He reports fluctuation in size , mild numbness in the hand , and occasional pain . What is the most likely diagnosis? (Q852713)

A. Lipoma

B. Ganglion cyst

C. Dermoid cyst

D. Hematoma



See Answer in Part B → Q101

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Q102: A patient with dilated tortuous veins of the leg presented to the OPD and is diagnosed with varicose vein of grade C4a. What is the best preferred treatment? (Q852721)

A. Compression

B. Endothermal ablation

C. Non endothermal non tumescent ablation

D. Open surgery

See Answer in Part B → Q102

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Q103: A 45-year-old man is found unconscious after a fall from a ladder. In the emergency department, his eyes do not open even in response to pain; he is making incomprehensible sounds, and he exhibits abnormal flexion in response to painful stimuli. What is his Glasgow Coma Scale (GCS) score? (Q852706)

A. 5

B. 6

C. 7

D. 8

See Answer in Part B → Q103

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Q104: A woman, a few weeks after delivery, complains of bloody discharge from nipple and fever. On examination, diffuse lump under areola. What is the diagnosis? (Q852719)

A. Galactocele

B. Lactational mastitis

C. Mondor disease

D. Fibrocystic disease

See Answer in Part B → Q104

@Neet_pg_bot

Q105: The ureter is safe in which type of hysterectomy? (Q852722)

A. Open laparotomy

B. Laparoscopy

C. Robotic

D. Vaginal

See Answer in Part B → Q105

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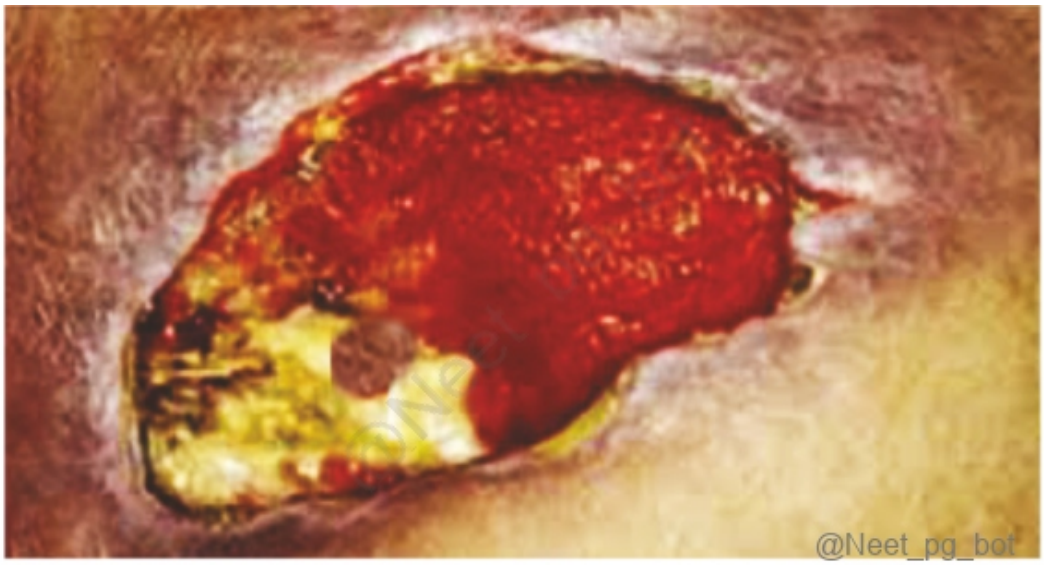
Q106: Identify the grade of the condition given in the image below ? (Q844279)

A. Grade 1

B. Grade 2

C. Grade 3

D. Grade 4



See Answer in Part B → Q106

@Neet_pg_bot

Q107: What is the ideal pressure setting for vacuum-assisted closure (VAC) therapy? (Q844308)

A. -125 mm Hg

B. 60 to 80 mm Hg

C. 130 mm Hg

D. 80 to 100 mm Hg

See Answer in Part B → Q107

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Q108: A 20-year-old chronic alcoholic presents with severe hematemesis. An ultrasound (USG) shows distention of the portal vein, and the liver appears hyperechoic. Pantoprazole has been administered. What is the next appropriate step in management? (Q844303)

A. Initiate a course of broad-spectrum antibiotics

B. Order a liver biopsy to assess for fibrosis

C. Administer intravenous fluids and electrolyte replacement

D. Perform an endoscopy to look for varices

See Answer in Part B → Q108

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Q109: Which of the following is a complication of Total Parenteral Nutrition (TPN) in a sepsis patient in the ICU? (Q844304)

A. Hyperlipidemia

B. Hyperglycemia

C. Hyperglyceridemia

D. Hypoglycemia

See Answer in Part B → Q109

@Neet_pg_bot

Q110: Which of the following is characteristic of hypovolemic shock? (Q860374)

A. Increase in cardiac output

B. High vascular resistance

C. Increase in venous pressure

D. Increased mixed venous saturation

See Answer in Part B → Q110

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Q111: Identify the type of ulcer shown in the image below: (Q860399)

A. Venous ulcer

B. Malignant ulcer

C. Arterial ulcer

D. Trophic ulcer



See Answer in Part B → Q111

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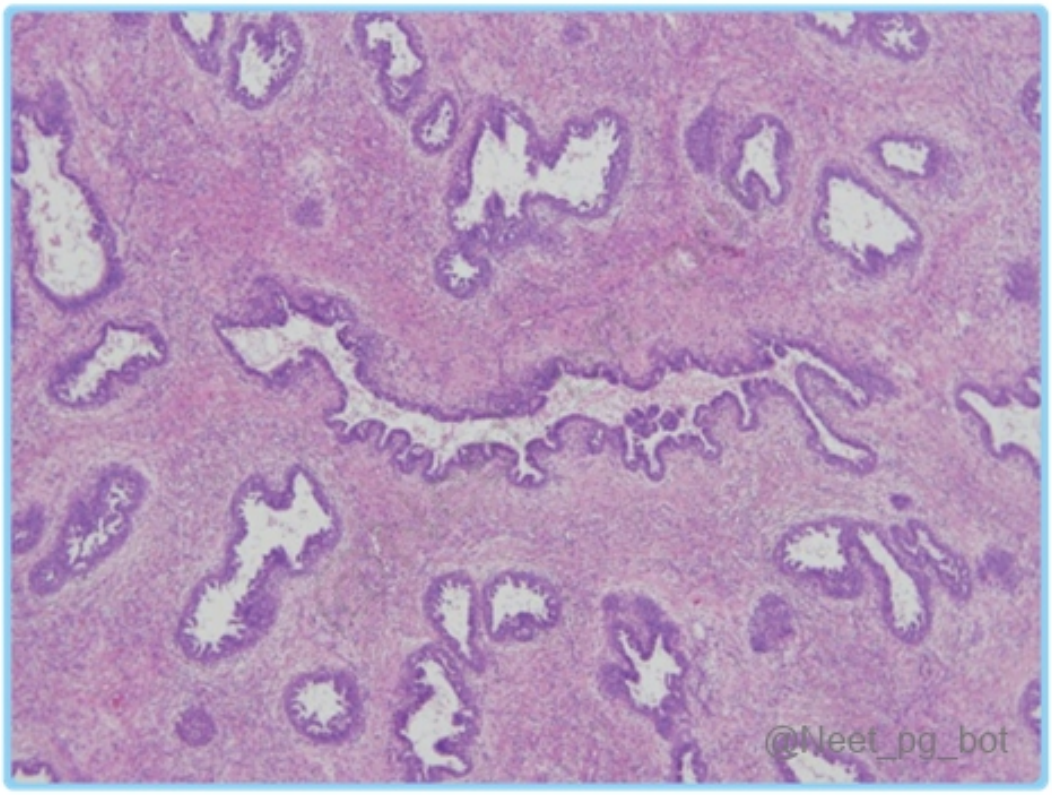
Q112: A 30-year-old female who is receiving cyclosporine A following renal transplantation develops multiple and bilateral breast lumps that regress after cessation of the treatment. Biopsy image is given below. What is the most likely diagnosis? (Q860452)

A. Fat necrosis

B. Phyllodes tumour

C. Fibroadenoma

D. Carcinoma breast



See Answer in Part B → Q112

@Neet_pg_bot

Q113: A 65-year-old male presents to the outpatient department with a swelling in the back of his neck that has been present for almost a year. The swelling has not increased in size. On examination, it is non-pulsatile, and the slip sign is positive, with the swelling measuring 3x3 cm. Which of the following statements is most likely true? (Q860457)

A. High chances of malignant transformation

B. FNAC necessary for diagnosis

C. PET scan necessary for staging

D. Excision can be done if the patient requests it



See Answer in Part B → Q113

@Neet_pg_bot

Q114: A 47-year-old man presents with a chronic non-healing painless ulcer over his scalp for 8 years. He has a history of electric burns to the scalp 8 years ago. The examination findings are shown below. Which of the following statements is true? (Q860461)

A. Radiotherapy is useful

B. It can progress to squamous cell carcinoma

C. No lymphatic spread

D. Long-duration antibiotics will improve the condition.



See Answer in Part B → Q114

@Neet_pg_bot

Q115: A 25-year-old woman presents with severe pain and swelling in her right hand, which is increasing in size and severity. She had a prick injury in the garden 5 days ago. On examination, she cries out in pain when her hand is extended and when the palmar aspect is palpated passively. Which of the following statements is true about the condition? (Q860463)

A. More common in the dorsal aspect of the hand

B. X-ray imaging will aid in the location of the foreign body in all patients

C. It requires incision and drainage

D. Oral analgesics are the mainstay of treatment



See Answer in Part B → Q115

@Neet_pg_bot

Q116: A patient fell from a train onto the railway track and injured both his legs severely. He was urgently taken to the hospital, and the following procedure was performed (image shown below). What is the rationale for performing this procedure? (Q860466)

A. Better fit for prosthesis

B. Life-saving procedure

C. Reduces risk of cancer

D. Good cosmetic outcomes



See Answer in Part B → Q116

@Neet_pg_bot

Q117: In solid organ transplantation, which of the following organs is associated with a higher incidence of rejection? (Q860491)

A. Lungs

B. Intestine

C. Kidney

D. Liver

See Answer in Part B → Q117

@Neet_pg_bot

Q118: A 55-year-old female patient with chronic pancreatitis undergoes a Puestow procedure. What is the most preferred route for supplementary nutrition in this patient? (Q860504)

A. TPN (Total Parenteral Nutrition)

B. Oral feeding

C. Feeding gastrostomy

D. Feeding jejunostomy

See Answer in Part B → Q118

@Neet_pg_bot

Q119: A 35-year-old woman, 10 years after mastectomy, notices gradual swelling and heaviness in her right upper limb without pain. On examination, bluish nodules on the skin with no infections are noted. What is the most likely cause of her symptoms? (Q860167)

A. Lymphangiosarcoma

B. Thoracic outlet syndrome

C. Chronic venous insufficiency

D. Recurrent breast cancer

See Answer in Part B → Q119

@Neet_pg_bot

Q120: A patient presents to the emergency room after a road traffic accident with shock and hypotension. The extended focused assessment with sonography for trauma (eFAST) is negative, the X-ray is normal, and the ECG shows bradycardia. The patient's SpO2 is 93%, blood pressure is 80/60 mmHg, and pulse rate is 40/min. Based on this information, what type of shock is most likely? (Q860219)

A. Septic shock

B. Hemorrhagic shock

C. Cardiogenic shock

D. Neurogenic shock

See Answer in Part B → Q120

@Neet_pg_bot

Q121: In patients at risk of refeeding syndrome, which of the following electrolyte imbalances is typically not associated with this condition? (Q860221)

A. Hypokalemia

B. Hyperkalemia

C. Hypocalcemia

D. Hypophosphatemia

See Answer in Part B → Q121

@Neet_pg_bot

Q122: Identify the edges of the lesion given in the image: (Q860254)

A. Everted

B. Rolled out

C. Sloping

D. Punched out



See Answer in Part B → Q122

@Neet_pg_bot

Q123: A patient following a road traffic accident (RTA) with a crush injury presents with crepitus and a reddish-brown wound within 3 days after amputation. What is the most likely condition? (Q860260)

A. Gas gangrene

B. Impetigo

C. Tetanus

D. Cellulitis

See Answer in Part B → Q123

@Neet_pg_bot

Q124: Arrange the stages of wound healing in the correct sequence: (Q860267)

A. Proliferation, hemostasis, inflammation, remodeling

B. Inflammation, remodeling, hemostasis, proliferation

C. Hemostasis, inflammation, proliferation, remodeling

D. Remodeling, proliferation, hemostasis, inflammation

See Answer in Part B → Q124

@Neet_pg_bot

Q125: Which of the following is considered a “sure sign” of abdominal wound dehiscence in a post-operative hypotensive patient? (Q860272)

A. Increased bowel sounds

B. Persistent abdominal pain

C. Serosanguinous drainage from the wound

D. Widening of the abdominal scar with palpable edges

See Answer in Part B → Q125

@Neet_pg_bot

Q126: An elderly chronic smoker male is diagnosed with squamous cell carcinoma of the lower lip with no lymph node involvement. What is the treatment of choice? (Q860276)

A. Radiotherapy

B. Combined chemoradiotherapy

C. Wide local excision with negative borders

D. Wide local excision with frozen section

See Answer in Part B → Q126

@Neet_pg_bot

Q127: In a triage setting, which of the following categories requires the highest priority intervention? (Q860294)

A. Red

B. Yellow

C. Green

D. Black

See Answer in Part B → Q127

@Neet_pg_bot

Q128: What type of skin graft is used in the image shown? (Q860305)

A. Split thickness

B. Full thickness

C. Wolfe graft

D. Local flap



See Answer in Part B → Q128

@Neet_pg_bot

Q129: A female patient presents to the outpatient department 10 days postpartum with complaints of a fluctuant breast mass with tenderness, high-grade fever, and cracked nipples. What is the most probable diagnosis? (Q860324)

A. Breast engorgement

B. Breast abscess

C. Acute mastitis

D. Fibroadenoma

See Answer in Part B → Q129

@Neet_pg_bot

Q130: What kind of wound is an open cardiac massage? (Q857262)

A. Clean

B. Contaminated

C. Dirty

D. Clean Contaminated

See Answer in Part B → Q130

@Neet_pg_bot

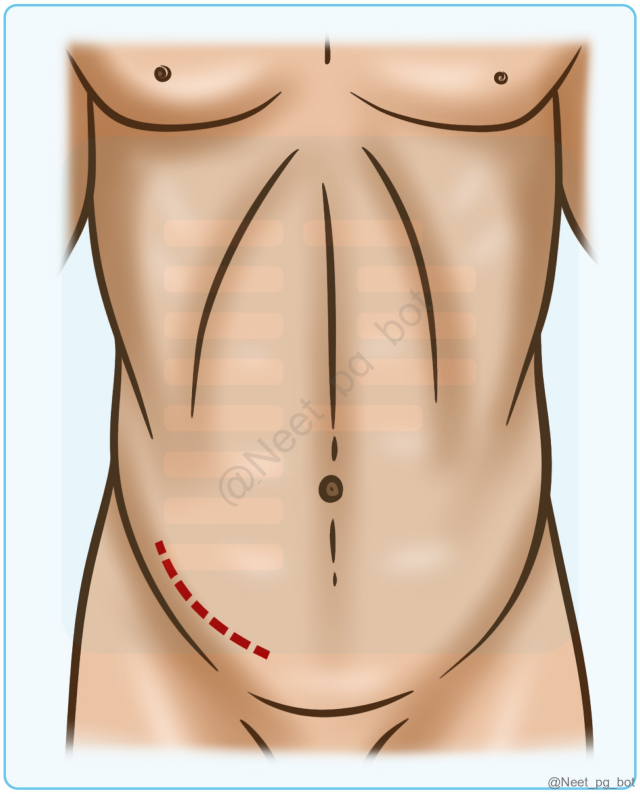
Q131: Identify the incision made and marked in the image. (Q857292)

A. Robson

B. Maylard

C. Gibson Abernathy

D. Kocher's



See Answer in Part B → Q131

@Neet_pg_bot

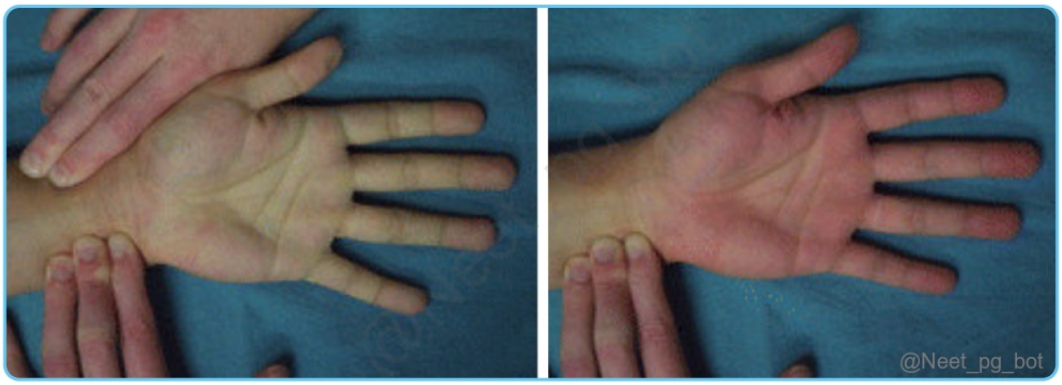
Q132: Identify the test provided in the image below. (Q857294)

A. Allen’s test

B. Adson’s test

C. Elevated arm stress test

D. Nicoladoni’s test



See Answer in Part B → Q132

@Neet_pg_bot

Q133: Smoking increases the risk of which of the following diseases? Duct ectasia Fibroadenoma Mondor disease Breast carcinoma (Q857295)

A. 2, 3

B. 1, 4

C. 2, 3, 4

D. 1, 3, 4

See Answer in Part B → Q133

@Neet_pg_bot

Q134: A 25-year-old male patient is brought to the casualty after a road traffic accident (RTA) with suspected pelvic fractures. On examination, he is found to be in hypovolemic shock. What is the earliest treatment for control of haemorrhage in this case? (Q857297)

A. Immediate internal fixation

B. Multiple blood transfusions

C. Use bedsheets to compress the pelvis

D. Emergency external fixation

See Answer in Part B → Q134

@Neet_pg_bot

Q135: A soldier arrives at a referral hospital 24 hours after experiencing a shrapnel injury to his right thigh caused by a high-speed projectile. He expresses significant discomfort at the site of the wound. Upon examination, there is evidence of crepitus. Which of the following microorganisms is the probable culprit behind his current state? (Q857804)

A. Clostridium septicum

B. Clostridium difficile

C. Clostridium novyi

D. Clostridium perfringens

See Answer in Part B → Q135

@Neet_pg_bot

Q136: A 32-year-old female undergoes emergency laparotomy for perforation peritonitis. Which of the following is the surest sign of wound dehiscence? (Q857853)

A. Copious sero-sanguinous discharge

B. Rebound tenderness

C. Hemorrhage

D. Hypotension

See Answer in Part B → Q136

@Neet_pg_bot

Q137: What should be the next course of action in the management of a 30-year-old breastfeeding mother who is experiencing pain and fever in her left breast? The left

breast appears abnormal as depicted in the provided image. There is slight swelling of the lymph nodes in the armpit on the affected side, while the opposite breast appears normal. Despite multiple attempts at draining the fluid with the use of antibiotics, it was unsuccessful. An ultrasound examination revealed the presence of fluid collection. (Q793402)

A. Incision an drainage

B. Broad spectrum antibiotics only

C. Breast conservation surgery

D. Punch biopsy



See Answer in Part B → Q137

@Neet_pg_bot

Q138: A barber aged 42 years presented with a healed ulcer as below, over the lower medial aspect of the right leg. On examination, he has varicose veins on both his legs. What is the most likely type of ulcer he had? (Q859836)

A. Neuropathic ulcer

B. Arterial ulcer

C. Venous ulcer

D. Tubercular ulcer



See Answer in Part B → Q138

@Neet_pg_bot

Q139: False regarding deep second-degree burns: (Q859883)

A. Heal by scar deposition

B. No blanching

C. Damage to the deeper dermis

D. Completely painless

See Answer in Part B → Q139

@Neet_pg_bot

Q140: What is the diagnosis based on the image below? (Q859893)

A. Botryomycosis

B. Erysipelas

C. Ecthyma

D. Carbuncle



See Answer in Part B → Q140

@Neet_pg_bot

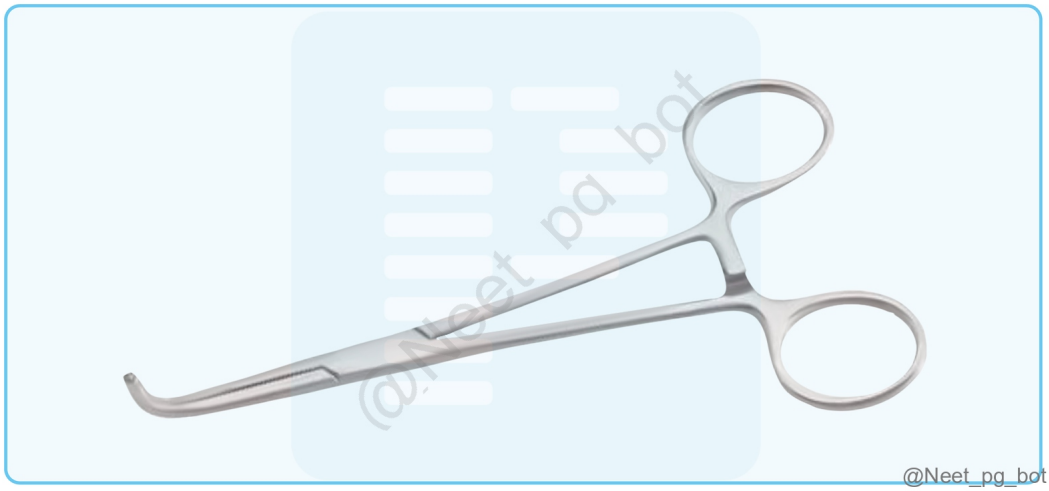
Q141: Identify the surgical instrument depicted in the provided image. (Q854778)

A. Mixter Forceps

B. Rampley Forceps

C. Kocher Forceps

D. Adson Forceps



See Answer in Part B → Q141

@Neet_pg_bot

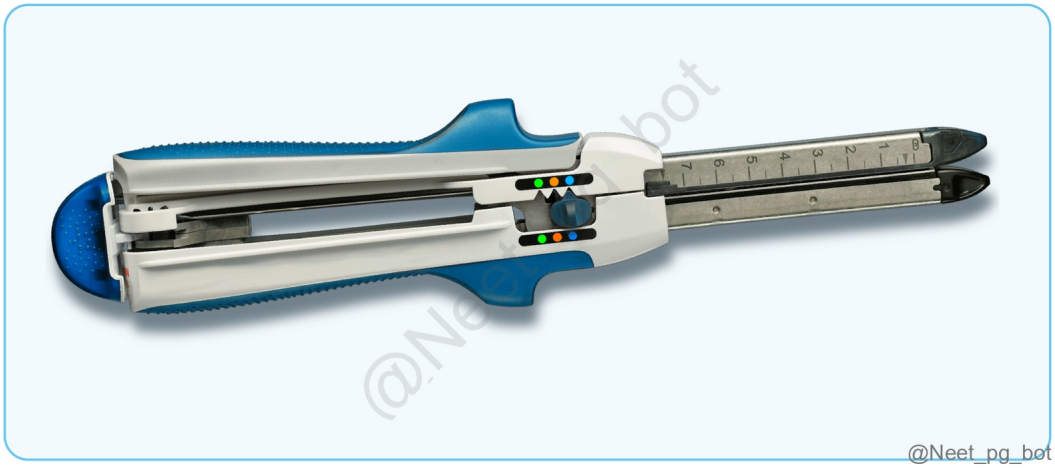
Q142: Please determine the instrument provided. (Q857871)

A. Linear stapler

B. Skin stapler

C. Circular stapler

D. Curved stapler



See Answer in Part B → Q142

@Neet_pg_bot

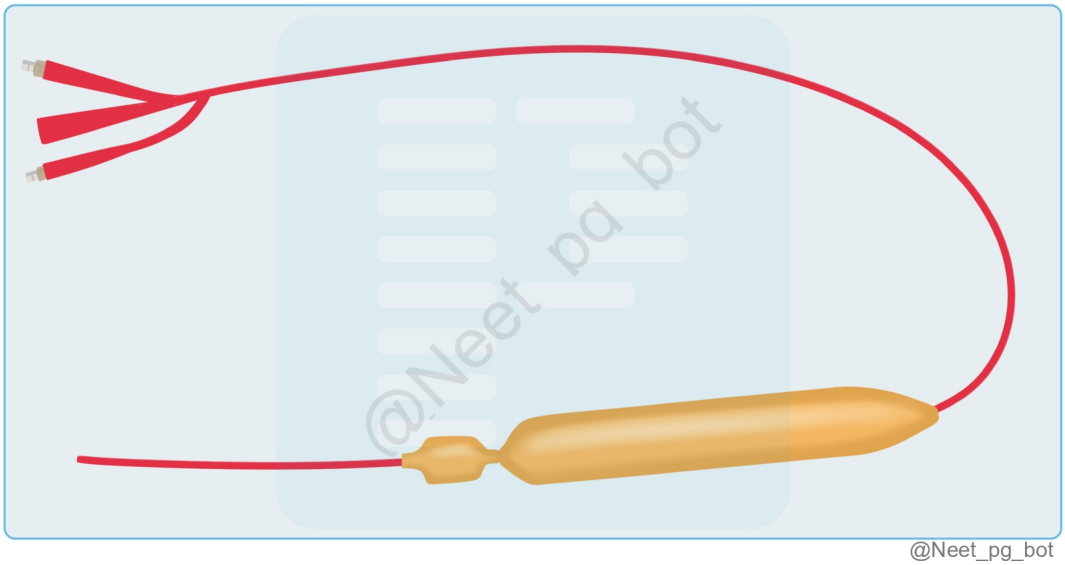
Q143: Which of the following are used to stop oesophagal variceal bleeding? A. B. C. D. (Q856236)

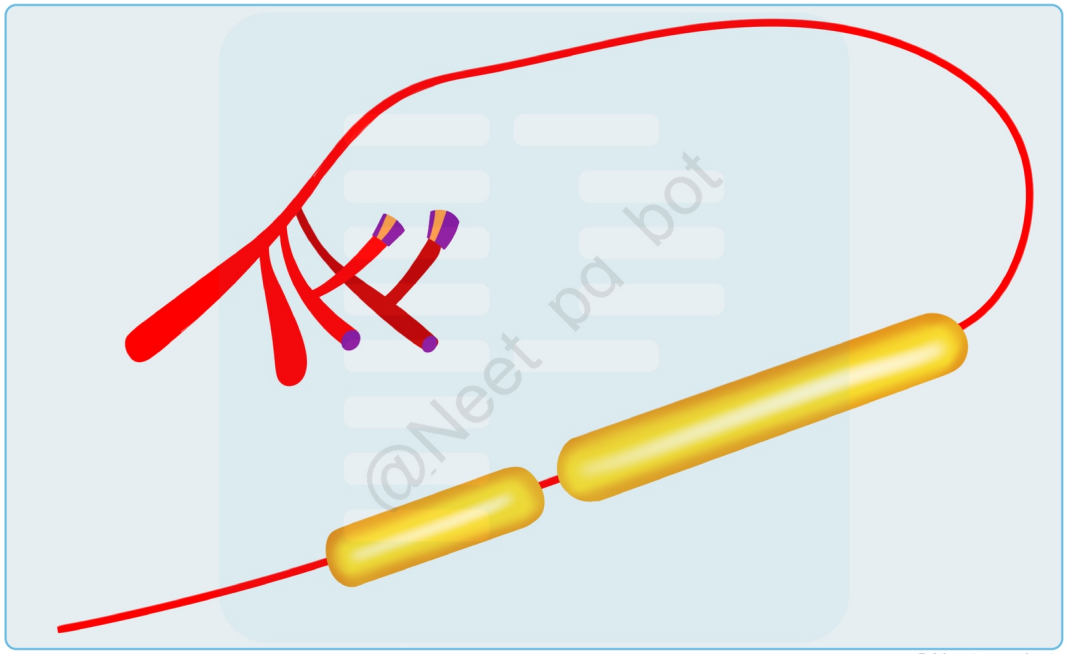
A. A, B & C

B. A and B only

C. B and C

D. A, B and D





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See Answer in Part B → Q143

@Neet_pg_bot

Q144: A 38-year-old man was brought to the emergency department after sustaining an RTA and injury to the lower chest. On presentation, the patient is stable, and vitals are normal . Chest radiography showed clear lung fields. What is the next step in management? (Q801160)

A. eFAST

B. Tube thoracostomy

C. CECT chest

D. CECT abdomen

See Answer in Part B → Q144

@Neet_pg_bot

Q145: Which of the following CT findings is not an indication to perform angiography in a splenic trauma patient under conservative management? (Q793370)

A. Subcapsular hematoma covering 40% surface area.

B. Significant hemoperitoneum

C. Presence of pseudoaneurysm

D. Contrast extravasation

See Answer in Part B → Q145

@Neet_pg_bot

Q146: What would be the subsequent course of action for this injury depicted in the image after a three-day period following a Road Traffic Accident (RTA)? (Q793911)

A. Debridement of necrotic tissue with primary closure

B. Debridement of necrotic tissue and hyperbaric oxygen

C. Amputation

D. Clean and close with rotation flap



See Answer in Part B → Q146

@Neet_pg_bot

Q147: What is the likely reason behind the occurrence of surgical emphysema in the patient following an emergency tracheostomy performed outside of the hospital? (Q793917)

A. Puncture of posterior wall

B. High tracheostomy

C. Blockage of the tube

D. Tight suture

See Answer in Part B → Q147

@Neet_pg_bot

Q148: Which of the following is not included in the AAST grading system for splenic trauma? (Q793921)

A. Parenchymal destruction

B. Vascular involvement

C. Adjacent organ involvement

D. Hematoma

See Answer in Part B → Q148

@Neet_pg_bot

Q149: What guidance would you provide to the female patient prior to undergoing laparoscopic surgery? (Q793926)

A. Eat full before surgery.

B. Drink plenty of water before surgery.

C. Enema on the night before surgery

D. NPO for specific hours before surgery

See Answer in Part B → Q149

@Neet_pg_bot

Q150: Which of the following tests is not conducted before a blood transfusion for a person with RTA, when a family member is volunteering for blood donation? (Q793932)

A. Hepatitis A

B. Hepatitis B

C. Hepatitis C

D. HIV 1 & 2

See Answer in Part B → Q150

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Part B — All Answers & Explanations

• [01_Neurosurgery] 001 Cerebrovascular Diseases

« Back to Folder Directory

[01_Neurosurgery] 001 Cerebrovascular Diseases — Quick Jump

Q1 (p. 1120) *Q2 (p. 1122)* *Q3 (p. 1124)* *Q4 (p. 1125)* *Q5 (p. 1126)* *Q6 (p. 1128)*
Q7 (p. 1130) *Q8 (p. 1132)* *Q9 (p. 1134)* *Q10 (p. 1135)* *Q11 (p. 1137)* *Q12 (p. 1138)*

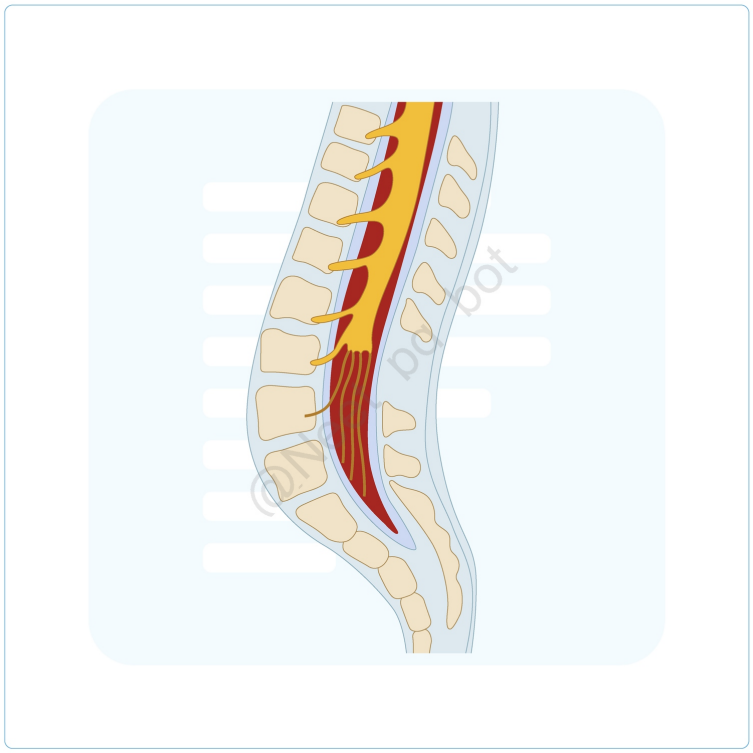
Q1: A 25-year-old asymptomatic patient undergoes a routine lumbar spine X-ray for an unrelated complaint. The radiologist notices an incidental finding on the image. Which of the following findings would be inconsistent with spina bifida occulta? (Q849163)

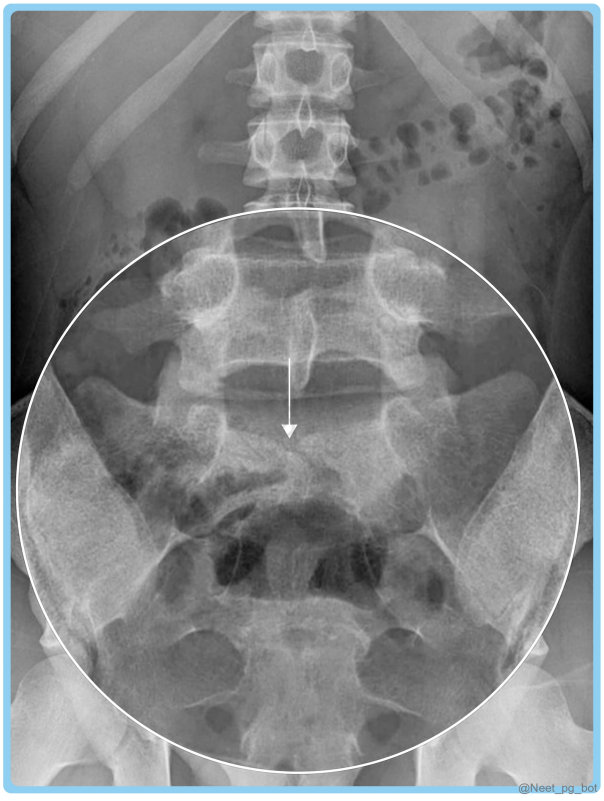
A. Tuft of hair or dimple over the affected area

B. Often asymptomatic and found incidentally on imaging

C. Failure of vertebral arches to fuse with intact spinal cord and meninges

D. Visible sac with cerebrospinal fluid and neural elements protruding through a defect



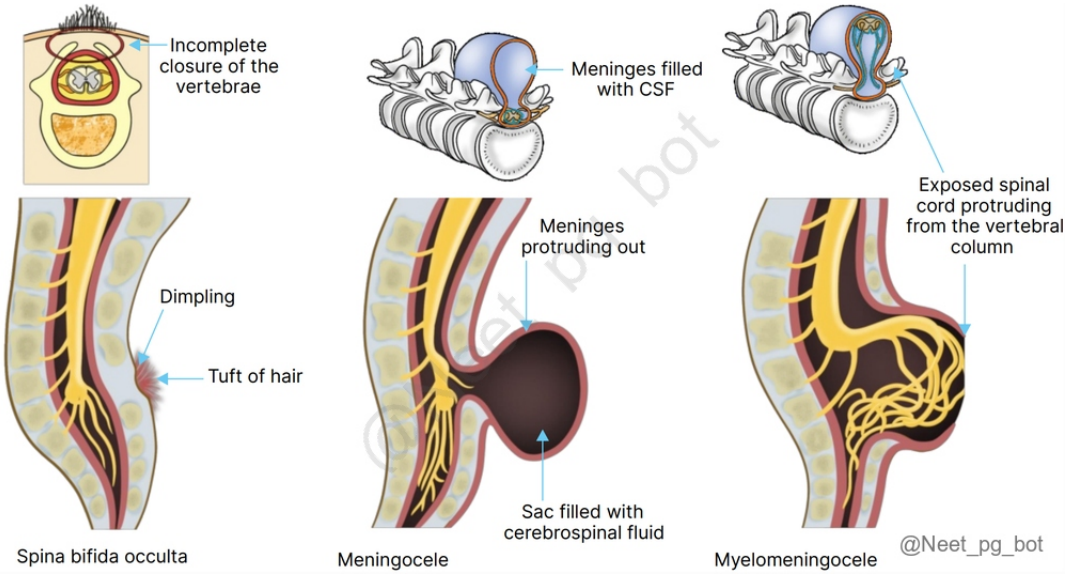


Correct Answer: D. Visible sac with cerebrospinal fluid and neural elements protruding through a defect

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Spina bifida occulta is characterised by: Failure of vertebral arches to fuse with the spinal cord and meninges remaining within the spinal canal (Option C). It is often asymptomatic and discovered incidentally on imaging (Option B). External signs like a tuft of hair or dimple over the affected area (Option A). In contrast, a visible sac containing cerebrospinal fluid and neural elements protruding through a defect (Option D) indicates spina bifida aperta , specifically meningocele and myelomeningocele, not spina bifida occulta.



References:

Schwartz's Principles of Surgery, 11th edition, Pg 1872

↑ *Back to this question in Part A*

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Q2: A 28-year-old pregnant woman at 20 weeks of gestation undergoes a routine ultrasound, which reveals a fluid-filled sac at the lower back of the fetus. Which statement about myelomeningocele is most accurate? (Q849164)

A. Protrusion of meninges through a vertebral defect

B. Sac contains cerebrospinal fluid but no neural elements.

C. Better prognosis than other spina bifida types

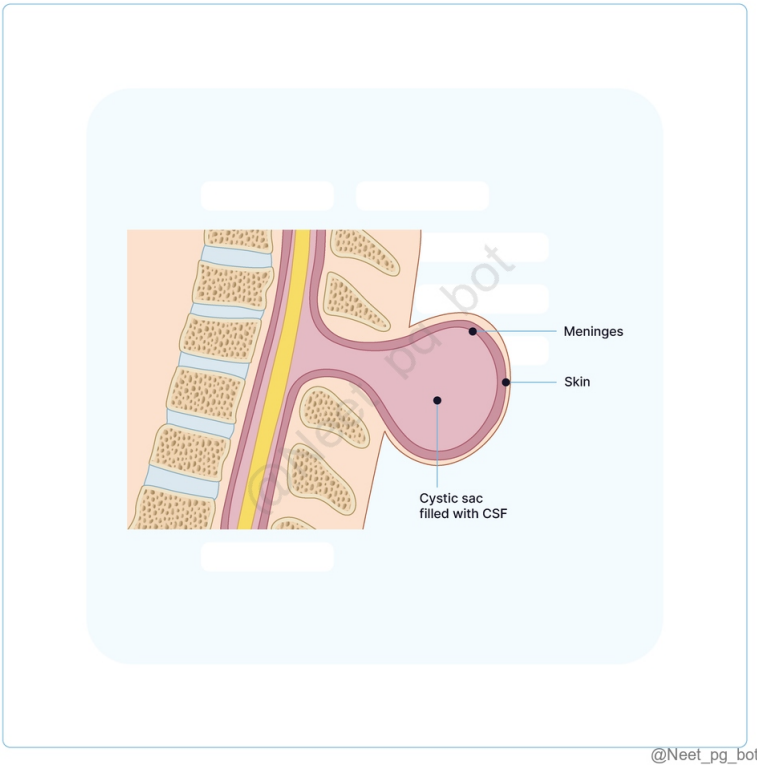
D. Includes spinal cord tissue within the protruding sac.

Correct Answer: D. Includes spinal cord tissue within the protruding sac.

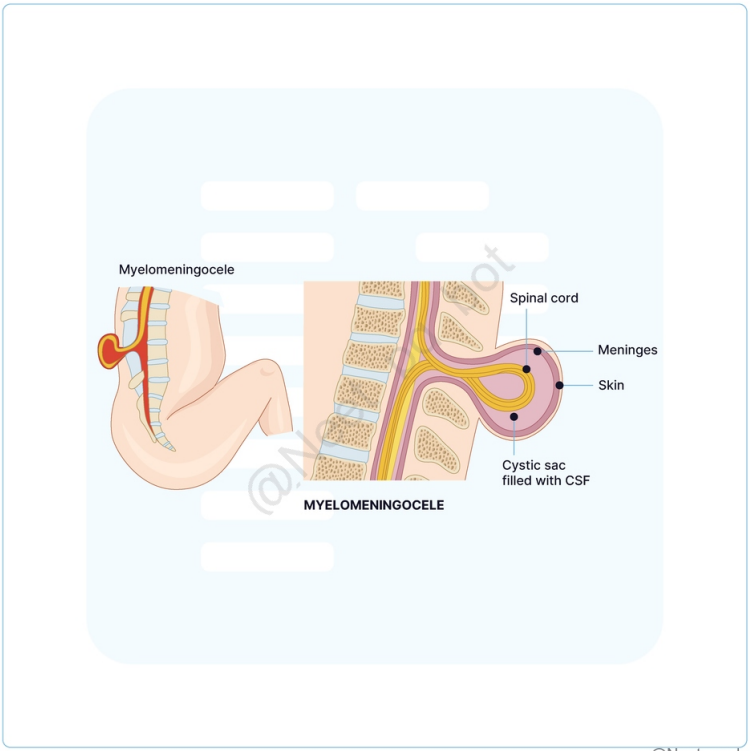
■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Myelomeningocele involves the herniation of the spinal cord, meninges, and cerebrospinal fluid through a vertebral defect. The presence of spinal cord tissue within the sac differentiates myelomeningocele from other forms of spina bifida, such as meningocele , in which only the meninges and cerebrospinal fluid are present in the sac without spinal cord involvement. Feature Meningocele Myelomeningocele Definition Protrusion of meninges through a vertebral defect (Option A) Protrusion of meninges and spinal cord through a vertebral defect (Option D) Sac contents Cerebrospinal fluid only. Cerebrospinal fluid and neural tissue. Neural involvement No neural elements in the sac (Option B) Spinal cord and/or nerve roots in the sac Skin coverage Often covered by skin Usually not covered by skin (open lesion) Neurological deficits Typically mild or absent Often severe Hydrocephalus risk Lower risk Higher risk Prognosis Generally better (Option C) Generally worse Surgical complexity Less complex More complex Long-term complications Fewer More frequent and severe Associated anomalies Less common More common



@Neet_pg_bot



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References:

Schwartz's Principles of Surgery, 11th edition, Pg 1872 Bailey & Love's Short Practice of Surgery, 28th edition, Pg 522, 719

↑ *Back to this question in Part A*

@Neet_pg_bot

Q3: Which of the following medications, when taken during pregnancy, is most strongly associated with an increased risk of myelomeningocele in the developing fetus? (Q849165)

A. Metformin

B. Valproic acid

C. Amoxicillin

D. Levothyroxine

Correct Answer: B. Valproic acid

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Valproic acid (anti-convulsant) is most strongly associated with an increased risk of myelomeningocele when taken during pregnancy. Metformin, amoxicillin, and levothyroxine are not specifically associated with significantly increased myelomeningocele risk (Options A, C, and D ruled out) Other drugs associated with increased risk of neural tube defects: Medication Primary Use Valproic acid Epilepsy, Bipolar disorder Carbamazepine Epilepsy, Trigeminal neuralgia Phenytoin Epilepsy Topiramate Epilepsy, Migraine prevention Methotrexate Cancer, Autoimmune diseases Trimethoprim Urinary tract infections Sulfasalazine Inflammatory bowel disease, Rheumatoid arthritis Mycophenolate mofetil Organ transplant rejection prevention Isotretinoin Severe acne Lithium Bipolar disorder

References:

https://pubmed.ncbi.nlm.nih.gov/12790884/

↑ *Back to this question in Part A*

@Neet_pg_bot

Q4: Which of the following is most commonly associated with Arnold-Chiari malformation type II? (Q849166)

A. Syringomyelia

B. Myelomeningocele

C. Adult-onset headaches

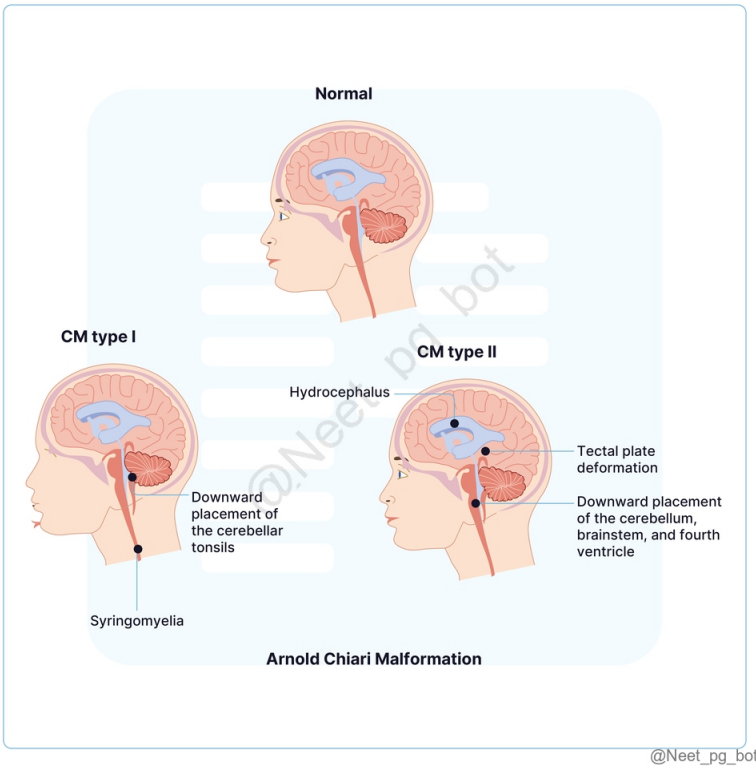
D. Scoliosis

Correct Answer: B. Myelomeningocele

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Arnold-Chiari malformation type II is almost always associated with myelomeningocele, a severe form of spina bifida where the spinal cord and meninges protrude through a defect in the spine. Feature Chiari I Chiari II Myelomeningocele Rare Almost always present Age at diagnosis Often adolescence/adulthood Usually, infancy or prenatal Syringomyelia Can occur More frequent Herniated structures Cerebellar tonsils only Cerebellar tonsils, vermis, brainstem Hydrocephalus Less common Very common



References:

Sabiston's Textbook of Surgery, 21 edition, pg 1909 - 1911 Bailey & Love's Short Practice of Surgery, 28th edition, Pg 719

↑ *Back to this question in Part A*

@Neet_pg_bot

Q5: Which of the following is NOT part of the classic triad of Dandy-Walker malformation? (Q849167)

A. Cystic dilatation of the fourth ventricle

B. Complete or partial agenesis of the cerebellar vermis

C. Enlarged posterior fossa

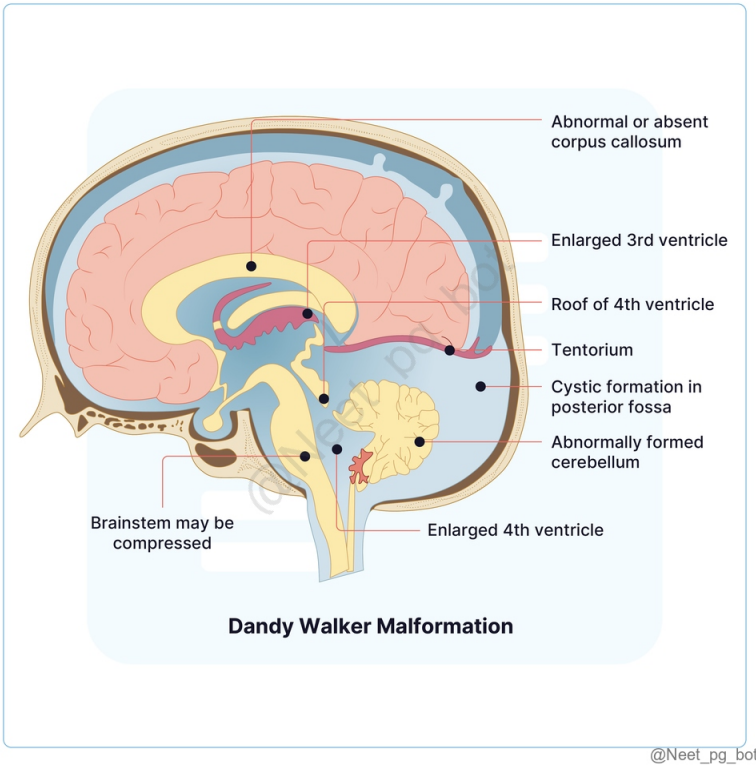
D. Hydrocephalus

Correct Answer: D. Hydrocephalus

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Hydrocephalus is not part of the classic triad of Dandy-Walker malformation. Dandy-Walker Malformation: Most frequent posterior fossa malformation and is due to the developmental failure of the fourth ventricle's roof. The classic triad consists of: Cystic dilatation of the fourth ventricle (Option A) Complete or partial agenesis of the cerebellar vermis (Option B) Enlarged posterior fossa with elevation of the tentorium cerebelli (Option C) Clinical Presentation: Macrocephaly (most common manifestation). Rapid head growth with prominent occiput. Possible long tract signs and cerebellar ataxia. Delayed motor/cognitive milestones. Associated Anomalies: CNS abnormalities in 70% of cases, including: Agenesis of posterior cerebellar vermis and corpus callosum Cortical dysplasia Polymicrogyria Diagnosis: MRI is the imaging modality of choice Treatment: Shunt placement for cystic cavity in patients with hydrocephalus.





MRI of a Dandy - Walker Variant Showing

(A) Axial T2W

(B, C) Coronal T1W

(D) Shows hypoplasia of the inferior vermis with anterosuperior rotation

@Neet_pg_bot

References:

Bailey & Love's Short Practice of Surgery, 28th edition, Pg 719

↑ *Back to this question in Part A*

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Q6: A 42-year-old male is brought to the emergency department after collapsing at home. His family reports that he suddenly screamed in pain, clutching his head and describing it as the "worst headache of his life," followed by several episodes of vomiting. On examination, he is confused, has significant neck stiffness (nuchal rigidity), and shows marked photophobia. There is no history of recent head trauma. A non-contrast CT scan of the brain is shown below. Which of the following is the most common cause of this patient's condition? (Q849169)

A. Smoking

B. Rupture of a berry aneurysm

C. Severe hypertension

D. Arteriovenous malformation



Correct Answer: B. Rupture of a berry aneurysm

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The patient’s presentation of a 'thunderclap' headache during activity, in the absence of trauma, combined with the CT findings of blood in the basal cisterns, is pathognomonic for a spontaneous Subarachnoid Hemorrhage (SAH) ." Subarachnoid Hemorrhage: Causes: Ruptured Berry Aneurysm: The most common cause of spontaneous SAH . Most frequently located in the Anterior Communicating Artery of the Circle of Willis. (Option B) Arteriovenous Malformation (AVM): A less common cause of spontaneous SAH, more frequently associated with intraparenchymal bleeds in younger patients. (Option D) Perimesencephalic SAH : Bleeding is confined to the basal cisterns due to venous bleeding and is associated with a better prognosis. Risk factors: Female sex Hypertension (Option C) Smoking & Cocaine use (Option A) Genetic disorders (e.g., adult polycystic kidney disease , Marfan syndrome) Symptoms: Thunderclap Headache : Sudden and severe headache. Associated with Seizures (10%), Unresponsiveness (50%) and Vomiting (70%) Diagnosis: CT Scan : First-line imaging , effective within 12 hours of onset, and its sensitivity decreases after one week. Lumbar Puncture : Used if CT is negative but SAH is suspected. Digital Subtraction Angiography (DSA) : Gold standard for visualising aneurysms. Management: Surgical or endovascular intervention and addressing complications such as vasospasm and electrolyte imbalances . Early and effective treatment is crucial for improving outcomes.

References:

Bailey & Love’s Short Practice of Surgery, 28th edition, Pg - 708, 709

↑ *Back to this question in Part A*

Q7: A 55-year-old patient presents with a sudden severe headache, brief loss of consciousness, nausea, and vomiting. Neurological examination shows decreased consciousness and mild focal deficits. A non-contrast CT scan of the head is provided. What is the most probable diagnosis? (Q849170)

A. Subdural Hematoma (SDH)

B. Extradural Hematoma (EDH)

C. Subarachnoid Hemorrhage

D. Periventricular Hemorrhage



Correct Answer: A. Subdural Hematoma (SDH)

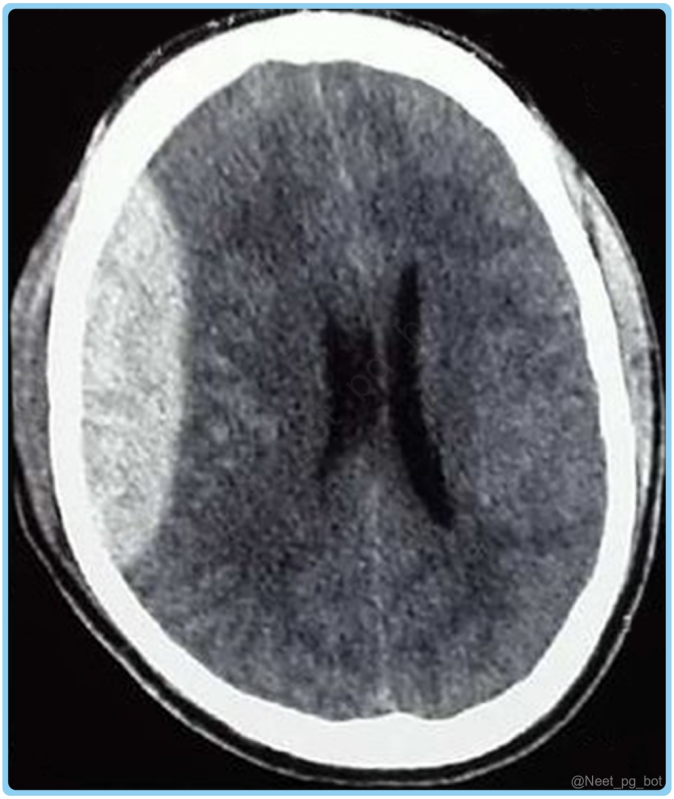
■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Given the clinical scenario and radiological findings showing a crescent-shaped blood collection that follows the brain's contours and crossing suture lines , the most probable diagnosis is Subdural Hematoma. Features Subdural Hematoma Extradural Hematoma (Option B) Location Between Dura and Arachnoid Between

Dura and Skull CT Appearance Crescent-shaped Crosses suture lines Biconvex or lens-shaped Well-defined & Localized, Won’t cross suture lines Common Causes Tearing of bridging veins , often due to blunt trauma / acceleration-deceleration injuries Rupture of the middle meningeal artery or vein due to skull fracture or trauma Onset Develop over days to weeks; Acute SDH can occur rapidly Usually develop rapidly Management Craniotomy / Craniectomy , if significant. Conservative management for smaller, stable cases. Burr hole drainage is preferred for significant chronic cases Urgent surgical evacuation for significant or deteriorating cases.





References:

Bailey & Love's Short Practice of Surgery, 28th edition, Page - 365, 366, 367

↑ *Back to this question in Part A*

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Q8: A 52-year-old male with a history of hypertension and smoking presents with sudden onset of nausea, vomiting, and confusion. On examination, he has a decreased level of consciousness and neck stiffness. A non-contrast CT scan reveals subarachnoid haemorrhage. Which of the following statements about Berry aneurysms is not true? (Q849173)

A. Associated with connective tissue disorders like Marfan's syndrome.

B. Absence of smooth muscle and intimal elastic lamina.

C. Most commonly seen at the bifurcation of the vertebrobasilar arteries.

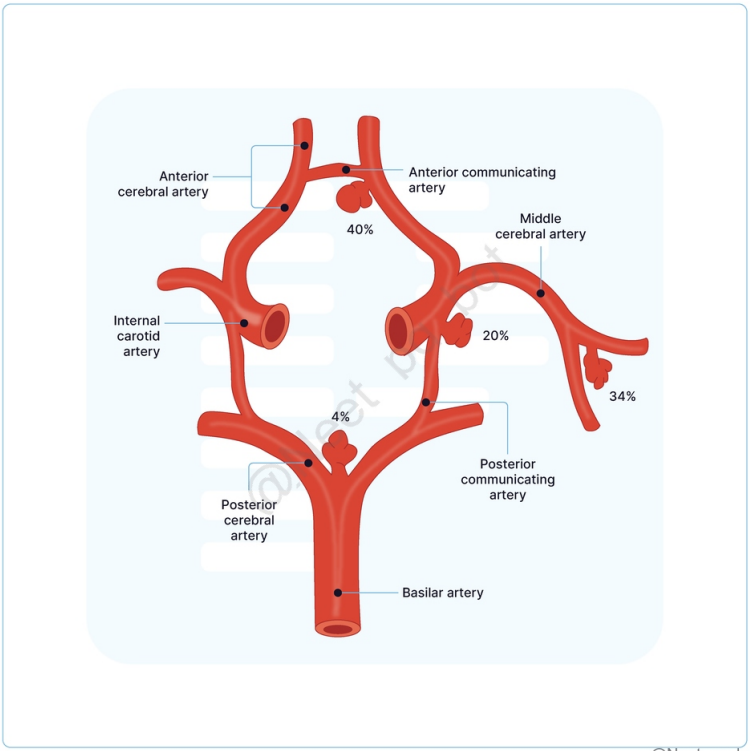
D. Unruptured cases are asymptomatic

Correct Answer: C. Most commonly seen at the bifurcation of the vertebrobasilar arteries.

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Berry aneurysms are most commonly found at the bifurcations in the anterior circulation of the Circle of Willis, such as the junction of the anterior cerebral and anterior communicating artery , not at the bifurcation of the vertebrobasilar arteries. It is the most common type of intracranial aneurysm. Saccular & typically located in the anterior circulation of the Circle of Willis. Common Sites: Junction of Anterior Communicating and Anterior Cerebral Artery (Most Common) > Bifurcation of MCA (2nd Most Common) > Junction of PCA and Internal Carotid Artery > Intracranial Carotid Bifurcation > Bifurcation of Vertebrobasilar (Option C) Structural Features: Absence of Smooth Muscle and Intimal Elastic Lamina (Option B) Wall Composition: Thickened, hyalinised intima Clinical Presentation: Ruptured Berry Aneurysm: Can cause subarachnoid haemorrhage (SAH) or intracerebral haemorrhage and the most common rupture site is the dome or apex. Unruptured Berry Aneurysm: Usually asymptomatic and often discovered incidentally. (Option D) Treatment: Endovascular Coil Occlusion: Preferred method. Surgical Clipping: Used if endovascular methods are unsuitable. Conditions Associated with Berry Aneurysms: Fibromuscular Dysplasia (FMD) Marfan's Syndrome (Option A) Ehlers-Danlos Syndrome Coarctation of aorta Autosomal dominant Polycystic Kidney disease



References:

Sabiston's Textbook of Surgery, 21 edition, Pg - 1887, 1888

↑ *Back to this question in Part A*

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Q9: A 45-year-old man with a recent dental infection presents with persistent headaches, fever, and confusion. He exhibits focal neurological deficits and seizures. The radiological findings are provided. Given his clinical presentation and imaging, what is the most appropriate next step in the management of this patient? (Q849174)

A. Initiate IV antibiotics and immediate surgical drainage

B. Start oral antibiotics and monitor with CT every 48 hours

C. Administer high-dose corticosteroids and supportive care

D. Begin antiepileptic medications and refer for op follow-up.



Correct Answer: A. Initiate IV antibiotics and immediate surgical drainage

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Given the history of a recent dental infection, along with imaging showing a ring-enhancing lesion in the frontal lobe and symptoms of fever, confusion, and seizures, the most likely diagnosis is a Brain abscess. The mainstay treatment includes both surgical intervention and antibiotic therapy. Brain Abscess: Pathology: Direct Spread: From air sinus infections or following brain surgery. Hematogenous Spread: Typically associated with respiratory infections, endocarditis, or dental infections. Symptoms include fever, confusion, seizures, focal

neurological deficits and raised ICT. Most common in the frontal lobe , but are also frequently found in the parietal lobe, particularly in cases of hematogenous spread. Imaging: CT Scan (Initial Choice) : Shows hypodense oedema initially, progressing to a ring-enhancing mass as the abscess matures. MRI (IOC): Identifies restricted diffusion Management: (Mainstay: Surgery + Antibiotics) Early Surgical Drainage: Essential for effective treatment. Antibiotics: IV antibiotics are administered for approximately 6 weeks. Prophylactic Anticonvulsants: Considered due to a high risk of seizures. Multiple smaller abscesses: IV Antibiotics. Steroids: Reduce oedema and alleviate symptoms of mass effect.



References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 706, 707

↑ *Back to this question in Part A*

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Q10: A 58-year-old patient presents with a significant right-sided brain tumour. During the neurological examination, the patient exhibits right-sided weakness. Which of the following best accounts for this presentation? (Q849175)

A. Kernohan notch phenomenon

B. Brown-Sequard syndrome

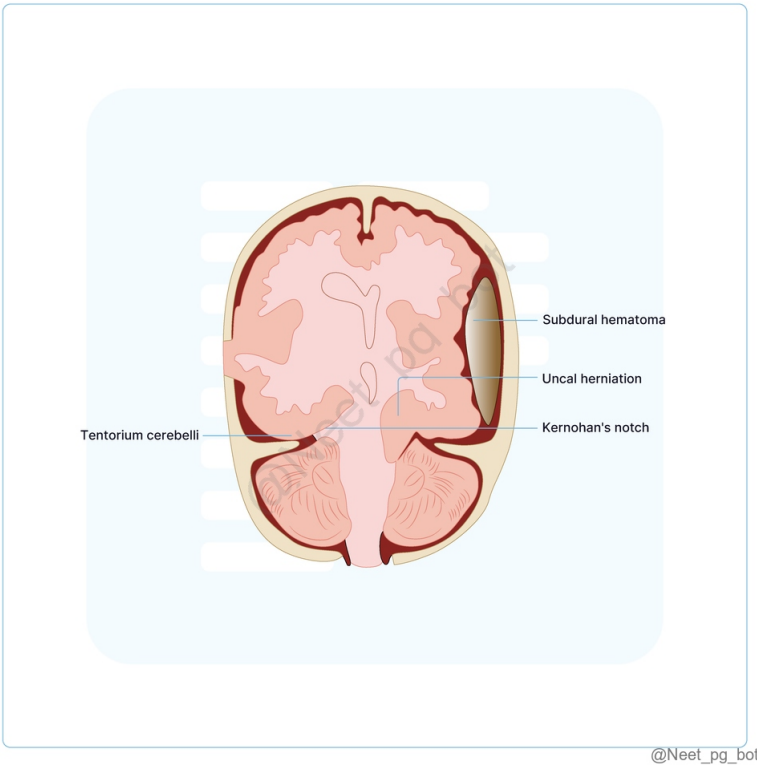
C. Tullio phenomenon

D. Uhthoff's phenomenon

Correct Answer: A. Kernohan notch phenomenon

- *Listen (English)*
- *Listen (Hindi)*

Explanation: Kernohan notch phenomenon is a false localizing sign where a large intracranial mass (SOL) causes motor paralysis on the ipsilateral (same) side as the lesion. Mechanism: Mass Effect: A large mass (e.g., right-sided subdural hematoma or tumor) causes uncal herniation, pushing the midbrain toward the opposite side. Contralateral Compression: The opposite (left) cerebral peduncle is forced against the tough, sharp edge of the tentorium cerebelli (the "notch"). Indentation: This creates a physical indentation (Kernohan's notch) in the motor fibers of that peduncle. Paradoxical Result: Because the motor fibers in the left peduncle have not yet crossed (decussated) to the other side of the body, damaging them results in weakness on the right side of the body. Clinical Presentation: Ipsilateral Hemiparesis: Weakness occurs on the same side as the primary mass. This is "false localizing" because normally, a right-sided brain mass causes left-sided weakness. Ipsilateral CN III Palsy: The oculomotor nerve on the side of the mass is often compressed, leading to a "blown pupil" and ptosis on the same side as the tumor. Brown-Sequard Syndrome (Option B) involves damage to one side of the spinal cord, leading to specific patterns of sensory and motor deficits which don't match the brain tumour scenario. Tullio Phenomenon (Option C) is associated with inner ear disorders causing dizziness and hearing problems, and it is not relevant to motor deficits from a brain tumour. Uhthoff's Phenomenon (Option D) involves the worsening of neurological symptoms with heat in conditions like multiple sclerosis, which is not related to a brain tumour's mass effect.



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References:

SRB’s Manual of Surgery, 6th Edition, Page - 1077, 1081

↑ *Back to this question in Part A*

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Q11: A 62-year-old man is brought to the emergency department after a fall from a ladder. He has a GCS score of 9 (E2V3M4), and his right pupil is dilated and nonreactive. The CT scan shows a large right-sided subdural hematoma with a significant midline shift to the left. BP: 180/100 mmHg, HR: 52 beats/minute with irregular breathing patterns. Which type of brain herniation is most likely occurring in this patient? (Q849177)

A. Subfalcine herniation

B. Tonsillar herniation

C. Upward transtentorial herniation

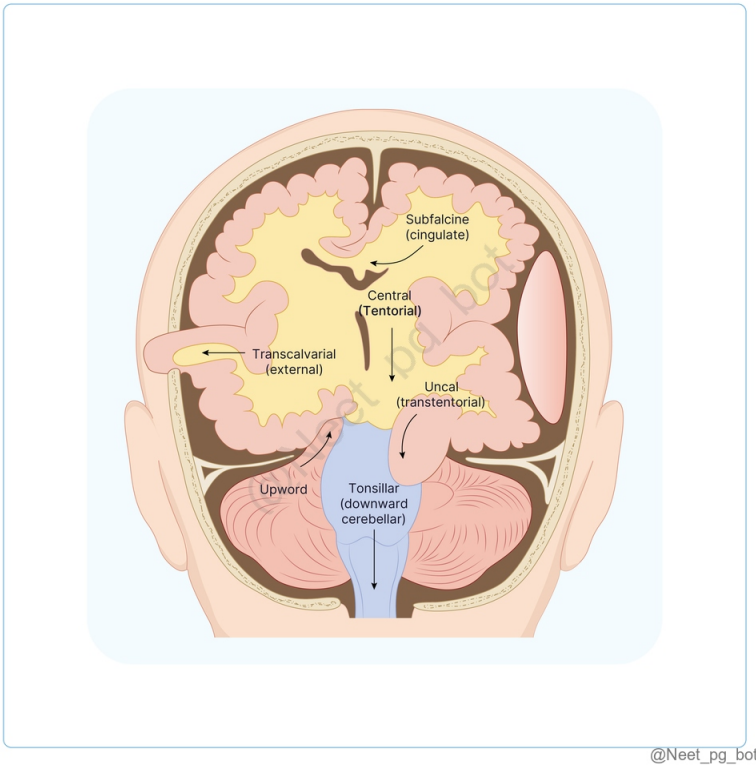
D. Uncal herniation

Correct Answer: D. Uncal herniation

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The patient is most likely experiencing uncal herniation based on the following findings: Large Right-Sided Subdural Hematoma: Creates a space-occupying lesion, leading to significant mass effect. Significant Midline Shift to the Left : Indicates severe displacement of brain structures. Dilated and Nonreactive Right Pupil: A classic sign of uncal herniation due to oculomotor nerve compression. Decreased Level of Consciousness (GCS 9): Resulting from brainstem compression. Signs of Cushing's Triad: I ncluding hypertension, bradycardia, and irregular breathing, indicative of increased intracranial pressure. Uncal herniation occurs when the medial temporal lobe (uncus) is displaced downward through the tentorial notch, compressing the ipsilateral oculomotor nerve and brainstem .



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References:

Bailey & Love's Short Practice of Surgery, 28th edition, page 360, 361

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Q12: A 62-year-old man undergoes emergent decompressive craniectomy for a large right hemispheric infarct with significant mass effect. Post-surgery, he remains comatose and, six hours later, develops pinpoint pupils and irregular breathing. A stat CT scan shows resolution of the midline shift but reveals new bilateral hyperdense lesions in the midbrain. What is the most likely explanation for these new CT findings? (Q849179)

A. Contrast extravasation

B. Hemorrhagic transformation of infarct

C. Duret haemorrhage

D. Hypertensive microbleeds

Correct Answer: C. Duret haemorrhage

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The new CT findings are most consistent with Duret haemorrhage , characterised by small, linear or flame-shaped haemorrhages primarily in the midbrain and upper pons. It is typically caused by the rapid displacement of the brainstem, which can occur due to significant mass effects or sudden changes in intracranial pressure, such as those seen after decompressive surgery. This results from stretching and tearing the perforating branches of the basilar artery. Clinically present with persistent coma, pinpoint pupils, and irregular breathing suggest brainstem dysfunction, suggesting brainstem dysfunction. Contrast extravasation (Option A) would be unusual without recent contrast administration and typically doesn't present with bilateral midbrain lesions. Hemorrhagic transformation of infarct (Option B) : While possible, this would typically occur in the area of the original infarct (right hemisphere), not in the midbrain. Hypertensive microbleeds (Option D) usually occur over time and are more commonly found in other areas of the brain, not specifically bilateral in the midbrain.

References:

Sabiston’s Textbook of Surgery, 21st edition, page 1885

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• [01_Neurosurgery] 002 Cns Tumors

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[01_Neurosurgery] 002 Cns Tumors — Quick Jump

Q1 (p. 1140)	*Q2 (p. 1141)*	*Q3 (p. 1141)*	*Q4 (p. 1142)*	*Q5 (p. 1143)*	*Q6 (p. 1145)*
Q7 (p. 1147)	*Q8 (p. 1148)*	*Q9 (p. 1150)*	*Q10 (p. 1151)*	*Q11 (p. 1152)*	*Q12 (p. 1154)*
Q13 (p. 1156)	*Q14 (p. 1157)*	*Q15 (p. 1158)*	*Q16 (p. 1161)*	*Q17 (p. 1163)*	

Q1: A 7-year-old child presents with a headache which gets worse in the morning, associated with nausea, vomiting, and vertigo. The radiograph revealed a type of brain tumour in the 4th ventricle. Which of the following is the investigation of choice in this case? (Q849223)

A. MRI

B. Ultrasonography

C. X-ray

D. CT scan

Correct Answer: A. MRI

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The clinical presentation suggests Ependymoma , and the investigation of choice for this condition is MRI. Origin: Arises from the cuboidal or columnar epithelium lining the ventricular system in the cerebral hemisphere In children , ependymoma is typically located in the 4th ventricle , whereas in adults, it commonly arises from the filum terminale in the lumbosacral region. MRI is the investigation of choice, and it is treated by resection followed by EBRT (External Radiation Beam Therapy) Ultrasound (Option B) , CT scan (Option D), and X-ray (Option C) might help detect it , but cannot be confirmed.

References:

Schwartz’s Principles of Surgery, 11th Edition, Page 1856.

Sabiston’s Textbook of Surgery, 21st Edition, Pages 1894-1895.

↑ *Back to this question in Part A*

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Q2: A 40-year-old man presents with symptoms of spinal cord compression, including back pain and weakness in the legs. MRI reveals a spinal tumour. Which of the following statements about spinal tumours is NOT true? (Q849239)

A. Osteoblastic metastases are often associated with prostate cancer

B. Ependymomas are the most common intramedullary tumours in adults

C. The malignant primary tumour usually involves the vertebral body

D. Most common metastases to the spine are from the Lungs

Correct Answer: D. Most common metastases to the spine are from the Lungs

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The most common metastases to the spine are from Breast malignancies followed by Lung. . Tumor Category Type Description Extradural Tumors (55%) Metastatic Tumors The most common spine tumours, with the most common metastases, are Breast (21%), Lung (14%), Prostate (7.5%), and RCC. Osteolytic Mets Lung cancer, RCC, Multiple myeloma. Osteoblastic Mets Prostate cancer. (Option A) Primary Tumors (2%) Benign Osteoid osteoma, osteoblastoma, chondroma, chondroblastoma, giant cell tumours, hemangioma, and lymphangioma typically occur in posterior elements. Intermediate Aggressive osteoblastoma, chordoma. Malignant Osteosarcoma, chondrosarcoma, Ewing's sarcoma, neuroectodermal tumours, lymphoma, fibrosarcoma, and liposarcoma It usually involves the vertebral body. (Option C) Intradural Tumors (40%) Extramedullary They arise from the meninges or nerve roots. Examples include meningiomas (dural-based, often in the thoracic spine) and schwannomas (benign, from the nerve sheath). Neurofibromas are fusiform and can grow within nerve roots. Intramedullary Arise within spinal cord parenchyma; include ependymomas (most common in adults) (Option B) and astrocytomas (common in children).

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Pages 516-520.

Schwartz's Principles of Surgery, 11th Edition, Pages 1859-1860.

↑ *Back to this question in Part A*

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Q3: A 55-year-old man with a history of immunosuppression is suspected for Primary CNS lymphoma and evaluated. Which of the following is not accurate about this condition? (Q849238)

A. Often shows a dramatic but short-lived response to steroids.

B. Steroids should be withheld before biopsy.

C. Shows no response to steroids.

D. Diagnosis is confirmed with a stereotactic biopsy.

Correct Answer: C. Shows no response to steroids.

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Primary CNS lymphoma typically shows a dramatic but short-lived response to steroids . (Option A) Steroids have a cytolytic effect on the tumour cells and should be withheld before biopsy to ensure accurate diagnosis. (Option B) Cytolytic effect of steroids causes partial/complete resolution on CT. Hence, it is also called a Ghost cell tumour . Primary CNS lymphoma is a rare but increasingly common tumour of the central nervous system, particularly in immunocompromised individuals such as those with AIDS or transplant recipients. Imaging typically shows hyperdense, enhancing lesions. Diagnosis: Confirmed via stereotactic biopsy. (Option D) Treatment : Chemotherapy (especially high-dose methotrexate) and Radiation therapy (EBRT) AIDS patient - Include highly active antiretroviral therapy (HAART).

References:

Sabiston’s Textbook of Surgery, 21st Edition, Page 1896.

↑ *Back to this question in Part A*

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Q4: A 65-year-old patient with a small brain metastasis is being considered for Stereotactic Radiosurgery (SRS). Which statement correctly describes Stereotactic Radiosurgery (SRS)? (Q849237)

A. Delivers broad radiation to treat the entire brain.

B. Delivers a focused dose of radiation to the tumour from multiple angles.

C. Requires prior surgical removal of the tumour.

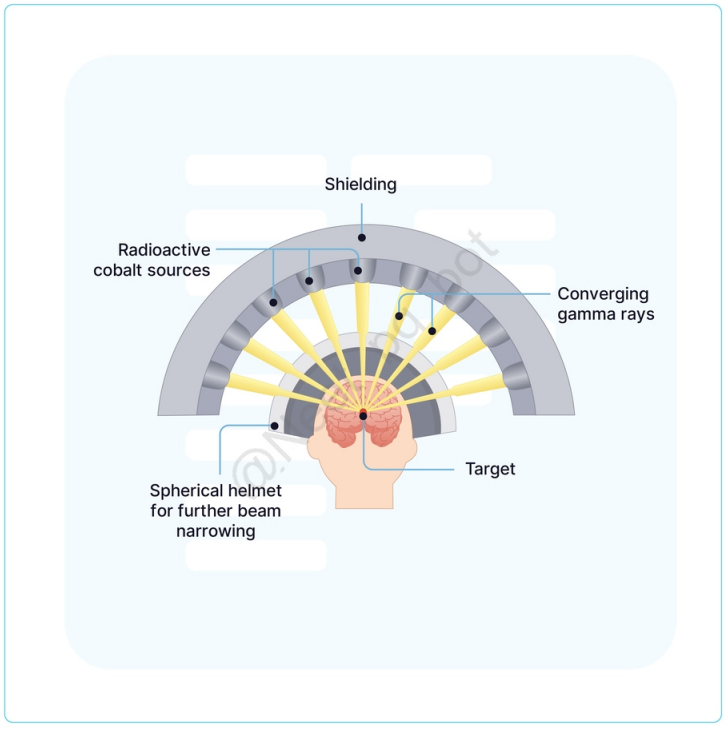
D. Used for large, invasive tumours needing extensive surgery.

Correct Answer: B. Delivers a focused dose of radiation to the tumour from multiple angles.

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Stereotactic Radiation Surgery (SRS) delivers a high dose of targeted radiation to a specific brain volume, minimizing damage to surrounding tissue. Non-surgical radiation therapy to treat functional brain abnormalities and small tumours. Techniques: Gamma Knife (Source: Cobalt-60): Focuses radiation from multiple directions on a single point. Modified Linear Accelerator (Source: High-energy X-rays): Delivers radiation in multiple arcs to minimise damage to surrounding tissue. Applications: SRS is Commonly used in conditions like Brain tumours Benign lesions of cranial nerves Arteriovenous malformations (AVMs) Trigeminal neuralgia Risks: Radiation necrosis Damage to surrounding brain structures



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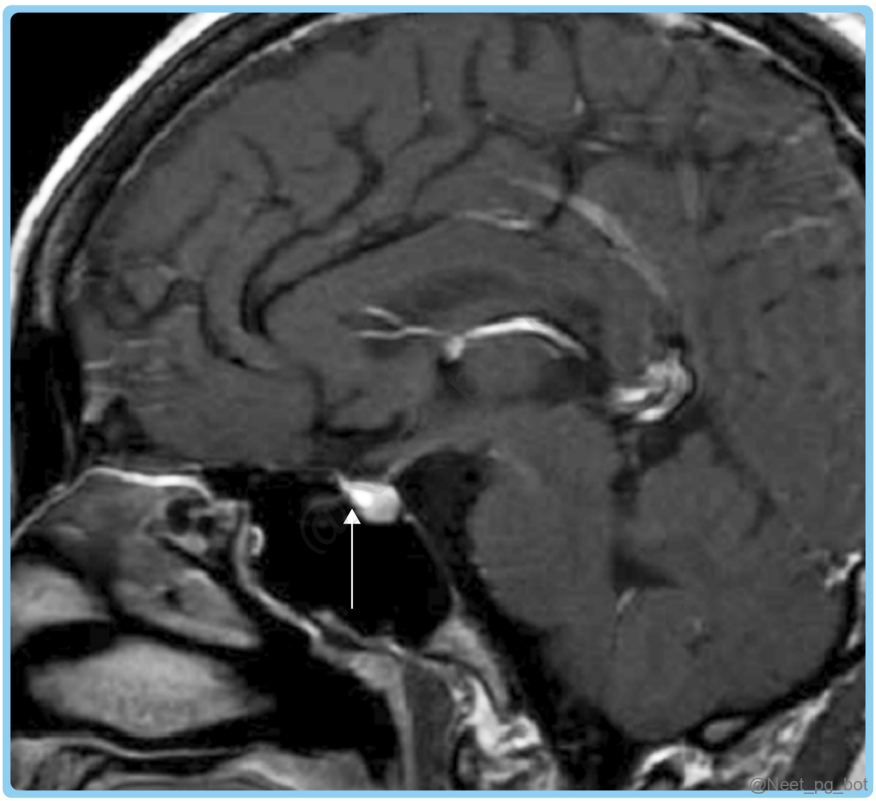
References:

Sabiston’s Textbook of Surgery, 21st Edition, Page 1906.

↑ *Back to this question in Part A*

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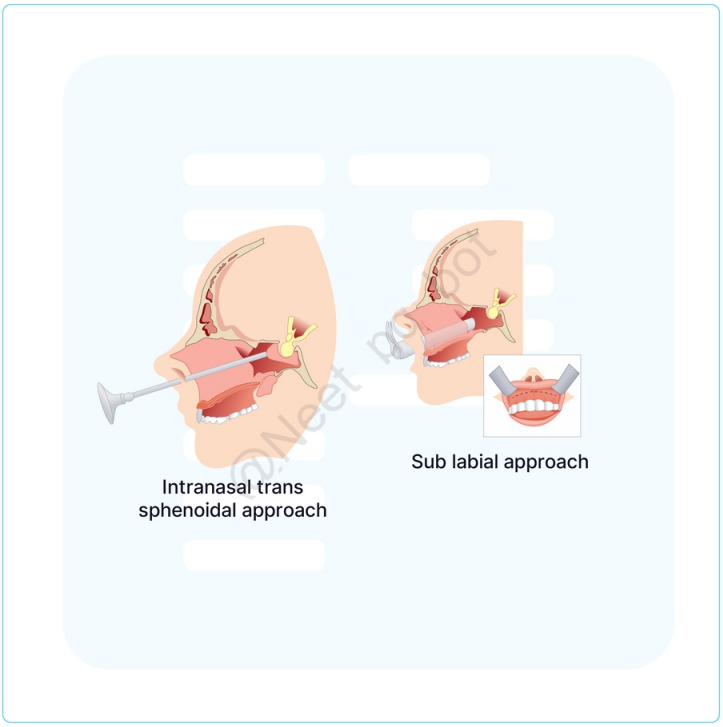
Q5: A 32-year-old woman visits your clinic with complaints of missed periods and noticeable visual disturbances over the past few months. She also reports frequent headaches and mild galactorrhea. MRI shows the findings given in the image. What visual defect is most commonly associated with this condition? (Q849236)



Correct Answer: Unknown

- *Listen (English)*
- *Listen (Hindi)*

Explanation: The given clinical scenario, with Amenorrhea and Galactirhea and an MRI showing mass in the Sella tunica, most probably indicates Pituitary Adenoma (Prolactinoma). The most common visual defect associated with Pituitary Adenoma is Bitemporal hemianopia, which results from the compression of Binasal fibres that cross at the Optic Chiasma. It is the most common Suprasellar mass in adults . Classification: Microadenomas : <10 mm; often incidental or present with endocrine symptoms. Macroadenomas : >10 mm; may cause visual field deficits due to mass effect. Clinical features: Visual Defect : Compression of the optic chiasm often causes bitemporal hemianopia . Endocrine Symptoms : Amenorrhea, galactorrhea, and other hormonal imbalances. Imaging and diagnosis involve MRI as the primary modality, along with serum prolactin and thyroid function tests and visual field charting. Treatment : Medical management Prolactinomas : Dopamine agonists (e.g., bromocriptine, cabergoline). Growth Hormone-Secreting Tumors : Somatostatin analogues (e.g., octreotide). Surgical managemnt Transsphenoidal Approach : Preferred for most cases; craniotomy may be needed for large tumours. Sublabial Approach Indications : Acute visual deterioration, GH-secreting tumours, Cushing's disease, or large non-functioning adenomas causing symptoms.



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References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Pages 716-717.

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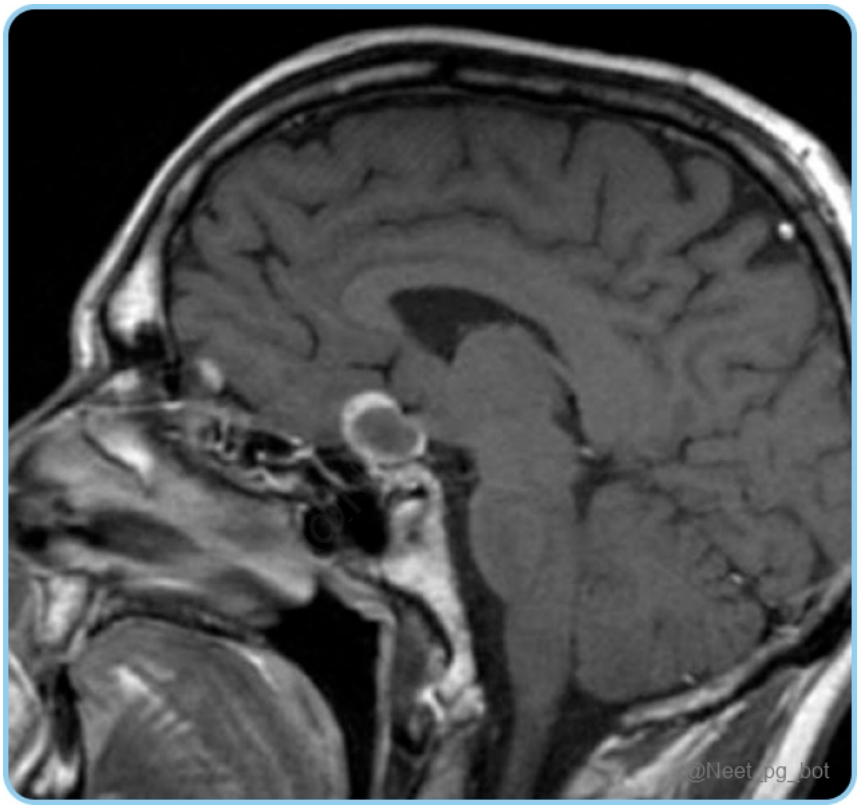
Q6: A 6-year-old child presents with headache, vomiting, blurring of vision, weakness, recent aggression, and weight gain. Examination reveals growth retardation and signs of hypopituitarism. MRI findings are noted. Which of the following is not true regarding this condition? (Q849235)

A. Hypopituitarism is the characteristic feature

B. It is more common in children

C. It is derived from pituitary stalk

D. Growth retardation is also observed



Correct Answer: C. It is derived from pituitary stalk

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The clinical triad of visual field defects , hypopituitarism , and suprasellar calcification in a child strongly suggests a Craniopharyngioma . Origin: It is derived from remnants of Rathke's pouch (the craniopharyngeal duct), not the pituitary stalk itself, though it frequently compresses the stalk. Characteristic MRI & Gross Findings: Cystic Component: This is a hallmark of the adamantinomatous type. On MRI, cysts often show high signal on T1 and T2 sequences due to high protein and cholesterol content. "Machinery Oil" Appearance: On gross inspection or surgical aspiration, the cyst contains a thick, brownish-yellow fluid. This is famously described as looking like "machinery oil" or "crankcase oil" and contains shimmering cholesterol crystals. Calcification: Observed in approximately 90% of pediatric cases. While best seen on CT, it appears as "signal voids" (black spots) on MRI. Solid Component: Usually shows strong, heterogeneous enhancement after contrast administration. Clinical Features: It is more commonly seen in children, with the peak incidence between 5 and 10 years of age (Option B). It presents with headache, vomiting, papilledema, hydrocephalus, visual field, abnormality, cranial nerve palsies, sleep difficulty, weight gain, personality changes, etc. Its characteristic features are: Hypopituitarism (Option A) Growth retardation (Option D) Diabetes insipidus Investigations used are MRI and CT. Management is by surgical resection followed by post-op radiotherapy.

References:

Sabiston's textbook of surgery, 21st Edition, Page 1898.

↑ *Back to this question in Part A*

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Q7: A 52-year-old female patient presents with complaints of difficulty understanding speech and tinnitus. On examination, there is unilateral sensorineural hearing loss, reduced corneal sensitivity, and numbness of the face. Which of the following nerves is most commonly involved in this condition? (Q849234)

A. Inferior vestibular nerve

B. Superior vestibular nerve

C. Cochlear nerve

D. Facial nerve

Correct Answer: A. Inferior vestibular nerve

- *Listen (English)*
- *Listen (Hindi)*

Explanation: The given scenario suggests a case of Acoustic neuroma (also known as vestibular schwannoma, neurilemmoma, or eight-nerve tumour), which most commonly involves the inferior vestibular nerve. It is a benign, encapsulated, extremely slow-growing tumour of the VIII cranial nerve. It consists of spindle cells with rod-shaped nuclei lying in rows. The tumour most commonly emerges from the inferior vestibular nerve (Option A) and compresses the superior vestibular nerve (Option B) , cochlear nerve (Option C) and facial nerve (Option D) . Clinical features: Commonly seen in the age group of 40-60 years. Progressive unilateral sensorineural hearing loss Tinnitus Difficulty in understanding speech, Reduced corneal sensitivity Numbness or paresthesia Speech and swallowing problems are seen Ataxia The investigation of choice is MRI with contrast, which shows the appearance of an ice cream cone . BERA is also used to investigate audiological issues. Management includes surgical excision (if the size is more than 3cm) and radiosurgery (for tumours less than 30cc)



References:

Dingra, 8th Edition, Pages 132 - 134. Bailey & Love's Short Practice of Surgery, 28th Edition, Page 717.

↑ *Back to this question in Part A*

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Q8: A 48-year-old male presented with headache, blurring of vision, weakness and loss of balance. His radiological investigations suggested hydrocephalus and pheochromocytoma. A tumour is detected whose radiograph is given below. Which of the following genetic syndromes is most commonly associated with this condition? (Q849233)

A. MEN 1 syndrome

B. VHL syndrome

C. Lynch syndrome

D. Gardner's syndrome



Correct Answer: B. VHL syndrome

- *Listen (English)*
- *Listen (Hindi)*

Explanation: The above features suggest Hemangioblastoma and the associated genetic disorder is VHL (Von Hippel-Lindau) syndrome. Hemangioblastoma is a benign vascular tumour of the central nervous system associated with VHL (Von Hippel-Lindau) syndrome, which consists of the following, Cerebellar hemangioblastoma. Retinal hemangioma RCC(Renal Cell Carcinoma) Renal cyst Pheochromocytoma Epididymal/ broad ligament cyst adenoma Endolymphatic sac tumours Pancreatic neuroendocrine tumors MRI in hemangioblastoma shows a cystic tumour with a non-enhancing wall and enhancing mural nodule , which is managed by surgical resection. Management: Pre-Operative Stabilization: Prioritize the Pheochromocytoma: You must stabilize the adrenal tumor before any neurosurgery to avoid a hypertensive crisis. Medical Blockade: Start α -blockers (e.g., phenoxybenzamine) first, followed by β -blockers . Resection: Perform adrenalectomy once hemodynamically stable. Neurosurgical Intervention: Symptom Relief: If hydrocephalus is acute, place an External Ventricular Drain (EVD) . Tumor Removal: Microsurgical resection of the mural nodule of the hemangioblastoma. The cyst wall itself is usually non-neoplastic and can be left. Long-term Management: Medical Therapy: Consider Belzutifan (HIF-2α inhibitor) for non-emergency tumors. Surveillance: Annual screening for retinal lesions and plasma metanephrines; biennial MRI of the brain, spine, and abdomen.



References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Pages 203, 899.

↑ *Back to this question in Part A*

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Q9: A 3-year-old child presented with complaints of severe morning headache associated with nausea, vomiting and seizure. On examination, the doctor suspected a brain tumour and suggested an MRI, which revealed a tumour at the vermis region. Which of the following syndromes is associated with this condition? (Q849224)

A. Gorlin syndrome

B. NF1 syndrome

C. VHL syndrome

D. Turcot's syndrome

Correct Answer: D. Turcot's syndrome

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The above features suggest Medulloblastoma, the most common type of primitive neuroectodermal tumour (PNET) and the most common malignant pediatric brain tumour. It predominantly occurs in the first decade of life, with a second peak around age 30. Histology: Characterized by densely packed small round cells with large nuclei and scant cytoplasm. Location: Typically found in the cerebellum (vermis) in children and the lateral cerebellar hemisphere in adults. Clinical Presentation : Symptoms include headache, vomiting, nausea, weakness, papilledema, and ataxia. Diagnosis: MRI is used for imaging. Management: Treatment involves surgical resection followed by radiotherapy and chemotherapy. Association: Medulloblastoma is associated with Turcot's syndrome. Types of Turcot Syndrome: Type 1: Associated with Lynch Syndrome (HNPCC): Caused by mutations in DNA Mismatch Repair (MMR) genes (most commonly MLH1 , MSH2 , or PMS2). Colonic Finding: Few large polyps that have a high tendency to become malignant quickly. Brain Tumor: Most commonly Glioblastoma Multiforme (GBM) or other high-grade astrocytomas. Inheritance: Autosomal recessive (usually). Type 2: Associated with Familial Adenomatous Polyposis (FAP): C aused by a mutation in the APC gene on chromosome 5q21. Colonic Finding: Hundreds to thousands of adenomatous polyps covering the colon. Brain Tumor: Most commonly Medulloblastoma (classically located in the cerebellar vermis, as seen in your case study). Inheritance: Autosomal dominant. Other Extracolonic Manifestations: Since Turcot syndrome is a variant of FAP or Lynch Syndrome, patients often present with other "Gardner-like" or "Lynch-like" features: Skin Lesions: Sebaceous cysts, lipomas, and café-au-lait spots. Eye Findings: Congenital Hypertrophy of the Retinal Pigment Epithelium (CHRPE) - often a diagnostic "clue" found during a funduscopic exam. Other Tumors: Osteomas (especially of the mandible). Desmoid tumors (aggressive fibrous tumors, often in the abdomen). Dental abnormalities (supernumerary teeth). Brain Tumor Syndromes: Syndrome Gene Mutation Primary Brain Tumor Distinguishing Feature Turcot (Type 2) APC Medulloblastoma Thousands of colonic polyps Gorlin PTCH1 Medulloblastoma Basal cell carcinomas, jaw cysts Li-Fraumeni TP53 Astrocytoma / GBM Breast cancer, Sarcomas NF1 NF1 Optic Nerve Glioma Café-au-lait spots, Lisch nodules NF2 NF2 Schwannoma Bilateral acoustic neuromas VHL VHL Hemangioblastoma Renal cell carcinoma, Polycythemia Cowden PTEN Lhermitte-Duclos Breast/Thyroid cancer, Macrocephaly

References:

Schwartz’s Principles of Surgery, 11th Edition, Page 1857.

↑ *Back to this question in Part A*

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Q10: A 45-year-old woman presents with worsening headaches, cognitive issues, and personality changes. MRI reveals a large mass in the left frontal lobe with surrounding oedema, likely a primary brain tumour. What is the overall most common type of primary brain tumour in adults? (Q849181)

A. Medulloblastoma

B. Glioblastoma

C. Meningioma

D. Oligodendroglioma

Correct Answer: C. Meningioma

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Meningiomas are the most common primary brain tumours in adults. They are typically benign and arise from the meninges, the layers of tissue covering the brain and spinal cord. They account for about 36-37% of all primary brain tumours in adults, making them the most frequent type. Depending on their location, meningiomas can cause symptoms such as headaches, seizures, and neurological deficits, including cognitive and personality changes when located in the frontal lobe. The slow-growing nature of these tumours often leads to gradual symptom progression. Medulloblastomas (Option A) are highly malignant tumours originating from the cerebellum and are most commonly seen in children. They typically cause cerebellar dysfunction, such as ataxia, and increased intracranial pressure, leading to headaches and vomiting. These tumours are rare in adults, especially in the frontal lobe. Glioblastomas (GBMs) (Option B) are aggressive, malignant tumours arising from astrocytes and are the most common malignant primary brain tumour in adults. They present rapidly with symptoms like headaches, seizures, cognitive decline, and focal neurological deficits. However, they are less common than meningiomas. Oligodendrogliomas (Option D) originate from oligodendrocytes , which produce the myelin sheath in the central nervous system. These tumours often present with seizures and may occur in the frontal lobe. They are less common than meningiomas, slower-growing than glioblastomas, and have a better prognosis

References:

Bailey & Love’s Short Practice of Surgery, 28th Edition, Pages 714-716.

↑ *Back to this question in Part A*

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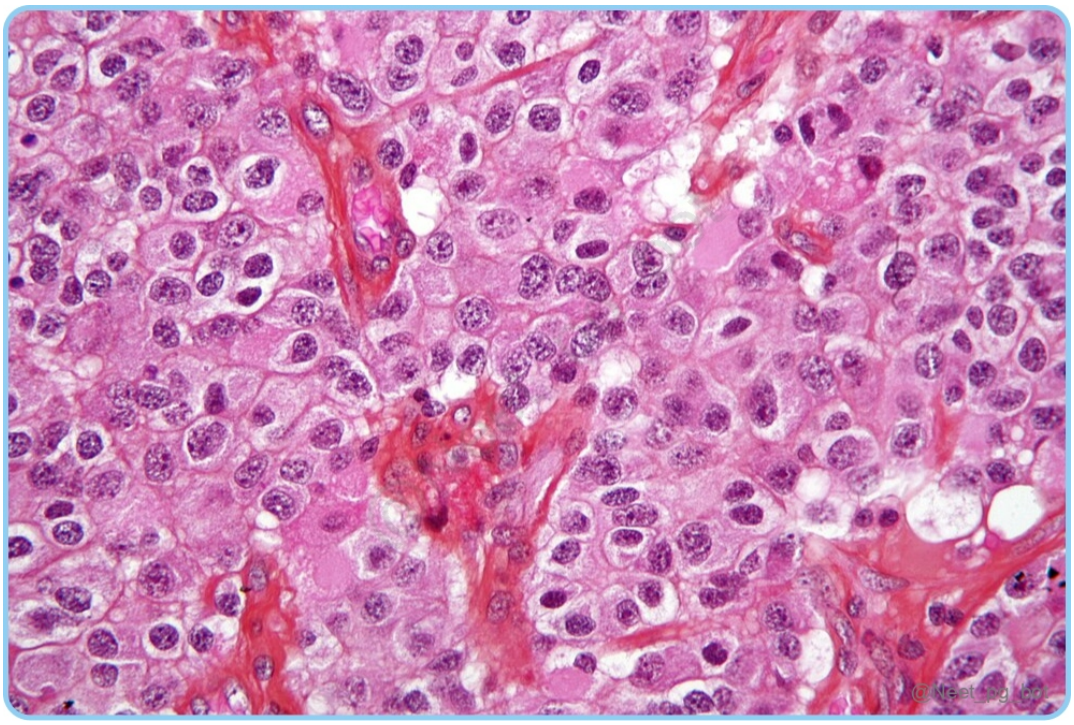
Q11: A 45-year-old male presents with recurrent seizures and headaches. MRI reveals a mass located in the cerebral hemisphere. Histopathological examination of the mass shows cells with a "fried egg" appearance and a chicken-wire capillary pattern. Which of the following is the most likely diagnosis? (Q849222)

A. Meningioma

B. Oligodendroglioma

C. Craniopharyngioma

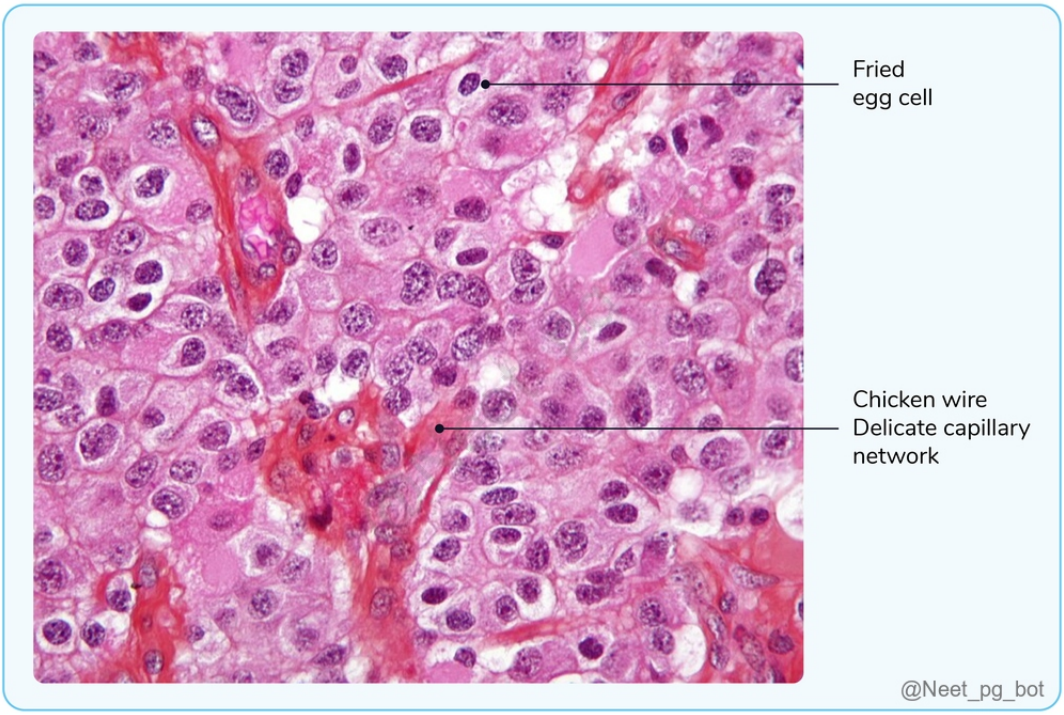
D. Glioblastoma



Correct Answer: B. Oligodendroglioma

- *Listen (English)*
- *Listen (Hindi)*

Explanation: The given clinical presentation and histopathological features suggest Oligodendroglioma. Oligodendroglioma: Aspect Description Definition Primary brain tumours arise from oligodendrocytes (glial cells supporting neurons). It is often slow-growing and typically occurs in adults aged 40-50. Clinical Features Seizures Headaches Focal neurological deficits Histopathological (HPE) Findings "Fried-egg" appearance of tumour cells Chicken-wire capillary pattern Radiological Findings MRI is preferred for diagnosis. Contrast-enhancing mass in the cerebral hemispheres It may show calcifications and oedema Treatment Surgery: Aim to remove as much of the tumour as possible while preserving brain tissue. 5-ALA fluorescence-guided surgery: Helps visualise tumour cells for more accurate resection. Chemotherapy: Temozolomide is commonly used. Radiation Therapy: Recommended for high-grade tumors or when complete removal is not feasible.



References:

Sabiston’s Textbook of Surgery, 21st Edition, Page 1894.

Bailey & Love’s Short Practice of Surgery, 28th Edition, Pages 715-716.

↑ *Back to this question in Part A*

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Q12: A 55-year-old female presents with headaches and visual disturbances. Imaging studies reveal a well-circumscribed mass in the brain. On histopathological examination, the tumour shows calcifications and cells arranged in whorls. Which of the following radiological findings is most characteristic of this tumour type? (Q849221)

A. Calcified mass

B. Ring enhancement

C. Dural tail sign

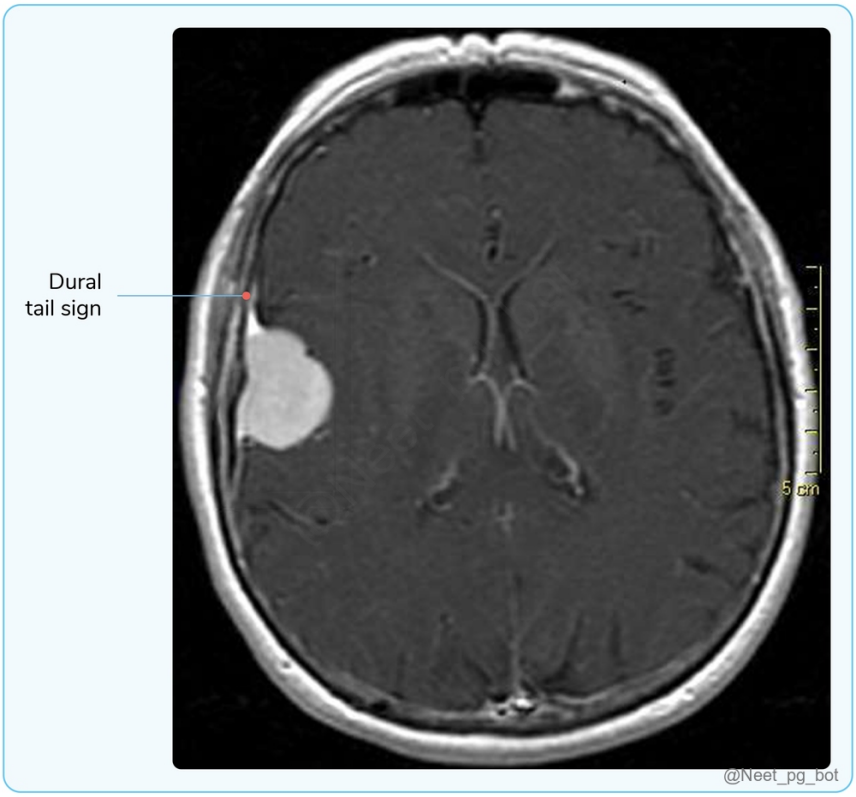
D. Vasogenic oedema

Correct Answer: C. Dural tail sign

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The patient presents with headaches and visual disturbances, and imaging studies reveal a well-circumscribed brain mass and histopathological examination showing calcifications and cells arranged in whorls strongly suggests a diagnosis of meningioma. The dural tail sign is the most characteristic imaging feature associated with meningiomas Meningioma: Aspect Description Definition Benign tumours arise from the meninges surrounding the brain and spinal cord. Clinical Features Headaches Visual disturbances Neurological deficits due to mass effect Vasogenic oedema (brain swelling) Potential for obstructive hydrocephalus (if CSF flow is blocked) Radiological Features Contrast-enhancing mass Dural base attachment Possible calcifications Dural tail sign (specific to meningiomas) Management Surgery (preferred if the tumour is large or symptomatic) Radiotherapy or stereotactic radiosurgery if surgery is risky. Watch-and-wait approach for small, incidental tumours in older patients. Calcified mass (Option A): Calcifications are usually seen in meningiomas but are not as specific as the dural tail sign. Ring enhancement (Option B) pattern is more commonly associated with abscesses or glioblastomas and is not characteristic of meningiomas. Vasogenic oedema (Option D): Meningiomas can cause vasogenic oedema due to the mass effect on surrounding brain tissue. However, this finding is non-specific and can be seen with various other brain tumours.



References:

Sabiston’s Textbook of Surgery, 21st Edition Pages 1896, 1897.

Bailey & Love’s Short Practice of Surgery, 28th Edition, Page 716.

↑ *Back to this question in Part A*

Q13: A 60-year-old patient presents with worsening headaches, focal neurological deficits, and personality changes. MRI imaging reveals a ring-enhancing lesion surrounded by significant oedema. Based on these imaging characteristics, which of the following is the most likely diagnosis and management in recurrent cases? (Q849220)

A. Meningioma, Bevacizumab

B. Glioblastoma Multiforme, Temozolomide

C. Metastatic Brain Tumor, Evacizumab

D. Primary CNS Lymphoma, Doxorubicin



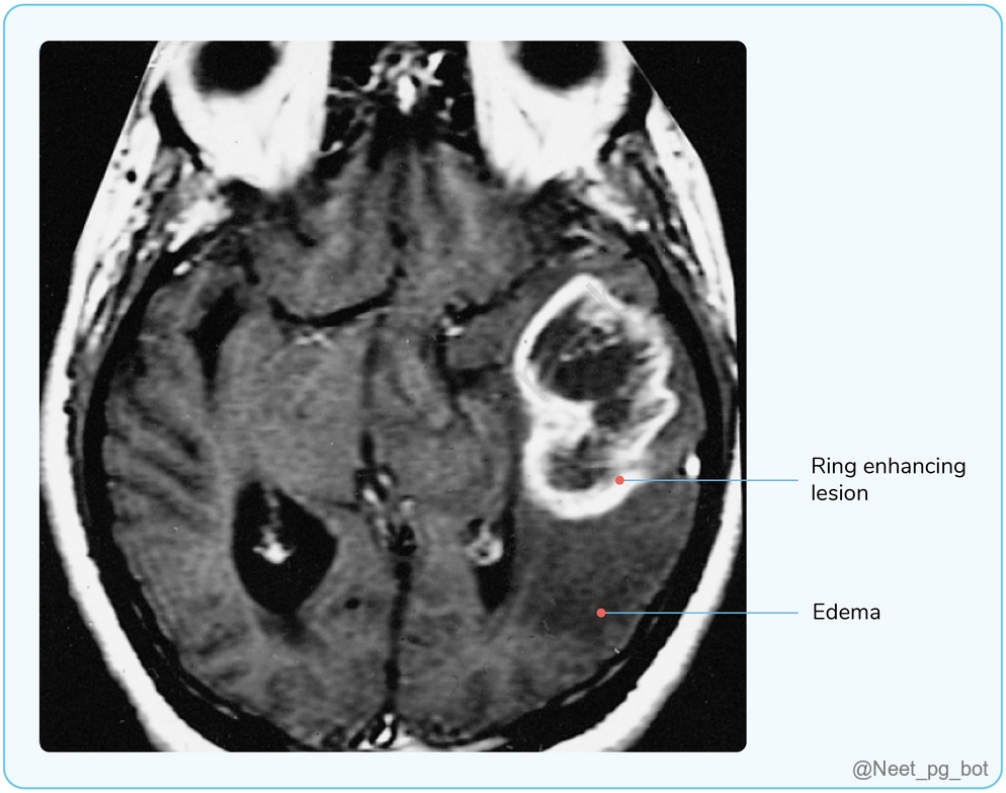
Correct Answer: B. Glioblastoma Multiforme, Temozolomide

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The imaging findings of a ring-enhancing lesion with significant surrounding oedema are characteristic of Glioblastoma Multiforme (GBM), AKA Grade 4 Astrocytoma . It is a Grade IV glioma characterised by ring-enhancing lesions on MRI with surrounding oedema and is associated with poor prognosis. It

is highly aggressive and presents with necrosis and microvascular proliferation. Temozolomide is the current chemotherapy drug of choice for GBM.



References:

Sabiston's Textbook of Surgery, 21 Edition, Pages 1893, 1894.

↑ *Back to this question in Part A*

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Q14: A 45-year-old patient presents with headaches and focal neurological deficits. Imaging reveals a tumour located in the cerebral hemispheres, characterised by infiltrative growth and low cellularity. Which of the following options best describes the likely diagnosis for this tumour? (Q849195)

A. Pilocytic Astrocytoma

B. Diffuse Astrocytoma

C. Anaplastic Astrocytoma

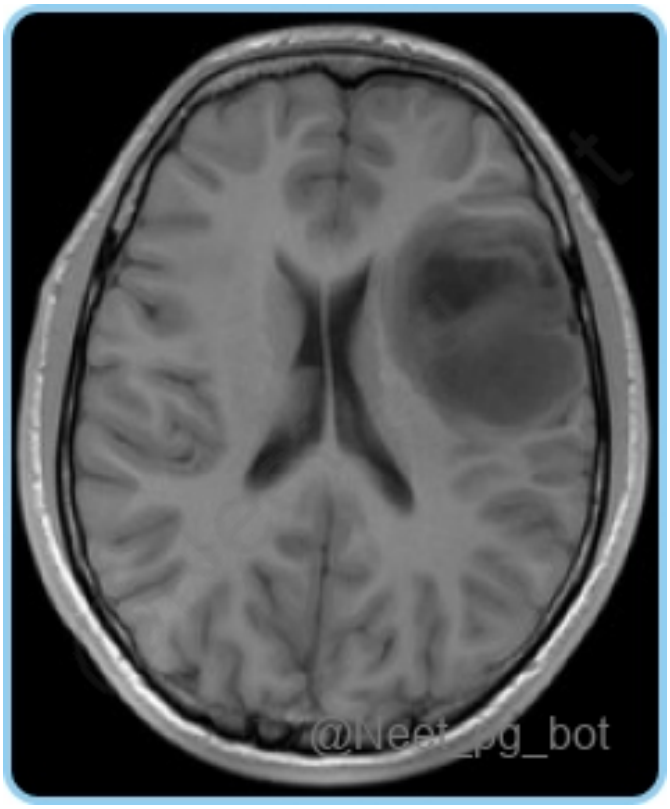
D. Glioblastoma Multiforme

Correct Answer: B. Diffuse Astrocytoma

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The diffuse astrocytoma fits the clinical description of infiltrative growth and low cellularity and is commonly located in the cerebral hemispheres. Diffuse Astrocytoma Prognosis : Intermediate Common Site : Cerebral hemispheres Histological Features : Infiltrative, low cellularity. These tumours are characterised by their gradual growth and infiltration into surrounding brain tissue. Management : Surgical resection is the primary treatment. Radiation or chemotherapy might be considered based on risk factors or residual disease.



References:

Sabiston's Textbook of Surgery, 21 Edition, Pages 1893, 1894.

↑ *Back to this question in Part A*

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Q15: A 12-year-old child presents with headaches, vomiting, and unsteady gait. Imaging reveals a mass in the posterior fossa. The lesion is surgically resected, and histology reveals a tumour with a low mitotic index. Which of the following best describes the most common location and prognosis of this tumour? (Q849189)

A. Hypothalamus, Poor prognosis

B. Cerebellum, Good prognosis

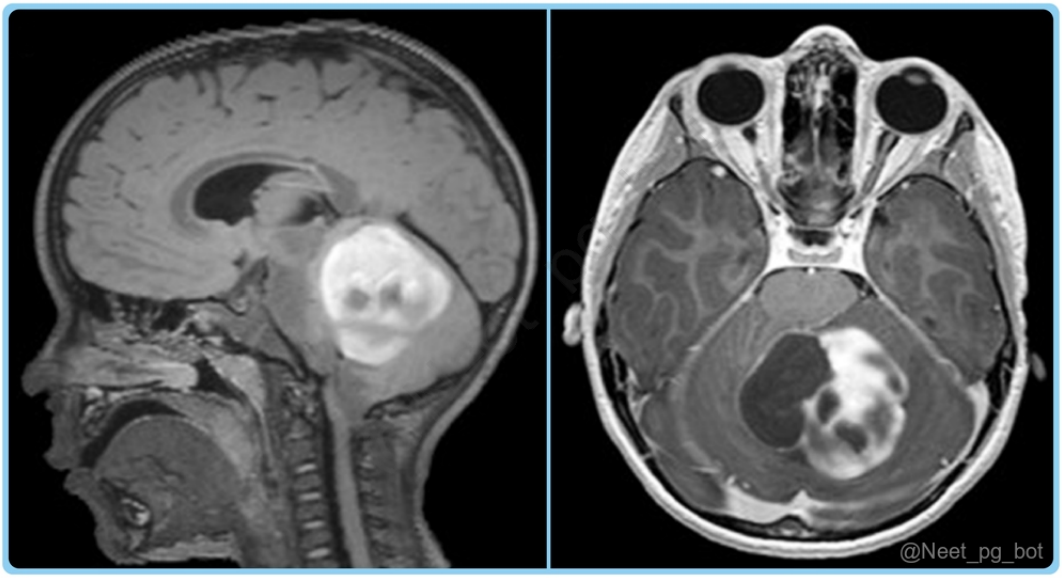
C. Cerebellum, Poor prognosis

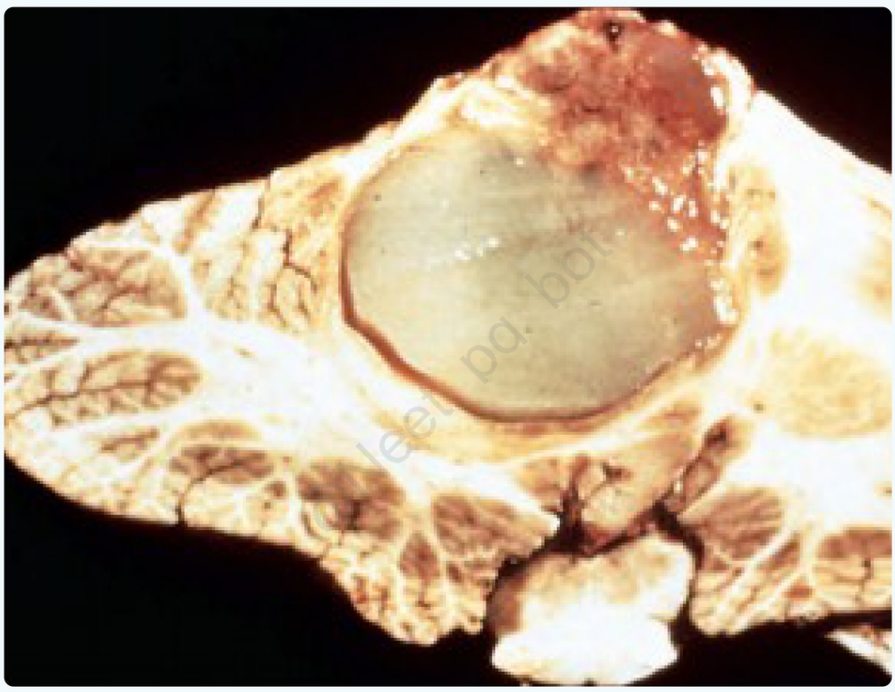
D. Hypothalamus, Good prognosis

Correct Answer: B. Cerebellum, Good prognosis

- *Listen (English)*
- *Listen (Hindi)*

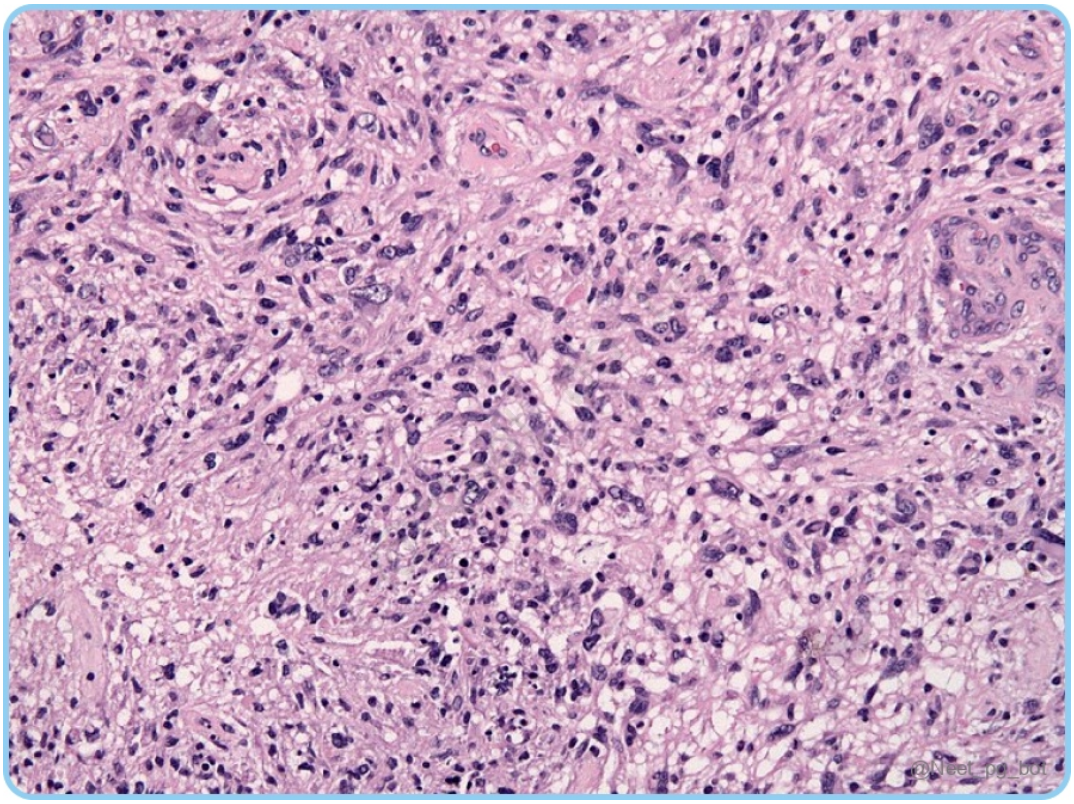
Explanation: The given scenario with mass in the posterior fossa is highly suggestive of a tumour in the cerebellum, particularly a pilocytic astrocytoma, which has a good prognosis . It is a low-grade (WHO Grade I), slow-growing, often benign brain tumour primarily affecting children and young adults. They usually arise in the cerebellum but can also be found in the optic pathways, brainstem, and spinal cord. Histologically, it is characterised by Biphasic pattern with dense fibrillary areas and loose microcystic regions. Rosenthal fibres (eosinophilic, corkscrew-shaped fibres) are often present. Clinical features: Symptoms: Increased intracranial pressure (morning headaches, nausea, projectile vomiting) due to 4th ventricle obstruction. Signs: Truncial ataxia (unsteady gait), dysmetria, and papilledema. Diagnosis: MRI: Classic appearance of a large cyst with a brightly enhancing mural nodule . Histology: Rosenthal fibers: Eosinophilic, corkscrew-shaped bundles. Biphasic pattern: Compact piloid cells and loose microcystic areas. GFAP positive: Confirms astrocytic origin. WHO Grade I: Indicates a benign, slow-growing tumor. Management: Surgical resection is the primary treatment and can be curative due to the tumour's well-defined borders. Adjuvant Therapy: Radiation or chemotherapy is rarely needed unless the tumor is unresectable (e.g., optic chiasm involvement). Excellent prognosis , with long-term survival rates exceeding 90% following complete resection. If fully removed, recurrence is rare. Histopathology of Pilocytic astrocytoma





Gross image of pilocytic astrocytoma

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References:

Sabiston’s Textbook of Surgery, 21st Edition, Pages 1893, 1894. Robbins Pathology Textbook,10th Edition, Pages 1296, 1297.

↑ *Back to this question in Part A*

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Q16: Which type of brain tumour is most likely to cause personality changes, impaired judgment, and difficulty with motor planning? (Q849183)

A. Frontal lobe tumors

B. Temporal lobe tumors

C. Occipital lobe tumors

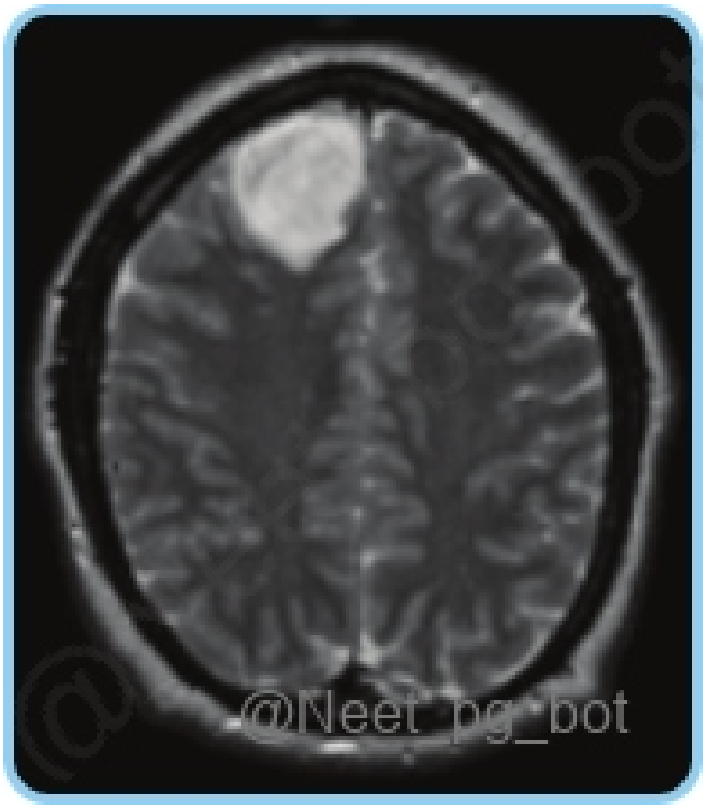
D. Cerebellar tumors

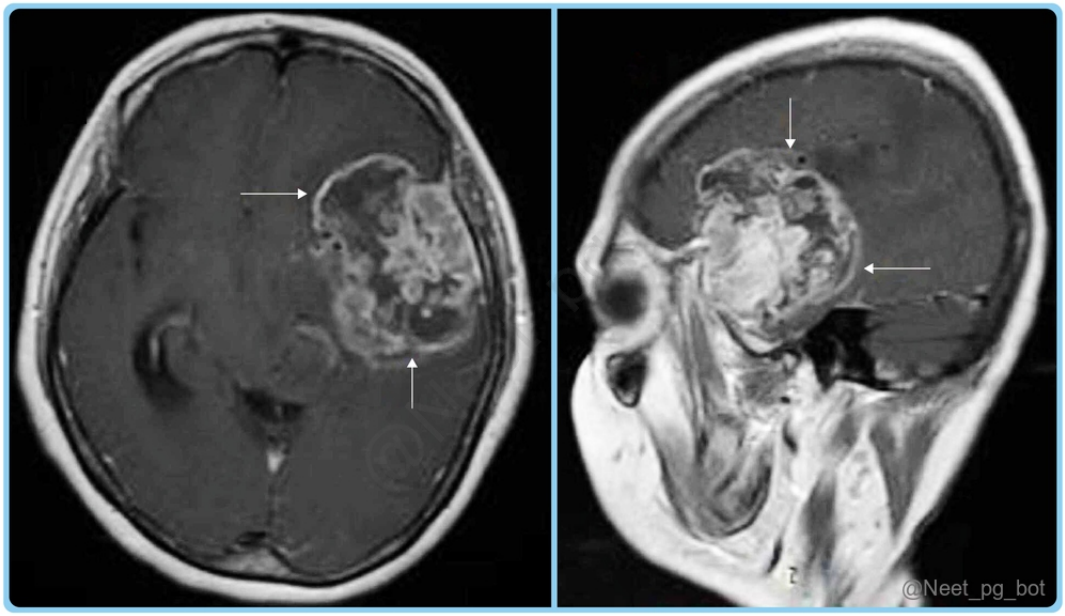
Correct Answer: A. Frontal lobe tumors

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Frontal lobe tumours are most likely to cause personality changes, impaired judgment, and difficulty with motor planning. Functions of the frontal lobe: Executive Functions: The frontal lobe is essential for reasoning, planning, and decision-making, and tumours can impair these abilities, affecting judgment. Personality and Social Behavior: Tumours can lead to significant personality changes and inappropriate behaviour . Motor Planning and Control: The primary motor cortex in the frontal lobe controls voluntary movements, and tumours can disrupt motor planning and execution, leading to difficulties with complex movements. Temporal lobe tumours (Option B) typically cause memory problems (particularly difficulty forming new memories), auditory hallucinations, language comprehension difficulties, and seizures. Occipital lobe tumours (Option C) mainly affect vision and visual processing, causing symptoms such as visual hallucinations, difficulty recognising objects or faces, and partial or complete loss of vision. Cerebellar tumours (Option D) typically cause problems with balance and coordination, difficulty with fine motor skills, nystagmus (involuntary eye movements), and slurred speech.





References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 714.

↑ *Back to this question in Part A*

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Q17: A 62-year-old man with a 40-pack-year smoking history presents with worsening headaches, confusion, ataxia, and right-sided weakness. A CT scan reveals multiple ring-enhancing brain lesions and further imaging identifies a mass in the right upper lobe of the lung. What is the most likely primary source of brain metastases? (Q849182)

A. Colorectal cancer

B. Prostate cancer

C. Lung cancer

D. Melanoma

Correct Answer: C. Lung cancer

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Lung cancer is the most common cause of brain metastases, accounting for 40-50% of all cases. It is the leading cause of brain metastases, particularly in patients with a history of smoking by hematogenous spread. Symptoms include worsening headaches, confusion, and balance issues, which are consistent with brain metastases. The presence of multiple ring-enhancing brain lesions is typical of metastatic brain disease.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Pages 714-715.

↑ *Back to this question in Part A*

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Q13 (p. 1188)	*Q14 (p. 1189)*	*Q15 (p. 1191)*	*Q16 (p. 1192)*	*Q17 (p. 1193)*	*Q18 (p. 1194)*
Q19 (p. 1197)	*Q20 (p. 1198)*	*Q21 (p. 1201)*	*Q22 (p. 1201)*		

Q1: What is the classification of the head injury of a patient involved in a road traffic accident, based on a GCS score of 10? (Q793536)

A. Moderate traumatic brain injury

B. Severe traumatic brain injury

C. Minor traumatic brain injury

D. Mild traumatic brain injury

Correct Answer: A. Moderate traumatic brain injury

Explanation: Answer option A The GCS (Glasgow Coma Scale) scoring system is used to assess the level of consciousness in patients with traumatic brain injury. It is a scale that ranges from 3 to 15, with lower scores indicating more severe injury and higher scores indicating a better level of consciousness. In this case, the patient's GCS score is 10, which falls in the range of 9-12. According to the GCS scoring system, this indicates moderate traumatic brain injury. The GCS scoring system classifies traumatic brain injury as follows: Severe traumatic brain injury: GCS score of 8 or less Moderate traumatic brain injury: GCS score of 9-12 Minor traumatic brain injury: GCS score of 13-15 with loss of consciousness Mild traumatic brain injury: GCS score of 13-15 without loss of consciousness Therefore, in this case, the patient's head injury is classified as moderate traumatic brain injury based on the GCS score of 10. This indicates that the patient has significant brain injury and may require close monitoring and treatment. Incorrect Choices: Option b. Severe traumatic brain injury is incorrect because GCS score of the patient is 10. Option c. Minor traumatic brain injury is incorrect because GCS score of the patient is 10. Option d. Mild traumatic brain injury is incorrect because GCS score of the patient is 10.

References:

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↑ *Back to this question in Part A*

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Q2: Which of the following is most likely to be seen due to the rupture of a saccular aneurysm? (Q855826)

A. Subdural hemorrhage

B. Subarachnoid hemorrhage

C. Intracerebral hemorrhage

D. Hydrocephalus

Correct Answer: B. Subarachnoid hemorrhage

Explanation: The most common consequence of the rupture of a saccular aneurysm is subarachnoid hemorrhage (SAH) , which is a life-threatening emergency . A saccular aneurysm , also known as a berry aneurysm , is a small, bulging outpouching of a blood vessel at branching points of cerebral arteries. These aneurysms are prone to rupture , and when they do, the blood leaks into the subarachnoid space which lies between the arachnoid and pia mater {{caption_text}} Subdural haemorrhage (Option A) occurs due to the rupture of veins that bridge the subdural space, often from trauma. It is not associated with the rupture of an aneurysm . Intracerebral hemorrhage (Option C) refers to bleeding within the brain tissue itself. It happens due to the rupture of arteries within brain parenchyma, mostly due to hypertension or trauma , not directly from a saccular aneurysm rupture. Hydrocephalus (Option D) is an abnormal accumulation of cerebrospinal fluid (CSF) in the brain, leading to increased intracranial pressure. It can happen due to various factors, but it is not the immediate consequence of an aneurysm rupture itself.



References:

B. D. Chaurasia's Human Anatomy, VOL-3, 8th Edition, Page 216

↑ *Back to this question in Part A*

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Q3: A cricket player was initially hit on the head with a cricket ball, appearing fine but later collapsing, regaining consciousness to play well, and then found unconscious in the dressing room. What is the probable diagnosis based on the result of the CT scan provided? (Q859882)

A. Extradural hemorrhage

B. Artifact

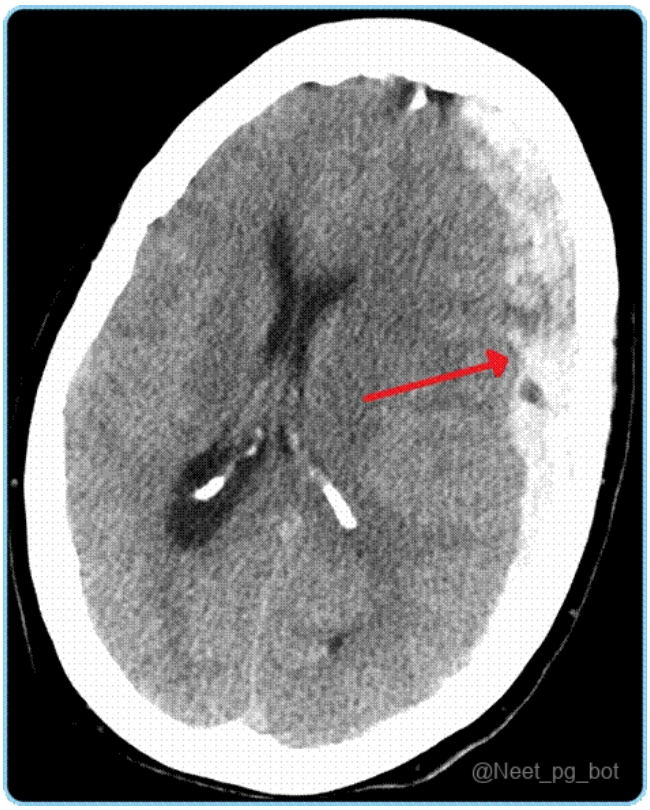
C. Subdural hemorrhage

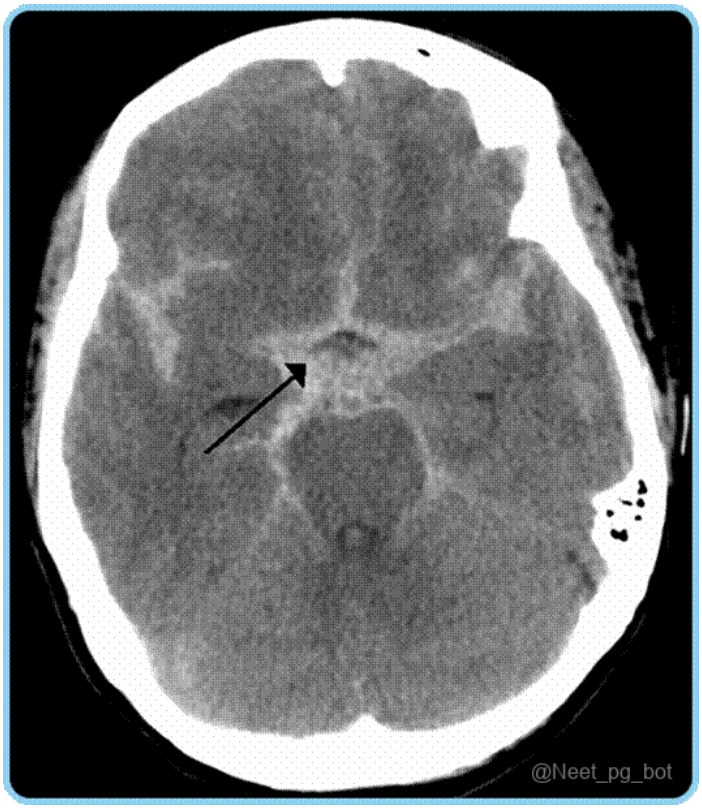
D. Subarachnoid hemorrhage



Correct Answer: A. Extradural hemorrhage

Explanation: The most likely diagnosis here, given the sequence of events and CT scan showing the biconvex lens-shaped collection of blood , is Extradural Hemorrhage. It is also called epidural haemorrhage & occurs when there is bleeding between the skull and the dura mater (the outermost layer covering the brain). It is typically caused by trauma, like being hit on the head, which is consistent with the patient's history of being struck by a cricket ball. Clinical features include: Initial Loss of Consciousness Neurological Deterioration Variable Consciousness Levels Posterior Fossa EDH (Rare) Signs of Elevated ICP They are neurosurgical emergencies when symptomatic. Their management includes: Emergency - Burr hole surgery. Definitive - Craniotomy with hematoma evacuation. Artifact (Option B) on a CT scan refers to image distortion or interference that does not represent actual pathology. Given the clear clinical scenario of trauma and the CT finding of a hematoma , an artefact is unlikely to be the cause of the findings. Subdural haemorrhage (Option C) occurs when blood accumulates between the dura mater and the arachnoid membrane . They tend to be crescent-shaped on CT, unlike the biconvex lens-shaped appearance of an extradural haemorrhage. {{caption_text}} Subarachnoid haemorrhage (Option D) refers to bleeding into the subarachnoid space , which is the area between the arachnoid membrane and the pia mater . CT appearance of subarachnoid haemorrhage is usually diffuse , with blood visible in the subarachnoid space, whereas extradural haemorrhage appears as a localised biconvex mass. {{caption_text}}





References:

Harrison’s Principle of Internal Medicine 21st Edition, Pages 3457, 3458

↑ *Back to this question in Part A*

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Q4: A 27-year-old man came to the clinic with a headache, palpitations, and sweating. As there is a history of renal problems in his brother and father, he requested an abdominal ultrasound, which revealed the presence of multiple renal and pancreatic cysts. 24-hour urinary metanephrine was sent, which was elevated. What is the most likely diagnosis? (Q859827)

A. Multiple endocrine neoplasia type I

B. Von Hippel-Lindau disease

C. Birt-Hogg-Dube syndrome

D. Tuberous sclerosis

Correct Answer: B. Von Hippel-Lindau disease

Explanation: The most likely diagnosis is Von Hippel-Lindau (VHL) disease , a hereditary condition characterised by the development of multiple cysts in the kidneys, pancreas, and other organs. VHL is an autosomal dominant disorder due to VHL gene mutation on chromosome 3. Patients often have an increased risk of developing pheochromocytomas, which can cause symptoms like headaches, palpitations, and sweating. The elevated urinary metanephrines further support this diagnosis, as they are markers for pheochromocytomas. It is also associated with the development of various tumours like Hemangioblastomas in the CNS (cerebellum and retina) Cysts of the pancreas, liver, and kidneys Renal cell carcinomas Multiple endocrine neoplasia type I (Option A) is a genetic condition characterised by the development of tumours in multiple endocrine glands, and it typically features hyperparathyroidism, pituitary adenomas, and pancreatic tumours, rather than the renal and pancreatic cysts as seen in VHL. Birt-Hogg-Dube syndrome (Option C) is a rare autosomal dominant disorder clinically manifested by fibrofolliculomas, renal cell carcinoma, lung cysts, and spontaneous pneumothorax. It is caused by mutations in the FLCN gene. Though they develop renal tumours, they do not commonly cause pancreatic cysts , pheochromocytomas , or elevated metanephrines . Tuberous sclerosis (Option D), also called Tuberous sclerosis complex (TSC), is an autosomal dominant condition caused by mutations in either the TSC1 or TSC2 gene. It causes benign tumours in various organs, including the brain, kidneys, heart, and skin. It also leads to skin lesions like ash-leaf spots, shagreen patches, and facial angiofibroma. However, pancreatic cysts and pheochromocytomas are not typically associated with tuberous sclerosis.

References:

Robbins and Cotran’s Pathologic Basis of Disease, 10th Edition, Pages 809, 1032

↑ *Back to this question in Part A*

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Q5: What is the diagnosis for the unconscious patient brought to the casualty department following a road accident, as depicted in the provided CT scan image? (Q859631)

A. Extradural hematoma (EDH)

B. Subdural hematoma (SDH)

C. Intraparenchymal bleed

D. Subarachnoid hemorrhage (SAH)

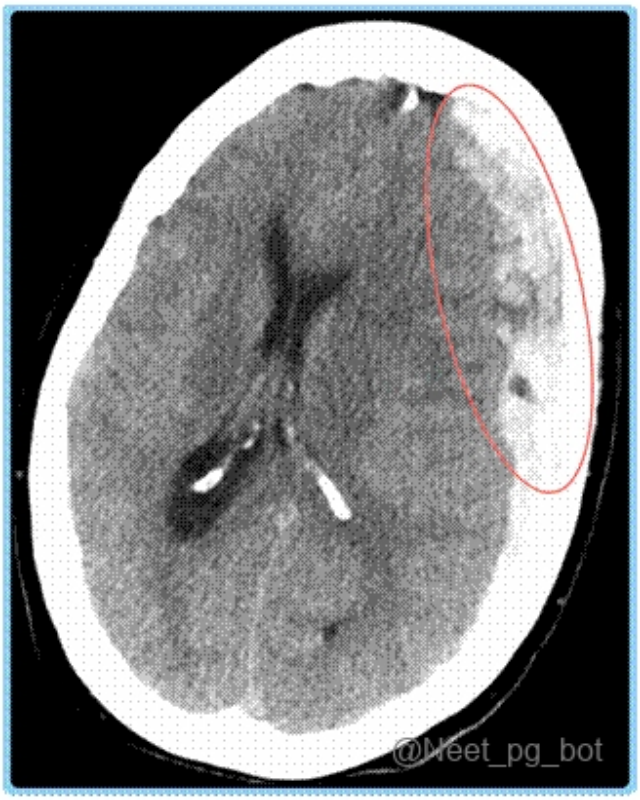


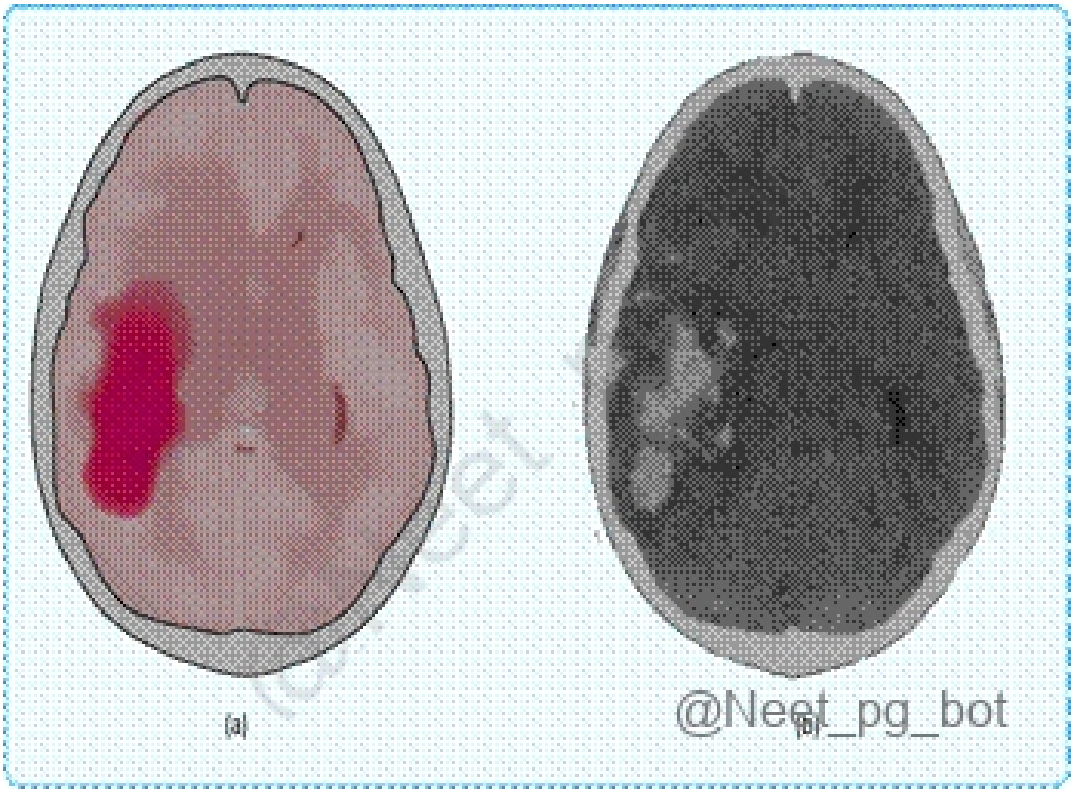
Correct Answer: B. Subdural hematoma (SDH)

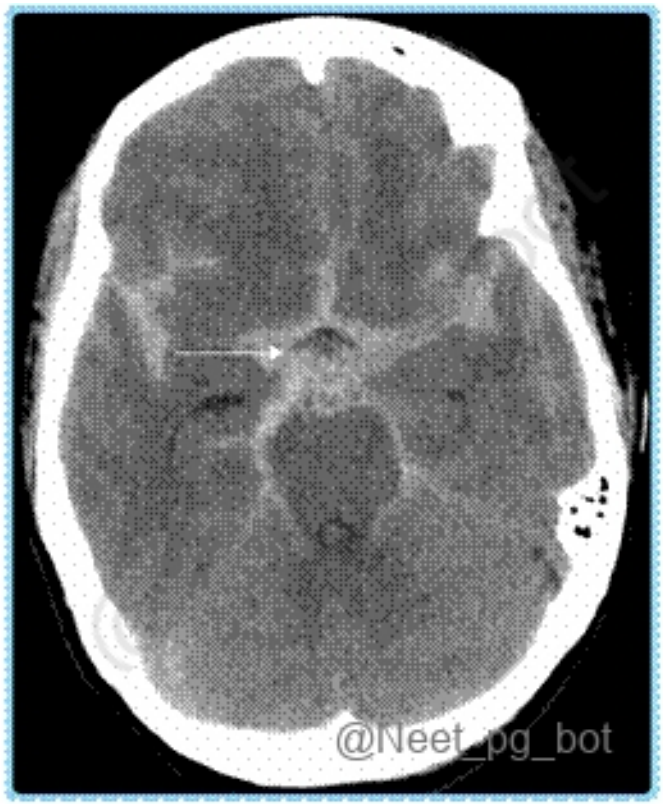
Explanation: A crescent-shaped or concave collection of blood on a CT scan is characteristic of a subdural hematoma, which often results from trauma, such as a road accident. This type of hematoma occurs between the dura mater and the brain, commonly due to the tearing of bridging veins. Symptoms include Rapid deterioration Loss of consciousness Focal deficits High mortality It can be managed conservatively or it might need surgery based on the type and size of the SDH. Types of brain haemorrhage Type CT Findings Mechanism Epidural or Extradural Hematoma (Option A ruled out) {{caption_text}} Biconvex/lentiform shape Does not cross suture lines Cross-dural venous sinuses Hyperdense Usually unilateral Typically, meningeal artery injury (especially middle meningeal) High-velocity trauma Young patient Always traumatic Subdural Hematoma {{caption_text}} Crescent-shaped Crosses suture lines Can be bilateral Don't cross dural venous sinuses Follows brain surface

Bridging vein tears Can be Traumatic or non-traumatic Elderly patients Extent of brain injury more in SDH than in EDH Intraparenchymal Hematoma (Option C ruled out) {{caption_text}} Irregular shape within brain tissue May have surrounding oedema Direct tissue damage or coagulopathy Subarachnoid Haemorrhage (Option D ruled out) {{caption_text}} Blood in sulci/cisterns Follows CSF spaces Trauma or aneurysm rupture




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(a)
(b)
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References:

Harrison’s Principle of Internal Medicine 21st Edition, Page 3457, 3458

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Q6: A 15-year-old boy presents with a slow-growing, rubbery, non-tender swelling on the side of the neck, as shown in the image. Examination shows the presence of freckles and light skin patches over the face and trunk. What is the most likely diagnosis? (Q856736)

A. Cystic hygroma

B. Chemodectoma

C. Neural tumour

D. Lipoma



Correct Answer: C. Neural tumour

Explanation: The presence of freckles, light skin patches , and a rubbery swelling in the neck in this 15-year-old boy strongly points to neural tumours. Neurofibromatosis type 1 (NF1) is a genetic disorder that often presents with freckling in the axillary (called Crowe's sign) or inguinal areas and café-au-lait spots (the skin patches). These skin findings are characteristic of the disorder. Neurofibromas , are benign neural tumours that arise from the nerve sheath and commonly appear as soft, rubbery, non-tender swellings in affected areas like the neck. Cystic hygroma (Option A) is a type of cavernous haemangioma , present since the time of birth, which is benign and grows rapidly in years, often over the neck or axilla. It is not associated with freckles or café-au-lait spots. Chemodectoma (Option B) (Paragangliomas) arise from paraganglia , which are clusters of neuroendocrine cells located in various parts of the body. They are commonly found in the head and neck regions . Freckles and skin patches are not typically associated with them but rather with Peutz-Jeghers syndrome . Lipomas (Option D) are benign fatty tumours that can occur in various body parts, including the neck. They are usually soft, movable , and painless , but they do not present with freckles or café-au-lait spots .

References:

Nelson Textbook of Pediatrics, 21st Edition, Page 3140 - 3134, 3142 - 3143,

SRB’s Manual of Surgery, 6th Edition, Page 424.

↑ *Back to this question in Part A*

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Q7: Calculate the Glasgow Coma Scale (GCS) of a patient admitted after a road traffic accident and receiving mechanical ventilation. The patient demonstrates a response by opening their eyes upon verbal command and exhibits spontaneous movement in all four limbs. (Q856539)

A. Eyes-2, Verbal-1, Motor-5

B. Eyes-2, Verbal-NT, Motor-5

C. Eyes-3, Verbal-1, Motor-6

D. Eyes-3, Verbal-NT, Motor-6

Correct Answer: D. Eyes-3, Verbal-NT, Motor-6

Explanation: Eyes-3, Verbal-NT, Motor-6 indicates that the patient opens eyes spontaneously, but the verbal response is not testable (NT), and the patient exhibits purposeful motor response. Since the verbal response is not provided, the total GCS score cannot be determined. Eyes-2, Verbal-1, Motor-5 (Option A) suggests that the patient opens their eyes in response to pain, gives an inappropriate verbal response, and exhibits localized motor response.The total GCS score would be 8. Eyes-2, Verbal-NT, Motor-5 (Option B) indicates that the patient opens their eyes in response to pain, but the verbal response is not testable (NT), and the patient exhibits a localized motor response. Since the verbal response is not provided, the total GCS score cannot be determined. Eyes-3, Verbal-1, Motor-6 (Option C) suggests that the patient opens their eyes spontaneously, gives an inappropriate verbal response, and exhibits purposeful motor response. The total GCS score would be 10. Glasgow Coma Scale (GCS): Eye Opening (E) Spontaneous 4 Eyes open without stimulation. To verbal command 3 Eyes open in response to speech. To pain 2 Eyes open in response to painful stimuli. No response 1 No eye opening. Verbal Response (V) Oriented 5 Correctly answers questions about self, location, and time. Confused 4 Speech is coherent but disoriented. Inappropriate words 3 Random or unrelated words in response. Incomprehensible sounds 2 Moaning or groaning without forming words. No response 1 No verbal sounds. Motor Response (M) Obeys commands 6 Follows simple motor commands (e.g., "Lift your arm"). Localizes pain 5 Purposefully moves to remove painful stimulus. Withdraws from pain 4 Flexion response to painful stimuli. Abnormal flexion (decorticate posturing) 3 Flexion of arms with extension of legs in response to pain. Abnormal extension (decerebrate posturing) 2 Extension of arms and legs in response to pain. No response 1 No motor movement. Calculating the Total GCS Score Formula : GCS = E (Eye opening) + V (Verbal response) + M (Motor response). Range : 3 to 15.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, pages 363, 364

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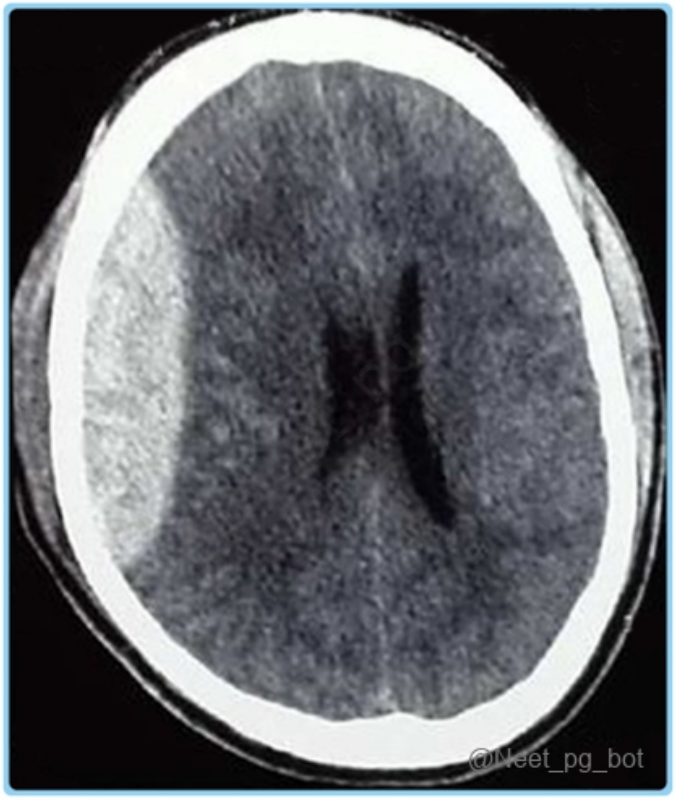
Q8: What potential diagnosis should be considered for a patient admitted to the Emergency department following a road traffic accident exhibiting an altered level of consciousness and a Glasgow Coma Scale (GCS) score of 10, as depicted in the provided CT scan? (Q857436)

A. Subdural hematoma

B. Intracerebral hemorrhage

C. Extradural hematoma

D. Hemorrhagic contusion



Correct Answer: C. Extradural hematoma

Explanation: The CT scan shows a biconvex (lentiform), hyperdense collection between the skull and dura. This shape is characteristic of an extradural (epidural) hematoma . Clinically, the patient has a GCS of 10 after an RTA, consistent with a space-occupying lesion causing mass effect and altered consciousness. Extradural hematomas are typically due to middle meningeal artery injury from a temporal bone fracture and classically appear as a lens-shaped hyperdensity on CT. Subdural hematoma (Option A) is commonly seen due to injury in cortical bridging veins. In the CT scan, the lesion is seen as a concave-convex lesion in the subdural space. Intracerebral hemorrhage (Option B) Commonly seen due to rupture of an aneurysm inside the brain. The CT scan usually shows a well-defined hyperdensity and is usually surrounded by hypodense edema. Hemorrhagic contusion (Option D) Usually seen as small punctate hyperdense foci in the CT.

References:

https://www.ncbi.nlm.nih.gov/books/NBK518982/

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Q9: An old lady sustained a fall and developed a headache and neurological symptoms a few days later. What is your diagnosis? (Q855261)

A. Multi-infarct dementia

B. Frontal lobe meningioma

C. Korsakoff disease

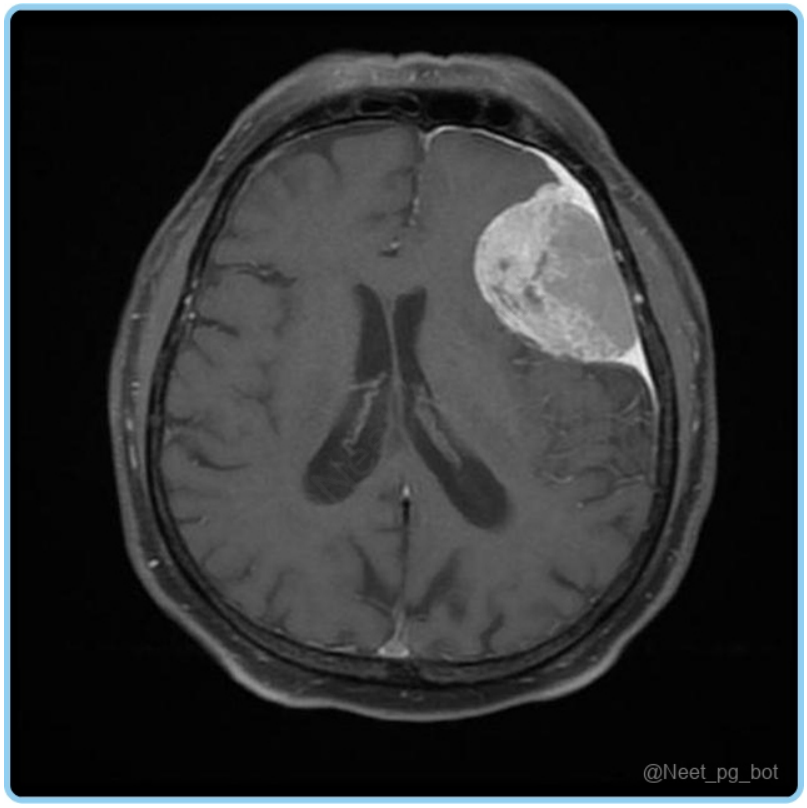
D. Subdural hematoma

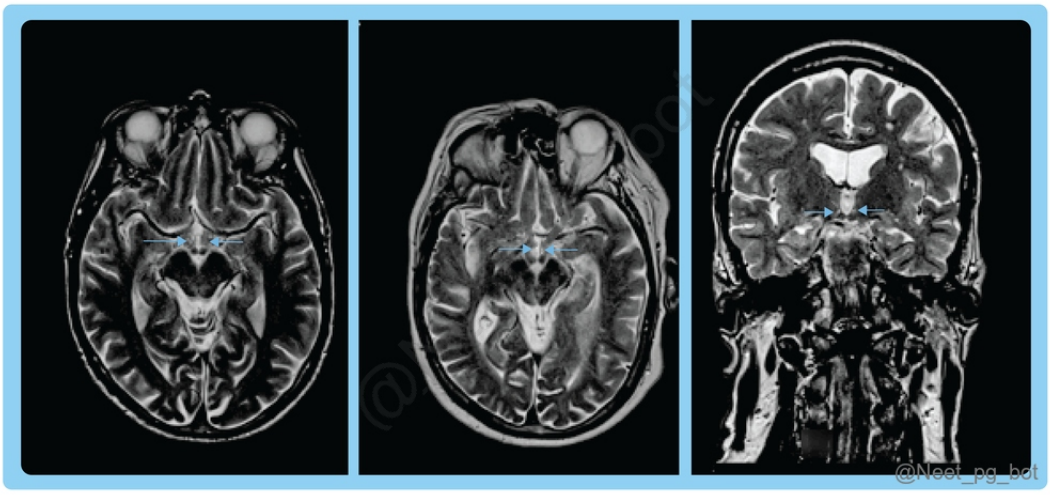
Correct Answer: D. Subdural hematoma

Explanation: In the given scenario, a fall followed by headache and neurological symptoms suggests a Subdural Hematoma (SDH) , which can occur from torn bridging veins and lead to headache, altered mental status, and focal neurological deficits. Subdural Hematoma (SDH) Causes Tearing of bridging veins , often due to blunt trauma / acceleration-deceleration injuries. Mechanism High-energy injury: Rupture of cortical surface vessels . Low-energy injury: Venous bleeding , common in older adults on anticoagulants. Clinical Presentation Variable presentation depending on injury severity and timing. Signs of raised intracranial pressure: Headache, reduced consciousness, focal neurological deficits. CT Appearance Diffuse concave hyperdense (acute), isodense (subacute), or hypodense (chronic) lesions over the brain surface, often crossing suture lines. {{caption_text}} Management Depends on size, location, and clinical status: 1. Large or worsening hematomas: Urgent evacuation by craniotomy or craniectomy. 2. Smaller, stable bleeds: Conservative management initially, with surgery if needed. Multi-infarct dementia (Option A) occurs due to multiple small strokes over time, leading to gradual cognitive decline rather than acute symptoms after trauma. On imaging, multiple small infarcts are seen, often in subcortical or deep brain areas, not an acute blood collection like in a subdural hematoma. {{caption_text}} Frontal lobe meningioma (Option B) is a slow-growing tumour that usually causes gradual symptoms like seizures or focal deficits, not acute neurological changes after a fall. On CT or MRI, it appears as a well-defined mass, often calcified, with possible brain compression, but not as an acute blood collection like in a subdural hematoma. {{caption_text}} Korsakoff disease (Option C) is caused by chronic alcohol use leading to thiamine deficiency and results in severe memory impairment, not acute symptoms after a fall. Imaging may show brain atrophy, especially in the mammillary bodies, but no acute haemorrhage or mass effect like a subdural hematoma. {{caption_text}}


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References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 365-367, 711.

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Q10: A 34-year-old woman was brought to the AIIMS emergency following a road traffic accident. She was hemodynamically stable, and her GCS score was 3. She was intubated and sent for non-contrast C,T which was found to be normal. What is the most likely diagnosis? (Q855175)

A. Subdural hemorrhage

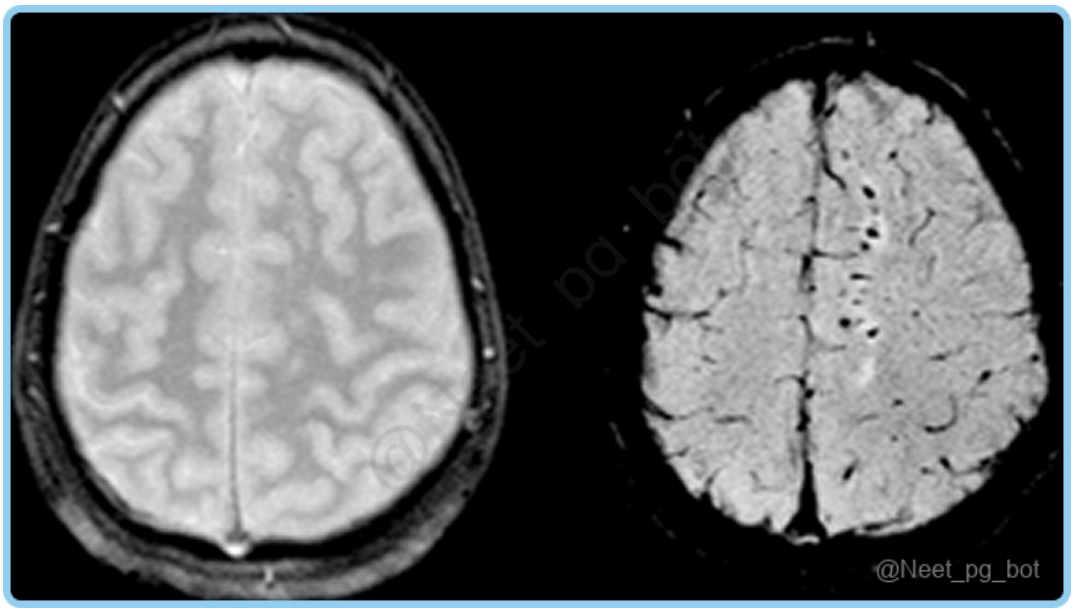
B. Extradural hemorrhage

C. Diffuse axonal injury

D. Cerebral contusion

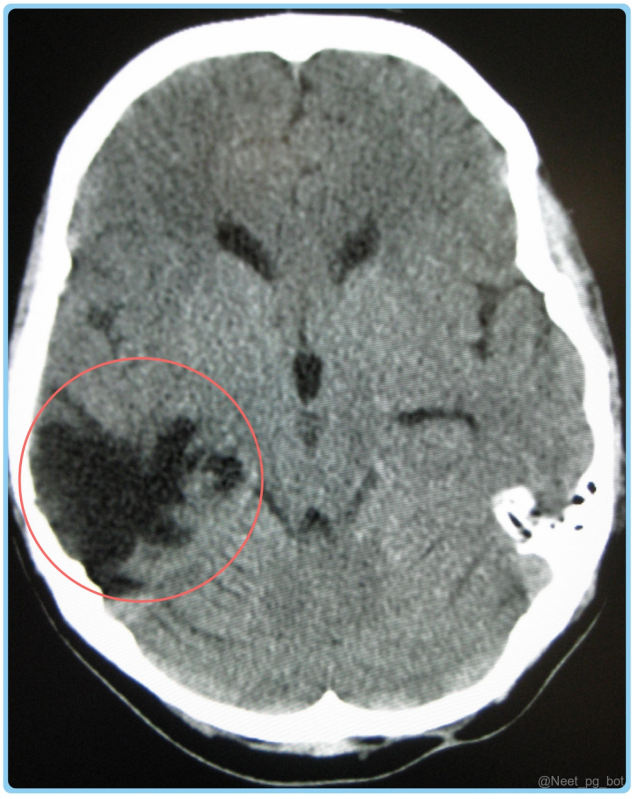
Correct Answer: C. Diffuse axonal injury

Explanation: In this road traffic accident scenario with a low GCS score of 3 and a normal CT scan, the most likely diagnosis is Diffuse Axonal Injury (DAI) , which often appears normal on CT despite causing severe neurological damage. Diffuse Axonal Injury (DAI) A form of primary brain injury caused by widespread damage to axons due to rotational acceleration and deceleration forces, often associated with high-energy trauma. Cause Rotational forces: High-energy accidents involving rapid acceleration and deceleration (e.g., motor vehicle collisions). Trauma: Blunt force impacts that cause the brain to rotate within the skull. Clinical Features Impaired arousal : Often presents as coma or reduced consciousness due to damage in critical brain areas (e.g., pontine reticular activating system, bilateral thalami). Neurological deficits: Poor neurological examination despite the absence of obvious radiographic global brain injury. Irreversible consequences: DAI is often associated with severe and lasting neurological impairment. Investigations CT scan: May show hemorrhagic foci in the corpus callosum and dorsolateral rostral brainstem in severe cases. MRI: More sensitive than CT . It shows small haemorrhages and diffuse axonal injury, particularly in patients who fail to improve neurologically. {{caption_text}} Postmortem examination: Confirms the diagnosis with axonal disruption and formation of axon balls. Prognosis Very poor due to high risk of severe disability or death due to extensive brain damage. Subdural hemorrhage (Option A) would usually cause a gradual decline in GCS, and a CT scan would typically show a crescent-shaped blood collection. The normal CT scan, in this case, makes subdural hemorrhage less likely. {{caption_text}} Extradural haemorrhage (Option B) presents with a brief loss of consciousness followed by a lucid interval, and a CT scan typically shows a convex-shaped blood collection. The normal CT, in this case, makes extradural hemorrhage unlikely. {{caption_text}} Cerebral contusion (Option D) can result from trauma and may cause neurological deficits; they typically appear as focal areas of haemorrhage or swelling on a CT scan. A normal CT scan, as seen here, makes this diagnosis less likely. {{caption_text}}


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References:

Bailey & Love's Short Practice of Surgery, 28 Edition, Page 368. Schwartz Textbook of Surgery, 11th Edition, Page, 1837.

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Q11: A 30 year male old patient presents to OPD with complaints of recurrent headache and nausea, MRI brain shown. What is the diagnosis? (Q866457)

A. Meningioma

B. Glioma

C. Ependymoma

D. Pilocytic astrocytoma



Correct Answer: A. Meningioma

Explanation: Meningiomas are extra-axial, slow-growing tumors arising from arachnoid cap cells . On MRI (especially with contrast), they frequently show the dural tail sign - thickening and enhancement of the dura adjacent to the tumor. This sign is highly suggestive of meningioma due to reactive dural vascularity and tumor infiltration. Glioma (Option B): Intra-axial tumor without dural attachment; typically does not show dural tail sign.

Ependymoma (Option C): Usually arises from the ventricular system, particularly the 4th ventricle in children, not from dura. Pilocytic astrocytoma (Option D): Commonly seen in children, typically in the cerebellum, and does not exhibit dural tail sign.

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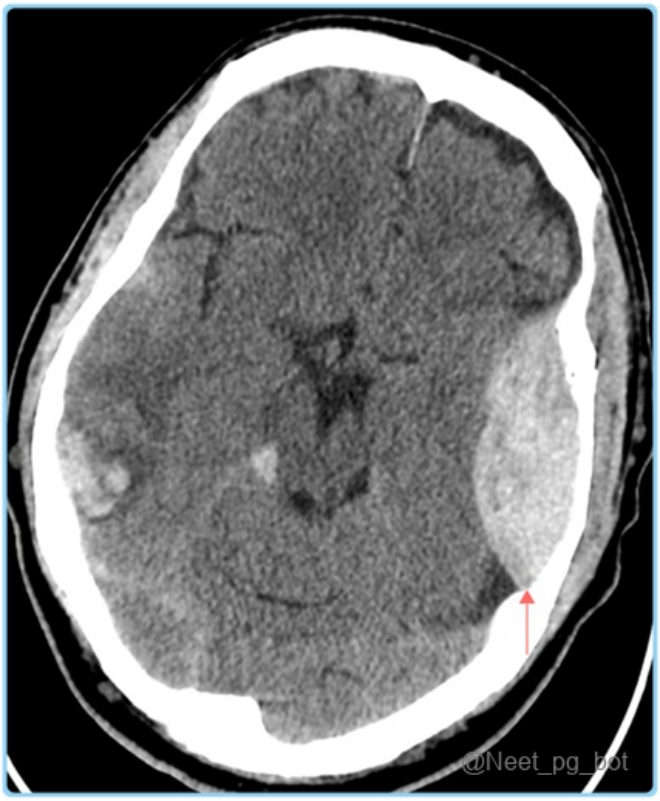
Q12: What is the probable diagnosis for a 30-year-old woman who experienced nausea and vomiting after being involved in a road traffic accident, and was brought to the emergency room unconscious, based on the findings of the NCCT brain? (Q857856)

A. Extradural hemorrhage

B. Subdural hemorrhage

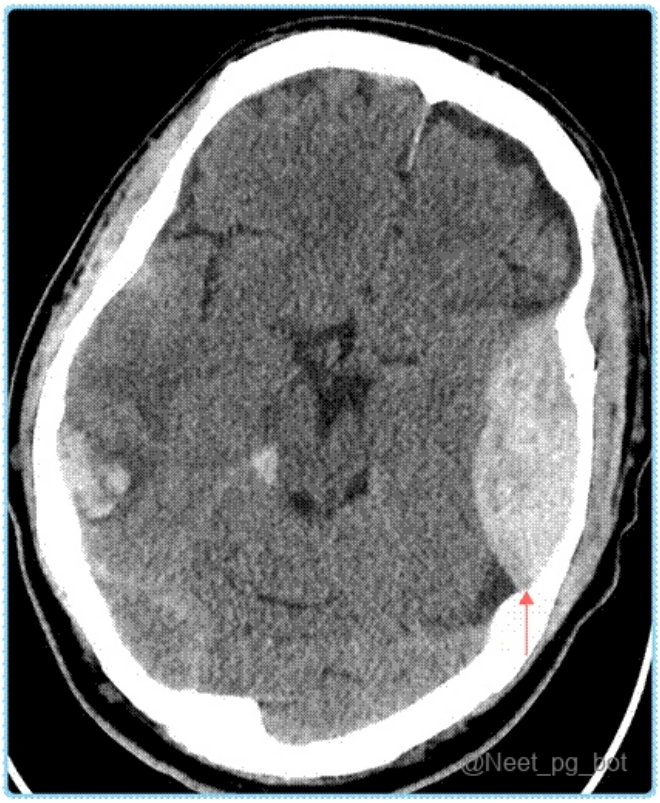
C. Intra-parenchymal hemorrhage

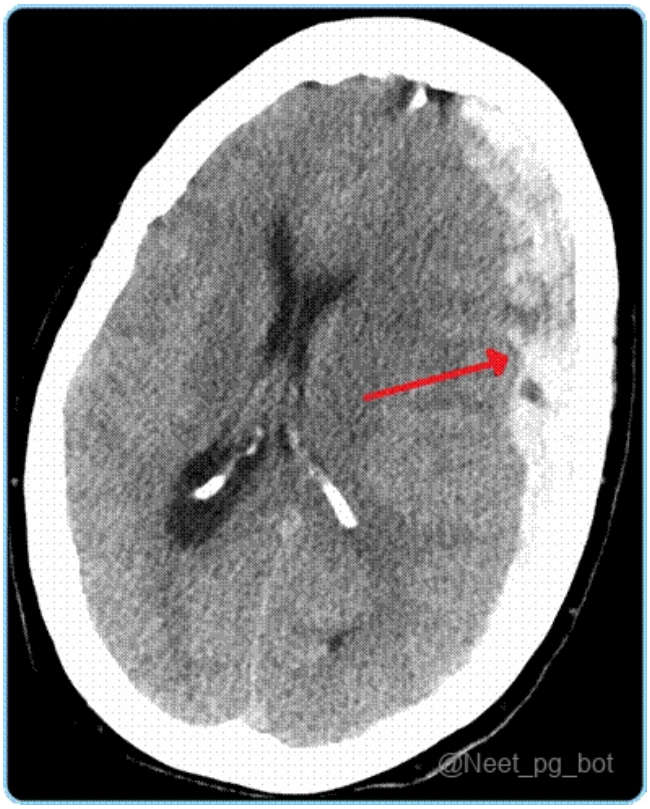
D. Subarachnoid hemorrhage

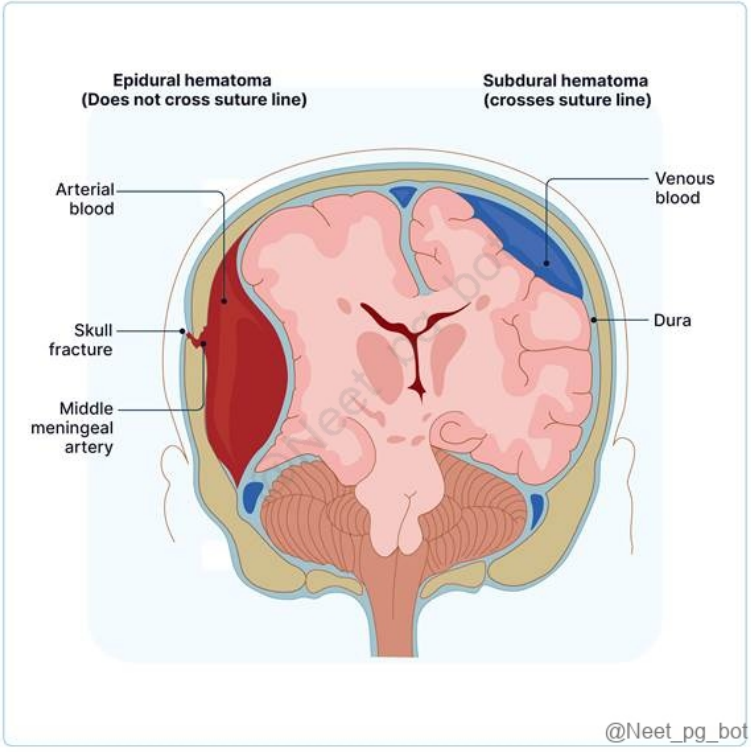


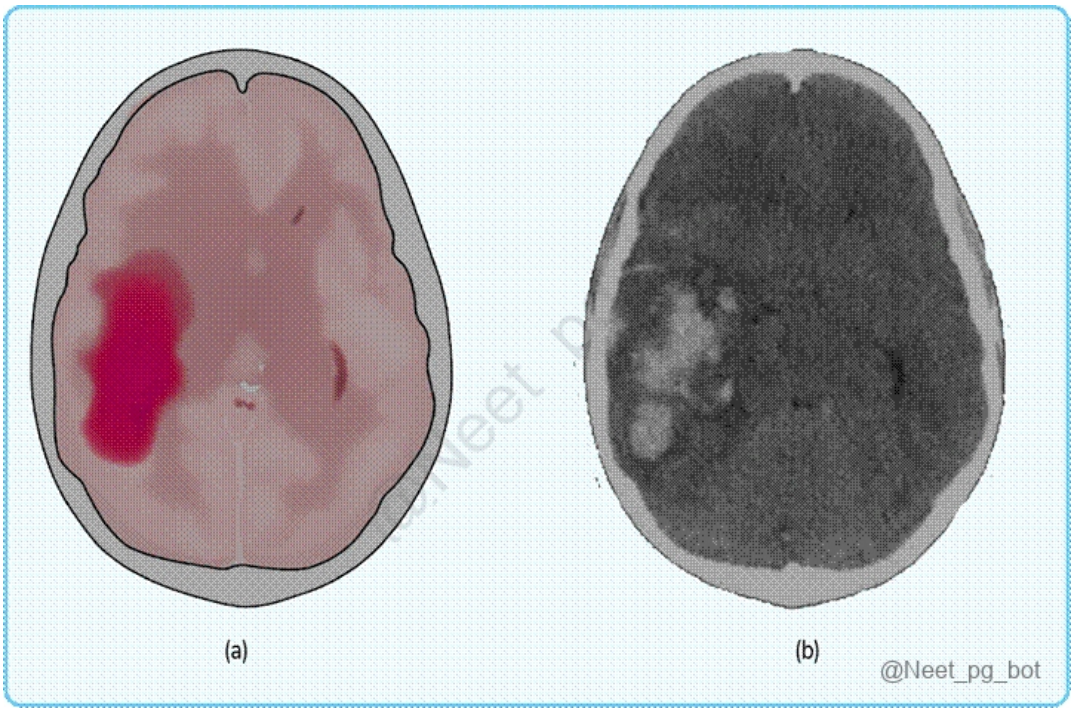
Correct Answer: A. Extradural hemorrhage

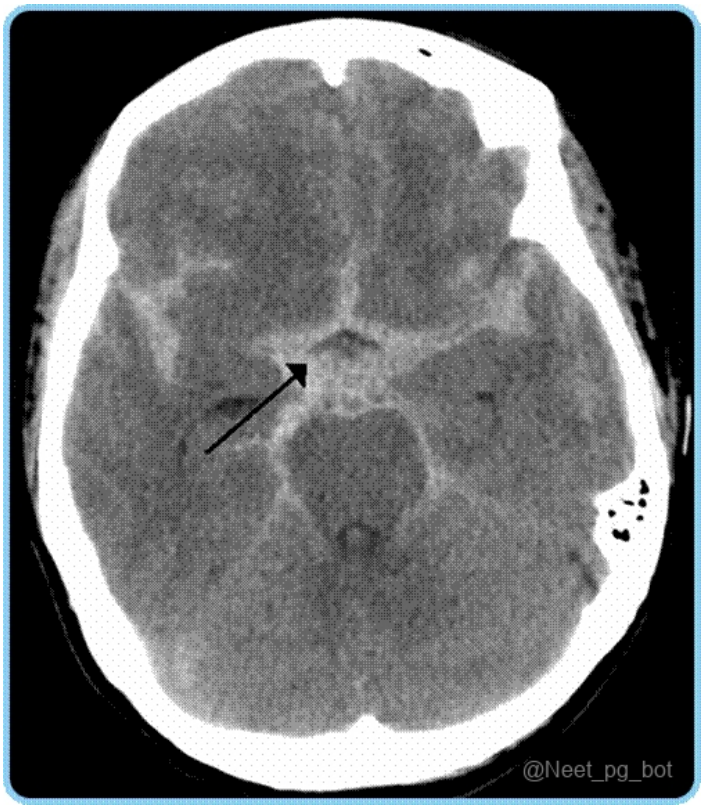
Explanation: The likely diagnosis for a woman presenting with nausea and vomiting after a road traffic accident, and NCCT head showing a lens-shaped or biconvex hematoma between the inner surface of the skull and the outer layer of the dura mater, is Extradural Hemorrhage (Epidural Hemorrhage) . Aspect Epidural Hematoma (EDH) (Option A) Subdural Hematoma (SDH) (Option B ruled out) Mechanism Rupture of an artery, often the middle meningeal artery, usually due to a skull fracture, commonly in the temporal bone. Two contexts: High-energy injury: Rupture of cortical surface vessels. Low-energy injury: Venous bleeding, common in older adults on anticoagulants. Clinical Presentation Classic: Transient loss of consciousness, lucid interval, rapid neurological decline. Headaches are common. Brain compression signs: Contralateral hemiparesis, reduced consciousness, ipsilateral pupillary dilation. Variable presentation depending on injury severity and timing. Signs of raised intracranial pressure: Headache, reduced consciousness, focal neurological deficits. CT Appearance Lentiform (lens-shaped or biconvex) hyperdense lesion between the skull and the brain. {{caption_text}} Diffuse concave hyperdense (acute), isodense (subacute), or hypodense (chronic) crescent-shaped lesions over the brain surface, often crossing suture lines. {{caption_text}} Management Neurosurgical emergency; requires immediate evacuation, usually by craniotomy. Depends on size, location, and clinical status: 1. Large or worsening hematomas: Urgent evacuation by craniotomy or craniectomy. 2. Smaller, stable bleeds: Conservative management initially, with surgery if needed. Summary EDH often follows a predictable course with a lucid interval. SDH has a more variable presentation and distinct CT appearance. Intra-parenchymal hemorrhage (Option C) involves bleeding within the brain tissue, appearing as a high-density, irregular mass on NCCT. It is commonly associated with hypertension or stroke, not trauma. While unconsciousness may suggest a severe injury, the imaging would not show the "lens-shaped" hematoma seen in extradural hemorrhage. {{caption_text}} Subarachnoid hemorrhage (Option D) involves bleeding between the brain and arachnoid mater, often from a ruptured aneurysm. On NCCT, it appears as diffuse blood in the sulci. While trauma and unconsciousness may raise suspicion, it doesn't show the biconvex hematoma seen in extradural hemorrhage. {{caption_text}}




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Epidural hematoma
(Does not cross suture line)
Subdural hematoma
(crosses suture line)
Arterial blood
Venous blood
Skull fracture
Dura
Middle meningeal artery
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References:

Bailey & Love's Short Practice of Surgery, 28th Edition,Page, 365- 367, 711.

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Q13: What is the most appropriate course of action for the management of a patient who presents to the emergency department with a severe headache and has a blood pressure reading of 160/100 mmHg, along with a CT scan showing evidence of a subarachnoid haemorrhage? (Q855267)

A. Nimodipine

B. Angiography

C. Surgery

D. Fibrinolytic therapy

Correct Answer: B. Angiography

Explanation: In a patient presenting with a subarachnoid haemorrhage (SAH) and a severe headache, angiography is the most appropriate next step. This is crucial for identifying the source of the haemorrhage, such as an aneurysm or arteriovenous malformation (AVM). Subarachnoid Hemorrhage: Causes: Most common: Trauma Ruptured Aneurysm : Most commonly located in the Circle of Willis. Arteriovenous Malformation (AVM) Perimesencephalic SAH : Bleeding is confined to the basal cisterns due to venous bleeding and is associated with a better prognosis. Risk factors: Female sex Hypertension Smoking & Cocaine use Genetic disorders (e.g., adult polycystic kidney disease , Marfan syndrome) Symptoms: Thunderclap Headache : Sudden and severe headache. Associated with Seizures (10%), Unresponsiveness (50%) and Vomiting (70%) Diagnosis: CT Scan : First-line imaging , effective within 12 hours of onset, and its sensitivity decreases after one week. Fisher Grading for SAH on CT: Grade I No bleeding. Grade II Diffuse SAH with layers <1mm thick. Grade III Localised clots or SAH layers >1mm thick. Grade IV SAH minimal/absent, with intracerebral/intraventricular haemorrhage. Lumbar Puncture : Used if CT is negative but SAH is suspected. Digital Subtraction Angiography (DSA) : Gold standard for visualising aneurysms. Management: Surgical or endovascular intervention and addressing complications such as vasospasm and electrolyte imbalances . Early and effective treatment is crucial for improving outcomes. Nimodipine (Option A) is a calcium channel blocker commonly used in the management of SAH to prevent vasospasm, a frequent complication. However, it is not the immediate next step after the diagnosis of SAH. Surgery (Option C) may be needed to treat the cause of SAH, such as a ruptured aneurysm. However, angiography is generally performed first to identify the location and extent of the aneurysm before proceeding with surgery. Fibrinolytic therapy (Option D) is not typically used in the acute management of SAH. It is designed to dissolve intravascular clots and improve blood flow in ischemic conditions, but it is not indicated for SAH.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 708,709

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Q14: A 50-year-old patient presents with confusion and ataxia following trauma one week ago. He has a history of alcohol dependence, with his last intake 2 weeks ago. A CT scan reveals the following findings. What is the most likely diagnosis? (Q855207)

A. Extradural hemorrhage

B. Subdural hemorrhage

C. Intra-parenchymal hemorrhage

D. Subarachnoid hemorrhage

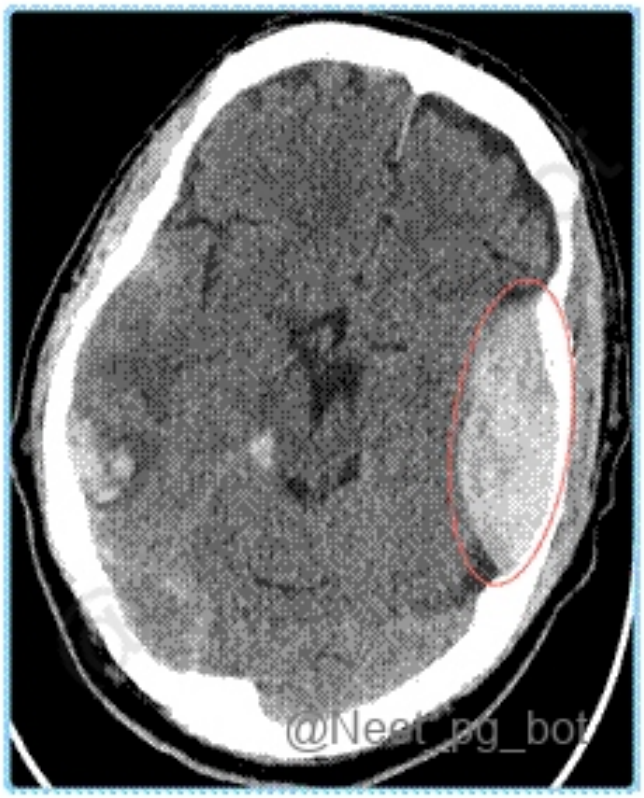


Correct Answer: B. Subdural hemorrhage

Explanation: Given the clinical scenario and radiological findings showing a crescent-shaped blood collection that follows the brain's contours and crosses suture lines , the most probable diagnosis is Subdural Hematoma. Features Subdural Hematoma Extradural Hematoma (Option A) Location Between Dura and Arachnoid Between Dura and Skull CT Appearance Crescent-shaped Crosses suture lines Biconvex or lens-shaped Well-defined & Localized, Won’t cross suture lines Common Causes Tearing of bridging veins , often due to blunt trauma / acceleration-deceleration injuries Rupture of the middle meningeal artery or vein due to skull fracture or trauma Onset Develop over days to weeks; Acute SDH can occur rapidly Usually develop rapidly Management Craniotomy / Craniectomy , if significant. Conservative management for smaller, stable cases. Burr hole drainage is preferred for significant chronic cases Urgent surgical evacuation for significant or deteriorating cases.

{{caption_text}} {{caption_text}} Intra-parenchymal hemorrhage (Option C) is a type of hemorrhage that involves bleeding within the brain tissue itself and is typically associated with conditions like hypertension, cerebral amyloid angiopathy, or direct traumatic brain injury. Subarachnoid Hemorrhage (Option D) typically causes sudden severe headache, often described as a "thunderclap," and is seen on CT as blood in the subarachnoid space, often with associated hydrocephalus. It does not usually present with the crescent-shaped lesions seen in SDH.





References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 365-367

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Q15: What is the Glasgow Coma Scale (GCS) score of a patient who was admitted to the emergency room after being involved in a road traffic accident and, on examination, opens his eyes in response to a painful stimulus, speaks inappropriately, and withdraws his limbs in response to a painful stimulus? (Q855182)

A. E2V2M3

B. E3V3M3

C. E2V3M4

D. E3V2M2

Correct Answer: C. E2V3M4

Explanation: Eye-opening (E) : The patient opens their eyes in response to a painful stimulus, which corresponds to E2 (eye-opening to pain). Verbal response (V) : The patient speaks inappropriately, corresponding to V3 (inappropriate words). Motor response (M) : The patient withdraws their limbs in response to a painful stimulus, which corresponds to M4 (withdraws to pain). Glasgow Coma Scale (GCS): Category Response Score Eye Opening (E) Spontaneous 4 To speech 3 To pain 2 None 1 Verbal Response (V) Oriented 5 Confused conversation 4 Inappropriate words 3 Incomprehensible sounds 2 None 1 Motor Response (M) Obeys commands 6 Localizes to pain 5 Withdraws from pain 4 Abnormal flexion (decorticate) 3 Abnormal extension (decerebrate) 2 No response 1 Head Injury Severity: Clinical Classification Minor head injury GCS 15 with no LOC (loss of consciousness) Mild head injury GCS 14 or 15 with LOC Moderate head injury GCS 9 - 13 Severe head injury GCS 3 - 8 The GCS-P score is calculated by subtracting the Pupil Reactivity Score (PRS) from the Glasgow Coma Scale (GCS) total score: GCS-P = GCS - PRS. Pupils Unreactive to Light Pupil Reactivity Score Both Pupils 2 One Pupil 1 Neither Pupil 0 GCS-P score can range from 1 to 15 GCS-P score values between one and 8 denote a severe injury

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 357,361

https://www.glasgowcomascale.org/what-is-gcs-p/

https://www.ncbi.nlm.nih.gov/books/NBK513298/

↑ *Back to this question in Part A*

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Q16: Which of the following conditions is associated with perineural invasion? (Q854781)

A. Adenoid cystic carcinoma

B. Pleomorphic adenoma

C. Mucoepidermoid tumour

D. Pancreatic cancer

Correct Answer: A. Adenoid cystic carcinoma

Explanation: Adenoid cystic carcinoma is known for its tendency to invade along nerves (perineural invasion) , which is a key feature of its aggressive nature. Adenoid cystic carcinoma: This type of cancer primarily affects the submandibular and sublingual salivary glands, with approximately half of the cases occurring in minor salivary glands, especially in the palate. It is relatively rare in the parotid gland. Clinical features: Facial nerve palsy Pain or numbness High risk of distant metastasis, especially - lung. Histopathology of adenoid cystic carcinoma: Type: Unencapsulated, infiltrative biphasic neoplasm. Cell Types: Variable proportions of epithelial and myoepithelial cells. Patterns: Cribriform: Cells around sharply punched-out cylindromatous spaces with basophilic matrix. It is the most common type and has a better prognosis. Tubular: Bilayered tubules with a true lumen. Solid: Sheets and nests of tumour cells without a lumen. Carries poor prognosis. Nuclear Features: Small, angulated, hyperchromatic

nuclei with scant cytoplasm. Perineural Invasion: Common in adenoid cystic carcinoma. High-Grade Transformation: Can occur Immunohistochemistry: Ductal cells: Positive for c-KIT. Myoepithelial cells: Positive for p63 and SMA. Incorrect Options: Pleomorphic adenoma (Option B) : This tumour generally does not show perineural invasion unless it undergoes a malignant transformation. Even in cases of malignancy, vascular invasion is more commonly seen than perineural invasion. Mucoepidermoid tumour (Option C) : While mucoepidermoid tumours can invade surrounding tissues, including nerves, perineural invasion is less common compared to adenoid cystic carcinoma. Pancreatic cancer (Option D) can invade adjacent structures and spread to distant organs, but perineural invasion is not a characteristic feature of this type of cancer.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 841

SRB's Manual of Surgery, 6th Edition, Page 405

↑ *Back to this question in Part A*

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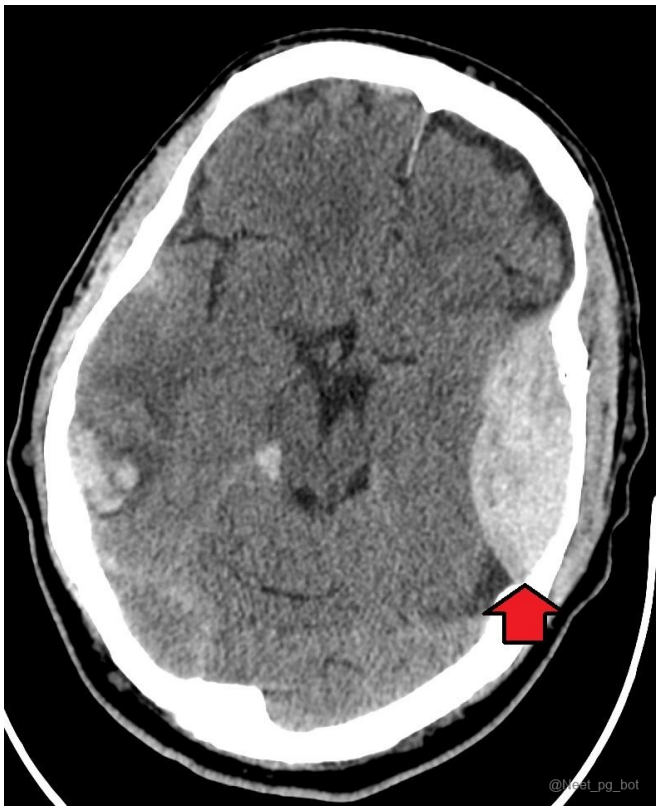
Q17: A 32-year-old patient had a RTA and was brought to the ER. On examination, his GCS was E2M4V2 and his CT scan is given below. Which of the following is the preferred treatment in this condition? (Q820167)

A. Ventilation

B. Craniotomy with evacuation of hematoma

C. Anticoagulants

D. Steroids



Correct Answer: B. Craniotomy with evacuation of hematoma

Explanation: Correct option B - Craniotomy with evacuation of hematoma CT scan shows extradural hematoma. Extradural hematoma causes increased intracranial pressure, leading to brain compression and potential life-threatening complications. Craniotomy with evacuation of hematoma can relieve pressure on the brain and prevent further damage. Incorrect options: Option A, C and D are not the treatment of extradural hematoma.

↑ *Back to this question in Part A*

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Q18: Which type of intracranial hemorrhage is most likely depicted in the image given below? (Q860287)

A. Extradural hemorrhage

B. Subarachnoid hemorrhage

C. Subdural hematoma

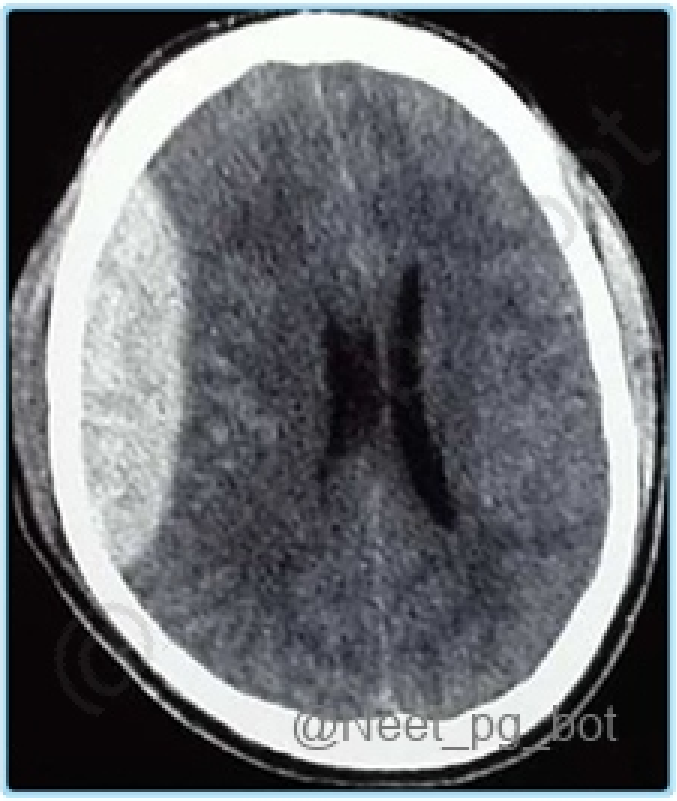
D. Intraparenchymal hemorrhage



Correct Answer: C. Subdural hematoma

Explanation: The given image shows a crescent-shaped blood collection that follows the brain's contours and crosses suture lines , the most probable diagnosis is Subdural Hematoma. Features Subdural Hematoma Extradural Hematoma (Option A) Location Between Dura and Arachnoid Between Dura and Skull CT Appearance Crescent-shaped Crosses suture lines Biconvex or lens-shaped Well-defined & Localized, Won’t cross suture lines Common Causes Tearing of bridging veins , often due to blunt trauma / acceleration-deceleration injuries Rupture of the middle meningeal artery or vein due to skull fracture or trauma Onset Develop over days to weeks; Acute SDH can occur rapidly Usually develop rapidly Management Craniotomy / Craniectomy , if significant. Conservative management for smaller, stable cases. Burr hole drainage is preferred for significant chronic cases Urgent surgical evacuation for significant or deteriorating cases. {{caption_text}} {{caption_text}} Incorrect Options: Intra-parenchymal hemorrhage (Option D) is a type of hemorrhage that involves bleeding within the brain tissue itself and is typically associated with conditions like hypertension, cerebral amyloid angiopathy, or direct traumatic brain injury. Subarachnoid Hemorrhage (Option B) typically causes sudden severe headache, often described as a "thunderclap," and is seen on CT as blood in the subarachnoid space, often with associated hydrocephalus. It does not usually present with the crescent-shaped lesions seen in SDH.





References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 365-367

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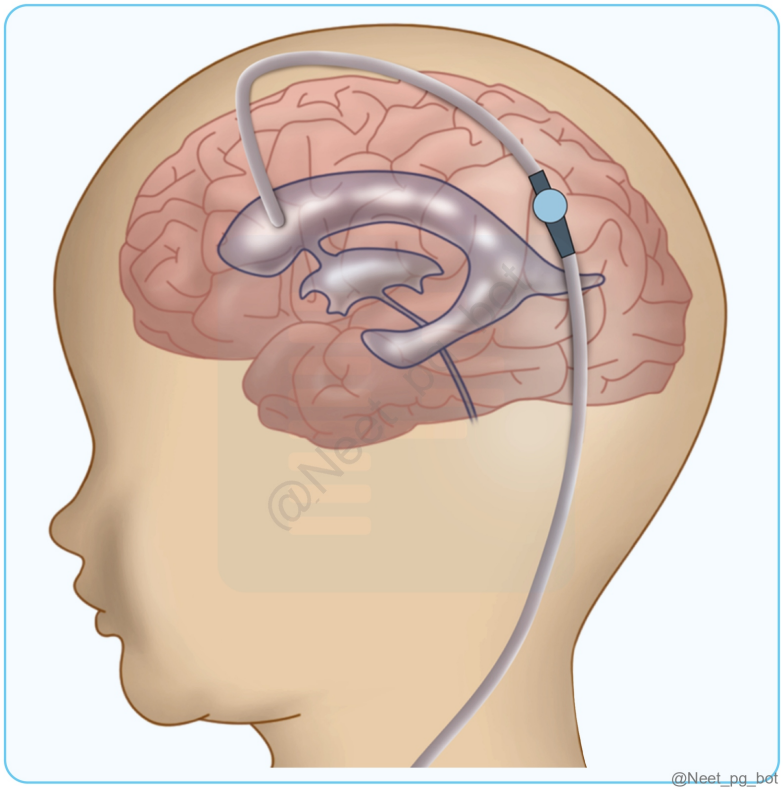
Q19: A 7-year-old boy is brought with complaints of headache, and vomiting for a few days. He had undergone a ventriculoperitoneal (VP) shunt placement for hydrocephalus a year ago. What is the most common cause of shunt malfunction in this patient? (Q860460)

A. Shunt infection

B. Shunt obstruction

C. Shunt tip migration

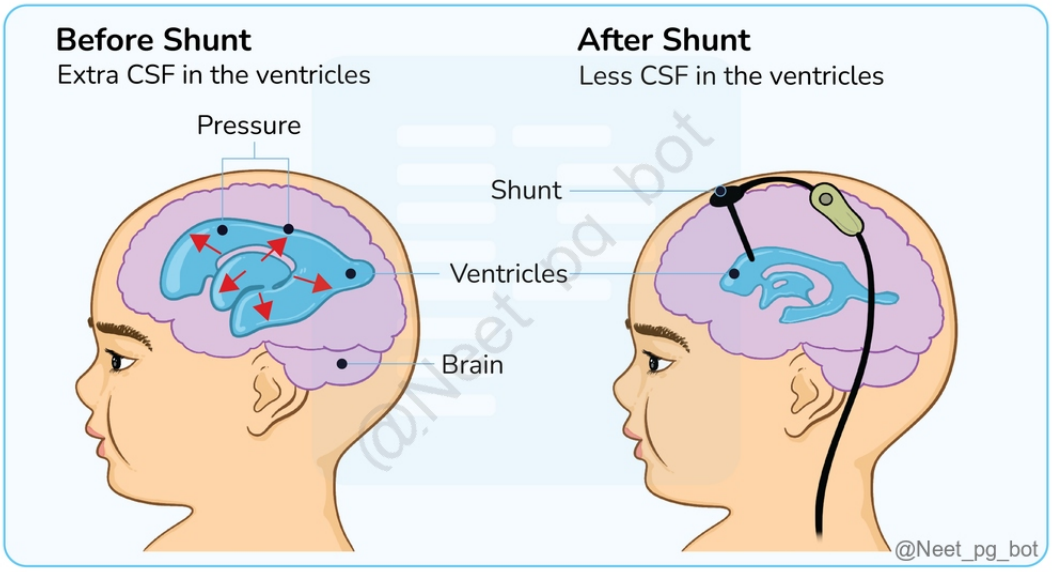
D. Shunt disconnection



Correct Answer: B. Shunt obstruction

Explanation: Shunt obstruction is the most common cause of VP shunt malfunction. This can occur anywhere along the length of the shunt, but it often happens at the distal catheter (the part of the shunt that drains into the peritoneum). A Ventriculoperitoneal (VP) shunt is generally considered for long-term management of hydrocephalus . It is implanted surgically to divert excess cerebrospinal fluid (CSF) from the ventricles of the

brain to the peritoneal cavity , where it can be absorbed by the body. Management of Hydrocephalus: Medical : Acetazolamide and furosemide can temporarily reduce CSF production but are not effective long-term. Surgical: (CSF Diversion) Ventriculoperitoneal Shunt: Valved tubing from the ventricle to the peritoneal cavity. Endoscopic Third Ventriculostomy: It is a useful treatment for certain cases of hydrocephalus, especially when there is an obstructive pattern that can be bypassed surgically and not always suitable for all patients and is considered an alternative to shunt placement Intrauterine Treatment : Results are generally poor except in cases associated with fetal meningomyelocele. Complications: Shunt occlusion (headache, papilledema, vomiting, altered mental status) and bacterial infection leading to meningitis/peritonitis (fever, headache, meningismus), typically caused by Staphylococcus epidermidis. Other options: Option A: Shunt infection Although infection is a common early complication (first few months), it is not the most common cause overall. Infections usually present with fever, erythema over tract, CSF pleocytosis, which are not mentioned in this case. Option C: Shunt tip migration Migration can occur but is far less common than obstruction. Usually presents with abdominal symptoms if the peritoneal end migrates, or subcutaneous swelling if dislodged—not seen here. Option D: Shunt disconnection Occurs due to breakage at connector sites, especially in growing children. Again, not as common as obstruction, and often presents with palpable discontinuity along the shunt tract.



References:

Nelson Textbook of Pediatrics, 21st Edition, Page 3080

↑ *Back to this question in Part A*

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Q20: A 65-year-old patient with a history of thromboembolic stroke, currently taking warfarin and aspirin, presents with a headache and confusion after a fall in the toilet. A non-contrast CT of the head is given in the image. What is the next best step in management? (Q860383)

A. Aspirin + Clopidogrel

B. Vitamin K + FFP + Neurosurgery consultation

C. IV Mannitol

D. Observation

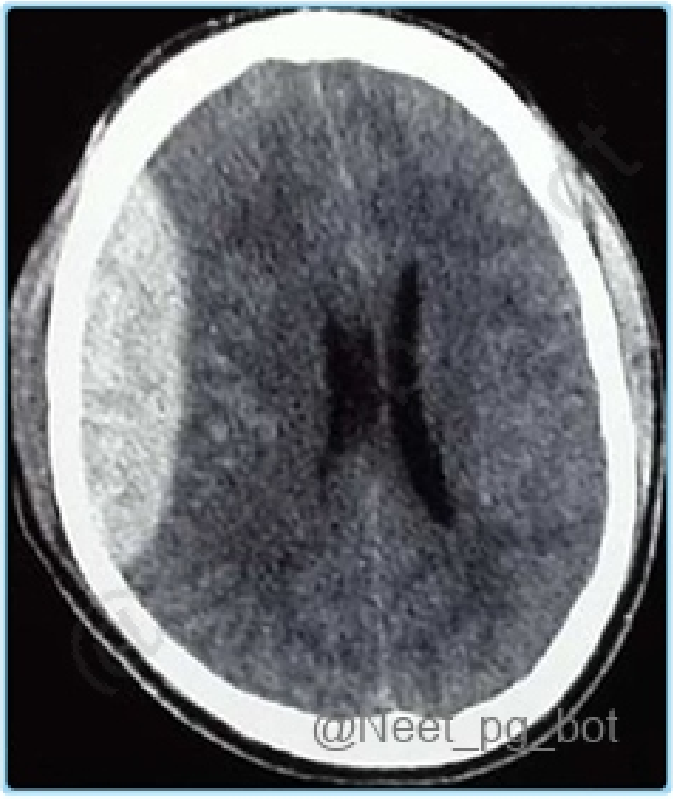


Correct Answer: B. Vitamin K + FFP + Neurosurgery consultation

Explanation: The given image shows a crescent-shaped blood collection that follows the brain's contours and crosses suture lines , the most probable diagnosis is Subdural Hematoma. In a patient on warfarin with a subdural hematoma (SDH), the primary concern is managing the anticoagulation effect and addressing the hemorrhage. The next best step involves: Vitamin K to reverse the effects of warfarin. FFP (Fresh Frozen Plasma) to provide clotting factors. Neurosurgery consultation to assess the need for surgical intervention (e.g., evacuation of the hematoma). Features Subdural Hematoma Extradural Hematoma (Option A ruled out) Location Between Dura and Arachnoid Between Dura and Skull CT Appearance Crescent-shaped Crosses suture lines Biconvex or lens-shaped Well-defined & Localized, Won’t cross suture lines Common Causes Tearing of bridging veins , often due to blunt trauma / acceleration-deceleration injuries Rupture of the middle meningeal artery or vein due to skull fracture or trauma Onset Develop over days to weeks; Acute SDH can occur rapidly Usually develop rapidly Management Craniotomy / Craniectomy , if significant. Conservative management for smaller, stable cases. Burr hole drainage is preferred for significant chronic cases Urgent surgical evacuation for significant or deteriorating cases. {{caption_text}} {{caption_text}} Incorrect Options: Aspirin + Clopidogrel (Option A) would not be appropriate because they both increase bleeding risk and do not address the anticoagulation from warfarin. IV Mannitol (Option C) is used to reduce intracranial pressure, but the priority in this case is reversing anticoagulation and

consulting neurosurgery. Observation (Option D) alone is not sufficient, especially with the anticoagulant therapy involved and the size of the SDH shown on CT, which may require surgical intervention.





References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 365-367

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Q21: A 25 year patient had a Road traffic accident was initially conscious but later became unconscious and subsequently died. On postmortem examination, multiple petechial haemorrhages are seen in the corpus callosum, what is the probable diagnosis (Q866463)

A. EDH

B. Diffuse axonal injury

C. Subdural hematoma

D. SAH

Correct Answer: B. Diffuse axonal injury

Explanation: The scenario depicts diffuse axonal injury (DAI), which is a severe form of traumatic brain injury caused by shearing forces during rapid acceleration–deceleration (as in high-speed RTA). Pathology: Axonal disruption at the gray–white junction, corpus callosum, and brainstem. Postmortem finding: Multiple petechial hemorrhages in these areas. Clinical course: Often the patient becomes unconscious immediately or shortly after injury and remains comatose; some may have a brief lucid period. Mortality is high. DAI hallmark: Microscopic or small petechial hemorrhages at the gray–white junction and corpus callosum . Poor prognosis; often diagnosed by MRI (CT may be normal). Epidural hematoma (EDH) (Option A): Classically due to middle meningeal artery rupture; features a lucid interval , biconvex hyperdensity on CT, localized, not petechial hemorrhages in corpus callosum. Subdural hematoma (SDH) (Option C): Due to bridging vein rupture; appears crescent-shaped on CT; not characterized by multiple petechial hemorrhages in deep white matter. SAH (Option D): Presents with thunderclap headache; due to aneurysmal rupture or trauma, but hemorrhage is in subarachnoid space, not localized petechiae in corpus callosum.

↑ *Back to this question in Part A*

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Q22: Which of the following is the next step in the management of an old patient who has undergone complete excision of glioblastoma ? (Q793556)

A. Chemotherapy with Bevacizumab

B. No further management

C. Chemoradiation

D. Radiotherapy

Correct Answer: D. Radiotherapy

Explanation: Correct Option D - Radiotherapy: After complete excision of glioblastoma, the next step in management typically involves adjuvant therapy to target any residual tumor cells and prevent recurrence. Radiotherapy, also known as radiation therapy, is a crucial component of adjuvant treatment for glioblastoma. It helps to destroy any remaining cancer cells in the brain following surgery, reducing the risk of tumor recurrence and improving overall survival rates. Therefore, radiotherapy is the appropriate next step in the management of an old patient who has undergone complete excision of glioblastoma. Incorrect Options: Option A - Chemotherapy with Bevacizumab: While chemotherapy is an essential component of the treatment for glioblastoma, particularly in conjunction with radiotherapy, the use of Bevacizumab (Avastin) specifically is not typically the next step after complete excision of the tumor. Bevacizumab is a monoclonal antibody that targets vascular endothelial growth factor (VEGF) and is often used in the treatment of recurrent glioblastoma or as a second-line therapy. It is not typically the first choice for adjuvant treatment immediately following surgical excision. Option B - No further management: This option is incorrect because after surgical excision of glioblastoma, adjuvant treatment is essential to target any remaining cancer cells and prevent recurrence. Without further management, there is a high risk of tumor recurrence, which can lead to worsening symptoms and reduced survival rates. Therefore, no further management is not an appropriate option in this scenario. Option C - Chemoradiation: While chemoradiation (combining chemotherapy and radiotherapy) is a common treatment approach for glioblastoma, it is typically used as initial treatment or as adjuvant therapy following partial surgical resection. Complete excision of the tumor reduces the need for immediate chemoradiation as the primary treatment modality. Therefore, opting for chemoradiation immediately after complete excision may expose the patient to unnecessary side effects without clear benefit.

References:

Prepladder Notes

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• [02_Head And Neck] 004 Oral Cavity

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[02_Head And Neck] 004 Oral Cavity — Quick Jump

Q1 (p. 1203)	*Q2 (p. 1204)*	*Q3 (p. 1205)*	*Q4 (p. 1206)*	*Q5 (p. 1207)*	*Q6 (p. 1210)*
Q7 (p. 1211)	*Q8 (p. 1214)*	*Q9 (p. 1218)*	*Q10 (p. 1219)*	*Q11 (p. 1221)*	*Q12 (p. 1222)*
Q13 (p. 1223)	*Q14 (p. 1224)*	*Q15 (p. 1227)*	*Q16 (p. 1228)*	*Q17 (p. 1229)*	*Q18 (p. 1230)*
Q19 (p. 1231)	*Q20 (p. 1234)*	*Q21 (p. 1235)*	*Q22 (p. 1236)*	*Q23 (p. 1236)*	*Q24 (p. 1237)*
Q25 (p. 1240)	*Q26 (p. 1241)*				

Q1: A 55-year-old male presents with a 2 cm ulcerative lesion located on the lateral border of the anterior portion of the tongue, closer to the tip. During surgical planning, which group of lymph nodes is the most likely initial site of lymphatic drainage for this lesion? (Q849605)

A. Level I

B. Level II

C. Level III

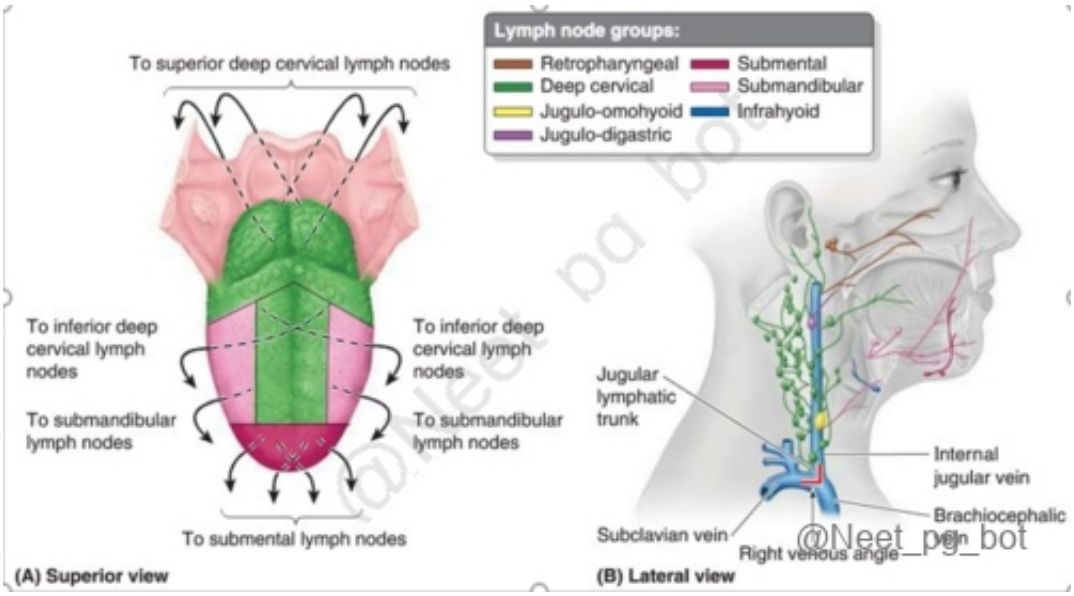
D. Level IV

Correct Answer: A. Level I

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The lymphatic vessels from the anterior lateral tongue drain primarily to the submandibular lymph nodes . The tip of the tongue drains to the submental nodes and then the submandibular nodes. The submental nodes are classified as Level Ia , and the submandibular nodes are classified as Level Ib . Together, Level Ia and Level Ib make up Level I . Level II (Option B): This is often the second station of drainage after Level I. While oral tongue cancers frequently metastasize to Level II, it is not typically the initial site. Level III & IV (Option C &D): These levels are further down the lymphatic chain. Involvement of these nodes usually occurs after the cancer has already spread to the upper levels (I and II) and indicates more advanced disease.



References:

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7450815/

SRB's Manual of Surgery, Edition 6, page no: 359,382,383,384

↑ *Back to this question in Part A*

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Q2: A 65-year-old patient presents with metastatic adenocarcinoma, but the primary tumor site remains unidentified. Which of the following is the most appropriate next step in the workup to help locate the primary tumor? (Q849630)

A. Complete blood count

B. PET scan

C. Start chemotherapy

D. Exploratory surgery

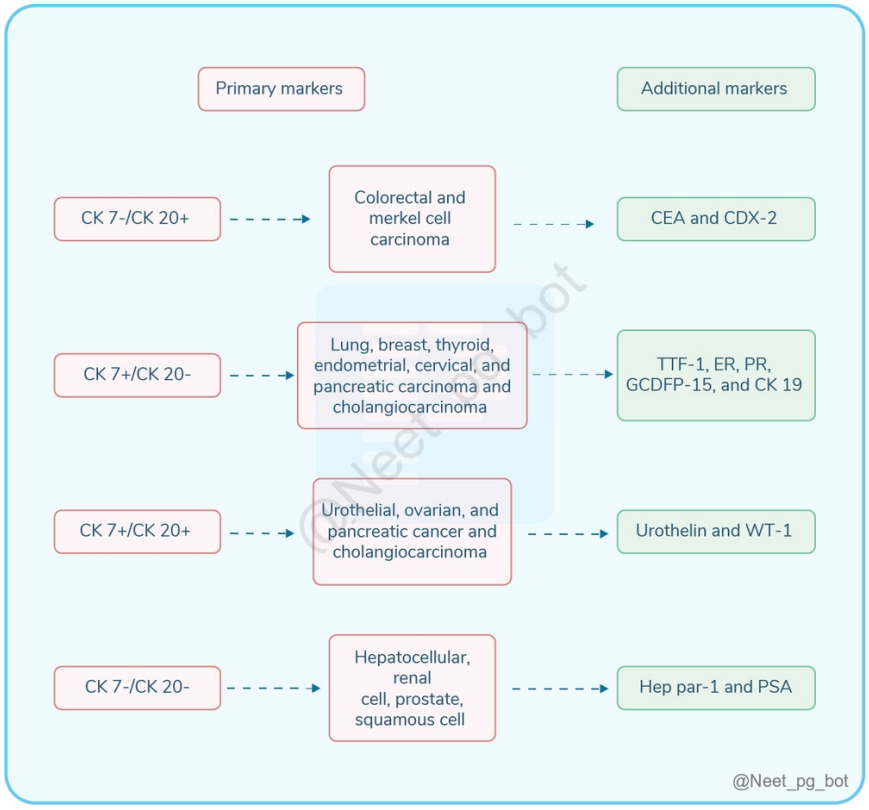
Correct Answer: B. PET scan

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Carcinoma of unknown primary origin (CUP) r efers to metastatic cancer where the primary tumor is not identified at initial presentation. The most appropriate next step to locate the primary tumor is imaging studies, among which a PET scan is particularly useful. Diagnostic Workup: Clinicopathologic diagnosis: Evaluation of

family and personal history: Identifies potential primary sites and risk factors. Physical examination: H/o previous surgeries and lesions. Biopsy and pathology: Fine-needle aspiration or core biopsy. Light microscopy with hematoxylin-and-eosin staining identifies the cancer type. Immunohistochemical tests: Immunohistochemical markers: These are peroxidase-labeled antibodies against specific tumor antigens, and help determine the tumor lineage. For e.g.: PSA and thyroglobulin (prostate and thyroid cancers). Cytokeratin stains: CK 7 and CK 20 determine tumor origin. Serum Tumor Markers and Cytogenetics: Tumor markers: PSA (for adenocarcinoma with bone metastasis), beta-human chorionic gonadotropin, alpha-fetoprotein (for germ cell tumors). Cytogenetics: Occasionally used to rule out lymphoma. Imaging Studies: CT scan: Abdominal and pelvic CT to locate the primary tumor and evaluate the disease extent. Mammography: Recommended for women with metastatic adenocarcinoma. MRI: Effective for assessing isolated axillary lymph node metastases and suspected occult primary breast carcinoma. PET Scan: Useful in non-cervical carcinoma of unknown primary origin (CUP) to guide biopsy and assess disease extent. (Option B) Advanced Techniques: Gene expression profiling: Uses DNA microarrays and RT-PCR to predict tumor origin based on gene expression patterns.



References:

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2631214/

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Q3: A 58-year-old patient who recently had a neck dissection is experiencing swelling, pain, and fluid accumulation in the surgical area. Which of the following is NOT a typical complication associated with neck dissection? (Q849629)

A. Wound dehiscence

B. Chyle leak

C. Accessory nerve injury

D. Facial nerve paralysis

Correct Answer: D. Facial nerve paralysis

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Facial nerve paralysis is more associated with surgeries of the parotid gland rather than neck dissection. Complications of Neck dissection: Intraoperative Complications Postoperative Complication Hemorrhage Injury to nerves Accessory nerve injury (Option C) Marginal mandibular nerve injury Vagus nerve injury Hypoglossal nerve injury Phrenic nerve injury Sympathetic trunk injury Thoracic duct injury (Option B) Pneumothorax Salivary leakage Hemorrhage Deep dehiscence (Option A) Wound infection Cephalic vein stasis Bronchopneumonia

References:

Bailey & Love's Short Practice of Surgery, Edition 28, page no:848
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9442196/

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Q4: A patient undergoes a neck dissection that involves removing lymph nodes from levels I-V, while preserving the spinal accessory nerve, and internal jugular vein. What type of neck dissection was performed? (Q849628)

A. Radical neck dissection

B. Anterolateral Neck Dissection

C. Modified Radical Neck Dissection Type II

D. Modified Radical Neck Dissection Type III

Correct Answer: C. Modified Radical Neck Dissection Type II

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Type of Neck Dissection Nodes Removed Structures Preserved Comprehensive: 1. Radical Neck Dissection (RND) (Option A) Level I - V None 2. Bilateral Radical Neck Dissection Level I - V (both sides) - 3. Modified Radical Neck Dissection Type I Level I - V SAN 4. Modified Radical Neck Dissection Type II (Option C) Level I - V SAN, IJV 5. Modified Radical Neck Dissection Type III (Option D) Level I - V SAN, SCM, IJV Selective Node Dissection: 1. Supraomohyoid Neck Dissection Level I - III SAN, SCM, IJV 2. Extended Supraomohyoid (Anterolateral Neck Dissection) (Option B) Level I - IV 3. Posterolateral Neck Dissection Level II - V with suboccipital, retroauricular nodes 4. Anterior/ Central Dissection Level VI SAN: Spinal accessory nerve; SCM: Sternocleidomastoid muscle; IJV: Internal jugular vein

References:

Bailey & Love's Short Practice of Surgery, Edition 28, page no:811

SRB's Surgical Operations, Edition 6, page no:440

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Q5: A 58-year-old male is scheduled for a neck dissection due to metastatic squamous cell carcinoma of the oral cavity. Which incision will the surgeon choose to provide optimal access to all cervical lymph node levels? (Q849619)

A. Macfee incision

B. Modified Schobinger incision

C. Y-shaped incision

D. Modified Macfee incision

Correct Answer: B. Modified Schobinger incision

■ *Listen (English)*

■ *Listen (Hindi)*

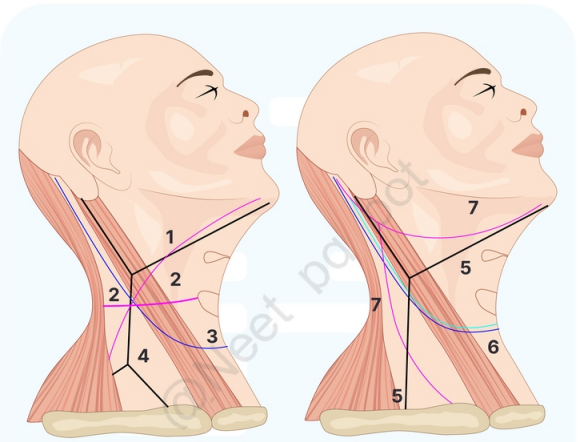
Explanation: Modified Schobinger Incision is the most preferred incision for adequate access to all levels of the neck lymph nodes. Types of Incisions in Neck Dissection 1. Macfee Incision: Two horizontal parallel incisions. Provide the best scar cosmesis. Limited access to deeper structures. 2. Modified Macfee Incision: Improves access to all neck node levels and a narrow bridge, thus facilitating an easier dissection of the spinal accessory nerve. 3. Reversed Hockey Stick Incision: Long anterior skin flap, superior access to all five lymph node levels.


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References:

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6897041/ https://www.ncbi.nlm.nih.gov/books/NBK563186/

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Q6: A 60-year-old female diagnosed with oral cavity cancer presents with a non-healing ulcer on her lower lip. Which of the following lymph node levels is most likely involved in this patient? (Q849618)

A. Levels IV and V

B. Levels II, III and IV

C. Levels I, II and III

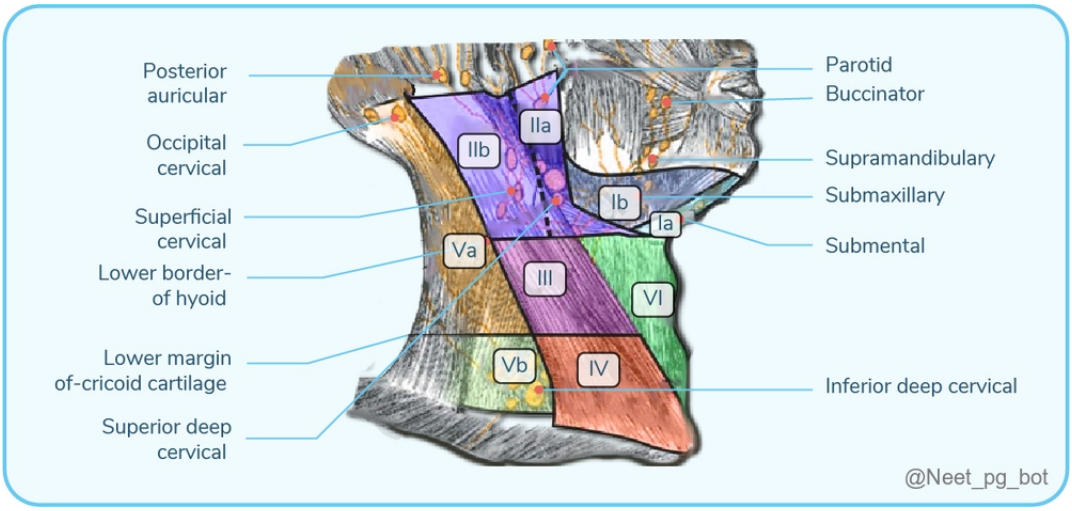
D. Level VII

Correct Answer: C. Levels I, II and III

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Levels of lymph nodes of neck: Levels Lymph nodes Boundaries Associated primary malignancy I Ia: Submental Anterior belly of digastric muscle, hyoid bone, midline, mandible. Floor of mouth, Anterior tongue, Mandibular alveolar ridge, Lower lip (Option C) Ib: Submandibular nodes Anterior and posterior bellies of digastric muscle, inferior border of mandible. Oral cavity (Option C) Anterior nasal cavity Mid-face soft tissues Submandibular gland II Upper jugular group Skull base, horizontal plane extending from hyoid bone and sternocleidomastoid. IIa: Anterior to the spinal accessory nerve. IIb: Posterior to the spinal accessory nerve. Nasal and oral cavities, (Option C) Nasopharynx Oropharynx Hypopharynx Larynx, (Option B) Major salivary glands. III Middle jugular group Strap muscles, sternocleidomastoid, horizontal plane from inferior border of cricoid cartilage. Oral cavity Nasopharynx Oropharynx Hypopharynx Larynx (Option B) IV Lower jugular group Strap muscles, sternocleidomastoid, and clavicle. Hypopharynx Oropharynx Larynx (Option B) Thyroid gland (Option A) Cervical esophagus V Posterior triangle group Va: Lateral to SCM muscle, inferior and medial to splenius capitis and trapezius, superior to the spinal accessory nerve. Nasopharynx Oropharynx Thyroid gland (Option A) Vb: Lateral to SCM muscle, medial to trapezius, inferior to the spinal accessory nerve, superior to the clavicle. VI Anterior compartment group Hyoid bone, suprasternal notch, lateral extent of the strap muscles bilaterally. Lower lip Soft tissues of the chin VII Superior mediastinal nodes Inferior to the suprasternal notch in the upper mediastinum. Nasopharynx Pharyngeal wall Oropharynx (Option D)



References:

Sabiston Textbook of Surgery, Edition 21, page no:775 Schwartz Textbook of Surgery, Edition 11, page no: 646,647 https://www.ncbi.nlm.nih.gov/books/NBK513317/

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Q7: A 35-year-old male presents with a smooth, tender swelling in the right lower jaw in relation to tooth caries. A panoramic radiograph shows a well-defined radiolucency around the roots of the lower right first molar. What is the most likely diagnosis?

(Q849612)

A. Dentigerous cyst

B. Dental cyst

C. Ameloblastoma

D. Epulis

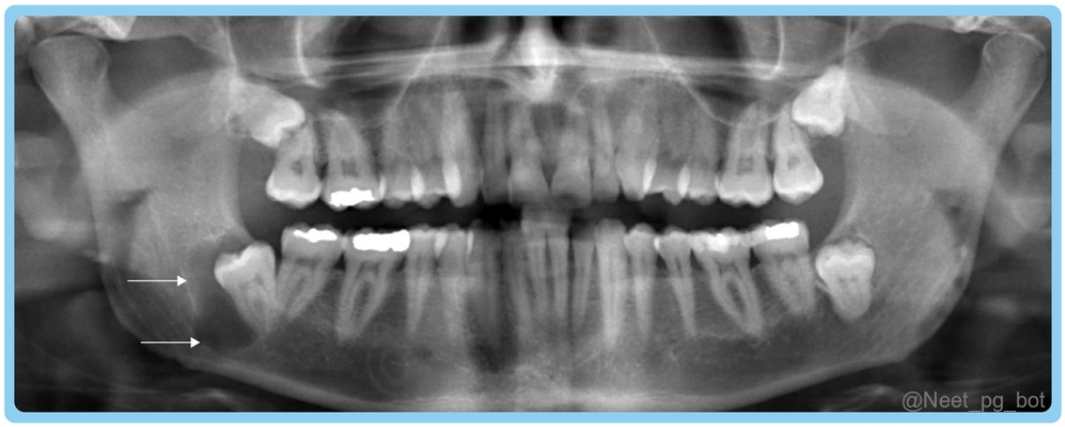
Correct Answer: B. Dental cyst

■ *Listen (English)*

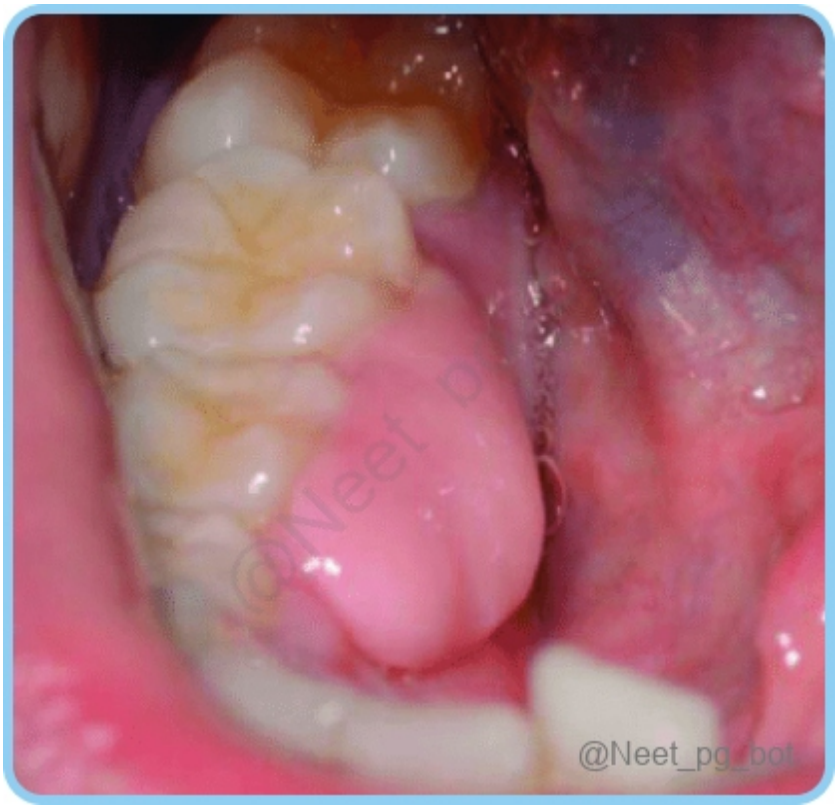
■ *Listen (Hindi)*

Explanation: Feature Ameloblastoma (Option C) Dentigerous Cyst (Option A) Dental Cyst (Option B) Description Arises from dental epithelium, probably from the enamel/ dental lamina. Occurs commonly in the mandible or maxilla, occasionally in the skull base Locally malignant tumor Unilocular cystic swelling arising to the dental epithelium from an unerupted tooth. Common in the lower jaw but can also occur in the upper jaw. Occurs over the crown of an unerupted tooth; commonly seen in relation to premolars or molars. Occurs under the root of a chronically infected dead erupted tooth. Clinical Features Painless, Progressively enlarging swelling in the jaw (usually mandible), Smooth and hard, with an intact inner table. Painless, Smooth, hard swelling over the crown of an unerupted tooth, Causes expansion of the outer table of the mandible. Smooth, tender swelling in the jaw related to a caries tooth, Causes expansion of the jaw bone. Investigations Orthopantomogram (OPG): Honeycomb appearance CT scan Biopsy Orthopantomogram (OPG): Tooth within the cyst, which is well defined. Orthopantomogram (OPG): Circular radiolucent area in relation to the root of a normally erupted tooth. Treatment Segmental resection of mandible or hemimandibulectomy with reconstruction of the mandible. Small cyst: Excision of the cyst. Large cysts: Initial marsupialization followed by excision. Extraction of unerupted tooth. Antibiotics, Drainage or excision of the cyst with extraction of the infected tooth. Epulis (Option D) is swelling arising from the mucoperiosteum of gums (gingiva).


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References:

SRB’s Textbook of Surgery, Edition 6, page no:350-352

↑ *Back to this question in Part A*

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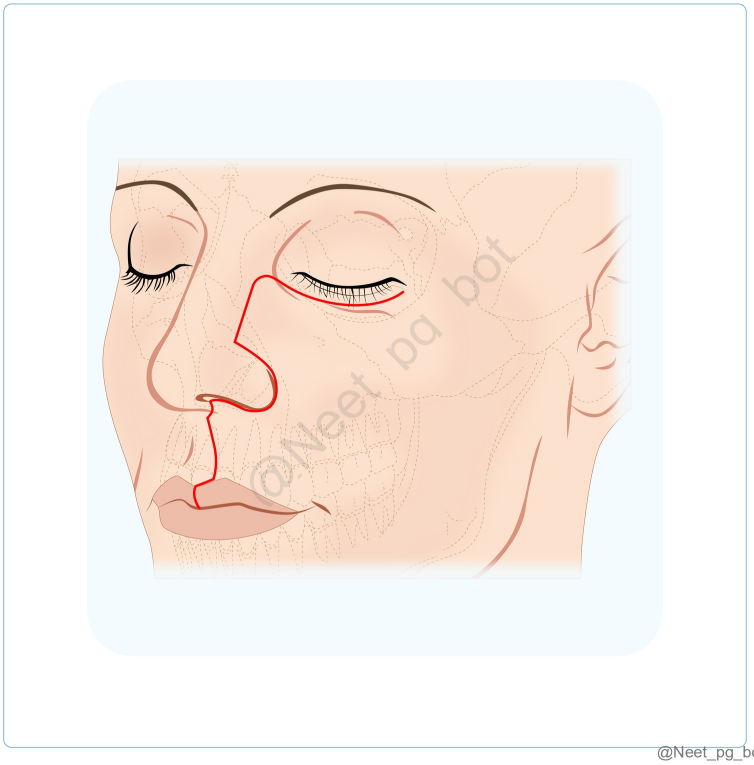
Q8: A 55-year-old male presents with a large tumor involving the floor of the maxillary sinus, causing facial swelling and nasal obstruction. During surgery, the surgical team uses the approach shown in the image. Identify the type of incision used in this procedure. (Q849611)

A. Caldwell-Luc Incision

B. Weber-Fergusson Incision

C. Modified Blair Incision

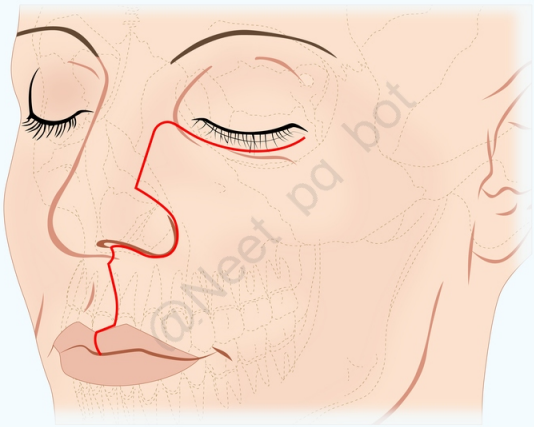
D. Lateral Rhinotomy Incision



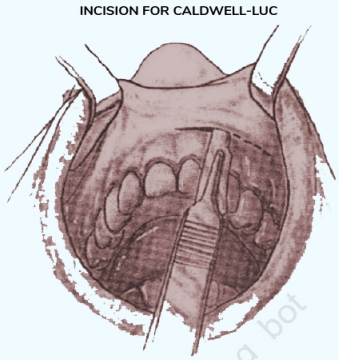
Correct Answer: B. Weber-Fergusson Incision

- *Listen (English)*
- *Listen (Hindi)*

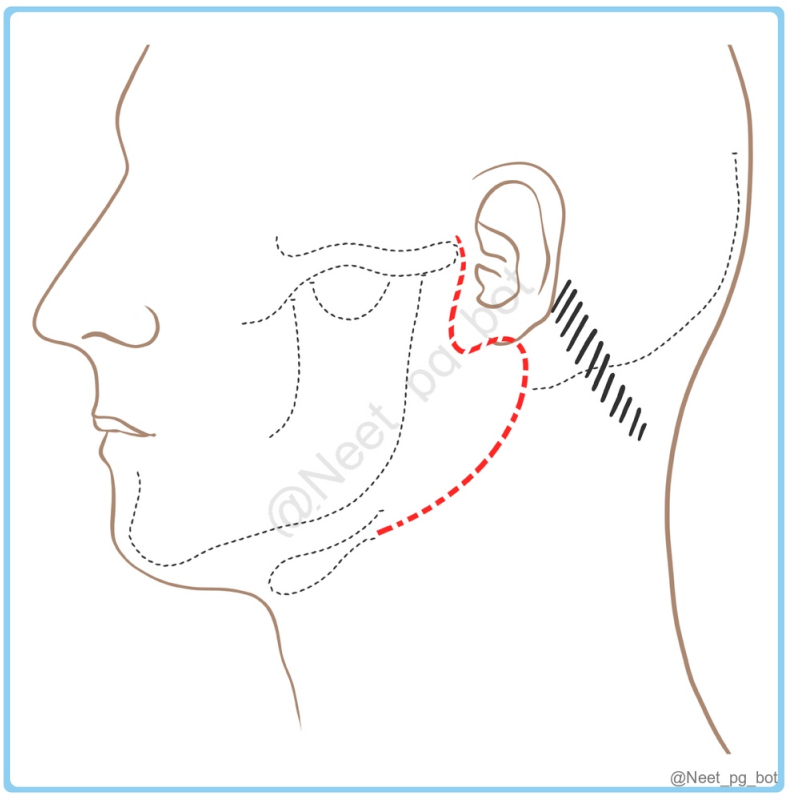
Explanation: Weber-Fergusson Approach: Provides access to the maxilla and periorbital area. Uses: Partial/total maxillectomy for malignant or extensive benign tumors of maxillary sinus and nasal cavity; midfacial tumor resections. Caldwell-Luc incision (Option A) is placed 3 mm above the line of reflection and runs laterally for 3.5 - 4 cm parallel to the teeth, starting at the canine ridge. Uses: Access to maxillary sinus for antrostomy, removal of cysts or foreign bodies, biopsy; now largely replaced by endoscopic sinus surgery. Modified Blair incision (Option C): It combines the inverted L-shaped preauricular incision of Blair with a cervical limb extending into the neck. Uses: Superficial or total parotidectomy, parotid tumors, some temporomandibular joint and upper neck procedures; designed to give wide exposure with acceptable cosmesis. Lateral rhinotomy incision (Option D) is placed in the nasofacial groove. Uses: Wide exposure of nasal cavity, ethmoid and frontal sinuses, upper nasal septum, and anterior skull base tumors when endoscopic access is inadequate. Lateral rhinotomy is an established approach to the midfacial skeleton.

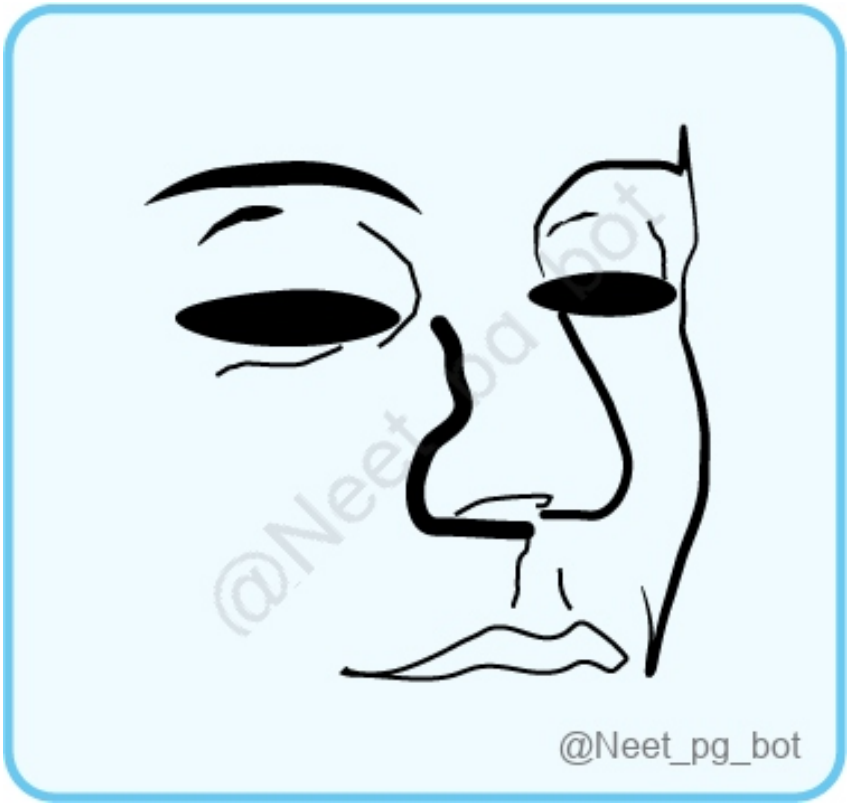


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References:

Bailey & Love’s Short Practice of Surgery, Edition 28, page no:821

Dhingra’s ENT Edition 8, page no: 241-245

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www.joms.org/article/S0278-2391(08)01242-1/abstract

↑ *Back to this question in Part A*

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Q9: A 55-year-old male patient requires mandibular reconstruction following the resection of a tumor. The surgeon is considering different bone graft options. Which of the following bone grafts is not likely to be chosen for bony reconstruction of the mandible? (Q849610)

A. Fibula bone graft

B. Iliac crest bone graft

C. Tibia bone graft

D. Scapula bone graft

Correct Answer: C. Tibia bone graft

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The tibia is generally avoided in modern maxillofacial reconstruction for several reasons: Poor Vascular Anatomy: Unlike the fibula, which has the reliable peroneal artery, the tibia does not have a well-defined segmental blood supply that allows it to be easily harvested as a vascularized free flap . Donor Site Morbidity: Removing a significant portion of the tibia severely compromises the weight-bearing capability of the leg, leading to a high risk of proximal or distal fractures . Cortical Density: The bone is often too dense and brittle to be easily contoured (osteotomized) to mimic the shape of the jaw. Mandibular Reconstruction: Gold Standard Flap Reconstruction with composite free flaps is considered the gold standard for segmental mandibular defects. Choice of Flap Depends on defect site, size, complexity, patient comorbidities, and surgeon’s training and preference. Anterior Defect More challenging to reconstruct than posterior defects; crucial for achieving satisfactory function. Graft used (Options A, B & D) Fibula Iliac crest Scapula Radius

References:

Bailey & Love’s Short Practice of Surgery, Edition 28, page no: 825

www.ncbi.nlm.nih.gov/books/NBK563241/

↑ *Back to this question in Part A*

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Q10: A patient is scheduled for segmental mandibulectomy due to a lower alveolar tumor invading the mandible. Which statement accurately describes this procedure? (Q849609)

A. Preserves mandible continuity.

B. Suitable for tumors not invading the mandible.

C. Removes the entire height of the mandible.

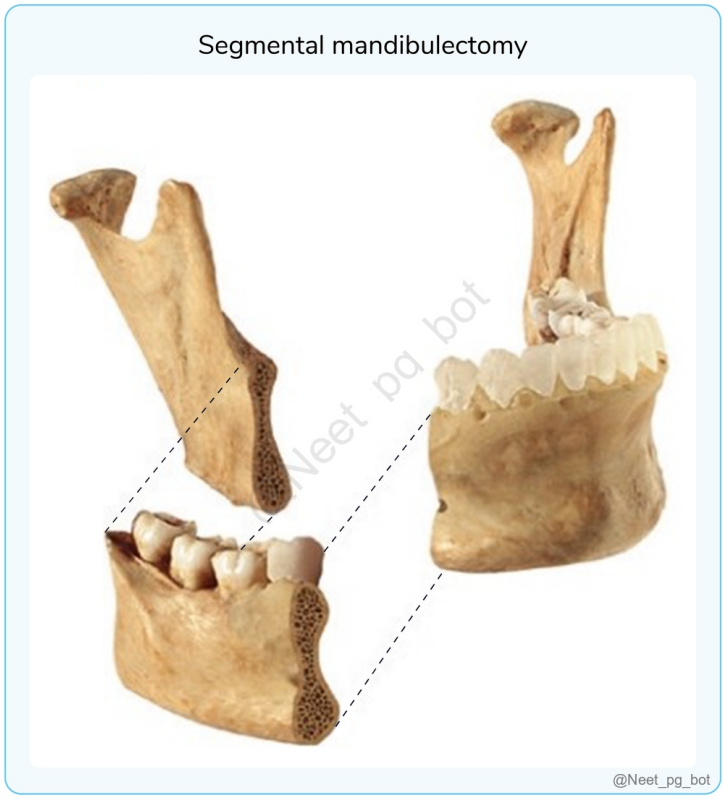
D. Resection of partial thickness of the mandible.

Correct Answer: C. Removes the entire height of the mandible.

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Feature Segmental Mandibulectomy Marginal Mandibulectomy Definition Removal of the full height of the invaded section of the mandible. (Option C) Removal of a partial thickness of the mandible. (Option D) Continuity of mandible Loss of continuity of the lower border. Continuity of the lower border remains intact. (Option A) Indication Tumor invading the mandible, often through the dental root leading into the mandibular canal and cancellous bone. Tumor is close to the mandible but does not invade it. (Option B) Image





References:

Bailey & Love Edition 28 page no:821 SRB Surgery Edition 6 page no: 372,373

↑ *Back to this question in Part A*

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Q11: A 65-year-old male with lower alveolar squamous cell carcinoma presents with an ulcerated mass, extensive cortical bone erosion, invasion beyond the inferior alveolar canal. What is the most appropriate treatment? (Q849608)

A. Radiotherapy

B. Local excision with marginal resection

C. Segmental mandibulectomy

D. Marginal resection, along with block dissection

Correct Answer: C. Segmental mandibulectomy

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: If there is more than superficial cortical erosion of the mandible, the marrow space is at risk of harboring malignancy and thus, segmental mandibulectomy is required for adequate margin control. Lower Alveolar Cancer: Mostly seen in men. Squamous cell carcinoma(SCC) is the most common malignancy of the lower alveolus. Tumor Spread: Can extend to the cheek, floor of the mouth, retromolar trigone, or hard palate. May invade underlying bone and spread rapidly along the neurovascular bundle. Nodal metastases commonly occur in submandibular and upper jugular nodes. Surgery: Preferred treatment method. Early Lesions (tumors adherent to periosteum): Treated by local excision with marginal resection of the mandible. Extensive Lesions (bone invasion present): Require wide excision, potentially involving segmental or hemimandibulectomy. Nodal Involvement: Block dissection may be performed if nodes are palpable. Management of Lower Alveolar Carcinoma: Stage Bone Involvement Surgical Choice Rationale Early (T1/T2) None or strictly superficial Wide Local Excision No bony invasion; periosteum acts as a barrier. Early (T1/T2) Erosion of alveolar crest only Marginal Mandibulectomy Preserves the lower border for structural continuity. Advanced (T3) Deep cortical invasion Segmental Mandibulectomy Required if $<1\text{ cm}$ of healthy bone height would remain. Advanced (T4a) Invasion of Mandibular Canal Segmental Mandibulectomy The IAN canal is a "highway" for spread; continuity must be broken. Recurrent Prior Radiation / Osteonecrosis Segmental + Free Flap Irradiated bone cannot heal via marginal resection.



References:

Sabiston Textbook of Surgery, Edition 21, page no:780

Dhingra's ENT, Edition 8, page no: 268

↑ *Back to this question in Part A*

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Q12: A patient presents with 2.5 cm ulceroproliferative adenoid cystic carcinoma on the left side of the hard palate. Imaging shows no evidence of bone invasion or lymph node involvement. Which of the following is the most appropriate management strategy? (Q849607)

A. Wide local excision with frozen section control

B. Partial maxillectomy with ipsilateral neck dissection

C. Partial maxillectomy without neck dissection

D. Radiotherapy alone

Correct Answer: C. Partial maxillectomy without neck dissection

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: For an adenoid cystic carcinoma of the hard palate, partial maxillectomy is the appropriate surgical approach to ensure adequate margins. Despite the absence of clinical bone invasion, microscopic invasion is common in these tumors. Elective neck dissection is generally not performed for adenoid cystic carcinomas of the hard palate due to their low propensity for lymphatic spread. Carcinoma of the Hard Palate Salivary gland tumors in the palate are often malignant, with adenoid cystic carcinoma being common. Adenoid cystic carcinoma : Present as a single, solid, smooth swelling with an ulcer on the summit. Squamous cell carcinoma : Characterized by an ulcer with raised and everted edges. Upper deep cervical lymph nodes are involved in 25% of cases. Malignant tumors can invade the periosteum, bone, maxilla, sinus, or nose. Treatment Wide excision with removal of the underlying palatal bone. Maxillectomy: Partial or total, often done using the Weber-Ferguson incision . Reconstruction: With a myocutaneous flap and dental prosthesis. Postoperative radiotherapy and neck block dissection are often required. Management Protocol by Depth of Invasion: Depth / Findings Stage Management Strategy Superficial (Mobile) T1 Wide Local Excision: Must include the underlying periosteum to ensure a safe deep margin. Intermediate (Fixed) T2 Partial Maxillectomy: Removal of the tumor with a cuff of the underlying palatal bone. Deep (Bone Erosion) T3 Infrastructure Maxillectomy: Removal of the hard palate and alveolar ridge while preserving the orbital floor. Extensive (Sinus/Nasal) T4a Total Maxillectomy: Removal of the entire maxilla; may require orbital exenteration if the orbit is involved. Reconstruction Options After Maxillectomy: Reconstructing the palate is vital for speech (preventing hypernasality) and swallowing (preventing nasal regurgitation). 1. Prosthetic Rehabilitation (Obturator): Mechanism: A specialized dental prosthesis (like a high-tech denture) that plugs the hole in the palate. Advantages: Allows direct visualization of the surgical cavity for tumor surveillance; easy to adjust. Best for: Small to medium defects where the patient has enough teeth to anchor the device. 2. Local/Regional Flaps: Palatal Island Flap: For very small defects; uses adjacent palatal mucosa. Temporalis Muscle Flap: The muscle is tunneled under the zygomatic arch to fill the maxillary void. FAMM Flap (Facial Artery Myomucosal): Uses cheek tissue. 3. Microvascular Free Flaps (Gold Standard for Large Defects): Radial Forearm Free Flap (RFFF): Excellent for thin, pliable tissue to close the palatal "roof" without adding bulk. Anterolateral Thigh (ALT) Flap: Used when more bulk is needed to fill a large maxillectomy cavity. Fibula Free Flap: Used if the alveolar ridge and teeth need to be reconstructed for dental implants.

References:

Sabiston Textbook of Surgery, 21st edition, Pages: 780, 791

SRB’s Manual of Surgery, Edition 6, page no: 388,389

↑ *Back to this question in Part A*

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Q13: A female who chews betel quid has pale, fibrous oral mucosa and a 2 cm interincisal opening. Biopsy revealed increased collagen deposition in the lamina propria. Which of the following is the most likely complication of this condition if left untreated? (Q849606)

A. Candidiasis

B. Malignant transformation

C. Bilateral submandibular gland hypertrophy

D. Spontaneous remission of fibrosis

Correct Answer: B. Malignant transformation

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The patient's presentation is consistent with oral submucous fibrosis (OSMF). The most significant long-term complication of untreated OSMF is malignant transformation. Oral submucous fibrosis is considered a potentially malignant disorder due to its significant risk of progressing to oral squamous cell carcinoma. Regular follow-up and screening of OSMF patients are crucial for the early detection of any malignant changes. Management should focus on habit cessation, nutritional support, and addressing fibrosis to potentially reduce the risk of malignant transformation. Complications of Oral Submucous Fibrosis (OSMF): Malignant Transformation: Development of Squamous Cell Carcinoma (SCC). The fibrosis causes chronic hypoxia and atrophy of the epithelium, making it more susceptible to carcinogens. Progressive Trismus: Increasing inability to open the mouth due to vertical fibrous bands, leading to poor oral hygiene and malnutrition. Hearing Loss: Fibrosis can involve the opening of the Eustachian tube in the nasopharynx, leading to conductive hearing loss or serous otitis media. Speech and Swallowing Defects: Involvement of the soft palate and tongue reduces mobility, causing "hot potato" voice and dysphagia. Nutritional Deficiencies: Limited intake of solid food often leads to iron and vitamin B12 deficiencies, which further thins the oral mucosa (a vicious cycle). Candidiasis (Option A): While oral candidiasis can occur in OSMF patients due to an altered oral environment, it is not considered a major complication of untreated OSMF. Bilateral submandibular gland hypertrophy (Option C) is not a typical complication of OSMF. In fact, OSMF may lead to atrophy of salivary glands rather than hypertrophy. Spontaneous remission of fibrosis (Option D): OSMF is a progressive condition and does not undergo spontaneous remission. Without intervention, the fibrosis typically worsens over time.

References:

Sabiston Textbook of Surgery, 21st edition, page 780

SRB’s Manual of Surgery, Edition 6, page no: 364-370

↑ *Back to this question in Part A*

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Q14: Which of the following statements about the extent of the oral cavity is false? (Q849562)

A. The anterior border of the oral cavity begins at the vermillion border.

B. Superiorly, the oral cavity includes the soft palate up to the uvula.

C. The posterior extent of the oral cavity ends at the circumvallate papillae of the tongue.

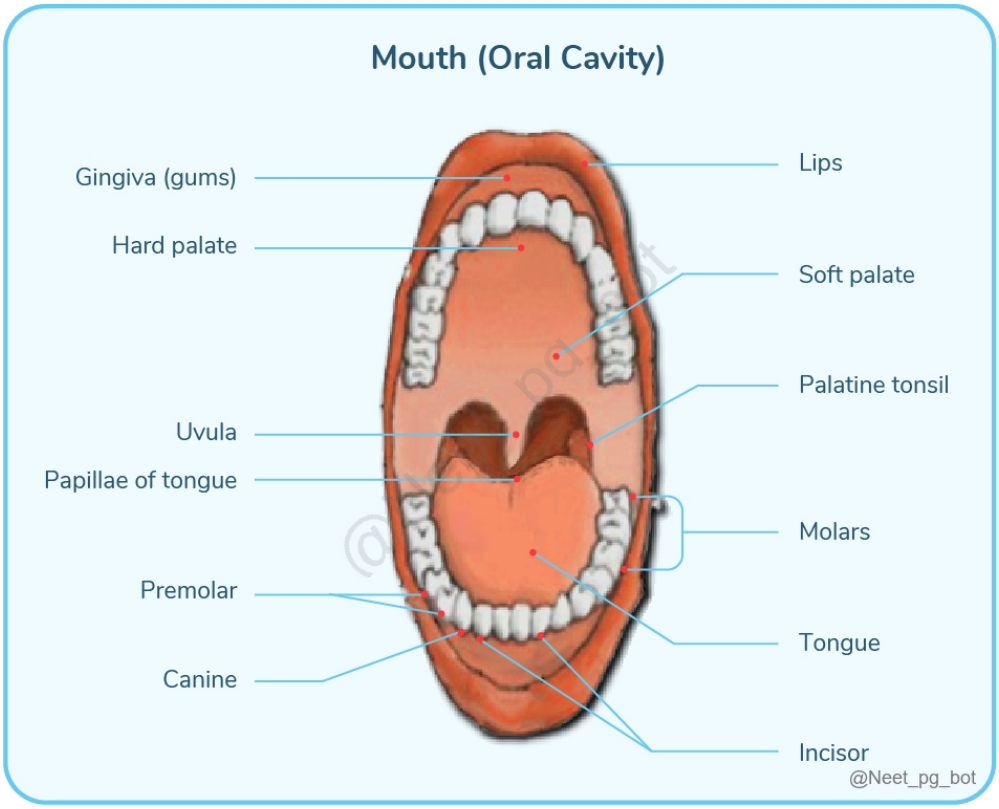
D. The tonsils are not a part of the oral cavity.

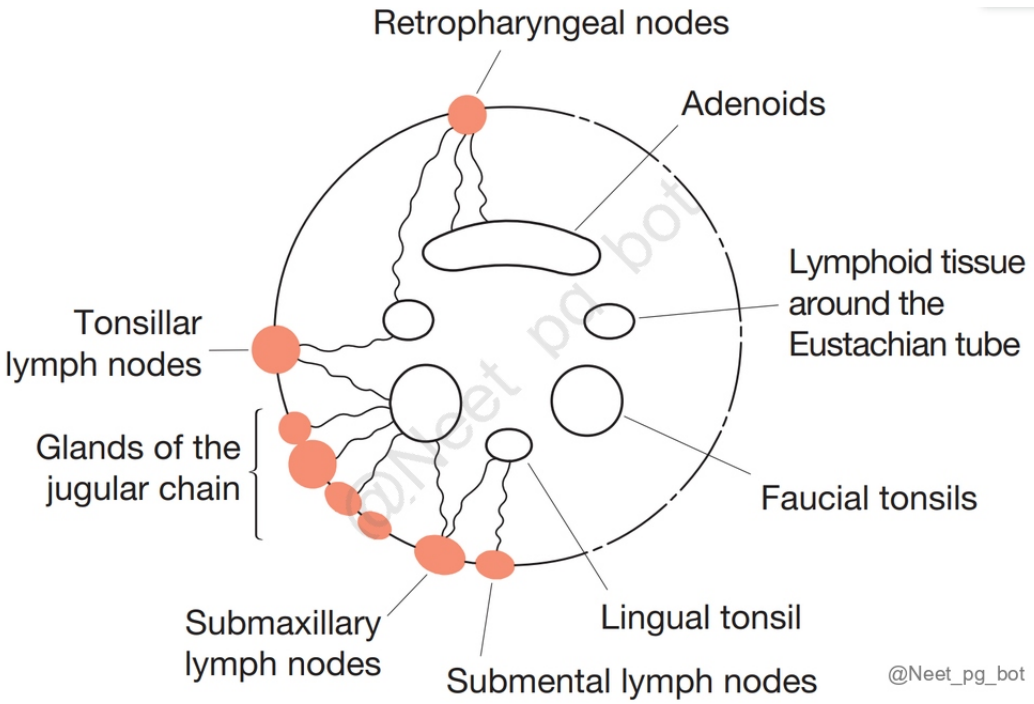
Correct Answer: B. Superiorly, the oral cavity includes the soft palate up to the uvula.

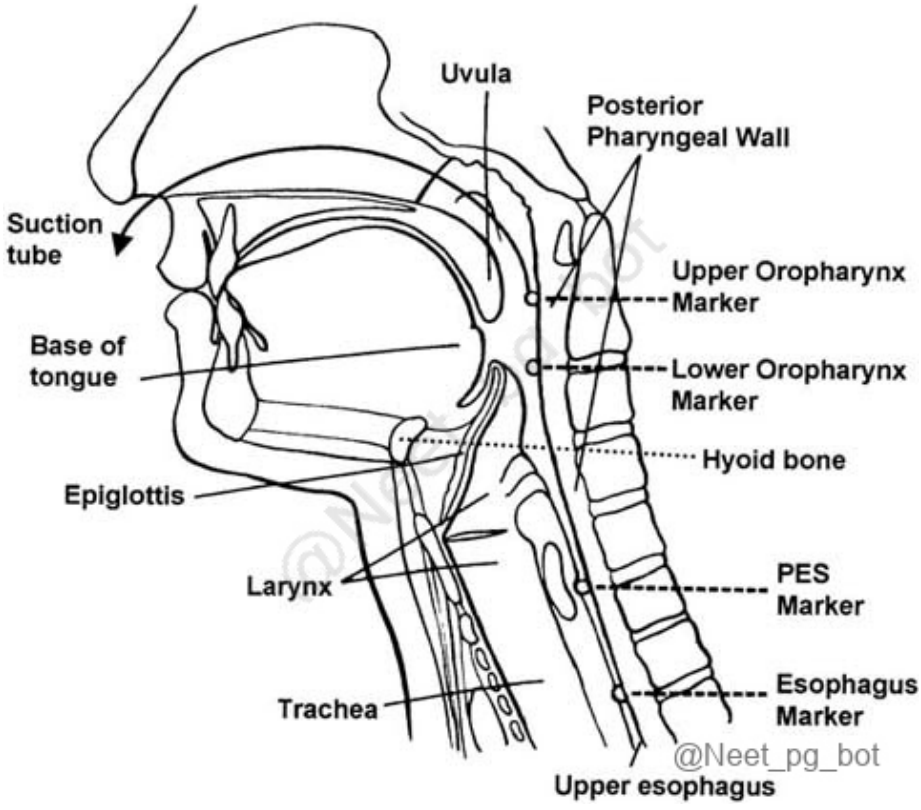
■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The soft palate is a part of the oropharynx and is not included in the oral cavity. The extent of the oral cavity is as follows: Anteriorly, it starts from the vermillion border of the lip (Option A) . Superiorly, it extends up to the junction of hard palate and soft palate. It extends postero - inferiorly up to the junction of the anterior 2/3rd and the posterior 1/3rd of the tongue, i.e., till the circumvallate papillae (Option C) . And laterally till the anterior tonsillar pillars . The tonsils , uvula, and soft palate are part of the oropharynx, which shows different characteristics from the oral cavity. Waldeyer's ring: Posterior pharyngeal wall:







References:

Bailey & Love's Short Practice of Surgery, 28th edition, pg: 813. Schwartz Principles of Surgery, 11th edition, pg: 630.

↑ *Back to this question in Part A*

Q15: A 65-year-old patient presents with a 2.5 cm ulcerative lesion on the right side of his lower lip confirmed as squamous cell carcinoma. Which of the following statements is correct regarding the primary lymphatic drainage and surgical management of this lesion? (Q849594)

A. Drains to submental nodes; level I neck dissection is sufficient.

B. Drains to ipsilateral submandibular nodes; levels I-III neck dissection is recommended.

C. High risk of contralateral metastasis; bilateral neck dissection is needed.

D. Drains to preauricular and parotid nodes; requires superficial parotidectomy.

Correct Answer: B. Drains to ipsilateral submandibular nodes; levels I-III neck dissection is recommended.

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The lymphatic drainage of the lower lip is primarily to the submental (level IA) and submandibular (level IB) nodes . There's a significant risk of occult nodal metastasis for a lesion of this size, especially one close to the commissure. Therefore, a selective neck dissection, including levels I-III on the ipsilateral side, is typically recommended even in N0. Management 1. Early Stage (T1-T2N0): Wide local excision with 1 cm margins Consider elective neck dissection for tumors >2 cm or >4 mm depth Reconstruction: Primary closure, local flaps, or skin grafts 2. Advanced Stage (T3-T4 or N+): Wide local excision with ≥1 cm margins Neck dissection (comprehensive or selective based on nodal status) Complex reconstruction (local/regional flaps, free tissue transfer) Adjuvant radiotherapy or chemoradiotherapy based on pathological findings 3. Management of the Neck: Elective neck dissection for high-risk tumors (>2 cm, >4 mm depth) Therapeutic neck dissection for clinically positive nodes Levels typically addressed: I-III for N0 neck, I-V for N+ neck Other options: Option A: Drains to submental nodes; level I dissection is sufficient Submental (Ia) drainage is more typical for midline lower-lip lesions. A 2.5 cm lateral lesion drains primarily to Ib, and Level I alone is inadequate. Option C: Bilateral neck dissection is needed Contralateral metastasis is uncommon except in midline or advanced (T3/T4) lesions. This lesion is lateral → unilateral dissection is adequate. Option D: Drains to preauricular/parotid nodes These nodes are involved in upper lip, cheek, and cutaneous facial SCC, not lower lip. Parotidectomy is not indicated.

References:

Sabiston Textbook of Surgery, 21st edition, Pages: 777, 779. SRB’s Manual of Surgery, Edition 6, page no 375,376

↑ *Back to this question in Part A*

Q16: A 72-year-old farmer presents with a 3.5 cm exophytic lesion on his lower lip. Biopsy confirms well-differentiated squamous cell carcinoma with 8 mm depth of invasion. There are no palpable lymph nodes. Which of the following is the correct management strategy? (Q849593)

A. Wide local excision with 5 mm margins and neck observation.

B. Wide local excision with 1 cm margins and ipsilateral neck dissection.

C. Wide local excision with 1 cm margins and bilateral neck dissection.

D. Radiotherapy alone.

Correct Answer: B. Wide local excision with 1 cm margins and ipsilateral neck dissection.

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: For a T2 lesion (>2 cm but ≤4 cm) with >5 mm depth of invasion, wide local excision with at least 1 cm margins is recommended. The risk of occult cervical metastasis is 20–30% . Therefore, ipsilateral selective neck dissection (levels I-III) is appropriate for unilateral lesions not crossing the midline even when neck is clinically N0 Management of Carcinoma lip: Early Stage (T1-T2N0) Wide local excision with 1 cm margins Consider elective neck dissection for tumors >2 cm or >4 mm depth Reconstruction: Primary closure, local flaps, or skin grafts Advanced Stage (T3-T4 or N+) Wide local excision with ≥1 cm margins Neck dissection (comprehensive or selective based on nodal status) Complex reconstruction (local/regional flaps, free tissue transfer) Adjuvant radiotherapy or chemoradiotherapy based on pathological findings Reconstruction Options Wedge excision and primary closure (for small lesions) Local flaps: Abbe-Estlander, Karapandzic, nasolabial Regional flaps: Forehead, cervicofacial Free tissue transfer: Radial forearm free flap, anterolateral thigh flap Management of the Neck Elective neck dissection for high-risk tumors (>2 cm, >4 mm depth) Therapeutic neck dissection for clinically positive nodes Levels typically addressed: I-III for N0 neck, I-V for N+ neck Radiotherapy Adjuvant: For positive margins, perineural invasion, multiple positive nodes Definitive: For patients unfit for surgery or refusing surgery Brachytherapy: Can be considered for select early-stage lesions Chemotherapy Not routinely used in early-stage disease May be combined with radiotherapy in locally advanced cases Follow-up and Surveillance Regular follow-up visits: Every 1-3 months for the first year, then gradually decreasing frequency Wide local excision with 5 mm margins and observation (Option A): A 5 mm margin is insufficient for invasive SCC of this size. Observation is unsafe because depth >4 mm warrants neck management. Wide local excision with 1 cm margins and bilateral neck dissection (Option C): Bilateral neck dissection is not indicated unless midline involvement or clinical nodal disease is present. The lesion is unilateral, so ipsilateral dissection is adequate. Radiotherapy alone (Option D): RT is reserved for medically unfit patients or for adjuvant therapy. Primary RT is inferior to surgery in resectable lip cancers.



References:

Sabiston Textbook of Surgery, 21st edition, Pages: 777, 779.

↑ *Back to this question in Part A*

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Q17: A 62-year-old male with recurrent squamous cell carcinoma of the oral cavity is being considered for immunotherapy using pembrolizumab. Which of the following correctly describes the mechanism of action of the drug? (Q849592)

A. Inhibits VEGF to prevent tumor angiogenesis

B. Blocks PD-1 receptor, enhancing T-cell anti-tumor activity

C. Targets EGFR to inhibit tumor cell proliferation

D. Activates NK cells to induce antibody-dependent cellular cytotoxicity

Correct Answer: B. Blocks PD-1 receptor, enhancing T-cell anti-tumor activity

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Pembrolizumab is a monoclonal antibody that targets the programmed cell death-1 (PD-1) receptor. By blocking PD-1, it prevents the interaction between PD-1 and its ligands (PD-L1 and PD-L2). This blockade enhances T-cell function and anti-tumor immune responses. In oral cavity cancers, this leads to improved tumor cell recognition and destruction by the immune system. Inhibiting VEGF to prevent tumor angiogenesis (Option A) is the mechanism of action for drugs like bevacizumab. Targeting EGFR to inhibit tumor cell proliferation (Option C) describes the mechanism of action for cetuximab. Activating NK cells to induce antibody-dependent cellular cytotoxicity (Option D) is more closely associated with drugs like cetuximab, which can induce ADCC.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, 830.

↑ *Back to this question in Part A*

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Q18: A 59-year-old male with T2N2bM0 squamous cell carcinoma of the buccal mucosa underwent surgery. The postoperative histopathology report reveals close surgical margin (< 5 mm) and extracapsular extension in two lymph nodes. What is the most appropriate adjuvant treatment for this patient? (Q849591)

A. Radiotherapy alone

B. Chemotherapy alone

C. Concurrent chemoradiotherapy

D. Observation and close follow-up

Correct Answer: C. Concurrent chemoradiotherapy

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Concurrent chemoradiotherapy is the most appropriate adjuvant treatment for this patient due to the presence of high-risk features: close surgical margins and extracapsular extension (ECE) in lymph nodes. In this case, the close margin and ECE in multiple nodes warrant the addition of chemotherapy to radiotherapy to improve locoregional control and overall survival. Indications for Adjuvant Therapy: Therapy Indications Radiotherapy alone Intermediate risk features: T3 or T4a primary tumors N2 or N3 nodal disease (without extracapsular extension) Perineural invasion Lymphovascular invasion Single node >3 cm or multiple positive nodes Close margins (between 5mm and 1cm) Concurrent chemoradiotherapy High-risk features: Positive surgical margins Extracapsular extension of nodal disease T4b tumors N3 nodal disease Multiple positive nodes with extracapsular extension Specific indications pT3 or pT4 primary tumors N2 or N3 neck disease Perineural invasion Vascular embolism Lymphatic invasion Considerations for chemotherapy addition Age <70 years Good performance status No significant comorbidities

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 829.

↑ *Back to this question in Part A*

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Q19: A 58-year-old male with a 6 cm x 4 cm defect involving more than 50% of the tongue after excision for a T3N1M0 squamous cell carcinoma needs reconstruction. Which of the following flaps would be most appropriate for reconstruction for this patient? (Q849590)

A. Radial forearm free flap

B. Anterolateral thigh free flap

C. Pectoralis major myocutaneous flap

D. Supraclavicular artery island flap

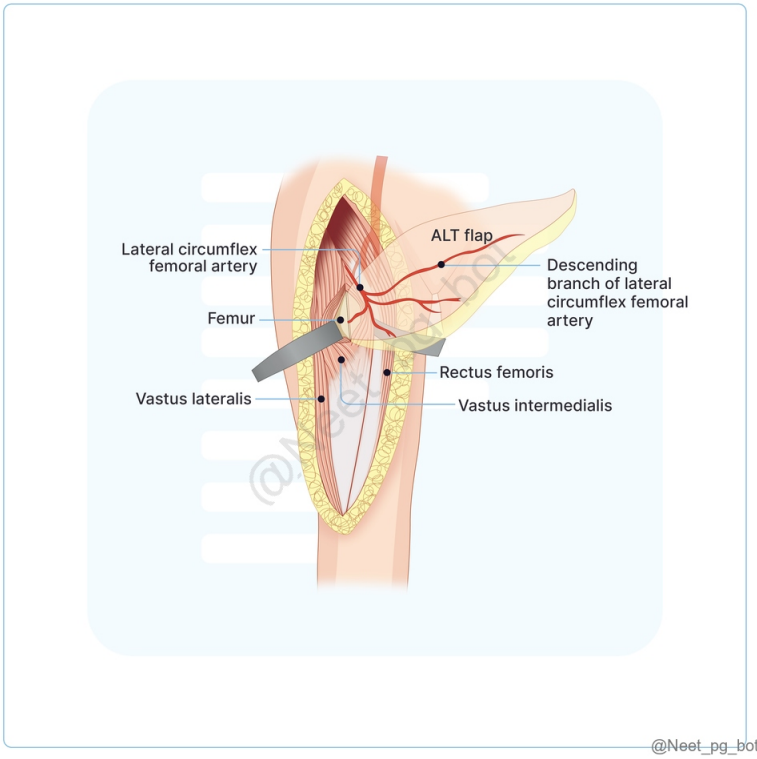
Correct Answer: A. Radial forearm free flap

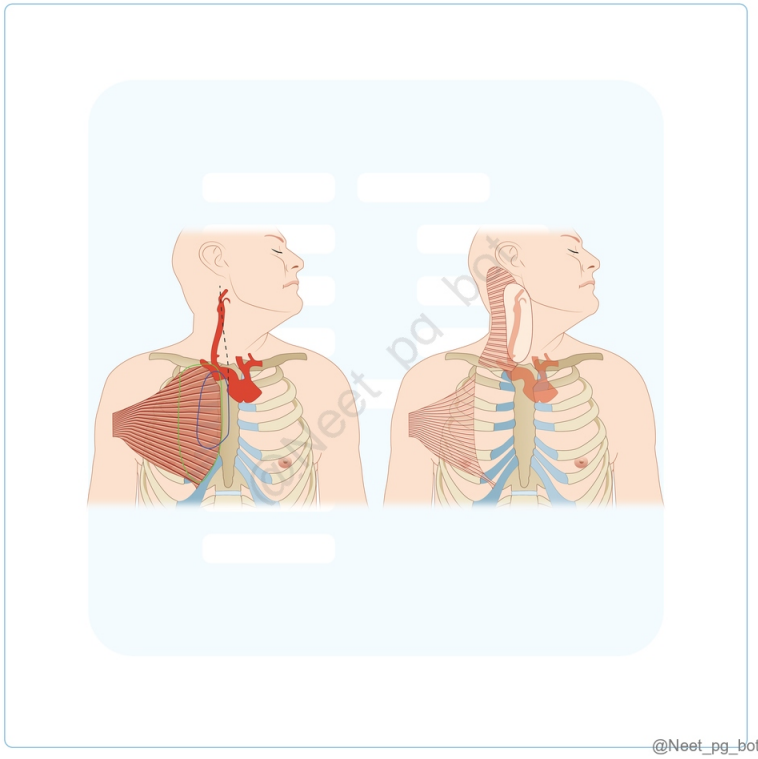
■ *Listen (English)*

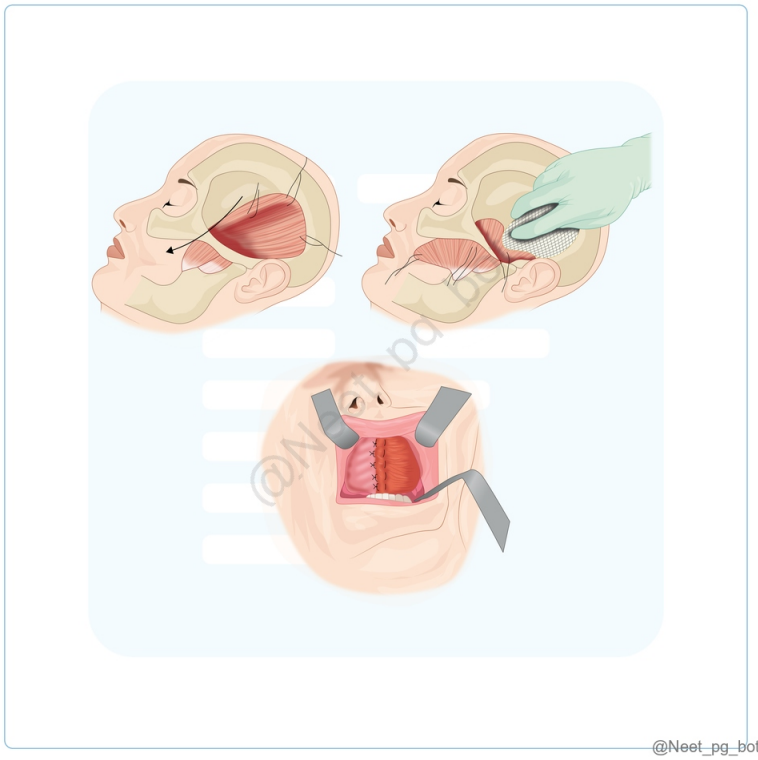
■ *Listen (Hindi)*

Explanation: The radial forearm free flap (RFFF) is the most appropriate choice for reconstructing this oral cavity defect involving a significant portion of the mobile tongue. In this case, where more than 50% of the mobile tongue is involved, the RFFF would provide the best functional outcome in terms of speech and swallowing. The RFFF is considered the gold standard for tongue reconstruction due to its: Thin and pliable nature, allowing for better mobility and articulation Long vascular pedicle, facilitating easier anastomosis Large surface area that can be harvested Minimal bulk, which is crucial for preserving tongue function Ability to provide sensate reconstruction if needed Anterolateral Thigh (ALT) Free Flap (Option B): Versatile for larger defects of the mandible, floor of mouth, or pharynx, especially in patients who are poor candidates for free flap surgery. Can be thinned for intraoral use. Minimal donor site morbidity Fibula Free Flap: Gold standard for mandibular reconstruction. Can provide bone, muscle, and skin. Pectoralis Major Myocutaneous Flap (Option C): Workhorse pedicled flap for head and neck. Useful for salvage cases or when free flaps are contraindicated. Submental Island Flap: Regional flap for small to medium intraoral defects. Good color match for facial skin. Temporalis Muscle Flap: For palate and maxillary defects. Proximity to defect site. Supraclavicular artery island flap (Option D) is a regional flap that, while useful for some head and neck reconstructions, lacks the pliability and thinness required for optimal tongue reconstruction. It's more suitable for cutaneous defects of the face and neck.


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Lateral circumflex femoral artery
ALT flap
Descending branch of lateral circumflex femoral artery
Femur
Rectus femoris
Vastus lateralis
Vastus intermedialis
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References:

Bailey & Love's Short Practice of Surgery, 28th Edition, 823, 824.

↑ *Back to this question in Part A*

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Q20: A 62-year-old male presents with a T2N1M0 squamous cell carcinoma of the lateral border of the tongue. According to the latest National Comprehensive Cancer Network (NCCN) guidelines, what is the most appropriate initial management for this patient? (Q849589)

A. Wide local excision of the primary tumor only.

B. Definitive radiotherapy with concurrent chemotherapy.

C. Surgery followed by adjuvant radiotherapy.

D. Neoadjuvant chemotherapy followed by surgery.

Correct Answer: C. Surgery followed by adjuvant radiotherapy.

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: According to the AJCC classification, T2N1M0 squamous cell carcinoma of the tongue is Stage III . The correct treatment for this T2N1M0 with Stage III squamous cell carcinoma of the tongue is surgery followed by adjuvant radiotherapy. For T2N1M0 oral cavity cancers, the standard of care is surgical resection of the primary tumor with appropriate margins, along with neck dissection for the clinically positive lymph nodes. Adjuvant radiotherapy is typically recommended for patients with intermediate to high-risk features, which include positive lymph nodes. Preservation of radiotherapy as an adjuvant treatment, which can address microscopic disease and reduce the risk of locoregional recurrence. Multidisciplinary approach for oral cancer: Stage Treatment Early-stage (I-II) Surgery is the mainstay of treatment. Radiotherapy can be an alternative in select cases. Locally advanced (III-IVA/B) Resectable: Surgery followed by adjuvant therapy (radiotherapy or chemoradiotherapy) based on pathological risk factors. Unresectable: Concurrent chemoradiotherapy or radiotherapy alone for patients unfit for chemotherapy. Metastatic (IVC) Palliative chemotherapy, immunotherapy, or best supportive care. Surgical management: Wide local excision with 1-1.5 cm margins Neck dissection for clinically node-positive disease and elective neck dissection for high-risk node-negative disease Reconstruction to optimize functional and aesthetic outcomes. Adjuvant Therapy in Oral Cavity Cancer: Adjuvant therapy refers to additional treatment given after primary treatment (usually surgery) to reduce the risk of cancer recurrence. In oral cavity cancer, it typically involves radiation therapy, chemotherapy, or a combination of both. Risk Category Pathological Findings Recommended Adjuvant Therapy High Risk Positive Margins or Extracapsular Spread (ECS/ENE) Chemoradiotherapy (CRT) (Cisplatin + Radiation) Intermediate Risk T3/T4 primary, N2/N3 nodes, PNI, or LVSI Radiotherapy (RT) alone Low Risk T1/T2, negative margins, N0, no PNI/LVSI Observation PNI: Perineural Invasion LVSI: Lymphovascular Space Invasion ENE: Extranodal Extension (the most significant negative prognostic factor) Risk Factors for Oral Cavity SCC: External Carcinogens Tobacco: The most common risk factor (synergistic with alcohol). Alcohol: Acts as a solvent for tobacco carcinogens and produces acetaldehyde. Betel Quid/Areca Nut: Specific to South Asia; leads to Oral

Submucous Fibrosis . UV Radiation: Primarily for Lip Cancer . Biological/Other Factors HPV (Human Papillomavirus): While strongly linked to Oropharyngeal cancer (tonsils/base of tongue), it is less common in the Oral Cavity (mobile tongue/floor of mouth). Chronic Irritation: Ill-fitting dentures or jagged teeth (minor risk). Diet: Low intake of fruits and vegetables (Vitamin A/C deficiency). Immunosuppression: Post-transplant patients have higher rates of aggressive SCC.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Pages 829, 830.

↑ *Back to this question in Part A*

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Q21: A male presents with a painful 2.5 cm ulceroproliferative growth on the right lateral border of the tongue with induration extending to the floor of the mouth and a single, firm, mobile 1.5 cm lymph node palpable in the right submandibular region. The CT scan shows no mandible or extrinsic muscle involvement. What is the correct TNM staging for this patient? (Q849570)

A. T2N1M0

B. T3N1M0

C. T4aN1M0

D. T2N2aM0

Correct Answer: A. T2N1M0

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The correct staging for this patient's oral cavity cancer is T2N1M0. Staging of Oral Cavity Cancer (AJCC 8th Edition): T (Primary Tumor): Tx: Primary tumor cannot be assessed. Tis: Carcinoma in situ. T1: Tumor ≤2 cm, ≤5 mm depth of invasion (DOI). T2: Tumor ≤2 cm, DOI >5 mm and ≤10 mm; or tumor >2 cm but ≤4 cm , and ≤10 mm DOI. T3: Tumor >4 cm; or any tumor >10 mm DOI. T4a: Moderately advanced local disease - Invades through cortical bone, deep/ extrinsic muscle of tongue, maxillary sinus, or skin of the face. T4b: Very advanced local disease - Invades masticator space, pterygoid plates, skull base, or encases internal carotid artery. N (Regional Lymph Nodes): Nx: Regional lymph nodes cannot be assessed. N0: No regional lymph node metastasis. N1: Metastasis in a single ipsilateral lymph node , ≤3 cm in greatest dimension . N2: N2a: Metastasis in a single ipsilateral node, >3 cm but ≤6 cm in greatest dimension. N2b: Metastasis in multiple ipsilateral nodes, all ≤6 cm). N2c: Metastasis in bilateral or contralateral lymph nodes, all ≤6 cm. N3: N3a: Metastasis in a lymph node >6 cm in greatest dimension, ENE(-). N3b: Metastasis in any node(s) with clinically overt ENE(+). M (Distant Metastasis): M0: No distant metastasis M1: Distant metastasis Stage Grouping: Stage 0 Tis N0 M0 Stage I T1 N0 M0 Stage II T2 N0 M0 Stage III T3 N0 M0 or T1-3 N1 M0 Stage IVA T4a N0-1 M0 or T1-4a N2 M0 Stage IVB

Any T N3 M0 or T4b Any N M0 Stage IVC Any T Any N M1

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Pages 816, 817.

↑ *Back to this question in Part A*

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Q22: A 55-year-old patient presents with a non-healing ulcer in the oral cavity and is diagnosed with carcinoma oral cavity. Which of the following statements regarding carcinoma oral cavity is most accurate? (Q849569)

A. Distant metastasis is common.

B. Ulcer lasting over 3 weeks is significant.

C. Adenocarcinoma is the most common oral cancer.

D. Oral carcinoma is the least common among head and neck tumors.

Correct Answer: B. Ulcer lasting over 3 weeks is significant.

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Clinical features of oral carcinoma: Signs Symptoms Non-healing ulcer (>3 weeks duration) (Option B) Persistent neck swelling/ lymphadenopathy Pigmented lesion with a progressive increase in size Lesion with associated induration Soft-tissue lesion with associated radiographic changes Unexplained tooth mobility Sensory nerve deficit Chronic otalgia Trismus of unknown etiology Dysphagia Sore tongue Metastasis : HPV-negative cervical node metastasis has a bad prognosis. Most metastases occur in Level I and Level II on neck lymph nodes. Distant metastasis is rare (Option A) Adenocarcinoma is the most common oral cancer (Option C): The most common cancer of the oral cavity is squamous cell carcinoma, not adenocarcinoma. Oral carcinoma is the least common among head and neck tumors (Option D): Oral carcinoma is the most common head and neck tumor.

References:

Bailey and Love’s Short Practice of Surgery, 28th edition, pg: 818. Sabiston’s principles of surgery, 21st edition, pg: 778. SRB’s textbook of surgery, 6th edition, pg: 363.

↑ *Back to this question in Part A*

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Q23: A patient who had developed a buccal squamous cell carcinoma was treated by complete resection and radiation therapy. After his treatment was completed and he had clear margins after the resection, he developed a new tumor in his oral cavity on his tongue. What is the basis of this development of a second primary tumor? (Q849568)

A. Field defect

B. Field effect

C. Field cancerization

D. All of the above

Correct Answer: D. All of the above

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Field cancerization, field defect, or field effect refers to the condition in which a particular site is completely exposed to carcinogens often and hence has a tendency to develop a malignancy entirely or at multiple sites instead of at just one focal point. This explains the recurrence of tumors and the development of second primary tumors after the removal of the first, particularly in the oral cavity. Field cancerization is a process of transforming a precancerous lesion into a cancerous one. Prolonged exposure to carcinogens like tobacco and alcohol in the oral cavity leads to widespread epithelial changes, resulting in multifocal carcinoma. Criteria for a second primary to be due to field cancerization: The neoplasm must be distinct and anatomically separate (dysplastic mucosa around a tumor depicts a multicentric primary neoplasm and not a new primary tumor). A potential second primary due to metastasis or local relapse must be excluded (tumor after 3 years of first diagnosis or new tumor at least 2cm of normal epithelium away from the first one).

References:

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4419611/

↑ *Back to this question in Part A*

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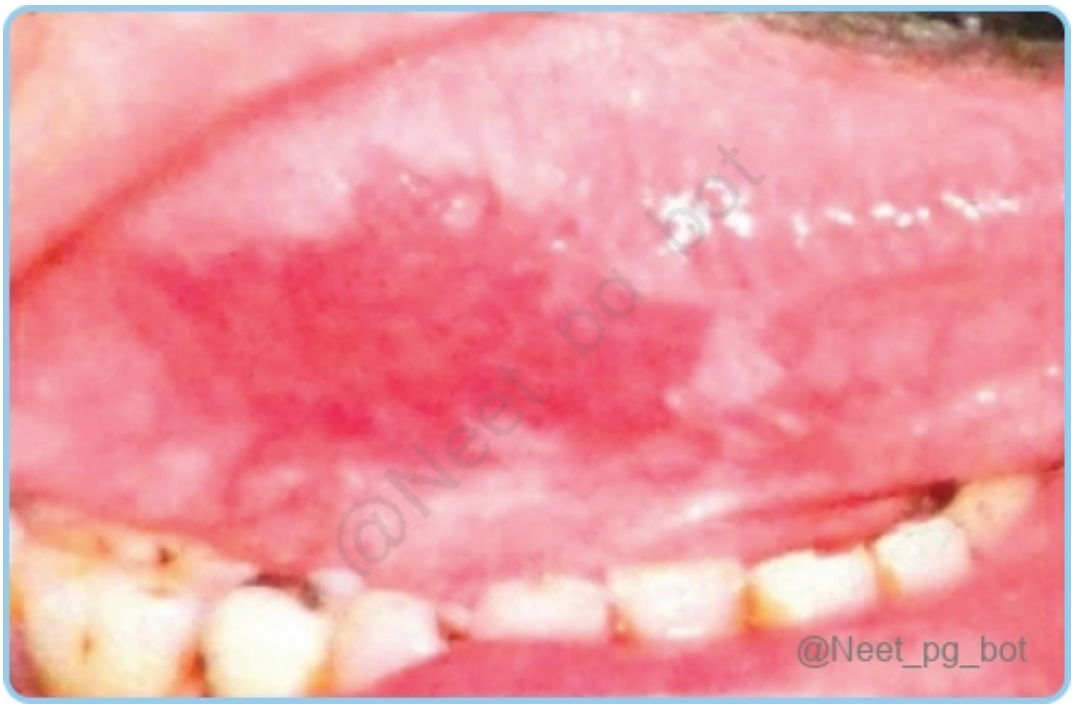
Q24: A 45-year-old female comes to the clinic with a reddish patch on her tongue, as shown in the figure. She gives a history of chewing pan masala for more than 15 years. She has no difficulty in opening her mouth and has no other comorbidities. What is the most probable diagnosis? (Q849565)

A. Oral submucosal fibrosis

B. Erythroplakia

C. Plummer-Vinson syndrome

D. Leukoerythroplakia



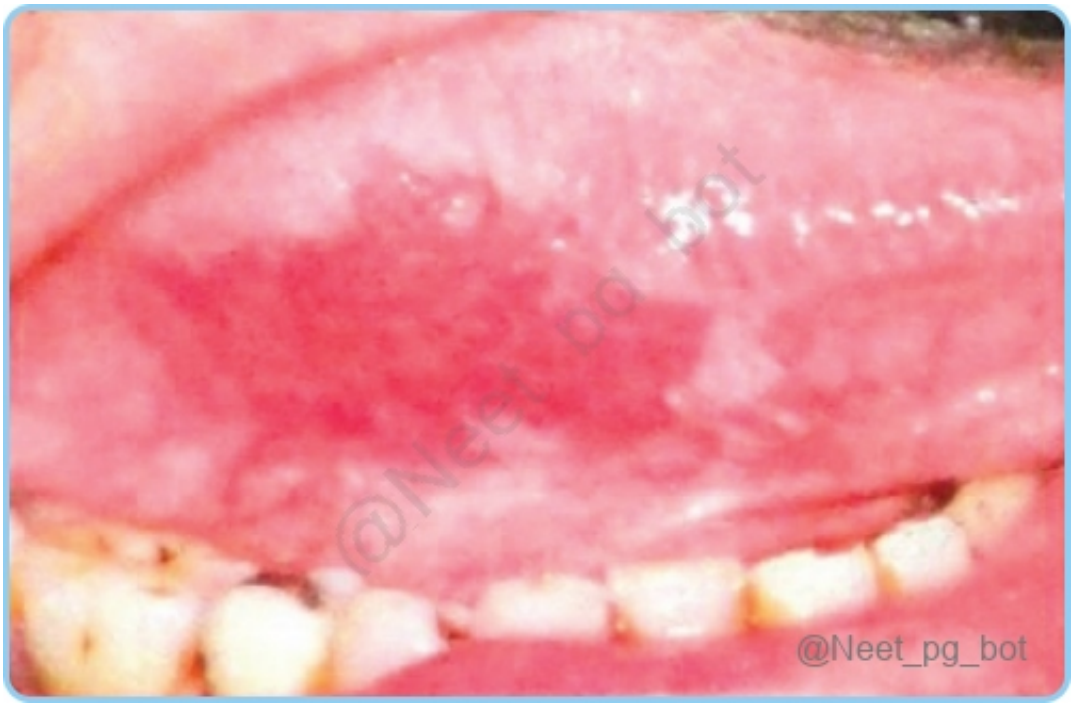
Correct Answer: B. Erythroplakia

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The condition here is erythroplakia. Erythroplakia is a bright red velvety plaque that cannot be characterized clinically or pathologically as any other disease. Has a higher malignant potential than leukoplakia. Types : Homogenous Speckled Granular Erythroplakia interspersed with leukoplakia Management : Biopsy for diagnosis Surgical excision Strict follow-up





References:

SRB's Textbook of Surgery, 6th edition, pg: 360, 791.

↑ *Back to this question in Part A*

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Q25: A 50-year-old patient comes to the OPD concerned about a newly developed whitish discolouration in his mouth. On examination, a white plaque-like lesion was found in his buccal mucosa, which could not be rubbed off. What is the most likely diagnosis? (Q849564)

A. Leukoplakia

B. Erythroplakia

C. Speckled leukoplakia

D. Chronic hyperplastic Candidiasis



Correct Answer: A. Leukoplakia

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The clinical scenario here points to the diagnosis of leukoplakia . Leukoplakia is defined as a white patch or plaque that cannot be rubbed off, and cannot be characterized clinically or pathologically as any other disease. It is a premalignant lesion and is painless/non-tender . Types : Homogenous Nodular Speckled Hairy:

Associated with EBV. It is not actually hairy but appears so due to the corrugation caused by severe hyperkeratosis and acanthosis. Common in AIDS patients. Management : Biopsy to rule out carcinoma and confirm diagnosis. Stop smoking/ alcohol/ betel quid. Excision, skin grafting if needed. Regular follow-up. Isotretinoin, tocopherol, and beta-carotene. CO2 laser.

References:

Bailey & Love's Short Practice of Surgery, 28th edition, pg: 815. SRB's textbook of Surgery, 6th edition, pg: 359, 360,361.

↑ *Back to this question in Part A*

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Q26: A 45-year-old male comes to the hospital after noticing abnormal growth on the right side of his mouth. He has had a habit of smoking and chewing betel quid for more than 20 years. On further evaluation, he also gives a history of a red lesion present in the same location before the current state. Which of the following, in this case, is not a risk factor for oral carcinoma? (Q849563)

A. Age above 40 years

B. Erythroplakia

C. Smoking

D. Betel quid

Correct Answer: A. Age above 40 years

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: In the above scenario, the patient's age is not a factor in increasing the risk of oral carcinoma. Oral carcinoma is one of the most common cancers in India. Risk factors: Tobacco/ pan masala (Option C) Alcohol Betel quid(areca nut, catechu, slaked lime wrapped in a piper betel leaf) (Option D) Previous exposure to radiation Chronic infections Immunosuppression Hereditary diseases like Fanconi anemia and Li-Fraumeni syndrome. Active HPV Premalignant lesions Potentially/premalignant lesions: Leukoplakia Erythroplakia (Option B) Erythroleukoplakia Proliferative verrucous leukoplakia (PVL) Oral submucous fibrosis Oral lichen planus Lupus erythematosus Epidermolysis bullosa Dyskeratosis congenita

References:

Bailey and Love's Short Practice of Surgery, 28th edition, pg: 814, 815.

↑ *Back to this question in Part A*

• [02_Head And Neck] 005 Salivary Glands

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[02_Head And Neck] 005 Salivary Glands — Quick Jump

Q1 (p. 1243) *Q2 (p. 1244)* *Q3 (p. 1245)* *Q4 (p. 1248)* *Q5 (p. 1251)* *Q6 (p. 1252)*
Q7 (p. 1253) *Q8 (p. 1255)* *Q9 (p. 1256)* *Q10 (p. 1257)* *Q11 (p. 1258)* *Q12 (p. 1259)*
Q13 (p. 1260) *Q14 (p. 1261)* *Q15 (p. 1263)* *Q16 (p. 1263)* *Q17 (p. 1265)* *Q18 (p. 1265)*
Q19 (p. 1266)

Q1: A 45 y/o woman undergoes a superficial parotidectomy for a pleomorphic adenoma. Which of the following is a known complication associated with this condition or its treatment? (Q849649)

A. Permanent facial nerve paralysis is common after parotidectomy.

B. Pleomorphic adenomas rarely recur after surgical excision.

C. Radiotherapy for pleomorphic adenoma is risk-free and only used as a primary treatment.

D. Frey’s syndrome is characterized by sweating and flushing in the preauricular area during meals.

Correct Answer: D. Frey’s syndrome is characterized by sweating and flushing in the preauricular area during meals.

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Frey’s syndrome, also known as gustatory sweating, can occur after parotidectomy due to aberrant nerve regeneration, leading to sweating and flushing in the preauricular area during meals. This complication has an incidence of about 10%. Complications of Pleomorphic Adenoma: Tumor-related Complications: Recurrence: Pleomorphic adenomas can recur after surgery (Option B) , especially if not completely excised. Factors contributing to recurrence include tumour spillage during surgery, inadequate surgical margins, and microscopic extensions (pseudopods). Malignant Transformation: Although typically benign, pleomorphic adenomas can undergo malignant transformation into carcinoma ex pleomorphic adenoma. This risk increases in long-standing tumours (over 15 years) or recurrent tumours, with a risk exceeding 15%. Indicators of malignant transformation include sudden tumour growth, pain, tissue fixation, skin ulceration, and facial nerve involvement. Treatment-Related Complications: Surgical Complications (Parotidectomy): Facial Nerve Injury: Common (30% temporary weakness), but permanent paralysis can occur (rarely). (Option A) Risk factors include tumour size, location, and surgical technique. Hemorrhage: Significant bleeding is rare but may require transfusion or re-operation. Infection: Postoperative infection risk can be minimized with sterile techniques and prophylactic antibiotics. Sialocele: Accumulation of saliva in tissue pockets due to duct damage during surgery. Frey's

Syndrome: Characterized by sweating, flushing, and pain in the preauricular area during meals, with a 10% incidence. Cosmetic Deformities: Includes scarring, hollowing of the retromandibular area, and earlobe numbness due to great auricular nerve injury. Complications of Other Treatments: Radiotherapy (Option C): Used in cases of recurrence, high-grade transformation, or incomplete excision. Risks include xerostomia, damage to surrounding tissues, and potential secondary malignancies. Fine-Needle Aspiration Cytology (FNAC): Generally safe, but can cause bleeding or, rarely, tumour seeding along the needle track.

References:

SRB's Manual of Surgery, 6th Edition, Page 403, 408

↑ *Back to this question in Part A*

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Q2: A 28-y/o male presents with a painless, soft swelling in the submandibular region that has been gradually enlarging over the past 2 months. On examination, the swelling is dumbbell-shaped, fluctuant, and bidigitally palpable. The overlying mucosa appears thick with a bluish hue. Fine needle aspiration yields a viscous, "egg white-like" fluid with high amylase content, confirming the diagnosis. What is the most appropriate treatment for this patient? (Q849658)

A. Incision and drainage of the cyst

B. Marsupialization (unroofing) of the ranula

C. Surgical excision of the ranula and involved sublingual gland

D. Observation and follow-up

Correct Answer: C. Surgical excision of the ranula and involved sublingual gland

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The given clinical scenario suggests that this is a case of plunging ranula. Surgical excision of both the ranula and the involved sublingual gland is the definitive treatment. This approach reduces the risk of recurrence and addresses the underlying cause of the ranula. Plunging Ranula Definition When a ranula extends into the submandibular region through the deeper part of the posterior margin of the mylohyoid muscle it is called a plunging ranula. Key Features Painless, soft, fluctuant dumbbell-shaped swelling in the submandibular region or sublingual area. It is bidigitally palpable. May have a bluish hue and thick overlying mucosa. Often presents with both oral and cervical components. Typically occurs in the third decade of life. Diagnosis Based on history, clinical features, and imaging. Fine needle aspiration yields a viscous, "egg white-like" fluid with high amylase content. Ultrasonography or CT shows a well-circumscribed cystic mass extending through the mylohyoid muscle. Treatment Surgical excision of the ranula and involved sublingual gland is the definitive treatment. Recurrence is

possible if the sublingual gland is not completely removed. Incision and drainage of the cyst (Option A) may provide temporary relief but are not definitive treatments for a plunging ranula. This approach does not address the underlying cause and is associated with a high risk of recurrence. Marsupialization (unroofing) of the ranula (Option B): While marsupialization can be used for smaller ranulas, it is less effective for plunging ranulas, which often require complete excision to prevent recurrence. Observation and follow-up (Option D): Observation alone is not appropriate for a plunging ranula, as the cyst is likely to continue growing and causing further symptoms. Definitive surgical treatment is required to prevent complications and recurrence.



References:

www.ncbi.nlm.nih.gov/pmc/articles/PMC3303342/

www.ncbi.nlm.nih.gov/pmc/articles/PMC5771944/

SRB's Manual of Surgery, 6th Edition, Page 357

↑ *Back to this question in Part A*

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Q3: A 16 y/o female has a painless, soft, fluctuant swelling in the anterior floor of her mouth that has increased in size over a few weeks. There is no history of trauma or infection. What is the most appropriate next step in confirming the diagnosis? (Q849657)

A. Magnetic Resonance Imaging

B. Computed Tomography

C. Incisional biopsy

D. Aspiration of the lesion



Correct Answer: A. Magnetic Resonance Imaging

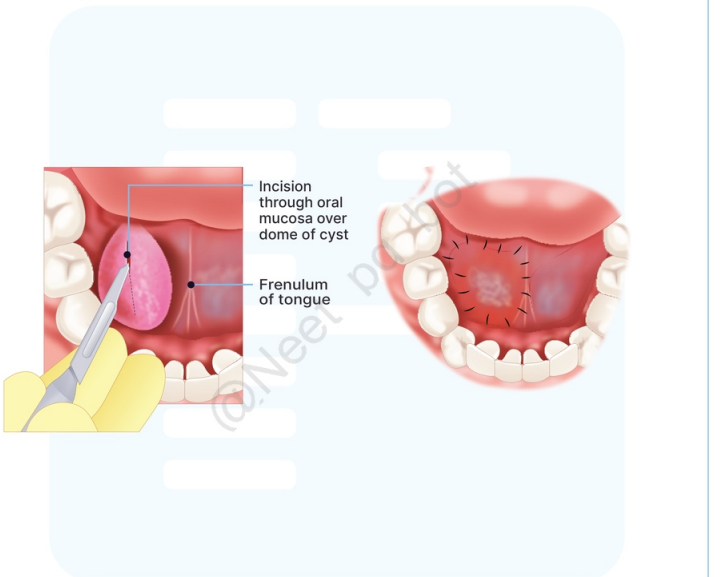
■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: MRI is the most appropriate imaging modality to confirm the diagnosis of a ranula. It provides detailed information about the extent of the lesion and helps differentiate it from other lesions, such as lymphangiomas. Ranula Definition Ranulas are a type of extravasation mucocele , caused by the rupture of the main duct or obstructed acini of the sublingual gland. They appear as bluish swellings on the floor of the mouth and resemble the belly of a frog. Location Commonly found in the anterior floor of the mouth. When it extends through the mylohyoid muscle, it presents as a submental swelling known as a "plunging ranula." Symptoms Typically soft, fluctuant, and painless unless infected. Diagnosis Confirmed through Magnetic Resonance Imaging (MRI) Ultrasound Aspiration of thick sticky saliva differentiates it from a lymphangioma. Treatment Removal of the sublingual gland is preferred. Incision, drainage, and marsupialization have low success rates. Although marsupialization is often adequate, it has a higher recurrence rate compared to sublingual gland excision. OK-432 injection Botulinum toxin injections CT (Option B): Although CT can be used to visualize the lesion, MRI is preferred due to its superior soft tissue contrast and ability to better delineate the extent of the lesion, especially in cases of plunging ranulas. Incisional biopsy (Option C) is generally not indicated for diagnosing a ranula. The

diagnosis is typically made based on clinical presentation and imaging. Biopsy may be reserved for atypical cases where malignancy or another condition is suspected. Aspiration of the lesion (Option D): Aspiration of thick sticky saliva can help differentiate a ranula from a lymphangioma. However, it is often used as a supplementary diagnostic method alongside imaging, rather than the first line of investigation.





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References:

Bailey and Love's Short Practice of Surgery, 28th Edition, Page 834

SRB's Manual of Surgery, 6th Edition, Page 357

↑ *Back to this question in Part A*

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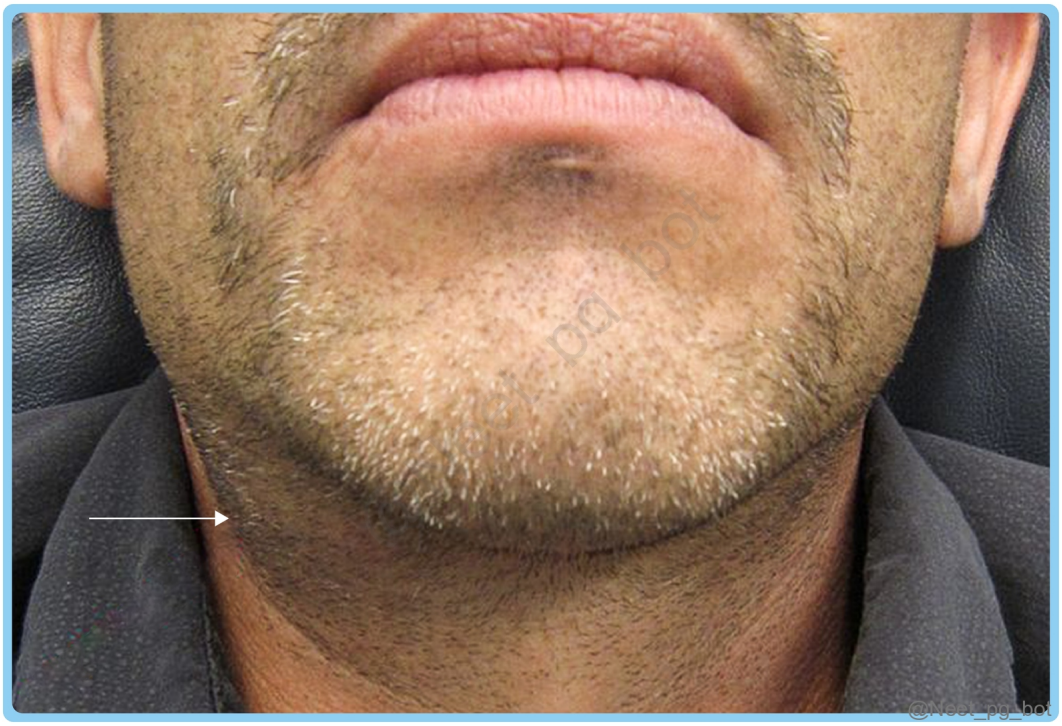
Q4: A 52 y/o male has recurrent pain and swelling in the left lower jaw, worsening over several months. On examination, there is a significant swelling of the right submandibular gland, but no palpable stone. A CT scan shows an 8 mm stone deep within the submandibular gland, inaccessible by sialendoscopy. What is the best next step in management? (Q849656)

A. Endoscopic removal of the stone

B. Ductal slitting for stone extraction

C. External shock wave lithotripsy (ESWL)

D. Gland excision



Correct Answer: C. External shock wave lithotripsy (ESWL)

- *Listen (English)*
- *Listen (Hindi)*

Explanation: ESWL is an appropriate treatment for larger stones (7–10 mm) that are not easily accessible via endoscopy. It uses shock waves to break the stone into smaller fragments that can then pass through the duct or be removed by other means. Sialolithiasis Definition Formation of salivary gland stones within the gland ducts Commonly Affected Age 30 to 60 years Commonly Affected Gland Submandibular gland (85%), due to its ascending duct course and the mucinous, viscous saliva it produces, leads to stagnation and stone formation. Risk Factors Duct abnormalities Inflammation Increased calcium content in saliva Chronic dehydration Medications causing decreased salivary flow Clinical Features Cyclical postprandial swelling, dryness, asymmetrical gland enlargement, palpable stone, possible abscess formation. Submandibular Swelling Diagnostic Methods Conventional Radiographs : Initial diagnostic test, but may miss small stones. CT Scanning, USG, Magnetic Resonance Sialogram : More sensitive, especially for small stones. Sialography : Gold standard; involves dye injection for diagnosis and potential therapeutic use. Sialendoscopy : Direct visualization and removal of stones, safer than open surgery. CT- Wharton’s duct Sialolithiasis Treatment Options Small Distal Stones (<5 mm) : Endoscopic removal (Option A) Large Distal Stones (>5 mm) : Duct slitting (Option B) Impacted Stones : Transoral route Intraparenchymal Stones (5–7 mm) : Endoscopic extraction Large Stones (7-10 mm) : May require transoral slitting or external shock wave lithotripsy (ESWL) Hilar Stones : Endoscopic removal Gland Removal : Last resort if other treatments fail (Option D)





Wharton's duct Sialolithiasis

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References:

Bailey and Love's Short Practice of Surgery, 28th Edition, Page 836- 838

Sabiston Textbook of Surgery, 21st Edition, Page 789

↑ *Back to this question in Part A*

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Q5: A 45 y/o woman is undergoing surgery for the removal of a submandibular gland mass. Postoperatively, she complains of numbness and a burning sensation of her tongue. Which nerve is most likely to have been injured during the procedure? (Q849655)

A. Facial Nerve

B. Lingual Nerve

C. Hypoglossal Nerve

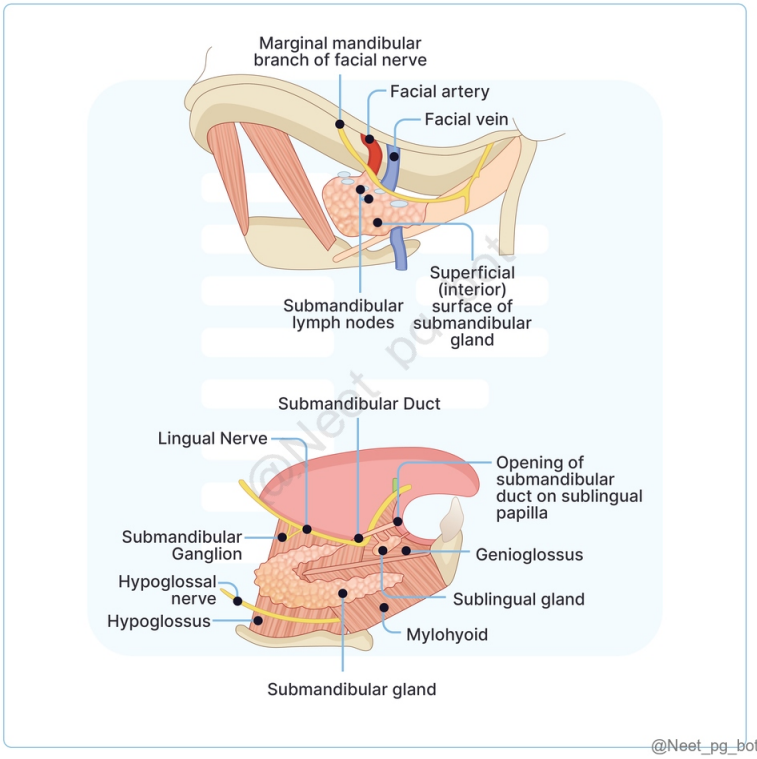
D. Glossopharyngeal Nerve

Correct Answer: B. Lingual Nerve

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The lingual nerve , a branch of the mandibular division of the trigeminal nerve (V3), is the most commonly injured nerve during submandibular gland surgery. This is due to its course, which brings it into proximity to the submandibular gland and its duct, making it highly susceptible to damage during surgical procedures in this area. The lingual nerve originates from the posterior division of the mandibular nerve (V3) in the infratemporal fossa. It then descends and moves forward, initially positioned medially to the lateral pterygoid muscle and deep to the ramus of the mandible. As it enters the floor of the mouth, it lies superficial to the hyoglossus muscle and deep to the submandibular duct. The nerve loops under the duct, passing from lateral to medial, before ascending to supply sensory innervation to the anterior two-thirds of the tongue. This intricate course places the lingual nerve close to the submandibular gland, making it particularly susceptible to injury during surgical procedures in this area. Facial Nerve (Option A): The facial nerve is responsible for motor innervation to the muscles of facial expression. It is more commonly at risk during parotid gland surgeries rather than submandibular gland surgeries . Hypoglossal Nerve (Option C): The hypoglossal nerve supplies motor innervation to the muscles of the tongue. While it runs near the submandibular gland, it is usually located deeper and more posteriorly compared to the lingual nerve, making it less likely to be injured during submandibular gland surgery. Glossopharyngeal Nerve (Option D): The glossopharyngeal nerve primarily provides sensory innervation to the oropharynx and the posterior third of the tongue. It is anatomically distant from the submandibular gland and is not typically at risk during submandibular gland surgery.



References:

Sabiston Textbook of Surgery, 21st Edition, Page 780

Bailey and Love's Short Practice of Surgery, 28th Edition, Page 833, 849

SRB's Manual of Surgery, 6th Edition, Page 394, 398

www.ncbi.nlm.nih.gov/books/NBK546652/#:~:text=The%20nerve%20passes%20between%20the,raphe's%20attachment%20in%20the%20mandible.

↑ *Back to this question in Part A*

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Q6: A 60 y/o man with a diagnosis of adenoid cystic carcinoma has undergone surgical resection of a tumour located in the palate. Postoperative imaging reveals no residual tumour but shows the involvement of regional lymph nodes. What is the most appropriate additional treatment for this patient? (Q849654)

A. Additional surgical resection

B. External beam radiotherapy

C. Preoperative chemotherapy

D. Observation and regular follow-up

Correct Answer: B. External beam radiotherapy

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: External beam radiotherapy is the most appropriate additional treatment given the involvement of regional lymph nodes. Adenoid cystic carcinoma is considered to be a radio-sensitive tumour, and as such, radiotherapy is often used in its management, usually in the postoperative setting. Radiotherapy is effective in targeting residual microscopic disease and reducing the risk of recurrence in the lymph nodes which is crucial in managing adenoid cystic carcinoma. Additional surgical resection (Option A): Further surgical intervention might be considered if there were residual diseases or if the tumour had not been completely removed. However, in this case, the imaging shows no residual tumour but regional lymph node involvement. Additional surgery might not address the lymph node involvement effectively and could increase the risk of complications. Preoperative chemotherapy (Option C): Chemotherapy is not typically used as a preoperative treatment for adenoid cystic carcinoma. It is not as effective as radiotherapy in the context of adenoid cystic carcinoma and is generally reserved for cases with distant metastases or palliative care. Observation and regular follow-up (Option D): While regular follow-up is essential to monitor for recurrence, observation alone is inadequate given the lymph node involvement.

References:

Bailey and Love’s Short Practice of Surgery, 28th Edition, Page 841, 842, 843

SRB’s Manual of Surgery, 6th Edition, Page 405, 408, 409

↑ *Back to this question in Part A*

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Q7: A 60 y/o man presents with a slow-growing, painless mass in the submandibular region. O/E, the mass is firm and non-tender and biopsy reveals a tumor with a combination of tubular and solid histological patterns. Imaging shows perineural invasion extending towards the base of the skull. Which histopathological type in this carcinoma is associated with the worst prognosis? (Q849653)

A. Cribriform

B. Tubular

C. Solid

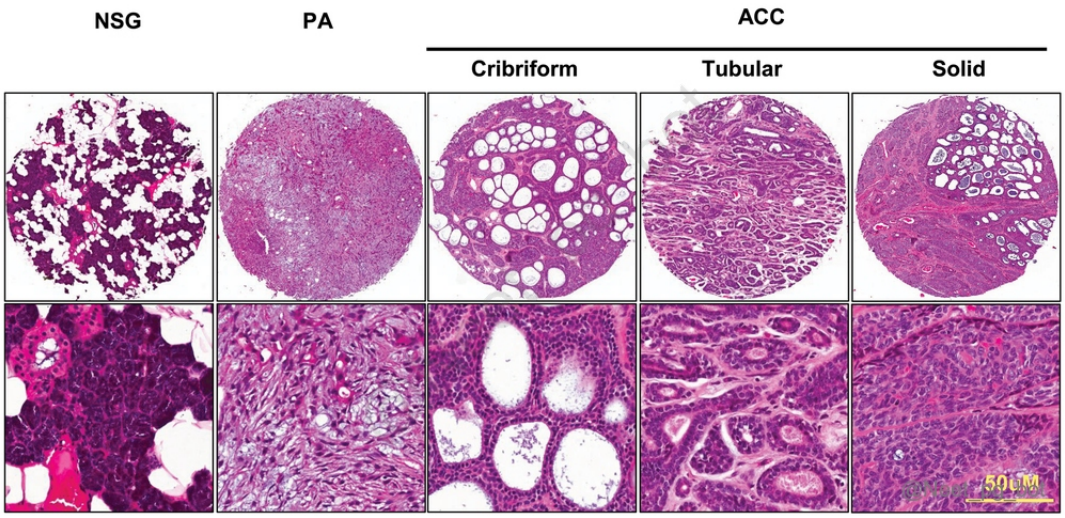
D. Papillary

Correct Answer: C. Solid

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The clinical features suggest adenoid cystic carcinoma which is a slow-growing malignant tumor composed of both epithelial and myoepithelial cells. It is notable for its tendency to spread along nerve pathways. The solid pattern is linked to the worst prognosis due to its aggressive nature, higher propensity for recurrence, and increased risk of metastasis. It often necessitates more extensive surgical intervention. This type of cancer primarily affects the submandibular and sublingual salivary glands, with approximately half of the cases occurring in minor salivary glands, especially in the palate. It is relatively rare in the parotid gland. Clinical features: Facial nerve palsy Pain or numbness High risk of distant metastasis especially - lung. Histopathology of adenoid cystic carcinoma: Type: Unencapsulated, infiltrative biphasic neoplasm. Cell Types: Variable proportions of epithelial and myoepithelial cells. Patterns: Cribriform (Option A) : Cells around sharply punched-out cylindromatous spaces with basophilic matrix. Most common type and has a better prognosis. Tubular (Option B) : Bilayered tubules with a true lumen. Solid (Option C): Sheets and nests of tumour cells without a lumen. Carries poor prognosis. Nuclear Features: Small, angulated, hyperchromatic nuclei with scant cytoplasm. Perineural Invasion: Common in adenoid cystic carcinoma. High-Grade Transformation: Can occur. Immunohistochemistry: Ductal cells: Positive for c-KIT. Myoepithelial cells: Positive for p63 and SMA. Management Based on Risk Classification: 1. Low-Risk Disease: Criteria: Small tumors (T1), negative surgical margins, no perineural invasion (PNI), and no lymph node involvement. Management: Primary Surgery: Wide local excision with the goal of "negative" (clear) margins. Observation: Postoperative radiotherapy may be omitted in very select, small, low-grade tumors with widely clear margins, though many surgeons still favor radiation due to the "skip lesions" common in ACC. 2. Intermediate-Risk Disease: Criteria: T2 tumors, close surgical margins (< 5mm), or the presence of Perineural Invasion (PNI). Management: Surgery + Adjuvant Radiotherapy: Surgery remains the first step, but External Beam Radiotherapy (EBRT) is mandatory to address potential microscopic spread along nerve sheaths. 3. High-Risk Disease: Criteria: T3/T4 tumors, positive surgical margins, Solid growth pattern (>30%) , lymph node involvement, or extensive perineural invasion (especially extending to the skull base). Management: Radical Surgery: Aggressive resection, often including sacrifice of involved nerves and regional neck dissection if nodes are involved. Postoperative Radiotherapy (PORT): High-dose EBRT is essential. In cases of skull base extension, Neutron Beam Therapy or Proton Therapy may be used as they offer superior dose distribution for ACC compared to conventional photons. Systemic Therapy: Chemotherapy (e.g., Cisplatin-based) is occasionally used as a radiosensitizer, though its impact on long-term survival for ACC is still being debated. Papillary (Option D): Papillary is not a recognized histological type for adenoid cystic carcinoma, making it an irrelevant option in this context.



References:

Bailey and Love's Short Practice of Surgery, 28th Edition, Page 841

SRB's Manual of Surgery, 6th Edition, Page 405

↑ *Back to this question in Part A*

@Neet_pg_bot

Q8: Which immunohistochemical marker helps to distinguish acinic cell carcinoma from secretory carcinoma? (Q849652)

A. p53

B. Mammaglobin

C. S100

D. Ki-67

Correct Answer: B. Mammaglobin

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Mammaglobin is a protein commonly expressed in secretory carcinoma but not in acinic cell carcinoma. The absence of mammaglobin in acinic cell carcinoma is a key feature used to distinguish it from secretory carcinoma, making it a useful diagnostic marker. Acinar cell carcinoma Tumor cells resemble normal serous acinar cells. They are rarely malignant. Immunohistochemically they are positive for DOG1 and SOX10 and negative for mammaglobin. Treatment: Radical excision p53 (Option A) is a tumour suppressor gene that is often used to assess mutations in various cancers but is not specific for distinguishing these two types of

carcinoma. S100 (Option C) is a protein expressed in various cell types and can be positive in many salivary gland tumours, including acinic cell carcinoma. However, it is not specific enough to differentiate acinic cell carcinoma from secretory carcinoma, as it can be positive in both tumour types. Ki-67 (Option D): Ki-67 is a proliferation marker used to assess the growth rate of tumour cells. While it provides information on the aggressiveness of a tumour, it is not specific to acinic cell carcinoma or secretory carcinoma and cannot be used to differentiate between the two.

References:

Bailey and Love's Short Practice of Surgery, 28th Edition, Page 840, 841, 931

Ki-67 as a prognostic marker according to breast cancer molecular subtype - PMC

Diagnosis and treatment of secretory CA

SOX 10

↑ *Back to this question in Part A*

@Neet_pg_bot

Q9: A 45 y/o female has a firm, enlarging swelling below her left ear for 6 months. O/E, the swelling is hard and nodular, with no signs of facial nerve involvement. FNAC shows malignant cells, and imaging reveals a tumour in both lobes of the parotid gland with no distant metastases. What is the most likely diagnosis? (Q849651)

A. Pleomorphic adenoma

B. Mucoepidermoid carcinoma

C. Adenoid cystic carcinoma

D. Warthin's tumor

Correct Answer: B. Mucoepidermoid carcinoma

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Mucoepidermoid carcinoma is the correct diagnosis in this scenario. Mucoepidermoid carcinoma is the most common malignant tumour of the parotid gland, particularly in adults. The slow-growing, firm, and nodular swelling in the parotid region, combined with the FNAC findings of malignancy , strongly indicates this type of carcinoma. The absence of facial nerve involvement and the slow progression further support this diagnosis, as these features are typical of low- to intermediate-grade mucoepidermoid carcinoma. High-grade carcinoma typically is locally aggressive and shows nodal metastases. Pleomorphic adenoma (Option A): This is a benign salivary gland tumour and the most common neoplasm of the parotid gland. It typically presents as a painless, mobile, and slow-growing mass. Adenoid cystic carcinoma (Option C): While adenoid cystic carcinoma

is another malignant salivary gland tumour, it is more commonly associated with minor salivary glands and tends to show a propensity for perineural invasion, often leading to early facial nerve involvement. Warthin's tumor (Option D) or Cystadenoma lymphomatosum, is a benign salivary gland tumor, commonly found in the parotid gland. It typically presents as a painless, cystic mass, often in older males.

References:

Bailey and Love's Short Practice of Surgery, 28th Edition, Page 839, 840

SRB's Manual of Surgery, 6th Edition, Page 404, 405

↑ *Back to this question in Part A*

@Neet_pg_bot

Q10: Which of the following statements about Warthin's tumour and its diagnostic features is correct? (Q849650)

A. It is best identified on imaging by its hypoechoic appearance and confirmed with FNAC.

B. A Tc99 pertechnetate scan showing a "hotspot" is indicative of Warthin's tumour.

C. HPE shows mucin-secreting cells

D. Warthin's tumour generally exhibits low uptake on Tc99 pertechnetate scans

Correct Answer: B. A Tc99 pertechnetate scan showing a "hotspot" is indicative of Warthin's tumour.

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Warthin's tumour shows increased uptake on Tc99 pertechnetate scans because of its high mitochondrial content. Histopathological features include papillary structures, cystic spaces, oncocytic epithelial cells, and lymphoid stroma. Tc99 Pertechnetate Scan: Purpose : Assesses salivary gland function and detects abnormal areas. Hot Spot : Increased uptake of the radioactive tracer (Option D) , indicating high mitochondrial content typical of Warthin's tumour. Histopathology (HPE) (Option C): Papillary Structures: Finger-like projections extending into cystic spaces. Cystic Spaces: Fluid-filled cavities within the tumor. Oncocytic Epithelial Cells: Two layers of cells with abundant mitochondria lining the papillary and cystic areas. Lymphoid Stroma: Supporting tissue with lymphocytes and germinal centres, resembling lymph node tissue. It is best identified on imaging by its hypoechoic appearance and confirmed with FNAC (Option A): While FNAC is used for diagnosis, Warthin's tumour typically shows a "hot spot" on Tc99 pertechnetate scans due to high mitochondrial content, not just hypoechoic appearance. FNAC might not always reveal the distinct features of Warthin's tumour.

References:

SRB's Manual of Surgery, 6th Edition, Page 403, 404

↑ *Back to this question in Part A*

@Neet_pg_bot

Q11: Which of the following salivary glands secretes saliva through Stensen’s duct? (Q849640)

A. Parotid gland

B. Submandibular gland

C. Sublingual gland

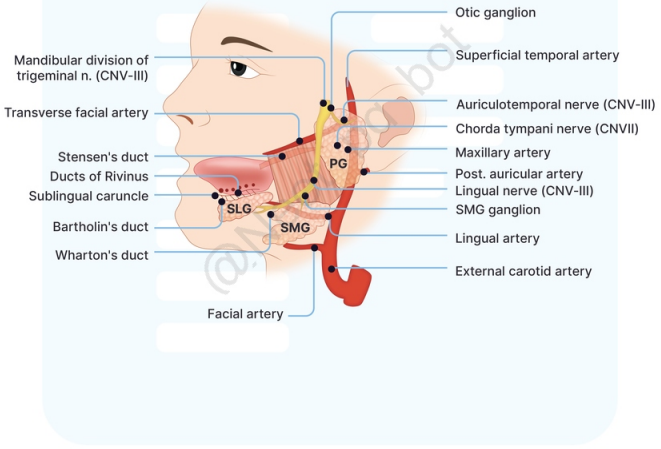
D. Minor salivary glands

Correct Answer: A. Parotid gland

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The parotid gland is the largest salivary gland and secretes saliva through Stensen’s duct , which opens into the oral cavity near the upper second molar. They are primarily serous glands that produce watery saliva. The duct emerges from the anterior surface of the parotid gland, travels over the masseter muscle, pierces the buccinator muscle, and opens into the oral cavity opposite the crown of the upper second molar tooth. Gland Duct Parotid gland Stensen’s Duct Submandibular gland (Option B) Wharton’s Duct Sublingual gland (Option C) Ducts of Rivinus Minor salivary glands (Option D) Numerous small ducts



References:

Bailey and Love's Short Practice of Surgery, 28th Edition, Page 831, 833

SRB's Manual of Surgery, 6th Edition, Page 394, 395

↑ *Back to this question in Part A*

@Neet_pg_bot

Q12: A 35 y/o female has a slowly enlarging, painless, well-defined mass in the left parotid gland, present for two years. O/E there is no facial nerve involvement. Ultrasound shows a well-lobulated, hypoechoic lesion, and FNAC suggests a benign neoplasm. What is the most appropriate next step in management? (Q849648)

A. Observation and follow-up

B. Radiotherapy

C. Surgical excision with a margin of normal tissue

D. Enucleation of the tumour

Correct Answer: C. Surgical excision with a margin of normal tissue

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The clinical presentation and findings suggest a diagnosis of Pleomorphic Adenoma . Surgical excision with a margin of normal tissue is the most appropriate management for pleomorphic adenoma. The goal is to remove the tumor completely with a margin of normal tissue to prevent recurrence and avoid spillage of tumor cells. This approach minimizes the risk of malignant transformation and recurrence. Pleomorphic Adenoma : Clinical Presentation : Painless, well-defined, solitary, mobile masses. Commonly located in the parotid glands (>80% of cases). Can also occur in the submandibular gland and hard palate. Sudden growth of facial nerve palsy may suggest malignant transformation (rare). Imaging : USG: Well-lobulated, hypoechoic lesions with possible calcifications. CT: Provides detailed anatomical imaging along with the extent of the tumor. MRI: Helps differentiate between benign and malignant tumors Fine-Needle Aspiration Cytology (FNAC) : Differentiates between inflammatory conditions and tumors- high sensitivity and specificity Histopathology : Gross Examination: Tumors are well-circumscribed, nodular, and firm, with a white to tan cut surface. May show cartilaginous areas; large tumors may exhibit degeneration or cystic changes. Microscopy: A mixture of epithelial, myoepithelial, and stromal components. Possible malignant changes: Ductal atypia, diffuse fibrosis, or necrosis Treatment: Surgical Excision of the tumor along with a cuff of normal tissue. Enucleation (Option D) is not recommended due to the risk of capsular breach, tumor spillage, and recurrence. Observation and follow-up(Option A): Although the tumor is benign and asymptomatic, observation is not appropriate because pleomorphic adenomas can undergo malignant transformation over time. Radiotherapy(Option B): It is generally reserved for malignant tumors or cases where surgical excision is not possible.

References:

Bailey & Love’s Short Practice of Surgery, 28th Edition, Page 839, 840, 842

↑ *Back to this question in Part A*

@Neet_pg_bot

Q13: A 50 y/o female with swelling and pus discharge from the left cheek for two weeks, worsening with eating, recently had a superficial parotidectomy. Examination reveals a small external opening at the parotid region with saliva-like discharge. What is the best initial management? (Q849647)

A. Antibiotics and observation

B. Sialography to evaluate the fistula

C. Surgical exploration and repair

D. Anticholinergic therapy with hyoscine bromide

Correct Answer: D. Anticholinergic therapy with hyoscine bromide

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The clinical presentation and findings suggest a diagnosis of Parotid Fistula. Anticholinergic therapy is the most appropriate initial management. It reduces salivary secretion, which can decrease the flow through the fistula, potentially allowing it to close spontaneously. This non-invasive approach is preferred before considering more aggressive interventions like surgery. Parotid Fistula Definition : A parotid fistula is an abnormal connection involving the parotid gland or its ducts, leading to saliva leakage. It can be: Internal: Draining into the mouth External: Draining onto the skin Discharge : Duct fistula: Typically profuse Gland fistula: Minimal discharge Risk Factors Surgical Trauma: Direct injury to the Stensen's duct or inadequate closure of the parotid fascia (Epstein's fascia). Post-op Infection: Abscess formation or sialadenitis that breaks down healing tissue. Distal Obstruction: A stone (sialolith) or stricture in the main duct that forces saliva out the surgical wound. Poor Healing: History of radiation therapy , uncontrolled diabetes, or malnutrition. Malignancy: Extensive resections for invasive tumors that compromise skin integrity. Investigations: Sialography: Identifies the origin of the fistula (gland, duct, or ductules) Other Imaging: Fistulogram, CT fistulogram, and MRI for detailed anatomy Discharge Study: Amylase content analysis to confirm saliva Management : Conservative : Anticholinergics (e.g., hyoscine bromide): Reduce salivary secretion. Radiotherapy: Low-dose radiation for longstanding fistulas. Surgical : Exploration and Repair: Dissect and repair the fistula tract; techniques like Newman Seabrock's operation may be used. Duct Repositioning: Redirects the duct into the oral mucosa. Auriculotemporal Nerve Sectioning: Reduces salivary flow by disrupting nerve supply. Total Conservative Parotidectomy: Last resort for persistent fistulas Antibiotics and observation (Option A): Antibiotics may help with infection, but they don't address the salivary fistula itself. Sialography to evaluate the fistula (Option B): Sialography helps identify the origin and extent of the fistula but is not the initial management step. It is used primarily when planning surgery if conservative treatments fail. Surgical exploration and repair (Option C): Surgical intervention is reserved for cases where conservative management fails or the fistula persists long-term.

References:

SRB's Manual of Surgery, 6th Edition, Page 399

↑ *Back to this question in Part A*

@Neet_pg_bot

Q14: A 60 y/o male undergoes a parotidectomy for a benign tumour located in the superficial lobe of the parotid gland. On the second postoperative day, he notices sweating and flushing in the area just in front of his ear when he eats. The patient also reports mild numbness of the earlobe. Which of the following nerves is most commonly affected? (Q849646)

A. Facial nerve

B. Auriculotemporal nerve

C. Great auricular nerve

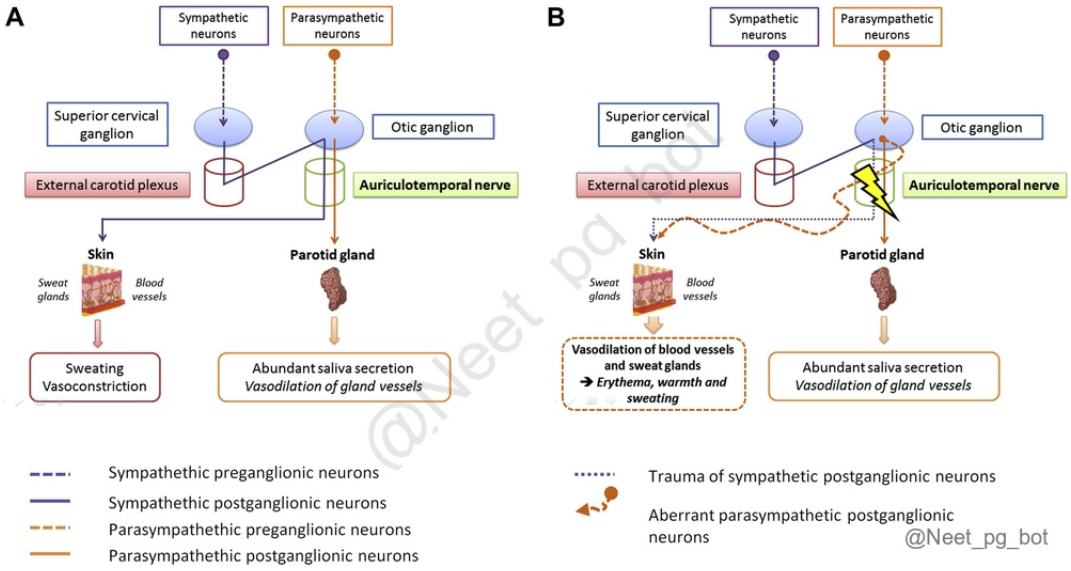
D. Hypoglossal nerve

Correct Answer: B. Auriculotemporal nerve

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The given clinical presentation suggests Frey's Syndrome, also known as gustatory sweating, is the most likely cause of the sweating and flushing the patient experiences while eating, resulting from damage to the auriculotemporal nerve , which carries the parasympathetic fibres to the parotid gland. This condition occurs due to the aberrant regeneration of parasympathetic nerve fibres, leading to the cross-innervation of sweat glands in the area. Complications of Parotidectomy: Complication Description Temporary Facial Palsy Mostly the lower branches of the facial nerve - the marginal mandibular nerve. Most patients recover over time. Infection Rare, as parotidectomy is a clean procedure. Aseptic precautions and timely drain removal reduce the risk. Hematoma Formation Uncommon. Careful intraoperative hemostasis can prevent it. Larger hematomas may indicate a bleeding disorder and require management. Sialocele Formation Occurs if the main ductal system is exposed. Preventable with subcapsular dissection. Treatment: Anticholinergics, aspiration, and pressure dressings. Retromandibular area hollowing Can occur post-surgery Reduced by placing autologous fat grafts during the surgery. Frey's Syndrome Also known as gustatory sweating; Caused by the cross-innervation of sweat glands by regenerating nerve fibres of the auriculotemporal nerve. (Option B) For mild cases : Give antiperspirants; Severe cases : Botulinum toxin injections or tympanic neurectomy. Permanent Facial Nerve Weakness D/t transection of the facial nerve during the surgery. (Option A) Facial Numbness Permanent numbness of the earlobe, D/t transection of the great auricular nerve during the surgery. (Option C) Pathophysiology: A, Normal physiology of auriculo-temporal nerve, and B: In case of injury of the auriculo-temporal nerve. The hypoglossal nerve (Option D) causes deviation of the tongue towards the affected side. It does not supply the parotid gland or front of the ear.



References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 848, 849

www.ncbi.nlm.nih.gov/books/NBK532869/#article-23265.s7:~:text=the%20tongue%2C%20when%20protruded%2C%20deviates%20towards%20the%20damaged%20nerve%20because%20of%20the%20overaction%20of%20the%20strong%20genioglossus%20muscles

↑ *Back to this question in Part A*

@Neet_pg_bot

Q15: A 45 y/o patient presents with a parotid gland tumour located deep to the facial nerve. The tumour has been identified as malignant and has extended beyond the parotid gland. Given these findings, which surgical approach is most appropriate for this patient? (Q849645)

A. Radical parotidectomy

B. Total conservative parotidectomy

C. Superficial parotidectomy

D. Adequate parotidectomy

Correct Answer: A. Radical parotidectomy

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: This procedure involves the complete removal of the parotid gland along with any involved facial nerve branches. It is typically indicated for malignant tumors that have extended beyond the gland, making it the most appropriate choice for this patient's condition. Types of Parotidectomy: Type Description Extracapsular Dissection Tumor removed. No facial nerve dissection. ↓ Chances of temporary facial palsy. Adequate Parotidectomy (Option D) Tumor removal along with some healthy tissue. Aimed to preserve the gland. Challenging if the tumor is near the facial nerve. Superficial Parotidectomy (Option C) Performed when the tumor is located lateral to the facial nerve. Total Parotidectomy Indicated when the tumor is deep to the facial nerve. Total Conservative Parotidectomy (Option B) Involves removing both superficial and deep lobes while preserving the facial nerves. Used for tumors crossing the facial nerve plane. Radical Parotidectomy Complete removal of the parotid gland, including any involved facial nerve branches, for malignant tumors extending beyond the gland. Common Incisions: Modified Blair Incision: A preauricular incision curving under the earlobe and extending along the anterior border of the sternocleidomastoid. Facelift Incision: Similar to the modified Blair incision, but with the posterior part curving into the hairline to avoid a neck incision.

References:

Bailey & Love’s Short Practice of Surgery, 28th Edition, Page 846, 848

↑ *Back to this question in Part A*

@Neet_pg_bot

Q16: A 62 y/o woman presents with a recurrent adenoid cystic carcinoma of the submandibular gland. The tumour has been surgically resected twice before, and each time, the pathology report showed perineural invasion. What is the most appropriate next step in managing her condition? (Q849644)

A. Repeat surgical excision

B. Radiation therapy

C. Chemotherapy

D. Targeted therapy

Correct Answer: B. Radiation therapy

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Given the tumor's tendency for perineural spread and the risk of local recurrence, radiation therapy is an appropriate adjuvant treatment to help control the disease. Radiation therapy uses high-energy rays to destroy cancer cells and is often used as adjuvant therapy after surgery or as the primary treatment for inoperable tumors. Perineural invasion, common in adenoid cystic carcinoma, refers to cancer spreading along nerves. Radiation therapy targets these tumor extensions to reduce recurrence. Radiotherapy Indications Adenoid cystic carcinomas After surgery for malignant salivary gland tumors High-grade tumors Close/inadequate clearance margin Deep lobe tumor Perineural spread Vascular involvement Multiple neck node involvement Recurrent malignant tumors Recurrent pleomorphic adenoma Repeat surgical excision (Option A) aims to remove salivary gland tumors with negative margins (no cancer cells at the edges of the removed tissue). However, due to perineural invasion and recurrent surgeries, it risks damaging vital structures and incomplete removal, making it unsuitable in this case. Chemotherapy (Option C): It is not typically the first-line treatment for adenoid cystic carcinoma, especially in cases of localized recurrence. Chemotherapy is more often used for systemic control when there is evidence of distant metastases or when other treatments are not feasible. Targeted Therapy (Option D): Targeted therapy uses drugs that specifically target molecules involved in cancer cell growth and survival. Salivary duct carcinomas often express androgen receptors and HER2 receptors, making them potential targets for therapies that block these receptors. However, targeted therapy is not currently a standard treatment for adenoid cystic carcinoma. Note: Neck dissection is usually performed in node-positive tumors, high-grade tumors, and malignant tumors with lymph nodal spread. It is also indicated for salivary duct carcinoma.

References:

Sabiston Textbook of Surgery, 21st Edition, Page 777, 791

Bailey and Love’s Short Practice of Surgery, 28th Edition, Page 811, 841, 842

SRB’s Manual of Surgery, 6th Edition, Page 408

↑ *Back to this question in Part A*

@Neet_pg_bot

Q17: A 45 y/o woman presents with a progressively enlarging mass in her right parotid gland. The mass is non-tender and has been present for 6 months. An ultrasound revealed a well-defined hypoechoic lesion with no evidence of calcification or increased vascularity. Which of the following is the most appropriate next step for this patient? (Q849643)

A. Sialography

B. Positron Emission Tomography (PET-CT)

C. Core Needle Biopsy

D. Fine-needle aspiration Cytology (FNAC)

Correct Answer: D. Fine-needle aspiration Cytology (FNAC)

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: FNAC is a minimally invasive procedure used to extract cells from the suspicious mass using a fine needle, which is then examined under a microscope. FNAC is highly sensitive and specific for distinguishing between inflammatory and neoplastic lesions and between benign and malignant tumours. It is the most appropriate next step for evaluating a parotid gland mass due to its simplicity, safety, and ability to guide further management based on the cytological findings. Sialography (Option A): It involves injecting a contrast dye into the salivary ductal system to visualize it on X-ray. This technique is useful for diagnosing ductal abnormalities such as sialolithiasis (stones) and sialectasis but is not particularly useful for assessing salivary gland tumours. Positron Emission Tomography (PET-CT) (Option B): It is typically used to detect distant metastases in high-grade salivary gland malignancies and to identify primary tumours when metastatic involvement of the salivary glands is suspected. PET-CT is not indicated as a first-line investigation for a parotid mass, especially without suspicion of malignancy. Core Needle Biopsy (Option C): It involves taking a larger sample of tissue compared to FNAC and is more invasive. It is typically reserved for situations where FNAC results are inconclusive or additional tissue is needed for a more accurate diagnosis. Given the availability of FNAC for initial assessment, it is not the most appropriate next step at this stage.

References:

Schwartz’s Principles of Surgery, 11th Edition, Page 650

Bailey and Love’s Short Practice of Surgery, 28th Edition, Page 837, 842

↑ *Back to this question in Part A*

@Neet_pg_bot

Q18: Which is the most common salivary gland tumour found in infants and young children? (Q849642)

A. Pleomorphic adenoma

B. Mucoepidermoid carcinoma

C. Hemangioma

D. Adenoid cystic carcinoma

Correct Answer: C. Hemangioma

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Hemangiomas are the most common benign vascular tumours seen in infants and young children. They often develop within the first few weeks of life and are the most frequent vascular lesions in early childhood. While many hemangiomas regress on their own, some may need treatment due to complications such as breathing difficulties or vision problems. Pleomorphic adenoma (Option A): This is the most prevalent benign tumour in the salivary glands of adults. It typically affects the parotid gland and contains a mix of epithelial, myoepithelial, and stromal components. Although benign, it can become malignant over time, particularly carcinoma, eg., pleomorphic adenoma. Mucoepidermoid carcinoma (Option B): This malignant tumour is the most common type of salivary gland cancer, especially in children and young adults. It consists of a mix of mucin-producing, intermediate, and squamoid cells, and occurs in the parotid gland. Adenoid cystic carcinoma (Option D): This is a slow-growing malignant tumour of the salivary glands, more often diagnosed in adults during their 50s. It has a notable tendency to invade nerves and is characterized by late distant metastases. Adenoid cystic carcinoma is the most common malignant tumour of the minor salivary glands, particularly on the palate. Salivary gland tumors The most common benign tumour Pleomorphic adenoma The most common benign tumour of infants and young children Hemangioma The most common malignan t tumour Mucoepidermoid carcinoma The most common malignant tumour in children and young adults Mucoepidermoid carcinoma The most common malignant tumour of Minor salivary glands Adenoid cystic carcinoma

References:

Schwartz’s Principles of Surgery, 11th Edition, Page 626, 650

Bailey and Love’s Short Practice of Surgery, 28th Edition, Page 840, 841

SRB’s Manual of Surgery, 6th Edition, Page 405

↑ *Back to this question in Part A*

@Neet_pg_bot

Q19: A 50 y/o male presents with a swelling in his parotid gland, and a biopsy reveals a Warthin's tumour. Which of the following is most likely a contributing risk factor

for this patient's condition? (Q849641)

A. Radiation exposure in childhood

B. Chronic inflammation of the salivary glands

C. Smoking history

D. Immunocompromised state

Correct Answer: C. Smoking history

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: There is a strong association between smoking and the development of Warthin's tumors. Studies indicate that smokers have up to an 8-fold increased risk of developing this type of tumor compared to non-smokers. Risk factors of salivary gland tumors: Smoking: increases the risk of Warthin’s tumor. Radiation exposure (Option A) - increases the risk of mucoepidermoid CA. Viral infections (EBV, mumps). Recurrent & chronic inflammation (Option B) , eg. chronic Sialadenitis. Sex - More common in females. Environment - Nickel, rubber industries, hair dye. Pathogenesis: The Inclusion Theory: During embryological development, salivary gland tissue becomes trapped within parotid lymph nodes. These "heterotopic" rests later undergo cystic and papillary changes. The Irritant Theory: Smoking is the primary risk factor. Smoking acts as a chronic irritant to these trapped ductal elements, triggering the characteristic lymphoid reaction and metaplasia. Other Factors: While radiation (Option A) is linked to mucoepidermoid carcinoma, it is less strongly associated with Warthin's. Unlike pleomorphic adenoma, Warthin's is rarely associated with genetic mutations like PLAG1. Clinical Features: Demographics: Classically seen in males aged 50–70. Location: Almost exclusively occurs in the parotid gland , usually in the tail (inferior pole). It is the most common salivary tumor to be bilateral or multicentric (multiple spots in one gland). The "Rule of 10s": Roughly 10% are bilateral and 10% are multifocal (multiple tumors in one gland). Presentation: A slow-growing, painless, soft/fluctuant mass. Imaging: On a Technetium-99m pertechnetate scan, it appears as a "hot" spot because the oncocytes concentrate the isotope. Management: Warthin’s tumor is strictly benign with an extremely low rate of malignant transformation (<1%). Observation: A "watch and wait" approach is appropriate for elderly or high-risk surgical patients once confirmed by FNAC. Surgical Excision: The standard treatment is a superficial parotidectomy or a more conservative extracapsular dissection . It is vital to preserve the facial nerve. Immunocompromised state (Option D): Immunocompromised states, such as those seen in patients with HIV or those who have undergone organ transplants, can increase the risk of various head and neck cancers, but they are not specifically linked to Warthin's tumour.

References:

Bailey and Love’s Short Practice of Surgery, 28th Edition, Page 838

SRB’s Manual of Surgery, 6th Edition, Page 400, 403

pubmed.ncbi.nlm.nih.gov/8678050/

↑ *Back to this question in Part A*

@Neet_pg_bot

• [02_Head And Neck] 006 Neck Facial Injuries Abnormalities

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[02_Head And Neck] 006 Neck Facial Injuries Abnormalities — Quick Jump

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Q7 (p. 1277)	*Q8 (p. 1278)*	*Q9 (p. 1280)*	*Q10 (p. 1281)*	*Q11 (p. 1283)*	*Q12 (p. 1283)*
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Q19 (p. 1299)	*Q20 (p. 1300)*	*Q21 (p. 1301)*	*Q22 (p. 1304)*	*Q23 (p. 1305)*	*Q24 (p. 1307)*
Q25 (p. 1309)					

Q1: A patient is brought to the trauma unit after being assaulted. He presents with severe pain, swelling, and deformity in the lower jaw. Imaging confirms a "bucket handle" fracture of the mandible. What is the most likely nerve to be injured in this type of fracture? (Q849719)

A. Lingual nerve

B. Inferior alveolar nerve

C. Hypoglossal nerve

D. Facial nerve

Correct Answer: B. Inferior alveolar nerve

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Inferior alveolar nerve runs through the mandibular canal and is at risk of injury in fractures of the mandible, especially those involving the body of the mandible, like butterfly fractures. Butterfly Fractures of the Mandible: Also Known As : "Bucket handle" fractures. Type : Bilateral body fractures of the mandible. Common Causes : High-energy impacts (e.g., motor vehicle accidents, assaults). Main Complication : Airway obstruction. Characteristics and Mechanism: Appearance : Fracture creates a "butterfly" pattern. Impact : Significant compromise of mandible’s structural integrity. Injury Mechanism : Involves high-force trauma, potentially leading to additional injuries in surrounding tissues. Management Strategies: Method Indication Details Closed Reduction Non-displaced or minimally displaced fractures Uses intermaxillary fixation (MMF) for stabilization. Open Reduction and Internal Fixation (ORIF) Displaced fractures Surgical realignment and stabilization using plates/screws. Complications: Malocclusion : Misalignment of teeth. Non-union : Failure of the fracture to heal properly. Nerve Injury : Particularly to the inferior alveolar nerve, causing altered sensation in the lower lip. Lingual nerve (Option A) : This nerve is less likely to be injured in a mandibular body fracture as it is located more medially and higher up in the jaw. Hypoglossal nerve (Option C) : This nerve is involved in tongue movement and is not typically affected by mandible fractures. Facial nerve (Option D) : The facial nerve controls facial muscles

and is usually affected by fractures of the zygomatic arch or parotid area, not the mandible.

References:

www.ncbi.nlm.nih.gov/books/NBK553119/

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8604616/

↑ *Back to this question in Part A*

@Neet_pg_bot

Q2: Match the following LeFort's fracture types: LeFort's types Features 1. LeFort's I a- Craniofacial dislocation 2. LeFort's II b- Horizontal fracture 3. LeFort's III c- Pyramidal fracture d- Tripod fracture (Q849716)

A. 1-b, 2-c, 3-a

B. 1-d, 2-b, 3-a

C. 1-c, 2-d, 3-b

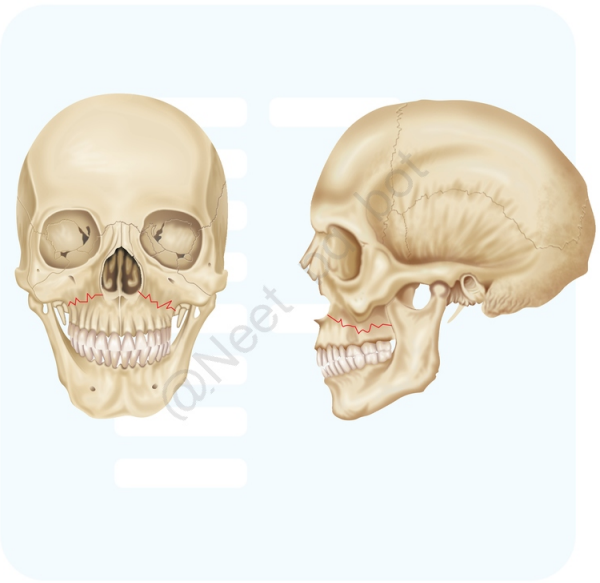
D. 1-a, 2-c, 3-b

Correct Answer: A. 1-b, 2-c, 3-a

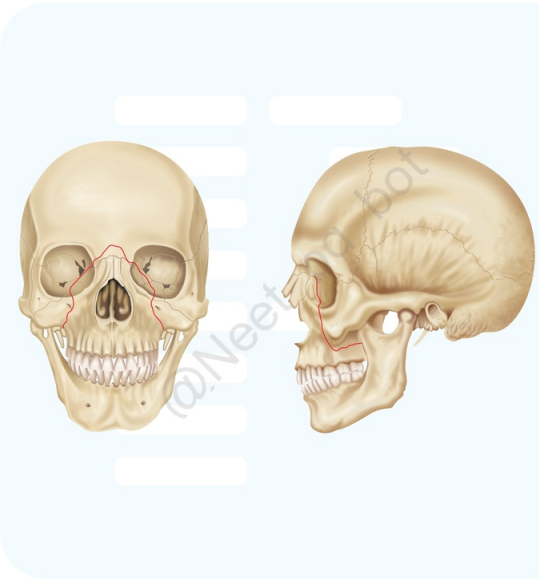
■ *Listen (English)*

■ *Listen (Hindi)*

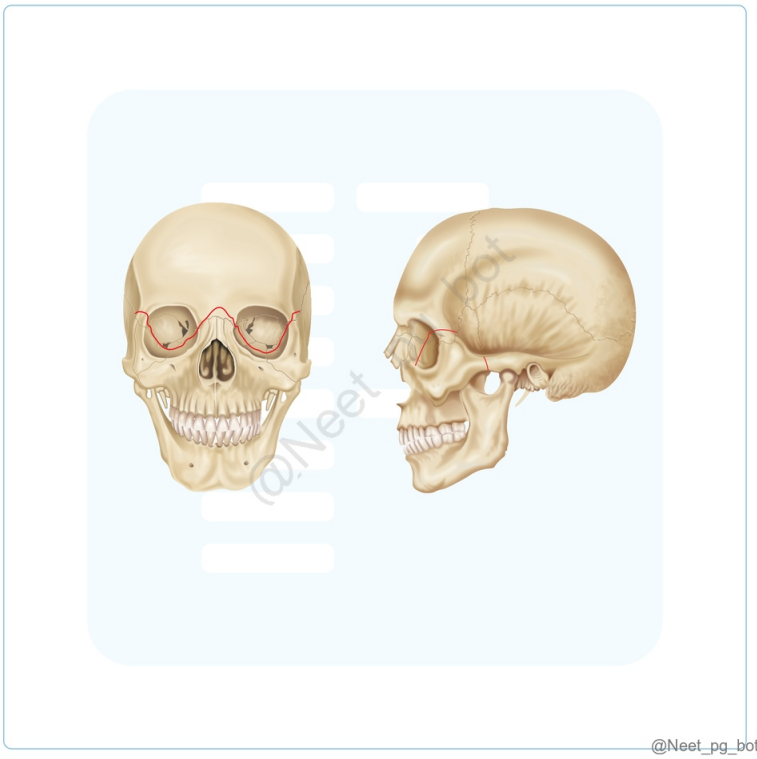
Explanation: LeFort's types Features Image LeFort's I (Horizontal fracture/ floating fracture) Fracture line runs horizontally above the floor of the nasal cavity. Separates alveolus and palate from facial skeleton LeFort's II (Pyramidal fracture) Fracture line passes through: Nose, lacrimal bone, orbital floor, maxillary sinus, pterygoid plate LeFort's III (Craniofacial dislocation) Fracture runs parallel to the skull to skull base. It passes through the nasal bridge, septum, lacrimal bone, ethmoid bone, orbit, pterygomaxillary fissure and lateral orbital frontozygomatic suture NSE of Z (mnemonic)



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References:

Bailey and Love short practice of surgery, 28th edition, page 412

SRB’s Manual of Surgery 6th edition, page 343, 344

↑ *Back to this question in Part A*

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Q3: A 30-year-old male presents to the emergency department after a motor vehicle accident. On assessment, there is bruising around the left eye, and tenderness over the zygomatic arch. Which of the following imaging views is most appropriate for assessing a suspected zygomatic bone fracture? (Q849715)

A. Caldwell's view

B. Water's view

C. Lateral skull view

D. Towne's view

Correct Answer: B. Water's view

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Water’s view plain film x-ray is preferred for evaluating zygomatic arch fractures. Investigations for zygomatic bone fracture: X-ray: water’s view (occipitomental view) is preferred CT scan- best investigation Treatment: Undisplaced fracture: Conservative management Displaced and symptomatic: Open reduction and internal fixation Caldwell's view (Option A) : (Occipitofrontal view) assessing fractures, and pathologies in the frontal and ethmoidal sinuses. Lateral skull view (Option C): Non-angled lateral radiograph of the skull. Useful in basal skull fracture. Towne's view (Option D) : Useful for identifying fractures in the occipital bone.



References:

Bailey and Love short practice of surgery, 28e pg 411

https://www.ncbi.nlm.nih.gov/books/NBK549898/

https://radiopaedia.org/articles/skull-lateral-view-1

https://radiopaedia.org/articles/skull-towne-view-1

https://radiopaedia.org/articles/skull-caldwell-view-2

↑ *Back to this question in Part A*

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Q4: All of the following are true regarding the clinical presentation of zygomatic bone fracture except? (Q849714)

A. Epistaxis

B. Anesthesia in infra-orbital nerve distribution

C. Flattening of malar prominence

D. Deranged dental occlusion

Correct Answer: D. Deranged dental occlusion

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Deranged dental occlusion is a manifestation of mandibular fracture. Zygomatic bone fracture: (tripod fracture) Fractures in 3 places: Zygomatico-frontal Zygomatico-temporal Infraorbital Clinical features: Swelling and bruising in the cheek. Flattening of the cheek (malar) prominence. (Option C ruled out) Step deformity of the infraorbital region. Epistaxis (Option A) Sensory loss in superior orbital nerve. Sensory loss in infraorbital nerve (Option B) : upper lip, and alar region of the nose. Enophthalmos is due to herniation of the orbital fat across the fracture floor of the orbit into the antrum. Diplopia- entrapment of the inferior rectus muscle restricting upward rotation of the eyeball while looking up. Infraorbital ecchymosis: Panda sign. Subcutaneous emphysema.

References:

Bailey and Love short practice of surgery, 28e pg 410, 411.

SRB’s Manual of Surgery 6e, pg 345

https://www.ncbi.nlm.nih.gov/books/NBK549898/

↑ *Back to this question in Part A*

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Q5: A 22-year-old male presents with pain in the jaw and difficulty opening his mouth after a fall from a bicycle, landing directly on his chin. On examination, there is tenderness at the left preauricular region with limited mouth opening. CT scan confirms an undisplaced fracture of the left mandibular condyle. The patient has no other injuries and is otherwise stable. What is the most appropriate management? (Q849708)

A. Open reduction with internal fixation (ORIF)

B. Observation with a soft diet

C. Intermaxillary fixation (IMF)

D. Surgical excision of the condylar head

Correct Answer: C. Intermaxillary fixation (IMF)

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Most condylar fractures can be treated with closed reduction with intermaxillary fixation (IMF) and a strict soft diet and analgesic regimen. Investigation of mandibular fracture: X-ray of the mandible: Panoramic view Towne view CT head and face. Treatment: Restoration of dental occlusion is the foundation of mandibular fracture management. Condylar fracture: Closed reduction with IMF elastic guidance and a strict soft diet and analgesic regimen . (Option B) Displaced condylar neck fractures with significant loss of mandibular "font-size:11pt; font-variant:normal; white-space:pre-wrap"> ORIF techniques. (Option A) Displaced mandibular fractures: Antibiotics on admission followed by open reduction and internal fixation (ORIF). Severely comminuted fractures and difficult to fx with titanium plates: Intermaxillary fixation (IMF) with wires. Facial bones heal well after about 4 weeks. Surgical excision of the condylar head (Option D) : In condylar hyperplasia condition.



References:

Bailey and Love Short Practice of surgery, 28e, pg 410

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5423793/

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2760163/

↑ *Back to this question in Part A*

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Q6: A 24-year-old male presents to the emergency department after a motorcycle accident. He complains of severe pain in his lower jaw, difficulty closing his mouth properly, and numbness in his lower lip on the right side. Physical examination reveals swelling and tenderness over the right jaw, malocclusion, and a palpable step-off in the premolar region. The paresthesia in the patient's lower lip is most likely due to the involvement of which nerve? (Q849707)

A. Facial nerve

B. Inferior alveolar nerve

C. Mental nerve

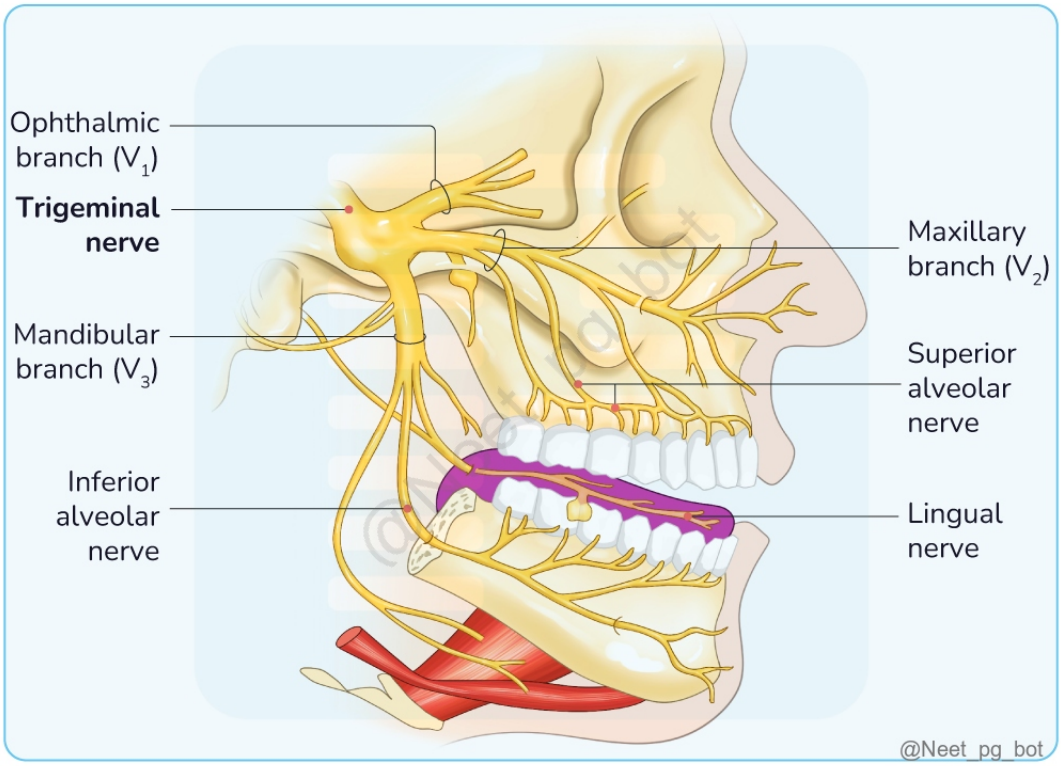
D. Lingual nerve

Correct Answer: B. Inferior alveolar nerve

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The inferior alveolar nerve, a branch of the mandibular nerve (V3), runs through the mandible and provides sensation to the lower teeth and lower lip. A fracture of the mandible can lead to compression or damage to this nerve, resulting in paresthesia in the lower lip. Mandibular fractures often present with several key clinical features, such as: Pain and tenderness: Especially over the site of the fracture. Malocclusion: A feeling that the teeth do not fit together properly due to misalignment of the fracture segments. Swelling and bruising: Over the area of the fracture. Step deformity: A palpable step-off along the jawline where the fracture has occurred. Paresthesia: Numbness or tingling in the lower lip and chin due to injury to the inferior alveolar nerve, which runs through the mandible. Facial nerve (Option A): primarily responsible for facial expression and not sensation in the lower lip. Mental nerve (Option C): a branch of the inferior alveolar nerve that only supplies the chin and lower lip externally. Isolated involvement of this nerve is uncommon in mandibular fractures. Lingual nerve (Option D): provides sensation to the anterior two-thirds of the tongue, not the lower lip or jaw.



References:

Bailey and love short practice of surgery, ed.28, page 410.

↑ *Back to this question in Part A*

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Q7: A 3-month-old female infant presents with feeding difficulties and a noticeable facial deformity. On examination, the infant has a unilateral complete cleft involving the left lip, extending through the alveolus and hard palate, with an intact soft palate on the left side. The right side of the lip and palate are completely intact. What is the LAHSHAL classification for this patient's cleft abnormality? (Q849706)

A. 0000HAL

B. LAH0000

C. LAHS000

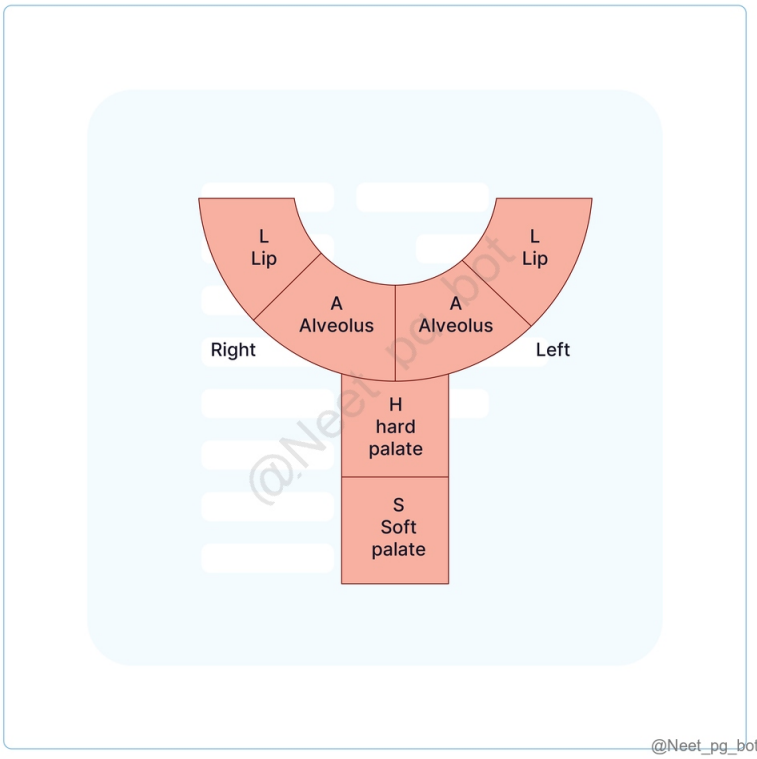
D. LAHSAL

Correct Answer: A. 0000HAL

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Understanding LAHSHAL Classification: LAHSHAL is a system used to describe cleft lip and palate in a topographic and symmetrical manner, from the patient's right to left : Letter Meaning L Lip A Alveolus H Hard palate S Soft palate Capital letter Complete cleft Lowercase letter Incomplete cleft "0" Normal segment So: The first 3 letters (L-A-H) refer to the right side The last 3 letters (H-A-L) refer to the left side Breakdown of the Case: Left side : Lip cleft → L (complete, hence capital) Alveolus cleft → A Hard palate cleft → H Soft palate is intact → S = 0 Right side : Everything intact → L-A-H = 0-0-0 Putting this into LAHSHAL: Right side (L-A-H) = 0-0-0 Left side (H-A-L) = H-A-L (from back to front) Final Code (Right to Left) = 0000HAL LAH0000 (Option B): Incorrect, implies cleft on right side. LAHS000 (Option C): Incorrect, implies soft palate cleft on right and lip/alveolus normal. LAHSAL (Option D): Implies bilateral complete cleft (both sides involved).



References:

Bailey and Love, Short Practice of Surgery, 28th Edition, Page 741

↑ *Back to this question in Part A*

@Neet_pg_bot

Q8: A mother brings her apparently normal 20-day-old newborn to the pediatric clinic with a complaint of milk coming through the nasal passages of the baby during feeding. Upon examination, you find the following: This condition is due to the failure

of which of the following processes during embryonic development? (Q849702)

A. Fusion of the maxillary and medial nasal processes

B. Formation of the lateral palatine processes

C. Fusion of the palatal shelves

D. Formation of the primary palate

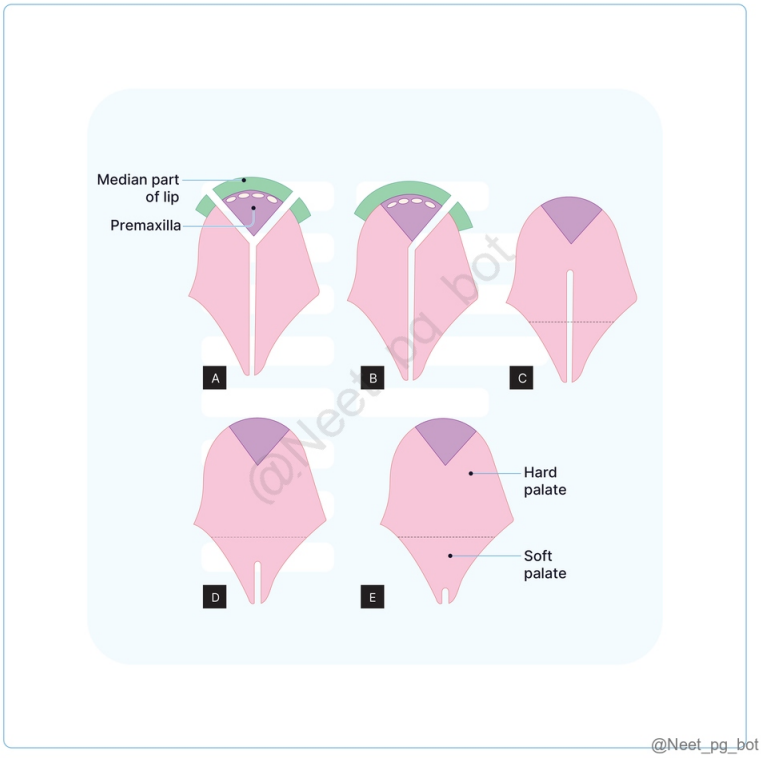


Correct Answer: C. Fusion of the palatal shelves

- *Listen (English)*
- *Listen (Hindi)*

Explanation: Cleft palate occurs when the palatal shelves fail to elevate and fuse properly during embryonic development, typically between the 6th and 9th weeks of gestation. This results in a gap in the palate, allowing communication between the oral and nasal cavities, as evidenced by milk coming through the nasal passages during feeding. Cleft palate: Defective fusion of the various components of the palate gives rise to clefts in the palate. Complete cleft palate: Bilateral complete cleft (A): Failure of fusion of both palatine processes of maxilla with premaxilla. A y-shaped cleft will be present between primary and secondary palate and between the two halves of secondary palate. It presents as a bilateral cleft of the upper lip also. Unilateral complete cleft (B): Nonfusion of one side palatine process of maxilla with premaxilla. It presents as a unilateral cleft of the upper lip. Incomplete cleft palate: Cleft of hard and soft palate(C): Cleft limited to hard palate. Cleft of soft palate (D): Cleft limited to hard palate. Bifid uvula (E): Cleft limited to uvula. Fusion of the maxillary and medial nasal processes (Option A): This contributes to formation of the upper lip and primary palate . Its failure leads to cleft lip , not cleft

palate. Formation of the lateral palatine processes (Option B): While formation is important, fusion failure (not formation) is responsible for the defect in this case. Formation of the primary palate (Option D): The primary palate forms the region anterior to the incisive foramen; its failure causes anterior clefting , not posterior palatal clefts.



References:

Inderbir Singh's Human embryology, 11th edition, pg 161

↑ *Back to this question in Part A*

@Neet_pg_bot

Q9: A 45-year-old male is diagnosed with a mandibular condyle fracture following an assault. The fracture is associated with malocclusion and facial asymmetry. Which of the following is a common post-surgical complication after open reduction and internal fixation (ORIF) of this fracture? (Q849718)

A. Temporomandibular joint ankylosis

B. Persistent pain and facial contour deformities

C. Complete loss of mandibular function

D. Intraoral hemorrhage

Correct Answer: B. Persistent pain and facial contour deformities

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Mandibular condyle fracture following assault is known as Guardsman fracture. Post-surgical complications of ORIF for mandibular condyle fractures often include persistent pain, malocclusion, and facial contour deformities, particularly in cases with multiple fracture sites. Overview of Guardsman Fractures Definition : Guardsman fractures, also known as mandibular condyle fractures, result from trauma like assaults or accidents. Location : These fractures typically occur in the mandibular condyle, the rounded end of the mandible that connects with the temporal bone. Associated Injuries : Often associated with other mandibular fractures; approximately 50% of mandibular injuries involve multiple fracture sites, complicating treatment and recovery. Management Approaches Surgical Intervention : Common Method : Open reduction and internal fixation (ORIF) is the primary treatment to realign and stabilize the fractured segments. Incision Techniques : Retromandibular Incision : Provides access to the fracture site from behind the mandible. Preauricular Incision : Allows access in front of the ear, particularly useful for accessing the condyle. Surgical Tools : Bone clamps and lag screws are typically used during surgery to achieve proper reduction. Complications : Common Issues : Persistent pain, malocclusion (misalignment of teeth), and facial contour deformities. Risk Factors : The presence of multiple fractures increases the risk of complications, making precise surgical planning crucial. Temporomandibular joint ankylosis (Option A) : Although a possible complication of condyle fractures, it is less common than pain and facial deformities following ORIF. Complete loss of mandibular function (Option C) : This is not a typical complication; ORIF aims to restore function rather than cause complete loss. Intraoral hemorrhage (Option D) : While hemorrhage can occur during surgery, it is not a common post-surgical complication specific to ORIF of the mandibular condyle.

References:

https://pubmed.ncbi.nlm.nih.gov/11883964/

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3324216/

↑ *Back to this question in Part A*

@Neet_pg_bot

Q10: All of the following statements are true regarding the management of midface fractures, except? (Q849717)

A. Interdental or intermaxillary fixation is not mandatory

B. Reestablish the proper dentoskeletal relationship

C. Immobilize the fractured bone

D. Ensure normal postoperative occlusion

Correct Answer: A. Interdental or intermaxillary fixation is not mandatory

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Interdental or intermaxillary fixation is mandatory in midface fracture particularly in: Le Fort fractures (I, II, III) - to restore proper occlusion and facial height Displaced maxillary fractures - to maintain reduction during healing Comminuted fractures - provides stability during bone healing Dentoalveolar injuries - to stabilize teeth and alveolar segments Purpose of IMF: Establishes proper dental occlusion as a reference point for reduction Maintains reduction while plates and screws are applied Provides postoperative stability during initial healing (typically 4-6 weeks) Acts as a "skeletal splint" to guide proper anatomical alignment Investigation of mandibular fracture: X-ray of the mandible: Panoramic view Towne view CT head and face. Treatment: Restoration of dental occlusion is the foundation of mandibular fracture management. Condylar fracture: Closed reduction with IMF elastic guidance and a strict soft diet and analgesic regimen . Displaced condylar neck fractures with significant loss of mandibular; white-space:pre-wrap"> ORIF techniques. Displaced mandibular fractures: Antibiotics on admission followed by open reduction and internal fixation (ORIF). Severely comminuted fractures and difficult to fix with titanium plates: Intermaxillary fixation (IMF) with wires. Facial bones heal well after about 4 weeks. Reestablish the proper dentoskeletal relationship (Option B): Primary goal of midface fracture treatment Restoration of occlusion, facial width, facial height, facial projection Immobilize the fractured bone (Option C): Essential principle of fracture management Achieved through: rigid internal fixation, intermaxillary fixation, external fixation Ensure normal postoperative occlusion (Option D): Critical endpoint to assess successful treatment



References:

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5423805/

https://www.sciencedirect.com/topics/medicine-and-dentistry/midface-fracture

↑ *Back to this question in Part A*

@Neet_pg_bot

Q11: A 3-month-old infant presents to the pediatric clinic with feeding difficulties and nasal regurgitation. On examination, the infant has a cleft involving only the soft palate. There are no other abnormalities or syndromic features observed. When should surgery be planned for this infant with a cleft of only the soft palate? (Q849705)

A. At birth

B. At 6 months

C. After 1 year

D. After 5 years

Correct Answer: B. At 6 months

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Surgery for a cleft of only the soft palate is ideally performed at around 6 months of age. This timing is crucial for optimal speech development and to minimize feeding difficulties, allowing the child to grow and develop normally. Management of cleft lip and cleft palate: Surgical principles: Cleft lip repair: reconnects the muscles around the oral sphincter. Cleft palate repair: anatomically closes the defect, facilitates speech development, minimizes maxillary growth difference and dentoalveolar deformities. Two-stage procedures may be used to minimize dissection. Secondary management (Post op): involves regular review by a multidisciplinary team for hearing, speech, dental development, and facial growth assessment. Surgical techniques: Cleft lip repair Cleft palate repair Millard rotation advancement technique(most widely used) Bardach's Method Le Mesurier's Von Langenbeck Method (bipedicled) Thompson Wardill-Kilner Method/ V-Y plasty (unipedicled) Tennison-Randall Timing of Repair: Cleft lip Unilateral 5-6 months Bilateral 4-5 months Cleft palate Soft palate only 6 months Hard palate only 15-18 months Both soft and hard palate 2 staged Soft palate - 6 months Hard palate - 15-18 months Cleft lip and palate Unilateral 2 staged Cleft lip and soft palate - 5-6 months Hard palate - 15-18 months Bilateral 2 staged Cleft lip and soft palate - 4-5 months Hard palate - 15-18 months

References:

Bailey and love short practice of surgery, ed.28, page 745.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q12: A 2-day-old male infant is born with a unilateral cleft lip and palate. He is the first child of healthy, non-consanguineous parents with no significant family history. On physical examination, the infant has a noticeable cleft lip and palate. No other obvious abnormalities are noted. You suspect a syndromic association. Which of the following is the most common syndrome associated with cleft lip? (Q849704)

A. Van der Woude syndrome

B. Pierre Robin sequence

C. Treacher Collins syndrome

D. DiGeorge syndrome

Correct Answer: A. Van der Woude syndrome

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Van der Woude syndrome is the most common syndrome associated with cleft lip and/or cleft palate. It is an autosomal dominant disorder characterized by the presence of cleft lip, cleft palate, and lip pits. It is due to mutations in Interferon Regulatory Factor 6 [IRF6]. Cleft Abnormalities: Cleft Lip (CL): Occurs when the maxillary prominence fails to fuse with the intermaxillary segment (merged medial nasal prominences) during the 6th week of gestation. Cleft Palate (CP): Occurs when the palatal shelves (lateral maxillary processes) fail to fuse with each other or with the primary palate/nasal septum during the 7th to 12th weeks Lip Pits: Occur when the persistent lateral grooves of the mandibular process fail to disappear during the 6th week of gestation, resulting in permanent invaginations (depressions) of the lower lip. Other syndromes associated with cleft abnormalities: 1 . Pierre Robin Sequence (Option B) Mechanism: Failure of the mandible to grow normally in utero (<11 weeks) prevents the tongue from descending. The high-positioned tongue then physically blocks the palatal shelves from fusing. The Triad: Micrognathia: A small, recessed lower jaw. Glossoptosis: Posteriors displacement of the tongue into the pharynx. U-shaped Cleft Palate: A wider, rounded cleft (unlike the V-shape in non-syndromic cases). Primary Concern: Upper airway obstruction and feeding difficulties. Infants often need to be placed in a prone (face down) position to keep the tongue forward. 2. Treacher Collins Syndrome (Option C) (Mandibulofacial Dysostosis): Also known as Mandibulofacial Dysostosis , this condition affects the development of the first and second branchial arches. Genetics: Typically autosomal dominant (TCOF1 gene). Craniofacial Features: Malar hypoplasia: Underdeveloped cheekbones and infraorbital ridges. Down-slanting palpebral fissures: Eyes slant downward. Colobomas: Notches in the lower eyelids. Ear Anomalies: Microtia (small ears) or atresia of the external auditory canal, leading to conductive hearing loss. Clefting: Cleft palate occurs in about 30% of cases. Cleft lip is rare. 3. DiGeorge Syndrome (Option D) (22q11.2 Deletion Syndrome): This is the most common microdeletion syndrome in humans and has a highly variable presentation (Velocardiofacial Syndrome). The "CATCH-22" Mnemonic: C: Cardiac defects (notably Tetralogy of Fallot or Interrupted Aortic Arch). A: Abnormal facies (long face, bulbous nose tip). T: Thymic hypoplasia (leading to T-cell deficiency). C: Cleft palate (specifically submucous cleft palate or Velopharyngeal Insufficiency). H: Hypocalcemia (due to hypoparathyroidism). Speech: These patients often have "hypernasal" speech even if a visible cleft is not present, due to muscle dysfunction in the soft palate. 4. Apert Syndrome: Apert is one of the craniosynostosis syndromes, where the skull sutures fuse prematurely. Genetics: Autosomal dominant (FGFR2 gene). Key Features:

Craniosynostosis: Usually the coronal suture, resulting in a tall, flattened forehead (turribrachycephaly). Midface Hypoplasia: The middle of the face appears "sunken," leading to bulging eyes (proptosis). Syndactyly: "Mitten-like" webbing of the fingers and toes is a hallmark. Clefting: Approximately 75% of patients have a high-arched or cleft palate. The palate often contains thick lateral swellings due to an accumulation of acid mucopolysaccharides. 5. Stickler Syndrome: Stickler syndrome is a progressive connective tissue disorder and is the most common identifiable cause of Pierre Robin Sequence. Genetics: Mutations in collagen genes (COL2A1, COL11A1). Key Features: Ocular: Severe myopia (nearsightedness), cataracts, and high risk for retinal detachment . Auditory: Sensorineural hearing loss. Joints: Early-onset osteoarthritis and joint hypermobility. Clefting: Highly associated with cleft palate and the Pierre Robin triad.

References:

Bailey and Love short practice of surgery, ed. 28, page 741, 742.

Langman’s medical embryology,ed.14, page 307.

↑ *Back to this question in Part A*

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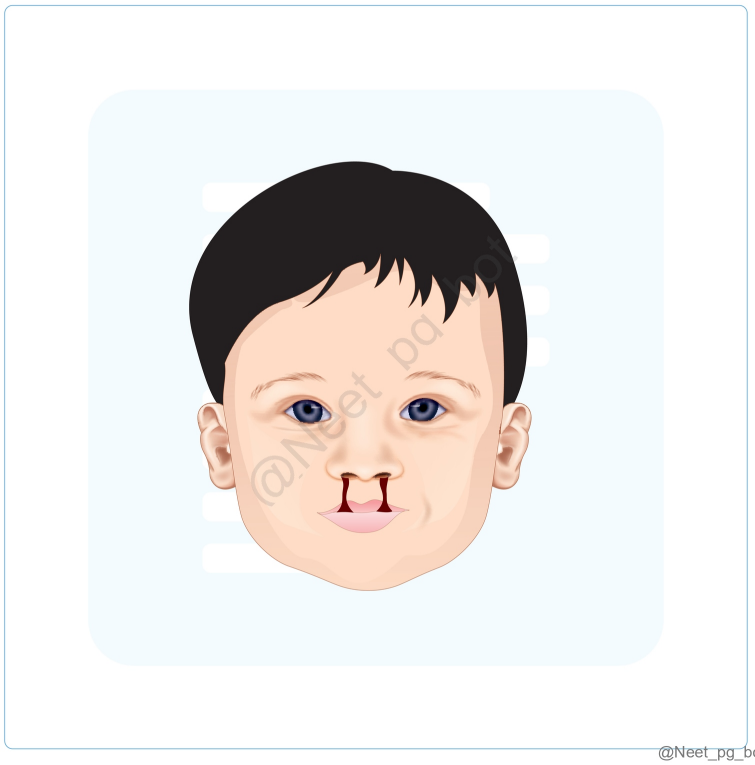
Q13: A 3-day-old male neonate is brought to you by his parents, concerned about the appearance of his face. On examination, the neonate has the appearance as shown in the image. Which of the following embryological events is most likely responsible for this defect? (Q849703)

A. Failure of fusion between the lateral palatine processes and nasal septum.

B. Non-fusion of the maxillary prominences and medial nasal prominences.

C. Incomplete fusion of the mandibular prominences.

D. Non-fusion of the lateral nasal prominences and the medial nasal prominences.



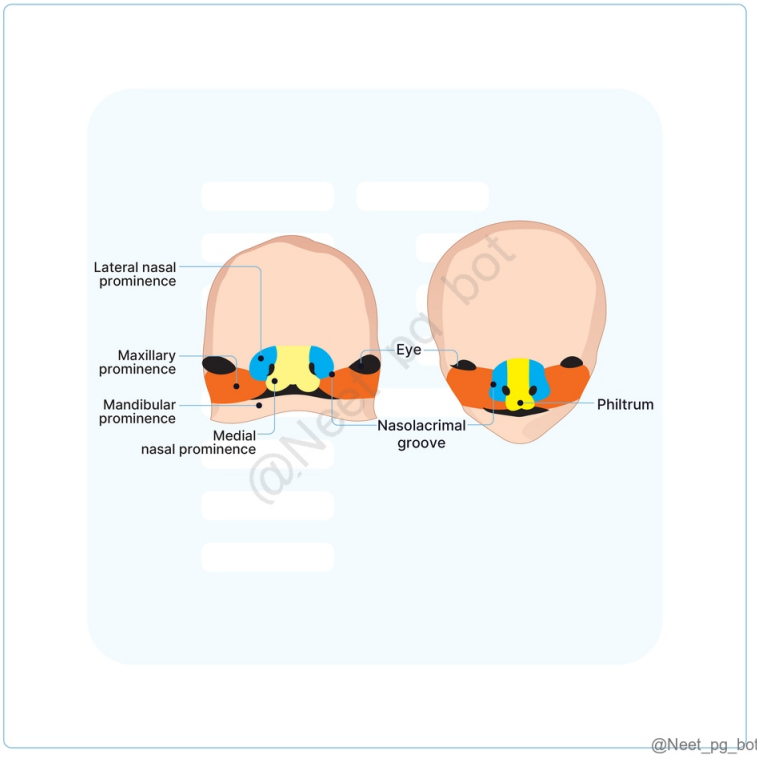
Correct Answer: B. Non-fusion of the maxillary prominences and medial nasal prominences.

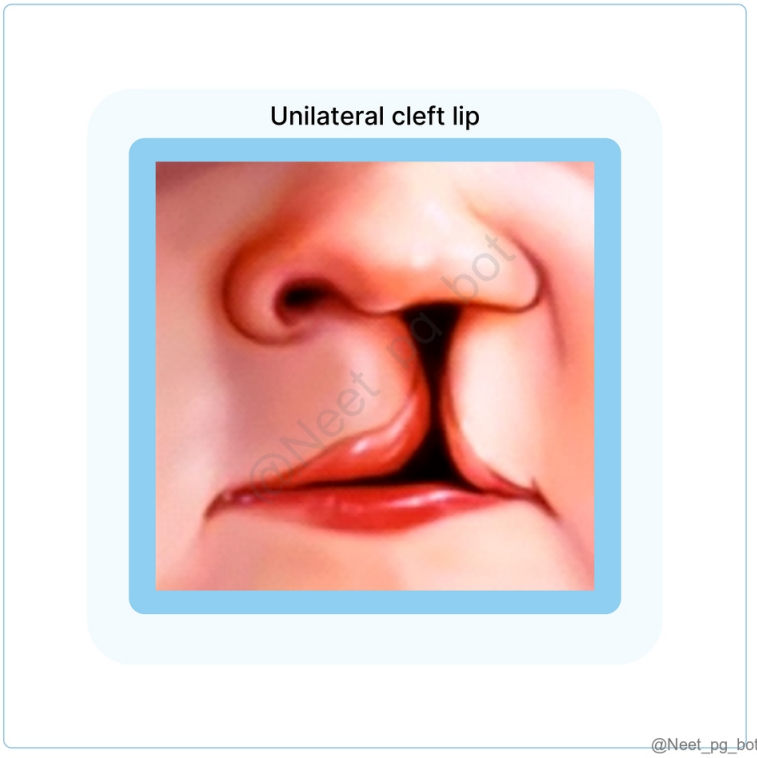
■ *Listen (English)*

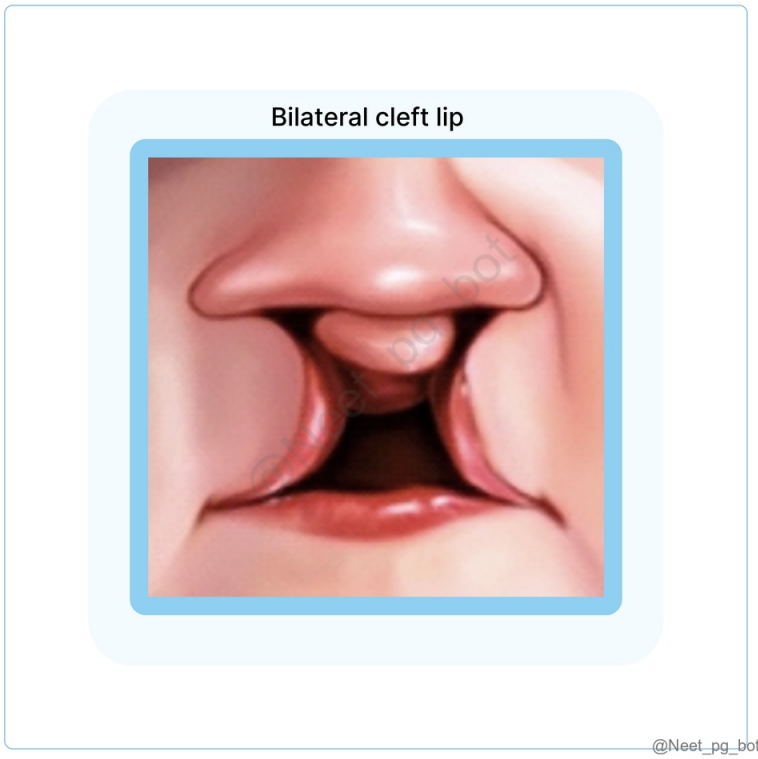
■ *Listen (Hindi)*

Explanation: Failure of fusion of both maxillary processes with the medial nasal process results in bilateral cleft lip. Development of The Lip: The upper lip is formed by the two medial nasal prominences and the two maxillary prominences. The lateral nasal prominences do not participate in formation of the upper lip. The lower lip and jaw form from the mandibular prominences that merge across the midline. Cleft lip/ Harelip: Cleft lip and/or palate is the most common congenital abnormality affecting the orofacial region. The upper lip of the hare normally has a cleft. Hence, the term harelip is used for defects of the lips . Unilateral harelip: failure of fusion of maxillary process with medial nasal process on one side. Bilateral harelip: failure of fusion of both maxillary processes with the medial nasal process. Clinical features: Bilateral Presentation: Unlike unilateral clefts, the bilateral version often results in the prolabium (the central part of the lip) and the premaxilla (the central tooth-bearing bone) being displaced forward (protrusion). Nasal Deformity: The nose typically appears flattened with widened nostrils and a shortened columella (the tissue between the nostrils). Feeding Difficulty: Inability to create a seal around a nipple, leading to poor suction and excessive air swallowing. Dental Issues: Misalignment or absence of the maxillary incisors is common as the cleft disrupts the dental lamina. Management: Phase Timing Intervention Neonatal Birth–1 Month Feeding Support: Use of Haberman feeders or obturators; Nasoalveolar Molding (NAM) to align segments. Surgical (Lip) 3–6 Months Cheiloplasty: Surgical repair of the lip (Rule of 10s: 10 weeks old, 10 lbs, 10g hemoglobin). Surgical (Palate) 9–18 Months Palatoplasty: Closure of the palate to allow for normal speech development. Middle Childhood 6–10 Years Speech Therapy & Audiology: Management of hypernasality and "glue ear" (tympanostomy tubes). Adolescence 8–12 Years Alveolar Bone Graft: Using hip bone to fill the gap in the gum line before permanent canines erupt. Final Phase 16–18 Years Orthognathic Surgery & Rhinoplasty: Correcting jaw alignment and nasal aesthetics after growth is complete. Failure of fusion between the lateral

palatine processes and nasal septum (Option A) results in cleft palate . Incomplete fusion of the mandibular prominences (Option C) results in cleft of lower lip. Non-fusion of the lateral nasal prominences and the medial nasal prominences (Option D) results in oblique facial cleft.







References:

Bailey and Love short practice of surgery, ed 28, page 740.

Inderbir Singh Human embryology, ed.11, page 157.

↑ *Back to this question in Part A*

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Q14: A 60-year-old patient is found to have a carotid body tumor that completely encases the carotid vessels, posing significant surgical challenges. According to the Shamblin classification system, what type of tumor does this describe? (Q849620)

A. Type I

B. Type II

C. Type III

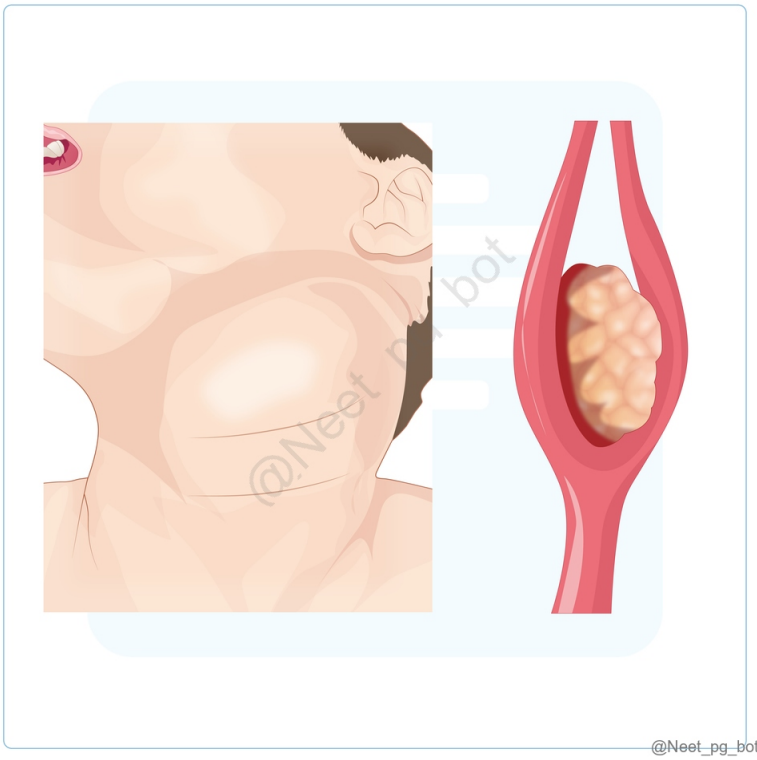
D. Cannot be determined.

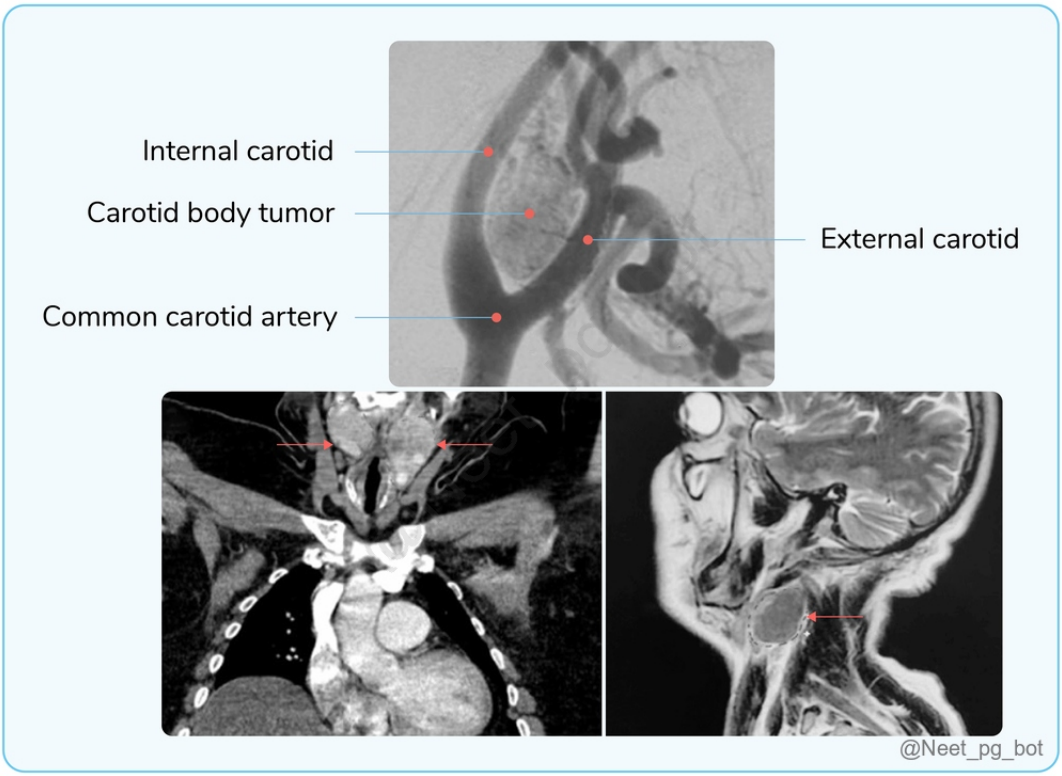
Correct Answer: C. Type III

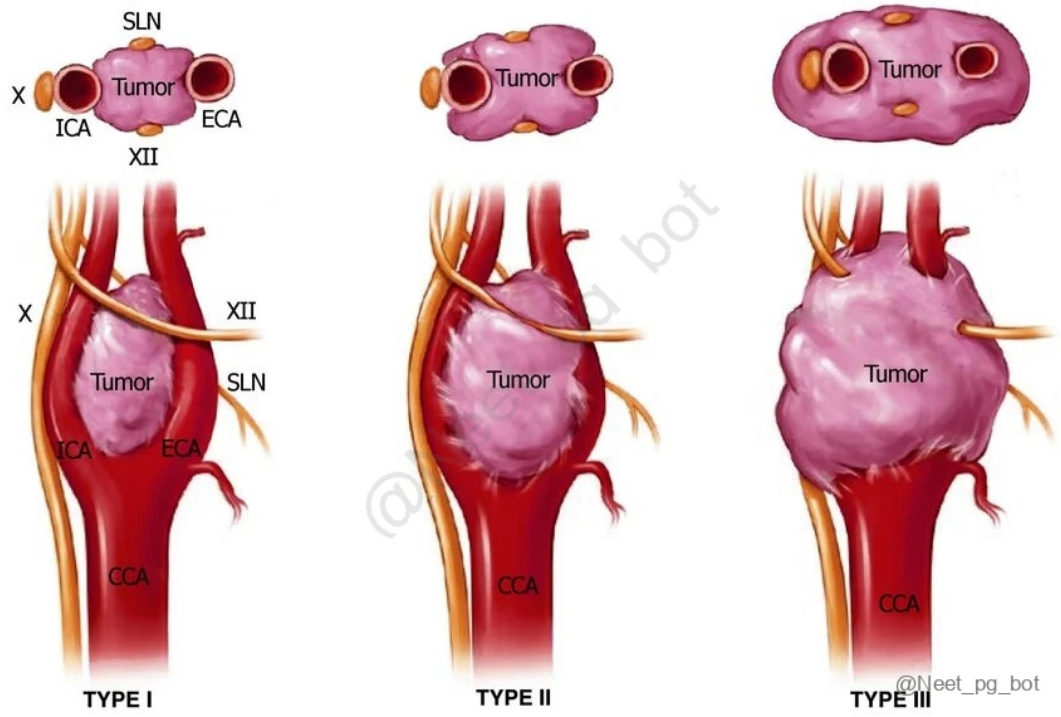
■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Type III completely encases the carotid vessels, making surgical resection more challenging. CAROTID BODY TUMOR: Carotid body tumor Details Origin Chemoreceptor cells at the carotid body (carotid bifurcation) Clinical Presentation Slow-growing, painless mass at carotid bifurcation Often pharyngeal mass Firm, rubbery, pulsatile, side-to-side mobility Bruit possible Avoid oral cavity biopsy for para pharyngeal swellings Usually benign; metastases are rare Diagnostic Tools Carotid Angiogram : Visualizes splayed bifurcation and outlines blood vessels MRI: Provides detailed anatomical information Contraindications: Biopsy and fine-needle aspiration (risk of bleeding) Shamblin Classification: Type I: Localized tumor. It involves less than 180° of the vessel circumference. These are easily dissected from the vessels. Type II: Adherent tumor. It surrounds the vessel by more than 180° . These are more difficult to separate and require careful sub-adventitial dissection. Type III: Enclosing tumor. It completely encases (360°) the carotid vessels and bifurcation. These are the most challenging and often require arterial resection and reconstruction.







References:

Bailey and Love short practice of surgery, Edition 28, Pg 809. 810

↑ *Back to this question in Part A*

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Q15: The intermaxillary segment gives rise to all of the following structures EXCEPT: (Q849701)

A. Philtrum of the lip

B. Primary palate

C. Secondary palate

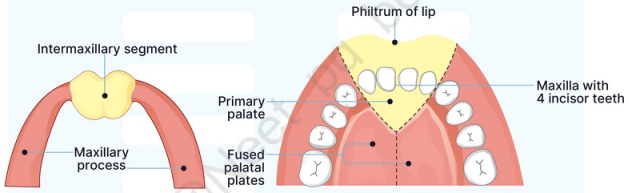
D. Four incisor teeth

Correct Answer: C. Secondary palate

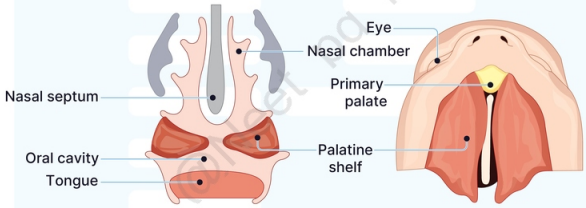
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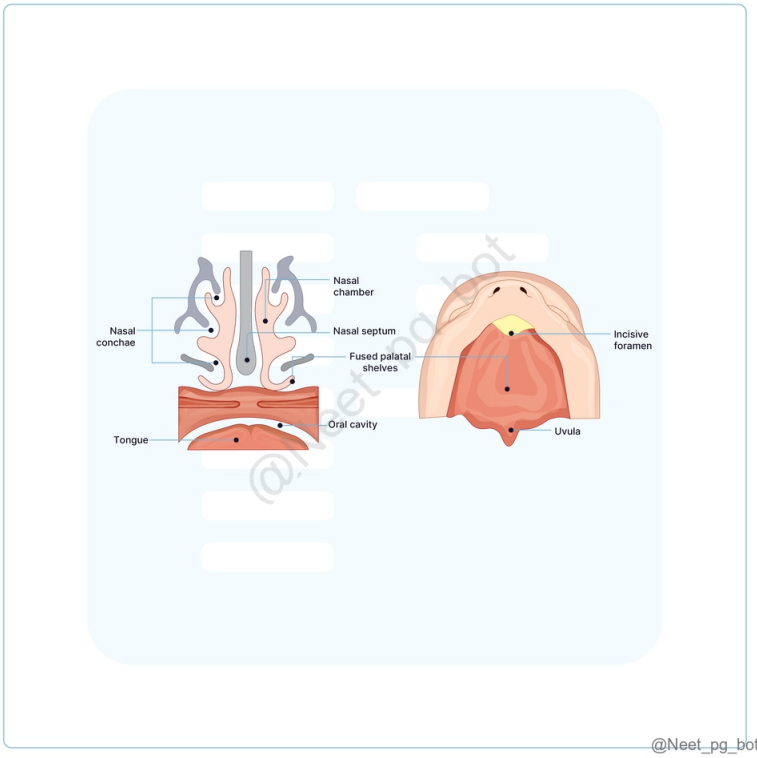
Explanation: The intermaxillary segment gives rise to the philtrum of the lip, four incisor teeth, and the primary palate. Development of the Lip and the Palate: The Lip: The upper lip is formed by the two medial nasal prominences and the two maxillary prominences. The lateral nasal prominences do not participate in formation of the upper lip. The lower lip and jaw form from the mandibular prominences that merge across the midline. The Palate: Intermaxillary Segment: Formation: Merging of the two medial nasal prominences, both at the surface and at a deeper level, due to the medial growth of the maxillary prominences. Components: Labial Component: Forms the philtrum of the upper lip. Upper Jaw Component: Contains the four incisor teeth. Palatal Component: Develops into the triangular primary palate. Secondary Palate: Origin: The secondary palate is primarily formed by two shelflike outgrowths, known as palatine shelves, from the maxillary prominences. Fusion: The palatine shelves fuse anteriorly with the triangular primary palate. The incisive foramen serves as the midline landmark between the primary and secondary



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References:

Langman's Medical embryology, edition14 , page 304.

↑ *Back to this question in Part A*

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Q16: Match the structures formed in Column II with the corresponding prominence in Column I: Column I Column II A. Lateral Nasal Prominence 1. Lower lip B. Maxillary Prominence 2. Philtrum of upper lip, crest, and tip of nose C. Medial Nasal Prominence 3. Cheeks, lateral portion of upper lip D. Mandibular Prominence 4. Alae of nose (Q849700)

A. A-2, B-1, C-3, D-2

B. A-4, B-1, C-3, D-2

C. A-2, B-3, C-4, D-1

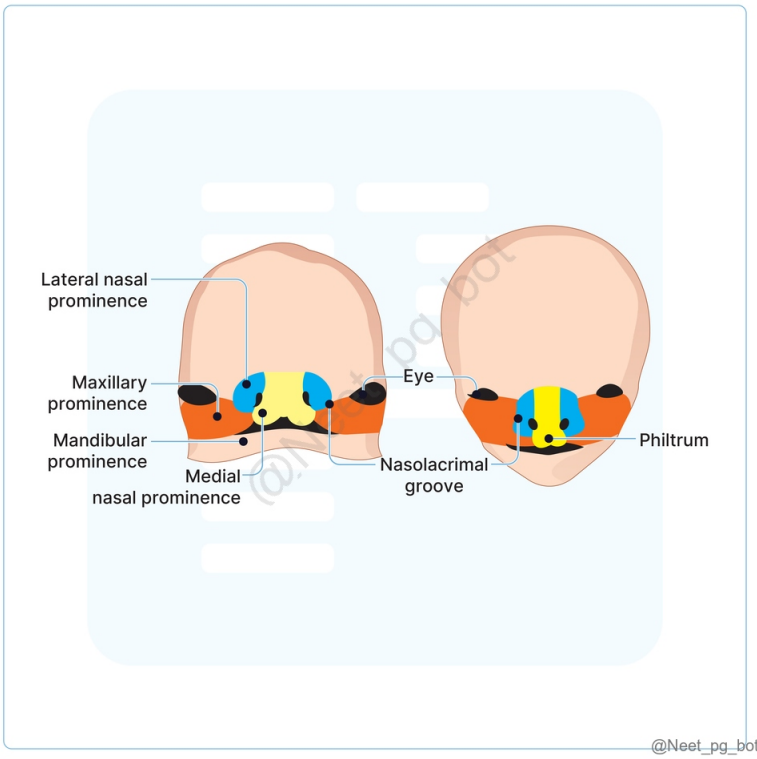
D. A-4, B-3, C-2, D-1

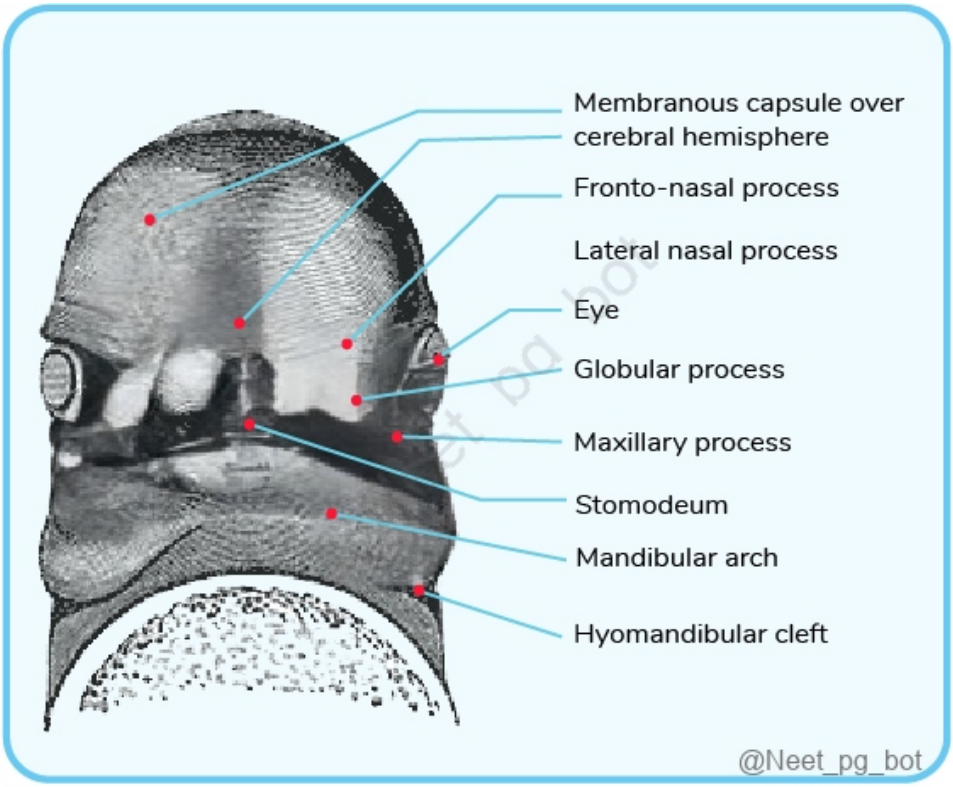
Correct Answer: D. A-4, B-3, C-2, D-1

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Structures contributing to the development of the face: Prominence Structures Formed Frontonasal Forehead, bridge of nose, and medial and lateral nasal prominences. Maxillary Cheekst, lateral portion of upper lip. Medial nasal Philtrum of upper lip, crest and tip of nose. Lateral nasal Alae of nose. Mandibular Lower lip. Frontonasal prominence is a single unpaired structure. The other prominences are paired.





References:

Langman’s medical embryology, ed 14, page 303 Image: Langman's medical embryology, ed.14, book page 303

↑ *Back to this question in Part A*

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Q17: A 55-year-old male patient with squamous cell carcinoma of the oral cavity undergoes a right radical neck dissection. Three days postoperatively, the patient complains of shoulder weakness and difficulty in lifting his right arm above his shoulder. On physical examination, he has a limited range of motion in the right shoulder and exhibits winging of the scapula on the right side. What is the most likely nerve injured during the neck dissection that could explain this patient’s symptoms? (Q849699)

A. Accessory nerve (CN XI)

B. Phrenic nerve

C. Cervical sympathetic chain

D. Hypoglossal nerve (CN XII)

Correct Answer: A. Accessory nerve (CN XI)

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The accessory nerve (cranial nerve XI) innervates the sternocleidomastoid and trapezius muscles. Injury to this nerve during a neck dissection can result in weakness of the trapezius muscle, leading to shoulder weakness , difficulty in lifting the arm above the shoulder , and winging of the scapula. Complications of Neck Dissection: 1. Nerve Injuries: Accessory nerve (CN XI) : (Option A) Shoulder weakness Difficulty lifting the arm above the shoulder Winging of the scapula Marginal mandibular nerve (branch of facial nerve): Asymmetrical smile due to drooping of the corner of the mouth Difficulty in controlling lower lip movements Hypoglossal nerve (CN XII) : (Option D) Tongue deviation towards the injured side Difficulty in speech and swallowing Phrenic nerve (Option B): Diaphragmatic paralysis leading to respiratory difficulties Vagus nerve (CN X): Hoarseness of voice Dysphagia Aspiration due to vocal cord paralysis Cervical sympathetic chain: (Option C ruled out) Horner's syndrome (ptosis, miosis, anhidrosis) 2. Vascular Complications: Hemorrhage: Hematoma: Chyle leak: Injury to the thoracic duct or lymphatic vessels Carotid artery rupture 3. Wound Complications: Infection Wound dehiscence Flap necrosis Seroma

References:

SRB's Manual of Surgery, edition 6, page 441

↑ *Back to this question in Part A*

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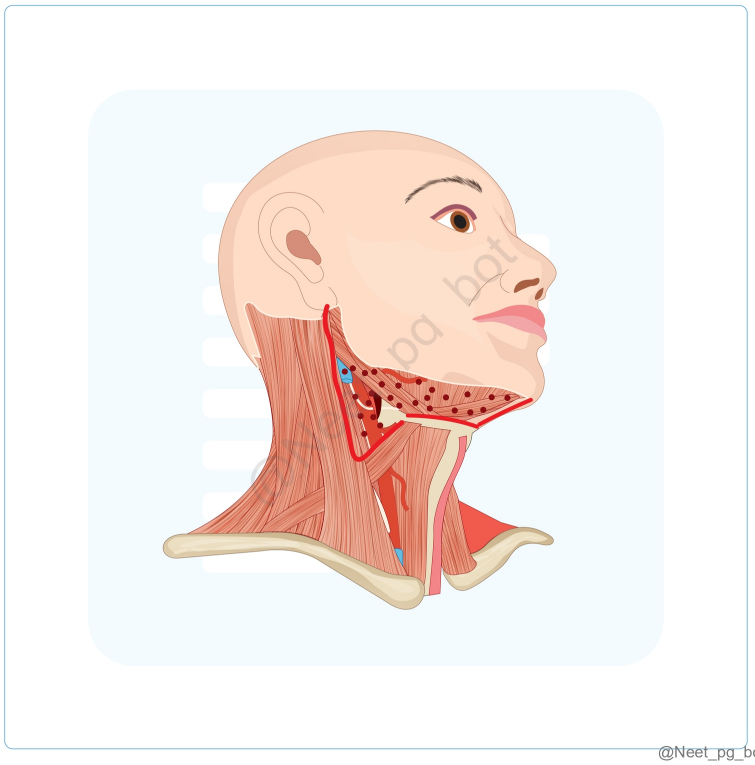
Q18: A 60-year-old male patient presents to the clinic with a non-healing ulcer on the left lateral border of the tongue. Upon examination, the lesion measures 2 cm and has been present for 6 weeks and there is a palpable lymph node in the left submandibular region. After evaluation, the surgeon decides to perform a neck dissection. The image below depicts the lymph nodes to be removed during the procedure. What type of neck dissection is planned for this patient? (Q849698)

A. Radical neck dissection

B. Modified radical neck dissection

C. Supraomohyoid neck dissection

D. Extended supraomohyoid neck dissection

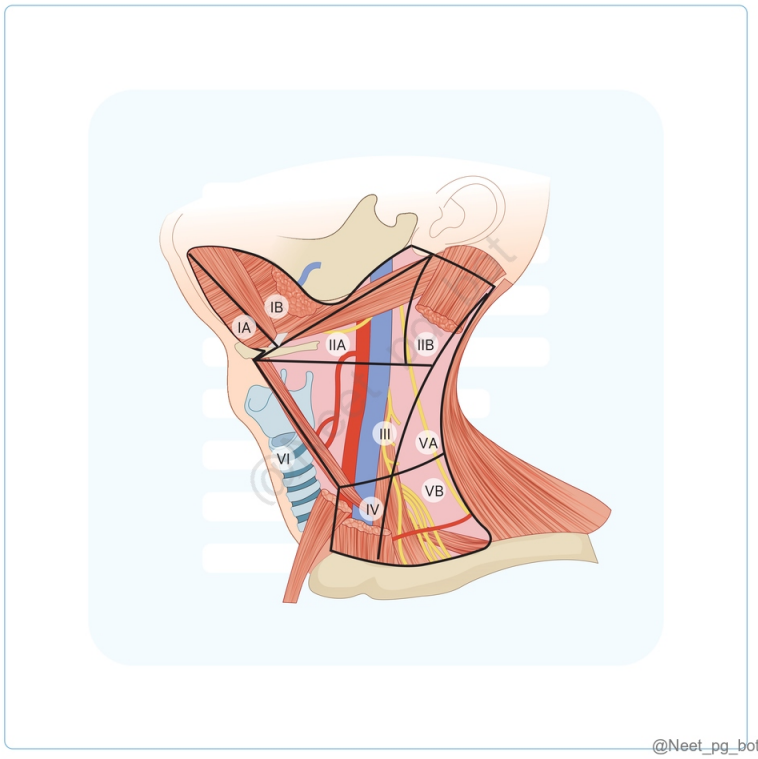


Correct Answer: C. Supraomohyoid neck dissection

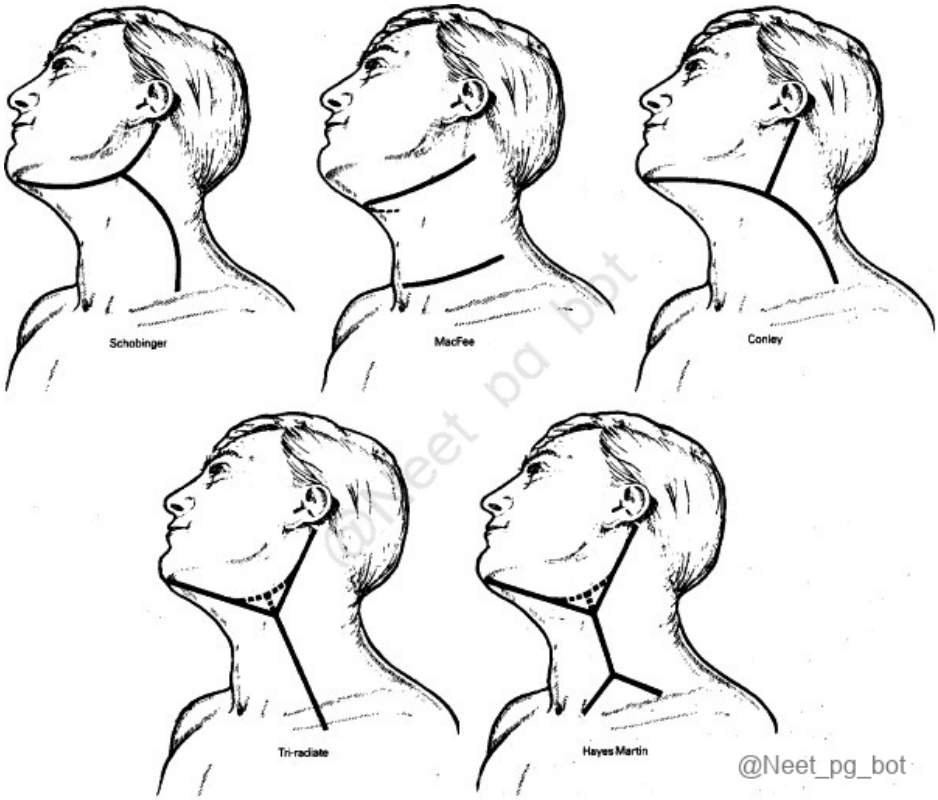
■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The image shows removal of lymph nodes at levels I, II, and III (submental, submandibular, and upper jugular nodes). This procedure is commonly used in cases with early-stage oral cavity cancers with limited nodal involvement and is known as supraomohyoid neck dissection. Levels of Neck nodes Types of Neck Dissections: Dissection LN removed Other structures removed/Preserved Radical Neck Dissection (Option A) I - V CN XI, IJV, and SCM removed Modified Radical Neck Dissection (MRND) I (Option B) I - V CN XI preserved MRND II I - V CN XI, IJV preserved MRND III I - V CN XI, IJV, SCM preserved Extended Neck Dissection I - V CN XI, IJV, SCM removed + one/more LN groups +/- Non lymphatic structures Selective Neck Dissections LN removed Primary site of cancer Supra-omohyoid I - III Oral cavity Extended Supra-omohyoid (Option D) I - IV Oral cavity and oropharynx Postero-Lateral II - V Skin over the posterior scalp and upper neck Lateral II - IV Oropharynx, Hypopharynx, Larynx Anterior/ Central VI Thyroid/ Midline structures Surgical Incisions for Neck Dissections: 1. Schobinger Shape: Large "Y" or "7" (Horizontal limb + Vertical limb). Use: Classic Radical Neck Dissection. Cons: High risk of skin flap necrosis at the "triple point" (junction). 2. MacFee Shape: Two Parallel Horizontal incisions. Use: Patients with previous Radiation . Pros: Best blood supply; protects the carotid artery. Cons: Harder to perform (requires "tunneling"). 3. Conley Shape: Modified Schobinger with a Posterior vertical limb. Use: Better access to the back of the neck. Pros: Moves the scar away from the carotid artery for safety. 4. Tri-radiate Shape: Three limbs meeting in a Central Point . Use: Quick access for large dissections. Cons: High risk of the central tip dying (necrosis); rarely used now. 5. Hayes Martin Shape: Double "Y" configuration. Use: Maximum exposure for very extensive tumors. Cons: Complex scarring and high risk of wound breakdown.



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References:

Bailey and Love short practice of surgery, 28th Edition, Page 821.

↑ *Back to this question in Part A*

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Q19: Which lymph node level in the neck is primarily responsible for draining the thyroid gland? (Q849627)

A. Level Ib

B. Level IIa

C. Level VI

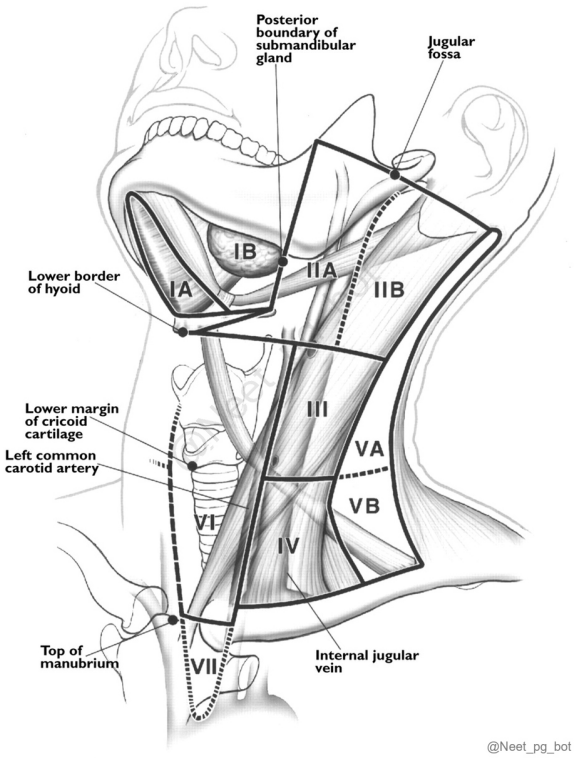
D. Level III

Correct Answer: C. Level VI

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Level VI , also known as the Anterior (Central) Compartment , is primarily responsible for draining the thyroid gland . Lymph Node Level Location Structures Drained Level I Submental and Submandibular Level Ia - Under the chin, between the anterior bellies of the digastric Lower lip, floor of the mouth, tip of the tongue Level Ib Between the mandible and the digastric muscle Upper lip, lateral lower lip, oral cavity, anterior tongue, submandibular gland Level II Upper Jugular (Deep Cervical) Level IIa Upper internal jugular vein, anterior to spinal accessory nerve Oropharynx, nasopharynx, parotid gland, auricle, adjacent scalp Level IIb - Posterior to spinal accessory nerve Similar to Level IIa Level III Middle Jugular (Deep Cervical) Middle third of internal jugular vein, between hyoid bone and cricoid cartilage Level IV Lower Jugular (Deep Cervical) Lower third of internal jugular vein, from cricoid cartilage to clavicle Level V Posterior Triangle Group Level Va - Posterior to SCM, above the cricoid cartilage Nasopharynx, scalp, supraclavicular fossa Level Vb - Posterior to SCM, below the cricoid cartilage Thyroid gland, hypopharynx, esophagus Level VI Anterior (Central) Compartment Between the carotid arteries, from hyoid bone to suprasternal notch Level VII Superior Mediastinal Below the suprasternal notch, in the superior mediastinum



References:

Gray's Anatomy: The Anatomical Basis of Clinical Practice, 42nd Edition, Page 550

↑ *Back to this question in Part A*

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Q20: Which of the following nerves is most likely to be injured during surgery in the posterior triangle of the neck, potentially leading to weakness in shoulder elevation? (Q849626)

A. Hypoglossal Nerve (CN XII)

B. Vagus Nerve (CN X)

C. Phrenic Nerve

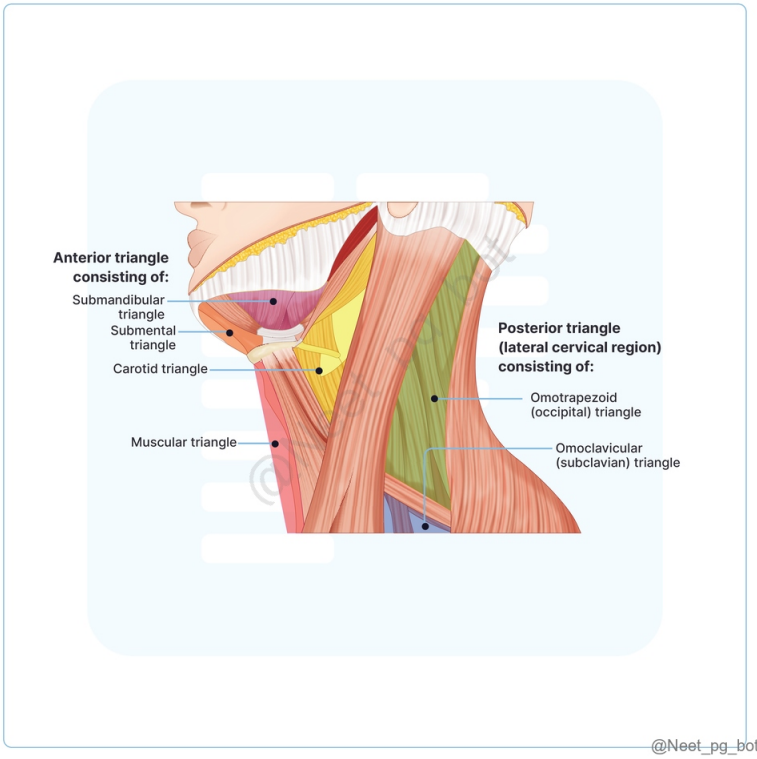
D. Spinal Accessory Nerve (CN XI)

Correct Answer: D. Spinal Accessory Nerve (CN XI)

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The Spinal Accessory Nerve (CN XI) is most likely to be injured during surgery in the Posterior Triangle of the neck. Injury to the spinal accessory nerve can lead to weakness in shoulder elevation and difficulty with scapular movements because the trapezius muscle is affected. The Hypoglossal Nerve (Option A) is found in the carotid triangle, primarily controlling tongue movements. The Vagus Nerve (Option B) runs within the carotid sheath in the carotid triangle. The Phrenic Nerve (Option C) runs along the anterior scalene muscle and is more associated with the lower neck and thoracic region, controlling the diaphragm. Triangles of Neck: Anterior Triangle Triangle Boundaries Contents Submental Triangle Hyoid bone Anterior bellies of the digastric muscles Submental lymph nodes Submandibular Triangle Mandible Anterior and posterior bellies of the digastric muscle Submandibular gland, lymph nodes Carotid Triangle SCM Superior belly of the omohyoid muscle Posterior belly of the digastric muscle Common carotid artery (bifurcation into internal and external carotid arteries) Muscular Triangle SCM Superior belly of the omohyoid Midline of the neck Infrahyoid muscles Triangle Boundaries Contents Posterior Triangle Occipital Triangle SCM Trapezius Inferior belly of omohyoid Spinal accessory nerve (CN XI), brachial plexus trunks, cervical plexus Supraclavicular (Subclavian) Triangle Clavicle SCM Inferior belly of omohyoid Subclavian artery and vein, external jugular vein, supraclavicular lymph nodes



References:

Grey’s Anatomy 42e page 555, 556

↑ *Back to this question in Part A*

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Q21: Which of the following conditions is most commonly associated with a cervical rib? (Q849625)

A. Rotator Cuff Tear

B. Cervical Spondylosis

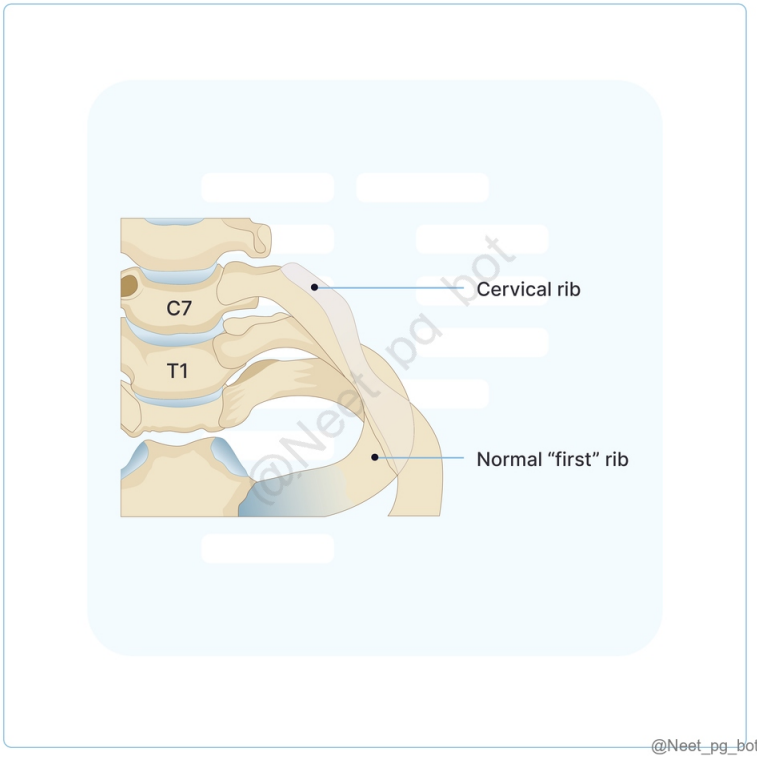
C. Thoracic Outlet Syndrome

D. Pancoast’s syndrome

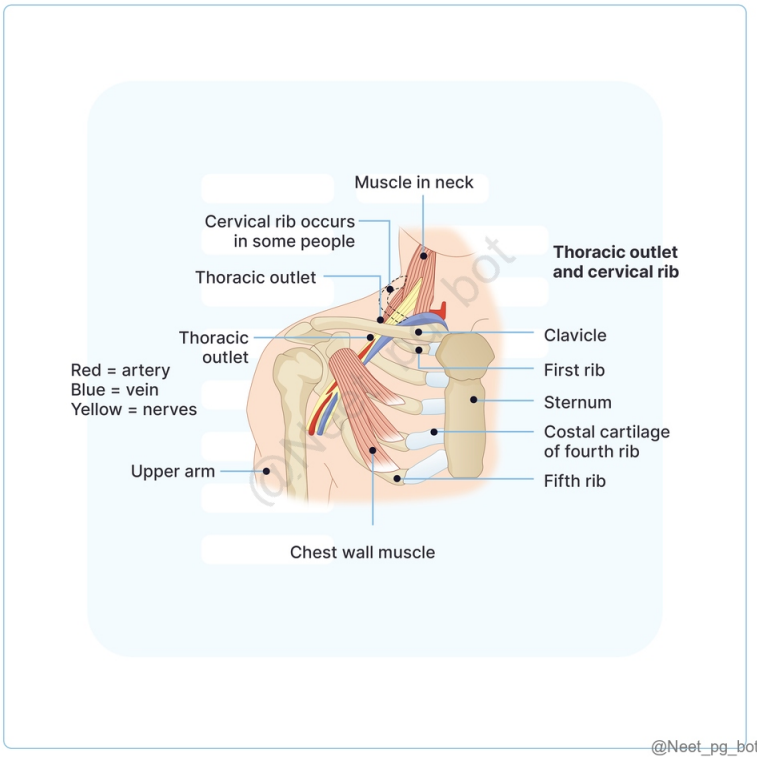
Correct Answer: C. Thoracic Outlet Syndrome

- *Listen (English)*
- *Listen (Hindi)*

Explanation: Thoracic Outlet Syndrome (TOS) is the condition most commonly associated with a cervical rib. Definition : A cervical rib is an extra rib that arises from the seventh cervical vertebra (C7), located above the first rib. Cervical ribs can be present on one side (unilateral) or both sides (bilateral) of the body. Prevalence : It is a congenital anomaly present in about 0.5% to 1% of the population. Symptoms : Many individuals are asymptomatic. When symptoms occur, they may include neck pain, shoulder pain, or numbness/tingling in the arm and hand, supplied by segment T1. Symptoms arise due to compression of nearby structures such as nerves (e.g., brachial plexus) or blood vessels (e.g., subclavian artery), leading to conditions like Thoracic Outlet Syndrome (TOS) , common condition associated with a cervical rib, resulting from compression of neurovascular structures. Diagnosis : Typically diagnosed via imaging studies such as X-ray (neck). Treatment : Mild cases: Sling exercises. Severe cases: Scalenotomy (Resection of scalenus anterior muscles). Troublesome cases: Excision of cervical rib. Types of cervical rib: Complete cervical rib: When it reaches up to the 1 cervical rib. Bulbous end. Tapering end. Fibrous Band: If the end is replaced by a fibrous band. Rotator Cuff Tear (Option A ruled out) : Sometimes cause pain radiating down the arm, and shoulder movement is likely to be abnormal. There are no neurological symptoms . Not associated with cervical rib. Cervical spondylosis (Option B ruled out): It is degenerative arthritis of the spine and rarely involves the T1 nerve root. Not associated with cervical rib. Pancoast’s syndrome (Option D ruled out): It is apical carcinoma of the bronchus invading structures at the root of the neck causing pain, numbness and weakness of the hand. Not associated with cervical rib.



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References:

BD Chaurasia 8e page 215

Bailey and Love short practice of surgery, Ed 28, page 995

Apley and Solomon System of Orthopaedics and trauma, 10e pg 309

↑ *Back to this question in Part A*

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Q22: Which branchial cleft remnant typically passes behind the carotid artery? (Q849624)

A. First branchial cleft remnant

B. Second branchial cleft remnant

C. Third branchial cleft remnant

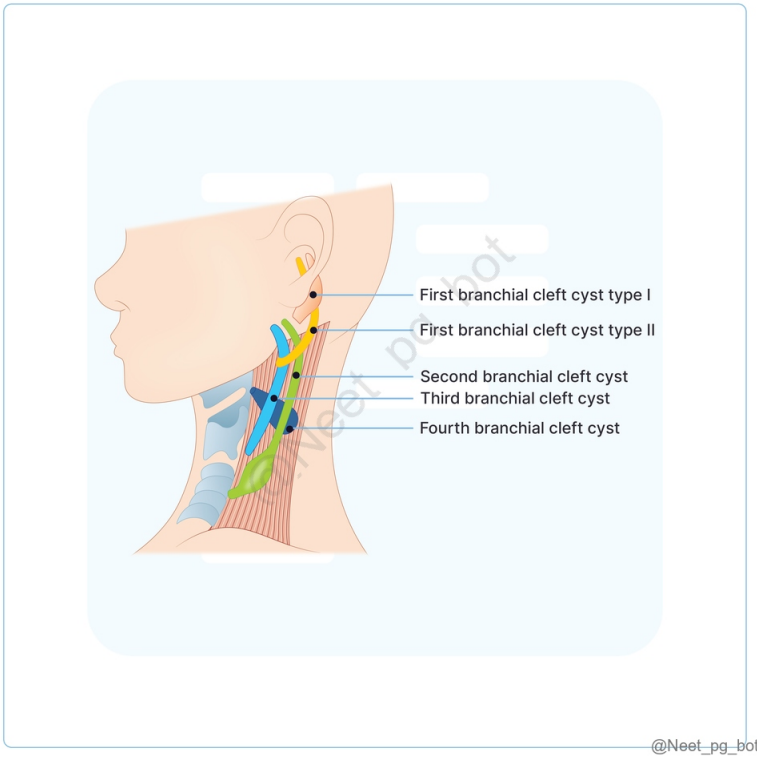
D. Fourth branchial cleft remnant

Correct Answer: C. Third branchial cleft remnant

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The third branchial cleft remnant typically passes behind the carotid artery, often traversing between the glossopharyngeal and vagus nerves. First branchial cleft remnants (Option A) are typically found near the external auditory canal and do not pass behind the carotid artery. Second branchial cleft remnants (Option B) are commonly located along the anterior border of the sternocleidomastoid muscle but do not typically pass behind the carotid artery. Fourth branchial cleft remnants (Option D) are rarer and typically have a different course, often involving the lower neck and potentially the mediastinum, rather than passing behind the carotid artery.



References:

https://www.ncbi.nlm.nih.gov/books/NBK499914/

https://www.massgeneral.org/children/branchial-cleft-cyst

↑ *Back to this question in Part A*

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Q23: A branchial fistula typically presents with which of the following characteristics? (Q849623)

A. A midline neck mass that moves with swallowing

B. A lateral neck opening that drains mucus or saliva

C. A neck swelling that enlarges after a respiratory infection

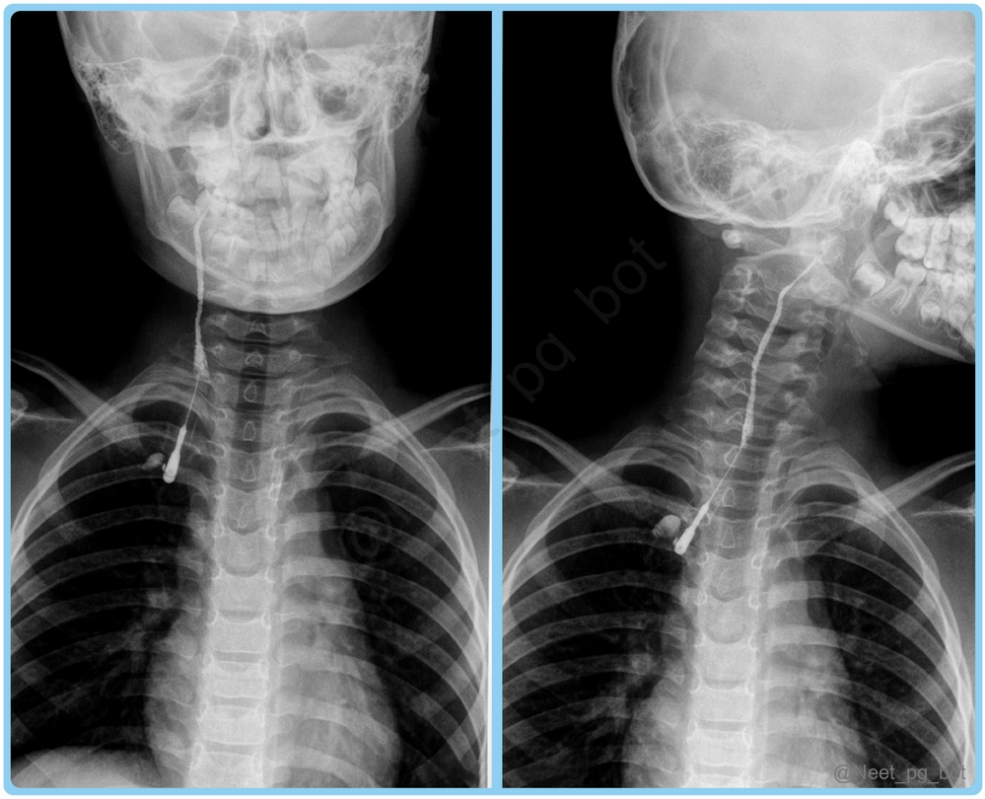
D. A solid mass in the posterior triangle of the neck

Correct Answer: B. A lateral neck opening that drains mucus or saliva

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: A branchial fistula typically presents as a small opening on the lateral aspect of the neck, often along the anterior border of the sternocleidomastoid muscle. A branchial fistula is a congenital abnormality resulting from the incomplete obliteration of the branchial clefts or pouches during embryonic development. Origin : Typically arises from the second branchial cleft (most common), which fails to close properly. Anatomy : The fistula is a complete ciliated columnar epithelium tract that connects the skin of the neck to the pharynx or tonsillar fossa. External Opening : Usually found along the anterior border of the sternocleidomastoid muscle in the lower third of the neck. Internal Opening : Typically located in the tonsillar fossa or near the pharyngeal wall. Location & Level: The "Classic" Site: The opening is most commonly found at the junction of the middle and lower thirds of the anterior border of the SCM. Anatomical Path: If it is a complete fistula, the tract travels upward, passing between the internal and external carotid arteries (deep to the second arch structures and superficial to the third). Internal Opening: It typically ends in the tonsillar fossa (supratonsillar fossa). Clinical Presentation : May present with a small opening on the neck that drains mucus or saliva. Can be associated with recurrent neck infections or abscesses. Swelling or discharge near the external opening is common. Diagnosis : Diagnosis is usually based on clinical examination. Imaging studies (e.g., ultrasound, fistulogram, or CT scan) may be used to delineate the fistula tract. Branchial sinus fistulography right side Treatment : Surgical excision of the entire fistula tract is the treatment of choice. Incomplete removal can lead to recurrence.



References:

Gray's Anatomy: The Anatomical Basis of Clinical Practice, 42nd Edition, Page 581

↑ *Back to this question in Part A*

Q24: A 38-year-old patient presents with a soft, translucent swelling on the front edge of the sternocleidomastoid muscle. The swelling is non-tender and has not been associated with any infection. It is diagnosed as a branchial cyst. Which of the following is false regarding the given diagnosis? (Q849622)

A. Typical location is the meeting of upper and middle thirds of sternocleidomastoid.

B. It has an onset in late adulthood.

C. Cancerous lymph nodes may have to be ruled out.

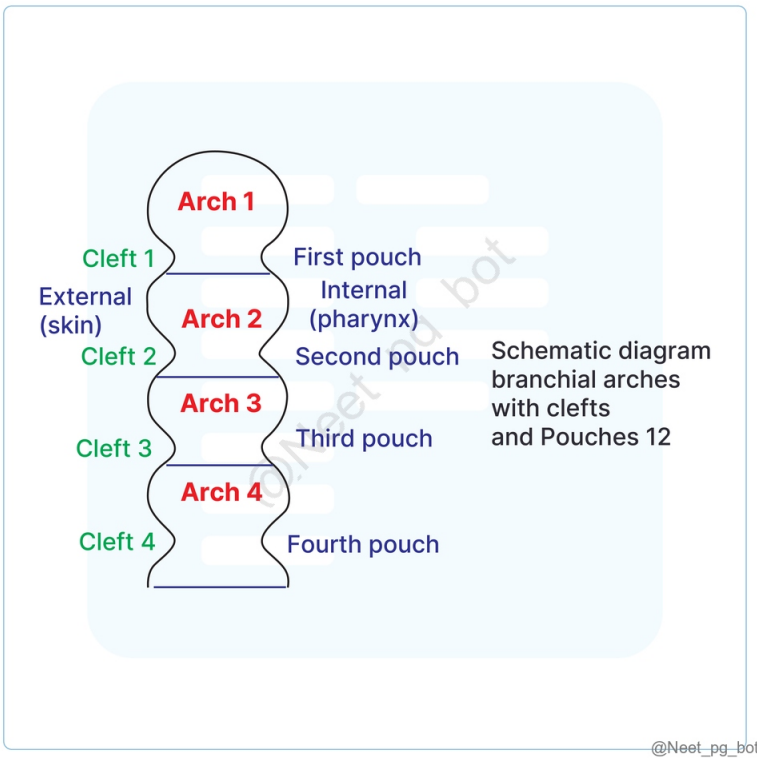
D. Complete removal is done, ideally when not infected.

Correct Answer: B. It has an onset in late adulthood.

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Branchial cysts typically present in early or middle adulthood. Branchial Cysts: Definition: Fluid-filled cysts from remnants of the second branchial cleft. Lined with squamous epithelium. Filled with thick, cloudy fluid. Appearance & Location: Typical Location: Front edge of the sternocleidomastoid muscle (where upper and middle thirds meet). (Option A) Onset: Early or middle adulthood. (Option B) Appearance: Soft, sometimes translucent swelling. Complications: Infection: May cause redness, tenderness, and difficulty in distinguishing from other neck masses. Age Consideration: In individuals over 35, rule out cancerous lymph nodes (Option C) before surgical removal. Treatment: Preferred Treatment: Complete removal, ideally when not infected. (Option D) Surgical Considerations: Cyst located above hypoglossal and glossopharyngeal nerves, but beneath the posterior belly of the digastric muscle. The spinal accessory nerve must also be identified to avoid damage.





References:

Bailey and Love short practice of surgery, Edition 28, Pg 805

↑ *Back to this question in Part A*

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Q25: An infant presents with a translucent swelling in the neck that has been expanding over time as shown in the image below The swelling is filled with clear lymph and increases in size when the infant coughs.. Which of the following is false regarding the given condition? (Q849621)

A. Common locations include the cheek, axilla, groin, and mediastinum.

B. It has an unpredictable growth pattern.

C. It is incompressible and cystic in nature.

D. Injection of sclerosing agents can be given to reduce size.

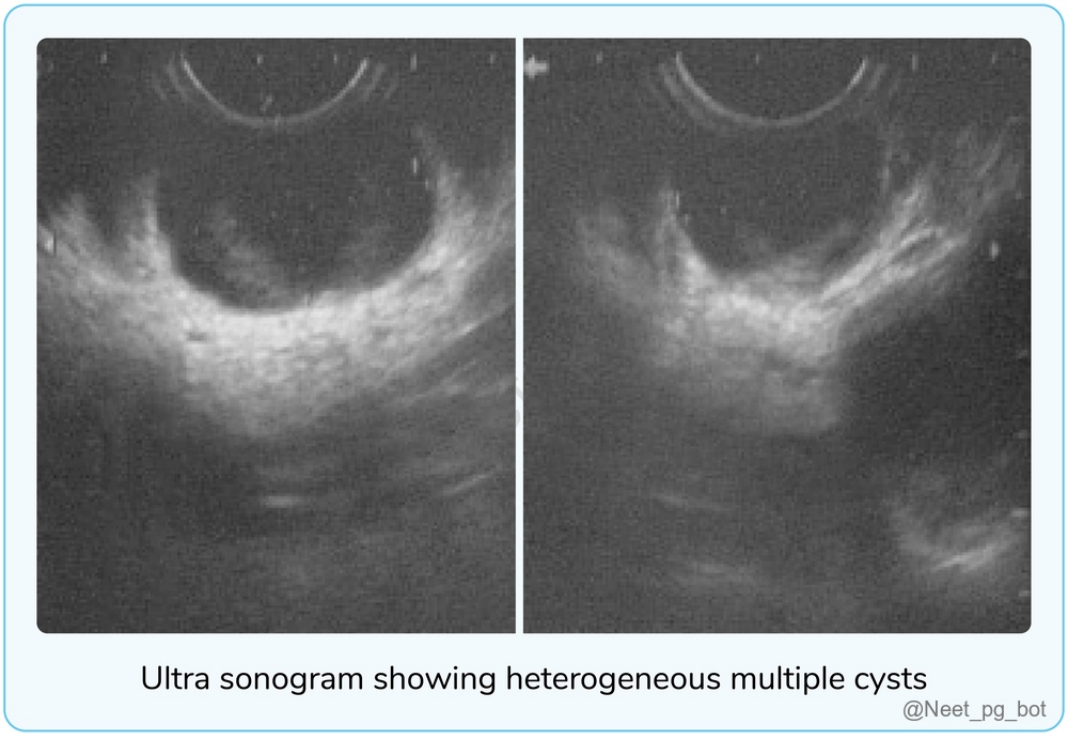


Correct Answer: C. It is incompressible and cystic in nature.

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The child is most likely suffering from Cystic hygroma , which is soft, partially compressible swelling filled with clear lymph. Features of Cystic Hygromas: Definition : Lymphatic malformations in neonates or infants. Appearance : Soft, partially compressible (Option C) swellings filled with clear lymph. Size Variation : May increase in size when the child cries or coughs. Common Locations : Neck (most common), face, submandibular region, tongue, floor of the mouth, cheek, axilla, groin, mediastinum . (Option A) Distinguishing Characteristics : Translucence. Behavior and Complications: Behavior : Unpredictable (Option B) ; can expand rapidly. Complications : Respiratory difficulties (may require aspiration or tracheostomy). Risk of infection. Treatment: Preferred Treatment : Early complete surgical excision. Alternative Treatment : Injection of sclerosing agents to reduce size. (Option D) Challenges : Complete resolution can be difficult due to its multicystic nature.



Ultra sonogram showing heterogeneous multiple cysts

References:

Bailey and Love short practice of surgery, Edition 28, Pg 805, 806.

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• [02_Head And Neck] 007 Previous Year Questions

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[02_Head And Neck] 007 Previous Year Questions — Quick Jump

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Q13 (p. 1323)	*Q14 (p. 1324)*	*Q15 (p. 1326)*	*Q16 (p. 1328)*	*Q17 (p. 1329)*	*Q18 (p. 1330)*
Q19 (p. 1332)	*Q20 (p. 1333)*	*Q21 (p. 1336)*	*Q22 (p. 1337)*	*Q23 (p. 1338)*	*Q24 (p. 1339)*
Q25 (p. 1340)	*Q26 (p. 1341)*	*Q27 (p. 1342)*	*Q28 (p. 1343)*	*Q29 (p. 1345)*	*Q30 (p. 1348)*
Q31 (p. 1351)	*Q32 (p. 1352)*	*Q33 (p. 1352)*	*Q34 (p. 1353)*	*Q35 (p. 1353)*	

Q1: What is the definition of the Miami criteria regarding intraoperative parathyroid hormone (PTH) measurement among the options listed below? (Q854934)

A. Quarter fall in 5 min

B. Quarter fall in 10 min

C. Half fall in 5 min

D. Half fall in 10 min

Correct Answer: D. Half fall in 10 min

Explanation: The Miami criteria are used in intraoperative parathyroid hormone (PTH) monitoring during parathyroidectomy. It states that a "half fall in PTH within 10 minutes after the removal of the suspected parathyroid adenoma indicates that the surgery has been successful" in curing the patient’s hyperparathyroidism. If PTH levels do not decrease after parathyroid surgery, it indicates that the cause of hyperparathyroidism may not have been fully addressed. Further investigation, reoperation, or imaging may be required to identify additional hyperfunctioning glands or exclude other potential causes.

References:

NIH Link Bailey & Love’s Short Practice of Surgery, 28th Edition, Page 879.

↑ *Back to this question in Part A*

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Q2: A 28-year-old female presents with a bluish translucent extravasation cystic sublingual swelling . The swelling is accompanied by visible veins over the swelling and is transilluminant . What is the most likely diagnosis? (Q820193)

A. Thyroglossal cyst

B. Dermoid cyst

C. Ranula

D. Sublingual tumour

Correct Answer: C. Ranula

Explanation: Correct option C - Ranula: Ranula is a cyst that forms within the floor of the mouth, often beneath the tongue. It is caused by the obstruction of a salivary gland duct. It appears bluish-translucent due to the accumulation of saliva within the cyst. There are visible veins over it due to increased pressure on the surrounding blood vessels. It is a transilluminant swelling. Incorrect options: Option A - Thyroglossal cyst: Thyroglossal cysts are congenital fluid-filled swellings that form along the path where the thyroid gland migrates during fetal development. They appear in the midline of the neck, above the hyoid bone. They neither present as bluish-translucent cystic sublingual swellings nor do they involve the sublingual area. Option B - Dermoid cyst: Dermoid cysts are benign tumors that contain a variety of tissues, including skin, hair, and sometimes even teeth. They are typically present at birth and slowly grow over time. Dermoid cysts are not located in the sublingual area and do not usually cause visible veins overlying the area. Option D - Sublingual tumor : This refers to a tumor or growth occurring in the sublingual area.

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Q3: A 6-year-old child presents with a swelling in the subhyoid region of the neck that moves with deglutition and protrusion of the tongue. What is the recommended treatment for this patient? (Q820236)

A. Total thyroidectomy

B. Ramstedt's operation

C. Hemi-thyroidectomy

D. Sistrunk's operation

Correct Answer: D. Sistrunk's operation

Explanation: Correct Option D - Sistrunk's operation: The given features in the question stem lead to the diagnosis of Thyroglossal duct cyst. Sistrunk's operation is a surgical procedure used to treat a thyroglossal duct cyst. Thyroglossal duct cyst is a developmental anomaly resulting from the persistence of the thyroglossal duct. This cyst can present as a swelling in the subhyoid region of the neck that moves with swallowing and tongue protrusion. Sistrunk's operation involves removing the cyst, along with a portion of the hyoid bone and the central portion of the body of the hyoid bone. This procedure helps prevent recurrence and ensures complete removal of the cyst. Incorrect Options: Option A - Total thyroidectomy: This option is not appropriate for the given scenario. Total thyroidectomy involves the complete removal of the thyroid gland, which is not indicated for a swelling in the subhyoid region of the neck that moves with swallowing and tongue protrusion. Additionally, total thyroidectomy is not a suitable approach for a pediatric patient without proper indications. Option B - Ramstedt's operation: Ramstedt's operation, also known as pyloromyotomy, is a surgical procedure performed to treat pyloric stenosis, which is a condition affecting the stomach's outlet. This option is not relevant to the given scenario of a swelling in the subhyoid region of the neck. Option C - Hemi-thyroidectomy: Hemi-thyroidectomy involves the removal of half of the thyroid gland. This option is also not appropriate for the situation described. The subhyoid swelling is not related to the thyroid gland and its removal would not address the issue.

References:

PREPLADDER notes

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Q4: A 45-year-old female patient undergoes a routine thyroid examination, during which a palpable thyroid nodule is discovered. Fine-needle aspiration cytology confirms the presence of papillary thyroid cancer. All of the following statements are true regarding papillary thyroid cancer Except: (Q820244)

A. It often presents with cervical lymph node metastases.

B. It is the most common type of thyroid cancer.

C. It arises from parafollicular C-cells

D. It is TSH dependent

Correct Answer: C. It arises from parafollicular C-cells

Explanation: Correct Option C - It arises from parafollicular C-cells: Papillary thyroid cancer arises from follicular cells of the thyroid gland, not from parafollicular C-cells. Parafollicular C-cells, also known as parathyroid cells or clear cells, are responsible for producing calcitonin, a hormone that regulates calcium levels in the body. Medullary thyroid cancer, a different type of thyroid cancer, arises from parafollicular C-cells. Incorrect Options: Option A - It often presents with cervical lymph node metastases: Papillary thyroid cancer commonly spreads to nearby lymph nodes in the neck. This is a characteristic feature of this type of thyroid cancer. Option B - It is the most common type of thyroid cancer: Papillary thyroid cancer is indeed the most common type of thyroid cancer,

accounting for approximately 70-80% of all cases. Option D - It is TSH dependent: Papillary thyroid cancer is generally considered to be TSH (thyroid-stimulating hormone) dependent. TSH, which is produced by the pituitary gland, stimulates the thyroid gland to produce thyroid hormones. Elevated TSH levels can contribute to the growth and function of papillary thyroid cancer cells. This is why TSH suppression therapy (using medications to lower TSH levels) is often part of the treatment plan for papillary thyroid cancer.

References:

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↑ *Back to this question in Part A*

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Q5: A patient presents with swelling in the floor of the mouth. Upon examination, the swelling appears as shown in the image. What is the most likely diagnosis? (Q854776)

A. Cystic hygroma

B. Ranula

C. Dermoid

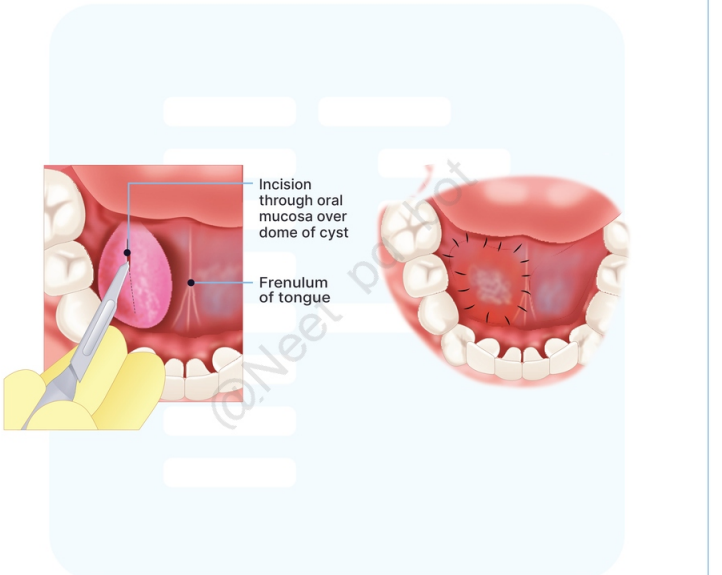
D. Branchial cyst



Correct Answer: B. Ranula

Explanation: The most likely diagnosis is Ranula, a specific type of mucus retention cyst that develops on the floor of the mouth, typically caused by blockage or rupture of the ducts of the sublingual or submandibular glands. This leads to mucus accumulation and the formation of a cystic swelling. Ranula Definition Ranulas are a type of extravasation mucocele caused by the rupture of the main duct or obstructed acini of the sublingual gland. They appear as bluish swellings on the floor of the mouth and resemble the belly of a frog. {{caption_text}} Location Commonly found in the anterior floor of the mouth. When it extends through the mylohyoid muscle, it presents as a submental swelling known as a "plunging ranula." Symptoms Typically soft, fluctuant, and painless unless infected. Diagnosis Confirmed through Magnetic Resonance Imaging (MRI) Ultrasound Aspiration of thick, sticky saliva differentiates it from a lymphangioma. Treatment Removal of the sublingual gland is preferred. Incision, drainage, and marsupialisation have low success rates. Although marsupialisation is often adequate, it has a higher recurrence rate compared to sublingual gland excision. OK-432 injection Botulinum toxin injections Incorrect Options: Cystic hygroma (Option A) is a congenital abnormality of the lymphatic system, usually presenting as a soft, cystic swelling in the neck area. It is not typically found on the floor of the mouth. Dermoid (Option C) cysts are developmental cysts that contain various tissues, such as skin, hair follicles, and sebaceous glands. While they can occur on the floor of the mouth, they are not exclusive to this region. Branchial cysts (Option D) are congenital cysts that form from remnants of the branchial apparatus. They are primarily found in the neck area and are not commonly seen on the floor of the mouth.





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References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 834

SRB's Manual of Surgery, 6th Edition, Page 357

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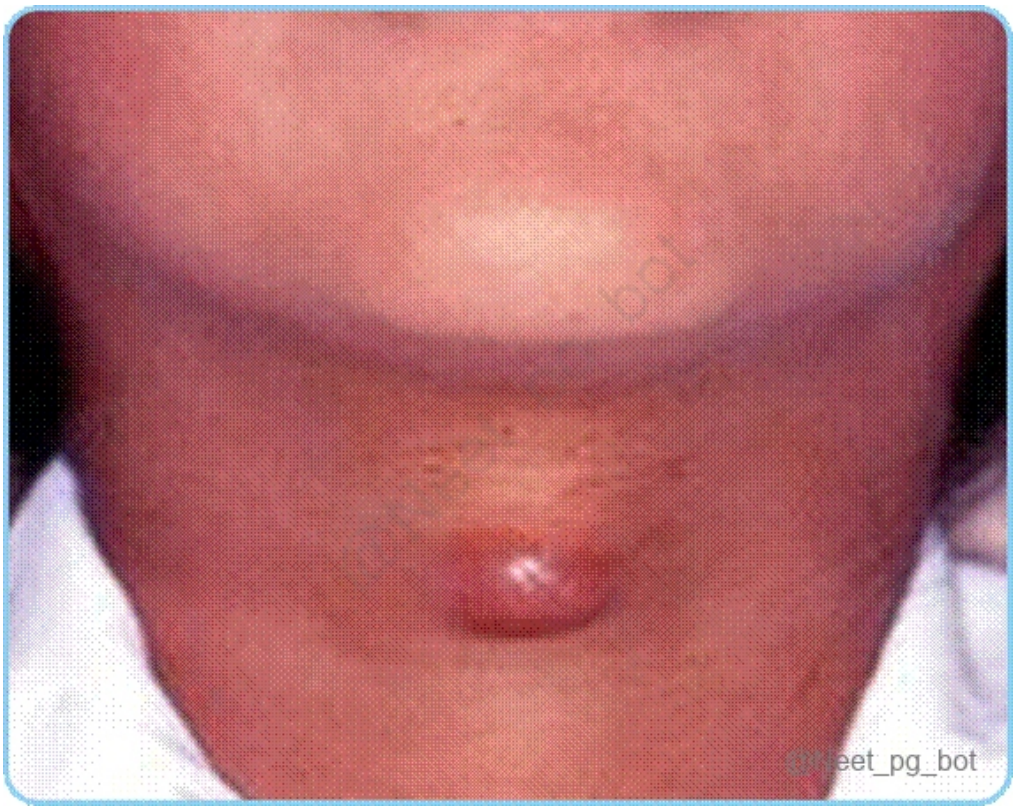
Q6: A 23-year-old male patient presents with a swelling in the midline of his neck that shifts when he swallows or sticks out his tongue. What is the probable diagnosis? (Q855273)

A. Brachial cyst

B. Thyroglossal cyst

C. Plunging ranula

D. Dermoid cyst



Correct Answer: B. Thyroglossal cyst

Explanation: A thyroglossal cyst is a midline neck swelling that typically moves with swallowing or protrusion of the tongue. It results from incomplete closure of the thyroglossal duct, which is an embryological remnant. The cyst often lies in close proximity to the hyoid bone and can be felt to shift with movement of the tongue or swallowing. Thyroglossal Cyst: It is a congenital neck mass resulting from the persistence of the thyroglossal duct, an embryological structure. It can also be present in adulthood. The cyst represents a remnant of this duct and can be found anywhere along the midline from the base of the tongue to the thyroid isthmus. Most Common Site: Subhyoid (can also be seen on the floor of the mouth, Suprahyoid, near thyroid cartilage and foramen caecum) Treatment: Sistrunk Procedure: Complete surgical excision of the cyst and its tract up to the base of the tongue and a portion of the hyoid bone to prevent recurrence. Incision and drainage are never done as they lead to the formation of a Thyroglossal fistula. (It also forms if an inflamed cyst ruptures.)—Always Acquired. Brachial cyst (Option A): A brachial cyst, or branchial cleft cyst, generally appears as a lump along the anterior border of the sternocleidomastoid muscle, not in the midline of the neck. Plunging ranula (Option C) is a mucous cyst found in the floor of the mouth, typically located laterally rather than in the midline, and it usually doesn't shift with swallowing or tongue protrusion. Dermoid cyst (Option D) , a type of teratoma, is often present at birth and can appear in the midline of the neck. However, these cysts typically do not move with swallowing or tongue protrusion.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 806

↑ *Back to this question in Part A*

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Q7: A 32-year-old man with a history of chronic tobacco chewing presents with a painless white patch in the gingivobuccal sulcus that has persisted for the past 7 months. The lesion is non-scrapable and there is no restriction of mouth opening. What is the most appropriate next step in management? (Q857858)

A. Local excision and biopsy

B. Advise cessation of tobacco and observe

C. Intralesional steroid injections

D. Sclerotherapy

Correct Answer: A. Local excision and biopsy

Explanation: A persistent, non-scrapable white lesion of the oral mucosa in a chronic tobacco chewer is most suggestive of oral leukoplakia , a premalignant condition . Any oral white lesion persisting for more than 2 weeks , especially in individuals with tobacco exposure, requires histopathological evaluation to assess for epithelial dysplasia or early squamous cell carcinoma . Therefore, biopsy is mandatory and represents the most appropriate next step in management. Option B. Advise cessation of tobacco and observe: Tobacco cessation is important but cannot replace biopsy in a persistent lesion. Option C. Intralesional steroid injections: Used in inflammatory or fibrotic conditions like oral submucous fibrosis, not leukoplakia . Option D. Sclerotherapy of the lesion: Reserved for vascular lesions; no role in premalignant oral lesions .

References:

Sabiston Textbook of Surgery, 21st Edition, Page 780.

SRB’s Manual of Surgery, 6th Edition, Page 360.

↑ *Back to this question in Part A*

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Q8: The false statement about cystic masses of the neck is: (Q857144)

A. Type 3 branchial fistula has its internal orifice on cricopharynxgeus

B. Cystic hygroma is filled with clear lymph

C. Thyroglossal cyst moves upwards on swallowing, and tongue protrusion

D. Fluctuation is positive in branchial cyst

Correct Answer: A. Type 3 branchial fistula has its internal orifice on cricopharynxgeus

Explanation: A branchial fistula can appear on one side or both sides and likely indicates a persistent second branchial cleft. The opening is typically found in the lower part of the neck near the front edge of the sternocleidomastoid muscle externally and internally; it's situated behind the tonsil on the front aspect of the posterior faucial pillar. In Type III cases, the passage runs between the internal and external carotid arteries, possibly reaching the pharynx's lateral wall or the base of the skull. Cystic hygroma is filled with clear lymph (Option B): Cystic hygroma lymphangioma is a birth defect with a large fluid-filled sac around the head and neck. The cyst comprises lymphatic tissues and white blood cells. Thyroglossal cyst moves upwards on swallowing and tongue protrusion (Option C): Thyroglossal duct cysts move upwards on swallowing and notably with tongue protrusion but this may occur with other midline cysts. Fluctuation is positive in branchial cyst (Option D): Branchial cyst is a fluctuant swelling that may transilluminate and is usually soft at its early stages, which makes it difficult to palpate.

References:

Bailey and Love Short Practice of Surgery, Edition 28, Pages 805, 806

↑ *Back to this question in Part A*

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Q9: Which of the following structures is most likely to be injured, leading to lower lip paralysis in a 30-year-old teacher who underwent parotidectomy? (Q856747)

A. Temporal branch of the facial nerve

B. Cervical branch of facial nerve

C. Parotid duct

D. Mandibular branch of facial nerve

Correct Answer: D. Mandibular branch of facial nerve

Explanation: Weakness of the left lower lip after parotid surgery suggests injury to the mandibular branch of the facial nerve. The facial nerve is responsible for motor innervation to the muscles of facial expression. It is more commonly at risk during parotid gland surgeries Complications of Parotidectomy: Complication Description Temporary Facial Palsy Mostly the lower branches of the facial nerve - the marginal mandibular nerve. Most patients recover over time. Infection Rare, as parotidectomy is a clean procedure. Aseptic precautions and timely drain removal reduce the risk. Hematoma Formation Uncommon. Careful intraoperative hemostasis can prevent it. Larger hematomas may indicate a bleeding disorder and require management. Sialocele Formation Occurs if the main ductal system is exposed. Preventable with subcapsular dissection. Treatment: Anticholinergics, aspiration, and pressure dressings. Retromandibular area hollowing Can occur post-surgery Reduced by placing autologous fat grafts during the surgery. Frey’s Syndrome Also known as gustatory sweating; Caused by the cross-innervation of sweat glands by regenerating nerve fibres of the auriculotemporal nerve. For mild cases : Give antiperspirants;

Severe cases: Botulinum toxin injections or tympanic neurectomy. Permanent Facial Nerve Weakness D/t transection of the facial nerve during the surgery. Facial Numbness Permanent numbness of the earlobe, D/t transection of the great auricular nerve during the surgery. Temporal branch of the facial nerve (Option A) controls the upper face (e.g., forehead and eyelid), so injury here would not affect the lower lip . Cervical branch of the facial nerve (Option B) innervates the platysma muscle, which primarily affects neck and lower face movement but would also cause some degree of neck weakness and not just isolated lower lip weakness . Parotid duct (Option C) damage can affect the saliva flow but does not result in weakness of the lower lip .

References:

Bailey and Love's Short Practice of Surgery, 28th edition, pages 848, 849

↑ *Back to this question in Part A*

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Q10: Which part of cranial fossa is injured in Raccoon eyes? (Q820177)

A. Anterior cranial fossa

B. Middle cranial fossa

C. Posterior cranial fossa

D. Bone aponeurotic layer

Correct Answer: A. Anterior cranial fossa

Explanation: Correct option B - Anterior cranial fossa Raccoon eyes, also known as periorbital ecchymosis , is a classic clinical sign of a basilar skull fracture , specifically involving the anterior cranial fossa . The bruising occurs when blood from a fracture (often involving the orbital plate of the frontal bone or the cribriform plate of the ethmoid) tracks forward into the loose subcutaneous tissue around the orbits. A key diagnostic feature is that the ecchymosis typically spares the tarsal plate , as the palpebral fascia prevents blood from crossing into the eyelid itself. Middl e cranial fossa (Option A): Typically associated with Battle's sign (post-auricular/mastoid ecchymosis), hemotympanum, and CSF otorrhea. Posterior cranial fossa (Option C): It usually involves injuries near the foramen magnum or occipital bone. B one aponeurotic layer (Option D): While a subgaleal hematoma (bleeding between the periosteum and the aponeurosis) can cause swelling, it is not the primary anatomical site of the fracture causing "Raccoon eyes."

References:

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↑ *Back to this question in Part A*

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Q11: Which statement regarding retrosternal goitre is accurate? (Q855029)

A. Operated in all patients regardless of symptoms

B. Sternal incision is always required to operate

C. It receives blood supply from the thoracodorsal artery

D. Most of the retrosternal goitres can be removed by a neck incision

Correct Answer: D. Most of the retrosternal goitres can be removed by a neck incision

Explanation: Surgical approach decisions for retrosternal goitre depend on the size , location , and associated symptoms , and while some may require a sternotomy, most can be removed through a neck incision alone. Retrosternal goitre Definition A thyroid gland enlargement that extends into the mediastinum behind the Sternum Types Primary: Ectopic thyroid tissue in the mediastinum (10%) Secondary: Starts from neck and extends retrosternally (90%) Clinical Features Neck Swelling with Compression Symptoms: Difficulty breathing (tracheal compression) and swallowing (esophageal compression). Pemberton Sign: Facial flushing and increased difficulty breathing when raising the arms due to thoracic inlet compression. Diagnosis Physical examination: Limited palpation of the lower border of the thyroid swelling. Imaging: Computed Tomography (CT) Scan of the Neck and Chest is IOC to assess the extent of mediastinal involvement and to evaluate compression of surrounding structures. Management Primary / Recurrent / Large Malignant Retrosternal Goiter - Median Sternotomy (Option B ruled out) Secondary Retrosternal Goiter - Cervical / Neck Incision Operated in all patients regardless of symptoms (Option A): Surgical resection is the preferred standard for managing symptomatic retrosternal goitres and some asymptomatic cases. However, a "watchful waiting" approach may be appropriate for selected asymptomatic patients, especially with the development of alternative treatments. It receives blood supply from the thoracodorsal artery (Option C): blood supply to a retrosternal goitre primarily comes from the thyroid arteries, and the thoracodorsal artery mainly supplies the latissimus dorsi muscle, not the thyroid or retrosternal goitre.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 860 NIH Link

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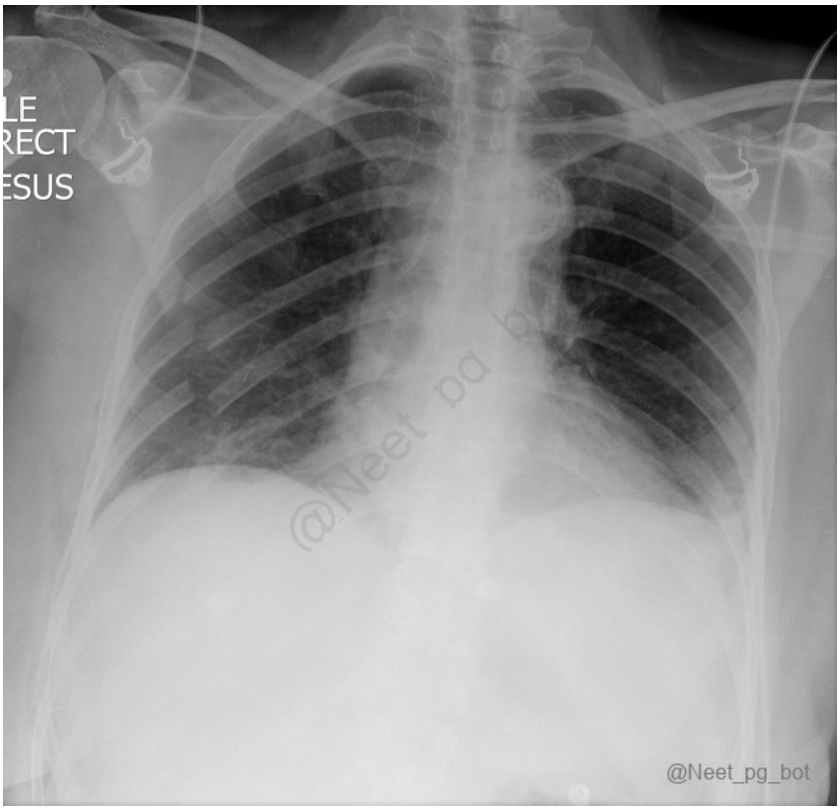
Q12: A car driver was brought into the A & E following a RTA with complaints of breathlessness. On examination, his vitals are PR-112/min, BP-100/70, SpO2-90 %, and there is extensive bruising on his chest. What is the management of this patient? (Q859614)

A. Chest tube drainage

B. 24% oxygen

C. IPPV

D. Internal operative fixation of the fracture’s segments



Correct Answer: C. IPPV

Explanation: The given condition, along with the X-ray showing multiple rib fractures, is suggestive of a Flail chest, and the most appropriate intervention in this case is IPPV . Positive pressure ventilation is the appropriate initial management in such cases, as it helps to stabilise the flail segment by providing consistent internal pressure, reducing paradoxical movement, and improving oxygenation. Flail chest Definition It occurs when three or more consecutive ribs are fractured in at least two places , creating a flail segment that moves independently. It exhibits paradoxical chest movement (inwards during inhalation & outwards during exhalation) Management Ventilation Support: Oxygen supplementation and Analgesics- Initial management IPPV is the preferred TOC. Tracheostomy if support exceeds 10 days. Injury Management: Intercostal Tube Drainage : Removes air/fluids from the pleural space. Rib Fixation (Option D) : Stabilises the chest wall. Supportive Care: Blood Transfusions : For blood loss. IV Fluids : For hydration. Antibiotics : To prevent infection. Medications : Bronchodilators and steroids. Thoracotomy: Considered in severe cases Chest tube drainage (Option A) is used for pneumothorax or hemothorax, which may accompany the flail chest. However, without these complications, immediate airway management and stabilisation are more crucial, given the severity of the respiratory distress. 24% oxygen (Option B) is not sufficient for a patient in respiratory distress with a SpO2 of 90% . The primary management here should be focused on supporting ventilation and ensuring adequate oxygenation, which IPPV would achieve more effectively.

References:

SRB’s Manual of Surgery, 6th Edition, Pages 1100, 1101

Bailey and Love’s Short Practice of Surgery, 28th Edition, Pages 375

↑ *Back to this question in Part A*

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Q13: Which of the following tests would a surgeon advise first in a patient with a large thyroid swelling? (Q859615)

A. Ultrasound of the neck

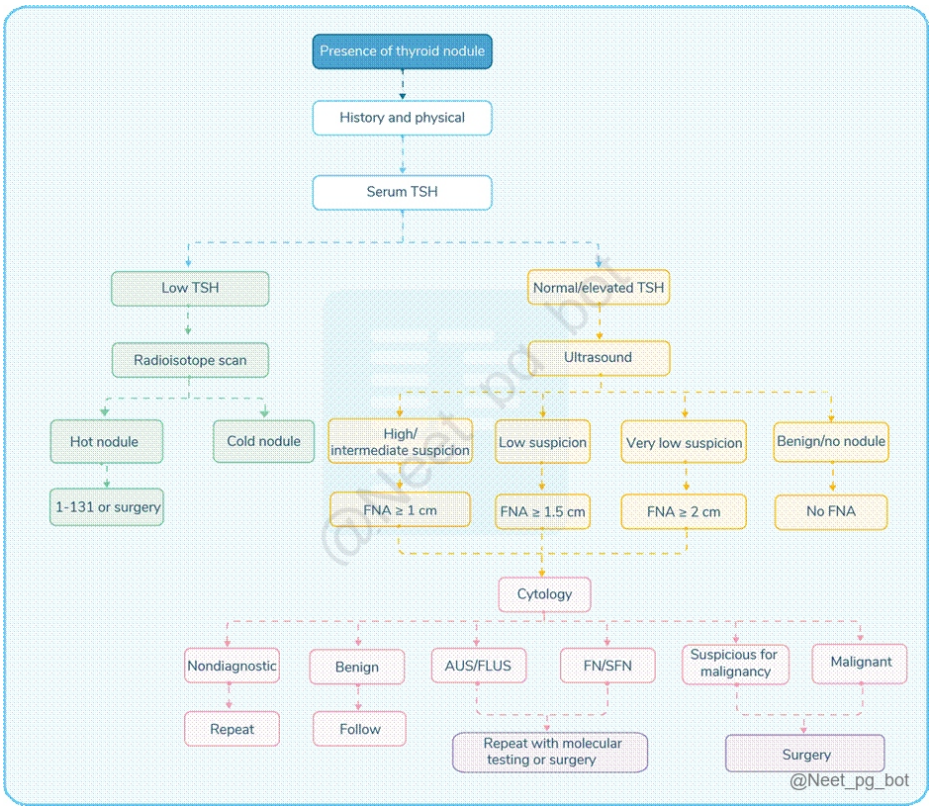
B. FNAC

C. Biopsy

D. Radioiodine uptake

Correct Answer: A. Ultrasound of the neck

Explanation: When a patient presents with a large thyroid swelling, the first step in evaluating the swelling is typically to perform an ultrasound of the neck . USG provides high resolution of the thyroid gland by well-characterizing parenchymal and nodular abnormalities. It provides valuable information about the size, characteristics, and composition of the swelling, and it also helps differentiate cystic and solid thyroid nodules. Ultrasound can guide further management, such as whether fine-needle aspiration cytology (FNAC) is necessary. {{caption_text}} FNAC (Option B) is a minimally invasive diagnostic procedure to evaluate abnormalities in various tissues, including thyroid nodules, but it is usually performed after imaging to assess the cytological details of the swelling. Biopsy (Option C) is generally not the first step in managing thyroid swelling. FNAC is typically preferred over a surgical biopsy for diagnostic purposes. A biopsy would be considered only if malignancy is strongly suspected and other tests (like FNAC) are inconclusive. Radioiodine uptake (Option D) is used to assess the functional status of the thyroid, but it is not the first step in evaluating a swelling. It is primarily used in cases where there are concerns about thyrotoxicosis or hyperthyroidism or in the context of thyroid nodules with known thyroid dysfunction.



References:

Sabiston, Text Book of Surgery, 21st Edition, page 892

Bailey & Love's Short Practice of Surgery, 28th Edition, Pages 858,859

↑ *Back to this question in Part A*

@Neet_pg_bot

Q14: A 32-year-old patient who is a chronic alcoholic presents with oral ulcers and a burning sensation. A picture of the oral cavity is given below. What is the most likely diagnosis? (Q855770)

A. Leukoplakia

B. Erythroplakia

C. Submucosal fibrosis

D. Malakoplakia



Correct Answer: A. Leukoplakia

Explanation: Leukoplakia is a precancerous lesion that typically presents as white patches or plaques on the mucosal surfaces, often seen in the mouth, tongue, and gums. Leukoplakia Definition White patch on oral mucosa, defined clinically, excluding conditions like lichen planus, candidiasis, etc. Causes Smoking, tobacco chewing Alcohol abuse (especially with smoking) Chronic trauma (ill-fitting dentures, cheek bites) Associated with submucous fibrosis, hyperplastic candidiasis, Plummer-Vinson syndrome Common sites Buccal mucosa (most common in India) Oral commissures, floor of mouth, tongue, gingivobuccal sulcus, lip mucosa Age & Gender Men in their 40s are 2-3 times more affected than females. Clinical types Homogenous : Smooth or wrinkled white patch, lower malignancy risk Nodular (speckled) : White patches on an erythematous base, higher malignancy risk Erosive (erythroleukoplakia) : Interspersed with red patches, fissures, highest malignancy risk Malignant potential 1-17.5% risk, average 5% malignant transformation Higher risk in dysplastic lesions and certain locations Treatment Remove causative factors : Spontaneous regression in some cases. Biopsy : For lesions with high malignant potential. Surgical excision or laser/cryotherapy : For suspicious or small lesions Erythroplakia (Option B) is a bright red velvety plaque that cannot be characterised clinically or pathologically as any other disease. While it is a more dangerous condition (having a higher risk of transformation to oral cancer), and it can sometimes present with ulcers , it does not typically present with a burning sensation in the same way that leukoplakia might. Submucosal fibrosis (Option C) is a progressive fibrosis deep in the mucosa of the oral cavity. It causes trismus and ankylosing glossitis, not necessarily with oral ulcers as the primary complaints. Malakoplakia (Option D) is a rare inflammatory condition characterised by soft, yellowish plaques and is often found in immunocompromised individuals. It is more commonly seen in the genitourinary tract and is associated with chronic infections.

References:

Scott-Brown’s Otorhinolaryngology, Head & Neck Surgery, 8th Edition, Page 434.

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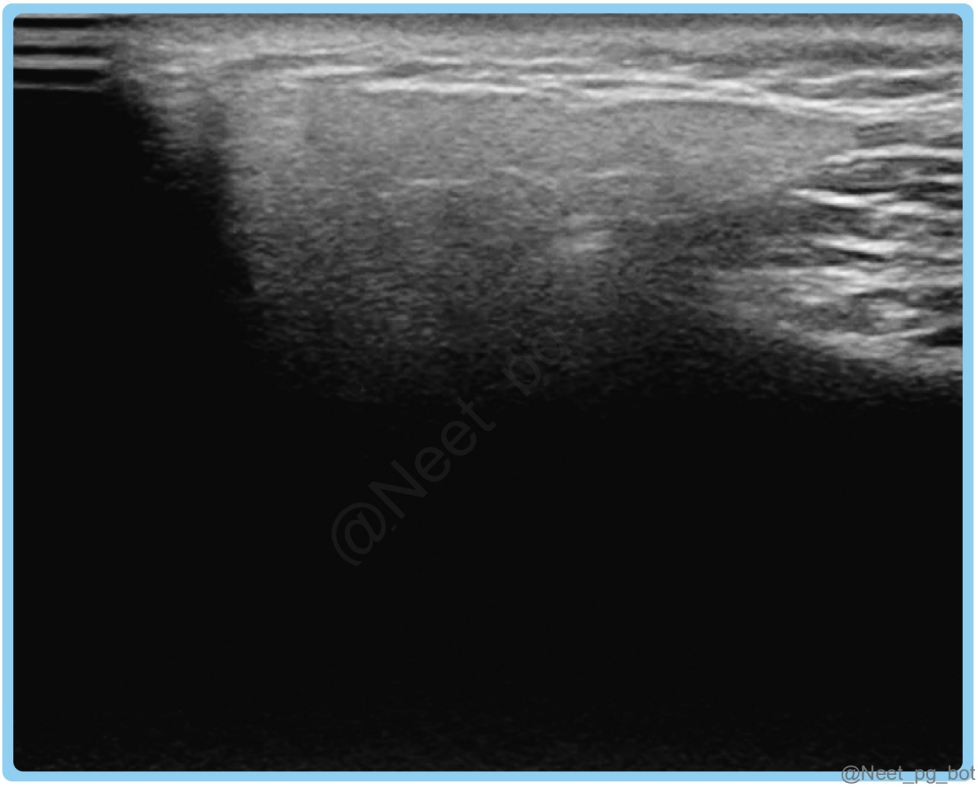
Q15: A 45-year-old patient complained of pain in one side of the neck. She is afraid of eating food as it worsens the pain. Ultrasound imaging of the salivary glands is done and shown below. What is the most likely diagnosis? (Q855805)

A. Sialolithiasis

B. Foreign body

C. Osteoma of the floor of the mouth

D. Cervical lymphadenopathy



Correct Answer: A. Sialolithiasis

Explanation: Sialolithiasis refers to the formation of salivary stones (sialoliths) in the salivary glands , which commonly occur in the submandibular gland . Ultrasound imaging is one of the most common diagnostic tools for identifying sialoliths , as it can show hyperechoic areas indicative of salivary stones and their location in the gland. Sialolithiasis Definition Formation of salivary gland stones within the gland ducts Commonly Affected Age 30 to 60 years Commonly Affected Gland Submandibular gland (85%), due to its ascending duct course and the

mucinous, viscous saliva it produces, leads to stagnation and stone formation. Risk Factors Duct abnormalities Inflammation Increased calcium content in saliva Chronic dehydration Medications causing decreased salivary flow Clinical Features Cyclical postprandial swelling, dryness, asymmetrical gland enlargement, palpable stone, possible abscess formation. {{caption_text}} Submandibular Swelling Diagnostic Methods Conventional Radiographs : Initial diagnostic test, but may miss small stones. CT Scanning, USG, Magnetic Resonance Sialogram : More sensitive, especially for small stones. Sialography : Gold standard; involves dye injection for diagnosis and potential therapeutic use. Sialendoscopy : Direct visualization and removal of stones, safer than open surgery. {{caption_text}} CT- Wharton’s duct Sialolithiasis Treatment Options Small Distal Stones (<5 mm) : Endoscopic removal Large Distal Stones (>5 mm) : Duct slitting Impacted Stones : Transoral route Intraparenchymal Stones (5–7 mm) : Endoscopic extraction Large Stones (7-10 mm) : May require transoral slitting or external shock wave lithotripsy (ESWL) Hilar Stones : Endoscopic removal Gland Removal : Last resort if other treatments fail Foreign body (Option B) in the salivary ducts can also cause symptoms of pain and swelling , but these are typically associated with a history of trauma or foreign object ingestion. The pain may not specifically worsen with eating as it does in sialolithiasis , and ultrasound would typically show a foreign object rather than a stone . Osteoma of the floor of the mouth (Option C) is a benign bone tumour that can occur in the jaw or floor of the mouth , but it does not typically cause the sharp, intermittent pain associated with sialolithiasis . Additionally, ultrasound would not typically identify an osteoma as it is a bone . Cervical lymphadenopathy (Option D) refers to enlarged lymph nodes in the neck, often due to infections or malignancy. It usually presents with swelling and tenderness in the neck region. However, it does not cause pain when eating or pain localised to a specific salivary gland, which is characteristic of sialolithiasis.





References:

Bailey and Love's Short Practice of Surgery, 28th edition, Pages 836 - 838

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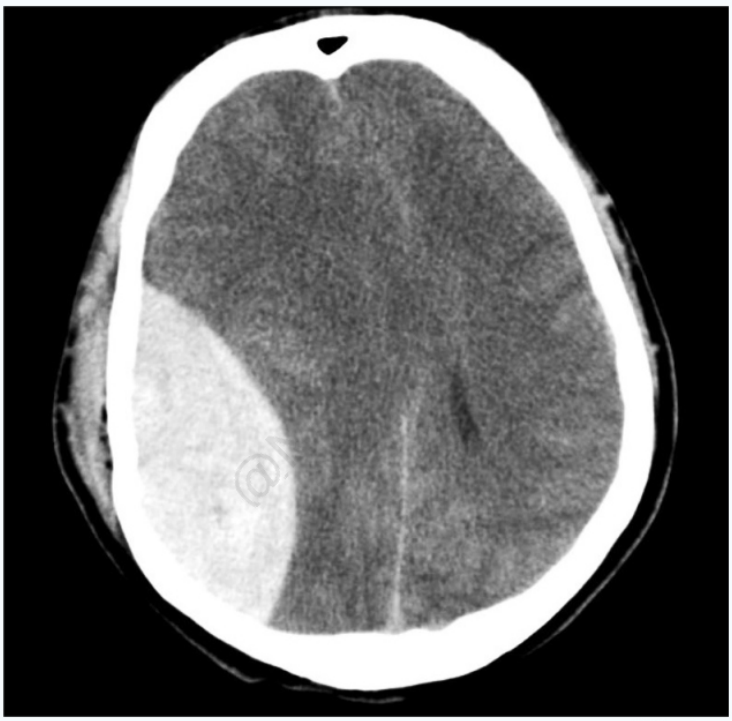
Q16: A 30-year-old patient of RTA was brought to the emergency department. There was a history of vomiting. The patient was initially conscious and oriented, but after a few hours, he became drowsy and then progressed to stupor and coma. This sequence of lucid interval was followed by neurological deterioration. What is the preferred treatment option? (Q879144)

A. Wait for spontaneous resolution

B. Burr hole and evacuation

C. Craniotomy

D. Conservative management with IV mannitol



Correct Answer: C. Craniotomy

Explanation: The clinical history and CT imaging with a biconvex/lentiform hyperdense hematoma point towards the diagnosis of Epidural/Extradural hematoma (EDH), which is a neurosurgical emergency because it can rapidly expand due to arterial bleeding. Craniotomy is required when there is: Hematoma >30 mL Thickness >15 mm Midline shift >5 mm Neurological deterioration present Craniotomy allows complete evacuation of the EDH, ligation of the bleeding meningeal artery and decompression of the brain. Wait for spontaneous resolution (Option A): Never appropriate in acute EDH, because it can lead to herniation. Burr hole evacuation (Option B): Not effective for EDH since blood will be clotted and arterial, hence it requires craniotomy. Conservative management with IV mannitol (Option D): Temporary measure before surgery, not definitive management.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 365,366,367. Epidural Hematoma - StatPearls - NCBI Bookshelf

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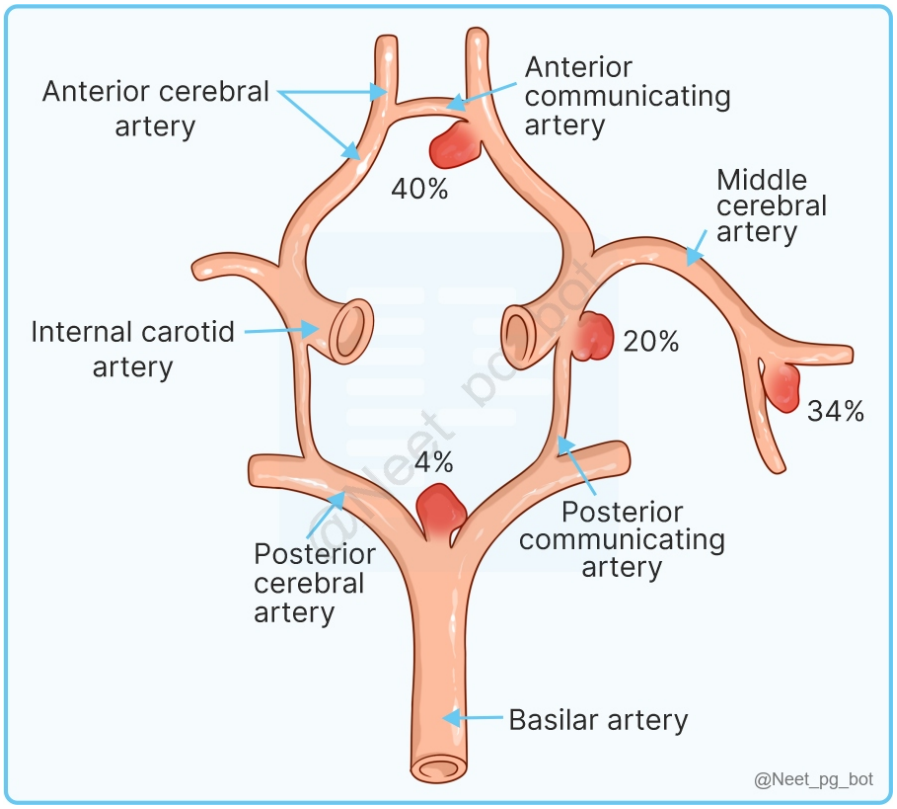
Q17: What is the most common site of a Berry aneurysm in the circle of Willis? (Q879234)

A. Anterior cerebral artery

B. Middle cerebral artery

C. Basilar artery

D. Vertebral artery



Correct Answer: A. Anterior cerebral artery

Explanation: Correct Option A - Anterior cerebral artery: The most common site of a Berry (saccular) aneurysm is at the anterior communicating artery (AComA) near the junction of the anterior cerebral arteries (ACA) . Berry Aneurysm Common sites Anterior communicating artery – 40% (Option A) Posterior communicating artery – 34% Middle cerebral artery – 20% (Option B ruled out) Basilar artery – 4% (Option C ruled out) Genetic associations ADPKD Ehlers–Danlos type IV Marfan syndrome NF1 Risk factors Hypertension, smoking, coarctation of aorta, fibromuscular dysplasia

References:

Robbins & Cotran, Pathologic Basis of Disease, 10th Edition, Page 1258-1260

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Q18: In modified radical neck dissection, which of the following structures is NOT preserved? (Q860278)

A. Sternocleidomastoid muscle

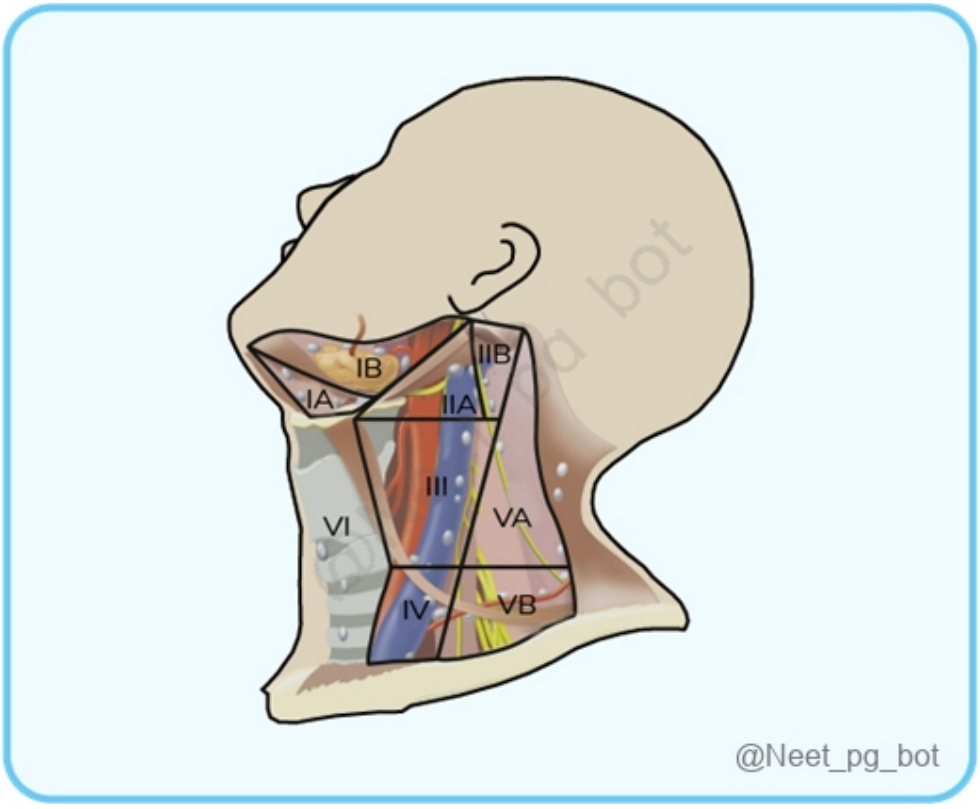
B. Internal jugular vein

C. Spinal accessory nerve

D. Submandibular gland

Correct Answer: D. Submandibular gland

Explanation: In a modified radical neck dissection, the sternocleidomastoid muscle , internal jugular vein , and spinal accessory nerve are typically preserved. Types of Neck Dissections: Dissection LN removed Other structures removed/Preserved Radical Neck Dissection I - V CN XI, IJV, and SCM removed Modified Radical Neck Dissection (MRND) I I - V CN XI preserved MRND II I - V CN XI, IJV preserved MRND III I - V CN XI, IJV, SCM preserved Extended Neck Dissection I - V CN XI, IJV, SCM removed + one/more LN groups +/- Non lymphatic structures Selective Neck Dissections LN removed Primary site of cancer Supra-omohyoid I - III Oral cavity Extended Supra-omohyoid I - IV Oral cavity and oropharynx Postero-Lateral II - V Skin over the posterior scalp and upper neck Lateral II - IV Oropharynx, Hypopharynx, Larynx Anterior/ Central VI Thyroid/ Midline structures



References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 821

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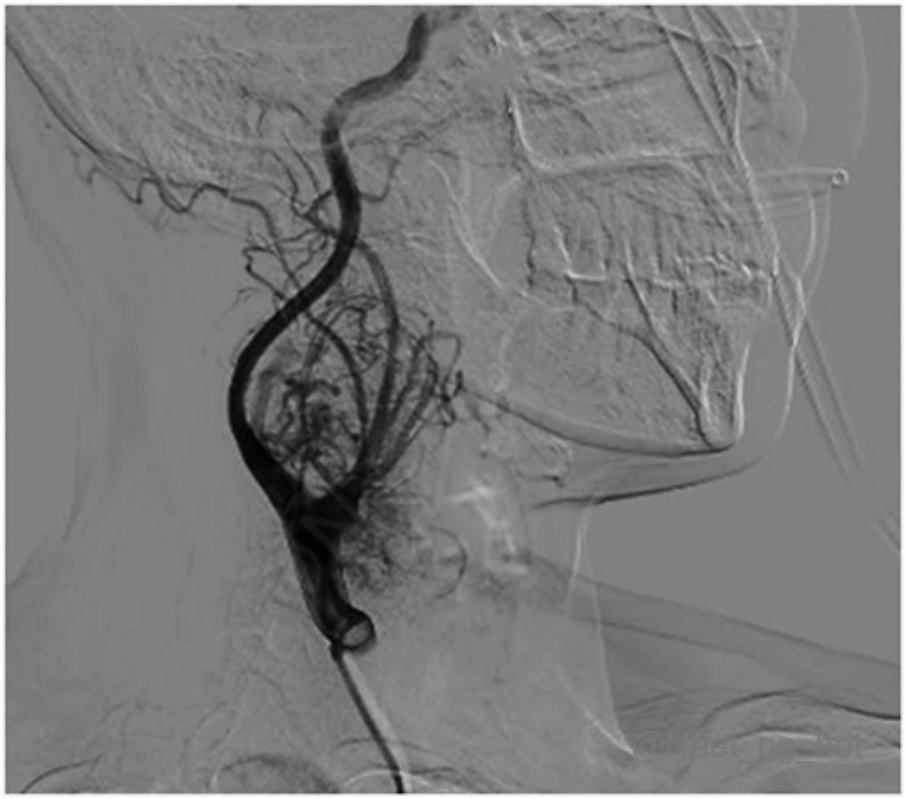
Q19: History of pulsatile mass in the neck. Digital angiography image shown. Not filling on carotid compression. But refilling on releasing pressure. What is the diagnosis? (Q866454)

A. Carotid Aneurysm

B. Carotid Body tumour

C. AV fistula

D. Haemangioma



Correct Answer: B. Carotid Body tumour

Explanation: The image depicts Carotid body tumor, which is a highly vascular mass located at the carotid bifurcation. On digital subtraction angiography, the lyre sign (splaying of the internal and external carotid arteries) is seen. The characteristic finding in this question is tumour blush that disappears with carotid compression (loss of

arterial inflow) and reappears upon release - indicating that the tumour's vascularity depends on carotid blood flow. Carotid aneurysm (Option A): Would show persistent filling even with carotid compression if proximal to the aneurysm, and would not have the tumour blush pattern. AV fistula (Option C): Demonstrates early venous filling on angiography, not the filling–emptying–refilling pattern described here. Haemangioma (Option D): Typically a soft tissue vascular lesion, often cutaneous/subcutaneous, and not fed directly by carotid branches in this manner.

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Q20: An elderly male presents with foul-smelling breath and dysphagia. A barium swallow X-ray is provided. What is the most likely diagnosis? (Q853043)

A. ■■■Tracheoesophageal fistula

B. Achalasia cardia

C. Carcinoma esophagus

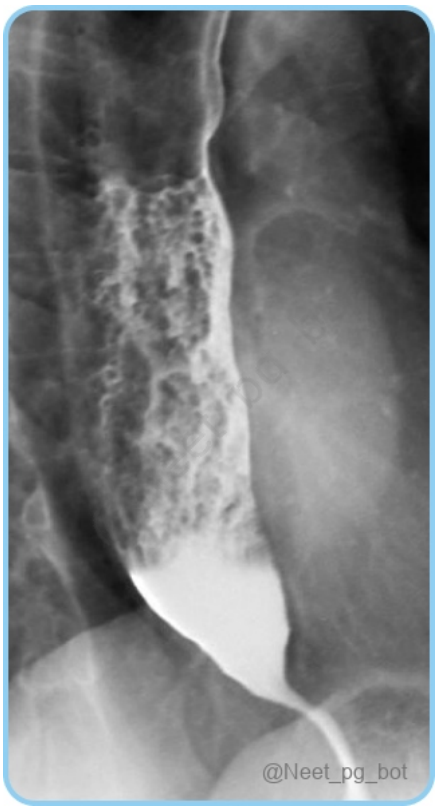
D. Zenker's diverticulum

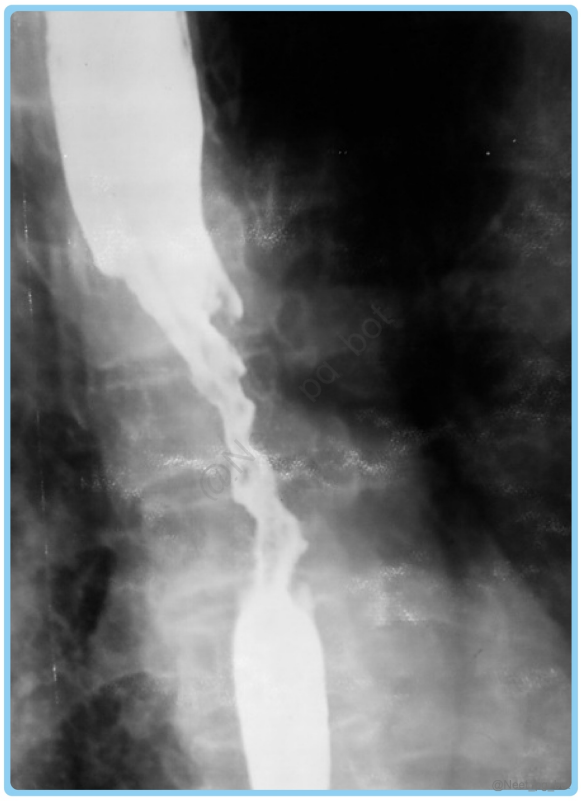


Correct Answer: D. Zenker's diverticulum

Explanation: The given barium swallow film shows a characteristic radiological finding known as a Pharyngeal pouch or Zenker's diverticulum , and the given symptoms also align with this diagnosis. It is an outpouching of the pharyngeal mucosa through a weak area in the posterior pharyngeal wall (Killian's dehiscence), which can trap food and cause bad breath. Zenker's diverticulum Clinical features: Dysphagia is the most prominent feature appears when the pouch gets filled with food and presses on the oesophagus. Gurgling sound is produced on swallowing. Regurgitation at night from undigested food causes cough and aspiration pneumonia. Halitosis (Chronic bad breathing) Malnourished due to dysphagia. Associated hiatus hernia Rarely can a coma develop in long-standing cases of pharyngeal pouches. Diagnosis: Barium swallow provides information regarding the size, location, and character of the mucosal lining. Endoscopy reveals fibrosis and pooling of food in the diverticulum. Treatment: Excision of the pouch and cricopharyngeal myotomy was done through a cervical approach. Dohlman’s procedure: The partition wall between the oesophagus and the pouch is exposed and divided by diathermy through a weerda scope. Endoscopic laser treatment: Partition wall between the oesophagus and the pouch is exposed and divided by CO2 laser using an endoscope. This procedure is known to have fewer recurrences and faster improvement in symptoms. Tracheoesophageal fistula (Option A) usually presents with cough, vomiting, difficulty in breathing , regurgitation and cyanosis. It is often seen in newborns or in patients with a history of oesophagal surgery or cancer. Achalasia cardia (Option B) is a disorder where the lower esophageal sphincter fails to relax properly, leading to dysphagia and regurgitation. Barium swallow shows dilated esophagus with a narrowing at the LES (Bird beak appearance/ Pencil tip appearance/ Rat tail appearance). Carcinoma esophagus (Option C) presents with narrowing or strictures in the esophagus due to tumour growth. Whereas a pharyngeal pouch (Zenker's diverticulum) is a protrusion from the pharynx







References:

PL Dhingra, Shruti Dhingra, Diseases of Ear, Nose and Throat and Head and Neck Surgery, 8th Edition, Pages 323, 324

↑ *Back to this question in Part A*

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Q21: A 60 y/o male suddenly experiences an intense headache, described as the worst headache of his life, followed by vomiting and photophobia. O/E he has neck stiffness and a dilated pupil on the right side. A CT scan reveals bleeding in the subarachnoid space. Which of the following is the most common cause of this condition? (Q852704)

A. Hypertension

B. Intracranial aneurysm

C. Arteriovenous malformation (AVM)

D. Brain tumour

Correct Answer: B. Intracranial aneurysm

Explanation: The clinical scenario described is highly indicative of a subarachnoid haemorrhage (SAH), which is characterized by the sudden onset of a severe headache, vomiting, photophobia, neck stiffness, and neurological signs such as a dilated pupil. The most common cause of subarachnoid haemorrhage (SAH) is the rupture of an intracranial aneurysm , responsible for about 50% of cases. Subarachnoid Haemorrhage (SAH) Intracranial haemorrhage into the subarachnoid space, typically originating from the basal cisterns. It may occur spontaneously or following trauma (Trauma > Spontaneous) Causes of spontaneous SAH: Intracranial aneurysms: The most common cause Hypertension: Contributing to the formation and rupture of aneurysms. Arteriovenous (A-V) malformations Blood dyscrasias Anticoagulant drugs: Increasing the risk of bleeding. Brain tumours (malignant): Causing vessel erosion or rupture. Clinical Features: Sudden onset: Severe headache with vomiting. Raised intracranial pressure : Signs like photophobia and neck stiffness. Focal neurological deficits: Hemiplegia, dysphasia. Eye changes: Ptosis, dilated pupil, abnormal eye movements. Sudden loss of consciousness Rebleeding risk: Occurs in 40% of patients within 6-8 weeks, often fatal. Investigations: Imaging: CT scan: Primary imaging modality. Angiography: Carotid and vertebral angiogram to identify aneurysms or vascular malformations. Lumbar puncture: Performed to differentiate from meningitis ; done cautiously due to risk of coning. Management: Surgical interventions: Clipping or wrapping of aneurysm. Craniotomy: Followed by necessary procedures. Ligation of the common carotid artery: Risk of hemiplegia. Therapeutic embolization : To block abnormal blood vessels. Excision of vascular malformations.

References:

SRB’s Manual of surgery, 6th edition, Pages 1083,1084

Bailey and Love Short manual of surgery, 28th Edition, Pages 708-711

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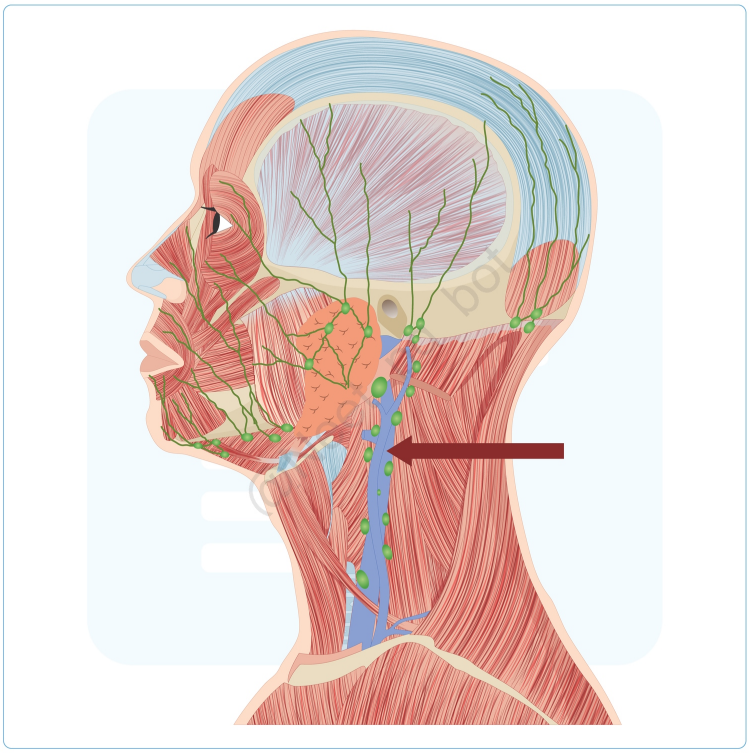
Q22: Identify the level of lymph nodes indicated in the marked region of the neck in the given anatomical image. (Q852717)

A. Level II

B. Level Ia

C. Level Ib

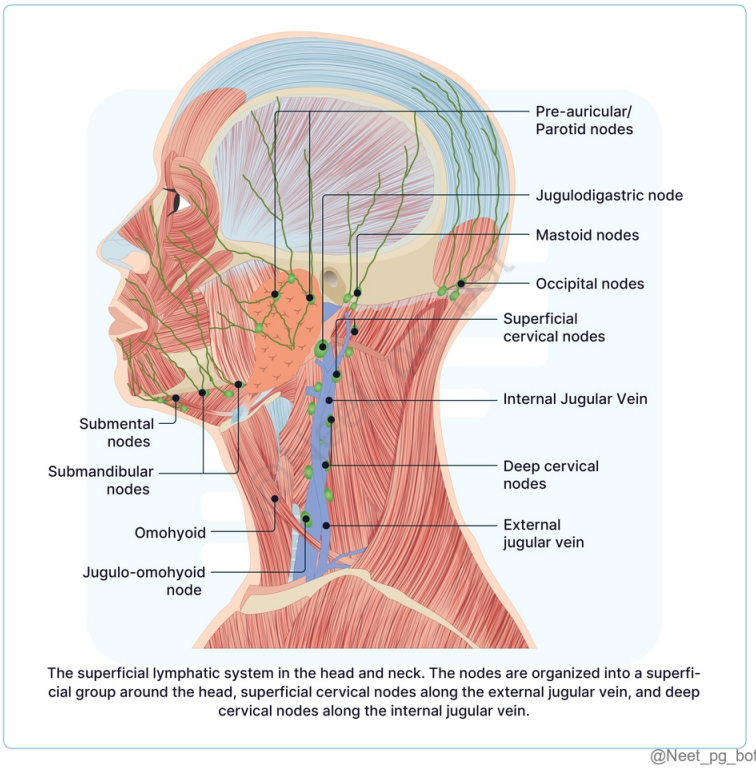
D. Level IV



Correct Answer: A. Level II

Explanation: The marked lymph nodes are located along the upper part of the internal jugular vein , extending from the skull base to the hyoid bone . Level II lymph nodes include the jugulodigastric nodes , commonly involved in head and neck malignancies . They are subdivided into: Level IIa: Medial to the sternocleidomastoid (SCM) muscle . Level IIb: Posterior to the SCM muscle . Cervical Lymph Node Levels Level Anatomical Location Key Features Level I Submental & submandibular Divided into Ia (midline) & Ib (lateral) Level II Upper internal jugular nodes Jugulodigastric region (common in nasopharyngeal CA) Level III Mid-jugular region

Between the hyoid & cricoid Level IV Lower jugular nodes Between the cricoid & clavicle Level V Posterior triangle Spinal accessory nodes Level Ia (Option B): Incorrect because these are submental nodes located in the midline under the chin. Level Ib (Option C): Incorrect because these are submandibular nodes located between the mandible and submental region . Level IV (Option D): Incorrect because these nodes are inferior to the cricoid cartilage , closer to the supraclavicular region .



The superficial lymphatic system in the head and neck. The nodes are organized into a superficial group around the head, superficial cervical nodes along the external jugular vein, and deep cervical nodes along the internal jugular vein.

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References:

Gray’s Anatomy The Anatomical Basis of Clinical Practice, Edition 41st- Pg 548, 593, 594, 595, 630

↑ *Back to this question in Part A*

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Q23: Which of the following is an indication for adjuvant radiotherapy in oral malignancy after resection and modified radical neck dissection (MRND)? (Q844310)

A. Extranodal extension

B. Multiple lymph node metastasis

C. T3 tumor

D. Close margin

Correct Answer: A. Extranodal extension

Explanation: Extranodal extension (ENE) is the strongest and most definitive indication for adjuvant radiotherapy after resection and modified radical neck dissection (MRND) in oral cavity squamous cell carcinoma. ENE signifies that tumor has penetrated beyond the lymph node capsule into surrounding soft tissues, which is associated with a markedly increased risk of locoregional recurrence and poor survival. Because of this high-risk biology, ENE typically requires post-operative chemoradiotherapy , making it the most important criterion among the options. Multiple lymph node metastasis (Option B): Multiple positive nodes (especially ≥2–3) are a recognized indication for adjuvant radiotherapy due to increased recurrence risk. However, the risk is not as severe as extranodal extension , making ENE the better single answer. T3 tumor (Option C): A T3 primary tumor is an intermediate-to-high-risk feature and often warrants postoperative radiotherapy to improve local control. But it is not as definitive or high-risk as ENE , so it is not the best choice. Close margin (Option D): Margins <5 mm are commonly treated with adjuvant radiotherapy, as they suggest potential microscopic residual disease. Still, this indication is less critical compared with extranodal extension, which carries the highest risk of recurrence.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 829

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Q24: In the evaluation of squamous cell carcinoma (SCC) of the lip, which biopsy technique is considered most appropriate for obtaining a representative tissue sample for histopathological diagnosis? (Q844291)

A. Superficial shave biopsy of the tumor surface

B. Complete excision of the lesion

C. Incisional biopsy including both tumor and adjacent normal tissue

D. Punch biopsy limited to the ulcerated surface

Correct Answer: C. Incisional biopsy including both tumor and adjacent normal tissue

Explanation: For suspected malignancies of the lip, the goal is to obtain an adequate depth and margin of tissue for accurate histopathological evaluation. An incisional biopsy that includes both tumor tissue and a small portion of adjacent clinically normal mucosa allows assessment of the transition zone and tumor invasion depth. It avoids unnecessary full excision before staging and planning treatment. It is considered the standard technique when the lesion is too large for excision or when diagnosis must be confirmed before definitive therapy. Incorrect Options: Option A) Superficial shave biopsy : Too superficial; risks missing depth of invasion, which is crucial for SCC prognosis. Option B) Complete excision of the lesion : Not preferred initially unless the lesion is very small (<1

cm) and clinically clearly resectable; unnecessary for larger or ill-defined SCC. Option D) Punch biopsy limited to the ulcerated surface : Inadequate; samples only the superficial ulcer, missing deeper invasive margins and leading to false-negative or incomplete diagnosis.

References:

SRB's Manual of Surgery, 6th Edition, Page 376

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Q25: A 65-year-old smoker presents with ulcerative lesions on his lower lip for the past year. On examination, there is a palpable ipsilateral submental lymph node approximately 5x5 cm. A biopsy from the lesion is suggestive of squamous cell carcinoma. What is the next step in management? (Q860454)

A. Radiotherapy

B. Combined chemoradiotherapy

C. Resection with primary closure alone

D. Resection of primary lesion with lip reconstruction and MRND



Correct Answer: D. Resection of primary lesion with lip reconstruction and MRND

Explanation: Resection of the primary lesion with lip reconstruction is necessary for the treatment of primary cancer, and given the presence of a palpable lymph node (suggesting potential nodal metastasis), modified radical neck dissection (MRND) is indicated to address any possible regional nodal spread. TNM Staging of Carcinoma lip: T Stage Tis: Carcinoma in situ T1 : Tumor ≤2 cm and ≤5 mm depth of invasion T2 : Tumor ≤2 cm and >5 mm but ≤10 mm depth, OR Tumor >2 cm but ≤4 cm and ≤10 mm depth T3 : Tumor >4 cm OR any tumor >10 mm depth of invasion T4 : Invasion of adjacent structures N Stage: N0: No regional lymph node metastasis N1-N3 : Based on number, size, and laterality of involved nodes M Stage: M0: No distant metastasis M1: Distant metastasis Management of Carcinoma lip: Early Stage (T1-T2N0) Wide local excision with 1 cm margins Consider elective neck dissection for tumours>2 cm or >4 mm in depth Reconstruction: Primary closure, local flaps, or skin grafts Advanced Stage (T3-T4 or N+) Wide local excision with ≥1 cm margins Neck dissection (comprehensive or selective based on nodal status) Complex reconstruction (local/regional flaps, free tissue transfer) Adjuvant radiotherapy or chemoradiotherapy based on pathological findings Reconstruction Options Wedge excision and primary closure (for small lesions) Local flaps: Abbe-Estlander, Karapandzic, nasolabial Regional flaps: Forehead, cervicofacial Free tissue transfer: Radial forearm free flap, anterolateral thigh flap Management of the Neck Elective neck dissection for high-risk tumours (>2 cm, >4 mm depth) Therapeutic neck dissection for clinically positive nodes Levels typically addressed: I-III for N0 neck, I-V for N+ neck Radiotherapy Adjuvant: For positive margins, perineural invasion, multiple positive nodes Definitive: For patients unfit for surgery or refusing surgery Brachytherapy: Can be considered for select early-stage lesions Chemotherapy Not routinely used in early-stage disease It may be combined with radiotherapy in locally advanced cases Follow-up and Surveillance Regular follow-up visits: Every 1-3 months for the first year, then gradually decreasing frequency

References:

Sabiston Textbook of Surgery, 21st Edition, Page 777, 779

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Q26: A patient arrives at the emergency department following severe maxillofacial trauma sustained in a road traffic accident. The airway is compromised, and immediate intervention is required. What is the most appropriate immediate management? (Q860234)

A. Tracheostomy

B. Orotracheal intubation

C. Cricothyroidotomy

D. Bag mask with jaw thrust

Correct Answer: C. Cricothyroidotomy

Explanation: Cricothyroidotomy is the most appropriate immediate management when oro- or nasotracheal intubation is not feasible due to severe maxillofacial trauma. It provides an emergency surgical airway when other methods fail. Emergency Assessment and Management of Maxillofacial Trauma: Initial Assessment: Airway, Breathing, Circulation (ABC): Prioritize airway management following ATLS guidelines. Remove visible airway obstructions and apply direct pressure to bleeding points. Midface Bleeding: In conscious patients, position them forward or in the recovery position to prevent blood from obstructing the airway. Caution with suspected spinal injury. Maxillofacial Skeleton Damage: In cases of maxilla detachment or bilateral mandibular fractures, airway compromise is common due to tongue displacement and soft tissue edema. Airway Management: Endotracheal Intubation: Prepare for intubation, needle cricothyroidotomy, or surgical airway if intubation is difficult. Relieving Airway Compromise: Disimpact the maxilla and pull the tongue forward using a suture or towel clip. Ensure high-volume suction to clear blood and debris. Hemorrhage Management: Severe Bleeding: Control hemorrhage from large lacerations or penetrating injuries with direct pressure, nasal packs, or Foley catheters. Airway Protection: If swelling threatens the airway, consider endotracheal intubation or surgical airway. Head and Orbital Injury Assessment: Head Injury: A CT scan should be performed to rule out intracranial injuries, especially in intoxicated patients. Orbital Damage: Orbital fractures may lead to vision loss if untreated. Retrobulbar hemorrhage can cause optic nerve compression, leading to blindness. Tracheostomy (Option A) although definitive, it is a time-consuming surgical procedure and not ideal in an emergency . Used when airway control is required for long-term ventilation or when the situation allows for a controlled surgical setting . Bag-mask ventilation with jaw thrust (Option D) is not suitable for this patient due to the extensive facial trauma, which compromises the airway and makes this method ineffective. Endotracheal intubation (Option B) would be attempted first, but in cases where maxillofacial trauma precludes this, other options like cricothyroidotomy are prioritized.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 405,406

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Q27: A child presented with the following findings and is planned to undergo surgery, which muscle will be repaired during surgery? (Q865320)

A. Orbicularis oris

B. Orbicularis oculi

C. Zygomaticus major

D. Levator alae nasi



Correct Answer: A. Orbicularis oris

Explanation: The image shows a child with a Cleft lip , a congenital anomaly resulting from the failure of fusion of facial processes during embryological development. Cleft lip and/or palate is the most common congenital abnormality affecting the orofacial region. The ultimate goal of cleft lip repair is to restore the sphincter function of the orbicularis oris muscle and obtain a cosmetically favourable outcome for the developing child. Management of cleft lip: Surgical principles: Cleft lip repair reconnects the muscles around the oral sphincter. Surgical techniques: Millard rotation advancement technique(most widely used) Le Mesurier's Thompson Tennison-Randall Orbicularis oculi (Option B) is a part of the anterior lamella in the eyelid; it encircles the eye and is involved in eyelid closure. It is not related to the lip. Zygomaticus major (Option C) is a facial muscle responsible for smiling and other facial expressions involving drawing the corner of the mouth upwards and outwards. It originates from the zygomatic bone and inserts into the angle of the mouth. Levator alae nasi (Option D) is a facial muscle that originates from the frontal process of the maxilla. It inserts into the skin of the ala of the nose and the upper lip. Its primary function is to elevate the upper lip and dilate the nostrils.

References:

Bailey and Love, Short Practice of Surgery, 28th Edition, Page 745

↑ *Back to this question in Part A*

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Q28: Which among the following is the most common parotid gland tumour? (Q860295)

A. Pleomorphic adenoma

B. Warthin’s tumor

C. Adenoid cystic carcinoma

D. Mucoepidermoid carcinoma

Correct Answer: A. Pleomorphic adenoma

Explanation: Pleomorphic adenoma is the most common benign tumor of the parotid gland, accounting for about 60-70% of all parotid gland tumors. It is typically slow-growing and presents as a painless swelling. Warthin’s tumor (Option B) is the second most common benign tumor of the parotid gland. Adenoid cystic carcinoma (Option C) and mucoepidermoid carcinoma (Option D) are malignant tumors, but they are less common than pleomorphic adenomas. Pleomorphic Adenoma: Clinical Presentation : Painless, well-defined, solitary, mobile masses. Commonly located in the parotid glands (>80% of cases). It can also occur in the submandibular gland and hard palate. Sudden growth of facial nerve palsy may suggest malignant transformation (rare). {{caption_text}} Imaging : USG: Well-lobulated, hypoechoic lesions with possible calcifications. CT: Provides detailed anatomical imaging along with the extent of the tumour. MRI: Helps differentiate between benign and malignant tumours Fine-Needle Aspiration Cytology (FNAC) : Differentiates between inflammatory conditions and tumour- high sensitivity and specificity Histopathology : Gross Examination: Tumours are well-circumscribed, nodular, and firm, with a white to tan cut surface. May show cartilaginous areas; large tumours may exhibit degeneration or cystic changes. Microscopy: A mixture of epithelial, myoepithelial, and stromal components. Possible malignant changes: Ductal atypia, diffuse fibrosis, or necrosis Treatment: Surgical Excision of the tumour along with a cuff of normal tissue. Enucleation is not recommended due to the risk of capsular breach, tumour spillage, and recurrence. Salivary gland tumors The most common benign tumour Pleomorphic adenoma The most common benign tumour of infants and young children Hemangioma The most common malignan t tumour Mucoepidermoid carcinoma The most common malignant tumour in children and young adults Mucoepidermoid carcinoma The most common malignant tumour of Minor salivary glands Adenoid cystic carcinoma



References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 839, 840, 842

↑ *Back to this question in Part A*

@Neet_pg_bot

Q29: What is the most likely diagnosis for a young patient under 5 years of age presenting with a painless, soft, fluctuating mass on the lateral side of the neck? (Q860298)

A. Thyroglossal cyst

B. Cystic hygroma

C. Cervical lymphadenopathy

D. Ranula

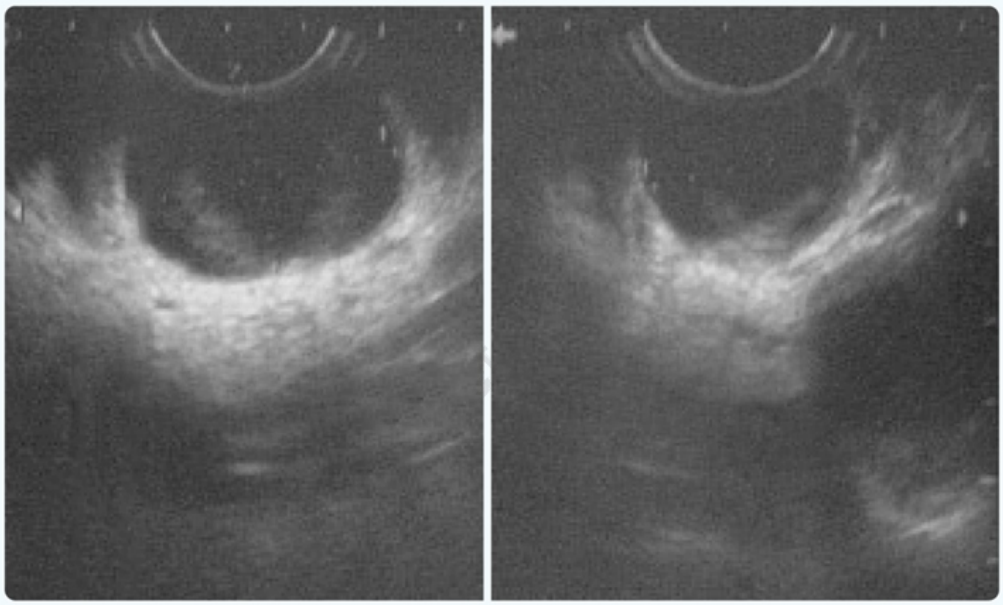


Correct Answer: B. Cystic hygroma

Explanation: The child is most likely suffering from Cystic hygroma , which is soft, partially compressible swelling filled with clear lymph. Features of Cystic Hygromas: Definition : Lymphatic malformations in neonates or infants. Appearance : Soft, partially compressible swellings filled with clear lymph. (Option C) Size Variation : May increase in size when the child cries or coughs. Common Locations : Neck (most common), face, submandibular region, tongue, floor of the mouth, cheek, axilla, groin, mediastinum . Distinguishing Characteristics : Translucence. Behavior and Complications: Behavior : Unpredictable; can expand rapidly. Complications : Respiratory difficulties (may require aspiration or tracheostomy). Risk of infection. Treatment: Preferred Treatment : Early complete surgical excision. Alternative Treatment : Injection of sclerosing agents to reduce size. Challenges : Complete resolution can be difficult due to its multicystic nature. {{caption_text}} {{caption_text}} {{caption_text}} Incorrect Options: Thyroglossal cysts (Option A) are usually present in the midline of the neck and may be associated with swallowing or tongue movements. Cervical lymphadenopathy (Option C) typically involves lymph nodes and is often tender or associated with infection. Ranula (Option D) is a type of mucous retention cyst in the floor of the mouth and would not present as a lateral neck mass.


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Ultra sonogram showing heterogeneous multiple cysts

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References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 805, 806

↑ *Back to this question in Part A*

@Neet_pg_bot

Q30: What is the condition depicted in the given image, and what is the next investigation required for management? (Q860313)

A. Erythroplakia and biopsy

B. Erythroplakia and observation

C. Leukoplakia and biopsy

D. Leukoplakia and observation



Correct Answer: A. Erythroplakia and biopsy

Explanation: The condition here is erythroplakia. Erythroplakia is a red, velvety lesion that is often highly suspicious for malignancy, and biopsy is indicated to rule out cancer. Erythroplakia is a bright red velvety plaque that cannot be characterized clinically or pathologically as any other disease. Has a higher malignant potential than leukoplakia. Types : Homogenous Speckled Granular Erythroplakia interspersed with leukoplakia Management : Biopsy for diagnosis Surgical excision Strict follow-up {{caption_text}} {{caption_text}} Leukoplakia is defined as a white patch or plaque that cannot be rubbed off, and cannot be characterized clinically or pathologically as any other disease. It is a premalignant lesion and is painless/non-tender . {{caption_text}} Types : Homogenous Nodular Speckled Hairy: Associated with EBV. It is not actually hairy but appears so due to the corrugation caused by severe hyperkeratosis and acanthosis. Common in AIDS patients. Management : Biopsy to rule out carcinoma and confirm diagnosis. Stop smoking/ alcohol/ betel quid. Excision, skin grafting if needed. Regular follow-up. Isotretinoin, tocopherol, and beta-carotene. CO 2 laser.


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References:

SRB's Manual of Surgery, 6th Edition, Page 359,360,361,791

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 815

↑ *Back to this question in Part A*

@Neet_pg_bot

Q31: Match the following features seen due to compression of the following structures in the case of thyroid swelling: Structure Features 1. Trachea a. Hoarseness 2. Esophagus b. Horner syndrome 3. Sympathetic chain c. Dyspnea 4. Recurrent laryngeal nerve d. Dysphagia (Q857298)

A. 1-c, 2-d, 3-b, 4-a

B. 1-d, 2-c, 3-a, 4-b

C. 1-a, 2-d, 3-b, 4-c

D. 1-c, 2-a, 3-d, 4-b

Correct Answer: A. 1-c, 2-d, 3-b, 4-a

Explanation: Structure Compressed Feature Trachea Dyspnea Esophagus Dysphagia Sympathetic chain Horner syndrome Recurrent laryngeal nerve Hoarseness Compression of the trachea can cause difficulty breathing (dyspnea) because it obstructs the airflow. If the oesophagus is compressed, it can cause difficulty swallowing (dysphagia) due to obstruction, making it hard for food or liquid to pass down the throat. The sympathetic chain, if compressed, can lead to Horner syndrome, which presents as ptosis (drooping eyelid), miosis (constricted pupil), anhidrosis (lack of sweating), and enophthalmos (sunken eyeball) on the affected side. Compression of the recurrent laryngeal nerve can cause hoarseness (changes in the voice or voice weakness) because this nerve controls the muscles of the vocal cords, and its dysfunction affects vocalisation.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 857,859

↑ *Back to this question in Part A*

@Neet_pg_bot

Q32: ABCD 2 scoring includes all the following parameters except? (Q820103)

A. Age

B. Hypertension

C. History of stroke

D. Diabetes Mellitus

Correct Answer: C. History of stroke

Explanation: of correct answer.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q33: A 25-year-old patient had a RTA and was brought to the emergency room with bradycardia and a high BP. The GCS of this patient is < 8. What should be the immediate management in this patient? (Q820119)

A. Urgent CT head

B. Intubate and IPPV

C. Thrombolysis

D. Normal saline infusion

Correct Answer: B. Intubate and IPPV

Explanation: of correct answer.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q34: What is the Intubation of choice in a Maxillofacial trauma patient? (Q820169)

A. Tracheostomy

B. Laryngeal mask airway

C. Orotracheal intubation

D. Mask ventilation

Correct Answer: A. Tracheostomy

Explanation: Correct Option A - Tracheostomy: Tracheostomy involves creating a surgical airway directly into the trachea through the neck. While it provides a secure airway, it's generally not the initial choice for managing airways in maxillofacial trauma patients unless there are specific indications, such as severe facial fractures that prevent other methods of intubation. Tracheostomy is considered a more invasive procedure and is usually reserved for situations where other methods are not feasible or have failed. Incorrect Options : Option B - Laryngeal Mask Airway (LMA): Laryngeal mask airway is a supraglottic airway device that is less invasive than tracheostomy. It sits in the pharynx and seals around the laryngeal inlet, allowing positive pressure ventilation. However, in cases of significant maxillofacial trauma, proper placement and effective ventilation might be compromised due to anatomical disruptions and bleeding. Option C - Orotracheal Intubation: Orotracheal intubation involves passing an endotracheal tube through the mouth into the trachea. It provides a secure airway and is often the preferred choice for managing maxillofacial trauma patients, as it bypasses the potential obstacles created by facial fractures, allowing effective ventilation and protection of the airway. Option D - Mask Ventilation: Mask ventilation involves using a bag-mask device to manually deliver positive pressure ventilation to a patient. While it might be used temporarily in situations where intubation is difficult, it's not the intubation method itself. In maxillofacial trauma, mask ventilation can be challenging due to disrupted facial anatomy and potential difficulty in achieving a proper seal.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q35: A 50-year-old male chronic smoker came to OPD with cough, dyspnea, and difficulty swallowing . A palpable lump was present in the neck. Which of the following are smokers most likely to develop? (Q793891)

A. Adenocarcinoma

B. Squamous cell carcinoma

C. Large cell carcinoma

D. Adenoid cystic carcinoma

Correct Answer: B. Squamous cell carcinoma

Explanation: Correct Option B - Squamous cell carcinoma: In this case, a palpable lump in the neck suggests the possibility of head and neck cancer, which is strongly associated with smoking. Squamous cell carcinoma is the most common type of head and neck cancer. It arises from the squamous cells that line the mucosal surfaces of the head and neck, including the mouth, throat, and larynx. Risk factors include smoking, heavy alcohol consumption, and infection with certain types of human papillomavirus (HPV). Incorrect Options: Option A - Adenocarcinoma: Adenocarcinoma is another type of cancer that can occur in the head and neck, but it is less common than squamous cell carcinoma. It arises from the glandular cells that produce mucus and is often associated with tobacco use and exposure to certain chemicals. Option C - Large cell carcinoma: Large cell carcinoma is a type of lung cancer, not head and neck cancer, that accounts for about 10-15% of all lung cancers. It is characterized by large, abnormal cells that grow and divide uncontrollably. Option D - Adenoid cystic carcinoma: Adenoid cystic carcinoma is a rare type of cancer that can occur in several areas of the body, including the head and neck. It arises from the secretory cells that line certain glands, such as the salivary glands. It is not strongly associated with smoking.

References:

Prepladder Notes

↑ *Back to this question in Part A*

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• [03_Cardiothoracic Vascular Surgery] 008 Arterial Disorders - I

« Back to Folder Directory

[03_Cardiothoracic Vascular Surgery] 008 Arterial Disorders - I — Quick Jump

Q1 (p. 1355)	*Q2 (p. 1356)*	*Q3 (p. 1358)*	*Q4 (p. 1359)*	*Q5 (p. 1362)*	*Q6 (p. 1362)*
Q7 (p. 1363)	*Q8 (p. 1365)*	*Q9 (p. 1366)*	*Q10 (p. 1367)*	*Q11 (p. 1368)*	*Q12 (p. 1370)*
Q13 (p. 1371)	*Q14 (p. 1373)*	*Q15 (p. 1374)*	*Q16 (p. 1375)*	*Q17 (p. 1378)*	*Q18 (p. 1379)*
Q19 (p. 1381)	*Q20 (p. 1382)*	*Q21 (p. 1383)*	*Q22 (p. 1384)*	*Q23 (p. 1385)*	*Q24 (p. 1386)*
Q25 (p. 1387)					

Q1: A 62-year-old male patient is having complaints of loss of vision in the form of a curtain coming down in front of the right eye. He has a history of 2 episodes of strokes, after which he has left-sided sensory and motor loss limited to the face and neck. Which of the following blood vessels might be stenosed in this case? (Q849435)

A. Left vertebral artery

B. Carotid artery

C. First part of the left subclavian artery

D. Superior mesenteric vein

Correct Answer: B. Carotid artery

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The condition is diagnosed as Carotid artery stenosis , having clinical features of face and neck paralysis along with Amaurosis fugax (loss of vision in the form of a curtain coming down in front of the eye). Carotid artery stenosis Carotid artery stenosis may cause TIAs (Transient Ischemic Attacks), which are short-lived mini strokes and are often recurrent, causing unilateral motor or sensory loss in the arm, leg or face. They are caused by the distal embolisation of platelet thrombi that form on the atheromatous plaque and enter the cerebral circulation. They are considered as a warning of impending major stroke. Duplex scan is done for assessment. Indications for Endarterectomy: Stenosis of more than or equal to 50% Ipsilateral amaurosis fugax or monocular blindness Contralateral facial paralysis or paresthesia Arm/leg paresthesia Hemianopia Dysphasia Sensory loss or visual inattention or neglect. Amaurosis fugax is the temporary loss of vision due decreased blood supply to the retina to blockage of arteries. It is presented as a feeling of a curtain coming down in front of the eyes.

References:

Bailey & Love’s Short Practice of Surgery, 28th Edition, Page 1008

↑ *Back to this question in Part A*

@Neet_pg_bot

Q2: A 67-year-old male was having complaints of sudden onset of severe chest pain, which was radiating to his back, and suddenly, he went unconscious. He was chronically hypertensive, a drug defaulter, and was having weakness, dizziness and dyspnea for 1 day. His current BP is 90/50 mm Hg, and his Heart Rate is 140 bpm. What is the best investigation of choice in this condition? (Q849415)

A. CT Angiography

B. Aortography

C. Trans Esophageal Echocardiography

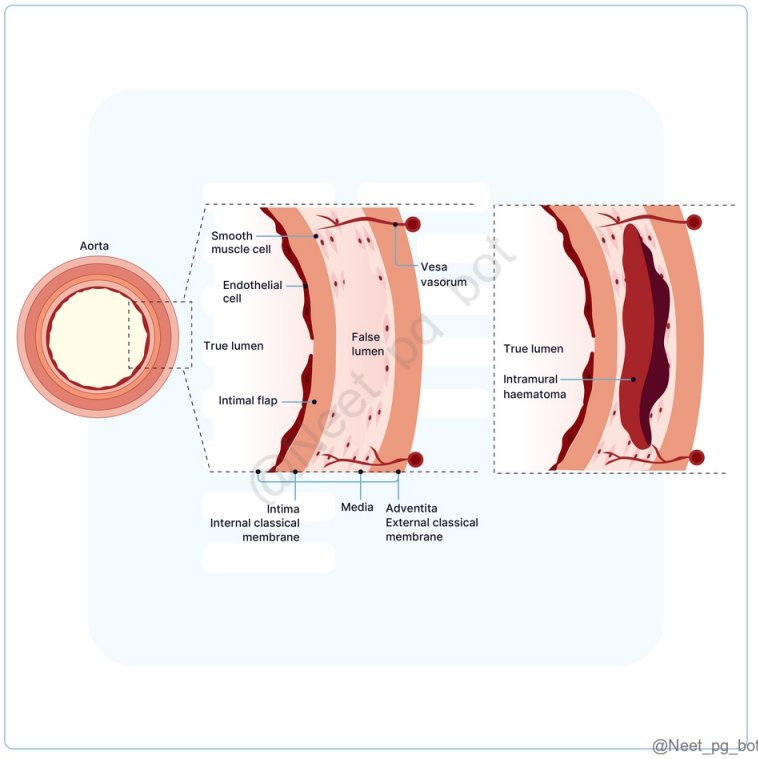
D. Chest x-ray

Correct Answer: C. Trans Esophageal Echocardiography

■ *Listen (English)*

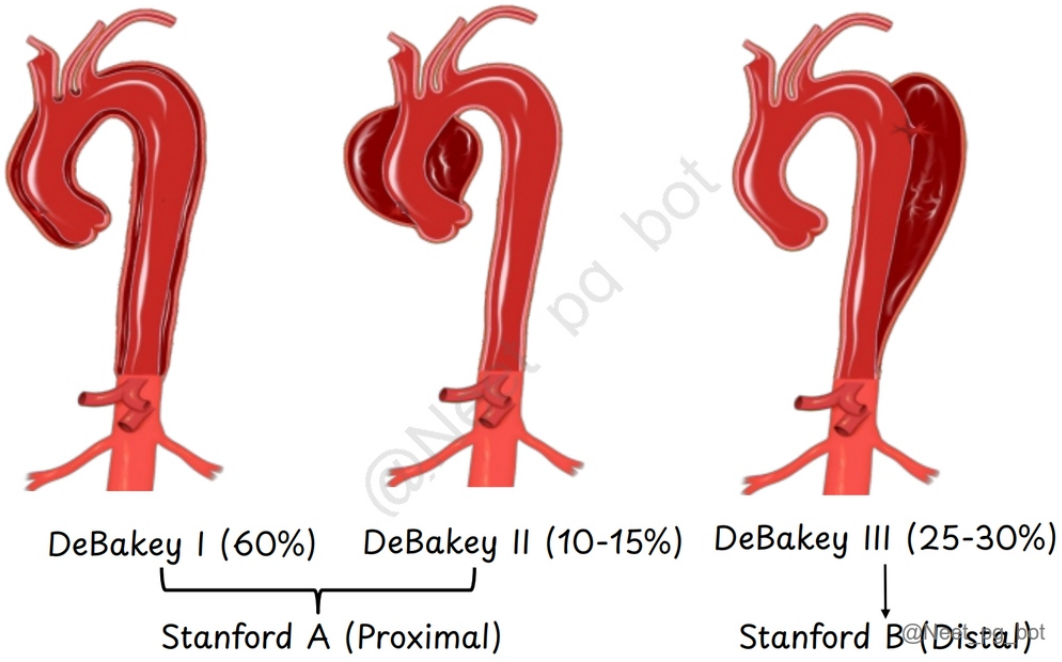
■ *Listen (Hindi)*

Explanation: The above given scenario is an unstable case of Aortic dissection, and the investigation of choice is TEE (Trans Esophageal Echocardiography). Aortic Dissection It occurs when a defect or a flap occurs in the aorta, resulting in blood tracking into aortic tissues, splitting the medial layer, and creating a false lumen. Clinical features: Sudden onset of severe, tearing chest, radiating to the interscapular region Renal pain and renal failure Paraplegia Syncope Weakness Hypotension or shock Investigations: If the patient is stable, CT angiography is the standard investigation of choice. (Option A) In the case of unstable patients (SBP<100 mm of HG, HR>100 bpm), the preferred investigation of choice will be TEE (TransEsophageal Echocardiography) MRI can also be done if CT is unequivocal. Chest x-ray (Option D) reveals widening of the mediastinum along with left-sided pleural effusion. TEE of an aortic dissection within the descending part Classification: DeBakey Classification (Based on the pattern of dissection) Type I Both ascending and descending aorta are involved Type II Only the ascending aorta is involved Type III Only the descending aorta is involved Stanford Classification (Based on whether the ascending aorta is involved in aortic dissection) Type A Only the ascending aorta or both ascending and descending aorta is involved. (It includes both Type I and Type II of DeBakey's classification) Type B Only the descending aorta is involved. (It includes Type III of DeBakey's classification) Aortography (Option B) is the investigation of choice for chronic mesenteric ischemia.


Aorta
Smooth muscle cell
Endothelial cell
True lumen
Intimal flap
False lumen
Vesa vasorum
True lumen
Intramural haematoma
Intima
Internal classical membrane
Media
Adventita
External classical membrane

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References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 970, 971

↑ *Back to this question in Part A*

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Q3: Which of the following signs is seen in Arteriovenous fistula? (Q849404)

A. Murphy's sign

B. Brudzinski's sign

C. Hegar's sign

D. Nicoladoni's sign

Correct Answer: D. Nicoladoni's sign

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Nicoladoni's / Branham's sign is observed in AVF: \ On pressing the artery proximal to the fistula, there is a decrease in the size of the pulsatile mass, disappearance of palpable thrill and decrease in heart rate. Arteriovenous Fistula (AVF) AVF is a communication between an artery and a vein that may be either congenital or acquired (trauma or surgical). Structurally, they are arterialised (become dilated, tortuous and thick-walled). Physiologically, there is an increase in venous return (as blood starts flowing from arteries to veins, which causes

an increase in cardiac output, which in turn results in an increase in systolic BP, leading to cardiac failure. On examination, there is a presence of pulsatile swelling, a thrill and auscultation reveals machinery murmur (buzzing continuous murmur) Murphy's sign (Option A): Pain during inspiration while palpating the right subcostal area is termed Murphy's sign. It is seen in acute cholecystitis. Brudzinski's sign (Option B): In meningitis, neck stiffness causes a patient's hips and knees to flex when the neck is flexed; this is Brudzinski's sign. Hegar's sign (Option C): Softening of the cervix in pregnancy is known as hegar's sign

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1023, 1024

↑ *Back to this question in Part A*

@Neet_pg_bot

Q4: A 35-year-old female experiences numbness and tingling in her right arm, worsened by arm elevation. During examination, she abducts her arms to 90° with external rotation, flexes her elbows to 90°, and opens and closes her hands for 3 minutes, which reproduces her symptoms. Which test was most likely performed? (Q849407)

A. Adson's Test

B. Roos Test

C. Wright's Test

D. Elvey Test

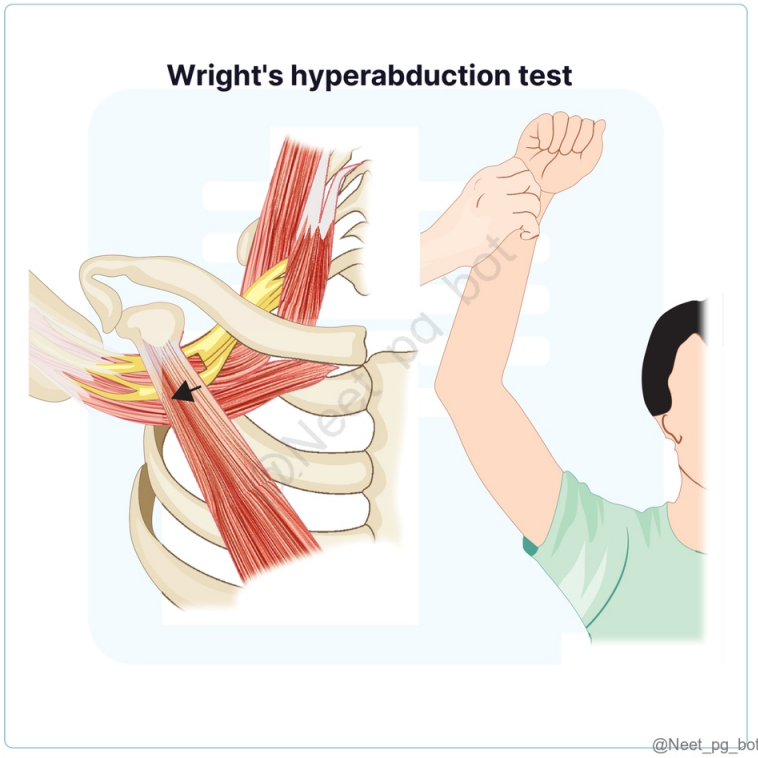
Correct Answer: B. Roos Test

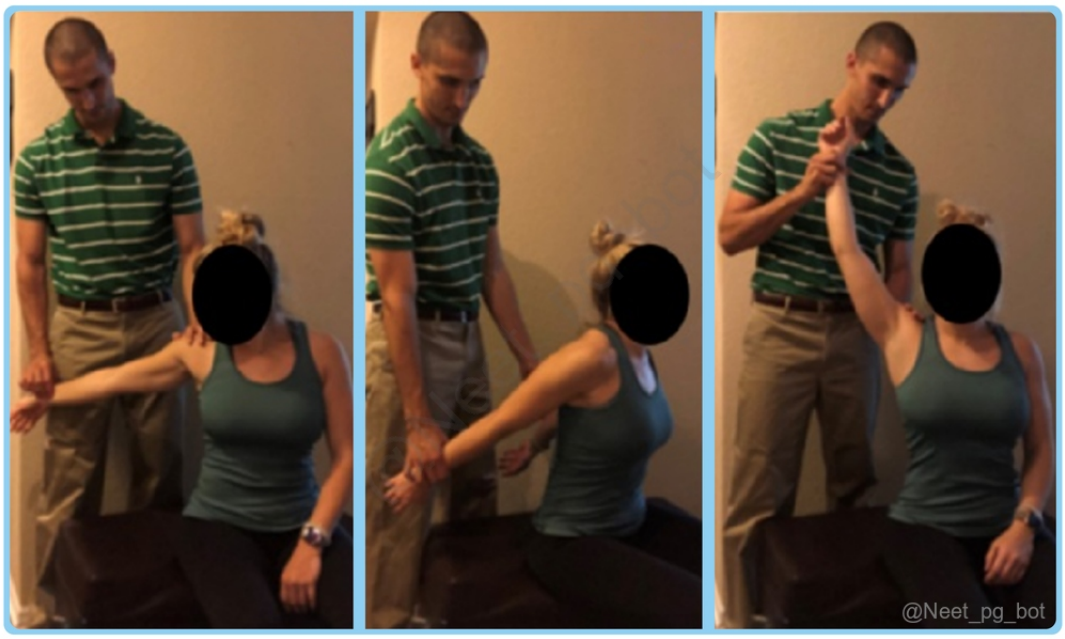
■ *Listen to Audio 1*

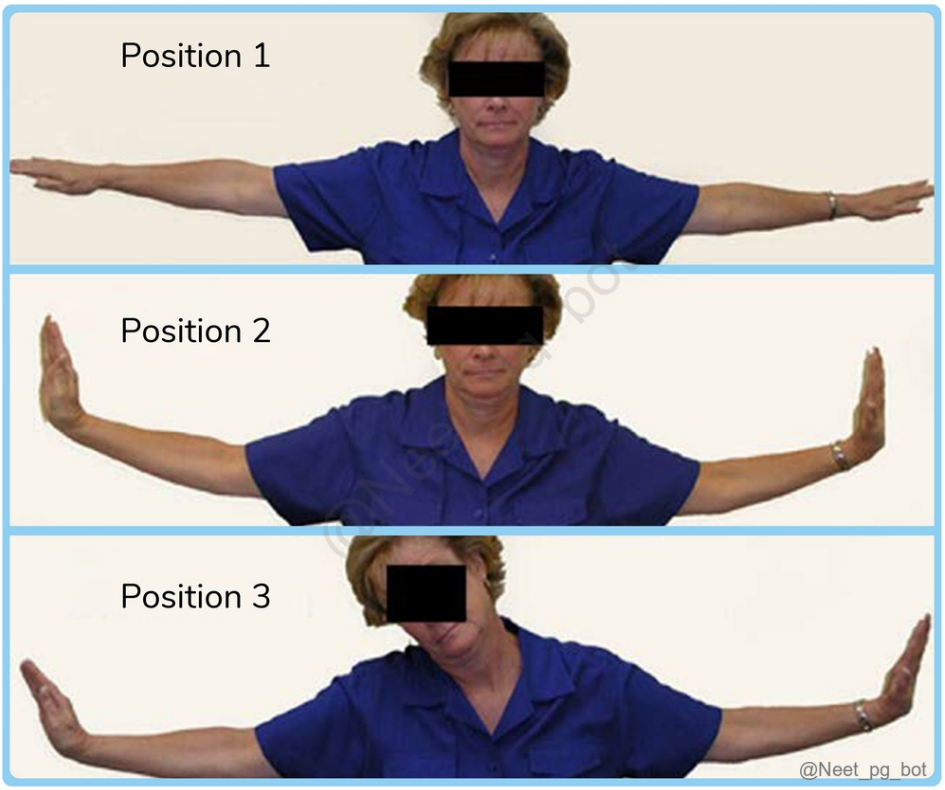
Explanation: The scenario describes the Roos test (also known as the Elevated Arm Stress Test), which is used to diagnose thoracic outlet syndrome (TOS). The test involves the patient abducting their arms to 90°, externally rotating them, flexing the elbows to 90°, and repeatedly opening and closing the hands for 3 minutes. Reproduction of symptoms like numbness or tingling during this test indicates a positive result, suggestive of TOS. Roos Test Common provocative diagnostic tests for Thoracic Outlet Syndrome (TOS): Test Maneuver Result Adson's Test (Option A) Arm abducted 30° and maximally extended. Patient extends neck, turns head toward the ipsilateral side, and inhales deeply. Decrease or absence of ipsilateral radial pulse. Elevated Arm Stress Test (EAST) / Roos Test (Option B) Arms in "surrender" position (abducted 90°, external rotation, elbows flexed 90°). The patient slowly opens and closes hands for 3 minutes. Pain, paresthesia, heaviness, or weakness precipitated. Upper Limb Tension Test (ULTT) / Elvey Test (Option D) Position 1: Arms abducted 90°, elbows flexed. Position 2: Active dorsiflexion of wrists. Position 3: Tilt head (ear to shoulder) in both directions. Symptoms in the ipsilateral arm (Position 1 & 2); Contralateral symptoms in Position 3. Wright's test (Option C) is a clinical sign in which the radial pulse weakens or disappears when the arm is abducted and externally rotated.

Adsons test is a physical examination maneuver used to detect vascular thoracic outlet syndrome (TOS) by assessing compression of the subclavian artery Elvey Test is a physical assessment used to evaluate the mobility and sensitivity of brachial plexus nerves in the arm, primarily to diagnose nerve compression, such as thoracic outlet syndrome









References:

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6514035/

↑ *Back to this question in Part A*

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Q5: A 23-year-old competitive swimmer presents with progressive weakness and tingling in his right hand. On examination, there is wasting of the small muscles of the hand and sensory loss in the medial side of the hand and forearm. Which of the following nerves is most likely compressed in this patient? (Q849406)

A. Median nerve (C5-T1

B. Ulnar nerve (C8-T1)

C. Radial nerve (C5-T1)

D. Axillary nerve (C5-C6)

Correct Answer: B. Ulnar nerve (C8-T1)

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The most likely diagnosis is thoracic outlet syndrome (TOS), where the ulnar nerve (C8-T1) is commonly compressed and presents with muscle wasting in the hand and sensory loss in the medial hand and forearm. TOS often presents in athletes like swimmers, who frequently use overhead movements. The ulnar nerve is vulnerable in TOS because it passes through the thoracic outlet and can be compressed by anatomical structures such as a cervical rib or tight scalene muscles. Thoracic outlet syndrome: Category Details Predisposing Factors Cervical Rib, Cervical Hematoma (Trauma), Pancoast Tumor, Osteoarthritis, Long Transverse Process of C7 Clinical Manifestations Neurogenic TOS: Pain, numbness, and tingling due to nerve compression Arterial TOS: Pain, coldness, and paleness due to impaired arterial blood flow Venous TOS: Swelling, pain, and discolouration due to impaired venous return

References:

Sabiston’s Textbook of Surgery, 21 Edition, Page 1801,1830 SRB’s Manual of Surgery, 6th Edition, Page 415

↑ *Back to this question in Part A*

@Neet_pg_bot

Q6: Which of the following is the most preferred vascular graft for CABG? (Q849434)

A. Long saphenous vein

B. Dacron

C. Polyurethane

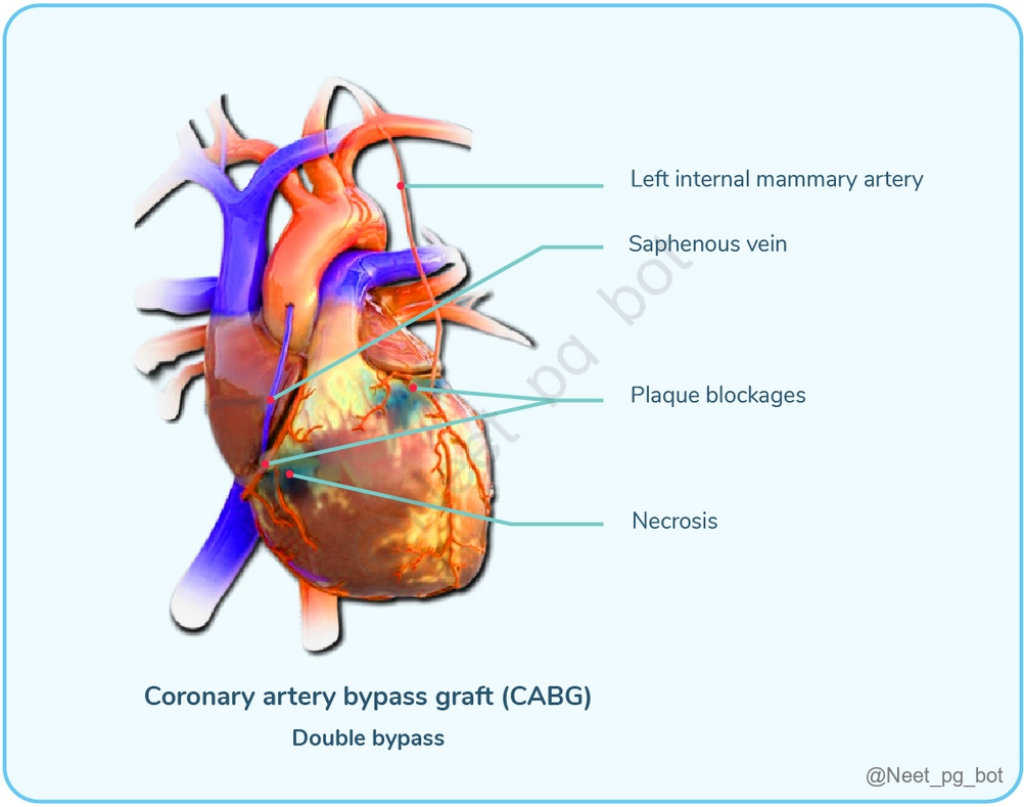
D. Left Internal Mammary Artery

Correct Answer: D. Left Internal Mammary Artery

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The most preferred vascular graft for CABG is LIMA (Left Internal Mammary Artery). Coronary Artery Bypass Graft (CABG) CABG is a procedure done by using a vascular graft for bypassing the blocked site of arteries and allowing the flow of blood to the heart muscles. Various types of grafts can be used as per need. For example, the most preferred graft for CABG is LIMA (Option D) , but the reversed long saphenous vein is more commonly used due to its extra length and it is easy to handle (Option A) . Dacron, polyurethane, and ePTFE (expanded polytetrafluoroethylene) are examples of synthetic vascular grafts. (Option B and C) .



References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 946-953

↑ *Back to this question in Part A*

@Neet_pg_bot

Q7: A 48-year-old male presents with retrosternal chest pain, which was radiation to the left arm and shoulder. He has a previous history of acute myocardial infarction.

CABG was advised, but the patient is insisting on using synthetic graft and wants to know more about it. Which of the following is the most preferred synthetic vascular graft for CABG? (Q849433)

A. Polyurethane

B. ePTFE

C. Dacron

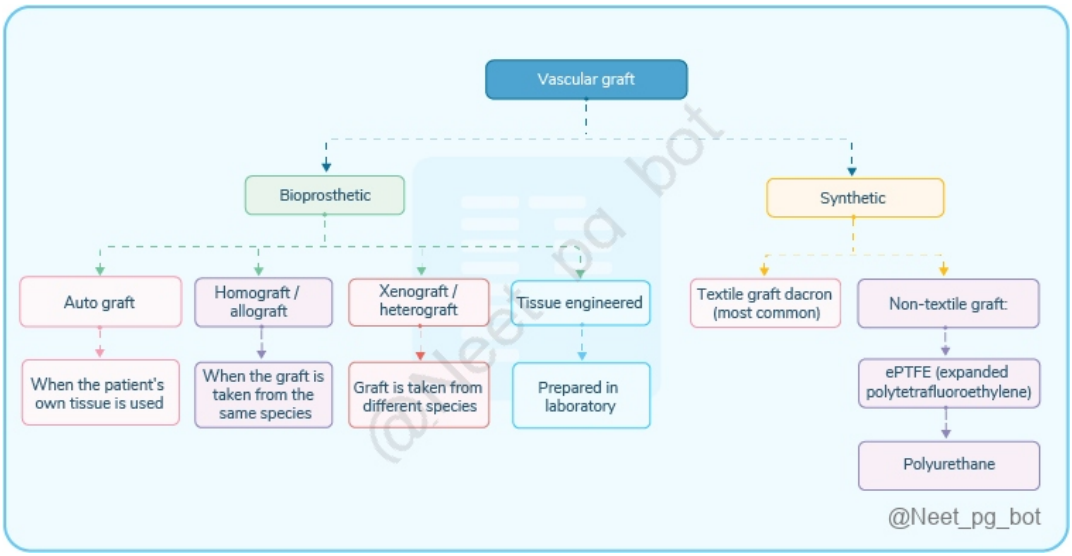
D. Long saphenous vein

Correct Answer: C. Dacron

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The best synthetic type of vascular graft for CABG is Dacron. It is the most preferred vascular graft for supra-inguinal bypass surgery. Classification of Vascular grafts: Bioprosthetic grafts LIMA (Left Internal Mammary Artery): The most preferred vascular graft for CABG Long saphenous vein: Most commonly used in infra-inguinal surgeries due to small and medium-sized vessels (Option D) Synthetic grafts Dacron: Most commonly used synthetic graft in supra inguinal surgeries due to large vessels. (Option C) Polyurethane (Option A) ePTFE (expanded polytetrafluoroethylene) (Option B)



References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 949, 950

↑ *Back to this question in Part A*

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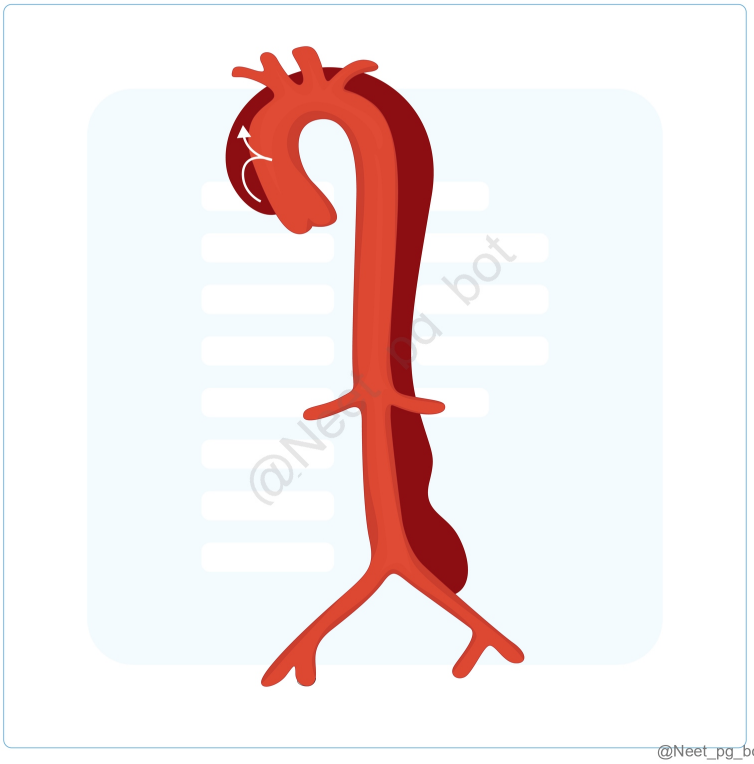
Q8: Based on the Stanford classification, which type of aortic dissection is shown below? (Q849418)

A. Type A

B. Type B

C. Type C

D. Type D



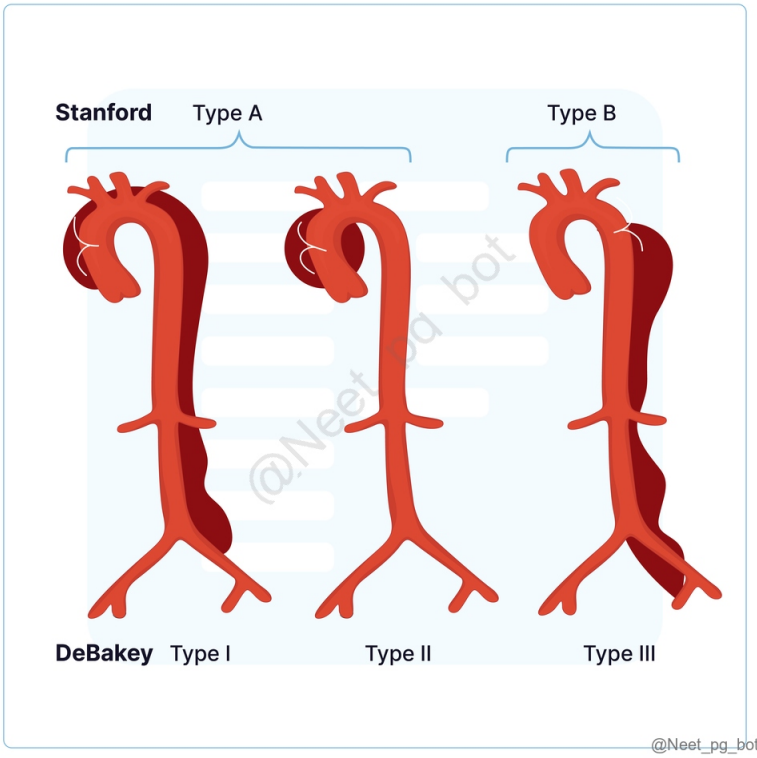
Correct Answer: A. Type A

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: According to the Stanford classification, the given image is classified as Type A aortic dissection. Aortic dissection occurs when a defect or a flap occurs in the aorta, resulting in blood tracking into aortic tissues, splitting the medial layer and creating a false lumen. There are 2 classifications, both of which are widely used for Aortic dissection. DeBakey Classification (Based on the pattern of dissection) Type I Both ascending and descending aorta are involved Type II Only the ascending aorta is involved Type III Only the descending aorta is involved Stanford Classification (Based on whether the ascending aorta is involved in aortic dissection) Type A Only the ascending aorta or both ascending and descending aorta is involved. (Option A) (It includes both Type I and Type II of DeBakey's classification) Type B Only the descending aorta is involved. (Option B) (It includes

Type III of DeBakey’s classification)



References:

Bailey & Love’s Short Practice of Surgery, 28th Edition, Page 970, 971 Schwartz’s Principles of Surgery, 11th Edition, Page 876, 877

↑ *Back to this question in Part A*

@Neet_pg_bot

Q9: A 72-year-old male with a history of hypertension and smoking presents with back pain, and imaging shows a thoracoabdominal aortic aneurysm starting at the sixth intercostal space and extending to just above the renal arteries. According to the Crawford classification, which type does this aneurysm correspond to? (Q849413)

A. Type I

B. Type II

C. Type III

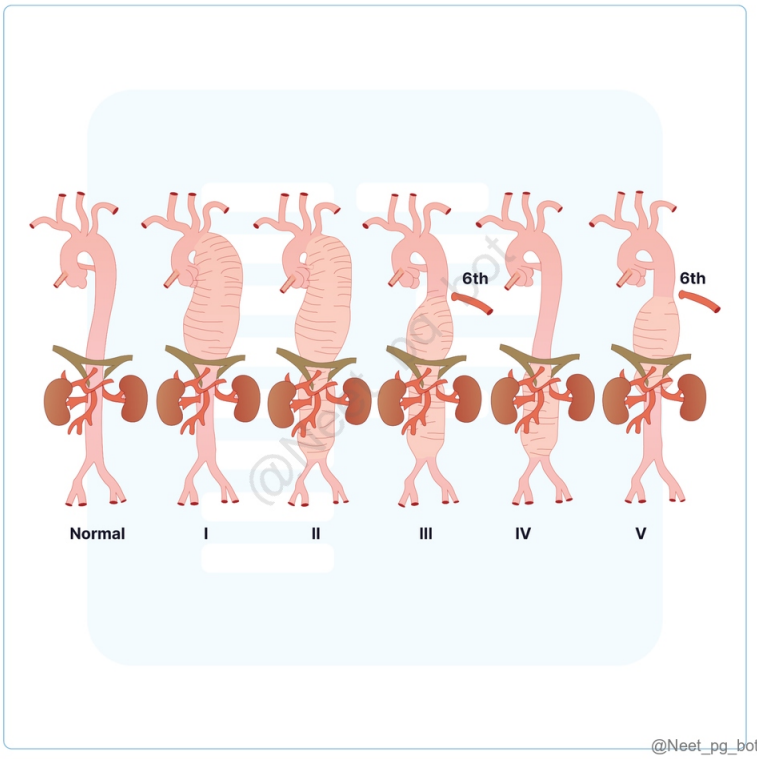
D. Type V

Correct Answer: D. Type V

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Given the description, the patient is diagnosed with Type V thoracoabdominal aortic aneurysm Crawford's classification of thoracoabdominal aortic aneurysm: Type Involvement I Descending thoracic aorta to above renal arteries. II Descending thoracic aorta to below renal arteries. III From the sixth intercostal space to below renal arteries. IV The entire abdominal aorta from the twelfth intercostal space to the aortic bifurcation. V Portion of the thoracic aorta below the sixth intercostal space to above renal arteries.



References:

Sabiston’s Textbook of Surgery, 21 Edition, Page 1747, 1748

↑ *Back to this question in Part A*

@Neet_pg_bot

Q10: A 65-year-old male with a history of hypertension and smoking presents with an abdominal aortic aneurysm measuring 6.0 cm in diameter, detected during routine surveillance. Which of the following is the most appropriate next step in the management of this patient? (Q849412)

A. Regular ultrasound surveillance every 6 months

B. Begin beta-blocker therapy

C. Endovascular aneurysm repair

D. Lifestyle modifications and smoking cessation

Correct Answer: C. Endovascular aneurysm repair

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Abdominal Aortic Aneurysm : For an abdominal aortic aneurysm (AAA) that has reached 6.0 cm in diameter, surgical intervention is generally recommended due to the high risk of rupture. Endovascular aneurysm repair (EVAR) is a minimally invasive surgical approach that is often preferred for eligible patients, given its lower complication rates compared to open surgery. Surveillance is appropriate for smaller aneurysms, and medical management, including blood pressure control and lifestyle modifications, is essential but not sufficient alone for an aneurysm of this size. Management of Abdominal Aortic Aneurysm (AAA): Aspect Details Surveillance Small AAAs (3.0–3.9 cm): Monitor every 2–3 years using ultrasound. Medium AAAs (4.0–5.4 cm): Monitor every 6–12 months with ultrasound. Large AAAs (≥5.5 cm): Surgical intervention recommended; if not, frequent imaging and clinical review. Medical Management Risk Factor Modification : Smoking Cessation Blood Pressure Control Cholesterol Management: Statins recommended. Surgical Intervention I ndications for Surgery: Aneurysm Diameter ≥ 5.5 cm (High risk of rupture) Rapid Growth: >0.5 cm increase in six months. Symptomatic AAAs : Consider surgery. Surgical Options : Open Surgical Repair: Using a Dacron graft which is durable and has higher morbidity. Endovascular Aneurysm Repair (EVAR): Less invasive, requires long-term surveillance for complications.

References:

Sabiston’s Textbook of Surgery, 21 Edition, Pages 1747-1751

↑ *Back to this question in Part A*

@Neet_pg_bot

Q11: A 45-year-old male with a history of bacterial endocarditis presents with sudden onset of severe headache, nausea, and vomiting. A CT scan of the head is shown below. Which of the following is the most likely cause of the haemorrhage in this patient? (Q849411)

A. Ruptured berry aneurysm

B. Traumatic brain injury

C. Hypertensive intracerebral haemorrhage

D. Ruptured mycotic aneurysm



Correct Answer: D. Ruptured mycotic aneurysm

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: In this clinical scenario, the patient has a history of bacterial endocarditis, which significantly raises the likelihood of developing mycotic aneurysms. These aneurysms often occur in cerebral arteries due to septic emboli from the heart lodging in the vessel walls, leading to infection and weakening of the artery. This condition can result in a subarachnoid hemorrhage if the aneurysm ruptures . Causes of mycotic aneurysm: Bacterial infection (e.g., Staphylococcus, Streptococcus, Salmonella) Fungal infection (e.g., Candida, Aspergillus) Septicemia or endocarditis Other options: Option A : Ruptured berry (saccular) aneurysm — Typically presents with non-traumatic subarachnoid haemorrhage (thunderclap headache, blood in the basal cisterns on CT). There is no specific association with acute bacterial endocarditis or septic emboli causing saccular aneurysms. Option B: Traumatic brain injury — Requires history of significant head trauma; the stem gives an infective cardiac source and sudden spontaneous haemorrhage without trauma, making this unlikely. Option C: Hypertensive intracerebral haemorrhage — Usually occurs in deep brain structures (basal ganglia, thalamus, pons, cerebellum) in long-standing poorly controlled hypertension. While hypertensive bleeds can present acutely, the important history of infective endocarditis strongly favors an infective (mycotic) cause.

References:

Bailey & Love’s Short Practice of Surgery, 28th Edition, Page 1014 Sabiston’s Textbook of Surgery, 21 Edition, Page 1748

↑ *Back to this question in Part A*

@Neet_pg_bot

Q12: A 58-year-old male presents with a pulsatile mass in the right groin following recent arterial catheterisation. Doppler ultrasound reveals an aneurysm. Which characteristic best describes this type of aneurysm? (Q849410)

A. Involves all three arterial wall layers

B. Fusiform dilation of the artery.

C. Wall composed of fibrous tissue only

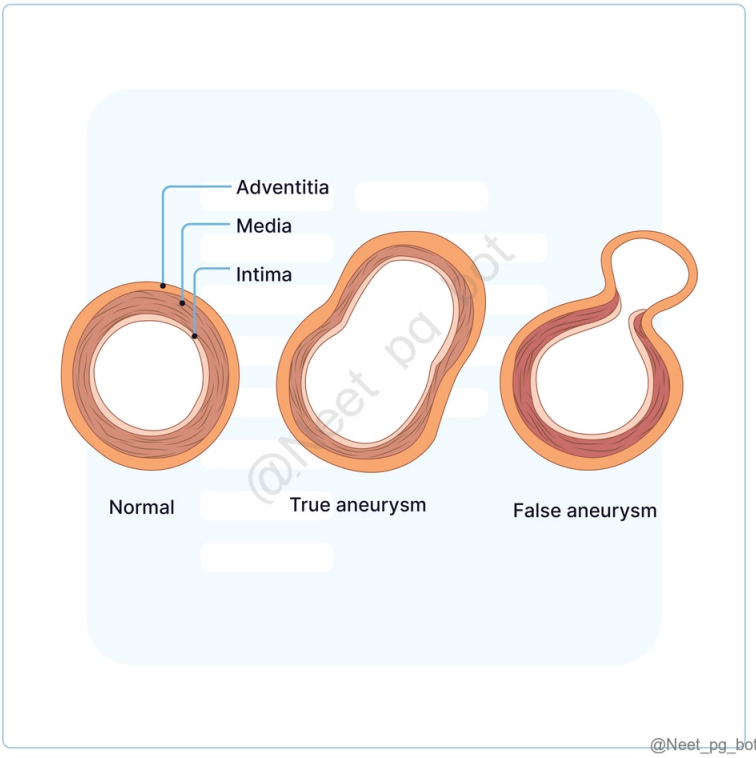
D. Commonly caused by atherosclerosis

Correct Answer: C. Wall composed of fibrous tissue only

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: With the given history, the patient has developed a Pseudoaneurysm post catheterisation. Aspect True Aneurysm False (Pseudoaneurysm) Aneurysm Definition Involves all three layers of the arterial wall. Involves only a layer of fibrous tissue outside the vessel. (Option A ruled out) Wall Structure Intima, media, and adventitia are involved. Only fibrous tissue surrounds the breach. Morphology Fusiform or saccular. Typically spherical or ovoid. (Option B ruled out) Aetiology Atherosclerosis, genetic conditions. Trauma, surgery, or arterial puncture. (Option D ruled out) Clinical Features May be asymptomatic until complications arise. Often presents with a pulsatile mass or pain. Common Locations Large arteries (e.g., aorta, iliac). Peripheral arteries (e.g., femoral, popliteal). Diagnosis Detected by ultrasound, CT, and MRI. Detected by ultrasound or angiography. Management Surgical repair or endovascular techniques. Repair or percutaneous methods (e.g., thrombin injection).



References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1005, 1017-1024

↑ *Back to this question in Part A*

@Neet_pg_bot

Q13: A 65-year-old male with a history of atrial fibrillation presents to the emergency department with sudden, severe abdominal pain that is disproportionate to physical examination findings. He also reports vomiting and the passage of blood in his stool. Given his history and clinical presentation, which artery is most likely involved in this patient's condition? (Q849409)

A. Superior Mesenteric Vein

B. Superior Mesenteric Artery

C. Inferior Mesenteric Artery

D. Inferior Mesenteric Vein

Correct Answer: B. Superior Mesenteric Artery

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Given the patient’s presentation, the diagnosis is Acute mesenteric ischemia and the most common artery involved is Superior mesenteric artery (SMA), which supplies a large portion of the small intestine and part of the colon. Occlusion of the SMA is the most common cause of acute mesenteric ischemia, leading to sudden, severe abdominal pain, particularly in patients with atrial fibrillation. Acute Mesenteric Ischemia (AMI): Aspects Description Definition Sudden reduction in blood supply to the intestines, leading to ischemia and potential necrosis. Commonly involves the Superior mesenteric artery (SMA). Clinical Features Pain: Severe, sudden-onset abdominal pain disproportionate to physical findings. Others: Nausea, vomiting, diarrhea, bloody stools, shock. Risk Factors Cardiovascular: Atrial fibrillation, recent MI, heart failure. Vascular: Atherosclerosis, vasculitis. Others: Hypercoagulable states. Radiological Features CT Angiography: Preferred diagnostic tool; reveals SMA occlusion, String of sausage sign , bowel wall thickening, pneumatosis intestinalis, portal venous gas. Management Initial: IV fluids, broad-spectrum antibiotics, pain control. Definitive: Anticoagulation (e.g., IV heparin), surgical embolectomy, bowel resection. Vasodilators (e.g., papaverine) can be used intra-arterially to relieve vasospasm.



References:

Bailey & Love’s Short Practice of Surgery, 28th Edition, Page 1312, 1313

↑ *Back to this question in Part A*

@Neet_pg_bot

Q14: A 24-year-old woman presents with episodic colour changes in her fingers triggered by cold temperatures and stress. The episodes follow a characteristic sequence. What is the correct sequence of events in the skin colour changes seen in the Raynaud phenomenon? (Q849408)

A. Rubor → Cyanosis → Pallor

B. Cyanosis → Pallor → Rubor

C. Pallor → Cyanosis → Rubor

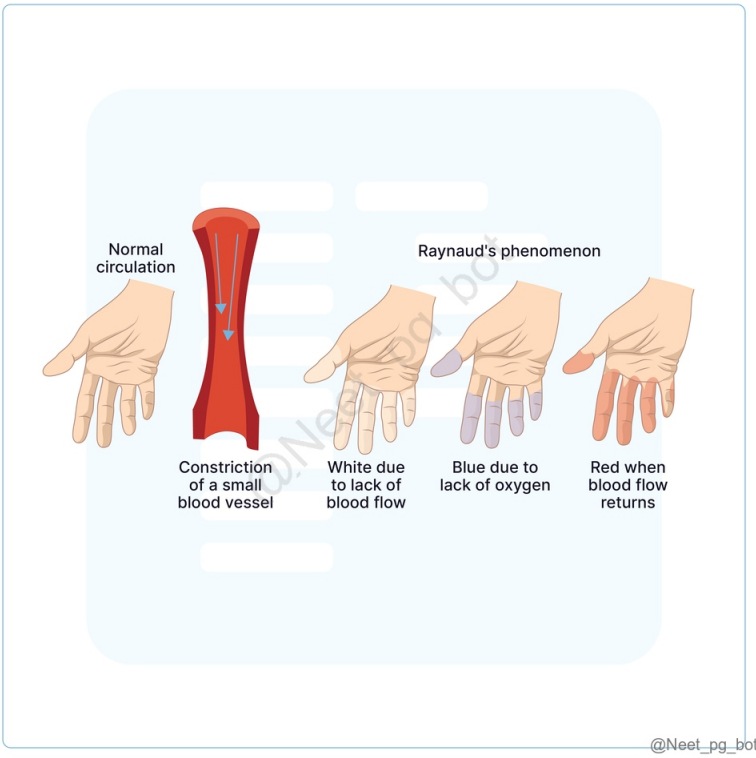
D. Rubor → Pallor → Cyanosis

Correct Answer: C. Pallor → Cyanosis → Rubor

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Sequence of events in Raynaud's phenomenon: Pallor : The initial phase where the skin becomes pale or white due to reduced blood flow and vasospasm. Cyanosis : Followed by a blue or purple colour due to continued reduced blood flow and lack of oxygen. Rubor : The final phase is where the skin turns red as blood flow returns and the area warms up.



References:

Ganong’s Review of Medical Physiology, 26th Edition, Page 260

↑ *Back to this question in Part A*

@Neet_pg_bot

Q15: A 58-year-old male presents to the emergency department with a sudden onset of severe pain in his left leg. The leg appears pale and feels cold to the touch, and the patient is unable to move or feel his toes. On examination, no pulses are detectable below the knee. What is the most likely diagnosis? (Q849347)

A. Deep vein thrombosis

B. Acute limb ischemia

C. Chronic venous insufficiency

D. Cellulitis

Correct Answer: B. Acute limb ischemia

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: This patient’s symptoms strongly suggest Acute limb ischemia , a serious condition caused by a sudden blockage of blood flow to the limb. It is typically recognised by the "5 P's": Pain : Intense, sudden pain in the affected limb. (most common symptom) Pallor: The limb appears pale due to reduced blood flow. Pulselessness: The absence of a pulse beyond the site of the blockage. Paresthesia: Numbness or tingling in the limb. Paralysis: The inability to move the limb due to muscle weakness. Prompt recognition and treatment are essential to restore blood flow and prevent permanent damage to the limb. Deep Vein Thrombosis (DVT) (Option A): DVT typically presents with swelling, pain, and redness in the affected leg, but it does not usually cause the leg to be pale and cold or result in a loss of pulses. The loss of pulses and coldness are more indicative of arterial rather than venous issues. Chronic Venous Insufficiency (Option C): Chronic venous insufficiency generally causes symptoms such as swelling, varicose veins, and skin changes over time. It does not typically present with sudden onset severe pain, pallor, coldness, or loss of pulses. Cellulitis (Option D): Cellulitis usually presents with redness, warmth, swelling, and tenderness of the skin. It typically does not cause loss of pulses, coldness, or the inability to move or feel the toes, which are more consistent with ischemic conditions rather than infection.

References:

Schwartz’s Principles of Surgery, 11th Edition, Page 954

↑ *Back to this question in Part A*

@Neet_pg_bot

Q16: A 65-year-old male presents with a sudden onset of severe pain in his left leg, which has become cold and pale. On examination, there is an absence of distal pulses. Imaging reveals a large saddle embolus at the aortic bifurcation. What is the most appropriate catheter to use for embolectomy in this case? (Q849405)

A. Seldinger catheter

B. Swan-Ganz catheter

C. Fogarty catheter

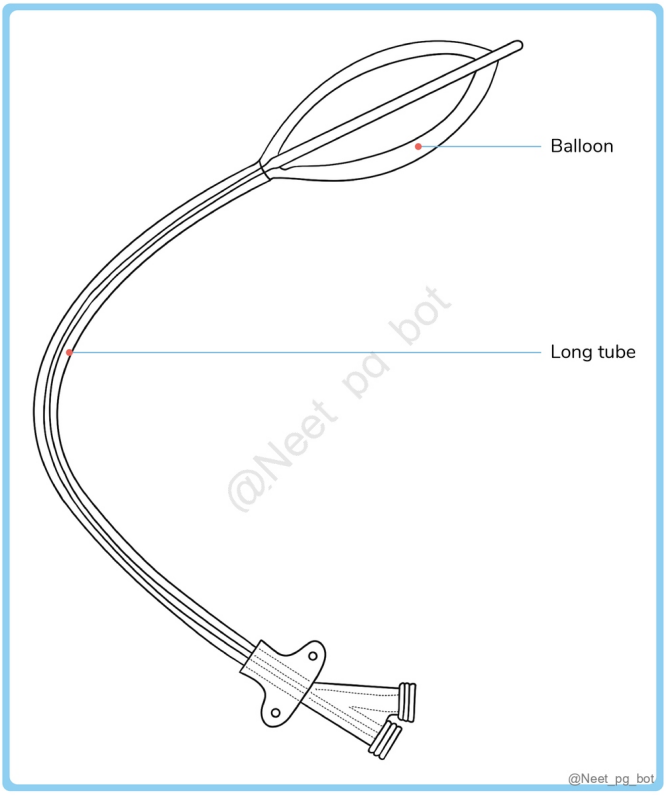
D. Tenckhoff catheter

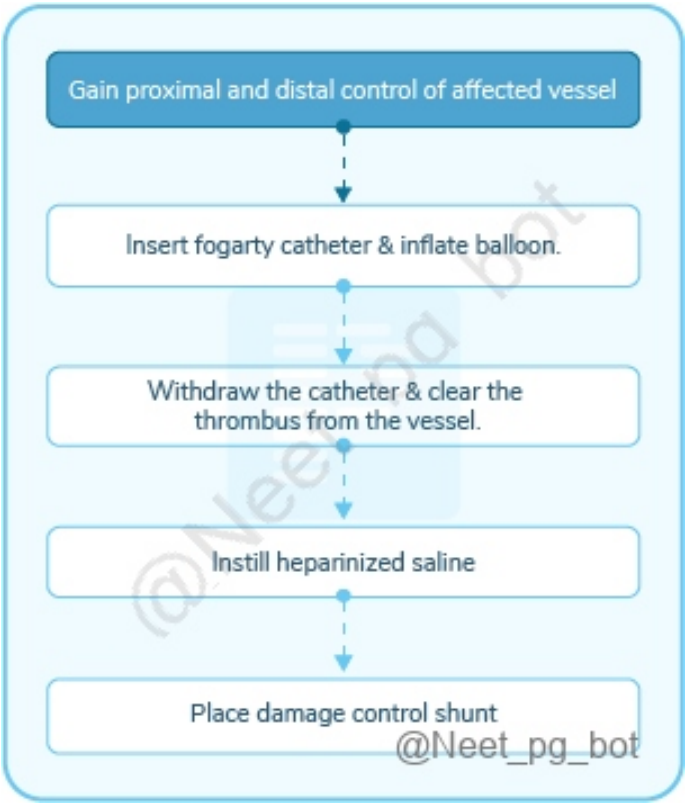
Correct Answer: C. Fogarty catheter

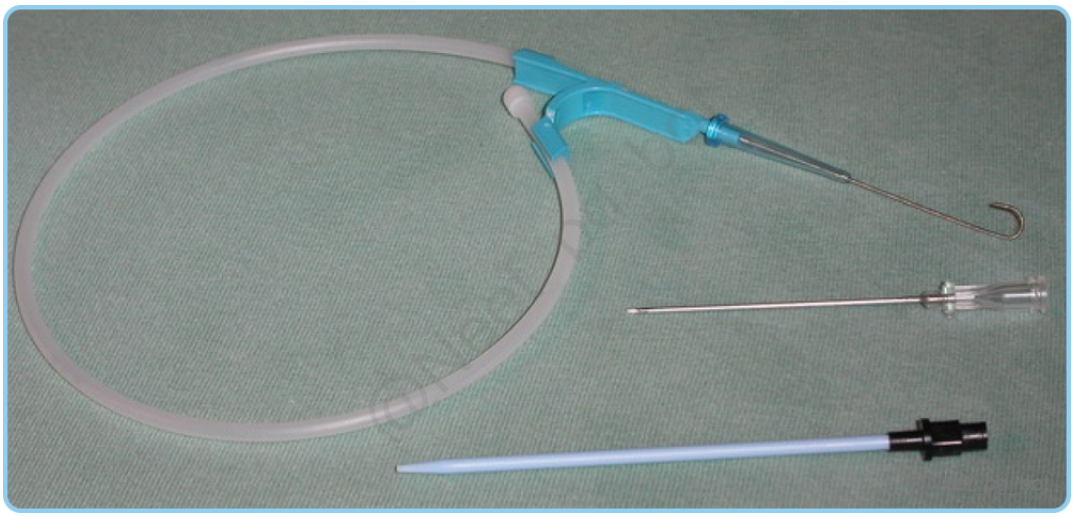
■ *Listen (English)*

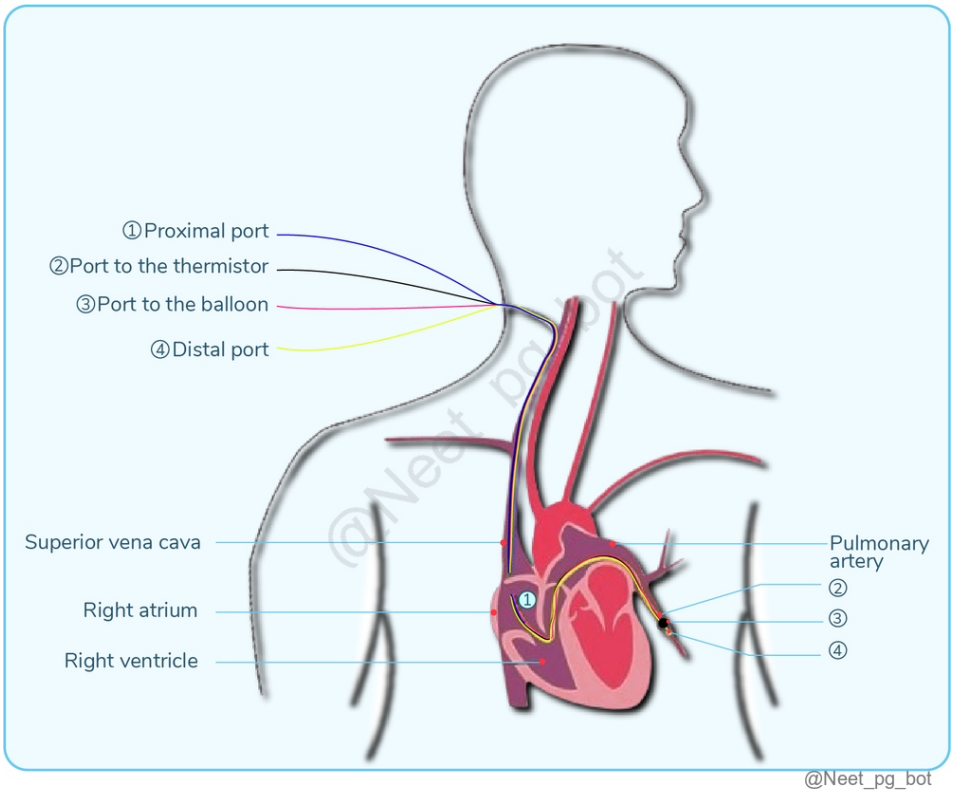
■ *Listen (Hindi)*

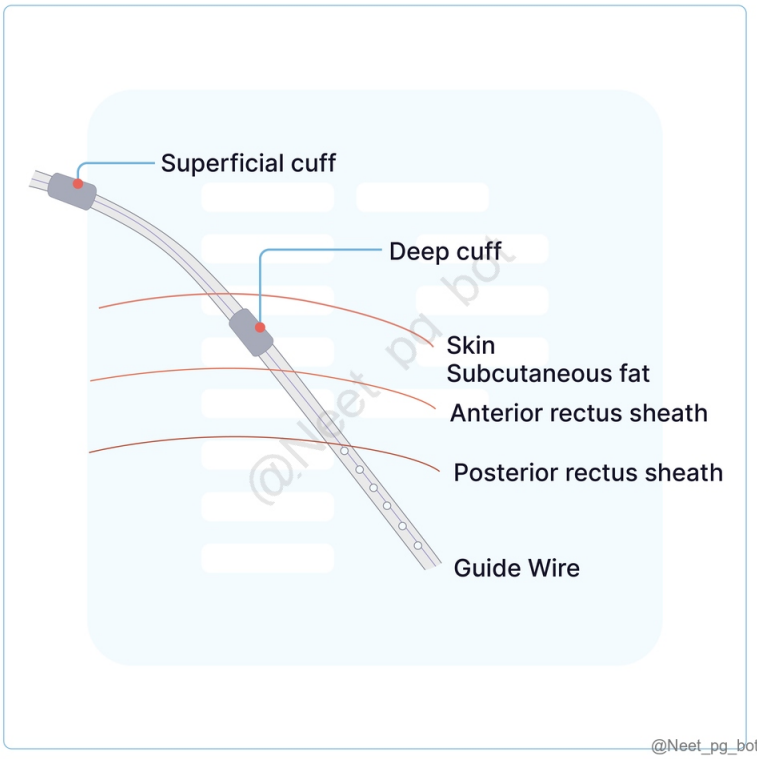
Explanation: Fogarty catheter – Specifically designed for embolectomy or thrombectomy. Embolectomy using Fogarty catheter: Seldinger catheter (Option A) is used for guiding wires in vascular procedures but not for embolectomy. Swan-Ganz catheter (Option B) is primarily used for measuring pulmonary artery pressures and cardiac output, not for embolectomy. Tenckhoff catheter (Option D) is typically used in peritoneal dialysis and is not applicable in vascular procedures like embolectomy.


Balloon
Long tube
@Neet_pg_bot


Gain proximal and distal control of affected vessel
Insert fogarty catheter & inflate balloon.
Withdraw the catheter & clear the thrombus from the vessel.
Instill heparinized saline
Place damage control shunt
@Neet_pg_bot




①Proximal port
②Port to the thermistor
③Port to the balloon
④Distal port
Superior vena cava
Right atrium
Right ventricle
Pulmonary artery
②
③
④
①
@Neet_pg_bot



References:

Sabiston's Textbook of Surgery, 21st Edition, Page 1800

↑ *Back to this question in Part A*

@Neet_pg_bot

Q17: A 60-year-old male with end-stage renal disease is scheduled for the creation of a surgically created arteriovenous (AV) fistula to facilitate long-term hemodialysis. Which of the following is the most commonly used type of AV fistula for this purpose? (Q849401)

A. Cimino-Brescia fistula

B. Blalock-Taussig shunt

C. Snuff box fistula

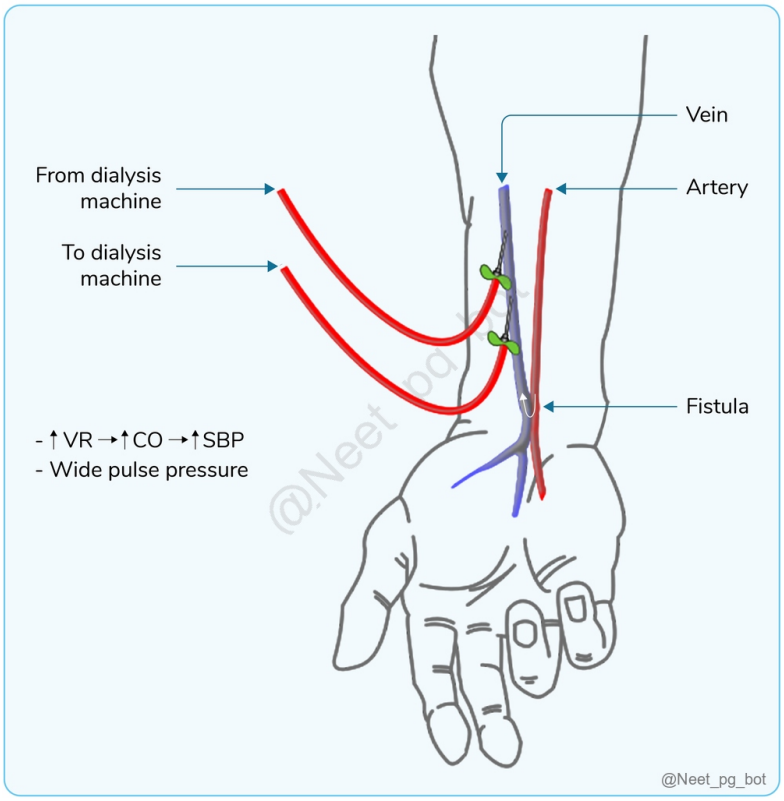
D. Axillary-axillary loop graf

Correct Answer: A. Cimino-Brescia fistula

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The Cimino-Brescia fistula is the most commonly used AV fistula for hemodialysis access. It involves connecting the radial artery to the cephalic vein at the wrist, creating a durable and reliable access point for hemodialysis. Surgically created Arterio-Venous fistula : It is a connection made between an artery and a vein, typically in the arm, and is most commonly used for patients with end-stage renal disease who require hemodialysis. Examples of Surgically created fistulas are: Brescia-Cimino fistula: It is created between the Radial artery and the Cephalic vein. Snuff Box fistula: It is created between the Posterior branch of the radial artery and Cephalic vein (Option C) Feinberg fistula: It is created between the Radial artery and the Basilic vein.



References:

SRB's Manual of Surgery, 6th Edition, Page 33

↑ *Back to this question in Part A*

@Neet_pg_bot

Q18: A 46-year-old male presents with intense pain in his left leg along with the following lesion. Which of the following is the most probable diagnosis? (Q849399)

A. Neuropathic ulcer

B. Venous ulcer

C. Arterial ulcer

D. Pressure ulcer



Correct Answer: C. Arterial ulcer

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The most probable diagnosis of the given ulcer is Arterial ulcer. It occurs due to severe arterial insufficiency of digital and medium sized arteries leading to ischemia and tissue death in the region. They may present as painful erosions, located between the toes, dorsum of feet, on the shin and around malleoli. Characteristic features of arterial ulcers: Punched-out edges are seen It is intensely painful Distal pulses are not palpable Thin, shiny skin is seen Loss of hair in the area Brittle nails are seen Venous ulcer (Option B) Arterial ulcer (Option C) Neuropathic ulcer (Option A) Pressure ulcer (Option D) Site Gaiter's area (area between malleolus and calf) At distal ends of limbs, such as toes, feet and legs. Over toe joints, under the heel, over malleoli, under the metatarsal head, etc Seen over pressure points, most common are ischium, greater trochanter, sacrum, hee, malleolus, occiput, etc Appearance Vertically oval with a sloping edge and will not penetrate deep fascia. Punched-out edges are seen in this type of ulcer. Ulcers can be associated with gangrene and abscesses; osteomyelitis can be seen here. Punched out ulcer with bone as a base. Cause Caused by ambulatory chronic venous hypertension due to varicose veins. This occurs due to severe arterial insufficiency of digital and medium-sized arteries, leading to ischemia and tissue death in the region. It is caused due to repeated trauma and ischemia due to microangiopathy in diabetic patients . It is tissue necrosis and ulceration due to prolonged pressure on any part of the body. Characteristics It is initially painful, then chronically becomes painless. It heals on rest and treatment but reforms again. It is intensely painful, distal pulses are not palpable, associated with shiny skin, brittle nails and loss of hair over the region. Also known as diabetic ulcer since it is seen in diabetic patients. It is common in bedridden patients with head injuries, neurological deficits, and comatose and stroke-ridden patients.



References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 998, 999

↑ *Back to this question in Part A*

@Neet_pg_bot

Q19: A 35-year-old male with a 12-year history of smoking presents with severe rest pain and discoloration of the left lower limb's digits as shown below. He has experienced worsening pain in this limb for the past 2 days, following 3 months of discomfort. What is the appropriate management for this condition? (Q849394)

A. Lumbar sympathectomy

B. Abstinence from smoking

C. Amputation

D. Vasodilators



Correct Answer: C. Amputation

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: This patient presents with advanced peripheral arterial disease , most likely Buerger’s disease (Thromboangiitis obliterans) , as suggested by: History of chronic smoking Rest pain in the limb Black discoloration of the toes (indicating dry gangrene) Progressive worsening of symptoms over months The blackened digits in the image represent non-viable tissue , which is: Irreversible A source of pain At risk of infection Amputation is required at this stage to: Remove gangrenous tissue Prevent secondary infection Relieve intractable rest pain

References:

Bailey & Love’s Short Practice of Surgery, 28th Edition, Page 1024

↑ *Back to this question in Part A*

@Neet_pg_bot

Q20: A 56-year-old male presents with sudden pain and numbness in his right lower limb for 1 day. On examination, the limb is cold and pale and exhibits loss of sensory and mild motor functions. Doppler studies reveal only venous signals. What grade of Rutherford's classification is this case? (Q849393)

A. Grade I

B. Grade IIA

C. Grade IIB

D. Grade III

Correct Answer: C. Grade IIB

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The above clinical scenario is a case of Acute Limb Ischemia (ALI) with Grade IIB of Rutherford's classification. Rutherford's classification of acute limb ischemia: Grade Category Sensory loss Motor deficit Arterial doppler signals Venous doppler signals Prognosis I (Option A) Viable none none Audible Audible No immediate threat IIA (Option B) Marginally Threatened None or minimal (toes) none Inaudible Audible Salvageable if promptly treated IIB (Option C) Immediately threatened More than toes Mild/moderate Inaudible Audible Salvageable with immediate revascularisation III (Option D) Irreversible Profound or insensate Paralyzed Inaudible Inaudible Limb is irreversibly damaged, major tissue loss, and amputation.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1012

↑ *Back to this question in Part A*

@Neet_pg_bot

Q21: A 38-year-old chronic smoker presents with lower limb pain during walking for 2 weeks. Examination reveals an ankle-to-brachial systolic pressure ratio of 0.7. What is the correct interpretation of this finding? (Q849392)

A. Critical limb ischemia

B. Intermittent claudication

C. Normal index

D. Calcified vessels

Correct Answer: B. Intermittent claudication

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: ABPI is measured supine by checking the systolic blood pressure in both upper and lower limbs (brachial, posterior tibial, and dorsalis pedis arteries). The higher value from each limb is used to calculate the ABPI. ABPI (Ankle brachial pressure index) or ABI (Ankle brachial index) here is 0.7 which indicates intermittent claudication in Buerger's disease. ABI / ABPI = Systolic BP in the Ankle/ Systolic BP in the arm Value Interpretation 0.1 - 0.4 Critical limb ischemia (Option A) 0.5 - 0.9 Intermittent claudication (Option B) 1.0 - 1.2 Normal (Option C) > 1.2 Calcified vessels (seen in patients with DM, End stage renal disease) (Option D)

References:

Sabiston’s Textbook of Surgery, 21st Edition, Page 1773

↑ *Back to this question in Part A*

@Neet_pg_bot

Q22: What is the most specific investigation of choice for peripheral arterial disease? (Q849391)

A. Ankle-Brachial Index

B. Duplex ultrasonography

C. CT angiography

D. Magnetic Resonance Angiography

Correct Answer: C. CT angiography

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: CT angiography is considered the most specific investigation of choice due to: High resolution: High-resolution imaging of the entire vascular tree from the abdominal aorta to the foot arteries in a single examination. 3D reconstruction: Providing 3D reconstructions is crucial for intervention planning. Calcification detection: Accurate detection and quantification of arterial calcification. Less invasive: Less invasive than conventional angiography while maintaining detailed imaging. Characteristic radiological findings in peripheral arterial disease include: Disease confinement to distal circulation. Segmental occlusions with "skip" lesions. Extensive collateralization, notably "corkscrew" collaterals .



References:

Schwartz’s Principles of Surgery, 11th Edition, Page 974

↑ *Back to this question in Part A*

@Neet_pg_bot

Q23: A 65-year-old man presents with pain in his right calf that occurs after walking 200 meters and is relieved by rest. The pain does not occur when he is at rest or when he walks shorter distances. Based on Boyd's classification of intermittent claudication, which grade best describes this patient's condition? (Q849390)

A. Grade 0

B. Grade I

C. Grade II

D. Grade III

Correct Answer: C. Grade II

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The patient's pain occurs after walking 200 meters and is relieved by rest, which corresponds to Grade II claudication. Boyd's classification of intermittent claudication : Grade Description Grade 0: Asymptomatic (Option A ruled out) No symptoms of claudication, even with exercise Grade I: Mild claudication (Option B ruled out) Able to walk more than 200 meters (about 650 feet) before onset of symptoms Grade II: Moderate claudication (option C) Able to walk between 50 and 200 meters (about 160 to 650 feet) before onset of symptoms Grade III: Severe claudication (Option D ruled out) Able to walk less than 50 meters (about 160 feet) before onset of symptoms Grade IV: Ischemic rest pain Pain occurs at rest or with minimal exertion

References:

Bailey & Love’s Short Practice of Surgery, 28th Edition, Page 998, 999

↑ *Back to this question in Part A*

@Neet_pg_bot

Q24: A 40-year-old male presents with pain in his hands and feet, which worsens with cold exposure. He has a history of heavy smoking. On examination, he has ulcers on his fingers and toes. Angiography reveals "corkscrew" collaterals and segmental occlusions. Which of the following conditions is most likely in this patient? (Q849389)

A. Systemic sclerosis

B. Thromboangiitis obliterans

C. Atherosclerosis

D. Frostbite

Correct Answer: B. Thromboangiitis obliterans

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The patient's age, heavy smoking history, and angiographic findings with "corkscrew" collaterals strongly indicate Buerger's Disease (Thromboangiitis obliterans). This condition involves inflammatory thrombosis affecting small and medium-sized vessels, primarily in the extremities. It presents with pain, ulcers, and claudication in both upper and lower limbs, often leading to gangrene if untreated. Smoking cessation is crucial for management, as it is the most important modifiable risk factor. Angiography shows "corkscrew" collaterals



References:

Bailey & Love’s Short Practice of Surgery, 28th Edition, Page 1024 Schwartz’s Principles of Surgery, 11th Edition, Page 974

↑ *Back to this question in Part A*

@Neet_pg_bot

Q25: A 72-year-old man presents with a sudden onset of severe pain, numbness, and coldness in his left leg. On examination, the left leg appears pale, and no pulse is palpable below the femoral artery. What is the most probable cause of this acute peripheral arterial occlusion? (Q849388)

A. Atherosclerosis

B. Buerger's disease

C. Fibromuscular dysplasia

D. Arterial dissection

Correct Answer: A. Atherosclerosis

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The patient shows classic features of acute limb ischemia- sudden severe pain, pallor, pulselessness, numbness, and coldness. In elderly patients, the most common cause of acute arterial occlusion is acute thrombosis superimposed on chronic atherosclerotic disease. Atherosclerotic plaques narrow the artery and predispose it to sudden clot formation, leading to complete occlusion. This mechanism is far more common, making atherosclerosis the most probable cause in this clinical scenario. Incorrect Options: Option B) Buerger's disease : Seen in young male smokers (20–40 years), affects small and medium vessels - rare in elderly. Option C) Fibromuscular dysplasia : Occurs in young to middle-aged women, commonly affecting renal and carotid arteries. Option D) Arterial dissection : More typical in the aorta or carotid arteries; peripheral arterial dissection causing acute limb ischemia in an elderly man is uncommon compared with atherosclerotic thrombosis.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1024 Schwartz's Principles of Surgery, 11th Edition, Page 974

↑ *Back to this question in Part A*

@Neet_pg_bot

• [03_Cardiothoracic Vascular Surgery] 009 Venous Disorders - I

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[03_Cardiothoracic Vascular Surgery] 009 Venous Disorders - I — Quick Jump

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Q19 (p. 1419)	*Q20 (p. 1421)*	*Q21 (p. 1422)*	*Q22 (p. 1424)*	*Q23 (p. 1425)*	*Q24 (p. 1428)*
Q25 (p. 1430)	*Q26 (p. 1430)*				

Q1: A 62-year-old male presents with left leg swelling and pain for 5 days and has a positive D-dimer test. Duplex ultrasonography confirms an extensive DVT involving the left popliteal and femoral veins. Which of the following is the most appropriate initial management strategy? (Q849439)

A. Unfractionated heparin followed by warfarin

B. LMWH followed by oral anticoagulant

C. Catheter-directed thrombolysis

D. IVC filter placement

Correct Answer: B. LMWH followed by oral anticoagulant

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Treatment of DVT: Anticoagulation: For initial management of acute DVT without contraindications to anticoagulation, the current recommended approach is to start with LMWH and transition to an oral anticoagulant. This approach has several advantages: LMWH provides rapid anticoagulation without the need for monitoring. Oral anticoagulants have shown non-inferiority or superiority to warfarin in large clinical trials. They have a better safety profile and do not require regular INR monitoring. This regimen allows for outpatient management in many cases, reducing hospitalization rates. Investigation of DVT: Venous Doppler with Duplex scanning Non-invasive; detects thrombus by impaired blood flow and inability to compress veins. Presence of echogenic material completely filling the lumen of vein Absence of compressibility Absence of blood flow Venogram Accurate for detecting and locating thrombus and differentiating occlusive and non-occlusive thrombus but less commonly used due to invasiveness. Impedance Plethysmography Measures changes in venous volume and flow using a cuff. Less useful for calf DVT and previous thrombosis. Fibrin and Fibrinogen Assays Measures fibrin degradation products, including D-dimer. D-dimer has a high negative predictive value. Radioactive Fibrinogen Study Uses radiolabeled fibrinogen to detect thrombus. Less commonly used. Magnetic Resonance Venous Imaging (MRVI) Non-invasive; Useful for imaging iliac veins and IVC. Management of DVT : Initial

Anticoagulation Subcutaneous LMWH: Rapidly anticoagulate confirmed DVT cases. Intravenous Unfractionated Heparin: For patients with significant renal impairment. Fondaparinux or Bivalirudin: Alternatives for those with heparin sensitivity or heparin-induced thrombocytopenia. Transition to Oral Anticoagulation Duration: At least 3 months or longer based on risk factors or recurrence. Novel anticoagulants (NOACs): Rivaroxaban, Apixaban (factor Xa inhibitors), Dabigatran (direct thrombin inhibitor). Vitamin K Antagonists: Warfarin (alternative to NOACs). Monitoring Anticoagulation Heparin: Activated partial thromboplastin time (APTT). Warfarin: INR maintained between 2.0 to 3.0. For Patients with contraindications to Anticoagulation Temporary IVC Filter (Option D): Consider if bleeding risk prevents anticoagulation or to prevent pulmonary embolism. It does not treat the existing thrombus and is associated with long-term complications. Endovascular Surgery Thrombus removal, lysis, and stenting. Beneficial in selected patients, especially those with iliofemoral thrombosis, to reduce risk of chronic post-thrombotic syndrome. Unfractionated heparin followed by warfarin (Option A) was the traditional approach, but it has largely been superseded by LMWH and DOACs due to the need for hospitalization, frequent aPTT monitoring for unfractionated heparin, and long-term INR monitoring for warfarin. Catheter-directed thrombolysis (Option C) is generally reserved for massive iliofemoral DVT with severe symptoms or limb-threatening situations. It carries a higher risk of bleeding and is not first-line therapy for most DVT cases.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1046

SRB’s Manual of Surgery, 6th Edition, Page 217

Sabiston Textbook of Surgery, 21st Edition, Page 1828, 1829

cdt.amegroups.org/article/view/13086/html#:~:text=The%20primary%20diagnostic%20US%20criteria%20for%20acute,flow%20phasicity%2C%20and%20loss%20of%20response%20to,PE

↑ *Back to this question in Part A*

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Q2: An infant presents with a large, rapidly growing vascular malformation, along with severe thrombocytopenia and microangiopathic hemolytic anemia. What is the most likely diagnosis? (Q849459)

A. Klippel-Trénaunay Syndrome

B. Kasabach-Merritt Syndrome

C. Sturge-Weber Syndrome

D. Capillary Hemangioma

Correct Answer: B. Kasabach-Merritt Syndrome

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Syndromes associated with AV Malformation: Klippel-Trénaunay syndrome Kasabach-Merritt Syndrome (KMS) A mesodermal abnormality characterized by: Cutaneous nevus, Persistent vestigial veins with varicose veins, Soft-tissue and bone hypertrophy. Segments of deep veins are hypoplastic or aplastic. Possible obstruction of lymphatics. Treatment: Conservative management with compression stockings. Removal of large superficial varicose veins done only if deep veins are patent. A life-threatening coagulopathy of infancy characterized by: Thrombocytopenia Microangiopathic hemolytic anemia Consumptive coagulopathy. Rapidly growing vascular tumor Treatment: Mainly supportive care Embolization: Possible if a single feeding vessel is present. Medical Therapies: Steroids,vincristine and sirolimus. Capillary hemangioma: Sturge-Weber Syndrome (Option C) is characterized by facial nevus or port wine stain and neurological symptoms like contralateral hemiparesis, focal seizures and/or intellectual disability. It is not associated with severe thrombocytopenia and microangiopathic hemolytic anemia. Capillary Hemangioma (Option D) is the commonest birthmark seen on the head and neck. Majority occurs as a consequence of intravascular thrombosis, fibrosis, and mast cell infiltration and resolve spontaneously. It is not associated with severe thrombocytopenia and microangiopathic hemolytic anemia.







References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 660, 1047
https://www.ncbi.nlm.nih.gov/books/NBK519053/ OP Ghai Pediatrics, 9th Edition, Page 558, 559

↑ *Back to this question in Part A*

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Q3: A 50-year-old man presents with prominent varicose veins on his medial thigh and calf. Upon examination, incompetence of the great saphenous vein (GSV) is identified. The surgeon is considering the appropriate surgical intervention. What is the primary indication for performing Saphenofemoral Junction Ligation and GSV Stripping? (Q849455)

A. Varicose veins on the posterolateral calf due to small saphenous vein incompetence

B. Incompetence of the great saphenous vein with varicose veins on the medial thigh and calf

C. Varicose veins on the anterior thigh due to incompetent perforator veins

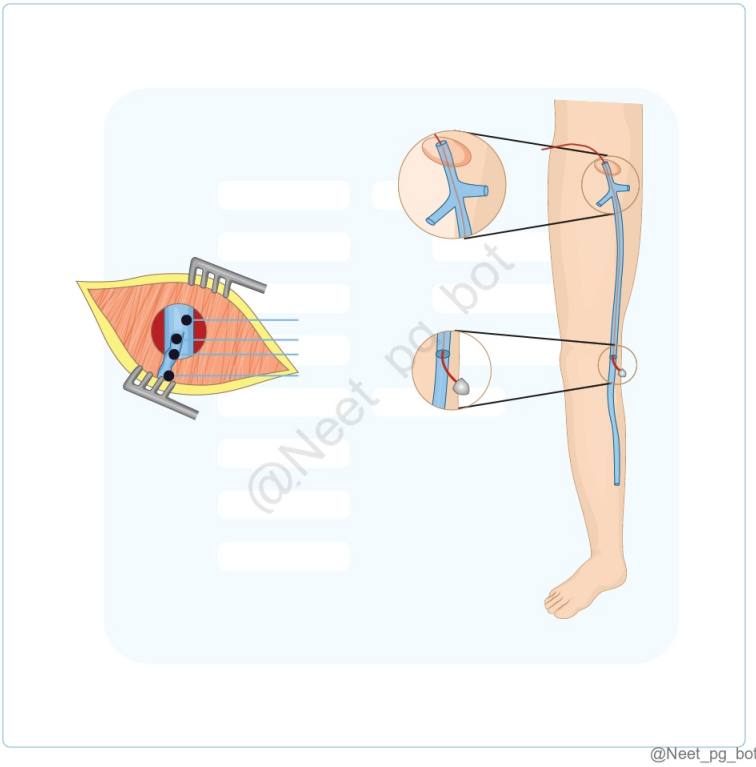
D. Small varicose veins unsuitable for endovenous ablation

Correct Answer: B. Incompetence of the great saphenous vein with varicose veins on the medial thigh and calf

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Incompetence of the great saphenous vein with varicose veins on the medial thigh and calf: Saphenofemoral Junction Ligation and GSV Stripping are indicated primarily for varicose veins resulting from GSV incompetence, particularly when these veins are located on the medial thigh and calf. Open Surgery Procedure Saphenofemoral Junction Ligation and Great Saphenous Vein Stripping Indication: Used for varicose veins in the medial thigh and calf due to great saphenous vein (GSV) incompetence. Procedure: An incision is made in the groin to access the saphenofemoral junction where the GSV meets the femoral vein. Tributaries of the GSV are ligated. Stripping: The GSV is tied off at the junction, and a device is inserted into the GSV and pulled out through an incision near the knee, stripping the vein as it is removed. Saphenopopliteal Junction Ligation and Small Saphenous Vein Stripping Indication: Used for varicose veins on the posterolateral calf due to small saphenous vein (SSV) incompetence. Procedure: An incision is made to access and ligate the saphenopopliteal junction where the SSV joins the popliteal vein. Stripping: Similar to the GSV procedure, the surgeon either strips the vein using a device or resects the proximal portion of the vein.



References:

Bailey and Love's Short Practice of Surgery, 28th Edition, Page 1037-1038

↑ *Back to this question in Part A*

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Q4: A 55-year-old male with chronic venous insufficiency presents with a venous ulcer on his lower leg. He has a history of prolonged standing at work and reports aching and heaviness in his legs. What is correct regarding compression therapy in this patient? (Q849453)

A. Class 1 compression hosiery exerts 18-24 mmHg of pressure

B. Compression bandaging typically exerts less pressure than compression hosiery

C. Compression bandaging should be avoided in patients with a history of venous ulcers

D. Compression therapy is most effective when it exerts a graduated pressure to promote venous return

Correct Answer: D. Compression therapy is most effective when it exerts a graduated pressure to promote venous return

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Compression therapy works by exerting graduated external pressure on the legs, which helps promote blood flow back to the heart and reduces venous hypertension. This is particularly important in conditions like varicose veins where venous return is compromised. Compression Therapy in Varicose Veins Mechanism: Graduated external pressure promotes venous return. Reduces venous pressure, especially in a standing position. Types of Compression: Compression Hosiery: Knee-length or thigh-length garments. Indications: Varicose Veins: Alleviates symptoms; first-line therapy. Post-Intervention: Used after varicose vein treatments. Minimizes complications, promotes healing, and prevents recurrence. Long-term Prevention: Lifelong Class 2 stockings are recommended Categories based on pressure levels: Class Pressure (mmHg) Class 1 14–17 (Option A) Class 2 18–24 Class 3 25–35 Compression Bandaging: Multi-layered approach for desired pressure. Compression bandaging applies more pressure than hosiery (Option B) and is more often used in cases like venous ulcers or more severe conditions. Indications: Venous Ulcers (Option C): Essential for ulcers from venous insufficiency; use 35–40 mmHg pressure. Mixed Ulcers: Caution with arterial disease; use 30 mmHg if ABPI 0.5–0.8. Severe Arterial Compromise: Revascularization advised before bandaging if ABPI < 0.5 or ankle pressure < 60 mmHg.

References:

Bailey and Love's Short Practice of Surgery, 28th Edition, Page 1033, 1041
https://www.sciencedirect.com/science/article/pii/S0102695X15001003

↑ *Back to this question in Part A*

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Q5: Which of the following statements about the pathophysiology of varicose veins is incorrect? (Q849447)

A. Defects in the walls or valves of the veins lead to retrograde blood flow.

B. Inflammatory changes in walls lead to dilatation, elongation and valvular dysfunction.

C. The veins have a low end-diastolic volume.

D. Chronic ambulatory venous hypertension develops.

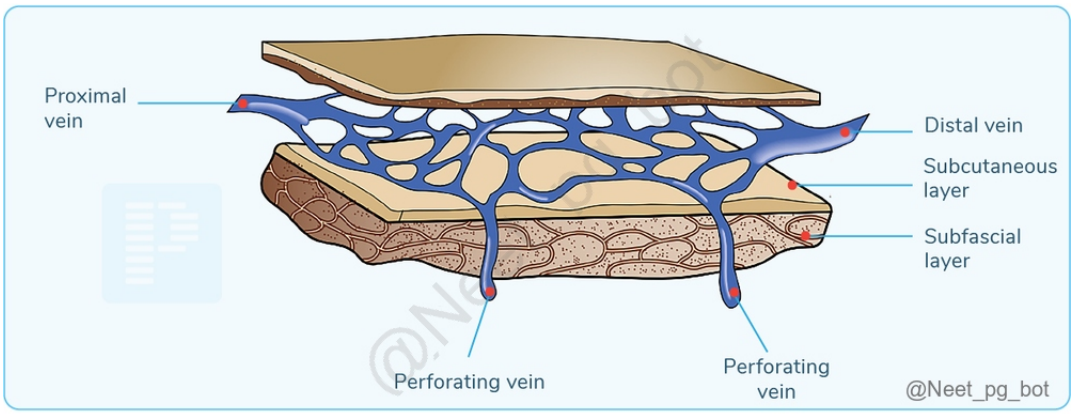
Correct Answer: C. The veins have a low end-diastolic volume.

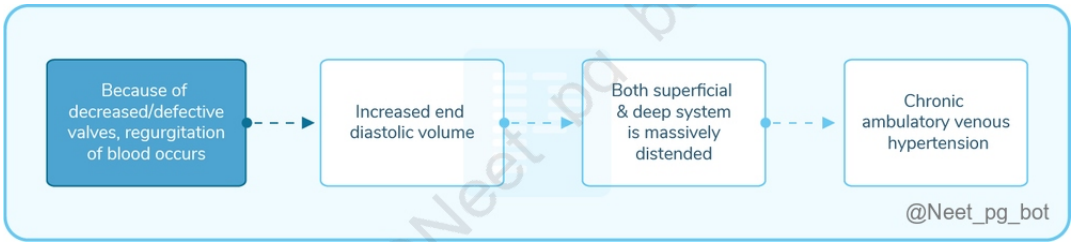
■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The pathophysiology of varicose veins includes the development of an increased end-diastolic volume. Pathophysiology of varicose veins: An anatomic or dynamic cause leads to damage of the valvular

system. Inflammatory changes affect the walls of the valves as well. This leads to the retrograde blood flow (Option A) and pooling of blood. This causes an increase in the end-diastolic volume in the veins. The superficial (visible) and deep venous systems are affected by this, which causes their dilatation (varicosity), elongation (Option B) , and even leads to secondary valvular dysfunction. This causes an increased ambulatory venous hypertension (Option D). This is responsible for the complications of varicose veins. Decreased amounts of elastin and an imbalance between collagen I and III suggest that the loss of the venous wall intimal architecture leads to dilation, tortuosity, and the formation of varicose veins . Dilation of superficial venous tributaries caused by increased transmission of pressure by the perforating veins: Pathophysiology:





References:

Sabiston's Textbook of Surgery, 21st Edition, Page 1815, 1816

↑ *Back to this question in Part A*

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Q6: A patient comes to the surgery OPD complaining of small swellings and a wound on his right lower leg. On clinical evaluation, he is found to have hyperpigmentation in his right leg around the ankle and lower third of the leg. He also has a healed venous ulcer and is symptomatic. According to the CEAP classification, what is the clinical stage of the disease in this case? (Q849449)

A. C5a

B. C5s

C. C3r

D. C6

Correct Answer: B. C5s

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: According to the CEAP classification, the healed venous ulcer belongs to the C5 group, and since the patient is symptomatic, it can be classified as C5s. The CEAP (Clinical- Etiology- Anatomy- Pathology) classification for chronic venous disorders: Feature Classification For clinical classification: No signs of venous disease C0 Telangiectasia (<1 mm) or reticular veins (1–3 mm) C1 Varicose veins (>3 mm) C2 Edema C3 Pigmentation or eczema C4a LDS or atrophic blanche C4b Corona phlebectatica C4c Healed venous ulcer C5 Active venous ulcer C6 Clinical class can be further characterised as symptomatic (s), asymptomatic (a) or recurrent following previous successful treatment or healing (r), e.g. C2a, C2s, C6r. For etiological classification: Congenital Ec Primary Ep Secondary (post-thrombotic) Es No venous cause identified En For anatomical classification: Superficial veins As Perforator veins Ap Deep veins Ad No venous location identified An For anatomical classification: Reflux Pr Obstruction Po Reflux and obstruction Pr,o No venous pathophysiology identified Pn Pigmentation/Eczema LDS Atrophic blanche Corona phlebectatica






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References:

Bailey and Love's Short Practice of Surgery, 28th Edition, Page 1030

CEAP

↑ *Back to this question in Part A*

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Q7: A 50-year-old woman with inflammatory bowel disease presents with a painful ulcer on her leg. The ulcer has a necrotic edge and a purulent base, with significant surrounding erythema. What type of ulcer is most consistent with this presentation? (Q849461)

A. Neurotrophic ulcer

B. Pyoderma gangrenosum

C. Venous ulcer

D. Arterial ulcer

Correct Answer: B. Pyoderma gangrenosum

■ *Listen (English)*

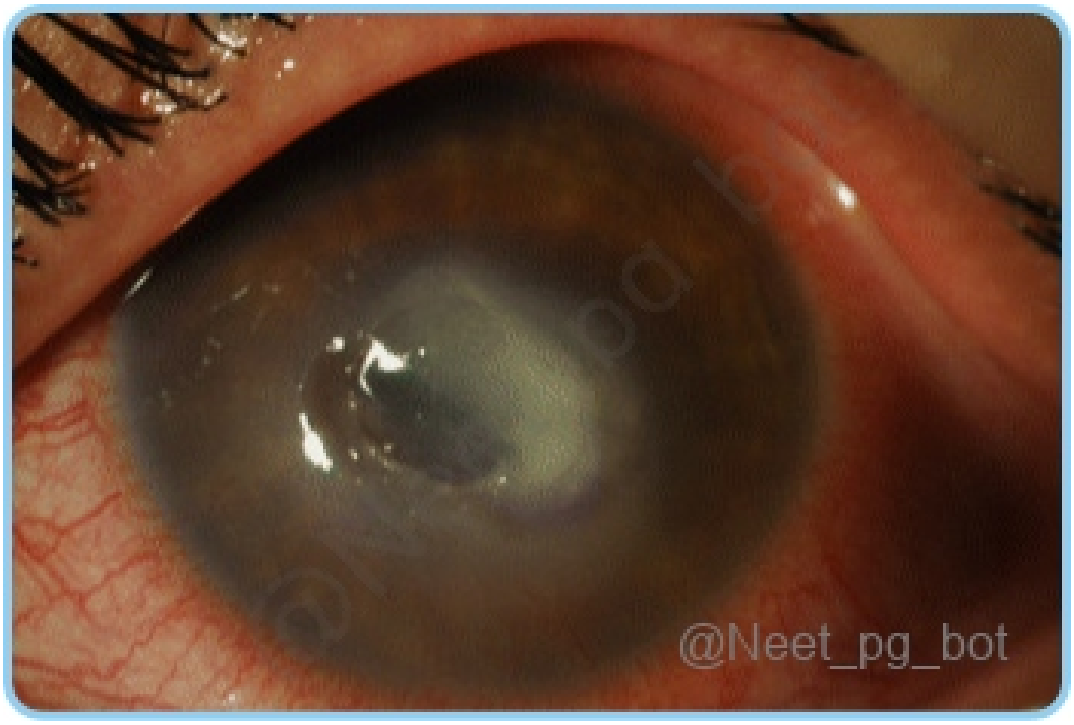
■ *Listen (Hindi)*

Explanation: The clinical scenario here points to pyoderma gangrenosum that is a lower limb ulcer associated with IBS. Types of Lower Limb Ulcers: Type History Location Pain Lesion Characteristics Associated Findings

Ischemic/ arterial (Option D) Smoking, Intermittent claudications Distal, on dorsum of foot or toes, over bony prominences Severe, particularly at night; relieved by dependency Irregular edge; poor granulation tissue, dry necrotic base; round or punched-out with sharp demarcation; no surrounding inflammation Trophic changes of chronic ischemia, pale, hair loss, atrophic skin, cool feet; absence of pulses, prolonged capillary refill; ankle brachial index (ABI) <0.5; dependent rubor, elevation pallor Venous (Option C) Varicose veins, DVT, trauma, surgery, multiple pregnancies; aching/ swelling worse at end of day, relieved with elevation Lower third of leg (gaiter area); between malleolus and lower calf, majority at medial malleolus Mild; relieved by elevation Shallow, irregular/shaggy shape; granulating base; flat or steep elevation margins; fibrinous material at ulcer bed with moderate to heavy exudate; surrounding inflammation present Lipodermatofibrosis/ lipodermatosclerosis, pigmentation, edema, atrophie blanche; telangiectasia; normal capillary refill time, normal ankle brachial index (ABI) Neurotrophic (Option A) Numbness, paresthesias, burning, loss sensation in foot, Diabetes mellitus Under calluses or pressure points (e.g., plantar aspect of first or fifth MTP joint) None Punched-out, with deep sinus, variable depth partial thickness to severe involving tendon, fascia, joint capsule, or bone; surrounding inflammation present Demonstrable neuropathy, may be associated with underlying osteomyelitis Vasculitis History of primary or secondary connective tissue disease Pretibial and dorsum of foot but not always geographically limited Extremely painful Multiple, punched-out, inflamed indurated base (pathergy phenomenon); surrounding inflammation present; surrounding skin shows reticulate vascular pattern Fat necrosis/chronic panniculitis on pathology Hypertensive (local infarct) Normal pulses Lateral malleoli Severe Black necrosis; surrounding inflammation present Aka Martorell's ulcer; seen in patients with prolonged/ suboptimal controlled hypertension Pyoderma Gangrenosum (Option B) Unknown pathogenesis Develops in sites of previous trauma, around scars, donor sites used for grafting Severe Non-infective ulceration with purulent base ; well-defined, bluish, undermined borders; surrounding erythema; deep necrotic ulcer; surrounding inflammation present Seen with inflammatory bowel disease , immunodeficient states, myeloma, leukemia, Behcet's syndrome




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References:

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3036466/

↑ *Back to this question in Part A*

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Q8: A 62-year-old man has a chronic ulcer on his leg from a burn injury sustained 12 years ago. Recently, the ulcer has developed indurated, painless, raised edges and surrounding fibrosis. What is the most likely diagnosis? (Q849460)

A. Venous ulcer

B. Pressure ulcer

C. Marjolin's ulcer

D. Actinic keratosis

Correct Answer: C. Marjolin's ulcer

■ *Listen to Audio 1*

Explanation: A Marjolin ulcer is a type of skin cancer that develops in areas of chronically damaged skin, such as old scars, burns, or non-healing wounds. It most commonly presents as squamous cell carcinoma Venous ulcers (Option A): Commonly located around and above the medial malleoli due to numerous perforators. Ulcer is large,

with a gently sloping edge and granulation tissue, nonhealing, tender, and recurrent, often with secondary infections. The surrounding skin often exhibits thickening, inflammation, induration, pigmentation (hemosiderosis), and fibrosis . Pressure ulcers (Option B) are the most common complication in bedridden patients or those with spinal cord injuries over bony prominences due to prolonged pressure. Marjolin's ulcer refers to a malignant transformation arising from burn scars or chronic non-healing wounds, such as pressure ulcers, over many years. Actinic Keratosis (Option D) are precancerous lesions that can lead to squamous cell carcinoma (SCC). Ill-marginated, erythematous, scaling, and rough papules or patches, often with signs of solar damage (atrophy, uneven pigmentation, telangiectasias).



References:

Bailey & Love’s Short Practice of Surgery, 28th Edition, Page 1039-1041

SRB’s Textbook of Surgery, 6th Edition, Page 232-284

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https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3018652/

Marjolins

↑ *Back to this question in Part A*

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Q9: A 64-year-old woman is scheduled for the great saphenous vein (GSV) stripping to treat her varicose veins. What is the most likely nerve injury she might experience post-operatively? (Q849458)

A. Sural nerve

B. Common peroneal nerve

C. Saphenous nerve

D. Tibial nerve

Correct Answer: C. Saphenous nerve

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The most likely nerve to be injured during GSV varicose vein surgery is the saphenous nerve. Complications of Varicose vein surgery: Wound infections: Most common complication, reduced by prophylactic antibiotics. Recurrent Varicose Veins(10-20%): Small saphenous vein surgery>>Great saphenous vein surgery Nerve injury: Most common serious complication. Saphenous nerve injury (Option C) (7%): Occurs following great saphenous vein (GSV) stripping to the knee. Sural nerve injury (Option A) (20%): Occurs following small saphenous vein (SSV) surgery. Common peroneal nerve injury (Option B) (4%): Occurs following small saphenous vein (SSV) surgery. Venous thromboembolic complications (0.5%): Deep vein thrombosis(DVT) Thrombophlebitis Hematoma, ecchymosis, local hyperpigmentation Lymphocele Tibial nerve (Option D) is less commonly affected as it descends along the back of the thigh and popliteal fossa to the distal border of the popliteus and is not closely associated with the surgical area of the great saphenous vein (GSV).

References:

Bailey & Love’s Short Practice of Surgery, 28th Edition, Page 1038 Schwartz Principles of Surgery, 11th Edition, Page 996 Gray’s Anatomy, 42nd Edition, Page 1427

↑ *Back to this question in Part A*

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Q10: A patient with chronic venous insufficiency presents with symptomatic varicose veins. The physician decides to use foam sclerotherapy, specifically the Tessari technique, to treat the affected veins. What is the typical ratio of sclerosant to air used in the Tessari technique for creating the foam? (Q849457)

A. 1:1

B. 1:2

C. 1:3

D. 1:6

Correct Answer: C. 1:3

- *Listen (English)*
- *Listen (Hindi)*

Explanation: In the Tessari technique, the typical ratio of sclerosant to air is 1:3. This ratio is used to create a stable foam with a larger surface area, which improves contact with the vein walls during sclerotherapy. Sclerotherapy A sclerosing agent, typically sodium tetradecyl sulphate , is injected into the affected vein. This agent damages the vein lining, causing it to collapse and eventually be absorbed by the body. To enhance the effectiveness of the sclerosant, it is mixed with air to create a foam . This foam allows for greater contact with the vein wall and displaces blood that could inactivate the sclerosant Indications: Telangiectasias, reticular veins, and small, nonaxial varicose veins (<6 mm) visible in chronic venous disease; suitable for patients with persistent symptoms despite medical management. Aspect Tessari Technique Sclerosants Indications and Contraindications Foam Preparation Two syringes: one with sclerosant, one with air/gas (CO2) Connected via multi-way stopcock. Sclerosant to air ratio is usually 1:3 or 1:4 Repeated plunger action to create foam STS: Synthetic sodium salt with anesthetic properties Polidocanol: Synthetic polyethylene glycol, also an anesthetic. Effective for telangiectasias, reticular veins HTS: 23% hypertonic saline, osmotic agent Candidates: Asymptomatic patients and those with controlled recent or recurrent venous bleeding may undergo sclerotherapy without additional diagnostics. Contraindications: Avoid sclerotherapy during acute venous thrombosis or pregnancy. Risks : Microembolism risk Vessel Size: Suitable for veins up to 6 mm in diameter, including small, nonaxial varicose veins, reticular veins, and telangiectasias. Injection Technique Downstream injection from larger to smaller veins. Controlled foam volume to displace blood. Advantages Minimally invasive, enhanced efficacy, safety profile. Reduced volume requirement due to foam. STS: Rapid clearance in blood, effective for larger veins. Polidocanol: Decreased risk of thrombosis, suitable for smaller veins. Tessari technique



References:

Bailey and Love's Short Practice of Surgery, 28th Edition, Page 1035
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↑ *Back to this question in Part A*

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Q11: Which of the following statements best describes the difference between Dodd and Cockett surgeries? (Q849456)

A. Dodd: ligation in the thigh; Cockett: ligation in the lower leg

B. Dodd: open surgery; Cockett: endoscopic

C. Dodd: targets superficial veins; Cockett: targets deep veins

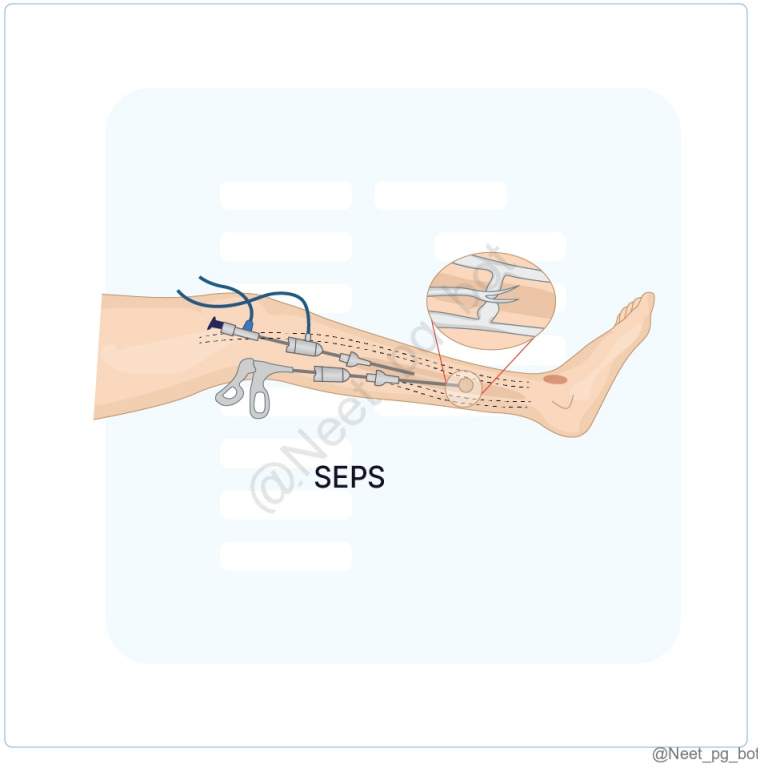
D. Dodd: higher risk of nerve injury; Cockett: lower risk

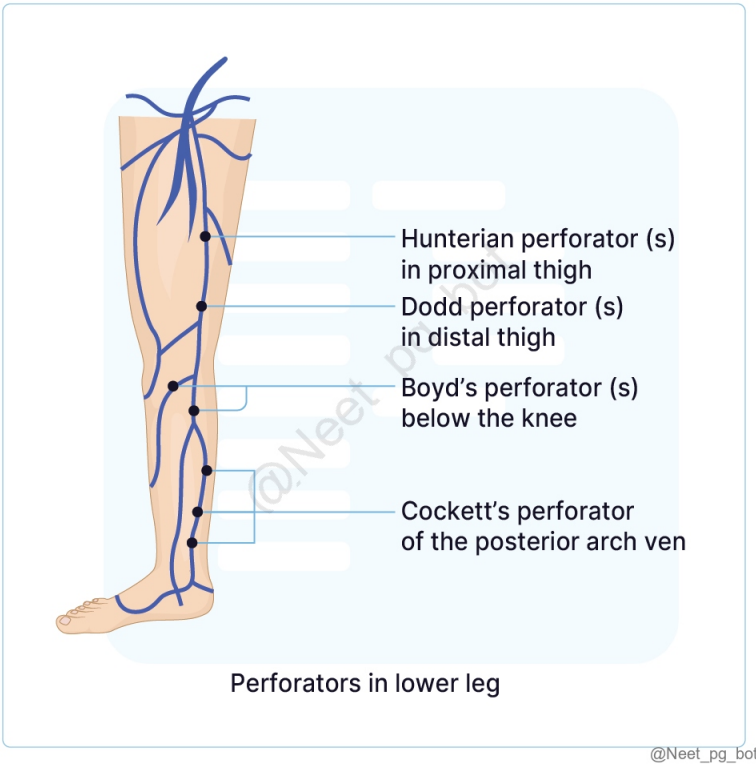
Correct Answer: A. Dodd: ligation in the thigh; Cockett: ligation in the lower leg

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Dodd surgery targets perforator veins in the thigh. Cockett surgery focuses on perforator veins in the lower leg. Surgery for Perforator incompetence Surgery Purpose Technique Advantages Current Relevance SEPS (Subfascial Endoscopic Perforator Vein Surgery) Treats chronic venous insufficiency by targeting incompetent perforator veins. Minimally invasive; uses an endoscope to access and clip/divide perforator veins. Less pain, shorter recovery, fewer complications. Preferred over open surgery; effective in preventing venous ulcers. Dodd Surgery Addresses incompetent perforator veins in the thigh. Open surgery ; incision made to ligate or divide thigh perforator veins (Dodd perforators). Direct access to perforator veins. Less common due to SEPS; historically significant. Cockett Surgery Targets incompetent perforator veins in the lower leg. Open surgery ; incision over the lower leg to ligate perforator veins near the medial malleolus (Cockett perforators). Direct access to lower leg perforator veins. Less common due to SEPS; historically significant.





References:

https://www.sciencedirect.com/topics/medicine-and-dentistry/subfascial-endoscopic-perforator-surgery
https://pubmed.ncbi.nlm.nih.gov/31942200/

↑ *Back to this question in Part A*

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Q12: A 45-year-old woman presents with symptomatic varicose veins. She is interested in learning about the available treatment options and their benefits. Her primary concern is to minimize recovery time and reduce post-operative pain. Which of the following surgical approaches is most appropriate for this patient? (Q849454)

A. Saphenofemoral ligation and great saphenous stripping

B. Saphenopopliteal junction ligation and small saphenous stripping

C. Endovenous laser ablation (EVLA)

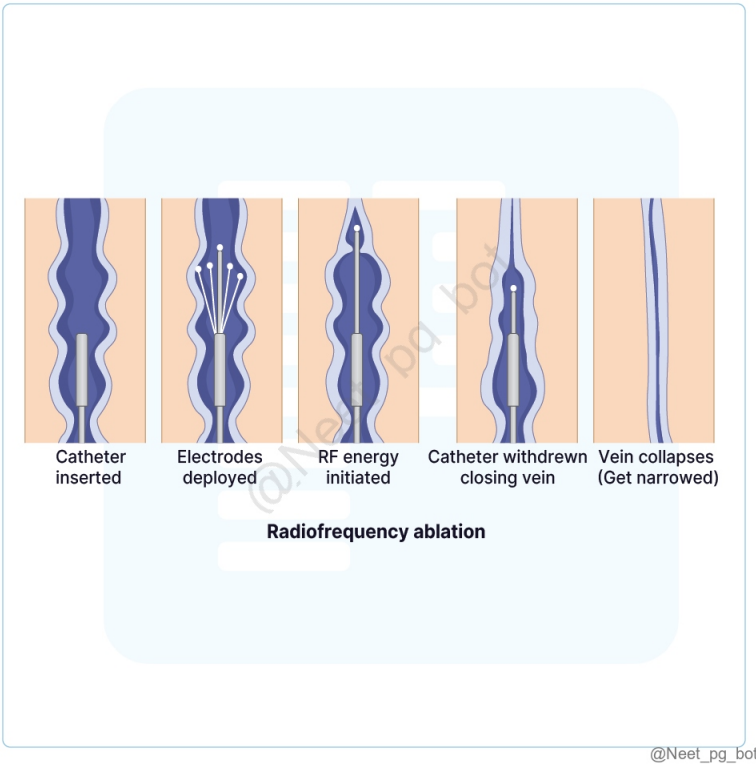
D. Phlebectomy as a standalone procedure

Correct Answer: C. Endovenous laser ablation (EVLA)

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Endovenous laser ablation (EVLA): EVLA is a minimally invasive procedure associated with faster recovery , less pain , and bruising compared to open surgery. It is the preferred option for patients seeking a quicker return to normal activities. Aspect Endovenous Laser Ablation (EVLA) Radiofrequency Ablation (RFA) Procedure Overview Minimally invasive, uses laser energy to close incompetent veins. Gold standard and has largely replaced surgical ligation and stripping. Minimally invasive, uses radiofrequency energy to close veins Indications Treats incompetent truncal veins, often used for varicose veins Treats incompetent truncal veins, similar to EVLA Advantages High efficacy (>95% closure rate) Cost-effective Versatile (treats large and small veins) Effective for tortuous veins Standard fibers treat perforator veins High efficacy (>95% closure rate) Standardized treatment cycles Potentially reduced post-procedural pain and bruising Simplified procedural setup without laser safety protocols Applications Varicose veins Venous ulcer treatment, when combined with compression therapy Varicose veins Key Differences Laser energy used for vein ablation Requires laser safety protocols Radiofrequency energy used for vein ablation Automated energy delivery simplifies the procedure Saphenofemoral ligation and great saphenous stripping (Option A) : An open surgical procedure with longer recovery and more post-operative pain, making it less ideal for patients wanting minimal downtime. Saphenopopliteal junction ligation and small saphenous stripping (Option B) : Another open surgery, associated with increased recovery time and discomfort post-operatively. Phlebectomy as a standalone procedure (Option D) : Involves small incisions to remove veins directly, but can cause more pain and extended recovery compared to minimally invasive options.



References:

Bailey and Love’s Short Practice of Surgery, 28th Edition, Page 1033-1035

↑ *Back to this question in Part A*

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Q13: A 45-year-old male presents with chronic leg pain, swelling, and visible varicose veins. A duplex ultrasound is performed to assess venous function. Which of the following statements is TRUE regarding interpreting the duplex scan in this patient? (Q849452)

A. The duplex scan should be performed with the patient in a supine position

B. A reflux time of less than 500 milliseconds is clinically significant

C. Presence of perforator vein with a diameter >3.5 mm is significant

D. The duplex scan is primarily used to locate perforating veins

Correct Answer: C. Presence of perforator vein with a diameter >3.5 mm is significant

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Duplex imaging is the preferred modality for assessing venous insufficiency. A significant finding in duplex imaging is a perforator vein with a diameter greater than 3.5 mm and a reflux time of 500 milliseconds or longer, which indicates significant perforator reflux. This finding helps guide the management of varicose veins and associated symptoms. The duplex scan should NOT be performed with the patient in a supine position (Option A) to evaluate reflux. In the supine position, valves may remain open without any flow, leading to an erroneous assessment. The correct method is to perform the scan with the patient standing or in a markedly trunk-elevated position to assess valve function and reflux accurately. A reflux time of 500 milliseconds or longer (Option B) is considered clinically significant, not <500 milliseconds. This threshold helps differentiate normal venous function from pathological reflux, which can contribute to varicose vein formation and chronic venous insufficiency. The duplex scan is not primarily used to locate perforating veins (Option D) . Instead, it is used to assess venous reflux in both superficial and deep veins , identifying incompetent valves and evaluating the overall function of the venous system. While perforator veins can be visualized, the scan’s main purpose is to determine the presence and extent of reflux. Parameter Significance Position during Scan Standing or trunk-elevated (NOT supine) Reflux Time (≥ 500 ms) Indicative of significant reflux Perforator Vein Diameter (> 3.5 mm) Suggestive of significant perforator reflux Primary Use of Duplex Scan Assess venous reflux, NOT locating perforators

References:

Sabiston Textbook of Surgery, 21st Edition, Page 1817, 1818

↑ *Back to this question in Part A*

@Neet_pg_bot

Q14: The following test was conducted in the clinic for a patient suffering from varicose veins. On releasing only tourniquet 3, the filling of blood was observed. What does this signify? (Q849451)

A. Hunterian’s perforator incompetence

B. Boyd’s perforator incompetence

C. Dodd’s perforator incompetence

D. Cockett’s perforator incompetence



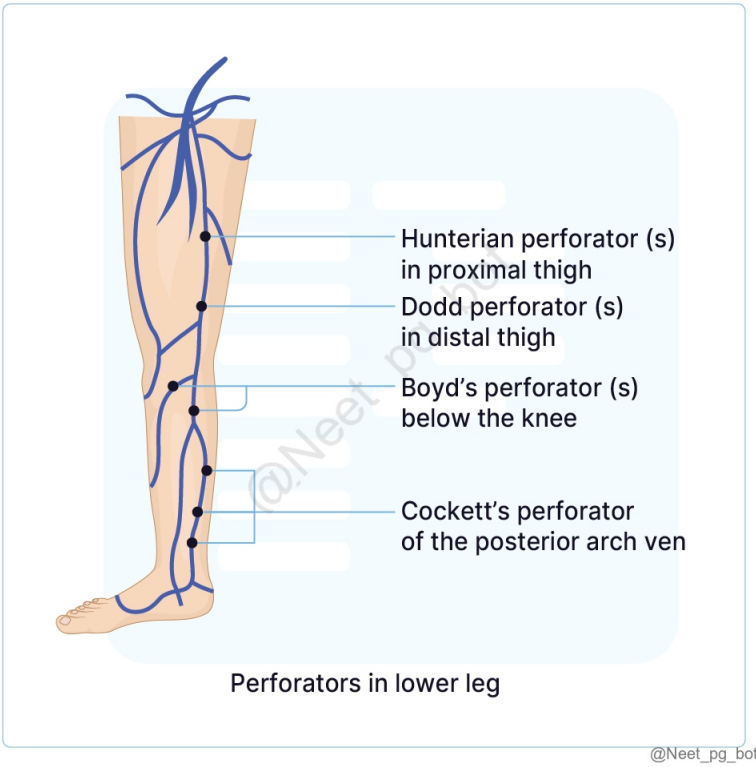
Correct Answer: D. Cockett’s perforator incompetence

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The test being done here is a multiple/three-tourniquet test. On releasing tourniquet 3, the filling of blood signifies Cockett’s perforator incompetence (ankle perforators). Multiple tourniquet test: This test is done to locate the exact perforator that is incompetent. Procedure: The patient is asked to lie in the supine position, and the limb is elevated to empty the veins. Multiple tourniquets are tied just below the locations of the perforators (one below the saphenofemoral junction, one above the knee and one below the knee), and the patient is asked to stand. The tourniquets are removed one by one from below upwards, checking each segment of the leg for filling of blood. Once the tourniquet is removed and the segment drained by a perforator shows filling, it depicts the

respective perforator incompetence (Proximal thigh- Hunterian perforator, distal thigh- Dodd's perforator, below knee- Boyd's perforator, ankle perforators- Cockett's perforators).



Perforators in lower leg

@Neet_pg_bot

References:

SRB's Manual of Surgery, 6th Edition, Page 224

↑ *Back to this question in Part A*

@Neet_pg_bot

Q15: A patient with varicose veins is being examined in the surgical OPD. The Brodie-Trendelenburg I test is done for the patient, and the surgeon notices that blood is filling from above. What does this signify? (Q849450)

A. Valvular incompetence

B. Perforator incompetence

C. Sapheno-femoral incompetence

D. Presence of DVT

Correct Answer: C. Sapheno-femoral incompetence

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The Brodie-Trendelenburg test/ Trendelenburg I test is done to determine the patency of the saphenofemoral junction and hence shows a saphenofemoral incompetence if filling from above is seen. Procedure: Patient is asked to lie in the supine position. The leg is elevated, the vein is emptied by “milking,” and a tourniquet is tied just below the saphenofemoral junction. Patient is asked to stand up quickly. The tourniquet is released. Observation: When there is rapid filling of blood from above, this signifies sapheno-femoral incompetence. Valvular incompetence (Option A) is determined by the Schwartz test . It involves tapping the lower end of the saphenous vein and feeling the impulse at the saphenofemoral junction in a standing position. This confirms the long, continuous column of blood in the vein due to valvular incompetence. Perforator incompetence (Option B) is determined by the Trendelenburg test II, which is similar to test I in that the patient is asked to stand up after the same steps. However, here, the tourniquet is not released, and the filling of blood from below signifies perforator incompetence. Presence of DVT (Option D) is determined by Perthe’s test, in which the patient is asked to walk around or exercise with an elastic bandage wrapped around the legs. The development of severe cramp-like pain in the calf determines DVT.

References:

SRB’s Manual of Surgery, 6th Edition, Page 223, 224.

Pratt

↑ *Back to this question in Part A*

@Neet_pg_bot

Q16: A 45-year-old man presents with left leg swelling and pain for 3 days. Duplex ultrasonography reveals a thrombus in the popliteal vein. Which of the following veins is most likely to be involved next in the progression of this DVT? (Q849436)

A. Great saphenous vein

B. Common femoral vein

C. Posterior tibial vein

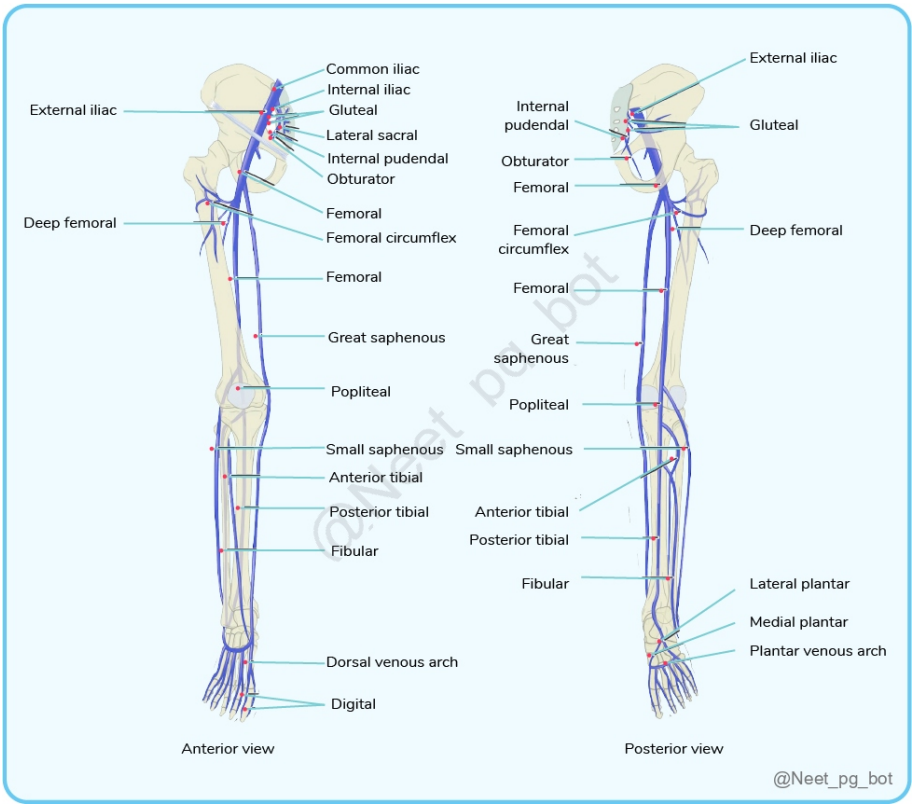
D. External iliac vein

Correct Answer: B. Common femoral vein

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The common femoral vein is the most likely to be involved next in the progression of this deep vein thrombosis. DVT typically propagates proximally, from the calf veins through the popliteal vein and into the femoral vein . The common femoral vein is the next major deep vein in the anatomical sequence above the popliteal vein. Most DVTs (about 90%) start in the calf veins, particularly in the soleal sinuses. From there, they can propagate proximally through the popliteal and femoral veins. Anatomy of Deep Veins in Lower Limb: Foot and ankle: Deep veins accompany the dorsalis pedis and posterior tibial arteries. Calf: Three pairs of deep veins - anterior tibial, posterior tibial (Option C) , and peroneal veins. These join to form the popliteal vein behind the knee. Thigh: The popliteal vein becomes the femoral vein as it passes through the adductor canal. The great saphenous vein (a superficial vein), and the deep femoral vein drain into the femoral vein in the femoral triangle when it becomes known as the common femoral vein. Pelvis: The common femoral vein becomes the external iliac vein (Option D) , which joins with the internal iliac vein to form the common iliac vein. Abdomen: The left and right common iliac veins join to form the inferior vena cava which goes on to the right atrium. The great saphenous vein (Option A) is a superficial vein, not part of the deep venous system. DVT primarily affects the deep veins and is less likely to involve superficial veins.



References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1025, 1043

↑ *Back to this question in Part A*

@Neet_pg_bot

Q17: After noticing small swellings over his legs, a 60-year-old man comes to the surgical OPD. He is a tailor by occupation and works long hours. He explains that he experiences a heaviness and aching in the legs after a long day of work but is relieved once he elevates his legs and rests. Which of the following is not a more severe sign of this disease? (Q849448)

A. Thrombophlebitis

B. Lipodermatosclerosis

C. Ulceration

D. Pedal edema

Correct Answer: D. Pedal edema

- *Listen (English)*
- *Listen (Hindi)*

Explanation: The clinical scenario here points to the diagnosis of varicose veins . Pedal edema is commonly seen and is not a severe sign of this disease. Clinical features of varicose veins: Unsightly appearance of tortuous veins Dull aching pain in the legs Heaviness of legs Early fatigue of the legs Pedal edema (Option D) Signs: Pruritis, telangiectasis, reticular veins, varicose veins, positive cough impulse at the saphenofemoral junction. These symptoms worsen with prolonged standing and sitting and relieve on limb elevation and rest. Varicose veins: Telangiectasias and reticular veins: More severe symptoms/ complications include: Thrombophlebitis (Option A) Hyperpigmentation (due to hemosiderrin deposits) Lipodermatosclerosis (Option B) associated with eczema Ulceration (loss of epithelium) (Option C) Bleeding from attenuated vein clusters Venous neuropathy Lipodermatosclerosis, atrophic blanche and brawny edema: Hyperpigmentation and eczema:









References:

Schwartz Principles of Surgery, 11th Edition, Page 996

↑ *Back to this question in Part A*

@Neet_pg_bot

Q18: A 50-year-old woman presents with visible, dilated veins on both legs. She has a history of two pregnancies and works as a retail clerk. On examination, the dilated veins are most prominent along the posterior aspect of her calves. Which of the following describes the classification of her varicose veins based on the involved venous system? (Q849446)

A. Great Saphenous Vein System

B. Small Saphenous Vein System

C. Non-saphenous veins

D. Perforator veins

Correct Answer: B. Small Saphenous Vein System

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The given anatomical description is characteristic of the Small Saphenous Vein (SSV) system as it runs at the posterior aspect of the calf . The risk factors in the above scenario suggest that this is likely a case of primary varicose veins , as opposed to secondary varicose veins that underlying conditions like deep venous thrombosis or syndromes like Klippel-Trenaunay would cause. Risk factors for varicose veins: Age: Incidence increases with age Gender: M/c in females Obesity Pregnancy and multiparity Prolonged standing or sitting Family history Previous deep vein thrombosis Hormonal factors (e.g., oral contraceptives, hormone replacement therapy) Classification based on involved veins: Great Saphenous Vein (GSV) system (Option A) typically involves the medial aspect of the leg and thigh. Small Saphenous Vein (SSV) system (Option B) involves the posterior aspect of the calf. Non-saphenous veins (Option C) include the lateral venous system. Perforator veins (Option D) connect superficial and deep veins. Classification based on cause: Primary varicose veins: These occur due to intrinsic venous wall or valvular weakness without any identifiable underlying cause. Secondary varicose veins: These develop due to an underlying condition, such as: Deep venous thrombosis (post-thrombotic syndrome) Arteriovenous fistula Klippel-Trenaunay syndrome May-Thurner syndrome

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1029 Sabiston Textbook of Surgery, 21st Edition, Page 1830, 1831

↑ *Back to this question in Part A*

@Neet_pg_bot

Q19: A 55-year-old woman presents with varicose veins in her left leg. On examination, you notice dilated, tortuous veins along the posterior aspect of her calf

and lateral thigh. To accurately map the incompetent veins for potential treatment, which of the following describes the most likely location of the Boyd perforator vein? (Q849445)

A. Medial ankle, posterior to the medial malleolus

B. Medial calf, approximately 10 cm above the medial malleolus

C. Lateral calf, at the junction of the middle and lower thirds

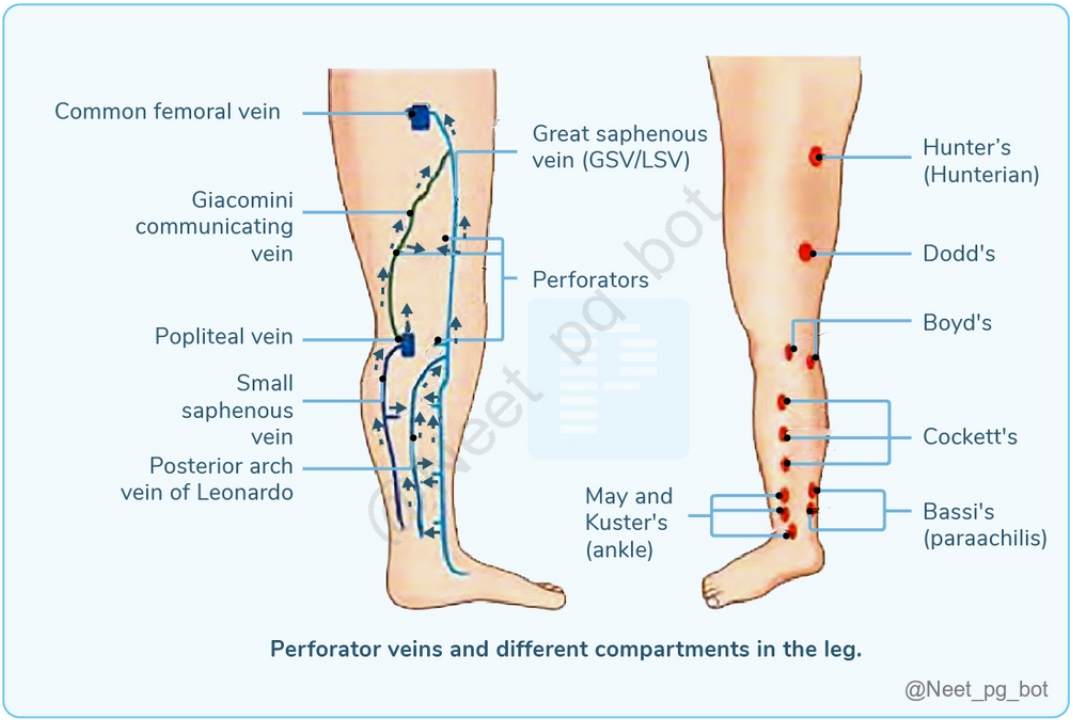
D. Medial knee, approximately 10 cm below the knee joint line

Correct Answer: D. Medial knee, approximately 10 cm below the knee joint line

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The Boyd perforator vein , also known as the upper paratibial perforator , is typically located on the medial aspect of the leg, approximately 10 cm below the knee joint line. This perforator connects the great saphenous vein or its tributaries to the deep veins of the leg, specifically the posterior tibial veins. Superficial veins: Great Saphenous Vein (GSV): Originates from the medial marginal vein of the foot, ascends along the medial aspect of the leg and thigh, and drains into the common femoral vein at the saphenofemoral junction. Small Saphenous Vein (SSV): Begins at the lateral aspect of the foot, ascends posteriorly along the calf, and typically drains into the popliteal vein at the saphenopopliteal junction which then becomes the femoral vein. Perforator veins: Perforators connect the superficial and deep venous systems, allowing blood to flow from superficial to deep veins. Key perforators include: Ankle perforators: Cockett perforators (posterior tibial perforators): Three perforators located along the medial ankle and distal calf. May and Kusters perforators Calf perforators: Boyd perforator: Located approximately 10 cm below the knee joint on the medial aspect of the leg, connects the great saphenous and superficial femoral veins. Sherman perforator: Located in the mid-calf region. Thigh perforators: Dodd perforator: Located in the middle third of the medial thigh. Hunterian perforator: Located in the upper thigh, connecting the GSV to the femoral vein. Lateral perforators: Lateral calf perforators: Less clinically significant, connecting the lateral venous system to deep veins. The medial ankle, posterior to the medial malleolus, describes the Cockett perforators (Option A) , a group of three perforators located in the distal third of the leg. The medial calf, approximately 10 cm above the medial malleolus, is more consistent with the position of the middle Cockett perforator (Option B) , not the Boyd perforator. The lateral calf, at the junction of the middle and lower thirds location (Option C), does not correspond to any major named perforator vein. The lateral aspect of the calf contains smaller, less clinically significant perforators.



Perforator veins and different compartments in the leg.

References:

Sabiston Textbook of Surgery, 21st Edition, Page 1814

www.researchgate.net/figure/Location-of-the-perforating-veins-on-the-front-and-inner-sides-of-the-calf-Blue_fig15_278656090#:~:text=The%20medial%20ankle%20perforating%20veins,the%20great%20saphenous%20vein%20territory.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q20: A 55-year-old woman presents with recurrent episodes of tender, erythematous cord-like swellings along different superficial veins of her lower extremities over the past 3 months. Which of the following is most likely to be associated with this presentation? (Q849444)

A. Recent childbirth

B. Thromboangiitis obliterans

C. Pancreatic malignancy

D. Polycythemia vera

Correct Answer: C. Pancreatic malignancy

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: This patient presents with symptoms of recurrent superficial thrombophlebitis, possibly migratory (thrombophlebitis migrans) . The recurrent nature and lack of obvious predisposing factors raise concern for an underlying systemic condition, particularly malignancy. Trousseau identified the association of migratory thrombophlebitis and malignant disease, involving the tail of the pancreas. This association, known as Trousseau's syndrome , is a classic presentation of occult pancreatic malignancy. While recent childbirth (Option A) is a risk factor for thrombophlebitis, it's not relevant in this case, given the patient's age and the recurrent nature of the symptoms over three months. Thromboangiitis obliterans (Buerger's disease) (Option B) typically affects young male smokers and involves both arteries and veins. It's less likely in this scenario compared to malignancy. Polycythemia vera (Option D) can be associated with thrombophlebitis, but the recurrent and migratory nature of the symptoms in this case is more suggestive of malignancy, particularly pancreatic cancer.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1046

STP

↑ *Back to this question in Part A*

@Neet_pg_bot

Q21: A 20-year-old competitive swimmer presents with a 2-day history of left arm pain, swelling, and mild discoloration after intense training. Duplex ultrasound shows a thrombus in the left subclavian vein. What is the most likely diagnosis? (Q849443)

A. Thoracic outlet syndrome

B. Paget-Schrotter syndrome

C. Raynaud's phenomenon

D. Lymphedema

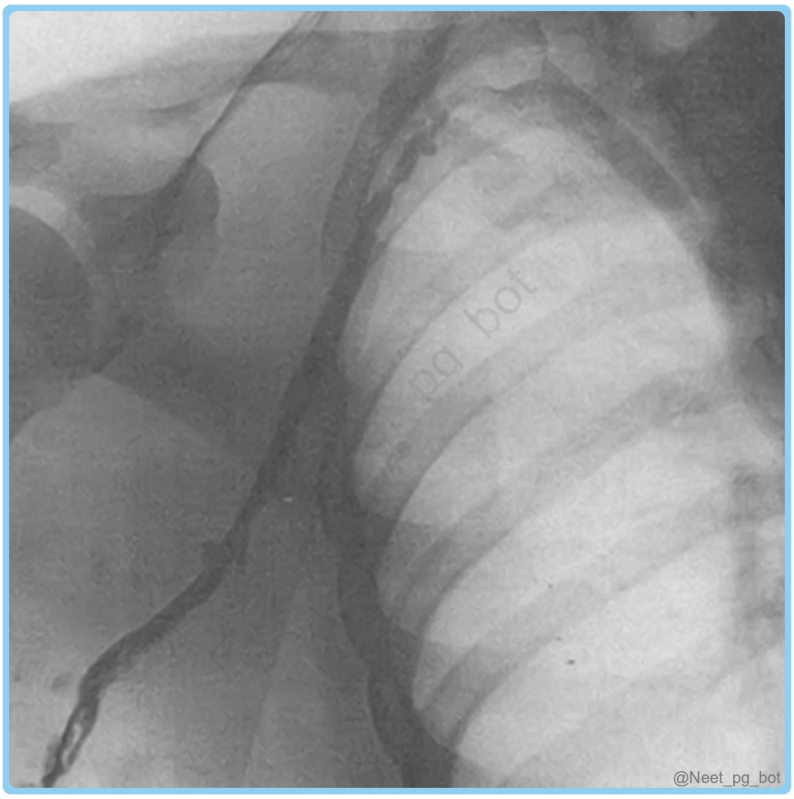
Correct Answer: B. Paget-Schrotter syndrome

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The patient is experiencing Paget-Schrotter syndrome, which is an effort induced thrombosis due to subclavian vein compression. Often seen in young athletes with repetitive upper extremity motion (e.g., swimming). Thoracic outlet syndrome (Option A) can lead to Paget-Schrotter syndrome but is incorrect because the ultrasound confirmed the presence of a thrombus. Raynaud's phenomenon (Option C) causes episodic color

changes in the fingers or toes in response to cold or stress, not with a thrombus in the subclavian vein. Lymphedema (Option D) results from impaired lymphatic drainage and usually develops gradually. It is less likely to occur suddenly after exercise.





References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1047 Sabiston’s Textbook of Surgery, 21st Edition, Page 1830

↑ *Back to this question in Part A*

@Neet_pg_bot

Q22: A 30-year-old woman is in the post-operative ward after a cesarean section. She had no complications and gave birth to a healthy baby. Which of the following is a prophylactic step she needs to be advised to prevent deep vein thrombosis? (Q849442)

A. Early mobilization along with compression stockings

B. Low molecular weight heparin

C. Low-dose unfractionated heparin

D. Fondaparinux

Correct Answer: A. Early mobilization along with compression stockings

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The case scenario here is of an abdominopelvic surgery that needs early mobilization with compression stockings as a prophylaxis for preventing DVT. In the above scenario, the risk factor for DVT is pregnancy and immediate postpartum, along with having undergone an abdominopelvic surgery which only needs mechanical methods of prophylaxis rather than pharmacological. Risk groups for deep vein thrombosis: Older age groups (>40 yrs) Hospitalized and immobilized patients Pregnancy and the recently postpartum state Those on hormonal replacement therapy Women on oral contraceptive pills Major surgery Long haul travellers (>6hrs) With conditions like: Past venous thromboembolism Malignancies Nephrotic syndrome Varicose veins Antiphospholipid syndrome Myeloproliferative disorders Polycythemia Obesity Level of risk Suggested thromboprophylaxis options Very low-risk General or abdominopelvic surgery No specific thromboprophylaxis Early ambulation along with compression stockings (Option A) Low risk General or abdominopelvic surgery Mechanical prophylaxis Early ambulation and mechanical device (compression stockings) Moderate risk General or abdominopelvic surgery LMWH (at recommended doses) (Option B) LDUH (Option C) or mechanical prophylaxis High bleeding risk Mechanical prophylaxis Early ambulation and mechanical device(compression stockings High risk General or abdominopelvic surgery LMWH (at recommended doses), fondaparinux (Option D) , and mechanical prophylaxis High bleeding risk General or abdominopelvic surgery for cancer Mechanical thromboprophylaxis Extended-duration LMWH (4 weeks)



References:

Sabiston's Textbook of Surgery, 21st Edition, Page 1829 Schwartz Principles of surgery, 11th Edition, Page 984, 985

↑ *Back to this question in Part A*

@Neet_pg_bot

Q23: A patient came with complaints of discoloration of his left leg as shown in the image. He has a history of deep vein thrombosis and has been inconsistent on medication. What is the possible diagnosis here? (Q849441)

A. Venous gangrene

B. Venous ulcer

C. Atrophic blanche

D. Post-thrombotic leg



Correct Answer: D. Post-thrombotic leg

- *Listen (English)*
- *Listen (Hindi)*

Explanation: The scenario here points to a post-thrombotic leg due to the history of previous DVT and non-compliance to oral anticoagulants Post-thrombotic syndrome: Post-thrombotic syndrome (PTS), also called postphlebitic syndrome and venous stress disorder is a medical condition that may occur as a long-term complication of deep vein thrombosis (DVT). Chronic venous insufficiency patients may have superficial vein incompetence with or without perforator incompetence or having previous DVT with complete obliteration or partial recanalisation with incompetence. Develop in 20% to 50% of patients after DVT. Symptoms: Leg pain Sensation of leg heaviness, pulling or fatigue Limb swelling Signs: Leg edema Redness Dusky cyanosis Perimalleolar or more extensive telangiectasia New varicose vein Stasis hyperpigmentation Lipodermatosclerosis Leg ulcer Venous gangrene (Option A): Presents with blackish discoloration, blebs and edema. Venous ulcer (Option B): Long saphenous vein perforator incompetence is often associated with venous ulcers, typically on the medial aspect of the ankle, and is often seen in long-standing varicose veins. Atrophic blanche (Option C): It is localized white atrophic skin surrounded by hyperpigmentation and dilated capillaries associated with varicose veins.









References:

Bailey and Love's Short Practice of Surgery, 28th Edition, Page 1028, 1042.

SRB's Manual of Surgery, 6th Edition, Page 216, 217, 220, 221

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6142466/,PTS

↑ *Back to this question in Part A*

@Neet_pg_bot

Q24: A 45-year-old man with metastatic colorectal cancer is diagnosed with an acute DVT of the left leg. He had an episode of upper GI bleed 2 days ago. His lab results show a platelet count of 40,000/μL and an INR of 1.8. Which of the following is the most appropriate management strategy for preventing pulmonary embolism in this patient? (Q849440)

A. Start anticoagulation with LMWH

B. Place a permanent IVC filter

C. Place a retrievable IVC filter

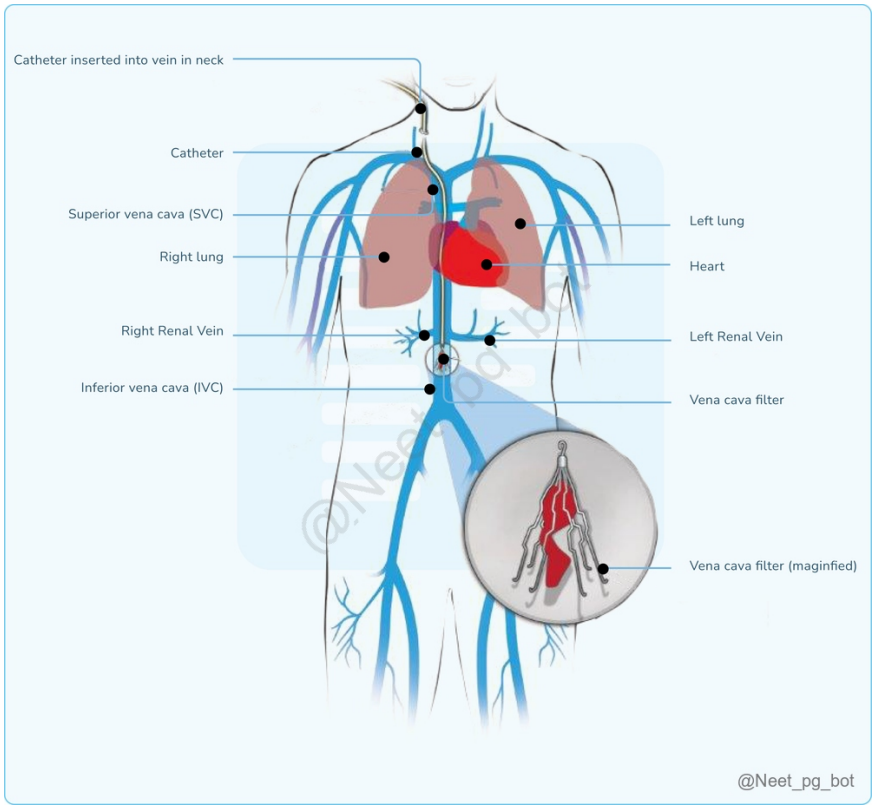
D. Start anticoagulation with UFH

Correct Answer: C. Place a retrievable IVC filter

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: In this case, the patient has an acute DVT with a high risk of progression to pulmonary embolism. However, he also has significant contraindications to anticoagulation: Thrombocytopenia (platelet count 40,000/µL) and Coagulopathy (INR 1.8). These factors make anticoagulation extremely high-risk. In such scenarios, where there is an acute proximal DVT and a contraindication to anticoagulation, placement of an IVC filter is indicated . The choice of a retrievable filter allows for potential removal once the contraindications to anticoagulation resolve. Reassessment in 3 months is appropriate to evaluate if the filter can be safely removed and anticoagulation initiated. Start anticoagulation with LMWH (Option A) is incorrect due to the high bleeding risk associated with the patient's active GI bleeding, thrombocytopenia, and coagulopathy. Place a permanent IVC filter (Option B): While an IVC filter is indicated, a permanent filter is not the best choice. Retrievable filters are preferred when possible, as they allow for removal once anticoagulation becomes feasible, reducing long-term complications associated with permanent filters. Start anticoagulation with UFH (Option D): Even anticoagulation with unfractionated heparin carries a significant risk of exacerbating the patient's bleeding complications.



References:

Sabiston Textbook of Surgery, 21st Edition, Page 1830, 1831

↑ *Back to this question in Part A*

@Neet_pg_bot

Q25: A 45-year-old man with a history of colorectal cancer underwent surgery 3 weeks ago and is now presenting with complaints of left leg swelling and pain for 3 days. His left calf is 4 cm larger than the right. Using Wells' criteria for DVT, what is his pre-test probability score and risk category? (Q849438)

A. 2 points; Moderate risk

B. 5 points; High risk

C. 3 points; Moderate risk

D. 4 points; High risk

Correct Answer: D. 4 points; High risk

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The Wells' criteria for Deep Vein Thrombosis is a clinical prediction rule used to estimate the pretest probability for DVT. It helps clinicians determine the need for further diagnostic testing. The patient scores 4 points (Option C) on the Wells' criteria, placing them in the high-risk category. Malignancy (Including treatment done within past 6 month) (1 point) Recently bedridden for >3 days or major surgery within last 4 weeks (1 point) Calf swelling > 3 cm compared to the other leg (1 point) Entire leg swollen (1 point) This scoring system, when combined with D-dimer testing, helps in the diagnostic algorithm for DVT, potentially reducing unnecessary imaging studies in low-risk patients. Well’s criteria for detecting DVT: Variable Score Active cancer (patient either receiving treatment for cancer within the previous 6 months or currently receiving palliative treatment) 1 Paralysis, paresis, or recent cast immobilization of the lower extremities 1 Recently bedridden for ≥ 3 days, or major surgery within the previous 12 weeks requiring general or regional anesthesia 1 Localized tenderness along the distribution of the deep venous system 1 Entire leg swelling 1 Calf swelling at least 3 cm larger than that on the asymptomatic side (measured 10 cm below tibial tuberosity) 1 Pitting edema confined to the symptomatic leg 1 Collateral superficial veins (non-varicose) 1 Previously documented deep vein thrombosis 1 Alternative diagnosis more likely than DVT -2 Low probability (5%) of DVT: score –2 to 0 Moderate probability (17%) of DVT: score 1 or 2 High probability (17–53%) of DVT: score >2

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1044, 1045

↑ *Back to this question in Part A*

@Neet_pg_bot

Q26: A 52-year-old male presents with a swollen, painful left calf that developed over the past two days. He reports no history of trauma, surgery, or prolonged immobility. Physical examination reveals a warm, erythematous, and tender left calf. Which of the following clinical features is most specific for diagnosing deep vein thrombosis? (Q849437)

A. Calf pain on dorsiflexion of the foot

B. Asymmetrical calf swelling

C. Pain that worsens with leg elevation

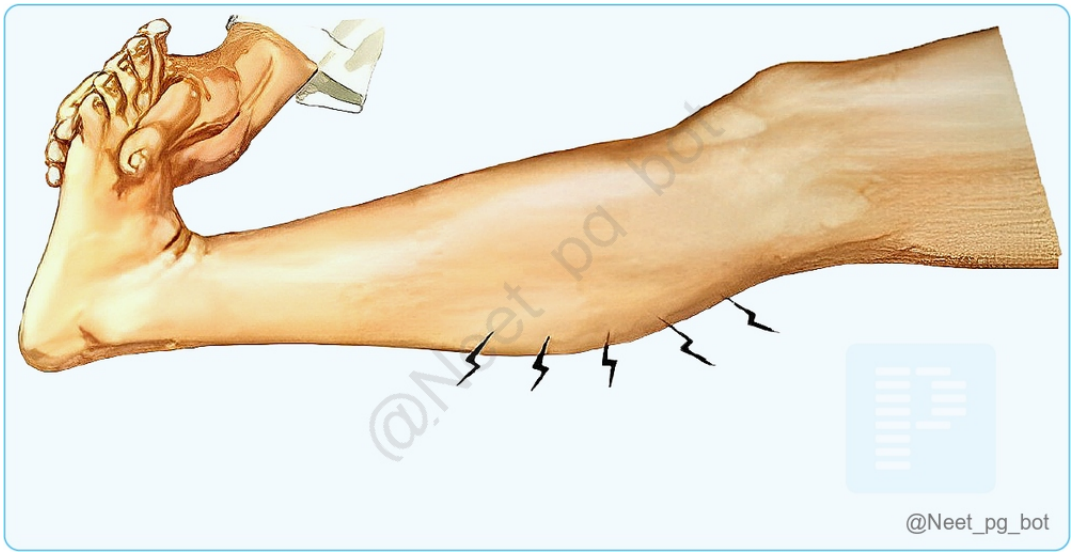
D. Localized tenderness along the course of the deep veins

Correct Answer: D. Localized tenderness along the course of the deep veins

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Localized tenderness along the course of the deep veins is one of the most specific clinical signs of DVT. This symptom occurs due to a thrombus within the deep veins, which triggers pain when pressure is applied along the affected vein. Clinical Feature Significance 1. Localized tenderness Specific for DVT; indicates inflammation along the vein. 2. Asymmetrical calf swelling Common but not specific to DVT. 3. Erythema and warmth Suggestive of inflammation or thrombosis. 4. Pain in the affected limb Can occur with or without movement; can indicate venous obstruction. 5. Dilated superficial veins May indicate compensatory circulation due to deep venous obstruction. 6. Homans' sign Non-specific; Passive forceful dorsiflexion of the foot with extended knee will cause tenderness in the calf. 7. Mose’s sign Painful response to gentle squeezing of the lower calf from side-to-side. 8. Neuhof's Sign Thickening and deep tenderness in the calf muscles upon palpation. 9. Phlegmasia Alba Dolens DVT of the femoral vein causes painful congestion and edema of the leg with lymphangitis, which further increases edema (white leg). 10. Phlegmasia Caerulea Dolens Extensive DVT in iliac and pelvic veins leading to a blue leg with possible venous gangrene or infarction. Pratt's sign : Applying pressure to the calf muscle; if it feels tense and causes pain, it may indicate acute deep vein thrombosis (DVT). Calf pain on dorsiflexion of the foot (Option A): Homans' sign is the pain or Resistance of the calf muscles to forcible dorsiflexion of the foot. It has been traditionally associated with DVT but is not specific and should not be routinely elicited due to its lack of reliability. Asymmetrical calf swelling (Option B) is a common feature of DVT but is not specific. It can be present in other conditions, such as lymphedema or muscular injuries. Pain that worsens with leg elevation (Option C) is more indicative of arterial insufficiency . In DVT, the pain may worsen with dependency due to increased venous pressure.



References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1044.

SRB’s Manual of Surgery, 6th Edition, Page 217

Pratt sign

↑ *Back to this question in Part A*

@Neet_pg_bot

• [03_Cardiothoracic Vascular Surgery] 010 Lymphatic System

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[03_Cardiothoracic Vascular Surgery] 010 Lymphatic System — Quick Jump

Q1 (p. 1433)	*Q2 (p. 1433)*	*Q3 (p. 1436)*	*Q4 (p. 1437)*	*Q5 (p. 1437)*	*Q6 (p. 1438)*
Q7 (p. 1439)	*Q8 (p. 1440)*	*Q9 (p. 1441)*	*Q10 (p. 1442)*	*Q11 (p. 1443)*	*Q12 (p. 1445)*
Q13 (p. 1445)	*Q14 (p. 1447)*	*Q15 (p. 1448)*	*Q16 (p. 1450)*	*Q17 (p. 1451)*	

Q1: A 40-year-old female presents with persistent swelling in her lower legs. Upon physical examination, the swelling is noted to be non-pitting, and the patient has no signs of irreversible skin changes. What is the most appropriate Brunner's classification grade for her condition? (Q849351)

A. Subclinical/latent

B. Grade I

C. Grade II

D. Grade III

Correct Answer: C. Grade II

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: This patient with non-pitting edema with no signs of irreversible skin changes belongs to Grade II of the Brunner’s classification. Brunner’s clinical classification of lymphedema: Grades Clinical Features Subclinical/Latent Excess interstitial fluid. Histological abnormality in lymphatics & lymph nodes. No clinically apparent lymphedema. I Pitting edema. II Non-pitting edema. III Edema with irreversible skin changes.

References:

https://www.researchgate.net/figure/Proposed-lymphedema-staging-system_tbl2_260170025

↑ *Back to this question in Part A*

@Neet_pg_bot

Q2: A 60-year-old female with severe lymphedema of the lower limb, not responding to conservative therapies. Due to persistent swelling and functional impairment, she

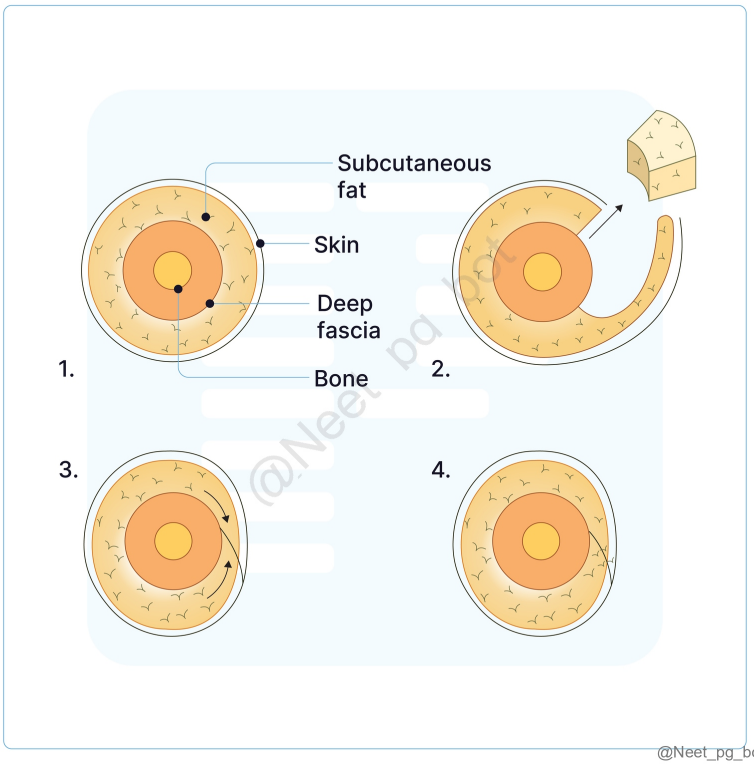
undergoes surgical intervention. An image of the surgical procedure is shown below. What is the procedure known as? (Q849354)

A. Thompson Procedure

B. Charles Procedure

C. Nielubowicz Operation

D. Kinmonth procedure

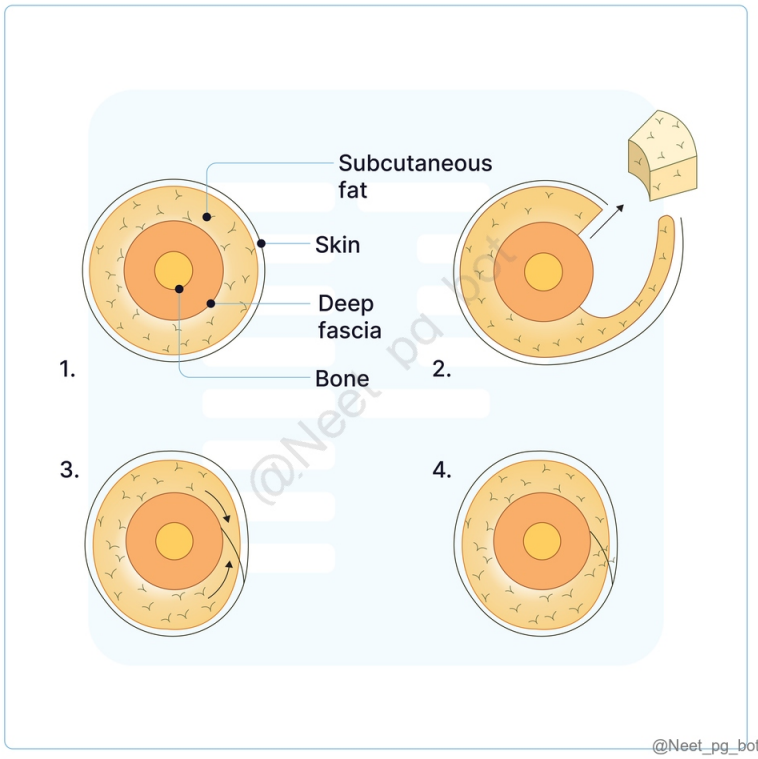


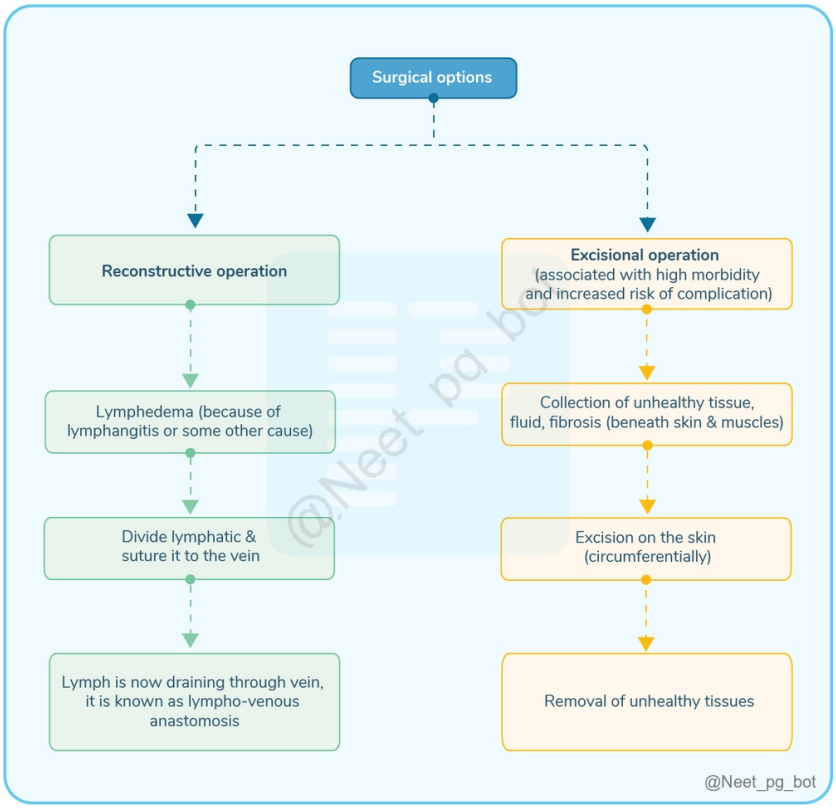
Correct Answer: A. Thompson Procedure

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The Thompson procedure is a type of excisional operative procedure that involves removing unhealthy tissues. Lymphedematous tissue is removed beneath the skin flaps. The epidermis and part of the dermis from one of these skin flaps are carefully shaved off with a Humby's knife. This shaved tissue is placed under the opposite flap, positioned deep beneath the deep fascia, similar to a Swiss roll. Charles Procedure Radical excision of all skin + subcutaneous tissue → STSG Used only in end-stage elephantiasis Much more destructive than Thompson Nielubowicz Operation Lymphatic–venous anastomosis A microvascular bypass procedure No large flap or excision 4. Kinmonth Procedure Lymph node transplantation (e.g., inguinal → axilla) No flap tunneling





References:

SRB's Manual of Surgery, 6th edition, Pages 246, 247, 248

↑ *Back to this question in Part A*

@Neet_pg_bot

Q3: A patient with breast carcinoma after 11 years of Modified radical mastectomy and radiotherapy, now presents with pain, skin nodules and worsening of swelling of left arm as shown in the image below. What is the most probable diagnosis? (Q849356)

A. Lymphangiosarcoma

B. Venous thrombosis

C. Cellulitis

D. Lymphedema



Correct Answer: A. Lymphangiosarcoma

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Lymphangiosarcoma is seen in chronic long-standing lymphedema following mastectomy (more than 10 years). They present as single/multiple bluish-red skin and subcutaneous nodules. They can ulcerate and bleed. Treatment: Neoadjuvant chemoradiation followed by surgical excision with or without amputation.

References:

Sabiston Textbook of Surgery, 21st edition, Pages 746, 832

↑ *Back to this question in Part A*

@Neet_pg_bot

Q4: A patient with chronic lymphedema is being evaluated for surgical management. Which of the following is not a reduction procedure for lymphedema? (Q889676)

A. Liposuction

B. Charles' procedure

C. Homans' procedure

D. Lymphatic–venous shunt

Correct Answer: D. Lymphatic–venous shunt

Explanation: Lymphatic–venous shunt is a physiologic/reconstructive procedure , not a reduction procedure. Reduction procedures (remove excess tissue): Liposuction (Option A) : Suction-assisted removal of adipose tissue; minimally invasive. Charles' procedure (Option B) : Radical excision of skin/subcutaneous tissue down to deep fascia; covered with skin grafts. Homans' procedure (Option C) : Elevation of skin flaps to excise subcutaneous tissue, followed by primary closure.

References:

https://baileyandlove.tandf.co.uk/advanced-learning-content/chapter-62a-lymphatic-disorders/

↑ *Back to this question in Part A*

@Neet_pg_bot

Q5: A 35-year-old man presents to the emergency department with a rapidly spreading reddish streak on his left arm, accompanied by fever and swollen axillary lymph nodes. He reports sustaining a small cut on his hand two days ago while gardening. Physical examination reveals a tender, warm, erythematous streak extending from the hand to the upper arm, with blanching on pressure. What is the next best step in the management of this patient? (Q849348)

A. Immediate surgical incision and drainage of the affected area

B. Oral antihistamines and topical corticosteroids

C. Limb elevation and initiation of intravenous antibiotics like penicillin or cloxacillin

D. Watchful waiting for 48 hours before initiating any treatment

Correct Answer: C. Limb elevation and initiation of intravenous antibiotics like penicillin or cloxacillin

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The rapidly spreading reddish streak on the arm, accompanied by fever and swollen regional (axillary) lymph nodes, are classic signs of acute lymphangitis. The recent history of a small cut while gardening provides a likely entry point for the causative organisms. The treatment primarily involves administration of broad-spectrum antibiotics (e.g. penicillin, cloxacillin) & elevation and rest of affected limb. Acute Lymphangitis Definition Acute nonsuppurative infection and spreading inflammation of lymphatics of skin and subcutaneous tissues Causative Organisms • Beta-hemolytic streptococci • Staphylococci • Clostridial organisms (less common) Risk Factors • Small trauma or skin break • In endemic areas: Wuchereria bancrofti (transmitted by Culex mosquito) Clinical Features • Streaky redness which is spreading (typical) • Pain • Fever • Palpable tender regional lymph nodes • Blanching on pressure • Fever, tachycardia (features of toxemia) Complications • Abscess formation • Toxaemia, septicemia • Chronic lymphangitis leading to acquired lymphoedema Investigations • Complete blood count • Renal and liver function tests • Blood culture Management • Broad-spectrum antibiotics (e.g. penicillin, cloxacillin) • Elevation and rest of affected limb • Glycerine magnesium sulphate dressing • Management of toxemia or septicemia if present {{caption_text}}



References:

SRB’s Manual of Surgery, 6th Edition, Pages 37, 38

↑ *Back to this question in Part A*

@Neet_pg_bot

Q6: A patient with chronic lymphedema is advised decongestive lymphatic therapy (DLT). Which of the following is not a component of decongestive lymphatic therapy? (Q889675)

A. Manual lymphatic drainage

B. Compression therapy

C. Regular diuretic therapy

D. Limb elevation

Correct Answer: C. Regular diuretic therapy

Explanation: Decongestive Lymphatic Therapy (DLT) improves lymphatic drainage and promotes collateral pathways. Diuretics are not part of DLT because they offer no long-term benefit in lymphedema and should be avoided. Components: Limb elevation (Option D) Manual lymphatic drainage (MLD) (Option A) : Proximal massage to direct lymph flow Compression therapy (Option B) : Multilayer bandaging/garments, intermittent pneumatic compression. Exercise Skin care Genital edema: scrotal support if needed

References:

https://baileyandlove.tandf.co.uk/advanced-learning-content/chapter-62a-lymphatic-disorders/

↑ *Back to this question in Part A*

@Neet_pg_bot

Q7: What is the most common site of mediastinal lymphoma? (Q889673)

A. Anterior mediastinum

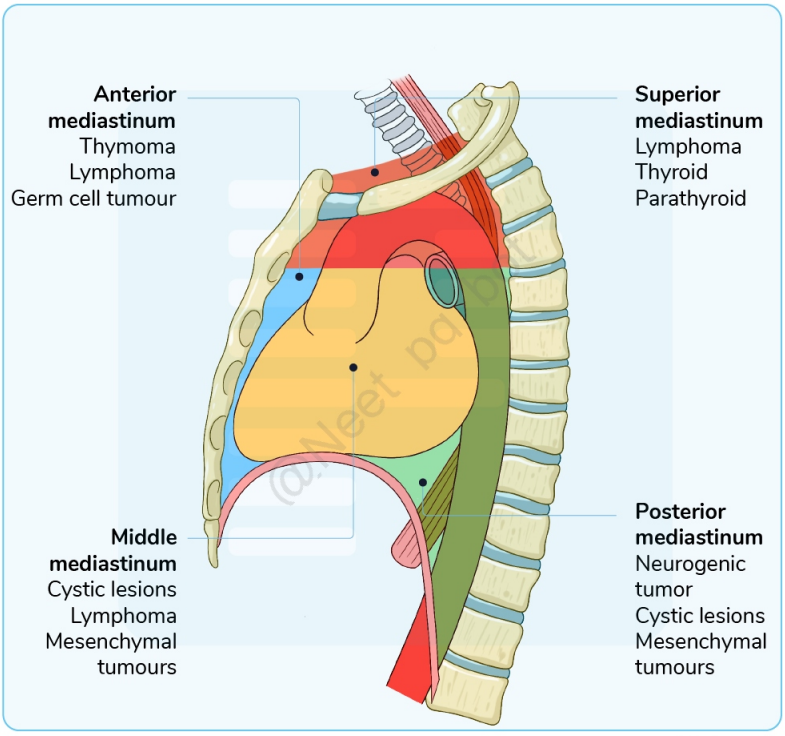
B. Middle mediastinum

C. Posterior mediastinum

D. Superior mediastinum

Correct Answer: A. Anterior mediastinum

Explanation: The anterior mediastinum is the most common site for several major "T" masses, including: Thymoma Teratoma Thyroid (retrosternal goitre) Terrible Lymphoma.



References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 992

↑ *Back to this question in Part A*

@Neet_pg_bot

Q8: A 60-year-old woman has had chronic lower-limb lymphedema for 15 years following cancer surgery. She presents for routine follow-up. Which of the following is not a complication of chronic lymphedema? (Q889672)

A. Recurrent cellulitis

B. Stewart-Treves Syndrome

C. Fibrosis

D. Venous ulcer

Correct Answer: D. Venous ulcer

Explanation: Venous ulcers are primarily a complication of venous insufficiency , not lymphedema. Complications of Lymphedema: Recurrent Cellulitis/Erysipelas (Option A) : Protein-rich fluid acts as a medium for bacterial growth, leading to frequent skin infections. Lymphangitis: Repeated inflammation further destroys remaining lymphatic channels. Dermatophytosis: Fungal infections like tinea pedis occur due to impaired local immunity. Progressive Fibrosis (Option C) : Chronic inflammation causes tissue to harden and become non-pitting. Skin Remodelling: Results in hyperkeratosis, acanthosis (thickening), and wart-like papillomatosis. Lymphostatic Elephantiasis: The terminal stage involving extreme limb deformity and deep skin folds. Stewart-Treves Syndrome (Option B) : A rare, highly lethal angiosarcoma arising in long-standing lymphedema (typically >10 years).

References:

Schwartz's Principles of Surgery, 11th Edition, Page 1002.

Sabiston Textbook of Surgery, 21st Edition, Page 1836.

https://www.ncbi.nlm.nih.gov/books/NBK537239/

↑ *Back to this question in Part A*

@Neet_pg_bot

Q9: Direct contrast lymphangiography is planned in a patient with a suspected lymphatic abnormality. Which of the following statements regarding this procedure is true? (Q889670)

A. It is a noninvasive imaging technique requiring no anaesthesia

B. Contrast is injected rapidly into a peripheral vein

C. Cannulation is usually performed on lymphatic vessels at the dorsum of the foot

D. It is commonly used as a routine diagnostic test for lymphedema

Correct Answer: C. Cannulation is usually performed on lymphatic vessels at the dorsum of the foot

Explanation: Direct contrast lymphangiography is an invasive procedure that provides the finest anatomical detail of the lymphatic system. Superficial lymphatic vessels on the dorsum of the foot are cannulated- slow injection of oil-based contrast (ethiodized oil). Complications: Lymphatic vessel damage & allergic reactions Pulmonary embolism (if contrast enters the venous system via lymphovenous anastomoses)



References:

Sabiston Textbook of Surgery, 21st Edition, Page 1837

↑ *Back to this question in Part A*

@Neet_pg_bot

Q10: A newborn is noted to have bilateral, non-pitting swelling of the feet and lower legs present since birth, as shown in the image. Examination shows thickened skin and prominent veins over the dorsum of the feet. The child's father has similar leg swelling. There is no history of surgery, infection, or trauma. Which of the following statements regarding this condition is true? (Q889667)

A. It is most commonly caused by filarial infection

B. It is inherited in an autosomal recessive pattern

C. It is associated with mutations in the FLT4 (VEGFR-3) gene

D. The lymphedema typically resolves spontaneously with age



Correct Answer: C. It is associated with mutations in the FLT4 (VEGFR-3) gene

Explanation: The scenario describes Milroy's disease. A genetic primary lymphedema presenting with congenital or early-onset lower-limb swelling due to impaired lymphatic drainage. Swelling: Present at birth or soon after, usually bilateral lower-limb lymphedema (often feet), may be asymmetric. Gene: Pathogenic variants in FLT4 (VEGFR-3) , affecting lymphatic vessel development. Autosomal dominant (Option B) with variable expression and reduced penetrance. Other signs: Prominent veins below knees, upslanting toenails, hydrocele in males, papillomatosis. Filarial infection (Option A) : This is the most common cause of secondary lymphedema worldwide, but it is an acquired parasitic infection, not a congenital genetic condition present from birth. Spontaneous resolution (Option D): Lymphedema is a progressive and usually irreversible condition. Without management, it typically worsens through stages of fibrosis rather than resolving.

References:

Sabiston Textbook of Surgery, 21st Edition, Page 1836

https://baileyandlove.tandf.co.uk/advanced-learning-content/chapter-62a-lymphatic-disorders/

https://www.ncbi.nlm.nih.gov/books/NBK1239/

↑ *Back to this question in Part A*

@Neet_pg_bot

Q11: A 52-year-old woman with a history of pelvic surgery and radiotherapy presents with long-standing swelling of the left leg.The clinical appearance is shown. Which grade of lymphedema does this most likely represent? (Q889664)

A. Grade 0

B. Grade I

C. Grade II

D. Grade III



Correct Answer: D. Grade III

Explanation: The patient's presentation of a grossly enlarged limb with hyperkeratosis , thickened skin , and deep skin folds matches the advanced tissue injury and fibrosis characteristic of the third stage. Grading of Lymphedema: Stage Key Features 0 Lymphatic fibrosis occurs, but there is no clinical evidence of edema. I Protein-rich fluid accumulation results in soft pitting edema. II Local inflammation and deposition of connective and adipose tissue result in non-pitting, spongy edema that does not reduce with elevation. III Recurrent infections and severe subcutaneous fibrosis lead to irreversible edema and skin changes of lymphostatic elephantiasis.

References:

Sabiston Textbook of Surgery, 21st Edition, Page 1836

https://baileyandlove.tandf.co.uk/advanced-learning-content/chapter-62a-lymphatic-disorders/

↑ *Back to this question in Part A*

@Neet_pg_bot

Q12: Identify the given condition and choose among the following: {{caption_text}} (Q849357)

A. Stewart - Treves syndrome

B. Lymphedema

C. Cystic hygroma

D. Marjolin’s ulcer



Correct Answer: A. Stewart - Treves syndrome

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: This image shows lymphedema with bluish-red skin with subcutaneous nodules which suggests a diagnosis of Stewart - Treves syndrome. It occurs in a patient with breast carcinoma after about 10 years of MRM and radiotherapy, if the patient has severe lymphedema and is left untreated. Clinically presented as bluish-red skin with subcutaneous nodules that ulcerate and bleed (Option A) .

References:

Sabiston Textbook of Surgery, 21st edition, Page 746, 832

www.ncbi.nlm.nih.gov/pmc/articles/PMC9546750/#:~:text=Breast%20cancer%E2%80%93related%20lymphedema%20(BCRL)%20impacts%20approximately%2019%25%20of%20survivors%20of%20breast%20cancer%20(BC)%2C%20most%20commonly%20within%20the%20first%202%C2%A0years%20after%20treatment

↑ *Back to this question in Part A*

@Neet_pg_bot

Q13: A 4-month-old baby is brought to the hospital with complaints of swelling in the neck as given in the image and diagnosed as cystic hygroma. Which of the following is

true regarding the condition? {{caption_text}} (Q849355)

A. Swelling presents after the age of 1 year

B. It is a benign tumor

C. Laser excision is the treatment of choice

D. The size remains constant throughout the life



Correct Answer: B. It is a benign tumor

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Cystic hygroma is a type of cavernous lymphangioma. Lymphangioma is the lymphatic analog of hemangioma of blood vessels. They are congenital benign tumors of the lymphatic system (Option A) . They are isolated cystic masses of lymphatic tissue that can produce lymph. Over time the tumor enlarges due to the accumulation of lymph within the cyst (Option D) . Treatment includes surgical excision of the tumor (Option C) .

References:

Sabiston Textbook of Surgery, 21st edition, Pages 746,747

↑ *Back to this question in Part A*

@Neet_pg_bot

Q14: Which of the following is the least preferred treatment option for early management of lymphedema? (Q849353)

A. Use of compression stockings

B. Limb elevation, regular check-up

C. Specialized complex physical therapy

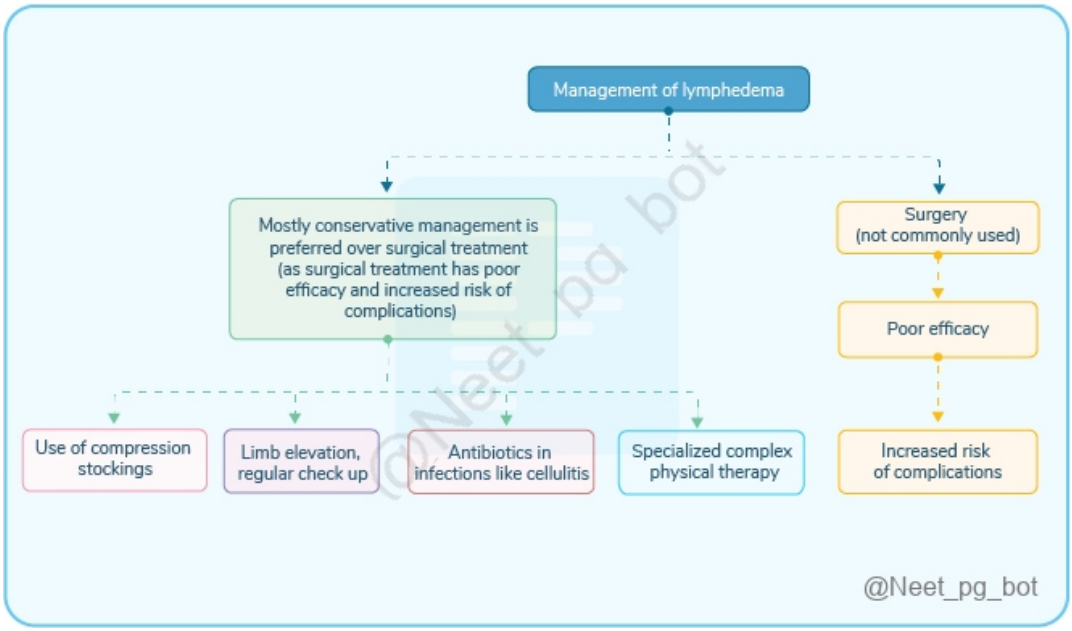
D. Nielubowicz procedure

Correct Answer: D. Nielubowicz procedure

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Conservative management is the most commonly preferred treatment for lymphedema. (Option A, B & C) Surgical procedures (eg. Nielubowicz procedure) are only done in severe chronic lymphedema due to poor efficacy and complications (Option D) .



References:

www.cancer.gov/about-cancer/treatment/side-effects/lymphedema#how-is-lymphedema-treated

↑ *Back to this question in Part A*

@Neet_pg_bot

Q15: A 55-year-old male with chronic leg swelling presents with difficulty pinching the skin over the dorsum of his foot. What is this sign known as? {{caption_text}} (Q849352)

A. Buffalo hump

B. Square toes

C. Stemmer's sign

D. Merkel's sign



Correct Answer: C. Stemmer's sign

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The sign of inability to pinch a fold of skin at the root of the second toe suggesting lymphedema is known as Stemmer’s sign. Clinical features of Lymphedema: Buffalo hump: Refers to a fat pad that develops on the dorsum of foot, often associated with conditions like Cushing’s syndrome or prolonged use of corticosteroids. It is not related to skin pinching or lymphedema (Option A) . {{caption_text}} Square toes : The toes appear square-shaped due to prolonged confinement in tight footwear (Option B) . {{caption_text}} Stemmer's sign : Skin over the dorsum of the foot cannot be pinched because of subcutaneous fibrosis (Option C) . {{caption_text}}


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References:

https://www.jvsvenous.org/article/S2213-333X(19)30318-X/pdf

↑ *Back to this question in Part A*

@Neet_pg_bot

Q16: A 25-year-old female presents with swelling in her right calf and foot, which has gradually worsened over the past few years. She reports that the swelling started in her teenage years and has become more pronounced with time. What is the diagnosis in this patient? (Q849350)

A. Congenital lymphedema

B. Lymphedema praecox

C. Lymphedema tarda

D. None of the above

Correct Answer: B. Lymphedema praecox

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The above clinical scenario is a case of Lymphedema praecox , a type of primary lymphedema. Types of primary lymphedema: Congenital Lymphedema (Option A) Lymphedema Praecox (Option B) Lymphedema Tarda (Option C) Age: Seen in < 1 year of age Present at birth. Lower limb, genitalia, and face are involved. Usually B/L and multiple limbs are involved. Familial version of congenital lymphedema – known as Milroy's disease. M/C type of primary lymphedema (>90% of cases). Age: 1 to 35 years . M/C seen in females . Usually unilateral . Involves calf and foot Familial version of lymphedema praecox - known as Meig's disease. Age: Usually seen in > 35 years age group It is a rare disease.

References:

www.ncbi.nlm.nih.gov/books/NBK537239/

↑ *Back to this question in Part A*

@Neet_pg_bot

Q17: A 55-year-old woman presents with chronic swelling of her left arm. She has a history of breast cancer treatment 2 years ago. Which of the following is the most common iatrogenic cause of lymphedema in this patient's scenario? (Q849349)

A. Radiotherapy

B. Lymph node dissection

C. Chemotherapy

D. Biologic Targeted Therapy

Correct Answer: B. Lymph node dissection

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The clinical presentation indicates secondary lymphedema due to axillary lymph node dissection, which is the most common iatrogenic cause of secondary lymphoedema. Secondary Lymphedema Filariasis MC overall cause of lymphedema worldwide MC secondary cause of lymphedema Lymphoedema due to Lymphatic obstruction Surgery Axillary block dissection- MC cause of secondary lymphedema in the USA MC iatrogenic cause of secondary lymphedem Inguinal block dissection Lymphedema due to Lymphatic disruption Infections Tuberculosis Syphilis Fungal and Bacterial infections Other causes: Trauma Malignancy Radiotherapy

References:

SRB's Manual of Surgery, 6th Edition, Page 242

↑ *Back to this question in Part A*

• [03_Cardiothoracic Vascular Surgery] 011 Thorax And Mediastinum

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[03_Cardiothoracic Vascular Surgery] 011 Thorax And Mediastinum — Quick Jump

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Q7 (p. 1460)	*Q8 (p. 1461)*	*Q9 (p. 1462)*	*Q10 (p. 1463)*	*Q11 (p. 1464)*	*Q12 (p. 1465)*
Q13 (p. 1466)	*Q14 (p. 1467)*	*Q15 (p. 1468)*	*Q16 (p. 1469)*	*Q17 (p. 1470)*	*Q18 (p. 1471)*
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Q31 (p. 1494)	*Q32 (p. 1496)*	*Q33 (p. 1497)*	*Q34 (p. 1499)*	*Q35 (p. 1501)*	

Q1: Which of the following paraneoplastic syndromes is NOT commonly associated with small cell lung carcinoma (SCLC)? (Q849541)

A. Syndrome of Inappropriate Antidiuretic Hormone (SIADH)

B. Eaton-Lambert Syndrome

C. Hypercalcemia

D. Cushing's Syndrome

Correct Answer: C. Hypercalcemia

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Hypercalcemia is more commonly associated with squamous cell carcinoma (SCC) of the lung rather than small cell lung carcinoma (SCLC). It usually results from the ectopic production of parathyroid hormone-related protein (PTHrP) . Lung Cancer Type Paraneoplastic Syndromes Small Cell Lung Cancer (SCLC) Hyponatremia (SIADH) (Option A) Ectopic ACTH Production (Cushing-like syndrome) (Option D) Eaton-Lambert Syndrome (common) (Option B) Hypertrophic Osteoarthropathy Peripheral Neuropathy, Cerebellar Degeneration Thrombotic Events (occasionally) Adenocarcinoma Hypertrophic Osteoarthropathy (1-10% of cases) Neurological and Muscular Syndromes (rarely) Squamous Cell Carcinoma (SCC) Hypercalcemia (frequent due to PTHrP) Thrombotic Events (e.g., Trousseau’s syndrome) Peripheral and central neuropathies Common Across Lung Cancers Hematologic Syndromes (e.g., Thrombotic Events, Leukemoid reactions, Pure red cell aplasia) Neurological and Muscular Syndromes (e.g., Peripheral Neuropathy, Cerebellar Degeneration) Nonbacterial thrombotic (marantic) endocarditis (NBTE) Carcinoid syndrome Gynecomastia Acanthosis nigricans Erythema gyratum repens Nephrotic syndrome Hypouricemia

References:

Schwartz Surgery. 11th edition. Pg. 681, 682

Harrison’s Principles of Internal Medicine. 21st edition. Pg. 599

↑ *Back to this question in Part A*

@Neet_pg_bot

Q2: A 3-year-old child presents with a history of choking followed by intermittent coughing and wheezing. The X-ray is as follows. What is the most appropriate investigation for diagnosis and intervention? (Q849521)

A. Chest X-ray

B. CT Scan

C. Rigid Bronchoscopy

D. Flexible Bronchoscopy



Correct Answer: C. Rigid Bronchoscopy

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The X-ray shows a foreign body in the tracheobronchial tree. Tracheo-Bronchial Foreign Body Most Common Site: Right Main Bronchus (RMB): The wider calibre and vertical alignment make it the most frequent site for foreign body lodgment. Symptoms: Asymptomatic: Some cases may not present any symptoms. Wheezing: Due to airway narrowing, often accompanied by a persistent cough and signs of obstructive emphysema. Pyrexia (Fever) and Productive Cough: Indicative of pulmonary suppuration (infection). Investigations: Rigid Bronchoscopy: The gold standard for both diagnosis and removal of foreign bodies . It allows direct visualization and retrieval. It reaches up to the third-generation bronchioles and requires general anaesthesia, with ventilation facilitated by multiple holes in the scope. Flexible Bronchoscopy (Option D) is primarily used for diagnostics and deep lung biopsies, performed under local anaesthesia. While it can remove foreign bodies, rigid bronchoscopy is more effective, especially for larger objects and in pediatric cases. Complications: Lung Collapse (Atelectasis) Pneumonia Respiratory Failure Acute Respiratory Distress Syndrome (ARDS) Bleeding Infection Perforation Bronchospasm Chest X-ray (Option A) and CT Scan (Option B) are primarily diagnostic tools rather than therapeutic ones.

References:

Bailey and Love Surgery, 28th edition. Pg. 984

SRB’s Manual of Surgery, 6th Edition, Pg.1103

UTD_9_4_262_266.pdf (journalagent.com)

↑ *Back to this question in Part A*

@Neet_pg_bot

Q3: A 55 y/o male with a persistent cough and occasional chest discomfort has a chest X-ray showing a 2.5 cm peripheral, sharply demarcated, lobulated mass with a “popcorn” appearance. No smoking history. What is the most likely diagnosis? (Q849522)

A. Pancoast Tumor

B. Pulmonary Hamartoma

C. Lung Abscess

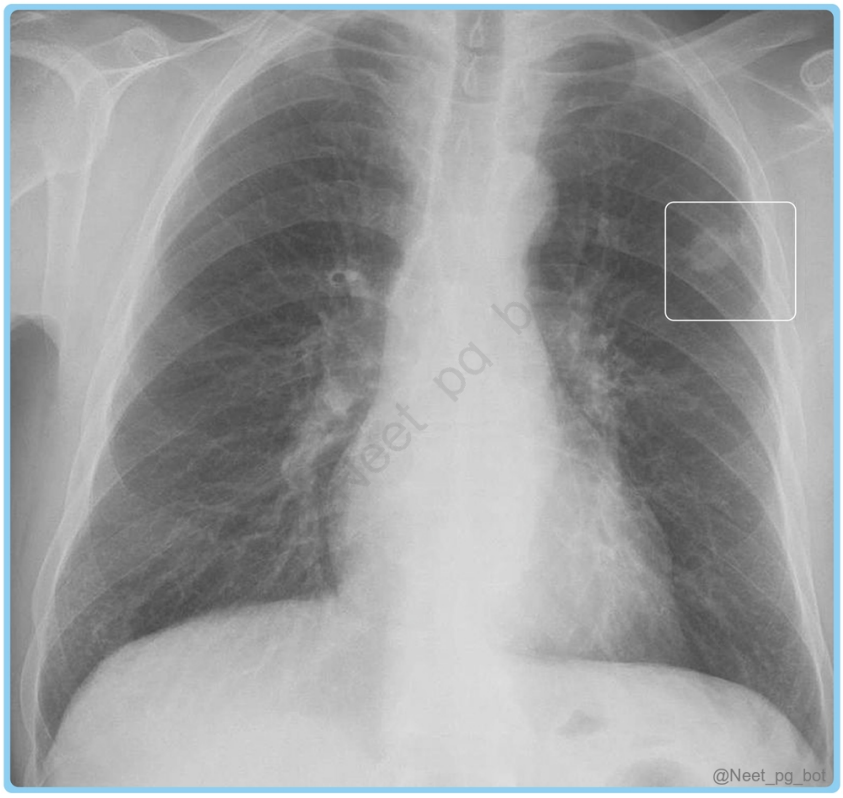
D. Cystic Adenomatoid Malformation

Correct Answer: B. Pulmonary Hamartoma

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Pulmonary hamartomas are the most common benign lung tumours and are characterized by a peripheral, sharply demarcated, lobulated mass with a “popcorn” appearance on X-ray. They often consist of normal tissue elements like cartilage in an abnormal location and are commonly found in patients aged 40 to 60 years. PULMONARY HAMARTOMA Characteristics Most frequent benign tumour of the lung. Consist of normal tissue elements containing mesothelial and endothelial elements in an abnormal location; overgrowth of cartilage. Age & Sex 40 to 60 years. More common in males. Location Usually peripheral and slow-growing. Imaging Findings CXR shows a 2 to 3-cm mass that is sharply demarcated and lobulated; Usually not calcified “Popcorn” appearance is characteristic Treatment Excision of the lesion Related Conditions Cystic adenomatoid malformation (Option D) in infants may represent adenomatous hamartomas Pancoast tumours (Option A) are peripheral lung carcinomas at the lung apex that invade nearby structures like the brachial plexus and sympathetic chain. They typically cause severe upper chest/arm pain and weakness, which this patient does not have. Lung Abscess(Option C) often presents with acute or recurrent fever, cough with pleuritic pain, and hemoptysis with foul-smelling sputum. Chest X-ray typically reveals a localized opacity with smooth margins and fluid level. The “popcorn” appearance is not associated with abscesses.



References:

Sabiston Textbook of Surgery, 21st edition, Pg.1619

Bailey and Love Surgery, 28th edition. Pg. 991

SRB Surgery 6th edition. Pg. 1112, 1104,1105,1112

↑ *Back to this question in Part A*

@Neet_pg_bot

Q4: A 45 y/o male with a 3-month history of cough, hemoptysis, and wheezing has a CXR showing a central mass obstructing the right bronchus. Biopsy reveals a low-grade malignant tumour diagnosed as bronchial adenoma. Which of the following is NOT a type of bronchial adenoma? (Q849528)

A. Adenoid Cystic Carcinoma

B. Carcinoid

C. Small Cell Carcinoma

D. Mucoepidermoid Carcinoma

Correct Answer: C. Small Cell Carcinoma

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Small cell carcinoma is a highly malignant and aggressive type of lung cancer, not considered a bronchial adenoma. It has a different origin and clinical behaviour compared to bronchial adenomas. BRONCHIAL ADENOMA Definition Tumours arising from bronchial epithelium or glands are less aggressive than typical lung cancers. Types Carcinoids (Option B) (85%): Low-grade, typical and atypical variants. Adenoid Cystic Carcinoma (ACC) (Option A): Slow-growing, 10% of adenomas. Mucous Gland Adenomas: Benign, arise from mucous glands. Mucoepidermoid Carcinomas (Option D): 1-5% of adenomas, varying malignancy. Symptoms Central Lesions: Dyspnea, stridor, wheezing, cough, hemoptysis, recurrent infections. Peripheral Lesions: Often asymptomatic, may be discovered incidentally. Diagnostic Tests Chest X-ray: Detects nodules or masses, central lesions best seen with an oblique view CT Scan: Assesses tumor size, location, lymph node spread Bronchoscopy: Visualizes airways, allows biopsy MRI: Used when CT is unclear Octreotide Nuclear Scan: Detects carcinoid tumors, metastasis sites CT-Guided Fine-Needle Aspiration: For peripheral nodules Treatment Surgical Resection: Main treatment Bronchoscopic Surgery: For small tumours; higher bleeding risk. Open Lung Surgery/VATS: Preferred for complete removal, maximal parenchymal preservation Laser Ablation: Not recommended as primary treatment, used for recurrent tumours. Prognosis The 5-year survival rate is 96% following complete surgical resection.

References:

www.emedicinehealth.com/bronchial_adenoma/article_em.htm

emedicine.medscape.com/article/295573-overview

www.ncbi.nlm.nih.gov/pmc/articles/PMC4129603/

↑ *Back to this question in Part A*

@Neet_pg_bot

Q5: A 65-y/o male, who worked for 30 years in shipbuilding, presents with a 6-month h/o progressive shortness of breath, chest pain, and significant weight loss. A CXR reveals a pleural effusion and a subsequent pleural biopsy confirms the diagnosis of malignant mesothelioma. Which subtype of malignant mesothelioma is most likely to be associated with a better prognosis in this patient? (Q849529)

A. Sarcomatoid subtype

B. Epithelial subtype

C. Mixed (biphasic) subtype

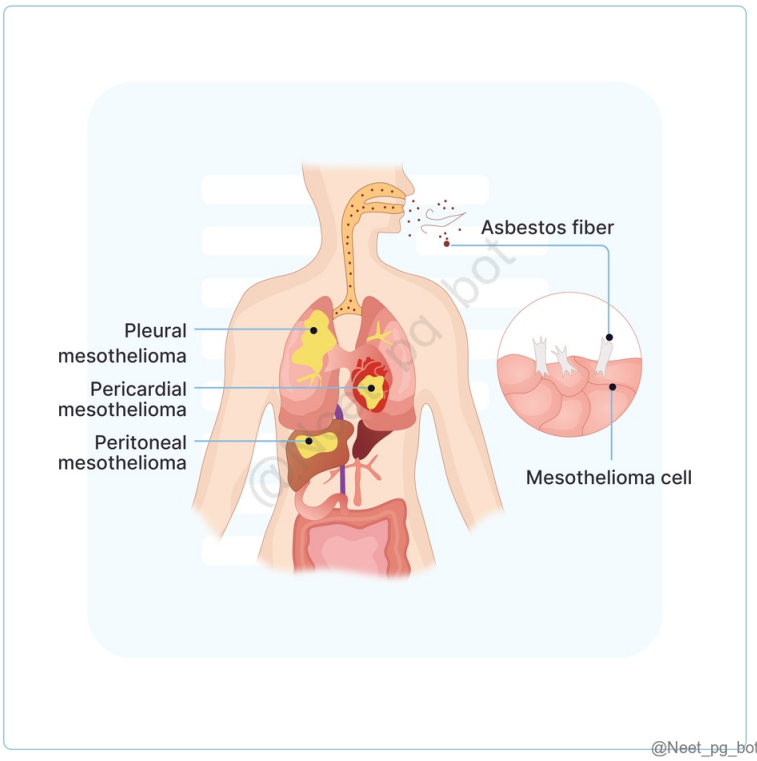
D. Both B and C

Correct Answer: B. Epithelial subtype

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Epithelial subtype is the most common and is associated with a better prognosis compared to other types. MALIGNANT MESOTHELIOMA About Highly aggressive malignancy originating from pleural mesothelial cells, strongly linked to asbestos. The most common primary pleural tumor. Latency Period 15–40 years after asbestos exposure. Risk Factors Male predominance (2:1); Most common after age 40. Asbestos exposure (occupational, familial): Commonly in industries like shipbuilding, brake pad manufacturing, and other asbestos-related manufacturing processes. Secondary Exposure : Family members of workers exposed their clothes and belongings. Types of Asbestos Serpentine fibres (less likely to cause mesothelioma) Amphibole fibres (higher risk, especially crocidolite). Histologic Subtypes Epithelial: Better prognosis Sarcomatoid (Option A): More aggressive Mixed (Option C): Combination of both; Aggressive Symptoms Dyspnea, chest pain, pleural effusion in over 90% of cases, weight loss, fever. Onset: Insidious, leading to late-stage diagnosis in most patients.



References:

Schwartz's Principles of Surgery, 11th edition, Pg. 743-744

Sabiston Textbook of Surgery, 21st edition, Pg. 1631-1632

↑ *Back to this question in Part A*

@Neet_pg_bot

Q6: A 65 y/o male with a 30-year history in brake pad manufacturing presents with dyspnea, chest discomfort, and cough. Imaging shows pleural thickening and nodules. Biopsy confirms early-stage malignant mesothelioma. Which IHC markers and treatments are most consistent with this diagnosis? (Q849534)

A. Positive CEA, negative vimentin, treated with radiation therapy alone

B. Negative CEA, positive vimentin, treated with Extended Pleurectomy and Decortication (EPD) combined with chemotherapy

C. Positive CEA, negative cytokeratins, treated with chemotherapy only

D. Negative vimentin, positive cytokeratins, treated with Extrapleural Pneumonectomy (EPP) alone

Correct Answer: B. Negative CEA, positive vimentin, treated with Extended Pleurectomy and Decortication (EPD) combined with chemotherapy

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: This IHC profile is consistent with malignant mesothelioma. The combination of EPD, a lung-preserving surgery, with chemotherapy is an appropriate and effective treatment approach, aiming to achieve complete macroscopic resection and improve survival. MALIGNANT MESOTHELIOMA About Highly aggressive malignancy originating from pleural mesothelial cells, strongly linked to asbestos. The most common primary pleural tumour. Diagnosis Imaging : CXR, CT, MRI, FDG-PET: Assess tumour invasion and metastasis ECG: Checks for cardiac involvement Biopsy : Pleural Biopsy: Via thoracoscopy, thoracentesis, or open techniques. Immunohistochemistry findings: Diagnosis Mesothelioma Adenocarcinoma Carcinoembryonic Antigen (CEA) Negative Positive Vimentin Positive Negative Low Molecular Weight Cytokines Positive Negative Electron Microscopy Long, sinuous villi Short, straight villi with fuzzy glycocalyx Staging : Based on tumour invasion (T), lymph node involvement (N), and metastasis (M). Treatment Multimodality Therapy: Early-stage: Surgery (EPP or EPD) with cisplatin-based chemotherapy and radiotherapy. Advanced Disease: Chemotherapy may extend survival but not cure. Palliative Care: Pleural catheters, pleurodesis. Surgical Options: Extrapleural Pneumonectomy (EPP): Complete lung resection; higher risk but more extensive. Extended Pleurectomy and Decortication (EPD): Lung-preserving, safer, preferred in many centres. Prognosis Median survival is 24–36 months depending on stage and treatment.

References:

Schwartz Textbook of Surgery, 11th edition, Pg. 743,744

Sabiston Textbook of Surgery, 21st edition, Pg. 1631, 1632

↑ *Back to this question in Part A*

@Neet_pg_bot

Q7: What is the most common type of lung carcinoma? (Q849535)

A. Small cell lung carcinoma

B. Bronchogenic carcinoma

C. Adenocarcinoma

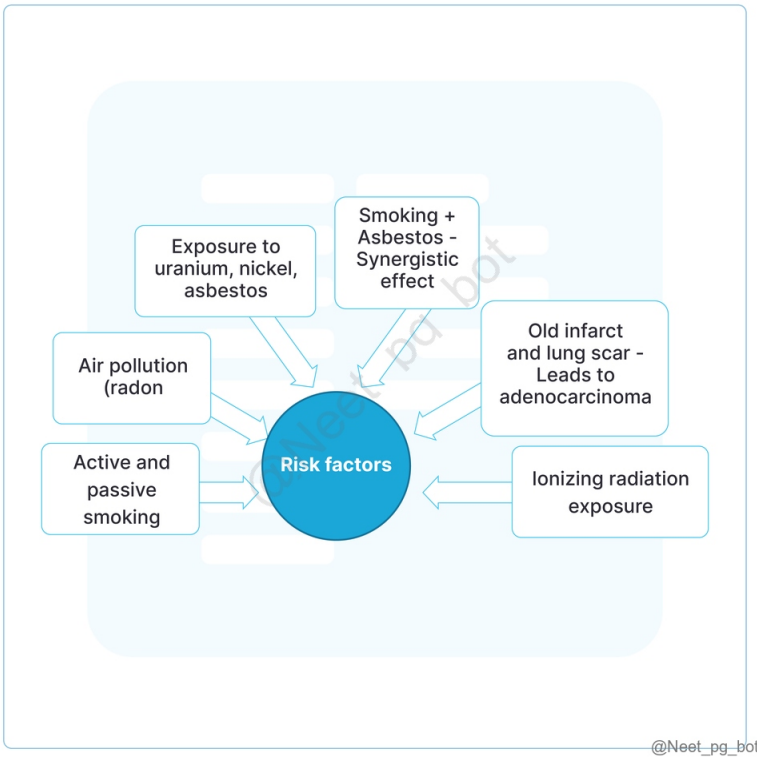
D. Squamous cell carcinoma

Correct Answer: C. Adenocarcinoma

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Adenocarcinoma is the most common histological type of lung cancer, particularly in non-smokers and women. It accounts for around 45% of all lung cancers It originates in the peripheral parts of the lungs and is a subtype of non-small cell lung carcinoma. While it is associated with various risk factors, including smoking, it also frequently occurs in non-smokers. \ Risk factors of Lung Cancer Small cell lung carcinoma (Option A) is a type of lung cancer that is more aggressive and often associated with smoking. However, it is not the most common type of lung neoplasm. Bronchogenic carcinoma (Option B) is a broad term used to describe any lung cancer originating in the bronchi or lung parenchyma. However, adenocarcinoma is the most common specific type of lung cancer. Squamous cell carcinoma (Option D) is also linked to smoking and occurs in the central parts of the lungs. While it is a common type of lung cancer, it is less prevalent than adenocarcinoma.



References:

Sabiston Textbook of Surgery, 21st edition, Pg. 1594, 1595

Bailey and Love Surgery, 28th edition. Pg. 985

Types of lung cancer | Cancer Research UK

Lung Cancer - StatPearls - NCBI Bookshelf (nih.gov)

↑ *Back to this question in Part A*

@Neet_pg_bot

Q8: A 60-year-old male, with a 40-year history of smoking, presents with a persistent cough, hoarseness, and recent onset of facial swelling and distended neck veins. Imaging reveals a mass in the central region of the right lung. Based on the location and clinical features, what is the most likely diagnosis? (Q849538)

A. Adenocarcinoma

B. Squamous Cell Carcinoma (SCC)

C. Large Cell Carcinoma

D. Apical (Pancoast's) Tumor

Correct Answer: B. Squamous Cell Carcinoma (SCC)

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Squamous Cell Carcinoma (SCC) is strongly associated with smoking and is commonly located centrally in the lungs. It can compress surrounding structures, leading to symptoms like hoarseness (due to recurrent laryngeal nerve involvement) and superior vena cava syndrome, making this the most likely diagnosis. Type of Lung Cancer Key Features Tumor Location Adenocarcinoma (Option A ruled out) Most common histologic type (45% of lung cancers). Early metastasis, CNS involvement, mucin production, glandular differentiation Peripheral Squamous Cell Carcinoma (SCC) Associated with smoking (90% of cases). Keratinization, intercellular bridges, central necrosis & cavitation. Central Large Cell Carcinoma (Option C ruled out) Highly aggressive Undifferentiated, lacks specific features. Slow-growing, but highly vascular. Peripheral Small Cell Neuroendocrine Tumors Highly aggressive Early metastasis to lymph node, Neuroendocrine origin Central Typical/Atypical Carcinoids Typical Carcinoids- Indolent growth Atypical Carcinoids- Aggressive growth Varies Apical (Pancoast's Tumors) (Option D ruled out) Invades brachial plexus Causes severe localized pain. Pancoast’s syndrome Apical (Upper Lung)

References:

Sabiston Textbook of Surgery, 21st edition, Pg. 1595

Bailey and Love Surgery, 28th edition. Pg. 985

↑ *Back to this question in Part A*

@Neet_pg_bot

Q9: What is the most common site of metastasis for lung cancer? (Q849539)

A. Liver

B. Brain

C. Adrenal Glands

D. Bone

Correct Answer: B. Brain

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The Brain is the most common site of metastasis for lung cancer , with approximately 47% of patients with non-small cell lung cancer (NSCLC) showing brain involvement. This high prevalence is due to the vascular nature of the brain and the tendency of lung cancer cells to spread hematogenously. The most common site of metastasis in Ca lung is the brain Brain > bone > liver > adrenal glands > distant lymph nodes Ca lung is the most common primary for metastasis to: (Pneumonic- KEPABS) K– Kidney E– Esophagus P– Pancreas A– Adrenal B– Brain S– Skin The liver (Option A) is a common site for metastasis from various cancers, including lung cancer, but it is not the most frequent site for lung cancer metastasis. Studies indicate that liver metastases occur in about 22% of lung cancer cases. Adrenal Glands (Option C) metastasis is relatively common, occurring in about 15% of lung cancer cases. While significant, it ranks lower than brain metastases. Bone (Option D) metastases are also common in lung cancer, affecting around 36% of patients. However, they are still less prevalent than brain metastases.

References:

Sabiston Textbook of Surgery, 21st edition, Pg. 1595

Non-small cell lung CA metastaes

↑ *Back to this question in Part A*

@Neet_pg_bot

Q10: A 65 y/o woman presents to the emergency with a sudden onset of shortness of breath, chest pain, and hypotension. She is diagnosed with a massive pulmonary embolism. Which of the following is the most appropriate initial treatment for this patient? (Q849520)

A. Inferior Vena Cava (IVC) Filter

B. Thrombolytic Therapy

C. Ventilator Support

D. Vitamin K Antagonists

Correct Answer: B. Thrombolytic Therapy

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Thrombolytics are the treatment of choice for patients with massive PE who are experiencing severe circulatory compromise (e.g., hypotension, shock). These medications help break down the clot quickly, reducing the risk of further complications and improving blood flow. Eg. Streptokinasse- 6 lakh units can be given initially Management: Anticoagulants and observation. Patients with severe right heart strain and shortness of breath, following is the treatment: Fibrinolytics Radiologically guided catheter embolectomy Inferior Vena Cava (IVC) Filter (Option A): In the case of a massive PE with hemodynamic instability, the priority is to quickly restore blood flow using thrombolytics or mechanical embolectomy. IVC filters do not treat existing clots and are not the immediate choice for unstable patients. They are typically used for patients who have contraindications to anticoagulation therapy or for those with recurrent PEs despite adequate anticoagulation. Ventilator Support (Option C): While important for managing respiratory failure, ventilator support does not directly address the underlying cause of the embolism. Thrombolytics or surgical intervention is needed to treat the clot. Vitamin K Antagonists (Option D): Vitamin K antagonists are not used for the immediate treatment of a massive PE. Their effect is not rapid enough to be effective in the acute setting of a hemodynamically unstable patient.

References:

SRB’s Manual of Surgery, 6th Edition, Pg.1108

Sabiston Textbook of Surgery, 21st edition, Pg.1830

www.ncbi.nlm.nih.gov/pmc/articles/PMC3665123/

↑ *Back to this question in Part A*

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Q11: A 65 y/o male with a 35-pack-year smoking history presents with worsening dyspnea, cough, and weight loss. A CT shows a 6.5 cm right upper lobe mass invading the chest wall, with ipsilateral mediastinal lymph node involvement and liver metastasis as seen on the PET scan. What is the TNM stage of his lung cancer? (Q849543)

A. T2b, N1, M0

B. T3, N2, M1b

C. T4, N2, M1a

D. T3, N3, M1c

Correct Answer: B. T3, N2, M1b

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: T3 refers to a tumour>5 to ≤7 cm with chest wall invasion, N2 indicates ipsilateral mediastinal nodes, and M1b refers to a single extrathoracic metastasis. AJCC 8TH EDITION OF TNM STAGING OF LUNG CARCINOMA PRIMARY TUMOR (T) T1 T1a(mi) Minimally invasive carcinoma T1a ≤ 1 cm T1b 1 - 2 cm T1c 2 - 3 cm T2 Involvement of the main bronchus with the involvement of carina Involvement of visceral pleura Association with atelectasis or obstructive pneumonitis T2a 3 - ≤4 cm T2b 4 - ≤5 cm T3 > 5 - ≤7 cm OR Direct invasion of Chest wall, Phrenic nerve, Pericardium OR Satellite nodules in the same lobe T4 > 7 cm in greatest dimension OR Any tumour with invasion of the mediastinum, diaphragm, heart, great vessels, recurrent laryngeal nerve, carina, trachea, oesophagus, spine OR Separate tumours in different lobes of the ipsilateral lung. LYMPH NODE (N) N1 Ipsilateral peribronchial and/or hilar nodes and intrapulmonary nodes N2 Ipsilateral mediastinal and/or subcarinal nodes N3 Contralateral mediastinal or hilar; ipsilateral/contralateral scalene/supraclavicular DISTANT METASTASIS (M) M1 Distant metastasis M1a Tumor in contralateral lung or pleural/pericardial nodule/malignant effusion M1b Single extrathoracic metastasis, including single non-regional lymph node M1c Multiple extrathoracic metastases in one or more organs T2b, N1, M0 (Option A) : T2b refers to a tumour>4 to ≤5 cm without chest wall involvement, and N1 refers to ipsilateral peribronchial or hilar nodes, without distant metastasis. T4, N2, M1a (Option C) : T4 would indicate a tumour>7 cm or with extensive invasion, and M1a refers to a tumour spread within the thoracic cavity but not to distant organs. T3, N3, M1c (Option D) : N3 indicates contralateral lymph node involvement, and M1c refers to multiple extrathoracic metastases in one or more organs.

References:

Harrison’s Principles of Internal Medicine. 21st edition. Pg. 601

TNMC classification

↑ *Back to this question in Part A*

@Neet_pg_bot

Q12: A 65 y/o male with a confirmed diagnosis of stage IIIB non-small cell lung cancer (NSCLC) is being evaluated for treatment options. His disease is localized with significant mediastinal lymph node involvement, and he has a good performance status. Which of the following is the most appropriate initial treatment for this patient? (Q849544)

A. Surgical resection followed by adjuvant chemotherapy

B. Chemoradiation followed by maintenance immunotherapy

C. Systemic therapy with palliative radiation

D. Adjuvant chemotherapy alone

Correct Answer: B. Chemoradiation followed by maintenance immunotherapy

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: For stage IIIB lung cancer, which involves significant mediastinal lymph node involvement but not distant metastasis, the standard treatment approach is combined chemoradiation. This is followed by maintenance immunotherapy to improve outcomes and manage residual disease. Treatment of CA lung Stage IA: Surgical resection only. No chemotherapy. Stage IB: Surgical resection Adjuvant chemotherapy if the tumour is greater than 4 cm. (Option A) Stage IIA & IIB: Surgery followed by adjuvant chemotherapy; lobectomy is preferred. Stage IIIA (minimal N2 involvement): Chemoradiation or surgery followed by adjuvant chemotherapy. Stage IIIB: Combined chemoradiation followed by maintenance immunotherapy for 1 year. Stage IV: Systemic therapy with palliative radiation (Option C) including targeted therapy or immunotherapy based on mutation status. Adjuvant chemotherapy alone (Option D) is typically used after surgical resection in earlier-stage NSCLC (e.g., stage I, II, or IIIA) to eliminate any remaining cancer cells. It is not appropriate as a standalone treatment for stage IIIB disease, where chemoradiation or combined modalities are more effective.

References:

Sabiston textbook of Surgery 21st edition Pg 1596.

Treatment of CA lung

↑ *Back to this question in Part A*

@Neet_pg_bot

Q13: A 63-year-old man with a history of smoking presents with a central lung mass, weight loss, and a new diagnosis of squamous cell carcinoma (SCC). Which of the following is a common clinical presentation associated with squamous cell carcinoma of the lung due to its typical location? (Q849545)

A. Pleural effusion causing dyspnea

B. Hypercalcemia with renal stones

C. Superior vena cava syndrome

D. Horner's syndrome

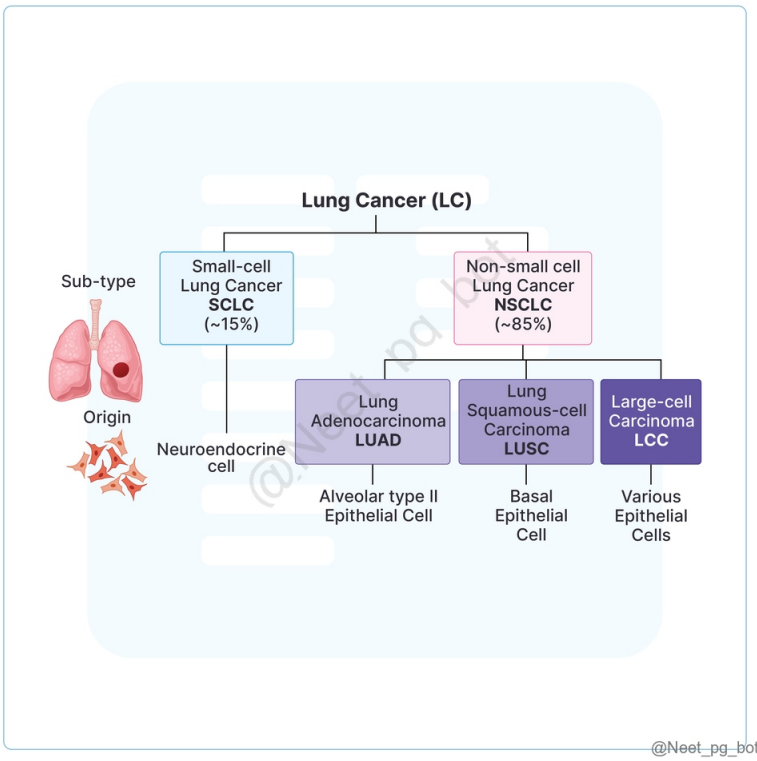
Correct Answer: C. Superior vena cava syndrome

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Squamous cell carcinoma of the lung often presents with central tumors that can obstruct the superior vena cava, leading to superior vena cava syndrome. Superior vena cava syndrome (SVCS) is a condition caused by the obstruction of blood flow through the superior vena cava, leading to symptoms like facial swelling, distended neck veins, and upper body edema. Pleural effusion causing dyspnea (Option A): While pleural effusion can occur

in lung cancer, it is not specifically associated with SCC's typical central location as prominently as superior vena cava syndrome. Hypercalcemia with renal stones (Option B): Hypercalcemia can be seen in SCC due to paraneoplastic syndromes, but renal stones are not a specific or primary presentation related to the tumor's central location. Horner's syndrome (Option D) is more commonly associated with Pancoast tumors (a type of lung cancer affecting the apex of the lung), not the centrally located squamous cell carcinoma.



References:

Lung cancer

Sabiston textbook of surgery, pg no 1595

Superior vena cava syndrome

↑ *Back to this question in Part A*

@Neet_pg_bot

Q14: A 62- y/o man with a history of heavy smoking is diagnosed with a central lung mass. He is also noted to have severe hypercalcemia and is receiving chemotherapy and radiation therapy. Which of the following statements is true? (Q849546)

A. SCLC is less aggressive than large cell carcinoma

B. Oat cells are seen in Large cell carcinoma

C. SCLC is strongly linked to smoking and can cause SIADH

D. Large cell carcinoma usually presents in central lung areas

Correct Answer: C. SCLC is strongly linked to smoking and can cause SIADH

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Small cell carcinoma is highly associated with smoking and often presents with paraneoplastic syndromes such as SIADH, Cushing syndrome, and Lambert-Eaton syndrome. Symptoms of paraneoplastic syndromes include muscle cramps, muscle weakness, elevation of calcium in the blood and clubbing, a change in the shape of the fingertips. Small cell carcinoma Large cell carcinoma Histology Small, oval-shaped cells, High nucleus-to-cytoplasm ratio, scant cytoplasm; often contains "oat cells" (Option B ruled out). Large cells with abundant cytoplasm, and prominent nucleoli. Growth Highly aggressive, rapid growth, early spread (Option A ruled out). Less aggressive than SCLC, but still fast-growing. Aetiology Strongly associated with smoking. Significantly associated with smoking Location Central lung areas Peripheral lung areas (Option D ruled out) Treatment Highly responsive to radiotherapy and chemotherapy. Moderate response to treatment often requires surgery. Prognosis Poor, due to early metastasis. Better than SCLC but still poor compared to other NSCLC types. Associated conditions Paraneoplastic syndromes, SIADH, Cushing's. (Option C) Rarely associated with paraneoplastic syndromes.

References:

Small cell lung CA

Large cell lung CA

Schwartz 11th edition , Page 671,672

↑ *Back to this question in Part A*

@Neet_pg_bot

Q15: A 72 y/o woman presents with severe shoulder pain and noticeable ptosis. Imaging reveals a mass at the apex of the lung, involving the upper ribs and vertebrae. Horner's syndrome is observed. Which imaging modalities are most suitable for the evaluation of this condition? (Q849547)

A. Chest X-ray

B. Ultrasound

C. CT scan

D. MRI

Correct Answer: D. MRI

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Given the symptoms, a Pancoast tumor is suspected, which may invade soft tissues like the brachial plexus and sympathetic chain. MRI is ideal for assessing the involvement of these structures. Pancoast Tumor Also known as Superior Sulcus Tumor, is a rare peripheral lung carcinoma originating from the apex of the lung, accounting for 5% of lung cancers. Invades the brachial plexus, sympathetic chain, upper ribs, and vertebrae. Symptoms: Intractable upper chest and arm pain, arm weakness. Presentations: Pancoast's Syndrome: Lower brachial plexus palsy, Horner's syndrome, rib erosion, and apical shadow on imaging. Horner's Syndrome: Characterized by miosis, enophthalmos, anhidrosis, ptosis, and loss of spino-ciliary reflex. Investigations: Imaging: Chest X-ray, CT scan, MRI (preferred for visualizing brachial plexus and sympathetic chain involvement). Biopsy: Bronchoscopy with biopsy, CT-guided biopsy. Treatment: Surgery: Lobectomy or pneumonectomy. Radiotherapy Chemotherapy: Methotrexate. Chest X-ray (Option A) can detect a lung mass, but it is not detailed enough to fully evaluate the extent of the tumour or its involvement with surrounding structures. Ultrasound (Option B) is not suitable for evaluating lung masses or bony structures in the chest; it is better suited for soft tissue assessment and fluid-filled areas. CT scan (Option C) provides detailed imaging of the lung mass, including its relationship to the ribs, vertebrae, and surrounding structures, however, MRI would provide additional critical information regarding soft tissue and nerve involvement, which is why it might be considered more appropriate in this specific context.



References:

SRB’s Manual of Surgery. 6th edition. Pg.1112

Bailey and Love Short manual of surgery, pg no 1986

Schwartz 11th edition , pg no 680,698

↑ *Back to this question in Part A*

@Neet_pg_bot

Q16: Which of the following statements regarding cardiac tumours is true? (Q849548)

A. Angiosarcomas are the most common benign primary cardiac tumours.

B. Nearly 90% of primary cardiac tumours are malignant.

C. Myxomas are the most common primary cardiac tumours in adults.

D. Cardiac myocytes have high proliferative activity, contributing to the formation of cardiac tumours.

Correct Answer: C. Myxomas are the most common primary cardiac tumours in adults.

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Myxomas account for more than half of all primary cardiac tumours and are the most common type in adults. Cardiac Tumours Classification: Primary Tumours: Rare, divided into benign congenital, benign acquired, and malignant tumours. Metastatic Tumours: Secondary tumours spread to the heart from other body sites. Types of Cardiac Tumours Tumour Type Description Myxoma The most common primary cardiac tumour- accounts for over 50% of cases. Rhabdomyoma Most common in infants and children, often linked to tuberous sclerosis. Angiosarcoma (Option A) The most common malignant primary cardiac tumour. Incidence and Prognosis: Benign Tumors: Constitute nearly 90% of primary cardiac tumors. (Option B) Malignant Tumors: Rare, making up 10% of primary cardiac tumors; poor prognosis if metastases are present. Reasons for Rarity: Cardiac Myocytes: Terminally differentiated with tight cell cycle control, reducing the risk of tumour formation. (Option D) Low Proliferative Activity: Limited opportunities for the abnormalities in cell cycle kinetics that typically lead to tumours. Treatment and Research: Specialized Care: Referring patients to hospitals experienced in cardiac tumours can improve outcomes. Research Gap: Due to the extreme rarity of cardiac tumours, there is a lack of organized research on their aetiology and treatment.

References:

www.ncbi.nlm.nih.gov/books/NBK537144/

www.cancer.gov/types/metastatic-cancer/research/cardiac-tumors

↑ *Back to this question in Part A*

@Neet_pg_bot

Q17: A 55 y/o female presents with symptoms of shortness of breath, occasional dizziness, and a recent episode of fever and weight loss. Imaging studies reveal a mass in the left atrium and is diagnosed with atrial myxoma. Which of the following is true? (Q849549)

A. The majority of atrial myxomas arise from the right atrium.

B. Atrial myxomas are more common in males, around 3rd decade of life.

C. Atrial myxomas can cause systemic emboli and obstruction of blood flow.

D. The genetic cause of atrial myxomas is always linked to an autosomal recessive pattern.

Correct Answer: C. Atrial myxomas can cause systemic emboli and obstruction of blood flow.

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Atrial myxomas can lead to systemic emboli due to tumor fragments breaking off and obstructing blood flow, which can cause symptoms such as shortness of breath and dizziness. Atrial Myxoma Overview More common in females between 40 -60 years of age. (Option B) Embryology: Originate from multipotent mesenchymal cells with potential for neural and endothelial differentiation. Inheritance: Familial- 10 % - inked to autosomal dominant pattern (Option D) Sporadic - 90% Location: Left atrium (75%) > Right Atrium (25%) (Option A ruled out) > both atria & ventricles (5%) Characteristically found in the interatrial septum. Clinical features: Systemic embolization (since they lack a strong structure) - leads to neurologic deficit. Intracardiac obstruction- leading to mitral stenosis /valve obstruction symptoms Atrial myxomas, although rare, can lead to significant complications if not promptly diagnosed and treated.

References:

www.ncbi.nlm.nih.gov/books/NBK556040/

www.ncbi.nlm.nih.gov/pmc/articles/PMC9048271/

↑ *Back to this question in Part A*

@Neet_pg_bot

Q18: A 14 y/o boy presents with a chest wall deformity characterized by a protruding sternum, resulting in a convex appearance of the chest. The patient is otherwise asymptomatic, and his chest wall growth is nearing completion. Which of the following statements about the management of this condition is true? (Q849550)

A. The Nuss procedure is the preferred surgical approach.

B. Non-surgical bracing is effective in correcting pectus carinatum

C. The modified Ravitch procedure is exclusively used for treating the Pigeon chest.

D. Surgical intervention for pectus carinatum is typically recommended for cosmetic reasons.

Correct Answer: D. Surgical intervention for pectus carinatum is typically recommended for cosmetic reasons.

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Surgical correction for pectus carinatum is usually performed in the late teens after chest wall growth has slowed, and it is often done for cosmetic reasons. Chest Wall Deformities: Pectus Excavatum and Pectus Carinatum Pectus Excavatum: Description: Depression of the sternum leading to a concave chest appearance. Surgical Approaches: Modified Ravitch Procedure: Removal of affected cartilage and repositioning of the sternum. Nuss Procedure (Option A): Minimally invasive insertion of a metal bar behind the sternum to reshape the chest, which is later removed. Pectus Carinatum (Pigeon Chest): Description: Elevated sternum resulting in a convex chest appearance. Clinical Features: Patients are almost always asymptomatic, hence, treatment is often offered for aesthetic purposes. Surgical Intervention: Modified Ravitch Procedure (Option C): Repositioning of the sternum and cartilage, so that the sternum can be flattened out. A similar to the approach for pectus excavatum. Done only after late teens- when no further growth of chest wall will happen. Non-Surgical Options: External Bracing (Option B): Used for younger patients whose chest wall growth is not completed yet, to correct deformity before growth slows.





References:

Bailey & Love’s Short Practice of Surgery, Ed 28, Pg. 995, 996

↑ *Back to this question in Part A*

@Neet_pg_bot

Q19: The thoracic duct, the largest lymphatic vessel in the body, passes through the posterior mediastinum. Which of the following anatomical triangles is the key area used for locating and managing the thoracic duct? (Q849492)

A. Simon's triangle

B. Lesgaft's triangle

C. The triangle of Petit

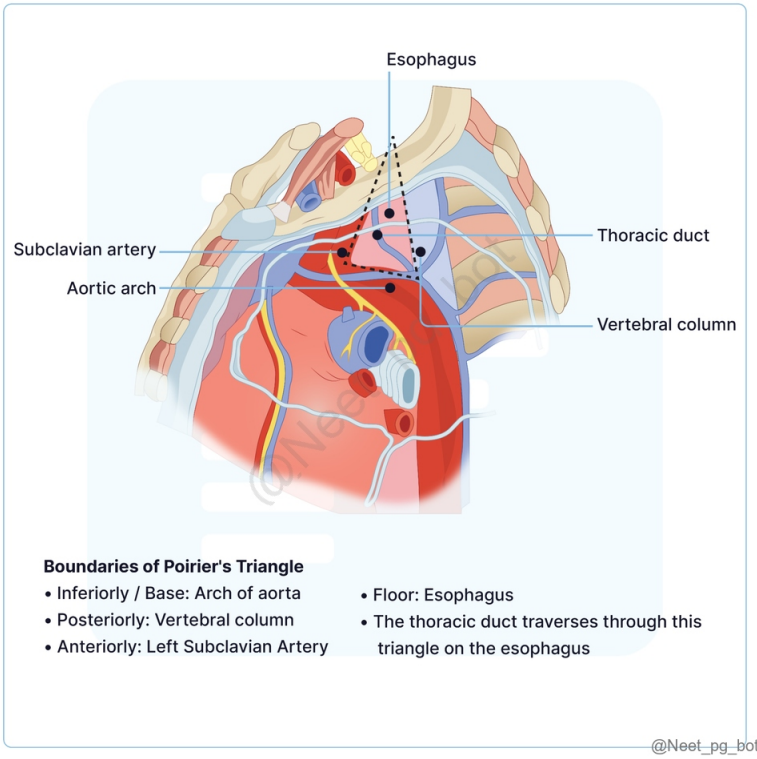
D. Poirier’s Triangle

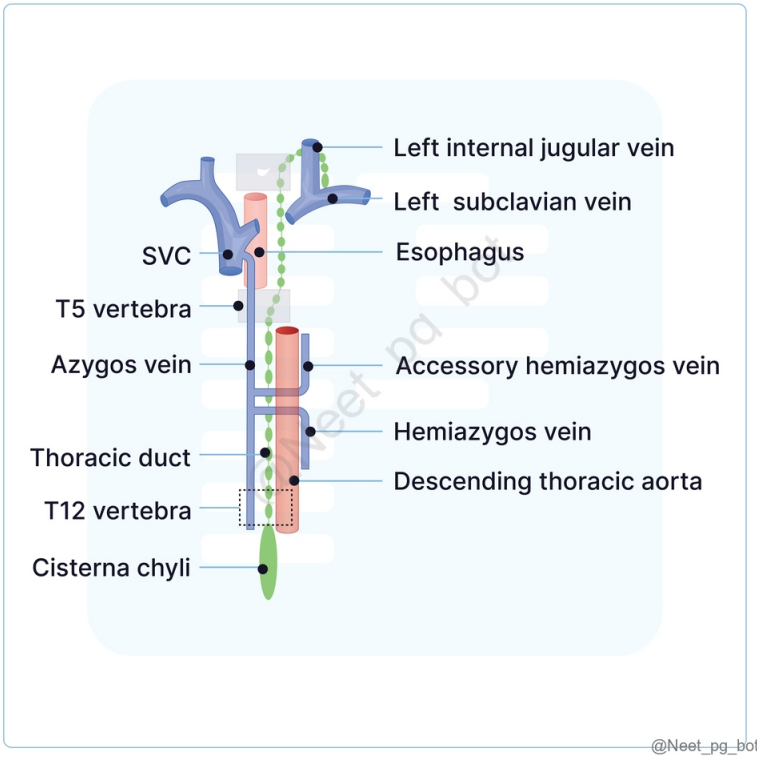
Correct Answer: D. Poirier’s Triangle

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: By performing left posterolateral thoracotomy, the thoracic duct can be identified in a triangle known as Poirier's triangle THORACIC DUCT Simon's triangle (Option A) is defined by the recurrent laryngeal nerve on the anterior side, the common carotid artery on the posterior side, and the inferior thyroid artery forming the base. This triangle is significant because it helps in locating the recurrent laryngeal nerve. Lesgaft's triangle (Option B) or the superior lumbar triangle is bordered by the sacrospinalis muscle, the 12th rib, and the posterior edge of the internal oblique muscle. The triangle of Petit (Option C) or the inferior lumbar triangle is defined by the boundaries of the latissimus dorsi muscle, the external oblique muscle, and the iliac crest.





References:

SRB Surgery 6th Edition. Pg.239, 240, 774, 1179

Uniportal Thoracoscopic Thoracic Duct Clipping in Poirier's Triangle for Postoperative Chylothorax (annalsthoracicsurgery.org)

Reliability of Poirier’s triangle in localizing the thoracic duct in the thorax | Request PDF (researchgate.net)

Reliability of Poirier’s triangle in localizing the thoracic duct in the thorax | Surgical and Radiologic Anatomy (springer.com)

↑ *Back to this question in Part A*

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Q20: A 48 y/o female presents with fluctuating muscle weakness, difficulty speaking, and drooping eyelids that worsen with physical activity. Imaging reveals a mass in the anterior mediastinum. Which of the following is the most likely paraneoplastic syndrome associated with her condition? (Q849463)

A. Lambert-Eaton myasthenic syndrome

B. Myasthenia gravis

C. Cushing syndrome

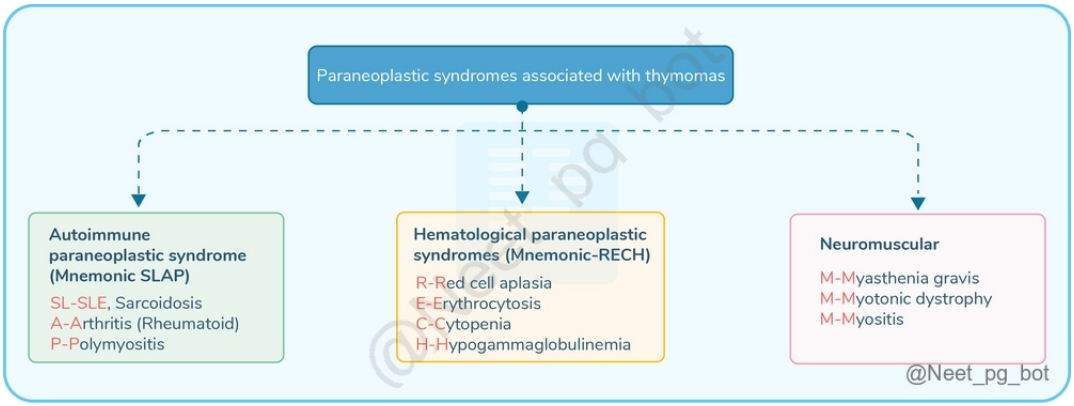
D. Syndrome of inappropriate antidiuretic hormone (SIADH)

Correct Answer: B. Myasthenia gravis

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: A mass in the anterior mediastinum is commonly associated with a thymoma . Thymomas are strongly associated with myasthenia gravis (MG). 50% of thymoma patients have MG. The symptoms of muscle weakness, dysarthria, and ptosis that worsen with activity are classic hallmarks of myasthenia gravis (MG). Lambert-Eaton myasthenic syndrome (Option A) is a paraneoplastic syndrome typically associated with small-cell lung cancer, not thymomas. It presents with proximal muscle weakness and autonomic dysfunction, but it is less common than myasthenia gravis in thymoma cases. Cushing syndrome (Option C) is usually associated with ectopic ACTH production from tumours like small-cell lung cancer or adrenal adenomas, not thymomas. Syndrome of inappropriate antidiuretic hormone (Option D) is another paraneoplastic syndrome more commonly linked with small cell lung cancer, leading to hyponatremia, rather than thymomas.



References:

Sabiston Textbook of Surgery, 21st edition, Pg.1635

Bailey & Love's Short Practice of Surgery (28th Edition), Page 992.

Schwartz’s Principles of Surgery, 11th Edition, Pg.681,731

Paraneoplastic disorders in thymoma patients - PMC

↑ *Back to this question in Part A*

@Neet_pg_bot

Q21: A 55 y/o male presents with a persistent cough and dyspnea on exertion. A chest x-ray reveals an anterior mediastinal mass with tracheal deviation. What is the next best step in evaluating this patient for a potential thymoma? (Q849464)

A. Serum markers

B. Chest X-ray with lateral view

C. Contrast-enhanced CT scan

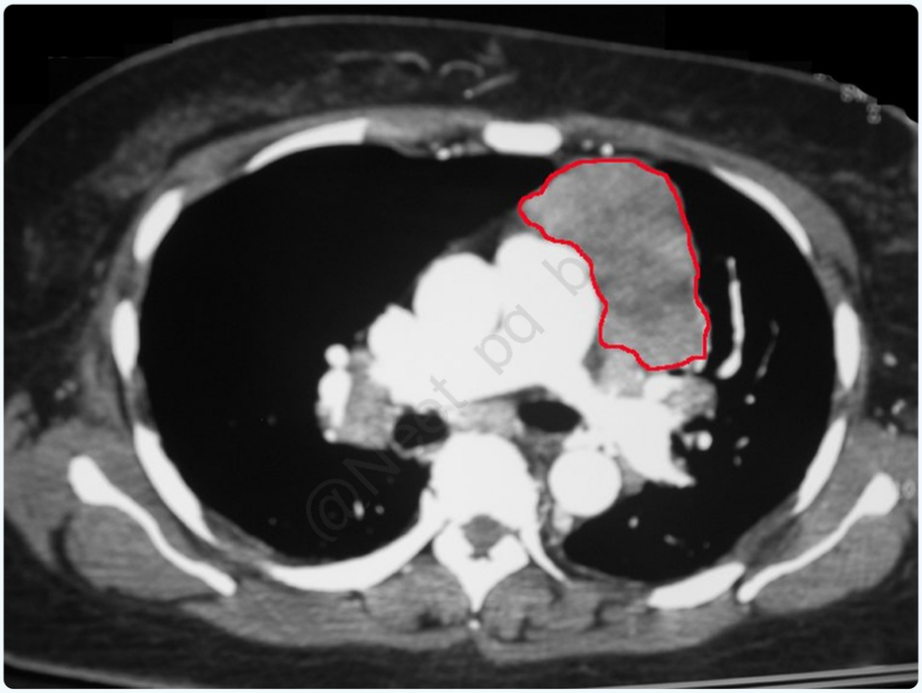
D. Pulmonary function tests (PFTs)

Correct Answer: C. Contrast-enhanced CT scan

■ *Listen (English)*

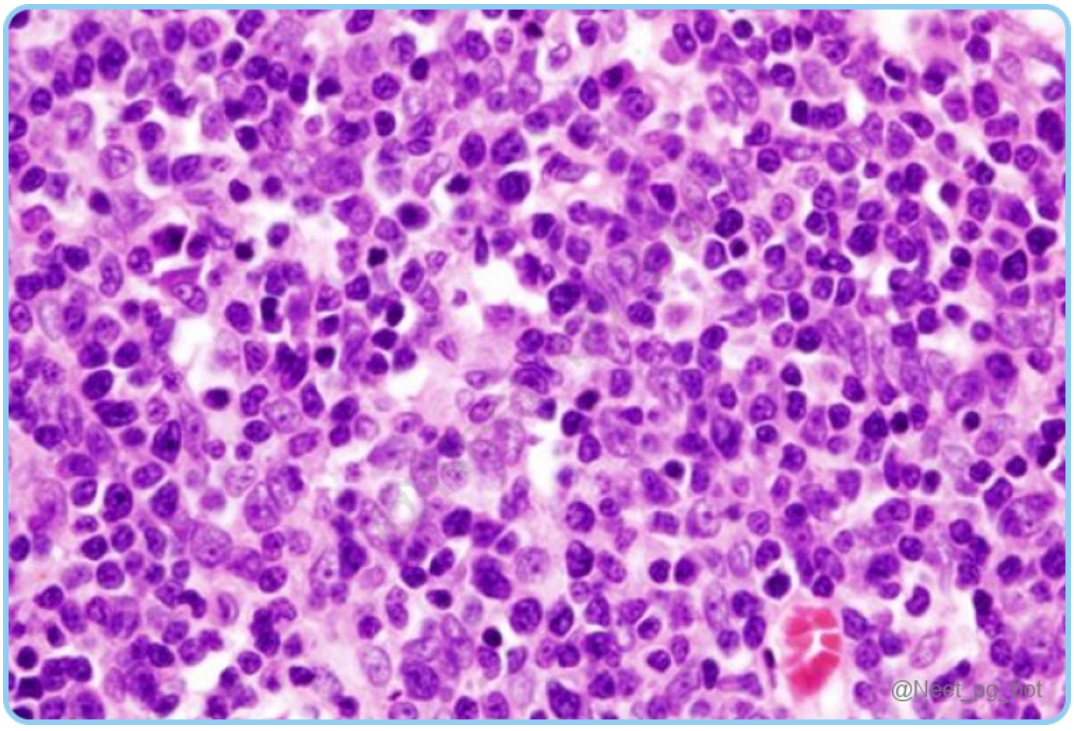
■ *Listen (Hindi)*

Explanation: A contrast-enhanced CT scan is the next best step for evaluating a thymoma. It provides detailed imaging, assessing the tumour's relationship with surrounding structures and helping to determine the extent of the disease. Clinical features Mostly asymptomatic (small tumor), incidentally detected. It may compress the trachea (dyspnea), esophagus (dysphagia), recurrent laryngeal nerve (dysphonia or hoarseness of voice), and superior vena cava (superior vena cava syndrome). Investigations: CT scan: Investigation of choice Determine the extent of the disease. Histology (definitive diagnosis) Noninvasive thymomas: Medullary-type epithelial cells (elongated or spindle-shaped) or a mixture of medullary- and cortical-type epithelial cells (admixture of polygonal cortical-type epithelial cells and a denser infiltrate of thymocytes). Invasive thymoma: Cytologically benign but locally invasive. The epithelial cells are with abundant cytoplasm and rounded vesicular nuclei, mixed with numerous thymocytes. Cytokeratin (marker to distinguish thymoma from lymphoma, thymomas are positive for cytokeratin) Serum markers (Option A) are not typically used to evaluate an anterior mediastinal mass suspected to be a thymoma. They are generally used to differentiate between seminimatous & non-seminimatous germ cell tumours based on the AFP levels. Chest X-ray with a lateral view (Option B): While a lateral chest X-ray can help localize the mass within the mediastinum, it is not as informative as a CT scan. A lateral view could provide some additional information, but a CT scan is superior in detailing the characteristics and extent of the mass. Pulmonary function tests (Option D) are important in assessing lung function, particularly before surgery, but they do not provide specific information about the thymoma itself. They are useful in surgical planning rather than in the initial evaluation.

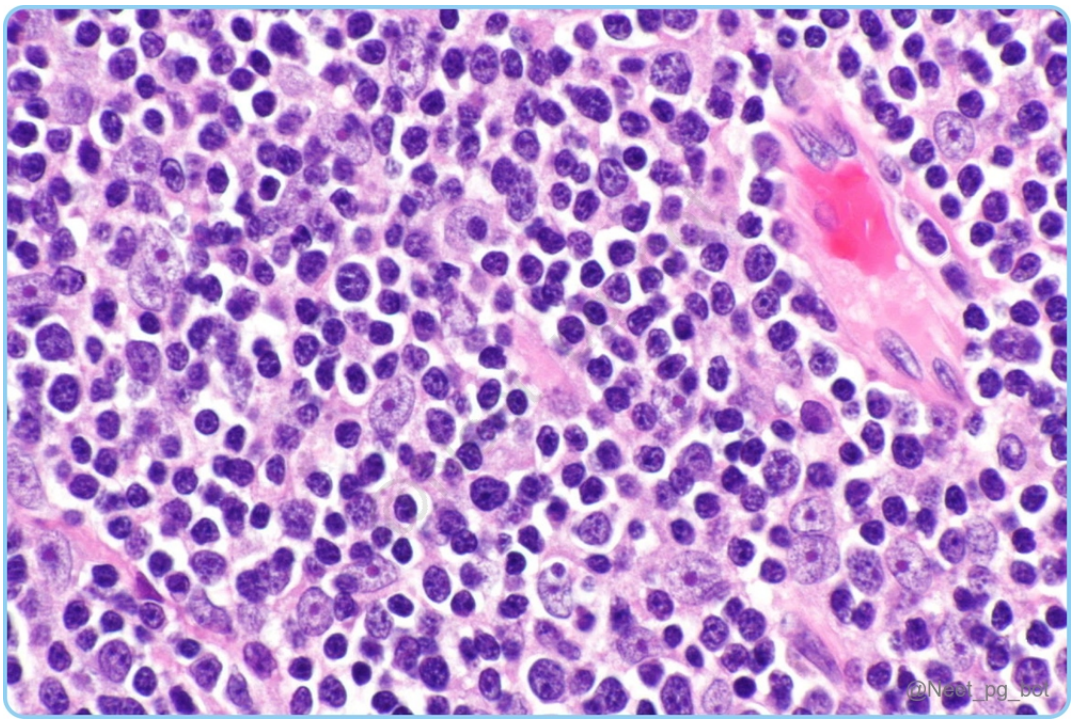


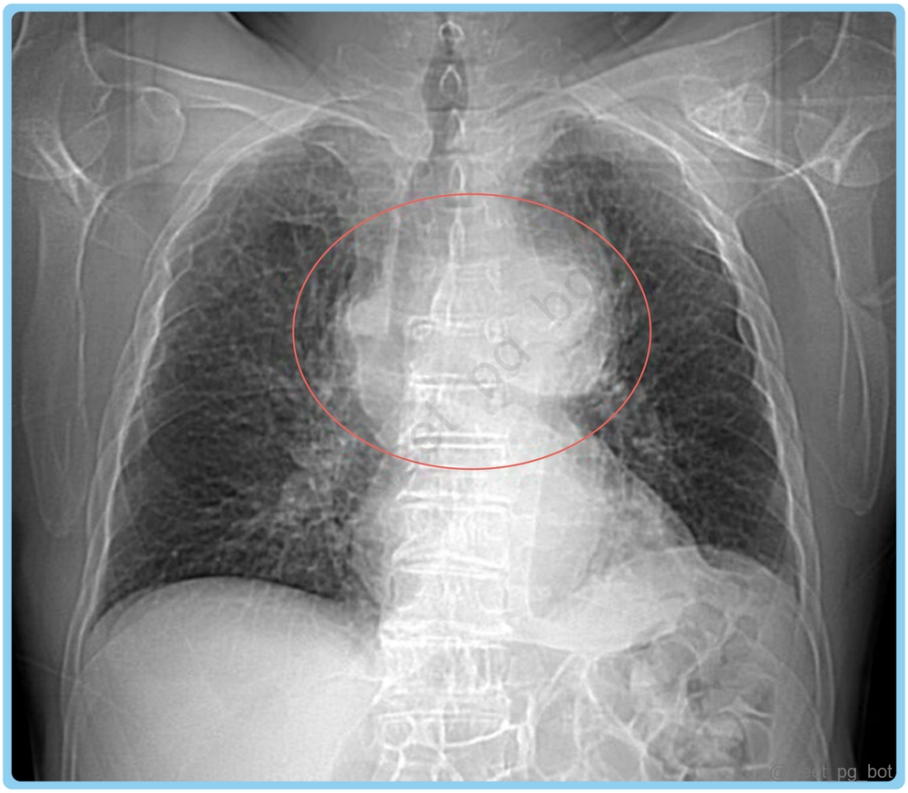
CT scan of thymoma

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References:

Bailey & Love's Short Practice of Surgery 28th Edition, Page 992.

Schwartz’s Principles of Surgery, 11th Edition, Page.727,731

↑ *Back to this question in Part A*

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Q22: A 63 y/o female is diagnosed with a Stage III thymoma and presents with symptoms of myasthenia gravis. The tumour appears to have invaded the superior vena cava and pericardium. What is the most appropriate treatment plan for this patient? (Q849465)

A. Complete surgical resection

B. Radiation therapy alone

C. Observation and periodic follow-up imaging

D. Chemotherapy as a primary treatment without surgery

Correct Answer: A. Complete surgical resection

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Complete surgical resection of the tumour is the most appropriate treatment plan for a Stage III thymoma with invasion into nearby structures. Surgical resection may include removing and r econstructing the involved structures, such as the pericardium and superior vena cava. For optimising patient care, a multidisciplinary approach with chemotherapy, neoadjuvant chemotherapy, radiotherapy and immunotherapy is usually undertaken after resection and reconstruction to prevent disease recurrence. The Masaoka-Koga system is based on surgical findings and describes the extent of tumour spread. It categorizes thymomas into stages I-IV, with higher stages indicating more extensive disease. Masaoka-Koga Staging System Stage I The tumour is completely encapsulated, meaning it is confined within the thymus gland and has not spread beyond its capsule. Stage II The tumour has spread beyond the capsule of the thymus. Microscopic or macroscopic invasion into the surrounding fatty tissue or mediastinal pleura. Stage III The tumour has spread to adjacent organs in the chest, such as the pericardium, the lungs, or the great vessels (aorta, vena cava, pulmonary artery). Stage IV The tumour has spread to distant sites in the body. Stage IVa : Spread to the pericardium or pleura Stage IVb : Spread to distant organs through the bloodstream or lymphatic system. Radiation therapy alone (Option B) is generally not sufficient for a Stage III thymoma, especially one that has invaded surrounding structures. It is typically used as an adjunctive treatment after surgery or as palliative therapy in inoperable cases. Observation and periodic follow-up imaging (Option C) is not an appropriate treatment strategy for a Stage III thymoma. This approach might be suitable for small, asymptomatic, and non-invasive thymomas, but not for advanced-stage tumors. Chemotherapy as a primary treatment without surgery (Option D): While chemotherapy can be used as a primary treatment for patients who are not candidates for surgery, this patient has no contraindications to surgery and would benefit from the curative option of surgical resection following chemotherapy.

References:

Schwartz’s Principles of Surgery, 11th Edition, Pg.731

Sabiston Textbook of Surgery (21st Edition), Page 1635.

↑ *Back to this question in Part A*

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Q23: A 48 y/o man with a history of pulmonary TB presents with progressive shortness of breath, facial swelling, and difficulty swallowing. His chest X-ray shows an abnormal shadow in the mediastinum. A CT scan reveals extensive fibrotic tissue compressing the SVC and oesophagus. What is the most likely diagnosis? (Q849466)

A. Superior vena cava syndrome

B. Pulmonary embolism

C. Chronic fibrous mediastinitis

D. Thymoma

Correct Answer: C. Chronic fibrous mediastinitis

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The patient's history of pulmonary tuberculosis, along with imaging findings showing fibrosis and compression of the SVC and oesophagus, strongly suggest chronic fibrous mediastinitis. Chronic fibrous mediastinitis is a rare disorder characterized by extensive fibrotic tissue formation in the mediastinum. This fibrosis can compress vital mediastinal structures such as the SVC, oesophagus, trachea, and pulmonary arteries, leading to symptoms like shortness of breath, facial swelling, and dysphagia. The condition often follows a history of granulomatous infections such as tuberculosis or histoplasmosis, which provoke a chronic inflammatory response in the mediastinum. Superior vena cava syndrome (Option A): This is a condition where the SVC is obstructed, leading to symptoms like facial swelling and difficulty swallowing but there is no associated mediastinal fibrosis. It is not the primary diagnosis. Pulmonary embolism (Option B): This condition causes sudden shortness of breath and chest pain but does not typically cause facial swelling or difficulty swallowing. There is also no associated mediastinal fibrosis. Thymoma (Option D) is a tumour that occurs in the anterior mediastinum. It can cause compression of mediastinal structures but is less likely to be associated with a history of granulomatous infection and extensive fibrosis.

References:

Schwartz's Principles of Surgery, 11th Edition, Pg.736

↑ *Back to this question in Part A*

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Q24: A 72-year-old male with COPD presents with sudden severe shortness of breath and right-sided chest pain. On examination, he is cyanotic, in respiratory distress, and has diminished breath sounds on the right side. A CXR shows a large air collection in the right pleural space. What is the most likely diagnosis? (Q849474)

A. Primary Spontaneous Pneumothorax (PSP)

B. Secondary Spontaneous Pneumothorax (SSP)

C. Chylothorax

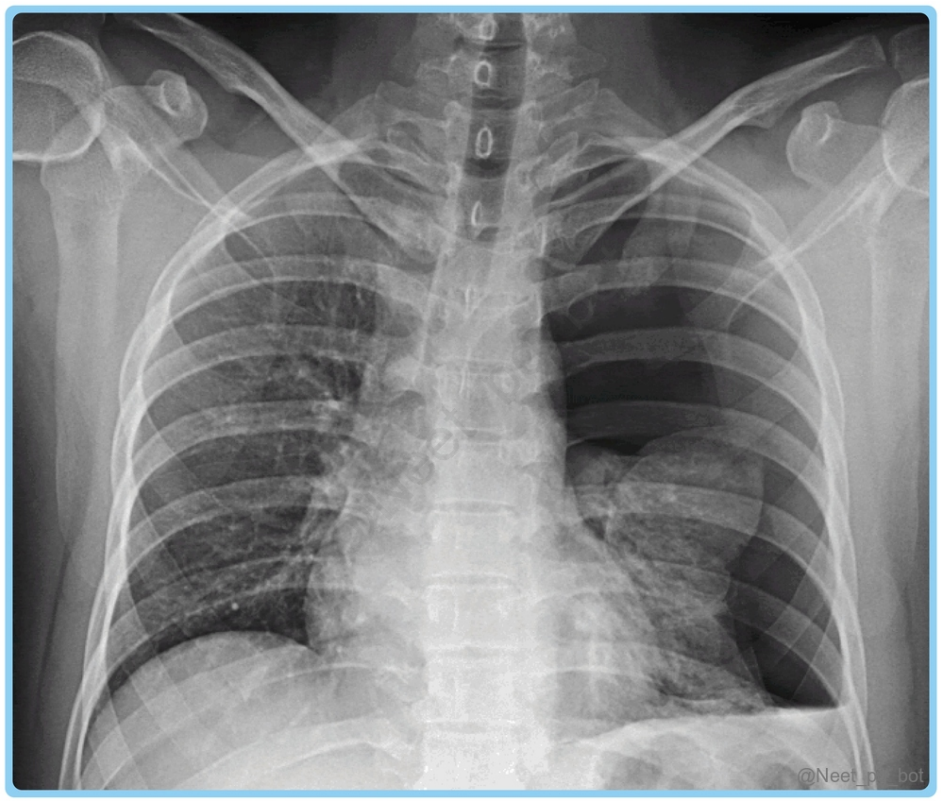
D. Hemothorax

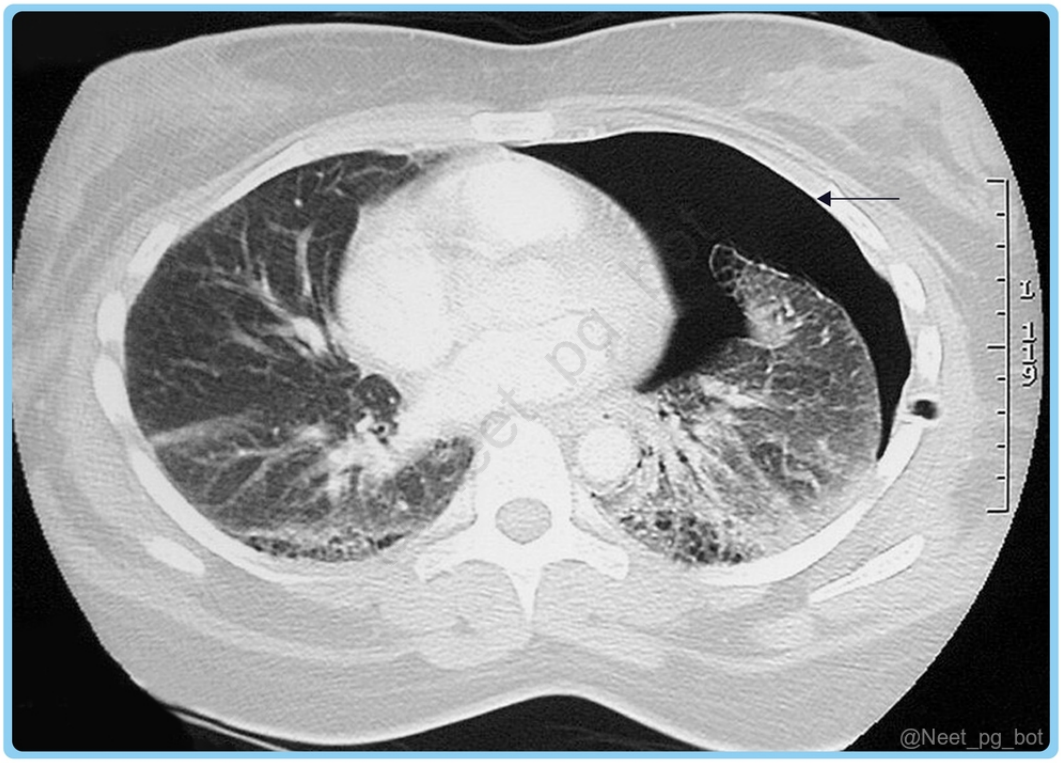
Correct Answer: B. Secondary Spontaneous Pneumothorax (SSP)

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: SSP is common in older adults with underlying lung diseases such as COPD. The patient's symptoms of severe shortness of breath, chest pain, and a history of COPD are classic for SSP. Aspect Primary Spontaneous Pneumothorax (PSP) Secondary Spontaneous Pneumothorax (SSP) About Occurs without underlying lung disease. (Option A) Typically affects young individuals (under 35 years) It arises from the rupture of small blebs or cysts on the lung surface, leading to air entering the pleural space. . Occurs in individuals with existing lung pathology. More common in older adults (typically over 45 years). Recurrence rates are higher compared to PSP, with up to 80% of patients experiencing additional episodes Risk Factors Male sex Tall and thin body type Smoking Family history of pneumothorax Chronic obstructive pulmonary disease (COPD) Cystic fibrosis Tuberculosis Lung cancer Other lung diseases (e.g., asthma, sarcoidosis) Clinical Features Sudden onset of chest pain Mild to moderate dyspnea Rarely life-threatening Severe dyspnea Hypoxemia and hypercapnia Chest pain Potential for acute respiratory failure Investigations Chest X-ray CT scan may be used for confirmation in some cases Chest X-ray CT scan for differential diagnosis, especially in emphysema cases Treatment Observation for small, asymptomatic cases. Needle aspiration for larger cases. Chest tube placement if aspiration fails. Surgical options (VATS, pleurodesis) for recurrent cases. Hospital admission for monitoring. Chest tube placement for large or symptomatic cases. Surgical intervention based on underlying disease. Chest X-ray of Pneumothorax CT of Pneumothorax Chylothorax (Option C): Chylothorax is caused by the accumulation of chyle (a milky fluid rich in triglycerides, chylomicrons, and white blood cells) in the pleural space due to disruption of the thoracic duct. It is associated with dyspnea and cough, but the pleural fluid is typically milky or clear. This patient’s presentation of sudden chest pain and respiratory distress with a history of COPD is more indicative of SSP rather than chylothorax. Hemothorax (Option D): Hemothorax refers to the presence of blood in the pleural cavity, often caused by trauma, surgery, tumours, or spontaneous bleeding. It presents with chest pain, signs of shock, and dullness on percussion. The patient’s history and the absence of trauma or surgery make SSP a more likely diagnosis in this case. Hemothorax would also typically present with signs of bleeding and shock, which are not described here.


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References:

Bailey and Love Surgery, 28th edition. Pages. 979-981

Sabiston Textbook of Surgery, 21st edition, Pages.1630, 1631

SRB Surgery 6th Edition. Page.1102

Pneumothorax: from definition to diagnosis and treatment - PMC (nih.gov)

Primary and Secondary Spontaneous Pneumothorax: Prevalence, Clinical Features, and In-Hospital Mortality - PMC (nih.gov)

ERS task force statement: diagnosis and treatment of primary spontaneous pneumothorax | European Respiratory Society (ersjournals.com)

Spontaneous pneumothorax: epidemiology, pathophysiology, and cause | European Respiratory Society (ersjournals.com)

↑ *Back to this question in Part A*

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Q25: A 30-year-old male presents to the emergency department after a stabbing injury to the chest, having respiratory distress, 4 cm wound on the right side. On

examination, his breath sounds are decreased on the right side, and he shows signs of hypoxia. His vital signs are stable. What is the most appropriate first step in managing this patient? (Q849479)

A. Perform needle thoracocentesis in the 2nd intercostal space, midclavicular line

B. Insert a chest tube immediately at the site of the injury

C. Apply a sterile occlusive dressing over the wound, taped on three sides

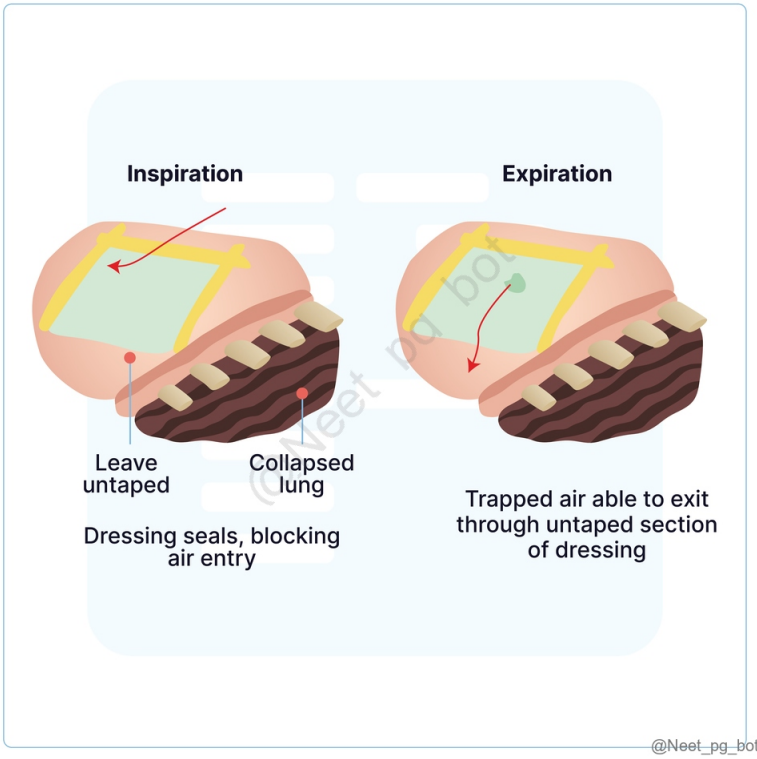
D. Obtain a chest X-ray to assess the injury and confirm the diagnosis

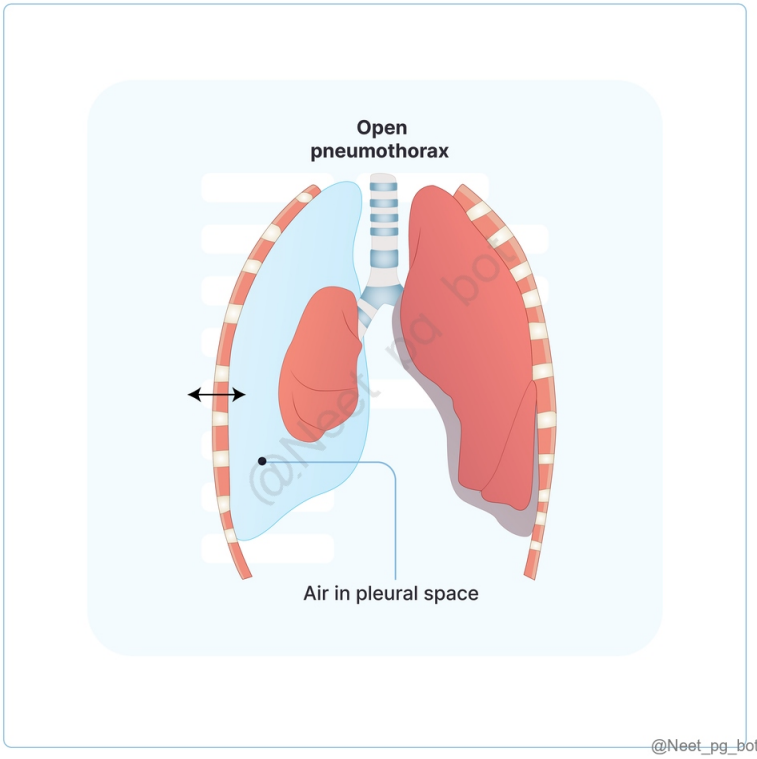
Correct Answer: C. Apply a sterile occlusive dressing over the wound, taped on three sides

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The patient’s history of trauma to the chest leading to an open wound of 4cm and clinical findings of absent breath sounds are characteristic of open pneumothorax. Applying a sterile occlusive dressing, taped on three sides, helps to seal the wound and prevent air from being drawn into the pleural space with each breath, which can help stabilize the patient and prevent progression to a tension pneumothorax. OPEN PNEUMOTHORAX Pathophysiology Large defect in the chest wall (>3 cm). Intrathoracic pressure = Atmospheric pressure. If the size of the defect > 2/3rds of the trachea’s diameter, the air is drawn through the wound rather than the trachea, leading to air accumulation in the hemithorax, hypoventilation, and hypoxia. Initial Management Seal the Defect with a sterile occlusive plastic dressing (e.g., OPSITE™) taped on three sides to create a flutter valve. Chest Tube Placement: Insert a chest tube as soon as possible at a site distant from the injury. Potential Complications Tension Pneumothorax if the defect creates a one-way valve effect. Perform needle thoracocentesis in the 2nd intercostal space, midclavicular line (Option A): Needle thoracocentesis is used for tension pneumothorax, not open pneumothorax. Insert a chest tube immediately at the site of the injury (Option B): While chest tube placement is crucial for managing pneumothorax and pleural effusion, it should be performed at a site remote from the injury. The immediate priority for an open pneumothorax is to seal the defect first to prevent further complications. Obtain a chest X-ray to assess the injury and confirm the diagnosis (Option D): Although a chest X-ray is helpful for diagnosis, the management of an open pneumothorax should not be delayed for imaging. Immediate sealing of the wound is critical to stabilize the patient and prevent further complications.





References:

Bailey and Love Surgery, 28th edition. Page. 375

Pneumothorax - StatPearls - NCBI Bookshelf

↑ *Back to this question in Part A*

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Q26: A 25-year-old male, after a motor vehicle accident, presents with severe respiratory distress, decreased breath sounds on the right, hyper-resonance, and tracheal deviation to the left. His BP is 85/55 mmHg, and jugular veins are distended. What is the most appropriate next step in management? (Q849480)

A. Order an urgent chest X-ray to confirm the diagnosis

B. Perform an immediate needle thoracocentesis in the 5th intercostal space, in anterior axillary line

C. Insert a chest tube into the 5th intercostal space in the anterior axillary line

D. Perform a finger thoracostomy in the safe triangle

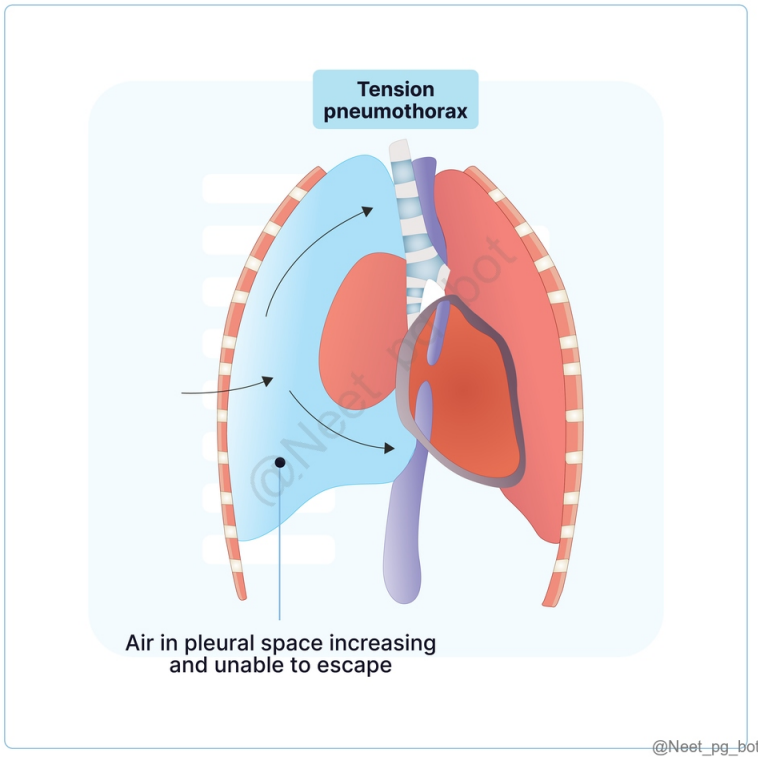
Correct Answer: B. Perform an immediate needle thoracocentesis in the 5th intercostal space, in anterior axillary line

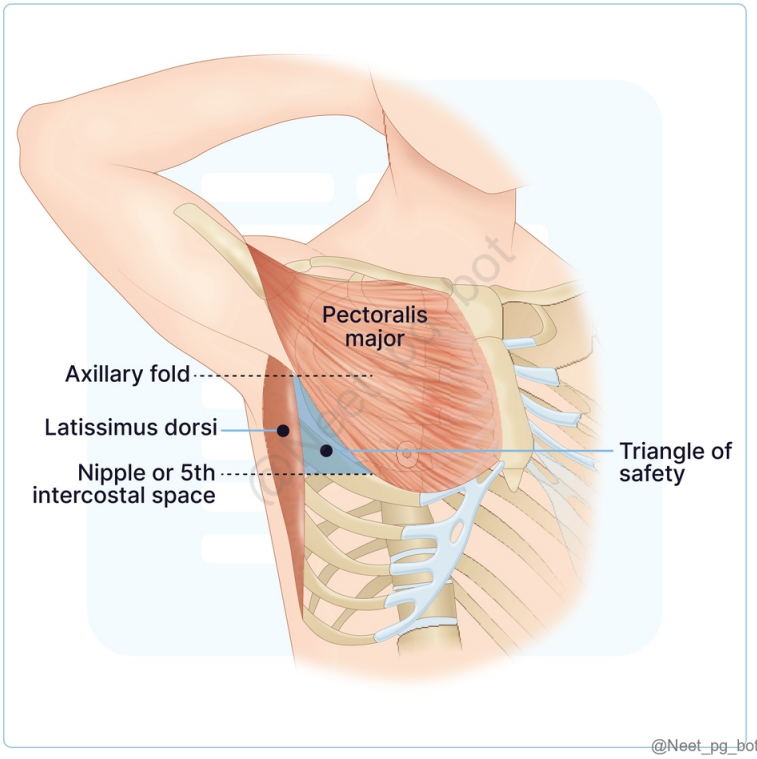
■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The patient presents with low blood pressure, distended jugular veins, and signs of tension pneumothorax, including severe respiratory distress, tracheal deviation, and hyper-resonance. This life-threatening condition requires immediate needle thoracocentesis to relieve the pressure. Once stable, a chest tube should be inserted. TENSION PNEUMOTHORAX Pathophysiology D/t ‘one-way valve’ air leaks from the lung or chest wall. Air is sucked into the thoracic cavity without any escape, collapsing and compressing the affected lung. The mediastinum shifts to the opposite side, reducing venous return and compressing the opposite lung, leading to decreased cardiac output and function. This can result in sudden death. Causes Penetrating Chest Trauma. Blunt Chest Trauma with parenchymal lung injury and persistent air leak. Iatrogenic Lung Injury (e.g., central venepuncture) Mechanical Positive-Pressure Ventilation. Clinical Features Tachypnea and Tachycardia Hyper-resonance and Decreased/Absent Breath Sounds Resonant Percussion with severe mediastinal/tracheal shift Cyanosis and Hypotension Chest Pain Distended Neck Veins Emergency Management Tension pneumothorax is a clinical diagnosis and treatment should never be delayed by waiting for radiological confirmation. Immediate Thoracocentesis (needle): Wide bore needle (typically a 20- or 22-gauge) in the 5nd intercostal space in the safety triangle. Decompression should be performed in the "safe triangle." Safe Triangle Boundaries : Posterior: Latissimus dorsi Anterior: Lateral border of the pectoralis major Inferior: A line drawn perpendicularly from the nipple to the back, just anterior to the mid-axillary line. In critical situations, a finger thoracostomy can be done in the same location. Nasal Oxygen for support. Intercostal Tube Placement (ICT) once stable and confirmed by chest X-ray. Additional Care Antibiotics and analgesics for treatment. Ventilator Support with IPPV in severe cases. Order an urgent chest X-ray to confirm the diagnosis (Option A): While a chest X-ray can confirm the diagnosis of tension pneumothorax, it should not delay immediate treatment. Tension pneumothorax is a clinical

diagnosis and requires urgent intervention without waiting for imaging confirmation. Insert a chest tube into the 5th intercostal space in the anterior axillary line (Option C): Chest tube insertion is an important step after initial decompression but is not the first intervention. Needle thoracocentesis is performed first to immediately relieve the pressure. Perform a finger thoracostomy in the safe triangle (Option D): A finger thoracostomy may be performed in extreme situations where other methods are not feasible or in a pre-hospital setting, but needle thoracocentesis is typically the preferred method in an emergency department setting.





References:

Bailey and Love Surgery, 28th edition. Pg. 374

Sabiston Textbook of Surgery, 21st edition, Pg. 404, 405, 1632

www.ncbi.nlm.nih.gov/books/NBK559090/

↑ *Back to this question in Part A*

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Q27: A 70 y/o woman with lung cancer presents with sudden severe chest pain and shortness of breath, 3 weeks post-lobectomy. She is pale, tachypneic, with BP 85/50 mmHg and HR 120 bpm. Examination reveals right-sided dullness and diminished breath sounds. A CXR shows a large pleural effusion, and thoracentesis drains 1000ml of blood. What is the most appropriate next step in management? (Q849481)

A. Observation and follow-up with chest X-ray

B. Administration of antibiotics and bronchodilators only

C. Thoracotomy with evacuation and lung decortication

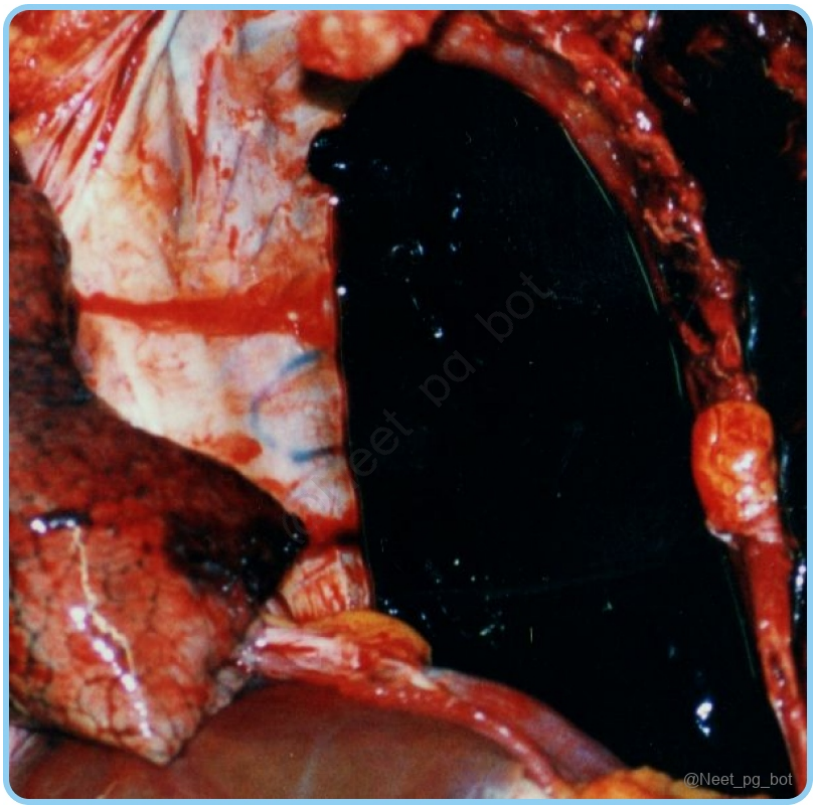
D. Intercostal chest tube (ICT) placement

Correct Answer: D. Intercostal chest tube (ICT) placement

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Given the significant blood in the pleural cavity (hemothorax) and the patient's hemodynamic instability, ICT placement is necessary to evacuate the blood, relieve pressure on the lung, and stabilize the patient before considering further surgical intervention if needed. HEMOTHORAX Definition The presence of blood in the pleural cavity, causes irritation, pain, and potential shock. Causes Trauma (e.g., rib fractures) Postoperative complications (e.g., lung, cardiac, esophageal surgeries) Tumours (lung, mediastinum, pleura) Leaking aneurysms Clinical Features Chest pain and tenderness Dyspnea Dullness on percussion Diminished breath sounds Signs of shock Investigations Chest X-ray Aspiration (pleural tap) Chest CT scan Treatment Intercostal chest tube (ICT) placement in the mid-axillary line in the 5th intercostal space. Antibiotics and bronchodilators Thoracotomy if persistent or large blood loss Criteria for Thoracotomy: >1.5 L blood lost in last 1 hour (or) >200cc/hour over next 2-4 hours Complications Infection and empyema Acute respiratory distress syndrome (ARDS) Observation and follow-up with chest X-ray (Option A): Observation is inappropriate in this case due to the large blood volume in the pleural cavity and the patient's hemodynamic instability. Immediate intervention is required to address the underlying issue. Administration of antibiotics and bronchodilators only (Option B): While antibiotics and bronchodilators may be necessary adjuncts to prevent infection and improve lung function, they are not sufficient for the initial management of a large hemothorax. Thoracotomy with evacuation and lung decortication (Option C): Thoracotomy is usually reserved for cases where there is initial chest tube output of 1500 ml of blood or persistent bleeding (over 200-300 mL/hr) or clotted hemothorax that cannot be managed with chest tube drainage alone. Although this might be considered later, the initial step should be ICT placement.



References:

SRB Surgery 6th Edition. Pg.1102

Bailey and Love Surgery, 28th edition. Pg. 375

Hemothorax - StatPearls - NCBI Bookshelf

↑ *Back to this question in Part A*

@Neet_pg_bot

Q28: Which of the following is least likely to be found in the posterior mediastinum? (Q849462)

A. Neurofibroma

B. Thymoma

C. Ganglioneuroma

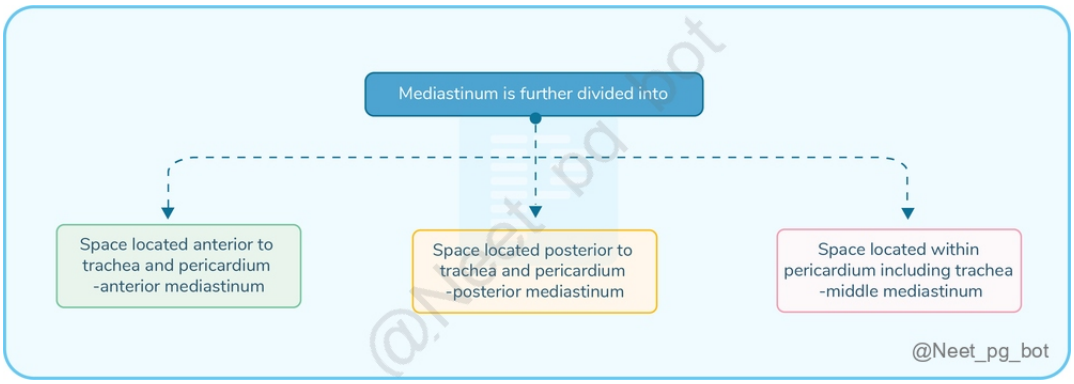
D. Aneurysm of descending aorta

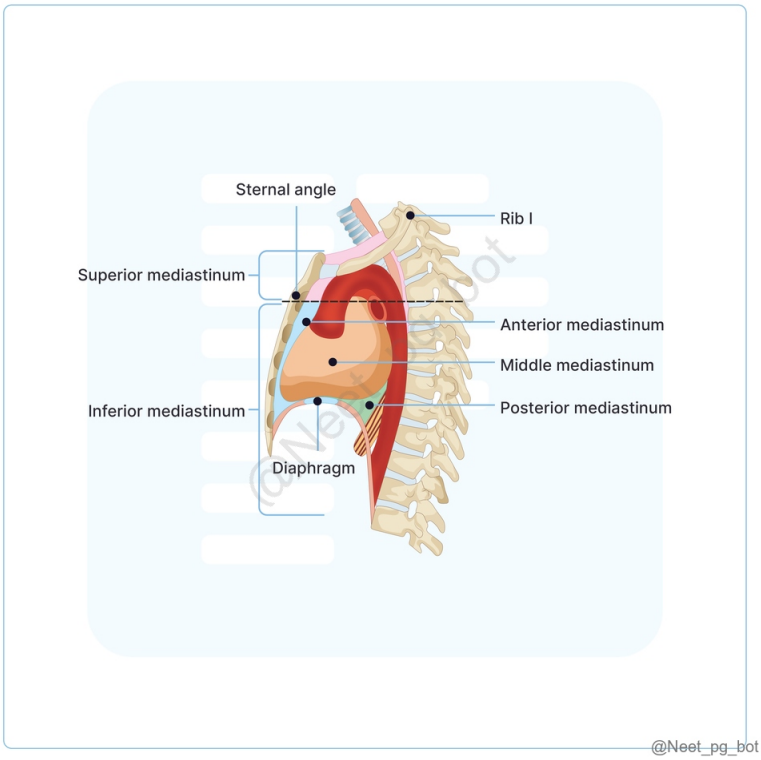
Correct Answer: B. Thymoma

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Thymomas are primarily located in the anterior mediastinum , making them unlikely to be found in the posterior mediastinum. Neurofibroma (Option A) is the most common type of neurogenic tumor in the posterior mediastinum, accounting for a significant percentage of cases. Ganglioneuroma (Option C) is a neurogenic tumor typically found in the posterior mediastinum. Aneurysm of descending aorta (Option D): This vascular mass can be found in the posterior mediastinum, where the descending aorta is located. Tumors of mediastinum Anterior mediastinum Middle mediastinum Posterior mediastinum Thymomas Thymic carcinomas Thymic cyst Germ cell tumors Lymphomas Parathyroid adenomas Carcinoid tumor Fibroma Lymphomas Tumors of the heart and great vessels Tumors of the trachea, mainstem bronchi, and oesophagus Aortic pathologies such as aortic aneurysm, abscess, or dissection. Pericardial cysts Bronchogenic cysts Neuroenteric cyst Mesothelial cyst Pheochromocytoma Neurilemomas (schwannomas) Neurofibromas Ganglioneuromas Ganglioneuroblastomas Neuroblastomas Pheochromocytomas The mediastinum is the central area within the chest, between the thoracic inlet superiorly and the diaphragm inferiorly. Laterally, it is bordered by the parietal pleura, while the sternum marks its anterior boundary and the vertebral column is its posterior limit.





References:

Sabiston Textbook of Surgery, 21st edition, Pg.1587,1633

Bailey & Love's Short Practice of Surgery (28th Edition), Page 991-993.

SRB’s Manual of Surgery, 6th Edition, Pg.1110

Schwartz’s Principles of Surgery, 11th Edition, Pg.728

↑ *Back to this question in Part A*

@Neet_pg_bot

Q29: A 45 y/o male presents with chest pain and dyspnea one week after undergoing oesophagal surgery. A pleural tap reveals milky white fluid with high triglyceride levels. Which of the following is the most appropriate next step in the management of this patient? (Q849493)

A. Oral antibiotics

B. Thoracic duct ligation via thoracoscopy

C. Oral diet with medium-chain triglycerides

D. Immediate pleurodesis with talc

Correct Answer: C. Oral diet with medium-chain triglycerides

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Oral diet with medium-chain triglycerides (option C) is the appropriate first-line management for postoperative chylothorax . MCTs are absorbed directly into the portal venous system, bypassing the lymphatic channels, and thus reduce the chyle leak. Initial conservative treatment includes: MCT-based oral diet or NPO with TPN Chest tube drainage Somatostatin or octreotide Monitoring of output volume Management of chylothorax: Initial Treatment: Intercostal tube (ICT) drainage, oral diet with medium-chain triglycerides, and total parenteral nutrition (TPN) to bypass the lymphatic system. Done before surgical repair via thoracoscopy Antibiotics: Administered to treat the underlying cause. Oral antibiotics (Option A): is incorrect because there is no evidence of infection or empyema. Antibiotics are not routinely used in sterile chylous effusion. Thoracic duct ligation via thoracoscopy (Option B): is incorrect at this stage. It is a second-line intervention , reserved for persistent high-output leaks (>1,000 mL/day for 5–7 days) or failure of conservative treatment. Immediate pleurodesis with talc (Option D): is incorrect because pleurodesis is considered only in refractory or inoperable cases , not as a first-line treatment.

References:

SRB’s Manual of Surgery, 6th Edition, Pg 256

Schwartz’s Principles of Surgery, 11th Edition, Pg 741

↑ *Back to this question in Part A*

@Neet_pg_bot

Q30: A 35 y/o male presents with milky urine and abdominal pain after a fatty meal. He reports weight loss and frequent urinary infections. Urinalysis shows chyluria. What is the most likely underlying cause of chyluria in this patient? (Q849494)

A. Renal stone disease

B. Filarial infection

C. Tuberculosis

D. Diabetes mellitus

Correct Answer: B. Filarial infection

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Filarial infection is the most common cause of chyluria, as it can obstruct intestinal lymphatics, leading to lymph leakage into the urine. Chyluria Passage of milky white chylous urine, aggravated after fatty meals. Causes: Most Common: Filarial infections (2% of cases). Other Causes: Tumors, tuberculosis, malaria, and ascariasis infestation. Mechanism: Obstruction of intestinal lymphatic vessels leads to high lymphatic pressure, causing lymph to enter the renal lymphatics, or rupture of intestinal lymphatics into the renal pelvis/ureter, forming a lympho-urinary fistula. Clinical Features: Symptoms mimic bacterial or tuberculous pyuria and may include urinary infections and protein loss. Possible presentation of colic due to lymph clots in the urinary system. Diagnostic Tools: Urine study, culture, intravenous urogram (IVU), lymphangiography, and abdominal ultrasound. Management: Dietary changes (low-fat, protein-rich diet). Antibiotics and diethylcarbamazine (DEC). Increase oral fluid intake. Surgical options include ligation of dilated lymphatics or sclerosing lymph vessels. Renal stone disease (Option A): While renal stones can cause urinary symptoms, they do not typically lead to chyluria or milky white urine. Tuberculosis (Option C): Although tuberculosis can cause urinary symptoms, it is not the most common cause of chyluria compared to filarial infections & also the history is not pointing towards TB. Diabetes mellitus (Option D) can lead to various urinary symptoms but is not associated with the development of chyluria.

References:

SRB’s Manual of Surgery, 6th Edition, Pg 256, 257

Bailey and Love’s Short Practice of Surgery, 28th Edition, Pg 73,1449

↑ *Back to this question in Part A*

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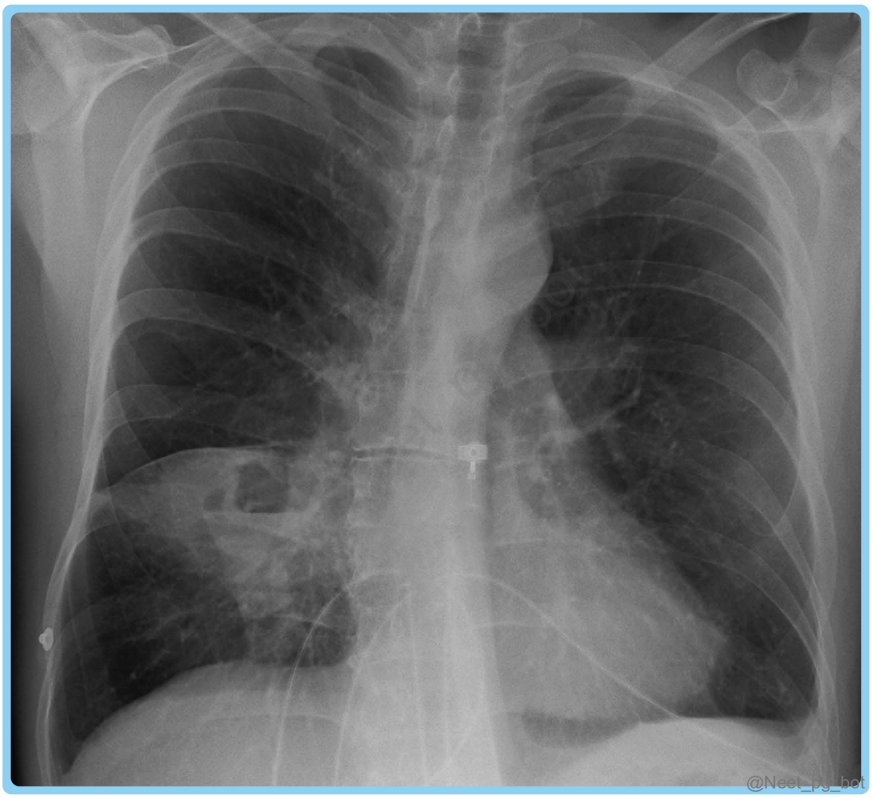
Q31: A 60 y/o male presents with fever, cough, and foul-smelling sputum. A chest X-ray reveals a localized opacity in the apical lower lobe. Sputum culture shows the presence of anaerobic bacteria. Which of the following is the most likely cause? (Q849495)

A. Aspiration of oropharyngeal secretions

B. Hematogenous spread from endocarditis

C. Direct extension from pneumonia

D. Bronchial obstruction due to lung cancer



Correct Answer: A. Aspiration of oropharyngeal secretions

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The X-ray shows a lung abscess. Aspiration is the most common cause of lung abscesses , particularly in the apical lower lobe, and is frequently associated with anaerobic bacteria from the oral cavity. Lung Abscess Localized suppuration in the lung is characterized by tissue necrosis Aetiology: Infectious: Pneumonia due to Streptococcus, Pneumococcus, Haemophilus, Staphylococcus, anaerobic bacteria, etc. Chronic upper respiratory infections (e.g., sinusitis, tonsillitis, dental infections). Mechanical: Bronchial obstruction due to tumours or foreign bodies. Other Causes: Septicaemia and aspiration, commonly lead to lung abscess in the apical lower lobe. Sites of Infection: Apical Lower Lobe: Most frequently involved in aspiration-related lung abscesses. Posterior Segments: Can be affected due to gravity when aspiration occurs. Upper Lobes: May be involved in cases of tuberculosis or certain types of pneumonia. Routes of Infection: Aspiration: Inhalation of oropharyngeal or gastrointestinal secretions, often leading to anaerobic infections from the oral cavity. Hematogenous Spread: From e.g., endocarditis or septicemia Direct Extension: Localized infections in adjacent structures (e.g., pneumonia, empyema) can extend into lung tissue. Hematogenous spread from endocarditis (Option B) : While it can cause lung abscesses, it is less common than aspiration in the context of anaerobic infections and would typically present with multiple abscesses rather than a localized opacity. Direct extension from pneumonia (Option C) can cause lung abscesses, but in this case, the specific presence of anaerobic bacteria and the apical location suggest aspiration as the more likely cause. Bronchial obstruction due to lung cancer (Option D) is a possible

cause of infection and abscess formation, but the presence of anaerobic bacteria and the patient's age make aspiration a more plausible cause, especially in the context of a localized opacity in the lung.

References:

SRB’s Manual of Surgery, 6th Edition, Pages 1104-1105

Bailey and Love’s Short Practice of Surgery, Pages 993-994

Schwartz’s Principles of Surgery, 11th Edition, Pages 706-709

↑ *Back to this question in Part A*

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Q32: A 58 y/o male with a history of chronic kidney disease presents to the clinic with shortness of breath and chest discomfort. A chest X-ray shows a pleural effusion on the right side. Analysis of the pleural fluid reveals the following: Pleural fluid protein to serum protein ratio: 0.7 Pleural fluid lactate dehydrogenase (LDH) to serum LDH ratio: 0.65 Pleural fluid LDH level: 300 U/L (serum LDH upper limit of normal is 200 U/L) Based on these findings and Light’s criteria, which of the following is the most likely cause of this patient's pleural effusion? (Q849496)

A. Congestive heart failure

B. Lung cancer

C. Nephrotic syndrome

D. Cirrhosis

Correct Answer: B. Lung cancer

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The high protein and LDH ratios, along with the elevated LDH level, are consistent with a pleural effusion due to exudative cause. Lung cancer is a common cause of exudative pleural effusions, which meet Light’s criteria for exudates. Transudative effusions result from an imbalance in hydrostatic or oncotic pressure, leading to protein-poor, clear or straw-coloured fluid. Exudative effusions stem from inflammation or increased capillary permeability, producing protein-rich, often turbid, bloody, or purulent fluid. Light's criteria for exudative effusions Pleural fluid protein to serum protein ratio > 0.5 Pleural fluid LDH to serum LDH ratio > 0.6 Pleural fluid LDH level > 2/3 of the upper limit of normal for serum LDH Causes of Pleural Effusion Transudative Exudative Congestive heart failure Cirrhosis Nephrotic syndrome Superior vena cava obstruction Pulmonary embolism Sarcoidosis Hypoalbuminemia Fluid retention/overload Lobar collapse Meigs syndrome Malignant: Lung cancer Lymphoma Mesothelioma Metastatic cancers Infectious: Bacterial pneumonia/empyema

Tuberculosis Fungal infections Viral infections Parasitic infections Collagen Vascular Disease-related: Rheumatoid arthritis Wegener granulomatosis Systemic lupus erythematosus Churg-Strauss syndrome Abdominal/Gastrointestinal disease-related: Esophageal perforation Subphrenic abscess Pancreatitis/pancreatic pseudocyst Meigs syndrome Other Causes: Pulmonary embolism with infarction Coronary artery bypass grafting Radiation/trauma Dressler syndrome Asbestosis After lung transplantation After bone marrow transplantation Drug-induced Uremia Congestive heart failure (Option A): Typically associated with transudative effusions, which are low in protein and LDH. This patient's pleural fluid analysis suggests an exudative effusion, making this option less likely. Nephrotic syndrome (Option C): Usually causes transudative effusions due to low protein levels. This effusion has a higher protein content, making this option unlikely. Cirrhosis (Option D): Also commonly leads to transudative effusions due to low oncotic pressure from hypoalbuminemia. The characteristics of this effusion align more with an exudative process.

References:

Sabiston Textbook of Surgery, 21st edition, Pg.1629

Schwartz's Principles of Surgery, 11th Edition, Pg.738,739

↑ *Back to this question in Part A*

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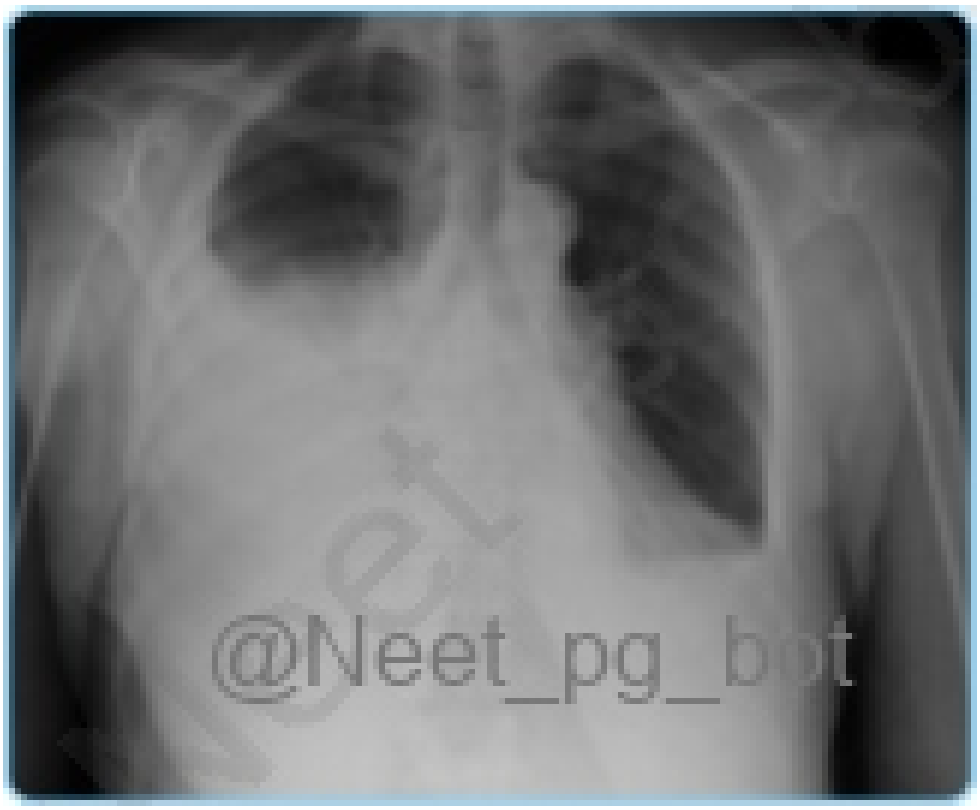
Q33: A 72 y/o male with h/o COPD presents with progressive shortness of breath and chest pain. The chest X-ray findings are shown below. Thoracentesis is performed, and analysis of the pleural fluid reveals high protein & LDH levels. Which of the following is the next best step in managing this patient? (Q849497)

A. Initiate diuretic therapy

B. Perform a pleural biopsy

C. Insert a chest tube for drainage

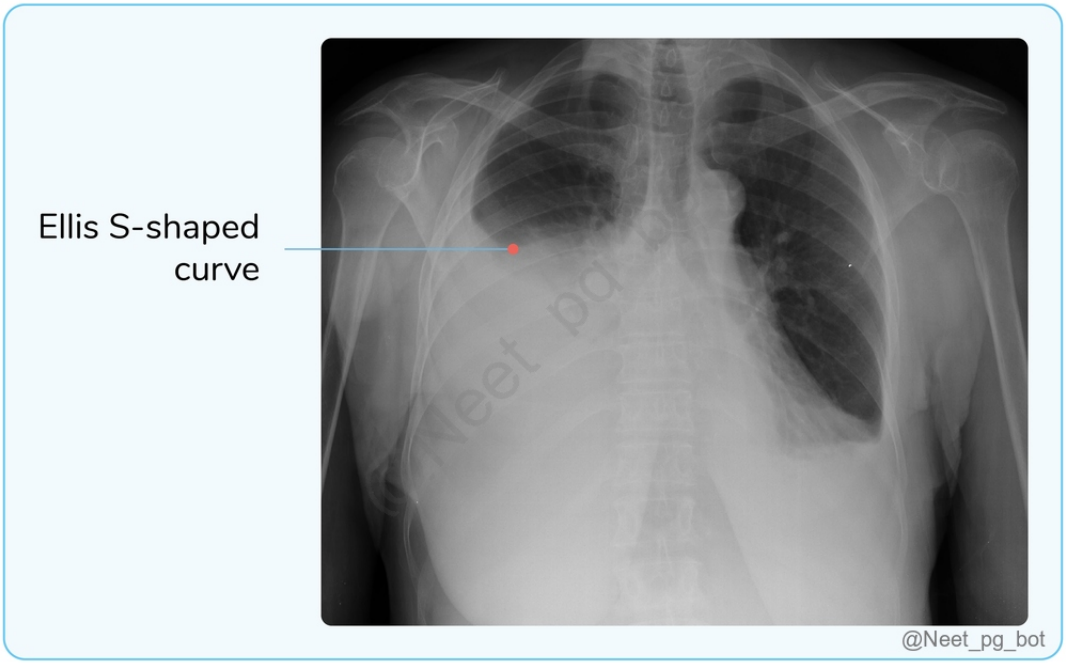
D. Administer antibiotics



Correct Answer: C. Insert a chest tube for drainage

- *Listen (English)*
- *Listen (Hindi)*

Explanation: The Chest X-ray shows massive amounts of fluid in the right lung and a characteristic Ellis S-shaped curve. Based on investigatory findings & the Light's criteria, this patient is having exudative pleural effusion. Inserting a chest tube is the most appropriate next step for this patient, as it directly addresses the symptoms of dyspnea and chest pain by removing the excess fluid. The high protein content and elevated LDH levels indicate an exudative effusion, likely caused by inflammation or malignancy, which needs to be drained. The Ellis S-shaped curve on the chest X-ray further supports the presence of a large effusion that is causing significant lung compression. By draining the fluid, the patient's respiratory symptoms can be alleviated, and further diagnostic testing can be performed if needed. Initiate diuretic therapy (Option A): Diuretics are typically used to manage pleural effusions associated with heart failure or fluid overload. However, given the evidence of a large effusion and the elevated protein and LDH levels, indicating an exudative process, diuretics alone would not be sufficient. Perform a pleural biopsy (Option B): Although a pleural biopsy might be indicated if malignancy is suspected, the immediate concern is to relieve the patient's symptoms by draining the effusion. A biopsy can be considered later if needed. Administer antibiotics (Option D): Antibiotics are necessary if there is evidence of an infectious process, such as pneumonia. However, there is no indication of infection, making antibiotics an inappropriate first step.



References:

Sabiston Textbook of Surgery, 21st edition, Pg.1629

Schwartz's Principles of Surgery, 11th Edition, Pg.704,737

Pleural effusion: diagnosis, treatment, and management - PMC

↑ *Back to this question in Part A*

@Neet_pg_bot

Q34: A 50 y/o male patient has been hospitalized following a hip replacement surgery for the past 6 days. He has a history of obesity and smoking. On the sixth day, he suddenly develops shortness of breath, and chest pain, and coughs up blood. Which of the following is the most likely contributing factor to his current condition? (Q849518)

A. Prolonged immobility

B. Dehydration

C. High blood pressure

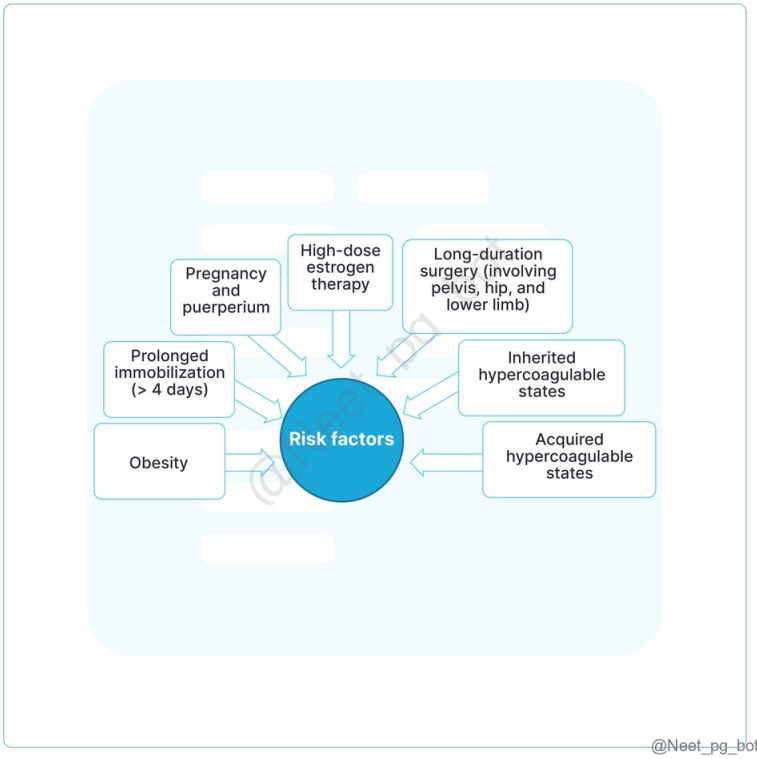
D. Recent blood transfusion

Correct Answer: A. Prolonged immobility

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The patient's prolonged bed rest following hip replacement surgery is the most likely contributing factor to his condition. The patient’s symptoms of sudden dyspnea, chest pain & hemoptysis following prolonged immobilization give rise to the suspicion of a pulmonary embolism. Immobility → DVT → Pulmonary embolism → Clot lodges in pulmonary artery & blocks blood flow to a portion of the lung → Dyspnea & chest pain. Risk factors (for PE): Dehydration (Option B): While dehydration could potentially contribute to clot formation, the primary risk factor in this scenario is the prolonged immobility associated with postoperative bed rest, making it a more significant factor for developing a pulmonary embolism. High blood pressure (Option C) is not directly associated with an increased risk of pulmonary embolism. The patient’s symptoms and recent surgery-related immobility are more indicative of a thromboembolic event rather than issues related to hypertension. Recent blood transfusion (Option D): Although blood transfusions can have various complications, they are not commonly associated with an increased risk of pulmonary embolism. The key risk factor here is the patient’s prolonged immobility after hip surgery.



References:

Pulmonary embolism, part I: Epidemiology, risk factors, and risk stratification, pathophysiology, clinical presentation, diagnosis, and non-thrombotic pulmonary embolism

Pulmonary embolism - PMC

SRB’s Manual of Surgery, 6th Edition, Pg.1107,1108

Sabiston Textbook of Surgery, 21st edition, Pg.1827

↑ *Back to this question in Part A*

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Q35: Which of the following is the most commonly used gold standard investigation for diagnosing pulmonary embolism in a clinical setting? (Q849519)

A. Doppler Ultrasound

B. Chest X-ray

C. Ventilation-Perfusion (V/Q) Lung Scan

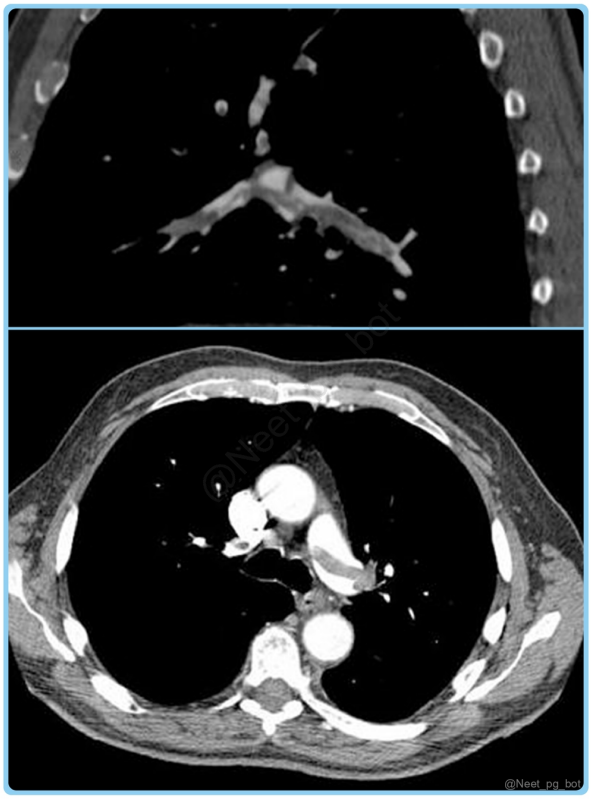
D. CT Pulmonary Angiography (CTPA)

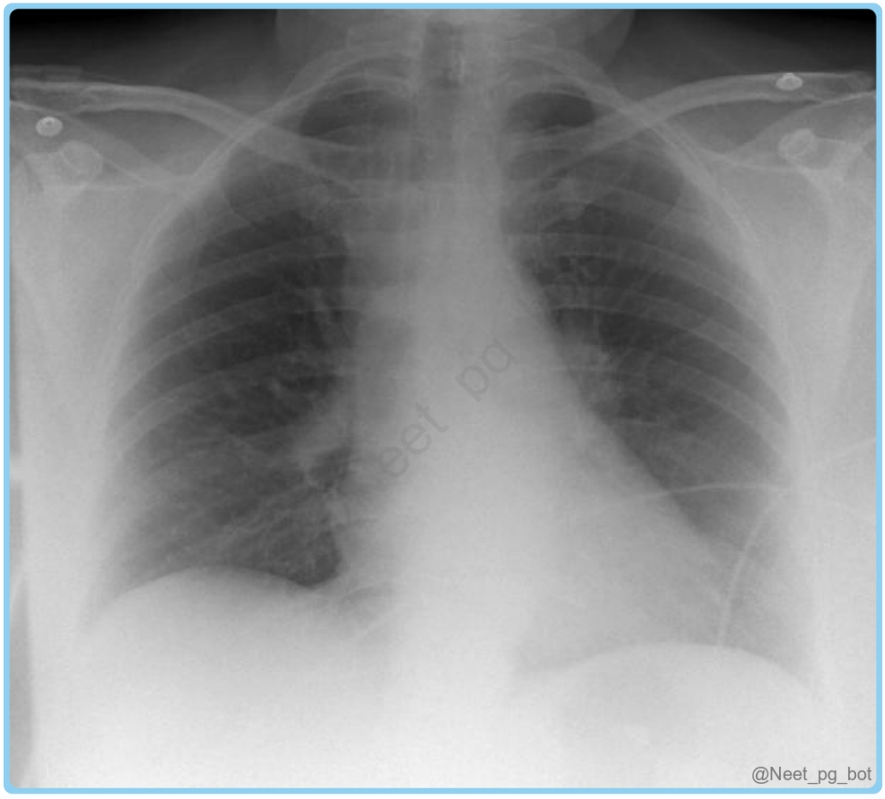
Correct Answer: D. CT Pulmonary Angiography (CTPA)

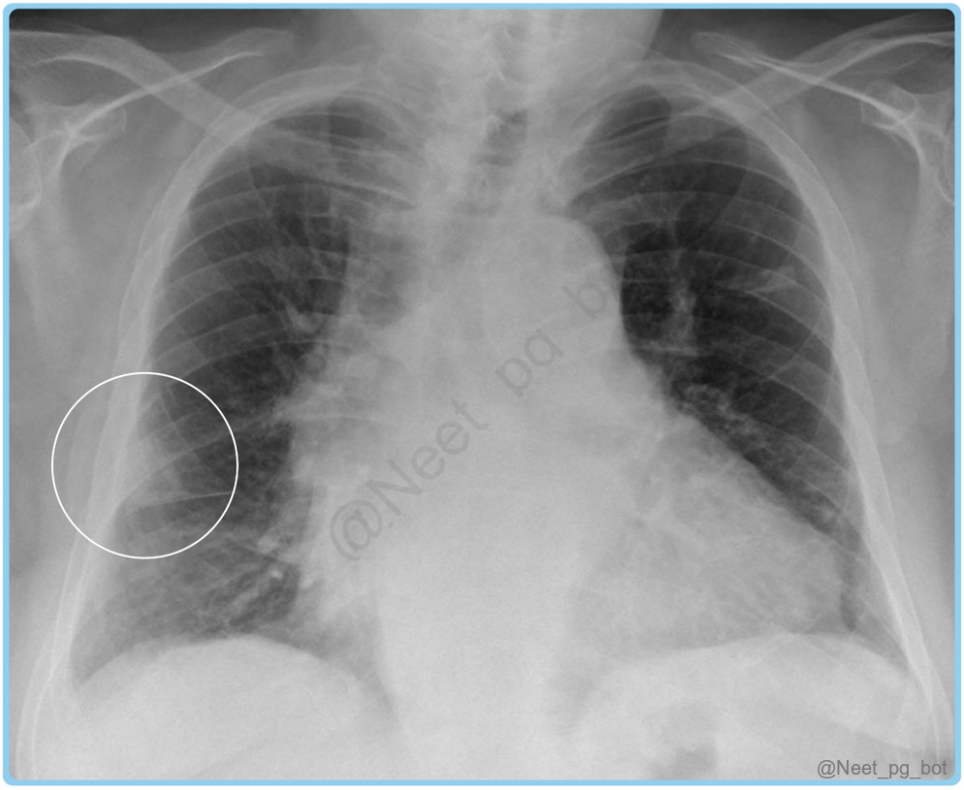
■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: CTPA is widely accepted as the gold standard investigation for diagnosing pulmonary embolism due to its high accuracy, speed, and ability to provide comprehensive diagnostic information. It is the preferred test in most clinical scenarios when PE is suspected. Investigations: Multidetector CT (MDCT): Investigation of choice (best investigation) CTPA (CT pulmonary angiography): Gold standard CT pulmonary angiography shows the presence of a saddle embolus and substantial thrombus burden in the lobar branches of both main pulmonary arteries. ECG findings: Sinus tachycardia (Most specific finding) S1Q3T3 (most specific finding) Doppler Ultrasound (Option A) is primarily used to assess the risk of PE by looking for DVT in the legs but does not serve as a direct diagnostic tool for PE. Therefore, it is not considered the gold standard for diagnosing pulmonary embolism. Chest X-ray (Option B): While useful for ruling out other conditions, a chest X-ray cannot directly identify a pulmonary embolism. Findings suggestive of PE, such as the Westermark sign or Hampton's hump, are rare and not always conclusive. The Westermark sign is characterized by a focal area of hyperlucency on chest radiographs, caused by oligemia distal to a pulmonary artery obstruction, often indicating a pulmonary embolism. Hampton’s hump is seen as a wedge-shaped opacity on the radiograph, typically located at the lung periphery, suggesting pulmonary infarction. Ventilation-Perfusion (V/Q) Lung Scan (Option C): Despite being a valuable diagnostic tool, the V/Q scan is less specific and sensitive compared to CT pulmonary angiography. Its results often need confirmation by additional testing. Modified Well’s Criteria It is a scoring system to determine the likelihood of PE and thromboembolic events. Features Score Symptoms and signs of DVT 3 PE more likely than an alternate diagnosis 3 Heart rate >100 bpm 1.5 Recent immobilization or surgery (<4 weeks) 1.5 Previous PE or DVT 1.5 Hemoptysis 1 Active Cancer 1 Score: >4 - PE likely ; </= 4 - PE unlikely


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References:

SRB’s Manual of Surgery, 6th Edition, Pg.1108

Bailey and Love’s Short Practice of Surgery, 28th Edition, Pg.1045

Pulmonary embolism - PMC

Pulmonary embolism, part I: Epidemiology, risk factors, and risk stratification, pathophysiology, clinical presentation, diagnosis, and non-thrombotic pulmonary embolism

Westermark sign | Radiology Reference Article | Radiopaedia.org

Hampton’s hump, Westermark’s sign and Palla’s sign in acute pulmonary thromboembolism: a rare concurrence | BMJ Case Reports

↑ *Back to this question in Part A*

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• [03_Cardiothoracic Vascular Surgery] 012 Previous Year Questions

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[03_Cardiothoracic Vascular Surgery] 012 Previous Year Questions — Quick Jump

Q1 (p. 1504)	*Q2 (p. 1505)*	*Q3 (p. 1507)*	*Q4 (p. 1508)*	*Q5 (p. 1510)*	*Q6 (p. 1511)*
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Q37 (p. 1550)	*Q38 (p. 1551)*	*Q39 (p. 1553)*	*Q40 (p. 1554)*	*Q41 (p. 1555)*	*Q42 (p. 1556)*
Q43 (p. 1557)	*Q44 (p. 1558)*	*Q45 (p. 1559)*	*Q46 (p. 1560)*	*Q47 (p. 1560)*	*Q48 (p. 1561)*
Q49 (p. 1562)	*Q50 (p. 1563)*	*Q51 (p. 1566)*	*Q52 (p. 1567)*	*Q53 (p. 1570)*	*Q54 (p. 1573)*
Q55 (p. 1576)	*Q56 (p. 1577)*	*Q57 (p. 1578)*			

Q1: In a 35-year-old individual with a history of chronic smoking who is experiencing bluish discoloration of the toes and intermittent claudication, what would be the most suitable investigation to conduct next? (Q856763)

A. CT Angiography

B. MR Angiography

C. Digital subtraction angiography

D. Duplex scan

Correct Answer: D. Duplex scan

Explanation: The most appropriate investigation to confirm the diagnosis and assess the severity of the arterial occlusion in the lower limbs is a Duplex scan. The given case with chronic smoking, bluish toes, and intermittent claudication is suggestive of peripheral arterial disease (PAD), commonly linked to atherosclerosis in smokers. Duplex Doppler ultrasound (DUS) combines B-mode ultrasound for imaging vessels and Doppler ultrasound to assess blood flow, providing an accurate, cost-effective, and non-invasive alternative to angiography for detecting vascular issues. It is useful for initial evaluation but may have limitations in visualising deeper arteries. CT Angiography (Option A) is considered more specific and detailed imaging, and it's not the first-line investigation for peripheral arterial disease (PAD). It is usually considered when other non-invasive tests (like duplex scans) are inconclusive or when a more detailed assessment is required. MR Angiography (Option B) is similar to CT

angiography, which provides detailed vascular imaging but is not the initial choice. It's generally used when other methods are not feasible or are contraindicated. Digital subtraction angiography (Option C) is an invasive procedure that involves the injection of contrast dye into the blood vessels followed by X-ray imaging. It is generally reserved for cases where other imaging modalities have not provided sufficient information or when endovascular intervention (such as angioplasty) is planned.

References:

Schwartz’s Principles of Surgery, 11th Edition, Page 974.

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↑ *Back to this question in Part A*

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Q2: Identify the type of ulcer? (Q866906)

A. Arterial Ulcer

B. Venous ulcer

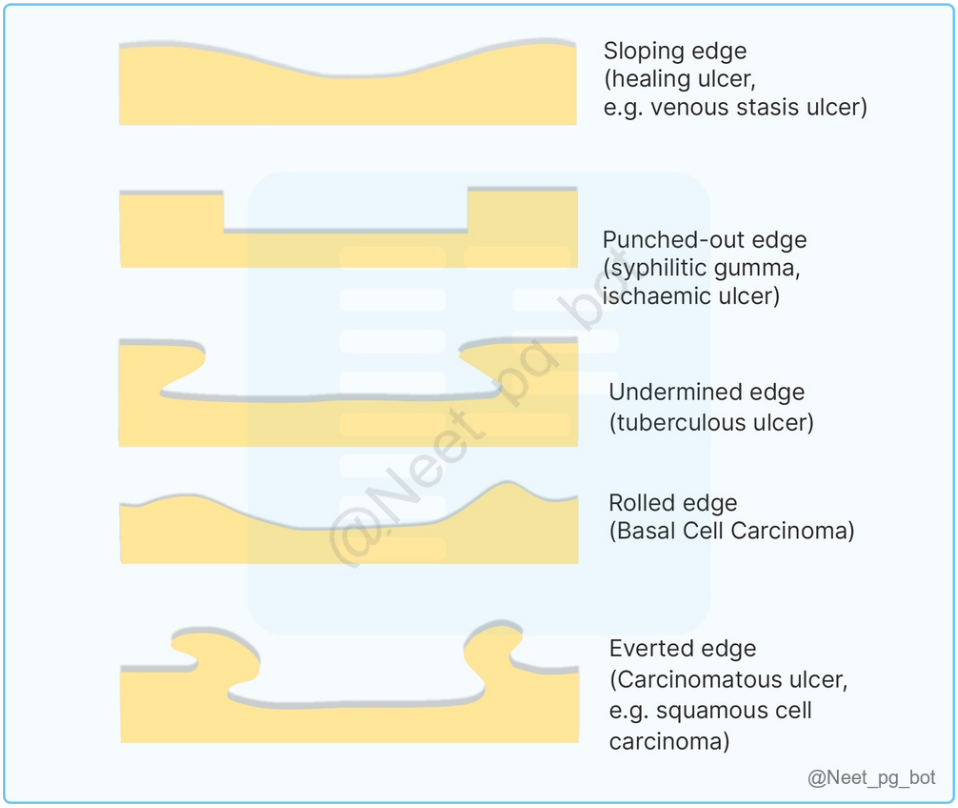
C. Diabetic ulcer

D. Neuropathic



Correct Answer: B. Venous ulcer

Explanation: An ulcer in the gaiter area (medial aspect of the lower leg, above the ankle) is most commonly due to chronic venous insufficiency . These ulcers are typically shallow, have irregular margins, and are associated with skin changes like hyperpigmentation, lipodermatosclerosis, and edema. The type of ulcer edges seen in various clinical conditions is listed in the table below: Type of edges Clinical conditions Details Sloping edge Healing ulcer Varicose ulcer Inner part: Red (healthy granulation tissue) Middle part: Blue (epithelial proliferation) Outer part: White (scar/fibrous tissue) Undermined edge Tubercular ulcers Disease process advances in the deeper plane (subcutaneous tissue) whereas (skin) epidermis proliferates inwards Punched out edge Arterial / Ischemic ulcers Gummatous (syphilitic) ulcer Trophic ulcer Due to endarteritis Raised and beaded edge Rolled out / Pearly white edge Rodent ulcer- Basal cell carcinoma Beads are due to proliferating active cells Pearly white in appearance Everted edge / Rolled out edge Squamous cell carcinoma Due to the spill of proliferating malignant tissue over the normal skin Arterial ulcer (Option A): Usually found on toes, dorsum of foot, or pressure points; have “punched-out” edges, very painful, and are associated with diminished pulses. Diabetic ulcer (Option C): Typically over pressure points of the foot (metatarsal heads, heel) due to neuropathy; often painless. Neuropathic ulcer (Option D): Similar to diabetic ulcers but specifically due to peripheral neuropathy from any cause; usually over pressure-bearing areas.



References:

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↑ *Back to this question in Part A*

@Neet_pg_bot

Q3: A 50-year-old diabetic man presents with a progressive increase in pain in his calf. He now prefers to sleep in a seated position by hanging his leg to alleviate pain.Pain is more in the distal part like toes and feet. It gets aggravated with movements and pressure. The pain is increased in lying down and elevation of foot; it may be reduced on hanging the foot down. Which of the following is the most likely cause? (Q793482)

A. Rest pain

B. Sciatica

C. Neurological claudication

D. Venous claudication

Correct Answer: A. Rest pain

Explanation: Correct option : Option a: The most likely cause of the patient's symptoms, based on the provided information, is rest pain. Rest pain It is continuous aching in calf or feet and toes or in the region even at rest depending on site of obstruction. It is a ‘ cry of dying nerves’ due to ischemia of the somatic nerves. It signifies severe decompensated ischemia. Pain gets aggravated by elevation and is relieved in dependent position of the limb Pain is more in the distal part like toes and feet. It gets aggravated with movements and pressure. Rest pain is increased in lying down and elevation of foot; it may be reduced on hanging the foot down. Incorrect Choices: Option b: Sciatica is a condition that causes pain, numbness, or weakness in the lower back, buttocks, and legs due to compression or irritation of the sciatic nerve. However, the patient's symptoms of worsening pain with walking and relief by hanging the leg are inconsistent with sciatica. Option c: Neurogenic claudication is another possible cause of the patient's symptoms, which occurs due to spinal stenosis or nerve root compression, causing pain, numbness, and weakness in the lower back, buttocks, and legs. However, the patient's symptoms of worsening pain with walking and relief by hanging the leg are not typical of neurogenic claudication. Option d: Venous claudication is caused by chronic venous insufficiency, leading to decreased blood flow and oxygen supply to the affected tissues. However, the patient's symptoms of worsening pain with walking and relief by hanging the leg are not typical of venous claudication.

References:

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↑ *Back to this question in Part A*

@Neet_pg_bot

Q4: Which of the following findings is likely to be seen in this patient? (Q855695)

A. Decreased posterior tibial & dorasalis pedis pulsations

B. Loss of sensation over the foot

C. Positive tredelenberg sign

D. Pain on compression of the calf



Correct Answer: B. Loss of sensation over the foot

Explanation: The given image depicts a neurotrophic (diabetic) ulcer, where the loss of sensation in the foot is typically observed. Clinical features of different ulcers are as follows: Venous ulcer Arterial ulcer Neurotrophic ulcer Pressure ulcer Site Gaiter's area (area between malleolus and calf) At distal ends of limbs, such as toes, feet and legs. Over toe joints, under the heel, over malleoli, under the metatarsal head, etc Seen over pressure points, most common are ischium, greater trochanter, sacrum, hee, malleolus, occiput, etc Appearance Vertically oval with a sloping edge and will not penetrate deep fascia. Punched-out edges are seen in this type of ulcer. Ulcers can be associated with gangrene and abscesses; osteomyelitis can be seen here. Punched out ulcer with bone as a base. Cause Caused by ambulatory chronic venous hypertension due to varicose veins. This occurs due to severe arterial insufficiency of digital and medium-sized arteries, leading to ischemia and tissue death in the region. It is caused due to repeated trauma and ischemia due to microangiopathy in diabetic patients . It is tissue necrosis and ulceration due to prolonged pressure on any part of the body. Characteristics It is initially painful, then chronically becomes painless. It heals on rest and treatment but reforms again. It is intensely painful, and distal pulses are not palpable, and associated with shiny skin, brittle nails and loss of hair over the region. Numbness Paresthesias Burning or loss of sensation in the foot Diabetes mellitus (also known as diabetic ulcer) It is common in bedridden patients with head injuries, neurological deficits, and comatose and stroke-ridden patients. Decreased posterior tibial & dorsalis pedis pulsations (Option A) suggest a vascular problem, such as peripheral artery disease, which affects blood flow to the feet. Neurotrophic ulcers are caused by nerve damage, not vascular issues. Positive Trendelenburg sign (Option C) is a sign of hip or pelvic injury, indicating weakness in the gluteus medius muscle. It is unrelated to neurotrophic ulcers, which affect the feet due to nerve damage. Pain on compression of cthe alf (Option D) is typically associated with compartment syndrome or deep vein thrombosis (DVT), which involves swelling or clot formation in the legs. Neurotrophic ulcers are linked to sensory loss from nerve damage, not pain from calf compression.



References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page, 998-999.

↑ *Back to this question in Part A*

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Q5: A 32-year-old male chronic smoker presents with pain in the fingers for a few months. On examination, gangrenous ulcers were present in the fingers, as shown below. Investigation showed blood glucose and lipid profile within normal limits. Which of the following is the most likely diagnosis? (Q857126)

A. Buerger's disease

B. Diabetic ulcers

C. Acute paronychia

D. Raynaud's phenomenon



Correct Answer: A. Buerger’s disease

Explanation: Buerger’s Disease (Thromboangitis Obliterans) Feature Details Definition Non-atherosclerotic, segmental inflammatory vasculitis affecting small & medium-sized arteries and veins. Etiology Strong association with tobacco use (smoking or chewing). Exact cause unknown (likely immune-mediated). Epidemiology Young males (20–45 years), most commonly smokers. More common in Middle East, South Asia. Pathophysiology Inflammation leads to thrombosis and vascular occlusion. Sparing of proximal arteries (unlike atherosclerosis). Segmental involvement (skip lesions). Clinical Features Claudication, rest pain (foot, hands). Raynaud’s phenomenon (vasospasm causing colour changes in fingers/toes). Ulcers & gangrene (especially in fingers/toes). Migratory superficial thrombophlebitis (inflamed veins). Diagnosis Clinical diagnosis (no specific lab tests). Doppler & Angiography → Corkscrew collateral vessels (pathognomonic). Exclusion of other causes (diabetes, atherosclerosis, vasculitis). Management Complete smoking cessation (most important). Vasodilators (e.g., calcium channel blockers for Raynaud’s). Antiplatelets & anticoagulants (limited benefit). Pain management (NSAIDs, opioids if needed). Amputation (for non-healing ulcers or gangrene). Prognosis Poor if smoking continues but stabilises with smoking cessation. Diabetic ulcers (Option B) Occurs more commonly among patients(both males and females) with diabetes. It is seen more commonly in the foot. Acute paronychia (Option C) This is the most common infection of the hand. It is often caused by careless nail trimming or picking the skin around the nail fold. The pus is trapped beside the nail. Raynaud’s phenomenon (Option D) This phenomenon causes the blood vessels in the extremities to narrow, and it restricts the blood flow. This usually affects the fingers and toes.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1024, 1046

↑ *Back to this question in Part A*

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Q6: What is the probable medical condition for an 80-year-old male who experienced pain and swelling in the calf muscle on the right side after being immobilized due to a fracture in the right inter-trochanteric region? (Q857130)

A. Chronic osteomyelitis

B. Deep vein thrombosis

C. Compartment syndrome

D. Arterial claudication

Correct Answer: B. Deep vein thrombosis

Explanation: The scenario of a patient being immobilised and exhibiting symptoms such as calf swelling and pain strongly indicate the likelihood of DVT. Deep vein thrombosis (DVT) occurs when a blood clot forms in a deep vein, typically in the lower leg, thigh, or pelvis. Symptoms may include pain, swelling, and tenderness in the calf or thigh, along with warm and red skin. Virchow's Triad components - endothelial injury, stasis, and hypercoagulable state - increase the risk of DVT. Chronic osteomyelitis (Option A) The intraosseous blood vessels thrombose, and bone infarcts. Pus lifts the periosteum. To treat osteomyelitis, all dead tissue needs to be removed. If a fracture exists, it needs to be stabilized. Compartment syndrome (Option C) A compartment syndrome develops at any time during the first 48 hours after the accident or surgery. The patient usually complains of severe pain with some numbness in the foot. The foot may be cold still with pulses. Arterial claudication (Option D) Claudication is usually a symptom of peripheral artery disease, in which the arteries that supply blood, usually the legs, are narrowed.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1044.

SRB’s Manual of Surgery, 6th Edition, Page 217

↑ *Back to this question in Part A*

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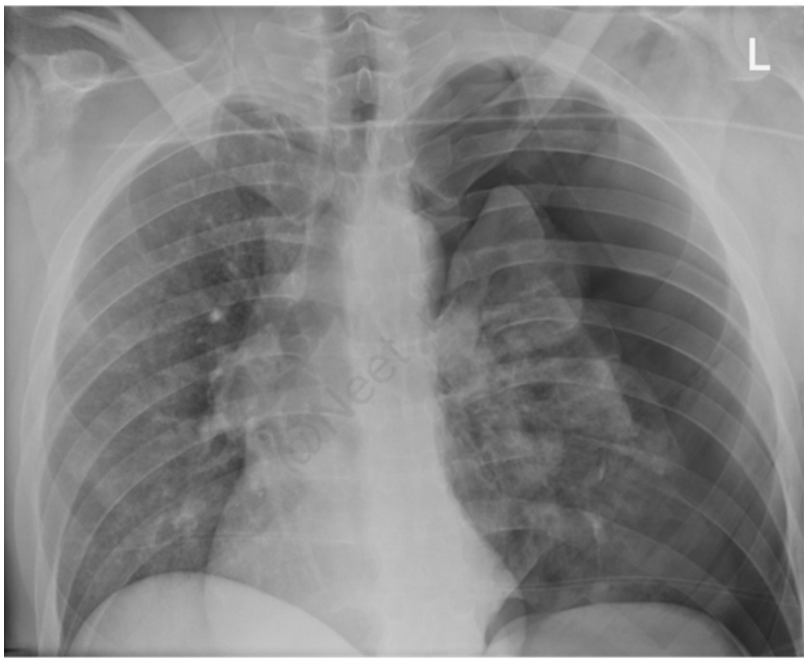
Q7: A 25-year-old male patient involved in a road traffic accident was managed upon arrival at the emergency room, with a respiratory rate of 25 breaths per minute and a blood pressure of 80/45mmHg, and exhibiting hyper-resonance on the left side of the chest, what is the appropriate action based on the findings from the chest x-ray? (Q857456)

A. Wide bore needle insertion in the 2nd ICS

B. Wide bore needle insertion in the 5th ICS followed by an intercostal drain in the 5th ICS

C. Aspiration of the pleural fluid

D. No intervention needed



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Correct Answer: B. Wide bore needle insertion in the 5th ICS followed by an intercostal drain in the 5th ICS

Explanation: The patient shows signs of tension pneumothorax: hypotension, tachypnea, and unilateral hyper-resonance. Immediate decompression is required in adults at the 5th ICS, anterior axillary line. This is followed by definitive intercostal chest drain (ICD) insertion in the triangle of safety. Delay in intervention can lead to cardiovascular collapse and death. Incorrect Options: Option A) Widebore needle in 2nd ICS: Traditional site; less preferred in adults due to higher failure rates. Option C) Aspiration of pleural fluid: Used for simple pleural effusion, not tension pneumothorax. Option D) No intervention: Incorrect; patient is hemodynamically unstable and requires urgent decompression.

References:

Bailey and Love Short Practice of Surgery, 28th Edition, Page 374

↑ *Back to this question in Part A*

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Q8: A patient underwent surgery, for which she was immobilised. Patient started complaining of leg pain on the 5th postoperative day. On examination , Homan’s sign is positive. What is the most probable diagnosis? (Q857539)

A. Deep Venous thrombosis

B. Urinary sepsis

C. Peripheral vascular disease

D. Lymphangitis

Correct Answer: A. Deep Venous thrombosis

Explanation: Based on the information provided, the most probable diagnosis for the patient experiencing leg pain on the 5th postoperative day with a positive Homan's sign is Deep Venous Thrombosis (DVT). Homan's sign refers to calf pain elicited by dorsiflexion of the foot, and it is often associated with DVT. DVT is a condition in which a blood clot forms in a deep vein, commonly in the lower extremities. Immobilization following surgery is a known risk factor for the development of DVT. Other risk factors include a history of DVT, obesity, smoking, and certain medical conditions. Urinary sepsis (Option B) Urinary sepsis typically presents with symptoms such as fever, urinary urgency, and dysuria (painful urination), rather than leg pain. Peripheral vascular disease (Option C) Peripheral vascular disease refers to conditions that affect blood flow to the extremities and may cause pain or cramping during physical activity, but it is less likely to be related to the immobilization following surgery. Lymphangitis (Option D) Lymphangitis refers to the inflammation of lymphatic vessels, which can cause red streaks on the skin and swollen lymph nodes but is less likely to be associated with leg pain in this context. Clinical features of DVT : Clinical Feature Significance Localized tenderness Specific for DVT; indicates inflammation along the vein. Asymmetrical calf swelling Common but not specific to DVT. Erythema and warmth Suggestive of inflammation or thrombosis. Pain in the affected limb Can occur with or without movement; can indicate venous obstruction. Dilated superficial veins May indicate compensatory circulation due to deep venous obstruction. Homans' sign Non-specific; Passive forceful dorsiflexion of the foot with extended knee will cause tenderness in the calf. Mose’s sign Painful response to gentle squeezing of the lower calf from side-to-side. Neuhof's Sign Thickening and deep tenderness in the calf muscles upon palpation. Phlegmasia Alba Dolens DVT of the femoral vein causes painful congestion and edema of the leg with lymphangitis, which further increases edema (white leg). Phlegmasia Caerulea Dolens Extensive DVT in iliac and pelvic veins leading to a blue leg with possible venous gangrene or infarction.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1044.

SRB’s Manual of Surgery, 6th Edition, Page 217

Pratt sign

↑ *Back to this question in Part A*

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Q9: How is empyema thoracis treated? (Q857541)

A. Antibiotics alone

B. Chest tube drainage and antibiotics

C. ICD alone

D. Wait and watch

Correct Answer: B. Chest tube drainage and antibiotics

Explanation: Intercostal Chest Drainage (ICD) + IV Antibiotics is the standard treatment. Chest tube (ICD) removes pus, while broad-spectrum antibiotics (e.g., ceftriaxone + metronidazole or piperacillin-tazobactam) control infection.\ If loculated collections persist, intrapleural fibrinolytics (streptokinase, urokinase) may be needed . Antibiotics alone (Option A) Antibiotics are necessary but not sufficient because pus in the pleural cavity needs mechanical drainage . Without drainage, antibiotics cannot penetrate the thick fibrinous collections , leading to persistent infection. ICD alone (Option C) Drainage without antibiotics will not treat the underlying infection , leading to recurrence and sepsis . Wait and watch (Option D) Empyema needs urgent intervention . Delayed treatment can lead to fibrothorax (thickened pleura), lung entrapment, and sepsis .

References:

Thoracis empyema

↑ *Back to this question in Part A*

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Q10: A man presented with a history of stab injury to the arm. On examination, there was a hematoma, and radial and ulnar pulses were not felt. A 3.5cm longitudinal tear is noted in the brachial artery. Which among the following is the best treatment option? (Q858346)

A. Primary repair with end-to-end anastomosis

B. Repair with great saphenous vein graft

C. Repair with prosthetic graft

D. Repair with saphenous vein patch

Correct Answer: B. Repair with great saphenous vein graft

Explanation: This patient presents with a severe brachial artery injury, causing the absence of radial and ulnar pulses, indicating compromised blood flow to the arm's distal part. Urgent surgical intervention is crucial to restore blood flow and prevent ischemic complications. Using a great saphenous vein graft from the patient's lower extremity is a suitable option for arterial repair, facilitating reestablishment of blood flow and preservation of distal circulation. Primary repair with end-to-end anastomosis (Option A) Primary repair alone may not be feasible or successful in achieving adequate vessel approximation and blood flow restoration. Repair with prosthetic graft (Option C) . Prosthetic grafts can be used for arterial repairs, they are typically reserved for larger vessels or when autologous vein grafts are not available or suitable. In this case, with a 3.5cm tear in the brachial artery, a prosthetic graft may not be the optimal choice. Repair with saphenous vein patch (Option D) : the tear in the brachial artery is longitudinal and 3.5cm in length, which may require a more substantial vascular reconstruction with a graft rather than a patch.

References:

https://pmc.ncbi.nlm.nih.gov/articles/PMC2813640/

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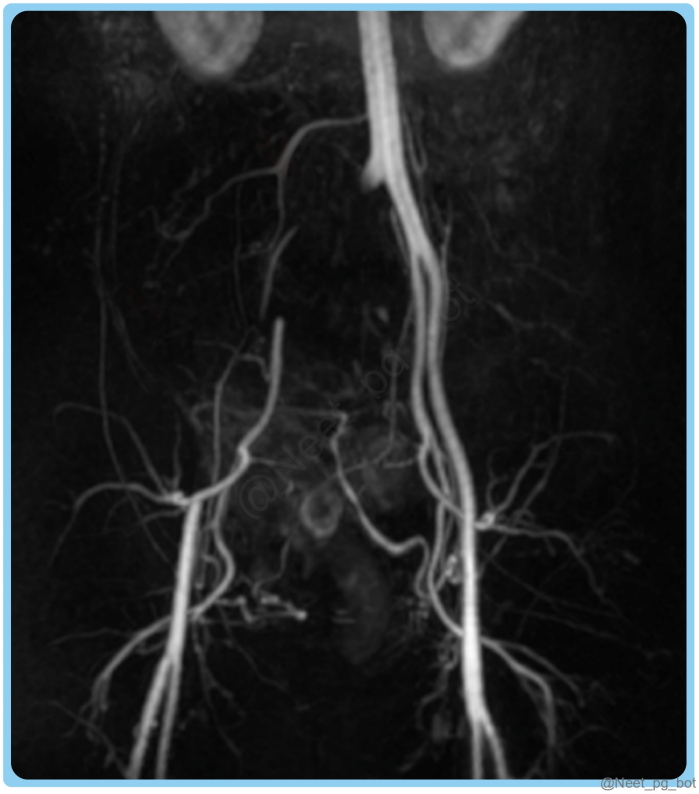
Q11: A 70-year-old female patient presents with pain in the thigh during walking. MRA shows complete long-segment occlusion of the right common iliac artery extending into the proximal external iliac artery, with distal reconstitution through internal iliac collaterals. What is the best surgical management? (Q856200)

A. PTA with stenting

B. Femoroiliac bypass

C. Aortofemoral bypass

D. Aorto-iliac bypass



Correct Answer: C. Aortofemoral bypass

Explanation: The MRA demonstrates complete long-segment occlusion of the common iliac artery extending into the proximal external iliac artery, with distal flow maintained only through collateral circulation . This pattern represents a TASC II C/D aorto-iliac occlusive lesion , for which open surgical reconstruction is the recommended treatment. Aortofemoral bypass provides the most durable long-term patency in extensive aorto-iliac occlusion. PTA with stenting (Option A): Suitable only for short-segment (TASC A/B) lesions. Not appropriate for long, chronic occlusions. Femoroiliac bypass (Option B): Used only when the disease is limited to the distal iliac artery or when the patient cannot undergo aortic surgery. Aorto-iliac bypass (Option D): More commonly used for bilateral aorto-iliac occlusion such as Leriche syndrome. The lesion here is unilateral.

References:

Textbook of SRB's Surgical Operations, 6th Edition, Page 288-294.

↑ *Back to this question in Part A*

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Q12: According to the CEAP classification, What will be the stage in this patient as the patient presents with the same problem again and again? (Q856207)

A. C2

B. C1

C. C4a

D. C5



Correct Answer: A. C2

Explanation: According to the CEAP (Clinical- Etiology- Anatomy- Pathology) , the stage in this case is C2, as the patient is experiencing recurrent symptoms, indicating that varicose veins are likely the underlying cause, which corresponds to stage C2. Feature Classification For clinical classification: No signs of venous disease Telangiectasia (<1 mm) or reticular veins (1-3 mm dilated veins) Varicose veins (>3 mm) Edema Pigmentation or eczema LDS or atrophic blanche Corona phlebectatica Healed venous ulcer Active venous ulcer Clinical class can be further characterised as symptomatic (s), asymptomatic (a) or recurrent following previous successful treatment or healing (r), e.g. C2a, C2s, C6r. C0 C1 (Option B ruled out) C2 (Option A) C3 C4a (Option C ruled out) C4b C4c C5 (Option D ruled out) C6 For etiological classification: Congenital Primary Secondary (post-thrombotic) No venous cause identified Ec Ep Es En For anatomical classification: Superficial veins Perforator veins Deep veins No venous location identified As Ap Ad An For pathophysiological classification: Reflux Obstruction Reflux and obstruction No venous pathophysiology identified Pr Po Pr,o Pn LDS: {{caption_text}} Pigmentation/Eczema: {{caption_text}} Atrophic blanche: {{caption_text}} Corona phlebectatica: {{caption_text}}




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References:

Bailey and Love Short Practice of Surgery, 28th Edition, Page 1030.

CEAP

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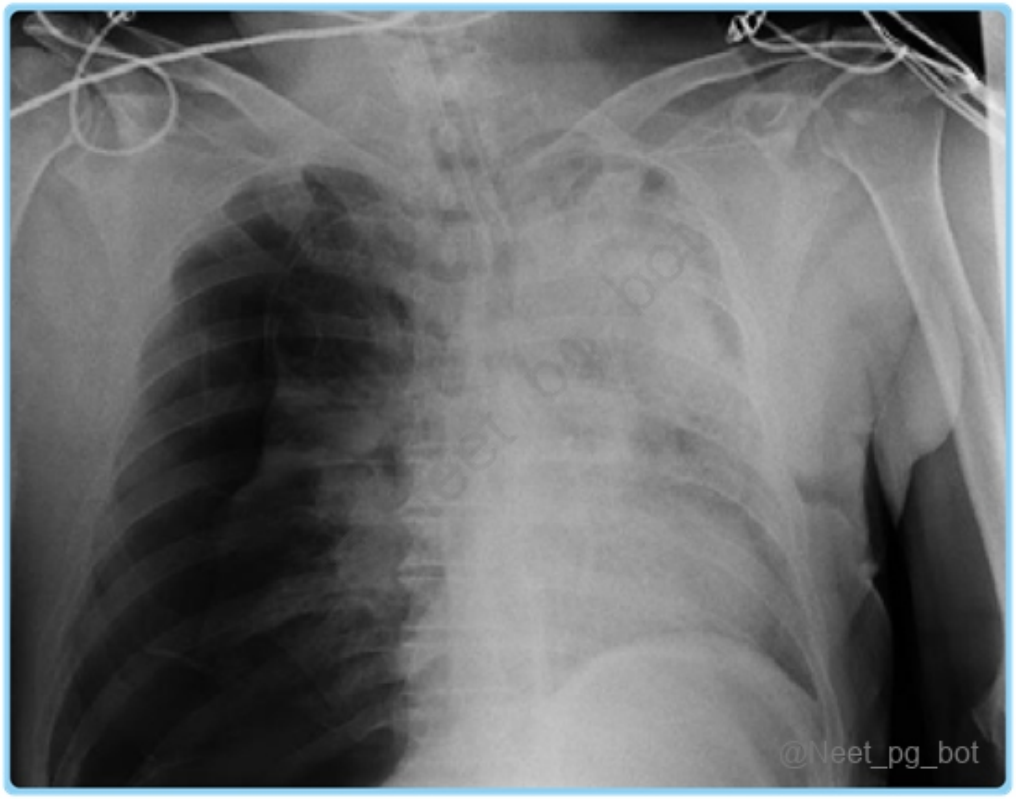
Q13: What is the appropriate course of action for managing a 25-year-old male patient who was brought to the emergency room following a road traffic accident? The patient has a respiratory rate of 25 breaths per minute and a blood pressure of 80/45 mmHg. During examination, hyper-resonance is detected on the right side of the chest. Please refer to the provided chest X-ray for further evaluation. (Q856746)

A. Wide bore needle insertion in the 5th intercostal space (ICS)

B. Wide bore needle insertion in the 5th ICS followed by an intercostal drain in the 5th ICS

C. Aspiration of the pleural fluid

D. No intervention is needed



Correct Answer: B. Wide bore needle insertion in the 5th ICS followed by an intercostal drain in the 5th ICS

Explanation: The patient presents with a traumatic injury after a road traffic accident . His clinical findings, along with the given chest X-ray, are suggestive of tension pneumothorax. A wide bore needle is inserted into the 5th intercostal space at the mid-axillary line to decompress the pleural space and allow the trapped air to escape, which is the first emergency intervention in suspected tension pneumothorax . After the initial needle decompression, the next step is to insert a chest tube (intercostal drain) in the same location to allow for continuous drainage of air or fluid from the pleural space. (Options A & D ruled out) This will help the lung re-expand and prevent the

pneumothorax from recurring. Aspiration of the pleural fluid (Option C) is done for pleural effusion , where fluid accumulates in the pleural space. In this case, the clinical findings suggest pneumothorax , where air is trapped, not fluid. Therefore, aspiration is not the correct approach here.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 374

↑ *Back to this question in Part A*

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Q14: A bus conductor was diagnosed with varicose veins. On examination, skin eczema and lipodermatosclerosis were noted. According to the CEAP classification system, he would be classified as: (Q856753)

A. C1

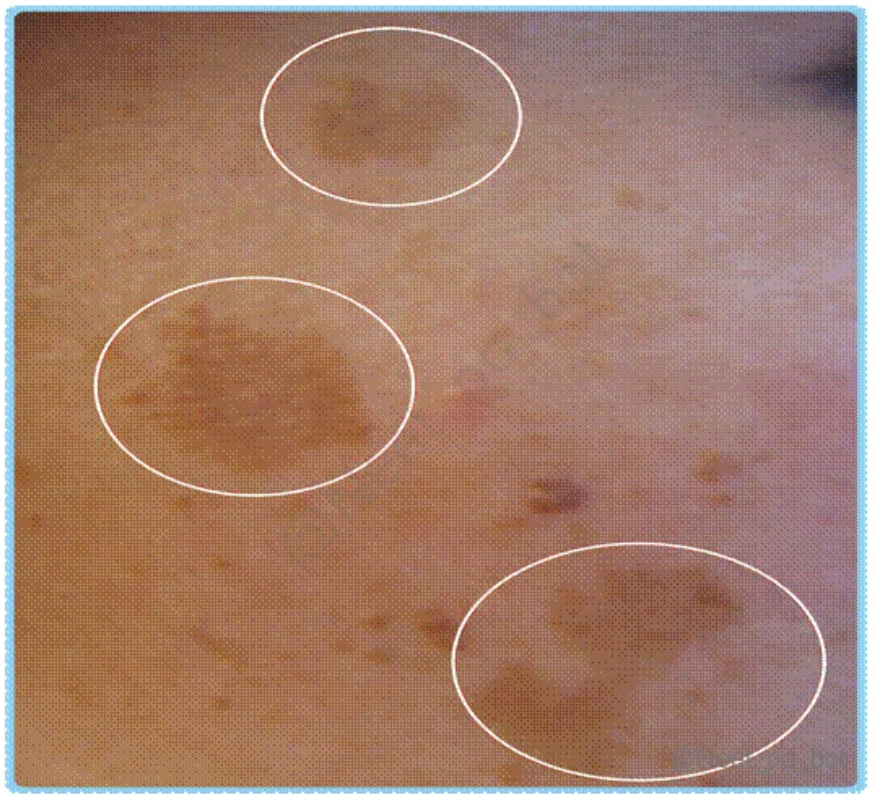
B. C2

C. C3

D. C4

Correct Answer: D. C4

Explanation: In this case, the bus conductor has skin eczema and lipodermatosclerosis , which are indicative of chronic venous insufficiency , hence classified as C4 . The CEAP (Clinical, Etiological, Anatomical, and Pathophysiological) classification system is used to classify chronic venous disorders CEAP (Clinical, Etiological, Anatomical, and Pathophysiological) classification Clinical classification: C0 No signs of venous disease C1 Telangiectasia (<1 mm) or reticular veins (1-3 mm dilated veins) C2 Varicose veins (>3 mm) C3 Edema C4 C4a - Pigmentation or eczema C4b - LDS or atrophic blanche C4c - Corona phlebectatica C5 Healed venous ulcer C6 Active venous ulcer Clinical class can be further characterised as symptomatic (s), asymptomatic (a) or recurrent following previous successful treatment or healing (r), e.g. C2a, C2s, C6r. Etiological classification: Ec Congenital Ep Primary Es Secondary (post-thrombotic) En No venous cause identified Anatomical classification: As Superficial veins Ap Perforator veins Ad Deep veins An No venous location identified Pathophysiological classification: Pr Reflux Po Obstruction Pr,o Reflux and obstruction Pn No venous pathophysiology identified Pigmentation/Eczema: {{caption_text}} LDS: {{caption_text}} Atrophic blanche: {{caption_text}} {{caption_text}}









References:

Bailey and Love's Short Practice of Surgery, 28th Edition, Page 1030

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↑ *Back to this question in Part A*

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Q15: A 40-year-old smoker presents with sudden, severe, tearing chest pain radiating to his back, shortness of breath, and mild nausea. His BP is 190/110 mmHg, and heart rate is 105 bpm. What is the initial management? (Q857860)

A. Control blood pressure

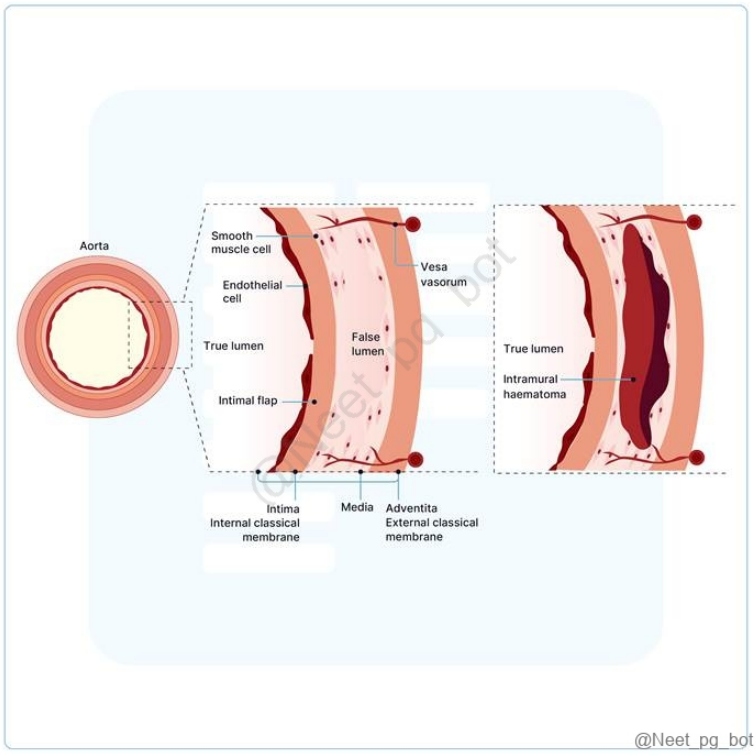
B. Urgent surgery

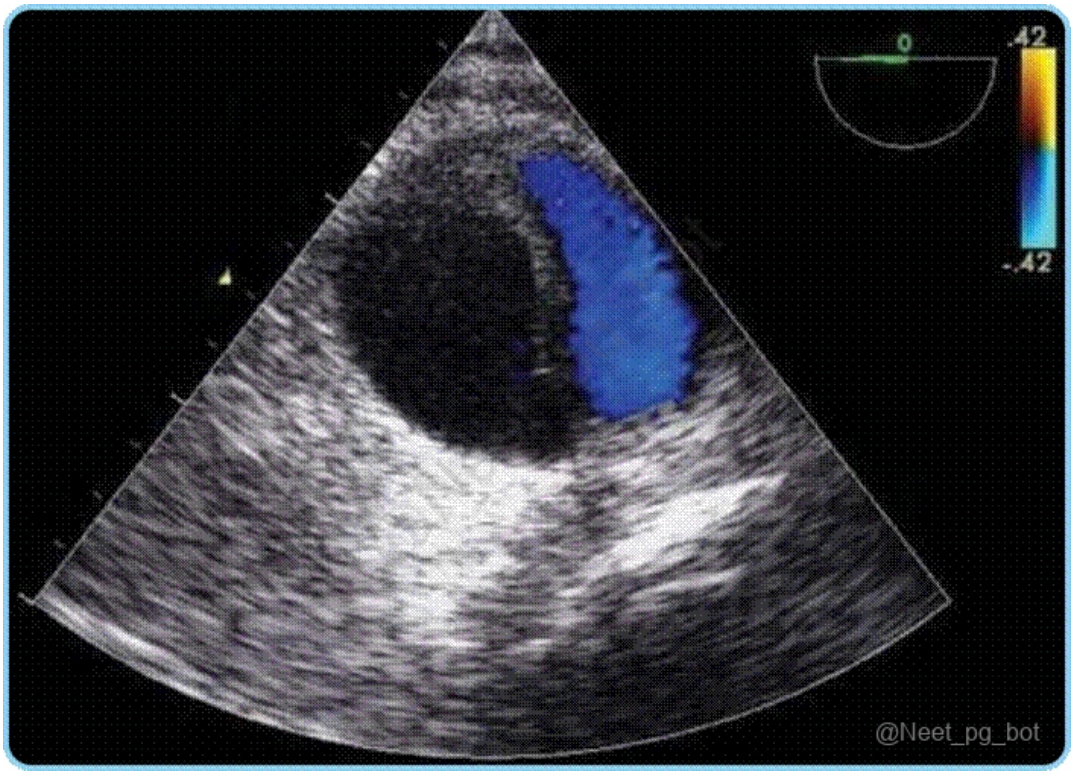
C. Wait and watch

D. Blood transfusion

Correct Answer: A. Control blood pressure

Explanation: The case scenario of a smoker presenting with severe, tearing chest pain radiating to his back, shortness of breath, and mild nausea, along with a BP of 190/110 mmHg and heart rate of 105 bpm, is likely experiencing Aortic Dissection , where the initial management focuses on BP control. It occurs when a defect or a flap occurs in the aorta, resulting in blood tracking into aortic tissues, splitting the medial layer, and creating a false lumen. Clinical features Sudden onset of severe, tearing chest, radiating to the interscapular region Renal pain and renal failure Paraplegia Syncope Weakness Hypotension or shock Investigations Stable Patient: CT angiography is the standard investigation of choice. Unstable Patients (SBP<100 mm of HG, HR>100 bpm) : TEE (TransEsophageal Echocardiography) (preferred investigation of choice) MRI can also be done if CT is unequivocal. Chest x-ray reveals widening of mediastinum along with left-sided pleural effusion {{caption_text}} TEE of an aortic dissection within the descending part Management Initial Management: Initial management of all types of aortic dissection includes: Blood pressure control (which is usually high at presentation) (Option A) Strict pain management, Prompt referral for specialist management Surgical Management Type A (or type I and II) dissections Type B (or type III) dissections Those involving the ascending aorta usually require surgical intervention. Synthetic graft if needed Anastomosis Endovascular stenting of type A dissections. Initial management: Antihypertensive drugs Monitoring on an acute care unit Complicated cases: If pain worsens, fails to resolve, or malperfusion signs appear (e.g., organ, limb, or neurological symptoms) Percutaneous endovascular stents Surgery (rarely used) Urgent surgery (Option B) : Although surgery is often required for aortic dissection, blood pressure control is the initial and most critical step before surgery. Stabilizing the patient with medications like labetalol helps reduce the force on the aorta, preventing further dissection or rupture. Surgery would follow once the patient is stabilized. Wait and watch (Option C) is not an option for aortic dissection. Aortic dissection is a medical emergency that requires immediate intervention. Delaying treatment with a "wait and watch" approach can lead to life-threatening complications, such as rupture or organ failure. Blood transfusion (Option D) may be necessary if there is significant blood loss, but it is not the first line of management for aortic dissection. The priority is stabilizing the patient with blood pressure control to minimize the risk of further dissection or rupture before considering other interventions like a transfusion.





References:

Bailey & Love’s Short Practice of Surgery, 28th Edition, Page, 970-971.

↑ *Back to this question in Part A*

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Q16: What is the most likely diagnosis of the lesion shown in the image below? (Q856766)

A. Arterial insufficiency

B. Neuropathic ulcer

C. Venous ulcer

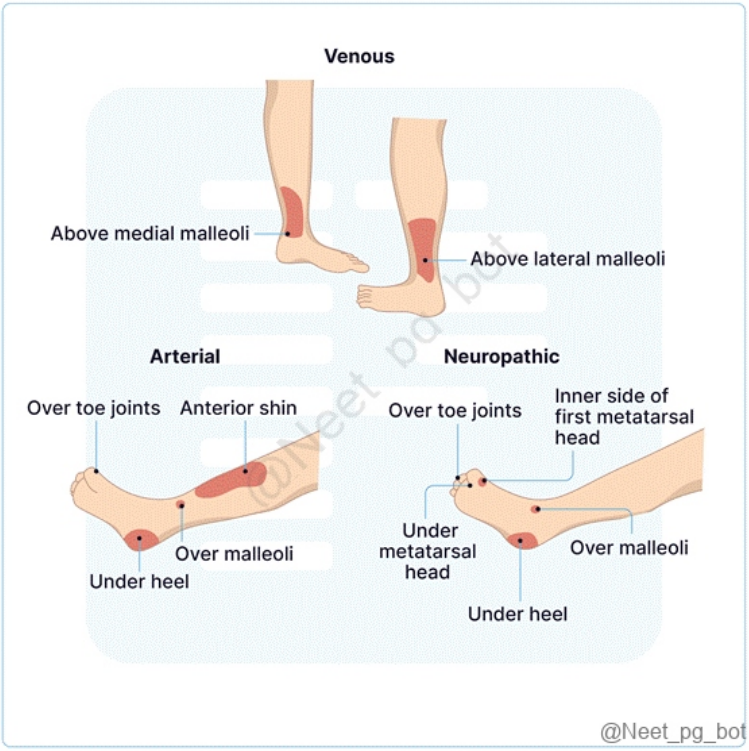
D. Tuberculous ulcer



Correct Answer: B. Neuropathic ulcer

Explanation: The given image is suggestive of a neurogenic ulcer, which is a common type of ulcer seen in individuals with peripheral neuropathy and is often associated with diabetes or other conditions that cause nerve damage. The loss of sensation in the affected area leads to unawareness of trauma or pressure , making individuals more prone to developing these ulcers over time. Non-healing, painless, shallow, and punched-out appearance is characteristic of these ulcers and they commonly appear on weight-bearing areas like the feet or toes because these areas endure the most pressure. Clinical features of different ulcers Features Venous ulcer (Option C) Arterial

ulcer (Option A) Neuropathic ulcer (Option B) Pressure ulcer Site Gaiter's area (area between malleolus and calf) At distal ends of limbs, such as toes, feet and legs. Over toe joints, under the feet, heel, over malleoli, under the metatarsal head, etc Seen over pressure points, most common are ischium, greater trochanter, sacrum, hee, malleolus, occiput, etc Appearance Vertically oval with a sloping edge and will not penetrate deep fascia. Punched-out edges are seen in this type of ulcer. Ulcers can be associated with gangrene and abscesses; osteomyelitis can be seen here. Punched out ulcer with bone as a base. Cause Caused by ambulatory chronic venous hypertension due to varicose veins. This occurs due to severe arterial insufficiency of digital and medium-sized arteries, leading to ischemia and tissue death in the region. It is caused due to repeated trauma and ischemia due to microangiopathy in diabetic patients . It is tissue necrosis and ulceration due to prolonged pressure on any part of the body. Characteristics It is initially painful, then chronically becomes painless. It heals on rest and treatment but reforms again. It is intensely painful; distal pulses are not palpable, and associated with shiny skin, brittle nails and loss of hair over the region. It is also known as diabetic ulcer since it is seen in diabetic patients. It is common in bedridden patients with head injuries, neurological deficits, and comatose and stroke-ridden patients. Tuberculous ulcer (Option D) occurs when tuberculosis affecting the lungs spreads to the skin . This type of ulcer is relatively uncommon but can develop in individuals with advanced or untreated TB. These ulcers typically have distinct characteristics like an undermined edge and necrotic base and may show signs like scarring or lymphadenopathy.



References:

NIHLink,

Bailey & Love's Short Practice of Surgery, 28th Edition, Pages 998, 999

↑ *Back to this question in Part A*

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Q17: Which of the following adverse effects is not observed following a massive blood transfusion? (Q856773)

A. Hypocalcemia

B. Hypercalcemia

C. Hypokalemia

D. Hyperkalemia

Correct Answer: B. Hypercalcemia

Explanation: Hypercalcemia is not commonly seen in massive blood transfusions. In fact, the risk is usually the opposite (hypocalcemia) due to citrate-binding calcium. Massive blood transfusion refers to the transfusion of a large volume of blood products over a relatively short period. While blood transfusions can be life-saving, they can also be associated with certain adverse effects. Complications of massive blood transfusion Complication Cause Effect Hypothermia Transfusion of cold blood (stored at 4°C). Body temperature drops, leading to impaired clotting mechanisms (coagulopathy) and worsening bleeding. Coagulopathy Dilution of clotting factors and platelets due to transfusion; consumption of clotting factors by ongoing haemorrhage. Impaired blood clotting, prolonged bleeding time, increased risk of continued bleeding. Citrate Toxicity Large volumes of transfused blood contain citrate, which binds to calcium. Hypocalcemia leads to muscle cramps, seizures, and cardiac arrhythmias. Hypocalcemia (Option A ruled out) Packed red blood cells (PRBCs) and other blood products are preserved with citrate , an anticoagulant. Citrate binds to ionised calcium (Ca^{2}■) in the recipient's blood, reducing the free calcium level - hypocalcemia Presents as muscle spasms, cardiac arrhythmias, and decreased myocardial contractility Hyperkalemia (Option D ruled out) Potassium leaks from stored red blood cells into plasma during storage. Elevated potassium levels (hyperkalemia) can cause cardiac arrhythmias, potentially leading to cardiac arrest. Hypokalemia (Option C ruled out) Potassium may shift intracellularly once transfused red blood cells are metabolically revived. Hypokalemia, causing muscle weakness, paralysis, and cardiac arrhythmias. Metabolic Alkalosis Rapid metabolism of citrate into bicarbonate. Increased pH (alkalosis) can lead to muscle twitching, irritability, and impaired oxygen release from haemoglobin. Metabolic Acidosis Inadequate tissue perfusion leads to lactic acid accumulation. Lowered blood pH (acidosis) leads to confusion, fatigue, rapid breathing, and worsened cardiovascular function. Transfusion Related Acute Lung Injury (TRALI) Antibodies in transfused blood activate the recipient's immune response, causing inflammation and fluid buildup in the lungs. Non-cardiogenic pulmonary oedema, presenting as acute respiratory distress with hypoxia within 6 hours of transfusion. Transfusion Associated Circulatory Overload (TACO) Volume of transfused blood exceeds the patient’s capacity to manage, leading to fluid overload. Pulmonary edema, shortness of breath, hypertension, and signs of heart failure. Iron Overload Repeated transfusions lead to excessive accumulation of iron. Iron deposits in organs (e.g., liver, heart, pancreas), lead to organ damage and failure over time. Hemolytic Reactions ABO or Rh incompatibility. Rapid destruction of red blood cells (hemolysis), causing fever, chills, hemoglobinuria, and potentially acute renal failure or shock. Allergic Reactions Reaction to proteins in transfused blood products. Symptoms range from mild itching, rash, or hives to severe anaphylaxis (airway constriction, low blood pressure, shock). Bacterial Contamination Blood products are contaminated during collection or storage. Sepsis is characterized by fever, chills, low blood pressure, and possibly septic shock.

References:

Harrison's Principles of Internal Medicine, 21st Edition, Pages 888 - 896,

Davidson's Principles and Practice of Medicine, 24th Edition, Pages 931 - 934,

NIHLink.

↑ *Back to this question in Part A*

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Q18: A 55-year-old man with IHD presents with sudden, severe, generalised abdominal pain and multiple episodes of vomiting. On examination, the pulse rate is 118 bpm, rhythm is irregularly irregular, and BP is 90/60 mmHg. The abdomen appears soft and non-distended, and bowel sounds are absent. Which of the following could be a likely diagnosis in this case? (Q856298)

A. Acute severe pancreatitis

B. Ruptured aortic aneurysm

C. Acute mesenteric ischemia

D. Peptic ulcer perforation

Correct Answer: C. Acute mesenteric ischemia

Explanation: Acute mesenteric ischemia is the most likely diagnosis due to the patient's risk factors (IHD), sudden onset of severe abdominal pain, vomiting, hypotension, and absent bowel sounds. This condition is caused by a reduction or cessation of blood flow to the intestines, leading to tissue ischemia. Acute mesenteric ischemia Aspects Description Definition Sudden reduction in blood supply to the intestines, leading to ischemia and potential necrosis. Commonly involves the Superior mesenteric artery (SMA). Clinical Features Pain: Severe, sudden-onset abdominal pain disproportionate to physical findings. Others: Nausea, vomiting, diarrhea, bloody stools, shock. Risk Factors Cardiovascular: Atrial fibrillation, recent MI, heart failure. Vascular: Atherosclerosis, vasculitis. Others: Hypercoagulable states. Radiological Features CT Angiography: Preferred diagnostic tool; reveals SMA occlusion, String of sausage sign , bowel wall thickening, pneumatosis intestinalis, portal venous gas. {{caption_text}} Management Initial: IV fluids, broad-spectrum antibiotics, pain control. Definitive: Anticoagulation (e.g., IV heparin), surgical embolectomy, bowel resection. Vasodilators (e.g., papaverine) can be used intra-arterially to relieve vasospasm. Acute severe pancreatitis (Option A) presents with severe epigastric pain that can radiate to the back, but not generalised abdominal pain. The patient also often has elevated pancreatic enzymes (amylase/lipase), and abdominal tenderness would usually be present. The absence of bowel sounds and the patient's cardiac symptoms are suggestive of acute mesenteric ischemia. Ruptured aortic aneurysm (Option B) is a life-threatening condition that causes severe, tearing abdominal pain and sudden, severe hypotension. This patient lacks key signs like a pulsatile mass, significant tenderness, or acute collapse, making it less likely. Peptic ulcer perforation (Option D) presents with acute abdominal pain, tachycardia, guarding and rigidity of the anterior

abdominal wall, it can lead to peritonitis and sepsis. The soft, non-distended abdomen in this case and the absence of these physical findings suggest this is less likely.



References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Pages 1312, 1313.

↑ *Back to this question in Part A*

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Q19: What is the management approach for a 50-year-old male patient who has a 40 mm abdominal aortic aneurysm detected during his routine annual checkup? (Q854937)

A. Urgent endovascular aneurysm repair

B. Surgery is indicated if the aneurysmal diameter is > 55mm

C. Urgently wheel the patient to OT for surgery

D. Surgery is indicated only if the aneurysm is > 77mm

Correct Answer: B. Surgery is indicated if the aneurysmal diameter is > 55mm

Explanation: According to guidelines, surgery is generally recommended for abdominal aortic aneurysms greater than 5.5 cm (55 mm) in diameter. Management of abdominal aortic aneurysm depends on the aneurysm size, symptoms, and patient's condition. A 40 mm abdominal aortic aneurysm (AAA) is considered smaller than the threshold for surgical intervention. (Option A ruled out) . Management of Abdominal Aortic Aneurysm (AAA) Aspect Details Surveillance Small AAAs (3.0–3.9 cm): Monitor every 2–3 years using ultrasound. Medium AAAs (4.0–5.4 cm): Monitor every 6–12 months with ultrasound. Large AAAs (≥5.5 cm): Surgical intervention recommended; if not, frequent imaging and clinical review. Medical Management Risk Factor Modification : Smoking Cessation Blood Pressure Control Cholesterol Management: Statins recommended. Surgical Intervention (Option C & D ruled out) I ndications for Surgery: Aneurysm Diameter ≥ 55 mm (High risk of rupture) Rapid Growth: > 5 mm increase in six months. Symptomatic AAAs : Consider surgery. Surgical Options : Open Surgical Repair: Using a Dacron graft, which is durable and has higher morbidity. Endovascular Aneurysm Repair (EVAR): Less invasive, requires long-term surveillance for complications.

References:

Sabiston, Text Book of Surgery, 21st Edition, Pages 1747 - 1751

↑ *Back to this question in Part A*

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Q20: Which of the following statements regarding intermittent claudication is accurate? (Q854944)

A. Felt at rest

B. Most commonly felt in the calf muscles

C. Day-to-day distance is variable

D. Relieved after getting out of bed

Correct Answer: B. Most commonly felt in the calf muscles

Explanation: - Most commonly felt in the calf muscles: Intermittent claudication is a condition caused by peripheral arterial disease (PAD) , which leads to insufficient blood flow to the muscles, particularly during exercise or physical exertion. The pain is typically muscle pain , cramping , or aching , and it most commonly affects the calf muscles because of their large muscle mass and high demand for oxygen during activity. The pain occurs with activity and is relieved by rest . (Options A & D ruled out) Boyd's classification of intermittent claudication : Grade Description Grade 0: Asymptomatic No symptoms of claudication, even with exercise Grade I: Mild claudication Able to walk more than 200 meters (about 650 feet) before onset of symptoms Grade II: Moderate claudication Able to walk between 50 and 200 meters (about 160 to 650 feet) before onset of symptoms Grade III: Severe claudication Able to walk less than 50 meters (about 160 feet) before onset of symptoms Grade IV: Ischemic rest pain Pain occurs at rest or with minimal exertion Day-to-day distance is variable (Option C) and

is incorrect because the distance a person can walk before pain sets in is usually fairly consistent over time in intermittent claudication.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Pages 998, 999, NIH Link

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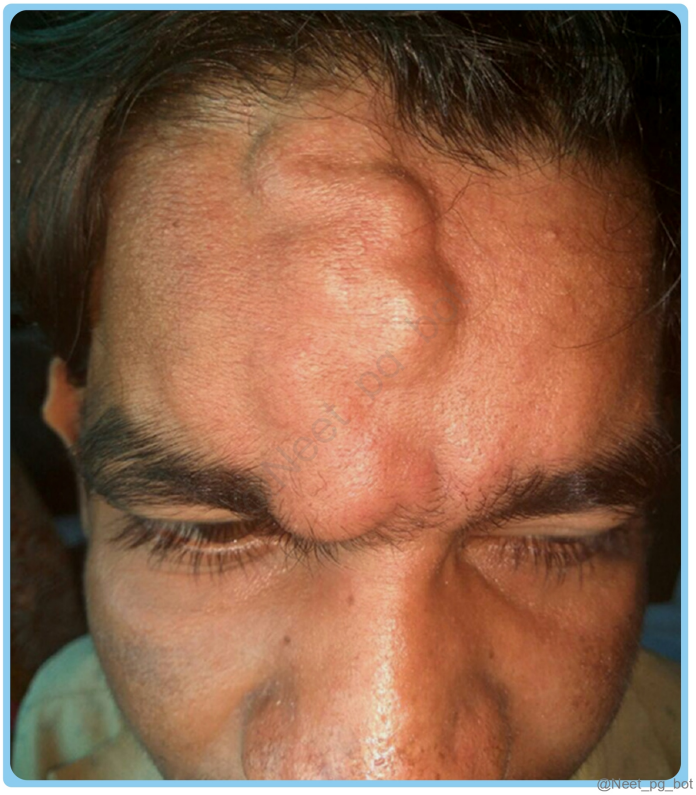
Q21: What is the most probable diagnosis for a 41-year-old female patient who presented with a twisted swelling on the scalp and face, accompanied by a pulsating sensation and a bruit heard during auscultation? (Q854947)

A. Neurofibromatosis

B. Liposarcoma

C. Cirsoid Aneurysm

D. Varicocele



Correct Answer: C. Cirsoid Aneurysm

Explanation: In this case, the most likely diagnosis is a cirsoid aneurysm , given the pulsatile swelling, the bruit heard on auscultation, and the location of the lesion (scalp/face). It is a vascular malformation characterised by abnormal communication between arteries and veins, leading to variceal dilatation of the draining veins . This results in a pulsatile swelling, often associated with a palpable thrill and an audible bruit, which are hallmark signs of this condition. The mass in a cirsoid aneurysm can cause cosmetic concerns and may also lead to local pain , headache , tinnitus , and hemorrhage . Treatment for cirsoid aneurysm typically involves surgical fistula repair through simple ligation or endovascular embolisation techniques (using coils or cyanoacrylate). In some cases, gross total resection by a plastic surgery team is also done. Neurofibromatosis (Option A) is benign nerve sheath tumours (neurofibromas) that may present as skin nodules or masses. These tumours would not produce the characteristic pulsatile swelling or bruit associated with a cirsoid aneurysm. Liposarcomas (Option B) are malignant tumours of the adipose tissue . They can cause swelling or mass, but unlike a cirsoid aneurysm , they do not present with a pulsatile sensation or an audible bruit . Varicocele (Option D) is a condition characterised by the enlargement of veins within the scrotum, commonly occurring on the left side. It is not relevant to the case presented, as the description mentions a tortuous swelling over the left side of the scalp and face, not the scrotum.

References:

NIH Link

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Q22: According to the TNM staging, a patient with lung cancer of size 2.5 cm is staged as: (Q854986)

A. T1b

B. T1c

C. T2a

D. T1a

Correct Answer: B. T1c

Explanation: Given that the tumour size is 2.5 cm , it falls under T1c (as it is > 2 cm but ≤ 3 cm). AJCC 8TH Edition of TNM Staging of Lung Carcinoma Primary Tumor (T) T1 T1a(mi) Minimally invasive carcinoma T1a ≤ 1 cm (Option D ruled out) T1b 1 - 2 cm (Option A ruled out) T1c 2 - 3 cm T2 Involvement of the main bronchus with the involvement of carina Involvement of visceral pleura Association with atelectasis or obstructive pneumonitis T2a 3 - ≤4 cm (Option C ruled out) T2b 4 - ≤5 cm T3 > 5 - ≤7 cm OR Direct invasion of the Chest wall, Phrenic nerve, Pericardium, (Or) Satellite nodules in the same lobe T4 > 7 cm in greatest dimension (Or) Any tumour with invasion of the mediastinum, diaphragm, heart, great vessels, recurrent laryngeal nerve, carina, trachea, oesophagus, spine (Or) Separate tumours in different lobes of the ipsilateral lung. Lymph Node (N) N1 Ipsilateral peribronchial and/or hilar nodes and intrapulmonary nodes N2 Ipsilateral mediastinal and/or subcarinal nodes N3 Contralateral mediastinal or hilar; ipsilateral/contralateral scalene/supraclavicular Distant Metastasis

(M) M1 Distant metastasis M1a Tumor in contralateral lung or pleural/pericardial nodule/malignant effusion M1b Single extrathoracic metastasis, including single non-regional lymph node M1c Multiple extrathoracic metastases in one or more organs

References:

Harrison's Principles of Internal Medicine 21st Edition, Page 601

↑ *Back to this question in Part A*

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Q23: Which of the following is not a component of Thoracoscore? (Q855018)

A. Performance status

B. Complication of surgery

C. ASA grading

D. Priority of surgery

Correct Answer: B. Complication of surgery

Explanation: The Thoracoscore is a risk assessment tool used to evaluate the operative risk in patients undergoing thoracic surgery , but complications of surgery are not a component of it. The components of thoracoscore are: Age: <55 years, 55-65 years, >65 years Sex ASA Classification: ≤2, ≥3 (Option C ruled out) Performance status (Zubrod scale): ≤2, ≥3 (Option A ruled out) Severity of dyspnea (Medical Research Council Scale): ≤2, ≥3 Surgery Priority: Elective, Urgent/Emergency (Option D ruled out) Extent of resection: Pneumonectomy, Other Diagnosis: Malignant, Benign Comorbidity score

References:

NIH Link

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Q24: What is the probable diagnosis for a 50-year-old male who is a long-term smoker and experiences pain in both thighs and buttocks while walking approximately 500 meters? (Q858494)

A. Arterial disease involving the superficial femoral artery

B. Arterial disease with aortoiliac involvement

C. Femoral venous insufficiency

D. Arterial disease involving the profunda femoris artery

Correct Answer: B. Arterial disease with aortoiliac involvement

Explanation: Given the bilateral claudication affecting the thighs and buttocks, along with the patient's smoking history, the most probable diagnosis is arterial disease with aortoiliac involvement. The muscle group affected in claudication is one anatomical level below the level of arterial disease. Aortoiliac disease typically presents with bilateral symptoms such as pain in the buttocks , thighs , and sometimes the calves , which worsens with exertion. The pain is due to claudication caused by reduced blood flow to the lower extremities due to atherosclerosis or stenosis, commonly associated with chronic smoking. Arterial disease involving the superficial femoral artery (Option A) generally causes pain in the calf , not the thighs or buttocks , and it usually affects one leg, not both. Therefore, the bilateral nature of the pain makes this diagnosis less likely. Femoral venous insufficiency (Option C) presents with swelling & varicose veins rather than claudication pain. The pain described here is intermittent and related to exertion, which is more typical of arterial disease, not venous insufficiency. Arterial disease involving the profunda femoris artery (Option D) would lead to pain in the thigh (and possibly one leg), not typically in both the thigh and buttock . Also, the pattern of bilateral pain favours the involvement of aortoiliac vessels .

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1024

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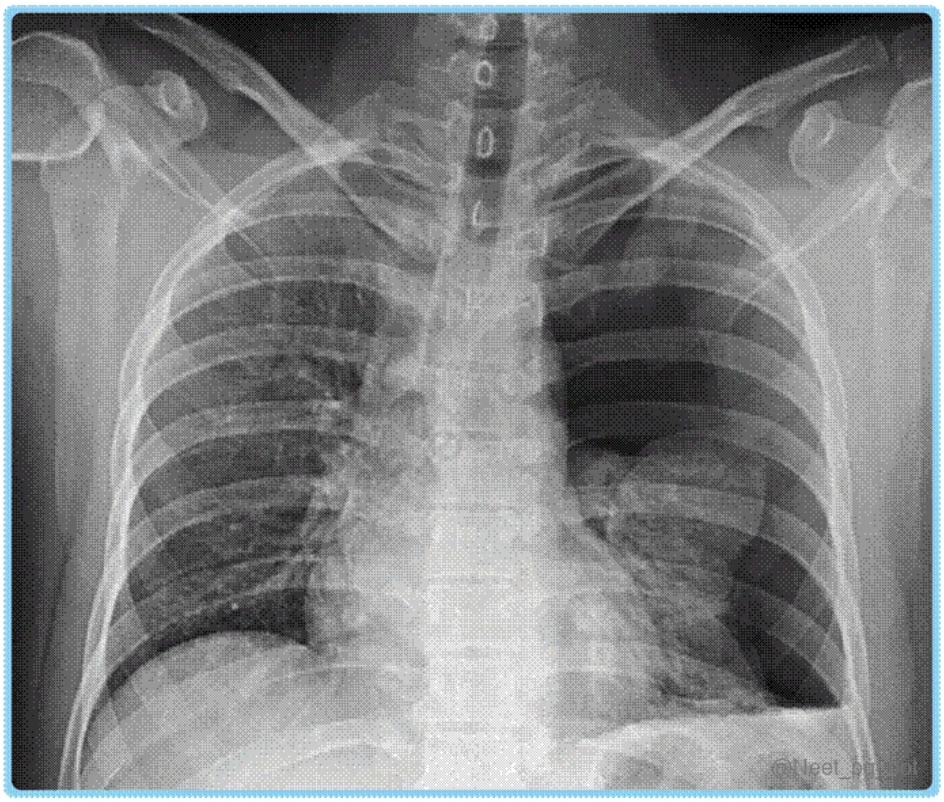
Q25: What would be the appropriate course of action for managing a 25-year-old male patient who was brought to the emergency department after a road traffic accident (RTA)? The patient has a respiratory rate of 25 breaths per minute and a blood pressure of 80/45 mmHg. During examination, hyper-resonance is detected over the left side of the chest. The provided chest x-ray is shown below. (Q859600)

A. Wide bore needle insertion in the right 5th ICS

B. Wide bore needle insertion in the left 5th ICS followed by an intercostal drain

C. Aspiration of the pleural fluid

D. No intervention is needed



Correct Answer: B. Wide bore needle insertion in the left 5th ICS followed by an intercostal drain

Explanation: The patient presents with a traumatic injury after a road traffic accident ; his clinical findings, along with the given chest X-ray suggest tension pneumothorax. A wide bore needle is inserted into the 5th intercostal space at the mid-axillary line to decompress the pleural space and allow the trapped air to escape, which is the first emergency intervention in suspected tension pneumothorax . After the initial needle decompression, the next step is to insert a chest tube (intercostal drain) in the same location to allow for continuous drainage of air or fluid from the pleural space. (Options A & D ruled out) This will help the lung re-expand and prevent the pneumothorax from recurring. Aspiration of the pleural fluid (Option C) is done for pleural effusion , where fluid accumulates in the pleural space. In this case, the clinical findings suggest pneumothorax , where air is trapped, not fluid. Therefore, aspiration is not the correct approach here.

References:

Bailey & Love’s Short Practice of Surgery, 28th Edition, Page 374

↑ *Back to this question in Part A*

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Q26: A male patient presents with impotence and absent femoral pulse. The pain in the gluteal region is observed. At which level has the pathology occurred? (Q855764)

A. Bilateral popliteal arteries

B. Bilateral internal iliac arteries

C. Aortoiliac bifurcation

D. Bilateral femoral arteries

Correct Answer: C. Aortoiliac bifurcation

Explanation: Aortoiliac bifurcation pathology is the most likely cause of the combination of symptoms described. Leriche's syndrome refers to a specific form of aortoiliac occlusion that results from the blockage or narrowing of the aortoiliac bifurcation , leading to reduced blood flow to the lower limbs and pelvic organs. Clinical features of this syndrome include: Impotence Claudication Absent femoral pulses Gluteal pain Vessels involved and common sites of obstruction (in Atherosclerosis) Vessel Common Sites of Obstruction Related Manifestations/Findings Aorta Infrarenal aorta Bilateral lower limb ischemia, absent femoral pulses Iliac arteries Common iliac bifurcation Unilateral lower limb ischemia, absent femoral pulse. Pain in the buttock is due to a block in the common iliac or aortoiliac segment (30%), often associated with impotence and is called Leriche's syndrome. Femoral artery (Option D ruled out) Common femoral artery Calf claudication, absent popliteal and distal pulses Popliteal artery (Option A ruled out) Adductor canal Calf and foot ischemia, absent pedal pulses Tibial arteries Proximal or mid-calf Foot ischemia, absent pedal pulses Subclavian artery Proximal subclavian Arm ischemia, absent radial/ulnar pulses. Subclavian steal syndrome: Obstruction of the first part of the subclavian artery can cause reverse blood flow through the vertebral artery, providing collateral circulation to the arm but affecting the posterior brain and upper limb, with steal being occult, partial, or complete. Brachial artery Mid-humerus level Forearm and hand ischemia, absent radial/ulnar pulses Bilateral internal iliac arteries (Option B) can lead to impotence and pain in the gluteal region, but they do not cause the absence of a femoral pulse.

References:

Bailey & Love’s Short Practice of Surgery, 28th Edition, page 1024

NIHLink.

↑ *Back to this question in Part A*

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Q27: A patient presents with a tender pulsatile mass, as shown in the image below. What will be done next for this patient? (Q855769)

A. Ultrasound Doppler

B. Needle aspiration

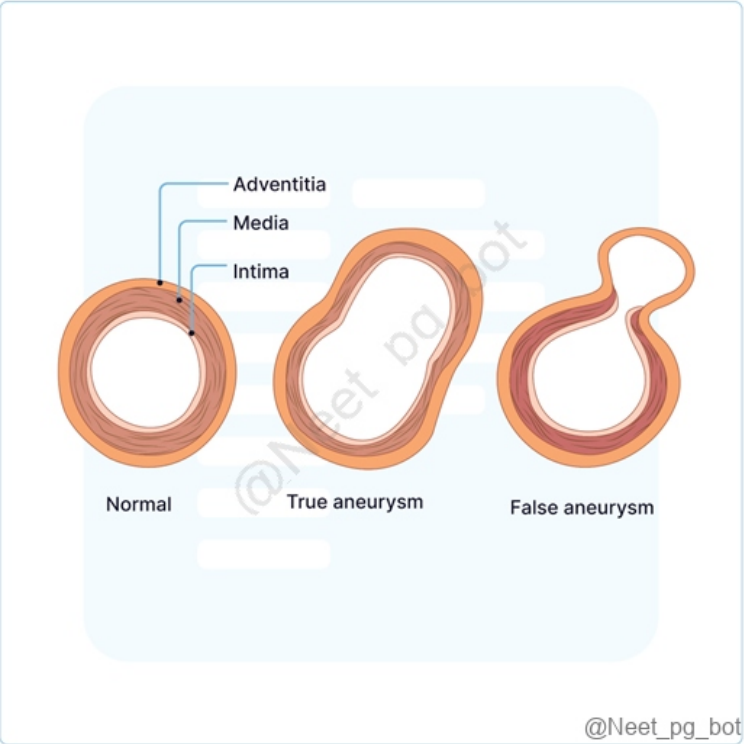
C. CT angiogram with percutaneous management

D. Intravenous antibiotics for 7 days



Correct Answer: A. Ultrasound Doppler

Explanation: A tender pulsatile mass is typically suggestive of an arterial aneurysm, and to assess the nature of the mass and its underlying cause, an Ultrasound Doppler is the most appropriate initial diagnostic test. Ultrasound Doppler is a non-invasive imaging technique that allows evaluation of blood flow and vessel structure, and it can differentiate between a true aneurysm and a pseudoaneurysm. Aspect True Aneurysm False (Pseudoaneurysm) Definition Involves all three layers of the arterial wall. Involves only a layer of fibrous tissue outside the vessel. Wall Structure Intima, media, and adventitia are involved. Only fibrous tissue surrounds the breach. Morphology Fusiform or saccular. Typically spherical or ovoid. Aetiology Atherosclerosis, genetic conditions. Trauma, surgery, or arterial puncture. Clinical Features May be asymptomatic until complications arise. Often presents with a pulsatile mass or pain. Common Locations Large arteries (e.g., aorta, iliac). Peripheral arteries (e.g., femoral, popliteal). Diagnosis Detected by ultrasound, CT, and MRI. Detected by ultrasound or angiography. Management Surgical repair or endovascular techniques. Repair or percutaneous methods (e.g., thrombin injection). Needle aspiration (Option B) is typically used for fluid collections (e.g., abscesses or cysts) and is not suitable for pulsatile masses that are suspected to be related to vascular conditions like aneurysms or pseudoaneurysms. Aspiration would not provide useful information for such vascular masses, and bleeding could possibly worsen if the mass is an aneurysm. CT angiogram with percutaneous management (Option C) may be necessary for detailed evaluation and treatment of vascular abnormalities, but it is not the first step in diagnosis. An ultrasound Doppler is done first because it is less invasive and can quickly confirm or rule out a vascular abnormality. Intravenous antibiotics for 7 days (Option D) are appropriate for treating infections like abscesses or cellulitis but would not be the correct treatment for a pulsatile mass, which suggests a vascular etiology rather than infection.



References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Pages 1005,1017-1024

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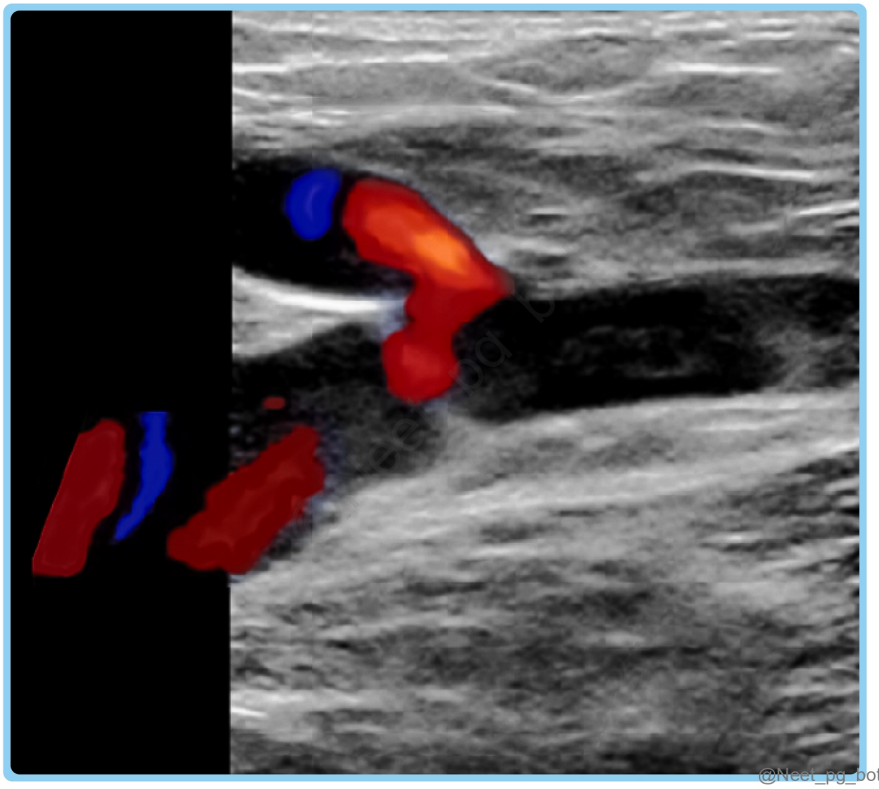
Q28: A patient presents with sudden onset right leg pain. An investigation was done, and the obtained image is shown below. What is the investigation? (Q855821)

A. Digital subtraction angiography

B. Ultrasound Doppler

C. MR angiography

D. Plethysmography



Correct Answer: B. Ultrasound Doppler

Explanation: The investigation performed here is an Ultrasound Doppler , which is commonly used to evaluate blood flow and detect vascular occlusion or stenosis in peripheral arteries. It provides a non-invasive method to assess blood flow through the arteries and veins, helping to identify thrombosis, embolism , or vascular abnormalities . In the case of acute leg pain, a Doppler ultrasound can quickly identify whether there is a blockage in the femoral, popliteal, or tibial arteries , which would be consistent with acute limb ischemia . Other options: Digital subtraction angiography (Option A) is an invasive imaging technique used to visualise blood vessels, typically in the case of suspected complex vascular abnormalities or prior to interventional procedures like angioplasty or stent placement . DSA is not typically used as the first-line diagnostic tool in cases of acute leg pain. MR angiography (Option C) is a non-invasive imaging technique that uses MRI to visualize blood vessels and assess for blockages or aneurysms . While MRA is useful for evaluating vascular disease, it is often reserved for more complex cases as it may be less available and more time-consuming than CT angiography. Plethysmography (Option D) is a non-invasive test that measures changes in blood volume in an organ or limb to assess circulation. It is not typically used as the first-line investigation for acute limb pain.

References:

NIH Link .

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Q29: A 39-year-old male who had a road traffic accident and suffered from chest trauma was admitted to the ER. About 1800 ml of blood loss from the chest tube in an hour. What is the next step in management for this condition? (Q820129)

A. Emergency Thoracotomy

B. Conservative for next 6-hours

C. Continue resuscitation

D. Wait & watch

Correct Answer: A. Emergency Thoracotomy

Explanation: Correct Option A - Emergency Thoracotomy: In a case where a 39-year-old male has suffered chest trauma with heavy bleeding in the lungs and significant blood loss (1800 ml) from the chest tube in an hour, an emergency thoracotomy is the appropriate next step. A thoracotomy involves making an incision into the chest wall to access the thoracic cavity. This procedure allows direct control of bleeding, repair of injuries, and potential life-saving measures. Given the severity of the situation and the rapid blood loss, immediate surgical intervention is necessary. Incorrect Options: Option B - Conservative for next 6 hours: Conservative management involves monitoring and treating the patient without immediate surgical intervention. However, in a case of heavy bleeding with ongoing blood loss, waiting for 6 hours is not appropriate. This delay could lead to further deterioration and worsening of the patient's condition. Option C - Continue resuscitation: While resuscitation is important, in a situation with significant and ongoing blood loss as described, simply continuing resuscitation without addressing the underlying cause (bleeding) may not be effective. Direct intervention to control the bleeding is crucial. Option D - Wait & watch: Waiting and watching the patient's condition without taking immediate action to control the bleeding could be dangerous in this scenario. The patient is actively bleeding with a large volume of blood loss, which requires prompt intervention to stabilize their condition.

References:

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↑ *Back to this question in Part A*

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Q30: A 30-year-old male presented to EMT with H/o Penetrating chest trauma. On examination, severe tracheal deviation was present. What is the immediate step of management? (Q866927)

A. Needle decompression

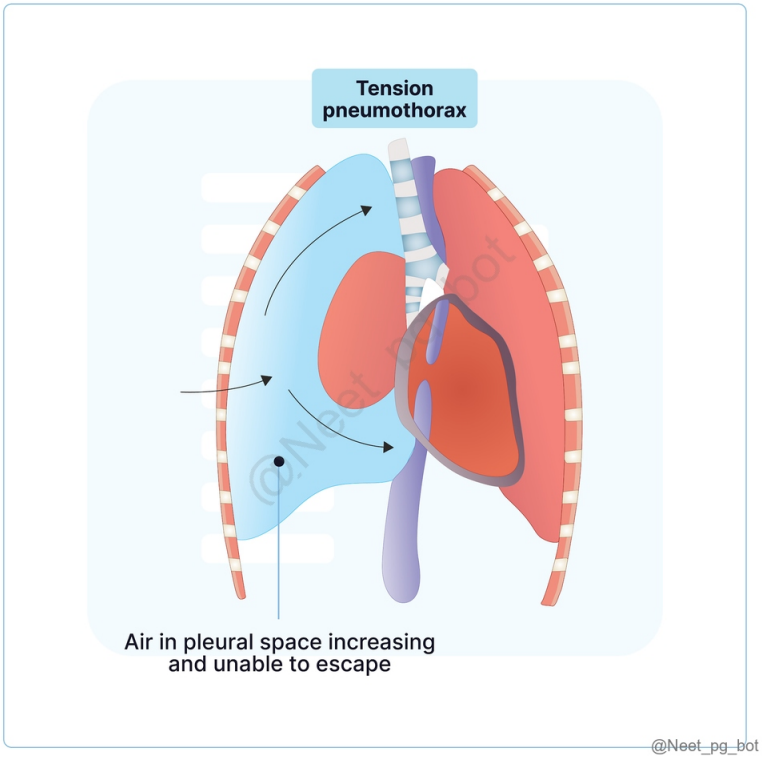
B. Chest X-ray

C. E-FAST

D. O2 support at 100%

Correct Answer: A. Needle decompression

Explanation: History of penetrating trauma, severe tracheal deviation after chest trauma strongly suggests tension pneumothorax. Tension pneumothorax is a life-threatening emergency caused by one-way air entry into the pleural space, leading to: Increased intrathoracic pressure → collapse of the ipsilateral lung → pushes mediastinum away from affected side. Mediastinal shift → compression of the opposite lung and major vessels Obstructive shock → ↓ venous return, ↓ cardiac output Do NOT wait for imaging like CXR or E-FAST; immediate decompression is required. Needle decompression → large-bore cannula into the 5th intercostal space (mid-axillary line), followed by ICD (chest tube) placement. Incorrect Options: Chest X-ray (Option B) – Imaging delays life-saving intervention; done after stabilizing the patient. E-FAST (Option C) – Bedside ultrasound is useful in trauma, but here the diagnosis is clinical, and urgent treatment is the priority. O■ support at 100% (Option D) – Oxygen is supportive but will not relieve the life-threatening pressure in the pleural space.



References:

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↑ *Back to this question in Part A*

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Q31: In a chronic limb ischemia patient, what is the ABI below which gangrene is imminent: (Q865388)

A. 0.5

B. 0.3

C. 0.9

D. 1

Correct Answer: B. 0.3

Explanation: An Ankle Brachial Index < 0.3 indicates an imminently threatened leg and requires urgent vascular assessment/revascularisation to prevent major amputation. Chronic Limb Threatening Ischemia (CLTI) is defined as rest pain or tissue loss (ulcers, or gangrene) supported by ischemia defined by the hemodynamic criteria of low ankle or toe pressures, or low transcutaneous oxygen (TcO2) values. Ankle pressure criteria range from less than 40–70mmHg, toe pressures less than 30–50mmHg, TcO2 less than 20–40mmHg. CLTI is assessed by measuring Ankle Brachial Pressure Index or Ankle Brachial Index (ABPI/ABI). ABPI is measured supine by checking the systolic blood pressure in both upper and lower limbs (brachial, posterior tibial, and dorsalis pedis arteries). The higher value from each limb is used to calculate the ABPI. This index is calculated as: ABI = Systolic BP in the Ankle/ Systolic BP in the arm Interpretations are as follows: Value Interpretation 0.1 - 0.4 Critical limb ischemia 0.5 - 0.9 Intermittent claudication 1.0 - 1.2 Normal > 1.2 Calcified vessels (seen in patients with DM, End stage renal disease)

References:

Sabiston’s Textbook of Surgery, 21st Edition, Page 1773

Bailey and Love Short Practice of Surgery, 28th Edition, Page 999.

https://pmc.ncbi.nlm.nih.gov/articles/PMC4827334/

↑ *Back to this question in Part A*

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Q32: A 56 years old man presents with the following pathology, which of the following is correct? (Q866445)

A. Sclerotherapy is the best treatment

B. Lipodermatosclerosis/eczema can occurs

C. Telangiectasia is rare

D. No possibility of venous ulcer



Correct Answer: B. Lipodermatosclerosis/eczema can occurs

Explanation: The image depicts varicose veins , which over time can cause chronic venous insufficiency (CVI) . Long-standing venous hypertension leads to skin and subcutaneous tissue changes, including: Venous eczema Lipodermatosclerosis Hyperpigmentation Venous ulcers Sclerotherapy is the best treatment (Option A): Sclerotherapy is effective for small varicosities or recurrent veins , not for large primary saphenous varicose veins , which are usually treated with endovenous ablation or surgical ligation/stripping . Telangiectasia is rare (Option C): Incorrect. Telangiectasias (spider veins) are common in chronic venous disease. No possibility of venous ulcer (Option D): Incorrect. Venous ulcers are a well-recognized complication of advanced varicose veins (CEAP class 6).

References:

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↑ *Back to this question in Part A*

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Q33: A chronic smoker presents with leg pain after walking 100 meters. On examination, there is an absent pulse in the bilateral dorsalis pedis, anterior tibial, and posterior tibial arteries, but no gangrene is noted. Intermittent claudication is

suspected. Which of the following statements about this condition is correct? (Q853070)

A. Pain is more at night and sleep

B. Pain aggravated by standing and relieved by bending forward

C. Development of pain on the 1st step of walking

D. Pain develops after walking some distance and is relieved by rest

Correct Answer: D. Pain develops after walking some distance and is relieved by rest

Explanation: Pain develops after walking some distance and relieved by rest is the correct description of intermittent claudication . This is a classic symptom of peripheral artery disease (PAD) . The pain is typically muscle pain , cramping , or aching , and it most commonly affects the calf muscles because of their large muscle mass and high demand for oxygen during activity. Boyd's classification of intermittent claudication : Grade Description Grade 0: Asymptomatic No symptoms of claudication, even with exercise Grade I: Mild claudication Able to walk more than 200 meters (about 650 feet) before onset of symptoms Grade II: Moderate claudication Able to walk between 50 and 200 meters (about 160 to 650 feet) before onset of symptoms Grade III: Severe claudication Able to walk less than 50 meters (about 160 feet) before onset of symptoms Grade IV: Ischemic rest pain Pain occurs at rest or with minimal exertion Pain is more at night and sleep (Option A) : Night pain is more characteristic of rest pain in advanced PAD, not intermittent claudication. Pain aggravated by standing and relieved by bending forward (Option B) : This description is more consistent with neurogenic claudication and is typical of lumbar canal stenosis , where pain worsens with standing or walking and is relieved by bending forward or sitting. Development of pain on the 1st step of walking (Option C) is associated with osteoarthritis , whereas the pain in intermittent claudication develops after walking for a certain distance, not immediately when taking the first step.

References:

Bailey & Love’s Short Practice of Surgery, 28th Edition, Pages 998, 999.

↑ *Back to this question in Part A*

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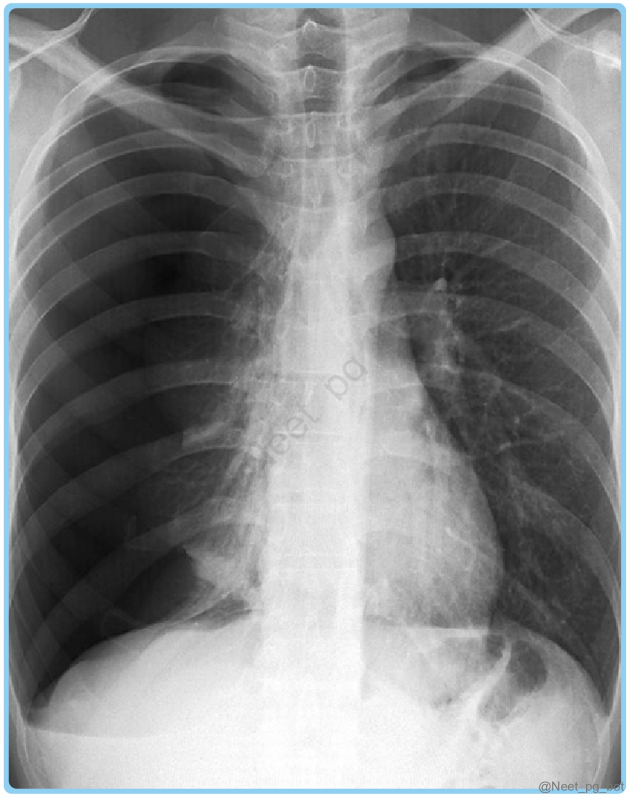
Q34: Following a fight between 2 groups, a boy was brought with severe pain in the chest, distended neck veins, dyspnea, and a BP of 80/50 mmHg. X-ray shows the following findings: What is the diagnosis? (Q852683)

A. Tension pneumothorax

B. Primary Spontaneous Pneumothorax

C. Traumatic Pneumothorax

D. Bilateral Pneumothorax



Correct Answer: A. Tension pneumothorax

Explanation: Clinical Presentation: Severe chest pain, dyspnea, distended neck veins (JVD), and hypotension (80/50 mmHg) suggest a life-threatening tension pneumothorax . Trauma history (fight) further supports the diagnosis. Increased Intrathoracic Pressure → Impaired Venous Return → Distended Neck Veins (JVD) As intrathoracic pressure rises, it compresses the superior vena cava (SVC) and right atrium , obstructing venous return to the heart. This results in jugular venous distension (JVD) due to backed-up blood in the venous system . Decreased Preload & Cardiac Output → Hypotension (Low BP) The compression of the right atrium and ventricle reduces blood filling (preload), decreasing stroke volume and cardiac output . This leads to severe hypotension and, if untreated, cardiac arrest due to obstructive shock. X-ray Findings: Hyperlucency (increased radiolucency) on the right side due to air accumulation. Mediastinal shift to the left due to increased intrathoracic pressure. Depressed diaphragm on the affected side. Absence of lung markings on the affected side. Management: Immediate needle decompression at the 2nd intercostal space (midclavicular line) followed by chest tube placement . Pneumothorax Types and Features Type Cause Clinical Features X-ray Findings Tension Pneumothorax Trauma, mechanical ventilation Severe dyspnea, hypotension, JVD, tracheal deviation Mediastinal shift away from affected side, hyperlucency Primary Spontaneous Pneumothorax Ruptured subpleural blebs (tall, thin males) Sudden dyspnea, pleuritic pain Hyperlucency without mediastinal shift Traumatic Pneumothorax Blunt/penetrating trauma, rib fractures Dyspnea, pain, absent breath sounds Hyperlucency, no mediastinal shift unless tension develops Bilateral Pneumothorax Rare, seen in severe trauma, barotrauma Respiratory distress, hypoxia Bilateral hyperlucency Primary Spontaneous Pneumothorax (Option B): incorrect because it occurs without trauma and does not cause severe hypotension or mediastinal shift. Traumatic Pneumothorax (Option C): incorrect because not all traumatic pneumothoraces lead to tension , and tension features (JVD, severe

hypotension, tracheal shift) are key here. Bilateral Pneumothorax (Option D): incorrect because the X-ray shows a unilateral pneumothorax , not bilateral lung collapse.

References:

Pneumothorax

Harrison's Principles of Internal Medicine, 21st edition, Page: 2200.

https://radiopaedia.org/articles/pneumothorax

https://pubmed.ncbi.nlm.nih.gov/17419871/

https://pubmed.ncbi.nlm.nih.gov/11464087/

↑ *Back to this question in Part A*

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Q35: A 62-year-old male presents with left leg swelling and pain for 5 days and has a positive D-dimer test. Duplex ultrasonography confirms an extensive DVT involving the left popliteal and femoral veins. Which of the following is the most appropriate initial management strategy? (Q852702)

A. Unfractionated heparin followed by warfarin

B. LMWH followed by oral anticoagulant

C. Catheter-directed thrombolysis

D. IVC filter placement

Correct Answer: B. LMWH followed by oral anticoagulant

Explanation: Treatment of DVT: Anticoagulation: For initial management of acute DVT without contraindications to anticoagulation, the current recommended approach is to start with LMWH and transition to an oral anticoagulant. This approach has several advantages: LMWH provides rapid anticoagulation without the need for monitoring. Oral anticoagulants have shown non-inferiority or superiority to warfarin in large clinical trials. They have a better safety profile and do not require regular INR monitoring. This regimen allows for outpatient management in many cases, reducing hospitalization rates. Investigation of DVT: Venous Doppler with Duplex scanning Non-invasive; detects thrombus by impaired blood flow and inability to compress veins. Presence of echogenic material completely filling the lumen of vein Absence of compressibility Absence of blood flow Venogram Accurate for detecting and locating thrombus and differentiating occlusive and non-occlusive thrombus but less commonly used due to invasiveness. Impedance Plethysmography Measures changes in venous volume and flow using a cuff. Less useful for calf DVT and previous thrombosis. Fibrin and Fibrinogen Assays Measures fibrin degradation products, including D-dimer. D-dimer has a high negative predictive value. Radioactive Fibrinogen Study Uses radiolabeled fibrinogen to detect thrombus. Less commonly used. Magnetic Resonance

Venous Imaging (MRVI) Non-invasive; Useful for imaging iliac veins and IVC. Management of DVT : Initial Anticoagulation Subcutaneous LMWH: Rapidly anticoagulate confirmed DVT cases. Intravenous Unfractionated Heparin: For patients with significant renal impairment. Fondaparinux or Bivalirudin: Alternatives for those with heparin sensitivity or heparin-induced thrombocytopenia. Transition to Oral Anticoagulation Duration: At least 3 months or longer based on risk factors or recurrence. Novel anticoagulants (NOACs): Rivaroxaban, Apixaban (factor Xa inhibitors), Dabigatran (direct thrombin inhibitor). Vitamin K Antagonists: Warfarin (alternative to NOACs). Monitoring Anticoagulation Heparin: Activated partial thromboplastin time (APTT). Warfarin: INR maintained between 2.0 to 3.0. For Patients with contraindications to Anticoagulation Temporary IVC Filter: Consider if bleeding risk prevents anticoagulation or to prevent pulmonary embolism. It does not treat the existing thrombus and is associated with long-term complications. (Option D) Endovascular Surgery Thrombus removal, lysis, and stenting. Beneficial in selected patients, especially those with iliofemoral thrombosis, to reduce risk of chronic post-thrombotic syndrome. Unfractionated heparin followed by warfarin (Option A) was the traditional approach. But it has largely been superseded by LMWH and DOACs due to the need for hospitalization, frequent aPTT monitoring for unfractionated heparin, and long-term INR monitoring for warfarin. Catheter-directed thrombolysis (Option C) is generally reserved for massive iliofemoral DVT with severe symptoms or limb-threatening situations. It carries a higher risk of bleeding and is not first-line therapy for most DVT cases.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1046

SRB’s Manual of Surgery, 6th Edition, Page 217

Sabiston Textbook of Surgery, 21st Edition, Page 1828, 1829

Doppler,PE

↑ *Back to this question in Part A*

@Neet_pg_bot

Q36: Which type of ulcer is given below? (Q844296)

A. Venous ulcer

B. Arterial ulcer

C. Trophic ulcer

D. Diabetic foot



Correct Answer: A. Venous ulcer

Explanation: Correct Option A - Venous ulcer: These ulcers are commonly found on the lower legs, particularly around the ankles. They typically have irregular borders, are shallow, and may present with a moist base. They are associated with chronic venous insufficiency, where poor blood flow in the veins leads to high pressure and fluid leakage in the tissues. Surrounding skin shows hyperpigmentation (hemosiderin deposition), lipodermatosclerosis, eczema-like changes, and edema. Incorrect Options: Option B - Arterial ulcer: These ulcers are generally found on the feet or toes and are characterized by well-defined, punched-out edges. They are usually painful, and the skin around the ulcer is often pale or cool to the touch. Arterial ulcers result from poor blood flow due to arterial disease, such as peripheral artery disease (PAD), which impairs oxygen and nutrient delivery to tissues. Option C - Trophic ulcer: Trophic ulcers are less common and are associated with conditions that cause nerve damage, such as diabetes or leprosy. These ulcers are typically painless and occur on areas prone to trauma or pressure. The affected skin may be dry and necrotic, and the ulcers are usually located on areas with poor sensation. Option D - Diabetic foot: Diabetic foot ulcers can occur anywhere on the foot and are often associated with diabetes-related neuropathy and peripheral vascular disease. They are typically found on pressure points and can have a deep, necrotic base. The ulcers may be surrounded by calloused skin and are often complicated by infection.

References:

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↑ *Back to this question in Part A*

@Neet_pg_bot

Q37: What is the appropriate management for a patient presenting with constant chest pain and radiological findings of stanford type A aortic dissection? (Q844300)

A. Surgical management

B. Vasodilator

C. Beta blocker

D. Beta blocker plus vasodilator

Correct Answer: A. Surgical management

Explanation: Correct Option A - Surgical Management: Type A dissections involve the ascending aorta, which carries the highest risk of: Aortic rupture Cardiac tamponade Acute aortic regurgitation Coronary artery occlusion Surgical intervention is indicated in cases of aortic dissection, especially if the dissection involves the ascending aorta or if there are signs of compromise to vital organs. Surgery is typically required for Type A aortic dissections (involving the ascending aorta) due to the high risk of life-threatening complications. Immediate surgical repair aims to stabilize the aorta, prevent further dissection, and manage complications. Incorrect Options: Option B - Vasodilator: Vasodilators alone are not typically the first-line treatment for aortic dissection. While they can help manage hypertension, they do not address the critical need to control the force of blood flow through the aorta, which is crucial in the acute management of dissection. Option C - Beta Blocker: Beta blockers are a cornerstone in the medical management of aortic dissection. They reduce heart rate and blood pressure, thereby decreasing the shear stress on the aortic wall and preventing further dissection. Beta blockers are particularly important in Type B dissections (involving only the descending aorta) where surgery may not be immediately necessary. Option D - Beta Blocker plus Vasodilator: In some cases, a combination of beta blockers and vasodilators may be used to manage blood pressure and reduce heart rate. However, for aortic dissection, the immediate priority is to control blood pressure and heart rate, with beta blockers being the primary treatment. Vasodilators can be used in conjunction if needed to further control blood pressure, but they are not a replacement for beta blockers.

References:

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↑ *Back to this question in Part A*

@Neet_pg_bot

Q38: A patient presented to the outpatient department with a dilated, tortuous vein in the leg. The patient reported a history of trauma to the same area 10 years prior. Upon examination, a pulsatile vein was also noted. What is the most likely diagnosis? (Q860393)

A. Varicose vein

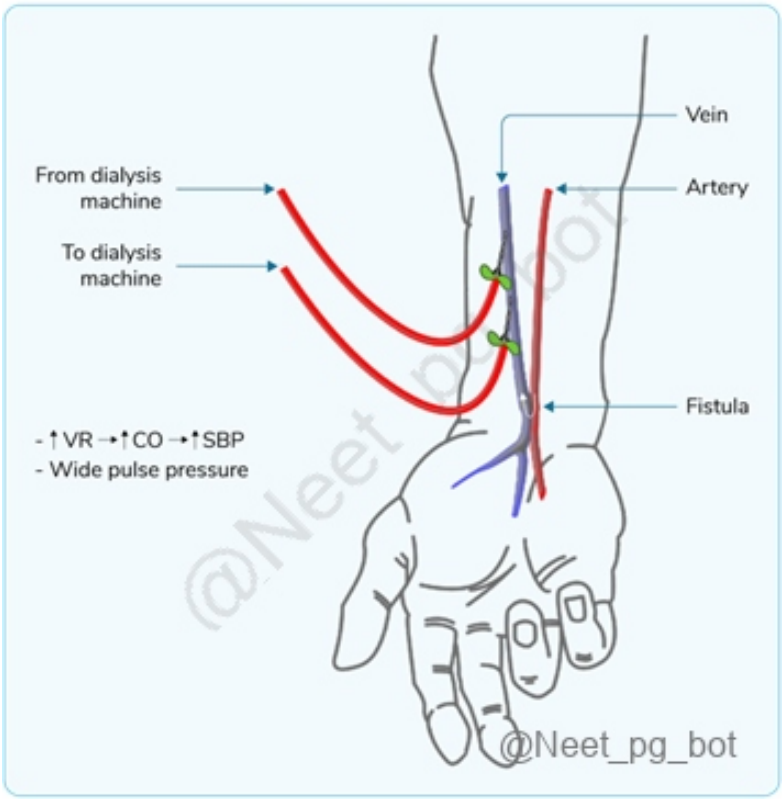
B. Angiofibroma

C. Hemangioma

D. A-V Fistula

Correct Answer: D. A-V Fistula

Explanation: The pulsatile nature of the vein in this case suggests an A-V fistula , as it indicates direct arterial blood flow into the venous system. The patient's history of trauma further supports this diagnosis, since A-V fistulas can result from penetrating injuries or iatrogenic causes. Arteriovenous Fistula (AVF) AVF is a communication between an artery and a vein that may be either congenital or acquired (trauma or surgical) . Structurally, they are arterialised (become dilated, tortuous and thick-walled). Physiologically, there is an increase in venous return (as blood starts flowing from arteries to veins, which causes an increase in cardiac output, which in turn results in an increase in systolic BP, leading to cardiac failure. On examination, there is a presence of pulsatile swelling, a thrill and auscultation reveals machinery murmur (buzzing continuous murmur) Nicoladoni's / Branham's sign is observed in AVF: On pressing the artery proximal to the fistula, there is a decrease in the size of the pulsatile mass, disappearance of palpable thrill and decrease in heart rate. Surgically created Arterio-Venous fistula: It is commonly used for patients with end-stage renal disease who require hemodialysis. Aspect Details Purpose Used for hemodialysis Provides high blood flow for effective dialysis Site Selection Prefer distal placement Non-dominant arm is typically used Arterial Quality Requires a strong arterial pulse for success Vein Preservation Avoid placing venous lines in the arm intended for fistula Examples of Surgically created fistulas are: Brescia-Cimino fistula: It is created between the Radial artery and the Cephalic vein. Snuff Box fistula: It is created between the Posterior branch of the radial artery and Cephalic vein Feinberg fistula: It is created between the Radial artery and the Basilic vein. Incorrect Options: Varicose veins (Option A) are dilated, tortuous veins, but they are not pulsatile and are typically not associated with trauma or arterial involvement. Angiofibromas (Option B) are benign tumors of blood vessels and fibrous tissue, but they would not typically present with a pulsatile vein or a history of trauma. Hemangiomas (Option C) are benign vascular tumors that usually appear as red or blue lesions and are not typically pulsatile. They are more common in infants and children.



References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1023,1024

SRB's Manual of Surgery, 6th Edition, Page 334

↑ *Back to this question in Part A*

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Q39: An elderly man with a chronic history of IV drug use presents with progressively increasing swelling in the groin on the right side. The swelling is non-fluctuant but pulsatile on examination. He has diminished pulses distal to the swelling on the same side. What is the next step in the management of this patient? (Q860455)

A. CT angiography followed by surgery

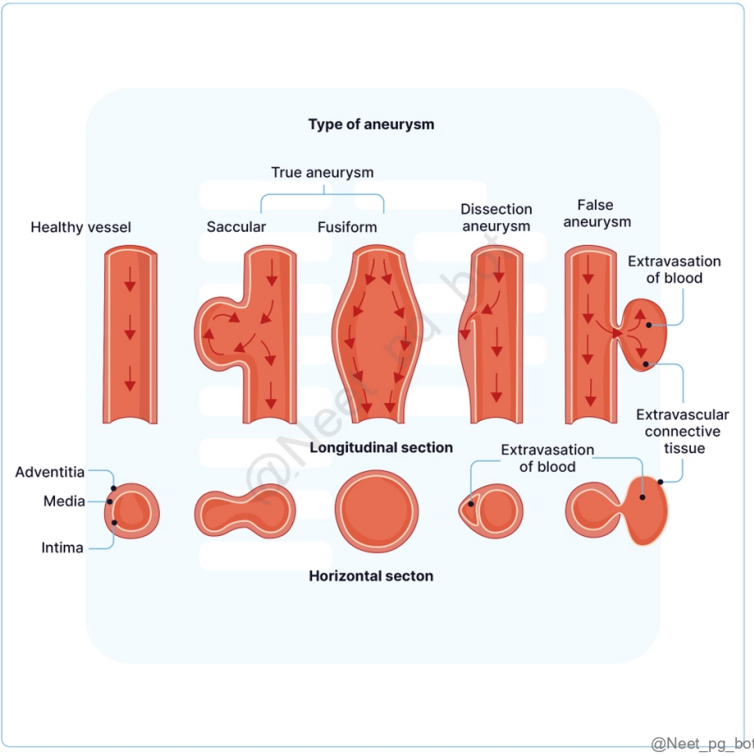
B. Oral antibiotics and observation

C. Compression stocking

D. Incision and drainage

Correct Answer: A. CT angiography followed by surgery

Explanation: The pulsatile nature of the swelling, along with diminished distal pulses & history of chronic IV drug use , most likely suggests pseudoaneurysm. CT angiography is the gold standard for diagnosing pseudoaneurysms, as it provides detailed imaging of the blood vessels and helps in planning surgical or endovascular repair. Surgical treatment or endovascular embolisation may be required depending on the size and location of the pseudoaneurysm. Aspect True Aneurysm False (Pseudoaneurysm) Definition Involves all three layers of the arterial wall. Involves only a layer of fibrous tissue outside the vessel. Wall Structure Intima, media, and adventitia are involved. Only fibrous tissue surrounds the breach. Morphology Fusiform or saccular. Typically spherical or ovoid. Aetiology Atherosclerosis, genetic conditions. Trauma, surgery, or arterial puncture. Clinical Features May be asymptomatic until complications arise. Often presents with a pulsatile mass or pain. Common Locations Large arteries (e.g., aorta, iliac). Peripheral arteries (e.g., femoral, popliteal). Diagnosis Detected by ultrasound, CT, and MRI. Detected by ultrasound or angiography. Management Surgical repair or endovascular techniques. Repair or percutaneous methods (e.g., thrombin injection). Incorrect Options: Oral antibiotics and observation (Option B) would not be appropriate here because there is no indication of infection (e.g., no fluctuance or signs of abscess), and this is a likely vascular issue requiring surgical intervention. Compression stockings (Option C) are used to treat venous insufficiency or varicose veins. Incision and drainage (Option D) are typically used for abscesses or collections of pus, & should be avoided in this case.



References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 798

↑ *Back to this question in Part A*

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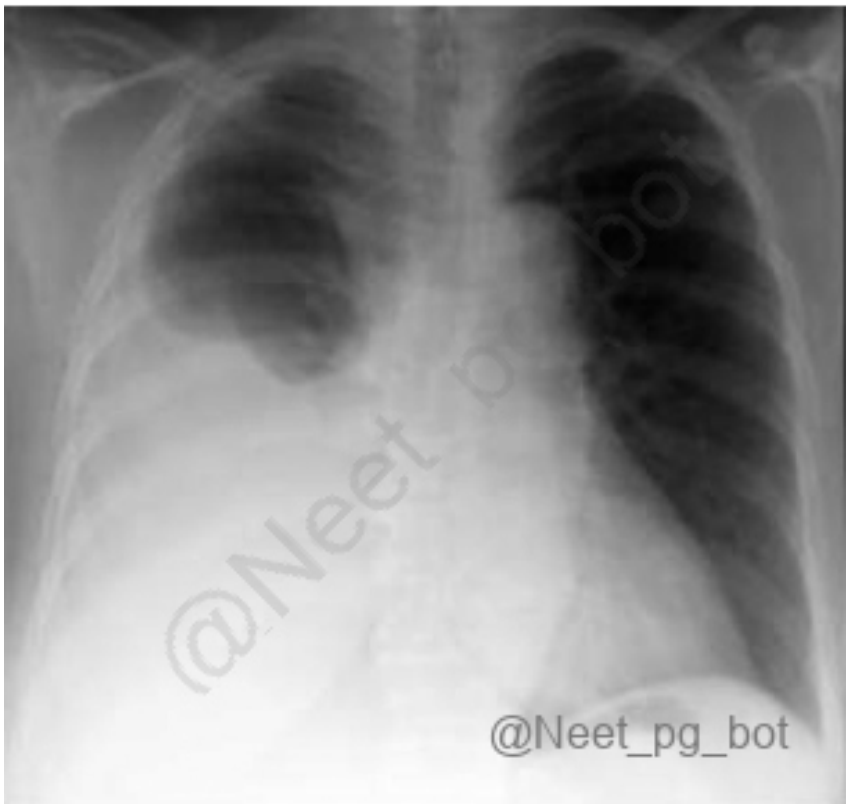
Q40: A 32-year-old male presents to the emergency department after sustaining a stab wound to the right side of his chest. He is in acute distress, with a heart rate of 120 beats per minute, blood pressure of 90/60 mmHg, and respiratory rate of 28 breaths per minute. On physical examination, there are decreased breath sounds on the right side. A chest X-ray is shown below. What is the diagnosis? (Q840044)

A. Pneumothorax

B. Hemothorax

C. Tension Pneumothorax

D. Hydrothorax



Correct Answer: B. Hemothorax

Explanation: The chest X-ray shows a homogeneous white opacity occupying the right hemithorax, which indicates fluid, not air. In trauma patients, such opacity most commonly represents blood collection in the pleural cavity. The patient sustained a stab wound, a classic cause of intrathoracic bleeding. He also presents with hypotension (90/60 mmHg), which strongly supports significant blood loss. Tachycardia and dyspnea further correlate with a large hemothorax compromising lung expansion. Breath sounds are decreased on the right, matching the side of opacification. Incorrect Options: Option A - Pneumothorax: Would appear as a hyperlucent (black) area without lung markings. The X-ray instead shows a white fluid opacity, not air. Option C - Tension Pneumothorax: Shows mediastinal shift and a dark hemithorax filled with air. No mediastinal shift or air-filled space is seen here. Option D - Hydrothorax: Occurs from serous fluid due to CHF, renal, or liver disease. In trauma, pleural fluid is blood, making hydrothorax unlikely.

References:

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↑ *Back to this question in Part A*

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Q41: A patient presents with calf pain while walking a certain distance. The pain is severe enough that he must stop and rest before continuing. According to Boyd's

grading, which of the following grades best describes this condition? (Q860217)

A. Grade 1

B. Grade 2

C. Grade 3

D. Grade 4

Correct Answer: C. Grade 3

Explanation: Grade III is characterised by pain that persists during walking, and the patient has to stop and rest to relieve the pain. Boyd's classification of intermittent claudication : Grade Description Grade I Pain develops after walking a certain distance (claudication distance). The pain subsides due to increased blood flow and collateral circulation. Grade II Pain persists even while continuing to walk, but the patient can still walk with effort. Grade III Patient must stop and rest to relieve the pain; walking becomes significantly impaired. Grade IV Patient experiences rest pain, and the pain persists even at rest, indicating severe arterial disease.

References:

SRB's Manual of Surgery, 6th Edition, Page 162

↑ *Back to this question in Part A*

@Neet_pg_bot

Q42: A man presented with a history of stab injury over the arm. On examination, there was the presence of hematoma, and radial and ulnar pulses were not felt. A 3.5 cm longitudinal tear is noted in the brachial artery. Which of the following is the best treatment option? (Q857300)

A. Primary repair with end-to-end anastomosis

B. Repair with great saphenous vein graft

C. Repair with prosthetic graft

D. Repair with saphenous vein patch

Correct Answer: B. Repair with great saphenous vein graft

Explanation: In this patient with a longitudinal tear to the brachial artery due to a stab injury, the best treatment is to repair it with a great saphenous vein interposition graft harvested from an uninjured leg. Great saphenous vein is the ideal graft: Matches arterial pulsatile flow and size. (Elastic property) Non-thrombogenic with superior long-term patency. Best for small vessels like popliteal and tibial arteries. Other grafts: Cephalic vein and lesser

saphenous vein can be used, but the cephalic vein may be problematic in trauma cases. Timing of Definitive Repair: It is performed once: Hemorrhage is controlled. Coagulopathy and acidosis are corrected. Body temperature is normalised. End-to-end anastomosis (Option A) can only be done when the arterial ends can be easily approximated without tension. If there is a significant gap or tension, a graft is necessary to bridge the gap. Prosthetic grafts (Option C) , such as PTFE (polytetrafluoroethylene), are used in cases where there is trauma to the native saphenous vein or a size mismatch between the artery and the graft. Prosthetic grafts are often considered when vein grafts are not available or not suitable. PTFE is effective for proximal injuries (brachial, popliteal) but inferior for more distal extremity injuries. Saphenous vein patch (Option D) is primarily used to close arteriotomy sites in procedures like carotid endarterectomy , where a patch is used to widen the artery or close the site of an incision, rather than being used for a direct tear repair.

References:

Sabiston Textbook of Surgery, 21st Edition, Page 1800

↑ *Back to this question in Part A*

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Q43: After undergoing surgery to correct a left-sided varicocele, a 30-year-old male patient inquires about the primary route through which venous drainage occurs following the surgery. How should the surgeon correctly respond to the patient's question? (Q857310)

A. Cremasteric veins

B. Penile veins

C. Ectopic drainage in the iliac fossa

D. Testicular veins

Correct Answer: A. Cremasteric veins

Explanation: After surgery for a varicocele, which involves ligating the abnormal veins (high ligation of the internal spermatic vein) in the scrotum, venous drainage is redirected through the cremasteric veins . These veins are part of the venous system of the spermatic cord and are an important alternative route for venous drainage from the testicle once the abnormal venous flow is corrected. Varicocele: Pathophysiology: The pampiniform plexus drains the testis and epididymis. The testicular veins converge at the inguinal ring and ascend retroperitoneally. The left testicular vein drains into the left renal vein, and the right testicular vein drains into the inferior vena cava. Cremasteric veins provide an alternative venous return, draining into the inferior epigastric veins. Causes: Antireflux valve failure at the junction of the testicular vein and renal vein or inferior vena cava causes reflux. Nutcracker effect from compression of the left testicular vein between the superior mesenteric artery and aorta. Angulation at the junction of the left testicular vein and renal vein. Rare causes include renal tumours , deep vein thrombosis , and pampiniform plexus thrombosis . An isolated right-sided varicocele warrants imaging to rule out retroperitoneal masses. Other options: Option B: Penile veins Penile venous drainage does not contribute

meaningfully to testicular venous outflow. These veins drain the corpora and skin of the penis, not the spermatic cord or testes. Option C: Ectopic drainage in the iliac fossa Although aberrant venous connections may exist, they are not the primary or consistent drainage route after a varicocelectomy. They are anatomical variations, not predictable pathways. Option D: Testicular veins The internal spermatic (testicular) vein is ligated during varicocelectomy, so it cannot remain the primary drainage route. Collaterals—not the original vein—take over the function.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1563

↑ *Back to this question in Part A*

@Neet_pg_bot

Q44: Which is the least commonly used graft for coronary artery bypass graft (CABG)? (Q857806)

A. Long saphenous vein

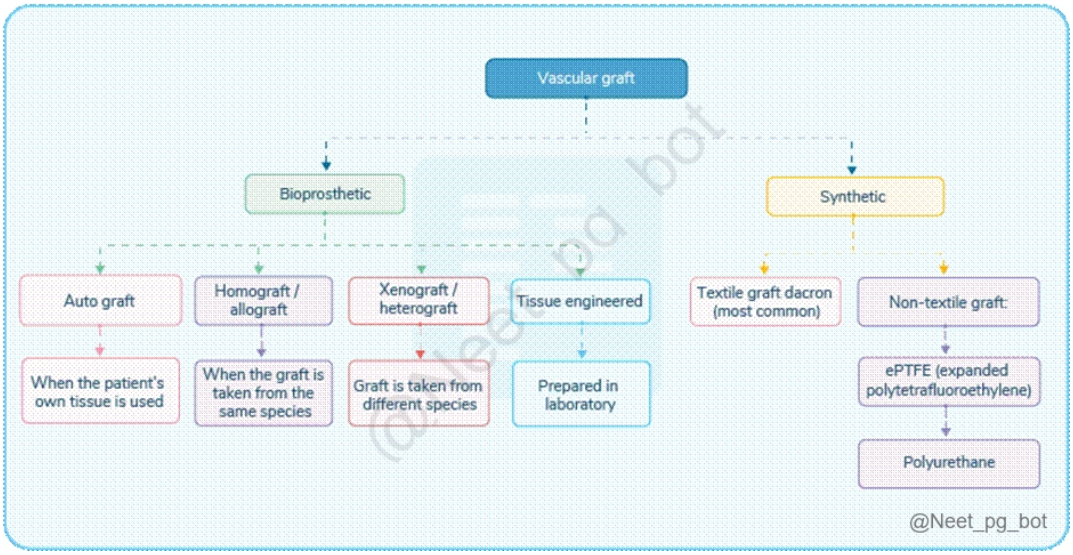
B. Internal mammary artery

C. Intercostal artery

D. Radial artery

Correct Answer: C. Intercostal artery

Explanation: The intercostal artery is the least commonly used graft in Coronary Artery Bypass Graft (CABG) due to its limited availability and potential complications, with the long saphenous vein, internal mammary artery, and radial artery being preferred options. It is a procedure done by using a vascular graft for bypassing the blocked site of arteries and allowing the flow of blood to the heart muscles. Indications: Triple vessel stenosis Left main stem stenosis Chronic stable angina Angina with persistent chest pain >70% blockage of coronary vessels Classification of Vascular grafts: Bioprosthetic grafts LIMA (Left Internal Mammary Artery) (Option B ruled out) Long saphenous vein: Most commonly used in infra-inguinal surgeries due to small and medium-sized vessels. (Option A ruled out) Synthetic grafts Dacron: Most commonly used synthetic graft in supra inguinal surgeries due to large vessels. Polyurethane ePTFE (expanded polytetrafluoroethylene) Most preferred graft for CABG is LIMA , but the Long saphenous vein is more commonly used due to its extra length and it is easy to handle. Radial artery (Option D) is a commonly used graft in CABG, offering comparable long-term patency to the internal mammary artery and is particularly useful for smaller coronary arteries. It’s a good alternative to vein grafts, but requires careful harvesting and postoperative monitoring for complications.



References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 946-953.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q45: In a patient with aortic dissection, injury to which of the following structure will cause hiccups? (Q820139)

A. Phrenic nerve

B. Abdominal aorta

C. Thoracic aorta

D. Spinal accesory nerve

Correct Answer: A. Phrenic nerve

Explanation: Correct option A - Phrenic nerve: In a patient with aortic dissection, injury to the phrenic nerve can cause hiccups. Phrenic nerve receives contributions from the cervical nerve roots (C3-C5) and travels along the mediastinum and pericardium, running close to the thoracic aorta. An aortic dissection, particularly involving the ascending aorta or arch, can lead to irritation or compression of the phrenic nerve, causing it to become hyperactive. This hyperactivity can manifest as hiccups, which are involuntary contractions of the diaphragm. Incorrect options: Option B, C and D are incorrect.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q46: A 56-year-old patient presented with varicose veins. What is the investigation of choice for varicose veins? (Q820163)

A. Duplex scan

B. Plethysmography

C. MRI

D. CT

Correct Answer: A. Duplex scan

Explanation: Correct option A - Duplex scan: Duplex scan is the investigation of choice for varicose veins. It is a non-invasive imaging technique that combines conventional ultrasound with Doppler ultrasound. It allows visualization of blood flow in the veins and can identify abnormalities, such as reflux (backward flow of blood) in the veins, which is a common finding in varicose veins. It provides valuable information about the anatomy and function of the veins, helping to guide treatment decisions. Incorrect options: Option B - Plethysmography: Plethysmography is a technique used to measure changes in the volume of an organ or limb. While it can provide information about blood volume changes, it is not as specific or accurate in diagnosing the underlying causes of varicose veins as duplex ultrasound. Option C - MRI (Magnetic Resonance Imaging): While MRI can provide detailed images of soft tissues, it is usually reserved for more complex cases or when other imaging methods are inconclusive. Duplex ultrasound is preferred due to its cost-effectiveness and accuracy in diagnosing varicose veins. Option D - CT (Computed Tomography): CT scans involve ionizing radiation and are generally used for specific indications. Duplex ultrasound is safer, non-invasive and more suitable for evaluating venous abnormalities like varicose veins.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q47: What is the most preferred site for the insertion of the intercostal tube drain? (Q820173)

A. Upper border of lower rib

B. Lower border of upper rib

C. Lower border of lower rib

D. Middle of intercostal space

Correct Answer: A. Upper border of lower rib

Explanation: Correct option A - Upper border of lower rib The upper border of lower rib is the most preferred site because it helps to avoid injury to important structures like the neurovascular bundle that runs along the lower border of the rib. By inserting the needle just above the upper border of the lower rib, there's a decreased risk of damaging these structures. Incorrect options: Option B, C and D are not the preferred sites for the insertion of intercostal tube drain.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q48: A patient presents with dull, aching pain and tortuous veins in both lower limbs. Which test would be appropriate for evaluating superficial femoral vein (SFJ) competence? (Q854740)

A. Fegan's test

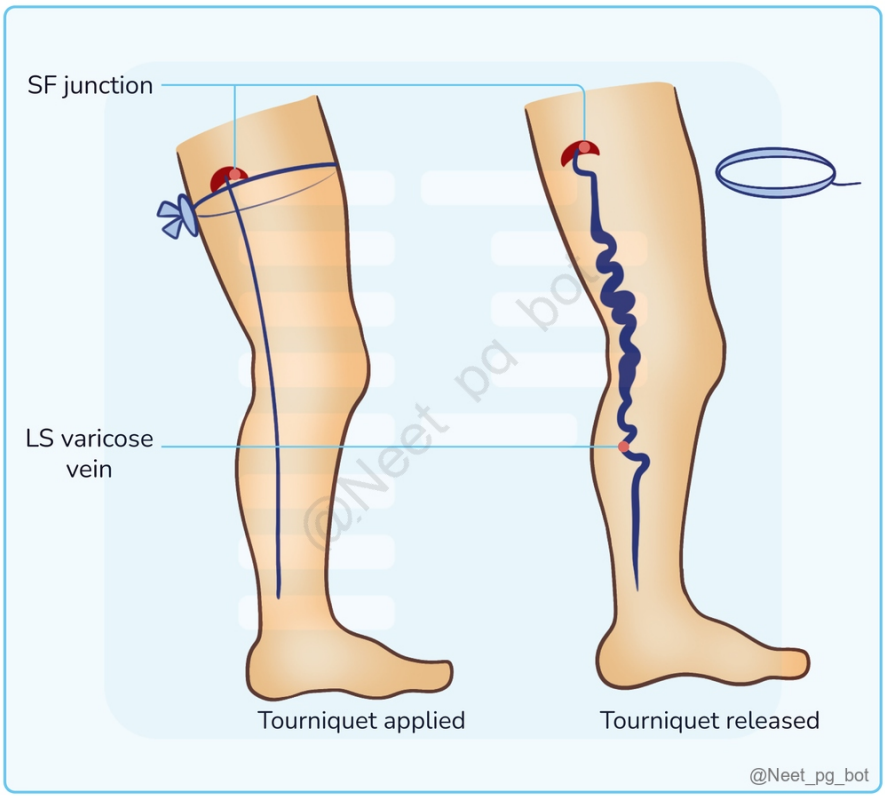
B. Homan’s test

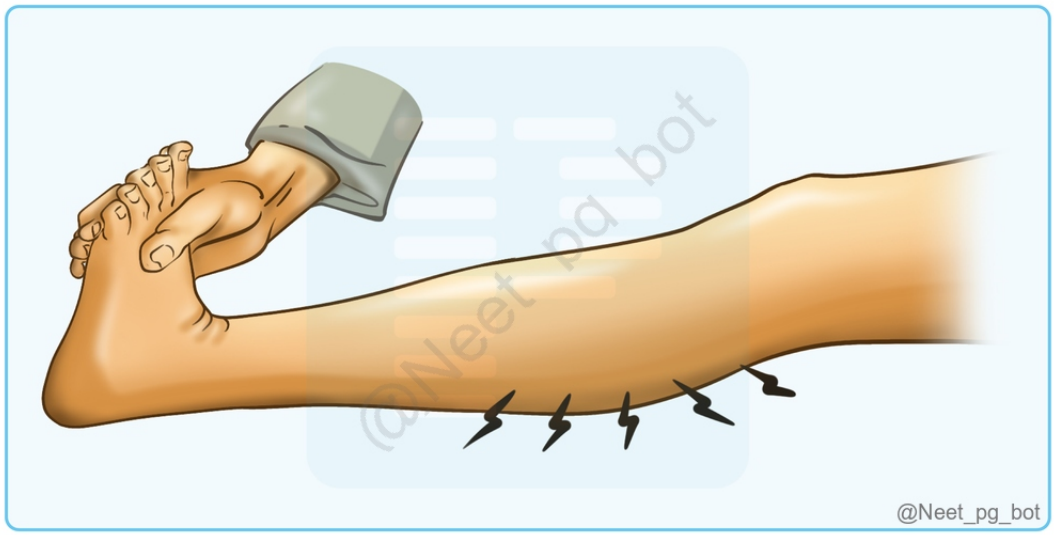
C. Modified Perthes test

D. Brodie Trendelenburg test

Correct Answer: D. Brodie Trendelenburg test

Explanation: The Brodie-Trendelenburg test/ Trendelenburg I test is done to determine the patency of the saphenofemoral junction. Procedure: The patient is asked to lie in the supine position. The leg is elevated, the vein is emptied by “milking,” and a tourniquet is tied just below the saphenofemoral junction. The patient is asked to stand up quickly. The tourniquet is released. Observation: When there is rapid filling of blood from above, this signifies saphenofemoral incompetence. Other tests for varicose veins: Modified Perthe’s test (Option C) : For DVT After elevating the limb and emptying the veins, a tourniquet is applied at the SFJ and the patient is asked to walk around for a few minutes. If the dilated veins become more prominent, it signifies deep venous obstruction. Three tourniquet test: for specific perforator Fegan’s test for perforator (Option A) : On standing, the line of varicosity is marked, and then the veins are emptied in the supine position. The examiner palpates along the marked line and notices any pits or gaps in the deep fascia that signify perforator incompetence at that site. Pratt’s test for perforator: Applying pressure to the calf muscle; if it feels tense and causes pain, it may indicate acute deep vein thrombosis (DVT). Morrisey’s cough impulse test for SFJ incompetence: The patient is asked to turn their face away from the examiner and cough while the examiner keeps a finger at the SFJ, and an expansile cough impulse is felt. Signifies SFJ incompetence. Ian-Aird test for SFJ incompetence. Homan’s test (Option B) is a test for deep vein thrombosis (DVT) rather than venous insufficiency. It involves dorsiflexing the foot and assessing for pain in the calf, which may suggest a clot.





References:

SRB's Manual of Surgery, 6th Edition, Page 223,224

↑ *Back to this question in Part A*

@Neet_pg_bot

Q49: A 62-year-old patient presents with pain in the calf muscles while walking. The pain subsides with rest. Which of the following is not typically seen in intermittent claudication? (Q854759)

A. Cramping in the muscles during exercise

B. Pain starting on taking the first step

C. The most common cause is atheroma

D. The level of occlusion cannot be decided based on symptoms

Correct Answer: B. Pain starting on taking the first step

Explanation: Intermittent claudication typically involves cramping pain in the calf muscles during exercise (such as walking), which subsides with rest. The pain usually starts after walking for a certain distance and is relieved by rest, not immediately upon taking the first step. Boyd's classification of intermittent claudication : Grade Description Grade 0: Asymptomatic No symptoms of claudication, even with exercise Grade I: Mild claudication Able to walk more than 200 meters (about 650 feet) before onset of symptoms Grade II: Moderate claudication Able to walk between 50 and 200 meters (about 160 to 650 feet) before onset of symptoms Grade III: Severe claudication Able to walk less than 50 meters (about 160 feet) before onset of symptoms Grade IV: Ischemic rest pain Pain occurs at rest or with minimal exertion Incorrect Options: Cramping in the muscles during exercise (Option A) : Intermittent claudication is characterised by pain or cramping in the muscles during exercise, usually affecting the lower extremities. The most common cause is atheroma (Option C) : Atheroma, which is the accumulation of fatty plaques in the arteries, is the primary cause of intermittent claudication. The narrowing of the arteries due to atheroma restricts blood flow to the muscles during physical activity, resulting in pain. Level of occlusion cannot be decided based on symptoms (Option D) : The exact level of arterial occlusion cannot be determined by symptoms alone in intermittent claudication. Diagnostic tests, such as ankle-brachial index (ABI) or angiography, are needed to assess the location and extent of arterial blockage. ABI/ABPI: ABPI (Ankle brachial pressure index) is measured supine by checking the systolic blood pressure in both upper and lower limbs (brachial, posterior tibial, and dorsalis pedis arteries). The higher value from each limb is used to calculate the ABPI. This index is calculated as: ABI / ABPI = Systolic BP in the Ankle/ Systolic BP in the arm Interpretations are as follows: Value Interpretation 0.1 - 0.4 Critical limb ischemia 0.5 - 0.9 Intermittent claudication 1.0 - 1.2 Normal > 1.2 Calcified vessels (seen in patients with DM, End stage renal disease)

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 998,999

Sabiston Textbook of Surgery, 21st Edition, Page 1773

↑ *Back to this question in Part A*

@Neet_pg_bot

Q50: A patient presents with a sudden onset of chest pain shooting to the neck and interscapular region. X-ray shows a widened mediastinum. Blood pressure is 110/90 mmHg in the right upper limb and 160/100 mmHg in the left upper limb. What is the most likely diagnosis? (Q855199)

A. Acute coronary syndrome

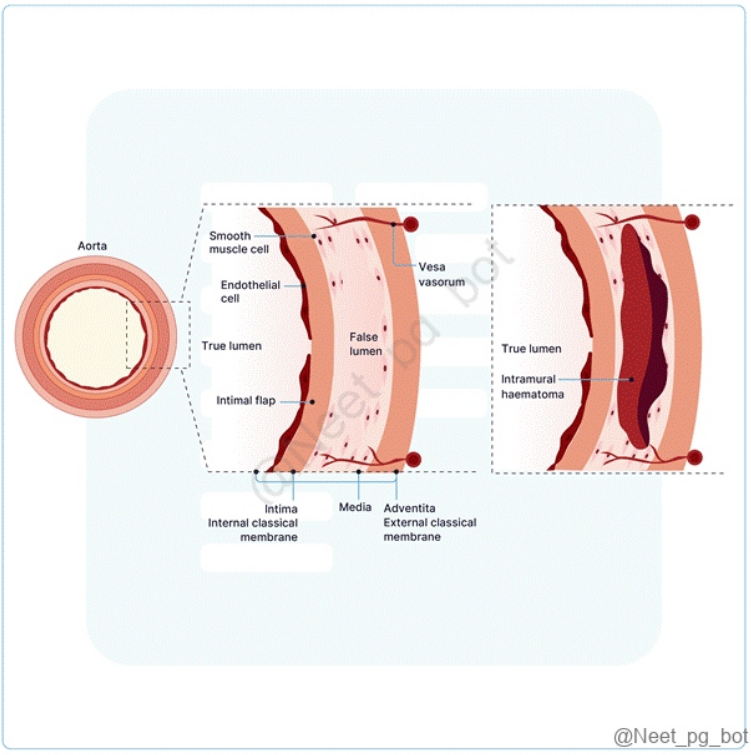
B. Acute pulmonary embolism

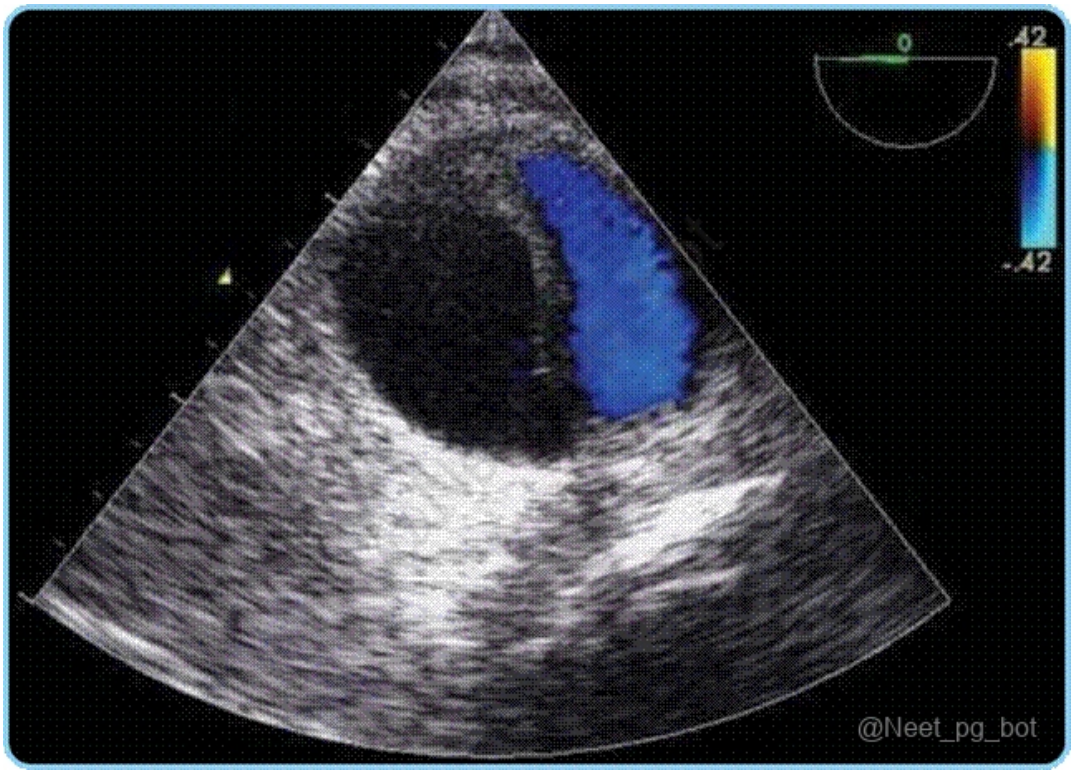
C. Acute aortic dissection

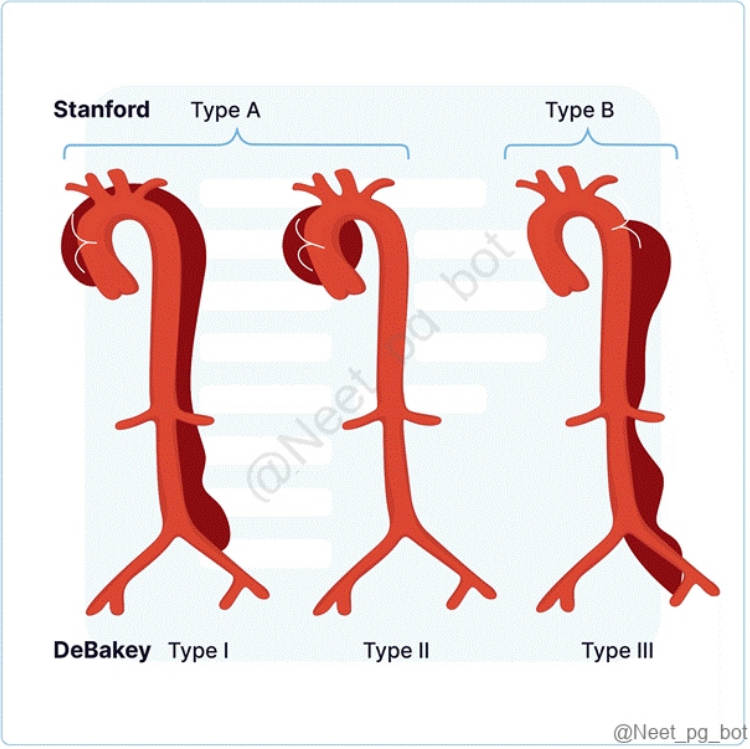
D. Esophageal rupture

Correct Answer: C. Acute aortic dissection

Explanation: Acute aortic dissection often presents with sudden, severe chest pain radiating to the neck and interscapular region. A widened mediastinum on X-ray is a classic sign. The significant difference in blood pressure between the right and left upper limbs suggests aortic dissection, as it can cause unequal blood flow due to dissection of the aortic wall. Aortic Dissection: Occurs when a defect or a flap occurs in the aorta, resulting in blood tracking into aortic tissues, splitting the medial layer, and creating a false lumen. {{caption_text}} Clinical features: Sudden onset of severe, tearing chest, radiating to the interscapular region Renal pain and renal failure Paraplegia Syncope Weakness Hypotension or shock Investigations: If the patient is stable, CT angiography is the standard investigation of choice. In the case of unstable patients (SBP<100 mm of HG, HR>100 bpm), the preferred investigation of choice will be TEE (TransEsophageal Echocardiography)(Option C) MRI can also be done if CT is unequivocal. Chest x-ray reveals widening of mediastinum along with left-sided pleural effusion. {{caption_text}} TEE of an aortic dissection within the descending part DeBakey Classification (Based on the pattern of dissection) Type I Both ascending and descending aorta are involved Type II Only the ascending aorta is involved Type III Only the descending aorta is involved Stanford Classification (Based on whether the ascending aorta is involved in aortic dissection) Type A Only the ascending aorta or both ascending and descending aorta is involved. (It includes both Type I and Type II of DeBakey's classification) Type B Only the descending aorta is involved. (It includes Type III of DeBakey's classification) {{caption_text}} Acute coronary syndrome (Option A): This condition usually presents with central chest pain radiating to the left arm or jaw, often accompanied by sweating, nausea, and shortness of breath. The difference in blood pressure between the arms is not a characteristic feature of acute coronary syndrome. Acute pulmonary embolism (Option B) typically presents with sudden onset dyspnea, chest pain, and possibly hemoptysis. While an ECG might show signs of right heart strain or sinus tachycardia, it does not cause a discrepancy in blood pressure between the limbs. Esophageal rupture (Option D) often occurs after severe vomiting (e.g., Boerhaave's syndrome) and presents with severe chest pain. The X-ray would typically show mediastinal air rather than a widened mediastinum.


Aorta
Smooth muscle cell
Endothelial cell
True lumen
Intimal flap
False lumen
Vesa vasorum
Intima
Internal classical membrane
Media
Adventita
External classical membrane
True lumen
Intramural haematoma
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References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 970, 971

↑ *Back to this question in Part A*

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Q51: A construction worker presents to the OPD with complaints of white fingers. He has been working in the cement and concrete industry and has spent 20 years using heavy machinery drills and polishing wood and furniture. What is the most likely etiology for this condition? (Q855246)

A. Candidal infection of the fingers due to continuous exposure to water

B. Exposure to thinners and paints

C. Continuous exposure to cement and concrete

D. Continuous exposure to drills and machines

Correct Answer: D. Continuous exposure to drills and machines

Explanation: The patient's symptoms of white fingers are suggestive of the vibration-induced white finger (VWF) or hand-arm vibration syndrome (HAVS) , a secondary form of Raynaud syndrome, which is caused by prolonged exposure to vibrating tools and machinery. This condition leads to reduced blood flow and ischemia in the fingers, resulting in the characteristic whiteness of the fingers. Raynaud's Syndrome: Raynaud's syndrome is the peripheral arterial manifestation of a collagen vascular disease, such as systemic lupus erythematosus or rheumatoid arthritis. It shares clinical features with Raynaud's disease but is often more severe. It can also occur due to vibrating tool use , a recognised industrial disease known as vibration white finger . Clinical features: The symptoms are similar to Raynaud's disease but can be more aggressive. In secondary Raynaud's syndrome (due to collagen diseases), there may be necrosis of digits and multiple amputations . Management: Primary treatment focuses on addressing the underlying condition . Conservative measures can be helpful, including: Nifedipine Steroids Vasospastic antagonists Sympathectomy generally provides poor outcomes and is not recommended . Prevention: Patients with a vibrated white finger should avoid vibrating tools to prevent further damage. Other options: Option A: Candidal infection from water exposure - Candidiasis causes paronychia, nail fold swelling, and discharge—not episodic blanching triggered by cold or vibration. Option B: Exposure to thinners and paints - These may cause dermatitis or inhalational toxicity but not vasospastic white fingers. Option C: Continuous exposure to cement and concrete - Cement exposure can lead to irritant dermatitis and alkaline burns, not vibration-induced vasospasm

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1024

↑ *Back to this question in Part A*

@Neet_pg_bot

Q52: Identify the given condition: (Q855253)

A. Venous ulcer

B. Malignant ulcer

C. Arterial ulcer

D. Trophic ulcer



Correct Answer: D. Trophic ulcer

Explanation: Trophic ulcers, also called neuropathic ulcers, occur due to a loss of sensation and an impaired ability to protect the skin, often resulting from conditions like peripheral neuropathy or poor circulation. These ulcers usually have well-defined borders and a pale or pink wound bed, commonly located in weight-bearing areas where pressure or friction is frequent. Type of Ulcer: Type History Lesion Characteristics Pain Ischemic/Arterial Smoking, intermittent claudication Irregular edges, poor granulation tissue, dry necrotic base; round or punched-out with sharp demarcation {{caption_text}} Severe, particularly at night; relieved by dependency Venous Varicose veins, DVT, trauma, surgery, multiple pregnancies Shallow, irregular/shaggy shape, granulating base, fibrinous material with moderate to heavy exudate {{caption_text}} Mild; relieved by elevation Neurotrophic Numbness, paresthesias, burning, loss of sensation in the foot, DM Punched-out, deep sinus, variable depth, partial thickness to severe, involving the tendon, fascia, joint capsule, or bone None Malignant Ulcer History of skin cancer (e.g., basal or squamous cell carcinoma) Irregular, raised borders, ulcerating tumour with hard, indurated tissue Often painful, it can be associated with bleeding or foul odour





References:

https://pmc.ncbi.nlm.nih.gov/articles/PMC3036466/

↑ *Back to this question in Part A*

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Q53: A patient with varicose veins complains of eczema in the same region. According to the CEAP guidelines, what is the stage of the clinical classification? (Q855257)

A. C2

B. C3

C. C4a

D. C4b

Correct Answer: C. C4a

Explanation: According to the CEAP (Clinical, Etiological, Anatomical, and Pathophysiological) classification system for chronic venous disease, C4a refers to skin changes such as eczema or pigmentation in the presence of varicose veins. The CEAP (Clinical- Etiology- Anatomy- Pathology) classification for chronic venous disorders: Clinical Classification (C): Class Description C0 No visible or palpable signs of venous disease C1 Telangiectasia or reticular veins (<1–3 mm) C2 Varicose veins (>3 mm) C3 Edema without skin changes C4a Pigmentation or eczema C4b Lipodermatosclerosis (LDS) or atrophie blanche C4c Corona phlebectatica C5 Healed venous ulcer C6 Active venous ulcer Each class can be followed by a modifier : a = Asymptomatic s = Symptomatic r = Recurrent (after successful treatment/healing) Example : C2s, C6r Etiological Classification (E) Code Description Ec Congenital Ep Primary Es Secondary (e.g., post-thrombotic) En No venous etiology identified Anatomical Classification (A) Code Description As Superficial veins Ap Perforator veins Ad Deep veins An No venous location identified Pathophysiological Classification (P) Code Description Pr Reflux Po Obstruction Pr,o Reflux and obstruction Pn No identifiable pathology {{caption_text}} {{caption_text}} Pigmentation/Eczema LDS {{caption_text}} {{caption_text}} Atrophic blanche Corona phlebectatica









References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1030

https://www.ncbi.nlm.nih.gov/books/NBK557410/

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Q54: A 17-year-old woman with no comorbidities presents with numbness and paraesthesia of the fingers along with the characteristic finding as shown in the image below. She has no history of smoking or history of other illnesses. She mentions the episodes occur when she is under excess stress or during cold temperatures. What is the most likely diagnosis? (Q857783)

A. Buerger's disease

B. Atherosclerosis

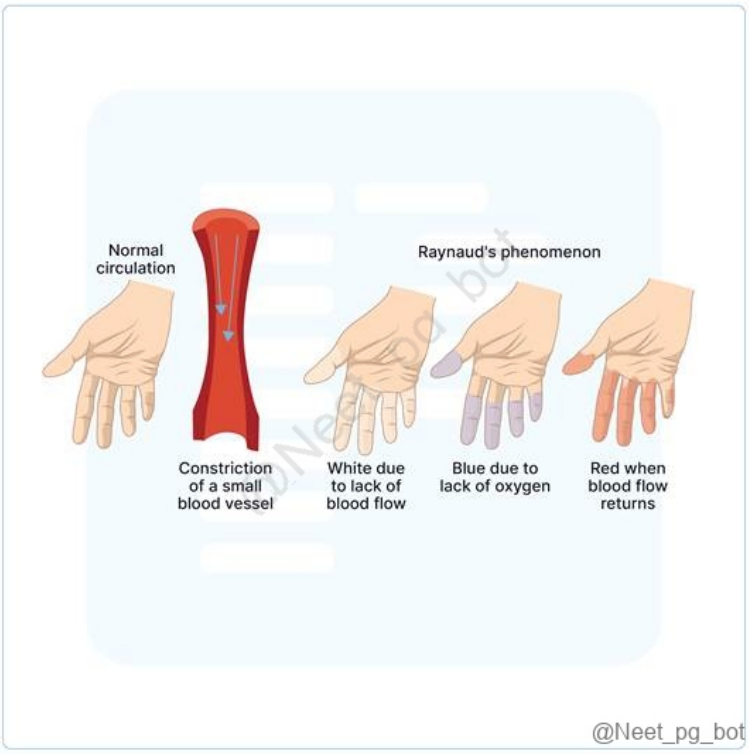
C. Raynaud's phenomenon

D. Giant cell arteritis



Correct Answer: C. Raynaud's phenomenon

Explanation: The scenario of a young woman experiencing numbness, paresthesia, and bluish discoloration of the fingers during cold stress or excessive stress, with no comorbidities, smoking history, or other illnesses, is most likely diagnosed as Raynaud's Phenomenon . Category Description Definition It is characterized by episodic reduction in blood flow, typically in the fingers, triggered by cold exposure or stress. Clinical Features Pallor: Skin becomes pale or white due to reduced blood flow. Cyanosis: Skin turns blue or purple due to deoxygenation of blood. Rubor: Skin turns red as blood flow returns, often with swelling and tingling. Cold Sensitivity: Cold, numb fingers. Pain: Pain during the cyanotic phase. Swelling and Tingling: Occurs in the rubor phase. Types Primary Raynaud Phenomenon (Raynaud Disease): Occurs without underlying disease. More common and has a better prognosis. Secondary Raynaud Phenomenon (Raynaud Syndrome): Occurs due to an underlying condition (e.g., scleroderma, lupus). Often more severe. Management Lifestyle Modifications: Avoid cold exposure, stress reduction, and smoking cessation. Medications: Calcium channel blockers (e.g., nifedipine), alpha-blockers (e.g., prazosin), and other vasodilators. Avoidance of Triggers: Avoid cold, beta-blockers, and caffeine. Advanced Treatments: Surgical sympathectomy for severe cases. Diagnosis Clinical Presentation and History: Based on symptoms and triggers. Nailfold Capillaroscopy: To examine capillary changes. Blood Tests: To identify underlying autoimmune or connective tissue diseases. Sequence of events in Raynaud’s phenomenon: Pallor : The initial phase where the skin becomes pale or white due to reduced blood flow and vasospasm. Cyanosis : Followed by a blue or purple colour due to continued reduced blood flow and lack of oxygen. Rubor : The final phase is where the skin turns red as blood flow returns and the area warms up. Buerger’s disease (thromboangiitis obliterans) (Option A) is an inflammatory condition affecting small and medium-sized arteries and veins, leading to clot formation and reduced blood flow. It is most commonly seen in young male smokers and is characterized by painful ischemia, ulceration, or gangrene of the fingers or toes. This diagnosis is unlikely due to the absence of smoking history, risk factors, and ulcerative symptoms. {{caption_text}} Atherosclerosis (Option B) is the buildup of fatty plaques in arteries, often seen in older individuals with risk factors like smoking, high cholesterol, hypertension, and diabetes. This diagnosis is unlikely for the young woman, as she has no comorbidities or risk factors, and atherosclerosis typically presents with chronic symptoms such as pain or claudication, rather than intermittent symptoms triggered by cold or stress. Giant cell arteritis (GCA) (Option D) affects large arteries in people over 50, causing headaches, scalp tenderness, jaw claudication, and vision issues.





References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page, 1024.

Ganong’s Review of Medical Physiology, 26th Edition, Page 260.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q55: All of the following are classic anterior mediastinal masses EXCEPT: (Q857785)

A. Parathyroid adenoma

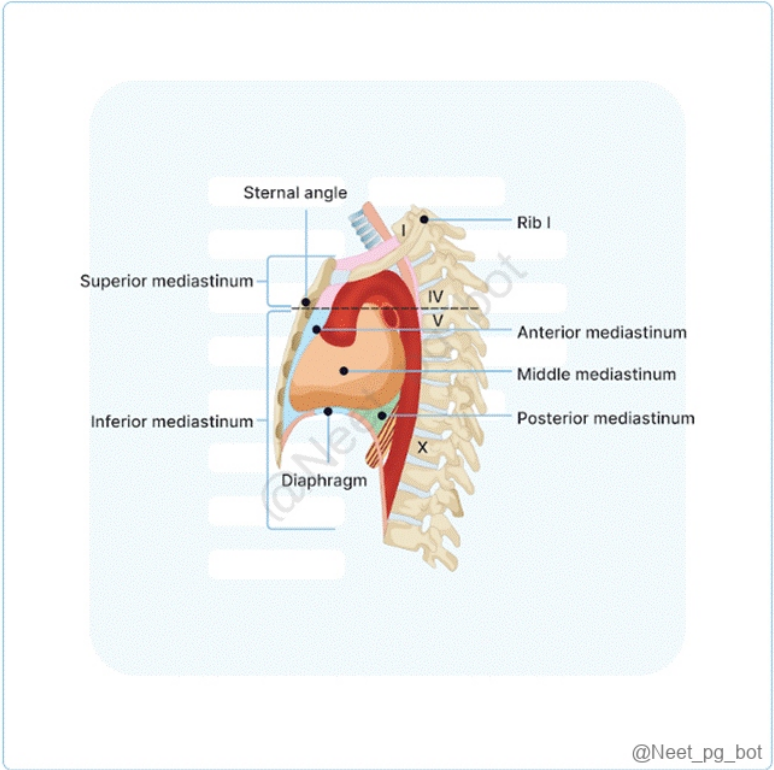
B. Lymphoma

C. Teratoma

D. Thymoma

Correct Answer: B. Lymphoma

Explanation: Lymphoma is a tumor of both the anterior and middle mediastinum. Tumors of mediastinum Anterior mediastinum Middle mediastinum Posterior mediastinum Thymomas (Option D ruled out) Thymic carcinomas Thymic cyst Germ cell tumors (Option C ruled out) Lymphomas Parathyroid adenomas (Option A ruled out) Carcinoid tumour Fibroma Lymphomas (Option B) Tumors of the heart and great vessels Tumours of the trachea, mainstem bronchi, and oesophagus Aortic pathologies such as aortic aneurysm, abscess, or dissection. Pericardial cysts Bronchogenic cysts Neuroenteric cyst Mesothelial cyst Pheochromocytoma Neurilemomas (schwannomas) Neurofibromas Ganglioneuromas Ganglioneuroblastomas Neuroblastomas Pheochromocytomas



References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 991-993.

Sabiston Textbook of Surgery, 21st Edition, Page 1587,1633.

Schwartz’s Principles of Surgery, 11th Edition, Page 728.

SRB’s Manual of Surgery, 6th Edition, Page 1110.

↑ *Back to this question in Part A*

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Q56: While washing clothes in cold water, a female patient exhibits color changes in her hands from white to red . Which of the following drugs is best suited for this patient? (Q793884)

A. ACE inhibitors

B. Calcium channel blockers

C. Thiazides

D. Alpha-blockers

Correct Answer: B. Calcium channel blockers

Explanation: Correct Option B - Calcium channel blockers: The symptoms described in the question suggest that the patient is experiencing Raynaud's phenomenon. In this condition, the blood vessels in the fingers and toes spasm and temporarily restrict blood flow. This can cause the affected areas to turn white, blue, and red. Cold temperatures or emotional stress can trigger the spasms. The best-suited drug for this patient would be a calcium channel blocker. These drugs work by relaxing the smooth muscle in the blood vessel walls, which can help to prevent or reduce the frequency of vasospasms. Calcium channel blockers are often used as first-line therapy for Raynaud's phenomenon. Incorrect Options: Option A - ACE inhibitors: ACE inhibitors are a type of blood pressure medication that works by blocking the production of angiotensin II, a hormone that can constrict blood vessels. However, they are ineffective in treating vasospastic disorders like Raynaud's phenomenon. Option C - Thiazides: Thiazides are a type of diuretic used to treat high blood pressure and edema, but they do not affect the blood vessels in a way that would be useful for treating Raynaud's phenomenon. Option D - Alpha-blockers: Alpha-blockers are another type of blood pressure medication that blocks the alpha receptors on blood vessel walls, causing them to relax and dilate. However, alpha-blockers are ineffective in treating Raynaud's phenomenon because they do not target the underlying vasospasms.

References:

Prepladder Notes

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Q57: Which of the following provides long-lasting results in a coronary artery bypass graft (CABG) ? (Q793485)

A. Long saphenous vein

B. Internal mammary artery

C. Poly tetra fluoro eythlene (PTFE)

D. Gastroepiploic artery

Correct Answer: B. Internal mammary artery

Explanation: Correct Option B - Internal mammary artery: The internal mammary artery is the vessel that provides long-lasting results in a coronary artery bypass graft (CABG). Coronary artery bypass grafting is a surgical procedure that is used to improve blood flow to the heart muscle by bypassing blocked or narrowed coronary arteries. During the procedure, a healthy blood vessel from another part of the body is grafted onto the blocked or narrowed artery, creating a new route for blood to flow to the heart. The internal mammary artery is located inside the chest, and it supplies blood to the chest wall and the heart muscle. It is an ideal vessel for CABG because it is resistant to the development of atherosclerosis (a buildup of plaque inside the artery), which can lead to

re-narrowing or blockage of the grafted vessel over time. Incorrect Options: Option A - Long saphenous vein: The long saphenous vein is often used in CABG procedures, may develop atherosclerosis and become blocked over time, leading to the need for repeat surgeries. Option C - Poly tetra fluoro eythlene (PTFE): PTFE is a synthetic material that can be used in CABG, but it may also develop atherosclerosis over time. Option D - Gastroepiploic artery: The gastroepiploic artery is another option, but it is not as commonly used as the internal mammary artery.

References:

Prepladder Notes

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@Neet_pg_bot

• [04_Hepatobiliary Pancreatic Surgery] 013 Liver Tumors - I

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[04_Hepatobiliary Pancreatic Surgery] 013 Liver Tumors - I — Quick Jump

Q1 (p. 1580) *Q2 (p. 1581)* *Q3 (p. 1581)* *Q4 (p. 1583)* *Q5 (p. 1584)* *Q6 (p. 1585)*
Q7 (p. 1587) *Q8 (p. 1588)* *Q9 (p. 1590)* *Q10 (p. 1590)* *Q11 (p. 1592)* *Q12 (p. 1593)*
Q13 (p. 1594) *Q14 (p. 1595)*

Q1: Which of the following is the most common type of primary liver tumor? (Q848891)

A. Metastasis

B. Hepatocellular carcinoma

C. Hepatoblastoma

D. Hemangioma

Correct Answer: B. Hepatocellular carcinoma

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Hepatocellular carcinoma (HCC) is the most common type of primary liver tumor. It arises from hepatocytes and is frequently associated with chronic liver diseases such as hepatitis B and C, as well as cirrhosis. Metastatic tumors are the most common type of liver tumor overall (Option A). The liver is a common site for metastasis from cancers such as colorectal, breast, and lung cancer. Hepatoblastoma is the most common pediatric liver cancer but is much less common than HCC in adults. (Option C) Hemangioma is the most common benign liver tumor and is usually asymptomatic, often discovered incidentally during imaging for other reasons. (Option D)

References:

Bailey & Love's Short Practice of Surgery (28th Edition), Page 1214.

Schwartz's Principles of Surgery (11th Edition), Page 1376.

SRB's Manual of Surgery (6th Edition), Page 598, 599.

↑ *Back to this question in Part A*

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Q2: A 55-year-old male patient with a history of chronic hepatitis B presents with abdominal discomfort and weight loss. Imaging studies reveal a primary liver tumor with multiple metastatic lesions. Considering the typical metastatic pattern of liver tumors, what is the most likely site of these metastases? (Q848892)

A. Bones

B. Brain

C. Lungs

D. Kidneys

Correct Answer: C. Lungs

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Primary liver tumors, such as hepatocellular carcinoma (HCC), typically metastasize to specific sites in a common order: Lungs : The lungs are the most common site for metastasis from HCC. Pulmonary metastases often occur due to the extensive blood flow from the liver to the lungs. Lymph nodes : Regional lymph nodes are also frequently involved in metastasis from liver tumors. Bones : Metastasis to bones can occur and may present with symptoms such as bone pain or fractures. Brain : While less common, brain metastases can occur in advanced stages of liver cancer. Kidneys : Metastasis to the kidneys is not typical for primary liver tumors.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1216

Schwartz's Principles of Surgery, 11th Edition, Page 1376,1377

Sabiston Textbook of Surgery, 21st Edition, Page 1467

SRB's Manual of Surgery, 6th Edition, Page 601

www.ncbi.nlm.nih.gov/books/NBK559177/#

www.ncbi.nlm.nih.gov/pmc/articles/PMC4945942/

↑ *Back to this question in Part A*

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Q3: A 45-year-old woman is incidentally found to have a 5 cm hepatic lesion on an ultrasound performed for evaluation of vague abdominal discomfort. A

contrast-enhanced MRI shows a lesion with peripheral nodular enhancement and centripetal filling in the delayed phase. What is the most appropriate management for this patient? (Q848893)

A. Immediate surgical resection

B. Percutaneous biopsy

C. Observation with periodic imaging

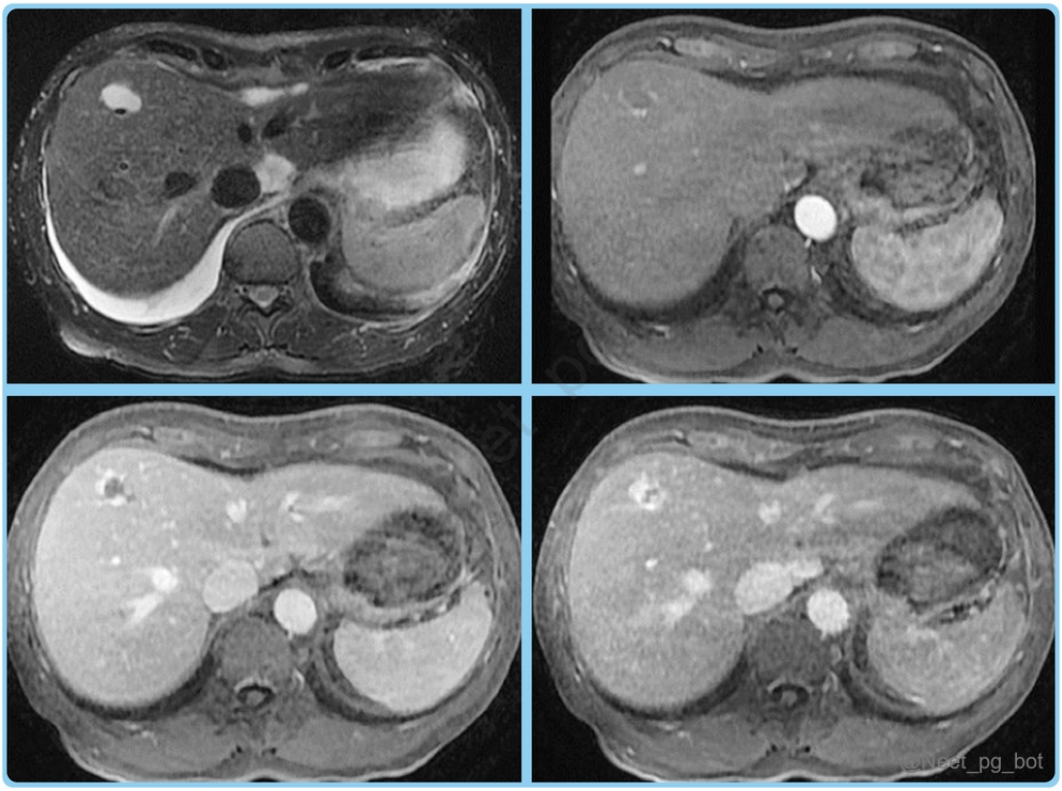
D. Radiofrequency ablation

Correct Answer: C. Observation with periodic imaging

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: A hepatic lesion was incidentally discovered on ultrasound, commonly associated with hepatic hemangiomas. MRI reveals peripheral nodular enhancement with centripetal filling in the delayed phase, highly specific for hepatic hemangiomas. Given these imaging features and the absence of symptoms or abnormal liver function, the diagnosis of a hepatic hemangioma is strongly supported. Management For small, asymptomatic hemangiomas, the standard management is observation with periodic imaging. Surgical intervention is reserved for cases where the hemangioma is symptomatic, exceeds 10 cm, shows diagnostic uncertainty after imaging, ruptures, or leads to Kasabach-Merritt syndrome. When surgery is indicated, the preferred approach is enucleation with arterial inflow control.



References:

Bailey & Love's Short Practice of Surgery (28th Edition), Page 1213.

Schwartz's Principles of Surgery (11th Edition), Page 1375.

Sabiston Textbook of Surgery (21st Edition), Page 1464.

SRB's Manual of Surgery (6th Edition), Page 598.

Hepatic hemangioma -review- - PMC

Liver Masses: A Clinical, Radiological and Pathological Perspective For

↑ *Back to this question in Part A*

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Q4: During a routine abdominal ultrasound of a 35-year-old female, a liver lesion was noted. imaging with a CECT scan shows a central stellate scar within the lesion. What is the most likely diagnosis? (Q848894)

A. Hepatocellular carcinoma

B. Focal nodular hyperplasia

C. Hepatic adenoma

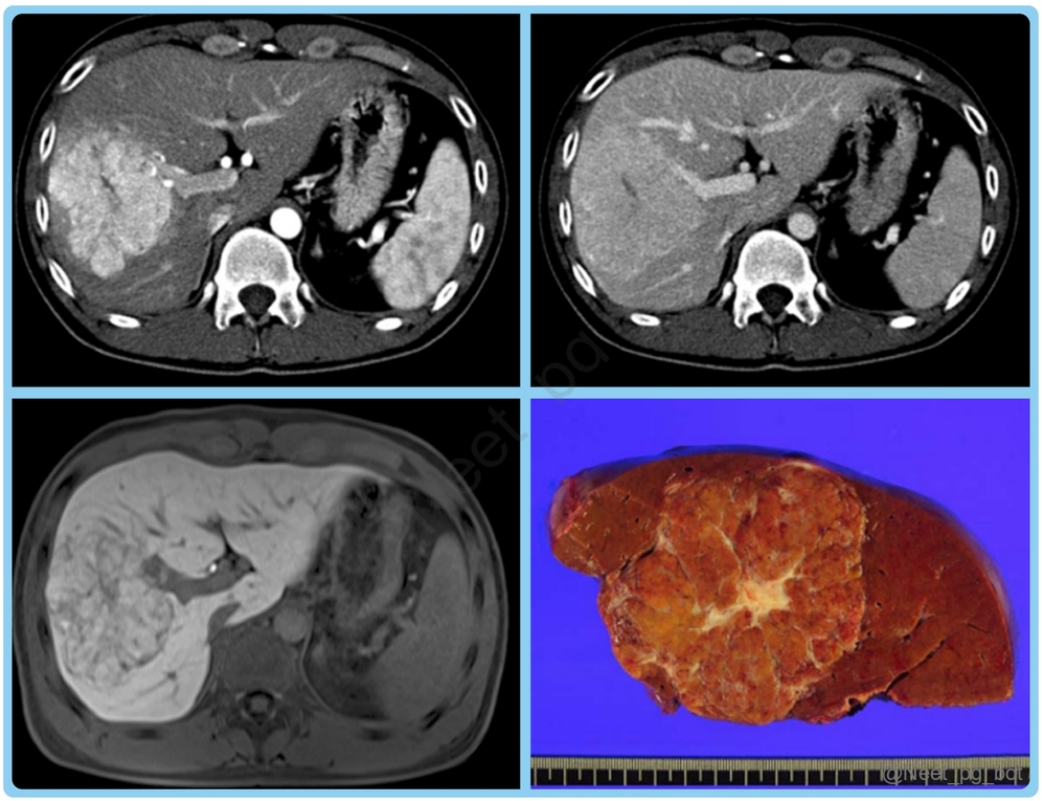
D. Hemangioma

Correct Answer: B. Focal nodular hyperplasia

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Focal nodular hyperplasia (FNH) is the 2nd most common benign tumor of the liver. It is typically asymptomatic and often discovered incidentally during imaging for other reasons. It is more common in females Diagnosis: The investigation of choice for FNH is contrast-enhanced CT (CECT), which typically shows a characteristic central stellate scar due to the presence of a central feeding arteriole with multiple peripheral branches. Angiography may show a spoke-wheel or cartwheel pattern due to abnormal vascularity. A : arterial phase B : portal phase C : magnetic resonance imaging(MRI) D : pathological examination of the resected specimen.



References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1213

Schwartz's Principles of Surgery, 11th Edition, Page 1376

Sabiston Textbook of Surgery, 21st Edition, Pages 1464, 1465

SRB's Manual of Surgery, 6th Edition, Page 599

↑ *Back to this question in Part A*

@Neet_pg_bot

Q5: A 24-year-old woman presents with complaints of right upper quadrant abdominal pain for the past few weeks. She has a history of using oral contraceptive pills for the past 5 years. On examination, the physician palpates a slightly tender, smooth, and well-defined mass in the right upper quadrant. Which of the following is the most likely diagnosis? (Q848895)

A. Hepatocellular carcinoma

B. Hepatic hemangioma

C. Hepatic adenoma

D. Focal nodular hyperplasia

Correct Answer: C. Hepatic adenoma

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Hepatic adenoma is a benign proliferative disorder of hepatocytes. They are more common in females on OCPs . They are characterized by poorly supported peripherally located blood vessels. This can lead to: An increased risk of hemorrhage and necrosis Abdominal pain A high risk of tumor rupture (30-50%). In contrast, the risk of rupture in hepatocellular carcinoma is only 3-5%. An increased risk of tumour rupture during pregnancy Hepatocellular carcinoma (Option A) usually occurs in older patients with chronic liver disease (cirrhosis, hepatitis B/C). It is typically associated with weight loss, cachexia, and liver dysfunction , not isolated OCP use. A 24-year-old healthy woman on OCPs is highly unlikely to have HCC, so this option is ruled out. Hepatic hemangioma (Option B) is the most common benign liver tumor , but it is usually asymptomatic and found incidentally. It is typically non-tender and does not present with pain unless very large. It has no strong association with OCP use , making it less likely here. Focal Nodular Hyperplasia (Option D) occurs in young women but is not strongly linked to OCP use . It is usually asymptomatic and incidentally detected , unlike this painful presentation. It has a central stellate scar on imaging and low risk of rupture , so pain and tenderness are uncommon.

References:

Bailey & Love's Short Practice of Surgery (28th Edition), Page 1212, 1213

Schwartz's Principles of Surgery (11th Edition), Page 1375, 1376

Sabiston Textbook of Surgery (21st Edition), Page 1463

SRB's Manual of Surgery (6th Edition), Page 598, 599

↑ *Back to this question in Part A*

@Neet_pg_bot

Q6: In which of the following conditions are these CECT findings seen? (Q848896)

A. Focal nodular hyperplasia

B. Serous cystadenoma of the pancreas

C. Renal oncocytoma

D. All of the above

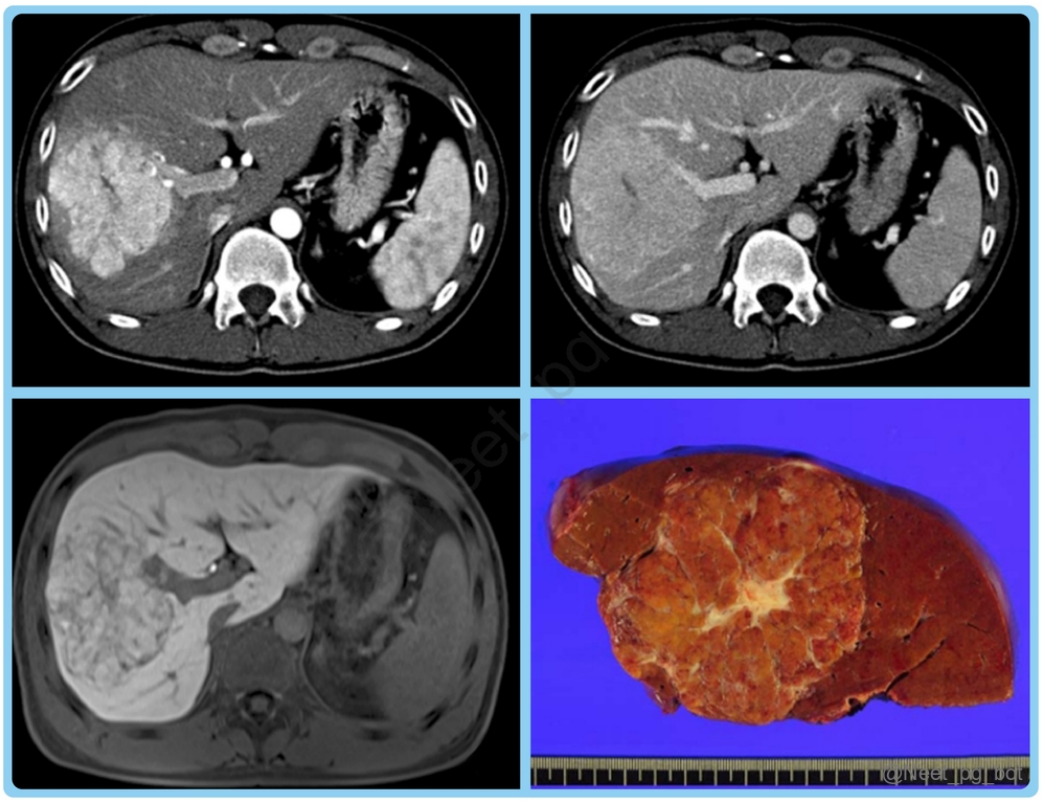


Correct Answer: D. All of the above

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The above CECT image shows a C entral Stellate Scar, most commonly seen in Focal Nodular Hyperplasia. This is because of the central feeding arteriole, which has multiple peripheral branches. It can also be seen in: Fibrolamellar variant of Hepatocellular carcinoma Serous cystadenoma of the pancreas (Option B ruled out) Renal oncocytoma ■■■■■■■(Option C ruled out) ■■■■■■■ A : arterial phase B : portal phase C : magnetic resonance imaging(MRI) D : pathological examination of the resected specimen.



References:

Bailey and Short's, 28th Edition, Page 1213

www.ncbi.nlm.nih.gov/pmc/articles/PMC4918295/

www.ncbi.nlm.nih.gov/books/NBK557432/

pubmed.ncbi.nlm.nih.gov/35983823/

↑ *Back to this question in Part A*

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Q7: A 55-year-old male patient presents with persistent abdominal pain and unexplained weight loss He has a history of chronic hepatitis B infection and moderate alcohol consumption. Physical examination reveals mild jaundice and hepatomegaly. Which of the following risk factors is most strongly associated with developing hepatocellular carcinoma (HCC) in this patient? (Q848901)

A. Age

B. Alcohol consumption

C. Hepatitis B infection

D. Male gender

Correct Answer: C. Hepatitis B infection

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Worldwide, the most common risk factor for liver cancer is chronic (long-term) infection with hepatitis B virus (HBV) or hepatitis C virus (HCV). Risk factors for HCC: Cirrhosis Metabolic disorders Environmental factors HBV infection HCV infection Alcohol NAFLD Primary biliary cirrhosis Chronic active hepatitis Hemochromatosis Wilson's Disease Glycogen Storage Disorder α1AT-deficiency Porphyria cutanea tarda Citrullinemia Orotic aciduria Alagille's syndrome Cigarette Smoking Anabolic steroids Aflatoxin Thorotrast

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1214

Schwartz's Principles of Surgery, 11th Edition, Page 1376

Sabiston Textbook of Surgery, 21st Edition, Page 1465

SRB's Manual of Surgery, 6th Edition, Page 600

www.cancer.org/cancer/types/liver-cancer/causes-risks-prevention/risk-factors.html

↑ *Back to this question in Part A*

@Neet_pg_bot

Q8: A 55-year-old man with a history of chronic hepatitis C and cirrhosis presents to the clinic with complaints of fatigue, unintentional weight loss, and abdominal discomfort. On physical examination, you note mild ascites and hepatomegaly. The serum alpha-fetoprotein level is elevated. What is the investigation of choice in this patient? (Q848902)

A. MRI with MRCP

B. CECT

C. Triple phase CT

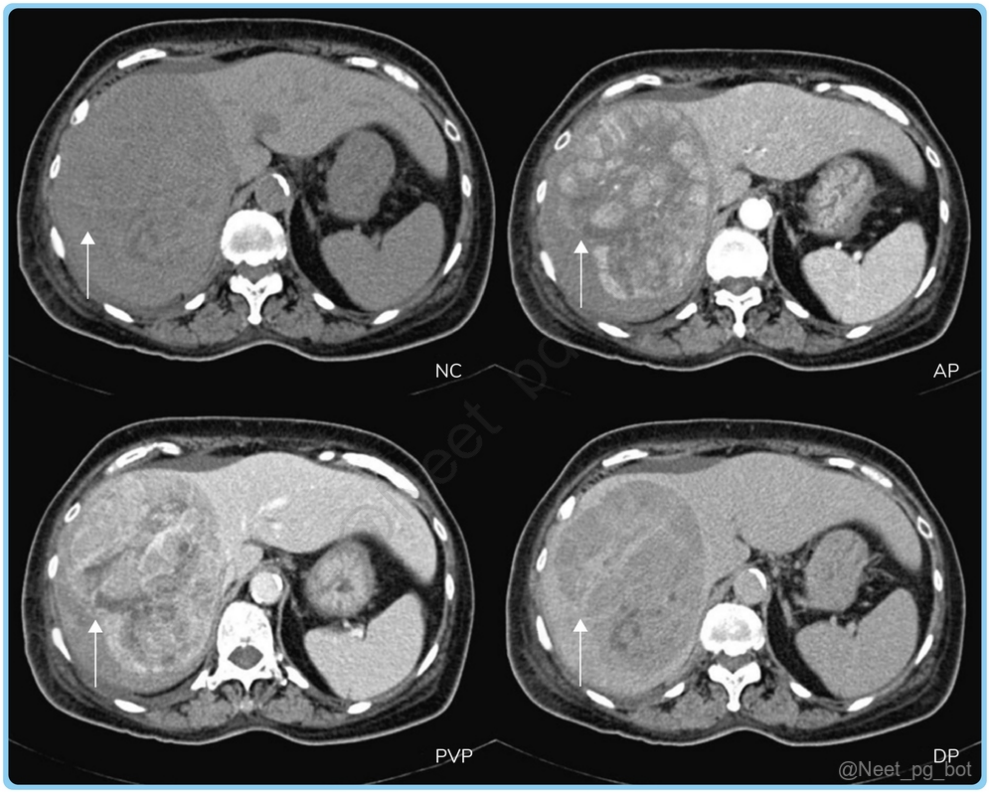
D. Liver biopsy

Correct Answer: C. Triple phase CT

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: In a patient with known risk factors for hepatocellular carcinoma (HCC) , such as chronic hepatitis C and cirrhosis, and elevated serum alpha-fetoprotein levels, the investigation of choice is Triple phase CT. The preferred method for definitive diagnosis of HCC is a Triple Phase CT scan , which highlights arterial hypervascularization and venous washout. A triple-phase CT scan has the following phases: Arterial Phase - HCC shows hyperenhancement due to its arterial blood supply. Portal Venous Phase - HCC may appear isodense or hypodense as it becomes less conspicuous compared to the surrounding liver tissue. Delayed Phase - HCC exhibits washout, a characteristic feature - appearing hypodense relative to the liver parenchyma.



References:

Bailey & Love's Short Practice of Surgery (28th Edition), Page 1215

Schwartz's Principles of Surgery (11th Edition), Page 1376

Sabiston Textbook of Surgery (21st Edition), Page 1466,1467

SRB's Manual of Surgery (6th Edition), Page 601, 602

emedicine.medscape.com/article/197319-workup#:~:text=Triple-phase%20CT%20

↑ *Back to this question in Part A*

@Neet_pg_bot

Q9: A 12-year-old boy presents with a history of fatigue, abdominal distension, and jaundice. He has a known diagnosis of liver cirrhosis secondary to chronic hepatitis B infection. Recently, he has developed a palpable liver mass, and imaging studies confirm the presence of hepatocellular carcinoma. Which of the following parameters is not typically used in the prognosis of his condition? (Q848903)

A. Serum bilirubin

B. Serum ammonia

C. Serum albumin

D. Prothrombin time/INR

Correct Answer: B. Serum ammonia

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The prognosis of hepatocellular carcinoma (HCC) in patients with underlying liver cirrhosis is heavily influenced by liver function, which is often assessed using the Child-Pugh (CP) score. Serum ammonia is typically associated with hepatic encephalopathy rather than being a direct measure used in the prognosis of HCC. Therefore, it is not typically used in the prognosis of hepatocellular carcinoma. Child-Pugh Score Parameter 1 Point 2 Points 3 Points Serum Bilirubin (mg/dL) < 2 2-3 > 3 Serum Albumin (g/dL) > 3.5 2.8-3.5 < 2.8 Prothrombin Time/ INR < 4 <1.7 4-6 1.7–2.2 > 6 >2.2 Ascites None Mild Moderate to Severe Encephalopathy None Grade 1-2 Grade 3-4 Class A : 5-6 points (well-compensated disease) Class B : 7-9 points (significant functional compromise) Class C : 10-15 points (decompensated disease)

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1196

Sabiston Textbook of Surgery, 21st Edition, Page 1443, 1444.

SRB's Manual of Surgery, 6th Edition, Page 615

https://www.ncbi.nlm.nih.gov/books/NBK542308/

↑ *Back to this question in Part A*

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Q10: A 65-year-old male with a history of chronic hepatitis B presents with increasing fatigue, weight loss, and right upper quadrant pain. Physical examination reveals

jaundice and hepatomegaly. Imaging shows multiple lesions with a 4 cm mass in the right lobe and satellite nodules in the left lobe, along with portal vein thrombosis. His LFT shows elevated bilirubin and low albumin levels. The patient is diagnosed with HCC. According to standard protocol, what is the most appropriate treatment option for this patient? (Q848905)

A. Surgical Resection

B. Liver Transplantation

C. Transarterial Chemoembolization (TACE)

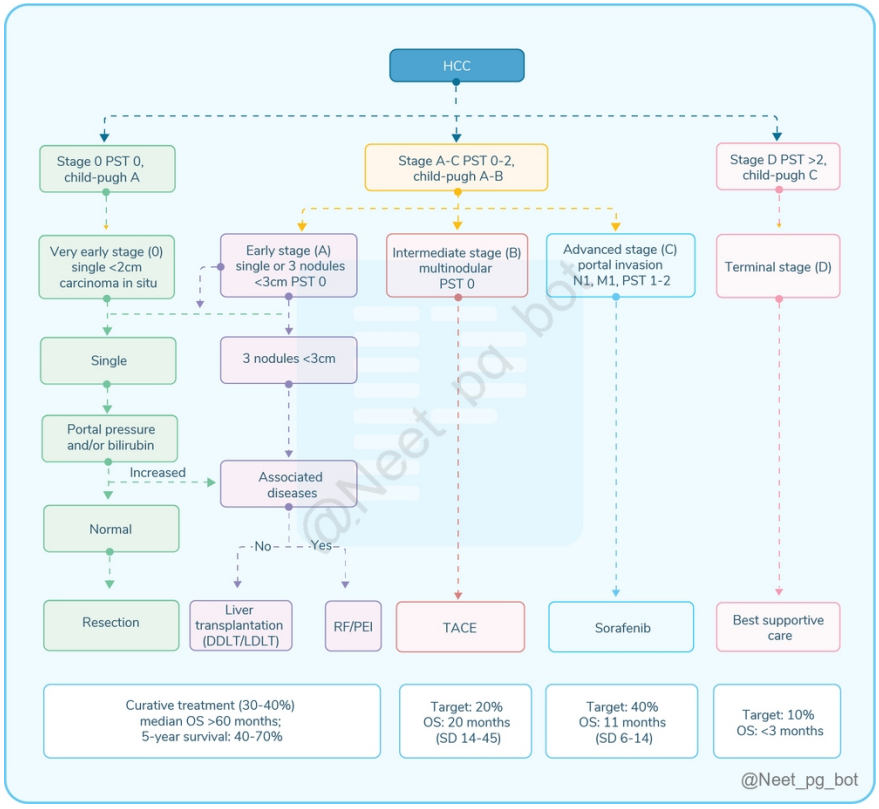
D. Sorafenib

Correct Answer: D. Sorafenib

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The patient has BCLC Stage C Hepatocellular carcinoma , characterized by the presence of vascular invasion, extrahepatic spread, or performance status of 1-2, the recommended treatment is systemic therapy with Sorafenib . Sorafenib is used for both advanced and metastatic HCC as the preferred agent. The treatment protocol adheres to the Barcelona Clinic Liver Cancer (BCLC) guidelines for hepatocellular carcinoma (HCC)
Management of HCC Barcelona Clinic Liver Cancer (BCLC) Staging system



References:

Bailey & Love's Short Practice of Surgery (28th Edition), Page 1214, 1215.

Sabiston Textbook of Surgery (21st Edition), Page 1468-1470.

SRB's Manual of Surgery (6th Edition), Page 600, 602,603

↑ *Back to this question in Part A*

@Neet_pg_bot

Q11: A 24-year-old female from Southeast Asia presents with abdominal pain and a palpable liver mass. She has no history of hepatitis B or C infection, and no signs of cirrhosis. Imaging studies show a well-circumscribed, non-encapsulated tumor in the liver with a central stellate scar. Laboratory tests reveal normal alpha-fetoprotein levels but elevated neurotensin and B12 binding globulin. What is the most likely diagnosis? (Q848906)

A. Scirrhous Variant of Hepatocellular Carcinoma

B. Fibrolamellar Variant of Hepatocellular Carcinoma

C. Cholangiocarcinoma

D. Metastatic Liver Cancer

Correct Answer: B. Fibrolamellar Variant of Hepatocellular Carcinoma

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The Fibrolamellar Variant of Hepatocellular Carcinoma, unlike other variants of HCC, has the following characteristics: Seen in young patients (<35 years), and the incidence is the same in Males &Females Well-circumscribed non-encapsulated tumor with a fibrous stroma and lamellar structure. Not associated with hepatitis B, hepatitis C, or cirrhosis. Presence of a central stellate scar on imaging. Normal alpha-fetoprotein levels, along with elevated neurotensin and B12 binding globulin. The investigation of choice is CECT, and the treatment is resection of the tumor-infested hepatic region. Scirrhous Variant of Hepatocellular Carcinoma (Option A) occurs in older patients and is usually associated with cirrhosis . It does not characteristically show a central stellate scar on imaging. AFP may be elevated , unlike this case. Cholangiocarcinoma (Option C) is typically seen in older individuals , often associated with: Primary sclerosing cholangitis Chronic biliary disease Imaging shows irregular mass with biliary duct dilatation , not a well-circumscribed lesion with central scar Tumor markers: CA 19-9 elevated , not neurotensin/B12 binding globulin Metastatic Liver Cancer (Option D) usually presents as multiple liver lesions , not a single well-circumscribed mass. No central stellate scar pattern typical of fibrolamellar HCC. Clinical history often reveals a primary tumor elsewhere .

References:

www.ncbi.nlm.nih.gov/pmc/articles/PMC10035696/

fibrofoundation.org/about-fibro/what-is-fibrolamellar-carcinoma/

Sabiston Textbook of Surgery (21st Edition), Page 1470,1471

SRB's Manual of Surgery (6th Edition), Page 600

↑ *Back to this question in Part A*

@Neet_pg_bot

Q12: A 2-year-old male presents with an asymptomatic palpable abdominal mass detected during a routine physical examination. The child has a history of low birth weight and no history of hepatitis B or C infection. Laboratory tests reveal elevated alpha-fetoprotein levels. Imaging studies show a large intra-abdominal mass. Biopsy confirms hepatoblastoma. Which of the following statements about hepatoblastoma is incorrect? (Q848907)

A. Hepatoblastoma is the most common primary malignancy of the liver in children.

B. The most common route of spread for hepatoblastoma is lymphatic.

C. Hepatoblastoma is not associated with Hepatitis B or C infection.

D. The most characteristic laboratory abnormality is thrombocytosis.

Correct Answer: B. The most common route of spread for hepatoblastoma is lymphatic.

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The most common route of spread for hepatoblastoma is hematogenous, not lymphatic. Hematogenous spread primarily involves the lungs as the most common site of metastasis. Hepatoblastoma Incidence The most common primary malignancy of the liver in children Age Group Most patients are less than 18 months old All patients are less than 3 years old Associated with Familial Adenomatous Polyposis Beckwith-Wiedemann Syndrome Low Birth Weight (LBW) Not associated with Hepatitis B or C, metabolic disorders, or cirrhosis Clinical Presentation Asymptomatic palpable intra-abdominal mass (hepatomegaly) Laboratory Findings Elevated alpha-fetoprotein level in 90% of patients Thrombocytosis (Most characteristic) Route of Spread; MC organ of metastasis Hematogenous; Lungs Diagnosis Biopsy (Investigation of choice) CECT (Radiological Investigation of choice) Management No metastasis- Resection Metastasis- Resection + Neoadjuvant Chemotherapy (Vincristine, Cisplatin, 5-Fluorouracil)

References:

National Cancer Institute

Sabiston Textbook of Surgery (21st Edition), Page 1472.

SRB's Manual of Surgery (6th Edition), Page 599.

↑ *Back to this question in Part A*

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Q13: A 55-year-old male with a history of chronic liver disease secondary to hepatitis C presents for evaluation due to worsening ascites, jaundice, and weight loss. He has been diagnosed with hepatocellular carcinoma (HCC). Imaging reveals a single liver lesion measuring 4 cm in diameter with no evidence of vascular invasion or extrahepatic spread. Laboratory studies show stable liver function tests and AFP levels below 100 ng/mL. Which of the following criteria is the most critical in determining his eligibility for liver transplantation? (Q848908)

A. Tumor size less than or equal to 5 cm

B. Absence of portal vein thrombosis

C. AFP (Alpha-fetoprotein) levels below 400 ng/mL

D. Platelet count greater than 100,000/µL

Correct Answer: A. Tumor size less than or equal to 5 cm

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Milan Criteria is used to determine the eligibility of patients with hepatocellular carcinoma (HCC) for liver transplantation. It helps to select patients who are most likely to benefit from the transplant, with a lower risk of cancer recurrence Milan Criteria for Liver Transplantation Criteria Details Tumor Size and Number Single tumor ≤ 5 cm in diameter Up to three tumors, each ≤ 3 cm in diameter Absence of Vascular Invasion No evidence of invasion of the major blood vessels by the tumor No Extrahepatic Spread No metastasis or spread of the tumor outside the liver

References:

Bailey & Love's Short Practice of Surgery (28th Edition), Page 1216.

Schwartz's Principles of Surgery (11th Edition), Page 1380.

↑ *Back to this question in Part A*

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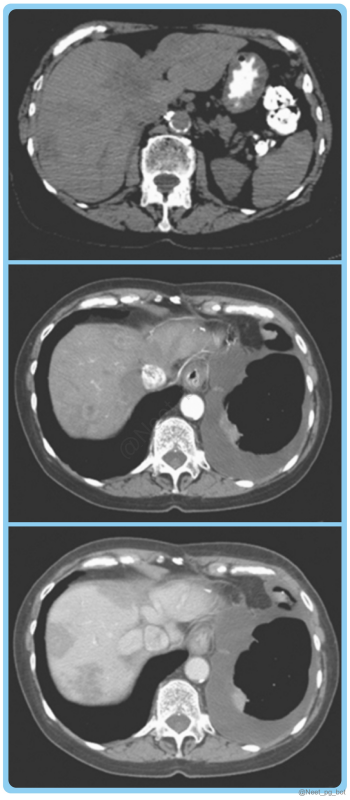
Q14: From the below given triple phase CT scan, which of the following statements is true regarding Liver cancer? (Q848909)

A. Hypodense in arterial phase in HCC

B. Hyperdense in arterial phase in Metastasis liver disease

C. Hyperdense in non-contrast CT in HCC

D. Hypodense in venous phase in Metastasis liver disease



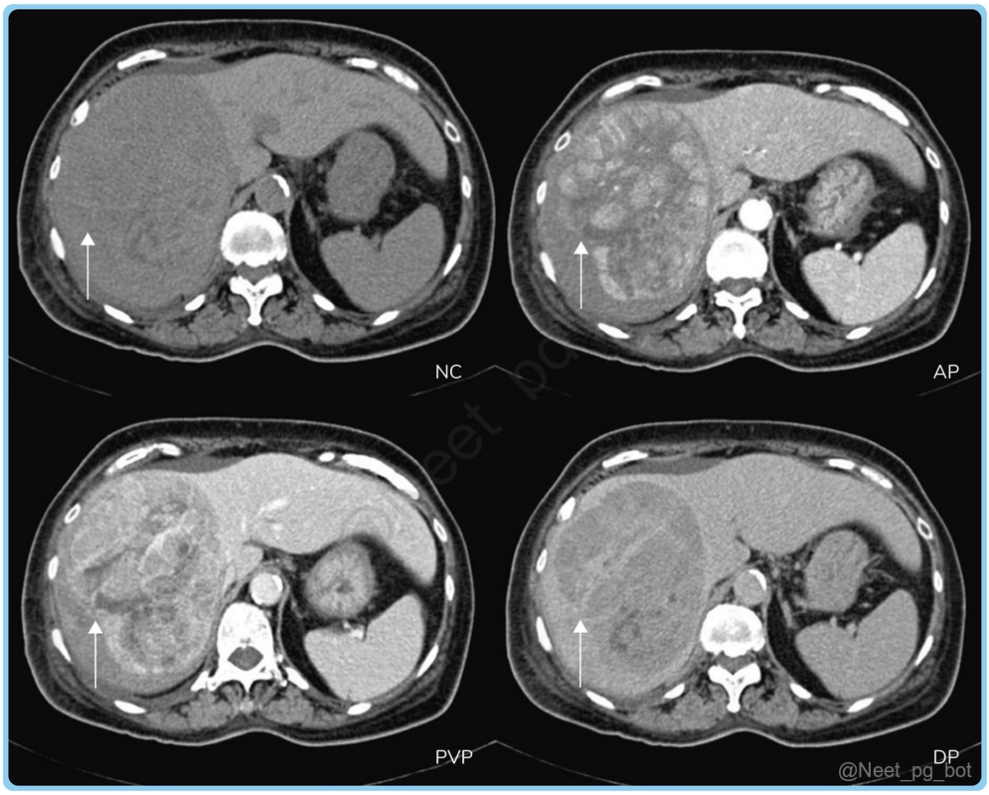
Correct Answer: D. Hypodense in venous phase in Metastasis liver disease

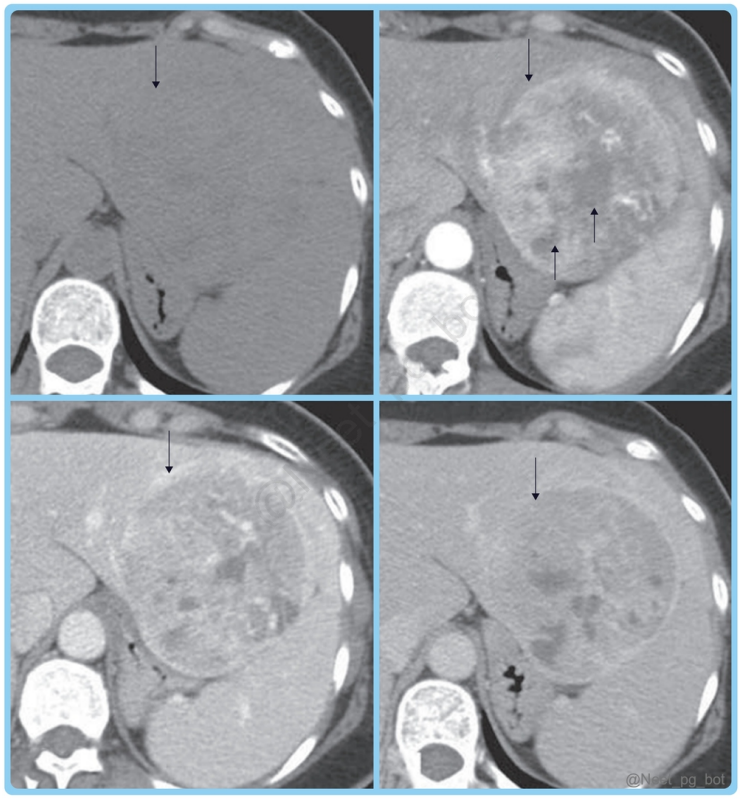
■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Triple-phase CT in Different Liver Pathologies Phase Arterial Phase Portal Venous Phase Delayed Phase Hepatocellular Carcinoma (HCC) Hypervascular with intense enhancement; lesion appears hyperdense compared to surrounding liver. Washout of contrast; lesion appears hypodense (darker) compared to liver tissue. Further washout; lesion remains hypodense or becomes isodense (similar density to liver). Liver Metastasis Hypovascular metastases appear hypodense. Hypervascular metastases (e.g., neuroendocrine tumors) may show rim enhancement. Lesions appear hypodense and become more distinct. Lesions remain hypodense, continuing to

stand out from liver tissue. Triple Phase CT in Hepatic Cell Carcinoma Triple Phase CT in Liver Metastasis





References:

Bailey & Love's Short Practice of Surgery, 28th Ed, Pg. 1196.

Sabiston Textbook of Surgery (21st Edition), Page 1467.

SRB's Manual of Surgery (6th Edition), Page 601,602.

Liver Masses: A Clinical, Radiological and Pathological Perspective For

↑ *Back to this question in Part A*

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• [04_Hepatobiliary Pancreatic Surgery] 014 Portal Hypertension

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[04_Hepatobiliary Pancreatic Surgery] 014 Portal Hypertension — Quick Jump

Q1 (p. 1598) *Q2 (p. 1599)* *Q3 (p. 1599)* *Q4 (p. 1601)* *Q5 (p. 1602)* *Q6 (p. 1604)*
Q7 (p. 1607) *Q8 (p. 1608)* *Q9 (p. 1610)* *Q10 (p. 1612)* *Q11 (p. 1613)* *Q12 (p. 1614)*
Q13 (p. 1615) *Q14 (p. 1616)*

Q1: A 45-year-old female who recently underwent bone marrow transplantation presents with abdominal pain and swelling. The clinical features resonate with hepatic veno-occlusive disease and a transvenous hepatic biopsy confirms the diagnosis. Which of the following symptoms is NOT a part of the clinical triad of hepatic veno-occlusive disease? (Q849016)

A. Tender hepatomegaly

B. Hyperbilirubinemia (jaundice)

C. Retention of fluid (ascites)

D. Portal hypertension

Correct Answer: D. Portal hypertension

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The clinical triad of veno-occlusive disease includes tender hepatomegaly, hyperbilirubinemia (jaundice), and retention of fluid (ascites) While portal hypertension can be a complication of VOD, it is not part of the clinical triad Hepatic veno-occlusive disease / Sinusoidal Obstruction Syndrome Definition Hepatic venous outflow obstruction caused by endothelial sclerosis of sublobular hepatic veins and venules Etiology The most common cause in Western countries: Bone marrow transplantation Chemotherapy agents: Cytarabine, Thioguanine, Gemtuzumab, Ozogamicin Immunosuppressive agents: Azathioprine Consumption of bush teas: Crotalaria and Senecio (contain pyrrolizidine alkaloids) Clinical Features (Triad) Tender hepatomegaly Hyperbilirubinemia (jaundice) Retention of fluid (ascites) Diagnosis Investigation of choice: Biopsy Management SSPCS (Side-to-side portocaval shunt): Only if hepatic venous outflow obstruction with IVC sparing Liver transplantation: For hepatic failure Defibrotide: Improves survival

References:

https://www.sciencedirect.com/science/article/pii/S1083879115006497?ref=pdf_download&fr=RR-2&rr=9ddf00be3a9c898a

↑ *Back to this question in Part A*

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Q2: Which of the following is a pre-sinusoidal cause of portal hypertension? (Q849006)

A. Cirrhosis

B. Budd-Chiari syndrome

C. Congestive cardiac failure

D. Schistosomiasis

Correct Answer: D. Schistosomiasis

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Schistosomiasis is one of the pre-sinusoidal intrahepatic Causes of Portal Hypertension. Pre-sinusoidal Extrahepatic Portal vein thrombosis Splenic vein thrombosis Myelofibrosis Arterioportal shunt Tropical splenomegaly Intrahepatic Schistosomiasis Congenital hepatic fibrosis Portal infiltration (e.g., sarcoidosis) Drugs and toxins Sinusoidal ■■■■■■■ Cirrhosis (Option A ruled out) Post-sinusoidal ■■■■■■■■ ■■■■■■■■ Hepatic vein occlusion: Budd-Chiari syndrome (Option B ruled out) Veno-occlusive disease Congestive cardiac failure (Option C ruled out)

References:

Bailey and Love’s Short Practice of Surgery, 28th Edition, Page 1203-1204.

↑ *Back to this question in Part A*

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Q3: A 52-year-old man presents to the emergency department with worsening abdominal distension and visible abdominal veins. He has a history of chronic alcohol abuse and has been experiencing increasing fatigue and jaundice. Collaterals are between the paraumbilical vein &.....: Which of the following vessels is involved in this condition? (Q849007)

A. Left gastric vein

B. Superior and inferior epigastric vein

C. Superior mesenteric vein

D. Inferior vena cava

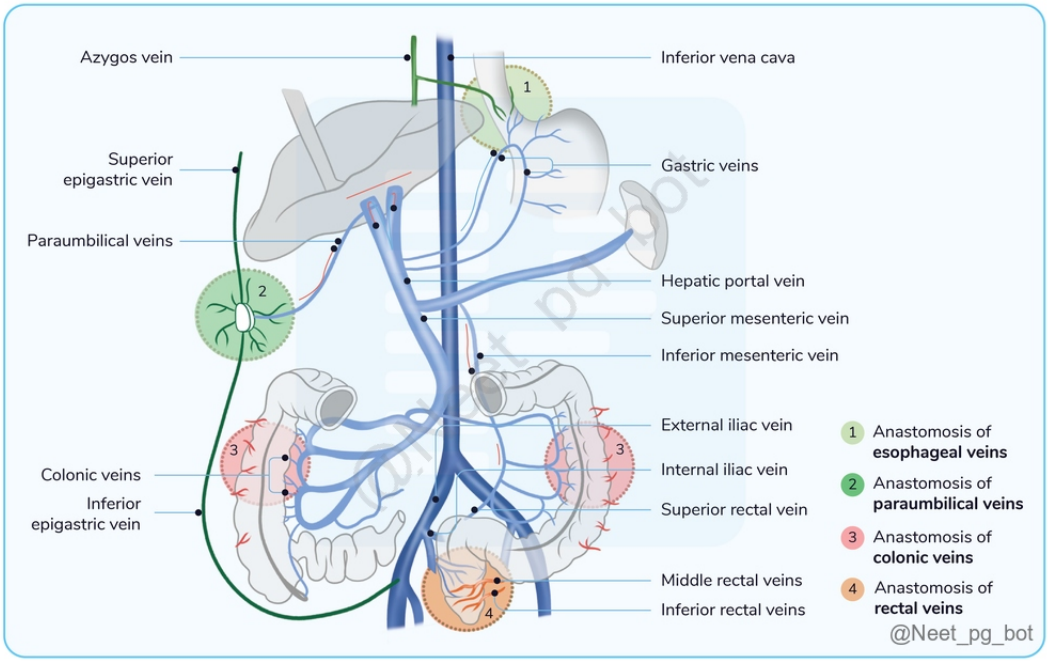


Correct Answer: B. Superior and inferior epigastric vein

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Caput medusae is a clinical sign associated with portal hypertension . It occurs due to increased pressure in the portal venous system, resulting in the development of engorged veins around the umbilicus. It usually forms a shunt between the paraumbilical vein and the inferior and superior epigastric vein . Sites of portosystemic anastomosis:



Portal venous component	Systemic venous component	Manifestation and site
Left gastric vein (aka coronary vein)	Azygous vein	Esophageal varices at GE junction (A)
Superior rectal vein	Middle and inferior rectal veins	Rectal varices (internal hemorrhoids) at the rectum (B)
Paraumbilical vein	Superior and inferior epigastric vein	Caput medusae at the umbilicus (C)

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References:

www.ncbi.nlm.nih.gov/pmc/articles/PMC5198179/

www.ncbi.nlm.nih.gov/pmc/articles/PMC5198179/

↑ *Back to this question in Part A*

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Q4: A 55-year-old man with a history of cirrhosis presents to the emergency department with hematemesis and melena. He is hypotensive and tachycardic. Which of the following is the most appropriate initial step in management? (Q849008)

A. Order an urgent upper endoscopy

B. Administer a proton pump inhibitor

C. Request a CT scan of the abdomen

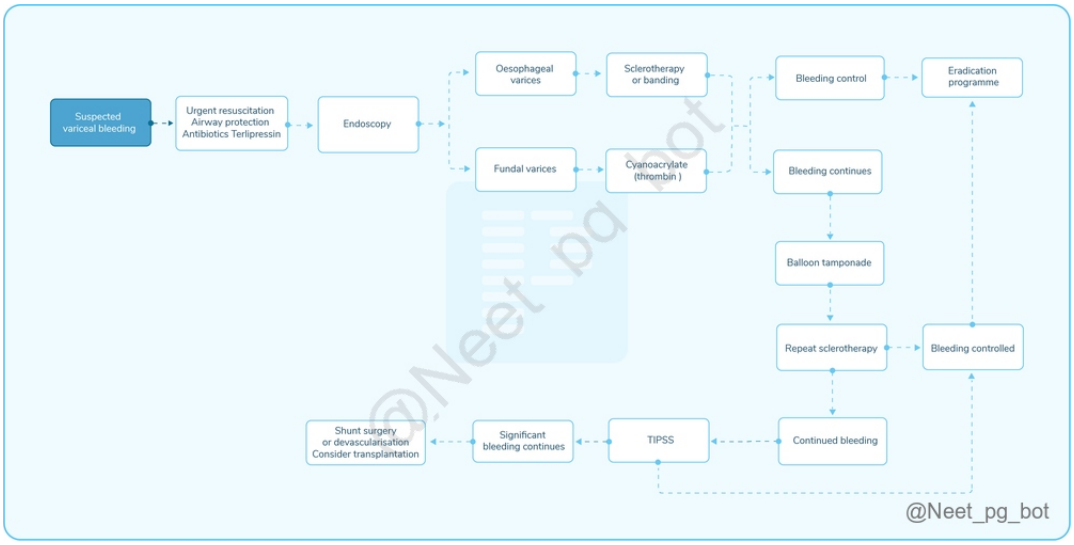
D. Initiate fluid resuscitation

Correct Answer: D. Initiate fluid resuscitation

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The immediate priority in managing variceal bleeding is stabilizing the patient's condition. This involves the airway, breathing, and circulation. Establishing intravenous access with large-bore cannulae allows for rapid fluid resuscitation , ideally with blood transfusions, to restore circulatory volume and address hypotension. While endoscopy (Option A) is crucial for diagnosis and definitive treatment of variceal bleeding, it should only be performed after the patient is hemodynamically stable. Proton pump inhibitors (Option B) reduce gastric acid secretion but have no role in the initial management of acute variceal bleeding. CT scanning (Option C) can help evaluate the liver and portal vein, but it is not a priority during the initial resuscitation phase.



References:

Bailey and Love’s Short practice of surgery, 28th Edition, Page 1203-1204.

↑ *Back to this question in Part A*

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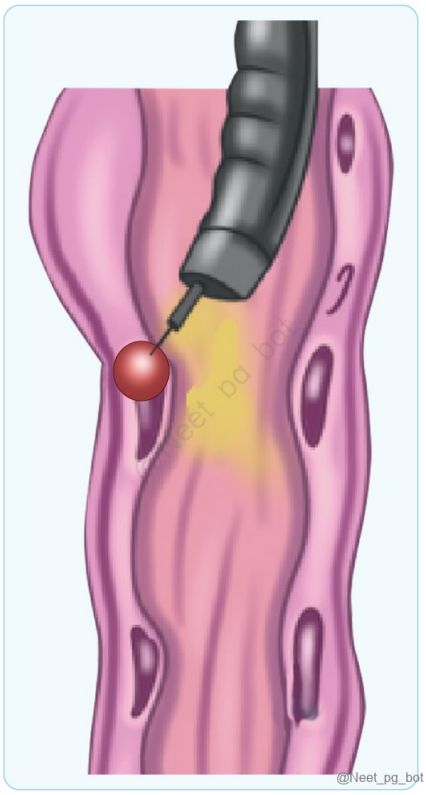
Q5: Which of the following statements is true about the image below? (Q849009)

A. Technically difficult to perform

B. Decreased chances of perforation

C. Always preferred over ligation

D. Lack of depth perception is present

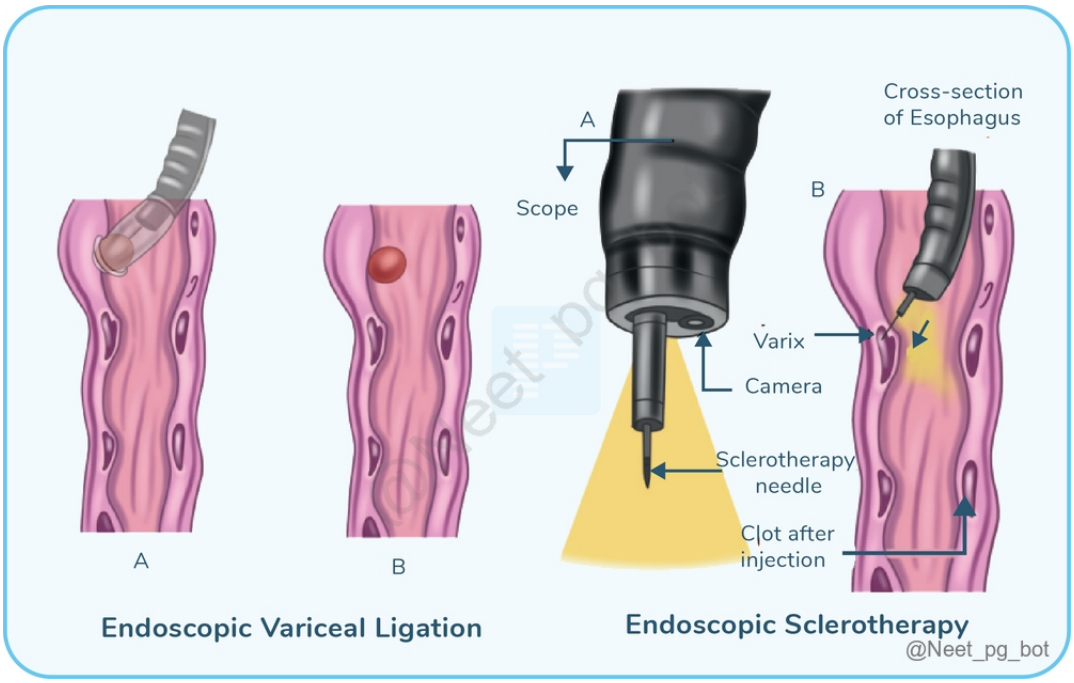


Correct Answer: D. Lack of depth perception is present

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The image is a procedure of Endoscopic sclerotherapy commonly done in the case of esophageal variceal bleeding. Endoscopic sclerotherapy , while easier to perform, has a higher risk of esophageal perforation due to reduced depth perception during the procedure. A double-channel endoscope equipped with a bridge is essential for performing sclerotherapy. The bridge facilitates suction during the injection process and enhances the maneuverability of the needle. The sclerosants commonly used include Sodium Tetradecyl Sulfate, ethanolamine oleate , etc. Treatment of Choice to Control Bleeding: Endoscopic Variceal Ligation (Option C) is preferred over endoscopic sclerotherapy for controlling bleeding from variceal hemorrhage. EVL is technically more challenging to perform but carries a lower risk of esophageal perforation compared to sclerotherapy.



References:

Bailey and Love's practice of Surgery, 28th Edition, Page 1205

↑ *Back to this question in Part A*

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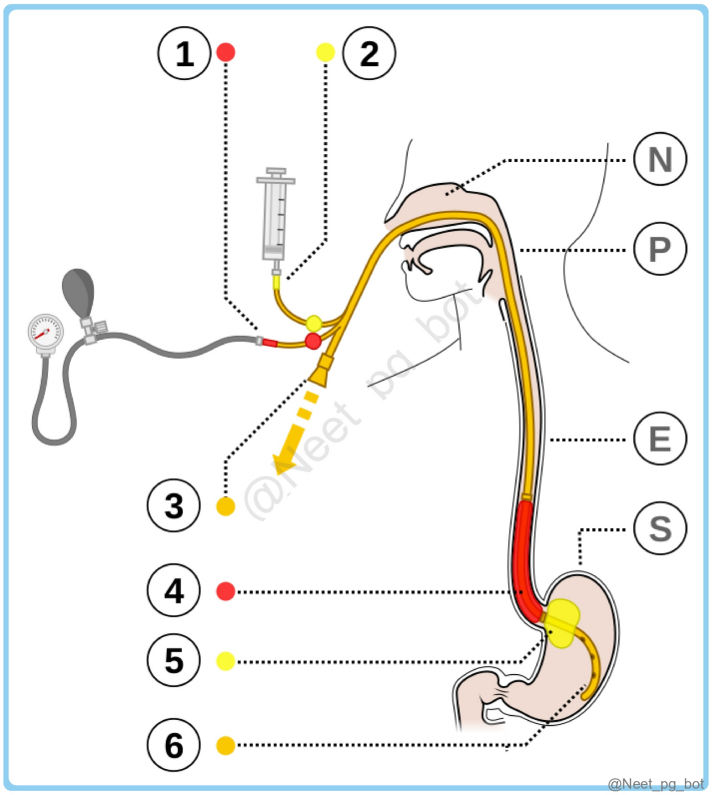
Q6: Identify the tube shown in the following image used in the management of portal hypertension. (Q849010)

A. Sengstaken-Blakemore tube

B. Minnesota tube

C. Linton-Nachlas tube

D. Nasogastric (Ryle's) tube

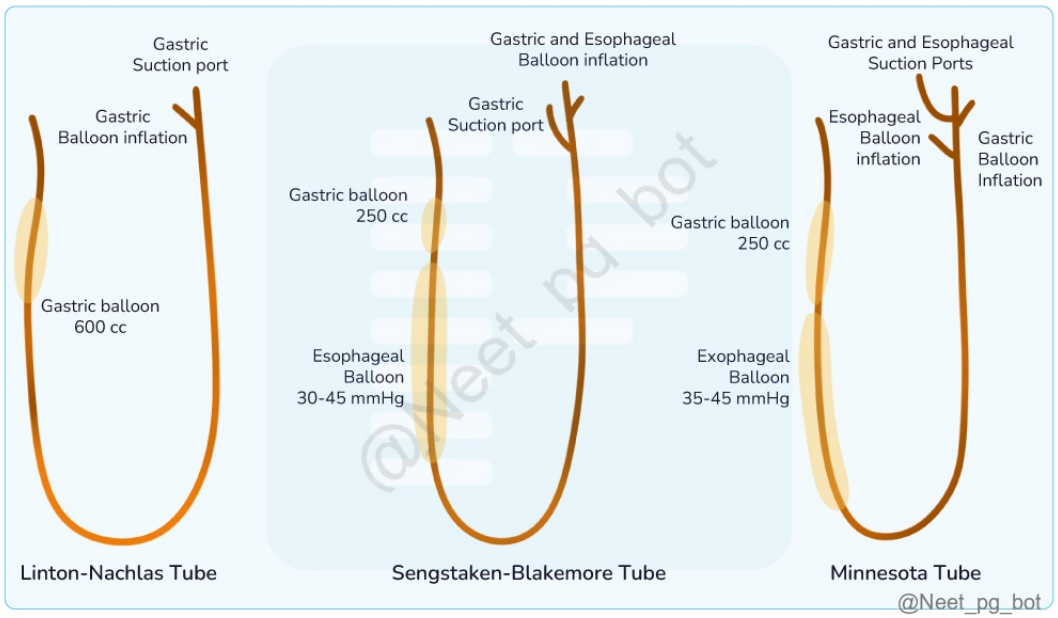


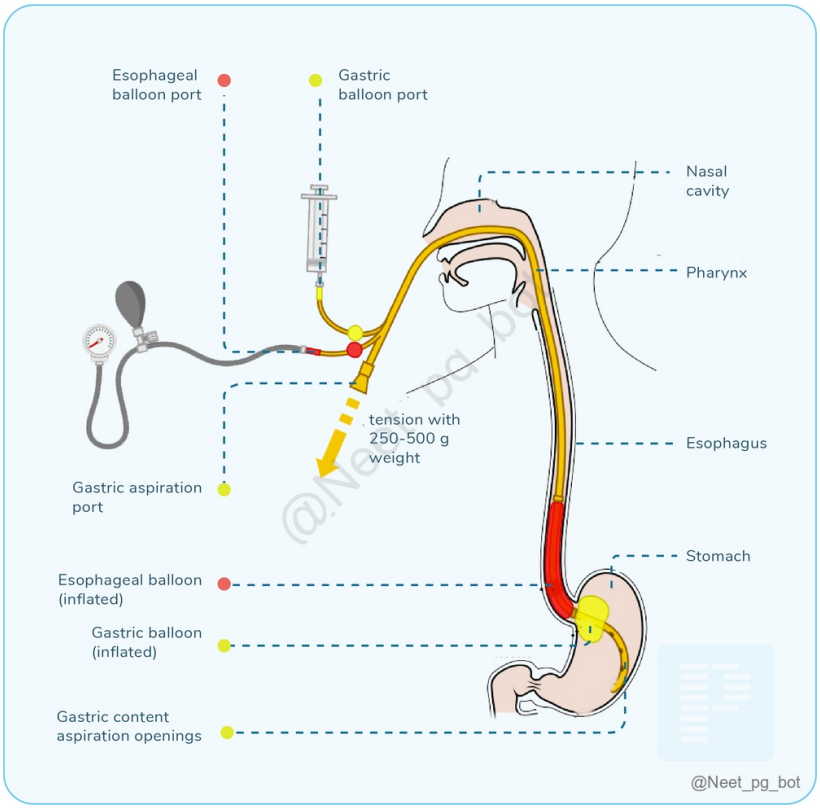
Correct Answer: A. Sengstaken-Blakemore tube

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The Sengstaken-Blakemore tube is used to manage esophageal variceal bleeding. The tube has 3 lumens and 2 inflatable balloons: Lumens : Gastric Aspiration Lumen : This lumen allows for the drainage of gastric contents. It helps to monitor and manage any bleeding from the stomach. Gastric Balloon Lumen : This lumen is connected to the gastric balloon and is used to inflate it with air or saline, anchoring the tube in place within the stomach. Esophageal Balloon Lumen : This lumen is connected to the esophageal balloon and is used to inflate it, applying pressure to the esophageal varices to stop bleeding. Balloons : Gastric Balloon : Positioned in the stomach, this balloon is inflated to anchor the tube and to apply pressure to the area of bleeding if necessary. Esophageal Balloon : This balloon is inflated within the esophagus to exert pressure directly on the bleeding varices, helping to control hemorrhage. The tube is inserted through the nose or mouth and carefully advanced into the stomach. Once in position, the balloons are sequentially inflated to apply pressure on the bleeding varices, effectively controlling hemorrhage. This intervention is temporary and used in the emergency setting until definitive treatments, such as endoscopic procedures, can be performed. The Minnesota tube (Option B) is similar to the Sengstaken-Blakemore tube but with an additional lumen for the suction of esophageal secretions. The Linton-Nachlas tube (Option C) is used for the decompression of the stomach and the prevention of aspiration in cases of massive upper gastrointestinal hemorrhage. It is not commonly used for esophageal varices but rather for general decompression and bleeding control in the stomach. Nasogastric (Ryle's) tube (Option D) is used for gastric decompression, feeding, and administering medications. It is not designed for controlling esophageal variceal bleeding.





References:

Sabiston Textbook of Surgery, 21st Edition, Page 1446.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q7: A 60-year-old patient with refractory ascites secondary to cirrhosis undergoes Transjugular intrahepatic portosystemic shunt placement. Two days post-procedure, the patient develops severe dyspnea, peripheral edema, jugular venous distension, and hypotension. A Doppler ultrasound reveals a patent shunt. Which of the following is the most likely cause of the patient's symptoms? (Q849011)

A. Right heart failure

B. Hepatorenal syndrome

C. Pulmonary hypertension

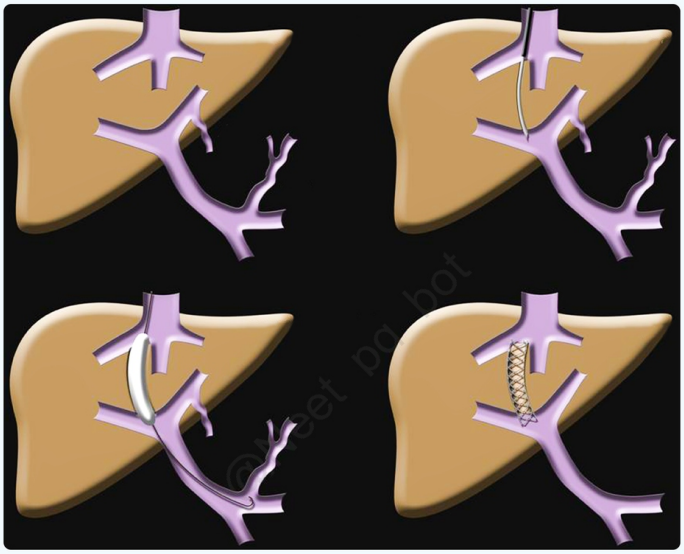
D. Porto-pulmonary hypertension

Correct Answer: A. Right heart failure

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Post-TIPSS, the increased preload from the diverted blood flow can overwhelm the right heart, leading to right heart failure. This presents as severe dyspnea, peripheral edema, jugular venous distension, and hypotension. The management includes the use of diuretics to reduce fluid overload. TIPSS (Transjugular Intrahepatic Porto Systemic Shunt) It is a nonselective shunt used to treat complications of portal hypertension. The liver is accessed through the Jugular vein and the stent is placed to create a channel between the right Hepatic vein and the right branch of the portal vein. Reduces portal pressure by diverting blood flow. Indications Contraindications Variceal bleeding Refractory ascites Hepatic hydrothorax Budd Chiari Syndrome Portal Hypertensive gastropathy Severe hepatic encephalopathy Severe heart failure Severe pulmonary hypertension Uncontrolled systemic infection Polycystic liver disease The hepatorenal syndrome (Option B) occurs in advanced liver disease characterized by renal failure due to altered renal perfusion without structural kidney damage. It presents with renal dysfunction (e.g., oliguria, elevated serum creatinine) rather than severe dyspnea, peripheral edema, and jugular venous distension. Pulmonary hypertension (Option C) can occur in liver disease but is less likely to cause acute severe dyspnea, peripheral edema, and jugular venous distension immediately post-TIPSS. This condition usually develops gradually and presents with symptoms like fatigue, chest pain, and dyspnea on exertion. Porto-pulmonary hypertension (Option D) develops over time and is characterized by increased pulmonary artery pressure.



Steps in a TIPS procedure :

A Portal hypertension has caused the coronary vein (arrow) and the umbilical vein (arrowhead) to dilate and flow in reverse.
B A needle has been introduced (via the jugular vein) and is passing from the hepatic vein into the portal vein
C The tract is dilated with a balloon.
D After placement of a stent, portal pressure is normalized

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References:

Bailey & Love Short Practice of Surgery, 28th Edition, Page 1205.

↑ *Back to this question in Part A*

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Q8: Which of the following complications is most likely to occur after the creation of a side-to-side portocaval shunt (SSPCS)? (Q849012)

A. Encephalopathy

B. Renal failure

C. Recurrent variceal bleeding

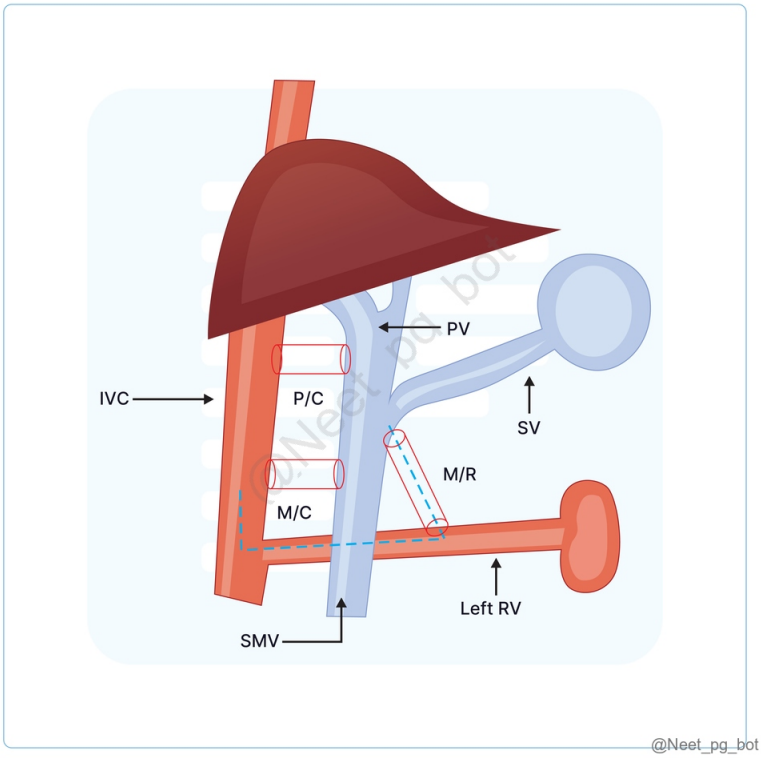
D. Portal vein thrombosis

Correct Answer: A. Encephalopathy

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Encephalopathy is a common complication following the creation of a non-selective shunt like the side-to-side portocaval shunt (SSPCS). This is because the shunt allows portal blood which contains toxins, to bypass the liver and enter the systemic circulation directly, leading to hepatic encephalopathy. Non-Selective Shunts: Non-selective shunts are surgical procedures used to manage portal hypertension by diverting blood flow from the portal venous system directly into the systemic circulation, bypassing the liver. This reduces portal pressure and decreases complications like variceal bleeding. However, they also reduce hepatic blood flow, potentially leading to liver ischemia and worsening hepatic function. Side-to-side portocaval Shunt (SSPCS) involves a side-to-side anastomosis between the portal vein and the inferior vena cava. Used for conditions such as Budd-Chiari syndrome, veno-occlusive disease, and refractory ascites. Most widely performed shunt due to its effectiveness in reducing portal pressure. High risk of hepatic encephalopathy due to the diversion of blood away from the liver, reducing its detoxification capacity. Other Non-Selective Shunts: Eck Fistula is an end-to-side portocaval shunt where the portal vein is divided, and its proximal part is sutured to the inferior vena cava. Interposition Grafts - A vascular graft is used to connect the portal vein to the systemic circulation. Types include portocaval, mesocaval (superior mesenteric vein to inferior vena cava), and mesorenal (superior mesenteric vein to left renal vein) grafts. Used when a direct shunt is not feasible or preferred. IVC - Inferior Vena Cava; P/C - Porto-caval; M/C - Meso-caval; M/R - Meso-renal; PV - Portal Vein; SMV - Superior Mesenteric Vein; SV - Splenic Vein; Left RV - Left Renal Vein



References:

Sabiston Textbook of Surgery, 21st Edition, Page 1448.

↑ *Back to this question in Part A*

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Q9: Which selective shunt procedure is associated with the preservation of portal perfusion to the liver while effectively decompressing varices? (Q849013)

A. Distal splenorenal shunt (DSRS)

B. Proximal splenorenal shunt (PSRS)

C. Side-to-side portocaval shunt (SSPCS)

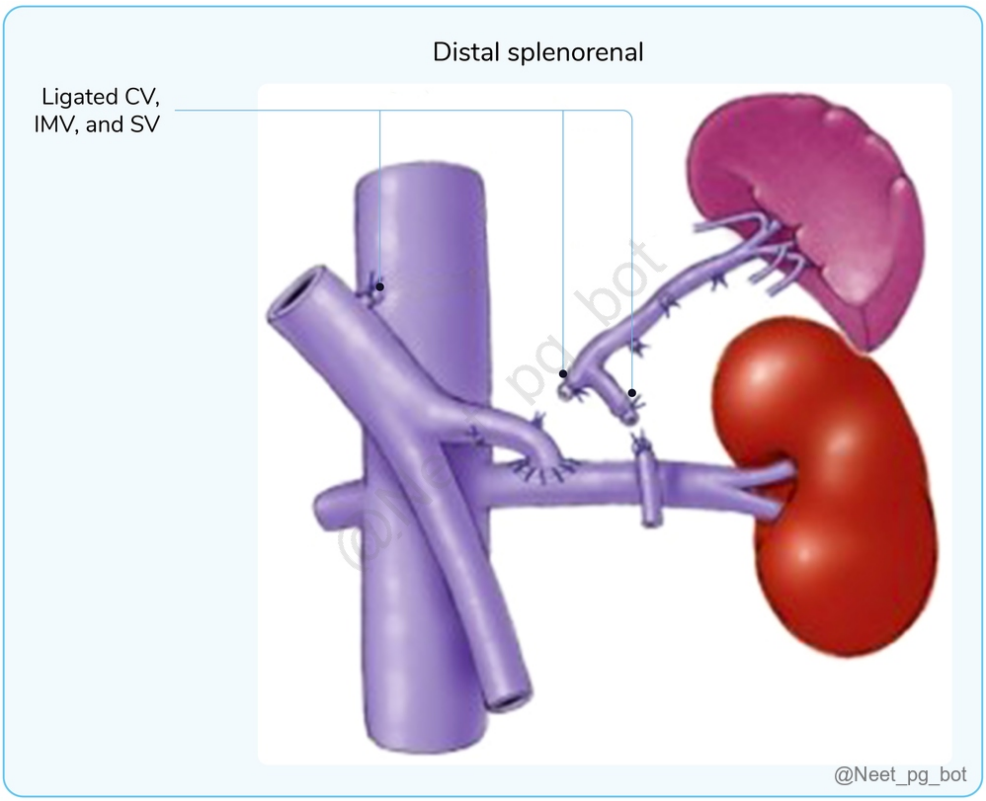
D. Interposition grafts

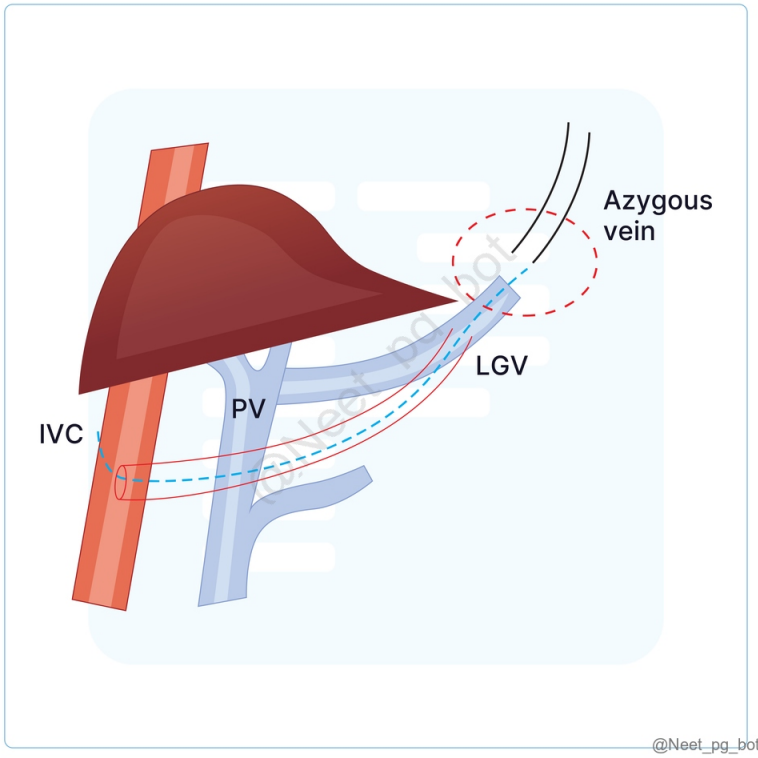
Correct Answer: A. Distal splenorenal shunt (DSRS)

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Selective shunts are designed to divert blood from specific parts of the portal system, preserving some hepatic portal perfusion and reducing the risk of hepatic encephalopathy. Distal Splenorenal Shunt (DSRS) or Warren Shunt The distal part of the splenic vein is anastomosed to the left renal vein. Selectively decompresses the spleen and gastroesophageal junction varices while maintaining hepatic portal flow. Lower risk of encephalopathy compared to non-selective shunts. Inokuchi Shunt Involves an interposition graft between the left gastric vein and the inferior vena cava. Used for selectively draining the gastroesophageal junction, particularly in patients with gastroesophageal varices. Proximal splenorenal shunt (Option B) after splenectomy, connects the proximal splenic vein to the left renal vein but does not specifically focus on preserving portal perfusion to the liver. Side-to-side portocaval shunt (Option C) diverts a significant portion of portal blood flow to the inferior vena cava, reducing portal pressure but not preserving liver perfusion. Interposition grafts (Option D) are non-selective shunts that can be used to connect the portal vein to the systemic circulation.





References:

Sabiston Textbook of Surgery, 21st Edition, Page 1449

↑ *Back to this question in Part A*

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Q10: In a patient with Budd Chiari Syndrome, which of the following imaging findings is most indicative of chronic disease? (Q849014)

A. Enlarged caudate lobe

B. Ascites

C. Hepatic vein thrombosis

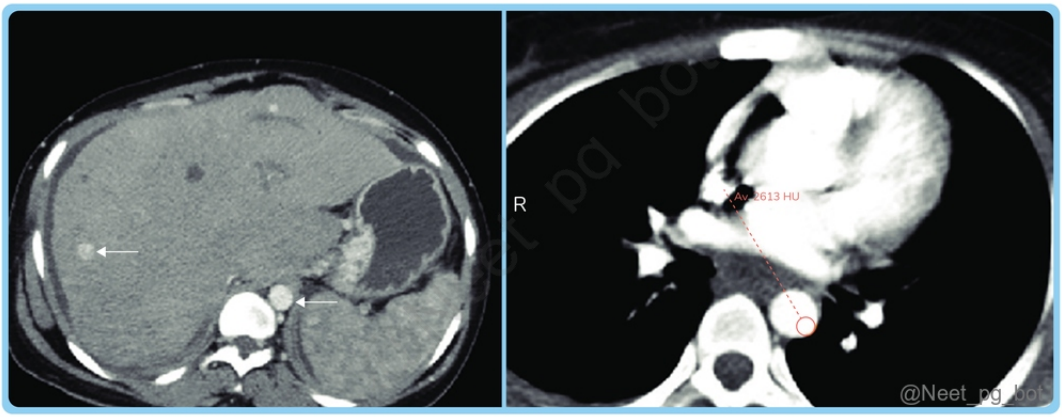
D. Splenomegaly

Correct Answer: A. Enlarged caudate lobe

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The enlarged caudate lobe is a hallmark of chronic Budd Chiari Syndrome. The caudate lobe has its own venous drainage directly into the inferior vena cava, allowing it to remain viable and potentially enlarge when the rest of the liver is affected by venous outflow obstruction. Budd-Chiari Syndrome Etiology The most common cause is hepatic venous thrombosis. Other causes include inferior vena cava obstruction. Risk Factors: Polycythemia vera Thrombophilic disorders Malignancies Clinical Features The characteristic triad includes ascites, hepatomegaly, and abdominal pain. Jaundice, encephalopathy, anorexia, and fatigue may occur if hepatic failure develops. Diagnosis Venography is the investigation of choice, showing spider web collaterals if the hepatic veins are involved, or vena cavography if the inferior vena cava is obstructed Treatment Treatment includes anticoagulants, thrombolysis (if within the window period), and surgical intervention. In cases of liver failure, liver transplantation is the treatment of choice Ascites (Option B) can occur in both acute and chronic Budd Chiari Syndrome and is not specific to the chronic stage of the disease. While hepatic vein thrombosis (Option C) is a key feature of Budd-Chiari Syndrome, it can be present in both acute and chronic stages and does not specifically indicate chronicity. Splenomegaly (Option D) is a common finding due to portal hypertension but can be seen in both acute and chronic phases, thus not specifically indicative of chronic disease.



References:

Bailey & Love Short Practice of Surgery, 28th Edition, Page 1208

↑ *Back to this question in Part A*

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Q11: A 12-year-old boy presents with a history of recurrent episodes of gastrointestinal bleeding. He has no history of liver disease, jaundice, or ascites. Physical examination reveals moderate splenomegaly but no hepatomegaly. Doppler ultrasound of the abdomen shows obstruction at the confluence of the splenic vein and the superior mesenteric vein. What is the most likely diagnosis? (Q849015)

A. Cirrhosis

B. Non-Cirrhotic Portal Fibrosis (NCPF)

C. Extrahepatic Portal Vein Obstruction (EHPVO)

D. Budd-Chiari Syndrome

Correct Answer: C. Extrahepatic Portal Vein Obstruction (EHPVO)

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Extrahepatic Portal Vein Obstruction (EHPVO) is characterized by obstruction of the portal vein outside the liver, commonly at the confluence of the splenic vein and superior mesenteric vein. It is often seen in younger patients 1st to 2nd decade of life and can present with gastrointestinal bleeding and splenomegaly without signs of liver disease Other options: Cirrhosis (Option A) typically presents with signs of liver disease, such as jaundice, ascites, and hepatomegaly, none of which are present in this patient. Non-Cirrhotic Portal Fibrosis (NCPF) (Option B) involves the intrahepatic branches of the portal vein and typically presents in the 2nd to 4th

decades of life, with more severe splenomegaly. It is associated with certain substances such as Vinyl chloride, Arsenic, and Copper. Budd-Chiari Syndrome (Option D) involves obstruction of the hepatic veins, often presenting with hepatomegaly, ascites, and liver dysfunction, which are not seen in this patient.

References:

Bailey & Love Edition, 28th Edition, Pages 1204 & 1205.

www.ncbi.nlm.nih.gov/pmc/articles/PMC10606323/

www.ncbi.nlm.nih.gov/pmc/articles/PMC4455142/

↑ *Back to this question in Part A*

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Q12: A 45-year-old man presents to the emergency department with a 3-day history of left upper quadrant abdominal pain and nausea. He has a history of chronic pancreatitis due to alcohol abuse. Physical examination reveals tenderness in the left upper quadrant and splenomegaly. Abdominal CT scan without contrast shows a thrombus in the splenic vein. What type of varices are likely to be seen on endoscopic examination? (Q849017)

A. Esophageal varices

B. Gastric varices

C. Esophageal and gastric varices, with esophageal predominant

D. Duodenal varices

Correct Answer: B. Gastric varices

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: This clinical scenario is typical of splenic vein thrombosis (SVT) , a condition often associated with chronic pancreatitis. The patient's history of chronic pancreatitis, left upper quadrant pain, splenomegaly, and the CT finding of a thrombus in the splenic vein all point to this diagnosis.Splenic vein thrombosis predominantly shows gastric varices on endoscopy. Splenic vein thrombosis Etiology Pancreatic disorders (most common) : Acute or chronic pancreatitis Pancreatic cancer Abdominal trauma or surgery Hypercoagulable states Pathophysiology Obstruction of splenic vein leading to increased pressure in splenic circulation Development of collateral circulation (left-sided portal hypertension) Formation of gastric (predominantly) and esophageal varices Splenomegaly due to congestion Diagnosis CT or MRI showing splenic vein occlusion Endoscopic ultrasound Angiography (less commonly used) Clinical signs : splenomegaly, gastric varices, normal liver function Treatment Treat underlying cause (e.g., pancreatitis) Anticoagulant therapy using LMWH Splenectomy

for symptomatic patients or those with bleeding varices Endoscopic management of bleeding varices Esophageal varices (Option A) are more commonly associated with cirrhosis and generalized portal hypertension, rather than isolated splenic vein thrombosis. While it's possible to have both esophageal and gastric varices (Option C), the predominance of esophageal varices is more characteristic of portal hypertension (as seen in cirrhosis) rather than splenic vein thrombosis. Duodenal varices (Option D) are rare and usually associated with generalized portal hypertension or portal vein thrombosis, not isolated splenic vein thrombosis.

References:

www.ncbi.nlm.nih.gov/books/NBK553170/

www.ncbi.nlm.nih.gov/pmc/articles/PMC9339209/

↑ *Back to this question in Part A*

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Q13: A 60-year-old male with a history of cirrhosis presents with recurrent esophageal variceal bleeding that has not responded to endoscopic treatments. The patient is scheduled for a Sugiura procedure. Which of the following components is NOT part of the Sugiura procedure? (Q849018)

A. Splenectomy

B. Esophagogastric devascularization

C. Intraesophageal portacaval shunt

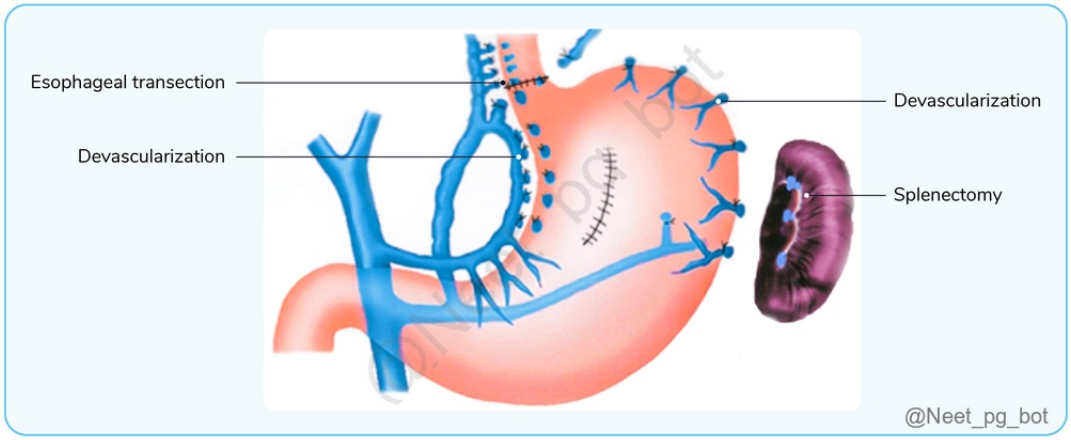
D. Esophageal transection

Correct Answer: C. Intraesophageal portacaval shunt

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The Sugiura procedure includes: Splenectomy Esophagogastric devascularization: Surgically cutting off the blood supply to the esophagus to reduce the pressure in the varices and prevent bleeding. Esophageal transection: Diverting blood flow away from the esophageal varices, such as creating a shunt or performing other decompression techniques Sugiura procedure is used to manage recurrent esophageal variceal bleeding that does not improve on conventional treatment protocols.



References:

Bailey & Love's Short practice of surgery, 28th Edition, Page 1206.

↑ *Back to this question in Part A*

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Q14: A 48-year-old male is diagnosed with portal hypertension. Hepatic venous pressure gradient (HVPG) measurements are taken to assess the severity of his portal hypertension. Based on the prognostic values of HVPG, what are the cut-off HVPG values for clinically significant portal hypertension and increased risk of acute variceal bleeding respectively? (Q849019)

A. ≥6 mm Hg, ≥10mm Hg

B. ≥8 mm Hg, ≥12 mm Hg

C. ≥10 mm Hg, ≥12 mm Hg

D. ≥16 mm Hg, ≥18 mm Hg

Correct Answer: C. ≥10 mm Hg, ≥12 mm Hg

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Clinically significant portal hypertension is defined by an HVPG of ≥10 mm Hg. HVPG of ≥12 mm Hg is associated with an increased risk of acute variceal bleeding. These cut-off values are used to evaluate the prognosis of patients with chronic liver disease and portal hypertension. Prognostic value of HPVG in patients of Chronic Liver Disease & Portal HTN HVPG-Values Significance 1-5 mm Hg Normal 6-10 mm Hg Preclinical sinusoidal portal hypertension ≥10 mm Hg Clinically significant portal hypertension ≥12 mm Hg Increased risk

for rupture of varices ≥16 mm Hg Increased risk of mortality ≥20 mm Hg Treatment failure and mortality in acute variceal bleeding

References:

https://www.nature.com/articles/nrgastro.2009.149

↑ *Back to this question in Part A*

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• [04_Hepatobiliary Pancreatic Surgery] 015 Gall Bladder - I

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[04_Hepatobiliary Pancreatic Surgery] 015 Gall Bladder - I — Quick Jump

Q1 (p. 1618)	*Q2 (p. 1619)*	*Q3 (p. 1623)*	*Q4 (p. 1623)*	*Q5 (p. 1625)*	*Q6 (p. 1626)*
Q7 (p. 1627)	*Q8 (p. 1629)*	*Q9 (p. 1632)*	*Q10 (p. 1632)*	*Q11 (p. 1634)*	*Q12 (p. 1635)*
Q13 (p. 1636)	*Q14 (p. 1637)*	*Q15 (p. 1638)*	*Q16 (p. 1640)*	*Q17 (p. 1640)*	*Q18 (p. 1641)*
Q19 (p. 1642)	*Q20 (p. 1644)*	*Q21 (p. 1645)*	*Q22 (p. 1646)*	*Q23 (p. 1647)*	*Q24 (p. 1648)*
Q25 (p. 1649)	*Q26 (p. 1653)*	*Q27 (p. 1655)*	*Q28 (p. 1657)*	*Q29 (p. 1658)*	*Q30 (p. 1660)*

Q1: Which of the following is not a risk factor for gallbladder carcinoma? (Q849000)

A. Smoking

B. Gallstones

C. Porcelain gallbladder

D. Hepatitis B

Correct Answer: A. Smoking

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: While smoking is a risk factor for several cancers, it is not specifically recognized as a risk factor for gallbladder carcinoma. Risk Factors For Carcinoma GB Gallstones : 90% of gallbladder carcinoma cases are associated with gallstones. (Option B) The risk of developing carcinoma in gallstone disease is 7-10 times higher than in the general population. Relative risk based on stone size: Less than 2 cm: Lower risk 2-3 cm: Relative risk of 2.5 More than 3 cm: Relative risk of 10 or more Other Conditions : Choledochal cyst Anomalous pancreaticobiliary duct junction (20%) Cholesteroses of the gallbladder Gallbladder polyps (more than 1 cm in size, more than 3 in number, or adenomatous polyps) Porcelain gallbladder (Option C) : 25% risk of malignant transformation, with 90% being inoperable tumours Infections and Inflammatory Conditions : Chronic typhoid carriers Inflammatory bowel disease Hepatitis B (Option D) and hepatitis C virus infections Other factors: Polypoid lesions (GB polyp) Xanthogranulomatous cholecystitis Nitrosamines Carcinogens

References:

SRB’s manual of surgery 6th edition, pg no 651

Bailey and Love Short manual of surgery, pg no 1258

↑ *Back to this question in Part A*

Q2: A 65-year-old female presents with severe right upper quadrant pain, jaundice, and a history of recurrent cholangitis. Imaging reveals a cholecystocholedochal fistula involving up to two-thirds of the circumference of the common bile duct. Which type of Mirizzi syndrome is seen in this patient? (Q848994)

A. Type I

B. Type II

C. Type III

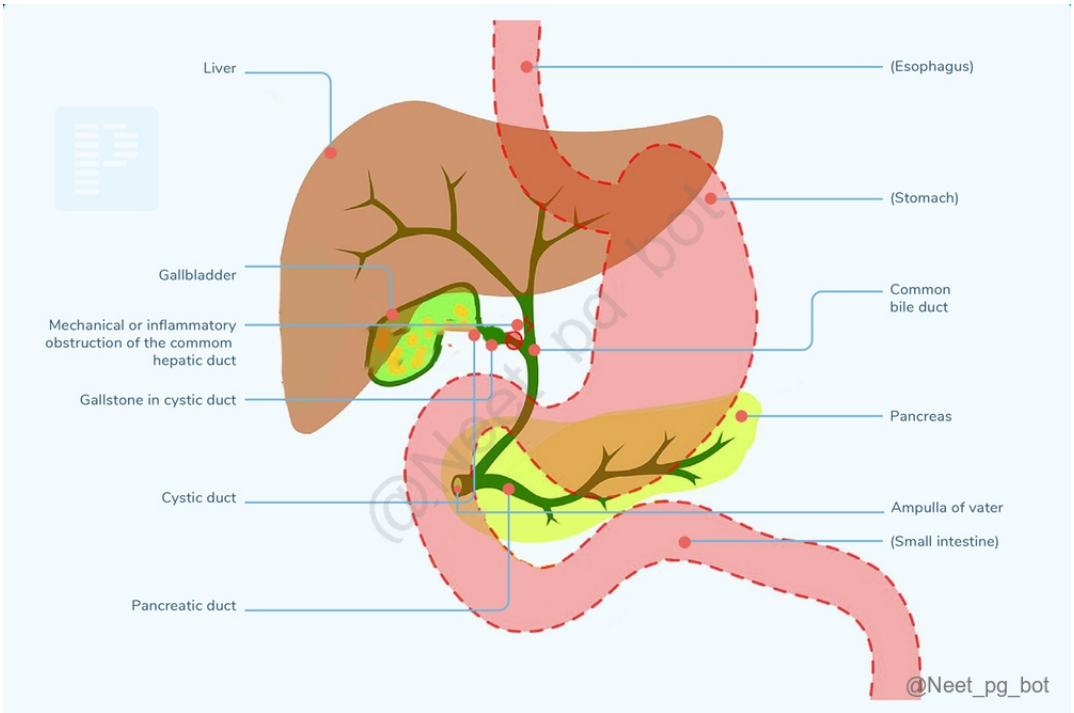
D. Type IV

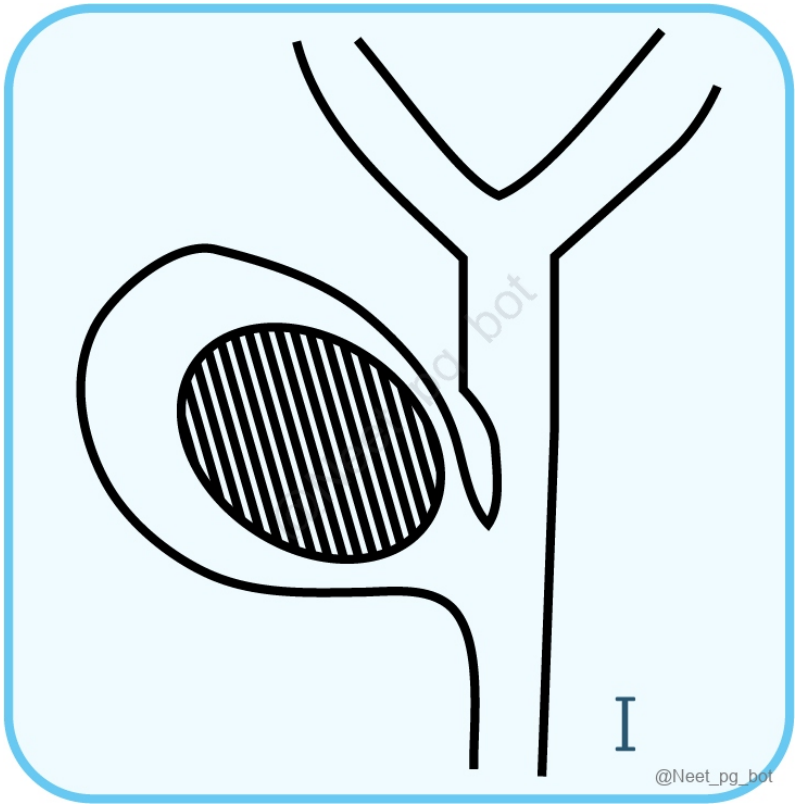
Correct Answer: C. Type III

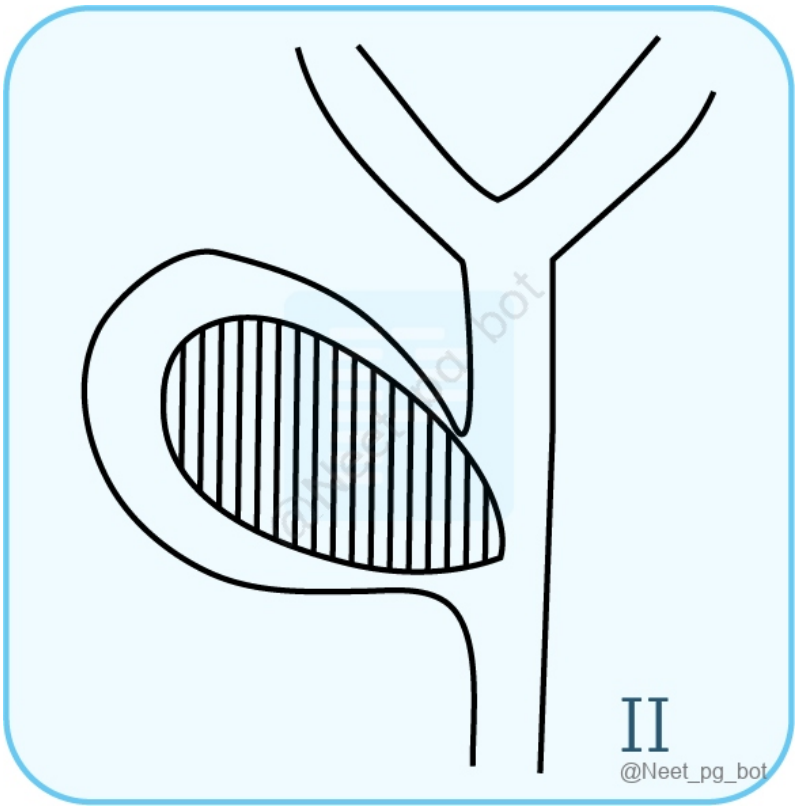
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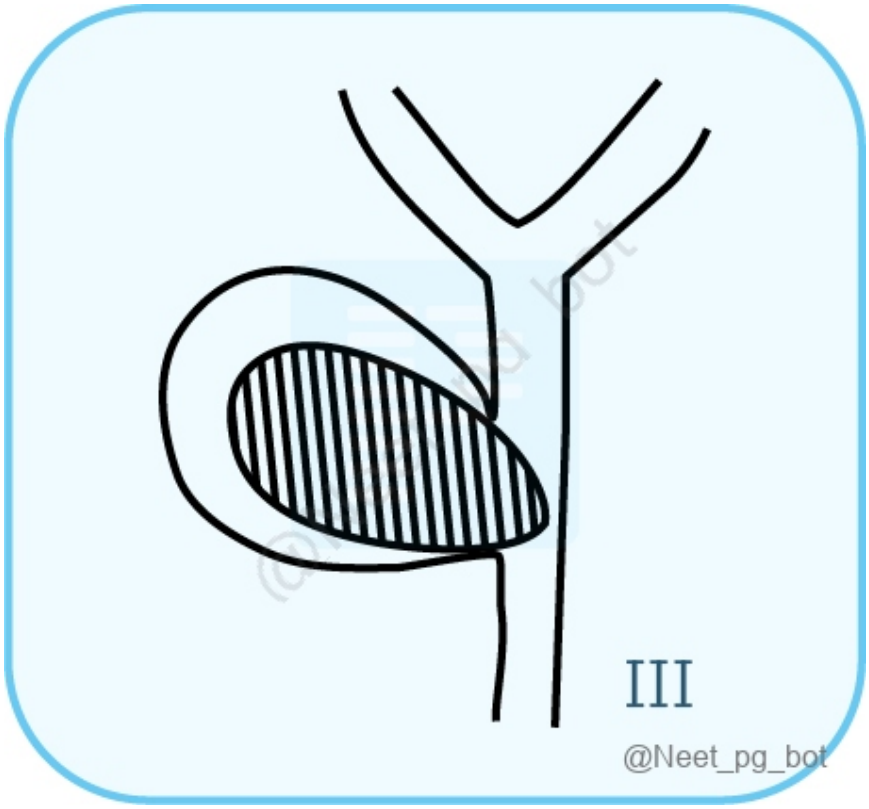
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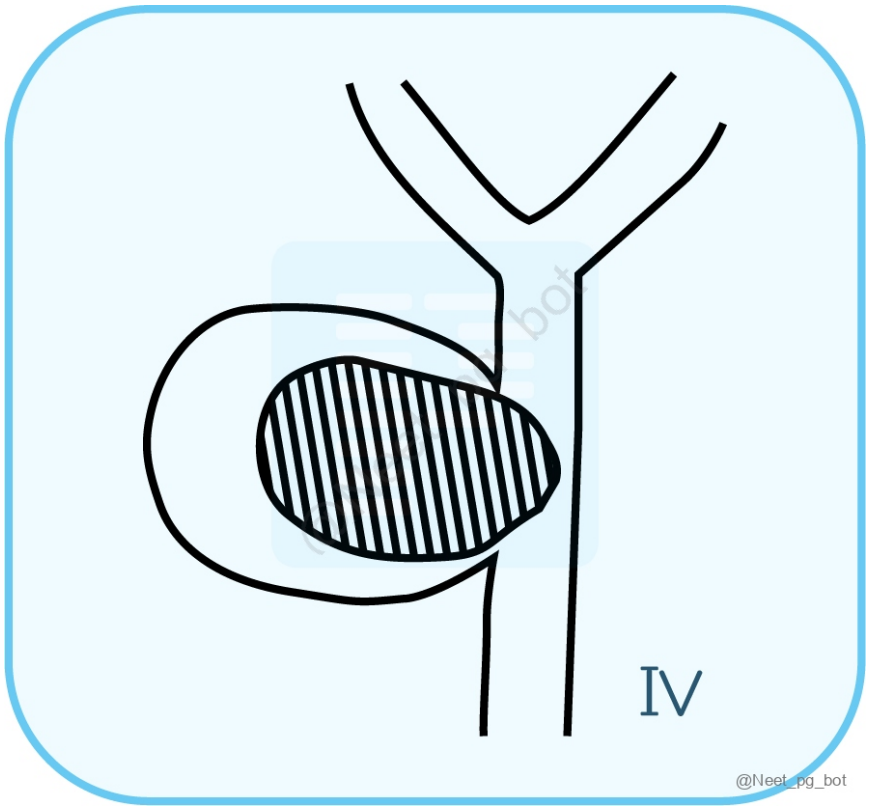
Explanation: In this scenario, the imaging findings indicate that the fistula involves up to two-thirds of the circumference of the CBD, consistent with Type III Mirizzi syndrome Mirizzi's syndrome It is seen in 1% of all cholecystectomies where a gallstone impacts the gallbladder wall, leading to compression and pressure necrosis. This often results in adherence to the common hepatic duct (CHD) or common bile duct (CBD) wall and can occasionally lead to a cholecystocholedochal fistula. Csendes Classification : Mirizzi's Type Features Image Type I Extrinsic compression of the CBD/CHD by a large impacted stone in Hartmann's pouch; IA- the presence of cystic duct IB- is obliterated cystic duct Type II The stone has eroded the CBD/CHD less than 1/3rd circumference of the CBD/CHD forming a fistula Type III Involving up to 2/3rd of the circumference of CBD/ CHD Type IV Cholecystocholedochal fistula (>2/3rd) involving the entire circumference of the CBD/CHD TypeV Cholecystocholedochal fistula with cholecystoenteric fistula without gallstone ileus (VA) or with gallstone ileus (VB)

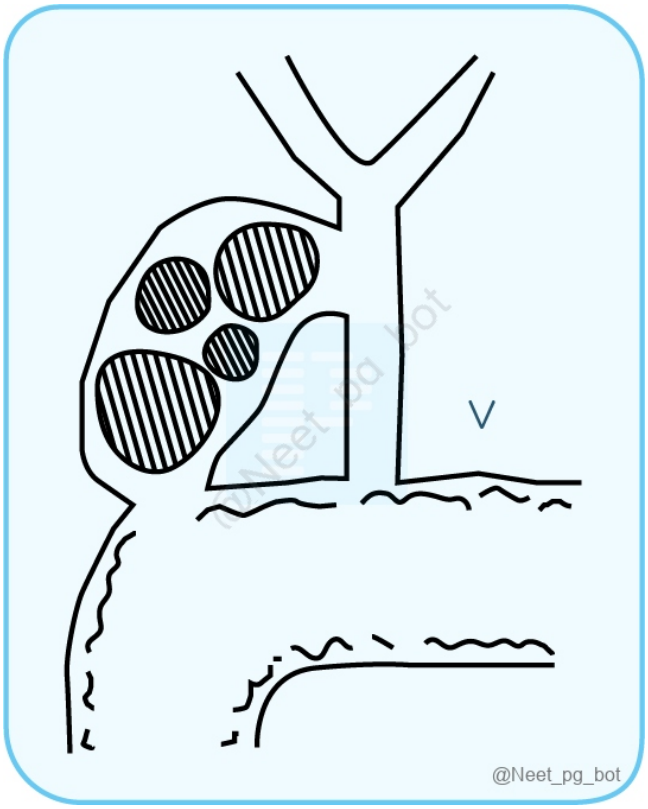

Liver
(Esophagus)
(Stomach)
Gallbladder
Common bile duct
Mechanical or inflammatory obstruction of the commom hepatic duct
Gallstone in cystic duct
Pancreas
Cystic duct
Ampulla of vater
(Small intestine)
Pancreatic duct
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I
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II
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III
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References:

SRB’s manual of surgery 6th edition, pg no 638

Schwartz 11th edition , pg no 1405

↑ *Back to this question in Part A*

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Q3: A 75-year-old male in the ICU with sepsis and multiple organ failure develops sudden right upper quadrant pain and fever. Ultrasound reveals a distended gallbladder with thickened walls and no gallstones. Which of the following is not a predisposing factor for acalculous cholecystitis? (Q848992)

A. Parenteral nutrition

B. Extensive burns

C. Hypertension

D. Diabetes

Correct Answer: C. Hypertension

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Hypertension is not an established predisposing factor for acalculous cholecystitis Acalculous cholecystitis Acalculous cholecystitis is an acute inflammation of the gallbladder that occurs without the presence of gallstones. It is typically observed in critically ill patients or in patients who have undergone major surgeries, trauma, burns, or prolonged illness with multi-system failure. Causes Predisposing Factors Gallbladder distention Bile stasis Ischemia Cystic artery occlusion Primary bacterial infections (e.g., E. coli, Salmonella, Clostridia) may contribute Critically ill ICU patients Patients on parenteral nutrition (Option A) Extensive burns (Option B) Sepsis Major surgeries (especially non-biliary) Multiple trauma Prolonged illness with multiple organ system failure Elderly males Diabetic patients (Option D) Patients on atherosclerotic agents. Patients with AIDS Presence of malignancies (biliary or other)

References:

Schwartz's Principles of Surgery, 11th Edition, Page 1415

SRB’s Manual of Surgery, 6th Edition, Page 637

↑ *Back to this question in Part A*

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Q4: A 75-year-old female with a history of cholelithiasis presents with acute abdominal pain, vomiting, and signs of bowel obstruction. O/E, she has abdominal distension and high-pitched bowel sounds. A radiograph shows pneumobilia and a calcified gallstone in the right lower quadrant. CT confirms an abnormal gallbladder with air and fluid accumulation. What is the most appropriate management for this patient? (Q848991)

A. Cholecystectomy and fistula repair

B. Endoscopic removal of the gallstone

C. Enterolithotomy

D. Conservative management with IV fluids and antibiotics

Correct Answer: C. Enterolithotomy

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Given the clinical scenario with Rigler's triad (small bowel obstruction, pneumobilia, and ectopic gallstone) and the corresponding imaging findings, the most likely diagnosis is gallstone ileus . The optimal initial surgical management is enterolithotomy , which effectively relieves the intestinal obstruction by removing the impacted gallstone. Effects and Complications of Gallstones: Gallbladder Common bile duct and pancreas Small intestine Acute cholecystitis Chronic cholecystitis Mucocele Empyema Gangrene Perforation Carcinoma gallbladder CBD stones Biliary obstruction (Jaundice) Acute pancreatitis Mirizzi syndrome Gallstone ileus leading to intestinal obstruction Gallstone Ileus Acute cholecystitis→ erosion of inflamed tissues → Formation of a cholecystointestinal fistula→ Gallstone ileus Small gallstones typically pass through the intestines, but stones 2–5 cm in size can become impacted, usually in the terminal ileum or at the ileocecal valve. Clinical Manifestations: Acute, intermittent, or chronic episodes of partial or complete gastrointestinal obstruction. Signs of obstruction include dehydration, abdominal distension and tenderness, high-pitched bowel sounds, and obstructive jaundice. Diagnosis: Plain Abdominal Radiograph: Partial or complete intestinal obstruction Pneumobilia or contrast material in the biliary tree Calcified gallstone with position changes on serial films (tumbling sign) CT Scan: Superior sensitivity (up to 93%) Shows abnormal gallbladder with air, air-fluid level, or fluid accumulation with an irregular wall Management: Management of intestinal obstruction Enterolithotomy: The most common surgical procedure A longitudinal incision on the antimesenteric border proximal to the site of impaction Gallstone is brought to a non-edematous bowel segment by gentle manipulation and extraction. Cholecystoenteric fistula resection only if the patient is stable and there are residual gallstones that may cause infection or recurrent ileus Cholecystectomy and fistula repair (Option A): While important, this is not the initial step due to the patient's unstable condition and intestinal obstruction. Endoscopic removal of the gallstone (Option B): Not feasible for this condition due to the intestinal obstruction. Conservative management with IV fluids and antibiotics (Option D): Not sufficient for resolving the mechanical obstruction.

References:

SRB’s manual of surgery 6th edition, pg no 633, 634

Bailey and Love Short manual of surgery, pg no 1244,12

↑ *Back to this question in Part A*

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Q5: A 65-year-old male with a history of diabetes presents with severe right upper quadrant pain, fever, and jaundice. Imaging reveals gas within the gallbladder wall. Which of the following organisms is most likely to be the causative agent in this patient's condition? (Q848990)

A. Clostridium perfringens

B. Staphylococcus aureus

C. Streptococcus pyogenes

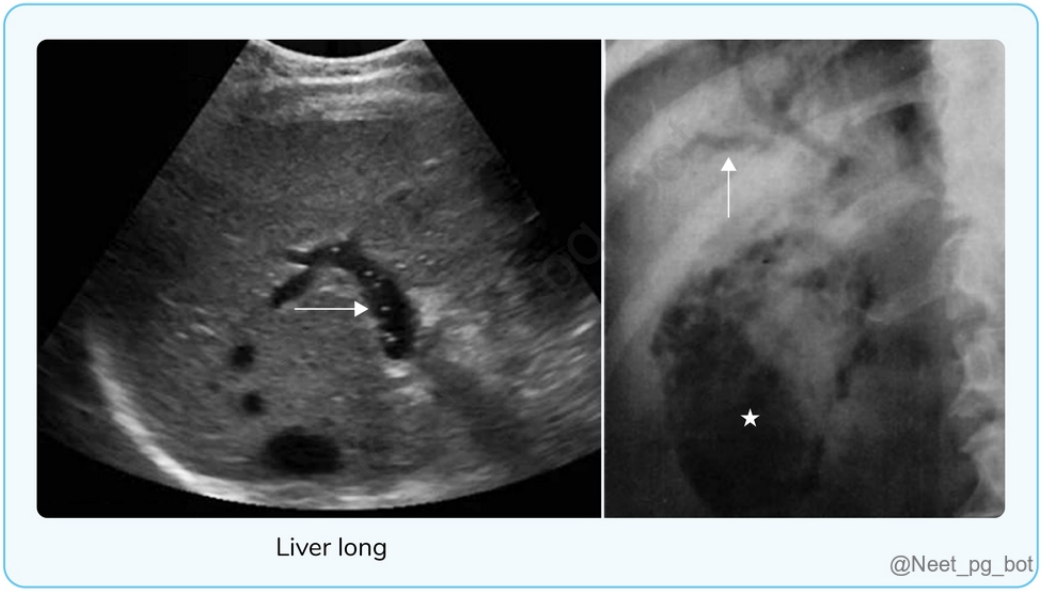
D. Pseudomonas aeruginosa

Correct Answer: A. Clostridium perfringens

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The patient is presenting with emphysematous cholecystitis, a severe form of acute cholecystitis characterized by the presence of gas in the gallbladder wall. This condition is often caused by gas-forming bacteria. Clostridium perfringens is the most commonly implicated bacterium in this condition, especially in patients with underlying diabetes. Causative Organisms of Emphysematous Cholecystitis: Clostridium perfringens Clostridium welchii Escherichia coli Klebsiella Management of Emphysematous Cholecystitis: Initial Stabilization (Resuscitation) Nil per oral (NPO) IV fluids (correct dehydration, shock) Electrolyte correction Broad-spectrum IV antibiotics: Coverage for anaerobes (Clostridium) + gram-negative organisms Example: Piperacillin–tazobactam / Carbapenems Definitive Management Emergency cholecystectomy Usually open cholecystectomy (due to severe inflammation) Laparoscopy may be attempted in stable patients If Patient is Unstable/High-risk Percutaneous cholecystostomy (USG-guided) Temporary life-saving measure Followed by an interval cholecystectomy



References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1235

www.healthline.com/health/emphysematous-cholecystitis#symptoms

↑ *Back to this question in Part A*

@Neet_pg_bot

Q6: A 65-year-old female presents with right upper quadrant pain and nausea. An ultrasound reveals a 1.5 cm gallbladder polyp, and a follow-up scan shows an increase in size from the previous scan six months ago. She also has a history of gallstones. Which of the following factors increases the risk of invasive cancer in gallbladder polyps? (Q848996)

A. Age less than 60 years

B. Presence of gallstones

C. Polyp size more than 0.5 cm

D. The same polyp size on repeated scans

Correct Answer: B. Presence of gallstones

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The presence of gallstones increases the risk of malignancy Ultrasonography demonstrating a gallbladder polyp Cholesterol polyp Adenomatous polyp More common Small <10 mm Multiple Benign Pedunculated Less common Large >10mm Single Premalignant Sessile Factors that increase the risk of invasive cancer in adenomatous polyp: Age more than 60 years (Option A) Presence of gallstone Size of polyp more than 1 cm (Option C) Documented increase in size on repeated scans (Option D) Treatment: Cholecystectomy is recommended for symptomatic patients or as a preventive measure to reduce the risk of cancer in individuals who have additional conditions like gallstones, primary sclerosing cholangitis (PSC), biliary colic, or pancreatitis. Polyps in patients over 50, sessile polyps with wall thickening exceeding 4 mm, and those larger than 10 mm warrant surgical removal. Smaller polyps should be monitored, with surgery indicated if there is evidence of growth.



References:

www.ncbi.nlm.nih.gov/pmc/articles/PMC6969319/

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1247

↑ *Back to this question in Part A*

@Neet_pg_bot

Q7: A 70-year-old female presents with vague right upper quadrant discomfort, but she is mostly asymptomatic. An abdominal X-ray reveals extensive calcification of the

gallbladder wall. There is bluish appearance and brittle consistency of the gallbladder. What is the most likely diagnosis? (Q848999)

A. Gallbladder carcinoma

B. Cholesterolosis

C. Porcelain gallbladder

D. Acute cholecystitis

Correct Answer: C. Porcelain gallbladder

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The findings of extensive calcification of the gallbladder wall, along with the bluish appearance and brittle consistency, are characteristic features of a porcelain gallbladder. Porcelain Gallbladder Definition Also known as a calcified gallbladder, characterized by extensive calcium encrustation in the gallbladder wall Characteristics Bluish appearance of the gallbladder Brittle consistency of the gallbladder wall Clinical Features Most patients are asymptomatic Increased risk of malignancy Diagnosis Incidental findings on abdominal X-ray or CT Treatment Early laparoscopic cholecystectomy is recommended due to the increased risk of malignancy Gallbladder carcinoma (Option A): While there is an increased risk of malignancy associated with porcelain gallbladder, the symptoms and imaging findings in this scenario point more directly to porcelain gallbladder rather than cancer itself, especially given that the patient is asymptomatic. Cholesterolosis (Option B): This condition is characterized by lipid accumulation in the gallbladder mucosa and does not present with calcification of the gallbladder wall. Acute cholecystitis (Option D): This would typically present with acute pain, fever, and signs of inflammation, which are not described in this scenario.



References:

Sabiston Textbook of Surgery, 21st Edition, Page 1516

Schwartz's Principles of Surgery, 10th Edition, Page 1401,1402

www.ncbi.nlm.nih.gov/books/NBK518979/#

↑ *Back to this question in Part A*

@Neet_pg_bot

Q8: A 50 y/o woman undergoing laparoscopic cholecystectomy is found to have a structure that appears to have a spiral configuration. What is the most likely anatomical feature being observed? (Q843481)

A. Vasa vasorum

B. Sphincter of Oddi

C. Accessory Pancreatic Duct

D. Valves of Heister

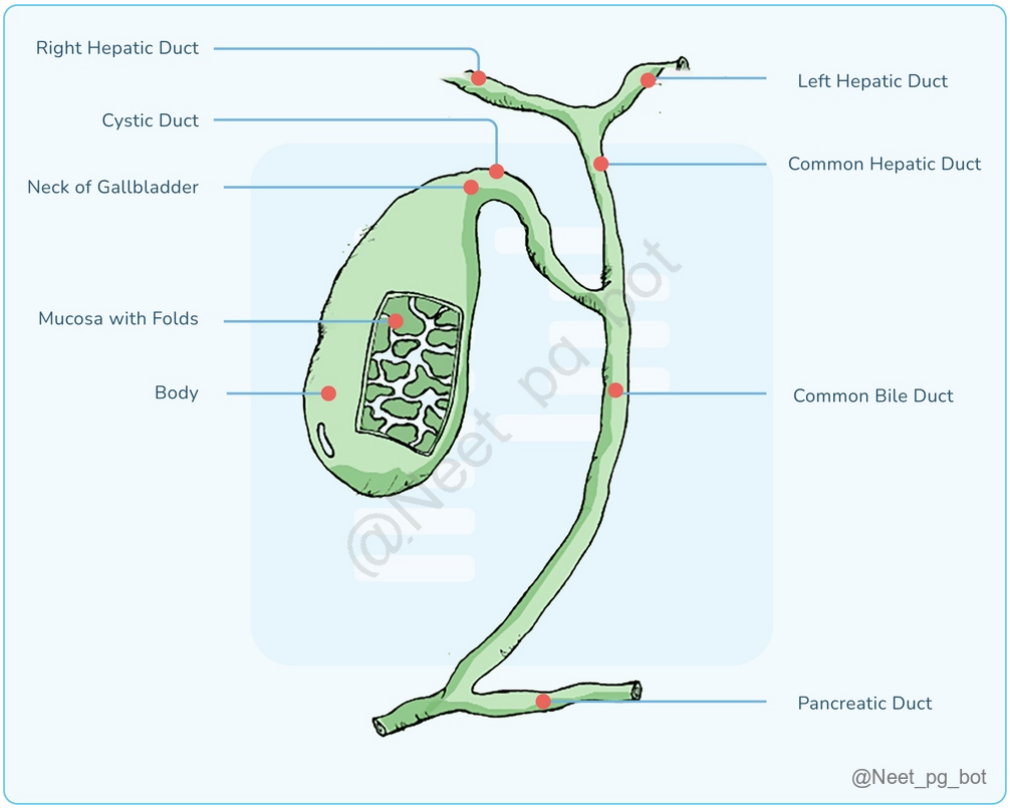


Correct Answer: D. Valves of Heister

- *Listen (English)*
- *Listen (Hindi)*

Explanation: The Valves of Heister are spiral mucosal folds within the cystic duct. They help regulate the flow of bile and prevent excessive emptying of the gallbladder. These folds are a key feature of the cystic duct and are noted during cholecystectomy. The cystic duct serves as the conduit between the gallbladder, where bile is stored, and the common bile duct, which carries bile to the duodenum. The Sphincter of Lütkens is a muscular structure encircling the cystic duct which plays a role in regulating bile flow into and out of the gallbladder.





References:

Bailey and Love's Short Practice of Surgery, 28th Edition, Pg. 1232, 1262

Sabiston Textbook of Surgery, 21st edition, Pg.1489, 1530

SRB’s Manual of Surgery, 6th Edition, Pg. 623

↑ *Back to this question in Part A*

@Neet_pg_bot

Q9: Which of the following risk factors is associated with both gallbladder cancer and cholangiocarcinoma? (Q849001)

A. Gallstones

B. Porcelain gallbladder

C. Primary sclerosing cholangitis (PSC)

D. Hepatitis C virus infection

Correct Answer: C. Primary sclerosing cholangitis (PSC)

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Primary sclerosing cholangitis (PSC), particularly when associated with inflammatory bowel disease (IBD), is a major risk factor for both gallbladder cancer and cholangiocarcinoma. Aspect Gallbladder Cancer Cholangiocarcinoma Risk Factors Gallstones, porcelain gallbladder, PSC, abnormal pancreatic-biliary junction PSC, congenital cystic disease, hepatolithiasis, liver flukes Clinical Presentation Abdominal pain, early satiety, anorexia, weight loss, jaundice, Courvoisier's sign Similar non-specific symptoms, jaundice, Courvoisier's sign Diagnosis USG, CT, MRI/MRCP, elevated ALT, AST, CA19-9, and ERCP/PTC, staging laparoscopy Similar diagnostic tools and markers Treatment Radical en bloc resection for resectable cases Hepatic/bile duct resection, pancreaticoduodenectomy, transplantation for select cases Prognosis Poor, low 5-year survival rate Poor, low 5-year survival rate Gallstones (Option A) are strongly associated with gallbladder cancer, while the relationship with cholangiocarcinoma is less clear. Porcelain gallbladder (Option B) is a risk factor for gallbladder cancer only Hepatitis C virus infection (Option D) is a risk factor primarily for cholangiocarcinoma.

References:

Bailey & Love’s Short Practice of Surgery, Ed 28, Pg 1256-1259

↑ *Back to this question in Part A*

@Neet_pg_bot

Q10: A 45 y/o patient presents with recurrent right upper quadrant pain and nausea. Imaging reveals a pathological outpouching in the infundibular region of the gallbladder containing multiple gallstones. What is this feature known as? (Q843479)

A. Phrygian cap

B. Floating gallbladder

C. Hartmann's pouch

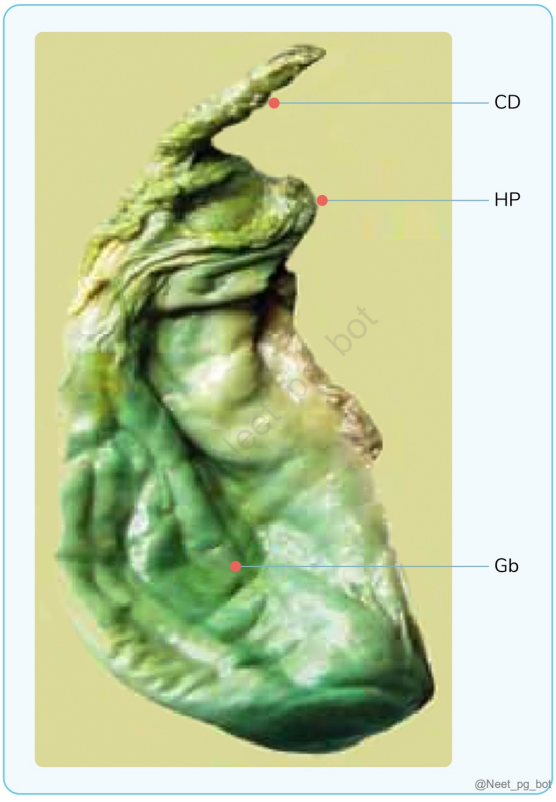
D. Gallbladder carcinoma

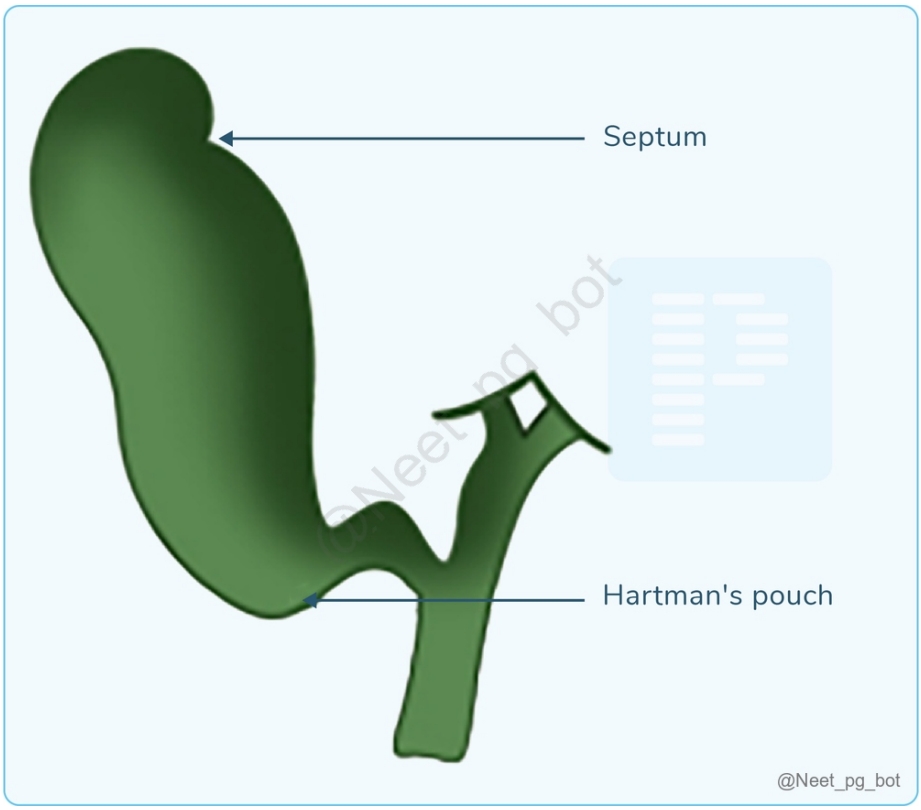
Correct Answer: C. Hartmann's pouch

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Hartmann's pouch is a pathological outpouching in the infundibular region of the gallbladder, typically associated with the presence of gallstones. It results from adhesions forming between the cystic duct and the neck of the gallbladder. CD - Cystic duct HP - Hartmann’s pouch Gb - Gall Bladder Phrygian cap (Option A): is a benign congenital anatomical variant of the gallbladder, characterized by a fold at the fundus that creates a cap-like appearance. It does not involve the presence of gallstones. A floating gallbladder (Option B) is a rare anatomical pathological variant where the gallbladder is not properly attached and can move within the abdominal cavity. It does not result in an outpouching containing stones. Gallbladder carcinoma (Option D) is a malignant tumour of the gallbladder and does not match the patient’s imaging results of outpouching.





References:

Bailey and Love’s Short Practice of Surgery, 28th Edition, Pg. 1240

Sabiston Textbook of Surgery, 21st edition, Pg.1434, 1489, 1516

SRB’s Manual of Surgery, 6th Edition, Pg. 623, 633

Hartmann pouch herniation in Calot’s triangle: A case report - PMC

↑ *Back to this question in Part A*

@Neet_pg_bot

Q11: Which layer of the gastric wall is considered the strongest? (Q843478)

A. Mucosa

B. Submucosa

C. Muscularis Externa

D. Serosa

Correct Answer: B. Submucosa

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The submucosa is rich in collagen and provides the strongest structural support among the gastric wall layers. It is the strongest layer. Layers Features Serosa Outermost layer Covered by peritoneum Muscularis Propria / Muscularis externa Divided into Outer longitudinal layer Inner circular layer Contains Auerbach Plexus Submucosa Collagen-rich connective tissue layer Strongest It contains a network of blood vessels, lymphatics, and Meissner Plexus Mucosa Has 3 layers Surface epithelium - innermost layer in contact with the lumen Lamina Propria - connective tissue layer Muscularis Mucosa - rugae formation

References:

Bailey and Love's Short Practice of Surgery, 28th Edition, Pg.1149

Sabiston Textbook of Surgery, 21st edition, Pg. 1018, 1198, 1333

Neuroanatomy, Auerbach Plexus - StatPearls - NCBI Bookshelf

↑ *Back to this question in Part A*

@Neet_pg_bot

Q12: A 65 y/o female presents with a 3-month history of intermittent upper right quadrant pain, weight loss, and loss of appetite. She has jaundice and a palpable mass in the right upper quadrant. Laboratory tests reveal mild anaemia, leukocytosis, and elevated CA19-9 and carcinoembryonic antigen. USG suggests a gallbladder mass and a CT scan confirms the mass without distant metastases. What is the most appropriate next step in management? (Q849002)

A. Immediate laparoscopic cholecystectomy

B. Percutaneous biopsy of the gallbladder mass

C. Referral for palliative chemotherapy

D. Laparoscopic examination for staging

Correct Answer: D. Laparoscopic examination for staging

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Given the patient's symptoms, physical findings, and elevated tumor markers, gallbladder cancer is highly suspected. Although imaging studies have been done, accurate staging is crucial before deciding on a definitive treatment. A laparoscopic examination will help to detect any peritoneal metastasis, liver surface

deposits and small volume carcinomatosis that could preclude surgical resection, thereby guiding the appropriate management plan. Diagnosis and staging of Gallbladder cancer: Non-specific indicators Anemia Leukocytosis Slight increase in transaminases Tumor markers Elevated CA19-9 Elevated carcinoembryonic antigen (in ~80% of patients) Diagnostic Imaging Ultrasonography (USG): Initial diagnosis CT Scans: Thorax, abdomen, and pelvis for confirmation and staging MRI/MRCP: For accurate preoperative staging PET Scans: To identify metastatic disease Staging and Biopsy Preoperative Staging: Crucial to assess local disease extent and rule out distant metastases Percutaneous Biopsy: Guided by radiological imaging for unresectable tumors Laparoscopic Examination: Detects peritoneal or liver metastases that preclude surgery Immediate laparoscopic cholecystectomy (Option A): This is generally considered if the diagnosis is benign or if it's a straightforward case of symptomatic gallbladder disease. Given the suspicion of malignancy (indicated by elevated tumor markers and imaging findings), it is crucial to stage the disease before proceeding with surgical intervention. Percutaneous biopsy of the gallbladder mass (Option B): While this could be useful, gallbladder cancers are often difficult to biopsy percutaneously, and the risk of seeding the tumor or causing complications is a concern. Referral for palliative chemotherapy (Option C): This should only be considered if there is confirmed advanced or metastatic cancer. In this case, there is no evidence of distant metastases from the CT scan.

References:

Bailey & Love’s Short Practice of Surgery, 28th Edition, Page 1258

↑ *Back to this question in Part A*

@Neet_pg_bot

Q13: Which of the following surgeons is correctly matched with their pioneering laparoscopic procedure and year of achievement? (Q849005)

A. Professor Erich Mühe - First video-assisted laparoscopic cholecystectomy in 1987

B. Dr. Philippe Mouret - First laparoscopic cholecystectomy in 1985

C. Dr. Kurt Semm - First laparoscopic appendicectomy in 1983

D. Professor Erich Mühe - First laparoscopic appendicectomy in 1983

Correct Answer: C. Dr. Kurt Semm - First laparoscopic appendicectomy in 1983

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Dr. Kurt Semm performed the first laparoscopic appendicectomy in 1983. Professor Erich Mühe of Germany is acknowledged as the pioneer who performed the first laparoscopic cholecystectomy in 1985. (Options A & D ruled out) Dr. Philippe Mouret performed the first video-assisted laparoscopic cholecystectomy in 1987. (Option B ruled out)

References:

www.ncbi.nlm.nih.gov/pmc/articles/PMC3015420/

www.frontiersin.org/journals/surgery/articles/10.3389/fsurg.2021.799442/full

www.ncbi.nlm.nih.gov/pmc/articles/PMC3820597/

↑ *Back to this question in Part A*

@Neet_pg_bot

Q14: A 62-year-old male presents with intermittent right upper quadrant pain and nausea. An ultrasound shows significant thickening of the gallbladder wall and hyperproliferation of the mucosa. Which of the following is NOT a USG finding in Adenomyomatosis? (Q848998)

A. Diamond ring sign

B. Comet tail artefacts

C. V-shaped artefacts

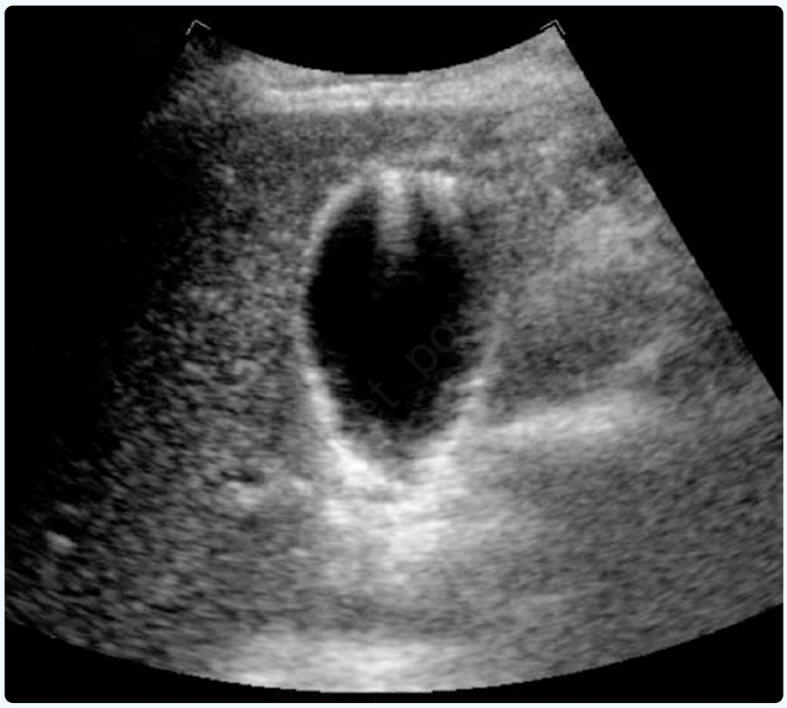
D. Porcelain appearance

Correct Answer: D. Porcelain appearance

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Porcelain appearance is usually seen as associated with calcifications of the gall bladder and not adenomyomatosis Adenomyomatosis Definition A benign condition characterised by hyperplastic changes in the gallbladder wall, often associated with cholesterol stones Characteristics Hyperplastic Changes: Overgrowth of the gallbladder mucosa Significant thickening of the muscle layer Deposition of cholesterol crystals in the deep Rokitansky-Aschoff sinuses Diagnosis Ultrasound Findings: Diamond ring sign. (Option A) Comet tail artefacts. (Option B) V-shaped artefacts. (Option C) Treatment Symptomatic Patients with Gallstones: Laparoscopic cholecystectomy



References:

www.ncbi.nlm.nih.gov/books/NBK482244/#

Bailey & Love's Short Practice of Surgery, 27th Edition, Page 1245

↑ *Back to this question in Part A*

@Neet_pg_bot

Q15: A 58-year-old male, with past h/o cholesterol stones, presents with intermittent right upper quadrant pain and occasional nausea.USG reveals the gallbladder mucosa has a coarse, granular appearance with small nodules and some larger polypoid formations. On performing laparoscopic cholecystectomy of this patient, the following appearance of the gall bladder was observed. What is the most likely diagnosis? (Q848997)

A. Acute cholecystitis

B. Porcelain gallbladder

C. Cholesterolosis

D. Gallbladder carcinoma



Correct Answer: C. Cholesterolosis

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: These specific ultrasound findings and the specimen along with the association with cholesterol stones are characteristic of Strawberry Gallbladder (Cholesterolosis) . Accumulation of lipids (triglycerides, cholesterol precursors, and cholesterol esters) in the gallbladder mucosa. Appearance: Nodules <1 mm in diameter in about two-thirds of cases, giving the mucosa a coarse, granular look. Remaining one-third of cases - Nodules are larger and polypoid (polypoid form). Yellow lipid deposits on a hyperaemic mucosa background create the ‘strawberry gallbladder’ appearance Might be associated with cholesterol stones. Management: Laparoscopic cholecystectomy in symptomatic patients. Acute cholecystitis (Option A): Typically presents with more acute symptoms, such as severe right upper quadrant pain, fever, and leukocytosis, without the specific ultrasound appearance described. Porcelain gallbladder (Option B): Characterized by extensive calcium encrustation of the gallbladder wall, giving a bluish, brittle appearance, not mentioned in the scenario. Gallbladder carcinoma (Option D): Typically associated with more serious symptoms and imaging findings of masses or irregular thickening, not specifically described in this scenario.

References:

Sabiston Textbook of Surgery, 21st edition, Page 1499

Bailey and Love Short manual of surgery, 27th Edition, Page 1245

↑ *Back to this question in Part A*

@Neet_pg_bot

Q16: A 65 y/o presents with jaundice, weight loss, and abdominal pain. O/E a palpable mass is noted in the right upper quadrant. Imaging studies reveal a mass involving the gallbladder, with signs of local invasion but no distant or lymph node metastasis. A biopsy confirms gallbladder carcinoma. Based on the TNM classification, which stage is most likely for this patient's tumour? (Q849003)

A. T1a N0 M0

B. T2b N1 M0

C. T3 N0 M0

D. T4 N2 M1

Correct Answer: C. T3 N0 M0

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The patient's presentation of jaundice, weight loss, abdominal pain, and a palpable mass, along with imaging showing local invasion but no distant metastasis, suggests an advanced stage. According to the TNM classification: T3 : Tumor perforates the serosa and/or invades the liver or adjacent organs. N0 : No regional lymph node metastasis. M0 : No distant metastasis. This corresponds to T3 N0 M0. T1a N0 M0 (Option A) T1a tumours invade only the lamina propria. They do not invade the liver or perforate the serosa. The presence of direct liver invasion rules out T1a. T2b N1 M0 (Option B) T2b indicates tumour invading the perimuscular connective tissue on the hepatic (liver) side of the gallbladder, but the option also includes N1 (regional node positive). The vignette specifies no regional lymph-node involvement, so any option with N1 is inconsistent with the findings. T4 N2 M1 (Option D) This indicates very advanced disease (invasion of main portal vein or two or more extrahepatic organs, and/or advanced nodal disease and distant metastasis). The stem states local invasion only, without nodal or distant spread, so this is not applicable.

References:

radiopaedia.org/articles/gallbladder-cancer-staging-ajcc-8th-edition?lang=us

↑ *Back to this question in Part A*

@Neet_pg_bot

Q17: A 58 y/o presents with jaundice, weight loss, and upper right abdominal pain. Imaging studies including CT and MRI reveal a mass in the gallbladder with local

invasion into the liver but no distant metastasis. The patient undergoes a laparoscopic examination confirming the staging. What is the most appropriate treatment approach for this patient? (Q849004)

A. Endoscopic stenting to relieve jaundice

B. Radical en bloc resection of the gallbladder, liver wedge, and regional lymph nodes

C. Palliative chemotherapy

D. No further treatment if the tumor is confined to the mucosa

Correct Answer: B. Radical en bloc resection of the gallbladder, liver wedge, and regional lymph nodes

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: For a patient with gallbladder cancer of T3 N0 M0 staging, radical en bloc resection is the most appropriate treatment approach. This involves the surgical removal of the gallbladder, the invaded portion of the liver, and potentially affected regional lymph nodes. This approach aims to achieve clear margins and effectively treat the localized disease, offering the best chance for a cure in the absence of distant metastasis. Staging aims to: Assess local disease . Detects metastatic disease in the liver, peritoneum, lymphatics, or locations outside the abdomen. Treatment Based on Stage: If Gallbladder cancer is found incidentally on resection of the gallbladder for gallstones, then: If early disease: For a disease confined to the mucosa , if negative cystic duct margin and no recurrence on imaging: No further treatment For transmural disease- Radical en bloc resection of the gallbladder fossa, liver wedge, and regional lymph nodes. If advanced Cancer: Non-operative palliative care. Endoscopic/percutaneous methods to relieve obstructive jaundice. Adenocarcinoma: Early-stage limited to the mucosa: No additional treatment is required if imaging shows no recurrence. Beyond mucosa: Extensive surgery involving gallbladder fossa, a portion of the liver, and nearby lymph nodes. Endoscopic stenting to relieve jaundice (Option A): Given the cancer's local invasion into the liver, endoscopic stenting alone does not provide a treatment for the cancer itself. Palliative chemotherapy (Option C): Typically used for cancers that are not amenable to surgical resection or have spread beyond the local area (distant metastasis). No further treatment if the tumor is confined to the mucosa (Option D) : Since local invasion into the liver is present, a more aggressive treatment approach is required.

References:

Bailey & Love’s Short Practice of Surgery, 28th Edition, Pages 1258, 1259

↑ *Back to this question in Part A*

@Neet_pg_bot

Q18: A 58-year-old male presents with right upper quadrant pain, jaundice, and fever. Imaging reveals a gallstone eroding less than one-third of the circumference of

the common bile duct. What is the management? (Q848995)

A. Bilio-enteric anastomosis

B. Percutaneous cholecystostomy

C. Subtotal/Partial cholecystectomy + ERCP stenting

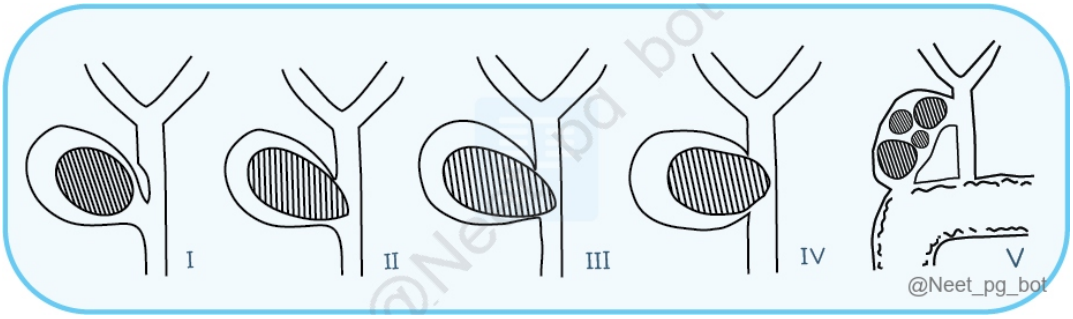
D. Partial cholecystectomy with choledochoplasty

Correct Answer: D. Partial cholecystectomy with choledochoplasty

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: This patient's presentation matches the features of Type II Mirizzi syndrome, characterized by a gallstone eroding less than one-third of the circumference of the common bile duct (CBD) or common hepatic duct (CHD). Type II Mirizzi syndrome is managed by partial cholecystectomy with choledochoplasty. Csendes classification: Mirizzi's Type Features Treatment Type I Extrinsic compression of the CBD/CHD by a large impacted stone in Hartmann's pouch; IA- the presence of cystic duct IB- is obliterated cystic duct Subtotal/Partial cholecystectomy + ERCP stenting (Option C ruled out) Type II The stone has eroded the CBD/CHD less than 1/3rd circumference of the CBD/CHD forming a fistula Partial cholecystectomy with choledochoplasty Type III Involving up to 2/3rd of the circumference of CBD/ CHO Partial cholecystectomy with choledochoplasty Type IV Cholecystocholedochal fistula (>2/3rd) involving the entire circumference of the CBD/CHD Bilio-enteric anastomosis (Option A ruled out) TypeV Cholecystocholedochal fistula with cholecystoenteric fistula without gallstone ileus (VA) or with gallstone ileus (VB) Bilio-enteric anastomosis Percutaneous cholecystostomy (Option B): Typically a temporary measure for critically ill patients who cannot undergo immediate surgery



References:

SRB's manual of surgery 6th edition, pg no 638

Bailey and Love Short manual of surgery, pg no 1249

↑ *Back to this question in Part A*

@Neet_pg_bot

Q19: A 45-y/o female presents with symptomatic gallstones and is scheduled for laparoscopic cholecystectomy. During the procedure, the surgeon encounters difficulty due to unexpected anatomical variations. The right hepatic artery appears very tortuous and is located close to the cystic duct. What is the most likely anatomical anomaly encountered in this case? (Q843338)

A. Phrygian cap

B. Moynihan Hump

C. Floating Gallbladder

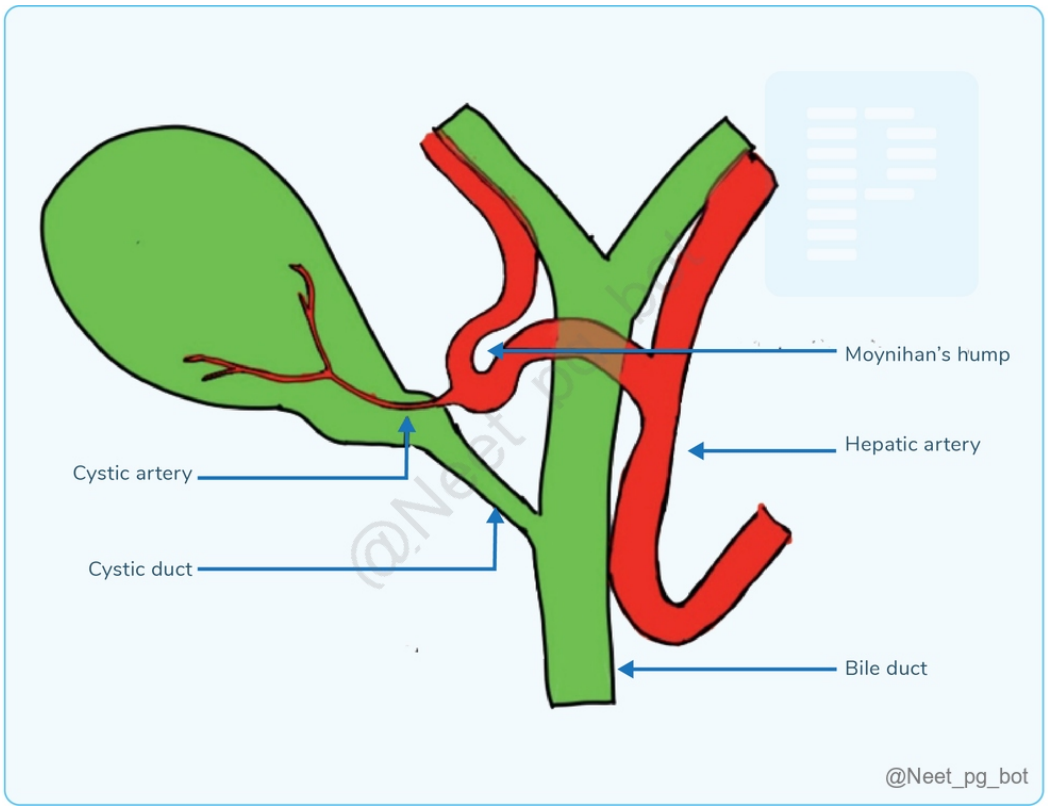
D. Mirizzi Syndrome

Correct Answer: B. Moynihan Hump

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Moynihan's hump , also known as the ' caterpillar turn ,' describes a very tortuous common or right hepatic artery in front of the cystic duct's origin. This tortuosity often results in a short cystic artery, increasing the risk of arterial injury during cholecystectomy. It is the most dangerous anomaly to be encountered during laparoscopic cholecystectomy as it can lead to heavy bleeding due to injury to the arteries. Phrygian cap (Option A) is a congenital variant of the gallbladder characterized by a fold at the fundus that resembles a cap. It is a benign condition and is typically asymptomatic, with its appearance being consistent with a cap-like structure on ultrasound. It has no clinical significance and does not affect gallbladder function. Floating gallbladder (Option C) refers to an abnormal positioning of the gallbladder within the abdominal cavity, often due to a lack of supporting attachments. This condition does not present as a cap-like fold on ultrasound. Mirizzi syndrome (Option D) occurs when a gallstone migrates from the gallbladder and obstructs or compresses the common bile duct, often due to a stone in the lower end of the cystic duct ulcerating into the common bile duct.



References:

Bailey and Love's Short Practice of Surgery, 28th Edition, Pg. 1233, 1240,1244

SRB's Manual of Surgery, 6th Edition, Pg. 627

↑ *Back to this question in Part A*

@Neet_pg_bot

Q20: A 70-year-old critically ill male in the ICU with sepsis and multiple organ failure presents with sudden onset of right upper quadrant pain, fever, and jaundice. Bedside ultrasonography shows a distended gallbladder with thickened walls and pericholecystic fluid but no gallstones. What is the treatment of choice for this patient? (Q848993)

A. Laparoscopic cholecystectomy

B. Oral antibiotics and observation

C. Endoscopic retrograde cholangiopancreatography (ERCP)

D. Percutaneous cholecystostomy

Correct Answer: D. Percutaneous cholecystostomy

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Given the clinical scenario and the USG findings, this patient is most likely suffering from Acalculous cholecystitis. Percutaneous cholecystostomy is the most appropriate management for a critically ill, unstable patient with acalculous cholecystitis, as it provides effective drainage and infection control with minimal risk. Treatment: Initial Management: Early broad-spectrum antibiotics Fluid resuscitation Definitive Treatment: Laparoscopic Cholecystectomy: Most definitive treatment Safe even with severe acute inflammation if the patient is stable for surgery For Critically Ill, Unfit for Surgery Patients: Percutaneous Cholecystostomy : Preferred treatment Approximately 90% improvement rate with a cholecystostomy tube Interval Cholecystectomy : Can be considered after recovery, but not mandatory in the absence of gallstones or other gallbladder pathology Laparoscopic cholecystectomy (Option A): Although this is the definitive treatment for cholecystitis, it is often too risky for critically ill, unstable patients due to the invasive nature of the procedure and the need for general anaesthesia. Oral antibiotics and observation (Option B): This approach is insufficient for acalculous cholecystitis, which typically requires more aggressive intervention to manage the infection and decompress the gallbladder. Endoscopic retrograde cholangiopancreatography (ERCP) (Option C): While ERCP can be useful for managing bile duct stones and obstructions, it is not the standard treatment for acalculous cholecystitis, which involves inflammation of the gallbladder without gallstones.

References:

Schwartz, 11th Edition, Page1415

↑ *Back to this question in Part A*

@Neet_pg_bot

Q21: A 45-year-old woman with asymptomatic gallstones is being evaluated for prophylactic cholecystectomy. Which of the following is NOT typically considered an indication for prophylactic cholecystectomy? (Q848989)

A. Gallstones larger than 3 cm

B. Presence of gallstones in the common bile duct

C. Asymptomatic small gallbladder polyps

D. Undergoing bariatric surgery

Correct Answer: C. Asymptomatic small gallbladder polyps

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Small asymptomatic gallbladder polyps are generally not an indication for prophylactic cholecystectomy unless they are larger than 1 cm or have other risk factors for malignancy. Prophylactic Cholecystectomy: Prophylactic cholecystectomy involves the removal of the gallbladder in patients with gallstones who are asymptomatic. This procedure is considered when the potential risk of gallstone-related complications outweighs the surgical risks. Specific situations warranting prophylactic cholecystectomy include: Large Gallstones (Option A) : Stones >3 cm have a higher likelihood of causing complications. Choledocholithiasis (Option B) : Gallstones in the common bile duct increase the risk of cholangitis and pancreatitis. Chronic Hemolytic Conditions : Conditions like sickle cell disease and hereditary spherocytosis lead to pigment stone formation. Gallbladder Polyps : Polyps >1 cm may become malignant, justifying prophylactic surgery. Suspicion of Malignancy : Anomalous pancreatic ductal drainage may raise concern for cancer. Porcelain Gallbladder : Calcified gallbladder walls are linked to a higher cancer risk. High-Risk Ethnic Groups : Certain groups, such as Native Americans and people from northern India, have a higher incidence of gallbladder cancer associated with gallstones. Transplant Patients : Prophylactic removal during transplantation can prevent future complications. Bariatric Surgery (Option D) : Concurrent gallbladder removal during bariatric surgery can reduce future risks. Absolute contraindications for laparoscopic cholecystectomy include: Sepsis : Risk of complications and need for extensive surgery. Severe Bleeding Disorders : Difficult hemorrhage control. Empyema of the gallbladder Gangrenous cholecystitis Portal hypertension Peritonitis

References:

Bailey & Love’s Short Practice of Surgery, Ed 28, Pg 1244

Contraindications of laparoscopic cholecystectomy

Absolute Contraindications for Laparoscopic Cholecystectomy

↑ *Back to this question in Part A*

@Neet_pg_bot

Q22: Which of the following is an indication for dissolution therapy in gallstone management? (Q848988)

A. Non-functioning gallbladder

B. Stone larger than 1.5 cm

C. Cholesterol stones which are typically radiolucent

D. Multiple stones

Correct Answer: C. Cholesterol stones which are typically radiolucent

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Dissolution therapy is indicated for cholesterol stones, which are usually radiolucent, in patients with a functioning gallbladder and stones smaller than 1 cm. Dissolution Therapy for Gallstones: Mechanism: Bile Acids: Medications like chenodeoxycholic acid (CDCA) and ursodeoxycholic acid (UDCA) dissolve cholesterol gallstones by inhibiting cholesterol absorption from the gut and reducing cholesterol synthesis in the liver. HMG-CoA Reductase Inhibition: These medications inhibit HMG-CoA reductase, a key enzyme in cholesterol production, and UDCA also hinders cholesterol absorption in the gastrointestinal tract. Indications: Functioning gallbladders Cholesterol stones (typically radiolucent) Single stone smaller than 1 cm Elderly patients or those unfit for surgery Contraindications: Non-functioning gallbladder (Option A) Stone larger than 1 cm (Option B) Radio-opaque stones Multiple stones (Option D) Drawbacks: Duration: Long-term medication use, often up to two years. Efficacy: Inconsistent results and incomplete stone dissolution. Cost: Expensive treatment. Side Effects: Diarrhea, pruritus, and liver dysfunction.

References:

SRB's Manual of Surgery, Ed 6, Page 642

↑ *Back to this question in Part A*

@Neet_pg_bot

Q23: A 60-year-old patient with a history of diabetes and hypertension presents with right upper quadrant pain, fever, and elevated white blood cell count. According to the Tokyo Guidelines (2013/2018), what is the recommended treatment approach if the patient is diagnosed with Grade II acute cholecystitis and does not respond to antibiotic treatment and supportive care? (Q848987)

A. Early laparoscopic cholecystectomy within 5-7 days.

B. Immediate discharge with oral antibiotics.

C. Early gallbladder drainage followed by delayed/elective cholecystectomy.

D. Delayed cholecystectomy after 6 weeks.

Correct Answer: C. Early gallbladder drainage followed by delayed/elective cholecystectomy.

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Early gallbladder drainage is recommended for patients with Grade II acute cholecystitis with failure of response to antibiotics and general supportive care. Delayed/elective cholecystectomy can be considered if the patient's performance status improves. Acute cholecystitis grading: Grade Features I Mild Cholecystitis II Moderate Cholecystitis Along with one of the following Increased TLC (> 18,000/mm 3) Lasting > 72 hours Palpable tender mass in RUQ of the abdomen Biliary peritonitis, pericholecystic abscess, gangrenous cholecystitis, hepatic abscess, emphysematous cholecystitis III Severe Cholecystitis along with organ dysfunction Tokyo Guidelines for Acute Cholecystitis Treatment (2013/2018) 1. Initial Non-Operative Treatment: Nil by Mouth :

Patients should not eat or drink until the pain subsides. Intravenous Fluids : Administered until pain resolves. Analgesics : Pain management. Antibiotics : Broad-spectrum antibiotics effective against Gram-negative aerobes (e.g., cefazolin, cefuroxime, ciprofloxacin). 2. Definitive treatment: Grade 1 If fit for surgery- then do early laparoscopic cholecystectomy (Option A) If unfit: Give antibiotics and supportive care Observe Then do delayed laparoscopic cholecystectomy Grade 2 First antibiotics and supportive care are to be given If fit for surgery- then do early laparoscopic cholecystectomy If unfit: GB drainage via tube cholecystectomy (tube compresses GB, hence causing a decrease in inflammation) Then do delayed laparoscopic cholecystectomy (Option D) Grade 3 First antibiotics and supportive care are to be given If no negative predictive factors and good performance status: Then do early laparoscopic cholecystectomy If negative predictive factors are present Then do Tube cholecystectomy/drainage first. If the patient then shows Good performance status - do delayed laparoscopic cholecystectomy Poor performance status - observe Timing of Surgery Early Cholecystectomy : Performed within 5-7 days of symptom onset. Shortens hospital stays but has a higher conversion rate to open surgery. Delayed Cholecystectomy : Surgery is delayed approximately 6 weeks if early cholecystectomy is not indicated.

References:

Bailey & Love’s Short Practice of Surgery, 28th Edition, Pages 1244-1246

↑ *Back to this question in Part A*

@Neet_pg_bot

Q24: A 45-year-old patient presents with right upper quadrant (RUQ) pain and fever. On examination, the clinician notes localized tenderness over the right hypochondrium. USG of the abdomen reveals gallbladder wall thickness of about 5mm along with the presence of pericholecystic fluid. According to the Tokyo Guidelines, which combination of findings would confirm a diagnosis of acute cholecystitis? (Q848986)

A. RUQ tenderness, elevated C-reactive protein, gallbladder wall thickening on USG.

B. Murphy's sign, fever, normal gallbladder wall on USG.

C. Palpable RUQ mass, normal white blood cell count, pericholecystic fluid on USG.

D. RUQ pain, elevated C-reactive protein, no imaging finding

Correct Answer: A. RUQ tenderness, elevated C-reactive protein, gallbladder wall thickening on USG.

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Above case meets all criteria (local sign, systemic sign, and characteristic imaging findings) for diagnosing acute cholecystitis. Tokyo Guidelines for Acute Cholecystitis (2013/2018) A) Local Signs of Inflammation : Murphy's sign Right upper quadrant (RUQ) pain/ tenderness, or a palpable mass. B) Systemic

Signs of Inflammation: Fever Elevated CRP Elevated WBC C) Imaging Findings: Gallbladder wall thickening (>3 mm) Pericholecystic fluid, Ultrasonographic Murphy's sign. Suspected acute cholecystitis is diagnosed when one local sign and one systemic sign of inflammation are present. Other options: Option B: Murphy’s sign, fever, normal gallbladder wall on USG Meets local + systemic signs Fails imaging criteria → cannot confirm diagnosis Option C: Palpable RUQ mass, normal WBC, pericholecystic fluid on USG Systemic signs missing (normal WBC and no fever mentioned) Tokyo Guidelines require systemic inflammation for confirmation Option D: RUQ pain, elevated CRP, no imaging finding Imaging is mandatory for confirmation Without imaging evidence → only "suspected" cholecystitis, not "definite"

References:

Bailey & Love’s Short Practice of Surgery, Ed 28, Page 1235, 1236, 1244

↑ *Back to this question in Part A*

@Neet_pg_bot

Q25: An ultrasound image of the gallbladder is consistent with a congenital anatomical variant. What is the most likely diagnosis? (Q843484)

A. Floating gallbladder

B. Accessory gallbladder

C. Phrygian cap

D. Gallbladder septum

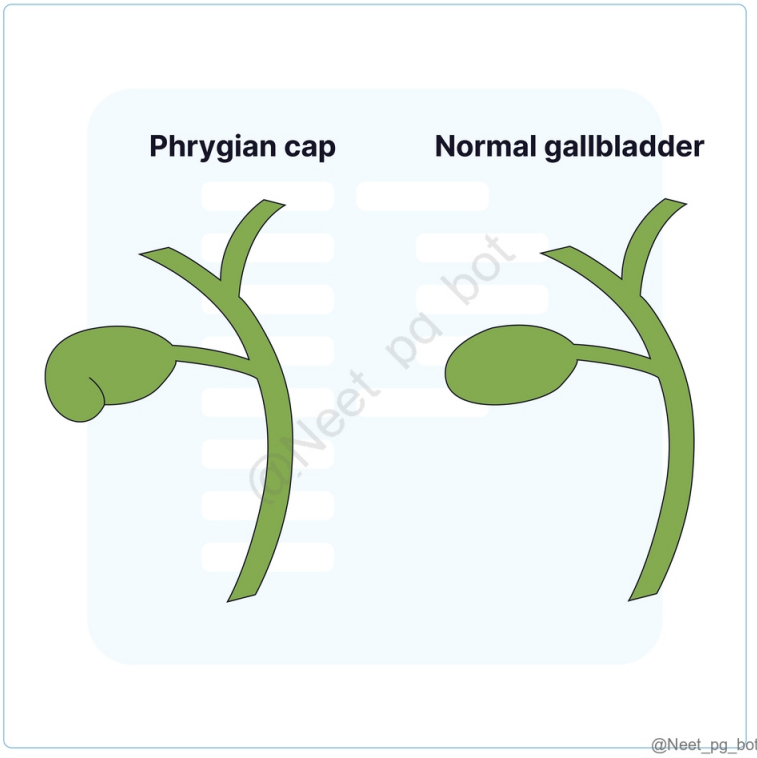


Correct Answer: C. Phrygian cap

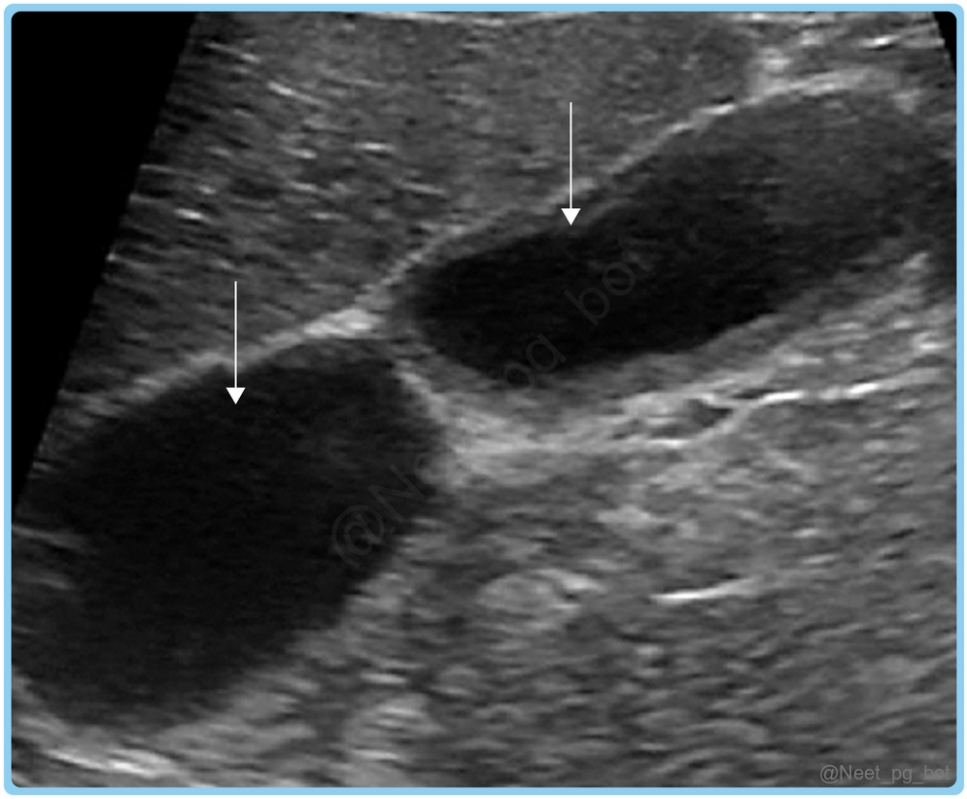
- *Listen (English)*
- *Listen (Hindi)*

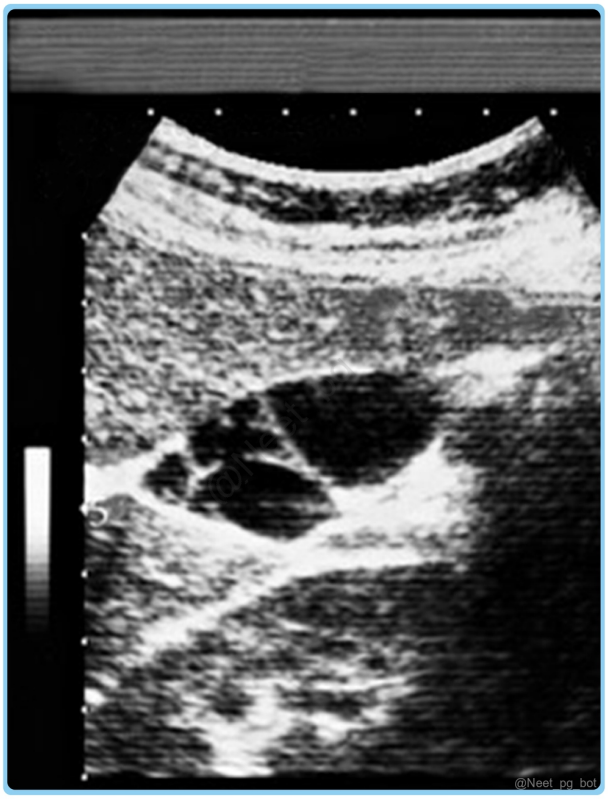
Explanation: A Phrygian cap is a congenital variant of the gallbladder characterized by a fold at the fundus that resembles a cap. It is a benign condition and is typically asymptomatic, with its appearance being consistent with a cap-like structure on ultrasound. It has no pathological significance and does not affect gallbladder function. A floating gallbladder (or gallbladder volvulus) (Option A) refers to abnormal positioning of the gallbladder within the abdominal cavity, often due to the presence of an abnormally long mesentery from the gallbladder to the liver bed, allowing it to float freely. This makes the gallbladder prone to volvulus. This condition does not present as a cap-like fold on ultrasound. An accessory gallbladder (Option B) is a rare condition where an additional gallbladder exists alongside the normal one. It appears as a separate entity on imaging. A gallbladder septum (Option D) is an abnormal partition within the gallbladder that can be mistaken for a Phrygian cap. It appears as a distinct partition.


@Neet_pg_bot


Phrygian cap
Normal gallbladder
@Neet_pg_bot







References:

Bailey and Love's Short Practice of Surgery, 28th Edition, Pg. 1240

radiopaedia.org/articles/phrygian-cap

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↑ *Back to this question in Part A*

@Neet_pg_bot

Q26: A 45 y/o woman presents to the ER with severe right upper quadrant abdominal pain, nausea, and vomiting. She has a history of gallstones and is diagnosed with acute cholecystitis. During laparoscopic cholecystectomy, the surgeon encounters difficulty identifying the cystic artery due to inflammation. Which anatomical landmarks within

Calot's triangle would be most helpful in locating the cystic artery? (Q843480)

A. Gallbladder fundus

B. Cystic lymph node

C. Common bile duct

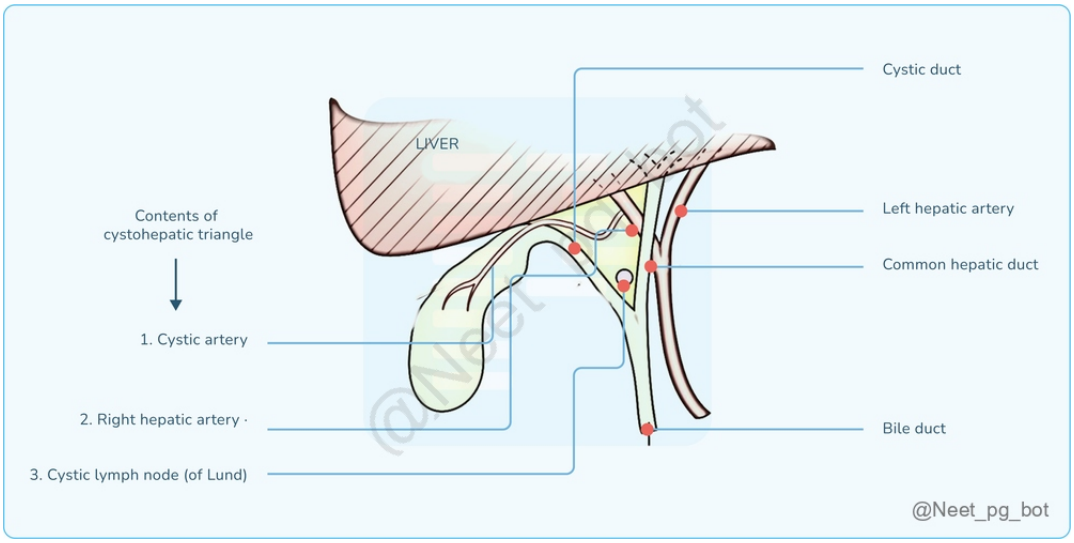
D. Portal vein

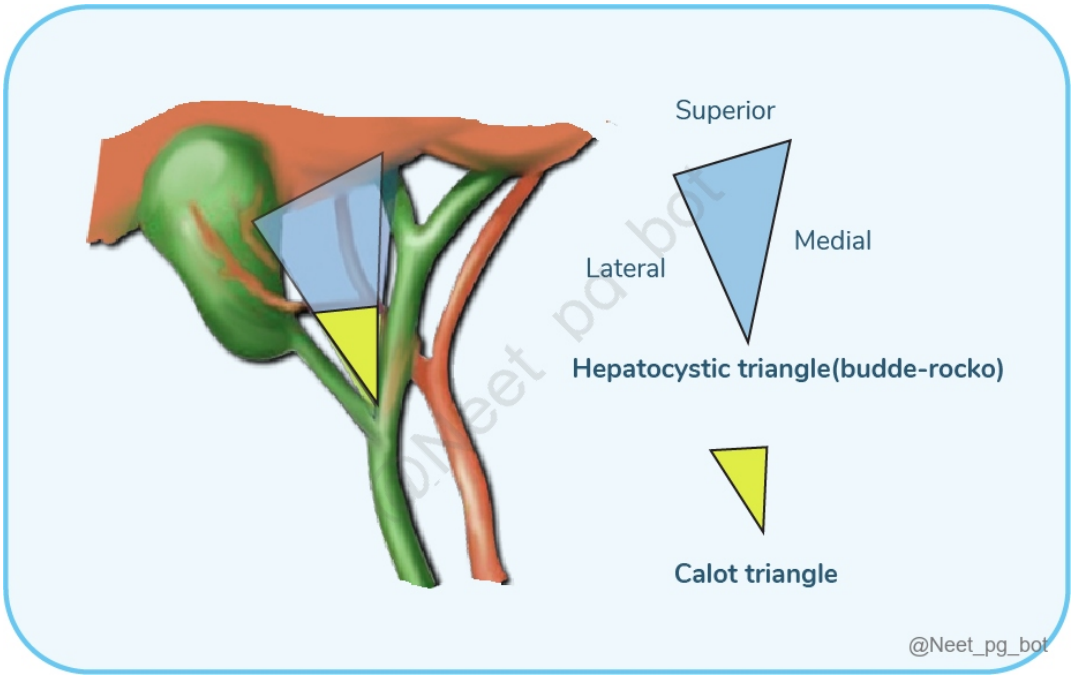
Correct Answer: B. Cystic lymph node

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The cystic lymph node, or Lund’s node , is located within Calot's triangle. It serves as an important landmark for identifying the cystic artery. Inflammation or anatomical variations can obscure typical landmarks, making the cystic lymph node a valuable reference point during surgery. Calot's triangle, also known as the cystohepatic triangle, is an important anatomical area during gallbladder surgery. The boundaries of Calot's triangle are defined by: Cystic duct (lateral boundary) Common hepatic duct (medial boundary) The inferior surface of the liver (superior boundary) The contents of Calot's triangle typically include the cystic artery, which supplies blood to the gallbladder, and the cystic lymph node (Lund’s node). Identification of these structures is crucial during a cholecystectomy to avoid accidental injury to the biliary or vascular systems. Note: The term "hepatocystic triangle" is often used interchangeably with Calot's triangle. It emphasizes the inclusion of the liver's inferior surface as part of the boundaries, along with the cystic duct and the common hepatic duct. Other options: Option A: Gallbladder fundus The fundus is NOT within Calot's triangle - it's located superiorly/laterally Calot's triangle is in the hepatocystic region, near the neck of gallbladder The fundus is too distant from the cystic artery to serve as a useful landmark Option C:Common bile duct (CBD) While the CBD forms the medial/inferior boundary of Calot's triangle, it's NOT within the triangle The CBD is an important structure to avoid injuring, not a landmark for finding the cystic artery Option D: Portal vein The portal vein is located posterior and deep to Calot's triangle It's in the hepatoduodenal ligament, behind the bile duct NOT an anatomical boundary or contents of Calot's triangle





References:

Bailey and Love's Short Practice of Surgery, 28th Edition, Pg. 1232, 1233

SRB's Manual of Surgery, 6th Edition, Pg. 623, 656

↑ *Back to this question in Part A*

@Neet_pg_bot

Q27: A 45 y/o woman presents with severe right upper quadrant pain, fever, and nausea. She has a history of pain after fatty meals. O/E, she has right upper quadrant tenderness and a positive Murphy's sign. Lab tests show elevated alkaline phosphatase, bilirubin, transaminases, and leukocytosis. Which investigation is best to confirm this patient's diagnosis? (Q843342)

A. USG- Sonographic Murphy's sign positive.

B. Plain X-Ray- Identifies radio-opaque gallstones

C. CT Scan- Pericholecystic fluid, Impacted stones, gallbladder wall thickness

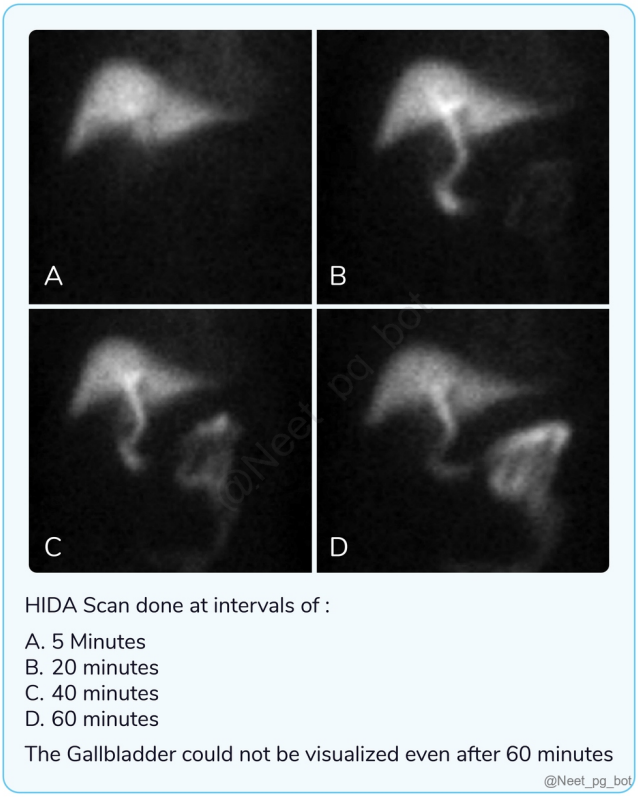
D. HIDA Scan- Non-visualization of the gallbladder

Correct Answer: D. HIDA Scan- Non-visualization of the gallbladder

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The patient’s clinical features and lab results are suggestive of acute cholecystitis. HIDA Scan can be used to confirm (Gold standard) acute cholecystitis when ultrasound findings are inconclusive. Non-visualization of the gallbladder on a HIDA scan indicates cystic duct obstruction, a key characteristic of acute cholecystitis thus making it a diagnostic feature. ASPECT INVESTIGATIONS Investigation of Choice/ Initial Inv. Ultrasound Abdomen: Reveals the presence or absence of gallstones. Posterior acoustic shadowing Thickening of the gallbladder wall. Sonographic Murphy's sign may be positive. (tenderness in the abdomen due to pressure of the ultrasound probe over the visualized gallbladder) (Option A) Gold Standard Combination of clinical assessment, laboratory findings, and imaging results: Patient history : This includes the presence of symptoms like right upper quadrant pain, fever, and a positive Murphy's sign on physical examination. Laboratory tests : Findings might include mild elevations in alkaline phosphatase, bilirubin, transaminases, and leukocytosis. Imaging : Ultrasound is the primary imaging tool, with HIDA scans and CT scans serving as supplementary tools when needed. Other Investigations HIDA/PIPIDA Radioisotope Study : Useful for assessing gallbladder visualization. Non-visualization of the gallbladder is diagnostic. CT Scan Abdomen : Identifies perforation, pericholecystic fluid, impacted stones, gallbladder wall thickness, and edema. (Option C) Useful for detecting stones in the common bile duct (CBD). Plain X-ray Abdomen : Identifies radio-opaque gallstones (10% of cases). (Option B) Rules out other causes of acute abdominal pain. May show gas in the emphysematous gallbladder. Useful to rule out duodenal ulcer perforation or peritonitis. Liver Function Tests (LFT) Total White Blood Cell Count (WBC Count)



References:

Bailey and Love’s Short Practice of Surgery, 28th Edition, Pg. 1244

SRB’s Manual of Surgery, 6th Edition, Pg. 634, 636

Sabiston Textbook of Surgery, 21st edition, Pg. 1499, 1500

Sonographic Murphy’s sign

↑ *Back to this question in Part A*

@Neet_pg_bot

Q28: A 45 y/o woman presents to the ER with severe right upper quadrant pain radiating to her back. She has a h/o gallstones. O/E, she exhibits tenderness in the right upper quadrant. An abdominal CT scan shows a characteristic triradiate pattern of gas within a gallstone. Based on the CT findings, which of the following signs is most likely being described? (Q843341)

A. Murphy sign

B. Mermaid sign

C. Stellate scar sign

D. Mercedes-Benz sign

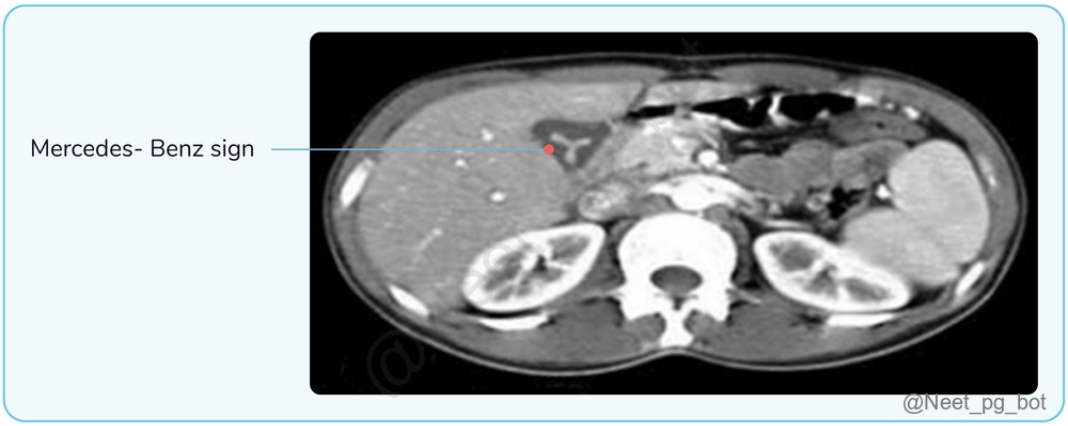


Correct Answer: D. Mercedes-Benz sign

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The "Mercedes Benz sign" and "seagull sign" are terms used to describe the appearance of specific types of radiopaque gallstones on plain radiographs and CT scans which have a radiolucent triradiate (Mercedes Benz sign) or biradiate (seagull sign) fissure in the centre containing nitrogen gas resembling the Mercedes-Benz logo. Murphy sign (Option A) is a clinical finding elicited during a physical exam that indicates gallbladder inflammation and acute cholecystitis While palpating the right upper quadrant, the examiner observes if the patient stops breathing voluntarily when the examiner exerts pressure under the right costal margin. Mermaid sign (Option B) and Stellate scar sign (Option C) are not established radiological terms related to gallstones and can be seen in conditions like ‘fetal abnormalities’ and ‘renal cell carcinoma’ respectively.



References:

Bailey and Love’s Short Practice of Surgery, 28th Edition, Pg. 1234,1244

SRB’s Manual of Surgery, 6th Edition, Pg. 632, 634

Sabiston Textbook of Surgery, 21st edition, Pg. 1499

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↑ *Back to this question in Part A*

@Neet_pg_bot

Q29: Which of the following statements accurately describes a characteristic of pigment stones? (Q843340)

A. Black pigment stones are associated with bacterial β-glucuronidase activity in the bile duct.

B. Black pigment stones are associated with hemolysis.

C. Brown pigment stones are associated with excess bilirubin from hemolysis.

D. Black pigment stones are primarily composed of calcium bilirubinate and cholesterol.

Correct Answer: B. Black pigment stones are associated with hemolysis.

- *Listen (English)*
- *Listen (Hindi)*

Explanation: Black pigment stones are associated with conditions causing hemolysis such as hereditary spherocytosis, and sickle cell disease, and are mainly composed of insoluble bilirubin pigment polymers. Feature Black Pigment Stones Brown Pigment Stones Composition Insoluble bilirubin pigment polymer, calcium phosphate, calcium bicarbonate Calcium bilirubinate, calcium palmitate, calcium stearate, cholesterol (Option D) Location Gallbladder Bile ducts Associated Conditions Hemolysis (hereditary spherocytosis, sickle cell disease), cirrhosis Bile stasis, infection, foreign bodies or parasites in the bile duct (Clonorchis sinensis, Ascaris lumbricoides) Pathophysiology Excess bilirubin from hemolysis precipitates in the gallbladder (Option C) Bacterial β-glucuronidase deconjugates bilirubin in the bile duct; unconjugated bilirubin precipitates (Option A) Image





References:

Bailey and Love’s Short Practice of Surgery, 28th Edition, Pg. 1243

Sabiston Textbook of Surgery, 21st edition, Pg. 1497

↑ *Back to this question in Part A*

@Neet_pg_bot

Q30: A 49-y/o woman presents with intermittent right upper quadrant pain that worsens after fatty meals. She has a history of Sickle cell disease and has been on total parenteral nutrition (TPN) for the past six months due to severe Crohn's disease post-ileal resection. She also gives a h/o OCP usage for 5 years. The patient underwent cholecystectomy which showed the following finding. Which of the following factors is least likely to contribute to the formation of this patient's condition? (Q843339)

A. Total parenteral nutrition

B. Sickle cell disease

C. Ileal resection due to Crohn's disease

D. OCP usage



Correct Answer: B. Sickle cell disease

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The image shows cholesterol gallstones. They are the most common type of gallstone in Europe and the U.S., accounting for 80% of cases. They form when cholesterol precipitates out of bile and combines with calcium salts, bile acids, bile pigments, and phospholipids. Cholesterol makes up between 50% and 99% of these gallstones. Sickle cell disease is not associated with cholesterol Gallstones but rather with black pigment stones because these stones occur in hemolytic states. Cholesterol Gallstones Formation Mechanism Cholesterol precipitates out into crystals when the concentration exceeds the solubility Contributing Factors Obesity High-calorie diet Oral contraceptives (Option D) Ileal disease/resection (Option C) Abnormal gallbladder emptying Supersaturation of Bile High cholesterol and lipid concentrations in bile secreted from the liver The concentration of bile in the Gallbladder Bile is concentrated through the absorption of water and sodium, increasing solutes and calcium Crystal Nucleation Cholesterol crystallizes when concentration exceeds solubility; accelerated by glycoproteins and immunoglobulins Gallbladder Dysmotility Increased stasis due to abnormal motility, promoting stone formation Associated Conditions Prolonged fasting Total parenteral nutrition (Option A) Vagotomy Use of somatostatin analogues

References:

Bailey and Love’s Short Practice of Surgery, 28th Edition, Pg. 1243

Sabiston Textbook of Surgery, 21st edition, Pg. 1497

↑ *Back to this question in Part A*

@Neet_pg_bot

• [04_Hepatobiliary Pancreatic Surgery] 016 Bile Duct

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[04_Hepatobiliary Pancreatic Surgery] 016 Bile Duct — Quick Jump

Q1 (p. 1662)	*Q2 (p. 1663)*	*Q3 (p. 1664)*	*Q4 (p. 1665)*	*Q5 (p. 1666)*	*Q6 (p. 1668)*
Q7 (p. 1670)	*Q8 (p. 1671)*	*Q9 (p. 1673)*	*Q10 (p. 1674)*	*Q11 (p. 1675)*	*Q12 (p. 1677)*
Q13 (p. 1678)	*Q14 (p. 1678)*	*Q15 (p. 1679)*	*Q16 (p. 1681)*	*Q17 (p. 1682)*	*Q18 (p. 1684)*
Q19 (p. 1686)	*Q20 (p. 1687)*	*Q21 (p. 1691)*	*Q22 (p. 1694)*	*Q23 (p. 1695)*	

Q1: A 50 year old woman presents with complaints of persistent fatigue, itching, and mild right upper quadrant abdominal pain. On examination, she has jaundice and hepatomegaly. Laboratory tests reveal elevated alkaline phosphatase and positive anti-mitochondrial antibodies. What is the most likely diagnosis? (Q843496)

A. Primary biliary cirrhosis

B. Primary sclerosing cholangitis

C. Autoimmune hepatitis

D. Drug-induced liver disease

Correct Answer: A. Primary biliary cirrhosis

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The patient's symptoms, including fatigue, itching, jaundice, and hepatomegaly, along with elevated alkaline phosphatase and positive anti-mitochondrial antibodies, are characteristic of primary biliary cirrhosis (PBC) . PBC is an autoimmune disorder leading to the gradual destruction of intrahepatic bile ducts, resulting in cholestasis and liver damage. Primary sclerosing cholangitis (Option A) also presents with cholestasis but is more often associated with inflammatory bowel disease (IBD). PSC involves both intrahepatic and extrahepatic bile ducts, which would typically be identified in imaging studies. This patient has no history of IBD, and the presentation and test results align more closely with PBC. Autoimmune hepatitis (Option C) is characterized by elevated serum transaminases rather than an isolated elevation in alkaline phosphatase. It is not commonly associated with anti-mitochondrial antibodies. While drug-induced liver disease (Option D) can cause cholestasis and elevated liver enzymes, the presence of specific antibodies (AMA), the chronic nature of the patient's symptoms and the absence of drug history are more indicative of an autoimmune process like PBC .

References:

www.ncbi.nlm.nih.gov/books/NBK459209/#

Bailey and Love’s Short Practice of Surgery, 28th Edition, Page 1207,1208,1254

Sabiston Textbook of Surgery, 21st Edition, Page 616

↑ *Back to this question in Part A*

@Neet_pg_bot

Q2: A 70 year old male presents with painless obstructive jaundice, significant weight loss, and a palpable, non-tender mass in the right hypochondrium. Imaging reveals a mass at the liver hilum with no evidence of distant metastasis. What is the correct management of this patient? (Q848917)

A. Stenting through PTC or ERCP

B. Portal region clearance with hemihepatectomy

C. Extensive bile duct resection, nodal clearance, caudate lobe removal, and cholecystectomy

D. Chemotherapy with 5-FU and cisplatin

Correct Answer: C. Extensive bile duct resection, nodal clearance, caudate lobe removal, and cholecystectomy

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The clinical scenario is suggestive of perihilar cholangiocarcinoma, given the presentation of painless jaundice, weight loss, and a palpable mass at the liver hilum with no evidence of distant metastasis, indicating that the tumor is operable. Extensive bile duct resection, nodal clearance, caudate lobe removal, and cholecystectomy are the correct surgical management, aiming for complete resection of the tumor. Management of cholangiocarcinoma: Surgical options (if operable) Portal region clearance with hemi-hepatectomy (for intrahepatic type) Hemi-hepatectomy or extensive bile duct resection, nodal clearance, caudate lobe removal, cholecystectomy (for perihilar type) Whipple's pancreaticoduodenectomy (for distal tumors) Palliative options (if operable) Stenting to relieve jaundice (through PTC or ERCP or intraoperatively) Chemotherapy 5-Fluorouracil (5-FU) Gemcitabine Cisplatin Radiotherapy External Beam Radiotherapy (ERBT) in combination with chemotherapy Stenting through PTC or ERCP (Option A): This is a palliative option for inoperable cases to relieve jaundice. Portal region clearance with hemihepatectomy (Option B) : Appropriate for intrahepatic type, not specifically for perihilar cholangiocarcinoma. Chemotherapy with 5-FU and cisplatin (Option D): This is an option for adjuvant or palliative treatment, not the primary management for an operable tumour.

References:

SRB’s Manual of Surgery, 6th Edition, Page 653

Bailey and Love’s Short Practice of Surgery, 28th Edition, Page 1256,1257

↑ *Back to this question in Part A*

@Neet_pg_bot

Q3: A 55 year old woman undergoes a cholecystectomy, after which she develops jaundice and abdominal pain. Imaging reveals a bile duct stricture at the confluence of the right and left hepatic ducts, but the ducts themselves are intact. According to the Bismuth classification, what type of stricture does she have? (Q843542)

A. Type I

B. Type II

C. Type III

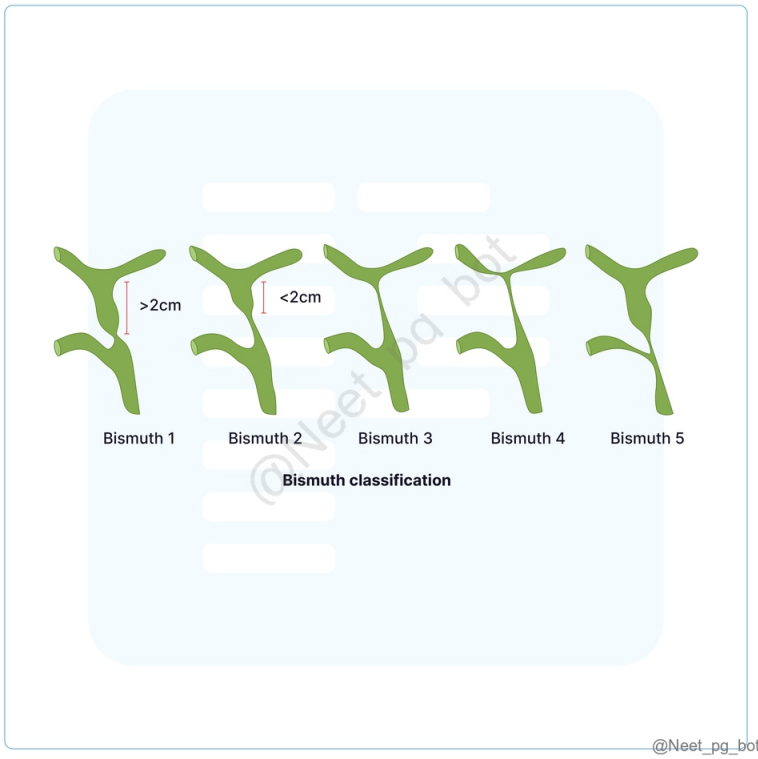
D. Type IV

Correct Answer: C. Type III

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Type III strictures are located at the confluence of the right and left hepatic ducts, with the ducts themselves remaining intact. This matches the description given in the scenario. Bismuth classification for biliary strictures Type I Common hepatic duct stump >2cm Stricture is Low (Option A) Type II Common hepatic duct stump <2cm Stricture is mid (Option B) Type III Hilar stricture with intact confluence Stricture is high Type IV Hilar stricture with destroyed confluence (Option D) Type V Stricture involving aberrant right sectoral duct with or without stricture of common hepatic duct Drawbacks of bismuth classification: No information about the bile leak No information about the types of injuries in laparoscopic surgeries



References:

Iatrogenic bile duct injury

Sabiston Textbook of Surgery, 21st Edition, Page 1511

SRB's Manual of Surgery, 6th Edition, Page 649

↑ *Back to this question in Part A*

@Neet_pg_bot

Q4: A 25-year-old woman presents with persistent right upper quadrant pain for several days, fever, and jaundice. On examination, right upper quadrant tenderness is present. On USG, cystic dilation of the common bile duct is seen. Which of the following malignancies is not associated with this condition? (Q848898)

A. Cholangiocarcinoma

B. Squamous Cell carcinoma

C. Pancreatic Carcinoma

D. Renal cell carcinoma

Correct Answer: D. Renal cell carcinoma

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The clinical scenario points to a choledochal cyst due to the presence of right upper quadrant pain, jaundice, and ultrasound showing cystic dilation of the common bile duct, which are hallmark features of this condition. Choledochal cysts, congenital dilatations of the intra- and/or extrahepatic biliary system, can present at any age. Renal carcinomas are not seen to be associated with choledochal cysts. Clinical features of choledochal cysts: Patients may present with jaundice, fever, abdominal pain, and a right upper quadrant mass. Pancreatitis is a frequent presentation in adults. Approximately 60% of cases are diagnosed before the age of 10 years. The classical triad of jaundice, right upper quadrant mass, and abdominal pain is present in only a minority of patients (0–17%) Malignancies associated with choledochal cysts may arise within the cyst or elsewhere within the liver or pancreaticobiliary tract. Patients with choledochal cysts have an increased risk of developing malignancies like: Cholangiocarcinoma (Option A) Squamous cell carcinoma (Option B) Bile duct sarcoma Hepatoma Pancreatic carcinoma (Option C) Gallbladder carcinoma

References:

Bailey light-coloured Practice of Surgery, 28th Edition, Page 1242

Sabiston Textbook of Surgery, 21st edition, Page 1505

SRB’s Manual of Surgery, 6th Edition, Page 629

Diagnosis and Management of Choledochal Cysts

Choledochal Cyst and Malignancy

Choledochal cyst

↑ *Back to this question in Part A*

@Neet_pg_bot

Q5: A 45-year-old woman presents with worsening abdominal pain, jaundice, and fever. Ultrasound shows a choledochal cyst and bile duct obstruction. What imaging study is most appropriate for the next step in management? (Q848899)

A. CT Scan

B. Magnetic Resonance Cholangiopancreatography

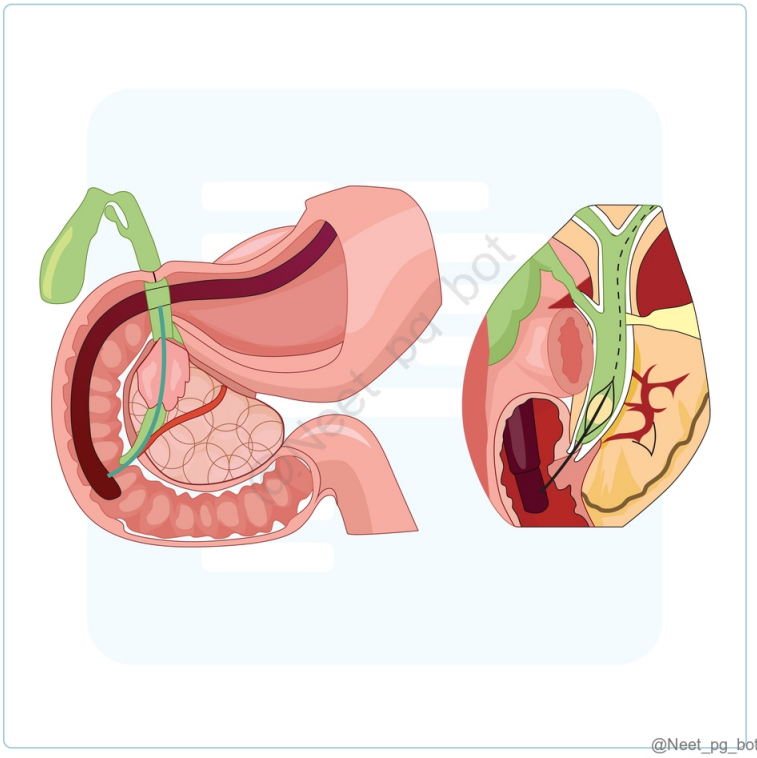
C. Endoscopic Retrograde Cholangiopancreatography

D. Percutaneous Transhepatic Cholangiography

Correct Answer: C. Endoscopic Retrograde Cholangiopancreatography

- *Listen (English)*
- *Listen (Hindi)*

Explanation: ERCP is appropriate in this scenario as it allows for both diagnostic evaluation and therapeutic interventions. It enables the physician to obtain detailed images of the bile ducts, perform tissue sampling, decompress obstructions, and treat conditions like choledocholithiasis. INVESTIGATIONS - CHOLEDOCHAL CYST Ultrasound The first imaging test that is performed. Confirms the presence of the cyst. Reveals anatomical details, including bile duct and pancreatic duct relationship. Magnetic Resonance Cholangiopancreatography (MRCP) (Option B) Non-invasive imaging technique. Provides detailed images of the gallbladder and biliary system. Highly sensitive (>90%) and specific (>99%) for identifying common bile duct stones. Visualizes biliary anatomy and the extent of dilatation. Endoscopic Retrograde Cholangiopancreatography (ERCP): Invasive procedure with endoscope and contrast material. Diagnostic and therapeutic capabilities (tissue sampling, decompression, treatment of choledocholithiasis). Effective but has a complication rate of up to 10%. Percutaneous Transhepatic Cholangiography (PTC) (Option D) Invasive procedure with a needle directly into the liver. Useful for intrahepatic biliary disease or when ERCP is not feasible. Helps delineate surgical anatomy and enables drainage catheter and stent placement. CT SCAN (Option A) Mainly to see the intrahepatic biliary system Other Tests Hepatobiliary nuclide Scanning Liver Function Tests MRCP: Excellent for diagnosis, sensitive, and specific. ERCP: Preferred for treatment due to therapeutic capabilities, and higher complication risk. PTC: Useful when ERCP is not feasible, especially in cases with dilated biliary systems



References:

Bailey and Love’s Short Practice of Surgery, 28th Edition, Page 1242, 1236-1238

Sabiston Textbook of Surgery, 21st Edition, Page 1501, 1505

SRB's Manual of Surgery, 6th Edition, Page 629

↑ *Back to this question in Part A*

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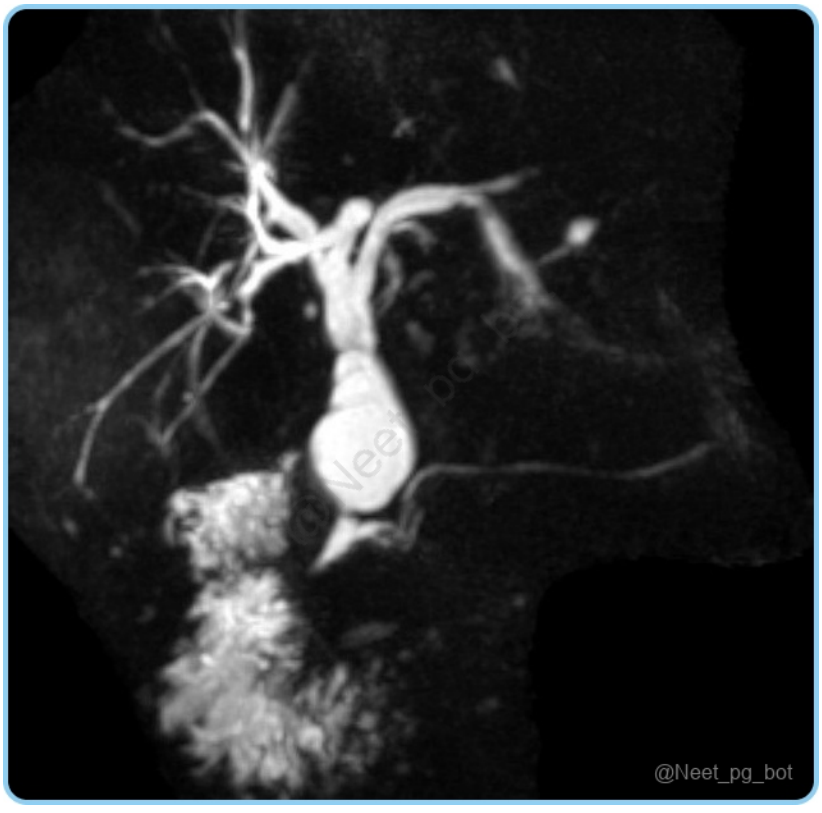
Q6: MRCP imaging studies done for a 35 year old woman who presented with a history of recurrent cholangitis, jaundice, and right upper quadrant pain reveal the following. Based on the Todani classification, what is the most appropriate surgical treatment for this patient? (Q848897)

A. Liver transplantation

B. Transduodenal sphincteroplasty

C. Roux-en-Y hepaticojejunostomy

D. Partial hepatectomy



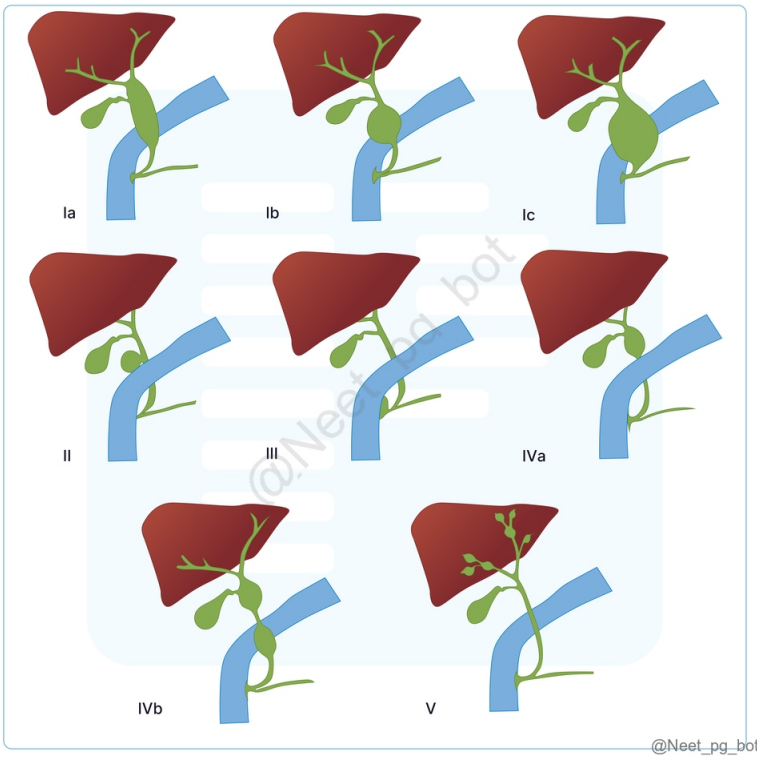
Correct Answer: C. Roux-en-Y hepaticojejunostomy

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Imaging shows an anomalous pancreaticobiliary junction , with a high junction of the pancreatic duct with the common bile duct resulting in a long common channel. There is fusiform dilation of the common bile duct, compatible with a type I choledochal cyst. The recommended treatment for Type I cysts is complete surgical excision, cholecystectomy, and Roux-en-Y hepaticojejunostomy. Choledochal cysts are congenital anomalies characterized by the dilatation of the intrahepatic and/or extrahepatic bile ducts. The exact cause of choledochal cysts is unknown, but they are thought to be premalignant. Todani modification of Alonso- Lej classification Type I Ia Cystic dilation of the extrahepatic bile duct (Most common) Ib Focal segmental dilation of extrahepatic bile duct Ic Fusiform dilation of extrahepatic bile duct Type II Diverticular dilation of extrahepatic bile duct Type III Dilatation of intraduodenal part of bile duct (choledochocele) Type IV IV a Dilatation of both intra and extrahepatic bile duct IV b Multiple cysts involving extrahepatic bile duct only Type V Multiple cysts involving intrahepatic bile duct only (Caroli's disease) Type Treatment Type I Complete excision, cholecystectomy, Roux-en-Y hepaticojejunostomy Type II Complete excision Type III Transduodenal excision or sphincteroplasty (Option B) ; endoscopic drainage may suffice Type IVa Tailored to anatomy: extrahepatic cysts treated like Type I; partial hepatectomy (Option D) and reconstruction for localized intrahepatic involvement Type IVb Managed like Type I Type V (Caroli disease) Resection for unilobar disease; liver transplantation for diffuse disease (Option A)





References:

Bailey and Love's Short Practice of Surgery, 28th Edition, Page 1242

Sabiston Textbook of Surgery, 21st Edition, Page 1504, 1505

SRB's Manual of Surgery, 6th Edition, Page 628, 629

↑ *Back to this question in Part A*

@Neet_pg_bot

Q7: During a laparoscopic cholecystectomy, a lateral injury to the Common Bile Duct is identified. What is the most appropriate next step in management? (Q882176)

A. Continue the laparoscopic procedure and place a drain

B. Convert to open procedure with T-tube drainage

C. Ligate the duct proximal to the injury

D. Close the abdomen and refer for ERCP

Correct Answer: B. Convert to open procedure with T-tube drainage

Explanation: A lateral injury to the CBD identified intraoperatively represents a Strasberg type D injury. The recommended management is immediate repair in the same sitting. Conversion to an open procedure allows proper exposure, assessment of the extent of injury, and controlled biliary drainage using a T-tube after primary repair. This approach reduces the risk of bile leak, stricture formation, and long-term morbidity when expertise is available. Continue the laparoscopic procedure and place a drain (Option A): Drain placement alone is inadequate and leads to persistent bile leak, biliary peritonitis, and stricture formation. Ligate the duct proximal to the injury (Option C): Ligation of the CBD causes obstructive jaundice and secondary biliary cirrhosis and is never appropriate. Close the abdomen and refer for ERCP (Option D): ERCP is useful for postoperative bile leaks or minor injuries, not for a recognized intraoperative CBD injury, where immediate surgical repair is preferred.

References:

Bailey and Love's Short Practice of Surgery, 28th Edition, Page 1236

↑ *Back to this question in Part A*

@Neet_pg_bot

Q8: According to the Strasberg classification, what type of bile duct injury does this image show? (Q848919)

A. Class A

B. Class B

C. Class C

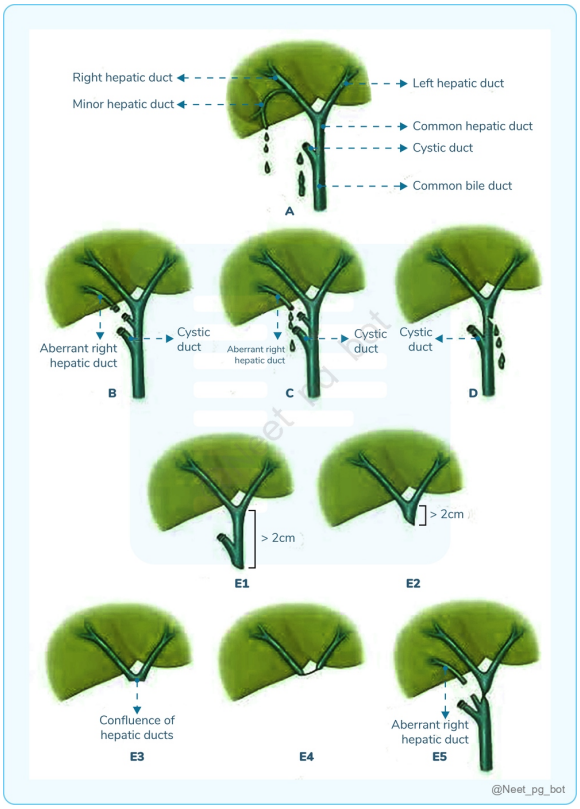
D. Class D



Correct Answer: A. Class A

- *Listen (English)*
- *Listen (Hindi)*

Explanation: Class A of Strasberg's classification of bile duct injuries involves leakage of bile from the cystic duct or an accessory duct that is still connected to the common bile duct, which matches the given image. The Strasberg classification divides bile duct injuries into five main classes: Type A (M/C) Cystic duct stump leak or leak from sub-vesical duct of Luschka Type B Ligation or occlusion of aberrant right sectoral duct Type C Transection without occlusion of the aberrant right sectoral duct Type D Injury to the lateral wall of the Common hepatic duct Type E E1 to E5 Bismuth classification



References:

Bailey and Love's Short Practice of Surgery, 28th Edition, Page 1252

Sabiston Textbook of Surgery, 21st Edition, Page 1511

SRB's Manual of Surgery, 6th Edition, Page 658

↑ *Back to this question in Part A*

@Neet_pg_bot

Q9: A 45-year-old male presents with severe colicky pain in the upper right quadrant, jaundice, and episodes of haematemesis and melaena. He had a history of blunt abdominal trauma a few weeks ago. Which is the investigation of choice for detecting the bleeding site in this patient? (Q848918)

A. Liver Function Tests

B. Ultrasound of the abdomen

C. Selective arteriography

D. Upper GI endoscopy

Correct Answer: C. Selective arteriography

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The clinical features and history provided in the clinical scenario point to a diagnosis of Hemobilia. Selective arteriography is the investigation of choice, with a 90% success rate in detecting the bleeding site , providing detailed vascular imaging necessary for precise diagnosis and treatment planning. Hemobilia is bleeding from the liver or, less commonly, from the gallbladder into the biliary tract due to abnormal communication between a blood vessel and a bile duct or any part of the biliary tree. Causes Trauma Vascular Diseases Liver Diseases Others Accidental blunt trauma Iatrogenic trauma Percutaneous diagnostic and therapeutic procedures Hepatic artery diseases (10%) Hepatic artery aneurysm (common cause) Malignant liver diseases (more common, 5%) Benign liver diseases Parasitic liver diseases (e.g., hydatid disease) Arterial hemobilia(common) Portal hypertension Gallstones (rare) Portal venous hemobilia (rare) Clinical Features Quinckes Triad Pain : Colicky Jaundice : Obstructive Jaundice Gastrointestinal Bleeding : Hematemesis Melaena Investigations Imaging: Ultrasound (US) of the abdomen Selective arteriography (test of choice) CT angiogram Treatment Initial Management: Antibiotics Blood transfusions Selective arterial embolization (Transarterial Embolisation, TAE) Surgical Intervention (rare, indicated in failed TAE): Laparotomy Ligation of the bleeding vessel or hepatic artery Excision of aneurysm Hepatic resection Liver Function Tests (LFTs) (Option A) : These tests help assess liver function but do not identify the bleeding site. Ultrasound (US) of the abdomen (Option B) : Useful for initial evaluation and detecting biliary dilation or hepatic lesions but not as specific for locating the bleeding source. Upper GI endoscopy (Option D) : Useful in identifying upper gastrointestinal bleeding but has limited value in diagnosing hemobilia, as it can only detect the source in about 10% of cases.

References:

SRB’s Manual of Surgery, 6th Edition, Page 654,655.

Sabiston Textbook of Surgery, 21st Edition, Page 1158.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q10: A 65 year old female presents with painless jaundice and a palpable, non-tender, globular mass in the right hypochondrium. Imaging suggests an obstructed biliary system. The patient has no history of gallstones. Based on Courvoisier's law, which of the following conditions is not an exception to the rule? (Q848916)

A. Double impacted stone

B. A large stone in Hartmann's pouch

C. Empyema of the gallbladder with a CBD stone

D. Chronic cholecystitis with multiple gallstones

Correct Answer: D. Chronic cholecystitis with multiple gallstones

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Chronic cholecystitis with multiple gallstones is not an exception, as the gallbladder is typically contracted, fibrotic, and non-distensible in chronic cholecystitis. It simply defies courvoisier's law. Courvoisier's Law : It states that in a patient with jaundice, if there is a palpable gallbladder, it is not due to stones Gallbladder and Stones: In obstruction due to common bile duct (CBD) stones, the gallbladder does not distend. The gallbladder is typically chronically inflamed, thickened, fibrotic, contracted, and nondistensible in the presence of stones. Gallbladder and Malignancy: In malignancies such as carcinoma of the head of the pancreas or periampullary carcinoma, the gallbladder will be distended and palpable. The gallbladder presents as a non-tender, globular, smooth, soft, dull mass that moves with respiration and tumourorizontal mobility, located to the right of the rectus muscle in the right hypochondrium. Exceptions to Courvoisier's Law Double Impacted Stone (Option A) : One stone in the CBD and another in the cystic duct, leading to mucocele of the gallbladder. A large Stone in Hartmann's Pouch (Option B) : Obstructing the cystic duct, causing distention of the gallbladder. Empyema Gallbladder with CBD Stone (Option C) : Infection and accumulation of pus in the gallbladder combined with CBD stone obstruction. Ampullary vs Periampullary carcinoma: Ampullary Periampullary They originate in the ampulla of Vater. They originate in the pancreas, bile duct, or intestines close to the ampulla of Vater. They have a better survival rate than periampullary cancers. Poorer survival rate.

References:

Ampullary carcinoma

SRB's Manual of Surgery, 6th Edition, Page 646

Schwartz's Principles of Surgery, 11th Edition, Page 1499

Bailey and Love's Short Practice of Surgery, 28th Edition, Page 1283

↑ *Back to this question in Part A*

@Neet_pg_bot

Q11: A 58 year old female presents with painless obstructive jaundice, significant weight loss, and anorexia. Imaging reveals a tumour involving the confluence of the right hepatic duct and left hepatic duct, extending into both ducts. Based on the Bismuth-Corlette classification, which type of perihilar cholangiocarcinoma is most consistent with these findings? (Q848915)

A. Type 1

B. Type 2

C. Type 3A

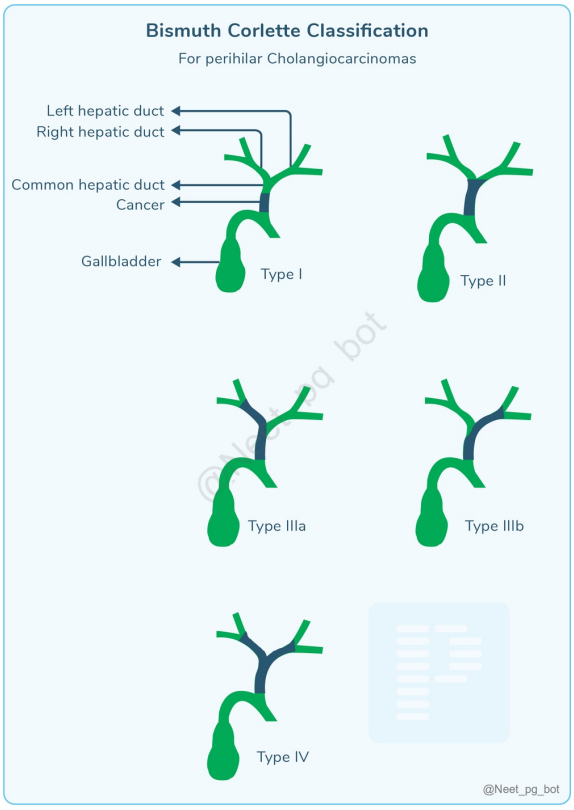
D. Type 4

Correct Answer: D. Type 4

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: In this scenario, the tumor involves the confluence and extends into both the RHD and LHD, indicating Type 4 cholangiocarcinoma. Bismuth Corlette's classification of perihilar cholangiocarcinoma Type 1 Below the confluence of RHD and LHD Type 2 Reaching the confluence of RHD and LHD Type 3A Type 3B Involving CHD with RHD Involving CHD with LHD Type 4 Involving confluence and both RHD and LHD or multicentric tumor



References:

SRB’s Manual of Surgery, 6th Edition, Page 653

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1257, 1258

Schwartz's Principles of Surgery, 11th Edition, Page 1423

Sabiston Textbook of Surgery, 21st Edition, Page 1524

↑ *Back to this question in Part A*

@Neet_pg_bot

Q12: Which of the following is not a risk factor for cholangiocarcinoma? (Q848914)

A. Primary sclerosing cholangitis

B. Hepatitis C

C. Clonorchis sinensis infestation

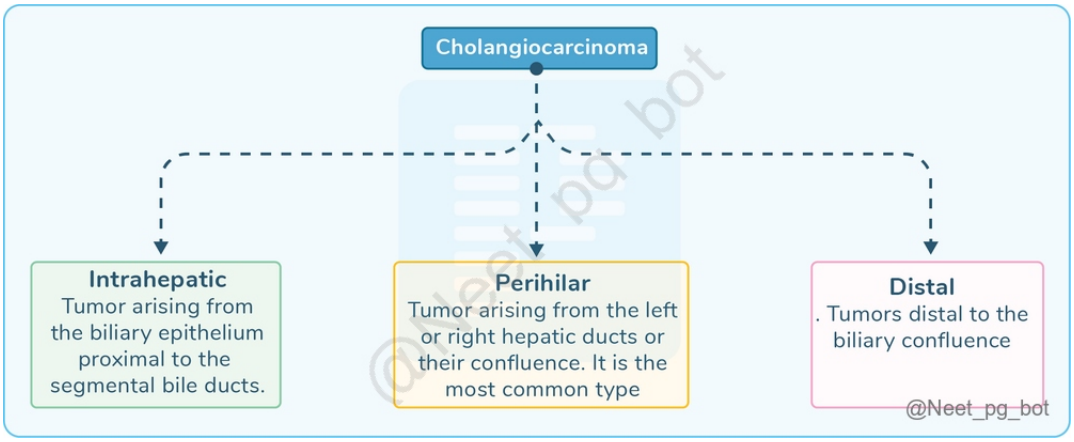
D. Alcohol consumption

Correct Answer: D. Alcohol consumption

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Alcohol consumption is not specifically a risk factor for cholangiocarcinoma Cholangiocarcinoma Cholangiocarcinoma is an aggressive adenocarcinoma of the bile ducts, commonly presenting as obstructive jaundice. Risk Factors Biliary and Liver Conditions : Primary sclerosing cholangitis (PSC) (Option A) Choledochal cyst Hepatolithiasis Caroli's disease Infections : Clonorchis sinensis infestation (Option C) Hepatitis B and C (Option B) (risk factors for intrahepatic cholangiocarcinoma) Genetic Conditions : Lynch syndrome II Other Conditions : Multiple biliary papillomatosis Previous biliary enteric anastomosis Toxins : Thorotrast Nitrosamines Dioxin Types based on its location



References:

SRB’s Manual of Surgery, 6th Edition, Pages 653, 654

www.ncbi.nlm.nih.gov/books/NBK560708/

Bailey and Love’s Short Practice of Surgery, 28th Edition, Page 1256

↑ *Back to this question in Part A*

@Neet_pg_bot

Q13: Which of the following is the classical triad of acute cholangitis? (Q848911)

A. Pain, jaundice, fever

B. Pain, jaundice, shock

C. Fever, jaundice, ↑WBC

D. Pain, ↑WBC, ↑Bilirubin

Correct Answer: A. Pain, jaundice, fever

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Pain, jaundice, fever - this triad, known as Charcot's triad - indicates cholangitis . Cholangitis Aetiology Often due to obstruction in the biliary tree, leading to bacterial infection by organisms like Klebsiella, E. coli, Enterobacter, Pseudomonas, and Citrobacter species. Symptoms Charcot's triad - pain, jaundice, fever Additional tenderness in the epigastrium and right hypochondrium is common. Severe Form: Reynolds pentad - persistent pain, fever, jaundice, shock, and altered mental status Indicates acute obstructive suppurative cholangitis. Lab Findings Elevated white blood cell count, bilirubin, and alkaline phosphatase levels. Chronic cases may show lobar or segmental atrophy or hypertrophy. Recurrent Pyogenic Cholangitis More common in East Asian populations, caused by intrahepatic stones and infections Risk factors include parasitic infections like Clonorchis sinensis and Ascaris lumbricoides. Pain, jaundice, shock (Option B): This option is incorrect as shock is not part of Charcot's triad but is part of Reynolds's pentad. Fever, jaundice, ↑WBC (Option C): ↑WBC, although it does occur in cholangitis, is not a component of Charcot's triad. Pain, ↑WBC, ↑Bilirubin (Option D): ↑Bilirubin, although it does occur in cholangitis, is not a component of Charcot's triad.

References:

Bailey and Love’s Short Practice of Surgery, 28th Edition, Page 1253

Sabiston Textbook of Surgery, 21st Edition, Page 1515

SRB’s Manual of Surgery, 6th Edition, Page 643

↑ *Back to this question in Part A*

@Neet_pg_bot

Q14: A 40 year old patient is experiencing persistent abdominal pain and elevated serum amylase after undergoing ERCP. The pain began shortly after the procedure. Which of the following is the most likely cause of the patient's symptoms? (Q848910)

A. Post-ERCP pancreatitis

B. Post-ERCP duodenal perforation

C. Post-ERCP cholangitis

D. Post-ERCP sphincter stenosis

Correct Answer: A. Post-ERCP pancreatitis

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Elevated serum amylase and abdominal pain shortly after ERCP strongly suggest pancreatitis, a common complication Complications of ERCP: Duodenal perforation Hemorrhage post-sphincterotomy Pancreatitis It can be severe with extensive pancreatic necrosis Associated with a significant mortality rate Use of per-rectal indometacin/diclofenac to reduce risk Sepsis Other complications: Cholangitis Sphincter stenosis Post-ERCP duodenal perforation (Option B) : Typically presents with severe pain and peritoneal signs rather than elevated amylase. Post-ERCP cholangitis (Option C) : Usually involves fever and jaundice, not elevated amylase alone. Post-ERCP sphincter stenosis (Option D) : Causes obstructive symptoms over time, not acute pain and elevated amylase.

References:

Bailey and Love's Short Practice of Surgery, 28th Edition, Page 156

SRB's Manual of Surgery, 6th Edition, Page 625

↑ *Back to this question in Part A*

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Q15: A 55 year old male with history of obesity and a low-protein diet presents with intermittent abdominal pain, jaundice, and recurrent episodes of dark urine and light-colored stools. Recently, he developed a fever with chills. Blood tests show elevated WBC count and abnormal liver function tests. MRCP reveals multiple pigmented stones in the common bile duct and intrahepatic ducts. What is the most likely cause of his condition? (Q843489)

A. Primary Choledocholithiasis

B. Secondary Choledocholithiasis

C. Gallstone ileus

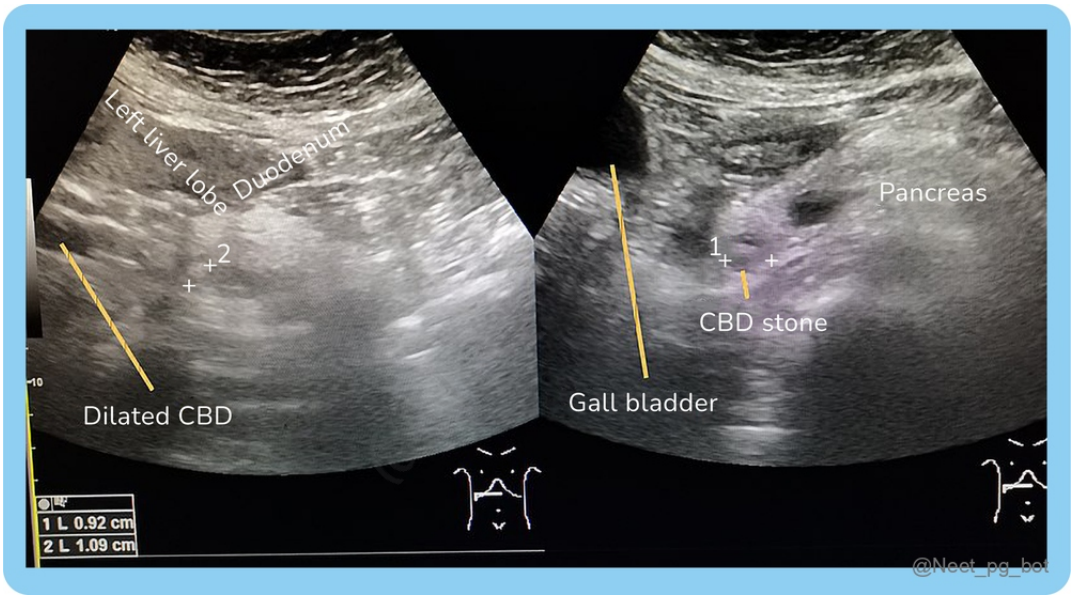
D. Chronic Pancreatitis

Correct Answer: A. Primary Choledocholithiasis

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The patient's symptoms of intermittent abdominal pain, jaundice, dark urine, light-colored stools, and recent fever suggest primary choledocholithiasis, where stones form directly in the bile ducts and cause recurrent symptoms. Primary stones form within the bile ducts due to biliary stasis, infections, or congenital conditions. Primary stones can be present in intrahepatic ducts as well as in the common bile ducts. They are often multiple and pigmented, as seen in this patient's MRCP results. Primary CBD stone Secondary CBD stone Formed inside the common bile duct The most common stone is the brown stone. More common in developing countries due to worm infestations such as Ascaris and Clonorchis sinensis. Formed in the gall bladder which slips into the common bile duct. The most common type: is cholesterol stone More common in developed countries Secondary choledocholithiasis (Option B): They cause obstruction and symptoms like biliary colic and jaundice. However, the presence of multiple pigmented stones in both the common bile duct and intrahepatic ducts suggests primary stones rather than secondary ones. Gallstone ileus (Option C): It involves a large gallstone causing mechanical intestinal obstruction, typically in the terminal ileum, following erosion into the duodenum. This condition presents with signs of intestinal obstruction, not intermittent jaundice and fever as seen in this scenario. (sab 1502) Chronic pancreatitis (Option D): It involves persistent inflammation of the pancreas, often causing continuous abdominal pain and malabsorption. This patient's symptoms do not align with chronic pancreatitis. Ultrasound showing CBD stone Symptoms Features Pain Biliary colic to non-specific abdominal pain. Biliary colic is a sudden, severe, colicky pain in the right upper quadrant that radiates to the back and shoulder. It is precipitated by a fatty or heavy meal and can last for a few hours. The pain is typically located in the epigastrum and right hypochondrium. Jaundice Jaundice, a yellowing of the skin and eyes, is the most common clinical manifestation of choledocholithiasis. It occurs due to the obstruction of bile flow, leading to the accumulation of bilirubin in the blood. The jaundice associated with choledocholithiasis is likely to be painful because the onset of obstruction is often acute. Fever The presence of fever with chills and rigors is suggestive of cholangitis, a serious complication of choledocholithiasis. Cholangitis occurs when the obstruction of the bile duct leads to bacterial infection and inflammation. Charcot’s triad : Pain + Fever + Jaundice Reynauld’s pentad : Mental status changes + Hypotension + Charcot’s triad Changes in urine and stool Obstruction of the bile duct can lead to darkening of the urine and lightening of the stools. Steatorrhea, or fatty stools, may occur due to the impaired absorption of fat and fat-soluble vitamins caused by the lack of bile in the intestines. Other symptoms Pruritus (itching), loss of appetite, weight loss, nausea, and vomiting.



References:

Bailey and Love's Short Practice of Surgery, 28th Edition, Page 1253 Sabiston Textbook of Surgery, 21st Edition, Page 1500 SRB's Manual of Surgery, 6th Edition, Page 642, 643

↑ *Back to this question in Part A*

@Neet_pg_bot

Q16: How many sphincters make up the Sphincter of Oddi Complex? (Q848889)

A. 12

B. 9

C. 6

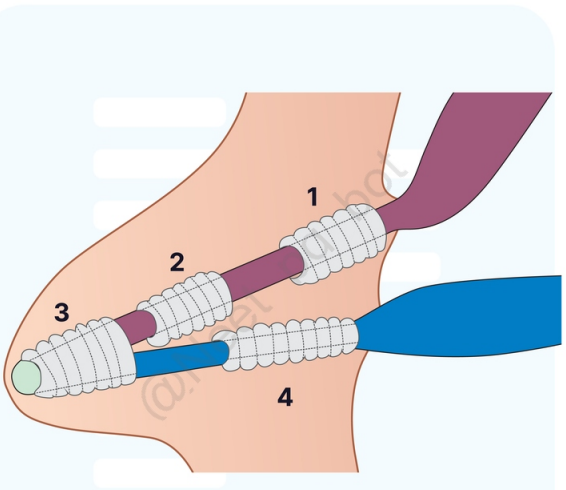
D. 4

Correct Answer: D. 4

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The Sphincter of Oddi Complex consists of four smooth muscle sphincters: Superior Choledochal Sphincter: Also known as the Sphincter of Boyden Inferior Choledochal Sphincter Sphincter Ampullae Sphincter Pancreaticus They are located within the duodenal wall These sphincters collaborate to Manage and regulate the secretion of neighbouring fluids from the bile duct and pancreatic ducts Prevent reflux from the duodenum into the biliary and pancreatic ducts.



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References:

radiopaedia.org/articles/sphincter-of-oddi

↑ *Back to this question in Part A*

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Q17: During a gallbladder surgery, the surgeon identifies the hepatic artery running medially and carefully avoids injuring a structure located laterally to it. Which of the following is the most likely structure located lateral to the hepatic artery? (Q848888)

A. Common hepatic duct

B. Portal vein

C. Cystic artery

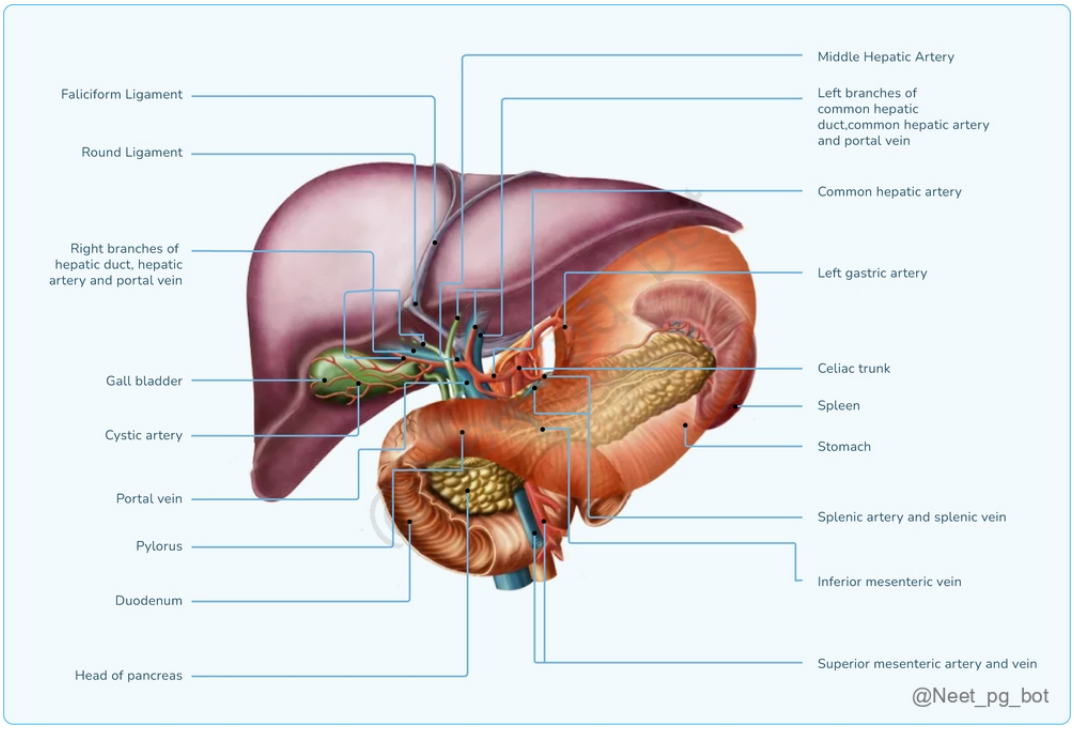
D. Common bile duct

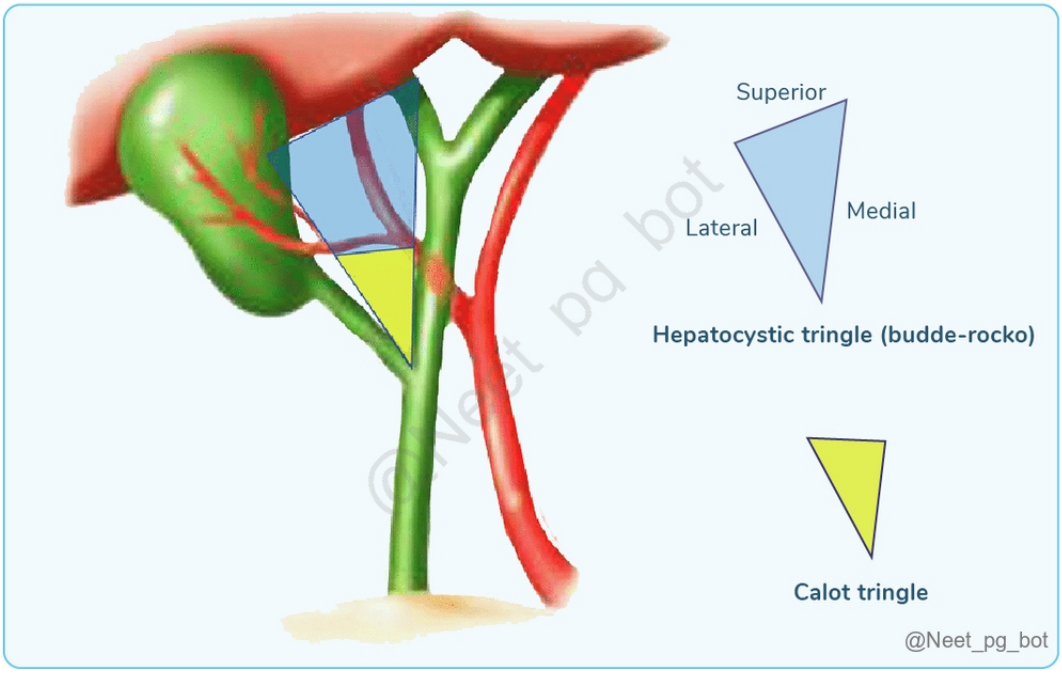
Correct Answer: D. Common bile duct

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The common bile duct runs lateral to the hepatic artery throughout its course, making it the correct answer. Hepatic Artery and Its Relations Origin : Arises from the coeliac axis. Transition : Becomes the hepatic artery proper after giving off the gastroduodenal artery. Accompanies the portal vein and bile duct, forming the portal triad. Course : Crosses posterior to the common bile duct (CBD). Lies anterior to the portal vein at the porta hepatis. Relations : The hepatic artery is always medial to the common bile duct throughout its course. Divisions : Right hepatic artery: Passes between the bile duct (laterally) and portal vein (medially); divides into anterior and posterior branches. Left hepatic artery: Curves anteriorly, and divides into segmental branches. Calot's Triangle (Hepatobiliary Triangle) Borders : Inferior : Cystic duct. Medial : Common hepatic duct. Lateral : Cystic artery. Clinical Importance : Landmark for safe identification of cystic duct and artery during gallbladder surgery. Common hepatic duct (Option A) : Medial to the hepatic artery, not lateral. Portal vein (Option B) : Lies posterior to the hepatic artery, not lateral. Cystic artery (Option C) : Forms part of Calot's triangle but is not lateral to the hepatic artery.





References:

Bailey and Love's Short Practice of Surgery, 28th Edition, Page 1232, 1233

Schwartz's Principles of Surgery, 11th Edition, Page 1348

www.sciencedirect.com/topics/medicine-and-dentistry/common-hepatic-artery#:~:text=The%20hepatic%20artery%20travels%20in,splenic%20and%20left%20gastric%20arteries.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q18: Which artery primarily supplies the common hepatic duct and the common bile duct? (Q848887)

A. Gastroduodenal artery

B. Pancreaticoduodenal artery

C. Right hepatic artery

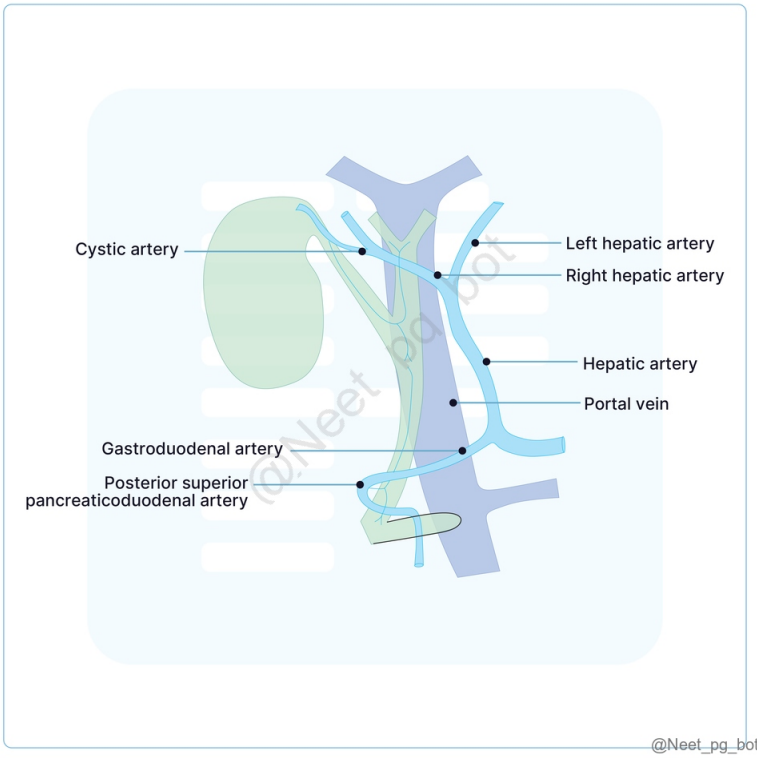
D. Left hepatic artery

Correct Answer: C. Right hepatic artery

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The common hepatic duct and CBD receive blood supply from the right hepatic and cystic arteries. Blood Supply of the Bile Ducts The biliary tree receives its blood supply entirely from arteries, unlike the hepatic parenchyma, which has dual perfusion from the portal vein. This makes the biliary tree vulnerable to ischemic injury. Cystic Artery: Typically branches from the right hepatic artery but may also originate from the left hepatic, proper hepatic, common hepatic, gastroduodenal, or superior mesenteric arteries. It can pass either posterior or anterior to the CBD. The common hepatic duct and CBD receive blood supply from the right hepatic and cystic arteries. Branches of the posterosuperior pancreaticoduodenal (Option B) and gastroduodenal arteries (Option A) supply the inferior bile duct (distal to the duodenal bulb). These smaller branches can merge into two vessels along the CBD, posing a risk of ischemic injury if damaged during surgical dissection. The left hepatic artery (Option D) primarily supplies the left lobe of the liver. It does not significantly contribute to the blood supply of the common hepatic or bile duct.



References:

Bailey and Love’s Short Practice of Surgery, 28th Edition, Page 1232, 1233

Sabiston Textbook of Surgery, 21st Edition, Page 1489, 1490

SRB’s Manual of Surgery, 6th Edition, Page 624

Bile duct anatomy

Blood supply of bile duct-1

Blood supply of bile duct- 2

↑ *Back to this question in Part A*

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Q19: A 50 year old man presents with jaundice and abdominal pain one week after a cholecystectomy. Imaging confirms a bile duct injury with a complete transection of the common bile duct. What is the recommended management for this injury at this stage? (Q843544)

A. Immediate surgical repair

B. Conservative management with antibiotics and observation

C. Delay repair for 4-6 weeks and then perform Roux-en-Y choledochojejunostomy

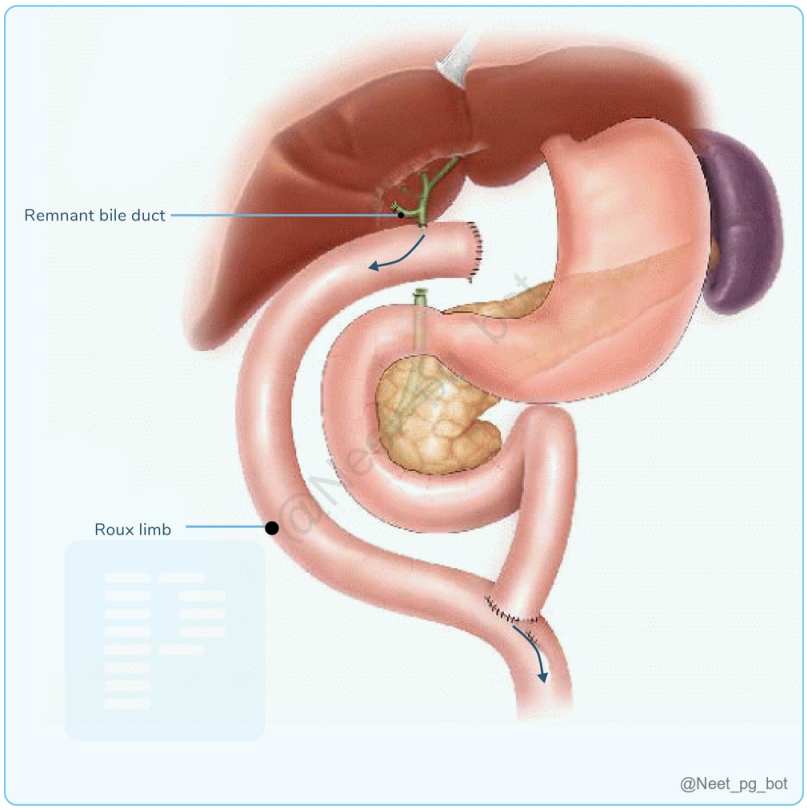
D. Endoscopic stenting and balloon dilation

Correct Answer: C. Delay repair for 4-6 weeks and then perform Roux-en-Y choledochojejunostomy

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Delaying the repair for 4-6 weeks allows for the inflammation to subside, which facilitates easier identification and dissection of the bile ducts during surgery. A Roux-en-Y choledochojejunostomy is a common and effective reconstructive technique used to restore bile flow by connecting the common bile duct to a loop of the jejunum. Immediate surgical repair (Option A) is preferred if the bile duct injury is identified intraoperatively. Postoperative repair is avoided due to inflammation and edema, which increase complication risks. Conservative management with antibiotics and observation (Option B) insufficient for complete bile duct transection; surgical intervention is necessary to restore biliary continuity Endoscopic stenting and balloon dilation (Option D) are suitable for bile leaks and strictures but are ineffective for complete bile duct transections, which require surgical reconstruction.



References:

Bailey and Love's Short Practice of Surgery, 28th Edition, Page 1252

SRB's Manual of Surgery, 6th Edition, Page 658

↑ *Back to this question in Part A*

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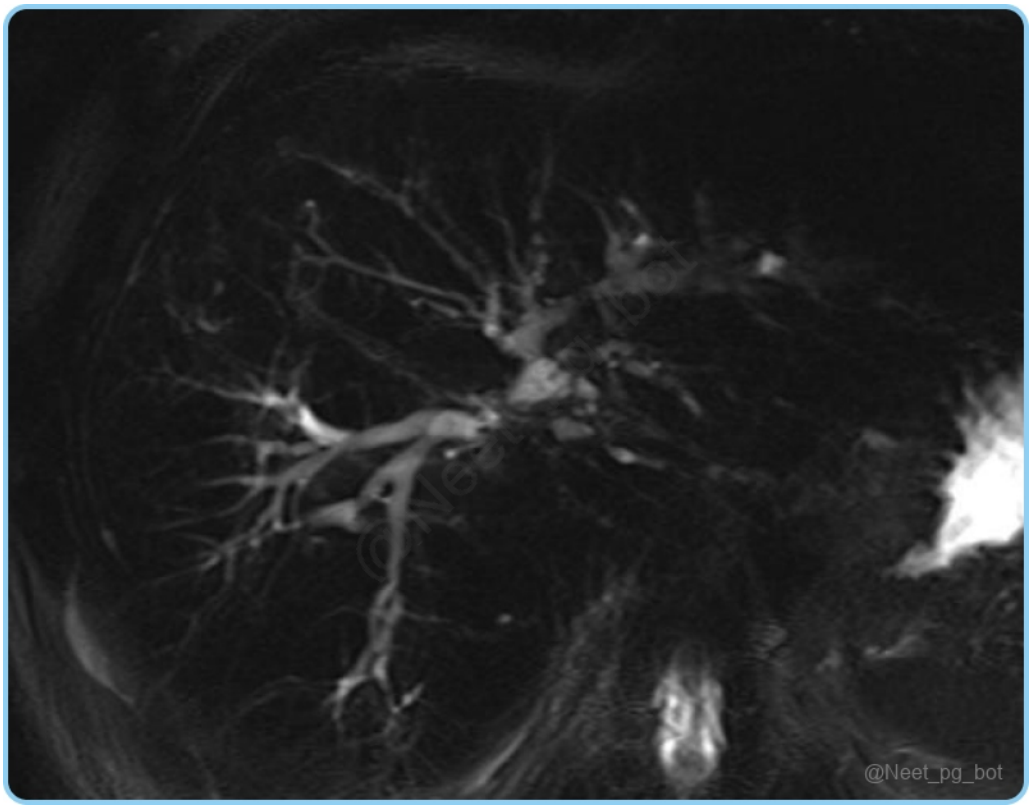
Q20: A 40 year old male with a history of ulcerative colitis presents with fatigue, pruritus, jaundice, elevated ALP, and GGTP. The MRCP and Liver biopsy show the following findings. Despite endoscopic stenting, his symptoms persist, and liver function continues to decline. What is the most definitive treatment option for this patient? (Q843541)

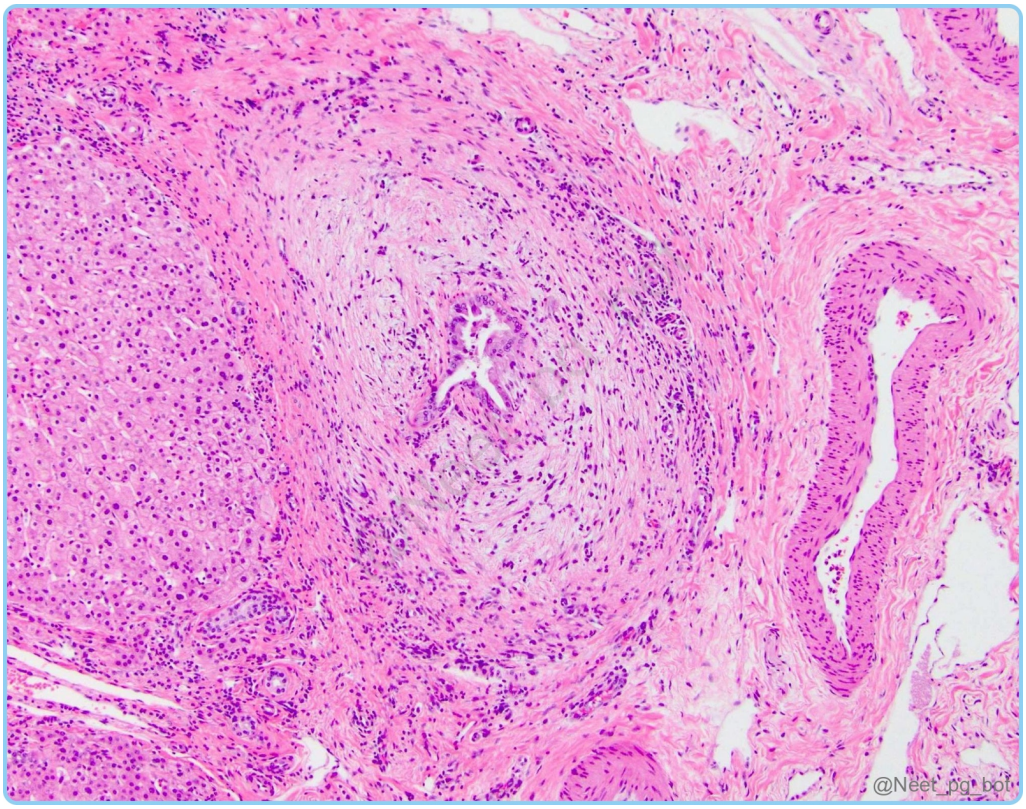
A. Antibiotics and cholestyramine

B. Endoscopic retrograde cholangiopancreatography

C. Liver transplantation

D. Operative resection



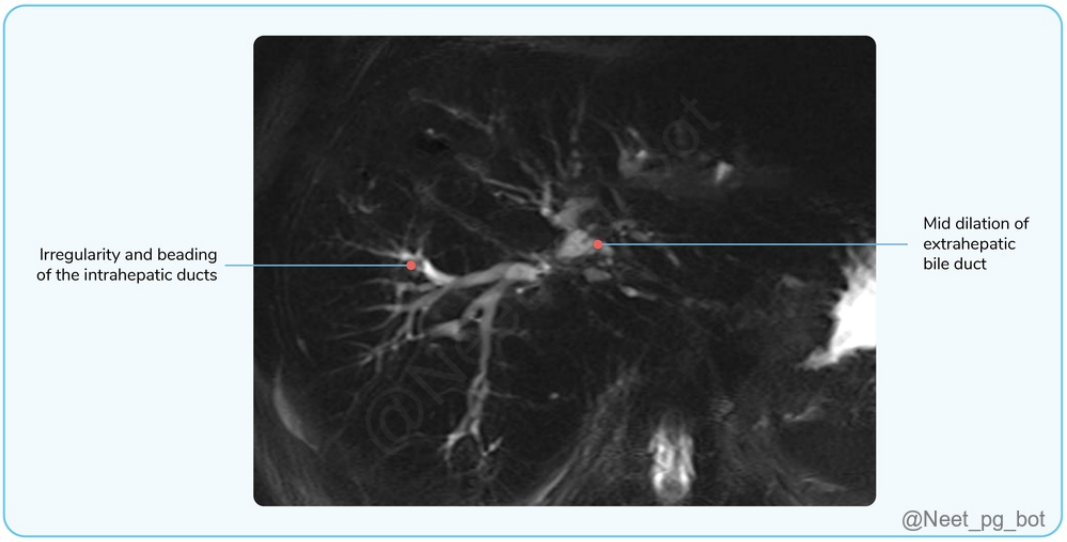


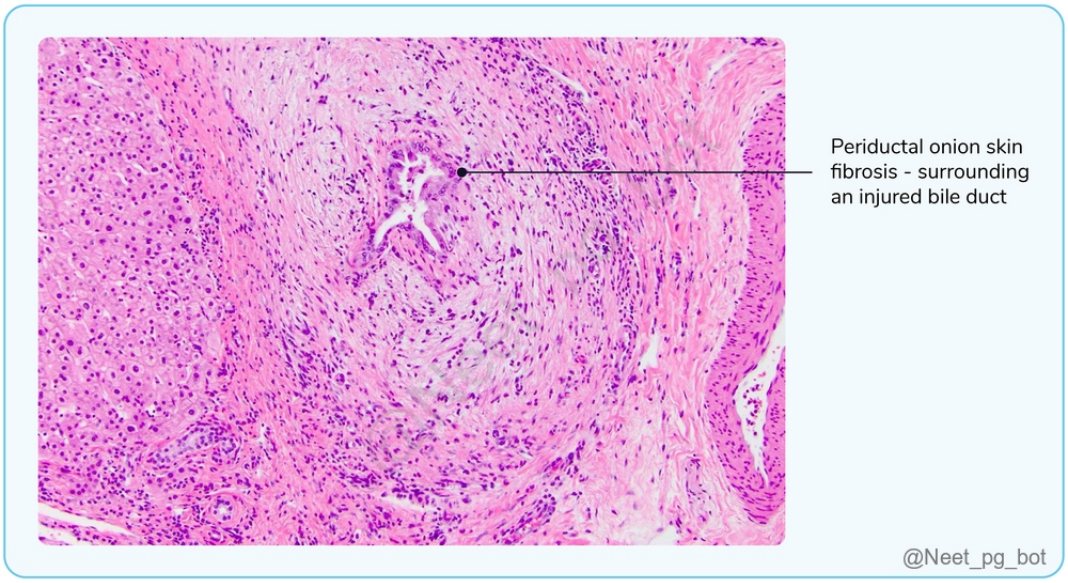
Correct Answer: C. Liver transplantation

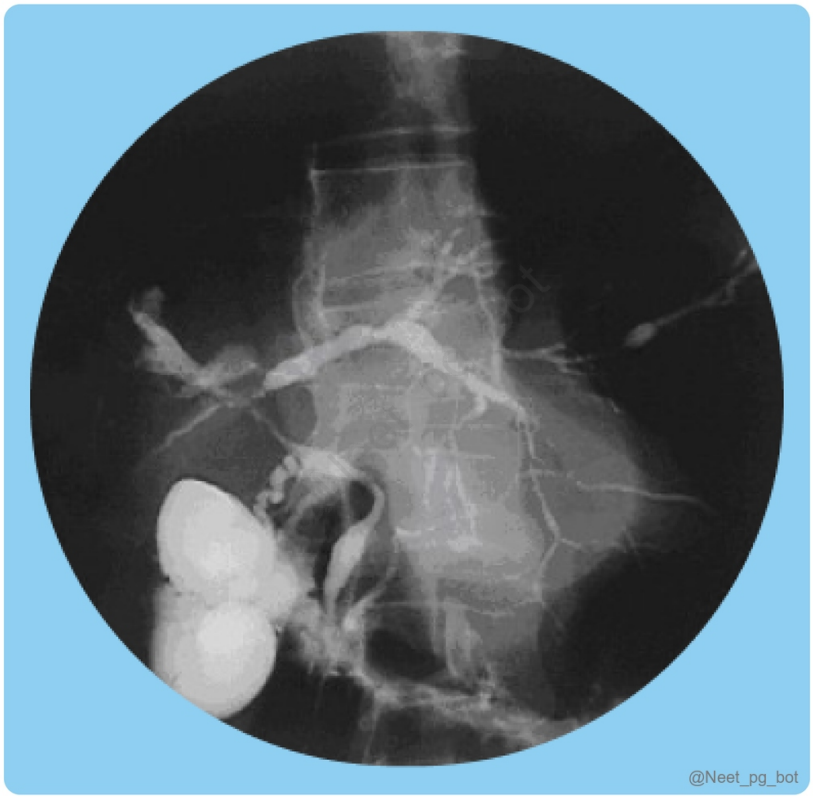
■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The given scenario points towards Primary Sclerosing Cholangitis (PSC) . MRCP shows multifocal diffuse dilation and stricturing of the intrahepatic and extrahepatic biliary trees. Liver biopsy reveals concentric periductal onion skin fibrosis. MRCP Histology Liver transplantation is the most definitive treatment for PSC patients who progress to cirrhosis and liver failure. It offers the best long-term outcomes, with a 5-year survival rate above 80%. Investigations: 1. ERCP: Shows multifocal diffuse dilation and stricturing of the intrahepatic and/or extrahepatic biliary trees. This pattern is called “beading” or “chain of lakes” and is characteristic of PSC. Can be used therapeutically to treat major strictures. Cholangiogram of Primary Sclerosing Cholangitis 2. MRCP: Helps in the diagnosis and surveillance of PSC patients 3. LFT: Showing elevated ALP and GGTP levels. 4. Liver biopsy: showing concentric periductal “onion skinning” due to fibrosis. Treatment: Treatment of choice: Liver transplantation. To control inflammation: UDCA (ursodeoxycholic acid) and antibiotics For pruritis: Cholestyramine Antibiotics and cholestyramine (Option A): Antibiotics can help manage superimposed infections, and cholestyramine can relieve pruritus associated with cholestasis. However, these treatments do not stop the progression of primary sclerosing cholangitis (PSC) or address liver failure. Endoscopic retrograde cholangiopancreatography (ERCP) (Option B): ERCP is useful for treating strictures and alleviating bile duct obstructions. However, it is not a definitive treatment for PSC and does not prevent the progression of liver failure. Operative resection (Option D): Operative resection may be considered for selected patients with predominantly extrahepatic disease, but it is not the standard treatment for advanced PSC with cirrhosis and declining liver function. Liver transplantation remains the definitive treatment in such cases.







References:

Bailey and Love’s Short Practice of Surgery, 28th Edition, Page 1255

Sabiston Textbook of Surgery, 21st Edition, Page 1503, 1504

SRB’s Manual of Surgery, 6th Edition, Page 650

↑ *Back to this question in Part A*

Q21: A 45 year old male with a history of ulcerative colitis presents with jaundice, right upper quadrant pain, and intermittent fever. Laboratory tests reveal elevated serum ALP and gamma-glutamyl transpeptidase (GGTP). MRCP shows stricturing and beading of the bile ducts. What is the most likely diagnosis? (Q843540)

A. Primary sclerosing cholangitis

B. Acute cholangitis

C. Choledocholithiasis

D. Hepatocellular carcinoma

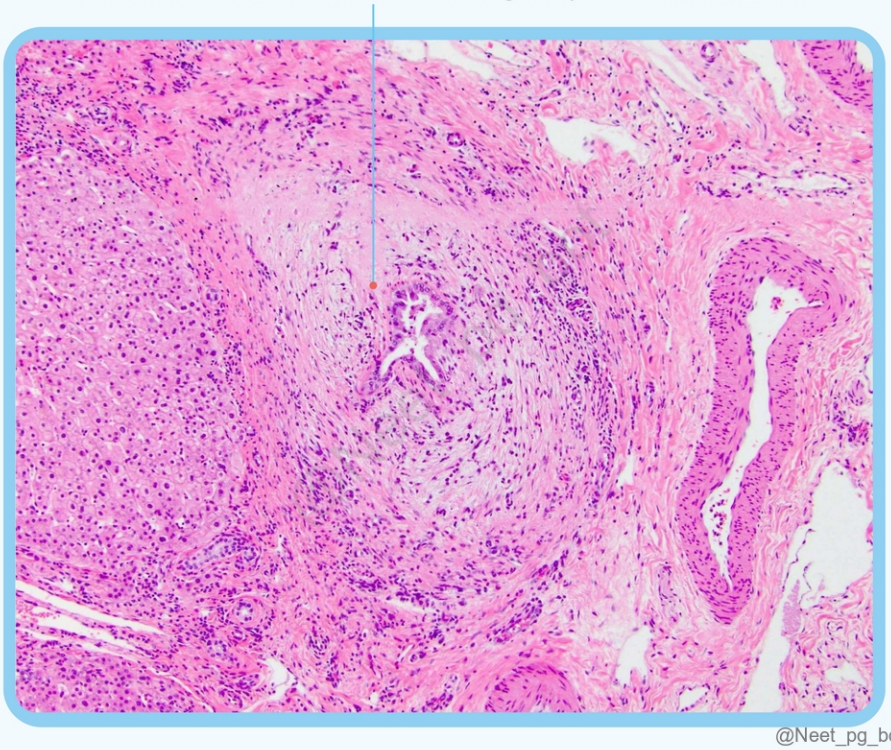
Correct Answer: A. Primary sclerosing cholangitis

■ *Listen (English)*

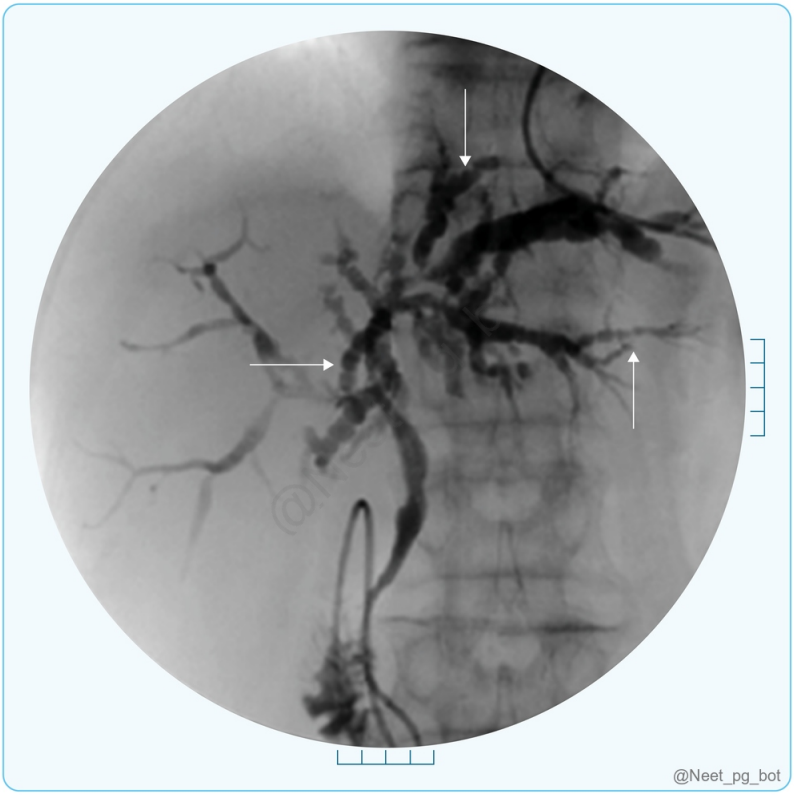
■ *Listen (Hindi)*

Explanation: The clinical presentation of jaundice, right upper quadrant pain, and intermittent fever, along with elevated serum ALP and GGTP, and,MRCP findings of bile duct stricture and beading, are highly suggestive of Primary sclerosing cholangitis (PSC). PSC is a chronic liver disease characterized by inflammation and scarring of the bile ducts, often associated with inflammatory bowel disease (IBD), especially ulcerative colitis. Primary Sclerosing Cholangitis Etiology: unknown Risk factors : Diseases: Ulcerative colitis, Crohn's disease, Sjogren’s syndrome, Graves disease Gender: Male predominance Age: 30-60 years of age Pathophysiology : It causes diffuse inflammation, sclerosis, and obliteration of the intra- and extrahepatic biliary systems Resulting in multiple areas of stricture and dilatations of the bile duct (beaded appearance) These bile ducts, on the cut section, give an onion skin appearance due to fibrosis. The selective destruction of terminal intra-hepatic ducts gives a Pruned tree appearance. A) Beaded appearance B) Pruned tree appearance C) Band-like strictures Acute cholangitis (Option B) : While the symptoms can be similar, acute cholangitis is an acute condition and does not show the characteristic beading and stricturing of the bile ducts seen in PSC. Choledocholithiasis (Option C) : In choledocholithiasis, imaging usually reveals stones or a dilated bile duct rather than the beading and stricturing characteristic of PSC. Hepatocellular carcinoma (HCC) (Option D) typically presents with weight loss, abdominal pain, jaundice, a liver mass on imaging, elevated alpha-fetoprotein (AFP) levels, and is not associated with bile duct stricturing or beading.

Periductal “onion skin” fibrosis surrounding an injured but intact bile duct

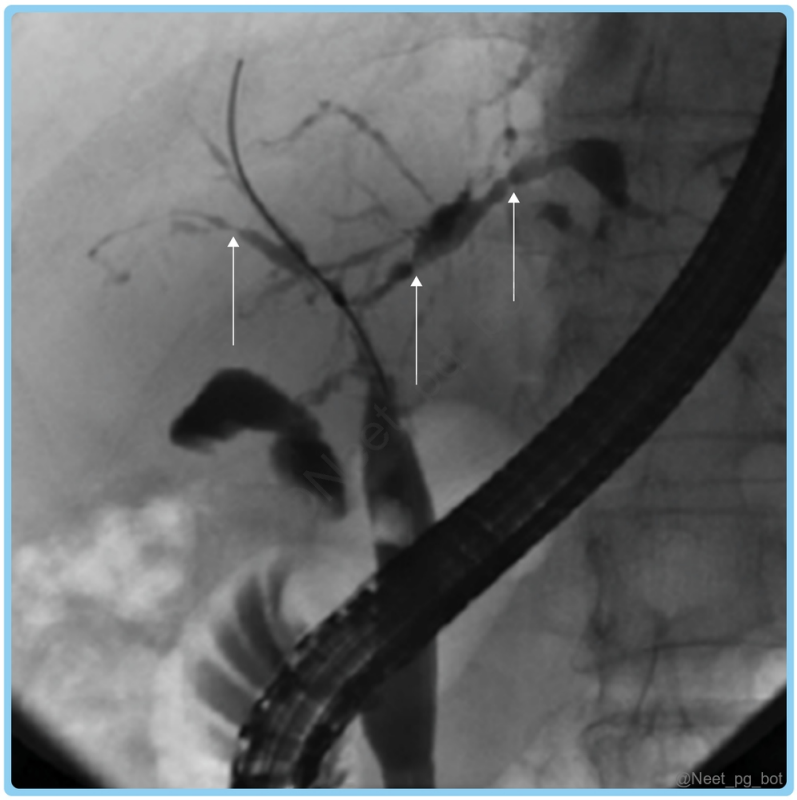


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References:

Bailey and Love's Short Practice of Surgery, 28th Edition, Page 1254

Sabiston Textbook of Surgery, 21st Edition, Page 1503

SRB’s Manual of Surgery, 6th Edition, Page 650

Pruned Tree Appearance

Onion skin appearance

↑ *Back to this question in Part A*

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Q22: A 70 year old female presents with signs of severe cholangitis. Despite initial treatment with broad-spectrum antibiotics and an unsuccessful ERCP attempt, her condition continues to worsen. An ultrasound shows multiple stones and a severely dilated common bile duct. What is the next best step in management? (Q843495)

A. Repeat ERCP

B. Percutaneous transhepatic cholangiography (PTC)

C. Open biliary decompression

D. Continued observation and supportive care

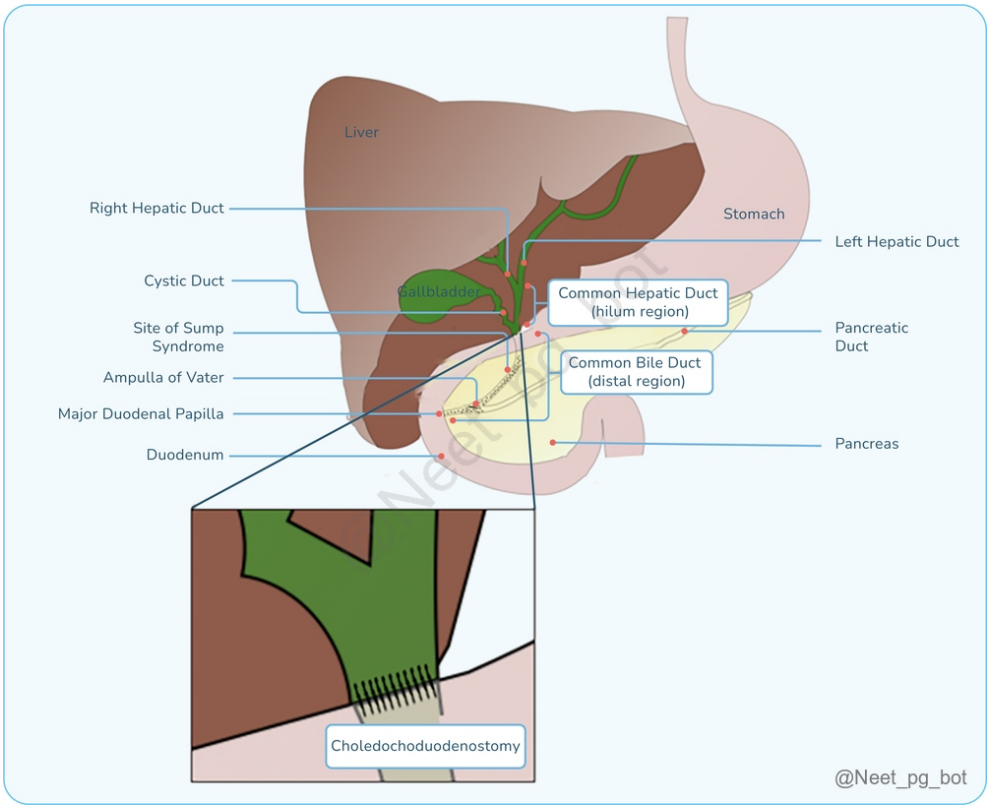
Correct Answer: C. Open biliary decompression

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Open biliary decompression is the correct answer. Given the patient’s deteriorating condition, complex biliary anatomy, and failure of ERCP, open biliary decompression is necessary. This procedure directly addresses the severe obstruction and infection, providing a more definitive solution. Management of cholangitis: Antibiotic Therapy: Broad-spectrum IV antibiotics targeting common pathogens like E. coli, Klebsiella, and Enterobacter. Biliary Drainage: Essential to relieve obstruction. Methods include ERCP, PTC, or open surgical intervention. Surgical Intervention: Needed in severe cases, complex strictures, or failure of less invasive methods. Techniques include: Choledochotomy: Incision in the common bile duct to remove the blockage, often with T-tube placement. Choledochoduodenostomy: Connecting the common bile duct to the duodenum to bypass the obstruction. Choledochojejunostomy: Connecting the common bile duct to the jejunum, often using a Roux-en-Y configuration to prevent bile reflux. Supportive Care: IV fluids, pain management, blood pressure support, and monitoring of vital signs and organ function. Repeat ERCP (Option A): Repeating ERCP may be considered in some cases. However, given the severity of the patient’s condition and the previous failure, it is unlikely to be effective. Persistent symptoms and hypotension indicate a need for a more definitive intervention. Percutaneous transhepatic cholangiography (PTC) (Option B): PTC is another less invasive option that involves accessing the biliary system through the liver. While it can be useful in some cases, it may not be sufficient for a severely ill patient with complex stones and failed initial endoscopic treatment. Continued observation and supportive care

(Option D): This option is incorrect as it fails to address the worsening biliary obstruction and severe infection. Delaying intervention can lead to life-threatening complications like sepsis and multi-organ failure.



References:

Bailey and Love's Short Practice of Surgery, 28th Edition, Page 1237, 1238 Sabiston Textbook of Surgery, 21st Edition, Page 1515 SRB's Manual of Surgery, 6th Edition, Page 643

↑ *Back to this question in Part A*

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Q23: A 62 year old male presents with jaundice and severe abdominal pain in the right upper quadrant that started abruptly after a heavy meal. He also reports dark urine, pale stools, and intermittent fever with chills. An ultrasound shows a dilated common bile duct. ERCP is planned for stone removal. What is the maximum size of the stone that can typically be removed by ERCP without additional procedures? (Q843491)

A. 17 mm

B. 15 mm

C. 20 mm

D. 25 mm

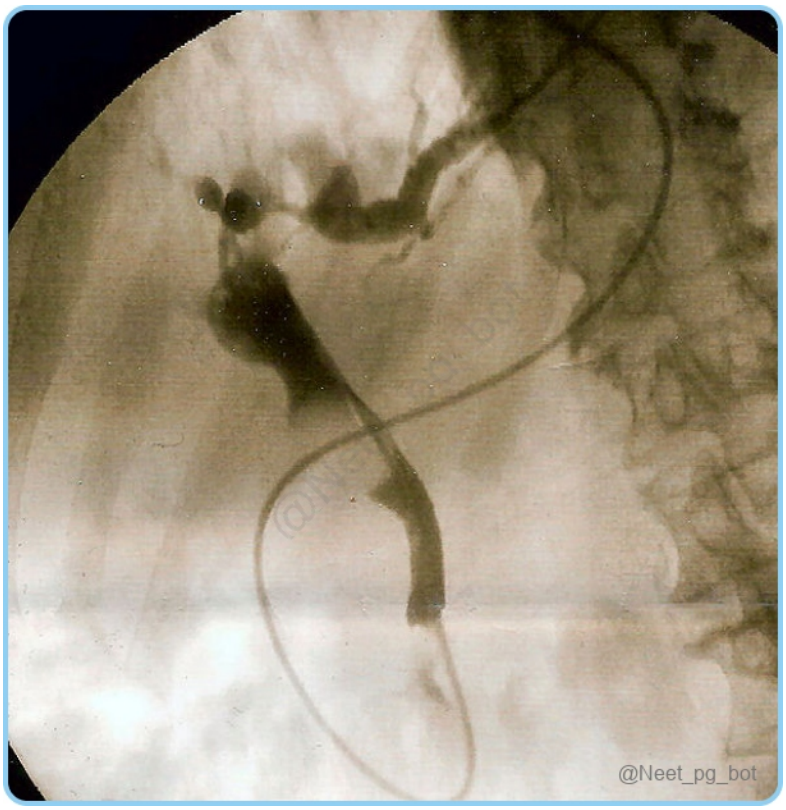
Correct Answer: B. 15 mm

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Stones up to 15 mm can usually be removed by Endoscopic Retrograde Cholangiopancreatography - ERCP without requiring additional procedures. Options A, C and D are incorrect as stones of these sizes typically require additional procedures like mechanical lithotripsy or balloon sphincteroplasty. MRCP of CBD stone ERCP of a distal CBD stone





References:

Successful Removal of Giant CBD Stone by ERCP: A Rare Case: 1353 Bailey and Love's Short Practice of Surgery, 28th Edition, Page 1236-1238, 1254 Sabiston Textbook of Surgery, 21st Edition, Page 1501, 1502 SRB's Manual of Surgery, 6th Edition, Page 643-645

↑ *Back to this question in Part A*

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• [04_Hepatobiliary Pancreatic Surgery] 017 Pancreatic Tumors - I

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[04_Hepatobiliary Pancreatic Surgery] 017 Pancreatic Tumors - I — Quick Jump

Q1 (p. 1698)	*Q2 (p. 1699)*	*Q3 (p. 1700)*	*Q4 (p. 1701)*	*Q5 (p. 1702)*	*Q6 (p. 1703)*
Q7 (p. 1704)	*Q8 (p. 1705)*	*Q9 (p. 1706)*	*Q10 (p. 1707)*	*Q11 (p. 1708)*	*Q12 (p. 1709)*
Q13 (p. 1710)	*Q14 (p. 1711)*	*Q15 (p. 1712)*	*Q16 (p. 1713)*	*Q17 (p. 1714)*	*Q18 (p. 1715)*
Q19 (p. 1715)	*Q20 (p. 1718)*	*Q21 (p. 1721)*	*Q22 (p. 1722)*	*Q23 (p. 1722)*	

Q1: Which type of pancreatic neoplasm most commonly arises in the tail of the pancreas? (Q848982)

A. Serous cystadenoma.

B. Mucinous cystadenoma

C. VIPOMA

D. Adenocarcinoma pancreas

Correct Answer: C. VIPOMA

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Common site for vasoactive intestinal peptide tumor (VIPOMA) is the tail of the pancreas. Location Tumors Head Adenocarcinoma pancreas (Option D) Serous cystadenoma (Option A) Intraductal Papillary Mucinous neoplasm Somatostatinoma PPOMA (Pancreatic Polypeptide cell tumor) Body and tail Glucagonoma Mucinous cystadenoma (Option B) Tail VIPOMA (Vasoactive intestinal peptide tumor) Equal distribution in body, head and tail. Insulinoma

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1281

Sabiston Textbook of Surgery, 21st Edition, Page 1547

SRB’s Manual of Surgery, 6th Edition, Page 702-704

https://www.ncbi.nlm.nih.gov/books/NBK551613/

↑ *Back to this question in Part A*

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Q2: A 60-year-old male presents with recurrent episodes of abdominal pain and is found to have jaundice. An ERCP is performed, revealing thick mucus extruding through the ampulla of Vater. Which of the following is the most likely diagnosis? (Q848974)

A. Pseudocyst

B. Main duct IPMN

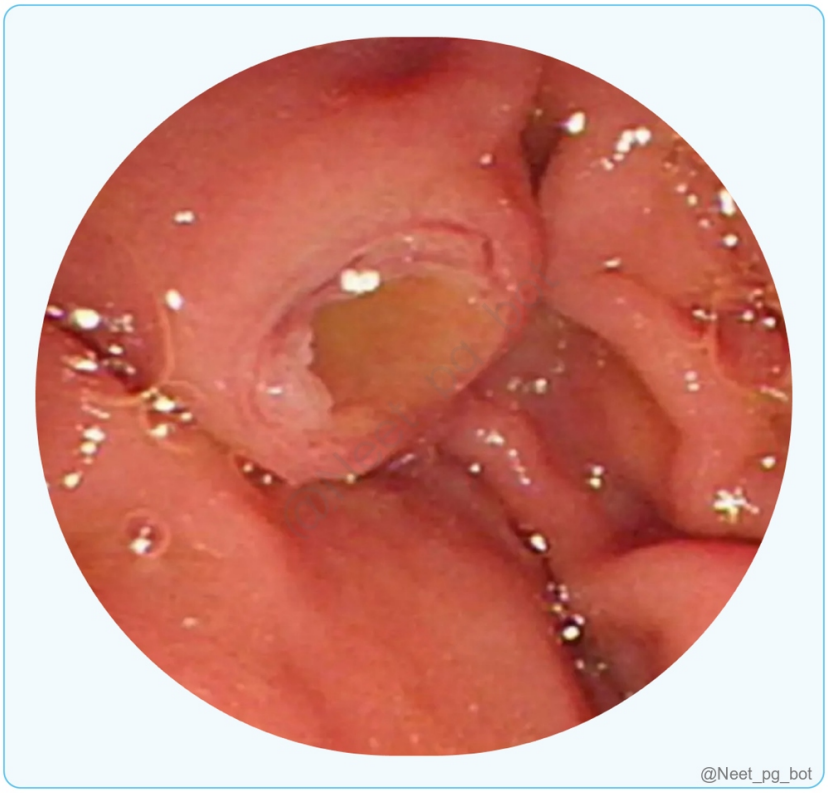
C. Chronic pancreatitis

D. Pancreatic adenocarcinoma

Correct Answer: B. Main duct IPMN

- *Listen (English)*
- *Listen (Hindi)*

Explanation: The presence of thick mucus extruding through the ampulla of Vater during an ERCP is diagnostic of a main duct IPMN, a mucinous tumor that produces large amounts of mucus. Diagnostic significance of thick mucus during ERCP Finding: Thick mucus extruding through the ampulla of Vater during ERCP Diagnostic of: Main duct IPMN (intraductal papillary mucinous neoplasm) Pseudocyst (Option A): While pseudocysts can be associated with mucus, they do not typically cause mucus extrusion through the ampulla of Vater during ERCP. Chronic pancreatitis (Option C): It is characterized by inflammation and fibrosis, not mucus production. Pancreatic adenocarcinoma (Option D): These are solid, scirrhous tumors, characterized by neoplastic tubular glands, which do not produce thick mucus that extrudes through the ampulla of Vater during an ERCP.



References:

Bailey &Love's Short Practice of Surgery, 28th Edition, Page 1265,1281

https://www.ncbi.nlm.nih.gov/books/NBK507779/

↑ *Back to this question in Part A*

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Q3: What is the most common complication and common cause of death in a patient post pancreaticoduodenectomy? (Q848927)

A. Delayed gastric emptying, Pulmonary complication

B. Anastomosis leak, Pulmonary complication

C. Delayed gastric emptying, Perforated bowel obstruction

D. Anastomosis leak, Perforated bowel obstruction

Correct Answer: A. Delayed gastric emptying, Pulmonary complication

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The most common complication of pancreatoduodenectomy is delayed gastric emptying, while the most common cause of death is pulmonary complications. Pancreatoduodenectomy: Also known as Whipple's procedure, involves the excision of the pancreatic head, duodenum, distal stomach, gallbladder, and distal bile duct. The most common complication of pancreatoduodenectomy is delayed gastric emptying. The most common cause of death is pulmonary complications. Anastomosis leak is another common complication of pancreatoduodenectomy and can result in the formation of pancreatic fistula severely affecting the mortality and morbidity of the patient Complication Frequency (%) Delayed gastric emptying (Option A) 18 Pancreas fistula 12 Wound infection 7 Intraabdominal abscess 6 Cardiac events 3 Bile leak 2 Overall reoperation 3

References:

Sabiston Textbook of Surgery, 21st Edition, Page 1558 https://www.nature.com/articles/s41598-022-26814-7 Postoperative morbidity following Whipple's procedure

↑ *Back to this question in Part A*

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Q4: A 48-year-old perimenopausal woman presents with abdominal discomfort. Imaging reveals a multilocular cyst with thick walls located in the pancreatic tail. Fine-needle aspiration of the cyst fluid shows high carcinoembryonic antigen levels exceeding 400 ng/mL, with normal amylase levels. What is the most likely diagnosis? (Q848965)

A. Pancreatic pseudocyst

B. Serous cystadenoma

C. Mucinous cystic neoplasm

D. Adenoma of the Ampulla of Vater

Correct Answer: C. Mucinous cystic neoplasm

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Cyst characteristics (multilocular cyst with thick walls in the pancreatic tail), and high CEA levels strongly point towards the diagnosis of MCN. It is commonly seen in perimenopausal women. Mucinous cystic neoplasms (MCNs) and adenomas represent distinct types of cystic pancreatic tumors with varying malignant potential. Factor MCNs Adenomas (Option D) Pseudocysts (Option A) Serous cystadenoma (Option B) Demographics Perimenopausal women Varied History of pancreatitis Older woman Location Pancreatic body or tail Ampulla of Vater Anywhere in the pancreas Tail of pancreas Characteristics Multilocular cysts, thick walls Polypoid submucosal masses Cysts with elevated amylase Lobular, hypodense lesion with multiple small cysts

Key Diagnostic Tool CEA levels (>400 ng/mL) Endoscopy History, imaging, amylase levels CECT: Central stellate scar, central sunburst calcification

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1276, 1281, 1282

↑ *Back to this question in Part A*

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Q5: A 45-year-old male has a history of recurrent peptic ulcers and severe abdominal pain. Despite the use of proton pump inhibitors, his symptoms persist. Endoscopic examination reveals small nodules in the medial wall of the duodenum. His family history is significant for multiple endocrine neoplasia type I. Which of the following statements is most likely true regarding his condition? (Q848952)

A. The tumors are most commonly found in the tail of the pancreas.

B. The condition is curable with surgical removal of the primary tumor.

C. The patient's gastrinoma is likely located within the gastrinoma triangle.

D. The use of proton pump inhibitors has made diagnosis of this condition easier

Correct Answer: C. The patient's gastrinoma is likely located within the gastrinoma triangle.

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Recurrent peptic ulcers, nodules in the duodenal wall, and MEN 1 family history point to a diagnosis of Zollinger- Ellison syndrome, in which gastrinomas are predominant. Gastrinomas are often located within the gastrinoma triangle, defined by cystic duct/common bile duct, duodenum, and pancreas. Zollinger-Ellison syndrome: Aspect Details Tumor Location Duodenal loop (Option A) , Pancreas (head) Causes Persistent peptic ulceration Historical Recognition Severe peptic ulcers unresponsive to surgery pre-PPI era. The use of proton pump inhibitors (Option D) has made the condition controllable but harder to recognize. Types Sporadic, MEN type I (with parathyroid adenoma) Common Locations Gastrinoma Triangle (Option C) (cystic duct/common bile duct, duodenum, pancreas) 90% located in Gastrinoma triangle/ Passaro's triangle Detection Small nodules in duodenal wall, endoscopic and surgical inspection needed Course Indolent for some malignant gastrinomas Treatment Palliative liver resection, liver transplantation, surgical removal for palliation in MEN type I as they are incurable. (Option B) Prognosis Worse for tumors outside gastrinoma triangle

References:

Bailey and Love Short Practice of Surgery, 28th Edition, Page 1179, 1180

↑ *Back to this question in Part A*

Q6: A 70-year-old female patient is evaluated for a pancreatic cystic mass. The CT scan shows a lobular, hypodense lesion with multiple small cysts, a central hyperdense scar, and scattered "sunburst" calcifications. Based on these findings, what is the most likely diagnosis? (Q848962)

A. Mucinous cystic neoplasm

B. Pancreatic pseudocyst

C. Serous cystadenoma

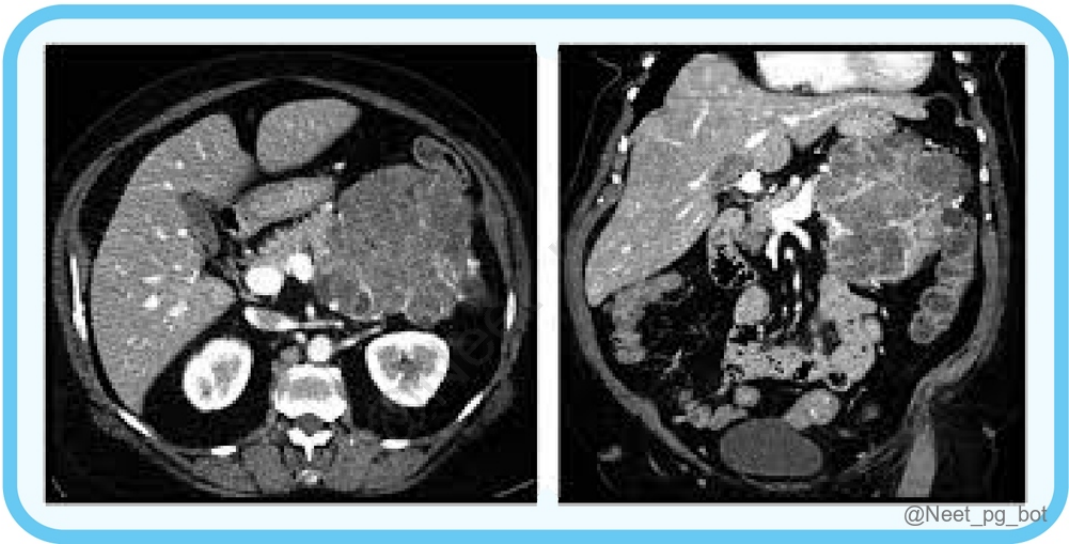
D. Intraductal papillary mucinous neoplasm

Correct Answer: C. Serous cystadenoma

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The CT features described, lobular hypodense lesion with a central hyperdense scar and "sunburst" calcifications , are characteristic of a serous cystadenoma. Serous Cystic Neoplasms (SCNs): Characteristics : Benign tumors with multiple small cysts resembling bubble wrap. Commonly found in older women. Management : Surgery : Consider if a solid mass is present or if surgical intervention is indicated. Monitoring : For patients unfit for surgery or without surgical indications, use clinical evaluations, serum CA 19-9 tests, MRCP, and EUS. CT Findings of Serous Cystadenomas: Feature Description Shape and Density Lobular shape; hypodense due to high water content. Calcifications Present in up to 30%; can show a " sunburst " pattern. Central Fibrous Scar Hyperdense, stellate pattern, enhances with contrast. Enhancement Patterns Hypervascular; fibrous portions enhance post-contrast fluid density in less fibrous areas. Oligocystic and Macrocystic Variants Oligocystic patterns may mimic mucinous neoplasms; macrocystic variants may resemble pseudocysts or mucinous cysts. Differentiation Challenging to distinguish from other cystic pancreatic neoplasms; an MRI may be needed. Mucinous cystic neoplasms (Option A): MCNs are seen in perimenopausal women, as multilocular thick-walled cysts in the pancreatic body or tail, and histologically, contain an ovarian-type stroma. They can turn malignant. Pancreatic pseudocysts (Option B): Usually lack central scarring and specific calcification. Intraductal papillary mucinous neoplasm (IPMN) (Option D): IPMNs are more common in older men and mostly involve the pancreatic head. Thick mucus is seen extruding from the ampulla on ERCP, which is diagnostic of IPMN. It has a greater tendency to prove malignant.



References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1281, 1282

https://www.ncbi.nlm.nih.gov/books/NBK557432/

↑ *Back to this question in Part A*

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Q7: What is the most common site of gastrinoma in patients with Zollinger–Ellison syndrome (Q848953)

A. Stomach

B. Pancreas

C. Duodenum

D. Liver

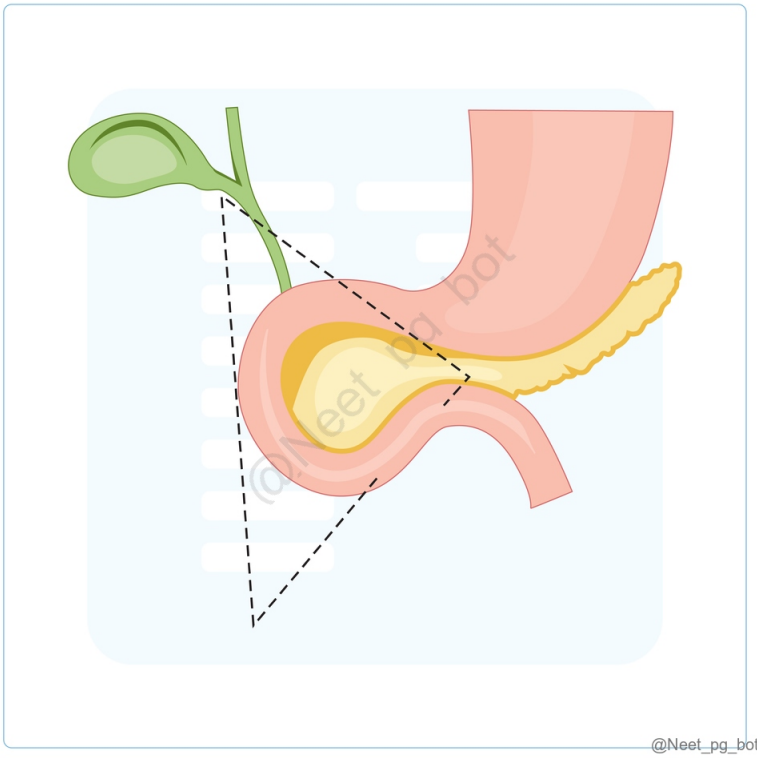
Correct Answer: C. Duodenum

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Majority of gastrinomas are located in the duodenum in both sporadic cases (50% to 88% of cases) and those associated with MEN 1 (70% to 100% of cases). Gastrinoma Pathology Sporadic Disease: Tumors mainly in duodenum (50% to 88%) Small (<5 mm) and multiple MEN 1: Tumors in the duodenum 90% occur within the 'gastrinoma triangle': Bounded by the pancreas neck/body junction, second/third parts of the duodenum, and cystic/common bile ducts junction. Gastrinoma Overview: Category Details Definition

Fulminating ulcer diathesis, recurrent ulceration, non-β islet cell tumors (gastrinoma) Incidence 0.5-4 per million, 0.1% of duodenal ulcers, 20-25% associated with MEN Rarely occur in the stomach, peripancreatic lymph nodes, liver, bile duct, ovary, and heart Pancreatic gastrinoma comprises 25% of the cases Pathology Sporadic (duodenum, small, multiple), MEN 1 (duodenum, gastrinoma triangle) Clinical Peptic ulcers, diarrhea, abdominal pain, high alcohol use history Diagnosis Elevated FSG (fasting serum gastrin), gastric pH <2, secretin provocation test, MEN 1 screening, localization studies Treatment Surgery (sporadic without metastases, MEN 1 >2 cm) Medical (PPI, SSA, locoregional therapy)



References:

Bailey and Love Short Practice of Surgery, 28th Edition, Page 907
https://www.ncbi.nlm.nih.gov/books/NBK441842/

↑ *Back to this question in Part A*

@Neet_pg_bot

Q8: Among the following, which option correctly describes the most common location of origin of insulinoma in the pancreas? (Q848984)

A. Head > Body > Tail

B. Body = Tail > Head

C. Tail > Body > Head

D. Head = Body = Tail

Correct Answer: D. Head = Body = Tail

■ *Listen to Audio 1*

Explanation: Common sites for origin of insulinoma in pancreas are the head, body and tail of the pancreas equally. Location Tumors Head Carcinoma pancreas Serous cystadenoma Intraductal Papillary Mucinous neoplasm Somatostatinoma PPOMA (Pancreatic Polypeptide cell tumor) Body and tail Glucagonoma Mucinous cystadenoma Tail VIPOMA (Vasoactive Intestinal Peptide tumor) Equal distribution in body, head and tail. Insulinoma

References:

Bailey & Love's Short Practice of Surgery, 28th Edition,Page 1281

Sabiston Textbook of Surgery, 21st Edition, Page 1547

SRB’s Manual of Surgery, 6th Edition, Page 702-704

https://www.ncbi.nlm.nih.gov/books/NBK551613/

↑ *Back to this question in Part A*

@Neet_pg_bot

Q9: Which type of pancreatic neoplasm most commonly arises in the body and tail of the pancreas? (Q848978)

A. Serous cystadenom

B. Mucinous cystadenoma

C. Intraductal papillary mucinous neoplasm

D. Adenocarcinoma pancreas

Correct Answer: B. Mucinous cystadenoma

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The body and tail of the pancreas are the most common site for mucinous cystadenoma. Table shows the common location of the tumors of the pancreas: Location Tumors Head Adenocarcinoma pancreas (Option D) Serous cystadenoma (Option A) Intraductal Papillary Mucinous neoplasm (Option C) Somatostatinoma PPOMA (Pancreatic Polypeptide cell tumor) Body and tail Glucagonoma Mucinous cystadenoma Tail VIPOMA (Vasoactive intestinal peptide tumor) Equal distribution in body, head and tail. Insulinoma

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1281

Sabiston Textbook of Surgery, 21st Edition, Page 1547

SRB'sManual of Surgery, 6th Edition, Page 702-704

https://www.ncbi.nlm.nih.gov/books/NBK551613/

↑ *Back to this question in Part A*

@Neet_pg_bot

Q10: A 55-year-old male presents with jaundice, weight loss, and epigastric pain. Imaging reveals a mass in the head of the pancreas. Which of the following conditions is most likely responsible for these symptoms? (Q848976)

A. Chronic Pancreatitis

B. Ductal Adenocarcinoma

C. Solid Pseudopapillary Neoplasm

D. Intraductal Papillary Mucinous Neoplasm

Correct Answer: B. Ductal Adenocarcinoma

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Ductal Adenocarcinoma is the most common malignancy of the pancreas, most commonly occurring in the head region. It typically presents with symptoms like jaundice (due to bile duct obstruction), weight loss, and epigastric pain. Imaging often reveals a mass in the head of the pancreas, making it the most likely diagnosis in this clinical scenario. Common Conditions in the Head of the Pancreas: Ductal Adenocarcinomas Most prevalent condition in the head of the pancreas. Can occur throughout the pancreas but predominantly originates in the head. Other Conditions Commonly Found in the Head of the Pancreas: Chronic Pancreatitis (Option A) Affects the entire pancreas, but pain is often concentrated in the head if it is the primary disease site. Intraductal Papillary Mucinous Neoplasms (IPMNs) (Option D) Frequently found in the head of the pancreas. Characterized by mucus production, observable during ERCP. Solid Pseudopapillary Neoplasms (Option C) Rare malignant lesions, more common in the head of the pancreas. More commonly seen in women of childbearing age. Ampullary Tumors Originate from the ampulla of Vater or the distal common bile duct. Present as a mass in the head of the pancreas due to the ampulla of Vater's location. Include adenomas and adenocarcinomas, often mistaken for pancreatic head tumors due to proximity.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1281

↑ *Back to this question in Part A*

@Neet_pg_bot

Q11: A patient with a suspected intraductal papillary mucinous neoplasm (IPMN) has elevated serum CA 19-9 levels. What does this finding most likely suggest? (Q848971)

A. The IPMN is benign and does not require surgical intervention

B. The IPMN is likely malignant or has high-grade dysplasia

C. The IPMN is a branch duct type and requires conservative management

D. The IPMN is likely malignant and surgery is contraindicated

Correct Answer: B. The IPMN is likely malignant or has high-grade dysplasia

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Elevated CA 19-9 levels are often associated with malignancy or high-grade dysplasia in IPMNs, suggesting a need for further evaluation and potentially surgery. Intraductal Papillary Mucinous Neoplasms (IPMNs) Location: Predominantly in the head of the pancreas . More common in older men . Pathology: The whole pancreatic duct is distended with the mucin secreted and may cause obstruction Types: Main duct IPMN (High risk of malignancy) Side branch IPMN (Low risk of malignancy) Mixed IPMN Investigations: MRCP is the first line and investigation of choice. CT in MRI contraindicated patients. EUS (endoscopic ultrasound) with FNA (Fine needle aspiration) of the cyst fluid for analysis: Mucinous content Increased CEA and amylase levels On endoscopy, visualization of thick mucus extruding from the ampulla is diagnostic of a main duct IPMN. Risk of malignant transformation IN IPMN: Main duct 5–9 mm Enhancing mural nodule <5 mm Thickened, enhancing cyst wall BD-IPMN >3 cm Lymphadenopathy Pancreatitis Increased serum CA 19–9 Cyst growth >5 mm over 2 years Management Algorithm: Aspect Details Management Pathways Surgical Indications : Confirmed carcinoma/high-grade dysplasia, solid mass, jaundice, mural nodules, significant duct dilation. Non-Surgical Management : For unsuitable candidates or non-surgical criteria, with regular monitoring (clinical, CA 19-9, imaging). Surgical Options Pylorus-Preserving Pancreatoduodenectomy (PPPD) : For pancreatic head tumors. Distal Pancreatectomy : For body/tail tumors. Total Pancreatectomy : For multifocal tumors, unsafe bowel anastomosis and whole duct involvement.

References:

Bailey &Love's Short Practice of Surgery, 28th Edition, Page 1281-1287

https://www.ncbi.nlm.nih.gov/books/NBK507779/

Sabiston Textbook of Surgery, 21st Edition, Page 1548, 1549

↑ *Back to this question in Part A*

Q12: In a patient with a pancreatic cyst, peripheral eggshell calcification on CT is: (Q848967)

A. Common in benign cysts and easily detected.

B. Easily detected and a definitive marker of malignancy.

C. Difficult to detect but highly indicative of malignancy in mucinous cystic neoplasms.

D. Exclusively associated with pancreatic pseudocysts, not with malignancy.

Correct Answer: C. Difficult to detect but highly indicative of malignancy in mucinous cystic neoplasms.

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Peripheral eggshell calcification is subtle on CT but a strong indicator of malignancy in mucinous cystic neoplasms. Peripheral Eggshell Calcification in Mucinous Cystic Neoplasms (MCNs) of the Pancreas: Aspect Details Calcification Type Peripheral eggshell Imaging Modality CT scan (challenging to detect) Predictive Value High for malignancy Typical Patient Middle-aged females Cyst Characteristics Unilocular or multilocular macrocysts Possible Imaging Findings Thickened wall, vascular involvement Clinical Action Further assessment and potential surgery



References:

Sabiston Textbook of Surgery, 21st Edition, Page 1547 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5051074/

↑ *Back to this question in Part A*

@Neet_pg_bot

Q13: A 45-year-old patient presents with chronic watery diarrhea. Laboratory tests reveal elevated levels of vasoactive intestinal peptide (VIP) > 150 pg/ml, achlorhydria, and hypokalemia. Imaging studies show a solitary mass in the body of the pancreas. What is the treatment of choice in this condition? (Q848960)

A. Initiate high-dose corticosteroid therapy with Prednisolone

B. Start treatment with Octreotide

C. Perform a distal pancreatectomy

D. Begin broad-spectrum antibiotic therapy

Correct Answer: C. Perform a distal pancreatectomy

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The described scenario is that of VIPOMA . Distal pancreatectomy is the treatment of choice for VIPOMA, especially when the tumor is solitary and located in the body or tail of the pancreas. VIPOMA Source: D2 cells of the pancreas. Alternative Names: Pancreatic cholera, Verner-Morrison syndrome, weak-tea syndrome. Nature: Usually malignant. Clinical Features (WDHA Syndrome) Watery diarrhea. Hypokalemia. Achlorhydria. Biochemical Markers Vasoactive Intestinal Peptide (VIP): Secretion > 150 pg/ml. Location Typically found in the body and tail of the pancreas. Treatment Surgical: Distal pancreatectomy is the treatment of choice when the tumor is solitary and located in the body or tail of the pancreas Medications: Prednisolone (Option A) : Controls diarrhea. Octreotide (Option B) : Useful in managing symptoms. Begin broad-spectrum antibiotic therapy (Option D): Antibiotics are not indicated in the management of VIPOMA, as the condition is related to a tumor rather than an infection.

References:

SRB Manual of Surgery, 6th Edition, Page 704

↑ *Back to this question in Part A*

@Neet_pg_bot

Q14: A 58-year-old female presents with diarrhea, weight loss, and itchy lesions around the mouth and vagina. Physical examination reveals a rash as shown in the image below. On evaluation, she has diabetes, and imaging studies indicate a large pancreatic mass. Which of the following is the most likely diagnosis? (Q848956)

A. Gastrinoma

B. Insulinoma

C. Glucagonoma

D. VIPoma



Correct Answer: C. Glucagonoma

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The above symptoms of weight loss, diarrhea, stomatitis and vulvovaginitis with the characteristic rash suggestive of necrolytic migratory erythema , along with large pancreatic mass points towards the diagnosis of glucagonoma. Aspect Details Origin Alpha cells of the pancreas Common Locations Body and tail of the pancreas Size 5-10 cm Prevalence Sporadic; 17% with MEN type II syndrome Gender More common in females Malignancy 80% malignant; 80% spread to liver Symptoms Necrolytic migratory erythema, diabetes, diarrhea, weight loss, stomatitis, anemia, amino acid deficiency, vulvovaginitis Diagnostic Tests MRI, CT scan, Endosonography, Angiogram, Serum glucagon levels (>50 pmol/L) Treatment Anemia and deficiency correction, IV amino acids, DVT prevention, Distal pancreatectomy, Whipple's/total pancreatectomy, Enucleation, Dacarbazine Gastrinoma (Option A): Typically associated with Zollinger-Ellison syndrome, presenting with recurrent peptic ulcers rather than necrolytic migratory erythema. Insulinoma (Option B): Characterized by hypoglycemia and hyperinsulinemia, not typically associated with necrolytic migratory erythema. VIPoma (Option D): Associated with WDHA syndrome (Watery Diarrhea, Hypokalemia, Achlorhydria) and not with necrolytic migratory erythema.

References:

SRB Manual of Surgery, 6th Edition, Pages 703, 704

↑ *Back to this question in Part A*

@Neet_pg_bot

Q15: A 45-year-old woman with a family history of cancer presents for a routine check-up. Her mother and maternal aunt both had pancreatic cancer. Genetic testing reveals a gain-of-function mutation in the PRSS1 gene. Which of the following factors contributes the most to her increased risk of developing pancreatic cancer? (Q848920)

A. Chronic pancreatitis

B. Germline BRCA2 mutation

C. Lynch syndrome

D. Hereditary pancreatitis

Correct Answer: D. Hereditary pancreatitis

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Hereditary pancreatitis is associated with a gain-of-function mutation in the PRSS1 gene and increases the risk of pancreatic cancer by 50-70 times. Genetic Risk Factors for Pancreatic Cancer: Family History

: Two first-degree relatives with pancreatic cancer increase risk by 18-57 times. Germline BRCA2 Mutations : Present in some rare high-risk families. Hereditary Pancreatitis : 50-70 times increased risk. Chronic Pancreatitis : 5-15 times increased risk. Other Syndromes : Lynch Syndrome (HNPCC) Ataxia Telangiectasia Peutz-Jeghers Syndrome Familial Breast-Ovarian Cancer Syndrome Familial Atypical Multiple Mole Melanoma Familial Adenomatous Polyposis (risk of ampullary/duodenal carcinoma) Hereditary Pancreatitis: Inheritance : Autosomal dominant with 80% penetrance. Mutations : PRSS1 : Gain-of-function mutation on chromosome 7, producing degradation-resistant trypsin. SPINK1 : Loss-of-function mutation predisposes to idiopathic pancreatitis. CFTR : Mutations linked to idiopathic chronic pancreatitis. Cancer Risk : Significantly increased, especially with tobacco use. Other Risk Factors: Demographic factors Environmental/Lifestyle factors Genetic Factor Relative Risk Increase Family History (two first-degree relatives) 18-57 times Germline BRCA2 Mutations High-risk families Hereditary Pancreatitis 50-70 times Chronic Pancreatitis 5-15 times

References:

Bailey and Love Short Practice of Surgery, 28th Edition, Page 1277, 1278, 1281

↑ *Back to this question in Part A*

@Neet_pg_bot

Q16: Which diagnostic finding is most indicative of an insulinoma? (Q848951)

A. Elevated serum glucose levels

B. Low C-peptide levels

C. Elevated serum insulin levels during hypoglycemia

D. Hyperinsulinemic response to oral glucose tolerance test

Correct Answer: C. Elevated serum insulin levels during hypoglycemia

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The most indicative diagnostic finding for an insulinoma is elevated serum insulin levels during hypoglycemia. This confirms that hypoglycemia is due to endogenous insulin production, which is characteristic of insulinoma. Category Details Definition A rare, typically benign tumor of the pancreatic islet cells that produces excess insulin. Clinical Features Whipple's Triad- Documented low blood glucose levels during symptomatic episodes Relief of symptoms upon administration of glucose Symptoms often occur during fasting or after exercise Symptoms of hypoglycemia (e.g., sweating, palpitations, confusion, visual disturbances, seizures) Diagnosis Gold-standard test for diagnosing insulinoma is a 72-hour fast. (Option C) Combination of plasma glucose < 55 mg/dL + insulin level ≥ 3 microUnits/mL + C peptide level ≥ to 0.6 ng/mL + proinsulin ≥ 5 pmol/L, + negative sulfonylurea level indicates that the hypoglycemia induction is by hyperinsulinemia Insulin/glucose ratio > 0.4 is diagnostic Imaging: CT, MRI, EUS Management Surgical resection is the treatment of choice Medical management with diazoxide or octreotide for non-surgical candidates or unresectable tumors Elevated serum glucose levels (Option A) : Insulinomas cause hypoglycemia, not elevated glucose levels. Low C-peptide levels

(Option B) : Insulinomas typically show elevated C-peptide levels, indicating endogenous insulin production. Low C-peptide levels would suggest exogenous insulin administration. Hyperinsulinemic response to oral glucose tolerance test (Option D) : While insulinomas cause excessive insulin production, the diagnosis is confirmed by measuring insulin levels during hypoglycemic episodes, not after an oral glucose load.

References:

Bailey and Love Short Practice of Surgery, 28th Edition, Page 906

https://www.ncbi.nlm.nih.gov/books/NBK544299/

↑ *Back to this question in Part A*

@Neet_pg_bot

Q17: Which of the following statements is true regarding neuroendocrine tumors of the pancreas? (Q848928)

A. The most common non-functional neuroendocrine tumor of the pancreas is insulinoma

B. Somatostatin receptor scintigraphy is used for the localization of NETs

C. The most common site of metastasis is the lungs

D. Functional NETs are diagnosed at a later stage and have poor prognosis

Correct Answer: B. Somatostatin receptor scintigraphy is used for the localization of NETs

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Neuroendocrine tumors of the pancreas (NETs): Type Description Examples Key Features Functional NETs Secrete hormones causing clinical syndrome Insulinoma(MC), Gastrinoma, Glucagonoma, VIPoma, Somatostatinoma Present early due to symptoms Non-functional NETs Do not produce active hormones Polypeptide cell tumor (PPOMA) - Most common type Present late with mass effect The most common functional and malignant neuroendocrine tumor of the pancreas is a gastrinoma. It is also the most common in MEN syndrome. The most common site of metastasis is the liver. Neuroendocrine tumors are symptomatic due to the secretion of active substances. Consequently, patients are: Symptomatic at an early stage and diagnosed at an early stage Early diagnosis improves outcomes Diagnosis: Laboratory measurement of active substances or their by-products. Somatostatin receptor scintigraphy (SRS) is used for the localization of NETs.

References:

Bailey and Love Short Practice of Surgery, 28th Edition, Page 905

www.ncbi.nlm.nih.gov/books/NBK544299/#

www.ncbi.nlm.nih.gov/pmc/articles/PMC3590956/#

www.ncbi.nlm.nih.gov/books/NBK441842/#

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5871954/

↑ *Back to this question in Part A*

@Neet_pg_bot

Q18: Which surgical procedure is characterized by the resection of the pancreatic head while preserving the stomach and pylorus? (Q848926)

A. Whipple procedure

B. Distal pancreatectomy

C. Longmire Traverso procedure

D. Total pancreatectomy

Correct Answer: C. Longmire Traverso procedure

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Longmire Traverso procedure is also called Pylorus Preserving Pancreaticoduodenectomy. Pylorus-Preserving Pancreaticoduodenectomy (PPPD) Preserves the gastric antrum, pylorus, and proximal duodenum, anastomosing the duodenum to the jejunum to maintain gastrointestinal continuity. Indications: Malignant or premalignant neoplasms in the pancreatic head or periampullary structures (bile duct, ampulla, or duodenum) Advantages of PPPD compared to conventional pancreaticoduodenectomy are: Reduced incidence of postoperative complications like dumping syndrome, marginal ulceration, and bile reflux gastritis. Improved gastrointestinal function due to preservation of the gastric antrum and pylorus in PPPD leading to more physiological gastric emptying. Reduced operative time and blood Loss Lower perioperative mortality In pylorus-preserving pancreaticoduodenectomy (PPPD), the sequence of anastomoses typically follows these steps: 1st - Pancreaticojejunostomy 2nd - Hepaticojejunostomy 3rd - Duodenojejunostomy

References:

www.uptodate.com/contents/pylorus-preserving-pancreaticoduodenectomy?search=whipple%20procedure&source=search_result&selectedTitle=1~60&usage_type=default&display_rank=1

↑ *Back to this question in Part A*

@Neet_pg_bot

Q19: A patient is scheduled to undergo a Whipple procedure for the treatment of pancreatic cancer. The surgeon needs to perform anastomosis to reconstruct the digestive tract after removing the affected tissues. In which sequence are the anastomoses typically performed during a Whipple procedure? (Q848925)

A. Hepaticojejunostomy → Pancreaticojejunostomy → Gastrojejunostomy

B. Pancreaticojejunostomy → Hepaticojejunostomy → Gastrojejunostomy

C. Gastrojejunostomy → Pancreaticojejunostomy → Hepaticojejunostomy

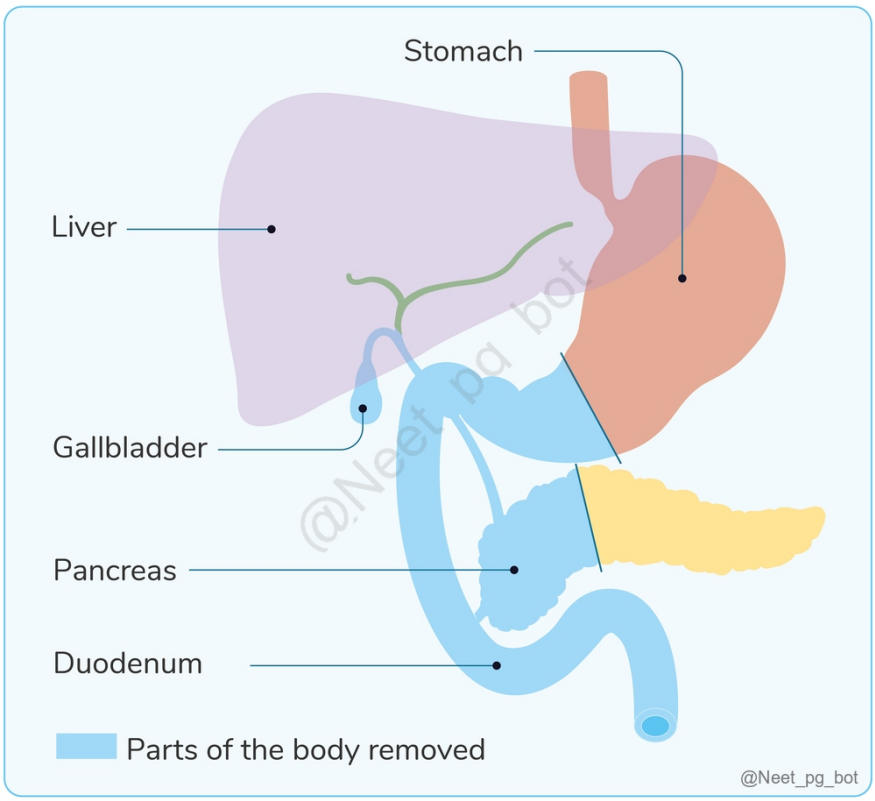
D. Pancreaticojejunostomy → Gastrojejunostomy → Hepaticojejunostomy

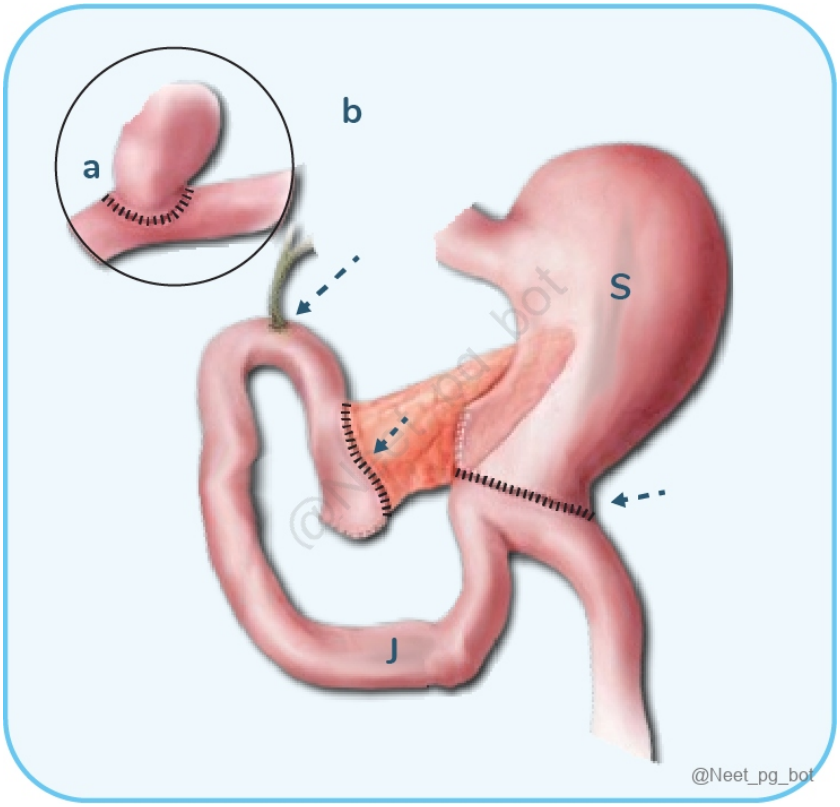
Correct Answer: B. Pancreaticojejunostomy → Hepaticojejunostomy → Gastrojejunostomy

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The typical sequence for performing anastomosis in a Whipple procedure is to start with the pancreaticojejunostomy, followed by the hepaticojejunostomy, and finally the gastrojejunostomy. This order allows for proper reconstruction of the digestive system following the removal of the affected tissues. Whipple's procedure (Pancreaticoduodenectomy) Structures removed: Head of the pancreas, the first part of the small intestine (duodenum), the gallbladder, and a portion of the bile duct. Types: Pylorus-Preserving Whipple Procedure (Preferred) Non–Pylorus-Preserving Whipple Procedure Indications Pancreatic Cancer: Commonly treated with Whipple if cancer is localized to the head of the pancreas. Chronic Pancreatitis: when uncontrolled by medical management. Tumors in Pancreas/Surrounding Areas: Includes duodenum, distal bile duct, and ampulla of Vater. Procedure Steps Tumor Assessment: Explore abdomen to assess tumor size, location, and spread. Resection: Remove head of pancreas, duodenum, gallbladder, and part of bile duct; this may include partial stomach resection. Lymph Node Dissection: Remove and examine nearby lymph nodes. Reconstruction Pancreaticojejunostomy: Connect remaining pancreas to jejunum. Hepaticojejunostomy: Connect common bile duct to jejunum. Gastrojejunostomy: Connect stomach to jejunum. Anastomosis Principles Tension-Free Connection: Achieve mucosa-to-mucosa connection for healing. Order of Anastomoses: Pancreaticojejunostomy → Hepaticojejunostomy → Gastrojejunostomy Stent Placement: May use internal/external stents for small ducts. Complications Pancreatic Fistula: Major issue; managed with somatostatin analogues. Delayed Gastric Emptying Bleeding, wound infection Reoperation, increased mortality Dumping/Bile Reflux: Common after non-pylorus-preserving Whipple; pylorus-preserving method has uncertain benefits. Other options: Option A: Hepaticojejunostomy → Pancreaticojejunostomy → Gastrojejunostomy Biliary anastomosis is not performed before the pancreatic one because pancreatic stump handling becomes more difficult due to edema. Option C: Gastrojejunostomy → Pancreaticojejunostomy → Hepaticojejunostomy Gastric reconstruction is always performed last, not first. Option D: Pancreaticojejunostomy → Gastrojejunostomy → Hepaticojejunostomy The bile duct anastomosis should precede gastric reconstruction; this order is not surgical standard.





References:

Sabiston Textbook of Surgery, 21st Edition, Page 1556-1559

↑ *Back to this question in Part A*

@Neet_pg_bot

Q20: A 65-year-old male presents with jaundice, dark urine, and weight loss over the past two months. Courvoisier's Sign is positive on physical examination. What is the next best step in the management of this patient to both visualize pancreatic and biliary ducts, and tissue sampling? (Q848924)

A. Computed Tomography

B. Endoscopic Ultrasonography

C. Endoscopic Retrograde Cholangiopancreatography

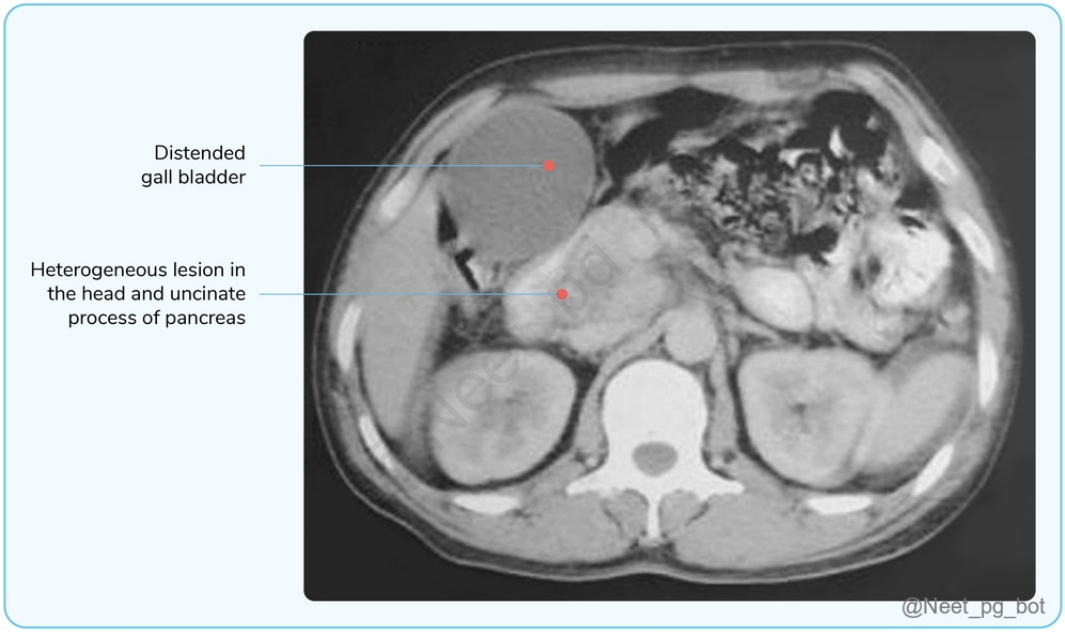
D. Diagnostic Laparoscopy

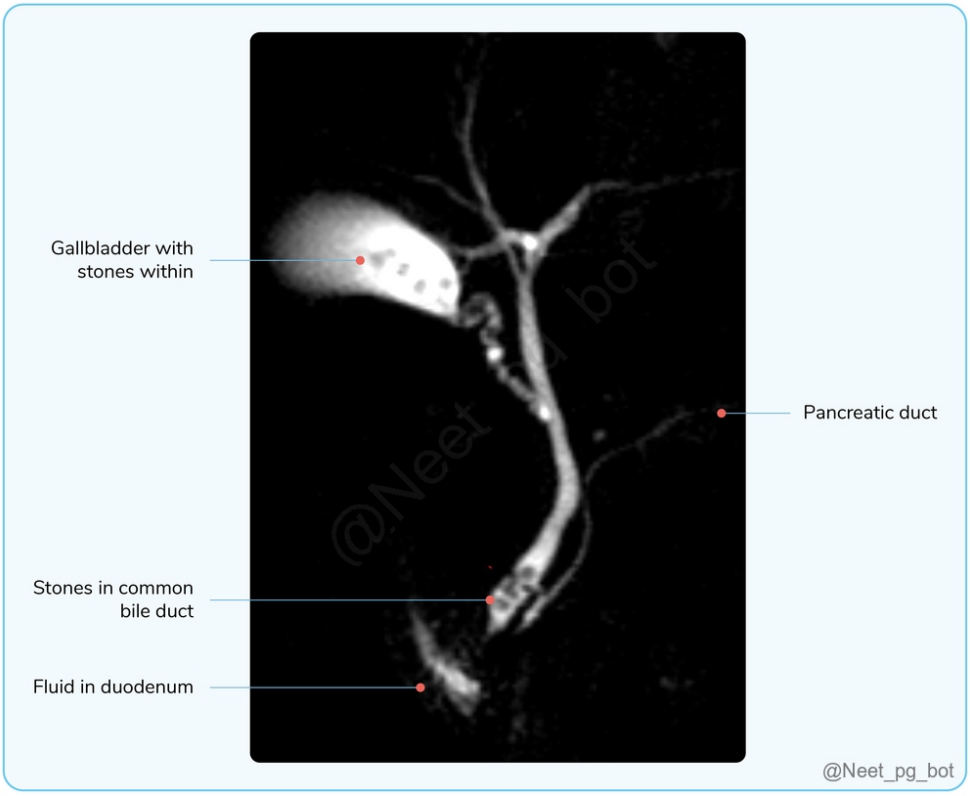
Correct Answer: C. Endoscopic Retrograde Cholangiopancreatography

■ *Listen (English)*

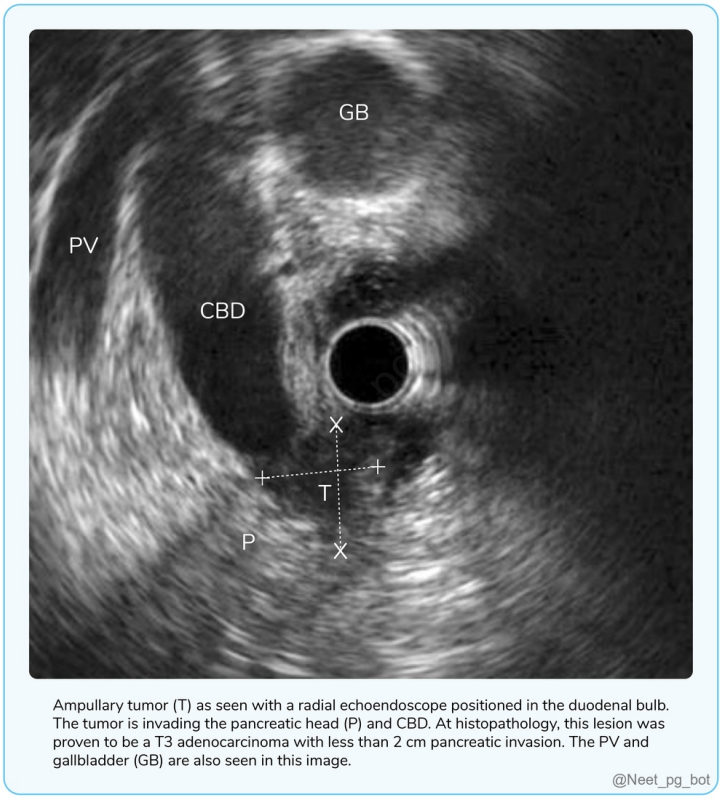
■ *Listen (Hindi)*

Explanation: The presence of jaundice, dark urine, weight loss, and Courvoisier's sign is positive on physical examination is suggestive of pancreatic cancer. ERCP is used for visualizing bile and pancreatic ducts and can obtain brush cytology or biopsy samples but is less effective at detecting small pancreatic tumors compared to EUS. Imaging techniques and their usefulness: Technique Uses and key features CT Scan (Option A) First choice for diagnosing pancreatic cancer. Detects mass, duct dilation, and pancreatic atrophy. Detection of metastasis. MRI/MRCP (Magnetic Resonance Cholangiopancreatography) Complementary to CT for additional information. MRCP identifies biliary obstruction and pancreatic duct issues. Does not show calcification visible on CT. ERCP (Endoscopic Retrograde Cholangiopancreatography) Visualizes pancreatic and biliary ducts. Allows for tissue sampling. Key signs: Narrowing of ducts, double duct sign. EUS (Endoscopic Ultrasound) (Option B) Useful when CT does not show a tumor. Assesses vascular invasion and differentiates cystic tumors from pseudocyst Additional Procedures: Diagnostic Laparoscopy : (Option D) Uses: Identifies small peritoneal and liver metastases to assess resectability Not suitable for visualisation of the pancreatic and biliary ducts.


Distended gall bladder
Heterogeneous lesion in the head and uncinate process of pancreas
@Neet_pg_bot


Gallbladder with stones within
Pancreatic duct
Stones in common bile duct
Fluid in duodenum
@Neet_pg_bot





Ampullary tumor (T) as seen with a radial echoendoscope positioned in the duodenal bulb. The tumor is invading the pancreatic head (P) and CBD. At histopathology, this lesion was proven to be a T3 adenocarcinoma with less than 2 cm pancreatic invasion. The PV and gallbladder (GB) are also seen in this image.

References:

Bailey and Love Short Practice of Surgery, 28th Edition, Page 1263- 1267, 1283

↑ *Back to this question in Part A*

@Neet_pg_bot

Q21: A 55-year-old man with no history of obesity or a family history of diabetes is recently diagnosed with diabetes mellitus. He also reports vague upper abdominal discomfort, significant weight loss, and mild jaundice. Which of the following findings on physical examination would most likely suggest a diagnosis of pancreatic cancer? (Q848923)

A. Tender and enlarged gallbladder

B. Hepatomegaly with jaundice

C. Courvoisier's sign

D. Murphy’s sign

Correct Answer: C. Courvoisier's sign

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Courvoisier's sign is the presence of a palpable, non-tender gallbladder , which strongly suggests malignant obstruction of the bile duct , typically from a pancreatic head tumor. This is a classic sign associated with pancreatic cancer. Pancreatic carcinomas are highly aggressive tumors, more than 85% of it being ductal adenocarcinomas. Symptoms: Jaundice secondary to obstruction is the most common symptom Characteristically painless, but may be associated with nausea and epigastric discomfort Pruritus, dark urine and pale stools with steatorrhea Weight loss Signs: Courvoisier’s sign - palpable, non-tender gallbladder Palpable liver and ascites Diabetes mellitus depending on the location of tumor Tender and enlarged gallbladder (Option A): A tender gallbladder is more suggestive of acute cholecystitis or gallstone disease rather than pancreatic cancer. Hepatomegaly with jaundice (Option B): While hepatomegaly and jaundice can be present in pancreatic cancer, they are less specific. Hepatomegaly can occur due to a variety of other conditions, including liver metastasis. Murphy’s sign (Option D) is said to be positive when there is pain in right upper abdomen with deep palpation, classically seen in acute cholecystitis.

References:

Bailey and Love Short Practice of Surgery, 28th Edition, Page 1282, 1283 https://www.ncbi.nlm.nih.gov/books/NBK459171/#article-19448.s7:~:text=The%20finding%20of%20right%20upper%20abdominal%20pain%20with%20deep%20palpation%2C%20Murphy%20sign%2C%20is%20usually%20classic%20for%20this%20disease .

↑ *Back to this question in Part A*

@Neet_pg_bot

Q22: A 56-year-old patient with pancreatic cancer has completed initial treatment. To monitor for potential recurrence, the oncologist decides to check a tumor marker. Which of the following tumor markers is commonly used for establishing a baseline and monitoring for recurrence in pancreatic cancer? (Q848922)

A. Alpha-fetoprotein

B. Carbohydrate Antigen 19-9

C. Carcinoembryonic Antigen

D. Human Chorionic Gonadotropin

Correct Answer: B. Carbohydrate Antigen 19-9

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Carbohydrate Antigen 19-9 (CA19-9) is commonly used to establish a baseline level and monitoring for recurrence in pancreatic cancer. Pancreatic cancer tumor marker: Carbohydrate Antigen 19-9 (CA19-9) Usage : Establish a baseline level for monitoring. Characteristics : Not highly specific or sensitive. Useful for detecting recurrence if initial levels are raised Alpha-fetoprotein (AFP) (Option A) : Primarily useful for liver cancer and germ cell tumors, not specific to pancreatic cancer. Carcinoembryonic Antigen (CEA) (Option C) : More commonly used for colorectal cancer, not specifically for pancreatic cancer. Human Chorionic Gonadotropin (hCG) (Option D) : Primarily used in the context of trophoblastic diseases and certain germ cell tumors, not for pancreatic cancer.

References:

Bailey and Love Short Practice of Surgery, 28th Edition, Page 1283,1284, 1571, 1572, 1364, 1618

↑ *Back to this question in Part A*

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Q23: A 65-year-old man presents with symptoms of jaundice and abdominal pain. Imaging studies reveal a solid mass in the pancreatic head. Histological examination shows a dense fibrous stroma with neoplastic tubular glands. The tumor is characterized by local spread along nerves, lymphatics, and blood vessels, and has metastasized to the liver. What is the most likely diagnosis? (Q848921)

A. Serous cystadenoma

B. Mucinous cystic neoplasm

C. Ductal adenocarcinoma

D. Solid pseudopapillary neoplasm

Correct Answer: C. Ductal adenocarcinoma

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Ductal adenocarcinoma type of pancreatic cancer is characterized by a solid mass with neoplastic tubular glands in a dense fibrous stroma, local spread, and metastasis, as described in the given scenario. Ductal Adenocarcinoma: Prevalence : >85% of pancreatic cancer cases (most common) Origin : Ductal cells of the pancreas. Characteristics : Solid tumors with neoplastic tubular glands in dense fibrous stroma. Spread : Locally along nerves, lymphatics, and blood vessels; metastasis often to the liver and peritoneum. Challenges : Histological differentiation can be difficult due to similarities with chronic pancreatitis. Tumor Type Characteristics Common Locations Typical Patients Ductal Adenocarcinoma Solid tumors with neoplastic tubular glands Pancreas (general) - Serous Cystadenomas (Option A) Large clusters of small cysts Pancreas Older women Mucinous Cystic Neoplasms (Option B) Thick-walled, multilocular cysts Pancreatic body or tail Perimenopausal women Intraductal Papillary Mucinous Neoplasms (IPMNs) Multifocal, more likely malignant Pancreatic head Older men Solid Pseudopapillary Neoplasms (Option D) Large, partially solid, partially cystic masses Pancreas Women of childbearing age Adenomas of the Ampulla of Vater Smooth, polypoid submucosal masses Ampulla of Vater - Ampullary Adenocarcinomas Early presentation with biliary obstruction Ampulla of Vater -

References:

Bailey and Love Short Practice of Surgery, 28th Edition, Page 1281, 1282

↑ *Back to this question in Part A*

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• [04_Hepatobiliary Pancreatic Surgery] 018 Previous Year Questions

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[04_Hepatobiliary Pancreatic Surgery] 018 Previous Year Questions — Quick Jump

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Q61 (p. 1805)	*Q62 (p. 1806)*	*Q63 (p. 1807)*	*Q64 (p. 1809)*	*Q65 (p. 1811)*	*Q66 (p. 1811)*
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Q1: What is the most probable diagnosis for a 42-year-old woman who came with symptoms of fever, vomiting, and right hypochondriac pain, which radiates to the neck? She has experienced similar episodes in the past, and a positive Murphy's sign was observed during the examination. (Q857521)

A. Acute cholecystitis

B. Carcinoma gallbladder

C. Peptic ulcer

D. Acute appendicitis

Correct Answer: A. Acute cholecystitis

Explanation: Murphy's sign : when we place the fingers on the right hypochondrium and ask the patient to take deep inspiration. At the height of inspiration, there is a sudden catch. This catch is due to an inflamed gallbladder coming in contact with the abdominal wall. This produces pain. In the case of acute cholecystitis, there is inflammation of the gallbladder, and Murphy's sign is positive. Murphy’s sign is not positive in carcinoma of the

gallbladder (Option B), peptic ulcer (Option C), or acute appendicitis (Option D), as it is specifically associated with acute cholecystitis.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1235, 1236, 1244

↑ *Back to this question in Part A*

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Q2: ERCP is least useful in the diagnosis of: (Q856781)

A. Recurrent pancreatitis

B. Unexplained jaundice

C. Periampullary mass

D. Acute Pancreatitis without choledocholithiasis

Correct Answer: D. Acute Pancreatitis without choledocholithiasis

Explanation: Acute pancreatitis is inflammation of the pancreas, often linked to biliary causes like gallstones or choledocholithiasis; however, when choledocholithiasis is absent, and no bile duct obstruction is present, ERCP is not typically recommended. ERCP (Endoscopic Retrograde Cholangiopancreatography) is an invasive diagnostic and therapeutic procedure used to examine and treat disorders of the bile ducts , pancreatic ducts , and gallbladder . In the given case, non-invasive imaging like abdominal ultrasound, CT scan, or MRI is sufficient to assess the pancreas and biliary tree, and ERCP is reserved for patients with evidence of bile duct obstruction . Recurrent pancreatitis (Option A) can be caused by bile duct stones, pancreatic duct abnormalities, or strictures. ERCP helps by identifying obstructions, structural changes, and stones in the bile duct or pancreatic duct . It also allows therapeutic interventions such as stone removal or stenting of the bile duct. Therefore, ERCP is often used in recurrent pancreatitis if there is suspicion of biliary causes. Unexplained jaundice (Option B) can arise from a variety of causes, but one of the most common is obstruction of the bile duct, often by stones, tumours, or strictures. ERCP is an excellent diagnostic tool for identifying the cause of jaundice. Periampullary mass (Option C) is a growth near the Ampulla of Vater, and ERCP is particularly useful in the diagnosis of these as it provides detailed imaging of the ampulla of Vater and helps identify the location, extent, and nature of the mass, aiding in further management decisions.

References:

Bailey and Love's Short Practice of Surgery, 28th Edition, Page 154

SRB's Manual of Surgery, 6th Edition, Pages675 - 68

↑ *Back to this question in Part A*

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Q3: A 54-year-old female patient presents with abdominal pain and bilious vomiting. She had a history of abdominal hysterectomy 2 years back. On examination, abdomen auscultation revealed high-pitched bowel sounds. Investigations showed air within the biliary tree. What is the most likely diagnosis? (Q856242)

A. Gallstone ileus

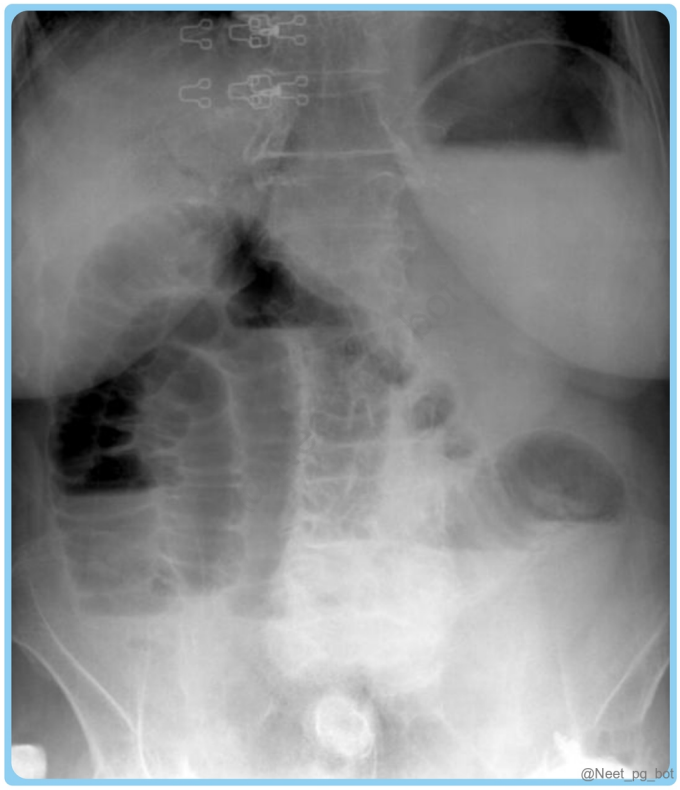
B. Adhesive intestinal obstruction

C. Ischemic enterocolitis

D. Diverticulitis

Correct Answer: A. Gallstone ileus

Explanation: The patient, with a history of abdominal hysterectomy 2 years ago, presents with abdominal pain, bilious vomiting, high-pitched bowel sounds on auscultation, and investigations revealing air within the biliary tree, indicating Gallstone ileus. A rare complication of cholelithiasis (0.4%) caused by the impaction of one or more gallstones within the gastrointestinal tract, is more common in the elderly and women. Pathophysiology: Acute cholecystitis→ erosion of inflamed tissues → Formation of a cholecystointestinal fistula→ Gallstone ileus Small gallstones typically pass through the intestines, but stones 2–5 cm in size can become impacted, usually in the terminal ileum or at the ileocecal valve. Clinical Manifestations: Acute, intermittent, or chronic episodes of partial or complete gastrointestinal obstruction. Signs of obstruction include dehydration, abdominal distension and tenderness, high-pitched bowel sounds, and obstructive jaundice. (Option A) Diagnosis: Plain Abdominal Radiograph: Partial or complete intestinal obstruction Pneumobilia or contrast material in the biliary tree Calcified gallstone with position changes on serial films (tumbling sign) {{caption_text}} CT Scan: Superior sensitivity (up to 93%) Shows abnormal gallbladder with air, air-fluid level, or fluid accumulation with an irregular wall (Option A) {{caption_text}} Management: Management of intestinal obstruction Enterolithotomy: The most common surgical procedure A longitudinal incision on the antimesenteric border proximal to the site of impaction Gallstone is brought to a non-edematous bowel segment by gentle manipulation and extraction. Cholecystoenteric fistula resection only if the patient is stable and there are residual gallstones that may cause infection or recurrent ileus. Adhesive intestinal obstruction (Option B) occurs when scar tissue from previous abdominal surgery causes bowel loops to stick together, leading to obstruction. It typically presents with symptoms of bowel obstruction (pain, vomiting, distention) but would not show air in the biliary tree. Ischemic enterocolitis (Option C) results from reduced blood flow to the intestines, often due to arterial blockage or low blood pressure. It causes diffuse abdominal pain, tenderness, and sometimes bloody diarrhoea, but does not cause the air in the biliary tree. Diverticulitis (Option D) is inflammation or infection of small pouches (diverticula) in the colon. It usually presents with lower abdominal pain, fever, and changes in bowel habits, and does not cause air in the biliary tree.





References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1244.

Textbook of SRB’s Surgical Operations, 6th Edition, Page 633-634.

↑ *Back to this question in Part A*

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Q4: An alcoholic patient presented with severe abdominal pain. Pancreatitis was suspected, and a CT scan revealed lesions with fluid collected near the body of the pancreas. Which of the following enzymes is most likely to be elevated? (Q856230)

A. Serum GGT

B. CEA

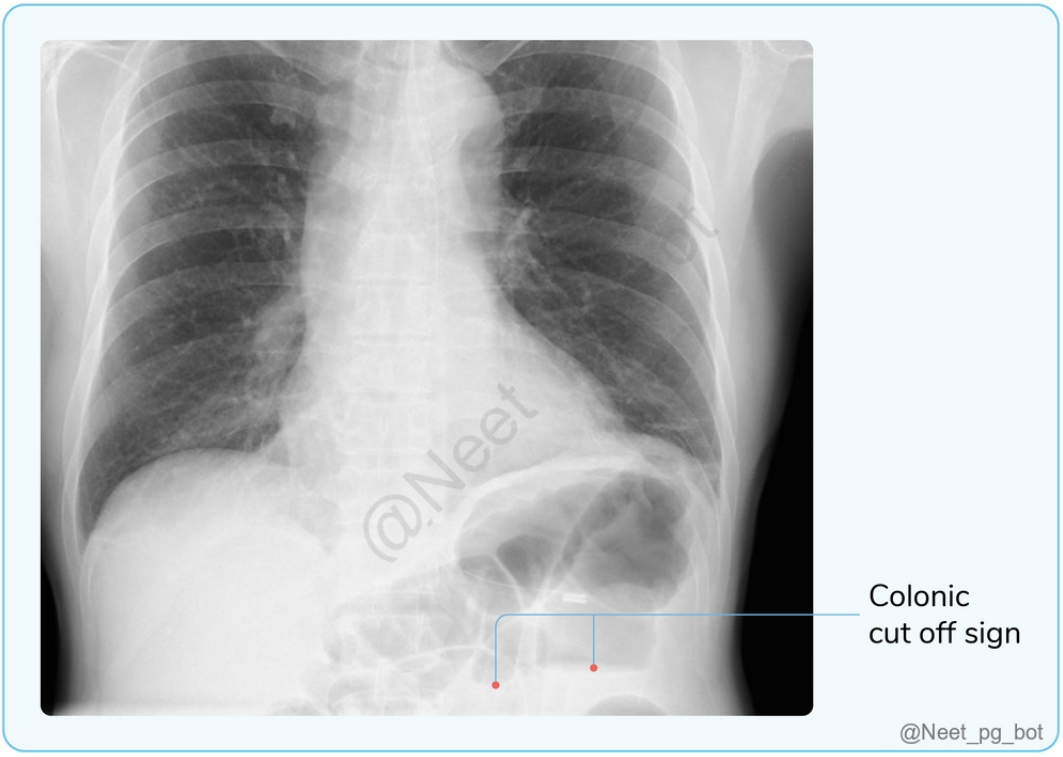
C. Serum lipase

D. Serum bilirubin

Correct Answer: C. Serum lipase

Explanation: The patient's severe abdominal pain and CT scan showing fluid-filled lesions near the body of the pancreas suggest an inflammatory process, diagnosed as Pancreatitis , with elevated serum lipase levels. Clinical Diagnosis (Requires 2 of 3): Abdominal pain is strongly suggestive of acute pancreatitis. Serum amylase and/or lipase (more specific) level at least 3 times the upper limit of normal. Imaging findings characteristic of acute pancreatitis. X-ray Features Sentinel loop sign : Dilated loop of small intestine near the inflamed pancreas due to localised ileus. Significance : Early indicator of acute pancreatitis on X-ray. Sentinel loop sign {{caption_text}} Colon cut-off sign : Abrupt termination of gas in the colon at the splenic flexure, with collapsed distal colon loops. Significance : Suggests localised pancreatic inflammation, causing colonic spasm as an indirect sign of acute pancreatitis {{caption_text}} Investigations of Choice: Contrast-enhanced CT (CECT) : Primary tool for assessing pancreatic necrosis, peripancreatic inflammation, fluid collections, and complications. Most reliable for staging and detecting complications. It may underestimate necrosis if done in the first 24 hours. Morphological Types (Revised Atlanta Classification 2008): Interstitial oedematous pancreatitis : Mild form with pancreatic oedema and swelling but no necrosis. Necrotising pancreatitis : Severe form involving pancreatic parenchymal necrosis, associated with higher morbidity and mortality. Serum GGT (Gamma-Glutamyl Transferase) (Option A) is elevated in liver disease, especially in cases of alcohol abuse, but it's not specific to pancreatitis. CEA (Option B) , carcinoembryonic antigen, is a tumour marker not typically elevated in pancreatitis. Serum bilirubin (Option D) may be elevated in biliary obstruction or liver disease; it is not a primary marker for pancreatitis.





References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1262-1263.

↑ *Back to this question in Part A*

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Q5: A patient underwent cholecystectomy for gallstones 2.5 years ago. She now presents with symptoms of obstructive jaundice. Investigation reveals a stone in the common bile duct. What is the stone most likely to be? (Q856204)

A. Primary

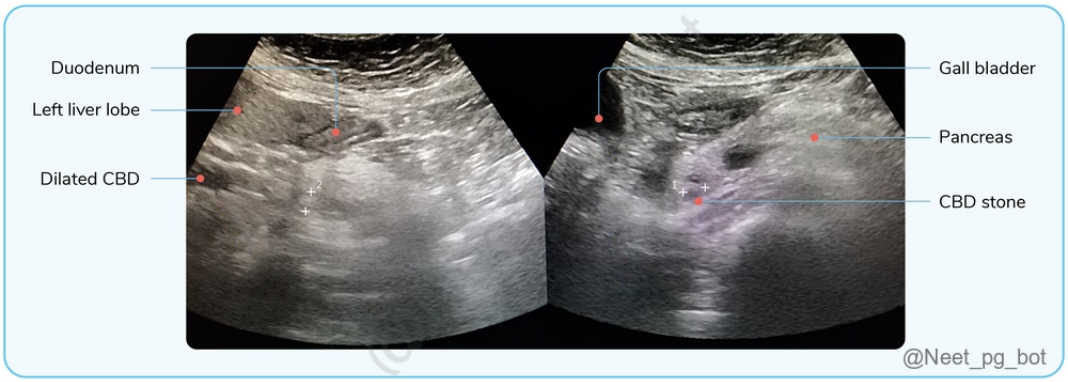
B. Secondary

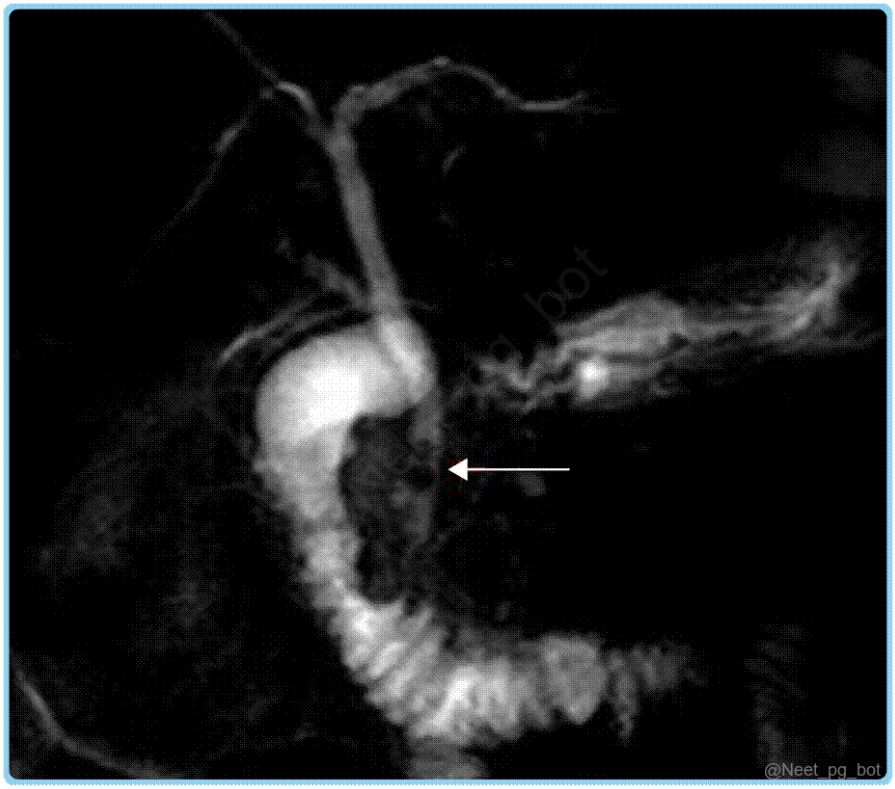
C. Tertiary

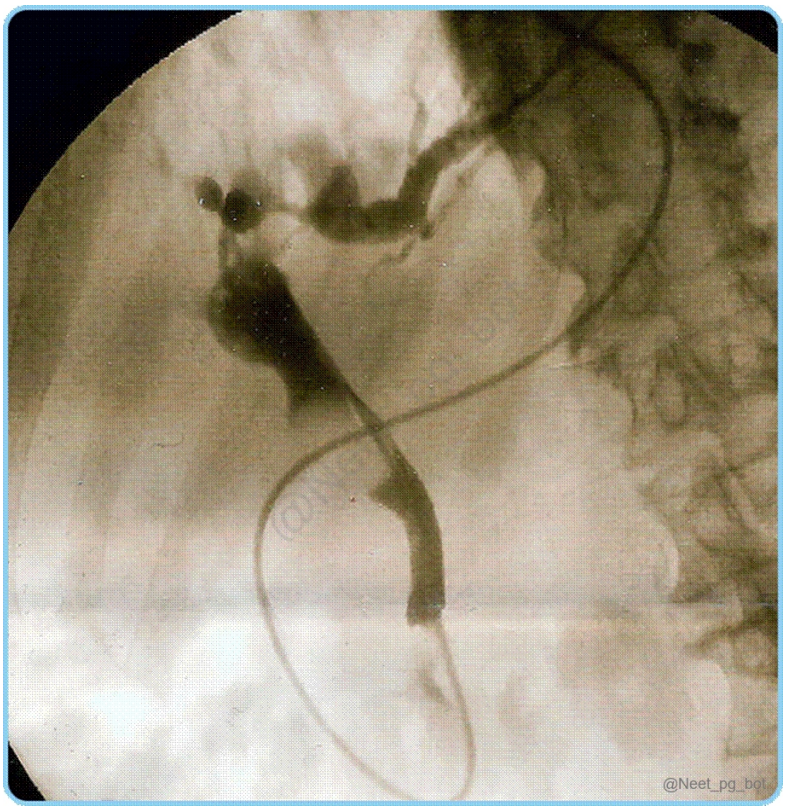
D. Recurrent

Correct Answer: D. Recurrent

Explanation: The given scenario, where a patient has a history of cholecystectomy (gallbladder removal) for gallstones 2.5 years ago and is now presenting with obstructive jaundice and a gallstone in the common bile duct (CBD), indicates a case of recurrent type of Common Bile Duct Stones (Choledocholithiasis) . Types Retained common bile duct stones Detected within 2 years of cholecystectomy Recurrent common bile duct stones Detected after 2 years of cholecystectomy (Option D) Clinical features Charcot's triad : Pain + Fever + Jaundice Reynauld's pentad: Mental status changes + Hypotension + Charcot's triad Biliary colic: A sudden, severe, colicky pain in the right upper quadrant that radiates to the back and shoulder, precipitated by a fatty or heavy meal, and can last for a few hours. Darkening of the urine and lightening of the stools. Steatorrhea, or fatty stools Pruritus (itching), loss of appetite, weight loss, nausea, and vomiting Investigation Ultrasound: Useful for detecting gallstones and CBD dilation but has limited sensitivity for CBD stones. {{caption_text}} MRCP: Non-invasive, excellent for visualising biliary tree anatomy and pathology. ERCP: Highly sensitive, both diagnostic and therapeutic for CBD stones. PTC: Used when ERCP is not feasible, such as post-gastrectomy patients or unsuccessful ERCP attempts. EUS: Invasive but accurate for diagnosing choledocholithiasis. Blood Tests: ↑ bilirubin, ↑alkaline phosphatase, and ↑white blood cell count indicate choledocholithiasis and possible complications like cholangitis. Treatment Endoscopic Management: ERCP with sphincterotomy and stone extraction; stenting if necessary. Percutaneous Removal: Used when endoscopic access is difficult. Surgery: Options include laparoscopic and open choledocholithotomy, choledochoduodenostomy, and choledochojejunostomy. Complications Cholangitis Pancreatitis Liver Damage Biliary Stricture Gallstone Ileus {{caption_text}} MRCP of CBD stone {{caption_text}} ERCP of a distal CBD stone Primary (Option A) forms inside the common bile duct (CBD), with brownstones being the most common type. These stones are often associated with underlying conditions such as primary sclerosing cholangitis or Caroli disease. Secondary (Option B) are those that form in the gallbladder and later migrate into the common bile duct (CBD). The most common type is cholesterol stones, which can subsequently move into the CBD. Tertiary (Option C) are formed within the bile ducts as a result of bacterial or parasitic infection.


Duodenum
Left liver lobe
Dilated CBD
Gall bladder
Pancreas
CBD stone
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References:

Bailey and Love's Short Practice of Surgery, 28th Edition, Page 1253.

Sabiston Textbook of Surgery, 21st edition, Page 1500.

SRB's Manual of Surgery, 6th Edition, Page 642,643.

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Q6: What should be the subsequent course of action in the management of a female patient who experienced abdominal pain and increased heart rate three days after cholecystectomy? Her white blood cell count is 11000 cells / mm^3, and an ultrasound examination revealed a 5x5 cm accumulation of fluid in the sub-hepatic space on the right side. (Q856532)

A. Antibiotics and send home

B. USG-guided pigtail catheter drainage

C. Laparoscopy and re-exploration

D. ERCP and T-tube placement

Correct Answer: B. USG-guided pigtail catheter drainage

Explanation: The next step in managing a woman who presented with abdominal pain and tachycardia, with a fluid collection in the right sub-hepatic space seen on ultrasound, is USG-guided pigtail catheter drainage as this is a case of bile duct injury following cholecystectomy. Ultrasound-guided pigtail catheter drainage offers several advantages, including improved accuracy in locating the fluid collection and minimizing the risk of complications. Antibiotics and send home (Option A) The presence of a fluid collection and symptoms suggestive of postoperative complications necessitates intervention rather than sending the patient home with antibiotics alone. Laparoscopy and re-exploration (Option C) are not the first-line management options for a fluid collection in the subhepatic space. Less invasive measures like drainage should be attempted first. ERCP and T-tube placement (Option D) are indicated in biliary tract-related issues, which may not be the primary cause of the fluid collection in this scenario.

References:

Bailey & Love's Short Practice of Surgery (28th Edition) page 1252

↑ *Back to this question in Part A*

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Q7: A 16-year-old female with recurrent jaundice and abdominal pain is found to have a fusiform cystic dilatation of the common bile duct on ultrasound. Which investigation is best to fully delineate the biliary anatomy and confirm the diagnosis before surgery? (Q858369)

A. Magnetic Resonance Cholangiopancreatography

B. Endoscopic ultrasound

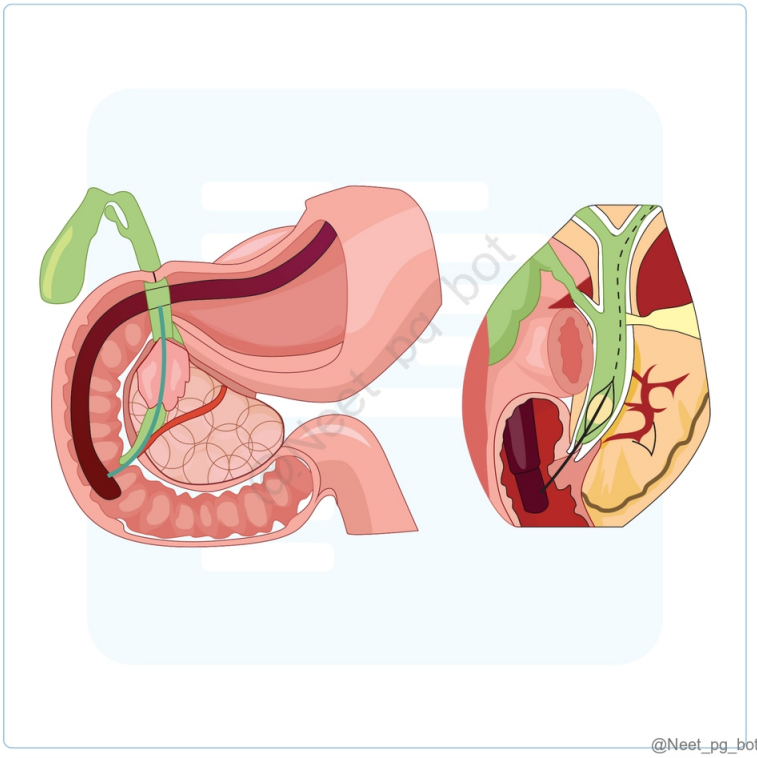
C. Percutaneous transhepatic cholangiography

D. Endoscopic retrograde cholangiopancreatography

Correct Answer: A. Magnetic Resonance Cholangiopancreatography

Explanation: Magnetic Resonance Cholangiopancreatography (MRCP) is: A non-invasive imaging modality. Excellent for visualising the biliary tree and pancreatic ducts . Particularly useful in obstructive jaundice to evaluate: Site of obstruction Cause (e.g., stones, strictures, tumours) Extent of biliary dilatation It does not require contrast injection into the ducts and has no risk of pancreatitis or infection , unlike ERCP. {{caption_text}} INVESTIGATIONS Endoscopic Ultrasound (Option B ruled out) The first imaging test that is performed. Confirms the presence of the cyst. Reveals anatomical details, including bile duct and pancreatic duct relationship. Magnetic Resonance Cholangiopancreatography (MRCP) Non-invasive imaging technique. Provides detailed

images of the gallbladder and biliary system. Highly sensitive (>90%) and specific (>99%) for identifying common bile duct stones. Visualizes biliary anatomy and the extent of dilatation. Endoscopic Retrograde Cholangiopancreatography (ERCP): (Option D ruled out) Invasive procedure with endoscope and contrast material. Diagnostic and therapeutic capabilities (tissue sampling, decompression, treatment of choledocholithiasis). Effective but has a complication rate of up to 10%. Percutaneous Transhepatic Cholangiography (PTC) Invasive procedure with a needle directly into the liver. Useful for intrahepatic biliary disease or when ERCP is not feasible. (Option C ruled out) Helps delineate surgical anatomy and enables drainage catheter and stent placement. CT SCAN Mainly to see the intrahepatic biliary system Other Tests Hepatobiliary nuclide Scanning Liver Function Tests



References:

Bailey and Love's Short Practice of Surgery, 28th Edition, Page 1242, 1236-1238

Sabiston Textbook of Surgery, 21st Edition, Page 1501, 1505

SRB's Manual of Surgery, 6th Edition, Page 629

↑ *Back to this question in Part A*

@Neet_pg_bot

Q8: Which of the following statements about hepatocellular carcinoma (HCC) is/are correct? 1. TACE(Transarterial chemoembolization) is used for multinodular lesions

2. Lenvatinib is used for lesions less than 3 cm 3. The incidence of HCC is increasing 4. NASH and NAFLD are risk factors for HCC (Q858368)

A. 1, 2, 3

B. 2, 3, 4

C. 1, 3, 4

D. 1 and 2

Correct Answer: C. 1, 3, 4

Explanation: of Statements Statement True/False

References:

Bailey and Love's Short Practice of Surgery, 28th Edition, Page 1208, 1215
https://journals.lww.com/hep/fulltext/2018/01000/aasld_guidelines_for_the_treatment_of.32.aspx

↑ *Back to this question in Part A*

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Q9: A 40 year old woman presented with jaundice, fever, and abdominal pain. She is suspected to have cholangitis. Which of the following apart from abdominal pain makes up Reynold pentad? 1. Fever 2. Jaundice 3. Hypotension 4. Altered sensorium 5. Hematemesis 6. Melena (Q858359)

A. 1, 2, 3, 4

B. 2, 3, 4, 5

C. 1, 3, 4, 5

D. 1, 2, 4, 5

Correct Answer: A. 1, 2, 3, 4

Explanation: Reynold's Pentad is seen in severe (suppurative) cholangitis , which includes: 1. Fever with chills 2. Jaundice 3. Hypotension (Shock) 4. Altered mental status (Confusion, delirium) 5. Right upper quadrant (RUQ) pain Cholangitis Aetiology Often due to obstruction in the biliary tree, leading to bacterial infection by organisms like Klebsiella, E. coli, Enterobacter, Pseudomonas, and Citrobacter species. Symptoms Charcot's triad - pain, jaundice, fever Additional tenderness in the epigastrium and right hypochondrium is common. Severe Form: Reynolds pentad - persistent pain, fever, jaundice, shock, and altered mental status Indicates acute obstructive

suppurative cholangitis. Lab Findings Elevated white blood cell count, bilirubin, and alkaline phosphatase levels. Chronic cases may show lobar or segmental atrophy or hypertrophy. Recurrent Pyogenic Cholangitis More common in East Asian populations, caused by intrahepatic stones and infections Risk factors include parasitic infections like Clonorchis sinensis and Ascaris lumbricoides. 2, 3, 4, 5 (Option B) Includes hematemesis , which is NOT a feature of Reynold's Pentad. 1, 3, 4, 5 (Option C) Misses jaundice and includes hematemesis , which is NOT a feature of Reynold's Pentad 1, 2, 4, 5) (Option D) Includes hematemesis , which is unrelated to cholangitis. I

References:

Bailey and Love's Short Practice of Surgery, 28th Edition, Page 1253

Sabiston Textbook of Surgery, 21st Edition, Page 1515

SRB's Manual of Surgery, 6th Edition, Page 643

↑ *Back to this question in Part A*

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Q10: What is the most appropriate next step in the management of a female patient who has abdominal pain, multiple gallstones with no thickening of the gallbladder wall as seen on ultrasound, a common bile duct diameter of 12mm, serum bilirubin level of 0.8, alkaline phosphatase level of 380, and a 5-fold increase in GGT? (Q858345)

A. MRCP

B. ERCP

C. Endoscopic ultrasound

D. Laparoscopic cholecystectomy

Correct Answer: A. MRCP

Explanation: The patient has multiple gallstones, and the CBD diameter is increased at 12mm, which suggests the possibility of choledocholithiasis (stones in the common bile duct). The elevated alkaline phosphatase and significantly raised GGT levels also indicate some degree of biliary obstruction. MRCP can accurately assess the CBD and help identify the presence, location, and size of any stones within the duct. It can also evaluate the pancreatic duct for any associated pathology. By obtaining this information, MRCP can guide further management decisions and determine the most appropriate intervention, whether it's endoscopic or surgical. ERCP (Endoscopic Retrograde Cholangiopancreatography) (Option B) ERCP can be therapeutic and used for stone removal, it is typically reserved for cases where there is a clear indication for intervention, such as symptomatic choledocholithiasis or evidence of biliary obstruction with significant symptoms or abnormal liver function tests. Endoscopic ultrasound (Option C) EUS can be useful for evaluating certain conditions, such as pancreatic tumours or staging of gastrointestinal malignancies, it is not the primary modality for assessing gallstones or the biliary

system. Laparoscopic cholecystectomy (Option D) in this case, the focus is primarily on the evaluation of the biliary system. Therefore, performing a cholecystectomy without further assessment and identification of possible choledocholithiasis would be premature.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1237- 1242

↑ *Back to this question in Part A*

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Q11: A patient presents with pain in the right upper quadrant on the second postoperative day following a cholecystectomy. Evaluation reveals a collection in the subhepatic space. A bile leak is suspected. What is the best next step in management? (Q856233)

A. MRCP

B. ERCP

C. HIDA

D. CECT

Correct Answer: B. ERCP

Explanation: In the context of a postoperative cholecystectomy patient where imaging has already confirmed a bile leak , the best next step in management is ERCP (Endoscopic Retrograde Cholangiopancreatography) . ERCP not only helps confirm and localise the leak but, more importantly, allows therapeutic intervention , such as placement of a biliary stent, which reduces intraductal pressure and promotes closure of the leak. Endoscopic Retrograde Cholangiopancreatography (ERCP) Definition It is an invasive diagnostic and therapeutic procedure used to examine and treat disorders of the bile ducts , pancreatic ducts , and gallbladder . Indications It allows for visual assessment of the duodenum and ampulla of Vater. Allows biopsies, stone extraction, and other Interventional procedures like sphincterotomy, biliary stenting, and biliary stricture dilation. In Jaundice Less suitable for jaundiced patients as it is invasive Imaging Type Provides dynamic information during contrast introduction Image {{caption_text}} MRCP (Option A) is a non-invasive imaging technique that can help visualise bile ducts, but it doesn't provide the same ability for therapeutic intervention as ERCP . HIDA (Option C) (Hepatobiliary Iminodiacetic Acid scan) is useful for evaluating biliary patency and assessing bile flow . Though it can be used for detecting bile flow abnormalities, it cannot be used for therapeutic management, hence ERCP is generally considered the best for diagnosing and managing bile leaks. CECT (Option D) can be used to detect collections or fluid accumulation and its evaluation but it lacks the therapeutic intervention that ERCP can offer. Additionally, CECT involves radiation exposure and may not be the optimal choice when a more specific investigation like ERCP is available.



References:

David Sutton Textbook of Radiology and Imaging, Volume 1, 8th Edition, Page 2596, 2597, 2603

↑ *Back to this question in Part A*

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Q12: A 36-year-old man presents with dull aching epigastric pain. He gives a history of acute abdominal pain following a binge of alcohol 5 weeks back, which was managed conservatively. On examination, he appeared icteric, and a firm mass was palpable in the epigastrium. His CT scan is given below. Which of the following is the most likely diagnosis? (Q857497)

A. Pancreatic pseudocyst

B. Large choledochal cyst

C. Gastric duplication cyst

D. Mesenteric cyst

Correct Answer: A. Pancreatic pseudocyst

Explanation: Pancreatic pseudocyst is a complication seen after 2 weeks of an acute pancreatitis attack. It is commonly seen in alcoholism. The cyst is usually located between the stomach and transverse colon, between the stomach and liver or Behind or below the transverse colon. Clinically a tense cystic mass in the epigastrium, umbilical region or left hypochondrium can be seen. Large choledochal cyst (Option B) Choledochal cyst is a congenital cyst and is not caused due to alcoholism. It is not seen as a tense mass in the epigastrium. Gastric duplication cyst (Option C) It is a congenital cyst and is not caused by alcoholism. It is seen usually in relation to the distal region of the greater curvature. There is no clinically evident tense mass near the epigastrium. Mesenteric cyst (Option D) This cyst is congenital

References:

https://www.ncbi.nlm.nih.gov/books/NBK557594/

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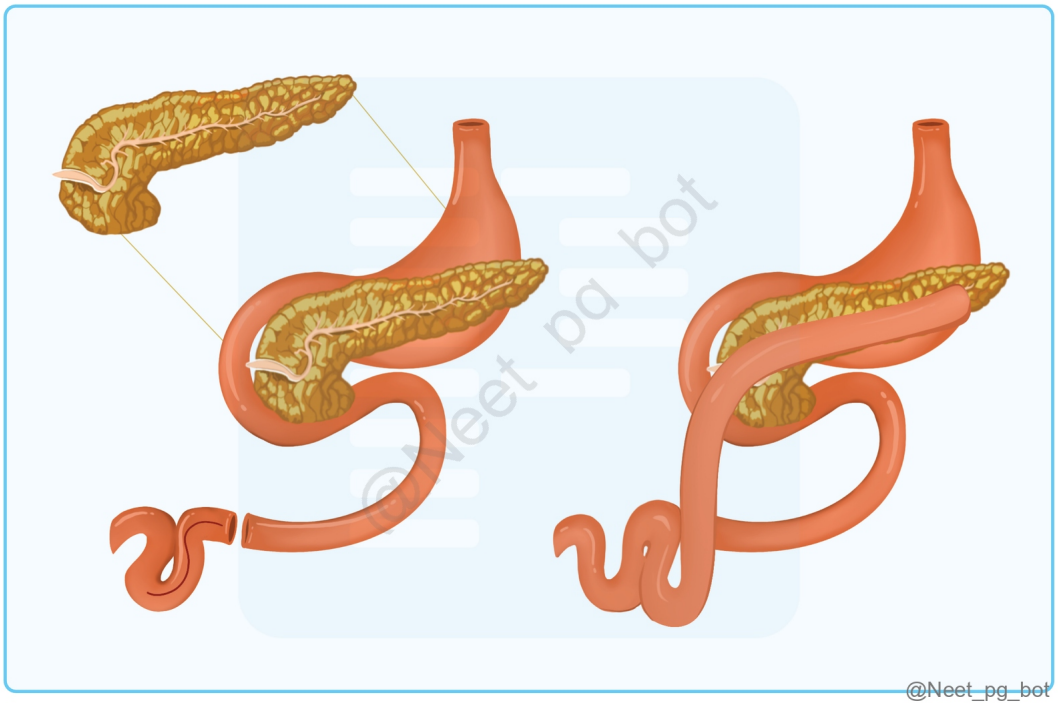
Q13: Identify the procedure shown in the image below. (Q857478)

A. Gastrojejunostomy

B. Pancreaticojejunostomy

C. Pancreatic Ileostomy

D. Duodenojejunostomy



Correct Answer: B. Pancreaticojejunostomy

Explanation: The procedure shown in the above image is pancreaticojejunostomy. Puestow's operation is indicated for diffuse chronic pancreatitis and dilated pancreatic duct. The duct is opened wide, strictures are cut open, stones are removed, and it is anastomosed to one of the loops of jejunum. This is a by-pass procedure. It preserves both endocrine and exocrine functions. Gastrojejunostomy (Option A) It is the anastomosis of the body of the stomach to the first loop of the jejunum, by passing the duodenum. This procedure does not include the pancreas. Pancreatic Ileostomy (Option C) is done in case of pancreatic duct obstruction, and the pancreas is anastomosed to the ileum. This procedure is not indicated in the image. Duodenojejunostomy (Option D) It is a procedure done to anastomose a part of the duodenum to the jejunum to bypass an obstruction in the duodenum. This procedure is not indicated in the image.

References:

https://www.researchgate.net/publication/318295858_Longitudinal_Pancreaticojejunostomy_Puestow_Procedure

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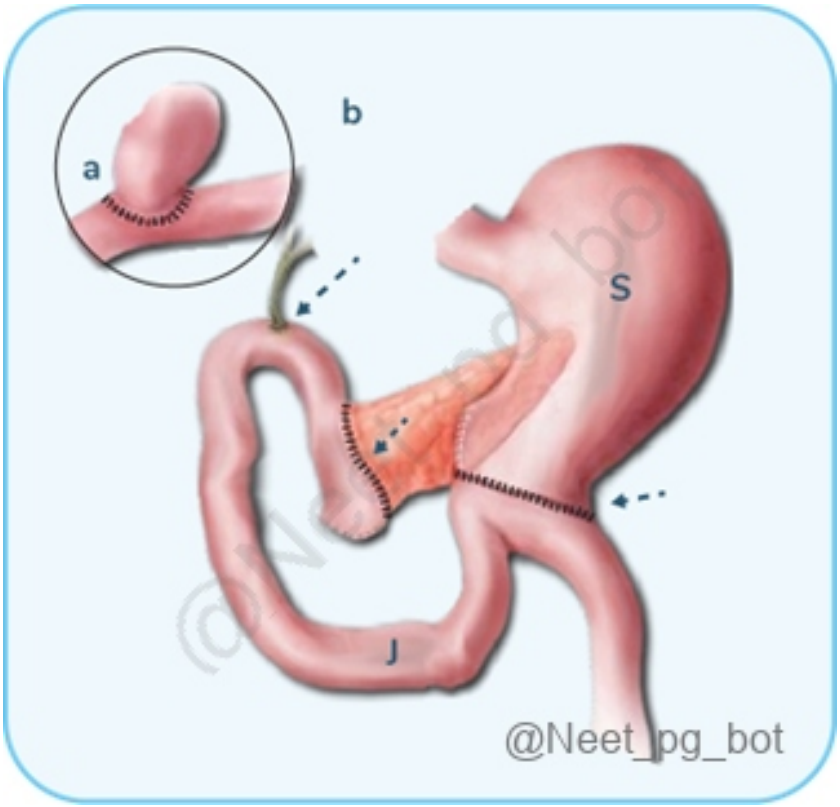
Q14: Identify the procedure shown in the image: (Q857473)

A. Beger’s procedure

B. Whipple’s procedure

C. Frey’s procedure

D. Pancreatic redivision



Correct Answer: B. Whipple’s procedure

Explanation: Correct answer B) Whipple’s procedure Explaantion: The procedure shown in the image is Whipple’s procedure or pancreaticoduodenectomy. It is the primary surgical treatment for pancreatic cancer. The head of the pancreas, most of the duodenum, a portion of the bile duct, the gallbladder, and associated lymph nodes are removed. Whipple's pancreaticoduodenectomy involves resecting the tumour along with the 'C' loop of duodenum up to DJ flexure, proximal jejunum, head of the pancreas up to the neck, and partial gastrectomy, followed by three anastomoses: Pancreaticojejunostomy, Hepaticojejunostomy and Gastrojejunostomy typically performed for a mobile growth without metastasis. Berger’s procedure (Option A) In Beger’s procedure all of the head of the pancreas is removed but the bile duct, stomach and duodenum are preserved. Frey’s procedure (Option C) This procedure includes head coring (a portion of the head of the pancreas is incised). The Duodenum is spared. Pancreatic division (Option D) The image shown indicates Pancreaticoduodenectomy and not pancreatic division.

References:

Sabiston’s Textbook of Surgery, 21st Edition, Page 1556-1559

Images:Image 1:https://commons.wikimedia.org/wiki/File:Diagram_showing_the_parts_removed_with_a_Whipple%27s_operation_CRUK_337.svgImage 2:https://commons.wikimedia.org/wiki/File:Illustration_of_Whipple_procedure.webp

Image 1:https://commons.wikimedia.org/wiki/File:Diagram_showing_the_parts_removed_with_a_Whipple%27s_operation_CRUK_337.svg

Image 2:https://commons.wikimedia.org/wiki/File:Illustration_of_Whipple_procedure.webp

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Q15: A 40-year-old man is brought to the casualty with severe abdominal pain radiating to the back for the past 1 day and has had 3 episodes of vomiting. The pain radiates to the back and is slightly relieved in the sitting forward position. The following signs are seen on examination and lab investigations reveal elevated lipase and amylase. Which of the following is the most likely diagnosis? (Q857470)

A. Acute appendicitis

B. Acute cholecystitis

C. Acute pancreatitis

D. Acute ischemic colitis



Correct Answer: C. Acute pancreatitis

Explanation: The image shows Cullen’s sign , which is superficial edema with bruising in the subcutaneous fatty tissue around the peri-umbilical region, as well as the Grey Turner sign, which is flank ecchymosis. These signs are indicative of acute pancreatitis . Acute pancreatitis is characterised by pain in the abdomen that radiates to the back and is relieved in the sitting forward position. Elevated lipase and amylase are seen in acute pancreatitis. Acute Appendicitis (Option A) Pain typically starts as periumbilical and later localizes to the right lower quadrant (RLQ) (McBurney’s point). No back radiation or elevated lipase/amylase . Acute Cholecystitis (Option B) presents with RUQ pain , Murphy’s sign (+) , and fever. No back radiation or lipase elevation unless complicated by gallstone pancreatitis. Acute Ischemic Colitis (Option D) presents sudden severe abdominal pain (out of proportion to clinical findings) , often in elderly patients with vascular disease . No elevated lipase/amylase or back radiation.

References:

Bailey and Love Short Practice of Surgery, 28th Edition, Pages 139, 140

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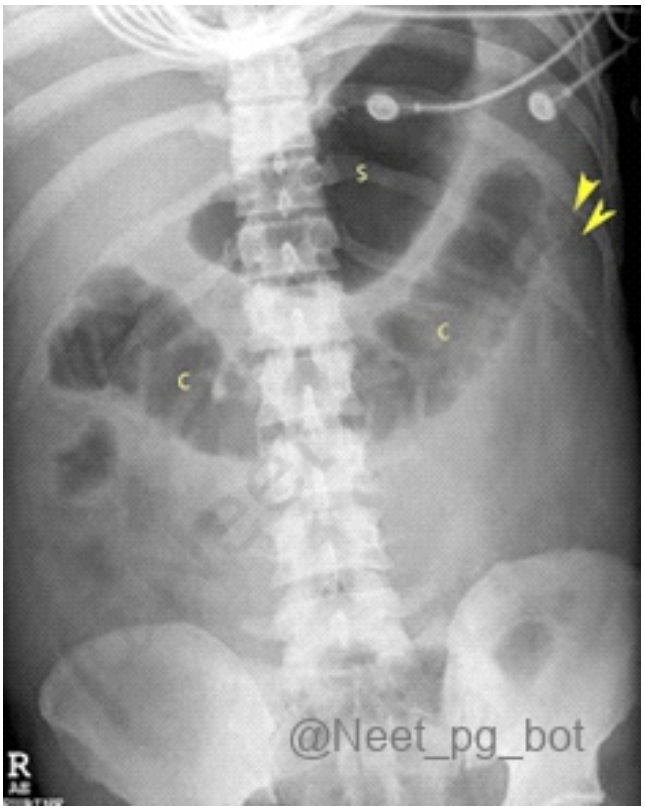
Q16: A young man presents to the emergency department with complaints of severe abdominal pain and 3 episodes of vomiting in the past 9 hours. He says that the pain radiates to the back and is partially relieved by bending forwards. The abdominal radiograph of the patient is given below which shows a ‘colon cut-off sign ’. What is the most likely diagnosis? (Q857194)

A. Acute hepatitis

B. Acute pancreatitis

C. Acute colitis

D. Intestinal obstruction



Correct Answer: B. Acute pancreatitis

Explanation: Acute Pancreatitis Feature Description Definition Acute inflammation of the pancreas due to premature enzyme activation , leads to autodigestion. Common Causes (Mnemonic: "I GET SMASHED") I diopathic, G allstones (most common), E thanol, T rauma, S teroids, M umps, A utoimmune, S corpion sting, H yperlipidemia/hypercalcemia, E RCP, D rugs (thiazides, azathioprine). Clinical Features Severe epigastric pain (radiates to back, worsens after food), nausea, vomiting, fever . Severe cases: Cullen's Sign (periumbilical bruising), Grey Turner's Sign (flank bruising), Colon Cutoff Sign (gas-filled, distended transverse colon with abrupt cut-off at splenic flexure due to inflammation). (Option B) Diagnosis (Atlanta Criteria) ≥2 of 3 criteria : (1) Lipase >3x ULN (more specific than amylase), (2) Epigastric pain , (3) Imaging (CT/USG/MRI) evidence . CT scan (best for complications), Ultrasound (detects gallstones). Severity Classification Mild: No organ failure, Moderate: <48 hrs organ failure, Severe: >48 hrs organ failure. Management IV Fluids (Ringer's lactate), NPO (Bowel Rest), Pain Control (IV opioids), and Enteral feeding are preferred over TPN. ERCP only if gallstone pancreatitis with cholangitis. No routine antibiotics unless infected necrosis. Complications Early (<1 week): SIRS, Shock, ARDS, Renal failure, DIC, Hypocalcemia. Late (>1 week): Necrosis (sterile/infected), Pseudocyst, Abscess, Chronic Pancreatitis, Biliary obstruction. Acute hepatitis (Option A) Symptoms of acute hepatitis are fever, fatigue, loss of appetite, nausea, vomiting, abdominal pain, dark urine, light-coloured stools, joint pain, and jaundice. Acute colitis (Option C) In colitis, the mucosal lining of the colon becomes acutely or chronically inflamed. Symptoms of patients with colitis include watery diarrhoea, abdominal pain, tenesmus, urgency, fever, subjective fatigue, or blood in the stool. Intestinal obstruction (Option D) Intestinal obstructions present with dilated bowel loops with multiple air-fluid levels on abdominal x-ray.

References:

Bailey and Love Short Practice of Surgery, 28th Edition, Pages 1270- 1273

↑ *Back to this question in Part A*

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Q17: Which of the following is the most common side effect of cholecystectomy? (Q857190)

A. Acute kidney injury

B. Osteoporosis

C. Steatorrhea

D. Colorectal cancer

Correct Answer: C. Steatorrhea

Explanation: Complications of Cholecystectomy Category Complication Description/Features Early (Intraoperative & Immediate Postoperative) Bile Duct Injury Accidental damage to the common bile duct (CBD) leads to bile leakage or strictures (More common in laparoscopic cholecystectomy). Hemorrhage Bleeding from the cystic artery or liver bed; managed with hemostasis or blood transfusion if severe. Bowel Injury Unintended injury to the duodenum or colon , is rare but serious. Anesthesia-related Complications Aspiration, respiratory depression, hypotension , and arrhythmias. Early Postoperative (0–7 Days) Infection (Wound/Port-Site Abscess) Fever, erythema, tenderness at the incision site. More common in diabetics or immunocompromised patients. Bile Leak (Biloma) Fever, abdominal pain, nausea , and localized fluid collection on imaging. Often from cystic duct stump or accessory bile duct injury . Subhepatic Collection (Abscess) Fever, RUQ pain, and tachycardia ; requires percutaneous drainage . Retained Gallstones Residual gallstones in the bile duct can cause biliary colic or cholangitis postoperatively. Deep Vein Thrombosis (DVT) & Pulmonary Embolism (PE) Due to prolonged immobilization , leading to leg swelling or sudden dyspnea (Prevent with early ambulation, anticoagulation). Late Postoperative (>7 Days – Months/Years) Steatorrhea (Fatty Stools) (Option C) Most common long-term issue due to continuous bile secretion , leading to fat malabsorption . Post-Cholecystectomy Syndrome (PCS) Persistent dyspepsia, bloating, diarrhea, or RUQ pain due to bile reflux or remnant stones. Biliary Strictures Chronic narrowing of the CBD , leading to jaundice and cholangitis . Chronic Diarrhea Related to altered bile acid metabolism , may require bile acid sequestrants (e.g., cholestyramine). Increased Risk of Colorectal Cancer (Debatable) Some studies suggest a mild increase in colon cancer risk due to altered bile acid metabolism , but evidence is weak . Acute Kidney Injury (AKI) (Option A) Not a common direct complication of cholecystectomy; it could occur due to severe infection or intraoperative hypotension, but it is rare. Osteoporosis (Option B) No direct link; chronic fat malabsorption (as in severe bile acid diarrhoea) can lead to vitamin D deficiency, but this is uncommon in routine cholecystectomy cases. Colorectal Cancer (Option D) Some studies suggest a mild increase in colon cancer risk due to altered bile acid metabolism, but it is not a direct or common consequence of cholecystectomy.

References:

Bailey and Love Short Practice of Surgery, 28th Edition, Pages 1251, 1254

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Q18: What would be your approach in managing a patient who is a 40-year-old woman with a 5 mm gallbladder polyp detected on abdominal ultrasound, but no gallbladder stones? The patient is overall healthy and shows no symptoms. (Q857186)

A. Regular follow-up every 2 months

B. Polypectomy

C. Laparoscopic cholecystectomy

D. Open cholecystectomy

Correct Answer: A. Regular follow-up every 2 months

Explanation: Management Approach for Gallbladder Polyps Polyp Size Management <6 mm Regular follow-up (USG every 6–12 months for 2 years) 6–9 mm Follow-up every 3–6 months , consider cholecystectomy if growth or risk factors ≥10 mm Laparoscopic cholecystectomy (higher malignancy risk) Any size + symptoms or high-risk features Laparoscopic cholecystectomy Polypectomy (Option B) Not feasible since the gallbladder lacks mucosal resection capability like the colon. Laparoscopic Cholecystectomy (Option C) Only indicated if: Polyp ≥10 mm Rapid growth (>2 mm/year) High-risk features (PSC, age >50, sessile polyp, associated gallstones) Open Cholecystectomy (Option D) Only needed if there’s suspicion of malignancy or difficult laparoscopic access .

References:

Bailey and Love Short Practice of Surgery, 28th Edition, Pages 1247, 1248.

↑ *Back to this question in Part A*

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Q19: A patient underwent laparoscopic cholecystectomy and was discharged after removing the drain tube on the first postoperative day. On day two, the patient came back to the hospital with complaints of increasing abdominal pain with tachycardia and was febrile on examination. On ultrasound examination, there was a 5 x 5 cm collection in the subhepatic space. What is the most likely cause of this condition? (Q857185)

A. Infection

B. Surgical site pain

C. Bile leak

D. Retained gallstones

Correct Answer: C. Bile leak

Explanation: The given findings are highly suggestive of a bile leak , which is one of the most common early complications of laparoscopic cholecystectomy , occurring when bile escapes from an injured cystic duct stump or accessory bile duct . Infection (Option A) Would take more time (5–7 days post-op) to develop and is less likely to cause localized fluid collection early . Surgical Site Pain (Option B) Would not cause fever, tachycardia, or fluid collection on imaging. Retained Gallstones (Option D) Can cause biliary colic or cholangitis , but does not usually present this early with localized fluid collection ; more common after weeks to months .

References:

Bailey and Love short practice of surgery, 28th Edition, Pages 1252, 1253

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Q20: What is the term for a stone obstructing the cystic duct, causing dilation of the common hepatic duct, resulting in CBD obstruction and jaundice? (Q859850)

A. Acute cholecystitis

B. Porcelain gallbladder

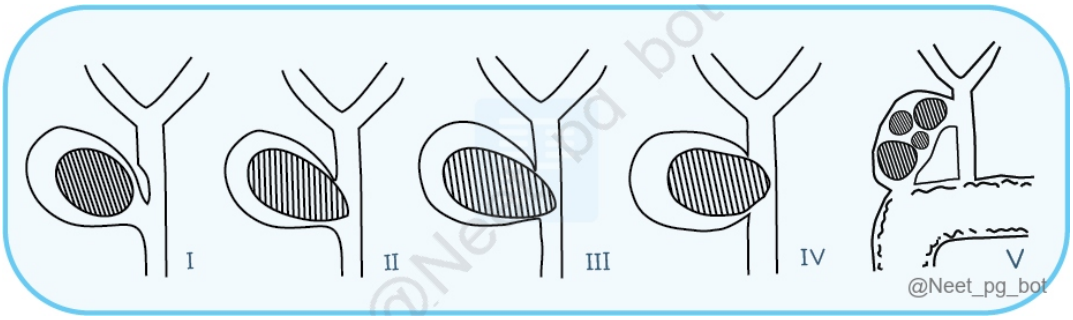
C. Cholesterolosis

D. Mirizzi’s syndrome

Correct Answer: D. Mirizzi’s syndrome

Explanation: The condition described in the question is known as Mirizzi’s syndrome . Mirizzi's syndrome is seen in 1% of all cholecystectomies, where a gallstone impacts the gallbladder wall, leading to compression and pressure necrosis. This often results in adherence to the common hepatic duct (CHD) or common bile duct (CBD) wall and can occasionally lead to a cholecystocholedochal fistula. It leads to biliary obstruction , which can result in jaundice and dilation of the bile ducts (CHD and CBD). Mirizzi’s syndrome Pathophysiology The gallstone usually impacts from the Hartmann's pouch, leading to compression of the CHD/CBD. Can also occur from the fundus of the gallbladder into the CBD. Clinical features Fever Abdominal pain Obstructive jaundice Upper abdominal tenderness on the right side Possible palpable soft, enlarged liver Csendes Classification Type I - Extrinsic compression of the CBD/CHD by a large impacted stone in Hartmann's pouch; IA- the presence of cystic duct IB- is obliterated cystic duct Type II - The stone has eroded the CBD/CHD less than 1/3rd of the

circumference of the CBD/CHD, forming a fistula Type III - Involving up to 2/3rd of the circumference of CBD/ CHD Type IV - Cholecystocholedochal fistula (>2/3rd) involving the entire circumference of the CBD/CHD Type V - Cholecystocholedochal fistula with cholecystoenteric fistula without gallstone ileus (VA) or with gallstone ileus (VB) {{caption_text}} Investigations Ultrasonography (USG): Initial imaging to assess gallbladder and ducts. CT Scan: Provides detailed imaging of the biliary system. ERCP/ MRCP: Essential for delineating duct anatomy and identifying the site of obstruction. HIDA Scan: Useful for functional assessment of the biliary system. Findings: Dilatation of the intrahepatic biliary system with a block at the common hepatic duct (CHD). Acute cholecystitis (Option A) is inflammation of the gallbladder, typically due to gallstone obstruction of the cystic duct. While this condition can cause pain and tenderness in the right upper quadrant , it does not commonly cause dilation of the common hepatic duct or jaundice unless there is a secondary obstruction of the CBD or cystic duct. Porcelain gallbladder (Option B) refers to calcification of the gallbladder wall, usually due to chronic cholecystitis . This condition is associated with an increased risk of gallbladder cancer but does not cause biliary obstruction or jaundice due to stone impaction in the cystic duct. Cholesterolosis (Option C), also called strawberry gallbladder, involves lipid deposits in the gallbladder mucosa, leading to a characteristic appearance on imaging. It is often asymptomatic and does not typically cause biliary obstruction or jaundice .



References:

SRB's Manual of Surgery, 6th Edition, Page 638.

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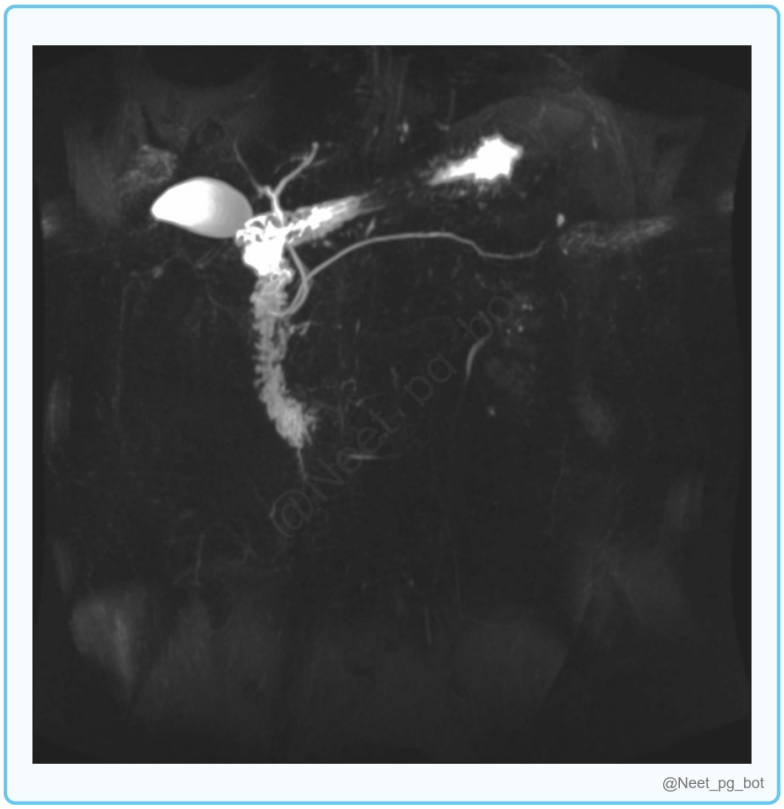
Q21: A 17-year-old boy presents with recurrent episodes of abdominal pain. Serum amylase and lipase are elevated on two occasions, but exocrine pancreatic function is normal. An MRCP image is shown below. Which of the following is the most likely diagnosis? (Q879143)

A. Annular pancreas

B. Chronic pancreatitis

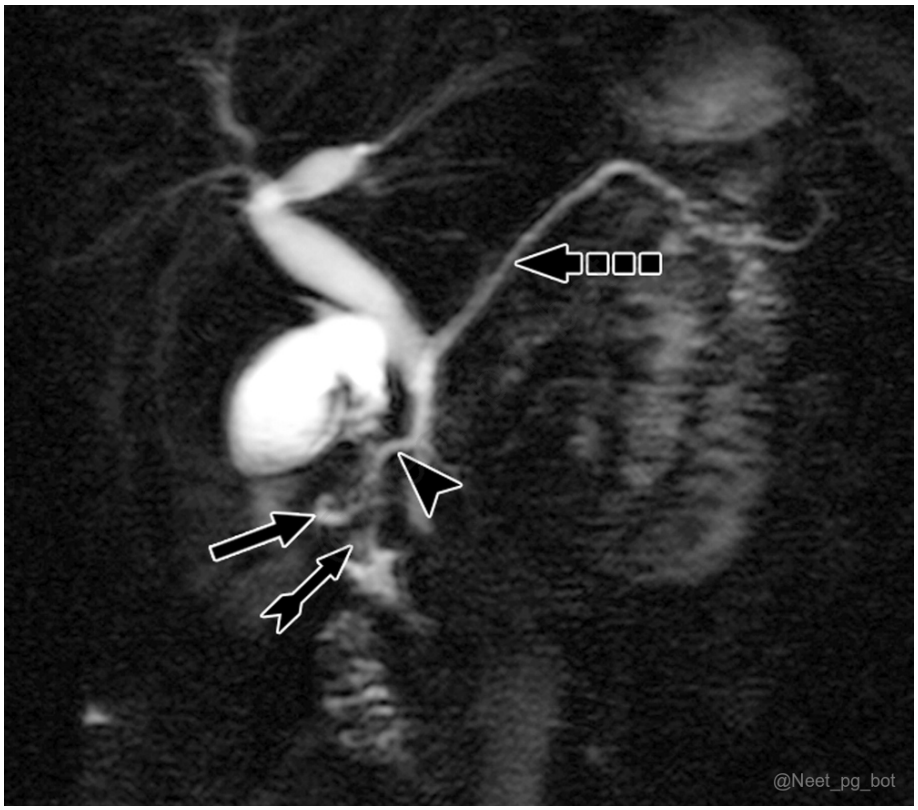
C. Pancreas divisum

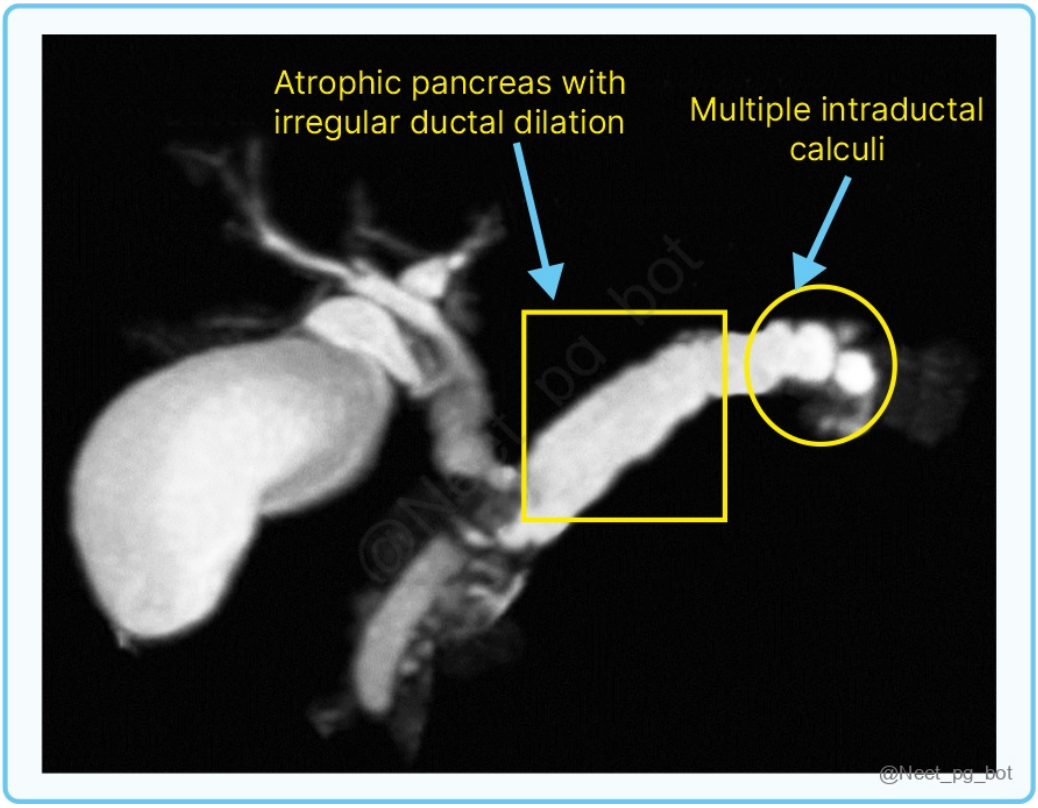
D. Choledochal cyst

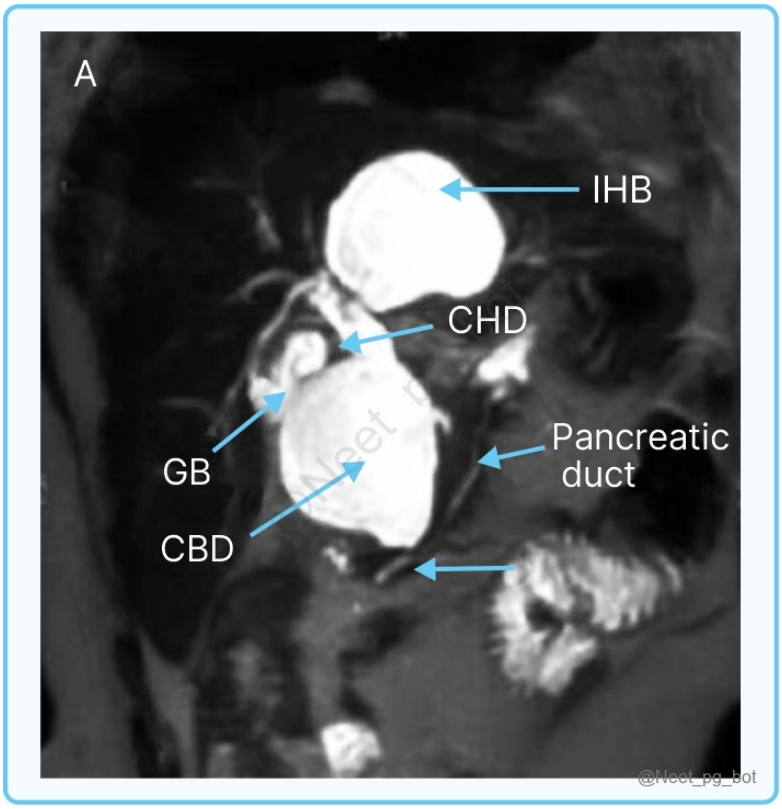


Correct Answer: C. Pancreas divisum

Explanation: The patient has recurrent episodes of acute pancreatitis (elevated amylase & lipase on multiple occasions) with normal exocrine pancreatic function, meaning the pancreas is not chronically damaged, which rules out chronic pancreatitis. On MRCP, the presence of two distinct pancreatic ducts, dorsal and ventral, without any junction between them, is characteristic of pancreatic divisum, a congenital anomaly resulting from the failure of these ducts to fuse during embryologic development, which presents as recurrent episodes of acute pancreatitis with elevated amylase/lipase, normal fecal elastase (normal exocrine function) in adolescents or young adults. Annular pancreas (Option A): It presents as duodenal obstruction and shows a ring of pancreatic tissue around the duodenum on MRCP. MRCP shows an annular duct (solid arrow) joining the duct of Santorini (arrowhead). The main pancreatic duct (dashed arrow) does not have a stricture. The duodenal lumen (winged arrow) is narrow. Chronic pancreatitis (Option B): Presents as abnormal exocrine function , ductal irregularity, or calcifications presenting as “chain of lakes” on MRCP. Choledochal cyst (Option D): A bile duct dilation, presenting with jaundice/cholangitis, appearing on MRCP as T2-bright (hyperintense) fluid-filled structures demonstrating cystic dilatation of bile ducts. Type IV-A choledochal cyst with anomalous pancreaticobiliary duct junction (blue arrow)


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Atrophic pancreas with irregular ductal dilation
Multiple intraductal calculi
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References:

Identification and Management of Pancreas Divisum - PMC

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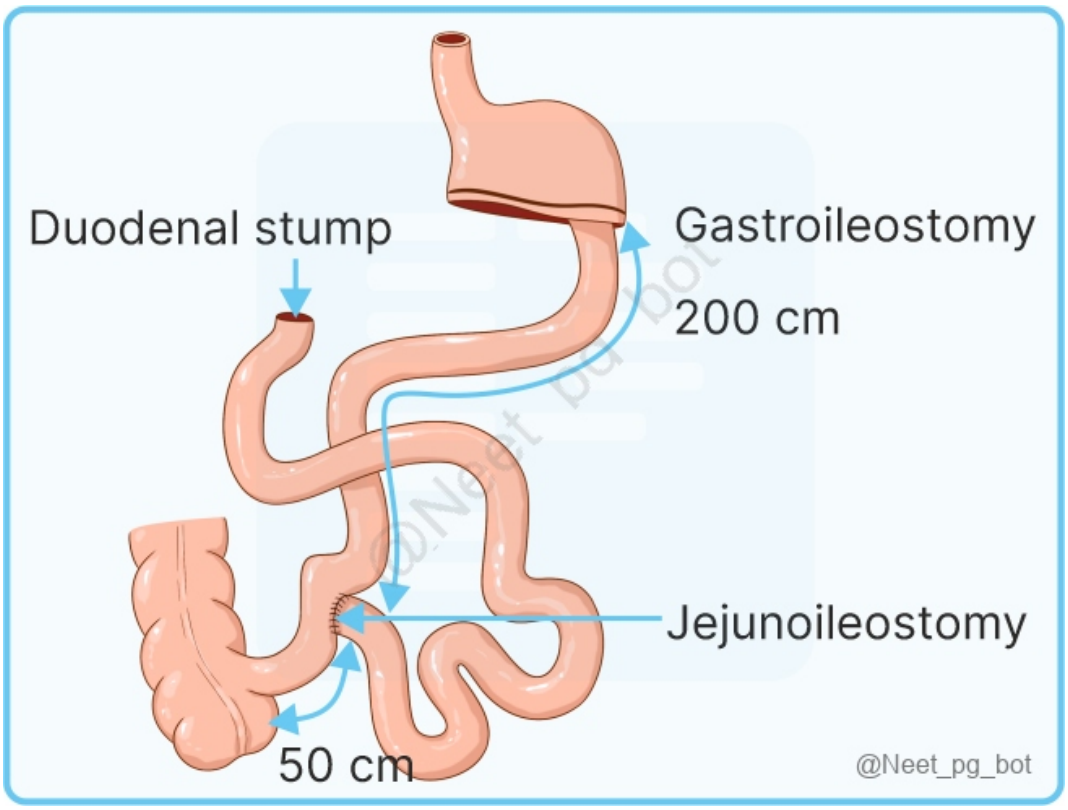
Q22: Identify the procedure: (Q879138)

A. Biliopancreatic diversion

B. Roux -en Y procedure

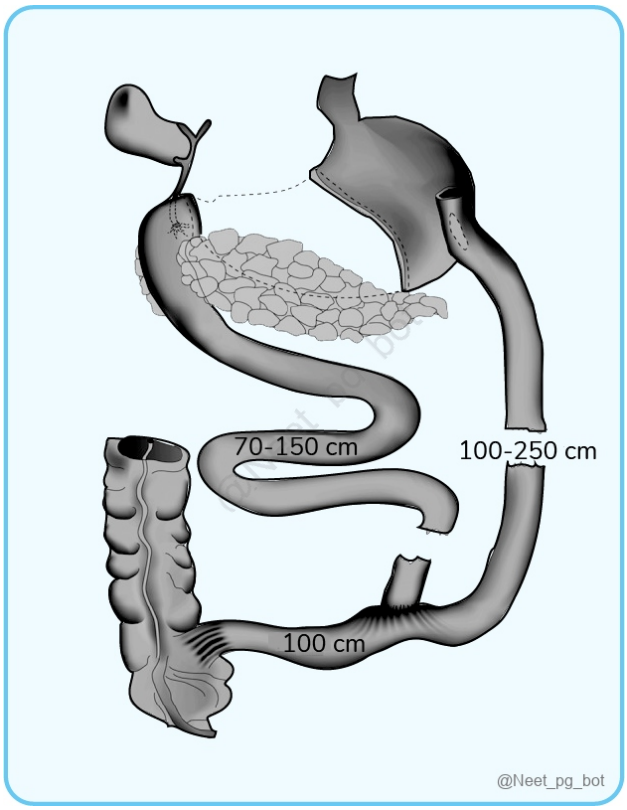
C. Sleeve gastrectomy

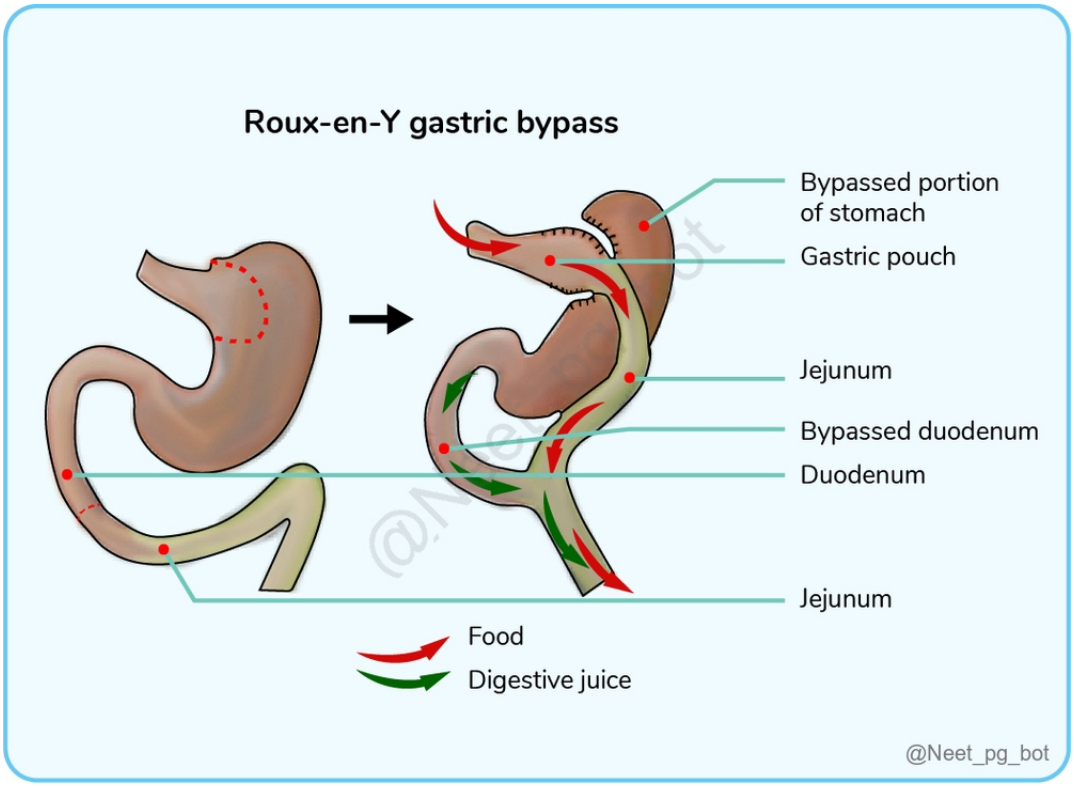
D. Duodenal switch



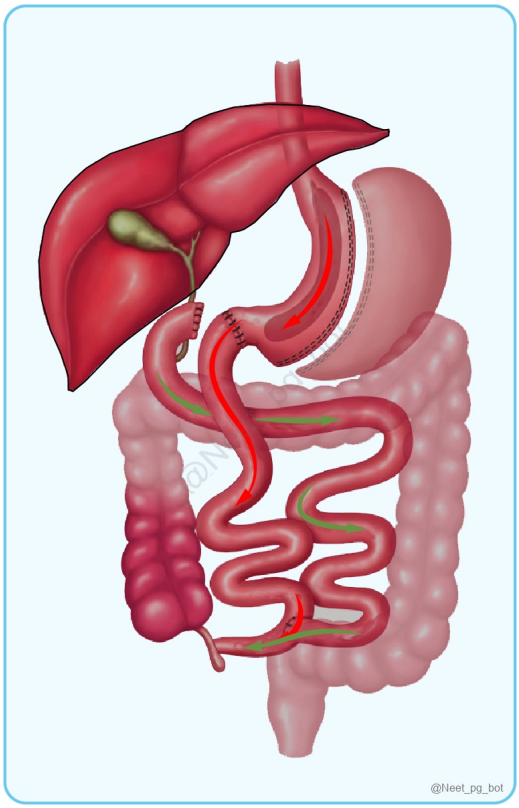
Correct Answer: A. Biliopancreatic diversion

Explanation: Correct Option A - Biliopancreatic diversion: The image shows Biliopancreatic Diversion (BPD). A partial gastrectomy with gastroileostomy A very long Roux limb (~200 cm) A short common channel (~50 cm) A distal jejunoileostomy A disconnected duodenum (duodenal stump) ■Incorrect Options: Roux-en-Y procedure (Option B): Has a short Roux limb and does not have a short 50 cm common channel. Sleeve gastrectomy (Option C): No intestinal bypass at all; only tubular stomach resection. ■■■■■■■ Duodenal switch■ (Option D): Almost the entire stomach is resected except a narrow lesser curvature, the duodenum is divided, and its end is anastomosed to the distal 250 cm of ileum. Classic BPD differs because the duodenum is not preserved or connected to the ileum.


70-150 cm
100-250 cm
100 cm
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Roux-en-Y gastric bypass
Bypassed portion of stomach
Gastric pouch
Jejunum
Bypassed duodenum
Duodenum
Jejunum
Food
Digestive juice
@Neet_pg_bot





References:

Schwartz Principles of Surgery, 11th Edition, Pages 1189,1190.

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Q23: TIGARO classification is used for? (Q879133)

A. Acute pancreatitis

B. Chronic pancreatitis

C. Acute cholecystitis

D. Pancreatic cancer

Correct Answer: B. Chronic pancreatitis

Explanation: Correct Option B - Chronic pancreatitis: TIGAR-O classification is used to identify etiologies (risk factors) of chronic pancreatitis . TIGAR-O Classification of Chronic Pancreatitis Etiology T T oxic-metabolic I I diopathic G G enetic A A utoimmune R R ecurrent & severe acute pancreatitis O O bstructive

References:

Pancreatitis: TIGAR-O Version 2 Risk/Etiology Checklist With Topic Reviews, Updates, and Use Primers

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Q24: A patient has undergone a laparoscopic cholecystectomy. A drain was inserted because of a difficult gallbladder dissection. Day 7 drain output is 300 ml. The patient is afebrile, and MRCP shows cystic duct stump leak. What is the next best management? (Q879124)

A. ERCP with or without a stent

B. USG-guided pigtail catheter insertion

C. Re – do laparoscopic ligation of the bile stump

D. Follow up as it will heal on its own

Correct Answer: A. ERCP with or without a stent

Explanation: Correct Option A - ERCP with or without a stent: The patient is stable, afebrile , and the leak is confirmed → Endoscopic management is first-line . A post-cholecystectomy bile leak from the cystic duct stump is best managed by ERCP with sphincterotomy and/or biliary stent placement . This reduces intraductal pressure and allows the leak to seal. Bile Duct Injuries Diagnosis USG: Collections, CBD dilatation. CT: Collections, obstruction, vascular injury. MRCP (gold standard): Defines level/type of injury. HIDA: Confirms leak/obstruction. ERCP: Diagnostic + therapeutic (stent for cystic duct stump leak). Management Stabilize + drain collections. ERCP stenting = first choice for cystic duct leaks/early strictures. Percutaneous drainage if unstable/debilitated. Definitive surgery: Roux-en-Y hepaticojejunostomy for benign strictures or duct transection. Incorrect Options: USG-guided pigtail catheter insertion (Option B): This is used for biloma or localized collection , but here the drain output is already externalized and MRCP shows stump leak, so definitive ductal management is needed. Re-do laparoscopic ligation of cystic stump (Option C): Re-exploration is reserved for major duct injuries, uncontrolled sepsis, or failed ERCP. Not required in a classic cystic duct stump leak. Follow-up and expectant management (Option D): Persistent leak (>50–100 mL/day after 48 hours) requires intervention. It will not reliably close on its own.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1252

↑ *Back to this question in Part A*

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Q25: Arrange the following steps of surgery in order: A. Creating pneumoperitoneum B. Dissection of hepatocystic triangle C. Ligation of cystic duct and artery D. Separation of the gallbladder from the liver bed (Q879106)

A. A-B-C-D

B. A-C-B-D

C. B-A-C-D

D. D-A-B-C

Correct Answer: A. A-B-C-D

Explanation: Correct Option A - A-B-C-D: The standard sequence for laparoscopic cholecystectomy is: A – Creating pneumoperitoneum B – Dissection of hepatocystic triangle (Calot’s triangle) C – Ligation of cystic duct and artery D – Separation of the gallbladder from the liver bed

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1250

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Q26: On day 3 after laparoscopic cholecystectomy, a stable patient develops worsening RUQ pain and low-grade fever. Imaging shows a 6-cm biloma and a small cystic duct stump leak. Symptoms persist despite antibiotics and observation. What is the next best step in management? (Q879097)

A. Observation

B. IV antibiotics

C. Image-guided pigtail drainage

D. ERCP with stenting

Correct Answer: C. Image-guided pigtail drainage

Explanation: Correct Option C - Image-guided pigtail drainage: The best next step for a stable patient with a symptomatic 6-cm biloma due to a small cystic duct stump leak is image-guided pigtail drainage , followed by ERCP with stenting if required. The biloma is large and symptomatic, with increasing pain and low-grade fever → indicating inflammation or early infection (6-cm collection will not resolve with observation or antibiotics alone). (Option A, B ruled out) Percutaneous drainage under USG/CT guidance: The standard first step to relieve symptoms, control infection risk, and prevent bile peritonitis. (Option C) After drainage, ERCP with biliary stenting lowers ductal pressure, diverts bile into the duodenum, and more effectively promotes closure of the small cystic duct stump leak than sphincterotomy alone. (Option D ruled out)

References:

Bailey & Love’s Short Practice of Surgery, 28th Edition, Page 1089.

↑ *Back to this question in Part A*

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Q27: What is the most frequently occurring location for an intraperitoneal abscess to develop? (Q855584)

A. Suprahepatic

B. Subhepatic

C. Left lobe of the liver

D. Left side below diaphragm

Correct Answer: B. Subhepatic

Explanation: The most common site for an intraperitoneal abscess to develop is the subhepatic area, typically located beneath the liver. This location is prone to abscess formation due to its proximity to the biliary system and gastrointestinal tract, where infections can easily spread. Most common site of intraperitoneal abscess: In recumbent or lying down position: Morrison pouch/subhepatic space In upright posture: Pelvis (Pouch of Douglas) MC site (Overall): Pelvis (Pouch of Douglas) Suprahepatic (Option A) refers to the area above the liver . While abscesses like subphrenic abscesses can occasionally form in this region, it is not the most common site for intraperitoneal abscesses. Left lobe of the liver (Option C) is not the most common location for general intraperitoneal abscess formation. Left side below the diaphragm (Option D) is not as commonly associated with intraperitoneal abscesses as the subhepatic space. The left side of the diaphragm area can have abscesses like subphrenic abscesses.

References:

Sabiston, Text Book of Surgery, 21st Edition, Page 229.

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Q28: A 70-year-old woman had her routine follow-up, and her USG is shown below. She is asymptomatic at present but has a history of mild right hypochondriac pain, which is relieved by taking analgesics. What is the most likely diagnosis? (Q859867)

A. Gallstones

B. Amoebic liver abscess

C. Hydatid cyst

D. Acute cholecystitis



Correct Answer: A. Gallstones

Explanation: The most likely diagnosis is Gallstones , based on the USG findings of a thickened gallbladder wall with biliary sludge, acoustic shadowing and the patient's history of mild right hypochondriac pain that responds to analgesics. Gallstones can sometimes be asymptomatic or present with mild right upper quadrant pain , which is relieved by analgesics. This suggests biliary colic rather than an acute infection. Biliary sludge, often seen on imaging, is a precursor to gallstones and can occur due to stagnation of bile in the gallbladder, often in the presence of gallstones. Amoebic liver abscess (Option B) presents with fever , right upper quadrant pain , and liver enlargement . It is often seen in patients with a history of amoebic dysentery (entamoeba histolytica infection). The USG would show a hypoechoic mass in the liver, which is not consistent with the findings in this case. {{caption_text}} Hydatid cyst (Option C) is caused by Echinococcus tapeworm infection and is usually found in the liver. The USG appearance of a hydatid cyst typically shows water-lily signs multilocular cysts, or honeycomb patterns, which is not seen here. Symptoms include abdominal pain, nausea, vomiting, and jaundice. {{caption_text}} Acute cholecystitis (Option D) presents with severe right upper quadrant pain , fever , and Murphy's sign (pain on palpation of the right upper quadrant). It generally presents more acutely and is associated with inflammation and infection , leading to more severe symptoms .





References:

Bailey and Love's Short Practice of Surgery, 28th Edition, Page 1244

SRB’s Manual of Surgery, 6th Edition, Pages 634, 636.

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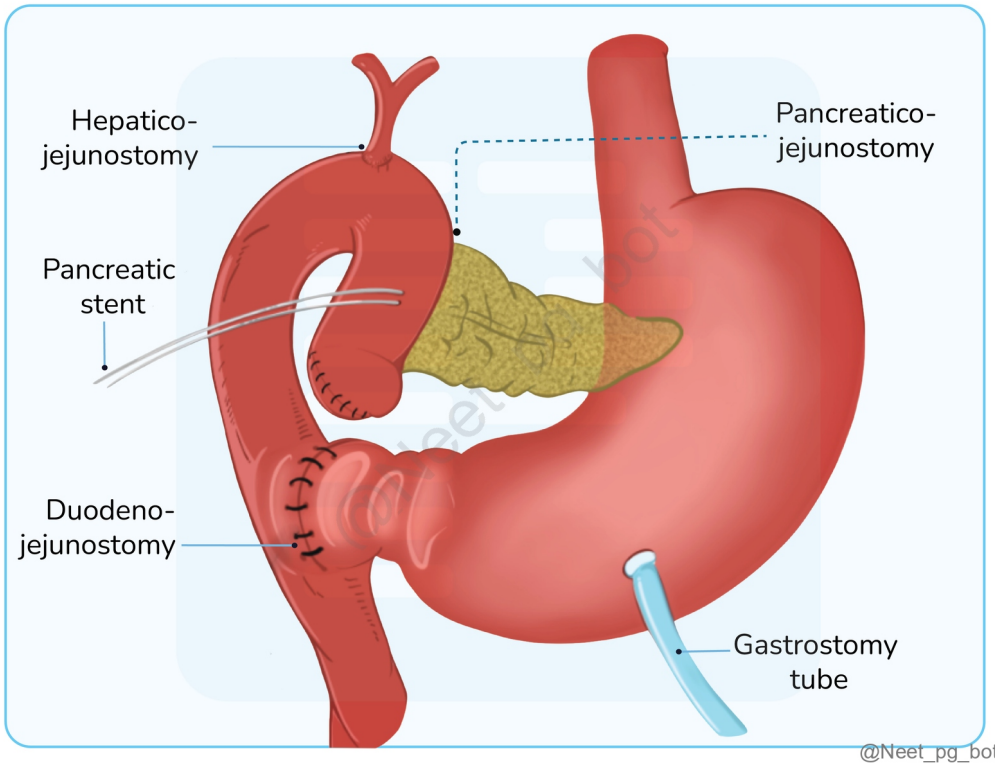
Q29: The following procedure is performed for the management of? (Q855692)

A. Advanced gastric carcinoma

B. Gallbladder carcinoma

C. Distal cholangiocarinoma

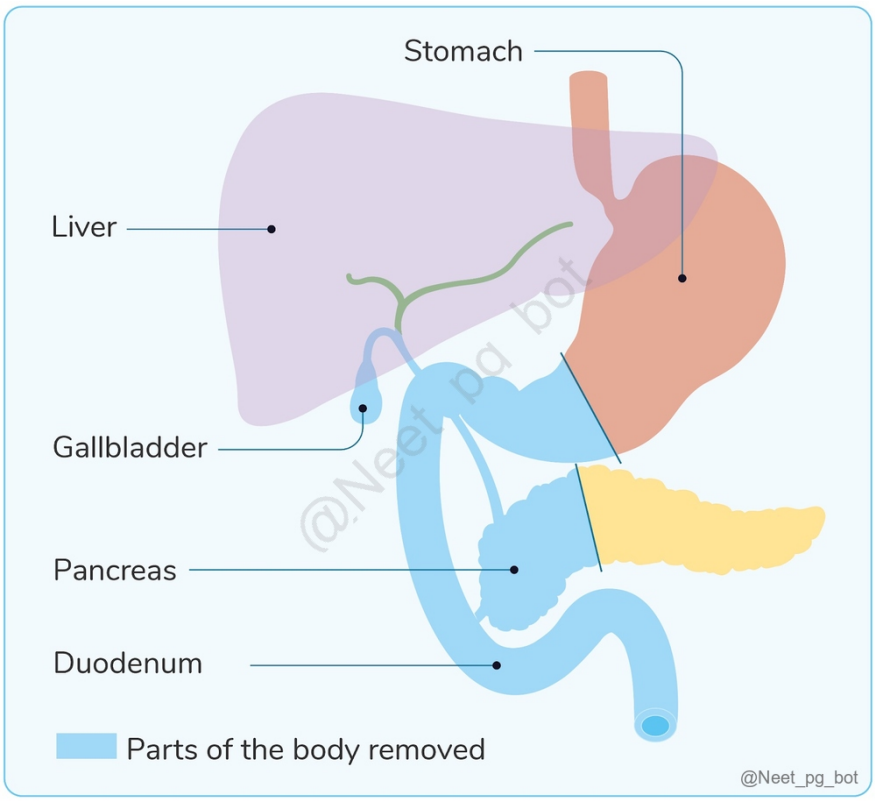
D. Chronic calcific pancreatitis

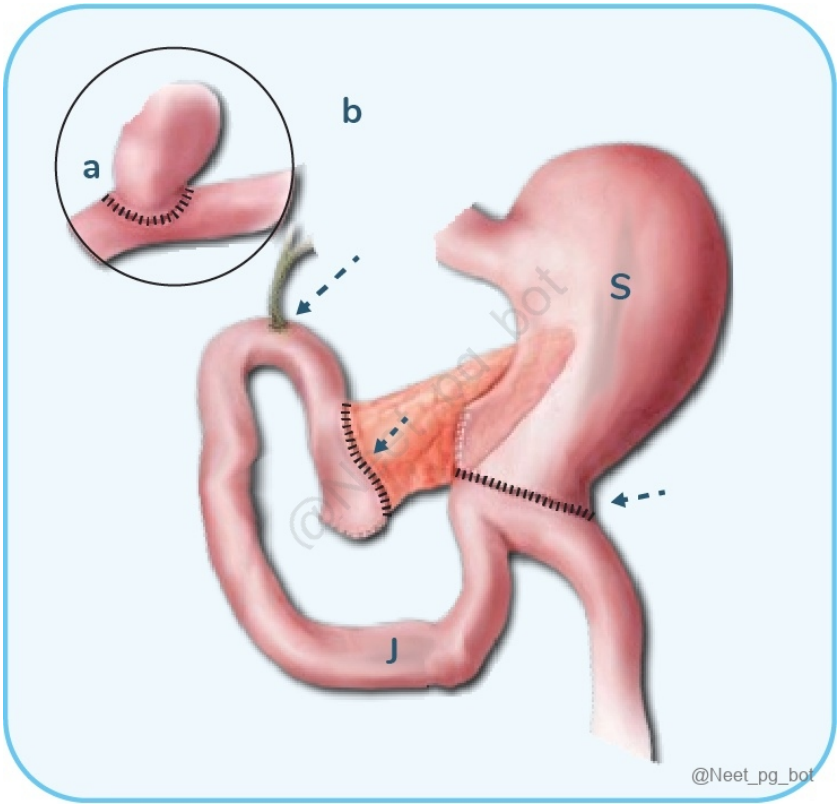


Correct Answer: C. Distal cholangiocarinoma

Explanation: The given image depicts the Pylorus Preserving Whipple’s Procedure (Pancreaticoduodenectomy) , which is used in the management of distal cholangiocarcinoma. Structures removed Head of the pancreas, the first part of the small intestine (duodenum), the gallbladder, and a portion of the bile duct. Types • Pylorus-Preserving Whipple Procedure • Non–Pylorus-Preserving Whipple Procedure Indications Pancreatic Cancer: Commonly treated with Whipple if cancer is localised to the head of the pancreas. Chronic Pancreatitis: when uncontrolled by medical management. Tumors in Pancreas/Surrounding Areas: Includes duodenum, distal bile duct (distal

cholangiocarcinoma), and ampulla of Vater. (Option C) Procedure Steps Tumor Assessment: Explore the abdomen to assess tumor size, location, and spread. Resection: Remove the head of the pancreas, duodenum, gallbladder, and part of the bile duct; this may include partial stomach resection. Lymph Node Dissection: Remove and examine nearby lymph nodes. {{caption_text}} Reconstruction Pancreaticojejunostomy: Connect the remaining pancreas to the jejunum. Hepaticojejunostomy: Connect common bile duct to the jejunum. Gastrojejunostomy: Connect stomach to jejunum. Anastomosis Principles Tension-Free Connection: Achieve mucosa-to-mucosa connection for healing. Order of Anastomoses: Pancreaticojejunostomy → Hepaticojejunostomy → Gastrojejunostomy Stent Placement: May use internal/external stents for small ducts. {{caption_text}} Complications • Pancreatic Fistula: Major issue; managed with somatostatin analogues. • Delayed Gastric Emptying • Bleeding, wound infection • Reoperation, increased mortality • Dumping/Bile Reflux: Common after non-pylorus-preserving Whipple, the pylorus-preserving method has uncertain benefits. Advanced gastric carcinoma (Option A): Treatment depends on tumour location. For proximal tumours, extended gastrectomy with D2 lymphadenectomy is done; for middle tumours, total gastrectomy; and for distal tumours, subtotal gastrectomy. The Whipple procedure is specific to pancreaticoduodenal cancers, not gastric carcinoma. Gallbladder carcinoma (Option B): Treatment involves an extended cholecystectomy, which includes removal of the liver segments, gallbladder, and surrounding lymph nodes. The Whipple procedure is not typically used unless the tumour invades the bile duct or pancreas. Chronic calcific pancreatitis (Option D): Treatment involves enzyme supplementation, pain management with NSAIDs and opioids, and procedures like ERCP with stenting or drainage. The Whipple procedure is not the first choice; instead, pancreaticojejunostomy or drainage surgeries are preferred based on the extent of the damage.





References:

Sabiston Textbook of Surgery, 21st Edition, Page 1556-1559.

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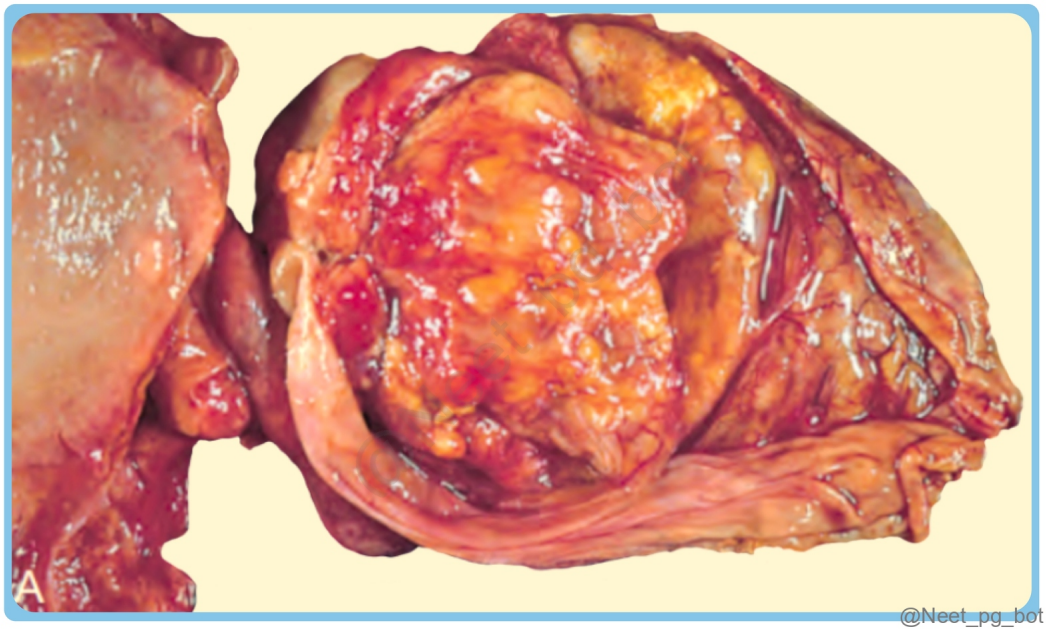
Q30: A patient underwent a laparoscopic cholecystectomy for cholelithiasis. A picture of the resected gall bladder is shown below. What is the diagnosis? (Q859620)

A. Gall bladder carcinoma

B. Mixed stone in gallbladder

C. Cholecystitis

D. Choledocholithiasis



Correct Answer: A. Gall bladder carcinoma

Explanation: The given image shows a resected gall bladder with features suggestive of carcinoma, it is typically nodular and infiltrative , causing thickening of the gall bladder wall, which may extend to the entire gall bladder. It is often difficult to differentiate from chronic cholecystitis. Gall bladder carcinoma Risk factors Gallstones, (The risk of developing carcinoma in gallstone disease is 7-10 times higher than in the general population) Porcelain gallbladder, PSC, Abnormal pancreatic-biliary junction Presentation Often indistinguishable from benign gallbladder diseases Symptoms include: Biliary colic Cholecystitis (especially in older individuals) Jaundice (late-stage) Loss of appetite (late-stage) Palpable mass (late-stage) Lab investigation Non-specific indicators: Anemia Leukocytosis Slight increase in transaminases Tumor markers: Elevated CA19-9 Elevated carcinoembryonic antigen (in ~80% of patients) Diagnosis Ultrasonography (USG): Initial diagnosis CT Scans: Thorax, abdomen, and pelvis for confirmation and staging MRI/MRCP: For accurate preoperative staging PET Scans: To identify metastatic disease Staging & Biopsy Preoperative Staging: Crucial to assess local disease extent and rule out distant metastases Percutaneous Biopsy: Guided by radiological imaging for unresectable tumours Laparoscopic Examination: Detects peritoneal or liver metastases that preclude surgery Mixed stone in gall bladder (Option B) refers to gallstones composed of a mixture of cholesterol, bilirubin, and calcium salts. They are normally identified through imaging methods such as ultrasound and may not appear visibly as a carcinoma. Cholecystitis (Option C) refers to inflammation of the gall bladder, often due to gallstones or infection. It can present with acute symptoms like pain, fever, and nausea. Imaging shows gallbladder wall thickening (>3 mm), pericholecystic fluid, & ultrasonographic Murphy's sign. Choledocholithiasis (Option D) refers to the presence of stones in the common bile duct, and its diagnosis typically requires imaging to show stones in the bile duct.

References:

Bailey & Love’s Short Practice of Surgery, 28th Edition, Page 1258

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Q31: Which of the following is a tumour marker of pancreatic cancer? (Q859616)

A. NSE

B. Alpha-Fetoprotein

C. Ca 15-3

D. CA 19-9

Correct Answer: D. CA 19-9

Explanation: CA 19-9 is a tumour marker that is commonly associated with pancreatic cancer . Pancreatic cancer tumor marker: Carbohydrate Antigen 19-9 (CA19-9) Usage : Establish a baseline level for monitoring. Characteristics : Not highly specific or sensitive. Useful for detecting recurrence if initial levels are raised Tumor markers Tumor marker Associated conditions Alpha-fetoprotein (AFP) (Option B ruled out) Hepatocellular carcinoma (HCC) Hepatoblastoma Yolk sac tumour (endodermal sinus tumour) Nonseminomatous germ cell tumour of testis ↑ AFP: abdominal wall defects, neural tube defects ↓ AFP: associated with trisomy 21, 18, and 13 β-HCG Nonseminomatous testicular germ cell tumours (choriocarcinoma, embryonal cell carcinoma, mixed germ cell tumour, seminoma) Ovarian cancer: choriocarcinoma (gestational trophoblastic disease) Carcinoembryonic antigen (CEA) Colorectal cancer Pancreatic cancer Breast cancer Lung cancer (especially in non-small cell cancers) Gastric cancer Prostate-specific antigen (PSA) Prostate cancer Benign prostatic hyperplasia Prostatitis Calcitonin Medullary thyroid cancer (both sporadic and associated with MEN 1 and MEN 2) Alkaline phosphatase Metastases to bone or liver Paget disease of the bone Placental alkaline phosphatase Seminoma Lactate dehydrogenase Ovarian cancer (dysgerminoma) Testicular germ cell tumours (both seminoma and nonseminoma) Lymphomas Ewing's sarcoma Neuron specific enolase (NSE) (Option A ruled out) Neuroendocrine tumors Small cell lung cancer Carcinoid tumour Neuroblastoma CA 19–9 (Option D) Pancreatic adenocarcinoma Colon cancer Cholangiocarcinoma CA 15–3 and CA 27–29 (Option C ruled out) Breast cancer CA 125 Ovarian carcinoma Other gynecologic malignancies S-100 protein (S100A) and (S100B) Malignant melanoma SMRP Mesothelioma

References:

Bailey and Love Short Practise of Surgery, 28th Edition, Page 1283,1284, 1571, 1572, 1364, 1618.

Robbins and Cotran’s Pathologic Basis of Disease, 10th Edition, Page 336.

↑ *Back to this question in Part A*

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Q32: A young sheep farmer presents to the OPD with pain in the right upper part of the abdomen. Upon examination, there was tenderness and enlargement of the liver. Blood investigations show eosinophilia, elevated liver enzymes, and abdominal ultrasound, as shown below. Which of the following is the most likely diagnosis?

(Q859613)

A. Amoebic liver abscess

B. Hydatid cyst

C. Pyogenic liver abscess

D. Hepatocellular carcinoma



Correct Answer: B. Hydatid cyst

Explanation: The clinical presentation described, along with the ultrasound provided her,e suggests Hydatid disease . The given ultrasound shows a characteristic waterlily sign, indicating a cyst with a detached membrane floating within the cyst cavity, which is a hallmark of stage CE 3. Hydatid cyst Causative agent Echinococcus granulosus Commonly Affected Organs Liver (most common site, about 60-70% of cases) Lungs (second most common site) Other organs (rare but possible): Brain, spleen, kidneys, bones, and peritoneum Clinical Features Asymptomatic Phase: Common due to slow cyst growth. Symptomatic Phase: Liver Involvement: Mostly right lobe; Abdominal pain, hepatomegaly, obstructive jaundice, portal hypertension. Lung Involvement: Cough, chest pain, dyspnea, hemoptysis, pneumothorax. Investigations Imaging Studies: USG is the first-line imaging modality, particularly for liver involvement. Features: Echinococcal cyst wall shows double echogenic lines separated by a hypoechoic layer (double contour) CT Scan MRI Serological Tests: ELISA Immunoblotting Other tests: Casoni Intradermal Test ARC5 Immunoelectrophoresis Amoebic liver abscess (Option A) can cause pain and liver enlargement, they are more common in individuals who have a history of travel to endemic areas and typically present with an abscess in the liver, not a cyst. Pyogenic liver abscess (Option C) are mostly caused by bacterial

infections and are more likely to present with fever, chills, and more localized pain. They would not typically cause the marked eosinophilia seen in this case. Hepatocellular carcinoma (Option D) can cause liver enlargement; it is a malignant tumour and generally doesn't present with the eosinophilia or characteristic ultrasound findings seen in parasitic infections.

References:

Paniker's Textbook of Medical Parasitology, 8th Edition, Pages 133 -135.

Apurba S Sastry Essentials of Practical Microbiology, 3rd Edition, Pages 494 - 496.

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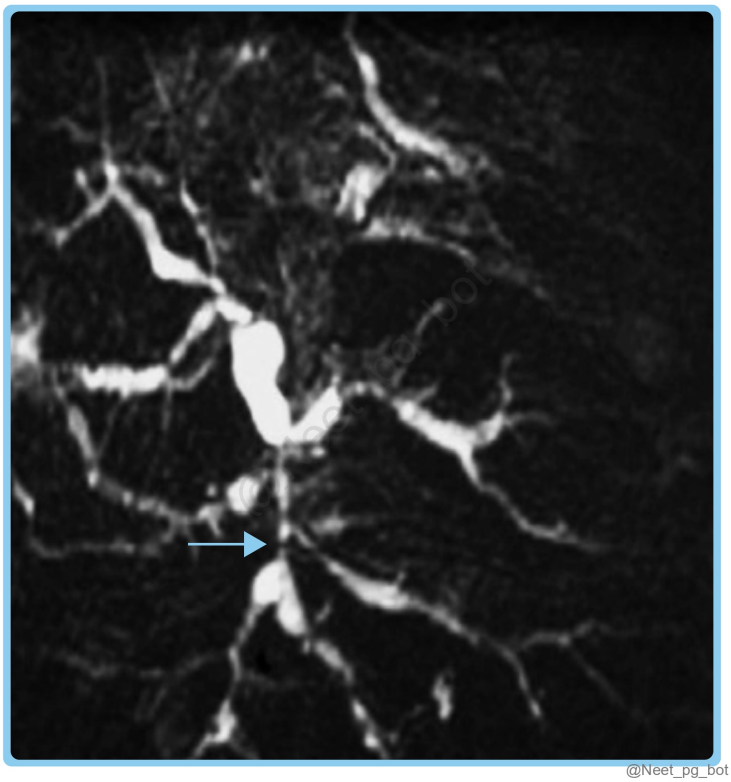
Q33: A 35-year-old man presented with recurrent episodes of fever with chills. The MRCP image is shown below. What is the most likely diagnosis? (Q858489)

A. Primary sclerosing cholangitis

B. Caroli disease

C. Oriental cholangitis

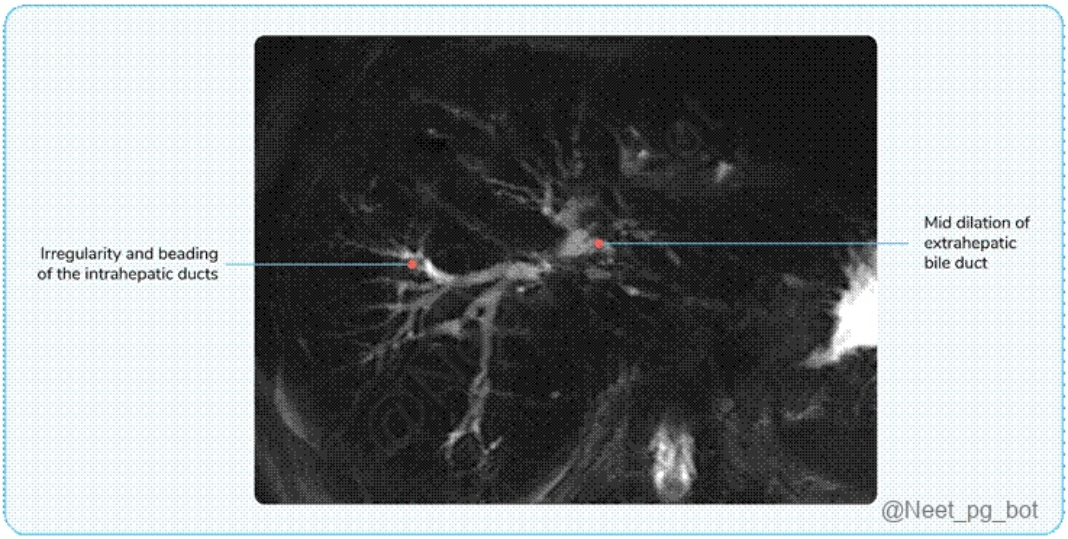
D. Primary biliary carcinoma

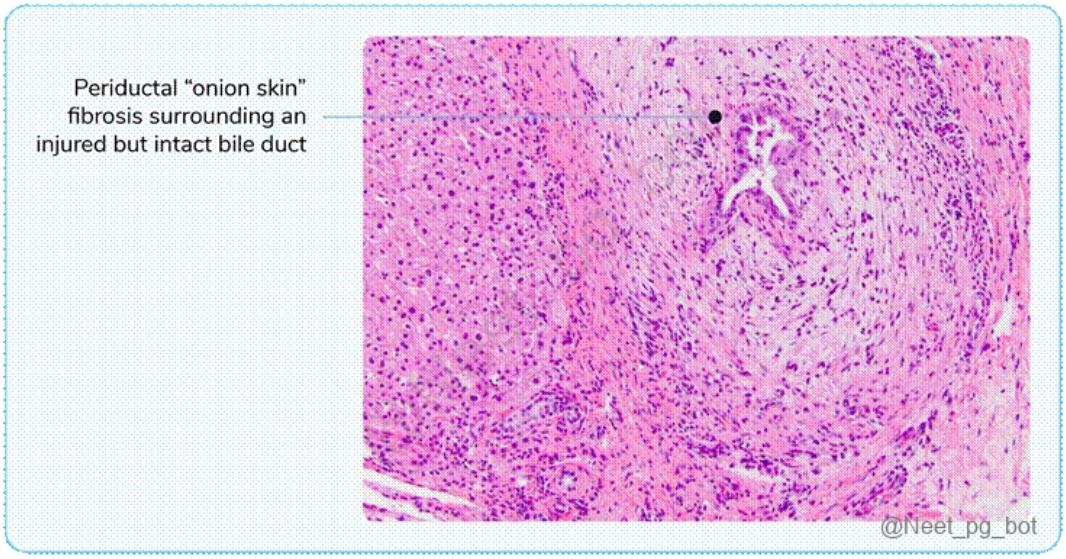


Correct Answer: A. Primary sclerosing cholangitis

Explanation: The patient's age, male predominance, along with MRCP findings of (beading) multiple irregular stricturing and dilatations of the bile duct, suggest Primary Sclerosing Cholangitis . Primary Sclerosing Cholangitis (PSC) PSC is characterised by inflammation and obliterative fibrosis of extrahepatic and large intrahepatic bile ducts, with dilation of preserved segments. Demographics It commonly occurs in individuals aged 30-50 years. Has a male predominance of 2:1. Pathogenesis It suggests an immunologically mediated process supported by circulating autoantibodies and T lymphocytes in the periductal stroma, as well as associations with HLA-B8 and ulcerative colitis . A mix of environmental & genetic factors may trigger bile duct injury. Increased risk of PSC in first-degree relatives indicates a genetic component. Activated T cells from ulcerative colitis mucosa may migrate to the liver, targeting bile duct antigens. Changes in the intestinal microbiome or infections may alter cholangiocytes, causing inflammation. Atypical perinuclear antineutrophil cytoplasmic antibodies (pANCA) are Clinical features Common symptoms include fatigue, pruritus, and jaundice. Nearly 50% of patients are asymptomatic at diagnosis, often identified through elevated serum alkaline phosphatase. Ascending cholangitis, chronic pancreatitis, and chronic cholecystitis may also occur. Fibrosis can progress to cirrhosis over 10-15 years. Characteristic findings ERCP/MRCP shows the beaded appearance of bile ducts {{caption_text}} Biopsy, Early features: Periductal "onion skin" fibrosis & inflammation Portal edema & bile ductular proliferation Later stages show progressive fibrosis leading to biliary cirrhosis and obliterative cholangitis, resulting in "vanishing bile duct syndrome" {{caption_text}} Associated conditions Ulcerative colitis, risk of developing cholangiocarcinoma Complication Lifetime risk of developing cholangiocarcinoma is about 20%. Caroli disease (Option B) is a rare congenital condition characterised by cystic dilatation of the intrahepatic bile ducts . On MRCP, it shows diffuse bile duct dilation with saccular and fusiform features, along with a peripheral funnel-shaped sign. Unlike PSC, Caroli disease typically involves only the intrahepatic ducts, without extrahepatic duct involvement. Oriental cholangitis (Option C) is seen in Asian populations and is often related to hepatolithiasis and biliary tract infections . It doesn’t normally show the beaded appearance on MRCP, which is

more characteristic of primary sclerosing cholangitis . Primary biliary carcinoma (Option D) is also known as Cholangiocarcinoma and presents with obstructive jaundice , but it doesn't usually cause recurrent fever and chills as cholangitis does. On MRCP, it shows focal or diffuse bile duct strictures or mass lesions rather than the beaded appearance.





References:

Davidson's Principle and Practice of Medicine, 24th Edition,Pages 889, 890.

SRB's Manual of Surgery, 6th Edition, Page 649

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Q34: An 80-year-old woman presented with fatigue. Imaging revealed a scleroatrophic gallbladder with impacted stones and a large stone in the common bile duct, causing dilation of the biliary tree. What is the next step in management? (Q855020)

A. Immediately take up the patient for cholecystectomy

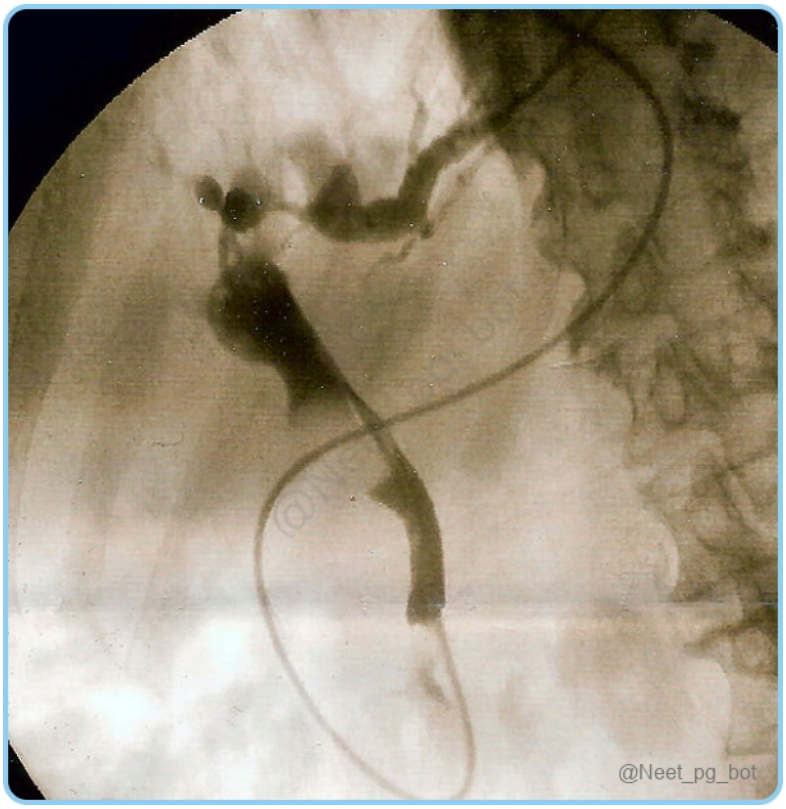
B. Endoscopic retrograde cholangiopancreatography

C. Wait and watch

D. CT scan

Correct Answer: B. Endoscopic retrograde cholangiopancreatography

Explanation: The next step in the management of this patient is ERCP , which is used to relieve biliary obstruction caused by the stone in the common bile duct. It is a procedure that combines endoscopy and fluoroscopy to visualise and treat conditions affecting the bile ducts and pancreatic ducts. It allows for the removal of common bile duct stones, dilation of strictures, and placement of stents to relieve biliary obstruction. It has both diagnostic and therapeutic capabilities. Stones up to 12 mm can usually be removed by Endoscopic Retrograde. Choledocholithiasis Investigation Ultrasound: Useful for detecting gallstones and CBD dilation but has limited sensitivity for CBD stones. MRCP: Non-invasive, excellent for visualising biliary tree anatomy and pathology. ERCP: Highly sensitive, both diagnostic and therapeutic for CBD stones. PTC: Used when ERCP is not feasible, such as post-gastrectomy patients or unsuccessful ERCP attempts. EUS: Invasive but accurate for diagnosing choledocholithiasis. Blood Tests: ↑ bilirubin, ↑alkaline phosphatase, and ↑white blood cell count indicate choledocholithiasis and possible complications like cholangitis. Treatment Endoscopic Management: ERCP with sphincterotomy and stone extraction; stenting if necessary. {{caption_text}} Percutaneous Removal: Used when endoscopic access is difficult. Surgery: Options include laparoscopic and open choledocholithotomy, choledochoduodenostomy, and choledochojejunostomy. Complications Cholangitis: Bacterial infection due to obstructed bile flow, leading to fever, chills, right upper quadrant pain, and jaundice. Pancreatitis: Inflammation of the pancreas due to obstruction at the ampulla of Vater. Liver Damage: Prolonged obstruction can cause biliary cirrhosis and liver failure. Biliary Stricture: Chronic inflammation can lead to the narrowing of the bile ducts. Gallstone Ileus: Large gallstone eroding into the intestine, causing mechanical obstruction. Immediately take up the patient for cholecystectomy (Option A): Cholecystectomy is the surgical removal of the gall bladder. When there is an active obstruction of the bile duct, the focus should first be on relieving the biliary obstruction before considering cholecystectomy. Once the obstruction is addressed, the patient can undergo cholecystectomy to prevent future complications. Wait and watch (Option C) is not appropriate in this case because the patient has an impacted stone in the common bile duct with associated dilation of the biliary tree and is symptomatic. If left management is delayed, it could lead to complications. CT scan (Option D) may provide additional information about the extent of the biliary tree dilatation and the presence of other abnormalities, but it does not address the immediate need for intervention to relieve the biliary obstruction.



References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Pages 1236-1238,1254

↑ *Back to this question in Part A*

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Q35: A 5-year-old child with Wilson's disease is being considered for liver transplantation. Which of the following is not a parameter in the selection criteria for transplantation? (Q855014)

A. Age < 10 years

B. Bilirubin > 300µmol/L

C. AST > 300 IU/L

D. PT > 100 s

Correct Answer: A. Age < 10 years

Explanation: The Nazer score (Wilson Prognostic Index) evaluates prognosis in Wilson's disease–related liver failure using three biochemical parameters only : 1. Serum Bilirubin µmol/L) 2. AST(IU/L) 3. Prothrombin time (seconds) Each parameter is scored from 0–4 , and a total score ≥7 indicates poor prognosis , warranting liver transplantation . Age is not a component of this score. Parameter 0 1 2 3 4 Serum bilirubin (µmol/L) <100 100-149 150-199 200-299 ≥ 300 AST (IU/L) <100 100-149 150- 199 200-299 ≥ 300 PT (s) <20 20-39 40-59 60-79 ≥ 80

References:

Harrison's Principles of Internal Medicine, 21st Edition, Pages 648, 2552.

↑ *Back to this question in Part A*

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Q36: A patient with recurrent pain in the right hypochondrium, nausea, and vomiting is diagnosed with biliary dyskinesia. Which of the following is least useful in the diagnosis of this condition? (Q856301)

A. CT scan

B. HIDA scan

C. ERCP

D. Endoscopy

Correct Answer: C. ERCP

Explanation: Biliary dyskinesia is a functional disorder of the gallbladder, characterised by abnormal motility, and diagnosis is typically made through tests that evaluate gallbladder function rather than its structure. Diagnosis: It is a diagnosis of exclusion CT Scan is used for detecting structural abnormalities, and can help rule out other non-biliary causes of abdominal pain if the diagnosis is unclear. (Option A ruled out) Endoscopy: It is essential to rule out peptic ulcer disease or common upper GI conditions. (Option D ruled out) A HIDA scan is useful in diagnosis, as it evaluates gallbladder function using a radioactive tracer. (Option B ruled out) ERCP is an invasive and high-risk therapeutic procedure , not a primary diagnostic tool for gallbladder function. It is used with sphincterotomy in non-responders to cholecystectomy.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 156 Sabiston Textbook of Surgery 21st Edition, Page no. 1503

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Q37: According to Strasberg's classification of bile duct injuries, a bile leak from the cystic duct stump or a minor duct in the gallbladder fossa with continuity to the common bile duct is classified as: (Q856250)

A. Type A

B. Type B

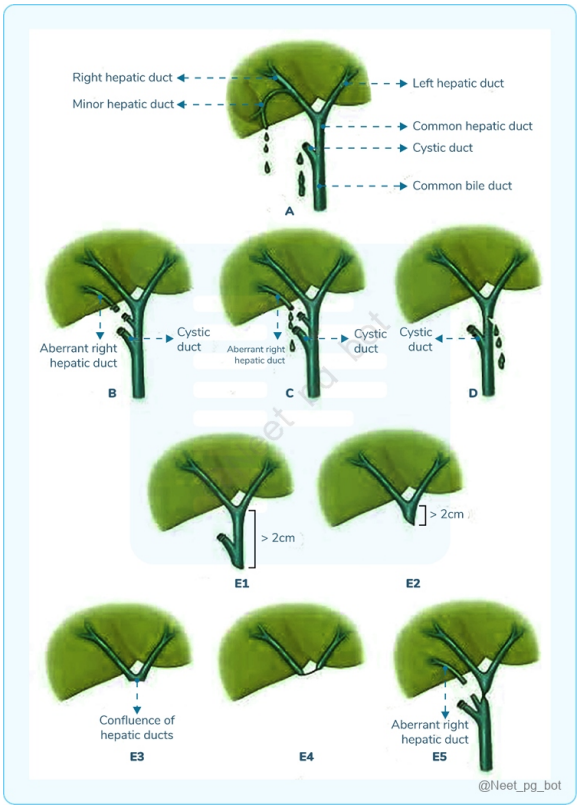
C. Type C

D. Type D



Correct Answer: A. Type A

Explanation: Strasberg Type A bile duct injury refers to a bile leak from the cystic duct stump or a minor accessory bile duct that remains connected to the common bile duct. This is usually a minor injury causing bile leakage without disruption of the main bile duct continuity. It is often managed conservatively or with endoscopic procedures. The Strasberg classification of bile duct injuries Type A (M/C) (Option A) Cystic duct stump leak or leak from sub-vesical duct of Luschka Type B (Option B ruled out) Ligation or occlusion of aberrant right sectoral duct Type C (Option C ruled out) Transection without occlusion of the aberrant right sectoral duct Type D (Option D ruled out) Injury to the lateral wall of the Common hepatic duct Type E E1 to E5 Bismuth classification



References:

Bailey and Love's Short Practice of Surgery, 28th Edition, Page 1252

Sabiston Textbook of Surgery, 21st edition, Page 1511

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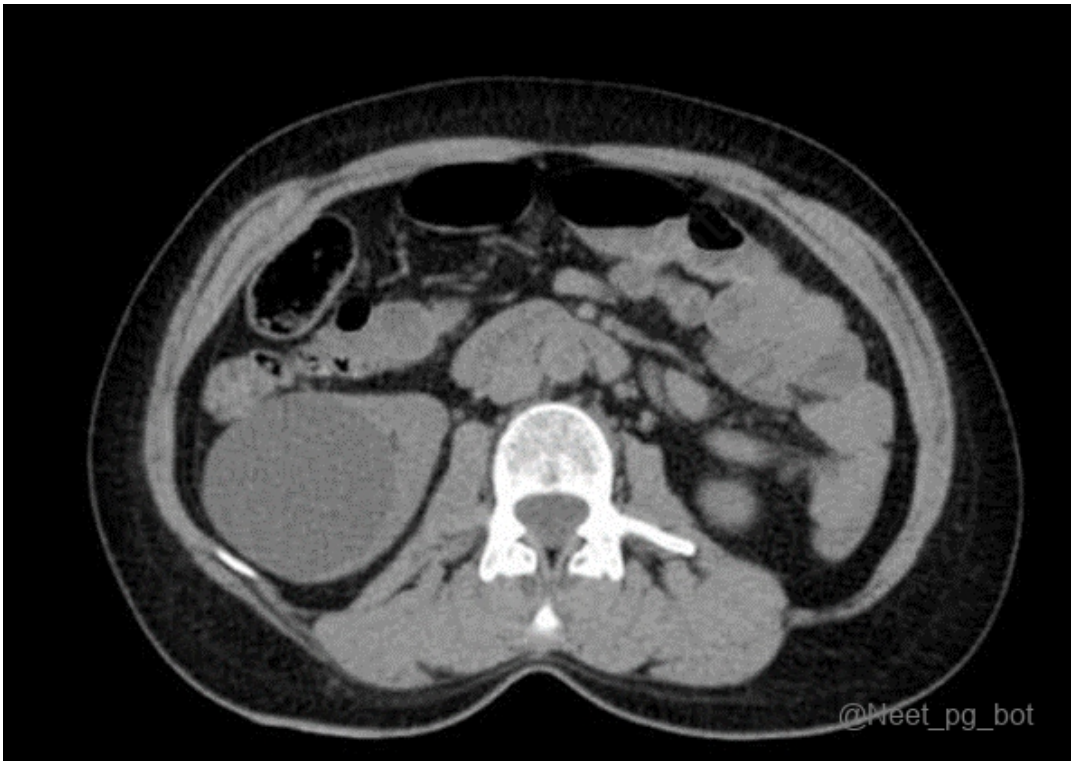
Q38: A 62-year-old female undergoes a contrast-enhanced abdominal CT scan for unrelated mild abdominal discomfort. The scan reveals a solitary, 4 cm, round, dark, fluid-filled lesion in the right kidney as shown in the image. The lesion does not change in appearance or become brighter after the administration of intravenous contrast. Based on these findings, what is the most likely diagnosis? (Q844294)

A. Renal cyst

B. Renal tumor

C. ADPKD

D. Hydatid cyst



Correct Answer: A. Renal cyst

Explanation: Correct Option A - Renal cyst: The most likely diagnosis is a Simple Renal Cyst . The CT findings of a solitary, fluid-filled lesion with a paper-thin wall and no internal complexity (septations or calcifications) are classic for this benign condition. Most importantly, the lack of enhancement after contrast administration definitively rules out a solid renal tumor, which would be vascular and become brighter. Incorrect Options: Option B - Renal tumor: A solid renal tumor would appear as a dense mass (not dark and fluid-filled) and would significantly enhance (become brighter) with contrast due to its rich blood supply. A cystic tumor would have thick, irregular walls or enhancing internal septa. Option C - Autosomal Dominant Polycystic Kidney Disease (ADPKD): his condition is characterized by multiple cysts in both kidneys , often causing the kidneys to be enlarged and distorted. The question describes a solitary lesion. Option D - Hydatid cyst: This would typically appear as a complex cyst with a thick, well-defined wall (not paper-thin) and classic internal daughter cysts giving it a multiseptated appearance.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1469

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Q39: A patient underwent cholecystectomy, and the histopathology reveals carcinoma with invasion into the muscular layer. What is the next best step? (Q857249)

A. Radiotherapy

B. Chemotherapy

C. Excision of the stump

D. Extended Cholecystectomy

Correct Answer: D. Extended Cholecystectomy

Explanation: T1b lesions refer to gallbladder cancer that invades the muscular layer but not beyond the deeper layers. The next best step is extended cholecystectomy to ensure an R0 resection , which includes removal of the surrounding lymph nodes (e.g., hepatoduodenal, gastrohepatic) and possibly part of the hepatic parenchyma to achieve clear margins. TNM Staging of Gall bladder Carcinoma: Category Description Tis Carcinoma in situ T1 Tumor invades lamina propria or muscle layer T1a Tumor invades lamina propria T1b Tumor invades muscle layer T2 Tumor invades perimuscular connective tissue T2a Tumor does not extend to serosa T2b Tumor extends to serosa, but does not invade the liver T3 Tumor perforates serosa and/or invades liver/adjacent organs T4 Tumor invades main portal vein/hepatic artery/multiple extrahepatic organs Lymph node N0 No regional lymph node metastasis N1 Metastases to 1-3 regional lymph nodes N2 Metastases to >3 regional lymph nodes Metastasis M0 No distant metastasis M1 Distant metastasis Gallbladder Cancer Treatment: Gallbladder Polyp: Adenomatous polyps have malignant potential. Risk factors for malignancy: Single polyp, size >1 cm, age >50 years. Management: Cholecystectomy is recommended for polyps >1 cm. Polyps <1 cm may undergo surveillance, except in PSC (where earlier cholecystectomy is advised). Gallbladder Cancer Post-Cholecystectomy: T1a Lesions (mucosa, lamina propria): Cholecystectomy T1b Lesions (muscular invasion) : Extended cholecystectomy is recommended, especially with vascular, perineural, or lymphatic invasion. T2 Lesions (past muscularis): Radical cholecystectomy with lymph node removal as more than 40% have nodal metastasis. T3/T4 Lesions (extensive): Extended surgery, including liver resection, may be needed for R0 margins.

References:

Sabiston Textbook of Surgery, 21st Edition, Page 1518,1519

↑ *Back to this question in Part A*

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Q40: Which classification system is used for bile duct injury, taking location, injury to the duct, and vessel involvement into account? (Q857247)

A. Bismuth

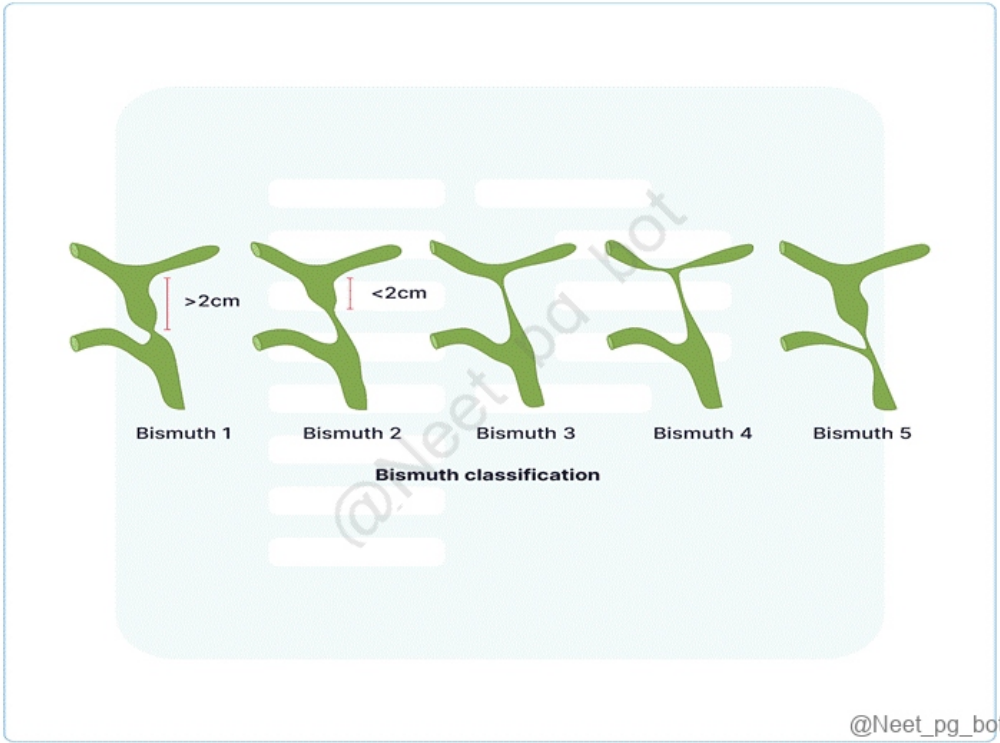
B. Strasberg

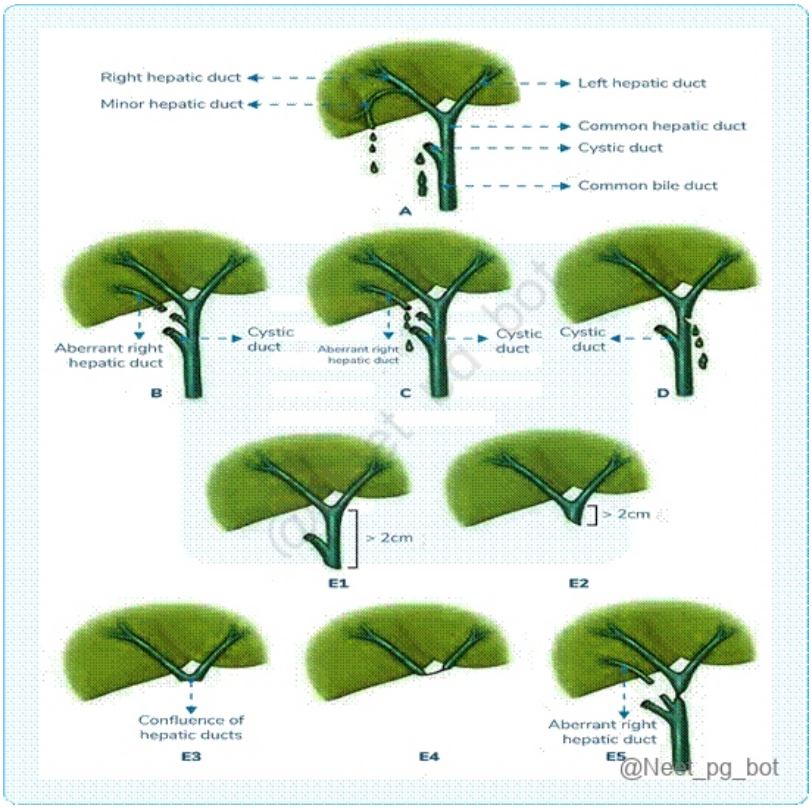
C. Stewart Way

D. Hannover

Correct Answer: D. Hannover

Explanation: The Hannover classification is a comprehensive system for bile duct injuries , particularly post-cholecystectomy, that accounts for: Location of injury Type of duct injury (partial or complete) Presence of vascular injury (e.g., to the right hepatic artery) It provides a more detailed description compared to older systems and is especially useful in surgical planning. Type A : Cystic duct or gallbladder bed leak. Type B : Incomplete or complete stenosis. Type C : Lateral tangential injuries. Type D : Complete bile duct injury with vascular injuries. Type E : Late bile duct stenosis. Bismuth Classification: (Option A) Describes strictures of the biliary system , particularly benign biliary strictures after surgery. It is based solely on the location of the stricture relative to the hepatic duct confluence. Bismuth classification for biliary strictures Type I Common hepatic duct stump >2cm Stricture is Low Type II Common hepatic duct stump <2cm Stricture is mid Type III Hilar stricture with intact confluence Stricture is high Type IV Hilar stricture with destroyed confluence Type V Stricture involving aberrant right sectoral duct with or without stricture of common hepatic duct Strasberg classification (Option B) divides bile duct injuries into five main classes: Type A (M/C) Cystic duct stump leak or leak from sub-vesical duct of Luschka Type B Ligation or occlusion of aberrant right sectoral duct Type C Transection without occlusion of the aberrant right sectoral duct Type D Injury to the lateral wall of the Common hepatic duct Type E E1 to E5 Bismuth classification {{caption_text}} Stewart-Way Classification (Option C): Focuses on mechanisms of injury and surgeon-related errors , useful for root cause analysis rather than guiding surgical repair. Stewart-Way Classification: Class I : Incomplete injury. Class II : Lateral injury with bile leak and stenosis. Class III : Complete transection of the common bile duct (most common, 60%). Class IV : Duct branch injuries with involvement of the right hepatic artery.





References:

SRB's Manual of Surgery, 6th Edition, Page 658

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1252

↑ *Back to this question in Part A*

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Q41: Which of the following is not a risk factor for gallbladder cancer? (Q857241)

A. Porcelain Gall Bladder

B. Primary Sclerosing Cholangitis

C. Polyp <10 mm

D. Gallstone >3 cm

Correct Answer: C. Polyp <10 mm

Explanation: Gallbladder polyps smaller than 10 mm are generally not considered a significant risk factor for gallbladder cancer, while other conditions like porcelain gallbladder, primary sclerosing cholangitis, and large

gallstones are associated with an increased risk. Risk Factors For Carcinoma GB Gallstones : 90% of carcinoma cases are associated with gallstones. The risk of developing carcinoma in gallstone disease is 7-10 times higher than in the general population. Relative risk based on stone size: Less than 2 cm: Lower risk 2-3 cm: Relative risk of 2.5 More than 3 cm (Option D) : Relative risk of 10 or more Other Conditions : Choledochal cyst Anomalous pancreaticobiliary duct junction (20%) Gallbladder polyps (more than 1 cm in size, more than 3 in number, or adenomatous polyps) Porcelain gallbladder (Option A): 25% risk of malignant transformation, with 90% being inoperable tumours Primary Sclerosing Cholangitis (Option B) Infections and Inflammatory Conditions : Chronic typhoid carriers Inflammatory bowel disease Hepatitis B and hepatitis C virus infections Other factors: Polypoid lesions (GB polyp) Xanthogranulomatous cholecystitis Nitrosamines Carcinogens

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1258

SRB's Manual of Surgery, 6th Edition, Page 651

↑ *Back to this question in Part A*

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Q42: A 45-year-old male presents to the emergency department with severe abdominal pain radiating to the back. Laboratory investigations reveal elevated serum amylase and lipase levels. Which of the following should be avoided in the management of the given condition? (Q860175)

A. Nil per oral

B. Administration of 5% dextrose

C. Parenteral nutrition

D. Early initiation of oral feedings

Correct Answer: B. Administration of 5% dextrose

Explanation: The clinical presentation suggests acute pancreatitis. In managing acute pancreatitis , administration of 5% dextrose should be avoided in the initial phase because it can excessively increase blood glucose levels. Elevated glucose can stimulate the pancreas and worsen the condition by increasing pancreatic activity. This can exacerbate inflammation and further damage the pancreas. Acute pancreatitis: Clinical features: Pain (severe , constant , and often resistant to common analgesics) . In about 50% of patients , the pain radiates to the back , and some patients may find relief by sitting or leaning forward . Nausea and vomiting are usually prominent, and retching may persist even with nasogastric aspiration. Examination findings: Patient's condition: well to severely ill with signs of shock and toxicity . Tachypnea , tachycardia , and hypotension are commonly observed. Mild icterus may suggest biliary obstruction (in gallstone pancreatitis). SIRS may be present Bluish discolouration (Grey Turner’s sign or Cullen’s sign). Abdominal distension due to ileus or ascites is common, and muscle guarding is often present. Diagnosis: Serum amylase level > 3x the normal value is strongly indicative. Serum

lipase is more sensitive and specific than amylase. CECT scan is the gold standard for confirming the diagnosis. Management: Mild cases may be managed with IV fluids (Option C) , analgesics , and antiemetics . Nil per oral: (NPO) is typically advised initially to avoid stimulating the pancreas. Antibiotics are not generally indicated unless there is suspicion of infection Management of severe cases: Admit to intensive care or a high-dependency unit for close monitoring. Aggressive fluid resuscitation is critical, guided by vital signs, urine output, and central venous pressure. Oxygen supplementation and serial blood gas analysis . If nutritional support is necessary, enteral feeding via nasogastric tube is preferred over parenteral nutrition. (Option D) Management of specific complications: Antibiotics may be indicated if cholangitis or other infections are suspected. Prophylactic antibiotics should not exceed 14 days . If gallstone pancreatitis is suspected and there is biliary obstruction , ERCP should be performed within 72 hours . Complications: Shock , arrhythmias , ARDS (acute respiratory distress syndrome), renal failure , and DIC (disseminated intravascular coagulation) . Metabolic derangements like hypocalcemia , hyperglycemia , and hyperlipidemia may occur. Peripancreatic fluid collection , pancreatic abscess , pseudocyst , and pancreatic necrosis . Pleural effusion , pancreatic ascites , and pancreatic haemorrhage (pseudoaneurysm) are also common.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1272-1274

↑ *Back to this question in Part A*

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Q43: What is the most common complication of ERCP? (Q860172)

A. Duodenal perforation

B. Cholangitis

C. Hemorrhage

D. Pancreatitis

Correct Answer: D. Pancreatitis

Explanation: Pancreatitis is the most common complication of ERCP, with an incidence of approximately 4.3%. While post-ERCP pancreatitis is typically mild, it can become severe with extensive pancreatic necrosis in some cases. Complications of ERCP: Pancreatitis (Most Common) It can be severe, with extensive pancreatic necrosis Associated with a significant mortality rate Use of per-rectal indometacin/diclofenac to reduce risk Duodenal perforation (Option A) Haemorrhage post-sphincterotomy (Option C) Sepsis Cholangitis (Option B) Sphincter stenosis

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 156

SRB's Manual of Surgery, 6th Edition, Page 625

↑ *Back to this question in Part A*

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Q44: A newborn presents with jaundice. Biliary atresia is suspected when jaundice is persistent and exceeds? (Q860450)

A. 2 days

B. 2 weeks

C. 2 months

D. 2 years

Correct Answer: B. 2 weeks

Explanation: Biliary atresia is a serious condition that causes bile ducts to become obstructed or absent, leading to cholestasis and liver damage. In newborns, jaundice that persists beyond 2 weeks is a key clinical sign of biliary atresia, as physiological jaundice typically resolves within the first 1-2 weeks of life. Extra-Hepatic Biliary Atresia: Also known as Non-Cystic Obliterative Cholangiopathy. Characterised by complete obliteration of extrahepatic bile ducts and intrahepatic ducts at the hilum. Typically appear by 2 to 6 weeks of age Jaundice (yellowish coloration of skin and sclera) Abnormally pale stools Dark urine Commonly associated with polysplenia or asplenia Investigations: Liver Function Tests: Increased conjugated bilirubin. Markers of cholestasis: 5' nucleotidase Alkaline phosphatase (ALP) GGT (Gamma-glutamyl transferase): Normal: Up to 40 U/L 4x elevation: Intrahepatic causes 10x elevation: Extrahepatic causes Exception: Low in PFIC type I and II Ultrasound: High-frequency USG (HUS) for neonatal cholestasis. Fasting USG is the gold standard when biliary atresia is suspected. Characteristic findings: Triangular cord sign (hyperechoic areas indicating fibrous/atretic bile duct) Non-visualized gallbladder/micro gallbladder/gallbladder ghost Radionucleotide Study: HIDA Scan (Hepatobiliary scan with Tc labelled imino-di-acetic acid): Used as a screening test. Decreased tracer excretion due to obstruction Phenobarbitone loading/priming (5 days) to improve tracer uptake Used as a screening test, not specific Best Investigation: Liver biopsy: IOC for confirming diagnosis. Surgical Management: Temporary procedure: Kasai procedure/hepaticojejunostomy Definitive management: Liver transplantation Kasai Procedure: Temporary procedure Creates communication between the liver and jejunum for bile drainage Should be performed within 8 weeks after birth

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1241

https://www.pathologyoutlines.com/topic/liverextrahepaticbiliaryatresia.html

Nelson Textbook of Pediatrics, 21st Edition, Page 2097-2099

↑ *Back to this question in Part A*

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Q45: A 45-year-old alcoholic patient presents to the ER with severe abdominal pain radiating to the back. Blood investigations reveal increased serum amylase and lipase levels. What is the most likely diagnosis? (Q860443)

A. Peptic ulcer disease

B. Acute pancreatitis

C. Acute cholecystitis

D. Pyogenic liver abscess

Correct Answer: B. Acute pancreatitis

Explanation: The patient's history of alcohol consumption, along with severe abdominal pain radiating to the back and significantly elevated serum amylase and lipase levels , points strongly toward acute pancreatitis. Acute pancreatitis: Clinical features: Pain (severe , constant , and often resistant to common analgesics) . In about 50% of patients , the pain radiates to the back , and some patients may find relief by sitting or leaning forward . Nausea and vomiting are usually prominent, and retching may persist even with nasogastric aspiration. Examination findings: Patient's condition: well to severely ill with signs of shock and toxicity . Tachypnea , tachycardia , and hypotension are commonly observed. Mild icterus may suggest biliary obstruction (in gallstone pancreatitis). SIRS may be present Bluish discolouration (Grey Turner’s sign or Cullen’s sign). Abdominal distension due to ileus or ascites is common, and muscle guarding is often present. Diagnosis: Serum amylase level > 3x the normal value is strongly indicative. Serum lipase is more sensitive and specific than amylase. CECT scan is the gold standard for confirming the diagnosis. Management: Mild cases may be managed with IV fluids , analgesics , and antiemetics . Nil per os (NPO) is typically advised initially to avoid stimulating the pancreas. Antibiotics are not generally indicated unless there is suspicion of infection Management of severe cases: Admit to intensive care or a high-dependency unit for close monitoring. Aggressive fluid resuscitation is critical, guided by vital signs, urine output, and central venous pressure. Oxygen supplementation and serial blood gas analysis . If nutritional support is necessary, enteral feeding via nasogastric tube is preferred over parenteral nutrition. Management of specific complications: Antibiotics may be indicated if cholangitis or other infections are suspected. Prophylactic antibiotics should not exceed 14 days . If gallstone pancreatitis is suspected and there is biliary obstruction , ERCP should be performed within 72 hours . Complications: Shock , arrhythmias , ARDS (acute respiratory distress syndrome), renal failure , and DIC (disseminated intravascular coagulation) . Metabolic derangements like hypocalcemia , hyperglycemia , and hyperlipidemia may occur. Peripancreatic fluid collection , pancreatic abscess , pseudocyst , and pancreatic necrosis . Pleural effusion , pancreatic ascites , and pancreatic haemorrhage (pseudoaneurysm) are also common. Incorrect Options: Peptic ulcer disease (Option A) typically presents with epigastric pain, but it doesn't radiate to the back & does not cause elevated amylase and lipase levels. Acute cholecystitis (Option C) presents with right upper quadrant abdominal pain, often with fever and nausea, but it is not typically associated with marked increases in amylase and lipase. This condition would usually show elevated liver enzymes and bilirubin. Pyogenic liver abscess (Option D) can present with fever and abdominal pain, but it does not typically cause significant increases in amylase and lipase. This condition would be more likely to show abnormal liver function tests and may be associated with other findings like fever or jaundice.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1272-1274

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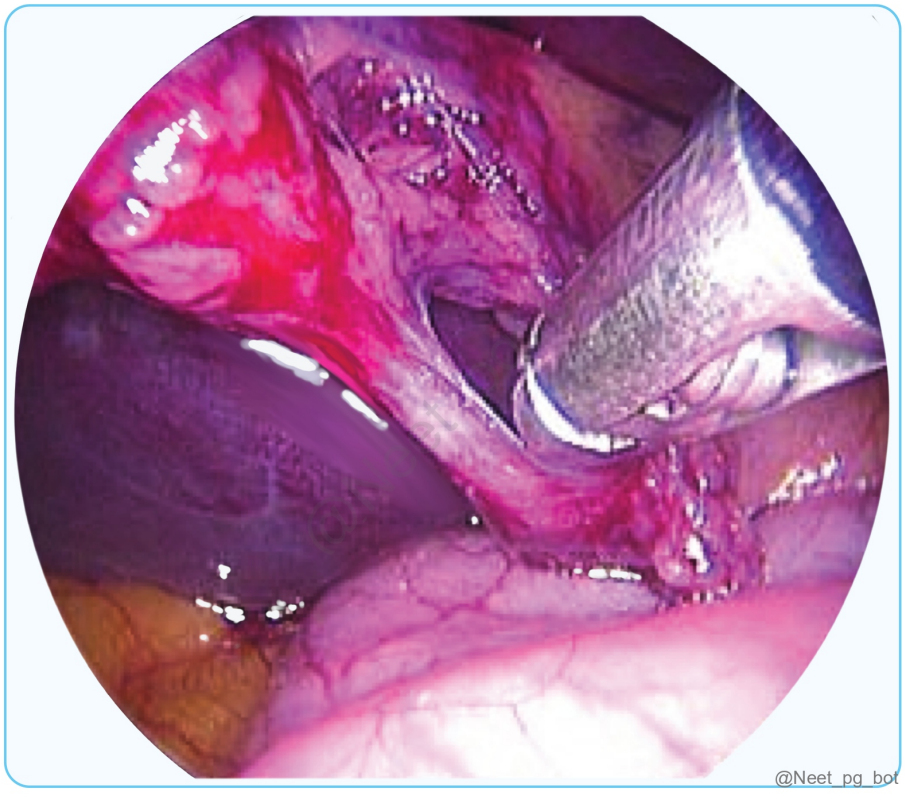
Q46: A patient underwent laparoscopic cholecystectomy. Identify the marked structure in the image. (Q860420)

A. Cystic artery

B. Cystic duct

C. Right hepatic artery

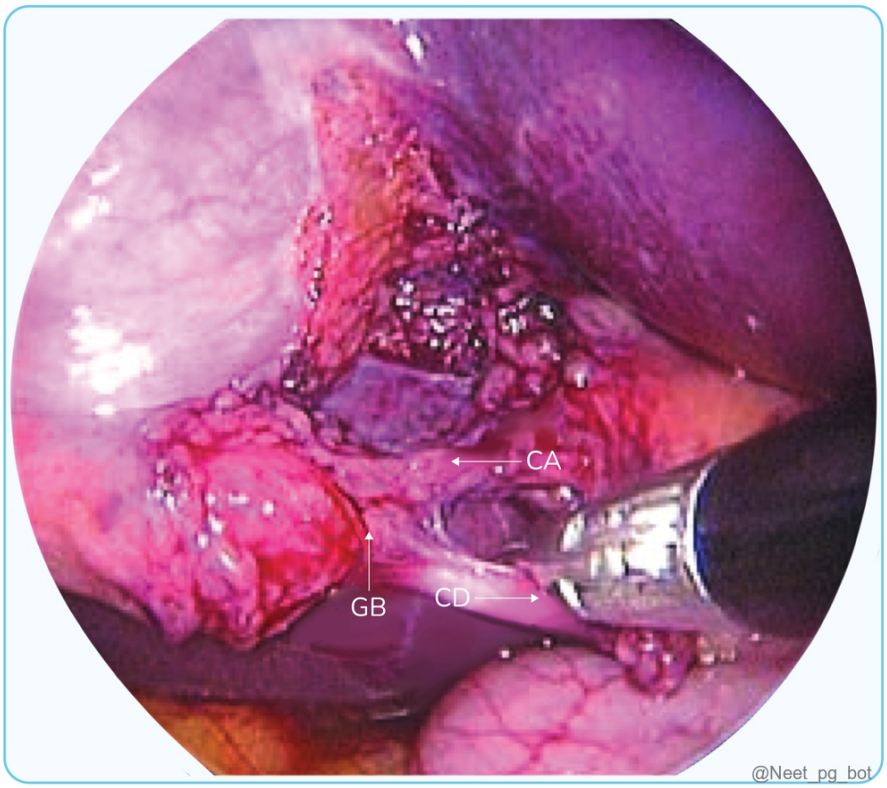
D. Hepatic duct

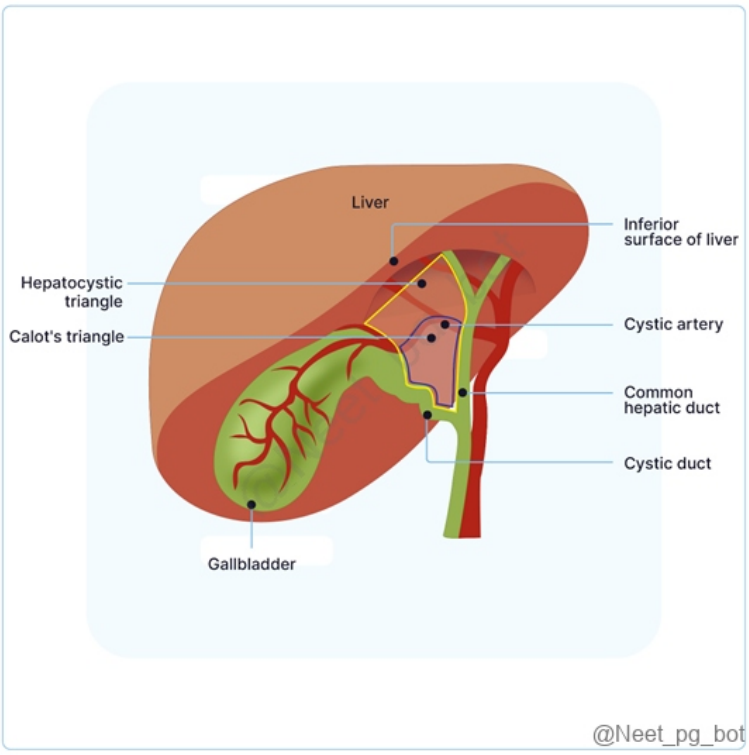


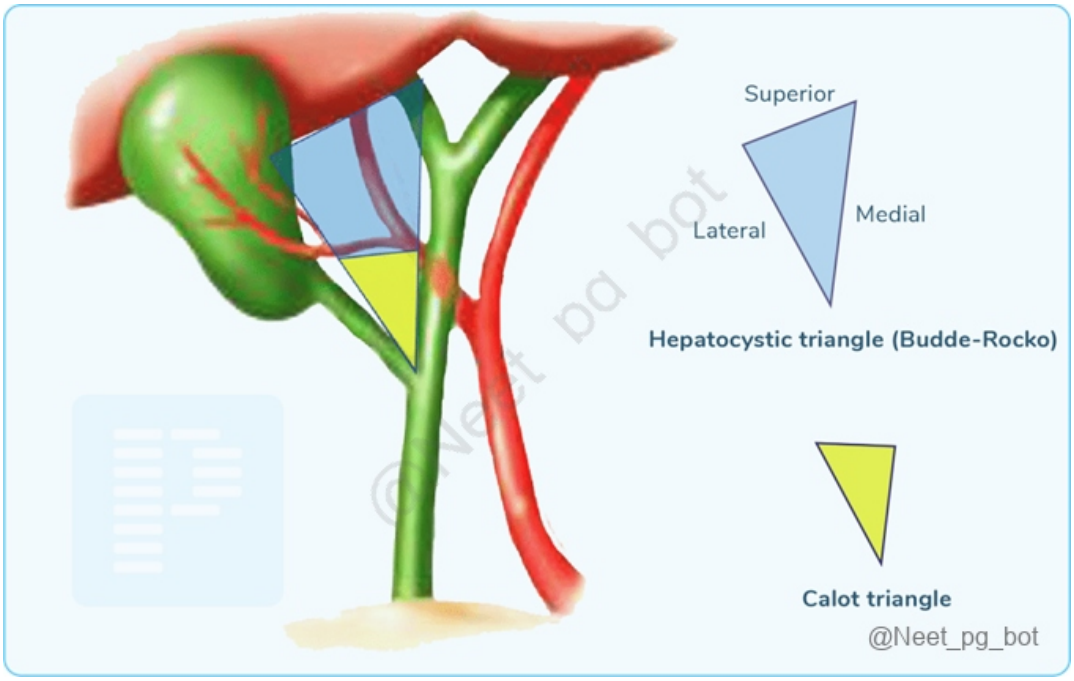
Correct Answer: B. Cystic duct

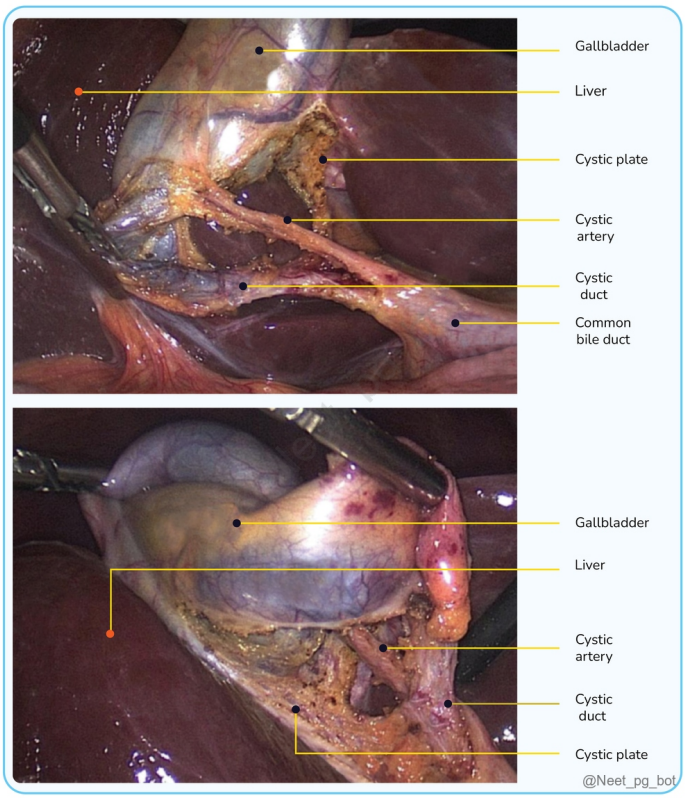
Explanation: The marked structure is a Cystic duct. {{caption_text}} GB - Gall Bladder CA - Cystic Artery CD - Cystic Duct Calot's triangle, also known as the cystohepatic triangle, is an important anatomical area during gallbladder surgery. The boundaries of Calot's triangle are defined by: Cystic duct (lateral boundary) Common

hepatic duct (medial boundary) The inferior surface of the liver (superior boundary) The contents of Calot's triangle typically include the cystic artery, which supplies blood to the gallbladder, and the cystic lymph node (Lund’s node). Identification of these structures is crucial during a cholecystectomy to avoid accidental injury to the biliary or vascular systems. Note: The term "hepatocystic triangle" is often used interchangeably with Calot's triangle. It emphasizes the inclusion of the liver's inferior surface as part of the boundaries, along with the cystic duct and the common hepatic duct. {{caption_text}}




Liver
Inferior surface of liver
Hepatocystic triangle
Calot's triangle
Cystic artery
Common hepatic duct
Cystic duct
Gallbladder
@Neet_pg_bot


Superior
Lateral
Medial
Hepatocystic triangle (Budde-Rocko)
Calot triangle
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References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1232,1233,1250

SRB’s Manual of Surgery, 6th Edition, Page 623,656

↑ *Back to this question in Part A*

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Q47: Which of the following statements about Choledochal Cyst is incorrect? (Q857250)

A. Increased risk of cholangiocarcinoma

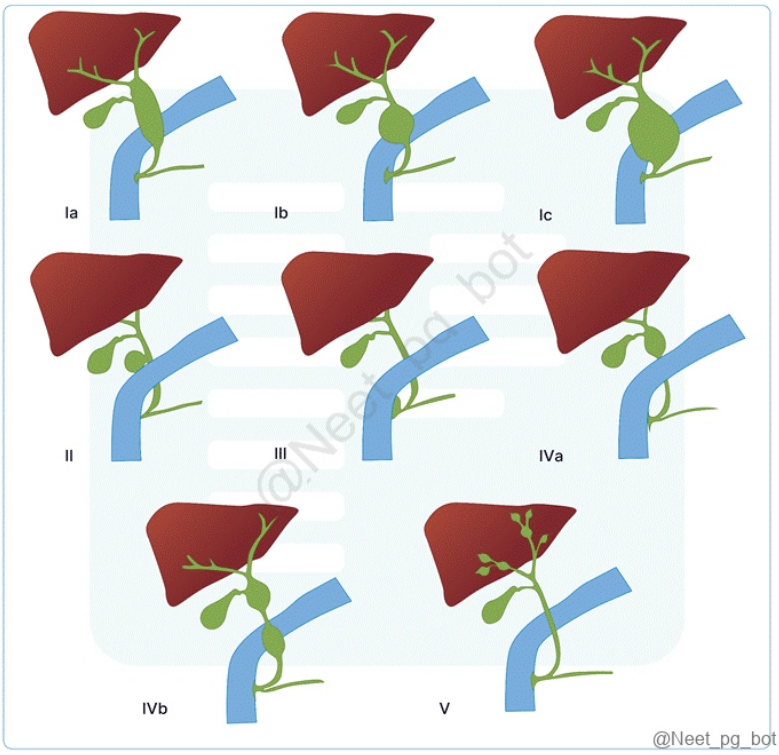
B. The cyst can be opened directly and drained

C. Todani classification is used for grading

D. Associated with abnormal Bilio-Pancreatic Junction

Correct Answer: B. The cyst can be opened directly and drained

Explanation: Choledochal cysts should not be simply drained. Direct drainage can lead to complications, including infection and further dilation. The proper treatment usually involves surgical resection of the cyst and reconstruction of the bile duct. Choledochal Cyst: Congenital dilatations of the intra- and/or extrahepatic biliary system can present at any age. In choledochal cysts, there is an abnormal junction between the bile duct and the pancreatic duct (Option D) , leading to the reflux of pancreatic enzymes into the common bile duct (CBD). The presence of these enzymes in the CBD causes its dilation. Clinical features : Patients may present with jaundice, fever, abdominal pain, and a right upper quadrant mass. Pancreatitis is a frequent presentation in adults. Approximately 60% of cases are diagnosed before the age of 10 years. The classical triad of jaundice, right upper quadrant mass, and abdominal pain is present in only a minority of patients (0–17%) Patients have an increased risk of developing malignancies like: Cholangiocarcinoma (Option A) Squamous cell carcinoma Bile duct sarcoma Hepatoma Pancreatic carcinoma Gallbladder carcinoma Todani modification of Alonso- Lej classification (Option C) Type I Ia Cystic dilation of the extrahepatic bile duct (Most common) Ib Focal segmental dilation of extrahepatic bile duct Ic Fusiform dilation of extrahepatic bile duct Type II Diverticular dilation of extrahepatic bile duct Type III Dilatation of intraduodenal part of bile duct (choledochocele) Type IV IV a Dilatation of both intra and extrahepatic bile duct IV b Multiple cysts involving extrahepatic bile duct only Type V Multiple cysts involving intrahepatic bile duct only (Caroli's disease) Type Treatment Type I Complete excision, cholecystectomy, Roux-en-Y hepaticojejunostomy Type II Complete excision Type III Transduodenal excision or sphincteroplasty, endoscopic drainage may suffice Type IVa Tailored to anatomy: extrahepatic cysts treated like Type I; partial hepatectomy and reconstruction for localised intrahepatic involvement Type IVb Managed like Type I Type V (Caroli disease) Resection for unilobar disease; liver transplantation for diffuse disease



References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1242

Sabiston Textbook of Surgery, 21st Edition, Page 1504,1505

SRB’s Manual of Surgery, 6th Edition, Page 628, 629

↑ *Back to this question in Part A*

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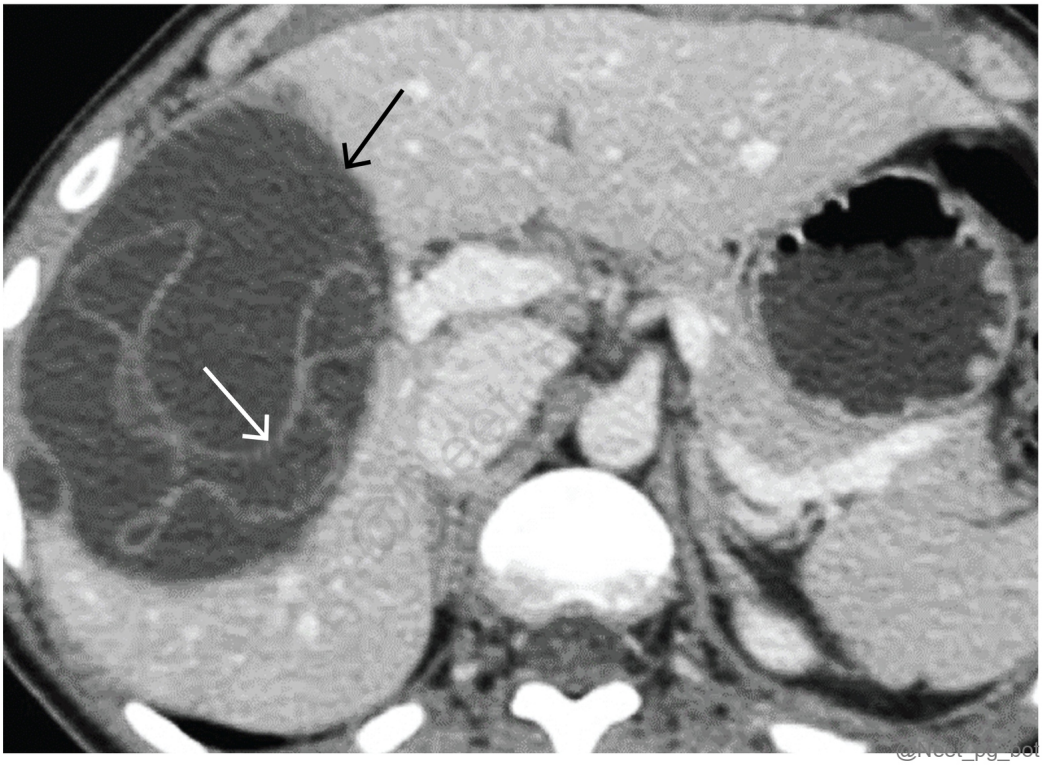
Q48: Identify the stage of disease given in the image. (Q844272)

A. Type 1

B. Type 2

C. Type 3

D. Type 4



Correct Answer: B. Type 2

Explanation: Correct Option B - Type 2: The cyst becomes more complex, often with the presence of daughter cysts, membranes, or debris. The cyst wall may show signs of rupture or detachment. Imaging Characteristics: A mixed pattern with daughter cysts, floating membranes ("water lily sign"), or internal debris. This stage indicates an ongoing degenerative process of the cyst, with possible partial rupture. WHO-IWGE staging Gharbi classification Description Stage CE1 Type I Unilocular anechoic cystic lesion with double line sign Active CE2 Type III Multiseptated, "rosette-like" "honeycomb" cyst Active CE3 A Type II Cyst with detached membranes

(water-lily sign) Transitional CE3 B Type III Cyst with daughter cysts in solid matrix Transitional CE4 Type IV Cyst with heterogenous hypoechoic/hyperechoic contents. No daughter cysts Inactive CE5 Type V Solid cyst with calcified wall Inactive Incorrect Options: Option A - Type 1: The cyst is small and filled with clear fluid, with no visible daughter cysts or debris. This represents the early, uncomplicated stage. Imaging Characteristics: A purely cystic lesion with smooth walls, no internal septations, or calcifications. Option C - Type 3: The cyst begins to mature, showing internal septations or a "honeycomb" appearance as daughter cysts start forming within the main cyst. Imaging Characteristics: Multiple small cysts within the main cyst, leading to a multilocular appearance. The cyst walls remain intact, and the fluid is still clear. Option D - Type 4: The cyst shows evidence of complete degeneration, with a solidified appearance. The cyst is often calcified and may no longer be active. Imaging Characteristics: A dense, calcified mass with no visible fluid or daughter cysts. The cyst is inactive or dead.

References:

Bailey & Love’s Short Practice of Surgery, 28th Edition, Page 75 SRB’s Manual of Surgery, 6th Edition, Page 595

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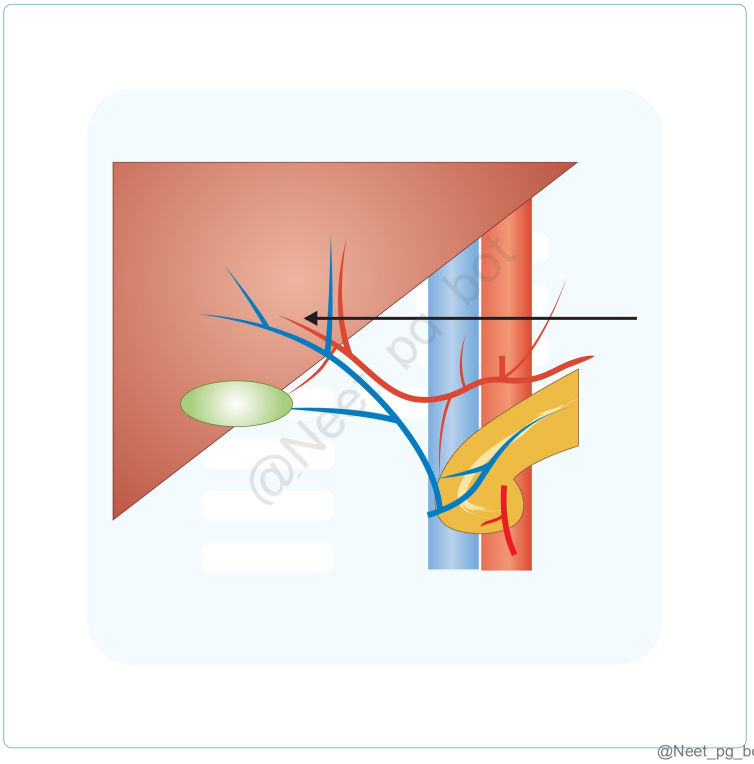
Q49: Identify the marked structure? (Q852723)

A. Cystic artery

B. Right Hepatic artery

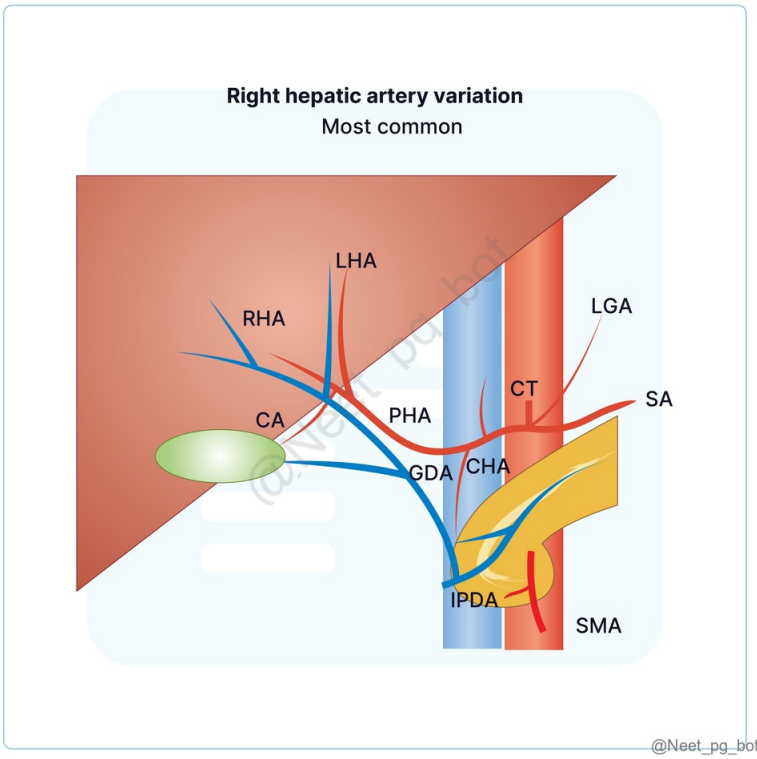
C. Hepatic duct

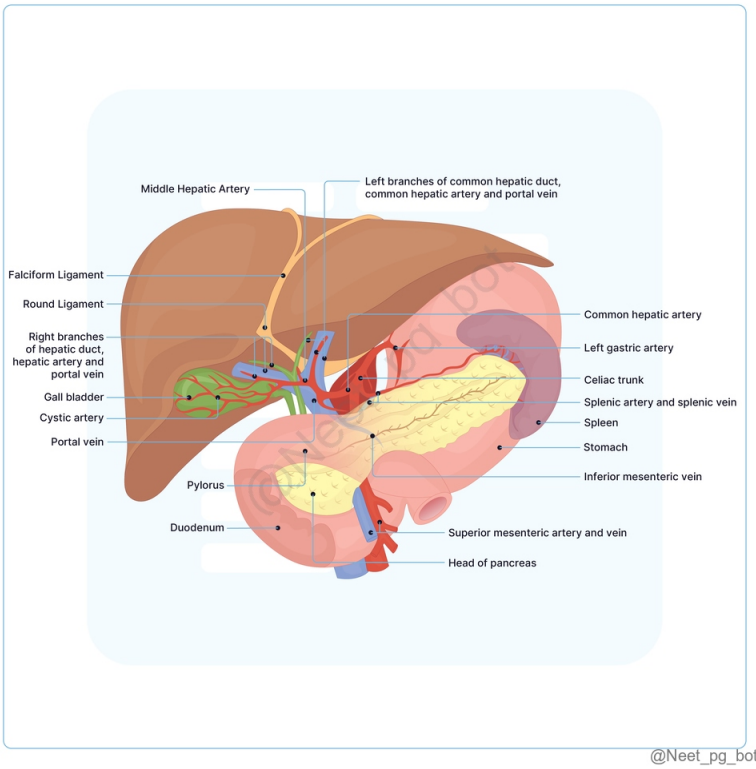
D. Cystic duct



Correct Answer: B. Right Hepatic artery

Explanation: Course and Branching: The Right Hepatic Artery (RHA) originates from the Proper Hepatic Artery and courses toward the right lobe of the liver . It runs behind the common hepatic duct and gives rise to the Cystic Artery , which supplies the gallbladder. Image-Based Identification: The marked structure is seen branching toward the right lobe of the liver , which aligns with the usual anatomical location of the Right Hepatic Artery . Its size and direction distinguish it from smaller branches such as the Cystic Artery . Right Hepatic Artery Feature Description Origin Proper Hepatic Artery (branch of Common Hepatic Artery) Course Runs behind the common hepatic duct and ascends toward the right lobe of the liver Branches Cystic artery (to gallbladder), Segmental branches to liver Function Supplies the right lobe of the liver and gallbladder Clinical Importance Injury during cholecystectomy can lead to hemorrhage or hepatic ischemia Cystic Artery (Option A): Incorrect because the cystic artery is a smaller branch of the RHA that supplies the gallbladder, whereas the marked structure is larger and directed toward the liver. Hepatic Duct (Option C): Incorrect because the hepatic duct is a biliary structure that transports bile, not an artery. Cystic Duct (Option D): Incorrect because the cystic duct connects the gallbladder to the bile duct system and does not match the marked arterial structure.





References:

Bailey and Love’s Short Practice of Surgery, 28th Edition, Page 1232, 1233

Schwartz’s Principles of Surgery, 11th Edition, Page 1348

Hepatic Artery

↑ *Back to this question in Part A*

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Q50: Which of the following is the classical triad of acute cholangitis? (Q852707)

A. Pain, jaundice, fever

B. Pain, jaundice, shock

C. Fever, jaundice, ↑WBC

D. Pain, ↑WBC, ↑Bilirubin

Correct Answer: A. Pain, jaundice, fever

Explanation: Pain, jaundice, fever - this triad, known as Charcot's triad- indicates cholangitis. Cholangitis Aetiology Often due to obstruction in the biliary tree, leading to bacterial infection by organisms like Klebsiella, E. coli, Enterobacter, Pseudomonas, and Citrobacter species. Symptoms Charcot's triad - pain, jaundice, fever Additional tenderness in the epigastrium and right hypochondrium is common. Severe Form: Reynolds pentad - persistent pain, fever, jaundice, shock, and altered mental status Indicates acute obstructive suppurative cholangitis. Lab Findings Elevated white blood cell count, bilirubin, and alkaline phosphatase levels. Chronic cases may show lobar or segmental atrophy or hypertrophy. Recurrent Pyogenic Cholangitis More common in East Asian populations, caused by intrahepatic stones and infections Risk factors include parasitic infections like Clonorchis sinensis and Ascaris lumbricoides. Pain, jaundice, shock (Option B): This option is incorrect as shock is not part of Charcot's triad but is part of Reynolds's pentad. Fever, jaundice, ↑WBC (Option C): ↑WBC, although it does occur in cholangitis, is not a component of Charcot's triad. Pain, ↑WBC, ↑Bilirubin (Option D): ↑Bilirubin, although it does occur in cholangitis, is not a component of Charcot's triad.

References:

Bailey and Love’s Short Practice of Surgery, 28th Edition, Page 1253

Sabiston Textbook of Surgery, 21st Edition, Page 1515

SRB’s Manual of Surgery, 6th Edition, Page 643

↑ *Back to this question in Part A*

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Q51: A 20-year-old male presents with acute epigastric pain and fever. He has a history of cholelithiasis. On examination, abdominal guarding and rigidity are noted. Laboratory results show elevated serum amylase and lipase levels, along with leukocytosis. What is the most likely diagnosis for his condition? (Q853061)

A. Serum amylase remains elevated even after 30 days of resolution of acute pancreatitis

B. ■■■> 75 per cent of patients present with hypercalcemia

C. Serum lipase is more specific than serum amylase

D. Increase in the level of serum lipase is directly proportional to the severity

Correct Answer: C. Serum lipase is more specific than serum amylase

Explanation: The most likely diagnosis here is acute pancreatitis , given the acute epigastric pain, fever, history of cholelithiasis, abdominal guarding, rigidity, & elevated serum amylase and lipase levels along with leukocytosis. Serum lipase is indeed more specific than amylase for diagnosing acute pancreatitis. While both enzymes are elevated in pancreatitis, lipase tends to remain elevated longer and is more directly associated with pancreatic damage. (Option A ruled out) Serum amylase levels can also be elevated in other acute abdominal conditions such as perforation, volvulus, and torsion. If amylase remains elevated for more than a few weeks, it could indicate a chronic condition or other non-pancreatic diseases. > 75 per cent of patients present with hypercalcemia (Option B) : Hypercalcemia is not a common feature of acute pancreatitis. In fact, hypocalcemia is more commonly observed in acute pancreatitis, which happens due to the precipitation of calcium salts in the pancreatic tissue because of the saponification of fat. Increase in the level of serum lipase is directly proportional to the severity (Option D) : Lipase and amylase do not directly correlate with the severity of the disease, and n one of the commonly used scoring systems for grading pancreatitis directly rely on the values of amylase or lipase to assess the severity of the condition.

References:

SRB’s Manual of Surgery, 6th Edition, Pages 675 - 680

↑ *Back to this question in Part A*

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Q52: A patient presents with a 2-year history of anorexia, epigastric pain, jaundice, and itching (pruritis). On examination, the gallbladder is palpable. What is the most likely diagnosis? (Q866482)

A. Gallbladder carcinoma

B. Hepatocellular carcinoma (HCC)

C. Cholelithiasis (gallstones)

D. Ca of the head of the pancreas

Correct Answer: D. Ca of the head of the pancreas

Explanation: Prolonged anorexia, epigastric pain, jaundice, and pruritis with a palpable gallbladder (Courvoisier's sign) indicate chronic biliary obstruction, most commonly caused by carcinoma of the head of the pancreas. CA Pancreas Symptoms: Jaundice secondary to obstruction is the most common symptom Characteristically painless, but may be associated with nausea and epigastric discomfort Pruritus, dark urine and pale stools with steatorrhea Weight loss Signs: Courvoisier's sign - palpable, non-tender gallbladder (Option D) Palpable liver and ascites Diabetes mellitus depending on the location of tumor Gallbladder carcinoma (Option A): Although gallbladder carcinoma can cause jaundice and a palpable gallbladder, it is less common and usually presents with more localized symptoms. Hepatocellular carcinoma (HCC) (Option B) rarely causes biliary obstruction or a palpable gallbladder. Cholelithiasis (gallstones) (Option C) usually causes episodic pain and does not present with a palpable gallbladder or chronic jaundice.

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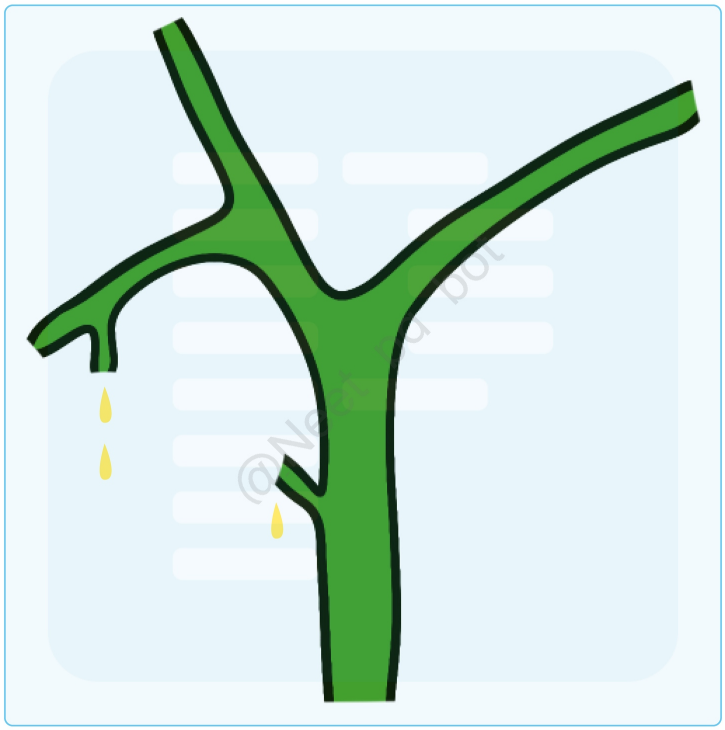
Q53: Based on the given image, which type of injury is shown according to the Bismuth-Strasberg classification: (Q866466)

A. Type A

B. Type B

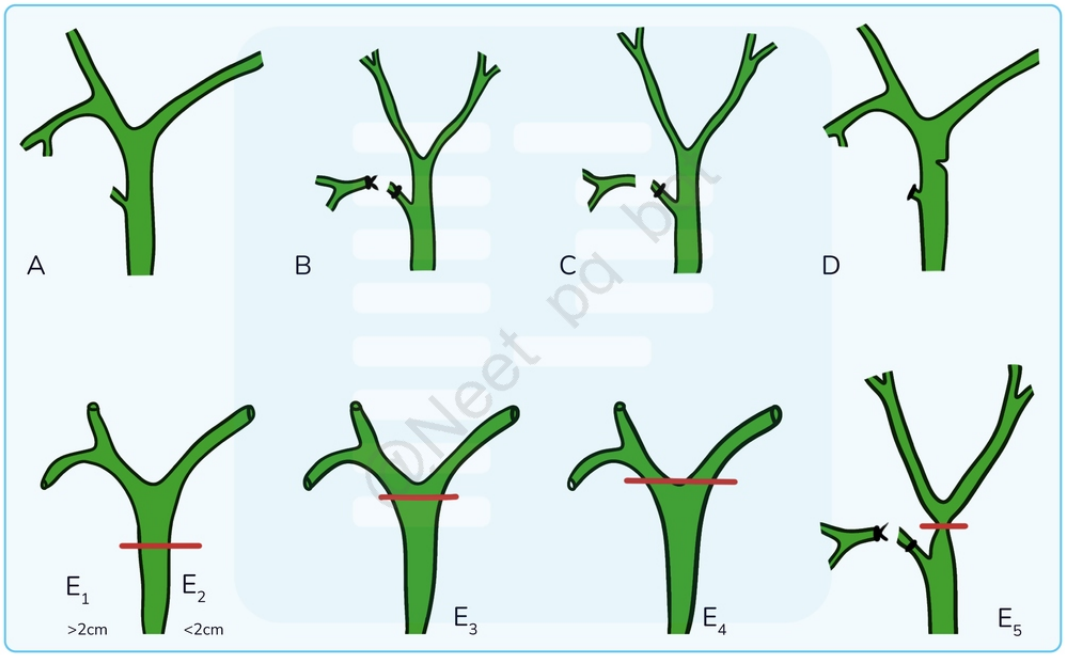
C. Type C

D. Type D



Correct Answer: A. Type A

Explanation: According to the Bismuth-Strasberg classification, the image shows a Type A injury, which involves a cystic duct stump leak or leakage from small ducts in the liver bed, and is the most common type, typically occurring without damage to the major bile ducts. Bismuth classification for biliary strictures Type A Bile leak from cystic duct or liver bed (Option A) Type B Occlusion of the right segmental duct (Option B ruled out) Type C Bile leak from divided right segmental duct (Option C ruled out) Type D Lateral injury to the common hepatic duct (Option D ruled out) Type E E1: Main bile duct injury, more than 2 cm from the confluence E2: Main bile duct injury, less than 2 cm from the confluence E3: Hilar injury with intact confluence E4: Injury involving the confluence; right and left hepatic ducts are separated E5: Injury of aberrant right sectoral duct with simultaneous injury of the main bile duct.



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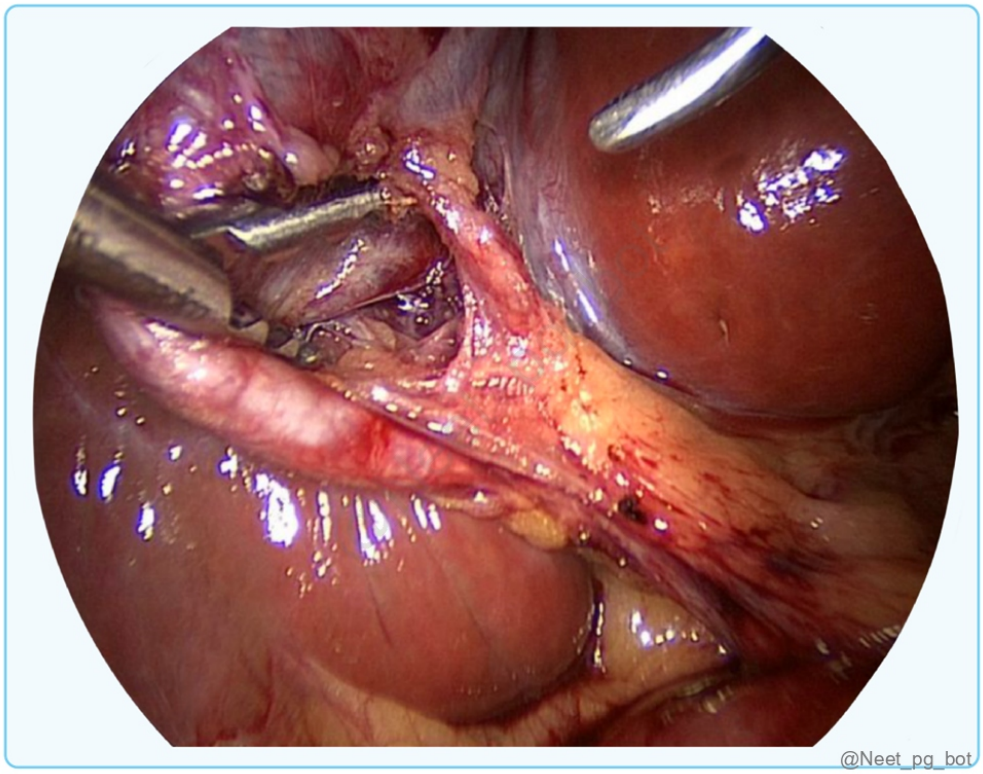
Q54: During a laparoscopic cholecystectomy, the surgeon carefully identifies the boundaries of the hepatocystic triangle to avoid injury to important structures. Which of the following is not a boundary of the hepatocystic triangle? (Q865336)

A. Cystic duct

B. Common hepatic duct

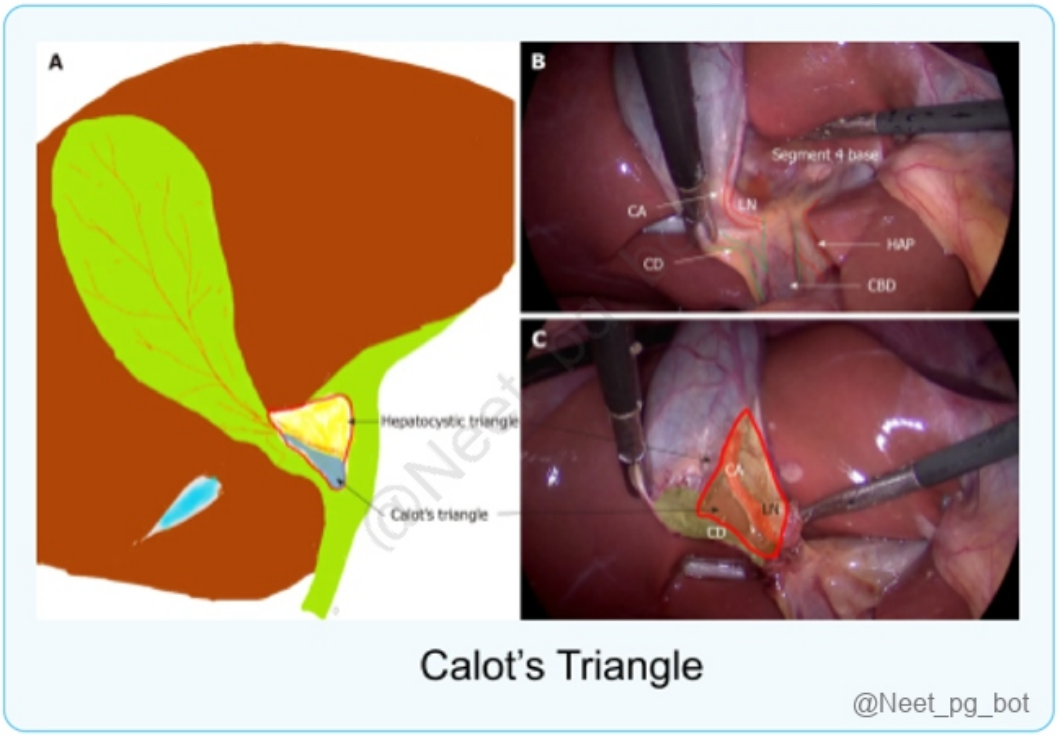
C. Inferior border of the liver

D. Cystic artery



Correct Answer: D. Cystic artery

Explanation: The hepatocystic triangle (also called Calot's triangle) is an important anatomical area identified during laparoscopic cholecystectomy to prevent injury to the common bile duct and other vital structures. The Cystic artery (D) is not a boundary; rather, it is the most important content of the triangle. Boundaries of Hepatocystic (Calot's) triangle: Medially: The Common hepatic duct (Option B) Laterally: The Cystic duct (Option A) Superiorly: The Inferior border of the liver (Option C) Contents of Hepatocystic (Calot's) triangle: Cystic artery (Option D) (supplies blood to the gallbladder) Cystic lymph node (Lund's node) Autonomic fibers reaching the gallbladder



References:

Bailey and Love's Short Practice of Surgery, 28th Edition, Pg. 1232, 1233

SRB's Manual of Surgery, 6th Edition, Pg. 623, 656

↑ *Back to this question in Part A*

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Q55: A 30-year-old female presented with pain in the right upper quadrant of the abdomen after 4 days of cholecystectomy. On USG, it showed a significant collection in RUQ. What will you do further? (Q866916)

A. Re-explore laparoscopically

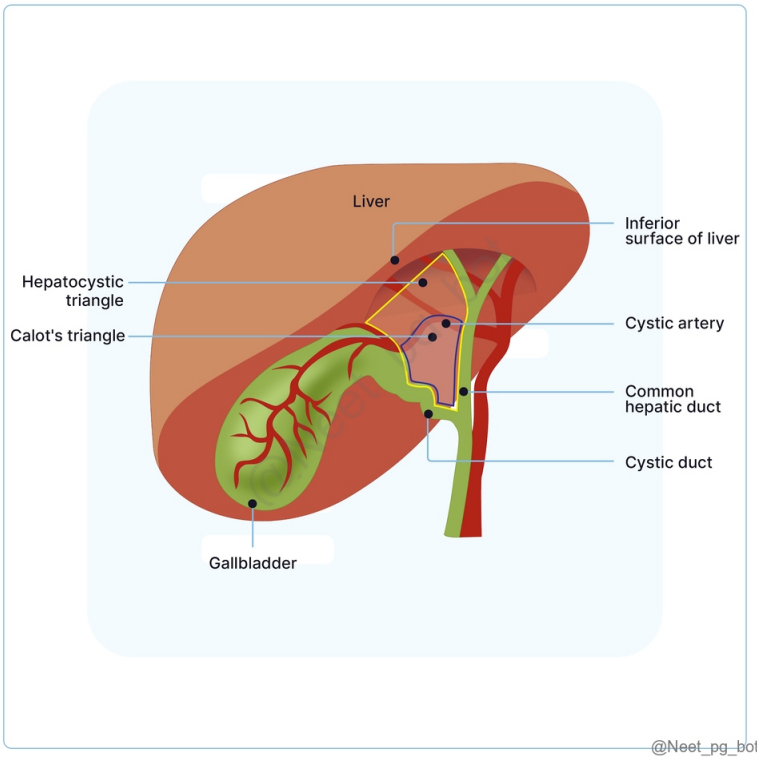
B. Higher antibiotics

C. MRCP

D. USG guided aspiration of content

Correct Answer: D. USG guided aspiration of content

Explanation: The patient presents 4 days post-cholecystectomy with a localized collection in the right upper quadrant on ultrasound. The immediate priority here is diagnosis and therapeutic drainage — aspiration will relieve symptoms, confirm the nature of the fluid (bile, pus, blood), and guide further management. If the aspirated content is bile → further evaluation with MRCP or ERCP can be planned to localize and treat the leak. Aspiration is minimally invasive and avoids unnecessary re-exploration in a stable patient. Post-Cholecystectomy Collections: Causes: Bile leak (cystic duct stump leak, accessory duct injury), intra-abdominal abscess, hematoma, seroma. Symptoms: Fever, abdominal pain, localized tenderness, distension, jaundice (if major duct injury). Diagnosis: USG: Detects and localizes fluid collection. Aspiration: Confirms content type. MRCP: Maps biliary anatomy if a bile leak is suspected. ERCP: Diagnostic + therapeutic (stenting, sphincterotomy). Surgical anatomy: Calot's triangle boundaries → Cystic duct (medial), common hepatic duct (lateral), inferior surface of liver (superior). Contents: Cystic artery, cystic lymph node of Lund, connective tissue. Management pathway: USG-guided aspiration. If bile leak → MRCP/ERCP. Persistent leak or large duct injury → surgical repair. Re-explore laparoscopically (Option A) – Too invasive without knowing the nature of the collection. Higher antibiotics (Option B) – Won't resolve a large collection; drainage is required. MRCP (Option C) – Useful after confirming bile in the aspirate, but here aspiration is the first step.



↑ *Back to this question in Part A*

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Q56: A 55-year-old alcoholic patient presents with sudden and unintentional weight loss. Lab investigations revealed serum alkaline phosphatase (ALP) of 240 IU/L, alpha-fetoprotein (AFP) of 600 ng/ml, and normal serum AST and ALT levels. What

is the most likely diagnosis? (Q855185)

A. Hepatic adenoma

B. Cholangiocarcinoma

C. Hepatocellular carcinoma

D. Alcoholic hepatitis

Correct Answer: C. Hepatocellular carcinoma

Explanation: The patient's normal AST and ALT, along with the raised ALP, are consistent with cholestasis or hepatic malignancy. Hepatocellular carcinoma (HCC) is a primary liver cancer often seen in patients with chronic liver disease, including those with alcoholism. The elevated alpha-fetoprotein (AFP) is a marker commonly associated with HCC. Tumor Markers: Elevated Alpha-fetoprotein (AFP) levels above 20 ng/ml are observed in approximately 70% of cases of hepatocellular carcinoma. An increase in PIVKA-II (Protein Induced by Vitamin K Absence or Antagonism-II) is also noted. Risk factors for HCC: Cirrhosis Metabolic disorders Environmental factors HBV infection HCV infection Alcohol NAFLD Primary biliary cirrhosis Chronic active hepatitis Hemochromatosis Wilson's Disease Glycogen Storage Disorder α1AT-deficiency Porphyria cutanea tarda Citrullinemia Orotic aciduria Alagille's syndrome Cigarette Smoking Anabolic steroids Aflatoxin Thorotrast Other options: Option A: Hepatic adenoma Typically occurs in young women on OCPs. AFP does not rise in hepatic adenoma. ALP elevation is not characteristic. Option B: Cholangiocarcinoma Causes marked ALP elevation but AFP is not elevated; CA19-9 may rise instead. Option D: Alcoholic hepatitis Characteristically shows AST : ALT ratio >2, both elevated. AFP does not rise significantly. ALP is not disproportionately elevated compared to transaminases.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1214,1215

Schwartz’s Principles of Surgery, 11th Edition, Page 1376

Sabiston Textbook of Surgery, 21st Edition, Page 1465.

SRB's Manual of Surgery, 6th Edition, Page 600

↑ *Back to this question in Part A*

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Q57: A 50-year-old alcoholic patient presents with a history of waxing and waning jaundice for the past 2 months. His CT examination reveals dilatation of the common bile duct and pancreatic duct. What is the most probable diagnosis in the patient? (Q855691)

A. Cholangiocarcinoma

B. Periampullary carcinoma

C. Common bile duct stone

D. Head of the pancreas carcinoma

Correct Answer: B. Periampullary carcinoma

Explanation: The scenario of an alcoholic patient experiencing fluctuating jaundice, with a CT scan showing dilation of both the common bile duct and pancreatic duct, is most likely indicative of Periampullary Carcinoma . It originates in the pancreas, bile duct, or intestines close to the ampulla of Vater (the region where the common bile duct and pancreatic duct converge and enter the duodenum). They can cause obstruction of both the common bile duct and pancreatic duct. Clinical features: Jaundice (waxing and waning) (most common) A palpable, non-tender gallbladder Weight loss Abdominal pain Nausea/vomiting Pruritus Fever Gastrointestinal bleeding Cholangiocarcinoma (Option A) arises from the bile ducts and can cause common bile duct dilatation. However, the waxing and waning jaundice and dilatation of the pancreatic duct, in this case, are more indicative of periampullary carcinoma. Cholangiocarcinoma usually presents with more progressive jaundice. Common bile duct stone (Option C) can cause ductal dilatation, but the waxing and waning jaundice and pancreatic duct involvement make periampullary carcinoma more likely. Bile duct stones typically cause acute, not fluctuating, jaundice. Head of the pancreas carcinoma (Option D) can cause ductal dilatation, but periampullary carcinoma is a more specific diagnosis given the involvement of both the common bile duct and pancreatic duct. Pancreatic cancer typically presents with continuous jaundice, not fluctuating.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1244. Sabiston Textbook of Surgery, 21st Edition, Page 1553-1555.

↑ *Back to this question in Part A*

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Q58: A chronic-alcoholic presents to the emergency room with acute pain in the abdomen in the epigastric region radiating to the back with nausea, anorexia, and occasional vomiting. Investigations showed elevated amylase levels (3 times) and total count. Likely diagnosis is: (Q857788)

A. Acute hepatitis

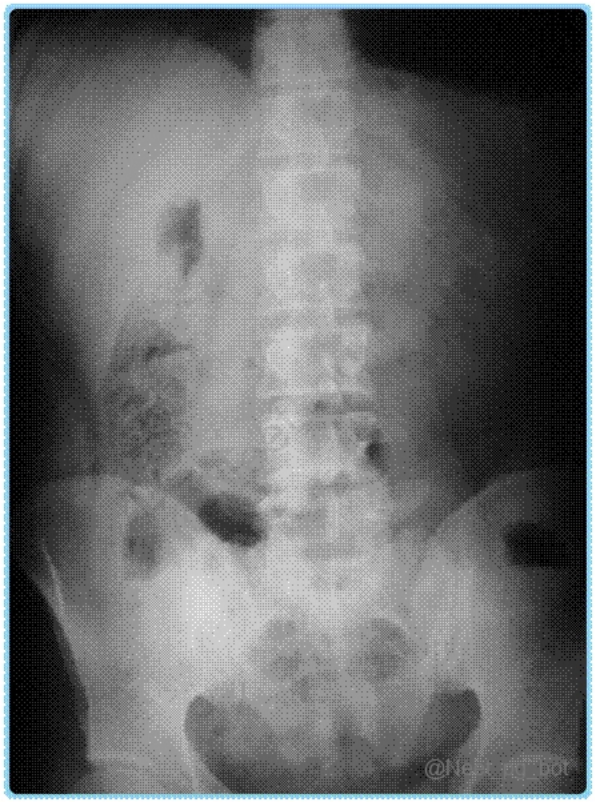
B. Acute pancreatitis

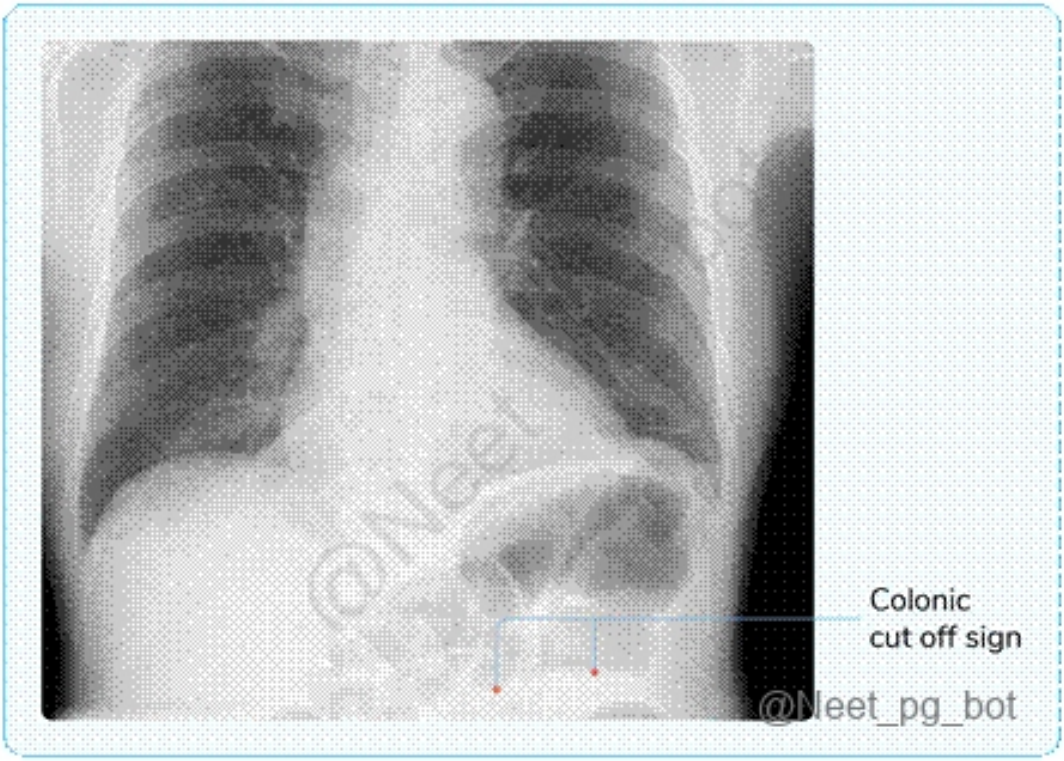
C. Acute cholecystitis

D. Acute appendicitis

Correct Answer: B. Acute pancreatitis

Explanation: The scenario of a chronic alcoholic presenting with epigastric abdominal pain radiating to the back, along with nausea, anorexia, occasional vomiting, and elevated amylase levels and total count, is indicative of Acute Pancreatitis. Clinical Diagnosis (Requires 2 of 3): Abdominal pain is strongly suggestive of acute pancreatitis. (Option B) Serum amylase and/or lipase (more specific) level at least 3 times the upper limit of normal. (Option B) Imaging findings characteristic of acute pancreatitis. X-ray Features Sentinel loop sign : Dilated loop of small intestine near the inflamed pancreas due to localized ileus. Significance : Early indicator of acute pancreatitis on X-ray. {{caption_text}} Sentinel loop sign Colon cut-off sign : Abrupt termination of gas in the colon at the splenic flexure, with collapsed distal colon loops. Significance : Suggests localized pancreatic inflammation, causing colonic spasm as an indirect sign of acute pancreatitis {{caption_text}} Investigations of Choice: Contrast-enhanced CT (CECT) : Primary tool for assessing pancreatic necrosis, peripancreatic inflammation, fluid collections, and complications. Most reliable for staging and detecting complications. May underestimate necrosis if done in the first 24 hours. Morphological Types (Revised Atlanta Classification 2008): Interstitial oedematous pancreatitis : Mild form with pancreatic oedema and swelling but no necrosis. Necrotising pancreatitis: Severe form involving pancreatic parenchymal necrosis, associated with higher morbidity and mortality. Acute hepatitis (Option A) is liver inflammation, often caused by viral infections, alcohol, or toxins, with symptoms like jaundice, fatigue, dark urine, and elevated liver enzymes (ALT, AST). This diagnosis is unlikely for the patient, as her symptoms of epigastric pain, elevated amylase, and the absence of jaundice or liver enzyme elevation point more toward pancreatitis. Acute Cholecystitis (Option C) , caused by gallstones, presents with right upper quadrant pain, fever, and nausea, with ultrasound showing gallstones or thickened walls. However, the patient's epigastric pain and elevated amylase suggest pancreatitis, not cholecystitis. Acute appendicitis (Option D) presents with right lower quadrant pain, fever, elevated white blood cell count, and pain that starts around the umbilicus, shifting to the lower right abdomen. In this case, the patient has epigastric pain and elevated amylase, making appendicitis unlikely, as it doesn’t typically affect amylase levels.





References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1262-1263.

Sabiston Textbook of Surgery, 21st Edition, Page 1533-1535.

↑ *Back to this question in Part A*

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Q59: Which of the following is the best preferred investigation for Neuroendocrine Tumors (NETs)? (Q857777)

A. USG

B. SRS

C. MRI

D. PET

Correct Answer: D. PET

Explanation: Pancreatic Neuroendocrine Tumors (PNETs) are derived from pluripotent stem cells. Classified as functional and non-functional PNETs Subtypes: Insulinoma (most common functional PNET) Gastrinoma (most common functional and malignant PNET) Non-functional tumors VIPoma Glucagonoma Somatostatinoma Carcinoid ACTHoma GRFoma It is symptomatic and diagnosed at an early stage. Diagnosis: Laboratory measurement of active substances or its by products. PET (Positron Emission Tomography)/CT: Preferred investigation for NETs nowadays. (Option D) Tracer: 68Gallium (68Ga)-labeled somatostatin analogs Somatostatin receptor scintigraphy (SRS) is used for the localization of NETs. (IOC). All Neuroendocrine tumors express Somatostatin receptors except Insulinoma. It is not used nowadays. (Option B ruled out) USG (ultrasound) (Option A) is not the best choice for pancreatic NETs because the pancreas is deep in the abdomen, making it hard to visualize. It is useful for detecting large masses but is less sensitive for smaller tumors or those without distinct features. MRI (Option C) is useful for pancreatic tumors and liver metastases but lacks the functional detail of SRS. SRS is the gold standard for detecting somatostatin receptor-positive NETs.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 905.

Harrison’s Principles of Internal Medicine, 21st Edition, Page 634.

PET/CT imaging of neuroendocrine tumors with 68Gallium-labeled somatostatin analogues: An overview and single institutional experience from India

↑ *Back to this question in Part A*

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Q60: A patient arrives with pain in the right upper abdomen. One week ago, the patient experienced a bout of diarrhoea. Abdominal CT scan results indicate the presence of a liver abscess measuring approximately 25 cubic centimetres. What should be the subsequent course of action in treating this patient? (Q855205)

A. PAIR

B. Surgery

C. Medical therapy

D. Percutaneous drainage

Correct Answer: C. Medical therapy

Explanation: The key feature in the patient's history is the bout of diarrhea one week prior . This strongly suggests an enteric pathogen as the cause. Entamoeba histolytica, the protozoan that causes amebiasis, infects the colon (causing diarrhea/dysentery) and can then travel via the portal vein to the liver, forming an abscess. The initial treatment for a liver abscess typically involves medical therapy with broad-spectrum antibiotics. Percutaneous drainage or PAIR may be considered if the abscess does not improve with antibiotics or if it grows in size or

becomes symptomatic. Surgery is reserved for more complicated or non-drainable abscesses. Management of Hepatic Pyogenic Abscess: Initial Management: Broad-Spectrum Antibiotics: Start immediately to control bacteremia and prevent complications. Antibiotics should cover gram-negative, gram-positive, and anaerobic organisms (e.g., ampicillin, aminoglycoside, metronidazole). Typically 2 weeks or more, depending on infection resolution and drainage success. Drainage Techniques: Percutaneous Drainage: First-line treatment with success rates of 66% to 90% . Advantages: Simpler, avoids general anaesthesia. Contraindications: Ascites, coagulopathy, proximity to vital structures. Percutaneous drainage should be attempted first, reserving surgery for failures. Percutaneous Aspiration: Less effective than percutaneous catheter drainage but reasonable for initial treatment. Surgical drainage: Reserved for cases where percutaneous drainage fails or when surgery is needed for underlying conditions (e.g., appendicitis). Feature Amebic Abscess Pyogenic Abscess Age 20–40 years >50 years Male-to-Female Ratio ≥10:1 1.5:1 Solitary vs Multiple Solitary 80% Solitary 50% Location Usually right liver Usually right liver Travel in Endemic Area Yes No Diabetes Uncommon (~2%) More common (~27%) Alcohol Use Common Common Jaundice Uncommon Common Elevated Bilirubin Uncommon Common Elevated Alkaline Phosphatase Common Common Positive Blood Culture No Common Positive Amebic Serology Yes No

References:

Sabiston Textbook of Surgery, 21st Edition, Page 1455,1459

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Q61: A patient presents with features of chronic pancreatitis, including recurrent attacks, and has a 10 mm dilatation of the pancreatic duct with intraductal calculi present. Which of the following is the surgery of choice? (Q855189)

A. Pancreaticoduodenectomy

B. Longitudinal pancreaticojejunostomy

C. ERCP and sphincterotomy

D. Coring of the pancreas head

Correct Answer: B. Longitudinal pancreaticojejunostomy

Explanation: In chronic pancreatitis, a main pancreatic duct dilatation ≥7 mm with intraductal stones indicates an obstructive form of the disease. The Puestow procedure (Longitudinal pancreaticojejunostomy) decompresses the duct by opening it along its length and anastomosing it to a Roux-en-Y jejunal loop. It effectively relieves pain by reducing intraductal pressure and facilitates drainage of calculi. It is the procedure of choice when dilation is significant (like 10 mm). Incorrect Options: Option A) Pancreaticoduodenectomy (Whipple) : Reserved for head mass, suspicion of malignancy, or unrelieved obstruction- not for a dilated duct alone. Option C) ERCP and sphincterotomy : Useful for small stones or strictures; not effective for diffuse pancreatic duct stones in a markedly dilated duct. Option D) Coring of the pancreas head (Frey procedure) : Indicated when inflammatory mass in the pancreatic head coexists; not needed here if only duct dilation + stones are present.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1279,1280

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Q62: A 46 year male had a tumor in his left lobe of liver, so left sided hemi hepatectomy was planned, which of the following lobes of liver will be resected in this procedure? (Q866907)

A. 2,3 and 4

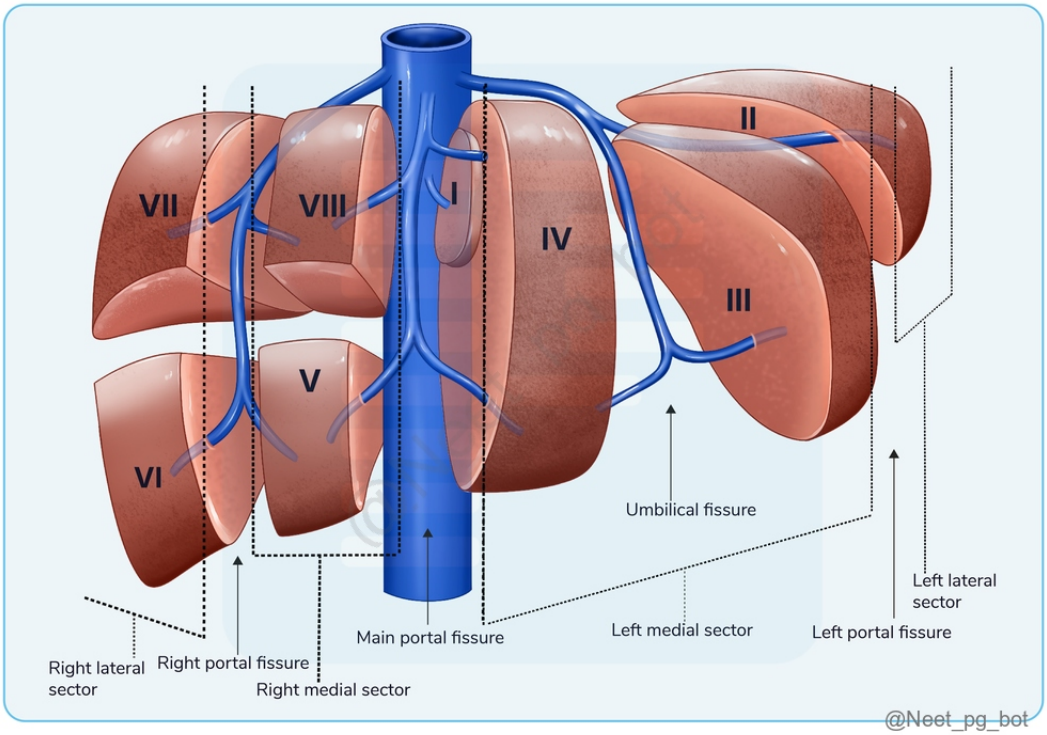
B. 1,2 & 3

C. 5, 6, 7 & 8

D. 2, 3, 4 & 5

Correct Answer: A. 2,3 and 4

Explanation: Liver lobes are defined surgically based on Couinaud's segmental anatomy (functional anatomy), which follows the portal vein and hepatic vein divisions rather than the classical anatomical right/left lobes. In a left hemihepatectomy , the left functional lobe is removed. This includes segments II, III, and IV : Segment II & III: Left lateral section Segment IV: Left medial section Segments of the liver Segment VIII: The superior part of the right anterior sector. Drainage: Drains into the right and middle hepatic veins. Segment I (Caudate Lobe): Posterior to segment IV, straddles the inferior vena cava. Drainage: Multiple small veins drain directly into the inferior vena cava. Bile Ducts: Related to the confluence of the right and left hepatic ducts. Segment II: Posterolateral to the left portal fissure. Drainage: Drains into the left hepatic vein; rarely directly into the inferior vena cava. Segment VII: The superior part of the right posterior sector, posterior to the right hepatic vein. Drainage: Primarily into the right hepatic vein; occasionally directly into the inferior vena cava. Segment III: Between the umbilical and left portal fissures. Drainage: Primarily into the left hepatic vein; alternative drainage via falciform ligament veins. Segment VI: Inferior part of the right posterior sector, posterior to the right portal fissure. Drainage: Usually into the right hepatic vein; may drain directly into the inferior vena cava. Segment V: Inferior segment of the right anterior sector. Drainage: Typically into the right and middle hepatic veins; can drain directly into the inferior vena cava. Segment IV: Between the umbilical fissure and main portal fissure, anterior to segment I. Drainage: Usually into the middle hepatic vein; can also drain into the left hepatic vein. 1, 2 & 3 (Option B): Segment I is the caudate lobe, which is functionally separate and not routinely removed in a left hemihepatectomy. 5, 6, 7 & 8 (Option C): These are part of the right functional lobe. 2, 3, 4 & 5 (Option D): Segment 5 belongs to the right lobe.



References:

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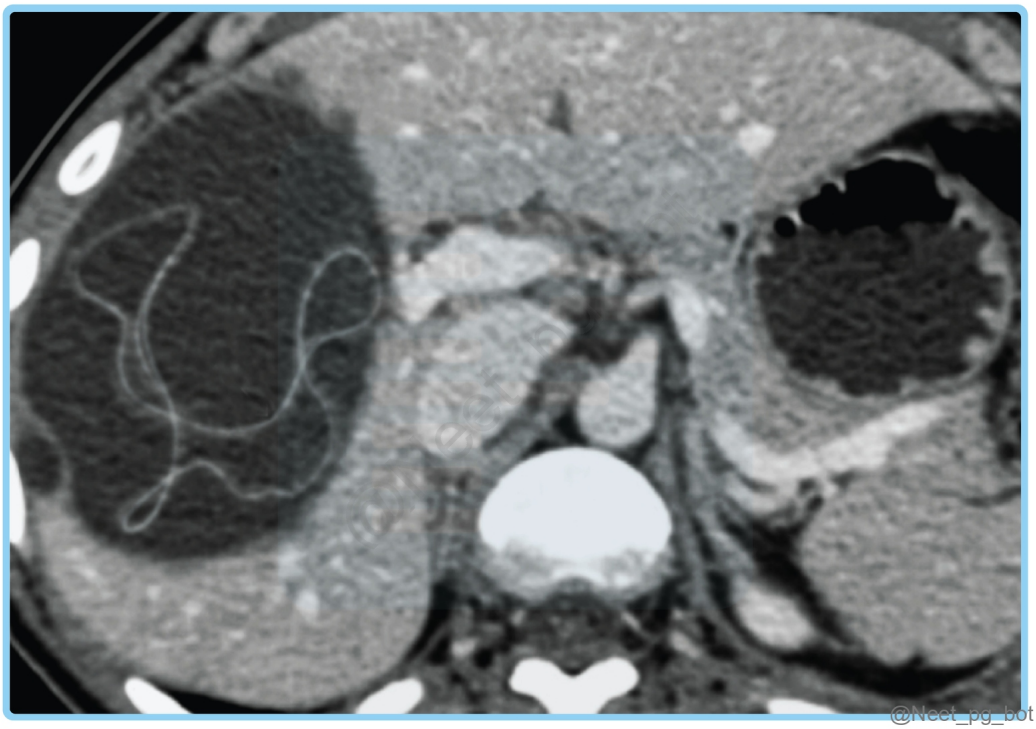
Q63: A patient presents with fever, abdominal pain, and jaundice. Investigations show the given findings. Which of the following statements is true regarding this condition? (Q855184)

A. Surgery is mandatory

B. Fine-needle aspiration cytology is diagnostic

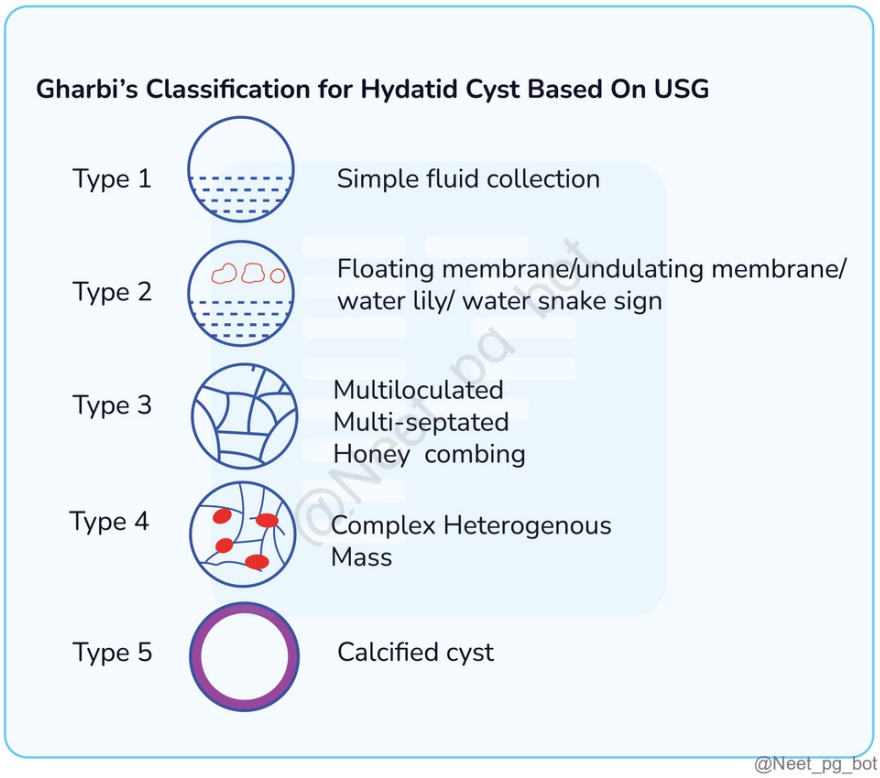
C. Angioembolization is the treatment of choice

D. Echinococcus species is involved in etiology



Correct Answer: D. Echinococcus species is involved in etiology

Explanation: The patient's symptoms of fever, abdominal pain, and jaundice, along with the provided findings of a serpentine linear membrane (a wavy membrane within the cyst), suggest a diagnosis of hydatid disease or echinococcosis . This condition is caused by infection with the Echinococcus species of tapeworm, typically transmitted through contact with dogs or livestock. Hydatid disease: Caused by Echinococcus granulosus (dog tapeworm). Humans are intermediate hosts, infected through oral ingestion of eggs from dogs. Clinical features: Common organs affected : Liver (most common), lungs, brain. Symptoms: Abdominal pain, jaundice, dysphagia, dyspnea, neurological signs (headache, ICP). It can present after trauma or with anaphylactic shock. Diagnosis: Eosinophilia , positive serology (ELISA, immunoelectrophoresis). Imaging : Ultrasound, CT, MRCP (for biliary involvement). {{caption_text}} Treatment: PAIR technique (Puncture, Aspiration, Injection, Reaspiration) after albendazole or praziquantel. Radical pericystectomy or segmentectomy for hepatic cases. Omentoplasty or laparoscopic marsupialization for cysts. Scolicidal agents : Hypertonic saline, ethanol, or povidone-iodine used during surgery. Laparoscopic marsupialization (deroofing) for cysts. Cyst aspiration, followed by scolicidal agent application and sealing biliary communications. Surgery is mandatory (Option A) : While surgery is often an effective treatment for hydatid cysts, it is not always required. In some cases, non-surgical options such as antiparasitic medications or percutaneous drainage may be more suitable. Fine-needle aspiration cytology is diagnostic (Option B) : Fine-needle aspiration (FNA) is generally avoided in the diagnosis of echinococcosis due to the risk of triggering anaphylaxis and the potential to spread the infection. Angioembolization is the treatment of choice (Option C) : Angioembolization is not typically the first-line treatment for hydatid disease and is not commonly used as a primary approach.



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References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 73-76

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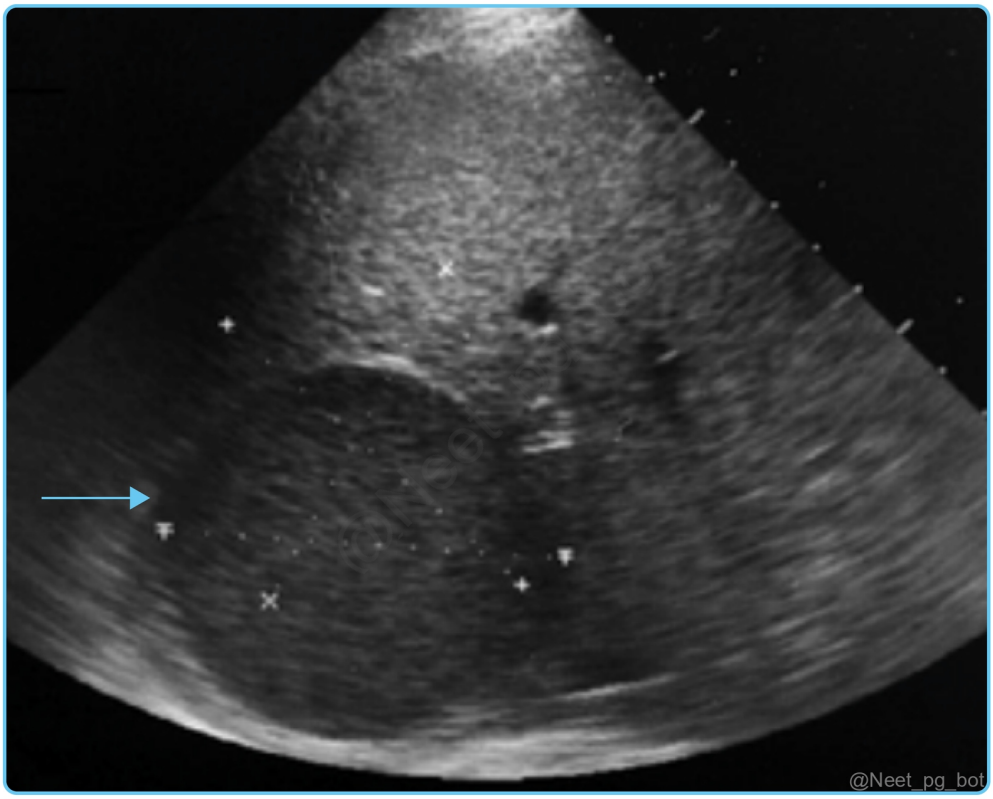
Q64: A 35-year-old patient with a history of dysentery for 6 weeks complains of pain in the right upper abdomen. On ultrasound, a hypoechoic hyperdense lesion is seen in the liver. Based on the given image, identify the condition. (Q854784)

A. Amoebic liver abscess

B. Pyogenic liver abscess

C. Hydatid cyst

D. Hemangioma



Correct Answer: A. Amoebic liver abscess

Explanation: The ultrasound image shows a hypoechoic hyperdense lesion in the liver. Given the patient's clinical history of dysentery, the most likely diagnosis is an amoebic liver abscess . Amoebic liver abscess is caused by the protozoan parasite Entamoeba histolytica , typically contracted through the ingestion of contaminated food or water. On ultrasound, the abscess appears as a well-defined, hypoechoic lesion with variable internal echoes . Mild to moderate oedema in the surrounding liver parenchyma may also be seen. Feature Amebic Abscess Pyogenic Abscess Age 20–40 years >50 years Male-to-Female Ratio ≥10:1 1.5:1 Solitary vs Multiple Solitary 80% Solitary 50% Location Usually right liver Usually right liver Travel in Endemic Area Yes No Diabetes Uncommon (~2%) More common (~27%) Alcohol Use Common Common Jaundice Uncommon Common Elevated Bilirubin Uncommon Common Elevated Alkaline Phosphatase Common Common Positive Blood Culture No Common Positive Amebic Serology Yes No Incorrect Options: Pyogenic liver abscess (Option B) : A pyogenic liver abscess, caused by bacterial infections like Escherichia coli or Klebsiella pneumoniae , usually presents as multiple hypoechoic lesions on ultrasound, rather than the single lesion shown here. Inflammation in the surrounding liver parenchyma may also be evident. Hydatid cyst (Option C) : Caused by the larval stage of Echinococcus granulosus , hydatid cysts typically appear as well-defined, anechoic, or hypoechoic lesions, often with multiple daughter cysts inside. The provided image shows a single hypoechoic hyperdense lesion, which is inconsistent with a hydatid cyst. Hemangioma (Option D) : Hemangiomas are benign vascular tumours that commonly occur in the liver. They usually appear as hyperechoic lesions with posterior acoustic enhancement on ultrasound. The lesion in the provided image, being hypoechoic and hyperdense, does not fit the typical characteristics of a hemangioma.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1455,1459

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Q65: After laparoscopic cholecystectomy, what should the expected urine output be in a patient with normal renal function? (Q854780)

A. 500 ml/day

B. 0.5 ml/min

C. 0.5-1.5 ml/kg/hour

D. 1 ml/kg/min

Correct Answer: C. 0.5-1.5 ml/kg/hour

Explanation: The normal urine output is around 1500 ml/day for a healthy adult, which roughly translates to 0.5-1.5 ml/kg/hour . (1x70(kg)x24(hours) ~ 1700 ml). Minimum urine output to excrete end products of protein metabolism: 500ml/day Ideal urine output in a normal 70kg adult: 1500 ml

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 792

↑ *Back to this question in Part A*

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Q66: What is the sign of the gallbladder seen in this USG? (Q854768)

A. Phrygian cap sign

B. Murphy sign

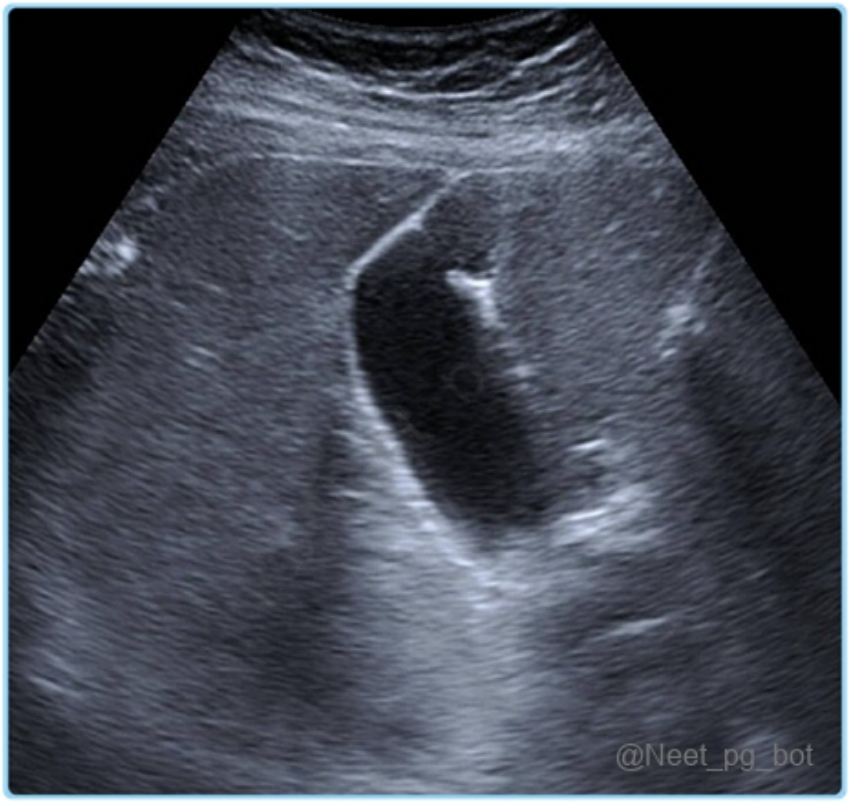
C. Claw sign

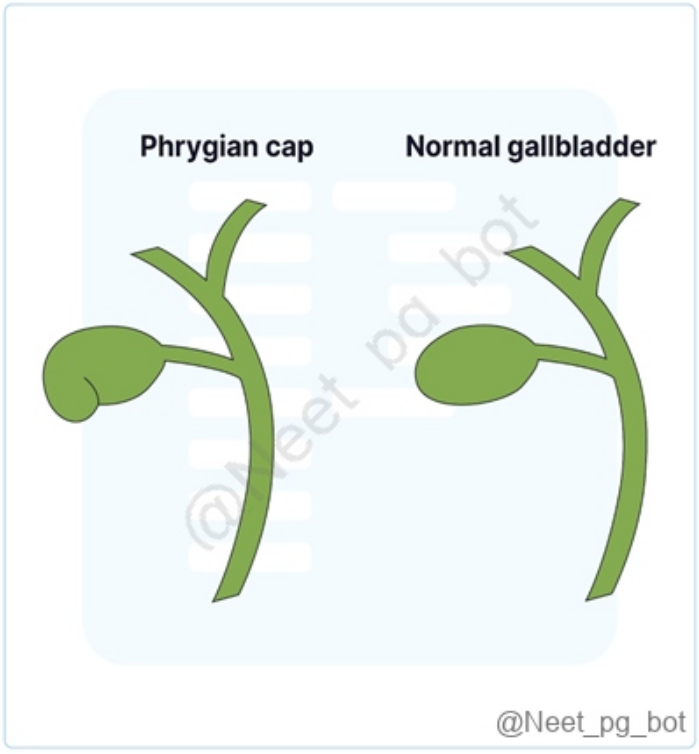
D. Omega sign

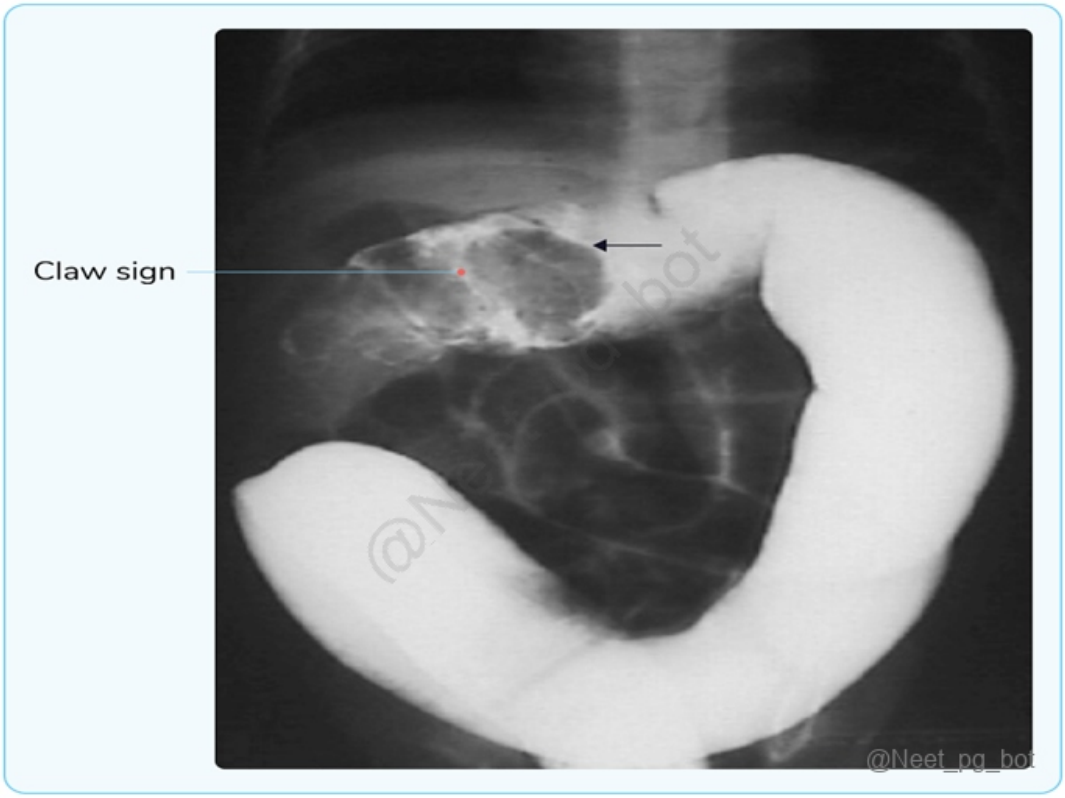


Correct Answer: A. Phrygian cap sign

Explanation: The image on the ultrasound (USG) shows the Phrygian cap sign , which is a common anatomical variation of the gallbladder. A Phrygian cap is a congenital variant of the gallbladder characterised by a fold at the fundus that resembles a cap. It is a benign condition and is typically asymptomatic, with its appearance being consistent with a cap-like structure on ultrasound. It has no pathological significance and does not affect gallbladder function. {{caption_text}} Incorrect Options: Murphy sign (Option B) is a clinical finding seen in acute cholecystitis, where pain and inspiratory arrest occur upon palpation of the gallbladder. It is not related to the anatomical variation seen in the USG image. Claw sign (Option C) is a radiological feature seen in intussusception , not related to the gallbladder. {{caption_text}} Omega sign (Option D) is a radiological finding observed in choledochal cysts , where the dilated common bile duct forms an "omega" or "figure-of-8" shape. It does not relate to the anomaly shown in the USG image.


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Phrygian cap
Normal gallbladder
@Neet_pg_bot



References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1240

Phrygian cap-Radiology

A Phrygian Cap

Soft-tissue images- Phrygian cap”

↑ *Back to this question in Part A*

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Q67: Which condition is most likely based on the image findings? {{caption_text}} (Q854742)

A. Stricture

B. Choledocholithiasis

C. Cholecystitis

D. Cholangiocarcinoma



Correct Answer: B. Choledocholithiasis

Explanation: The MRCP (Magnetic Resonance Cholangiopancreatography) image reveals dilation of the common bile duct (CBD) along with filling defects, representing gallstones within the duct. Filling defects on MRCP indicate an obstruction in the bile ducts, commonly caused by gallstones (choledocholithiasis) or other blockages. These defects appear as areas where the bile duct does not fill properly or has reduced signal intensity. Symptoms of choledocholithiasis typically include jaundice, abdominal pain, nausea, and vomiting. Treatment often involves endoscopic retrograde cholangiopancreatography (ERCP) with sphincterotomy and stone extraction. Incorrect Options: Stricture (Option A) : A bile duct stricture appears as narrowing or constriction of the bile duct caused by inflammation, scarring, or tumours obstructing the duct. While it can mimic choledocholithiasis on imaging, it does not show the characteristic filling defects seen in choledocholithiasis. Cholecystitis (Option C) is the inflammation of the gallbladder, usually due to gallstones blocking the cystic duct. MRCP typically shows gallbladder wall thickening, pericholecystic fluid, and gallstones in the gallbladder but not changes in the bile ducts, so it wouldn't cause CBD dilation or filling defects. Cholangiocarcinoma (Option D) is a malignant tumour of the bile duct epithelium. On MRCP, it can cause bile duct dilation and strictures and may also show intraductal masses or nodules. However, the pattern of obstruction caused by a tumour differs from the filling defects seen with choledocholithiasis, as these defects are caused by gallstones, not a mass.

References:

Sabiston’s Textbook of Surgery, 21st Edition, Page 1501.

↑ *Back to this question in Part A*

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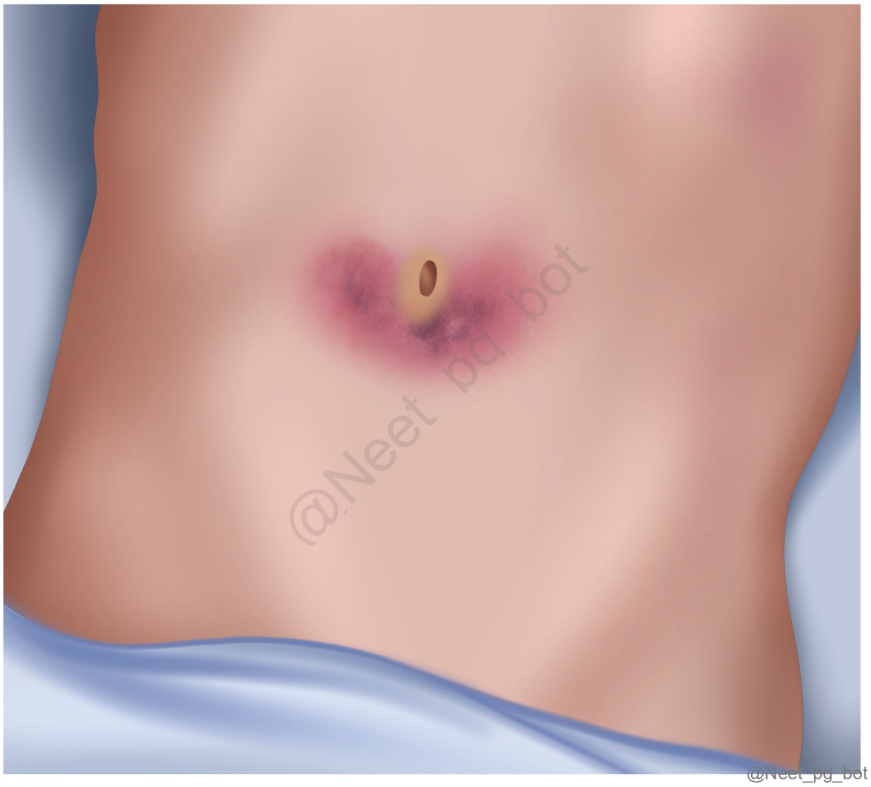
Q68: A 45-year-old male presents with abdominal pain in the emergency room. . On examination, there is blackish discoloration involving the periumbilical skin . What is the most likely diagnosis for this presentation? (Q820153)

A. Acute pancreatitis

B. Necrotizing fasciitis

C. Chronic pancreatitis

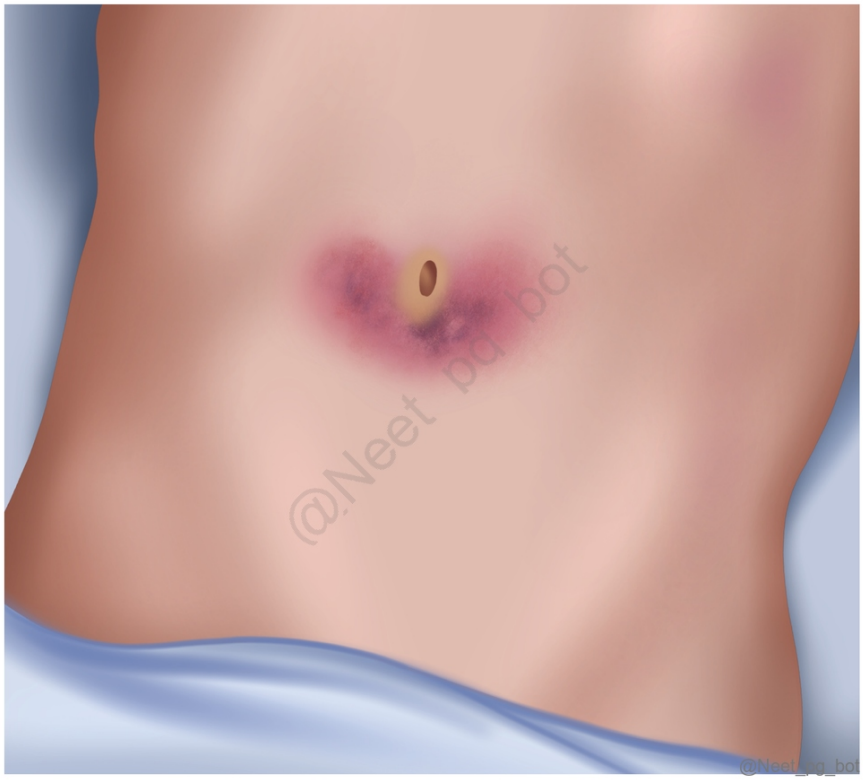
D. Traumatic fat necrosis



Correct Answer: A. Acute pancreatitis

Explanation: Option A - Acute Pancreatitis: Acute pancreatitis is characterized by inflammation of the pancreas and can cause severe abdominal pain. However, it typically doesn't lead to blackish discoloration of the perineal skin. Hypotension may occur in severe cases due to systemic inflammation and fluid shifts, but the perineal discoloration is not a common feature of acute pancreatitis. Presents with cullens sign Incorrect Options: Option B - Necrotizing Fasciitis: Deeper tissue injury, usually from anaerobic bacteria or S pyogenes . Pain may be out of proportion to exam findings. Results in crepitus from methane and CO2 production. “Flesh-eating bacteria.” Causes bullae and skin necrosis causing violaceous color of bullae, surrounding skin . Surgical emergency Option C - Chronic Pancreatitis: Chronic pancreatitis is a long-standing inflammation of the pancreas, often due to alcohol abuse or other underlying factors. It leads to persistent abdominal pain, digestive issues, and potentially

complications over time. However, it is unlikely to cause the rapid onset of perineal skin discoloration and hypotension as seen in the given presentation. Option D - Traumatic Fat Necrosis: Traumatic fat necrosis can occur as a result of physical trauma to fatty tissues, leading to localized inflammation and tissue damage. While it can cause skin discoloration, it typically presents as a localized issue rather than involving the perineal skin. It's also less likely to cause the severe systemic symptoms, including hypotension, seen in this case.



References:

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↑ *Back to this question in Part A*

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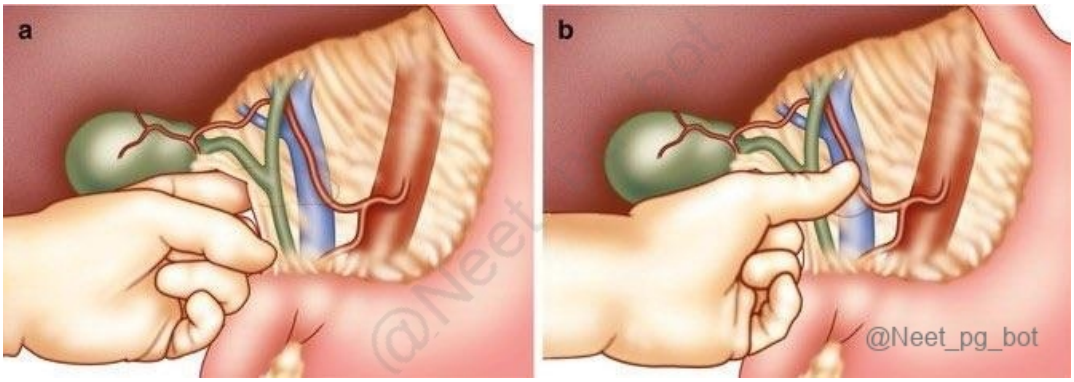
Q69: A 39-year-old patient presented with RTA and is brought to ER with a pulse rate of 120/min, and SBP of <80mmHg. Despite intravenous fluid resuscitation and BT, the patient's condition deteriorates with ongoing profuse bleeding from the liver . Identify the procedure shown in the image done to control massive liver bleed. (Q820112)

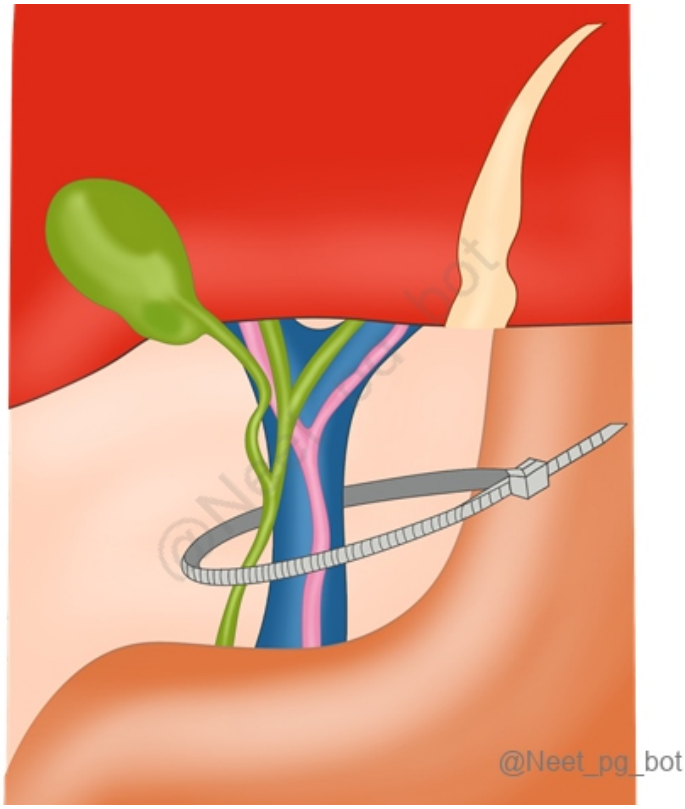
A. Kocher maneuver

B. Pringle’s maneuver

C. Cattell-Braasch maneuver

D. Mattox maneuver





Correct Answer: B. Pringle’s maneuver

Explanation: Correct option B - Pringle's maneuver Pringle's maneuver involves temporarily clamping the hepatoduodenal ligament, which contains the portal vein, hepatic artery, and common bile duct. This maneuver is used to control bleeding from the liver by temporarily interrupting blood flow to the liver. It is a common technique used during liver surgery or to manage traumatic liver bleeding. Incorrect options: Option A - Kocher maneuver: Kocher maneuver is a surgical technique used during cholecystectomy to mobilize the duodenum and improve access to the gallbladder. It is not relevant to controlling liver bleeding. Option C - Cattell-Braasch maneuver: Cattell-Braasch maneuver is a mobilization surgical technique that allows good access to the retroperitoneal structures. The inferior vena cava, abdominal aorta below the superior mesenteric artery, and retroperitoneal organs of the right side are exposed when it is completed. Option D - Mattox maneuver: Mattox

maneuver, also known as a left medial visceral rotation, is a surgical step to explore and handle Zone 1 and 2 retroperitoneal injuries (aorta, left iliac and pelvic vessels). It starts with incising the parietal peritoneum at the white line of Toldt from the sigmoid colon to the splenic flexure.

↑ *Back to this question in Part A*

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Q70: What is the optimal management approach for a patient presenting with fever and abdominal pain five days after experiencing a common bile duct injury resulting in a leak ? (Q793377)

A. Ultrasound–guided aspiration

B. ERCP and stenting

C. Re-exploration and hepaticojejunostomy

D. Re-exploration and primary repair

Correct Answer: B. ERCP and stenting

Explanation: Correct Option B - ERCP and stenting: ERCP (Endoscopic Retrograde Cholangiopancreatography) with stenting is the optimal management approach for a patient presenting with fever and abdominal pain five days after experiencing a common bile duct injury resulting in a leak. ERCP : This procedure allows direct visualization of the bile ducts and enables interventions such as stent placement to address the bile duct injury. ERCP is a minimally invasive procedure performed by passing an endoscope through the mouth, esophagus, and stomach into the duodenum to access the bile ducts. Stenting : Stents are inserted during ERCP to facilitate bile drainage and promote healing of the bile duct injury. They also help maintain the patency of the duct and prevent further complications such as bile leakage and bile peritonitis. Incorrect Options: Option A - Ultrasound-guided aspiration: While ultrasound-guided aspiration may be useful for draining a biloma (collection of bile outside the biliary system), it does not address the underlying bile duct injury. Therefore, it is not the definitive management approach for this condition. Option C - Re-exploration and hepaticojejunostomy: Re-exploration and hepaticojejunostomy involve surgical intervention to repair the bile duct injury by creating a new connection between the bile duct and the jejunum. While this approach may be necessary in some cases, it is usually reserved for more complex or severe injuries. In the presented case, less invasive options such as ERCP with stenting are preferred before resorting to surgical intervention. Option D - Re-exploration and primary repair: Similar to option C, re-exploration and primary repair involve surgical intervention to directly repair the bile duct injury. This approach may be considered if less invasive options fail or if the injury is severe. However, it is not the initial management approach for a patient presenting with fever and abdominal pain after a common bile duct injury.

References:

Prepladder Notes

↑ *Back to this question in Part A*

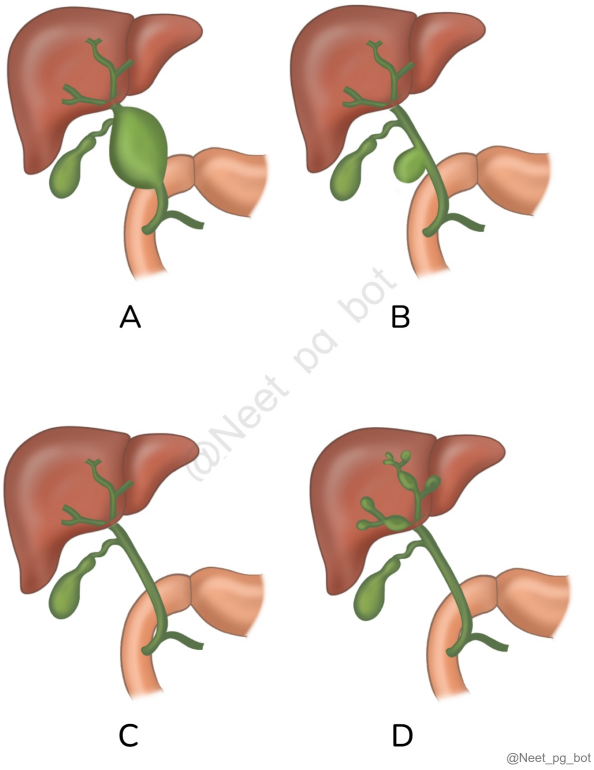
Q71: Which of the following represents a type III choledochal cyst from the given image ? (Q793411)

A. A

B. B

C. C

D. D



Correct Answer: C. C

Explanation: Correct Option C - C: Choledochal cysts are rare congenital anomalies that involve dilation of the biliary tree. These cysts can occur anywhere along the biliary tree, from the intrahepatic bile ducts to the common bile duct. Based on the location and extent of the dilation, choledochal cysts are classified into five types. Image C shows a Dilatation of the intraduodenal part of the bile duct (choledochocele); it represents a type III choledochal cyst. Incorrect Options: Option A - A: Type II cyst is Diverticular dilatation of the extrahepatic bile duct. Option B - B: Type I cyst is Cystic dilatation of extrahepatic bile duct (most common) Option D - D: Type V cyst involves multiple dilations of the intrahepatic and/or extrahepatic bile ducts.

References:

Prepladder Notes

↑ *Back to this question in Part A*

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Q72: Which neuroendocrine tumor of the pancreas is commonly linked with necrolytic erythema migrans ? (Q793855)

A. Insulinoma

B. Glucagonoma

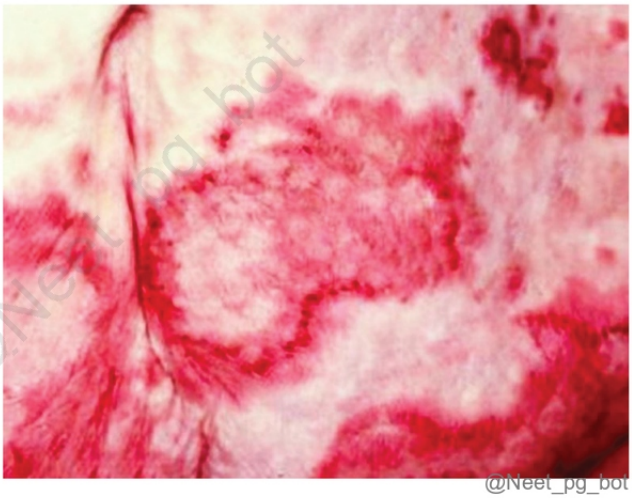
C. Somatostatinoma

D. VIPoma

Correct Answer: B. Glucagonoma

Explanation: Correct Option B - Glucagonoma: Necrolytic Erythema Migrans (NEM): This is a characteristic skin manifestation associated with glucagonoma, also known as the hyperglycemic cutaneous syndrome. NEM presents as a rash with erythema and necrosis, typically affecting the lower extremities and perineum. It's considered the most common symptom of glucagonoma. "4D" Syndrome: Glucagonoma is associated with a set of symptoms known as the "4D" syndrome: Diabetes Mellitus: Glucagonoma can lead to elevated blood glucose levels due to the excess release of glucagon, which opposes insulin action, contributing to the development of diabetes mellitus. Dermatitis: NEM, as described earlier, is the dermatological manifestation characterized by erythema and necrosis. Deep Vein Thrombosis (DVT): Glucagonoma can increase the risk of DVT formation due to various factors such as hypercoagulability. Depression: Patients with glucagonoma may experience depression, which could be attributed to various physiological and psychological factors associated with the disease. Incorrect Options: Option A - Insulinoma: Insulinomas are neuroendocrine tumors of the pancreas that primarily secrete insulin. While hypoglycemia is a hallmark symptom of insulinoma due to excess insulin secretion, it is not associated with necrolytic erythema migrans. Option C - Somatostatinoma: Somatostatinomas are rare neuroendocrine tumors that overproduce somatostatin. Dermatological manifestations associated with somatostatinoma typically include acanthosis nigricans and diabetes mellitus, but not necrolytic erythema migrans. Option D - VIPoma: VIPomas are neuroendocrine tumors that secrete vasoactive intestinal peptide (VIP), leading to profuse watery diarrhea, hypokalemia, and achlorhydria (WDHA syndrome). While VIPomas can lead to skin flushing, diarrhea is the prominent symptom, and necrolytic erythema migrans is not associated with VIPomas.





References:

Prepladder Notes

↑ *Back to this question in Part A*

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Q73: A 40-year-old man is brought to the casualty with severe abdominal pain radiating to the back for the past 1 day and has had 3 episodes of vomiting. The pain radiates to the back and is slightly relieved in the sitting forward position . The following signs are seen on examination and lab investigations reveal elevated lipase and amylase . Which of the following is the most likely diagnosis? (Q805008)

A. Acute appendicitis

B. Acute cholecystitis

C. Acute pancreatitis

D. Acute ischemic colitis



Correct Answer: C. Acute pancreatitis

Explanation: of correct answer.





References:

Prepladder Notes

↑ *Back to this question in Part A*

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• [05_Gastrointestinal Surgery] 019 Esophagus - I

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[05_Gastrointestinal Surgery] 019 Esophagus - I — Quick Jump

Q1 (p. 1825)	*Q2 (p. 1826)*	*Q3 (p. 1827)*	*Q4 (p. 1827)*	*Q5 (p. 1828)*	*Q6 (p. 1829)*
Q7 (p. 1830)	*Q8 (p. 1835)*	*Q9 (p. 1835)*	*Q10 (p. 1836)*	*Q11 (p. 1838)*	*Q12 (p. 1839)*
Q13 (p. 1840)	*Q14 (p. 1841)*	*Q15 (p. 1842)*	*Q16 (p. 1843)*	*Q17 (p. 1845)*	*Q18 (p. 1846)*
Q19 (p. 1848)	*Q20 (p. 1849)*	*Q21 (p. 1850)*	*Q22 (p. 1851)*	*Q23 (p. 1853)*	*Q24 (p. 1854)*
Q25 (p. 1855)					

Q1: A 45-year-old male presents to the emergency department with severe chest pain following forceful vomiting. Physical examination reveals subcutaneous emphysema. What is the most likely diagnosis? (Q849134)

A. Myocardial Infarction

B. Boerhaave's Syndrome

C. Acute Pancreatitis

D. Gastric Ulcer Perforation

Correct Answer: B. Boerhaave's Syndrome

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Boerhaave's syndrome is characterized by spontaneous esophageal perforation due to forceful vomiting. Key features include severe chest pain and subcutaneous emphysema. Boerhaave's syndrome Definition Spontaneous full-thickness tear of the esophagus, usually due to sudden increase in intraesophageal pressure against a closed glottis (forceful vomiting) Common Site Lower third of the esophagus, posterolateral aspect, usually toward the left pleural cavity Etiology / Causes Spontaneous emetogenic perforation (Boerhaave); iatrogenic perforation from endoscopy, dilation, EMR/ESD/POEM; direct trauma (rare); foreign body ingestion; corrosive ingestion; advanced esophageal cancer Classic Presentation Sudden severe chest pain, vomiting, subcutaneous emphysema; may have hematemesis; rapid accumulation of left pleural effusion Other Clinical Signs Shock, fever, tachycardia, tachypnea; Hamman’s sign (crunching sound over heart due to mediastinal air) Investigations Chest X-ray: pneumomediastinum, widened mediastinum, left pleural effusion; CT/MRI chest with IV/oral contrast; contrast swallow with Gastrografin (if patient stable); endoscopy (diagnostic and therapeutic) Complications Mediastinitis (most common cause of mortality), sepsis, pleural contamination, shock, high morbidity and mortality if untreated

References:

1.Bailey & Love's Short Practice of Surgery (28th Edition), Page: 1127, 1128 2.Sabiston Textbook of Surgery, 21st Edition, Page: 1034, 1035

↑ *Back to this question in Part A*

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Q2: A 45-year-old woman presents with fatigue, difficulty swallowing and pale skin. Investigation reveals a cervical esophageal web. Which of the following conditions is most likely? (Q849131)

A. Achalasia

B. Barrett’s Esophagus

C. Plummer-Vinson Syndrome

D. Esophageal Carcinoma

Correct Answer: C. Plummer-Vinson Syndrome

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Plummer-Vinson Syndrome is characterized by a cervical esophageal web, iron deficiency anemia, and dysphagia, fitting the patient’s symptoms. Plummer Vinson Syndrome Overview A rare condition affecting middle-aged women. Characterized by a triad of: Cervical esophageal web Iron deficiency anemia Dysphagia. Causes Iron/nutritional deficiencies Genetic factors Autoimmune conditions Risks Increased risk of post-cricoid and cervical esophageal cancer Treatment Iron supplements Dietary modifications, Endoscopic dilatation if necessary Achalasia (Option A) : Achalasia is due to failure of LES relaxation and presents with progressive dysphagia to both solids and liquids . It shows bird-beak appearance on barium swallow, not an esophageal web. It is not associated with iron deficiency anemia or cervical webs. Barrett’s Esophagus (Option B) : Barrett’s esophagus is a complication of chronic GERD , characterized by intestinal metaplasia of the lower esophagus . It presents with heartburn and reflux symptoms , not cervical dysphagia. It does not cause esophageal webs or iron deficiency anemia . Esophageal Carcinoma (Option D): Typically presents with progressive dysphagia (first solids, then liquids) , weight loss, and anorexia. It is seen in older patients , not classically associated with esophageal webs. Although Plummer–Vinson syndrome is a risk factor for carcinoma, the given presentation is of the syndrome itself , not malignancy.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Pages 1119, 1121, 1146, 1147

↑ *Back to this question in Part A*

@Neet_pg_bot

Q3: A 70-year-old male with a history of smoking presents with progressive dysphagia and weight loss. Endoscopy reveals a mass in the mid-esophagus. Biopsy confirms squamous cell carcinoma. Imaging shows the tumor invading the muscularis propria and metastasis to three regional lymph nodes. What is the TNM classification for this patient? (Q849128)

A. T2 N1 M0

B. T2 N2 M0

C. T3 N2 M0

D. T2 N3 M1

Correct Answer: B. T2 N2 M0

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: T2 N2 M0 indicates tumor invasion of the muscularis propria (T2), metastasis to 3-6 regional lymph nodes (N2), and no distant metastasis (M0). TNM Staging- Carcinoma Esophagus T Tx Tumor cannot be assessed T0 No primary tumor Tis High-grade dysplasia (malignant cells confined by basement membrane) T1 Tumor invades lamina propria, muscularis mucosae, or submucosa T1a Invades lamina propria or muscularis mucosae T1b Invades submucosa T2 Invades muscularis propria T3 Invades adventitia T4 Invades adjacent structures T4a Invades pleura, pericardium, azygos vein, diaphragm, or peritoneum T4b Invades aorta, vertebral body, or airway N Nx Nodes cannot be assessed N0 No regional node metastasis N1 Metastasis in 1-2 regional nodes N2 Metastasis in 3-6 regional nodes N3 Metastasis in 7+ regional nodes M M0 No distant metastasis M1 Distant metastasis

References:

Bailey & Love's Short Practice of Surgery (28th Edition), Page: 1138

↑ *Back to this question in Part A*

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Q4: A 45-year-old man presents with progressive dysphagia for both solids and liquids over the past year. He also reports occasional chest pain, especially after eating. Manometry is performed and analyzed using the Chicago Classification. The results show spastic contractions in the distal esophagus. Based on these findings, what type of achalasia is most likely? (Q849117)

A. Type I Achalasia

B. Type II Achalasia

C. Type III Achalasia

D. Diffuse Esophageal Spasm

Correct Answer: C. Type III Achalasia

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Chicago Classification 4.0 Revised Criteria for Esophageal Disorders: Esophageal Disorder Description Values Achalasia Type I Minimal contractility (Option A ruled out) IRP ≥ 15 mmHg, 100% failed peristalsis Type II Esophageal pan-pressurization (Option B ruled out) IRP ≥ 15 mmHg, 100% failed peristalsis with ≥ 20% pan-esophageal pressurization Type III Spastic contractions (Option C) IRP ≥ 15 mmHg, ≥ 20% spastic contractions (DCI > 8,000 mmHg·s·cm) IRP: Integrated Relaxation Pressure DCI: Distal Contractile Integral DL: Distal Latency

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1122.

Chicago Classification

↑ *Back to this question in Part A*

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Q5: A 40-year-old man complains of a burning sensation in his chest and regurgitation after meals. Symptoms improve with antacids and have no significant weight loss. What is the most likely diagnosis? (Q849123)

A. Peptic ulcer disease

B. Gastroesophageal reflux disease (GERD)

C. Gastritis

D. Esophageal spasm

Correct Answer: B. Gastroesophageal reflux disease (GERD)

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: GERD is a condition where stomach contents, including acid, reflux into the esophagus, causing symptoms like heartburn, regurgitation, difficulty swallowing and sometimes chest pain. The burning sensation behind the sternum after meals, improvement with antacids, and the absence of significant weight loss are classic signs of GERD, making it the most likely diagnosis in this case. The most important pathophysiological factor implicated in GERD is frequent transient LES relaxation. Diagnosis: Endoscopy: To visualize the esophagus and identify inflammation, ulcers, or Barrett's esophagus. 24-hour pH Monitoring: Gold standard for diagnosis of GERD which measures acid exposure in the esophagus over a day. Esophageal Manometry: Assesses esophageal motility and LES function. Barium Swallow: An X-ray test that evaluates swallowing and reflux patterns.

References:

Bailey & Love's short practice of surgery, Edition 28,page 1112, 1113&1114

GERD

↑ *Back to this question in Part A*

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Q6: Which of the following findings are diagnostic of nutcracker esophagus? Distal esophageal contraction amplitude > 180 mmHg Distal esophageal contraction amplitude > 45 mmHg Distal esophageal peristaltic wave duration > 6 cm Distal esophageal contraction amplitude < 30 mmHg Distal esophageal contraction duration > 6 seconds Multiple simultaneous contractions with an amplitude of > 30 mmHg. (Q849125)

A. 1 and 5

B. 2 and 3

C. 1, 3, and 5

D. 2 and 6

Correct Answer: A. 1 and 5

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Hypercontractile motility disorder Nutcracker/ Jackhammer Esophagus Definition Excessively intense, coordinated esophageal contractions with normal LES function. Investigations Esophageal Manometry High amplitude contractions (>180 mmHg) Prolonged contraction duration (>6 seconds) Normal LES pressure and relaxation Barium Swallow (Esophagram) "Corkscrew" or "rosary bead" appearance due to intense contractions Endoscopy Typically normal mucosa Used to rule out structural abnormalities

References:

Bailey & Love's Short Practice of Surgery (28th Edition), Page 1125, 1126.

Schwartz's Principles of Surgery (11th Edition), Page 1057.

SRB's Manual of Surgery (6th Edition), Page 788.

↑ *Back to this question in Part A*

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Q7: Match the following conditions with its endoscopy images A) Esophageal candidiasis 1) B) Feline esophagitis 2) C)Herpes simplex esophagitis 3) D)CMV esophagitis 4) (Q849135)

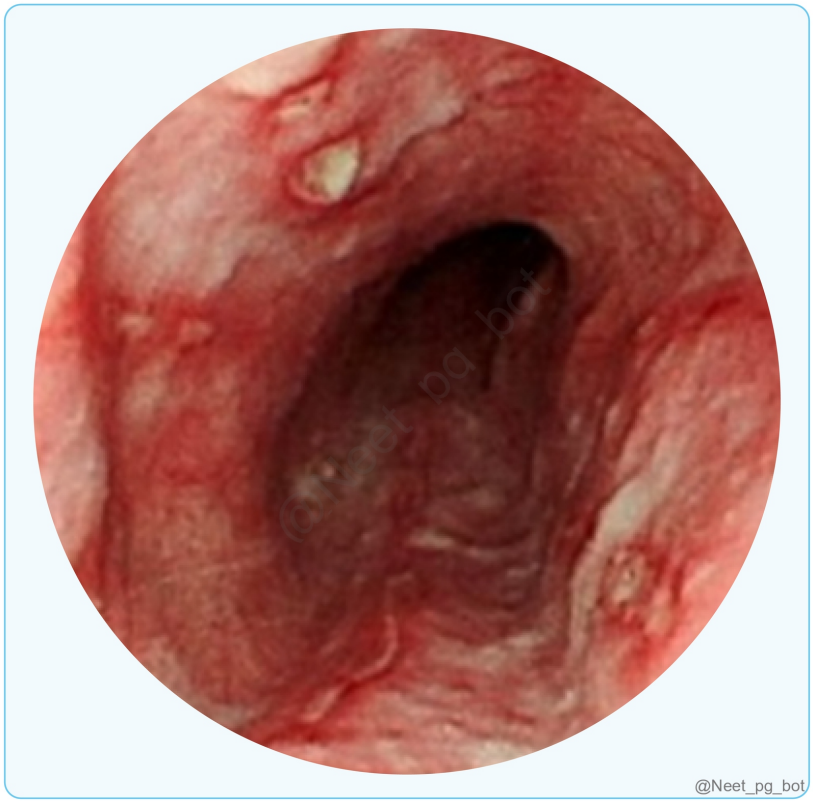
A. A-2, B-4, C-1, D-3

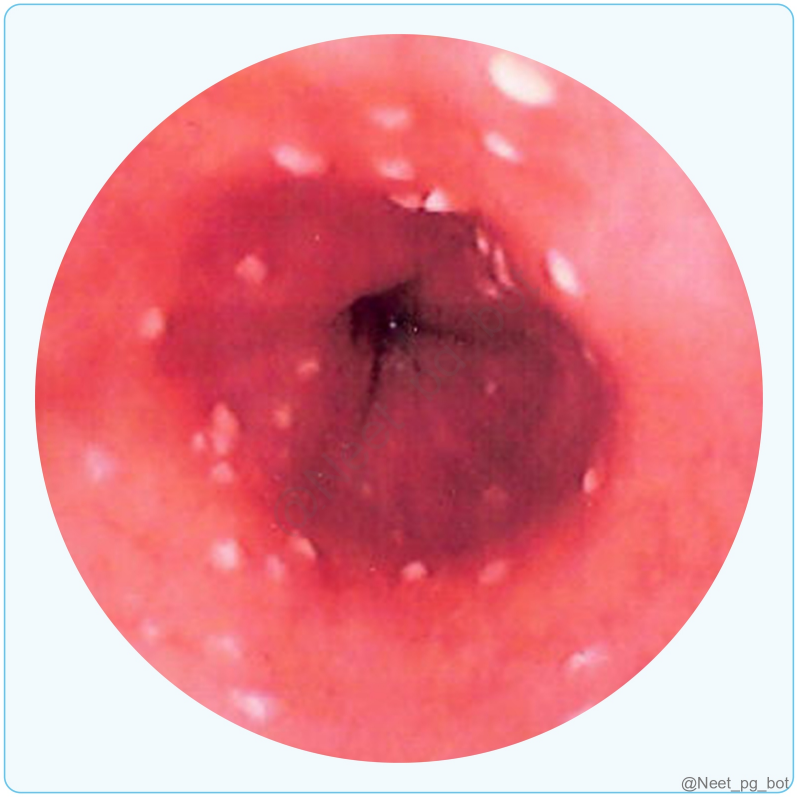
B. A-3, B-4, C-1, D-2

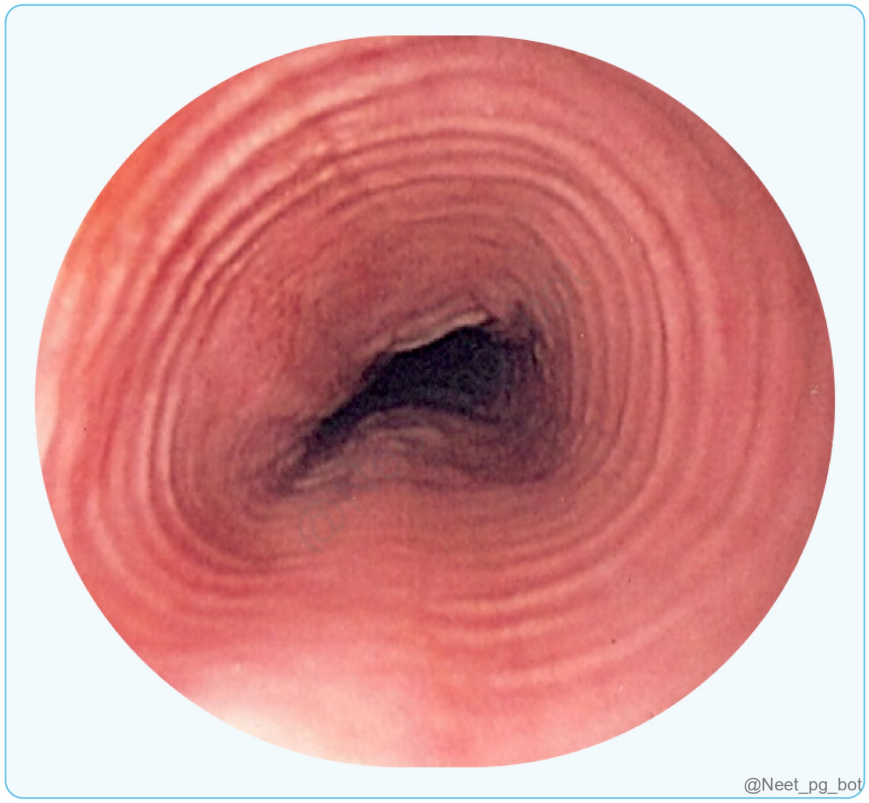
C. A-4, B-3, C-2, D-1

D. A-1, B-4, C-2, D-3




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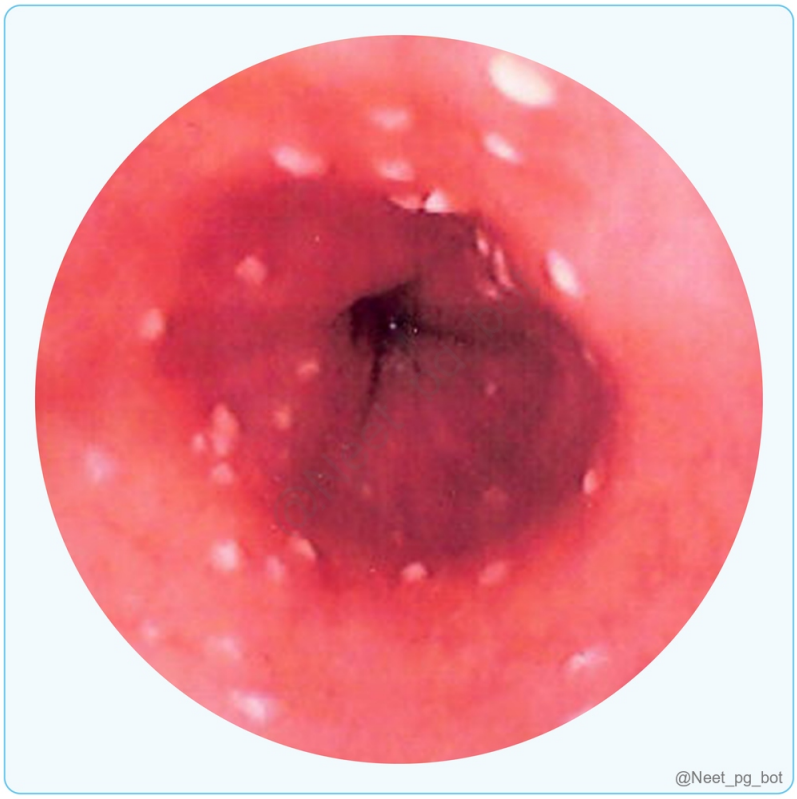

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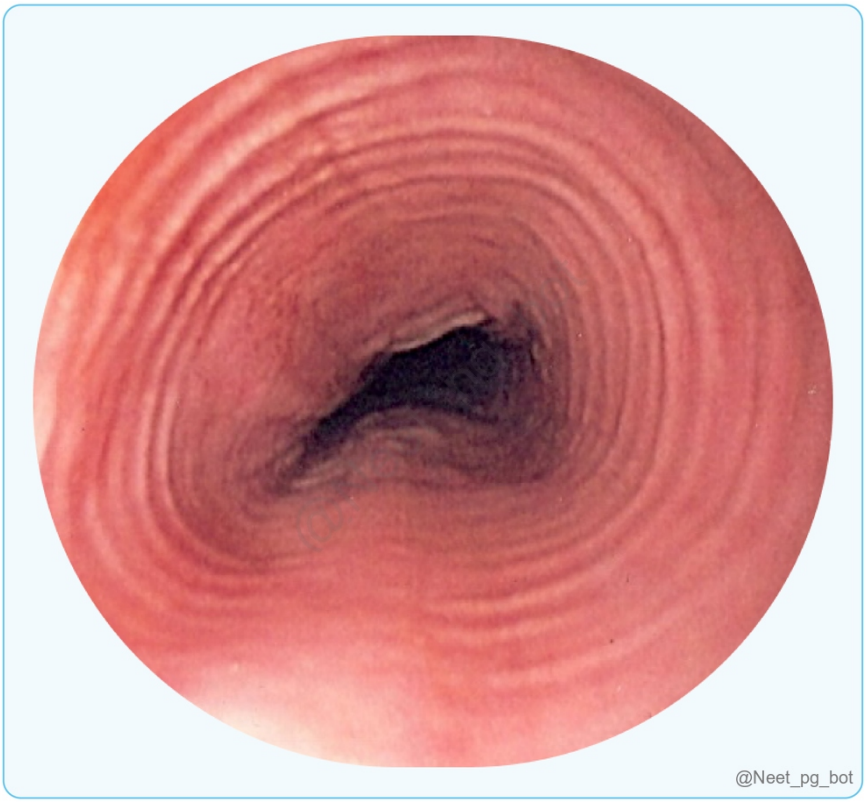


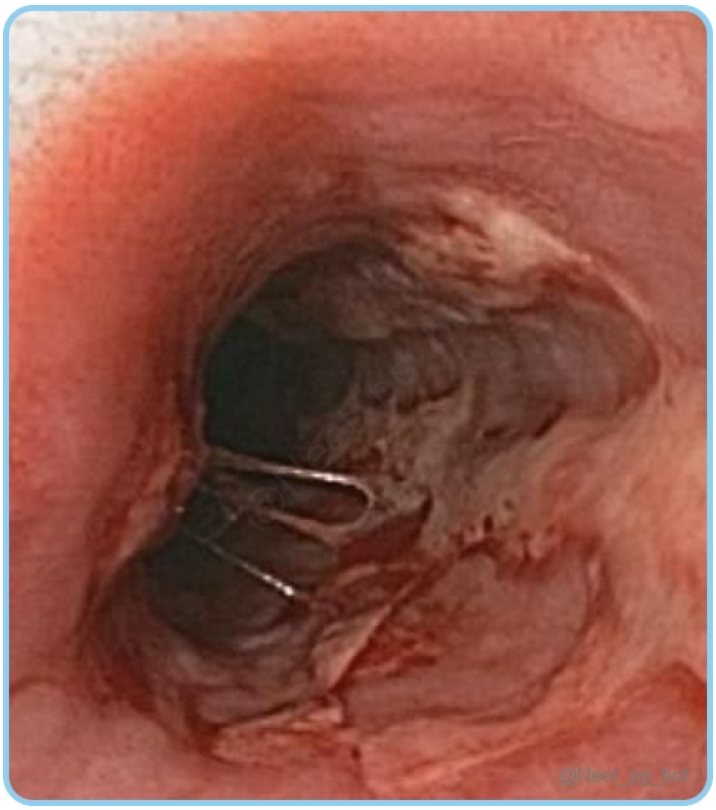
Correct Answer: B. A-3, B-4, C-1, D-2

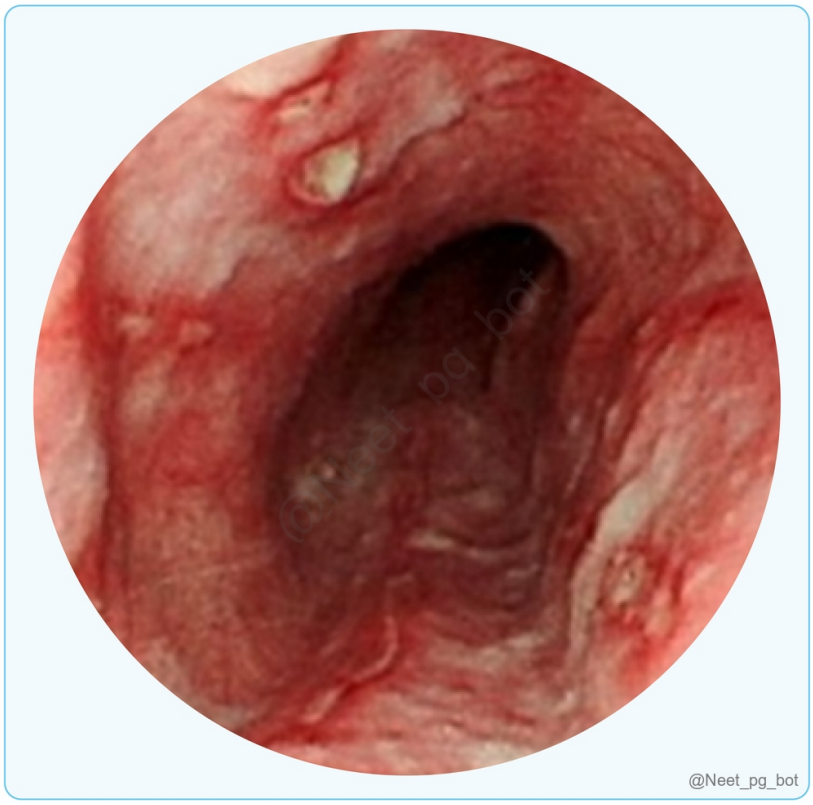
■ *Listen to Audio 1*

Explanation: A-3, B-4, C-1, D-2 Esophageal candidiasis Characterized by white, raised plaques that resemble cottage cheese or curd. These plaques are adherent and often found along the entire length of the esophagus. The surrounding mucosa may appear erythematous and friable. Feline esophagitis Often presents with concentric rings, giving the esophagus a "feline" appearance, Herpes simplex esophagitis Typically presents with multiple small, well-circumscribed, punched-out ulcers. These ulcers are often located in the mid-to-distal esophagus. The surrounding mucosa may be erythematous. CMV esophagitis Characterized by large, solitary or linear ulcers, often located in the mid-to-distal esophagus. The ulcers may have a well-defined border and are surrounded by relatively normal mucosa.


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References:

www.ncbi.nlm.nih.gov/books/NBK556110/ www.ncbi.nlm.nih.gov/books/NBK556110/
www.ncbi.nlm.nih.gov/pmc/articles/PMC10550305/

↑ *Back to this question in Part A*

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Q8: Which of the following is true regarding the esophagus? (Q849108)

A. The upper esophageal sphincter is composed of the thyropharyngeus and cricopharyngeus muscles

B. The lower esophageal sphincter is a physiological entity

C. The cervical esophagus is supplied by the inferior thyroid artery

D. All are true

Correct Answer: D. All are true

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Upper esophageal sphincter (UES): Feature Details Location The inlet of the esophagus, at the neck Muscle Composition Inferior pharyngeal constrictor composed of the thyropharyngeus and cricopharyngeus muscles (Option A) Weakness Point The transition between the thyropharyngeus (oblique fibers) and cricopharyngeus (horizontal fibers) creates the Killian triangle (site of Zenker diverticulum) Lower esophageal sphincter (LES): Feature Details Location The lower end of the esophagus, in the terminal 4 cm Function Prevents reflux of gastric and duodenal contents Specialty A physiological zone of high pressure (Option B) Vasculature: Segment Arterial Supply Venous Drainage Cervical Esophagus Inferior thyroid arteries (Option C) Inferior thyroid veins Thoracic Esophagus Descending thoracic aorta, bronchial arteries Azygos and hemiazygos veins Abdominal Esophagus Left gastric artery, paired inferior phrenic arteries Drains into systemic and portal venous systems via left and right phrenic veins, left gastric (coronary) vein, and short gastric veins

References:

Sabiston Textbook Of Surgery The Biological Basis Of Modern Surgical Practice, 21 Edition, pages 1015,1016,1017

SRB's Manual of Surgery, 6th edition, page 778

↑ *Back to this question in Part A*

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Q9: A 60-year-old male patient complains of intermittent dysphagia and episodes of food obstruction. Endoscopy reveals a fibrous band at the gastroesophageal junction. Which of the following is the most likely diagnosis? (Q849133)

A. Esophageal Web

B. Zenker's Diverticulum

C. Barrett's Esophagus

D. Schatzki Ring

Correct Answer: D. Schatzki Ring

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Schatzki ring is identified as a benign constricting band of fibrous tissue at the gastroesophageal junction, causing symptoms such as dysphagia and food obstruction. Schatzki Ring Overview A benign constricting band of fibrous tissue located at the gastroesophageal junction (GEJ). Characteristics Proximal side lined with squamous epithelium The distal side lined with columnar epithelium Causes Exact cause unclear Linked to gastroesophageal reflux disease (GERD) Often associated with hiatal hernia Symptoms Dysphagia (difficulty swallowing) Food obstruction Diagnosis Barium esophagram Endoscopy Treatment Endoscopic dilation using bougie or balloon Biopsy to rule out malignancy Repeated dilation may be necessary for symptomatic relief Esophageal Web (Option A): Esophageal webs are thin mucosal membranes located in the upper (cervical) esophagus , not at the GEJ. They are associated with iron deficiency anemia (Plummer–Vinson syndrome) . Zenker’s Diverticulum (Option B): Zenker’s diverticulum is a pharyngoesophageal pouch occurring at Killian’s dehiscence (upper esophagus). It presents with: Regurgitation of undigested food Halitosis Neck swelling Barrett’s Esophagus (Option C): Barrett’s esophagus involves intestinal metaplasia of distal esophagus due to GERD . It presents with chronic reflux symptoms , not intermittent obstruction. There is no fibrous ring formation .

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page: 1119, 1126, 1147

↑ *Back to this question in Part A*

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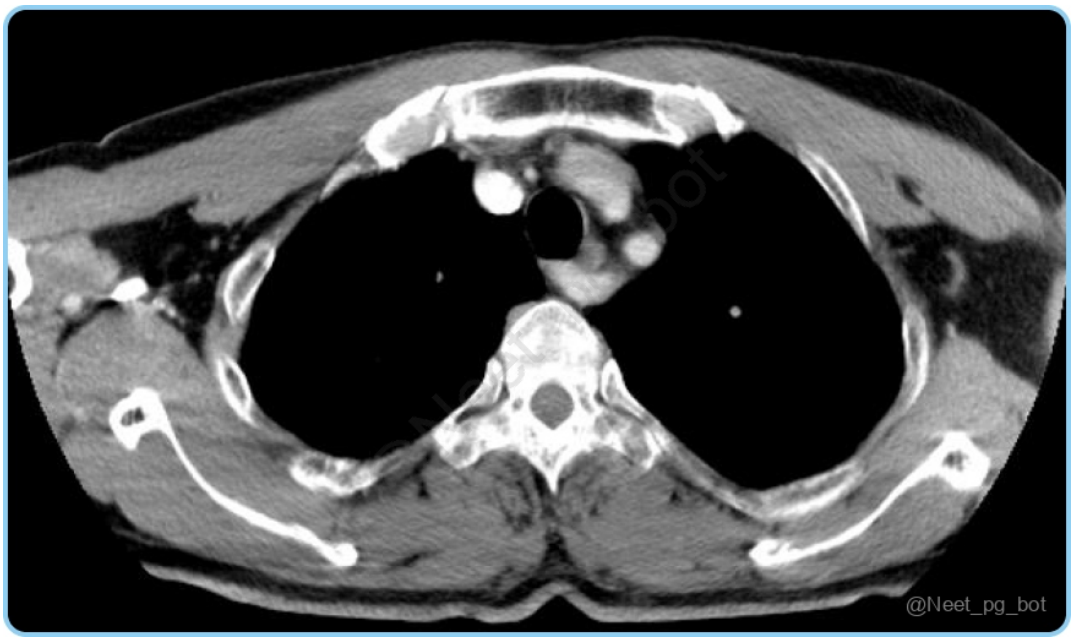
Q10: A 60-year-old patient presents with late-onset difficulty swallowing and significant weight loss. Imaging reveals an aberrant right subclavian artery compressing the esophagus. What is the most likely diagnosis? (Q849132)

A. Achalasia

B. Esophageal Cancer

C. Dysphagia Lusoria

D. Schatzki's Ring

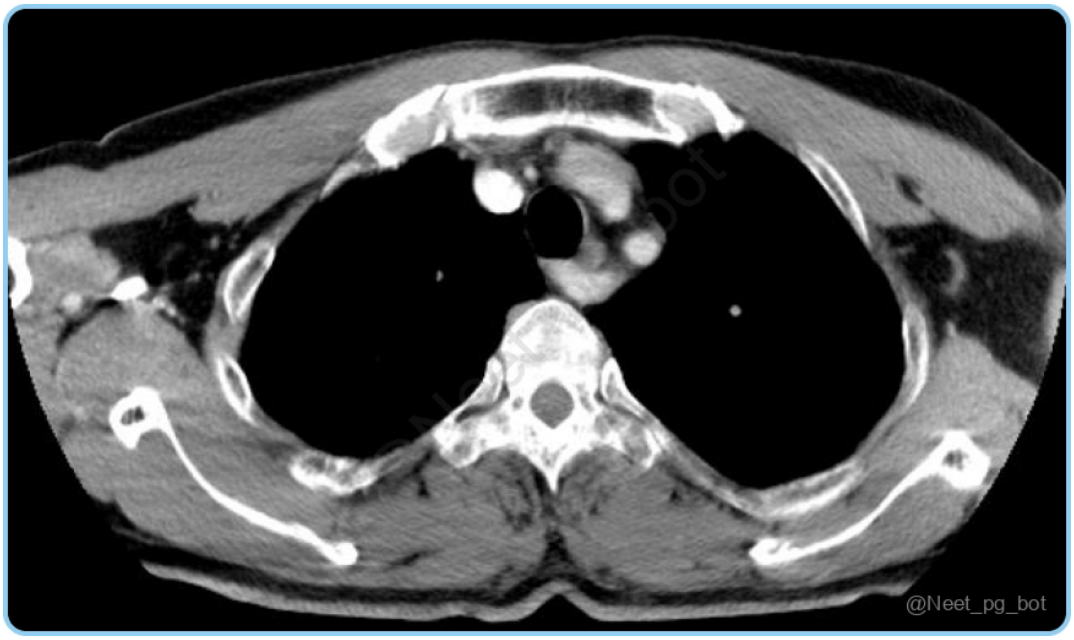


Correct Answer: C. Dysphagia Lusoria

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Dysphagia lusoria is caused by vascular compression of the esophagus due to an aberrant right subclavian artery, fitting the patient's symptoms and imaging findings. The CT scan shows an aberrant right subclavian artery (visible as a vessel passing behind the esophagus) causing esophageal compression Dysphagia Lusoria Definition Rare swallowing disorder due to vascular compression of the esophagus, mainly by an aberrant right subclavian artery (ARSA) Pathophysiology ARSA from the left aortic arch passes behind/in front of the esophagus, causing compression Symptoms Difficulty swallowing worsens with age, possible weight loss and nutritional deficiencies Diagnosis Imaging studies (barium swallow, chest CT) Manometric studies are not typically helpful Management Based on symptom severity Dietary modifications for mild cases. Surgical intervention for severe cases. Other options: Option A: Achalasia: Wouldn't show vascular abnormality; would show dilated esophagus with bird's beak appearance on barium swallow Option B: Esophageal Cancer : Would show a mass lesion, not just vascular compression Option D: Schatzki's Ring: Intermittent dysphagia to solids only; no weight loss or vascular findings



References:

Bailey & Love's Short Practice of Surgery (28th Edition), Page: 1121, 1135, 1147

Dysphagia Lusoria

Dysphagia lusoria

Dysphagia lusoria

↑ *Back to this question in Part A*

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Q11: A 45-year-old man undergoes an endoscopy for evaluation of dysphagia and an incidental mass is discovered in the esophagus. An endoscopic ultrasound (EUS) shows a hypoechoic mass originating from the muscularis propria. Which of the following statements regarding the esophageal lesion is most accurate? (Q849130)

A. Immediate biopsy and fine-needle aspiration (FNA) should be performed to confirm the diagnosis.

B. If the lesion is asymptomatic and small, it can be observed without biopsy.

C. The preferred treatment for small, symptomatic lesions is chemotherapy.

D. Large lesions (>5 cm) are best managed with radiofrequency ablation (RFA)

Correct Answer: B. If the lesion is asymptomatic and small, it can be observed without biopsy.

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The clinical scenario is suggestive of leiomyoma. Small, asymptomatic leiomyomas can be safely observed without biopsy. Esophageal Leiomyomas Overview Hypoechoic masses beneath the mucosa, typically found in the middle to distal esophagus Most common benign tumor in the esophagus Often found incidentally during endoscopies Origin Arise from the muscularis propria or submucosal layer Symptoms Usually asymptomatic, but large tumors can cause dysphagia or discomfort Imaging Barium esophagram: Smooth filling defect Endoscopy: Round protrusion with smooth overlying mucosa Endoscopic ultrasound (EUS): Hypoechoic with regular borders, originating from the fourth endosonographic layer Malignant Transformation Rare, resection is recommended if enlargement is observed during follow-up Biopsy Biopsies or FNAs are relatively contraindicated due to risk of scarring, which complicates enucleation (Option A ruled out) Surgical Approaches Enucleation: Thoracoscopic approach for smaller tumors. Chemotherapy is not indicated (Option C ruled out) Submucosal Tunneling Endoscopic Resection (STER): Minimally invasive, involves creating a submucosal tunnel for resection Thoracoscopy: Suitable for larger tumors (>5 cm) (Option D ruled out)

References:

Bailey & Love's Short Practice of Surgery (28th Edition), Page: 1134

Sabiston Textbook Of Surgery, 21st edition, page: 1037, 1038

↑ *Back to this question in Part A*

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Q12: A 62-year-old male presents with progressive dysphagia and weight loss over the past 3 months. An endoscopy reveals a tumor in the lower third of the esophagus. Biopsy confirms adenocarcinoma. Further investigation reveals, the tumor has invaded the muscularis propria but no distant metastasis is detected. Which treatment option is most appropriate for this patient? (Q849129)

A. Endoscopic Mucosal Resection (EMR)

B. Endoscopic Submucosal Dissection (ESD)

C. Esophagectomy

D. Radiofrequency Ablation (RFA)

Correct Answer: C. Esophagectomy

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Esophagectomy is the primary treatment for locally advanced esophageal cancer where the tumor has invaded the muscularis propria. Carcinoma Esophagus- Management Staging Accurate staging is essential for treatment planning. Early-Stage Disease Endoscopic Mucosal Resection (EMR): Removes superficial cancers (T1a) and early cancers with minimal submucosal invasion (T1b). (Option A ruled out) Endoscopic Submucosal Dissection (ESD): Removes larger lesions with en bloc resection. (Option B ruled out) Radiofrequency Ablation (RFA) : Treats early Barrett's esophagus-associated cancers. Uses heat to destroy cancer cells. No surgical specimen for pathological assessment. (Option D ruled out) Locally Advanced Disease Esophagectomy: Primary treatment for locally advanced cancer. Removes esophagus and reconstructs the digestive tract using the stomach, jejunum, or colon. Surgical approaches: transhiatal, transthoracic, minimally invasive (MIE). (Option C) Multimodality Therapy: Combines chemotherapy, radiation therapy, and surgery. Neoadjuvant Chemoradiation: Shrinks the tumor before surgery. CROSS trial showed survival benefit for neoadjuvant chemoradiation followed by surgery. Palliative Treatment Endoscopic Stenting: Maintains esophageal patency, helps with swallowing difficulties. Chemotherapy: Slows cancer progression, shrinks the tumor. Radiotherapy: Shrinks tumors, controls bleeding. Brachytherapy: Internal radiation therapy targeting the tumor.

References:

Bailey & Love's Short Practice of Surgery (28th Edition), Page: 1139, 1142, 1146

Sabiston Textbook Of Surgery, 21st edition, page: 1044, 1046, 1047, 1048

↑ *Back to this question in Part A*

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Q13: A 55-year-old male with a history of smoking and heavy alcohol consumption presents with progressive dysphagia and significant weight loss. Endoscopy reveals an ulcerated lesion in the mid-esophagus, and biopsies confirm squamous cell carcinoma. What is the most appropriate initial diagnostic step to assess the extent of the disease? (Q849127)

A. Chromoendoscopy

B. Barium contrast study

C. Endoscopic Ultrasound (EUS)

D. FDG-PET scan

Correct Answer: C. Endoscopic Ultrasound (EUS)

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Endoscopic Ultrasound (EUS) is the most accurate method for assessing the T stage of the primary tumour and the involvement of surrounding lymph nodes. Carcinoma Esophagus Investigation Endoscopy: Tumor

visualization, Biopsies, Chromoendoscopy , NBI Barium contrast study: Tumor as ulcerated/stenotic lesion Bronchoscopy: Check airway spread Endoscopic & Percutaneous Ultrasonography: EUS for staging tumor (T stage) and paraesophageal nodes (Option C) Percutaneous ultrasound of cervical nodes with FNA CT scan: Distant node assessment FDG-PET scan: Detects nodes/metastases, not for tumor staging

References:

Bailey & Love's Short Practice of Surgery (28th Edition), Page:1135-1139

↑ *Back to this question in Part A*

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Q14: A 60-year-old man with chronic GERD undergoes endoscopy, which shows a 3 cm segment of salmon-colored mucosa above the gastroesophageal junction. Biopsy confirms intestinal metaplasia without dysplasia, and no nodularity or ulceration is seen.What is the most appropriate next step in management? (Q849126)

A. Annual surveillance endoscopy

B. Immediate endoscopic mucosal resection (EMR)

C. High-dose proton pump inhibitor (PPI) therapy and aspirin

D. Endoscopic ablation with radiofrequency ablation (RFA)

Correct Answer: C. High-dose proton pump inhibitor (PPI) therapy and aspirin

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Endoscopy findings are consistent with Barrett’s Esophagus - High-dose PPI therapy can reduce acid reflux and allow for mucosal healing, while aspirin has been shown to have a chemopreventive effect (combination can improve outcomes). Treatment: Treat underlying GERD, same pharmacological therapy as symptomatic GERD Chemoprevention: Aspirin + high-dose PPI improves outcomes (Option C) Dysplastic Treatment: Ablate/resect without invasive cancer, controversial in non-dysplastic Ablative Therapy: Flat lesions only, RFA preferred EMR vs ESD EMR: easier, piecemeal; ESD: en bloc, better margins Post-Treatment: Surveillance for recurrence/persistent Barrett's or neoplasia

References:

Bailey & Love's Short Practice of Surgery (28th Edition), Page: 1119, 1120

↑ *Back to this question in Part A*

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Q15: A 55-year-old man presents with intermittent chest pain and difficulty swallowing for the past few months. The chest pain is often severe and mimics angina but is not related to exertion. His symptoms often occur at night. Barium swallow reveals a typical finding given below. Which of the following disorders is most likely responsible for these findings? (Q849124)

A. Achalasia cardia

B. Gastroesophageal reflux disease (GERD)

C. Esophageal stricture

D. Diffuse esophageal spasm



Correct Answer: D. Diffuse esophageal spasm

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Diffuse Esophageal Spasm (DES) Definition Uncoordinated, simultaneous contractions of the esophagus with normal LES function. Clinical Features Dysphagia (solids and liquids) Severe chest pain Less common regurgitation Globus sensation Investigations Esophageal Manometry: Multiple simultaneous non-peristaltic contractions with an amplitude of > 30 mmHg; normal LES pressure and relaxation. Barium

Swallow (Esophagram): "Corkscrew" or "Rosary bead" appearance. (Option A) Endoscopy: Generally normal mucosa; rule out structural abnormalities. Management Non-Pharmacological: Dietary Modifications (smaller, frequent meals) Pharmacological: Calcium Channel Blockers (e.g., nifedipine) Nitrates (e.g., isosorbide dinitrate) Botulinum Toxin Injection Surgical: Esophageal Myotomy (rare) Peroral Endoscopic Myotomy (POEM) Endoscopic: Dilation (less effective)



References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Pages 1121, 1122, 1126

Schwartz's Principles of Surgery, 11th Edition, Pages 1056-1058

SRB's Manual of Surgery, 6th Edition, Pages 788, 789, 791

↑ *Back to this question in Part A*

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Q16: Which of the following is considered a minimally invasive procedure for treating achalasia cardia? (Q849119)

A. Laparoscopic Heller's Cardiomyotomy

B. Partial Fundoplication

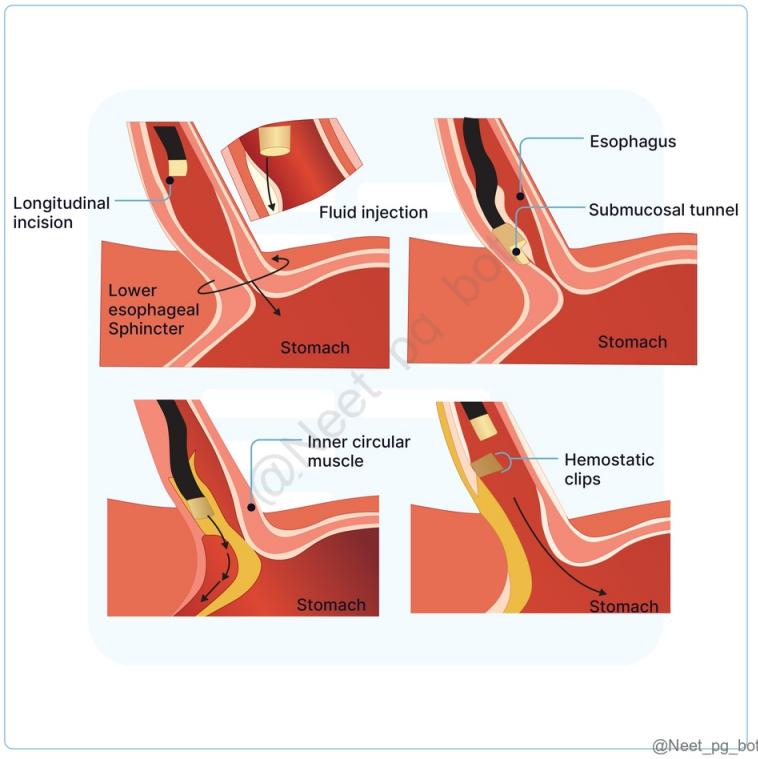
C. Per-Oral Endoscopic Myotomy (POEM)

D. Esophagectomy

Correct Answer: C. Per-Oral Endoscopic Myotomy (POEM)

- *Listen (English)*
- *Listen (Hindi)*

Explanation: Management of achalasia cardia Management Description Pharmacological Treatments Calcium Channel Blockers Reduce LES pressure. Nitrates Relax the LES. 5'-Phosphodiesterase Inhibitors Increase cyclic GMP to lower LES pressure. Botulinum Toxin (Botox) Injections Temporarily paralyze LES muscles. Non-Surgical Interventions Bougie/Balloon Dilatation Ruptures LES muscle fibers to reduce pressure. Surgical Treatments Laparoscopic Heller's Cardiomyotomy (Most common) Incision in LES muscle to reduce pressure. It is often combined with a fundoplication. (Option A ruled out) Partial Fundoplication Prevents reflux; options include Dor or Toupet fundoplication. (Option B ruled out) Endoscopic Treatments Per-Oral Endoscopic Myotomy (POEM) Newer Minimally invasive procedure involving dissection of LES muscle fibers. (Option C) Management of Chronic Cases Megaesophagus Severe cases may require esophagectomy (surgical removal of the esophagus). (Option D ruled out)



References:

Bailey & Love's Short Practice of Surgery (28th Edition), Page 1122-1125.

SRB's Manual of Surgery (6th Edition), Page 790, 791.

↑ *Back to this question in Part A*

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Q17: A 42-year-old man presents with progressive dysphagia for liquids more than solids for over six months, regurgitation of undigested food, nocturnal cough, and unintentional weight loss. The bird beak sign is seen on a barium swallow. Which investigation is the gold standard for diagnosing his condition? (Q849118)

A. Upper gastrointestinal endoscopy

B. High-resolution manometry

C. Barium swallow study

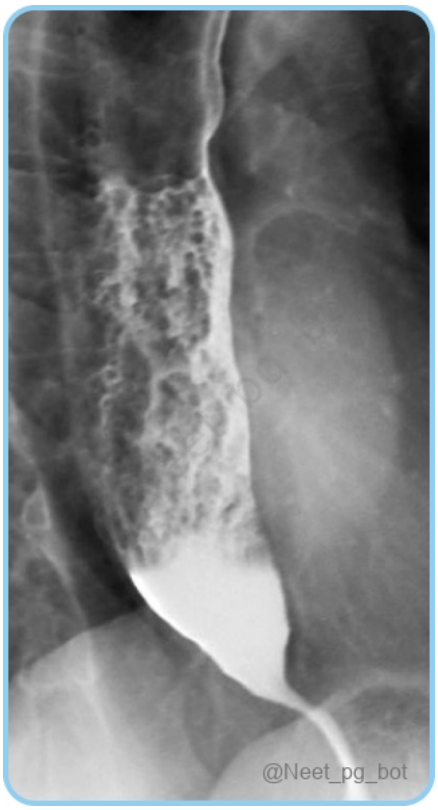
D. Chest X-ray

Correct Answer: B. High-resolution manometry

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Achalasia cardia Definition It is characterized by the progressive degeneration of ganglion cells in the esophageal wall. This leads to a loss of peristalsis in the lower esophagus and failure of the lower esophageal sphincter (LES) to relax during swallowing Clinical Features Dysphagia: May initially affect liquids more than solids. Regurgitation Halitosis Chest Pain Weight Loss Investigations: Esophageal Manometry Gold Standard: This is the definitive diagnostic test for achalasia. It measures the pressure and pattern of muscle contractions in the esophagus. Elevated resting LES pressure (typically > 45 mmHg). Incomplete LES relaxation. Absence of peristalsis in the esophageal body. Periodic contractions with normal amplitude or high amplitude contractions (type I and II achalasia). Barium Swallow (Esophagram) Dilated esophagus with a narrowing at the LES (Bird beak appearance). Upper GI Endoscopy (Option A) Normal mucosa, but may show a dilated esophagus with possible food debris. It is important to rule out other causes of dysphagia, such as tumors.



References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Pages 1121, 1122

Schwartz's Principles of Surgery, 11th Edition, Pages 1056, 1057

SRB's Manual of Surgery, 6th Edition, Pages 788, 789, 790

↑ *Back to this question in Part A*

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Q18: Which of the following statements is true about the Zenker’s diverticulum? (Q849116)

A. An enlarged diverticulum always results in desynchronization.

B. Halitosis is a symptom of an enlarged diverticulum.

C. Protrudes posteriorly below the cricopharyngeal sphincter.

D. Absence of a suture line increases the chance of a postoperative leak.

Correct Answer: B. Halitosis is a symptom of an enlarged diverticulum.

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Halitosis, or bad breath, can occur with an enlarged Zenker's diverticulum. This is due to food becoming trapped in the pouch and decomposing, leading to foul-smelling breath. This symptom is a direct result of the diverticulum filling with food, making this statement correct. An enlarged diverticulum always results in desynchronization (Option A): While desynchronization between pharyngeal contraction and the opening of the upper esophageal sphincter is a key factor in the formation of Zenker's diverticulum, it is not accurate to state that an enlarged diverticulum always results in desynchronization. As the diverticulum enlarges, symptoms usually are food trapping and regurgitation. Protrudes posteriorly below the cricopharyngeal sphincte r (Option C) : Zenker's diverticulum protrudes posteriorly above the cricopharyngeal sphincter, not below it. The diverticulum emerges through a natural weak point known as the dehiscence of Killian, located above the cricopharyngeal muscle. Absence of a suture line increases the chance of a postoperative leak (Option D) : The absence of a suture line decreases the risk of a postoperative leak



References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1126, 1127

www.ncbi.nlm.nih.gov/books/NBK499996/

https://share.google/tjWjcb1sLPdeSkPPM

↑ *Back to this question in Part A*

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Q19: A 55-year-old woman with persistent GERD symptoms despite optimal medical therapy is considered for surgery. What is the most appropriate surgical procedure for her condition? (Q849115)

A. Nissen fundoplication

B. Fontan procedure

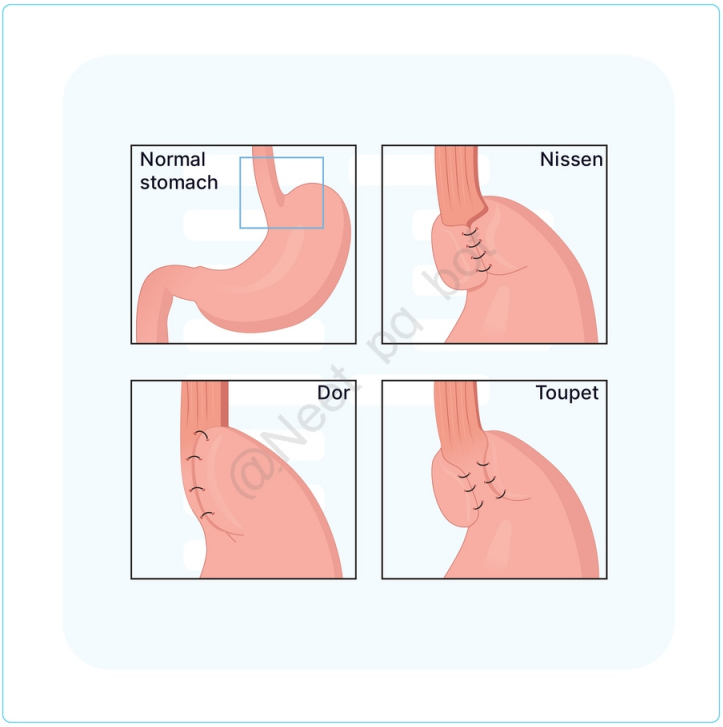
C. Hartmann procedure

D. Heineke–Mikulicz pyloroplasty

Correct Answer: A. Nissen fundoplication

- *Listen (English)*
- *Listen (Hindi)*

Explanation: Nissen fundoplication is the preferred surgical treatment for GERD when medical management fails. It involves wrapping the upper part of the stomach around the lower esophagus to increase the pressure at the lower esophageal sphincter (LES), reducing reflux. This procedure effectively controls GERD symptoms and is typically recommended for patients like this woman with persistent symptoms despite optimal medical therapy. Management of GERD: Lifestyle Changes: Elevate the head of the bed Avoid lying down after meals Quit smoking: Medical Management: Antacids: Neutralize stomach acid H2-receptor antagonists: Ranitidine, Famotidine Proton pump inhibitors (PPIs): Omeprazole, Esomeprazole Surgical Options: Antireflux operation: 3 components Restoration of intra abdominal segment of the esophagus Crural repair Reinforcement of the LES by the upper stomach or prosthesis. Fundoplication: A surgical procedure to wrap the top of the stomach around the lower esophagus to strengthen the sphincter. Complete fundoplication(Nissen) Partial fundoplication: Posteriorly (Toupet) or Anteriorly(Dor, Watson) has few short-term side effects but has a higher long-term failure rate. Transoral Incisionless Fundoplication (TIF): An endoscopic procedure performed through the mouth but may be less effective for severe GERD and not suitable for all patients. Magnetic Sphincter Augmentation (LINX Device): Involves implanting a ring of magnetic beads around the lower esophageal sphincter to enhance its function and prevent reflux.



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References:

Bailey & Love's short practice of surgery, edition 28, page 1115, 1116, 1117

GERD image

↑ *Back to this question in Part A*

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Q20: Which hormone is known to decrease LES pressure? (Q849114)

A. Gastrin

B. Cholecystokinin

C. Progesterone

D. Motilin

Correct Answer: C. Progesterone

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Lower Esophageal Sphincter (LES) is a muscle at the end of the esophagus where it meets the stomach. It helps prevent stomach acid and contents from flowing back into the esophagus. Under normal conditions the LES remains tonically contracted with an intra luminal pressure of about 30mm Hg. Factor Type Increase LES Pressure Decrease LES Pressure Hormones Cholecystokinin Gastrin Motilin Progesterone Estrogen Secretin Medications Metoclopramide Domperidone Calcium channel blockers Nitrates Theophylline Anticholinergics Benzodiazepines Physiological Conditions Fasting Standing upright Pregnancy Obesity Lying down Smoking Neurotransmitters Acetylcholine Serotonin Gastrointestinal Hormones Somatostatin Substance P Vasoactive intestinal peptide (VIP) Pathological Conditions Zollinger-Ellison syndrome GERD Scleroderma Diabetes Mellitus COPD Hiatus Hernia

References:

Bailey &Love's Short practice of surgery, edition 28, pg 1106

LES

LES pressure

↑ *Back to this question in Part A*

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Q21: A 55-year-old man presented with difficulty swallowing and chest discomfort after meals, which improved after forceful belching. On physical examination, he appeared pale. Chest X-ray revealed a gas-filled structure within the thoracic cavity. Which of the following is the most likely diagnosis? (Q849113)

A. Peptic ulcer disease

B. Hiatus hernia

C. Esophageal cancer

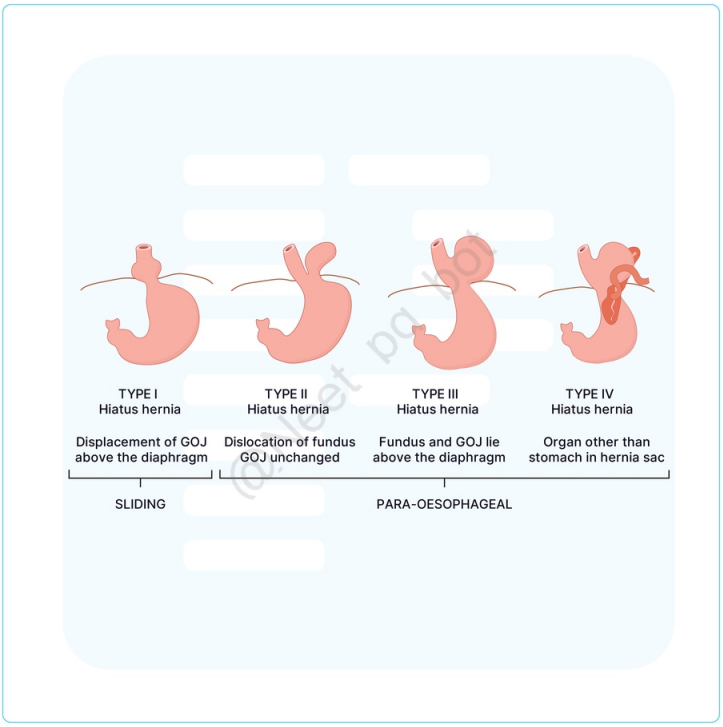
D. Gastritis

Correct Answer: B. Hiatus hernia

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Hiatus Hernia: Condition in which the abdominal contents pass through the hiatal opening of the diaphragm into the mediastinum. Types Description Type I/Sliding Hiatus Hernia The most common type. The gastroesophageal junction and part of the stomach slide up through the diaphragm. Type II/Paraesophageal Hiatus Hernia Part of the stomach pushes through the diaphragm next to the esophagus. The gastroesophageal junction remains in place. Type III/Mixed Hiatus Hernia Combines features of both sliding and paraesophageal hernias. Type IV Involves viscera other than the stomach in the hernial sac like colon



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References:

Bailey & Love's Short Practice of Surgery, Edition 28, page 1117, 1118

Hiatal Hernia

↑ *Back to this question in Part A*

@Neet_pg_bot

Q22: A newborn male presents with severe respiratory distress and a scaphoid abdomen. Chest X-ray reveals bowel loops in the left thoracic cavity. Immediate surgical intervention is planned to repair the diaphragmatic defect. Which of the following is the most likely diagnosis? (Q849112)

A. Bochdalek hernia

B. Morgagni hernia

C. Rolling hiatus hernia

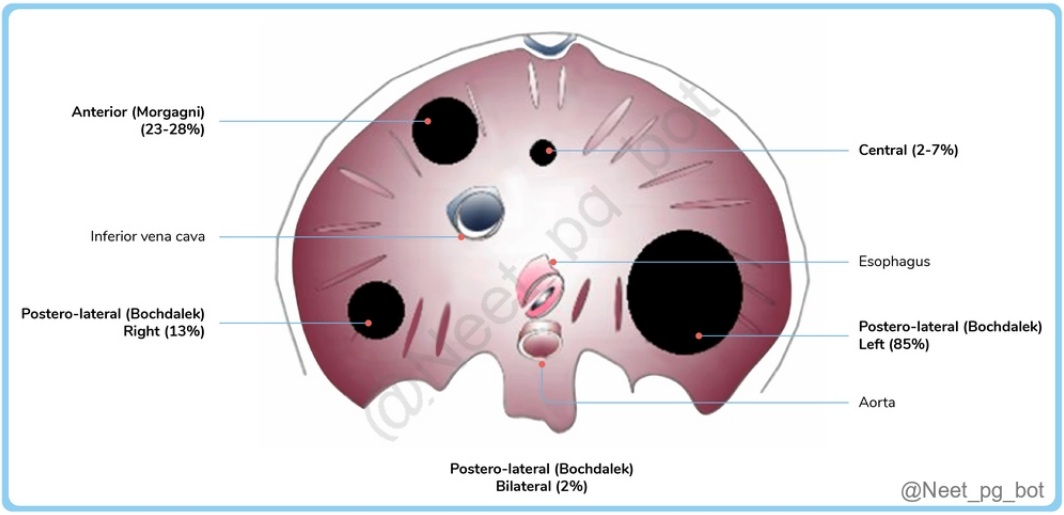
D. Sliding hiatus hernia



Correct Answer: A. Bochdalek hernia

- *Listen (English)*
- *Listen (Hindi)*

Explanation: Bochdalek hernia is the most common type of congenital diaphragmatic hernia (CDH), accounting for about 90% of cases. The clinical presentation typically includes severe respiratory distress, a scaphoid abdomen, and bowel sounds in the chest, as seen in this patient . A chest X-ray often reveals bowel loops in the thoracic cavity, and immediate surgical repair is necessary. It is usually found on the left side (80%), but can also occur on the right (15%) or be bilateral (5%). Morgagni hernia(Option B) is an anterior, usually right-sided defect, often containing colon, and is usually asymptomatic rather than causing neonatal distress. Rolling hiatus hernia(Option C) occurs in adults when the stomach herniates beside the esophagus, causing reflux or chest pain, not bowel loops in the thorax. Sliding hiatus hernia(Option D) is also an adult condition where the gastroesophageal junction and stomach slide into the chest, presenting with GERD, not neonatal respiratory distress



References:

SRB's Manual of Surgery, 6th edition, pages 1114, 1115, 1116

↑ *Back to this question in Part A*

@Neet_pg_bot

Q23: A newborn male, 1 day old, presents with persistent regurgitation of feeds and continuous drooling of saliva from the mouth. The baby exhibits frequent coughing and cyanosis, prompting an investigation that reveals a tracheoesophageal fistula. Which type is the most likely to be seen? (Q849111)

A. Type A

B. Type B

C. Type C

D. Type E

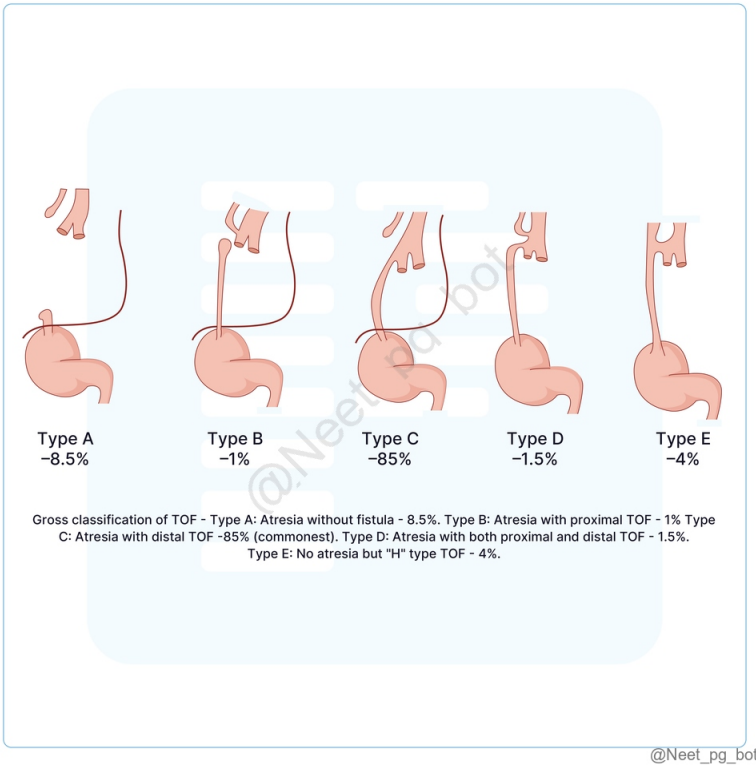
Correct Answer: C. Type C

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Tracheoesophageal fistula(TOF): Type C Tracheoesophageal fistula Aspect Details Most common type 85% are blind upper end with lower end communicating with the trachea(Type C); associated with VACTER anomalies VACTER Anomalies V - Vertebral defects A - Anal atresia C - Cardiac defect (e.g., pulmonary stenosis) T - Tracheoesophageal fistula R - Radial hypoplasia and renal agenesis Symptoms (Option C) Regurgitation Drooling Cough Cyanosis Often associated with maternal hydramnios (50%). Investigations

Nasogastric tube obstruction Contrast study Chest X-ray Echocardiography Treatment Surgical intervention



References:

SRB 6th edition, pages 793-794

↑ *Back to this question in Part A*

@Neet_pg_bot

Q24: A 35-year-old man ingests a household cleaner and sustains a corrosive injury to esophagus. Which of the following is false in this case? (Q849110)

A. Neutralization with vinegar/citrus for alkali; antacids/milk/egg whites for acid

B. Early endoscopy is not preferred

C. Avoid emetics and sodium bicarbonate to prevent perforation

D. All are false

Correct Answer: B. Early endoscopy is not preferred

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Early endoscopy is advised to assess severity and extent Corrosive injury to the esophagus happens on ingestion of acids or alkalis Acute Phase Management Neutralization: vinegar/citrus for alkali; antacids/milk/egg whites for acid (Option A ruled out) Early endoscopy to assess severity and extent (Option B) Avoid emetics and sodium bicarbonate to prevent perforation (Option C ruled out)

References:

SRB's Manual of Surgery, 6th edition, pages 791-792

↑ *Back to this question in Part A*

@Neet_pg_bot

Q25: A 5-year-old boy swallowed a disk battery and an x-ray revealed that it was lodged in the esophagus. What is the next step in the management of this patient? (Q849109)

A. Observe

B. Immediate endoscopic removal

C. Endoscopic removal after 1 day of observation

D. Endoscopic removal after 2 days of observation

Correct Answer: B. Immediate endoscopic removal

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The disk battery in the esophagus should be removed endoscopically as an emergency procedure. The battery can cause significant injury to the esophageal tissue within a short period, leading to serious complications. Foreign body in esophagus: Category Indications Management Emergency Esophageal obstruction (inability to handle oral secretions) Disk batteries Sharp-pointed objects Immediate endoscopic removal (Option B) Urgent Blunt objects Incomplete obstruction Multiple magnets (or single magnet plus another ferromagnetic object within endoscopic reach) Coins Endoscopic removal within 12 to 24 hours (Option C ruled out) Non Urgent Objects in stomach >2.5cm diameter Disc battery in the stomach for up to 48 hrs if asymptomatic Blunt objects that fail to pass the stomach in 3-4 weeks Observation (Option A, D ruled out)

References:

www.ncbi.nlm.nih.gov/books/NBK482131/#:~:text=Once%20the%20diagnosis%20is%20made,and%20others%20may%20require%20surgery

↑ *Back to this question in Part A*

@Neet_pg_bot

• [05_Gastrointestinal Surgery] 020 Stomach-I

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[05_Gastrointestinal Surgery] 020 Stomach-I — Quick Jump

Q1 (p. 1857)	*Q2 (p. 1859)*	*Q3 (p. 1860)*	*Q4 (p. 1861)*	*Q5 (p. 1862)*	*Q6 (p. 1863)*
Q7 (p. 1865)	*Q8 (p. 1867)*	*Q9 (p. 1868)*	*Q10 (p. 1868)*	*Q11 (p. 1870)*	*Q12 (p. 1870)*
Q13 (p. 1871)	*Q14 (p. 1872)*	*Q15 (p. 1873)*	*Q16 (p. 1874)*	*Q17 (p. 1875)*	*Q18 (p. 1876)*
Q19 (p. 1876)	*Q20 (p. 1879)*	*Q21 (p. 1880)*	*Q22 (p. 1881)*	*Q23 (p. 1882)*	*Q24 (p. 1883)*
Q25 (p. 1884)	*Q26 (p. 1885)*	*Q27 (p. 1887)*	*Q28 (p. 1888)*	*Q29 (p. 1889)*	*Q30 (p. 1893)*

Q1: A 58-year-old woman visits her primary care physician complaining of persistent upper abdominal pain that worsens after meals. She also reports experiencing nausea and occasional vomiting. After a thorough clinical evaluation, the physician suspects a gastric ulcer. What investigation should be done multiple times as a must in case of a gastric ulcer? (Q849029)

A. Endoscopy

B. Endoscopy with biopsy

C. Assessment for H pylori

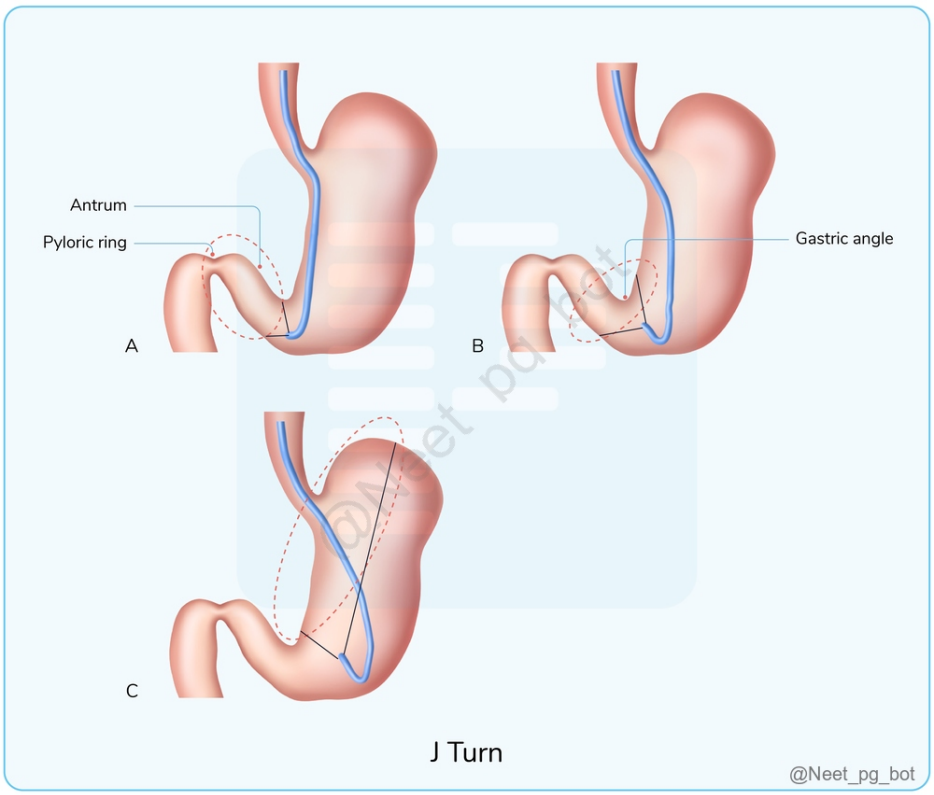
D. Ultrasonography

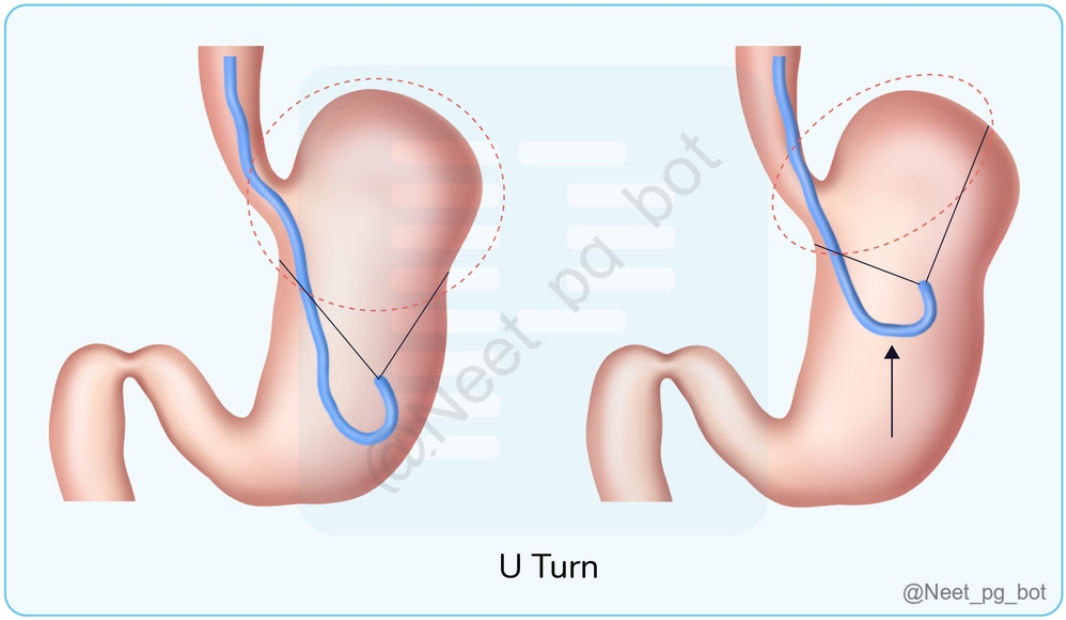
Correct Answer: B. Endoscopy with biopsy

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: In the case of a gastric ulcer, an endoscopy with multiple biopsies must be performed at any cost in order to rule out gastric carcinoma. Investigations : Endoscopy and biopsy : This is done because gastric carcinoma and gastric ulcer appear very similar, and the only way to differentiate them correctly is by biopsy and histopathological examination. Even if the first biopsy shows no signs of carcinoma, multiple biopsies must be done to rule it out confidently. Once it is ruled out, PPIs and H-pylori eradication medications can be advised in an uncomplicated case. The ‘U’ manoeuvre should be carried out to inspect the incisura, lesser curve, and gastro-oesophageal junction (GOJ), given the increasing incidence of cancer at the GOJ. Hence, the U and J manoeuvres are done to visualize the fundus and the GOJ. H pylori assessment (Option C) is also done but is not as important as the endoscopy and biopsy.





References:

Bailey and Love's Short Practice of Surgery, 28th Edition, Page 1159

Sabiston's Textbook of Surgery, 21st Edition, Page 1207, 1208

↑ *Back to this question in Part A*

@Neet_pg_bot

Q2: A patient with suspected gastric carcinoma undergoes an upper GI endoscopy. A large, malignant-appearing ulcer is noted. While there is a central crater, the endoscopist notes that its margins are ill-defined and blend into the surrounding gastric wall, causing localized rigidity. These findings are most characteristic of which Borrmann classification type? (Q849092)

A. Type I

B. Type II

C. Type III

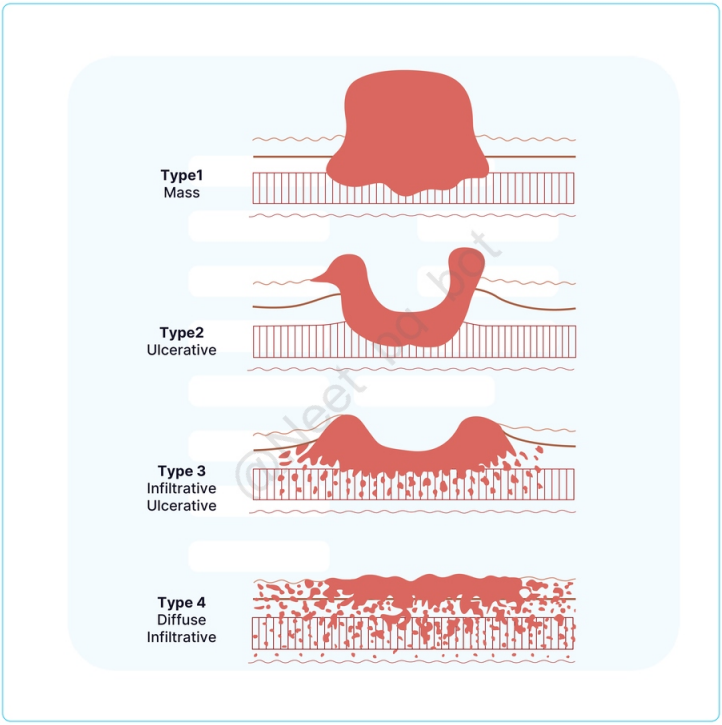
D. Type IV

Correct Answer: C. Type III

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The Borrmann classification system is used to describe the gross appearance of endoscopic findings



References:

Sabiston Textbook of Surgery, 21st Edition, Page 1221

Bailey and Love's Short Practice of Surgery, 28th Edition, Page 1172

Japanese classification of gastric carcinoma

↑ *Back to this question in Part A*

@Neet_pg_bot

Q3: A male patient comes to the clinic due to abdominal pain. He is a chronic smoker and has never been consistent with a healthy diet. An endoscopy and biopsy of the lesion in his stomach confirm gastric cancer. Which of the following statements regarding risk factors of gastric carcinoma is false? (Q849091)

A. High-salt foods like salted or smoked meat increase the risk of gastric carcinoma

B. H-pylori is the most common infectious cause of gastric carcinoma

C. Adenomatous polyps carry a risk of turning cancerous

D. Proton pump inhibitors have a protective effect against gastric cancer

Correct Answer: D. Proton pump inhibitors have a protective effect against gastric cancer

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The use of PPIs creates an achlorhydric state that in turn enables the growth of H. pylori and other bacteria in the stomach leading to an increased risk of gastric carcinoma. Category Risk factors Diet High-salt foods (e.g., salted and smoked meats), low intake of fruits and vegetables (Option A) N-nitroso compounds are formed from nitrates in high-salt and smoked foods; Similar to tobacco smoke Lifestyle habits Smoking, alcohol, poor food preparation (smoked, salted), lack of refrigeration, contaminated drinking water, low socioeconomic status Infectious Causes H- pylori infection: M/c infectious cause of gastric cancer. (Option B) Mechanism: Chronic inflammation leading to atrophic gastritis, intestinal metaplasia, dysplasia, and carcinoma Polyps Adenomatous polyps (risk of malignancy) (Option C) In multiple polyps, the largest one is excised, and biopsy from others is taken. Hereditary factors E-cadherin (CDH1) gene mutation (hereditary diffuse gastric cancer) Hereditary cancer syndromes Li- Fraumeni syndrome Medications Proton pump inhibitors (long-term use creates low-acid environment achlorhydria; Risk for H. pylori colonization) (Option D) Other risk factors Gastric ulcers, pernicious anaemia (achlorhydria), obesity, Epstein-Barr virus, prior abdominal irradiation (for testicular cancer or Hodgkin's lymphoma), prior gastric surgery, male sex Protective factors of Gastric carcinoma: Fruits and vegetables, especially citrus fruits, help decrease the risk of the disease. Exercise helps control the weight and improves muscle mass and overall health. Antioxidant supplements help, too. (beta carotene, vitamin C, vitamin A, selenium) Cessation of smoking is also necessary.

References:

Sabiston Textbook of Surgery, 21st Edition, Page 1219, 1220, 1221

Epidemiology of gastric cancer: global trends, risk factors and prevention

↑ *Back to this question in Part A*

@Neet_pg_bot

Q4: A 50-year-old male comes to the OPD for a follow-up of peptic ulcer disease. He has had an upper gastrointestinal bleed in the recent past and was endoscopically and medically managed. A repeat endoscopy is done to assess his risk of rebleed and a flat pigmented spot is viewed in the duodenum. According to the Forrest classification system, what is the classification of the ulcer and risk of rebleed observed here? (Q849090)

A. IA, high risk

B. IIB, high risk

C. III, low risk

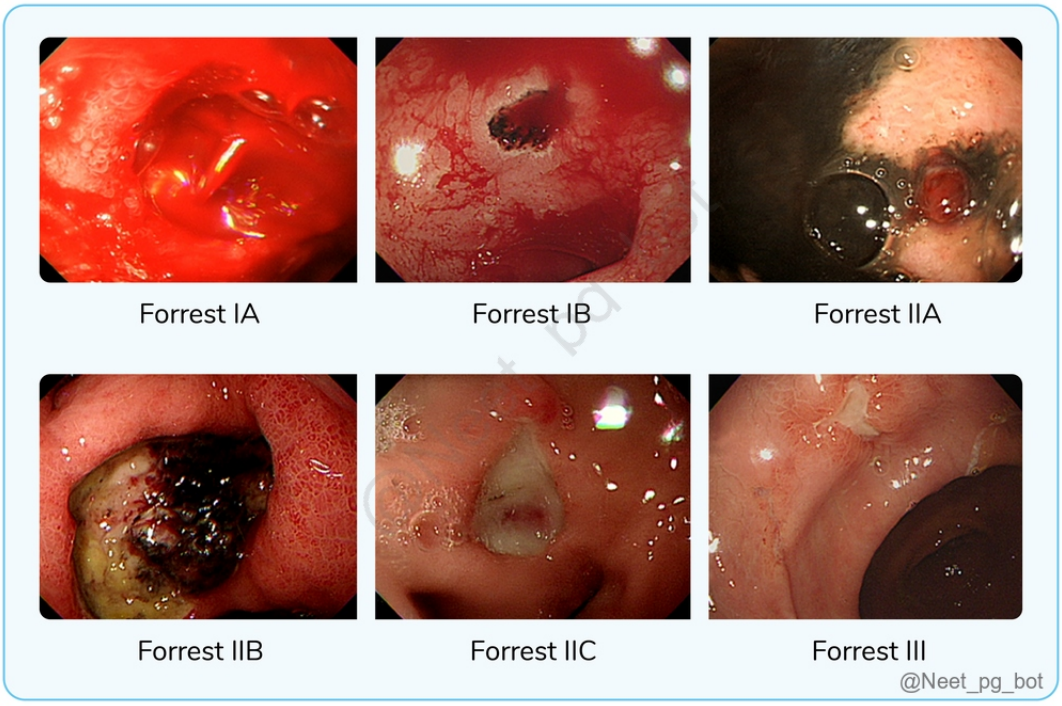
D. IIC, low risk

Correct Answer: D. IIC, low risk

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The endoscopic finding of a flat pigmented spot is IIC according to the Forrest classification system and it has a very low risk of rebleeding (5- 10 %). The Forrest classification system is used to predict the risk of recurrent bleeding in patients with UGI bleeding based on endoscopic findings. FORREST CLASSIFICATION: Stigmata of recent haemorrhage Forrest classification Risk of rebleed Active bleeding IA (Option A) : Active spurting IB: Active oozing 90% 10% - 20% Recent haemorrhage IIA: Non-bleeding visible vessel IIB (Option B): Adherent clot IIC: Flat pigmented spot 50% 25% - 30% 5% - 10% No signs of haemorrhage III (Option C): Clean-based ulcer 3% - 5%



References:

Sabiston Textbook of Surgery, 21st Edition, Page 1211

Bailey and Love's Short Practice of Surgery, 28th Edition, Page 1166

↑ *Back to this question in Part A*

@Neet_pg_bot

Q5: A 40-year-old patient is brought to the emergency department with melena and dizziness. Her BP is 100/ 80 mmHg, and her pulse rate is 100 bpm. Her lab investigations reveal Hb of 8 gm/dL and a blood urea nitrogen (BUN) of 25 mg/dL. Based on the Blatchford score, which of the following findings would most significantly increase her risk stratification score? a. Systolic blood pressure less than 100 mm of Hg b. High blood urea nitrogen level (> 25) c. Diagnosis of Mallory Weiss syndrome d. Heart rate more than 100 bpm (Q849089)

A. a and b only

B. a, b and c

C. a, c and d

D. a, b and d

Correct Answer: D. a, b and d

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: All the options except the diagnosis of Mallory Weiss syndrome are a component of the Blatchford scoring system. The most commonly used risk stratification systems include: Rockall- Bayler score Blatchford score Blatchford score Rockall- Bayler score Used for initial assessment in case of bleeds Most useful as it is based on endoscopic findings Pulse Blood Urea nitrogen Systolic Blood pressure Haemoglobin Presence of Melena Syncope Hepatic or Cardiac dysfunction Comorbid disease (cardiac, hepatic, renal, or disseminated) Age (<60 years, 60-79 years, >80 years) Shock Systolic BP <100 mm Hg Pulse rate >100 beats/min Diagnosis at the time of endoscopy (Non-malignant lesions, or malignant lesions like Mallory weiss syndrome, GI malignancy) Endoscopic Stigmata of recent bleed

References:

www.ncbi.nlm.nih.gov/pmc/articles/PMC6303462/

pmc.ncbi.nlm.nih.gov/articles/PMC3683686/

https://pmc.ncbi.nlm.nih.gov/articles/PMC6036534/

Bailey and Love's Short Practice of Surgery, 28th Edition, Page 1166

Sabiston Textbook of Surgery, 21st Edition, Page 1211

↑ *Back to this question in Part A*

@Neet_pg_bot

Q6: A 60-year-old patient presents with sudden, massive hematemesis. An upper endoscopy identifies a small mucosal defect surrounded by normal gastric mucosa. Angiography reveals a large, tortuous artery in the left gastric artery distribution. What is the underlying pathophysiological mechanism of bleeding in Dieulafoy's lesion? (Q849088)

A. Erosion of the mucosa due to excessive acid secretion

B. Rupture of varices caused by portal hypertension

C. Erosion of mucosa due to pulsations from a large submucosal artery

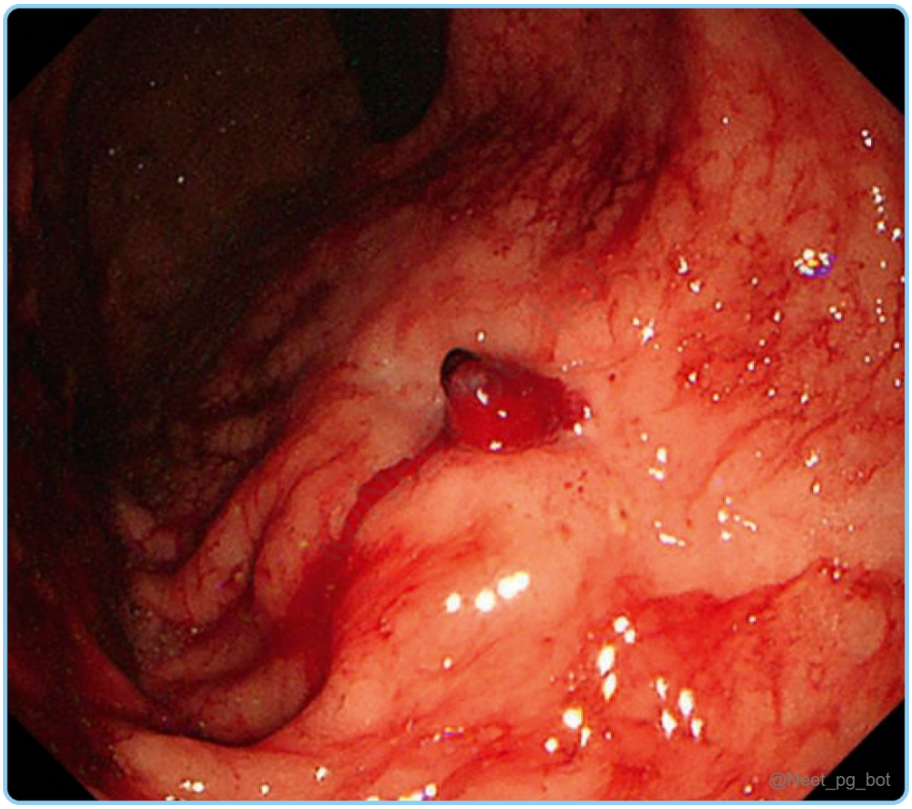
D. Ulceration of the gastric mucosa due to chronic use of NSAIDs

Correct Answer: C. Erosion of mucosa due to pulsations from a large submucosal artery

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Dieulafoy’s lesion involves a large, tortuous artery in the submucosa that causes erosion of the overlying mucosa due to its pulsations, leading to bleeding. Dieulafoy’s lesion Dieulafoy's lesion is characterized by an abnormally large, tortuous artery that runs through the submucosa of the stomach without a primary ulcer. Artery measures 1-3 mm and is typically found near the gastroesophageal junction along the lesser curvature. The lesion develops as the pulsations of the large submucosal artery erode the superficial mucosa. (Option C) The mucosal defect is usually small, measuring 2-5 mm, and is surrounded by normal-appearing gastric mucosa. Once the artery is exposed to gastric contents, further erosion and bleeding occur. Erosion due to excessive acid secretion (Option A) describes peptic ulcer disease . PUD shows a true ulcer crater with inflamed surrounding mucosa , not a small isolated defect. Bleeding is usually less abrupt compared to massive arterial bleed of Dieulafoy’s lesion. Rupture of varices due to portal hypertension (Option B) ; Endoscopy shows dilated veins , not a single mucosal defect with a visible artery. No mention of liver disease or portal hypertension , so ruled out. Ulceration due to chronic NSAID use (Option D) : NSAIDs cause gastric ulcers via prostaglandin inhibition . It leads to diffuse mucosal damage and ulcer formation , not a focal arterial lesion.



References:

Sabiston Textbook of Surgery, 21st Edition, Page 1235

Bailey and Love’s Short Practice of Surgery, 28th Edition, Page 1167

↑ *Back to this question in Part A*

@Neet_pg_bot

Q7: A 62-year-old female with a history of liver cirrhosis presents with symptoms of chronic gastrointestinal bleeding, including anaemia and fatigue. Upper endoscopy is shown below. Which of the following is the most appropriate initial treatment for this condition? (Q849087)

A. Radiofrequency ablation

B. Hormonal therapy

C. Argon plasma coagulation

D. Reducing portal pressure



Correct Answer: C. Argon plasma coagulation

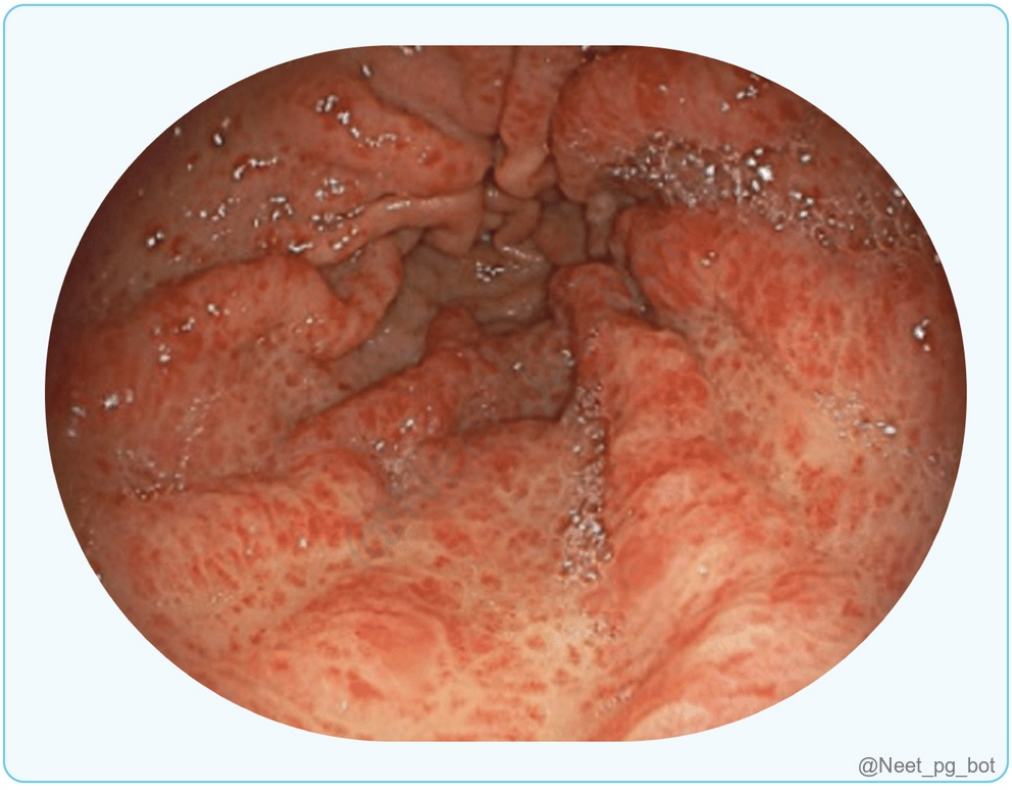
■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Upper endoscopy reveals a "watermelon" appearance of the stomach lining, characterized by flat, reddish stripes radiating from the pylorus into the antrum which points to Gastric Antral Vascular Ectasia. Argon Plasma Coagulation (APC) is the recommended first-line endoscopic treatment for Gastric Antral Vascular Ectasia (GAVE). APC utilizes high-frequency energy delivered through argon gas to coagulate bleeding vessels, effectively managing GAVE. Management: Initial Management: Fluid resuscitation, blood transfusions, iron

supplementation. Endoscopic Therapies: Argon Plasma Coagulation (APC): Coagulates bleeding vessels; may require multiple sessions. (Option C) Endoscopic Band Ligation (EBL) : Rubber bands around vessels; fewer complications, high success rate.





References:

Bailey and Love's Short Practice of Surgery, 28th Edition, Page 1167-1168

Sabiston Textbook of Surgery, 21st Edition, Page 1156

Comparison of portal hypertensive gastropathy and gastric antral vascular ectasia

↑ *Back to this question in Part A*

@Neet_pg_bot

Q8: A 56-year-old man arrives in the emergency department with severe upper gastrointestinal bleeding. On examination, he is pale, hypotensive, and has a rapid pulse. Which of the following is the initial priority in managing this patient? (Q849093)

A. Immediate endoscopy to identify the bleeding source

B. Assessment of airway, breathing, and circulation (ABCs) with intravenous access establishment

C. Administration of terlipressin for suspected variceal bleeding

D. Blood transfusion to raise hemoglobin above 10 g/dL

Correct Answer: B. Assessment of airway, breathing, and circulation (ABCs) with intravenous access establishment

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The primary step in managing acute UGIB is to ensure the patient's airway, breathing, and circulation (ABCs) are stable and establish intravenous access for fluid resuscitation. Management of acute UGI bleed Initial Stabilization and Resuscitation Prioritise assessment of airway, breathing, and circulation (ABCs). Establish intravenous access with two large-bore catheters for fluid resuscitation. Risk Stratification Use the Glasgow-Blatchford Score (GBS) for early risk assessment. Patients with a GBS of 0 are low-risk and may not need hospital admission. Blood Transfusion Strategy (Option D) Adopt a restrictive transfusion strategy, aiming for a haemoglobin level of 70–90 g/L. Consider a more liberal transfusion approach only in cases of massive blood loss. Pharmacotherapy (Option C) In suspected variceal bleeding, administer intravenous terlipressin to improve outcomes and reduce the need for additional interventions. Role of Endoscopy (Option A) Perform endoscopy urgently in unstable patients and within 24 hours for others. Endoscopy serves to: Identify the bleeding source. Assess prognosis using criteria like the Forrest classification. Treat with techniques such as: Injection therapy: Adrenaline injection. Thermal coagulation: Using heat probes or electrocoagulation. Mechanical methods: Endoscopic clips to close bleeding sites. Alternative Interventions If endoscopy fails or bleeding recurs, consider interventional radiology or surgery. Post-Endoscopy Management High-risk patients should receive intravenous

proton pump inhibitors (PPIs) for 72 hours, followed by twice-daily oral PPI for 11 days. Address underlying conditions, including the eradication of H. pylori if present, to prevent rebleeding.

References:

pmc.ncbi.nlm.nih.gov/articles/PMC4953237/#

Bailey and Love's Short Practice of Surgery, 28th Edition, Page 1166, 1167

Sabiston Textbook of Surgery, 21st Edition, Page 1151

↑ *Back to this question in Part A*

@Neet_pg_bot

Q9: In patients with AIDS, which of the following organisms is a recognised cause of gastritis? (Q890664)

A. Histoplasmosis

B. Cryptosporidiosis

C. Cytomegalovirus

D. Isospora belli

Correct Answer: B. Cryptosporidiosis

Explanation: In patients with AIDS, especially in severe immunosuppression, opportunistic infections commonly involve the gastrointestinal tract. Cryptosporidium is a recognized cause of gastritis , in addition to involvement of the duodenum and small intestine , leading to symptoms such as nausea, vomiting, and chronic diarrhea . It is classically associated with AIDS-related gastritis . Histoplasmosis (Option A) Causes disseminated gastrointestinal involvement with ulcerative or nodular lesions ; primary gastritis is not typical. Cytomegalovirus (Option C) Commonly causes esophagitis and colitis , and may produce gastric ulcers , but is not classically described as a cause of primary gastritis. Isospora belli (Option D) Primarily affects the small intestine , causing chronic diarrhoea ; gastric involvement is uncommon.

References:

Bailey & Love Short Practice of Surgery, 28th Edition, Page 1156

↑ *Back to this question in Part A*

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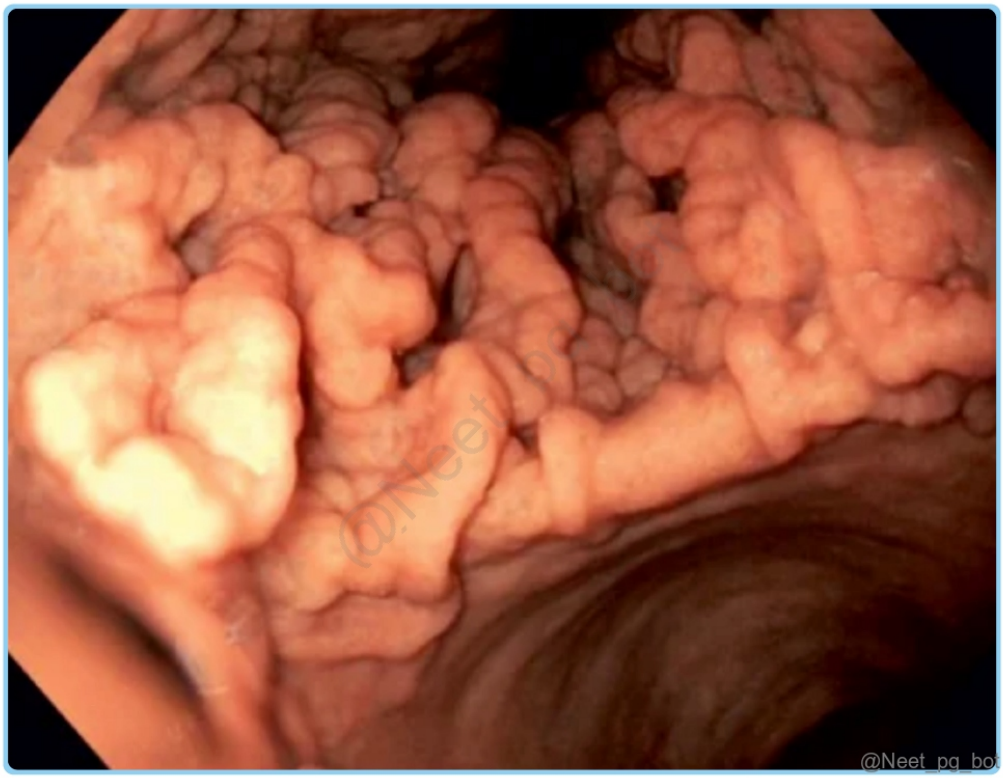
Q10: A 48-year-old man presents with progressive weight loss, early satiety, and bilateral pedal edema. Laboratory evaluation reveals hypoalbuminemia with normal liver function tests. Upper GI endoscopy shows the following appearance . Biopsy reveals foveolar hyperplasia with reduced parietal cells. Which of the following is the most likely underlying mechanism? (Q890677)

A. Autoimmune destruction of parietal cells leading to intrinsic factor deficiency

B. Overexpression of transforming growth factor-α causing mucous cell proliferation and reduced acid secretion

C. Increased gastrin secretion causing parietal cell hyperplasia and hyperchlorhydria

D. Chronic Helicobacter pylori infection causing antral-predominant inflammation



Correct Answer: B. Overexpression of transforming growth factor-α causing mucous cell proliferation and reduced acid secretion

Explanation: This patient has Ménétrier's disease , a protein-losing hypertrophic gastropathy characterized by massive enlargement of gastric folds in the fundus and body with sparing of the antrum , along with foveolar hyperplasia and parietal cell atrophy . Loss of protein through the gastric mucosa leads to hypoalbuminemia, edema, and ascites , while reduced parietal cell mass results in hypochlorhydria or achlorhydria . The underlying mechanism is overexpression of transforming growth factor-α (TGF-α) , which stimulates epithelial (mucous cell) proliferation and suppresses gastric acid secretion. The condition is premalignant with increased risk of gastric

carcinoma, and severe or refractory cases may require gastrectomy . Autoimmune destruction of parietal cells leading to intrinsic factor deficiency (Option A): Seen in Type A gastritis , associated with pernicious anemia. Increased gastrin secretion causing parietal cell hyperplasia and hyperchlorhydria (Option C): Seen in Zollinger-Ellison syndrome , not in this condition. Chronic Helicobacter pylori infection causing antral-predominant inflammation (Option D): Seen in Type B gastritis , not hypertrophic gastropathy.

References:

Sabiston’s principles of surgery, 21st Edition, Page 1235

↑ *Back to this question in Part A*

@Neet_pg_bot

Q11: A 26-year-old male presents with persistent dyspepsia despite a 1-month course of PPIs. A urea breath test is positive. What is the most likely diagnosis? (Q890663)

A. Type A gastritis

B. Type B gastritis

C. Reflux gastritis

D. Erosive gastritis

Correct Answer: B. Type B gastritis

Explanation: A positive urea breath test indicates infection with Helicobacter pylori , which plays a critical role in the development of chronic gastritis, peptic ulcer disease, and gastric cancer . This corresponds to Type B gastritis , which predominantly affects the antrum and commonly presents with dyspepsia . It may progress to pangastritis , and chronic atrophic changes can lead to intestinal metaplasia and increased malignant potential . PPIs alone do not eradicate the organism; treatment requires combination therapy with antibiotics and a PPI . Type A gastritis (Option A) Autoimmune gastritis affecting the body and fundus , associated with parietal cell antibodies , leading to achlorhydria, vitamin B12 deficiency, pernicious anemia, and increased gastric cancer risk ; antrum is typically spared. Reflux gastritis (Option C) Caused by enterogastric (bile) reflux , often seen after gastric surgery; not associated with H. pylori, so urea breath test is negative. Erosive gastritis (Option D) Caused by NSAIDs, alcohol, or stress , due to disruption of the mucosal barrier; not primarily related to H. pylori infection.

References:

Bailey & Love Short Practice of Surgery, 28th Edition, Page 1156

↑ *Back to this question in Part A*

@Neet_pg_bot

Q12: In hypovolemic shock, which part of the gastrointestinal tract is most vulnerable to ischemia due to poor collateral blood supply? (Q890660)

A. Griffith’s point

B. Sudeck’s point

C. Terminal ileum

D. Stomach

Correct Answer: A. Griffith’s point

Explanation: In hypovolemic shock, there is reduced splanchnic blood flow due to systemic hypoperfusion , with blood preferentially shunted to vital organs such as the brain and heart. As a result, ischemia occurs first in watershed areas of the colon , which have limited collateral circulation . The splenic flexure (Griffith’s point) lies at the junction of the superior mesenteric artery (SMA) and inferior mesenteric artery (IMA) territories and is therefore the most vulnerable site to ischemia in low-flow states . The rectosigmoid junction (Sudeck’s point) (Option B) is another watershed area but is less commonly affected initially. Terminal ileum (Option C): Typically affected in mesenteric arterial occlusion, not the earliest site in systemic hypoperfusion. Stomach (Option D): Highly resistant to ischemia due to rich collateral blood supply.

References:

https://pmc.ncbi.nlm.nih.gov/articles/PMC9374525/

https://www.ncbi.nlm.nih.gov/books/NBK554527/

↑ *Back to this question in Part A*

@Neet_pg_bot

Q13: A patient with severe burn injuries develops an upper gastrointestinal bleed. Endoscopy reveals multiple acute ulcers predominantly involving which part of the stomach? (Q890666)

A. Fundus and body

B. Antrum

C. Lesser curvature

D. Pyloric canal

Correct Answer: A. Fundus and body

Explanation: Curling’s ulcers are acute stress ulcers seen after severe burns (>35% TBSA) due to mucosal ischemia from hypovolemia and reduced splanchnic blood flow . These ulcers most commonly involve the fundus and body of the stomach , while the antrum and pyloric region are typically spared. They may present with hematemesis or upper gastrointestinal bleeding . Treatment is conservative: IV ranitidine IV pantoprazole 80 mg in 100 ml DNS-slow, later 40 mg IV maintenance. This contrasts with Cushing’s ulcers , which occur in CNS injury due to increased vagal stimulation and acid hypersecretion . Antrum (Option B): Typically spared in Curling’s ulcers; more commonly involved in H. pylori-related disease. Lesser curvature (Option C): Common site for chronic peptic ulcers, not stress-related ulcers. Pyloric canal (Option D): Not a typical site for Curling’s ulcers.

References:

SRB’s manual of surgery, 6th Edition, Page 813

↑ *Back to this question in Part A*

@Neet_pg_bot

Q14: Which of the following surgical procedures is specifically indicated for a Type IV proximal gastric ulcer? (Q890668)

A. Maki’s pylorus-preserving gastrectomy

B. De Miguel’s antrectomy

C. Kelling-Madlener procedure

D. Highly selective vagotomy with ulcer excision

Correct Answer: C. Kelling-Madlener procedure

Explanation: Type IV gastric ulcers are proximal ulcers near the gastroesophageal junction and are difficult to manage surgically due to their location. They are typically treated by more extensive resection , such as subtotal gastrectomy . The Kelling-Madlener procedure involves antrectomy with excision of the proximal gastric ulcer , and is specifically used for Type IV gastric ulcers . Variants like Csendes procedure or extended resections along the lesser curvature may also be used for these proximal lesions. Although medical therapy with PPIs and mucosal protective agents is first-line in modern practice, surgery is indicated in complicated, refractory, or suspicious (malignant potential) ulcers . Maki’s pylorus-preserving gastrectomy (Option A): Used in Type I gastric ulcer ; preserves pylorus but has higher recurrence rates. De Miguel’s antrectomy (Option B): Involves distal antrectomy with ulcer excision ; used for distal gastric ulcers, not proximal Type IV ulcers. Highly selective vagotomy with ulcer excision (Option D): Used in selected peptic ulcer disease; not appropriate for proximal Type IV gastric ulcers.

References:

SRB’s manual of surgery, 6th Edition, Page 815

↑ *Back to this question in Part A*

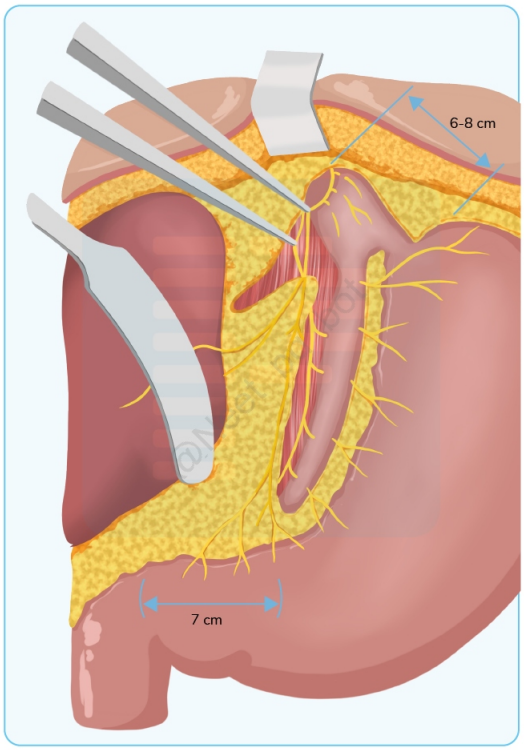
Q15: Which of the following statements is incorrect regarding the image shown below? (Q890670)

A. Ulcer recurrence rate is highest

B. Acid reduction is maximum

C. Nerve of Latarjet is spared

D. Postoperative complications are minimal



Correct Answer: B. Acid reduction is maximum

Explanation: Highly selective vagotomy (HSV) , also called parietal cell vagotomy or superselective vagotomy , involves division of vagal fibers supplying the parietal cell mass (fundus and body) while preserving the nerve of Latarjet (Option C) , which maintains antral pump and pyloric function ; hence no drainage procedure is required . The distal 6 cm of stomach proximal to the pylorus (Crow's foot) is preserved to maintain gastric emptying. Because only the acid-secreting area is denervated, acid reduction is the least among vagotomy procedures , making option B incorrect. This limited acid reduction explains the higher recurrence rate (~10-15%) (Option A) compared to more extensive procedures. However, preservation of normal gastric motility results in minimal postoperative complications (Option D) such as dumping syndrome and diarrhea. HSV has low operative mortality

and morbidity , but complications like lesser curvature ischemia can occur.

References:

SRB’s manual of surgery, 6th Edition, Page 818

↑ *Back to this question in Part A*

@Neet_pg_bot

Q16: A 40-year-old man presents with sudden onset severe abdominal pain. On examination, he is tachycardic, hypotensive, and has board-like abdominal rigidity. An erect chest X-ray reveals the following finding. What is the most appropriate immediate management? Ultrasound abdomen Intravenous fluid resuscitation Exploratory laparotomy Elective surgery Conservative management (Q890672)

A. 2, 3

B. 1, 4

C. 3, 4, 5

D. 1, 2, 5



@Neet_pg_bot

Correct Answer: A. 2, 3

Explanation: The patient has hollow viscus perforation with generalized peritonitis , evidenced by sudden severe pain, board-like rigidity, shock (tachycardia + hypotension), and free air under the diaphragm . This is a life-threatening surgical emergency . Immediate management requires aggressive intravenous fluid resuscitation to correct hypovolemia and stabilize circulation, followed by urgent exploratory laparotomy for source control (repair of perforation and peritoneal lavage) . Supportive measures such as nasogastric decompression, urinary catheterization, and broad-spectrum antibiotics are also initiated concurrently. Ultrasound abdomen (1) Not required; diagnosis is already confirmed by X-ray and clinical findings, and it may delay urgent management. Elective surgery (4) Inappropriate in an emergency setting. Conservative management (5) Contraindicated in generalized peritonitis with hemodynamic instability ; reserved only for stable, sealed perforations.

References:

Bailey & Love Short Practice of Surgery, 28th Edition, Page 1088

↑ *Back to this question in Part A*

@Neet_pg_bot

Q17: A patient develops sweating, tachycardia, colicky abdominal pain, and diarrhea within 30-40 minutes of meals following gastric surgery. Which of the following best explains the underlying mechanism? (Q890673)

A. Excess insulin secretion leading to hypoglycemia

B. Rapid entry of hyperosmolar chyme causing fluid shift into the intestinal lumen

C. Increased gastric acid secretion due to vagal overactivity

D. Delayed gastric emptying causing gastric distension

Correct Answer: B. Rapid entry of hyperosmolar chyme causing fluid shift into the intestinal lumen

Explanation: This is early dumping syndrome , commonly seen after procedures such as Billroth II or Roux-en-Y surgery . It occurs immediately after meals (within 30-40 minutes) and is often more severe and precipitated by bulky or carbohydrate-rich meals. The underlying mechanism is rapid emptying of hyperosmolar gastric contents into the small intestine , which draws fluid from the intravascular compartment into the intestinal lumen , leading to hypovolemia and increased intestinal motility . This produces vasomotor symptoms (sweating, tachycardia, hypotension) and gastrointestinal symptoms (colicky pain, diarrhea). Symptoms are often relieved by lying down . In contrast, late dumping syndrome occurs 1-3 hours after meals due to excess insulin release following initial hyperglycemia , resulting in hypoglycemia with features like tremor and fainting . (Option A) Increased gastric acid secretion due to vagal overactivity (Option C) Not related to dumping syndrome; seen in conditions like Cushing’s ulcer . Delayed gastric emptying causing gastric distension (Option D) Opposite mechanism; dumping is due to rapid gastric emptying .

References:

SRB’s manual of surgery, 6th Edition, Page 830

↑ *Back to this question in Part A*

@Neet_pg_bot

Q18: Which of the following statements best describes organoaxial gastric volvulus? (Q890675)

A. Rotation occurs along the transverse (short) axis of the stomach

B. It is less common and usually not associated with diaphragmatic defects

C. It occurs along the longitudinal axis between the cardia and pylorus and is commonly associated with paraoesophageal hernia

D. It rarely requires surgical management

Correct Answer: C. It occurs along the longitudinal axis between the cardia and pylorus and is commonly associated with paraoesophageal hernia

Explanation: Gastric volvulus is defined as rotation of the stomach around its fixed points-the cardia and pylorus . In the organoaxial type , the stomach rotates along its longitudinal axis , making it the most common form . It is frequently associated with diaphragmatic defects (Option B) , especially paraoesophageal hernia , where the stomach (often along with the transverse colon) may herniate into the thoracic cavity. The condition may be chronic with symptoms like difficulty in eating , or acute with ischemia , presenting with Borchardt triad (pain, retching, inability to pass NG tube) . Management is surgical (Option D) , increasingly via a laparoscopic transabdominal approach, involving reduction of herniated contents, closure of the diaphragmatic defect (± mesh), and anterior gastropexy to fix the stomach . Rotation occurs along the transverse (short) axis of the stomach (Option A) Describes mesenteroaxial volvulus , not organoaxial.

References:

Bailey & Love Short Practice of Surgery, 28th Edition, Page 1180

↑ *Back to this question in Part A*

@Neet_pg_bot

Q19: During a Billroth II procedure, the surgeon carefully dissects the pyloric region. Which of the following statements about this area's anatomy is most accurate? (Q849020)

A. The right gastric artery originates directly from the celiac trunk

B. The vagus nerve forms a single identifiable trunk in this region

C. Lymph nodes here drain exclusively into the pancreaticolienal group

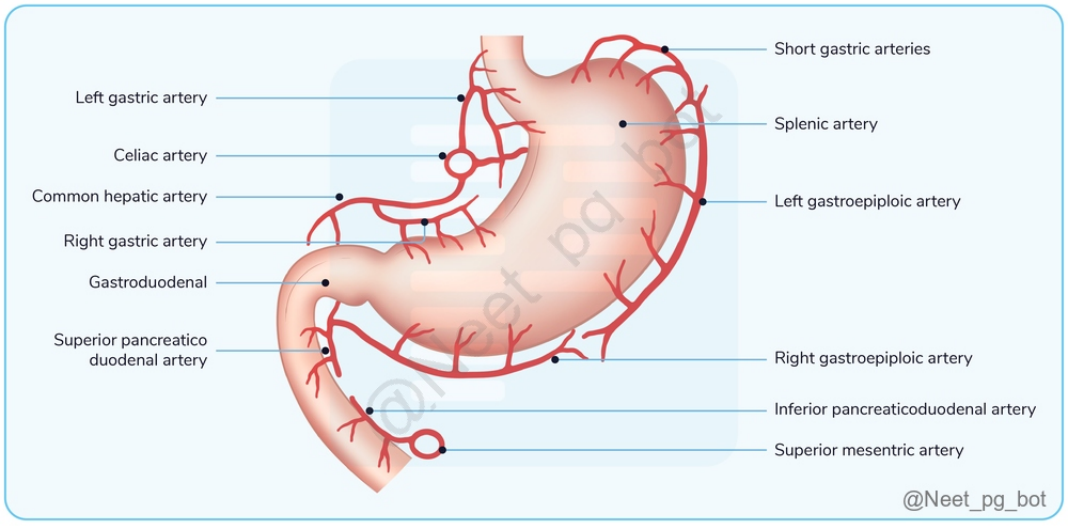
D. The gastroduodenal artery passes posterior to the first part of the duodenum

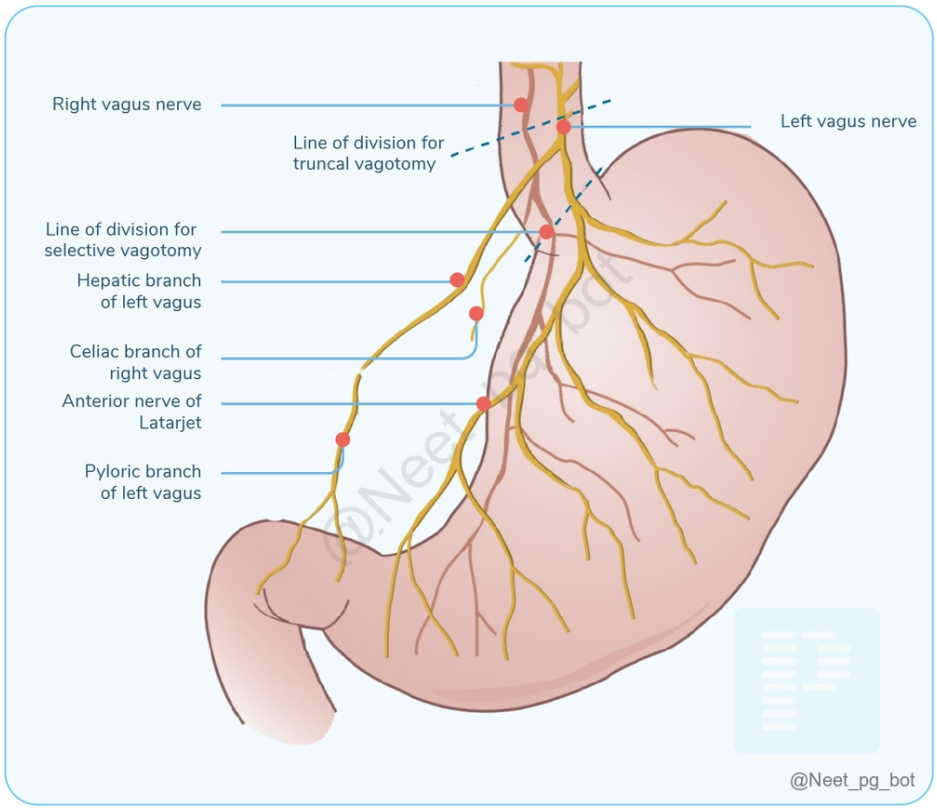
Correct Answer: D. The gastroduodenal artery passes posterior to the first part of the duodenum

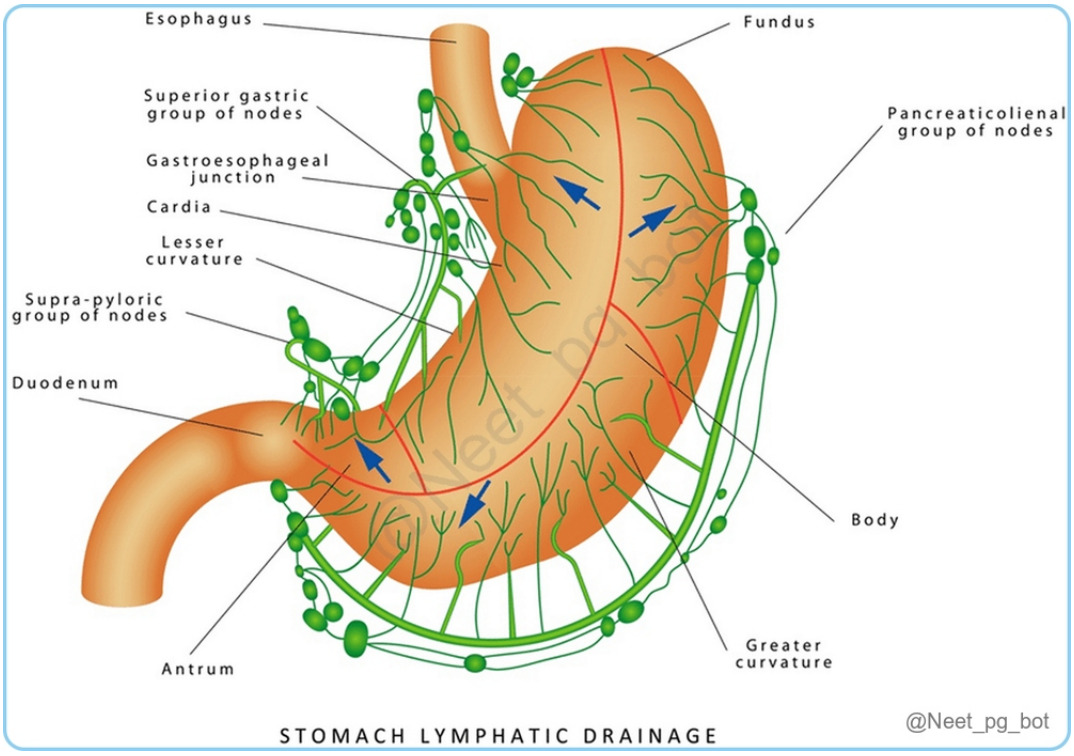
■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The gastroduodenal artery , a branch of the hepatic artery, passes behind the first part of the duodenum , which is highly relevant with respect to a bleeding duodenal ulcer. The right gastric artery originates directly from the celiac trunk (Option A): The right gastric artery arises from the common hepatic artery. The arterial blood supply of the stomach: The vagus nerve forms a single identifiable trunk in this region (Option B): The vagus nerve does not form a single identifiable trunk in the Pyloric region. The vagal plexus around the oesophagus condenses into bundles that pass through the oesophageal hiatus, the posterior bundle being usually identifiable as a large nerve trunk. The nerve supply of the stomach: Lymph nodes here drain exclusively into the pancreaticolienal group (Option C): The lymphatic drainage of this area is not exclusive to the pancreaticolienal group. The supra pyloric group of nodes drains the antral segment on the lesser curvature of the stomach into the right supra pancreatic nodes. The inferior gastric and sub-pyloric group of nodes drains lymph along the right gastroepiploic vascular pedicle. All four lymph node zones drain into the celiac nodes and eventually into the thoracic duct. Lymphatic drainage of the stomach:







References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1148, 1149

Sabiston Textbook of Surgery, 21st Edition, Page 1197

Anterior nerve of latarjet

↑ *Back to this question in Part A*

@Neet_pg_bot

Q20: A 45-year-old male with a history of chronic alcoholism presents to the emergency department after a night of intense vomiting following a drinking binge. He complains of severe upper abdominal pain and is found to have hematemesis. An urgent upper GI endoscopy is performed, revealing a mucosal laceration near the GE junction. Which of the following is not a management option for the above condition? (Q849086)

A. Multipolar electrocoagulation

B. Epinephrine injection

C. Endoscopic band ligation

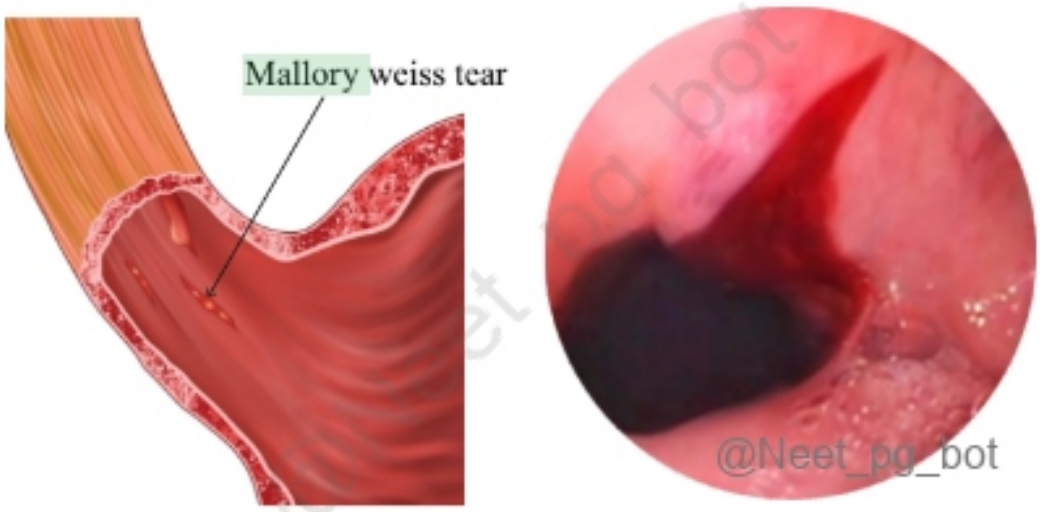
D. Balloon tamponade

Correct Answer: D. Balloon tamponade

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Balloon tamponade is not a management option for Mallory-Weiss syndrome . It is primarily used for controlling bleeding from oesophagal varices, not for mucosal lacerations like those seen in Mallory-Weiss tears. Mallory-Weiss Tears: Treatment Endoscopic Methods: Multipolar electrocoagulation (Option A) Epinephrine injection (Option B) Endoscopic band ligation (Option C) Endoscopic hemoclipping For Persistent/Recurrent Bleeding: Angiographic transarterial embolization Surgical intervention (rare): Approach through the anterior gastrotomy Oversew bleeding site with deep 2-0 silk ligatures Severe/Ongoing Bleeding: Endoscopic therapy (injection or electrocoagulation) Angiographic embolization with absorbable material (e.g., gelatin sponge) High gastrotomy and suturing of the mucosal tear if other methods fail



References:

Sabiston Textbook of Surgery, 21st Edition, Page 1235

Bailey and Love's Short Practice of Surgery, 28th Edition, Page 1127-1129

↑ *Back to this question in Part A*

@Neet_pg_bot

Q21: Which of the following is NOT a cause of upper gastrointestinal bleeding? (Q849085)

A. Peptic Ulcer Disease

B. Esophageal Varices

C. Mallory-Weiss Tear

D. Angiodysplasia

Correct Answer: D. Angiodysplasia

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Angiodysplasia is primarily a cause of lower gastrointestinal (LGI) bleeding . Cause Description Peptic Ulcers (Option A) Bleeding from peptic ulcers in the stomach or duodenum is the most common cause of upper GI bleeding. MC artery involved in Duodenal ulcer - Gastroduodenal artery Gastric ulcer - Left gastric artery Mallory-Weiss Syndrome (Option C) Tears in the mucosa of the esophagus or stomach, are typically caused by severe vomiting, resulting in significant bleeding. Esophageal Varices (Option B) Enlarged veins in the oesophagus that can rupture and bleed, are commonly a complication of chronic liver disease. Primarily due to

Portal Hypertension.

References:

Bailey and Love's Short Practice of Surgery, 28th Edition, Page 1157-58, 1167-68

SRB's Manual of Surgery, 6th Edition, Page 793, 812, 824, 827, 900

www.ncbi.nlm.nih.gov/books/NBK470300/#

www.ncbi.nlm.nih.gov/books/NBK442012/

↑ *Back to this question in Part A*

@Neet_pg_bot

Q22: A patient presents with early satiety, weight loss, nausea, and vomiting. An upper endoscopy reveals a narrowing of the pylorus due to inflammation and scarring from peptic ulcer disease. What is the most appropriate initial step in managing this patient's gastric outlet obstruction? (Q849084)

A. Surgical antrectomy with reconstruction and vagotomy

B. Endoscopic dilation with stent placement

C. Placement of a nasogastric tube and correction of fluid/electrolyte imbalances

D. Immediate initiation of H. pylori eradication therapy

Correct Answer: C. Placement of a nasogastric tube and correction of fluid/electrolyte imbalances

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Initial management of GOO from PUD involves decompressing the stomach using an NG tube to relieve pressure and correct any fluid and electrolyte imbalances caused by vomiting. Gastric Outlet Obstruction (GOO) from Peptic Ulcer Disease (PUD) Pathogenesis In adults , GOO is most commonly due to PUD (benign) or gastric cancer (malignant). In infants- congenital pyloric stenosis. H. pylori → Chronic active gastritis (most common worldwide) ↑ Gastrin → Hyperacidity → Peptic ulcer disease Antral-predominant → Duodenal ulcer Corpus-predominant → Gastric ulcer Chronic inflammation + fibrosis near pylorus → Gastric Outlet Obstruction (GOO) Long-term infection → Gastric adenocarcinoma & MALT lymphoma → WHO Class I carcinogen Diagnosis Primary Diagnostic Approach : Differentiate PUD vs malignancy. Endoscopy: Directly visualizes the pylorus to evaluate stenosis and obtain biopsies to rule out cancer. Assess for H. pylori infection. (Option D) Contrast Radiology: Assesses pylorus narrowing and obstruction severity Treatment Initial Stabilization : (Option C) Gastric Decompression: NG tube placement. Fluid and Electrolyte Correction: Intravenous fluids and electrolytes. Nutritional Support: Dietary modifications, enteral or parenteral nutrition. Addressing Underlying PUD : Medical Therapy: H. pylori eradication therapy, Proton pump inhibitors (PPIs). Endoscopic Dilation: Dilate

narrowed tract area; stent placement (Option B) . Surgical Intervention : Antrectomy with Reconstruction and Vagotomy: Removal of antrum, stomach reconnection, and vagus nerve cutting (Option A) . Vagotomy with Drainage Procedure: Jaboulay Gastroduodenostomy, Gastrojejunostomy, Pyloroplasty.

References:

Bailey and Love's Short Practice of Surgery, 28th Edition, Page 1168-1169

Sabiston Textbook of Surgery, 21st Edition, Page 1212-1215

↑ *Back to this question in Part A*

@Neet_pg_bot

Q23: A 65-year-old man presents with severe epigastric pain and black, tarry stools. He has a history of chronic gastritis and NSAID use for osteoarthritis. Upper GI endoscopy reveals a gastric ulcer and a biopsy is taken for histological analysis. According to the modified Johnson's criteria, what type of ulcer is most likely? (Q849028)

A. Type I

B. Type IV

C. Type III

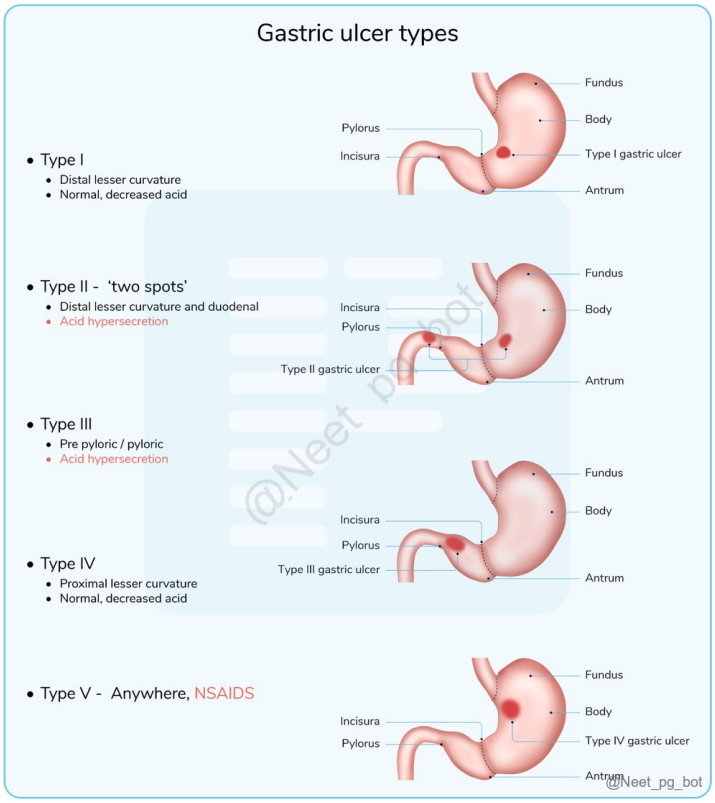
D. Type V

Correct Answer: D. Type V

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The clinical scenario here points to a Type V gastric ulcer since it is NSAID-induced. Modified Johnson's criteria for classification of gastric ulcers: Types Location Acid level Type I Ulcer at lesser curve incisura angularis Most common Low to normal Type II Ulcer at the gastric body and Duodenal ulcer Increased Type III Ulcer is pre-pyloric Increased Type IV Ulcers higher on the lesser curvature, M/C type to bleed. Normal Type V Any location/throughout the stomach but NSAID-induced ulcers. Normal



References:

Sabiston's Textbook of Surgery, 21st Edition, Page 1207

↑ *Back to this question in Part A*

@Neet_pg_bot

Q24: A 60-year-old male with a long-standing history of duodenal ulcer on treatment with proton pump inhibitors presents to the clinic with sudden severe epigastric pain, rebound tenderness, and air under the diaphragm. Based on this history, what is the complication? (Q849027)

A. Perforated duodenal ulcer

B. Pyloric stenosis

C. Gastric outlet obstruction

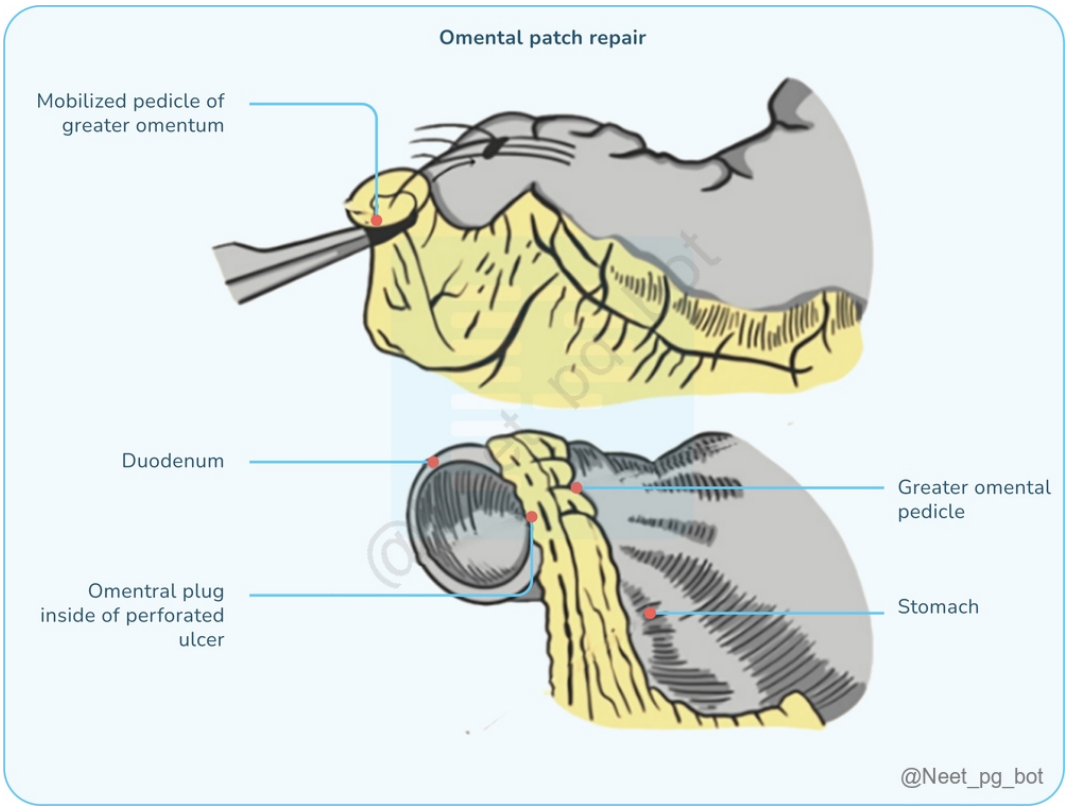
D. Hourglass deformity of stomach

Correct Answer: A. Perforated duodenal ulcer

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The clinical scenario here points to the diagnosis of a perforated duodenal ulcer leading to air under the diaphragm . Complications of duodenal ulcer: 1) Duodenal ulcer perforation: Common with anterior duodenal ulcers. Presents with an acute abdomen with sudden-onset, severe epigastric pain, rebound tenderness, and air under the diaphragm in the radiograph. Management: Non-surgical: Nil per-oral IV antibiotics and PPIs Surgical: Initial empirical antibiotic treatment. The perforation is approached by a small upper midline incision Perforations <1cm are closed primarily and buttressed with a well-vascularized omentum Larger perforations & with fibrotic edges: Modified Graham's Repair or Omental Patch Repair. The vascularized pedicle of the greater omentum is patched over the defect. 2) Bleeding duodenal ulcer 3) Gastric Outlet Obstruction (GOO) (Option C) 4) Hourglass deformity (Option D) 5) Pyloric stenosis (Option B)



References:

Sabiston’s Textbook of Surgery, 21st Edition, Page 1210-1211, 1213-1214

↑ *Back to this question in Part A*

@Neet_pg_bot

Q25: A 35-year-old man comes to the clinic with pain in the epigastrium and uneasiness for 2 months, which is temporarily relieved by antacids. He has a history of smoking and takes nonsteroidal anti-inflammatory drugs (NSAIDs) occasionally for

back pain. An upper gastrointestinal endoscopy reveals a duodenal ulcer. What would be the best line of treatment in this case? (Q849026)

A. H. pylori eradication

B. Proton pump inhibitors

C. Antacids like aluminium hydroxide

D. Highly selective vagotomy

Correct Answer: B. Proton pump inhibitors

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: This patient has a duodenal ulcer likely precipitated by NSAID use and smoking, both of which impair mucosal defense. In such cases, the first-line treatment is a course of Proton Pump Inhibitors (PPIs) for 4–8 weeks, along with cessation of NSAIDs and smoking. PPIs rapidly suppress acid secretion and are the most effective agents for NSAID-associated ulcer healing. H. pylori testing is recommended, but eradication therapy is only indicated if the test is positive. Empiric eradication without testing is not standard for NSAID-related ulcers. Incorrect Options: Option A) H. pylori eradication : Only indicated if H. pylori infection is confirmed. This case has a clear NSAID + smoking etiology, so eradication is not the primary step. Option C) Antacids like aluminium hydroxide : Provide short-term symptom relief but do not heal duodenal ulcers or address the underlying cause. Option D) Highly selective vagotomy : A surgical approach rarely used today; reserved for refractory or complicated ulcers (bleeding, perforation), not for an uncomplicated NSAID-associated ulcer.

References:

Bailey and Love's Short Practice of Surgery, 28th Edition, Page 1159, 1160, 1161

↑ *Back to this question in Part A*

@Neet_pg_bot

Q26: A 50-year-old woman with a history of gastric carcinoma comes to the OPD with abdominal pain, early satiety, diarrhoea, and bloating. On examination, she is tachycardic and has palpitations. She also complains of headaches. She has undergone partial gastrectomy and Billroth type II reconstruction. What is the diagnosis here? (Q849025)

A. Recurrence of gastric carcinoma

B. Dumping syndrome

C. Gastric ulcer, Type V

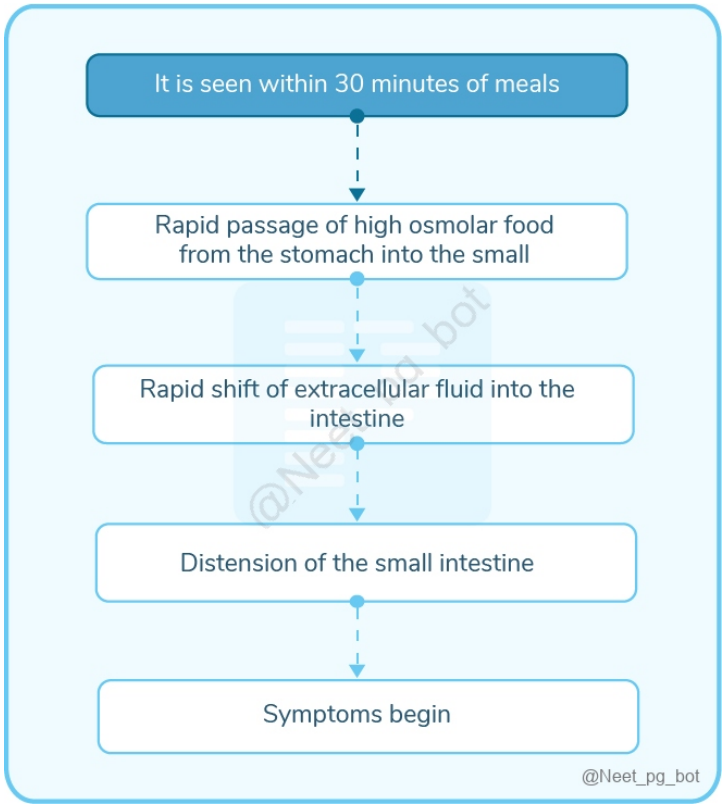
D. Irritable bowel syndrome

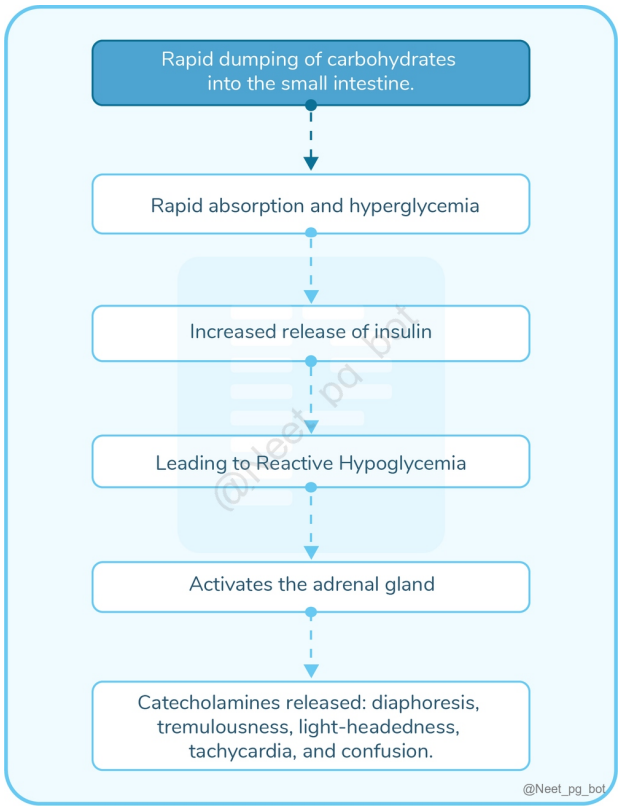
Correct Answer: B. Dumping syndrome

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The patient's symptoms, along with a history of partial gastrectomy and Billroth II reconstruction, are most consistent with dumping syndrome. It is a group of symptoms due to the accelerated emptying or dumping of hyperosmolar content into the proximal part of the small intestine. Dumping syndrome is a combination of both gastrointestinal and vasomotor symptoms due to rapid postprandial gastric emptying. GI symptoms : Abdominal pain, early satiety, nausea, vomiting, diarrhoea, bloating Vasomotor systemic symptoms: Diaphoresis, tachycardia, palpitations, headache, syncope It's more commonly seen in Billroth II type surgery. Early Dumping Late Dumping It is seen within 30 minutes of meals Worsens with food intake Relieved by lying down It is seen after 1-3 hours of meals Less common Worsens with exercise Relieved by food Treatment: Intravenous fluids Treatment: Oral glucose is given





References:

Sabiston Textbook of Surgery, 21st Edition, Page 1217

↑ *Back to this question in Part A*

@Neet_pg_bot

Q27: A 60-year-old male with a history of peptic ulcer disease underwent partial gastrectomy with Roux-en-Y reconstruction five years ago. He presents with symptoms of severe diarrhoea, foul breath, and significant weight loss over the past few months. Which of the following is the most likely complication he is experiencing? (Q849024)

A. Gastrocolic fistula

B. Postvagotomy diarrhoea

C. Bilious vomiting

D. Nutritional deficiency

Correct Answer: A. Gastrocolic fistula

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Gastric surgery can lead to various physiological disruptions due to the loss of stomach reservoir function, disruption of the pyloric sphincter mechanism, and transection of the vagus nerve. These gastrointestinal and cardiovascular symptoms can give rise to a group of conditions known as postgastrectomy syndromes. The patient's symptoms of severe diarrhoea following meals, foul breath, and significant weight loss align with a gastrocolic fistula, where an anastomotic ulcer in the gastrojejunostomy penetrates the transverse colon. This condition results in jejunal contamination with colonic bacteria, leading to severe diarrhoea and nutritional disturbances. Imaging techniques like CT with oral contrast or a barium enema can confirm this diagnosis. Other complications of Gastric Reconstruction and Vagotomy: Complication Symptoms Postvagotomy Diarrhea (Option B) Diarrhoea, rapid gastric emptying, no foul breath Bilious Vomiting (Option C) Vomiting bile and food, abdominal pain, reflux symptoms Nutritional Deficiency (Option D) Weight loss, iron deficiency anaemia, vitamin B12 deficiency, osteoporosis

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1162, 1163, 1164

Sabiston Textbook of Surgery, 21st Edition, Page 1218

↑ *Back to this question in Part A*

@Neet_pg_bot

Q28: A 62-year-old woman is diagnosed with a T3N1M0 gastric adenocarcinoma located in the proximal third of the stomach, extending to the gastroesophageal junction. Which of the following gastrectomy procedures is most appropriate for curative intent? (Q849023)

A. Distal gastrectomy

B. Proximal gastrectomy

C. Total gastrectomy

D. Sleeve gastrectomy

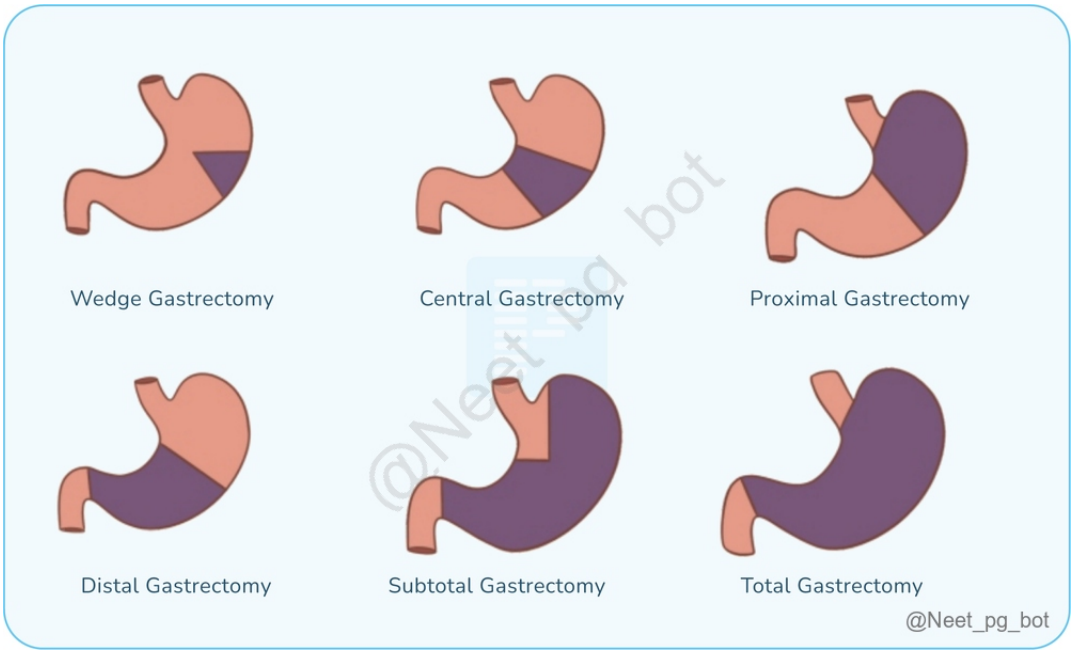
Correct Answer: C. Total gastrectomy

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The most appropriate procedure for this patient is total gastrectomy. In total gastrectomy, the entire stomach is removed, along with the greater and lesser omentum and regional lymph nodes. This procedure is

indicated for tumours located in the proximal or middle third of the stomach, especially those extending to the gastroesophageal junction. It ensures the complete removal of the tumour with adequate margins and allows for extensive lymphadenectomy, which is crucial for the proper staging and treatment of gastric cancer. Type of Gastrectomy Total Gastrectomy (The most appropriate procedure for this patient is total gastrectomy.) Distal Gastrectomy (Option A ruled out) It is typically used for tumours located in the distal third of the stomach or antrum.) Billroth I is done for benign condition. Here along with partial gastrectomy, gastroduodenostomy is done. Billroth II is done for carcinoma stomach. After partial gastrectomy, gastrojejunostomy is done and duodenal stump is closed. Proximal Gastrectomy (Option B ruled out) is generally reserved for early-stage cancers of the upper third of the stomach that do not involve the gastroesophageal junction. Sleeve Gastrectomy (Option D ruled out) is primarily a bariatric procedure and is not used for gastric cancer treatment.)



References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1161

Sabiston Textbook of Surgery, 21st Edition, Page 1215

↑ *Back to this question in Part A*

@Neet_pg_bot

Q29: A 55-year-old man undergoes a distal gastrectomy for gastric cancer. The surgeon wants to restore gastrointestinal continuity with a method that minimizes bile reflux gastritis. Which of the following reconstruction techniques is most appropriate? (Q849022)

A. Billroth I

B. Billroth II

C. Roux-en-Y gastrojejunostomy

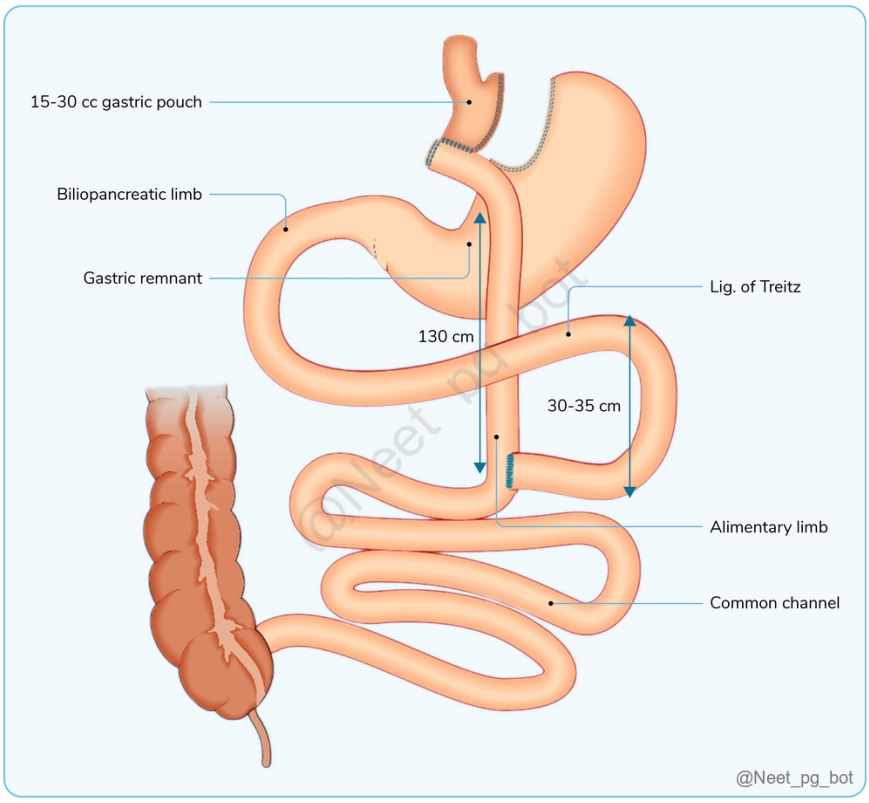
D. Jejunal interposition

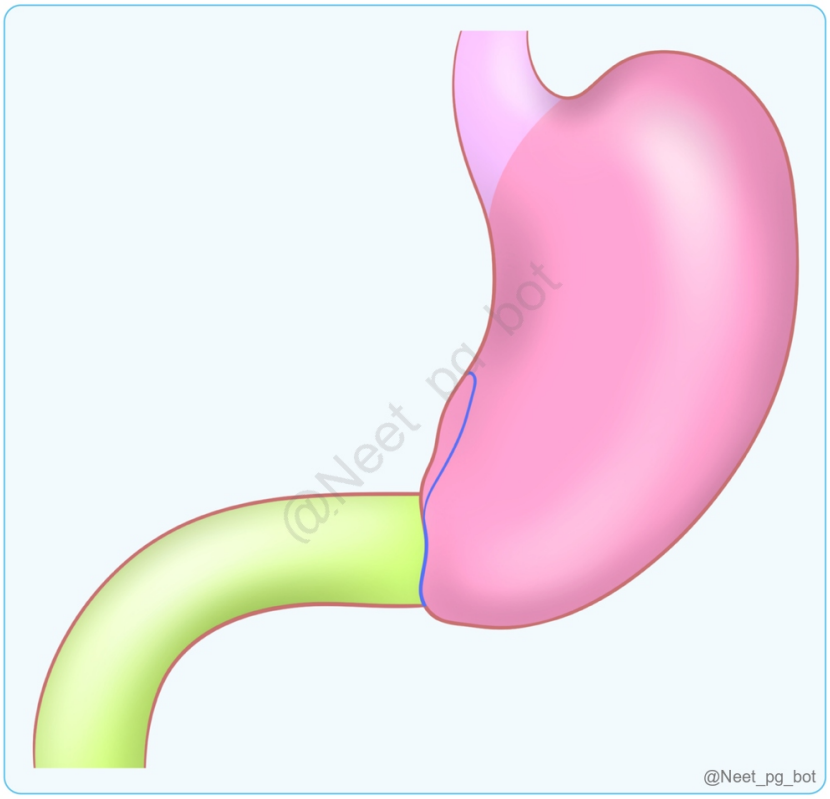
Correct Answer: C. Roux-en-Y gastrojejunostomy

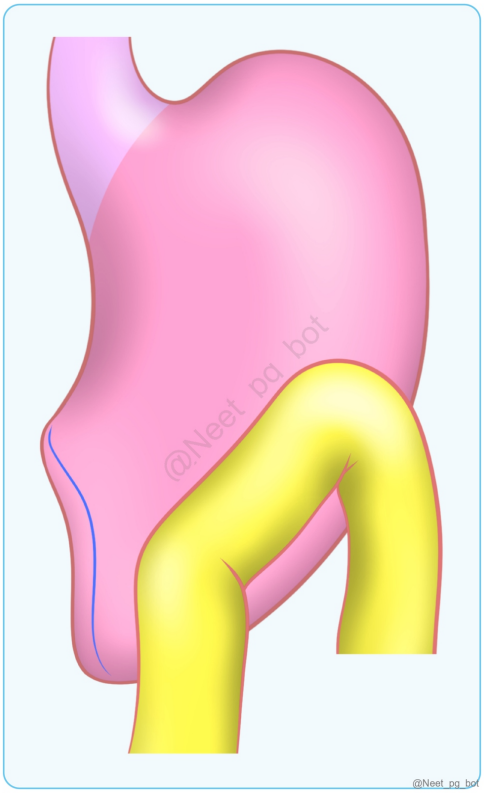
■ *Listen (English)*

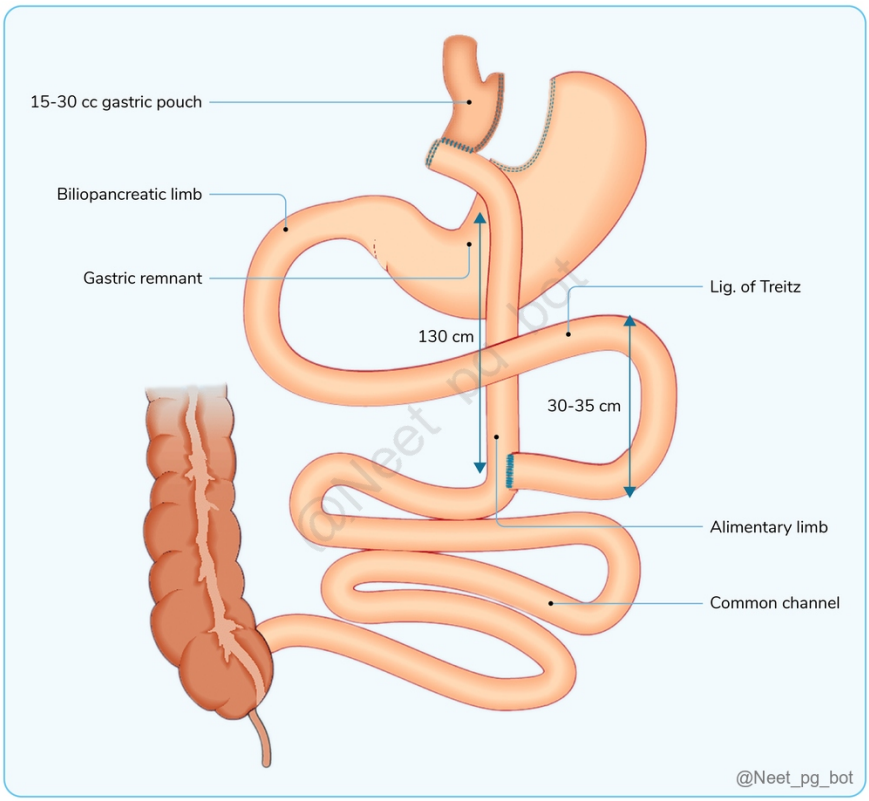
■ *Listen (Hindi)*

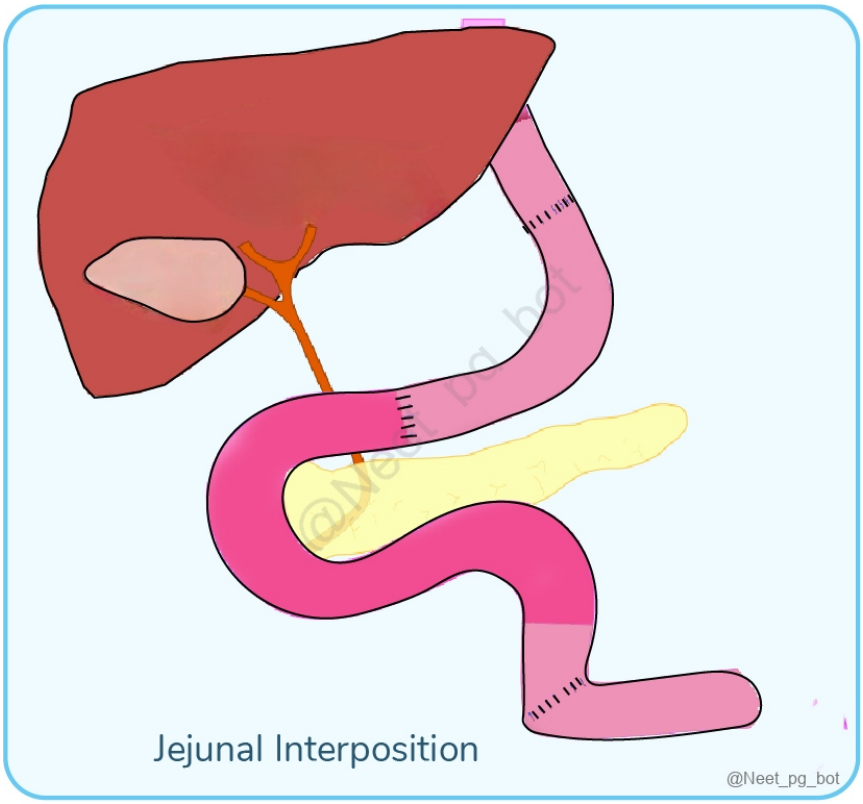
Explanation: Roux-en-Y gastrojejunostomy is the most appropriate reconstruction technique in this case because it effectively minimizes bile reflux gastritis. In this method, a Roux limb of the jejunum is created and anastomosed to the gastric remnant, while the biliopancreatic limb is connected to the Roux limb at least 40-50 cm distal to the gastrojejunostomy. This arrangement prevents bile and pancreatic secretions from reaching the gastric remnant, significantly reducing the risk of bile reflux gastritis. Gastrectomy Reconstruction Techniques: Technique Bile Reflux Risk Image Billroth I Partial gastrectomy and gastroduodenostomy High Billroth II Partial gastrectomy+ gastrojejunostomy, and closure of duodenal stump High Roux-en-Y Low Jejunal Interposition Moderate




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References:

Bailey & Love's Short Practice of Surgery, 27th Edition, Page 1160, 1163

Sabiston Textbookof Surgery, 21st Edition, Page 1215

SRB’s Manual of Surgery, 6th Edition, Page 849

Petersen's Hernia After Roux-en-Y Gastric Bypass:

↑ *Back to this question in Part A*

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Q30: A 45-year-old man with refractory peptic ulcer disease is being considered for surgical intervention. Which of the following procedures will most likely preserve the vagal innervation of the gastric antrum and pylorus while reducing acid secretion? (Q849021)

A. Truncal vagotomy

B. Selective vagotomy

C. Truncal vagotomy with antrectomy

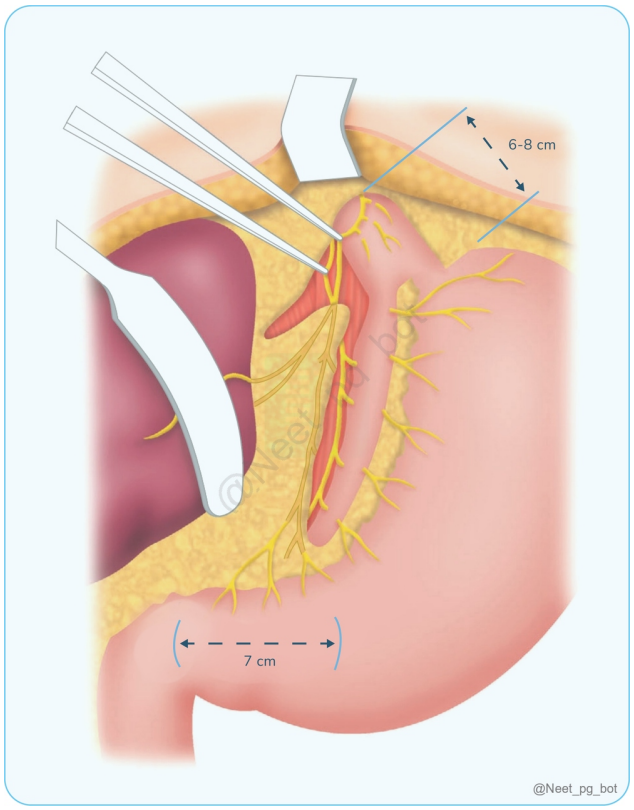
D. Highly selective vagotomy

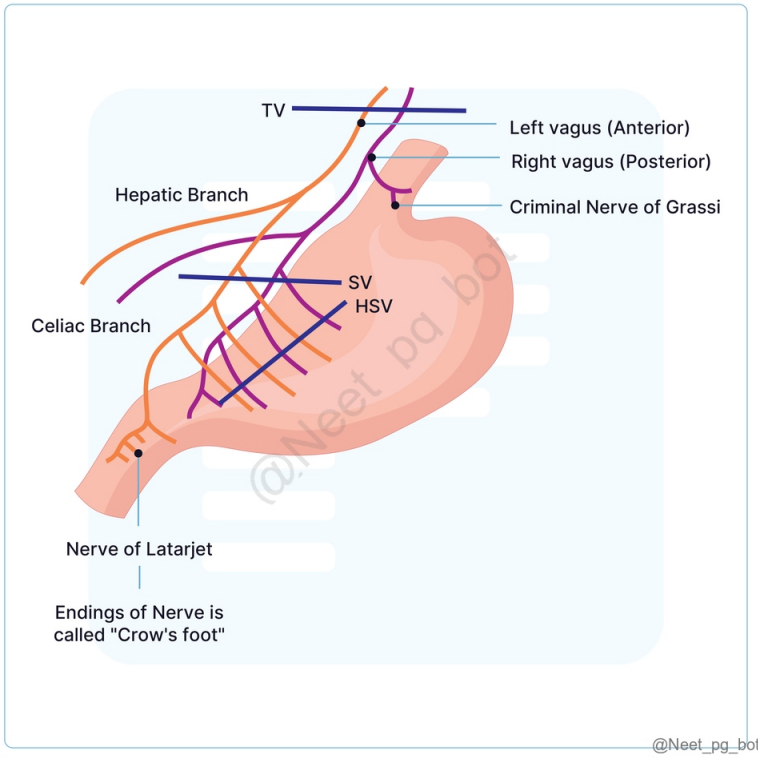
Correct Answer: D. Highly selective vagotomy

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Highly selective vagotomy , also known as parietal cell vagotomy or proximal gastric vagotomy , is the procedure that best preserves the vagal innervation of the gastric antrum and pylorus. A highly selective vagotomy divides only the vagus nerves supplying the acid-producing portion of the stomach within the corpus and fundus, so there is no need for routine drainage procedures. Characteristic Truncal Vagotomy (Option A) Truncal Vagotomy with Antrectomy (Option C) Selective Vagotomy (Option B) Highly Selective Vagotomy Nerves Divided Left and right vagus above hepatic and celiac branches Truncal vagotomy plus removal of the antrum Main right and left vagus distal to celiac and hepatic branches Only nerves to the acid-producing portion (all branches to the fundus and body) of the stomach





References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1161

Sabiston Textbook of Surgery, 21st edition, Page 1213, 1214

↑ *Back to this question in Part A*

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• [05_Gastrointestinal Surgery] 021 Stomach-Ii

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[05_Gastrointestinal Surgery] 021 Stomach-Ii — Quick Jump

Q1 (p. 1896)	*Q2 (p. 1897)*	*Q3 (p. 1898)*	*Q4 (p. 1903)*	*Q5 (p. 1904)*	*Q6 (p. 1905)*
Q7 (p. 1908)	*Q8 (p. 1909)*	*Q9 (p. 1912)*	*Q10 (p. 1913)*	*Q11 (p. 1914)*	*Q12 (p. 1915)*
Q13 (p. 1916)	*Q14 (p. 1917)*	*Q15 (p. 1918)*	*Q16 (p. 1919)*	*Q17 (p. 1920)*	*Q18 (p. 1920)*
Q19 (p. 1921)	*Q20 (p. 1922)*	*Q21 (p. 1922)*	*Q22 (p. 1923)*	*Q23 (p. 1924)*	*Q24 (p. 1924)*
Q25 (p. 1925)	*Q26 (p. 1926)*	*Q27 (p. 1926)*	*Q28 (p. 1927)*	*Q29 (p. 1928)*	*Q30 (p. 1928)*
Q31 (p. 1929)	*Q32 (p. 1930)*				

Q1: A 58 year old man is diagnosed with an adenocarcinoma located 4 cm below the gastroesophageal junction. According to the Siewert classification system, what type of tumour does he have, and how should it be treated if it does not extend into the GE junction? (Q849095)

A. Type I; treated as esophageal adenocarcinoma

B. Type II; treated as gastric adenocarcinoma

C. Type III; treated as gastric adenocarcinoma

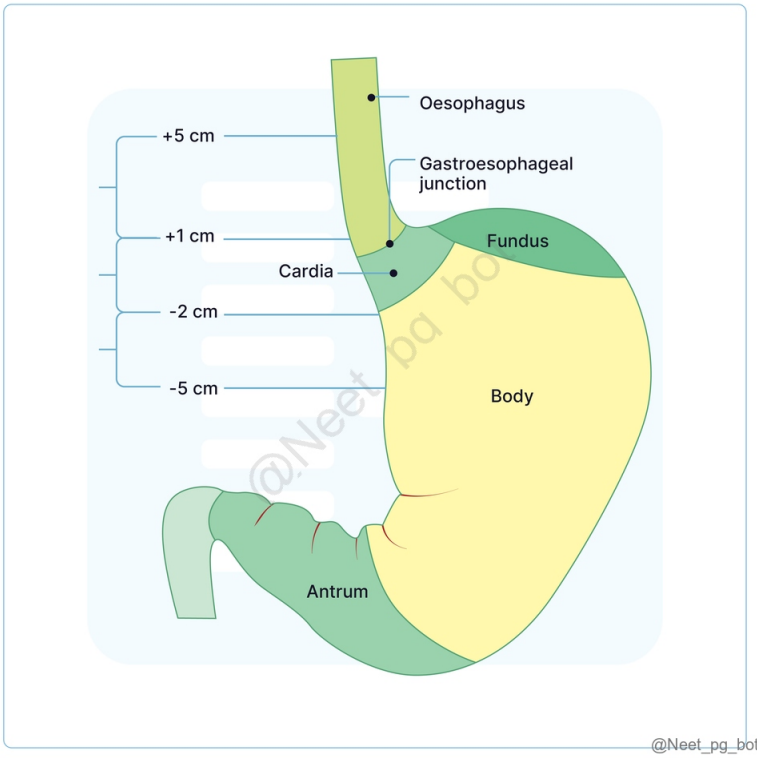
D. Type III; treated as esophageal adenocarcinoma

Correct Answer: C. Type III; treated as gastric adenocarcinoma

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Type III tumors are located between 2 and 5 cm below the GE junction and are treated according to guidelines for gastric adenocarcinoma , provided they do not extend into the GE junction. Type Adenocarcinoma around cardia Location Type I (Option A) Distal esophagus 1-5cm above the cardia Type II (Option B) Real Cardia 1cm above and 2cm below cardia Type III (Option C) Sub-cardial stomach 2-5cm below cardia Type III; treated as esophageal adenocarcinoma (Option D), Type III tumors are treated as gastric adenocarcinoma if they do not involve the GE junction.



References:

Sabiston Textbook of Surgery, 21st Edition, Page 1222

↑ *Back to this question in Part A*

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Q2: A 60 year old woman presents with fatigue, loss of appetite, and a palpable mass in the upper abdomen. Endoscopic examination and biopsy confirmed diffuse large B-cell lymphoma of the stomach. What is the most appropriate treatment regimen for this patient? (Q849122)

A. H. pylori eradication therapy

B. Radiation therapy alone

C. Chemotherapy with R-CHOP

D. Immunotherapy with checkpoint inhibitors

Correct Answer: C. Chemotherapy with R-CHOP

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The R-CHOP regimen , which includes Rituximab, Cyclophosphamide, Doxorubicin, Vincristine, and Prednisone, is the standard treatment for diffuse large B-cell lymphoma of the stomach. This combination therapy is designed to target the aggressive nature of DLBCL and is effective in managing the disease. Note: Gastric lymphoma, including MALToma and diffuse large B-cell lymphoma (DLBCL), involves malignancies originating in the stomach. Gastric MALT lymphoma is often associated with Helicobacter pylori infection and can be treated initially with H. pylori eradication therapy. In contrast, DLBCL usually requires a combination of chemotherapy (such as the R-CHOP regimen) and may involve surgery or radiation therapy for specific complications or cases. H. pylori eradication therapy (Option A) is effective for treating gastric MALToma due to its association with the bacterium, it is not adequate for managing diffuse large B-cell lymphoma (DLBCL) of the stomach. Radiation therapy alone (Option B) can be part of the treatment plan, particularly in cases where there are localized complications or in combination with other therapies, it is not usually effective as a standalone treatment for this aggressive lymphoma. Immunotherapy with checkpoint inhibitors (Option D) is not considered the first-line treatment. Although it represents a promising area of research, the standard initial treatment remains chemotherapy with R-CHOP.

References:

Sabiston Textbook of Surgery, 21st Edition, Page 1231,1232

↑ *Back to this question in Part A*

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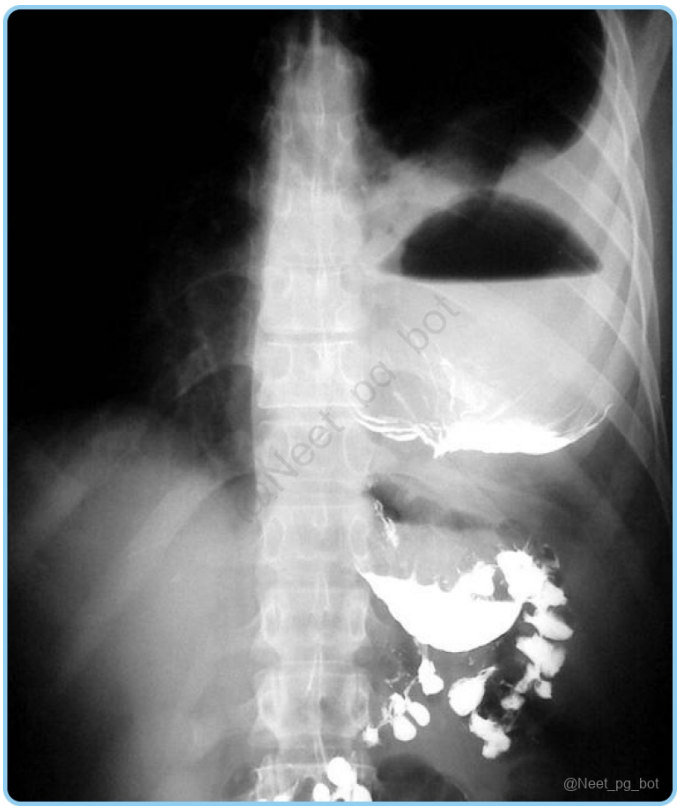
Q3: Match the following conditions with their corresponding X-ray findings: i) Teapot stomach a) ii) Hourglass stomach b) iii) Congenital Hypertrophic Pyloric Stenosis c) iv) Leather bottle stomach d) (Q849121)

A. i-a, ii-d, iii-c, iv-b

B. i-d, ii-a, iii-c, iv-b

C. i-d, ii-a, iii-b, iv-c

D. i-c, ii-b, iii-a, iv-d


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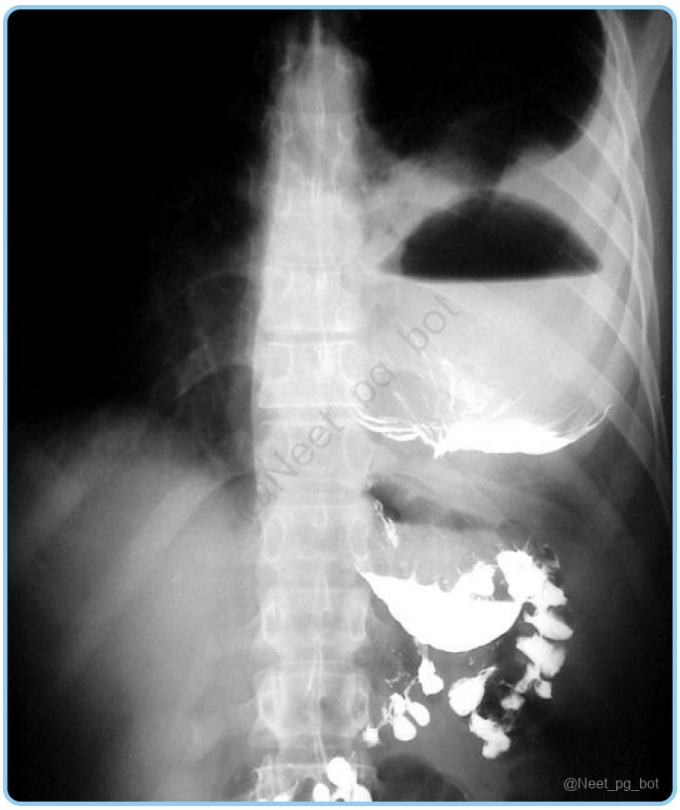
Correct Answer: C. i-d, ii-a, iii-b, iv-c

■ *Listen (English)*

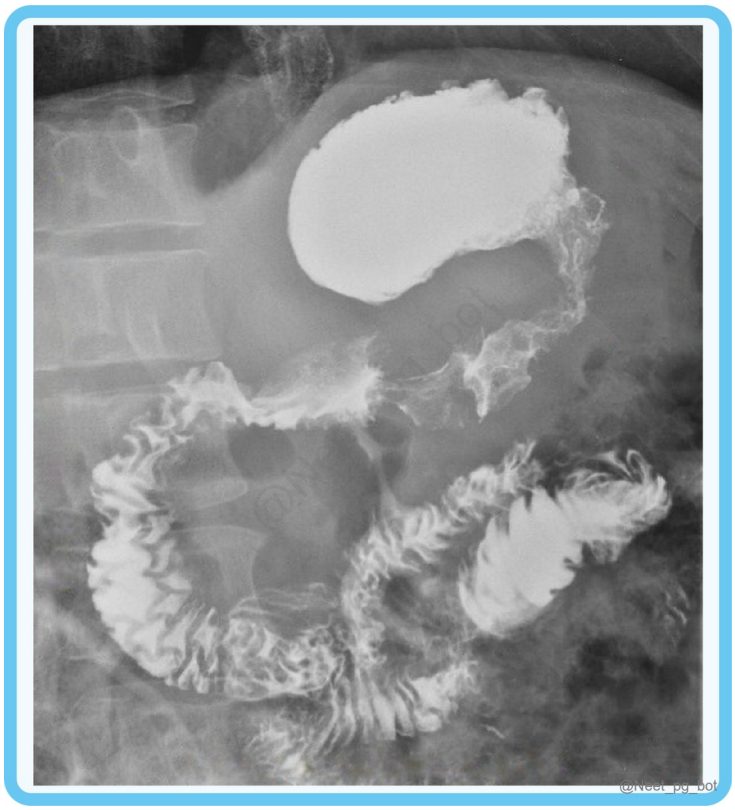
■ *Listen (Hindi)*

Explanation: i) Teapot stomach d) The Teapot Stomach, also known as "Hand-bag stomach," is a deformity caused by scarring and shortening of the lesser curvature of the stomach. This condition is usually a complication of gastric ulcers. The deformity leads to symptoms similar to those of pyloric stenosis, such as vomiting and gastric outlet obstruction. ii) Hourglass stomach a) Hourglass Stomach is a deformity of the stomach caused by cicatrial contracture of lesser curvature, often associated with gastric ulcers. This fibrosis divides the stomach into two compartments, creating an hourglass shape. Symptoms include persistent pain, vomiting, loss of appetite, and weight loss. On a barium meal X-ray, this condition is identified by the double-pouched appearance, indicating two separate sections within the stomach. iii) Congenital Hypertrophic Pyloric Stenosis b) CHPS is a condition in infants where the musculature of the pyloric antrum, particularly the circular muscle fibres, thickens. This thickening leads to the primary failure of the pylorus to relax, resulting in pyloric obstruction. Single bubble sign refers to the visible gas bubble in the stomach iv) Leather bottle stomach c) Leather Bottle Stomach, also known as linitis plastica, is a type of aggressive, diffuse gastric cancer (Type IV gastric carcinoma). This condition involves enormous fibrous tissue proliferation in the submucosa of the stomach, causing diffuse thickening of the stomach walls. Note: Gastric ulcers → most common at the lesser curvature near the incisura Duodenal ulcers → usually in the first part of the duodenum (duodenal bulb) Linitis plastica → diffuse infiltration of the stomach wall , often involving the fundus and body , leading to a “leather bottle” stomach




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References:

Bailey and Love's Short Practice of Surgery, 28th Edition, Page 259, 1172

SRB's Manual of Surgery, 6th Edition, Page 811, 815, 840

↑ *Back to this question in Part A*

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Q4: A 45 year old male presents with severe epigastric pain and inability to vomit despite repeated attempts. On examination, he has significant abdominal distention, and attempts to pass a nasogastric tube were unsuccessful. Which of the following best describes the condition represented by this clinical presentation? (Q849120)

A. Gastric cancer

B. Acute gastric volvulus

C. Peptic ulcer disease

D. Intestinal obstruction

Correct Answer: B. Acute gastric volvulus

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: s: The symptoms of unproductive retching, epigastric pain & distention, and inability to pass a nasogastric tube align with Borchardt's triad , indicating acute gastric volvulus. Gastric Volvulus: Definition: Rotation/Torsion of the stomach around the axis between the cardia and pylorus. Types: Horizontal (organoaxial)- rotation occurs in the horizontal direction (most common) Vertical (mesentroaxial)- rotation occurs along the vertical direction Associated Condition: Linked with para-esophageal herniation due to a diaphragmatic defect, causing the transverse colon and stomach shift upward. Presentation: Chronic: Difficulty eating. Acute: Ischemia and risk of gastric infarction. Diagnosis: Endoscopy may be challenging; contrast radiography is preferred. Treatment: Surgical intervention, often laparoscopic. Reposition hernial sac if present; close diaphragm defect with mesh. Anterior gastropexy to prevent future rotation. Gastric Cancer (Option A) can also cause abdominal pain and distention, but it is less likely to present with the specific symptoms of unproductive retching and inability to pass a nasogastric tube characteristic of gastric volvulus. Peptic ulcer disease (Option C) can also cause abdominal pain and vomiting, they do not typically present with the hallmark symptoms of Borchardt's triad, particularly the inability to pass a nasogastric tube. Intestinal obstruction (Option D) can also cause abdominal distention and vomiting, but the specific combination of symptoms described, particularly the unproductive retching and failure of the nasogastric tube, is more indicative of gastric volvulus.

References:

Bailey & Love’s Short Practice of Surgery, 26th Edition, Page 1180, 1181

Borchardt's triad

↑ *Back to this question in Part A*

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Q5: A 17 year old girl with a history of depression presents with complaints of epigastric pain, early satiety, and vomiting of blood. She elicited a history of eating her hair due to stress. On examination, a palpable epigastric mass is noted. A CT scan of the abdomen reveals a large mass in the stomach. What is the most likely diagnosis? (Q849107)

A. Phytobezoar

B. Trichobezoar

C. Gastric carcinoma

D. Intestinal obstruction

Correct Answer: B. Trichobezoar

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: s: Trichobezoars are hairballs that commonly occur in young females with psychiatric issues who swallow hair. Typically found in young females with psychiatric conditions who habitually swallow hair. This can occupy the entire stomach and extend into the duodenum and jejunum (known as Rapunzel syndrome). Aspect Trichobezoars Phytobezoars Definition Hairballs formed in the stomach Solid masses from plant fibres and seeds Common Population Young females with psychiatric conditions Patients with partial gastrectomy, diabetics with neuropathy Symptoms Epigastric pain, early satiety, hematemesis, gastritis, loss of appetite, perforation, palpable mass Similar symptoms, but often asymptomatic initially Diagnosis CT scan CT scan or endoscopy Primary Treatment Surgical removal via gastrotomy psychiatric counselling Enzymatic digestion or surgical removal



References:

SRB's Manual of Surgery, 6th Edition, Page 831, 832

↑ *Back to this question in Part A*

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Q6: A 2-week-old infant presents with vomiting, dehydration, and poor feeding. An abdominal X-ray shows a "double bubble" sign. Which of the following statements correctly differentiates Congenital Hypertrophic Pyloric Stenosis from Duodenal

Atresia? (Q849106)

A. CHPS typically presents with bilious vomiting, while Duodenal Atresia presents with non-bilious vomiting.

B. In CHPS, infants are often hungry after vomiting, whereas in Duodenal Atresia, infants have no desire to feed.

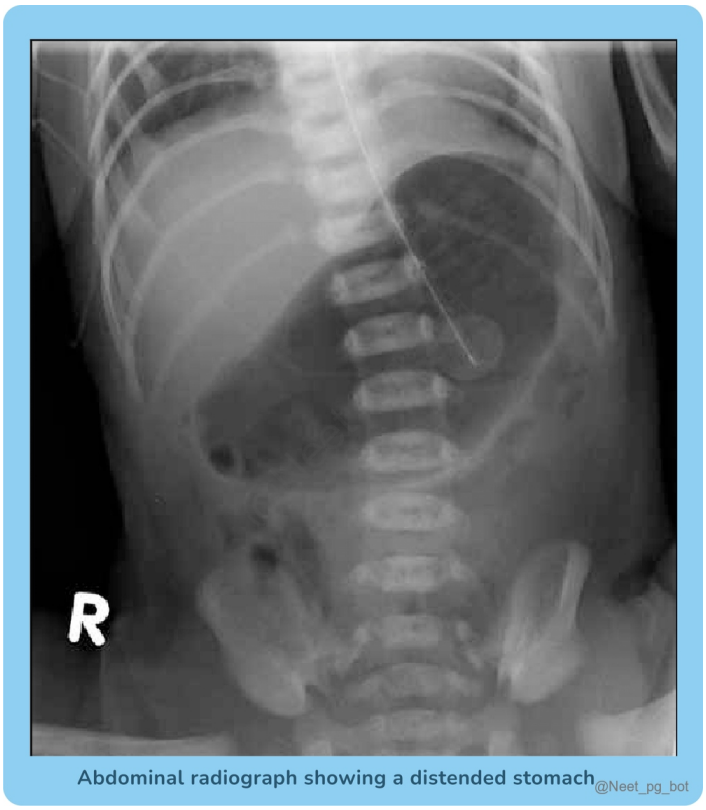
C. Both conditions present with projectile vomiting, but CHPS is diagnosed by X-ray showing the "double bubble" sign.

D. Duodenal Atresia is commonly treated with Ramstedt's pyloromyotomy, whereas CHPS requires surgical correction of the duodenum.

Correct Answer: B. In CHPS, infants are often hungry after vomiting, whereas in Duodenal Atresia, infants have no desire to feed.

- *Listen (English)*
- *Listen (Hindi)*

Explanation: s: Infants with CHPS generally show a desire to feed after vomiting, while those with Duodenal Atresia often do not due to the obstruction. CHPS vs. Duodenal Atresia Aspect Congenital Hypertrophic Pyloric Stenosis (CHPS) Duodenal Atresia Aetiology Thickening of pyloric muscle Congenital obstruction of the duodenum Age of Presentation 3 to 6 weeks Typically presents shortly after birth Vomiting Characteristics Forceful, non-bilious, projectile vomiting Bilious vomiting due to distal obstruction Feeding Behaviour Infants are hungry and seek re-feeding Often no desire to feed due to persistent vomiting Physical Exam & X-ray Findings Palpable “olive-like” mass in the right upper quadrant. “Single bubble” sign on X-ray. "Double bubble" sign on X-ray; no palpable mass. Diagnosis Clinical history, physical exam, and ultrasound X-ray or ultrasound showing a "double bubble" sign Treatment Surgical: Ramstedt's pyloromyotomy; non-surgical not advised Surgical: Duodenoduodenostomy or duodenojejunostomy required





References:

SRB’s Manual of Surgery, 6th Edition, Page 811, 812, 915, 916

Bailey & Love’s Short Practice of Surgery, 28th Edition, Page 280

↑ *Back to this question in Part A*

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Q7: A 3-week-old infant is diagnosed with Congenital Hypertrophic Pyloric Stenosis after presenting with projectile vomiting and signs of dehydration. The surgical team plans to perform Ramstedt's pyloromyotomy. Which of the following statements about this condition and its management is true? (Q849105)

A. The incision during Ramstedt's pyloromyotomy should only involve the mucosal layer to avoid complications.

B. Infants with CHPS typically do not exhibit hunger after vomiting.

C. Postoperative intravenous fluids are administered until the infant can resume feeding, which usually occurs within 24 hours.

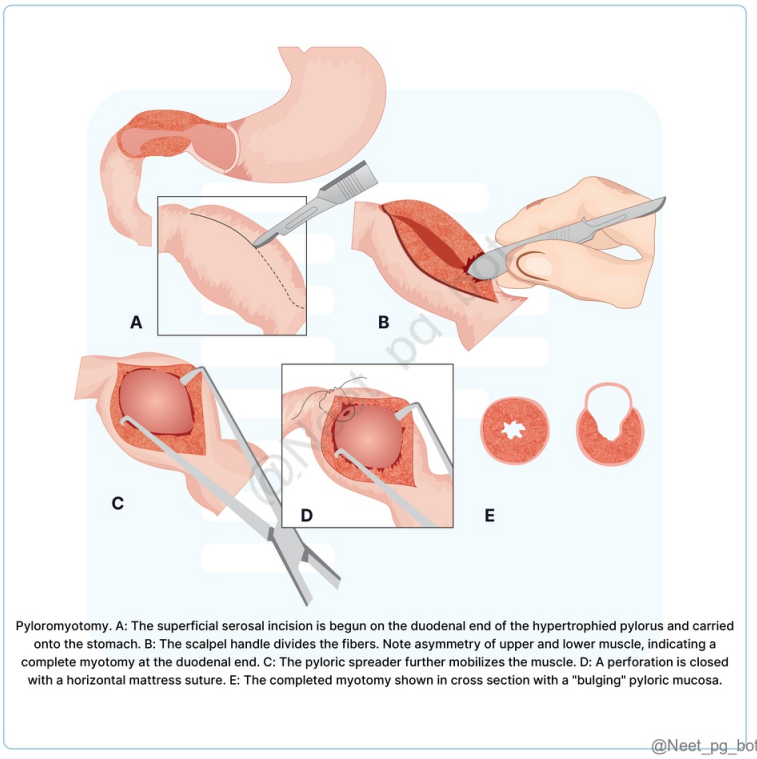
D. Persistent vomiting after surgery is primarily due to incomplete myotomy

Correct Answer: C. Postoperative intravenous fluids are administered until the infant can resume feeding, which usually occurs within 24 hours.

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: After surgery, intravenous fluids are given until the infant can begin feeding, typically within 24 hours. Treatment of Congenital Hypertrophic Pyloric Stenosis (CHPS) 1. Fluid Resuscitation: To correct the hypokalemia, hypochloremia & metabolic alkalosis 0.9% saline 0.15%KCl 5% glucose 2. Surgical Treatment: Procedure: Ramstedt's pyloromyotomy Can be performed laparoscopically or via incision in the supraumbilical or right upper quadrant. Involves incision in the serosa of the pylorus while preserving the submucosa from the duodenum to the gastric antrum. The incision must extend onto the stomach to prevent an early recurrence. 3. Postoperative Care: Intravenous fluids are administered until the infant can resume feeding, typically within 24 hours. Some vomiting may occur immediately after surgery but usually resolves quickly. Persistent vomiting is more likely due to gastro-esophageal reflux rather than incomplete myotomy. The incision during Ramstedt's pyloromyotomy should only involve the mucosal layer to avoid complications (Option A), The incision must involve the serosa of the pylorus while preserving the submucosa to prevent complications. Infants with CHPS typically do not exhibit hunger after vomiting (Option B), Infants with CHPS often show hunger after vomiting, distinguishing it from vomiting caused by infections. Persistent vomiting after surgery is primarily due to incomplete myotomy (Option D), Persistent vomiting is more likely due to gastroesophageal reflux rather than incomplete myotomy.



Pyloromyotomy. A: The superficial serosal incision is begun on the duodenal end of the hypertrophied pylorus and carried onto the stomach. B: The scalpel handle divides the fibers. Note asymmetry of upper and lower muscle, indicating a complete myotomy at the duodenal end. C: The pyloric spreader further mobilizes the muscle. D: A perforation is closed with a horizontal mattress suture. E: The completed myotomy shown in cross section with a "bulging" pyloric mucosa.

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References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 259, 260

↑ *Back to this question in Part A*

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Q8: A 3-week-old infant presents with persistent projectile non-bilious vomiting, dehydration, and weight loss. The physical examination reveals a palpable mass in the right upper quadrant. An abdominal ultrasound shows a thickened pylorus. Which of the following electrolyte imbalances is most likely to be seen in this patient? (Q849104)

A. Hyperkalemia

B. Hypernatremia

C. Hypokalemia

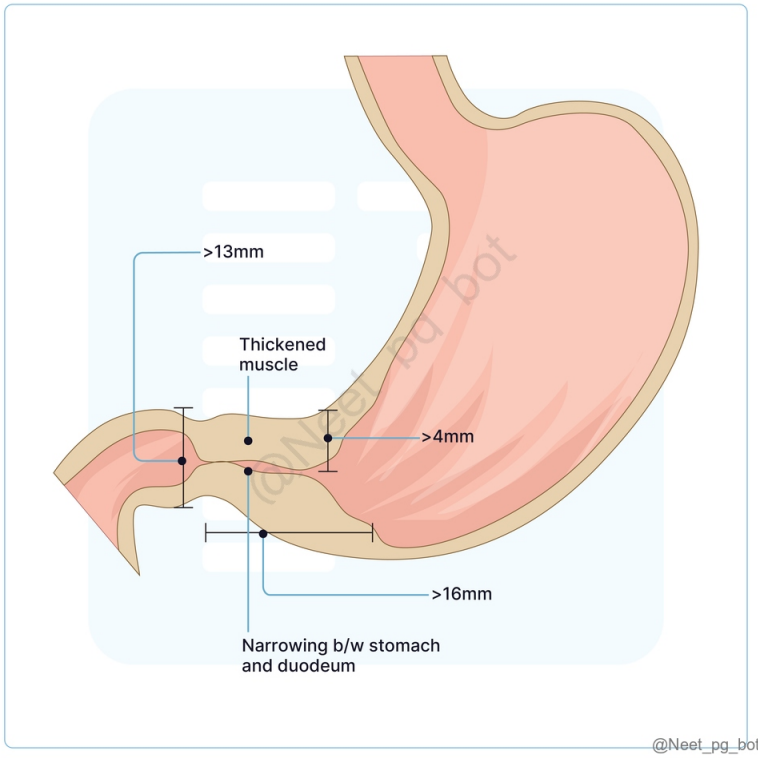
D. Hypocalcemia

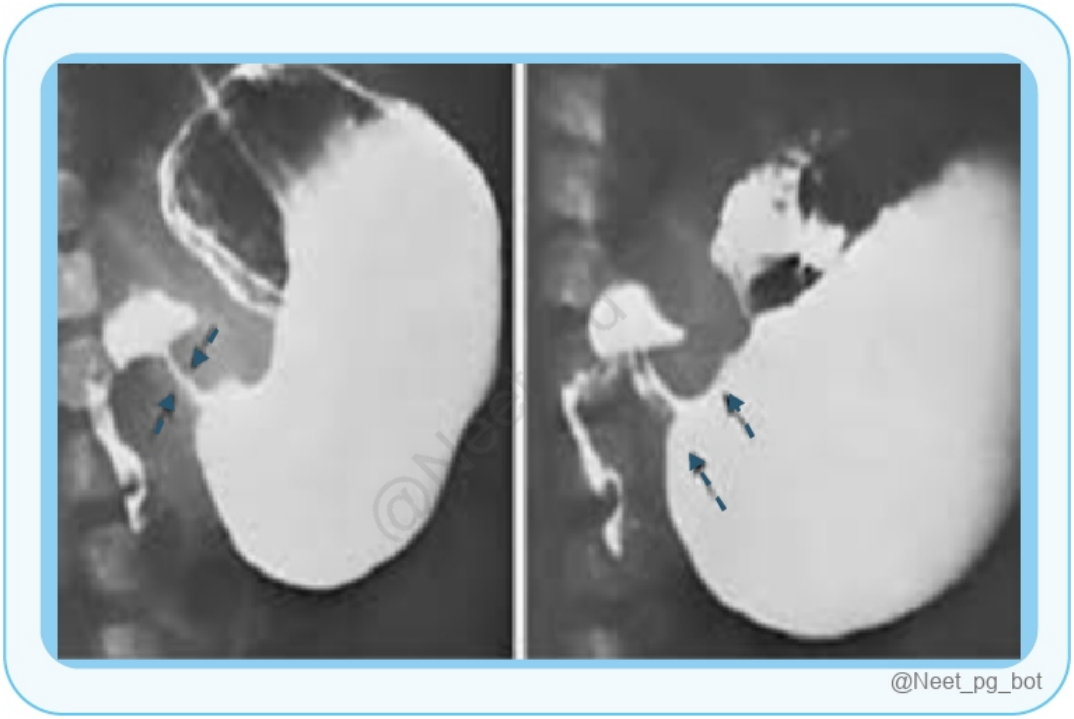
Correct Answer: C. Hypokalemia

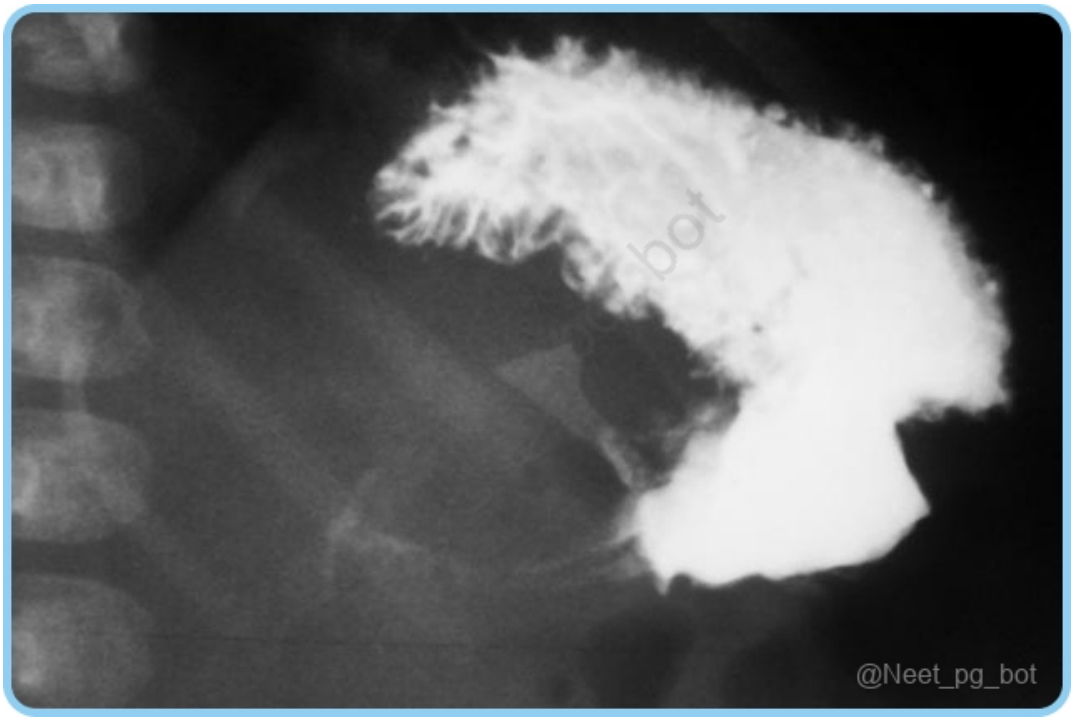
■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: s: The given condition is congenital hypertrophic pyloric stenosis. Persistent vomiting causes a loss of gastric acid (HCl), leading to metabolic alkalosis and hypokalemia, which is a common electrolyte disturbance in infants with pyloric stenosis. Diagnosis of Congenital Hypertrophic Pyloric Stenosis (CHPS) 1. Clinical Presentation: Typical onset: 3 to 6 weeks of age Symptoms: Projectile, non-bilious vomiting Visible gastric peristalsis Palpable "olive-like" mass in the abdomen (hypertrophied pylorus), best felt from the left side Dyselectrolytemias- Hypochloremia Hypokalemia due to persistent vomiting Metabolic alkalosis (due to loss of H+). 2. Imaging Techniques: Ultrasound (Gold Standard): Characteristic "doughnut sign" indicating thickened pyloric muscle Diagnostic criteria: Pyloric muscle thickness ≥ 4 mm Pyloric canal length > 14 mm "Cervix sign" on long-axis view "Target sign" on short-axis view Barium Meal (Less Common): Can assist in diagnosis but is less accurate than ultrasound Signs suggestive of CHPS: "String sign": Thin streak of contrast through narrowed pylorus "Railroad track sign": Two thin lines of contrast indicating mild narrowing "Double track sign": Similar to railroad track sign, indicating thickened muscle Hyperkalemia (Option A) refers to elevated potassium levels, which are not typically associated with pyloric stenosis. Persistent vomiting usually leads to low potassium levels. Hypernatremia (Option B), While dehydration can lead to elevated sodium levels, hypernatremia is not a characteristic finding specifically associated with pyloric stenosis. Hypocalcemia (Option D) refers to low calcium levels, which is not typically associated with pyloric stenosis or vomiting and is not the expected electrolyte disturbance in this condition.







References:

SRB's Manual of Surgery, 6th Edition, Page 811, 812

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 280

↑ *Back to this question in Part A*

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Q9: A 65 year old male presents with complaints of persistent abdominal pain and weight loss. After evaluation, he is diagnosed with resectable gastric cancer. Based on the information provided, which of the following treatment options would likely offer the best median overall survival for this patient? (Q849103)

A. ECF (epirubicin, cisplatin, 5-fluorouracil) regimen

B. FLOT (fluorouracil, leucovorin, oxaliplatin, docetaxel) regimen

C. Palliative chemotherapy

D. Total gastrectomy without prior chemotherapy

Correct Answer: B. FLOT (fluorouracil, leucovorin, oxaliplatin, docetaxel) regimen

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The FLOT regimen has been demonstrated to provide a significant survival advantage, with a median overall survival of 50 months as per the FLOT4 trial. This makes it the most effective neoadjuvant chemotherapy option for patients diagnosed with resectable gastric cancer, thus making this the correct answer. Treatment of Stomach Cancer Surgical Treatment: Surgical resection is the only curative treatment for gastric cancer. Neoadjuvant Chemotherapy: Most surgical candidates receive neoadjuvant chemotherapy to improve survival. The FLOT4 trial found that the FLOT (fluorouracil, leucovorin, oxaliplatin, docetaxel) regimen offers a significant survival advantage over the ECF (epirubicin, cisplatin, 5-fluorouracil) regimen (median overall survival: 50 months vs 35 months). Types of Gastric Resection Total Gastrectomy: Involves the removal of the stomach, spleen, and pancreas. Includes D2 lymphadenectomy. Preferred for resectable gastric cancer. Subtotal Gastrectomy: May be performed if the tumour is located in the distal stomach. Involves Roux-en-Y reconstruction. Palliative Surgery: Considered for symptom alleviation in inoperable or metastatic gastric cancer. Non-Surgical Treatment Palliative Chemotherapy or Radiotherapy: Offered to patients with advanced gastric cancer. ECF (epirubicin, cisplatin, 5-fluorouracil) regimen (Option A) has been a standard chemotherapy protocol for gastric cancer; however, recent clinical trials, such as the FLOT4 trial, have shown that it offers a lower median overall survival (50 months vs 35 months) compared to the FLOT regimen. Palliative chemotherapy (Option C) is typically offered to patients with advanced or metastatic gastric cancer, where the intent is not curative but to alleviate symptoms. Total gastrectomy without prior chemotherapy (Option D), While total gastrectomy may be an appropriate surgical option for resectable gastric cancer, proceeding without prior neoadjuvant chemotherapy would not give the same results. Neoadjuvant chemotherapy is recommended to enhance surgical outcomes and overall survival.

References:

Bailey & Love’s Short Practice of Surgery, 28th Edition, Page 1174-1177

GIST

↑ *Back to this question in Part A*

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Q10: A 55-year-old woman presents with abdominal pain and a palpable epigastric mass. CT shows a well-defined stomach mass. Biopsy confirms a gastrointestinal stromal tumor, with CD117 and DOG1 positivity. Which statement is most accurate about this patient? (Q849101)

A. CD117 positivity confirms the diagnosis of GIST, and DOG1 is not relevant

B. The primary treatment for GISTs is chemotherapy

C. Surgery is the mainstay of treatment for localized GISTs

D. GISTs most commonly occur in the small intestine and are rarely found in the stomach

Correct Answer: C. Surgery is the mainstay of treatment for localized GISTs

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Surgical resection is the primary treatment for localized GISTs, aiming to remove the tumour completely. Gastrointestinal stromal tumour (GIST) Common Locations: Stomach: 60-70% of cases. Small Intestine: 20-30%. Other Areas: Colon, rectum, and oesophagus (less common). Origin: The Interstitial cells of Cajal (Gastric pacemaker cells) Immunohistochemistry Markers for GISTs Category Marker Expression in GISTs Significance Old Markers CD117 (c-KIT) Expressed in approximately 97% of GISTs Crucial for diagnosis CD34 Expressed in 70% GISTs Associated with hematopoietic progenitor cells SMA Some GISTs show positivity Less common compared to CD117 and CD34 New Markers PDGFRA Mutations found in approximately 5-10% of GISTs Additional diagnostic marker DOG1 Expressed in many GISTs, including those negative for CD117 Alternative diagnostic tool CD117 positivity confirms the diagnosis of GIST, and DOG1 is not relevant (Option A): While CD117 positivity is crucial for diagnosing GIST, DOG1 is also a relevant and useful marker, especially for CD117-negative cases. The primary treatment for GISTs is chemotherapy (Option B): The primary treatment for localized GISTs is surgical resection. Chemotherapy, particularly with tyrosine kinase inhibitors like imatinib, is used in metastatic or unresectable cases and as adjuvant therapy. GISTs most commonly occur in the small intestine and are rarely found in the stomach (Option D): GISTs are most commonly found in the stomach (60-70%) and then in the small intestine (20-30%).

References:

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3644178/

↑ *Back to this question in Part A*

@Neet_pg_bot

Q11: A 52-year-old man presents with epigastric pain, weight loss, and early satiety for three months. On examination, mild epigastric tenderness is seen. Upper GI endoscopy reveals an ulcerated mass in the stomach antrum, confirmed as adenocarcinoma. Staging shows no distant metastases but involves perigastric lymph nodes. What is the next step in management? (Q849100)

A. Neoadjuvant chemotherapy followed by total gastrectomy

B. Subtotal gastrectomy with D1 lymph node dissection

C. Subtotal gastrectomy with D2 lymph node dissection

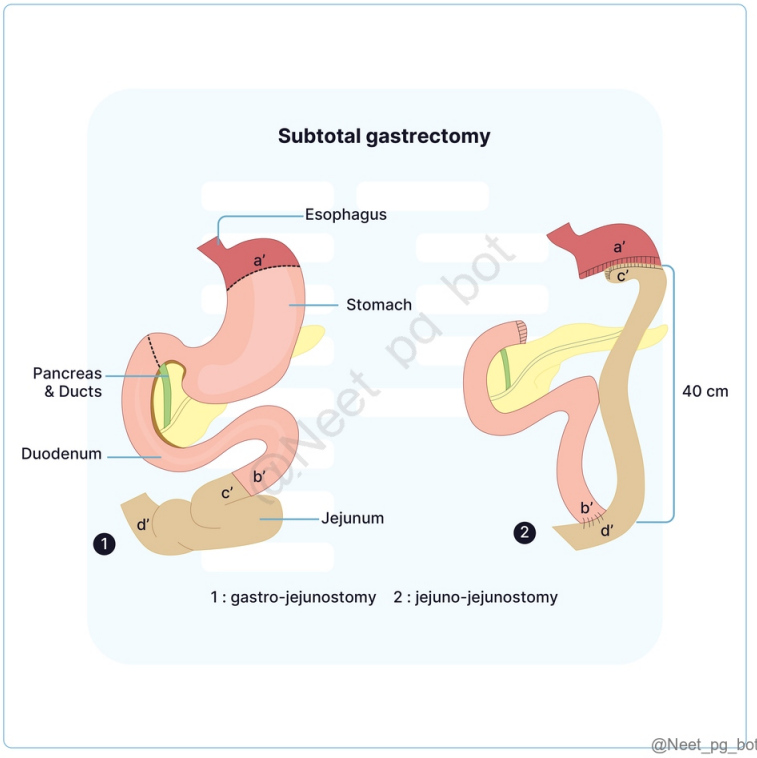
D. Palliative chemotherapy

Correct Answer: C. Subtotal gastrectomy with D2 lymph node dissection

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Subtotal gastrectomy is suitable for tumors in the antrum , and a D2 lymph node dissection involves removing the perigastric lymph nodes as well as nodes along the major arterial trunks. This extensive dissection is recommended in cases with lymph node involvement to ensure a more thorough removal of potentially cancerous nodes and to improve survival rates. Primary Treatment of stomach cancer- Surgical Resection Types of Surgical Resection : Total Gastrectomy : Removes the entire stomach; used for proximal or middle stomach tumors. Subtotal Gastrectomy : Removes a portion of the stomach; used for distal stomach tumors. Lymph Node Dissection : D1 (perigastric nodes) or D2 (major arterial trunks) based on tumor location and stage. Reconstruction : Roux-en-Y method connects the esophagus to the remaining stomach or small intestine. Distal Pancreatectomy and Splenectomy: Part of radical gastrectomy to remove potentially cancerous lymph nodes. Additional Treatments: Neoadjuvant Chemotherapy : Platinum-based triplet regimen administered before surgery to improve survival rates. (ECF- Epirubicin, Cisplatin, 5-Flurouracil) Palliative Treatment : For incurable diseases, options include chemotherapy, radiotherapy, and palliative surgery to relieve symptoms and improve quality of life. Neoadjuvant chemotherapy followed by total gastrectomy (Option A) is often used for advanced gastric cancer to shrink the tumor before surgery, making it easier to remove and improving survival rates. Subtotal gastrectomy with D1 lymph node dissection (Option B) is appropriate for tumors in the distal stomach (such as the antrum). However, a D1 lymph node dissection involves only the removal of the perigastric lymph nodes and is considered less extensive than a D2 dissection. Palliative chemotherapy (Option D) is used to relieve symptoms and improve the quality of life in cases of incurable or metastatic gastric cancer. Since the patient has no distant metastases and the disease is potentially curable with surgery, palliative chemotherapy is not indicated in this situation.



References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1152-1153, 1174-1177

↑ *Back to this question in Part A*

@Neet_pg_bot

Q12: A 55 year old patient is diagnosed with gastric cancer and is preparing for surgical treatment. The surgical team is reviewing the guidelines for lymph node resection to ensure optimal patient outcomes. According to current recommendations, what is the minimum number of lymph nodes that should be removed and examined during the surgery for gastric cancer? (Q849099)

A. 4 lymph nodes

B. 12 lymph nodes

C. 16 lymph nodes

D. 20 lymph nodes

Correct Answer: C. 16 lymph nodes

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Current guidelines recommend that at least 16 lymph nodes be removed and examined during surgical treatment for gastric cancer. This standard is outlined in the 8th edition of the AJCC staging manual and is associated with improved survival rates. Minimum number of LN Resected for Various Carcinomas: Cancer Minimum Lymph Nodes 1. CA Gall Bladder 4 (Option A) 2. CA Stomach 16 3. CA Colon 12 (Option B) 4. CA Rectum 12 5. CA Esophagus 15 This minimum number is linked to improved survival outcomes. Research shows that more extensive lymphadenectomy (evaluating more than the minimum number of lymph nodes) is associated with better survival rates in cancer patients. 20 lymph nodes (Option D): While removing 20 or more lymph nodes may provide additional benefits, it is not the minimum requirement for gastric cancer.

References:

jgo.amegroups.org/article/view/4399/html

www.ncbi.nlm.nih.gov/pmc/articles/PMC8121255/

www.ncbi.nlm.nih.gov/pmc/articles/PMC10720778/

www.ncbi.nlm.nih.gov/pmc/articles/PMC7561013/

↑ *Back to this question in Part A*

@Neet_pg_bot

Q13: A 62 year old male undergoes an endoscopic biopsy for a gastric mass. The pathology report reveals that the tumour invades the muscularis propria but does not extend into the subserosal connective tissue. What is the appropriate T classification for this tumour? (Q849098)

A. T1b

B. T2

C. T3

D. T4a

Correct Answer: B. T2

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: According to the TNM classification, a T2 tumor invades the muscularis propria . This matches the case described, where the tumor has invaded this layer without further extension. Tis Carcinoma in situ or

high-grade dysplasia T1a Tumor invades the lamina propria or muscularis mucosa T1b (Option A) Tumor invades submucosa T2 Tumor invades the muscularis propria T3 (Option C) Tumor penetrates subserosal connective tissue without invasion of visceral peritoneum or adjacent structures T4a (Option D) Involvement of visceral peritoneum/serosa T4b Involvement of adjacent structures N1 Metastasis to 1-2 regional LN N2 Metastasis to 3-6 regional LN N3a Metastasis to 7-15 regional LN N3b Metastasis to 16 or more regional LN M0 No metastasis M1 Distant metastasis

References:

Bailey and Love's Short Practice of Surgery, 28th Edition, Page 1173

Sabiston Textbook of Surgery, 21st Edition, Page 1223

SRB's Manual of Surgery, 6th Edition, Page 840

↑ *Back to this question in Part A*

@Neet_pg_bot

Q14: A 55 year old female presents with a palpable nodule in her umbilicus. She also has a history of weight loss and abdominal discomfort. Imaging reveals metastatic spread of gastric cancer. Which of the following is the term for this clinical finding, and what is its typical route of spread? (Q849097)

A. Krukenberg tumor; hematogenous spread

B. Blumer shelf; transperitoneal spread

C. Sister Mary Joseph's nodule; transperitoneal spread

D. Virchow's node; retrograde lymphatic spread

Correct Answer: C. Sister Mary Joseph's nodule; transperitoneal spread

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Sister Mary Joseph's nodule is palpable in the umbilicus, caused by the transperitoneal spread of gastric cancer through the ligamentum teres. Gastric Carcinoma atypical presentation Name Spread Feature Sister Mary Joseph's nodule (Option C) Transperitoneal spread A palpable nodule in the umbilicus Krukenberg tumor (Option A) Peritoneal lymphatics/ Retrograde lymphatic spread from the stomach to the ovary Metastatic tumors in the ovary frequently originate from gastric cancer. Blumer shelf (Option B) Transperitoneal spread Rectovesical secondaries Virchow's node (Option D) Retrograde lymphatic spread Left supraclavicular node enlargement is often seen in advanced abdominal malignancies. (Troisier's sign) Irish node Lymphatic Left anterior axillary lymph node metastases Atypical presentations typically manifest as metastatic disease, indicating a poor prognosis.

References:

Sabiston Textbook of Surgery, 21st Edition, Page 1222

SRB's Manual of Surgery, 6th Edition, Page 839, 841

Virchow, Irish

↑ *Back to this question in Part A*

@Neet_pg_bot

Q15: A 28 year old man presents with recurrent abdominal pain and gastrointestinal bleeding. Imaging studies reveal the presence of multiple gastrointestinal stromal tumors (GISTs) in his stomach. His medical history includes a diagnosis of paragangliomas, and his mother has a history of lung tumors. What is the most likely genetic syndrome associated with this patient's findings? (Q849102)

A. Neurofibromatosis type 1

B. Carney's Triad

C. Familial adenomatous polyposis

D. Peutz-Jeghers syndrome

Correct Answer: B. Carney's Triad

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: In this patient, the presence of multiple GISTs and a prior history of paragangliomas, along with a family history suggestive of pulmonary tumors, is consistent with the diagnosis of Carney's Gastrointestinal stromal tumors (GIST) Clinical features: GI Bleed (most common) Abdominal Pain Weight loss Large abdominal mass- it arises from the submucosa - hence it is extraluminal- but expands and compresses the mucosa Metastasis to liver Carney's Triad: It is a rare syndrome characterized by the presence of three specific tumors: gastrointestinal stromal tumors (GISTs), extra-adrenal paragangliomas, and pulmonary chondromas. Tumor Type Characteristics Gastrointestinal Stromal Tumors (GISTs) Often found in the stomach and multifocal. Distinct from sporadic GISTs (no c-KIT or PDGFRA mutations). May exhibit loss of genetic material on chromosome 1. Associated with SDH deficiency. Paragangliomas Arise from paraganglia (neuroendocrine cell clusters). Typically extra-adrenal. Can occur in various locations. Pulmonary Chondromas Benign tumors of cartilage. Found in the lungs. Neurofibromatosis type 1 (NF1) (Option A) is characterized by skin changes, such as café-au-lait spots, neurofibromas, and an increased risk of various tumors, including malignant peripheral nerve sheath tumors. While NF1 can be associated with GISTs. Familial adenomatous polyposis (FAP) (Option C) is characterized by the development of hundreds to thousands of polyps in the colon and rectum, leading to a high risk of colorectal cancer. It is not associated with GISTs or paragangliomas. Peutz-Jeghers syndrome (Option D) is characterized by

intestinal polyps and mucocutaneous pigmentation, along with an increased risk of various cancers, including gastrointestinal cancers. However, it is not associated with GISTs or paragangliomas.

References:

SRB's Manual of Surgery, 6th Edition, Page 848

jmedicalcasereports.biomedcentral.com/articles/10.1186/s13256-021-03149-x

www.ncbi.nlm.nih.gov/pmc/articles/PMC7222320/

↑ *Back to this question in Part A*

@Neet_pg_bot

Q16: A 65 year old male presents with vague epigastric discomfort and constant, non-radiating pain that is not related to food intake. He has a history of iron deficiency anaemia. Considering the regional differences in the prevalence of stomach cancer sites, what is the most likely location of his cancer if he resides in the West? (Q849094)

A. Distal stomach

B. Proximal stomach

C. Antrum of the stomach

D. Body of the stomach

Correct Answer: B. Proximal stomach

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: In Western countries, gastric cancer shows a strong shift toward proximal stomach (cardia) cancers , often associated with obesity, GERD, and Barrett's esophagus. Distal/antral gastric cancers are more common in Asian regions due to higher H. pylori prevalence. Given the patient's age, vague symptoms, and Western epidemiology, a proximal (cardia) gastric cancer is the most likely site. Distal stomach (Option A): This is more commonly the site for stomach cancer in Asian countries. Antrum of the stomach (Option C): While it can be affected in various gastric conditions, it is not the most common site for stomach cancer in the West. Body of the stomach (Option D): This area is often affected by pernicious anaemia, which involves the parietal cells.

References:

Bailey and Love's Short Practice of Surgery, 28th Edition, Page 1170

Sabiston Textbook of Surgery, 21st Edition, Page 1222

Pernicious anemia

↑ *Back to this question in Part A*

@Neet_pg_bot

Q17: A patient with advanced gastric adenocarcinoma is found to have HER2/neu overexpression. Which targeted therapy is the drug of choice in this setting? (Q888695)

A. Bevacizumab

B. Cetuximab

C. Trastuzumab

D. Pembrolizumab

Correct Answer: C. Trastuzumab

Explanation: For HER2/neu-positive (overexpressed or amplified) advanced gastric or gastroesophageal junction adenocarcinoma , the targeted therapy trastuzumab (a monoclonal antibody against HER2) is the standard drug of choice when combined with chemotherapy. Pembrolizumab is used for PD-L1-positive tumours, not specifically for HER2. Bevacizumab (anti-VEGF) (Option B) has shown limited benefit in gastric cancer and is not standard for HER2-positive disease. Cetuximab (anti-EGFR) (Option D) is not effective in gastric adenocarcinoma, including HER2-positive tumours, and is not recommended. Pembrolizumab (anti-PD-1) (Option A) is used in advanced gastric cancer that is PD-L1 positive or MSI-H/dMMR, not specifically for HER2-overexpressing tumours as first-line targeted therapy.

References:

Bailey & Love’s Short Practice of Surgery, 28th Edition, Page 1178.

Schwartz’s Principles of Surgery, 11th Edition, Page 578.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q18: A patient with a high-risk gastric gastrointestinal stromal tumour (GIST) undergoes complete surgical resection. What is the most appropriate next step in management? (Q888694)

A. Adjuvant external beam radiotherapy

B. Adjuvant chemotherapy with 5-fluorouracil

C. Adjuvant therapy with imatinib

D. Routine surveillance only

Correct Answer: C. Adjuvant therapy with imatinib

Explanation: For high-risk GISTs (based on size and mitotic index), adjuvant therapy with the tyrosine kinase inhibitor imatinib is recommended after complete surgical resection to reduce recurrence risk. GISTs are radioresistant and do not respond to conventional chemotherapy. (Option B ruled out) Lymphadenectomy is not indicated, as GIST rarely metastasises to lymph nodes. Adjuvant external beam radiotherapy (Option A): Radiotherapy is generally ineffective for GIST due to its radioresistance and is not part of standard adjuvant management. Routine surveillance only (Option D): While surveillance is part of management, for high-risk GIST, adjuvant imatinib is recommended before surveillance, as it significantly improves recurrence-free survival.

References:

Schwartz's Principles of Surgery, 11th Edition, Page 1149-1151.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q19: What is the most common metabolic complication observed in patients after a gastrectomy? (Q888693)

A. Vitamin B12 deficiency

B. Osteoporosis

C. Iron deficiency anaemia

D. Calcium deficiency

Correct Answer: C. Iron deficiency anaemia

Explanation: Following gastrectomy, the most common metabolic complication is iron deficiency anaemia . This results from decreased dietary intake, impaired iron absorption due to reduced gastric acid (needed for converting dietary iron to absorbable ferrous form), and potential chronic blood loss. Vitamin B12 deficiency also occurs, but typically appears later. Vitamin B12 deficiency (Option A) is classic after total gastrectomy (loss of intrinsic factor), but it is less common after partial gastrectomy and not the most frequent overall metabolic complication across all gastrectomy types. Osteoporosis (Option B): Metabolic bone disease (osteoporosis/osteomalacia) can occur due to calcium and vitamin D malabsorption, but generally develops later and is less common than iron deficiency anaemia. Calcium deficiency (Option D): Calcium malabsorption may occur, but it is typically less

frequent and often associated with the later development of bone disease, not the most common early metabolic complication.

References:

Schwartz's Principles of Surgery, 11th Edition, Page 1156-1159

↑ *Back to this question in Part A*

@Neet_pg_bot

Q20: For which of the following clinical scenarios is surgery most appropriately indicated in a patient with gastric lymphoma? (Q888692)

A. Intractable pain without other complications

B. Asymptomatic, incidentally discovered gastric wall thickening

C. First-line chemotherapy failure with persistent symptomatic disease

D. Mild H. pylori-positive gastritis without lymphoma progression

Correct Answer: C. First-line chemotherapy failure with persistent symptomatic disease

Explanation: Surgery for gastric lymphoma is indicated in cases of: Symptomatic recurrence Treatment failure Managing complications (bleeding, obstruction, or perforation). Intractable pain without other complications (Option A): Intractable pain alone is not an indication for surgery; management typically involves optimisation of medical therapy (chemotherapy/radiation) and symptomatic care. Asymptomatic, incidentally discovered gastric wall thickening (Option B): Asymptomatic or incidental findings are evaluated and staged. Primary treatment is usually systemic (chemotherapy/immunotherapy) or H. pylori eradication for MALT lymphoma, not surgery. Mild H. pylori-positive gastritis without lymphoma progression (Option D): This scenario describes gastritis, not confirmed lymphoma. Even for early H. pylori-positive gastric MALT lymphoma, first-line therapy is antibiotic eradication, not surgery.

References:

Schwartz's Principles of Surgery, 11th Edition, Page 1149.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q21: What is the most common histological subtype of primary gastric non-Hodgkin lymphoma? (Q888691)

A. Gastric MALT lymphoma

B. Burkitt lymphoma

C. Diffuse large B-cell lymphoma

D. Follicular lymphoma

Correct Answer: C. Diffuse large B-cell lymphoma

Explanation: While gastric MALT lymphoma is strongly associated with H. pylori infection, the most common overall primary gastric lymphoma is diffuse large B-cell lymphoma (DLBCL) , accounting for approximately 55% of cases. MALT lymphoma is the second most common type. (Option A ruled out) Burkitt lymphoma (Option B) is rare in the stomach and is more typically found in the ileocecal region or as part of systemic disease, especially in pediatric or immunocompromised patients. Follicular lymphoma (Option D) is predominantly a nodal lymphoma; primary gastric involvement is uncommon and represents a small minority of gastric lymphomas.

References:

Schwartz's Principles of Surgery, 11th Edition, Page 1149.

Gastric Lymphoma - StatPearls - NCBI Bookshelf

↑ *Back to this question in Part A*

@Neet_pg_bot

Q22: During curative surgical resection for gastric adenocarcinoma, what is the recommended minimum proximal and distal gross negative margin from the tumour edge? (Q888690)

A. 1 cm

B. 2 cm

C. 5 cm

D. 10 cm

Correct Answer: C. 5 cm

Explanation: For gastric cancer resection, a grossly negative margin of at least 5 cm is generally recommended proximally and distally from the tumour to ensure adequate oncologic clearance and reduce the risk of local recurrence. Frozen section confirmation of microscopic negativity at the margin is also typically performed. 1 cm (Option A): A 1 cm margin is generally insufficient due to the risk of intramural spread, particularly in diffuse-type or advanced gastric cancers. 2 cm (Option B): While 2 cm may be adequate for some early, well-differentiated intestinal-type tumours, it is not the standard minimum recommendation for all curative

resections. 10 cm (Option D): A 10 cm margin is excessive and not routinely required; it could lead to unnecessarily extensive resection without proven survival benefit.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1175

↑ *Back to this question in Part A*

@Neet_pg_bot

Q23: According to the Japanese Gastric Cancer Association (JGCA) classification, suprapyloric lymph nodes correspond to which nodal station? (Q888689)

A. Station 1

B. Station 3

C. Station 5

D. Station 7

Correct Answer: C. Station 5

Explanation: In the Japanese classification, perigastric lymph nodes are numbered 1-6. The suprapyloric nodes are specifically designated as Station 5. A D1 gastrectomy involves the removal of perigastric stations 1-6, while a D2 gastrectomy extends to more distant nodal groups (stations 1-11). Station 1 (Option A) : Station 1 refers to the right paracardial lymph nodes, not suprapyloric. Station 3 (Option B) : Station 3 refers to lesser curvature nodes along the left gastric artery, not suprapyloric. Station 7 (Option D): Station 7 refers to left gastric artery nodes, which are located more proximally along the celiac axis, not suprapyloric.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1177

↑ *Back to this question in Part A*

@Neet_pg_bot

Q24: According to standard criteria, which of the following is an absolute contraindication for endoscopic mucosal resection (EMR) in early gastric cancer? (Q888686)

A. Tumour size 1.5 cm

B. Well-differentiated histology

C. Presence of ulceration

D. Tumour confined to the mucosa

Correct Answer: C. Presence of ulceration

Explanation: Endoscopic mucosal resection is indicated only for early gastric cancers that meet strict criteria, including no ulceration. The presence of ulceration is a contraindication due to a higher risk of submucosal invasion and lymph node metastasis, necessitating surgical resection with lymph node dissection instead. Tumour size 1.5 cm (Option A): Size ≤ 2 cm is generally acceptable for EMR/ESD under standard criteria if other favourable features (differentiated, intramucosal, no ulcer) are present. Well-differentiated histology (Option B): Well-differentiated histology is a favourable criterion and supports eligibility for endoscopic resection, not a contraindication. Tumour confined to the mucosa (Option D): Confinement to the mucosa (intramucosal carcinoma) is a key criterion for endoscopic resection, as the risk of lymph node metastasis is very low.

References:

https://pmc.ncbi.nlm.nih.gov/articles/PMC4250634/

↑ *Back to this question in Part A*

@Neet_pg_bot

Q25: Troisier's sign, characterised by enlargement of the left supraclavicular lymph node (Virchow's node), is most indicative of metastasis from which primary cancer site? (Q888662)

A. Breast

B. Lung

C. Stomach

D. Colon

Correct Answer: C. Stomach

Explanation: Troisier's sign refers specifically to palpable left supraclavicular lymphadenopathy (Virchow's node) resulting from metastasis via the thoracic duct. It is classically associated with advanced gastric adenocarcinoma, although it can rarely occur with other abdominal or thoracic malignancies. Breast (Option A): While breast cancer can metastasise to axillary and supraclavicular nodes, the left supraclavicular (Virchow's) node is not the most characteristic or specific site for breast cancer metastasis. Lung (Option B): Lung cancer commonly metastasises to supraclavicular nodes, but it involves both sides (right more for right lung, left more for left lung) and is not as classically linked to Virchow's node as gastric cancer. Colon (Option D): Colon cancer metastases typically

involve the periumbilical (Sister Mary Joseph node) or inguinal regions via portal or systemic routes, not characteristically the left supraclavicular node.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1171

↑ *Back to this question in Part A*

@Neet_pg_bot

Q26: According to the Japanese classification, early gastric cancer is defined by tumour invasion limited to which layers of the gastric wall? (Q888661)

A. Mucosa and submucosa only

B. Muscularis propria

C. Serosa

D. Adjacent organs

Correct Answer: A. Mucosa and submucosa only

Explanation: Early gastric cancer is defined as carcinoma confined to the mucosa or submucosa, regardless of lymph node involvement. This stage has an excellent prognosis with a high chance of cure, especially with endoscopic or surgical resection. Once the tumour invades the muscularis propria or beyond, it is classified as advanced gastric cancer. Muscularis propria (Option B): Invasion into the muscularis propria or beyond is classified as advanced gastric cancer, not early. Serosa (Option C): Serosal involvement indicates locally advanced disease (T4a) and is not considered early gastric cancer. Adjacent organs (Option D): Invasion of adjacent organs (T4b) represents the most locally advanced stage and is far beyond the definition of early gastric cancer.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1173.

Sabiston Textbook of Surgery, 21st Edition, Page 1223.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q27: A patient presents with gastric outlet obstruction caused by a diffusely infiltrating gastric carcinoma. This presentation is classic for which condition, and how is it classified in the Bormann system? (Q888657)

A. Linitis plastica; Type III (Ulcerating)

B. Linitis plastica; Type IV (Diffuse infiltrating)

C. Krukenberg tumour; Type II (Ulcerofungating)

D. Gastric adenoma; Type I (Polypoid)

Correct Answer: B. Linitis plastica; Type IV (Diffuse infiltrating)

Explanation: Linitis plastica refers to a diffusely infiltrating gastric carcinoma that leads to a rigid, thickened "leather bottle" stomach, often causing gastric outlet obstruction. In Bormann's classification of gastric cancer, this corresponds to Type IV (Diffuse infiltrating). Linitis plastica; Type III (Ulcerating) (Option A): Linitis plastica is not Type III. Bormann Type III is an ulcerating carcinoma with elevated margins, not the diffuse infiltrating form. Krukenberg tumour; Type II (Ulcerofungating) (Option C): A Krukenberg tumour is a metastatic ovarian tumour, often from a gastric primary, but it is not a Bormann gastric classification. Type II is ulcerofungating, not diffuse infiltrating. Gastric adenoma; Type I (Polypoid) (Option D): Gastric adenoma is a benign polypoid lesion. Bormann Type I is a polypoid/circumscribed carcinoma, not a diffuse infiltrating cause of gastric outlet obstruction.

References:

Sabiston Textbook of Surgery, 21st Edition, Page 1221.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q28: Which molecular alteration is characteristic of the intestinal type of gastric adenocarcinoma according to Lauren's classification? (Q888652)

A. Mutation of E-cadherin

B. Loss of heterozygosity in the APC gene

C. Inactivation of p53 only

D. KRAS mutation

Correct Answer: B. Loss of heterozygosity in the APC gene

Explanation: In Lauren's classification, the intestinal type of gastric adenocarcinoma is associated with specific molecular pathologies, including mutation or loss of heterozygosity in the APC gene or β-catenin. In contrast, the diffuse type is characterised by mutations in the E-cadherin gene. While p53 inactivation can occur in both types, APC/β-catenin alterations are more specific to the intestinal type. Mutation of E-cadherin (Option A): E-cadherin (CDH1) mutations are characteristic of the diffuse (hereditary) type, not the intestinal type. Inactivation of p53

only (Option C): p53 mutations are common in both intestinal and diffuse types and are not specific to intestinal-type adenocarcinoma. KRAS mutation (Option D): KRAS mutations are uncommon in gastric adenocarcinoma overall and are not a defining feature of the intestinal type according to Lauren's classification.

References:

Sabiston Textbook of Surgery, 21st Edition, Pages 1220, 1221.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q29: According to Lauren's classification, which type of gastric adenocarcinoma is primarily associated with hematogenous spread? (Q888650)

A. Type II (Diffuse type)

B. Mixed type

C. Type I (Intestinal type)

D. Indeterminate type

Correct Answer: C. Type I (Intestinal type)

Explanation: Lauren's classification categorises gastric adenocarcinoma into two types: intestinal (Type I) and diffuse (Type II). The intestinal type (Type I) is characterised by hematogenous spread, while the diffuse type (Type II) typically spreads via transmural and lymphatic routes. Type II (Diffuse type) (Option A): The diffuse type is characterised by poorly cohesive cells (e.g., signet ring cells) that typically spread via lymphatic and peritoneal routes rather than hematogenously. Mixed type (Option B): Mixed type contains features of both intestinal and diffuse types but does not show a predilection for hematogenous spread distinct from the patterns seen in its component types. Indeterminate type (Option D): Indeterminate type lacks clear intestinal or diffuse features; a primary association with hematogenous spread is not established.

References:

Sabiston Textbook of Surgery, 21st Edition, Page 1221.

https://pmc.ncbi.nlm.nih.gov/articles/PMC4840723/

↑ *Back to this question in Part A*

@Neet_pg_bot

Q30: A patient with Helicobacter pylori infection is found to have gastric polyps. Which type of gastric polyp is most commonly associated with H. pylori and typically regresses after eradication therapy? (Q888648)

A. Adenoma

B. Fundic gland polyp

C. Hyperplastic polyp

D. Hamartomatous polyp

Correct Answer: C. Hyperplastic polyp

Explanation: Hyperplastic polyps are the most common benign gastric polyps associated with Helicobacter pylori (H. pylori) infection. They are non-neoplastic and often regress following successful H. pylori eradication therapy. Adenoma (Option A): Gastric adenomas are neoplastic polyps associated with chronic atrophic gastritis and intestinal metaplasia. They do not typically regress after H. pylori eradication and are not the most common polyps linked directly to active H. pylori infection. Fundic gland polyp (Option B): Fundic gland polyps are associated with proton pump inhibitor (PPI) use and familial adenomatous polyposis (FAP), not with H. pylori infection. They do not regress after H. pylori eradication. Hamartomatous polyp (Option D): Hamartomatous polyps (e.g., in Peutz-Jeghers or Juvenile polyposis syndromes) are genetic in origin and not causally linked to H. pylori infection. They do not regress after eradication therapy.

References:

Bailey & Love’s Short Practice of Surgery, 28th Edition, Page 1169.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q31: Which of the following is the most common location of gastric adenocarcinoma in Asian populations, and why? (Q888645)

A. Proximal stomach, due to the high prevalence of GERD

B. Antrum, due to the higher prevalence of H. pylori infections

C. Cardia, due to obesity-related factors

D. Fundus, due to autoimmune gastritis

Correct Answer: B. Antrum, due to the higher prevalence of H. pylori infections

Explanation: In Asian populations, the most common site of gastric adenocarcinoma is the antrum, which is strongly associated with a higher prevalence of untreated H. pylori infection. This contrasts with Western populations, where proximal gastric adenocarcinoma is more common, often linked to chronic GERD and obesity. Proximal stomach, due to the high prevalence of GERD (Option A): Proximal (cardia) gastric cancer is more typical in Western populations with high GERD and obesity rates, not the predominant pattern in most Asian countries. Cardia, due to obesity-related factors (Option C): While cardia cancer is rising globally, it remains less common than distal cancer in Asian populations; obesity-related mechanisms are not the primary driver in the high-incidence Asian regions. Fundus, due to autoimmune gastritis (Option D): Adenocarcinoma in the fundus is uncommon overall; autoimmune gastritis is rare in Asian populations and is more associated with corporal atrophy and intestinal-type cancer in Western settings.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Pages 1169, 1170.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q32: A 35 year old male presents with severe weight loss and loss of appetite. Endoscopic examination reveals a thickened, rigid stomach with a "mother of pearl" appearance. Biopsy shows poorly differentiated cells with signet ring cells. What is the most appropriate treatment for his condition? (Q849096)

A. Partial gastrectomy

B. Chemotherapy alone

C. Total gastrectomy with oesophagojejunal anastomosis

D. Proton pump inhibitors and antibiotics

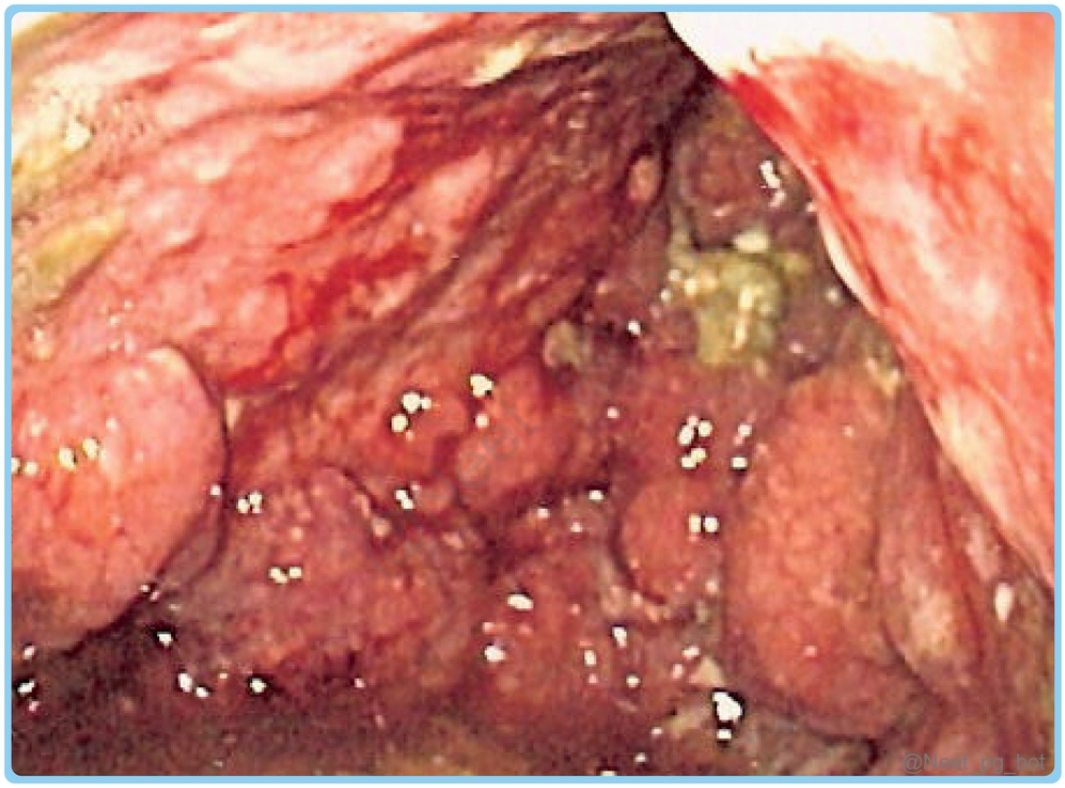
Correct Answer: C. Total gastrectomy with oesophagojejunal anastomosis

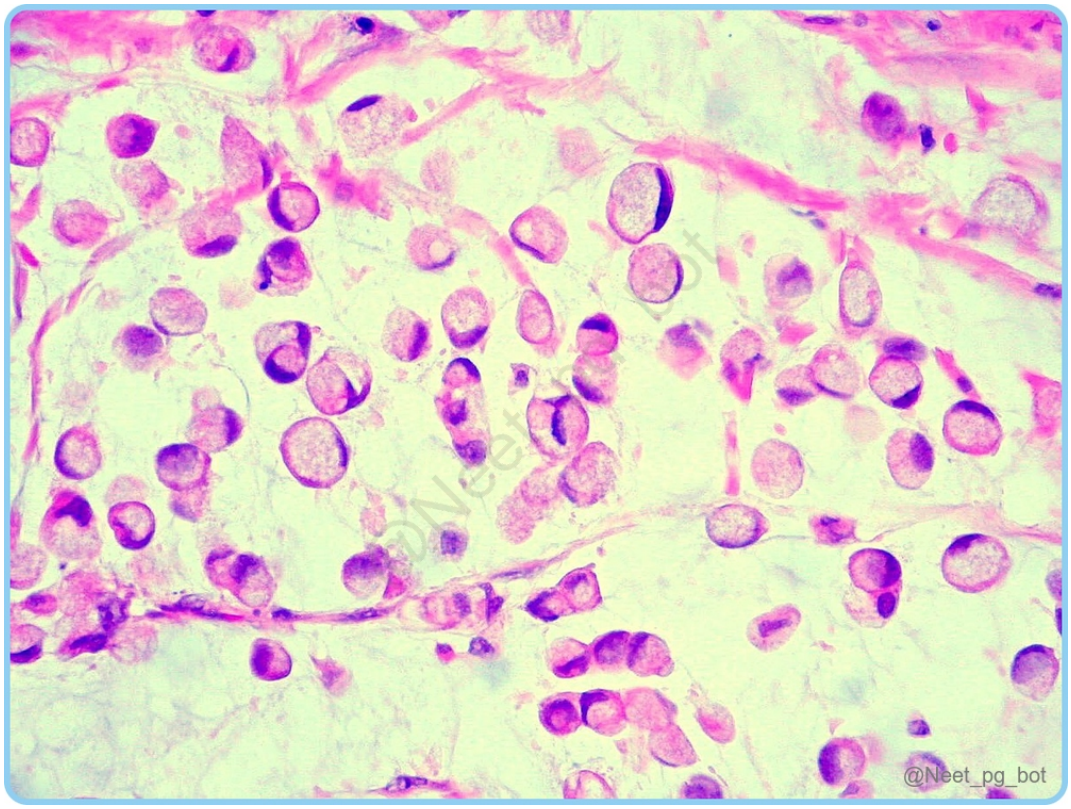
■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The symptoms and imaging point to Linitis Plastica which is a diffuse type of stomach cancer with enormous fibrous tissue proliferation in the submucosa. Linitis plastica is a rare and aggressive form of gastric cancer. The submucosa becomes thick, giving the stomach a 'mother-of-pearl' appearance. Plastica is leather-like. Signet ring cells are often present. The most appropriate treatment for linitis plastica is a total gastrectomy with oesophagojejunal anastomosis . This procedure involves completely removing the stomach, followed by connecting the oesophagus directly to the jejunum. This extensive surgical approach is necessary due to the diffuse spread and aggressive nature of linitis plastica. Partial gastrectomy (Option A) which involves removing only a portion of the stomach, is not adequate for treating linitis plastica. Chemotherapy (Option B), While chemotherapy can be a part of the treatment plan, it is not sufficient by itself for managing linitis plastica. Proton pump inhibitors

and antibiotics (Option D) is typically used for managing peptic ulcer disease, especially when associated with H. pylori infection.





References:

SRB’s Manual of Surgery, 6th Edition, Page 840

Sabiston Textbook of Surgery, 21st Edition, Page 1221

↑ *Back to this question in Part A*

@Neet_pg_bot

• [05_Gastrointestinal Surgery] 022 Peritoneum

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[05_Gastrointestinal Surgery] 022 Peritoneum — Quick Jump

Q1 (p. 1933) *Q2 (p. 1934)* *Q3 (p. 1935)* *Q4 (p. 1937)* *Q5 (p. 1938)* *Q6 (p. 1939)*
Q7 (p. 1939) *Q8 (p. 1940)* *Q9 (p. 1941)* *Q10 (p. 1943)*

Q1: A 35-year-old female presents with painless swelling in the umbilical region. On physical examination, the swelling is found to be soft, smooth, and freely mobile in a direction perpendicular to the line of the mesentery. Imaging studies confirm the presence of a mesenteric cyst. Which of the following is not a component of Tillaux's triad? (Q849228)

A. Soft, smooth swelling in the umbilical region

B. Freely mobile in a direction perpendicular to mesentery

C. Presence of tenderness

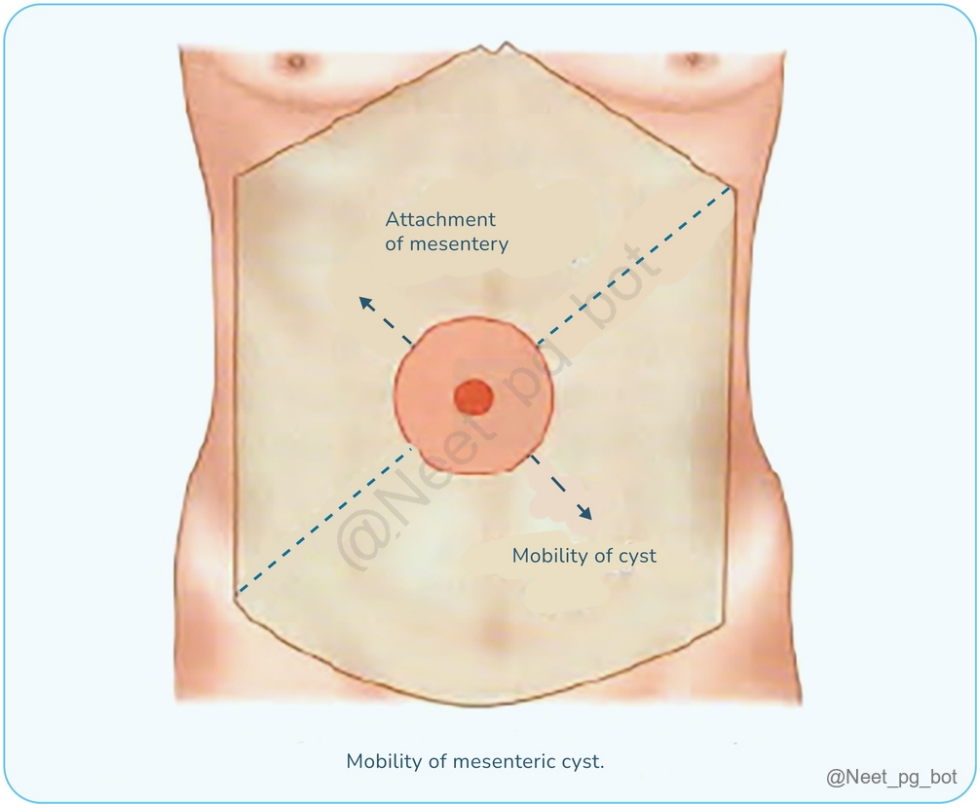
D. Zone of resonance all around

Correct Answer: C. Presence of tenderness

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Presence of tenderness is not a part of Tillaux’s triad. Mesenteric cyst: It presents as a painless, abdominal swelling in the umbilical region. Commonly seen in the 2nd decade of life. There is a band of resonance in front of the cyst. Tillaux's triad for mesenteric cysts includes: A soft, smooth swelling in the umbilical region. (Option A ruled out) Freely mobile mass in a direction perpendicular to line of the mesentery (Tillaux Sign) (Option B ruled out) A zone of resonance all around. (Option D ruled out)



Mobility of mesenteric cyst.

References:

SRB's Manual of Surgery, 6th Edition, Page 569, 570

↑ *Back to this question in Part A*

@Neet_pg_bot

Q2: A 52-year-old woman presents with abdominal distension, colicky pain that worsens after meals, and a gradual decline in her overall health. On examination, she has multiple hernias and ascites that do not demonstrate shifting dullness. Imaging reveals a jelly-like substance throughout the peritoneal cavity and mesentery. What is the most likely diagnosis for this patient? (Q849229)

A. Ovarian cystic tumor

B. Pseudomyxoma peritonei

C. Ascitic fluid due to liver cirrhosis

D. Colorectal carcinoma

Correct Answer: B. Pseudomyxoma peritonei

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Pseudomyxoma peritonei (PMP) is a rare condition characterized by the progressive accumulation of tumor deposits in the peritoneum, along with mucinous ascites and the formation of an omental cake. PMP is typically caused by the perforation of a mucinous appendiceal tumor . Clinical Features of pseudomyxoma peritonei: Many patients remain asymptomatic during the early stages. Abdominal distension is common. Colicky pain, particularly after eating, results from partial intestinal obstruction. There is a progressive decline in overall health as amino acids are diverted for the production of the jelly-like substance. On physical examination: Multiple hernias may be observed due to increased intra-abdominal pressure. Ascites is present but lack shifting dullness, owing to the accumulation of a semi-solid substance. Investigation: High-resolution CT scan of both the abdomen and pelvis, incorporating oral and intravenous contrast Treatment: Cytoreductive Surgery (CRS) : This includes multiple peritonectomy procedures and may involve extensive multivisceral resections to achieve complete tumor removal (complete cytoreduction). Hyperthermic Intraperitoneal Chemotherapy (HIPEC) : Following CRS, HIPEC is administered to target any remaining microscopic disease. Common agents used are mitomycin C or oxaliplatin. Ovarian cystic tumor (Option A) may present with abdominal distension and pelvic mass , but they typically produce serous or hemorrhagic fluid , not thick mucinous (“jelly-like”) ascites . Ascitic fluid due to liver cirrhosis (Option C) is free-flowing fluid , which shows shifting dullness on examination . It is transudative and watery , not thick or gelatinous. Colorectal carcinoma (Option D) usually presents with altered bowel habits, bleeding per rectum, and obstruction . While it can metastasize to the peritoneum, it does not produce the classical “jelly belly” mucinous ascites seen in pseudomyxoma peritonei.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1349-1353

↑ *Back to this question in Part A*

@Neet_pg_bot

Q3: A CT scan reveals periaortic soft tissue mass encasing both ureters. Regarding retroperitoneal fibrosis, which of the following statements is false? (Q849231)

A. Methysergide use is a recognized etiology in some cases.

B. Bilateral ureteric obstruction is best managed initially with bilateral nephrostomies.

C. Tamoxifen is contraindicated in the medical management of this condition.

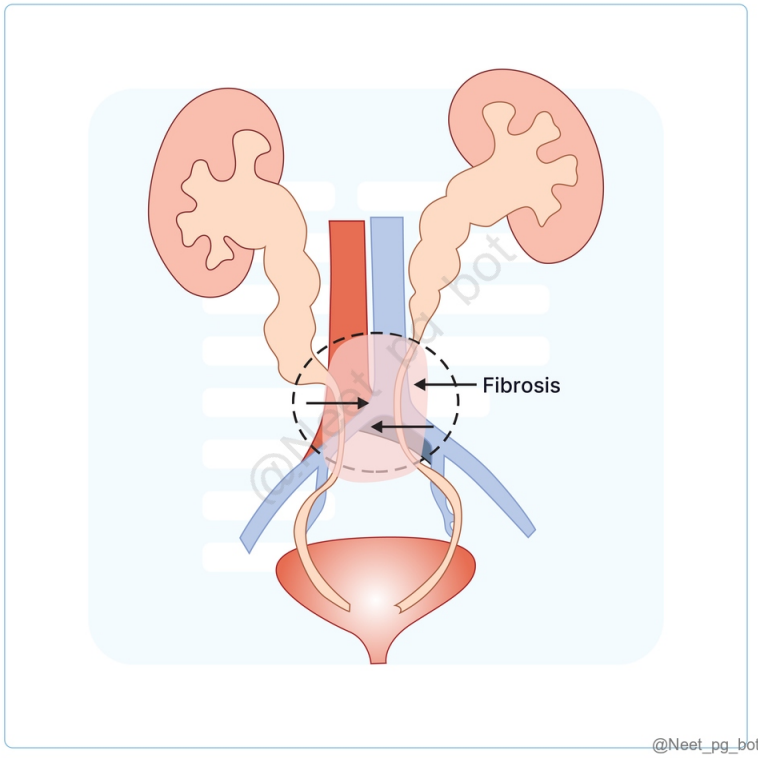
D. Laparoscopic ureterolysis with omental wrapping is a surgical option for persistent cases.

Correct Answer: C. Tamoxifen is contraindicated in the medical management of this condition.

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Tamoxifen is one of the medical management options for retroperitoneal fibrosis. Management: Medical management: Corticosteroids (first-line treatment) Immunosuppressants (e.g., azathioprine, mycophenolate mofetil) Tamoxifen (hormonal therapy) Surgical management: Ureterolysis with omental wrapping Laparoscopic or open approach Methysergide use is a recognized etiology in some cases (Option A): Methysergide, an ergot alkaloid used for migraine prophylaxis, has been associated with causing retroperitoneal fibrosis. Bilateral ureteric obstruction is best managed initially with bilateral nephrostomies (Option B): In cases of significant obstruction causing renal impairment, temporary urinary diversion with nephrostomies or ureteric stents is often the first step before definitive treatment. Laparoscopic ureterolysis with omental wrapping is a surgical option for persistent cases (Option D): For cases that don't respond to medical management or have persistent ureteral obstruction, laparoscopic ureterolysis with omental wrapping is a recognized surgical approach.





References:

Sabiston Textbook of Surgery, 21st Edition, Page 1100, 1101

↑ *Back to this question in Part A*

@Neet_pg_bot

Q4: A 55-year-old male with a history of liver cirrhosis and ascites presents to the emergency department with fever, abdominal pain, and tenderness. Paracentesis is performed, and the ascitic fluid analysis shows an elevated white blood cell count. Which of the following organisms is the most common cause of spontaneous bacterial peritonitis in patients with ascites along with its source of infection? (Q849176)

A. Escherichia coli, Extraperitoneal source

B. Staphylococcus, Extraperitoneal source

C. Escherichia coli, Intraperitoneal source

D. Streptococcus pneumonia, Intraperitoneal source

Correct Answer: A. Escherichia coli, Extraperitoneal source

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Escherichia coli is the most common organism causing spontaneous bacterial peritonitis (SBP) in patients with liver cirrhosis and ascites. SBP typically results from the translocation of enteric bacteria (extraperitoneal source) into the ascitic fluid. This process occurs due to the compromised gut barrier function and immune system in cirrhotic patients. Spontaneous bacterial peritonitis (SBP) is a type of Primary Bacterial Peritonitis where there is inflammation of the parietal and serosal layer of the peritoneum without any documented source of infection. The most common causes of SBP are Escherichia coli (gram negative bacteria), Streptococci and Enterococci (gram positive cocci). Staphylococcus , Extraperitoneal source (Option B): Staphylococcus is not a common cause of SBP. It is more commonly associated with: Skin infections Catheter-related infections Escherichia coli , Intraperitoneal source (Option C) : An intraperitoneal source implies secondary peritonitis (e.g., perforation, abscess). SBP occurs without perforation , via bacterial translocation , hence extraperitoneal. Streptococcus pneumoniae , Intraperitoneal source (Option D): Streptococcus pneumoniae can rarely cause SBP, especially in: Children Nephrotic syndrome

References:

SRB Manual of Surgery, 6th Edition, Page 558

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1089

↑ *Back to this question in Part A*

@Neet_pg_bot

Q5: Which of the following statements is false regarding spontaneous bacterial peritonitis (Q849178)

A. Translocation of bacteria from the gut causes SBP

B. Neutrophil count >250/mm is present in SBP

C. Cefotaxime is the first-line treatment for SBP

D. SBP is a polymicrobial infection of ascitic fluid

Correct Answer: D. SBP is a polymicrobial infection of ascitic fluid

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Spontaneous bacterial peritonitis (SBP) is an acute bacterial infection of ascitic fluid. It often affects individuals with a history of cirrhosis and ascites. SBP is a monobacterial infection, usually translocated from the gut to the ascitic fluid. (Option A ruled out) Clinical features: Abdominal pain and tenderness Fever with chills and rigor Tachycardia Investigations: Paracentesis gives a definitive diagnosis. A confirmed diagnosis requires an

elevated neutrophil count of 250/mm3 or higher in the aspirated ascitic fluid (Option B ruled out) Treatment: Drug of choice: IV Cefotaxime + Albumin (Option C ruled out) Patients with cirrhosis often experience hypoalbuminemia for which Albumin is administered.

References:

Bailey & Love's Short Practice of Surgery, 28 Edition, Page 1089

Spontaneous Bacterial Peritonitis - StatPearls - NCBI Bookshelf

↑ *Back to this question in Part A*

@Neet_pg_bot

Q6: What is the most common anaerobe responsible for Secondary Bacterial Peritonitis? (Q849180)

A. E. coli

B. Bacteroides fragilis

C. Klebsiella

D. Clostridium difficile

Correct Answer: B. Bacteroides fragilis

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Secondary bacterial peritonitis results from bacterial contamination originating from the digestive tract mainly seen secondary to visceral perforation. Etiology: Most common anaerobic pathogen: Bacteroides fragilis Most common aerobic pathogen: E.coli (Option A ruled out) Management: Erect Chest X-ray: Useful for detecting free gas under the diaphragm (pneumoperitoneum), indicating a perforation Surgery: Exploratory laparotomy + Peritoneal lavage + Repair of perforation

References:

Bailey & Love's Short Practice of Surgery, 28 Edition, Page 1088, 1089

Bacterial and Antibiotic Sensitivity Pattern in Secondary Peritonitis - PMC

↑ *Back to this question in Part A*

@Neet_pg_bot

Q7: Which of the following statements about continuous ambulatory peritoneal dialysis are true? (Q849225)

A. The most common organism causing peritonitis in CAPD is Staphylococcus saprophyticus

B. Treatment involves intraperitoneal instillation of first-generation cephalosporin via catheter for treating CAPD peritonitis

C. Recurrent attacks of peritonitis in CAPD should not be considered hemodialysis

D. None of the above

Correct Answer: B. Treatment involves intraperitoneal instillation of first-generation cephalosporin via catheter for treating CAPD peritonitis

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Continuous ambulatory peritoneal dialysis (CAPD) related peritonitis is a major cause of technique failure, morbidity, and mortality in patients with CAPD. The most frequent cause of peritonitis in Continuous Ambulatory Peritoneal Dialysis (CAPD) is also Staphylococcus epidermidis. (Option A ruled out) Treatment: Administer first-generation cephalosporin intraperitoneally through the catheter. For patients experiencing repeated episodes of peritonitis: Replace the catheter. Consider switching to hemodialysis. (Option C ruled out)

References:

www.ncbi.nlm.nih.gov/pmc/articles/PMC6001843/

www.ncbi.nlm.nih.gov/pmc/articles/PMC3524923/

↑ *Back to this question in Part A*

@Neet_pg_bot

Q8: A 55-year-old woman presents with a 3-day history of worsening lower abdominal pain, fever, and diarrhea with mucus. She reports a feeling of pressure in her pelvis and says that even sitting is excruciating. Her medical history is significant for diverticulitis, which was treated conservatively 6 weeks ago. Tenderness to palpation in the lower abdomen, and a rectal examination are present. What is the most likely diagnosis? (Q849226)

A. Acute appendicitis

B. Diverticulitis flare-up

C. Pelvic inflammatory disease

D. Pelvic abscess

Correct Answer: D. Pelvic abscess

Listen (English)

Listen (Hindi)

Explanation: This patient's symptoms, combined with her recent history of diverticulitis, point towards a pelvic abscess. Pelvic Abscess Clinical Features Lower abdominal pain and tenderness due to pus accumulation Fever accompanied by chills and rigor Pus irritates the anterior rectal wall (since the pouch of Douglas is in contact with this area), causing multiple episodes of loose stools with mucus Digital rectal examination may reveal a bulge on the anterior wall of the rectum Investigation Initial investigation: Ultrasound. Investigation of choice: Contrast-enhanced computed tomography (CECT) Management If a clean window is present: Percutaneous aspiration guided by ultrasound or CT (preferred treatment) is performed If no clean window is available due to bowel loops adhering to the abscess cavity: For females: Posterior colpotomy through the posterior vaginal wall (in close contact with the pouch of Douglas) For males: Anterior rectal drainage through the anterior rectal wall Acute appendicitis (Option A) typically presents with initial periumbilical pain migrating to the right lower quadrant , along with nausea and vomiting. It does not usually present with mucus diarrhea, pelvic pressure, or severe pain on sitting , nor is it associated with a recent history of diverticulitis. Diverticulitis flare-up (Option B): Although the patient has a history of diverticulitis, a simple flare-up usually presents with localized left lower quadrant pain and fever . The presence of mucus diarrhea, severe pelvic pressure, and signs suggestive of a localized collection (abscess) indicates a complication rather than a recurrence . Pelvic inflammatory disease (Option C) typically occurs in sexually active women and presents with lower abdominal pain, vaginal discharge, cervical motion tenderness, and menstrual irregularities . The absence of gynecological symptoms and the presence of a recent diverticulitis history make PID unlikely.

References:

Bailey & Love's Short Practice of Surgery, 28 Edition, Pages 1093-1094

pubmed.ncbi.nlm.nih.gov/7333045/#

↑ *Back to this question in Part A*

@Neet_pg_bot

Q9: Which of the following statements are true about mesenteric cyst? (Q849227)

A. Enterogenous cyst has an independent vascular supply

B. Walls of chylolymphatic cysts are thicker than enterogenous cysts

C. Treatment of chylolymphatic cyst is resection and anastomosis

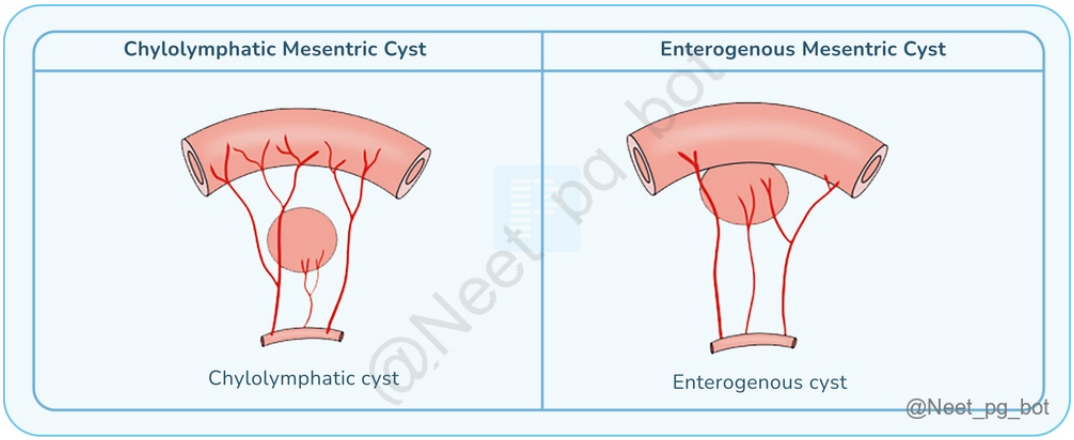
D. Fluid in enterogenous cyst is produced by goblet cells of viscera

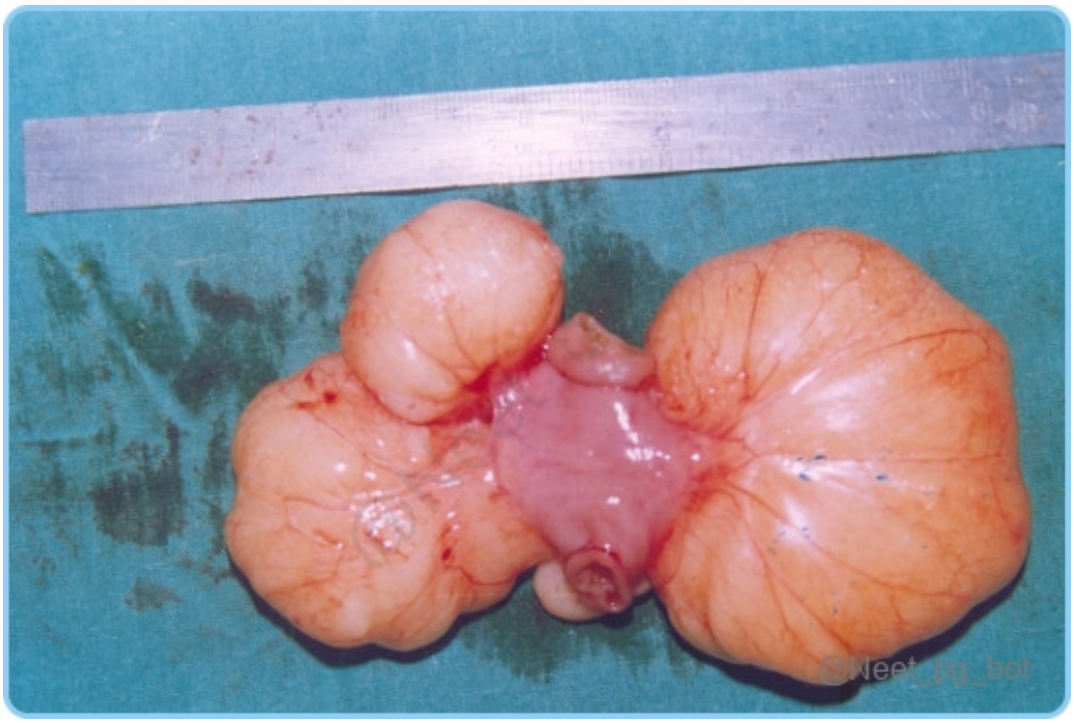
Correct Answer: D. Fluid in enterogenous cyst is produced by goblet cells of viscera

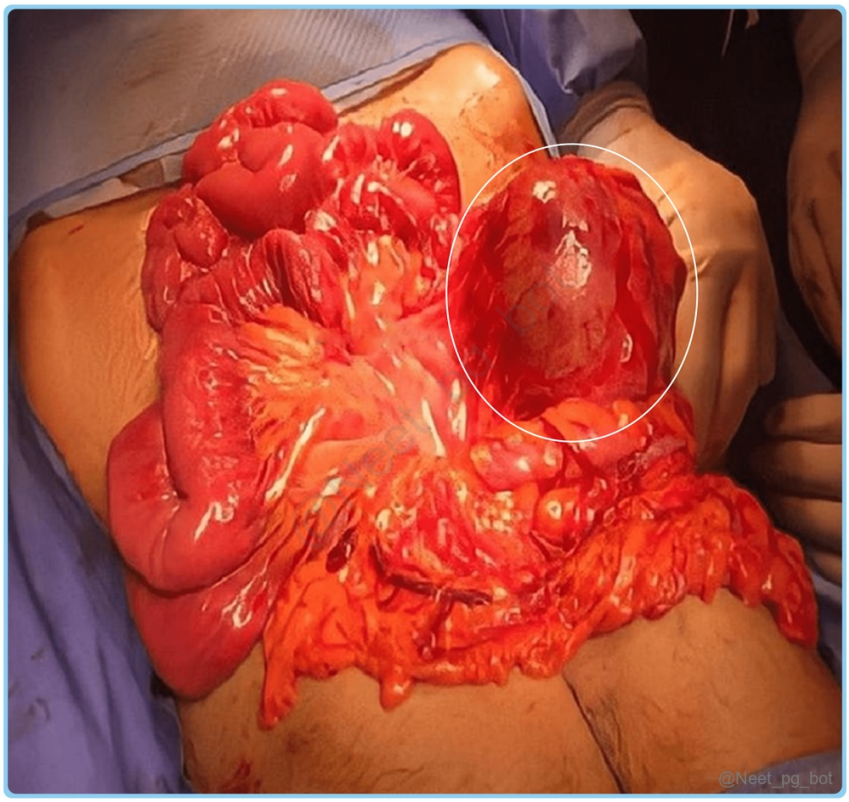
■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Chylolymphatic Cyst Enterogenous Mesenteric Cyst Cyst has chylous collection. Congenitally misplaced lymphatics in the ileum with afferent lymphatics only. Absence of efferent lymphatics → collection of chyle → progressive increase in the size of the cyst. Independent vascular supply and there is no shared wall. TOC: Enucleation. “Entero” means: small bowel and “genous” means: Origin. Indirectly or directly arising from the small bowel. Patients have either diverticula or duplication cysts. Over a period of time, the diverticula will be walled off leading to the formation of 2 separate lumens, known as duplication cyst. The small intestine is lined with columnar epithelium and goblet cells which secrete mucin and collect inside the cyst increasing its size (enterogenous cyst). Treatment: Resection + Anastomosis (due to shared wall and shared vascular supply).







References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1100, 1101

↑ *Back to this question in Part A*

@Neet_pg_bot

Q10: A male presents with bilateral flank pain, lower extremity edema, and elevated serum creatinine. CT scan reveals a retroperitoneal mass encasing both ureters. Biopsy shows dense fibrocollagenous tissue with chronic inflammation. Which of the following is the most likely etiology of this patient's condition? (Q849230)

A. IgG4-related disease

B. Metastatic prostate cancer

C. Methysergide use

D. Erdheim-Chester disease

Correct Answer: A. IgG4-related disease

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Most idiopathic cases of retroperitoneal fibrosis are now recognized as part of IgG4-related disease. This systemic condition is characterized by dense lymphoplasmacytic infiltrates rich in IgG4-positive plasma cells, storiform fibrosis, and often elevated serum IgG4 levels. The CT findings of a retroperitoneal mass encasing the ureters, along with the biopsy showing dense fibro-collagenous tissue with chronic inflammation, are typical of IgG4-related retroperitoneal fibrosis. Category of Secondary RPF Drugs Mnemonic: “ MAHE BP ” M – M ethysergide (Most important drug) A – A mphetamines H – H ydralazine E – E ntacapone B – B eta-blockers, B romocriptine P – P henacetin Malignancy Non-Hodgkin lymphoma Gastric carcinoma Carcinoid tumor Infection Mnemonic: “ CATH ” Chronic pancreatitis Actinomycosis TB Histoplasmosis Others Autoimmune disorders Radiation exposure Metastatic prostate cancer (Option B) can involve the retroperitoneum, but it typically presents with irregular mass lesions, lymphadenopathy, or bone metastasis , rather than diffuse fibrocollagenous encasement of ureters . Histology would show malignant cells , not benign fibrotic tissue with chronic inflammation. Methysergide use (Option C) is a known cause of secondary retroperitoneal fibrosis , but the question does not provide any history of drug intake. In the absence of such history, the most common cause remains idiopathic IgG4-related disease , making this option less likely. Erdheim–Chester disease (Option D) is a rare non-Langerhans cell histiocytosis that can cause retroperitoneal fibrosis, but it is usually associated with: Skeletal involvement (long bone sclerosis) Xanthogranulomatous infiltration Histology showing foamy histiocytes , not fibrocollagenous tissue

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Pages 1103, 1104

↑ *Back to this question in Part A*

@Neet_pg_bot

• [05_Gastrointestinal Surgery] 023 Small Intestine - I

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[05_Gastrointestinal Surgery] 023 Small Intestine - I — Quick Jump

Q1 (p. 1945)	*Q2 (p. 1946)*	*Q3 (p. 1947)*	*Q4 (p. 1948)*	*Q5 (p. 1949)*	*Q6 (p. 1949)*
Q7 (p. 1950)	*Q8 (p. 1951)*	*Q9 (p. 1952)*	*Q10 (p. 1953)*	*Q11 (p. 1954)*	*Q12 (p. 1954)*
Q13 (p. 1955)	*Q14 (p. 1956)*	*Q15 (p. 1957)*	*Q16 (p. 1958)*	*Q17 (p. 1958)*	*Q18 (p. 1959)*
Q19 (p. 1960)	*Q20 (p. 1961)*	*Q21 (p. 1962)*	*Q22 (p. 1963)*	*Q23 (p. 1965)*	*Q24 (p. 1966)*
Q25 (p. 1967)					

Q1: A 3-year-old child with short bowel syndrome presents with severe malabsorption. Which surgical procedure involves stapling a dilated bowel into V shapes on alternating sides, decreasing the width and increasing the bowel length to improve nutrient absorption? (Q849162)

A. Bianchi procedure

B. Whipple Procedure

C. Billroth I and II Procedures

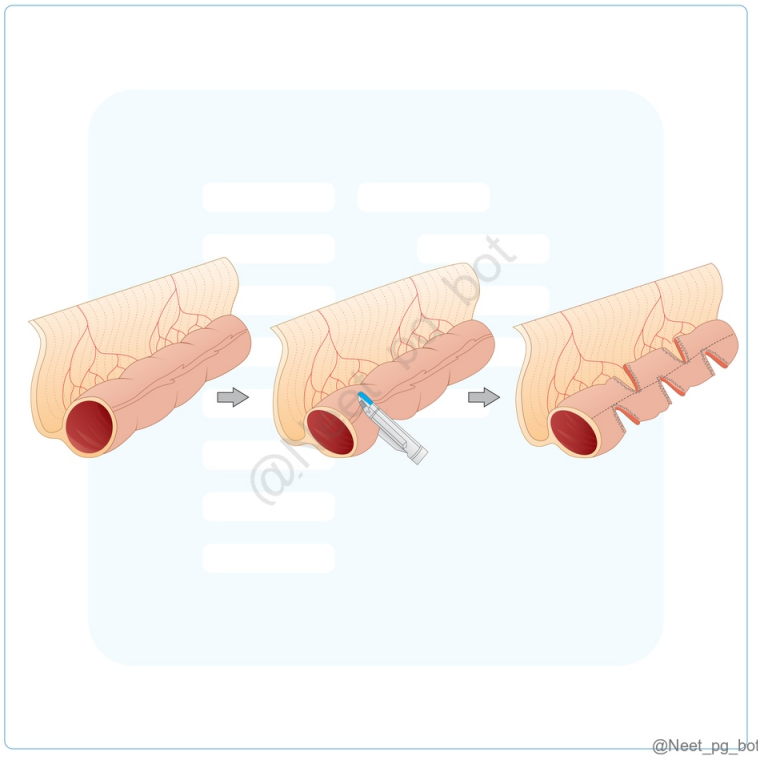
D. STEP procedure

Correct Answer: D. STEP procedure

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The Serial Transverse Enteroplasty (STEP) is a minimal dissection procedure that narrows the lumen of the dilated small intestine by stapling it transversely, effectively increasing its length. This technique allows food to travel in a zig-zag pattern, enhancing tolerance to enteral feeding and promoting significant catch-up growth. Bianchi procedure (longitudinal intestinal lengthening and tailoring) (Option A) involves splitting a dilated bowel longitudinally into two hemiloops and anastomosing them end-to-end, thereby doubling the length. It does not involve stapling in a zig-zag or V-shaped manner. Whipple Procedure (Pancreaticoduodenectomy) (Option B) involves resection of the pancreatic head, duodenum, part of the stomach, gallbladder, and bile duct, typically for malignancy. It has no role in short bowel syndrome or bowel lengthening Billroth I and II Procedures (Option C) are types of gastric reconstruction after distal gastrectomy. They involve gastroduodenostomy (Billroth I) or gastrojejunostomy (Billroth II) and are unrelated to intestinal lengthening procedures, so they are not applicable here.



References:

Bailey and Love's Short Practice of Surgery, 28th Edition, Pages 1316, 1317

Sabiston Textbook of Surgery, 21st Edition, Pages 1859, 1559, 419

↑ *Back to this question in Part A*

@Neet_pg_bot

Q2: A 6-year-old child with a history of extensive small bowel resection due to necrotizing enterocolitis is diagnosed with short bowel syndrome. Which among the following surgical procedures can help increase the bowel length and potentially reduce the dependency on parenteral nutrition? (Q849161)

A. Bianchi procedure

B. Whipple Procedure

C. Billroth I and II Procedures

D. Ileostomy

Correct Answer: A. Bianchi procedure

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The Bianchi procedure/ Longitudinal intestinal lengthening and tailoring (LILT) is recognised as an effective surgical treatment for short bowel syndrome (SBS). Bianchi initially described the procedure for intestinal lengthening where the mesenteric vascular bed is divided into two systems. The enlarged small intestine is split into two parallel segments, each with its own blood supply, and then reconnected. This technique reduces the small intestine's diameter by 50% and doubles its length . Whipple Procedure (Pancreaticoduodenectomy), Billroth I and II procedures and Ileostomy (Option B, C and D) don't involve intestinal lengthening

References:

Bailey and Love’s Short Practice of Surgery, 28th Edition, Page1316, 1317.

Sabiston Textbook of Surgery, 21st Edition, Page 1559, 419, 1859

↑ *Back to this question in Part A*

@Neet_pg_bot

Q3: A 45-year-old male presents with severe malnutrition and liver dysfunction even after subclavian parenteral nutrition for extensive small bowel resection. Which of the following is the most definitive treatment for his condition? (Q849160)

A. Jugular Parenteral Nutrition (TPN)

B. Small bowel transplantation

C. Serial transverse enteroplasty

D. Ileostomy

Correct Answer: B. Small bowel transplantation

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Small bowel transplantation is the definitive treatment for severe malnutrition and liver dysfunction after extensive small bowel resection when parenteral nutrition is insufficient. Treatment of Short bowel syndrome: Medical/ supportive: Total parenteral nutrition (Subclavian preferred over jugular) (Option A ruled out) and long-term home parenteral nutrition. Diarrhea: loperamide/codeine phosphate. To bind bile salts: Oral cholestyramine To reduce secretions from the stomach, liver and pancreas: H2 antagonists/PPls/somatostatin. Octreotide: reduces the secretion and reduces GI motility. Fluid and electrolyte management. Surgical management: Principle: To delay the intestinal transit time and increase the absorption surface. Small bowel transplantation is the ideal. (Option B) Intestinal lengthening procedures: Binachi's surgery, serial transverse

enteroplasty (STEP). These procedures are not definitive. (Option C ruled out)

References:

Bailey and Love's Short Practice of Surgery, 28th Edition, Page1316, 1317

Sabiston Textbook of Surgery, 21st Edition, Page 1859

SRB's Manual of Surgery, 6th Edition, Page 871

Short bowel syndrome

↑ *Back to this question in Part A*

@Neet_pg_bot

Q4: A 52-year-old male patient who underwent extensive resection of the small intestine for Crohn's disease presents with persistent diarrhea and worsening malnutrition. Despite following a strict dietary regimen, he is unable to maintain adequate nutritional status or fluid balance without intravenous support. What is the most appropriate management strategy for this patient? (Q849159)

A. Oral rehydration therapy

B. Enteral nutrition

C. Parenteral nutrition

D. Antidiarrheal medications

Correct Answer: C. Parenteral nutrition

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Parenteral nutrition is the appropriate management strategy for patients with short bowel syndrome who cannot maintain nutritional and fluid balance through oral or enteral means. This approach provides essential nutrients directly into the bloodstream. Total Parenteral Nutrition (TPN) : Intravenous administration of nutrients (carbohydrates, proteins, fats, vitamins, minerals),for patients unable to maintain nutrition through oral intake alone Intestinal Failure is the inability to maintain satisfactory fluid, electrolyte, or nutritional homeostasis without intravenous support, therefore rendering oral rehydration and enteral nutrition insufficient. This is due to poor absorption (Options A & B ruled out) Antidiarrheal medications (Option D) : These may alleviate diarrhea symptoms but do not resolve the underlying issue of inadequate nutrient and fluid absorption.

References:

Bailey and Love's Short Practice of Surgery, 28th Edition, Page1316

↑ *Back to this question in Part A*

@Neet_pg_bot

Q5: A 60-year-old woman with a history of extensive small bowel resection presents with persistent diarrhea, significant weight loss, and signs of malnutrition. She is unable to maintain adequate fluid and nutritional balance despite dietary modifications. what condition is she most likely experiencing? (Q849158)

A. Intestinal obstruction

B. Short bowel syndrome

C. Celiac disease

D. Crohn’s disease

Correct Answer: B. Short bowel syndrome

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The clinical features of persistent diarrhea, significant weight loss, and malnutrition, along with difficulty maintaining fluid and nutritional balance, are indicative of short bowel syndrome, especially following extensive small bowel resection. Short Bowel Syndrome (SBS): Clinical Features: Intractable diarrhea Impaired nutrient absorption Progressive malnutrition Cause: Resection or bypass of the small intestine Intestinal Failure: Inability to maintain satisfactory fluid, electrolyte, or nutritional homeostasis without intravenous support, therefore rendering oral rehydration and enteral nutrition insufficient. This is due to poor absorption. Treatment: Parenteral nutrition

References:

Bailey and Love’s Short Practice of Surgery, 28th Edition, Page1316

↑ *Back to this question in Part A*

@Neet_pg_bot

Q6: A 55-year-old patient with radiation enteritis undergoes bowel resection and develops short bowel syndrome. Which statement about bowel function is correct? (Q849157)

A. The jejunum compensates well for the loss of the ileum.

B. The ileum can compensate for a resected jejunum due to better absorption.

C. Short bowel syndrome is less severe with distal bowel loss.

D. The ileum’s compensation is reduced due to looser junctions.

Correct Answer: B. The ileum can compensate for a resected jejunum due to better absorption.

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The ileum has tighter intercellular junctions and superior fluid absorptive capacity. (Option D ruled out) The ileum can compensate for the loss of the jejunum, making it capable of taking over some of the jejunal functions. But the jejunum cannot compensate for a missing ileum. (Option A ruled out) Therefore, jejunal resections are better tolerated because of the adaptability of the ileum. Short bowel syndrome usually affects the distal small intestine more than the proximal, and distal bowel loss results in a more severe form of SBS. (Option C ruled out)

References:

Bailey and Love’s Short Practice of Surgery, 28th Edition, Page 1316

↑ *Back to this question in Part A*

@Neet_pg_bot

Q7: A 60-year-old man presents with complaints of fatigue, shortness of breath, and swelling in his legs. He has had a history of intermittent facial flushing and diarrhea for the past several years. Physical examination reveals a new heart murmur. Which of the following is the most likely diagnosis? (Q849155)

A. Aortic stenosis

B. Mitral regurgitation

C. Carcinoid heart disease

D. Pulmonary embolism

Correct Answer: C. Carcinoid heart disease

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The patient's history of facial flushing, diarrhea, and a newly detected heart murmur, coupled with symptoms of right-sided heart failure (such as leg swelling and shortness of breath), strongly points toward

carcinoid heart disease. Carcinoid heart disease is a complication of carcinoid syndrome, which results from the release of serotonin and other vasoactive substances by a carcinoid tumor. Pathophysiology: Plaque-like deposits composed of smooth muscle cells, myofibroblasts, extracellular matrix and an overlying endothelial layer which lead to valve dysfunction. Valvular dysfunction can lead to edema, ascites and right-sided heart failure. Pulmonary heart disease primarily affects the right side of the heart. Within the right heart, the tricuspid valve is the first to be affected, followed by the pulmonary valve. Regurgitant lesions are more common than stenotic lesions.

References:

Bailey and Love's Short Practice of Surgery, 28th Edition, Page 1310

Carcinoid heart disease: presentation, diagnosis, and management - PMC

Carcinoid heart disease

↑ *Back to this question in Part A*

@Neet_pg_bot

Q8: Which of the following diagnostic steps is most appropriate to establish a definitive diagnosis of abdominal TB in this patient? (Q849150)

A. Serum-ascites albumin gradient (SAAG) measurement

B. Computed tomography (CT) with enterography protocol

C. Peritoneal fluid adenosine deaminase (ADA) level

D. Biopsy of the involved site with mycobacterial culture and nucleic acid amplification test (NAAT)

Correct Answer: D. Biopsy of the involved site with mycobacterial culture and nucleic acid amplification test (NAAT)

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Biopsy of the involved site with mycobacterial culture and nucleic acid amplification test (NAAT): It's the most definitive method for diagnosing abdominal TB, and allows for the direct demonstration of M. tuberculosis in tissue or fluid samples, providing conclusive evidence of the infection. Diagnostic Method Details Definitive Diagnosis (Option D) M. tuberculosis Demonstration: Peritoneal fluid (in ascites) Biopsy specimen (peritoneum, intestine, liver) Mycobacterial culture and/or NAAT: Histopathology: The presence of caseating granulomas suggests TB but is not pathognomonic Radiographic Imaging CT with Enterography Protocol: (Option B ruled out) Preferred for cross-sectional evaluation Intestinal TB: Concentric mural thickening in the ileocecal region, lymphadenopathy with hypodense centers Peritoneal TB: Ascites, lymph nodes, mesentery and omental thickening, peritoneal thickening Hepatic TB: Miliary disease: Multiple low-density micronodules throughout the liver Local disease: Large solitary nodule or 2-3 low-density nodules with calcification and peripheral

enhancement Ultrasound: Detects lymphadenopathy, ascites, peritoneal thickening, omental thickening, bowel wall thickening Other Imaging: Small bowel follow-through/barium enema: Mucosal ulcerations, strictures, deformed cecum, incompetent ileocecal valve Plain radiography: Air fluid levels, dilated small bowel loops, hepatic calcifications Chest radiography: For suspected abdominal TB Ascitic Fluid Analysis Routine Tests: Cell count and differential, albumin and protein concentration, Gram stain TB-specific Tests: ADA level (Option C ruled out) , AFB smear, mycobacterial culture, NAAT for M. tuberculosis (if available) Typical Findings: Lymphocytic ascites with SAAG <1.1 g/dL in noncirrhotic patients (Option A ruled out) Straw-colored ascites leukocyte count 150-4000 cells/mm^3 relative lymphocytic pleocytosis Protein content >3.0 g/dL The sensitivity of AFB smear and mycobacterial culture is low Biopsy Specimens Laparoscopy: Visualization of peritoneum, peritoneal biopsy Endoscopy: Biopsies in the setting of intestinal involvement Radiographic-guided interventions Histopathology: Caseating granulomas and positive acid-fast stain in fewer than 33% of cases Confluent granulomas, granulomas >400 micrometres, >5 granulomas in one segment, and submucosal granulomas suggest TB enteritis Additional Diagnostic Tools Tuberculin skin test/interferon-gamma release assay: Positive in abdominal TB but limited value (does not differentiate active disease from latent infection) Stool PCR: Useful adjunctive tool for diagnosing intestinal TB

References:

.https://www.uptodate.com/contents/abdominal-tuberculosis?search=gi%20tuberculosis&source=search_result&selectedTitle=1~29&usage_type=default&display_rank=1

↑ *Back to this question in Part A*

@Neet_pg_bot

Q9: A 65-year-old male presents with sudden onset severe abdominal pain that started 30 minutes after his last meal. He is tachycardic and hypotensive and laboratory investigations reveal leukocytosis and elevated chromogranin A levels. A CT scan shows bowel wall enhancement and free fluid in the abdomen. Which of the following is the most preferred treatment? (Q849156)

A. Segmental resection + En-bloc lymphadenectomy

B. Chemotherapy regimen

C. Somatostatin analogue therapy

D. Total bowel resection

Correct Answer: A. Segmental resection + En-bloc lymphadenectomy

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: This patient with sudden onset abdominal pain and elevated levels of chromogranin A is a case of a small bowel carcinoid tumor. The most preferred treatment option is surgical exploration with segmental bowel

resection with en-block lymphadenectomy. Management: The preferred treatment approach is segmental resection combined with en-bloc lymphadenectomy . (Option A) Total bowel resection is a highly aggressive approach that is generally avoided unless necessary. Intestinal resection should be limited as carcinoid patients will do poorly if a short bowel syndrome results. (Option D ruled out) Somatostatin analogue therapy has antiproliferative effects and is used in unresectable or metastatic disease. (Option C ruled out) Chemotherapy Regimen (preferred if surgery is not possible) (Option B ruled out) D – Dacarbazine E – Epirubicin F5 – Fluorouracil

References:

www.ncbi.nlm.nih.gov/pmc/articles/PMC5502737/

www.ncbi.nlm.nih.gov/pmc/articles/PMC6091496/

SRB's Manual of Surgery, 6th Edition, Page 870,871

↑ *Back to this question in Part A*

@Neet_pg_bot

Q10: A 48-year-old woman presents with episodes of flushing, diarrhea, and abdominal pain over the past six months. She also reports intermittent wheezing and feels her symptoms worsen after consuming certain foods. On physical examination, she exhibits a rash on her face and neck. Imaging studies reveal a tumor in the ileum of the small intestine. What is the initial investigation of choice for localisation in this patient? (Q849154)

A. Contrast-enhanced CT abdomen

B. DOPA-PET

C. Urinary detention of 5-HIAA

D. Somatostatin receptor scintigraphy (SRS)

Correct Answer: D. Somatostatin receptor scintigraphy (SRS)

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The clinical scenario is suggestive of a carcinoid tumor. Somatostatin receptor scintigraphy (SRS) is used as the initial investigation for localization as it is the most sensitive test for diagnosing carcinoid syndrome . The extent of disease can be assessed preoperatively using octreotide scanning i.e somatostatin receptor scintigraphy , which may detect the tumor. Investigations Urinary detention of 5-HIAA is used to detect Carcinoid tumor .It is the investigation of choice but SRS is the initial investigation (Option C ruled out) The most effective investigation for precise localization is DOPA–PET. (Option B ruled out) Triple phase contrast-enhanced CT scan is most commonly used as it is widely available but CT scan sensitivity is low (50%) and not the initial

investigation of choice (Option A ruled out) .

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1310

↑ *Back to this question in Part A*

@Neet_pg_bot

Q11: What is the most peculiar feature of gastric carcinoid tumor? (Q849153)

A. Abdominal pain

B. Abdominal distension

C. Bowel obstruction

D. Bright red patchy flushing of skin

Correct Answer: D. Bright red patchy flushing of skin

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Bright red patchy flushing of skin is a peculiar feature of the bowel carcinoid tumor due to the excessive production of vasoactive peptides , primarily serotonin. Clinical features: Reddish-blue cyanosis, facial and upper chest flushing attacks, diarrhoea, asthmatic attacks (bronchospasm) and tricuspid regurgitation. (Option D) Abdominal pain, bowel obstruction and abdominal distension are non-specific and not peculiar features of bowel carcinoid tumors. (Option A, B, C)

References:

Bailey and Love's Short Practice of Surgery, 28th Edition, Page 1310

↑ *Back to this question in Part A*

@Neet_pg_bot

Q12: A 55 y/o male presents with flushing, diarrhea, and recurrent episodes of bronchospasm. Imaging reveals multiple masses in the ileum. Laboratory tests show elevated serotonin levels. What is the most likely type of tumor responsible for his symptoms? (Q849152)

A. Foregut Carcinoid Tumor

B. Midgut Carcinoid Tumor

C. Hindgut Carcinoid Tumor

D. Non-Syndromic Neuroendocrine Tumor

Correct Answer: B. Midgut Carcinoid Tumor

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The patient presents with flushing, diarrhea, and bronchospasm , which are classical features of carcinoid syndrome . This syndrome occurs due to excessive secretion of serotonin and other vasoactive substances . The presence of multiple masses in the ileum strongly points toward a midgut carcinoid tumor , as midgut tumors commonly arise from the jejunum, ileum, appendix, and right colon and are the most common cause of carcinoid syndrome . These tumors produce large amounts of serotonin, leading to the characteristic symptoms. Foregut carcinoid tumors (Option A) arise from the stomach, duodenum, pancreas, or bronchus . They typically produce 5-HTP (serotonin precursor) rather than serotonin and often lack the enzyme to convert it efficiently. As a result, classical carcinoid syndrome is uncommon , and serotonin levels are usually not markedly elevated. Hindgut carcinoid tumors (Option C) arise from the distal colon and rectum . These tumors are usually non-functional and rarely secrete serotonin , so they do not typically produce carcinoid syndrome . Hence, this option is unlikely. Non-syndromic neuroendocrine tumors (Option D) do not secrete active hormones and therefore do not cause symptoms like flushing, diarrhea, or bronchospasm. The presence of clear hormonal symptoms and elevated serotonin rules out this option.

References:

SRB’s Manual of Surgery, 6th Edition, Page 868

pathology.jhu.edu/pancreas/neuroendocrine/syndromic-vs-non-syndromic#

↑ *Back to this question in Part A*

@Neet_pg_bot

Q13: Which of the following statements is correct? (Q849151)

A. The most common small bowel tumor in adults is carcinoid tumor.

B. The most common small bowel tumor in children is a neuroendocrine tumor.

C. The most common primary malignant small bowel tumor is adenocarcinoma.

D. The most common small bowel tumor in adults is lymphoma.

Correct Answer: C. The most common primary malignant small bowel tumor is adenocarcinoma.

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Adenocarcinoma is the most frequently occurring malignant small bowel tumor. Classification of Small Bowel Tumors Benign Tumors Adenomas: Most common benign SBT is adenoma Lipomas Haemangiomas Neurogenic tumors Malignant Tumors Adenocarcinoma (Option C) The most common primary malignant SBT is: Adenocarcinoma > Carcinoid>Lymphoma and (Option A ruled out) Neuroendocrine Tumors (NETs) Arise from Kulchitsky cells, small primary tumor with potential for significant lymph node metastases, up to one-third involve multiple tumors. Lymphomas The most common SBT in children is Lymphoma. (Opti on B and D ruled out) MALT lymphoma is associated with H.pylori infection. Lymphoma is the most common malignant neoplasm of spleen. Stomach is the most common site for extranodal lymphoma. Burkitt's lymphoma affects the ileocaecal junction Gastrointestinal Stromal Tumors (GISTs) Mesenchymal tumors, are difficult to classify as benign or malignant, with larger size and high c-kit (CD117) staining associated with malignancy.

References:

SRB’s Manual of Surgery, 6th Edition, Page 865,866,867

Bailey and Love’s Short Practice of Surgery, 28th Edition, Page 1309,1310,1311

Small Bowel Cancer

↑ *Back to this question in Part A*

@Neet_pg_bot

Q14: A 65 y/o male presents with chronic abdominal discomfort and bloating. Imaging shows multiple jejunal diverticula. The physician suspects these are due to increased intraluminal pressure. What is the most likely etiology of these diverticula? (Q849138)

A. Congenital origin due to incomplete recanalization of the duodenum

B. Acquired origin due to smooth muscle motor dysfunction

C. Remnant of the omphalomesenteric duct

D. Protrusion of the entire intestinal wall layers

Correct Answer: B. Acquired origin due to smooth muscle motor dysfunction

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Jejunal diverticula are acquired in origin. They are false diverticula, meaning they involve herniation of the mucosa and submucosa through the muscular layer of the intestine. They result from a motor dysfunction of the smooth muscle or the myenteric plexus. This dysfunction causes abnormal contractions of the small bowel, leading to increased pressure inside the lumen and subsequent herniation of the mucosal and submucosal layers

through the weakest parts of the bowel wall. Acquired diverticula of the small intestine most commonly occur in the duodenum. Congenital origin due to incomplete recanalization of the duodenum (Option A): This describes conditions like duodenal atresia or stenosis , which are congenital anomalies seen in neonates. Jejunal diverticula, however, are acquired lesions in adults and are not related to recanalization defects. Remnant of the omphalomesenteric duct (Option C): This refers to Meckel's diverticulum , which is a true congenital diverticulum located in the ileum , not the jejunum. It contains all layers of the intestinal wall and is unrelated to increased intraluminal pressure. Protrusion of the entire intestinal wall layers (Option D): This describes a true diverticulum , whereas jejunal diverticula are false (pseudodiverticula) involving only mucosa and submucosa. Hence, this option is incorrect.

References:

Sabiston Textbook of Surgery, 21st Edition, Page 1286,1288,1289

↑ *Back to this question in Part A*

@Neet_pg_bot

Q15: A 28-year-old patient with gastrointestinal tuberculosis presents with abdominal pain and intermittent diarrhea. Imaging studies reveal a long, narrow filling defect in the terminal ileum. What is the most likely diagnosis based on these findings? (Q849149)

A. Ulcerative tuberculosis with subacute obstruction and perforation

B. Crohn's disease with a narrowed segment and proximal distension

C. Hyperplastic tuberculosis with a filling defect in the terminal ileum and lymphadenopathy

D. Appendicitis with mass in the right iliac fossa

Correct Answer: C. Hyperplastic tuberculosis with a filling defect in the terminal ileum and lymphadenopathy

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Hyperplastic tuberculosis often presents with a long, narrow filling defect in the terminal ileum on imaging, and it is associated with lymphadenopathy. This lines with the patient's presentation and imaging findings. Feature Hyperplastic Tuberculosis Symptoms Abdominal pain Intermittent diarrhea Complications/Consequences Incomplete ileal obstruction Stasis Bacterial overgrowth Steatorrhea Anemia Weight loss Diagnostic Findings Physical exam: Mass in right iliac fossa Barium follow-through/small bowel enema: Long, narrow filling defect in terminal ileum CT scan: Narrowed segment with proximal distension and lymphadenopathy

References:

Bailey and Love's Short Practice of Surgery, 28th Edition, Pg.1308.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q16: A patient with pulmonary tuberculosis is diagnosed with ulcers in the terminal ileum. Which form of gastrointestinal tuberculosis is characterized by this presentation? (Q849148)

A. Hyperplastic tuberculosis with intestinal wall thickening.

B. Ulcerative tuberculosis with transverse ulcers and serosal thickening.

C. Crohn's disease with abscesses and fistulas.

D. Hyperplastic tuberculosis with abscesses and fistulas.

Correct Answer: B. Ulcerative tuberculosis with transverse ulcers and serosal thickening.

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Ulcerative tuberculosis is characterized by multiple transverse ulcers in the terminal ileum and the thickening of the serosa. Pathological Variants of GI Tuberculosis: Variant Description Ulcerative Tuberculosis (Option B) Caused by ingestion of Mycobacterium tuberculosis , often in those with pulmonary TB. Results in multiple transverse ulcers, primarily in the terminal ileum. Leads to thickening and inflammation of the serosa, covered in tubercles. Hyperplastic Tuberculosis (Option A ruled out) Develops in individuals with high resistance to Mycobacterium tuberculosis who ingest the bacteria. Commonly affects the ileocaecal region and distal ileum. Causes chronic inflammation in lymphoid follicles, thickening of the intestinal wall, and narrowing of the lumen. Less likely to cause abscesses and fistulas, and often presents with regional lymph node involvement with potential caseation.

References:

Bailey and Love's Short Practice of Surgery, 28th Edition, Page 1308

↑ *Back to this question in Part A*

@Neet_pg_bot

Q17: A 35-year-old male presents with symptoms of abdominal pain and weight loss. He has a history of pulmonary tuberculosis. On examination, his abdomen is tender in the right iliac fossa. A barium follow-through study reveals a long, narrow filling

defect in the terminal ileum. Which of the following is the most likely diagnosis? (Q849147)

A. Crohn's disease

B. Hyperplastic tuberculosis

C. Appendicitis

D. Carcinoma of the ileum

Correct Answer: B. Hyperplastic tuberculosis

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The patient presents with abdominal pain, weight loss, and right iliac fossa tenderness , along with a history of pulmonary tuberculosis , which strongly suggests intestinal tuberculosis . The barium follow-through showing a long, narrow filling defect in the terminal ileum is characteristic of hyperplastic tuberculosis , where there is marked bowel wall thickening and luminal narrowing due to chronic granulomatous inflammation. The ileocaecal region is the most common site of involvement in gastrointestinal tuberculosis. Etiopathogenesis of Gastrointestinal Tuberculosis (GI TB) Hyperplastic Tuberculosis Cause Ingestion of Mycobacterium tuberculosis by individuals with high resistance. Affected Area The ileocaecal region; can also affect the distal ileum Characteristics Chronic inflammation in lymphoid follicles. Thickening of the intestinal wall and lumen narrowing. Rare abscess and fistula formation. Early involvement of regional lymph nodes, which may caseate Barium follow-through and CT Long narrow filling defect CT shows a narrowed segment with proximal distension Crohn’s disease (Option A) can also involve the terminal ileum and cause strictures, but it typically shows skip lesions, cobblestone appearance, and string sign due to transmural inflammation . There is no history of tuberculosis , and systemic features like perianal disease or fistulae are more common. The presence of prior pulmonary TB strongly favors intestinal TB over Crohn’s disease. Appendicitis (Option C) presents with acute onset pain , usually starting in the periumbilical region and localizing to the right iliac fossa. It is an acute condition , not associated with chronic weight loss or long-segment narrowing on imaging . Hence, this diagnosis is unlikely. Carcinoma of the ileum (Option D) is rare and usually presents as a short, irregular constricting lesion (“apple-core” lesion) rather than a long, smooth narrowing . It is more common in older individuals and is not typically associated with a history of tuberculosis .

References:

Bailey and Love’s Short Practice of Surgery, 28th Edition, Page 933,1308

↑ *Back to this question in Part A*

@Neet_pg_bot

Q18: A 25-year-old female with a history of weight loss presents with intermittent abdominal pain, nausea, and vomiting. Imaging shows compression of the third

portion of the duodenum between the aorta and the superior mesenteric artery. Conservative dietary management has failed. What is the next best step in management? (Q849146)

A. Laparoscopic duodenojejunostomy

B. Open duodenal bypass surgery

C. Continued conservative management

D. Open duodenojejunostomy

Correct Answer: A. Laparoscopic duodenojejunostomy

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Laparoscopic duodenojejunostomy is the preferred surgical option for treating superior mesenteric artery syndrome after conservative management has failed due to its minimally invasive approach. Superior Mesenteric Artery (SMA) Syndrome: Description : This rare condition is characterized by compression of the third portion of the duodenum between the aorta and the superior mesenteric artery. Symptoms : This leads to proximal small bowel obstruction, especially in individuals with significant weight loss or other risk factors. Surgical Treatments for SMA Syndrome Treatment Type Description Strong Procedure Duodenum is mobilized by dividing the ligament of Treitz. Once the duodenal jejunal junction is mobilized, the duodenum is positioned to the right of the superior mesenteric artery Laparoscopic Duodenojejunostomy (Option A) Optimal definitive treatment; involves creating a bypass from the duodenum to the jejunum. Open Surgical Procedures (Option B & D ruled out) Employed when laparoscopic methods are not feasible or have failed. Other Interventions Conservative management (dietary modifications, nutritional support) is attempted first but often fails. (Option C ruled out)

References:

www.ncbi.nlm.nih.gov/books/NBK482209/

↑ *Back to this question in Part A*

@Neet_pg_bot

Q19: A 30 y/o male with a history of rapid weight loss presents with severe postprandial abdominal pain and vomiting. The physician suspects Superior Mesenteric Artery (SMA) syndrome. Which imaging technique is most suitable for visualizing the compression of the duodenum by the SMA and accurately measuring the aortomesenteric angle? (Q849145)

A. Endoscopy

B. Computed Tomography (CT) Scan

C. Barium X-ray Study

D. Abdominal Ultrasound

Correct Answer: B. Computed Tomography (CT) Scan

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: A CT scan is the preferred diagnostic tool for SMA syndrome . A computed tomography (CT) offers detailed visualization of the duodenum, SMA, and aorta. It enables precise measurement of the aortomesenteric angle and distance, which are critical for confirming the diagnosis. Additionally, it can detect associated complications, such as acute pancreatitis or gastric necrosis, making it the most comprehensive method.

References:

www.ncbi.nlm.nih.gov/pmc/articles/PMC10294176/pdf/WJCC-11-3369.pdf, Pages 3374,3375

↑ *Back to this question in Part A*

@Neet_pg_bot

Q20: Which of the following is NOT TRUE regarding superior mesenteric artery syndrome? (Q849144)

A. Early satiety and postprandial epigastric pain are present.

B. The knee to the chest or left lateral decubitus position alleviates symptoms.

C. Presentation is always acute, needing emergency intervention.

D. All of the above.

Correct Answer: C. Presentation is always acute, needing emergency intervention.

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Depending on the severity of the duodenal obstruction, pain can be intermittent to constant. Clinical manifestations of SMA syndrome: The most common symptoms are epigastric pain, nausea, and vomiting. Others: abdominal distension, weight loss, early satiety and postprandial epigastric pain which worsens in the supine position. (Option A ruled out) Pain can be intermittent or constant depending on the severity. Alleviating factors: Increasing the angle which can be demonstrated in a prone, knee to the chest, or left lateral decubitus position. (Option B ruled out) Can present as acute or chronic. (Option C) In the acute phase : Severe intestinal obstruction

can be life-threatening. In the chronic state : Intermittent postprandial pain, nausea, vomiting, and weight loss, thus worsening the syndrome.

References:

Sabiston Textbook of Surgery, 21st edition, Pg.1297

https://www.ncbi.nlm.nih.gov/books/NBK482209/

↑ *Back to this question in Part A*

@Neet_pg_bot

Q21: Which part of the duodenum is compressed in superior mesenteric artery syndrome? (Q849143)

A. First

B. Second

C. Third

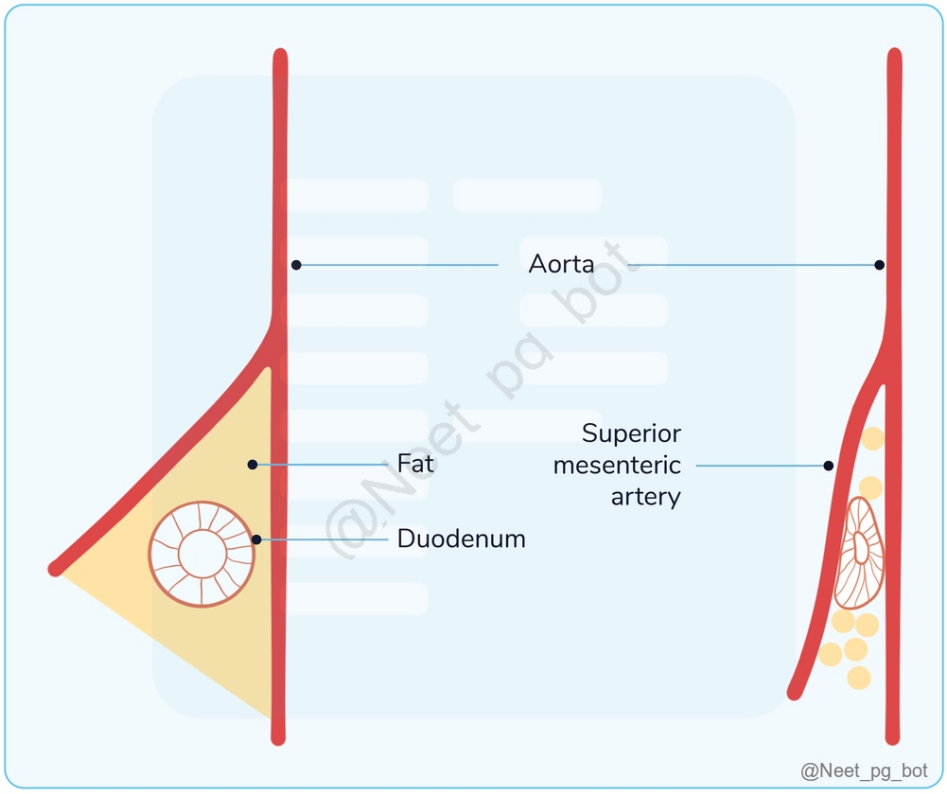
D. Fourth

Correct Answer: C. Third

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Superior mesenteric artery syndrome or Wilkie syndrome, or Cast syndrome is characterized by compression of the third portion of the duodenum by the artery as it passes over the third part of the duodenum. Rare cause of proximal small bowel obstruction.



References:

Sabiston Textbook of Surgery, 21st Edition, Page 1297

Superior Mesenteric Artery Syndrome

↑ *Back to this question in Part A*

@Neet_pg_bot

Q22: A 6-year-old boy is diagnosed with symptomatic Meckel's diverticulum after presenting with painless rectal bleeding. The diverticulum is found to be inflamed and with ulcers in the base. Which of the following surgical procedures is most appropriate for this patient? (Q849142)

A. Amputation at base and invagination.

B. Resection of small bowel with diverticulum.

C. Ileostomy.

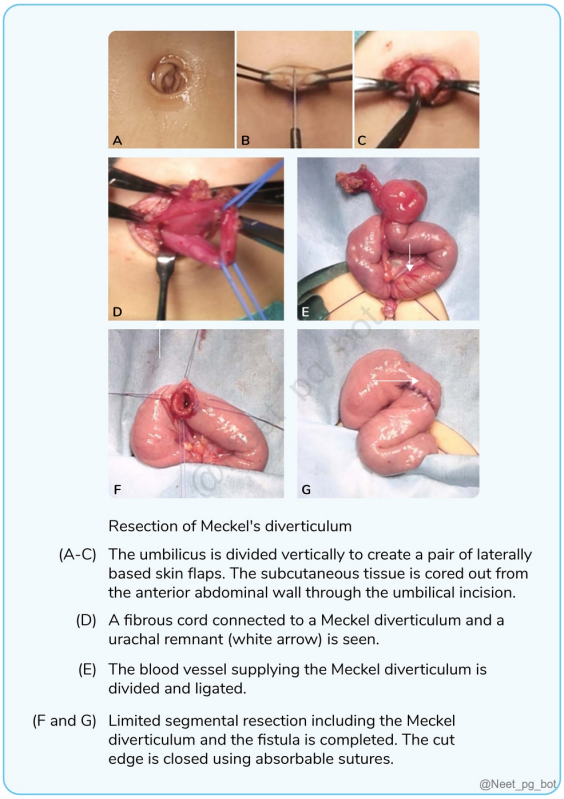
D. Diverticulectomy.

Correct Answer: B. Resection of small bowel with diverticulum.

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: If the base of the diverticulum is unhealthy (indurated, ulcerated), it is safer to perform limited small bowel resection of the involved segment, followed by anastomosis. Treatment of Meckel's diverticulum: Healthy base (no induration or ulceration) : Diverculectomy (excision of the diverticulum only) + anastomosis. (Option D ruled out) Unhealthy base (ulceration, presence of gastric mucosa) : Resection of the small bowel with the diverticulum + anastomosis. (Option B) Incidentally detected during an elective surgery: Diverculectomy is performed as it has an increased risk of complications (12% risk if left untreated). (a-c) The umbilicus is divided vertically to create a pair of laterally based skin flaps. The subcutaneous tissue is cored out from the anterior abdominal wall through the umbilical incision (d) A fibrous cord connected to a Meckel diverticulum and a urachal remnant (white arrow) is seen (e) The blood vessel supplying the Meckel diverticulum is divided and ligated (f and g) Limited segmental resection including the Meckel diverticulum and the fistula is completed. The cut edge is closed using absorbable sutures



References:

Bailey and Love's Short Practice of Surgery, 28th Edition, Page 1312

Sabiston Textbook of Surgery, 21st Edition, Page 1290.

www.ncbi.nlm.nih.gov/books/NBK499960/

↑ *Back to this question in Part A*

@Neet_pg_bot

Q23: A 7-year-old boy presents with intermittent episodes of blood in his stools without pain. On examination, there are no signs of acute abdomen. Blood investigations reveal he is anemic. Which is the investigation of choice in this case for Meckel's diverticulum? (Q849141)

A. USG abdomen

B. Colonoscopy

C. Tc-pertechnetate scan

D. CT abdomen

Correct Answer: C. Tc-pertechnetate scan

- *Listen (English)*
- *Listen (Hindi)*

Explanation: 99mTc-pertechnetate scan is the investigation of choice for Meckel’s diverticulum in the presence of gastric mucosa which is suspected due to painless bleeding in this case scenario. Investigations in Meckel’s diverticulum: 99mTc-pertechnetate scan: Absorbed by the ectopic gastric mucosa, allowing for visualization. Sensitivity is 85%, specificity is 95%, and an accuracy of 90% in the pediatric age group. (Option C) Plain abdominal radiography, CT abdomen (Option D ruled out) , and ultrasonography (Option A ruled out) are seldom useful. Endoscopy: (Option B ruled out) Helpful in false-negative cases, but not the investigation of choice.



References:

Bailey and Love's Short Practice of Surgery, 28th Edition, Page1311, 1312,

Sabiston Textbook of Surgery, 21st Edition, Page 1289, 1290

Meckel Diverticulum

↑ *Back to this question in Part A*

@Neet_pg_bot

Q24: A 2-year-old boy presents with painless rectal bleeding. CT scans show a diverticulum 2 inches long located around 2 feet proximal to the ileocaecal valve. A Technetium-99m pertechnetate scan shows an area of increased uptake in the right lower quadrant. What is the most likely type of ectopic mucosal tissue found in the diverticulum that can explain these findings? (Q849140)

A. Gastric

B. Pancreatic

C. Colonic

D. Jejunal

Correct Answer: A. Gastric

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: In this scenario, the boy is most likely to be having Meckel's diverticulum and ulcers are formed in the surrounding area due to acid secreted from the ectopic gastric mucosa in Meckel's diverticulum, which causes bleeding. The 99mTc-pertechnetate scan helps in the visualization of the ectopic gastric mucosa. Most common ectopic mucosa in Meckel's diverticulum is Gastric (Option A) > Pancreatic > Colonic Rule of 2 in Meckel's diverticulum: Seen in 2% of the population. Usually, the length is 2 inches Location: 2 feet proximal to the ileocecal junction. Diameter: 2 cm. Mostly symptomatic in children <2 years of age.

References:

Bailey and Love's Short Practice of Surgery, 28th Edition, Page 1311, 1312

Sabiston Textbook of Surgery, 21st Edition, Page 1288, 1289.

↑ *Back to this question in Part A*

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Q25: Which of the following characteristics is true regarding Meckel's diverticulum? (Q849139)

A. Located approximately 30 cm from the ileocecal valve.

B. Always lined with ectopic pancreatic tissue

C. Arises from the mesenteric border of the ileum.

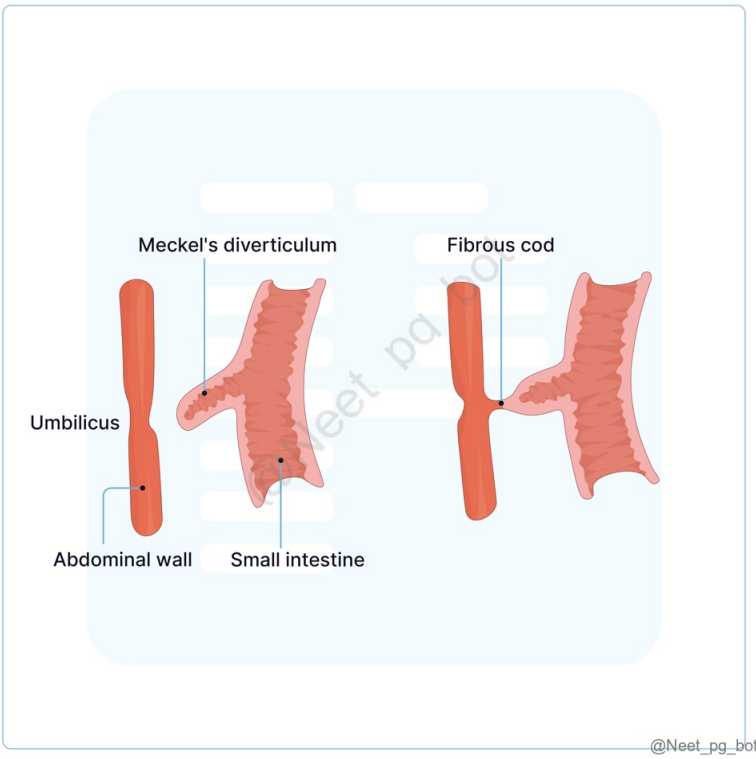
D. Contains all the layers of the bowel wall.

Correct Answer: D. Contains all the layers of the bowel wall.

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Meckel's diverticulum contains all three coats of the bowel wall and has its own blood supply. Anatomy of Meckel's diverticulum : Embryology: Persistent remnant of the Vitello-intestinal duct or omphalomesenteric duct. Location: Antimesenteric side of the ileum (Option C ruled out) , approximately 60 cm from the ileocaecal valve. (Option A ruled out) Size: 5 cm long. It contains all three coats of the bowel wall and has its own blood supply. (Option D) Lined by pluripotent cells. Most commonly lined by gastric mucosa (50%). Pancreatic mucosa only in 5% of cases. (Option B ruled out)



References:

Bailey and Love’s Short Practice of Surgery, 28th Edition, Page 1311

Sabiston Textbook of Surgery, 21st Edition, Page 1289

Meckel’s diverticulum

↑ *Back to this question in Part A*

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• [05_Gastrointestinal Surgery] 024 Intestinal Obstruction

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[05_Gastrointestinal Surgery] 024 Intestinal Obstruction — Quick Jump

Q1 (p. 1969) *Q2 (p. 1970)* *Q3 (p. 1970)* *Q4 (p. 1971)* *Q5 (p. 1975)* *Q6 (p. 1977)*
Q7 (p. 1979) *Q8 (p. 1980)* *Q9 (p. 1982)* *Q10 (p. 1982)* *Q11 (p. 1984)*

Q1: Which of the following statements regarding intraoperative findings for treatment of large bowel obstruction is incorrect? (Q849076)

A. A distended caecum during laparotomy indicates a large bowel obstruction.

B. Emergency caecostomy can be done to stabilize the patient.

C. A collapsed caecum during laparotomy suggests a large bowel obstruction.

D. Resection and anastomosis are appropriate treatments for Crohn's disease

Correct Answer: C. A collapsed caecum during laparotomy suggests a large bowel obstruction.

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: A collapsed caecum indicates that the obstruction is in the small bowel. In contrast, a distended caecum is indicative of a large bowel obstruction. Management of Large Bowel Obstruction: Surgical Management: Malignant Lesions: Resectable Lesions: Perform emergency right hemicolectomy with primary anastomosis if the patient's condition allows. Non-Resectable Lesions: Consider proximal stoma (colostomy or ileostomy) or ileo-transverse bypass. Splenic Flexure Obstruction: Extended right hemicolectomy with ileo-descending anastomosis. Left Colon or Rectosigmoid Junction Obstruction: Immediate resection unless contraindicated. Emergency Procedures: Imminent Perforation: Perform emergency caecostomy or loop colostomy/ileostomy to stabilize the patient. (Option B) Intraoperative Considerations: Colostomy: Often performed if the distal bowel cannot be closed; Hartmann’s procedure if the distal bowel is not suitable for closure. Anastomosis: Consider using proximal colon if feasible, with on-table colonic lavage for decompression and cleaning. Palliative and Preoperative Stenting: Self-Expanding Metal Stent: Preferred in palliative care. Stenting as a Bridge to Surgery: Recommended for potentially curable left-sided colon cancer. Alternative to Stenting: Decompressing Stoma: If colonic stenting is not feasible Adhesions: Perform adhesiolysis. Malignancy: Resection and anastomosis (for peritoneal carcinomatosis) Hernia: Perform reduction Crohn's Disease: Resection and anastomosis (Option D) Laparotomy Findings: Distended Caecum: Indicates large bowel obstruction. (Option A) Collapsed Caecum: Indicates small bowel obstruction.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1389.

↑ *Back to this question in Part A*

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Q2: A 45-year-old patient with a history of previous abdominal surgeries presents with severe abdominal pain that initially started as crampy but has become constant and steady. The patient has a temperature of 102 degrees, 128 beats per minute heart rate, and elevated white blood cell count. Which diagnostic test is most appropriate for confirming in this patient? (Q849077)

A. Abdominal X-ray

B. CECT

C. USG abdomen

D. MRI abdomen

Correct Answer: B. CECT

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: This is a case of strangulating obstruction , characterized by constant, steady pain, fever, tachycardia, and elevated white blood cell count. Given the patient's history of previous abdominal surgeries, there is a risk of adhesions leading to strangulation. Contrast-enhanced CT (CECT) is the most appropriate diagnostic test to confirm this condition, as it provides detailed images that help identify bowel ischemia and assess vascular compromise effectively. Strangulating obstruction Feature Strangulating Obstruction Definition Mechanical obstruction with compromised blood supply. Pain Constant, steady pain. Systemic Symptoms Fever, tachycardia, and elevated white blood cell count. Diagnostic Tests Contrast-Enhanced CT (CECT) for detailed evaluation. Additional Features Systemic signs of infection (e.g., fever) and inflammation. Management Requires urgent surgical intervention to address ischemia and restore blood flow .

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1376.

↑ *Back to this question in Part A*

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Q3: A 55-year-old female patient presents with a history of abdominal surgery performed 3 days ago. She reports worsening abdominal distension and has not passed

stool since the surgery. On examination her abdomen is distended, and bowel sounds are absent. Which of the following statements is correct regarding this condition? (Q849078)

A. Caused by increased peristaltic activity.

B. Surgery is the first-line treatment.

C. X-ray shows dilated bowel loops and air-fluid levels

D. Associated with hyperkalemia.

Correct Answer: C. X-ray shows dilated bowel loops and air-fluid levels

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: This presentation is consistent with Paralytic Ileus, a condition where impaired peristaltic activity results in decreased bowel motility. Characterized by: Impaired intestinal motility due to failure of peristaltic wave transmission. Collection of food and fluid in the bowel (Option A). Abdominal distension . Etiology Abdominal surgery. Uremia. Mesenteric ischemia. Retroperitoneal hematoma. Intra-abdominal sepsis. Dyselectrolytemia (e.g., hypokalemia) (Option D ruled out). Drugs affecting intestinal motility: Opiates. Antipsychotics. Investigations IOC: Abdominal X-ray. (Option C ruled out) Findings: Dilated bowel loops. Gas in the colon and rectum. Multiple air-fluid levels.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1391,1392. Sabiston Textbook of Surgery- 21st Edition, Page 262,263 Postoperative Ileus - StatPearls - NCBI Bookshelf (nih.gov)

↑ *Back to this question in Part A*

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Q4: A 4-year-old boy is brought with intermittent episodes of severe abdominal pain, during which he pulls his knees to his chest and cries inconsolably. He passed a small amount of "red, jelly-like" stool. On examination, the child appears pale, lethargic, and mildly dehydrated. What is the most likely abdominal CT finding seen in this condition? (Q849079)

A. Target sign

B. Claw sign

C. Coiled spring sign

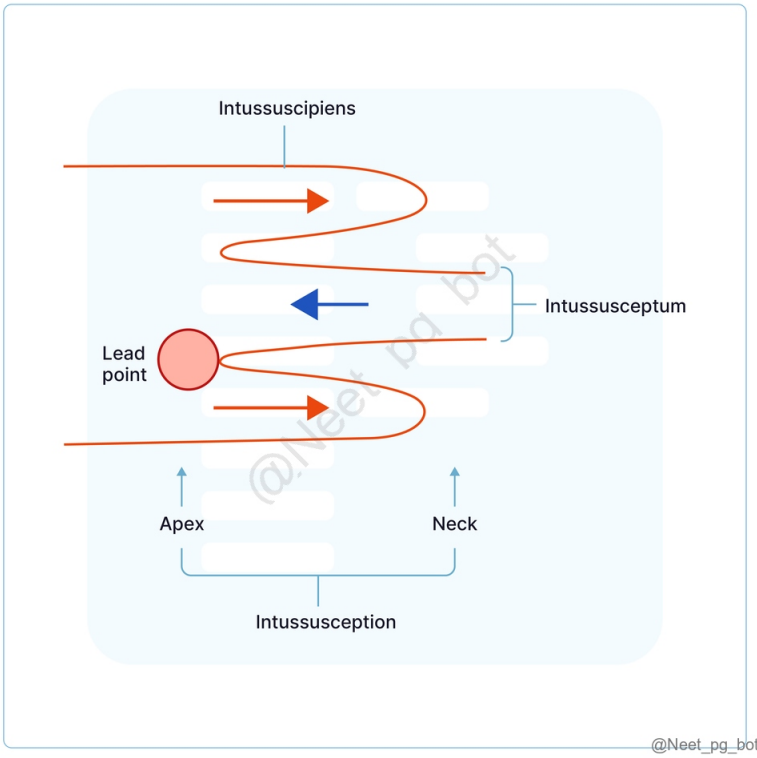
D. Coffee bean sign

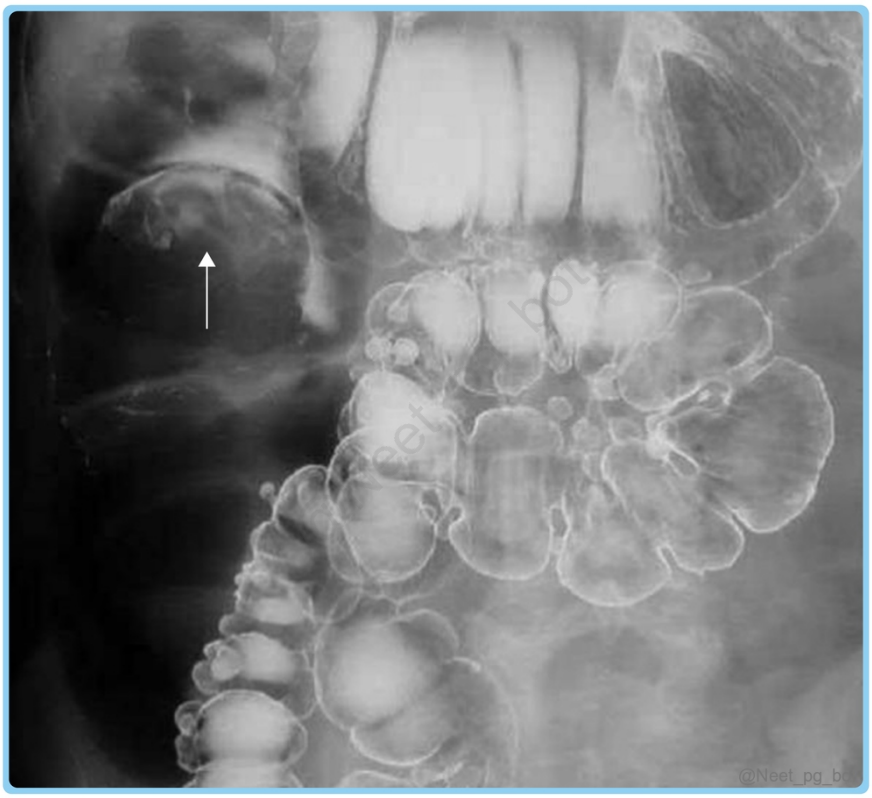
Correct Answer: A. Target sign

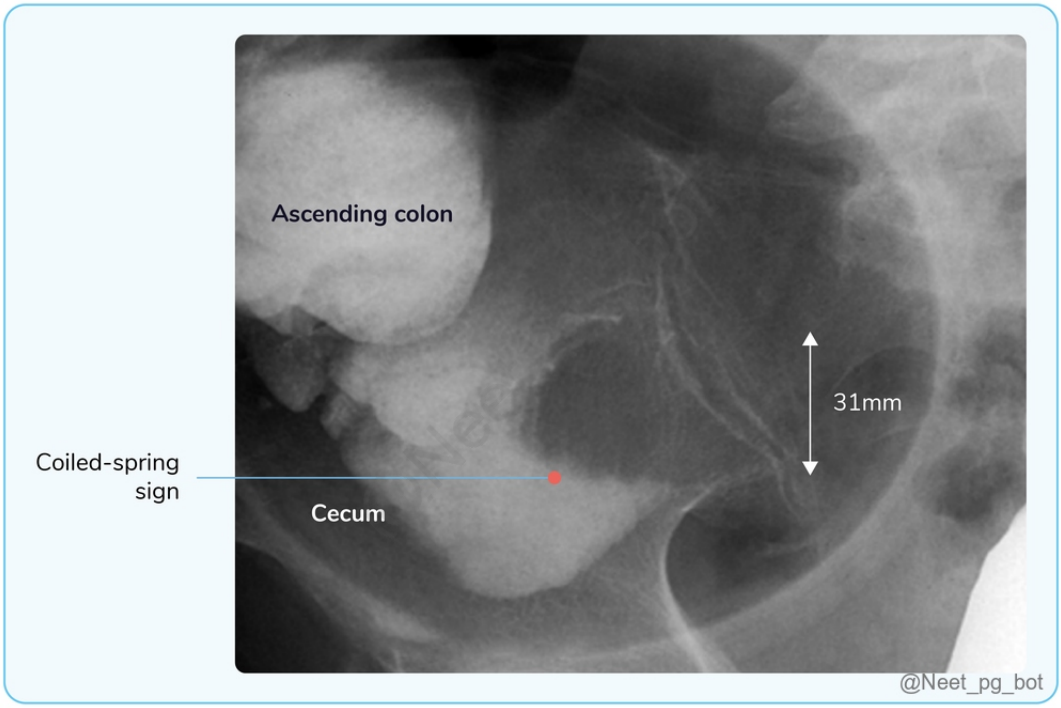
■ *Listen (English)*

■ *Listen (Hindi)*

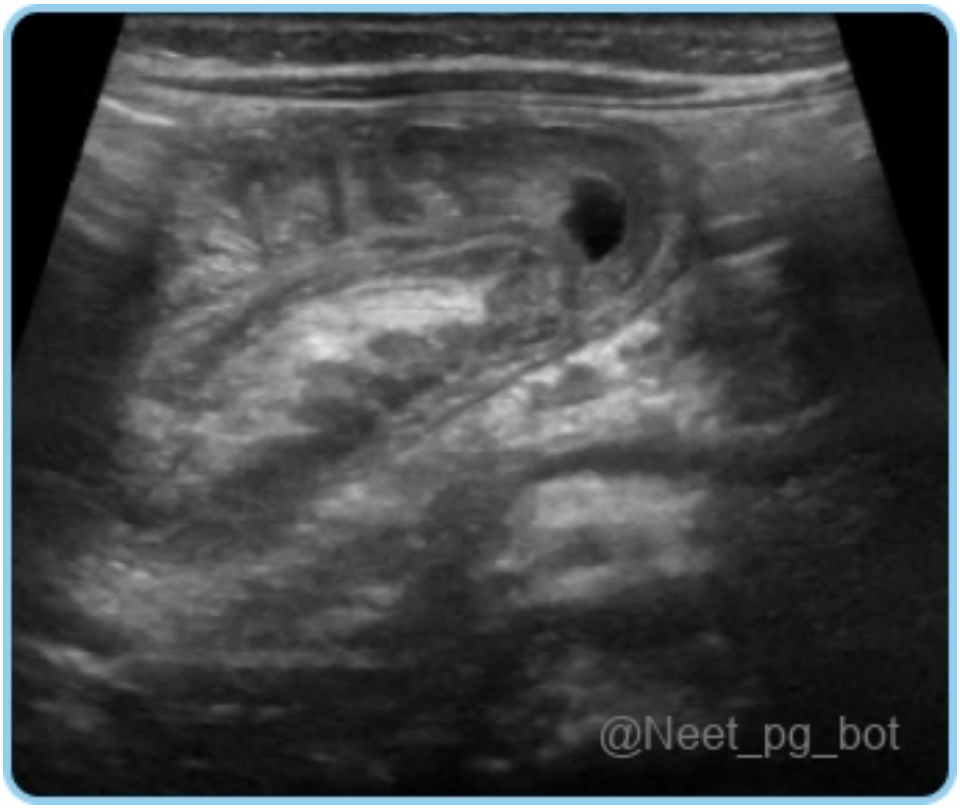
Explanation: Intussusception is the most probable diagnosis in this scenario Presents most commonly in children with episodic abdominal pain, lethargy, vomiting, and "red currant jelly" stools Target sign is seen in the CT abdomen due to telescoping of one segment of the bowel into another Intussusception: It is telescoping of one segment of the bowel into another Most common type in adults is colo-colic. Lead point is usually meckel's diverticulum, polyp, malignancy etc. Parts of Intussusception: Clinical manifestations: Colicky pain Episodes of crying, vomiting (bilious), and drawing up of the legs to the chest The attacks last for a few minutes In between the attacks, the child is asymptomatic Stool mixed with blood and mucus - ' redcurrant jelly' stool On rectal examination, blood-stained mucus may be found on the finger On per abdomen examination: Sausage-shaped lump with concavity towards the umbilicus Emptiness in right iliac fossa- the sign of Dance Investigations: USG is the IOC in children and CECT is the IOC in adults. Barium enema: Claw sign (Option B) Coiled spring sign (Option C) Ultrasound/CT: Target /donut/ bull's eye sign- transverse view (Option A) Pseudokidney sign- longitudinal view X-ray abdomen: Multiple air-fluid levels suggestive of bowel obstruction




@Neet_pg_bot


Ascending colon
31mm
Coiled-spring sign
Cecum
@Neet_pg_bot





References:

Bailey & Love's Short Practice of Surgery- 28th Edition, Page 1378-79, 1383-85, 1388

Sabiston Textbook of Surgery- 21st Edition, Page 262, 263.

SRB's Manual of Surgery- 6th Edition, Page 921

↑ *Back to this question in Part A*

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Q5: A 75-year-old male patient, bedridden after hip surgery, presents with a 4-day history of progressive abdominal distension, nausea, and constipation. On physical examination, his abdomen is distended but non-tender, with decreased bowel sounds. An abdominal X-ray shows dilated loops of colon, particularly in the cecum, but no air-fluid levels or evidence of mechanical obstruction. His vital signs are stable, and there is no fever. Which of the following drugs is commonly used in pharmacologic treatment of this condition? (Q849080)

A. Loperamide

B. Neostigmine

C. Stimulant laxatives

D. Osmotic laxatives

Correct Answer: B. Neostigmine

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Neostigmine is a parasympathomimetic drug , which is the preferred treatment in colonic pseudo-obstruction It causes strong colonic peristalsis that usually leads to subsequent flatus and bowel movements Colonic Pseudo-Obstruction (Ogilvie's syndrome): It is massive dilatation of the colon with obstructive symptoms but in the absence of mechanical obstruction. Investigations: X-ray abdomen: Colonic dilatation Definitive investigation- CT Treatment: Correction of risk factors: Correct fluid and electrolyte imbalance factors Stop offending drugs like opioids, anticholinergics, and calcium channel blockers Empty the rectum by enemas and/or flatus tube Endoscopic decompression: Colonoscopy +/– flatus tube Pharmacological treatment: Intravenous neostigmine (Option B) Contraindicated in: Arrhythmia Bronchospasm Surgery: Subtotal colectomy with ileostomy





References:

Bailey & Love's Short Practice of Surgery- 28th Edition, Page 1293, 1294.

Sabiston Textbook of Surgery- 21st Edition, Page 1344

↑ *Back to this question in Part A*

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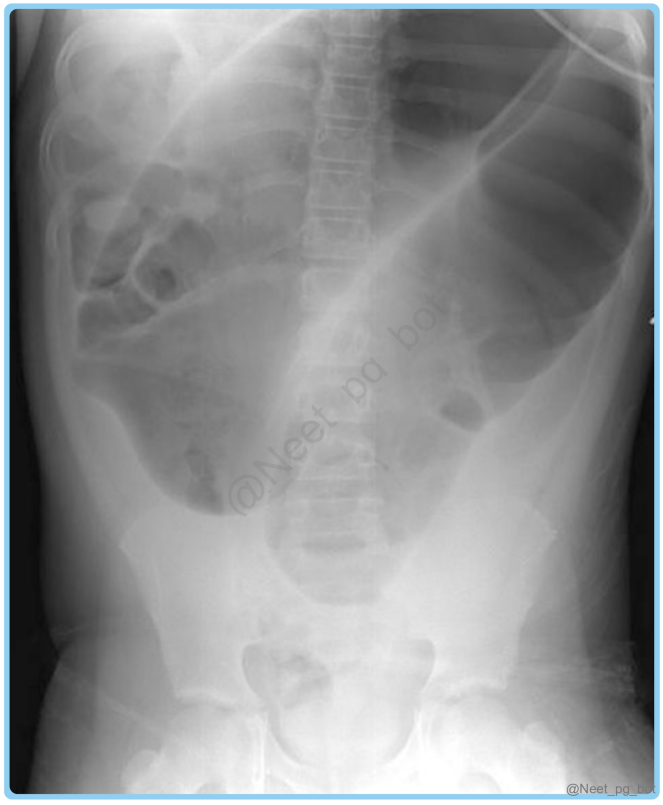
Q6: A 72-year-old male presents with a 2-day history of progressive abdominal distension, constipation, and colicky pain. He has a history of chronic constipation and has been bedridden for the past few months due to a hip fracture. On examination, his abdomen is distended and tympanic, with mild tenderness. Abdominal guarding and rigidity not observed. X-ray of the abdomen is shown below. Which of the following factors does not predispose to this condition? (Q849081)

A. Chronic constipation with laxative abuse

B. Anticholinergic drugs

C. Mentally-retarded individuals

D. Short pelvic mesocolon



Correct Answer: D. Short pelvic mesocolon

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Based on the clinical presentation and coffee bean sign in the X-ray abdomen, the most probable diagnosis is sigmoid volvulus Long pelvic mesocolon allows the sigmoid colon to move excessively, predisposing it to twist upon its own mesenteric axis causing sigmoid volvulus. Sigmoid volvulus: It is the twist (rotation) in the axis of the loop of the bowel Predisposing factors: High-residue diet Elderly patients with chronic constipation (Option A ruled out) Chronic psychotropic drug Anticholinergic drugs (Option B ruled out) Mentally-retarded individuals (Option C ruled out) Adhesions; Peridiverticulitis Overloaded redundant pelvic colon Long pelvic mesocolon (Option D) Narrow attachment of sigmoid mesocolon Investigations: Plain X-ray omega sign- single grossly distended loop of colon arising out of the pelvis and extending towards the diaphragm. Coffee-bean sign or Bent-inner tube sign Contrast enema: Bird's beak sign (ace of spades appearance)- Upper end of the barium column tapers into the spirally twisted distal sigmoid colon.





References:

Bailey & Love's Short Practice of Surgery- 28th Edition, Page 1293, 1380, 1383, 1385, 1390

SRB’s Manual of Surgery- 6th Edition, Page 922, 923.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q7: Which of the following options is not true regarding caecal volvulus? (Q849082)

A. Rotation is more commonly seen in clockwise direction

B. Caecal volvulus involves the terminal ileum and the right colon

C. In caecal bascule, there is axial twisting

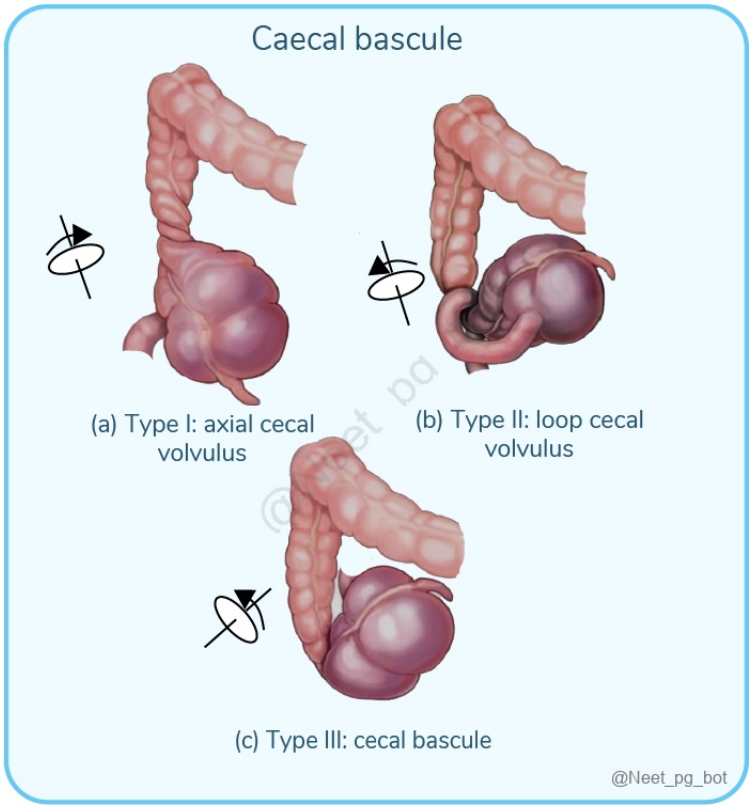
D. Clinically, it may manifest as small bowel obstruction

Correct Answer: C. In caecal bascule, there is axial twisting

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The caecal bascule is the upward folding of the caecum and there is no axial twisting Caecal volvulus: Caecum, terminal ileum, and right colon are involved in the volvulus (Option B ruled out) Caecal bascule is the upward folding of the cecum anteriorly and there is no axial twisting. Only caecum is involved in this. Rotation is more commonly clockwise (Option A ruled out) {{caption_text}} Clinical features: Since the ileum is involved, patients have signs and symptoms of small bowel obstruction (Option D ruled out) Colicky pain Multiple episodes of bilious vomiting Obstipation Ischaemia is common



References:

Bailey & Love's Short Practice of Surgery- 28th Edition, Page 1383, 1385, 1390

Cecal Volvulus - StatPearls - NCBI Bookshelf (nih.gov)

Cecal bascule – An unusual cause of intestinal obstruction: A case report - PMC (nih.gov)

↑ *Back to this question in Part A*

@Neet_pg_bot

Q8: Which of the following is/are components of Hartmann’s procedure? (Q849083)

A. Sigmoidectomy

B. Closure of rectal stump

C. Descending colostomy

D. All of the above

Correct Answer: D. All of the above

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Components of Hartmann’s procedure are rectosigmoid resection, closure of the rectal stump, and formation of an end colostomy. Hartmann’s procedure: Developed due to high rates of anastomotic failure and mortality following resection and primary anastomosis in obstructing left-sided colonic carcinoma In elderly people, anastomosis is not preferred during an emergency Hence, instead of performing anastomosis, we go for Hartman's procedure to manage Sigmoidectomy in the elderly It is usually followed by subsequent re-anastomosis Components: Rectosigmoid resection Closure of the rectal stump Formation of an end colostomy



References:

Bailey & Love's Short Practice of Surgery- 28th Edition, Pg No. 1389-90

Hartmann’s procedure, reversal and rate of stoma-free survival - PMC (nih.gov)

↑ *Back to this question in Part A*

@Neet_pg_bot

Q9: A 45-year-old man with a history of abdominal surgery presents with severe crampy abdominal pain and bilious vomiting. On examination, his abdomen is distended, and he has not had a bowel movement for three days. Which of the following is the most likely cause of his obstruction? (Q849073)

A. Pelvic Adhesions

B. Colorectal Cancer

C. Inguinal Hernia

D. Crohn's Disease

Correct Answer: A. Pelvic Adhesions

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The patient shows symptoms of small bowel obstruction, including severe crampy abdominal pain, bilious vomiting, abdominal distension, and constipation. Most likely due to pelvic adhesions, often a result of previous abdominal surgery. Small Bowel Obstruction (SBO) Causes Adhesions (Option A) (Most common) Malignancy Metastasis Peritoneal carcinomatosis Hernia Crohn's Disease Tb PID Post radiotherapy Cancer

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1381

SRB's Manual of Surgery, 6th Edition, Page 909-912

↑ *Back to this question in Part A*

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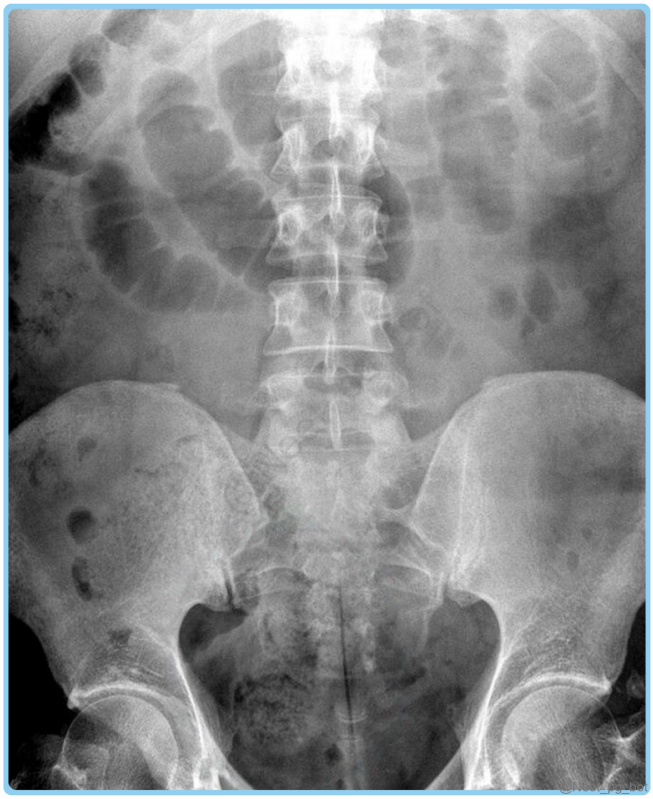
Q10: A 50-year-old man presents with acute abdominal pain, and bilious vomiting. Physical examination reveals a distended abdomen, and he has not had a bowel movement for three days. An abdominal X-ray is shown below. What is the most appropriate next step in management ? (Q849074)

A. Administer oral laxatives

B. Start IV fluids (RL)

C. Exploratory laparotomy

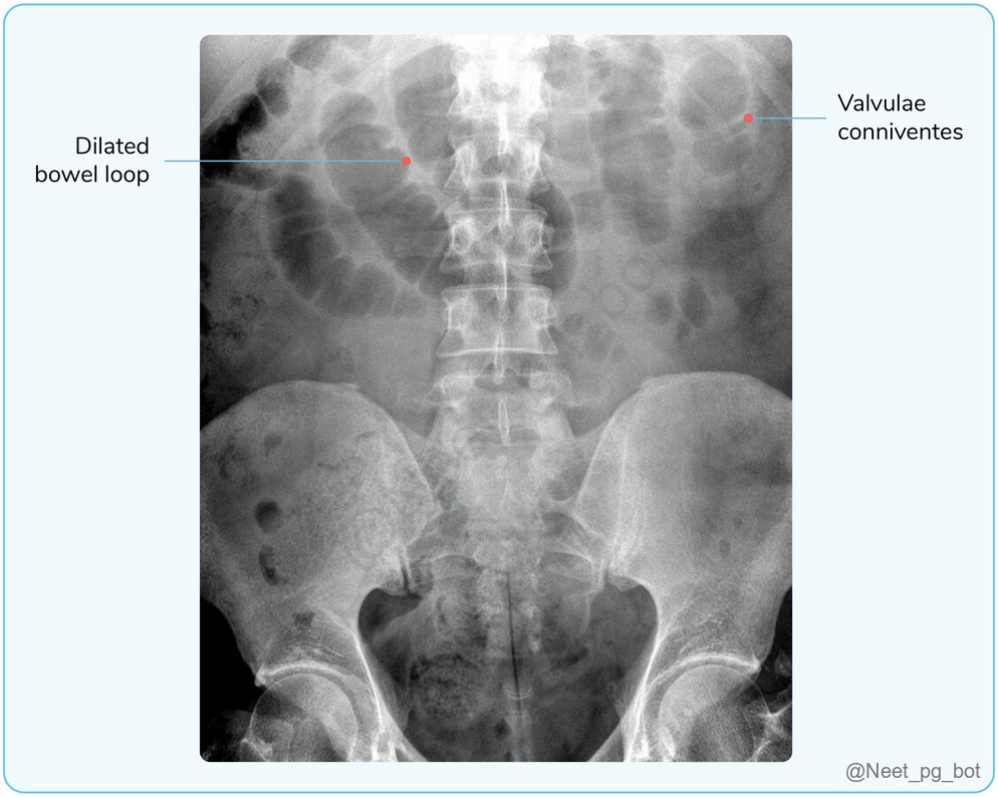
D. IV Prokinetics



Correct Answer: B. Start IV fluids (RL)

- *Listen (English)*
- *Listen (Hindi)*

Explanation: The patient’s presentation of acute abdominal pain, distension, and bilious vomiting, along with the abdominal X-ray findings showing dilated bowel loops and valvulae conniventes, confirms the diagnosis of small bowel obstruction (SBO). T he best initial step is to start IV fluids (RL). Management of Small Bowel Obstruction: Initial Steps: NIL per oral Insert 2 large-bore IV cannulas. Start IV fluids. (Option B) Fluid of choice: Ringer's lactate. Proximal Decompression with nasogastric aspiration Monitoring, including urine output, and supportive treatment



References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1384.

SRB’s Manual of Surgery, 6th Edition, Page 912-914.

↑ *Back to this question in Part A*

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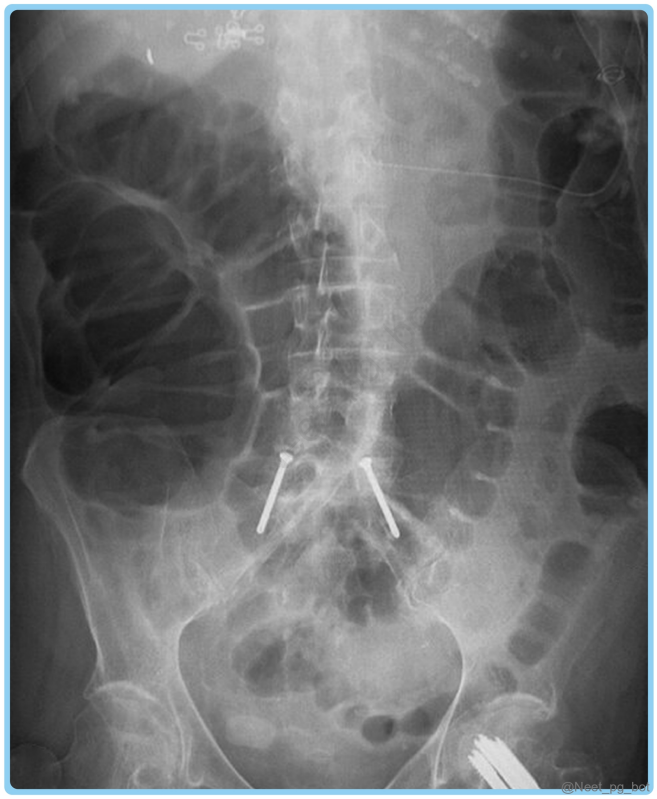
Q11: Based on the findings visible in the X-ray, all of the following are true, except: (Q849075)

A. Haustral folds are irregularly spaced and do not span the full lumen

B. Dilated bowel loops are typically peripheral in location on a supine film

C. Haustral markings do not form complete mucosal rings across the bowel

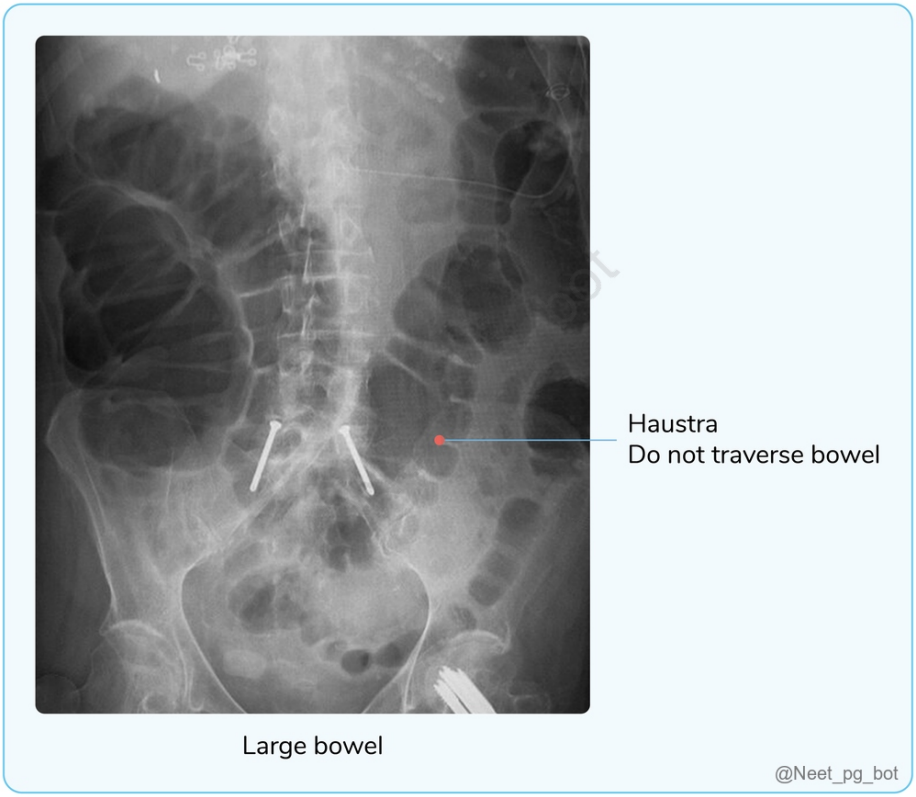
D. Presence of centrally located featureless loops without haustra is typical of large bowel obstruction



Correct Answer: D. Presence of centrally located featureless loops without haustra is typical of large bowel obstruction

- *Listen (English)*
- *Listen (Hindi)*

Explanation: Centrally located, smooth, featureless loops without haustra describe small bowel obstruction , not large bowel obstruction. The X-ray provided shows features of large bowel obstruction , including peripheral dilated bowel loops with visible haustral markings that are irregularly spaced and do not span the full diameter of the bowel. These are classic characteristics of large bowel dilation. Features of large bowel obstruction: Haustral folds are irregularly spaced and do not cross the entire lumen (Option A). Dilated large bowel loops appear peripherally on a supine film (Option B). Haustral folds do not form complete mucosal rings (Option C).



References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1384.

↑ *Back to this question in Part A*

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• [05_Gastrointestinal Surgery] 025 Large Intestine-I

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[05_Gastrointestinal Surgery] 025 Large Intestine-I — Quick Jump

Q1 (p. 1987)	*Q2 (p. 1988)*	*Q3 (p. 1989)*	*Q4 (p. 1990)*	*Q5 (p. 1992)*	*Q6 (p. 1992)*
Q7 (p. 1993)	*Q8 (p. 1994)*	*Q9 (p. 1995)*	*Q10 (p. 1996)*	*Q11 (p. 1997)*	*Q12 (p. 1998)*
Q13 (p. 1999)	*Q14 (p. 1999)*	*Q15 (p. 2000)*	*Q16 (p. 2001)*	*Q17 (p. 2002)*	*Q18 (p. 2003)*
Q19 (p. 2004)	*Q20 (p. 2005)*	*Q21 (p. 2006)*	*Q22 (p. 2007)*	*Q23 (p. 2008)*	*Q24 (p. 2013)*
Q25 (p. 2013)	*Q26 (p. 2016)*	*Q27 (p. 2016)*			

Q1: Which of the following statements about diverticulitis is incorrect? Diverticulitis often presents with abdominal pain localized to the lower left side. A barium enema is a preferred imaging method for diagnosing diverticulitis. Colostomy is often performed as a first-line treatment. Stage Ib of the Modified Hinchey Classification refers to a pericolic abscess. Complications of diverticulitis may include fistula formation, such as colovesical fistula. (Q849048)

A. 1 and 5

B. 2 and 4

C. 4 and 5

D. 2 and 3

Correct Answer: D. 2 and 3

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Diverticulitis Definition Inflammation or infection of diverticula in the colon. Etiology Obstruction (fecal matter or food): Trapped fecal matter or food causes pressure and inflammation. Bacterial infection: Infection occurs when bacteria proliferate in obstructed diverticula. Pathophysiology Increased pressure from trapped fecal matter can lead to inflammation, infection, and sometimes perforation of the diverticula. Symptoms Abdominal pain (lower left side) (Statement 1 ruled out) Fever Nausea, vomiting Change in bowel habits (diarrhea or constipation) Tenderness on examination Diagnosis CT Scan (IOC): Preferred for detailed imaging of the colon, identifying inflammation and abscesses. Ultrasound: Can detect inflammation and abscesses, but less detailed than CT. Blood Tests: Elevated white blood cell count suggests infection or inflammation. Barium Enema (contraindicated) (Statement 2): Should be avoided as it can worsen symptoms. Management Antibiotics Pain management (analgesics) Dietary modifications (clear liquids, then low-fiber, high-fiber) Surgery (for severe cases or complications) Resection: Removal of the affected segment of the colon to treat severe diverticulitis or

complications. Colostomy (Statement 3) : Creation of an abdominal opening for waste elimination, often used in severe cases. Drainage of Abscesses: Percutaneous or surgical methods to drain abscesses associated with diverticulitis. Modified Hinchey Classification (Severity of acute diverticulitis) Stage 0: Mild diverticulitis Stage I: Ia: Pericolic inflammation Ib: Pericolic abscess (Statement 4 ruled out) Stage II: Pelvic or intra-abdominal abscess Stage III: Purulent peritonitis Stage IV: Fecal peritonitis Complications Hemorrhage (painless and profuse) Perforation (can cause pericolic abscess) Intestinal Obstruction (large or small bowel) Fistula Formation (e.g., colovesical) (Statement 5 ruled out) Leads to frequent UTIs, fecaluria, pneumaturia

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1368-1370.

Schwartz's Principles of Surgery, 11th Edition, Page 1286-1288.

SRB's Manual of Surgery, 6th Edition, Page 879-882.

↑ *Back to this question in Part A*

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Q2: Which variant of Familial Adenomatous Polyposis is associated with both colorectal cancer and brain tumors? (Q849052)

A. Classic FAP

B. Attenuated FAP

C. Gardner's Syndrome

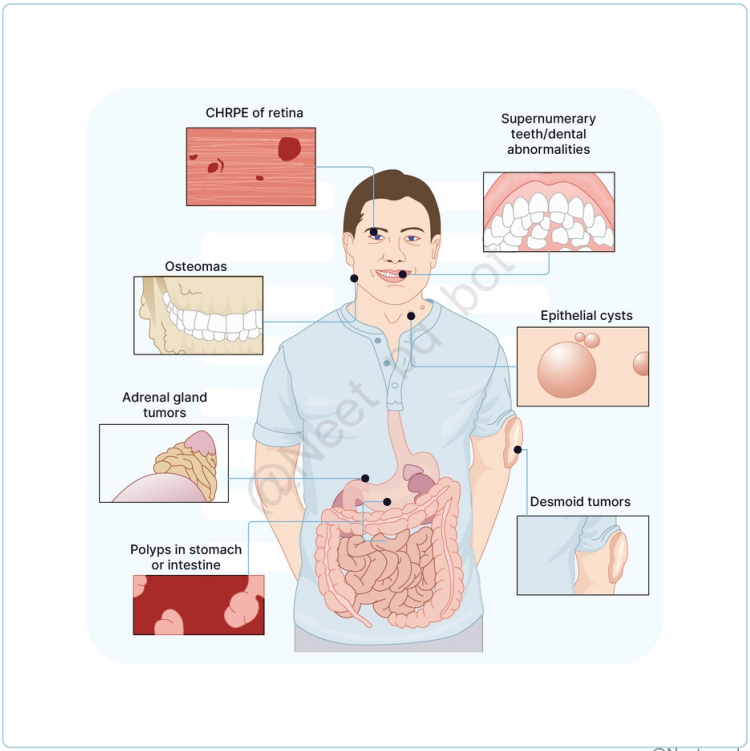
D. Turcot Syndrome

Correct Answer: D. Turcot Syndrome

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Turcot syndrome is associated with both colorectal cancer and brain tumors. Variants of FAP: Classic FAP (Option A) Most common form with extensive polyps Attenuated FAP (Option B) Milder form with fewer polyps Gardner syndrome (Option C) Classic FAP + additional tumors Turcot syndrome (Option D) FAP variant with brain tumor Gardner Syndrome Turcot Syndrome Autosomal dominant variant Autosomal recessive variant Associated with Osteoma Congenital Hypertrophy of retinal Pigment Epithelium(CHRPE) Desmoid tumor Epidermoid cyst Supernumerary teeth Benign lymphoid polyposis of ileum Sebaceous cyst Associated with brain tumors in both FAP and lynch syndrome In FAP, causes Medulloblastoma. In lynch syndrome, causes Glioblastoma multiforme.



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References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1356

Gardner syndrome

↑ *Back to this question in Part A*

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Q3: A 45-year-old woman presents with a history of recurrent colorectal cancer. Her family history reveals that her mother was diagnosed with endometrial cancer at age 50, and her aunt had ovarian cancer. Genetic testing is recommended. What is the most likely diagnosis? (Q849053)

A. Cowden Syndrome

B. Lynch Syndrome

C. Peutz-Jeghers Syndrome

D. MUTYH-Associated Polyposis (MAP)

Correct Answer: B. Lynch Syndrome

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The patient presents with recurrent colorectal cancer along with a strong family history of endometrial and ovarian cancers , which is highly suggestive of Lynch syndrome (Hereditary Non-Polyposis Colorectal Cancer, HNPCC) . It is an autosomal dominant disorder caused by mutations in DNA mismatch repair (MMR) genes such as MLH1, MSH2, MSH6, and PMS2 , leading to microsatellite instability . Lynch syndrome is characterized by: Early-onset colorectal cancer Association with endometrial cancer (most common extracolonic malignancy) Increased risk of ovarian, gastric, small bowel, and urinary tract cancer The family history involving multiple Lynch-associated cancers across generations strongly supports this diagnosis. Amsterdam II Criteria Three or more family members with Lynch syndrome-related cancer, one of whom is a 1° relative Two or more successive affected generations At least one tumor diagnosed before the age of 50 years FAP excluded Cowden Syndrome (Option A) is associated with mutations in the PTEN gene and presents with: Multiple hamartomas Increased risk of breast, thyroid (follicular), and endometrial cancers It is not primarily associated with colorectal cancer recurrence or mismatch repair defects . Peutz-Jeghers Syndrome (Option C) is characterized by: Hamartomatous polyps in the GI tract Mucocutaneous pigmentation (around lips, buccal mucosa) Although there is an increased cancer risk, the hallmark features are pigmentation and polyps , which are not mentioned in this case. MUTYH-Associated Polyposis (MAP) (Option D) is an autosomal recessive condition characterized by: Multiple adenomatous polyps (similar to attenuated FAP) Increased risk of colorectal cancer However, it is not associated with strong extracolonic cancers like endometrial and ovarian cancers , and the inheritance pattern does not fit the family history.

References:

Bailey & Love’s Short Practice of Surgery, 28th Edition, Page 1358

↑ *Back to this question in Part A*

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Q4: A 35-year-old woman presents with multiple oral papillomas, facial trichilemmomas, and a history of thyroid nodules. She also reports that her mother had breast cancer at a young age. On examination, multiple small, wart-like growths on her hands is noted. What is the most likely diagnosis? (Q849054)

A. Neurofibromatosis

B. Cowden disease

C. Peutz-Jeghers syndrome

D. Gardner syndrome

Correct Answer: B. Cowden disease

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The most likely diagnosis in the above case scenario is Cowden disease. Cowden disease / Multiple Hamartomas: Loss of PTEN function leads to activation of the PI3K/AKT/mTOR pathway, promoting cell proliferation and survival. Clinical manifestations such as Hamartomas , Trichilemmomas, papillomatous papules, acral keratoses, Oral papillomas, Multinodular goiter, and adenomas. Patients need to have two major criteria to be diagnosed with Cowden disease. (One of the two must be either Lhermitte-Duclos disease or macrocephaly) Lhermitte-Duclos disease Thyroid carcinoma Macrocephaly Breast cancer Treatment: Surveillance, Removal of symptomatic hamartomas or cancers, and cutaneous lesions treated with surgical excision and 5-fluorouracil. Neurofibromatosis (Option A) presents with neurofibromas, café-au-lait spots, axillary freckling, and lisch nodules in the iris. It does not present with oral papillomas, trichilemmomas, or PTEN-related features. Peutz-Jeghers syndrome (Option C) is characterized by mucocutaneous pigmentation (around lips, buccal mucosa) and hamartomatous GI polyps. There are no papillomas or trichilemmomas, and pigmentation (not wart-like lesions). Gardner syndrome (Option D) presents with multiple colonic adenomatous polyps, osteomas, epidermoid cysts, and desmoid tumors. It does not show mucocutaneous papillomas or trichilemmomas.



References:

www.ncbi.nlm.nih.gov/books/NBK525984/

Sabiston Textbook of Surgery, 21st Edition, Page 672

↑ *Back to this question in Part A*

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Q5: Which of the following endoscopic findings is considered the earliest and most characteristic lesion seen in Crohn's disease? (Q883976)

A. Cobblestoning mucosa

B. Deep serpiginous ulcers

C. Aphthous ulcers

D. Pseudopolyps

Correct Answer: C. Aphthous ulcers

Explanation: In early Crohn's disease , aphthous ulcers - small, superficial, punched-out ulcers surrounded by a rim of erythematous mucosa are the earliest visible endoscopic lesions. These result from the expansion of submucosal lymphoid follicles. Cobblestoning and deeper serpiginous ulcers develop as the disease progresses and becomes more severe. (Option A, B ruled out) Pseudopolyps (inflammatory polyps) (Option D) are seen in both Crohn’s disease and ulcerative colitis as a result of healing and regeneration; they are not an early finding.

References:

Bailey & Love’s Short Practice of Surgery, 28th Edition, Page 1329.

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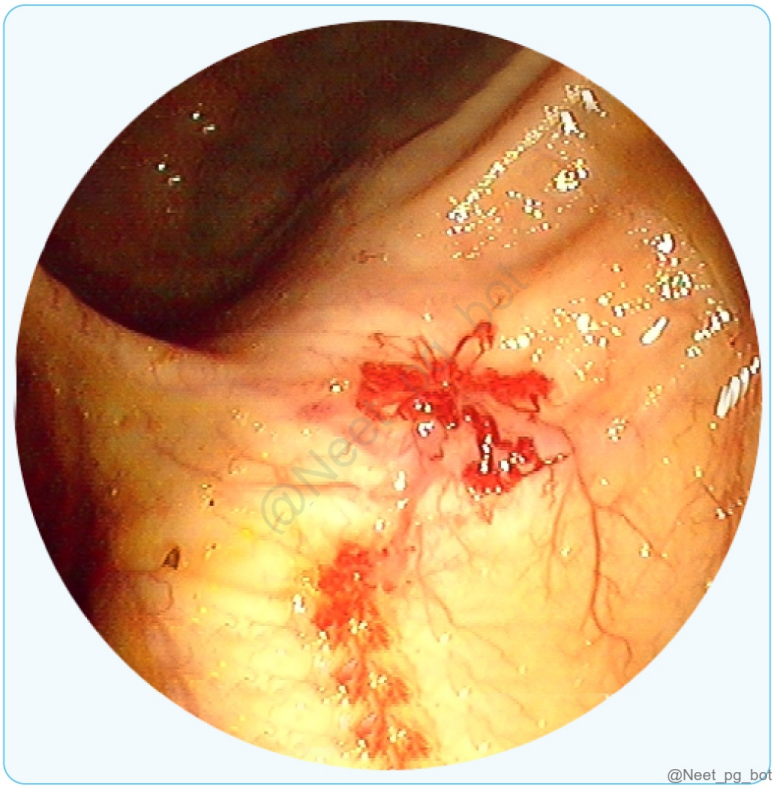
Q6: A 75-year-old patient presents with recurrent episodes of painless lower gastrointestinal bleeding. Colonoscopy is performed, and the image above is obtained. What is the most likely diagnosis? (Q883989)

A. Diverticular bleeding

B. Colonic carcinoma

C. Angiodysplasia

D. Ulcerative colitis



Correct Answer: C. Angiodysplasia

Explanation: The image shows a flat, bright red vascular lesion with a fern-like or spider-like pattern of dilated mucosal vessels, characteristic of colonic angiodysplasia. Angiodysplasia is a common cause of painless lower GI bleeding in the elderly. These are degenerative vascular lesions that appear endoscopically as flat, red, fern-like or stellate patches, most commonly located in the cecum and right colon. Diverticular bleeding is also common but typically presents with abrupt, painless maroon or bright red bleeding and is often seen in the sigmoid colon. Diverticular bleeding (Option A) : Diverticular bleeding typically appears as active bleeding or a visible vessel in a diverticulum, not as a flat, fern-like vascular lesion. It is also more common in the left colon. Colonic carcinoma (Option B) : Colonic carcinomas are usually polypoid, ulcerated, or mass-like lesions, not flat, red, fern-like vascular lesions. Ulcerative colitis (Option D) : Ulcerative colitis presents with diffuse mucosal inflammation, ulceration, and friability starting in the rectum, not as an isolated cecal vascular lesion.

References:

Sabiston Textbook of Surgery, 21st Edition, Page 1163.

↑ *Back to this question in Part A*

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Q7: Which colonic region is most vulnerable to ischemic colitis due to its watershed vascular supply? (Q883988)

A. Cecum

B. Hepatic flexure

C. Rectum

D. Splenic flexure

Correct Answer: D. Splenic flexure

Explanation: The splenic flexure (Griffith's point) is the most common site for ischemic colitis because it is a watershed area between the superior mesenteric artery (SMA) and inferior mesenteric artery (IMA) circulations. The marginal artery of Drummond may be tenuous here, making this region particularly susceptible to low-flow states or arterial occlusion. The rectosigmoid junction (Sudeck's point) is another watershed area but is less commonly affected than the splenic flexure. Cecum (Option A) : The cecum is supplied by the ileocolic artery (from the SMA) and is less commonly affected in typical non-occlusive ischemic colitis compared to watershed areas. Hepatic flexure (Option B) : The hepatic flexure is supplied by the right colic artery (from the SMA) and is not a classic watershed zone like the splenic flexure. Rectum (Option C) : The rectum has a dual blood supply (superior rectal artery from the IMA and middle/inferior rectal arteries from the internal iliac arteries), making it relatively resistant to ischemia.

References:

Schwartz’s Principles of Surgery, 11th Edition, Page 1309.

↑ *Back to this question in Part A*

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Q8: The radiographic finding of "thumbprinting" on a plain abdominal X-ray is most indicative of which pathological process? (Q883987)

A. Intraluminal faecal impaction

B. Colonic submucosal oedema or haemorrhage

C. Extrinsic compression by an abdominal mass

D. Pneumatosis intestinalis

Correct Answer: B. Colonic submucosal oedema or haemorrhage

Explanation: Thumbprinting on abdominal X-ray refers to smooth, rounded, thumb-like impressions along the colonic wall caused by submucosal oedema or haemorrhage. This nonspecific sign can be seen in conditions such as i schemic colitis, pseudomembranous colitis, inflammatory bowel disease, or infectious colitis. It reflects thickening of the bowel wall rather than an intraluminal or extrinsic process. Intraluminal faecal impaction (Option A) : Faecal impaction appears as a large, heterogeneous intraluminal mass with stool density, not as regular,

thumb-like indentations of the colonic wall. Extrinsic compression by an abdominal mass (Option C) : Extrinsic compression typically causes a smooth, broader indentation from outside the bowel, not multiple, rounded, submucosal-type impressions like thumbprinting. Pneumatosis intestinalis (Option D) : Pneumatosis intestinalis appears as linear or cystic intramural gas, not as soft■tissue thumb■like projections into the lumen.

References:

Sabiston Textbook of Surgery, 21st Edition, Page 1359

↑ *Back to this question in Part A*

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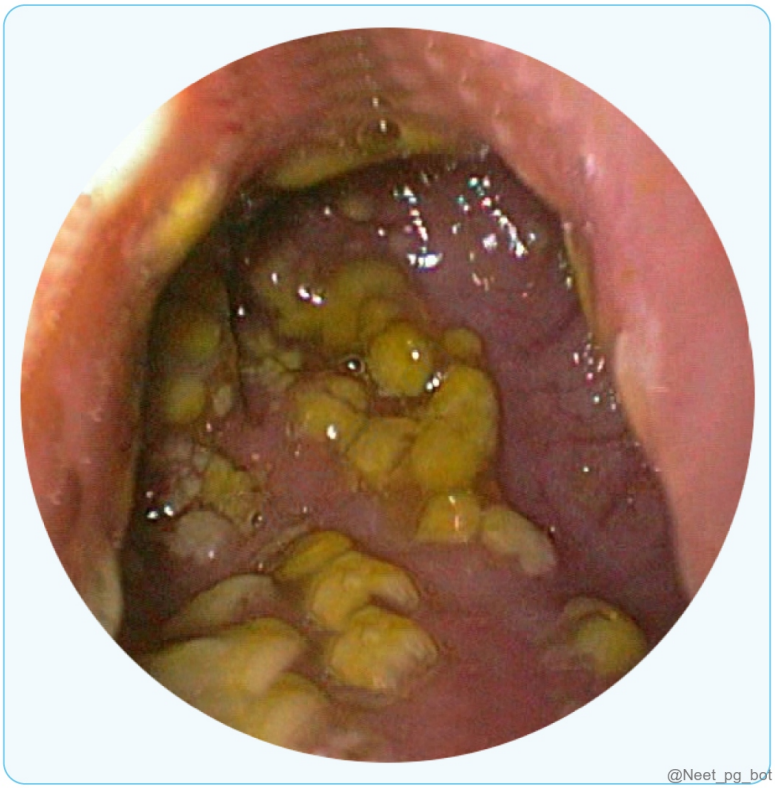
Q9: A 64-year-old woman was recently treated for antibiotic-associated diarrhea and initially improved. Two weeks later, she returns with recurrent abdominal cramps and foul-smelling watery diarrhea. Stool toxin assay is positive for Clostridioides difficile. Sigmoidoscopy findings are shown above. What is the preferred antibiotic for management at this stage? (Q883986)

A. Oral metronidazole

B. Intravenous vancomycin

C. Oral fidaxomicin

D. Oral ciprofloxacin



Correct Answer: C. Oral fidaxomicin

Explanation: The image shows yellow-white pseudomembranes adherent to the colonic mucosa on endoscopy, characteristic of pseudomembranous colitis caused by Clostridioides difficile. For the first recurrence of C. difficile infection (including moderate cases), oral fidaxomicin is the preferred drug of choice due to its narrow spectrum and lower recurrence rates compared to vancomycin. Oral vancomycin is an alternative. Oral metronidazole (Option A) : Metronidazole is no longer recommended for recurrent CDI except when other agents are unavailable, due to higher relapse rates and potential toxicity with prolonged use. Intravenous vancomycin (Option B) : Intravenous vancomycin does not achieve adequate luminal concentrations in the colon and is ineffective for treating CDI. Only oral/enteral vancomycin is effective. Oral ciprofloxacin (Option D) : Ciprofloxacin is a fluoroquinolone antibiotic that can precipitate CDI and is not used for its treatment.

References:

Harrison's Principles of Internal Medicine, 21st Edition, Page 1069.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q10: In which patient population is a colovesical fistula due to diverticulitis most commonly seen? (Q883985)

A. Young women

B. Men and women equally

C. Women who have had a hysterectomy

D. Men

Correct Answer: D. Men

Explanation: Colovesical fistula secondary to diverticulitis is more common in men because the sigmoid colon lies in direct anatomical proximity to the bladder without an intervening uterus. In women (Option A) , the uterus normally separates the sigmoid colon from the bladder, providing a protective barrier; however, women who have undergone a hysterectomy (Option C) are at increased risk due to the loss of this separation. Men and women equally (Option B) : There is a significant male predominance (≥3:1) in colovesical fistulas.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Pages 1369, 1370.

Schwartz's Principles of Surgery, 11th Edition, Page 1288.

↑ *Back to this question in Part A*

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Q11: A patient with multiple episodes of diverticulitis develops UTIs and says the urine sometimes contains air and particles resembling stool. What is the likely complication? (Q883984)

A. Emphysematous cystitis

B. Colovesical fistula

C. Pericolic abscess

D. Diverticular bleeding

Correct Answer: B. Colovesical fistula

Explanation: Pneumaturia (air in urine) and fecaluria, in the setting of recurrent diverticulitis, are classic for a colovesical fistula , which is an abnormal communication between the colon (usually sigmoid) and the bladder. This results from inflammatory erosion of a diverticulum into the adjacent bladder wall, allowing passage of gas and faecal material into the urinary tract. Emphysematous cystitis can cause pneumaturia, but it is due to gas-forming bacteria in the bladder wall, not a fistula. Emphysematous cystitis (Option A) : Emphysematous cystitis is a rare infection of the bladder wall with gas-forming bacteria, which can cause pneumaturia but is not associated with fecaluria or diverticulitis history. Pericolic abscess (Option C) : A pericolic abscess presents with

localised pain, fever, and possibly a palpable mass, but not with pneumaturia or fecaluria. Diverticular bleeding (Option D) : Diverticular bleeding manifests as acute, painless hematochezia, not urinary symptoms like pneumaturia or fecaluria.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Pages 1369, 1370.

Schwartz's Principles of Surgery, 11th Edition, Page 1288.

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Q12: A patient presents with generalised peritonitis due to perforated sigmoid diverticulitis with faecal contamination. Which surgical procedure is most appropriate in this emergency setting? (Q883983)

A. Primary anastomosis without diversion

B. Loop ileostomy

C. Hartmann's procedure

D. Total colectomy with ileorectal anastomosis

Correct Answer: C. Hartmann's procedure

Explanation: In the setting of faecal peritonitis from perforated diverticulitis, the preferred emergency surgery is Hartmann's procedure. Resection of the affected sigmoid colon, creation of an end colostomy, and closure of the distal rectal stump. This avoids a high-risk primary anastomosis in a contaminated, unstable patient. The colostomy can potentially be reversed later. Primary anastomosis without diversion (Option A) : Primary anastomosis is generally contraindicated in faecal peritonitis due to the high risk of anastomotic leak and mortality in this septic, hemodynamically unstable setting. Loop ileostomy (Option B) : A loop ileostomy is typically used for diversion with an anastomosis (e.g., in ulcerative colitis surgery) or to protect a low rectal anastomosis, not as the primary resectional procedure for perforated diverticulitis. Total colectomy with ileorectal anastomosis (Option D) : This extensive resection is not indicated for localised sigmoid diverticular disease. It is reserved for conditions like toxic megacolon, ischemic colitis, or synchronous colonic pathology.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1369.

Schwartz's Principles of Surgery, 11th Edition, Pages 1286, 1287.

↑ *Back to this question in Part A*

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Q13: An elderly patient with multiple comorbidities presents with acute complicated diverticulitis and a pericolic abscess measuring 7 cm on CT scan. What is the most appropriate initial intervention? (Q883982)

A. Immediate surgical resection

B. CT-guided percutaneous drainage and intravenous antibiotics

C. Outpatient oral antibiotics and liquid diet

D. Colonoscopic drainage

Correct Answer: B. CT-guided percutaneous drainage and intravenous antibiotics

Explanation: For a complicated diverticulitis with an abscess larger than 5 cm , especially in an elderly patient with comorbidities, the recommended initial management is CT-guided percutaneous drainage combined with intravenous antibiotics. This approach stabilises the patient and may allow for elective surgery later, if needed, rather than urgent high-risk surgery. Immediate surgery is reserved for peritonitis, perforation, or failure of percutaneous drainage. Immediate surgical resection (Option A) : Emergency surgery is typically reserved for perforation with generalised peritonitis (Hinchey III/IV) or failure of percutaneous drainage. Initial drainage and antibiotics are preferred for an accessible abscess. Outpatient oral antibiotics and liquid diet (Option C) : This conservative approach may be used for uncomplicated diverticulitis. A 6 cm abscess is complicated and requires drainage and IV antibiotics, often with hospitalisation. Colonoscopic drainage (Option D) : Colonoscopic drainage is not standard for pericolic abscesses due to the risk of perforation and incomplete drainage. Percutaneous CT-guided drainage is safer and more effective.

References:

Bailey & Love’s Short Practice of Surgery, 28th Edition, Pages 1369, 1370.

Schwartz’s Principles of Surgery, 11th Edition, Pages 1286, 1287

↑ *Back to this question in Part A*

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Q14: According to the Hinchey classification of acute diverticulitis, which stage is characterised by faecal peritonitis? (Q883981)

A. Stage I

B. Stage II

C. Stage III

D. Stage IV

Correct Answer: D. Stage IV

Explanation: The Hinchey classification for complications of acute diverticulitis is as follows: Stage Description Stage I Pericolic or mesenteric abscess (Option A) Stage II Pelvic abscess (Option B) Stage III Purulent peritonitis (Option C) Stage IV Faecal peritonitis (perforation with faecal contamination of the peritoneal cavity)

References:

Sabiston Textbook of Surgery, 21st Edition, Page 1338.

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1368.

↑ *Back to this question in Part A*

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Q15: What is currently the preferred initial imaging modality for evaluating suspected acute diverticulitis? (Q883980)

A. Barium enema

B. Plain abdominal radiography

C. Computed tomography

D. Colonoscopy

Correct Answer: C. Computed tomography

Explanation: Computed tomography (CT) of the abdomen and pelvis is the standard imaging modality for acute diverticulitis . It can accurately detect colonic wall thickening, periodic fat stranding, abscess formation, and complications like perforation, while also assessing extracolonic structures. Barium enema is contraindicated in acute settings due to the risk of perforation and extravasation. (Option A ruled out) Plain abdominal radiography (Option B): Plain films are nonspecific and insensitive for diagnosing diverticulitis. They may show ileus or free air, but cannot confirm inflammation or complications like CT can. Colonoscopy (Option D) is avoided in acute diverticulitis due to the risk of perforation. It is performed later (after 6–8 weeks) to confirm the diagnosis and rule out malignancy.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1342.

Schwartz's Principles of Surgery, 11th Edition, Page 1286-1287.

↑ *Back to this question in Part A*

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Q16: A 62-year-old man presents with intermittent lower abdominal discomfort and altered bowel habits. A contrast radiographic study of the colon is performed, and the image is shown above. The outpouchings seen in this condition are best described as which of the following? (Q883979)

A. True diverticula involve all bowel layers

B. False diverticula involving mucosa and submucosa only

C. Congenital outpouchings are most common in the cecum

D. Inflammatory pseudopolyps associated with ulcerative colitis



Correct Answer: B. False diverticula involving mucosa and submucosa only

Explanation: The image shows a barium enema demonstrating multiple small outpouchings from the colonic wall consistent with colonic diverticulosis. Colonic diverticula in diverticulosis are acquired false diverticula (pseudodiverticula) , which involve herniation of only the mucosa and submucosa through weakened points in the muscularis propria, typically where nutrient arteries penetrate the wall. They are associated with low-fibre diets

and are most common in the sigmoid colon. True diverticula involving all bowel layers (Option A) are rare in the colon and are characteristic of congenital conditions (e.g., Meckel's diverticulum), not acquired diverticulosis. Congenital outpouchings are most common in the cecum (Option C): Congenital cecal diverticula are rare true diverticula, while typical diverticulosis is acquired, left-sided (sigmoid), and age-related. Inflammatory pseudopolyps associated with ulcerative colitis (Option D): Pseudopolyps are inflammatory regenerative tissue in colitis, not diverticula. They have no structural or pathological resemblance to diverticula.

References:

Schwartz’s Principles of Surgery, 10th Edition, Page 1286.

↑ *Back to this question in Part A*

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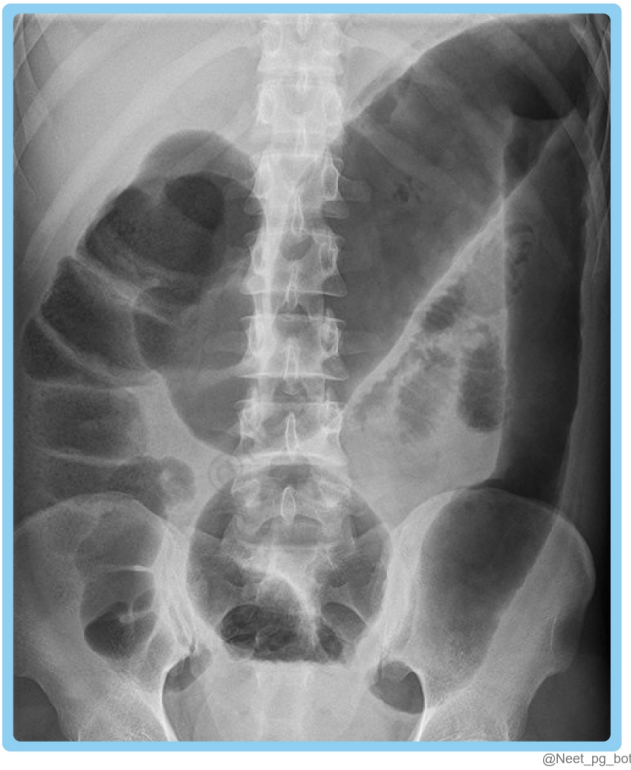
Q17: A patient with severe ulcerative colitis presents with high fever, abdominal distension, and tenderness. An abdominal X-ray shows the following findings. What is the most likely diagnosis? (Q883978)

A. Sigmoid volvulus

B. Crohn's disease flare

C. Toxic megacolon

D. Ogilvie's syndrome



Correct Answer: C. Toxic megacolon

Explanation: An ulcerative colitis patient with an abdominal X-ray showing a dilated colon with loss of haustrations, points towards toxic megacolon. Toxic megacolon is a severe, life-threatening complication of ulcerative colitis (and rarely Crohn's disease) characterised by acute colonic dilation (>6 cm), systemic toxicity, and loss of haustral markings on imaging. It is often precipitated by severe inflammation, electrolyte imbalance, or narcotics. Urgent colectomy may be required if medical management fails or if perforation occurs. Sigmoid volvulus (Option A) typically shows a “coffee■bean” shaped loop arising from the pelvis, not generalised transverse colon dilation with loss of haustra in the setting of active colitis. Crohn’s disease flare (Option B): While Crohn’s can cause severe colitis, the combination of megacolon, systemic toxicity, and known ulcerative colitis points specifically to toxic megacolon as the acute complication. Ogilvie’s syndrome (Option D): Ogilvie’s (acute colonic pseudo■obstruction) causes massive dilation but usually occurs in hospitalised, elderly, or postoperative patients without active colitis, and it lacks the systemic inflammatory signs of toxic megacolon.

References:

Bailey & Love’s Short Practice of Surgery, 28th Edition, Page 1319.

↑ *Back to this question in Part A*

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Q18: Which of the following statements is TRUE regarding the postoperative recurrence of Crohn's disease? (Q883977)

A. The risk of relapse is highest immediately after surgery and decreases over time.

B. The presence of active disease at the resection margins guarantees early recurrence.

C. The probability of symptomatic relapse increases with time since resection

D. Surgery is curative in the majority of patients with ileocecal Crohn's disease

Correct Answer: C. The probability of symptomatic relapse increases with time since resection

Explanation: Crohn’s disease is chronic and relapsing. Endoscopic recurrence occurs early (weeks-months), but clinical relapse increases progressively with time. (Option A ruled out) (Option C) Surgery relieves complications but is not curative. (Option D ruled out) Active disease at margins increases risk but does not guarantee recurrence. (Option B ruled out)

References:

Bailey & Love’s Short Practice of Surgery, 28th Edition, Page 1332.

↑ *Back to this question in Part A*

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Q19: A 45-year-old male presents with severe abdominal pain, vomiting, and abdominal distension along with tenderness. X-ray shows dilated bowel loops with air-fluid levels. The patient is taken for exploratory laparotomy. Which of the following structures is most likely to be visualized first to differentiate between small intestine and large intestine obstruction? (Q849042)

A. Cecum

B. Ileum

C. Ascending Colon

D. Sigmoid Colon

Correct Answer: A. Cecum

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The cecum, located in the right lower quadrant of the abdomen, is the first part of the large intestine and is typically the first structure visualized during surgery for suspected intestinal obstruction. It helps in differentiating between small and large intestine obstructions: Dilated cecum: Indicates a large bowel obstruction, as it is proximal to the blockage. Collapsed cecum with dilated small intestines: Suggests a small bowel

obstruction. Identifying the cecum first allows surgeons to accurately determine the obstruction site and guide appropriate surgical management.

References:

SRB's Manual of Surgery, 6th Edition, Page 913.

Gray’s Anatomy, 42nd Edition, Page 1189.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q20: A 16-year-old boy is brought to the clinic by his mother due to rectal bleeding. His father died of colon cancer at age 40. Colonoscopy reveals hundreds of polyps throughout the colon. Which of the following is the most likely diagnosis? (Q849051)

A. Crohn's disease

B. Familial adenomatous polyposis (FAP)

C. Lynch syndrome

D. Juvenile polyposis syndrome

Correct Answer: B. Familial adenomatous polyposis (FAP)

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The patient is a 16-year-old boy with rectal bleeding, a strong family history of early-onset colorectal cancer, and colonoscopy showing hundreds of polyps , which is classical for Familial Adenomatous Polyposis (FAP) . Itis an autosomal dominant disorder caused by mutation in the APC gene (chromosome 5q21) It is characterized by the development of numerous (>100) adenomatous polyps in the colon during adolescence If left untreated, FAP carries a near 100% risk of progression to colorectal cancer , usually by the 3rd–4th decade , making early diagnosis and prophylactic surgery essential Crohn’s disease (Option A) presents with abdominal pain, diarrhea, weight loss, and skip lesions on endoscopy. It does not present with hundreds of colonic polyps , and there is no strong hereditary polyposis pattern as seen in this case. Lynch syndrome (Option C) is characterized by early-onset colorectal cancer without multiple polyps . Patients typically have few or no polyps , unlike the hundreds of polyps seen in this patient, making this diagnosis unlikely. Juvenile polyposis syndrome (Option D) involves hamartomatous polyps , usually fewer in number (not typically hundreds). It presents in childhood but does not show the massive adenomatous polyposis characteristic of FAP.



References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1356, 1357

↑ *Back to this question in Part A*

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Q21: A 16-year-old girl presents with intermittent abdominal pain, occasional rectal bleeding, and pigmented macules on her lips, buccal mucosa, and digits. Her mother had similar pigmented spots. What is the most likely diagnosis? (Q849050)

A. Familial Adenomatous Polyposis (FAP)

B. Lynch Syndrome

C. Peutz-Jeghers Syndrome

D. Cowden Syndrome

Correct Answer: C. Peutz-Jeghers Syndrome

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The patient presents with intermittent abdominal pain, rectal bleeding, and characteristic mucocutaneous pigmentation over the lips, buccal mucosa, and digits , along with a positive family history , which is classical for Peutz-Jeghers syndrome (PJS) . It is an autosomal dominant disorder caused by a mutation in the STK11 (LKB1) gene The gastrointestinal symptoms are due to hamartomatous polyps , most commonly in the small intestine , which can lead to intussusception, obstruction, and bleeding . The pigmented macules (dark blue-brown spots) on mucocutaneous surfaces are a hallmark feature and are often present since childhood. Associated with increased risk of gastrointestinal, pancreatic, breast, ovarian, cervical, and testicular cancers Familial Adenomatous Polyposis (FAP) (Option A) is characterized by hundreds to thousands of adenomatous polyps in the colon with a high risk of colorectal cancer. It does not present with mucocutaneous pigmentation , which is a key feature in this case. Lynch Syndrome (Option B) presents with early-onset colorectal cancer and extracolonic malignancies but does not involve polyposis or mucocutaneous pigmentation . The absence of these hallmark features rules it out. Cowden Syndrome (Option D) is associated with oral papillomas, trichilemmomas, and a PTEN mutation , along with an increased risk of breast and thyroid cancers. It does not present with pigmented macules on the lips and digits , making it unlikely.



References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1309, 1310

↑ *Back to this question in Part A*

@Neet_pg_bot

Q22: Which of the following correctly identifies a type of non-neoplastic polyp? (Q849049)

A. Tubular adenomatous polyp

B. Sessile serrated polyp

C. Juvenile polyp

D. Villous adenomatous polyp

Correct Answer: C. Juvenile polyp

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: ■Classification of Colorectal Polyps Neoplastic Polyps Non-Neoplastic Polyps Adenomatous Polyps (Adenomas) Tubular (Option A) Villous (Option D) Tubulovillous Inflammatory Polyps Associated with inflammatory bowel disease (e.g., Crohn's disease, ulcerative colitis) Serrated Polyps Hyperplastic Polyps Sessile Serrated Adenomas (SSA/Ps) (Option B) Traditional Serrated Adenomas (TSAs) Hamartomatous Polyps Juvenile Polyps: Usually in children, generally benign but associated with Juvenile Polyposis Syndrome. (Option C) Peutz-Jeghers Polyps: Associated with Peutz-Jeghers syndrome, characterized by pigmentation around the mouth. Lymphoid Polyps Composed of lymphoid tissue, usually benign and associated with the immune response

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1355.

Schwartz's Principles of Surgery, 11th Edition, Page 1290,1291.

SRB's Manual of Surgery, 6th Edition, Page 889.

↑ *Back to this question in Part A*

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Q23: A 55-year-old patient presents with symptoms of abdominal pain and changes in bowel habits. A barium enema is performed, which reveals a characteristic finding on imaging given below. Which of the following is the most likely diagnosis? (Q849047)

A. Diverticulosis

B. Colon Cancer

C. Pseudomembranous Colitis

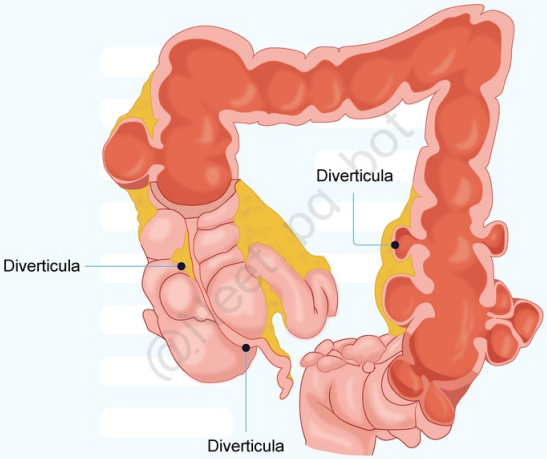
D. Ischemic colitis



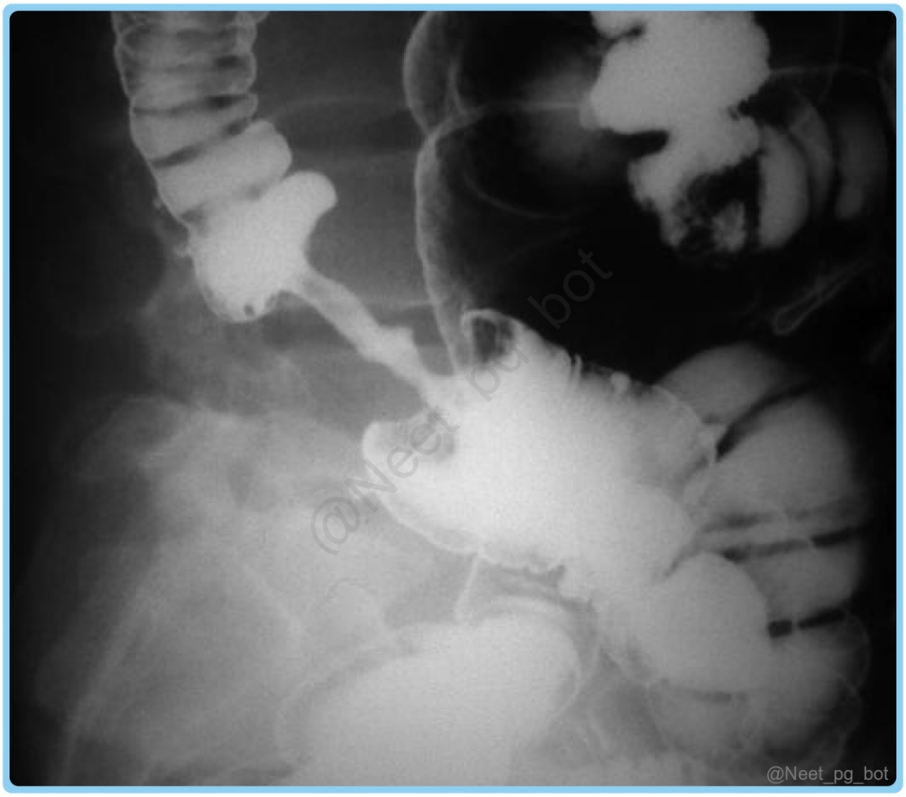
Correct Answer: A. Diverticulosis

- *Listen (English)*
- *Listen (Hindi)*

Explanation: The given image shows saw tooth appearance indicating Diverticulosis. Diverticulosis Definition Presence of small, bulging pouches (diverticula) in the colon, most commonly in the sigmoid colon. Symptoms Often asymptomatic; may include mild abdominal discomfort, bloating, and changes in bowel habits. Diagnosis (Option A) Colonoscopy: Direct visualization. CT Scan: Detailed images of the colon. Barium enema: Less common, show a characteristic sawtooth appearance Colon Cancer (Option B): On Barium enema Apple core appearance/napkin ring-like lesions are seen. Pseudomembranous colitis (Option C): In CECT, Accordion sign can be seen Ischemic colitis (Option D): On barium enema or plain x-ray, Thumb-print sign (characteristic sign) is seen.



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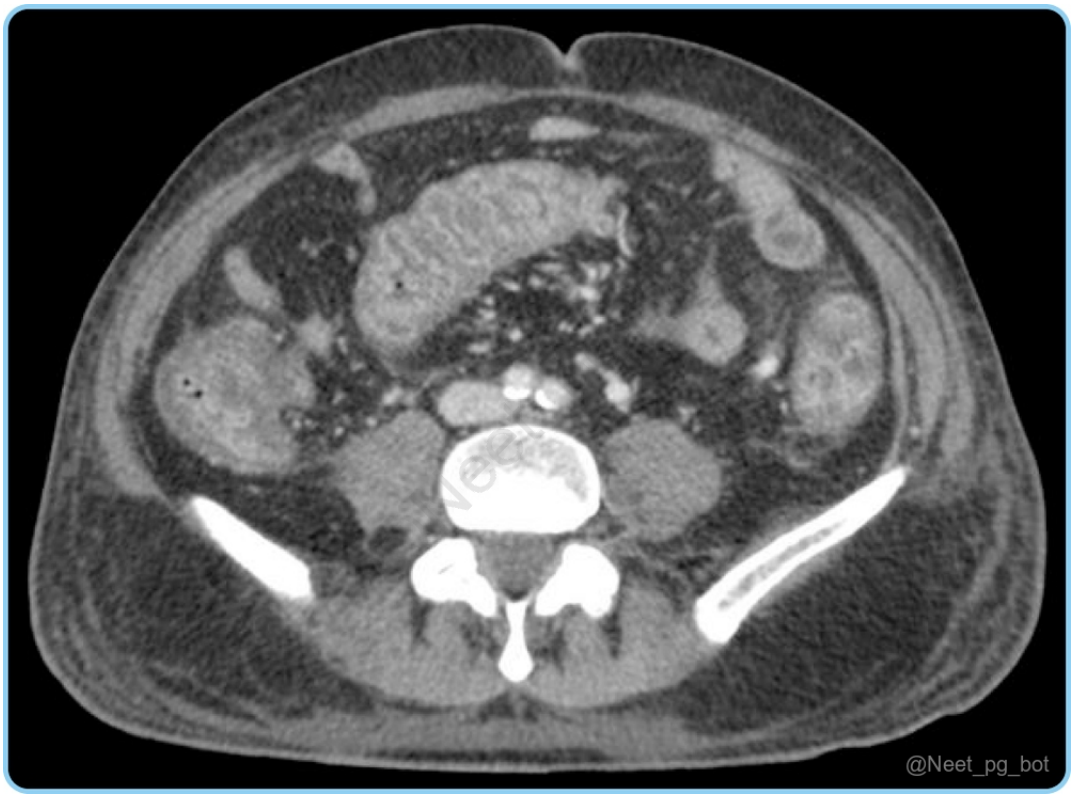


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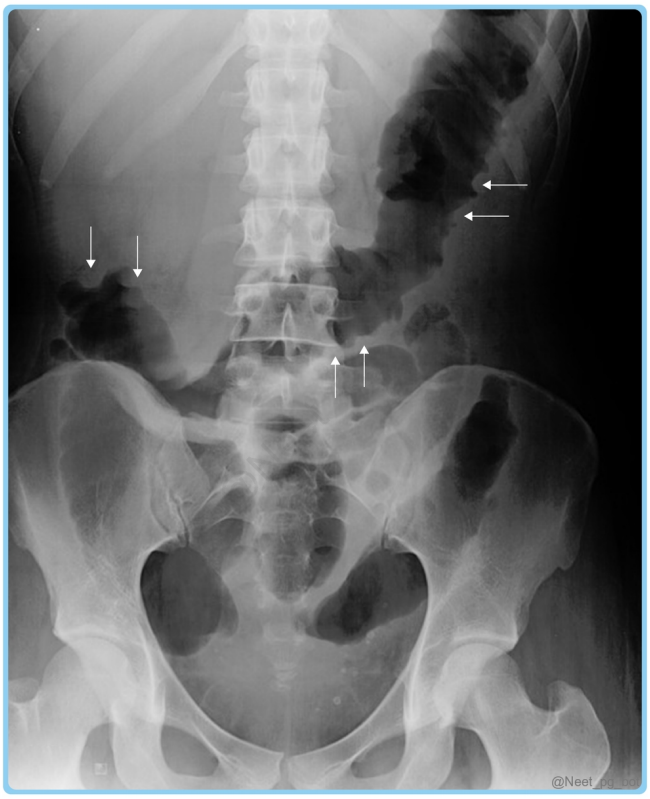


Accordion sign

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References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1368-1370.

Schwartz's Principles of Surgery, 11th Edition, Page 1286-1288.

SRB's Manual of Surgery, 6th Edition, Page 879-882.

↑ *Back to this question in Part A*

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Q24: A 55-year-old male presents to the clinic with complaints of intermittent chest pain and difficulty swallowing. He gives a history of gastrointestinal discomfort and was recently diagnosed with both hiatal hernia and diverticulosis during a routine endoscopic examination. Given his current history, what is the other condition that has the highest probability for which he should be evaluated? (Q849046)

A. Gallstones

B. Peptic ulcer disease

C. Inflammatory bowel disease

D. Chronic pancreatitis

Correct Answer: A. Gallstones

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The given condition is suggestive of Saint’s triad, therefore, gallstones should be evaluated. Saint's triad is a rare clinical syndrome that includes the following three conditions: Hiatal hernia: A condition where part of the stomach pushes up through the diaphragm muscle. Diverticulosis : The presence of diverticula in the colon. Gallstones: Solid particles that form from bile cholesterol and bilirubin in the gallbladder.

References:

SRB's Manual of Surgery, 6th Edition, Page 879.

↑ *Back to this question in Part A*

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Q25: A 2-day-old neonate presents with abdominal distension, vomiting, and failure to pass meconium within the first 48 hours of life. On physical examination, the abdomen is distended, and a digital rectal examination reveals a tight anal sphincter with an

explosive discharge of stool upon withdrawal of the finger. What is the best step of investigation to confirm the exact pathology? (Q849045)

A. Abdominal X-ray

B. Barium enema

C. Rectal biopsy

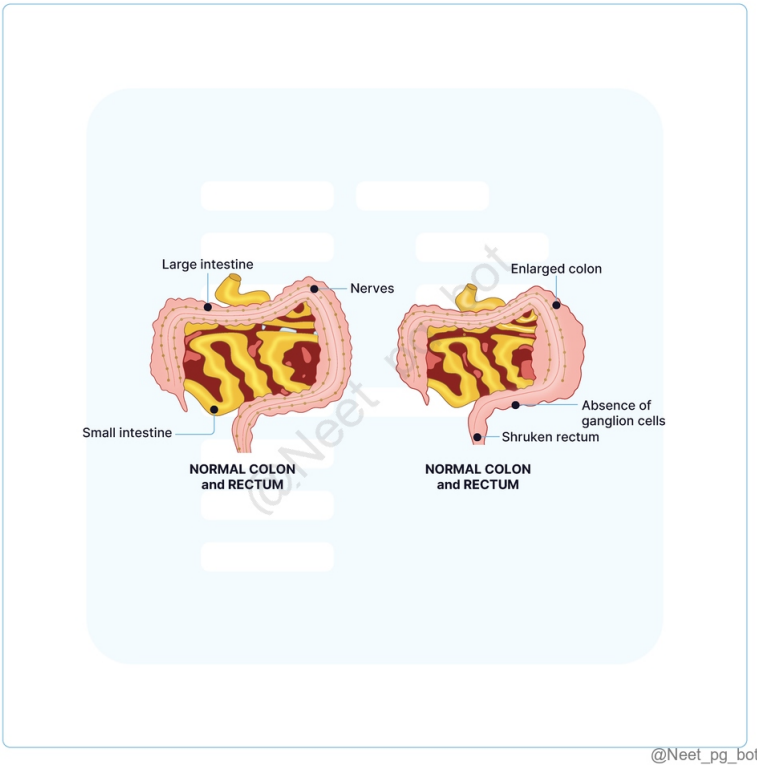
D. Anorectal manometry

Correct Answer: C. Rectal biopsy

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Rectal biopsy is the investigation of choice for Hirschprung’s disease. Hirschsprung's Disease Introduction Congenital disorder known as congenital aganglionic megacolon or aganglionosis. Pathophysiology CLINICAL PRESENTATION Neonates: Failure to pass meconium within the first 48 hours. Abdominal distension. Bilious vomiting Infants and Children Chronic constipation Poor feeding Failure to thrive Enterocolitis (fever, diarrhea, and abdominal distension) DIAGNOSIS Clinical Evaluation History and physical examination indicating chronic constipation and failure to pass meconium. Radiological Abdominal X-ray: Shows dilated bowel loops with air-fluid levels. (Option A) Contrast (Barium) Enema: Demonstrates a transition zone between dilated proximal and narrow distal bowel. (Option B) Rectal Biopsy Gold standard and IOC for diagnosis, showing the absence of ganglion cells. (Option C) Anorectal Manometry Shows lack of rectoanal inhibitory reflex. (Option D)



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References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1296-1298.

Schwartz's Principles of Surgery, 11th Edition, Page 1308.

SRB's Manual of Surgery, 6th Edition, Page 877-879.

↑ *Back to this question in Part A*

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Q26: Assertion: The colon plays a significant role in the production of short-chain fatty acids (SCFAs) from dietary fibers. Reason: Fermentation of dietary fibers by gut bacteria in the colon produces SCFAs like butyrate, acetate, and propionate, which serve as metabolic fuel for colon cells. (Q849044)

A. Both Assertion and Reason are true, and the Reason is the correct explanation for the Assertion.

B. Both Assertion and Reason are true, but the Reason is not the correct explanation for the Assertion.

C. The Assertion is true, but the Reason is false.

D. Both Assertion and Reason are false

Correct Answer: A. Both Assertion and Reason are true, and the Reason is the correct explanation for the Assertion.

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: for the Assertion.

References:

Ganong’s Review of Medical Physiology, 26th Edition, Page 476.

G. K Pal, Comprehensive textbook of medical physiology, 1st Edition, Page 423.

Schwartz's Principles of Surgery, 11th Edition, Page 1263,1264.

↑ *Back to this question in Part A*

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Q27: A 60-year-old male presents with severe abdominal pain, distension, and constipation. A CT scan reveals a large intestinal obstruction at the level of the descending colon. Which of the following arteries is primarily responsible for

providing collateral circulation in this situation? (Q849043)

A. Superior Mesenteric Artery

B. Inferior Mesenteric Artery

C. Marginal Artery of Drummond

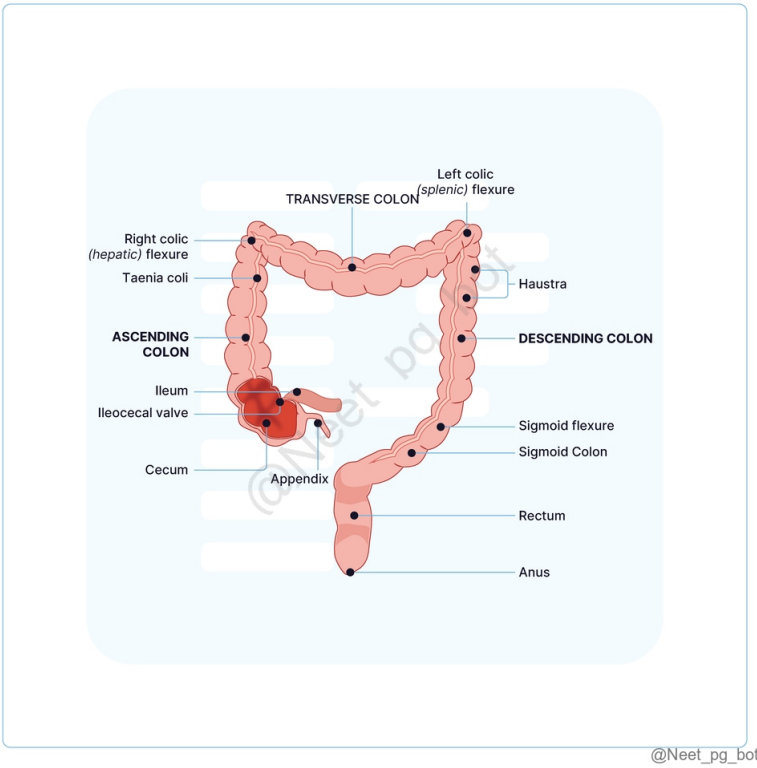
D. Arc of Riolan

Correct Answer: C. Marginal Artery of Drummond

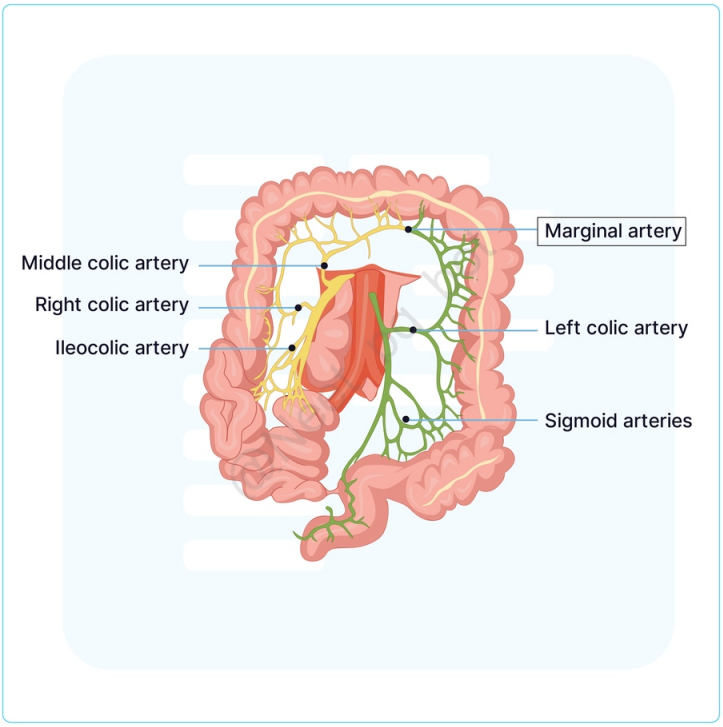
■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: ■■■■■■ In a large bowel obstruction at the descending colon, perfusion to the obstructed segment depends on collateral pathways between SMA and IMA. The artery most consistently providing collateral flow is the Marginal Artery of Drummond, which forms a continuous arterial arcade along the colon. It is the primary and most reliable collateral pathway between SMA and IMA. Runs along the inner border of the colon. Supplies descending colon when IMA flow is compromised (as in obstruction, stenosis, or ligation during surgery). Anatomy of the Large Intestine Segments: Blood supply of the Large Intestine Arterial Supply Superior Mesenteric Artery (SMA): Supplies the cecum, ascending colon, and proximal two-thirds of the transverse colon. (Option A) Inferior Mesenteric Artery (IMA): Supplies the distal one-third of the transverse colon, descending colon, sigmoid colon, and rectum. (Option B) Marginal Artery of Drummond: An important arterial anastomosis running along the inner border of the colon, connecting branches of the SMA and IMA, ensuring continuous blood supply and providing collateral circulation. (Option C) Arc of Riolan / Meandering mesenteric artery: It is a collateral branch running close to the mesentery, connecting superior mesenteric artery to inferior mesenteric artery. It also connects proximal part of middle colic artery to left colic artery (Option D) Venous Drainage Blood from the colon drains into the superior mesenteric vein and inferior mesenteric vein , which then drain into the portal vein leading to the liver. Lymphatic Drainage Lymph from the colon drains into the mesenteric lymph nodes and ultimately into the thoracic duct.



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References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1354.

Schwartz's Principles of Surgery, 11th Edition, Page 1260.

Gray’s Anatomy, 42nd Edition, Page 1197.

↑ *Back to this question in Part A*

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• [05_Gastrointestinal Surgery] 026 Large Intestine-Ii

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[05_Gastrointestinal Surgery] 026 Large Intestine-Ii — Quick Jump

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Q25 (p. 2044)	*Q26 (p. 2045)*	*Q27 (p. 2046)*	*Q28 (p. 2046)*		

Q1: Which of the following is the most accurate screening method for colon cancer? (Q849056)

A. Flexible sigmoidoscopy

B. Colonoscopy

C. Fecal Occult Blood Test

D. Virtual Colonoscopy

Correct Answer: B. Colonoscopy

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Colonoscopy is considered the most accurate screening method for colon cancer due to its comprehensive nature and therapeutic capabilities. Colon cancer screening: Screening Method Description Advantages Limitations Fecal Occult Blood Test (FOBT) (Option C) Nonspecific Detects peroxidase activity in hemoglobin Simple and non-invasive Low specificity Flexible Sigmoidoscopy (Option A) Once every 5 years to identify adenomas, often combined with FOBT Direct visualisation Limited to the lower colon Colonoscopy (Option B) Most accurate Comprehensive and therapeutic Bowel preparation Invasive Air Contrast Barium Enema Detects polyps larger than 1 cm Non-invasive Can evaluate the entire colon Less accurate in the sigmoid colon CT Colonography (Virtual Colonoscopy) (Option D) Helical CT scan that creates 3D images of the colon's interior Non-invasive Detailed imaging Requires bowel preparation Air insufflation Radiation

References:

SRB’s Manual of Surgery, 6th Edition, Page 896

↑ *Back to this question in Part A*

@Neet_pg_bot

Q2: A 15-year-old patient is diagnosed with juvenile polyposis syndrome (JPS). Which of the following statements accurately describes the management and characteristics of JPS? (Q849072)

A. The initial colonoscopy screening should be started by age 10

B. JPS is caused by mutations in the SMAD4 or BMPR1A genes

C. Prophylactic colectomy is indicated only when iron-deficiency anemia is present

D. Best managed with immediate total colectomy regardless of the number of polyps

Correct Answer: B. JPS is caused by mutations in the SMAD4 or BMPR1A genes

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: JPS is linked to mutations in SMAD4 or BMPR1A genes. Juvenile polyp Genetics Autosomal dominant inheritance; Mutations in BMPR1A, SMAD4, or ENG genes Key Characteristics Hamartomatous polyps in intestines No pigmentation (unlike Peutz–Jeghers syndrome) Cancer Risk 10% to 38% lifetime risk of colon cancer; Average age of diagnosis: 34 years Clinical Diagnosis At least five juvenile polyps in the colorectum Multiple juvenile polyps throughout the GI tract Any number of juvenile polyps with a family history of JPS Symptoms Acute or chronic gastrointestinal bleeding Iron-deficiency anemia Prolapsed rectal polyps Abdominal pain Diarrhea Screening Recommendations Initial colonoscopy between ages 12 and 15 (Option A) Repeat colonoscopy in 2-3 years if no polyps are found Annual colonoscopies if polyps are found and removed Surgical Indications (Option D) High-grade dysplasia or cancer presence Polyp burden unmanageable endoscopically Surgical Options Subtotal colectomy with ileorectal anastomosis (IRA) Segmental colectomy Total colectomy with ileal pouch-anal anastomosis (IPAA) Prophylactic Surgery Considerations (Option C) Poor surveillance compliance Family history of colorectal cancer

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1357

Sabiston Textbook of Surgery, 21st Edition, Page 1372

↑ *Back to this question in Part A*

@Neet_pg_bot

Q3: A 65-year-old male presents with acute lower gastrointestinal bleeding. He is hemodynamically stable but has a significant amount of blood in his stool. What is the next best step in management? (Q849071)

A. Outpatient colonoscopy

B. Immediate surgery

C. CT angiogram

D. Inpatient colonoscopy

Correct Answer: D. Inpatient colonoscopy

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The patient is hemodynamically stable with significant bleeding, making an inpatient colonoscopy the next best step to identify the bleeding source. Lower GI Bleeding Management Active Bleeding with Hypovolemic Shock: CT angiogram, embolisation, inpatient colonoscopy, therapeutic endoscopy/surgery. Significant Bleeding without Hypovolemic Shock: Inpatient colonoscopy, EGD, capsule endoscopy/CT angiogram/nuclear medicine scanning. Minor Bleeding: Outpatient investigations. General Considerations: Withhold anticoagulants, transfuse blood products as needed.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1355-1371

Sabiston Textbook of Surgery, 21st Edition, Page 1325-1328, 1337,1387

↑ *Back to this question in Part A*

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Q4: A 65-year-old woman presents to the emergency department with a sudden onset of severe abdominal pain, bloody diarrhea, and low-grade fever. Her medical history includes hypertension and a recent episode of congestive heart failure. An abdominal CT scan reveals signs of bowel ischemia. Which of the following is the most likely diagnosis? (Q849070)

A. Acute mesenteric ischemia

B. Ischemic colitis

C. Diverticulitis

D. Crohn's disease

Correct Answer: B. Ischemic colitis

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Ischemic colitis typically presents with sudden abdominal pain, bloody diarrhea, and systemic signs like low-grade fever, especially in older adults with underlying cardiovascular conditions. The CT findings and symptoms align with this diagnosis. Ischemic Colitis Definition Ischemic colitis is the most common form of gastrointestinal ischemia. It occurs when there is insufficient blood flow to the colon, leading to tissue injury. Causes Thrombotic occlusion: Often linked to atherosclerosis; presents with abdominal pain, raised white cell count, and rectal bleeding. Embolic events: Can cause acute ischemia with severe pain, bloody diarrhea, and hemodynamic instability. Low-flow states: Conditions like septic shock, heart failure, and hypotension increase the risk. Risk Factors Predominantly affects older adults, women, and individuals with comorbidities. Increased risk in case of atherosclerosis, abdominal surgeries, certain medications, and illicit drug use. Clinical Presentation Symptoms: Sudden abdominal pain, tenesmus, bloody diarrhea, nausea, vomiting, low-grade fever, abdominal distension, and tenderness. Mild cases may have nonspecific symptoms; severe cases can lead to shock and require urgent treatment. Diagnosis Imaging: Abdominal plain films may show "thumb-printing"; CT scans with contrast are preferred. Colonoscopy: Gold standard for diagnosis, showing characteristic mucosal changes. Vascular Imaging: Used in suspected acute mesenteric ischemia. Treatment Conservative Management: Includes bowel rest, IV fluids, broad-spectrum antibiotics, and addressing underlying conditions. Surgical Intervention: Necessary for severe cases; involves removing gangrenous bowel and ensuring adequate blood supply. Acute mesenteric ischemia (Option A) usually presents with severe abdominal pain out of proportion to physical findings , often without early bloody diarrhea. It is more acute and catastrophic, commonly due to arterial embolism or thrombosis , and patients rapidly progress to peritonitis and shock . The relatively stable presentation with bloody diarrhea favors ischemic colitis instead. Diverticulitis (Option C) presents with left lower quadrant pain, fever, and leukocytosis , but bloody diarrhea is uncommon . It is primarily an inflammatory condition , not ischemic, and does not typically present with acute bowel ischemia on imaging. Crohn’s disease (Option D) is a chronic inflammatory bowel disease presenting with recurrent abdominal pain, diarrhea, weight loss, and skip lesions . It does not typically present with sudden onset severe pain and acute bloody diarrhea in an elderly patient with vascular risk factors , making it unlikely.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Pages 1367-1368

Sabiston Textbook of Surgery, 21st Edition, Pages 1358-1361

↑ *Back to this question in Part A*

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Q5: A 65-year-old male presents with a 5-day history of watery diarrhea, abdominal cramping, and low-grade fever. He was recently treated with cephalosporins for a respiratory infection. Upon examination, the patient is dehydrated but stable. Endoscopy reveals raised yellowish-white plaques on the colonic mucosa. What is the most likely diagnosis? (Q849069)

A. Ulcerative colitis

B. Crohn’s disease

C. Pseudomembranous colitis

D. Ischemic colitis

Correct Answer: C. Pseudomembranous colitis

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The patient’s recent antibiotic use, clinical symptoms, and endoscopic findings of raised yellowish-white plaques strongly suggest pseudomembranous colitis, which is typically caused by Clostridium difficile infection. Pseudomembranous Colitis Cause Primarily caused by Clostridium difficile infection Often associated with antibiotic use, especially cephalosporins Clinical Presentation Symptoms: Diarrhea, abdominal pain, and fever Severe cases: Pseudomembranous colitis with raised, yellowish-white plaques on colonic mucosa Nonspecific colitis or fulminant colitis may also occur, with a higher risk of perforation Diagnosis Based on clinical symptoms and stool tests for C. difficile toxins, antigens, or bacteria Flexible sigmoidoscopy for inconclusive stool tests or to exclude other causes Colonoscopy is used cautiously in fulminant colitis Treatment Antibiotics: Oral vancomycin, fidaxomicin, or metronidazole Fecal microbiota transplantation for unresponsive cases Emergency subtotal colectomy and ileostomy for severe cases Prevention Isolation of suspected cases Use of protective equipment by healthcare staff Thorough disinfection and meticulous hand hygiene Ulcerative colitis (Option A) presents with chronic bloody diarrhea, tenesmus, and continuous mucosal involvement starting from the rectum . Endoscopy shows diffuse erythema, ulceration, and pseudopolyps , not yellowish pseudomembranes , and there is no association with recent antibiotic use . Crohn’s disease (Option B) is a chronic inflammatory condition characterized by skip lesions, cobblestone appearance, and transmural inflammation . It does not present acutely after antibiotic use, nor does it show pseudomembrane formation on endoscopy. Ischemic colitis (Option D) typically presents in elderly patients with vascular risk factors with sudden abdominal pain followed by bloody diarrhea . Endoscopy may show pale mucosa, petechiae, or ulceration , but not yellowish plaques , and there is no relation to antibiotic use.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1366

Sabiston Textbook of Surgery, 21st Edition, Page 1355-1357

↑ *Back to this question in Part A*

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Q6: A 45-year-old woman, recently diagnosed with colon and bladder cancer, presents with a notable family history; her mother also had both cancers and succumbed to them. Additionally, she has a history of sebaceous adenomas. Which other malignancy should she be evaluated for, considering the potential hereditary cancer syndrome?

(Q849068)

A. Thyroid cancer

B. Liver cancer

C. Breast carcinoma

D. Pancreatic cancer

Correct Answer: C. Breast carcinoma

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The patient presents with colon cancer, bladder cancer, a strong family history of similar malignancies, and sebaceous adenomas , which is highly suggestive of Muir-Torre syndrome , a variant of Lynch syndrome (HNPCC) . It is an autosomal dominant disorder due to mutations in DNA mismatch repair genes , leading to microsatellite instability . The hallmark of Muir-Torre syndrome is the presence of: Sebaceous tumors (adenomas, carcinomas, and hyperplasia) Visceral malignancies , especially: Colorectal cancer - Most common, diagnosed by colonoscopy and genetic testing Genitourinary cancers (including bladder, ureters, and kidneys) - Diagnosed with imaging and cystoscopy Breast carcinoma (Option C) - Managed with mammography and possibly breast MRI Others: Non-Hodgkin lymphoma Thyroid cancer (Option A) is more commonly associated with Cowden syndrome (PTEN mutation) and not typically linked to Lynch or Muir-Torre syndrome . Liver cancer (Option B) is not a classical association with Lynch or Muir-Torre syndrome. While metastasis to the liver can occur from colorectal cancer, it is not a primary associated malignancy in this syndrome. Pancreatic cancer (Option D) can be seen in some hereditary syndromes (like BRCA or Peutz-Jeghers), but it is not associateed with Muir-Torre syndrome .

References:

www.ncbi.nlm.nih.gov/books/NBK513271/#

Schwartz's Principles of Surgery, 11th Edition, Page 559

SRB's Manual of Surgery, 6th Edition, Page 277

↑ *Back to this question in Part A*

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Q7: Which of the following statements regarding the therapy for colon carcinoma are correct? Statements: 1. Chemotherapy is often used in the adjuvant setting after surgery to reduce the risk of recurrence in patients with Stage III colon cancer 2. Immunotherapy is typically used as a first-line treatment for patients with colon cancer who have microsatellite instability-high (MSI-H) or mismatch repair deficiency

3. Chemotherapy with FOLFOX (5-Fluorouracil, Leucovorin, and Oxaliplatin) is commonly used for Stage IV colon cancer to achieve a cure 4. Checkpoint inhibitors like Pembrolizumab are effective in colon cancer patients with microsatellite instability-high (MSI-H) or mismatch repair deficiency 5. Radiotherapy is not preferred for colon cancer due to its limited benefit in local control (Q849067)

A. 1, 2, and 4

B. 2, 4, and 5

C. 1, 4, and 5

D. 3, 4, and 5

Correct Answer: C. 1, 4, and 5

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Chemotherapy Regimens: It is a standard approach for Stage III colon cancer patients after surgery. (Statement 1) Indications: Adjuvant Therapy: Stage III colon cancer, high-risk Stage II colon cancer. Palliative Therapy: Advanced or metastatic disease. FOLFOX is used for Stage III to manage the disease and FOLFIRI in Stage IV colon cancer. (Statement 3 ruled out) Regimen Components FOLFOX 5-Fluorouracil (5-FU) Folinic Acid Oxaliplatin FOLFIRI 5-Fluorouracil (5-FU) Folinic Acid Irinotecan CapeOx Capecitabine Oxaliplatin Immunotherapy and Targeted Therapy Indications: Advanced or Metastatic Disease: Particularly patients with microsatellite instability-high (MSI-H) or mismatch repair deficiency. (Statement 2 ruled out) Category Drug Immunotherapy Pembrolizumab (Statement 4) Nivolumab Ipilimumab Targeted Therapy Bevacizumab Cetuximab Panitumumab Radiotherapy: Radiotherapy is not preferred for colon cancer due to its limited benefit in local control. (Statement 5) The mobile nature of the colon and its location within the abdominal cavity make radiotherapy less effective and potentially more toxic for surrounding organs.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1364

SRB's Manual of Surgery, 6th Edition, Page 899

↑ *Back to this question in Part A*

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Q8: A 62-year-old male underwent a right hemicolectomy for carcinoma of the colon. On the fourth postoperative day, he developed severe abdominal pain, fever, tachycardia, and hypotension. On physical examination, his abdomen is distended and diffusely tender with guarding and rigidity. Laboratory results show elevated white

blood cell count. A CT scan of the abdomen reveals free fluid and air in the peritoneal cavity. Considering the clinical presentation and imaging findings, what is the most likely cause of his current condition? (Q849066)

A. Surgical site infection

B. Anastomotic leak

C. Bowel obstruction

D. Ileus

Correct Answer: B. Anastomotic leak

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Anastomotic leak is a serious complication after colorectal surgery and is characterized by leakage of bowel contents at the site of the surgical anastomosis. This can lead to peritonitis, which explains the patient's severe abdominal pain, fever, and signs of sepsis. The CT findings of free air and fluid are also consistent with this diagnosis. Timing : Anastomotic leaks typically present 3-7 days after surgery, fitting with this patient's presentation on the fourth postoperative day. Clinical signs: The patient's severe abdominal pain, fever, tachycardia, and hypotension are consistent with peritonitis and developing sepsis, which can result from an anastomotic leak. Physical examination: The distended, diffusely tender abdomen with guarding and rigidity strongly suggests peritoneal inflammation. Laboratory findings: An elevated white blood cell count indicates a significant inflammatory response. Imaging : The CT scan showing free fluid and air in the peritoneal cavity is highly suggestive of a perforation, which is most likely due to an anastomotic leak in this post-surgical context.

References:

SRB's Manual of Surgery, 6th Edition, Page 899

↑ *Back to this question in Part A*

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Q9: A 55-year-old male presents with fatigue, weight loss, and intermittent abdominal pain. He has a history of occasional rectal bleeding. On examination, he has mild pallor, and there is a palpable mass in the right upper quadrant. A colonoscopy is performed, revealing a large ulcerative mass at the hepatic flexure of the colon. Biopsy confirms the diagnosis of adenocarcinoma. What is the most appropriate next step in the management of this patient? (Q849065)

A. Segmental resection of the hepatic flexure

B. Right hemicolectomy

C. Extended right hemicolectomy

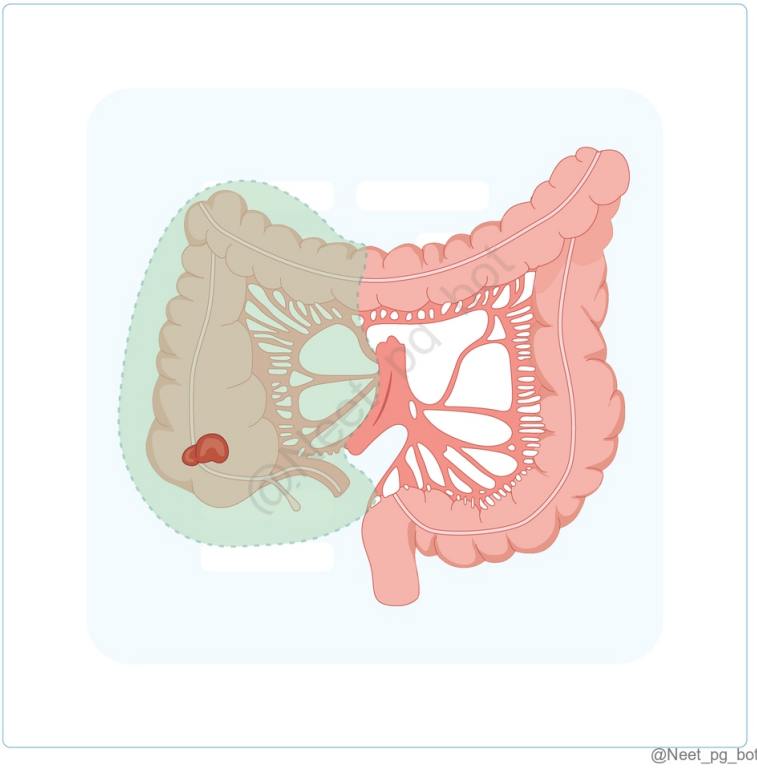
D. Total colectomy

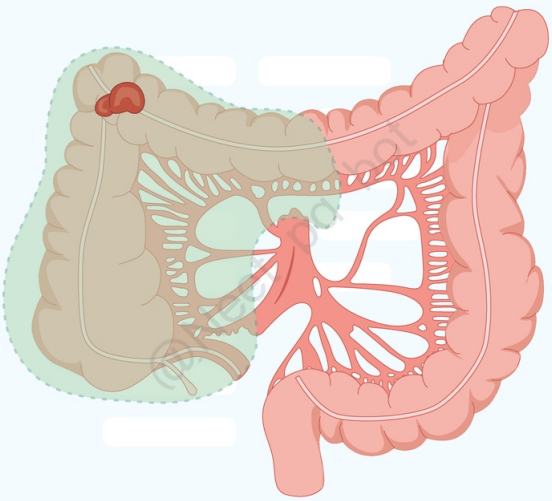
Correct Answer: C. Extended right hemicolectomy

■ *Listen (English)*

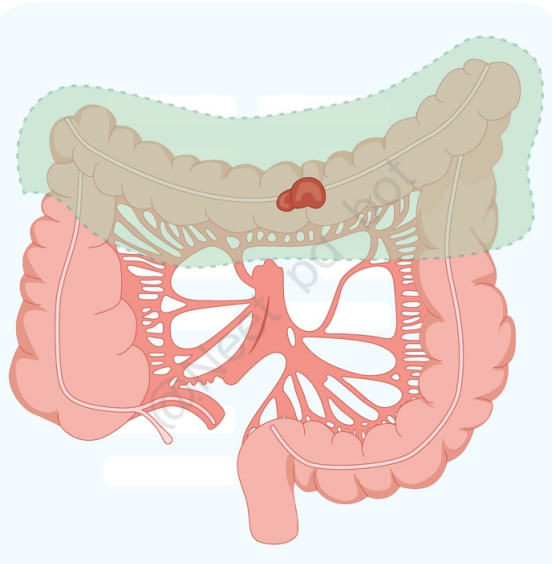
■ *Listen (Hindi)*

Explanation: Extended right hemicolectomy involves removing the right colon, including the cecum, ascending colon, hepatic flexure, and a portion of the transverse colon, along with regional lymph nodes. It is the most appropriate surgical approach for a tumor located at the hepatic flexure, ensuring adequate margins and lymph node clearance. Site of Colon Cancer Surgery Performed Diagram of Surgery Cecum & ascending colon Right hemicolectomy Hepatic flexure Extended right hemicolectomy Transverse colon Transverse colectomy Splenic flexure Extended left hemicolectomy Descending colon Left hemicolectomy Sigmoid colon Sigmoid colectomy Rectosigmoid junction, upper rectum & middle rectum Low Anterior Resection (LAR) Lower rectum Abdominoperineal Resection (APR)

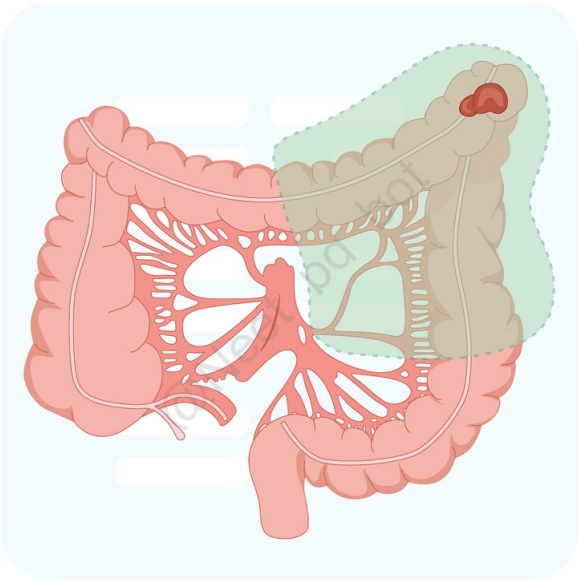




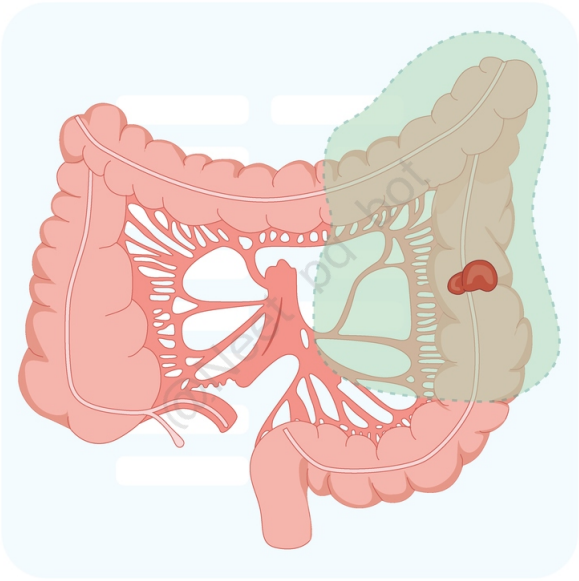
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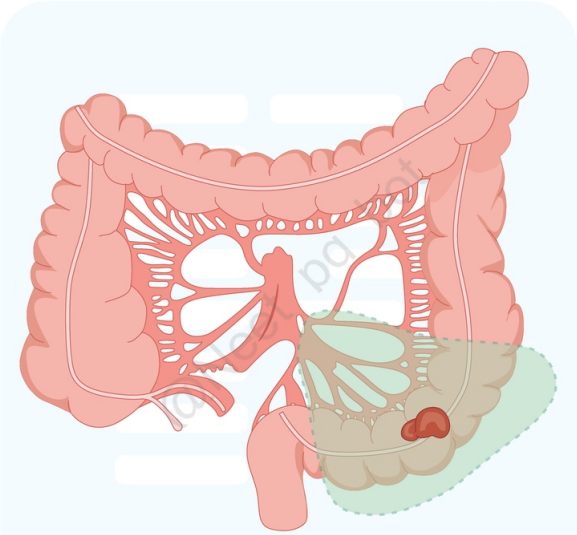
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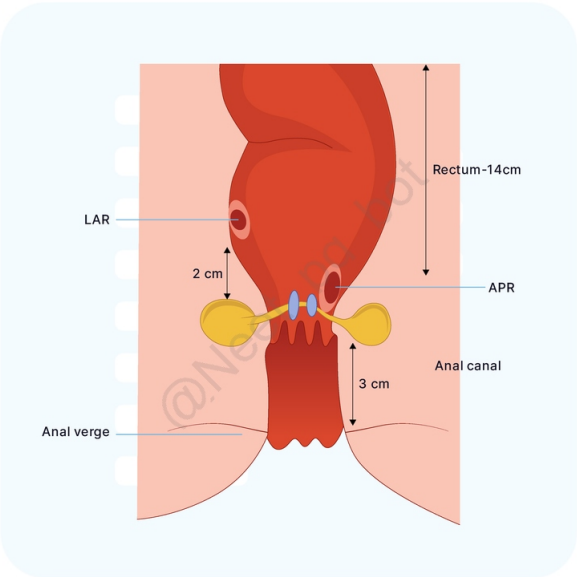
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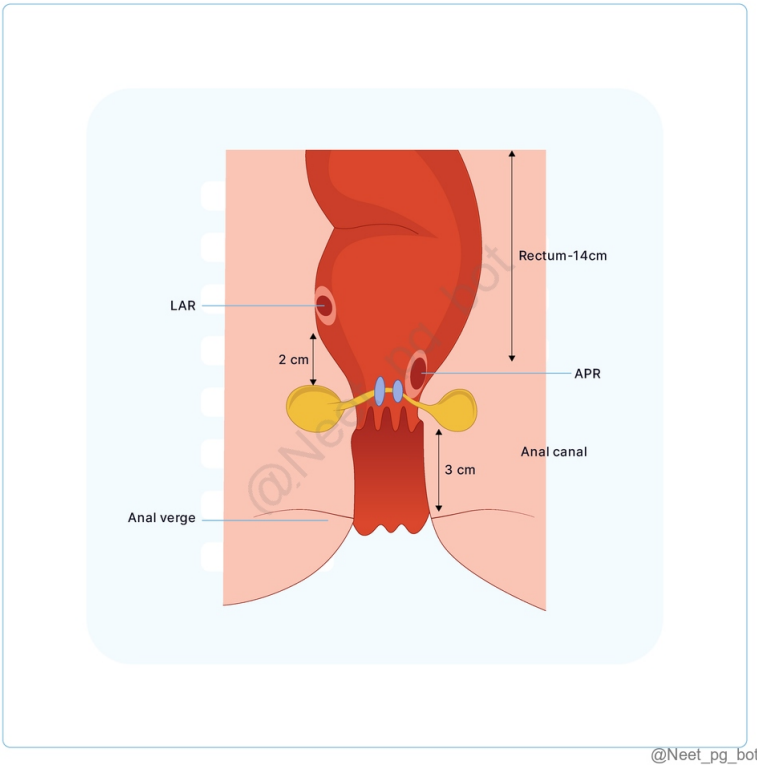
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References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1361,1362.

Schwartz's Principles of Surgery, 11th Edition, Page 1270-1272.

SRB's Manual of Surgery, 6th Edition, Page 895-898.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q10: Which chemotherapy regimen is standard for adjuvant treatment in a patient with stage III colon cancer? (Q849063)

A. Capecitabine

B. FOLFOX

C. FOLFIRI

D. Bevacizumab

Correct Answer: B. FOLFOX

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: STAGE OF COLON CANCER CHEMOTHERAPY STAGE III FOLFOX FOL: Folinic acid (Leucovorin) F: 5-Fluorouracil OX : Oxaliplatin STAGE IV/Metastatic Colon Cancer First-line therapy: FOLFIRI FOL: Folinic acid (Leucovorin) F: 5-Fluorouracil IRI: Irinotecan Second line therapy : Bevacizumab - VEGF inhibitor Cetuximab - EGFR inhibitor

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1363, 1364

Chemotherapy

↑ *Back to this question in Part A*

@Neet_pg_bot

Q11: A 72-year-old female is found to have a 3 cm mass in the ascending colon during colonoscopy. A CT scan of the abdomen and pelvis shows no evidence of lymph node involvement or distant metastases. What is the most appropriate management for this patient? (Q849062)

A. Perform a right hemicolectomy with en-bloc lymph node dissection.

B. Recommend adjuvant chemotherapy following the surgical resection.

C. Proceed with endoscopic mucosal resection of the tumor.

D. Recommend Endoscopic polypectomy

Correct Answer: A. Perform a right hemicolectomy with en-bloc lymph node dissection.

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: A 3-cm malignant lesion in the ascending colon is considered an invasive colonic adenocarcinoma, not an early superficial polyp. The standard of care for localized colon cancer—even when lymph nodes appear uninvolved—is segmental colectomy with systematic lymphadenectomy. This ensures complete oncologic resection and accurate staging STAGING TREATMENT Stage 0 (Tis, N0, M0) Endoscopic polypectomy Stage 1 (T1, N0, M0) Segmental colectomy Stage 2 (T1-3,N0,M0) Surgical resection with 5 cm margin and anastomosis Stage 3 (T any, N1, M0) Surgical resection + adjuvant chemotherapy Stage 4 (T any, N any, M1) Resection of metastases + palliative chemotherapy/radiotherapy Other options: Option B: Adjuvant chemotherapy Not indicated upfront. Chemotherapy is offered after surgery only if adverse pathological features (e.g., T3/T4, N+) are identified. It is never a substitute for curative resection in non-metastatic colon cancer. Option C: Endoscopic mucosal resection (EMR) EMR is suitable for superficial T1 lesions limited to mucosa/submucosa. A 3-cm adenocarcinoma in the ascending colon is highly unlikely to be confined—therefore EMR is oncologically

inadequate. Option D: Endoscopic polypectomy This is used for benign polyps or small (<2 cm) suspected early lesions. A confirmed malignant tumour of this size requires surgical resection.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1363

Management

↑ *Back to this question in Part A*

@Neet_pg_bot

Q12: Which of the following is a possible description of a T3 colon tumour? (Q849061)

A. Tumour invades submucosa

B. Tumour invades subserosa

C. Tumour invades adjacent organs or structures

D. Tumour confined to the mucosa

Correct Answer: B. Tumour invades subserosa

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Stage T3 of colon cancer involves a tumor which invades through subserosa or into pericolorectal tissues. TNM classification of colon cancer: T (Tumor) Tis Carcinoma in situ/tumour confined to mucosa (Option D) T1 Tumour invades the submucosa (Option A) T2 Tumour invades the muscularis propria T3 Tumour invades through subserosa or into pericolorectal tissues T4a Tumours breach the visceral peritoneum T4b Tumor directly invades or is adherent to other organs or structures (Option C) N (Lymph Node) N1a Metastasis in 1 regional lymph node. N1b Metastasis in 2-3 regional lymph nodes. N1c Tumor deposits in the subserosa, mesentery, or non-peritonealized pericolic or perirectal tissues without regional nodal metastasis. N2a Metastasis in 4-6 regional lymph nodes. N2b Metastasis in 7 or more regional lymph nodes. M (Metastasis) M1a Metastasis confined to one organ or site M1b Metastasis to more than one organ/site or the peritoneum. M1c Metastasis to the peritoneum with or without other organ involvement.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1360

↑ *Back to this question in Part A*

@Neet_pg_bot

Q13: Which of the following best describes the Modified Dukes' Staging System for colorectal cancer? (Q849060)

A. Dukes A: Tumour invades the muscularis propria but no lymph node involvement

B. Dukes B: Tumour penetrates through the muscularis propria with positive lymph nodes

C. Dukes C: Tumour invades beyond the bowel wall, no lymph node involvement

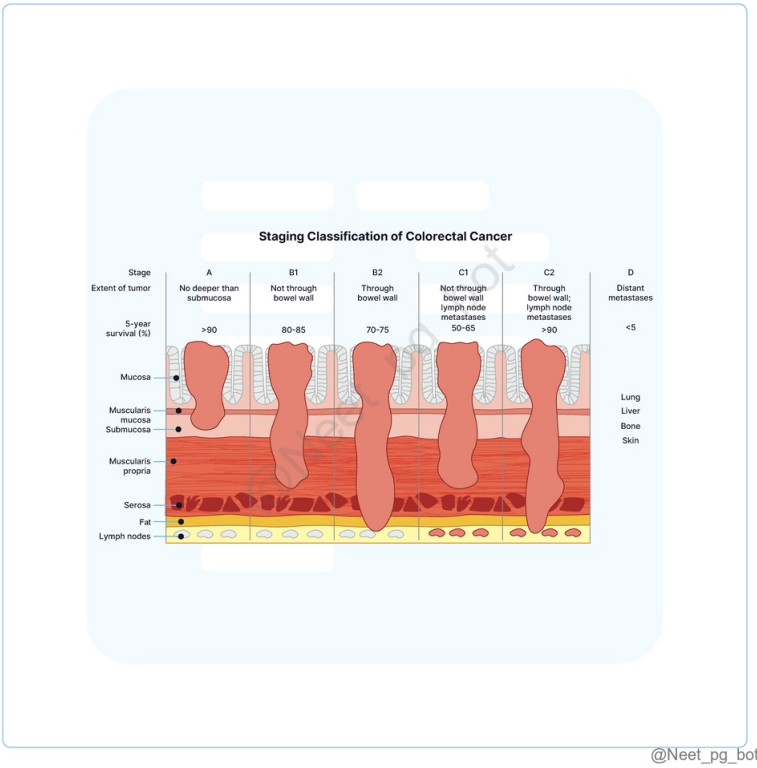
D. Dukes D: Tumour has distant metastasis regardless of lymph node status

Correct Answer: D. Dukes D: Tumour has distant metastasis regardless of lymph node status

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Modified Dukes' Staging System is a classification used to stage colorectal cancer based on the extent of tumour invasion and the presence of lymph node involvement or distant metastasis. STAGING DESCRIPTION Dukes A (Option A) Tumor confined to the mucosa (Stage I in modern TNM staging). Dukes B (Option B) B1- Partial penetration of muscularis propria B2- Full penetration of muscularis propria Dukes C (Option C) C1- LN involvement without penetration of entire bowel wall C2- LN involvement with penetration of entire bowel wall Dukes D (Option D) Tumor has distant metastasis regardless of lymph node status



@Neet_pg_bot

References:

Bailey & Love’s Short Practice of Surgery, 28th Edition, Page 1359

Dukes

↑ *Back to this question in Part A*

@Neet_pg_bot

Q14: On barium enema investigation of a 54-year-old male with colon cancer an apple core lesion was found. What is the location of the carcinoma? (Q849059)

A. Left

B. Right

C. Transverse colon

D. Any of the above

Correct Answer: A. Left

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The " apple core " lesion on barium enema is characteristic of left-sided colon cancer . This appearance is due to the annular, constrictive nature of these tumors, which tend to grow circumferentially around the bowel wall. The narrowed lumen surrounded by the bulging tumor creates an image that resembles an apple core on barium studies. Characteristics Right-Sided Tumours Left-Sided Tumours Location Cecum, ascending colon, proximal transverse colon Distal transverse colon, descending colon, sigmoid colon Growth pattern Typically polypoid or fungating Often annular or constricting Common symptoms Anemia (due to chronic blood loss) Fatigue Weakness Abdominal mass Altered bowel habits Constipation Narrow stools Obstruction Pain Less common, vague discomfort More common, colicky pain Bleeding Occult bleeding (melena) Hematochezia (bright red blood) Physical exam Palpable mass in right iliac fossa Less likely to have a palpable mass Barium enema finding Filling defect "Apple core" lesion Iron deficiency anaemia More common Less common

References:

SRB’s Manual of Surgery, 6th Edition, Page 895-897

↑ *Back to this question in Part A*

@Neet_pg_bot

Q15: Arrange the steps in the pathogenesis of colon cancer Dysplasia Intermediate adenoma DNA methylation 18q loss DCC (Q849058)

A. 1,3,2,4

B. 1,2,3,4

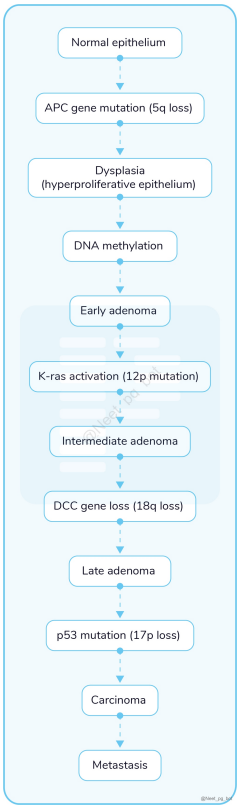
C. 4,3,2,1

D. 3,2,1,4

Correct Answer: A. 1,3,2,4

- *Listen (English)*
- *Listen (Hindi)*

Explanation: Adenoma-carcinoma sequence: The adenoma-carcinoma sequence describes the progression from normal colonic epithelium to colorectal cancer. This process involves a series of genetic and epigenetic changes that occur in a specific order. Dysplasia: This is an early step in the process. Dysplasia refers to abnormal cell growth and organization within the epithelium. It is characterized by hyperproliferation of cells and is considered a precancerous change. DNA methylation: DNA methylation can silence tumor suppressor genes, contributing to the progression of the adenoma. Intermediate adenoma: As the genetic and epigenetic changes accumulate, the lesion progresses from an early to an intermediate adenoma. This stage represents a more advanced precancerous lesion. 18q loss (DCC gene): The loss of the long arm of chromosome 18, which includes the DCC (Deleted in Colorectal Cancer) gene, typically occurs in the transition from intermediate to late adenoma.



References:

SRB’s Manual of Surgery, 6th Edition, Page 892

↑ *Back to this question in Part A*

@Neet_pg_bot

Q16: A 62-year-old male with a history of long-standing ulcerative colitis presents with rectal bleeding, unintentional weight loss, and altered bowel habits. A colonoscopy reveals a large, ulcerated mass in the sigmoid colon, and a biopsy confirms adenocarcinoma. Which of these factors in his history would not have served as risk factors for developing colon cancer? (Q849057)

A. Long-standing ulcerative colitis

B. Smoking

C. Use of NSAIDs

D. Red meat in the diet

Correct Answer: C. Use of NSAIDs

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: NSAID is protective against colon cancer, rest are risk factors. Colon cancer: Dietary Risk Factors High red meat (Option D) Low dietary fiber intake High-fat diet Alcohol consumption Cigarette smoking (Option B) Lack of dietary vitamins A, C, E, and zinc Genetic Risk Factors Familial adenomatous polyposis (FAP) Gardner's syndrome Turcot's syndrome Family history of colon cancer (2-4 times increased risk) Hereditary nonpolyposis colorectal cancer (HNPCC) Medical Risk Factors Long-standing ulcerative colitis (Option A) Crohn's disease (less risk compared to ulcerative colitis) History of cholecystectomy Ileal resection (increased bile salts) Radiation exposure (mucinous type) Ureterosigmoidostomy (100-500 times increased risk) Acromegaly PROTECTIVE FACTORS High-fiber diet Dietary calcium Aspirin and other NSAIDs (Option C)

References:

SRB’s Manual of Surgery, 6th Edition, Page 892

↑ *Back to this question in Part A*

@Neet_pg_bot

Q17: A 54-year-old female with intractable diarrhea and pigmentation was diagnosed with Cronkhite-Canada syndrome. Which of the following statements regarding the disease are true? Hamartomatous polyp of colon Seen only in females Polyps can be

present in the stomach and duodenum as well 15% can turn malignant (Q849055)

A. 1,4

B. 2,3,4

C. 1,2

D. 1,2,3,4

Correct Answer: D. 1,2,3,4

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Cronkhite-Canada syndrome: A rare, non-hereditary syndrome characterised by gastrointestinal polyposis and ectodermal changes. Demographics: Predominantly affects females, typically diagnosed in middle to late adulthood. (Statement 2) Clinical Features: Intractable diarrhoea Cutaneous hyperpigmentation Alopecia (hair loss) Onychodystrophy (nail abnormalities) Polyp Distribution: Hamartomatous polyps are present throughout the gastrointestinal tract, primarily in the stomach, duodenum, and colorectum. (Statements 1 and 3) Malignancy Risk: Approximately 15% of cases may undergo malignant transformation. (Statement 4) Management: Requires a multidisciplinary approach, including nutritional support, endoscopic surveillance, and treatment of associated complications.

References:

SRB’s Manual of Surgery, 6th Edition, Page 889, 891

↑ *Back to this question in Part A*

@Neet_pg_bot

Q18: A 62-year-old patient is diagnosed with a large, invasive adenocarcinoma of the splenic flexure of the colon. The colorectal surgeon recommends surgical resection. Which of the following colectomy procedures would be most appropriate for this patient? (Q849064)

A. Left hemicolectomy

B. Extended left hemicolectomy

C. Subtotal colectomy

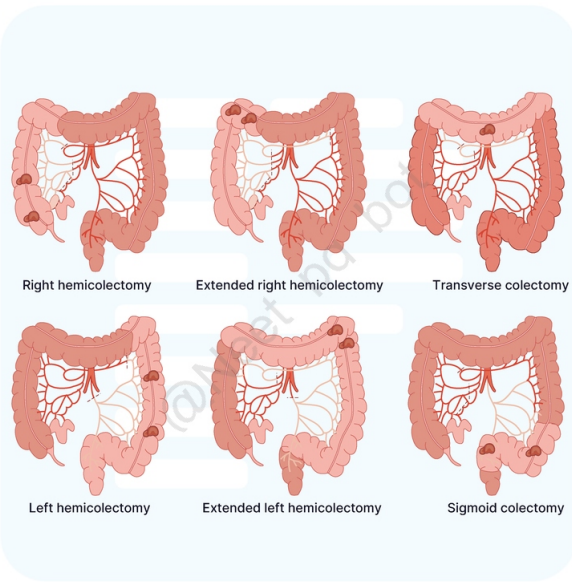
D. Total proctocolectomy

Correct Answer: B. Extended left hemicolectomy

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Extended left hemicolectomy is the most appropriate procedure as this involves removing the left side of the colon, including the splenic flexure. Distal 2/3rd of transverse colon, splenic flexure, descending colon, portion of sigmoid colon are removed in extended left hemicolectomy. Type of Colectomy Structures removed Total Colectomy Removal of entire colon Total Proctocolectomy Total Colectomy + removal of rectum Subtotal Colectomy Removal of entire colon except the rectum Right Hemicolectomy Terminal ileum, cecum, ascending colon, hepatic flexure, right half of transverse colon Extended Right Hemicolectomy Terminal ileum, cecum, ascending colon, hepatic flexure, proximal 2/3rd of transverse colon Left Hemicolectomy Distal 1/3rd of transverse colon, splenic flexure, descending colon, portion of sigmoid colon Extended Left Hemicolectomy Distal 2/3rd of transverse colon, splenic flexure, descending colon, portion of sigmoid colon Transverse Colectomy Removal of the transverse colon Sigmoid Colectomy Removal of the sigmoid colon



@Neet_pg_bot

References:

SRB’s Manual of Surgery, 6th Edition, Page 954-956 Colectomy

↑ *Back to this question in Part A*

@Neet_pg_bot

Q19: Which diagnostic modality can detect active gastrointestinal bleeding at the lowest rate of blood loss? (Q883999)

A. CT angiography

B. Selective mesenteric angiography

C. 99m Tc-labelled red blood cell scintigraphy

D. Colonoscopy

Correct Answer: C. 99m Tc-labelled red blood cell scintigraphy

Explanation: The 99mTc-labelled red blood cell (RBC) scintigraphy is the most sensitive modality for detecting active GI bleeding at the lowest bleeding rates , typically ≥0.1 mL/min . It is especially useful for intermittent or slow bleeding , as it allows continuous monitoring over several hours . CT angiography (Option A) : Detects bleeding at ≥0.3-0.5 mL/min ; fast and non-invasive, but less sensitive for slow bleeding. Selective mesenteric angiography (Option B) : Detects bleeding at ≥0.5-1 mL/min ; allows for therapeutic embolisation. Colonoscopy (Option D) : Useful for localisation and therapy , but sensitivity is limited for active, rapid, or intermittent bleeding , and bowel prep may be required.

References:

Schwartz’s Principles of Surgery, 11th Edition, Pages 1250, 1251.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q20: A guaiac-based faecal occult blood test (gFOBT) is most sensitive for detecting bleeding originating from which part of the gastrointestinal tract? (Q883998)

A. Upper GI tract (e.g., stomach)

B. Small intestine

C. Oesophagus

D. Colon

Correct Answer: D. Colon

Explanation: The guaiac faecal occult blood test (gFOBT) is more sensitive for lower GI bleeding (colon) because haemoglobin from upper GI sources is often degraded by digestive enzymes during transit, reducing its peroxidase activity . For the test to be positive, faecal haemoglobin typically needs to exceed about 10 mg/g of stool , which corresponds to a daily blood loss of roughly 10 mL. Upper GI tract (e.g., stomach) (Option A) : Upper GI bleeding often results in degraded heme (by digestive enzymes and gastric acid), making gFOBT less sensitive compared to tests like immunochemical FOBT (iFOBT) or upper endoscopy. Small intestine (Option B) : Sensitivity is lower because bleeding may be intermittent, and haemoglobin is partially degraded. Oesophagus (Option C) :

Oesophagal bleeding (e.g., varices, esophagitis) is an upper GI source; like gastric bleeding, heme is often degraded, reducing gFOBT sensitivity.

References:

Schwartz's Principles of Surgery, 11th Edition, Page 1251.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q21: In a hemodynamically stable patient presenting with acute hematochezia, what is the appropriate initial diagnostic step? (Q883997)

A. Immediate angiography

B. Urgent exploratory laparotomy

C. Colonoscopy after bowel preparation

D. Upper endoscopy (EGD)

Correct Answer: C. Colonoscopy after bowel preparation

Explanation: For hemodynamically stable patients with acute lower GI bleeding (hematochezia), the initial diagnostic procedure of choice is colonoscopy after adequate bowel preparation, performed within 24 hours. If no source is found on colonoscopy, an upper endoscopy (EGD) should be considered to rule out an upper GI source. In unstable patients, resuscitation and urgent EGD are typically performed first to exclude a massive upper GI bleed. Immediate angiography (Option A) : Reserved for active, brisk bleeding or if colonoscopy is non-diagnostic. Urgent exploratory laparotomy (Option B) : Considered only in hemodynamically unstable patients with ongoing massive bleeding. Upper endoscopy (EGD) (Option D) : Indicated if an upper GI source is suspected (e.g., melena or hemodynamic instability), but hematochezia in a stable patient usually suggests a lower GI source .

References:

https://acgcdn.gi.org/wp-content/uploads/2016/03/ACGGuideline-Acute-Lower-GI-Bleeding-03012016.pdf

Schwartz's Principles of Surgery, 11th Edition, Pages 1250, 1251.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q22: Along which anatomical structure are the paracolic lymph nodes primarily located? (Q883996)

A. Superior mesenteric artery

B. Marginal artery of Drummond

C. Inferior mesenteric vein

D. Middle colic artery

Correct Answer: B. Marginal artery of Drummond

Explanation: The paracolic lymph nodes are the primary (first-tier) nodes in the colonic lymphatic drainage pathway. They lie adjacent to the colon along the course of the marginal artery of Drummond, which runs parallel to the colon and connects the SMA and IMA circulations. Lymph then drains sequentially to intermediate nodes and finally to principal nodes at the root of the mesentery. Superior mesenteric artery (Option A) : Lymph nodes along the superior mesenteric artery are central or intermediate nodes (e.g., ileocolic, right colic, middle colic groups), not the paracolic group. Inferior mesenteric vein (Option C) : The inferior mesenteric vein ascends retroperitoneally and does not have a constant anatomical relationship with the paracolic lymph nodes, which follow the marginal artery. Middle colic artery (Option D) : The middle colic artery supplies the transverse colon, and its associated nodes are part of the middle colic group, not the paracolic group.

References:

https://ajronline.org/doi/10.2214/ajr.169.5.9353437

↑ *Back to this question in Part A*

@Neet_pg_bot

Q23: A flexible sigmoidoscope is typically designed to visualise the colon up to what approximate length from the anal verge? (Q883995)

A. 25 cm

B. 40 cm

C. 60 cm

D. 100 cm

Correct Answer: C. 60 cm

Explanation: A flexible sigmoidoscope is approximately 60 cm in length and is used to examine the r ectum, sigmoid colon, and often part of the descending colon. This contrasts with a colonoscope (100–160 cm), which can

reach the cecum, and a rigid proctoscope (15 cm) or rectoscope (25 cm).

References:

Schwartz's Principles of Surgery, 11th Edition, Page 1264.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q24: A 2-year-old boy undergoes a pull-through procedure for Hirschsprung disease. What is the most common postoperative complication overall? (Q883994)

A. Enterocolitis

B. Faecal incontinence

C. Constipation

D. Anastomotic leak

Correct Answer: C. Constipation

Explanation: Constipation is the most frequent long-term problem after pull-through surgery for Hirschsprung disease, occurring in a significant proportion of patients. Other complications include faecal incontinence, anastomotic stricture, and postoperative enterocolitis, which is a serious but less common complication. Enterocolitis (Option A) : Common early & serious complication, but not the most common overall Faecal incontinence (Option B) : While faecal incontinence can occur, especially early after surgery, it is less common than enterocolitis and often improves with time in most patients. Anastomotic leak (Option D) : Anastomotic leak is a serious but relatively uncommon surgical complication, not the most common postoperative issue overall.

References:

Sabiston Textbook of Surgery, 21st Edition, Page 1861.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q25: A 3-month-old infant presents with chronic constipation, abdominal distension, and failure to pass meconium within the first 48 hours of life. A rectal biopsy confirms aganglionosis of the distal colon, consistent with Hirschsprung disease. Which surgical procedure is considered a definitive treatment for this condition? (Q883993)

A. Duhamel pull-through

B. Nissen fundoplication

C. Heineke-Mikulicz pyloroplasty

D. Whipple procedure

Correct Answer: A. Duhamel pull-through

Explanation: The definitive surgical treatment for Hirschsprung disease involves a pull-through procedure that removes the aganglionic segment and brings normally innervated bowel down to the anus. The three classic operations are: Swenson Duhamel Soave procedures. Nissen fundoplication (Option B) : This is an anti-reflux procedure for gastroesophageal reflux disease (GERD). Heineke-Mikulicz pyloroplasty (Option C) : Procedure to widen the pylorus, typically used in pyloric stenosis (gastric outlet obstruction) or peptic stricture. Whipple procedure (Option D) : Pancreaticoduodenectomy, used for pancreatic head tumours and periampullary malignancies.

References:

Sabiston Textbook of Surgery, 21st Edition, Page 1861.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q26: When performing a rectal biopsy to diagnose Hirschsprung disease, at what distance above the dentate line should the sample ideally be taken to avoid a false-positive result? (Q883992)

A. 0.5 cm

B. 1.0 cm

C. 2.0 cm

D. 5.0 cm

Correct Answer: C. 2.0 cm

Explanation: The aganglionic segment in Hirschsprung disease typically begins at the internal anal sphincter and extends proximally. The normal physiological hypoganglionic zone extends up to 2 cm above the dentate line. Therefore, a biopsy should be taken at least 2 cm above the dentate line to avoid sampling this normally sparse area and obtaining a false-positive result. The biopsy will show hypertrophied nerve trunks and the absence of ganglion cells in the diseased segment. 0.5 cm (Option A) : Biopsy at 0.5 cm is within the normal aganglionic/hypoganglionic zone and would likely show absent ganglia, leading to a false-positive diagnosis. 1.0 cm (Option B) : Biopsy at 1.0 cm may still sample the transitional hypoganglionic area and risk a false-positive

result. 5.0 cm (Option D) : While 5.0 cm is safely above the hypoganglionic zone, it is higher than the standard recommendation (2–3 cm) and may miss very short-segment disease. The ideal distance is ≥2 cm.

References:

Sabiston Textbook of Surgery, 21st Edition, Page 1860.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q27: Hirschsprung disease is most frequently associated with mutations in which gene? (Q883991)

A. APC

B. RET

C. BRCA1

D. CFTR

Correct Answer: B. RET

Explanation: Hirschsprung disease is most commonly linked to mutations in the RET proto-oncogene on chromosome 10, which encodes a receptor tyrosine kinase involved in enteric neural crest cell migration and survival. Mutations in genes for its ligand GDNF and co-receptor GFRA1 are also associated. Down syndrome (trisomy 21) is a strong risk factor. APC (Option A) : Associated with familial adenomatous polyposis & colorectal cancer. BRCA1 (Option C) : Linked to hereditary breast/ovarian cancers. CFTR (Option D) : CFTR mutations cause cystic fibrosis, which can involve gastrointestinal manifestations (meconium ileus, distal intestinal obstruction syndrome) but are distinct from the aganglionosis of Hirschsprung disease.

References:

Sabiston Textbook of Surgery, 21st Edition, Pages 1860, 1861.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q28: What combination of clinical features is typically seen in Heyde’s syndrome? (Q883990)

A. Aortic stenosis, colonic diverticulosis, and iron deficiency anaemia

B. Mitral stenosis, angiodysplasia, acquired von Willebrand disease

C. Aortic stenosis, angiodysplasia, acquired von Willebrand disease

D. Aortic regurgitation, peptic ulcer disease, thrombocytopenia

Correct Answer: C. Aortic stenosis, angiodysplasia, acquired von Willebrand disease

Explanation: Heyde's syndrome is defined by the triad of: Aortic stenosis (usually calcific) Gastrointestinal bleeding from angiodysplasia (most often in the right colon) Acquired type 2A von Willebrand disease due to shear stress-induced cleavage of von Willebrand factor multimers across the stenotic valve. Correction of the aortic stenosis (e.g., via valve replacement) typically resolves the bleeding tendency.

References:

Prepladder Notes

↑ *Back to this question in Part A*

@Neet_pg_bot

• [05_Gastrointestinal Surgery] 027 Ileostomy Colostomy And Ibd

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[05_Gastrointestinal Surgery] 027 Ileostomy Colostomy And Ibd — Quick Jump

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Q13 (p. 2062)	*Q14 (p. 2065)*	*Q15 (p. 2066)*	*Q16 (p. 2067)*	*Q17 (p. 2070)*	*Q18 (p. 2071)*
Q19 (p. 2072)	*Q20 (p. 2077)*	*Q21 (p. 2078)*	*Q22 (p. 2082)*	*Q23 (p. 2083)*	*Q24 (p. 2084)*

Q1: Which of the following macroscopic features is most characteristic of Crohn's disease compared to ulcerative colitis? (Q849290)

A. Continuous inflammation from the rectum extending proximally

B. Erythematous, granular mucosa with superficial ulcerations

C. Transmural inflammation in UC

D. Thickened bowel wall and mesenteric fat wrapping

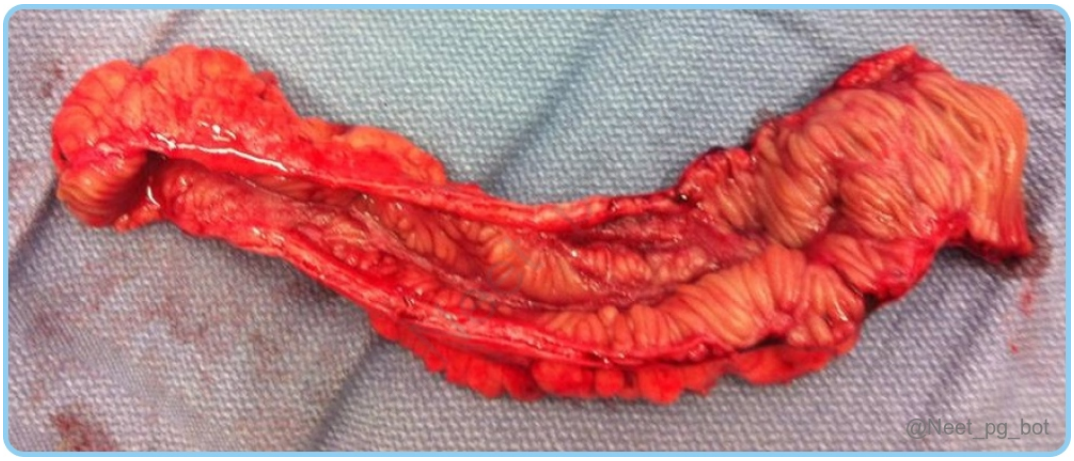
Correct Answer: D. Thickened bowel wall and mesenteric fat wrapping

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Thickened Bowel Wall and Mesenteric Fat Wrapping are typical features of Crohn’s disease. The bowel wall becomes thickened due to transmural inflammation, and there is often “creeping fat” around the bowel. Macroscopic features of UC and Crohn’s: Feature Ulcerative Colitis Crohn's Disease Location Rectum and colon, continuous; does not involve small intestine. Any part of the GI tract, often the terminal ileum or colon, can involve the small bowel and upper GI tract, rectum usually spared. (Option A ruled out) Extent Continuous inflammation; no skip lesions. Patchy inflammation with skip lesions between affected areas. Appearance Erythematous, granular mucosa; superficial ulcers. (Option B ruled out) Deep, serpiginous ulcers, especially on the mesenteric side. Wall Involvement Mucosa and submucosa only. Transmural inflammation through all bowel layers. (Option C ruled out) Strictures Rare. Common due to transmural inflammation and fibrosis. Fistulas Rare, usually perianal. Common, including between bowel loops and adjacent organs. Fat Wrapping Absent. Present; "creeping fat" around the bowel wall. Additional Features - Thickened bowel wall; thickened mesentery with enlarged lymph nodes. Images {{caption_text}} {{caption_text}}





References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1321

↑ *Back to this question in Part A*

@Neet_pg_bot

Q2: A 52-year-old male with a history of ulcerative colitis presents with severe abdominal pain and distention, fever, and tachycardia. He appears ill and is in

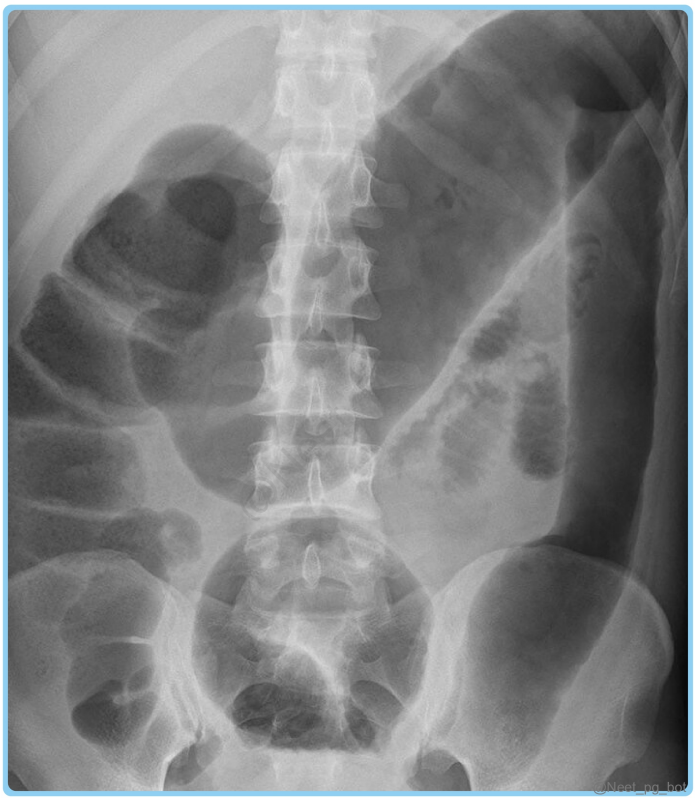
significant discomfort. Lab tests show leukocytosis and electrolyte imbalances. An X-ray of the abdomen is taken. Which of the following surgical procedures is the most appropriate for this patient? {{caption_text}} (Q849289)

A. Segmental Colectomy

B. Total Abdominal Colectomy with End Ileostomy

C. Diverting Loop Ileostomy with Colonic Lavage

D. Laparoscopic Colonic Decompression



Correct Answer: B. Total Abdominal Colectomy with End Ileostomy

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The patient's severe symptoms and lab abnormalities, along with X-ray findings of significant colonic dilation, suggest a critical condition like toxic megacolon. The most appropriate surgical procedure is Total Abdominal Colectomy with End Ileostomy, as it has been associated with lower mortality compared to segmental colectomy, especially in the presence of colonic perforation or necrosis. Management of Toxic megacolon: Therapies IBD-Related : Intravenous glucocorticoids (e.g., hydrocortisone 100 mg every 6-8 hours) as first-line therapy; infliximab or cyclosporine if no response within 3 days C. difficile Colitis : Stop inciting antibiotics; steroids not used; metronidazole, vancomycin, or fidaxomicin for medical therapy; fecal microbial transplantation considered in some cases Surgical Indications Absolute indications : Perforation, life-threatening

hemorrhage, worsening toxicity, worsening dilatation IBD : Colectomy if no improvement after 24-48 hours; subtotal colectomy preferred for emergency surgery C. difficile : Surgery for perforation, necrosis, or severe complications; early colectomy reduces the mortality rate Procedure Indications Advantages Disadvantages Total Abdominal Colectomy with End Ileostomy Colonic perforation, necrosis, abdominal compartment syndrome Resolves abdominal compartment syndrome, lower mortality compared to segmental resection More invasive, irreversible stomas in many cases Diverting Loop Ileostomy with Colonic Lavage No perforation, necrosis, or compartment syndrome Minimally invasive, higher likelihood of stoma reversal May leave inflamed colon, slower recovery, potential ongoing critical illness Segmental Colectomy (Option A) is associated with higher mortality in fulminant C. difficile colitis and is no longer recommended.

References:

Sabiston's textbook of surgery, 21st Edition, Page 1352

https://www.uptodate.com/contents/surgical-management-of-clostridioides-difficile-colitis-in-adults?sectionName=WHICH%20PROCEDURE%20TO%20PERFORM%3F&search=toxic%20megacolon&topicRef=1381&anchor=H1331958192&source=see_link#H1331958192

https://www.uptodate.com/contents/toxic-megacolon?search=toxic%20megacolon&source=search_result&selectedTitle=1~42&usage_type=default&display_rank=1

↑ *Back to this question in Part A*

@Neet_pg_bot

Q3: A 38-year-old male presents with severe abdominal distension and diarrhea. His vitals show a heart rate of 125 beats/min, fever of 38.9°C, and a white blood cell count of 13,800/microL. A radiograph reveals colonic dilation of 7 cm. Which of the following additional findings would not confirm the diagnosis of toxic megacolon? (Q849288)

A. Anemia

B. Altered sensorium

C. Hypotension

D. Electrolyte disturbances

Correct Answer: A. Anemia

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Anemia is one of the systemic signs considered in the diagnostic criteria but does not fulfill the additional systemic toxicity criteria (which are altered sensorium, dehydration, electrolyte disturbances, or

hypotension). Thus, anemia alone would not be sufficient to confirm toxic megacolon when assessing the systemic toxicity criteria. Diagnosis and Evaluation of Toxic Megacolon Diagnosis Criteria Radiographic Evidence: Colonic dilation (diameter >6 cm) PLUS at least three of the following: Fever >38ºC Heart rate >120 beats/min Neutrophilic leukocytosis >10,500/microL Anemia PLUS at least one of the following: Dehydration Altered sensorium (Option B) Electrolyte disturbances (Option D) Hypotension (Option C) Differential Diagnosis Congenital megacolon (Hirschsprung's disease). Acquired megacolon (chronic constipation). Chagas megacolon. Colonic pseudo-obstruction (Ogilvie syndrome). Diffuse gastrointestinal dysmotility. Acute colonic obstruction from diverticulitis, volvulus, tumors.

References:

Sabiston’s textbook of surgery, 21st Edition, Page 1352

https://www.uptodate.com/contents/toxic-megacolon?search=toxic%20megacolon&source=search_result&selectedTitle=1~42&usage_type=default&display_rank=1

↑ *Back to this question in Part A*

@Neet_pg_bot

Q4: A 32-year-old patient diagnosed with mild Crohn's disease affecting the ileocecal region presents to your clinic. The patient has mild symptoms with no significant systemic involvement. What is the most appropriate first-line drug to prescribe for this patient to induce remission in mild Crohn's disease? (Q849267)

A. Prednisone

B. Azathioprine

C. Infliximab

D. Budesonide

Correct Answer: D. Budesonide

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Budesonide is a first-line treatment for inducing remission in mild to moderate Crohn's disease, especially when the disease is localized in the ileocecal region. It is a corticosteroid with a high first-pass metabolism, resulting in fewer systemic side effects than corticosteroids like prednisone. Category Mild Crohn's Disease Moderate to Severe Crohn's Disease Induction Therapy First-line : Budesonide (Option D) (preferred for ileocecal disease)or aminosalicylates (e.g., mesalamine). Prednisone (Option A) for those who do not respond to budesonide. Alternative : Enteral nutrition. First-line : Corticosteroids (e.g., prednisone for short term) or biologics Anti-TNF agents (Infliximab (Option C) , Adalimumab) Anti-integrin therapy (Vedolizumab) Anti-interleukin therapy (Ustekinumab) Combination therapy : Anti-TNF agents plus immunomodulators (Azathioprine, 6-MP)

(Option B) Maintenance Therapy First-line : Continue aminosalicylates if effective. Alternative : Thiopurines (azathioprine, 6-MP) for patients intolerant to aminosalicylates. Anti-TNF monotherapy : Long-term for maintaining remission. Combination therapy : Anti-TNF agents with immunomodulators (for severe cases or history of nonresponse to biologics). Continue anti-integrin or anti-interleukin agents for those induced by these therapies Monitoring Regular follow-up to monitor symptoms and inflammation. Ileocolonoscopy 6-12 months post-remission. Drug level monitoring and fecal calprotectin to assess mucosal healing.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1330.

https://www.uptodate.com/contents/overview-of-the-medical-management-of-mild-low-risk-crohn-disease-in-adults?search=crohn&source=search_result&selectedTitle=1~150&usage_type=default&display_rank=1

https://www.uptodate.com/contents/medical-management-of-moderate-to-severe-crohn-disease-in-adults?search=crohn&topicRef=4069&source=see_link

https://www.uptodate.com/contents/perianal-crohn-disease?search=fistulizing%20Crohn%27s&source=search_result&selectedTitle=2~150&usage_type=default&display_rank=2

↑ *Back to this question in Part A*

@Neet_pg_bot

Q5: A patient with chronic ulcerative colitis who had undergone total proctocolectomy with ileal pouch-anal anastomosis has come to the department complaining of diarrhoea, abdominal pain, fever and malaise. On examination, hematochezia is noted. What is the first line of treatment here? (Q849287)

A. Antibiotic therapy

B. Biologic agents

C. Probiotics

D. Pouch excision

Correct Answer: A. Antibiotic therapy

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The clinical scenario points to the diagnosis of pouchitis. The first line of treatment for pouchitis is antibiotic therapy. Definition: Pouchitis is an inflammatory condition affecting the ileal pouch and continent ileostomy reservoirs. It occurs in 30% to 55% of cases. Etiology: The actual etiology is unknown. It may be due to fecal stasis in the pouch, but emptying studies are not confirmatory. Clinical features: Diarrhea Hematochezia Fever Pain abdomen Malaise Investigation and diagnosis: Endoscopy and biopsy Management : First line:

Antibiotic therapy using metronidazole +/- ciprofloxacin . Oral preparations or enemas can be given. In chronic pouchitis, ongoing suppressive therapy is to be given. Salicylate and corticosteroids can also be used. In case of refractory disease, normal flora in the intestine is reintroduced with the help of probiotics (Option C) and/ or an elemental diet . Biological agents (Option B) like TNF■ (infliximab, vedolizumab, ustekinumab) Pouch excision (Option D) is done in cases of chronic pouchitis.

References:

Schwartz Principles of Surgery, 11th Edition, Page 1278.

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1326.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q6: A 45-year-old male with a long-standing history of chronic inflammatory bowel disease presents for routine follow-up. He undergoes a colonoscopy, during which suspicious lesions are identified. A biopsy confirms the presence of malignancy. Which of the following types of cancer is more commonly associated with Crohn's disease than with ulcerative colitis? (Q849280)

A. Colon carcinoma

B. Small intestine carcinoma

C. Cholangiocarcinoma

D. Gastric cancer

Correct Answer: B. Small intestine carcinoma

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Small intestine cancers are more prone to Crohn’s disease than ulcerative colitis. Small bowel adenocarcinoma is a rare complication associated with Crohn’s disease. This is because the small bowel (ileum) is the most common part of the intestine affected by Crohn’s disease. Risk factors of carcinoma in ulcerative colitis: Pancolonic disease Duration (Long-standing disease) Dysplasias Left-sided colitis Primary sclerosing cholangitis Hereditary colon cancer Young age Features of colitis-associated carcinoma: Age group >30 years Due to prolonged colitis Develops from colitis → dysplasia → carcinoma Dysplasia seen here is flat dysplasia Pancolonic disease: multicentric and infiltrative Increased mortality Endoscopic removal or colonoscopy is done Interval cancers are possible NOTE: Risk for colonic carcinoma: CD=UC Risk for small bowel malignancy: CD>UC Risk for Cholangiocarcinoma: UC>CD Colon carcinoma (Option A) is a complication of both Crohn’s and ulcerative colitis with equal occurrences. Cholangiocarcinoma (Option C) is associated with ulcerative colitis. The risk factor here is primary sclerosing cholangitis. Gastric cancer (Option D) is not associated with Ulcerative colitis or

Crohn’s disease. It is rather associated with chronic peptic ulcers .

References:

Schwartz Principles of Surgery, 11th edition, Page 1283.

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7988828/

↑ *Back to this question in Part A*

@Neet_pg_bot

Q7: Which of the following would be a differentiating feature of Colitis-associated colon carcinoma (CAC) from sporadic colon cancer? (Q849279)

A. Sporadic colon cancer develops due to chronic inflammation and dysplasia

B. CAC has a lower mortality

C. CAC is more common after the age of 30

D. Sporadic colon cancer is associated with young individuals

Correct Answer: C. CAC is more common after the age of 30

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Colitis-associated colon carcinoma (CAC) is more common after 30 years and sporadic colon cancer is most common in the 8th decade. Colitis-associated colon cancer Sporadic colon cancer Age group >30 years Due to prolonged colitis Develops from colitis to dysplasia to carcinoma Dysplasia seen here is flat dysplasia Pancolonic disease: multicentric and infiltrative Increased mortality (Option B) Endoscopic removal or colonoscopy is done Interval cancers are possible Age group > 50 years (Option D) Most common in 8th decade Most common site is the sigmoid colon, with left-side predominance Usually arises from an adenomatous polyp (Option A)

References:

Schwartz Principles of Surgery, 11th Edition, Pages 1282, 1283.

Sabiston Textbook of Surgery, 21st Edition, Page 1367.

https://pubmed.ncbi.nlm.nih.gov/37663937/

↑ *Back to this question in Part A*

@Neet_pg_bot

Q8: A 58-year-old male comes to the hospital complaining of intermittent pain in the anal region and intermittent diarrhea for 6 months. On examination, he was found to have complex perianal fistulas bilaterally, with skin tags, as shown in the image. His blood investigations reveal anemia. What could be the possible diagnosis leading to this? {{caption_text}} (Q849278)

A. Crohn’s disease of anorectum

B. Ulcerative colitis

C. Carcinoma rectum

D. Hemorrhoids



Correct Answer: A. Crohn’s disease of anorectum

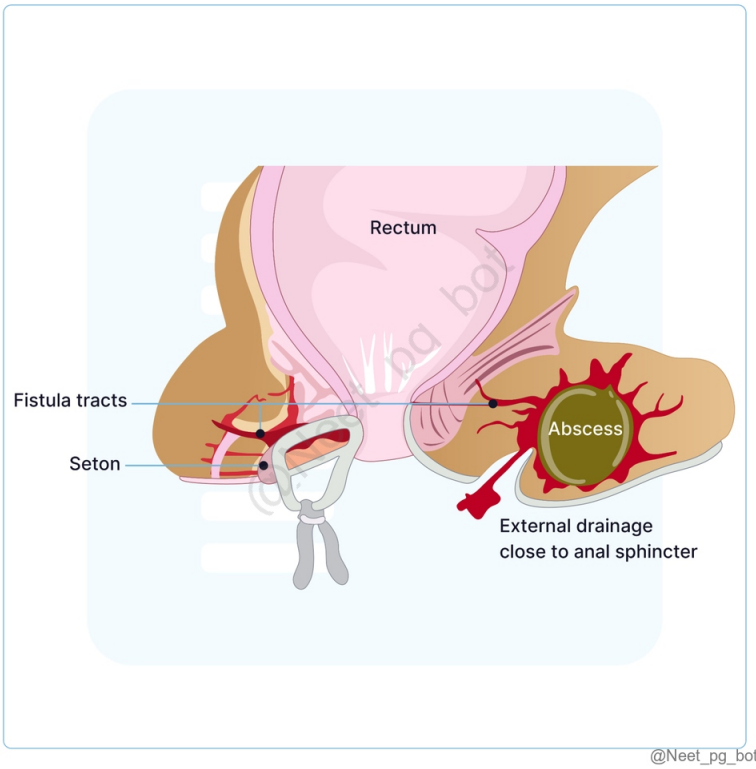
■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Crohn’s disease of the anorectum presents with multiple complex fistulae mostly bilateral and with purplish skin tags that give an “elephant ear" appearance. {{caption_text}} Clinical features: Bilaterally located complex anal fistula Elephant ear type large skin tags-edematous and purplish. Broad-based anal fissures away from the midline Anorectal abscess, which may rupture and lead to fistulae Ulceration Treatment : Control of

infection, treatment of underlying mucosal disease, and sphincter preservation. Drain abscesses, if any, to prevent the development of perineal sepsis. Medical therapy: antibiotics (metronidazole), immunomodulators , and biologic agents (ANF alpha agents: infliximab, adalimumab); (salicylates and/or corticosteroid enemas for proctitis) Early fecal diversion for anovaginal fistula. Endoanal mucosal advancement flap repair. Anal strictures may be dilated if symptomatic. Ulcerative colitis (Option B) commonly presents with bloody diarrhea but does not cause perianal disease with fissures or tags. Carcinoma rectum (Option C) may present with bleeding per rectum and will have a complex of symptoms like weight loss, early morning diarrhea, and pain which is a late symptom. A full colorectal examination and a CT are necessary here. Hemorrhoids (Option D) may be present in Crohn’s of the anorectum but not with the above-mentioned clinical features. There won't usually be anal pain.





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References:

Sabiston Textbook of Surgery, 21st Edition, Pages 1415,1416.

Schwartz Principles of Surgery, 11th Edition, Pages 1285,1286.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q9: A patient with a history of ulcerative colitis (UC) has undergone a total proctocolectomy with ileal pouch-anal anastomosis (TPA + IPAA) as part of their treatment. Which of the following is not a possible complication of the procedure? (Q849277)

A. Anastomotic leak

B. Pouchitis

C. Pelvic sepsis

D. Peritonitis

Correct Answer: D. Peritonitis

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The patient has undergone total proctocolectomy with ileal pouch-anal anastomosis (IPAA) , which is the surgery of choice for ulcerative colitis requiring definitive treatment . This procedure involves creating an ileal pouch (J-pouch) and anastomosing it to the anal canal. Common complications of IPAA include: Pouchitis (most common): It presents with increased stool frequency, urgency, abdominal cramps, and sometimes bleeding , and is a hallmark complication of this surgery Anastomotic leak (Option A) Pelvic sepsis (Option C) can occur due to anastomotic leak or infection of the pelvic cavity after surgery Pouch fistula, strictures, and pouch failure Anastomosis and pouch line leaks (Option A) Peritonitis, however, is not considered a direct or typical complication of the procedure itself . It is more commonly related to disease-related complications (like perforation) or secondary to severe intra-abdominal infection , rather than a complication of IPAA.

References:

www.ncbi.nlm.nih.gov/pmc/articles/PMC10455305/

Sabiston Textbook of Surgery, 21st Edition, Page 1355.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q10: Which of the following procedures is the definitive management of Ulcerative colitis? (Q849276)

A. Total Proctocolectomy with End Ileostomy(TPA+EI)

B. Total Proctocolectomy with Ileal Pouch-Anal Anastomosis (TPA+IPAA)

C. Total Proctocolectomy with mucosectomy with hand-sewn IPAA

D. Total abdominal colectomy with very low Hartmann closure with end ileostomy

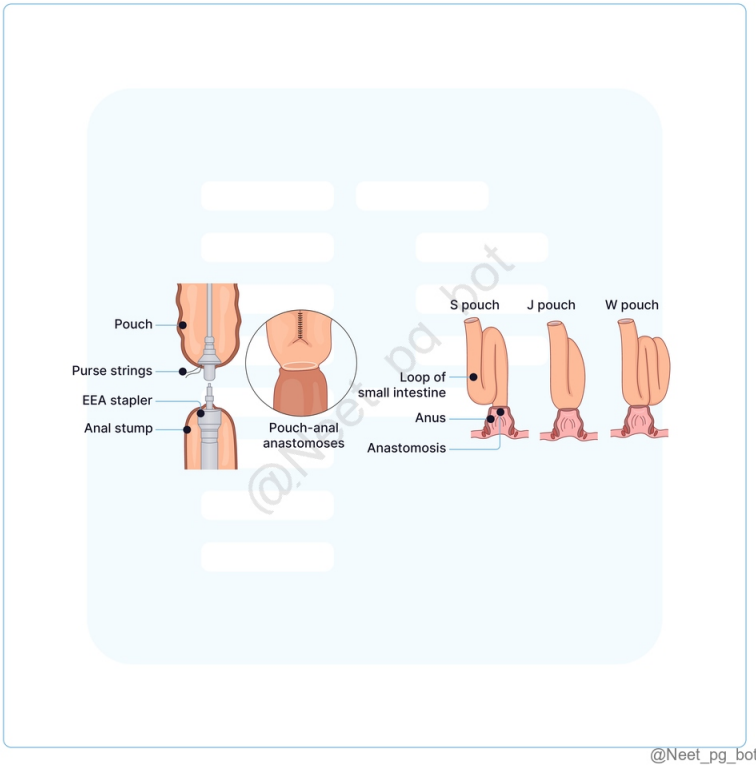
Correct Answer: B. Total Proctocolectomy with Ileal Pouch-Anal Anastomosis (TPA+IPAA)

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Total Proctocolectomy with Ileal Pouch-Anal Anastomosis (TPA + IPAA) Indications: Definitive treatment for ulcerative colitis, especially in young patients. Eliminates risk of colorectal cancer and colitis-related symptoms. Typically done in two stages: Proctocolectomy and ileal pouch creation. Closure of the ileostomy after pouch healing. Proctocolectomy (First Stage) Remove the colon and rectum. Preserve the anal canal. ↓ Ileal Pouch Creation Create a J-shaped ileal pouch from a segment of the ileum. Connect the pouch to the anal canal (ileal pouch-anal anastomosis). ↓ Anastomosis and Ileostomy Anastomose the J-pouch to the anal canal. Perform a covering loop ileostomy to divert intestinal contents and protect the pouch. ↓ Post-operative Imaging Conduct a

Gastrografin contrast enema to confirm the integrity and healing of the pouch. ↓ Closure of Ileostomy (Second Stage) Close the ileostomy once pouch healing is confirmed through imaging. ↓ Post-surgical Outcomes Monitor for adjustment to stool frequency and management of minor issues like urgency or fecal incontinence, which usually improve over time. TPC + End Ileostomy (Option A) is preferred for older patients and patients with fecal incontinence. TPC + mucosectomy with hand-sewn IPAA (Option C) is a procedure done in case of the presence of rectal dysplasia. Total abdominal colectomy with very low Hartmann closure with end ileostomy (Option D) is done in more debilitating cases and those who can't tolerate long duration of surgery. The rectum is spared here.



References:

Sabiston Textbook of Surgery, 21st Edition, Pages 1352- 1354.

Bailey & Love's Short Practice of Surgery, 28th Edition, Pages 1324, 1325.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q11: A 45-year-old patient presents with a history of chronic abdominal pain, frequent bloody diarrhea, and an urgent need to defecate. Colonoscopy reveals continuous inflammation starting from the rectum and extending through the colon. Despite receiving the highest doses of medical therapy, the symptoms have worsened. Which of the following would not be considered an indication for surgery in this

patient? (Q849269)

A. Failure of maximum medical therapy

B. Multiple bowel movements

C. Fulminant colitis

D. Enteroenteric fistula

Correct Answer: D. Enteroenteric fistula

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Surgery is the preferred choice of treatment in case of complications of Crohn’s disease such as tenesmus, multiple bowel movements, fulminant colitis, failure of maximum medical management and those with poor quality of life as a result of poor nutritional status. However, enteroenteric fistulas do not require surgery unless they are accompanied by notable symptoms, such as obstruction or significant discomfort. Abdominal pain caused by obstruction is also regarded as an indication for surgery. Indications of surgery in IBD: Ulcerative colitis Crohn’s disease: Failure of maximum medical therapy (Option A) Poor quality of life due to tenesmus, urgency, and low body weight. Multiple bowel movements (Option B) , poor nutritional status, and weak physical health. Growth retardation in children or adolescents; Fulminant colitis (Option C) . Some of these cases may also have toxic megacolon. Severe colitis leads to chronic ileus and a dilated colon, both leading to an increased risk of perforation. Significant GI bleeding Associated sclerosing cholangitis Presence of colonic dysplasia or cancer in colonoscopic surveillance (chronic UC > 8 years) Perianal disease not responding to treatment. Severe extra-intestinal disease Children with failure to thrive Symptoms of obstruction secondary to fibrostenosing Crohn's disease Perforated Crohn’s disease with associated abscess or fistula Severe abdominal pain with obstruction Cancer or dysplasia Isolated terminal ileal disease Recurrent disease Incidental finding of Crohn’s during an appendectomy

References:

Sabiston Textbook of Surgery, 21st Edition, Pages 1349, 1350

Bailey & Love’s Short Practice of Surgery, 28th Edition, Pages 1331, 1332.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q12: A 35-year-old patient with moderate to severe ulcerative colitis has achieved clinical remission with a biologic agent. Which of the following drugs is used in the maintenance therapy for moderate to severe ulcerative colitis? (Q849268)

A. Mesalamine

B. Adalimumab

C. Sulfasalazine

D. Hydrocortisone

Correct Answer: B. Adalimumab

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Adalimumab is an anti-TNF agent used in the maintenance therapy of moderate to severe ulcerative colitis. It helps maintain remission after the initial response. Aspect Mild to Moderate UC Moderate to Severe UC Goals of Therapy Induce and maintain clinical remission. Achieve and maintain glucocorticoid-free remission, prevent relapse. Initial Treatment 5-ASA compounds (e.g., mesalamine, sulfasalazine) or topical corticosteroids. 5-ASA compounds, corticosteroids, or biologics (e.g., anti-TNF agents, vedolizumab). Maintenance Therapy 5-ASA compounds; consider thiopurines for non-responders or relapsers. Biologics (e.g., anti-TNF agents-infliximab, adalimumab; vedolizumab), thiopurines, or small molecules (e.g., JAK inhibitors). Lab Monitoring CBC, liver tests every 3-4 months; electrolytes and renal function annually. Endoscopic Evaluation Not routinely required unless symptoms persist. Colonoscopy or flexible sigmoidoscopy every 6 months, or based on clinical need. Inflammatory Markers CRP and fecal calprotectin every 3-4 months if used. Relapse Management Optimize dosage, consider switching therapies if necessary. Evaluate for co-existing conditions and adherence. Specific Therapies Thiopurines: Consider if non-responsive to 5-ASA. Anti-TNF Agents Vedolizumab Ustekinumab Mirikizumab JAK Inhibitors (Tofacitinib, Upadacitinib) S1P Receptor Modulators (Ozanimod, Etrasimod)

References:

Sabiston Textbook of Surgery, 21st Edition, Pages 1348, 1349.

https://www.uptodate.com/contents/medical-management-of-low-risk-adult-patients-with-mild-to-moderate-ulcerative-colitis?search=Medical%20management%20of%20Ulcerative%20colitis&source=search_result&selectedTitle=3~150&usage_type=default&display_rank=3

↑ *Back to this question in Part A*

@Neet_pg_bot

Q13: A 55-year-old male patient presents with a low rectal tumor and requires bowel diversion. The surgeon is considering the type of stoma to be created. Which of the following indications best matches the need for an ileostomy rather than a colostomy? (Q849254)

A. To relieve bowel obstruction when resection is not feasible.

B. To protect a distal anastomosis after low anterior resection.

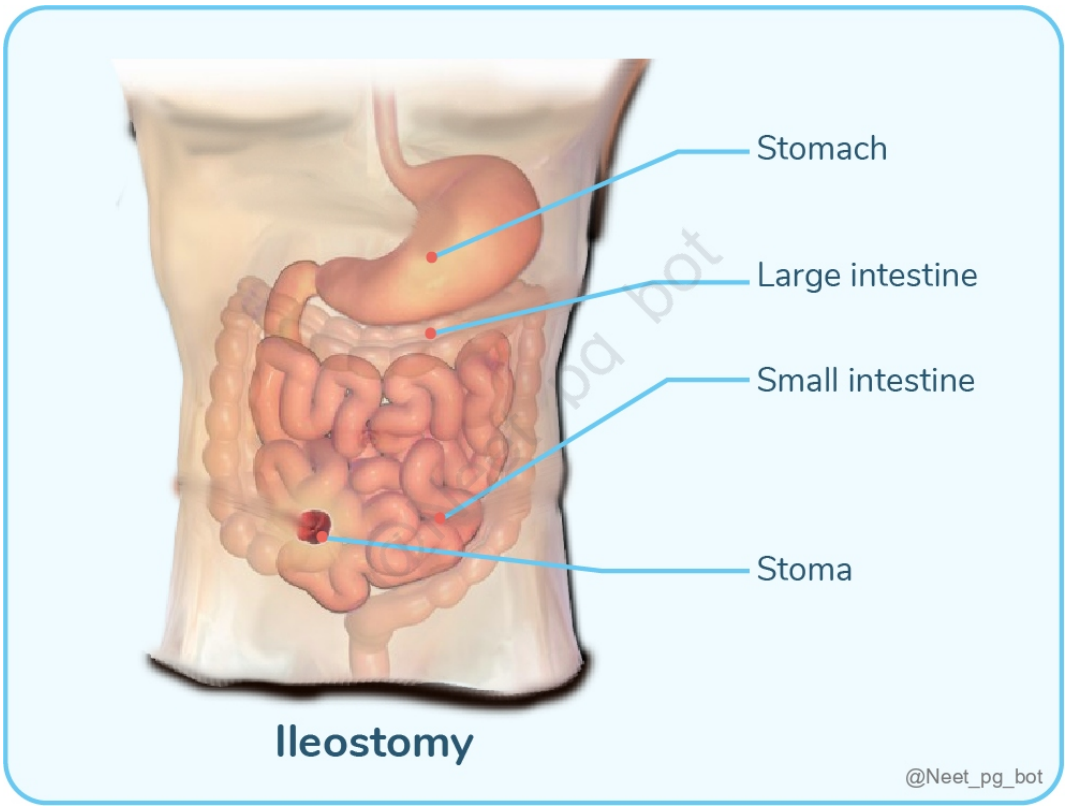
C. To manage inflammatory diseases with severe perianal disease.

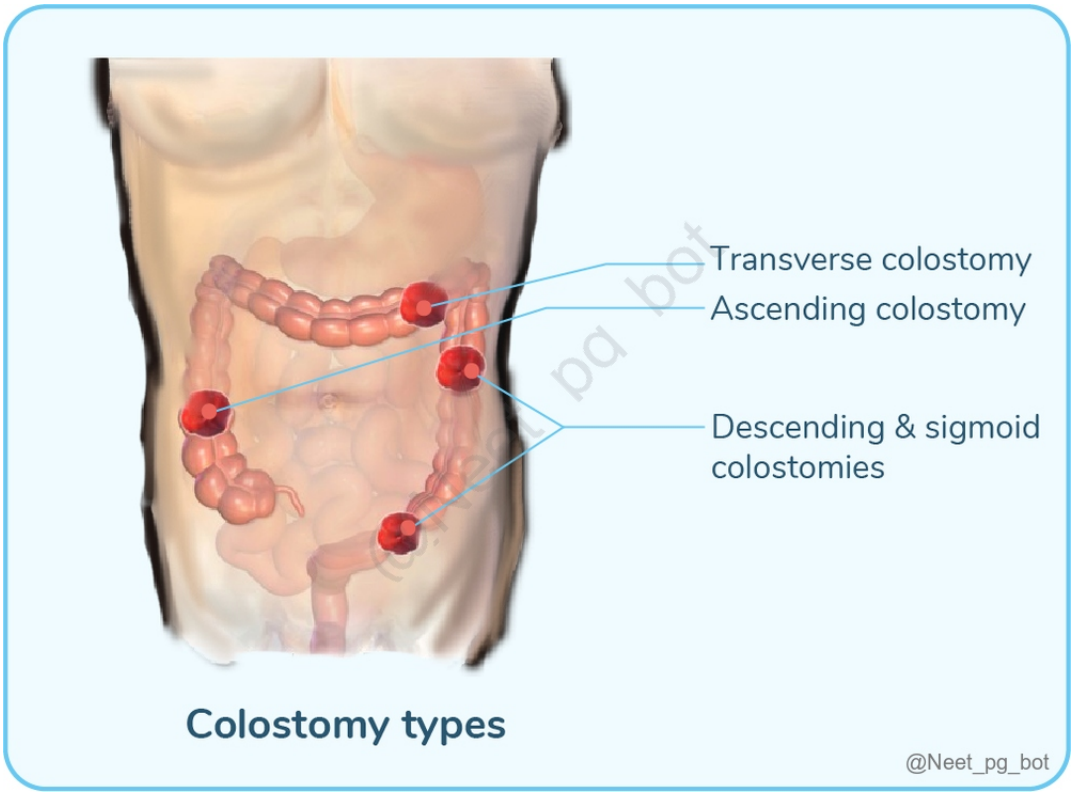
D. Permanent fecal diversion following total colectomy

Correct Answer: D. Permanent fecal diversion following total colectomy

- *Listen (English)*
- *Listen (Hindi)*

Explanation: Permanent fecal diversion following total colectomy is one of the major indications for Ileostomy. An end ileostomy is indicated following total colectomy for conditions such as Rectal carcinoma or familial adenomatous polyposis (FAP). This results in a permanent stoma, where the ileum is brought to the surface, and the patient manages the stoma for life. The absence of the colon necessitates this approach, making it specific to conditions involving the entire colon removal. Feature Ileostomy Colostomy Location Typically located in the right iliac fossa Typically located in the left iliac fossa Stool Consistency Usually results in liquid or semi-liquid stool Produces a more formed stool Spout Ileostomy is usually spouted Colostomy is usually flush Use To defunction the rest of the bowel in order to protect a distal anastomosis To evacuate stool from the body if the entire colon has been removed (such as in colorectal cancer, IBD) To relieve bowel obstruction To protect a distal anastomosis or allow healing away from the faecal flow Following resection when anastomosis is unsafe or not possible To relieve obstruction when resection is not feasible To reduce disease activity (e.g. Crohn’s disease) To allow alternative bowel control (incontinence) Fluid and electrolyte problems More likely Less likely Appliances Requires bags that often need to be emptied frequently due to the liquid consistency of the stool Uses appliances that may be changed as needed, depending on the type of colostomy and stool consistency Image {{caption_text}} {{caption_text}} A colostomy can be used to relieve obstruction when resection isn't possible (Option A) , such as in cases of obstructing rectal cancer or sigmoid volvulus. It helps divert stool away from the obstruction site. A colostomy is commonly used to protect a distal anastomosis (Option B) , especially after rectal surgery, by diverting fecal flow and allowing the anastomosis to heal without the risk of contamination from fecal material. While ileostomy may sometimes be used in Crohn's and other inflammatory diseases, colostomy can also be indicated, particularly when the disease is localized to the colon and perianal regions (Option C) . It helps manage fecal diversion in severe cases, allowing perianal lesions to heal.





References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Pages 1372, 1373.

https://www.ncbi.nlm.nih.gov/books/NBK519003/

SRB's Manual of Surgery, 6th Edition, Page 901.

https://www.ncbi.nlm.nih.gov/books/NBK519003/

↑ *Back to this question in Part A*

@Neet_pg_bot

Q14: A 39-year-old male with a 12-year history of ulcerative colitis presents with worsening symptoms despite maximum medical therapy. He experiences >10 bowel movements per day, urgency, tenesmus, and significant weight loss. Biopsies show high-grade dysplasia. The surgical team plans a total proctocolectomy with ileal pouch-anal anastomosis (IPAA). What is the primary goal of the planned surgery for this patient? (Q849266)

A. Palliative

B. Curative

C. Remission

D. Maintenance

Correct Answer: B. Curative

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The primary goal of the planned surgery, which is a total proctocolectomy with Ileal pouch-anal anastomosis (IPAA), is to cure ulcerative colitis. IPAA has become the most popular procedure for Ulcerative colitis not responding to medical therapy as well as for patients requiring colectomy for the presence of dysplasia. It significantly improves the patient's quality of life and effectively cures the colonic manifestation of ulcerative colitis■. Palliative surgery (Option A) relieves symptoms without addressing the underlying cause. While it may be used to manage severe symptoms in some cases, the primary goal of a proctocolectomy in ulcerative colitis is to remove the diseased bowel and provide a cure, not just symptom relief■. Achieving remission (Option B) refers to controlling the symptoms and inflammation with medication . Surgery, in this case, is intended to cure the disease by removing the entire diseased colon and rectum, not just to put the disease into remission■ Maintenance (Option D) typically refers to ongoing medical therapy to manage the disease. In the context of high-grade dysplasia in ulcerative colitis, the surgery is performed with a curative intent to prevent cancer.

References:

Sabiston Textbook of Surgery, 21st Edition, Pages 1349,1350,1352.

Bailey & Love's Short Practice of Surgery, 28th Edition, Pages 1323, 1325.

↑ *Back to this question in Part A*

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Q15: Which of the following statements regarding ulcerative colitis is correct? (Q849265)

A. Backwash ileitis, where there is secondary inflammation in the terminal ileum, is a common finding in all patients with ulcerative colitis.

B. Extraintestinal manifestations such as arthritis are more likely to occur in patients with proctitis alone.

C. 8 bloody stools per day and associated joint pain are classified as moderate ulcerative colitis.

D. Fulminant ulcerative colitis is characterized by >10 bowel movements daily, continuous bleeding, and evidence of systemic toxicity.

Correct Answer: D. Fulminant ulcerative colitis is characterized by >10 bowel movements daily, continuous bleeding, and evidence of systemic toxicity.

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Fulminant ulcerative colitis is associated with >10 bowel movements daily, fever, tachycardia, continuous bleeding, anemia, hypoalbuminemia, abdominal tenderness and distension , the need for blood transfusion and, in the most severe cases, progressive colonic dilation (toxic megacolon). This is a very significant finding, suggestive of disintegrative colitis, and an indication for emergency surgery if colonic perforation is to be avoided. Backwash ileitis (Option A) is a secondary inflammation in the terminal ileum, seen in some patients with pancolitis but not all ulcerative colitis patients. It involves retrograde inflammation extending 2–3 cm into the terminal ileum from the colon. Risk factors include extensive colitis and primary sclerosing cholangitis. Biopsies help distinguish backwash ileitis from Crohn's disease-related ileitis. If inflammation is confined to the rectum (proctitis) , there are usually no systemic symptoms, and extra-alimentary manifestations are rare (Option B) . The main symptoms are rectal bleeding, tenesmus and mucous discharge. According to the severity classification, a patient with > 6 bloody stools per day and evidence of systemic illness, such as joint pain, would be classified as having severe ulcerative colitis , not moderate. Truelove and Witts Severity Classification for Ulcerative Colitis: Severity Stool Frequency Systemic Symptoms and signs Mild <4 stools/day No systemic signs of toxicity Moderate (Option C) >4 stools/day Fever, abdominal pain, Elevated ESR, CRP Severe >6 stools/day Fever, tachycardia, anemia, systemic illness, hypoalbuminuria, Elevated ESR, CRP Fulminant >10 stools/day Continuous bleeding, fever, tachycardia, abdominal tenderness & distension, “Toxic megacolon” (progressive colonic dilation, an indication for emergency surgery) in severe cases

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Pages 1319, 1327

https://www.uptodate.com/contents/endoscopic-diagnosis-of-inflammatory-bowel-disease-in-adults?search=backwash%20ileitis&source=search_result&selectedTitle=1%7E8&usage_type=default&display_rank=1#H3285139932

↑ *Back to this question in Part A*

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Q16: A 38-year-old patient with a history of chronic diarrhea and rectal bleeding undergoes a barium enema for evaluation. The radiological image shows changes in the colonic mucosa. Based on the findings of the barium enema, which of the following radiological features is most indicative of Ulcerative colitis (UC)? {{caption_text}} (Q849264)

A. Narrowed, constricted colon with a "hose pipe" appearance

B. Multiple deep ulcers with surrounding inflammation

C. Discontinuous patches of inflammation with normal segments in between

D. Presence of pseudopolyps

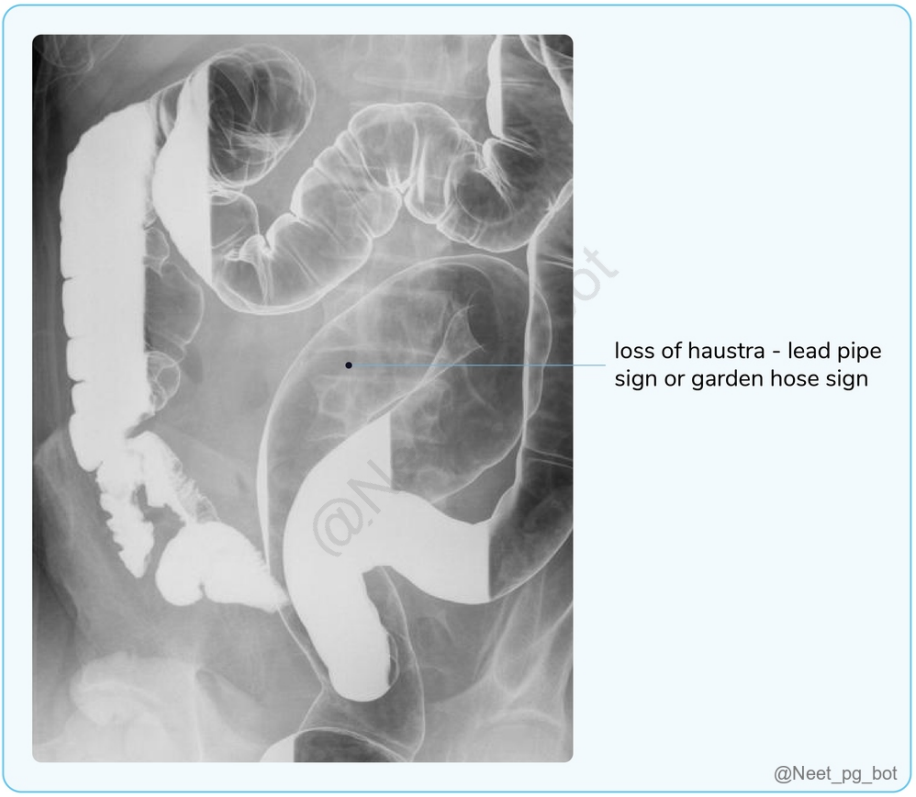


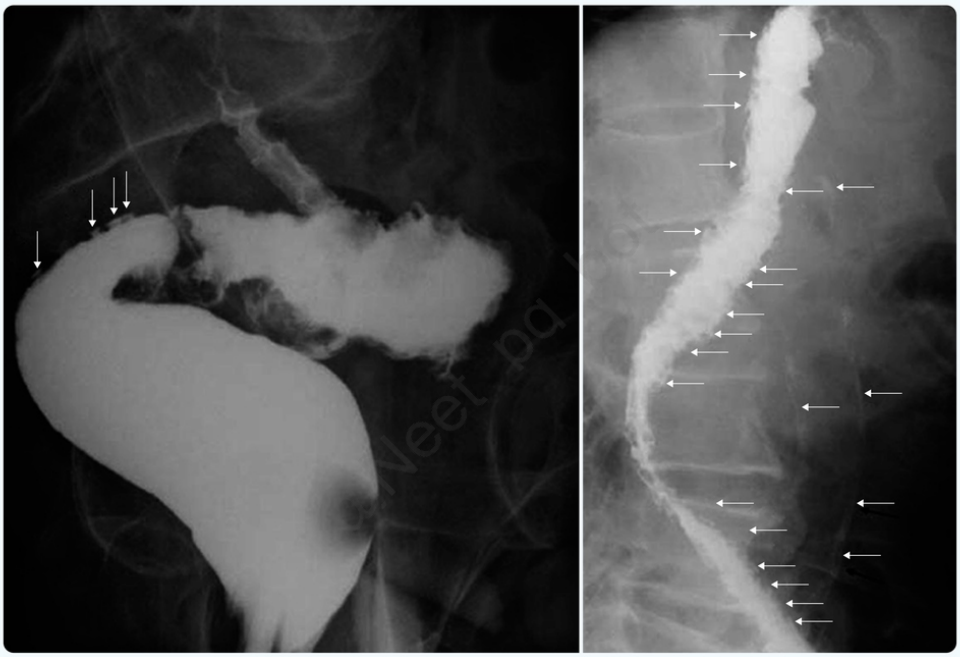
Correct Answer: A. Narrowed, constricted colon with a "hose pipe" appearance

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Ulcerative colitis is characterized by the loss of haustrations and narrowing of the colon, which can appear like a "hose pipe" on a barium enema. {{caption_text}} {{caption_text}} {{caption_text}} Diagnostic and Investigatory Methods for UC: Colonoscopy: Primary method; examines the entire colon, includes biopsy to confirm diagnosis. Histology: Biopsies show significant inflammation, with polymorphonuclear leukocytes, goblet cell depletion, and crypt abscesses. UC inflammation is confined to the mucosal surface. Barium Enema: Shows loss of haustrations, narrowed colon - Garden hose appearance/ Pipestem colon/Lead pipe sign/ Stove pipe sign mucosal changes pseudopolyps Avoided in fulminant cases. Sigmoidoscopy and Biopsy: Visualizes rectum and lower colon, and allows biopsy for diagnostic confirmation. Plain X-ray Abdomen : Identifies complications like bowel obstruction, toxic megacolon, and perforation. CRP Test: Elevated during acute UC phase. pANCA Test: Helps differentiate UC from Crohn's disease; present in ~85% of UC patients.





Radiograph of barium enema study. Clear collar button signs were observed in the (A) sigmoid colon (arrows) and the (B) descending colon (short arrows). Long fine arrows in (B) show calcification of the aorta

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Pseudopolyps

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References:

Sabiston Textbook of Surgery, 21st Edition, Pages 1345, 1346

SRB's Manual of Surgery, 6th Edition, Pages 884, 885

Bailey & Love's Short Practice of Surgery, 28th Edition, Pages 1320-1322.

↑ *Back to this question in Part A*

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Q17: A 30-year-old patient presents with persistent and worsening chronic diarrhea, rectal bleeding, and abdominal pain for the past several months. An endoscopic examination reveals continuous mucosal inflammation starting at the rectum and extending proximally. Which of the following findings is most characteristic of ulcerative colitis (UC) and helps differentiate it from Crohn's disease? (Q849263)

A. Patchy inflammation with skip lesions

B. Continuous inflammation starting from the rectum

C. Transmural inflammation with cobblestone appearance

D. Presence of granulomas in the mucosal layer

Correct Answer: B. Continuous inflammation starting from the rectum

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Ulcerative colitis is characterized by inflammation that begins at the rectum and extends proximally in a continuous manner without skip lesions. This differentiates it from Crohn’s disease, which often presents with patchy inflammation and skip lesions. Ulcerative Colitis (UC) UC is an inflammatory bowel disease (IBD) characterized by chronic inflammation primarily affecting the mucosal layer of the colon. Unlike Crohn's disease, which can affect any part of the gastrointestinal tract and involves deeper bowel layers, UC is limited to the colon and involves only the mucosal layer. Contributing factors Defective mucin production: Mucosal immunological reactions Autoimmune factors (Cytotoxic T cells, anticolon antibodies) HLA DR2 association Family history Cow's milk allergy Stress and lifestyle associations Protective factors Appendicectomy Smoking Sites of involvement UC is confined to the large intestine. Always involves the rectum; extends proximally continuously. Extent of involvement: Proctitis/Proctosigmoiditis (Limited to the rectum and sigmoid colon) Left-Sided Colitis Pancolitis (Entire colon) Colonoscopy Findings Continuous inflammation from the dentate line of the rectum and extends proximally. Initially, mucosa appears erythematous, granular, or roughened; it worsens over time. Ulcers are long, serpentine, covered in fibrin, with a "bear claw" appearance. Significant bleeding can occur due to ulcer erosion into blood vessels. Microscopic Findings Inflammation limited to the mucosal layer Polymorphonuclear leukocytes in lamina propria. Depletion of mucin in goblet cells. Crypt abscesses contain inflammatory cells within Lieberkühn crypts. No granulomas, deep fissural ulcers, or transmural lymphoid aggregates.

References:

Sabiston Textbook of Surgery, 21st Edition, Pages 1344-1346

SRB's Manual of Surgery, 6th Edition, Page 883

Bailey & Love's Short Practice of Surgery, 28th Edition, Pages 1318, 1319.

↑ *Back to this question in Part A*

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Q18: Which extraintestinal manifestation is most commonly associated with Crohn's disease? (Q849262)

A. Uveitis

B. Pyoderma gangrenosum

C. Erythema nodosum

D. Nephrotic syndrome

Correct Answer: C. Erythema nodosum

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The most common extraintestinal manifestation of Crohn’s disease is skin lesions. Specifically, erythema nodosum and pyoderma gangrenosum are the most common skin conditions. Erythema nodosum is characterised by painful, red nodules usually located on the shin of tibia. Extra intestinal manifestations can occur in about 30% of Crohn's patients. 1. Skin Erythema nodosum Erythema multiforme Pyoderma gangrenosum 2. Eyes Iritis Uveitis Conjunctivitis 3. Blood Anemia Thrombocytosis Phlebothrombosis Arterial thrombosis 4. Joints Peripheral Arthritis Ankylosing spondylitis Sacroiliitis 5. Liver Non-specific Hepatitis Primary sclerosing cholangitis Cholesterol gallstones 6. Kidney Nephrotic syndrome (Rare) 7. Urological Stones (Most common type: Oxalate stones) Ureteral obstruction Entero-vesical fistula 8. Pancreas Pancreatitis (Rare) 9. Amyloidosis (Rare) Most common cutaneous manifestation of IBD - Erythema Nodosum Erythema Nodosum Most responsive for Rx of bowel disease Persistence of Erythema Nodosum - Indicates inadequate control of IBD Other options: Option A: Uveitis It can occur in Crohn’s disease but is less common than erythema nodosum. Typically associated with severe or long-standing disease. Option B: Pyoderma gangrenosum Seen in inflammatory bowel disease but is much less common than erythema nodosum. Represents a deeper, ulcerative neutrophilic dermatosis. Option D: Nephrotic syndrome Very rare in Crohn’s disease; when present, often due to secondary amyloidosis — not a common manifestation

References:

Sabiston Textbook of Surgery, 21st Edition, Page 1261

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1329.

SRB's Manual of Surgery, 6th Edition, Page 857.

↑ *Back to this question in Part A*

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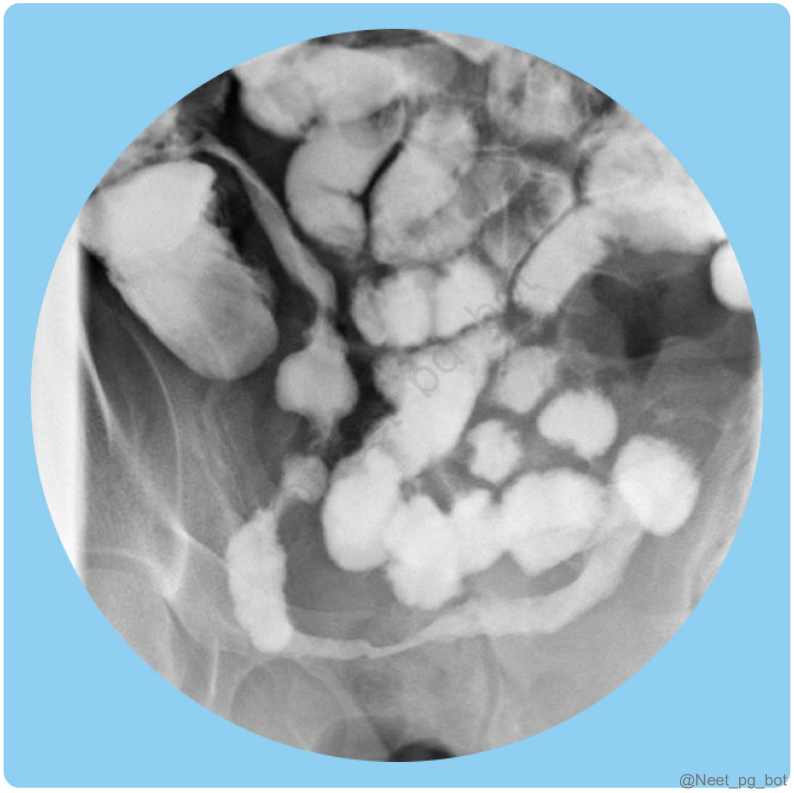
Q19: A 45-year-old patient with a history of long-standing Crohn's disease presents for a follow-up examination. An abdominal X-ray with barium contrast is performed to evaluate the current state of the small bowel. Based on the barium radiographic image provided, which of the following signs is depicted below? {{caption_text}} (Q849261)

A. String Sign of Kantor

B. Apple-Core Sign

C. Lead-Pipe Appearance

D. Bird-Beak Sign

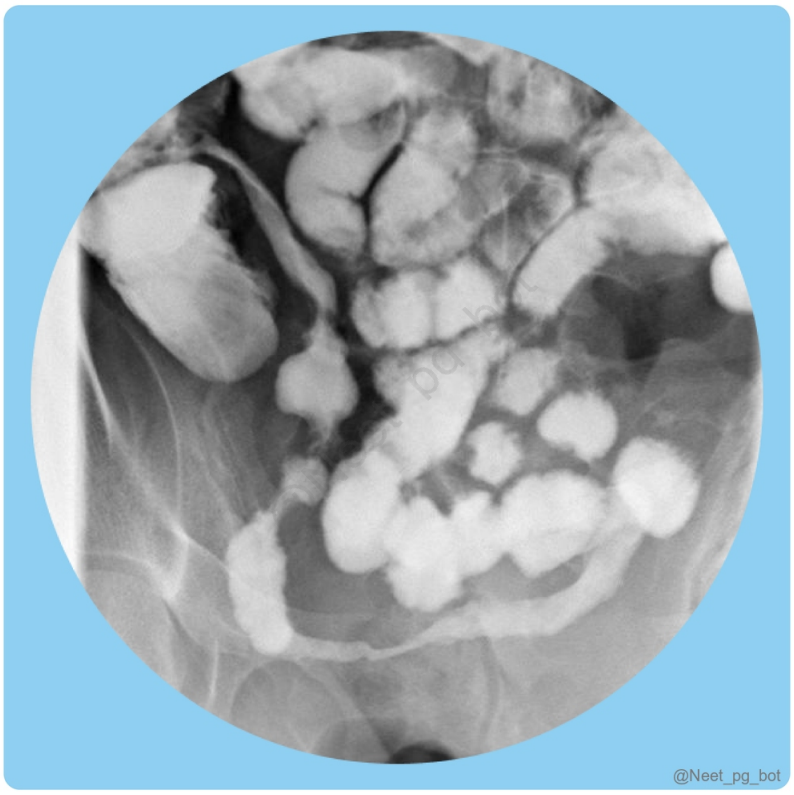


Correct Answer: A. String Sign of Kantor

■ *Listen (English)*

■ *Listen (Hindi)*

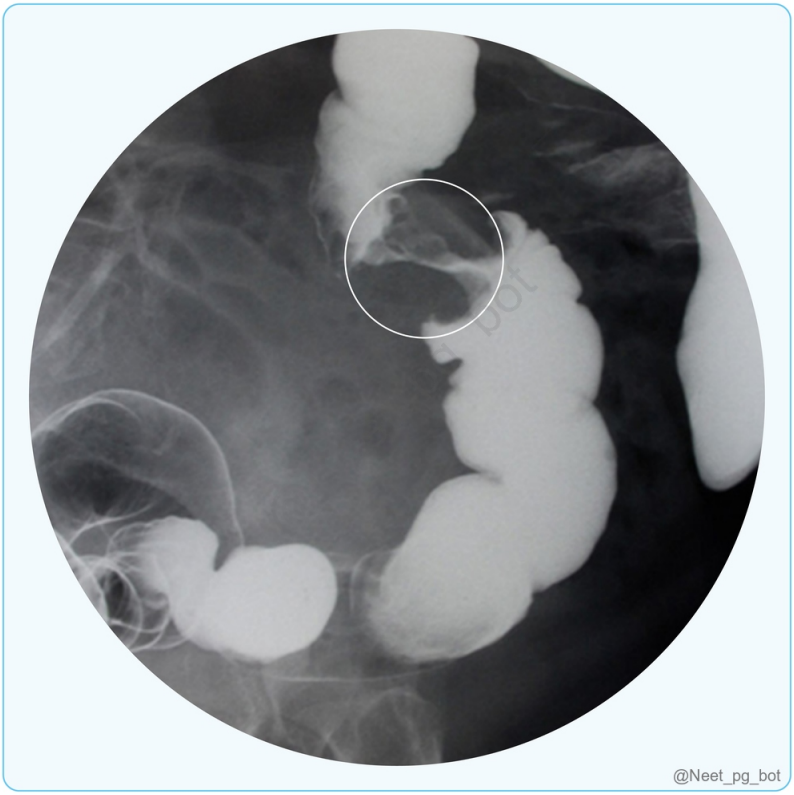
Explanation: String Sign of Kantor is associated with long-standing Crohn’s disease . It is characterised by multiple filling defects seen in barium studies due to kinking and fibrosis of the bowel, especially the terminal ileum. Radiological signs of Crohn’s disease String sign of Kantor Cicatrization of the ileum, which is a narrowing of the ileum caused by scarring. {{caption_text}} Fat halo sign: Low attenuation of submucosal fat around the bowel {{caption_text}} Rose thorn or raspberry thorn appearance: Linear transmural ulcers {{caption_text}} Vascular jejunization of ileum: Comb sign {{caption_text}} Apple-Core Sign (Option B) is typically associated with colorectal cancer and presents as a constricted lesion with an "apple-core" appearance. {{caption_text}} Lead-pipe appearance (Option C) indicates ulcerative colitis, in which the colon appears smooth and rigid due to the loss of haustral folds. {{caption_text}} Bird-beak sign (Option D) is seen in esophageal conditions such as achalasia, where the esophagus narrows like a bird's beak. {{caption_text}}



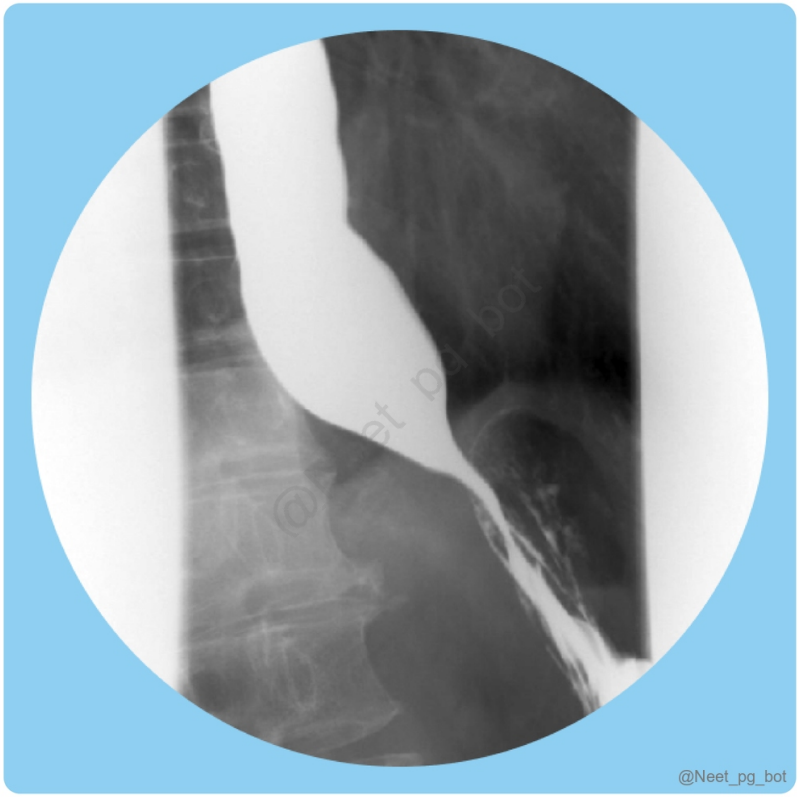

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References:

Sabiston Textbook of Surgery, 21st Edition, Pages 1262-1264

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8566824/

↑ *Back to this question in Part A*

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Q20: A 34-year-old female with a known diagnosis of Crohn's disease presents with symptoms of abdominal pain, weight loss, and intermittent diarrhea. Imaging studies reveal significant inflammation and strictures in the gastrointestinal tract. Which part of the gastrointestinal tract is most commonly affected by Crohn's disease, leading to ulcers and strictures? (Q849260)

A. Duodenum

B. Jejunum

C. Ileum

D. Colon

Correct Answer: C. Ileum

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The ileum is the most common site affected by Crohn's disease, where complications such as enterocutaneous fistulas, enterovesical fistulas, ulcers, strictures, and carcinoma frequently occur. Crohn's disease is a chronic, transmural inflammatory condition of the gastrointestinal (GI) tract, most commonly affecting the ileum. It presents with insidious onset, chronic diarrhea (with loose bowel movements, rarely containing blood, pus, or mucus.), intermittent colicky abdominal pain (often in the right lower quadrant- mimics appendicitis), systemic symptoms like weight loss, and low-grade fever. The disease can affect any part of the GI tract (mouth to anus) but most frequently involves the small intestine and colon with discontinuous "skip areas." Complications: Complication Description Obstruction Acute inflammation, edema, chronic fibrotic lesions Perforation This leads to fistulas, localized abscesses, and rarely generalized peritonitis Toxic Megacolon Colonic dilation, abdominal tenderness, fever, leukocytosis Bleeding Chronic, indolent, possible massive bleeding with duodenal involvement

References:

Sabiston Textbook of Surgery, 21st Edition, Pages 1260-1262

Bailey & Love's Short Practice of Surgery, 28th Edition, Pages 1327,1328

SRB's Manual of Surgery, 6th Edition, Pages 856, 857

↑ *Back to this question in Part A*

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Q21: A 35-year-old patient presents with chronic diarrhea, abdominal pain, and weight loss. A resection of the terminal ileum is performed, and the findings are shown in the image below. Which of the following findings is most characteristic of this disease? {{caption_text}} (Q849258)

A. Continuous mucosal lesions and crypt abscesses

B. Cobblestone appearance and transmural inflammation

C. Superficial ulceration and loss of haustrations

D. Pseudopolyps and mucosal inflammation



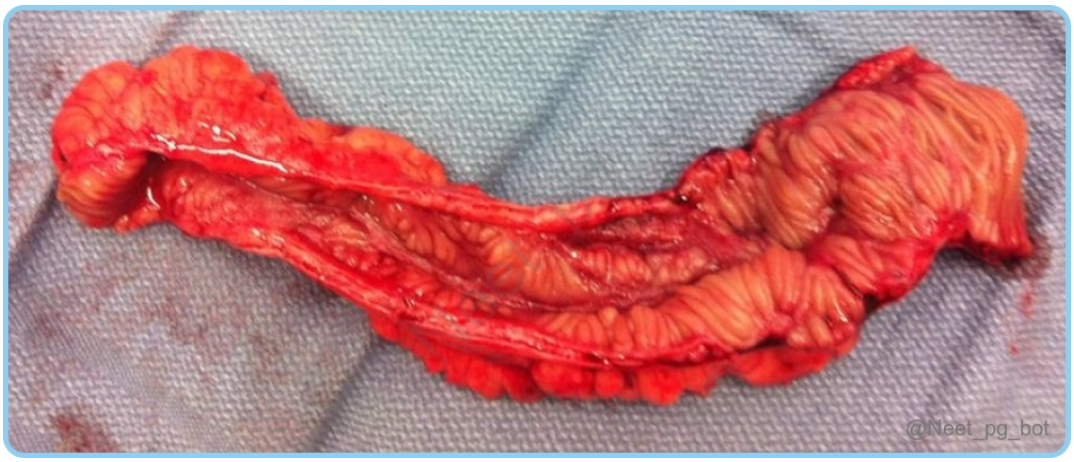
Correct Answer: B. Cobblestone appearance and transmural inflammation

■ *Listen (English)*

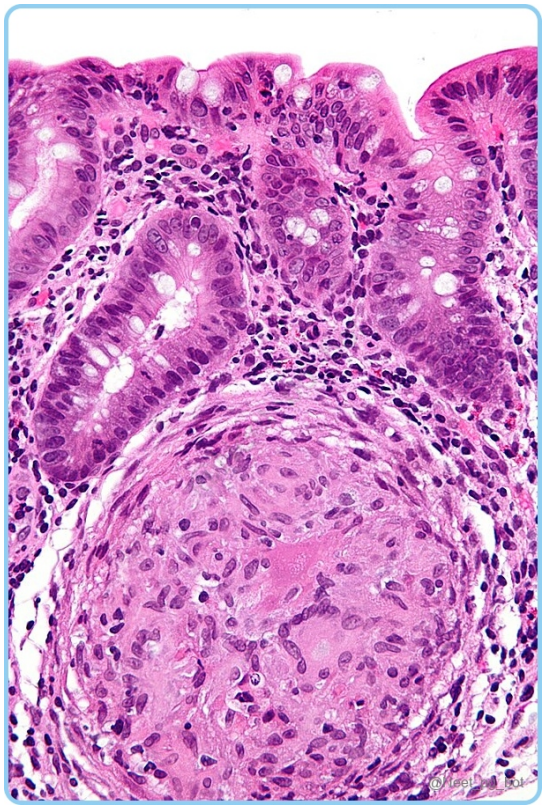
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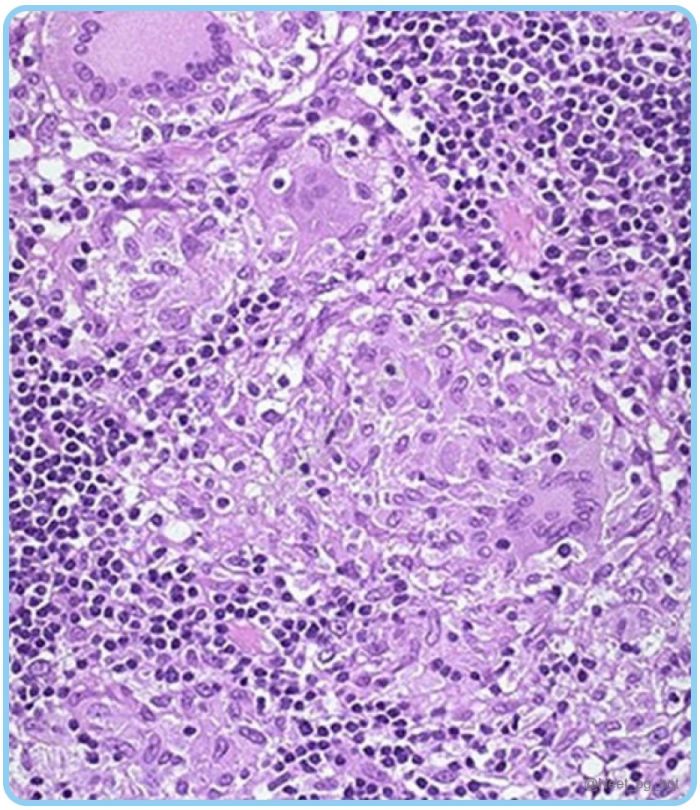
Explanation: The given image of the respected terminal ileum shows a Cobblestone appearance along with longitudinal ulcerations , characteristic of Crohn’s disease. Cobblestone appearance is a hallmark of Crohn's disease, resulting from deep ulcerations and intervening areas of normal mucosa. Transmural inflammation , which affects all layers of the bowel wall, is a characteristic microscopic finding in Crohn's disease. Continuous mucosal

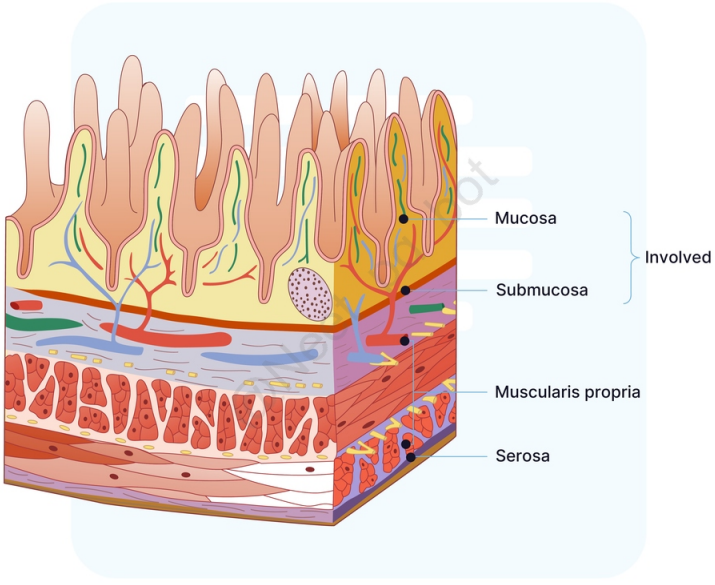
lesions and crypt abscesses (Option A) are more characteristic of Ulcerative Colitis (UC). UC typically shows continuous lesions starting from the rectum and crypt abscesses confined to the mucosa and submucosa. Crohn’s disease, in contrast, shows skip lesions and transmural involvement. Superficial ulceration and loss of haustrations (Option C), leading to a "lead pipe" appearance seen on barium enema, are more indicative of Ulcerative Colitis rather than Crohn’s disease. Crohn’s disease involves deeper, transmural ulcerations. Pseudopolyps (Option D) are often seen in UC due to repeated cycles of ulceration and healing. Mucosal inflammation alone, without transmural involvement, is more typical of UC. Crohn's disease involves deeper layers, creating a cobblestone appearance on endoscopy. Differences between Crohn's Disease and Ulcerative Colitis Feature Crohn's Disease Ulcerative Colitis Gross Morphology Skip lesions : Involves terminal ileum and colon Cobblestone appearance : Transmural inflammation results in cobblestone mucosa {{caption_text}} Continuous lesions : Affects colon in continuous manner starting from rectum Presence of pseudopolyps {{caption_text}} Microscopic Morphology Transmural inflammation : Involves all layers of the bowel wall {{caption_text}} Non-caseating granulomas : Characteristic finding {{caption_text}} Mucosal inflammation : Confined to mucosa and submucosa Crypt abscesses : Neutrophil infiltration into crypts {{caption_text}}



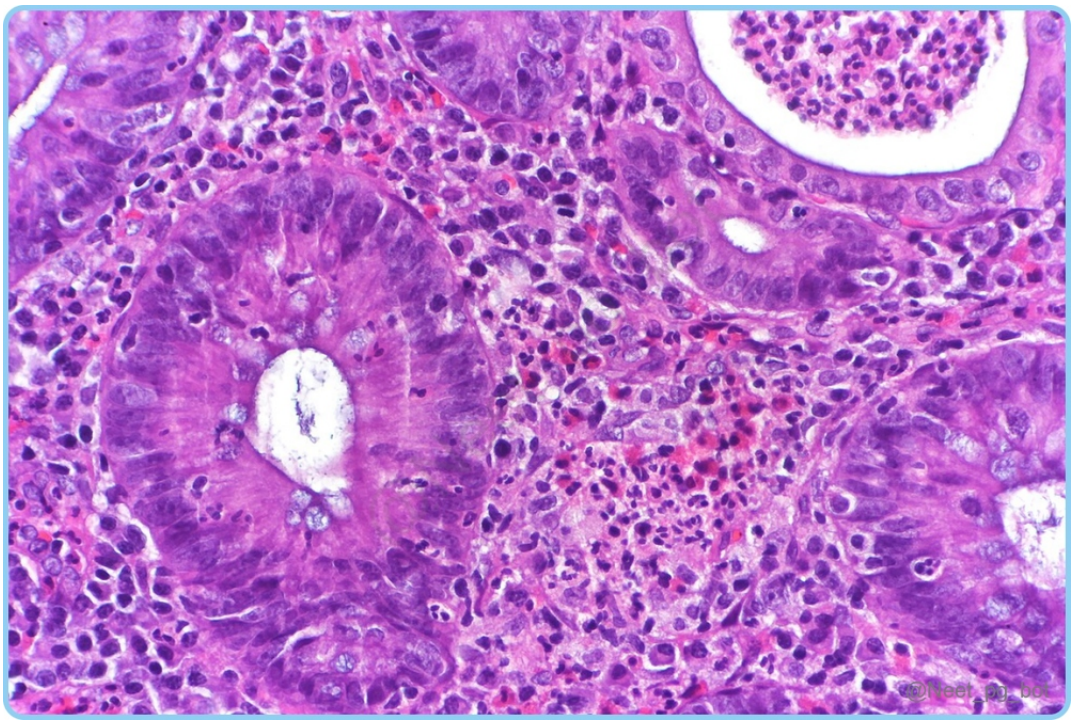

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References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Pages 1319, 1320, 1321, 1327, 1328.

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Q22: A 40-year-old male presents with chronic diarrhea, abdominal pain, and recent weight loss. On examination, there is tenderness in the right lower quadrant, and a colonoscopy revealed patchy inflammation in the terminal ileum with skip lesions. Which of the following combinations of risk factors and etiological factors is most consistent with the diagnosis? (Q849257)

A. NOD2/CARD15 gene mutation, smoking

B. HLA-DR2 association, appendectomy

C. Autoimmune etiology, non-smoker

D. Milk allergy, personality disorders

Correct Answer: A. NOD2/CARD15 gene mutation, smoking

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The given presentation of chronic diarrhea, abdominal pain, and recent weight loss, with tenderness in the right lower quadrant, along with patchy inflammation in the terminal ileum with skip lesions on colonoscopy, is consistent with Crohn's disease. The NOD2/CARD15 gene mutation on chromosome 16 is strongly associated with Crohn's disease. Smoking worsens the condition. Etiology and Risk Factors in Crohn's Disease vs. Ulcerative Colitis Feature Crohn's Disease Ulcerative Colitis Genetic Factors NOD2/CARD15 gene mutation on chromosome 16 (Option A) HLA-DR2 association (Option B) Smoking Increases risk Protective effect, lowers risk (Option C) Diet Highly refined food, food additives, particularly preservatives Westernized diet, red meat, milk allergy (Option D) . Less common in vegetarians. Autoimmune Factors Bacterial dysbiosis with aggressive T cell immune response to specific components of intestinal microbes Cytotoxic T lymphocytes against Colonic epithelial cells and the presence of anticolon antibodies. (Option C) Appendectomy No clear association (Option B) Protective Environmental Triggers Mycobacterium infection, high levels of sanitation in childhood Stress, personality disorders (Option D) Family History Strong familial association, 10% of first-degree relatives and 50% of monozygotic twins. Familial tendency present, less frequent

References:

SRB's Manual of Surgery, 6th Edition, Pages 855, 883.

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1327

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5759609/

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Q23: A 65-year-old woman undergoes an emergency ileostomy following bowel obstruction. Two weeks postoperatively, she presents with increased pain and swelling around the stoma site. On examination, a bulge is noted adjacent to the stoma. The stoma itself appears healthy, with no signs of necrosis or ischemia. What is the most likely diagnosis? (Q849256)

A. Stoma Stenosis

B. Stoma Retraction

C. Parastomal Hernia

D. Stoma Prolapse

Correct Answer: C. Parastomal Hernia

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: A parastomal hernia occurs when the abdominal contents protrude through the defect in the abdominal wall created for the stoma. It typically presents as a bulge around the stoma and can lead to discomfort, pain, and cosmetic concerns■ . This complication is more common with ileostomies due to the increased intra-abdominal pressure and the nature of the bowel segment used. Stoma Complications Complications Description Key Characteristics Stoma Ischemia Lack of blood supply causing stoma discoloration and necrosis Occurs early post-op (within days), Discolored Stoma Prolapse (Option D) Excessive protrusion of the stoma through the abdominal wall Protrusion, more common in loop stomas Stoma Retraction (Option B) Stoma sinks below skin level; often leads to poor appliance fit and skin irritation Concave surface, skin irritation Parastomal Hernia (Option C) Herniation of abdominal contents through the stoma opening Bulging adjacent to the stoma, discomfort Stoma Stenosis (Option A) Narrowing of stoma, leading to obstruction Narrowed opening, obstruction symptoms Skin Irritation Irritation or breakdown of skin around the stoma due to appliance use Poor appliance fitting, leakage Bleeding May occur due to trauma or mucosal irritation Trauma, irritation Fistulation Formation of abnormal connections between the stoma and other organs or skin Infection

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Pages 1314, 1373.

SRB's Manual of Surgery, 6th Edition, Page 902.

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Q24: A 55-year-old male patient undergoes emergency abdominal surgery for a perforated sigmoid diverticulitis with peritonitis. The surgeon decides to create a stoma as part of the management plan. Which of the following stomas is most appropriate for diverting fecal content and allowing distal bowel healing while planning for potential future reconnection? (Q849255)

A. End colostomy

B. Loop ileostomy

C. Double-barrel colostomy

D. Permanent ileostomy

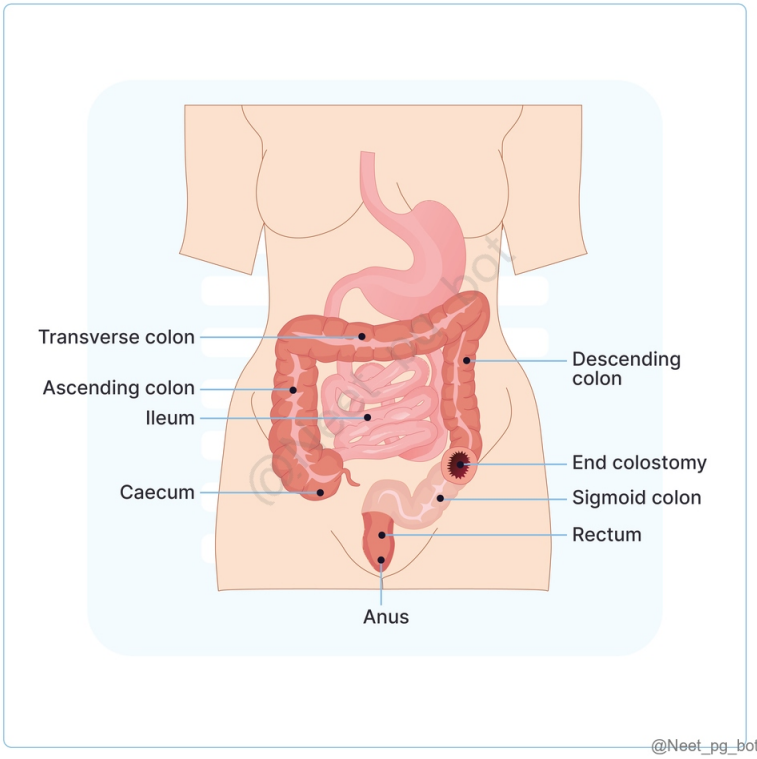
Correct Answer: B. Loop ileostomy

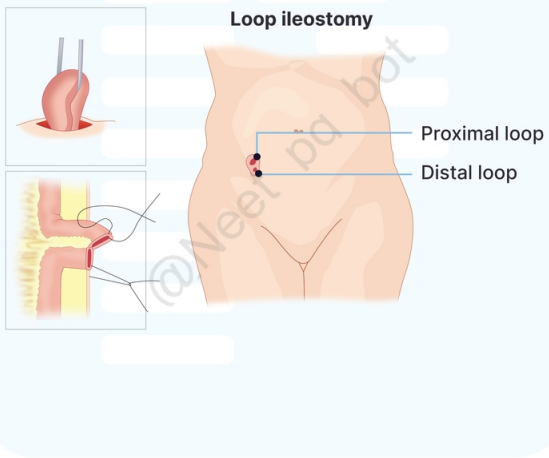
■ *Listen (English)*

■ *Listen (Hindi)*

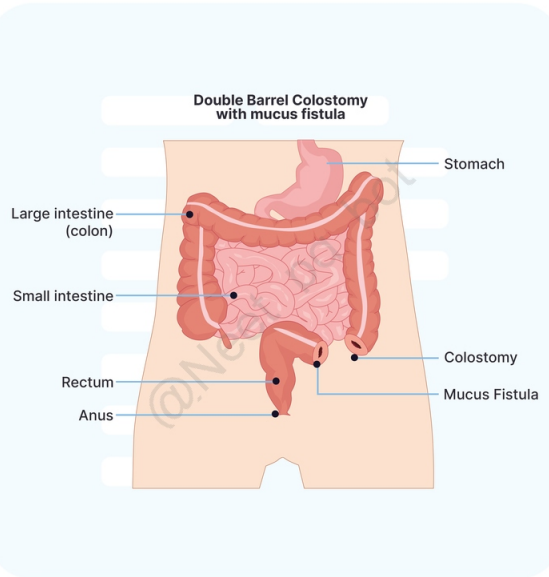
Explanation: A loop ileostomy is commonly used to divert fecal content in emergency situations and allows for the distal bowel to heal, making it ideal for temporary diversion. It provides an easy way to reverse the stoma when the patient is stable and reconnection is feasible . Types of Stomas Type Description Common Uses Reversibility

End Colostomy (Option A) Single opening from the proximal bowel. Often permanent. Used when the distal bowel is removed or left in place, e.g., Hartmann's procedure Often permanent Loop Ileostomy (Option B) Loop of bowel is brought to the surface, and an incision is made Temporary diversion, especially in emergencies, and easily reversible Usually temporary Double-barrel Colostomy (Option C) Two stomas are created: one for faecal output and one for mucus discharge Rarely used; can be for cases requiring both resection and exteriorization, offering mucous fistula Can be temporary Permanent Ileostomy (Option D) Terminal ileum is brought to the surface after a colectomy Used when reconnection is not planned, often after total proctocolectomy for conditions like FAP Permanent

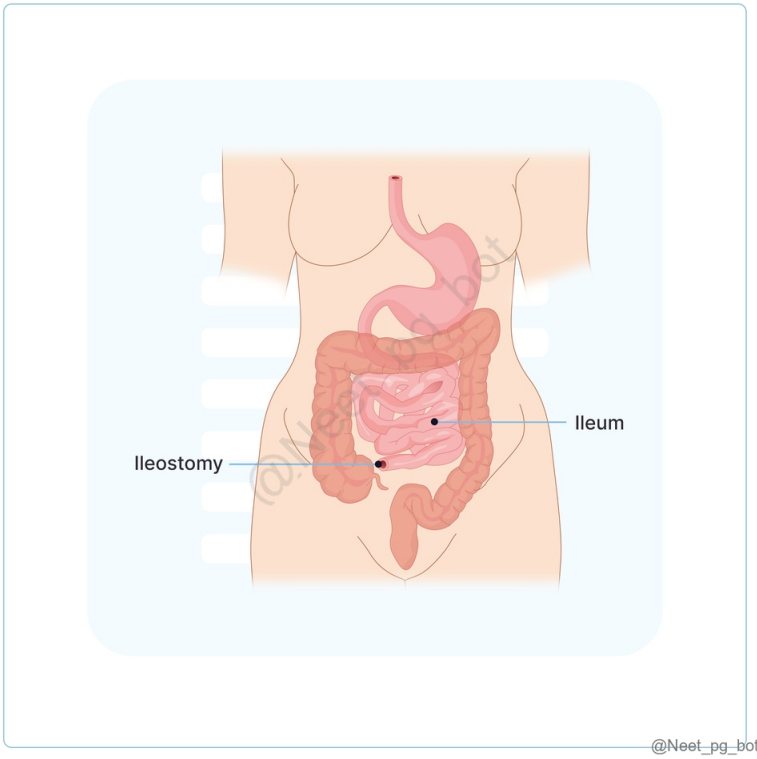




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References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Pages 1313, 1372, 1373.

SRB's Manual of Surgery, 6th Edition, Pages 901,902.

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Q7 (p. 2094)	*Q8 (p. 2095)*	*Q9 (p. 2096)*	*Q10 (p. 2097)*	*Q11 (p. 2098)*	*Q12 (p. 2098)*
Q13 (p. 2100)	*Q14 (p. 2101)*	*Q15 (p. 2102)*	*Q16 (p. 2102)*	*Q17 (p. 2103)*	*Q18 (p. 2104)*
Q19 (p. 2104)	*Q20 (p. 2106)*	*Q21 (p. 2107)*	*Q22 (p. 2108)*	*Q23 (p. 2109)*	*Q24 (p. 2110)*
Q25 (p. 2111)	*Q26 (p. 2112)*	*Q27 (p. 2113)*	*Q28 (p. 2114)*	*Q29 (p. 2114)*	*Q30 (p. 2115)*

Q1: A 34-year-old male undergoes an open appendectomy for acute appendicitis. The choice of incision was McBurney's incision. Postoperatively, after a few days, he presents with pain and bulging in the right lower quadrant, which is diagnosed as an indirect inguinal hernia. Which nerve injury during the appendectomy is most likely responsible for this complication? (Q849041)

A. Ilioinguinal nerve

B. Femoral nerve

C. Genitofemoral nerve

D. Pudendal nerve

Correct Answer: A. Ilioinguinal nerve

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Injury to the ilioinguinal nerve during an appendectomy, especially with McBurney's incision, is a documented complication that can lead to weakness of the inguinal canal structures. This weakness can predispose the patient to the development of an indirect inguinal hernia. The complications associated with appendectomy are listed below: Complication Description 1. Wound infection The MC postoperative complication involves infection at the surgical site. 2. Intraabdominal abscess Collection of pus within the abdominal cavity, typically due to infection. 3. Ileus Temporary cessation of bowel function, leading to abdominal distension and discomfort. 4. Venous thrombosis leading to embolism Formation of blood clots in the veins, which can travel to the lungs or other parts of the body. 5. Portal pyemia (Pylephlebitis) Infection and thrombosis of the portal vein, a rare but serious complication. 6. Adhesive intestinal obstruction Formation of scar tissue causing bowel obstruction; MC late complication 7. Fecal fistula Leakage from the appendiceal stump. 8. Nerve injury Injury to the Ilioinguinal nerve and iliohypogastric nerve

References:

SRB's Manual of Surgery, 6th Edition, Page 935

↑ *Back to this question in Part A*

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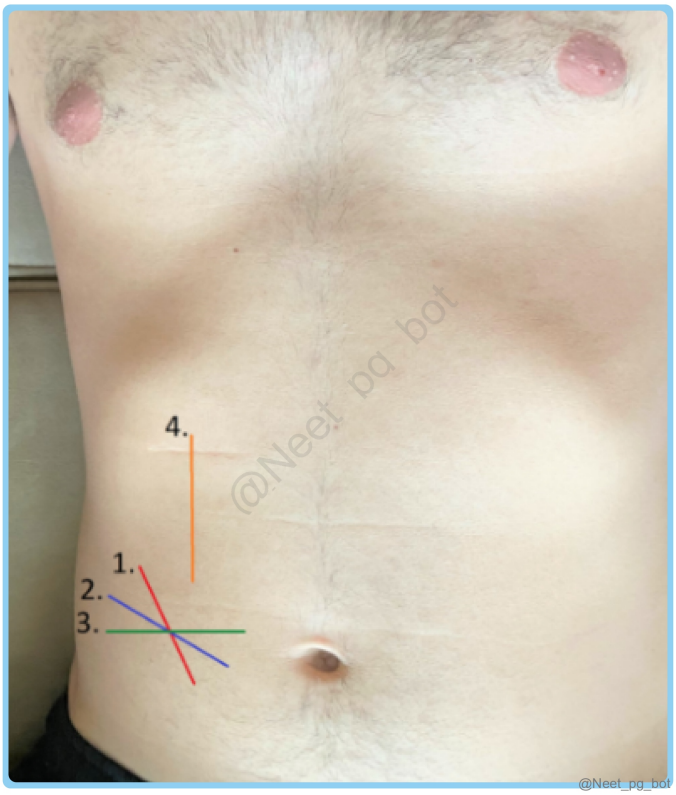
Q2: A 25-year-old male presents with right lower quadrant abdominal pain and is diagnosed with acute appendicitis. The surgical team plans to perform an appendectomy. Which of the following correctly represents the type of Incision used in appendicectomy? a-Rutherford Morrison b-Lanz c-McBurney's d-Battle (Q849039)

A. 1-a, 2-c, 3-b, 4-d

B. 1-a, 2-b, 3-c, 4-d

C. 1-c, 2-b, 3-a, 4-d

D. 1-c, 2-a, 3-b, 4-d



Correct Answer: D. 1-c, 2-a, 3-b, 4-d

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: 1-c, 2-a, 3-b, 4-d Explanatio n The Incisions typically used for appendicectomy are given in the table below: McBurney's incision Centered on McBurney's point, perpendicular to the umbilical ASIS line Junction of lateral 1/3 from umbilicus & medial 2/3 from ASIS McBurney's point corresponds to the base of the appendix Muscle splitting incision Aka Grid iron incision / McArthur incision Lanz incision Placed transversely 2 cm below the umbilicus on the line joining the midpoint of the clavicle to the midpoint of the inguinal ligament Muscle splitting incision Cosmetically better incision Aka Modified McBurney's incision / Rocky Davis incision / Bikini incision (good cosmetic appearance) Rutherford-Morrison incision Extension of McBurney's incision for retrocecal appendicitis Upward & laterally by cutting conjoint tendon Muscle cutting incision Preferred for retrocecal appendix

References:

www.ncbi.nlm.nih.gov/pmc/articles/PMC5684497/

SRB's Manual of Surgery, 6th Edition, Page 934, 1156.

↑ *Back to this question in Part A*

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Q3: A 25-year-old male presents with right lower quadrant abdominal pain and is diagnosed with acute appendicitis. He undergoes an open appendectomy. Which of the following statements regarding the steps of an open appendectomy is incorrect? (Q849040)

A. The incision is made at McBurney's point and extended down to the external oblique aponeurosis.

B. Cecum is identified with the help of taenia coli and ileocecal junction.

C. Mesoappendix and appendicular artery are ligated to prevent bleeding.

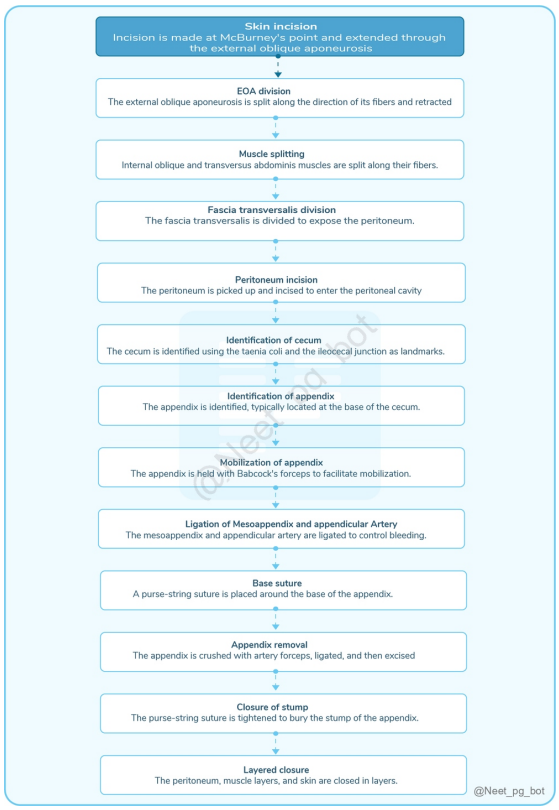
D. A lock-stitch suture is placed around the base of the appendix which is used to bury the stump after excision of the appendix.

Correct Answer: D. A lock-stitch suture is placed around the base of the appendix which is used to bury the stump after excision of the appendix.

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: In an open appendectomy, a purse-string suture, not a lock-stitch suture, is placed around the base of the appendix to help bury the stump after the appendix is excised. Steps during Open Appendicectomy



References:

SRB's Manual of Surgery, 6th Edition, Page 934

↑ *Back to this question in Part A*

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Q4: A 24-year-old man presents with acute onset of right lower abdominal pain, fever, and nausea. During physical examination, the manoeuvre shown in the image is performed, which elicits pain in the right lower quadrant. This clinical finding is known as: (Q884006)

A. Obturator sign

B. Rovsing's sign

C. Psoas sign

D. Murphy's sign



Correct Answer: C. Psoas sign

Explanation: The image demonstrates passive extension of the patient’s right hip to stretch the psoas muscle , which produces pain in cases of retrocecal appendicitis , known as the psoas sign . The psoas sign is positive when pain is elicited by passive extension of the right hip or by flexion of the hip against resistance. This occurs because an inflamed retrocecal appendix lies in contact with the psoas muscle, and stretching the muscle irritates the adjacent peritoneum. Obturator sign (Option A) : The obturator sign involves pain on internal rotation of the flexed right hip, not hyperextension. Rovsing's sign (Option B) : Rovsing's sign is pain in the right lower quadrant upon palpation of the left lower quadrant. Murphy's sign (Option D) : Murphy's sign is right upper quadrant tenderness on inspiration, associated with cholecystitis, not appendicitis.

References:

Bailey & Love’s Short Practice of Surgery, 28th Edition, Page 1339.

↑ *Back to this question in Part A*

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Q5: What is the typical initial location and character of abdominal pain at the onset of acute appendicitis? (Q884004)

A. Right lower quadrant, sharp and constant

B. Epigastric, burning

C. Periumbilical, colicky and poorly localised

D. Diffuse, crampy

Correct Answer: C. Periumbilical, colicky and poorly localised

Explanation: In acute appendicitis, the initial pain is visceral, colicky, and poorly localised to the periumbilical region (T8–T10 dermatomes), resulting from luminal obstruction and distention of the appendix. Over several hours, as inflammation spreads to the parietal peritoneum, the pain typically shifts and localises to the right lower quadrant (McBurney's point), becoming sharper and constant. Right lower quadrant, sharp and constant (Option A) : This describes later somatic pain after peritoneal involvement, not the initial presentation. Epigastric, burning (Option B) : Epigastric burning is typical of peptic ulcer disease or gastritis, not appendicitis. Diffuse, crampy (Option D) : Diffuse crampy pain is more characteristic of gastroenteritis or small bowel obstruction, not the early, localised visceral pain of appendicitis.

References:

Bailey & Love’s Short Practice of Surgery, 28th Edition, Page 1338.

↑ *Back to this question in Part A*

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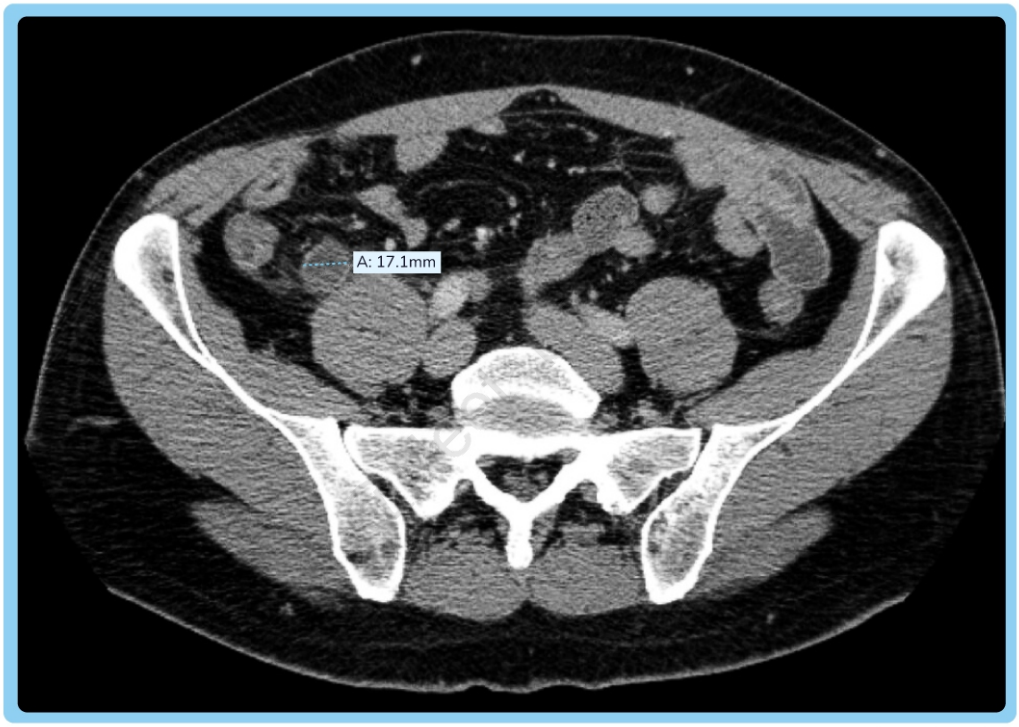
Q6: A 26-year-old patient presents with acute right lower quadrant abdominal pain, nausea, and low-grade fever. A contrast-enhanced CT scan of the abdomen is obtained and is shown above. Which of the following physical examination findings is not typically associated with this condition? (Q884007)

A. Psoas sign

B. Rovsing's sign

C. Ballance sign

D. McBurney's sign



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Correct Answer: C. Ballance sign

Explanation: The CT image demonstrates an enlarged, thickened appendix consistent with acute appendicitis. Ballance's sign is associated with ruptured spleen, not appendicitis. It is characterised by fixed dullness in the left flank (due to clotted blood) and shifting dullness in the right flank (due to liquid blood in the peritoneal cavity). Psoas sign (Option A) : The psoas sign is associated with acute appendicitis (especially retrocecal appendicitis). Rovsing's sign (Option B) : Rovsing's sign is a classic physical finding in acute appendicitis. McBurney's sign (Option D) : Tenderness at McBurney's point (one-third the distance from the ASIS to the umbilicus) is a hallmark sign of acute appendicitis.

References:

https://pmc.ncbi.nlm.nih.gov/articles/PMC7153795/

Bailey & Love’s Short Practice of Surgery, 28th Edition, Page 1339,

↑ *Back to this question in Part A*

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Q7: In a pediatric patient with suspected acute appendicitis, what is the preferred initial imaging modality to avoid radiation exposure? (Q884008)

A. Plain abdominal X-ray

B. CT scan of the abdomen and pelvis

C. Ultrasound of the abdomen

D. MRI of the abdomen

Correct Answer: C. Ultrasound of the abdomen

Explanation: For pediatric patients with suspected appendicitis, ultrasonography is the preferred initial imaging study because it avoids ionising radiation and can reliably diagnose appendicitis when performed by an experienced operator. In adults , a CT scan is generally the most accurate modality. MRI is also radiation-free, but is less commonly used as a first-line test due to availability and cost. Plain abdominal X-ray (Option A) : Plain films have low sensitivity and specificity for appendicitis and still involve radiation exposure. They are not the preferred initial imaging choice. CT scan of the abdomen and pelvis (Option B) : CT involves significant radiation and is typically reserved for cases where ultrasound is equivocal or not diagnostic, especially in older children or when complications are suspected. MRI of the abdomen (Option D) : MRI avoids radiation but is less widely available, more time■consuming, often requires sedation in young children, and is not the first■line imaging choice. It may be used selectively if ultrasound is nondiagnostic.

References:

Bailey & Love’s Short Practice of Surgery, 28th Edition, Page 1342.

↑ *Back to this question in Part A*

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Q8: A 28-year-old man presents with fever, right lower quadrant pain, and signs of peritonitis. Exploratory laparotomy reveals a perforated appendix with purulent peritoneal fluid. Cultures are obtained. Which anaerobic organism is most commonly isolated in this scenario? (Q884009)

A. Escherichia coli

B. Bacteroides fragilis

C. Clostridium perfringens

D. Klebsiella pneumoniae

Correct Answer: B. Bacteroides fragilis

Explanation: In perforated appendicitis, the most common anaerobic pathogen isolated is Bacteroides fragilis, found in approximately 80% of cases. The most common aerobic pathogen is Escherichia coli. Antibiotic coverage for complicated appendicitis should target both gram-negative aerobes and anaerobes. Escherichia coli (Option A) : E. coli is the most common aerobic Gram-negative bacterium isolated in appendicitis; however, the question asks

for the most common anaerobic bacterium. Clostridium perfringens (Option C) : Clostridium perfringens can be found, but is less prevalent than Bacteroides fragilis in perforated appendicitis. Klebsiella pneumoniae (Option D) : Klebsiella is an aerobic Gram■negative rod that may be present but is not the predominant anaerobic isolate.

References:

Sabiston Textbook of Surgery, 21st Edition, Page 1302.

↑ *Back to this question in Part A*

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Q9: A patient with a palpable, tender right lower quadrant mass and a history of abdominal pain for 5 days is diagnosed with an appendiceal mass. The patient is hemodynamically stable. What is the most appropriate initial management? (Q884010)

A. Immediate appendectomy

B. Ochsner-Sherren regimen

C. Percutaneous drainage of the mass

D. Laparoscopic exploration

Correct Answer: B. Ochsner-Sherren regimen

Explanation: For a stable patient with an appendiceal mass (phlegmon or abscess) that is already walled off, the recommended initial approach is the Ochsner-Sherren (conservative) regimen: Bowel rest Intravenous antibiotics Hydration and close observation. Surgery at this stage can be difficult and risks spreading localised infection. If the mass resolves, an interval appendectomy may be performed 6–8 weeks later. Percutaneous drainage is considered if an abscess >3-4 cm is present. Immediate appendectomy (Option A) : Immediate surgery in the setting of a well■contained mass is technically difficult, carries a high risk of injury to adjacent inflamed structures (e.g., bowel, ureter), and is associated with higher complication rates. Percutaneous drainage of the mass (Option C) : Percutaneous drainage is reserved for a clearly defined abscess that fails to respond to antibiotics or causes persistent sepsis. It is not the first step for all appendiceal masses, especially phlegmons. Laparoscopic exploration (Option D) : Laparoscopy in the presence of an established mass is challenging and risky due to adhesions and inflammation; conservative management is preferred initially.

References:

Bailey & Love’s Short Practice of Surgery, 28th Edition, Page 1343.

↑ *Back to this question in Part A*

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Q10: When converting a gridiron (McBurney) incision to a Rutherford Morison incision during an appendectomy, which of the following muscle layers are divided? (Q884011)

A. Only the external oblique muscle

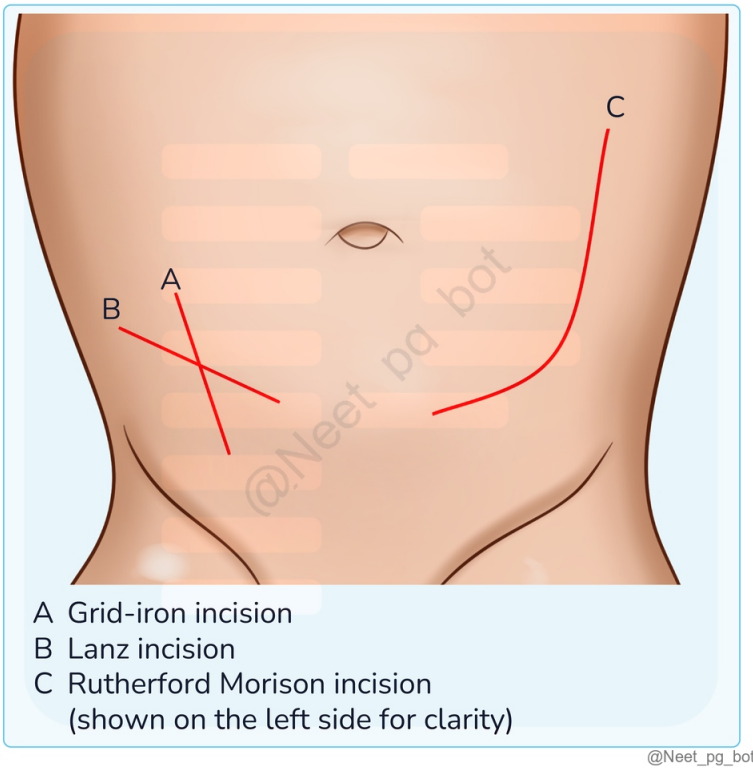
B. External oblique, internal oblique, and transversus abdominis muscles

C. Rectus abdominis muscle only

D. External oblique and transversus abdominis muscles only

Correct Answer: B. External oblique, internal oblique, and transversus abdominis muscles

Explanation: The Rutherford Morison incision is an oblique muscle-cutting extension of the gridiron incision, made when greater exposure is needed. It involves the division of the external oblique, internal oblique, and transversus abdominis muscles along the line of the incision. In contrast, the standard gridiron incision splits these muscles along their fibre directions without cutting them. Only the external oblique muscle (Option A) : This describes only the initial step of the gridiron incision, where the external oblique aponeurosis is split, not cut. Rectus abdominis muscle only (Option C) : The rectus abdominis is not typically involved in a standard Rutherford Morison extension for appendectomy; this muscle lies medial to the common appendiceal incisions. External oblique and transversus abdominis muscles only (Option D) : The internal oblique muscle must also be divided to convert to a Rutherford Morison incision; it is not spared.



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References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1344.

↑ *Back to this question in Part A*

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Q11: A surgeon performing an appendectomy ensures that only a very short appendiceal stump is left behind to avoid stump appendicitis. What is the recommended maximum length of the residual appendiceal stump? (Q884012)

A. 1 mm

B. 3 mm

C. 5 mm

D. 10 mm

Correct Answer: C. 5 mm

Explanation: To minimise the risk of stump appendicitis (inflammation of residual appendiceal tissue after appendectomy), the residual stump should be no longer than 5 mm. Leaving a longer stump increases the chance that retained faecal material or inflammation can occur in the remnant. Stump appendicitis typically presents with symptoms similar to acute appendicitis and may require reoperation. 1 mm (Option A) : While shorter is generally better, a 1 mm stump is technically difficult to achieve consistently and is not a standard requirement. 3 mm (Option B) : Although short, this is n ot the accepted upper limit cited in surgical guidelines. 10 mm (Option D) : A 10 mm (1 cm) stump is excessively long and significantly increases the risk of complications.

References:

Schwartz's Principles of Surgery, 11th Edition, Page 1338.

↑ *Back to this question in Part A*

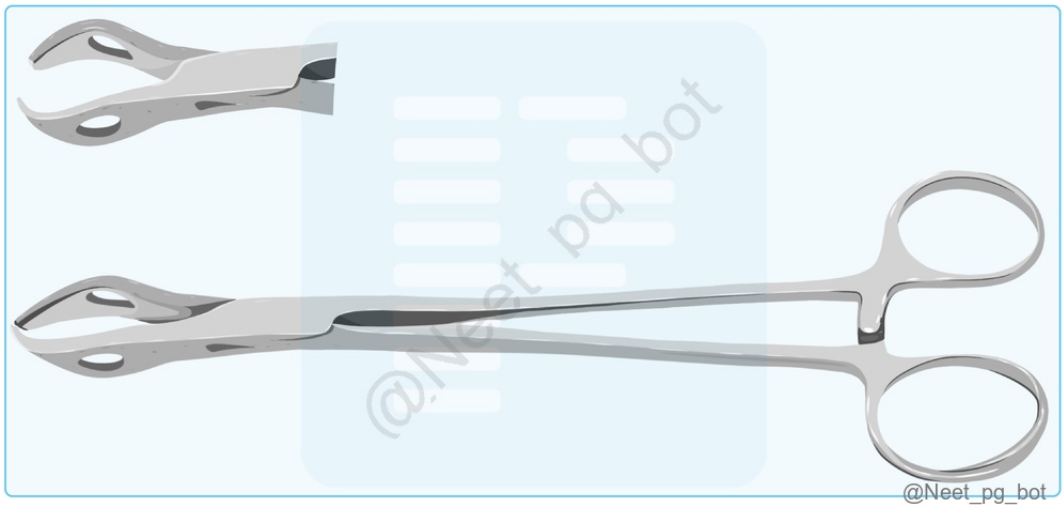
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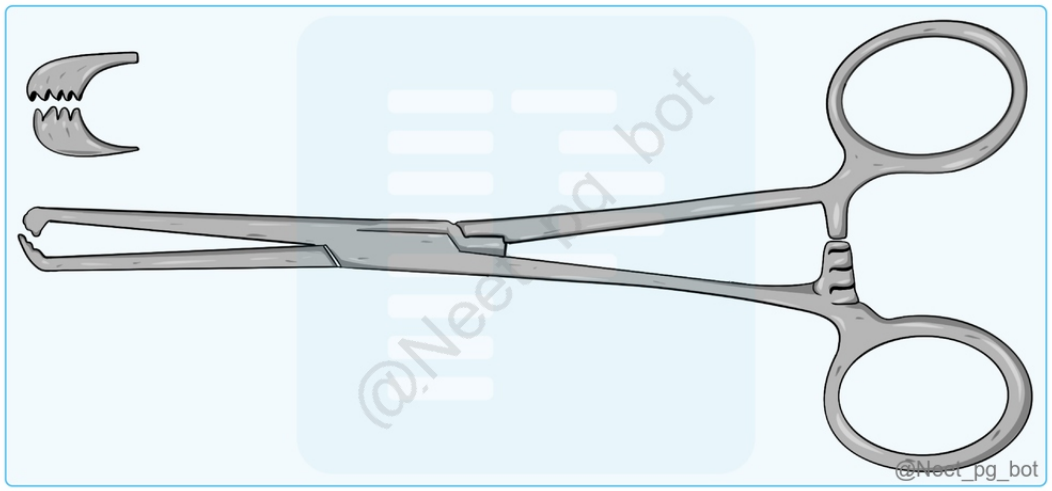
Q12: During an open appendectomy, which instrument is specifically designed for atraumatic grasping of delicate structures like the appendix or fallopian tube? (Q884013)

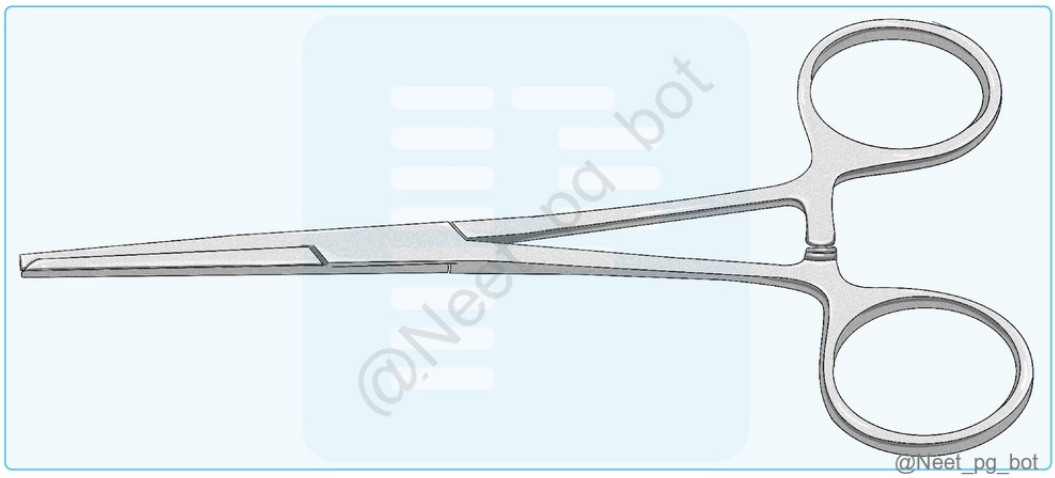
Correct Answer: Unknown

Explanation: Babcock's forceps have a fenestrated, curved distal blade with transverse serrations and a non-traumatic tip, making them ideal for grasping delicate tubular structures (e.g., appendix, bowel, ureter, fallopian tube) without causing crush injury. Lane's tissue forceps (Option A) : Lane's forceps are traumatic, toothed forceps used for grasping dense tissue (e.g., fascia, skin) and would damage delicate structures. Allis forceps (Option C) : Allis forceps have interlocking teeth and are used for grasping tougher tissues (e.g., fascia, uterus) but can crush or injure delicate tubes. Kocher's forceps (Option D) : Kocher's forceps have sharp teeth at the tip and are designed for grasping dense, fibrous tissues (e.g., fascia, tendons) or for hemostasis; they are traumatic and not suitable for delicate structures.









References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Pages 1344, 1345.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q13: What is the most common site within the appendix for a carcinoid tumour to arise? (Q884014)

A. Base of the appendix

B. Mid-appendix

C. Tip (distal third) of the appendix

D. Appendiceal orifice

Correct Answer: C. Tip (distal third) of the appendix

Explanation: Appendiceal carcinoid tumours most commonly arise in the tip (distal third) of the appendix. They are the most common primary tumours of the appendix, but are usually discovered incidentally. Diagnosis: Based on immunohistochemical staining for synaptophysin and chromogranin A . Classified as grade 1–3 according to their proliferative capacity (determined by the Ki-67 index and mitotic rate). Base of the appendix (Option A) : Carcinoids at the base are less common and carry a higher risk of obstruction or involvement of the cecum, often requiring more extensive resection. Mid-appendix (Option B) : Mid■appendix carcinoids occur but are less frequent than those at the tip. Appendiceal orifice (Option D) : This location is rare and may be associated with involvement of the cecal wall, but it is not the most common site.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1349.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q14: A 1.8 cm carcinoid tumour is found at the tip of the appendix on histopathology after an appendectomy. There is no invasion of the mesoappendix, and margins are clear. What is the most appropriate next step in management? (Q884015)

A. Observation only

B. Completion of right hemicolectomy

C. Chemotherapy

D. Repeat appendectomy with wider margins

Correct Answer: A. Observation only

Explanation: Appendiceal carcinoids < 2 cm , located at the tip , with clear margins and no mesoappendiceal invasion, carry a low risk of metastasis . Therefore, right hemicolectomy is not indicated , and the appropriate next step is observation alone . Most are benign Appendiceal carcinoids 1–2 cm in size located in the tip with no high-risk features (mesoappendiceal invasion, lymphovascular invasion, positive margins, or base involvement) are treated with a simple appendectomy. Right hemicolectomy (Option B) is considered for: Tumours ≥2 cm Mesoappendiceal invasion Lymph node involvement. Chemotherapy (Option C) : Chemotherapy has no role in localised, low■risk appendiceal carcinoids treated with complete surgical resection. Repeat appendectomy with wider margins (Option D) : Wider margins are unnecessary if the initial resection margins are negative and the tumour is low■risk (≤2 cm, tip location).

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Pages 1349, 1350.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q15: An incidental 0.5 cm carcinoid tumour at the tip of the appendix with clear margins and no high-risk features is discovered after an appendectomy. What is the appropriate management? (Q884016)

A. Completion of right hemicolectomy

B. Adjuvant chemotherapy

C. Observation only

D. Radiation therapy

Correct Answer: C. Observation only

Explanation: For carcinoid tumours <1 cm located in the appendix with negative margins and no high-risk features (mesoappendiceal invasion, lymphovascular invasion, base involvement), observation alone is sufficient after appendectomy, as the risk of metastasis is extremely low. Right hemicolectomy is reserved for tumours≥2 cm or smaller tumours with adverse features. Completion right hemicolectomy (Option A) : Right hemicolectomy is reserved for tumours>2 cm or those with high-risk features (location at base, mesoappendix invasion >3 mm, positive margins, lymphovascular invasion). Adjuvant chemotherapy (Option B) : Chemotherapy has no role in localised, low-grade carcinoids completely resected with low-risk features. Radiation therapy (Option D) : Radiation is not indicated for low-risk, completely resected appendiceal carcinoids.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Pages 1349, 1350.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q16: Which pathogen is classically associated with mesenteric lymph node enlargement producing symptoms similar to acute appendicitis? (Q884017)

A. Salmonella typhi

B. Campylobacter jejuni

C. Mycobacterium tuberculosis

D. Yersinia enterocolitica

Correct Answer: D. Yersinia enterocolitica

Explanation: Yersinia enterocolitica infection typically causes acute terminal ileitis, mesenteric lymphadenitis, and right lower quadrant pain that can closely mimic acute appendicitis. It is a common cause of acute mesenteric lymphadenitis in children and young adults. At surgery, the appendix is normal, but enlarged mesenteric lymph nodes are present. Salmonella typhi (Option A) causes typhoid fever, which can lead to ileocecal lymphoid hyperplasia or perforation, but it is not the most common cause of isolated mesenteric lymphadenitis mimicking appendicitis. Campylobacter jejuni (Option B) : Campylobacter typically causes enterocolitis with diarrhoea. Mycobacterium tuberculosis (Option C) : Tuberculous lymphadenitis can involve mesenteric nodes but usually presents with chronic symptoms, weight loss, and systemic features.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1340.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q17: Pseudomyxoma peritonei most commonly arises from rupture or leakage of which type of tumour? (Q884018)

A. Colonic adenocarcinoma

B. Appendiceal mucinous cystadenoma

C. Ovarian serous cystadenocarcinoma

D. Gastric signet ring carcinoma

Correct Answer: B. Appendiceal mucinous cystadenoma

Explanation: Pseudomyxoma Peritonei is a rare condition characterised by gelatinous mucinous ascites diffusely coating peritoneal surfaces. It occurs due to rupture of a mucin-producing epithelial tumour with peritoneal dissemination of mucin. Most common primary site: Appendix (mucinous cystadenoma / low-grade appendiceal mucinous neoplasm). Ovarian mucinous tumours are usually secondary. Clinical features: Progressive abdominal distension, vague abdominal pain, weight loss, bowel obstruction (late). Treatment: Cytoreductive surgery + hyperthermic intraperitoneal chemotherapy (HIPEC). Prognosis: Depends on tumour grade and completeness of cytoreduction; better in low-grade disease. Colonic adenocarcinoma (Option A) : While colorectal cancer can cause peritoneal carcinomatosis, it typically presents with solid metastases and ascites, not the classic diffuse gelatinous mucin of pseudomyxoma peritonei. Ovarian serous cystadenocarcinoma (Option C) : Ovarian carcinomas cause malignant ascites and peritoneal spread but are not the classic source of pseudomyxoma peritonei, which is mucin■producing and often indolent. Gastric signet-ring carcinoma (Option D) : Gastric

signet■ring cell carcinoma causes peritoneal carcinomatosis (linitis plastica■like) with mucin■producing cells but not the extensive, acellular gelatinous ascites characteristic of pseudomyxoma peritonei.

References:

Bailey & Love’s Short Practice of Surgery, 28th Edition, Page 1351.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q18: Which physical examination manoeuvre, when performed in the left lower quadrant, elicits pain in the right lower quadrant and is suggestive of acute appendicitis? (Q884005)

A. Psoas sign

B. Obturator sign

C. Murphy's sign

D. Rovsing's sign

Correct Answer: D. Rovsing's sign

Explanation: Rovsing's sign is elicited by palpation or deep pressure in the left lower quadrant, which causes referred pain in the right lower quadrant due to displacement of colonic gas toward an inflamed appendix. This is a classic sign of acute appendicitis. Psoas sign (Option A) : The psoas sign involves pain on right hip extension (e.g., with the patient lying on their left side), indicating an inflamed appendix overlying the psoas muscle, not left-sided palpation. Obturator sign (Option B) : The obturator sign is pain on internal rotation of the flexed right hip, suggesting an inflamed appendix in contact with the obturator internus muscle. Murphy's sign (Option C) : Murphy's sign is right upper quadrant tenderness with inspiration, associated with acute cholecystitis, not appendicitis.

References:

Bailey & Love’s Short Practice of Surgery, 28th Edition, Page 1339.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q19: A 28-year-old woman presented with a 3-day history of vague lower abdominal pain, low-grade fever, and urinary frequency. Initial pelvic examination and

urinalysis were inconclusive. CT scan revealed acute appendicitis with an inflamed appendix located in the pelvis. The delayed diagnosis in this case was most likely due to: (Q849031)

A. The appendix's pelvic location masking classic right lower quadrant signs

B. Misinterpretation of urinary symptoms as a primary urological issue

C. Lack of characteristic migration of pain from periumbilical to right iliac fossa

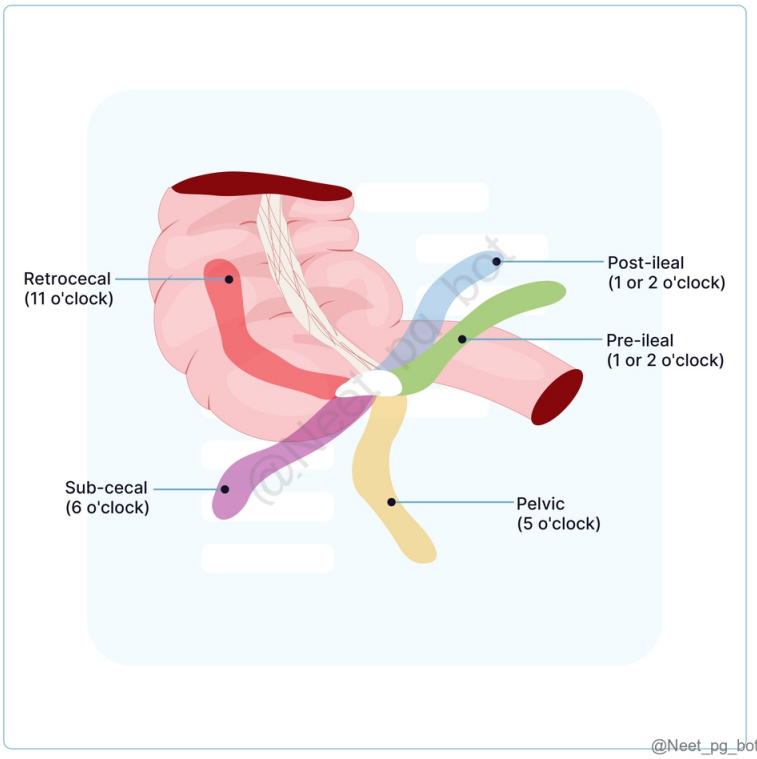
D. Absence of typical anorexia and vomiting in early appendicitis

Correct Answer: A. The appendix's pelvic location masking classic right lower quadrant signs

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Pelvic appendicitis occurs when the appendix is anatomically located in the pelvis, which happens in about 20-30% of the population. In these cases, the classic signs and symptoms of appendicitis may be altered, leading to a delayed diagnosis. The patient's presentation with vague lower abdominal pain, low-grade fever, and dysuria is consistent with pelvic appendicitis. The pelvic location of the appendix can mask the classic right lower quadrant signs by: Altering the location of pain and tenderness (more suprapubic or diffuse lower abdominal) Reducing the likelihood of a positive Rovsing's sign Potentially causing a positive obturator sign due to irritation of the obturator internus muscle Other locations of the appendix and their presentations: Location Presentation Retrocecal May present with flank or back pain Subcecal Can mimic gynecological disorders or urinary tract infection Pre-ileal May cause small bowel obstruction symptoms Post-ileal May cause small bowel obstruction symptoms Paracecal Can present with typical right lower quadrant pain Subhepatic Can be mistaken for cholecystitis Pelvic Can mimic symptoms of pelvic inflammatory disease or ovarian pathology Misinterpretation of urinary symptoms as a primary urological issue (Option B): Urinary symptom is a consequence of the appendix's pelvic location rather than the primary cause. The proximity to the bladder can cause urinary symptoms making it a presentation of pelvic appendicitis . In pelvic appendicitis, the migration pattern (Option C) might not be as noticeable due to the appendix’s atypical location. However, this does not fully explain a delayed diagnosis, as some degree of migration can still occur or other signs may be evident. Therefore, this option is not the best



References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1339

↑ *Back to this question in Part A*

@Neet_pg_bot

Q20: Which pathological process marks the starting point in the evolution of acute appendicitis? (Q884003)

A. Luminal obstruction

B. Ischemic injury due to arterial embolism

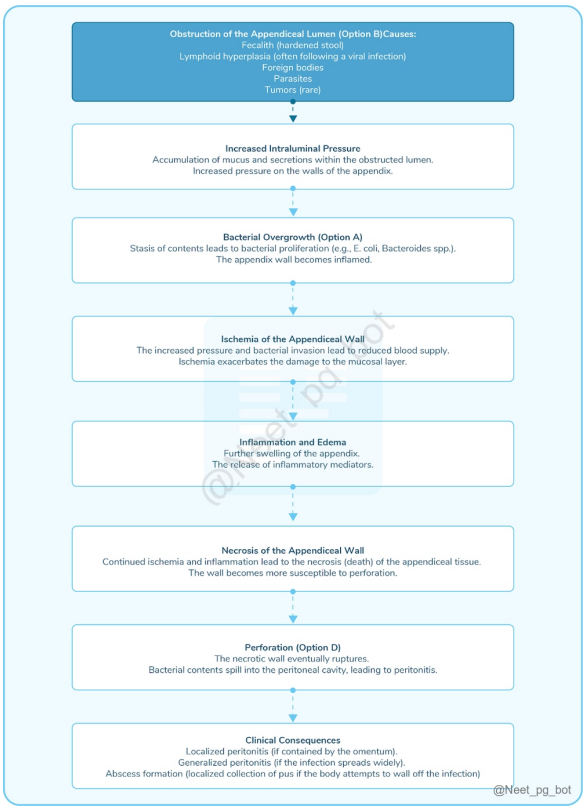
C. Bacterial translocation from the colon

D. Autoimmune inflammation

Correct Answer: A. Luminal obstruction

Explanation: Acute appendicitis most commonly begins with luminal obstruction, often by a fecalith (appendicolith), lymphoid hyperplasia, or, less commonly, by a foreign body or tumour. Ischemic injury due to

arterial embolism (Option B) : Primary arterial occlusion (e.g., embolism) is a rare cause of appendicitis; ischemia in typical appendicitis results from venous outflow obstruction secondary to luminal blockage. Bacterial translocation from the colon (Option C) : Bacterial invasion is a secondary event following mucosal compromise due to obstruction and ischemia, not the initial trigger. Autoimmune inflammation (Option D) : Appendicitis is not an autoimmune process; inflammation is secondary to obstruction and bacterial proliferation.



References:

Bailey & Love’s Short Practice of Surgery, 28th Edition, Pages 1337, 1338.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q21: Which anatomical structure serves as a surgical landmark to identify the ileocecal junction during appendectomy? (Q884002)

A. Jackson membrane

B. Gerlach valve

C. Fold of Treves

D. Mesoappendix

Correct Answer: C. Fold of Treves

Explanation: The fold of Treves (ileocecal fold) is an antimesenteric peritoneal fold at the ileocecal junction that contains no significant blood vessels, hence called the "bloodless fold." It is used intraoperatively as a landmark to locate the appendix and guide the extent of coagulation to avoid thermal injury to adjacent bowel. The Gerlach valve is a mucosal fold at the appendiceal orifice, and the Jackson membrane is an adhesion from the abdominal wall to the ascending colon. Jackson membrane (Option A) : Jackson's membrane is a peritoneal fold sometimes covering the ascending colon, not a specific ileocecal landmark. Gerlach valve (Option B) : This is an alternative name for the ileocecal valve itself, not an external peritoneal fold. Mesoappendix (Option D) : The mesoappendix is the mesentery of the appendix containing the appendicular artery, not an avascular fold marking the ileocecal junction.

References:

https://www.sciencedirect.com/topics/medicine-and-dentistry/cecum#:~:text=The%20superior%20ileocecal%20fold%20extends,posterior%20to%20the%20corresponding%20fold.

Bailey & Love's Short Practice of Surgery, 28th Edition, Pages 1345, 1346.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q22: A patient undergoes an appendectomy. While separating the mesoappendix, the operating surgeon cauterises and ligates the vessel within it. Which artery is this? (Q884001)

A. Ileocolic artery

B. Right colic artery

C. Appendicular artery

D. Middle colic artery

Correct Answer: C. Appendicular artery

Explanation: The appendicular artery, a branch of the lower division of the ileocolic artery, runs within the mesoappendix and is the primary vessel ligated during appendectomy. It is an end-artery supplying only the appendix. Thrombosis of this artery in acute appendicitis can lead to gangrene and perforation of the appendix. Ileocolic artery (Option A) : The ileocolic artery is the parent vessel but is not ligated during a routine appendectomy; only its terminal branch, the appendicular artery, is divided. Right colic artery (Option B) : The right colic artery supplies the ascending colon and is not involved in the blood supply of the appendix or the mesoappendix. Middle colic artery (Option D) : The middle colic artery supplies the transverse colon and is unrelated to the appendix or its mesentery.

References:

Bailey & Love’s Short Practice of Surgery, 28th Edition, Page 1346.

Sabiston Textbook of Surgery, 21st Edition, Page 1307.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q23: A surgeon performing an appendectomy notes the appendix in its typical location. Which anatomical position is this most likely to be? (Q884000)

A. Pelvic

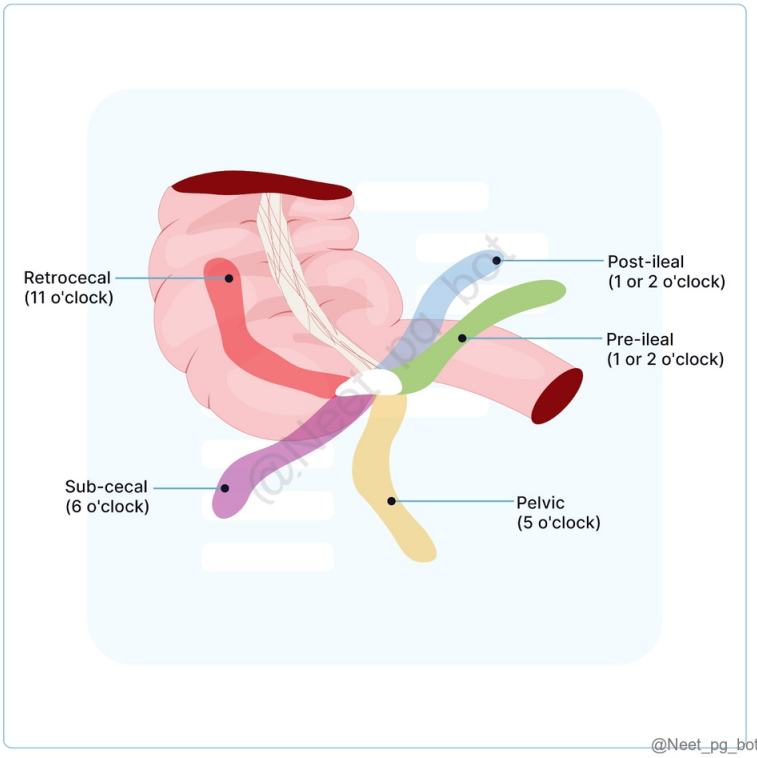
B. Retrocaeal

C. Subcaecal

D. Pre-ileal

Correct Answer: B. Retrocaeal

Explanation: The retrocaecal position is the most common location of the appendix, found in approximately 74% of individuals. In this position, the appendix lies behind the cecum, which can lead to atypical presentations of appendicitis due to its retroperitoneal location. Appendix positions (most to least common): Retrocaecal : ~60–74% Pelvic (descending) (Option A) : ~20–30% Subcaecal (Option C) : ~2–5% Pre-ileal (Option D) : ~1–5% Post-ileal : ~1–5%



References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1335.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q24: A 30-year-old female presents with right lower quadrant abdominal pain and is diagnosed with acute appendicitis. During surgery, a small mass is found at the tip of the appendix, which is subsequently identified as a carcinoid tumour. Which of the following statements about carcinoid tumours in the appendix is correct? (Q849038)

A. They are most commonly found at the base of the appendix.

B. They typically produce excessive amounts of insulin.

C. For carcinoid tumors >2cm, right hemicolectomy is the preferred modality of treatment

D. They are associated with a high risk of metastasis.

Correct Answer: C. For carcinoid tumors >2cm, right hemicolectomy is the preferred modality of treatment

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: For carcinoma tumors greater than 2 cm, right hemicolectomy is recommended because these larger tumors have a higher risk of metastasis and recurrence. Carcinoid tumor of the appendix (aka Argentaffinoma) MC Location Tip of the appendix Clinical Presentation Mostly discovered incidentally during surgery Larger tumors may cause abdominal pain, flushing, and diarrhea due to hormone secretion Hormone Secretion Secretes serotonin and other vasoactive substances. Risk of Metastasis Low for tumors <2 cm Higher for tumors >2 cm Diagnosis Confirmed by histopathological examination Treatment <2 cm : Appendectomy >2 cm : Right hemicolectomy

References:

SRB Manual of Surgery, 6th Edition, Page 869

↑ *Back to this question in Part A*

@Neet_pg_bot

Q25: A 55-year-old male with a history of appendicitis presents with severe right lower quadrant pain, fever, tachycardia, and tenderness. An ultrasound shows an appendix mass. Despite conservative treatment, his condition worsens. Which sign or symptom indicates the need for surgical intervention? (Q849037)

A. Increased white blood cell count with stable abdominal findings

B. Rising pulse rate with increasing size of the appendix mass

C. Localized right iliac fossa pain with no change in pulse rate

D. Generalized abdominal pain with no fever

Correct Answer: B. Rising pulse rate with increasing size of the appendix mass

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: A rising pulse rate with increasing size of the appendix mass strongly suggests worsening infection, potential abscess formation, and failure of conservative management, necessitating urgent surgical intervention. Appendicular Perforation Appendix rupture causes peritoneal contamination, leading to peritonitis. Risk Factors Extremes of age (<5 years, >65 years) Immunosuppression Diabetes mellitus Faecolith obstruction Pelvic appendix Previous abdominal surgery Pathophysiology Lumen obstruction (often by faecolith) increases intraluminal pressure. Venous obstruction and ischemia occur. Bacterial invasion through the appendix wall. Ischemic necrosis leads to rupture and contamination of the peritoneum. Clinical Presentation Initial colicky periumbilical pain, progressing to intense RLQ pain. Signs of diffuse peritonitis (rigid abdomen, systemic sepsis). Systemic signs (fever, tachycardia, leukocytosis). Management: Preoperative Intravenous fluid resuscitation Broad-spectrum antibiotics Venous thromboembolism prophylaxis Hyperpyrexia treatment in children Surgical

Approach Laparoscopic appendectomy is preferred for quicker recovery and reduced wound infection risk. Indicators for stopping conservative treatment of an appendix mass and planning surgical intervention: Rising Pulse Rate: Indicates worsening infection and potential sepsis; requires immediate surgical intervention. Spreading Abdominal Pain: Suggests peritonitis, moving beyond the right iliac fossa; necessitates immediate surgery. Increasing Mass Size: Indicates potential abscess growth or inadequate infection containment; requires surgical drainage and possible appendicectomy. Drain abscess if present.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1337-1338; 1343-1344

↑ *Back to this question in Part A*

@Neet_pg_bot

Q26: A 45-year-old male presents with a 3-day history of right lower quadrant pain, fever, and anorexia. His examination is significant for a palpable mass in the right lower quadrant with guarding and rebound. A CT scan demonstrates an appendiceal mass. He was admitted to the hospital and started on intravenous antibiotics. After 48 hours, his fever has resolved, and his abdominal pain has significantly improved. What is the most appropriate next step in management? (Q849036)

A. Discharge home on oral antibiotics

B. Continue IV antibiotics and observe

C. Laparoscopic appendectomy

D. Colonoscopy

Correct Answer: B. Continue IV antibiotics and observe

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The patient in this scenario is presenting with an appendix mass . This occurs when the inflamed appendix becomes encased in a phlegmonous mass due to the adherence of the greater omentum and loops of the small bowel. When a patient presents with an appendix mass, the standard treatment is the conservative Ochsner-Sherren regimen , which prioritizes observation and a non-operative approach unless necessary. Given that the patient has demonstrated significant clinical improvement after 48 hours of IV antibiotics, with the resolution of fever and improvement in abdominal pain, the most appropriate next step is to continue the conservative management with IV antibiotics and observe for further improvement. Convert IV → Oral Antibiotics Indications for Discharge Do NOT Discharge / Continue IV Fever resolved (>24 hrs afebrile) Afebrile & stable vitals Persistent fever or tachycardia Pain significantly reduced Minimal abdominal pain, improving tenderness Worsening abdominal pain or peritonitis Able to tolerate oral diet Tolerating full oral diet & oral meds

Persistent vomiting, unable to take oral meds Hemodynamically stable Ambulating comfortably Hemodynamic instability (low BP, high HR) WBC improving No signs requiring inpatient monitoring Rising WBC or metabolic abnormalities No enlarging abscess on imaging No complications on imaging CT shows enlarging abscess/phlegmon No nausea/vomiting Follow-up arranged & patient reliable Social issues preventing safe discharge Discharge home on oral antibiotics (Option A): Too early—patient still needs inpatient IV antibiotics and observation until fully stable. Laparoscopic appendectomy (Option C): Not preferred in appendicular mass; high risk of bowel injury due to dense adhesions. Colonoscopy (Option D): Has no role in acute appendicitis; used only in suspected colonic pathology (e.g., carcinoma)

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1343,1344

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@Neet_pg_bot

Q27: Which of the following statements is true about acute appendicitis? (Q849035)

A. Diagnosis in children can be done by clinical signs only

B. Diagnosis in adults requires additional imaging modalities

C. The gold standard test is the USG abdomen

D. A shift to the left in the leukocyte count is seen

Correct Answer: D. A shift to the left in the leukocyte count is seen

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Leukocytosis, along with a shift to the left, is a common investigative finding in the case of acute appendicitis Diagnosis of Acute Appendicitis: In adults, the diagnosis is primarily based on clinical signs and symptoms (Option B) Laboratory tests and ultrasound of the abdomen can support the clinical diagnosis. Leukocytosis is often observed in laboratory investigations. Imaging of Choice: In Children: Ultrasound is preferred as children may not cooperate with a thorough clinical examination (Option A) In Adults: Diagnosis is usually clinical, with imaging used to support the diagnosis if necessary. Gold Standard for Diagnosis: CECT (Contrast-Enhanced Computed Tomography) is considered the gold standard (Option C) for diagnosing acute appendicitis, even in cases where the diagnosis is uncertain.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1342

↑ *Back to this question in Part A*

@Neet_pg_bot

Q28: A 16-year-old male presents to the emergency department with a 12-hour history of abdominal pain. The pain was initially periumbilical and colicky in nature but has since localized to the right iliac fossa. He has also experienced one episode of vomiting and has no appetite. His Alvarado score is 5. What is the inference of this score? (Q849034)

A. Negative for acute appendicitis

B. Diagnosis for acute appendicitis is confirmed

C. CECT is indicated in this patient

D. None of the above

Correct Answer: C. CECT is indicated in this patient

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The Alvarado score is a clinical scoring system used to help diagnose acute appendicitis. The score is based on symptoms, signs, and laboratory results, with a score of 7 or more being strongly predictive of acute appendicitis. A score of 5 is equivocal, suggesting additional investigation with USG or CECT for the confirmation of diagnosis of acute appendicitis. MANTREL Score Migratory pain 1 Anorexia 1 Nausea, Vomiting 1 Tenderness 2 Rebound tenderness 1 Elevated Temperature 1 Leukocytosis 2 Shift to Left 1 Score of 9-10: Diagnosis is certain Score of 7-8: High likelihood of diagnosis Score of 5-6: Equivocal (most dangerous) CECT is indicated in cases of Equivocal MANTREL score findings to confirm the diagnosis. Score of 1-4: Negative for acute appendicitis

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1342

↑ *Back to this question in Part A*

@Neet_pg_bot

Q29: A 22-year-old male presents with right lower quadrant pain for the past 24 hours. On examination, the surgeon demonstrates cutaneous hyperesthesia in an area bounded by a line joining the anterior superior iliac spine, the umbilicus, and the pubic symphysis. Which of the following statements is most accurate regarding this clinical sign? (Q849033)

A. This sign is known as Sherren's triangle and is specific to retro-cecal appendicitis

B. The hyperesthesia is due to irritation of the T10-L1 nerve roots by the inflamed appendix

C. This sign is highly specific for appendicitis and rules out other causes of right lower quadrant pain

D. The presence of this sign contraindicates the use of laparoscopy for appendectomy

Correct Answer: B. The hyperesthesia is due to irritation of the T10-L1 nerve roots by the inflamed appendix

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Sherren's triangle: It is a clinical sign in acute appendicitis characterized by cutaneous hyperesthesia in the right lower quadrant. The area is roughly triangular, bounded by lines joining the anterior superior iliac spine, umbilicus, and pubic symphysis. It is caused by irritation of the nerves supplying the anterior abdominal wall (T10-L1) by the inflamed appendix. Clinical features of Appendicitis Symptoms Pain Initial: Vague, dull pain around the umbilicus. Progression: Pain localizes to the right lower quadrant (RLQ) due to parietal peritoneum involvement. Nausea and Vomiting Due to abdominal inflammation. Anorexia Loss of appetite. Signs Tenderness Tenderness at McBurney's point (one-third of the distance from the anterior superior iliac spine to the umbilicus on the right side). Rebound Tenderness Increased pain upon sudden release of pressure on the abdomen, indicating peritoneal irritation. Rovsing's Sign Positive when palpation of the left lower quadrant causes pain in the right lower quadrant, suggesting peritoneal irritation. Psoas Sign Pain on passive extension of the right hip, indicating irritation of the iliopsoas muscle group. Obturator Sign Pain elicited by internal rotation of the right thigh while supine, suggesting irritation of the obturator internus muscle. Dunphy's Sign Increased pain in the RLQ with coughing, indicating peritoneal irritation. Aaron's Sign Referred pain in the epigastrium upon pressure over McBurney's point. Ten Horn Sign Increased pain during gentle traction or pulling of the right testicle in male patients, suggesting an inflamed appendix close to the right spermatic cord. Sherren’s triangle (Option A) is not specific to retrocecal appendicitis. It can be seen in appendicitis irrespective of the position of the appendix. Sherren’s triangle (Option C) is not highly specific for appendicitis and does not rule out other causes of right lower quadrant pain, such as mesenteric adenitis, ureteric colic, or gynecological conditions. The presence of Sherren’s triangle (Option D) does not influence the choice of surgical approach. Laparoscopic appendectomy remains safe and is commonly preferred depending on patient factors and surgeon expertise.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1338, 1339

litfl.com/sherren-triangle/

↑ *Back to this question in Part A*

@Neet_pg_bot

Q30: A 28-year-old male presents with right lower quadrant pain, nausea, and low-grade fever. Upon examination, he exhibits rebound tenderness at McBurney's

point. Which of the following is the most likely initial event in the pathogenesis of this patient's condition? (Q849032)

A. Bacterial invasion of the appendiceal wall

B. Obstruction of the appendiceal lumen

C. Thrombosis of appendiceal vessels

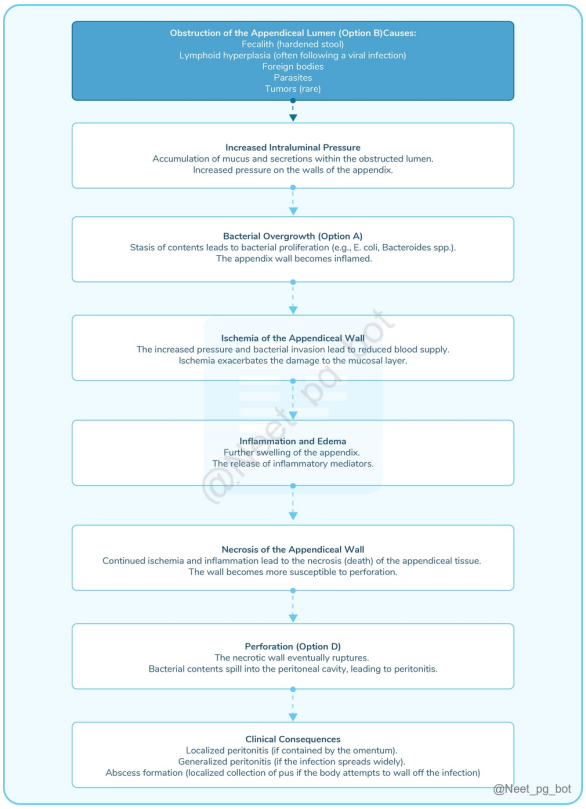
D. Perforation of the appendix

Correct Answer: B. Obstruction of the appendiceal lumen

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The above clinical scenario is suggestive of acute appendicitis. Obstruction of the appendiceal lumen is considered the primary initiating event in the pathogenesis of acute appendicitis. Pathogenesis of Appendicitis: Thrombosis of appendiceal vessels (Option C) can occur as a complication of acute appendicitis, but it is not the initial event in the pathogenesis. Vascular compromise is usually a result of increased intraluminal pressure and inflammation rather than a primary cause



References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 337,1338

↑ *Back to this question in Part A*

@Neet_pg_bot

• [05_Gastrointestinal Surgery] 029 Rectum And Anal Canal - I

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[05_Gastrointestinal Surgery] 029 Rectum And Anal Canal - I — Quick Jump

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Q7 (p. 2123)	*Q8 (p. 2124)*	*Q9 (p. 2126)*	*Q10 (p. 2127)*	*Q11 (p. 2128)*	*Q12 (p. 2129)*
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Q19 (p. 2137)	*Q20 (p. 2138)*	*Q21 (p. 2139)*	*Q22 (p. 2140)*	*Q23 (p. 2141)*	*Q24 (p. 2142)*
Q25 (p. 2143)	*Q26 (p. 2144)*				

Q1: A 28 y/o female presents with a history of chronic constipation, rectal pain, and bleeding. On examination, an ulcer is found on the anterior wall of the rectum, 7 cm from the anal verge. Proctography reveals rectal intussusception. Which is the most appropriate treatment for this patient's condition? (Q849210)

A. STARR Procedure

B. Abdominal Rectopexy

C. Histology

D. Colostomy

Correct Answer: A. STARR Procedure

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The patient’s symptoms and examination & diagnostic findings, lead us to the diagnosis of solitary rectal ulcer syndrome (SRUS) The STARR procedure (Stapled Transanal Resection of the Rectum) is the preferred surgical treatment for rectal intussusception associated with SRUS, addressing both the underlying intussusception and the ulcer. Solitary Rectal Ulcer Syndrome (SRUS) SRUS can be associated with obstructed defecation syndrome. Location: Typically presents as an ulcer on the anterior wall of the rectum, 6–8 cm from the anal verge. The ulcer may heal and leave a polypoid appearance. Diagnostic Tools: Proctography: May reveal rectal intussusception or anterior rectal wall prolapse. Histology: Confirms the diagnosis. Treatment: Surgical Options: STARR Procedure: Stapled Transanal Resection of the Rectum. Abdominal Rectopexy: Resuspension of the rectum. Abdominal Rectopexy (Option B) is another surgical option for rectal prolapse but is generally more invasive and typically reserved for cases of full-thickness rectal prolapse, not the localized intussusception seen in SRUS. Histology (Option C) is crucial for confirming the diagnosis of SRUS, but it is a diagnostic tool, not a treatment modality. Colostomy (Option D) is not indicated in the management of SRUS; it is typically reserved for more severe anorectal malformations or cases where bowel rest is required.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1398

SRB's manual of surgery, 6th Edition, Page 957

↑ *Back to this question in Part A*

@Neet_pg_bot

Q2: A 55 y/o male presents with rectal bleeding and pain during defecation. O/E, a firm mass is palpable in the anal canal. A biopsy confirms carcinoma of the anal canal. Imaging shows no distant metastasis, but inguinal nodes are enlarged. Which of the following is the most appropriate initial treatment for this patient? (Q849209)

A. Abdominoperineal Resection (APR) with Colostomy

B. Chemoradiation

C. Radiotherapy alone

D. Neoadjuvant Chemotherapy followed by surgery

Correct Answer: B. Chemoradiation

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The preferred treatment for carcinoma of the anal canal, particularly in the absence of distant metastasis and with localized inguinal lymph node involvement, is chemoradiation (Nigro regimen). Treatment of Carcinoma of the Anal Canal Chemoradiation (Nigro regimen): The preferred treatment modality for carcinoma of the anal canal. Chemotherapy Drugs: Commonly used drugs include 5-fluorouracil (5-FU), bleomycin, vincristine, and adriamycin. Radiotherapy: Often used alone in advanced cases where the tumour is not resectable. Surgical Interventions: Abdominoperineal Resection (APR) with Colostomy: Indicated for persistent or recurrent disease after combined modality therapy (CMT), or for cases where the tumor does not respond to chemoradiation. Neoadjuvant Chemotherapy: Involves using 5-FU, cisplatin, and mitomycin C before surgery to shrink the tumour. Abdominoperineal Resection (APR) with Colostomy (Option A) APR is not the initial treatment . Reserved for residual or recurrent disease after chemoradiation. Radiotherapy alone (Option C) Inferior outcomes. Chemoradiation is superior for anal canal cancer. Neoadjuvant chemotherapy followed by surgery (Option D) Not standard for anal canal carcinoma. Surgery is only for failures of chemoradiation.

References:

SRB's Manual of Surgery, 6th Edition, Page 977

Bailey and Love Short Manual of Surgery, 28th Edition, Page 1444

Schwartz’s Principles of Surgery, 11th Edition, Page 1304

↑ *Back to this question in Part A*

@Neet_pg_bot

Q3: A 60 y/o patient is diagnosed with anal canal cancer. A tumour of size 3cm invades through the muscularis propria into the perirectal tissue, involving 4-6 regional lymph nodes without distant metastasis. Which of the following stages correctly describes this condition? (Q849208)

A. Stage I (T1-T2, N0, M0)

B. Stage II (T1-T2, N1, M0)

C. Stage III (T1-T4, N2, M0)

D. Stage IV (T1-T4, N1-N3, M1)

Correct Answer: C. Stage III (T1-T4, N2, M0)

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The scenario indicates a tumour that invades the muscularis propria (T3) with the involvement of 4-6 regional lymph nodes (N2) and no distant metastasis (M0). TNM Classification Classification Description T0 No evidence of a primary tumour Tis Carcinoma in situ (localized) Aka Bowens disease Anal intraepithelial neoplasia(AIN) type I - III T1 Tumor ≤ 2cm, Invades the submucosa T2 Tumor >2 cm but <5 cm, Invades the muscularis propria T3 Tumor>5 cm, Invades the subserosa T4 Tumour of any size that invades adjacent organs or structures eg. Vagina, urethra, Bladder N0 No regional lymph node involvement N1 Involvement of 1-3 regional lymph nodes N2 Involvement of 4-6 regional lymph nodes N3 Involvement of 7 or more regional lymph nodes M0 No distant metastasis M1 Distant metastasis present Staging Summary: Stage Criteria Stage 0 Tis, N0, M0 (carcinoma in situ) Stage I T1-T2, N0, M0 (localized) Stage II T1-T2, N1, M0 (locally advanced) Stage III T1-T4, N2-N3, M0 (late locally advanced) Stage IV T1-T4, N1-N3, M1 (metastatic)

References:

CA Anal Canal TNM Classification

8th AJCC TNM Classification

Bailey and Love Short manual of surgery, 28th Edition, Page 1444

Schwartz’s Principles of Surgery, 11th Edition, Page 1304

↑ *Back to this question in Part A*

@Neet_pg_bot

Q4: A 58 y/o woman presents with anal pain, bleeding during bowel movements, and the presence of a palpable mass. She has a history of multiple sexual partners and was recently diagnosed with human papillomavirus (HPV) infection. Which of the following risk factors is most strongly associated with the development of anal canal cancer in this patient? (Q849207)

A. HPV infection leads to anal condylomata.

B. Immunosuppression due to a recent organ transplant.

C. History of vulvar intraepithelial neoplasia (VIN).

D. Chronic constipation resulting in haemorrhoids.

Correct Answer: A. HPV infection leads to anal condylomata.

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The presence of extensive anal warts (condylomata) is strongly associated with HPV infection and significantly increases the risk of anal canal cancer due to the high likelihood of HPV-related changes in the anal epithelium. Risk Factors: Factor Description Human Papillomavirus (HPV) Infection Strongly linked to anal canal cancer, particularly high-risk subtypes (16, 18, 31, 33) Anal Intraepithelial Neoplasia (AIN) A precancerous condition significantly increases the risk of progression to anal canal cancer, especially from AIN II or III. Immunosuppression Individuals with weakened immune systems (e.g., HIV-positive, transplant recipients) have a higher risk due to impaired HPV response and AIN development. Sexual Practices Anal intercourse increases HPV transmission risk. History of Other Genital Neoplasia A history of vulvar intraepithelial neoplasia (VIN) or cervical intraepithelial neoplasia (CIN) raises the risk. Extensive Anogenital Condylomata The presence of extensive anal warts linked to HPV infection elevates the risk of anal canal cancer.

References:

Bailey & Love’s Short Practice of Surgery,28th Edition, Pages 1442, 1443, 1444

↑ *Back to this question in Part A*

@Neet_pg_bot

Q5: .A 78-year-old woman with a history of chronic constipation and faecal incontinence presents with a complaint of a mass that protrudes circumferentially from her anus, which she can manually reduce. She also reports occasional bleeding

and difficulty with bowel movements. Which of the following is the most appropriate management for this patient's rectal prolapse? (Q849192)

A. Perineal rectopexy

B. Rubber band ligation

C. Abdominal rectopexy

D. Infrared photocoagulation

Correct Answer: A. Perineal rectopexy

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Perineal rectopexy is the preferred option for elderly patients or those with high surgical risk due to its lower operative morbidity and mortality, making it suitable for this 78-year-old patient. Management of Rectal prolapse: Non-Operative Management Medical Treatment: Palliates symptoms of constipation and faecal incontinence with fluid intake, fibre supplements, stool softeners, and topical treatments for mucosal oedema. Enemas and Suppositories: Assist in defecation and reduce symptoms. Operative Management Rectopexy is fixing the rectum to the sacrum by sutures or mesh after complete mobilization of the rectum Aspect Abdominal Rectopexy Perineal Rectopexy Types Prosthetic or mesh rectopexy-anterior/ posterior- Well's, Ripstein Suture rectopexy- Lahaut Anterior Resection Resection Rectopexy Mucosal sleeve resection (Delrome's) Perineal recto sigmoidectomy (Altemeier's) Posterior fixation of the rectum of Lockhardt-Mummery Mickulicz Miles perineal transanal recto sigmoidectomy Anal encircling (Thiersch) Advantages Fixation of the rectum provides adequate tension to prevent recurrence. Minimally invasive options (laparoscopic or robotic) offer benefits in pain control, hospital stay, and recovery time Lower operative morbidity and mortality, suitable for elderly or medically unfit patients. Disadvantages Requires extensive dissection and fixation, which may have higher morbidity (10%-33%). Risk of mesh-related complications such as erosion, infection, bowel obstruction, and migration. Higher recurrence rates compared to abdominal approaches

References:

Sabiston Textbook of Surgery, 21st Edition, Pages 1392,1394

SRB’s Manual of Surgery, 6th Edition, Pages 961, 962, 957

↑ *Back to this question in Part A*

@Neet_pg_bot

Q6: A 58 y/o man presents with bright red blood in his stool, tenesmus, and intermittent abdominal pain for one month. A digital rectal exam reveals a hard mass 5 cm from the anal verge. Rigid sigmoidoscopy confirms a neoplasm. What is the next step to evaluate the extent of his disease? (Q849205)

A. Perform a CT scan of the abdomen and pelvis.

B. Schedule a colonoscopy.

C. Obtain a biopsy of the rectal mass.

D. Surgical intervention

Correct Answer: A. Perform a CT scan of the abdomen and pelvis.

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The patient’s clinical examination & investigation findings point toward the diagnosis of rectal cancer. Performing a CT scan of the abdomen and pelvis is the correct next step to assess the extent of the disease and check for any distant metastases, which is essential for staging rectal carcinoma. Investigations and Diagnosis of Rectal Carcinoma Digital Rectal Examination : Used to assess the size, consistency (hard), shape (Irregular), and mobility (mobile, tethered, or fixed). A vaginal examination is recommended for women to check for involvement of the posterior vaginal wall. Rigid Sigmoidoscopy : Outpatient procedure for visualizing the neoplasm and obtaining biopsies Biopsy and Histological Analysis : Crucial for confirming the diagnosis and distinguishing rectal carcinoma from conditions that may mimic it, such as inflammatory strictures, granulomas, and benign adenomas. Staging Investigations : CT chest, abdomen, and pelvis. Local pelvic imaging with MRI and/or endoluminal ultrasonography provides detailed information about local tumour spread, including infiltration into surrounding tissues and lymph node involvement. Colonoscopy : Essential for most patients to rule out synchronous tumours elsewhere in the colon. Techniques like "dye spray" colonoscopy help differentiate benign from malignant lesions based on mucosal 'pit patterns'. Proximal adenomas can be removed during the procedure; finding synchronous carcinomas may alter surgical strategy. CT Colonography or Barium Enema : Alternatives to colonoscopy if full visualization of the colon is not possible due to stenosing cancer.

References:

Bailey & Love’s Short Practice of Surgery, 28th Edition, Page 1406

↑ *Back to this question in Part A*

@Neet_pg_bot

Q7: A 35-year-old woman experiencing severe pain during bowel movements, bright red blood on toilet paper, and chronic anal fissures has not improved with conservative treatment and is being referred for surgery. Which surgical procedure is aimed at reducing anal sphincter tone to promote healing of the fissure while maintaining continence? (Q849202)

A. Fissurectomy

B. Lateral Internal Sphincterotomy

C. Anal Advancement Flap

D. Botulinum toxin injection

Correct Answer: B. Lateral Internal Sphincterotomy

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Lateral Internal Sphincterotomy involves dividing a portion of the internal anal sphincter, which reduces sphincter tone and allows the fissure to heal. It is designed to maintain continence while addressing the fissure. Management of anal fissures involves a combination of conservative and surgical interventions if conservative measures are ineffective. Conservative Management Lifestyle and Dietary Modifications Aim: To soften stools and reduce pain Increase fiber intake Adequate fluid intake Warm Sitz baths to relax the anal sphincter. Topical anaesthetics. Anorectal biofeedback: Helps patients learn to relax the anal sphincter and improve bowel control. Pharmacological Treatment 1. Topical medications: Glyceryl trinitrate (GTN) ointment (0.2%) : Applied 2-3 times daily; a nitric oxide donor that promotes relaxation but may cause headaches. Diltiazem (2%) : Applied twice daily; a calcium channel blocker that induces sphincter relaxation with fewer side effects compared to GTN. 2. Botulinum toxin injections: 10-100 units injected into the internal anal sphincter to reduce pressure and allow healing by blocking acetylcholine release. Surgical Interventions Consider if conservative measures fail, especially for chronic cases. Lateral Internal Sphincterotomy Divides a small portion of the internal anal sphincter. Approaches: Closed Method: Small incision over the intersphincteric groove to divide the sphincter under the mucosa. Open Technique: Incision through the anoderm for direct access to the internal sphincter. Fissurectomy (Option A ruled out) Excision of the fissure, including fibrotic edges and associated skin tags. Often combined with an anal advancement flap. Anal Advancement Flap (Option C ruled out) Used when there’s an increased risk of incontinence after sphincterotomy, especially in women post-childbirth. Involves advancing a flap of healthy skin from the perianal area to cover the fissure, promoting healing and reducing tension.

References:

Bailey & Love’s Short Practice of Surgery, 28th Edition, Pages 1428, 1429

↑ *Back to this question in Part A*

@Neet_pg_bot

Q8: A 35-year-old woman with a recurrent anal abscess has developed an anal fistula. She is concerned about continence after surgery. Which surgical option is best to treat her condition while minimizing incontinence risk? (Q849199)

A. Fistulotomy

B. Fistulectomy

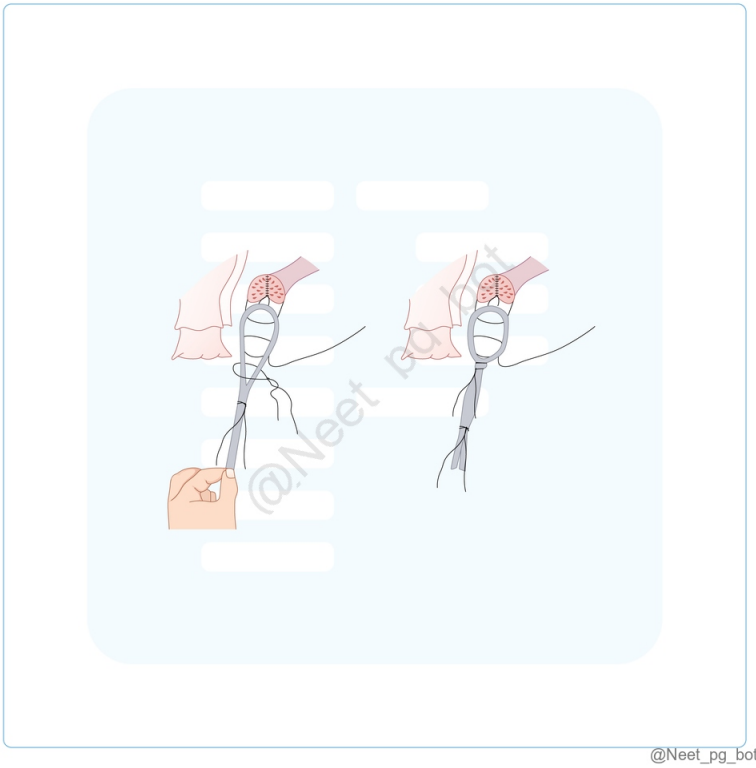
C. Setons

D. Ligation of the Intersphincteric Fistula Tract (LIFT)

Correct Answer: D. Ligation of the Intersphincteric Fistula Tract (LIFT)

- *Listen (English)*
- *Listen (Hindi)*

Explanation: The LIFT (Ligation of the Intersphincteric Fistula Tract) procedure is a sphincter-preserving technique that disconnects the internal opening of the fistula from the tract while minimizing damage to the anal sphincter. This approach is particularly suitable for patients who are concerned about maintaining continence post-surgery, making it the most appropriate option for the patient in this scenario. Fistula-in-Ano: A chronic abnormal communication between the anorectal lumen (internal opening) and an external opening on the skin of the perineum, buttock, or, rarely, the vagina in women. Common Treatment Options Treatment Description Indications Fistulotomy (Option A ruled out) Opening the fistula tract to heal by secondary intention. Used for intersphincteric and trans-sphincteric fistula involving <30% of external sphincter; not for anterior fistula in women. Fistulectomy (Option B ruled out) Removal of the fistula using diathermy cautery for better visualization of anatomy. Effective for understanding the fistula's anatomy and extensions. Setons (Option C ruled out) Materials are inserted into the fistula tract for drainage or gradual cutting. Loose setons promote drainage; tight/cutting setons cut through muscle over time. Advancement Flaps Closing the internal opening with a flap of anorectal mucosa is used when the sphincter complex is not extensively indurated. Effective for certain fistula configurations.



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References:

Bailey & Love’s Short Practice of Surgery, 28th Edition, Pages 1439, 1440

↑ *Back to this question in Part A*

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Q9: A 1-week-old girl with a newly diagnosed rectovestibular fistula is undergoing evaluation. Which of the following is the most appropriate initial treatment for a newborn with a rectovestibular fistula? (Q849211)

A. Single-stage anoplasty

B. Initial colostomy followed by definitive pull-through operation

C. Wangenstein's Invertogram to determine the level of the rectal pouch

D. Aspiration of meconium and dye injection for fistula assessment

Correct Answer: B. Initial colostomy followed by definitive pull-through operation

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: A rectovestibular fistula is a type of high fistula in girls, which typically requires an initial colostomy to manage the bowel function. A definitive pull-through operation (posterior sagittal anorectoplasty) is then performed as a second stage to correct the malformation. Anorectal Malformations (ARM): Cause Results from the imperfect fusion of the post-allantoic gut with the proctodaeum. Incidence Occurs in 1 in 4500 newborns; associated with anomalies like VATER/VACTERL, including cardiac, trachea-esophageal fistula, renal, and spinal anomalies. Types Male: Rectobulbar fistula (the fistula originating distal to the puborectalis) Female: Rectovestibular fistula. Investigations Wangenstein's invertogram is used to determine the level of the rectal pouch relative to the pubococcygeal (Stephen’s) line. Murugassu's technique: Involves aspiration of meconium from the rectum and dye injection to assess fistula level. USG abdomen, cardiac function evaluation, MRI spine. Treatment Low Fistula: Single-stage reconstruction like anoplasty, ano vestibuloplasty, anal dilation, or incision of the anal membrane with excellent outcomes. High Fistula: Initial colostomy followed by a definitive “Pull-through operation” (posterior sagittal anorectoplasty) and later colostomy closure. Complications Infection Fecal fistula Stenosis Colitis Malnutrition Fecal incontinence Single-stage anoplasty (Option A) is generally suitable for low fistulas, not high fistulas like the rectovestibular type. Wangenstein's Invertogram to determine the level of the rectal pouch (Option C) is useful as a diagnostic tool rather than a treatment method. Aspiration of meconium and dye injection for fistula assessment (Option D), Murugassu’s technique is used for assessing the level of the fistula, but it is not a treatment method.

References:

Bailey & Love’s Short Practice of Surgery, 28th Edition, Page 1398

SRB’s Manual of Surgery, 6th Edition, Page 957

↑ *Back to this question in Part A*

@Neet_pg_bot

Q10: A 62 y/o woman diagnosed with rectal carcinoma is being evaluated for treatment options. Which of the following statements regarding the treatment strategies for rectal carcinoma is true? (Q849206)

A. Total mesorectal excision (TME) is a method of palliative care in patients with advanced rectal cancer.

B. Neoadjuvant chemoradiotherapy is used after surgical resection to minimize the risk of local recurrence.

C. Local excision is indicated for early-stage rectal cancers with good prognostic factors.

D. Abdominoperineal excision (APR) is the preferred surgical approach for all cases of rectal carcinoma.

Correct Answer: C. Local excision is indicated for early-stage rectal cancers with good prognostic factors.

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: s: Local excision is appropriate for early-stage cancers(T1 & T2), allowing for the removal of the tumour while preserving the rectum and anal sphincter, thus minimizing the impact on bowel function. Treatment Options for Rectal Carcinoma Surgical Treatment Goals of Surgery : Achieve complete oncological clearance by removing the tumour, surrounding mesorectum, and lymph nodes (Total Mesorectal Excision - TME) to minimize local recurrence risk. TME is a curative and gold-standard approach to completely removing rectal cancer. (Option A ruled out) Neoadjuvant Therapy : Chemoradiotherapy is often used before surgery to downstage cancer, facilitating easier removal and improving resection success. (Option B ruled out) Surgical Techniques : Technique Indications Local Excision (Option C) Suitable for early-stage cancers (T1 and selected T2) with good prognostic factors; preserves rectum and anal sphincter, minimizing bowel function impact. Anterior Resection Preferred for most cancers in the middle and lower rectum; involves removing affected rectal parts and reconnecting the colon to the remaining rectum. Abdominoperineal Excision (APR) (Option D ruled out) Reserved for low-lying, extensive tumours unsuitable for sphincter-saving; involves removing rectum, anus, and surrounding tissues, creating a permanent colostomy. Hartmann's Procedure Involves removing the rectum and creating a temporary colostomy, suitable for elderly or frail patients. Pelvic Exenteration : Radical surgery for advanced cases with cancer spread to adjacent organs; removes rectum, bladder, prostate (in men), and/or reproductive organs (in women) for clear margins. Non-Surgical Treatment: Wait and watch : Considered for patients with complete clinical response to neoadjuvant chemoradiotherapy (about 20% of cases); involves close monitoring with potential surgery if recurrence occurs. Endoluminal Stenting : Used palliatively to relieve obstruction from inoperable tumours or to facilitate elective surgery; suitable for tumours in the upper rectum or rectosigmoid junction. Palliative Colostomy : Indicated in inoperable rectal cancer or cancers causing obstruction. Adjuvant Therapy Radiotherapy : May be used pre- or post-surgery to destroy remaining cancer cells and reduce recurrence

risk. Chemotherapy : Typically 5-fluorouracil(5-FU) based regimens are often combined with radiotherapy or given post-surgery to eliminate remaining cancer cells.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Pages 1409, 1412-1415

↑ *Back to this question in Part A*

@Neet_pg_bot

Q11: A 60-year-old male presents with bright red, painless rectal bleeding and a feeling of incomplete evacuation. Digital rectal examination (DRE) reveals a firm, irregular, palpable mass located 6 cm from the anal verge. Which statement about the clinical features of rectal carcinoma is most accurate? (Q849204)

A. Tenesmus is a late symptom.

B. Rectal carcinoma typically presents without any changes in bowel habits.

C. Rectal carcinoma is most common in patients under 55 years of age.

D. The presence of a hard mass within 7-8 cm of the anal verge.

Correct Answer: D. The presence of a hard mass within 7-8 cm of the anal verge.

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The rectal neoplasm may be palpable within 7-8 cm of the anal verge, appearing as a raised, firm mass. Clinical Features of Rectal Carcinoma: Commonly seen in >55 years of age (Option C ruled out) Early Symptoms : Bleeding per rectum: The most common early symptom, often bright red and painless, which can be mistaken for hemorrhoidal bleeding. Tenesmus: It is an important early symptom. It is the feeling of incomplete evacuation, often present with lower rectal tumours, leading to frequent attempts to pass stool or gas. (Option A ruled out) Diarrhoea: Early morning diarrhoea may occur. (Option B ruled out) Late Symptoms : Constipation can develop with rectosigmoid junction tumours. (Option B ruled out) Colicky pain may indicate obstruction and advanced cancers may cause severe pain due to invasion of nearby structures. Weight loss indicates metastatic disease. Abdominal Examination Findings : Early cases may be normal while obstructing tumours can show signs of subacute bowel obstruction. Palpable liver enlargement may indicate liver metastases, and cachexia can be present. Ascites may be found in cases of peritoneal spread. Rectal Examination Findings : The tumour is palpable within 7-8 cm of the anal verge, appearing as a raised, hard mass. If ulcerated, it may present as a depression with everted edges. (Option D) Mobility and distance from the anal sphincter complex are important for assessing resectability and surgical planning.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Pages 1405, 1406

↑ *Back to this question in Part A*

@Neet_pg_bot

Q12: A 24-year-old male presents with recurrent painful swelling and discharge at the natal cleft. He has coarse hair and reports worsening after prolonged sitting. On examination, a tender fluctuant swelling with a midline pit is noted.What is the most appropriate initial management? (Q849203)

A. Complete surgical excision of the sinus

B. Cauterization using silver nitrate

C. Drainage through a midline incision

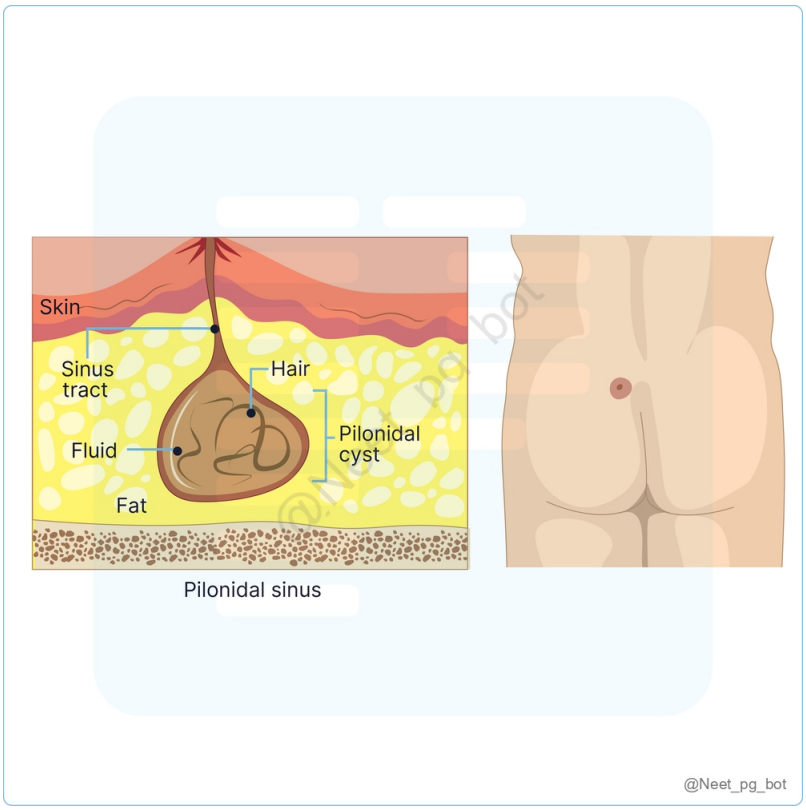
D. Lateral internal sphincterotomy

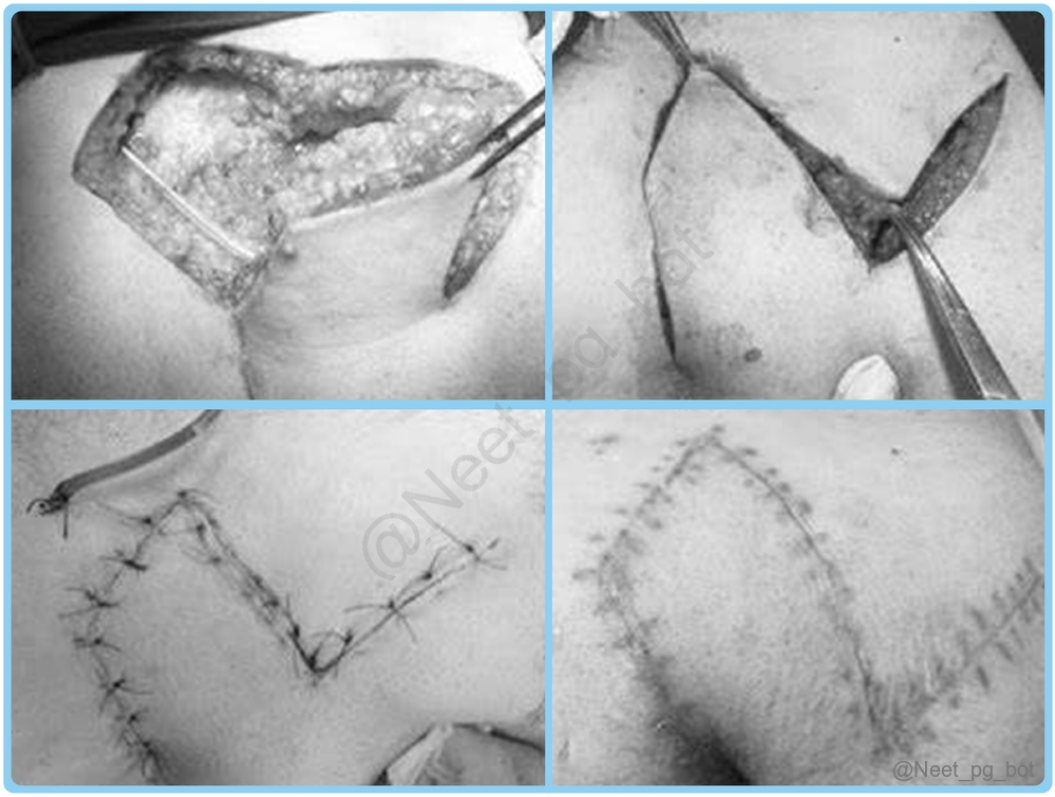
Correct Answer: C. Drainage through a midline incision

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Drainage through a midline incision is the most appropriate initial management for an acute pilonidal abscess . It involves creating a small incision to drain the abscess and clean the cavity. Pilonidal sinuses are found in the natal cleft (the groove at the top of the buttocks), consisting of one or more skin openings connected to a subcutaneous track lined with granulation tissue, often containing hair. Treatment Options: Conservative: Cleaning, hair removal, and hygiene maintenance. Cauterization with silver nitrate or laser Acute Abscess Treatment: Drainage through a small longitudinal incision over the abscess (Option C ruled out) . Surgical: Laying open sinus tracks (with/without marsupialisation) Complete excision (with/without primary closure) Off-midline closure techniques (Limberg, Z-plasty, Karydakis procedures). Bascom Procedure: Lateral incision to clean the sinus cavity, excise midline pits, and leave lateral wounds open to heal secondarily. Flap Procedures: If initial treatments fail or if the sinus recurs Pilonidal sinus excision and repair by rhomboid flap {{caption_text}}





References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1423

↑ *Back to this question in Part A*

@Neet_pg_bot

Q13: A 32 y/o woman presents with severe pain during bowel movements and bright red blood on toilet paper for 2 weeks. She describes the pain as excruciating and sharp, akin to "passing glass.” Based on this clinical scenario, which of the following statements is correct? (Q849201)

A. It mainly presents with anal itching & discharge

B. The hallmark symptom is severe pain during defecation that usually subsides after bowel movements.

C. This condition is characterized by a thickened anal papilla and a skin tag.

D. The majority of cases occur in the anterior midline in women due to childbirth.

Correct Answer: B. The hallmark symptom is severe pain during defecation that usually subsides after bowel movements.

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The diagnosis of the given scenario is acute anal fissure. Severe pain during defecation that usually subsides afterwards is a key feature of this condition Anal Fissure Most anal fissures occur in the posterior midline due to concentrated pressure during bowel movements. (Option D ruled out) Anterior anal fissures are more common in women, often linked to childbirth trauma. They may be acute or chronic as described below Feature Acute Anal Fissures Chronic Anal Fissures Cause Trauma to the anal canal lining. (Passage of hard stools, prolonged diarrhoea, childbirth). Increased anal sphincter tone converts acute to chronic fissure, Elevated muscle tension reduces blood flow to the anal canal. Impaired healing leads to a cycle of repeated injury. Pain Excruciating, sharp pain during defecation (described as "passing glass"). May be less intense than acute but can still be painful. Duration of Pain The pain subsides after defecation but returns with the next bowel movement. (Option B) Persistent pain may occur, with periods of discomfort. Bleeding Bright red blood on toilet paper after wiping. May also experience blood but less prominently reported. Physical Exam Difficult without anaesthesia due to intense pain. An exam may be possible, with signs of irritation from the skin tag. Additional Symptoms Notable pain prevents physical examination; anal spasms may be present. Presents with anal itching, discharge, or intersphincteric fistula. (Option A ruled out) Identifying Features Fresh, superficial tears in the anal canal. Thickened anal papilla and skin tag present; fissure between these structures. (Option C ruled out)

References:

Bailey & Love’s Short Practice of Surgery, 28th Edition, Pages 1427, 1428

↑ *Back to this question in Part A*

@Neet_pg_bot

Q14: A 35 y/o woman presents with severe pain during bowel movements and bright red blood on toilet tissue. Upon examination, the physician suspects an anal fissure. Which of the following characteristics is most likely associated with a chronic anal fissure? (Q849200)

A. Presence of bright red blood only after bowel movements.

B. Severe sharp pain during bowel movements that subside afterwards.

C. Thickened anal papilla and skin tag are present at the fissure site.

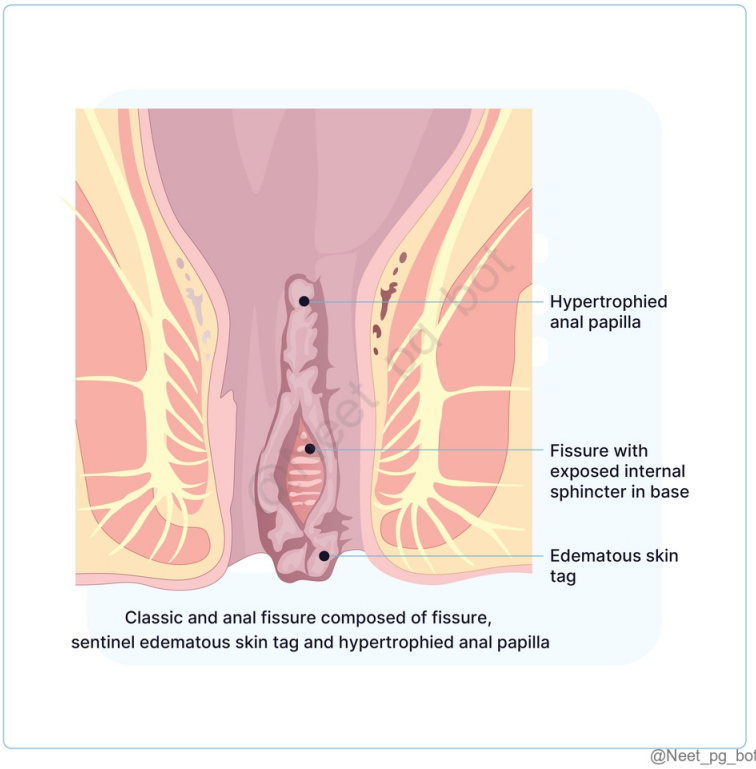
D. Extensive oedema and inflammation

Correct Answer: C. Thickened anal papilla and skin tag are present at the fissure site.

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The presence of a thickened anal papilla and an external skin tag is a characteristic of chronic fissures. Anal Fissures: Ulcer in the longitudinal axis of the anal canal Characteristic Acute Anal Fissures Chronic Anal Fissures Description Fresh, superficial tears in the anal canal lining. Develop when acute fissures fail to heal due to ongoing trauma and increased anal sphincter tone. Symptoms Severe, sharp pain during bowel movements (subsides afterwards) (Option B ruled out) Bright red blood on toilet tissue after wiping (Option A ruled out) . Physical examination often requires general anaesthesia due to pain. Presence of a thickened anal papilla and an external skin tag (Option C) . May cause anal itching due to skin tag irritation. Discharge from the fissure or a co-existing intersphincteric fistula. Often less painful than acute fissures due to associated inflammation.



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References:

SRB’s Manual of Surgery, 6th Edition, Pages 967, 968

Bailey & Love’s Short Practice of Surgery, 28th Edition, Page 1428

↑ *Back to this question in Part A*

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Q15: During a detailed anatomical study, a researcher examines the fascia layers associated with the rectum. Which of the following structures separates the rectum from the prostate in males? (Q849184)

A. Presacral fascia

B. Fascia propria

C. Denonvilliers' fascia

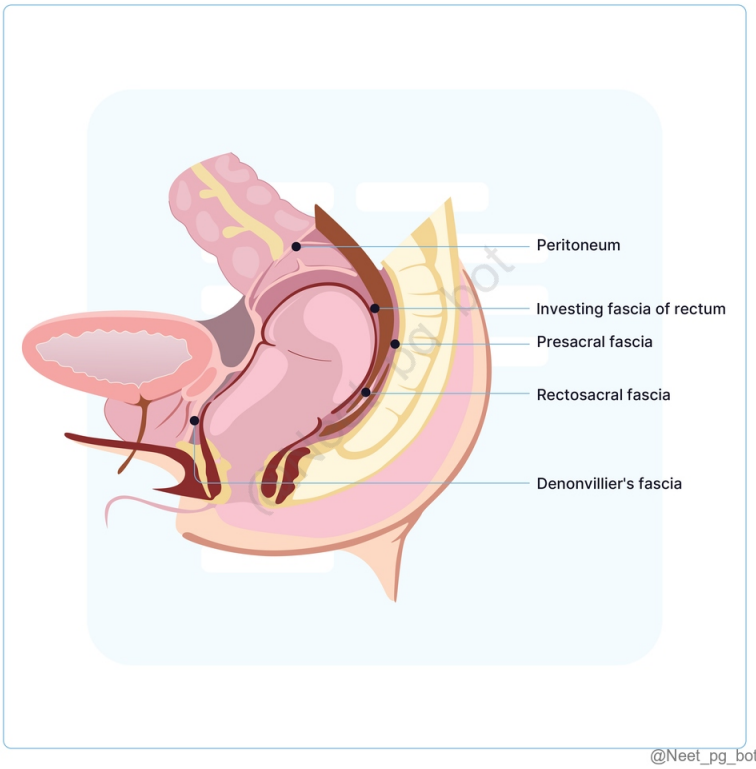
D. Waldeyer's fascia

Correct Answer: C. Denonvilliers' fascia

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Denonvilliers' fascia is the membranous layer located anterior to the rectum, acting as a barrier between the rectum and the prostate, seminal vesicles, and bladder in males. Presacral fascia (Option A) : Situated posterior to the rectum, covering the anterior surface of the sacrum and coccyx. Fascia propria (Option B) : Thin layer of fascia around the mesorectum, which surrounds the rectum. Waldeyer's fascia (Option D (also known as recto sacral fascia): Condensation of endopelvic fascia connecting the presacral fascia to the fascia propria at the S4 level. It separates the rectum from the sacrum.



References:

Sabiston Textbook of Surgery, 21st edition, Page 1328

SRB’s Manual of Surgery, 6th Edition, Pages 942,943

↑ *Back to this question in Part A*

@Neet_pg_bot

Q16: A 32 y/o male presents with intermittent discharge of pus from an external opening near the anus, accompanied by discomfort and occasional blood in the discharge. He has a history of anorectal abscess treated six months ago and reports pain during bowel movements. Which of the following is the investigation of choice in

this case? (Q849198)

A. Fistulography (X-ray)

B. Endoscopic Ultrasound

C. Anoscopy

D. MRI

Correct Answer: D. MRI

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: MRI (MR fistulogram) is the investigation of choice as it provides detailed images of the fistula tunnel, the sphincter muscle, and other pelvic floor structures. It can identify secondary extensions and associated complications that may influence surgical management. Investigations for Fistula-in-Ano MRI (Option D) Maps the fistula tunnel and provides detailed images of the sphincter muscle and pelvic floor structures. (Investigation of choice) Endoscopic Ultrasound (Option B ruled out) It uses high-frequency sound waves to identify the fistula, sphincter muscles, and surrounding tissues. Fistulography (Option A ruled out) An X-ray procedure using injected contrast to visualize the anal fistula tunnel. Examination Under Anesthesia Allows for thorough evaluation of the fistula tunnel and identification of potential complications. Fistula Probe A specialized instrument is inserted through the fistula to identify the fistula tunnel. Anoscopy (Option C ruled out) A small endoscope is used to visualize the anal canal for assessment of fistulas during anoscopy

References:

Investigations

Schwartz’s Principles of Surgery, 11th Edition, Page 1317

SRB’s Manual of Surgery, 6th Edition, Page 973

↑ *Back to this question in Part A*

@Neet_pg_bot

Q17: A 45 y/o male presents to the clinic with a persistent anal discharge and discomfort. He has a history of recurrent perianal abscesses over the past year. O/E an external opening is noted near the anal margin. Which of the following is the most likely cause of the anal fistula in this patient? (Q849197)

A. Crohn's disease

B. Tuberculosis

C. Actinomycosis

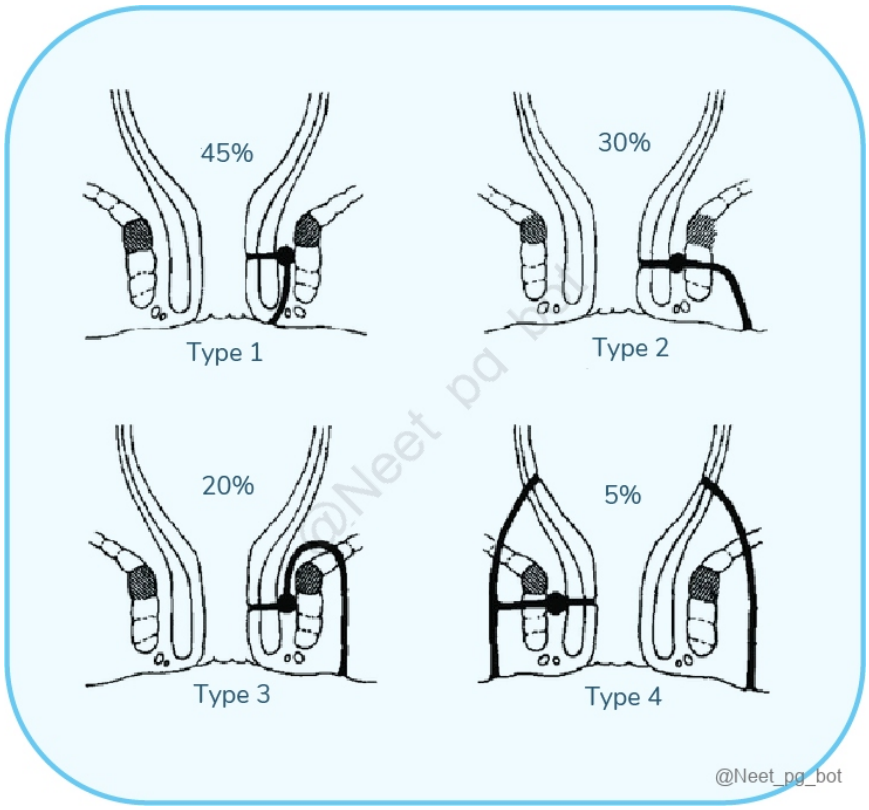
D. Cryptoglandular infection

Correct Answer: D. Cryptoglandular infection

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Cryptoglandular infection is the most common cause of anal fistulas, particularly following an anorectal abscess, as mentioned in the above scenario. Fistula-in-Ano A chronic abnormal communication between the anorectal lumen (internal opening) and an external opening on the skin of the perineum, buttock, or, rarely, the vagina in women. Causes Idiopathic/Cryptoglandular: The most common cause , often associated with prior anorectal sepsis. (Option D) Associated Conditions: Crohn’s disease (Option A ruled out) Tuberculosis (Option B ruled out) Lymphogranuloma venereum Actinomycosis (Option C ruled out) Rectal duplication Foreign bodies Malignancy (rare, can develop within a longstanding fistula) {{caption_text}}



References:

SRB’s Manual of Surgery, 6th Edition, Page 972

Bailey and Love’s Short Practice of Surgery, 28th Edition, Pages 1436, 1437

↑ *Back to this question in Part A*

@Neet_pg_bot

Q18: A 38-year-old man presents with severe anal pain and a tender, indurated lump at the anal margin. He reports a two-day history of progressively localized pain but has no systemic symptoms such as fever or malaise. What is the next best step in managing this patient? (Q849196)

A. Immediate antibiotic therapy

B. Surgical drainage under anaesthesia

C. Observation and follow-up in 48 hours

D. Imaging studies to confirm diagnosis

Correct Answer: B. Surgical drainage under anaesthesia

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The patient's presentation with a tender, palpable mass at the anal verge and localized pain suggests an abscess that requires prompt surgical drainage, which is the definitive treatment to prevent complications. Anorectal Abscess: A localized collection of pus in the perianal or perirectal region, often resulting from a cryptoglandular infection. Treatment: Surgical Drainage: Primary treatment, often performed under anaesthesia. (Option B) Perianal and Ischiorectal Abscesses: Drained via perineal skin using a cruciate incision, avoiding excessive excision of healthy tissue. Supralevator Sepsis: Management depends on the origin; may require intrarectal drainage or treatment of underlying pelvic disease. Antibiotics: Indicated in cases with extensive cellulitis, diabetes, or immunosuppression.

References:

Schwartz's Principles of Surgery, 11th Edition, Pages 1313,1314

Bailey and Love's Short Practice of Surgery, 28th Edition, Pages 1435, 1436

↑ *Back to this question in Part A*

@Neet_pg_bot

Q19: A 45-year-old diabetic male reports deep, intense pain "inside" the anal area that worsens with coughing or sneezing. The examination shows minimal external swelling, but the significant discomfort prevents a complete digital rectal exam. Given this clinical picture, which type of anorectal abscess is most likely present in this patient? (Q849194)

A. Perianal Abscess

B. Ischiorectal Abscess

C. Intersphincteric Abscess

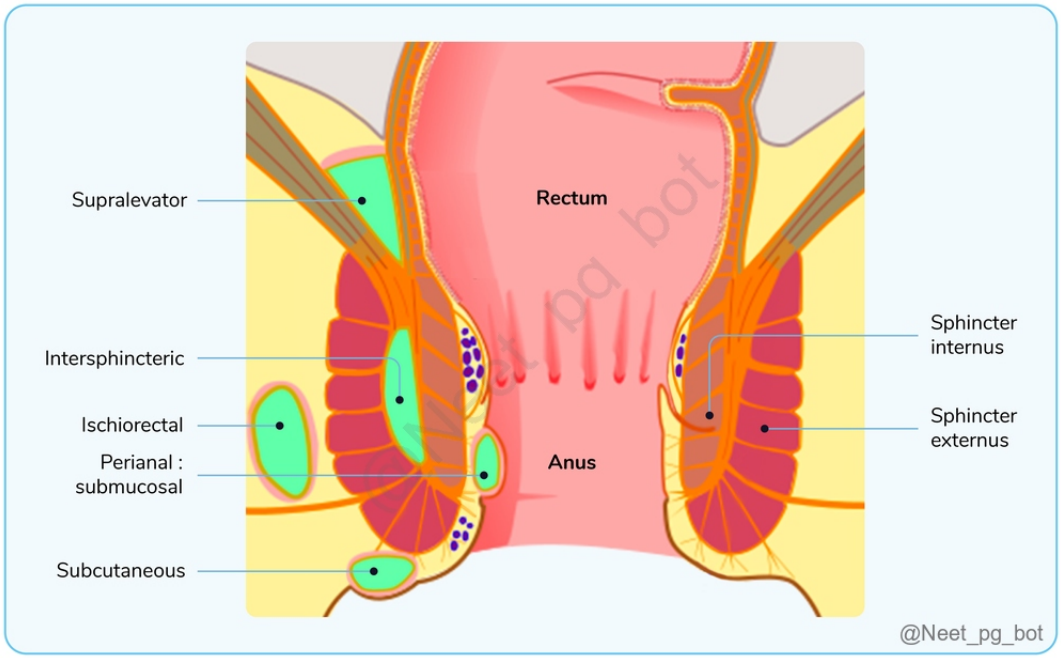
D. Supralevator Abscess

Correct Answer: C. Intersphincteric Abscess

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The scenario describes intense, deep anal pain with minimal external signs and difficulty in performing a digital rectal exam, which is characteristic of an intersphincteric abscess . This type of abscess presents with few external signs but causes severe pain which is exacerbated by actions like coughing or sneezing. Once identified, the abscess can be drained through a limited, typically posterior, internal sphincterotomy, usually performed under anaesthesia. Classification of Anorectal Abscess {{caption_text}}



References:

Schwartz’s Principles of Surgery, 11th Edition, Pages 1314,1316

SRB’s Manual of Surgery, 6th Edition, Pages 969-971

↑ *Back to this question in Part A*

@Neet_pg_bot

Q20: A 55-year-old man presents with difficulty urinating and lower abdominal discomfort. The doctor advises a digital rectal examination (DRE) to assess for potential prostate enlargement or other rectal abnormalities. Which of the following is not an external inspection finding? (Q849193)

A. Anal fissures

B. Rectal polyps

C. Pilonidal sinus

D. External hemorrhoids

Correct Answer: B. Rectal polyps

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Rectal polyps are identified through internal inspection, not external. Digital rectal examination Diagnostic process in cases including, but not limited to, gastrointestinal bleeding, inflammatory bowel disease, haemorrhoids, constipation, trauma, and neurological disorders Rectal exam findings on external and internal inspection: External Inspection Internal Inspection Anal fissures (Option A) Anal fistula Genital warts External haemorrhoids (Option D) Pilonidal sinus (Option C) Skin disease (seborrhoeic eczema, skin cancer, natal cleft dermatitis) Skin tags Skin discoloration with Crohn's disease Rectal prolapse Internal haemorrhoids Rectal carcinoma Rectal polyps Tenderness with prostatitis or acute appendicitis Malignant or inflammatory conditions of the peritoneum with anterior palpation

References:

Rectal examination

Bailey and Love Short Manual of Surgery, Page 1395

↑ *Back to this question in Part A*

@Neet_pg_bot

Q21: A 72-year-old multiparous woman presents with a painless mass protruding from her anus along with occasional bleeding and fecal incontinence. O/E the mass is circumferential, red in colour, and reducible. Which of the following is the most likely type of rectal prolapse? (Q849191)

A. Partial prolapse

B. Mucosal prolapse

C. Complete prolapse

D. Internal haemorrhoids

Correct Answer: C. Complete prolapse

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The given clinical scenario describes a complete prolapse. Complete prolapse involves the descent of all layers of the rectum, leading to a full-thickness, circumferential protrusion that is often reducible and associated with symptoms such as bleeding and faecal incontinence. Rectal Prolapse: It is the circumferential descent of the rectum through the anal canal Types of Rectal Prolapse: Partial Complete Mucosal There is no descent of the muscular layer. It is the most common type of rectal prolapse. History of mass per anum. It is pink in colour and circumferential. Complete-full thickness. The descent contains all layers of the rectum (i.e. including the muscular layer). Complete descent of rectum as mass per anum circumferentially which is red in colour. Mass is usually reducible and painless. It may be associated with uterine prolapse (uterine procidentia) in females. Fecal incontinence (75%) is very common. Bleeding can occur because of the congestion. Sepsis, discharge, fever, and anaemia are other features.

References:

SRB's Manual of Surgery, 6th Edition, Pages 952, 953, 954

Bailey and Love Short manual of surgery, Pages 1397, 1398

↑ *Back to this question in Part A*

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Q22: A 45-year-old man presents with persistent bleeding from haemorrhoids despite dietary changes and non-operative treatments. Examination reveals third-degree internal haemorrhoids. Which of the following is not an indication of hemorrhoidectomy? (Q849190)

A. Third-degree haemorrhoids

B. Second-degree haemorrhoids

C. 'Mixed' haemorrhoids with a well-defined external component

D. Fourth-degree haemorrhoids

Correct Answer: B. Second-degree haemorrhoids

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Second-degree haemorrhoids are usually managed by non-operative methods and are indicated for hemorrhoidectomy only if not cured by non-operative treatments. Haemorrhoidectomy A surgical procedure based on decreasing blood flow to the hemorrhoidal plexuses and excising redundant anoderm and mucosa. Indications for Haemorrhoidectomy Third- and fourth-degree haemorrhoids (Option A and D ruled out) Second-degree haemorrhoids that have not been cured by non-operative treatments 'Mixed' haemorrhoids when the external component is well-defined (Option C ruled out) Bleeding causes anaemia.

References:

Bailey and Love's Short Practice of Surgery, 28th Edition, Pages 1431, 1434

Schwartz's Principles of Surgery, 11th Edition, Pages 1310, 1311

↑ *Back to this question in Part A*

@Neet_pg_bot

Q23: A 50-year-old woman presents with bright red bleeding during defecation and a prolapsed haemorrhoid that cannot be reduced manually. What is the most suitable management for this patient? (Q849188)

A. Dietary and lifestyle changes

B. Rubber band ligation

C. Sclerotherapy

D. Hemorrhoidectomy

Correct Answer: D. Hemorrhoidectomy

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Prolapsed haemorrhoids that cannot be reduced manually are classified as 4th-degree haemorrhoids . Operative hemorrhoidectomy is the standard treatment for fourth-degree addressing both the prolapse and associated symptoms. It is the elective resection of symptomatic haemorrhoids by decreasing blood flow and excising redundant tissue. Used in 3rd and 4th-degree haemorrhoids. Treatment of Hemorrhoids Medical Therapy Dietary and Lifestyle Changes : Increased dietary fibre, stool softeners, fluid intake, and avoiding straining can improve first- and second-degree haemorrhoids. (Option A ruled out) Procedures Rubber Band Ligation Effective for persistent bleeding in first, second, and selected third-degree haemorrhoids by strangulating tissue to prevent further bleeding or prolapse. (Option B ruled out) Infrared Photocoagulation: Suitable for small first and second-degree haemorrhoids, coagulating the underlying plexus. Sclerotherapy Involves injecting sclerosing agents into first, second, and some third-degree haemorrhoids to cause fibrosis. (Option C ruled out) Excision of Thrombosed External Hemorrhoids Elliptical excision under local anaesthesia for acutely thrombosed external

haemorrhoids causing intense pain. Surgical Procedures Operative Hemorrhoidectomy Elective resection of symptomatic haemorrhoids by decreasing blood flow and excising redundant tissue.Used in 3rd and 4th-degree haemorrhoids (Option D) Doppler-Guided Hemorrhoidal Artery Ligation Uses a Doppler probe to identify and ligate arteries feeding the hemorrhoidal plexus, promising for symptomatic hemorrhoids but long-term effectiveness is still being evaluated.

References:

SRB's Manual of Surgery, 6th Edition, Page 962

Schwartz's Principles of Surgery, 11th Edition, Pages 1310,1312

↑ *Back to this question in Part A*

@Neet_pg_bot

Q24: A 45-year-old man reports experiencing bright red bleeding during bowel movements and a mass that protrudes from his anus, which he can manually reduce but does not reduce spontaneously. On examination, no thrombosed haemorrhoids are observed. Which degree of internal haemorrhoids is this patient most likely suffering from? (Q849187)

A. First degree

B. Second degree

C. Third degree

D. Fourth degree

Correct Answer: C. Third degree

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The clinical scenario describes a patient with internal haemorrhoids that prolapse through the anal canal and require manual reduction and do not reduce spontaneously. This is characteristic of third-degree haemorrhoids. Internal Haemorrhoids are classified into First-degree haemorrhoids: Bulge into the anal canal and may prolapse beyond the dentate line on straining. (Option A ruled out) Second-degree haemorrhoids: Prolapse through the anus but reduce spontaneously. (Option B ruled out) Third-degree haemorrhoids: Prolapse through the anal canal and require manual reduction. (Option C) Fourth-degree haemorrhoids: ■■■■■■■ Prolapse but cannot be reduced and are at risk for strangulation. (Option D ruled out)

References:

SRB's Manual of Surgery, 6th Edition, Pages 961,962

Schwartz’s Principles of Surgery, 11th Edition, Page 1310

↑ *Back to this question in Part A*

@Neet_pg_bot

Q25: A 55 y/o woman presents with complaints of rectal bleeding and discomfort during bowel movements. She mentions experiencing chronic constipation and frequent straining. Which pathophysiological mechanism is most likely contributing to her haemorrhoids? (Q849186)

A. High-fiber diet

B. Well-supported suspensory tissues

C. Excess venous drainage

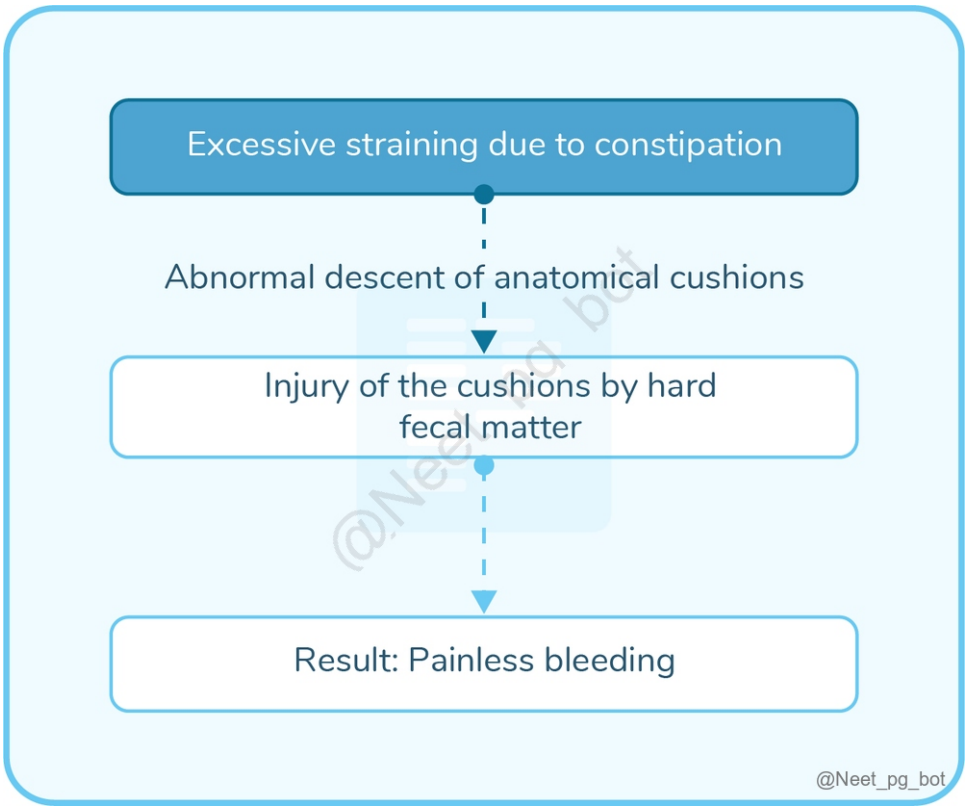
D. Increased intra-abdominal pressure

Correct Answer: D. Increased intra-abdominal pressure

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Increased intra-abdominal pressure , often due to chronic straining during bowel movements, is a significant factor in the development of haemorrhoids. This increased pressure causes the veins in the rectal area to swell and become engorged, leading to haemorrhoids. The patient's history of chronic constipation and frequent straining strongly suggests that increased intra-abdominal pressure is the primary pathophysiological mechanism in this case.



References:

Bailey and Love's Short Practice of Surgery, 28th Edition, Page 1430

SRB's Manual of Surgery, 6th Edition, Pages 961,962

↑ *Back to this question in Part A*

@Neet_pg_bot

Q26: A 58 y/o male presents with rectal cancer located just distal to the dentate line. During his evaluation for metastatic spread, which lymph nodes are most likely to be involved given the location of his cancer? (Q849185)

A. Internal iliac lymph nodes

B. Inferior mesenteric lymph nodes

C. Para-aortic lymph nodes

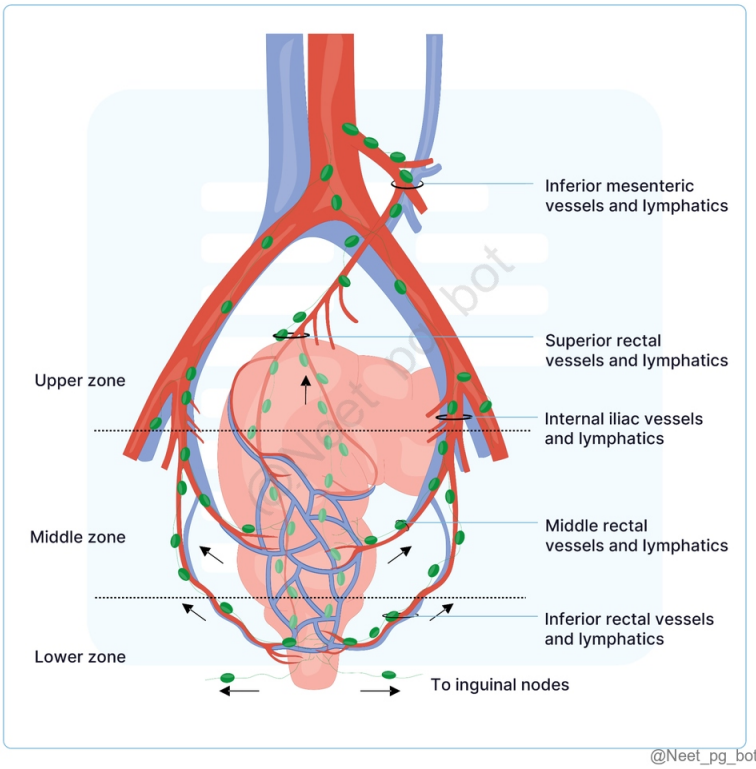
D. Inguinal lymph nodes

Correct Answer: D. Inguinal lymph nodes

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Inguinal lymph nodes are involved in the drainage of areas distal to the dentate line, including the anus. Due to the direct lymphatic drainage pattern, the inguinal lymph nodes are most likely involved in rectal cancers located just distal to the dentate line. Internal iliac lymph nodes (Option A): These nodes are involved in the drainage of the lower rectum and pelvic organs. Inferior mesenteric lymph nodes (Option B): These nodes drain the upper two-thirds of the rectum and are important for mid to upper rectal cancers. Para-aortic lymph nodes (Option C): These nodes receive lymphatic drainage from the upper rectum via the inferior mesenteric lymph nodes.



References:

Sabiston Textbook of Surgery, 21st edition, Page 1329

SRB’s Manual of Surgery, 6th Edition, Page 943

↑ *Back to this question in Part A*

@Neet_pg_bot

• [05_Gastrointestinal Surgery] 030 Hernia - I

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[05_Gastrointestinal Surgery] 030 Hernia - I — Quick Jump

Q1 (p. 2146)	*Q2 (p. 2148)*	*Q3 (p. 2149)*	*Q4 (p. 2150)*	*Q5 (p. 2151)*	*Q6 (p. 2153)*
Q7 (p. 2154)	*Q8 (p. 2156)*	*Q9 (p. 2158)*	*Q10 (p. 2159)*	*Q11 (p. 2160)*	*Q12 (p. 2163)*
Q13 (p. 2164)	*Q14 (p. 2165)*	*Q15 (p. 2168)*	*Q16 (p. 2168)*	*Q17 (p. 2170)*	*Q18 (p. 2172)*
Q19 (p. 2172)	*Q20 (p. 2174)*	*Q21 (p. 2175)*	*Q22 (p. 2175)*	*Q23 (p. 2177)*	*Q24 (p. 2181)*
Q25 (p. 2181)	*Q26 (p. 2183)*				

Q1: A 65-year-old male presents with a painful, irreducible groin hernia, severe colicky pain, bilious vomiting, and absence of faeces or flatus for 24 hours. The hernia is tense and extremely tender, with reddish-blue skin discolouration and no cough impulse. What is the immediate next step in management? (Q849330)

A. Administer IV antibiotics and fluids and proceed with surgery

B. Immediate surgical repair with synthetic mesh

C. Apply cold compresses to the hernia to reduce swelling

D. Start oral antibiotics and monitor the hernia for changes



Correct Answer: A. Administer IV antibiotics and fluids and proceed with surgery

- *Listen (English)*
- *Listen (Hindi)*

Explanation: The clinical presentation suggests a strangulated hernia, which requires urgent surgical intervention. The immediate next step is to administer IV antibiotics and fluids and proceed with surgery . Strangulated Hernia: A strangulated hernia occurs when a portion of tissue or intestine protrudes through a weakened area in the abdominal wall and becomes trapped. The trapped segment loses its blood supply, leading to tissue ischemia (lack of blood flow) and potential tissue death if not promptly treated. Clinical Features: Irreducibility: The hernia cannot be pushed back. Signs of Intestinal Obstruction : Colicky pain, bilious vomiting, absence of faeces and flatus. History: Sudden onset of pain at the hernia site, followed by generalised abdominal pain. Physical Examination Findings: Tense, extremely tender hernia with reddish or bluish skin discolouration and no cough impulse. Diagnosis is primarily based on clinical examination and physical findings. Treatment: Initial Resuscitation: Administer intravenous (IV) fluids. Provide IV antibiotics. Perform nasogastric aspiration. Insert Foley's catheter. Surgical intervention is done only after Initial Resuscitation. Mesh Usage: Synthetic mesh is contraindicated due to the increased risk of infection. If a mesh is necessary, bioprosthetic or absorbable mesh is preferred.



References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1060

↑ *Back to this question in Part A*

@Neet_pg_bot

Q2: A patient presents with an incisional hernia located just above the umbilicus in the midline of the abdomen. According to the EHS classification, how is this hernia classified? (Q849338)

A. M1

B. M2

C. M3

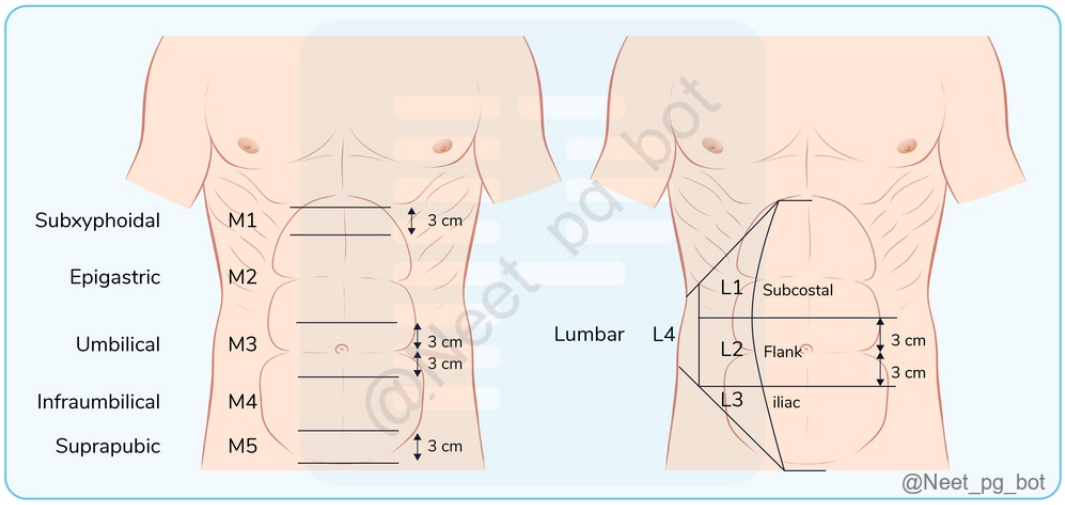
D. L2

Correct Answer: C. M3

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: In the EHS classification system, an incisional hernia located just above the umbilicus in the midline is classified as M3, which covers the area from 3 cm above to 3 cm below the umbilicus. The classification divides incisional hernias into two main categories: Midline & Lateral. EHS Classification of Incisional Hernia: Midline Subxiphoid M1 Epigastric M2 Umbilical M3 Infraumbilical M4 Suprapubic M5 Lateral Subcostal L1 Flank L2 Iliac L3 Lumbar L4



References:

www.researchgate.net/figure/Description-of-incisional-ventral-hernia-EHS-classification_tbl1_318667264

↑ *Back to this question in Part A*

@Neet_pg_bot

Q3: Which of the following is NOT typically considered an indication for surgical repair of an umbilical hernia in adults? (Q849337)

A. Incarceration or strangulation of hernia contents

B. Hernia size >2 cm in diameter

C. Symptomatic hernia causing pain or discomfort

D. Hernia in a patient with a BMI of 32

Correct Answer: D. Hernia in a patient with a BMI of 32

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: While obesity (BMI > 30) is a risk factor for hernia development and recurrence, the presence of a hernia in an obese patient is not, by itself, an absolute indication for surgical repair. The decision to repair would depend on other factors such as hernia size, symptoms, and overall patient health. Weight loss might be recommended before surgery to reduce operative risks and improve outcomes. Important indications for umbilical hernia repair in adults: Incarceration or strangulation (Option A) : Requires immediate repair due to the risk of bowel necrosis. Symptomatic hernias (Option C) : Indicated when the hernia causes pain or discomfort. Defects larger than 2 cm (Option B) : Larger defects are more prone to complications. Thinning of overlying skin: Increased risk of complications, such as skin breakdown or incarceration.

References:

Sabiston's Textbook of Surgery, 21st Edition, Page 1122

↑ *Back to this question in Part A*

@Neet_pg_bot

Q4: A 75-year-old thin woman presents with intermittent pain and paresthesia along the medial aspect of her right thigh. She reports nausea and vomiting over the past few days. On examination, hip flexion and external rotation exacerbate her thigh pain. Which of the following signs is most specific for the likely diagnosis? (Q849335)

A. Cough impulse

B. Howship-Romberg sign

C. Carnett's sign

D. Murphy's sign

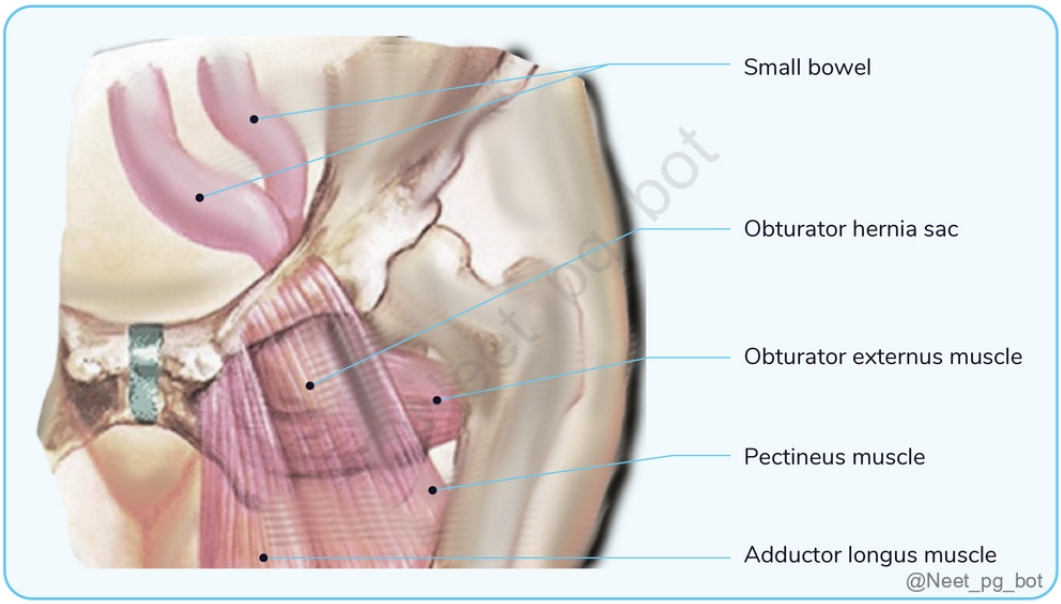
Correct Answer: B. Howship-Romberg sign

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The presentation suggests an obturator hernia, which is diagnosed based on thigh pain exacerbated by hip flexion and external rotation. The Howship-Romberg sign, specific for obturator hernia, involves pain along the medial thigh extending to the knee when the hip is flexed, adducted, and internally rotated, due to compression of the obturator nerve by the hernia. Obturator hernia: More common in thin and elderly females. Symptoms: Intermittent pain and paresthesia along the medial thigh (due to compression of the obturator nerve) Nausea and vomiting (suggest possible bowel obstruction) Physical examination: Pain exacerbated by hip flexion and external rotation. Howship - Romberg sign Hannington - Kiff sign: Absence of obturator reflex. Cough impulse (Option A) is more typical of inguinal or femoral hernias, where a bulge or impulse is felt when the patient coughs. Obturator hernias are usually not visible or palpable externally. Carnett's Sign (Option C) is not specific to hernias but helps differentiate abdominal wall pain from intra-abdominal pain. The examiner palpates a tender area while the patient tenses their abdominal muscles by lifting their head or legs. Increased or unchanged pain suggests an abdominal

wall origin; decreased pain points to an intra-abdominal source. Murphy's sign (Option D) is specific for acute cholecystitis and unrelated to the hernia. The examiner places their hand below the right costal margin and asks the patient to take a deep breath. Pain and breath-holding during this manoeuvre indicate gallbladder inflammation.



References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1079

↑ *Back to this question in Part A*

@Neet_pg_bot

Q5: A 55-year-old woman presents with a painful lump in her lower right abdomen, lateral to the rectus muscle. The swelling becomes more prominent when she stands or coughs. CT scan shows a defect in the transversus abdominis aponeurosis. What is the most likely diagnosis? (Q849334)

A. Epigastric hernia

B. Umbilical hernia

C. Spigelian hernia

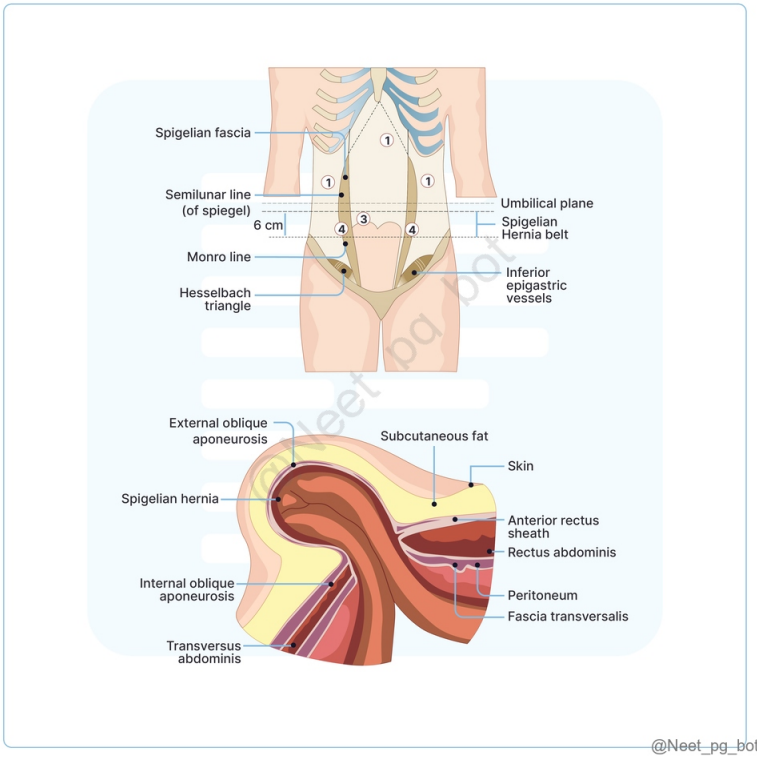
D. Incisional hernia

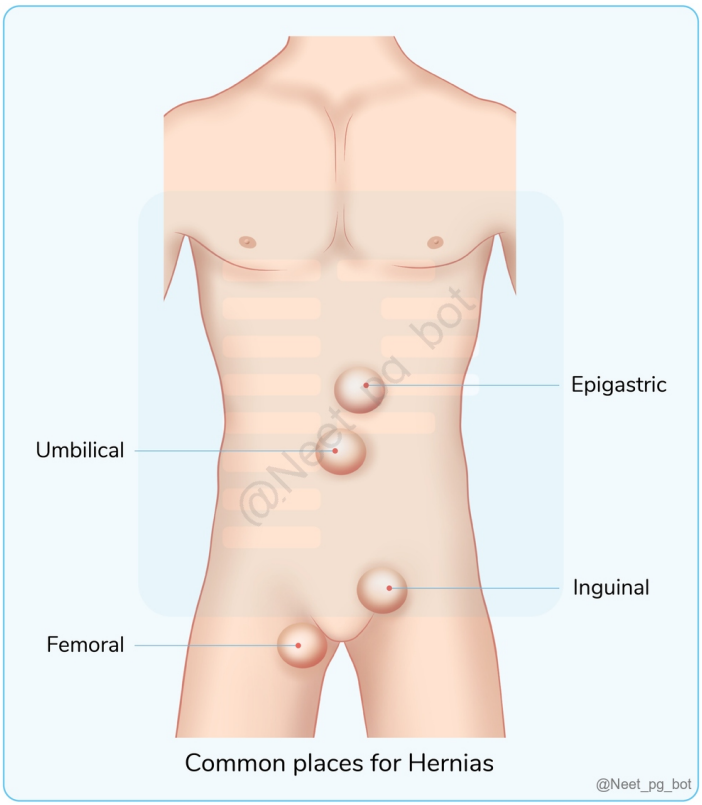
Correct Answer: C. Spigelian hernia

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The clinical scenario suggests a Spigelian hernia based on the lateral location of the swelling in the lower abdomen and a defect in the transversus abdominis aponeurosis seen on the CT scan. AKA ‘lateral ventral hernia or a hernia of the semilunar line’. It is the protrusion of preperitoneal fat, peritoneal sac, or organ(s) through a defect in the Spigelian fascia, which is the aponeurosis between the lateral edge of the rectus abdominis muscle medially and the semilunar line laterally. Typically presents as a painful lump that becomes more prominent when standing or coughing, and can be prone to incarceration due to its location. Surgical repair via an open or laparoscopic approach is recommended due to the high risk of complications. Epigastric hernia (Option A) occurs in the midline between the xiphoid process and umbilicus, is usually small, and is often asymptomatic. It has no relation to the transversus abdominis aponeurosis. Umbilical hernia (Option B) protrudes through the umbilicus, appearing as an outward bulge at the navel. This condition is more common in infants and obese adults, and its location at the umbilicus differs from the lateral abdominal wall. An incisional hernia (Option D) occurs at the site of a previous surgical incision and requires a history of abdominal surgery. It can occur anywhere on the abdominal wall, not specifically related to the transversus aponeurosis





References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1075

↑ *Back to this question in Part A*

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Q6: A 60-year-old male patient presents with right lower abdominal swelling and is diagnosed with a sliding hernia. After discussing the risks, his surgery is planned for hernia repair. Which of the following statements regarding sliding hernia is true? (Q849333)

A. More common in females than males

B. Anterior wall of the sac is formed by the viscera

C. There is an increased risk of bowel injury during management.

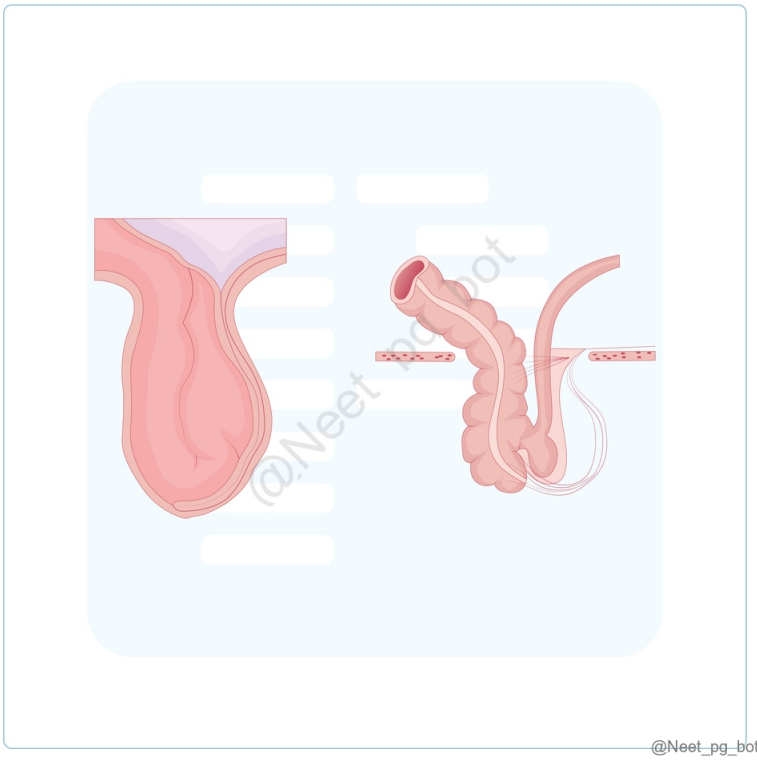
D. Most common content is the appendix.

Correct Answer: C. There is an increased risk of bowel injury during management.

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Surgical management of sliding hernia is associated with increased risk of bowel injury because the posterior wall of the hernia sac is formed by the viscera, which are directly involved in the hernia. Sliding hernia (Hernia-En-Glissade): It occurs when a portion of the peritoneum that normally lines the abdominal cavity slides through the hernia defect, bringing a partially retroperitoneal organ. More common in males (Option A) , particularly the elderly. and frequently occurs on the left side, where the sigmoid colon is the most common content, not the appendix. (Option D) The posterior wall of the hernia sac is formed by the viscera (commonly bowel), not the anterior wall. (Option B) Clinical presentation: Patients typically present with a reducible swelling in the groin or lower abdomen that worsens on standing due to gravity. Gastrointestinal symptoms like constipation and incomplete bowel emptying are common, indicating bowel involvement. Managed surgically by repairing or closing the defect, but associated with a higher risk of bowel injury due to the involvement of the viscera in the hernia sac.



References:

Sabiston’s Textbook of Surgery, 21st Edition, Page 1118

↑ *Back to this question in Part A*

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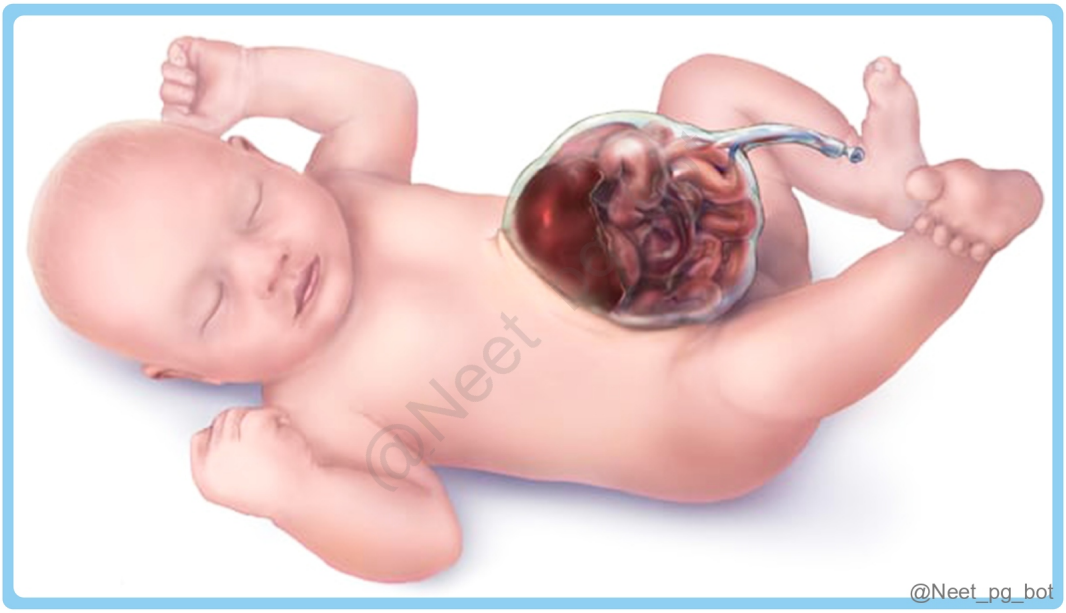
Q7: Which of the following is NOT a feature associated with the image shown below? (Q849340)

A. Covered by amnion and peritoneum layers

B. Higher incidence of associated chromosomal abnormalities like Trisomy 13, 18, and 21

C. The defect is usually located to the right of the umbilical cord insertion

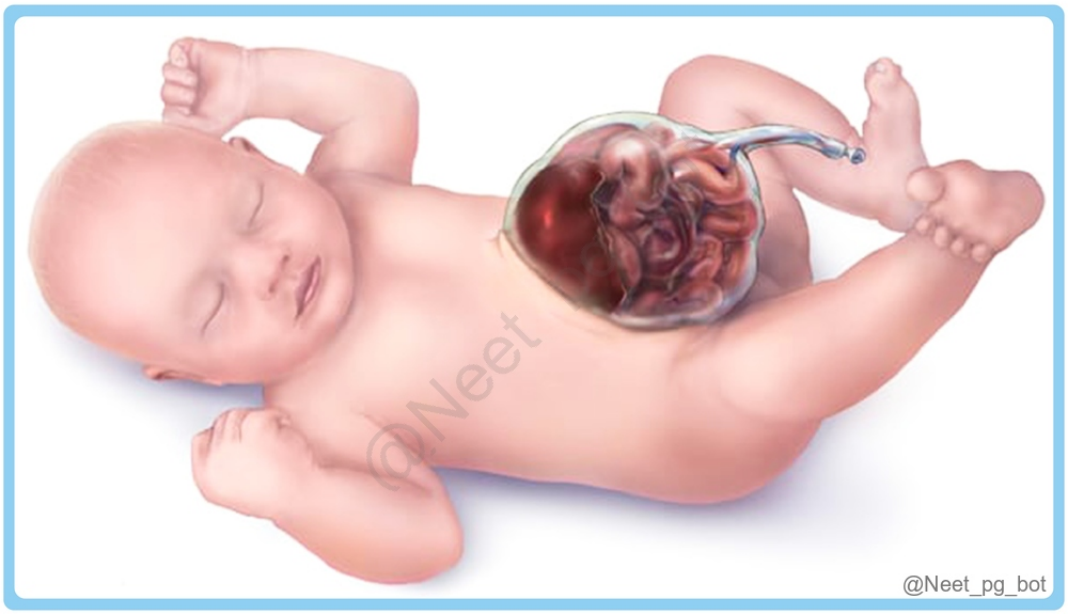
D. Can be associated with Beckwith-Wiedemann Syndrome



Correct Answer: C. The defect is usually located to the right of the umbilical cord insertion

- *Listen (English)*
- *Listen (Hindi)*

Explanation: The image shows an Omphalocele, where the defect is situated in the midline of the abdomen, typically at or near the umbilical cord insertion. In contrast, a defect located to the right of the umbilical cord insertion is indicative of Gastroschisis , not omphalocele. Feature Omphalocele Gastroschisis Definition Congenital abdominal wall defect where abdominal contents protrude through the base of the umbilicus . Congenital abdominal wall defect where abdominal contents protrude through a defect typically located to the right of the umbilicus. (Option C) Covering The herniated organs are covered by two layers: Amnion (outer) and peritoneum (inner) . (Option A) No membrane covers the exposed organs. Associated conditions Chromosomal abnormalities: Associated with Trisomy 13, 18, and 21. (Option B) Other congenital malformations affect multiple systems in the following order: cardiovascular> Muscular> gastrointestinal> genitourinary. (Mnemonic: "CM GIGU") Beckwith-Wiedemann Syndrome (Option D): Can include hemihypertrophy, macroglossia, visceromegaly, omphalocele, and increased risk of hepatoblastoma. Fewer chromosomal abnormalities compared to omphalocele. Higher risk of intestinal atresia and dysfunction. Prognosis Generally poor due to associated congenital malformations, which are the most common cause of death. Generally better than omphalocele due to fewer associated congenital anomalies.





References:

Sabiston's Textbook of Surgery, 21st Edition, Page 1867, 1868

↑ *Back to this question in Part A*

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Q8: A 45-year-old woman presents with a reducible swelling in the left groin below the inguinal ligament, suggesting a femoral hernia. The surgeon opts for a low approach to access the femoral canal directly without entering the inguinal canal. Which

technique is most appropriate for this approach? (Q849331)

A. Lockwood's technique

B. McEvedy's technique

C. Lotheissen's technique

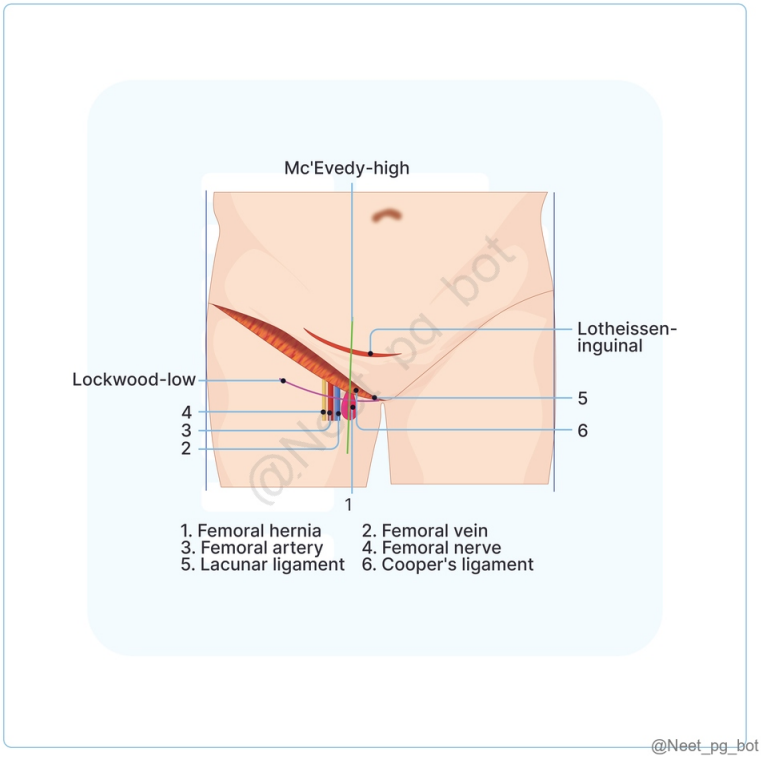
D. McVay repair

Correct Answer: A. Lockwood's technique

Listen (English)

Listen (Hindi)

Explanation: Lockwood's technique is a low approach that involves making an incision below the groin crease directly over the hernia. It provides excellent access to the femoral canal and is often considered the preferred method for femoral hernia repair due to its directness and effectiveness, particularly for uncomplicated cases. Treatment approaches for Femoral hernia: Technique Approach Description Lockwood's (Option A) Open, Low Incision below groin crease, directly over hernia; Elective repair McEvedy's (Option B) Open, High Oblique incision above inguinal ligament Lotheissen's (Option C) Open, High Access through the inguinal canal McVay (Option D) Open Suturing conjoint tendon to Cooper's ligament TEP (Totally Extraperitoneal) Laparoscopic Mesh placement without entering the peritoneal cavity TAPP (Transabdominal Preperitoneal) Laparoscopic Mesh placement after entering the peritoneal cavity



References:

Bailey & Love’s Short Practice of Surgery, 28th Edition, Page 1071, 1072

↑ *Back to this question in Part A*

@Neet_pg_bot

Q9: During laparoscopic inguinal hernia repair, which critical structure should the surgeon avoid to prevent significant bleeding? (Q849329)

A. Obturator Artery

B. Accessory Obturator Artery

C. Corona Mortis artery

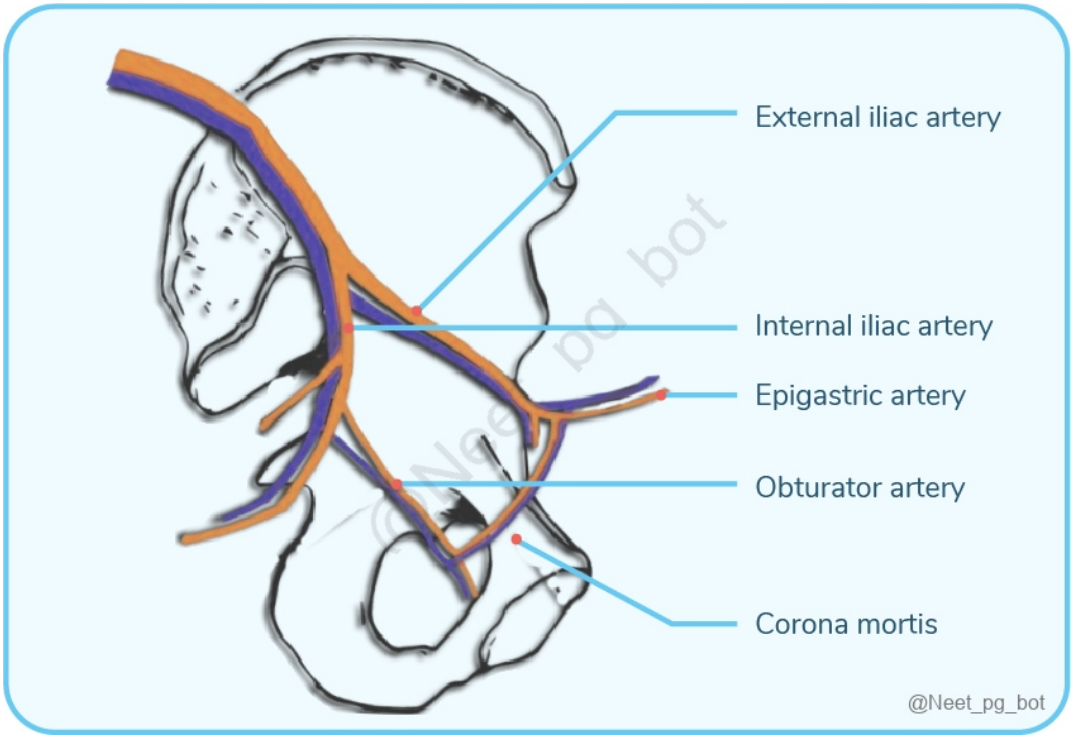
D. Superficial Epigastric Artery

Correct Answer: C. Corona Mortis artery

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The Corona mortis artery is the most critical structure to avoid during laparoscopic inguinal hernia repair because, if damaged, it can cause significant bleeding. Corona mortis (Crown of Death): Anatomical variant involving an abnormal connection between the External iliac artery and the Obturator artery. Located behind the superior pubic ramus. This variant is critical to identify during laparoscopic procedures because it can lead to severe and potentially life-threatening bleeding if damaged. The Obturator artery (Option A) is a significant vessel supplying the medial compartment of the thigh. Although its injury can cause bleeding, it is typically well protected in laparoscopic procedures and usually not as prone to causing severe haemorrhage as the Corona Mortis. The accessory Obturator Artery (Option B) is a variant of the obturator artery, less commonly encountered and associated with lower risk during laparoscopic procedures. The Superficial Epigastric Artery (Option D) branches from the femoral artery, supplying the lower abdomen's skin. Its injury is less likely to cause severe haemorrhage and is less critical than Corona Mortis in laparoscopic procedures.



References:

pubmed.ncbi.nlm.nih.gov/16944498/

↑ *Back to this question in Part A*

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Q10: A 42-year-old woman with a history of Gardner's syndrome presents with persistent abdominal pain and a palpable mass in the left lower quadrant. She has previously undergone an open proctocolectomy. Imaging studies reveal an infiltrative mass in the mesentery. What is the most appropriate management strategy for her recurrent intra-abdominal mass? (Q849341)

A. Immediate systemic chemotherapy without further surgical intervention.

B. Wide local excision with a 2 cm margin, potentially followed by radiotherapy.

C. Hormonal therapy to manage the tumor.

D. Laparoscopic surgery to remove the tumor, given its lower risk of recurrence.

Correct Answer: B. Wide local excision with a 2 cm margin, potentially followed by radiotherapy.

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The recurrent intra-abdominal mass is likely a Desmoid tumor , which is associated with Gardner's syndrome and previous abdominal surgery. These tumors are known for their infiltrative nature and aggressive growth. Wide local excision with a 2 cm margin is recommended to effectively manage the tumor, often followed by radiotherapy to reduce the risk of recurrence. Desmoid Tumor: Most common primary malignant tumors of the mesentery. Classified based on their location: Extra-abdominal : 60% Abdominal wall : 25% Intra-abdominal : 50% Risk Factors: History of surgery or trauma Estrogen : Estrogen stimulates tumor growth. Hence, more common in females. Genetic Factors : A variant of FAP (Gardner's syndrome) increases the risk. Characteristics: Unencapsulated Nature : Prone to cracking during surgical excision. No Distant Metastasis or Sarcomatous Change Clinical Features: Presentation : Most commonly presents as a palpable mass or lump. Location : Commonly arises from musculo-aponeurotic structures in the infra-umbilical region. Diagnosis is best confirmed with a biopsy, and the extent of the disease is assessed using MRI . Management: Surgery : Wide local excision with a 2 cm margin is preferred. Recurrent Tumors : Combination of surgery and radiotherapy.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1082

Sabiston's Textbook of Surgery, 21st Edition, Page 1098,1099

↑ *Back to this question in Part A*

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Q11: A 55-year-old woman with sudden groin pain and diarrhoea is found to have a small bulge in the right groin. She describes the pain as colicky and has symptoms resembling acute gastroenteritis. Which type of hernia is most likely associated with these symptoms? (Q849342)

A. Littre's hernia

B. Amyand's hernia

C. Maydl's hernia

D. Richter's hernia

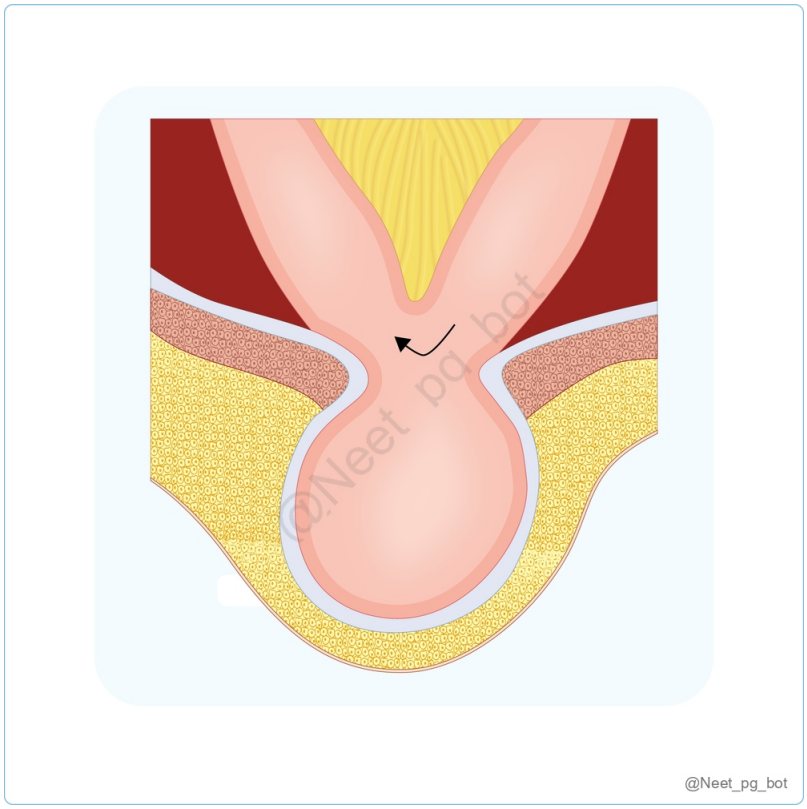
Correct Answer: D. Richter's hernia

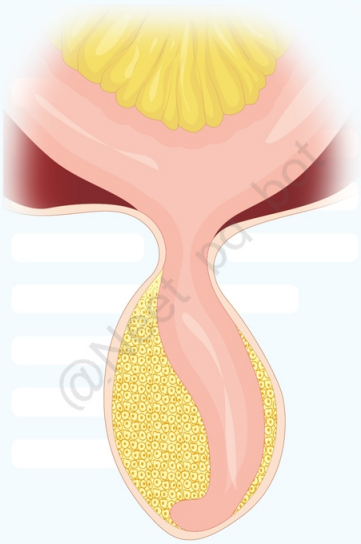
■ *Listen (English)*

■ *Listen (Hindi)*

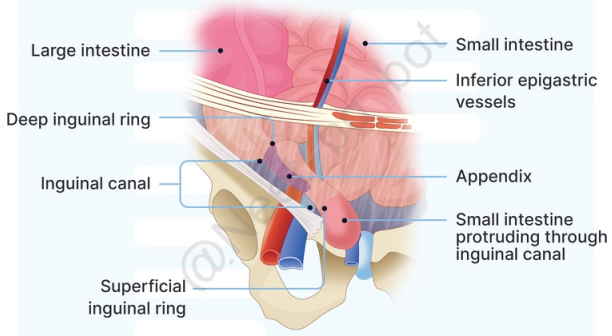
Explanation: The given scenario with groin pain, diarrhoea, and a small bulge in the right groin with symptoms resembling gastroenteritis points toward Richter's Hernia. Hernia Features Images Richter's Hernia (Option D) Herniation of only a portion of the bowel wall (circumference) into the hernia sac. Leads to localized strangulation

or incarceration of part of the bowel wall while the bowel lumen remains intact. Mimics Gastroenteritis (Diarrhea, colicky pain) potentially delaying diagnosis and increasing the risk of complications like strangulation. Seen in: (Narrow Defects) Paraumbilical Hernia Femoral Hernia Obturator Hernia Littre's Hernia (Option A) It involves a Meckel's diverticulum herniating into the sac. Amyand's Hernia (Option B) Contains the Appendix within the hernia sac. Maydl's Hernia (Option C) It involves two or more bowel loops that become incarcerated or strangulated within the hernia sac. The obstructed loop is present intraperitoneally and hence, easily missed during surgery.

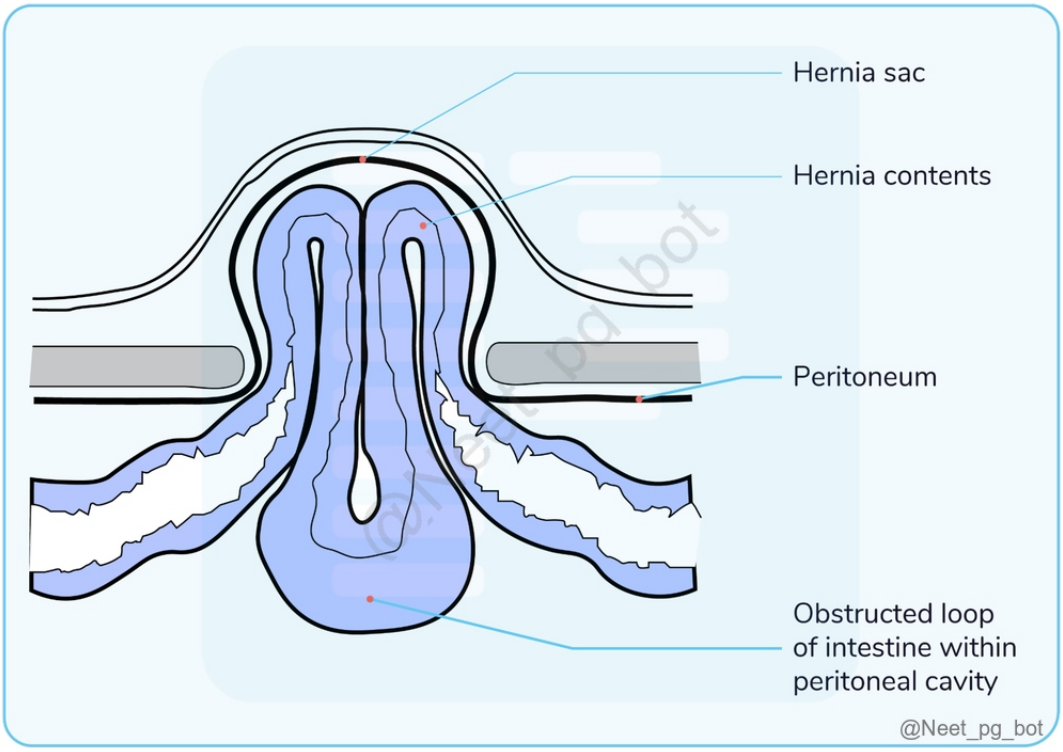




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References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 256

↑ *Back to this question in Part A*

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Q12: A 62-year-old male has a right groin bulge that worsens with standing and reduces when lying down. The bulge is medial to the inferior epigastric vessels. Based on the Nyhus classification, which type of hernia does this patient have? (Q849215)

A. Type I

B. Type II

C. Type III A

D. Type III B

Correct Answer: C. Type III A

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The given scenario suggests a Direct Inguinal Hernia, as the bulge is located medial to the inferior epigastric vessels and is caused by a defect in the posterior wall. It is classified as Type III A under the NYHUS Classification. NYHUS Classification: Type I Indirect inguinal hernia (Option A) Normal internal inguinal ring e.g., pediatric hernia Type II Indirect inguinal hernia (Option B) Dilated internal inguinal ring Posterior inguinal wall intact Type III A: Direct inguinal hernia (Option C) B: Indirect inguinal hernia (Option D) Internal inguinal ring dilated Encroaching medially or destroying the transversalis fascia of the Hesselbach triangle (e.g. scrotal sliding or pantaloon hernia) C: Femoral hernia Type IV (Recurrent Hernia) A: Direct B : Indirect C: Femoral D: Combined

References:

Sabiston's Textbook of Surgery, 21st edition, Page 1111

↑ *Back to this question in Part A*

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Q13: A newborn is diagnosed with a congenital diaphragmatic hernia (CDH) and presents with severe respiratory distress. Physical examination revealed a scaphoid abdomen and a chest X-ray showed bowel loops in the thoracic cavity and a mediastinal shift. What is the most appropriate initial intervention to stabilise the infant before surgical repair? (Q849345)

A. Bag-mask ventilation to ensure adequate oxygenation.

B. Placement of an Orogastric tube to decompress the stomach

C. IV Antibiotics to prevent infection in the herniated bowel.

D. Immediate surgery, irrespective of the status

Correct Answer: B. Placement of an Orogastric tube to decompress the stomach

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The placement of an orogastric tube is essential to decompress the stomach, reduce pressure on the lungs, and alleviate respiratory distress and mediastinal shift, helping to stabilize the infant before surgical repair. Repair is done only after pulmonary stabilization in CDH (Immediate surgery done in case of traumatic hernia) Management of Congenital Diaphragmatic Hernia: Initial Stabilization: Airway Management: Immediate endotracheal intubation is critical. Ventilation of Choice: IPPV If there is no response → ECMO Avoid excessive, mean airway pressure to prevent barotrauma Gastric Decompression: An orogastric tube is used to prevent gastric distention that worsens lung compression. Bag and Mask Ventilation is Contraindicated in CDH (Option A) Pulmonary Hypertension Management: Medications: Nitric oxide, prostaglandin E1, milrinone, and inotropes for cardiac dysfunction. Severe Cases: Extracorporeal Life Support (ECLS) may be required. Surgical Repair: Timing: Repair is performed once pulmonary circulation stabilizes. (Option D) For Small Defects: Sutures. For

large defects, use a conical silastic or GOR-TEX patch. IV Antibiotics to prevent infection in the herniated bowel (Option C), While antibiotics may be administered as part of the overall management, they are not the primary intervention for immediate stabilization of the infant.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 271

↑ *Back to this question in Part A*

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Q14: A 12-year-old girl presents with abdominal pain and intermittent nausea. Physical examination reveals a large, non-tender abdominal mass in the left lower quadrant, contiguous with the small intestine in the mesentery. Based on the findings, which type of mesenteric cyst is most likely, and what is the preferred management approach? (Q849346)

A. Enterogenous cyst; Resection and anastomosis

B. Chylolymphatic cyst; Enucleation

C. Hydatid cyst; Anti-parasitic therapy

D. Traumatic cyst; Observation

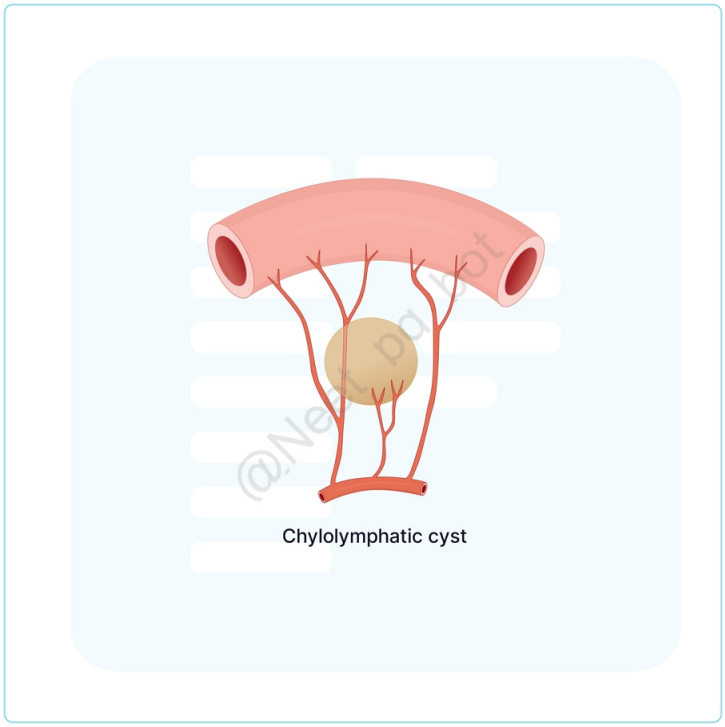
Correct Answer: A. Enterogenous cyst; Resection and anastomosis

■ *Listen (English)*

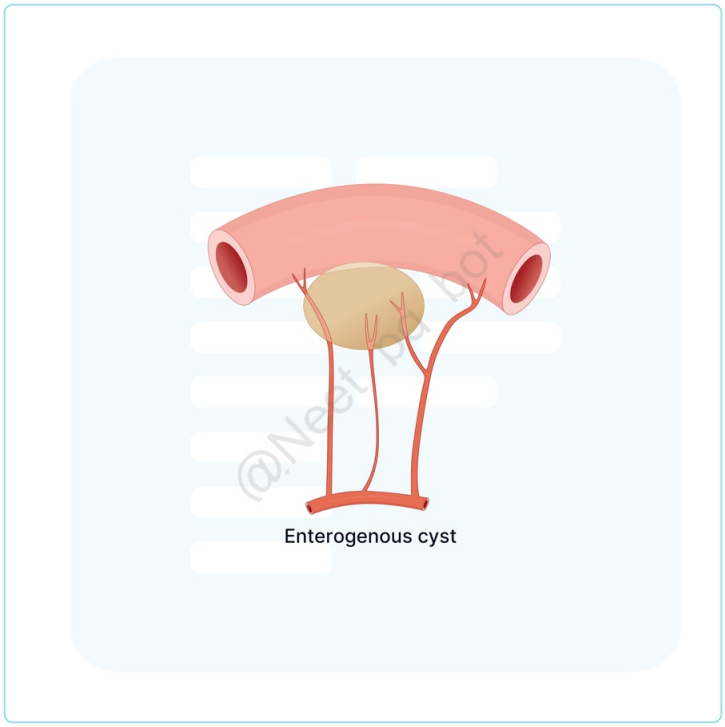
■ *Listen (Hindi)*

Explanation: The clinical presentation and imaging findings of a large, well-defined cystic lesion with thickened walls and contiguous with the small intestine are most consistent with an Enterogenous cyst . The preferred management for this type of cyst is resection and anastomosis due to its connection with the bowel. Tillaux sign - a finding associated with mesenteric cysts, where a mass lesion is only mobile in the horizontal direction (left to right) but not in the vertical direction, due to the attachment of the mesentery Mesenteric Cysts: Features Chylolymphatic (Option B) Enterogenous (Option A) Origin Arises from congenitally misplaced lymphatic tissue. Derived from a diverticulum or duplication of the intestine. Location Mesentery of the ileum. Mesentery of the small intestine. Wall Characteristic Thinner wall, composed of connective tissue. Thicker wall, lined by mucous membrane Fluid Clear lymph or chyle Mucinous fluid Colorless or yellowish brown. Blood supply Independent blood supply. Shares a blood supply with the adjacent bowel. Management Enucleation Resection of the cyst and affected bowel segment. Transillumination Transillumination (-ve) Transillumination (+ve) Hydatid cysts (Option C), caused by echinococcal infection, typically present as cystic lesions in the liver or lungs but can also occur in the mesentery. They are managed with antiparasitic therapy, but this diagnosis is less likely due to the usual homogeneous appearance and less internal complexity on imaging. Traumatic cysts (Option D) typically follow recent abdominal trauma, appearing as cystic structures with heterogeneous contents, especially if hemorrhage or

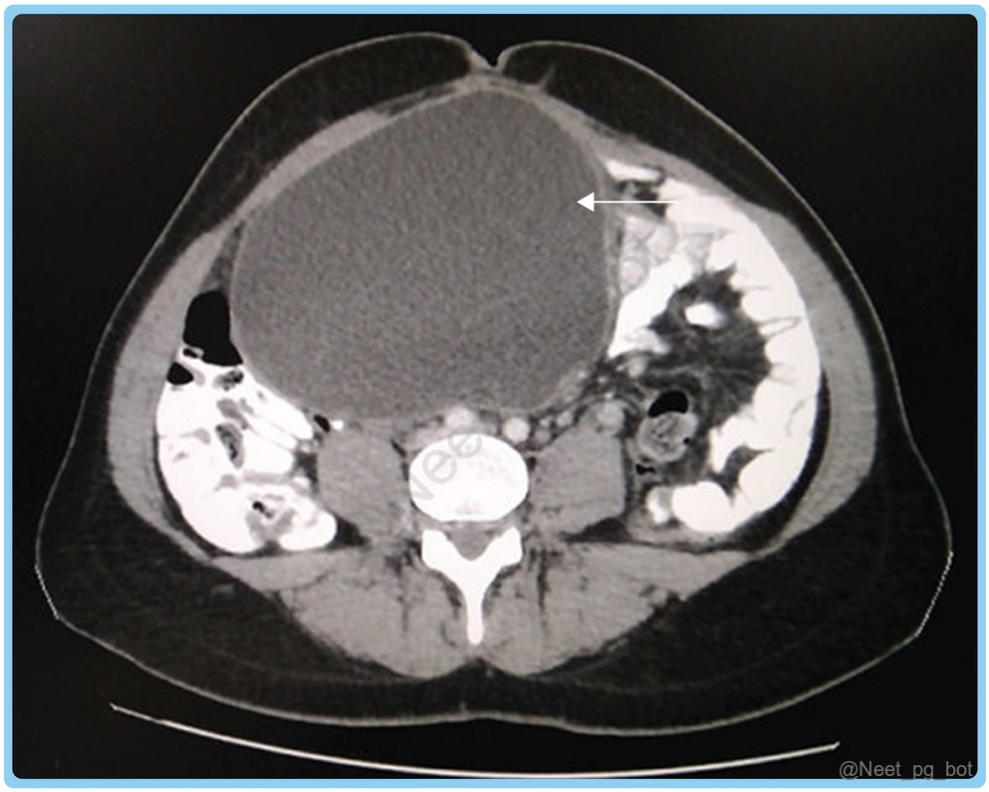
clot is present. They often have irregular margins and may show signs of inflammation or surrounding oedema.

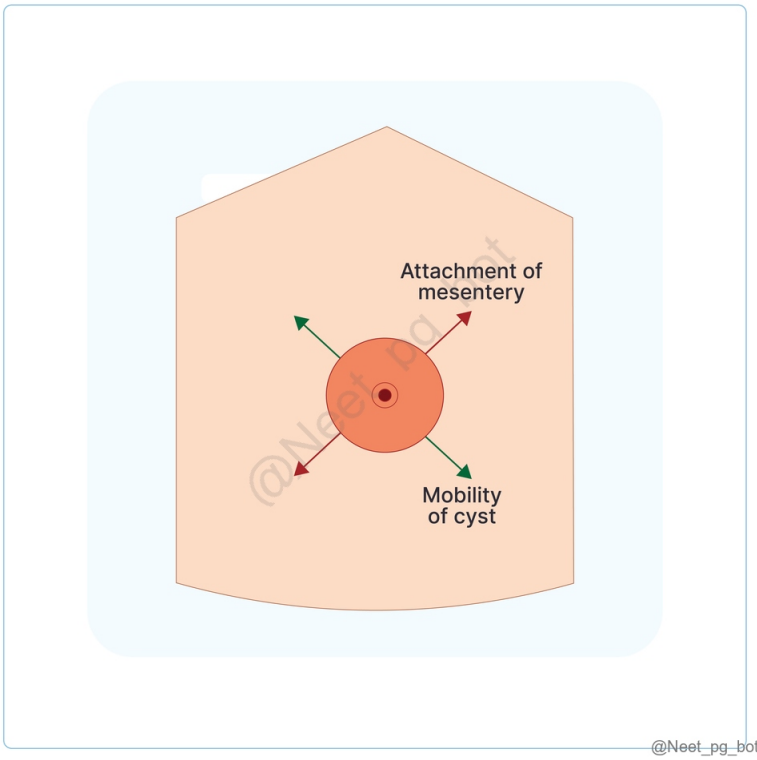


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References:

Bailey & Love’s Short Practice of Surgery, 28th Edition, Page 1100,1101

↑ *Back to this question in Part A*

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Q15: Match the following hernias with their respective defects. Hernia Defect 1. Berger's Hernia a) Defect in the conjoint tendon 2. Beclard's Hernia b) Hernia into the pouch of Douglas 3. Ogilvie's Hernia c) Hernia behind the Roux limb 4. Stammer's Hernia d) Through the saphenous opening 5. Peterson Hernia e) Through transverse mesocolon after retro colic gastro-jejunostomy (Q849343)

A. 1-b, 2-d, 3-a, 4-e, 5-c

B. 1-b, 2-c, 3-d, 4-a, 5-e

C. 1-d, 2-a, 3-e, 4-b, 5-c

D. 1-a, 2-d, 3-c, 4-e, 5-b

Correct Answer: A. 1-b, 2-d, 3-a, 4-e, 5-c

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Hernia Correct Defect Berger's Hernia Hernia into the pouch of Douglas (pelvic hernia) Beclard's Hernia Through the Beclard's triangle , near saphenous opening Ogilvie's Hernia Due to a defect in the conjoint tendon Stammer's Hernia Internal hernia through transverse mesocolon Peterson Hernia Behind the Roux limb , common post-bypass complication

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 256

Sabiston's Textbook of Surgery, 21st Edition, Page 1097

↑ *Back to this question in Part A*

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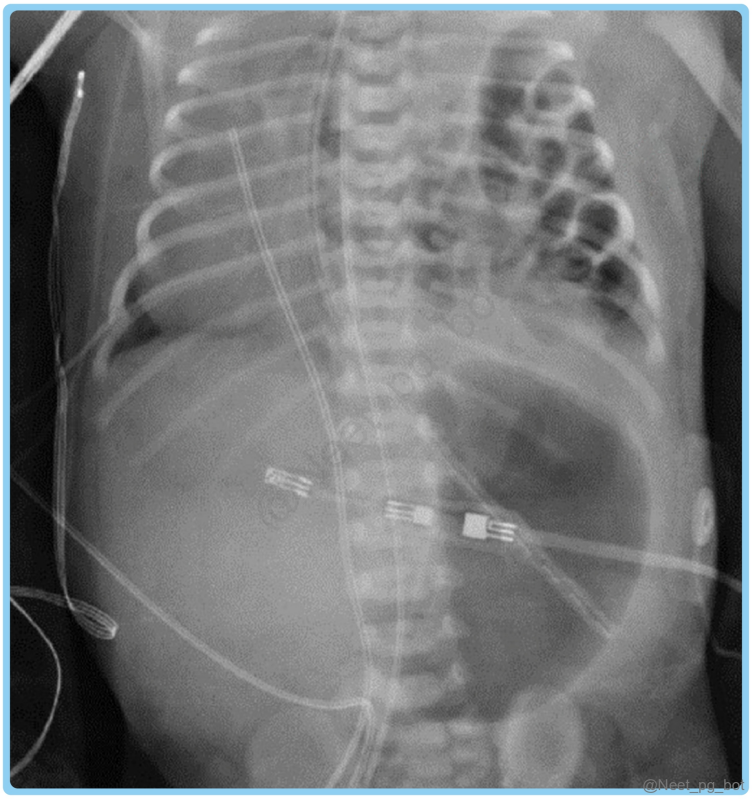
Q16: A day-old preterm infant is admitted with severe respiratory distress. Physical examination shows a scaphoid abdomen and chest X-rays reveal bowel loops in the thorax and a mediastinal shift. Despite intensive care, the infant's condition deteriorates rapidly and leads to death. Which of the following accurately describes a characteristic feature of the most common type of this condition? (Q849344)

A. Left-sided posteromedial defect with herniation of small intestine

B. Right-sided anterolateral defect associated with herniation of the liver

C. Defective central tendon of the diaphragm

D. Persistence of the pleuroperitoneal canal

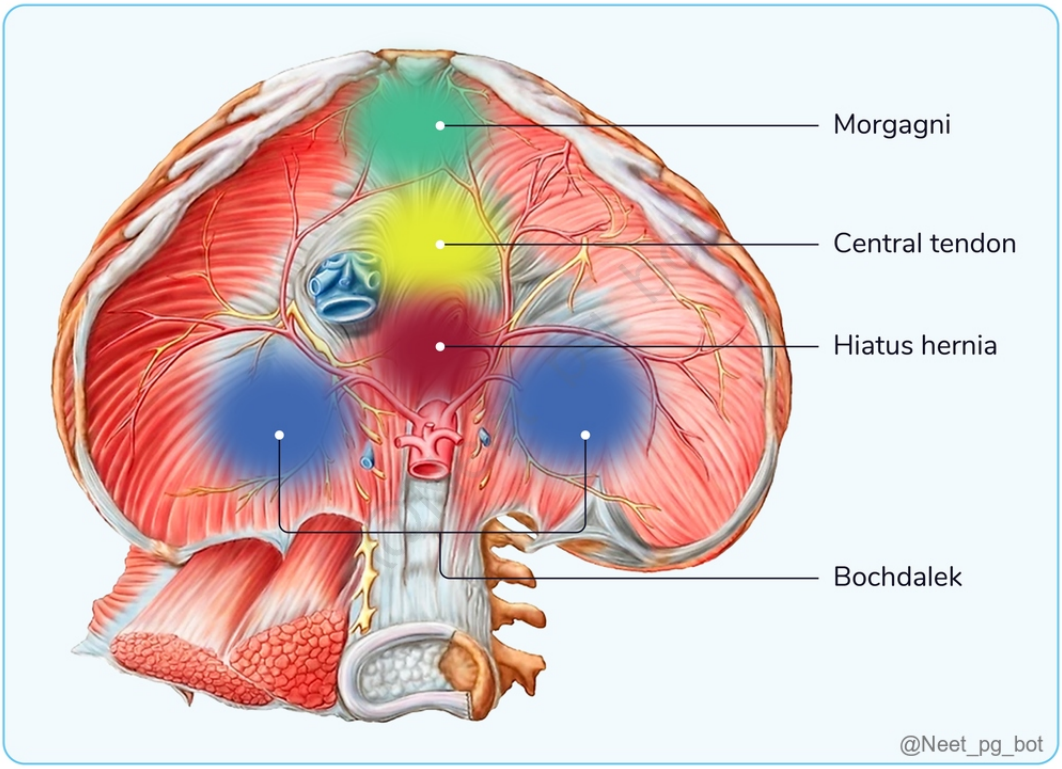


Correct Answer: D. Persistence of the pleuroperitoneal canal

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The given clinical scenario of a preterm with respiratory distress, scaphoid abdomen, and X-ray showing bowel loops in the thorax points towards Congenital Diaphragmatic Hernia (CDH) CDH is a birth defect with an abnormal opening in the diaphragm, allowing abdominal organs to move into the chest cavity and severely impair lung development. Most Common Side: Left (84%) > Right It is of two types: Bochdalek hernia is the most common type of CDH and is due to the persistence of the pleuroperitoneal canal. (Option D) Morgagni Hernia is due to the defective Central tendon (Option C) Feature Bochdalek Hernia Morgagni Hernia Side Left-sided Right-sided Location Posterolateral Anteromedial Herniated Organs Small intestine, stomach Transverse colon, sometimes liver Common Symptoms Scaphoid abdomen, respiratory distress, mediastinal shift Mostly Asymptomatic and Incidental Diagnostic Features Pulmonary hypoplasia Pulmonary hypertension Less severe respiratory distress Association Polyhydramnios, abnormal LHR, and liver position Rarely detected prenatally; usually diagnosed later Management Variable Generally Better prognosis



References:

Sabiston's Textbook of Surgery, 21st Edition, Page 1848

↑ *Back to this question in Part A*

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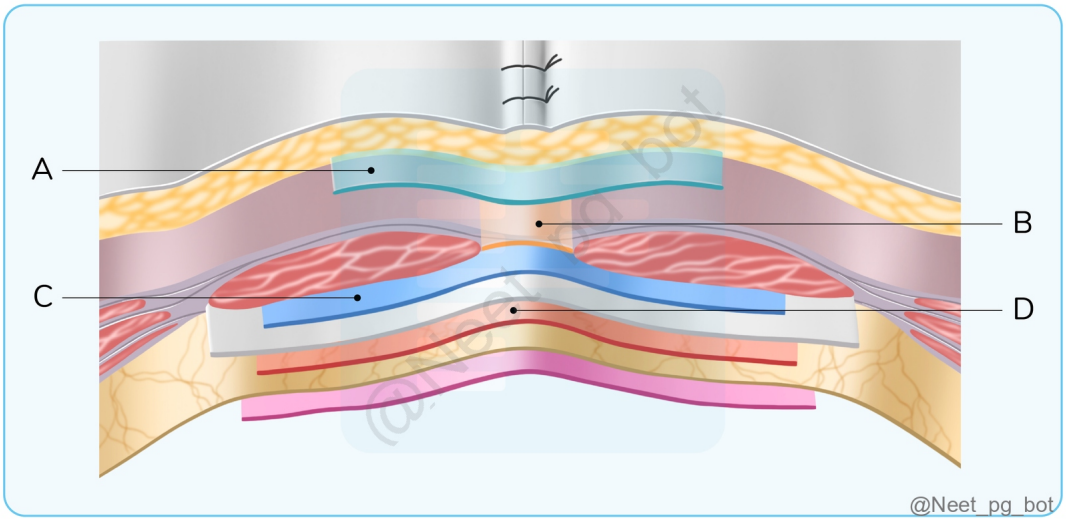
Q17: Which technique of incisional hernia is done at point B? (Q849339)

A. Onlay

B. Inlay

C. Retromuscular

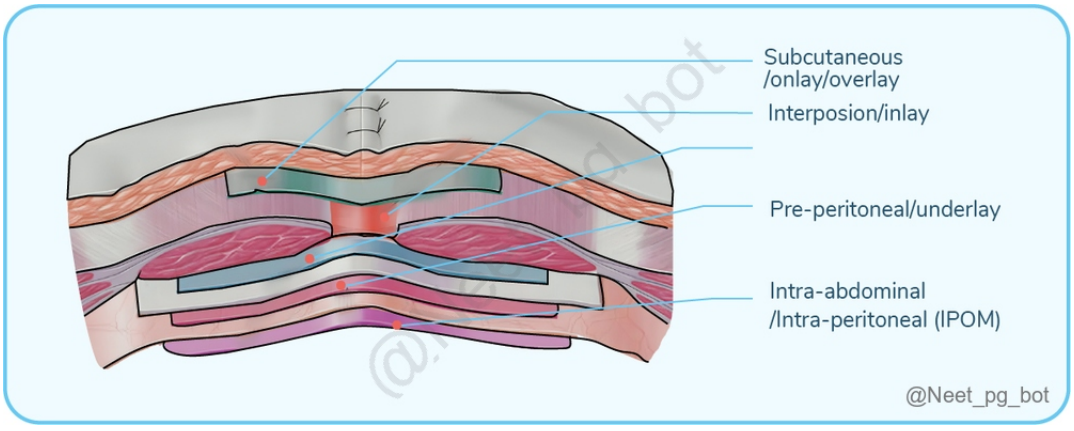
D. Preperitoneal



Correct Answer: B. Inlay

- *Listen (English)*
- *Listen (Hindi)*

Explanation: The inlay technique is characterized by placing the mesh within the defect and suturing it to the fascial edges. Incisional Hernia Mesh Placement Techniques: Technique Mesh Placement Procedure Advantages Disadvantages Inlay (Option B) Within the fascial defect itself Mesh is sutured to the edges of the fascial defect. It can be used for large defects where primary closure isn't possible. High recurrence rates due to mesh separation from fascial edges under abdominal pressure Onlay (Option A) On top of the anterior rectus sheath/external oblique aponeurosis Subcutaneous tissue is dissected off; the fascial defect is closed primarily, and the mesh is placed on top and secured Technically easier and less invasive. Higher risk of seroma formation, mesh infection, and skin necrosis. Retromuscular (Option C) Behind the rectus muscle but anterior to the posterior rectus sheath The posterior rectus sheath is opened, the mesh is placed in the created space, and the posterior sheath is closed over it Lower recurrence rates, mesh well incorporated into tissues More complex procedure, risk of injury to neurovascular bundles. Preperitoneal (Option D) Between the peritoneum and the posterior rectus sheath. Peritoneum is separated from posterior rectus sheath, mesh is placed in this space, peritoneum is closed over it. Good mesh incorporation, lower risk of adhesions. Technically challenging, risk of peritoneal tears.



References:

Bailey & Love’s Short Practice of Surgery, 28th edition, Page 1078

↑ *Back to this question in Part A*

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Q18: A 58-year-old male with chronic bronchitis, smoking history, and recent steroid use presents with a lower abdominal bulge that worsens with prolonged standing and heavy weight lifting. Which of these factors contributes to the risk of his condition? Chronic bronchitis Heavy weight lifting Smoking Steroid use (Q849212)

A. 1, 2, 3

B. 1, 3, 4

C. 2, 3, 4

D. 1, 2, 3, 4

Correct Answer: D. 1, 2, 3, 4

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: All listed factors are known risk factors for developing abdominal wall hernias. Hernia is an abnormal protrusion of an organ or tissue through an opening in the abdominal wall or cavity. Risk factors: Increased Abdominal Pressure: Chronic Cough (Chronic bronchitis) (Option A) Heavy weight Lifting (Option B) Obesity (Excess weight increases intra-abdominal pressure) Pregnancy (The expanding uterus increases pressure and stress on the abdominal wall). Chronic Constipation Ascites Obstructive uropathy (BPH / Stricture urethra) Weak Connective Tissue: Genetic Conditions: Collagen disorders like Ehlers-Danlos syndrome affect tissue strength and repair. Smoking (Option C): Impairs collagen maturation and healing, contributing to hernia development. Steroid intake (Option D) also impairs wound healing and weakens tissues. Aging: Age-related weakening of muscles and connective tissue increases susceptibility. Predisposing factors: Areas of Natural Weaknesses Lumbar triangles Inguinal Canal Oesophageal hiatus, umbilical cicatrix Developmental Abnormalities Failure of Closure: Patent processus vaginalis Congenital Hernias: Morgagni and Bochdalek hernias Injury and Surgery Surgical Incisions: weakened muscle strength at the site of incision Traumatic Injuries

References:

Bailey & Love’s Short Practice of Surgery, 28th Edition, Page 1059

↑ *Back to this question in Part A*

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Q19: Which type of lumbar hernia is characterized by a protrusion just below the 12th rib? (Q849336)

A. Petit's lumbar hernia

B. Grynfeltt-Lesshaft hernia

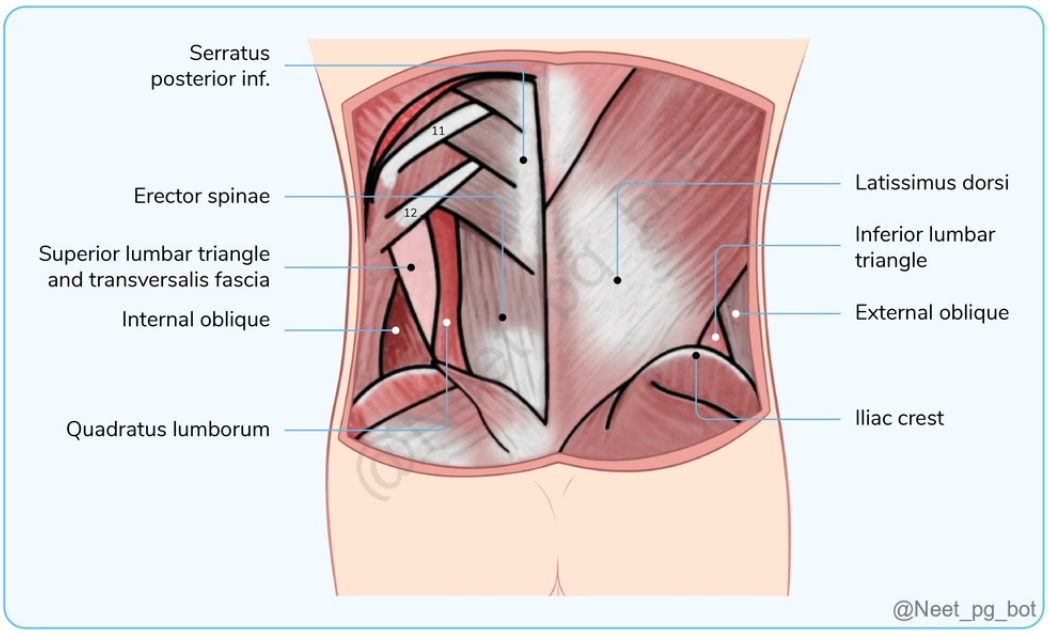
C. Gibbon's hernia

D. Pantaloon hernia

Correct Answer: B. Grynfeltt-Lesshaft hernia

- *Listen (English)*
- *Listen (Hindi)*

Explanation: The Grynfeltt-Lesshaft hernia, also known as the superior lumbar hernia, occurs in the superior lumbar triangle, located just below the 12th rib . This hernia is characterised by a protrusion through a weakness in the posterior abdominal wall in this specific area. Petit's lumbar hernia (Option A) occurs through the inferior lumbar triangle , bounded by the iliac crest, external oblique, and latissimus dorsi muscles. It typically appears as a bulge in the lower back, above the iliac crest, and is less common than the Grynfeltt-Lesshaft hernia. Gibbon's hernia (Option C) is not a type of lumbar hernia but refers to a parastomal hernia, which occurs around a stoma (an artificial abdominal opening for colostomy, ileostomy, or urostomy). It typically presents as a bulge around the stoma site. Pantaloon hernia (Option D) is not a lumbar hernia but a type of inguinal hernia where the sac protrudes on both sides of the inferior epigastric vessels, resembling pantaloons. The hernia sac straddles the inferior epigastric vessels and contains both direct and indirect components.



References:

Bailey & Love’s Short Practice of Surgery, 28th Edition, Page 1067

↑ *Back to this question in Part A*

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Q20: A 55-year-old woman presents with a small, reducible swelling in her right groin area. Upon examination, you noticed that the swelling was located lateral to the femoral vessels. Which variant of femoral hernia is this most likely to be? (Q849332)

A. Narath's hernia

B. Cloquet's hernia

C. Velpeau's hernia

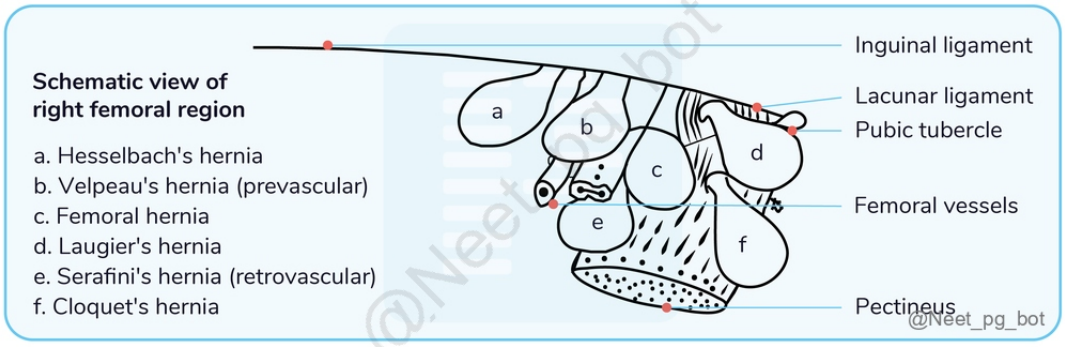
D. Laugier's hernia

Correct Answer: A. Narath's hernia

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The type of femoral hernia commonly associated with congenital hip dislocation is known as Narath's hernia. Variants of femoral hernia: Variant Location Characteristics Narath's hernia (Option A) Lateral to femoral vessels Also known as Lateral femoral hernia. Protrudes through the defect in the fascia lateral to the femoral vein. Associated with congenital hip dislocation. Cloquet's hernia (Option B) Behind femoral vessels Also known as pectineal hernia Extends through the defect in the pectineal fascia. Lies posterior to femoral vein. Velpeau's hernia (Option C) In front of femoral vessels Anterior femoral hernia. Protrudes through fascia covering femoral sheath. Lies anterior to femoral vessels. Laugier's hernia (Option D) Through Gimbernat's ligament Also known as lacunar hernia. Protrudes through the defect in the lacunar ligament. Serafini's hernia Through iliopectineal fascia Hernia sac passes between the iliac vein and the pubic bone. It can be mistaken for an obturator hernia.



References:

Bailey & Love’s Short Practice of Surgery, 28th Edition, Page 1071, 1072

↑ *Back to this question in Part A*

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Q21: A 55-year-old man undergoes emergency inguinal hernia surgery. Postoperatively, he experiences persistent groin pain, raising concerns about nerve injury. Which nerve is most commonly injured during open inguinal hernia surgery? (Q849328)

A. Iliohypogastric nerve

B. Ilioinguinal nerve

C. Genitofemoral nerve

D. Femoral nerve

Correct Answer: B. Ilioinguinal nerve

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The most commonly injured nerve during open inguinal hernia surgery is the ilioinguinal nerve, often leading to chronic pain as a complication. The most common nerve injured in: Open repair: Ilio-inguinal > Iliohypogastric > Genital branch of Genitofemoral nerve. Laparoscopy: Lateral Cutaneous nerve of thigh > Genito-femoral nerve. Landmarks in Laparoscopic Surgery: Triangle of Doom: Injury to Iliac vessels Triangle of Pain: Injury to Nerves causing postoperative pain Complications of Surgery: Immediate Complications: Bleeding/Hematoma: From subcutaneous or inferior epigastric vessels. Urinary Retention: May require catheterization. Femoral Nerve Blockade Early Postoperative Issues (within the first week): Pain, Bruising, Swelling: Common. Seroma Formation: Often resolves spontaneously; may need aspiration. Wound Infection: Less frequent; routine antibiotics not recommended. Testicular Infarction: Damage to the testicular artery during dissection or repair. Long-term Concerns: Chronic Pain: Nerve Injury: Damage to nerves such as the ilioinguinal or iliohypogastric nerves during surgery. Nerve Irritation: Chronic irritation by suture material or mesh. Psychological Factors Hernia Recurrence: Inadequate repair or weakness in the abdominal wall; mesh-related issues may also contribute.

References:

Bailey & Love’s Short Practice of Surgery, 28th Edition, Page 1070

↑ *Back to this question in Part A*

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Q22: A laparoscopic surgeon is repairing an inguinal hernia and wants to avoid using electrocautery in certain areas to prevent injury. Which anatomical region should the surgeon avoid? (Q849327)

A. Triangle of Doom

B. Triangle of Pain

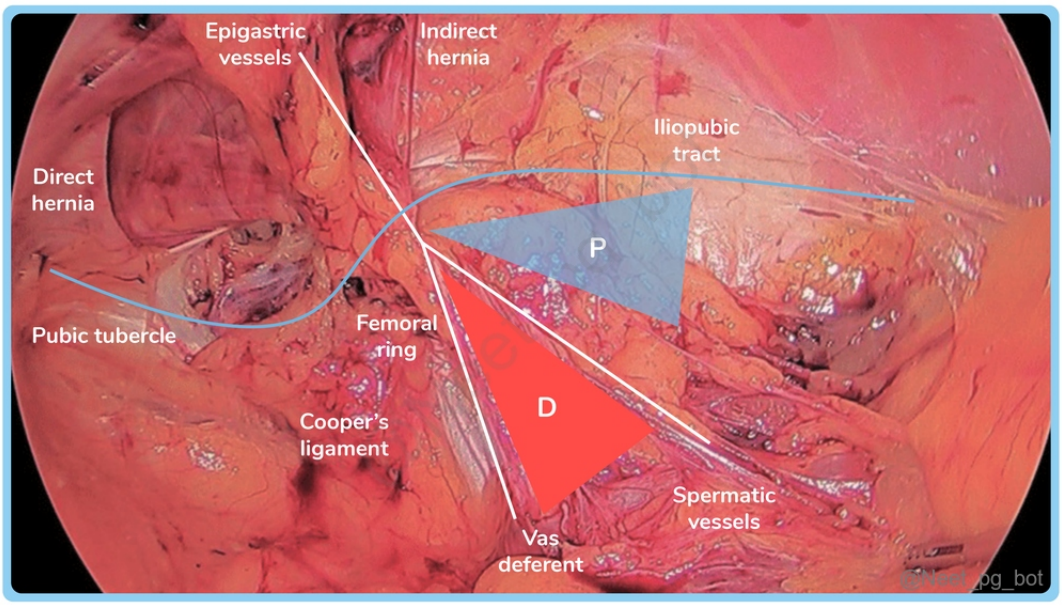
C. Triangle of Hesselbach

D. Triangle of Scarpa

Correct Answer: B. Triangle of Pain

- *Listen (English)*
- *Listen (Hindi)*

Explanation: Triangle of Pain contains nerves (such as the femoral branch of the genitofemoral nerve and the lateral cutaneous nerve of the thigh), and using electrocautery here can lead to nerve damage, resulting in chronic pain or numbness. Triangle of Doom (Option A) Triangle of Pain (Option B) Boundaries: Medial: Vas deferens Lateral: Gonadal vessels Base: Fold of peritoneum Apex: Deep inguinal ring Boundaries: Medial: Gonadal vessels Lateral: Fold of peritoneum Superior: Iliopubic tract Content : Iliac vessels are located behind the peritoneal fold. Content : (Medial to Lateral) Femoral nerve Femoral branch of the genitofemoral nerve Anterior cutaneous nerve of the thigh Lateral cutaneous nerve of the thigh Clinical Significance : Sharp dissection in this area risks damaging the iliac vessels, which can lead to severe bleeding and potentially life-threatening complications Clinical Significance : Potential risk of nerve damage if electrocautery is used. The lateral cutaneous nerve of the thigh is the most commonly injured nerve. Triangle of Hasselbach (Option C) is defined by the medial border of the inferior epigastric vessels, the lateral border of the rectus abdominis muscle, and the inguinal ligament inferiorly.It is primarily associated with inguinal hernias and is not specifically related to electrocautery hazards. Triangle of Scarpa (Option D), also known as the femoral triangle, is bordered by the inguinal ligament, sartorius muscle, and the adductor longus muscle. It identifies structures related to femoral vessels and nerves but is not the primary concern for electrocautery-related nerve injury in laparoscopic surgery.



References:

Schwartz's Principles of Surgery, 11th edition, Page 1603,1605

↑ *Back to this question in Part A*

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Q23: A 62-year-old male presents with a progressively worsening right groin bulge over 6 months, causing discomfort during lifting or prolonged standing. The hernia is reducible, and he is scheduled for elective repair. What is the gold standard surgical technique for his inguinal hernia repair? (Q849217)

A. Shouldice Repair

B. Lichtenstein Repair

C. Herniotomy

D. Stoppa Repair

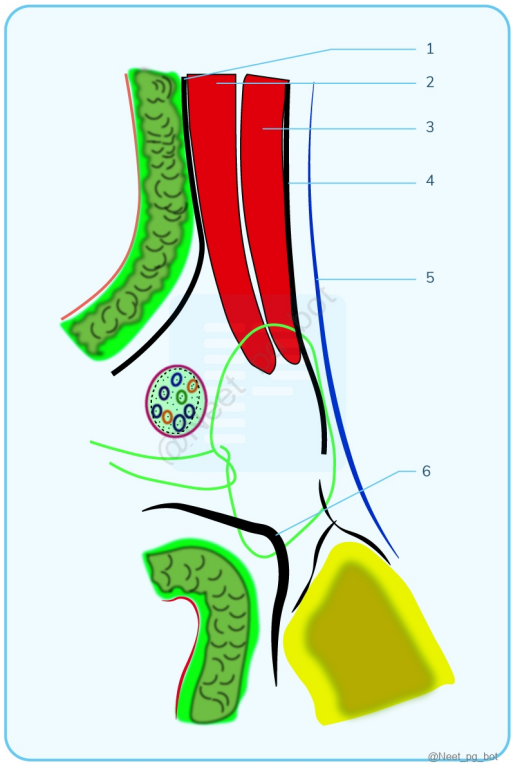
Correct Answer: B. Lichtenstein Repair

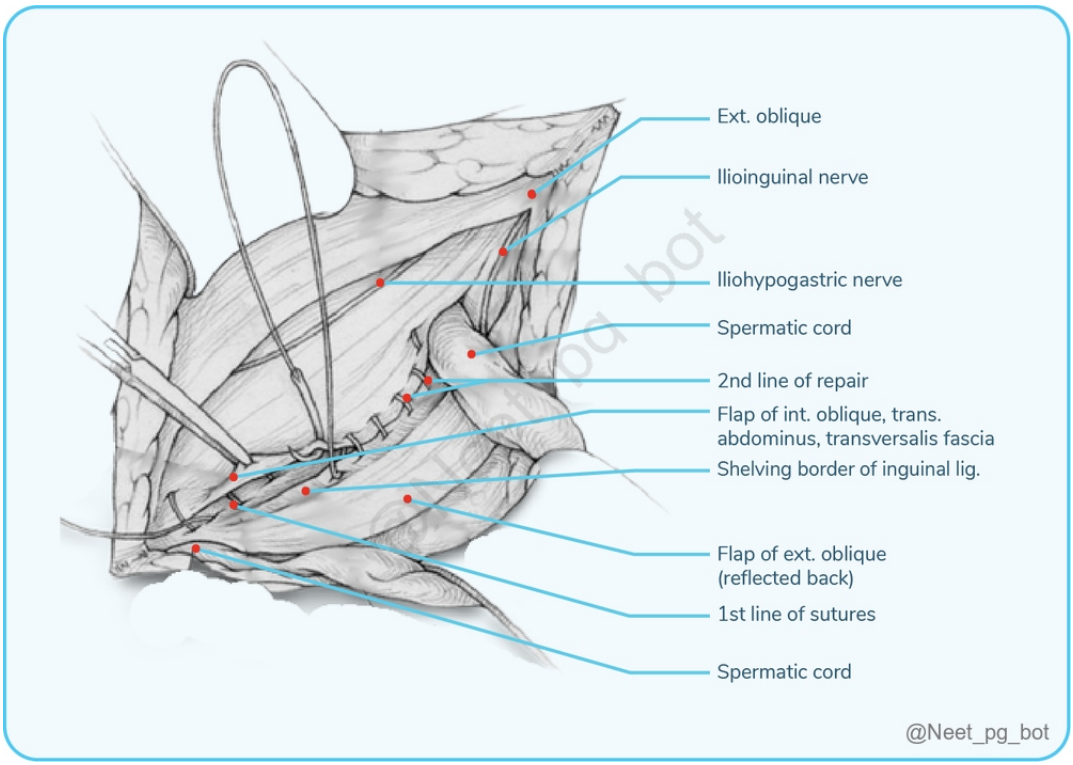
■ *Listen (English)*

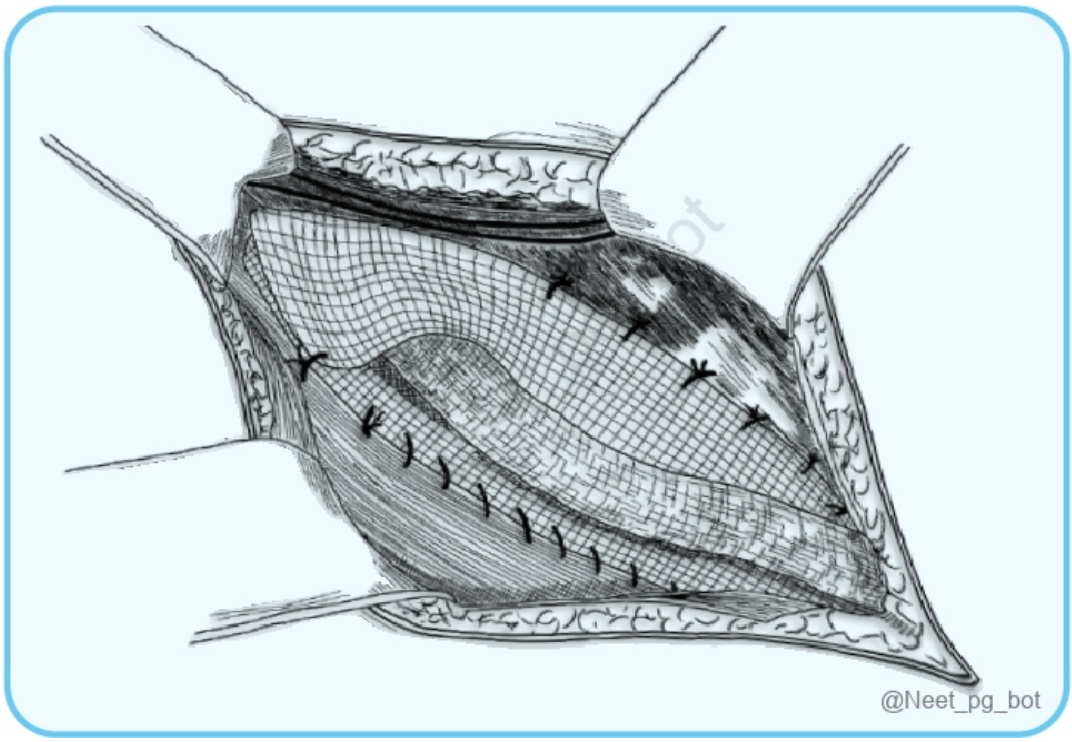
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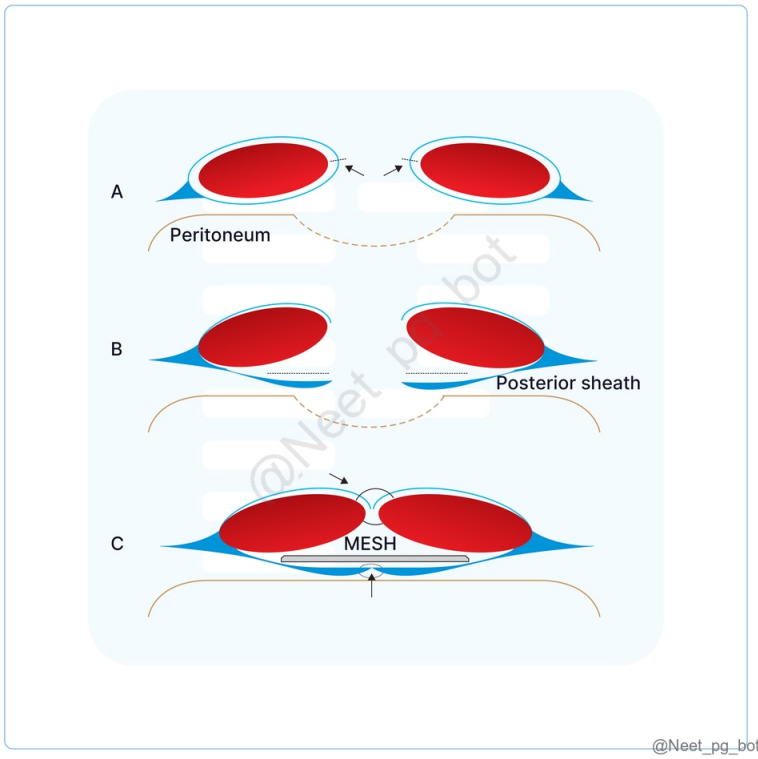
Explanation: The Lichtenstein repair is recognized as the gold standard for inguinal hernia surgery due to its tension-free approach using synthetic mesh. This technique is associated with low recurrence rates and favorable

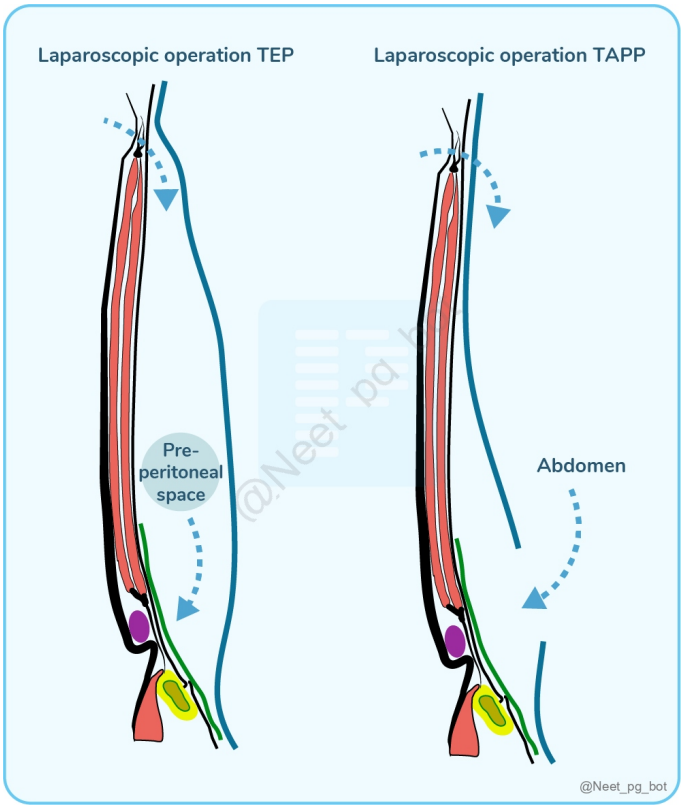
outcomes. Management of Inguinal Hernia: Surgical Approaches: Herniotomy (Option C) : It involves excising and closing the hernia sac Primarily used in children with lateral hernias and congenital hydrocele. In adults, herniotomy alone is insufficient due to high recurrence rates. Hernioplasty : Includes herniotomy plus inguinal floor reconstruction with mesh. Herniorrhaphy : Includes herniotomy plus reconstruction of the inguinal floor with sutures Techniques: Bassini's Repair: Involves suturing the internal oblique, transversus abdominis, and fascia transversalis to the inguinal ligament. Known as a triple-layer repair. Higher recurrence rates. Shouldice Repair (Option A): involves a four-layer repair (double breasting of fascia transversalis), resulting in lower recurrence rates compared to Bassini's. Modified Shouldice : A six-layer repair, including additional layers for reinforcement. Anterior Tension-Free Repair: Lichtenstein Repair : Utilizes a mesh to reinforce the inguinal floor, which is considered the gold standard due to lower recurrence rates and faster recovery. Open Preperitoneal Repair: Stoppa Repair (Option D) : Uses a mesh to reinforce the area behind the peritoneum Done in Recurrent inguinal hernia Laparoscopic Hernia Repair: Totally Extraperitoneal (TEP) Repair Transabdominal Preperitoneal (TAPP) Repair




Ext. oblique
Ilioinguinal nerve
Iliohypogastric nerve
Spermatic cord
2nd line of repair
Flap of int. oblique, trans. abdominus, transversalis fascia
Shelving border of inguinal lig.
Flap of ext. oblique (reflected back)
1st line of sutures
Spermatic cord
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References:

SRB's Manual of Surgery, 6th Edition, Page 745,746

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Q24: A 72-year-old female presents with a non-reducible right groin bulge below the inguinal ligament, confirmed by ultrasound to extend into the femoral canal. According to the Gilbert classification, which type best describes this condition? (Q849216)

A. Type 1

B. Type 3

C. Type 6

D. Type 7

Correct Answer: D. Type 7

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The patient's hernia, located below the inguinal ligament and extending into the femoral canal, is classified as a Type 7 (Femoral hernia) according to the Gilbert classification. Gilbert classification system for Groin Hernias: Type 1 : Indirect, small hernia (Option A) A hernia that protrudes through the deep inguinal ring. It is typically small and often seen in pediatric cases. Type 2 : Indirect, medium hernia An indirect hernia that is larger than Type 1 but does not yet cause significant displacement of the surrounding structures. Admits one finger but less than two-finger breadth. Type 3 : Indirect, large hernia (Option B) A significant indirect hernia may extend into the scrotum or cause a more noticeable displacement of structures. > 2 Finger breath Type 4 : Direct hernia, involves the entire floor A direct hernia that protrudes through the weakened area of the abdominal wall (Hesselbach's triangle), involving the entire floor of the inguinal canal. It has an intact internal ring. Type 5 : Direct hernia, diverticular A direct hernia where the sac resembles a diverticulum. It has an intact internal ring. Type 6 : Combined hernia (Romberg's hernia) (Option C) It involves both direct and indirect components, often referred to as a pantaloon or saddleback hernia. Type 7 : Femoral hernia (Option D) A hernia that protrudes through the femoral canal, located below the inguinal ligament. It is less common and more prone to complications like strangulation.

References:

SRB’s Manual of Surgery, 6th Edition, Page 745,746

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Q25: A 67-year-old male presents with a gradually increasing bulge in his right groin, which becomes more prominent when standing and straining and can be reduced when lying down. The bulge is medial to the inferior epigastric vessels. Which statement best describes this inguinal condition? (Q849214)

A. Direct hernia, passing through a defect in the abdominal wall.

B. Indirect hernia, passing through the deep inguinal ring into the scrotum.

C. Direct hernia, passing through the deep inguinal ring.

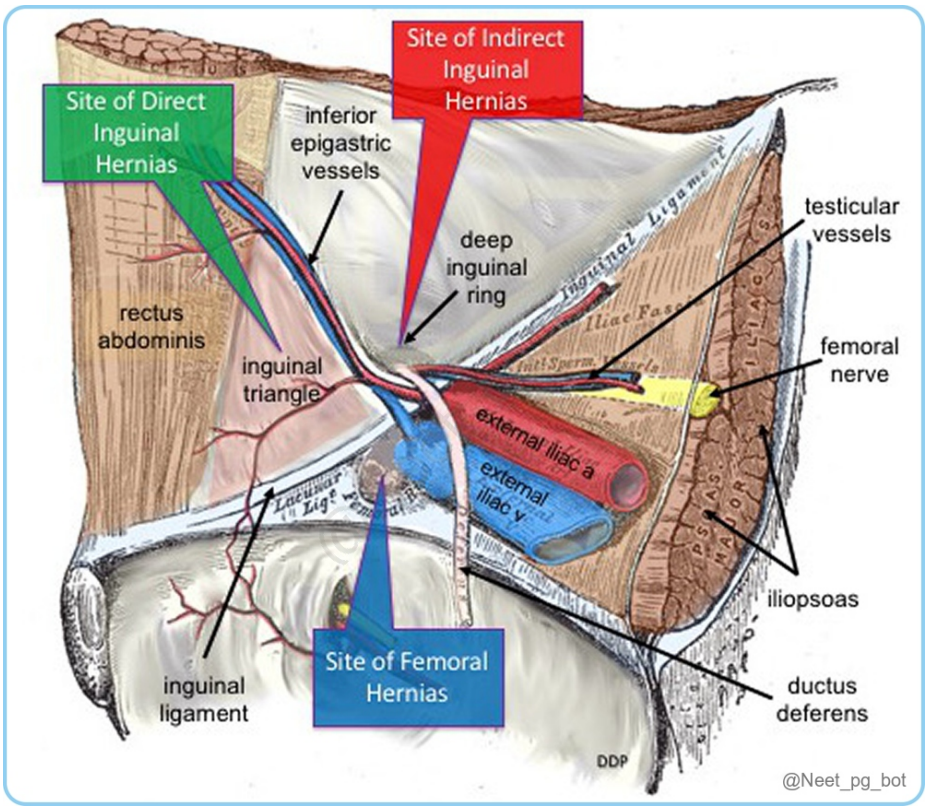
D. Indirect hernia, passing through a defect in the abdominal wall.

Correct Answer: A. Direct hernia, passing through a defect in the abdominal wall.

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The medial bulge to the inferior epigastric vessels indicates a direct inguinal hernia , which protrudes through a weakness in the abdominal wall at Hesselbach's triangle. Types of Inguinal Hernia: Inguinal Hernia is a condition where the viscus protrudes through a weak spot in the abdominal wall (Direct inguinal hernia) or inguinal canal in the groin area (Indirect inguinal hernia). Feature Indirect Inguinal Hernia Direct Inguinal Hernia Common in Young adults Elderly Course It enters through the deep inguinal ring, traverses the inguinal canal, and exits via the superficial inguinal ring. Protrudes directly through Hesselbach's triangle Relation to Spermatic Cord Anterolateral to the spermatic cord Posterior to the spermatic cord Location of Neck of Sac Above and medial to the pubic tubercle. Lies within the Hesselbach's triangle. Relation to Inferior Epigastric vessels Lateral to the inferior epigastric vessels. Medial to the inferior epigastric vessels. Relation to Scrotum Descends into the scrotum Does not Descend Types Bubonocele: Confined to inguinal canal Funicular: Processus vaginalis closed above epididymis, hernia content distinct from testis Complete/Scrotal: Testis in the lower part of the hernia —



References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1065,1066

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Q26: A 72-year-old man presents with a bulge in his lower abdomen that worsens with heavy lifting or coughing. Physical examination reveals a direct inguinal hernia. Which of the following correctly describes the boundaries of the involved anatomical triangle? (Q849213)

A. Lateral: Inferior epigastric vessels; Medial: Rectus abdominis; Inferior: Inguinal ligament

B. Lateral: Rectus abdominis; Medial: Inguinal ligament; Inferior: Femoral vessels

C. Lateral: Femoral vessels; Medial: Rectus abdominis; Inferior: Superior epigastric vessels

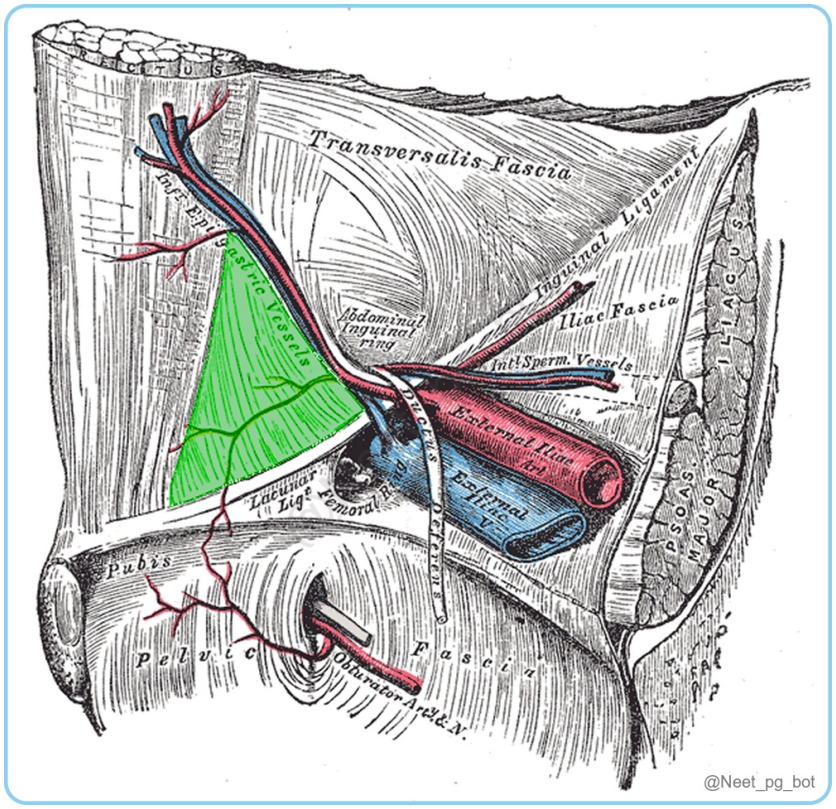
D. Lateral: Inguinal ligament; Medial: Femoral vessels; Inferior: Rectus abdominis

Correct Answer: A. Lateral: Inferior epigastric vessels; Medial: Rectus abdominis; Inferior: Inguinal ligament

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The given scenario suggests a Direct inguinal hernia , and Hesselbach’s triangle is associated with it. Hesselbach’s Triangle: Weak spot in the abdominal wall is where direct inguinal hernias occur. Covered only by the transversalis fascia and external oblique aponeurosis. Susceptible to herniation, especially in elderly patients or those with increased abdominal pressure. Boundaries: Lateral border : Inferior epigastric vessels Medial border : Rectus abdominis muscle Inferior border : Inguinal ligament (Poupart’s ligament)



References:

Bailey & Love’s Short Practice of Surgery, 28th Edition, Page 1066

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• [05_Gastrointestinal Surgery] 031 Spleen

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[05_Gastrointestinal Surgery] 031 Spleen — Quick Jump

Q1 (p. 2185) *Q2 (p. 2186)* *Q3 (p. 2187)* *Q4 (p. 2188)* *Q5 (p. 2189)* *Q6 (p. 2189)*
Q7 (p. 2190) *Q8 (p. 2191)* *Q9 (p. 2192)* *Q10 (p. 2193)*

Q1: Which of the following statements about the spleen is not true? (Q849317)

A. Normal adult spleen weights 75–250 g.

B. The long axis lies along the 10th rib.

C. It develops from the mesenchymal cells of the ventral mesogastrium.

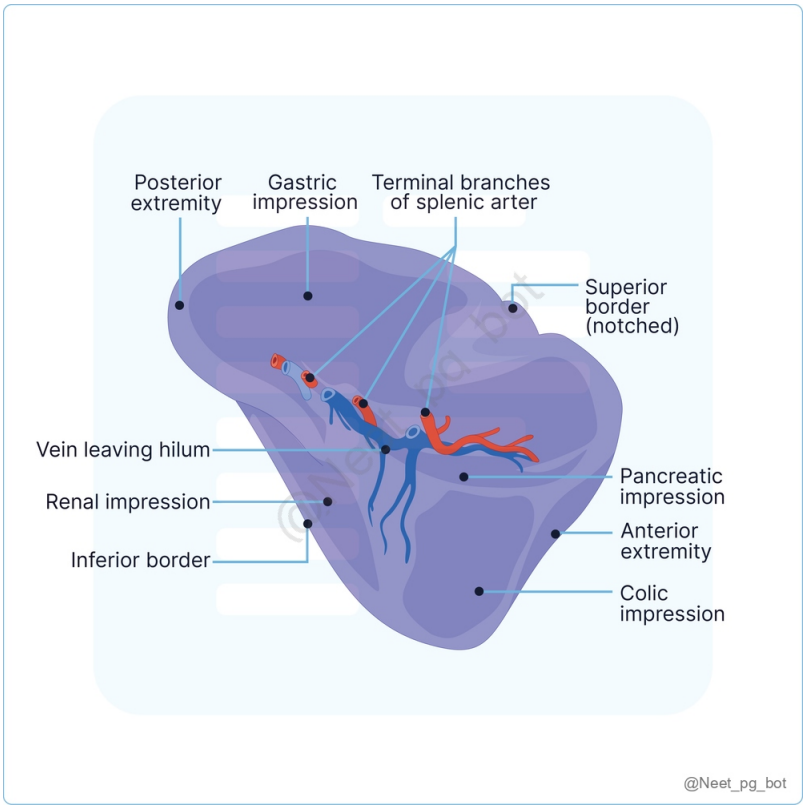
D. It is an intraperitoneal organ

Correct Answer: C. It develops from the mesenchymal cells of the ventral mesogastrium.

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Spleen develops from mesenchymal cells in the dorsal mesogastrium during 5th week of embryogenesis. Anatomy of spleen: Weight: 75 to 250 gm (Option A ruled out) Location: left hypochondrium, along the axis of the 10th rib. (Option B ruled out) It is an intraperitoneal organ. (Option D ruled out) Largest lymphatic organ In a healthy adult, the spleen is not usually palpable. It becomes palpable when the size increases by more than 2.5 times. Suspended by two ligaments: lienorenal ligament and gastrosplenic ligament. Relations of the spleen: Related to the 9th, 10th, and 11th rib, with its long axis along the 10th rib. It is related to the fundus of the stomach, the tail of the pancreas, the splenic flexure of the colon, and the anterior surface of the left kidney on it’s visceral surface. Two important ligaments that keep it in place are gastrosplenic and splenorenal ligaments .



References:

Bailey and Love's Short Practice of Surgery, 28th edition, pg 1219-1221

↑ *Back to this question in Part A*

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Q2: What is the most common indication for a splenectomy? (Q849318)

A. Hereditary spherocytosis

B. Idiopathic thrombocytopenic purpura (ITP)

C. Trauma

D. Abscess

Correct Answer: C. Trauma

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Splenic trauma is the most common indication for splenectomy. Most common indication of elective splenectomy- ITP (Idiopathic thrombocytopenic purpura) (Option B ruled out) Indications for splenectomy: Always indicated in: Usually indicated in: Low benefit: Grade V splenic injury Primary splenic tumor Hereditary spherocytosis (Option A ruled out) Chronic ITP Abscess (Option D ruled out) Splenic vein thrombosis leading to gastric varices Primary hypersplenism Autoimmune hemolytic anemia (AIHA) Thalassaemia Chronic myelogenous leukemia (CML) Gaucher's disease Hodgkin's lymphoma for staging laparotomy Sickle cell anemia

References:

Bailey and Love's Short Practice of Surgery, 28th edition, pg 1223-1229,

SRB's Manual of Surgery, 6th edition, pg 669.

https://www.ncbi.nlm.nih.gov/books/NBK560824/

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Q3: A 45-year-old male is planned for an elective splenectomy due to hereditary spherocytosis. Which of the following vaccination strategies is most appropriate to prevent infections post-splenectomy? (Q849319)

A. 10-12 weeks before surgery

B. Only if the patient shows signs of infection

C. Delay all vaccinations until 6 months after surgery

D. 1 week before the surgery

Correct Answer: A. 10-12 weeks before surgery

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: For patients planned for elective splenectomy, such as in hereditary spherocytosis, the best strategy to prevent overwhelming post-splenectomy infections (especially from encapsulated bacteria like Streptococcus pneumoniae, Haemophilus influenzae type b, and Neisseria meningitidis) involves administering vaccines well in advance of surgery. Vaccinating 10-12 weeks before surgery allows enough time for the patient's immune system to mount an effective response and develop optimal protective antibody levels before the spleen is removed. This vaccine timing provides the best opportunity for immunity to establish, minimizing the risk of severe infections after the spleen is removed. Key vaccines to administer: Pneumococcal vaccine (preferably PCV13 followed by PPSV23) Haemophilus influenzae type B (Hib) vaccine Meningococcal vaccine (covering groups A, C, W, and Y; MenB as needed) Annual influenza vaccination is also recommended Timing of Vaccination: Scenario Recommendation Elective splenectomy (ideal) 10–12 weeks before surgery (optimal for immune response) Elective splenectomy (minimum) At least 2 weeks before surgery Emergency splenectomy At hospital discharge

or 14 days post-op, whichever comes first

References:

Bailey and Love's Short Practice of Surgery, 28th edition, pg 1231

Sabiston Textbook of Surgery, 21st edition, pg 1579, 1580

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Q4: An elderly male undergoes an open splenectomy due to splenic rupture following a car accident. In the postoperative room, he complains of shortness of breath and chest discomfort. What is the MOST common immediate complication after a splenectomy? (Q849320)

A. Pulmonary embolism

B. Left basal atelectasis

C. Pleural effusion

D. Pneumonia

Correct Answer: B. Left basal atelectasis

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Left lobe atelectasis is the most common complication after a splenectomy. Complications after splenectomy: Short-term complications: Postoperative bleeding: Slipped ligature from the hilar vessels or short gastric vessels. Pneumonia (Option D ruled out) Left-sided pleural effusion (Option C ruled out) Pancreatic leak and fistula Left lobe atelectasis (Option B) Gastric perforation at the greater curvature and gastric fistula Post-splenectomy thrombosis of the splenic, mesenteric, and portal veins (PST-SMPv) Left subphrenic abscess Acute pancreatitis from injury to the tail of the pancreas Septicemia Late complications: Post-splenectomy thrombosis of the splenic, mesenteric, and portal veins (PST-SMPv). DVT/Pulmonary embolism (Option A ruled out) - due to post-splenectomy thrombosis and prolonged immobility. Overwhelming post-splenectomy infection (OPSI): Most common and fatal late complication. Septicemia

References:

Bailey and Love's Short Practice of Surgery, 28th edition, Page 1230, 1231.

https://www.ncbi.nlm.nih.gov/books/NBK560824/

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Q5: A 25-year-old woman with thalassemia major undergoes an elective splenectomy. She is informed about potential complications and the need for vaccinations. When is the most common Fatal late complication of splenectomy most likely to occur? (Q849321)

A. Within the first 6 months

B. 1-2 years post-splenectomy

C. 2-5 years post-splenectomy

D. 5-10 years post-splenectomy

Correct Answer: C. 2-5 years post-splenectomy

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Overwhelming Post-Splenectomy Infection (OPSI) is the most common fatal late complication usually seen after 2-5 years after splenectomy. Overwhelming Post-Splenectomy Infection (OPSI): Causative organisms: Polysaccharide encapsulated organisms like S. pneumoniae (Most common), N. meningitidis, and H. influenzae. Risk factors for OPSI: Young age Thalassemia major (8.2%) Sickle cell anemia (7.3%) Idiopathic thrombocytopenia (2.1%) Lymphoma Immunosuppression Time for vaccination: Ideally- 10-12 weeks before surgery At least 2 weeks before an elective surgery Emergency splenectomy- At discharge or 14 days after surgery whichever is first. Treatment: Broad-spectrum antibiotics and supportive care.

References:

Sabiston Textbook of Surgery, 21st edition, pg 1579, 1580

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Q6: A 4-year-old boy is brought to the clinic with a history of sudden onset of petechial hemorrhages and purpuric patches on the skin. The mother also reports episodes of spontaneous epistaxis over the past few days. He had a flu-like illness a few weeks ago. Laboratory investigations show isolated thrombocytopenia. Which of the following statements is most accurate about the disease? (Q849322)

A. Equal incidence in both males and females

B. Predominantly seen in females aged 15-50

C. Associated with renal dysfunction

D. Associated with hemolytic anemia and jaundice

Correct Answer: A. Equal incidence in both males and females

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Acute ITP typically presents in children under the age of 5 and affects both males and females equally. The sudden onset of petechiae, purpura, and spontaneous bleeding are characteristic features. Immune Thrombocytopenic Purpura (ITP) Definition : An autoimmune disease where antibodies attack platelet membrane glycoproteins, leading to isolated thrombocytopenia. Types : Acute ITP : Occurs in children. Chronic ITP : Occurs in adults. Clinical Features Chronic ITP : More common in women aged 15-50. (Option B ruled out) Can affect any age or sex. Acute ITP : Typically presents before age 5. Affects males and females equally. (Option A) Symptoms : Skin & Mucous Membranes : Purpuric patches (ecchymoses), petechial hemorrhages. Mucous Membranes : Spontaneous bleeding (e.g., epistaxis). Women : Menorrhagia. General : Prolonged bleeding from minor wounds. Renal dysfunction (Option C) is not a feature of ITP but is more characteristic of conditions like Hemolytic Uremic Syndrome (HUS) or Thrombotic Thrombocytopenic Purpura (TTP). Hemolytic anemia and jaundice (Option D) are associated with conditions like TTP or HUS, not ITP, where isolated thrombocytopenia is the primary finding.

References:

Bailey and Love’s Short Practice of Surgery, 28th edition, Pages 1226, 1227

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Q7: A 45-year-old patient presents with persistent petechiae, frequent nosebleeds, and heavy menstrual bleeding over the past 7 months. She is being considered for splenectomy. Which statement accurately reflects the current approach to this treatment? (Q849323)

A. Laparoscopic splenectomy is preferred.

B. Long-term steroid therapy is the primary approach.

C. Approximately 50% of patients will achieve complete remission post-splenectomy.

D. All patients receive pre-splenectomy transfusions immediately

Correct Answer: A. Laparoscopic splenectomy is preferred.

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The patient presents with petechiae, epistaxis, and menorrhagia, which are classical features of thrombocytopenia. The chronic duration of symptoms (>6 months) suggests chronic immune thrombocytopenic purpura (ITP) . In ITP, autoantibody-mediated destruction of platelets occurs primarily in the spleen, making splenectomy a definitive treatment in refractory or relapsing cases. Laparoscopic splenectomy is the preferred approach in current surgical practice because it is minimally invasive and associated with reduced postoperative pain, shorter hospital stay, faster recovery, and fewer complications compared to open splenectomy. It is especially suitable in ITP as the spleen is usually normal-sized or only mildly enlarged. During splenectomy, it is essential to identify and remove accessory spleens (splenunculi) , commonly located near the splenic hilum, tail of the pancreas, or omentum, as their persistence can lead to recurrence of the disease. Preoperatively, patients should receive vaccination against encapsulated organisms (pneumococcus, meningococcus, and Haemophilus influenzae) to prevent overwhelming post-splenectomy infection (OPSI). Treatment for ITP Acute ITP Chronic ITP (>6 months) Common in children Often resolves without treatment Short courses of corticosteroids are effective Prolonged steroid therapy is not recommended Typically affects adults Corticosteroids are used but prolonged use is not advised (Option B ruled out) For refractory or relapsing cases, splenectomy is generally recommended Pre-Splenectomy Considerations Vaccination Transfusions It may be necessary before a splenectomy Typically, it is not administered until the splenic vessels are controlled. (Option D ruled out)

References:

Bailey and Love’s Short Practice of Surgery, 28th edition, Page 1227

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Q8: A 45-year-old patient undergoes a splenectomy for an incidental finding. Histological examination of the spleen reveals a vascular tumor. Which of the following is the most likely type of tumor identified? (Q849325)

A. Histiocytic Lymphoma

B. Hemangioendothelioma

C. Non-Hodgkin’s Lymphoma

D. Plasmacytoma

Correct Answer: B. Hemangioendothelioma

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Hemangioendothelioma is a type of vascular tumor that is commonly found in the spleen. It arises from endothelial cells lining blood vessels, making it a likely candidate for a vascular tumor found in the spleen. Types of Splenic Tumors Non-Lymphoid Tumors Lymphoid Tumors Vascular Tumors (most common): Benign Hemangiomas Littoral Cell Angiomas Lymphangiomas Hemangioendotheliomas Other Tumors (less common): Fibrosarcoma Neurinoma Lipoma Hodgkin's Lymphoma Non-Hodgkin's Lymphoma Histiocytic Lymphoma Plasmacytoma Histiocytic Lymphoma (Option A) is a lymphoid malignancy , not a vascular tumor. It arises from reticuloendothelial/immune cells , not endothelial cells. Non-Hodgkin's Lymphoma (Option C) : Although it is the most common malignant tumor involving the spleen , it is a lymphoid tumor , not vascular. Histology would show lymphoid proliferation , not vascular channels. Plasmacytoma (Option D) usually involves: Bone (multiple myeloma) Occasionally soft tissues It is not a vascular tumor and rarely presents as a primary splenic lesion.

References:

www.ncbi.nlm.nih.gov/pmc/articles/PMC3614769/

www.ncbi.nlm.nih.gov/pmc/articles/PMC3578545/

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Q9: A 45-year-old patient presents with a one-week history of persistent left upper abdominal pain. The patient exhibits fever, left upper quadrant tenderness, and leukocytosis. Which of the following is the investigation of choice for confirming the diagnosis? (Q849326)

A. Chest X-ray

B. Abdominal Ultrasound

C. Computed Tomography (CT)

D. Radioisotope Scanning

Correct Answer: C. Computed Tomography (CT)

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Based on the clinical presentation of a 45-year-old patient with a one-week history of persistent left upper abdominal pain, fever, left upper quadrant tenderness, and leukocytosis, the most likely diagnosis is a splenic abscess . Computed Tomography (CT) is the investigation of choice with nearly 100% sensitivity for diagnosing splenic abscesses. It reveals low-density lesions that do not enhance with contrast and provides detailed information on size, location, and access routes. Imaging Studies: Type Findings Radiography (Option A ruled out) Chest X-ray: Non-specific for splenic abscess; may show: Elevated left hemidiaphragm (>30%) Pleural effusion (>20%) Abdominal X-ray : Non-specific; possible findings include: Abnormal soft-tissue density Gas

collection in the left upper quadrant Nuclear Studies (Option D ruled out) Radioisotope scanning: Limited value due to long test duration Ultrasonography (Option B ruled out) Cost-effective and non-invasive, but: Nonspecific and operator-dependent Computed Tomography (CT) (Option C) Criterion standard for diagnosing splenic abscess

References:

Bailey and Love's Short Practice of Surgery, 28th edition, Pg 1224

https://emedicine.medscape.com/article/194655-workup?form=fpf#c5

↑ *Back to this question in Part A*

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Q10: A 30-year-old patient presents with an abdominal mass. Imaging studies reveal a cystic structure in the spleen. Based on the imaging characteristics and the absence of an epithelial lining, which of the following is the most likely diagnosis? (Q849324)

A. Cystic hemangioma

B. Mesenchymal Inclusion Cyst

C. Secondary cyst

D. Dermoid cyst

Correct Answer: C. Secondary cyst

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Secondary cysts (pseudocysts) lack an epithelial lining and often develop following trauma. They typically contain serous or hemorrhagic fluid and may have calcified walls that resemble hydatid cysts on imaging. Overall, the most common splenic cyst is Pseudocyst. Primary (True) Cysts Secondary Cysts (Pseudocysts) Characteristics: Presence of an epithelial lining. Types: Dermoid Cysts: Derived from embryonal rests. (Option D ruled out) Mesenchymal Inclusion Cysts: Includes cystic hemangiomas, cystic lymphangiomas, epidermoid and dermoid cysts. (Option A, Option B ruled out) Characteristics: No epithelial lining; often develop post-trauma. Content: Serous or hemorrhagic fluid. Appearance: May have calcified walls, resembling hydatid cysts on imaging. Treatment: Splenectomy or partial splenectomy. Diagnosis: Typically through imaging. Treatment: Intervention only if symptomatic or persistent after observation.

References:

Bailey and Love's Short Practice of Surgery, 28th edition, Pages 1221, 1222

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• [05_Gastrointestinal Surgery] 032 Previous Year Questions

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Q1 (p. 2196)	*Q2 (p. 2198)*	*Q3 (p. 2199)*	*Q4 (p. 2200)*	*Q5 (p. 2201)*	*Q6 (p. 2202)*
Q7 (p. 2204)	*Q8 (p. 2205)*	*Q9 (p. 2206)*	*Q10 (p. 2207)*	*Q11 (p. 2208)*	*Q12 (p. 2211)*
Q13 (p. 2211)	*Q14 (p. 2214)*	*Q15 (p. 2215)*	*Q16 (p. 2216)*	*Q17 (p. 2217)*	*Q18 (p. 2218)*
Q19 (p. 2219)	*Q20 (p. 2220)*	*Q21 (p. 2221)*	*Q22 (p. 2222)*	*Q23 (p. 2223)*	*Q24 (p. 2224)*
Q25 (p. 2225)	*Q26 (p. 2226)*	*Q27 (p. 2228)*	*Q28 (p. 2229)*	*Q29 (p. 2231)*	*Q30 (p. 2232)*
Q31 (p. 2234)	*Q32 (p. 2235)*	*Q33 (p. 2238)*	*Q34 (p. 2241)*	*Q35 (p. 2243)*	*Q36 (p. 2243)*
Q37 (p. 2247)	*Q38 (p. 2248)*	*Q39 (p. 2249)*	*Q40 (p. 2252)*	*Q41 (p. 2253)*	*Q42 (p. 2256)*
Q43 (p. 2258)	*Q44 (p. 2258)*	*Q45 (p. 2259)*	*Q46 (p. 2260)*	*Q47 (p. 2261)*	*Q48 (p. 2262)*
Q49 (p. 2263)	*Q50 (p. 2265)*	*Q51 (p. 2266)*	*Q52 (p. 2267)*	*Q53 (p. 2269)*	*Q54 (p. 2271)*
Q55 (p. 2274)	*Q56 (p. 2276)*	*Q57 (p. 2276)*	*Q58 (p. 2278)*	*Q59 (p. 2281)*	*Q60 (p. 2282)*
Q61 (p. 2285)	*Q62 (p. 2286)*	*Q63 (p. 2287)*	*Q64 (p. 2288)*	*Q65 (p. 2288)*	*Q66 (p. 2289)*
Q67 (p. 2290)	*Q68 (p. 2291)*	*Q69 (p. 2292)*	*Q70 (p. 2292)*	*Q71 (p. 2293)*	*Q72 (p. 2295)*
Q73 (p. 2296)	*Q74 (p. 2297)*	*Q75 (p. 2297)*	*Q76 (p. 2298)*	*Q77 (p. 2299)*	*Q78 (p. 2300)*
Q79 (p. 2301)	*Q80 (p. 2302)*	*Q81 (p. 2305)*	*Q82 (p. 2306)*	*Q83 (p. 2307)*	*Q84 (p. 2309)*
Q85 (p. 2310)	*Q86 (p. 2312)*	*Q87 (p. 2312)*	*Q88 (p. 2313)*	*Q89 (p. 2315)*	*Q90 (p. 2316)*
Q91 (p. 2317)	*Q92 (p. 2317)*	*Q93 (p. 2318)*	*Q94 (p. 2321)*	*Q95 (p. 2322)*	*Q96 (p. 2324)*
Q97 (p. 2324)	*Q98 (p. 2326)*	*Q99 (p. 2328)*	*Q100 (p. 2329)*	*Q101 (p. 2330)*	*Q102 (p. 2332)*
Q103 (p. 2333)	*Q104 (p. 2334)*	*Q105 (p. 2335)*	*Q106 (p. 2336)*	*Q107 (p. 2337)*	*Q108 (p. 2337)*
Q109 (p. 2338)	*Q110 (p. 2340)*	*Q111 (p. 2341)*	*Q112 (p. 2342)*	*Q113 (p. 2342)*	*Q114 (p. 2344)*
Q115 (p. 2345)	*Q116 (p. 2348)*	*Q117 (p. 2349)*	*Q118 (p. 2350)*	*Q119 (p. 2352)*	*Q120 (p. 2353)*
Q121 (p. 2353)	*Q122 (p. 2354)*	*Q123 (p. 2355)*	*Q124 (p. 2356)*	*Q125 (p. 2356)*	*Q126 (p. 2357)*
Q127 (p. 2358)	*Q128 (p. 2359)*	*Q129 (p. 2360)*	*Q130 (p. 2360)*	*Q131 (p. 2361)*	*Q132 (p. 2362)*
Q133 (p. 2366)	*Q134 (p. 2368)*	*Q135 (p. 2370)*	*Q136 (p. 2371)*	*Q137 (p. 2373)*	*Q138 (p. 2375)*
Q139 (p. 2378)	*Q140 (p. 2379)*	*Q141 (p. 2381)*	*Q142 (p. 2381)*	*Q143 (p. 2382)*	*Q144 (p. 2383)*
Q145 (p. 2384)	*Q146 (p. 2385)*	*Q147 (p. 2385)*	*Q148 (p. 2386)*	*Q149 (p. 2390)*	*Q150 (p. 2391)*
Q151 (p. 2392)	*Q152 (p. 2395)*	*Q153 (p. 2396)*	*Q154 (p. 2396)*	*Q155 (p. 2397)*	*Q156 (p. 2398)*
Q157 (p. 2399)	*Q158 (p. 2400)*	*Q159 (p. 2401)*	*Q160 (p. 2403)*	*Q161 (p. 2406)*	*Q162 (p. 2410)*
Q163 (p. 2411)	*Q164 (p. 2412)*	*Q165 (p. 2414)*	*Q166 (p. 2416)*	*Q167 (p. 2417)*	*Q168 (p. 2417)*
Q169 (p. 2419)	*Q170 (p. 2420)*	*Q171 (p. 2422)*	*Q172 (p. 2423)*	*Q173 (p. 2423)*	*Q174 (p. 2425)*
Q175 (p. 2426)	*Q176 (p. 2429)*	*Q177 (p. 2429)*	*Q178 (p. 2430)*	*Q179 (p. 2432)*	*Q180 (p. 2435)*
Q181 (p. 2436)	*Q182 (p. 2437)*	*Q183 (p. 2437)*	*Q184 (p. 2438)*	*Q185 (p. 2438)*	*Q186 (p. 2440)*
Q187 (p. 2441)	*Q188 (p. 2441)*	*Q189 (p. 2442)*	*Q190 (p. 2443)*	*Q191 (p. 2444)*	*Q192 (p. 2445)*

Q193 (p. 2446) *Q194 (p. 2447)* *Q195 (p. 2447)* *Q196 (p. 2449)*

Q1: A 2-month-old male infant presents with a scrotal swelling that has been present since birth. Now, the swelling has become suddenly painful, red, and irreducible. What is the most likely diagnosis? (Q866898)

A. Acute epididymo-orchitis

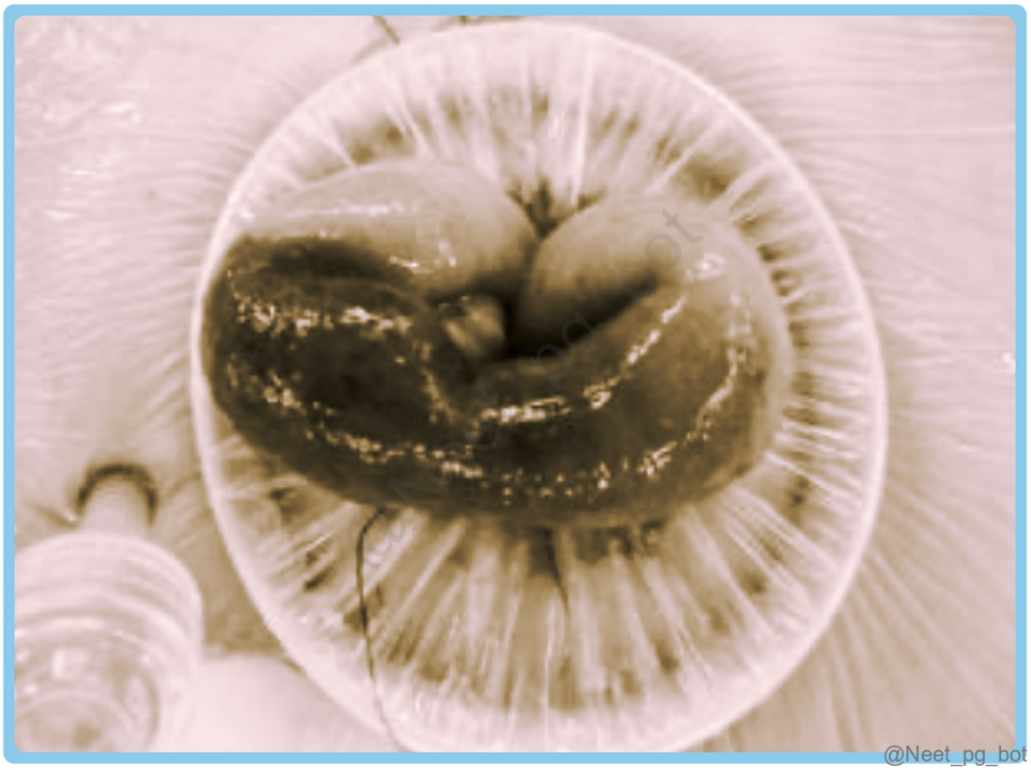
B. Testicular torsion

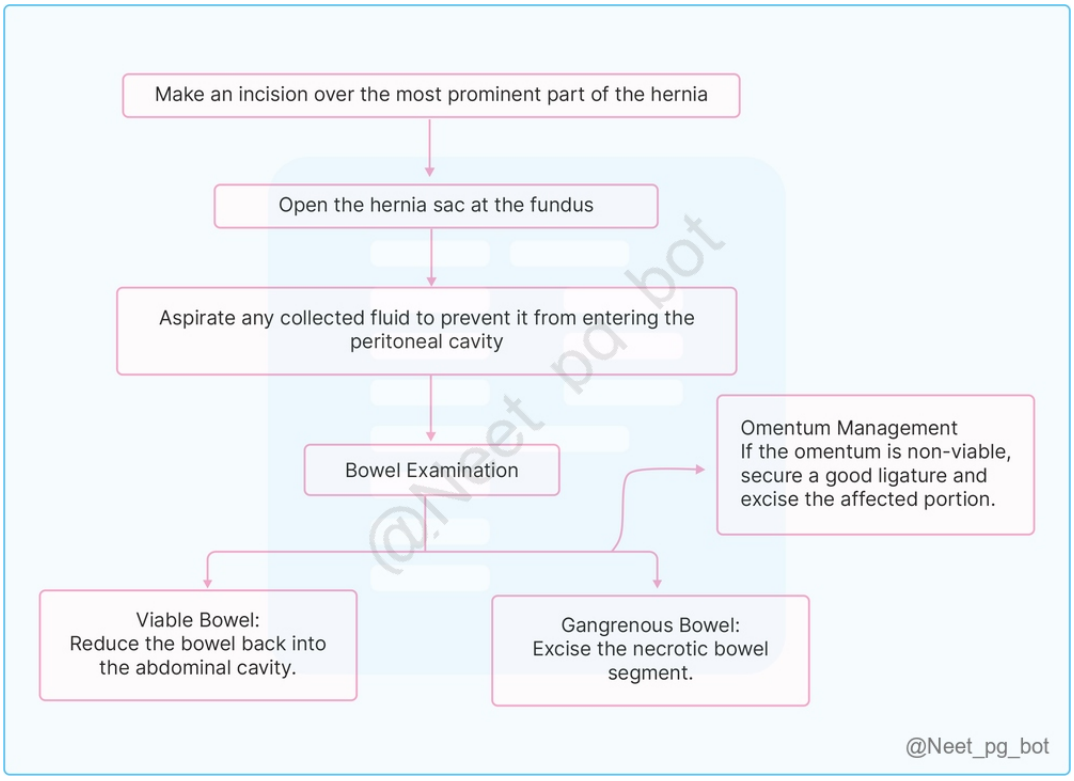
C. Strangulated inguinal hernia

D. Incarcerated inguinal hernia

Correct Answer: C. Strangulated inguinal hernia

Explanation: The infant has a congenital scrotal swelling (likely due to a hernia present since birth) that has become painful, red, and irreducible , suggesting that bowel has entered the hernial sac and is now compromised with vascular obstruction - this is the definition of a strangulated inguinal hernia . This is a surgical emergency requiring immediate intervention to prevent bowel necrosis. Strangulated Hernia: A strangulated hernia occurs when a portion of tissue or intestine protrudes through a weakened area in the abdominal wall and becomes trapped. The trapped segment loses its blood supply, leading to tissue ischemia (lack of blood flow) and potential tissue death if not promptly treated. Clinical Features: Irreducibility: The hernia cannot be pushed back. Signs of Intestinal Obstruction : Colicky pain, bilious vomiting, absence of faeces and flatus. History: Sudden onset of pain at the hernia site, followed by generalised abdominal pain. Physical Examination Findings: Tense, extremely tender hernia with reddish or bluish skin discolouration and no cough impulse. Diagnosis is primarily based on clinical examination and physical findings. Treatment: Initial Resuscitation: Administer intravenous (IV) fluids. Provide IV antibiotics. Perform nasogastric aspiration. Insert Foley's catheter. Surgical intervention is done only after Initial Resuscitation. Surgical management Algorithm: Mesh Usage: Synthetic mesh is contraindicated due to the increased risk of infection. If a mesh is necessary, bioprosthetic or absorbable mesh is preferred. Acute epididymo-orchitis (Option A): Presents with scrotal pain, swelling, and erythema but is rare in this age group and usually associated with urinary tract infection; swelling is not from birth. Testicular torsion (Option B): Sudden severe scrotal pain and swelling, but not present since birth; does not involve an irreducible groin/scrotal mass. Incarcerated inguinal hernia (Option D): Irreducible hernia without compromised blood supply; no redness or severe tenderness — if blood supply is compromised, it becomes strangulated.


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Make an incision over the most prominent part of the hernia
Open the hernia sac at the fundus
Aspirate any collected fluid to prevent it from entering the peritoneal cavity
Bowel Examination
Omentum Management
If the omentum is non-viable, secure a good ligature and excise the affected portion.
Viable Bowel:
Reduce the bowel back into the abdominal cavity.
Gangrenous Bowel:
Excise the necrotic bowel segment.
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References:

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↑ *Back to this question in Part A*

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Q2: Which of the following is a recommended treatment for esophageal varices? (Q866901)

A. Endoscopic ligation

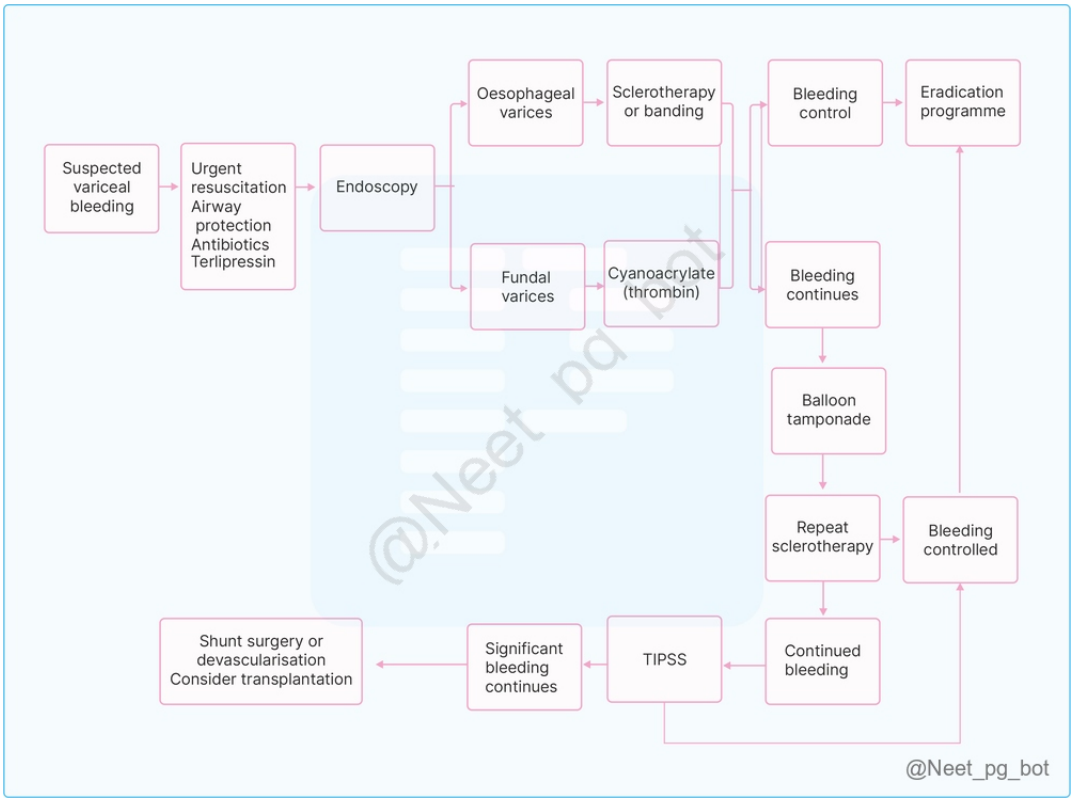
B. Transjugular intrahepatic portosystemic shunt (TIPS)

C. Intravenous labetalol

D. Oral amoxicillin

Correct Answer: A. Endoscopic ligation

Explanation: Endoscopic variceal ligation (EVL) is the first-line treatment for acute bleeding esophageal varices and for secondary prophylaxis. It works by mechanically strangulating varices, leading to thrombosis and obliteration, with fewer complications than sclerotherapy. Management of Esophageal varices: The immediate priority in managing variceal bleeding is stabilizing the patient's condition. This involves the airway, breathing, and circulation. Establishing intravenous access with large-bore cannulae allows for rapid fluid resuscitation , ideally with blood transfusions, to restore circulatory volume and address hypotension. Transjugular intrahepatic portosystemic shunt (TIPS) (Option B): Used as a salvage therapy when bleeding persists or recurs despite optimal endoscopic and pharmacologic management. Intravenous labetalol (Option C): Not used; nonselective beta-blockers like propranolol or nadolol are used for prophylaxis, not labetalol. Oral amoxicillin (Option D): Antibiotics (usually ceftriaxone) are given prophylactically in variceal bleeding, but amoxicillin is not the standard choice and does not control bleeding.



References:

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↑ *Back to this question in Part A*

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Q3: What is the most appropriate treatment for an 8cm chylolymphatic mesenteric cyst? (Q866911)

A. Aspiration

B. Enucleation

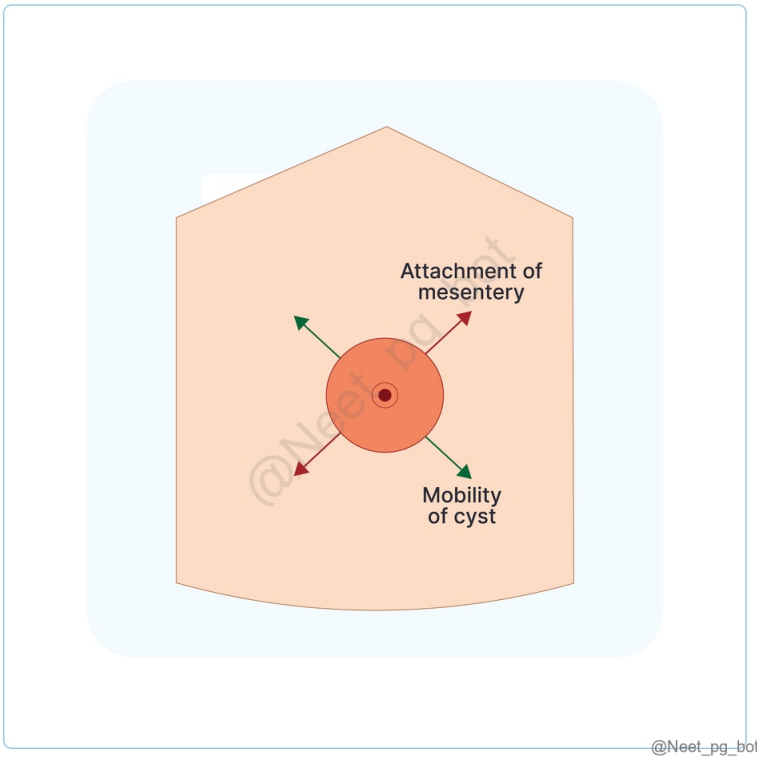
C. Resection of the cyst along with the adjacent bowel

D. Conservative

Correct Answer: B. Enucleation

Explanation: Chylolymphatic mesenteric cysts are typically benign, well-encapsulated lesions arising from lymphatic malformations in the mesentery. The majority are attached to the mesentery but do not infiltrate the bowel wall, meaning the cyst can be separated from the mesenteric vessels without compromising bowel blood

supply. Preferred treatment: Complete enucleation of the cyst while preserving the bowel, to prevent recurrence and avoid unnecessary resection. Tillaux Triad: Peri-umbilical swelling Tillaux sign → swelling moves at right angle to mesentery Transverse band of resonance Investigation of choice: Contrast-Enhanced CT (CECT) Types of Mesenteric Cysts Chylolymphatic cyst (most common) Enterogenous cyst Origin Sequestered lymphatic tissue Sequestered bowel tissue Wall Thin Thick Fluid Clear Turbid Blood supply Independent Shares with bowel Treatment Enucleation Resection + anastomosis Site distribution: Small intestine → 60% Colon → 40% Complications: Torsion Rupture Infection Hemorrhage Aspiration (Option A) – Not definitive; high recurrence/infection risk. Resection of the cyst along with the adjacent bowel (Option C) – Needed only when the cyst shares vascular supply with the bowel or infiltrates the wall. Conservative (Option D) – Not appropriate due to risk of enlargement, infection, torsion, or rupture.



↑ *Back to this question in Part A*

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Q4: A follow-up patient of GERD on endoscopy was having a nodule in the 2nd part of the duodenum, which hormone are you suspecting to be raised? (Q866920)

A. Gastrin

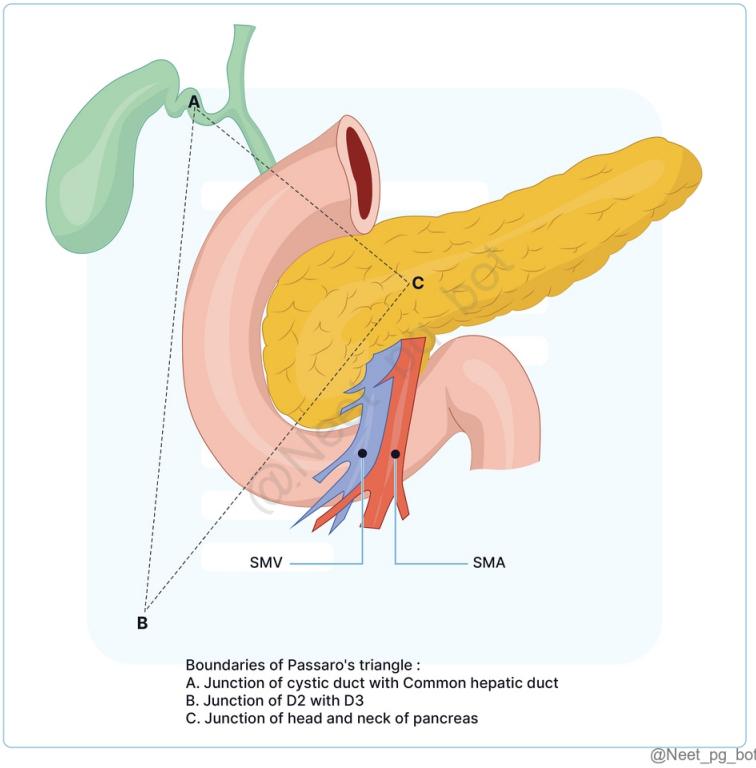
B. Inulin

C. VIP

D. Glucagon

Correct Answer: A. Gastrin

Explanation: A nodule in the 2nd part of the duodenum in a patient with GERD symptoms raises suspicion of a gastrinoma (Zollinger–Ellison syndrome). Gastrinoma: Gastrin-secreting neuroendocrine tumor → marked acid hypersecretion → severe peptic ulcer disease. Common sites: Duodenum (~70%) Pancreas (~25%) Other sites (~5%) — stomach, lymph nodes. Gastrinoma Triangle: Cystic duct–CBD junction Junction of 2nd & 3rd part of duodenum Neck & body of the pancreas. Associations: MEN1 (Multiple Endocrine Neoplasia type 1) → Gastrinoma + Pituitary adenoma + Parathyroid hyperplasia. Clinical features: Refractory peptic ulcers (often multiple, distal to duodenal bulb) GERD Chronic diarrhea (acid inactivates pancreatic enzymes → malabsorption) Diagnosis: Fasting serum gastrin >1000 pg/mL (very high suspicion) Secretin stimulation test → paradoxical rise in gastrin. Imaging: Endoscopic ultrasound, somatostatin receptor scintigraphy. Treatment: High-dose proton pump inhibitors (acid suppression). Surgical excision if localized. Inulin (Option B) – Not a hormone; used as a marker for GFR measurement. VIP (Option C) – Elevated in VIPoma; causes watery diarrhea, hypokalemia, achlorhydria (WDHA syndrome), and no duodenal nodules with GERD. Glucagon (Option D) – Elevated in glucagonoma; presents with necrolytic migratory erythema, diabetes, and anemia, typically in the pancreas, not the duodenum.



↑ *Back to this question in Part A*

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Q5: A neonate has intestines protruding from the abdomen without any covering. Initial management is done. If the viscera cannot be reduced into the abdomen, what is the appropriate next step in management? (Q866922)

A. Surgical correction

B. Conservative management with higher antibiotics

C. Silo placement → Serial reduction → Operative fascial closureCover the content with a Silo bag and wait

D. Cover with NS-soaked gauze

Correct Answer: C. Silo placement → Serial reduction → Operative fascial closureCover the content with a Silo bag and wait

Explanation: The neonate has gastroschisis with exposed intestines. Initial management involves covering the intestines and stabilizing the baby. If the intestines cannot be reduced into the abdomen, primary closure is unsafe. Silo placement allows gradual reduction of viscera without increasing intra-abdominal pressure. Serial reduction is done over days to slowly accommodate intestines. Once fully reduced, operative fascial closure secures the abdominal wall. This staged approach prevents abdominal compartment syndrome and respiratory compromise. Incorrect Options: Option A) Surgical correction: Primary surgical closure is risky if viscera cannot fit; may cause compartment syndrome. Option B) Conservative management with higher antibiotics: Antibiotics alone do not reduce intestines; only prevent infection. Option D) Cover with NS-soaked gauze: Only protects intestines temporarily; does not address inability to reduce viscera.

References:

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↑ *Back to this question in Part A*

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Q6: A 16-year-old boy presents with multiple episodes of abdominal pain and a history of passing blood in his stools. On examination, he has darkly pigmented spots on his lips and oral mucosa. Endoscopy reveals multiple hamartomatous polyps in the small intestine. What is the most likely diagnosis? (Q866926)

A. Familial Adenomatous Polyposis

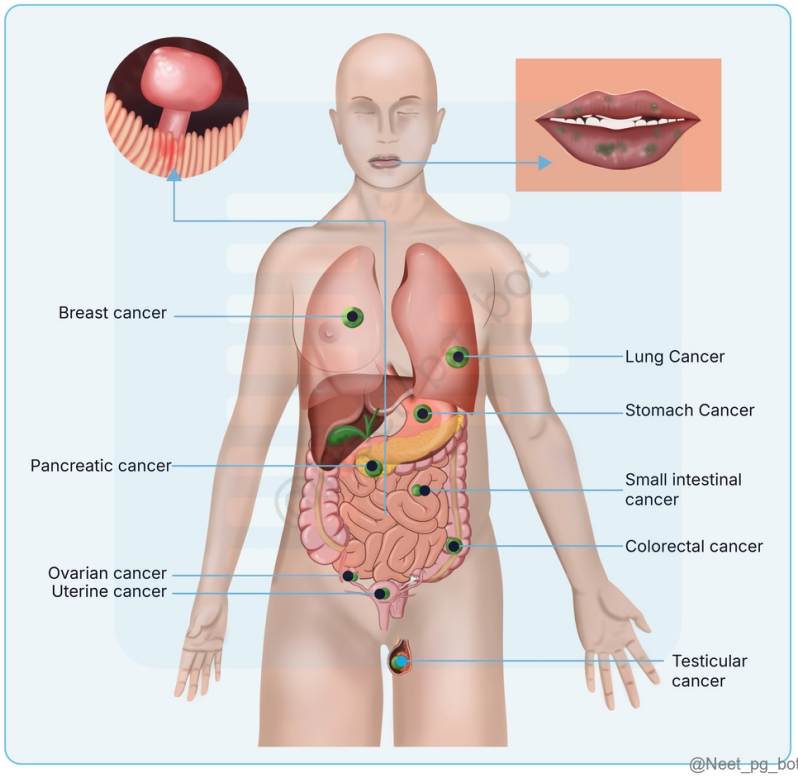
B. Peutz-Jeghers Syndrome

C. Juvenile Polyposis Syndrome

D. Cronkhite-Canada Syndrome

Correct Answer: B. Peutz-Jeghers Syndrome

Explanation: Based on the above signs and symptoms, this classic triad is diagnostic of Peutz–Jeghers syndrome (PJS) , a rare autosomal dominant disorder caused by STK11/LKB1 gene mutation. There is an increased risk for multiple cancers: GI (colon, stomach, pancreas), breast, ovary, cervix, and testes. Peutz–Jeghers Syndrome (PJS): Inheritance: Autosomal dominant. Gene: STK11/LKB1 tumor suppressor gene mutation (chromosome 19p13.3). Pathology: Multiple hamartomatous polyps (non-neoplastic, but with malignant potential due to genetic instability). Features: Mucocutaneous pigmentation → dark spots on lips, buccal mucosa, fingertips. Pigmentation is due to melanin deposition in the basal cell layer (resembles freckles, but in the mucosa too). Hamartomatous polyps predominantly in the small intestine (especially jejunum). Symptoms: abdominal pain, GI bleeding, intussusception (due to large polyps). Complications: Intussusception (the most common acute presentation in children) GI bleeding → anemia Malignancy risk: GI tract (esp. pancreas), breast, gonadal tumors Management: Symptomatic relief for obstruction/bleeding Endoscopic polypectomy for large polyps Cancer surveillance: colonoscopy, upper GI endoscopy, pancreatic screening Familial Adenomatous Polyposis (Option A) – Hundreds to thousands of adenomatous (not hamartomatous) polyps in the colon, due to APC gene mutation; no mucocutaneous pigmentation. Juvenile Polyposis Syndrome (Option C) – Multiple juvenile polyps (hamartomas) in colon/rectum, usually <5 years; no mucocutaneous pigmentation. Cronkhite–Canada Syndrome (Option D) – Non-hereditary, middle-aged adults; GI polyps + alopecia, skin hyperpigmentation, nail atrophy (but not perioral mucosal pigmentation pattern).





References:

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↑ *Back to this question in Part A*

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Q7: Identify the pathology in the child. (Q866930)

A. Umbilical Hernia

B. Spigelian Hernia

C. Inguinal Hernia

D. Femoral Hernia



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Correct Answer: A. Umbilical Hernia

Explanation: The image shows a soft swelling at the umbilicus in a child, which is characteristic of an Umbilical Hernia . Definition: Protrusion of abdominal contents through the umbilical ring due to incomplete closure of the abdominal wall after birth. Typical presentation in children: Soft bulge at the navel. More prominent when the child cries, coughs, or strains. Usually painless. Etiology: Common in infants, especially premature babies, due to delayed closure of the umbilical ring. Prognosis: Most close spontaneously by 2–3 years of age. Spigelian Hernia (Option B): Occurs along the semilunar line (lateral edge of the rectus abdominis muscle), not at the umbilicus. Inguinal Hernia (Option C): Presents as swelling in the groin or scrotum, not at the umbilicus. It is commonly due to a patent processus vaginalis. Femoral Hernia (Option D): Appears as swelling below the inguinal ligament , more common in adult females.

References:

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↑ *Back to this question in Part A*

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Q8: Which of the following veins are involved in the formation of esophageal varices? (Q866934)

A. Left gastric vein

B. Right gastric vein

C. Left gastroepiploic vein

D. Right gastroepiploic vein

Correct Answer: A. Left gastric vein

Explanation: Esophageal varices occur due to portal hypertension (commonly from liver cirrhosis). In portal hypertension, blood flow is obstructed in the portal vein, leading to the formation of portosystemic anastomoses. One important site is lower esophagus, where: Portal circulation: Left gastric vein (drains into portal vein) Systemic circulation: Esophageal veins (drain into azygos vein → superior vena cava) Increased pressure in the left gastric vein causes dilated submucosal esophageal veins → varices. Right gastric vein (Option B): Drains the lesser curvature of the stomach. It connects to the portal vein, but not a major contributor to lower esophageal varices. Left gastroepiploic vein (Option C): Drains the greater curvature of the stomach into the splenic vein (portal system). It is not involved in esophageal portosystemic anastomosis. Right gastroepiploic vein (Option D): Drains into the superior mesenteric vein (portal system). It has no role in esophageal varices.

↑ *Back to this question in Part A*

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Q9: A 22-year-old male presents to the emergency department with a 12-hour history of abdominal pain that started around the umbilicus and has now localised to the right lower quadrant. He also reports nausea and loss of appetite. On examination, he has tenderness in the right iliac fossa with rebound tenderness. His temperature is 38.2°C. Laboratory investigations reveal a white blood cell count of 14,000/mm 3 with a left shift. What is his pain score? (Q865323)

A. 5

B. 7

C. 8

D. 10

Correct Answer: D. 10

Explanation: The Alvarado score is a clinical scoring system used to help diagnose acute appendicitis. The score is based on symptoms, signs, and laboratory results, with a score of 7 or more being strongly predictive of acute appendicitis. A score of 5 is equivocal, suggesting additional investigation with USG or CECT for the confirmation of the diagnosis of acute appendicitis. MANTREL Score Migratory pain 1 Anorexia 1 Nausea, Vomiting 1 Tenderness 2 Rebound tenderness 1 Elevated Temperature 1 Leukocytosis 2 Shift to Left 1 Score of 9-10: Diagnosis is certain Score of 7-8: High likelihood of diagnosis Score of 5-6: Equivocal (most dangerous) CECT is indicated in cases of Equivocal MANTREL score findings to confirm the diagnosis. Score of 1-4: Negative for acute appendicitis According to the given situations MANTREL Pesent/Absent Score Migratory pain

Present 1 Anorexia Present 1 Nausea, Vomiting Present 1 Tenderness Present 2 Rebound tenderness Present 1 Elevated Temperature Present 1 Leukocytosis Present 2 Shift to Left Present 1 Hence, total MANTRELS score = 1 + 1 + 1 + 2 + 1 + 1 + 2 + 1 = 10

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1342

↑ *Back to this question in Part A*

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Q10: A 65-year-old patient undergoes colonoscopy for evaluation oc altered bowel habits. A 6cm colonic mass is identified and biopsied. Histopathology confirms adenocarcinoma that is confined to the mucosal layer, with no evidence of invasion into the submucosa or beyond. Imaging studies show no lymph node involvement or distant metastasis. Based on this information, what is the most appropriate TNM stage of this tumour? (Q865328)

A. Stage I

B. Stage IIA

C. Stage IIB

D. Stage 0

Correct Answer: D. Stage 0

Explanation: ■■This patient's colon cancer is confined to the mucosal layer (also known as carcinoma in situ) and does not invade the submucosa . According to the TNM (Tumor, Node, Metastasis) staging system, it is Stage 0. TNM classification of colon cancer T (Tumor) Tis Carcinoma in situ/tumor confined to mucosa T1 Tumor invades the submucosa T2 Tumor invades the muscularis propria T3 Tumor invades through subserosa or into pericolorectal tissues T4a Tumors breaches visceral peritoneum T4b Tumor directly invades or is adherent to other organs or structures. N (Lymph Node) N1a Metastasis in 1 regional lymph node. N1b Metastasis in 2-3 regional lymph nodes. N1c Tumor deposits in the subserosa, mesentery, or non-peritonealized pericolic or perirectal tissues without regional nodal metastasis. N2a Metastasis in 4-6 regional lymph nodes. N2b Metastasis in 7 or more regional lymph nodes. M (Metastasis) M1a Metastasis confined to one organ or site M1b Metastasis to more than one organ/site or the peritoneum. M1c Metastasis to the peritoneum with or without other organ involvement. Stage 0: Tis N0 M0 Stage 1: T1/T2 N0 M0 (Option A) Stage IIA: T3 N0 M0 (Option B) Stage IIB: T4a N0 M0 (Option C) Stage IIC: T4a N0 M0 Stage IIIA: T1/T2 N1/N1c M0 or T3/T4 N2a M0 Stage IIIB: T3/T4a N1/N1c M0 or T2/T3 N2a M0 or T1-T2 N2b M0 Stage IIIC: T4a N2a M or T3/T4a N2b M0 or T4b N1/N2 M0 Stage IVA: anyT anyN M1a Stage IVB: anyT anyN M1b Stage IVC: anyT anyN M1c

References:

Bailey & Love's Short Practice of Surgery, 28th edition, Page 1360

TNM classification

↑ *Back to this question in Part A*

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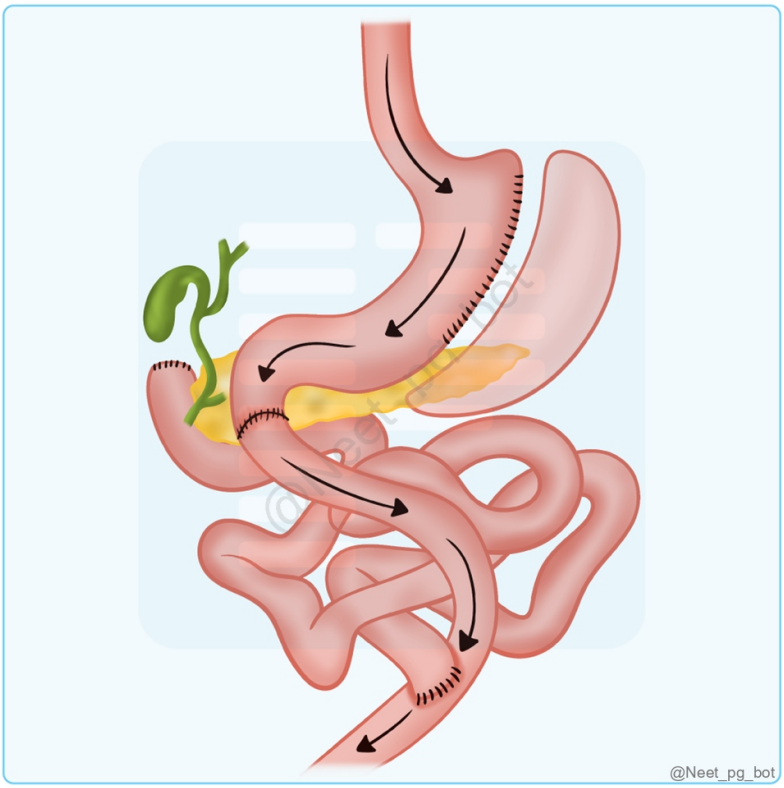
Q11: Identify the procedure done? (Q865332)

A. Single Anastamosis Duodenal-Ileal Bypass with Gastrectomy

B. Gastric bypass

C. Sleeve Gastrectomy

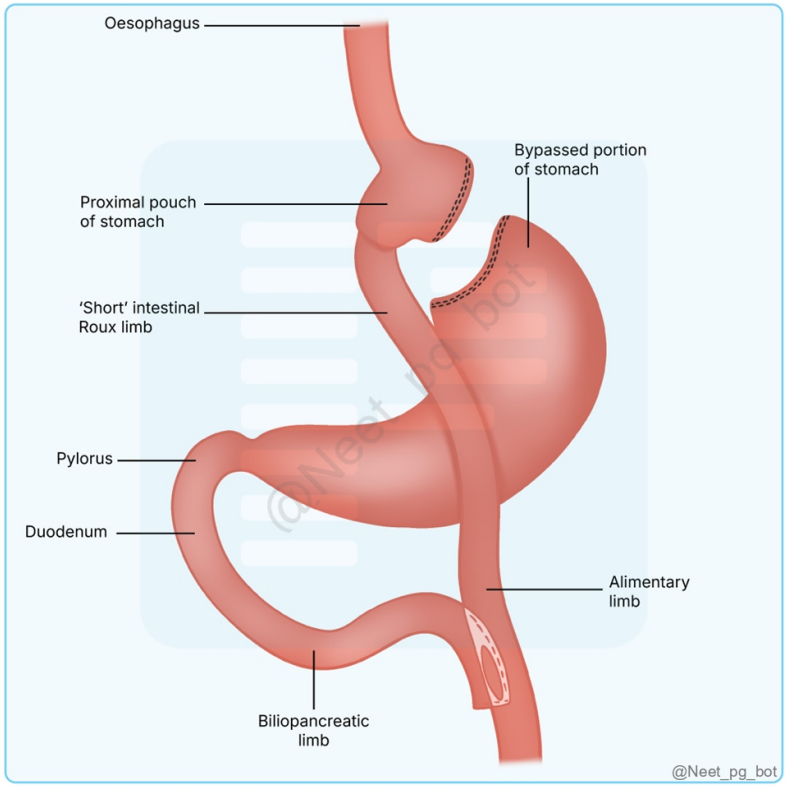
D. Adjustable gastric banding

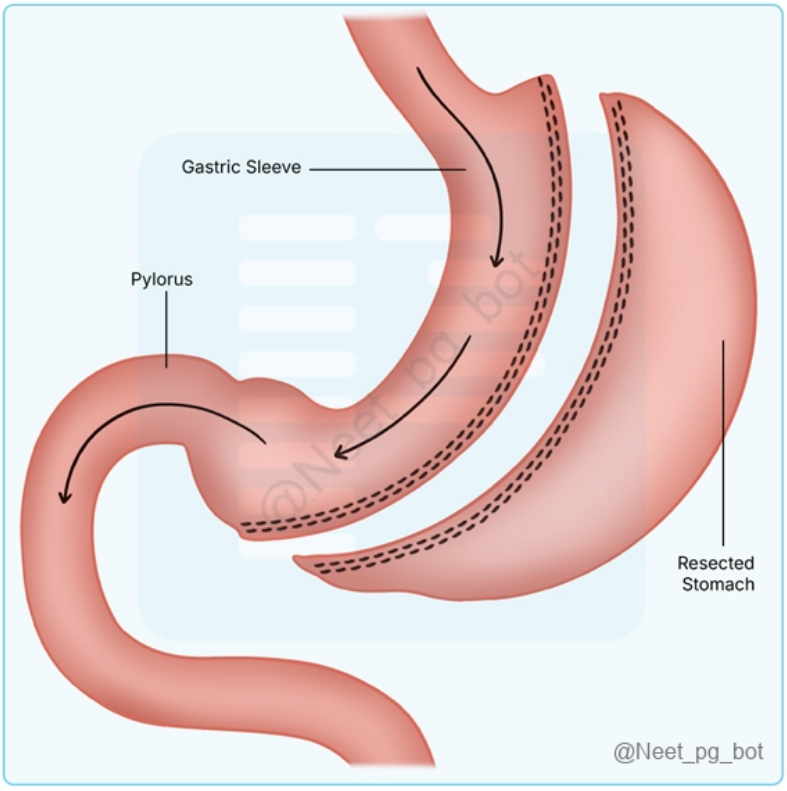


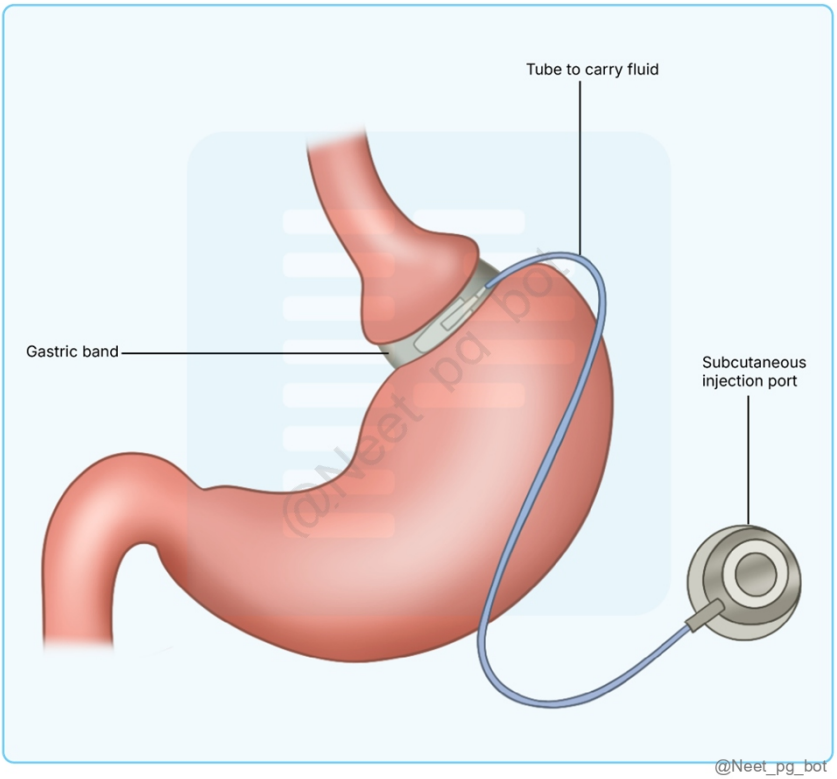
Correct Answer: A. Single Anastamosis Duodenal-Ileal Bypass with Gastrectomy

Explanation: The image is a Single Anastomosis Duodenal-Ileal Bypass with Gastrectomy. It is a is a bariatric surgery combining: Sleeve gastrectomy & Single anastomosis of the duodenum (just distal to the pylorus) directly to the ileum. Indications for bariatric surgery: International Population Asian Population (metabolic surgery) BMI ≥ 40kg/m2 with/without comorbidities (Option A) BMI ≥ 35kg/m2 with comorbidities (Option B) BMI ≥

37.5kg/m2 with/without comorbidities (Option D) BMI ≥ 32.5kg/m2 with comorbidities Gastric bypass (Option B) also Roux-en-Y involves the creation of a small gastric pouch from the proximal end of the stomach, which is then connected with the distal jejunum. It is different from the single anastomosis in SADI-S Sleeve Gastrectomy (Option C) involves resection of a large part of the stomach, which regulates appetite, creating a tube-like structure. It does not require gastrointestinal anastomosis or intestinal bypass. Adjustable gastric banding (Option D) is a purely restrictive bariatric procedure that creates a small proximal gastric pouch by placing an adjustable band around the stomach just below the cardia.







References:

Bailey & Love’s Short Practice of Surgery, Edition 28, Pages 1186,1187,1189

↑ *Back to this question in Part A*

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Q12: A 35-year-old patient presents with a history of diarrhea associated with blood in stool for several weeks. On examination, the patient is febrile and has abdominal distension and tenderness. A CT scan (coronal view) shows a grossly dilated colon with loss of haustrations. Laboratory investigations reveal leukocytosis and elevated inflammatory markers. Based on the clinical and radiological findings, what is the most likely diagnosis? (Q865369)

A. Ulcerative colitis

B. Crohn's disease

C. Colonic carcinoma

D. Intestinal tuberculosis

Correct Answer: A. Ulcerative colitis

Explanation: The clinical presentation and CT findings are suggestive of Toxic megacolon , which is a severe complication most commonly associated with Ulcerative colitis. It is a potentially life-threatening condition characterised by rapid dilation of the colon, systemic toxicity, and risk of perforation . Ulcerative colitis is a type of Inflammatory Bowel Disease (IBD) that presents with abdominal pain, diarrhoea, and rectal bleeding as it primarily affects the colon and almost always involves the rectum with broad areas of ulceration. Skip lesions, bowel wall thickening, and perianal manifestations like fissures and granulomas are uncommon in Ulcerative colitis. Complications of Ulcerative Colitis Complications of Crohn’s disease (Option B) Toxic megacolon Intestinal perforation Anaemia Colonic malignancy (UC is a premalignant condition) Perianal fistula Abscess Malabsorption syndrome Strictures Intestinal obstruction Colonic carcinoma (Option C) usually presents with weight loss, anaemia, and change in bowel habits , but not commonly with acute febrile illness or diffuse colonic dilatation. ■■■Intestinal tuberculosis (Option D) commonly affects the ileocecal region, presents with chronic symptoms like abdominal pain, weight loss, and sometimes obstruction, but not normally with toxic megacolon.

References:

Harrison’s Principles of Internal Medicine, 21st Edition, Pages 2475-2477

↑ *Back to this question in Part A*

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Q13: Which of the following is incorrectly matched with its corresponding scoring or classification system? (Q865384)

A. Pancreatitis -Atlanta classification

B. Achalasia - Los Angeles Score

C. Colonoscopy - Boston Score

D. Parathyroid - Miami criteria

Correct Answer: B. Achalasia - Los Angeles Score

Explanation: Achalasia is staged using the Eckardt score (symptom-based) or Chicago classification (manometry-based). The Los Angeles (LA) classification is used for Reflux esophagitis, not achalasia. Pancreatitis is graded using the Revised Atlanta Classification (Option A) The Boston Bowel Preparation Scale (BBPS) (Option C) assesses colonoscopy cleanliness. The Miami criteria (Option D) guide intraoperative parathyroid hormone (PTH) monitoring in primary hyperparathyroidism surgery. A drop in the PTH into the normal range and to less than half the maximum preoperative PTH at 10 minutes appears to accurately predict single-gland disease.

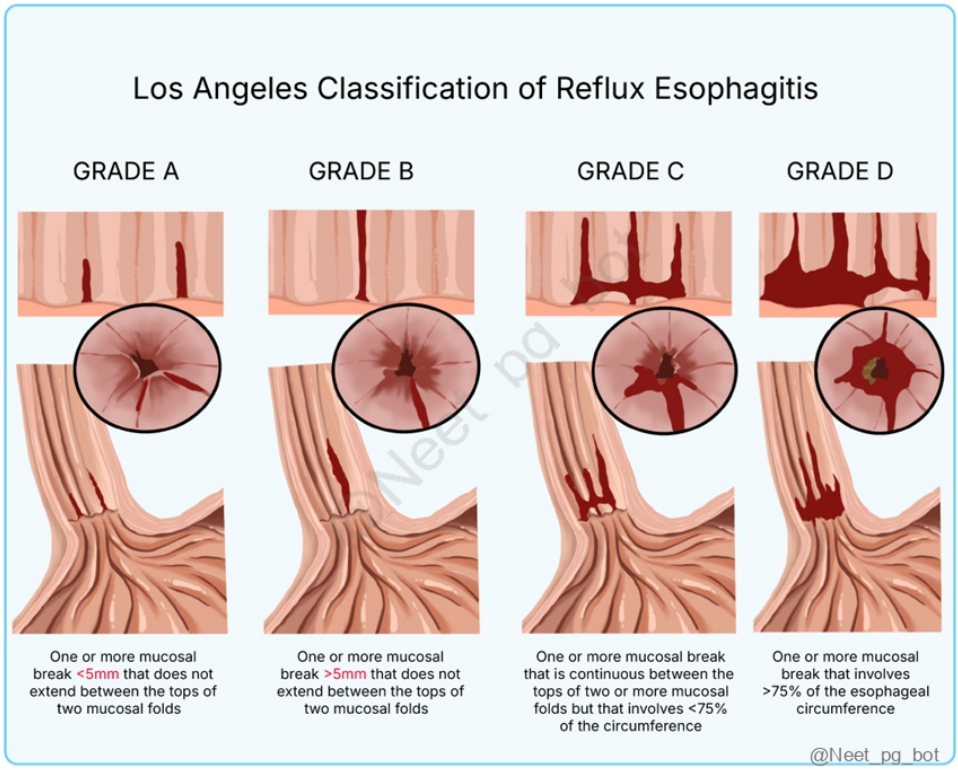
Achalasia Severity: Eckardt Score

	Score for each symptom/sign			
Symptom/Sign	0	1	2	3
Recent weight loss (Kg)	none	< 5	5-10	>10
Dysphagia	none	occasional	daily	each meal
Chest pain	none	occasional	daily	several times/day
Regurgitation	none	occasional	daily	each meal

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The Chicago Classification of Esophageal Motility	
Criteria	
Achalasia and Esophagogastric Junction Outflow Obstruction • Type I achalasia (Classic) • Type II achalasia (with esophageal compression) • Type III achalasia (Spastic achalasia) • Esophagogastric junction outflow obstruction (achalasia in evolution)	• Median IRP >15 mm Hg, 100% failed peristalsis (DCI <100 mm Hg/s/cm); premature contractions with DCI <450 mm Hg-s-cm satisfy criteria for failed peristalsis. • Median IRP >15 mm Hg; 100% failed peristalsis, paraesophageal pressurization with ≥20% of swallows • Median IRP >15 mm Hg; no normal peristalsis, spastic contractions with DCI >450 mm Hg/s/cm with ≥20% of swallows. • Median IRP >15 mm Hg; sufficient evidence of peristalsis such that criteria for types I-III are not met.
Major Disorders of Peristalsis • Absent contractility • Distal esophageal spasm • Hypercontractile esophageal (nutcracker/jackhammer esophagus)	• Normal median IRP, 100% failed peristalsis • Normal median IRP, >20% premature contractions with DCI >450 mmHg /s/cm. • At least 2 swallows with DCI 8000 mm Hg/s/cm.
Minor Disorders of Peristalsis • Infective esophageal motility • Fragmented peristalsis **Normal esophageal motility**	• >50% ineffective swallows • >50% fragmented contractions with DCI >450 mm Hg-s-cm • None of the above criteria are met

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References:

Sabiston Textbook of Surgery, 21st Edition, Page 1425.

Schwartz's Principles of Surgery, 11th Edition, Page 1012, 1008.

Bailey and Love Short Practice of Surgery, 28th Edition, Page 880.

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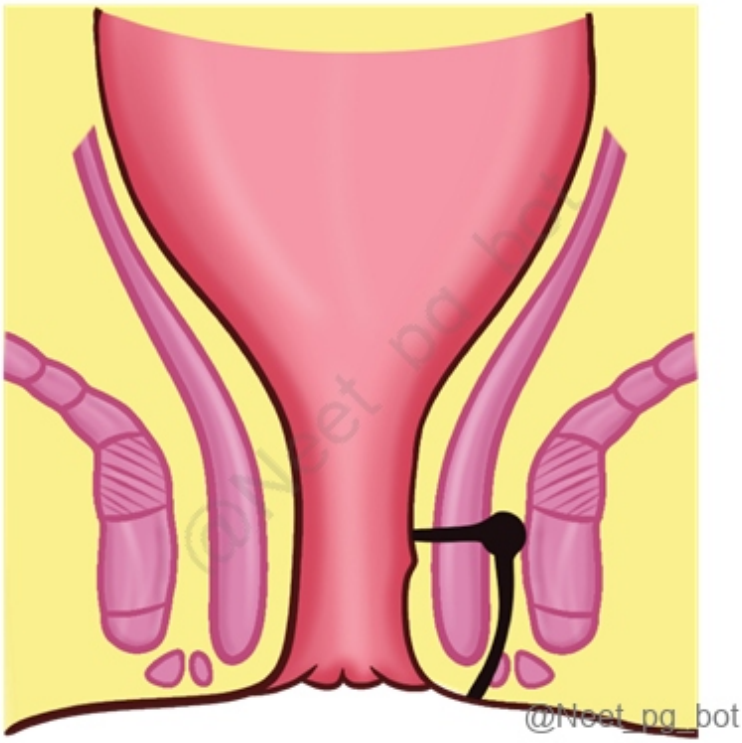
Q14: Identify the fistula according to park's classification? (Q866417)

A. Intersphincteric

B. Supra-sphincteric

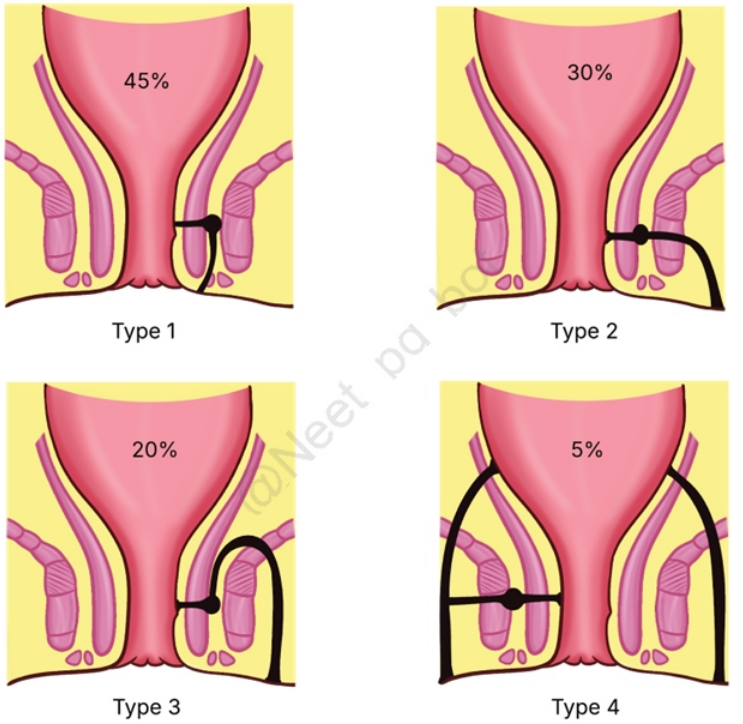
C. Extra-sphincteric

D. Trans-sphincteric high



Correct Answer: A. Intersphincteric

Explanation: The given image depicts an intersphincteric fistula. Parks classification: Type 1 Inter- sphincteric (most common, 70%) Type 2 Trans- sphincteric (25%) Type 3 Supra-sphincteric (4%) Type 4 Extra- sphincteric (1%)



References:

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↑ *Back to this question in Part A*

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Q15: During ward rounds, you encounter a patient who has been admitted with esophageal carcinoma. What is the most likely presentation for this patient? (Q853041)

A. Dysphagia of liquids followed by solids

B. Dysphagia of solids followed by liquids

C. Chest pain

D. Neck mass

Correct Answer: B. Dysphagia of solids followed by liquids

Explanation: Esophageal carcinoma typically presents with dysphagia, initially to solids and later to liquids , as the tumour obstructs and narrows the esophagus. Carcinoma Esophagus Types Squamous Cell Carcinoma Adenocarcinoma Risk Factors Squamous Cell Carcinoma: Smoking, Alcohol, Hot beverages, N-nitroso foods, Adenocarcinoma: Obesity, Gastroesophageal reflux, Barrett's esophagus Clinical Features Progressive dysphagia (initially for solids followed by liquids), Anorexia, Weight loss , Odynophagia, and Regurgitation. Advanced symptoms: Hoarseness, Aspiration, Choking, etc. Investigation Endoscopy: Tumor visualisation, Biopsies, Chromoendoscopy, NBI Barium contrast study: Tumor as ulcerated/stenotic lesion Bronchoscopy: Check airway spread Endoscopic & Percutaneous Ultrasonography: EUS for staging tumour (T stage) and para esophageal nodes Percutaneous ultrasound of cervical nodes with FNA CT scan: Distant node assessment FDG-PET scan: Detects nodes/metastases, not for tumour staging Dysphagia of liquids followed by solids (Option A) is more typical of conditions like achalasia cardia , which leads to a loss of peristalsis in the lower oesophagus and failure of the lower oesophagal sphincter (LES) to relax during swallowing. Chest pain (Option C) can occur in esophageal carcinoma; it is less common as an initial presentation compared to dysphagia . Chest pain in esophageal cancer usually occurs in advanced stages or if there is tumour invasion into nearby structures . Neck mass (Option D) can occur if the cancer metastasises to the lymph nodes in the neck (e.g., Virchow's node), but this is not the most common initial presentation.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Pages 1135, 1136, 1137, 1138, 1139.

↑ *Back to this question in Part A*

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Q16: A 30-year-old patient with peptic ulcer disease presents with persistent abdominal pain despite treatment at multiple hospitals. He has ulcers in the jejunum and ileum. His gastric pH is <2, and after discontinuing PPIs, his gastrin levels are 10 times higher than normal. What is the likely lesion, and what are the boundaries of the triangle containing it? (Q853042)

A. Insulinoma; triangle formed

B. ■■■Insulinoma; triangle formed by cystic duct, junction of D2-D3, neck and body of pancreas

C. Gastrinoma; triangle formed by cystic duct, junction of D2-D3, neck and body of pancreas

D. Gastrinoma; triangle formed by only common bile duct, junction of D2-D3, neck and body of pancreas

Correct Answer: C. Gastrinoma; triangle formed by cystic duct, junction of D2-D3, neck and body of pancreas

Explanation: This patient’s clinical presentation of persistent peptic ulcers , especially in the jejunal and ileal regions , combined with elevated gastrin levels (even after stopping PPIs) and a gastric pH <2 , is highly suggestive of a gastrinoma . Gastrinomas are tumours that secrete excess gastrin, commonly leading to

Zollinger-Ellison syndrome , which causes multiple peptic ulcers due to high gastric acid production. The gastrinoma triangle refers to a specific anatomical region in the pancreas where gastrinomas are most commonly located. (Pissaros triangle) this triangle is bordered by: Junction between cystic duct and CBD (option D ruled out) Junction of the 2nd and 3rd parts of the duodenum (D2-D3 junction) Junction between the head and neck of the pancreas Insulinoma; triangle formed (Option A) : Insulinomas are pancreatic tumours that secrete insulin , not gastrin . They cause hypoglycemia rather than peptic ulcers, so this option doesn't fit with the patient's symptoms or diagnostic findings. (Option B ruled out)

References:

SRB's Manual of Surgery, 6th Edition, Page 703

↑ *Back to this question in Part A*

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Q17: An intern assists in laparoscopic surgery, and the resident explains the instruments and operating ports. The surgeon then asks, "What is the angle between the camera port and the working port called?" (Q853044)

A. Azimuth's angle

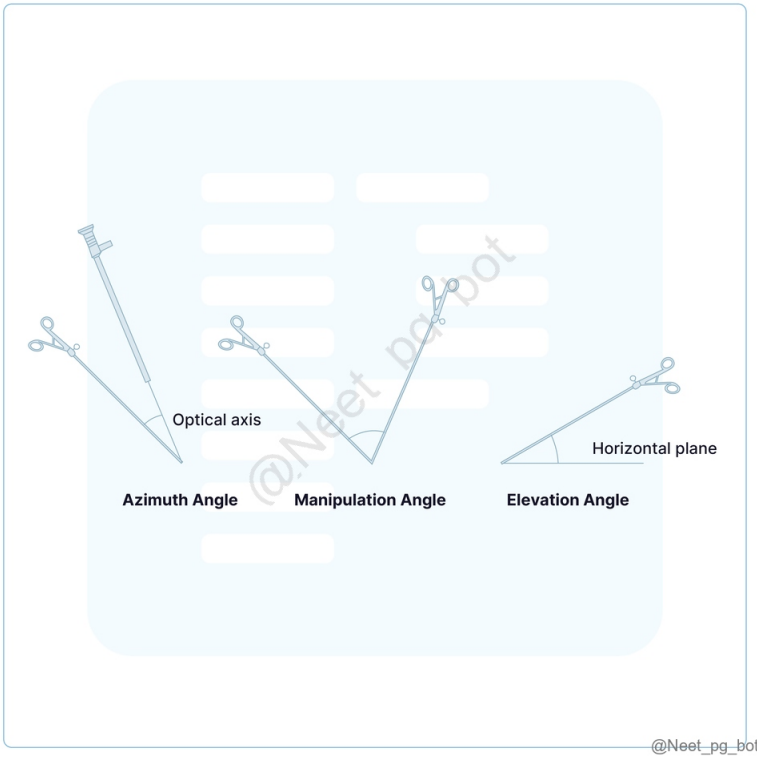
B. ■■■Elevation angle

C. Crossing angle

D. Manipulation angle

Correct Answer: A. Azimuth's angle

Explanation: Azimuth's angle is the correct term for describing the angle between the camera port and the working port in laparoscopic surgery. The ideal azimuth angle is between 30 - 45° for maximum productivity. Angles of laparoscopy Azimuth angle It is the angle between the camera port and the working port in laparoscopic surgery; the ideal azimuth angle is between 30 - 45° to avoid clashing of the instruments. Manipulation angle It is the angle between two working ports, and the ideal angle for this is 60°. Elevation angle This term is more related to the vertical positioning of instruments or the camera in relation to the surgical field, not the angle between ports; the ideal angle for this is also 60°. Crossing angle (Option C) is not a term specifically used to describe the angle between the camera port and the working port.



References:

NIHLink

ArticleLink

↑ *Back to this question in Part A*

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Q18: What is the Truelove and Witts classification used for? (Q853059)

A. ■■■Acute severe ulcerative colitis

B. ARDS

C. Acute encephalitis

D. Acute pancreatitis

Correct Answer: A. ■■■Acute severe ulcerative colitis

Explanation: The Truelove and Witts classification is specifically used to assess the severity of ulcerative colitis (UC). Truelove and Witts classification for Ulcerative Colitis Severity Stool Frequency Systemic Symptoms and

signs Mild <4 stools/day No systemic signs of toxicity Moderate >4 stools/day Fever, abdominal pain, Elevated ESR, CRP Severe >6 stools/day Fever, tachycardia, anaemia, systemic illness, hypoalbuminemia, Elevated ESR, CRP Fulminant >10 stools/day Continuous bleeding, fever, tachycardia, abdominal tenderness & distension, “Toxic megacolon” (progressive colonic dilation, an indication for emergency surgery) in severe cases ARDS (Option B) is acute respiratory distress syndrome involving the lungs, and the Truelove and Witts classification is not used for this. Acute encephalitis (Option C) is an inflammation of the brain, typically caused by infection, and the Truelove and Witts classification has no role here. Acute pancreatitis (Option D) is an inflammation of the pancreas, and it is not evaluated using the Truelove and Witts classification.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Pages 1319

↑ *Back to this question in Part A*

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Q19: Match the following diseases with their respective gene mutation: A. Familial adenomatous polyposis i. SMAD4 B. Juvenile polyposis ii. STK11 C. Tuberous sclerosis iii. APC gene D. Peutz-Jeghers syndrome iv. TSC1 (Q853060)

A. A-i, B-ii, C-iii, D-iv

B. A-ii, B-iii, C-i, D-iv

C. A-iii, B-i, C-iv, D-ii

D. A-iv, B-ii, C-iii, D-i

Correct Answer: C. A-iii, B-i, C-iv, D-ii

Explanation: A. Familial adenomatous polyposis iii. APC gene It is an a utosomal dominant disorder caused by APC gene mutations on chromosome 5. It is characterised by numerous intestinal polyps, which, if left untreated, have a h igh risk of developing colorectal cancer B. Juvenile polyposis i. SMAD4 It is also an autosomal dominant disorder that commonly affects children under 5 years of age, It is characterised by pedunculated polyps, usually less than 3 cm in diameter. It is linked to mutations in the SMAD4 and BMPR1A genes , part of the TGF-β signalling pathway. C. Tuberous sclerosis iv. TSC1 It is a neurocutaneous disorder resulting from mutations in the TSC1 (hamartin) or TSC2 (tuberin) genes. Patients exhibit neurological symptoms like seizures, along with skin abnormalities. The syndrome also includes hamartomatous polyps in the intestine. D. Peutz-Jeghers syndrome ii. STK11 It is also an autosomal dominant disorder caused by a loss-of-function mutation in the STK11 gene . It presents around 11 years of age and is characterised by Gastrointestinal hamartomatous polyps, especially in the small intestine Mucocutaneous hyperpigmentation (macules on lips, nostrils, buccal mucosa, and extremities).

References:

Robbins and Cotran’s Pathologic Basis of Disease, 10th Edition, Pages 808, 809, 812

↑ *Back to this question in Part A*

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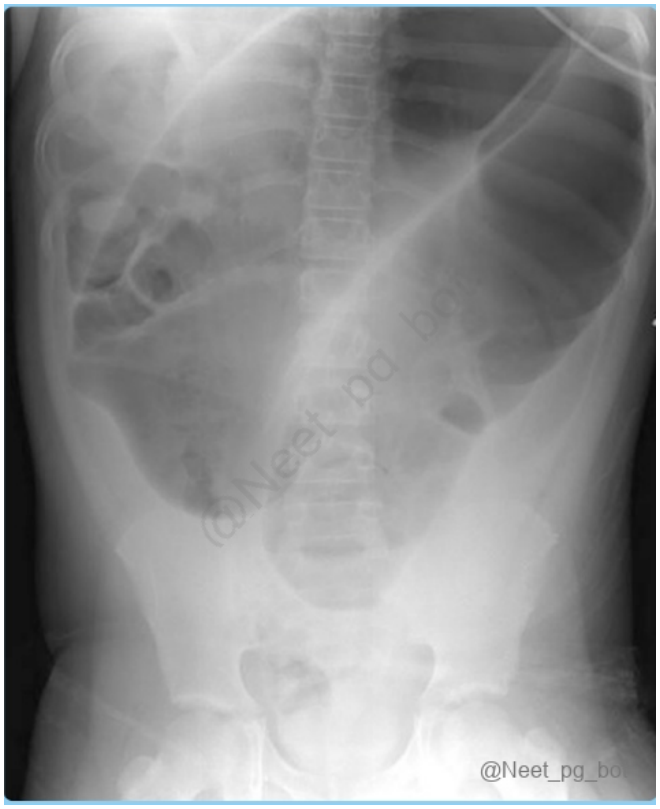
Q20: A 33-year-old male presents with sudden onset acute abdominal pain, constipation for 1 day, persistent hiccups, and occasional vomiting. An abdominal X-ray was performed. Identify the pathology. (Q852686)

A. Sigmoid volvulus

B. Caecal volvulus

C. Intussusception

D. Dynamic obstruction



Correct Answer: A. Sigmoid volvulus

Explanation: Clinical Features Suggest Bowel Obstruction: Acute abdominal pain and constipation are classic features. Persistent hiccups suggest diaphragmatic irritation due to massive bowel distension. Vomiting occurs as obstruction progresses. X-ray Findings: Massively dilated sigmoid colon with a characteristic "coffee bean" or "omega loop" sign . Few or no air-fluid levels , differentiating it from a small bowel obstruction. Absence of significant small bowel dilatation , favoring sigmoid over caecal volvulus. Management: Initial: Sigmoidoscopic

detorsion. Definitive: Elective sigmoidectomy to prevent recurrence. Emergency: If gangrene or perforation is suspected, immediate surgery is required . Volvulus Types & Features Feature Sigmoid Volvulus Caecal Volvulus Cause Twisting of sigmoid colon on its mesentery Twisting of caecum & ascending colon X-ray Sign "Coffee bean" or "Omega loop" sign "Comma" or "Kidney bean" sign Bowel Dilatation Sigmoid colon massively distended Dilated caecum, displaced medially Management Endoscopic detorsion or surgery Surgery (right hemicolectomy if gangrenous) Caecal Volvulus (Option B): incorrect because caecal volvulus typically shows a comma-shaped distended caecum in the right abdomen , unlike the coffee bean sign of sigmoid volvulus . Intussusception (Option C): incorrect because intussusception presents with a target sign on ultrasound , rather than massive colonic dilation on X-ray. Dynamic Obstruction (Option D): incorrect because sigmoid volvulus is a mechanical obstruction rather than a functional or paralytic one.

References:

Bailey & Love's Short Practice of Surgery- 28th Edition, Page 1293, 1380, 1383, 1385, 1390

SRB’s Manual of Surgery- 6th Edition, Page 922, 923.

↑ *Back to this question in Part A*

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Q21: A 34-year-old male undergoes an open appendectomy for acute appendicitis. The choice of incision was McBurney's incision. Postoperatively, after a few days, he presents with pain and bulging in the right lower quadrant, which is diagnosed as an indirect inguinal hernia. Which nerve injury during the appendectomy is most likely responsible for this complication? (Q852703)

A. Ilioinguinal nerve

B. Femoral nerve

C. Genitofemoral nerve

D. Pudendal nerve

Correct Answer: A. Ilioinguinal nerve

Explanation: Injury to the ilioinguinal nerve during an appendectomy, especially with McBurney's incision, is a documented complication that can lead to weakness of the inguinal canal structures. This weakness can predispose the patient to the development of an indirect inguinal hernia. The complications associated with appendectomy are listed below: Complication Description 1. Wound infection The MC postoperative complication involves infection at the surgical site. 2. Intraabdominal abscess Collection of pus within the abdominal cavity, typically due to infection. 3. Ileus Temporary cessation of bowel function, leading to abdominal distension and discomfort. 4. Venous thrombosis leading to embolism Formation of blood clots in the veins, which can travel to the lungs or other parts of the body. 5. Portal pyaemia (Pylephlebitis) Infection and thrombosis of the portal vein, a rare but serious complication. 6. Adhesive intestinal obstruction Formation of scar tissue causing bowel obstruction; MC

late complication 7. Fecal fistula Leakage from the appendiceal stump. 8. Nerve injury Injury to the Ilioinguinal nerve and iliohypogastric nerve

References:

SRB Manual of Surgery Edition 6th Pg. 935

↑ *Back to this question in Part A*

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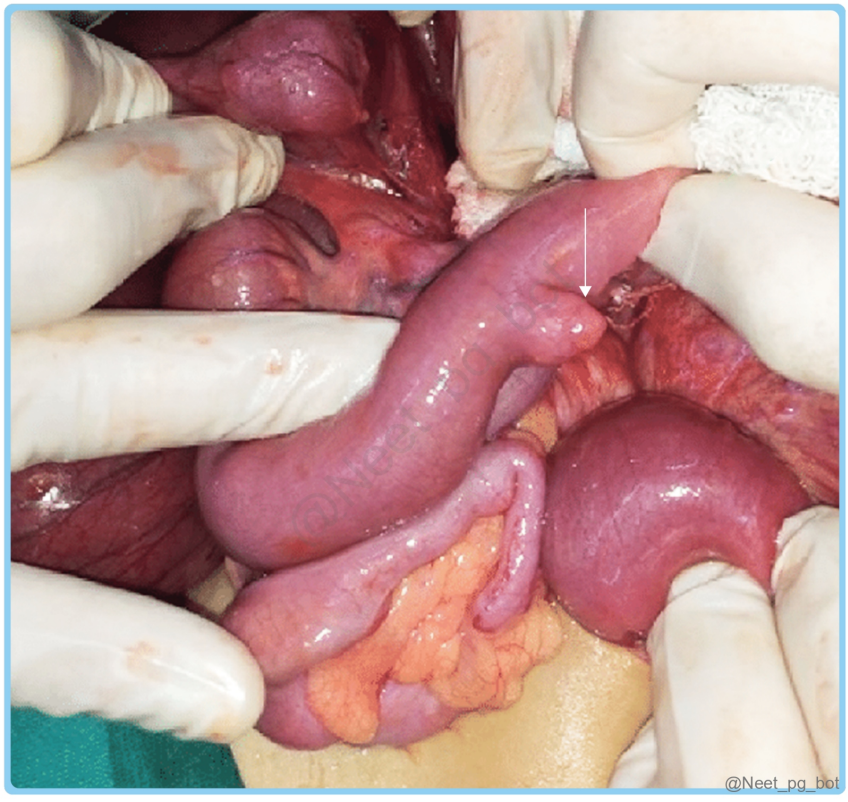
Q22: A 4-year-old boy was brought to the emergency department with complaints of melena that contains gastric mucosa and acute intermittent pain in the right iliac region. On surgical exploration, the following structure was found, what is the diagnosis? (Q852679)

A. Meckel's diverticulum

B. Appendicular lump

C. Carcinoid

D. Obstructed bowel loops



Correct Answer: A. Meckel's diverticulum

Explanation: The presence of melena (dark tarry stools) suggests gastrointestinal bleeding. The gastric mucosa in the ectopic location is a hallmark of Meckel's diverticulum. Intermittent pain in the right iliac region can occur due to inflammation or obstruction. Surgical exploration revealing a diverticular structure is characteristic of Meckel's diverticulum. Meckel's Diverticulum Feature Details Definition Congenital true diverticulum of the small intestine, resulting from the incomplete obliteration of the vitelline duct. Rule of 2's 2% population, 2 feet from the ileocecal valve, 2 inches in length, 2 types of ectopic tissue (gastric, pancreatic), 2 years most common presentation, 2:1 male predominance. Clinical Features Painless bleeding (melena), intestinal obstruction, diverticulitis, volvulus, intussusception. Diagnosis Meckel's scan (Tc-99m pertechnetate scan for ectopic gastric mucosa). Treatment Surgical resection (diverticulectomy or segmental resection) if symptomatic. Appendicular lump (Option B): incorrect because it typically presents with localized right lower quadrant pain, fever, and a mass due to inflammation, not melena or ectopic gastric mucosa. Carcinoid (Option C): incorrect because carcinoid tumors present with flushing, diarrhea, and wheezing due to serotonin secretion, not intermittent pain and melena. Obstructed bowel loops (Option D): incorrect because bowel obstruction typically presents with vomiting, distension, and absolute constipation, rather than melena and intermittent pain.

References:

Sabiston Textbook of Surgery, 21st edition, Pg.1286,1288,1289

Bailey and Love's Short Practice of Surgery, 28th Edition, Pg.1311

Meckel's diverticulum

↑ *Back to this question in Part A*

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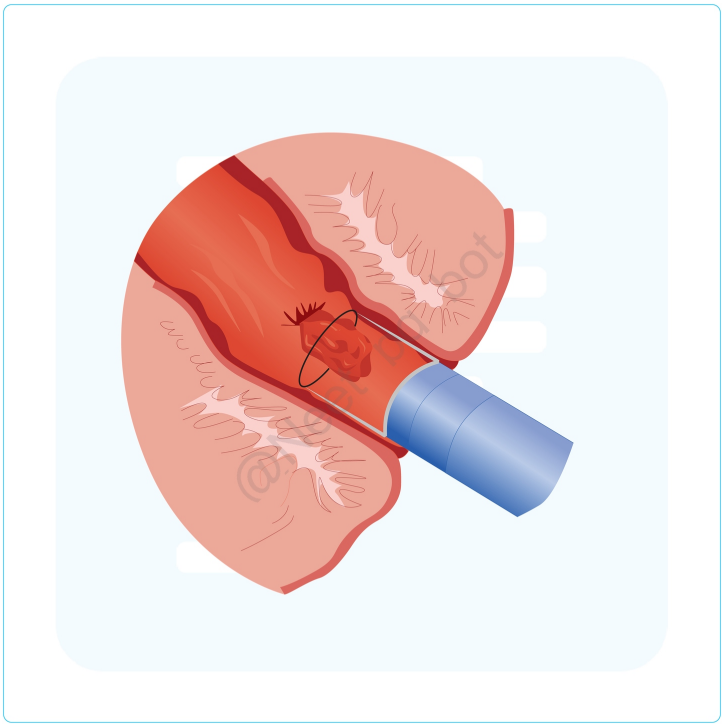
Q23: A patient with grade 4 hemorrhoids underwent surgery, identify the instrument. (Q852681)

A. Haemorrhoids resection kit

B. Stapler kit

C. Haemorrhoids band kit

D. CO2 laser



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Correct Answer: C. Haemorrhoids band kit

Explanation: Grade 4 hemorrhoids are permanently prolapsed and require surgical intervention. Rubber band ligation (RBL) is commonly used for hemorrhoid treatment, especially for grade 2 and 3 hemorrhoids , but may be attempted for early grade 4 cases before surgery. If the patient underwent surgery , the most likely instrument used would be a hemorrhoidectomy (stapler or excision-based) rather than a band kit . However, if ligation was performed prior to surgery , a haemorrhoid band kit could have been used. Hemorrhoid Treatment Options Grade of Hemorrhoids Treatment Options Grade 1 (No prolapse) Lifestyle modification, fiber, sitz bath, topical agents Grade 2 (Prolapse, spontaneous reduction) Rubber band ligation, sclerotherapy, infrared coagulation Grade 3 (Prolapse, manual reduction needed) Rubber band ligation, surgical excision if persistent symptoms Grade 4 (Irreducible prolapse) Surgical options: Hemorrhoidectomy (excision or stapler), laser hemorrhoidoplasty Haemorrhoid resection kit (Option A): incorrect because resection is not performed using a specific "kit"; rather, standard surgical instruments or a stapler are used . Stapler kit (Option B): incorrect because stapled hemorrhoidopexy (PPH) is an option, but not typically described as a "band kit" . CO2 laser (Option D): incorrect because laser hemorrhoidoplasty is an alternative to excision but is not the standard method for grade 4 hemorrhoids .

References:

Bailey & Love’s Short Practice of Surgery, 27th Edition- Page 1396-1401, 1423, 1430-33, 1435-1440

↑ *Back to this question in Part A*

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Q24: What is the most likely cause of lower right abdominal pain and rebound tenderness in a patient with Meckel's diverticulum? (Q852725)

A. Perforation

B. Intestinal obstruction

C. Appendicitis

D. Cholecystitis

Correct Answer: C. Appendicitis

Explanation: The clinical manifestations indicate acute appendicitis, despite the presence of Meckel's diverticulum. Lower right abdominal pain with rebound tenderness is a classic sign of acute appendicitis, and the presence of a Meckel's diverticulum does not change this presentation. While Meckel's diverticulum can cause abdominal pain, the specific location and presence of rebound tenderness strongly suggest appendicitis as the primary pathology. Perforation (Option A): While perforation of Meckel's diverticulum can occur, it typically presents with more diffuse abdominal pain and peritonitis rather than localized right lower quadrant pain. The presentation described is more consistent with appendicitis (Option A ruled out). Perforation would likely cause more widespread symptoms and signs of peritoneal irritation. Intestinal obstruction (Option B): Meckel's diverticulum can cause intestinal obstruction, but this typically presents with colicky abdominal pain, vomiting, and abdominal distention rather than localized rebound tenderness (Option B ruled out). The absence of these obstruction symptoms makes this diagnosis less likely. Cholecystitis (Option D): Cholecystitis typically presents with right upper quadrant pain and tenderness, not lower right abdominal pain. The location of pain and the presence of rebound tenderness in the right lower quadrant is inconsistent with cholecystitis (Option D ruled out). Murphy's sign would be expected in cholecystitis, which is elicited in the right upper quadrant.

References:

Schwartz's Principles of Surgery, 11th Edition, Page 1297

↑ *Back to this question in Part A*

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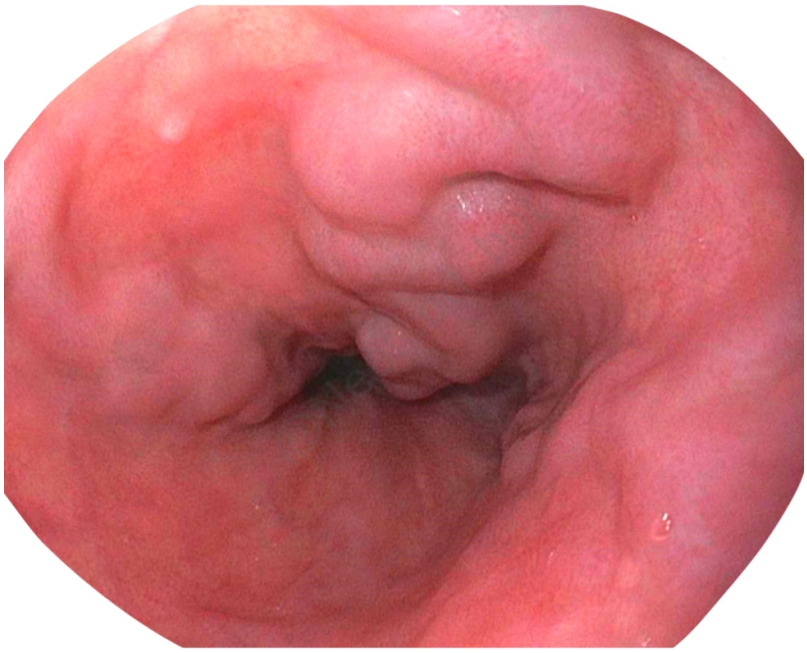
Q25: The endoscopic image shows the following finding. What is the diagnosis? (Q844309)

A. Barretts esophagus

B. Esophageal varices

C. Gastric erosion

D. Chronic GERD



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Correct Answer: B. Esophageal varices

Explanation: Correct Option B - Esophageal varices: Esophageal varices are dilated submucosal veins in the esophagus, typically seen in patients with portal hypertension, often due to liver cirrhosis. Endoscopically, they appear as prominent, tortuous veins along the esophageal wall, which is the key feature in the described image. Incorrect Options: Option A - Barrett's esophagus: Barrett's esophagus is characterized by the replacement of normal esophageal squamous epithelium with columnar epithelium due to chronic gastroesophageal reflux disease (GERD). Endoscopically, it appears as salmon-colored mucosa extending upward from the gastroesophageal junction. It does not present with dilated veins. Option C - Gastric erosion: Gastric erosions are superficial mucosal defects in the stomach lining. They may appear as small, shallow ulcers or red, inflamed areas during endoscopy, usually in the gastric mucosa, not the esophagus. Option D - Chronic GERD: Chronic GERD leads to mucosal changes in the esophagus, such as erosive esophagitis, strictures, or Barrett's esophagus. However, it does not cause the appearance of dilated veins seen with esophageal varices.

References:

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↑ *Back to this question in Part A*

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Q26: A patient presents with an umbilical hernia that was previously reducible but has now become irreducible. Which of the following is the most appropriate management option? (Q844312)

A. Umblical excision

B. Umbilical excision with mesh hernioplasty

C. Mesh hernioplasty

D. Conservative management



Correct Answer: A. Umblical excision

Explanation: Correct A - Umbilical excision: Given the change in the hernia's characteristics from reducible to irreducible, surgical intervention with umbilical excision is the most appropriate treatment to address the potential complications associated with the irreducible mass. surgical intervention should focus on excising the strangulated tissue and do suture repair. Then plan for a definite repair after few days. Incorrect Options: Option B - Umbilical excision with mesh hernioplasty: This option combines the excision of the umbilicus with the reinforcement of the abdominal wall using a mesh to prevent recurrence. It is often used in larger hernias or when there is significant weakening of the abdominal wall. Mesh hernioplasty is contraindicated in stangulation Option C - Mesh hernioplasty: This involves reinforcing the abdominal wall defect with a mesh without excising the umbilicus. It is generally used for larger or recurrent hernias to prevent recurrence. However, in the case of an irreducible hernia with concern about the umbilical skin viability, mesh hernioplasty is contraindicated in stangulation Option D - Conservative management: Conservative management is generally not appropriate for an irreducible hernia, as

there is a risk of complications such as strangulation or bowel obstruction.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1062, 1074

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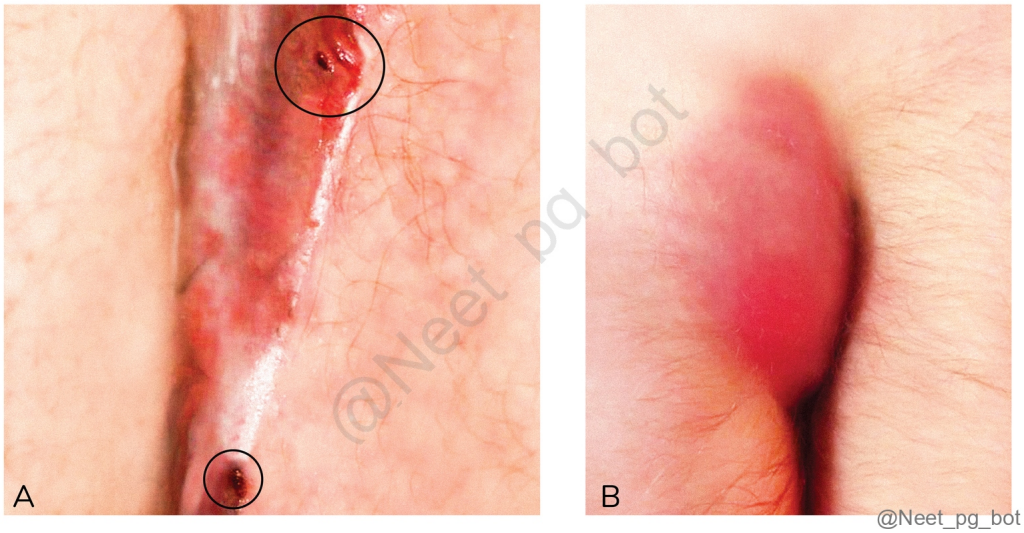
Q27: A jeep driver presented with pain in the gluteal region along with swelling. What is the most likely diagnosis? (Q844317)

A. Pilonidal sinus

B. Fistula in ano

C. Fissure in ano

D. Gluteal abscess



Correct Answer: A. Pilonidal sinus

Explanation: Correct Option A - Pilonidal sinus: This patient is a jeep driver with pain and swelling in the gluteal (natal cleft) region, which classically points toward a pilonidal sinus. A pilonidal sinus is a small, tunnel-like lesion that typically occurs near the sacrococcygeal area (lower back near the tailbone). It is often caused by prolonged sitting, friction and ingrown hair or debris that becomes trapped, leading to inflammation, sinus formation and infection. Pain, swelling, and sometimes discharge or abscess formation in the gluteal region. Incorrect Options: Option B - Fistula in ano: A fistula in ano is an abnormal connection between the anal canal and the skin around the anus. It usually results from an infection or abscess in the anal region. Pain, swelling, and discharge around the anus, rather than the gluteal region. The pain and swelling are typically localized around the

anus and not in the gluteal area. Option C - Fissure in ano : An anal fissure is a small tear in the lining of the anus, often caused by trauma or strain during bowel movements. Severe pain during and after bowel movements, possibly with bleeding, but usually localized to the anal region rather than the gluteal region. Option D - Gluteal abscess: A gluteal abscess is a collection of pus in the gluteal region, often due to infection. It may be related to trauma or infection. Pain, swelling, and redness in the gluteal region. While this condition could fit the description, pilonidal sinus is more specific to the scenario described, especially in the context of prolonged sitting.

References:

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Q28: A patient presents to the outpatient department (OPD) with recurrent diarrhea, abdominal pain, and foul-smelling stools. Following finding was observed on colonoscopy. what is the diagnosis? (Q844298)

A. Pseudomembranous colitis

B. FAP

C. Ulcerative colitis

D. Acute gastritis



Correct Answer: A. Pseudomembranous colitis

Explanation: Correct Option A - Pseudomembranous colitis: This condition is characterized by inflammation of the colon due to an overgrowth of Clostridioides difficile, often after antibiotic use. The hallmark of this disease on colonoscopy is the presence of raised, yellowish-white plaques or pseudomembranes on the mucosa, which can be seen as the yellowish findings described. Symptoms include recurrent diarrhea, abdominal pain, and foul-smelling stools Incorrect Options: Option B - Familial adenomatous polyposis (FAP): FAP is an inherited disorder characterized by the development of hundreds to thousands of adenomatous polyps in the colon and rectum. Patients typically do not present with recurrent diarrhea or foul-smelling stools but are at high risk for colorectal cancer. The colonoscopy findings in FAP would show numerous polyps rather than pseudomembranes. Option C - Ulcerative colitis: This is an inflammatory bowel disease that causes chronic inflammation and ulceration of the colonic mucosa. While patients may present with abdominal pain and diarrhea, the colonoscopy findings usually show continuous inflammation and ulceration, not pseudomembranes. Option D - Acute gastritis: This condition involves inflammation of the stomach lining and typically presents with upper abdominal pain, nausea, and vomiting rather than diarrhea. Colonoscopy is not used to diagnose gastritis as it affects the stomach, not the colon.



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References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1366

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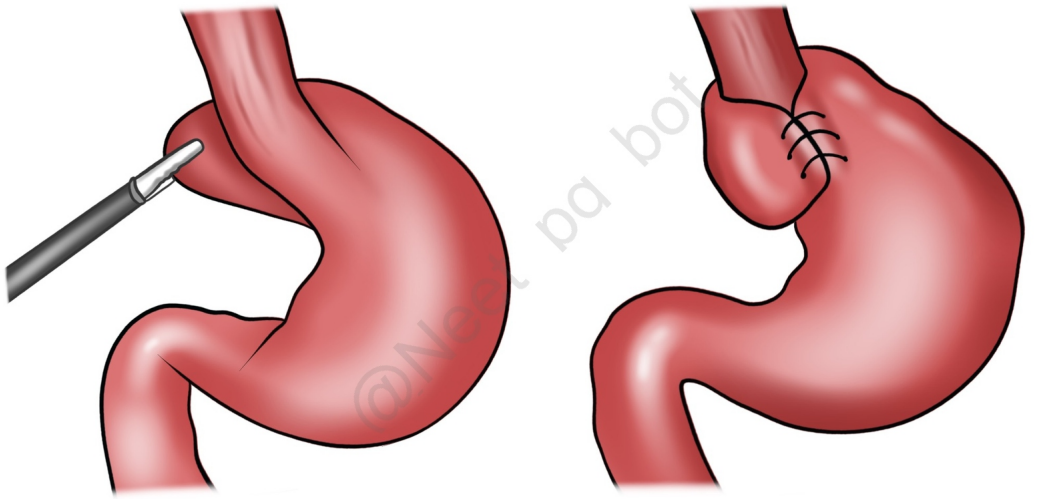
Q29: Identify the procedure commonly performed in patients with recurrent gastroesophageal reflux disease (GERD): (Q844301)

A. 360-degree Nissen fundoplication

B. Partial gastrectomy

C. Esophageal banding

D. 270-degree Nissen fundoplication



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Correct Answer: A. 360-degree Nissen fundoplication

Explanation: Correct Option A - 360-degree Nissen fundoplication: It is the most common surgical procedure performed for recurrent GERD. It is most commonly performed laparoscopically. It is the standard and definitive surgical treatment for GERD when medical therapy fails. In this procedure, the fundus of the stomach is wrapped completely (360 degrees) around the lower esophagus to reinforce the lower esophageal sphincter. The complete wrap increases LES pressure, preventing acid reflux into the esophagus. Incorrect Options: Option B - Partial gastrectomy: This procedure involves the removal of a portion of the stomach. It is not typically used for GERD treatment but rather for conditions like stomach cancer or severe peptic ulcer disease. Option C - Esophageal banding: This procedure involves placing a band around the esophagus, typically used to treat esophageal varices in patients with portal hypertension, not for GERD. Option D - 270-degree Nissen fundoplication: Also known as Toupet fundoplication, this procedure involves a partial (270 degrees) wrap of the stomach around the esophagus. While it can be used to treat GERD, it is less common than the 360-degree Nissen fundoplication, particularly in cases of recurrent GERD.

References:

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Q30: A child with recurrent vomiting undergoes an x-ray, as shown below. What is the most likely electrolyte imbalance in this patient? (Q860358)

A. Hypokalemia

B. Hyperkalemia

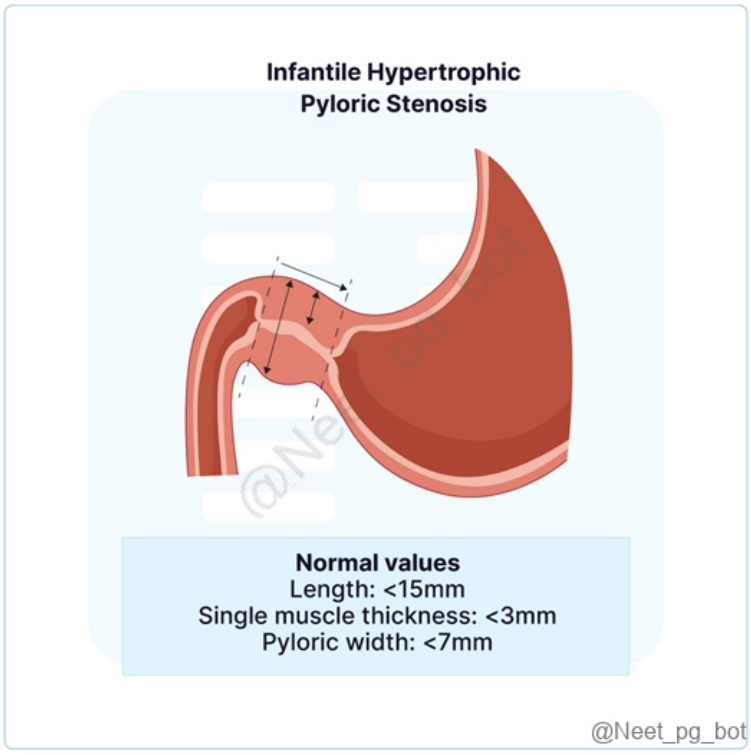
C. Hyponatremia

D. Hypernatremia



Correct Answer: A. Hypokalemia

Explanation: The "single bubble" sign on an X-ray is a characteristic feature of hypertrophic pyloric stenosis (HPS), which is commonly associated with hypokalemia resulting from the loss of potassium due to persistent vomiting. Congenital (Infantile) Hypertrophic Pyloric Stenosis (HPS): Hypertrophic pyloric stenosis is characterized by the hypertrophy of the pyloric antral musculature, particularly the circular muscle fibers, leading to the failure of the pylorus to relax. The duodenum remains normal. Increased risk if the newborn is administered erythromycin or azithromycin within the first 14 days of life. Symptoms typically develop between the 3rd and 6th week of life, as hypertrophy of the muscle leads to complete obstruction. Vomiting: Forcible, projectile, and non-bilious. Visible Gastric Peristalsis (VGP) Palpable Olive-like Mass: A smooth, mobile, firm, olive-shaped mass is felt on the left side of the abdomen. It moves with respiration, has well-defined borders, and demonstrates impaired resonance on percussion. This is the most important clinical feature (95% of cases). Constipation , dehydration & Weight Loss Electrolyte Imbalance: Hypokalemic metabolic alkalosis . Diagnosis: Clinical Examination: Primary method for diagnosis. Ultrasound Abdomen: Highly useful for diagnosis, showing Doughnut Sign. Pyloric Muscle Thickness: 4 mm or more. Pyloric Canal Length: > 14 mm. Cervix Sign (long axis) & Target Sign (short axis). Barium Meal: May show obstruction, but it is less commonly used. When done, it may demonstrate. String Sign, Railroad Track Sign, or Double Track Sign due to pyloric obstruction. Treatment: Correct Dehydration & Electrolyte Imbalance. Surgery: Ramstedt's Operation: Pyloromyotomy via laparotomy, ensuring mucosa is not breached. Laparoscopic Pyloromyotomy. Endoscopic Pyloromyotomy. Balloon Dilation (less effective).



References:

SRB's Manual of Surgery, 6th Edition, Page 811

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Q31: Which nerve is most commonly injured during indirect inguinal hernia surgery? (Q860378)

A. Femoral nerve

B. Genitofemoral nerve

C. Obturator nerve

D. Ilioinguinal nerve

Correct Answer: D. Ilioinguinal nerve

Explanation: The most commonly injured nerve during open inguinal hernia surgery is the ilioinguinal nerve, often leading to chronic pain as a complication. The most common nerve injured in: Open repair: Ilio-inguinal >

Iliohypogastric > Genital branch of Genitofemoral nerve. Laparoscopy: Lateral Cutaneous nerve of thigh > Genito-femoral nerve. Landmarks in Laparoscopic Surgery: Triangle of Doom: Injury to Iliac vessels Triangle of Pain: Injury to Nerves causing postoperative pain Complications of Surgery: Immediate Complications: Bleeding/Hematoma: From subcutaneous or inferior epigastric vessels. Urinary Retention: May require catheterization. Femoral Nerve Blockade Early Postoperative Issues (within the first week): Pain, Bruising, Swelling: Common. Seroma Formation: Often resolves spontaneously; may need aspiration. Wound Infection: Less frequent; routine antibiotics not recommended. Testicular Infarction: Damage to the testicular artery during dissection or repair. Long-term Concerns: Chronic Pain: Nerve Injury: Damage to nerves such as the ilioinguinal or iliohypogastric nerves during surgery. Nerve Irritation: Chronic irritation by suture material or mesh. Psychological Factors Hernia Recurrence: Inadequate repair or weakness in the abdominal wall; mesh-related issues may also contribute.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1070

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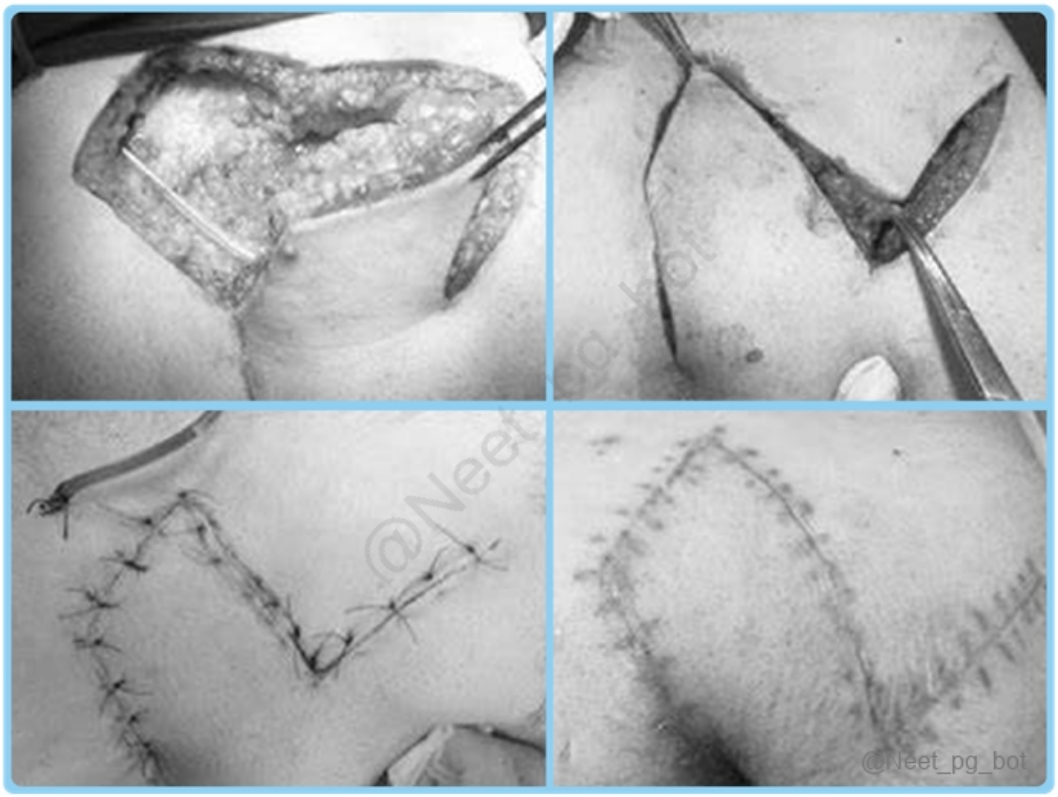
Q32: A patient underwent surgery for pilonidal sinus, which type of flap is used in this surgery? (Q860379)

A. Rhomboid flap

B. Advanced flap

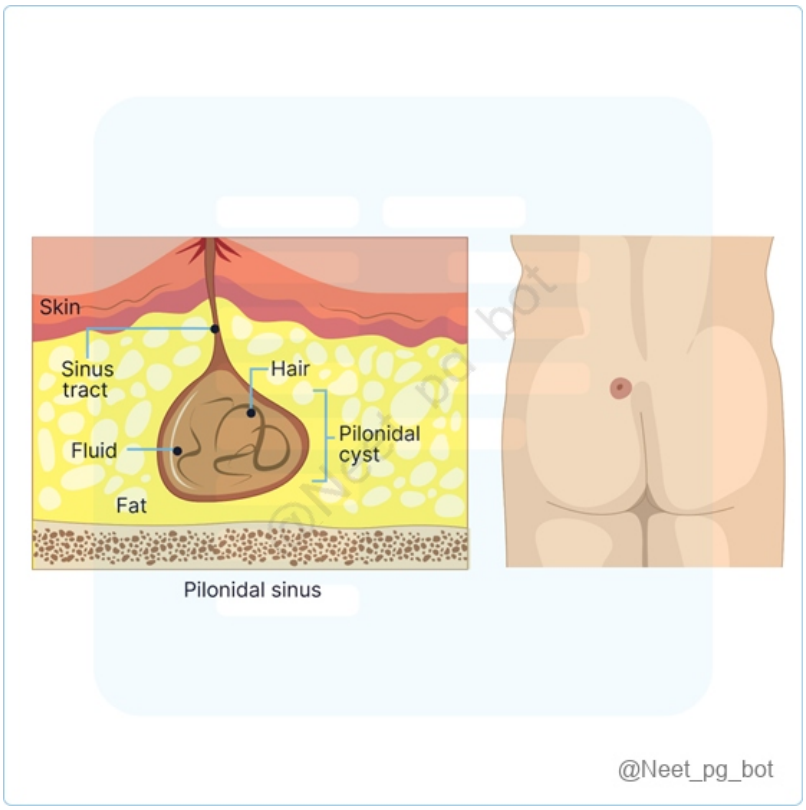
C. Rotational flap

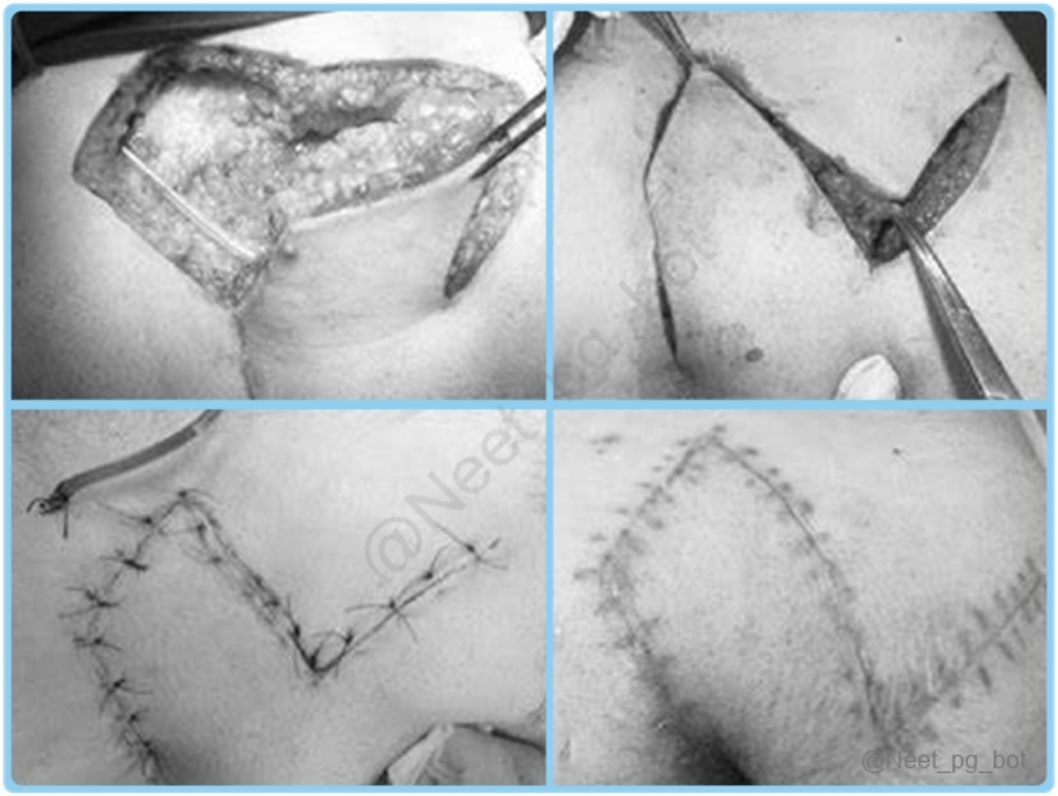
D. Free flap



Correct Answer: A. Rhomboid flap

Explanation: The Rhomboid (Limberg) flap is the most commonly used flap in the surgical management of pilonidal sinus when primary excision leaves a tissue defect that requires tension-free closure. This flap provides excellent coverage , flattens the natal cleft , and reduces recurrence compared to midline closures. {{caption_text}} Rhomboid (Limberg) Flap Technique: The sinus is excised in a rhomboid (diamond) shape . A rhomboid flap of equal dimensions is transposed from adjacent skin and subcutaneous tissue into the defect. Closure is done off the midline , ensuring tension-free healing and flattening of the cleft , which prevents hair re-entry and recurrence.





References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1423

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Q33: Which incision is most commonly used for an appendectomy? (Q860386)

A. McBurney incision

B. Kocher's incision

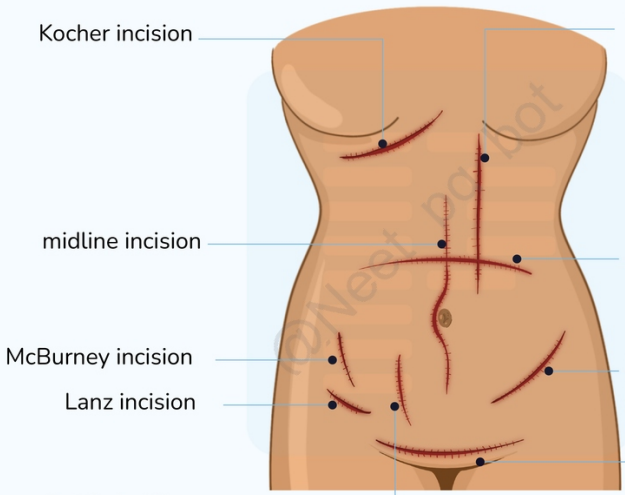
C. Midline incision

D. Battle incision

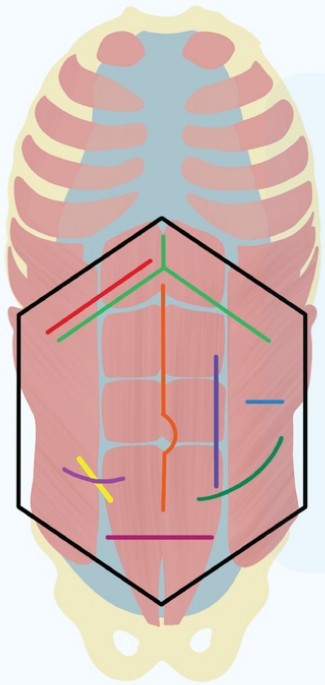
Correct Answer: A. McBurney incision

Explanation: McBurney incision is the classic and most commonly used incision for an appendectomy. It is located in the right lower quadrant of the abdomen, where the appendix is typically found. Incision Type Description Common Uses Abdominal Incisions Midline Longitudinal cut through the linea alba, bloodless access Exploratory laparotomy, trauma surgery, emergency surgeries Periumbilical Incisions around the umbilicus, avoiding the umbilical stalk Laparoscopy, umbilical hernia repairs, postpartum tubal ligation Pararectus Along the semilunar line, lateral to the rectus abdominis Abdominal wall hernia repairs, stoma creation, pelvic surgeries Paramedian Lateral to the linea alba, access to lateral viscera Lateral abdominal structures, Reduced hernia risk Kocher/Subcostal Inferior and parallel to the costal margin, access to upper abdomen structures Gallbladder, biliary tree, pancreas, liver transplants, epigastric surgeries Grindiron/ McBurney/ Lanz Lower abdomen incisions, typically for appendectomy Appendectomy (right side), sigmoid diverticulitis (left side), cosmetic appendectomy Thoracoabdominal From 7th intercostal space to the umbilicus, exposes thoracic and abdominal organs Retroperitoneal masses, pleural space, distal esophagus, abdominal organs Thoracic Incisions Thoracotomy Access to thoracic structures, various approaches Lung transplants, cardiac surgeries, trauma Median Sternotomy Vertical incision dividing the sternum, wide access to the mediastinum Open-heart surgery, anterior mediastinal tumor resection Trapdoor Complex incision, supraclavicular, sternal, and thoracotomy components Penetrating trauma, aortic arch aneurysms, complex cardiovascular access Infraclavicular A transverse incision just below the clavicle for subclavian vessel access Thoracic outlet syndrome, subclavian vessel surgeries Supraclavicular Superior to the clavicle, providing access to the subclavian vessels Trauma, thoracic outlet syndrome Neck Incisions Collar Incision above the sternal notch for thyroid surgeries Thyroid surgery, mid-neck structures Traumatic Neck Along the sternocleidomastoid muscle for trauma Vascular or traumatic neck injuries Tracheostomy Vertical/horizontal incision superior to the thyroid for tracheostomy Airway management in patients needing long-term ventilation Pelvic Incisions Pfannenstiel Transverse incision above the pubic symphysis Cesarean section, pelvic, urologic, and orthopaedic surgeries Maylard/Cherney Above pubic tubercle, provides access to pelvic structures Hysterectomy, pelvic lymph node dissection, lower pelvis surgeries Inguinal Above and parallel to the inguinal ligament Inguinal hernia repair, urologic surgeries (cryptorchidism, varicocele) McEvedy Vertical incision for femoral hernia repair Femoral hernia repair (obsolete now due to high hernia recurrence rate) Gibson Above inguinal ligament, arc to the lateral rectus sheath Kidney transplantation, retroperitoneal access (iliac vessels, ureter)

Abdominal incisions

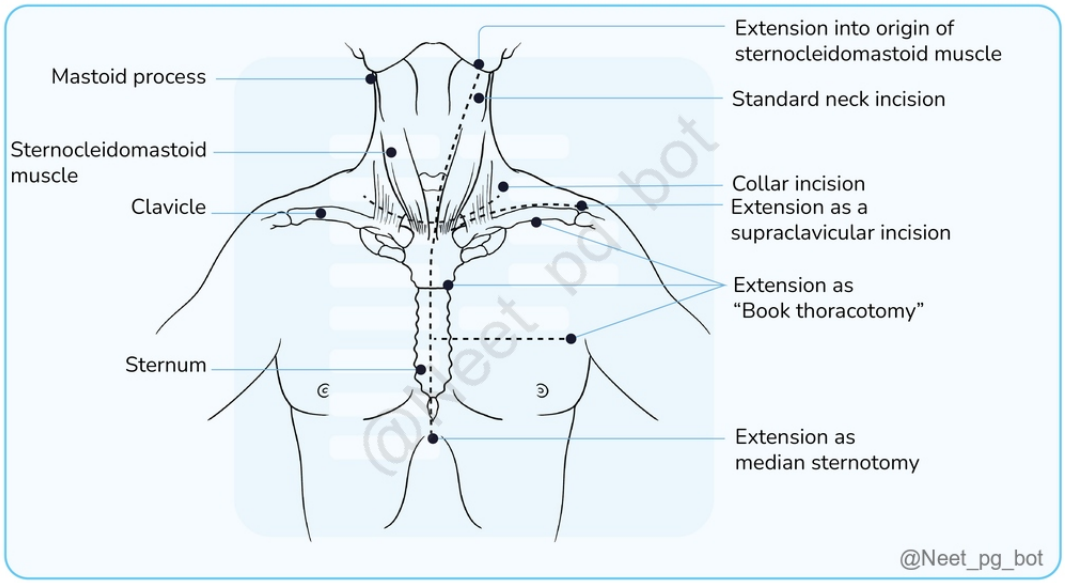


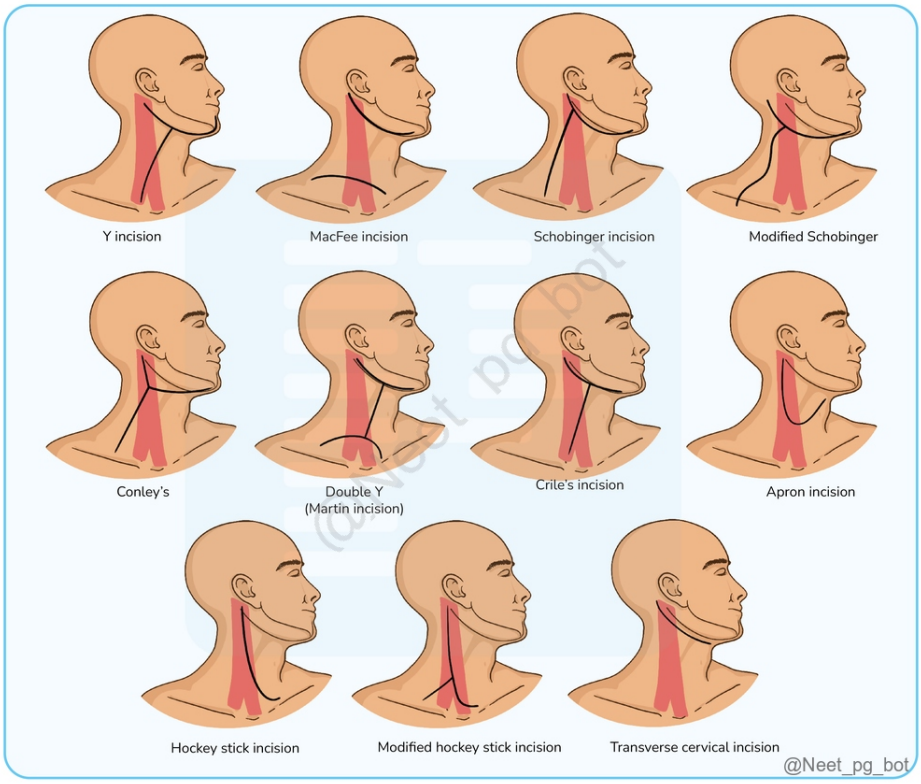
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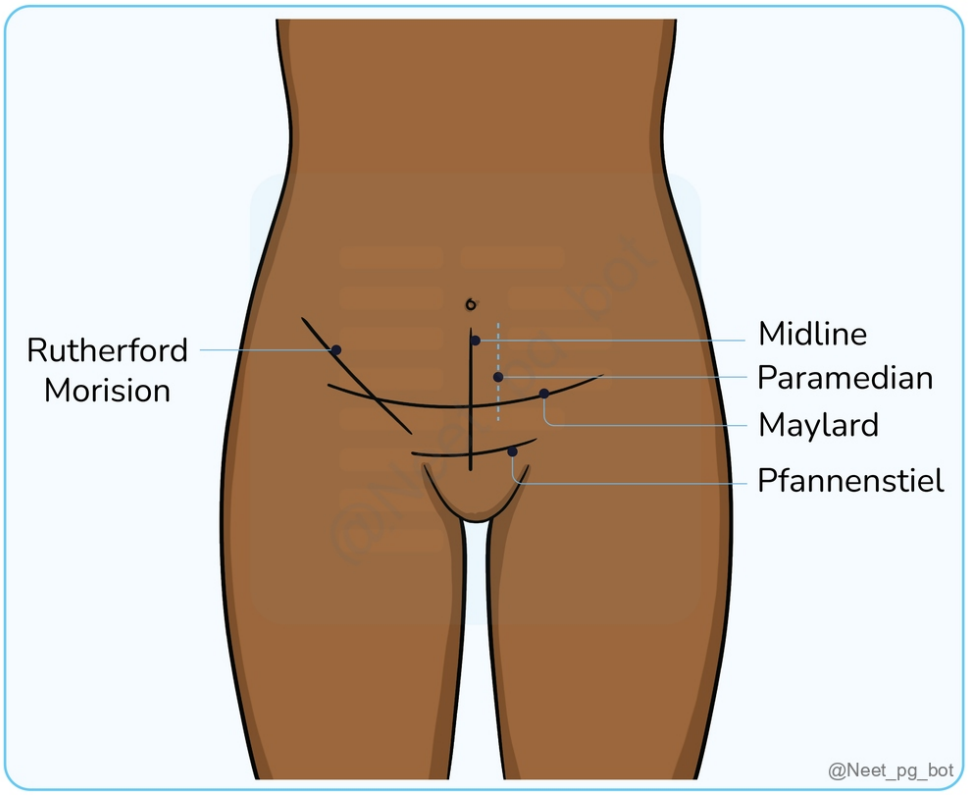


- KOCHER (OPEN CHOLECYSTECTOMY)
- 'MERCEDES BENZ' (LIVER TRANSPLANT)
- MIDLINE LAPAROTOMY (INTRA-ABDOMINAL ACCESS)
- PARAMEDIAN (INTRA-ABDOMINAL ACCESS)
- TRANSVERSE (STOMA CLOSURE/FORMATION)
- RUTHERFORD-MORRISON (KIDNEY TRANSPLANT - R/L)
- GRIDIRON (OPEN APPENDIECTOMY)
- LANZ (OPEN APPENDIECTOMY)
- PFANNENSTIEL (GYNAECOLOGICAL, OBSTERTIC)

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Extension into origin of sternocleidomastoid muscle
Mastoid process
Standard neck incision
Sternocleidomastoid muscle
Collar incision
Clavicle
Extension as a supraclavicular incision
Extension as "Book thoracotomy"
Sternum
Extension as median sternotomy
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Y incision
MacFee incision
Schobinger incision
Modified Schobinger
Conley's
Double Y (Martin incision)
Crile's incision
Apron incision
Hockey stick incision
Modified hockey stick incision
Transverse cervical incision
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References:

https://www.ncbi.nlm.nih.gov/books/NBK541018/

↑ *Back to this question in Part A*

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Q34: A 54-year-old male with a history of multiple episodes of vomiting, binge drinking, and heavy meals presents to the emergency department with sudden onset of severe left-sided chest pain radiating to the left shoulder. Pneumoperitoneum is noted on X-ray. What is the most likely diagnosis? (Q860410)

A. Mediastinal air leak

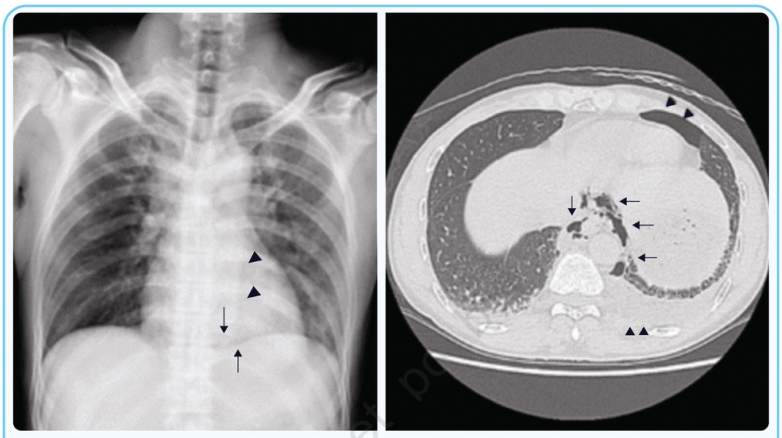
B. Esophageal perforation

C. Pneumoperitoneum

D. Peptic ulcer

Correct Answer: B. Esophageal perforation

Explanation: Esophageal perforation , particularly Boerhaave’s syndrome , is the most likely diagnosis. The patient’s history of multiple episodes of vomiting, binge drinking, and heavy meals, combined with sudden, severe chest pain radiating to the left shoulder, with pneumoperitoneum strongly suggests a rupture of the esophagus. (Boerhaave’s syndrome) Boerhaave's syndrome is characterized by spontaneous esophageal perforation due to forceful vomiting. Key features include severe chest pain and subcutaneous emphysema. Esophageal perforation Definition A breach in the esophageal wall leads to leakage and increased morbidity and mortality Causes Iatrogenic injury, emetogenic perforation (Boerhaave's syndrome), foreign bodies, corrosive substances, eosinophilic esophagitis, esophageal cancer Symptoms Varies by cause and location: Iatrogenic (recent instrumentation) Boerhaave's (vomiting, chest pain, emphysema) Cervical (neck pain, etc.) Diagnosis Imaging: Chest X-ray, contrast swallow studies, CT scan {{caption_text}} Management Seal perforation, ensure drainage, supportive measures (nutrition, cardiorespiratory support, sepsis control) Conservative Management: Suitable for stable patients: antibiotics, nil by mouth, observation Endoscopic Interventions: Visualization, retrieval, sealing with clips/stents, nasogastric tube placement Surgical Intervention: Required for significant sepsis, large perforations, pleural involvement, delayed presentation Surgical Options: Primary repair, controlled fistula creation, esophageal diversion, esophagectomy (rare) Incorrect Options: Mediastinal air leak (Option A) can be a result of various causes, including trauma or infections, but the patient’s history and symptoms make esophageal perforation more likely. Pneumoperitoneum (Option C) refers to air in the peritoneal cavity, often due to a perforated abdominal viscus, such as a perforated ulcer. However, the patient's presentation are more consistent with esophageal perforation. Peptic ulcer (Option D) can cause abdominal pain and potentially lead to perforation, but it typically does not cause chest pain radiating to the shoulder or the presence of pneumoperitoneum as seen in this case.



(A) Chest radiograph showing Naclerio’s V sign, which is the presence of air outlining the left, lower, lateral mediastinal border (arrows), with periaortic air streaks lateral to the descending aorta and above the left diaphragm (arrowheads). Naclerio’s V sign confirms pneumomediastinum. (B) Chest computed tomography scan showing pneumomediastinum (arrows) and left hydropneumothorax (arrowheads) suggestive of esophageal rupture

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References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1127,1128

Sabiston Textbook of Surgery, 21st Edition, Page 1034,1035

↑ *Back to this question in Part A*

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Q35: Which of the following is not an indication for splenectomy? (Q860413)

A. Iatrogenic splenic trauma

B. Thrombocytopenia

C. Hairy cell leukemia

D. Bone marrow failure

Correct Answer: D. Bone marrow failure

Explanation: Bone marrow failure (Option D) is not typically an indication for splenectomy. Bone marrow failure syndromes like aplastic anemia, myelodysplastic syndromes, or other causes of bone marrow suppression usually require treatment to support bone marrow function (e.g., transfusions, medications, or stem cell transplantation), rather than removal of the spleen Indications for Splenecomy: Hodgkin Lymphoma & Non-Hodgkin Lymphoma Hairy Cell Leukemia (Option C) CLL & CML Splenic Marginal Zone Lymphoma Metastatic Splenic Tumors Splenic Cysts (True and Pseudocysts) Splenic Abscess Angiosarcoma (Hemangiosarcoma) Lymphangioma and Lymphangiosarcoma Traumatic Splenic Rupture (Option A) Hypersplenism (due to various hematologic conditions) Non-Hematologic Primary Tumors (e.g., splenic hemangiomas) Immune Thrombocytopenia (ITP) (Option B) Hereditary Spherocytosis & Elliptocytosis Pyruvate Kinase Deficiency (PKD) Glucose-6-phosphate dehydrogenase Deficiency (G6PD) Sickle Cell Disease Thalassemia Acute Splenic Sequestration Crisis (in sickle cell disease or sickle-beta thalassemia)

References:

Sabiston Textbook of Surgery, 21st Edition, Page 1569-1575

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1229

↑ *Back to this question in Part A*

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Q36: A 60-year-old male patient presents with a left groin swelling for a few years, which increases in size on standing and decreases when lying down. On examination, the swelling shows a positive cough impulse. What is the appropriate management? (Q860416)

A. Incision and drainage

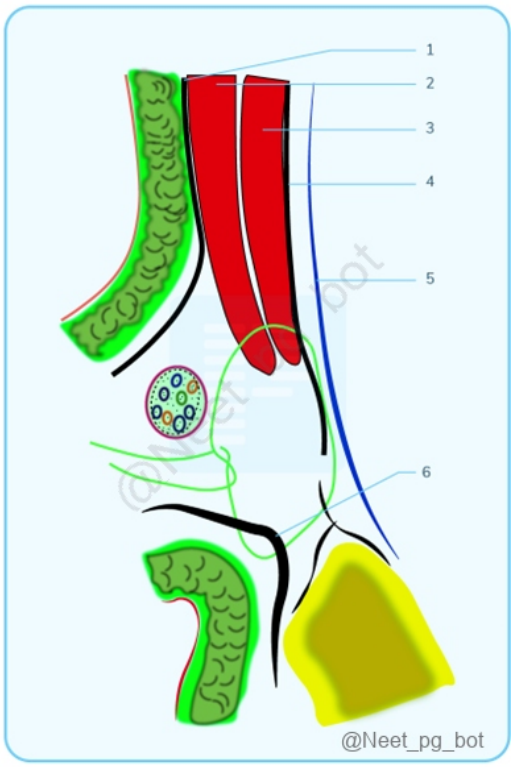
B. Herniotomy

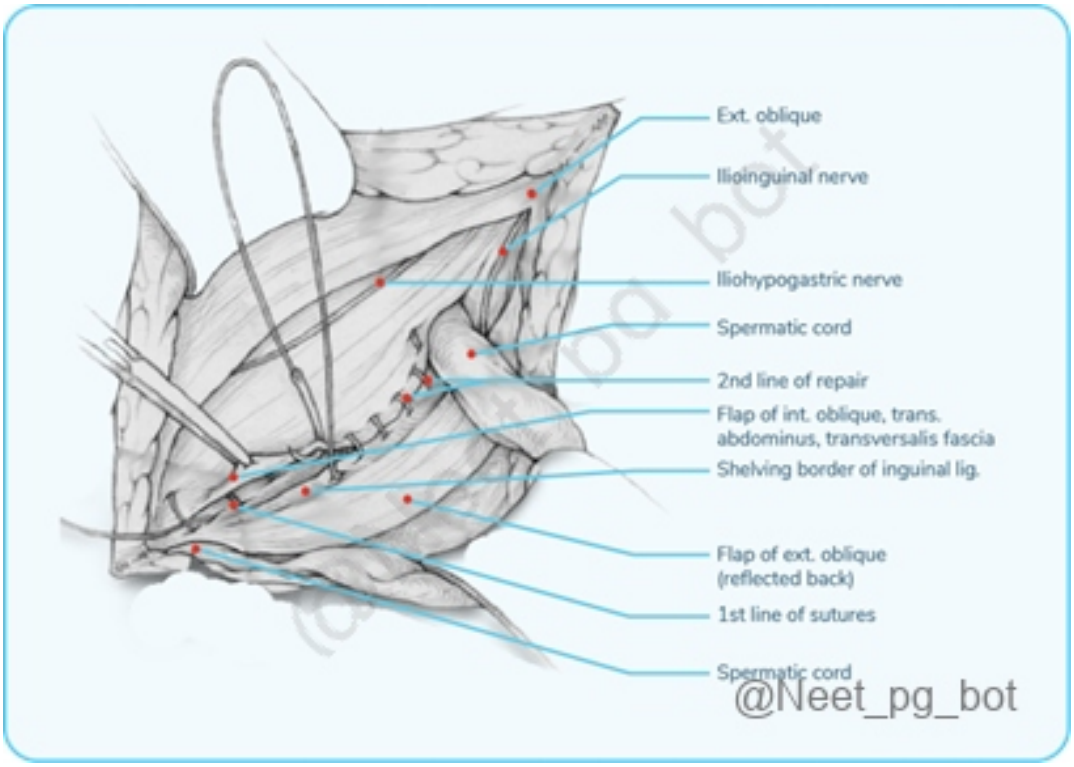
C. Herniorrhaphy

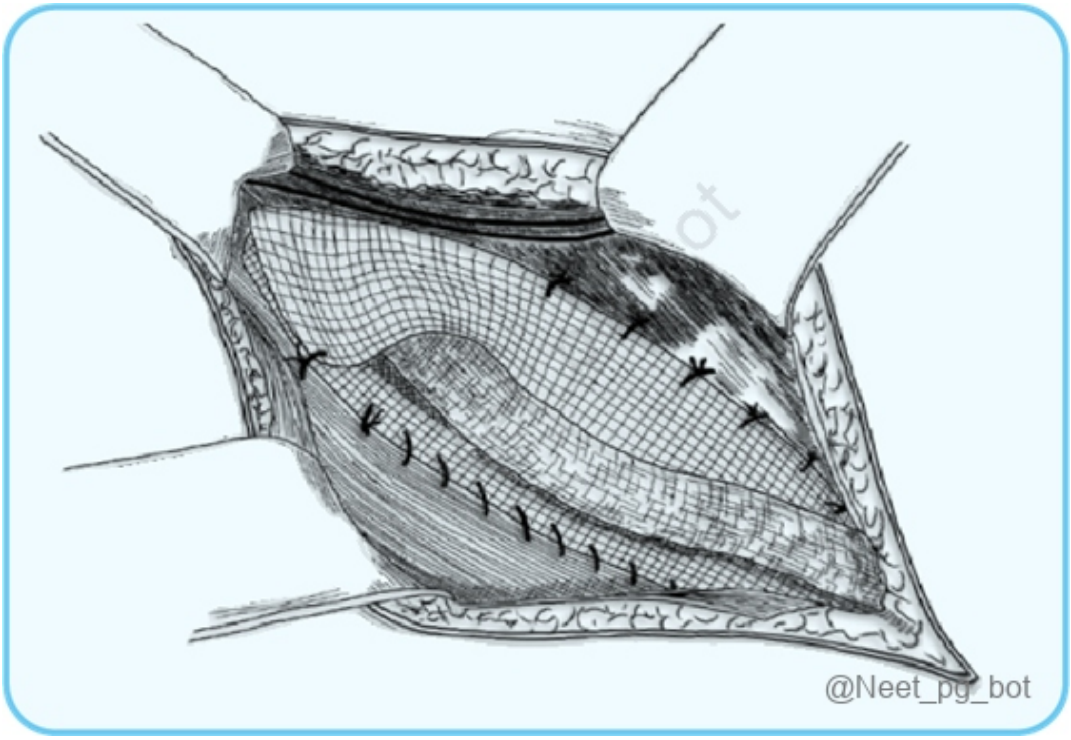
D. Reduction of contents, repair defects and reinforcement with mesh

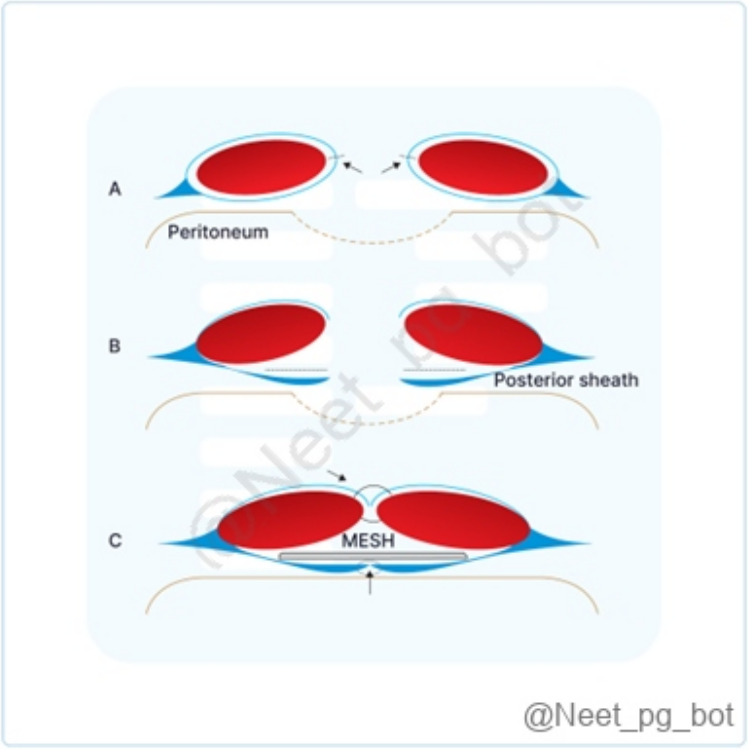
Correct Answer: D. Reduction of contents, repair defects and reinforcement with mesh

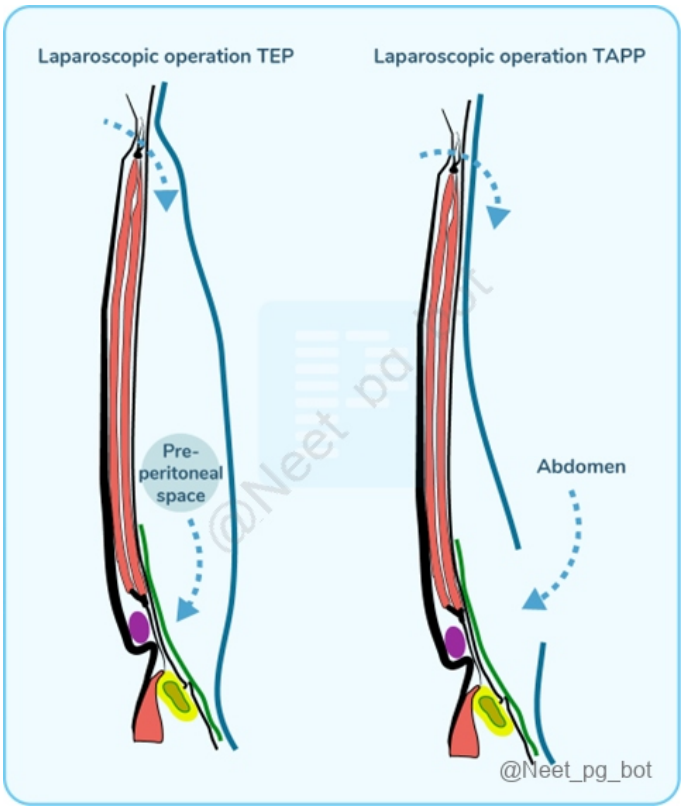
Explanation: The patient's presentation with a groin swelling that increases in size on standing, decreases when lying down, and shows a positive cough impulse is indicative of an inguinal hernia . Thus, the most appropriate management for this patient is reduction of contents, repair of the defect, and reinforcement with mesh . Management of Inguinal Hernia: Surgical Approaches: Herniotomy : (Option B) It involves excising and closing the hernia sac Primarily used in children with lateral hernias and congenital hydrocele. In adults, herniotomy alone is insufficient due to high recurrence rates. Hernioplasty : Includes herniotomy plus inguinal floor reconstruction with mesh. Herniorrhaphy : (Option C) Includes herniotomy plus reconstruction of the inguinal floor with sutures Techniques: Bassini's Repair: Involves suturing the internal oblique, transversus abdominis, and fascia transversalis to the inguinal ligament. Known as a triple-layer repair. Higher recurrence rates. Shouldice Repair involves a four-layer repair (double breasting of fascia transversalis), resulting in lower recurrence rates compared to Bassini's. {{caption_text}} Modified Shouldice : A six-layer repair, including additional layers for reinforcement. Anterior Tension-Free Repair: Lichtenstein Repair : Utilizes a mesh to reinforce the inguinal floor, which is considered the gold standard due to lower recurrence rates and faster recovery. Open Preperitoneal Repair: Stoppa Repair : (Option D) Uses a mesh to reinforce the area behind the peritoneum Done in Recurrent inguinal hernia Laparoscopic Hernia Repair: Totally Extraperitoneal (TEP) Repair Transabdominal Preperitoneal (TAPP) Repair TEP TAPP Procedure Surgery done above the peritoneum Surgery done beneath the peritoneum Advantages Lower risk of bowel injury and peritoneal complications. Reduced risk of adhesions. Larger working space Better visualisation Disadvantages Smaller working spaces can make the procedure more technically challenging. A higher risk of bowel injury and adhesion formation due to entry into the peritoneal cavity. Potential for increased postoperative pain compared to TEP. Incision and drainage (Option A) are typically used in cases of abscess or infection, which isn't the case here since the swelling is consistent with a hernia, not an infection.


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Ext. oblique
Ilioinguinal nerve
Iliohypogastric nerve
Spermatic cord
2nd line of repair
Flap of int. oblique, trans. abdominus, transversalis fascia
Shelving border of inguinal lig.
Flap of ext. oblique (reflected back)
1st line of sutures
Spermatic cord
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A
Peritoneum
B
Posterior sheath
C
MESH
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References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1068

↑ *Back to this question in Part A*

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Q37: Which of the following structures does not form the boundary of Hesselbach's triangle? (Q860425)

A. Inferior epigastric artery

B. Vas deferens

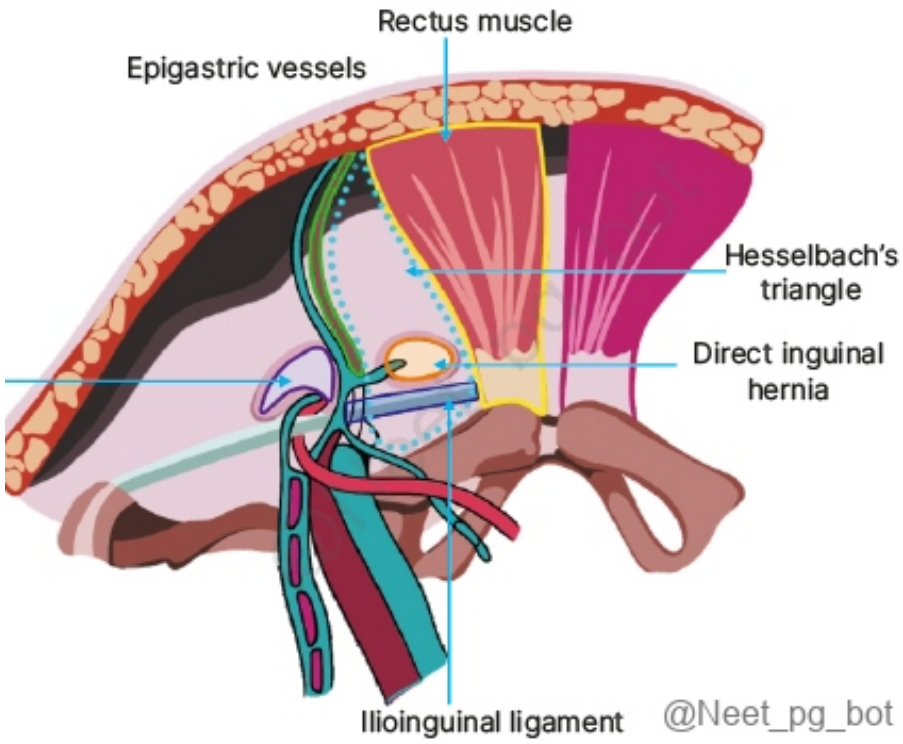
C. Rectus abdominis

D. Inguinal ligament

Correct Answer: B. Vas deferens

Explanation: The vas deferens do not form a boundary of Hesselbach's triangle. It passes through the inguinal canal and is located posterior to the inguinal ligament, but it is not part of the triangle's boundaries. Hesselbach’s

Triangle: A weak spot in the abdominal wall, where direct inguinal hernias occur. Covered only by the transversalis fascia and external oblique aponeurosis. Susceptible to herniation, especially in elderly patients or those with increased abdominal pressure. Boundaries: Lateral border : Inferior epigastric vessels (Option A) Medial border : Rectus abdominis muscle (Option C) Inferior border : Inguinal ligament (Poupart's ligament) (Option D)



References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1066

↑ *Back to this question in Part A*

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Q38: What is the type of hernia in which the internal organ forms a portion of the wall of the hernia sac? (Q860428)

A. Lumbar hernia

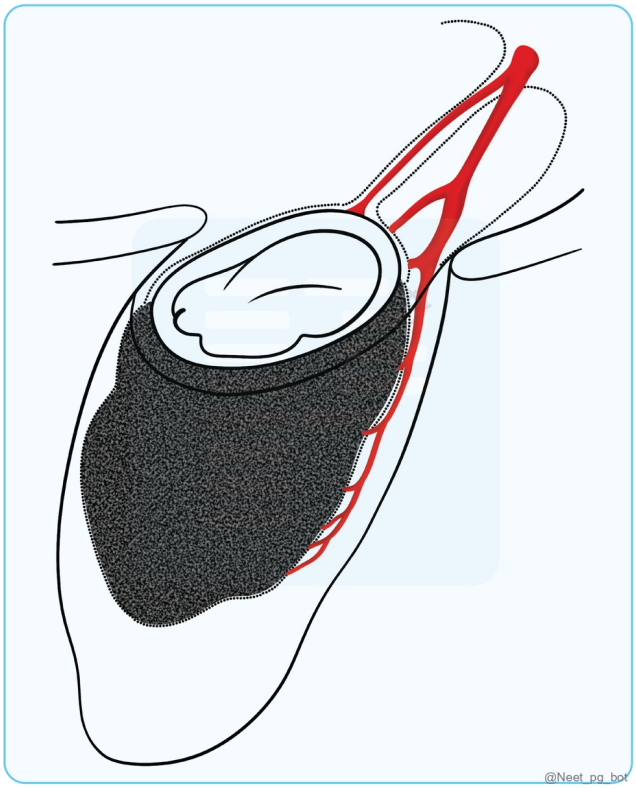
B. Sliding hernia

C. Spigelian hernia

D. Richter hernia

Correct Answer: B. Sliding hernia

Explanation: A sliding hernia is a unique type of hernia in which a part of an internal organ forms a portion of the wall of the hernia sac itself . This occurs because the organ is only partially covered by peritoneum and “slides” into the hernia defect. Key Features of Sliding Hernia: Viscus forms part of the sac wall → commonly the posterior wall of the sac. Most commonly involves: Sigmoid colon (Left-sided sliding inguinal hernia) Cecum (Right-sided sliding inguinal hernia) Bladder (especially in elderly men) More common in elderly males . During surgery, there is a high risk of bowel injury because the organ forms part of the sac wall. Lumbar hernia (Option A) refers to hernias occurring in the lumbar region of the abdominal wall but does not involve an internal organ forming part of the wall of the sac. Spigelian hernia (Option C) occurs through the Spigelian fascia, which is located on the lateral edge of the rectus abdominis muscle and does not involve an internal organ as part of the hernia sac wall. Richter hernia (Option D) is a type of hernia in which only a portion of the bowel wall (usually the antimesenteric border) is incarcerated, but it does not form the wall of the hernia sac.



References:

Sabiston Textbook of Surgery, 21st Edition, Page 1118

↑ *Back to this question in Part A*

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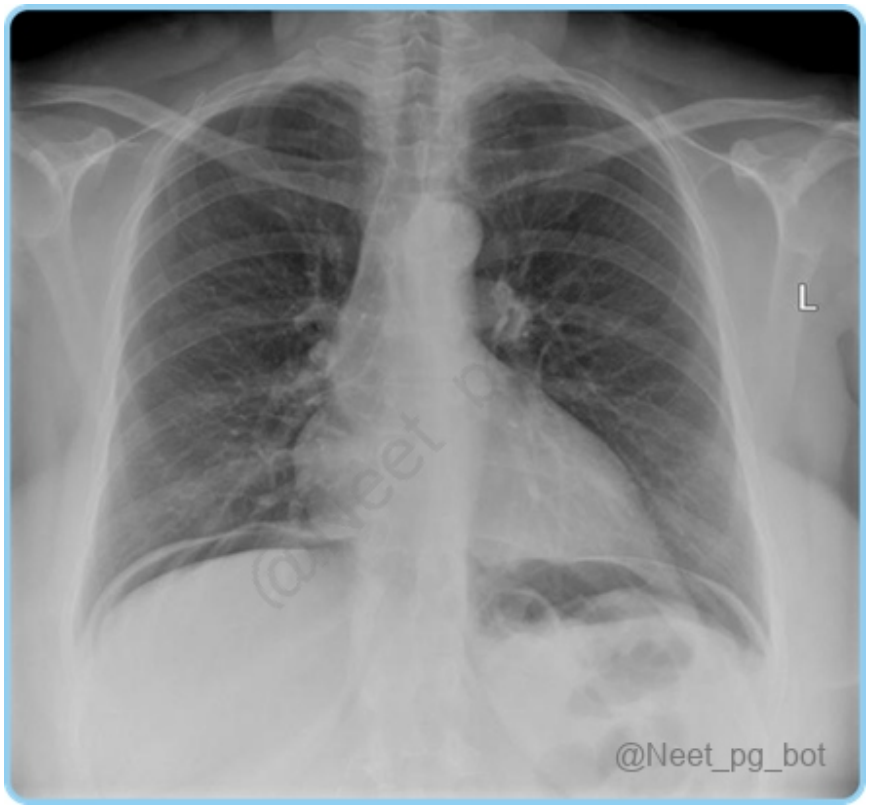
Q39: A 35-year-old male presents to the ER with complaints of epigastric pain for 1 day. On examination, his heart rate is 120/min, and blood pressure is 100/60 mmHg. There is tenderness, guarding, and rigidity on palpation. Based on the clinical presentation and the X-ray findings, what is the most likely cause of this patient's condition? (Q860453)

A. Acute cholecystitis

B. Hollow viscus perforation

C. Sigmoid volvulus

D. Small bowel obstruction

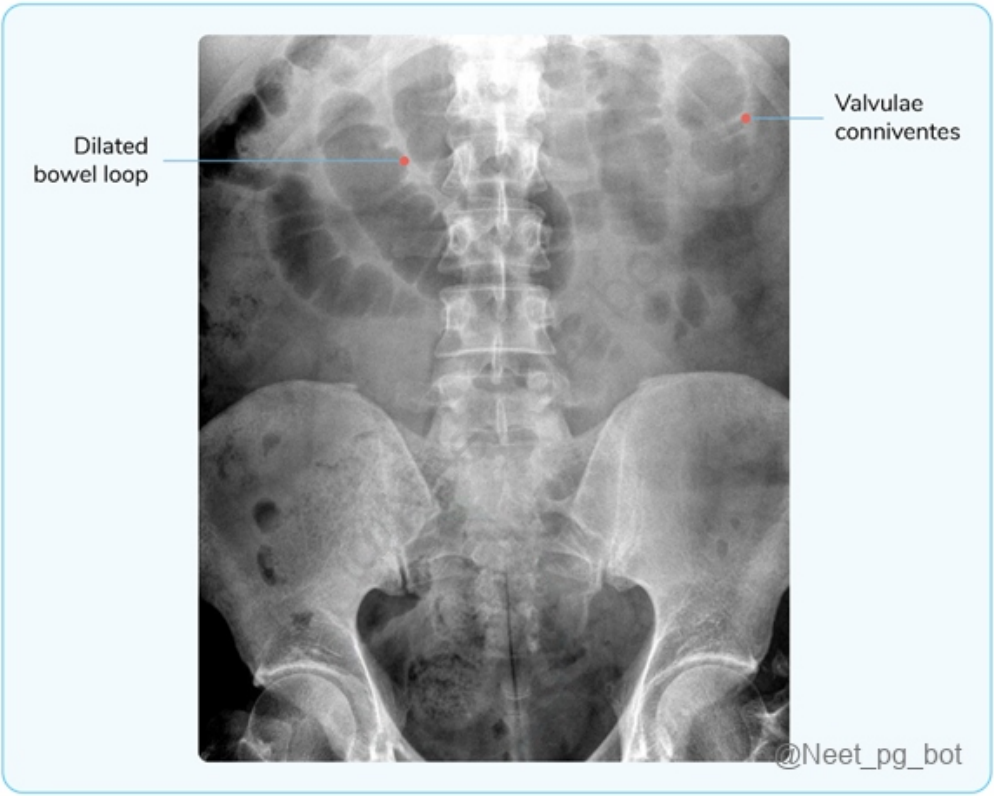


Correct Answer: B. Hollow viscus perforation

Explanation: The clinical presentation and the x-ray findings that show free air under the diaphragm, which is a classic sign of perforation, suggest hollow viscus perforation. A hollow viscus perforation occurs when there is a rupture or hole in a hollow organ (such as the stomach, small intestine, large intestine, or duodenum), allowing its contents to spill into the peritoneal cavity. This leads to peritonitis, a potentially life-threatening condition. Clinical features: Acute onset of severe abdominal pain , often described as sharp or stabbing. Generalized peritonitis : Tenderness and guarding over the entire abdomen. Rigidity (board-like abdomen). Tachycardia is due to pain and a systemic response to infection. Hypotension due to septic shock or fluid loss into the peritoneum. Nausea and vomiting are common & fever may develop as a sign of infection. Causes: Peptic ulcer perforation (most common

cause, especially in duodenum). Trauma (e.g., stab or gunshot wounds). Diverticulitis leads to colonic perforation. Inflammatory bowel disease (e.g., Crohn’s disease). Appendicitis that progresses to rupture. Foreign body ingestion leads to injury or perforation. X-ray findings: Free air under the diaphragm (classic sign) indicates that air has escaped into the peritoneal cavity. It may show air-fluid levels if associated with bowel obstruction. CECT: Most sensitive to detect minimal/suspected pneumoperitoneum. Management: Surgical intervention: Exploratory laparotomy done after stabilisation. Antibiotics : Broad-spectrum antibiotics are started to treat peritonitis and prevent septic shock. Fluid resuscitation : IV fluids are crucial to support blood pressure and organ function, especially in cases of sepsis. Incorrect Options: Acute cholecystitis (Option A) typically presents with right upper quadrant pain, fever, and a positive Murphy's sign, but it is less likely to present with generalised peritonitis (rigidity, guarding) or hypotension. Sigmoid volvulus (Option C) typically presents with abdominal distension and onstipation, may show a characteristic "coffee bean" sign on X-ray. {{caption_text}} Small bowel obstruction (Option D) can present with pain, distension, and vomiting, but the key finding in small bowel obstruction is dilated loops of bowel on X-ray, not free air (unless there is a perforation, which is less common). In cases of jejunal obstruction, valvulae conniventes, which are mucosal folds that span the entire diameter of the bowel, create a ladder effect. {{caption_text}}





References:

Sabiston Textbook of Surgery, 21st Edition, Page 656, 1236, 1140, 1455

↑ *Back to this question in Part A*

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Q40: During laparoscopic surgery, while inserting the trocar, which of the following is most prone to injury? (Q860456)

A. Abdominal aorta

B. Superior epigastric artery

C. Both superior and inferior epigastric arteries

D. Inferior epigastric artery

Correct Answer: D. Inferior epigastric artery

Explanation: During laparoscopic surgery, the inferior epigastric artery is the most commonly injured vessel during trocar insertion. This is because: It runs vertically on the posterior surface of the rectus abdominis , It lies

exactly in the region where secondary ports (5–10 mm) are typically inserted (midway between midline and ASIS), It is relatively fixed, large, and directly in the trocar path . Abdominal aorta (Option A): The abdominal aorta lies deep and centrally in the retroperitoneum . Although theoretically at risk with very deep or blind midline stab insertion, it is much less commonly injured than the inferior epigastric artery during standard laparoscopic trocar placement. Superior epigastric artery (Option B): The superior epigastric artery descends from the internal thoracic artery and runs behind the upper rectus near the costal margin . Routine laparoscopic ports are usually placed below the umbilicus or in the lower quadrants, so this vessel is rarely in the trocar path and is not the most commonly injured .

References:

Sabiston Textbook of Surgery, 20th Edition, Page 1127

Schwartz's Principles of Surgery, 10th Edition, Page 1501

↑ *Back to this question in Part A*

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Q41: A 40-year-old male presents with diffuse abdominal pain. Physical examination reveals rigidity and guarding. Abdominal X-ray shows air under the diaphragm. The patient is taken up for surgery, and an ileal perforation is noted intraoperatively with gross contamination of the abdomen with enteric and purulent content. What is the appropriate management of this patient? (Q860486)

A. Resection and anastomosis

B. Primary repair

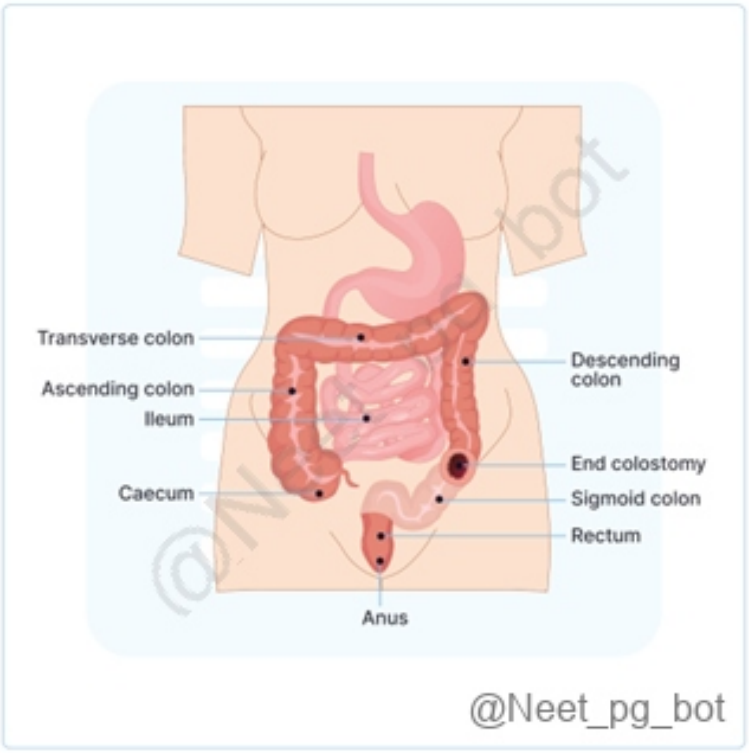
C. Urgent surgical exploration with ileostomy

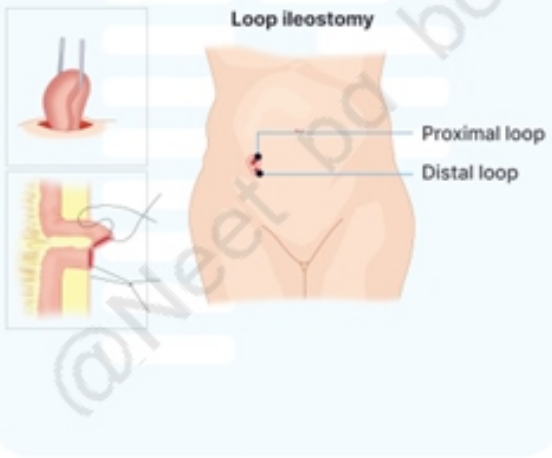
D. Omental patch closure

Correct Answer: C. Urgent surgical exploration with ileostomy

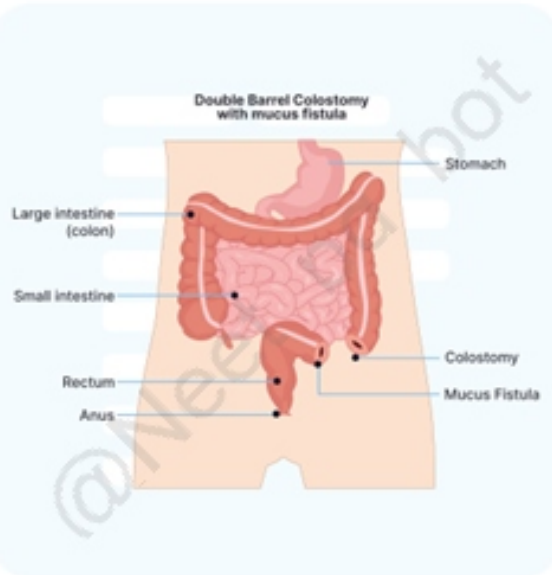
Explanation: Given the gross contamination with enteric and purulent contents, faecal diversion via ileostomy is usually recommended. This helps to prevent further contamination and allows the infected peritoneum to heal while diverting the faecal contents away from the abdomen. Types of Stomas: Type Description Common Uses Reversibility End Colostomy Single opening from the proximal bowel. Often permanent. Used when the distal bowel is removed or left in place, e.g., Hartmann's procedure Often permanent Loop Ileostomy Loop of the bowel is brought to the surface, and an incision is made Temporary diversion, especially in emergencies, and easily reversible Usually temporary Double-barrel Colostomy Two stomas are created: one for faecal output and one for mucus discharge Rarely used; can be for cases requiring both resection and exteriorization, offering mucous fistula Can be temporary Permanent Ileostomy Terminal ileum is brought to the surface after a colectomy Used when reconnection is not planned, often after total proctocolectomy for conditions like FAP Permanent Incorrect Options: Resection and anastomosis (Option A) is typically used in cases of multiple perforations , malignancy ,

suspected gangrene , or if there is significant tissue loss. It is not recommended in cases with severe peritoneal contamination , as the risk of infection, abscess formation, and anastomotic leak is high. Primary repair (Option B) is typically reserved for small perforations with minimal contamination and no signs of peritonitis. Omental patch closure (Option D) : While duodenal perforations are often treated with an omentum patch without resection, ileal perforations with significant contamination generally require more aggressive management, such as an ileostomy, to prevent sepsis and further complications.

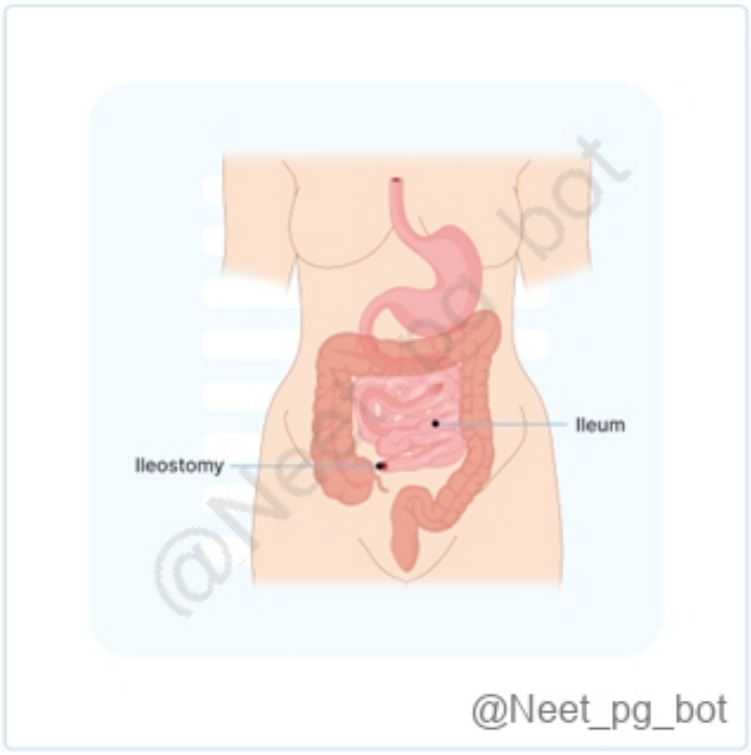




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References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1313, 1372, 1373

SRB's Manual of Surgery, 6th Edition, Page 901, 902

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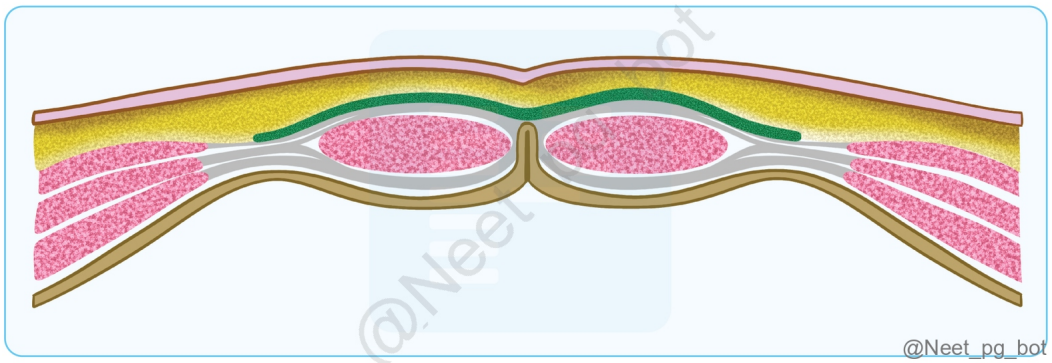
Q42: A 60-year-old female presents with a gradually progressive swelling over the abdomen for 1.5 years. She has a history of midline surgery. On examination, the swelling is 4 cm and is reducible with a palpable cough impulse. She is planning to undergo fascial closure with mesh repair. What is the most likely location of the mesh shown in the image? (Q860489)

A. Inlay

B. Sublay

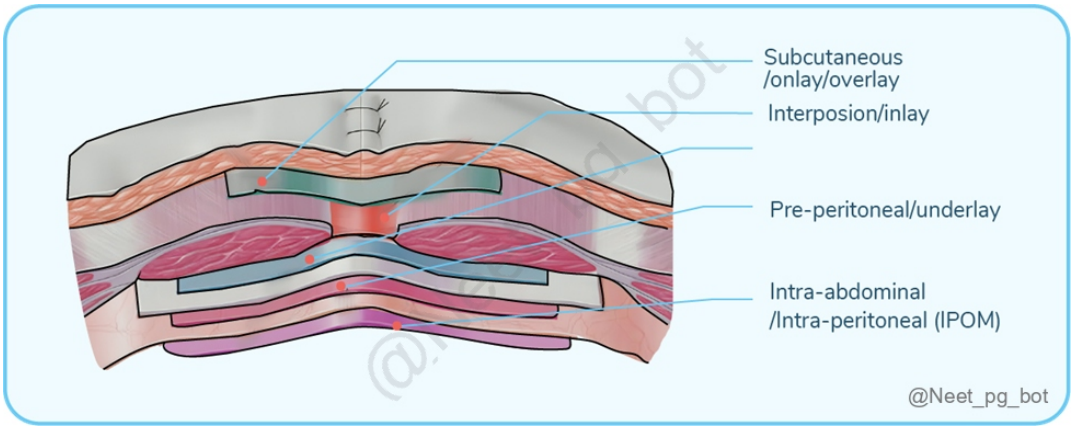
C. Onlay

D. Intraperitoneal repair



Correct Answer: C. Onlay

Explanation: This patient most likely has an incisional hernia , which is a common complication following midline surgery, characterised by a bulge or swelling at the site of a previous incision. The treatment often involves fascial closure with mesh repair to reinforce the weakened abdominal wall. The given image shows Onlay mesh repair technique. Incisional Hernia Mesh Placement Techniques: Technique Mesh Placement Procedure Advantages Disadvantages Inlay Within the fascial defect itself Mesh is sutured to the edges of the fascial defect. It can be used for large defects where primary closure isn't possible. High recurrence rates due to mesh separation from fascial edges under abdominal pressure Onlay On top of the anterior rectus sheath/external oblique aponeurosis Subcutaneous tissue is dissected off; the fascial defect is closed primarily, and the mesh is placed on top and secured Technically easier and less invasive. Higher risk of seroma formation , mesh infection, and skin necrosis. Retromuscular Behind the rectus muscle but anterior to the posterior rectus sheath The posterior rectus sheath is opened, the mesh is placed in the created space, and the posterior sheath is closed over it Lower recurrence rates , mesh well incorporated into tissues More complex procedure, risk of injury to neurovascular bundles. Preperitoneal Between the peritoneum and the posterior rectus sheath. Peritoneum is separated from the posterior rectus sheath; mesh is placed in this space, and the peritoneum is closed over it. Good mesh incorporation, lower risk of adhesions. Technically challenging, risk of peritoneal tears.



References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1078

↑ *Back to this question in Part A*

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Q43: Which of the following is the most common hernia in females? (Q840009)

A. Direct Inguinal hernia

B. Indirect inguinal hernia

C. Femoral hernia

D. Obturator hernia

Correct Answer: B. Indirect inguinal hernia

Explanation: Even though femoral hernias are more common in females compared to males , the most common hernia overall in females is still the indirect inguinal hernia. Indirect inguinal hernia is the most common type of hernia in both males and females . It occurs due to a persistent patent processus vaginalis and follows the path of the inguinal canal. Direct Inguinal hernia (Option A): Less common than indirect hernias and usually occurs due to weakness of the posterior wall of the inguinal canal; more common in older males rather than females. Femoral hernia (Option C): More common in females relative to males , but not the most common overall . Important because it has a high risk of strangulation. Obturator hernia (Option D): Rare; typically seen in elderly, thin females and presents with Howship–Romberg sign (medial thigh pain).

References:

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↑ *Back to this question in Part A*

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Q44: A 45-year-old patient presents to the clinic with complaints of food regurgitation and weight loss over the past several months. A barium swallow test is performed. What is the diagnosis? (Q840035)

A. Achalasia cardia

B. Esophageal carcinoma

C. Zenker's diverticulum

D. Diffuse esophageal spasm



Correct Answer: A. Achalasia cardia

Explanation: Correct Option A - Achalasia cardia: The above image is a barium swallow showing Rat tail appearance which is a diagnostic feature of Achalasia cardia. Achalasia cardia is characterized by the absence of lower esophageal sphincter relaxation. It presents with clincal triad of dysphagia, regurgitation and weight loss. On barium swallow it shows Bird’s beak appearance/pencil tip appearance/Rat tail appearance. Incorrect Options: Option B - Esophageal carcinoma: Esophageal carcinoma presents with progressive dysphagia nad on barium swallow it shows apple core appearance. Option C - Zenker's diverticulum: Zenker's diverticulum presents with dysphagia, aspiration pneumonitis, cervical web, halitosis. But weight loss is not a feature of Zenker's diverticulum. Option D - Diffuse esophageal spasm: Diffuse esophageal spasm presents with chest pain, dysphagia and on barium swallow it shows corkscrew or rosary bead appearance.

References:

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↑ *Back to this question in Part A*

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Q45: Which of the following are risk factors for cholangiocarcinoma? Hepatitis B PSC Caroli's disease Opisthorchis viverrini (Q840038)

A. 1, and 2 only

B. 2, 3, and 4 only

C. 4 only

D. 1, 2, 3, and 4

Correct Answer: D. 1, 2, 3, and 4

Explanation: All four listed conditions are established risk factors for cholangiocarcinoma . 1) Hepatitis B Chronic HBV infection increases risk of intrahepatic cholangiocarcinoma due to chronic inflammation and fibrosis. 2) Primary Sclerosing Cholangitis (PSC) PSC is one of the strongest risk factors for cholangiocarcinoma. Up to 10–20% of PSC patients develop it. 3) Caroli's disease A congenital bile duct dilatation disorder → chronic stasis → recurrent infections → high risk of cholangiocarcinoma. 4) Opisthorchis viverrini This liver fluke (along with Clonorchis sinensis) is a WHO class I carcinogen for cholangiocarcinoma.

References:

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↑ *Back to this question in Part A*

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Q46: A 20-year-old chronic alcoholic presents with severe hematemesis. USG shows distention of the portal vein and the liver appears hyperechoic. Pantoprazole has been initiated. What is the next appropriate step in management? (Q840054)

A. Initiate a course of broad-spectrum antibiotics

B. Order a liver biopsy to assess for fibrosis

C. Administer intravenous fluids and electrolyte replacement

D. Perform an endoscopy to look for varices

Correct Answer: C. Administer intravenous fluids and electrolyte replacement

Explanation: Correct Option C - Administer intravenous fluids and electrolyte replacement: The above clinical scenario points towards a diagnosis of upper GI bleed. The management of upper GI bleeding includes PPI/Tranexamic acid/Octreotide administration. IV fluids and electrolyte replacement to stabilize the patient. Following this endoscopic variceal ligation is performed followed by endoscopic sclerotherapy. Incorrect Options: Option A - Initiate a course of broad-spectrum antibiotics: Antibiotics are initiated only after the bleeding has been controlled. Option B - Order a liver biopsy to assess for fibrosis: Liver biopsy is not necessary in the initial management of upper GI bleed. Option D - Perform an endoscopy to look for varices: Endoscopy is performed after administration of pharmacotherapy and IV fluids.

↑ *Back to this question in Part A*

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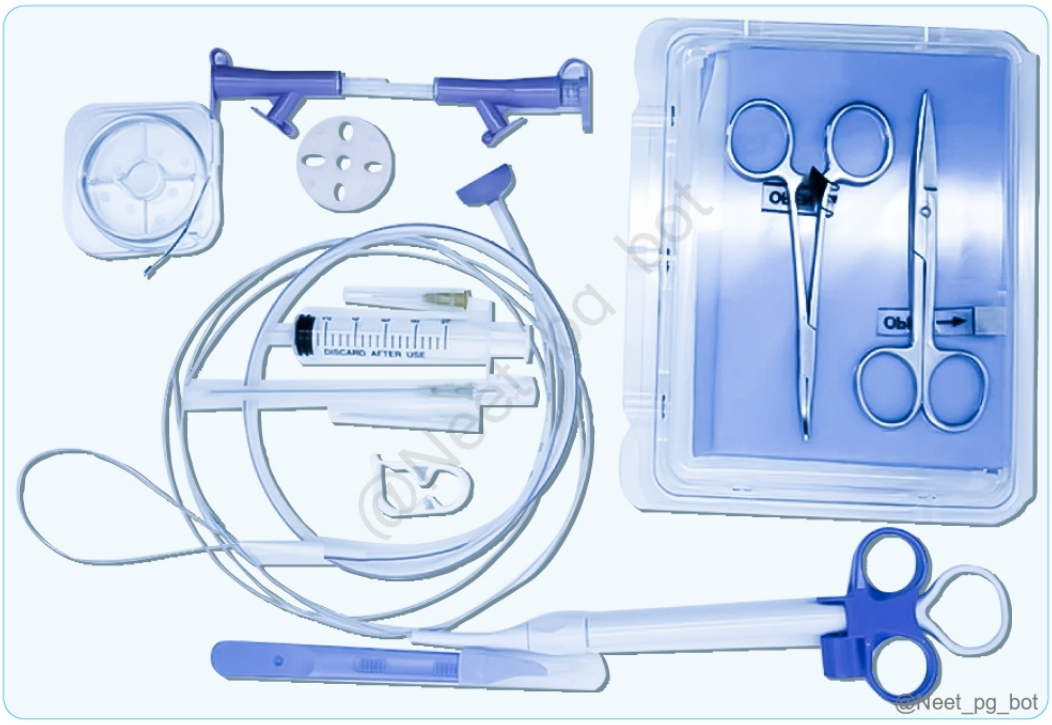
Q47: Identify the image given below? (Q840055)

A. PEG tube

B. Central line

C. Orogastric tube insertion

D. ICD



Correct Answer: A. PEG tube

Explanation: The above given image is of the Percutaneous Endoscopic Gastrostomy set. The most common indications for percutaneous endoscopic gastrostomy (PEG) include impaired swallowing mechanisms, oropharyngeal or esophageal obstruction, and major facial trauma. It is frequently used for debilitated patients requiring caloric supplementation, hydration, or frequent medication dosing. Incorrect Options: Option A - Central line: Central line is used for volume resuscitation, CVP monitoring. Option C - Orogastric tube insertion: Orogastric tube is used in suctioning of gastric contents, decompression, prevention of aspiration. Option D - ICD: ICD is used in case of massive hemothorax, tension pneumothorax.

References:

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↑ *Back to this question in Part A*

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Q48: A 28-year-old pregnant woman presents with a history of decreased fetal movements and respiratory distress in her newborn. On examination, the neonate appeared cyanotic, with increased breathing work. Auscultation reveals bowel sounds in the left hemithorax. A chest x-ray is given in the image. Which of the following congenital anomalies is most likely responsible for these findings? (Q860177)

A. Congenital diaphragmatic hernia

B. Tetralogy of Fallot

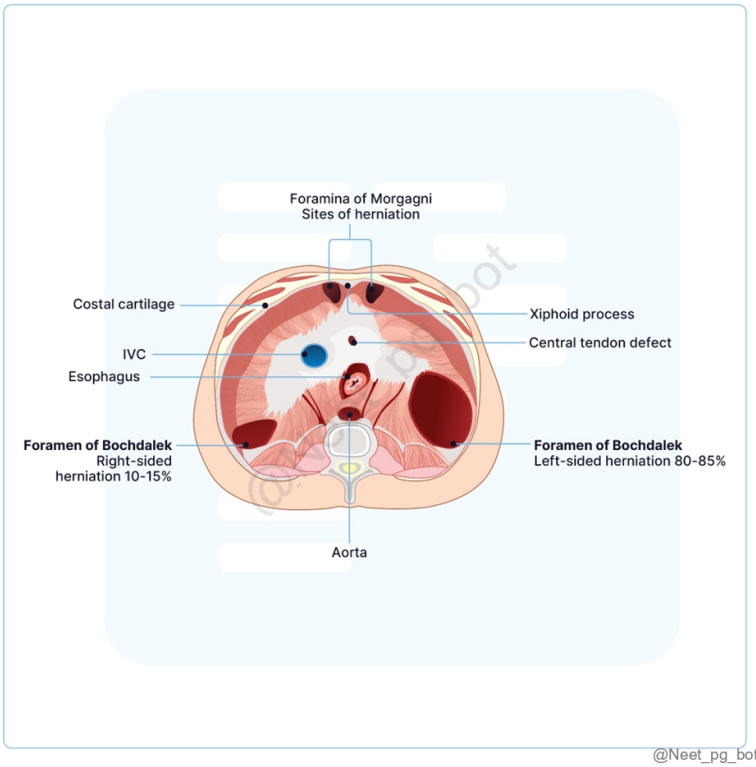
C. Transposition of the Great Vessels

D. Tracheoesophageal fistula



Correct Answer: A. Congenital diaphragmatic hernia

Explanation: The history provided, along with the chest X-ray showing multiple air-fluid levels above the diaphragm, strongly suggests a diagnosis of congenital diaphragmatic hernia (CDH) . Congenital Diaphragmatic Hernia: CDH is a birth defect with an abnormal opening in the diaphragm, allowing abdominal organs to move into the chest cavity and severely impair lung development. Most Common Side: Left (84%) > Right It is of two types: Bochdalek hernia is the most common type of CDH due to the failure of the development of the pleuroperitoneal canal. Morgagni Hernia is due to the defective Central tendon. Difference between Bochdalek and Morgagni Hernia: Feature Bochdalek Hernia Morgagni Hernia Side Left-sided Right-sided Location Posterolateral Anteromedial Herniated Organs Small intestine, stomach Transverse colon, sometimes liver Common Symptoms Scaphoid abdomen, respiratory distress, mediastinal shift Mostly Asymptomatic and Incidental Diagnostic Features Pulmonary hypoplasia Pulmonary hypertension Less severe respiratory distress Association Polyhydramnios, abnormal LHR, and liver position Rarely detected prenatally; usually diagnosed later Management Variable Generally Better prognosis Incorrect Options: Tetralogy of Fallot (Option B) The chest X-ray in Tetralogy of Fallot typically shows a boot-shaped heart. Transposition of the great vessels (Option C) The chest X-ray for transposition of the great vessels shows an "egg-on-a-string" appearance of the heart. Tracheoesophageal fistula (Option D) In tracheoesophageal fistula, a chest X-ray will often show a coiled nasogastric tube in the upper esophageal pouch.



References:

Sabiston Textbook of Surgery, 21st Edition, Page 1848

↑ *Back to this question in Part A*

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Q49: During an endoscopy, a man is found to have the squamocolumnar junction located more proximally than normal. Which of the following conditions is most likely responsible for this finding? (Q860181)

A. Achalasia cardia

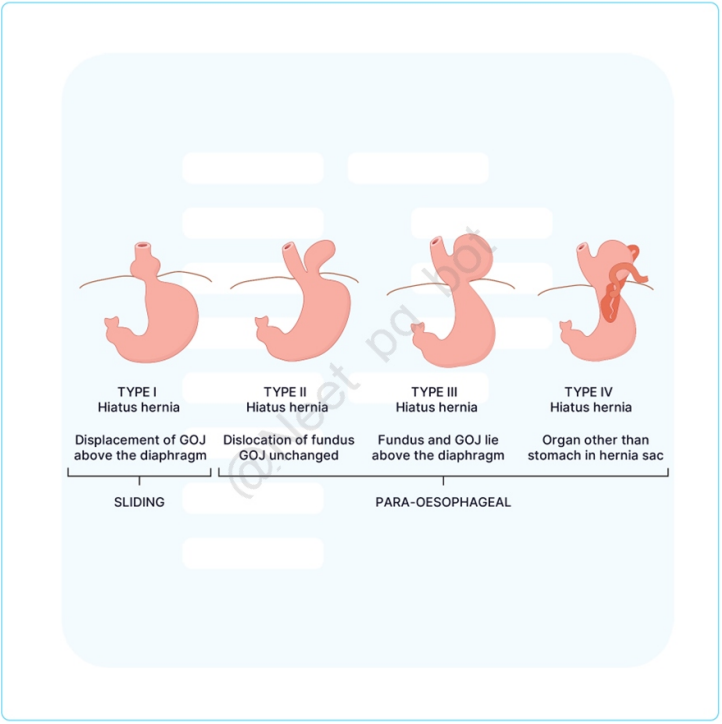
B. Sliding hernia

C. Rolling hernia

D. Gastroesophageal reflux disease

Correct Answer: B. Sliding hernia

Explanation: Sliding hernia is the most likely cause of the squamocolumnar junction being located more proximally than normal. This condition involves the upward displacement of the gastroesophageal junction into the thorax, which can result in the squamocolumnar junction appearing higher during an endoscopic examination. Hiatus Hernia: Condition in which the abdominal contents pass through the hiatal opening of the diaphragm into the mediastinum. Types Description Type I/Sliding Hiatus Hernia The most common type. The gastroesophageal junction and part of the stomach slide up through the diaphragm. Type II/Paraesophageal Hiatus Hernia Part of the stomach pushes through the diaphragm next to the oesophagus. The gastroesophageal junction remains in place. Type III/Mixed Hiatus Hernia Combines features of both sliding and paraesophageal hernias. Type IV Involves viscera other than the stomach in the hernial sac, like the colon. Achalasia cardia (Option A) typically causes failure of the lower esophageal sphincter to relax, leading to a dilated esophagus and difficulties with swallowing, but it doesn't affect the position of the squamocolumnar junction. Rolling hernia (Option C) (also called paraesophageal hernias) involves part of the stomach rolling into the chest beside the esophagus, but this does not typically affect the position of the squamocolumnar junction. Gastroesophageal reflux disease (GERD) (Option D) is associated with acid reflux and damage to the esophagus but does not cause the squamocolumnar junction to move proximally.



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References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1117,1118

https://www.ncbi.nlm.nih.gov/books/NBK562200/

↑ *Back to this question in Part A*

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Q50: Which appendicular carcinoma is most commonly associated with pseudomyxoma peritonei? (Q860183)

A. Mucinous cystadenocarcinoma

B. Adenocarcinoma

C. Carcinoid tumour

D. Serous cystadenoma

Correct Answer: A. Mucinous cystadenocarcinoma

Explanation: Pseudomyxoma peritonei (PMP) is a rare condition characterized by the accumulation of mucinous material in the peritoneal cavity, often caused by a rupture of a mucin-producing tumor like Mucinous cystadenocarcinoma. Pseudomyxoma Peritonei (PMP) is a rare, life-threatening condition characterized by progressive peritoneal tumour deposits, mucinous ascites, omental cake, and ovarian involvement. It is most commonly caused by the rupture of a mucinous appendiceal tumour . Symptoms include abdominal distension, anorexia, and bowel dysfunction. Classification: PMP is graded based on cytological atypia in peritoneal deposits: Acellular mucin Low-grade mucinous carcinoma peritonei High-grade mucinous carcinoma peritonei High-grade mucinous carcinoma peritonei with signet ring cells Treatment: The standard approach is Cytoreductive Surgery (CRS) combined with Hyperthermic Intraperitoneal Chemotherapy (HIPEC) . This extensive surgery, including organ removals, aims for complete tumour clearance. Survival rates after complete cytoreduction are 87% at 5 years and 70% at 10 years. Chemotherapy may be used for high-grade, unresectable cases or post-surgery in high-risk patients.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1352

↑ *Back to this question in Part A*

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Q51: Which of the following is the treatment of choice in a pregnant woman with an anal wart, as shown in the image given below? (Q860185)

A. Trichloroacetic acid application

B. Excision

C. Cryotherapy with liquid nitrogen

D. Oral acyclovir



Correct Answer: C. Cryotherapy with liquid nitrogen

Explanation: The image suggests a diagnosis of condyloma acuminata , which is the most common sexually transmitted anal disease caused by the human papillomavirus (HPV) . Cryotherapy with liquid nitrogen is the treatment of choice for removing anal warts in pregnant women. The advantage of cryotherapy is that it is relatively bloodless, painless, and allows precise control over the depth and extent of freezing. Condylomata Acuminata (Genital Warts): Genital warts are caused by infection with human papillomavirus (HPV) and are transmitted sexually. HPV infection is common, but only a small proportion of infected individuals develop visible warts. HPV types 6 and 11 are the most common causes of genital warts, and these types are not linked to cervical cancer. Genital warts are distinct from ordinary skin warts, as they tend to be softer, moister, and more often pedunculated. In women, warts are typically seen on the vulva and may line the vagina or appear on the cervix. Perianal warts are also common. Treatment Options: Podophyllin is a commonly used topical treatment. It is applied directly to the wart and carefully washed off after about 6 hours. An alternative chemical treatment is imiquimod . If chemical treatments are ineffective, other methods include cryosurgery , electrosurgery , laser ablation , or surgical excision . Circumcision may be recommended in cases of extensive lesions under the foreskin.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1557

↑ *Back to this question in Part A*

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Q52: A 70-year-old male patient who underwent gastrointestinal surgery one month ago, presents with a palpable abdominal bulge at the surgical site. Physical examination reveals a reducible 12 cm incisional hernia. What is the most appropriate next step in the management of this patient? (Q860195)

A. Schedule for laparoscopic mesh repair

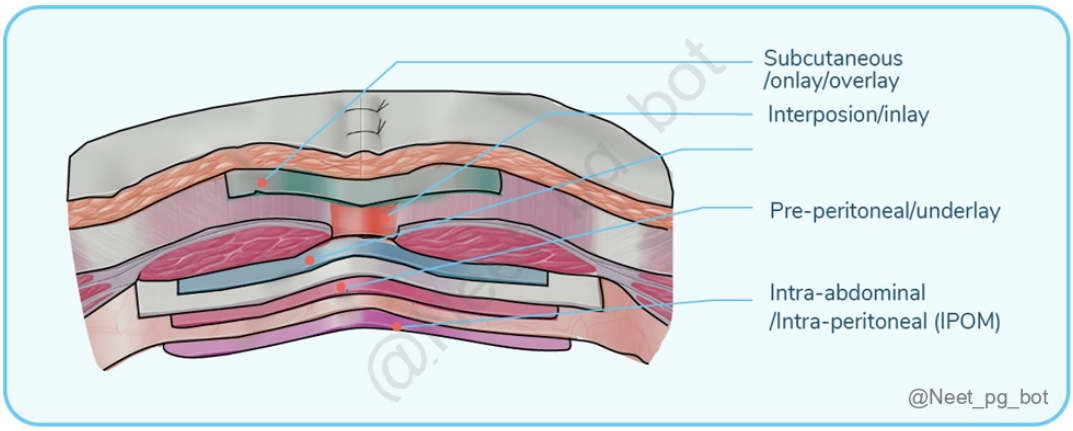
B. Prescribe an abdominal belt for daily use

C. Advise observation and reassessment in six months

D. Laparoscopic closure without mesh

Correct Answer: A. Schedule for laparoscopic mesh repair

Explanation: The gold standard treatment for an incisional hernia is intra-peritoneal onlay mesh repair . Mesh repair is preferred because it significantly reduces the risk of recurrence compared to other methods. An incisional hernia, also known as a post-operative ventral wall hernia , occurs when fascial tissues fail to fuse properly after surgery. Incisional Hernia Mesh Placement Techniques: Technique Mesh Placement Procedure Advantages Disadvantages Inlay Within the fascial defect itself Mesh is sutured to the edges of the fascial defect. It can be used for large defects where primary closure isn't possible. High recurrence rates due to mesh separation from fascial edges under abdominal pressure Onlay On top of the anterior rectus sheath/external oblique aponeurosis Subcutaneous tissue is dissected off; the fascial defect is closed primarily, and the mesh is placed on top and secured Technically easier and less invasive. Higher risk of seroma formation , mesh infection, and skin necrosis. Retromuscular Behind the rectus muscle but anterior to the posterior rectus sheath The posterior rectus sheath is opened, the mesh is placed in the created space, and the posterior sheath is closed over it Lower recurrence rates , mesh well incorporated into tissues More complex procedure, risk of injury to neurovascular bundles. Preperitoneal Between the peritoneum and the posterior rectus sheath. Peritoneum is separated from posterior rectus sheath, mesh is placed in this space, peritoneum is closed over it. Good mesh incorporation, lower risk of adhesions. Technically challenging, risk of peritoneal tears. Incorrect Options: Prescribe an abdominal belt for daily use (Option B): An abdominal belt may be prescribed temporarily for support and improved wound healing post-surgery, but it does not treat the hernia itself. Advise observation and reassessment in six months (Option C): This approach is not recommended, as incisional hernias can lead to complications such as strangulation , obstruction , and incarceration if left untreated. Laparoscopic closure without mesh (Option D) is not advisable due to higher recurrence rates associated with this approach. Mesh repair offers a more reliable long-term solution.



References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1078

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Q53: A neonate is diagnosed with gastroschisis. What is the most appropriate management strategy for this condition? (Q860202)

A. Surgical wall repair

B. Wait and watch

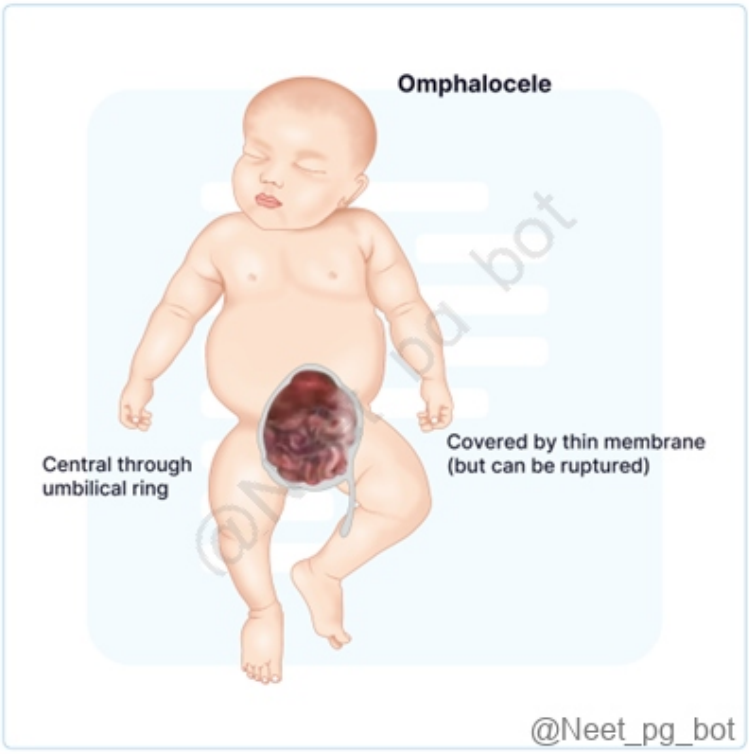
C. Slowly putting it inside

D. Surgical excision

Correct Answer: A. Surgical wall repair

Explanation: Gastroschisis is a congenital defect where the baby is born with the intestines exposed through a hole in the abdominal wall. The most appropriate treatment is surgical wall repair , where the exposed intestines are placed back into the abdomen, and the defect is closed. Feature Omphalocele Gastroschisis Definition Congenital abdominal wall defect where abdominal contents protrude through the base of the umbilicus . Congenital abdominal wall defect is when abdominal contents protrude through a defect typically located to the right of the umbilicus. Covering The herniated organs are covered by two layers: Amnion (outer) and peritoneum (inner) . No membrane covers the exposed organs. Associated conditions Chromosomal abnormalities: Associated with Trisomy 13, 18, and 21. Other congenital malformations affect multiple systems in the following order: cardiovascular> Muscular> gastrointestinal> genitourinary. (Mnemonic: "CM GIGU") Beckwith-Wiedemann Syndrome: Can include hemihypertrophy, macroglossia, visceromegaly, omphalocele, and increased risk of hepatoblastoma. Fewer chromosomal abnormalities compared to omphalocele. Higher risk of intestinal atresia and dysfunction. Prognosis Generally poor due to associated congenital malformations, which are the most common cause of death. Generally better than omphalocele due to fewer associated congenital anomalies. Management

Primary surgical closure is preferred for small to medium-sized defects. Larger defects may require: Prosthetic patch closure (e.g., Gore-Tex), Porcine small intestinal submucosa -derived biomaterials (e.g., Surgisis), Skin flap closure , or Placement of a silo for sequential reduction and staged closure . For giant omphaloceles , topical application of escharotic agents like povidone-iodine (Betadine) ointment or silver nitrate is used to thicken and epithelialize the sac. Primary closure is typically done under general anesthesia and often requires admission to the NICU for postoperative ventilation. Alternatively, a preformed silo can be placed at the bedside for gradual reduction, sometimes avoiding the need for general anesthesia altogether. Incorrect Options: Wait and watch (Option B) : This approach is not recommended as it can lead to complications such as fluid loss, hypothermia, hypovolemia, sepsis, metabolic acidosis, and necrotizing enterocolitis. Slowly putting it inside (Option C) : While the intestines are gradually pushed back inside during primary closure , this is not a management option by itself. Surgical excision (Option D) is only performed for non-viable bowel followed by anastomosis .





References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 270,

Sabiston Textbook of Surgery, 21st Edition, Page 1867,1868

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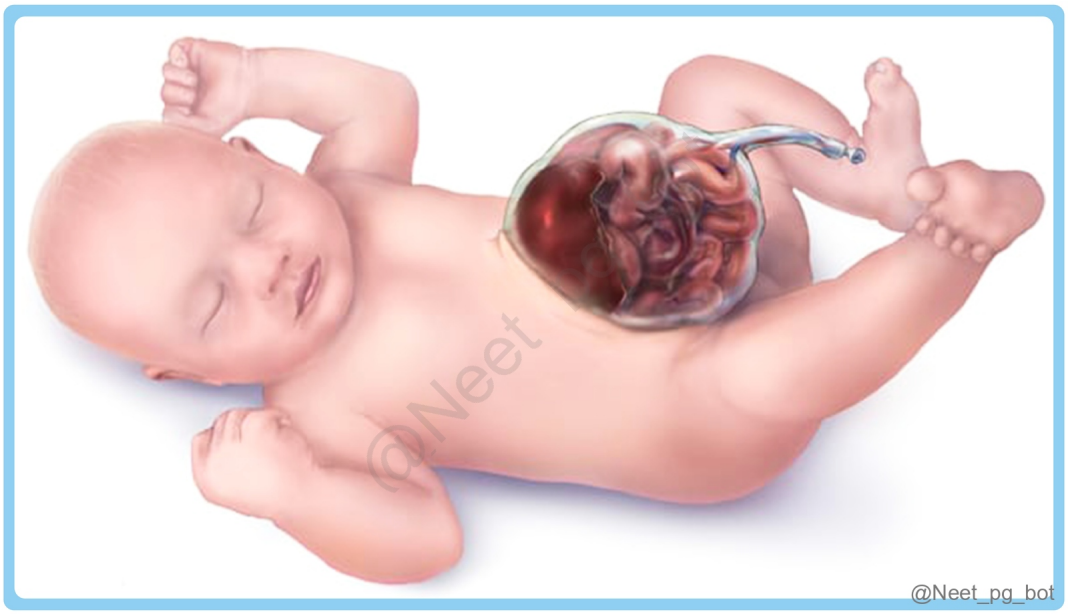
Q54: Identify the image: (Q860206)

A. Omphalocele

B. Urachal cyst

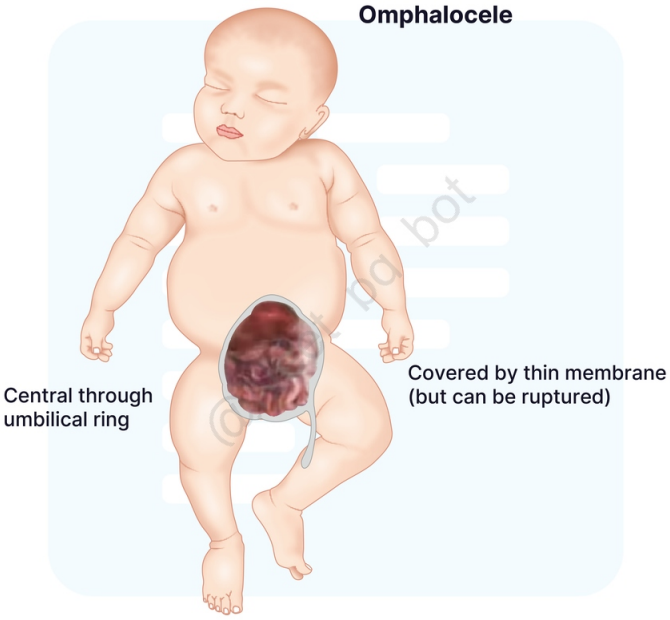
C. Umbilical hernia

D. Umbilical adenoma

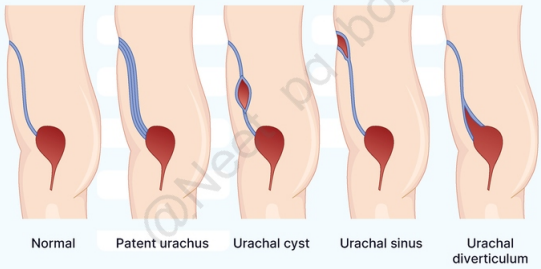


Correct Answer: A. Omphalocele

Explanation: The given image shows Omphalocele. Omphalocele is a central abdominal wall defect typically larger than 4 cm in diameter , characterized by an intact membranous sac composed of an outer layer of amnion and an inner layer of peritoneum . Defects smaller than 4 cm are classified as umbilical cord hernias . Associated anomalies: 50% of infants with omphalocele have associated anomalies, including: Beckwith-Wiedemann syndrome : A combination of gigantism , macroglossia , and an umbilical defect (either hernia or omphalocele). Chromosomal abnormalities such as trisomies 13, 15, 18, and 21 . Other conditions like bladder exstrophy , cloaca , and pentalogy of Cantrell , which includes: Omphalocele Anterior diaphragmatic hernia Sternal cleft Ectopia cordis Intracardiac defects , like ventricular septal defect . Initial management: The presence of an intact omphalocele sac is crucial for initial management. Preventing hypothermia is a primary concern. A comprehensive diagnostic workup is performed to identify associated anomalies. Surgical treatment: Primary surgical closure is preferred for small to medium-sized defects. Larger defects may require: Prosthetic patch closure (e.g., Gore-Tex), Porcine small intestinal submucosa -derived biomaterials (e.g., Surgisis), Skin flap closure , or Placement of a silo for sequential reduction and staged closure . For giant omphaloceles , topical application of escharotic agents like povidone-iodine (Betadine) ointment or silver nitrate is used to thicken and epithelialize the sac. The overall survival of infants with omphalocele depends largely on their lung maturity and the severity of associated anomalies . Urachal cyst (Option B) is a fluid-filled sac that results from the incomplete closure of the urachus (a remnant of the connection between the bladder and the umbilical cord). It doesn't present as an abdominal wall defect like omphalocele. Umbilical hernia (Option C) occurs when part of the intestine or other abdominal contents protrude through the umbilical opening in the abdominal muscles. It’s usually smaller and has no sac covering the contents, as seen in omphalocele. Umbilical adenoma (Option D) is a benign tumour located in or near the umbilicus, unrelated to abdominal wall defects like omphalocele.



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References:

Sabiston Textbook of Surgery, 21st Edition, Page 1867.

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Q55: In a seat belt injury, which of the following organs is most commonly affected? (Q860228)

A. Liver

B. Spleen

C. Pancreas

D. Hollow viscus

Correct Answer: D. Hollow viscus

Explanation: Hollow viscus (such as the small and large intestines) is the most commonly affected organ in seat belt injuries. Seat belt injury: The mesentery , a fold of tissue that attaches the intestines to the posterior abdominal

wall, is particularly vulnerable in seat belt injuries due to the compressive force of the belt across the abdomen. This can lead to mesenteric tears, avulsions, or hematomas, resulting in internal bleeding or ischemia, which often require surgical intervention to prevent complications like bowel necrosis. The classical seat belt sign refers to a distinctive pattern of bruising or contusion across the abdomen and chest resulting from the force of a seat belt during a car accident. This visible mark is a significant indicator of potential underlying injuries, including damage to internal organs like the mesentery, small intestine, or spine. Management of seat belt-related injuries: FAST is a quick and widely available method to detect intraperitoneal fluid or blood. Computed tomography (CT) scanning offers significant advantages by identifying critical details such as extraluminal air or contrast leakage, which can guide the need for surgical intervention. In cases where spinal injury is suspected, imaging of the entire spine should be conducted to rule out fractures, such as the Chance fracture commonly associated with seat belt injuries. Treatment: Immediate laparotomy. Seat belt syndrome describes the combination of the seat belt sign with associated internal injuries, such as abdominal organ damage or spinal fractures, particularly in the thoracolumbar region.



References:

SRB's Manual of Surgery, 6th Edition, Page 145

Schwartz’s Principles of Surgery, 11th Edition, Page 244

https://www.ncbi.nlm.nih.gov/books/NBK470262/#:~:text=Seatbelt%20injury%2C%20also%20called%20seatbelt,abdominal%20injuries%20and%20vertebral%20fractures

↑ *Back to this question in Part A*

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Q56: A young patient in the first decade of life presents with grade II splenic injury with no active bleeding. What is the management? (Q860297)

A. Splenectomy

B. Splenorrhaphy

C. Embolization

D. Conservative

Correct Answer: D. Conservative

Explanation: In the case of a grade II splenic injury without active bleeding, the management is generally conservative. This involves admission to the ICU for close monitoring, with repeated clinical assessments and possibly serial imaging to ensure there is no progression of injury or delayed bleeding. The goal is to preserve the spleen, thus avoiding the complications associated with splenectomy, such as OPSI (Overwhelming post-splenectomy infection) American Association for the Surgery of Trauma - AAST Spleen Injury scale Grade I (Minor Injury): Subcapsular hematoma affects less than 10% of the splenic surface area. Capsular tear that is less than 1 cm in depth without active bleeding. Grade II: Subcapsular hematoma involving 10-50% of the splenic surface area. Intraparenchymal hematoma less than 5 cm in diameter. Laceration between 1 and 3 cm in depth that doesn't involve trabecular vessels. Grade III: Subcapsular hematoma covering more than 50% of the splenic surface area or expanding hematoma. Intraparenchymal hematoma greater than 5 cm or expanding. Laceration is more than 3 cm in depth or involves trabecular vessels. Grade IV: Laceration affects segmental or hilar vessels, with evidence of devascularisation involving more than 25% of the spleen. Injury to the splenic parenchyma that results in major blood loss. Any injury in the presence of splenic vascular injury or active bleeding within the splenic capsule Grade V (Severe Injury): Completely shattered spleen. Vascular injury involving the splenic hilum that results in complete devascularization of the spleen. Management: Management of blunt trauma focuses on vigorous resuscitation. For hemodynamically stable patients with minor splenic injuries , non-operative management (NOM) (conservative) is the preferred approach. Splenectomy is recommended for severe injuries where bleeding control is prioritized over spleen preservation. In cases with active bleeding, splenic angiography and embolization can be used to avoid splenectomy, but this should not delay laparotomy in hemodynamically unstable patients.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1224

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Q57: What is the most likely diagnosis for an adult male patient with a history of intermittent purulent discharge with a slight blood tinge from an external opening

located in the perianal region? (Q860300)

A. Hemorrhoids

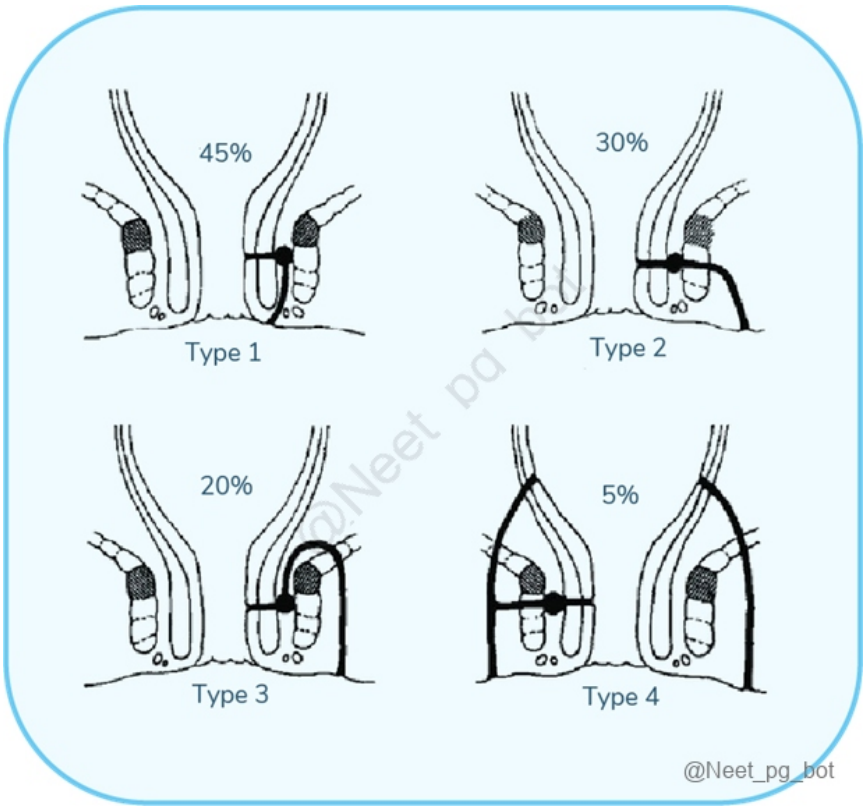
B. Pilonidal sinus

C. Perianal abscess

D. Fistula in ano

Correct Answer: D. Fistula in ano

Explanation: A fistula in ano is a common cause of intermittent purulent discharge with a slight blood tinge from an external opening near the perianal region. It often results from a previous perianal abscess that has developed into a chronic fistulous tract. Fistula-in-Ano A chronic abnormal communication between the anorectal lumen (internal opening) and an external opening on the skin of the perineum, buttock, or, rarely, the vagina in women. Causes Idiopathic/Cryptoglandular: The most common cause, often associated with prior anorectal sepsis. Associated Conditions: Crohn’s disease Tuberculosis Lymphogranuloma venereum Actinomycosis Rectal duplication Foreign bodies Malignancy (rare, can develop within a longstanding fistula) Clinical features Intermittent purulent discharge: This may be bloody and purulent. Discomfort typically increases until the pus discharges, providing temporary relief. Previous history of Anorectal abscess Passage of flatus or faeces: Through the external opening, (indicative of a rectal rather than an anal internal opening). Classifications: Low-level fistulas open into the anal canal below the internal ring. High-level fistulas open into the anal canal at or above the internal ring. Simple fistula without extensions Complex fistula with extensions. Parks classification Type 1 Inter-sphincteric (most common, 70%) Type 2 Trans- sphincteric (25%) Type 3 Supra- sphincteric (4%) Type 4 Extra-sphincteric (1%) Incorrect Options: Hemorrhoids (Option A) typically present with bleeding during defecation but do not produce purulent discharge. Pilonidal sinus (Option B) typically presents in the sacrococcygeal region and may involve purulent discharge, but is not commonly associated with blood-tinged drainage. Perianal abscess (Option C) is an acute condition characterized by pain, swelling, and often fever, with purulent drainage, but would not typically cause intermittent discharge over time without other symptoms of infection.



References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1436,1437

SRB's Manual of Surgery, 6th Edition, Page 972

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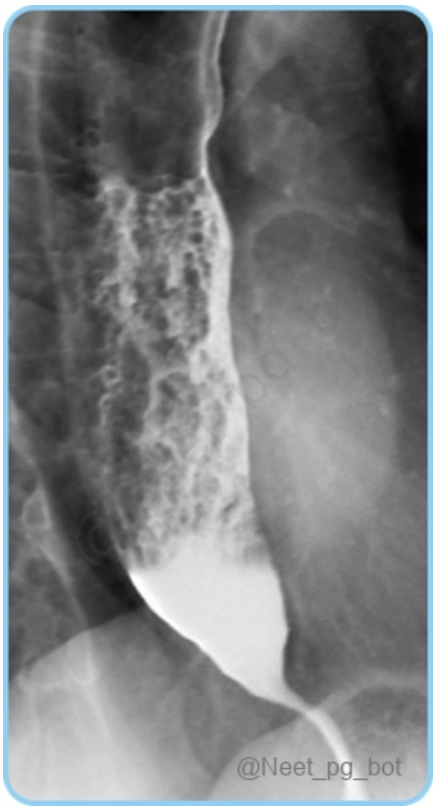
Q58: A barium swallow radiographic image of a woman with dysphagia is given below. What is the diagnosis? (Q860304)

A. Achalasia

B. Distal esophageal spasm

C. Jackhammer esophagus

D. None of the above

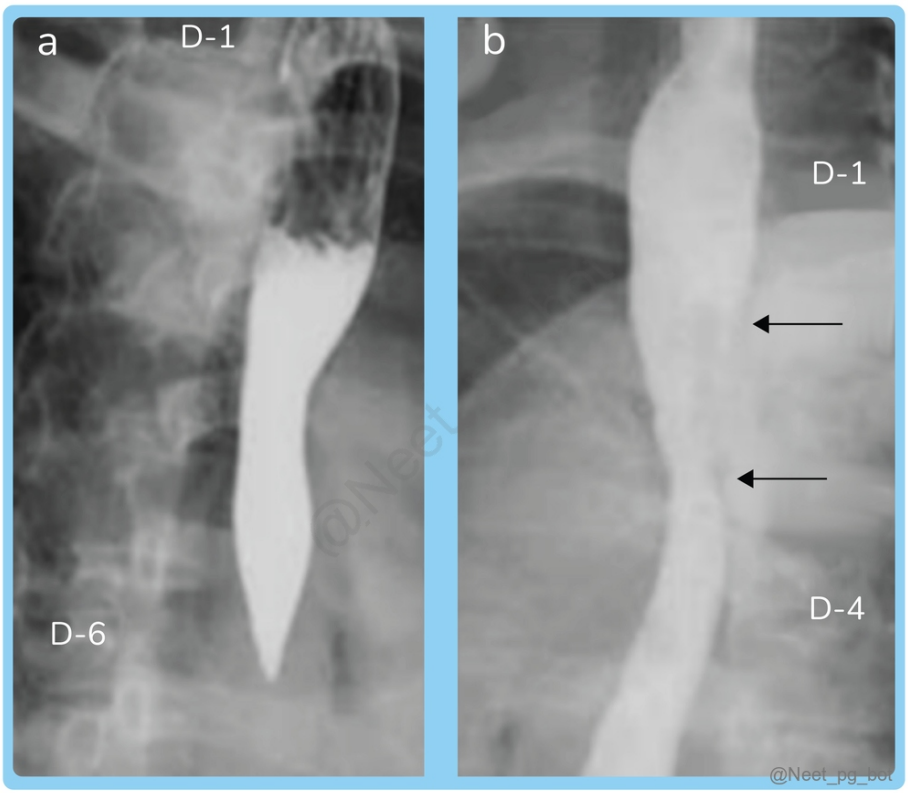


Correct Answer: A. Achalasia

Explanation: Achalasia is a disorder where the lower esophageal sphincter (LES) fails to relax properly, leading to a "bird-beak" appearance on a barium swallow, which is a classic finding in this condition. It causes difficulty swallowing (dysphagia) and often results in a progressive esophageal dilation above the constricted LES. Achalasia cardia Definition It is characterised by the progressive degeneration of ganglion cells in the esophageal wall. This leads to a loss of peristalsis in the lower esophagus and failure of the lower esophageal sphincter (LES) to relax during swallowing Clinical Features Dysphagia: May initially affect liquids more than solids. Regurgitation Halitosis Chest Pain Weight Loss Investigations: Esophageal Manometry Gold Standard: This is the definitive diagnostic test for achalasia. It measures the pressure and pattern of muscle contractions in the esophagus. (Option A) Elevated resting LES pressure (typically > 45 mmHg). Incomplete LES relaxation. Absence of peristalsis in the esophageal body. Periodic contractions with normal amplitude or high amplitude contractions (type I and II achalasia). Barium Swallow (Esophagram) Dilated esophagus with a narrowing at the LES (Bird beak appearance). {{caption_text}} Endoscopy: Normal mucosa but may show dilated esophagus with possible food debris, It is important to rule out other causes of dysphagia, such as tumors. Distal Esophageal Spasm : This condition presents with characteristic "corkscrew" appearance on barium swallow, due to irregular, simultaneous contractions in the distal esophagus. {{caption_text}} Jackhammer Esophagus : This condition involves excessive peristalsis with very strong contractions, resulting in a tight, hypercontractile esophagus . It can cause dysphagia but has a different radiographic appearance . {{caption_text}}


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References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1121,1122

SRB's Manual of Surgery, 6th Edition, Page 788, 789, 790

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Q59: A patient underwent bronchoscopy, during the procedure a perforation occurred at 25 cm. Which structure is most likely to be damaged? (Q860306)

A. Diaphragm

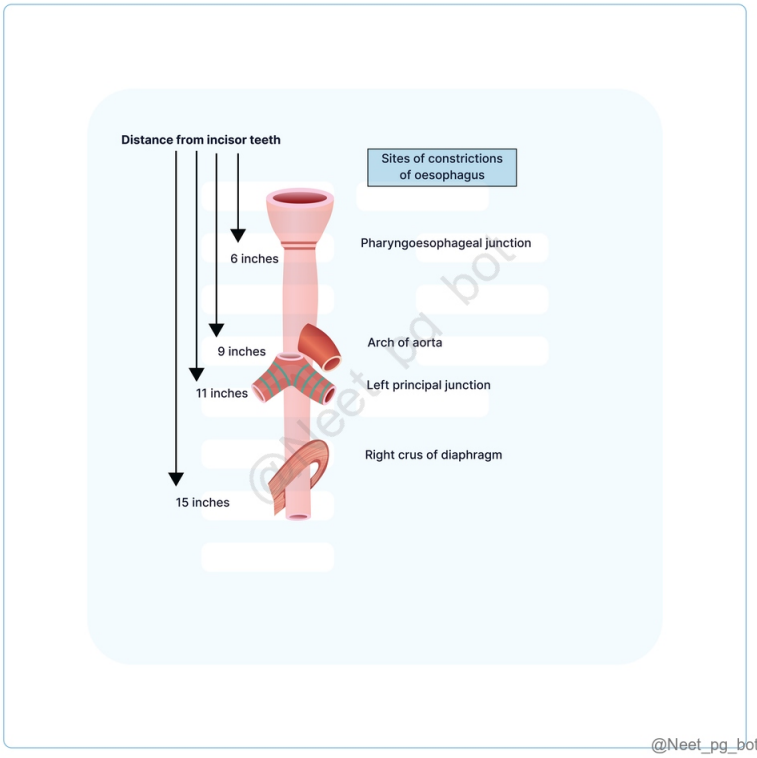
B. Arch of aorta

C. Pharyngoesophageal junction

D. T10

Correct Answer: B. Arch of aorta

Explanation: In the given scenario of perforation at 25 cm , the arch of the aorta is most likely to be damaged, as this is the region where the esophagus is compressed by the aorta and left bronchus. Constrictions of Esophagus: 0 cm - Incisor teeth (start of the esophagus). 15 cm - Cricopharyngeal constriction (upper esophageal sphincter). 25 cm - Aortic and bronchial constriction (due to the aorta and left bronchus). 40 cm - Diaphragmatic constriction (at the esophageal hiatus, lower esophageal sphincter).



References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1107

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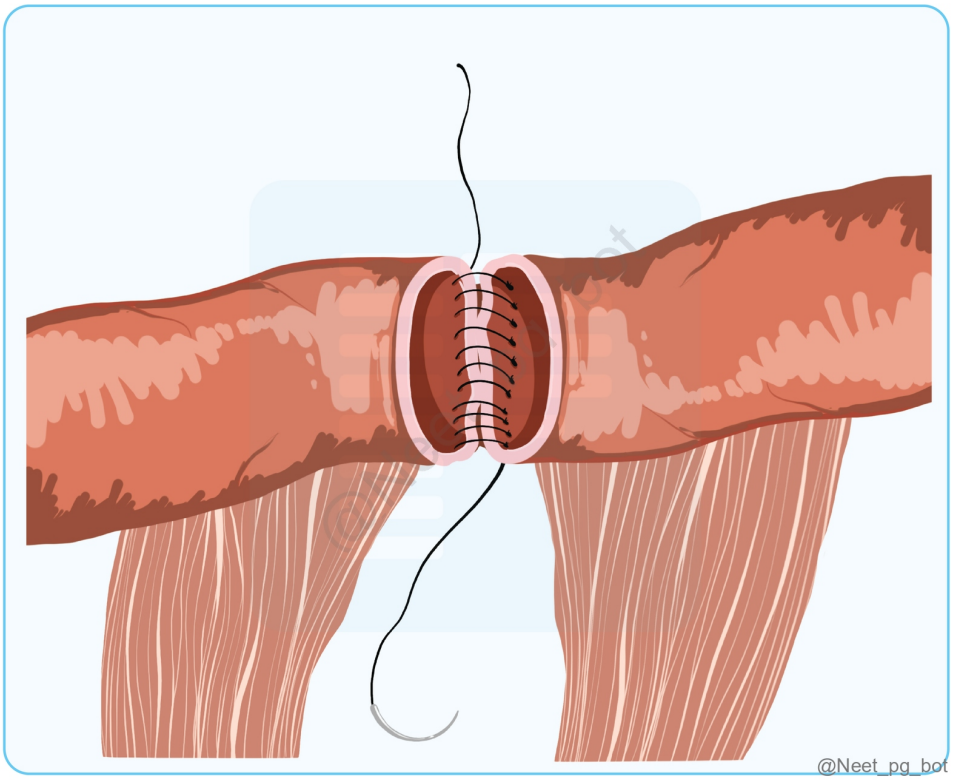
Q60: Identify the operative procedure shown in the image. (Q860308)

A. Primary closure of perforation

B. Resection and Anastomosis

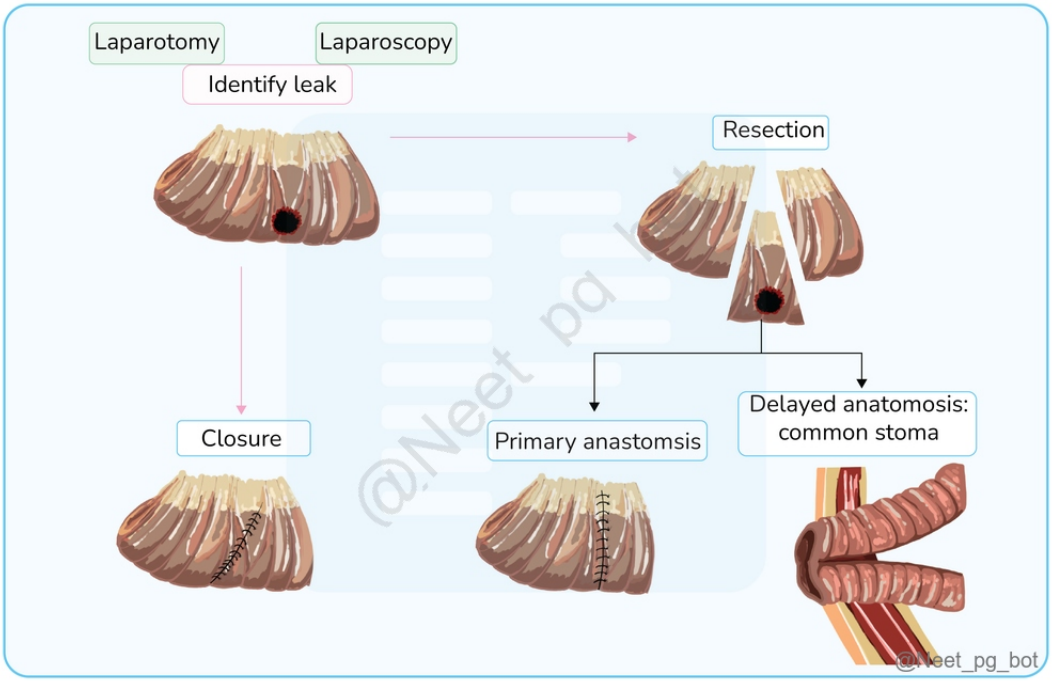
C. Ileostomy

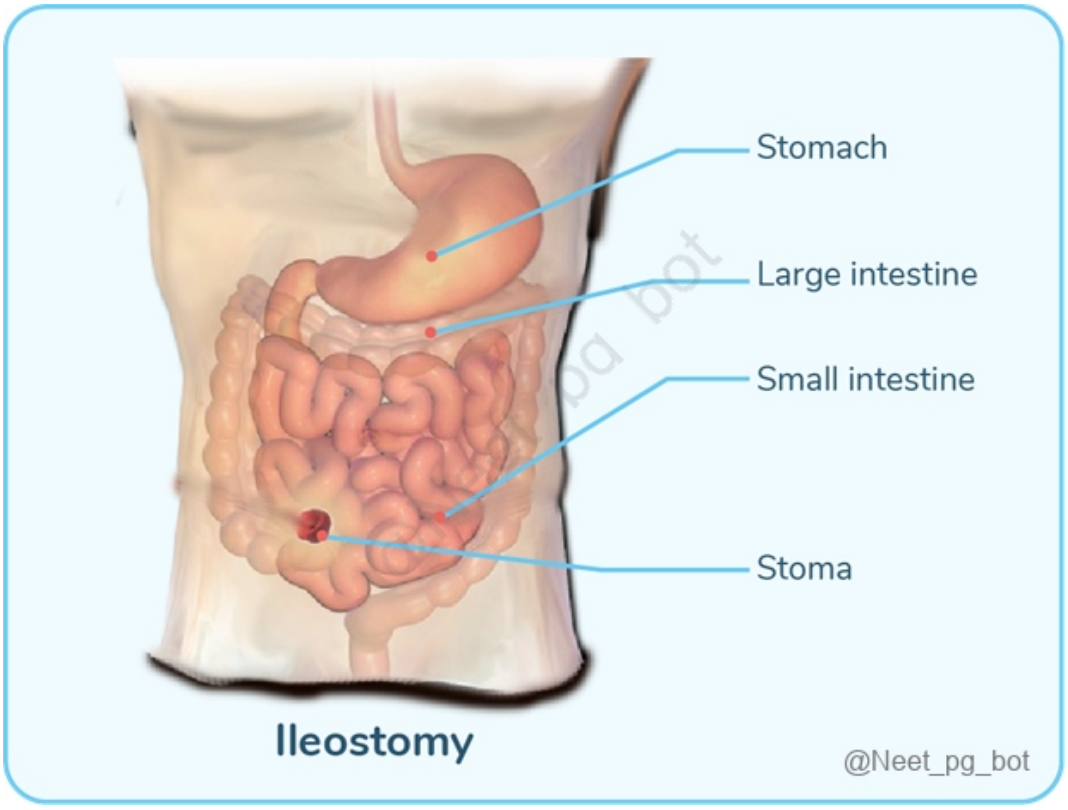
D. Resection alone



Correct Answer: B. Resection and Anastomosis

Explanation: The given image shows Resection and Anastomosis. This procedure involves the removal of a diseased or damaged segment of the bowel (resection) and then surgically joining the healthy ends of the remaining bowel (anastomosis). It's commonly performed in cases such as: Meckel’s diverticulum with an unhealthy base Transverse mesentery tear Small intestinal duplication Enterogenous cysts Primary closure of perforation : Typically involves suturing a hole or perforation in the gastrointestinal tract, usually performed in cases of bowel perforation. Ileostomy : A surgical procedure where the end of the ileum (small intestine) is brought to the surface of the abdomen to create an opening (stoma) for waste to exit. It may be used in cases of inflammatory bowel disease or after bowel resections. {{caption_text}} Resection alone : This refers to the removal of part of the gastrointestinal tract without performing an anastomosis. It might be used when a portion of the bowel is removed due to a tumor, but reconnection isn't necessary or feasible at the time.





References:

SRB's Manual of Surgery, 6th Edition, Page 882

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Q61: A young female presents with pain and vomiting in the ER. Clinical examination reveals a swelling lateral and below the pubic tubercle. X-ray shows intestinal obstruction. What is the most probable diagnosis? (Q857243)

A. Adhesions

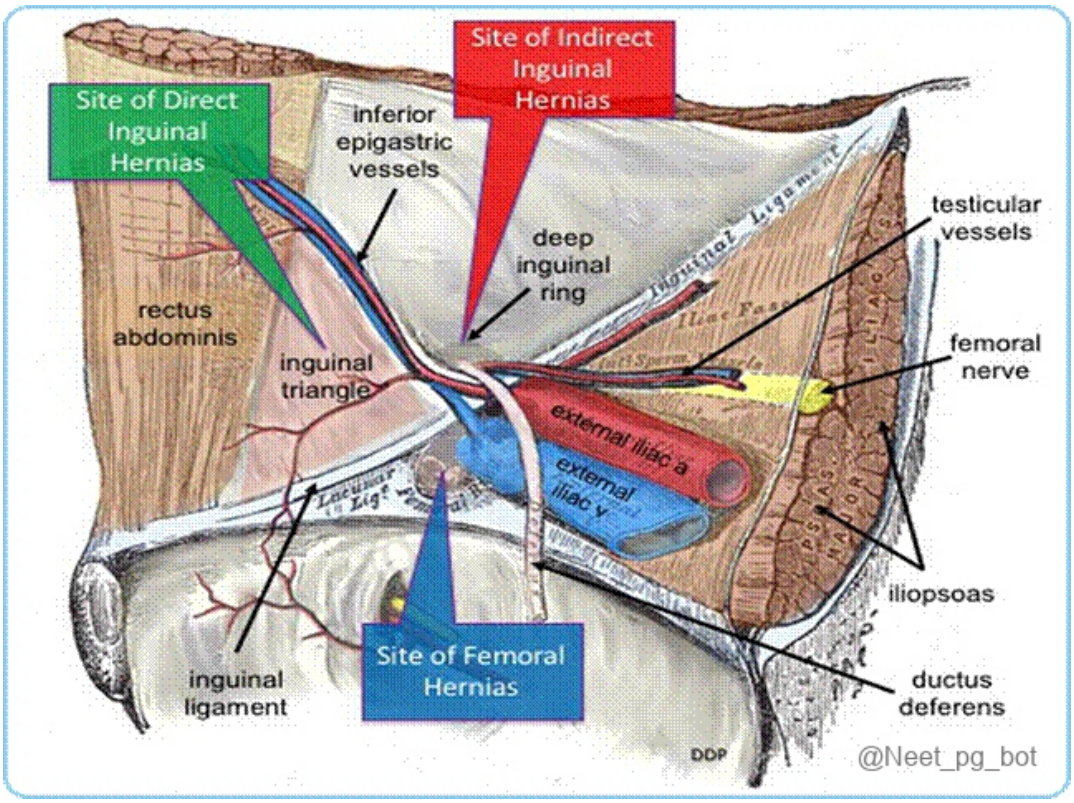
B. Strangulated Inguinal Hernia

C. Strangulated Femoral Hernia

D. Appendicular mass

Correct Answer: C. Strangulated Femoral Hernia

Explanation: The swelling lateral and below the pubic tubercle and the presence of intestinal obstruction are most likely indicative of a strangulated femoral hernia. In an indirect inguinal hernia (Option B) , the neck of the hernia is above and medial to the pubic tubercle. In contrast, the neck of the hernia in a femoral hernia is located below and lateral to the pubic tubercle. The femoral ring and canal are relatively rigid, which increases the risk of strangulation in these cases. {{caption_text}} Femoral Hernia: A groin hernia occurs when abdominal contents, typically a portion of the intestine or fatty tissue, protrude through the femoral canal in the lower abdominal wall. Location: Appears as a bulge in the upper thigh, just below the groin crease. Demographics: More common in women, especially older and overweight females. Risk: Higher risk of incarceration and strangulation compared to inguinal hernias. Symptoms: Lump in the groin or upper thigh, which may be painless or painful. Discomfort when standing, lifting, or straining. Nausea, vomiting, and abdominal pain if the hernia becomes incarcerated or strangulated. Adhesions (Option A): While adhesions can cause intestinal obstruction, they do not typically present with swelling. Appendicular Mass (Option D): An appendicular mass can cause swelling but is usually located in the right iliac fossa, not lateral and below the pubic tubercle.



References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1071,1072

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Q62: A 55-year-old male presents with complaints of dysphagia, halitosis, and regurgitation . Radiological imaging shows a blind pouch at the level of the pharynx. What is the likely diagnosis ? (Q820101)

A. Pulsion diverticula

B. Achalasia cardia

C. CA Esophagus

D. GERD

Correct Answer: A. Pulsion diverticula

Explanation: Correct Option A - Pulsion Diverticula Pulsion diverticula in the esophagus due to increased pressure in the esophageal wall, leading to the outpouching of the mucosa through weakened areas. This can cause symptoms like dysphagia (difficulty swallowing), regurgitation, and bad breath (halitosis). Incorrect Options: Option B - Achalasia Cardia : Achalasia is a disorder of the esophagus where the lower esophageal sphincter (LES) fails to relax properly, causing difficulty in food passage and esophageal dilation. Symptoms include dysphagia, regurgitation, and sometimes weight loss. While lobar pneumonia could potentially result from aspiration due to dysphagia, it is not a defining feature of achalasia. Option C - CA Esophagus (Esophageal Cancer): Esophageal cancer can lead to dysphagia, weight loss, and other symptoms. However, lobar pneumonia and consolidation are not directly related to esophageal cancer. CA Esophagus does not explain these radiological findings. Option D - GERD (Gastroesophageal Reflux Disease): GERD can cause symptoms like dysphagia, halitosis, and regurgitation. However, lobar pneumonia and consolidation are not typical consequences of GERD. These symptoms might arise due to chronic aspiration of stomach contents, leading to pneumonia, but GERD alone does not explain the presence of lobar pneumonia.

References:

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Q63: A 60-year-old man, a smoker, presented to the OPD with complaints of fatigue. He is known to be anemic and his sister had a history of endometrial cancer. The physician is considering appropriate colorectal cancer screening methods for this patient. Which screening method should be recommended for colorectal malignancy in this patient? (Q820105)

A. Barium enema

B. Colonoscopy every 10 years

C. Check for occult blood in stool

D. Flexible sigmoidoscopy yearly

Correct Answer: B. Colonoscopy every 10 years

Explanation: Correct option B - Colonoscopy every 10 years: Colonoscopy every 10 years is the recommended screening method for colorectal malignancy, especially in individuals with risk factors such as a family history of colorectal cancer and a personal history of anemia. Colonoscopy allows for direct visualization of the entire colon and rectum, and it can both detect and remove precancerous growths (polyps) during the same procedure. Incorrect options: Option A - Barium enema: Barium enema is not a method for colorectal cancer screening. Option C - Check for occult blood in stool: Occult blood can be an indicator of gastrointestinal bleeding. While fecal occult blood test (FOBT) is a screening method, it is not the most sensitive test and may require repeated testing. Option

D - Flexible sigmoidoscopy yearly: Flexible sigmoidoscopy is a screening method that involves examining the lower part of the colon and rectum using a flexible sigmoidoscope. While it can be effective, it only examines a portion of the colon. Colonoscopy provides a more comprehensive examination of the entire colon and is recommended every 10 years for colorectal cancer screening.

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Q64: What type of material is in the mesh used in Lichtenstein hernioplasty? (Q820106)

A. Polypropylene

B. Polyglactin

C. Polydioxanone

D. Polyacrilamide

Correct Answer: A. Polypropylene

Explanation: Correct option A - Polypropylene: In Lichtenstein hernioplasty, polypropylene meshes are used to reinforce the abdominal wall and prevent hernia recurrence due to their long-term stability and minimal tissue reaction. Incorrect options: Option B, C and D are not used as mesh material in Lichtenstein hernioplasty.

↑ *Back to this question in Part A*

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Q65: A 20-year-old male presents with a 5-day history of abdominal pain, fever and vomiting . On examination, there is a palpable mass in right iliac fossa with leukocytosis . What is the management plan for this condition? (Q820127)

A. Ochsner-Sherren regime

B. Alvarado scoring

C. Laparoscopic appendectomy

D. Cholecystectomy

Correct Answer: A. Ochsner-Sherren regime

Explanation: Correct option A - Ochsner-Sherren regime: Ochsner-Sherren regime is for the management of acute appendicular mass. It refers to a conservative approach involving antibiotics and bed rest for the treatment of an acute appendicular mass. The strategy of this regime is based on the presumption that the inflammatory process is already localized and that inadvertent surgery is challenging and may be unsafe. However, in many cases, surgical intervention is the preferred treatment. Incorrect options: Option B - Alvarado scoring: Alvarado scoring is a clinical scoring system used to assess the likelihood of acute appendicitis. Option C - Laparoscopic appendectomy: Laparoscopic appendectomy is a minimally invasive surgical procedure to remove the inflamed appendix. Option D - Cholecystectomy: Cholecystectomy is the surgical removal of the gallbladder.

↑ *Back to this question in Part A*

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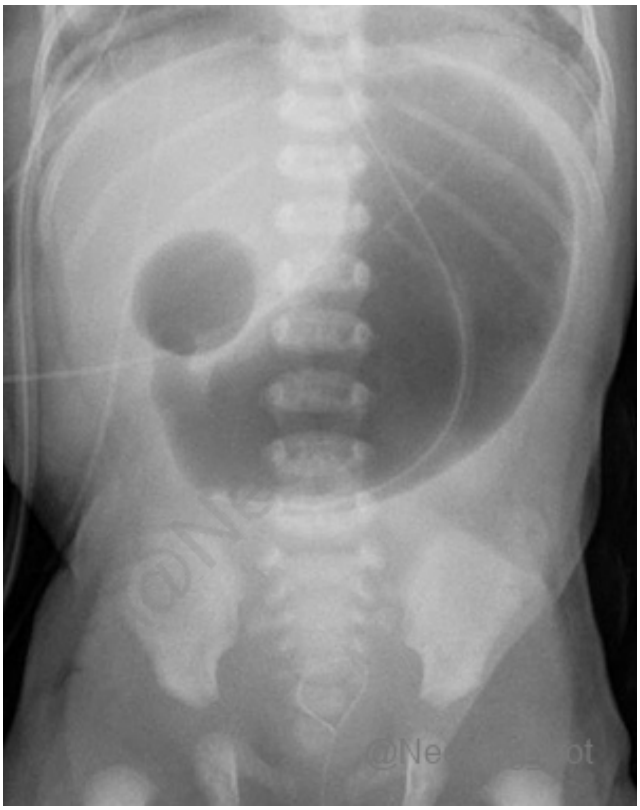
Q66: A newborn baby presents with bilious vomiting and abdominal distension within 2 days of birth . An X-ray abdomen was performed which is shown below. What is the most probable diagnosis? (Q820131)

A. Duodenal atresia

B. Pyloric stenosis

C. Esophageal atresia

D. Gas in bowel



Correct Answer: A. Duodenal atresia

Explanation: Correct option A - Duodenal atresia Duodenal atresia is a congenital condition in which there is a complete or partial obstruction of the lumen of the duodenum. This obstruction can lead to bilious vomiting and abdominal distension shortly after birth. X-ray image shows a characteristic "double bubble" sign, where there are two distinct air-filled bubbles in the abdomen, one representing the stomach and the other the dilated portion of the proximal duodenum, which is a typical radiological finding in duodenal atresia. Incorrect options: Option B - Pyloric stenosis: Pyloric stenosis is a condition in which the muscle at the pylorus becomes abnormally thickened, leading to obstruction of the gastric outlet. It typically presents with projectile, non-bilious vomiting and a palpable "olive-like" mass in the upper abdomen. X-ray findings for pyloric stenosis usually include a "string sign" - a narrow pyloric channel. Option C - Esophageal atresia: Esophageal atresia is a congenital condition in which the esophagus does not develop properly. This condition is associated with difficulty swallowing, drooling, choking and cyanosis. X-ray shows an absence of air in the stomach and the presence of air in the proximal esophagus. Option D - Gas in bowel: Gas in the bowel is a common finding in X-ray images of the abdomen and is present in normal conditions as well as various pathological conditions. It does not provide a specific diagnosis.

↑ *Back to this question in Part A*

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Q67: A 70-year-old male patient presents with progressive dysphagia to solids and liquids and the manometry findings include uncoordinated or absent peristalsis with increased LES resting pressure . What is the most likely diagnosis for this patient?

(Q820145)

A. Stomach cancer

B. Cancer esophagus

C. GERD

D. Achalasia cardia

Correct Answer: D. Achalasia cardia

Explanation: Correct option D - Achalasia cardia Achalasia is a motility disorder of the esophagus where there is impaired relaxation of the lower esophageal sphincter (LES), which leads to difficulty in moving food from the esophagus into the stomach. This disorder often presents with symptoms like regurgitation of undigested food, difficulty swallowing solids and liquids and chest pain. Incorrect options: Option A, B and D are incorrect.

↑ *Back to this question in Part A*

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Q68: A 45-year-old patient presents after undergoing a Billroth II gastrectomy operation and complains of symptoms suggestive of dumping syndrome , including vomiting and diarrhea occurring approximately 20 minutes after meals. What should be the initial management for this patient's condition? (Q820171)

A. Low fat diet

B. Small frequent meals

C. Insulin and protein

D. Reverse Billroth II to Billroth I

Correct Answer: B. Small frequent meals

Explanation: Correct option B - Small frequent meals Dumping syndrome is commonly seen after gastric surgery, such as Billroth II gastrectomy, where the pyloric valve is removed, leading to rapid emptying of the stomach contents into the small intestine. Consuming smaller, more frequent meals can help slow down the rate of stomach emptying, reducing the severity of symptoms like vomiting and diarrhea. Incorrect options: Option A - Low fat diet: A low fat diet might help to some extent, but the primary issue in dumping syndrome is the rapid emptying of the stomach, not necessarily the fat content of the food. Option C - Insulin and protein: Insulin and protein are not used as management for dumping syndrome. Option D - Reverse Billroth II to Billroth I: Reversing the surgical procedure to convert a Billroth II to a Billroth I gastrectomy is a major surgical decision that is generally not the initial management choice for dumping syndrome. Non-surgical approaches, like dietary modifications, are

usually tried first.

↑ *Back to this question in Part A*

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Q69: A 35-year-old patient is scheduled to undergo laparoscopic surgery. The surgical team plans to create a pneumoperitoneum to facilitate the procedure. Which gas is commonly used for creating the pneumoperitoneum in laparoscopic surgeries? (Q820240)

A. Helium

B. Oxygen

C. Nitrogen

D. Carbon dioxide

Correct Answer: D. Carbon dioxide

Explanation: Correct Option D - Carbon dioxide: Laparoscopic surgery is a minimally invasive surgical technique in which small incisions are made in the abdominal wall to insert a camera and surgical instruments. A pneumoperitoneum, which is the inflation of the abdominal cavity with gas, is created to create space for the surgeon to work and to provide a clear view of the surgical site. Carbon dioxide (CO2) is the gas commonly used for creating the pneumoperitoneum in laparoscopic surgeries. Incorrect Options: Option A - Helium: Helium is a noble gas that is lighter than air, but it is not commonly used for creating a pneumoperitoneum in laparoscopic surgeries. Helium is expensive and can lead to difficulties in accurately maintaining the desired pressure within the abdominal cavity. Option B - Oxygen: Oxygen is not used for creating a pneumoperitoneum. It is not suitable for this purpose because it can support combustion, and the risk of fire or explosion would be a concern in a surgical setting. Option C - Nitrogen: While nitrogen is an inert gas and is commonly found in the atmosphere, it is not the gas of choice for creating a pneumoperitoneum. Carbon dioxide is preferred over nitrogen due to its ability to be rapidly absorbed by the body if it enters the bloodstream, which reduces the risk of gas embolism.

↑ *Back to this question in Part A*

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Q70: A male patient complains of loss of appetite and dysphagia, with a weight loss of approximately 6 kg over the last three months. He had a previous diagnosis of esophageal cancer and underwent treatment. What might be the cause of his current symptoms? (Q830818)

A. Esophageal cancer recurrence

B. Fibrosis

C. Achalasia cardia

D. GERD

Correct Answer: A. Esophageal cancer recurrence

Explanation: Correct Option A - Esophageal cancer recurrence: Given the patient's history of esophageal cancer, recurrence is a significant concern, especially with symptoms such as dysphagia and weight loss. Esophageal cancer can recur, leading to the reemergence of symptoms Incorrect choices: Option B - Fibrosis: Fibrosis refers to the development of scar tissue. While it could occur post-treatment, it might not directly explain the recurrence of dysphagia and weight loss. Option C - Achalasia cardia: Achalasia is a motility disorder of the esophagus, but it is less likely in this case, considering the patient's history of esophageal cancer. Option D - GERD: GERD could cause symptoms like dysphagia and weight loss, but it might not fully explain the history of esophageal cancer.

References:

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↑ *Back to this question in Part A*

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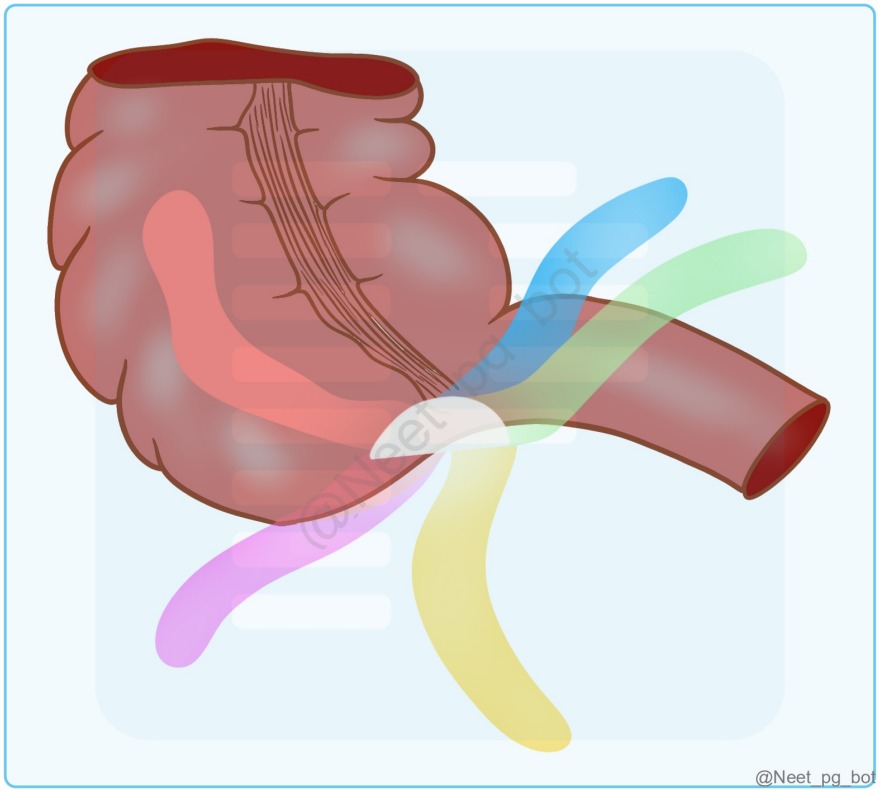
Q71: What is the position of the appendix marked in red colour? (Q854748)

A. Retrocecal

B. Preileal

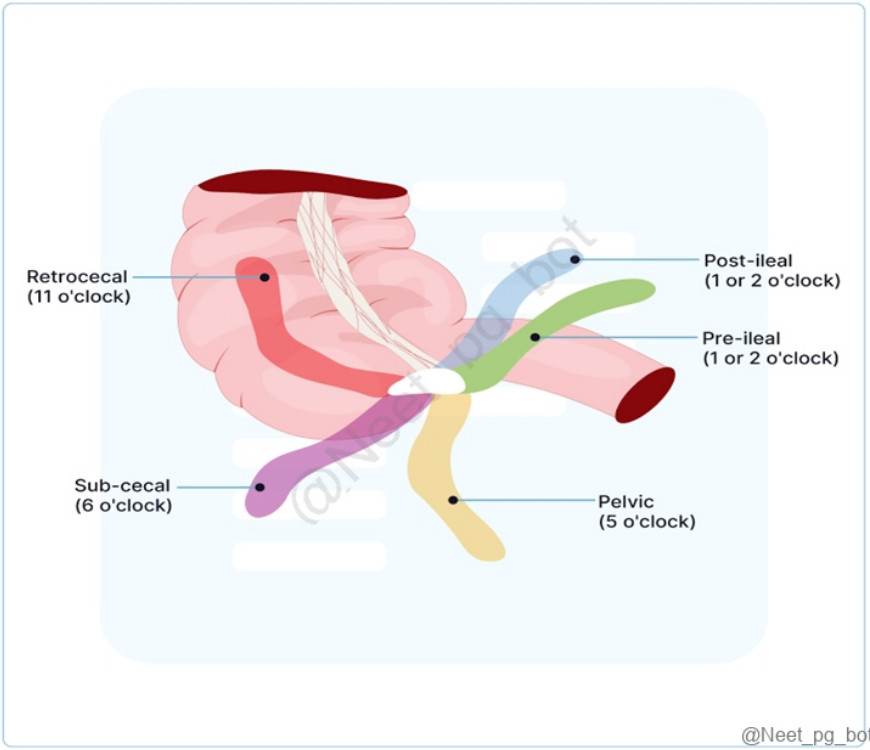
C. Subcecal

D. Pelvic



Correct Answer: A. Retrocecal

Explanation: The retrocecal position is one of the most common variations in the anatomical location of the appendix. In this position, the appendix is located behind the cecum, usually near the ileocecal valve. Locations of the appendix and their presentations: Location Presentation Retrocecal May present with flank or back pain Subcecal Can mimic gynaecological disorders or urinary tract infection Pre-ileal May cause small bowel obstruction symptoms Post-ileal May cause small bowel obstruction symptoms Paracecal Can present with typical right lower quadrant pain Subhepatic Can be mistaken for cholecystitis Pelvic Can mimic symptoms of pelvic inflammatory disease or ovarian pathology



References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1339

↑ *Back to this question in Part A*

@Neet_pg_bot

Q72: A surgeon examines a case of hernia and is able to retract the hernial sac but not its contents. Based on this examination, which type of hernia is most likely? (Q854750)

A. Incarcerated hernia

B. Reduction en masse

C. Sliding hernia

D. Maydl's hernia

Correct Answer: C. Sliding hernia

Explanation: In a sliding hernia , a part of the viscus forms a portion of the hernial sac wall (most commonly sigmoid colon on the left, cecum on the right, or bladder). Because the organ itself forms the posterior wall of the

sac , the surgeon may be able to retract or manipulate the peritoneal sac , but the hernia contents cannot be reduced , since the involved organ is fixed in position. Incarcerated hernia (Option A): In an incarcerated hernia, both the sac and its contents are irreducible because the bowel is trapped. You cannot retract the sac independently. Reduction en masse (Option B): Here, the entire sac + contents are accidentally reduced together into the preperitoneal space . You cannot retract only the sac; the sac and bowel move en bloc . Maydl's hernia (Option D): This "W-shaped hernia" involves two loops in the sac with the strangulated loop inside the abdomen . Both sac and contents coexist; the sac is not independently retractable , and the pattern of irreducibility differs completely from the scenario.

References:

SRB's Manual of Surgery, 6th Edition, Page 760,761

Sabiston Textbook of Surgery, 21st Edition, Page 1118

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 256

↑ *Back to this question in Part A*

@Neet_pg_bot

Q73: A 53-year-old patient presents with a complaint of per rectal bleeding. The surgeon suspects a possible colorectal pathology and wants to determine the most appropriate investigation for this patient. Which of the following options would be the best choice? (Q854758)

A. Colonoscopy

B. CEA levels

C. CA-19-9 levels

D. CECT

Correct Answer: A. Colonoscopy

Explanation: Colonoscopy is the most appropriate investigation for a patient presenting with per rectal bleeding. It allows direct visualisation of the colon and rectum, helping to diagnose conditions such as colorectal cancer, diverticular disease, or inflammatory bowel disease, which could be causing the bleeding. Incorrect Options: CEA levels (Option B) : While CEA levels can be useful for monitoring treatment response or detecting recurrence in patients with known colorectal cancer, they are not the primary diagnostic tool for the initial evaluation of per rectal bleeding. CA-19-9 (Option C) is a tumour marker primarily associated with pancreatic and hepatobiliary malignancies, not colorectal pathology. CECT (Contrast-enhanced CT scan) (Option D) may be used as an adjunct in specific cases or to assess extra-colonic findings, but it is not the first-line investigation for per rectal bleeding.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1406

↑ *Back to this question in Part A*

@Neet_pg_bot

Q74: Which of the following is not a perineal approach for rectal prolapse? (Q854766)

A. Altemeir

B. Frykman and Goldberg's

C. Thiersch

D. Delorme

Correct Answer: B. Frykman and Goldberg's

Explanation: Frykman and Goldberg's procedure is not a perineal approach for rectal prolapse. Instead, it is an abdominal approach used for rectal prolapse repair. This procedure involves a transabdominal posterior rectopexy and resection of the redundant left colon . Operative management of Rectal Prolapse: Rectopexy is fixing the rectum to the sacrum by sutures or mesh after complete mobilisation of the rectum. Aspect Abdominal Rectopexy Perineal Rectopexy Types Prosthetic or mesh rectopexy-anterior/ posterior- Well's, Ripstein Suture rectopexy-Lahaut Anterior Resection Resection Rectopexy Mucosal sleeve resection (Delrome's) (Option D) Perineal recto sigmoidectomy (Altemeier's) (Option A) Posterior fixation of the rectum of Lockhardt-Mummery Mickulicz Miles perineal transanal recto sigmoidectomy Anal encircling (Thiersch) (Option C) Advantages Fixation of the rectum provides adequate tension to prevent recurrence. Minimally invasive options (laparoscopic or robotic) offer benefits in pain control, hospital stay, and recovery time Lower operative morbidity and mortality, suitable for elderly or medically unfit patients. Disadvantages Requires extensive dissection and fixation, which may have higher morbidity (10%-33%). Risk of mesh-related complications such as erosion, infection, bowel obstruction, and migration. Higher recurrence rates compared to abdominal approaches

References:

Sabiston Textbook of Surgery, 21st Edition, Page 1392,1394

SRB's Manual of Surgery, 6th Edition, Page 957,961,962

↑ *Back to this question in Part A*

@Neet_pg_bot

Q75: Which of the following is the most common complication following ligation of the first vessel during abdominoperineal resection for rectal carcinoma? (Q855169)

A. Parasympathetic - bladder dysfunction and retrograde ejaculation

B. Sympathetic - bladder dysfunction and impotence

C. Sympathetic - retrograde ejaculation and bladder dysfunction

D. Sympathetic - impotence and loss of cutaneous sensation in the perineal region

Correct Answer: C. Sympathetic - retrograde ejaculation and bladder dysfunction

Explanation: The first vessel ligated during abdominoperineal resection is typically the inferior mesenteric artery (IMA) . High ligation of the IMA can damage the superior hypogastric nerve , leading to sympathetic dysfunction . This dysfunction can result in complications such as retrograde ejaculation and bladder dysfunction due to disruption of the sympathetic nerve pathways that control these functions. Abdominoperineal Resection (APR): APR, or the Miles procedure, is performed when the sphincters are infiltrated by tumour, requiring excision of the rectum, anus, and sphincter apparatus with a permanent colostomy. It's also used for elderly patients with distal rectal cancer and poor sphincter function. Other options: Option A: Parasympathetic – bladder dysfunction and retrograde ejaculation Parasympathetic injury (pelvic splanchnics) affects voiding (detrusor contraction), not ejaculation. Retrograde ejaculation is mainly sympathetic mediated. Option B:. Sympathetic – bladder dysfunction and impotence Impotence is predominantly related to parasympathetic cavernous nerves, not sympathetic fibers injured during high IMA ligation. Option D:Sympathetic – impotence and perineal sensory loss Perineal sensation is mediated by the pudendal nerve, not the sympathetic plexus. Impotence is again parasympathetic.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1413,1414

Sabiston Textbook of Surgery, 21st Edition, Page 1385

↑ *Back to this question in Part A*

@Neet_pg_bot

Q76: A 45-year-old male presents with right thigh pain after undergoing bilateral laparoscopic hernia repair for an inguinal hernia. Which nerve entrapment is most likely responsible for this symptom? (Q855178)

A. Ilioinguinal nerve

B. Iliohypogastric nerve

C. Femoral nerve

D. Lateral cutaneous nerve of thigh

Correct Answer: D. Lateral cutaneous nerve of thigh

Explanation: The patient has lateral femoral cutaneous nerve neuropathy (Meralgia paresthetica) due to entrapment during laparoscopic inguinal hernia repair. During laparoscopic or open inguinal hernia repair, sutures, staples, tacks, or mesh can entrap the lateral cutaneous nerve of the thigh (LCNT) near the anterior superior iliac spine (ASIS) . The nerve is purely sensory , explaining symptoms of burning pain, tingling, numbness over the anterolateral thigh without motor weakness. This is the most commonly injured nerve in laparoscopic repairs due to mesh fixation close to ASIS. Other options: Option A: Ilioinguinal nerve Injury causes pain in superomedial thigh, root of penis/scrotum or mons pubis/labia majora. Not the anterolateral thigh. Option B: Iliohypogastric nerve Injury leads to pain above the pubis or lower abdomen; does not supply the lateral thigh. Option C: Femoral nerve Would cause quadriceps weakness, loss of knee reflex, and sensory loss on anterior thigh — motor involvement would be present, which is absent here.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1070

Schwartz’s Principles of Surgery, 11th Edition, Page 1603,1605

↑ *Back to this question in Part A*

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Q77: A patient presents with swelling in the groin region, diagnosed as a direct inguinal hernia . Weakness in which of the following structures is most likely to cause this condition? (Q855239)

A. Pectineal ligament

B. Conjoint tendon

C. Reflected part of inguinal ligament

D. Lacunar ligament

Correct Answer: B. Conjoint tendon

Explanation: A direct inguinal hernia protrudes through Hesselbach’s triangle, an area bounded by the rectus abdominis, inferior epigastric vessels, and inguinal ligament. The conjoint tendon, created by the union of the internal oblique and transversus abdominis muscles, forms the medial portion of the posterior wall of the inguinal canal and contributes to the posterior wall of the superficial inguinal ring. Weakness in this structure can result in a direct inguinal hernia. Other options: Pectineal ligament (Option A): The pectineal ligament, though it contributes to the inguinal canal's floor, is not directly involved in the formation of a direct inguinal hernia. Its weakening alone does not typically cause this condition. Reflected part of the inguinal ligament (Option C) helps form the inguinal canal's floor, but it is not the primary structure responsible for the weakness leading to a direct inguinal hernia. The weakness is mainly related to the conjoint tendon . Lacunar ligament (Option D): The lacunar ligament, part of the inguinal ligament, contributes to the inguinal canal's floor but does not play a central role in the development of a direct inguinal hernia. The weakness of the conjoint tendon is the key factor here.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1065,1066

↑ *Back to this question in Part A*

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Q78: A 4-year-old child presents with a rectal polyp and painless rectal bleeding. Histopathological examination reveals enlarged and inflamed glands filled with mucin. The child is diagnosed with a juvenile rectal polyp. Which of the following best describes the polyp in this case? (Q855247)

A. Adenoma

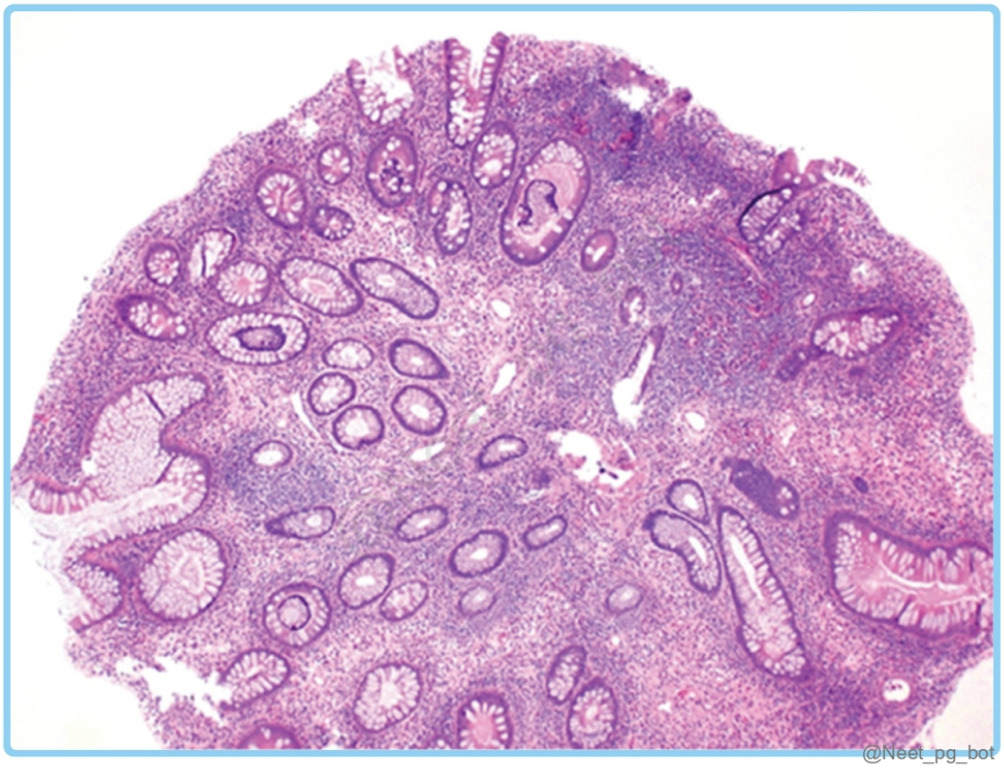
B. Choristoma

C. Hamartoma

D. Carcinoma

Correct Answer: C. Hamartoma

Explanation: Juvenile rectal polyps are hamartomatous in nature, typically solitary but can sometimes appear in multiples. These polyps are most commonly found in children under 5 years of age and usually present with rectal bleeding . The condition is associated with mutations in SMAD 2, SMAD 4, and BMPR1A . Extra-intestinal features may include digital clubbing and vascular malformations . The histological appearance of a juvenile rectal polyp is shown below: {{caption_text}} Adenomas (Option A) are benign tumours that originate from glandular tissue. While adenomas can occur in the rectum, they are rare in children. Choristoma (Option B) are ectopic tissues found in abnormal locations. They are rare in the rectum and are not typically associated with juvenile rectal polyps. Carcinoma (Option D) refers to malignant tumours that arise from epithelial cells. It is highly unlikely for a 5-year-old child to develop carcinoma, making this an unlikely diagnosis in this case.



References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1357,1358

↑ *Back to this question in Part A*

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Q79: A 20-year-old female patient consumed a cleaning product containing 90% sodium hydroxide. She is having complete dysphagia. What is the best step in management? (Q855272)

A. Esophagojejunostomy

B. Stent placement

C. Feeding jejunostomy

D. Gastrojejunostomy

Correct Answer: C. Feeding jejunostomy

Explanation: Ingesting strong alkalis like sodium hydroxide can lead to significant damage to the esophagus, resulting in a condition called caustic esophagitis. In the acute phase of corrosive alkali ingestion, definitive reconstructive surgery must NOT be performed immediately due to unstable tissue planes and risk of perforation. The priority is nutritional support while allowing the esophagus to heal and preventing further injury. Feeding jejunostomy provides a safe long-term enteral route while avoiding the injured esophagus and stomach. It does not interfere with future esophageal reconstruction. Other options: Option A: Esophagojejunostomy Definitive surgery is contraindicated in the acute inflammatory phase (first 4–6 weeks). Tissue friability → catastrophic risk of leaks and mediastinitis. Option B: Stent placement Not indicated in the acute phase because: Perforation risk is high Stent migration risk Used later for stricture management, not at presentation. Option D: Gastrojejunostomy Does not bypass the esophagus effectively for feeding. Still requires esophageal passage, which is not possible in complete dysphagia after alkali injury.

References:

SRB's Manual of Surgery, 6th Edition, Page 791,792

↑ *Back to this question in Part A*

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Q80: Which of the following is not true about Congenital Hypertrophic Pyloric Stenosis? (Q857791)

A. Presents with non-bilious vomiting

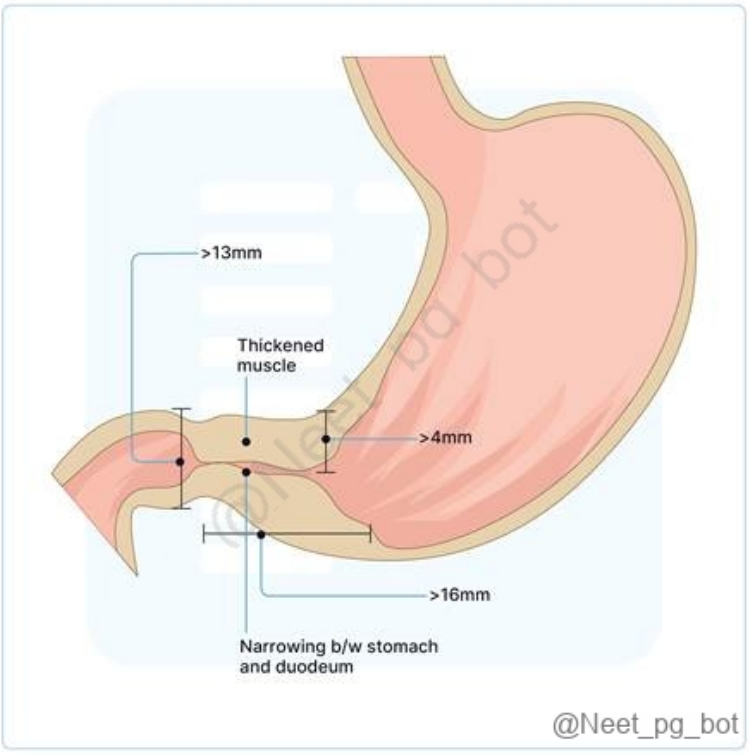
B. Caused by hypertrophy of longitudinal muscles

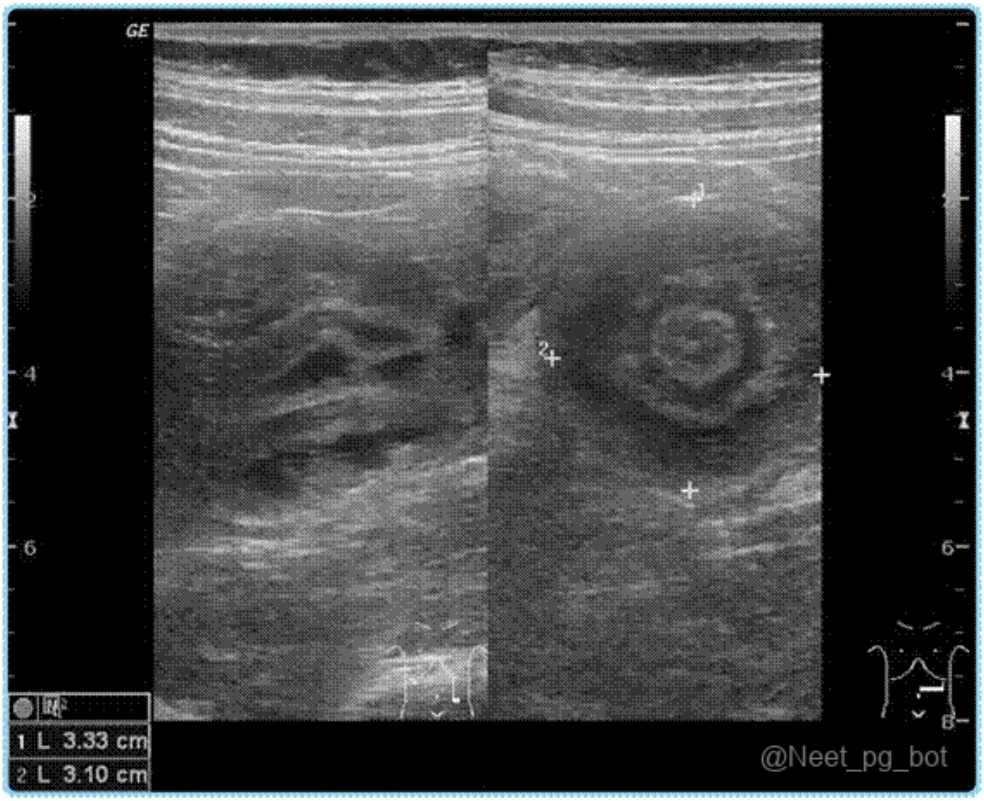
C. USG is the gold standard investigation for this condition

D. Hypokalemic metabolic alkalosis seen

Correct Answer: B. Caused by hypertrophy of longitudinal muscles

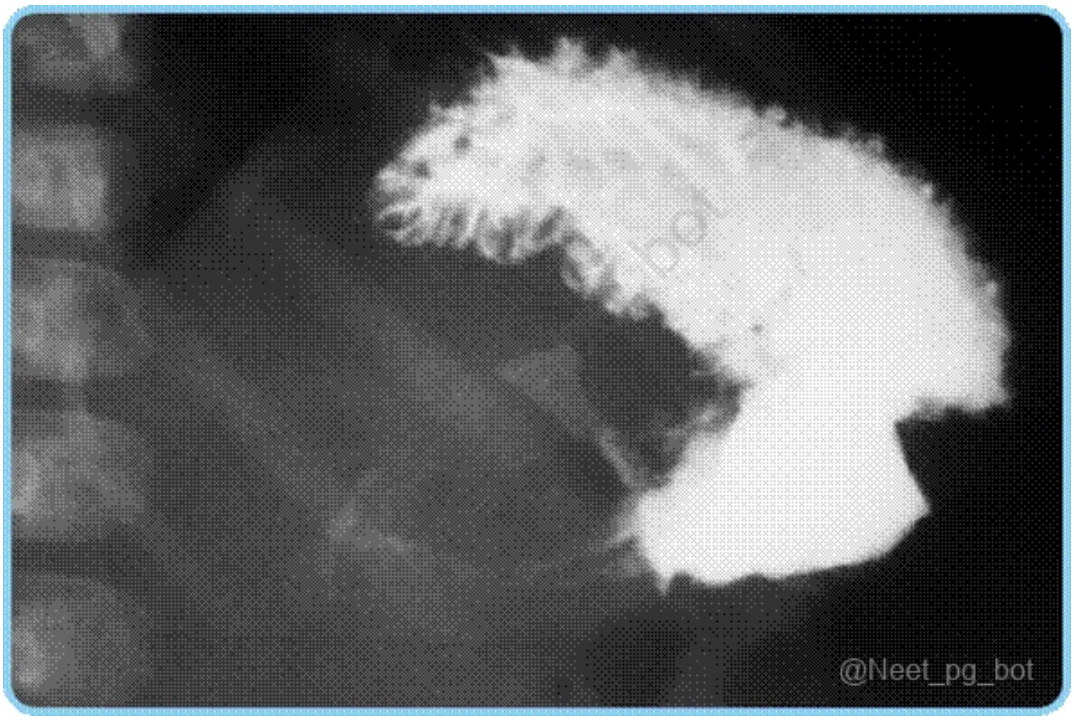
Explanation: Congenital Hypertrophic Pyloric Stenosis (CHPS) is caused by the hypertrophy of the circular muscles of the pylorus, not the longitudinal muscles. Clinical Presentation Typical onset: 3 to 6 weeks of age Symptoms: Projectile, non-bilious vomiting (Option A ruled out) Visible gastric peristalsis Palpable " olive-like " mass in the abdomen (hypertrophied pylorus), best felt from the left side Test feed: Gastric peristalsis is seen passing from left to right across the abdomen, and in a relaxed (feeding) baby, the pyloric ‘tumor’ is palpable as an ‘olive’ in the right upper quadrant. Dyselectrolytemias- Hypochloremia Hypokalemia due to persistent vomiting Metabolic alkalosis. (Option D ruled out) Ultrasound (Gold Standard) (Option C ruled out) Characteristic " doughnut sign " indicating thickened pyloric muscle {{caption_text}} Diagnostic criteria: Pyloric muscle thickness ≥ 4 mm Pyloric canal length > 14 mm "Cervix sign" on long-axis view "Target sign" on short-axis view {{caption_text}} Barium Meal (Less Common) Can assist in diagnosis but is less accurate than ultrasound, it reveals: "String sign": Thin streak of contrast through narrowed pylorus {{caption_text}} "Railroad track sign": Two thin lines of contrast indicating mild narrowing "Double track sign": Similar to railroad track sign, indicating thickened muscle {{caption_text}}


>13mm
Thickened muscle
>4mm
>16mm
Narrowing b/w stomach and duodeum
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GE
1 L 3.33 cm
2 L 3.10 cm
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References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 280.

SRB's Manual of Surgery, 6th Edition, Page 811-812

↑ *Back to this question in Part A*

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Q81: Which of the following is the most common type of anorectal fistula? (Q857797)

A. Intersphincteric

B. Trans-sphincteric

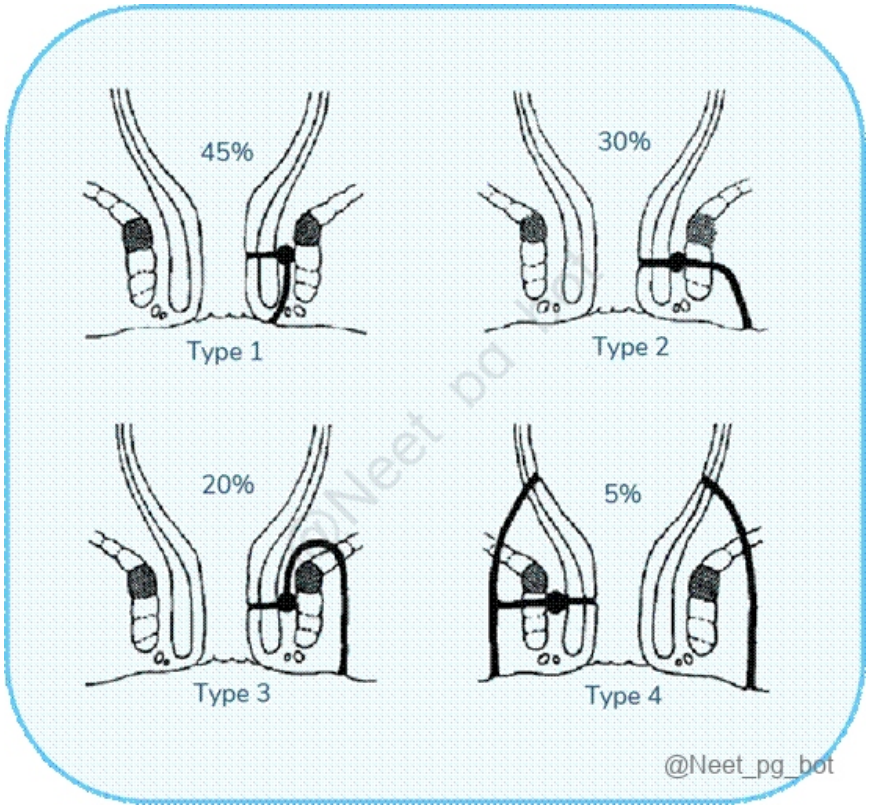
C. Suprasphincteric

D. Extrasphincteric

Correct Answer: A. Intersphincteric

Explanation: The intersphincteric type is the most common form of Anorectal Fistula (Fistula-in-Ano). A chronic abnormal communication between the anorectal lumen (internal opening) and an external opening on the skin of the perineum, buttock, or, rarely, the vagina in women. Classifications: Low-level fistulas open into the anal canal below the internal ring. High-level fistulas open into the anal canal at or above the internal ring. Simple fistula

without extensions Complex fistula with extensions. Parks classification: Type 1 Inter- sphincteric (most common , 70%) (Option A) Type 2 Trans- sphincteric (25%) (Option B ruled out) Type 3 Supra- sphincteric (4%) (Option C ruled out) Type 4 Extra- sphincteric (1%) (Option D ruled out) {{caption_text}}



References:

Bailey and Love's Short Practice of Surgery, 28th Edition, Pages 1436-1437.

SRB's Manual of Surgery, 6th Edition, Page 972.

↑ *Back to this question in Part A*

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Q82: During an endoscopy, when a constriction is detected at the esophageal junction approximately 25 cm from the incisor, what is the likely cause? (Q857827)

A. Inferior vena cava

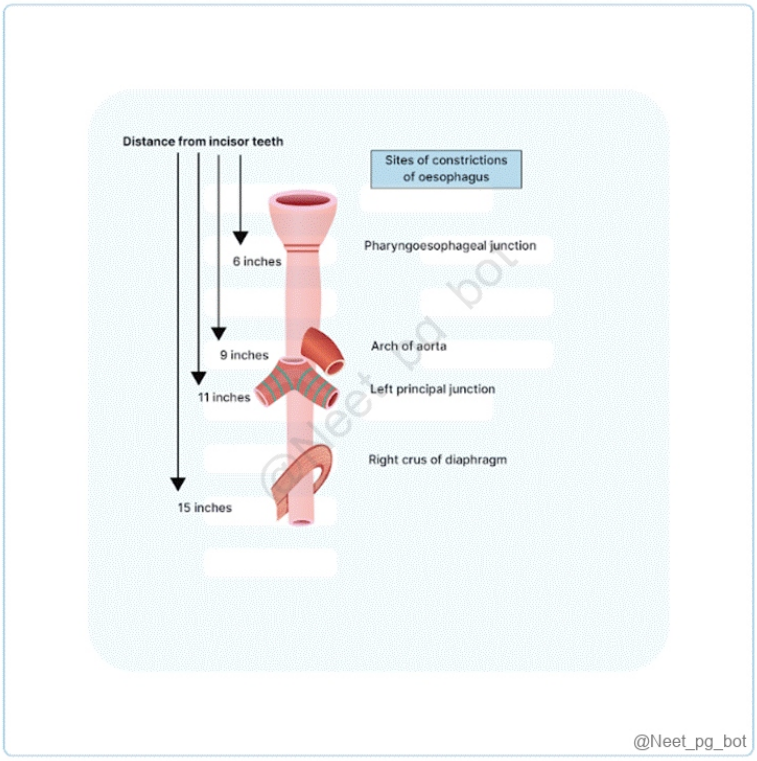
B. Arch of aorta

C. Right bronchus

D. Diaphragmatic opening

Correct Answer: B. Arch of aorta

Explanation: The constriction at the esophageal junction, about 25 cm from the incisor, is likely caused by the arch of the aorta, where the Esophagus passes behind the aorta and left main bronchus, leading to a physiological narrowing. Physical Narrowing The esophagus has three relatively narrow sections, with endoscopic measurements from the incisors. They are: Cricopharyngeus muscle (upper oesophageal sphincter) Where the left main bronchus and aorta cross the oesophagus Esophagogastric junction (lower oesophageal sphincter). Inferior vena cava (Option A) runs parallel to the aorta in the abdomen and does not cross the esophagus in the thoracic cavity, so it does not cause constriction at the esophageal junction. Right bronchus (Option C) crosses the esophagus lower in the thoracic cavity and does not cause constriction at the 25 cm level, where the esophagus is more closely related to the left bronchus and arch of the aorta. Diaphragmatic opening (Option D) is located around 40 cm from the incisors, lower than the 25 cm mark, and is not involved in constriction at this level.



References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page, 1107.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q83: A homosexual man presents with painful defecation and a protruding mass from the anal canal. Biopsy confirms squamous cell carcinoma of the anus. What is the

appropriate course of action for managing this patient? (Q857833)

A. Chemotherapy

B. Abdominoperineal repair

C. Combined chemoradiation

D. Wide local excision

Correct Answer: C. Combined chemoradiation

Explanation: Combined chemoradiation, involving chemotherapy (fluorouracil and mitomycin C) and radiation, is the standard treatment for localized squamous cell carcinoma of the anus, preserving anal function and improving local control and survival. Anal Canal Carcinoma Risk factors Human Papillomavirus (HPV) Infection: Strongly linked to anal canal cancer, particularly high-risk subtypes (16, 18, 31, 33) Anal Intraepithelial Neoplasia (AIN): A precancerous condition significantly increases the risk of progression to anal canal cancer, especially from AIN II or III. Immunosuppression (e.g., HIV-positive, transplant recipients) Sexual Practices: Anal intercourse increases HPV transmission risk. History of Other Genital Neoplasia: Vulvar intraepithelial neoplasia (VIN) or cervical intraepithelial neoplasia (CIN) Extensive Anogenital Condylomata: The presence of extensive anal warts linked to HPV infection Clinical features Pain Bleeding Palpable Mass Pruritus (Itching) Discharge Incontinence Fistulation (anterior tumour extension in women can create a fistula between the anus and vagina). Appearance : Anal margin tumours: Often resemble malignant ulcers with raised, hardened edges. Anal canal tumours: Typically palpable as irregular, hardened, and tender ulcerated areas. Lymph Node Involvement: Enlarged lymph nodes in the perirectal or groin regions may indicate cancer spread. Investigations Biopsy from the Anal Region: The primary diagnostic test to confirm the presence of carcinoma. FNAC of Inguinal Nod (assess metastasis). USG Abdomen (check for any spread of the disease). MRI of the Perineum (assess the extent of the tumour). Proctosigmoidoscopy: Assess the upper extent of the tumour within the anal canal. Management Chemoradiation (Nigro regimen): The preferred treatment modality for carcinoma of the anal canal. (Option C) Chemotherapy Drugs: Commonly used drugs include 5-fluorouracil (5-FU), bleomycin, vincristine, and adriamycin. Radiotherapy: Often used alone in advanced cases where the tumour is not resectable. Surgical Interventions: Abdominoperineal Resection (APR) with Colostomy: For persistent or recurrent disease after combined modality therapy (CMT), or for cases where the tumor does not respond to chemoradiation. (Option B ruled out) Neoadjuvant Chemotherapy: Involves using 5-FU, cisplatin, and mitomycin C before surgery to shrink the tumour. Chemotherapy (Option A) alone is not the primary treatment for squamous cell carcinoma of the anus; chemoradiation is preferred for better local control and survival. Wide local excision (Option D) is not the standard treatment for anal cancer, as chemoradiation is more effective in preserving function and reducing recurrence. Surgery is only considered if chemoradiation fails.

References:

Bailey and Love Short manual of surgery, 28th Edition, Page 1444.

Schwartz’s Principles of Surgery, 11th Edition, Page 1304.

SRB’s manual of surgery, 6th Edition, Page 977.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q84: A man came with complaints of recurrent discharge and pain due to lesions around the anus for 3 years. A diagnosis of fistula-in-ano is made. What is the gold standard investigation for this condition? (Q857874)

A. Fistulography

B. USG

C. CECT

D. MRI

Correct Answer: D. MRI

Explanation: The gold standard investigation in Fistula-in-Ano is MRI. Fistula-in-Ano A chronic abnormal communication between the anorectal lumen (internal opening) and an external opening on the skin of the perineum, buttock, or, rarely, the vagina in women. Causes Idiopathic/Cryptoglandular: The most common cause, often associated with prior anorectal sepsis. Associated Conditions: Crohn's disease Tuberculosis Lymphogranuloma venereum Actinomycosis Rectal duplication Foreign bodies Malignancy (rare, can develop within a longstanding fistula) Clinical features Intermittent purulent discharge: This may be bloody and purulent. Discomfort typically increases until the pus discharges, providing temporary relief. Previous history of Anorectal abscess Passage of flatus or faeces: Through the external opening, (indicative of a rectal rather than an anal internal opening). Investigation MRI: Maps the fistula tunnel and provides detailed images of the sphincter muscle and pelvic floor structures. (Investigation of choice) (Option D) Endoscopic Ultrasound: It uses high-frequency sound waves to identify the fistula, sphincter muscles, and surrounding tissues. Fistulography: An X-ray procedure using injected contrast to visualize the anal fistula tunnel, if an extrasphincteric fistula is suspected. (1st investigation) (Option A ruled out) Examination Under Anesthesia: Allows for thorough evaluation of the fistula tunnel and identification of potential complications. Fistula Probe: A specialized instrument is inserted through the fistula to identify the fistula tunnel. Anoscopy: A small endoscope is used to visualize the anal canal for assessment of fistulas during anoscopy. Management: Fistulotomy Opening the fistula tract to heal by secondary intention. Used for intersphincteric and trans-sphincteric fistula involving <30% of external sphincter; not for anterior fistula in women. Fistulectomy Removal of the fistula using diathermy cautery for better visualization of anatomy. Effective for understanding the fistula's anatomy and extensions. Setons Materials are inserted into the fistula tract for drainage or gradual cutting. Loose setons promote drainage; tight/cutting setons cut through muscle over time. Advancement Flaps Closing the internal opening with a flap of anorectal mucosa is used when the sphincter complex is not extensively indurated. Effective for certain fistula configurations. USG (Ultrasonography) (Option B) is useful for assessing superficial fistulas but is limited in evaluating deep or complex ones, lacking the detailed imaging of surrounding structures that MRI provides. CECT (Contrast Enhanced Computed Tomography) (Option C) is less ideal for fistula-in-ano due to lower soft tissue contrast and is indicated if an extrasphincteric fistula is suspected.

References:

Bailey and Love's Short Practice of Surgery, 28th edition, Pages 1436-1437.

SRB’s Manual of Surgery, 6th Edition, Page 972-973.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q85: Which of the following procedures has the highest risk of causing the recurrence of duodenal ulcers? (Q857899)

A. Selective Vagotomy

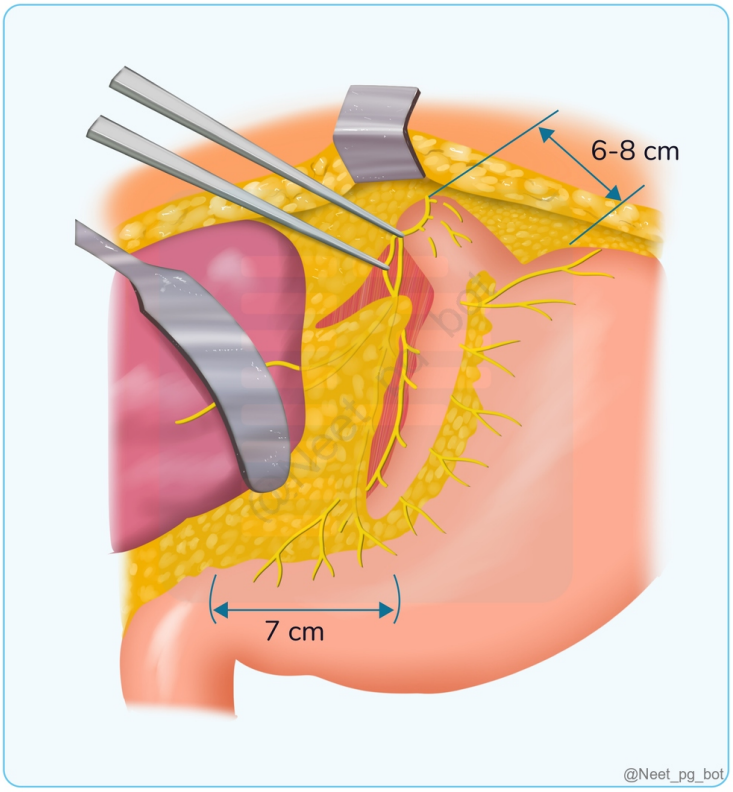
B. Highly selective vagotomy

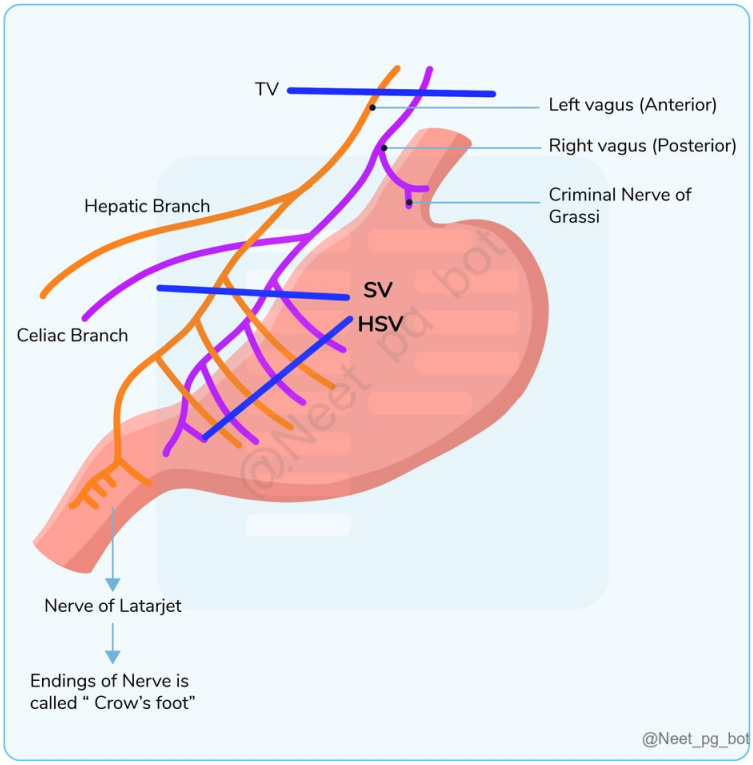
C. Truncal vagotomy

D. Truncal Vagotomy with Antrectomy

Correct Answer: B. Highly selective vagotomy

Explanation: Highly Selective Vagotomy (also known as Parietal Cell Vagotomy or Proximal Gastric Vagotomy) has the highest risk of causing the recurrence of duodenal ulcers. It is the procedure that best preserves the vagal innervation of the gastric antrum and pylorus. It divides only the vagus nerves supplying the acid-producing portion of the stomach within the corpus and fundus, so there is no need for routine drainage procedures. Characteristic Truncal Vagotomy (Option C ruled out) Truncal Vagotomy with Antrectomy (Option D ruled out) Selective Vagotomy (Option A ruled out) Highly Selective Vagotomy (Option B) Nerves Divided Left and right vagus above hepatic and celiac branches Truncal vagotomy plus removal of the antrum Main right and left vagus distal to celiac and hepatic branches Only nerves to the acid-producing portion (all branches to the fundus and body) of the stomach Drainage Procedure Usually required Not applicable Required Not required Acid Reduction ~50% ~85% <50% Variable Ulcer Recurrence 2-7% 1% 5-10% 2-10%% Significant side effects 10-20% 10-20% 10-20% <5%





References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1161.

Sabiston Textbook of Surgery, 21st Edition, Page 1213-1214.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q86: An elderly woman underwent surgical resection of her bowel; after a few months, she presents with easy fatigability and tiredness. Blood smear evaluation shows macrocytic anaemia. Resection of all of the following can cause this, except: (Q855654)

A. Jejunum

B. Duodenum

C. Ileum

D. Stomach

Correct Answer: B. Duodenum

Explanation: The patient has macrocytic anemia, most commonly caused by Vitamin B12 or folate deficiency. Vitamin B12 requires intrinsic factor from the stomach and is absorbed in the terminal ileum; deficiency occurs if stomach or ileum is resected. Folate is absorbed primarily in the jejunum; resection can cause folate deficiency → macrocytic anemia. Duodenum mainly absorbs iron and some calcium; it has minimal role in B12 or folate absorption. Therefore, duodenal resection does not usually cause macrocytic anemia, making it the exception. Incorrect Options: Option A) Jejunum: Resection → folate deficiency → macrocytic anemia. Option C) Ileum: Resection → Vitamin B12 deficiency → macrocytic anemia. Option D) Stomach: Loss of intrinsic factor → Vitamin B12 deficiency → macrocytic anemia.

References:

Sabiston Textbook of Surgery, 21st Edition, Page 1218. Robbins & Cotran Pathologic Basis of Diseases, 10th Edition, Page 652-653.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q87: Which of the following statements regarding acute cholecystitis is false? (Q855683)

A. Gall bladder thickness >3 mm on USG

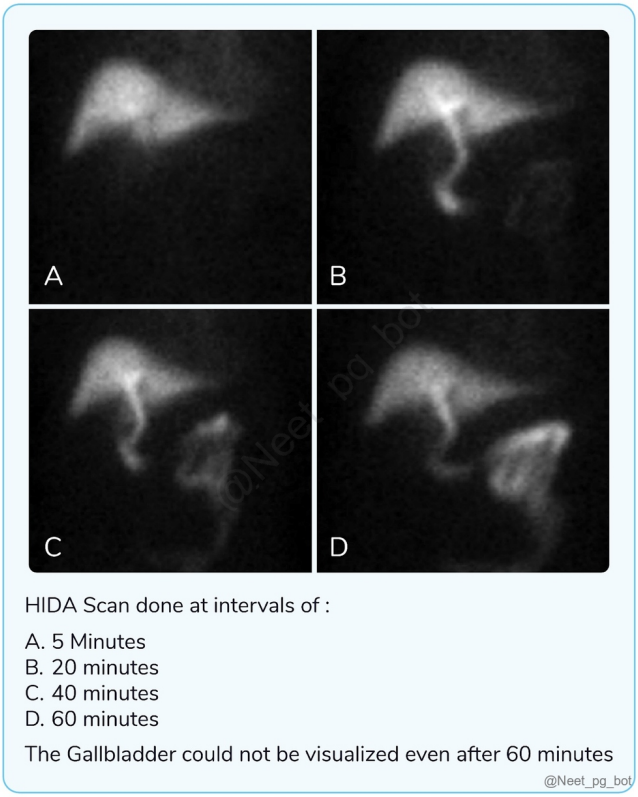
B. Murphy’s sign positive

C. Leukocytosis

D. Gold standard investigation is CT scan

Correct Answer: D. Gold standard investigation is CT scan

Explanation: The gold standard investigation for acute cholecystitis is the HIDA (Hepatobiliary Iminodiacetic Acid) Scan , not a CT scan. Non-visualization of the gallbladder on a HIDA scan indicates cystic duct obstruction , a key characteristic of acute cholecystitis, thus making it a diagnostic feature. {{caption_text}} Tokyo Guidelines for Acute Cholecystitis (2013/2018) Local Signs of Inflammation: Murphy's sign (Option B ruled out) Right upper quadrant (RUQ) pain/ tenderness or a palpable mass. Systemic Signs of Inflammation: Fever Elevated CRP Elevated WBC (Option C ruled out) Imaging Findings: Gallbladder wall thickening (>3 mm) (Option A ruled out) Pericholecystic fluid, Ultrasonographic Murphy's sign.



References:

Bailey & Love’s Short Practice of Surgery, 28th Edition, Page 1235-1236, 1244.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q88: Which of the following is not a perineal approach for the condition shown in the image? (Q855689)

A. Rip stein's procedure

B. Delorme’s operation

C. Thiersch operation

D. Altemeier’s procedure



Correct Answer: A. Rip stein's procedure

Explanation: The image depicts Rectal Prolapse , and Ripstein’s procedure, a surgical treatment, is not a perineal approach. It is the circumferential descent of the rectum through the anal canal. Management of Rectal prolapse: Non-Operative Management Medical Treatment : Palliates symptoms of constipation and faecal incontinence with fluid intake, fibre supplements, stool softeners, and topical treatments for mucosal oedema. Enemas and Suppositories : Assist in defecation and reduce symptoms. Operative Management Rectopexy is fixing the rectum to the sacrum by sutures or mesh after complete mobilisation of the rectum. Aspect Abdominal Rectopexy Perineal Rectopexy Types Prosthetic or mesh rectopexy-anterior/ posterior- Well's, Ripstein (Option A) Suture rectopexy-Lahaut Anterior Resection Resection Rectopexy Mucosal sleeve resection (Delrome's) (Option B ruled out) Perineal recto sigmoidectomy (Altemeier's) (Option D ruled out) Posterior fixation of the rectum of Lockhardt-Mummery Mickulicz Miles perineal transanal recto sigmoidectomy Anal encircling (Thiersch) (Option C ruled out) Advantages Fixation of the rectum provides adequate tension to prevent recurrence. Minimally invasive options (laparoscopic or robotic) offer benefits in pain control, hospital stay, and recovery time

Lower operative morbidity and mortality, suitable for elderly or medically unfit patients. Disadvantages Requires extensive dissection and fixation, which may have higher morbidity (10%-33%). Risk of mesh-related complications such as erosion, infection, bowel obstruction, and migration. Higher recurrence rates compared to abdominal approaches

References:

Sabiston Textbook of Surgery, 21st Edition, Page 1392,1394 SRB's Manual of Surgery, 6th Edition, Page 957, 961-962.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q89: A patient who had grade 3 splenic trauma was managed conservatively in the ICU. Which of the following signs on day 2 would indicate a need for surgery? (Q855694)

A. Hemoglobin falls from 12 mg/dL to 10 mg/dL

B. Extraperitoneal bladder rupture

C. Pneumoperitoneum

D. Air in gallbladder

Correct Answer: C. Pneumoperitoneum

Explanation: In a patient with grade 3 splenic trauma managed conservatively, the presence of pneumoperitoneum on day 2 is a critical sign of an Acute Abdomen , typically indicating a perforated viscus requiring urgent surgical intervention. It refers to the signs and symptoms of abdominal pain and tenderness. It represents an underlying surgical problem that requires prompt diagnosis and surgical treatment. Causes: Surgical Causes Non-surgical Causes Endocrine and Metabolic Acute intermittent porphyria Addisonian crisis Diabetic crisis Hereditary Mediterranean fever Uremia Hematologic Acute leukemia Sickle cell crisis Toxins and drugs Black widow spider poisoning Lead poisoning Other heavy metal poisoning Narcotic withdrawal Hemorrhage Aortoduodenal fistula after aortic vascular graft Arteriovenous malformation of the gastrointestinal tract Bleeding gastrointestinal diverticulum Hemorrhagic pancreatitis Intestinal ulceration Leaking or ruptured arterial aneurysm Mallory-Weiss syndrome Ruptured ectopic pregnancy Solid organ trauma Spontaneous splenic rupture Infections Appendicitis Cholecystitis Diverticulitis Hepatic abscess Meckel diverticulitis Psoas abscess Ischemia Buerger's disease Ischemic colitis Mesenteric thrombosis or embolism Ovarian torsion Strangulated hernia Testicular torsion Obstruction Cecal volvulus Gastrointestinal malignancy Incarcerated hernias Inflammatory bowel disease Intussusception Sigmoid volvulus Small bowel obstruction Perforation Boerhaave syndrome Perforated diverticulum Perforated gastrointestinal cancer Perforated gastrointestinal ulcer Hemoglobin falls from 12 mg/dL to 10 mg/dL (Option A) : A mild drop in hemoglobin may indicate blood loss but doesn't necessarily require surgery. Conservative management can continue if the patient remains stable, with surgery considered only for significant drops or signs of instability. Extraperitoneal bladder rupture (Option B) : While serious, extraperitoneal

bladder rupture is not directly related to grade 3 splenic trauma and is usually managed conservatively with catheter drainage. Surgery is reserved for intraperitoneal rupture or severe complications. Air in gallbladder (Pneumobilia) (Option D) indicates emphysematous cholecystitis, which may require surgery but is not as urgent as pneumoperitoneum, typically linked to a perforated organ and peritonitis.

References:

Bailey and Love's Short Practice of Surgery, 28th Edition, Page 1051. Sabiston Textbook of Surgery, 21st Edition, Page 1134-1135.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q90: A female patient was diagnosed with gastric cancer. On immunohistopathology, the biopsy sample was positive for CD117 and negative for LCA, cytokeratin, and S100. What is the diagnosis? LCA - Leucocyte common antigen GIST - Gastrointestinal stromal tumors SCC - Squamous cell carcinoma (Q855697)

A. GIST

B. Adenocarcinoma

C. Hodgkin's lymphoma

D. SCC

Correct Answer: A. GIST

Explanation: The biopsy findings showing positive CD117 (also known as c-Kit) and negative for LCA, cytokeratin, and S100 are characteristic of Gastrointestinal Stromal Tumors (GISTs) . Common Locations: Stomach (most common) Small Intestine Other Areas: Colon, rectum, and oesophagus (less common). Origin: The Interstitial cells of Cajal (Gastric pacemaker cells) Immunohistochemistry Markers for GISTs: (Option A) Category Marker Expression in GISTs Significance Old Markers CD117 (c-KIT) Expressed in approximately 97% of GISTs Crucial for diagnosis CD34 Expressed in 70% GISTs Associated with hematopoietic progenitor cells SMA Some GISTs show positivity Less common compared to CD117 and CD34 New Markers PDGFRA Mutations found in approximately 5-10% of GISTs Additional diagnostic marker DOG1 Expressed in many GISTs, including those negative for CD117 Alternative diagnostic tool Clinical features: GI Bleed (most common) Abdominal Pain Weightloss Large abdominal mass- it arises from the submucosa - hence, it is extraluminal- but expands and compresses the mucosa Metastasis to liver Carney's Triad: It is a rare syndrome characterised by the presence of three specific tumours: gastrointestinal stromal tumours (GISTs), extra-adrenal paragangliomas, and pulmonary chondromas. Adenocarcinoma (Option B) is a type of cancer that originates in epithelial cells and typically stains positive for cytokeratin, which is absent in this case. The absence of cytokeratin makes adenocarcinoma unlikely in this patient. Hodgkin's lymphoma (Option C) expresses LCA (Leucocyte Common Antigen), a marker for hematologic malignancies, especially lymphomas. Since the biopsy is negative for LCA, Hodgkin's lymphoma can be excluded as a diagnosis. SCC (Squamous Cell Carcinoma) (Option D) expresses

cytokeratin, a marker for epithelial differentiation. Since the biopsy is negative for cytokeratin, SCC is unlikely.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 190, 1311. GIST Markers

↑ *Back to this question in Part A*

@Neet_pg_bot

Q91: A female patient is planned for cholecystectomy. Which of the following is not an advantage of laparoscopic surgery? (Q855698)

A. Lesser post-operative pain

B. Cosmetically better

C. Earlier return to normal physiological function

D. Longer duration of stay in hospital

Correct Answer: D. Longer duration of stay in hospital

Explanation: Longer hospital stay is not an advantage of laparoscopic surgery . Advantages of laproscopic surgery: Less postoperative pain (Option A ruled out) Better cosmesis (Option B ruled out) Earlier return to normal physiology (Option C ruled out) Shorter hospital stays (Option D) Fewer intraoperative adhesions are created. Better perception of anatomy as the image is often magnified.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 103.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q92: Severe, intractable pain in advanced rectum cancers is due to: (Q855699)

A. Anterior infiltration in prostate

B. Anterior infiltration in the bladder

C. Posterior infiltration in sacral plexus

D. All of the above

Correct Answer: D. All of the above

Explanation: Advanced cancers invading outside the mesorectum may infiltrate the prostate or bladder anteriorly or the sacral plexus posteriorly, giving rise to severe, intractable pain. Clinical Features of Rectal Carcinoma: Commonly seen in >55 years of age Early Symptoms : Bleeding per rectum: The most common early symptom, often bright red and painless, which can be mistaken for hemorrhoidal bleeding. Tenesmus: It is an important early symptom. It is the feeling of incomplete evacuation, often present with lower rectal tumours, leading to frequent attempts to pass stool or gas. Diarrhoea: Early morning diarrhoea may occur. Late Symptoms : Constipation can develop with rectosigmoid junction tumours. Colicky pain may indicate obstruction and advanced cancers may cause severe pain due to invasion of nearby structures (prostate or bladder anteriorly or the sacral plexus posteriorly). (Option D) Weight loss indicates metastatic disease. Abdominal Examination Findings : Early cases may be normall while obstructing tumours can show signs of subacute bowel obstruction. Palpable liver enlargement may indicate liver metastases, and cachexia can be present. Ascites may be found in cases of peritoneal spread. Rectal Examination Findings : The tumour is palpable within 7-8 cm of the anal verge, appearing as a raised, hard mass. If ulcerated, it may present as a depression with everted edges. Mobility and distance from the anal sphincter complex are important for assessing resectability and surgical planning.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1406.

↑ *Back to this question in Part A*

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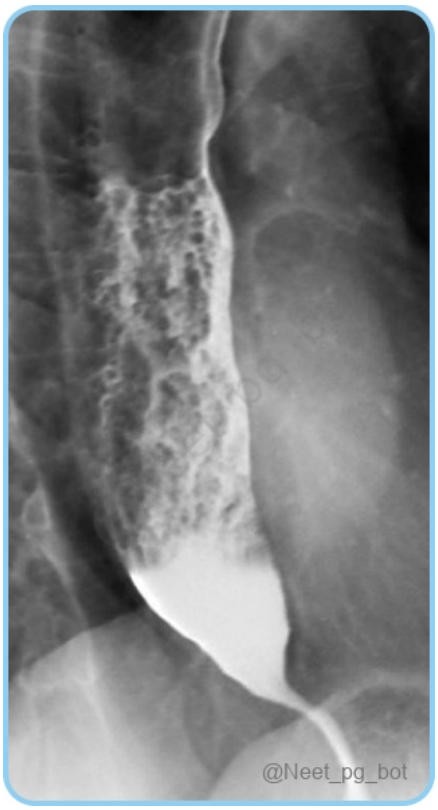
Q93: Which investigation is not necessary for the following condition? (Q855153)

A. Timed barium study

B. Endoscopy

C. Esophageal manometry

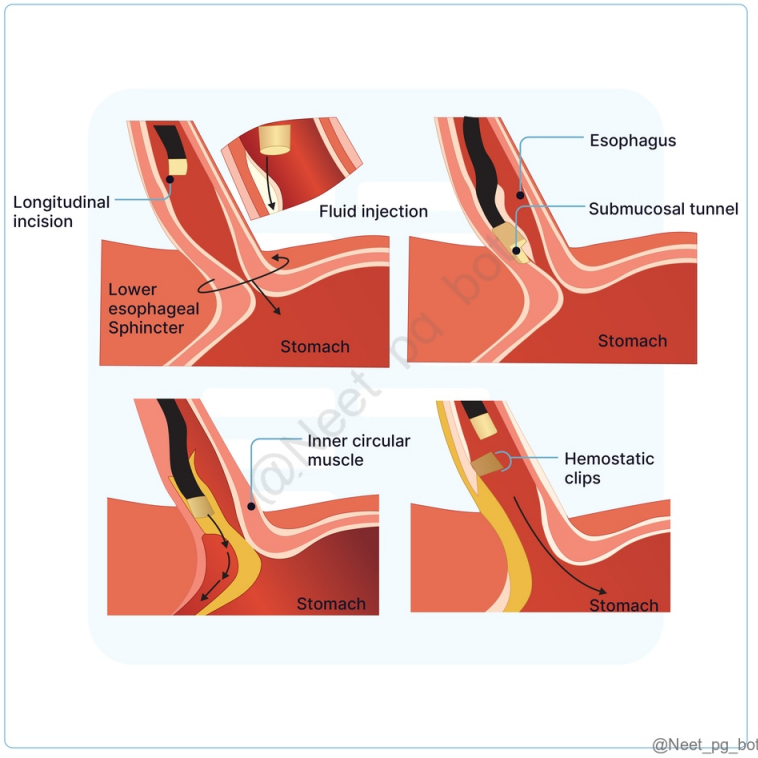
D. 24-hour pH monitoring



Correct Answer: D. 24-hour pH monitoring

Explanation: The image shows a dilated esophagus with a "bird beak" appearance, suggesting Achalasia Cardia , where 24-hour pH monitoring is unnecessary as the condition primarily involves structural and motility issues, not acid reflux. Achalasia Cardia Definition Progressive degeneration of ganglion cells in the oesophagal wall. This leads to a loss of peristalsis in the lower oesophagus and failure of the lower oesophagal sphincter (LES) to relax during swallowing. Clinical Features Dysphagia: May initially affect liquids more than solids. Regurgitation Halitosis Chest Pain Weight Loss Investigations Esophageal Manometry (Option C ruled out) Gold Standard: This is the definitive diagnostic test for achalasia. It measures the pressure and pattern of muscle contractions in the oesophagus. Elevated resting LES pressure (typically > 45 mmHg). Incomplete LES relaxation. Absence of peristalsis in the esophageal body. Periodic contractions with normal amplitude or high amplitude contractions (type I and II achalasia). Barium Swallow (Esophagram) (Option A ruled out) Dilated esophagus with a narrowing at the LES (Bird beak appearance). {{caption_text}} Endoscopy (Option B ruled out) Normal mucosa but may show dilated esophagus with possible food debris; it is important to rule out other causes of dysphagia, such as tumours. Management Pharmacological Treatments Calcium Channel Blockers (reduce LES pressure) Nitrates (relax the LES) 5'-Phosphodiesterase Inhibitors (increase cyclic GMP to lower LES pressure) Botulinum Toxin (Botox) Injections (temporarily paralyse LES muscles). Non-Surgical Interventions Bougie/Balloon Dilatation (ruptures LES muscle fibres to reduce pressure). Surgical Treatments Laparoscopic Heller's Cardiomyotomy (Most common) The incision in the LES muscle to reduce pressure. It is often combined with a fundoplication. Partial Fundoplication Prevents reflux; options include Dor or Toupet fundoplication. Esophagectomy Surgical removal of the esophagus (severe cases). Endoscopic Treatments Per-Oral Endoscopic Myotomy (POEM): A newer Minimally invasive procedure involving dissection of LES muscle fibres. {{caption_text}}




Longitudinal incision
Fluid injection
Esophagus
Submucosal tunnel
Lower esophageal Sphincter
Stomach
Stomach
Inner circular muscle
Hemostatic clips
Stomach
Stomach
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References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1122-1125. SRB's Manual of Surgery, 6th Edition, Page 790-791.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q94: Which of the following causes maximum malnutrition? (Q855159)

A. Pancreatic fistula

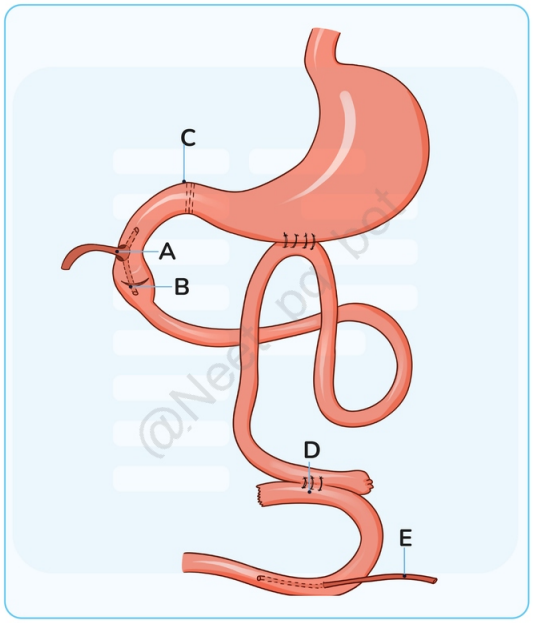
B. Duodenal fistula

C. Distal ileal fistula

D. Colonic fistula

Correct Answer: B. Duodenal fistula

Explanation: Duodenal Fistulas can cause maximum malnutrition, as the duodenum is crucial for nutrient absorption, including proteins, fats, carbohydrates, vitamins, and minerals. It occurs as a complication of: Gastric resection Duodenal resection Biliary tract procedures Pancreatic resections Trauma Perforated peptic ulcers Cancer. There is a direct connection between the duodenum and an abnormal opening, causing significant nutrient loss and malnutrition. {{caption_text}} (A) The smaller duodenal fistula was repaired over a t-tube; (B) The larger fistula was closed with interrupted sutures. (C) Pyloric exclusion; (D) Jejuno-jejunostomy following segmental resection of jejunal fistula; (E) Feeding jejunostomy Pancreatic fistula (Option A) leads to the loss of digestive enzymes, but the body can adapt to some extent, causing less severe malnutrition than a duodenal fistula, where nutrient absorption is directly impaired. Distal ileal fistula (Option C) affects the absorption of bile salts and vitamin B12, but it doesn’t impact the absorption of a wide range of nutrients like the duodenum, which is responsible for absorbing most nutrients from digested food. Colonic fistula (Option D) mainly affects water and electrolyte absorption, leading to dehydration or imbalances, but it has less impact on overall nutrient absorption compared to a duodenal fistula, which disrupts early nutrient uptake.



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References:

Sabiston Textbook of Surgery, 21st Edition, Page 272. Duodenal fistula: The most lethal surgical complication in a case series of radical gastrectomy - ScienceDirect

↑ *Back to this question in Part A*

@Neet_pg_bot

Q95: Which of the following nerves would be involved if a patient experiences a loss of sensations over the root of the penis after undergoing open hernia surgery? (Q855162)

A. Iliohypogastric nerve

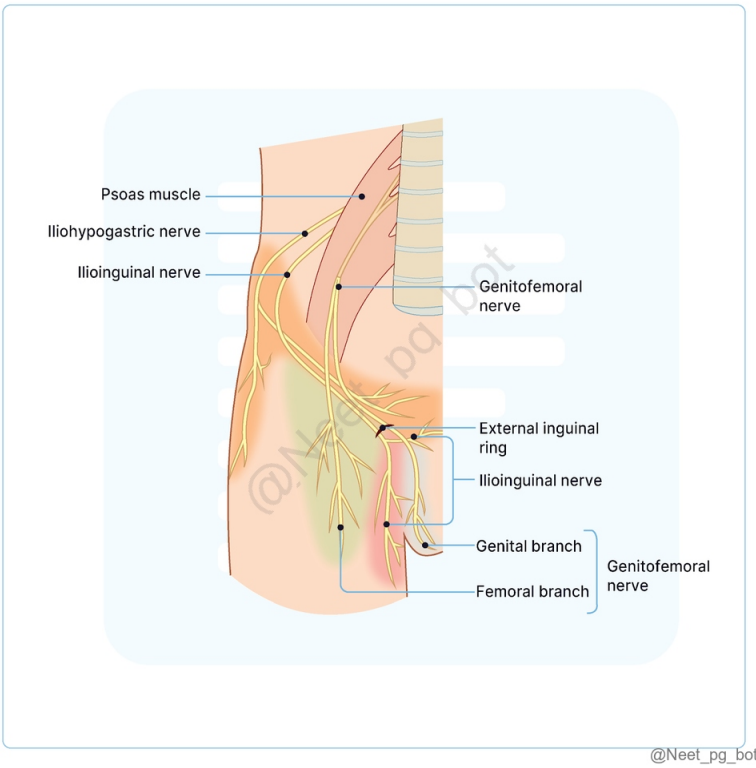
B. Ilioinguinal nerve

C. Genitofemoral nerve

D. Medial cutaneous nerve to thigh

Correct Answer: B. Ilioinguinal nerve

Explanation: The loss of sensation at the root of the penis after open hernia surgery likely involves the Ilioinguinal Nerve . It originates from the first lumbar nerve and passes through the inguinal canal. Supplies: Sensory innervation to the upper medial thigh, the root of the penis, and mons pubis in males. During open hernia surgery, this nerve can be damaged or irritated, resulting in a loss of sensation in the structures. {{caption_text}} Hernia Surgery The most common nerve injured in: Open repair: Ilio-inguinal > Iliohypogastric > Genital branch of Genitofemoral nerve. (Option B) Laparoscopy: Lateral Cutaneous nerve of thigh > Genito-femoral nerve. Landmarks in Laparoscopic Surgery: Triangle of Doom: Injury to Iliac vessels Triangle of Pain: Injury to Nerves causing postoperative pain Complications of Surgery: Immediate Complications: Bleeding/Hematoma: From subcutaneous or inferior epigastric vessels. Urinary Retention: May require catheterization. Femoral Nerve Blockade Early Postoperative Issues (within the first week): Pain, Bruising, Swelling: Common. Seroma Formation: Often resolves spontaneously; may need aspiration. Wound Infection: Less frequent; routine antibiotics not recommended. Testicular Infarction: Damage to the testicular artery during dissection or repair. Long-term Concerns: Chronic Pain: Nerve Injury: Damage to nerves such as the ilioinguinal or iliohypogastric nerves during surgery. Nerve Irritation: Chronic irritation by suture material or mesh. Psychological Factors Hernia Recurrence: Inadequate repair or weakness in the abdominal wall; mesh-related issues may also contribute. Iliohypogastric nerve (Option A) provides sensory innervation to the lower abdomen and the upper part of the thigh, but it does not innervate the root of the penis. It is less likely to be involved in loss of sensation at the root of the penis. Genitofemoral nerve (Option C) does provide sensation to the skin of the genital area; it mainly innervates the scrotum and labia, not specifically the root of the penis. It is less likely to be affected in this case. Medial cutaneous nerve to the thigh (Option D) provides sensation to the inner thigh, but it has no direct involvement in the sensory innervation of the penis. Therefore, it wouldn't cause loss of sensation over the root of the penis after surgery.



References:

Bailey & Love's Short Practice of Surgery, 28th edition, Page 1070. Sabiston Textbook of Surgery, 21st Edition, Page, 1109.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q96: A 10-year-old child with hereditary spherocytosis and hypersplenism presents to the hospital. A splenectomy is planned for this child. All the following vaccines are recommended before splenectomy except? (Q855165)

A. Pneumococcal vaccine

B. Typhoid vaccine

C. Haemophilus influenza B vaccine

D. Meningococcal vaccine

Correct Answer: B. Typhoid vaccine

Explanation: Typhoid vaccine is not recommended before Splenectomy , as Salmonella typhi is not an encapsulated organism and is not directly linked to the increased infection risk after the procedure. Reason for vaccination: Normal function of the spleen: Phagocytosis of encapsulated organisms. Post-splenectomy septicemia is majorly due to encapsulated organisms S. pneumoniae, Neisseria meningitides, Haemophilus influenzae, or Escherichia coli . Vaccine recommendations for asplenic patients: Vaccination Children Adults (age 19 and older) Pneumococcal (Option A ruled out) PCV13 followed by PVC13 8 weeks later. PPSV23 8 weeks later. Repeat PPSV23 at 5 years PCV13 followed by PPSV23 8 weeks later Repeat PPSV23 every 5 years Meningococcal (Option D ruled out) MenACWY series AND MenB series MenACWY or MPSV4 2 months apart Repeat MenACWY every 5 years AND MenB series once. Haemophilus influenzae type B (Option C ruled out) Hib once if 15 months or older and previously not vaccinated Hib once Time for vaccination: Ideally- 10-12 weeks before surgery At Least 2 weeks before an elective surgery Emergency splenectomy- At discharge or 14 days after surgery, whichever is first. CDC immunisation guidelines for 2020 also recommend tetanus (Tdap or Td), human papillomavirus (HPV), measles, mumps, and rubella (MMR), varicella, zoster, influenza, hepatitis A (hep A) and hepatitis B (hep B), and meningococcal vaccines.

References:

Bailey and Love's Short Practice of Surgery, 28th Edition, Page 1231 Sabiston's Textbook of Surgery, 21st Edition, Page 1579, 1580

↑ *Back to this question in Part A*

@Neet_pg_bot

Q97: Which of the following statements about psoas abscess are true? Fluctuant swelling in the hip Cold abscess can develop from Pott's abscess Pain on the passive extension of the hip joint is seen It develops more commonly through the hematogenous route in immunocompromised patients and elderly. (Q855170)

A. 1 and 2

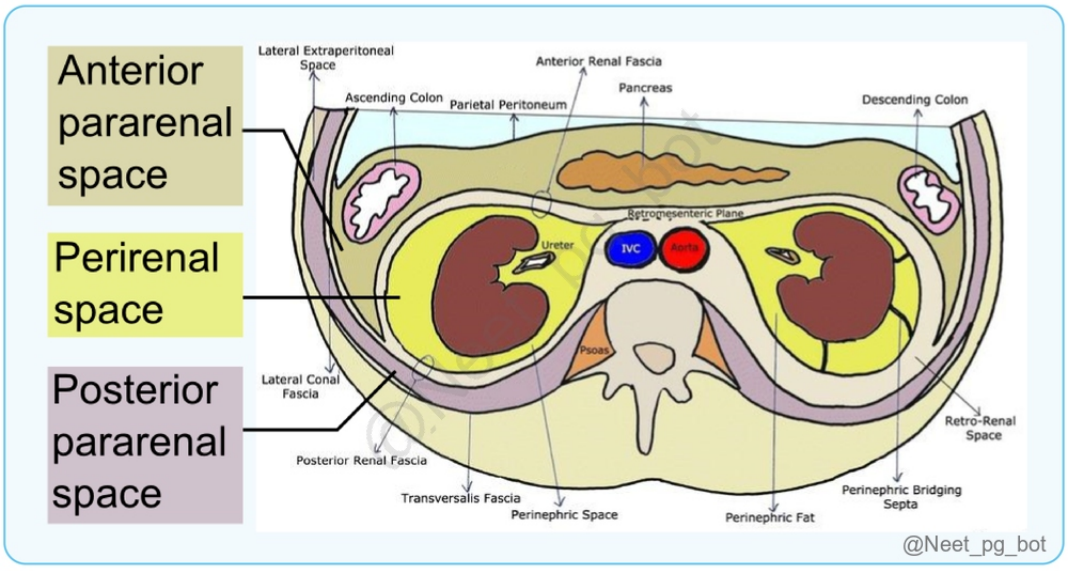
B. 1, 3 and 4

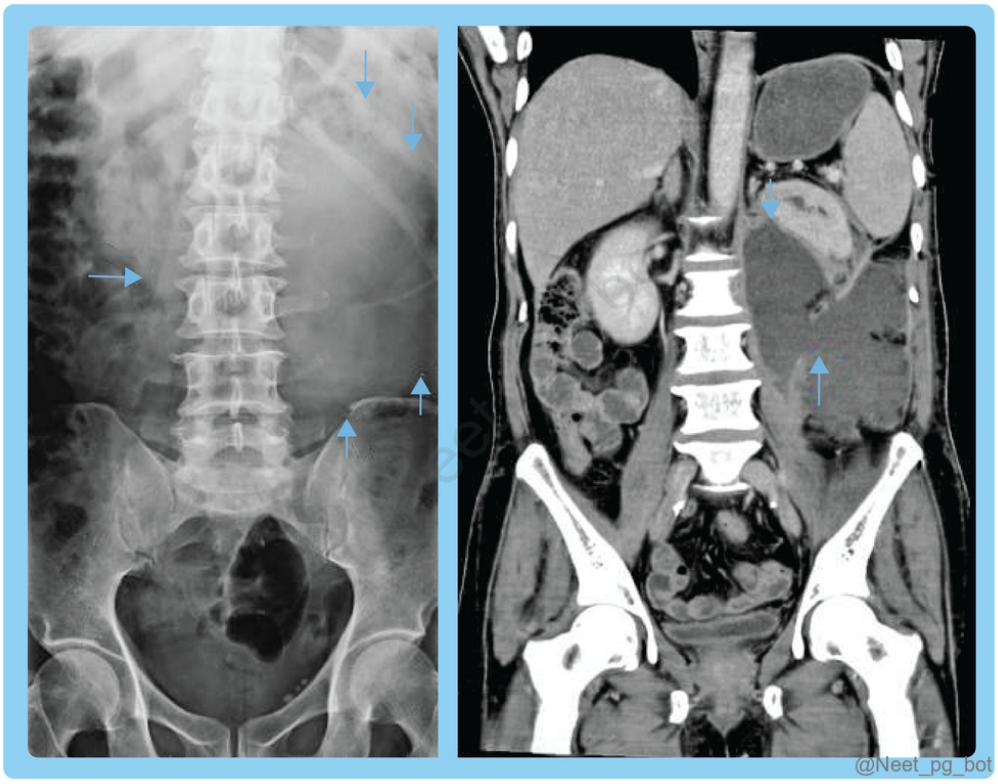
C. 1, 2, 3 and 4

D. 2, 3 and 4

Correct Answer: C. 1, 2, 3 and 4

Explanation: All of the above statements regarding Psoas Abscess (also known as Retroperitoneal Abscess) are correct. It is an abscess of the retroperitoneum. {{caption_text}} Causes: Tuberculosis (TB) of the spine (Pott's disease). (Statement 2) Secondary to direct spread of infection from the inflamed digestive or urinary tract (with or without perforation). Advanced Crohn's disease. Haematogenous spread from an occult source (immunocompromised patients) (Statement 4) Intravenous drug misuse. Presentation: A fluctuant swelling in the hip region with localised swelling and inflammation. (Statement 1) Pain and discomfort in the hip area. (Statement 3) Imaging: X-ray: Intact right psoas muscle shadow, but the left psoas shadow is absent, with a large radiopacity in the left lumbar region. CT Scan: A large bilobed, peripherally enhancing collection in the upper two-thirds of the left psoas muscle, extending into the left pararenal space, displacing the left kidney superiorly, with thickening of the lateroconal fascia. {{caption_text}}





References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1104. Sabiston Textbook of Surgery, 21st Edition, Page 1099.

↑ *Back to this question in Part A*

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Q98: Which of the following would be the most commonly encountered ectopic tissue in Meckel's diverticulum? (Q855203)

A. Gastric and pancreatic

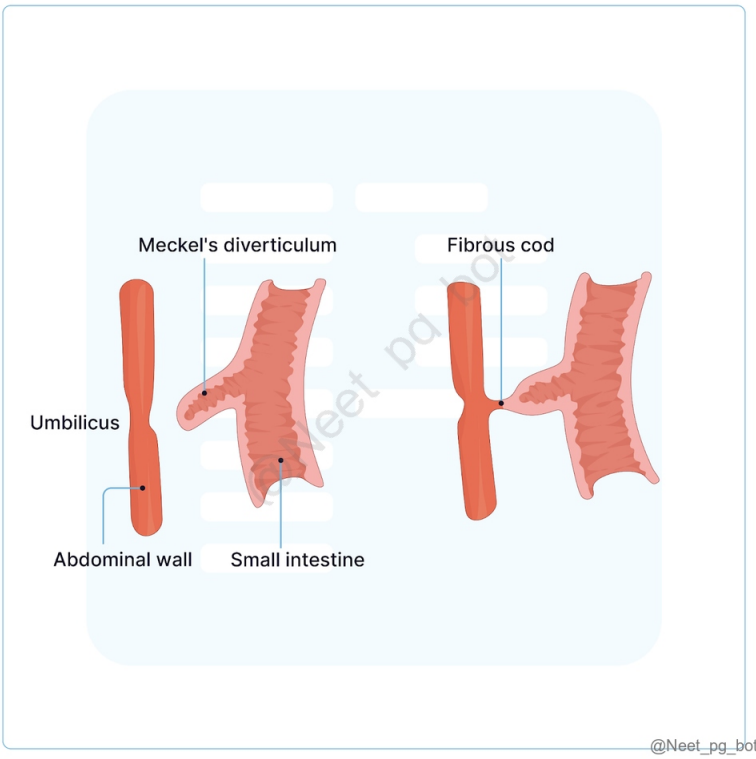
B. Colonic and pancreatic

C. Gastric and colonic

D. Thyroid and lung

Correct Answer: A. Gastric and pancreatic

Explanation: In Meckel's Diverticulum , the most frequently found ectopic tissues are gastric and pancreatic tissues. Persistent remnant of the Vitello-intestinal duct or omphalomesenteric duct. {{caption_text}} Meckel's Diverticulum Clinical features Most common ectopic mucosa in Meckel’s diverticulum is Gastric > Pancreatic > Colonic (Option A) (Option B, C ruled out) The most common symptom in children is gastrointestinal bleeding. Ulcers are formed in the surrounding area due to acid secreted from the ectopic gastric mucosa in Meckel’s diverticulum , which causes bleeding. The most common symptom in adults is abdominal pain. Complications: Volvulus, intestinal obstruction, intussusceptions, diverticulitis and perforation. Investigations 99mTc-pertechnetate scan: Absorbed by the ectopic gastric mucosa, allowing for visualisation. {{caption_text}} Plain abdominal radiography, CT abdomen, and ultrasonography are seldom useful. Endoscopy: Helpful in false-negative cases, but not the investigation of choice. Management Healthy base (no induration or ulceration) : Diverculectomy (excision of the diverticulum only) + anastomosis. Unhealthy base (ulceration, presence of gastric mucosa) : Resection of the small bowel with the diverticulum + anastomosis. Incidentally detected during an elective surgery: Diverculectomy. Thyroid and lung (Option D) tissue are extremely rare in Meckel’s diverticulum. These tissues are not typically associated with diverticular formations in the small intestine.





References:

Bailey and Love's Short Practice of Surgery, 28th Edition, Page 1311-1312. Sabiston Textbook of Surgery, 21st Edition, Page 1288-1289.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q99: What is true about gall bladder carcinoma? (Q855210)

A. Palpable abdominal lump is the earliest sign

B. Earliest sign is jaundice

C. Gallstones and gallbladder cancer are easily distinguished clinically

D. Median survival is less than 6 months

Correct Answer: D. Median survival is less than 6 months

Explanation: Gallbladder Cancer is a deadly disease with a median survival of less than 6 months, a 5-year survival rate of 50% for localised cases (with chemotherapy), and 2-5% for those with distant metastasis. Gallbladder Cancer Etiology Gallstones Choledochal cyst Anomalous pancreaticobiliary duct junction

Cholesterosis of the gallbladder Gallbladder polyps Porcelain gallbladder Infections and inflammatory conditions Chronic typhoid carriers Inflammatory bowel disease Hepatitis B and hepatitis C virus infections Other factors: Polypoid lesions (GB polyp) Xanthogranulomatous cholecystitis Nitrosamines Carcinogens Clinical features Often indistinguishable from benign gallbladder diseases (Option C ruled out) Symptoms include: Biliary colic Cholecystitis (especially in older individuals) Jaundice (late-stage) (Option B ruled out) Loss of appetite (late-stage) Palpable mass (late-stage) (Option A ruled out) Laboratory Findings Non-specific indicators: Anemia Leukocytosis Slight increase in transaminases Tumor markers: Elevated CA19-9 Elevated carcinoembryonic antigen (in ~80% of patients) Diagnostic Imaging Ultrasonography (USG): Initial diagnosis CT Scans: Thorax, abdomen, and pelvis for confirmation and staging MRI/MRCP: For accurate preoperative staging PET Scans: To identify metastatic disease Staging and Biopsy Preoperative Staging: Crucial to assess local disease extent and rule out distant metastases Percutaneous Biopsy: Guided by radiological imaging for unresectable tumours Laparoscopic Examination: Detects peritoneal or liver metastases that preclude surgery Management Early disease: For disease confined to the mucosa, if there is negative cystic duct margin and no recurrence on imaging- No further treatment For transmural disease- Radical en bloc resection of gallbladder fossa, liver wedge, and regional lymph nodes. Advanced Cancer: Non-operative palliative care. Endoscopic/percutaneous methods to relieve obstructive jaundice. Adenocarcinoma: Early-stage limited to mucosa: No additional treatment is required if imaging shows no recurrence. Beyond mucosa: Extensive surgery involving gallbladder fossa, a portion of the liver, and nearby lymph nodes.

References:

Bailey & Love’s Short Practice of Surgery, 28th Edition, Page 1257-1259.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q100: A patient who had undergone appendectomy 2 days ago presents with severe abdominal pain. On exploration, there is a collection of blood in the abdomen. Which of the following arteries should have been ligated during surgery? (Q855212)

A. Ileocolic artery

B. Right colic artery

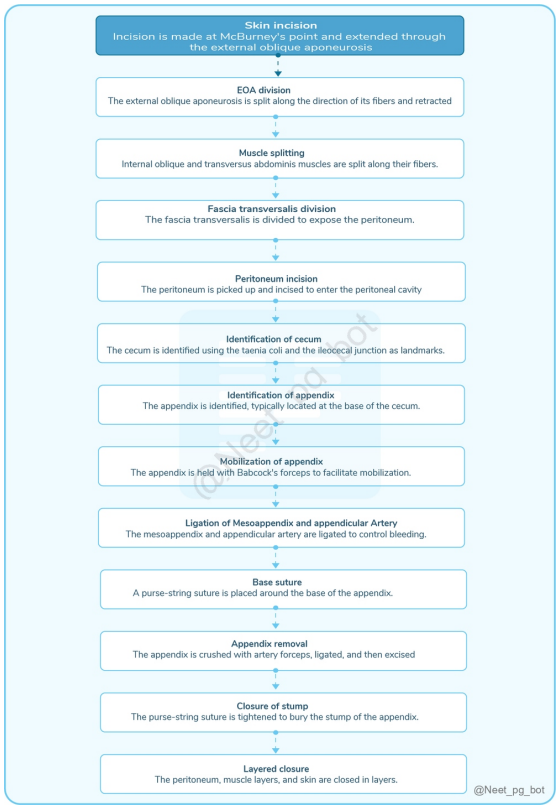
C. Superior rectal artery

D. Superior mesenteric artery

Correct Answer: A. Ileocolic artery

Explanation: The appendicular artery, a branch of the ileocolic artery , supplies the appendix, and if not properly ligated during an Appendectomy , can lead to postoperative bleeding and blood collection in the abdomen. Steps during Open Appendectomy: {{caption_text}} Right colic artery (Option B) supplies the ascending colon, not the appendix. It is not typically involved in an appendectomy, so failure to ligate it would not cause bleeding related to the appendix. Superior rectal artery (Option C) is a branch of the inferior mesenteric artery and supplies the

rectum. It has no role in the blood supply to the appendix, and failure to ligate it would not result in bleeding from an appendectomy. Superior mesenteric artery (Option D) supplies the small intestine, cecum, and parts of the colon, but it does not directly supply the appendix. Ligating this artery would affect a broader region but is not specific to preventing bleeding during appendectomy.



References:

Textbook of SRB's Surgical Operations, 6th Edition, Page 934.

↑ *Back to this question in Part A*

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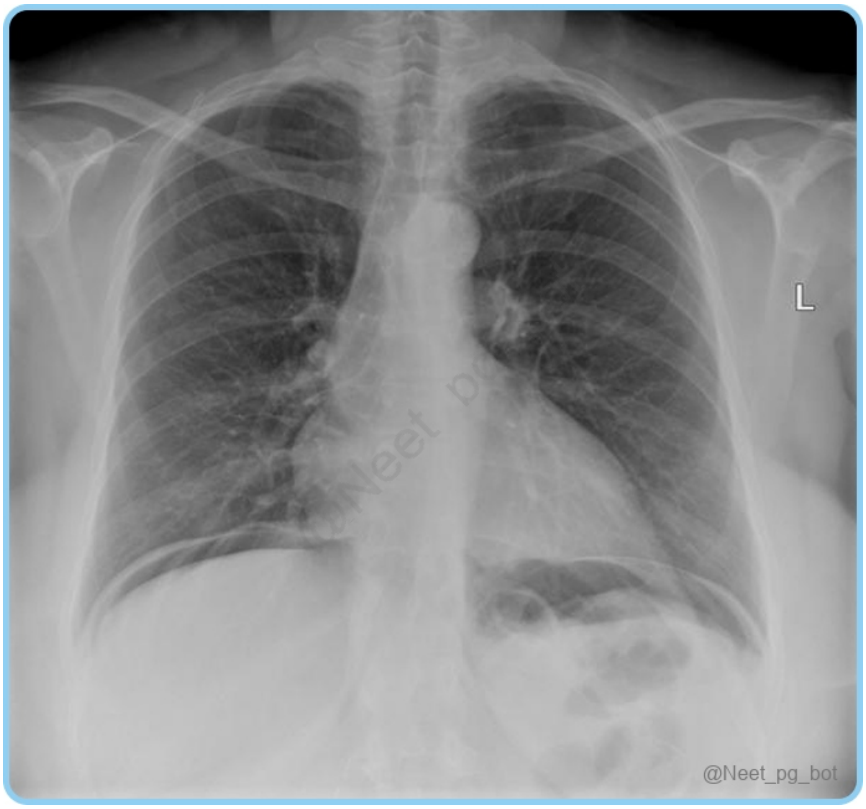
Q101: What should be the subsequent step in managing a 32-year-old male patient who comes to the surgical emergency department with a 2-day history of peptic ulcer disease, experiencing abdominal pain, bloating, and difficulty passing stools? IV fluids CECT abdomen Exploratory laparotomy Upper GI endoscopy Below is the provided X-ray film image (Q855215)

A. 1 and 2

B. 1 and 3

C. 1 and 4

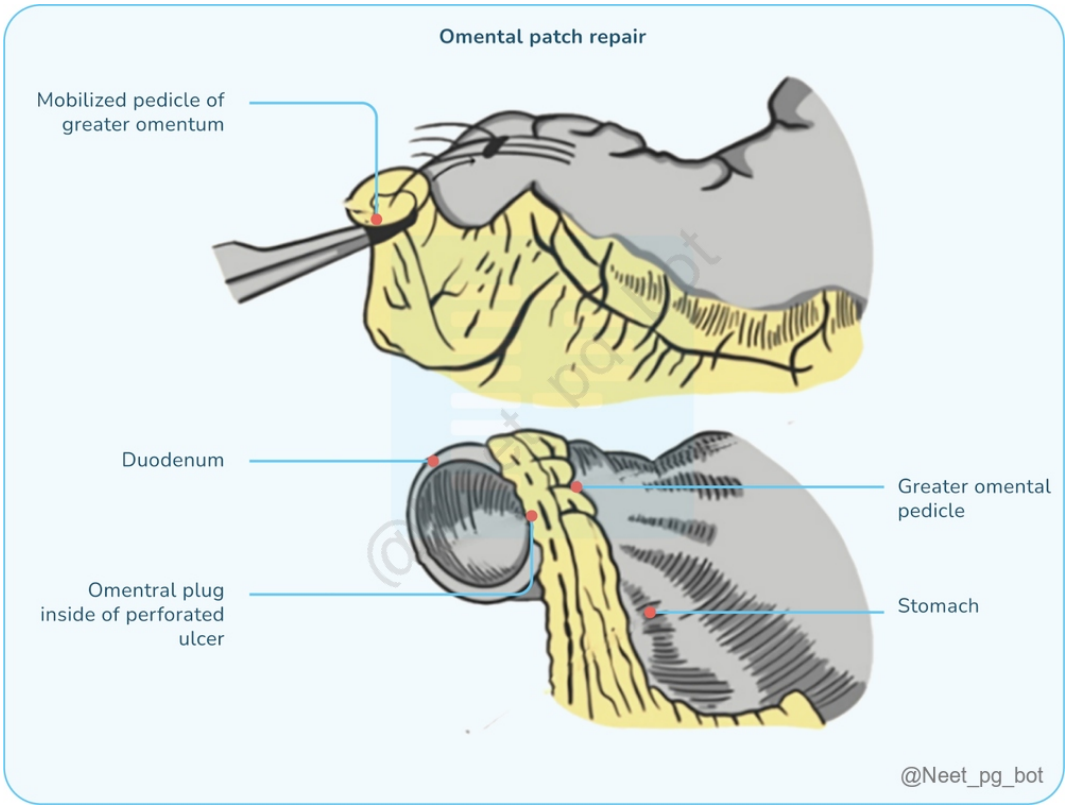
D. 1, 2 and 3



Correct Answer: B. 1 and 3

Explanation: The patient's symptoms of abdominal pain, bloating, difficulty passing stools, and air under the diaphragm suggest intestinal perforation, requiring IV fluids for stabilisation and exploratory laparotomy for surgical intervention. Complications of duodenal ulcer: Duodenal ulcer perforation Common with anterior duodenal ulcers. Presents with an acute abdomen with sudden-onset, severe epigastric pain, rebound tenderness, and air under the diaphragm in the radiograph. Management: (Option B) Non-surgical: Nil per-oral IV antibiotics and PPIs Surgical: Initial empirical antibiotic treatment. The perforation is approached by a small upper midline incision Perforations <1cm are closed primarily and buttressed with a well-vascularized omentum Larger perforations & with fibrotic edges: Modified Graham's Repair or Omental Patch Repair. The vascularized pedicle of the greater omentum is patched over the defect. {{caption_text}} Bleeding duodenal ulcer A posterior duodenal ulcer is the one that usually bleeds. It is due to the involvement of the gastroduodenal artery. This leads to hematemesis, melena or both i.e., an upper GI bleed. Bleeding is commonly associated with intake of NSAIDs. Management: Endoscopic: Done to find the bleeding source and manage bleeds endoscopically. Injection, thermal coagulation, plasma argon coagulation, mechanical clips, and fibrin glue are the methods used. (with or without adrenaline injection). Angiographic management: If endoscopic management fails. Surgical management: Exposure to the ulcer and ligation of the duodenum are the principles here. Duodenotomy Ligation of the bleeding vessel with truncal vagotomy with pyloroplasty Gastric Outlet Obstruction (GOO) Acute inflammation of the duodenum or pylorus leads to mechanical obstruction with a functional gastric outlet obstruction. Presents with nausea, early satiety, vomiting, loss of weight, and anorexia. Hourglass deformity It is seen in chronic gastric ulcers with scarring and fibrosis. Pyloric stenosis It is seen in cases of chronic ulcers, which lead to stricture and constriction of the pylorus. CECT abdomen (Statement B) can help assess the extent of the perforation, but it is not

the first step in this emergency scenario. The presence of air under the diaphragm on the X-ray already suggests perforation and surgical intervention is the priority. Upper GI endoscopy (Statement D) can diagnose peptic ulcers in the case of a perforation, but an immediate exploratory laparotomy is needed to repair the hole and prevent further complications. Endoscopy is not suitable for this emergency.



References:

Sabiston's Textbook of Surgery, 21st Edition, Page 1210-1211, 1213-1214

↑ *Back to this question in Part A*

@Neet_pg_bot

Q102: Identify the correct statement regarding gastric carcinoma: It is mostly hereditary E-cadherin adhesion defect is seen in diffuse types of gastric CA. Wnt signaling pathway defect is seen in intestinal-type gastric CA. Depth of cancer has no role in prognosis. (Q855250)

A. A, C, D

B. B, C

C. B, C, D

D. A, D

Correct Answer: B. B, C

Explanation: B and C statements are correct regarding Gastric Carcinoma . Category Risk factors Diet High-salt foods (e.g., salted and smoked meats), low intake of fruits and vegetables N-nitroso compounds are formed from nitrates in high-salt and smoked foods, Similar to tobacco smoke Lifestyle habits Smoking, alcohol, poor food preparation (smoked, salted), lack of refrigeration, contaminated drinking water, low socioeconomic status Infectious Causes H- pylori infection: M/c infectious cause of gastric cancer. Mechanism : Chronic inflammation leading to atrophic gastritis, intestinal metaplasia, dysplasia, and carcinoma Polyps Adenomatous polyps (risk of malignancy) In multiple polyps, the largest one is excised, and biopsy from others is taken. Hereditary factors E-cadherin (CDH1) gene mutation (hereditary diffuse gastric cancer) (Statement B) Hereditary cancer syndromes Li- Fraumeni syndrome Medications Proton pump inhibitors (long-term use creates low-acid environment achlorhydria; Risk for H. pylori colonisation) Other risk factors Gastric ulcers, pernicious anaemia (achlorhydria), obesity, Epstein-Barr virus, prior abdominal irradiation (for testicular cancer or Hodgkin's lymphoma), prior gastric surgery, male sex Wnt signalling pathway defect is seen in intestinal-type gastric carcinoma (Statement C) : The Wnt signalling pathway plays a crucial role in developing intestinal-type gastric carcinoma. Dysregulation of this pathway can lead to uncontrolled cell growth and tumour formation. Protective factors of Gastric carcinoma: Fruits and vegetables, especially citrus fruits, help decrease the risk of the disease. Exercise helps control the weight and improves muscle mass and overall health. Antioxidant supplements help, too. (beta carotene, vitamin C, vitamin A, selenium) Cessation of smoking is also necessary. It is mostly hereditary (Statement A) : There are certain genetic factors that can increase the risk of developing gastric cancer, but the majority of cases are not directly linked to hereditary factors. Depth of cancer has no role in prognosis (Statement D) : The depth of cancer invasion, known as tumour staging, is an important prognostic factor in gastric carcinoma.

References:

Sabiston's Textbook of Surgery, 21st Edition, Page 1219-1221.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q103: A patient presented with large intra-abdominal fluid accumulation and was found to have pancreatic necrosis. Which of the following are included in the management of the condition? Antibiotics IV IV fluids Culture MRI Assisted drainage Laparotomy (Q855349)

A. 1, 2, 3, 4 and 5

B. 2, 4, 5 and 6

C. 1, 2, 3, 5 and 6

D. 1, 2, 3, 4, 5 and 6

Correct Answer: C. 1, 2, 3, 5 and 6

Explanation: The statements 1, 2, 3, 5 and 6 are included in the management of Pancreatic Necrosis . It refers to a diffuse or focal area of non-viable parenchyma. Pathogenesis: It involves peripancreatic fat lysis, leading to an acute necrotic collection (ANC) with fluid and necrotic material, developing a defined inflammatory capsule, and evolving into walled-off necrosis (WON). Types: Sterile (initial stage) and Infected. CECT scan: An absence of parenchymal enhancement. Culture and Sensitivity: Aspirated fluid is sent for culture and sensitivity. (Statement 3) Management: Supportive measures (IV fluids and stabilisation) (Statement 2) Sterile necrotic material should not be drained or interfered with. Signs of sepsis (purulent aspirate) : Drainage (endoscopic ultrasound-guided is preferred) of the infected fluid. (Statement 5) Antibiotic therapy (Statement 1) Pancreatic necrosectomy (laparotomy). (Statement 6) Magnetic resonance imaging (MRI) (Statement 4) is not typically used in the management of pancreatic necrosis. It may be used later in the course of the disease to assess the extent of necrosis or complications. CT scan is preferred.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1274-1275.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q104: What is the most prevalent condition that leads to the occurrence of heartburn and chest pain in a patient? (Q857174)

A. Barrett's esophagus

B. Pneumonia

C. Myocardial infarction

D. Esophagitis

Correct Answer: D. Esophagitis

Explanation: Esophagitis, characterized by inflammation of the esophagus, presents symptoms such as chest pain, heartburn, acid regurgitation, and difficulty swallowing. Treatment typically involves Proton Pump Inhibitors (PPIs). Barrett's esophagus (Option A) In the lower part or distal oesophagus, the Squamous mucosa is replaced by columnar mucosa, and this is a serious complication of long-term, chronic esophagitis caused by GERD.. Pneumonia (Option B) This is an infection of the lungs. It can cause chest pain (often sharp and worse with breathing), but it does not cause heartburn. Myocardial infarction (Option C) is caused by decreased supply of blood flow to a portion of the myocardium. Clinical features include chest pain radiating to the left arm and neck, dyspnea, sweating, heartburn, fatigue, and weakness.

References:

Harrison's Principles of Internal Medicine, 21st Edition, Pages 294- 296

↑ *Back to this question in Part A*

@Neet_pg_bot

Q105: A baby playing unsupervised was brought with complaints of difficulty in swallowing for the last few hours. The x-ray image is given below. What is the diagnosis? (Q857178)

A. Foreign body in the trachea

B. Foreign body in the esophagus

C. Foreign body in lungs

D. Foreign body in pleura



Correct Answer: B. Foreign body in the esophagus

Explanation: On Chest Xray foreign body in the oesophagus is characterized by - On PA view: Flat surface of the coin On Lateral view: Edge of the coin Foreign body in the trachea (Option A) Tracheal foreign bodies are usually seen in the sagittal orientation on AP view due to the airflow pattern. It presents with cough, stridor, or wheezing

rather than pure dysphagia. Foreign body in lungs (Option C) More common in aspiration, affecting the right main bronchus. Symptoms include sudden onset cough, wheezing, respiratory distress, or asymmetric breath sounds. It may show air trapping on expiratory films. Foreign body in pleura (Option D) Foreign bodies do not typically enter the pleural space unless there is penetrating trauma. Pleural foreign bodies would cause pneumothorax or hemothorax, not dysphagia.

References:

Esophageal Foreign Body

↑ *Back to this question in Part A*

@Neet_pg_bot

Q106: What is the most appropriate next course of action in managing a male patient, aged 40, who presents with widespread abdominal pain and has a confirmed history of Crohn's disease, as well as rigidity and guarding observed during a physical examination, with ileal perforation being detected on imaging? (Q857216)

A. Antibiotics and NPO

B. Upper GI endoscopy

C. Urgent surgical exploration with ileostomy

D. CT abdomen

Correct Answer: C. Urgent surgical exploration with ileostomy

Explanation: Ileal perforation in Crohn’s disease is a life-threatening complication that requires immediate surgical intervention. Primary repair vs. Ileostomy: Primary repair is not ideal due to inflamed, friable tissue and high recurrence risk. An ileostomy is preferred to divert faecal contents and allow healing before later reversal. Without surgery, the patient risks septic shock, multi-organ failure, and death. Antibiotics and NPO (Option A) Supportive care alone is insufficient for a perforation. Antibiotics help control infection but do not treat the perforation. Surgery is mandatory to remove the perforated segment and control peritonitis. Upper GI endoscopy (Option B) Not useful for small bowel (ileal) disease. Contraindicated in perforation due to risk of further bowel injury. CT abdomen (Option D) Imaging is already done, confirming perforation. Further delay increases morbidity and mortality. The next step is definitive surgical intervention, not additional imaging.

References:

Bailey and Love’s Short Practice of Surgery, 28th Edition, Page 1330-1334

↑ *Back to this question in Part A*

@Neet_pg_bot

Q107: A 34-year-old male presented with a painless mass in the right inguinal region. On examination, there is a cough impulse on the index finger. The swelling reaches the scrotum and is reduced completely by pressing it through the deep inguinal ring with a gurgling sound. What is the likely diagnosis? (Q857238)

A. Femoral hernia

B. Direct inguinal hernia

C. Indirect inguinal hernia

D. Umbilical hernia

Correct Answer: C. Indirect inguinal hernia

Explanation: Origin: Lateral to the inferior epigastric vessels, entering the deep inguinal ring. Path: Passes through the inguinal canal, sometimes reaching the scrotum. Complete reduction through deep inguinal ring : Classic for an indirect hernia. Gurgling sound: Indicates the presence of bowel loops within the hernia sac. Femoral hernia (Option A) Located below the inguinal ligament, more common in women, and does not extend into the scrotum. No gurgling sound or reducibility through the deep ring. Direct inguinal hernia (Option B): Bulges through Hesselbach's triangle, medial to the inferior epigastric vessels. Does not extend into the scrotum and is usually more diffuse, not reducible through the deep ring. Umbilical hernia (Option D) Occurs at the umbilicus, unrelated to the inguinal region.

References:

SRB's Manual of Surgery, 6th Edition, Page 745,746

↑ *Back to this question in Part A*

@Neet_pg_bot

Q108: What is the likely diagnosis for a 40-year-old patient who has experienced the passage of mucus and blood in their stool, with inflammation predominantly observed in the rectum during sigmoidoscopy, and the presence of crypt abscess detected during biopsy? (Q857240)

A. Ulcerative colitis

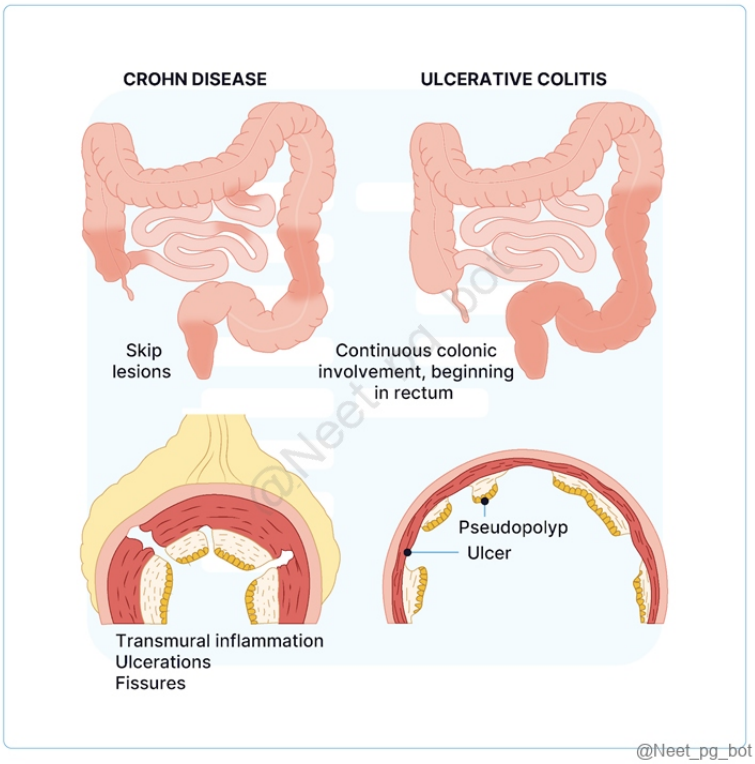
B. Irritable bowel syndrome

C. Crohn disease

D. Pseudomembranous colitis

Correct Answer: A. Ulcerative colitis

Explanation: Features Ulcerative colitis Crohn’s disease Location Limited to colon and rectum Can involve any part of the GI tract Distribution Diffuse lesion Patchy, with skip lesions. Gross appearance Mucosal erythema and granularity Broad-based ulcers with a continuous pattern Pseudopolyps Mucosal atrophy Smooth, continuous inflammation Transmural inflammation Aphthous ulcers Cobblestone appearance Fistulae, strictures, abscesses Creeping fat (mesenteric fat wrapping) Complications Toxic megacolon Colonic dilation Mucosal bridges Strictures Fistulae Irritable bowel syndrome (Option B) presents with features of abdominal discomfort, bloating, and altered bowel habits (diarrhoea or constipation). No blood in stool, no crypt abscesses, and no inflammation on biopsy. Crohn's disease (Option C) presents with features of skip lesions, transmural inflammation, and non-caseating granulomas. It can affect any part of the GI tract (mouth to anus), usually sparing the rectum. Fistulas, strictures, cobblestone appearance on endoscopy. Pseudomembranous colitis (Option D) presents with profuse, watery diarrhoea after recent antibiotic use. Pseudomembranes (yellow plaques) are seen on colonoscopy. No crypt abscesses and inflammation is not limited to the rectum.



References:

Robbin’s Pathology, 10th Edition, Pages 798-805

↑ *Back to this question in Part A*

@Neet_pg_bot

Q109: An elderly male patient presented with purulent discharge from an opening located in the perianal region. The patient is put in a lithotomy position, and the opening is located at the 11 o’clock position, 2 cm from the anal margin. What will be the likely position of the internal opening, and where does the internal opening start? (Q857258)

A. 12 o’clock and at the external anal sphincter

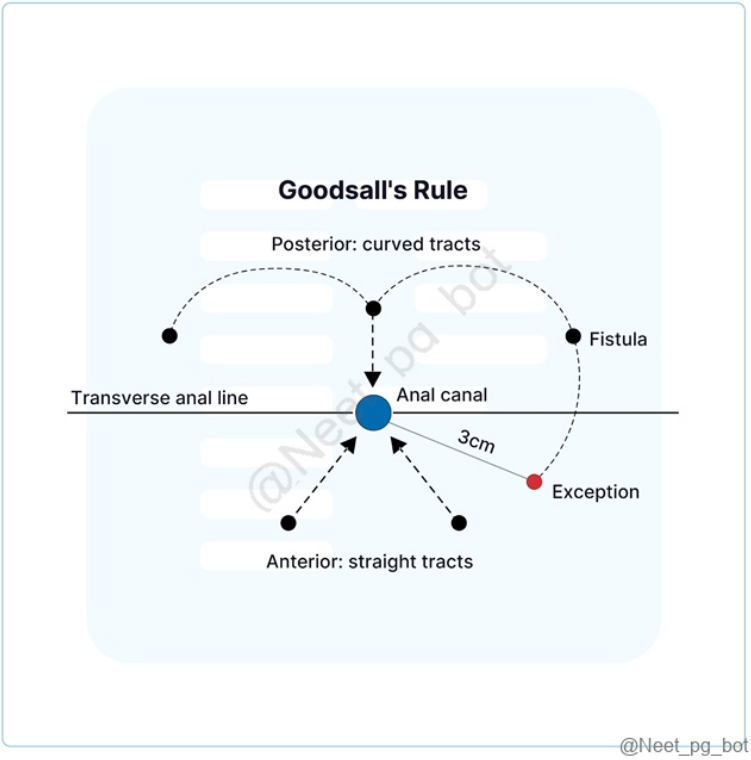
B. 11 o’clock and at the internal anal sphincter

C. 9 o’clock and at anal verge

D. 6 o’clock and crypt of the dentate line

Correct Answer: B. 11 o’clock and at the internal anal sphincter

Explanation: Goodsall's Rule: Anterior External Opening: If the fistula's external opening is in the anterior half of the anus (front side), the fistula usually follows a direct path to the internal opening within the anus. Posterior External Opening: If the fistula's external opening is in the posterior half of the anus (back side), the fistula typically follows a curved path, forming a horseshoe shape, and opens internally at the midline of the posterior anus. The exception to Goodsall's Rule: Anterior external opening more than 3 cm from the Anus: If the external opening is located more than 3 cm away from the anal margin (anterior side), the fistula is likely to track to the posterior midline, rather than following a direct path as Goodsall's Rule would typically suggest. 12 o’clock and at the external anal sphincter (Option A): The external sphincter is not the primary site for fistula origin; fistulas originate from the crypts in the dentate line . 11 o’clock, and at internal anal sphincter (Option C), does not follow Goodsall’s Rule ; posterior fistulae track to the midline (6 o’clock) . 9 o’clock and at the anal verge (Option D): This does not match the typical fistula pattern based on the location given.



References:

Investigations

Schwartz’s Principles of Surgery, 11th Edition, Page 1317

SRB’s Manual of Surgery, 6th Edition, Page 973

Bailey and Love’s Short Practice of Surgery, 28th Edition, Page 1436-1438

↑ *Back to this question in Part A*

@Neet_pg_bot

Q110: What is the most probable outcome for the patient after undergoing gastrectomy? (Q857271)

A. Folic acid deficiency

B. Vitamin B12 deficiency

C. Gastric ulcer

D. Constipation

Correct Answer: B. Vitamin B12 deficiency

Explanation: Gastrectomy (partial or total removal of the stomach) significantly affects nutrient absorption , particularly Vitamin B12 , due to the loss of intrinsic factors. Intrinsic factor (IF) , produced by gastric parietal cells , is essential for B12 absorption in the ileum . Gastrectomy removes parietal cells , leading to intrinsic factor deficiency and causing impaired vitamin B12 absorption . This leads to pernicious anemia , presenting with megaloblastic anemia, neuropathy, and glossitis . Management: Lifelong B12 supplementation (IM or high-dose oral). Folic acid deficiency (Option A) Folate is absorbed in the proximal jejunum , which remains intact after gastrectomy. It is not a direct consequence of gastrectomy unless there is associated malnutrition . Gastric ulcer (Option C) Gastrectomy reduces acid secretion , lowering the risk of gastric ulcers . However, marginal ulcers may develop at anastomotic sites in certain procedures. Constipation (Option D) Gastrectomy does not directly cause constipation; patients may experience dumping syndrome or diarrhoea instead.

References:

https://pubmed.ncbi.nlm.nih.gov/24096753/

↑ *Back to this question in Part A*

@Neet_pg_bot

Q111: What is the diagnosis for a patient who exhibits symptoms of dysphagia, experiencing pain behind the breastbone, and regurgitation accompanied by coughing following meals? (Q857274)

A. Brown Patterson Kelly syndrome

B. Achalasia

C. Esophageal diverticula

D. Reflux esophagitis

Correct Answer: C. Esophageal diverticula

Explanation: Esophageal diverticula are outpouches or pockets that develop in the wall of the esophagus. These diverticula can interfere with the normal passage of food, leading to symptoms such as dysphagia (difficulty swallowing) and regurgitation. Esophageal Diverticula : Type Location Cause Symptoms Diagnosis Treatment Zenker’s Diverticulum Upper esophagus (pharyngoesophageal junction) Cricopharyngeal muscle dysfunction (pulsion) Dysphagia, regurgitation, halitosis, aspiration Barium swallow (posterior outpouching) Diverticulectomy or endoscopic myotomy Mid-Esophageal Diverticulum Mid-esophagus (middle third) Traction from mediastinal inflammation (e.g., TB) Usually, asymptomatic or mild dysphagia Barium swallow (mid-esophageal outpouching) No treatment unless symptomatic Epiphrenic Diverticulum Lower oesophagus (above LES) Esophageal motility disorders (e.g., achalasia) Dysphagia, regurgitation, nocturnal cough Barium swallow (outpouching near LES) Surgical myotomy or diverticulectomy, if needed Brown Patterson Kelly syndrome (Option A) presents with iron

deficiency anaemia, esophageal webs, and dysphagia . It does not cause regurgitation or retrosternal pain . Achalasia (Option B) presents with progressive dysphagia for both solids and liquids. LES fails to relax, leading to the bird's beak sign on the barium swallow. It does not usually cause significant regurgitation with coughing after meals. Reflux esophagitis (Option D) presents with heartburn, acid regurgitation, and erosions due to GERD . Dysphagia occurs later due to stricture formation , not an early symptom.

References:

Bailey and Love's Short Practice of Surgery, 28th Edition, Pages 1126,1127

↑ *Back to this question in Part A*

@Neet_pg_bot

Q112: In a patient with ascites visiting your clinic for diagnostic paracentesis, you opt for a midline approach to remove the fluid. Which of the following size needles is used during this procedure? (Q857276)

A. 14 gauge

B. 16 gauge

C. 17 gauge

D. 22 gauge

Correct Answer: D. 22 gauge

Explanation: For diagnostic paracentesis, a 22-gauge needle is typically used. Diagnostic paracentesis requires a smaller needle to safely and comfortably extract ascitic fluid for analysis. Larger gauge needles (like 14, 16, or 17 gauge) are more commonly used for therapeutic paracentesis or catheter placement but are not preferred for routine diagnostic fluid sampling due to increased risk of complications and patient discomfort. Therapeutic vs. Diagnostic Paracentesis It's important to differentiate this from therapeutic paracentesis , which is performed to remove a large volume of ascitic fluid to relieve symptoms such as shortness of breath or abdominal pain. For therapeutic procedures, larger bore needles or catheters (usually 14 to 18 gauge) are often used to facilitate the faster drainage of a larger volume of fluid.

References:

Diagnostic and therapeutic abdominal paracentesis - PMC

↑ *Back to this question in Part A*

@Neet_pg_bot

Q113: A patient presented with retrosternal chest pain radiating to the jaw and dysphagia. A barium swallow was performed, and the following image was shown. Which of the following is the most likely diagnosis? (Q857438)

A. Infectious esophagitis

B. Diffuse esophageal spasm

C. Barrette’s esophagus

D. Esophageal stricture



Correct Answer: B. Diffuse esophageal spasm

Explanation: The barium swallow image shows a classic “corkscrew” appearance, characteristic of Diffuse Esophageal Spasm (DES). This occurs due to simultaneous, uncoordinated, high-amplitude contractions of the esophageal body. Patients typically present with retrosternal chest pain radiating to the jaw, often mimicking angina. Intermittent dysphagia to both solids and liquids is a key symptom. DES is caused by disordered inhibitory innervation of the esophageal smooth muscle. Diagnosis is confirmed by manometry, which shows premature, non-peristaltic contractions. Management includes nitrates, calcium channel blockers, botulinum toxin, or myotomy in resistant cases. Incorrect Options: Option A) Infectious esophagitis: Shows ulcerations, plaques, or a shaggy mucosa on barium study (e.g., Candida, CMV). Does not produce a corkscrew appearance. Option C) Barrett’s esophagus: A metaplastic change at the lower esophagus seen on endoscopy + biopsy, not barium swallow. Barium usually appears normal or may show reflux but never a corkscrew pattern. Option D) Esophageal stricture: Appears as a smooth, tapered narrowing ("rat-tail" or “bird-beak”), often from GERD or caustic injury.

Does not show multiple irregular indentations like DES.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition), Page 1125, 1126

↑ *Back to this question in Part A*

@Neet_pg_bot

Q114: The provided barium swallow indicates (Q857453)

A. Achalasia cardia

B. Diffuse esophageal spasm

C. Nutcracker oesophagus

D. Hypertensive lower esophageal sphincter



Correct Answer: A. Achalasia cardia

Explanation: The barium swallow image shows a dilated esophagus filled with retained contrast. There is a classic smooth, tapered narrowing at the distal end—called the bird-beak appearance. This occurs due to failure of LES

relaxation during swallowing. Loss of esophageal peristalsis leads to progressive dilation of the proximal esophagus. The contrast column appears long and uniformly filled, consistent with aperistalsis. These radiologic findings are diagnostic of Achalasia cardia. Confirmatory test is esophageal manometry, showing increased LES pressure and absent peristalsis. Incorrect Options: Option B) Diffuse Esophageal Spasm : Shows “corkscrew” or “rosary bead” esophagus with multiple simultaneous non-propulsive contractions. Not seen here. Option C) Nutcracker Esophagus : Barium swallow often appears normal ; diagnosis is via manometry showing very high-amplitude peristaltic waves . No bird-beak appearance. Option D) Hypertensive Lower Esophageal Sphincter : LES pressure is elevated, but relaxation is normal; barium swallow is usually near normal without dilation. Does not produce bird-beak tapering

References:

Bailey & Love's Short Practice of Surgery (28th Edition), Page 1121, 1123

↑ *Back to this question in Part A*

@Neet_pg_bot

Q115: Which of the following conditions has a barium enema as shown in the picture below? (Q857454)

A. Multiple colonic polyps

B. Ulcerative colitis

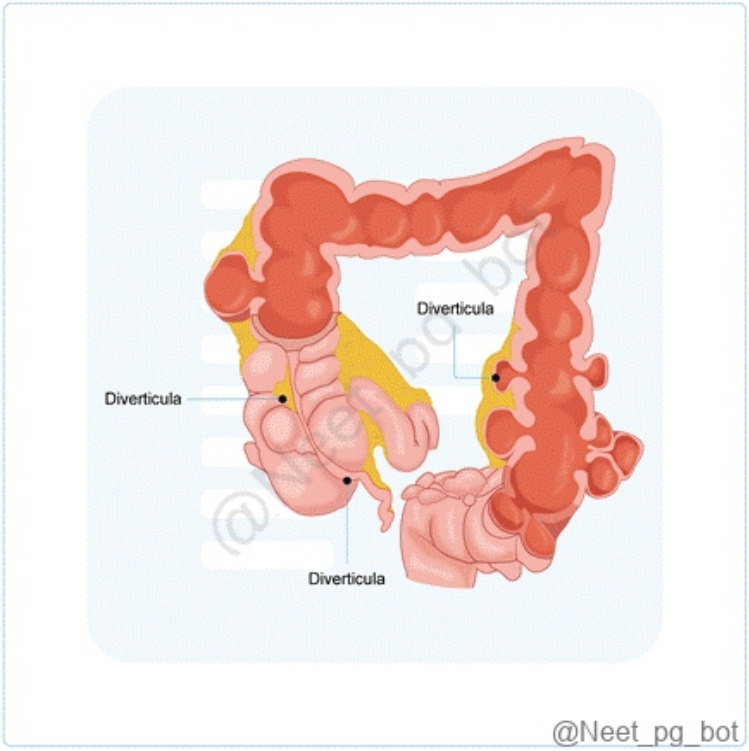
C. Diverticulosis

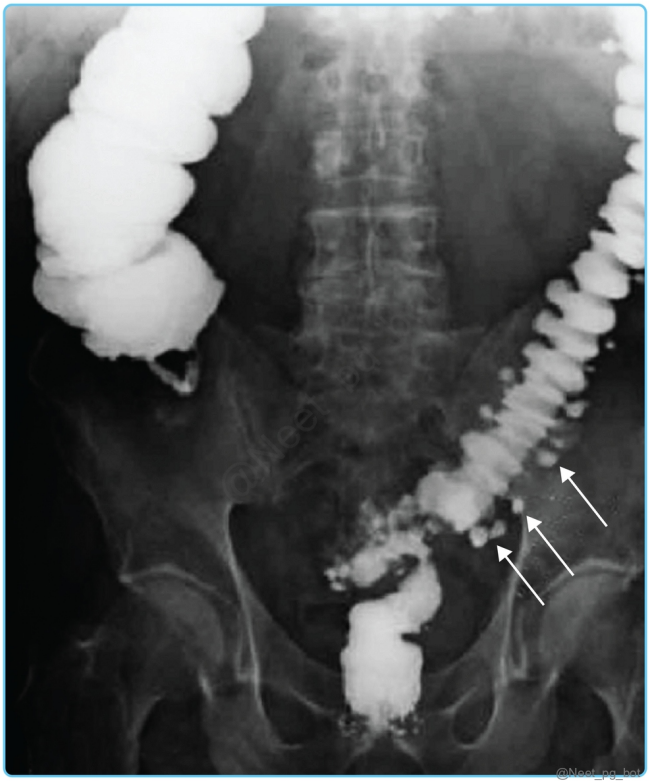
D. Irritable bowel syndrome



Correct Answer: C. Diverticulosis

Explanation: Correct answer C) Diverticulosis Diverticulosis is the outpouching of the colon wall. In a barium swallow, the contrast x ray shows an outpouching filled with barium as seen in the image it presents as a “ Saw tooth appearance ” It is most commonly seen in the sigmoid colon. Multiple colonic polyps (Option A) Colonic polyps appear as single polypoid lesions in the radiograph. It does not present a Sawtooth appearance. Ulcerative colitis (Option B) A smooth colon with no haustrations “Lead pipe colon” is seen in the radiograph. Irritable bowel Syndrome (Option D) Saw tooth appearance is not seen in irritable bowel syndrome. Diverticulosis Definition Presence of small, bulging pouches (diverticula) in the colon, most commonly in the sigmoid colon. {{caption_text}} Etiology Diet: A low-fiber diet increases colon pressure. Age: More common in those over 60. Genetics: Family history may increase risk. Pathophysiology Increased pressure: High colon pressure causes weak spots to bulge. Weak colonic wall: Weak areas, especially where blood vessels enter the mucosa, are prone to forming diverticula. Characteristics False diverticula: Involve only the mucosa and submucosa. Multiple and acquired: Typically multiple and not congenital. Location: Most commonly in the sigmoid colon, along the mesenteric aspect. Symptoms Often asymptomatic; may include mild abdominal discomfort, bloating, and changes in bowel habits. Diagnosis Colonoscopy: Direct visualization. CT Scan: Detailed images of the colon. Barium enema: Less common, shows a characteristic sawtooth appearance {{caption_text}} Management Diet: Increase fiber intake. Hydration: Drink plenty of fluids. Exercise: Promotes healthy bowel function. Complications Lower GI Bleed: Common cause of lower gastrointestinal bleeding.





References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1368-1370.

Schwartz's Principles of Surgery, 11th Edition, Page 1286-1288.

SRB's Manual of Surgery, 6th Edition, Page 879-882.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q116: A gross specimen of the colon obtained from a 14-year-old boy is shown below. Which of the following is the most likely diagnosis? (Q857499)

A. Crohn's disease

B. Familial adenomatous polyposis (FAP)

C. Lynch syndrome

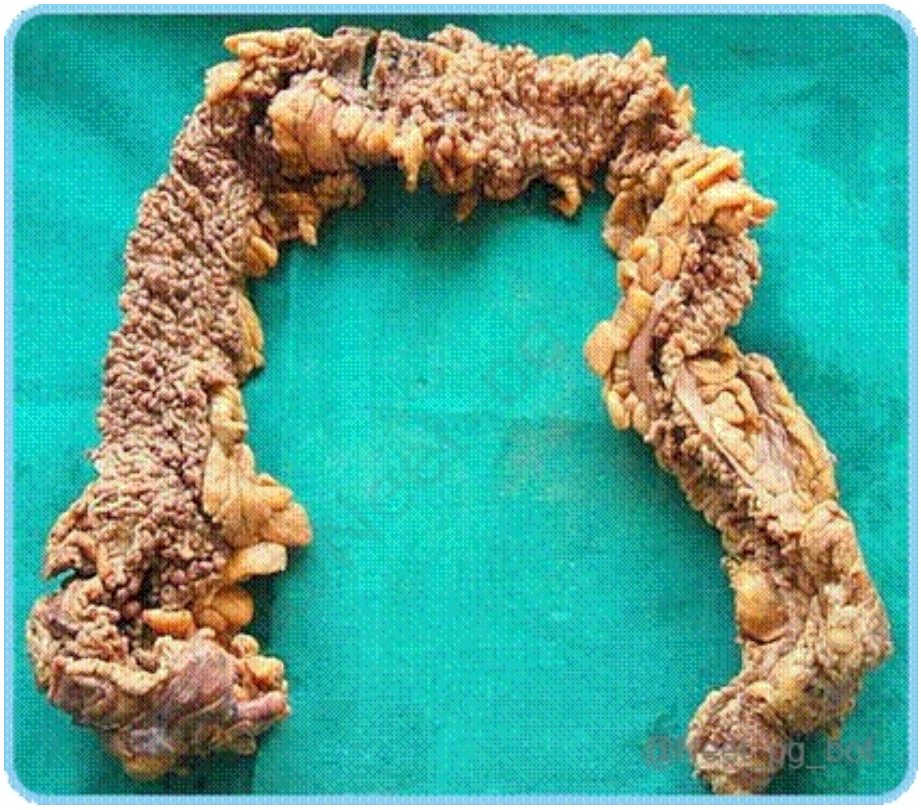
D. Juvenile polyposis syndrome



Correct Answer: B. Familial adenomatous polyposis (FAP)

Explanation: The most likely diagnosis in the above condition is FAP (familial adenomatous polyposis) Familial adenomatous polyposis (FAP): Caused Autosomal dominant mutation in the APC (Adenomatous Polyposis Coli) gene on chromosome 5q21. 100% risk of colorectal cancer in those with APC gene mutation. 80% of cases are

from positive family history. Clinical Features: Numerous (>100) colorectal adenomatous polyps, typically develop in adolescence or early adulthood. {{caption_text}} Rectal bleeding, diarrhoea, abdominal pain Extracolonic manifestations : Congenital hypertrophy of the retinal pigment epithelium (CHRPE), desmoid tumours, upper gastrointestinal polyps, epidermoid cyst (Gardner syndrome) Increased risk of other cancers: duodenal, thyroid, brain (medulloblastoma), hepatoblastoma Diagnosis: Colonoscopy showing >100 polyps and biopsy showing an adenomatous variety of polyp. Treatment: The aim of Surgery in FAP is to prevent the development of colorectal cancer. Restorative proctocolectomy with an ileal pouch-anal anastomosis. Colectomy with ileorectal anastomosis (IRA) Total proctocolectomy and end-ileostomy. Crohn's disease (Option A) While it can cause rectal bleeding, it doesn't typically present with numerous polyps throughout the colon. Lynch syndrome/Hereditary nonpolyposis colorectal cancer (HNPCC) (Option C) This condition increases cancer risk but doesn't usually cause numerous polyps. The average age of onset is later than FAP. Juvenile polyposis syndrome (Option D) This can cause multiple polyps, but they are typically hamartomatous rather than adenomatous, fewer in number than FAP.



References:

Bailey & Love’s Short Practice of Surgery, 28th Edition, Page 1356, 1357

↑ *Back to this question in Part A*

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Q117: During a routine check-up, an elderly male was discovered to have a rectal mass during a digital rectal examination, indicating the possibility of rectal carcinoma. Despite normal bowel habits, the next course of action for managing this patient should be: (Q857519)

A. CT scan of the abdomen

B. Rigid sigmoidoscopy and biopsy

C. Full colonoscopy and biopsy

D. Barium enema

Correct Answer: C. Full colonoscopy and biopsy

Explanation: A full colonoscopy is done to confirm the diagnosis of rectal carcinoma and to rule out the presence of any synchronous lesions. If any lesions are identified, a biopsy should be done to confirm the diagnosis and determine the stage and the characteristics of the tumor. Investigations and Diagnosis of Rectal Carcinoma Digital Rectal Examination : Used to assess the size, consistency (hard), shape (Irregular), and mobility (mobile, tethered, or fixed). A vaginal examination is recommended for women to check for involvement of the posterior vaginal wall. Rigid Sigmoidoscopy : Outpatient procedure for visualising the neoplasm and obtaining biopsies Biopsy and Histological Analysis : Crucial for confirming the diagnosis and distinguishing rectal carcinoma from conditions that may mimic it, such as inflammatory strictures, granulomas, and benign adenomas. Staging Investigations : CT chest, abdomen, and pelvis. Local pelvic imaging with MRI and/or endoluminal ultrasonography provides detailed information about local tumour spread, including infiltration into surrounding tissues and lymph node involvement. Colonoscopy : Essential for most patients to rule out synchronous tumours elsewhere in the colon. Techniques like "dye spray" colonoscopy help differentiate benign from malignant lesions based on mucosal 'pit patterns'. Proximal adenomas can be removed during the procedure; finding synchronous carcinomas may alter surgical strategy. CT Colonography or Barium Enema : Alternatives to colonoscopy if full visualization of the colon is not possible due to stenosing cancer. CT scan of the abdomen (Option A) CT scan of the abdomen is useful in determining the size, location and staging of the tumour. Rigid sigmoidoscopy and biopsy (Option B) This procedure can only be used to examine the distal portion of the rectum and sigmoid colon but not the entire colon. Barium enema (Option D) This technique was used earlier but now is vastly replaced by colonoscopy as it is a better diagnostic procedure.

References:

Bailey & Love’s Short Practice of Surgery, 28th Edition, Page 1406

↑ *Back to this question in Part A*

@Neet_pg_bot

Q118: A 30-year-old female presented with a low-grade fever of 1-week duration associated with loss of appetite and weight loss. Barium meal follow-through image of

the patient is given below. What is the probable diagnosis? (Q857520)

A. Ileocaecal TB

B. Ulcerative colitis

C. Crohn’s disease

D. Carcinoma caecum



Correct Answer: A. Ileocaecal TB

Explanation: In the barium study of the ileum in the case of ileocaecal TB, these are the signs that can be seen in the narrowing of the terminal ileum. Thickening of the ileocecal valve and the thickening of the cecal walls, the cecum appears as a conical shape. In later stages, the ileum is fixed and rigid. Ileocecal Tuberculosis: Feature Details Definition A form of abdominal tuberculosis affecting the ileocecal region, the most common site of gastrointestinal TB. Why the Ileocecal Region? Rich in lymphoid tissue, slow transit time, and increased uptake of tubercle bacilli. Common Symptoms Right lower quadrant (RLQ) pain, weight loss, fever, diarrhoea/constipation, and abdominal mass. Differential Diagnoses Crohn’s disease, appendicitis, colorectal cancer, lymphoma. Physical Examination RLQ tenderness, palpable mass, signs of obstruction (in severe cases). Imaging Findings Ultrasound/CT scan : Bowel wall thickening, lymphadenopathy, ascites, strictures. Endoscopic Findings Colonoscopy : Ulcers, nodularity, strictures in the ileocecal region. Histopathology Caseating granulomas, acid-fast bacilli (AFB) on Ziehl-Neelsen stain. Definitive Diagnosis AFB culture, PCR for Mycobacterium tuberculosis. Treatment Anti-TB Therapy (ATT) : Rifampicin, Isoniazid, Pyrazinamide, Ethambutol (2 months), followed by Rifampicin + Isoniazid (4 months). Indications for Surgery Bowel obstruction, perforation, abscess,

stricture, and unresponsiveness to ATT. Surgical Options Limited resection (if necessary), stricturoplasty (for non-resectable strictures). Ulcerative colitis (Option B): Radiologically, ulcerative colitis presents with a contracted, pipe-stem colon and thickened, edematous haustra. Crohn's disease (Option C): Radiologically, Crohn's disease is characterised by a cobblestone appearance. Carcinoma caecum (Option D) In the case of carcinoma of the cecum, you can see apple core deformity on the right side of the right iliac fossa and not at the terminal ileum.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 88 - 91

↑ *Back to this question in Part A*

@Neet_pg_bot

Q119: A 35-year-old man arrives at the emergency department with a concern of vomiting blood. He mentions a recent pattern of excessive alcohol consumption. Upon examination, his vital signs are steady, and he has a pale appearance. There are no indications of ongoing bleeding. The results of his liver function tests are within the normal range. To further assess the situation, an upper gastrointestinal endoscopy is scheduled. What is the most probable diagnosis? (Q857523)

A. Esophageal varices

B. Gastric ulcer

C. Mallory-Weiss tear

D. Alcoholic gastritis

Correct Answer: C. Mallory-Weiss tear

Explanation: Mallory-Weiss tears are longitudinal mucosal lacerations that occur at the gastroesophageal junction, usually due to severe vomiting or retching. Binge alcohol drinking can lead to forceful vomiting, which may cause these tears. Mallory-Weiss tears are a common cause of upper gastrointestinal bleeding in individuals with a history of alcohol abuse, and they can present with hematemesis. Esophageal varices (Option A) While alcohol abuse can contribute to liver disease, the absence of liver function abnormalities make esophageal varices less likely. Gastric ulcer (Option B) Risk factors like Helicobacter pylori infection or non-steroidal anti inflammatory drug (NSAID) use is usually more significant in developing gastric ulcers. Alcoholic gastritis (Option D) Absence of any liver function abnormalities and considering the presentation with hematemesis, Mallory-Weiss tear is a more probable diagnosis compared to alcoholic gastritis.

References:

Sabiston Textbook of Surgery, 21st edition, Page 1235

Bailey and Love’s Short Practice of Surgery, 28th Edition, Page 1127-1129

↑ *Back to this question in Part A*

@Neet_pg_bot

Q120: Which of the following accurately represents Bormann's classification for gastric carcinoma? (Q857524)

A. Type I: Polypoid tumor with a small ulcerated component

B. Type II: Ulcerated tumor with infiltrative margins

C. Type III: Diffusely infiltrative tumor with linitis plastica appearance

D. Type IV: Mucinous carcinoma with extensive peritoneal metastases

Correct Answer: A. Type I: Polypoid tumor with a small ulcerated component

Explanation: Borrman's classification is a pathologic classification system based on the macroscopic appearance of gastric carcinomas. Type I tumours are characterised by a diffuse polypoidal growth pattern. This combination of a predominantly polypoid growth with a small ulcerated area distinguishes Type I gastric carcinomas according to Borrman's classification. Bormann’s Classification of Gastric Carcinoma Bormann Type Macroscopic Appearance Key Features Type I (Polypoid type) Polypoid or fungating mass Well-defined borders , grow into the lumen, minimal invasion into the gastric wall, mand ay have a small ulcerated component . Type II (Ulcerated tumor with distinct borders) Ulcerated lesion with raised margins Clearly defined infiltrative edges , but not deeply penetrating into surrounding tissues. (Option B ruled out) Type III (Ulceroinfiltrative type) (Option C ruled out) Deep ulceration with infiltrative margins Irregular and poorly defined borders , penetrate deeper into the gastric wall, more aggressive than Type II. Type IV (Diffuse/Infiltrative type – Linitis Plastica) (Option D ruled out) Diffuse thickening of the stomach wall Infiltrative growth without a discrete mass , causes "a leather bottle stomach" appearance, commonly associated with signet-ring cell carcinoma .

References:

https://wjso.biomedcentral.com/articles/10.1186/s12957-016-0805-9

↑ *Back to this question in Part A*

@Neet_pg_bot

Q121: A 60-year-old male presents to the emergency department with abdominal pain and vomiting. He reports a 2-day history of constipation and bloating. On examination, he appears uncomfortable, and his abdomen is distended with high-pitched bowel sounds. X-ray reveals dilated loops of the small bowel. What is the

most likely cause of his symptoms? (Q857525)

A. Colonic malignancy

B. Small bowel obstruction

C. Acute pancreatitis

D. Gastric ulcer

Correct Answer: B. Small bowel obstruction

Explanation: Small bowel obstruction is the most likely cause in this case. The patient's acute symptoms, abdominal distension, high-pitched bowel sounds, and dilated loops of small bowel on X-ray is consistent with a mechanical obstruction in the small bowel. Colonic malignancy (Option A) Colonic malignancy can lead to obstruction, but it typically causes a gradual onset of symptoms, such as changes in bowel habits, blood in stool, and weight Loss. Acute pancreatitis (Option C) The presentation of acute pancreatitis often includes epigastric pain radiating to the back, elevated serum amylase or lipase levels and may be associated with gallstones or alcohol consumption. Gastric ulcer (Option D) Gastric ulcers are typically associated with symptoms such as epigastric pain, heartburn, and may be exacerbated by eating. Small Bowel Obstruction (SBO) Causes Adhesions (Most common) Malignancy Metastasis Peritoneal carcinomatosis Hernia Crohn's Disease Tb PID Post radiotherapy Cancer Surgeries with High Risk of Adhesive Small Bowel Obstruction (SBO) Pelvic surgeries (Highest risk) Lower abdominal surgeries Upper abdominal surgeries Malignancies Responsible for SBO Metastasis Peritoneal carcinomatosis Clinical Features of Small Bowel Obstruction: Colicky Abdominal Pain (First symptom): Due to hyperperistalsis in the small intestine caused by intestinal obstruction. Multiple Episodes of Bilious Vomiting Obstipation (Absolute Constipation) Proximal Small Bowel Obstruction Symptoms: Vomiting Dyselectrolytemia (electrolyte imbalances due to vomiting) Distal Small Bowel Obstruction Symptoms: Distension (more prominent)

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1381

SRB's Manual of Surgery, 6th Edition, Page 909-912

↑ *Back to this question in Part A*

@Neet_pg_bot

Q122: Which of the following findings of colonoscopy is highly malignant? (Q857526)

A. Multiple flat polyps about 100

B. Single pedunculated polyp

C. Multiple pedunculated polyps

D. Solitary flat polyp

Correct Answer: A. Multiple flat polyps about 100

Explanation: Among the options you provided, the finding of "Multiple flat polyps about 100" is concerning for a higher risk of malignancy. This is because having a large number of flat polyps (approximately 100) increases the likelihood of some of these polyps being dysplastic or even cancerous. Single pedunculated polyp (Option B) Any polyp has the potential to be cancerous, a single pedunculated polyp, especially if small and without concerning features, is typically considered low risk for malignancy. Multiple pedunculated polyps (Option C) In the context of multiple pedunculated polyps, further evaluation and genetic testing may be warranted to assess the risk of malignancy. Solitary flat polyp (Option D) Flat polyps have a higher potential for malignancy compared to pedunculated polyps; the risk still depends on other factors such as size, morphology, and histological characteristics. The malignancy risk of a solitary flat polyp would need to be assessed based on these factors.

References:

Bailey & Love's Short Practice of Surgery, 28th edition, Page 1356, 1357

↑ *Back to this question in Part A*

@Neet_pg_bot

Q123: Which of the following statements accurately describes McBurney's point in cases of acute appendicitis? (Q857527)

A. McBurney point is located in the left lower quadrant of the abdomen.

B. McBurney point corresponds to the site of maximal tenderness in acute appendicitis.

C. McBurney point is used to assess rebound tenderness in acute appendicitis.

D. McBurney point is located at the umbilicus in acute appendicitis.

Correct Answer: B. McBurney point corresponds to the site of maximal tenderness in acute appendicitis.

Explanation: McBurney point is approximately one-third of the distance from the anterior superior iliac spine to the umbilicus in the right lower quadrant. It is the site where the appendix is most likely to be inflamed and where maximal tenderness is commonly elicited during physical examination in cases of acute appendicitis. McBurney point is located in the left lower quadrant of the abdomen (Option A) McBurney point is not in the left lower quadrant but rather in the right lower quadrant of the Abdomen. McBurney point is used to assess rebound tenderness in acute appendicitis (Option C) Rebound tenderness is assessed by applying pressure at a different location, typically in the left lower quadrant, and observing if there is increased pain when the pressure is released. McBurney point is located at the umbilicus in acute appendicitis (Option D) McBurney point is not located at the umbilicus but rather in the right lower quadrant.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1339 - 1342

↑ *Back to this question in Part A*

@Neet_pg_bot

Q124: What is the likely diagnosis for a patient who has been experiencing fever and pain in the lower right abdomen for the past 5 days, with the presence of a tender mass in the right iliac fossa and an elevated leukocyte count? (Q857528)

A. Appendicitis

B. Hydronephrosis

C. Tuberculosis

D. Carcinoma colon

Correct Answer: A. Appendicitis

Explanation: Based on the symptoms described, including fever, pain in the right lower abdomen, apainful lump in the right iliac fossa, and an increased leukocyte count, the most probable diagnosis would be appendicitis. Appendicitis is the inflammation of the appendix, a small pouch-like organ located in the lower right abdomen. The classic symptoms include fever, abdominal pain (particularly in the right lower quadrant), and an elevated white blood cell count(leukocytosis). The presence of a painful lump in the right iliac fossa further supportsthe likelihood of appendicitis. Hydronephrosis (Option B) Would present with flank pain, not RLQ pain . No fever or leukocytosis unless there is a secondary infection (pyonephrosis) . Ultrasound/CT scan would show dilated renal pelvis and calyces. Tuberculosis (Ileocecal TB) (Option C) TB presents gradually with weight loss, low-grade fever, and chronic pain , not acute severe RLQ pain. A palpable mass may be present (due to a thickened ileocecal region), but no leukocytosis. Carcinoma Colon (Right-Sided) (Option D) Presents insidiously with anemia, weight loss, and altered bowel habits . A firm, non-tender mass may be found in the RLQ butis not typically associated with fever or leukocytosis.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Pages 138, 260, 261

↑ *Back to this question in Part A*

@Neet_pg_bot

Q125: What is the diagnosis of a female patient who presents with a mass in the inguinal area that can be reduced from the deep inguinal ring accompanied by a gurgling sound? (Q857530)

A. Direct inguinal hernia

B. Indirect inguinal hernia

C. Femoral hernia

D. Pantaloon hernia

Correct Answer: B. Indirect inguinal hernia

Explanation: Indirect inguinal hernias are the most common type, where abdominal contents protrude through the deep inguinal ring into the inguinal canal. They typically manifest as a palpable mass or bulge in the inguinal area, often reducible with manual manipulation, accompanied by a gurgling sound. More prevalent in males, they can be congenital or acquired later in life. Direct inguinal hernia (Option A) Involves protrusion through a weak point in the abdominal wall without passing through the deep inguinal ring. Common in older men, typically lacking the characteristic gurgling sound upon reduction. Femoral hernia (Option C) Arises when abdominal contents protrude through the femoral canal, primarily affecting women. Presents as a bulge in the upper thigh or groin area, distinct from the inguinal region, with a narrower passage and typically no gurgling sound upon Reduction. Pantaloon hernia (Option D) A specific type combining direct and indirect hernias, protruding both above and below the inguinal ligament. Presents with bulges on both sides of the inguinal region and may produce a gurgling sound upon reduction.

References:

Bailey & Love’s Short Practice of Surgery (28th edition) page - 1065,1066

↑ *Back to this question in Part A*

@Neet_pg_bot

Q126: All of the following are true about Crohn’s disease except (Q857554)

A. Rectum is involved

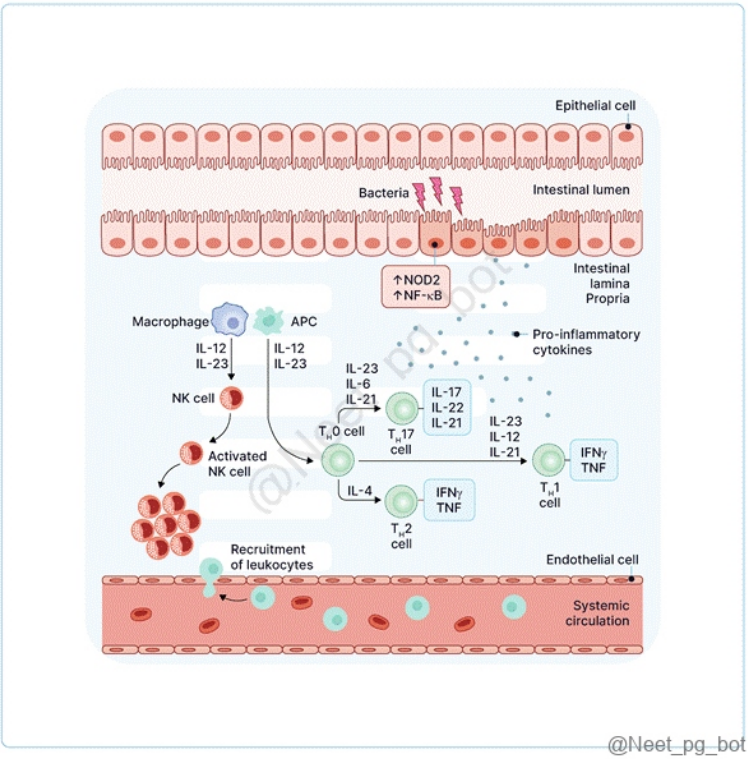
B. Serpiginous ulcers are formed

C. Transmural involvement

D. Recurrence is more common

Correct Answer: A. Rectum is involved

Explanation: Crohn’s disease is a chronic inflammatory bowel disease (IBD) that can affect any part of the gastrointestinal (GI) tract from the mouth to the anus , but it classically spares the rectum . This is a key differentiating feature from ulcerative colitis , which always involves the rectum . Crohn’s Disease Feature



References:

SRB’s Manual of Surgery, 6th Edition, Pages 855, 883.

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1327

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5759609/

Harrison’s Principles of Internal Medicine, 21st Edition, Page 2474

↑ *Back to this question in Part A*

@Neet_pg_bot

Q127: Which of the following statements are true about colon cancer? 1. Right and left colon cancers can behave differently 2. Colon cancers can be hereditary 3. Colon cancer risk can be reduced by metformin 4. Colon cancers frequently metastasize to the liver (Q858355)

A. 1, 2 and 3 only

B. 2, 3 and 4 only

C. 2 and 4 only

D. 1, 2, 3 and 4

Correct Answer: D. 1, 2, 3 and 4

Explanation: 1. Right and left colon cancers can behave differently. True Right-sided colon cancer (proximal) is more likely to present with anemia, occult bleeding, and larger polypoid tumors , while left-sided colon cancer (distal) presents with obstruction, hematochezia, and napkin-ring lesions . 2. Colon cancers can be hereditary. True Hereditary Nonpolyposis Colorectal Cancer (HNPCC/Lynch Syndrome) and Familial Adenomatous Polyposis (FAP) are genetic syndromes associated with increased colon cancer risk. 3. Colon cancer risk can be reduced by metformin. True Studies suggest that metformin reduces insulin resistance and suppresses colorectal cancer cell proliferation , lowering the risk, especially in diabetic patients . 4. Colon cancers frequently metastasize to the liver. True The portal venous system drains the colon to the liver , making it the most common site of metastasis. Other common sites include lungs and peritoneum .

References:

https://pubmed.ncbi.nlm.nih.gov/34749618/

Bailey & Love's Short Practice of Surgery, 28th Edition, pages 1360 - 1364

https://pmc.ncbi.nlm.nih.gov/articles/PMC10183151/

↑ *Back to this question in Part A*

@Neet_pg_bot

Q128: Nonclinical question: Match the following: 1. Hirschsprung’s disease A. MRCP 2. Posterior urethral valve B. CT scan 3. Choledochal cyst C. Rectal biopsy 4. Intussusception D. Micturating cystourethrogram (Q856527)

A. 1-C, 2-D, 3-B, 4-A

B. 1-A, 2-D, 3-B, 4-C

C. 1-C, 2-D, 3-A, 4-B

D. 1-D, 2-C, 3-A, 4-B

Correct Answer: C. 1-C, 2-D, 3-A, 4-B

Explanation: Condition Investigation

References:

Bailey & Love’s Short Practice of Surgery (28th Edition) page 989

↑ *Back to this question in Part A*

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Q129: Which of the following structures are incised by a surgeon during an appendectomy performed initially with a gridiron incision? 1. External oblique 2. Internal oblique 3. Transversus abdominis 4. Rectus abdominis (Q856574)

A. 1, 3, 4

B. 2, 3, 4

C. 1, 2, 3

D. 1, 2, 4

Correct Answer: C. 1, 2, 3

Explanation: A gridiron incision (also known as McBurney's incision) is a muscle-splitting incision used for an open appendectomy . The incision is made at McBurney's point (one-third of the way from the anterior superior iliac spine to the umbilicus). Layers Incised in a Gridiron Incision: Skin & Subcutaneous tissue External oblique aponeurosis → Incised Internal oblique muscle → Split along its fibers (NOT cut transversely) Transversus abdominis muscle → Split along its fibers Transversalis fascia & Peritoneum → Opened to access the appendix Why Not Rectus Abdominis? Rectus abdominis is NOT involved because the gridiron incision is made in the right lower quadrant , where the rectus abdominis does not extend laterally. If a paramedian or midline incision were used, rectus abdominis would be involved

References:

Pubmed

SRB's Manual of Surgery (6th Edition), Page 934, 1156.

↑ *Back to this question in Part A*

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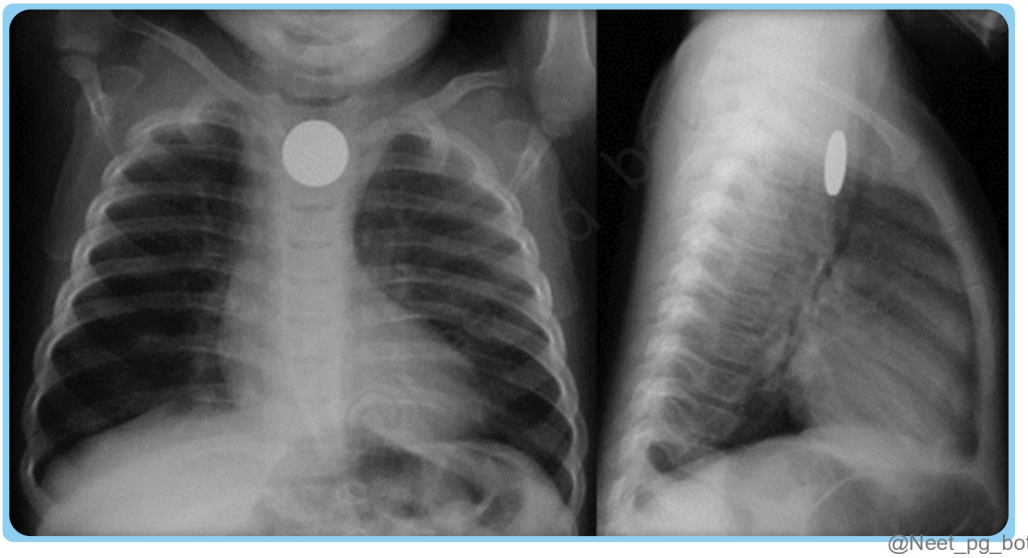
Q130: A baby playing unsupervised was brought with complaints of difficulty in swallowing for the last few hours. The x-ray image is given below. What is the diagnosis? (Q856208)

A. Foreign body in the trachea

B. Foreign body in the esophagus

C. Artifact

D. Soft tissue calcification in the neck



Correct Answer: B. Foreign body in the esophagus

Explanation: The most likely diagnosis is foreign body in the esophagus , as suggested by the X-ray showing an object lodged in the esophagus, causing difficulty swallowing. Category Indications Management Emergency Esophageal obstruction (inability to handle oral secretions) Disk batteries Sharp-pointed objects Immediate endoscopic removal Urgent Blunt objects Incomplete obstruction Multiple magnets (or single magnet plus another ferromagnetic object within endoscopic reach) Coins Endoscopic removal within 12 to 24 hours Non Urgent Objects in stomach >2.5cm diameter Disc battery in the stomach for up to 48 hrs if asymptomatic Blunt objects that fail to pass the stomach in 3-4 weeks Observation Foreign body in the trachea (Option A) would cause symptoms like coughing, wheezing, or stridor, but it typically appears as an object in the trachea on X-ray, which is not the case here. Artifacts (Option C) are typically caused by external factors like motion or poor technique during the X-ray, which would not show a clear foreign body in the esophagus. Soft tissue calcification in the neck (Option D) refers to calcified structures in the neck, such as lymph nodes or blood vessels, but would not present as a foreign object causing swallowing difficulty.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 262.

Sabiston Textbook of Surgery, 21st Edition, Page 1036.

↑ *Back to this question in Part A*

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Q131: A patient was found to have a mass arising from the antrum of the stomach, which involves the head of the pancreas and metastasis to the right lobe of the liver. How will you manage this patient? (Q856238)

A. Palliative gastrojejunostomy followed by chemotherapy

B. Radical gastrectomy

C. Whipple's procedure

D. Gastrectomy with right hepatectomy

Correct Answer: A. Palliative gastrojejunostomy followed by chemotherapy

Explanation: The most appropriate management for a patient with a mass arising from the antrum of the stomach involving the head of the pancreas and metastasis to the right lobe of the liver is Palliative gastrojejunostomy followed by chemotherapy. Treatment of Stomach Cancer Surgical Treatment: Surgical resection is the only curative treatment for gastric cancer. Neoadjuvant Chemotherapy: Most surgical candidates receive neoadjuvant chemotherapy to improve survival. The FLOT4 trial found that the FLOT (fluorouracil, leucovorin, oxaliplatin, docetaxel) regimen offers a significant survival advantage over the ECF (epirubicin, cisplatin, 5-fluorouracil) regimen (median overall survival: 50 months vs 35 months). Types of Gastric Resection Total Gastrectomy: Involves the removal of the stomach, spleen, and pancreas. Includes D2 lymphadenectomy. Preferred for resectable gastric cancer. Subtotal Gastrectomy: It may be performed if the tumour is located in the distal stomach. Involves Roux-en-Y reconstruction. Palliative Surgery: Considered for symptom alleviation in inoperable or metastatic gastric cancer. Non-Surgical Treatment Palliative Chemotherapy or Radiotherapy: Offered to patients with advanced gastric cancer. Radical gastrectomy (Option B) would be considered if there was no metastasis, but metastasis to the liver and involvement of the pancreas suggests an advanced stage, making this option less feasible. Whipple's procedure (Option C) is used for pancreatic cancer; this procedure is not appropriate here due to gastric cancer with liver metastasis. Gastrectomy with right hepatectomy (Option D) would be considered for resectable localised tumours, but with liver metastasis, it’s not an ideal option for curative intent.

References:

Bailey & Love’s Short Practice of Surgery, 28th Edition, Pg 1174, 1175, 1177

↑ *Back to this question in Part A*

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Q132: A patient presents with a hernia medial to the inferior epigastric artery. What is the most likely diagnosis and appropriate management for the same? (Q856248)

A. Direct hernia and Bassini repair

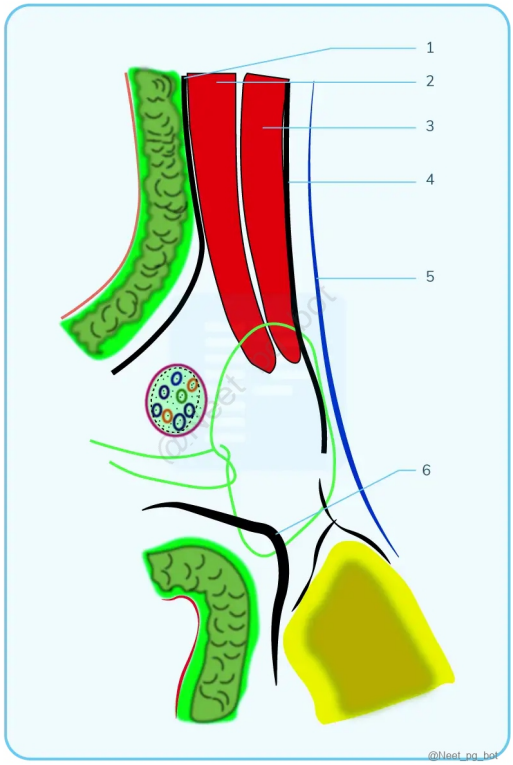
B. Direct hernia and Lichtenstein mesh repair

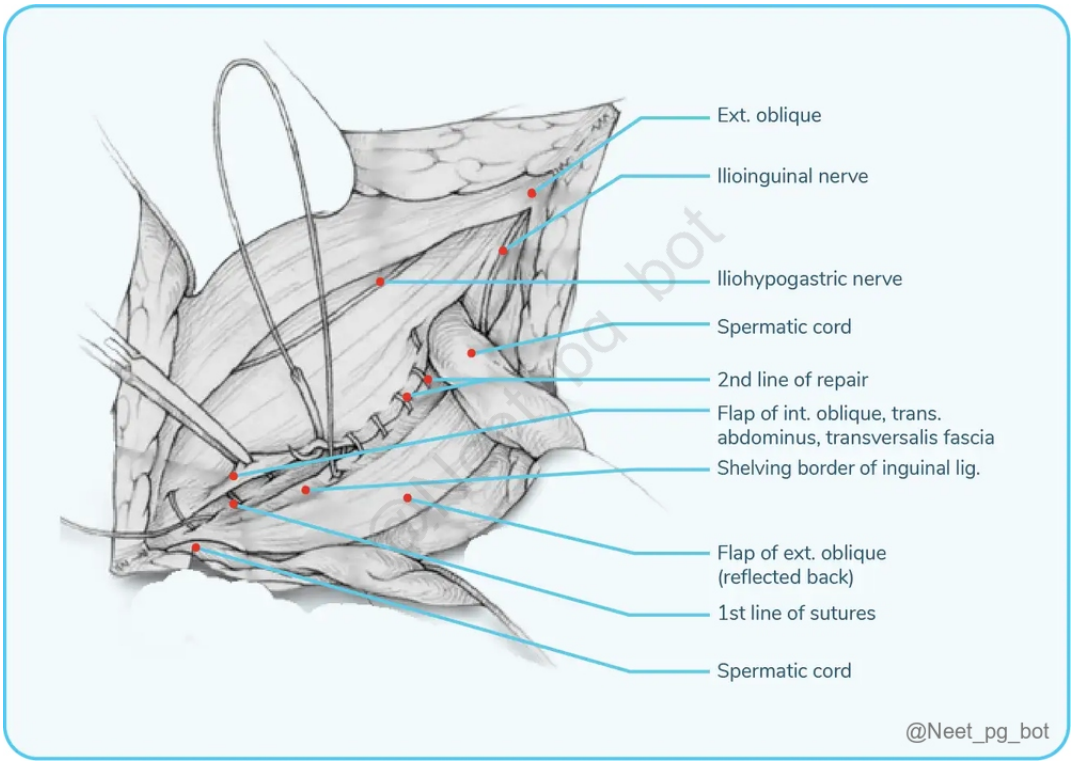
C. Indirect hernia and Bassini repair

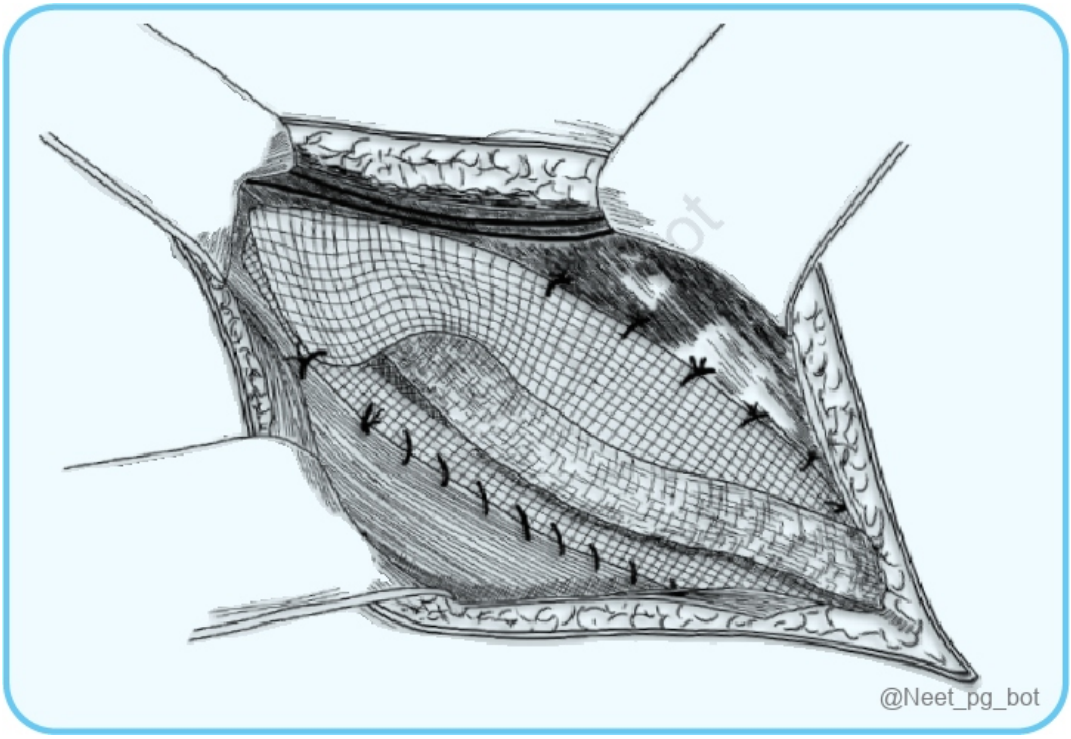
D. Indirect hernia and Lichtenstein mesh repair

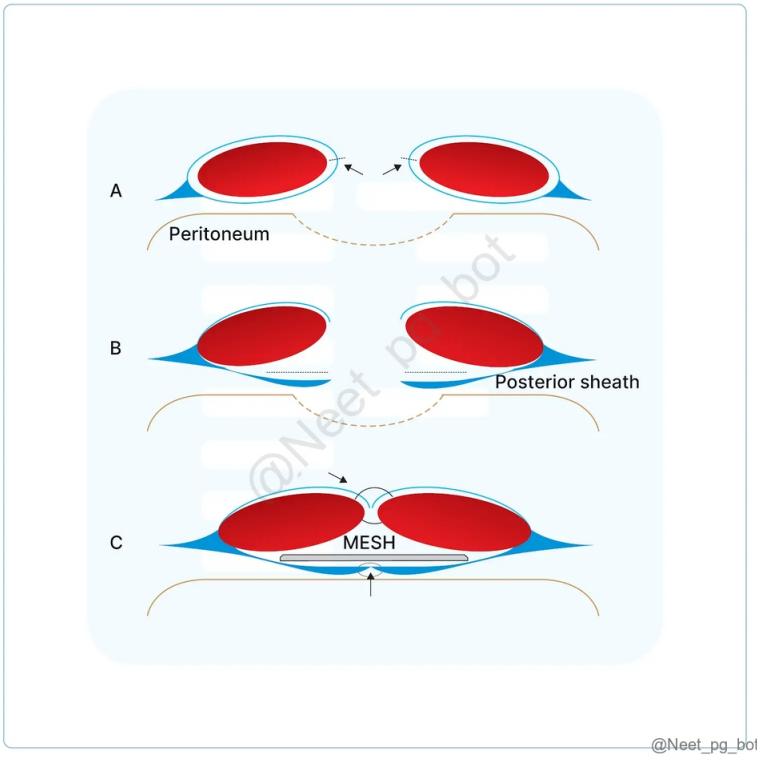
Correct Answer: B. Direct hernia and Lichtenstein mesh repair

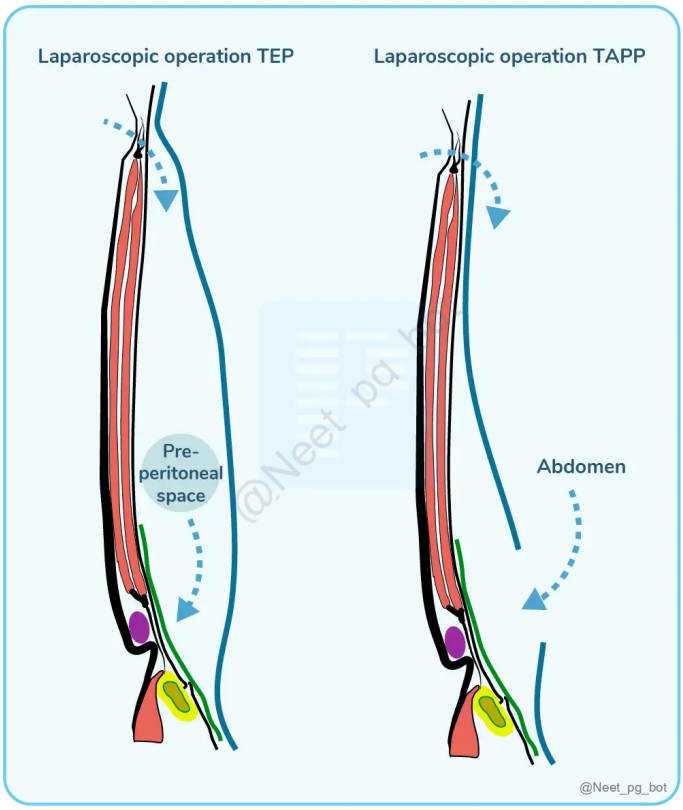
Explanation: The medial bulge near the inferior epigastric vessels suggests a direct Inguinal Hernia , which protrudes through a weakness in Hesselbach's triangle and is treated with Lichtenstein mesh repair. It is a condition where the viscus protrudes through a weak spot in the abdominal wall (Direct inguinal hernia) or inguinal canal in the groin area (Indirect inguinal hernia). (Option C, and D ruled out) Management of Inguinal Hernia: Surgical Approaches: Herniotomy : It involves excising and closing the hernia sac Primarily used in children with lateral hernias and congenital hydrocele. In adults, herniotomy alone is insufficient due to high recurrence rates. Hernioplasty : Includes herniotomy plus inguinal floor reconstruction with mesh. Herniorrhaphy : Includes herniotomy plus reconstruction of the inguinal floor with sutures Techniques: Bassini's Repair: Involves suturing the internal oblique, transversus abdominis, and fascia transversalis to the inguinal ligament. Known as a triple-layer repair. Higher recurrence rates. (Option A ruled out) {{caption_text}} Shouldice Repair: involves a four-layer repair (double breasting of fascia transversalis), resulting in lower recurrence rates compared to Bassini's. {{caption_text}} Modified Shouldice : A six-layer repair, including additional layers for reinforcement. Anterior Tension-Free Repair: Lichtenstein Repair (preferred): Utilizes a mesh to reinforce the inguinal floor, which is considered the gold standard due to lower recurrence rates and faster recovery. (Option A ruled out) {{caption_text}} Open Preperitoneal Repair: Stoppa Repair : Uses a mesh to reinforce the area behind the peritoneum Done in Recurrent inguinal hernia Laparoscopic Hernia Repair: Totally Extraperitoneal (TEP) Repair Transabdominal Preperitoneal (TAPP) Repair {{caption_text}} TEP TAPP Procedure Surgery done above the peritoneum Surgery done beneath the peritoneum Advantages Lower risk of bowel injury and peritoneal complications. Reduced risk of adhesions. Larger working space Better visualisation Disadvantages Smaller working spaces can make the procedure more technically challenging. A higher risk of bowel injury and adhesion formation due to entry into the peritoneal cavity. Potential for increased postoperative pain compared to TEP.


1
2
3
4
5
6
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Ext. oblique
Ilioinguinal nerve
Iliohypogastric nerve
Spermatic cord
2nd line of repair
Flap of int. oblique, trans. abdominus, transversalis fascia
Shelving border of inguinal lig.
Flap of ext. oblique (reflected back)
1st line of sutures
Spermatic cord
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A
Peritoneum
B
Posterior sheath
C
MESH
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References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1068.

↑ *Back to this question in Part A*

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Q133: A patient with rectal prolapse underwent surgery. The postoperative image is given below. Identify the Procedure. (Q856252)

A. Stapled hemorrhoidopexy

B. Well’s procedure

C. Thiersch wiring

D. Altemeier repair



Correct Answer: C. Thiersch wiring

Explanation: The procedure shown is Thiersch wiring , a technique for managing Rectal Prolapse by applying wires or sutures to support the rectal mucosa. It is the circumferential descent of the rectum through the anal canal Management of Rectal Prolapse: Non-Operative Management Medical Treatment: Palliates symptoms of constipation and faecal incontinence with fluid intake, fibre supplements, stool softeners, and topical treatments for mucosal oedema. Enemas and Suppositories: Assist in defecation and reduce symptoms. Operative Management Rectopexy is fixing the rectum to the sacrum by sutures or mesh after complete mobilization of the rectum. Aspect Abdominal Rectopexy Perineal Rectopexy Types Prosthetic or mesh rectopexy-anterior/ posterior-Well's, Ripstein Suture rectopexy- Lahaut Anterior Resection Resection Rectopexy Mucosal sleeve resection (Delrome's) Perineal recto sigmoidectomy (Altemeier's) Posterior fixation of the rectum of Lockhardt-Mummery Mickulicz Miles perineal transanal recto sigmoidectomy Anal encircling (Thiersch) (Option C) Advantages Fixation of the rectum provides adequate tension to prevent recurrence. Minimally invasive options (laparoscopic or robotic) offer benefits in pain control, hospital stay, and recovery time Lower operative morbidity and mortality, suitable for elderly or medically unfit patients. Disadvantages Requires extensive dissection and fixation, which may have higher morbidity (10%-33%). Risk of mesh-related complications such as erosion, infection, bowel obstruction, and migration. Higher recurrence rates compared to abdominal approaches Stapled hemorrhoidopexy (Option A) aims to remove or reduce prolapsed hemorrhoidal tissue and restore normal anatomical position. Well's procedure (Option B) is a rare procedure for rectal prolapse, but it involves resection and not the use of wires or sutures (shown above) as in Thiersch wiring. Altemeier repair (Option D) involves the removal of a segment of the sigmoid colon and rectum through an incision in the perineal area.

References:

Sabiston Textbook of Surgery, 21st Edition, Page 1392,1394.

Textbook of SRB's Surgical Operations, 6th Edition, Page 957, 961-962.

↑ *Back to this question in Part A*

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Q134: Which of the following statements regarding Peutz-Jeghers syndrome is correct? 1. Autosomal dominant disease 2. Defect in the STK11 gene 3. Melanin spots on digits and perianal skin 4. Autosomal recessive 5. Congenital hypertrophy of retinal pigment epithelium is seen (Q856731)

A. 2, 4 and 5

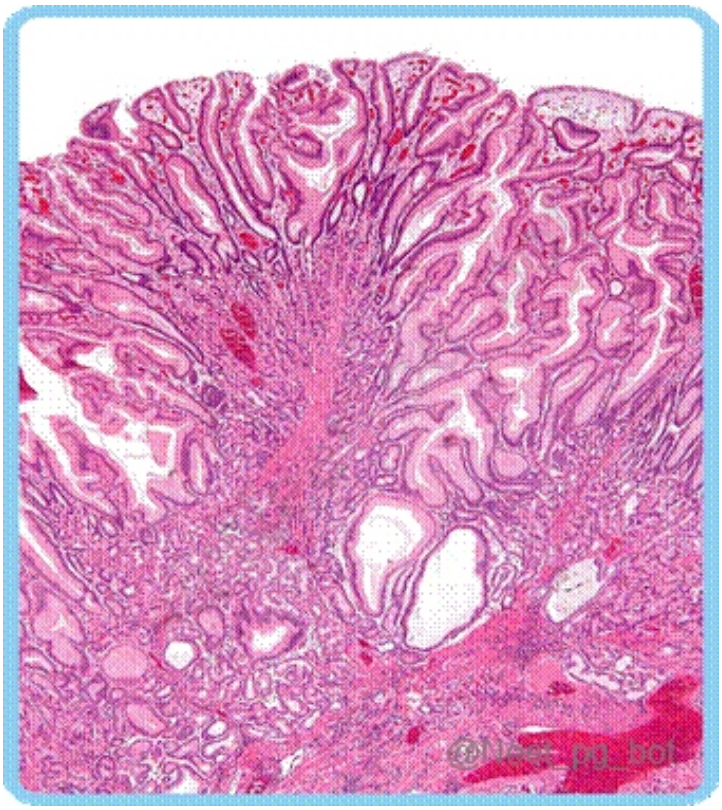
B. 1, 2 and 3

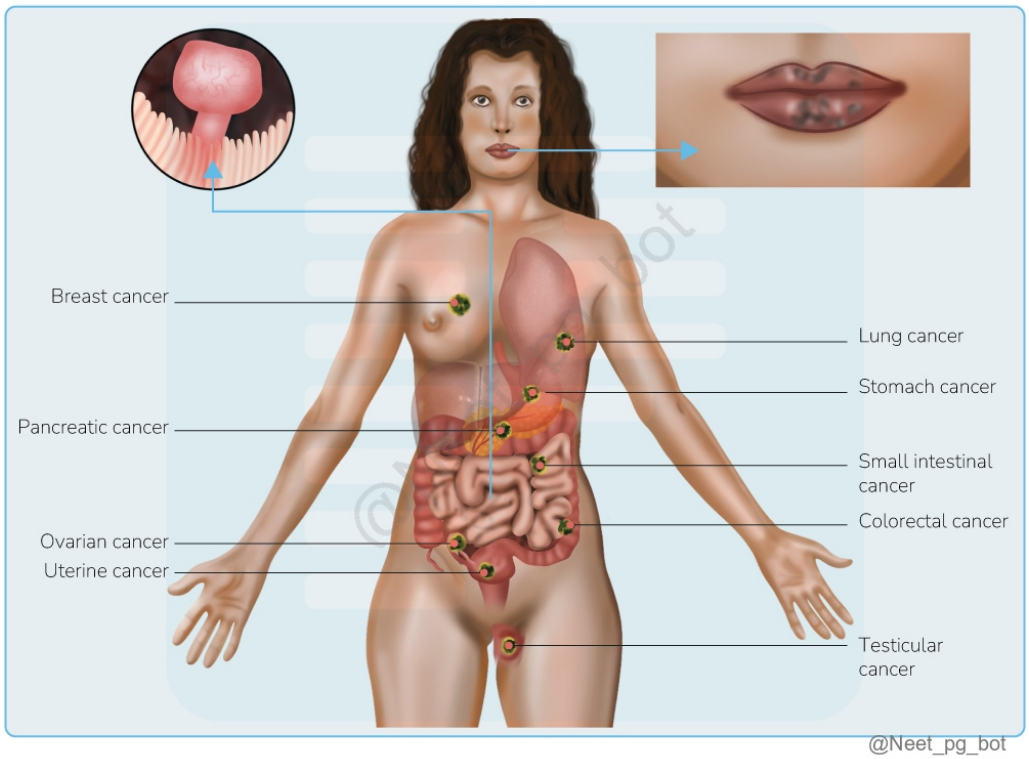
C. 1, 3 and 4

D. 2, 3 and 5

Correct Answer: B. 1, 2 and 3

Explanation: Peutz-Jeghers syndrome : It is an autosomal dominant disorder that is caused by a loss of function mutation in the STK11 gene (statements 1 & 2) (statement 4 ruled out) It presents around 11 years of age. Most cases are asymptomatic but may present with chronic bleeding, anaemia, or intussusception. Histology: An arborising pattern of smooth muscle and glands lined by normal epithelium. {{caption_text}} It is characterised by: Gastrointestinal hamartomatous polyps, especially in the small intestine Mucocutaneous hyperpigmentation (macules on lips, nostrils, buccal mucosa, perianal region and extremities) (statement 3) Polyps are large, pedunculated, and lobulated. Significant risk of cancers: Small bowel, colon, pancreas, lungs, testis, ovaries, breast, and endometrium Lifetime cancer risk is estimated at 40% {{caption_text}}





References:

Davidson’s Principles and Practice of Medicine, 24th Edition, Pages 828, 829.

↑ *Back to this question in Part A*

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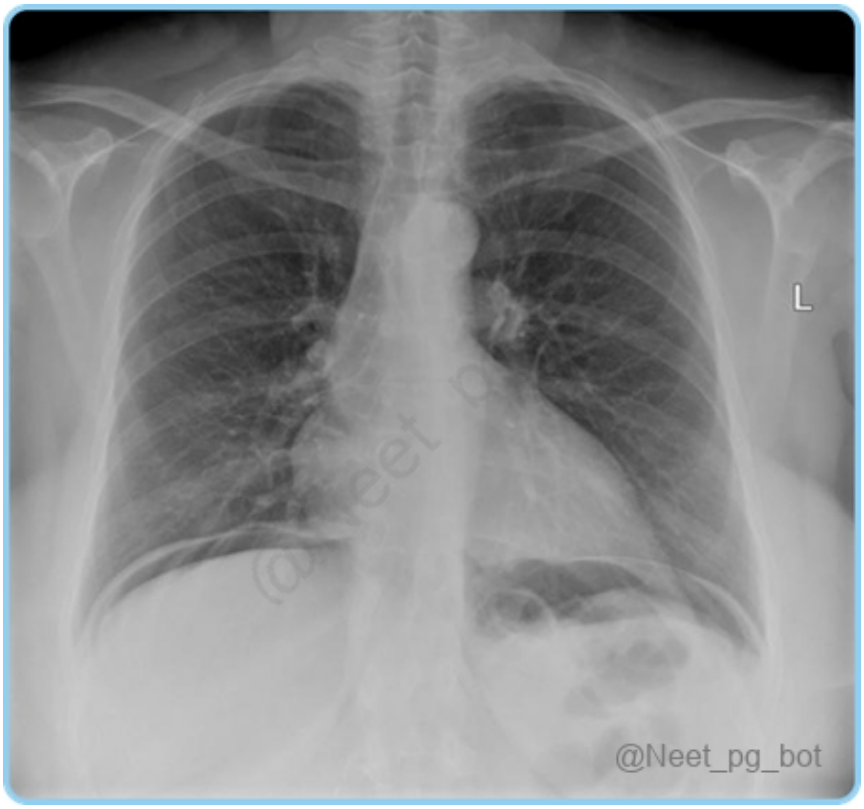
Q135: A 40-year-old man presents to the ER with severe abdominal pain. On examination, his HR is 110 bpm, BP-88/60 mmHg. Guarding is present on per abdomen examination. Erect abdominal X-ray is shown below. Which of the following would you proceed with for the management of this case? A. USG abdomen B. IV fluids C. Exploratory laparotomy D. Elective surgery E. Conservative management (Q856732)

A. B & C

B. B & D

C. A, B & C

D. A, B & E



Correct Answer: A. B & C

Explanation: The patient’s presentation, along with free air under the diaphragm (pneumoperitoneum) visible on the erect abdominal X-ray, strongly suggests the perforation of a hollow organ. The most appropriate management for this patient, who likely has a gastrointestinal perforation , is to administer IV fluids to stabilise the patient and then proceed with exploratory laparotomy for immediate surgical intervention. Elective surgery is not appropriate for a patient with an acute perforation as it is an emergency, and delaying surgery for an elective procedure would be harmful. (Statement D ruled out) Imaging is already done (X-ray showing free air), so no further imaging (like ultrasound) is required immediately, and conservative management would not be effective or appropriate in this emergency situation. (Statement A & E ruled out) Pneumoperitoneum Causes: Common: Perforated peptic ulcers, bowel obstruction, inflammatory conditions, ischemia, injury during colonoscopy. Other causes without peritonitis: Postoperative (up to 7 days), peritoneal dialysis, sealed perforation, and tracking from pneumomediastinum. Diagnosis on Imaging: Erect CXR: Free gas is seen under the right hemidiaphragm (cupola sign) , but it is difficult to differentiate on the left due to gastric or colonic gas. Supine AXR: Right upper quadrant gas in the perihepatic, subhepatic space, Morrison’s pouch, and ligament visualisation (e.g., falciform ligament). Rigler’s Sign: Visualization of both sides of the bowel wall due to surrounding gas. CT Scan: Most sensitive; small volumes of gas seen in the liver or peritoneal recesses, often using broad window settings. Management: is surgical, i.e., Exploratory laparotomy + Peritoneal lavage + Repair of perforation.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Pages 1088, 1089.

Grainger and Allison’s Textbook of Diagnostic Radiology, 7th Edition, Pages 463-465.

↑ *Back to this question in Part A*

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Q136: Identify the following correctly. (Q856734)

A. CA bladder

B. Right inguinal hernia

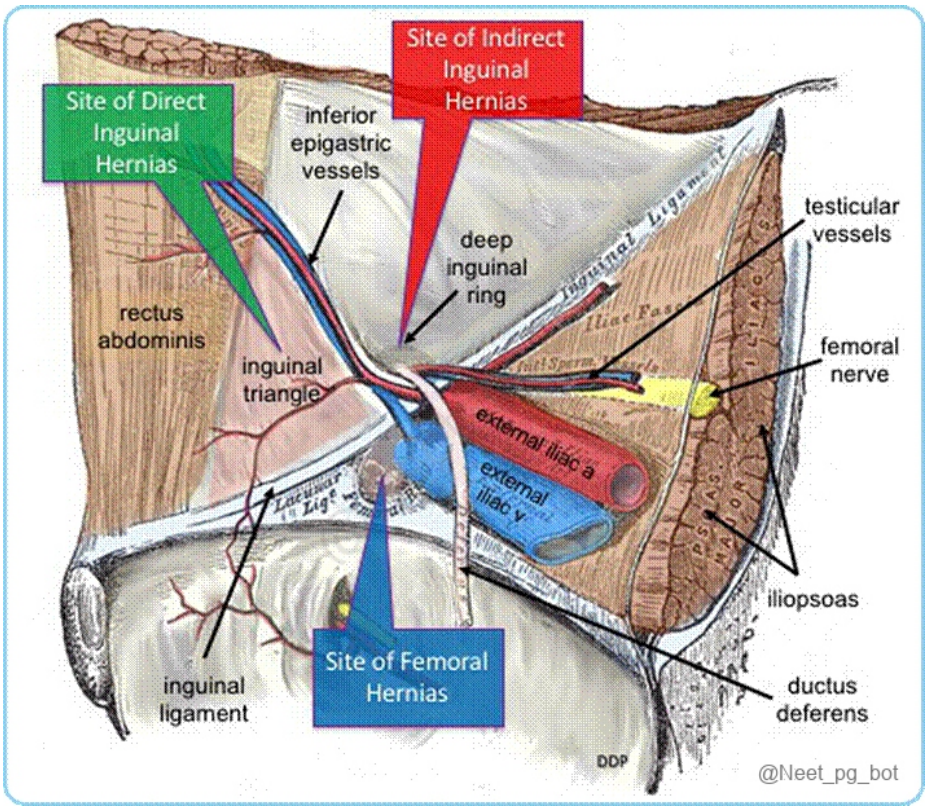
C. Left inguinal hernia

D. None of the above



Correct Answer: C. Left inguinal hernia

Explanation: An image of swelling in the left inguinal region is given, which suggests a left inguinal hernia. (Option B ruled out) Inguinal Hernia is a condition where the viscus protrudes through a weak spot in the abdominal wall (Direct inguinal hernia) or inguinal canal in the groin area (Indirect inguinal hernia). Feature Indirect Inguinal Hernia Direct Inguinal Hernia Common in Young adults Elderly Course It enters through the deep inguinal ring, traverses the inguinal canal, and exits via the superficial inguinal ring. Protrudes directly through Hesselbach's triangle Relation to Spermatic Cord Anterolateral to the spermatic cord Posterior to the spermatic cord Location of Neck of Sac Above and medial to the pubic tubercle. Lies within the Hesselbach's triangle. Relation to Inferior Epigastric vessels Lateral to the inferior epigastric vessels. Medial to the inferior epigastric vessels. Relation to Scrotum Descends into the scrotum Does not Descend Types Bubonocele: Confined to inguinal canal Funicular: Processus vaginalis closed above epididymis, hernia content distinct from testis Complete/Scrotal: Testis in the lower part of the hernia — {{caption_text}} CA bladder (Option A) generally causes symptoms like hematuria, increased frequency, or painful urination, but it would not normally present with bulging in the inguinal area.



References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Pages 1065, 1066

↑ *Back to this question in Part A*

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Q137: A man in his middle age arrives with a gradual onset of challenges while swallowing both solid and liquid substances over the course of 8 months. The results of a barium swallow test conducted are provided below. What additional examinations should be conducted for this individual? (Q856737)

A. Upper GI endoscopy & Manometry

B. Upper GI endoscopy & PET scan

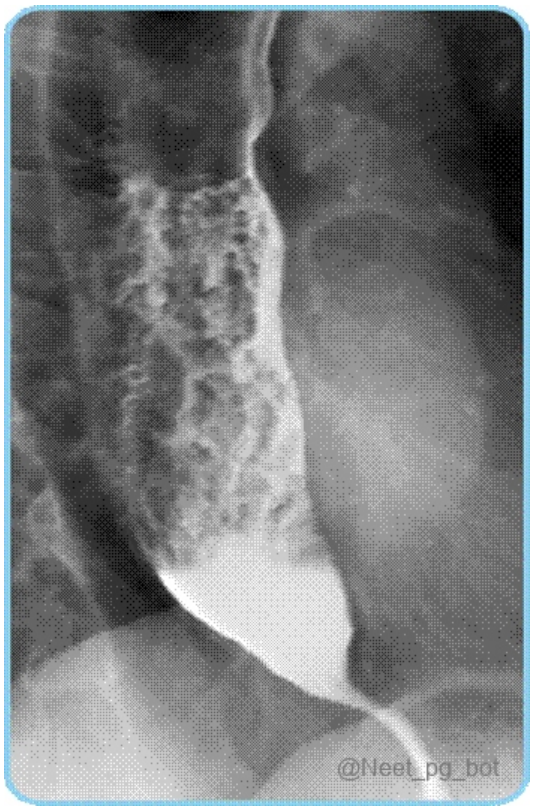
C. Upper GI endoscopy & CECT

D. Upper GI endoscopy & 24-hour pH monitoring



Correct Answer: A. Upper GI endoscopy & Manometry

Explanation: Given that the barium swallow findings are suggestive of achalasia , the appropriate next steps are to perform an upper GI endoscopy to rule out any other structural causes and oesophagal manometry to confirm the diagnosis. Achalasia cardia Definition It is characterised by the progressive degeneration of ganglion cells in the esophageal wall, which leads to a loss of peristalsis in the lower oesophagus and failure of the lower oesophagal sphincter (LES) to relax during swallowing Clinical Features Dysphagia: May initially affect liquids more than solids. Regurgitation Halitosis Chest Pain Weight Loss Investigations: Esophageal Manometry Gold Standard : This is the definitive diagnostic test for achalasia. It measures the pressure and pattern of muscle contractions in the esophagus. Elevated resting LES pressure (typically > 45 mmHg). Incomplete LES relaxation. Absence of peristalsis in the esophageal body. Periodic contractions with normal amplitude or high amplitude contractions (type I and II achalasia). Barium Swallow (Esophagram) Dilated esophagus with a narrowing at the LES (Bird beak appearance/ Pencil tip appearance/ Rat tail appearance). {{caption_text}} Endoscopy: Normal mucosa but may show dilated esophagus with possible food debris, It is important to rule out other causes of dysphagia such as tumors. Upper GI endoscopy & PET scan (Option B): PET scan is used to detect malignancy or assess metastasis . In the case of achalasia , PET scans are not indicated because this is a benign motility disorder . Upper GI endoscopy & CECT (Option C): CECT is helpful for evaluating masses , inflammation , or complications (e.g., abscess, perforation), but it would not provide any additional information on oesophagal motility, which is the primary concern in this case. Upper GI endoscopy & 24-hour pH monitoring (Option D): 24-hour pH monitoring is used primarily for diagnosing GERD , not achalasia .



References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Pages 1121, 1122

SRB's Manual of Surgery, 6th Edition, Pages 788, 789, 790

↑ *Back to this question in Part A*

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Q138: A child is diagnosed with congenital hypertrophic pyloric stenosis. Which among the following can be seen in this child? A. Bilious vomiting B. Visible peristalsis from left to right C. Hypochloremia and hypokalemia D. Metabolic alkalosis (Q856748)

A. B, C and D

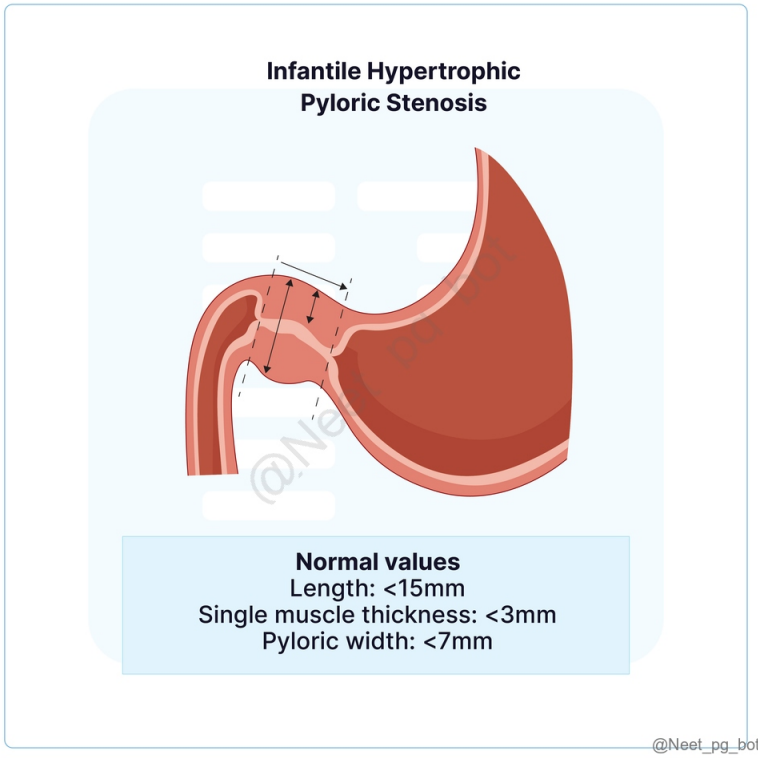
B. A and D only

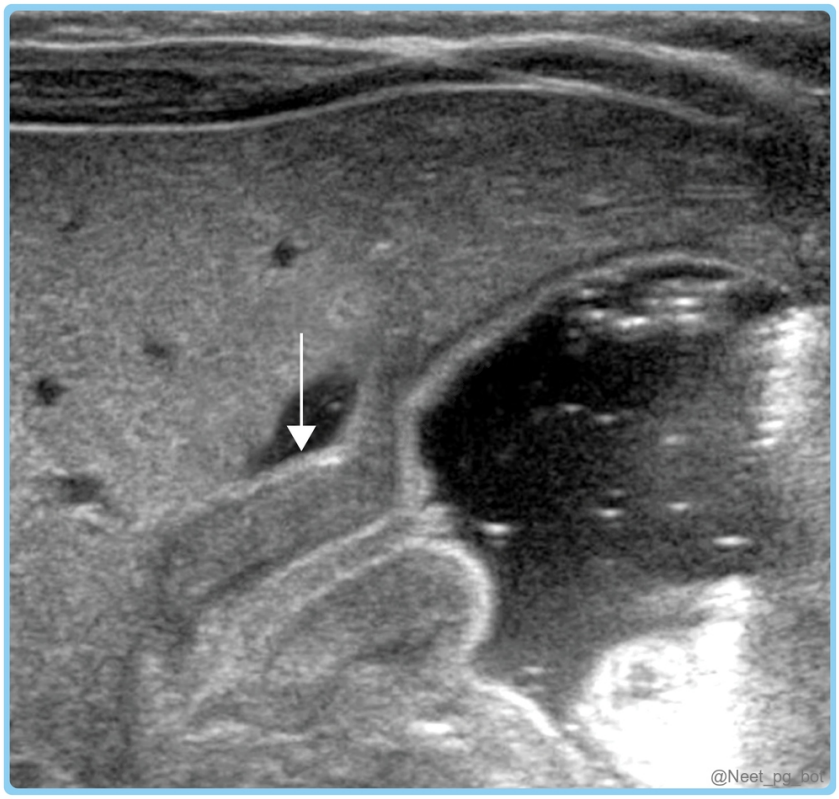
C. A, B and D

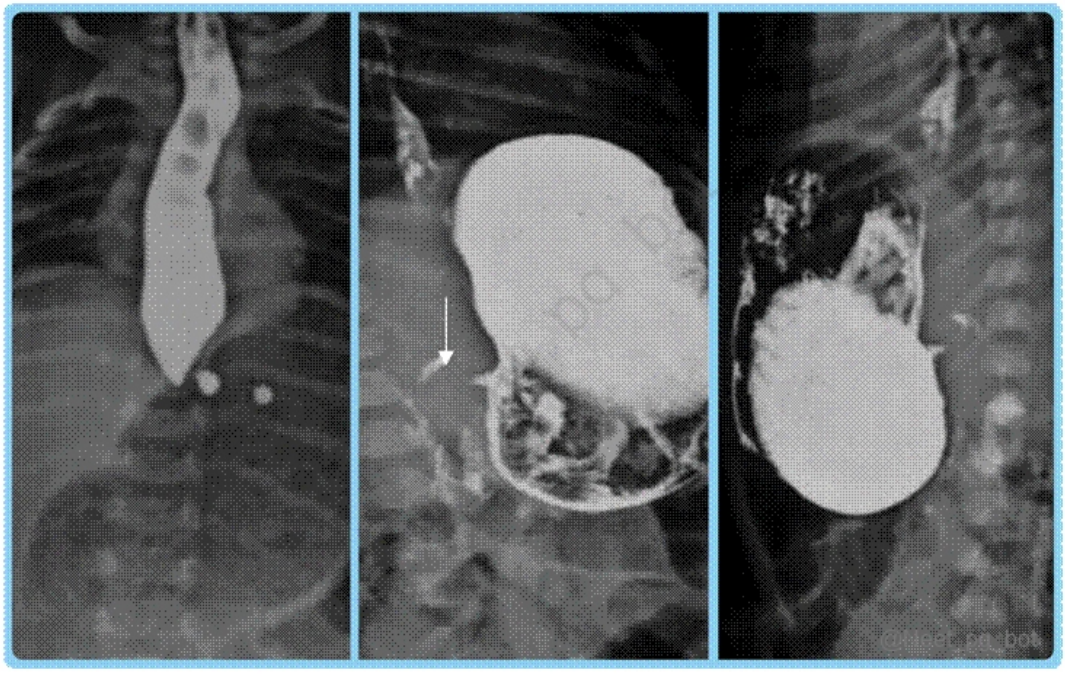
D. A, B, C and D

Correct Answer: A. B, C and D

Explanation: Visible peristalsis from left to right, hypochloremia and hypokalemia, and Metabolic alkalosis are seen in a child with congenital hypertrophic pyloric stenosis. Congenital hypertrophic pyloric stenosis (CHPS) Definition It is a condition involving hypertrophy of the pyloric muscle, leading to gastric outlet obstruction in male infants, typically between 2 - 6 weeks of age. Clinical Presentation Symptoms: Projectile, non-bilious vomiting after feeds, starting around 2 to 6 weeks of age. (Statement A ruled out) Persistent vomiting leads to dehydration, hypokalemia and hypochloremic metabolic alkalosis because the body loses hydrochloric acid (HCl) in the vomitus. Physical Examination: Visible gastric peristalsis from left to right and a palpable “olive-shaped” mass in the epigastric region. Diagnosis Ultrasound (USG) is the Investigation of choice for CHPS, characterised by Pyloric muscle thickness of > 3 mm Pyloric length > 14 mm The pyloric channel appears elongated and thickened (10-14 mm) {{caption_text}} Contrast Studies (Upper GI Series): Less frequently used, demonstrating the classic "string sign" with a thin line of contrast through the elongated and narrowed pyloric channel and delayed gastric emptying without duodenal dilation. {{caption_text}}







References:

Nelson Textbook of Pediatrics, 21st Edition, Page 1948

↑ *Back to this question in Part A*

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Q139: Which of the following statements accurately describes the Tillaux sign? (Q856752)

A. Mass is felt in the periumbilical region

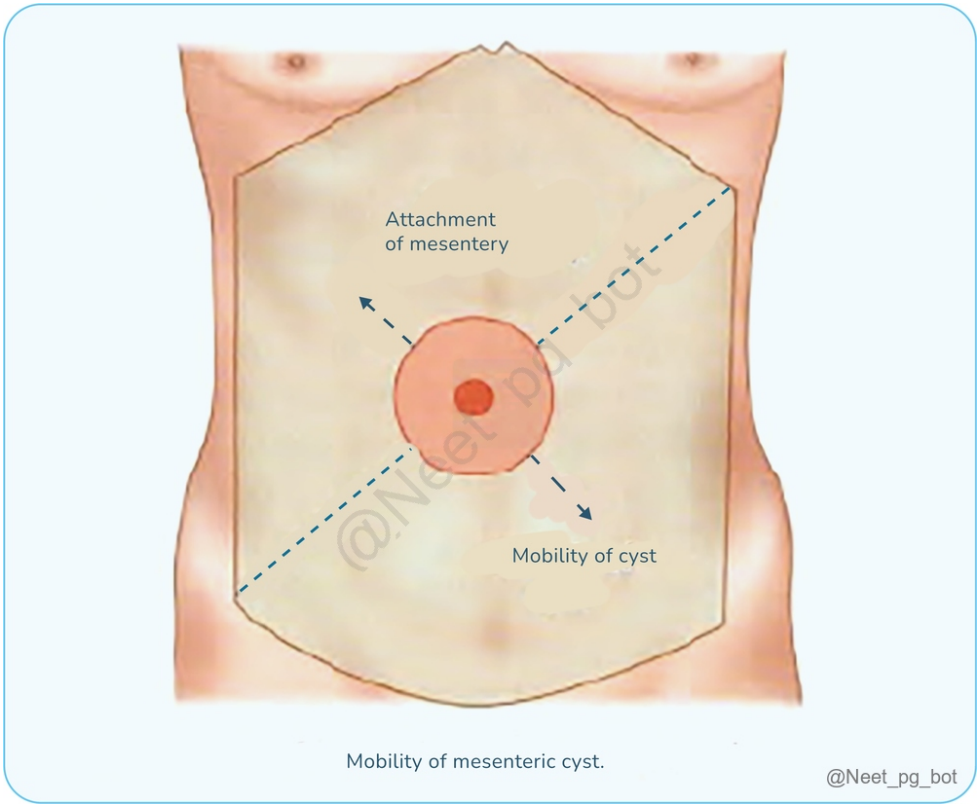
B. Mass is brilliantly transilluminate

C. Mass is mobile perpendicular to the mesentery attachment line

D. Fluctuation is positive

Correct Answer: C. Mass is mobile perpendicular to the mesentery attachment line

Explanation: Freely mobile mass in a direction perpendicular to the line of the mesentery accurately describes the Tillaux sign which is a component of Tillaux’s triad. Tillaux’s triad is associated with mesenteric cysts. Mesenteric cysts Definition It presents as a painless abdominal swelling in the umbilical region. Commonly seen in the 2nd decade of life. There is a band of resonance in front of the cyst. Tillaux's triad for mesenteric cysts A soft, smooth swelling in the umbilical region. (Option A ruled out) Freely mobile mass in a direction perpendicular to the line of the mesentery (Tillaux Sign) A zone of resonance all around. Complications Torsion of cysts can lead to volvulus of the adjacent bowel. Rupture of the cyst. Hemorrhage into the cyst. Infection Mass is brilliantly transilluminate (Option B): Transillumination refers to shining light through a cyst or mass and observing whether the light passes through, indicating it is filled with fluid or air. However, Tillaux’s sign is about the movement of the mass perpendicular to the mesentery . Fluctuation is positive (Option D): Fluctuation is a clinical sign used to detect fluid-filled masses noted in cases like hydatid cysts or cystic lesions. However, fluctuation is not specific to the Tillaux sign , which does not focus on detecting fluid content within the mass.



References:

SRB's Manual of Surgery, 6th Edition, Pages 569, 570

↑ *Back to this question in Part A*

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Q140: Which of the options accurately represents a valid statement concerning retroperitoneal trauma? (Q856775)

A. All zone 1 injury to be treated conservatively

B. Zone 3 injury, whether blunt or penetrative, should always be explored

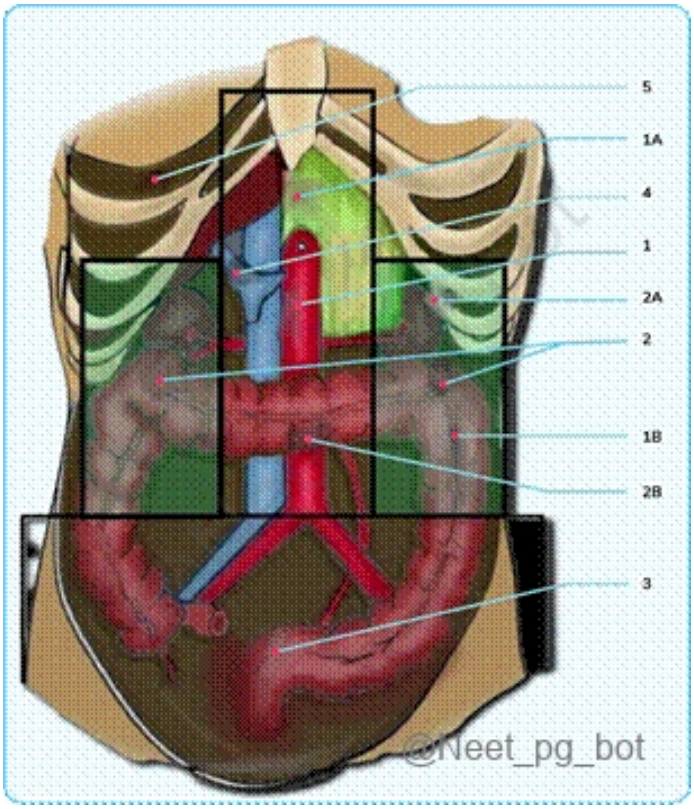
C. Zone 2 injury with expanding hematoma should be treated surgically

D. Mattox maneuver is when the ascending colon is mobilized to the right to visualise the Aorta

Correct Answer: C. Zone 2 injury with expanding hematoma should be treated surgically

Explanation: Zone 2 injury with expanding hematoma should be treated surgically, is the correct statement. In Zone 2, expanding hematoma confined to the lateral retroperitoneum without active bleeding and

hemodynamically stable patient angioembolisation is a suitable option to prevent or control bleeding while avoiding the risks associated with open surgery. Angioembolization is a minimally invasive procedure that involves the selective occlusion of bleeding vessels. The retroperitoneum is divided into three zones for intraoperative management in blunt trauma: {{caption_text}} Zone I – Central Associated with injuries of The aorta & its proximal branches Inferior vena cava & its proximal tributaries Management: Central hematoma - exploration with proximal & distal vascular control (Option A ruled out) . Zone 2 - Lateral Structures located - Distal renal vessels Management: Lateral hematoma (renal in origin) - managed nonoperatively (angioembolisation) (Option C) Pulsatile hematoma or penetrating injury present - exploration. Zone 3 - Pelvic Confined to the retroperitoneal zone of the pelvis Structures located - Iliac vessels Management: Pelvic hematoma is exceptionally difficult to control. Usually, it should not be opened. It is managed by packing/angioembolisation. Explored only if there is expanding or pulsatile, or penetrating injury present. (Option B ruled out) Mattox maneuver is when the ascending colon is mobilised to the right to visualise the Aorta (Option D). This is incorrect because the Mattox maneuver, also known as a left medial visceral rotation, is a surgical step to explore and handle Zone 1 and 2 retroperitoneal injuries, it involves mobilising the left colon (not the ascending colon) to gain better access to the aorta and other retroperitoneal structures for surgery.



References:

Sabiston, Text Book of Surgery, 21st Edition, Page 423.

Bailey and Love’s Short Practice of Surgery, 28th Edition, Pages 382, 383.

↑ *Back to this question in Part A*

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Q141: Which of the following is the most appropriate mesh for use in hernioplasty? (Q856253)

A. Heavyweight with small pores

B. Heavyweight mesh with large pores

C. Lightweight mesh with small pores

D. Lightweight mesh with large pores

Correct Answer: D. Lightweight mesh with large pores

Explanation: The mesh that is most appropriate for use during hernioplasty is Lightweight mesh with large pores. The choice of mesh is important as it affects the outcome of the procedure and the long-term success of the hernia repair. Lightweight: It provides sufficient strength and support while minimising the risk of complications like mesh-related pain and discomfort. The reduced material leads to less inflammation and tissue reaction, which improves patient comfort and recovery. (Options A & B ruled out) Large pores: Large-pore meshes allow better tissue integration, enabling the mesh to become well-incorporated into the patient's tissue. This improves healing and reduces complications like infection or seroma formation. The flexibility of large-pore meshes also helps with the natural movement of the abdominal wall, which is essential for long-term functionality. (Options A & C ruled out)

References:

NIH Link

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Q142: According to the European Hernia Society classification, M3 incisional hernia refers to: (Q856259)

A. Epigastric

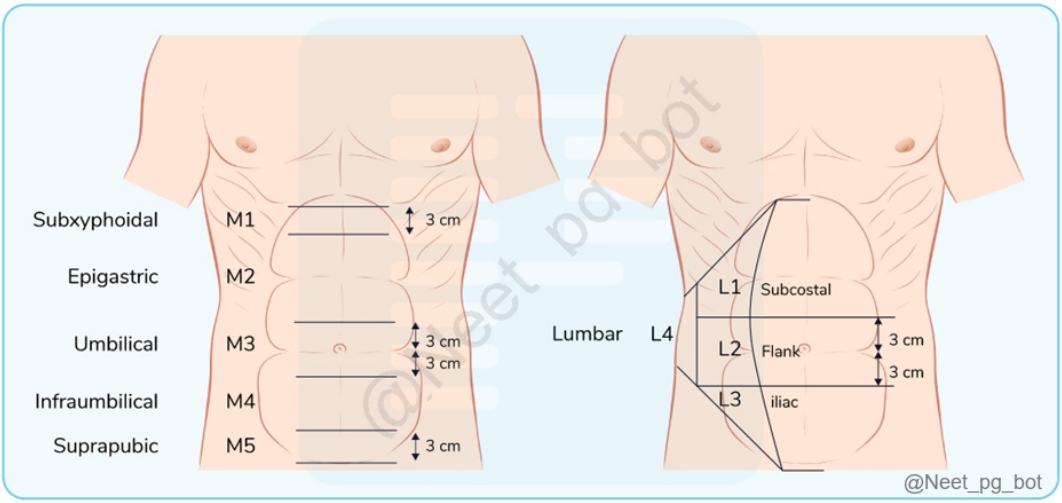
B. Infraumbilical

C. Umbilical

D. Suprapubic

Correct Answer: C. Umbilical

Explanation: According to the European Hernia Society (EHS) classification , M3 refers to an incisional hernia located in the umbilical region. The classification divides incisional hernias into two main categories: Midline & Lateral. EHS Classification of Incisional Hernia Midline Subxiphoid M1 Epigastric (Option A ruledout) M2 Umbilical M3 Infraumbilical (Option B ruledout) M4 Suprapubic (Option D ruledout) M5 Lateral Subcostal L1 Flank L2 Iliac L3 Lumbar L4



References:

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Q143: A 32-year-old male was diagnosed with achalasia cardia. High-resolution manometry revealed massive, simultaneous, high-pressure contractions of the distal oesophagus. According to the Chicago classification, which type of achalasia does the patient have? (Q855003)

A. Type II

B. Type I

C. Type IV

D. Type III

Correct Answer: D. Type III

Explanation: The given description in the question, massive, simultaneous, high-pressure contractions , corresponds to Type III achalasia and is defined by spastic contractions of the oesophagus. Chicago Classification

of Esophageal Motility (4.0) Esophageal Disorder Description Values 1. Achalasia Type I Minimal contractility (Option B ruled out) IRP ≥ 15 mmHg, 100% failed peristalsis Type II Esophageal pan-pressurization (Option A ruled out) IRP ≥ 15 mmHg, 100% failed peristalsis with ≥ 20% pan-esophageal pressurisation Type III Spastic contractions (Option D) IRP ≥ 15 mmHg, ≥ 20% spastic contractions (DCI > 8,000 mmHg·s·cm) 2. Esophagogastric Junction Outflow Obstruction (EGJOO) Elevated integrated relaxation pressure (IRP) with preserved peristalsis IRP ≥ 15 mmHg, some preserved peristalsis 3. Distal Esophageal Spasm (DES) Premature (rapid) contractions with normal IRP Normal IRP, ≥ 20% premature contractions (DL < 4.5 s) 4. Hypercontractile (Jackhammer) Esophagus Extremely strong peristaltic contractions Normal IRP, ≥ 20% hypercontractile contractions (DCI > 8,000 mmHg·s·cm) 5. Ineffective Esophageal Motility (IEM) Weak or failed peristalsis Normal IRP, > 50% ineffective swallows (DCI < 450 mmHg·s·cm for weak peristalsis) 6. Absent Contractility Complete lack of esophageal contractility Normal IRP, 100% failed peristalsis Type IV (Option C) is not part of the classification mentioned above.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1122

↑ *Back to this question in Part A*

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Q144: What is the likely diagnosis for a middle-aged man who comes to the emergency department with upper abdominal pain following a large meal? During clinical examination, there is tenderness in the upper abdomen, and a chest X-ray reveals a widening of the mediastinum and pneumomediastinum. (Q855009)

A. Spontaneous perforation of esophagus

B. Perforation of peptic ulcer

C. Foreign body in esophagus

D. Rupture of emphysematous bulla of the lung

Correct Answer: A. Spontaneous perforation of esophagus

Explanation: The given presentation, along with the findings on chest X-ray, is suggestive of esophageal perforation , particularly a spontaneous perforation (also known as Boerhaave syndrome). It is a spontaneous esophageal rupture caused by a sudden increase in intraesophageal pressure, typically from vomiting against a closed glottis resulting in a left-sided esophageal perforation . The rupture leads the gastric contents to spill into the pleural cavity, leading to a left pleural effusion and subcutaneous emphysema . Classic triad : Mackler’s triad (Vomiting, chest pain, and subcutaneous emphysema). Symptoms : May include fever, tachycardia, and tachypnea in the presence of sepsis. Physical exam : Hamman’s sign (crunching sound on auscultation due to surgical emphysema). Complications : Pneumothorax, mediastinitis, and sepsis. Perforation of peptic ulcer (Option B) can cause localised abdominal pain and even air under the diaphragm, but not pneumomediastinum . Foreign body in esophagus (Option C) presents with dysphagia, odynophagia, and discomfort . The clinical signs and

pneumomediastinum on the X-ray are more suggestive of perforation or rupture rather than foreign body ingestion. Rupture of emphysematous bulla of the lung (Option D) generally presents with respiratory symptoms like chest pain, shortness of breath, or cough , particularly in patients with COPD. The lack of these symptoms makes it less likely than oesophagal perforation.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Pages 1127, 1128 NIH Link

↑ *Back to this question in Part A*

@Neet_pg_bot

Q145: What is the most frequently encountered neuroendocrine tumour in the pancreas? (Q855011)

A. Gastrinoma

B. Somatostatinoma

C. Insulinoma

D. VIPoma

Correct Answer: C. Insulinoma

Explanation: Insulinoma Insulinoma is the most common type of neuroendocrine tumour found in the pancreas, which is usually benign and results in excessive insulin secretion , causing hypoglycemia. Insulinoma Category Details Definition A rare, typically benign tumour of the pancreatic islet cells that produce excess insulin. Clinical Features Whipple's Triad: Documented low blood glucose levels during symptomatic episodes Relief of symptoms upon administration of glucose Symptoms often occur during fasting or after exercise Symptoms of hypoglycemia (e.g., sweating, palpitations, confusion, visual disturbances, seizures) Diagnosis Gold-standard test for diagnosing insulinoma is a 72-hour fast. Combination of plasma glucose < 55 mg/dL + insulin level ≥ 3 microUnits/mL + C peptide level ≥ to 0.6 ng/mL + proinsulin ≥ 5 pmol/L, + negative sulfonylurea level indicates that the hypoglycemia induction is by hyperinsulinemia Insulin/glucose ratio > 0.4 is diagnostic Imaging: CT, MRI, EUS Management Surgical resection is the treatment of choice. Medical management with diazoxide or octreotide for non-surgical candidates or unresectable tumours. Gastrinoma (Option A) is a neuroendocrine tumour that arises from the cells producing gastrin in the pancreas. While they are commonly associated with a condition called Zollinger-Ellison syndrome, which involves excessive gastrin production and gastric acid hypersecretion, they are less common than insulinomas. Somatostatinoma (Option B) is a somatostatin- secreting tumour usually found in the pancreas or duodenum and is rarely associated with MEN1 syndrome . VIPoma (Option D) is a rare pancreatic neuroendocrine tumours that produce vasoactive intestinal peptide (VIP). They cause Verner-Morrison syndrome , characterised by watery diarrhoea , hypokalemia , and achlorhydria . VIPomas are much less common than insulinomas.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Pages 906, 907. Harrison’s Principles of Internal Medicine, 21st Edition, Page 665.

↑ *Back to this question in Part A*

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Q146: What stage of Hinchey's classification is indicated when a patient with clinical features suggestive of peritonitis presents with diverticular perforation and faecal peritonitis during surgery? (Q855025)

A. Stage 1

B. Stage 2

C. Stage 3

D. Stage 4

Correct Answer: D. Stage 4

Explanation: The presence of faecal peritonitis indicates that faecal material has spilled into the peritoneal cavity, which is a hallmark of Stage 4 in the Hinchey classification. The Hinchey classification is used to stage the severity of diverticulitis and its associated complications . Modified Hinchey Classification (Severity of acute diverticulitis) Stage 0 Mild diverticulitis Stage 1 (Option A ruled out) Ia : Pericolic inflammation Ib : Pericolic abscess Stage 2 (Option B ruled out) Pelvic or intra-abdominal abscess Stage 3 (Option C ruled out) Purulent peritonitis Stage 4 Fecal peritonitis

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Pages 1368-1370 SRB's Manual of Surgery, 6th Edition, Pages 879-882

↑ *Back to this question in Part A*

@Neet_pg_bot

Q147: In MEN 1 syndrome, where is the most frequent occurrence of gastrinoma observed? (Q855032)

A. Jejunum

B. Ileum

C. Duodenum

D. Stomach

Correct Answer: C. Duodenum

Explanation: In MEN 1 syndrome, the most frequent occurrence of gastrinomas is in the duodenum. Gastrinomas are tumours that secrete gastrin , a hormone that stimulates acid production in the stomach. This leads to conditions like Zollinger-Ellison syndrome . These tumours are mainly found in the small intestine or pancreas , with the duodenum being the most common extrapancreatic site for gastrinomas. While surgical resection is indicated in some cases, it is not curative in all. Surgical resection can be curative only if metastasis is absent. Treatment involves proton pump inhibitors (PPIs) for acid suppression, high-dose PPI therapy for acid control, and somatostatin analogues as adjunctive therapy

References:

Robbins and Cotran, Pathological Basis of Disease, 10th Edition, Page 773. Harrison’s Principle of Internal Medicine, 21st Edition, Pages 2983 - 2990.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q148: What does the given barium swallow film show? (Q858476)

A. Aortic aneurysm

B. Pharyngeal pouch

C. Carotid body tumour

D. Esophageal carcinoma



Correct Answer: B. Pharyngeal pouch

Explanation: The given barium swallow film shows a characteristic radiological finding known as a Pharyngeal pouch or Zenker's diverticulum. It is an outpouching of the pharyngeal mucosa through a weak area in the posterior pharyngeal wall (Killian's dehiscence). Zenker's diverticulum Clinical features: Dysphagia is the most prominent feature appears when the pouch gets filled with food and presses on the oesophagus. Gurgling sound is produced on swallowing. Regurgitation at night from undigested food causes cough and aspiration pneumonia. Halitosis(Chronic bad breathe) Malnourished due to dysphagia. Associated hiatus hernia Diagnosis: Barium swallow provides information regarding the size, location, and character of the mucosal lining. Endoscopy reveals fibrosis and pooling of food in the diverticulum. Treatment: Excision of the pouch and cricopharyngeal myotomy was done through a cervical approach. Dohlman’s procedure: Partition wall between the oesophagus and the pouch is exposed and divided by diathermy through a weerda scope. Endoscopic laser treatment: Partition wall between the oesophagus and the pouch is exposed and divided by CO2 laser using an endoscope. This procedure is known to have fewer recurrences and faster improvement in symptoms. Aortic aneurysm (Option A) is a dilatation or bulge in the aorta , which is the main artery that carries blood from the heart. It is visualised via CT scan or angiography but not barium swallow . Carotid body tumour (Option C) is a rare, slow-growing tumour that arises from the carotid body, which is located near the carotid bifurcation. They are better diagnosed using CT or MRI but not by using a barium swallow . Esophageal carcinoma (Option D) presents with narrowing or strictures in the oesophagus due to tumour growth. Whereas a pharyngeal pouch (Zenker's diverticulum) is a protrusion from the pharynx





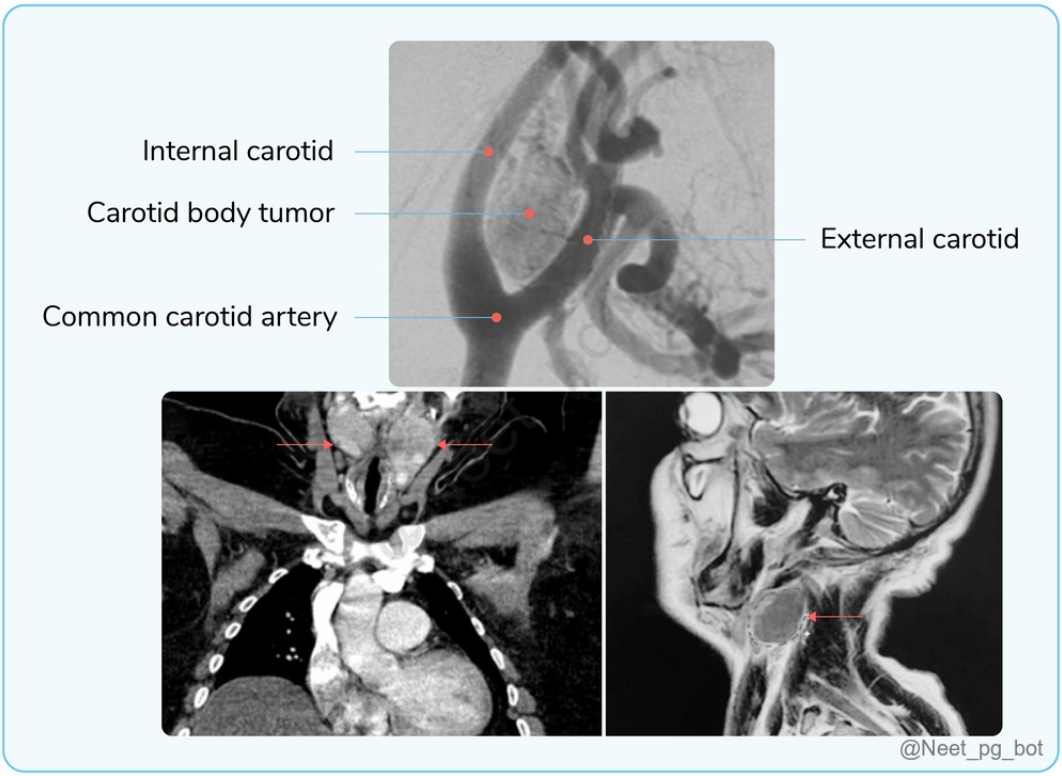
Draped aorta sign

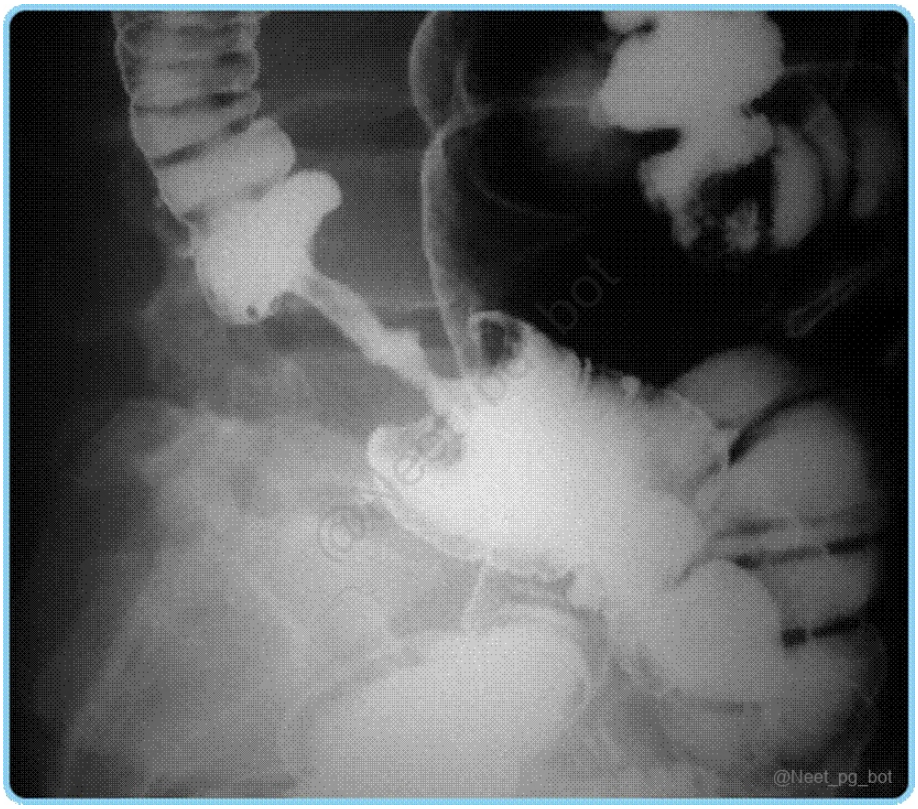
A. Illustration depicts loss of normal aneurysm wall convexity. The posterior wall of the aorta moulds to the anterior surface of the vertebral body.



B. Axial enhanced CT of an 85-year-old man with abdominal pain. The posterior aortic wall follows the contour of the anterior portion of the vertebra, with loss of fat planes between the aneurysm and vertebra (white arrowheads). Discrete thrombus fissuration (white arrow) is also seen. These are both signs of impending AAA rupture.

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References:

PL Dhingra, Shruti Dhingra, Diseases of Ear, Nose and Throat and Head and Neck Surgery, 8th Edition, Pages 323, 324

↑ *Back to this question in Part A*

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Q149: A middle-aged man presents with a gradual onset of swallowing difficulties for both solid and liquid foods, persisting for 8 months. The barium swallow test results are presented below. The patient undergoes upper gastrointestinal endoscopy and manometry. Which of the following statements is not true regarding this condition? (Q859597)

A. Loss of lower esophageal sphincter pressure causing reflux

B. <75% relaxation of the lower esophageal sphincter

C. It is a primary motility disorder

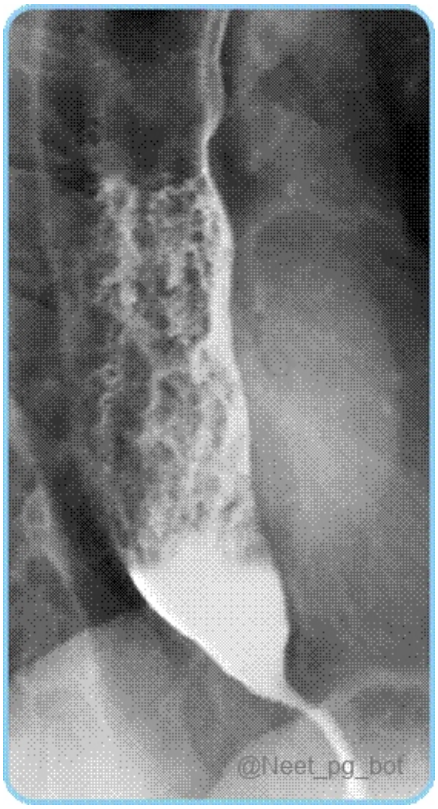
D. Esophageal peristalsis is absent



Correct Answer: A. Loss of lower esophageal sphincter pressure causing reflux

Explanation: The given condition, along with the barium swallow finding, is suggestive of Achalasia cardia, which is characterised by the failure of the lower esophageal sphincter (LES) to relax. Achalasia is associated with

increased pressure rather than a loss of pressure of the LES. Achalasia cardia Definition It is a primary motility disorder (Option B ruled out) characterised by the progressive degeneration of ganglion cells in the esophageal wall, which leads to a loss of peristalsis in the lower oesophagus and failure of the lower esophageal sphincter (LES) to relax during swallowing (Option A & D ruled out) Clinical Features Dysphagia: May initially affect liquids more than solids. Regurgitation Halitosis Chest Pain Weight Loss Investigations: Esophageal Manometry Gold Standard : This is the definitive diagnostic test for achalasia. It measures the pressure and pattern of muscle contractions in the esophagus. Elevated resting LES pressure (typically > 45 mmHg). Incomplete LES relaxation. Absence of peristalsis in the esophageal body. Periodic contractions with normal amplitude or high amplitude contractions (type I and II achalasia). Barium Swallow (Esophagram) Dilated esophagus with a narrowing at the LES (Bird beak appearance/ Pencil tip appearance/ Rat tail appearance). {{caption_text}} Endoscopy: Normal mucosa but may show dilated esophagus with possible food debris. It is important to rule out other causes of dysphagia, such as tumours.



References:

Bailey & Love’s Short Practice of Surgery, 28th Edition, Pages 1121, 1122

SRB’s Manual of Surgery, 6th Edition, Pages 788, 789, 790

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Q150: What would be the subsequent course of action for managing a 35-year-old woman who has been experiencing swelling in her right groin for the past six months, as determined during her arrival at the emergency department? Upon examination, a reducible hernia is observed in the right groin without any signs of strangulation. (Q859599)

A. Exploratory laparotomy

B. Reduce the swelling and later observe

C. Reduce the swelling and do elective surgery

D. Do a CT abdomen

Correct Answer: C. Reduce the swelling and do elective surgery

Explanation: For a reducible hernia with no signs of strangulation , the correct course of action is to reduce the swelling and proceed with elective surgery . A groin hernia occurs when abdominal contents, typically a portion of the intestine or fatty tissue, protrude through the femoral canal in the lower abdominal wall. They are at a higher risk of incarceration and strangulation compared to inguinal hernias. Hence, elective surgery is advised to repair the hernia and prevent complications. Exploratory laparotomy (Option A) is an invasive procedure that is usually performed when there is concern about internal injury, peritonitis, or significant abdominal pathology. In this case, since the hernia is reducible and there are no signs of strangulation, a laparotomy is not needed. Reduce the swelling and later observe (Option B) is not ideal as a surgical intervention should still be planned in the near future to prevent any complications like recurrent or incarcerated hernias. A CT abdomen (Option D) is not necessary here because the diagnosis of a reducible hernia is already done, and there are no signs of strangulation. It may be required if there is uncertainty about the diagnosis or if other abdominal pathologies are suspected.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Pages 1062, 1063

↑ *Back to this question in Part A*

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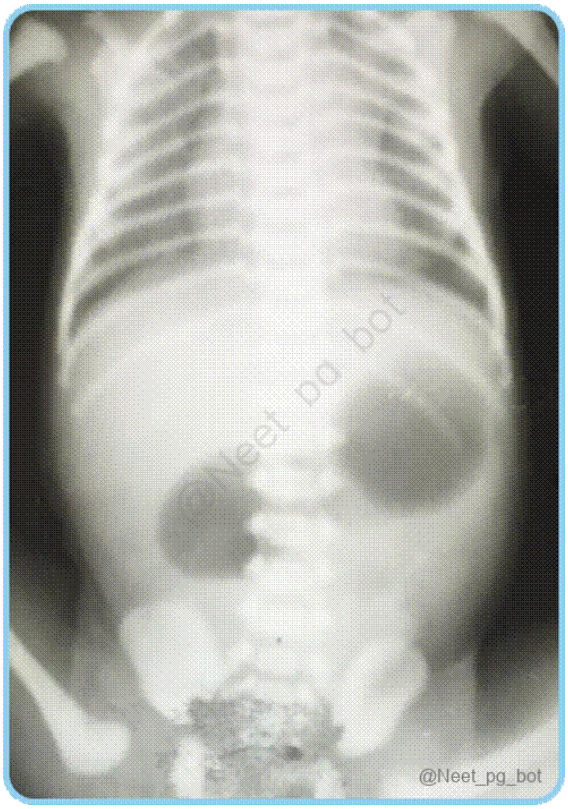
Q151: The likely diagnosis for a newborn infant presenting with signs of intestinal obstruction, as indicated by the x-ray image and CT abdomen showing an annular pancreas, is: (Q859607)

A. Jejunoileal atresia

B. Esophageal atresia

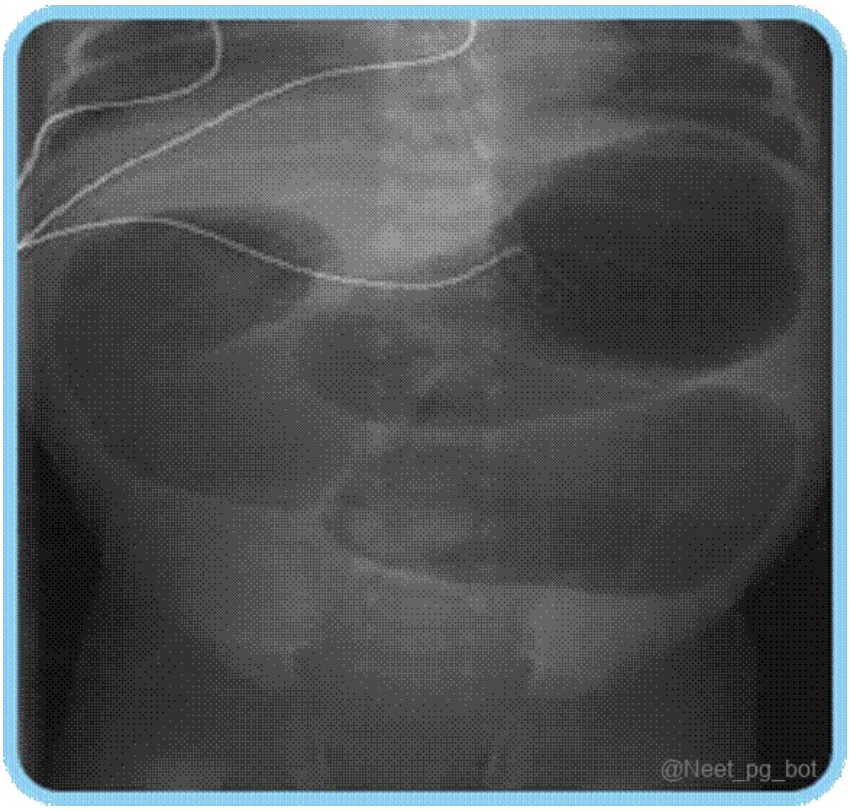
C. Duodenal atresia

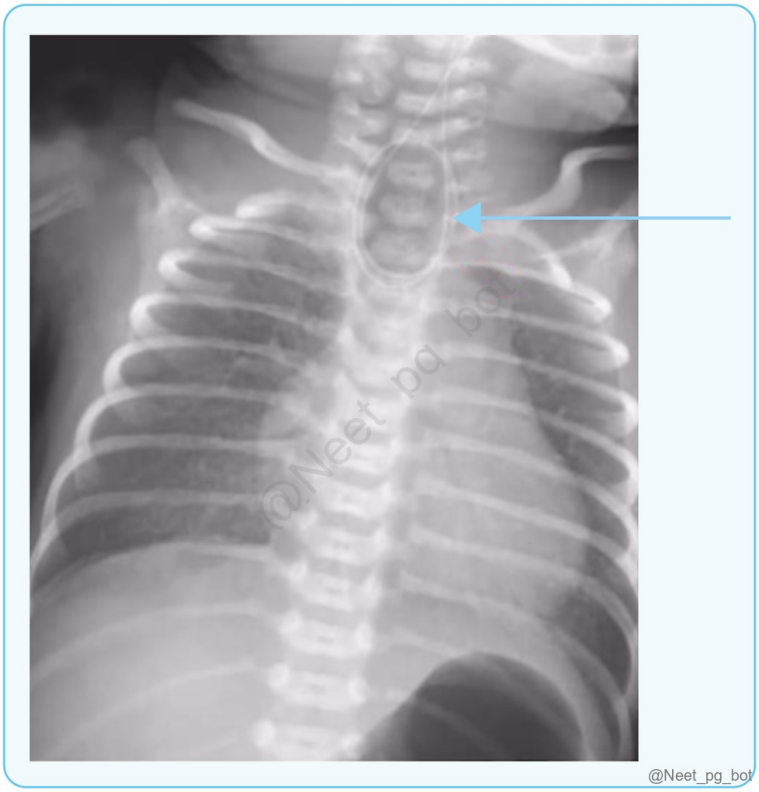
D. Colonic atresia



Correct Answer: C. Duodenal atresia

Explanation: The given x-ray shows a classic finding of Duodenal atresia, which is the "double bubble" sign , where there are two air-filled spaces visible: one in the stomach and one in the duodenum, indicating obstruction at the level of the duodenum . Duodenal Atresia Pathophysiology Failed recanalisation of intestinal lumen during gestation Associated Conditions Prematurity (50%) Congenital anomalies (heart disease, malrotation, annular pancreas, etc.) Chromosomal abnormalities (e.g., trisomy 21) Clinical Presentation Bilious vomiting without abdominal distention. Symptoms typically present within the first few days of life. Diagnosis Confirmed by the double bubble sign on the abdominal X-ray and prenatal ultrasonography. Treatment Initial: Nasogastric decompression and IV fluids Definitive: Surgical repair (Duodenoduodenostomy) Postoperative care: Gastrostomy tube, nutritional support Jejunoileal atresia (Option A) is characterised by multiple dilated loops of the small bowel and a "triple bubble sign" on X-ray, not the double bubble sign. It can cause bilious vomiting, and polyhydramnios association is less common compared to duodenal atresia. {{caption_text}} Esophageal atresia (Option B) involves a discontinuity or abnormality of the esophagus , often presenting with excessive drooling , coughing , difficulty feeding , and respiratory distress . Imaging shows a gas-filled or gasless abdomen and a coiled tube in the upper oesophagus. {{caption_text}} Colonic atresia (Option D) refers to a blockage or absence of a portion of the colon , which is less common than other forms of atresia. It would not present with the classic "double bubble" sign in duodenal atresia or annular pancreas.





References:

Nelson’s Textbook of Pediatrics, 21st Edition, Pages 1950 - 1953

↑ *Back to this question in Part A*

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Q152: A patient who underwent Nissen's fundoplication was seen in the ward during evening rounds. He is asymptomatic at present and has stable vitals. What is the next line of management for this patient? (Q859609)

A. Nasogastric tube to prevent gas bloat syndrome

B. Insert chest tube to prevent pneumothorax

C. Monitor vitals

D. Imaging to rule out perforation

Correct Answer: C. Monitor vitals

Explanation: Given that the patient is asymptomatic and has stable vitals , the primary management at this stage is to continue monitoring their vitals closely. Nissen fundoplication is a surgical procedure used to treat gastroesophageal reflux disease (GERD); it involves wrapping the upper part of the stomach around the lower oesophagus to increase the pressure at the lower oesophagal sphincter (LES), reducing reflux. Management of GERD Lifestyle Changes Elevate the head of the bed Avoid lying down after meals Quit smoking Medical management Antacids: Neutralize stomach acid H2-receptor antagonists: Ranitidine, Famotidine Proton pump inhibitors (PPIs): Omeprazole, Esomeprazole Surgical management Antireflux operation: 3 components Restoration of the intra-abdominal segment of the esophagus Crural repair Reinforcement of the LES by the upper stomach or prosthesis. Fundoplication: A surgical procedure to wrap the top of the stomach around the lower oesophagus to strengthen the sphincter. Complete fundoplication (Nissen) Partial fundoplication: Posteriorly (Toupet) or Anteriorly(Dor, Watson) has few short-term side effects but has a higher long-term failure rate. Transoral Incisionless Fundoplication (TIF): An endoscopic procedure performed through the mouth but may be less effective for severe GERD and not suitable for all patients. Magnetic Sphincter Augmentation (LINX Device): Involves implanting a ring of magnetic beads around the lower oesophagal sphincter to enhance its function and prevent reflux. Nasogastric tube to prevent gas bloat syndrome (Option A): While gas bloat syndrome can be a complication post-surgery, it would not necessitate routine nasogastric tube insertion unless symptoms of bloating or distension arise. Insert chest tube to prevent pneumothorax (Option B): There is no indication of a pneumothorax, and the patient is asymptomatic with stable vitals, making a chest tube unnecessary. Imaging to rule out perforation (Option D) is not recommended as the patient is asymptomatic and stable, without signs of perforation.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Pages 1115, 1116, 1117

↑ *Back to this question in Part A*

@Neet_pg_bot

Q153: Which of the following do not require instruments to examine? (Q859610)

A. Acute anal fissure

B. Carcinoma rectum

C. Hemorrhoids

D. Rectal polyp

Correct Answer: A. Acute anal fissure

Explanation: An acute anal fissure is a fresh, superficial tear in the anal canal lining typically caused by trauma, such as passing a large stool. It can be diagnosed through a visual inspection and digital rectal examination without the need for any specialised instruments like anoscopes or proctoscopes. Carcinoma rectum (Option B) requires a sigmoidoscopy or colonoscopy to visualise and assess the tumour's extent. Imaging studies are also needed to evaluate staging. Haemorrhoids (Option C): While external haemorrhoids can be diagnosed through visual inspection , internal haemorrhoids typically require the use of an anoscope or proctoscope for proper assessment. Rectal polyps (Option D) are usually diagnosed and removed using colonoscopy or flexible sigmoidoscopy , making instruments necessary for both diagnosis and treatment.

References:

Bailey & Love’s Short Practice of Surgery, 28th edition, page 1395

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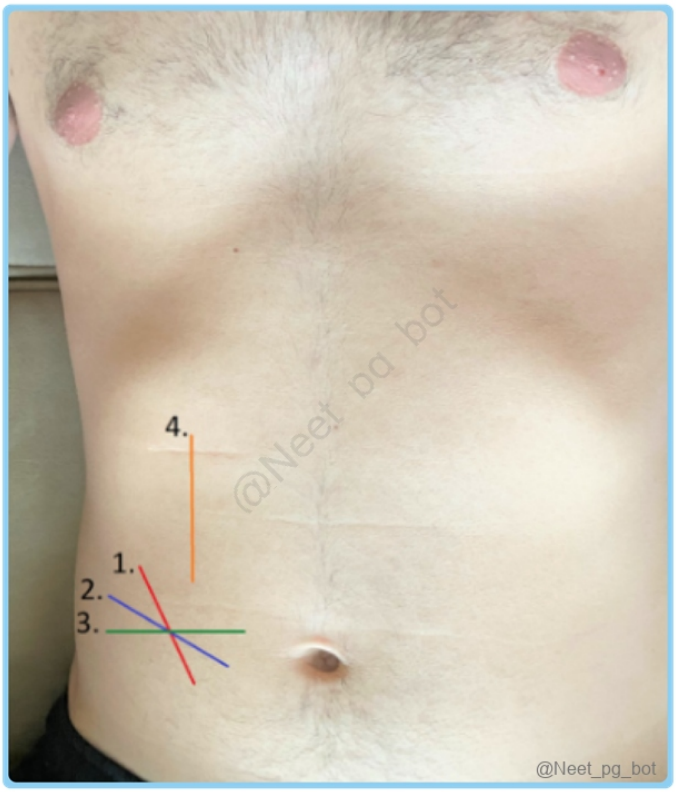
Q154: Identify the incision marked as 4. (Q859611)

A. Gridiron incision

B. Lanz incision

C. Rutherford - Morison incision

D. Paramedian incision



Correct Answer: D. Paramedian incision

Explanation: McBurney's incision, also known as gridiron incision Lanz incision Rutherford Morison incision Paramedian incision Incision Key Features Location & Orientation Primary Use McBurney's (Gridiron) Incision (Incision 1) Oblique splitting of muscle fibers. Right Lower Quadrant (RLQ), centered on McBurney's point. Oblique (diagonal) orientation. Uncomplicated Open Appendectomy. Lanz Incision (Incision 2) Excellent cosmetic outcome. RLQ, transverse (horizontal) orientation, usually following skin crease lines. Uncomplicated Open Appendectomy (when cosmesis is prioritized). Rutherford Morison Incision (Incision 3) Provides wide access to the RLQ and lateral gutter. RLQ, a longer, curvilinear oblique incision, more lateral than McBurney. Complicated Appendectomy (perforated appendix, large abscesses, or difficult exposure). Paramedian Incision (Incision 4) Vertical incision, parallel to midline. Runs vertically, 2-4 cm lateral to the midline (often in the upper abdomen). Access to organs lateral to the midline (e.g., kidney, colon), or other abdominal exploration.

References:

SRB’s Manual of Surgery, 6th Edition, Pages 934, 1156

↑ *Back to this question in Part A*

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Q155: Which of the following statements about carcinoid tumours in the appendix is false? (Q859612)

A. Size appears to be the best predictor of malignant behaviour and metastatic potential

B. Arise from Kulchitsky cells of the crypts of Leiberkuhn

C. Most common location is the base of the appendix

D. Most common tumor of the appendix

Correct Answer: C. Most common location is the base of the appendix

Explanation: The most common location of carcinoid tumours in the appendix is actually the tip of the appendix, not the base. Carcinoid tumor of the appendix (aka Argentaffinoma) Definition (Options A & D ruled out) They are neuroendocrine tumours that originate from the enterochromaffin cells (also known as Kulchitsky cells) of the crypts of Lieberkuhn . They are considered the most common tumours of the appendix. MC Location Tip of the appendix Clinical Presentation Mostly discovered incidentally during surgery Larger tumours may cause abdominal pain, flushing, and diarrhoea due to hormone secretion Hormone Secretion Secretes serotonin and other vasoactive substances. Risk of Metastasis (Option A ruled out) Low for tumours <2 cm Higher for tumours>2 cm Diagnosis Confirmed by histopathological examination Treatment <2 cm : Appendectomy >2 cm : Right hemicolectomy

References:

SRB’s Manual of Surgery, 6th Edition, Page 869

↑ *Back to this question in Part A*

@Neet_pg_bot

Q156: The most common type of gastric sarcoma: (Q859623)

A. GIST

B. Liposarcoma

C. Leiomyosarcoma

D. Epithelioid sarcoma

Correct Answer: A. GIST

Explanation: GISTs are the most common type of gastric sarcoma and arise from the interstitial cells of Cajal, which are involved in the regulation of gastric motility. These tumours are often located in the stomach and can be malignant. Gastrointestinal stromal tumour (GIST) Mutations Most common- c-KIT/CD117 Others: PDGFR- beta S uccinate dehydrogenase (SDH)- S mall baby(Pediatric GIST) Mechanism KIT (c-kit) is a proto-oncogene encoding a receptor tyrosine kinase. Mutations result in constant activation of KIT signalling, driving tumour growth and survival. Common Locations Stomach: 60-70% of cases. Small Intestine: 20-30%. Other Areas: Colon, rectum, and oesophagus (less common). Treatment Tyrosine Kinase inhibitors - Imatinib Surgical

management Liposarcoma (Option B) is a type of soft tissue sarcoma that originates from adipose (fat) tissue. While liposarcomas can occur in the stomach, they are less common compared to GIST. Leiomyosarcoma (Option C) is a malignant smooth muscle tumour. Although they can occur in the gastrointestinal tract, they are less common than GISTs in the stomach. Epithelioid sarcoma (Option D) is a rare and aggressive sarcoma that affects the soft tissues (primarily arise in the deep tissues) of the limbs or other peripheral areas; they can also happen anywhere in the body.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1174-1177,

Robbins and Cotran's Pathologic Basis of Disease, 10th Edition, Page 778.

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Q157: What structures are contained within the anterior pararenal space? Head, neck, and body of the pancreas Adrenal gland, kidney, ureters Aorta, inferior vena cava Ascending and descending colon (Q859825)

A. 1,4

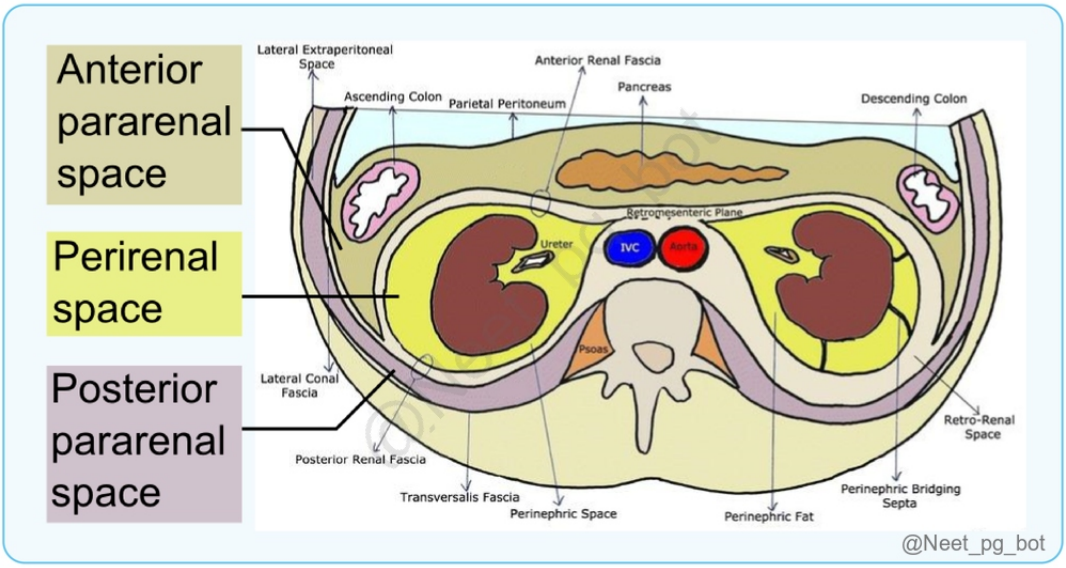
B. 3,4

C. 2,3

D. 1,2

Correct Answer: A. 1,4

Explanation: Anterior pararenal space lies between the posterior parietal peritoneum & the perirenal fat, and it contains the head, neck, and body of the pancreas (the tail of the pancreas is within the splenorenal ligament), ascending and descending colon, and the duodenum (except for the proximal first segment). The retroperitoneum divides into three main anatomical spaces: Retroperitoneal spaces Anterior pararenal space It contains the head, neck, and body of the pancreas (the tail of the pancreas is within the splenorenal ligament), the ascending and descending colon, and the duodenum (except for the proximal first segment). Perirenal space This includes the adrenal gland, kidney, ureters, and renal vessels. (Statement 2 ruled out) Posterior pararenal space It is surrounded by the posterior leaf of the renal fascia and muscles of the posterior abdominal wall , contains no major organs and is composed primarily of fat, blood vessels, and lymphatics. There is also a fourth, less well-defined space known as the great vessel space . It lies anterior to the vertebral bodies and psoas muscles and contains the aorta, inferior vena cava, and surrounding fat. (Statement 3 ruled out) {{caption_text}}



References:

Gray's Anatomy, The Anatomical Basis of Clinical Practice, 42nd Edition, Page 1119

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Q158: What electrolyte imbalance is commonly observed in patients with this postoperative condition, as depicted in the provided x-ray? (Q859829)

A. Hypocalcemia

B. Hypokalemia

C. Hyperkalemia

D. Hypercalcemia



Correct Answer: B. Hypokalemia

Explanation: The X-ray shows a typical appearance of a paralytic ileus. It is a common postoperative condition where the normal peristalsis of the intestines is temporarily reduced or absent, leading to a buildup of gas and fluid in the intestines, often seen on X-ray, which is frequently associated with hypokalemia . Paralytic ileus Etiology Abdominal surgery. Uremia. Mesenteric ischemia. Retroperitoneal hematoma. Intra-abdominal sepsis. Dyselectrolytemia (e.g. hypokalemia) (Option B) Drugs affecting intestinal motility: Opiates. Antipsychotics. Clinical Features Abdominal distension. Abdominal discomfort. Non-colicky pain. Vomiting. Non-passage of feces and flatus. Absence of bowel sounds. Investigations IOC: Abdominal X-ray. Findings: Dilated bowel loops. Gas in the colon and rectum. Multiple air-fluid levels. Management Decompression: Nasogastric aspiration. Diet: Restrict oral intake until bowel sounds return or the patient starts passing faeces and flatus. Treatment of Underlying Cause: Correct dyselectrolytemia (e.g., hypokalemia). Discontinue medications affecting motility (e.g., opiates). Hypocalcemia (Option A) can cause muscle cramps and other symptoms, but it is not typically associated with paralytic ileus. Hyperkalemia (Option C) does not commonly result in paralytic ileus. Hypercalcemia (Option D) is not associated with paralytic ileus.

References:

Bailey & Love’s Short Practice of Surgery, 28th Edition, Pages 1391,1392.

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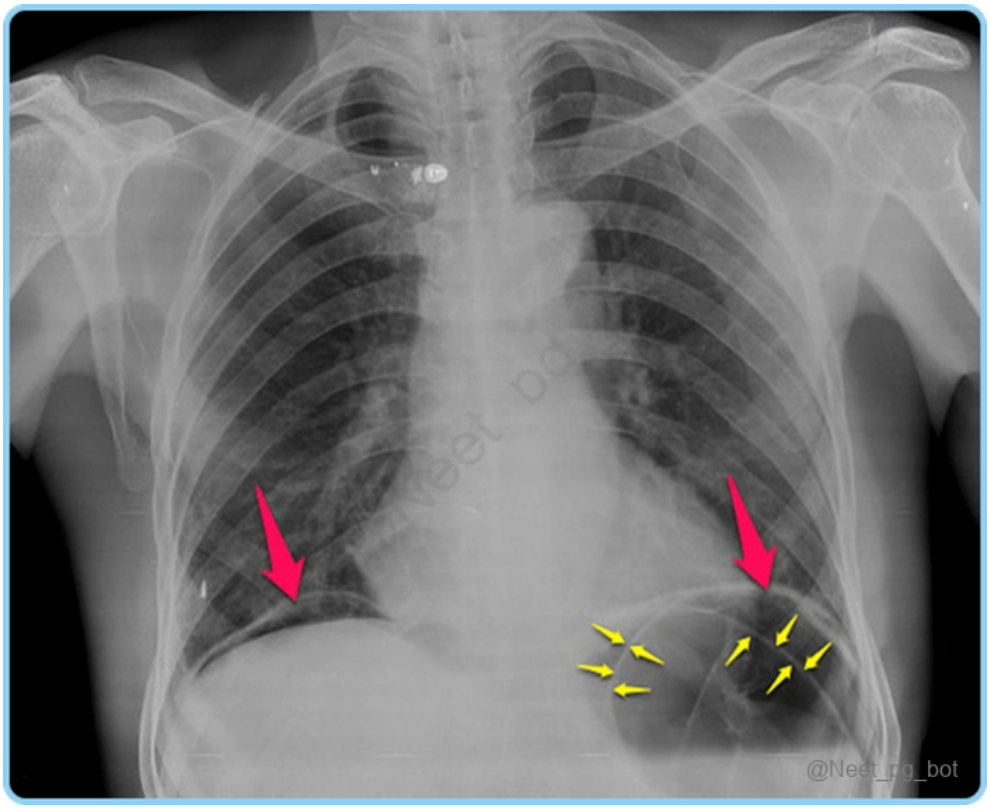
Q159: A 40-year-old male presents with diffuse abdominal pain. He has a past history of peptic ulcer disease. Physical examination reveals rigidity. An X-ray of the abdomen is shown below. What is the next best step in the management of this patient? (Q859831)

A. Antibiotics and NPO (nothing by mouth)

B. Upper GI endoscopy

C. Urgent surgical exploration

D. CT abdomen



Correct Answer: C. Urgent surgical exploration

Explanation: The presence of air under the diaphragm on an X-ray (pneumoperitoneum) is a classic sign of perforated viscus , most commonly due to a perforated peptic ulcer which is a surgical emergency. Physical examination findings of rigidity and past history of peptic ulcer disease also support this diagnosis. Hence, the most appropriate next step in management is urgent surgical exploration to repair the perforation and address any potential complications, such as peritonitis. Delaying the surgery can lead to potential complications. Antibiotics and NPO (nothing by mouth) (Option A) are part of the supportive treatment; they are not sufficient alone in this case. The presence of free air under the diaphragm indicates a perforation that requires immediate surgical intervention. Upper GI endoscopy (Option B) is useful for identifying ulcers in the non-perforated stage, but this patient already shows signs of perforation, including rigidity and free air; hence, surgery is the immediate priority.

CT abdomen (Option D) of the abdomen can provide valuable information in many cases of abdominal pain, including suspected perforation, but it is not the next best step when there are signs of peritonitis, such as rigidity during physical examination.

References:

Grainger and Allison’s Textbook of Diagnostic Radiology, 7th Edition, Pages 463-465

Bailey & Love's Short Practice of Surgery, 28th Edition, Pages 1088, 1089

Grainger and Allison’s Textbook of Diagnostic Radiology, 7th Edition, Pages 463-465

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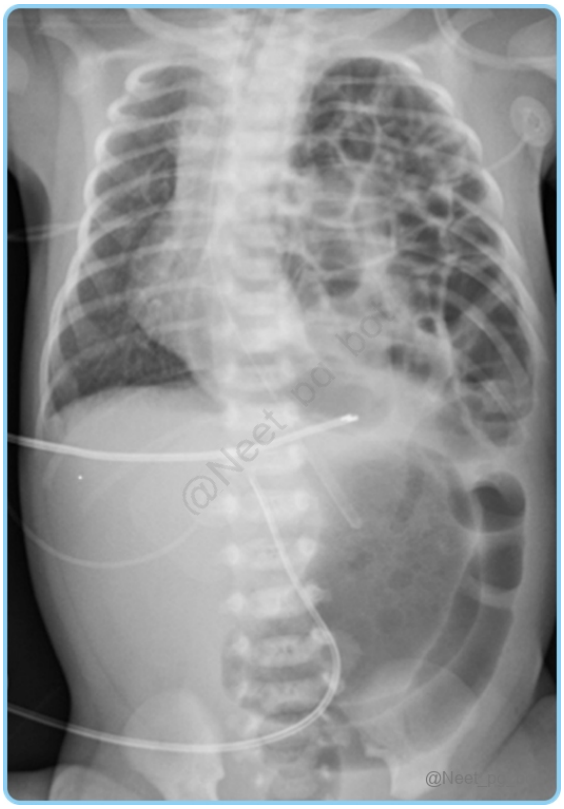
Q160: A neonate presented with mild intermittent upper abdominal pain. On examination, the infant has a scaphoid abdomen and breath sounds are decreased on both sides. The X-ray is given below. What is the diagnosis? (Q859848)

A. Bochdalek hernia

B. Pneumonia

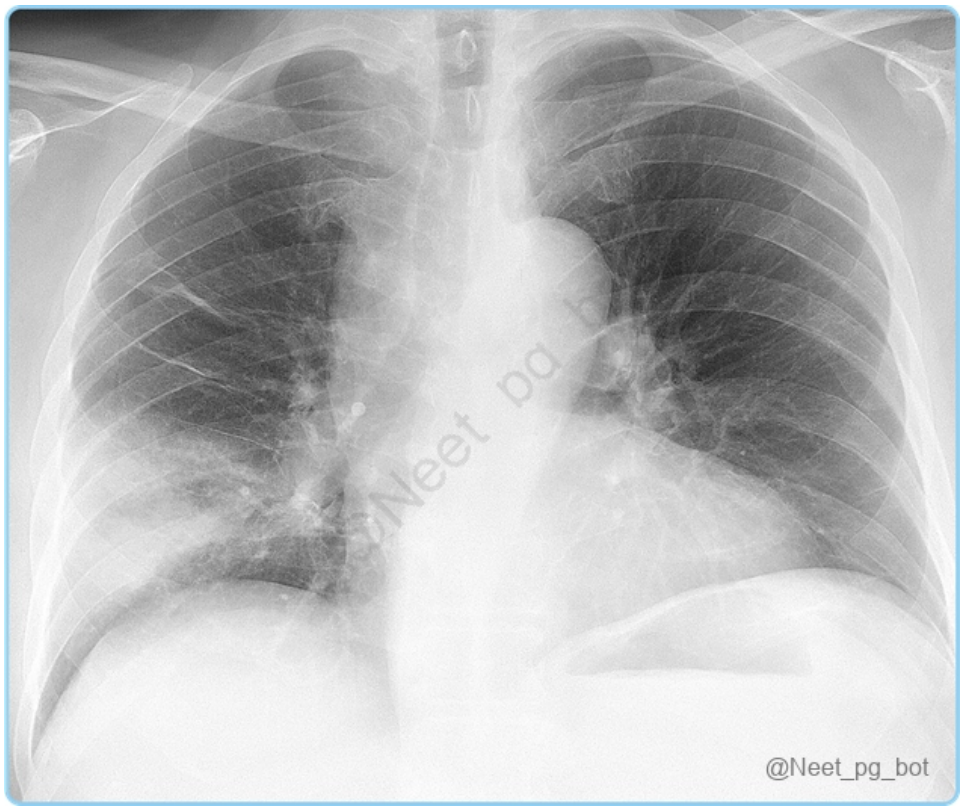
C. Gastric volvulus

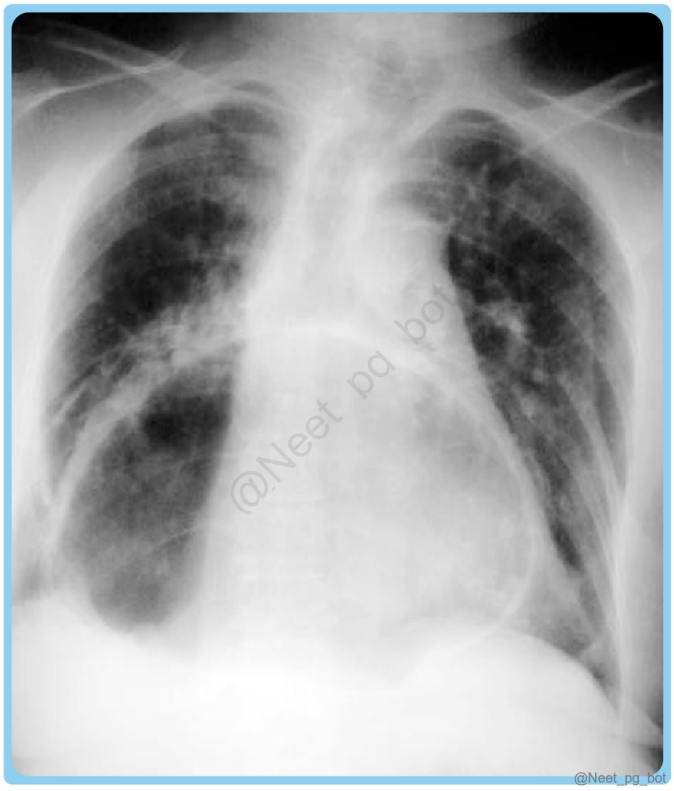
D. Eventration of diaphragm



Correct Answer: A. Bochdalek hernia

Explanation: The neonate's presentation of mild intermittent upper abdominal pain, scaphoid abdomen, and decreased breath sounds on both sides, along with X-ray findings showing bowel loops in the thoracic cavity , strongly points toward a Bochdalek hernia . It is the most common type of congenital diaphragmatic hernia (CDH) due to the failure of the development of the pleuroperitoneal canal. Bochdalek hernia Aspect Description It is due to the failure of the fusion of the pleuroperitoneal canal, which leads to direct communication between the pleura and peritoneum on the left side. Contents Colon, occasionally small bowel or stomach Associated Conditions Hypoplasia (potentially bilateral) Decreased bronchial branch generation Extension of tunica media beyond respiratory bronchioles Decreased total lung mass Diagnostic Features Pulmonary hypoplasia Pulmonary hypertension Clinical Features Respiratory embarrassment Scaphoid abdomen Bowel sounds on the left side of the chest Mediastinal shift towards the right side Intestinal obstruction Pneumonia (Option B) , while being a common cause of respiratory distress , would not typically present with bowel loops in the thoracic cavity on X-ray. It usually shows lung consolidation , infiltrates , or pleural effusion on imaging, not abdominal organs in the chest. {{caption_text}} Gastric volvulus (Option C) involves twisting of the stomach , which can lead to obstruction , pain , and vomiting, but it does not cause bowel loops in the thoracic cavity . {{caption_text}} Eventration of the diaphragm (Option D) is a condition where there is diaphragmatic weakness or paralysis , leading to the upward displacement of abdominal contents into the chest. While it may cause respiratory distress , it does not lead to bowel loops in the chest on X-ray. {{caption_text}}


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References:

Sabiston’s Text Book of Surgery, 21st Edition, Page 1848

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Q161: What is the diagnosis of a neonate who is brought to the hospital with complaints of forceful vomiting that is not accompanied by bile after feeding? The child appears lethargic and dehydrated, and abdominal examination shows visible movements of the stomach. A barium meal was conducted, and the image provided is shown below. (Q859853)

A. Hirschsprung’s disease

B. Congenital hypertrophic pyloric stenosis

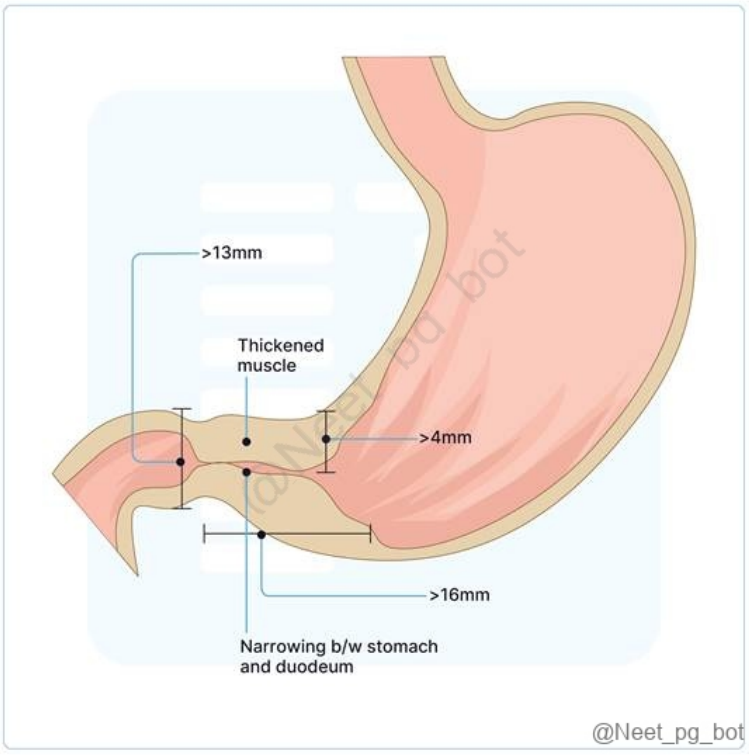
C. Jejunal atresia

D. Duodenal atresia

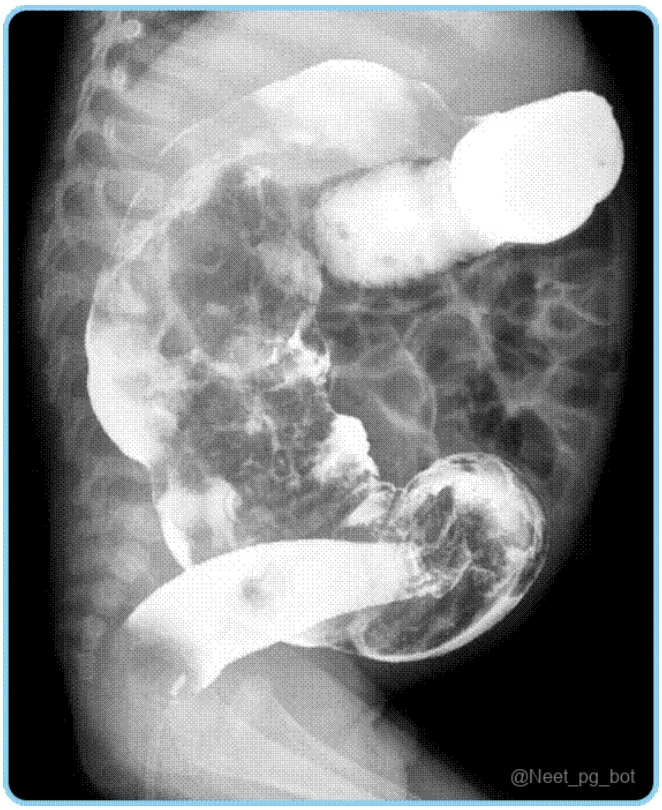


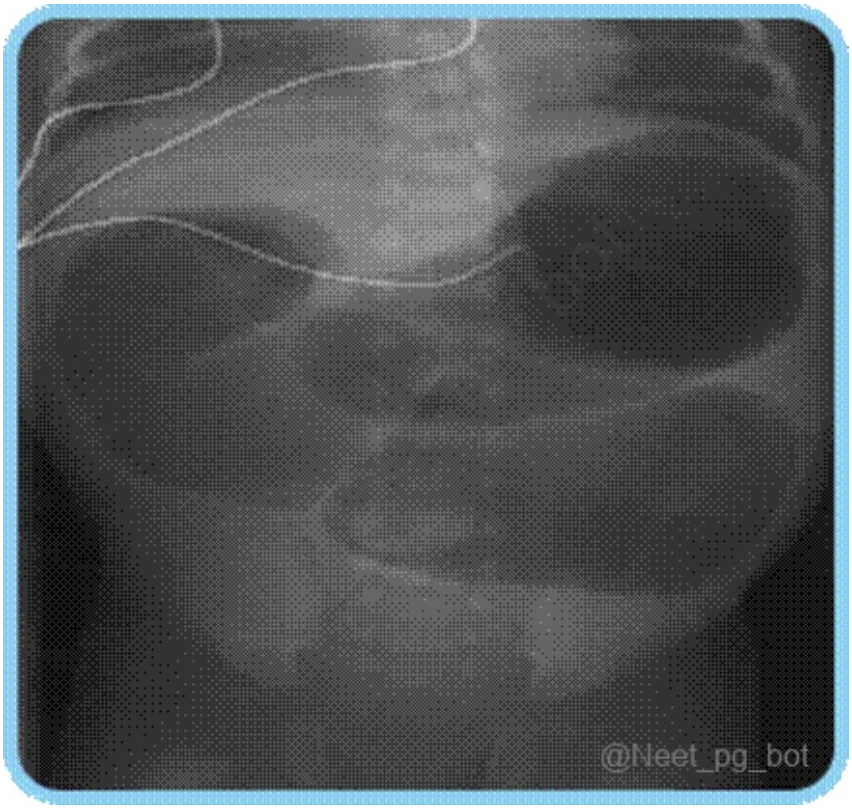
Correct Answer: B. Congenital hypertrophic pyloric stenosis

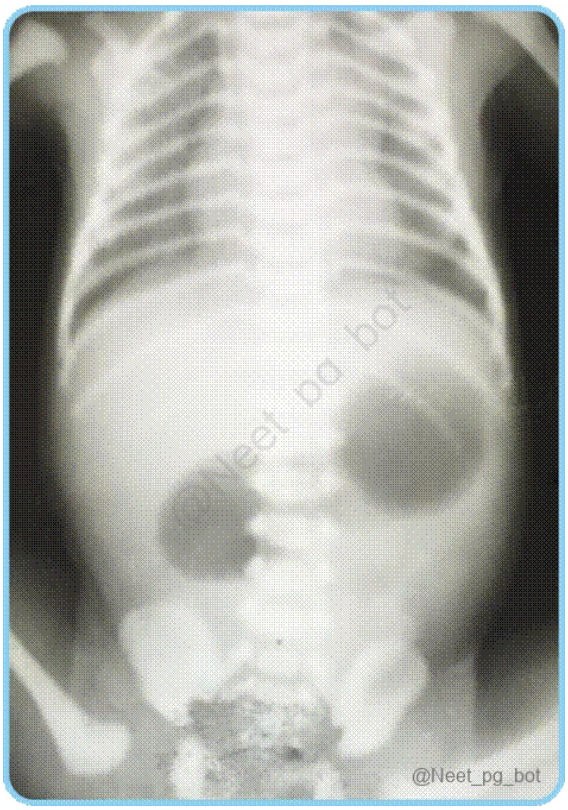
Explanation: The neonate presenting with the mentioned complaints and the barium swallow showing a “string sign” suggests Congenital Hypertrophic Pyloric Stenosis (CHPS) . Congenital hypertrophic pyloric stenosis (CHPS) Definition It is a condition involving hypertrophy of the pyloric muscle, leading to gastric outlet obstruction in male infants, typically between 2 and 6 weeks of age. Clinical Presentation Symptoms: Projectile, non-bilious vomiting after feeds, starting around 2 to 6 weeks of age. Persistent vomiting leads to dehydration, hypokalemia and hypochloremic metabolic alkalosis because the body loses hydrochloric acid (HCl) in the vomitus. Physical Examination: Visible gastric peristalsis from left to right and a palpable “olive-shaped” mass in the epigastric region. Diagnosis Ultrasound (USG) is the Investigation of choice for CHPS, characterised by Pyloric muscle thickness of > 3 mm Pyloric length > 14 mm The pyloric channel appears elongated and thickened (10-14 mm) Contrast Studies (Upper GI Series): Less frequently used, demonstrating the classic ¸ with a thin line of contrast through the elongated and narrowed pyloric channel and delayed gastric emptying without duodenal dilation. {{caption_text}} Hirschsprung’s disease (Option A) is characterized by the absence of ganglion cells in the distal intestine , which can present as delayed passing of meconium or constipation. Barium enema shows the dilated proximal segment and the transition zone. Forceful vomiting without bile and visible stomach movements are not typical of Hirschsprung's disease. {{caption_text}} Jejunal atresia (Option C) is a condition where there is a congenital obstruction in the jejunum , often presenting with bilious vomiting and abdominal distension . It is characterised by multiple dilated loops of the small bowel and a "triple bubble sign" on X-ray. In this case, the vomiting is non-bilious , which rules out this diagnosis. {{caption_text}} Duodenal atresia (Option D) is another congenital condition where there is a complete or partial obstruction of the duodenum , which results in bilious vomiting . It often presents with a "double bubble" sign on the X-ray. {{caption_text}}


>13mm
Thickened muscle
>4mm
>16mm
Narrowing b/w stomach and duodeum
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References:

Nelson Textbook of Pediatrics, 21st Edition, Page 1948

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Q162: What is the probable diagnosis for a 5-year-old child with abdominal swelling, mild discomfort, no pain or vomiting, and a fluctuant soft swelling that moves freely in a plane perpendicular to the mesentery attachment, as seen in the outpatient department? (Q859866)

A. Peritoneal cyst

B. Lipoma

C. Chylolymphatic cyst

D. Pseudocyst

Correct Answer: C. Chylolymphatic cyst

Explanation: The probable diagnosis for a 5-year-old child with a painless, soft, fluctuant abdominal swelling that demonstrates a unique pattern of mobility is a chylolymphatic cyst . It is a type of mesenteric cyst , Contains chyle (lymph + fat) Caused by congenital malformation of lymphatic channels Key Clinical Clues: Young child (5 years) → commonly seen in pediatric age group Painless abdominal swelling → benign, slowly enlarging lesion Soft, fluctuant mass → cystic in nature No vomiting or acute pain → rules out obstruction or inflammation Moves freely in a plane perpendicular to the mesenteric attachment ➜ Pathognomonic sign of a mesenteric cyst Peritoneal cysts (Option A) : Rare in children Does not show characteristic perpendicular mobility Less specific clinical behavior Lipoma (Option B) Solid , not fluctuant Fatty tumors are soft but not cystic Mobility not related to mesenteric planes Pseudocysts (Option D) Usually occur post-pancreatitis Presents with pain, vomiting, systemic symptoms Unlikely in a healthy child with painless swelling

References:

Bailey and Love's Short Practice of Surgery, 28th Edition, Pages 1100, 1101

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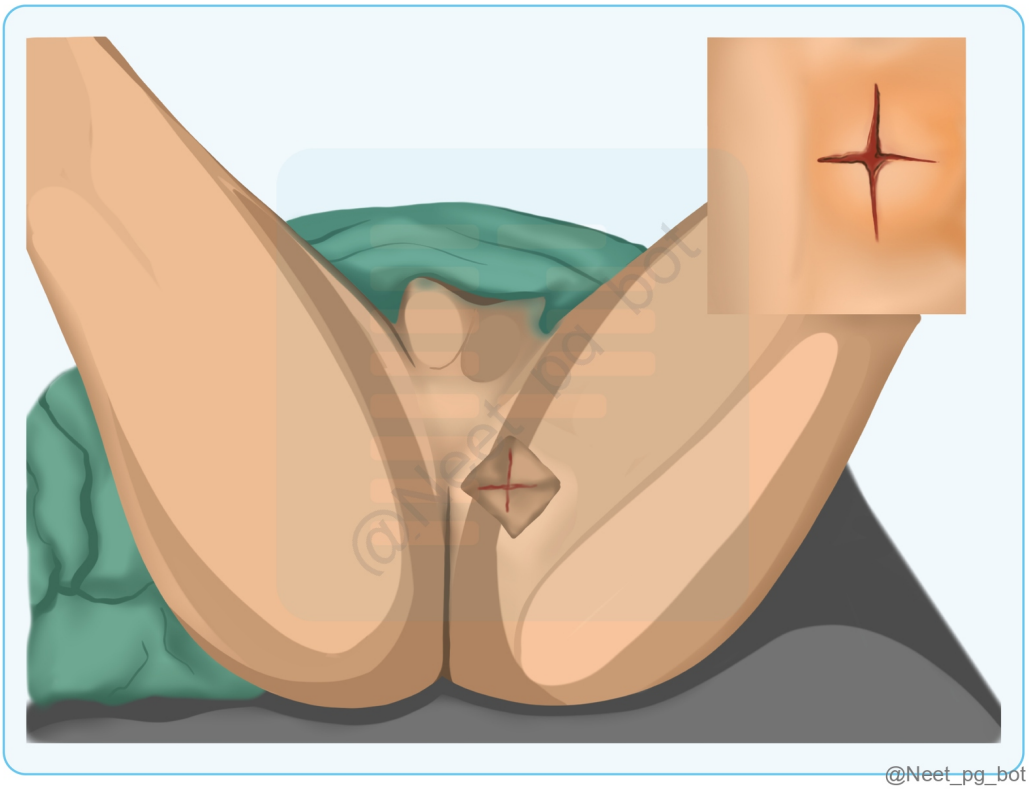
Q163: The image below shows an image of the anus. What is the most likely diagnosis, and it occurs when one of your anus glands becomes clogged and infected? Pus and fluid accumulate in the anal gland, resulting in an excruciatingly painful abscess around your anus? (Q859870)

A. Hemorrhoids

B. Pelvirectal abscess

C. Perianal abscess

D. Pilonidal sinus



Correct Answer: C. Perianal abscess

Explanation: The most likely diagnosis in this scenario, based on the symptoms described and the given clinical image, is a perianal abscess . It is an infection of one of the small glands near the anus, known as anal glands or crypts . These glands can become blocked or infected , leading to pus accumulation, resulting in an abscess . It is a type of anorectal abscess that occurs in the perianal region. It can also develop as a complication of Crohn's disease. Treatment of perianal abscess: Surgical Drainage: It is the primary treatment, often performed under anaesthesia. The abscesses are drained via perineal skin using a cruciate incision, avoiding excessive excision of healthy tissue. Antibiotics: Indicated in cases with extensive cellulitis, diabetes, or immunosuppression. Hemorrhoids (Option A) are swollen blood vessels in the rectum or anus. While they can cause pain, discomfort, and sometimes bleeding, haemorrhoids do not result in pus accumulation or an infected abscess . Pelvirectal abscess (Option B) develops when the intersphincteric abscess extends cranially past the levator muscles. The infection progresses semicircularly and primarily posteriorly, resulting in the creation of a horseshoe abscess or fistula. Such a condition does not represent the case here. Pilonidal sinus (Option D) are found in the natal cleft (the groove at the top of the buttocks), consisting of one or more skin openings connected to a subcutaneous track lined with granulation tissue, often containing hair. However, this condition is not located around the anus .

References:

Bailey and Love’s Short Practice of Surgery, 28th Edition, Pages 1435, 1436

↑ *Back to this question in Part A*

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Q164: Which of the following is the most probable diagnosis for a 38-year-old male patient who visited the surgery OPD with a history of occasional discharge of pus with a slight presence of blood from an external opening in the perianal region, despite multiple attempts at drainage? The examination of the perianal region is depicted below. (Q859872)

A. Pilonidal sinus

B. Perianal abscess

C. Hemorrhoids

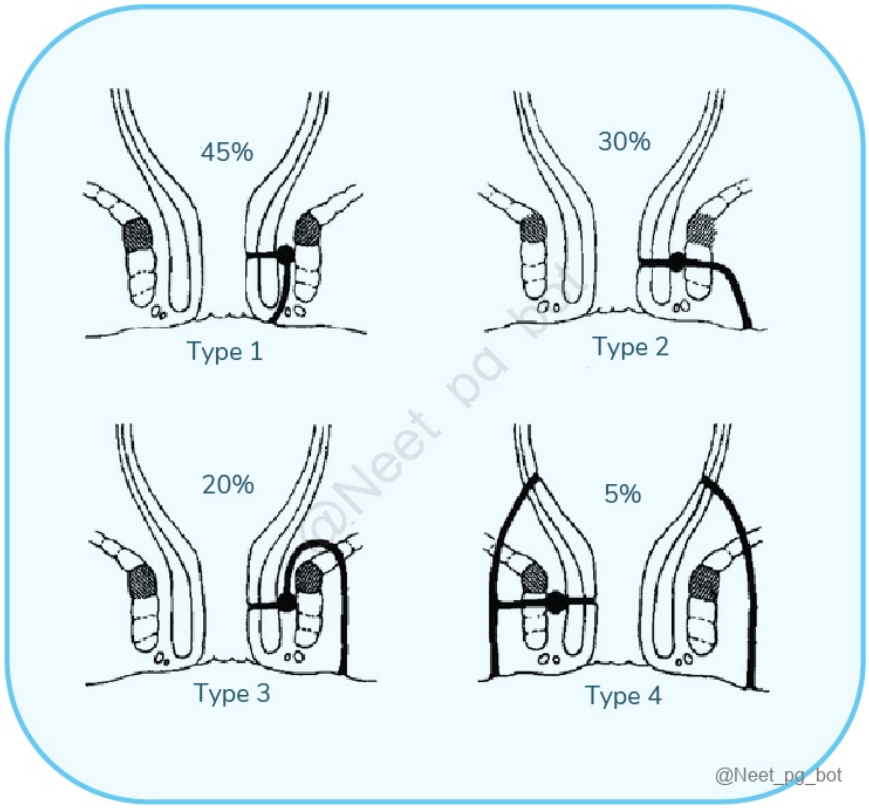
D. Fistula-in-ano



Correct Answer: D. Fistula-in-ano

Explanation: The most likely diagnosis for this patient, with an occasional discharge of pus with slight blood from an external opening in the perianal region , despite multiple drainage attempts, along with the findings of the clinical image given, is Fistula-in-Ano . It is a chronic abnormal communication between the anorectal lumen (internal opening) and an external opening on the skin of the perineum, buttock, or, rarely, the vagina in women. Fistula-in-ano Causes Idiopathic/Cryptoglandular: The most common cause, often associated with prior anorectal sepsis. Associated Conditions: Crohn’s disease Tuberculosis Lymphogranuloma venereum Actinomycosis Rectal duplication Foreign bodies Malignancy (rare, can develop within a longstanding fistula) Clinical features Intermittent purulent discharge: This may be bloody and purulent. Discomfort typically increases until the pus

discharges, providing temporary relief. Previous history of Anorectal abscess Passage of flatus or faeces: Through the external opening (indicative of a rectal rather than an anal internal opening). Parks classification Type 1 - Inter-sphincteric (most common, 70%) Type 2 - Trans- sphincteric (25%) Type 3 - Supra- sphincteric (4%) Type 4 - Extra- sphincteric (1%) {{caption_text}} Pilonidal sinus (Option A) is found in the natal cleft (the groove at the top of the buttocks), consisting of one or more skin openings connected to a subcutaneous track lined with granulation tissue, often containing hair. It occurs higher up near the coccyx , not in the perianal region. Perianal abscess (Option B) is an infection of one of the small glands near the anus, known as anal glands or crypts . These glands can become blocked or infected , leading to pus accumulation and abscess . This patient has had multiple drainage attempts and ongoing discharge , suggesting a chronic issue . Hence, he likely has a chronic fistula rather than an acute abscess. Hemorrhoids (Option C) are swollen blood vessels in the rectum or anus. While they can cause pain, discomfort, and sometimes bleeding, pus discharge is not characteristic of hemorrhoids.



References:

SRB’s Manual of Surgery, 6th Edition, Page 972

Bailey and Love’s Short Practice of Surgery, 28th Edition, Pages 1436, 1437

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Q165: An infant of 12 weeks presented with the following defect in the umbilical area. Identify the condition. (Q859875)

A. Omphalocele

B. Gastroschisis

C. Umbilical hernia

D. Paraumbilical hernia



Correct Answer: C. Umbilical hernia

Explanation: The most likely diagnosis for this 12-week-old infant with a defect in the umbilical area is Umbilical Hernia. It is a protrusion of abdominal contents (usually fat or intestines) through a weakness in the abdominal wall at the umbilical ring . This condition is more common in infants and obese adults. In infants, it is a benign condition , often noticed shortly after birth, and the hernia usually appears as a soft swelling in the umbilical area that may disappear when the infant is lying down or when pressure is applied. It mostly resolves spontaneously in infants before 2 years, without needing any intervention. If they have not resolved by 2 years of age, surgical repair is considered. Omphalocele (Option A) is a condition where, instead of the abdominal wall completely closing, some of the internal organs protrude out of the body through the umbilical area . These organs are not just exposed to the environment but are enclosed in a protective membrane (peritoneum, Wharton's jelly & amnion). They are usually much larger than hernia, and the given clinical condition aligns more with an umbilical hernia. Gastroschisis (Option B) is the evisceration of bowel contents through a defect in the anterior abdominal wall just lateral to the umbilicus. It is characterised by a defect beside the umbilicus and does not present in the same way as an umbilical hernia. Paraumbilical hernia (Option D) is a protrusion of abdominal contents through a defect in the abdominal wall , but it occurs slightly above or below the umbilicus rather than directly at the umbilical ring. The swelling is located directly at the umbilicus in the infant, which is more characteristic of an umbilical hernia rather

than a paraumbilical hernia.

References:

Bailey and Love's Short Practice of Surgery, 28th Edition, Page 1073.

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Q166: A patient, after heavy drinking of alcohol presents with multiple episodes of vomiting and hematemesis. The most likely diagnosis is: (Q859898)

A. Mallory-Weiss syndrome

B. Esophageal carcinoma

C. Achalasia cardia

D. Boerhaave's syndrome

Correct Answer: A. Mallory-Weiss syndrome

Explanation: Given the patient's history of heavy drinking , multiple episodes of vomiting , and hematemesis , the most likely diagnosis is Mallory-Weiss syndrome , where the vomiting-induced tear leads to bleeding from the oesophagus . Mallory-Weiss syndrome Definition It is defined as mucosal lacerations in the gastric mucosa at the gastroesophageal (GE) junction that are caused by forceful vomiting, retching, coughing, or straining. Epidemiology It accounts for 10-15% of acute upper gastrointestinal haemorrhages. The greatest risk for massive haemorrhage is alcoholic patients with preexisting portal hypertension. Risk Factors Alcoholic patients with intense vomiting after binge drinking. Forceful abdominal contractions against a closed cardia. Any patient with repeated episodes of emesis. Portal hypertension in alcoholic patients. Diagnosis The patient's history is crucial. It can be confirmed with endoscopy. Retroflexion manoeuvre during endoscopy is used to view the area below the gastroesophageal junction. Symptoms Vomiting, hematemesis, upper abdominal pain, hypotension, tachycardia Complications Rarely massive bleeding associated with portal hypertension Treatment Endoscopic methods (multipolar electrocoagulation, epinephrine injection, band ligation), angiographic transarterial embolisation, rarely surgery Prognosis Generally good with appropriate endoscopic treatment Esophageal carcinoma (Option B) can present with dysphagia , weight loss , and anorexia . It may cause hematemesis in advanced stages, but it is less likely to be associated with acute episodes of vomiting or retching, as seen in this patient. Achalasia cardia (Option C) is a disorder of the lower esophageal sphincter , causing difficulty in swallowing and regurgitation of food, but it doesn't usually present with hematemesis or the tears caused by vomiting. Boerhaave's syndrome (Option D) involves a rupture of the oesophagus due to severe vomiting or retching. It presents with severe chest pain , subcutaneous emphysema , pleural effusions , tachypnea , fever , and hypotension . It is a life-threatening condition often associated with violent vomiting , much more severe than Mallory-Weiss syndrome.

References:

Sabiston Textbook of Surgery, 21st Edition, Page 1235,

Bailey and Love's Short Practice of Surgery, 28th Edition, Page 1127-1129

↑ *Back to this question in Part A*

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Q167: The treatment of choice for inguinal hernia in infants is: (Q859899)

A. Herniotomy

B. Herniorrhaphy

C. TRUSS

D. Hernioplasty

Correct Answer: A. Herniotomy

Explanation: The treatment of choice for inguinal hernia in infants is herniotomy , which involves the removal of the hernial sac . This procedure is preferred in infants as it effectively addresses the condition by removing the sac and preventing further complications, such as incarceration or strangulation, without the need for complex repair techniques used in older patients. Herniorrhaphy (Option B) is a more complex procedure involving suturing the defect in the abdominal wall, which is more commonly used in older children and adults but not typically in infants due to the smaller size and risks associated with suturing in such delicate tissues. TRUSS (Option C) is a device used to support a hernia, but it is not a definitive treatment. It does not address the anatomical defect; hence, it is not preferred for managing inguinal hernias and is not recommended for infants. Hernioplasty (Option D) is a procedure that typically involves the use of a mesh to repair a hernia defect. It is usually employed in adults or in complex, large, or recurrent hernias. In infants and younger children, herniotomy is the preferred treatment. Hernioplasty is considered in specific, complex cases but is not the routine treatment for inguinal hernias in infants.

References:

Bailey and Love's Short Practice of Surgery, 28th Edition, Page 1068.

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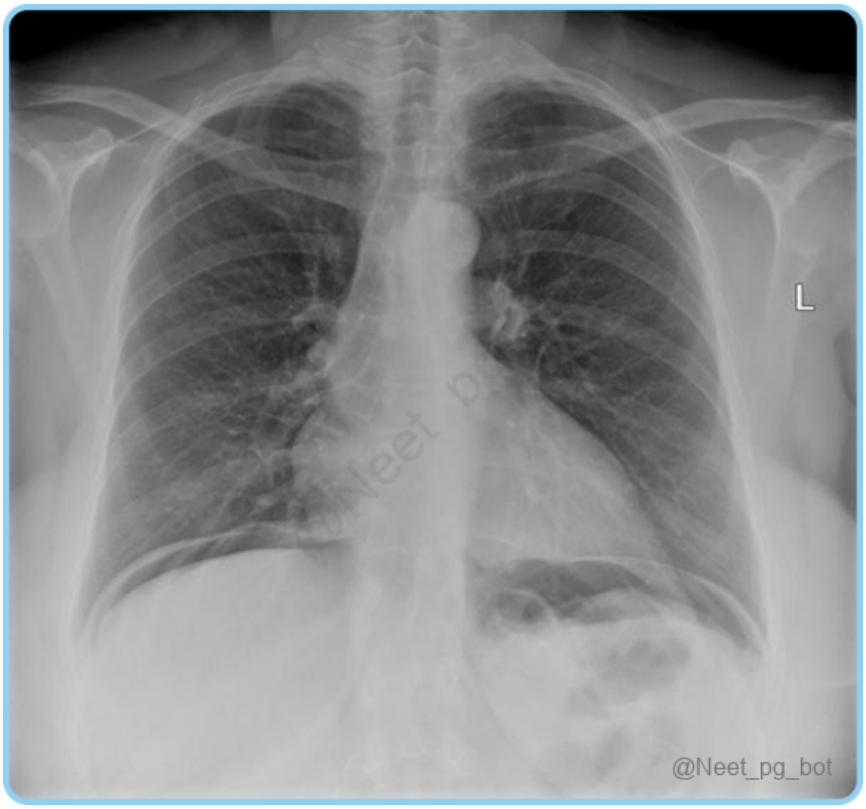
Q168: A patient presents with acute-onset, severe abdominal pain. He is hemodynamically stable. A chest X-ray is shown below. What is the next step in management? (Q855778)

A. Gastric lavage

B. Chest tube insertion

C. Tracheostomy

D. Resuscitation and laparotomy



Correct Answer: D. Resuscitation and laparotomy

Explanation: In this clinical scenario, the presence of free air under the right hemidiaphragm on an erect chest X-ray suggests pneumoperitoneum, which commonly indicates a perforated viscus, such as a peptic ulcer. In this case, since the patient is hemodynamically stable , the immediate step would be to resuscitate the patient to ensure they are stable before proceeding to laparotomy . Laparotomy is required to assess the source of the perforation, repair it, and prevent further contamination of the abdominal cavity. Pneumoperitoneum Causes: Common: Perforated peptic ulcers, bowel obstruction, inflammatory conditions, ischemia, injury during colonoscopy. Other causes without peritonitis: Postoperative (up to 7 days), peritoneal dialysis, sealed perforation, and tracking from pneumomediastinum. Diagnosis on Imaging: Erect CXR: Free gas is seen under the right hemidiaphragm (cupola sign) , but it is difficult to differentiate on the left due to gastric or colonic gas. Supine AXR: Right upper quadrant gas in the perihepatic, subhepatic space, Morrison's pouch, and ligament visualisation (e.g., falciform ligament). Rigler's Sign: Visualization of both sides of the bowel wall due to surrounding gas. CT Scan: Most sensitive; small volumes of gas seen in the liver or peritoneal recesses, often using broad window settings. Pseudo-pneumoperitoneum: Conditions mimicking free gas such as Chilaiditi syndrome (intestine between liver and diaphragm), subphrenic abscess, or subdiaphragmatic fat. Pneumoperitoneum may be clinically silent, especially in elderly, steroid-treated, unconscious, or critically ill patients. Other options: Gastric lavage (Option A) is used in cases of poisoning or overdose to remove ingested toxins from the stomach and is not appropriate in the case of a suspected bowel perforation. The priority here is surgical exploration , not clearing the stomach

contents. Chest tube insertion (Option B) is used for pneumothorax , hemothorax , or pleural effusions , where air or fluid accumulates in the pleural space. While gas under the diaphragm may be seen in the chest X-ray, the issue here is with the abdominal cavity , not the pleural space. Tracheostomy (Option C) is a procedure done when there is an upper airway obstruction or a need for a long-term airway. This patient is presenting with abdominal symptoms , and there is no indication of respiratory distress or an airway issue.

References:

Grainger and Allison’s Textbook of Diagnostic Radiology, 7th Edition, Page 463-465

↑ *Back to this question in Part A*

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Q169: A 1.5-month-old male infant presents to the outpatient department with vomiting after feeding and failure to thrive . On examination, a firm, olive-shaped mass is palpated in the upper abdomen . What is the most likely diagnosis? (Q852714)

A. Subacute Intestinal Obstruction

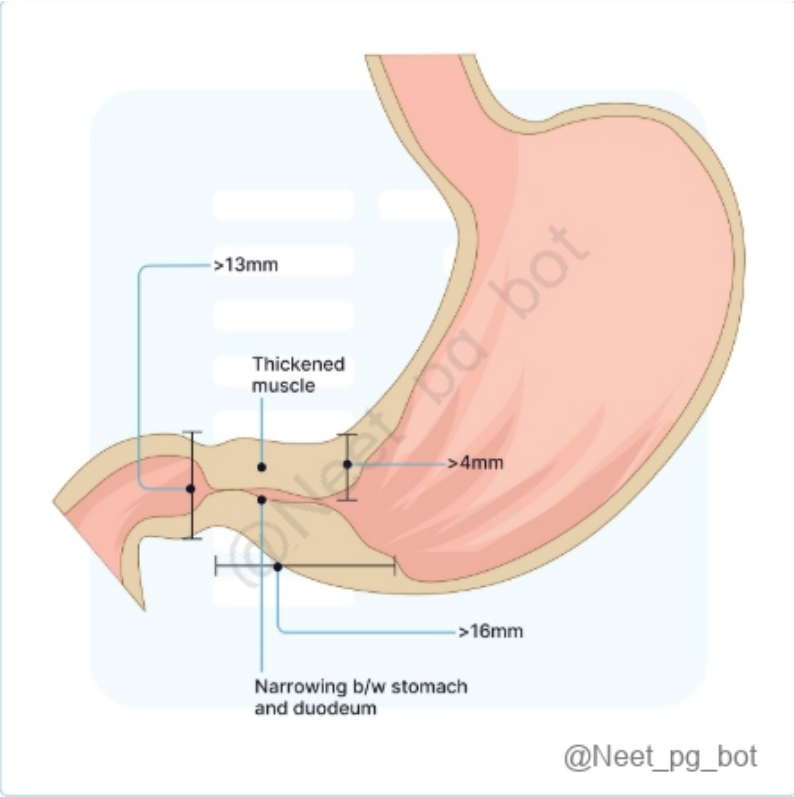
B. Pyloric Stenosis

C. GERD

D. Esophageal Atresia

Correct Answer: B. Pyloric Stenosis

Explanation: Projectile, non-bilious vomiting is the hallmark of infantile hypertrophic pyloric stenosis (IHPS) . The presence of a firm, olive-shaped mass in the epigastric region (hypertrophied pylorus) is a classic finding. Failure to thrive occurs due to chronic vomiting and dehydration . Ultrasound confirms the diagnosis by showing thickened pyloric muscle (>3mm thickness, >14mm length) . Hypertrophic Pyloric Stenosis (HPS) Feature Description Age of Presentation 3-6 weeks of life Symptoms Projectile, non-bilious vomiting Physical Exam Olive-shaped mass in epigastrium Diagnosis Ultrasound: Pyloric muscle hypertrophy Treatment Ramstedt's pyloromyotomy Subacute Intestinal Obstruction (Option A): Incorrect because it typically presents with bilious vomiting and distended abdomen , not an olive-shaped mass . GERD (Option C): Incorrect because GERD causes effortless regurgitation without an olive-shaped mass or projectile vomiting. Esophageal Atresia (Option D): Incorrect because it presents at birth with excessive drooling, choking, and respiratory distress , not progressive vomiting.



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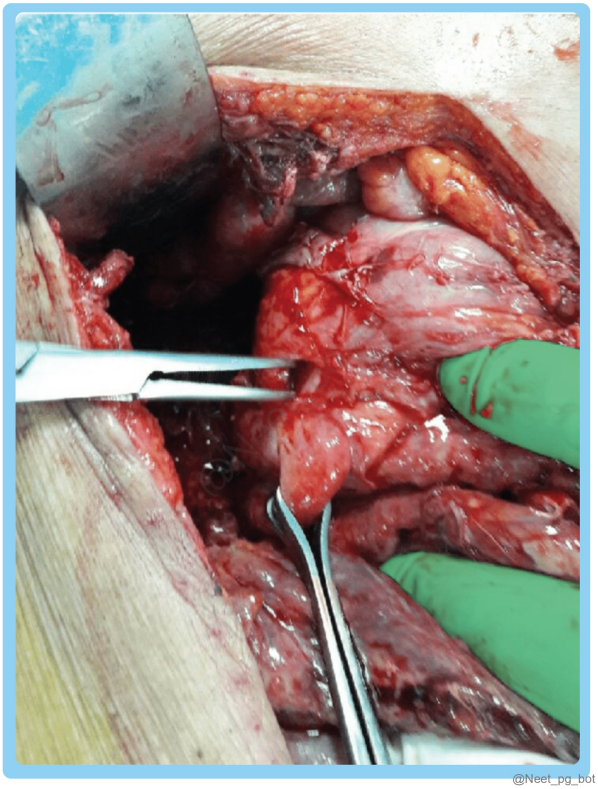
Q170: An alcoholic male patient diagnosed with hollow viscus perforation is taken up for laparotomy. Intraoperatively, a 2 cm perforation is seen in the duodenal region, as shown below. How can this patient be managed? (Q860458)

A. Primary closure of the defect

B. Omental pedicle repair

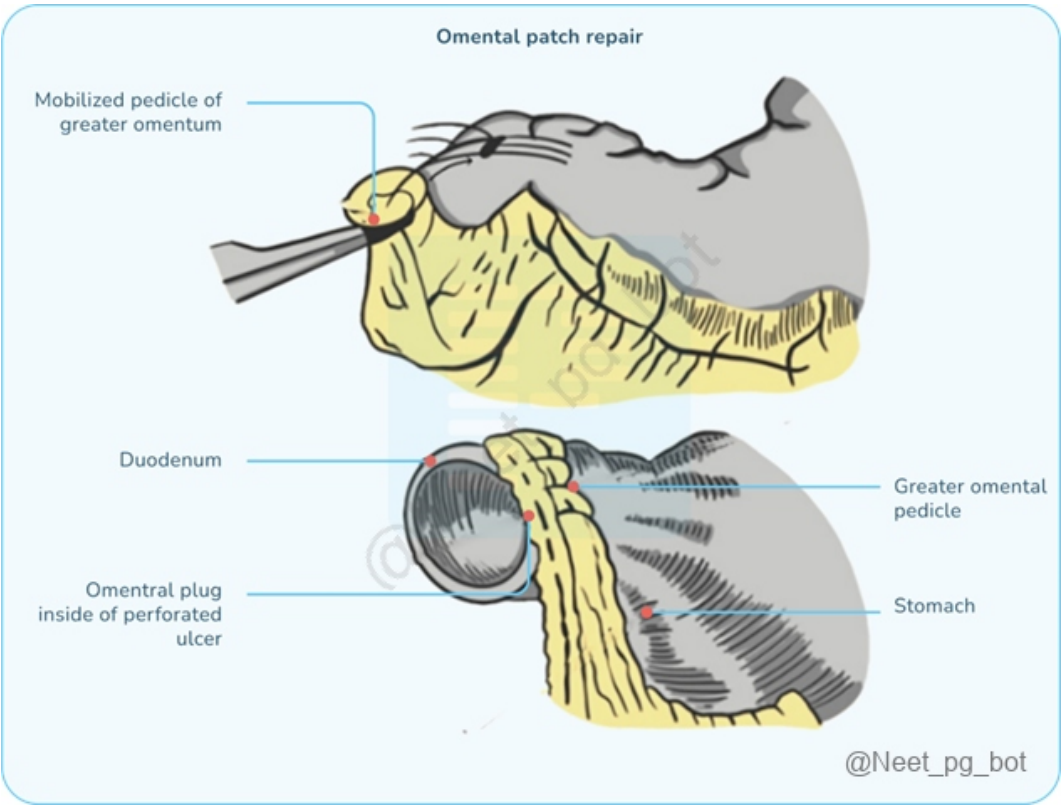
C. Billroth I

D. Billroth II



Correct Answer: B. Omental pedicle repair

Explanation: In case of a duodenal perforation , omental pedicle repair is the preferred method of treatment. The omentum , a highly vascular tissue, is mobilised and placed over the perforation. This provides a biological seal and promotes healing while reducing the risk of infection or further leakage. Duodenal ulcer perforation: Common with anterior duodenal ulcers. Presents with an acute abdomen with sudden-onset, severe epigastric pain, rebound tenderness, and air under the diaphragm in the radiograph. Management: Non-surgical: Nil per-oral IV antibiotics and PPIs Surgical: Initial empirical antibiotic treatment. The perforation is approached by a small upper midline incision Perforations <1cm are closed primarily and buttressed with a well-vascularized omentum Larger perforations & with fibrotic edges: Modified Graham's Repair or Omental Patch Repair. The vascularized pedicle of the greater omentum is patched over the defect. Bleeding duodenal ulcer: A posterior duodenal ulcer is the one that usually bleeds. It is due to the involvement of the gastroduodenal artery . This leads to hematemesis, melena or both i.e., an upper GI bleed. Bleeding is commonly associated with intake of NSAIDs . Management: Endoscopic: Done to find the bleeding source and manage bleeds endoscopically. Injection , thermal coagulation, plasma argon coagulation, mechanical clips, and fibrin glue are the methods used. (with or without adrenaline injection). Angiographic management: If endoscopic management fails. Surgical management: Exposure to the ulcer and ligation of the duodenum are the principles here. Duodenotomy Ligation of the bleeding vessel with truncal vagotomy with pyloroplasty



References:

Sabiston Textbook of Surgery, 20th Edition, Page 1210-1214

↑ *Back to this question in Part A*

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Q171: Which of the following is/are complications associated with GERD? Asthma Laryngitis Pulmonary Fibrosis Chronic cough (Q839982)

A. 1,2

B. 1,2,4

C. 1,2,3

D. 1,2,3,4

Correct Answer: D. 1,2,3,4

Explanation: Correct Option D - 1, 2, 3, 4: Asthma, laryngitis, pulmonary fibrosis, and chronic cough are all complications of GERD. Incorrect Options: Options A, B and C: These options are incorrect.

↑ *Back to this question in Part A*

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Q172: Which of the following is not a layer of esophagus? (Q820123)

A. Mucosa

B. Submucosa

C. Serosa

D. Muscularis

Correct Answer: C. Serosa

Explanation: Correct option C - Serosa The esophagus contains 4 layers: Mucosa (Option A) Submucosa (Option B) Muscularis propria (Option D) Tunica adventitia

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1107

↑ *Back to this question in Part A*

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Q173: Which of the following gene mutations are involved in carcinoma of the colon? (Q856243)

A. APC, BRCA, k-ras

B. APC, k-ras, p53

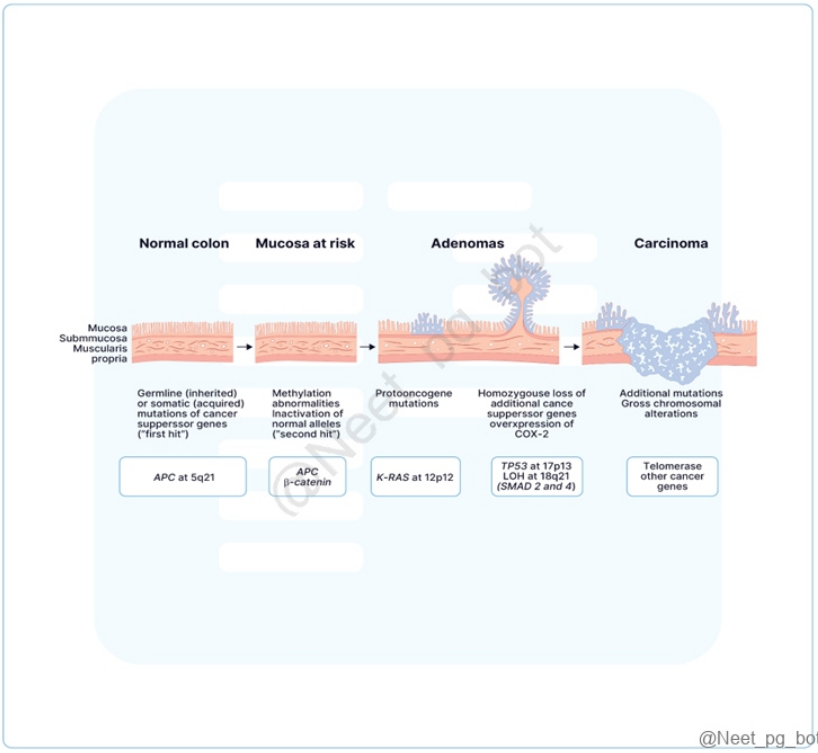
C. MYh, K-RAS, APC

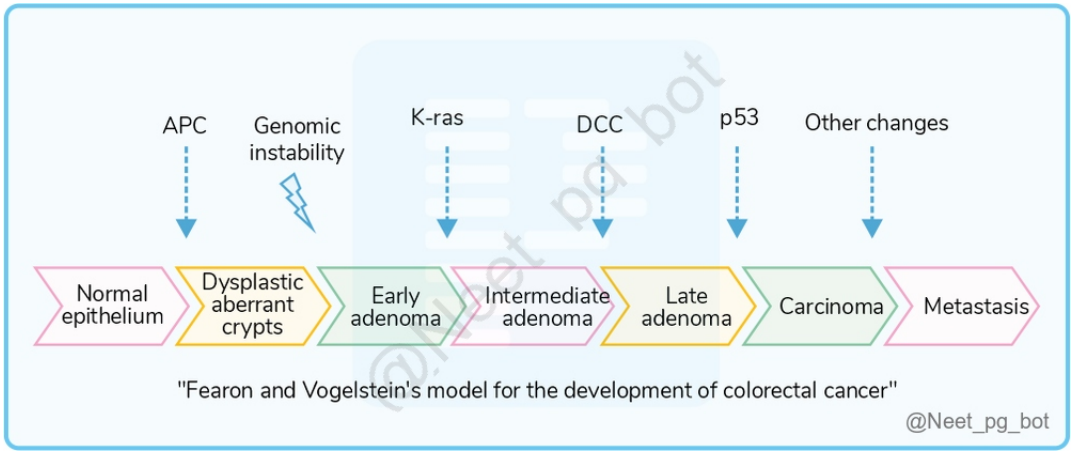
D. MYH, p53, DCC

Correct Answer: B. APC, k-ras, p53

Explanation: The genes associated with the development of colorectal carcinoma are APC, k-ras, p53 & SMAD4. Adenoma-Carcinoma Sequence: Accounts for up to 80% of sporadic cancers. APC Gene Mutations: Leads to β-catenin accumulation and Wnt pathway activation. "First hit": Sporadic inactivation of APC. "Second hit": Loss of second APC copy K-ras Mutations: Promote growth and prevent apoptosis. SMAD2 and SMAD4 Mutations:

Disrupt TGF-β pathway, causing uncontrolled proliferation. p53 Mutations: Occur in later stages of tumour progression. colorectal cancer" data-author="" data-hash="12179" data-license="" data-source="" data-tags="May2025" height="210" src="" width="500" /> Fearon and Vogelstein's model for the development of colorectal cancer APC, BRCA, k-ras (Option A): BRCA mutations are more commonly associated with breast and ovarian cancers, not colon cancer. MYh, K-RAS, APC (Option C): MYH-associated polyposis (MAP) is a rare autosomal recessive condition caused by mutations in the MUTYH gene. It can increase the risk of colorectal cancer, but MUTYH gene mutations are not directly associated with colon cancer. MYH, p53, DCC (Option D): MYH-associated polyposis (MAP) is a rare autosomal recessive condition caused by mutations in the MUTYH gene. It can increase the risk of colorectal cancer, but MUTYH gene mutations are not directly associated with colon cancer.





References:

Robbins and Cotran Pathologic Basis of Disease, 10th Edition, Page 815

↑ *Back to this question in Part A*

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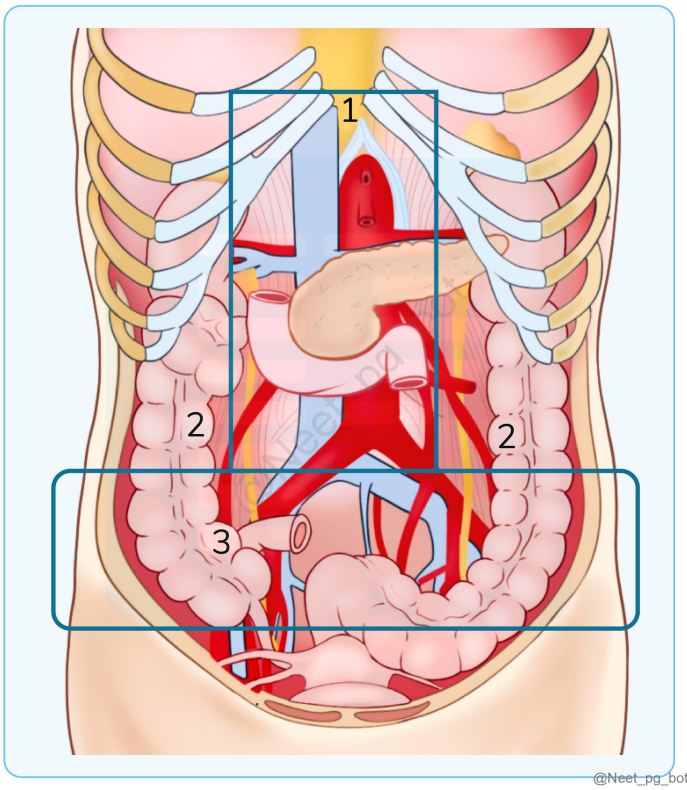
Q174: Mandatory exploration is required in the injuries. Which zones of retroperitoneum are required? (Q859819)

A. 1

B. 2

C. 3

D. 1 & 3



Correct Answer: A. 1

Explanation: Mandatory exploration is generally required for injuries in Zone 1 of the retroperitoneum. Zones of retroperitoneum Zones 1 2 3 Location Central Lateral Pelvic (retroperitoneal zone of the pelvis) Structures involve The aorta & its proximal branches Inferior vena cava & its proximal tributaries Distal renal vessels Iliac vessels Management (Other options ruled out) Exploration with proximal & distal vascular control Lateral hematoma (renal in origin) - managed nonoperatively (angioembolization) Pulsatile hematoma or penetrating injury present -

exploration. Pelvic hematoma is exceptionally difficult to control. Usually, it should not be opened. It is managed by packing/angioembolisation. Explored only if there is expanding or pulsatile or penetrating injury present.

References:

Sabiston, Text Book of Surgery, 21st Edition, Page 423,

Bailey and Love's Short Practice of Surgery, 28th Edition, Pages 382, 383

↑ *Back to this question in Part A*

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Q175: A 45-year-old man complained of recurrent discharge and pain due to lesions around the anus for 3 years. What is the diagnosis? (Q855580)

A. Pilonidal sinus

B. Carbuncle

C. Boil

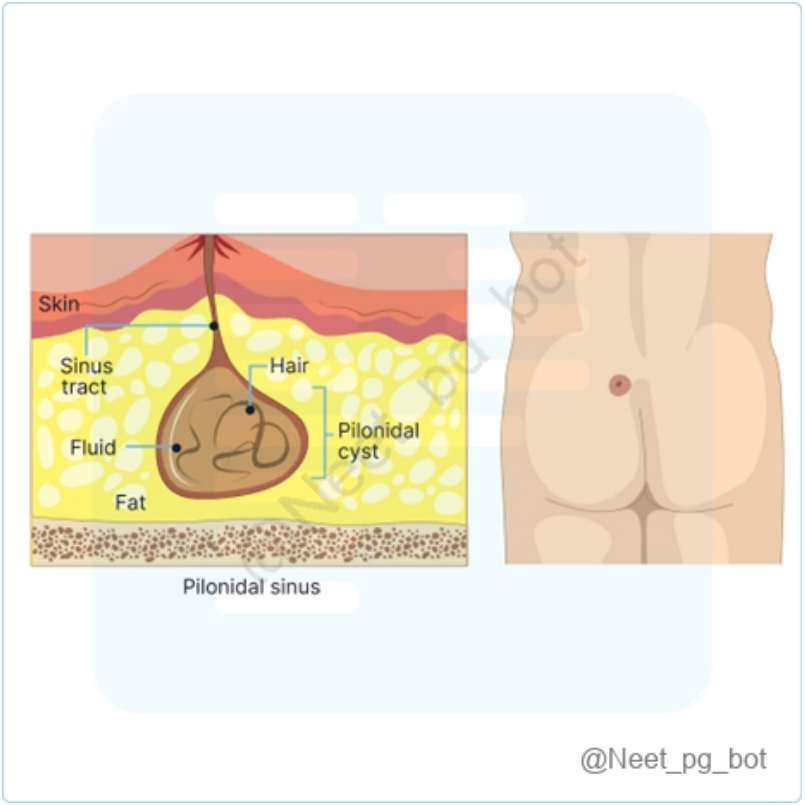
D. Fistula in ano



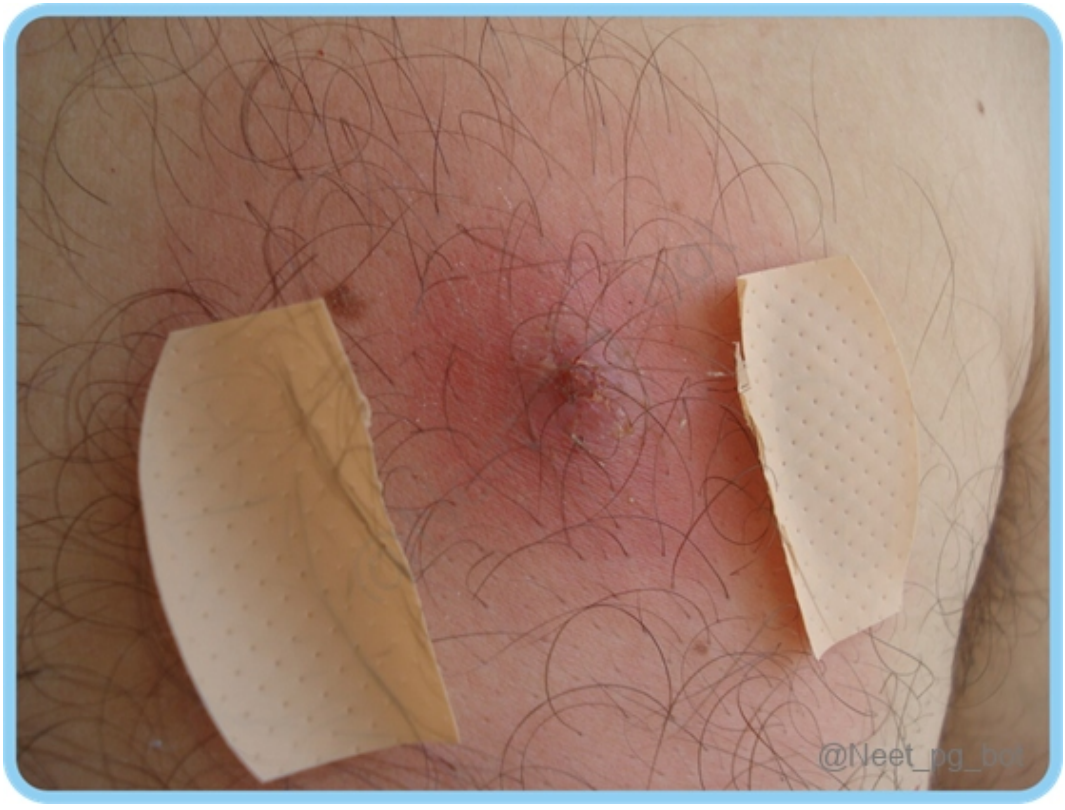
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Correct Answer: D. Fistula in ano

Explanation: The patient's history of recurrent discharge and pain due to lesions around the anus for 3 years suggests fistula in ano. A chronic abnormal communication between the anorectal lumen (internal opening) and an external opening on the skin of the perineum, buttock, or, rarely, the vagina in women. Fistula in ano Causes Idiopathic/Cryptoglandular: The most common cause, often associated with prior anorectal sepsis. Associated Conditions: Crohn’s disease Tuberculosis Lymphogranuloma venereum Actinomycosis Rectal duplication Foreign bodies Malignancy (rare, can develop within a longstanding fistula) Clinical features Intermittent purulent discharge: This may be bloody and purulent. Discomfort typically increases until the pus discharges, providing temporary relief. Previous history of Anorectal abscess Passage of flatus or faeces: Through the external opening (indicative of a rectal rather than an anal internal opening). Pilonidal sinus (Option A) is found in the natal cleft (the groove at the top of the buttocks), consisting of one or more skin openings connected to a subcutaneous track lined with granulation tissue, often containing hair; it is not located typically around the anus. Carbuncle (Option B) is a skin infection consisting of several boils that form a connected area of infection. It typically presents as a painful, swollen area of the skin, not as chronic drainage around the anus. {{caption_text}} Boil (Option C) or furuncle is a perifollicular abscess that typically has an erythematous, indurated, tender nodule with a pus point. While it can present near the anus, the chronic nature and recurrent discharge suggest a fistula, not a boil. {{caption_text}}







References:

SRB’s Manual of Surgery, 6th Edition, Page 972

Bailey and Love's Short Practice of Surgery, 28th Edition, Pages 1436, 1437

↑ *Back to this question in Part A*

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Q176: A 35-year-old man with a history of ulcerative colitis presents with fatigue and pruritus. Laboratory investigations show a cholestatic liver function test pattern. MRCP reveals multifocal strictures and beading of intrahepatic and extrahepatic bile ducts. Liver biopsy demonstrates concentric "onion-skin" fibrosis around bile ducts. What is the most likely diagnosis? (Q879028)

A. Primary biliary cholangitis

B. Primary sclerosing cholangitis

C. Autoimmune hepatitis

D. Secondary biliary cirrhosis

Correct Answer: B. Primary sclerosing cholangitis

Explanation: Correct Option B - Primary sclerosing cholangitis: The most accurate diagnosis for the 35-year-old man with cholestatic liver function tests, MRCP findings of multifocal strictures and beading of intrahepatic and extrahepatic bile ducts, and concentric "onion-skin" fibrosis on liver biopsy is Primary sclerosing cholangitis (PSC). PSC is a chronic cholestatic liver disease characterized by inflammation and fibrosis of both intra- and extrahepatic bile ducts, leading to multifocal strictures and beading seen on MRCP.■ Pathologically, the "onion-skin" concentric fibrosis around bile ducts is a hallmark histological feature of PSC.■ Most patients with PSC have an associated inflammatory bowel disease, especially ulcerative colitis, and present with cholestasis (as seen in this patient). Incorrect Options: Primary biliary cholangitis (Option A) mainly affects small intrahepatic bile ducts, with anti-mitochondrial antibodies. Autoimmune hepatitis (Option C) presents with hepatocellular pattern of injury and interface hepatitis. Secondary biliary cirrhosis (Option D) results from mechanical obstruction like stones or strictures, not autoimmune fibrosis.

References:

Robbins & Cotrans Pathologic Basis of Diseases, 10th Edition, Page 858-859.

↑ *Back to this question in Part A*

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Q177: The angle between two working ports in laparoscopic surgery? (Q879104)

A. Azimuth angle

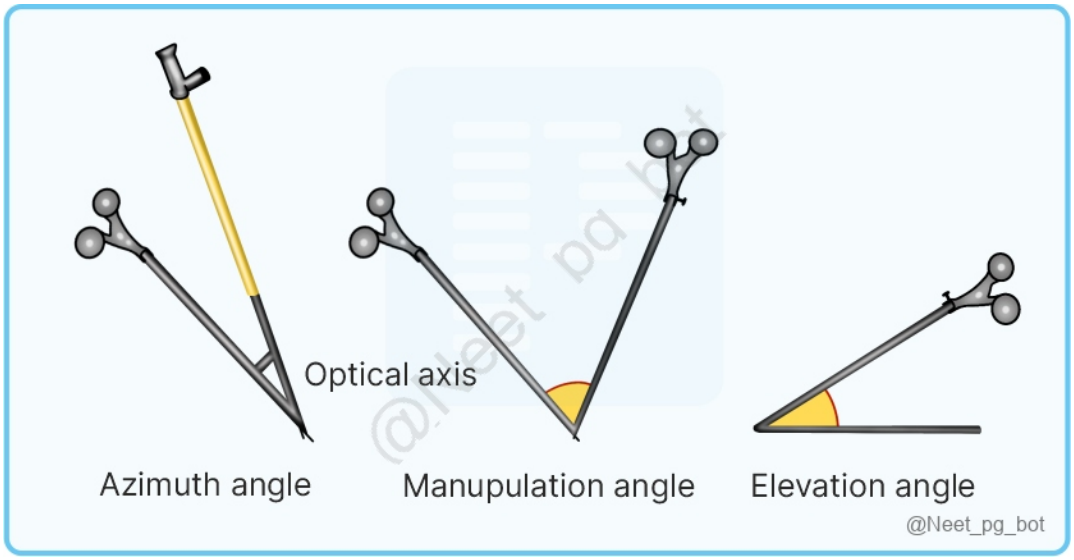
B. Elevation angle

C. Manipulation angle

D. Extreme angle

Correct Answer: C. Manipulation angle

Explanation: Correct Option C - Manipulation angle: The angle between two working ports in laparoscopy is called the manipulation angle . Optimal manipulation angle ≈ 45–75° for good ergonomics and instrument triangulation. Incorrect Options: Azimuth angle (Option A): Angle between a surgical instrument and the optical axis of the laparoscope (camera). Helps align the working instrument relative to the camera view. Elevation angle (Option B): Vertical angle measured between a horizontal plane and the instrument/object. Important for depth perception and vertical approach in laparoscopy. Extreme angle (Option D): Not a standard laparoscopic term



References:

Ergonomics in laparoscopic surgery - PMC

↑ *Back to this question in Part A*

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Q178: All of the following statements about stomas are true except? (Q879107)

A. Patients with a colostomy are at a higher risk of fluid and electrolyte imbalance

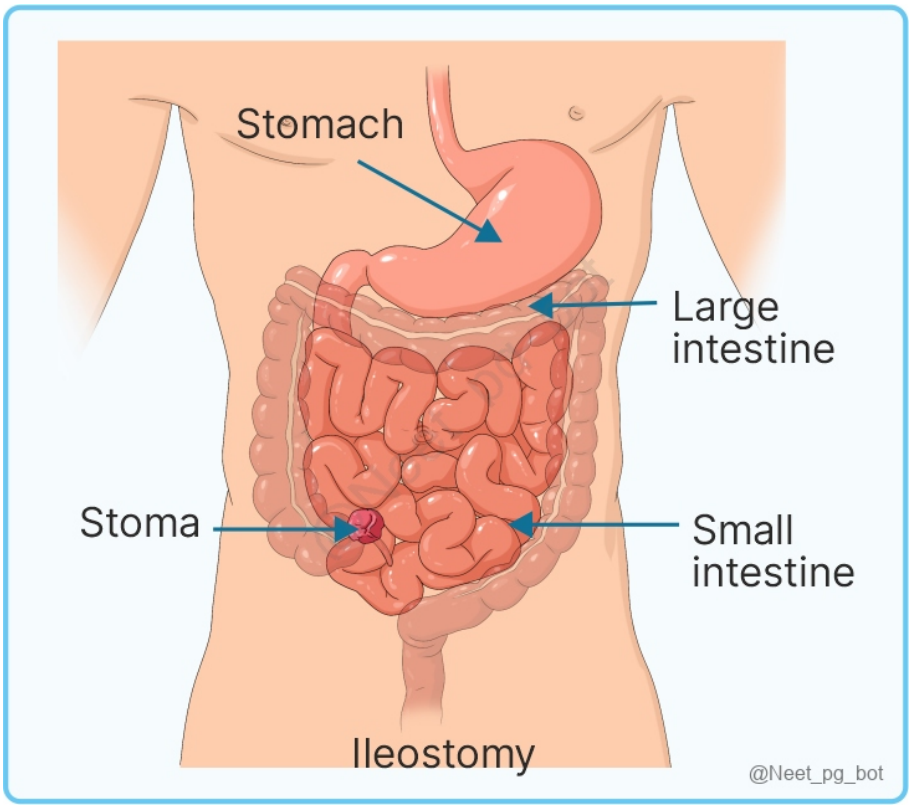
B. Ileostomy stoma is spouted

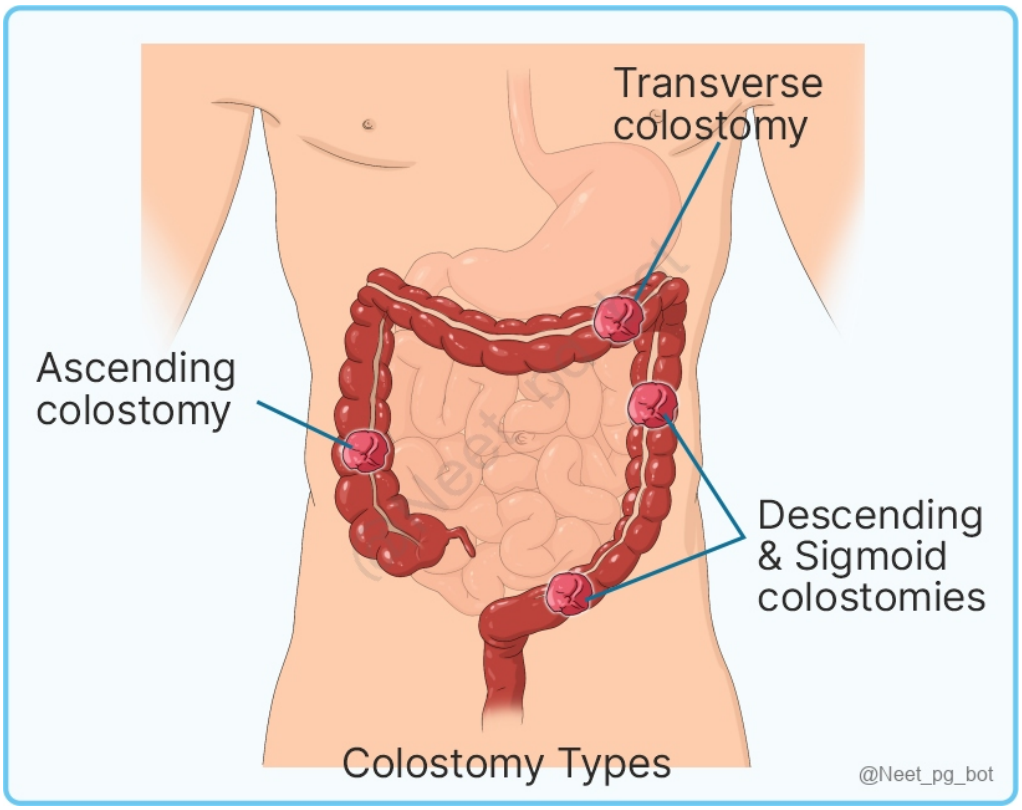
C. Temporary stomas are fashioned as a loop

D. Colostomy stoma is everted and flushed

Correct Answer: A. Patients with a colostomy are at a higher risk of fluid and electrolyte imbalance

Explanation: A stoma is a surgically created opening on the body surface that allows the passage of stool, urine, or other body fluids when the natural pathway is not functional or needs protection. There are 2 types of stomas depending on the site: Gastrointestinal stoma (colostomy, ileostomy and jejunostomy) and urinary stoma (ureterostomy, ileal conduit (Bricker) and continent urinary diversion. They can be classified on the basis of: Purpose: Temporary stoma Permanent stoma Construction: End stoma - bowel divided; proximal end brought out (Hartmann) Loop stoma - loop of bowel exteriorized; both limbs visible; preferred for temporary diversion; best for temporary diversion (Option C). Double-barrel stoma - both proximal and distal ends brought out separately. Output: High-output stoma (ileostomy, jejunostomy) – liquid; high fluid/electrolyte loss. Low-output stoma (colostomy) – more formed stool. Feature Ileostomy Colostomy Location Typically located in the right iliac fossa Typically located in the left iliac fossa Stool Consistency Usually results in liquid or semi-liquid stool Produces a more formed stool Spout Ileostomy is usually spouted (Option B ruled out) Colostomy is usually flush and everted (Option D ruled out) Use To defunction the rest of the bowel in order to protect a distal anastomosis To evacuate stool from the body if the entire colon has been removed (such as in colorectal cancer, IBD) To relieve bowel obstruction To protect a distal anastomosis or allow healing away from the faecal flow Following resection when anastomosis is unsafe or not possible To relieve obstruction when resection is not feasible To reduce disease activity (e.g. Crohn’s disease) To allow alternative bowel control (incontinence) Fluid and electrolyte problems More likely Less likely Appliances Requires bags that often need to be emptied frequently due to the liquid consistency of the stool Uses appliances that may be changed as needed, depending on the type of colostomy and stool consistency Image





References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Pages 1372, 1373.

https://www.ncbi.nlm.nih.gov/books/NBK519003/

SRB's Manual of Surgery, 6th Edition, Page 901.

↑ *Back to this question in Part A*

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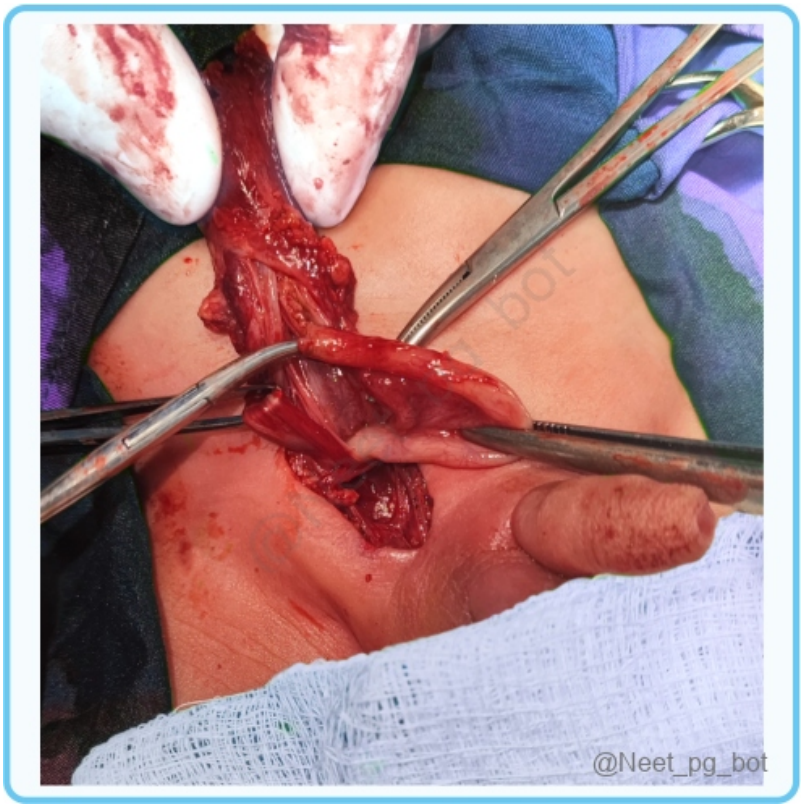
Q179: During surgery for an inguinal hernia, the appendix is found inside the hernia sac. What type of hernia is this? (Q879118)

A. Litter’s hernia

B. Amyand’s hernia

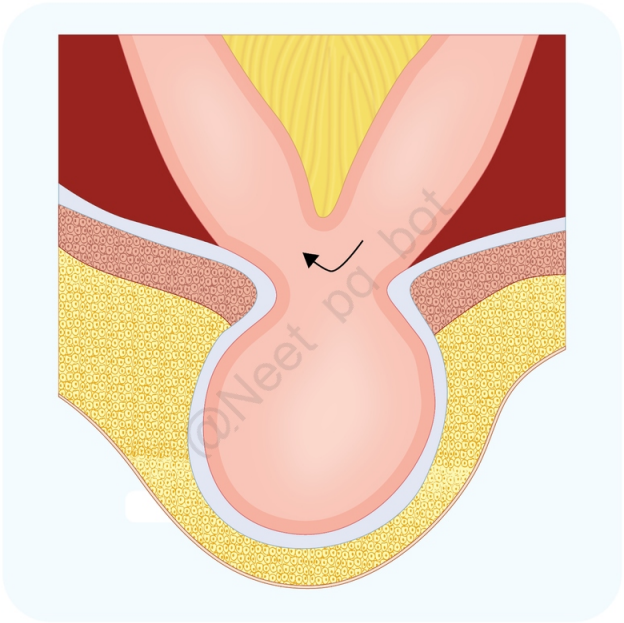
C. Gibbons hernia

D. Richter’s hernia

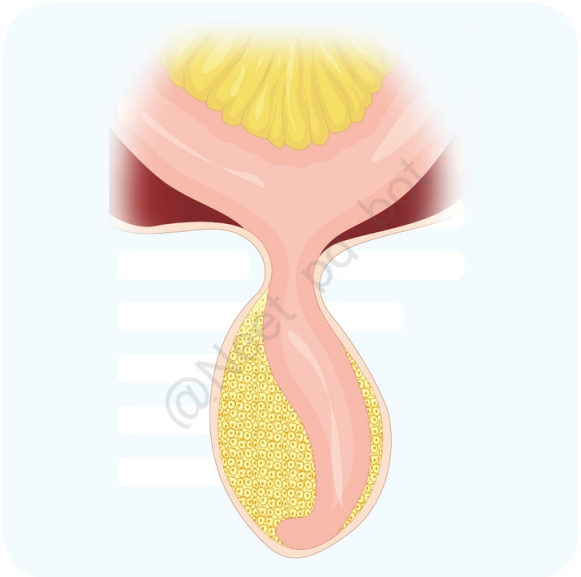


Correct Answer: B. Amyand’s hernia

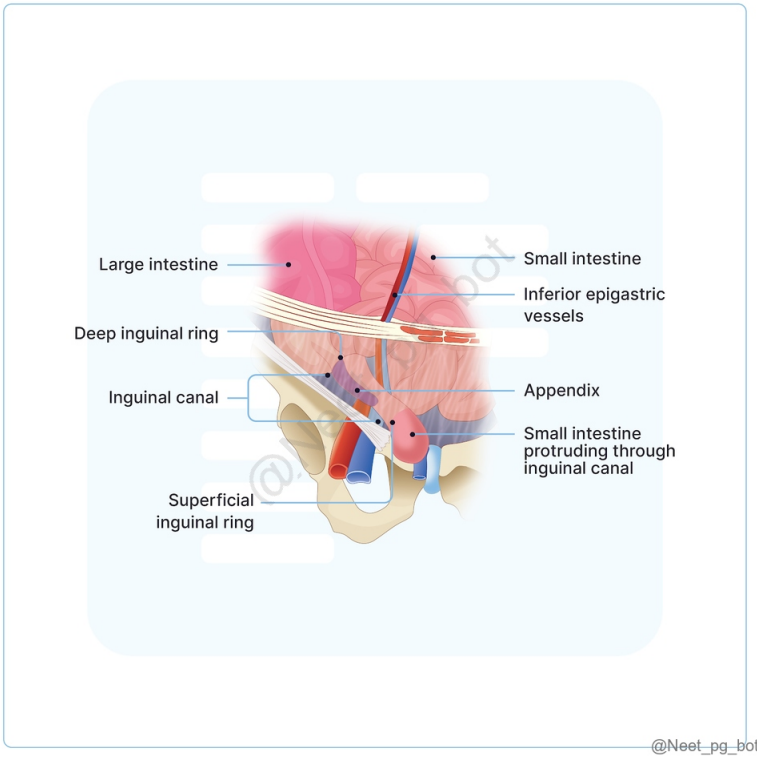
Explanation: Correct Option B - Amyand’s hernia: Amyand’s hernia → Inguinal hernia containing the appendix within the hernia sac. Hernia Features Richter’s Hernia (Option D ruled out) Herniation of only a portion of the bowel wall (circumference) into the hernia sac. Leads to localized strangulation or incarceration of part of the bowel wall while the bowel lumen remains intact. Mimics Gastroenteritis (Diarrhea, colicky pain) potentially delaying diagnosis and increasing the risk of complications like strangulation. Seen in: (Narrow Defects) Paraumbilical Hernia Femoral Hernia Obturator Hernia Littre’s Hernia (Option A ruled out) It involves a Meckel’s diverticulum herniating into the sac. Amyand’s Hernia (Option B) ■■■■■■■ Contains the Appendix within the hernia sac. Gibbon’s hernia (Option C) : Rare type involving part of the transverse colon .



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References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 256

↑ *Back to this question in Part A*

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Q180: A patient with recurrent history of gastric ulcers presented with severe pain abdomen on evaluation a small mass is found on the anterior wall of duodenum. Which investigation will help in the diagnosis? (Q879137)

A. Insulin levels

B. Gastrin level

C. Urea breath test

D. 24 hr PH monitoring

Correct Answer: B. Gastrin level

Explanation: Correct Option B - Gastrin level: Recurrent, refractory gastric ulcers with a duodenal mass strongly suggest Zollinger–Ellison syndrome (gastrinoma) . The most appropriate diagnostic test is fasting serum gastrin level , which will be significantly elevated. Zollinger-Ellison Syndrome (ZES) Tumor Location Duodenal loop, Pancreas (head) Causes Persistent peptic ulceration Historical Recognition Severe peptic ulcers unresponsive to surgery pre-PPI era. The use of proton pump inhibitors has made the condition controllable but harder to recognize. Types Sporadic, MEN type I (with parathyroid adenoma) Common Locations Gastrinoma Triangle (cystic duct/common bile duct, duodenum, pancreas) Detection Small nodules in duodenal wall, endoscopic and surgical inspection needed Course Indolent for some malignant gastrinomas Treatment Palliative liver resection, liver transplantation, surgical removal for palliation in MEN type I as they are incurable. Prognosis Worse for tumors outside gastrinoma triangle Incorrect Options: Insulin levels (Option A): Evaluates for insulinoma , not indicated in ulcer disease or duodenal masses. Urea breath test (Option C): Detects H. pylori , but does not explain a mass in the duodenum or recurrent severe ulcers. 24-hour pH monitoring (Option D): Used for diagnosing GERD , not for evaluating recurrent ulcers or duodenal tumors.

References:

Bailey & Love’s Short Practice of Surgery, 28th Edition, Page 1179,1180

↑ *Back to this question in Part A*

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Q181: Arrange the steps of hernioplasty: 1. Skin incision 2. Identify the sac and reduce the content 3. Place the mesh 4. Close the wound (Q879145)

A. 1 → 2 → 3 → 4

B. 1 → 3 → 2 → 4

C. 2 → 1 → 3 → 4

D. 1 → 2 → 4 → 3

Correct Answer: A. 1 → 2 → 3 → 4

Explanation: Correct Option A - 1 → 2 → 3 → 4: The correct sequence of steps in a standard open inguinal Lichtenstein Hernioplasty is: Skin incision - Access to the inguinal canal Identify the hernia sac and reduce contents - Essential surgical step Place the mesh - Tension-free repair Close the wound - Final step.

References:

Bailey & Love’s Short Practice of Surgery, 28th Edition, Page 1068-1070

↑ *Back to this question in Part A*

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Q182: A 20-year-old male presents with pain in the right iliac fossa for 4 days, associated with fever and vomiting. On examination, a tender, palpable mass is felt in the right iliac fossa. He is diagnosed with an appendicular lump. Which of the following statements is incorrect regarding this condition? (Q879226)

A. Ochsner– Sherren regimen is the initial treatment

B. Ultrasonography is useful in evaluation

C. Interval appendectomy is mandatory in all cases

D. Appendicular lump is a complication of acute appendicitis

Correct Answer: C. Interval appendectomy is mandatory in all cases

Explanation: An appendicular lump is a localized inflammatory mass formed as a complication of acute appendicitis. The standard initial management is conservative treatment (Ochsner–Sherren regimen). This allows inflammation to subside and avoids operative complications. Interval appendectomy is not mandatory after successful conservative management. Many patients remain asymptomatic without surgery. Appendectomy is reserved for recurrent symptoms or complications. Incorrect Options: Option A) Ochsner–Sherren regimen is the initial treatment : Standard conservative management including NPO, IV fluids, antibiotics, and observation. Option B) Ultrasonography is useful in evaluation : Helps confirm the lump and rule out abscess formation. Option D)Appendicular lump is a complication of acute appendicitis : Caused by localized inflammatory mass formed by omentum and bowel loops around the appendix.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1343,1344

↑ *Back to this question in Part A*

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Q183: What type of hernia is a funicular hernia ? (Q32236)

A. Direct inguinal hernia

B. Indirect inguinal hernia

C. Femoral hernia

D. Umbilical hernia

Correct Answer: B. Indirect inguinal hernia

Explanation: Correct Option B - Indirect inguinal hernia: The funicular is a type of indirect inguinal hernia. An indirect inguinal hernia occurs as a failure of the processus vaginalis to close. It passes lateral to the inferior epigastric artery. Incorrect Options: Option A - Direct inguinal hernia: Direct inguinal hernia occurs due to a defect in the transversalis fascia. Option C - Femoral hernia: It protrudes below the inguinal ligament , lateral to the pubic tubercle. Option D - Umbilical hernia: An umbilical hernia can occur when fatty tissue or a part of the bowel protrudes into an area near the umbilicus.

References:

A manual on clinical surgery by S. Das, 9th edition, page no. 598

↑ *Back to this question in Part A*

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Q184: Which of the following is the most common type of anorectal fistula ? (Q513252)

A. Intersphincteric

B. Trans-sphincteric

C. Suprasphincteric

D. Extrasphincteric

Correct Answer: A. Intersphincteric

Explanation: Correct Option A - Intersphincteric: Based on Park's classification , the most common type of anal fistula is intersphincteric. Incorrect Options: Option B - Trans-sphincteric: Trans-sphincteric is the second most common type of anal fistula. Option C - Suprasphincteric: They can be iatrogenic . Option D - Extrasphincteric: They usually result from pelvic disease or trauma .

References:

Bailey and Love's short practice of surgery, 27 th edition

↑ *Back to this question in Part A*

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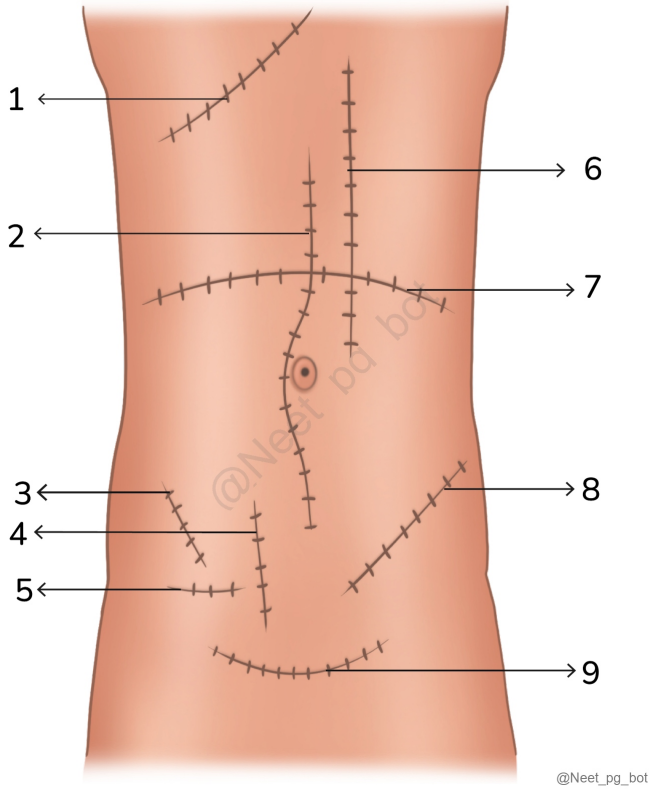
Q185: A 23-year-old male had acute appendicitis 3 days ago and presented to the surgery department with abdominal pain and tenderness . Which of the following incisions would be appropriate for this condition? (Q793366)

A. 1

B. 2

C. 3

D. 5



Correct Answer: C. 3

Explanation: Correct Option C - 3: The appropriate incision for acute appendicitis is McBurney's incision. It is in right lower quadrant of the abdomen, approximately one-third of the distance from the anterior superior iliac spine (ASIS) to the umbilicus. The incision is usually 4-5 cm long and is oriented obliquely with the upper end towards the ASIS. Incorrect Options: Option A - 1: Kocher's incision is a subcoastal incision to gain access for gall bladder and biliary tree pathology. Option B - 2: Midline incision -This type of incision is typically used for surgeries involving multiple organs or structures, such as bowel resections Option D - 5: Lanz incision -It is typically used for surgeries involving the descending colon and rectum.

References:

Prepladder Notes

↑ *Back to this question in Part A*

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Q186: A 45-year-old alcoholic with a history of binge drinking presents with an episode of vomiting bright red blood . His vitals are stable. An endoscopy was performed, an image of which is given below; what is the probable diagnosis here? (Q793397)

A. Tension pneumothorax

B. Boerhaave syndrome

C. Mallory Weiss Tear

D. Gastric ulcer perforation



Correct Answer: C. Mallory Weiss Tear

Explanation: Correct Option C - Mallory Weiss Tear: The most probable diagnosis for a 45-year-old alcoholic with a history of binge drinking who presents with an episode of vomiting bright red blood is Mallory Weiss Tear. Mallory Weiss Tear is a condition characterized by a tear between the esophagus and the stomach, known as the gastroesophageal junction. It is commonly associated with alcoholism and binge drinking, as well as with excessive vomiting and retching. Incorrect Options: Correct Option A - Tension pneumothorax: It typically presents with sudden onset shortness of breath, chest pain, and tachycardia and is a medical emergency that requires immediate intervention. Option B - Boerhaave syndrome: Boerhaave syndrome, also known as Spontaneous Esophageal Perforation, typically occurs due to forceful or repeated vomiting, predominantly

affecting males. Option D - Gastric ulcer perforation: Gastric ulcer perforation is when an ulcer in the stomach lining erodes through the stomach wall, leading to a hole or perforation.

References:

Prepladder Notes

↑ *Back to this question in Part A*

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Q187: What is the most probable cause of massive, sudden onset hematemesis in a 50-year-old patient with a history of chronic liver disease and chronic alcoholism, who has arrived at the emergency department? (Q793399)

A. Mallory Weiss tear

B. Bleeding esophageal varices

C. Boerhaave's syndrome

D. Perforated ulcer

Correct Answer: B. Bleeding esophageal varices

Explanation: Correct Option B - Bleeding esophageal varices: The most likely cause of massive, sudden onset hematemesis in a 50-year-old chronic alcoholic with a history of chronic liver disease is bleeding esophageal varices. As the portal hypertension worsens, pressure in the veins surrounding the liver increases, leading to the formation of collaterals or new blood vessels. These collaterals are fragile and can rupture easily, leading to massive bleeding. Incorrect Options: Option A - Mallory Weiss tear: Mallory Weiss tear refers to a tear in the mucous membrane at the junction of the esophagus and stomach, often caused by forceful vomiting or retching. Option C - Boer-haave's syndrome: Boer-haave's syndrome refers to a spontaneous rupture of the esophagus, typically caused by forceful vomiting or retching. Option D - Perforated ulcer: Perforated ulcer refers to a hole in the wall of the stomach or duodenum, typically caused by an ulcer.

References:

Prepladder Notes

↑ *Back to this question in Part A*

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Q188: A 3-day old neonat e presents abdominal distension and bilious vomiting . Among the following, which is the most appropriate investigation to diagnose the condition? (Q793487)

A. Barium swallow

B. Barium meal

C. Barium meal follow through

D. CECT abdomen

Correct Answer: D. CECT abdomen

Explanation: Correct Option D - CECT abdomen: The most appropriate investigation to diagnose the condition in a 3-day-old neonate with abdominal distension and bilious vomiting is a CECT (Contrast-enhanced computed tomography) abdomen. Incorrect Options: Option A, B & C - Barium swallow, Barium meal & Barium meal follow through: Ingestion of a significant amount of barium, which can be harmful to a newborn's delicate digestive system.

References:

Prepladder Notes

↑ *Back to this question in Part A*

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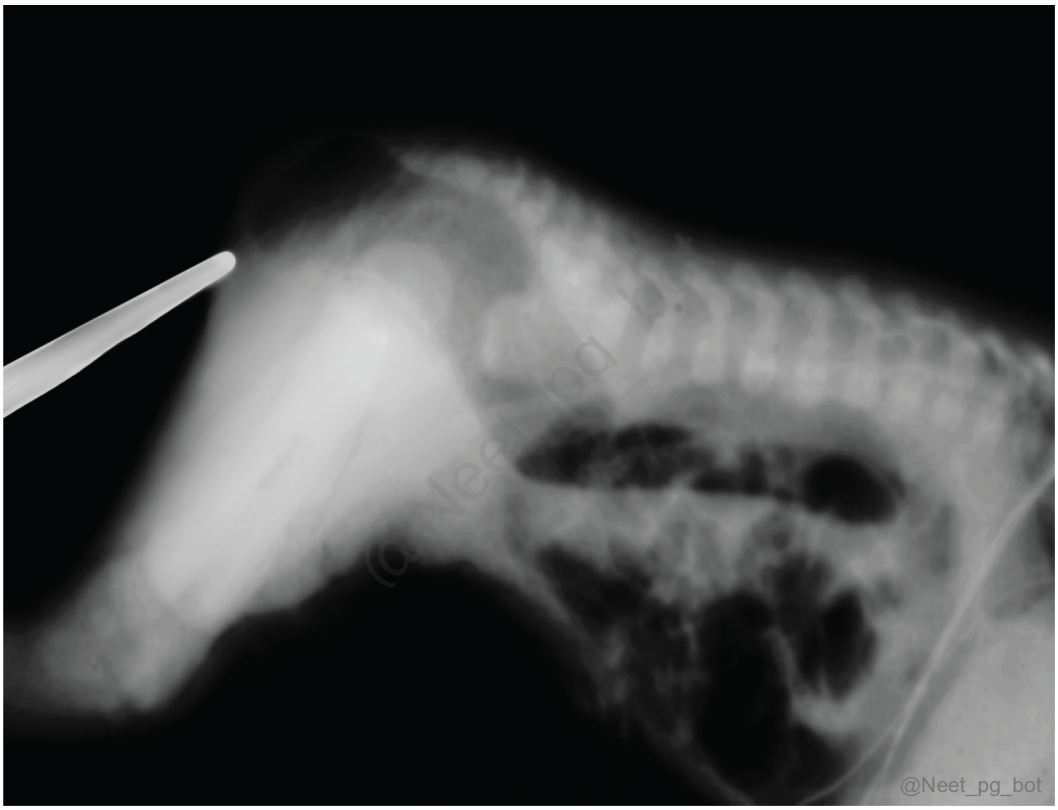
Q189: Identify the pathology in the given radiograph of a newborn .: (Q793490)

A. Meningocele

B. Imperforate anus

C. Congenital megacolon

D. Pyloric stenosis



Correct Answer: B. Imperforate anus

Explanation: Correct Option B - Imperforate anus: The given radiograph of a newborn indicates the presence of an imperforate anus. The radiograph shows the absence of a normal gas pattern in the rectum and sigmoid colon, which is indicative of an obstruction. This is further supported by the presence of a distended abdomen, which is a common symptom of an imperforate anus. Incorrect Options: Option A - Meningocele: This condition is not visible on a radiograph of the abdomen. Option C - Congenital megacolon: This condition can cause abdominal distension, but it does not involve the anus and would not show an absence of gas in the rectum and sigmoid colon. Option D - Pyloric stenosis: This condition can cause vomiting and dehydration, but it would not affect the anus and would not cause the absence of gas in the rectum and sigmoid colon.

References:

Prepladder Notes

↑ *Back to this question in Part A*

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Q190: Which of the following is the best investigation to establish a diagnosis of GERD ? (Q793499)

A. 24 hours ambulatory pH monitoring

B. Upper GI endoscopy

C. CECT

D. MRI

Correct Answer: A. 24 hours ambulatory pH monitoring

Explanation: Correct Option A - 24 hours ambulatory pH monitoring: 24-hour ambulatory pH monitoring is the best investigation to establish a diagnosis of GERD. It involves the insertion of a small probe through the nose into the esophagus to monitor acid levels in the esophagus over a 24-hour period. This test can help to identify episodes of acid reflux and assess the severity of the condition. Incorrect Options: Option B - Upper GI endoscopy: It can help to identify esophageal inflammation, ulcers, or other structural abnormalities that may be contributing to symptoms, but it may not always detect the presence of acid reflux. Option C & D: CECT & MRI are of no use in GERD.

References:

Prepladder Notes

↑ *Back to this question in Part A*

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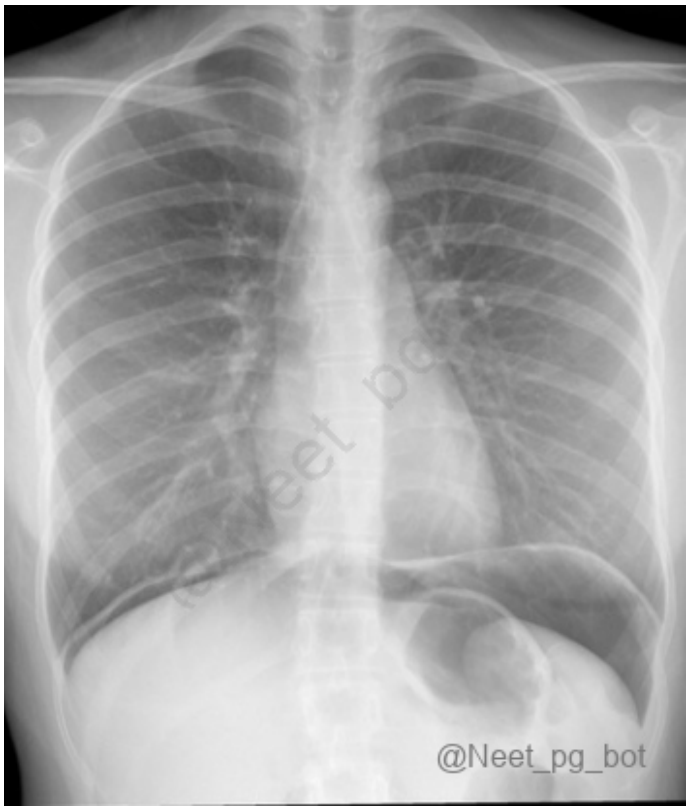
Q191: A 42-year-old alcoholic and a chronic smoker presented with bouts of vomiting and stabbing pain in the epigastrium . He was binge drinking shortly before the symptoms started. He is febrile and tachycardic . The given findings were seen on bedside radiological imaging. Which among the following is a likely cause of this? (Q793502)

A. Tension pneumothorax

B. Peptic ulcer perforation

C. Boerhaave syndrome

D. Mallory Weiss tear



Correct Answer: B. Peptic ulcer perforation

Explanation: Correct Option B - Peptic ulcer perforation: The likely cause of the patient's symptoms and findings on the bedside radiological imaging is Peptic ulcer perforation. Bedside radiological imaging may show the presence of free air in the peritoneal cavity, a classic finding in patients with a perforated peptic ulcer. The patient's fever and tachycardia may be due to the systemic inflammatory response caused by peritonitis. Incorrect Options: Option A - Tension pneumothorax: Tension pneumothorax is characterized by the presence of air in the pleural cavity, causing compression of the lung and mediastinal shift. Option C - Boerhaave syndrome: Boerhaave syndrome is a rare but life-threatening condition characterized by a spontaneous rupture of the esophagus, usually because of prolonged vomiting. Option D - Mallory Weiss tear: Mallory Weiss tear is a condition in which there is a tear in the mucosa at the junction of the esophagus and stomach, usually caused by excessive vomiting or retching.

References:

Prepladder Notes

↑ *Back to this question in Part A*

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Q192: Which of the following is the most common deficiency observed after gastric bypass /bariatric surgery ? (Q793518)

A. Iron

B. Copper

C. Zinc

D. Calcium

Correct Answer: A. Iron

Explanation: Correct Option A - Iron: Iron is the most common mineral deficiency seen after gastric bypass surgery. The stomach produces hydrochloric acid, which helps to break down food and release iron from it. After gastric bypass surgery, the amount of stomach acid produced is reduced, leading to decreased iron absorption. This can result in iron deficiency anemia, which can cause symptoms such as fatigue, weakness, and shortness of breath. Incorrect Options: Option B - Copper: Copper deficiency is also relatively common after bariatric surgery, particularly in people who have undergone malabsorptive procedures, but it is not the most common one.. Option C - Zinc: Zinc deficiency can occur after bariatric surgery, especially in people who have undergone malabsorptive procedures. Symptoms of zinc deficiency include hair loss, skin lesions, and impaired immune function. Option D - Calcium: Calcium deficiency is less common than iron, copper, or zinc deficiency after bariatric surgery, but it can still occur.

References:

Prepladder Notes

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Q193: An elderly man underwent Roux-en-Y gastric bypass surgery for obesity . He now presents to his physician with complaints of dizziness, fatigue, and tremors 2 hours after the ingestion of a carbohydrate-rich meal . His symptoms occur mainly due to 1. Hypoglycemia 2. Small volume of food intake 3. High osmotic load of food 4. Increased release of insulin 5. Increased release of glucagon (Q793528)

A. 1, 2 and 5

B. 1, 3 and 5

C. 1 and 4

D. 3 and 5

Correct Answer: C. 1 and 4

Explanation: of the correct option. Incorrect Statements (2) Small volume of food intake: Dumping syndrome is characterized by the rapid emptying of the stomach contents into the small intestine, after consuming a regular or large meal. (3) High osmotic load of food is incorrect because dumping syndrome does involve hyperosmolar contents being rapidly emptied into the jejunum. (5) Increased release of glucagon is incorrect because dumping syndrome leads to an increased release of insulin, not glucagon.

References:

Prepladder Notes

↑ *Back to this question in Part A*

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Q194: A young adult with gastric outlet obstruction presents with vomiting . Which of the following fluids is preferred in this patient for initial resuscitation ? (Q793531)

A. Normal saline

B. Ringer lactate

C. 5% dextrose in water

D. 20% dextrose in water

Correct Answer: A. Normal saline

Explanation: Correct Option A - Normal saline: Normal saline is an isotonic solution that is similar in composition to extracellular fluid. It is the preferred fluid in this condition as it helps to maintain fluid and electrolyte balance, does not affect gastric pH, and does not stimulate gastric secretions. Incorrect Options: Option B - Ringer lactate : it contains lactate, which can increase gastric acid production and worsen vomiting. Option C - 5% dextrose in water: 5% dextrose in water are hypertonic solution that can worsen fluid overload and hyponatremia in patients with gastric outlet obstruction. Option D - 20% dextrose in water: 20% dextrose in water are hypertonic solution that can worsen fluid overload and hyponatremia in patients with gastric outlet obstruction.

References:

Prepladder Notes

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Q195: A 34 years old female with a history of alcohol intake was taking NSAIDs for abdominal pain . She developed severe pain in the whole abdomen . A radiograph is

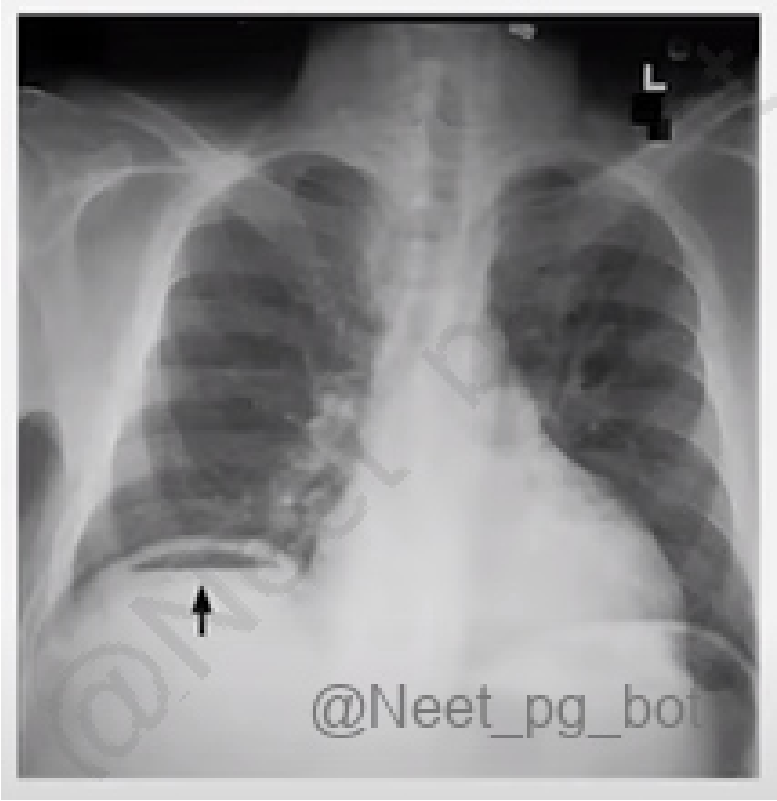
given below. What is the diagnosis? (Q793857)

A. Rupture of ectopic pregnancy

B. Acute pancreatitis

C. Perforated liver abscess

D. Hollow viscus perforation



Correct Answer: D. Hollow viscus perforation

Explanation: Correct Option D - Hollow viscus perforation: The radiograph in question shows air under the diaphragm, which indicates pneumoperitoneum. This finding is consistent with the diagnosis of "hollow viscus perforation." There is a tear in gastrointestinal organs like the stomach or intestines, causing leakage of digestive fluids and waste into the abdomen, leading to inflammation and potential infection. Incorrect Options: Option A - Rupture of ectopic pregnancy: Rupture of an ectopic pregnancy can cause internal bleeding and abdominal pain, but it typically does not cause pneumoperitoneum, as seen in the radiograph. Option B - Acute pancreatitis: it does not usually cause pneumoperitoneum, as seen in the radiograph. Option C - Perforated liver abscess: it typically does not cause pneumoperitoneum, as seen in the radiograph.

References:

Prepladder Notes

↑ *Back to this question in Part A*

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Q196: What is the diagnosis of a patient who had a bronchospasm history, and was found to have a tumor in their ileum along with elevated levels of 5-hydroxy indoleacetic acid in their urine? (Q793867)

A. Carcinoid tumor

B. Neuroblastoma

C. Leiomyoma

D. Chromaffinoma

Correct Answer: A. Carcinoid tumor

Explanation: Correct Option A - Carcinoid tumor: One of the hallmark features of carcinoid tumors is the secretion of serotonin, which can lead to elevated levels of urinary 5-hydroxy indole acetic acid (5-HIAA). This is because serotonin is converted to 5-HIAA in the liver and then excreted in the urine. Incorrect Options: Option B - Neuroblastoma: It is most commonly diagnosed in infants and young children and can cause symptoms such as abdominal swelling or pain, fever, and weight loss. Option C - Leiomyoma: Leiomyoma is a benign tumor arising from smooth muscle tissue and can occur in various parts of the body (including the uterus, gastrointestinal tract, and skin). Option D - Chromaffinoma: Chromaffinomas can cause symptoms such as high blood pressure, palpitations, sweating, and headache but do not typically secrete serotonin or cause elevated 5-HIAA levels (although they can secrete other hormones such as adrenaline and noradrenaline)

References:

Prepladder Notes

↑ *Back to this question in Part A*

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• [05_Gastrointestinal Surgery] 033 Previous Year Questions

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[05_Gastrointestinal Surgery] 033 Previous Year Questions — Quick Jump

Q1 (p. 2450) *Q2 (p. 2450)* *Q3 (p. 2451)* *Q4 (p. 2452)* *Q5 (p. 2455)* *Q6 (p. 2457)* *Q7 (p. 2458)*

Q1: Which of the following is not a layer of esophagus? (Q820123)

A. Mucosa

B. Submucosa

C. Serosa

D. Muscularis

Correct Answer: C. Serosa

Explanation: Correct option C - Serosa The esophagus contains 4 layers: Mucosa (Option A) Submucosa (Option B) Muscularis propria (Option D) Tunica adventitia

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1107

↑ *Back to this question in Part A*

@Neet_pg_bot

Q2: Which of the following is/are complications associated with GERD? Asthma Laryngitis Pulmonary Fibrosis Chronic cough (Q839982)

A. 1,2

B. 1,2,4

C. 1,2,3

D. 1,2,3,4

Correct Answer: D. 1,2,3,4

Explanation: Correct Option D - 1, 2, 3, 4: Asthma, laryngitis, pulmonary fibrosis, and chronic cough are all complications of GERD. Incorrect Options: Options A, B and C: These options are incorrect.

↑ *Back to this question in Part A*

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Q3: A 1.5-month-old male infant presents to the outpatient department with vomiting after feeding and failure to thrive . On examination, a firm, olive-shaped mass is palpated in the upper abdomen . What is the most likely diagnosis? (Q852714)

A. Subacute Intestinal Obstruction

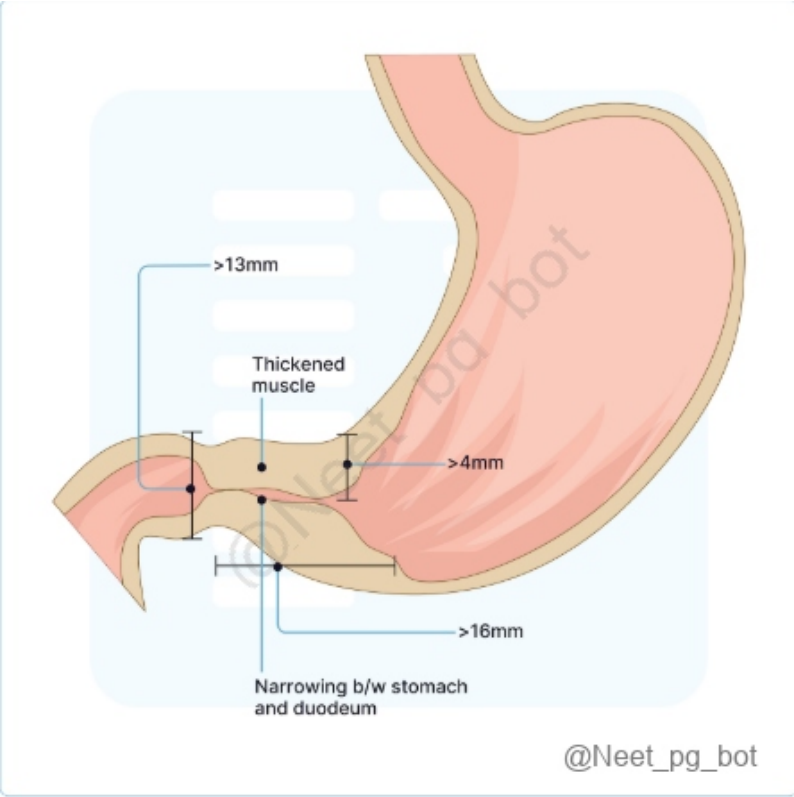
B. Pyloric Stenosis

C. GERD

D. Esophageal Atresia

Correct Answer: B. Pyloric Stenosis

Explanation: Projectile, non-bilious vomiting is the hallmark of infantile hypertrophic pyloric stenosis (IHPS) . The presence of a firm, olive-shaped mass in the epigastric region (hypertrophied pylorus) is a classic finding. Failure to thrive occurs due to chronic vomiting and dehydration . Ultrasound confirms the diagnosis by showing thickened pyloric muscle (>3mm thickness, >14mm length) . Hypertrophic Pyloric Stenosis (HPS) Feature Description Age of Presentation 3-6 weeks of life Symptoms Projectile, non-bilious vomiting Physical Exam Olive-shaped mass in epigastrium Diagnosis Ultrasound: Pyloric muscle hypertrophy Treatment Ramstedt's pyloromyotomy Subacute Intestinal Obstruction (Option A): Incorrect because it typically presents with bilious vomiting and distended abdomen , not an olive-shaped mass . GERD (Option C): Incorrect because GERD causes effortless regurgitation without an olive-shaped mass or projectile vomiting. Esophageal Atresia (Option D): Incorrect because it presents at birth with excessive drooling, choking, and respiratory distress , not progressive vomiting.



↑ *Back to this question in Part A*

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Q4: A 45-year-old man complained of recurrent discharge and pain due to lesions around the anus for 3 years. What is the diagnosis? (Q855580)

A. Pilonidal sinus

B. Carbuncle

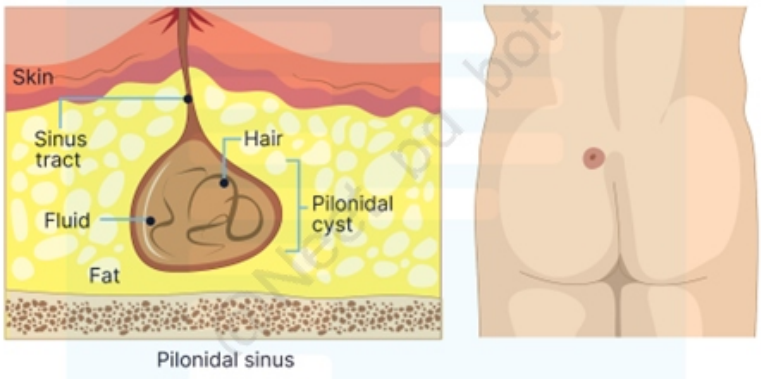
C. Boil

D. Fistula in ano



Correct Answer: D. Fistula in ano

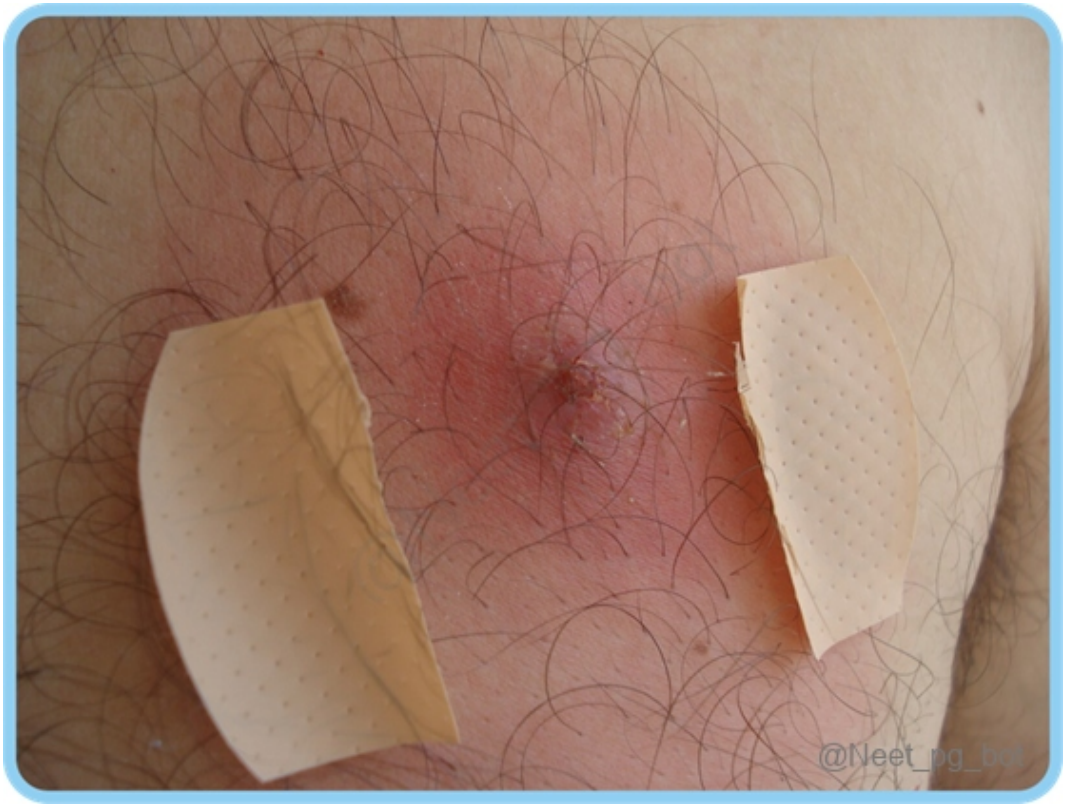
Explanation: The patient's history of recurrent discharge and pain due to lesions around the anus for 3 years suggests fistula in ano. A chronic abnormal communication between the anorectal lumen (internal opening) and an external opening on the skin of the perineum, buttock, or, rarely, the vagina in women. Fistula in ano Causes Idiopathic/Cryptoglandular: The most common cause, often associated with prior anorectal sepsis. Associated Conditions: Crohn’s disease Tuberculosis Lymphogranuloma venereum Actinomycosis Rectal duplication Foreign bodies Malignancy (rare, can develop within a longstanding fistula) Clinical features Intermittent purulent discharge: This may be bloody and purulent. Discomfort typically increases until the pus discharges, providing temporary relief. Previous history of Anorectal abscess Passage of flatus or faeces: Through the external opening (indicative of a rectal rather than an anal internal opening). Pilonidal sinus (Option A) is found in the natal cleft (the groove at the top of the buttocks), consisting of one or more skin openings connected to a subcutaneous track lined with granulation tissue, often containing hair; it is not located typically around the anus. Carbuncle (Option B) is a skin infection consisting of several boils that form a connected area of infection. It typically presents as a painful, swollen area of the skin, not as chronic drainage around the anus. {{caption_text}} Boil (Option C) or furuncle is a perifollicular abscess that typically has an erythematous, indurated, tender nodule with a pus point. While it can present near the anus, the chronic nature and recurrent discharge suggest a fistula, not a boil. {{caption_text}}



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References:

SRB’s Manual of Surgery, 6th Edition, Page 972

Bailey and Love’s Short Practice of Surgery, 28th Edition, Pages 1436, 1437

↑ *Back to this question in Part A*

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Q5: Which of the following gene mutations are involved in carcinoma of the colon? (Q856243)

A. APC, BRCA, k-ras

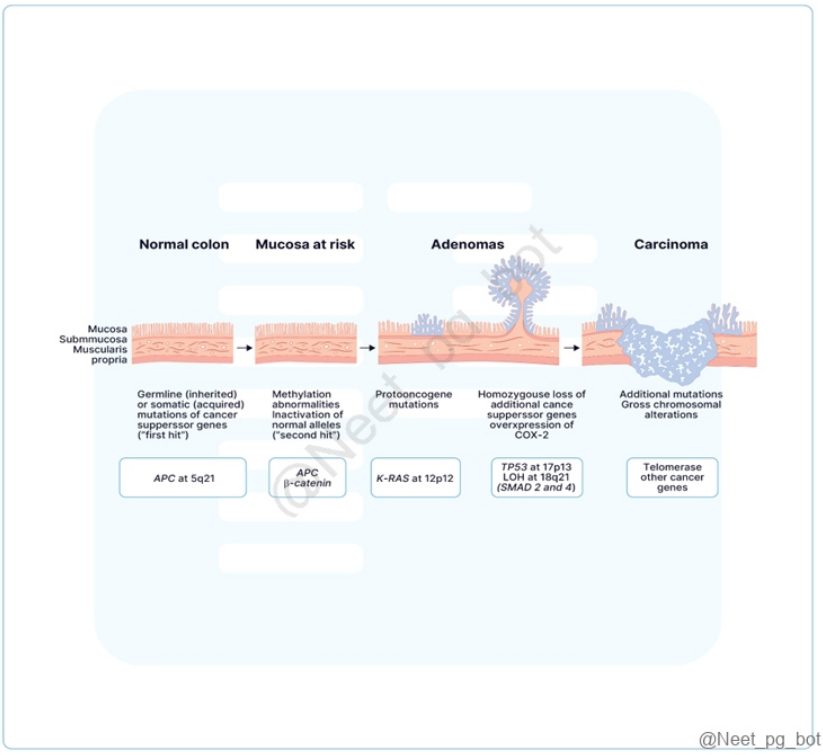
B. APC, k-ras, p53

C. MYh, K-RAS, APC

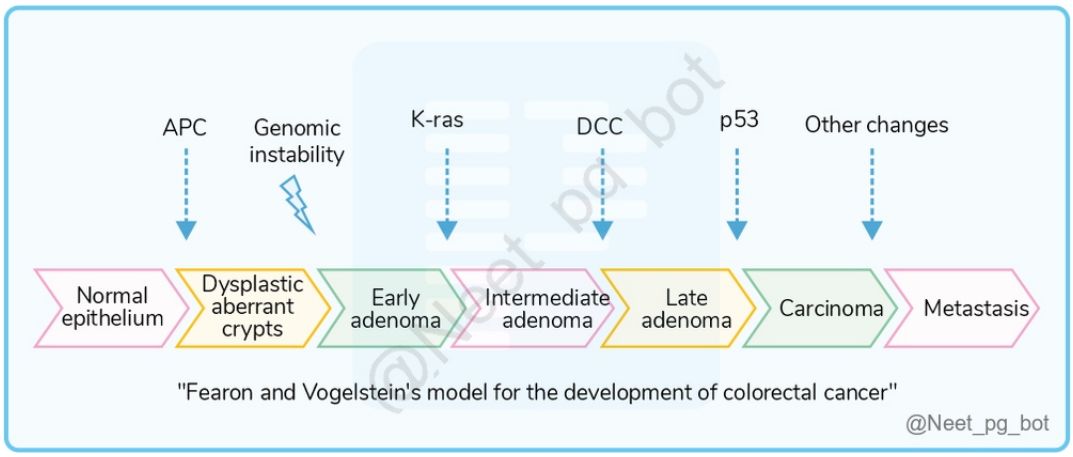
D. MYH, p53, DCC

Correct Answer: B. APC, k-ras, p53

Explanation: The genes associated with the development of colorectal carcinoma are APC, k-ras, p53 & SMAD4. Adenoma-Carcinoma Sequence: Accounts for up to 80% of sporadic cancers. APC Gene Mutations: Leads to β-catenin accumulation and Wnt pathway activation. "First hit": Sporadic inactivation of APC. "Second hit": Loss of second APC copy K-ras Mutations: Promote growth and prevent apoptosis. SMAD2 and SMAD4 Mutations: Disrupt TGF-β pathway, causing uncontrolled proliferation. p53 Mutations: Occur in later stages of tumour progression. colorectal cancer" data-author="" data-hash="12179" data-license="" data-source="" data-tags="May2025" height="210" src="" width="500" /> Fearon and Vogelstein's model for the development of colorectal cancer APC, BRCA, k-ras (Option A): BRCA mutations are more commonly associated with breast and ovarian cancers, not colon cancer. MYh, K-RAS, APC (Option C): MYH-associated polyposis (MAP) is a rare autosomal recessive condition caused by mutations in the MUTYH gene. It can increase the risk of colorectal cancer, but MUTYH gene mutations are not directly associated with colon cancer. MYH, p53, DCC (Option D): MYH-associated polyposis (MAP) is a rare autosomal recessive condition caused by mutations in the MUTYH gene. It can increase the risk of colorectal cancer, but MUTYH gene mutations are not directly associated with colon cancer.



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References:

Robbins and Cotran Pathologic Basis of Disease, 10th Edition, Page 815

↑ *Back to this question in Part A*

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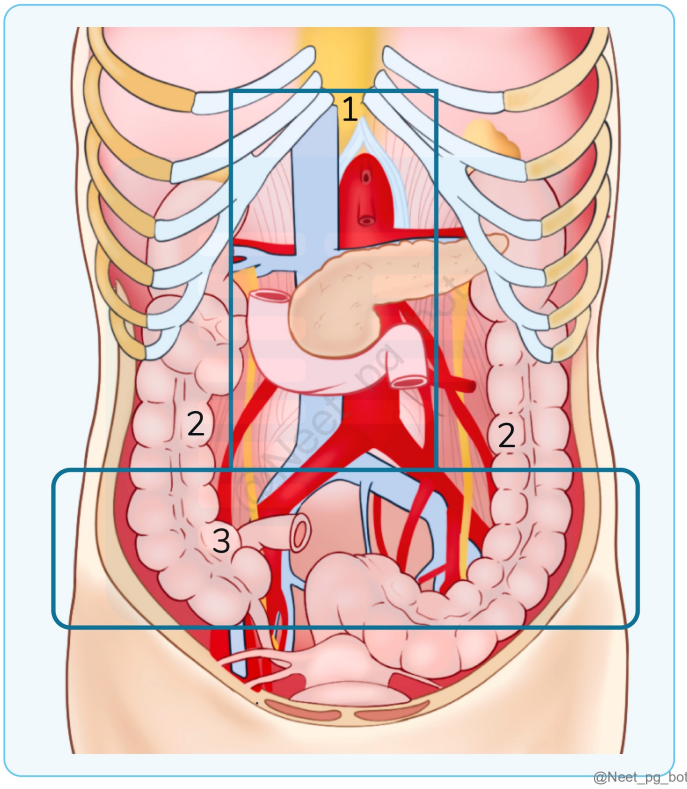
Q6: Mandatory exploration is required in the injuries. Which zones of retroperitoneum are required? (Q859819)

A. 1

B. 2

C. 3

D. 1 & 3



Correct Answer: A. 1

Explanation: Mandatory exploration is generally required for injuries in Zone 1 of the retroperitoneum. Zones of retroperitoneum Zones 1 2 3 Location Central Lateral Pelvic (retroperitoneal zone of the pelvis) Structures involve The aorta & its proximal branches Inferior vena cava & its proximal tributaries Distal renal vessels Iliac vessels Management (Other options ruled out) Exploration with proximal & distal vascular control Lateral hematoma (renal in origin) - managed nonoperatively (angioembolization) Pulsatile hematoma or penetrating injury present - exploration. Pelvic hematoma is exceptionally difficult to control. Usually, it should not be opened. It is managed by packing/angioembolisation. Explored only if there is expanding or pulsatile or penetrating injury present.

References:

Sabiston, Text Book of Surgery, 21st Edition, Page 423,

Bailey and Love's Short Practice of Surgery, 28th Edition, Pages 382, 383

↑ *Back to this question in Part A*

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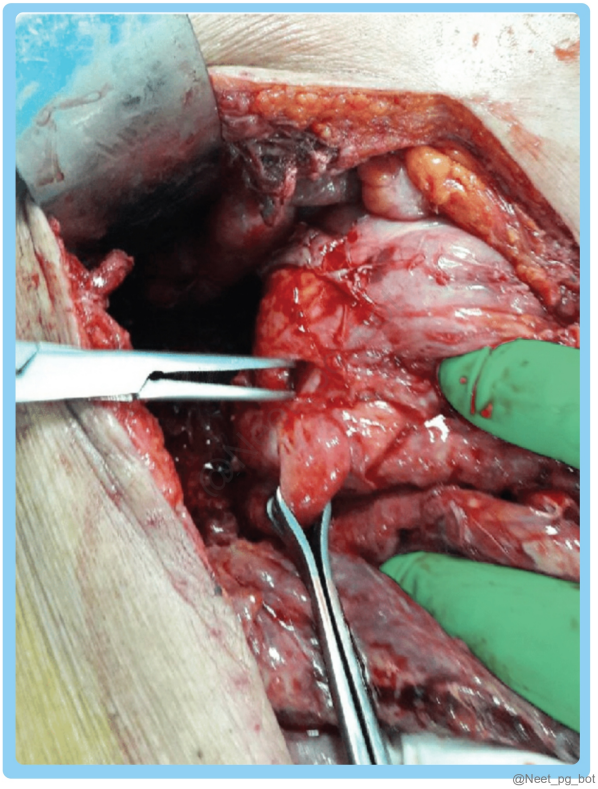
Q7: An alcoholic male patient diagnosed with hollow viscus perforation is taken up for laparotomy. Intraoperatively, a 2 cm perforation is seen in the duodenal region, as shown below. How can this patient be managed? (Q860458)

A. Primary closure of the defect

B. Omental pedicle repair

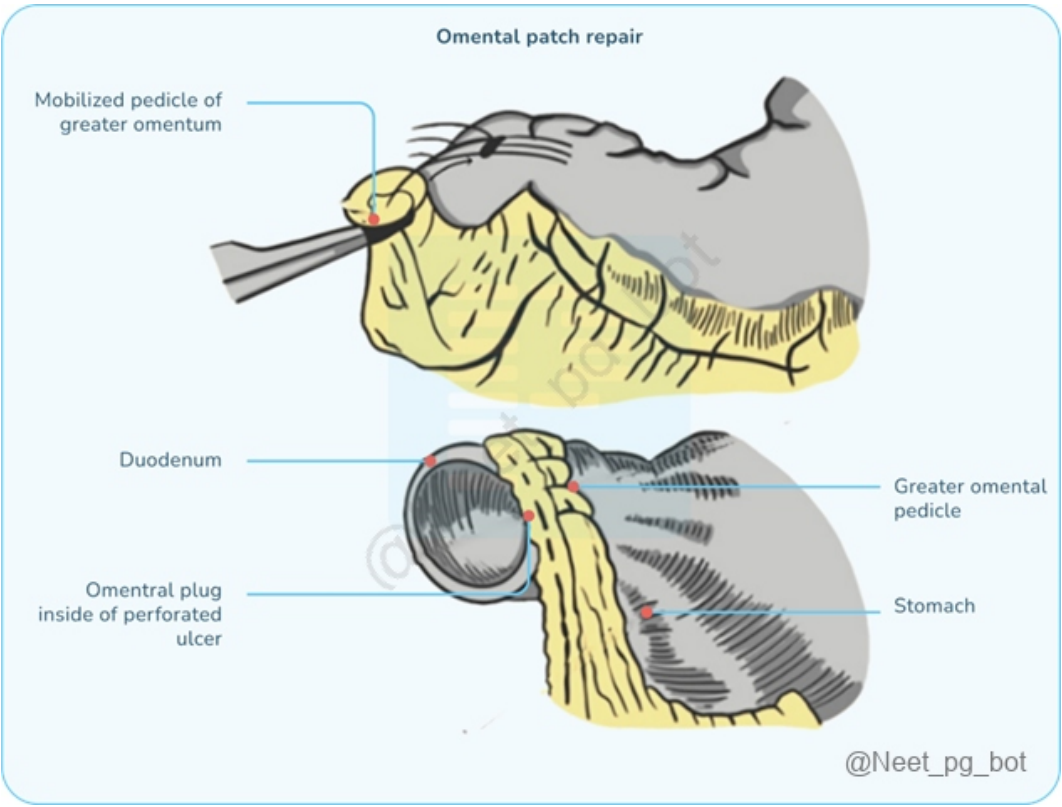
C. Billroth I

D. Billroth II



Correct Answer: B. Omental pedicle repair

Explanation: In case of a duodenal perforation , omental pedicle repair is the preferred method of treatment. The omentum , a highly vascular tissue, is mobilised and placed over the perforation. This provides a biological seal and promotes healing while reducing the risk of infection or further leakage. Duodenal ulcer perforation: Common with anterior duodenal ulcers. Presents with an acute abdomen with sudden-onset, severe epigastric pain, rebound tenderness, and air under the diaphragm in the radiograph. Management: Non-surgical: Nil per-oral IV antibiotics and PPIs Surgical: Initial empirical antibiotic treatment. The perforation is approached by a small upper midline incision Perforations <1cm are closed primarily and buttressed with a well-vascularized omentum Larger perforations & with fibrotic edges: Modified Graham's Repair or Omental Patch Repair. The vascularized pedicle of the greater omentum is patched over the defect. Bleeding duodenal ulcer: A posterior duodenal ulcer is the one that usually bleeds. It is due to the involvement of the gastroduodenal artery . This leads to hematemesis, melena or both i.e., an upper GI bleed. Bleeding is commonly associated with intake of NSAIDs . Management: Endoscopic: Done to find the bleeding source and manage bleeds endoscopically. Injection , thermal coagulation, plasma argon coagulation, mechanical clips, and fibrin glue are the methods used. (with or without adrenaline injection). Angiographic management: If endoscopic management fails. Surgical management: Exposure to the ulcer and ligation of the duodenum are the principles here. Duodenotomy Ligation of the bleeding vessel with truncal vagotomy with pyloroplasty



References:

Sabiston Textbook of Surgery, 20th Edition, Page 1210-1214

↑ *Back to this question in Part A*

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• [06_Urology] 034 Renal Stones Infections Disorders Of Kidney Hydronephrosis And Genitourinary Tuberculosis

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[06_Urology] 034 Renal Stones Infections Disorders Of Kidney Hydronephrosis And Genitourinary Tuberculosis — Quick Jump

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Q7 (p. 2468)	*Q8 (p. 2469)*	*Q9 (p. 2471)*	*Q10 (p. 2471)*	*Q11 (p. 2475)*	*Q12 (p. 2476)*
Q13 (p. 2478)	*Q14 (p. 2479)*	*Q15 (p. 2480)*	*Q16 (p. 2481)*	*Q17 (p. 2485)*	*Q18 (p. 2485)*

Q1: A urologist is teaching medical students about the causes of hydronephrosis. When discussing bilateral hydronephrosis, which of the following conditions is not typically associated with this presentation? (Q849270)

A. Bladder neck stenosis

B. Benign prostatic hyperplasia

C. Posterior urethral valve

D. Retrocaval ureter

Correct Answer: D. Retrocaval ureter

■ *Listen to Audio 1*

Explanation: Retrocaval ureter is not associated with bilateral hydronephrosis. It is associated with unilateral hydronephrosis. Unilateral Hydronephrosis Bilateral Hydronephrosis Extramural Causes: Advanced Malignancies Colorectal cancer Carcinoma cervix Carcinoma Prostate Retroperitoneal fibrosis Retrocaval Ureter (Option D) Congenital Causes: Posterior Urethral Valve (Option C ruled out) Urethral atresia Intramural Causes: PUJ Obstruction Ureterocele Ureteric Stricture Urothelial tumor Acquired Causes: Bladder neck stenosis (Option A ruled out) BPH (Benign Prostatic Hyperplasia) (Option B ruled out) CA Prostate Urethral strictures Intraluminal Causes: Stone Papillary Slough Due to: Analgesic nephropathy Sickle cell anemia

References:

SRB Manual of Surgery, 6th Edition, Page 1000, 1001

↑ *Back to this question in Part A*

@Neet_pg_bot

Q2: A male presents with a 3 cm stone in the middle calyx of the left kidney. Which of the following statements regarding the use of percutaneous nephrolithotomy (PCNL) in the management of this patient is correct? (Q849250)

A. PCNL involves creating a large flank incision to directly access the renal pelvis and remove the stone

B. PCNL is indicated for the treatment of renal stones larger than 2 cm in diameter or stones resistant to ESWL

C. PCNL is performed under general anesthesia, and the patient is required to remain immobilized for several days postoperatively

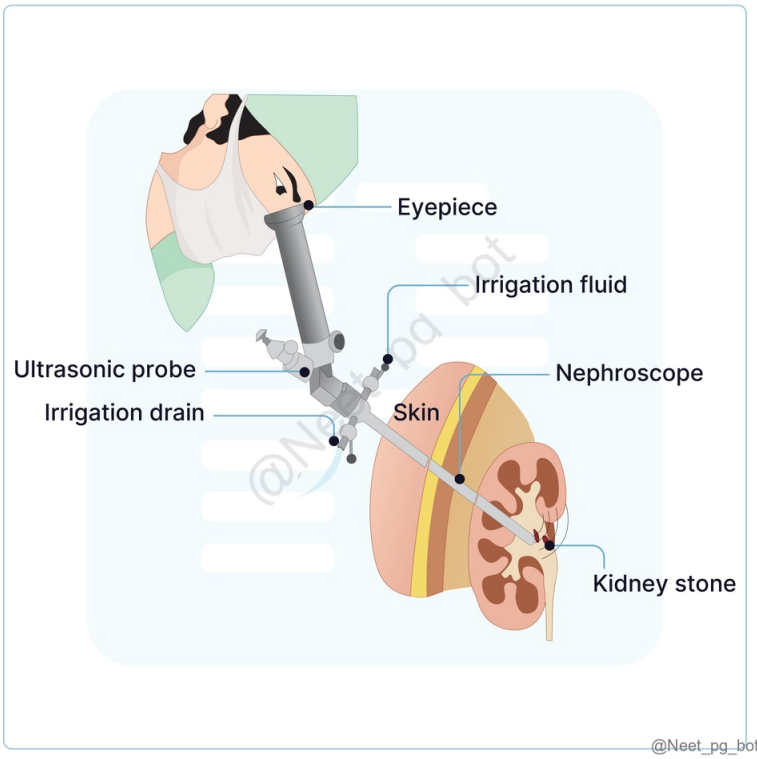
D. PCNL is contraindicated in patients with severe hydronephrosis or anatomical abnormalities of the urinary tract

Correct Answer: B. PCNL is indicated for the treatment of renal stones larger than 2 cm in diameter or stones resistant to ESWL

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: PCNL involves the creation of a small percutaneous tract through the skin, directly accessing the renal collecting system and is indicated for the treatment of renal stones larger than 2 cm in diameter or stones resistant to ESWL. Typically, this procedure is done in the prone position. Fluoroscopy or ultrasound is used for localisation. The posterolateral calyx is commonly chosen for entry. Principle of PCNL: PCNL involves the creation of a small percutaneous tract through the skin, directly accessing the renal collecting system. (Option A ruled out) Using this tract, the surgeon can then remove the stone using various instruments, such as forceps, baskets, or ultrasonic or pneumatic lithotripters. Indications for PCNL: Renal stones larger than 2 cm in diameter Stones resistant to or unsuitable for extracorporeal shock wave lithotripsy (ESWL) Stones in anomalous kidneys or in the setting of previous failed stone treatment (Option D ruled out) PCNL is typically performed under general anesthesia and the patient is generally encouraged to ambulate soon after the procedure. (Option C ruled out)



References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1477

↑ *Back to this question in Part A*

@Neet_pg_bot

Q3: In a 55-year-old male with sterile pyuria, flank pain, and a "moth-eaten" renal calyx appearance on CT, which test is the gold standard for confirming genitourinary tuberculosis? (Q849274)

A. Retrograde Pyelogram

B. Urine Culture & Sensitivity

C. Intravenous Pyelogram

D. Contrast-Enhanced CT

Correct Answer: B. Urine Culture & Sensitivity

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Genitourinary tuberculosis (GUTB) often presents with sterile pyuria , hematuria, and imaging features such as moth-eaten calyces . The gold standard for diagnosis is urine culture for Mycobacterium tuberculosis using 3 early-morning urine samples , as it confirms the presence of active infection. It is more specific than imaging and functional studies. Genitourinary Tuberculosis (GUTB) Feature Details Common symptoms Flank pain, dysuria, sterile pyuria, hematuria Key imaging findings Moth-eaten calyces, cortical scarring, shrunken kidney Gold standard diagnostic test Urine culture for M. tuberculosis (three early-morning samples) Other helpful tests PCR for TB, CT urogram, IVP for structural changes Typical CT/IVP appearance Irregular calyces, calcification, strictures, non-functioning kidney

References:

Bailey and Love's Short Practice of Surgery, 28th Edition, Page 1472, 1473

↑ *Back to this question in Part A*

@Neet_pg_bot

Q4: A 45-year-old man with a history of renal tuberculosis presents with increased urinary frequency and lower abdominal discomfort that has gradually worsened over the past few months. Imaging studies reveal significant fibrosis and a reduced bladder size. Which of the following features is present in the advanced stage, where the bladder is contracted? (Q849273)

A. Golf hole around the ureteric orifice

B. Calcification of bladder wall

C. The beaded appearance of the distal ureter

D. None of the above

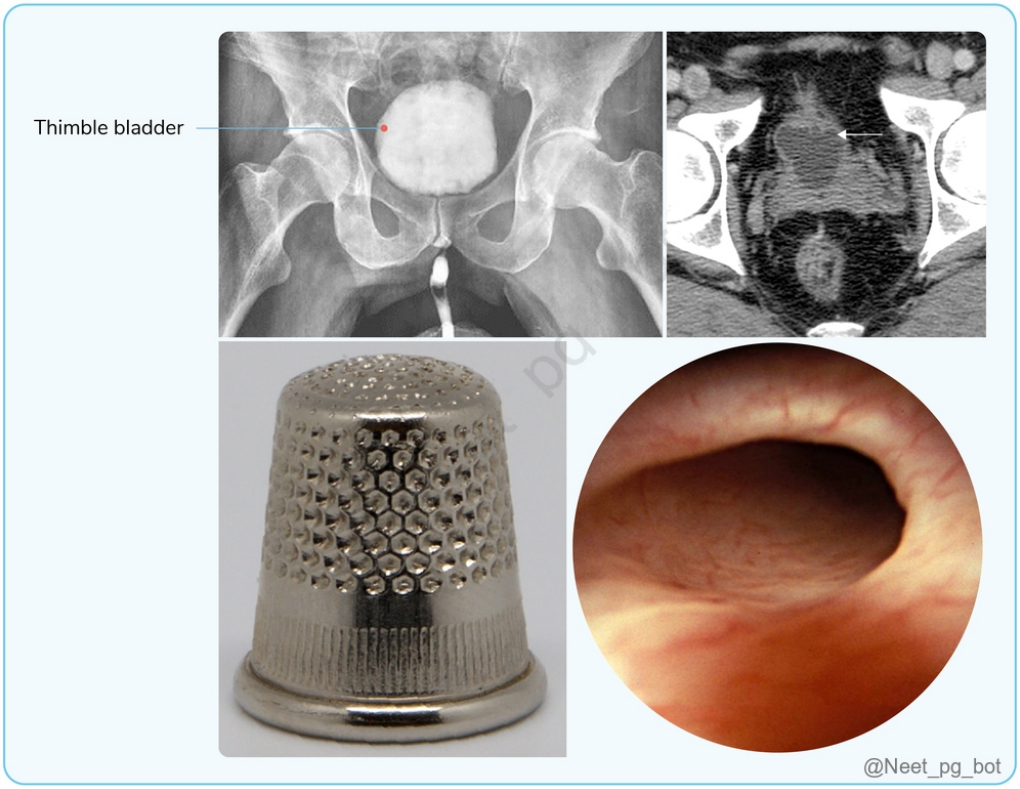
Correct Answer: A. Golf hole around the ureteric orifice

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The patient's history of renal tuberculosis with current symptoms and imaging findings, aligns most closely with Genitourinary Tuberculosis (GUTB) as the underlying cause of her bladder issues. In advanced cases, where the bladder is contracted, the ureteric orifices may appear as a "golf hole". Bladder TB: Infection Progression: The infection spreads from the ureter into the bladder, with an early sign observable during cystoscopy being pallor around the ureteric orifice in the bladder. Chronic Inflammation: This inflammation leads to the formation of tubercles in the bladder, followed by fibrosis. Bladder Changes: The fibrosis results in a small, contracted bladder with significantly reduced capacity, often referred to as a "thimble bladder." Advanced TB: In advanced cases, where the bladder is contracted, the ureteric orifices may appear as "golf hole" shapes. (Option A)

GUTB involving the prostate: Calcification: The affected area becomes calcified, resulting in a hard and nodular texture. (Option B ruled out) Testis: The testis is usually spared in cases of genitourinary tuberculosis. Characteristic Feature: A distinctive feature of tuberculosis is the "beaded" appearance of the vas deferens, often accompanied by multiple discharging sinuses through the scrotum. (Option C ruled out)



References:

Bailey and Love's Short Practice of Surgery, 28 Edition, Page 1472

↑ *Back to this question in Part A*

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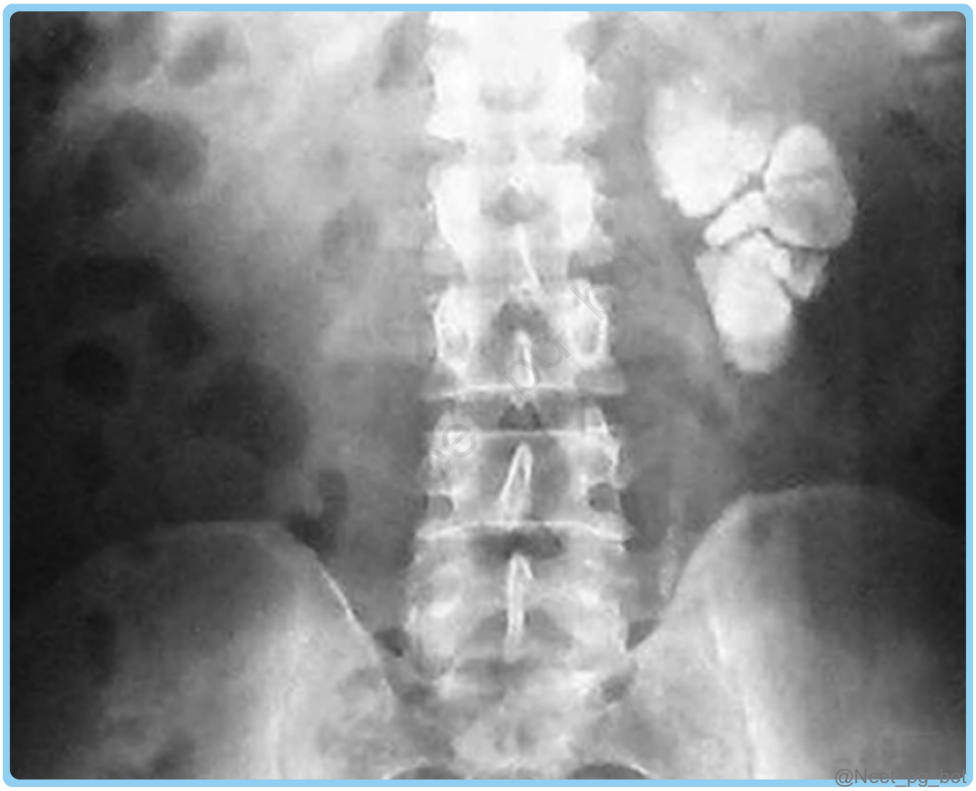
Q5: A 38-year-old male with a history of untreated pulmonary tuberculosis presents with symptoms of dysuria, hematuria, and flank pain, and noticed a gradual worsening of his symptoms. His laboratory tests are consistent with renal impairment. Which of the following features are seen in this condition? (Q849272)

A. Caseous necrosis and tissue destruction

B. Dystrophic calcification

C. Ureteric strictures and obstruction

D. All of the above



Correct Answer: D. All of the above

- *Listen (English)*
- *Listen (Hindi)*

Explanation: GUTB (Genitourinary TB) typically originates from the hematogenous spread of Mycobacterium tuberculosis from the lungs or thoracic lymph nodes. The bacteria lodge in the kidneys, triggering an inflammatory response causing tissue destruction, caseous necrosis, dystrophic calcification granuloma formation, and scarring and strictures in the ureter. The putty kidney is a sequela of genitourinary tuberculosis (GUTB) characterized by "extensive dystrophic calcification involving all or most of the kidney, seen as calcified non-functioning renal tissue. " It is the end stage of renal tuberculosis making the kidney non-functioning. Hematogenous spread and granuloma formation: GUTB typically originates from hematogenous spread of Mycobacterium tuberculosis from the lungs or thoracic lymph nodes. The bacteria lodge in the kidneys, triggering an inflammatory response that leads to the formation of granulomas. Caseous necrosis and tissue destruction : If the infection progresses, it can lead to caseous necrosis, a form of cell death characterized by a cheese-like appearance. This process destroys renal tissue, impairing kidney function. Ureteric strictures and obstruction : GUTB can also cause scarring and strictures in the ureters. These strictures obstruct the flow of urine, leading to hydronephrosis (swelling of the kidney due to urine buildup) and further damage to the kidney. Dystrophic calcification : Dystrophic calcification is the deposition of calcium salts in damaged or necrotic tissue. In the context of GUTB, the extensive tissue destruction caused by infection, inflammation, and obstruction creates an environment conducive to calcium deposition.



References:

Bailey and Love’s Short Practice of Surgery, 28th Edition, Page 1472, 1467

Remember the “Putty Kidney”—A Reminder of Days Gone by - ScienceDirect

↑ *Back to this question in Part A*

@Neet_pg_bot

Q6: A 35-year-old man presents with intermittent right flank pain and a palpable mass in his right loin. His urinalysis shows microscopic hematuria. Imaging reveals the presence of unilateral hydronephrosis. Which of the following correctly describes the condition known as Dietl's crisis? (Q849271)

A. Sudden onset of flank pain accompanied by fever and pyuria

B. Intermittent flank pain with a palpable abdominal mass that resolves after voiding large volume of urine

C. Constant dull ache in the loin with progressive renal failure

D. Acute anuria associated with bilateral ureteric obstruction

Correct Answer: B. Intermittent flank pain with a palpable abdominal mass that resolves after voiding large volume of urine

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Dietl’s crisis is seen in patients with unilateral hydronephrosis . Key components of Dietl's crisis include: Intermittent or acute attacks of renal colic (flank pain) Swelling or mass in the loin (palpable abdominal mass) Resolution of symptoms after passing a large volume of urine

References:

SRB Manual of Surgery, 6th Edition, Page 1002

↑ *Back to this question in Part A*

@Neet_pg_bot

Q7: A 62-year-old diabetic man presents with fever, flank pain, and a palpable mass in his left loin. Initial ultrasound reveals a fluid collection associated with the left kidney. Which of the following statements is incorrect with respect to the probable diagnosis of this patient? (Q849259)

A. Pyonephrosis is commonly seen in patients with hydronephrosis due to renal obstruction

B. Pyonephrosis can spread by cortical extension & hematogenous route

C. Pyonephrosis involves the collection of pus inside the kidney

D. Percutaneous nephrostomy is the treatment of choice for elderly and diabetic patients

Correct Answer: B. Pyonephrosis can spread by cortical extension & hematogenous route

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Pyonephrosis does not spread by cortical extension & hematogenous route . It involves pus collection inside the kidney and is commonly associated with chronic obstruction, especially hydronephrosis. Cortical and hematogenous spread is seen in Perinephric abscess. Feature Pyonephrosis Perinephric Abscess Definition Destruction of renal parenchyma followed by pus collection inside kidneys (Option C ruled out) Collection of pus around the kidney Spread by 2 routes: Cortical extension and Hematogenous spread (Option B) Most Common Cause Renal stones leading to hydronephrosis (the most common cause of obstruction) (Option A ruled out) E. coli > Proteus Urine culture positive in 1/3rd of cases Blood culture positive in 50% of cases Clinical Features Fever Anemia Mass in loin Pain Tenderness in flanks Fever Diagnosis USG USG/CT Management IV antibiotics + Drainage Percutaneous nephrostomy (Elderly, diabetic, etc) (Option D ruled out) For Non-Functioning Kidney: Nephrectomy IV antibiotics + percutaneous drainage If the patient does not respond after percutaneous drainage,

then go for Open drainage / Nephrectomy

References:

SRB Manual of Surgery, 6th Edition, Page 1004, 1005

↑ *Back to this question in Part A*

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Q8: A 55-year-old female with poorly controlled diabetes presents with fever, flank pain, and vomiting. Initial investigations reveal a kidney infection. Which of the following findings is likely to be seen in Emphysematous Pyelonephritis but not in Xanthogranulomatous Pyelonephritis? (Q849252)

A. Presence of Proteus as the causative organism

B. Air within the kidney or perinephric region on imaging

C. Association with struvite stones

D. Foamy lipid-laden histiocytes in renal parenchyma

Correct Answer: B. Air within the kidney or perinephric region on imaging

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Emphysematous Pyelonephritis is characterized by the presence of air around the kidney (perinephric region) or within the kidney itself. This is a key distinguishing feature visible on X-ray. CT scan is the investigation of choice for confirming this finding. Emphysematous Pyelonephritis Xanthogranulomatous Pyelonephritis Definition Presence of air around the kidney or within the kidney (Option B) Chronic bacterial infection Causative Organism E. coli, Klebsiella Proteus (most common) (Option A ruled out) Associations Diabetes (due to low immunity), Female gender Associated with Struvite stones (Option C ruled out) Clinical Features Flank pain, Fever, Vomiting Flank pain, Fever with chills and rigor, Flank Mass, Bacteriuria Investigation of Choice CT scan CECT (Bear’s paw sign) Findings The presence of air in renal parenchyma and parenchyma of surrounding structures Presence of Xanthoma cells in renal parenchyma (Foamy lipid-laden histiocytes) (Option D ruled out) Mimics Clear cell variant of RCC Treatment IV antibiotics Resuscitation Control blood glucose Percutaneous drainage if urinary tract obstruction is present Nephrectomy Initially, Partial Nephrectomy If not possible, total Nephrectomy Image This computed tomography (CT) scan demonstrates extensive destruction of the right kidney with intraparenchymal gas on the right, obliterating the renal architecture. The left kidney is normal. Xanthogranulomatous pyelonephritis with the ‘bear’s paw sign’





References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1471

↑ *Back to this question in Part A*

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Q9: A 60-year-old patient with a history of recurrent renal stones is scheduled for laser-based intracorporeal lithotripsy to treat a 2 cm stone in the renal pelvis. Which of the following lasers is most commonly used for intracorporeal lithotripsy procedures? (Q849251)

A. Carbon dioxide laser

B. Neodymium: YAG laser

C. Holmium: YAG laser

D. Helium laser

Correct Answer: C. Holmium: YAG laser

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The Holmium: YAG laser is the most commonly used laser for intracorporeal lithotripsy as it is highly effective in fragmenting stones and is widely used for treating both renal and ureteral stones. Types of Intracorporeal Lithotripsy Description Laser Lithotripsy Holmium: YAG laser Used in Renal stones and BPH Stone vaporization by photo-thermal mechanism Costly but safe Electrohydraulic Lithotripsy (EHL) Cheap but low safety margin Mainly used for bladder stones Ultrasonic Lithotripsy Not commonly used Ballistic Lithotripsy Not commonly used

References:

Campbell Walsh Textbook of Urology, 12th Edition, Page 1170-1174

Lasers for the treatment of urinary stone disease - PMC

Use of the CO2 laser in urology

↑ *Back to this question in Part A*

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Q10: Which of the following is the most common type of radiolucent renal stone? (Q849241)

A. Calcium Oxalate Stones

B. Uric Acid Stones

C. Cystine Stones

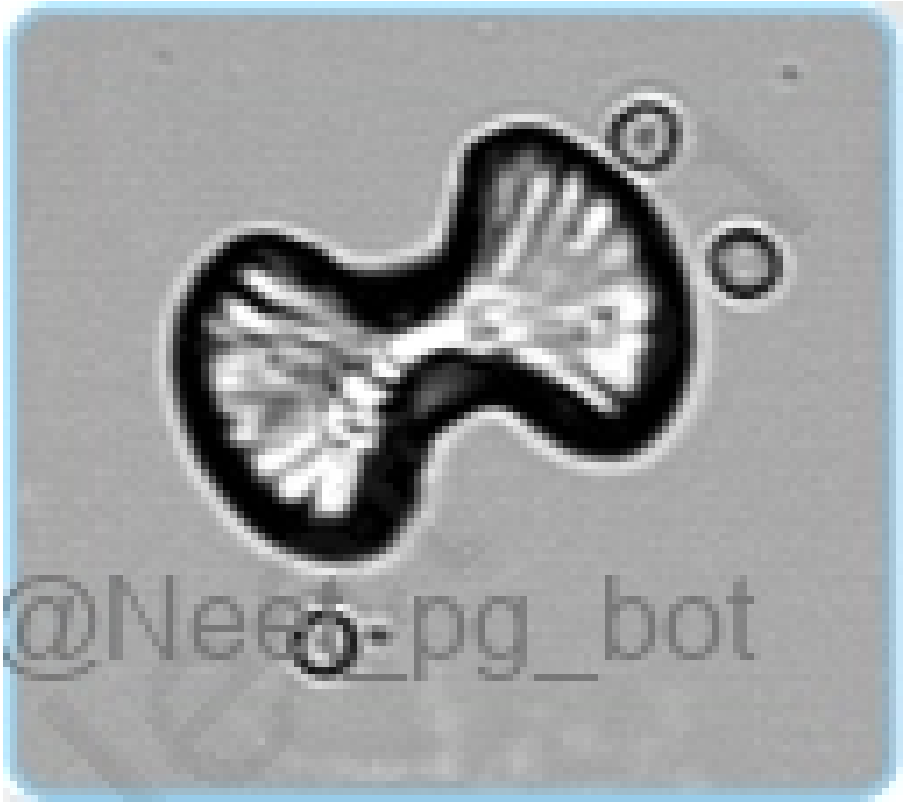
D. Xanthine Stones

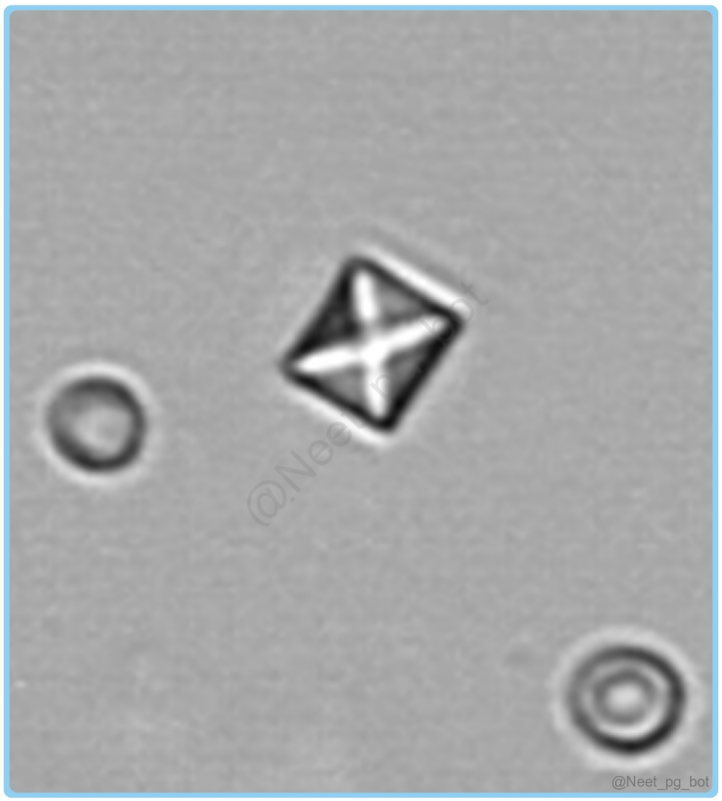
Correct Answer: B. Uric Acid Stones

■ *Listen (English)*

■ *Listen (Hindi)*

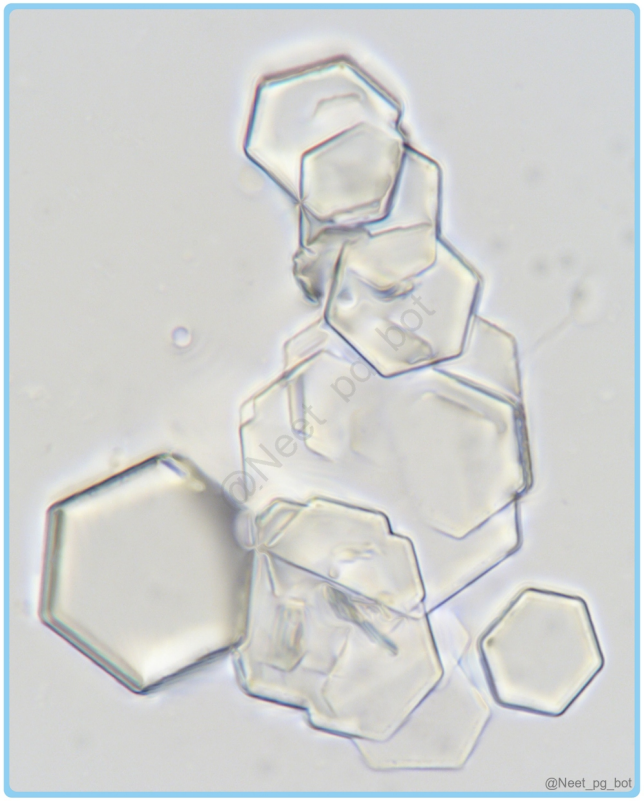
Explanation: Radiopaque stones: Calcium Oxalate Stones (Option A ruled out) Calcium Phosphate Stones Struvite Stones Cystine stones are also mildly radiopaque (Option C ruled out) Radiolucent stones include: Uric acid stones (most common) (Option B) Xanthine stones (rarely seen, mainly in patients with xanthinuria) (Option D ruled out) Stone Type Features Image Calcium Oxalate The most common type of stone (60–85% of all stones) ; Radiopaque Associated with hypercalciuria, hypercalcaemia, hyperoxaluria, hyperuricosuria, and hypocitraturia Types: monohydrate (dumbbell shaped) , dihydrate (envelope shaped) Calcium Phosphate Pure calcium phosphate stones are rare Types include apatite and brushite stones Apatite stones are seen with infection; brushite stones are associated with distal renal tubular acidosis Struvite Aka staghorn calculi / Triple phosphate stone (Ca, Mg, NH4+, Phosphate) Radiopaque Infection stones that form in alkaline urine due to urease-producing bacteria (e.g., Proteus, Klebsiella, Serratia, Enterobacter) Cystine Radiopaque , Constitute approximately 1% of stones Result from cystinuria , an autosomal recessive inherited disease that causes decreased reabsorption of cystine Very hard stones due to disulfide bonds Uric Acid Radiolucent Promoted by hyperuricosuria, which can be caused by conditions like gout and myeloproliferative disorders Precipitates in acidic urine and remains soluble in alkaline urine

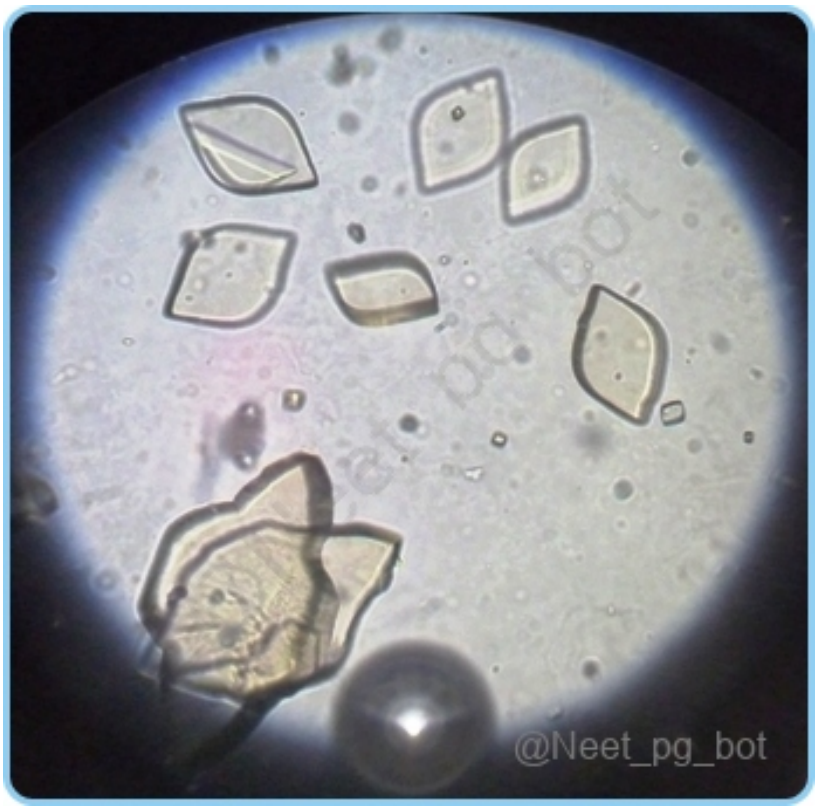



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References:

Bailey and Love's Short Practice of Surgery, 28th Edition, Page 1474-1475

↑ *Back to this question in Part A*

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Q11: A male underwent ESWL for a 2 cm renal stone 4 weeks ago. Imaging now reveals multiple small stone fragments (street of stone) in the ureter. Which of the following statements regarding the management of this condition is correct? (Q849249)

A. Urgent ureteroscopy should be performed to remove the obstructing stone fragments

B. Conservative management with alpha-blocker therapy is the first-line approach

C. Repeat ESWL is the preferred option to further fragment the retained stone pieces

D. Percutaneous nephrolithotomy is the treatment of choice to clear the Steinstrasse

Correct Answer: B. Conservative management with alpha-blocker therapy is the first-line approach

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Steinstrasse is the formation of a "stone street" or a column of stone fragments in the ureter following ESWL. In this case, with no obstruction, the initial approach should be conservative. It is a common complication, occurring in up to 15-20% of cases. The management of Steinstrasse depends on the severity of symptoms and the degree of obstruction. In this case, with intermittent symptoms and no complete obstruction, the initial approach should be conservative. This includes: Increased fluid intake to promote stone fragment passage Administration of alpha-blockers (e.g., tamsulosin) to facilitate ureteric relaxation and stone passage (Option B) Close monitoring with periodic imaging to assess the progress of stone passage If the conservative approach is unsuccessful or the patient develops severe symptoms or complete obstruction, then more invasive interventions, such as ureteroscopy (Option A ruled out) or percutaneous nephrolithotomy (Option D ruled out) , may be considered. Repeat ESWL is the preferred option to further fragment the retained stone pieces (Option C): Steinstrasse is a result of the initial ESWL, and further ESWL may not be effective in clearing the fragments and could potentially worsen the condition.



References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1476

↑ *Back to this question in Part A*

@Neet_pg_bot

Q12: A male presents with a 10 mm stone in the lower pole of the left kidney. Regarding the use of extracorporeal shock wave lithotripsy (ESWL) for this patient, which of the following statements is false? (Q849248)

A. ESWL works by generating focused shock waves that pass through the body and fragment the stone

B. ESWL is contraindicated in patients with significant skeletal deformities or obesity

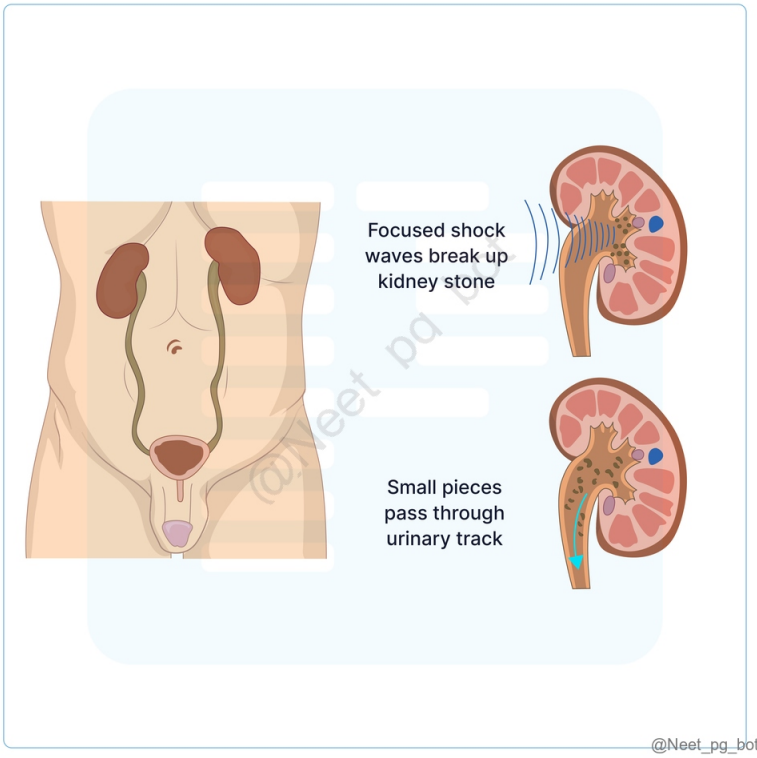
C. ESWL can be performed on stones less than 2 cm in diameter for optimal fragmentation

D. Post-ESWL, the patient is encouraged to ambulate soon after the procedure to facilitate stone passage

Correct Answer: C. ESWL can be performed on stones less than 2 cm in diameter for optimal fragmentation

- *Listen (English)*
- *Listen (Hindi)*

Explanation: While smaller stones (typically less than 2 cm) generally respond better to extracorporeal shock wave lithotripsy (ESWL), the procedure can be performed on stones up to 3-4 cm in diameter with appropriate patient selection and treatment parameters. Principles of Extracorporeal Shock Wave Lithotripsy (ESWL): Shock Wave Generation: (Option A ruled out) ESWL utilizes high-energy shock waves generated outside the body. These shock waves are focused on the location of the stone using imaging guidance (e.g., ultrasound, fluoroscopy). Stone Fragmentation: The focused shock waves create a rapid change in pressure at the stone's surface. This pressure change causes the stone to fracture into smaller fragments. Indications for ESWL: Radiolucent or radiopaque renal or ureteric stones less than 2 cm in diameter Stones located in the renal pelvis, upper, or middle ureter Patients with normal renal function and no severe hydronephrosis Contraindications to ESWL: Pregnancy Bleeding disorders or anticoagulant therapy Uncontrolled urinary tract infection Severe skeletal deformities or obesity (Option B ruled out) Distal ureteric obstruction Solitary kidney or severe renal impairment Patients are generally encouraged to ambulate soon after ESWL to facilitate the passage of the fragmented stones. (Option D ruled out)



References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1476

↑ *Back to this question in Part A*

@Neet_pg_bot

Q13: A male presents with a 5 mm lower-ureteric stone and no hydronephrosis. Which of the following is the most appropriate initial management strategy for this patient? (Q849247)

A. Urgent ureteroscopic stone extraction

B. Extracorporeal shock wave lithotripsy

C. Percutaneous nephrostomy tube placement

D. Trial of conservative management with medical expulsive therapy

Correct Answer: D. Trial of conservative management with medical expulsive therapy

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Indications for conservative management of renal stones: Upto 5 mm in size Non dilated ureter Stone located in the lower third of the ureter Progressive downward movement on repeated scan Medical expulsive therapy (MET) for conservative management: Involves the use of alpha-blocker medications (e.g., tamsulosin) or calcium channel blockers (e.g., nifedipine) Helps to relax the ureter smooth muscle, facilitating the spontaneous passage of the stone Typically recommended for stones up to 10 mm in size, with a success rate of 50-80% In cases where conservative management with MET fails or is not appropriate, other interventional options may be considered, such as: Ureteroscopic stone extraction (Option A ruled out) ESWL (for more distal ureteric stones or renal stones) (Option B ruled out) Percutaneous nephrolithotomy (for large or complex renal stones) (Option C ruled out)

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1476

↑ *Back to this question in Part A*

@Neet_pg_bot

Q14: A 30 years old male presents with recurrent episodes of right flank pain and hematuria. Ultrasonography and plain abdominal radiography are inconclusive for renal stones. Which of the following statements regarding the use of radionuclide scans in the evaluation of this patient is correct? (Q849246)

A. Technetium-99m dimercaptosuccinic acid (DMSA) scan is the preferred modality to diagnose renal stones

B. Gallium-67 citrate scan has higher sensitivity and specificity than DMSA scan for detecting renal stones

C. Radionuclide scans are exclusively reserved for patients with impaired renal function

D. Radionuclide scans can distinguish between obstructing and non-obstructing renal stones

Correct Answer: D. Radionuclide scans can distinguish between obstructing and non-obstructing renal stones

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Radionuclide scans can distinguish between obstructing and non-obstructing renal stones. Radionuclide scans, such as technetium- 99m mercaptoacetyltriglycine (MAG3) or diethylenetriaminepentaacetic acid (DTPA) scans, are useful in the evaluation of renal stones when other imaging modalities are inconclusive. Radionuclide scans assess renal function and the degree of obstruction, which can help differentiate between obstructing and non-obstructing stones. Obstructing stones will typically show delayed or decreased tracer accumulation in the affected kidney, indicating impaired drainage. Non-obstructing stones may not cause

significant changes in the radionucleotide scan. Radionuclide scans are especially helpful in patients with inconclusive findings on ultrasonography or plain radiography, as well as in those with impaired renal function. Radionuclide scans are more sensitive than intravenous pyelography (IVP) in detecting obstruction and can provide valuable information on renal function.

References:

www.ncbi.nlm.nih.gov/books/NBK562236/#:~:text=Renal%20scintigraphy%20has%20a%20role,diagnose%20compensated%20unilateral%20renal%20hypertension

↑ *Back to this question in Part A*

@Neet_pg_bot

Q15: Which of the following investigations is considered the gold standard for diagnosing renal stones and can identify both radiopaque and radiolucent stones? (Q849245)

A. Kidney, Ureter, and Bladder X-ray

B. Ultrasound

C. Non-contrast computed tomography

D. Intravenous urogram

Correct Answer: C. Non-contrast computed tomography

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Non-contrast computed tomography (NCCT) is considered the gold standard for diagnosing renal stones. NCCT scans provide detailed images of the urinary tract and can identify both radiopaque (visible on X-rays) and radiolucent (not easily visible on X-rays) stones. Investigations for renal stones: Urinalysis: This is often the initial investigation performed. It can reveal the presence of blood (hematuria), white blood cells (pyuria), and crystals in the urine, all suggestive of a possible stone. The pH of the urine can also give clues about the type of stone. Kidney, Ureter, and Bladder (KUB) X-ray : It can detect some types of stones, particularly calcium-containing stones, which appear opaque on X-rays. (Option A ruled out) Ultrasound : It's particularly useful for detecting hydronephrosis (swelling of the kidney due to urine blockage) caused by stones and can be helpful during pregnancy when minimizing radiation exposure is important. (Option B ruled out) Intravenous urogram (IVU): It involves injecting a contrast dye into a vein. The dye travels through the bloodstream to the kidneys, where it is filtered and excreted in the urine. X-rays are taken as the dye passes through the urinary tract, outlining the kidneys, ureters, and bladder. This test can reveal blockages in the urinary tract caused by stones. (Option D ruled out)

References:

Bailey and Love Short Practice of Surgery, 28th Edition, Page 1467, 1475, 1469

↑ *Back to this question in Part A*

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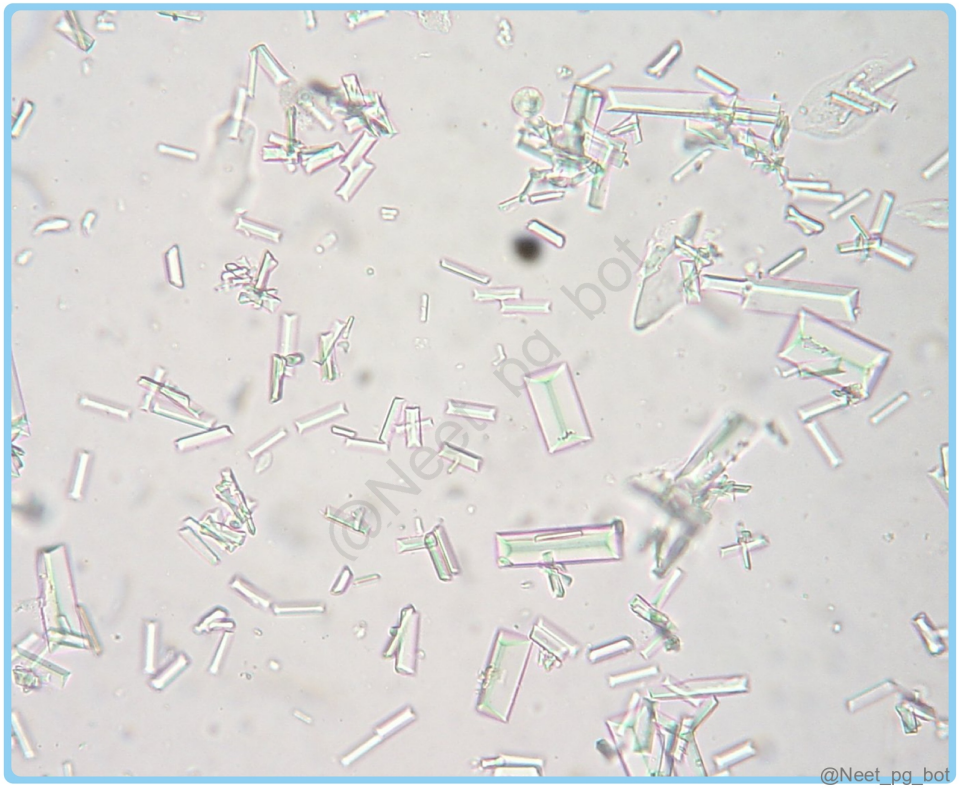
Q16: A 35-year-old woman presents with recurrent urinary tract infections (UTIs), persistent back pain, and hematuria. Imaging reveals a large, branched stone occupying a significant portion of her right kidney. Urinalysis shows alkaline pH, the presence of bacteria, and crystals as shown below. Which of the following is the most likely composition of this stone? (Q849244)

A. Calcium oxalate

B. Uric acid

C. Struvite

D. Cystine



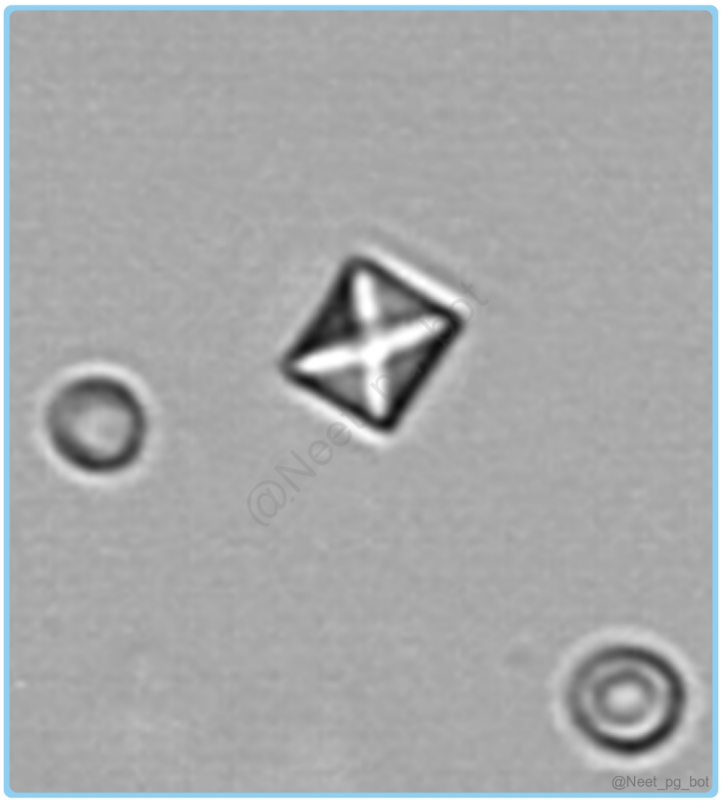
Correct Answer: C. Struvite

■ *Listen (English)*

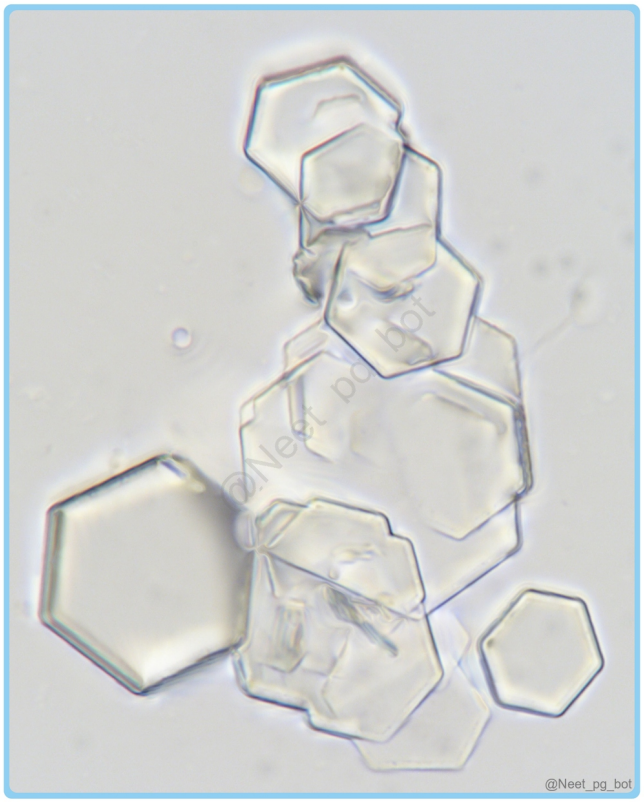
■ *Listen (Hindi)*

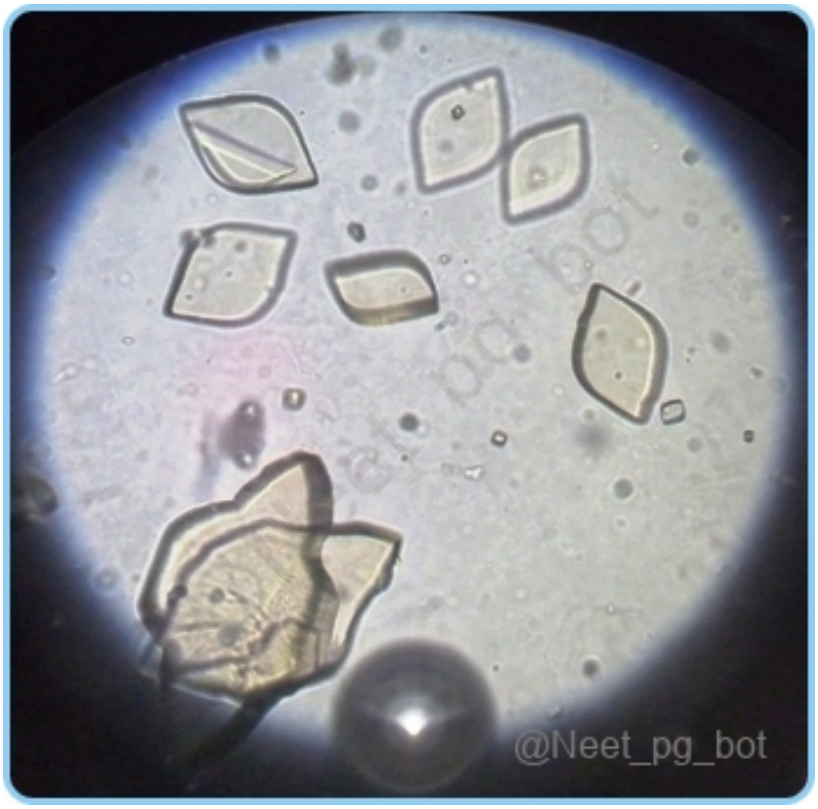
Explanation: Struvite (Magnesium Ammonium Phosphate): Found only in alkaline urine. Appears as coffin-lid-shaped crystals and is always associated with urinary infections. Calcium Oxalate (Option A ruled out): Shapes include envelopes, spindles, ovals, octahedral, picket fences, or dumbbell-shaped. Often feature an "X" in the center. Calcium Phosphate: Colorless crystals that appear as plates, stars, stellate shapes, or clusters of needles or rosettes. Typically found in more alkaline urine. Cystine (Option D ruled out): Crystals are hexagonal in shape and resemble nearly perfect benzene rings under the microscope. Uric Acid (Option B ruled out): Crystals can be rhomboidal-shaped, rosettes, or plates. Found in acidic urine with a pH of 5.5 or lower.




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References:

www.ncbi.nlm.nih.gov/books/NBK442014/

↑ *Back to this question in Part A*

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Q17: A 42-year-old male presents to the emergency department with severe abdominal pain. Imaging reveals that he has a renal stone lodged in the middle third of his ureter. He describes the pain as radiating to his hypogastrium. Which nerve is responsible for the radiation of pain to the hypogastrium? (Q849243)

A. Ilioinguinal Nerve

B. Iliohypogastric Nerve

C. Genitofemoral Nerve

D. Femoral Nerve

Correct Answer: B. Iliohypogastric Nerve

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The iliohypogastric nerve is responsible for sensation in the iliac fossa, hypogastrium, and groin area. It mediates the pain radiation from stones located in the middle third of the ureter . Pain radiation: Depends on the location of the stone. Upper 1/3 of the ureter: Testis in males. Labia majora in females. Middle 1/3 of the ureter: Iliac fossa, hypogastrium, and groin (via the iliohypogastric nerve). On the right side , this pain can mimic acute appendicitis as it radiates to the right iliac fossa. On the left side , this pain can mimic diverticulitis as it radiates to the left iliac fossa. Lower 1/3 of the Ureter: Scrotum, perineum, and the inner aspect of the thigh (via the ilioinguinal nerve) .

References:

Bailey and Love Short Practice of Surgery, 28th Edition, Page 1475-1476

↑ *Back to this question in Part A*

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Q18: A 50-year-old man with a history of HIV, on ART, presents to the emergency department with severe flank pain, hematuria, and difficulty urinating. Recent imaging studies reveal the presence of renal stones. Which of the following ART drugs is commonly associated with the development of renal stones? (Q849242)

A. Indinavir

B. Efavirenz

C. Nevirapine

D. None of the above

Correct Answer: A. Indinavir

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Indinavir is a protease inhibitor that has proven highly effective in boosting CD4+ cell counts and reducing HIV-RNA levels in patients with HIV and AIDS. However, patients taking indinavir are at a notable risk of developing urolithiasis. Drug-induced stones: Triamterene: Excessive use of this potassium-sparing diuretic can lead to the formation of radiolucent stones. Indinavir: This protease inhibitor used in HIV treatment can also cause the formation of radiolucent stones. Silicate Stones: These stones can form due to excessive consumption of antacids containing silica. Radiolucent Stones are caused by: (mnemonic: TIXU) T – Triamterene I – Indinavir X – Xanthine U – Uric acid

References:

pubmed.ncbi.nlm.nih.gov/11148725/

pubmed.ncbi.nlm.nih.gov/7431573/

↑ *Back to this question in Part A*

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• [06_Urology] 035 Renal Tumors And Renal Congenital Abnormalities

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[06_Urology] 035 Renal Tumors And Renal Congenital Abnormalities — Quick Jump

Q1 (p. 2487)	*Q2 (p. 2488)*	*Q3 (p. 2488)*	*Q4 (p. 2490)*	*Q5 (p. 2491)*	*Q6 (p. 2492)*
Q7 (p. 2493)	*Q8 (p. 2494)*	*Q9 (p. 2497)*	*Q10 (p. 2498)*	*Q11 (p. 2500)*	*Q12 (p. 2502)*
Q13 (p. 2502)	*Q14 (p. 2503)*	*Q15 (p. 2504)*	*Q16 (p. 2506)*	*Q17 (p. 2507)*	*Q18 (p. 2508)*
Q19 (p. 2509)	*Q20 (p. 2510)*				

Q1: A 55-year-old male presents with painless hematuria and weight loss over the past six months. CECT reveals a 9 cm enhancing mass in the right kidney, with evidence of invasion into the renal vein. Histopathology shows cells with clear cytoplasm and a delicate network of vasculature. Which of the following is the most likely variant of renal cell carcinoma? (Q849283)

A. Chromophobe renal cell carcinoma

B. Papillary renal cell carcinoma

C. Clear cell renal cell carcinoma

D. Collecting duct carcinoma

Correct Answer: C. Clear cell renal cell carcinoma

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The clinical presentation and histopathological findings are indicative of clear cell renal cell carcinoma (CCRCC). RCC Variants Salient features Clear cell renal cell carcinoma (CCRCC (Option C) Microscopy : cells have clear cytoplasm due to the presence of abundant lipids and glycogen, surrounded by a delicate network of vasculature. Papillary renal cell carcinoma (Option B) Type 1 has small basophilic cells and Type 2 is characterized by large eosinophilic cells. Chromophobe renal cell carcinoma (Option A) Microscopy: Characterized by large polygonal cells with prominent cell membranes and pale cytoplasm. Collecting duct carcinoma (Option D) Rare and aggressive form of RCC that arises from the collecting ducts in the renal medulla, hence centrally located.

References:

Bailey and Love’s Short Practice of Surgery, 8th Edition, Page 1483

↑ *Back to this question in Part A*

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Q2: A 70-year-old male with a history of hypertension is diagnosed with renal cell carcinoma (RCC) after a CT scan reveals a 5 cm tumor confined to the right kidney. His renal function is normal, and there is no evidence of metastasis. What is the most appropriate initial treatment for this patient? (Q849286)

A. Partial Nephrectomy

B. Radical Nephrectomy

C. Radiofrequency Ablation

D. Targeted Therapy

Correct Answer: A. Partial Nephrectomy

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: In this patient's case, with a 5 cm tumor confined to the kidney and no evidence of metastasis, Partial Nephrectomy is the most appropriate initial treatment option. This approach will effectively manage the localized RCC while preserving renal function. Treatment of RCC Surgical Management: Partial Nephrectomy (Option A) : Involves removing only the tumor while preserving the remainder of the kidney. Indications: T1 Disease(<7cm) Restricted to poles RCC in solitary functioning kidney Radical Nephrectomy (Option B): Involves removal of the kidney with Gerota's fascia, para-aortic nodes, and ureter up to the pelvic brim. Indications: Larger tumors or when partial nephrectomy is not feasible Ablative Techniques Radiofrequency Ablation (RFA) (Option C) and Cryoablation: Involve destroying the tumor using extreme temperatures. Indications: Patients who are not surgical candidates Patients with small tumors(T1a lesions) (usually <4 cm). Systemic Therapy (For advanced/ metastatic disease) Targeted Therapy (Option D): Tyrosine kinase inhibitors (e.g., sunitinib, pazopanib) mTOR inhibitors (e.g., everolimus) Immunotherapy: Immune checkpoint inhibitors (e.g., nivolumab)

References:

Sabiston Textbook of Surgery, 21st Edition, Page 2091, 2092

↑ *Back to this question in Part A*

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Q3: A 28-year-old woman is incidentally found to have a horseshoe kidney during an abdominal CT scan. She has no symptoms. Which of the following complications is she

at highest risk for developing? (Q849300)

A. Pelviureteric junction obstruction

B. Renal cell carcinoma

C. Renal artery stenosis

D. Nephroptosis

Correct Answer: A. Pelviureteric junction obstruction

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Horseshoe kidney increases the risk of PUJ obstruction due to the abnormal position of the kidneys and the associated vascular anomalies, which can compress the ureters and impair urine flow. Horseshoe Kidney Clinical Features: Mostly asymptomatic. Pain: due to obstruction or renal stones. Recurrent urinary tract infections (UTIs) Hydronephrosis Hematuria Rovsing's syndrome: Hyperextension of the spine- nausea, vomiting, abdominal pain. Investigations: CT Angiography (CT Angio): This is the investigation of choice for diagnosing a horseshoe kidney, as it allows for detailed visualization of the renal anatomy, the abnormal vascular supply, and associated complications. Contrast-Enhanced CT (CECT): Used when CT Angio is not available Intravenous Pyelogram (IVP) - characteristic findings include : Medial Orientation of Calyces: Referred to as the "Hand Joining Sign." High Insertion of Ureters with Anterior Transposition: This creates a "Flower Vase" appearance of the ureters.



Hand joining sign

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References:

Bailey and Love's Short Practice of Surgery, 28th Edition, Page 1466

↑ *Back to this question in Part A*

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Q4: A newborn presents with abdominal distension and respiratory distress. Ultrasound reveals bilaterally enlarged kidneys with multiple small cysts. Which of the following statements regarding the diagnosis is incorrect? (Q849296)

A. It follows an autosomal recessive pattern of inheritance

B. The gene involved is the PKHD1 gene on chromosome 7

C. USG shows enlarged, echogenic kidneys, with poor corticomedullary differentiation

D. Hepatic fibrosis is the cause of death

Correct Answer: B. The gene involved is the PKHD1 gene on chromosome 7

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The clinical scenario suggests that the patient has a case of Autosomal recessive polycystic kidney disease (ARPKD) , previously called Infantile Polycystic Kidney Disease. PKHD1 (Polycystic Kidney and Hepatic Disease 1), is located on the short (p) arm of chromosome 6, not chromosome 7. Infantile Polycystic Kidney Disease Inheritance Autosomal recessive (Option A) Gene Involved PKHD1 gene on chromosome 6p12.2 (Option B) Diagnosis Ultrasound: Enlarged, echogenic kidneys with poor corticomedullary differentiation (Option C) Genetic testing for PKHD1 mutations Main causes of death Congenital Hepatic fibrosis (Option D) Respiratory insufficiency Renal failure

References:

Pubmed

Radiopedia

↑ *Back to this question in Part A*

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Q5: Which of the following statements is incorrect regarding the investigations and treatment of Autosomal Dominant Polycystic Kidney Disease? (Q849295)

A. CECT is the investigation of choice for ADPKD

B. IVP may show a "spider leg" or "bell-shaped" appearance in ADPKD

C. Rovsing's operation is the gold standard for management which involves the opening and evacuation of fluid from cysts in ADPKD

D. Treatment is only done when cysts are overdistended causing pain, hemorrhage & infection

Correct Answer: C. Rovsing's operation is the gold standard for management which involves the opening and evacuation of fluid from cysts in ADPKD

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The gold standard management for ADPKD is renal transplantation , not Rovsing operation. Autosomal Dominant Polycystic Kidney Disease- Investigations and Management Investigations Investigation of choice: CECT (Option A) Ultrasound: Confirms the presence of cysts IVP (Intravenous Pyelogram): Spider leg/Bell-shaped appearance (Option B) Bubble appearance Swiss-cheese appearance Blood urea and serum creatinine : Elevated Urine: Shows low specific gravity Management Wait and watch initially. Surgical intervention is required only after cysts get overdistended causing pain, hemorrhage, and infection. (Option D) Gold Standard: Renal Transplantation Rovsing's Operation (Option C) : Deroofing of Cyst in ADPKD. The kidney is exposed. The cyst is opened. The fluid is evacuated. US-guided aspiration & Laparoscopic aspiration is commonly done as a simpler approach Once renal failure sets in, initial hemodialysis followed by bilateral nephrectomy is done and later renal transplantation can be planned

References:

SRB Manual of Surgery, 6th Edition, Page 994, 995

↑ *Back to this question in Part A*

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Q6: A 6-month-old child undergoes a micturating cystourethrogram for suspected vesicoureteric reflux. The radiologist notes reflux into the renal pelvis with mild distention of the collecting system. Which grade of vesicoureteric reflux does this finding represent? (Q849304)

A. Grade IV

B. Grade II

C. Grade III

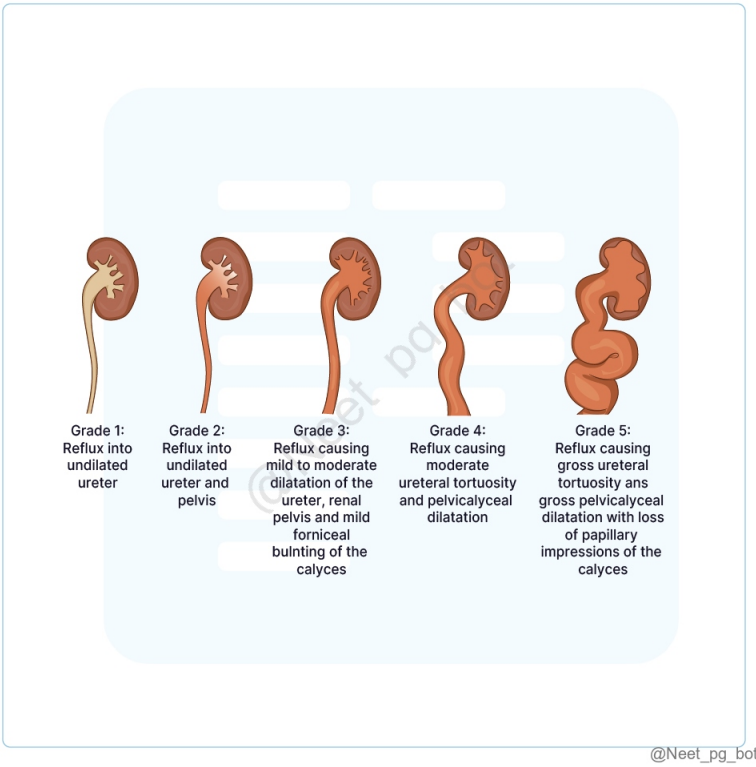
D. Grade I

Correct Answer: C. Grade III

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: According to the grading system for vesicoureteric reflux, Grade III is characterized by reflux with mild distention of the renal pelvis and ureter. Grade Description Chances of spontaneous resolution of VUR I Reflux into non-dilated ureter 80% II Reflux into the pelvicalyceal system 80% III Mild to moderate dilatation of the ureter with reflux into the pelvicalyceal system 50% IV Blunting of fornix with reflux into the pelvicalyceal system 20% V Dilated and tortuous ureter with reflux into the pelvicalyceal system 0-5%



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References:

SRB Manual of Surgery, 6th Edition, Page 1028, 1029

Pubmed

↑ *Back to this question in Part A*

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Q7: A 4-year-old boy presents with recurrent urinary tract infections and a palpable kidney mass in the loin region. Further, the patient is diagnosed with vesicoureteric reflux on both sides. Which of the following is an incorrect statement regarding the management of this condition? (Q849303)

A. Most cases resolve spontaneously without treatment

B. The investigation of choice is Intravenous Pyelogram

C. Symptomatic cases require surgical correction via ureteric reimplantation

D. Severe cases may require nephrectomy and renal transplantation

Correct Answer: B. The investigation of choice is Intravenous Pyelogram

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Investigation of choice for vesicoureteral reflux is Micturating cystourethrogram (MCU). Vesicoureteric reflux Investigations Micturating cystourethrogram (IOC) Intravenous urography Urine microscopy and C/S Blood urea and serum creatinine Treatment Grade I to III- Antibiotic Prophylaxis as it resolves spontaneously in most patients. (Option A) Grade IV to V- Antibiotics + Surgery Only symptomatic patients require surgical correction via ureteric reimplantation. (Option B) Surgery: Ureterovesicoplasty Ureteric reimplantation (Lich-Gregoir technique) STING Operation (Endoscopic) Severe cases may require nephrectomy and renal transplantation. (Option D)

References:

1. SRB Manual of Surgery, 6th Edition, Page 1028, 1029 2. www.ncbi.nlm.nih.gov/books/NBK563262/

↑ *Back to this question in Part A*

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Q8: A 5-year-old girl is brought to the pediatric urology clinic by her mother, who reports that the child has "never been dry" since birth. The mother notes that urine dribbles continuously via the vagina, but the child can also pass urine normally. An intravenous urogram is performed which is attached below. Which of the following is the most likely diagnosis? (Q849302)

A. Vesicoureteral reflux

B. Posterior urethral valves

C. Ectopic ureter from duplicated collecting system

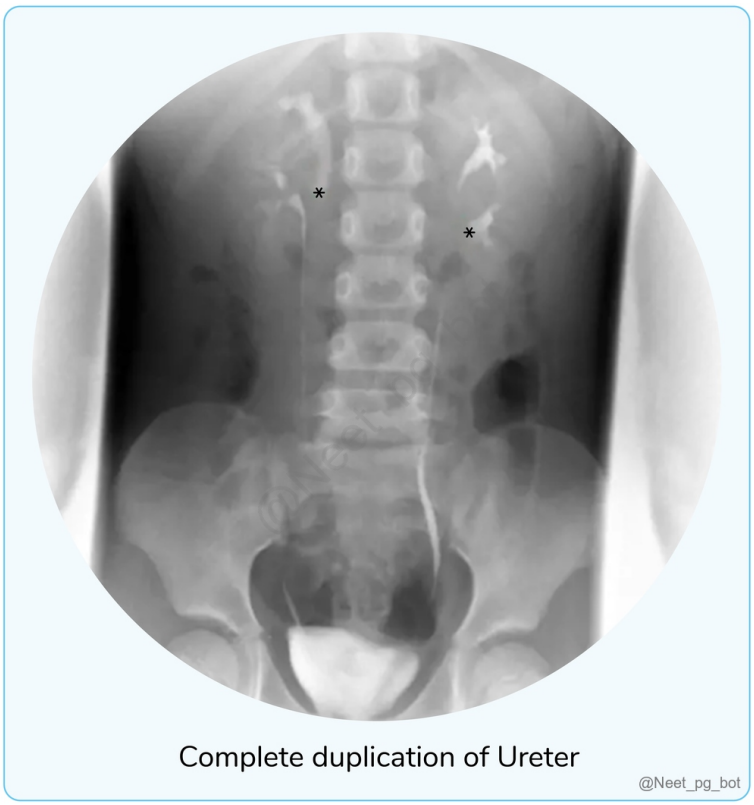
D. Ureterocele

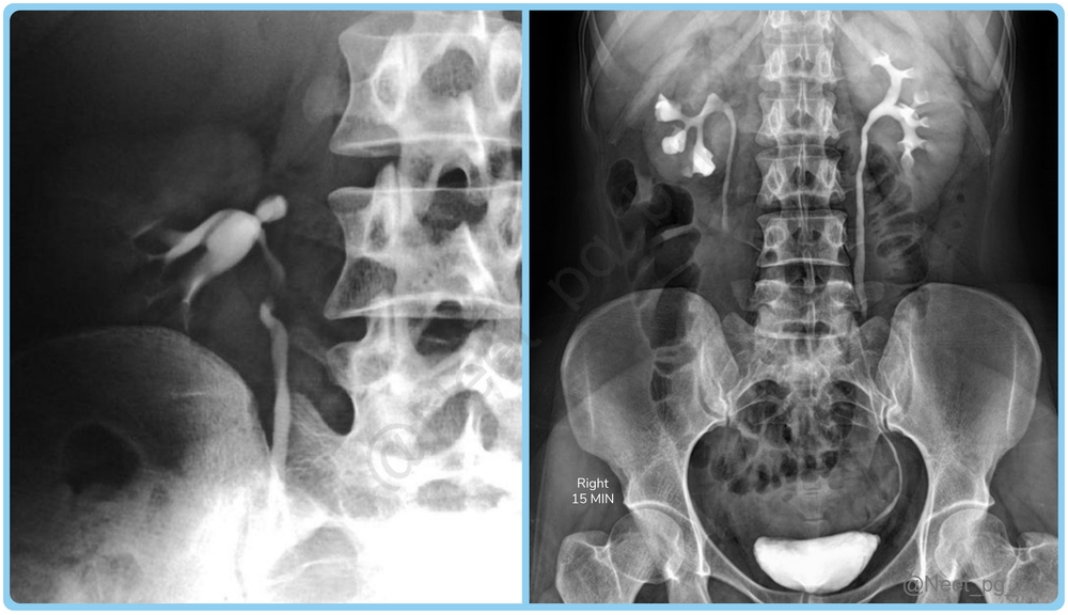


Correct Answer: C. Ectopic ureter from duplicated collecting system

- *Listen (English)*
- *Listen (Hindi)*

Explanation: The clinical presentation and radiological image support the diagnosis of bilateral complete duplication of ureter , opening into the vagina. Clinical Features In Males Recurrent infections In Females Continuous incontinence (dribbling) with normal voiding pattern Investigations IOC for is IVP Radiological Signs Yo-Yo reflux: Reflux of contrast in both limbs of the ureter on retrograde pyelogram in incomplete duplication Drooping lily sign : Seen in duplication with malrotation pelvis Vesicoureteral reflux (Option A) is incorrect because while it can cause recurrent UTIs, it doesn't typically cause continuous incontinence. Also the radiological image doesn’t support the diagnosis. Posterior urethral valves (Option B) is incorrect because this condition occurs in males and wouldn't explain vaginal dribbling. Also the radiological image doesn’t support the diagnosis. Ureterocele (Option D) is incorrect because it typically presents with urinary obstruction symptoms rather than continuous incontinence. Also the radiological image doesn’t support the diagnosis.





References:

World Journal of Clinical Cases

SRB Manual of Surgery, 6th Edition,Page 995, 996

Drooping Lily Sign

↑ *Back to this question in Part A*

Q9: A 6-year-old boy presents with recurrent urinary tract infections and a palpable abdominal mass. Imaging reveals a cystic dilation near the ureteral orifice within the bladder. Which of the following best describes the underlying condition? (Q849301)

A. Ureterocele

B. Bladder diverticulum

C. Ectopic ureter

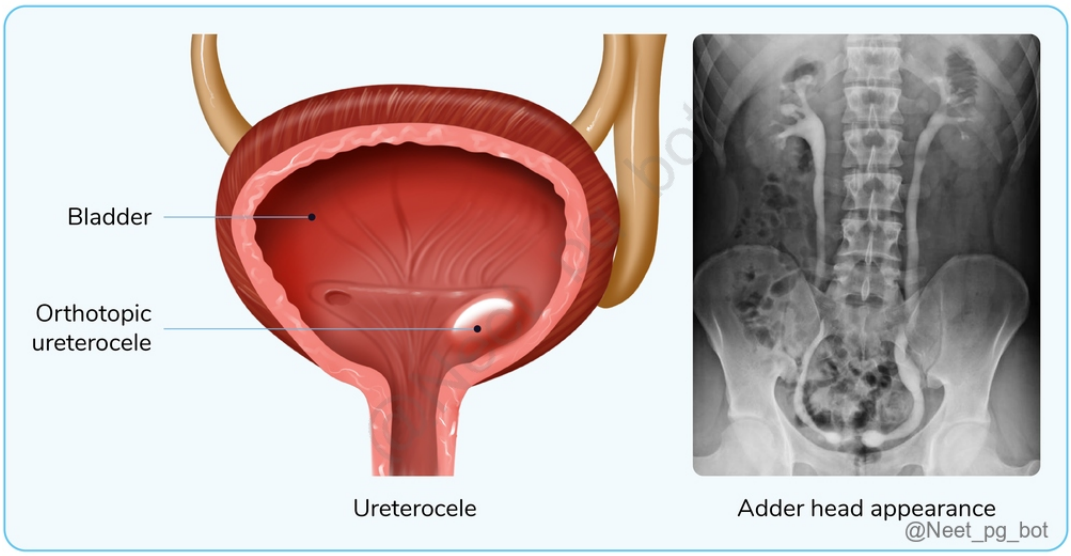
D. Vesicoureteral reflux

Correct Answer: A. Ureterocele

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The boy's recurrent UTIs and palpable abdominal mass, along with imaging showing cystic dilation near the ureteral orifice, are indicative of a ureterocele . Ureterocele is the congenital dilation of the distal ureter within the bladder wall. It can obstruct urine flow, leading to recurrent UTIs and hydronephrosis. Treatment often involves surgical correction to relieve the obstruction. Bladder diverticulum (Option B) : A bladder diverticulum is an outpouching of the bladder wall, not a cystic dilation of the ureter near the bladder. Ectopic ureter (Option C) : An ectopic ureter does not open into the bladder in its usual location. While it can cause obstruction and infection, it does not present as a cystic dilation within the bladder. Vesicoureteral reflux (Option D) : This condition involves the backflow of urine from the bladder into the ureters but does not typically present with a cystic dilation at the ureteral orifice, as seen in the ureterocele.



References:

Bailey and Love’s Short Practice of Surgery, 28th Edition, Page 1467

↑ *Back to this question in Part A*

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Q10: A 40-year-old male presents with right-sided flank pain and persistent hematuria. An intravenous urogram is done and given below. What is the definitive management of this condition? (Q849299)

A. Observation with serial imaging

B. Ureteric stent placement

C. Surgical repositioning of the ureter

D. Percutaneous nephrostomy

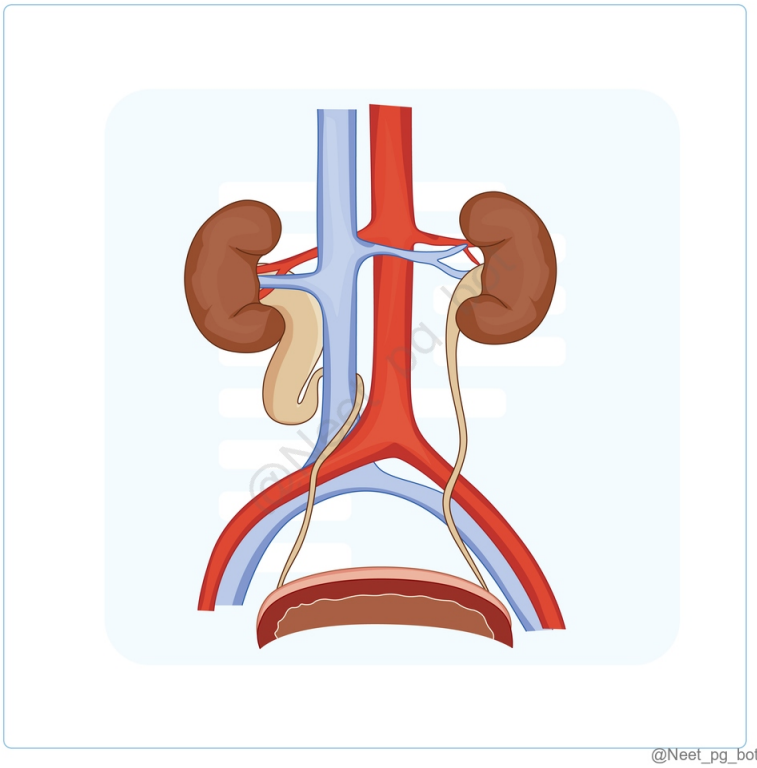


Correct Answer: C. Surgical repositioning of the ureter

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The retrocaval ureter is a congenital anomaly where the ureter passes behind the IVC causing obstruction. Surgical repositioning of the ureter anterior to the IVC is the definitive treatment to relieve the obstruction. Retrocaval Ureter: Rare congenital anomaly due to an abnormal development of the embryonic venous system (persistence of right posterior subcardinal vein). Investigations: An intravenous pyelogram (IVP) or computed tomography (CT) urogram can show the characteristic "fishhook" or "S-shaped" deformity of the proximal ureter as it loops behind the IVC. This deformity, along with signs of hydronephrosis, confirms the diagnosis. Treatment: The definitive treatment for retrocaval ureter is a surgical correction - ureteroureterostomy - where the ureter is repositioned anterior to the IVC to relieve the obstruction. This procedure restores normal urine flow and prevents further kidney damage. Temporary measures, like stenting, may be used in acute settings, but they do not provide a long-term solution.



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References:

Bailey and Love's Short Practice of Surgery, 28th Edition, Page 1467, 1468

Campbell Walsh, 12th Edition, Page 9073

↑ *Back to this question in Part A*

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Q11: A 35-year-old woman presents with intermittent left flank pain and episodes of gross hematuria. Imaging reveals a dilated renal pelvis with a narrowed ureteropelvic junction. Which of the following is the most appropriate long-term management? (Q849298)

A. Percutaneous nephrostomy

B. Watchful waiting with regular monitoring

C. Pyeloplasty

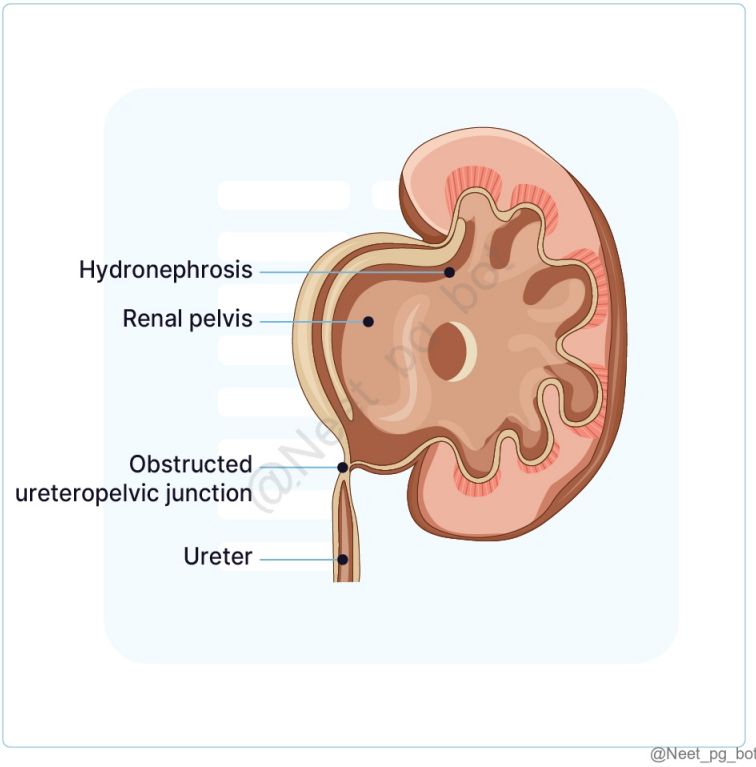
D. Ureteric balloon dilatation

Correct Answer: C. Pyeloplasty

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Pyeloplasty is the surgical procedure of choice for correcting PUJ obstruction. It involves reconstructing the ureteropelvic junction to relieve the obstruction, restoration of normal urine flow, and prevent further kidney damage. Pelviureteric Junction (PUJ) obstruction is a condition where the flow of urine from the renal pelvis into the ureter is impeded due to a narrowing or blockage at the junction between the renal pelvis and the ureter. Treatment: Surgical Treatment: Anderson-Hynes Dismembered Pyeloplasty (Option C) : Gold-standard treatment for PUJ obstruction. The procedure involves cutting out the narrowed segment and reattaching the healthy ureter to the renal pelvis, ensuring a wide and unobstructed passage. Foley V-Y Pyeloplasty: When there is a short segment of obstruction or if the pelvis is intrarenal (within the kidney tissue). Flap Pyeloplasty (Spiral or Vertical): Used in specific cases where the obstruction involves a small segment or an intrarenal pelvis. A flap of renal pelvis tissue is used to widen the narrowed area. Endoscopic Treatment (Option D) : Endopyelotomy: Using a laser or electrocautery - an incision is made within the PUJ via an endoscope to relieve the obstruction. Balloon Dilatation: A balloon is inflated at the site of the obstruction to widen the narrowed junction. Observation (Option B) : In asymptomatic patients with mild hydronephrosis, regular monitoring with imaging and renal function tests might be sufficient. Percutaneous nephrostomy (Option A) : This is a temporary measure for relieving obstruction in emergency cases, not a definitive treatment for PUJ obstruction.



References:

Bailey and Love’s Short Practice of Surgery, 28th Edition, Page 1468, 1469

↑ *Back to this question in Part A*

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Q12: A 20-year-old pregnant woman undergoes an ultrasound at 22 weeks' gestation. The scan reveals severe oligohydramnios and the fetal kidneys are not visualized. Which of the following additional findings is most likely to be present in the fetus? (Q849297)

A. Pulmonary hypoplasia

B. Normal lung development

C. Medullary sponge kidney

D. Enlarged fetal bladder

Correct Answer: A. Pulmonary hypoplasia

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: In bilateral renal agenesis , the absence of fetal kidneys leads to a lack of amniotic fluid (oligohydramnios), which is crucial for lung development. This results in underdeveloped lungs - pulmonary hypoplasia - leading to respiratory failure at birth. Renal agenesis is a congenital condition characterized by the absence of one or both kidneys. The bladder is usually absent. Bilateral renal agenesis causes Potter syndrome and is typically fatal. Potter syndrome is associated with: Oligohydramnios Pulmonary hypoplasia Potter facies Limb deformities - clubfoot or other positional abnormalities. Growth restriction

References:

Bailey and Love’s Short Practice of Surgery, 28th Edition, Page 1466

https://www.ncbi.nlm.nih.gov/books/NBK560858/

Smith and Tanagho’s General Urology, 19th Edition, Page 530

↑ *Back to this question in Part A*

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Q13: A 45-year-old woman with a history of tuberous sclerosis complex with angiomyolipoma (AML) presents with a sudden onset of severe left flank pain. On examination, she is hypotensive and has a tender left flank. Imaging reveals a large hemorrhage in the left kidney extending into the perirenal space. Which of the

following is the most likely diagnosis? (Q849281)

A. Pyelonephritis

B. Renal cell carcinoma

C. Wunderlich syndrome

D. Acute appendicitis

Correct Answer: C. Wunderlich syndrome

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Wunderlich syndrome is a rare, life-threatening condition characterized by spontaneous, non-traumatic renal hemorrhage into the subcapsular and perirenal spaces typically associated with renal angiomyolipomas (AMLs). In patients with renal angiomyolipoma, particularly those associated with tuberous sclerosis complex (TSC) , the risk of hemorrhage is heightened , leading to symptoms such as flank pain, hypotension, and tenderness. Pyelonephritis (Option A) typically presents with symptoms such as fever, chills, and flank pain, but does not typically cause a large hemorrhage or hypotension. Renal cell carcinoma (Option B) can present with hematuria, flank pain, and sometimes a mass, but it usually does not cause hemorrhage. Acute appendicitis (Option D) would be less likely to cause flank pain or a hemorrhage in the perirenal space.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1482

https://www.uptodate.com/contents/renal-angiomyolipomas-amls-epidemiology-pathogenesis-clinical-manifestations-and-diagnosis?search=angiomyolipoma%20of%20kidney&source=search_result&selectedTitle=2~150&usage_type=default&display_rank=2

Campbel Walsh, 12th Online Edition, Page 9854

↑ *Back to this question in Part A*

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Q14: Which of the following statements is incorrect regarding Autosomal Dominant Polycystic Kidney Disease? (Q849294)

A. The disease involves a mutation in the PKD1 and PKD2 genes on chromosomes 4 and 16 respectively

B. Hypertension is the most common manifestation

C. Cysts can be seen in the organs such as the ovary, and pancreas in patients with ADPKD

D. The most common extrarenal manifestation is polycystic liver disease

Correct Answer: A. The disease involves a mutation in the PKD1 and PKD2 genes on chromosomes 4 and 16 respectively

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Mutation in ADPKD is in the PKD1 gene on Chromosome 16 and the PKD2 gene on Chromosome 4 . Autosomal Dominant Polycystic Kidney Disease (ADPKD) Inheritance Autosomal Dominant Involvement of chromosome 16 (PKD1) and 4 (PKD2) Abnormal protein- Polycystin Both kidneys are replaced by multiple cysts Clinical Features (Intrarenal) Most common manifestation is hypertension (Option B) Polyuria, Nocturia, Hematuria Nephrolithiasis Chronic renal failure (Usually in the 5th to 6th decade) Any compression in the pelvicalyceal system will lead to HIS (Hydronephrosis; Infection; Stone) → Hematuria Clinical Features (Extrarenal) Polycystic Liver Disease (Most common) (Option D) Cyst in Ovary, Pancreas, Spleen (Option C) Berry Aneurysm Mitral Valve prolapse The most common cause of death is cardiovascular Disorders

References:

SRB Manual of Surgery, 6th Edition, Page 994, 995

↑ *Back to this question in Part A*

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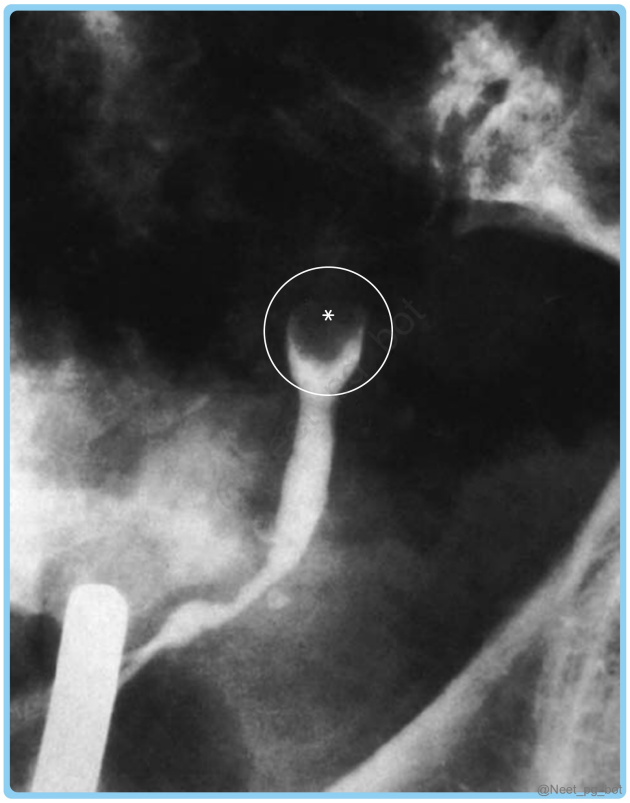
Q15: A 65-year-old man with a history of working in a dye factory for 30 years presents with flank pain and gross hematuria. Urinalysis confirms the presence of blood, and cytology shows atypical cells. A retrograde urogram was done given in the image below. He was diagnosed with carcinoma of the renal pelvis. Which of the following statements is incorrect regarding the diagnosis? (Q849293)

A. The radiographic image shows the Goblet sign.

B. Patients most commonly present with flank pain

C. CT urography is the investigation of choice for diagnosis

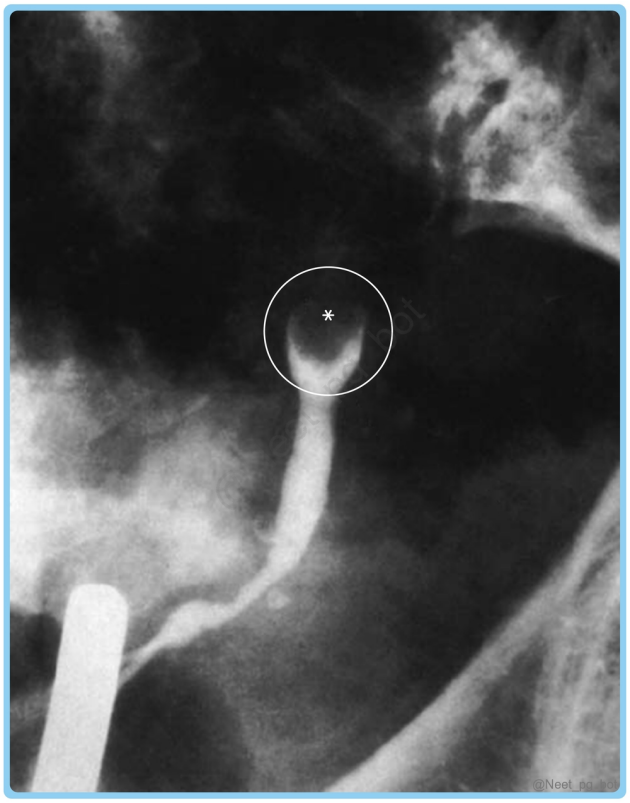
D. The most common histological type is transitional cell carcinoma



Correct Answer: B. Patients most commonly present with flank pain

- *Listen (English)*
- *Listen (Hindi)*

Explanation: The most common symptom with which carcinoma of the renal pelvis presents is painless gross hematuria . Carcinoma of the renal pelvis Type Most common: Transitional Cell Carcinoma (Option D) Clinical Features The most common symptom is painless gross hematuria (Option B) Flank pain Irritative voiding symptoms Investigations Ureteroscopic brush cytology: Can diagnose tumors at the renal pelvis IVP: Filling defect can be seen CT scan: Enhancing lesion in the renal pelvis with mild filling defects. Obstructive signs may or may not be present. Bergman sign : Coiling of the catheter distal to the obstruction Goblet sign: Dilation of parts of ureter distal to obstruction seen on Retrograde pyelography IOC for diagnosis : CT Urography (Option C)



References:

radiopaedia.org/articles/transitional-cell-carcinoma-renal-pelvis

www.cancer.gov/types/kidney/patient/transitional-cell-treatment-pdq

↑ *Back to this question in Part A*

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Q16: A 4-year-old girl is brought to the pediatrician with a palpable abdominal mass. Imaging studies reveal a large renal tumor and a biopsy confirms the diagnosis of Wilms tumor. Which of the following statements regarding Wilms tumor is correct? (Q849292)

A. Chemotherapy is contraindicated in Wilms tumor due to the young age of the patients

B. The most common site of metastasis in patients with Wilms tumor is the Liver.

C. A multimodal approach including surgery, chemotherapy, and radiation is typically used.

D. The route of spread is mostly lymphatic for metastasis of tumor foci.

Correct Answer: C. A multimodal approach including surgery, chemotherapy, and radiation is typically used.

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Wilms tumor requires a multimodal approach for treatment depending on histology and staging of tumor foci and clinical response of the patients. Treatment Treatment approach varies based on stage and histology- Multimodal approach Surgery : Radical nephrectomy or nephron-sparing surgery Chemotherapy : VCD regimen (Option A) Vincristine, Cyclophosphamide, Dactinomycin/Doxorubicin Radiation therapy : For higher stages or unfavorable histology Metastasis Mainly through a hematogenous route (Option D) into: Lungs (MC) (Option B) Liver Bones (Rarely)

References:

SRB Manual of Surgery, 6th Edition, Page 1012 & 1013

↑ *Back to this question in Part A*

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Q17: A 2-year-old male child presents with severe proteinuria, ambiguous genitalia, and hypertension. His karyotype is 46XY, and genetic testing reveals a missense mutation in the WT1 gene. Imaging studies show a unilateral renal mass. Which of the following is the most likely explanation for the patient's clinical presentation? (Q849291)

A. Beckwith-Wiedemann syndrome with Wilms' tumor

B. Denys-Drash syndrome with gonadal dysgenesis

C. Frasier syndrome with gonadoblastoma

D. Perlman syndrome with nephroblastomatosis

Correct Answer: B. Denys-Drash syndrome with gonadal dysgenesis

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The patient's severe proteinuria, ambiguous genitalia, hypertension, and WT1 gene mutation, along with the presence of a renal mass, are characteristic of Denys-Drash syndrome. Syndromes Associated with Wilms' Tumor: Denys-Drash Syndrome (DDS): Triad of Wilms' tumor , diffuse mesangial sclerosis leading to early-onset nephrotic syndrome, and male pseudohermaphroditism (ambiguous genitalia in a genetically male patient with 46XY karyotype). Typically present with severe proteinuria, ambiguous genitalia, and a high risk of developing Wilms' tumor, usually by the age of 3 years. WAGR Syndrome Beckwith-Wiedemann Syndrome (BWS) (Option A) Perlman Syndrome (Option D): A rare congenital overgrowth syndrome characterized by

nephroblastomatosis, macrosomia, umbilical hernia, and facial dysmorphism , with a high risk of Wilms tumor. Frasier Syndrome (Option C) presents with focal segmental glomerulosclerosis (FSGS) leading to slowly progressive nephropathy and an increased risk of gonadoblastoma . Wilms tumor is rare in this syndrome.

References:

Sabiston Textbook of Surgery, 21st Edition, Page 2091, 2092

↑ *Back to this question in Part A*

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Q18: A 55-year-old man presents with painless hematuria and a palpable mass in the left flank. Imaging studies reveal a renal mass measuring 8 cm with evidence of invasion into the renal vein but no involvement of surrounding lymph nodes or distant metastasis. According to the TNM staging system, what is the most appropriate stage of this renal cell carcinoma? (Q849285)

A. Stage I

B. Stage II

C. Stage III

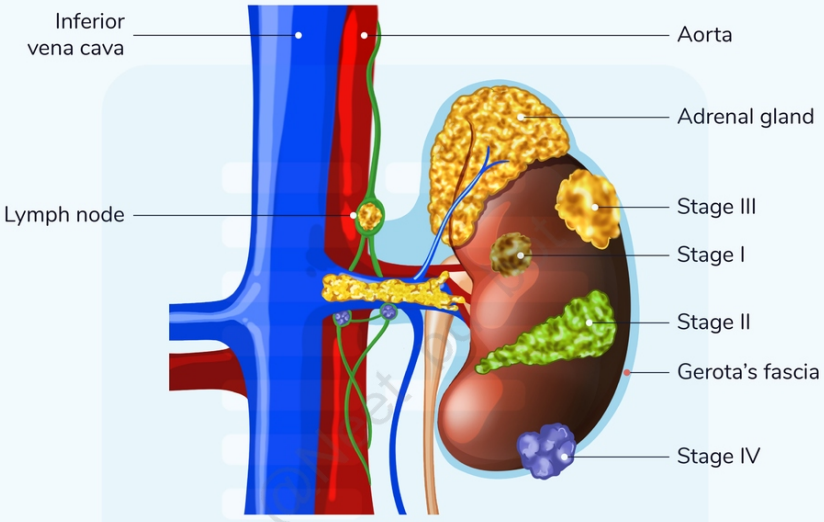
D. Stage IV

Correct Answer: C. Stage III

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The tumor has invaded the renal vein, which corresponds to T3a. There is no lymph node involvement (N0) or distant metastasis (M0). Therefore, according to the TNM staging system, the patient's RCC is classified as T3aN0M0 - Stage III. Category Code Description Tumor Tx Primary tumors cannot be assessed T0 No evidence of a primary tumor T1 Tumor ≤7 cm in greatest dimension, limited to the kidney T1a Tumor ≤4 cm T1b Tumor >4 cm but ≤7 cm T2 Tumor >7 cm, limited to the kidney T2a Tumor >7 cm but ≤10 cm T2b Tumor >10 cm T3 The tumor extends into major veins or perinephric tissues but not into the ipsilateral adrenal gland and not beyond Gerota’s fascia T3a The tumor extends into the renal vein or its segmental branches or invades perirenal and/or renal sinus fat but not beyond Gerota’s fascia T3b Tumor extends into the vena cava below the diaphragm T3c Tumor extends into the vena cava above the diaphragm or invades the wall of the vena cava T4 Tumor invades beyond Gerota’s fascia (including contiguous extension into the ipsilateral adrenal gland) Nodes Nx Regional lymph nodes cannot be assessed N0 No regional lymph node metastasis N1 Metastasis in regional lymph node(s) Metastasis M0 No distant metastasis M1 Distant metastasis present Stage Grouping: Stage I: T1, N0, M0 Stage II: T2, N0, M0 Stage III: T1 or T2, N1, M0 T3, N0 or N1, M0 Stage IV: T4 or M1, any N



Staging of renal cell carcinoma is based on size, position and lymph node involvement :

Stage I : Tumour <7 cm in the largest dimension, limited to the kidney.

Stage II : Tumour >7 cm in the largest dimension, limited to the kidney.

Stage III : Tumour in the major veins or adrenal gland with intact Gerota's fascia, or regional lymph nodes involved.

Stage IV : Tumour beyond Gerota's fascia.

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References:

Bailey and Love's Short Practice of Surgery, 8th Edition, Page 1484

Sabiston Textbook of Surgery, 21st Edition, Page 2091

↑ *Back to this question in Part A*

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Q19: A 62-year-old woman with a history of smoking presents with a sudden onset of headaches and visual disturbances. A CT scan shows a 5 cm mass in the left kidney. Which of the following is most likely associated with her condition? (Q849284)

A. Addison's disease

B. Hypocalcemia

C. Hypotension

D. Polycythemia

Correct Answer: D. Polycythemia

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Polycythemia in this patient is likely due to ectopic erythropoietin production by renal cell carcinoma, which is a known paraneoplastic manifestation. The sudden onset of symptoms like headaches and visual disturbances can be attributed to the increased blood viscosity caused by polycythemia. Paraneoplastic Manifestations of RCC: Elevated ESR . Hypercalcemia: The ectopic production of parathyroid hormone-related peptide (PTHrP) by the tumor, leads to increased calcium levels in the blood. This can cause symptoms like nausea, vomiting, and confusion (Option B) . Hypertension: Hypertension in RCC can be due to increased renin production by the tumor or as a result of polycythemia. (Option C) Cushing's disease: Although less common, Cushing's syndrome can occur as a paraneoplastic manifestation due to ectopic production of ACTH by the tumor, leading to elevated cortisol levels. Addison's disease is not generally caused by RCC (Option A) . Stauffer's syndrome: (Non metastatic reversible hepatitis) RCC patient with jaundice - Raised Bilirubin, ALP.

References:

Bailey and Love's Short Practice of Surgery, 8th Edition, Page 1482

↑ *Back to this question in Part A*

@Neet_pg_bot

Q20: A 65-year-old male presents with an incidental finding of a renal mass on imaging. The mass shows an enhancing appearance on cross-sectional imaging with a central stellate scar. A biopsy is inconclusive, and the mass is surgically removed. Histopathological examination reveals granular, eosinophilic cytoplasm within the tumor cells, negative for cytokeratin 7. What is the most likely diagnosis? (Q849282)

A. Clear Cell Renal Cell Carcinoma

B. Renal Oncocytoma

C. Chromophobe Renal Cell Carcinoma

D. Papillary Renal Cell Carcinoma

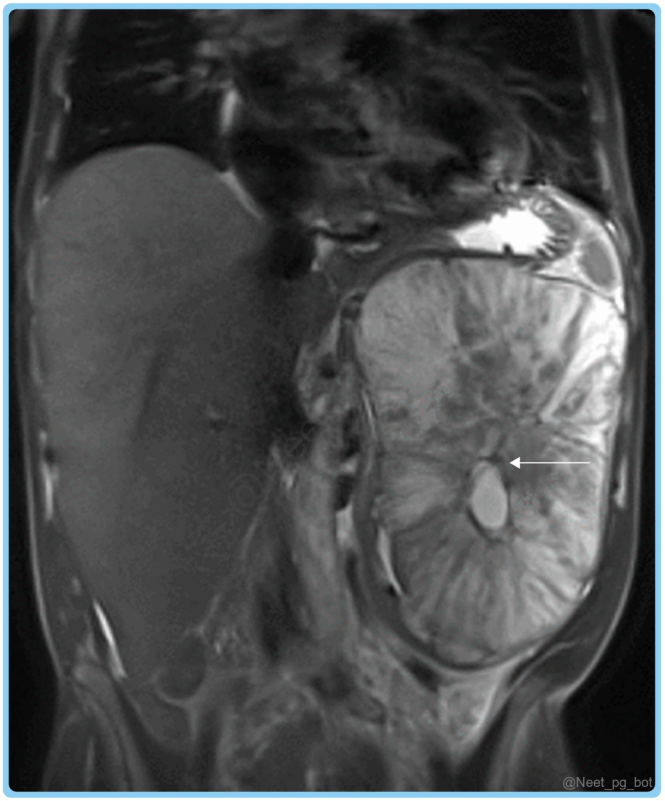
Correct Answer: B. Renal Oncocytoma

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Renal Oncocytoma is characterized by granular, eosinophilic cytoplasm due to abundant mitochondria (oncocytes). The enhancing mass with a central stellate scar is the suggestive feature. Renal Oncocytoma Definition & Prevalence Benign renal tumor with oncocytes, characterized by granular, eosinophilic cytoplasm. Diagnosis CECT : (Investigation of choice): Presents as an enhancing mass Central Stellate Scarring (star-shaped scar within the tumor). Spoke Wheel Appearance. Clear Cell Renal Cell Carcinoma (Option A)

typically has cells with clear cytoplasm due to the loss of lipids, and it does not commonly present with a central scar. Chromophobe Renal Cell Carcinoma (Option C) usually lacks the central stellate scar and has a different histological appearance with more distinct cell borders and perinuclear halos, staining positive for cytokeratin 7. Papillary Renal Cell Carcinoma (Option D) often has a papillary architecture and cells with more foamy or pale cytoplasm, and the presence of a central scar is not typical.



References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1481-1482

Campbell Walsh, 12th Online Edition, Page 9850

↑ *Back to this question in Part A*

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• [06_Urology] 036 Urinary Bladder

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[06_Urology] 036 Urinary Bladder — Quick Jump

Q1 (p. 2512)	*Q2 (p. 2512)*	*Q3 (p. 2513)*	*Q4 (p. 2515)*	*Q5 (p. 2515)*	*Q6 (p. 2517)*
Q7 (p. 2517)	*Q8 (p. 2518)*	*Q9 (p. 2519)*	*Q10 (p. 2520)*	*Q11 (p. 2521)*	*Q12 (p. 2525)*
Q13 (p. 2526)	*Q14 (p. 2527)*	*Q15 (p. 2531)*	*Q16 (p. 2533)*	*Q17 (p. 2534)*	*Q18 (p. 2535)*
Q19 (p. 2537)	*Q20 (p. 2538)*				

Q1: A 74-year-old man was diagnosed with squamous cell carcinoma of the bladder. Which of the following is the most likely risk factor for this type of bladder cancer? (Q849368)

A. History of schistosomiasis.

B. Previous bladder augmentation surgery.

C. Occupational exposure to aromatic hydrocarbons.

D. Use of drugs like cyclophosphamide

Correct Answer: A. History of schistosomiasis.

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Histologic Type of Bladder Carcinoma Risk Factors Transitional cell carcinoma (>97%) Smoking Occupational exposure (aromatic hydrocarbons): Rubber, paint and dyes, gas and tar industries Hairdressers, plumbers, and painters (Option C) Environmental carcinogens: Arsenic in drinking water Schistosomiasis (SCC >> transitional cell Ca) Drugs: Phenacetin, Cyclophosphamide (Option D) Pelvic radiotherapy Squamous Cell Carcinoma (1-7%) Schistosomiasis (Option A) Secondary to chronic infections: Indwelling catheter Bladder stone Recurrent infections Adenocarcinoma (2%) Urachus Augmentation enterocystoplasty (Option B) Bladder exstrophy repair

References:

Bailey and Love’s Short Practice of Surgery, 28th Edition, Pages 1515,1516

↑ *Back to this question in Part A*

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Q2: A patient who had undergone cystectomy and urinary diversion with an ileal conduit after being diagnosed with muscle-invasive bladder cancer comes for follow-up. His blood investigations revealed an electrolyte imbalance. Which of the following is not a possible imbalance in this condition? (Q849377)

A. Hypokalemia

B. Hyponatremia

C. Hypocalcemia

D. Hypomagnesemia

Correct Answer: B. Hyponatremia

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Ileal conduit uses a segment of ileum to divert urine. Ileal mucosa absorbs urinary solutes, especially ammonium and chloride, via ion exchange. This commonly leads to hyperchloremic metabolic acidosis, the hallmark disturbance. Hypokalemia, hypomagnesemia, and hypocalcemia can occur secondarily due to acidosis or chronic changes. (Option A, C & D ruled out) Sodium is usually maintained or slightly increased, so hyponatremia is not expected. Hyponatremia is rare in ileal conduits; it is more associated with jejunal conduits.

References:

www.ncbi.nlm.nih.gov/pmc/articles/PMC3822347/

↑ *Back to this question in Part A*

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Q3: A new mother comes to the outpatient department with her neonate as she notices intermittent fluid leaking from the umbilicus of the baby. On examination, the umbilicus is inflamed, enlarged, and there is delayed healing of the cord stump. What is the diagnosis? (Q849376)

A. Patent urachus

B. Urachal cyst

C. Umbilical-urachal sinus

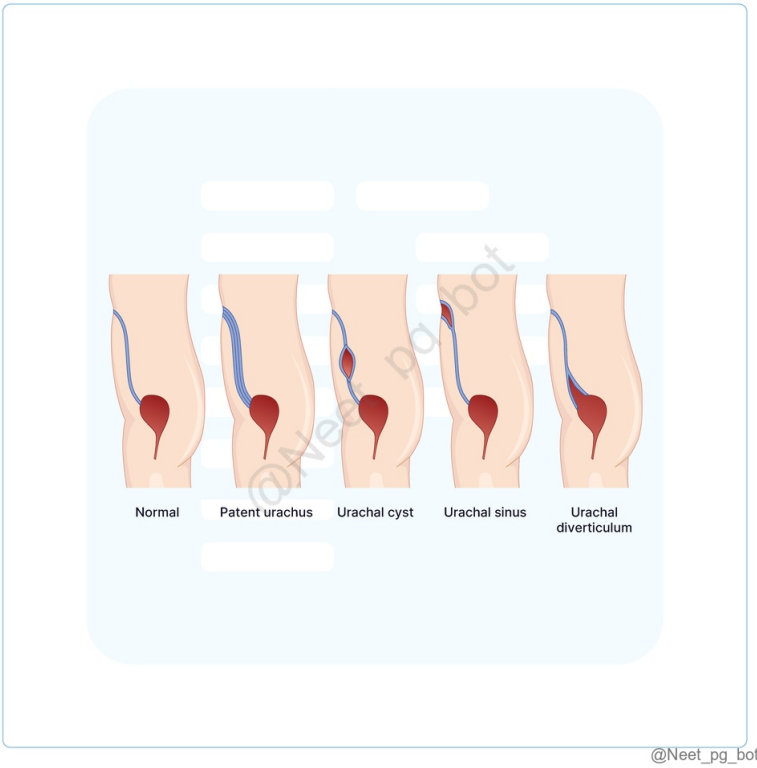
D. Vesico-urachal diverticulum

Correct Answer: A. Patent urachus

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The neonate presents with intermittent fluid discharge from the umbilicus, inflammation, and delayed cord healing , which is classical for a patent urachus . Patent Urachus Embryological Basis The urachus is a remnant of the allantois , connecting the fetal bladder to the umbilicus Normally, it obliterates after birth to form the median umbilical ligament Failure of obliteration leads to urachal anomalies In patent urachus, there is a complete persistent communication between bladder and umbilicus . Hence, urine leaks from the umbilicus. Clinical Features Clear fluid discharge from umbilicus (urine) May increase during crying or straining Umbilical inflammation and edema Delayed cord stump healing Risk of infection Management Definitive treatment → Surgical excision of the urachal tract Prevents: Recurrent infection Skin excoriation Rare malignant transformation (later life) Urachal cyst (Option B): The central part of the urachus persists, but both ends are closed . It presents as a m idline infraumbilical swelling that may become infected, causing pain and fever. There is n o discharge from the umbilicus . Umbilical-urachal sinus (Option C): Only the umbilical end remains open . It presents with purulent discharge from the umbilicus but does not communicate with the bladder , so urine leakage is absent Vesico-urachal diverticulum (Option D): Only the bladder end remains open and forms a diverticulum from the bladder dome. It is usually asymptomatic or may presents with UTI



References:

Campbell-Walsh-Wein Urology, 12th Edition, Pages 2383, 2384

↑ *Back to this question in Part A*

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Q4: A 55-year-old male with non-muscle invasive bladder carcinoma is advised TURBT and BCG immunotherapy due to a high risk of recurrence. Which condition is not a contraindication for BCG therapy? (Q849375)

A. Immunocompromised

B. Immediately after TURBT

C. Total urinary incontinence

D. Previous history of tuberculosis

Correct Answer: D. Previous history of tuberculosis

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: A history of previous tuberculosis is not an absolute contraindication for using BCG in a bladder carcinoma patient. However, it may increase the risk of complications or decrease the treatment effectiveness. Administration Intravesical instillations: Administered postoperatively Induction therapy: Weekly for 6 weeks Maintenance therapy: Every 3 weeks for 3 years (variable intervals for 1-3 years) Timing BCG Therapy: Administered 6 weeks post-operatively, not immediately. (Option B) Mitomycin C: Given immediately post-operatively. Contraindications Immunocompromised Patients: (Option A) Risk of BCG sepsis; requires a competent immune system. Gross Hematuria: Risk of BCG entering circulation and causing systemic infection. Total Urinary Incontinence (Option C) : BCG is ineffective if it cannot remain in the bladder. History of Previous BCG Sepsis or Hypersensitivity: Risk of severe reactions.

References:

Bailey & Love's Short Practice of Surgery, 28th edition, Page 1518.

Sabiston's Textbook of Surgery, 21st edition, Page 2093.

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2746687/

↑ *Back to this question in Part A*

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Q5: During a radical cystectomy for bladder cancer in males, which of the following structures is typically spared and not removed? (Q849374)

A. Seminal Vesicles

B. Prostate

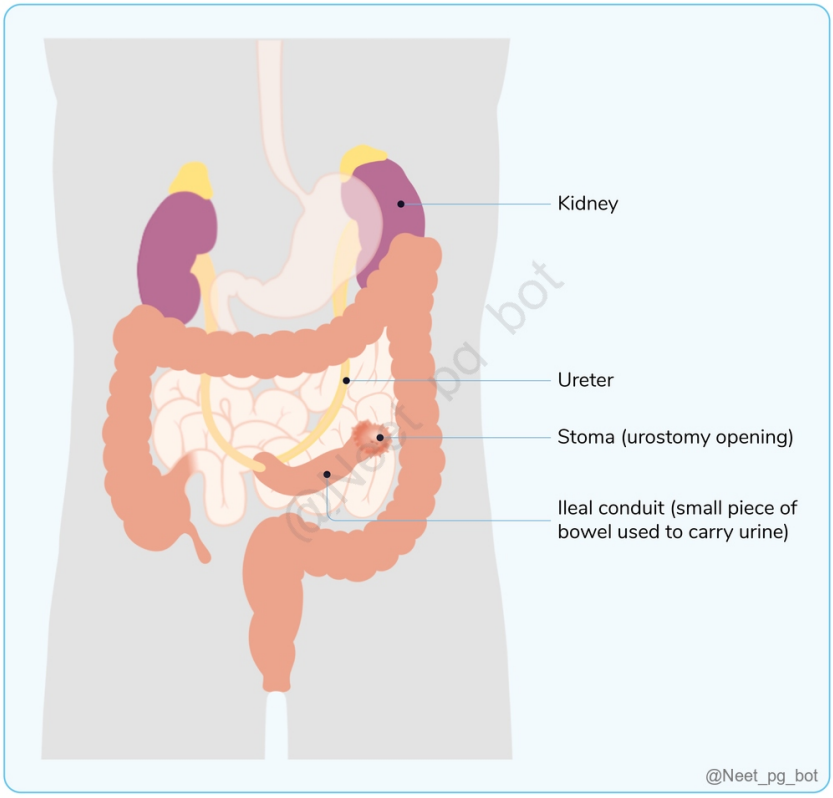
C. Urethra

D. Testes

Correct Answer: D. Testes

- *Listen (English)*
- *Listen (Hindi)*

Explanation: Structures Removed During Radical Cystectomy Indications for Radical Cystectomy Indications for Partial Cystectomy Entire Bladder Prostate (Males) (Option B) Seminal Vesicles (Option A) (Males) Urethra (Option C) Regional Lymph Nodes Uterus and Ovaries (Females) Invasive Bladder Cancer : Spread beyond the bladder lining Non-Muscle Invasive Bladder Cancer : Recurrent and unresponsive to other treatments Single Tumor : Confined to a single area of the bladder Limited to Bladder Wall : Does not involve surrounding tissues or organs Persistent or recurrent tumors in a localized area High-Grade Tumors : Confined to a specific area, does not involve deeper layers or distant sites Preservation of Bladder Function {{caption_text}}



References:

Sabiston Textbook of Surgery, 21st edition, Page 2093

www.niddk.nih.gov/health-information/urologic-diseases/urinary-diversion

www.ncbi.nlm.nih.gov/pmc/articles/PMC7807374/

↑ *Back to this question in Part A*

@Neet_pg_bot

Q6: Which of the following is the preferred initial therapy for a patient with carcinoma in situ (Tis) urinary bladder cancer after TURBT? (Q849373)

A. Intravesical Gemcitabine (single instillation)

B. Intravesical Mitomycin (single instillation)

C. Intravesical BCG therapy

D. Immediate Cystectomy

Correct Answer: C. Intravesical BCG therapy

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Carcinoma in situ (CIS) of the urinary bladder is a high-grade, non-muscle invasive bladder cancer (NMIBC) with a high risk of progression . After Transurethral Resection of Bladder Tumor (TURBT) , the treatment of choice is intravesical Bacillus Calmette-Guérin (BCG) therapy . BCG is an immunotherapy that induces a local immune response against tumor cells. It is most effective for high-risk NMIBC , especially: Carcinoma in situ (Tis) High-grade Ta/T1 tumors Regimen: Induction phase: Weekly instillations for 6 weeks Maintenance therapy: Given over months to years (improves outcomes) Benefits: Reduces recurrence Reduces progression to muscle-invasive disease Intravesical Gemcitabine (single instillation) (Option A): Gemcitabine is used as intravesical chemotherapy , but typically used in low/intermediate-risk tumors or in BCG-refractory cases . Also, a single instillation is insufficient for CIS . Intravesical Mitomycin C (single instillation) (Option B): Mitomycin is commonly given as a single immediate instillation after TURBT to reduce recurrence, mainly for low-risk tumors . It is not adequate for carcinoma in situ , which requires BCG therapy Immediate cystectomy (Option D): Radical cystectomy is reserved for BCG failure/refractory cases or very high-risk disease. It is not the initial therapy , especially when bladder preservation with BCG is possible.

References:

www.uptodate.com/contents/treatment-of-primary-non-muscle-invasive-urothelial-carcinoma-of-the-bladder?

↑ *Back to this question in Part A*

@Neet_pg_bot

Q7: Which of the following is not a tumor marker for urinary bladder cancer? (Q849372)

A. Hyaluronidase (HYAL-1)

B. Nuclear Matrix Protein 22

C. Bladder Tumor Antigen

D. Alpha-fetoprotein

Correct Answer: D. Alpha-fetoprotein

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Alpha-fetoprotein is not a tumour marker for urinary bladder cancer; it is primarily associated with liver cancer and germ cell tumours. Tumor Markers Helpful in diagnosis and for follow-up to assist the response of therapy and to detect recurrence NMP22 (Nuclear Matrix Protein 22) (Option B) Measures levels of a protein released from bladder cancer cells into the urine. BTA (Bladder Tumour Antigen) (Option C) Detects proteins associated with bladder cancer in the urine. Hyaluronidase (Option A) Elevated levels of urinary HA and HAase have been observed in patients with bladder cancer. HYAL-1 hyaluronidase is a potential prognostic marker for predicting muscle invasion and recurrence in non-muscle-invasive bladder cancer.

References:

www.uptodate.com/contents/clinical-presentation-diagnosis-and-staging-of-bladder-cancer

pubmed.ncbi.nlm.nih.gov/10604388/

pubmed.ncbi.nlm.nih.gov/2405185/

↑ *Back to this question in Part A*

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Q8: A 62-year-old male with a bladder tumor invading the muscle layer is classified as which TNM stage? (Q849371)

A. Ta

B. T1

C. T2

D. T3

Correct Answer: C. T2

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: T2 lesions indicate invasion into the muscle layer of the bladder. Primary Tumor Staging (TNM System) The depth of invasion of the primary tumor in bladder cancer is a crucial prognostic factor for recurrence and progression. Ta Lesions (Option A) Papillary (exophytic) tumors with a tendency to recur. Tis Lesions High-grade intraepithelial neoplasms (carcinoma in situ [CIS]) without invasion into subepithelial connective tissue. T1 Lesions (Option B) Tumors invade the submucosa or lamina propria, typically high-grade. T2 Lesions (Option C) Tumors invade muscle; cystectomy is standard therapy. Presence of muscle invasion increases the likelihood of nodal and distant metastases. T3 Lesions (Option D) Tumors extend beyond muscle into perivesical fat. Imaging (CT, MRI, PET) may help identify disease spread outside the bladder. T4 Lesions Tumors extend into adjacent organs. T4a - invasion into the prostate, vagina, uterus, or bowel T4b - tumors fixed to the abdominal wall, pelvic wall, or other organs.

References:

www.uptodate.com/contents/overview-of-the-initial-approach-and-management-of-urothelial-bladder-cancer

↑ *Back to this question in Part A*

@Neet_pg_bot

Q9: A 62-year-old patient with muscle-invasive bladder cancer is undergoing evaluation for metastasis. What is the most common lymphatic node involved in bladder cancer metastasis? (Q849370)

A. Supraclavicular nodes

B. Pelvic Nodes

C. Retroperitoneal Nodes

D. Intrathoracic Nodes

Correct Answer: B. Pelvic Nodes

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Metastasis of Carcinoma Bladder: Route of metastasis: Direct extension into adjacent organs and/or the pelvic sidewall Lymphatic spread Hematogenous spread Sites of Metastasis: Lymph Nodes (69%): Pelvic (m/c) (Option C)> Retroperitoneal (Option C) > Intrathoracic (Option D)> Supraclavicular Nodes (Option A) Bone (47%): Lytic lesions, sclerotic lesions or mixed lesions Lungs (37%): Pulmonary nodules or consolidations Liver (26%): Multiple Lesions or Solitary Lesions Peritoneum (16%) Other Metastatic Sites: Soft tissue, adrenal glands, brain Tumors in a more advanced T category and those with atypical histologic features metastasize earlier. Tumors with atypical histologic features also have a higher frequency of peritoneal metastasis.

References:

Bailey and Love’s Short Practice of Surgery, 28th Edition, Page 1516, 1517

https://pubmed.ncbi.nlm.nih.gov/21178055/

https://www.ncbi.nlm.nih.gov/books/NBK536923/

↑ *Back to this question in Part A*

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Q10: A 65-year-old male with a history of smoking presents with frequent urination and microscopic hematuria. Cystoscopy reveals a flat, high-grade lesion confined to the bladder epithelium. What is the most likely diagnosis? (Q849369)

A. Papillary tumor

B. Carcinoma in situ

C. Stage T1 urothelial carcinoma

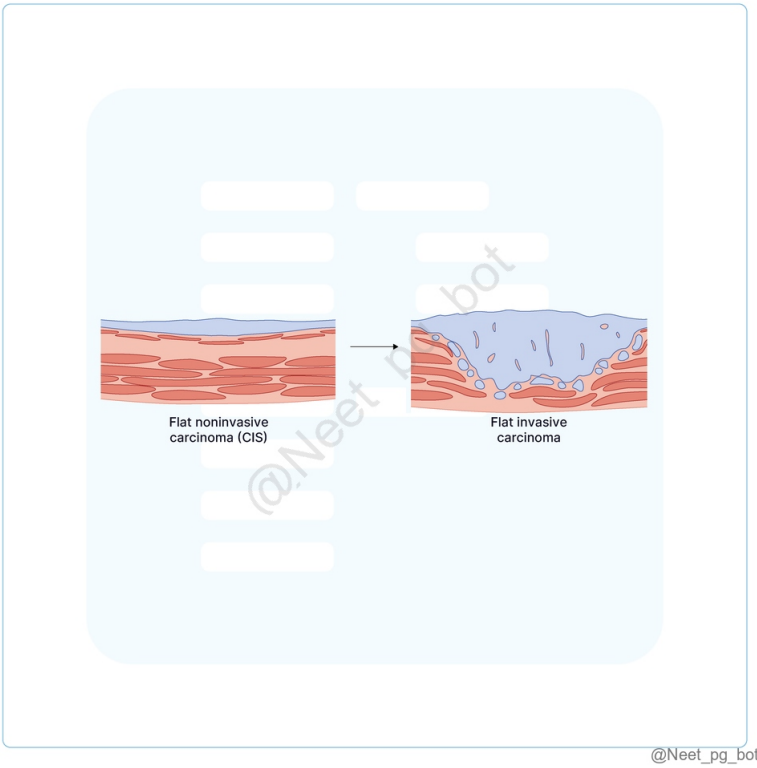
D. Squamous cell carcinoma of bladder

Correct Answer: B. Carcinoma in situ

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Precursor lesions of carcinoma bladder: Carcinoma in situ (CIS) Epithelial lesions that have cytologic features of malignancy but are confined to the epithelium, with no basement membrane invasion. Also called stage Tis bladder cancer or stage Tis transitional cell cancer (Tis, N0, M0). High-grade, flat tumor on the bladder's inner lining, not invading deeper tissues. Symptoms: Dysuria Nocturia Frequent and urgent urination Microscopic hematuria (Option B) Diagnosis: Urine cytology, histopathology, immunostaining (CK 20, p53, CD44), and FISH for chromosome abnormalities. Treatment: Intravesical BCG preferred



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References:

Robbins Pathological basis of diseases, 10th edition, Pages 957, 958

https://www.cancer.gov/publications/dictionaries/cancer-terms/def/noninvasive-papillary-carcinoma

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8319871/

https://pubmed.ncbi.nlm.nih.gov/19176205/

Bailey and Love's Short Practice of Surgery, 28th Edition, Page 1516

https://www.pathologyoutlines.com/topic/bladdersquamous.html

↑ *Back to this question in Part A*

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Q11: A 7-year-old boy with recurrent urinary tract infections (UTIs) is brought with a few episodes of hematuria and bladder discomfort. Imaging shows a diverticulum near the ureteric orifice. Which of the following statements is most accurate based on the clinical scenario? (Q849367)

A. Congenital diverticulum due to its location and UTIs.

B. Occurs secondary to high intravesical pressure.

C. Immediate surgery is needed regardless of symptoms.

D. Thick-walled bladder with multiple diverticula.

Correct Answer: A. Congenital diverticulum due to its location and UTIs.

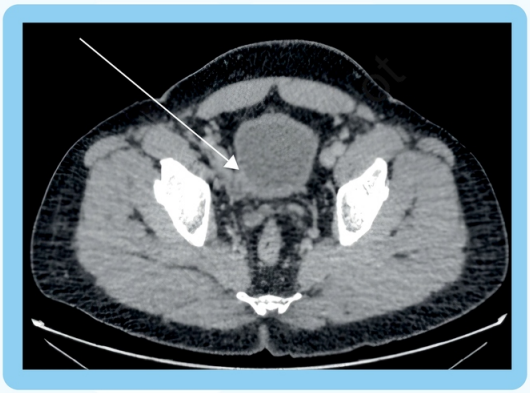
■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Bladder diverticula can be congenital or acquired (secondary to intravesical bladder outlet obstruction). Type Congenital Diverticula Acquired Diverticula Cause Develops due to herniation of bladder mucosa through congenital muscular defect between the intravesical ureter and roof of ureteral hiatus called Hutch diverticulum. Secondary to bladder outlet obstruction, often due to prostatic issues in adult men. Bladder characteristics Thin-walled, typically located near the ureteric orifice, associated with vesicoureteral reflux (VUR) (Option A) Thick-walled with trabeculations and multiple diverticula. (Option D) High intravesical pressure causes bladder mucosa to protrude, forming saccules, which can become diverticula. (Option B) Symptoms or complications Haematuria (due to infection, stone or tumor) (30%) Recurrent UTIs Bladder stones Urinary retention Hydronephrosis Bladder tumors (1%) Diagnosis Imaging (ultrasound, CT, MRI, cystogram) or cystoscopy. Confirm bladder outlet obstruction with urodynamics if suspected. Bladder diverticulum MRI: {{caption_text}} Bladder diverticulum CT: {{caption_text}} Cystogram with bladder diverticulum: {{caption_text}} Cystoscopical view of bladder diverticulum: {{caption_text}} Treatment Congenital bladder diverticula is treated if symptomatic or for suspected malignancy. (Option C) Open surgery or minimally invasive techniques for excision of diverticula; May require ureteric reimplantation based on diverticulum location. Repair is done extravesical or through a combined extravesical or intravesical approach.



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References:

Bailey and Love’s Short Practice of Surgery, 28th Edition, Pages 1490-1492

↑ *Back to this question in Part A*

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Q12: A 34-year-old male presents with severe abdominal pain and inability to urinate after a car accident. On examination, he has diffuse abdominal tenderness with guarding and rigidity. A cystogram reveals urine leakage into the peritoneal cavity. What is the next best step in management? (Q849366)

A. Foley’s catheterisation and observation

B. Emergency laparotomy

C. IV antibiotics and close monitoring

D. Delayed surgical repair

Correct Answer: B. Emergency laparotomy

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: In the above clinical scenario, the patient presents with signs and symptoms of intraperitoneal bladder rupture, which is a surgical emergency. Therefore, emergency laparotomy is done immediately. Intraperitoneal rupture Involves a tear or injury to the peritoneum over the bladder, and urine leaks into the peritoneal cavity in males. Causes: Often occurs in a fully distended bladder, usually due to trauma or injury. Clinical Features: Sudden, severe pain in the suprapubic region. Signs of shock and syncope. Diffuse abdominal pain with later features of peritonitis. Abdominal distension. Haematuria Absence of desire to urinate. Diagnosis: Plain X-ray: May show ground glass appearance. Peritoneal Tap: Used to collect urine from the abdominal cavity. Cystography: Iodine dye is injected via a catheter to visualize bladder tears and the dye entry into the peritoneal cavity. The contrast outlines the bowel loops. Ultrasound: To assess other abdominal injuries. {{caption_text}} Treatment: Emergency Laparotomy is required. (Option B). Bladder tear is sutured with polylactic acid (vicryl) in two layers. Peritoneal wash to clean out the peritoneal cavity. Separate drainage for prevesical space and peritoneal cavity. Administration of specific antibiotics to prevent sepsis. Catheterization: Malecot’s catheter is placed suprapubically. Foley's catheter passed urethrally. Complications: Cystitis /and pyelonephritis. Peritonitis. Pelvic abscess. Fistula formation (vesicovaginal or rectovesical). Paralytic ileus. Hemorrhage. Prognosis: 100% mortality without surgery.



References:

Bailey and Love's Short Practice of Surgery, 28th Edition, Page1520

SRB's Manual of Surgery, 6th Edition, Pages 224,225

↑ *Back to this question in Part A*

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Q13: A 48-year-old female presents with chronic pelvic pain, urinary urgency, and frequency. On cystoscopy, a characteristic bladder lesion with a small capacity and visible mucosal breaks is noted. What is the most likely diagnosis? (Q849364)

A. Bladder Cancer

B. Radiation Cystitis

C. Interstitial Cystitis with Hunner's Lesion

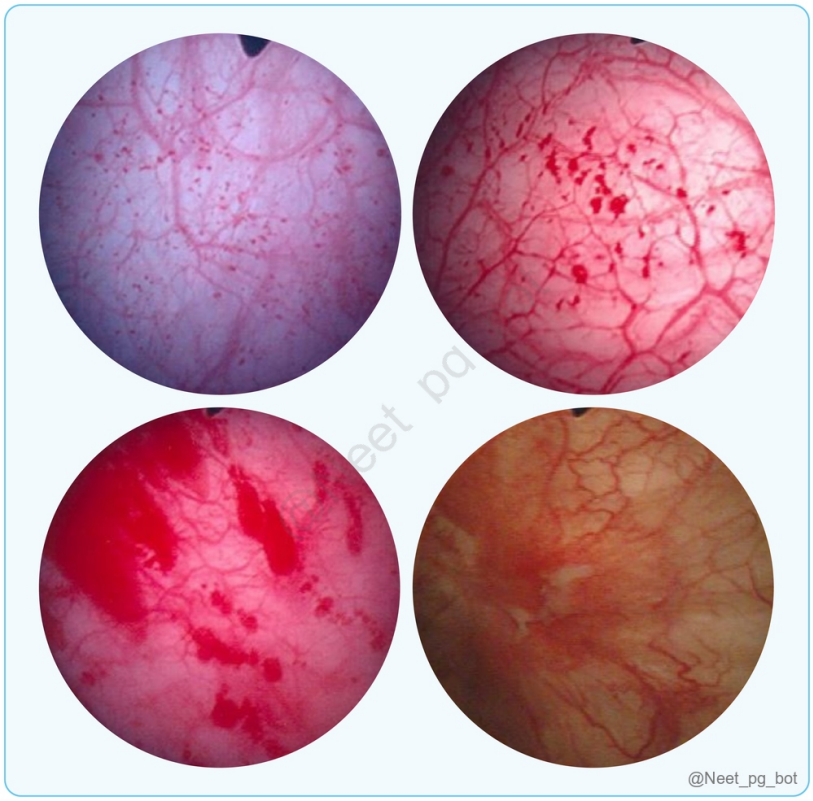
D. Urinary Tract Infection

Correct Answer: C. Interstitial Cystitis with Hunner's Lesion

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Interstitial Cystitis is a chronic bladder condition characterized by pelvic pain, urinary urgency, frequency, and a hallmark cystoscopic finding of Hunner’s lesions . These are inflamed, ulcerative lesions on the bladder wall that are pathognomonic for this condition. They often present with reduced bladder capacity and mucosal breaks, distinguishing them from other forms of cystitis and bladder pathologies. {{caption_text}}



References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Pages 1513, 1514.

https://www.intechopen.com/chapters/78509

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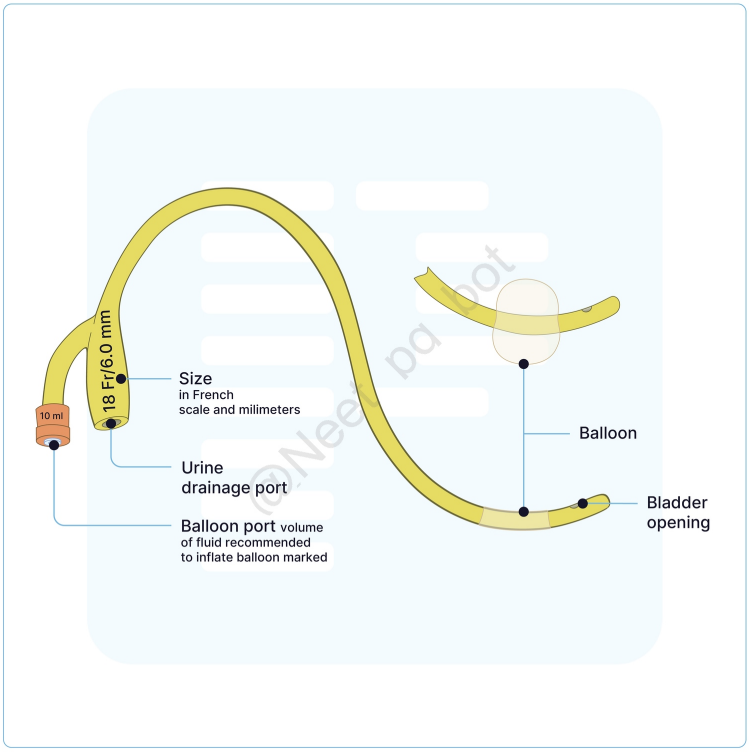
Q14: Based on the images provided, where would each of the shown catheters be used? Image 1: Image 2: (Q849358)

A. Image 1:Used for patients with acute urinary retention; Image 2:Used only in neurogenic bladder

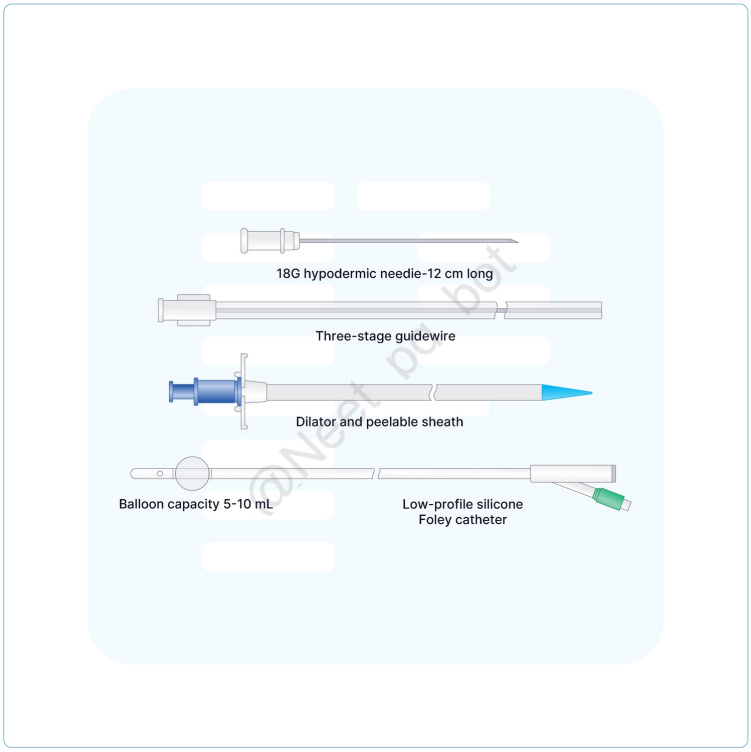
B. Image 1: Used for patients with an enlarged prostate causing retention; Image 2: Used in cases of urethral stricture or trauma

C. Image 1: Used for short-term postoperative bladder drainage; Image 2:Used only when Foley's catheterization is contraindicated

D. Image 1: Used for patients with acute urinary retention; Image 2:Used for continuous bladder irrigation



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Correct Answer: B. Image 1: Used for patients with an enlarged prostate causing retention; Image 2: Used in cases of urethral stricture or trauma

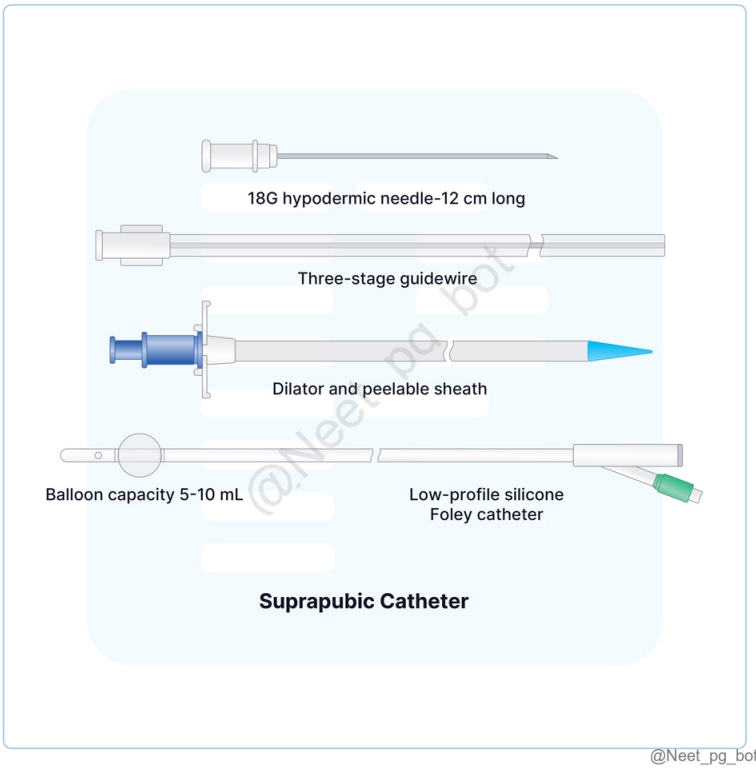
■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Image 1 - The image given is of a Foley's catheter and is typically used for bladder drainage in patients with an enlarged prostate, which causes urinary retention. Image 2 - This is an image of a Suprapubic Catheter (SPC) and is often chosen when there is a urethral stricture, trauma, or when urethral catheterization is not possible, but it is not the ONLY indication of using SPC



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References:

Bailey and Love’s Short Practice of Surgery, 28th Edition, Pages 1507-1509

↑ *Back to this question in Part A*

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Q15: A 35-year-old male presents to the emergency department after a motor vehicle accident with a pelvic fracture and gross hematuria. The CT cystogram showed the following characteristic findings. Which of the following statements regarding the diagnosis of this patient is incorrect? {{caption_text}} (Q849365)

A. Retrograde cystography demonstrates extravasation of contrast limited to the perivesical space.

B. Catheter drainage for 10-14 days is the treatment of choice for uncomplicated cases.

C. Immediate surgical repair in cases of bladder neck injury.

D. Both urethral and suprapubic catheters are recommended in all cases.



Correct Answer: D. Both urethral and suprapubic catheters are recommended in all cases.

■ *Listen to Audio 1*

Explanation: The contrast extravasation seen on CT cystography is confined to the perivesical space , giving a characteristic flame-shaped appearance , which is seen in Extraperitoneal bladder rupture. While the use of both

urethral and suprapubic catheters might be considered in complex cases, it is not universally recommended. Routine use of both types of catheters can increase morbidity and delay hospital discharge. The American Urological Association (AUA) guidelines recommend against the routine placement of a suprapubic catheter following bladder injury repair. Flame sign in Extraperitoneal bladder rupture : {{caption_text}} Retrograde cystography is the imaging modality of choice for diagnosing bladder ruptures, including extraperitoneal injuries. (Option A) Extravasation of contrast limited to the perivesical space is a key finding that helps differentiate extraperitoneal from intraperitoneal ruptures, where contrast would outline bowel loops. Conservative management with catheter drainage for 10-14 days is the standard treatment for uncomplicated extraperitoneal bladder injuries, especially when associated with pelvic fractures. (Option B) This approach allows time for the injury to heal without surgical intervention. Immediate surgical repair is indeed indicated in cases where there are complicating factors like intravesical bone spicules, bladder neck injuries , or associated vaginal or rectal lacerations. (Option C) These complications increase the risk of fistula formation, abscess, and incontinence, warranting prompt surgical intervention.



References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1513, 1514.

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6565401/

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10335098/

↑ *Back to this question in Part A*

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Q16: A 60-year-old female with recurrent UTIs and a history of chronic immunosuppression after a renal transplant presents with non-tender abdominal nodules. The biopsy shows histiocytes with basophilic inclusions staining positive for PAS and von Kossa stains. Which of the following is the most accurate statement regarding the diagnosis? (Q849363)

A. Commonly associated with Gram-negative bacteria like E. coli

B. Characteristic histological feature is Langhans giant cells

C. Treated primarily with high-dose corticosteroids

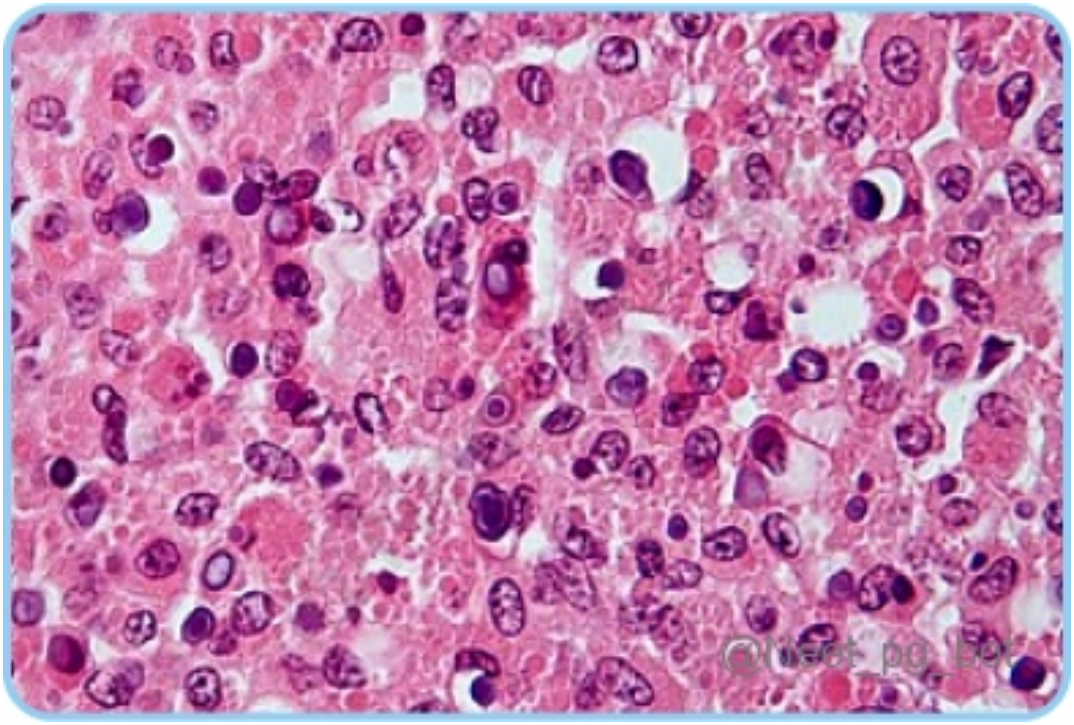
D. Usually self-limiting and resolves without treatment

Correct Answer: A. Commonly associated with Gram-negative bacteria like E. coli

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Malakoplakia is a rare inflammatory condition often seen in immunocompromised patients , such as those with chronic immunosuppression following organ transplants. It is commonly associated with Gram-negative bacteria, particularly Escherichia coli . The histological hallmark of malakoplakia is the presence of von Hansemann cells (large, foamy histiocytes) and Michaelis-Gutmann bodies (PAS-positive , basophilic intracytoplasmic inclusions that also stain with von Kossa and Perl’s stains) (Option B ruled out) Treatment- Antibiotics (fluoroquinolones, trimethoprim-sulfamethoxazole), possible surgical excision (Option C and D ruled out) Michaelis-Gutmann bodies: {{caption_text}}



References:

www.ncbi.nlm.nih.gov/books/NBK564348/

www.pathologyoutlines.com/topic/bladdermalakoplakia.html

↑ *Back to this question in Part A*

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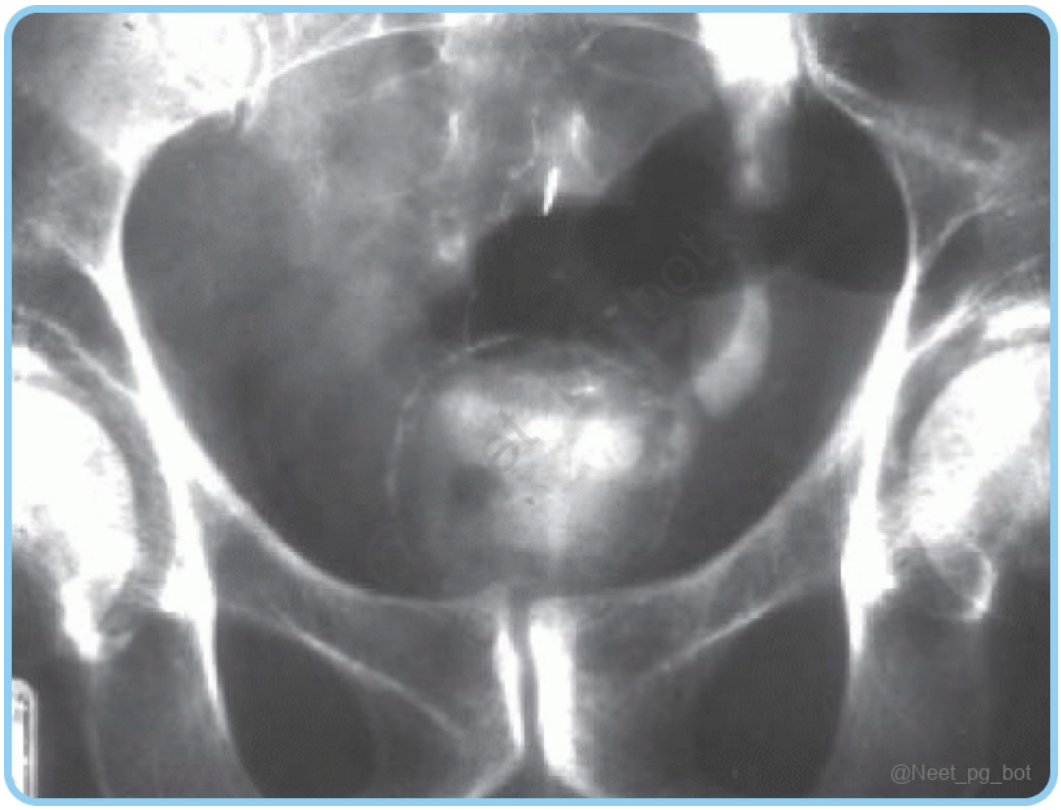
Q17: A 45-year-old male tourist from rural Egypt presents with recurrent hematuria and lower abdominal pain. A pelvic radiograph shows a circular calcification resembling a fetal head in the pelvis with associated faint calcification of the distal right ureter. What is the most likely diagnosis and appropriate next step? (Q849362)

A. Bladder stones; perform cystoscopy

B. Chronic schistosomiasis; obtain urine microscopy for ova

C. Pelvic tuberculosis; order interferon-gamma release assay

D. Calcified bladder tumor; schedule CT urography



Correct Answer: B. Chronic schistosomiasis; obtain urine microscopy for ova

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The " fetal head in pelvis " appearance on the pelvic radiograph is pathognomonic for chronic urinary schistosomiasis. Pelvic radiograph shows the classic appearance of the calcified bladder, which resembles a fetal head in the pelvis, with associated faint calcification of the distal right ureter. The patient's origin from rural Egypt, an endemic area for Schistosoma haematobium , further supports this diagnosis. Urine microscopy for ova remains the definitive diagnostic test for schistosomiasis.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1512

pubs.rsna.org/radiographics/doi/10.1148/rg.324115162

↑ *Back to this question in Part A*

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Q18: A 9-year-old boy from a rural area presents with suprapubic pain, increased urinary frequency, and occasional hematuria, with no incontinence or systemic symptoms. He appears thin, has normal external genitalia, and has no significant

medical history. Imaging shows multiple small, smooth bladder stones. What is the most likely cause? (Q849361)

A. Bladder outlet obstruction leading to urinary stasis

B. Infection with urease-producing bacteria

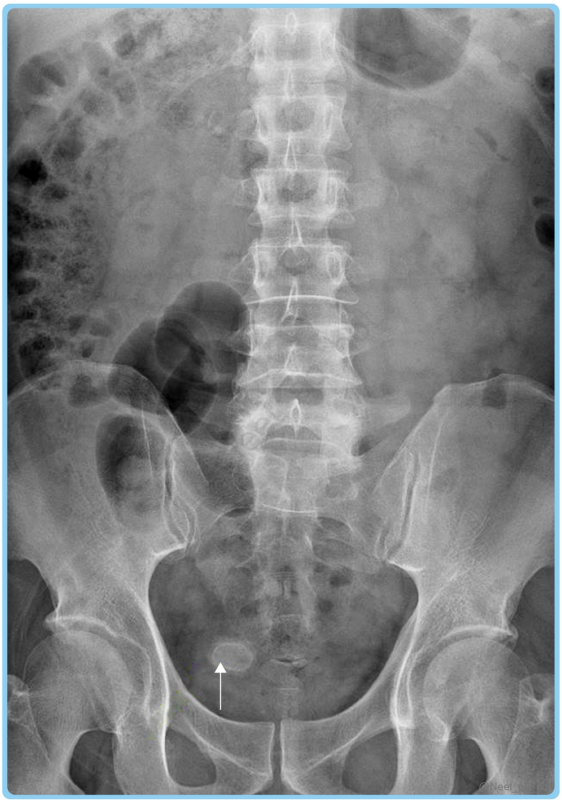
C. Nutritional deficiency

D. Foreign body presence in the bladder

Correct Answer: C. Nutritional deficiency

- *Listen (English)*
- *Listen (Hindi)*

Explanation: Primary bladder stones are commonly seen in children, often in developing regions, and are related to dietary deficiencies, particularly in vitamins A and B6, magnesium, and an imbalanced protein-carbohydrate ratio. This patient’s appearance, history, and lack of other contributory factors point towards a nutritional deficiency as the cause of his primary bladder stone. Aetiology of Bladder Stones Type Primary Bladder Stones Secondary Bladder Stones Causes Nutritional deficiency (Vitamins A, B6, magnesium, protein-carbohydrate imbalance) (Option C) Bladder outlet obstruction, infection, foreign body presence (Option A, B, D) Common Composition Ammonium urate, calcium oxalate Uric acid, struvite (infection-related) Common Population Children in developing countries Adults with urinary tract dysfunction or infection Clinical Presentation May be asymptomatic or present with dysuria, hematuria Hematuria, dysuria, frequency and urgency, {{caption_text}}



References:

Bailey and Love's Short Practice of Surgery, 28th Edition, Pages 1509, 1510

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3263228/

↑ *Back to this question in Part A*

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Q19: Which of the following statements about ectopia vesicae is correct? (Q849360)

A. More common in females than males

B. Presents with normal urinary continence

C. Increased risk of urinary bladder adenocarcinoma

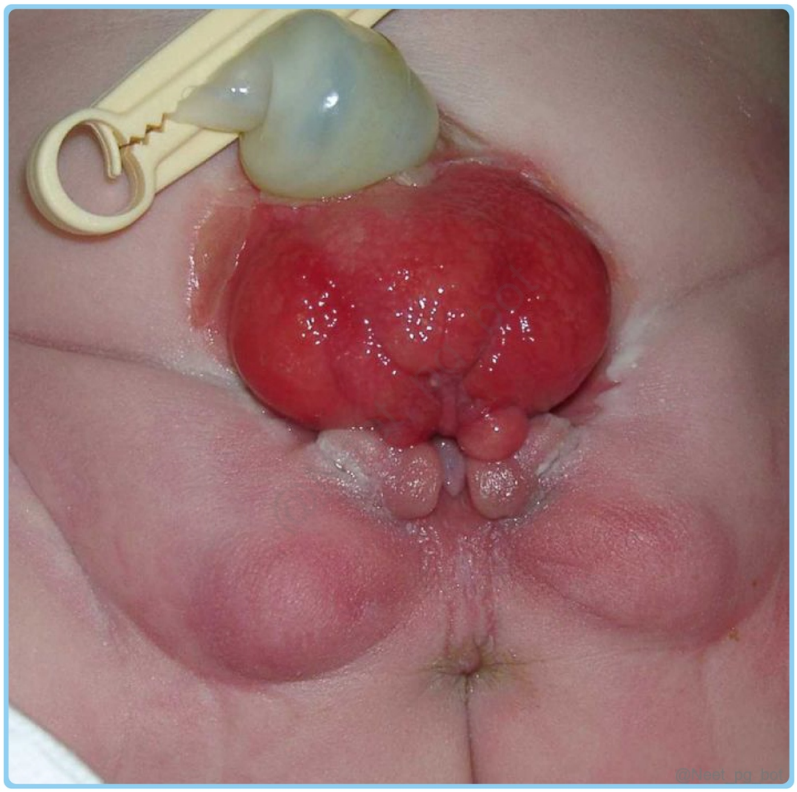
D. Resolves on its own without surgery

Correct Answer: C. Increased risk of urinary bladder adenocarcinoma

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Ectopia vesicae, also known as bladder exstrophy, is associated with an increased risk of developing urinary bladder adenocarcinoma due to chronic irritation and exposure of the bladder's internal lining. Ectopia vesicae : It is a rare congenital defect where the urinary bladder is exposed outside the abdomen due to a failure to develop the lower abdominal wall. M/c in males. (Option A ruled out) Continuous leakage of urine due to the inability to close the bladder outlet. Vesicoureteral reflux, possible renal anomalies like renal dysplasia or hydronephrosis. (Option B ruled out) Surgical Management of Ectopia Vesicae: (Option D ruled out) Staged Reconstruction with B/L pelvic osteotomies to facilitate abdominal wall closure and reduce tension in the neonatal period. Epispadias repair and reconstruction of the urethra and external genitalia at 6-12 months of age. Bladder Neck Reconstruction (BNR) to treat VUR at 5-7 yrs. {{caption_text}}



References:

Bailey and Love's Short Practice of Surgery, 28th Edition, Pages 1492, 1493

↑ *Back to this question in Part A*

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Q20: A 70-year-old male with diabetes and Parkinson's disease presents with a 6-month history of difficulty urinating, incomplete bladder emptying, and frequent nighttime urination. A post-void residual volume test shows significant urine retention. Which of the following conditions is least likely the primary cause of his chronic urinary retention? (Q849359)

A. Parkinson's disease

B. Diabetic neuropathy

C. Benign Prostatic Hyperplasia (BPH)

D. Overactive Bladder

Correct Answer: D. Overactive Bladder

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The patient presents with difficulty in urination, incomplete bladder emptying, nocturia, and increased post-void residual urine , which are classical features of chronic urinary retention . Chronic urinary retention occurs due to: Bladder outlet obstruction Detrusor underactivity (neurogenic bladder) In this elderly patient with diabetes and Parkinson's disease , multiple causes of retention are possible: Parkinson's disease (Option A) c auses neurogenic bladder dysfunction which can lead to Detrusor-sphincter dyssynergia and impaired bladder emptying. It can cause chronic urinary retention Diabetic neuropathy (Option B) leads to autonomic neuropathy affecting bladder and causes a tonic bladder (diabetic cystopathy) and reduced bladder sensation. It results in large post-void residual urine Benign Prostatic Hyperplasia (BPH) (Option C) is the most common cause of chronic urinary retention in elderly males and causes bladder outlet obstruction that leads to hesitancy, poor stream, and incomplete emptying. Overactive Bladder (Option D): It is characterized by urgency, frequency and urge incontinence. It is due to detrusor overactivity, not failure of emptying. Post-void residual is usually normal or minimal. It does not cause chronic urinary retention

References:

Bailey and Love's Short Practice of Surgery, 28th Edition, Pages 1507-1509

↑ *Back to this question in Part A*

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• [06_Urology] 037 Prostate And Seminal Vesicles

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[06_Urology] 037 Prostate And Seminal Vesicles — Quick Jump

Q1 (p. 2540) *Q2 (p. 2542)* *Q3 (p. 2543)* *Q4 (p. 2543)* *Q5 (p. 2544)* *Q6 (p. 2545)*
Q7 (p. 2546) *Q8 (p. 2547)* *Q9 (p. 2548)* *Q10 (p. 2549)* *Q11 (p. 2550)* *Q12 (p. 2551)*

Q1: An elderly male is identified to have a well-circumscribed lesion within the prostate suspicious of cancer. Based on the McNeal classification, in which prostatic zone is the lesion most likely to be located? (Q849305)

A. Transitional Zone

B. Peripheral Zone

C. Central Zone

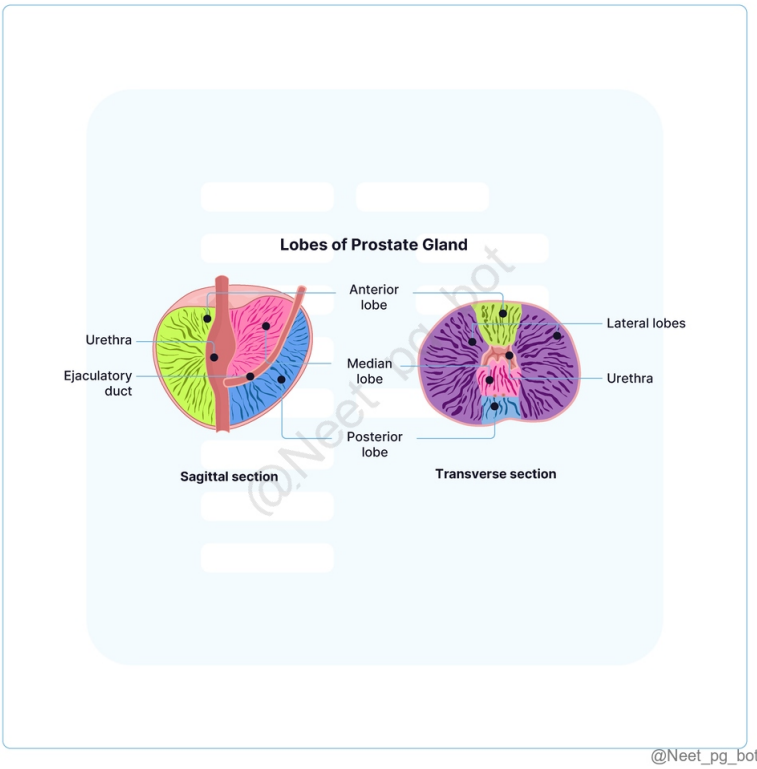
D. Anterior Fibromuscular Stroma

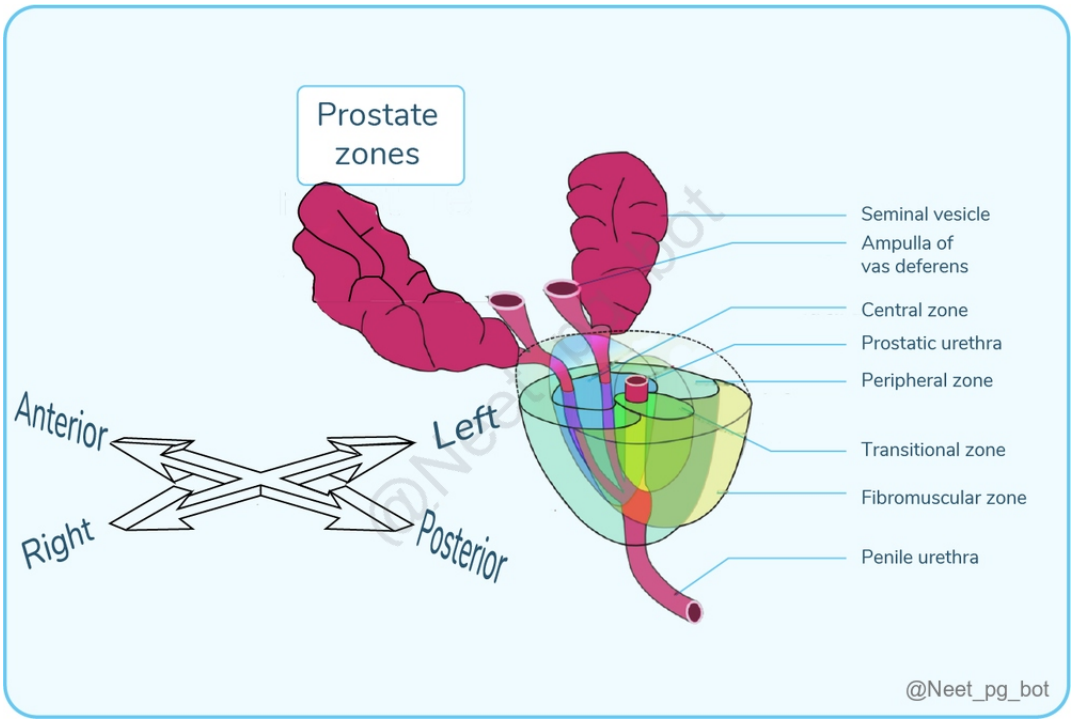
Correct Answer: B. Peripheral Zone

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The majority of prostate cancers originate in the peripheral zone according to McNeal’s Zonal classification of the prostate. McNeal Zonal classification of prostate gland: Peripheral zone: most common site for carcinoma. (Option B) Periurethral transition zone: most common site for BPH. (Option A ruled out) Central zone: surrounds the ejaculatory ducts. (Option C ruled out) Anterior Fibromuscular Stroma : Non-glandular area, and surrounds an inferior portion of the prostate called the apex (Option D ruled out)





References:

Sabiston Textbook of Surgery, 21st Edition, Page 2063

SRB’s Manual of Surgery, 6th Edition, Page 1032

https://www.ncbi.nlm.nih.gov/books/NBK540987/

↑ *Back to this question in Part A*

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Q2: A 75-year-old man presents with difficulty in urination, weak stream, and increased frequency. On digital rectal examination, his prostate is found to be enlarged, and his PSA levels are mildly elevated. Which enzyme converts testosterone to dihydrotestosterone, a hormone responsible for the pathogenesis of his condition? (Q849306)

A. Aromatase

B. 17-β Hydroxysteroid dehydrogenase

C. 5 ■ reductase

D. 21-Hydroxylase

Correct Answer: C. 5 ■ reductase

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The patient likely has benign prostatic hyperplasia (BPH) . Dihydrotestosterone (DHT) is the androgen that stimulates prostate growth . 5-α reductase is the enzyme that converts testosterone into DHT , making it central to BPH pathogenesis. Inhibitors of 5-α reductase (e.g., finasteride, dutasteride) are used in treatment. Testosterone Metabolism & BPH Enzyme Function 5-α Reductase Converts testosterone to DHT → promotes prostate growth Aromatase Converts androgens to estrogens 17-β Hydroxysteroid DH Converts androstenedione ↔ testosterone; not involved in DHT production 21-Hydroxylase Involved in cortisol/aldosterone synthesis, not androgen pathway

References:

Bailey and Love’s Short Practice of Surgery, 28th Edition, Page 1522, 1523

SRB’s Manual of Surgery, 6th Edition, Page 1033, 1034

Campbell Walsh Wein Urology, 12th Edition, Page 15091

Harper’s Illustrated Biochemistry, 32nd Edition, Page 494-497

↑ *Back to this question in Part A*

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Q3: A 68-year-old male presents with complaints of urinary frequency, nocturia, and a weak urinary stream. The International Prostate Symptom Score (IPSS) assessment reveals a score of 22. Which of the following best describes the severity of his symptoms according to the IPSS? (Q849307)

A. Mild

B. Moderate

C. Severe

D. Asymptomatic

Correct Answer: C. Severe

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: A score of 20 to 35 is severely symptomatic according to the International Prostate Symptom Score (IPSS). International Prostate Symptom Score (IPSS): Subjective assessment tool for BPH patients The questionnaire assesses the degree of LUTS and quality of life. SCORE : Mildly symptomatic: 0 to 7 (Option A ruled out) Moderately symptomatic: 8 to 19 (Option B ruled out) Severely symptomatic: 20 to 35 (Option C) The mnemonic " FUN WISE " can be used to remember the seven questions relating to symptoms of BPH in the IPSS questionnaire. F Frequency U Urgency N Nocturia W Weak stream I Intermittency S Straining E Sensation of incomplete emptying The symptoms must have been experienced in the last month and each answer is scored from 0 to 5 for a maximum score of 35 points.

References:

https://www.sciencedirect.com/topics/medicine-and-dentistry/international-prostate-symptom-score

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10196226/

↑ *Back to this question in Part A*

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Q4: A 65-year-old male presents with urinary frequency, nocturia, and a weak urinary stream for 6 months. His prostate is symmetrically enlarged, prostate-specific antigen (PSA) is slightly elevated and Qmax (Uroflowmetry) is 7 ml/sec. Which of the following is the most appropriate initial management for this patient? (Q849308)

A. Transurethral resection of the prostate

B. Tamsulosin

C. Immediate catheterization

D. Finasteride

Correct Answer: B. Tamsulosin

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: In this scenario, based on clinical symptoms, signs, and Qmax value he is suffering from BPH, and the initial management is Tamsulosin (■ 1 Blocker) . Treatment: Medical management: 1st line management: ■ 1 Blocker Prazosin Terazosin Silodosin Most commonly used: Tamsulosin (■ 1A selective Blocker) (Option B) 2nd line: 5 ■ Reductase inhibitors Finasteride (Option D ruled out) Dutasteride Triptorelin pamoate Combination treatment with ■ 1 Blocker and 5 ■ Reductase inhibitors are used in large prostate Acute management in urinary retention: urethral catheterization (Option C ruled out) and if it fails - suprapubic cystostomy (SPC). Surgical management: Indications: No improvement in medical management. Acute retention of urine Chronic urinary retention with residual urine of more than 200 ml. Complications like hydroureter, hydronephrosis, stone formation, recurrent infection, and gross haematuria Surgeries: Gold standard- TURP (Trans urethral resection of prostate). (Option A ruled out) Trans urethral incision of prostate (TUIP) Open prostatectomy procedures

References:

Bailey and Love's Short Practice of Surgery, 28th Edition, Page 1526-1529

↑ *Back to this question in Part A*

@Neet_pg_bot

Q5: Which of the following is the most common complication of TURP (Trans urethral resection of prostate)? (Q849309)

A. Retrograde ejaculation

B. TURP syndrome

C. Incontinence

D. Erectile dysfunction

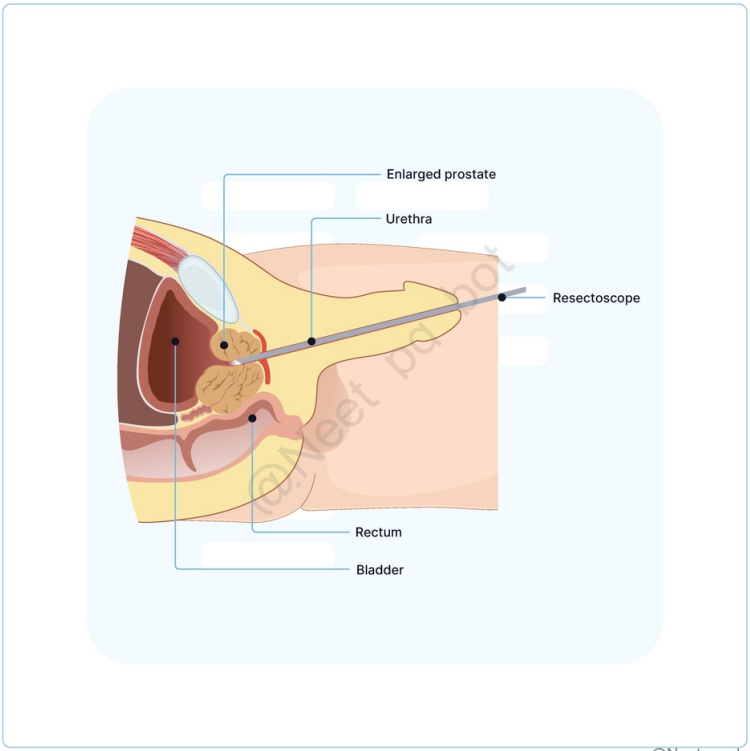
Correct Answer: A. Retrograde ejaculation

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The most common complication of TURP procedure is retrograde ejaculation (75% of the cases) due to disruption to the bladder-neck mechanism. Complications of TURP: Local complications: Hemorrhage,

perforation of bladder, prostatic capsule perforation Sepsis- Bacteraemia Incontinence- rare complication (Option C ruled out) Retrograde ejaculation- most common (>75% cases) (Option A) Erectile dysfunction- rare (Option D ruled out) Urethral stricture Bladder neck contracture- occasionally General complications: Cardiovascular Pulmonary atelectasis, pneumonia, myocardial infarction, congestive cardiac failure, and deep venous thrombosis TURP syndrome - less common with the use of isotonic glycine and saline as irrigants (Option B ruled out)



References:

Bailey and Love's Short Practice of Surgery, 28th Edition, Page 1528-1530

↑ *Back to this question in Part A*

@Neet_pg_bot

Q6: A 70-year-old man is undergoing transurethral resection of the prostate (TURP) for benign prostatic hyperplasia. Postoperatively, he gets agitated and complains of severe headache, nausea, and blurred vision. His lab results show a serum sodium level of 118 mEq/L. Which of the following is the most appropriate initial management? (Q849310)

A. Administer intravenous hypertonic saline

B. Start oral furosemide

C. Administer intravenous normal saline

D. Oral fluid restriction

Correct Answer: A. Administer intravenous hypertonic saline

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: In this scenario, the patient suffers from TURP syndrome, and hypertonic saline 3% is used cautiously in severe or symptomatic cases . TURP Syndrome (Dilutional hyponatremia): Pathophysiology: Fluid is absorbed intravascularly due to high volumes of hypotonic irrigation fluid used during the resection causing dilutional hyponatremia and various neurologic symptoms. Clinical features: Confusion, agitation, nervousness, nausea, hemolysis, visual disturbances, coma, and shock. Treatment: Drug of choice- IV furosemide. Mild to moderate cases: IV furosemide (Option B ruled out) and normal saline (Option C ruled out) Severe or symptomatic patients: IV 3% Saline (Option A) Fluid restriction (Option D ruled out) : Useful after initial stabilization and correction of severe hyponatremia to prevent further fluid overload.

References:

https://www.ncbi.nlm.nih.gov/books/NBK560884/

Bailey and Love’s Short Practice of Surgery, 28th Edition, Page 1530

↑ *Back to this question in Part A*

@Neet_pg_bot

Q7: A 65-year-old male is undergoing surgery for Benign Prostatic Hyperplasia with distressing LUTS (lower urinary tract symptoms). Prostate gland is significantly enlarged, measuring over 100 grams. Which among the following surgical approach is most appropriate? (Q849311)

A. Transurethral incision of prostate

B. Open prostatectomy

C. Frayer’s suprapubic prostatectomy

D. Young’s perineal prostatectomy

Correct Answer: B. Open prostatectomy

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Open prostatectomy is the preferred approach in cases where the prostate size is more than 75 grams. Open prostatectomy (Option B) : Indications: Size of prostate: > 75 grams Bladder stone Bladder diverticula Transurethral Incision of Prostate (Option A ruled out) : Procedure: An electrocautery device (Collin's knife) or laser is used to incise the prostate tissue from the bladder neck down to the verumontanum. Size of prostate: up to 30 grams Advantages: Less time consuming Lower risk of impotence and retrograde ejaculation Frayer's suprapubic prostatectomy (Option C ruled out) : Indication: Bladder stone and bladder diverticula along with BPH. Young's perineal prostatectomy (Option D ruled out) : Obsolete procedure.

References:

https://pubmed.ncbi.nlm.nih.gov/1283025/

https://www.sciencedirect.com/topics/medicine-and-dentistry/transurethral-incision-of-the-prostate

https://pubmed.ncbi.nlm.nih.gov/37794546/

SRB's Manual of Surgery, 6th Edition, Page 1035

Bailey and Love's Short Practice of Surgery, 28th Edition, Page 1528, 1529

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3921814/

↑ *Back to this question in Part A*

@Neet_pg_bot

Q8: A 55-year-old male, known diabetic presents to the emergency department with a high-grade fever, perineal pain, and difficulty urinating. He has a history of acute bacterial prostatitis, treated two weeks ago with antibiotics. On examination, the prostate is tender and swollen. What is the most likely diagnosis and investigation to confirm the same? (Q849312)

A. Prostatic abscess and Transrectal ultrasound

B. Chronic prostatitis and urine culture

C. Acute prostatitis and urine microscopy

D. Benign prostatic hyperplasia and PSA levels

Correct Answer: A. Prostatic abscess and Transrectal ultrasound

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Acute bacterial prostatitis can develop into a prostate abscess if the initial infection is not adequately treated or if the patient has comorbidities like diabetes as in this case. Persistent fever, perineal pain, and a tender,

swollen prostate on examination raise suspicion of prostate abscess. A transrectal ultrasound or CT pelvis is needed to evaluate and manage the condition. Condition Acute bacterial prostatitis (Option C ruled out) Chronic bacterial prostatitis (Option B ruled out) Prostatic abscess (Option A) Etiopathogenesis Acute inflammation of prostate. Risk factor- STI, prolonged catheterization and instrumentation. Gram-negative bacteria, enterobacteriaceae Common organism- E. coli Development of bacterial biofilms. Enterobacteriaceae Common organism- E. coli Complication of acute bacterial prostatitis High risk: Immunocompromised people Diabetes Chronic catheterization Clinical features Fever, chills, rigor Back pain Perineal pain/ heaviness Pain on defecation Associated UTI symptoms DRE: Tender, enlarged Persistent infection of prostate and recurrent attacks of UTI Fever, chills, rigor Back pain Perineal pain/ heaviness DRE: Tender, swollen prostate, positive fluctuation Investigation Urine routine and culture Transrectal US and CT pelvis to rule out abscess in high-risk patients Microscopy and culture of prostatic expresate and urine taken before and prostatic massage Transrectal US and CT pelvis Treatment Prolonged antibiotics Trimethoprim, ciprofloxacin, or aminoglycoside for 4 to 6 weeks to prevent chronic prostatitis Antibiotics for 3-4 months based on culture. Trans urethral drainage IV Antibiotics

References:

https://www.ncbi.nlm.nih.gov/books/NBK459257/

Bailey and Love's Short Practice of Surgery, 28th Edition, Page 1536, 1537, 1522, 1523.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q9: A 60-year-old male undergoes evaluation for a urinary tract infection. Imaging studies reveal multiple small stones within the prostate gland. Laboratory analysis of these prostatic calculi will most likely show which of the following compositions? (Q849313)

A. Uric acid

B. Struvite

C. Calcium oxalate

D. Calcium phosphate

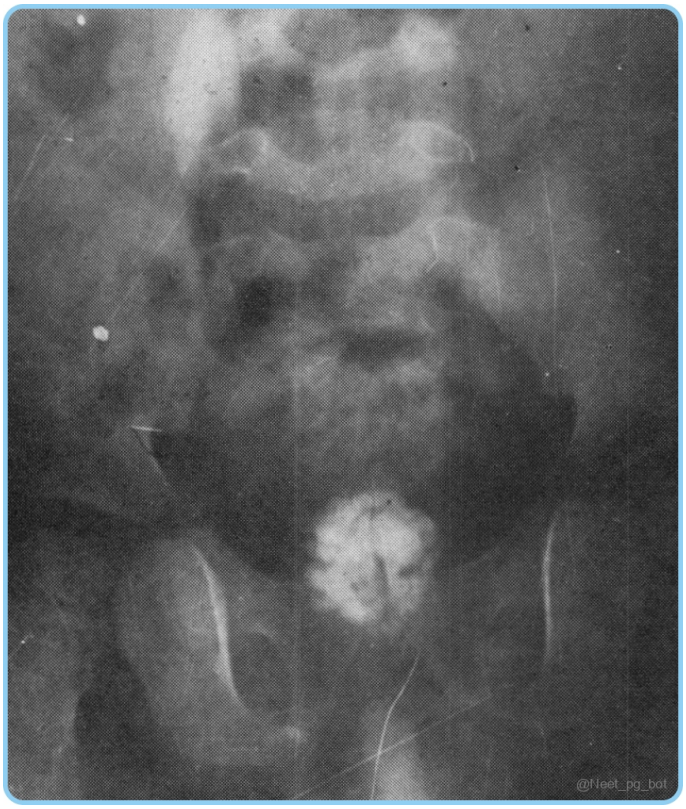
Correct Answer: D. Calcium phosphate

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Endogenous prostatic calculi are usually composed of calcium phosphate combined with about 20% organic material. Prostatic calculi: Two varieties: endogenous (common), and exogenous (urinary calculus that becomes arrested in the prostatic urethra) Composition: Calcium phosphate with about 20% organic material (Option D) Prostatic calculi are usually symptomless Doesn't predispose to infection Investigation: Imaging-

stones are often seen to form a horseshoe pattern . Occurs in clusters Treatment: Transurethral resection Forerunners of endogenous prostatic calculi are corpora amylacea.



References:

Bailey and Love's Short Practice of Surgery, 28th Edition, Page 1531

↑ *Back to this question in Part A*

@Neet_pg_bot

Q10: An elderly male presents with urinary hesitancy, weak stream, nocturia, weight loss, and back pain. DRE reveals a hard, irregular prostate. Which of the following is the common genetic alteration observed in his condition? (Q849314)

A. Mutation of the BRCA1 gene

B. Hypermethylation of GSTP1

C. Overexpression of HER2

D. Mutation of the RB1 gene

Correct Answer: B. Hypermethylation of GSTP1

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: In this scenario, the most likely diagnosis is carcinoma prostate and the common genetic alteration seen in carcinoma prostate is hypermethylation of GSTP1 (Glutathione transferase promoter region 1) located in chromosome 11. Pathology of Carcinoma prostate: Most common site- peripheral zone (75%) > transitional zone (15%) > central zone (10%) Most common histological type is adenocarcinoma Most common genetic alteration seen in CA prostate- hypermethylation of GSTP1 (Glutathione transferase promoter region 1) located on chromosome 11. (Option B) 70-80% of the cases. Microscopy: small, crowded, absent basal layer, lack of branching

References:

Bailey and Love's Short Practice of Surgery, 28th Edition, Page 940, 941, 1531-1534

https://www.ncbi.nlm.nih.gov/books/NBK563248/

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4995330/

https://www.ncbi.nlm.nih.gov/gene/5925

↑ *Back to this question in Part A*

@Neet_pg_bot

Q11: A 70-year-old male presents with an elevated PSA level of 12 ng/mL. A transrectal ultrasound-guided biopsy reveals a Gleason score of 9 (4 + 5). Which of the following is the most appropriate initial management approach for this patient? (Q849315)

A. Active surveillance with regular PSA monitoring and repeat biopsies

B. Radical prostatectomy

C. Hormone therapy and possibly radiation

D. Observation with no immediate treatment

Correct Answer: C. Hormone therapy and possibly radiation

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: A Gleason score of 9 (4 + 5) indicates a very high-grade and aggressive prostate cancer , likely to spread rapidly. The elevated PSA level and high Gleason score suggest advanced disease. Hormone therapy , which reduces or blocks testosterone, is a key treatment for advanced prostate cancer. Radiation therapy may also

be considered to control local disease . Gleason Score Grade Components Cancer Grade Description 6 3 + 3 Low-grade Cells resemble healthy tissue; low likelihood of growth and spread. 7 3 + 4 or 4 + 3 Intermediate-grade Cells show more variation; moderate risk of growth and spread. 8 4 + 4, 3 + 5, or 5 + 3 High-grade Cells look very different; higher likelihood of rapid growth and spread. 9 or 10 4 + 5, 5 + 4, or 5 + 5 Very high-grade Cells are highly aggressive; very likely to grow and spread quickly. Management Strategy Key Points Active Surveillance (Option A ruled out) For low-risk cases; regular monitoring Radical Prostatectomy (Option B ruled out) Surgery for localized cancer; potentially curative Radiation Therapy High-energy rays; external or brachytherapy Hormone Therapy (Option C) Reduces/block testosterone; for advanced/metastatic cases Chemotherapy Systemic drug treatment; for advanced/metastatic cases

References:

Bailey and Love's Short Practice of Surgery, 28th Edition, Page 1451 , 1533-1536

↑ *Back to this question in Part A*

@Neet_pg_bot

Q12: A 65-year-old male patient undergoes a transurethral resection of the prostate (TURP) for benign prostatic hyperplasia. During the procedure, a tumor is discovered, which involves less than 5% of the resected tissue and is well-differentiated. The tumor was an incidental finding and was not palpable during a digital rectal examination. Based on the TNM staging system for prostate cancer, what is the most appropriate stage for this tumor? (Q849316)

A. T1a

B. T1b

C. T2a

D. T3a

Correct Answer: A. T1a

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: T1a stage indicates that the tumor was found incidentally during a procedure like TURP and involves less than 5% of the resected tissue. The tumor is usually well-differentiated. TNM Staging System for Prostate Cancer T1 : Incidentally found tumors in a clinically benign gland. T1a : Tumor involves <5% of the resected specimen. (Option A) T1b : Tumor involves >5% of the resected specimen. (Option B ruled out) T1c : Impalpable tumor found due to raised PSA. T2 : Tumor confined within the prostate capsule. T2a : Involves one lobe. (Option C ruled out) T2b : Involves more than half of one side but not both sides. T2c : Involves both sides, confined within the capsule. T3 : Tumor extends through the capsule. T3a : Unilateral or bilateral extension. (Option D

ruled out) T3b : Extension into seminal vesicles. T4 : Tumor invades adjacent structures (e.g., levator muscles, external sphincter, rectum, pelvic sidewall). N0 : No regional lymph node involvement N1 : Regional lymph node involvement M0 : No distant metastasis M1 : Distant metastasis present

References:

Bailey and Love’s Short Practice of Surgery, 28th Edition, Page 1532-1535

↑ *Back to this question in Part A*

@Neet_pg_bot

• [06_Urology] 038 Urethra And Penis

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[06_Urology] 038 Urethra And Penis — Quick Jump

Q1 (p. 2553)	*Q2 (p. 2556)*	*Q3 (p. 2556)*	*Q4 (p. 2557)*	*Q5 (p. 2558)*	*Q6 (p. 2559)*
Q7 (p. 2560)	*Q8 (p. 2561)*	*Q9 (p. 2563)*	*Q10 (p. 2564)*	*Q11 (p. 2565)*	*Q12 (p. 2566)*
Q13 (p. 2567)	*Q14 (p. 2568)*	*Q15 (p. 2569)*	*Q16 (p. 2570)*	*Q17 (p. 2571)*	*Q18 (p. 2573)*
Q19 (p. 2574)	*Q20 (p. 2575)*				

Q1: A 28-year-old male was involved in a high-speed road traffic accident. He reports severe pelvic pain and difficulty in passing urine. On examination, there is blood at the urethral meatus, and the patient complains of suprapubic tenderness. The bladder appears to be distended, and there is a high-riding prostate on a digital rectal examination. Which of the following investigations is the most appropriate to confirm the suspected injury of this patient? (Q849422)

A. Retrograde Urethrography (RGU)

B. Cystoscopy

C. Voiding Cystourethrography

D. Intravenous Pyelography (IVP)

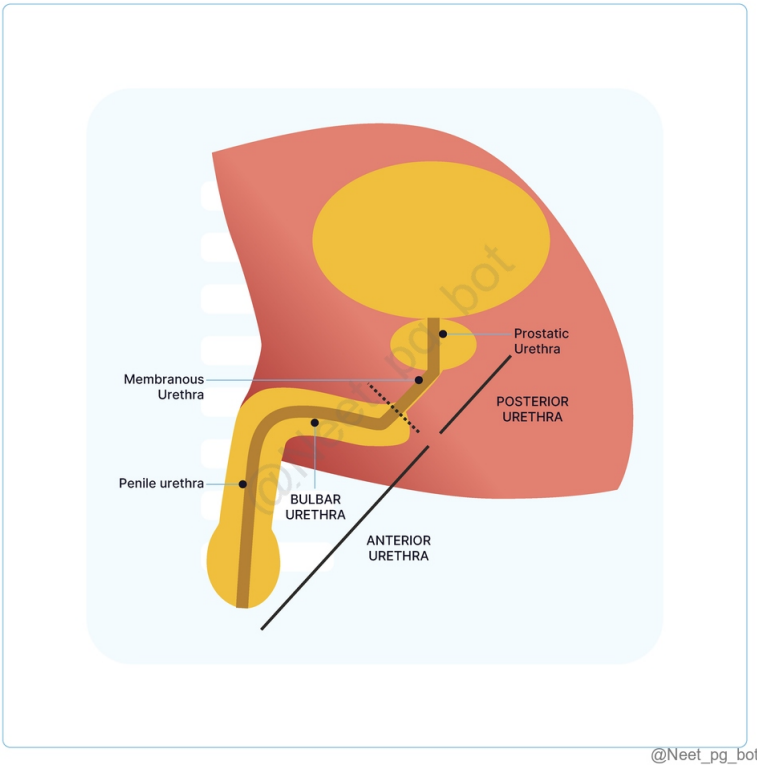
Correct Answer: A. Retrograde Urethrography (RGU)

■ *Listen (English)*

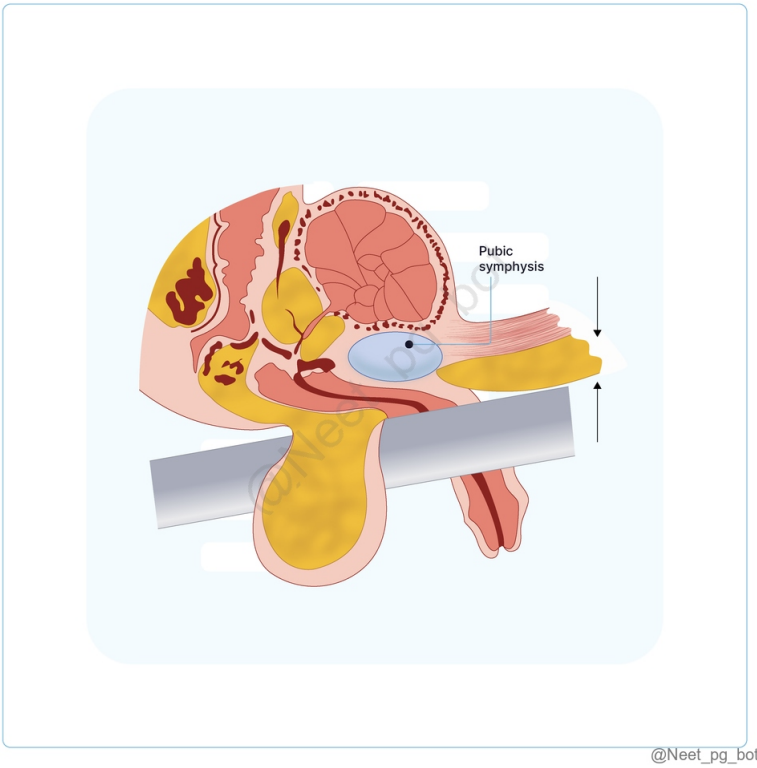
■ *Listen (Hindi)*

Explanation: This clinical scenario suggests a posterior urethral injury, often linked to pelvic fractures from high-speed road traffic accidents. Retrograde Urethrography (RGU) is the preferred investigation for diagnosing posterior urethral injuries. It involves injecting contrast media into the urethra and taking X-rays to assess the injury's location and extent. Urethral injury Urethral injuries refer to damage to urethra, the tube that carries urine from the bladder to the outside of the body. Anterior vs. Posterior Urethral Injuries Feature Anterior Urethral Injury Posterior Urethral Injury Location Bulbar urethra (most common) Penile urethra Membranous urethra (bulbomembranous junction most common) Prostatic urethra Common Causes Straddle injuries Direct trauma Iatrogenic injuries (catheterization, cystoscopy) Penetrating trauma (stab/gunshot wounds) Pelvic fractures (often due to motor vehicle accidents) Blunt trauma Clinical Features Hematuria (blood in urine) Penile/perineal bruising (butterfly-shaped hematoma) Perineal pain Urinary retention or difficulty voiding Possible swelling of the penis or scrotum due to hematoma Blood at the meatus Inability to void High-riding prostate on rectal exam Perineal or suprapubic pain Pelvic hematoma associated with pelvic fractures Possible concomitant bladder injury

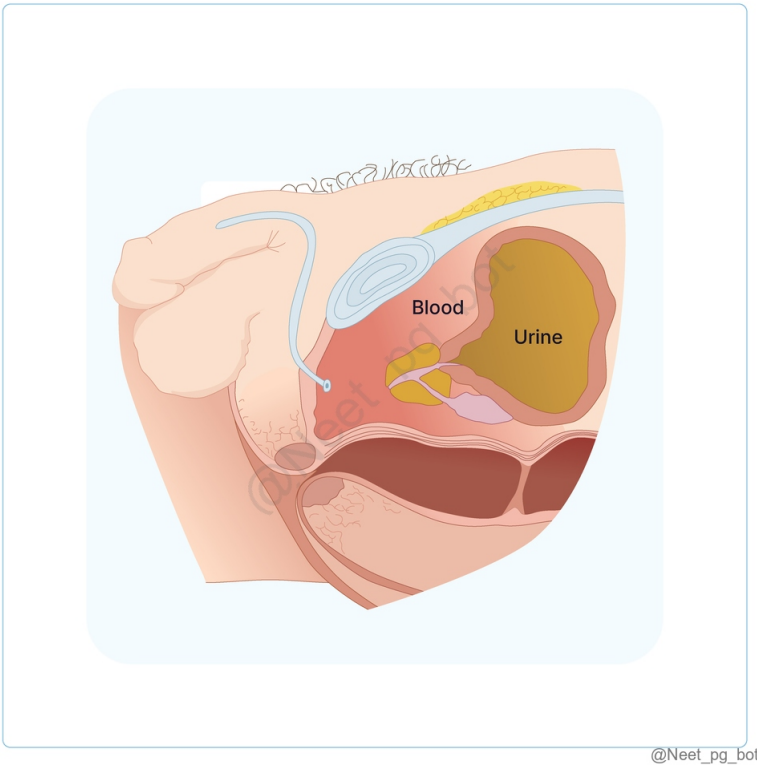
Investigations Retrograde Urethrography (RGU) : Gold standard, shows the extent and location of injury Voiding Cystourethrography (VCUG): Used to assess urethral patency post-repair (Option C) Ultrasound: Can detect hematoma or associated injuries Retrograde Urethrography (RGU) (Option A): Gold standard for initial assessment CT Urethrography: Useful in evaluating complex injuries Pelvic CT Scan: Important for associated pelvic fractures Cystoscopy: Sometimes performed for further evaluation (Option B) If injury at Prostatomembranous junction - High lying prostate → On IVP- Pie in sky appearance (Option D)



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References:

Bailey and Love’s Short Practice of Surgery, 28th Edition, Pages 1541, 1542.

Schwartz's Principles of Surgery, 11th Edition, Page 1767.

SRB's Manual of Surgery, 6th Edition, Pages 1040-1042.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q2: Which of the following statements are true regarding urethral carcinoma? (Q849431)

A. Bloody discharge present without infection

B. Prostatic urethral tumor is treated with laser ablation

C. Squamous carcinoma has a poor prognosis

D. All are true

Correct Answer: D. All are true

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: All of the statements are true Urethral carcinoma: Symptom Bloody urethral discharge without infection (Option A) Prostatic urethra tumor Usually associated with multifocal transitional cell carcinoma of the bladder Treatment- local laser ablation (Option B) Tendency for distant spread Squamous Carcinoma Can develop in areas of squamous metaplasia in patients with lichen sclerosus (LS) Treatment- radical surgery Poor prognosis (Option C)

References:

Bailey and Love’s Short Practice of Surgery, 28th Edition, Page 1545

↑ *Back to this question in Part A*

@Neet_pg_bot

Q3: A 45-year-old male presents with a carcinoma penis. After discussing treatment options, he is informed that his management plan may include partial penectomy. What is the nature of his cancer? (Q849430)

A. Localized tumor of glans

B. Proximal penile tumor

C. T1 stage

D. T2 stage

Correct Answer: D. T2 stage

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Partial penectomy is typically indicated for invasive penile cancers , particularly: Tumors involving the glans and/or distal shaft that have invaded the corpus spongiosum or cavernosum . These findings correspond to T2 stage disease as per AJCC staging . Penile Cancer Staging (AJCC – simplified): Stage Description Typical Treatment Tis Carcinoma in situ Topical therapy or laser excision T1 Invades subepithelial connective tissue Local excision, Mohs, radiation T2 Invades corpus spongiosum or cavernosum Partial penectomy , possibly LN eval T3 Invades urethra or prostate Partial or total penectomy T4 Invades other adjacent structures Total penectomy, systemic therapy Localized tumor of glans (Option A): This could be T1 or less, potentially managed with local therapies. Proximal penile tumor (Option B): These often require total penectomy , not partial. T1 stage (Option C): Treated more conservatively unless high-grade or high-risk histology is present.

References:

SRB’s Manual of Surgery, 6th Edition, Pages 1054-1055

↑ *Back to this question in Part A*

@Neet_pg_bot

Q4: A 45-year-old male presents with a noninvasive, localized squamous cell carcinoma on the glans penis. The lesion is well-demarcated and has not invaded deeper tissues. What is the TNM stage of his cancer? (Q849429)

A. T1

B. T2

C. T3

D. Ta

Correct Answer: D. Ta

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Noninvasive localized squamous cell carcinoma of the penis is classified under Ta according to TNM staging TNM staging of penile cancer AJCC 8th edition, 2018: Stage Description TX Primary tumors cannot be assessed T0 No evidence of a primary tumor Tis Carcinoma in situ (Penile intraepithelial neoplasia, PeIN) Ta Noninvasive localized squamous cell carcinoma (Option D) T1 Tumor invades lamina propria, dermis, or connective tissue with/without lymphovascular or perineural invasion (Option A) T1a: without invasion/high grade T1b: with invasion/high grade T2 Tumor invades corpus spongiosum with or without urethral invasion (Option B) T3 Tumor invades corpora cavernosa with or without urethral invasion (Option C) T4 Tumor invades adjacent structures (e.g., prostate, scrotum, pubic bone) cNX Regional nodes cannot be assessed cN0 No palpable or visible enlarged inguinal nodes cN1 Palpable mobile unilateral inguinal lymph node cN2 Palpable mobile unilateral ≥2 inguinal lymph nodes cN3 Palpable fixed inguinal nodal mass or pelvic lymphadenopathy (unilateral or bilateral) cM0 No distant metastases cM1 Distant metastases pM1 Distant metastasis microscopically confirmed

References:

SRB's Manual of Surgery, 6th Edition, Pages 1053-1054

↑ *Back to this question in Part A*

@Neet_pg_bot

Q5: A 52-year-old male presents with a large, dry, verrucae-like growth on the penis. Biopsy confirms it as a Buschke-Lowenstein tumor. Which of the following is the wrong statement regarding the disease? (Q849428)

A. Caused by HPV

B. Radiotherapy is contraindicated

C. Can spread through blood

D. It is curable

Correct Answer: C. Can spread through blood

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Buschke-Lowenstein tumor cannot spread through blood or lymph, it is locally invasive Buschke - Lowenstein tumor : {{caption_text}} Verrucous carcinoma of the penis due to HPV-6 and 11 Large, exophytic, dry, verrucae-like growth Curable malignancy Locally destructive, locally invasive No spread through lymphatics or blood Surgical excision or partial amputation after confirmation by biopsy Radiotherapy should not be given Systemic interferon ■ therapy and Nd:YAG laser therapy is successful.



References:

SRB's Manual of Surgery, 6th Edition, Page 1055

↑ *Back to this question in Part A*

@Neet_pg_bot

Q6: Bowen's disease, erythroplasia of Queyrat, and bowenoid papulosis are examples of: (Q849427)

A. Premalignant penile lesions

B. Benign tumors of the penise

C. Penile malignancies

D. None of the above

Correct Answer: A. Premalignant penile lesions

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Premalignant penile lesions: HPV-related lesions Non-HPV-related lesions Bowen's disease (BD) Erythroplasia of Queyrat (EQ) Bowenoid papulosis (BP) Giant condylomata acuminata (GCA) or Buschke–Lowenstein tumours Genital lichen sclerosus et atrophicus (LS) Penile cutaneous horn Leukoplakia Pseudoepitheliomatous, keratotic micaceous balanitis (PKMB)

References:

www.ncbi.nlm.nih.gov/pmc/articles/PMC3159400/

↑ *Back to this question in Part A*

@Neet_pg_bot

Q7: Which of the following statements are correct regarding Peyronie's Disease? Is characterized by fibrous plaques in the tunica albuginea of the penis. The plaques are typically found on the ventral aspect of the penis. Can be associated with Dupuytren's contracture. Oral medications like pentoxifylline and vitamin E are used in medical management. The primary treatment involves immediate surgical intervention (Nesbit Operation). (Q849426)

A. 1, 2, and 4 are correct

B. 2, 3, and 5 are correct

C. 1, 3, and 4 are correct

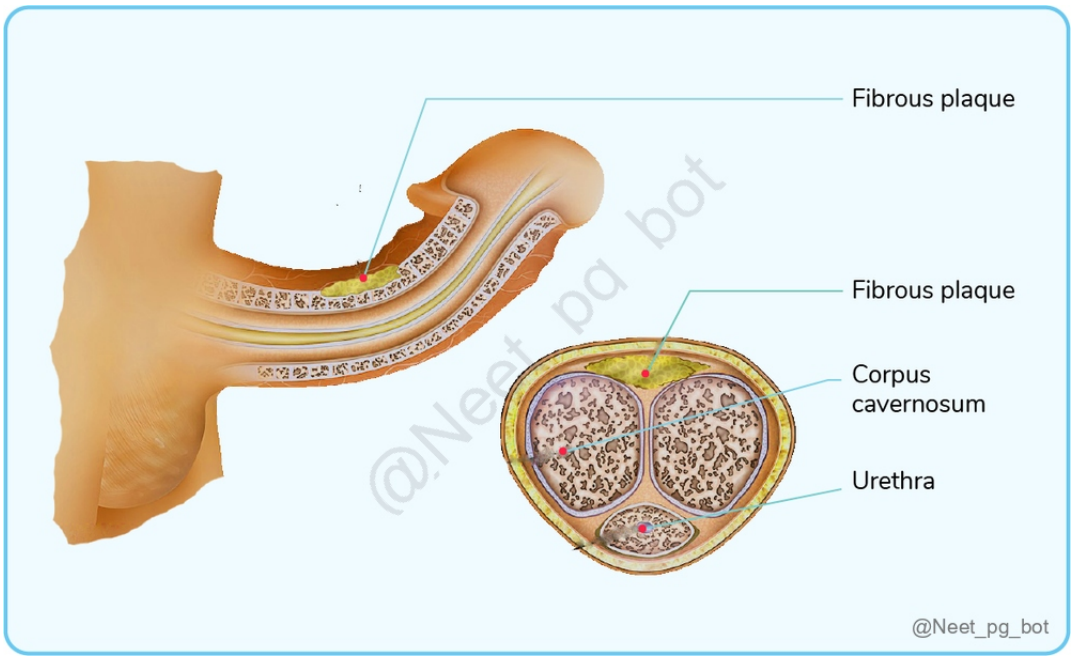
D. 2, 4, and 5 are correct

Correct Answer: C. 1, 3, and 4 are correct

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Peyronie's Disease Definition Characterized by fibrous plaques in the tunica albuginea of the penis, causing abnormal curvature during erections. Characteristics Plaque Location: Typically on the dorsolateral aspect of the penis. Curvature: Resulting from plaque contraction. {{caption_text}} Causes Trauma/Injury: Repeated minor trauma to the penis. Genetic Factors: Possible genetic predisposition. Connective Tissue Disorders: Associated with conditions like Dupuytren's contracture. Associated Conditions Galezia's Triad: Dupuytren's Contracture: Thickening and shortening of connective tissue in fingers. Retroperitoneal Fibrosis: Fibrosis in the retroperitoneal space. Peyronie's Disease Clinical Features Painful Erection Erectile Dysfunction Penile Curvature Palpable Plaques Impotence & Infertility (in severe cases) Treatment Observation: Spontaneous Resolution: Often improves without treatment. Medical Management: Oral Medications: Pentoxifylline, colchicine, vitamin E (efficacy varies). Surgical Intervention (If Spontaneous Resolution Does Not Occur): Nesbit Operation: Placement of a non-absorbable suture opposite the plaque to correct the curvature. Plication Surgery: Shortens the longer side of the penis. Plaque Excision and Grafting: Removes plaque and replaces it with graft material. Penile Prosthesis: For severe cases.



References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1550.

SRB's Manual of Surgery, 6th Edition, Page 1051.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q8: A 45-year-old man presents with symptoms of urinary obstruction, including difficulty in starting urination, weak urinary stream, and frequent urinary tract infections. On physical examination, he has a history of trauma to the pelvic region. A retrograde urethrogram (RGU) reveals a stricture in the anterior urethra measuring more than 2 cm. Which of the following is the most appropriate management option for this patient? (Q849425)

A. Urethral Dilatation

B. Optical Internal Urethrotomy

C. Excision and reconstruction with buccal mucosa

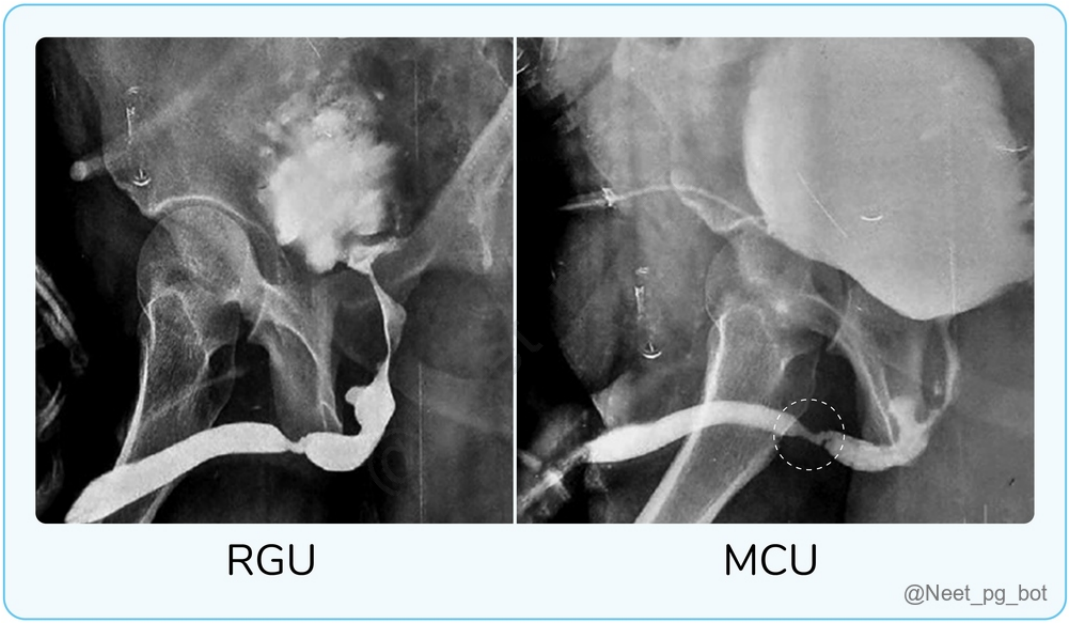
D. Urethral Stenting

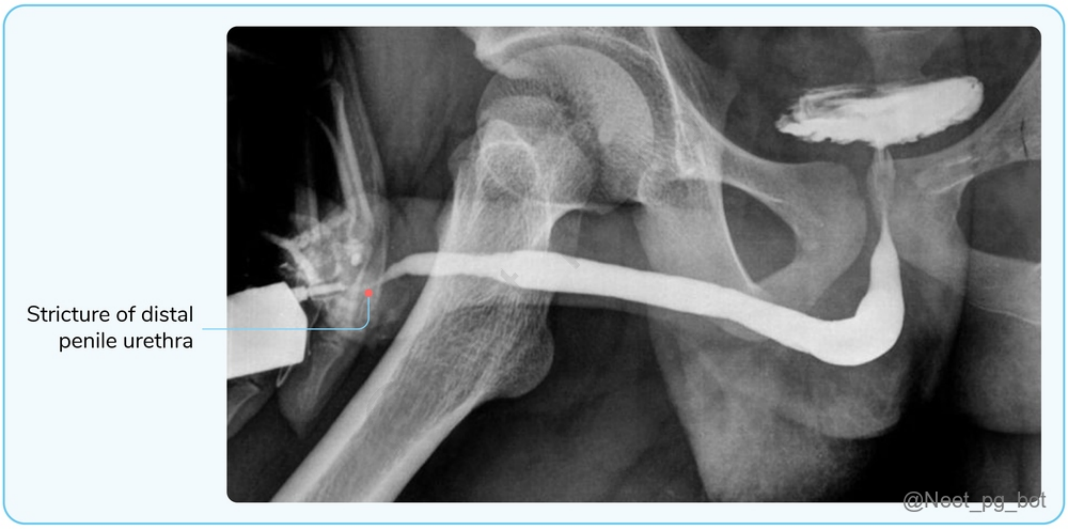
Correct Answer: C. Excision and reconstruction with buccal mucosa

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Urethroplasty (Surgical excision and reconstruction) is the gold standard for managing long strictures (greater than 2 cm). This surgical procedure involves removing the affected stricture segment and reconstructing the urethra using a graft taken from the buccal mucosa. Urethral Stricture Definition Abnormal narrowing of the urethra, causing partial or complete obstruction of urine flow, leading to discomfort and severe complications if untreated. Causes Trauma (Most common): Pelvic fractures, falls, accidents, or iatrogenic trauma from prolonged catheterization. Infections: STIs like gonorrhea and chlamydia causing urethritis. Medical Procedures : Urethral surgeries or radiation for pelvic cancers. Inflammatory Conditions: Chronic inflammation from conditions like lichen sclerosus. Investigations Posterior Urethral Stricture: Micturating Cystourethrogram (MCU) to visualize the posterior urethra and bladder during voiding. {{caption_text}} Anterior Urethral Stricture: Retrograde Urethrogram (RGU). {{caption_text}} Emergency Evaluation: Both RGU and MCU may be used in trauma cases or acute urinary retention. Management Urethral Dilation: Temporary relief with dilators, often leading to recurrence. (Option A) Optical Internal Urethrotomy (OIU): Endoscopic incision at the 12 o'clock position; effective for short bulbar strictures (<2 cm). (Option B) Urethroplasty: Surgical excision and reconstruction; the gold standard for recurrent or complex strictures (Option C) . Strictures up to 2 cm: Excision with end-to-end anastomosis. Strictures >2 cm: Excision and reconstruction with buccal mucosa, bladder mucosa, or penile skin. Urethral Stenting (Option D) involves placing a stent in the urethra to keep it open. While stenting can relieve obstruction temporarily, it is not a definitive treatment for strictures and may be associated with complications, such as infection and migration of the stent.





References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Pages 1542-1545.

Schwartz's Principles of Surgery, 11th Edition, Page 1764.

SRB's Manual of Surgery, 6th Edition, Pages 1042-1044.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q9: Assertion: Eggplant deformity is a clinical manifestation observed in penile fracture cases. Reason: It is caused by a tear in the corpus spongiosum layer of the penis. (Q849424)

A. Both Assertion and Reason are correct, and the Reason is the correct explanation for the Assertion

B. Both Assertion and Reason are correct, but the Reason is not the correct explanation for the Assertion

C. The Assertion is correct, but the Reason is incorrect

D. The Assertion is incorrect, but the Reason is correct

Correct Answer: C. The Assertion is correct, but the Reason is incorrect

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Eggplant deformity, which is characterized by significant swelling and bruising of the penile shaft, is indeed a clinical sign of penile fracture. The deformity occurs due to a tear in the tunica albuginea, the fibrous

covering of the corpora cavernosa that maintains penile rigidity. The tear leads to the leakage of blood and accumulation in the surrounding tissue. Penile Fracture (Fracture of the Shaft of the Penis) Definition Rupture of the tunica albuginea surrounding the corpora cavernosa, typically due to blunt trauma to an erect penis. Clinical Features Triad Symptoms: Audible Pop or Crack: Reported during trauma. Pain: Severe at the time of injury. Swelling and Bruising: Noticeable swelling and discoloration. {{caption_text}} Eggplant Deformity : Characteristic appearance due to extensive swelling and hematoma, associated with significant pain and discoloration. Blood at Urethral Meatus: Indicates possible urethral injury. Investigations Physical Examination: Initial assessment. Ultrasound: Evaluates injury extent and hematomas. Retrograde Urethrogram (RGU): Checks for urethral injury. Management Immediate Care: Ice packs to reduce swelling Pain management with analgesics Surgical Intervention: Repair of the ruptured tunica albuginea and any urethral injury Postoperative Care: Antibiotics to prevent infection Complications Penile Deformity: Possible curvature or fibrosis. Erectile Dysfunction: Potential if injury or repair is inadequate.



References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1549.

https://www.ncbi.nlm.nih.gov/books/NBK551618/

↑ *Back to this question in Part A*

@Neet_pg_bot

Q10: A 28-year-old male was involved in a high-speed motor vehicle accident. On examination, he has a high-riding prostate on rectal exam, and blood is noted at the urethral meatus. He complains of difficulty in urination, and imaging reveals a pelvic

fracture. Retrograde urethrography confirms a complete disruption of the posterior urethra. After initial stabilization, Which of the following is the most definitive method of management for this patient? (Q849423)

A. Immediate Surgical Repair of the Urethra

B. Suprapubic Catheter Placement Alone

C. Delayed Urethroplasty 3 months post-injury

D. Long-term Foley Catheterization

Correct Answer: C. Delayed Urethroplasty 3 months post-injury

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Delayed urethroplasty is the gold standard for definitive management of posterior urethral injuries, typically performed 3-6 months after the injury to allow inflammation to subside, Improve surgical outcomes, and reduce the risk of complications. Management & Complications of urethral injuries Anterior Urethral Injuries Posterior Urethral Injuries Management Minor Injuries: Managed conservatively with catheterization or suprapubic catheter if severe bruising Severe Injuries: Surgical intervention like primary repair, urethroplasty, or end-to-end anastomosis Antibiotics: To prevent infection Initial Management: Suprapubic catheterization for urinary diversion Delayed Urethroplasty (Definitive management): 3-6 months post-injury after inflammation and fibrosis have subsided Primary Realignment: Occasionally attempted if conditions permit Endoscopic Realignment: For selected cases, though often reserved for acute management Complications Urethral stricture (risk of recurrence) Erectile dysfunction (especially if injury near the penile base) Urinary incontinence (less common) Infection (urethritis or abscess formation) Urethral stricture (most common long-term complication) Urinary incontinence (due to sphincter damage) Erectile dysfunction (common, due to injury near neurovascular structures) Bladder neck contracture Chronic pelvic syndrome Immediate surgical repair (Option A) is generally not recommended due to the high risk of complications like infection and stricture formation. This approach is more suitable for anterior urethral injuries. Suprapubic catheterization (Option B) is a temporary measure for diverting urine and stabilizing the patient, not a definitive treatment. Long-term Foley catheterization (Option D) is also temporary and can lead to complications; definitive surgical repair is usually required.

References:

Bailey and Love’s Short Practice of Surgery, 28th Edition, Pages 1541,1542.

Schwartz's Principles of Surgery, 11th Edition, Page 1767.

SRB's Manual of Surgery, 6th Edition, Pages 1040-1042.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q11: Which of the following is the least dilatable part of the male urethra? (Q849378)

A. Prostatic urethra

B. Membranous urethra

C. Penile (spongy) urethra

D. Urethral meatus

Correct Answer: D. Urethral meatus

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Urethral meatus is the narrowest and least dilatable part of the entire male urethra. It is often a limiting point during procedures like catheterisation or instrumentation. The male urethra is divided into several parts: Part of Urethra Location Dilatability Prostatic urethra (Option A ruled out) Passes through prostate gland Most dilatable Membranous urethra (Option B ruled out) Passes through urogenital diaphragm Least dilatable internally due to being surrounded by external sphincter Penile (spongy) urethra (Option C ruled out) Within the corpus spongiosum of the penis Moderately dilatable Urethral meatus External opening of urethra Least dilatable overall The urethral meatus is the narrowest part of the male urethra and is the least dilatable overall. The membranous urethra is the shortest and least distensible segment of the urethra, but it is considered the second narrowest after the meatus.

References:

Bailey and Love’s Short Practice of Surgery, 28th Edition, Page 1538

↑ *Back to this question in Part A*

@Neet_pg_bot

Q12: A 35-year-old male presents with an erection lasting over 6 hours and initial aspiration fails to resolve the condition. What is the next appropriate step in the management of this patient? (Q849387)

A. Oral phosphodiesterase inhibitors

B. Observation

C. Intracavernosal phenylephrine injection

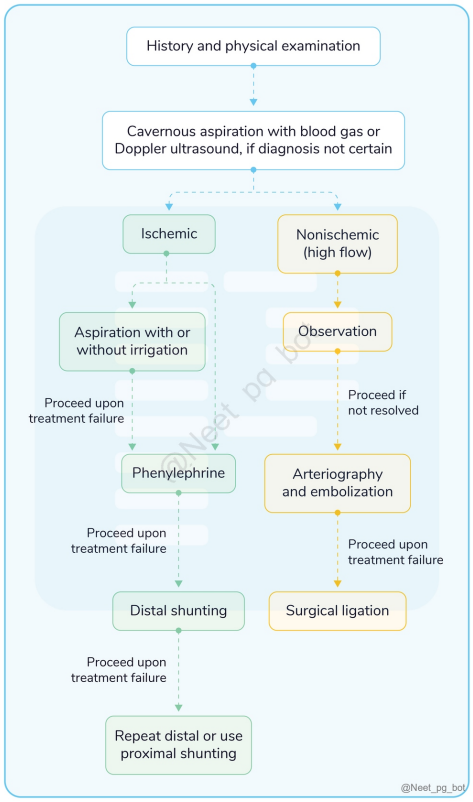
D. Penile prosthesis placement

Correct Answer: C. Intracavernosal phenylephrine injection

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Intracavernosal phenylephrine, a sympathomimetic drug, is the next step after aspiration fails. It helps to induce detumescence by constricting blood vessels and reducing blood flow into the penis. Oral phosphodiesterase inhibitors (Option A) are used to treat erectile dysfunction but are not appropriate for the acute management of priapism. Observation (Option B) may be appropriate in cases of non-ischemic priapism, but for ischemic priapism, active intervention is required. Penile prosthesis placement (Option D) is considered a last resort for refractory cases that do not respond to other treatments. It is not the next immediate step after aspiration failure.



References:

Bailey and Love’s Short Practice of Surgery, 28th Edition, Page 1551

https://www.uptodate.com/contents/priapism?search=drugs+causing+priapism&source=search_result

↑ *Back to this question in Part A*

@Neet_pg_bot

Q13: A 30 year old male presents with a painless erection following a penile trauma. Doppler ultrasound confirms the presence of blood flow and blood gas analysis shows arterial blood characteristics. What is the most likely type of priapism? (Q849386)

A. Ischaemic priapism

B. Non-ischaemic priapism

C. Neurogenic priapism

D. Recurrent priapism

Correct Answer: B. Non-ischaemic priapism

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Non-ischaemic priapism is characterized by a painless erection, typically following trauma, with normal or arterial blood gas characteristics which aligns with the patient's condition. Feature Ischemic Priapism (Option A) Nonischemic Priapism Alternative Names Low-flow, Anoxic, Veno-occlusive. High-flow, Arterial. Commonality More common Less common Onset Sudden, often painful. Gradual, less painful. Etiology Associated with sickle cell disease, medications (anticoagulants, antihypertensives, antidepressants, PDE5 inhibitors, intracavernous injections, alpha-blockers, methylphenidate, atomoxetine, cocaine), blood disorders (leukemia, thalassemia, multiple myeloma, thrombotic thrombocytopenic purpura). Often due to trauma (Perineal, pelvic, or penile trauma) or congenital arterial malformations. Blood Flow Decreased or absent (leading to hypoxia and acidosis) Increased (blood is well-oxygenated) Cavernosal Blood Gas Analysis Dark blood, pH <7.25, PO2 <30 mmHg, PCO2 >60 mmHg. Bright red blood, normal pH, normal PO2 and PCO2. Doppler Ultrasonography Minimal or no blood flow in the corpora cavernosa Normal to increased blood flow Urgency Medical emergency Not an emergency, often resolves spontaneously. Complications Risk of tissue damage, fibrosis and long-term erectile dysfunction. Rarely causes permanent damage. Treatment Intracavernosal sympathomimetic drugs (e.g., phenylephrine) Aspiration and irrigation. Surgical shunt or penile prosthesis if refractory. Observation Arteriography and embolization if intervention is desired. Prognosis Poor if untreated within 24-48 hours, leading to irreversible erectile dysfunction. Good, often resolves without long-term sequelae. Neurogenic priapism (Option C) , associated with spinal cord injuries, typically does not present with trauma-related symptoms and does not fit the provided clinical scenario. Recurrent priapism (Option D) refers to repeated episodes of priapism, often linked to conditions like sickle cell disease, but the patient's presentation aligns more with non-ischaemic priapism.

References:

Bailey and Love’s Short Practice of Surgery, 28th Edition, Page 1551

https://www.uptodate.com/contents/priapism?search=drugs+causing+priapism&source=search_result

↑ *Back to this question in Part A*

@Neet_pg_bot

Q14: A 60-year-old male presents to the emergency department with severe pain and swelling of the glans penis after retracting his foreskin for catheterization. The foreskin is stuck behind the glans with visible constriction. What is the most

appropriate initial management? (Q849385)

A. Circumcision

B. Manual reduction using compression methods

C. Topical corticosteroid application

D. Oral antibiotics

Correct Answer: B. Manual reduction using compression methods

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Manual reduction using compression methods is the first-line treatment for paraphimosis to reduce swelling and reposition the foreskin over the glans. Paraphimosis Definition A urologic emergency where the retracted foreskin becomes trapped behind the glans, leading to potential complications like strangulation, vascular compromise and necrosis. Etiology Iatrogenic causes (e.g., catheterization, cystoscopy, routine cleaning) Penile trauma Self-inflicted injuries Pathophysiology Impaired venous and lymphatic drainage when the foreskin is retracted for an extended period leads to reduced arterial blood flow leading to ischemia and potential necrosis if untreated. Symptoms Swelling and pain in the glans and foreskin. Erythema (redness) Diagnosis Based on history of foreskin retraction and physical examination showing the glans and a constricting band of tissue. Treatment Manual Reduction: Compression methods to reduce swelling and Osmotic agents (e.g., sugar or mannitol) to reduce edema. Surgical Options: Dorsal slit procedure to relieve pressure and circumcision for recurrent paraphimosis. Circumcision (Option A) is an option for recurrent paraphimosis but is not the immediate initial management in an acute case. Topical corticosteroids (Option C) are used for treating phimosis but are not effective in the acute management of paraphimosis. Oral antibiotics (Option D) may be necessary if there is an infection, but they are not the primary treatment for paraphimosis.

References:

Bailey and Love’s Short Practice of Surgery, 28th Edition, Page 1548

www.ncbi.nlm.nih.gov/books/NBK459233/#:~:text=Paraphimosis%20is%20a%20common%20urologic,%2C%20edema%2C%20and%20even%20necrosis.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q15: A 5 year old boy presents with a non-retractable foreskin that has a fibrotic ring around the preputial orifice. His parents report that he experiences pain and irritation during urination. What is the most likely diagnosis? (Q849384)

A. Physiologic phimosis

B. Paraphimosis

C. Pathologic phimosis

D. Balanitis

Correct Answer: C. Pathologic phimosis

Listen (English)

Listen (Hindi)

Explanation: Pathologic phimosis is characterized by a non-retractable foreskin with a fibrotic ring (cicatrix) and symptoms such as pain, irritation, and dysuria, which fits the patient's presentation. Feature Physiologic Phimosis (Option A) Pathologic Phimosis (Option C) Overview Inability to retract the foreskin due to congenital adhesions. Common in newborns and young boys Resolves spontaneously over time with normal penile growth and erections. Nonretractable foreskin due to scarring or fibrosis of the prepuce. Less common, typically occurs in older children or adults. Does not resolve spontaneously, often worsens without intervention. Onset Present at birth, with gradual improvement. May develop after trauma, infection, inflammation, or forcible retraction. Symptoms Typically asymptomatic, occasional mild discomfort during retraction. Pain, irritation, bleeding, dysuria, painful erections, recurrent infections. Appearance of Prepuce Normal appearance, foreskin adhered to glans. Presence of fibrotic ring (cicatrix) around the preputial orifice and white scarring. Management No treatment needed for most cases. Stretching exercises and topical corticosteroids if concerned. Surgical options like preputioplasty, dilation, or circumcision if severe. Complications Uncommon High risk of complications such as paraphimosis, recurrent UTIs, or balanitis xerotica obliterans (BXO). Paraphimosis (Option B) occurs when a retracted foreskin cannot be returned to its normal position, leading to a constricting band around the glans, but this does not match the description of a fibrotic ring and non-retractable foreskin. Balanitis (Option D) refers to inflammation of the glans penis, usually presenting with redness, swelling, and pain, but it does not involve a non-retractable foreskin with a fibrotic ring.

References:

Bailey and Love’s Short Practice of Surgery, 28th Edition, Pages 279, 1547

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1949079/

↑ *Back to this question in Part A*

@Neet_pg_bot

Q16: A newborn male presents with urinary retention, lethargy and a distended bladder. Antenatal ultrasound showed a "keyhole sign" with a thickened bladder wall. Which of the following is the most likely diagnosis? (Q849383)

A. Hypospadias

B. Vesicoureteral reflux

C. Posterior urethral valves

D. Neurogenic bladder

Correct Answer: C. Posterior urethral valves

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Posterior urethral valves are characterized by membranous folds in the posterior urethra leading to urinary obstruction, which matches the "keyhole sign" on ultrasound and the postnatal symptoms of urinary retention and lethargy. Posterior urethral valves Definition Urinary tract obstruction in male infants from membranous folds in the posterior urethra. Complications Chronic kidney disease, pulmonary hypoplasia from oligohydramnios. Classification Type I: Posterior urethral folds Type II: Membranes at bladder neck Type III: Round membrane at verumontanum Etiology Congenital, unclear embryological origin. Pathophysiology Increased bladder pressure → hypertrophy, vesicoureteric reflux, renal damage Diagnostic Tools Ultrasound, VCUG (voiding cystourethrogram) and Renal scintigraphy. Antenatal Diagnosis Ultrasound: Dilated bladder ("keyhole sign"), thickened walls. Postnatal Symptoms Urinary retention, infections, lethargy, respiratory distress. Management Antenatal: Vesicostomy, fetal valve ablation Postnatal: Stabilization, cystoscopic ablation Prognosis Depends on severity; long-term care needed for CKD, bladder dysfunction, recurrent UTIs. Hypospadias (Option A) involves an abnormal urethral opening and does not present with the obstructive symptoms described, such as a distended bladder and urinary retention. Vesicoureteral reflux (Option B) can occur secondary to posterior urethral valves but is not the primary condition associated with the described ultrasound findings and symptoms. Neurogenic bladder (Option D) results from nerve damage affecting bladder function, but it is not typically associated with the "keyhole sign" seen in posterior urethral valves.

References:

Bailey and Love’s Short Practice of Surgery, 28th Edition, Pages 1538,1539

https://www.ncbi.nlm.nih.gov/books/NBK560881/

↑ *Back to this question in Part A*

@Neet_pg_bot

Q17: A 4-year-old boy presents with complaints of recurrent UTI and difficulty urinating as mentioned by their parents.Upon examination, the physician notes that the urethral opening is located on the dorsal (top) aspect of the penis rather than at the tip. What is the most likely diagnosis? (Q849382)

A. Hypospadias

B. Peyronie’s disease

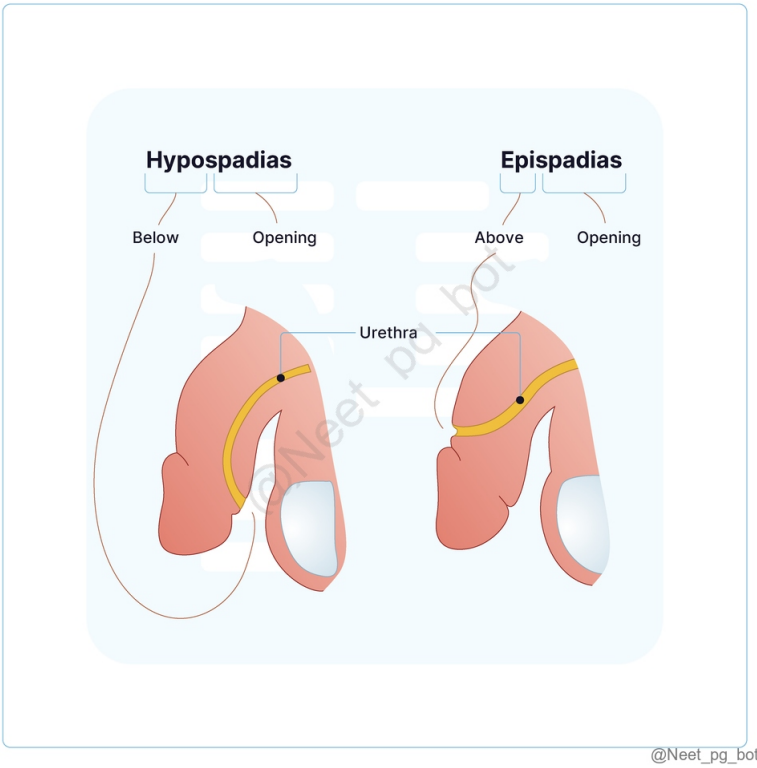
C. Epispadias

D. Phimosis

Correct Answer: C. Epispadias

- *Listen (English)*
- *Listen (Hindi)*

Explanation: Epispadias Congenital condition where the urethral opening is located on the dorsal (top) side of the penis (in males) or the clitoris (in females). Male Epispadias : Urethral opening on the top of the penis. Female Epispadias : Urethral opening located on the clitoris or along the dorsal side of the urethra. Associated with bladder exstrophy. Clinical features : Difficulty urinating, recurrent urinary tract infections, Undescended testis, Bifid clitoris, Widely separated labia, Urinary incontinence. Treatment : Modified Cantwell-Ransley repair and Mitchell repair. Epispadias repairs must deal with correction of the dorsal chordee and curvature, Dissection of the corpora and lengthening them by medial rotation, Urethral reconstruction for urination and ejaculation, Reconstruction of the glans penis. Hypospadias (Option A) : Congenital condition where the urethral opening is on the underside of the penis and not on the top side of penis. Peyronie Disease (Option B) : Characterized by the development of fibrous plaques in the penile tissue. It affects penile shape and function but not the position of the urethral opening. Phimosis (Option D) : Condition where the foreskin cannot be retracted over the glans (head) of the penis. This is not related to the position of the urethral opening.



References:

Bailey and Love’s Short Practice of Surgery, 28th Edition, Page 1540

Epispadias

↑ *Back to this question in Part A*

@Neet_pg_bot

Q18: A 4-year-old boy presents with recurrent urinary tract infections and a history of abnormal urination. Physical examination reveals an abnormal opening on the perineum instead of the tip of the penis. What is the most likely diagnosis? (Q849381)

A. Hypospadias

B. Epispadias

C. Ectopic vesicae

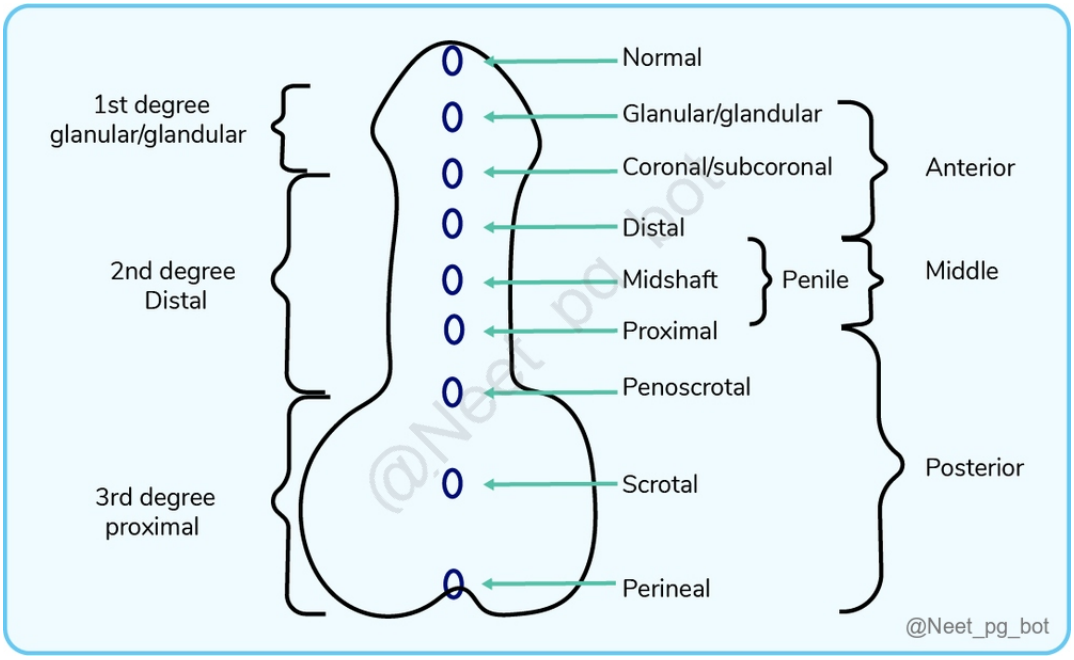
D. Phimosis

Correct Answer: A. Hypospadias

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Hypospadias: It is a congenital condition in which the urethral opening is located on the ventral (underside) of the penis, and in severe cases, may be found as far back as the perineum . Associated with abnormal urination , spraying , or downward deflection of urine. Can lead to recurrent UTIs due to poor urinary stream and stasis. Often associated with chordee (ventral penile curvature). Feature Description Definition A congenital anomaly where the urethral meatus opens on the ventral side (underside) of the penis instead of the tip Location of Meatus Anywhere along the ventral shaft , scrotum, or perineum (in severe cases) Types Glanular (near glans) Coronal Penile Penoscrotal Perineal Associated Abnormalities Chordee (ventral penile curvature) Incomplete foreskin (dorsal hood) Undescended testes (in some cases) Clinical Features Abnormal urinary stream Spraying or dribbling of urine May be noticed during urination or circumcision Recurrent UTIs (in severe cases) Diagnosis Clinical examination at birth Imaging (USG KUB, VCUG) if suspected associated anomalies or recurrent UTIs Differential Diagnoses Epispadias (dorsal meatus) Exstrophy of bladder Disorders of sexual development (if associated genital ambiguity) Management Avoid neonatal circumcision (foreskin may be needed for repair) Surgical correction ideally between 6–18 months of age Surgical Goals Position urethral meatus at the glans tip Straighten the penis (correct chordee) Create cosmetically normal appearance Prognosis Excellent with early surgical correction Most children have normal voiding and sexual function later in life Epispadias (Option B) is incorrect because the urethral opening is on the dorsal (upper) surface of the penis, not the perineum. It may also present with urinary incontinence, but is not consistent with the described perineal opening. Ectopic vesicae (Option C) is incorrect because it refers to exstrophy of the bladder , where the bladder is exposed outside the abdominal wall. It is typically diagnosed at birth and presents with visible bladder mucosa. Phimosis (Option D) is incorrect because it refers to the inability to retract the foreskin over the glans penis. It does not cause a displaced urethral opening and is not associated with an opening on the perineum.



References:

https://www.ncbi.nlm.nih.gov/books/NBK482122/

↑ *Back to this question in Part A*

@Neet_pg_bot

Q19: What is the correct sequence of steps for hypospadias repair? (Q849380)

A. Degloving, orthoplasty, urethroplasty, and glanuloplasty

B. Orthoplasty, degloving, urethroplasty, and glanuloplasty

C. Degloving, urethroplasty, orthoplasty, and glanuloplasty

D. Degloving, urethroplasty, glanuloplasty, and orthoplasty

Correct Answer: A. Degloving, orthoplasty, urethroplasty, and glanuloplasty

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Steps of Hypospadias repair: De-gloving ↓ Orthoplasty ↓ Urethroplasty ↓ Meatoplasty ↓ Glanuloplasty ↓ Penoplasty ↓ Scrotoplasty Degloving : Removal of the penile skin to expose the underlying structures. Orthoplasty : Correction of penile curvature and any associated penile shaft issues. This step involves mobilizing and repositioning the urethral plate if necessary. Urethroplasty : Creation or reconstruction of the neourethra using tissue flaps or grafts to form a functional urethra. Meatoplasty: Providing vascularised coverage

for the urethroplasty. Glanuloplasty : Reconstruction of the glans penis, focusing on creating a normal appearance and aligning the meatus. Penoplasty : Reconstruction of the penile shaft to restore or enhance its normal appearance and function. This may involve skin flaps or grafts. Scrotoplasty : Correction or reconstruction of the scrotum, which may be necessary if there are associated anomalies or for cosmetic reasons.

References:

www.ncbi.nlm.nih.gov/pmc/articles/PMC5332236/#:~:text=The%20operative%20steps%20of%20hypospadias,to%20create%20a%20circumcised%20penile

↑ *Back to this question in Part A*

@Neet_pg_bot

Q20: What is the most common type of hypospadias? (Q849379)

A. Scrotal hypospadias

B. Glanular hypospadias

C. Penoscrotal hypospadias

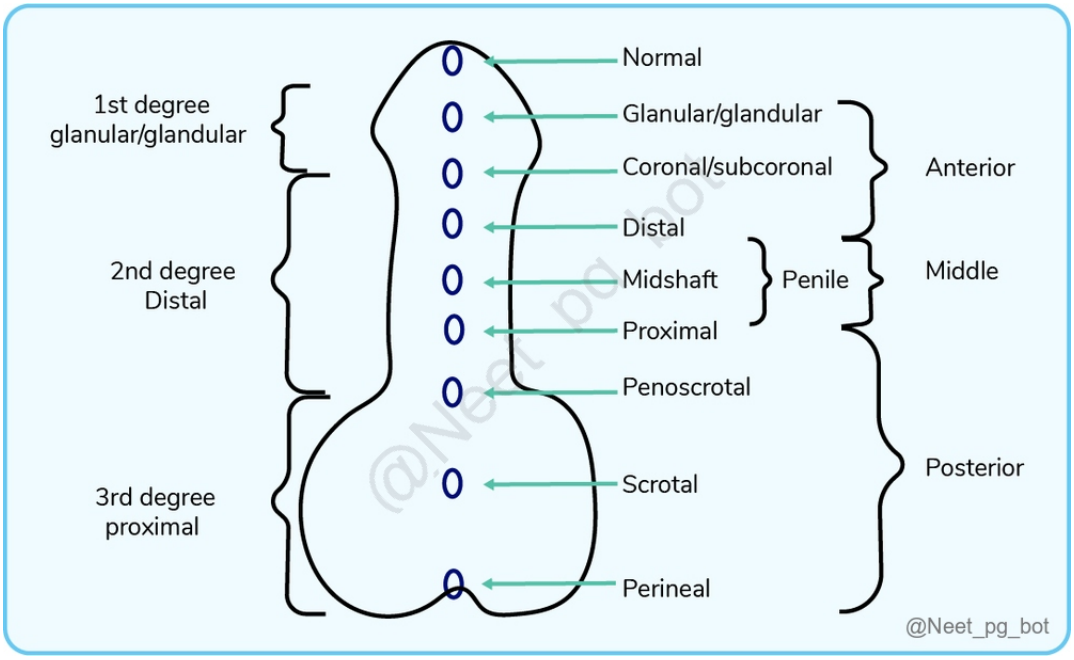
D. Perineal hypospadias

Correct Answer: B. Glanular hypospadias

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Hypospadias: Caused by failure of fusion of urethral folds- meatus in ventral aspect Affects about 1 in 300 male live births, Most common congenital abnormality of the urethra. Characterized by: Ectopic ventrally located urethral meatus, Ventral penile curvature (chordee), Incomplete dorsal hood prepuce. Classification/Types: Glanular Hypospadias: Most common type (Option B) Coronal Hypospadias Penile Hypospadias Penoscrotal Hypospadias Perineal Hypospadias Scrotal Hypospadias Distal penile Hypospadias {{caption_text}} Glandular, Coronal and Distal penile hypospadias account for 60-70% of cases of hypospadias. Treatment usually involves tubularized incised plate urethroplasty. Two-stage repair : First corrects penile curvature, second repairs urethra, Typically done before 18 months of age. Circumcision should be avoided to preserve preputial skin for future repairs. Failed repair can result in urethrocutaneous fistula.



References:

Bailey and Love's Short Practice of Surgery, 28th Edition, Page 1539 &1540

Hypospadias

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@Neet_pg_bot

• [06_Urology] 039 Testis And Scrotum

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[06_Urology] 039 Testis And Scrotum — Quick Jump

Q1 (p. 2577)	*Q2 (p. 2578)*	*Q3 (p. 2579)*	*Q4 (p. 2580)*	*Q5 (p. 2581)*	*Q6 (p. 2582)*
Q7 (p. 2583)	*Q8 (p. 2584)*	*Q9 (p. 2585)*	*Q10 (p. 2586)*	*Q11 (p. 2587)*	*Q12 (p. 2588)*
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Q19 (p. 2594)	*Q20 (p. 2596)*				

Q1: A 45-year-old man presents with bilateral scrotal swelling. On examination, tense clusters that feel like bunches of grapes are palpable posterior to the testis and positive transillumination seen. Which of the following is the most appropriate management option if the patient reports discomfort? (Q849482)

A. Aspiration of the cysts

B. Total epididymectomy

C. Ultrasound-guided drainage

D. Excision of the cysts

Correct Answer: D. Excision of the cysts

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The scenario suggests epididymal cyst. Excision of the cysts is recommended if the cysts cause discomfort, especially when they are large or symptomatic. Epididymal cyst Definition Fluid-filled sacs resulting from cystic degeneration of the epididymis Commonly found in middle-aged men Often bilaterally in the scrotum Location & Palpation Positioned posterior to and separate from the testis Palpable as tense clusters, resembling tiny bunches of grapes Diagnosis Transilluminate like other cystic scrotal lesions; confirmed by ultrasound examination Treatment Small, asymptomatic cysts may not require treatment Larger, symptomatic cysts can be surgically excised (Option D) Aspiration is ineffective due to the multilocular nature of the cysts (Option A) For recurrent or multilocular cysts, partial or total epididymectomy may be necessary (Option B) Ultrasound-guided drainage (Option C) is not typically used for epididymal cysts.

References:

Bailey & Love's Short Practice of Surgery (28th Edition), Page: 1566

↑ *Back to this question in Part A*

Q2: A 35-year-old man presents with a painless, firm scrotal mass. Serum alpha-fetoprotein (AFP) and human chorionic gonadotropin (hCG) levels are elevated. What is the most likely diagnosis? (Q849491)

A. Epididymal cyst

B. Orchitis

C. Chimney sweep cancer

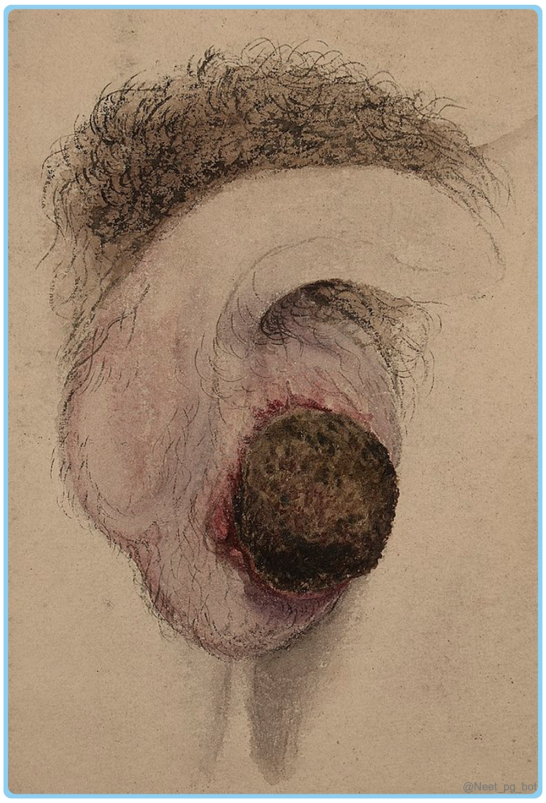
D. Hydrocele

Correct Answer: C. Chimney sweep cancer

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The clinical features and elevated AFP and hCG point towards Chimney sweep cancer. Carcinoma of Scrotum/Chimney sweep cancer Risk factors Aromatic cyclic hydrocarbons, Coal products.Most common in men between 15-35 years. Clinical features Typically presents as a painless, firm mass in the scrotum. May include swelling, heaviness, or discomfort, though it is often asymptomatic initially. Growth starts as ulcers with everted edges and indurated base. Tumor Markers Elevated serum levels of alpha-fetoprotein (AFP) and human chorionic gonadotropin (hCG). Investigation of Choice Testicular biopsy Treatment Wide local excision with 2 cm margin of healthy skin. High radical Orchidectomy Chemotherapy and Radiation Therapy Epididymal cyst (Option A) : Benign fluid-filled sac in the epididymis and typically does not elevate tumor markers like AFP or hCG. It usually presents as a smooth, painless mass. Orchitis (Option B) : Inflammation of the testicle, usually caused by infection. It is typically associated with pain, swelling and does not usually cause elevated tumor markers. Hydrocele (Option D) : Presents as a fluid-filled sac around the testicle, which is typically painless and would not cause elevated tumor markers like AFP or hCG.



References:

Bailey & Love edition 28,pg 1574

↑ *Back to this question in Part A*

@Neet_pg_bot

Q3: For a patient with Stage I seminoma, which of the following is the most appropriate treatment? (Q849490)

A. Radical Orchidectomy followed by adjuvant chemotherapy

B. Radical Orchidectomy followed by adjuvant radiotherapy

C. High-dose chemotherapy

D. Radical Orchidectomy alone

Correct Answer: B. Radical Orchidectomy followed by adjuvant radiotherapy

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Management of Testicular tumour based on staging: High Radical Orchidectomy is the primary intervention done in all patients of all stages followed by : Seminoma Non-Seminomatous GCT Stage I Radiotherapy RPLND Stage II Chemotherapy Chemotherapy + RPLND Stage III & IV Chemotherapy + Metastasectomy Chemotherapy + RPLND + Metastasectomy Chemotherapy: Bleomycin-Etoposide-Cisplatin(BEP) regimen is commonly used. RPLND(Retroperitoneal Lymph Node Dissection) : Removal of Precaval,Retrocaval, Paracaval, Interaortacaval, Retroaortic, Paraaortic, Common iliac nodes and Gonadal vein. Staging of Testicular Tumour STAGE DESCRIPTION Stage I Tumour confined to testis(T1-T2), No lymph node involvement and no distant metastasis Stage II Tumour with regional lymph node involvement (N1-N3), but no distant metastasis (M0). Stage III Tumour with distant metastasis (M1a or M1b). Stage IV Includes any T, any N, with distant metastasis (M1b), or with extensive local invasion.

References:

Bailey & Love edition 28,pg 1572

SRB Surgery edition 6,pg 1230&1231

Management

↑ *Back to this question in Part A*

@Neet_pg_bot

Q4: Match the tumor markers with their associated testicular tumor types: Tumor Markers Tumor Types 1. AFP (Alpha-fetoprotein) a. Seminoma 2. HCG (Human Chorionic Gonadotropin) b. Yolk Sac Tumor 3. LDH (Lactate Dehydrogenase) c. Choriocarcinoma 4. CA-125 d. Ovarian cancer (Q849489)

A. 1-b,2-c,3-a,4-d

B. 1-d,2-b,3-c,4-a

C. 1-a,2-d,3-b,4-c

D. 1-c,2-a,3-d,4-b

Correct Answer: A. 1-b,2-c,3-a,4-d

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Tumor marker Types of Tumor AFP (Alpha-fetoprotein) Yolk sac tumor Embryonal carcinoma Teratoma HCG (Human Chorionic Gonadotropin) Choriocarcinoma Embryonal carcinoma Mixed Germ Cell Tumor LDH (Lactate Dehydrogenase) Seminoma PLAP (Placenta Like Alkaline Phosphatase) Seminoma GGT (Gamma Glutamyl Transpeptidase) Seminoma CA-125 is elevated in case of : Ovarian Cancer Breast Cancer Adenocarcinoma of cervix Endometrial adenocarcinoma

References:

Bailey & Love edition 28,pg 1571

Tumour markers

Tumour marker-seminoma

↑ *Back to this question in Part A*

@Neet_pg_bot

Q5: A 25 years old man presents with a painless testicular mass. On examination, non-tender 3 cm mass in the right testicle is found.Ultrasound reveals a homogeneous, hypoechoic intratesticular mass. Serum tumor markers show elevated beta-hCG and LDH but normal AFP. Which of the following is the most likely diagnosis? (Q849488)

A. Leydig cell tumor

B. Embryonal carcinoma

C. Seminoma

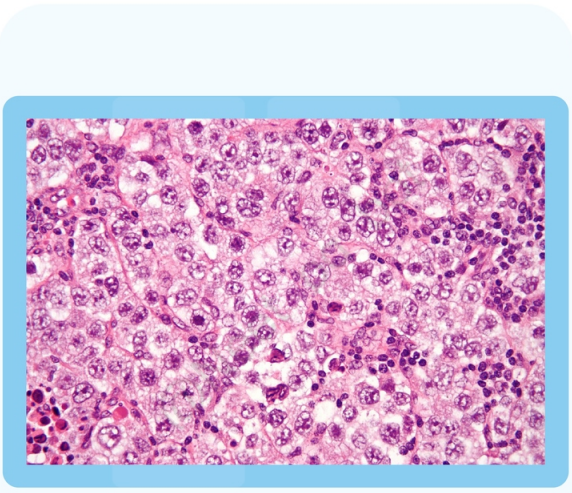
D. Teratoma

Correct Answer: C. Seminoma

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Seminoma Feature Details Tumor Type Seminoma, the most common pure testicular germ cell tumor in men aged 25-45 Origin Germinal epithelium of the seminiferous tubules Clinical Features Painless, firm swelling or mass in the testicle, typically unilateral. Accounts for 50% of all testicular germ cell tumors. 10% have secondary hydrocele, 5% have gynecomastia Diagnostic Markers AFP: Normal hCG: Normal or mildly elevated LDH: Elevated Investigation Ultrasound: Homogeneous, hypoechoic mass Histology: Sheets of oval cells with clear cytoplasm, large nuclei with prominent acidophilic nucleoli FNAC: Contraindicated due to risk of tumor cell seeding and lymph node metastasis Treatment Primary: High Inguinal Radical Orchidectomy Adjuvant: Radiation therapy or chemotherapy for positive lymph nodes Leydig cell tumor (Option A) : Benign testicular tumor that typically occurs in adults aged 30-60. While it presents as a painless testicular mass, Leydig cell tumors don't typically elevate beta-hCG. Embryonal carcinoma (Option B) : Aggressive germ cell tumor that often occurs in young men. However, it typically presents with both elevated AFP and beta-hCG, not just beta-hCG alone. It's also usually more heterogeneous on ultrasound. Teratoma (Option D) :Occur in young men, they typically have normal tumor markers (both beta-hCG and AFP). On ultrasound, they usually appear heterogeneous with cystic and solid components.



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References:

Bailey & Love edition 28,pg 1569,1572

Seminoma

↑ *Back to this question in Part A*

@Neet_pg_bot

Q6: A 28-year-old man undergoes a radical orchiectomy for a painless,enlarging testicular mass. Histopathology reveals neoplastic cells confined to the seminiferous tubules without stromal invasion.Serum tumor markers are within normal limits.Which of the following is the most likely diagnosis? (Q849487)

A. Seminoma

B. Yolk sac tumor

C. Leydig cell tumor

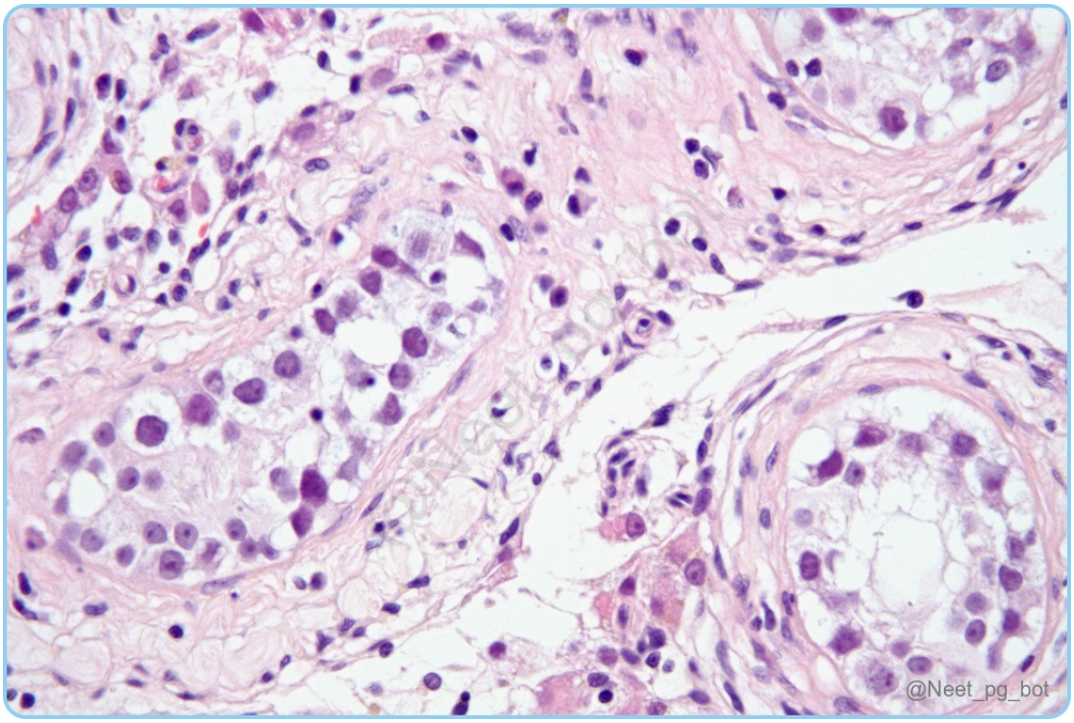
D. Intratubular germ cell neoplasm (ITGCN)

Correct Answer: D. Intratubular germ cell neoplasm (ITGCN)

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Intratubular Germ Cell Neoplasm (ITGCN): Precursor to invasive germ cell tumors except Teratoma, Yolk sac tumor, Spermatocytic seminoma Histology: Neoplastic germ cells are large, with clear cytoplasm and prominent nucleoli, confined within the seminiferous tubules. Risk of Progression: ITGCN has a high risk of progressing to invasive germ cell tumors, such as seminomas or non-seminomatous germ cell tumors. Clinical features: Serum tumor markers within normal limits(AFP,hCG and LDH), Affected testis is atrophied. Diagnosis: Gold standard investigation is Testicular biopsy. Treatment: Include close surveillance, radiation therapy to the contralateral testis and prophylactic orchidectomy. Seminoma (Option A): Invasive germ cell tumor with characteristic cells in sheets and lymphocytic stroma. Not confined to seminiferous tubules, unlike ITGCN. Yolk Sac Tumor (Option B): An invasive germ cell tumor often found in children, associated with elevated AFP. Histology shows Schiller-Duval bodies. Not confined to seminiferous tubules. Leydig Cell Tumor (Option C): A rare non-germ cell tumor arising from interstitial cells, often hormonally active. Not a germ cell neoplasm and not confined to seminiferous tubules.



References:

Bailey & Love edition 28,pg 1569

Germ cell tumor

↑ *Back to this question in Part A*

@Neet_pg_bot

Q7: Match the following WHO classification of tumors with its corresponding tumor :- 1. Germ cell tumors derived from germ cell neoplasia in situ A. Gonadoblastoma 2. Germ cell tumors unrelated to germ cell neoplasia in situ B. Prepubertal-type teratoma 3. Sex cord-stromal tumors C. Sertoli cell tumor 4.Nonseminomatous germ cell tumors D. Choriocarcinoma (Q849486)

A. 1 - A; 2 - B; 3 - C; 4 - D

B. 1 - B; 2 - A; 3 - C; 4 - D

C. 2 - B; 1 - C; 3 - D; 4 - A

D. 4 - A; 3 - B; 2 - C; 1 - D

Correct Answer: A. 1 - A; 2 - B; 3 - C; 4 - D

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: World Health Organization (WHO) classification of testicular tumors Germ cell tumors derived from germ cell neoplasia in situ Noninvasive germ cell neoplasia GCNIS (germ cell neoplasia in situ) Specific forms of intratubular germ cell neoplasia Gonadoblastoma The germinoma family of tumors Seminoma Nonseminomatous germ cell tumors Embryonal carcinoma Yolk sac tumor, postpubertal type Choriocarcinoma Placental site trophoblastic tumor Epithelioid trophoblastic tumor Teratoma, postpubertal type Teratoma with somatic-type malignancy Mixed germ cell tumors of the testis Mixed germ cell tumors Germ cell tumors of unknown type Regressed germ cell tumors Germ cell tumors unrelated to germ cell neoplasia in situ Spermatocytic tumor Teratoma, prepubertal-type Yolk sac tumor, prepubertal type Testicular neuroendocrine tumor, prepubertal type Mixed teratoma and yolk sac tumor, prepubertal type Sex cord-stromal tumors of the testis Leydig cell tumor Leydig cell tumor Sertoli cell tumor Sertoli cell tumor Large cell calcifying Sertoli cell tumor Granulosa cell tumor Adult granulosa cell tumor Juvenile granulosa cell tumor The fibroma thecoma family of tumors Tumors in the fibroma thecoma group Mixed and other sex cord-stromal tumors Mixed sex cord-stromal tumor Signet ring stromal tumor Myoid gonadal stromal tumor Sex cord-stromal tumor NOS (not otherwise specified)

References:

www.uptodate.com/contents/clinical-manifestations-diagnosis-and-staging-of-testicular-germ-cell-tumors?search=testicular%20tumor&source=search_result&selectedTitle=1~109&usage_type=default&display_rank=1#H2

↑ *Back to this question in Part A*

@Neet_pg_bot

Q8: A 30-year-old male presents with a painless testicular mass. On physical examination, a solid intratesticular mass is palpable, and there is difficulty in palpating the epididymis. Which of the following associated findings would most likely

be present in this patient? (Q849485)

A. Cough and dyspnea

B. Gynecomastia

C. Lower extremity swelling

D. Lumbar back pain

Correct Answer: B. Gynecomastia

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Gynecomastia is seen in approximately 5% of testicular tumor cases, mainly in non-seminomatous germ cell tumors due to hCG production. Testicular tumor- clinical features Common Presentation Initial Symptom: Painless testicular lump. Heaviness: Noted with larger tumors. Pain: Uncommon, may occur due to hemorrhage, mimicking torsion. Metastatic Disease: Rarely the first symptom. Physical Examination Solid Intratesticular Mass: Palpable. Secondary Hydrocele: May complicate examination. Epididymis: Difficult to palpate due to tumor. Gynaecomastia: Seen in ~5% of cases, mainly in non-seminomatous germ cell tumors. Bilateral Tumors: Present at diagnosis in 1-2% of cases. Presentation of Metastatic Disease (10%) Neck Mass: Supraclavicular lymph node metastasis. Cough/Dyspnea: Pulmonary metastasis. Gastrointestinal Symptoms: Anorexia, nausea, vomiting, or hemorrhage from retroduodenal metastasis. Lumbar Back Pain: Retroperitoneal disease involving psoas muscle or nerve roots. Bone Pain: Indicative of skeletal metastasis. Neurological Symptoms: CNS or peripheral nerve involvement. Lower Extremity Swelling: Due to iliac or caval venous obstruction or thrombosis. Systemic Endocrine Manifestations Gynecomastia: Linked to hCG, mainly in choriocarcinoma or trophoblastic cells. Paraneoplastic Hyperthyroidism: Due to hCG's thyroid-stimulating activity. Paraneoplastic Limbic Encephalitis: Rare, associated with anti-Ma2 antibodies. Precocious Puberty: Associated with Leydig cell tumors. Option A: Cough and dyspnea are related to pulmonary metastasis, which is less common in initial presentations. Option C : Lower extremity swelling is associated with venous obstruction or thrombosis due to metastatic disease. Option D: Lumbar back pain suggests retroperitoneal metastasis, typically seen in more advanced stages.

References:

Bailey & Love's Short Practice of Surgery (28th Edition), Page: 1571

Uptodate- Clinical features-testicular tumors

↑ *Back to this question in Part A*

@Neet_pg_bot

Q9: A 28-year-old man presents for a routine physical exam. He has a history of cryptorchidism corrected by orchidopexy in childhood. What is his relative risk of

developing testicular cancer compared to the general population? (Q849484)

A. No increased risk

B. 1.5 to 3.5 times higher

C. 2 times higher

D. 3.7 to 7.5 times higher

Correct Answer: D. 3.7 to 7.5 times higher

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Cryptorchidism increases the risk of developing testicular cancer by 3.7 to 7.5 times, even after surgical correction. Testicular tumor- risk factors Major Risk Factors Cryptorchidism: Most significant risk factor, increasing risk by 3.7 to 7.5 times, even after surgical correction (orchidopexy). Family History: 3.1-fold increased risk for first-degree relatives, 6.3-fold for brothers. Male Factor Infertility: Includes conditions like Klinefelter syndrome. Personal History: Previous contralateral tumor or germ cell neoplasia in situ (GCNIS). Maternal and Perinatal Factors: Low birth weight, perinatal inguinal hernia, maternal age at conception, and exposure to diethylstilbestrol (DES) during pregnancy. Additional Risk Factors Age: Most common in men aged 20–35; smaller peak after age 80. Ethnicity: Highest incidence in Caucasian men, followed by Hispanics, Asians, and African-Americans.. Age at Puberty: Early puberty may increase risk; late puberty may be protective. Genetic Conditions: Increased risk associated with Klinefelter syndrome and Down syndrome.

References:

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10145700/

Bailey & Love's Short Practice of Surgery (28th Edition), Page: 1569

↑ *Back to this question in Part A*

@Neet_pg_bot

Q10: A 60-year-old male with a history of diabetes presents with intense pain, swelling, and erythema of the scrotum. Physical examination reveals dusky skin and subcutaneous crepitation. What is the most appropriate initial management? (Q849483)

A. Oral antibiotics

B. Immediate surgical debridement

C. Observation and pain management

D. Aspiration of the affected area

Correct Answer: B. Immediate surgical debridement

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The scenario suggests Fournier's Gangrene. Immediate surgical debridement is crucial for removing necrotic tissue and controlling the infection. Fournier's Gangrene Definition Necrotizing infection of the soft tissues in the perineum, external genitalia, and perianal region, akin to necrotizing fasciitis. Clinical Presentation Symptoms: Intense pain in the genitalia, progressing through five phases: Prodromal Phase: Fever and lethargy. Early Pain Phase: Intense pain, possible edema, pruritus. Progressive Phase: Increased pain, erythema. Crepitation Phase: Dusky skin with subcutaneous crepitation. Gangrene Phase: Gangrene with purulent discharge. Pain may decrease as gangrene progresses. Severity ranges from localized tenderness to septic shock. Risk Factors Peripheral vascular disease, diabetes mellitus, malnutrition, alcoholism, immunocompromised states. Diagnosis Clinical presentation supported by imaging or lab findings. Management Initial Treatment: 1. Fluid resuscitation. 2. Broad-spectrum antibiotics. 3. Surgical debridement of necrotic tissue. Additional Measures: 1. Urinary and fecal diversion to prevent wound contamination. 2. Intensive monitoring for sepsis. 3. Wound review and vacuum-assisted dressing. 4. Skin grafting post-infection control. Option A: Oral antibiotics alone are insufficient for such a severe infection. Option C: Observation without intervention would allow the infection to progress rapidly. Option D: Aspiration is not effective in managing necrotizing infections.

References:

Bailey & Love's Short Practice of Surgery (28th Edition), Page: 1573-1574

Sabiston 21st edition, page: 1372

↑ *Back to this question in Part A*

@Neet_pg_bot

Q11: A 35-year-old man presented with a swelling of the scrotum, which was diagnosed as a spermatocele. Which of the following features of the swelling would have led to this diagnosis? (Q849478)

A. Location of the swelling at the head of the epididymis, above and behind the body of the testis

B. Soft, cystic, and transilluminant

C. Barley water-like fluid with spermatozoa on aspiration cytology

D. All of the above

Correct Answer: D. All of the above

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: All are features are suggestive of spermatocele Spermatocele: Definition A unilocular, acquired retention cyst derived from blockage of epididymis Location Head of the epididymis, above and behind the body of the testis Fluid Content Barley water-like Includes spermatozoa Characteristics Soft, cystic, and transilluminant Perceived by the patient as an additional testis Diagnosis Confirmed through aspiration cytology Treatment Can be left alone if asymptomatic Excision is performed if the spermatocele is large or symptomatic

References:

SRB 6th edition, page 1063

↑ *Back to this question in Part A*

@Neet_pg_bot

Q12: A 25-year-old tall, thin male presents with a dull, aching pain in his left groin and scrotum, describing a "bag of worms" sensation on palpation. He was suggested to undergo Palomo's Operation. Which of the following describes the procedure? (Q849477)

A. Suprainguinal extraperitoneal ligation of the testicular vein

B. Extraperitoneal excision of testicular vein

C. Excision of pampiniform plexus

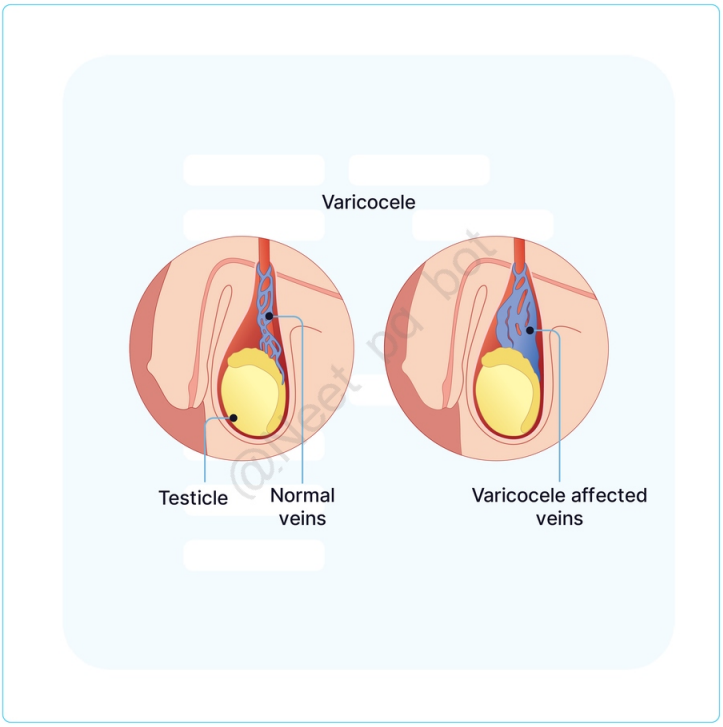
D. None of the above

Correct Answer: A. Suprainguinal extraperitoneal ligation of the testicular vein

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The scenario is that of varicocele Palomo's Operation involves suprainguinal extraperitoneal ligation of the testicular vein Varicocele : Dilatation and tortuosity of the pampiniform plexus of veins and testicular veins Common Occurrence More common in tall, thin young men More frequent on the left side, but can be bilateral Causes Idiopathic Absence or incompetent valve at the junction of the left testicular vein and left renal vein Perpendicular entry of the left testicular vein into the left renal vein Left-sided renal cell carcinoma causing blockage of the left testicular vein Effects Increased temperature in the scrotum, depressing spermatogenesis and causing infertility Symptoms Swelling at the root of the scrotum Dragging pain in the groin and scrotum "Bag of worms" feeling Impulse on coughing Swelling reduces on lying down (except in renal cell carcinoma) Investigations Venous Doppler of the scrotum and groin Ultrasound of the abdomen to check for kidney tumors Semen analysis Treatment Options Palomo's Operation: Suprainguinal extraperitoneal ligation of the testicular vein Ligation of veins Excision of veins



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References:

SRB 6th edition, pages 1063-1064

↑ *Back to this question in Part A*

@Neet_pg_bot

Q13: Which of the following statements on hydrocele is false? (Q849476)

A. Fluid is collected between the two layers of the tunica vaginalis

B. Primary vaginal hydrocele is common in middle-aged men

C. Lord's plication is done for large hydrocele

D. Congenital hydrocele is reduced on lying down

Correct Answer: C. Lord's plication is done for large hydrocele

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Lord’s plication is done for small, thin hydroceles with clear fluid Hydrocele: Collection of fluid between the two layers of the tunica vaginalis of the testis Aetiology Defective absorption of fluid by tunica vaginalis due to endothelial wall damage by low-grade infection Excessive production of fluid (secondary hydrocele) Interference with drainage of fluid by lymphatic vessels of the cord Communication with the peritoneal cavity Primary Vaginal Hydrocele Common in middle-aged men, prevalent in tropical countries Testis is usually large and non-palpable Fluctuant Can get above the swelling Initially transilluminant, but becomes non-transilluminant if long-standing Infantile Hydrocele Tunica and processus vaginalis distended up to the internal ring No connection with the peritoneal cavity Congenital Hydrocele Processus vaginalis communicates with the peritoneal cavity Fluid disappears when lying down and recollects when standing Encysted Hydrocele of the Cord Fluid collection in a portion of the patent funicular process of tunica vaginalis Fluctuant and transilluminant Located in the inguinal/inguinoscrotal/scrotal part Secondary Vaginal Hydrocele Causes: Infection (filariasis, tuberculosis), injury (trauma, post herniorrhaphy), tumor (malignancy) Usually small, lax, and testis is palpable except in cases of filariasis where it can be very large Surgical Procedure Lord's plication - small, thin hydrocele with clear fluid Jaboulay's operation - partial sac removal and eversion

References:

SRB's Manual of Surgery, 6th Edition, Pages 1057-1060

↑ *Back to this question in Part A*

@Neet_pg_bot

Q14: A 15-year-old boy presented with a sudden onset of pain in the scrotum, groin, and lower abdomen. On examination of the scrotum, he is showing Deming’s sign. What is Deming’s sign? (Q849475)

A. The affected testis is positioned high

B. The affected testis lies horizontally

C. Opposite testis is placed horizontally

D. The affected testis is positioned low

Correct Answer: B. The affected testis lies horizontally

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Deming’s sign refers to the horizontal (transverse) lie of the affected testis , which is a classic sign of testicular torsion . This occurs due to the bell-clapper deformity , where the testis lacks normal posterior fixation, allowing it to rotate and assume a horizontal orientation . Testicular Torsion: An emergency condition caused by twisting of the spermatic cord, leading to reduced blood supply. If untreated, it can cause ischemia and gangrene within 6–12 hours . Other signs: Ger’s sign: High-riding testis due to cord shortening (Option A) Prehn’s sign: Pain not relieved on elevation (negative Prehn’s sign in torsion)

References:

SRB 6th edition, pages 1068-1070

↑ *Back to this question in Part A*

@Neet_pg_bot

Q15: A 27-year-old male is presented with a swollen, red, and painful epididymis. On examination, his vas deferens has a beaded texture and epididymis is craggy. A diagnosis of epididymo-orchitis was made. What is the most likely causative organism? (Q849473)

A. Mumps

B. Filaria

C. Tuberculosis

D. Gonococci

Correct Answer: C. Tuberculosis

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: TB epididymo-orchitis presents with a beaded vas deferens and a craggy epididymis. Epididymo-orchitis: Inflammation of testes and epididymis It can be acute or chronic Causes Viral infections like mumps Bacterial Filarial Tuberculosis Gonococcal infections Schistosomiasis Features Epididymis - pain, tenderness, swelling, thickening Hydrocele Tuberculosis: Beaded vas deferens with a craggy epididymis Treatment General: Use of analgesics and antibiotics. Specific Treatment: Diethylcarbamazine citrate (DEC) 100 mg for 3 weeks. Evaluation: Specific causes should be ruled out. Psychological Care: Long-term epididymitis can cause psychological disturbance; reassurance is necessary.

References:

SRB 6th edition, page 1075

↑ *Back to this question in Part A*

@Neet_pg_bot

Q16: A 4-year-old boy has a right testis that intermittently moves between the scrotum and the groin, especially during physical activity. The testis is retractable but can be

brought down into the scrotum upon gentle manipulation, while the left testis is normally positioned. What is the most likely physiological explanation for this intermittent movement of the testis? (Q849472)

A. Patent processus vaginalis

B. Undescended testis

C. Overactive dartos muscle

D. Increased tone of the cremasteric muscle

Correct Answer: D. Increased tone of the cremasteric muscle

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: In this scenario, the intermittent movement of the testis between the scrotum and the groin, especially during physical activity, represents a retractile testis. Retractile testis A retractile testis is a condition where a normally descended testis moves between the scrotum and the groin due to an overactive cremasteric reflex and increased tone of the cremasteric muscle This reflex, which is triggered by physical activity or cold temperatures, causes the cremasteric muscle to contract, pulling the testis up into the groin In a retractile testis, the testis can be manually descended into the scrotum with gentle manipulation Typically, no treatment is required, as the condition often resolves spontaneously by puberty Patent processus vaginalis (Option A) is associated with indirect inguinal hernia or hydrocele, not with intermittent retraction of a normally descended testis. It does not explain the retractile nature of the testis. Undescended testis (Option B): The testis cannot be brought down into the scrotum on manipulation and remains fixed in an abnormal position. In this case, since the testis is manually reducible, it rules out an undescended testis. Overactive dartos muscle (Option C): The dartos muscle is responsible for wrinkling of the scrotal skin and does not significantly contribute to the movement of the testis between the scrotum and groin. The primary muscle responsible for testicular elevation is the cremaster muscle, not the dartos.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Pages 1559, 1560

SRB's Manual of Surgery, 6th Edition, Page 1069

↑ *Back to this question in Part A*

@Neet_pg_bot

Q17: A 2 year old boy underwent surgery for an ectopic testis, followed by an orchidopexy. Several weeks later, he presents with symptoms including swelling and pain in the scrotum, along with fever. On examination, the scrotum is tender, and the affected testis appears to be positioned higher than normal. What is the most likely

cause for these symptoms? (Q849471)

A. Abscess formation

B. Scrotal hematoma

C. Testicular atrophy

D. Testicular torsion

Correct Answer: D. Testicular torsion

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Testicular torsion is a possible complication after orchidopexy, especially if the fixation of the testis was not secure or if there was a delay in the procedure. The symptoms of pain, swelling, and high-riding testis are characteristic of torsion. This is a surgical emergency as it can lead to testicular ischemia and necrosis if not treated promptly. Complications of orchidopexy Infection Postoperative infection at the incision site or scrotum. Hemorrhage Bleeding or hematoma formation. Testicular Atrophy Shrinkage or loss of testicular function. Testicular Necrosis Death of testicular tissue due to inadequate blood supply. Recurrent Undescended Testicle Testicle reascends, possibly requiring reoperation. Scrotal Swelling Postoperative scrotal swelling or hydrocele formation. Infertility Rare, due to damage affecting fertility. Testicular Torsion Twisting of the testicle, risking blood supply. Injury to Adjacent Structures Potential damage to vas deferens or blood vessels. Abscess formation (Option A): Scrotal abscess usually presents with fluctuance, erythema, and purulence, and the testis position is usually normal. A high-riding testis is not typical. Scrotal hematoma (Option B) o ccurs earlier post-op (first few days), presents with ecchymosis, swelling, but the testis does not ride high. Pain is present, but torsion signs are more specific. Testicular atrophy (Option C) occurs weeks to months later, presenting as a small, shrunken, painless testis. Acute pain and fever do not fit.

References:

www.ncbi.nlm.nih.gov/books/NBK560904/

↑ *Back to this question in Part A*

@Neet_pg_bot

Q18: An 8 months old infant is undergoing surgical exploration for an undescended testis. The surgeon follows the standard approach and examines the inguinal canal but does not find the testis in the usual tract. Which location should the surgeon check next? (Q849470)

A. Superficial inguinal pouch

B. Perineum

C. Femoral canal

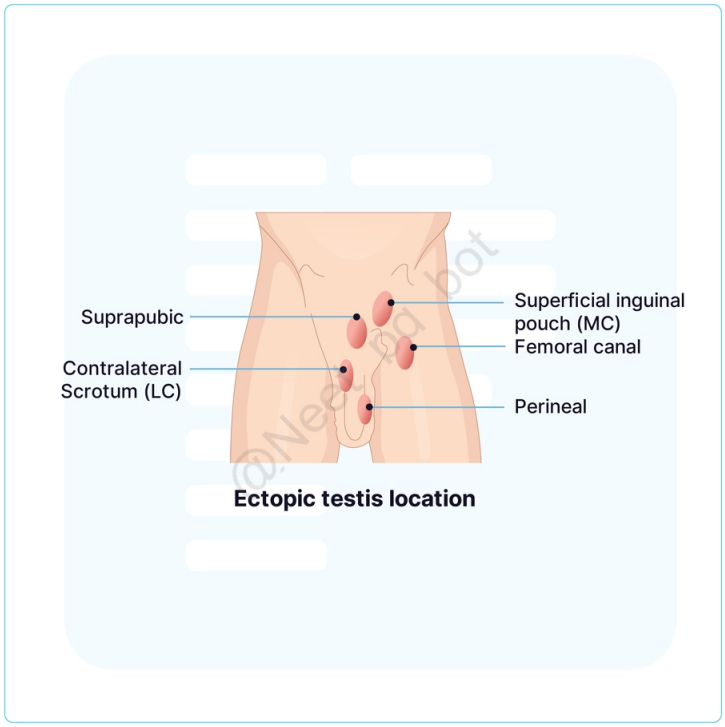
D. Retroperitoneum

Correct Answer: A. Superficial inguinal pouch

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: According to the given scenario, the diagnosis point towards ectopic testis The testis may end up in abnormal locations such as: Superficial Inguinal Pouch (Most Common) Femoral Region(Femoral canal) Perineum: Retroperitoneum Ectopic testis An ectopic testis is when a testicle fails to descend into the scrotum and lies outside the normal descent tract typically due to abnormalities in the gubernaculum Management: Surgical Correction (Orchidopexy): To reposition the testis into the scrotum. Complications: Infertility Increased risk of testicular cancer



References:

SRB's Manual of Surgery (6th Edition), Page 1068.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q19: All are true regarding undescended testis, except? (Q849469)

A. Seminoma is the most common tumor associated with undescended testis

B. Elevated abdominal temperature impairs sperm production

C. Orchidopexy is typically performed between 6-18 months of age.

D. Undescended testis causes loss of secondary sexual characteristics due to Leydig cell impairment.

Correct Answer: D. Undescended testis causes loss of secondary sexual characteristics due to Leydig cell impairment.

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Leydig cells are unaffected in cryptorchidism, maintaining secondary sexual characteristics, while Sertoli cells are impaired, affecting spermatogenesis. Undescended Testis (Cryptorchidism) Definition Cryptorchidism is a condition where one or both testes fail to descend into the scrotum from the abdomen. Locations Inguinal/Palpable undescended testis: 80% Abdominal/Non-Palpable undescended testis: 20% Causes and Associated Conditions Developmental and Genetic Factors: Conditions like Klinefelter syndrome and testosterone imbalances can impair testicular descent. Prematurity and Maternal Factors: Premature birth and maternal issues like diabetes or medication exposure can lead to undescended testes. Mechanical and Physical Factors: Obstructions in the inguinal canal, scrotum, or related conditions such as inguinal hernia can prevent normal testicular descent. Complications (SATHI Mnemonic): S: Sterility - Elevated abdominal temperature can impair sperm production, leading to potential infertility if untreated. (Option B) A: Atrophy - Prolonged exposure to heat can cause the testis to shrink or become non-functional. T: Trauma, Tumor, Torsion - Increased risk of testicular torsion, which can cause severe pain and potentially result in testicular loss. The most common tumor associated is seminoma (Option A) with the highest risk of tumor development in abdominal testes. H: Hernia - Over 90% of cases are associated with a patent processus vaginalis, increasing the risk of inguinal hernia. I: Inflammation - The undescended testis is more prone to inflammatory conditions. Note: Leydig cells are unaffected, maintaining secondary sexual characteristics, while Sertoli cells are impaired, affecting spermatogenesis. Diagnosis Palpable undescended testis: Inguinal exploration. Non-Palpable undescended testis: Diagnostic laparoscopy. Imaging: Ultrasound or MRI may be utilized to locate the testis. Treatment Surgical Repositioning (Orchidopexy): Usually performed when the child is between 6-18 months old. (Option C) Types of Orchidopexy Ombridannes Keetley-Torek Stephen-Fowler Ladd & Gross

References:

Bailey & Love's Short Practice of Surgery (28th Edition), Page 1559 -1561.

Schwartz's Principles of Surgery (11th Edition), Page 1777.

SRB's Manual of Surgery (6th Edition), Page 1065 -1068.

↑ *Back to this question in Part A*

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Q20: Which of the following factors are responsible for testicular descent? Testosterone Gubernaculum Intra-abdominal Pressure CGRP (Calcitonin Gene-Related Peptide) INSL3 (Insulin-like 3) Processus Vaginalis (Q849468)

A. 1, 2, and 3

B. 1, 2, and 6

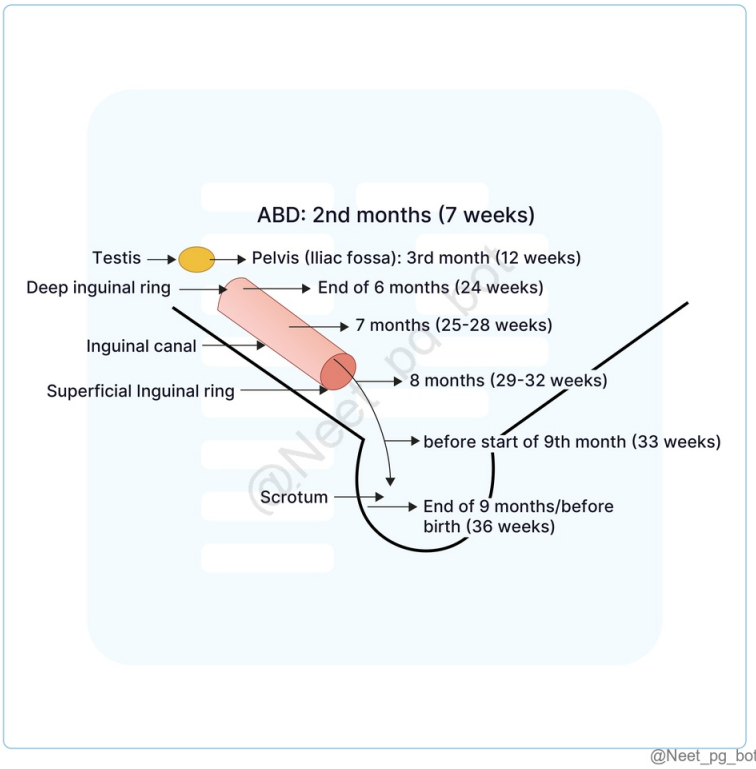
C. 1, 3, 4, and 6

D. 1,2,3,4,5,6

Correct Answer: D. 1,2,3,4,5,6

- *Listen (English)*
- *Listen (Hindi)*

Explanation: Factors responsible for testicular descent: Factor Role in Testicular Descent Testosterone Stimulates gubernaculum shortening, guiding the testes into the scrotum. Gubernaculum A ligament that pulls the testes down during descent. Intra-abdominal Pressure Helps push the testes through the inguinal canal. CGRP (Calcitonin Gene-Related Peptide) Supports gubernaculum development during the early transabdominal phase. INSL3 (Insulin-like 3) Promotes gubernaculum elongation, aiding descent. Processus Vaginalis Provides the pathway through which the testes descend. Position of Testis in Intrauterine Life Abdomen (2nd Month/7th Week) ↓ Pelvis (Iliac Fossa) (3rd Month/12th Week) ↓ Deep Inguinal Ring (End of 6th Month/24th Week) ↓ Passes Through Inguinal Canal (During 7th Month/25th-28th Week) ↓ Superficial Inguinal Ring (8th Month/29th-32nd Week) ↓ Enters Scrotum (Beginning of 9th Month/33rd Week) ↓ Base of Scrotum (Before Birth/End of 9th Month/36th Week) Cryptorchidism: Undescended testis; risks include infertility and cancer



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References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Pages 1558,1559

Schwartz's Principles of Surgery, 11th Edition, Pages 1760,1761,1777

SRB's Manual of Surgery, 6th Edition, Pages 1065,1066

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[06_Urology] 040 Previous Year Questions — Quick Jump

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Q55 (p. 2679)	*Q56 (p. 2680)*	*Q57 (p. 2681)*	*Q58 (p. 2682)*	*Q59 (p. 2685)*	*Q60 (p. 2685)*
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Q85 (p. 2723)	*Q86 (p. 2728)*	*Q87 (p. 2729)*	*Q88 (p. 2731)*	*Q89 (p. 2731)*	*Q90 (p. 2733)*
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Q103 (p. 2753)	*Q104 (p. 2753)*	*Q105 (p. 2754)*			

Q1: A 13-year-old boy presents to the OPD with sudden onset severe pain in the right testis 2 hours after being hit by a cricket ball. On examination: Severe tenderness of the right testis, absent cremasteric reflex & testis is high-riding. What is the next best step in management? (Q866925)

A. USG Arterial Doppler

B. NSAIDS

C. USG Venous Doppler

D. Surgical exploration

Correct Answer: D. Surgical exploration

Explanation: Surgical exploration is the gold standard and emergency management for testicular torsion: Diagnosis is primarily clinical: sudden onset pain, absent cremasteric reflex, high-riding testis. Immediate detorsion and orchidopexy of both testes is necessary to salvage the affected testis. Time is critical: salvage rate >90% if treated within 6 hours. If the testis is nonviable → orchidectomy is performed Incorrect Options: Option A) USG Arterial Doppler: Can detect absent blood flow, but should not delay surgery in a clinically obvious torsion. Option B) NSAIDs: Only provide pain relief; do not treat torsion . Delaying surgery risks testicular loss . Option C) USG Venous Doppler: Not indicated; torsion primarily affects arterial inflow .

References:

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↑ *Back to this question in Part A*

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Q2: Which of the following is not a recognised cause of recurrent renal stone formation? (Q865361)

A. Hyperoxaluria

B. Hypercalciuria

C. Hypercitraturia

D. Hyperuricosuria

Correct Answer: C. Hypercitraturia

Explanation: Hypercitraturia is not a known cause of recurrent renal stone formation, whereas Hypocitraturia is a common, correctable cause of recurrent stone formation. Risk factors for the formation of Renal Stones: Risk factors Description Dietary factors Low calcium intake can lead to stone formation (low calcium can lead to high oxalate absorption). High oxalate intake High animal protein intake (leads to hypercalciuria and hyperuricosuria) Higher sodium and sucrose intake (hypercalciuria) Dehydration or inadequate fluid intake (leads to volume depletion) Sugar-sweetened beverages Non-dietary factors More common in middle age group Low urine output (due to a hot environment, lack of access to water or a bathroom) Urinary factors Hypercalciuria (Option B) Hyperuricosuria (Option D) Hyperoxaluria (Option A) Low urine excretion of citrate (citrate inhibits stone formation) Urinary pH: Acidic: Uric acid stone formation Alkaline: Calcium phosphate stone formation Associated disorders Idiopathic hypercalciuria (recurrent renal stones) Inflammatory Bowel disease (IBD), especially Crohn’s Disease (calcium oxalate stones) Gastric bypass surgery Primary hyperparathyroidism (calcium oxalate stones) Obesity Recurrent urinary tract infection (UTI) Diabetes mellitus (Type 2) Renal tubular acidosis Type 1 or distal (calcium phosphate stones) Disorders like hypertension, gout, cardiovascular disease, cholelithiasis, reduced bone mineral density, and chronic kidney disease can also increase the risk for stone formation. Genetic disorders Family history of stones Medullary sponge kidney: A congenital disorder marked by malformations of the papillary collecting ducts in the renal pyramids, leading to microscopic and large medullary cysts, often presenting as renal stones. Cystinuria: Reabsorption of filtered cystine, ornithine, arginine, and lysine

caused by mutations in the SLC3A1 amino acid transporter gene , resulting in a high cystine concentration in urine and the formation of cystine stones. Primary hyperoxaluria: It is characterised by excessive endogenous oxalate production by the liver.

References:

Harrison’s Principles of Internal Medicine, 21st Edition, Volume I, Page 2368-2370

Davidson’s Principles and Practice of Medicine, 24th Edition, Page 431.

↑ *Back to this question in Part A*

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Q3: A 3 year old child was brought to OPD with complain of dysuria and ballooning on micturition and examination as given below, what is the diagnosis? (Q866452)

A. Balanitis xerotica obliterans

B. True phimosis

C. Recurrent balanoposthitis

D. Recurrent urinary tract infections



Correct Answer: B. True phimosis

Explanation: The image depicts true phimosis occurs when the preputial orifice is abnormally narrow due to fibrosis, preventing retraction of the foreskin over the glans. This leads to ballooning during urination as urine collects under the foreskin before exiting. In children, true phimosis is usually due to chronic inflammation or scarring, and unlike physiological phimosis of infants, it does not resolve spontaneously and often requires surgical intervention (circumcision). Balanitis xerotica obliterans (Option A): This is a chronic inflammatory skin condition (lichen sclerosus) causing white, atrophic patches and progressive foreskin tightening, more common in older boys and adults, not the classic cause in a 3-year-old. Recurrent balanoposthitis (Option C): Involves

repeated foreskin and glans inflammation with redness, swelling, and discharge — absent in this case. Recurrent urinary tract infections (Option D): While phimosis can predispose to UTIs, the primary presentation here is mechanical obstruction with ballooning , not multiple proven UTIs.

↑ *Back to this question in Part A*

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Q4: A middle-aged woman presents with flank pain and dysuria. The pain was temporarily relieved by intravenous analgesics administered at a nearby primary healthcare center. She is diagnosed with ureteric colic secondary to ureteric calculi. What is the most appropriate diagnostic modality in this case? (Q853039)

A. NCCT KUB

B. ■■■■■■■

C. USG KUB

D. ■■■Ureteroscopy

Correct Answer: A. NCCT KUB

Explanation: Non-contrast computed tomography (NCCT) is considered the gold standard for diagnosing renal stones. NCCT scans provide detailed images of the urinary tract and can identify both radiopaque (visible on X-rays) and radiolucent (not easily visible on X-rays) stones. Investigations for renal stones: Urinalysis This is often the initial investigation performed. It can reveal the presence of blood (hematuria), white blood cells (pyuria), and crystals in the urine, all suggestive of a possible stone. The pH of the urine can also give clues about the type of stone. Kidney, Ureter, and Bladder (KUB) X-ray It can detect some types of stones, particularly calcium-containing stones, which appear opaque on X-rays. Ultrasound (Option C ruled out) It's particularly useful for detecting hydronephrosis (swelling of the kidney due to urine blockage) caused by stones and can be helpful during pregnancy when minimising radiation exposure is important. Intravenous urogram (IVU) It involves injecting a contrast dye into a vein. The dye travels through the bloodstream to the kidneys, where it is filtered and excreted in the urine. X-rays are taken as the dye passes through the urinary tract, outlining the kidneys, ureters, and bladder. This test can reveal blockages in the urinary tract caused by stones. ■■■■ (Option B) is usually not the first choice for stone detection because contrast can obscure small stones . It should be avoided in suspected acute renal colic cases unless there are other indications. Ureteroscopy (Option D) is invasive and typically performed as a therapeutic procedure to remove stones, not as a diagnostic tool. It is used when stone extraction or biopsy is required but not for routine diagnosis.

References:

Bailey & Love’s Short Practice of Surgery, 28th Edition, Pages 1467, 1475, 1469

↑ *Back to this question in Part A*

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Q5: Identify the structure on prostate biopsy: (Q853040)

A. Psammoma bodies

B. Corpora arenacea

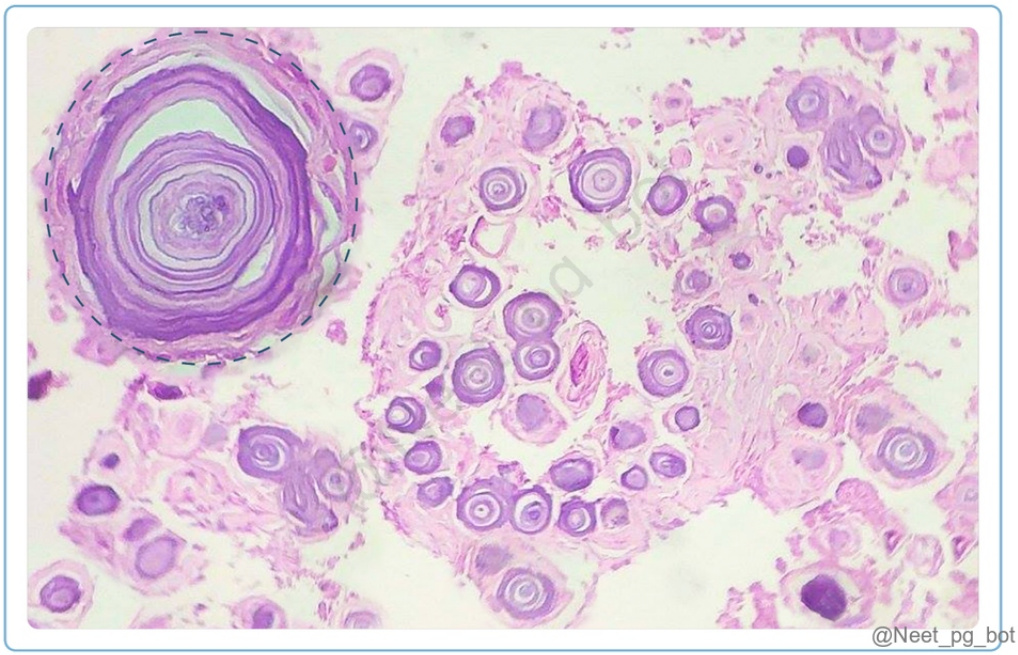
C. ■■■Amyloid

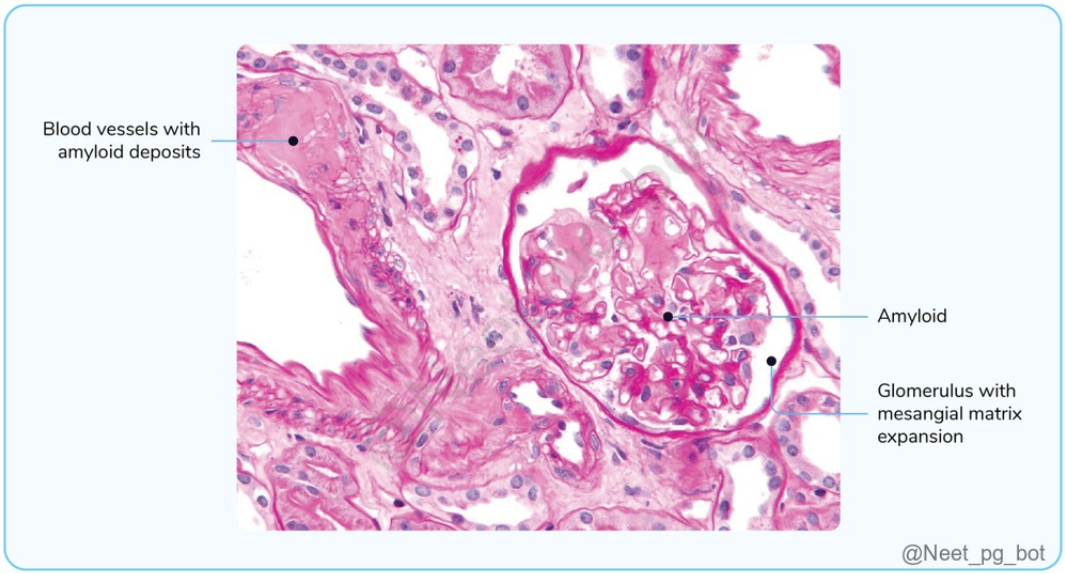
D. Corpora amylacea



Correct Answer: D. Corpora amylacea

Explanation: The laminated, round, basophilic bodies that can be seen in the prostate biopsy are Corpora amylacea. They are composed of proteinaceous material often found in the prostatic acini and ducts. They are believed to be precursors of prostatic calculi and are also commonly seen in BPH. Psammoma bodie s (Option A) are concentric, calcified structures commonly seen in certain tumours, like papillary thyroid carcinoma , serous ovarian carcinoma , or meningiomas . They are not typically associated with prostate tissue or prostate biopsies. Corpora arenacea (Option B), or brain sand , are calcified deposits in the pineal gland composed of calcium salts. They are a common and typically benign finding in the brain, particularly in older individuals. ■■■Amyloid (Option D) deposits are abnormal proteins that can accumulate in tissues in various diseases, such as amyloidosis . While it can sometimes be seen in prostate tissue in rare conditions, it is not a common finding on prostate biopsy and is not associated with the structure described in this case.





References:

Robbins and Cotran’s Pathologic Basis of Disease, 10th Edition, Page 976

↑ *Back to this question in Part A*

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Q6: A newborn male presents with urinary retention, lethargy and a distended bladder. Antenatal ultrasound showed a "keyhole sign" with a thickened bladder wall.

Which of the following is the most likely diagnosis? (Q852715)

A. Hypospadias

B. Vesicoureteral reflux

C. Posterior urethral valves

D. Neurogenic bladder

Correct Answer: C. Posterior urethral valves

Explanation: Posterior urethral valves are characterized by membranous folds in the posterior urethra leading to urinary obstruction, which matches the "keyhole sign" on ultrasound and the postnatal symptoms of urinary retention and lethargy. Posterior urethral valves Definition Urinary tract obstruction in male infants from membranous folds in the posterior urethra. Complications Chronic kidney disease, pulmonary hypoplasia from oligohydramnios. Classification Type I: Posterior urethral folds Type II: Membranes at bladder neck Type III: Round membrane at verumontanum Etiology Congenital, unclear embryological origin. Pathophysiology Increased bladder pressure → hypertrophy, vesicoureteric reflux, renal damage Diagnostic Tools Ultrasound, VCUG (voiding cystourethrogram) and Renal scintigraphy. Antenatal Diagnosis Ultrasound: Dilated bladder ("keyhole sign"), thickened walls. Postnatal Symptoms Urinary retention, infections, lethargy, respiratory distress. Management Antenatal: Vesicostomy, fetal valve ablation Postnatal: Stabilization, cystoscopic ablation Prognosis Depends on severity; long-term care needed for CKD, bladder dysfunction, recurrent UTIs. Hypospadias involves an abnormal urethral opening and does not present with the obstructive symptoms described, such as a distended bladder and urinary retention. (Option A) Vesicoureteral reflux can occur secondary to posterior urethral valves but is not the primary condition associated with the described ultrasound findings and symptoms. (Option B) Neurogenic bladder results from nerve damage affecting bladder function, but it is not typically associated with the "keyhole sign" seen in posterior urethral valves. (Option D)

References:

Bailey and Love’s Short Practice of Surgery, 28th Edition, Pages 1538,1539

https://www.ncbi.nlm.nih.gov/books/NBK560881/

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Q7: A 22-year-old male presents to the emergency department with a strong urge to urinate but is unable to do so. He has a history of perineal trauma. On examination, blood is noted at the external urethral meatus. Which structure is most likely injured? (Q852718)

A. Bulbar urethra

B. Posterior urethral valve

C. Intraperitoneal Bladder rupture

D. Membranous urethra

Correct Answer: A. Bulbar urethra

Explanation: Patient presentation: Severe urinary urgency but inability to void → Suggests urethral obstruction . History of perineal injury → Strongly suggests trauma to the anterior urethra . Blood at the meatus → A classic sign of urethral injury . Bulbar urethral injury is common in perineal trauma : Common mechanism : Straddle injuries (e.g., fall on a hard surface). Bulbar urethra is vulnerable due to its location in the anterior urethra. Extravasation of urine may be seen if severe. Urethral Injuries Urethral Segment Common Causes of Injury Clinical Features Bulbar urethra (Anterior) Straddle injuries, blunt perineal trauma Blood at meatus, urinary retention, perineal hematoma Membranous urethra (Posterior) Pelvic fractures High-riding prostate, inability to pass urine Intraperitoneal Bladder Rupture Blunt abdominal trauma Peritonitis, urinary ascites Posterior Urethral Valve Congenital anomaly Recurrent UTIs, voiding difficulty Posterior urethral valve (Option B): Incorrect because it is a congenital condition seen in infants, not in a previously healthy young adult. Intraperitoneal bladder rupture (Option C): Incorrect because it presents with peritonitis and urinary ascites , not blood at the meatus or perineal trauma. Membranous urethra (Option D): Incorrect because it is typically injured in pelvic fractures , which are not mentioned in the history.

References:

Bailey and Love’s Short Practice of Surgery, 28th Edition, Page 1541,1542.

Schwartz's Principles of Surgery, 11th Edition, Page 1767.

SRB's Manual of Surgery, 6th Edition, Pages 1040-1042.

↑ *Back to this question in Part A*

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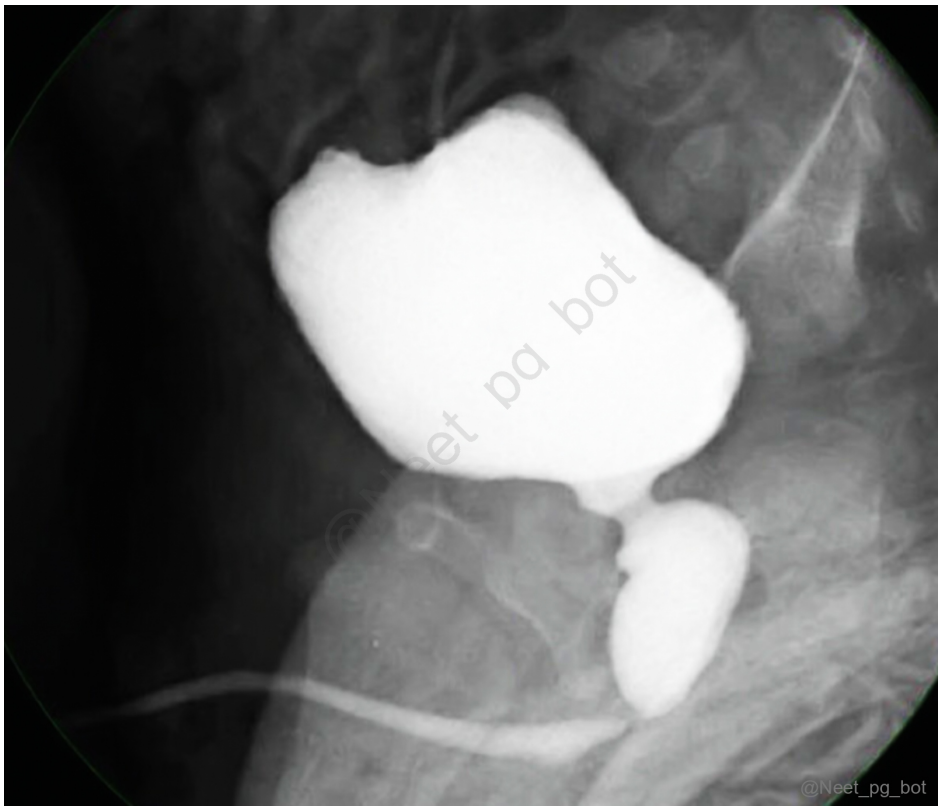
Q8: A child presents to the outpatient department (OPD) with a radiological image as given. What is the most appropriate management for this condition? (Q844289)

A. Endoscopic ablation

B. Dilation of urethra

C. Dilation of urethra and bladder

D. Conservative



Correct Answer: A. Endoscopic ablation

Explanation: Correct Option A - Endoscopic ablation: This radiological image shows a micturating cystourethrogram (MCUG) demonstrating: A large, dilated posterior urethra (the large white area) A smaller, narrowed anterior urethra (the smaller white area below) This creates a "keyhole" appearance This is classic for Posterior Urethral Valves (PUV) - the most common cause of urethral obstruction in male infants. The most appropriate management for this condition is endoscopic ablation. This procedure involves using a cystoscope to remove or ablate the obstructive valve tissue, thereby relieving the obstruction and improving urine flow. Incorrect Options: Option B - Dilation of urethra: Dilation involves stretching the urethra to relieve obstruction. However, this is not suitable for treating PUV because the obstruction is caused by a valve rather than a stenotic segment. Dilation does not address the underlying problem of the valve. Option C - Dilation of urethra and bladder: While dilation of the urethra might alleviate some symptoms, it does not address the underlying issue of PUV. Additionally, bladder dilation is not a standard treatment for PUV and does not effectively manage the obstruction. Option D - Conservative: Conservative management may include monitoring and supportive care, but it does not resolve the obstruction caused by PUV. This approach is not adequate for managing the condition, as it fails to address the cause of the urinary obstruction.

References:

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↑ *Back to this question in Part A*

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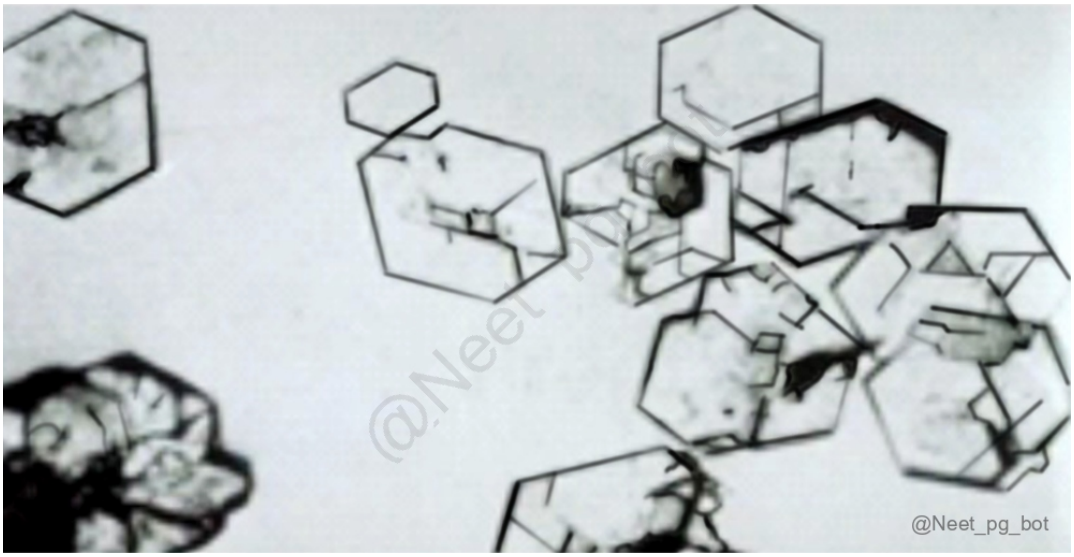
Q9: A young patient presents to the outpatient department (OPD) with recurrent colicky abdominal pain. Urine examination reveals the presence of red blood cells (RBCs). What is the most likely diagnosis? (Q844290)

A. Glomerulonephritis

B. Oxalate stone

C. Polycystic kidney disease

D. Cystine stone



Correct Answer: D. Cystine stone

Explanation: Correct Option D - Cystine stone: The presence of benzene-shaped (hexagonal) crystals in the urine, along with RBCs, strongly suggests cystinuria, a genetic disorder that leads to the formation of cystine stones. These stones are rare and are caused by the poor reabsorption of cystine in the kidneys, leading to its crystallization in urine. The recurrent colicky abdominal pain is typical of urolithiasis. Incorrect Options: Option A - Glomerulonephritis: This condition involves inflammation of the glomeruli in the kidneys and typically presents with hematuria, proteinuria, and sometimes RBC casts, but not with benzene-shaped crystals. Option B - Oxalate stone: Calcium oxalate stones are common and may present with similar symptoms, but they are characterized by envelope-shaped crystals in the urine, not benzene-shaped crystals. Option C - Polycystic kidney disease: This genetic disorder leads to the development of multiple cysts in the kidneys and can cause hematuria, hypertension, and renal failure. However, it does not cause the formation of benzene-shaped crystals in the urine.

References:

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↑ *Back to this question in Part A*

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Q10: A 12-year-old child presents to the outpatient department (OPD) with a complaint of scrotal pain, with a history of trauma 6 hours prior. Upon surgical exploration, the findings suggest significant damage. What is the most likely diagnosis? (Q844297)

A. Testicular torsion with gangrene

B. Torsion of testicular appendages with gangrene

C. Gangrene

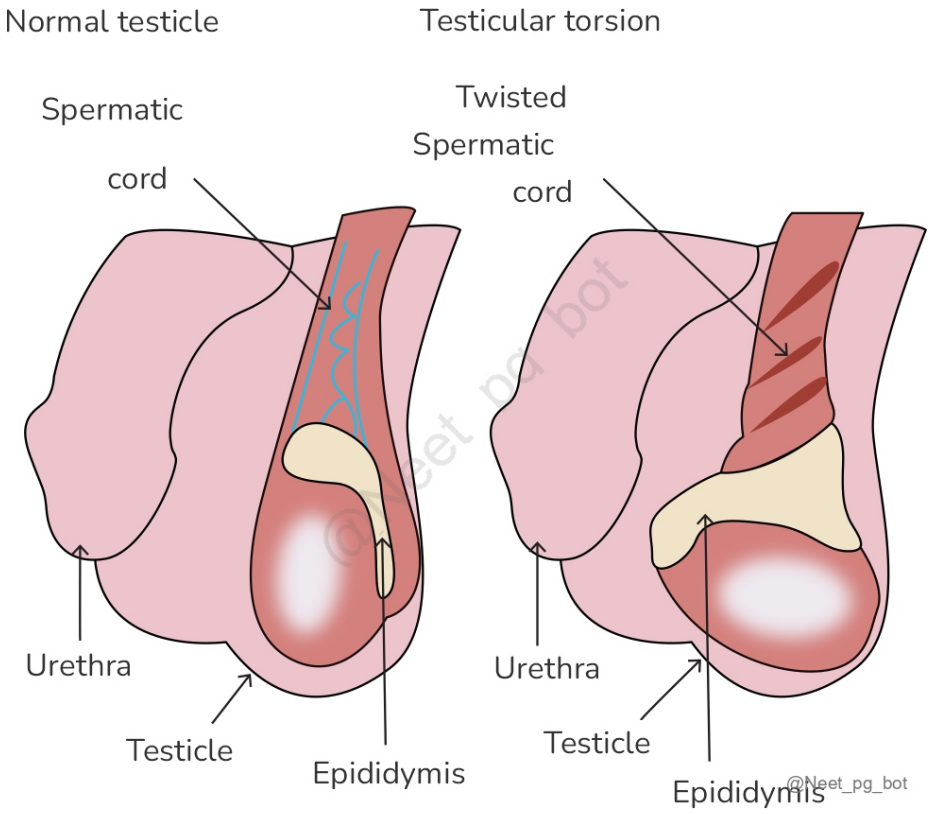
D. Hematoma

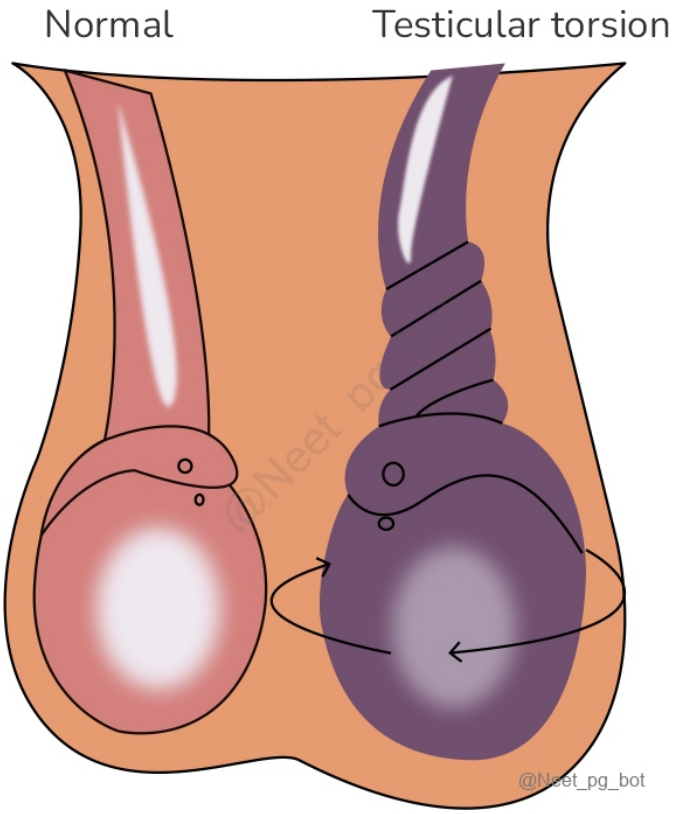


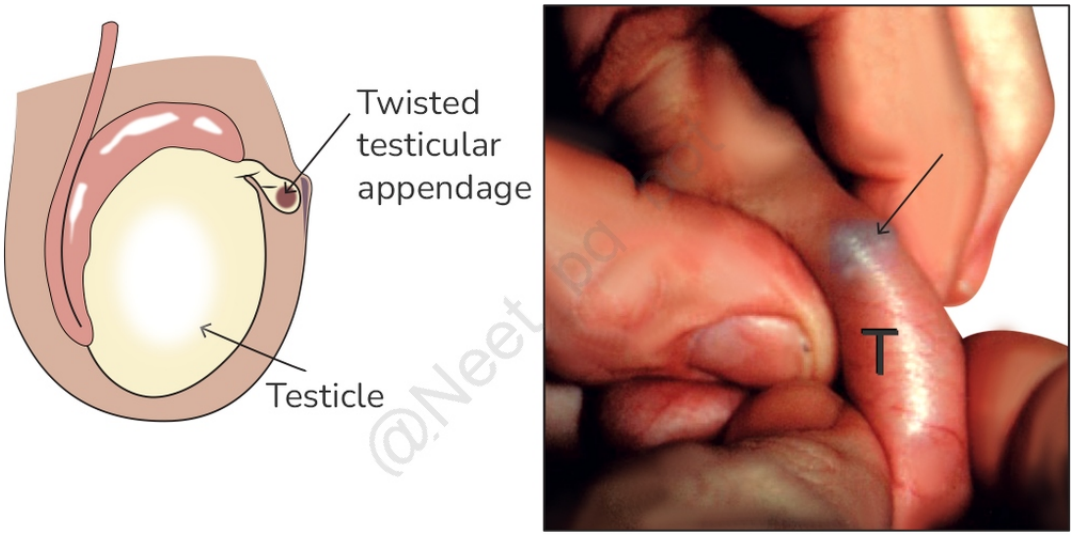
Correct Answer: A. Testicular torsion with gangrene

Explanation: Correct Option A - Testicular torsion with gangrene: Testicular torsion occurs when the spermatic cord twists, cutting off the blood supply to the testicle. Testicular torsion can be precipitated by trauma If untreated for several hours, this can lead to gangrene due to ischemia. The history of trauma and rapid onset of pain, along with surgical findings, strongly suggest testicular torsion with gangrene. Incorrect Options: Option B - Torsion of testicular appendages with gangrene: Torsion of testicular appendages, such as the appendix testis, is less common and usually presents with localized pain. While it can cause significant discomfort, it typically does not lead to the severe ischemia and gangrene seen in testicular torsion. Blue dot sign: torsion of appendage of testis Option C - Gangrene: Gangrene refers to tissue death due to loss of blood supply. In this context, the term alone is

nonspecific, and without the identification of an underlying cause, such as testicular torsion, it does not fully describe the condition. Option D - Hematoma: A hematoma can occur due to trauma, leading to localized swelling and pain. However, it would not typically present with the severe ischemic changes seen in testicular torsion unless associated with vascular injury.







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References:

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↑ *Back to this question in Part A*

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Q11: What instrument is used to insert this tube? (Q844311)

A. Nephroscope

B. Cysto urethroscope

C. Ureteroscope

D. Endoscope



Correct Answer: B. Cysto urethroscope

Explanation: Correct Option B - Cysto-urethroscope: A DJ stent is typically placed in a retrograde fashion, meaning from the bladder upwards into the ureter. A cysto-urethroscope is the primary instrument used to enter the bladder through the urethra to visualize the ureteric opening. The stent is then passed through the scope's channel, over a guidewire, and up into the ureter. Incorrect Options: Option A - Nephroscope: This instrument is specifically used to visualize and treat conditions within the kidney. It is typically employed for procedures such as percutaneous nephrolithotomy (PCNL) to remove kidney stones. It is not used for inserting tubes into the urinary tract. Option C - Ureteroscope : A ureteroscope is a thinner scope that is passed through a cysto-urethroscope and up into the ureter itself. It is used for procedures within the ureter, like breaking up a stone (ureteroscopy). Option D - Endoscope: This is a very general term for any instrument used to look inside the body. While a cysto-urethroscope is a type of endoscope, it is not the most specific or correct answer.

References:

Sabiston Textbookof Surgery, 21st Edition, Page 2064

↑ *Back to this question in Part A*

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Q12: A patient was brought to the emergency department with a history of fall and head injury. What is the diagnosis? (Q844292)

A. EDH

B. SDH

C. SAH

D. Contusion



Correct Answer: B. SDH

Explanation: Correct Option B - Subdural Hematoma (SDH): CT findings: A hyperdense (bright white) crescent-shaped collection along the right cerebral convexity The collection crosses suture lines It follows the contour of the brain surface There is mass effect with midline shift to the left This is classic for SDH (Subdural Hematoma) Subdural Hematoma: Appears as a crescent-shaped, hyperdense or isodense lesion on a CT scan, located between the dura mater and the brain's surface. It is commonly associated with bridging vein rupture, often seen in cases of trauma or in the elderly. It often has a more diffuse and irregular boundary compared to EDH.

Incorrect Options: Option A - Epidural Hematoma (EDH): Typically appears as a biconvex (lens-shaped) hyperdense lesion on a CT scan, located between the dura mater and the skull. It is usually associated with a skull fracture and tends to have a more well-defined boundary. It occurs due to rupture of the meningeal arteries. Option C - Subarachnoid Hemorrhage (SAH): Typically appears as hyperdensity in the subarachnoid space surrounding the brain on a CT scan. It is often diffuse and can be seen around the sulci and ventricles. It usually occurs due to the rupture of a cerebral aneurysm or arteriovenous malformation. Option D - Contusion: Appears as localized areas of hemorrhage within the brain tissue itself. On a CT scan, it often shows as areas of mixed density with associated edema, and it is typically more focal rather than diffuse or crescent-shaped.

References:

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↑ *Back to this question in Part A*

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Q13: Identify the procedure done. (Q844299)

A. Orchidectomy

B. Total penectomy

C. Partial penectomy

D. None of the above



Correct Answer: B. Total penectomy

Explanation: Correct Option B - Total Penectomy: This procedure involves the complete surgical removal of the entire penis. It is typically performed in cases of penile cancer or severe trauma. Incorrect Options: Option A - Orchidectomy: This procedure involves the surgical removal of one or both testicles for testicular carcinoma, not penile cancer. Option C - Partial Penectomy: This procedure involves the surgical removal of part of the penis. It is usually done for localized penile cancer, where only a portion of the penis is affected.

↑ *Back to this question in Part A*

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Q14: A patient presents with a growth over the penis that is classified as a T3 lesion, with no enlarged inguinal lymph nodes detected. What is the best method of management? (Q844305)

A. Penectomy

B. Penectomy with orchidectomy

C. Penectomy with superficial / modified inguinal lymph node dissection

D. Penectomy with deep inguinal lymph node dissection

Correct Answer: C. Penectomy with superficial / modified inguinal lymph node dissection

Explanation: A T3 penile carcinoma (invasion into the corpora cavernosa) is classified as high-risk , even when there are no clinically palpable inguinal lymph nodes (cN0) . High-risk cN0 patients have a significant chance of occult metastasis; therefore, prophylactic groin management is recommended. A modified/superficial inguinal lymph node dissection provides accurate staging with lower morbidity and is the standard approach along with penectomy for T3 disease. Penectomy (Option A): Insufficient for T3 high-risk lesions because groin evaluation is mandatory due to high risk of occult nodal spread. Penectomy with orchidectomy (Option B): Orchidectomy is not part of routine penile cancer surgery unless there is direct testicular involvement, which is extremely rare. Penectomy with deep inguinal lymph node dissection (Option D): Deep ILND is performed only if superficial/modified dissection is positive. It is not indicated upfront in a clinically node-negative patient.

References:

SRB’s Manual of Surgery, 6th Edition, Page 1055,1056

↑ *Back to this question in Part A*

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Q15: A 35-year-old male presents with a bulky scrotal swelling. On evaluation, malignancy is suspected, and an orchidectomy is performed. The gross section of the

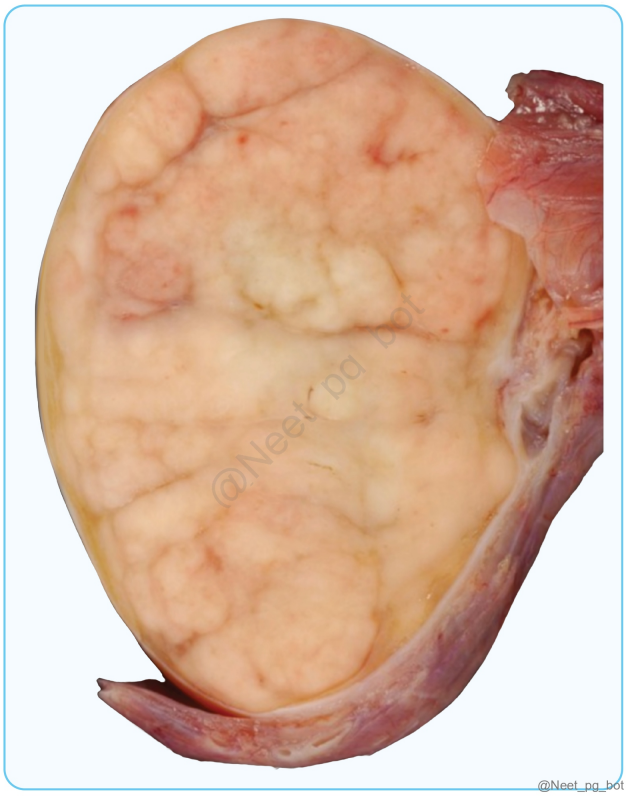
testicular mass is shown in the image. What is the most likely diagnosis? (Q860402)

A. Seminoma

B. Teratoma

C. Yolk sac tumour

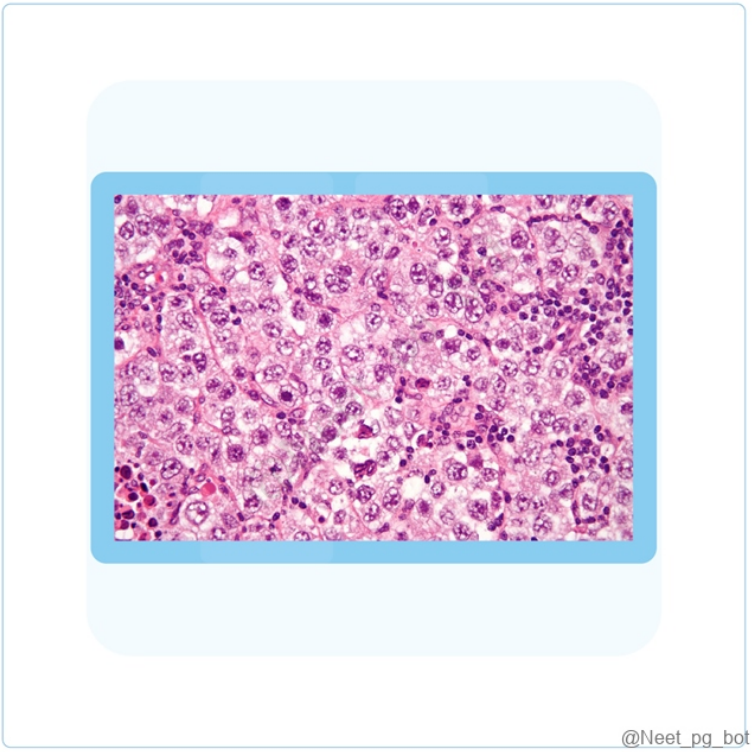
D. Endodermal sinus tumor



Correct Answer: A. Seminoma

Explanation: The gross section of the testicular mass shows a homogeneous, grey-white appearance without necrosis or hemorrhage, suggesting Seminoma, which is the most common testicular tumour. Seminoma Feature Details Tumor Type Seminoma, the most common pure testicular germ cell tumour in men aged 25-45 Origin Germinal epithelium of the seminiferous tubules Clinical Features Painless, firm swelling or mass in the testicle, typically unilateral. Accounts for 50% of all testicular germ cell tumors. 10% have secondary hydrocele, 5% have gynecomastia Diagnostic Markers AFP: Normal hCG: Normal or mildly elevated LDH: Elevated Investigation Ultrasound: Homogeneous, hypoechoic mass Histology: Sheets of oval cells with clear cytoplasm, large nuclei with prominent acidophilic nucleoli {{caption_text}} FNAC: Contraindicated due to risk of tumor cell seeding and lymph node metastasis Treatment Primary: High Inguinal Radical Orchidectomy Adjuvant: Radiation therapy or chemotherapy for positive lymph nodes Incorrect Options: Teratoma (Option B) , often contains multiple tissue types (e.g., cartilage, muscle, fat), and its gross appearance can be more heterogeneous, with cystic areas or areas of necrosis or hemorrhage. Yolk sac tumor (Option C) (also known as an endodermal sinus tumor (Option BD)) is another common germ cell tumor, but it typically presents with areas of hemorrhage or necrosis, and is not

homogenous with elevated alpha-fetoprotein (AFP) levels.



References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1569,1572

↑ *Back to this question in Part A*

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Q16: An adult male presents to the outpatient department with a painful scrotal swelling accompanied by fever. The swelling is associated with the tunica vaginalis and is characterized by fluid accumulation. What is the likely diagnosis? (Q860406)

A. Varicocele

B. Hydrocele

C. Cystocele

D. Torsion testis

Correct Answer: B. Hydrocele

Explanation: A hydrocele is characterized by the buildup of fluid within the tunica vaginalis, the protective membrane surrounding the testis. This condition can cause scrotal swelling, which may be painful or uncomfortable and occasionally accompanied by fever. Hydrocele: Collection of fluid between the two layers of the tunica vaginalis of the testis Aetiology Defective absorption of fluid by tunica vaginalis due to endothelial wall damage by low-grade infection Excessive production of fluid (secondary hydrocele) Interference with drainage of fluid by lymphatic vessels of the cord Communication with the peritoneal cavity Primary Vaginal Hydrocele Common in middle-aged men, prevalent in tropical countries Testis is usually large and non-palpable Fluctuant Can get above the swelling Initially transilluminant, but becomes non-transilluminant if long-standing Infantile Hydrocele Tunica and processus vaginalis distended up to the internal ring No connection with the peritoneal cavity Congenital Hydrocele Processus vaginalis communicates with the peritoneal cavity Fluid disappears when lying down and recollects when standing Encysted Hydrocele of the Cord Fluid collection in a portion of the patent funicular process of tunica vaginalis Fluctuant and transilluminant Located in the inguinal/inguinoscrotal/scrotal part Secondary Vaginal Hydrocele Causes: Infection (filariasis, tuberculosis), injury (trauma, post herniorrhaphy), tumor (malignancy) Usually small, lax, and testis is palpable except in cases of filariasis where it can be very large Surgical Procedure Lord's plication - small, thin hydrocele with clear fluid Jaboulay's operation - partial sac removal and eversion Incorrect Options: Varicocele (Option A) involves dilation of the pampiniform plexus of veins and typically presents as a soft, irregular mass that may feel like a "bag of worms." It is usually asymptomatic, though it can sometimes cause pain or infertility. Cystocele (Option C) refers to the prolapse of the bladder into the vaginal canal and is not related to scrotal swelling. Torsion testis (Option D) is a surgical emergency caused by twisting of the spermatic cord, leading to compromised blood flow to the testis. It typically presents with acute, severe pain and swelling but does not usually involve fluid accumulation in the tunica vaginalis. The swelling is often more tender and associated with an absence of the cremasteric reflex.

References:

SRB's Manual of Surgery, 6th Edition, Page 1057-1060

↑ *Back to this question in Part A*

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Q17: A 40-year-old man presents with gynecomastia. Ultrasound reveals a 1 cm solid mass within the body of the testis. Serum testosterone is 600 ng/dL, and estradiol is 35 pg/mL. What is the most likely diagnosis? (Q860423)

A. Spermatocytic tumor

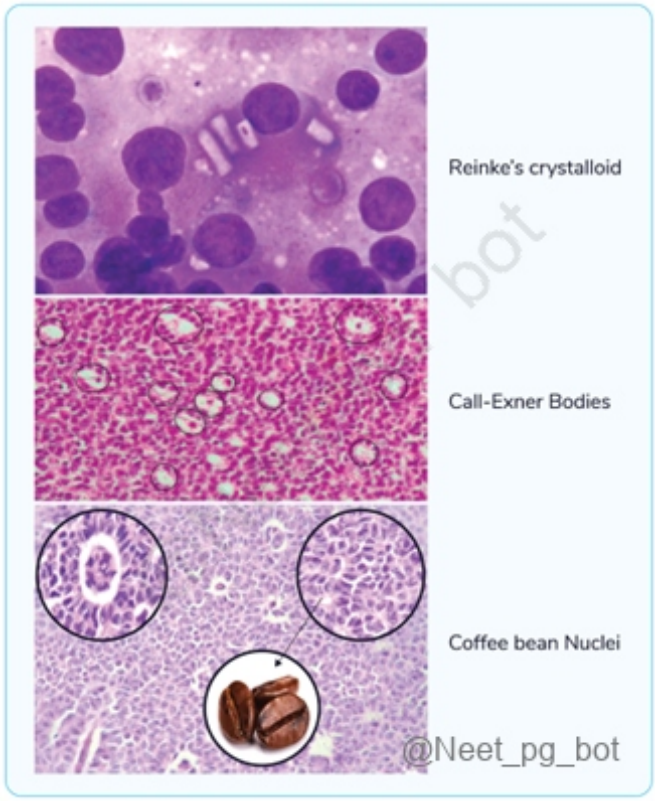
B. Sertoli cell tumor

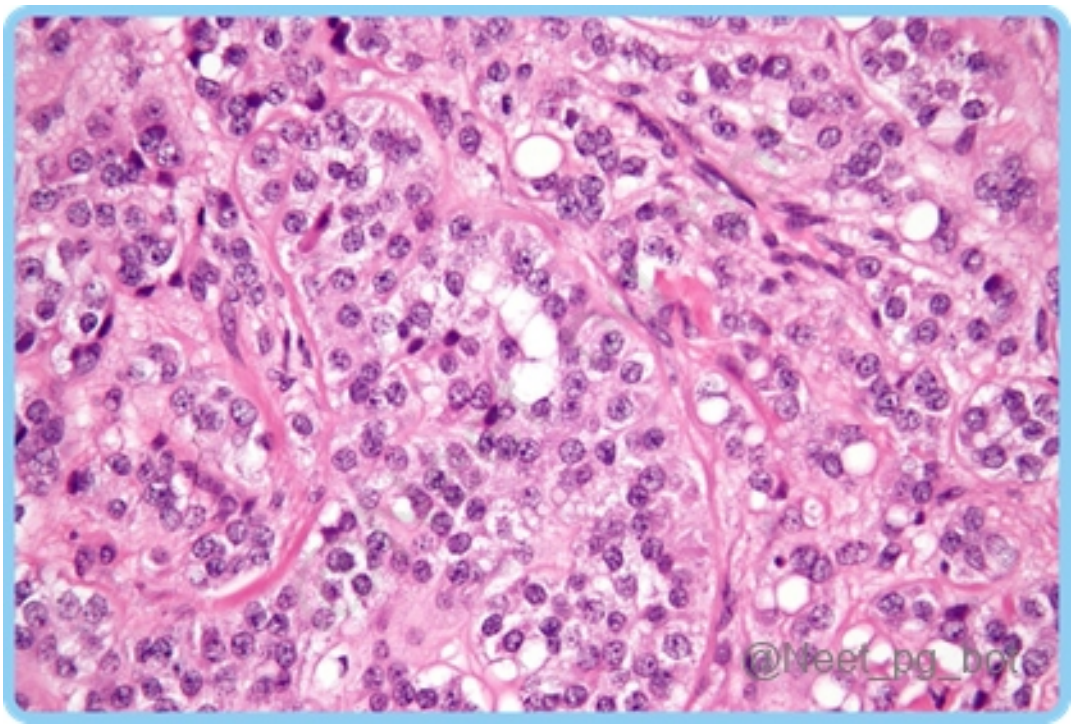
C. Granulosa cell tumor

D. Leydig cell tumor

Correct Answer: D. Leydig cell tumor

Explanation: Leydig cell tumors are the most likely diagnosis in this case. These tumors often present with gynecomastia due to the production of estrogens, as they secrete both testosterone and estrogen. The patient's elevated serum sex hormones suggests Leydig cell tumors. Sex cord-stromal tumours have two major subtypes: Leydig cell and Sertoli cell tumour. Leydig cell tumour Sertoli cell tumour Hormonal involvement It often involves androgens, oestrogens, and corticosteroids. Hormonally silent. Conditions associated with Klinefelter syndrome. Cryptorchidism. Renal cell carcinoma. Carney complex. Peutz-Jeghers syndrome. Familial adenomatous polyposis. Malignancy 10% (in adults) 10% Gross Circumscribed nodules, usually < 5 cm in diameter. They have a distinctive golden brown, homogeneous appearance on cut surfaces. Firm, small nodules with a homogeneous grey-white to yellow cut surface. Histology The tumour cells resemble their normal counterparts. They are large in size and have round or polygonal cell outlines , abundant granular eosinophilic cytoplasm , and a round central nucleus. The cytoplasm frequently contains lipid droplets , vacuoles , or lipofuscin pigment and, most characteristically, rod-shaped Reinke crystalloids (25% of the tumours). The tumour cells are arranged in distinctive trabeculae that tend to form cord-like structures and tubules. Image {{caption_text}} {{caption_text}} Incorrect Options: Spermatocytic tumors (Option A) are typically benign and present with a painless testicular mass. They are usually diagnosed in older men (over 50 years of age) and are characterised by a slow-growing mass & do not secrete any hormones. Sertoli cell tumours (Option B) mostly present as painless testicular masses. They are hormonally silent but sometimes produce estrogen & are less commonly associated with elevated estradiol levels compared to Leydig cell tumors. The presence of gynaecomastia along with increased testosterone makes Leydig cell tumour more likely. Granulosa cell tumours (Option C) are more commonly seen in females and are extremely rare in males. They usually present as slow-growing and non-functioning testicular mass.





References:

Robbins & Cotran Pathologic Basis of Disease, 10th Edition, Page 974

↑ *Back to this question in Part A*

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Q18: A 55-year-old man presents with abdominal pain. A CECT (Contrast Enhanced CT) abdomen was done. What is the likely source of pain? (Q860459)

A. Gall bladder

B. Spleen

C. Kidney

D. Liver



Correct Answer: C. Kidney

Explanation: The most likely diagnosis in this case, given the irregular enhancement and enlargement of the renal lesion on CECT, is Renal Cell Carcinoma (RCC), making the origin of pain the kidney most likely. Clinical Features of Renal Cell Carcinoma (RCC): Classic symptoms such as hematuria, flank pain, and a palpable abdominal mass - " TOO - LATE" TRIAD seen in 10% of patients with advanced disease. Systemic symptoms like weight loss, fever, and fatigue can also occur. In advanced stages, RCC may metastasise to the lungs, bones, and brain. A non-reducing varicocele, referred to as a suspicious varicocele , may indicate the presence of renal cell carcinoma (RCC), often due to a thrombus originating from the left RCC. Treatment of RCC: RCCs are radio and chemo-resistant. Surgical Management: Partial Nephrectomy (Option A): Involves removing only the tumour while preserving the remainder of the kidney. Indications: T1 Disease(<7cm) Restricted to poles RCC in solitary functioning kidney Radical Nephrectomy: Involves removal of the kidney with Gerota's fascia, para-aortic nodes, and ureter up to the pelvic brim. Indications: Larger tumours or when partial nephrectomy is not feasible Ablative Techniques Radiofrequency Ablation (RFA) and Cryoablation Involve destroying the tumor using extreme temperatures. Indications: Patients who are not surgical candidates Patients with small tumours (T1a lesions) (usually <4 cm). Systemic Therapy (For advanced/ metastatic disease) Targeted Therapy Tyrosine kinase inhibitors (e.g., sunitinib, pazopanib) mTOR inhibitors (e.g., everolimus) Immunotherapy: Immune checkpoint inhibitors (e.g., nivolumab)

References:

Sabiston Textbook of Surgery, 20th Edition, Page 2091, 2092

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1482

↑ *Back to this question in Part A*

@Neet_pg_bot

Q19: All of the following statements regarding Wilms tumor are true, except? (Q840019)

A. Presents as an abdominal mass

B. Most commonly seen <5yrs of age

C. Majority patients recover due to chemotherapy and radiotherapy

D. Lung involvement in uncommon and occurs late

Correct Answer: D. Lung involvement in uncommon and occurs late

Explanation: Wilms tumor is the most common renal malignancy in children, typically presenting as a painless abdominal mass. Peak incidence is in children <5 years of age, often discovered by parents or during routine exams. Modern treatment with surgery (nephrectomy) and adjuvant chemotherapy ± radiotherapy leads to excellent survival rates (~90%). Lung metastasis is most common, occurring in up to 10–20% at diagnosis, and may also appear early, not late. Other metastasis sites include liver and regional lymph nodes. Clinical features may also include hematuria, hypertension, or abdominal pain, but mass is most common. Early detection and multimodal therapy significantly improve outcomes. Therefore, the statement “lung involvement is uncommon and occurs late” is incorrect. Incorrect Options: Option A) Presents as an abdominal mass : Classic presentation; most patients present with a palpable, painless mass. Option B) Most commonly seen <5 years of age : Peak incidence is 2–5 years , rare after age 10. Option C) Majority patients recover due to chemotherapy and radiotherapy : Modern multimodal therapy has excellent prognosis , survival >85–90%.

References:

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↑ *Back to this question in Part A*

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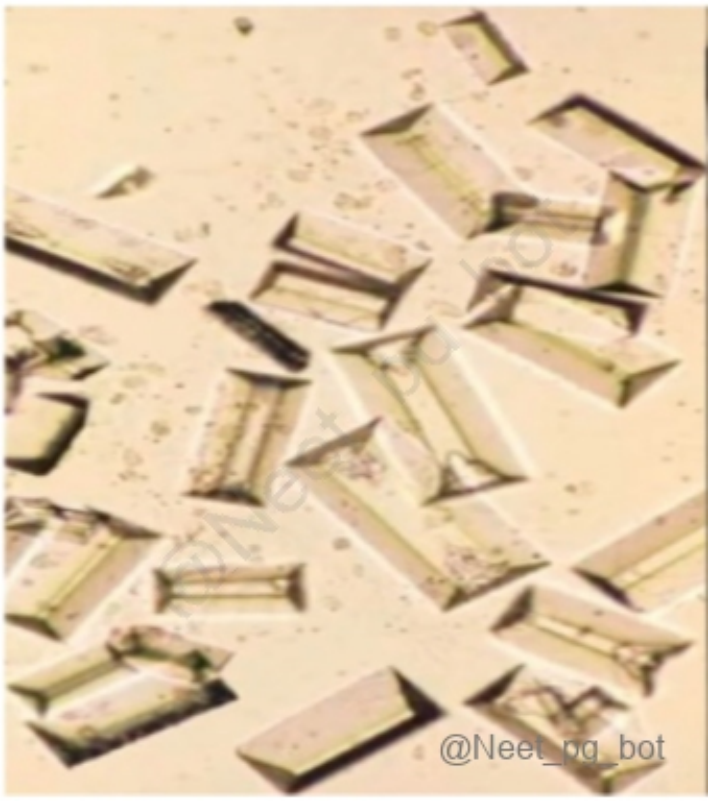
Q20: 45-year-old female presents with recurrent episodes of right flank pain, hematuria, and a history of urinary tract infections. Urine analysis shows alkaline urine with a pH of 8.0. Microscopy revealed the following finding. Which of the following is the most likely underlying cause of this patient's condition? (Q840022)

A. Triple phosphate stone

B. Ca Oxalate Stones

C. Uric Acid Stones

D. Cystine Stones



Correct Answer: A. Triple phosphate stone

Explanation: Microscopy: Coffin-lid shaped crystals → diagnostic of struvite stones . Composition: Magnesium ammonium phosphate (Ca, Mg, NH■■, PO■³■). Clinical association: More common in females due to short urethra → higher risk of UTIs , particularly with Proteus species . Proteus produces urease , which converts urea → ammonia → precipitation of struvite crystals. Morphology: Often large staghorn calculi filling the renal pelvis and calyces → can cause silent destruction of the kidney if untreated. Option B – Calcium oxalate stones: Monohydrate → dumbbell-shaped Dihydrate → envelope-shaped Option C – Uric acid stones: Rosette-shaped and multi-faceted crystals Radiolucent on X-ray Option D – Cystine stones: Hexagonal or benzene-ring shaped crystals Often associated with cystinuria

References:

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↑ *Back to this question in Part A*

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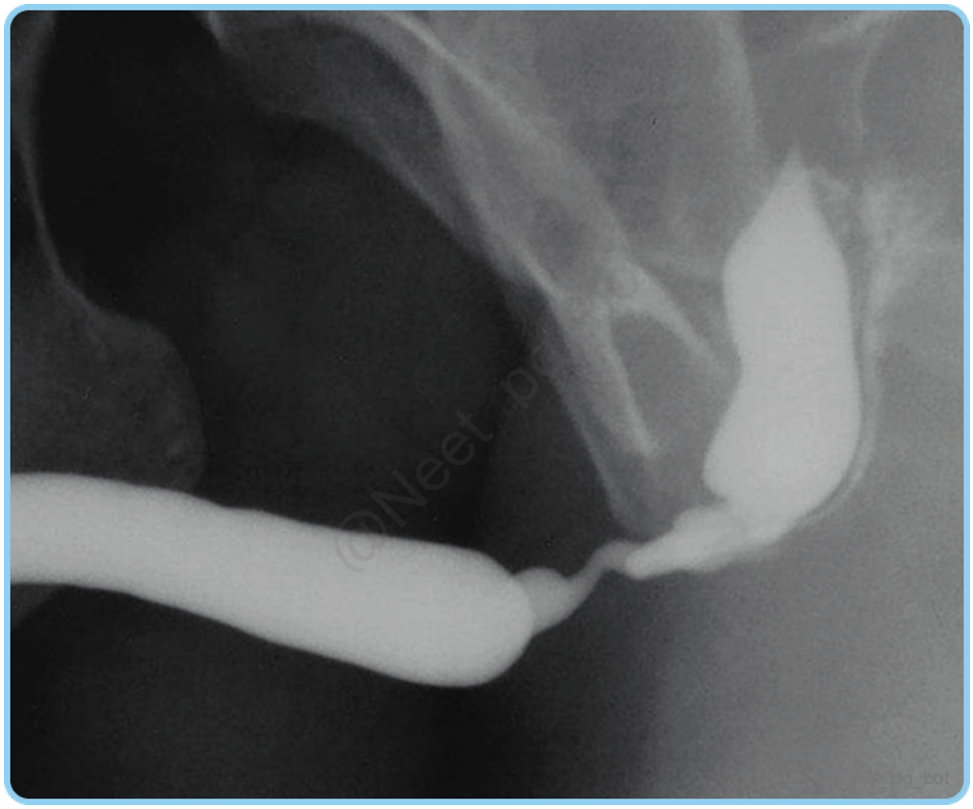
Q21: Identify the condition in the image: (Q860209)

A. Bulbar urethral stricture

B. Membranous urethral injury

C. Urethral tear

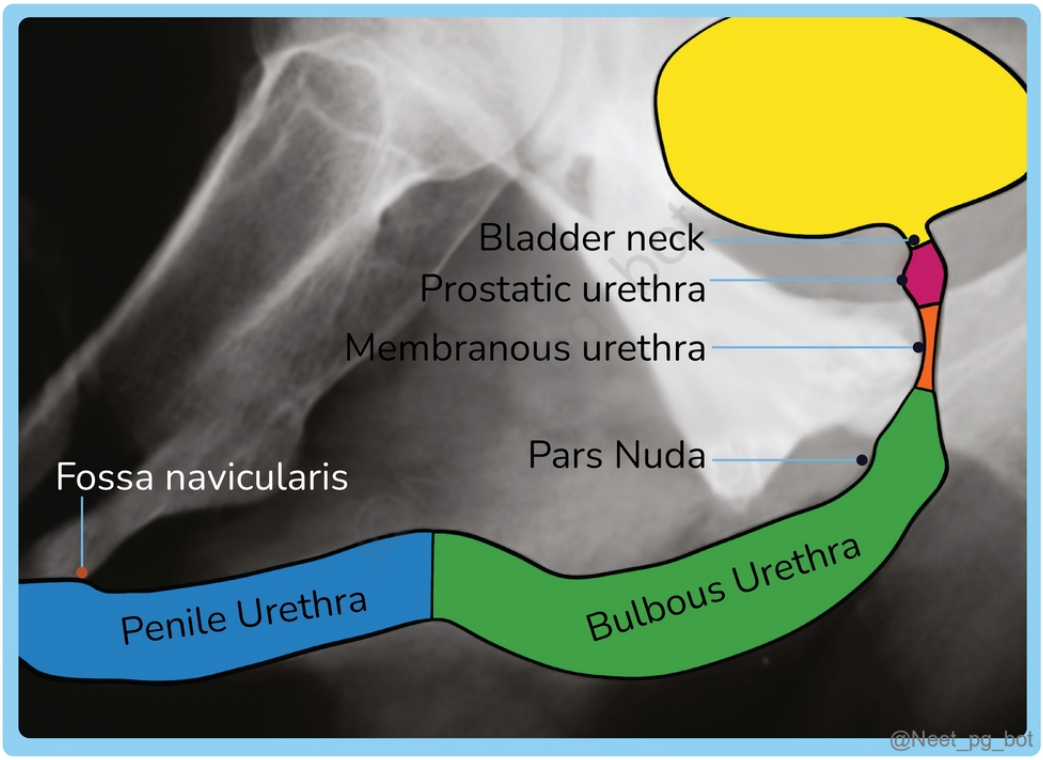
D. Prostate hyperplasia

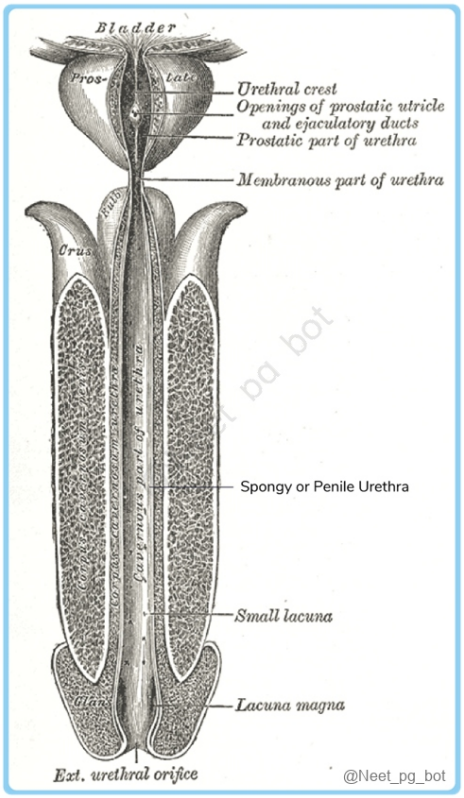


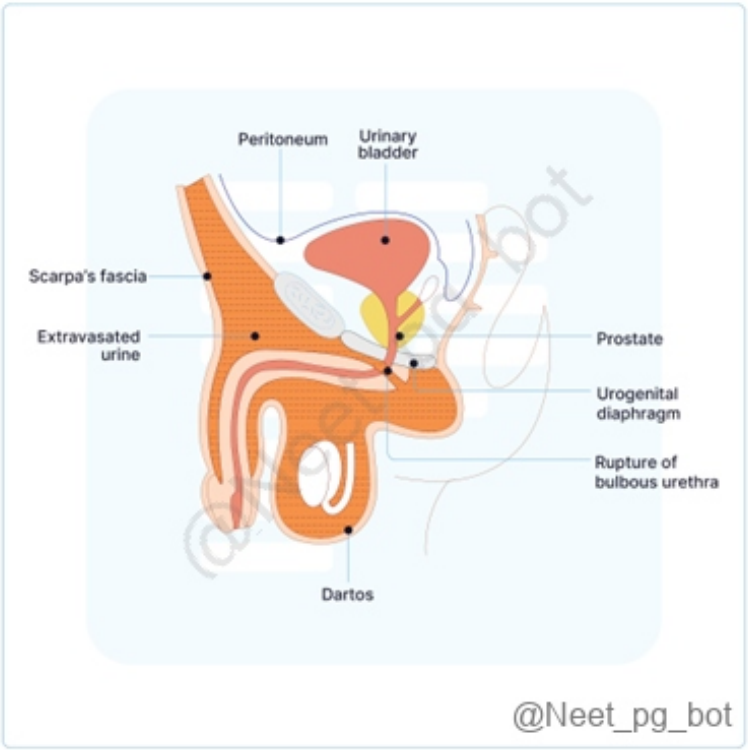
Correct Answer: A. Bulbar urethral stricture

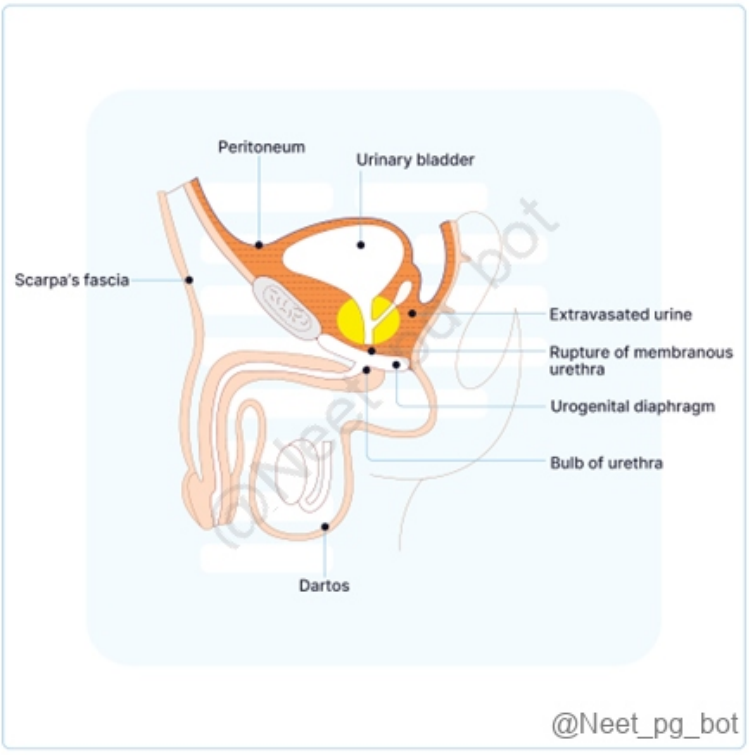
Explanation: The image shows a micturating cysto-urethrogram (MCU) , which reveals a bulbar urethral stricture . The most common cause of urethral stricture is trauma , often due to external forces like an external blow , kick , or straddle injuries (e.g., falling onto a hard object like a manhole). Bulbar urethral injury falls under anterior urethral injury , and retrograde urethrogram (RGU) is the investigation of choice for such injuries. However, both RGU and MCU are often performed in emergency cases. {{caption_text}} Male Urethra: Fibromuscular tube extending from the bladder neck to the meatus and functions to transport urine and semen. {{caption_text}} Posterior urethra: Prostatic urethra and membranous urethra. Anterior urethra : Bulbar urethra, Penile urethra, and Urethral meatus. Urethral Meatus : Vertical slit-like opening at the tip of the glans penis. Glandular Urethra, also known as the fossa navicularis. Penile Urethra : Extends from the meatus to the penoscrotal junction. The longest part of the urethra Bulbar Urethra : Extends from the penoscrotal junction to the bulbomembranous junction. Membranous Urethra : Extends from the bulbomembranous junction to the verumontanum. The shortest, narrowest, and least dilated part is innervated by the pudendal nerve from spinal segments S2-4. Prostatic Urethra : Extends from the bladder neck to the verumontanum and is surrounded by the prostate. The widest and most dilatable part of the urethra. Feature Anterior Urethral Injury Posterior Urethral Injury Location Bulbar urethra (most common) Penile urethra Membranous urethra (bulbomembranous junction most common) Prostatic urethra Common Causes Straddle injuries Direct trauma Iatrogenic injuries (catheterization, cystoscopy) Penetrating

trauma (stab/gunshot wounds) Pelvic fractures (often due to motor vehicle accidents) Blunt trauma Clinical Features Hematuria (blood in urine) Penile/perineal bruising (butterfly-shaped hematoma) Perineal pain Urinary retention or difficulty voiding Possible swelling of the penis or scrotum due to hematoma Blood at the meatus Inability to void High-riding prostate on rectal exam Perineal or suprapubic pain Pelvic hematoma associated with pelvic fractures Possible concomitant bladder injury Investigations Retrograde Urethrography (RGU) : Gold standard, shows the extent and location of the injury. Voiding Cystourethrography (VCUG): Used to assess urethral patency post-repair Ultrasound: Can detect hematoma or associated injuries Retrograde Urethrography (RGU): Gold standard for initial assessment CT Urethrography: Useful in evaluating complex injuries Pelvic CT Scan: Important for associated pelvic fractures Cystoscopy: Sometimes performed for further evaluation If injury at Prostatomembranous junction - High lying prostate → On IVP- Pie in-sky appearance Incorrect Options: Membranous urethral injury (Option B) This refers to a posterior urethral injury , which typically occurs further up the urethra and is different from anterior injuries like bulbar urethral stricture. Urethral tear (Option C) is typically seen as a focal area of contrast extravasation or leakage outside the normal urethral lumen, which is not the case in this stricture. Prostate hyperplasia (Option D) is marked by an enlarged transition zone in imaging studies like MRI, not related to urethral stricture.




Bladder
Urethral crest
Openings of prostatic utricle and ejaculatory ducts
Prostatic part of urethra
Membranous part of urethra
Spongy or Penile Urethra
Small lacuna
Lacuna magna
Ext. urethral orifice
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Peritoneum
Urinary bladder
Scarpa's fascia
Extravasated urine
Prostate
Urogenital diaphragm
Rupture of bulbous urethra
Dartos
@Neet_pg_bot



References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1538, 1541, 1532

SRB's Manual of Surgery, 6th Edition, Page 1040-1042

↑ *Back to this question in Part A*

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Q22: A patient develops a severe infection and necrosis in the scrotal region after 5 days of catheterization. Based on the clinical presentation, what is the most likely diagnosis? (Q860214)

A. Fournier’s gangrene

B. Gas gangrene

C. Wet gangrene

D. Scrotal hematoma



Correct Answer: A. Fournier’s gangrene

Explanation: The clinical presentation suggests Fournier's gangrene , a severe soft tissue infection involving the perineum. This condition is typically caused by a mixed aerobic and anaerobic infection . This condition is characterised by a mixed infection involving both aerobic and anaerobic bacteria. The most common aerobic microorganisms include Escherichia coli, Proteus, Staphylococcus, Klebsiella, and Streptococcus. The predominant anaerobic microorganisms are Bacteroides, Clostridium, and Peptostreptococcus. Fournier's Gangrene Definition Necrotizing infection of the soft tissues in the perineum, external genitalia, and perianal region, akin to necrotizing fasciitis. Clinical Presentation Symptoms: Intense pain in the genitalia, progressing through five phases: Prodromal Phase: Fever and lethargy. Early Pain Phase: Intense pain, possible edema, pruritus. Progressive Phase: Increased pain, and erythema. Crepitation Phase: Dusky skin with subcutaneous crepitation. Gangrene Phase: Gangrene with purulent discharge. Pain may decrease as gangrene progresses. Severity ranges from localized tenderness to septic shock. Risk Factors Peripheral vascular disease, diabetes mellitus, malnutrition, alcoholism, immunocompromised states. Diagnosis Clinical presentation supported by imaging or lab findings. Management Initial Treatment: Fluid resuscitation. Broad-spectrum antibiotics. Surgical debridement of necrotic tissue. Additional Measures: Urinary and faecal diversion to prevent wound contamination. Intensive monitoring for sepsis. Wound review and vacuum-assisted dressing. Skin grafting post-infection control. Incorrect Options: Gas gangrene (Option B) i s a severe infectious condition caused by clostridial organisms, primarily affecting skeletal muscle and leading to edematous myonecrosis. Wet gangrene (Option C) refers to a form of necrosis associated with bacterial infection and rapid tissue death, but the term is not specific to the genital area. Scrotal hematoma (Option D) usually results from damage to the venous structures due to trauma, testicular torsion, inguinal hernia, or other injuries.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1573,1574

↑ *Back to this question in Part A*

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Q23: A 35-year-old male presents with a painless testicular mass. After orchidectomy, histopathological examination reveals the presence of Reinke's crystals within the tumor cells. What is the most likely diagnosis? (Q860215)

A. Sertoli cell tumor

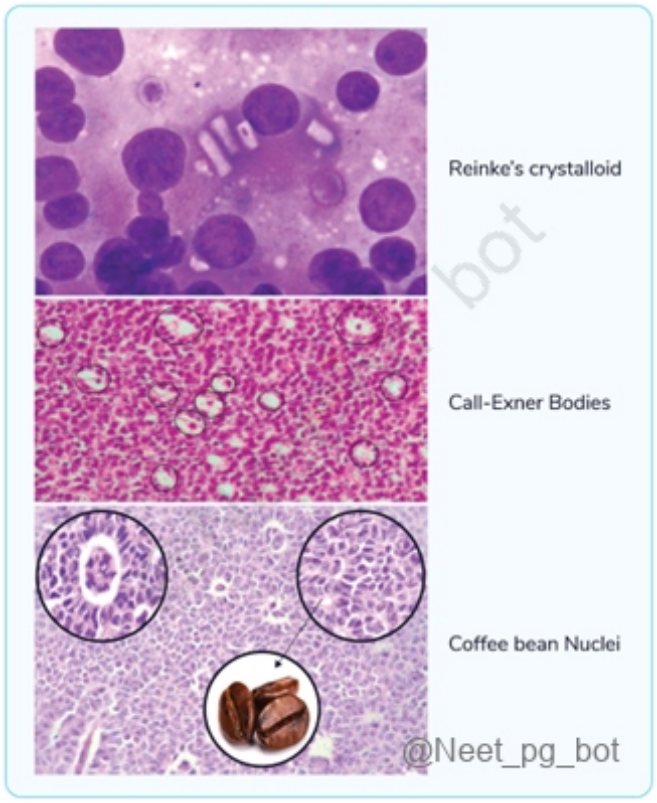
B. Leydig cell tumor

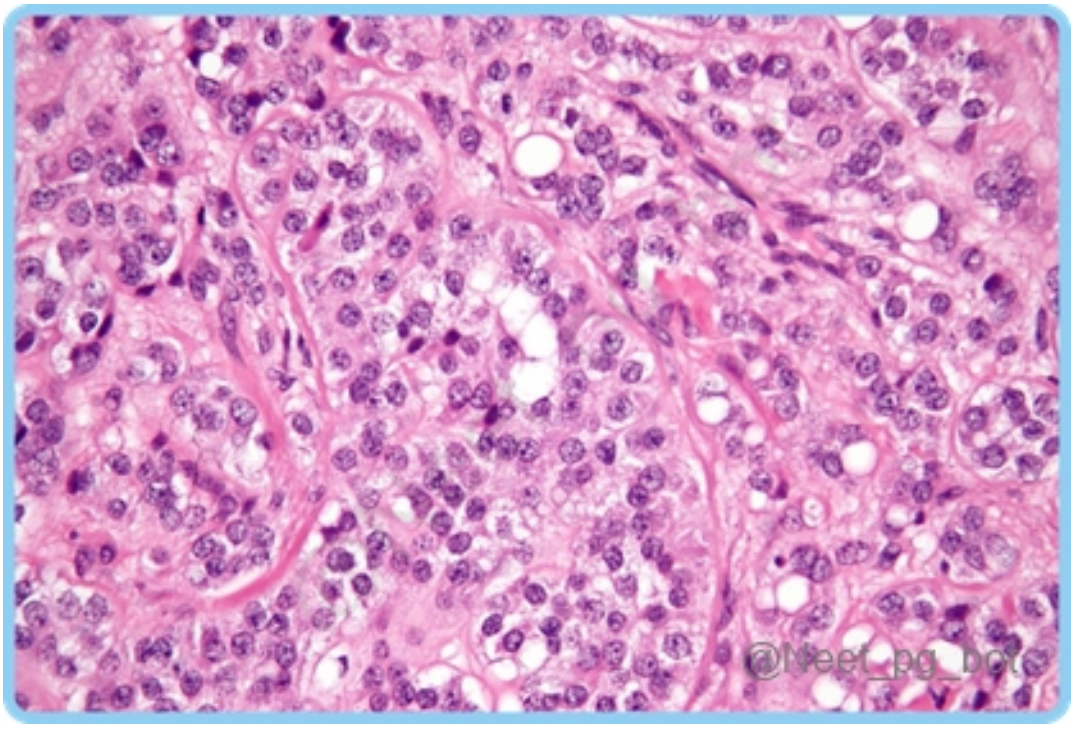
C. Seminoma

D. Yolk sac tumor

Correct Answer: B. Leydig cell tumor

Explanation: Reinke's Crystals are typically seen in Leydig cell tumors, which is a type of sex cord-stromal tumor. Sexcord stromal tumors: Leydig cell tumour Sertoli cell tumor (Option A ruled out) Hormonal involvement It often involves androgens, estrogens, and corticosteroids. Hormonally silent. Conditions associated with Klinefelter syndrome. Cryptorchidism. Renal cell carcinoma. Carney complex. Peutz-Jeghers syndrome. Familial adenomatous polyposis. Malignancy 10% (in adults) 10% Gross Circumscribed nodules, usually < 5 cm in diameter. They have a distinctive golden brown, homogeneous appearance on cut surfaces. Firm, small nodules with a homogeneous grey-white to yellow cut surface. Histology The tumour cells resemble their normal counterparts. They are large and have round or polygonal cell outlines , abundant granular eosinophilic cytoplasm , and a round central nucleus. The cytoplasm frequently contains lipid droplets , vacuoles , or lipofuscin pigment and, most characteristically, rod-shaped Reinke crystalloids (25% of the tumors). The tumour cells are arranged in distinctive trabeculae that tend to form cord-like structures and tubules. Image {{caption_text}} {{caption_text}} Seminoma: (Option C ruled out) Reinke's Crystals are not present in seminomas. Seminoma is the most common testicular tumour, typically seen in the 3rd and 4th decades of life. Tumor markers associated with seminomas include beta-HCG, which is commonly elevated, along with markers related to disease bulk, such as: LDH PLAP GGT Yolk sac tumor: (Option D ruled out) The tumor marker for yolk sac tumors is alpha-fetoprotein. Yolk sac tumors are the most common testicular tumors in children, particularly between 1-3 years of age. Yolk sac tumors are also associated with the best prognosis among testicular tumors.





References:

Robbins & Cotran Pathologic Basis of Disease, 10th Edition, Page 974

↑ *Back to this question in Part A*

Q24: Post-orchidectomy, the specimen shows Reinke's Crystals. What is the diagnosis? (Q857248)

A. Seminoma

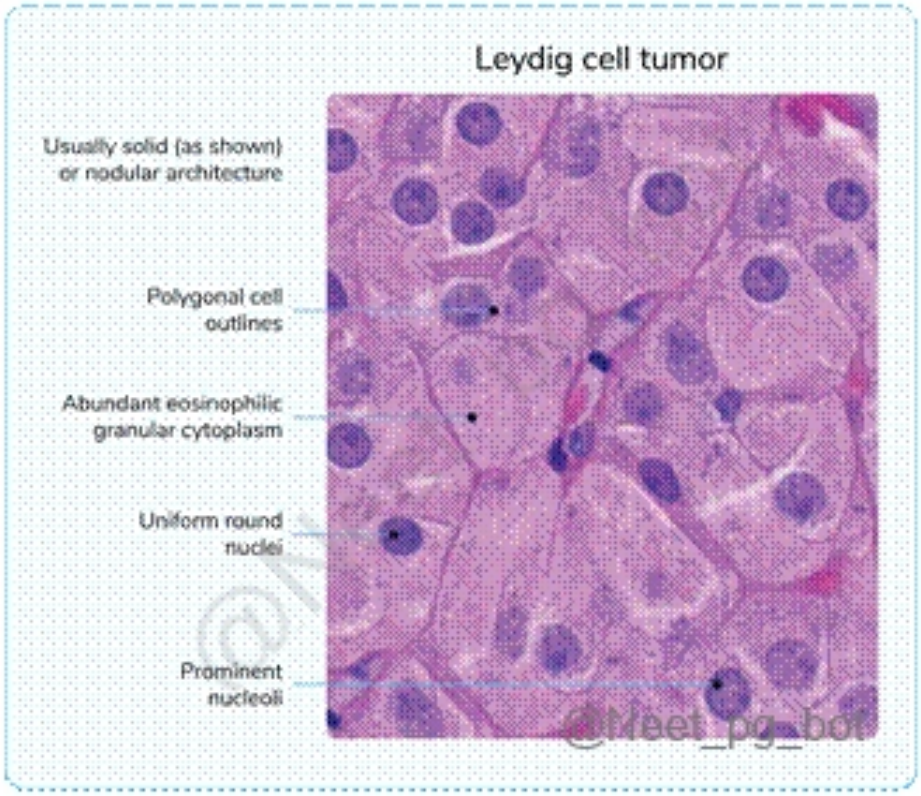
B. Leydig Cell Tumor

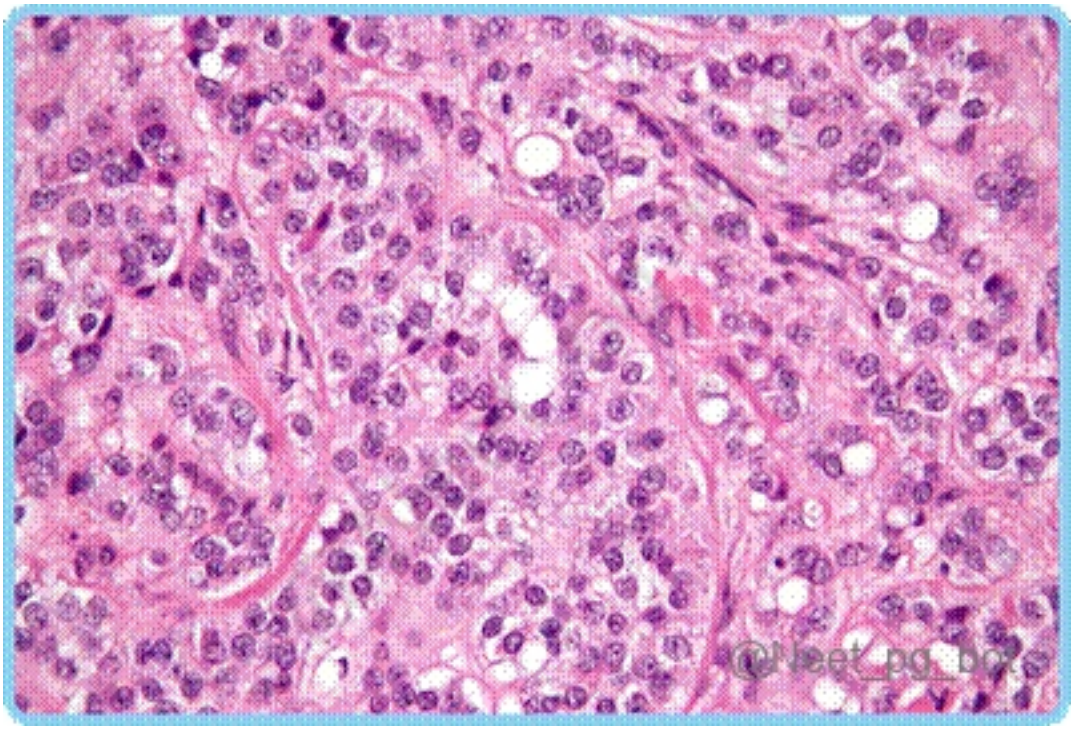
C. Metastasis

D. Yolk sac tumour

Correct Answer: B. Leydig Cell Tumor

Explanation: Reinke's Crystals are typically seen in Leydig cell tumours, which is a type of sex cord-stromal tumour. Sexcord stromal tumors: Leydig cell tumour Sertoli cell tumour Hormonal involvement It often involves androgens, oestrogens, and corticosteroids. Hormonally silent. Conditions associated with Klinefelter syndrome. Cryptorchidism. Renal cell carcinoma. Carney complex. Peutz-Jeghers syndrome. Familial adenomatous polyposis. Malignancy 10% (in adults) 10% Gross Circumscribed nodules, usually < 5 cm in diameter. They have a distinctive golden brown, homogeneous appearance on cut surfaces. Firm, small nodules with a homogeneous grey-white to yellow cut surface. Histology The tumour cells resemble their normal counterparts. They are large in size and have round or polygonal cell outlines , abundant granular eosinophilic cytoplasm , and a round central nucleus. The cytoplasm frequently contains lipid droplets , vacuoles , or lipofuscin pigment and, most characteristically, rod-shaped Reinke crystalloids (25% of the tumours). The tumour cells are arranged in distinctive trabeculae that tend to form cord-like structures and tubules. Image {{caption_text}} {{caption_text}} Seminoma: (Option A) Reinke's Crystals are not present in seminomas. Seminoma is the most common testicular tumour, typically seen in the 3rd and 4th decades of life. Tumor markers associated with seminomas include beta-HCG, which is commonly elevated, along with markers related to disease bulk, such as: LDH PLAP GGT Metastasis (Option C): Reinke's Crystals are not found in metastatic testicular disease. Yolk sac tumor: (Option D) The tumour marker for yolk sac tumours is alpha-fetoprotein. Yolk sac tumours are the most common testicular tumours in children, particularly between 1-3 years of age. Yolk sac tumours are also associated with the best prognosis among testicular tumours.





References:

Robbins & Cotran Pathologic Basis of Disease, 10th Edition, Page 974.

↑ *Back to this question in Part A*

Q25: A 45 year old patient with a history of kidney stones that were surgically removed 2 years ago presents with complaints of fever and flank pain. Imaging done is shown here. What would be the most appropriate next step in the management of this patient? (Q820137)

A. Laparotomy to remove the stones

B. Lithotripsy to remove recurrent stone

C. Leave the foreign body inside

D. Cystoscopic retrieval of foreign Body



Correct Answer: D. Cystoscopic retrieval of foreign Body

Explanation: Correct Option D - Cystoscopic retrieval of foreign Body: The given image is of foreign body in bladder. Cystoscopy is a minimally invasive procedure that involves inserting a thin tube with a camera (cystoscope) into the urinary tract to visualize and potentially remove foreign bodies or stones. This option seems reasonable if the imaging has revealed the presence of a foreign body in the urinary tract and it's contributing to the patient's symptoms. Cystoscopic retrieval is a less invasive approach compared to open surgery. Incorrect Options:

Option A - Laparotomy to remove the stones: Laparotomy involves making a surgical incision in the abdominal wall to access the internal organs. It is generally not the first-line approach for kidney stone removal. Kidney stones can often be managed through less invasive methods such as lithotripsy or endoscopic procedures. Laparotomy might be considered in very complex or unusual cases but is not usually the initial choice. Option B - Lithotripsy to remove recurrent stone: Lithotripsy is a non-invasive procedure that uses shock waves to break down kidney stones into smaller fragments that can be passed naturally. It's a common approach for kidney stone management, especially when the stones are relatively small. If the patient has recurrent kidney stones, lithotripsy could be a reasonable option depending on the size, location, and composition of the stones. Option C - Leave the foreign body inside: Leaving a foreign body inside the body is generally not a recommended approach, especially if it is causing symptoms such as fever and flank pain. Foreign bodies can lead to complications like infection, obstruction, or damage to the surrounding tissues. Removing the foreign body would be a more appropriate course of action if it's contributing to the patient's symptoms.

References:

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↑ *Back to this question in Part A*

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Q26: A 65-year-old male patient presents with urinary complaints. He has a history of working in a dye factory in the past. On USG examination, his bladder walls are found to be thickened and irregular. What is the most appropriate management for this patient? (Q820175)

A. Instillation of BCG

B. Cystoscopy with tumor removal

C. Intravesical mitomycin C

D. Radical cystectomy



Correct Answer: D. Radical cystectomy

Explanation: Correct Option D - Radical Cystectomy: Radical cystectomy is the surgical removal of the entire bladder. This option is the most appropriate choice based on the patient's history of working in a dye factory, urinary complaints, and findings of thickened and irregular bladder walls. Exposure to certain chemicals, such as those used in dye factories, can increase the risk of bladder cancer. The presentation suggests a potential malignancy, and radical cystectomy is a definitive treatment for invasive bladder cancer that hasn't responded to more conservative treatments. It involves removing the bladder along with nearby lymph nodes and, in some cases, other adjacent organs. This procedure is reserved for cases where the cancer has invaded the bladder wall or has a high likelihood of spreading. Incorrect Options: Option A - Instillation of BCG: Bacillus Calmette-Guérin (BCG) instillation is a treatment commonly used for superficial bladder cancer and not for urinary complaints related to thickened and irregular bladder walls. BCG is a type of immunotherapy that helps stimulate the immune system to fight cancer cells. It is not appropriate for this patient's presentation. Option B - Cystoscopy with Tumor Removal: While cystoscopy with tumor removal is indicated for patients with bladder tumors or suspected bladder cancer, this patient's presentation of urinary complaints, thickened, and irregular bladder walls is not indicative of a tumor. Therefore, this option is not the most appropriate management for this patient. Option C - Intravesical Mitomycin C: Intravesical mitomycin C is a treatment option for superficial bladder cancer, similar to BCG instillation. It is not typically used for urinary complaints related to thickened and irregular bladder walls. Thus, it's not the most suitable choice for this patient.

References:

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↑ *Back to this question in Part A*

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Q27: What is the best investigation to assess renal perfusion? (Q820191)

A. DTPA scan

B. DMSA scan

C. RGU

D. CT urogram

Correct Answer: A. DTPA scan

Explanation: Correct option A - DTPA (diethylenetriaminepentaacetic acid) scan It is a nuclear medicine test that involves injecting a radioactive tracer (DTPA) into the bloodstream. The tracer is taken up by the kidneys and then its distribution and clearance are monitored using gamma camera imaging. This allows for the assessment of renal blood flow, glomerular filtration rate (GFR) and overall renal perfusion. It is particularly useful in diagnosing conditions like renal artery stenosis or renal vascular disorders that affect renal perfusion. Incorrect options: Option B - DMSA (Dimercaptosuccinic acid) scan: DMSA scan is used to assess the functioning of the renal parenchyma. It is used to diagnose or monitor kidney infections and scarring. Option C - RGU (retrograde urethrogram): RGU is an imaging test used to visualize the urethra and the urinary bladder. Option D - CT urogram: CT urogram is a radiological examination that involves the use of a contrast dye to visualize the urinary tract structures, including the kidneys, ureters, and bladder. It is more focused on detecting structural abnormalities.

↑ *Back to this question in Part A*

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Q28: A 4-year-old child is brought to the emergency department with a painless abdominal swelling noticed by the parents. On examination, a large, firm, mobile abdominal mass is noted. The mass is unilateral and does not cross the midline. There is no associated hematuria, fever, or weight loss. What is the most probable diagnosis? (Q830828)

A. Neuroblastoma

B. Angiomyolipoma

C. Renal cell carcinoma

D. Wilm’s tumor

Correct Answer: D. Wilm’s tumor

Explanation: Correct Option D) Wilm’s tumor The child is 4 years old, which is within the typical age range (2–5 years) for Wilm’s tumor. Presents as a painless, firm, unilateral abdominal mass. The mass is mobile and does not cross the midline, which is characteristic. Usually arises from the kidney and may be associated with hypertension or hematuria in some cases. Early detection is common as parents notice the swelling. Surgical excision with chemotherapy is the standard treatment. Incorrect Options: Option A) Neuroblastoma: Often firm, irregular, crosses the midline, may have systemic symptoms (fever, weight loss). Option B) Angiomyolipoma: Rare in children; mostly in adults, often associated with tuberous sclerosis . Option C) Renal cell carcinoma: Very rare in children; typically occurs in adolescents or adults.

↑ *Back to this question in Part A*

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Q29: A 45-year-old patient presents with complaints of dysuria and intermittent back pain. On examination, there are no palpable abdominal masses or tenderness. An X-ray image of the abdomen is shown. What is the most likely diagnosis? (Q854769)

A. PTH adenoma

B. Wilm's tumour

C. Renal cell carcinoma

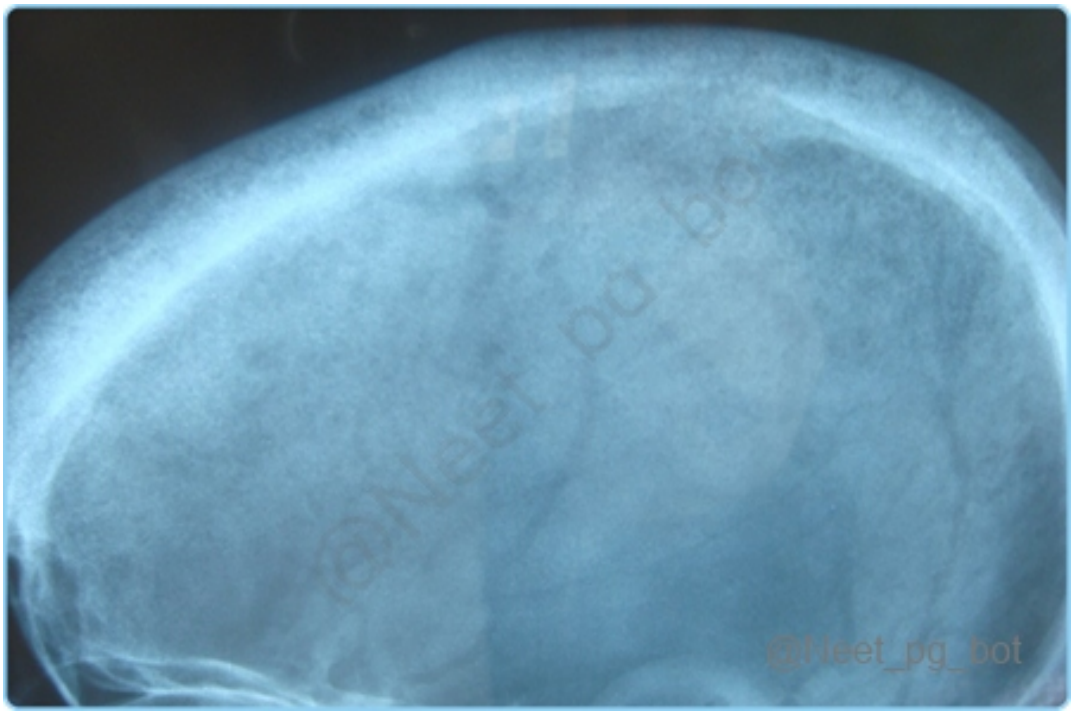
D. Lipoma



Correct Answer: A. PTH adenoma

Explanation: The most likely diagnosis is PTH adenoma . Parathyroid hormone (PTH) adenoma can cause hypercalcemia , which may lead to symptoms like dysuria and back pain. Radiologically, PTH adenoma may cause characteristic findings, such as kidney stones or calcifications due to calcium imbalance. Causes of primary hyperparathyroidism : The most common cause of primary hyperparathyroidism is a solitary parathyroid adenoma (most common on the inferior lobe of the right parathyroid). Double adenomas are rare (2-4%). Parathyroid hyperplasia: enlargement of all 4 glands. Parathyroid carcinoma Manifestations of PHPT: System Manifestations Reason Renal system (stones) Hypercalciuria Nephrocalcinosis Nephrolithiasis Polydipsia, polyuria, nocturia Excretion of excess serum calcium Calcium deposition in renal parenchyma Precipitation of calcium with phosphate or oxalate Inhibition of ADH due to ↑ serum calcium. Skeletal system Osteoporosis Subperiosteal resorption(radial aspect) Tufting of distal phalanx Brown tumour/ osteitis fibrosa cystica {{caption_text}} Salt and pepper skull {{caption_text}} Chondrocalcinosis Pseudo gout Joint pain Calcium resorption Deposition of hemosiderin in the lesion. Abdomen (abdominal groans) Nausea Vomiting Constipation Peptic ulcer disease: abdominal groans Inhibitory effect of hypercalcemia on gastrointestinal (GI) smooth muscle contraction. Spasm of sphincters Increased gastrin CNS (psychiatric moans) Confusion Anxiety Depression Psychosis: psychic moans Some mild memory loss Depression of the nervous system Muscular system Weakness Fatigue overtones Decreased muscle activity. Incorrect Options: Wilms' tumour (Option B) is a type of kidney cancer that predominantly affects children. It typically presents as a renal mass on imaging studies, but this would not be the correct diagnosis based on the provided X-ray image. Renal cell carcinoma (Option C) is the most common form of kidney cancer in adults. While it may show up in imaging studies, an X-ray alone is insufficient to conclusively diagnose renal cell carcinoma. Lipoma (Option D) is a benign tumour made up of fatty tissue. On imaging, it typically appears as a well-defined soft tissue mass. However, based on the X-ray image provided, a lipoma would not be the most likely diagnosis.





References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 875,876

↑ *Back to this question in Part A*

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Q30: A 55-year-old male presented with verrucous carcinoma around the glans of the penis. Examination reveals that the inguinal lymph nodes are not enlarged. What is the appropriate management for this patient? (Q855147)

A. Total penectomy

B. CO2 laser excision

C. Topical 5-fluorouracil

D. Partial penectomy

Correct Answer: D. Partial penectomy

Explanation: Partial penectomy is the preferred management when verrucous carcinoma involves the glans or distal shaft but is still resectable with preservation of as much penile length as possible. This ensures complete oncologic clearance, prevents local recurrence, and maintains acceptable function. As lymph node metastasis is extremely rare in verrucous carcinoma, absence of palpable nodes means no immediate lymph node surgery is required. Management of Penile carcinoma: Cancer Type/Stage Management Localized Tumor - Glans Only Partial penectomy Distal Penile Involvement Partial penectomy with 2cm margin Proximal Penile Involvement /Anaplastic Tumors Total penectomy with perineal urethrostomy Carcinoma in situ, T1 Lesions, Well-Differentiated Tumors in Young Circumcision followed by curative radiotherapy Inguinal Lymph Node Involvement Bilateral ilioinguinal lymph node dissection Advanced Disease - T2 or Poorly Differentiated Tumors Prophylactic inguinal nodal dissection Carcinoma in situ Topical treatments (5-FU cream , imiquimod), Mohs surgery, laser therapy , or limited excision Chemotherapy Combination chemotherapy (5-FU, methotrexate, bleomycin, cisplatin, vincristine) Other options: Option A: Total penectomy Reserved for extensive or proximal disease where adequate surgical margins cannot be achieved with penile preservation. Overtreatment for localized verrucous carcinoma confined to the glans. Option B: CO■ laser excision Can be used for very superficial penile lesions, but verrucous carcinoma is typically bulky and deeply invading locally. Higher chance of incomplete excision and recurrence. Option C: Topical 5-fluorouracil Used for premalignant lesions such as Bowen's disease or penile intraepithelial neoplasia, not for invasive carcinoma. Ineffective for verrucous carcinoma.

References:

SRB’s Manual of Surgery, 6th Edition, Page 1053-1055

↑ *Back to this question in Part A*

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Q31: A diabetic patient presents with sudden-onset perineal pain. On examination, foul-smelling discharge and necrotic tissue, as seen in the image, are noted. Which of the following is true about the given condition? (Q855167)

A. Anti-gas gangrene serum is indicated for all cases

B. Urinary diversion is the next step

C. A bilateral orchidectomy must be done

D. Mixed aerobic and anaerobic infection



Correct Answer: D. Mixed aerobic and anaerobic infection

Explanation: The clinical presentation suggests Fournier's gangrene , a severe soft tissue infection involving the perineum. This condition is typically caused by a mixed aerobic and anaerobic infection . The most common aerobic microorganisms include Escherichia coli , Proteus , Staphylococcus , Klebsiella , and Streptococcus . The predominant anaerobic microorganisms are Bacteroides , Clostridium , and Peptostreptococcus . Fournier's Gangrene Definition Necrotizing infection of the soft tissues in the perineum, external genitalia, and perianal region, akin to necrotizing fasciitis. Clinical Presentation Symptoms: Intense pain in the genitalia, progressing through five phases: Prodromal Phase: Fever and lethargy. Early Pain Phase: Intense pain, possible edema, pruritus. Progressive Phase: Increased pain and erythema. Crepitation Phase: Dusky skin with subcutaneous crepitation. Gangrene Phase: Gangrene with purulent discharge. Pain may decrease as gangrene progresses. Severity ranges from localized tenderness to septic shock. Risk Factors Peripheral vascular disease, diabetes mellitus, malnutrition, alcoholism, immunocompromised states. Diagnosis Clinical presentation supported by

imaging or lab findings. Management Initial Treatment: Fluid resuscitation. Broad-spectrum antibiotics. Surgical debridement of necrotic tissue. Additional Measures: Urinary and faecal diversion to prevent wound contamination. Intensive monitoring for sepsis. Wound review and vacuum-assisted dressing. Skin grafting post-infection control. Other options: Option A: Anti-gas gangrene serum is indicated for all cases Antitoxin is used only for Clostridial myonecrosis, not for polymicrobial Fournier gangrene. Fournier gangrene requires broad-spectrum antibiotics and urgent debridement, not antitoxin therapy. Option B: Urinary diversion is the next step Not routinely required. Performed only if urethral injury or urinary extravasation occurs. Initial steps are aggressive resuscitation, urgent surgical debridement, and broad-spectrum antibiotics. Option C: A bilateral orchidectomy must be done Testes have separate blood supply from the abdominal aorta, so they are often viable even in extensive gangrene. Orchidectomy is done only if testicular necrosis occurs, which is rare.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1573,1574

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Q32: Which of the following statements is not true regarding the provided medical condition? (Q855208)

A. Repeated radical surgery every 24 hours may be required to adequately manage this condition

B. This is a case of Meleney's gangrene

C. The condition is caused by β-hemolytic streptococcus and may sometimes be polymicrobial

D. Hyperbaric oxygen has no role in the treatment of this condition.



Correct Answer: D. Hyperbaric oxygen has no role in the treatment of this condition.

Explanation: The image shows Meleney’s gangrene. Hyperbaric oxygen is actually beneficial in the management of Meleney's gangrene, as it helps to improve oxygen delivery to tissues, inhibit bacterial growth, and promote wound healing. Necrotizing Fasciitis and Related Conditions: Meleney’s Synergistic Gangrene and Fournier’s Gangrene are variants of a similar disease process. Necrotising fasciitis is caused by a synergistic polymicrobial infection , most commonly involving Group A β-hemolytic Streptococcus combined with other bacteria such as Staphylococcus, Escherichia coli, Pseudomonas, Proteus, Bacteroides, or Clostridium. 80% of cases are linked to a history of previous trauma or infection. Common locations : Lower extremities in over 60% of cases. Predisposing conditions include: Diabetes mellitus Smoking Penetrating trauma (e.g., bites, abrasions) Pressure sores Immunosuppression Intravenous drug abuse Perineal infections (e.g., perianal abscess, Bartholin’s cyst) Skin infections (e.g., boils) Clinical features: Early signs: Oedema extending beyond visible erythema "Woody" or hard texture in subcutaneous tissues Difficulty distinguishing fascial planes and muscles on palpation Disproportionate pain compared to the affected area Skin vesicles and soft-tissue crepitus Absence of lymphangitis is typical. Progression : Rapid onset of fever, tachycardia, and rapid progression to septic shock. Radiological findings : Air in the tissues may be visible on radiographs, although urgent treatment should not be delayed for imaging. Immediate management: Fluid resuscitation and monitoring of hemodynamic status. Administration of high-dose intravenous broad-spectrum antibiotics . Surgical management: Urgent debridement of necrotic tissue until healthy, viable tissue is reached. The use of vacuum-assisted dressings is recommended. Additional management: Early skin grafting may reduce protein and fluid loss in selected cases. Hyperbaric oxygen therapy after debridement can be beneficial if available. Prognosis: Mortality rate : 30–50%, even with prompt surgical intervention.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 644

↑ *Back to this question in Part A*

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Q33: A 55-year-old male patient presents with hematuria and a neovascular mass in the left kidney on a CT scan, as shown below. What is the diagnosis? (Q857778)

A. Renal cell carcinoma

B. Renal oncocytoma

C. Renal angiomyolipoma

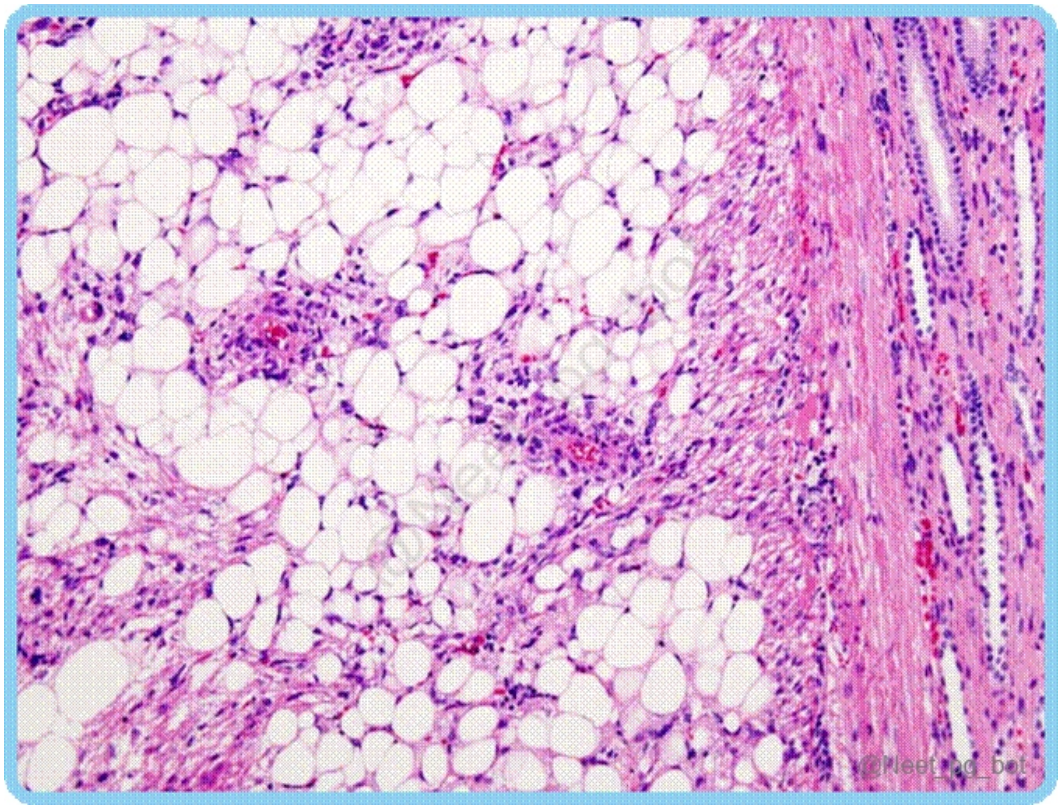
D. Renal cyst

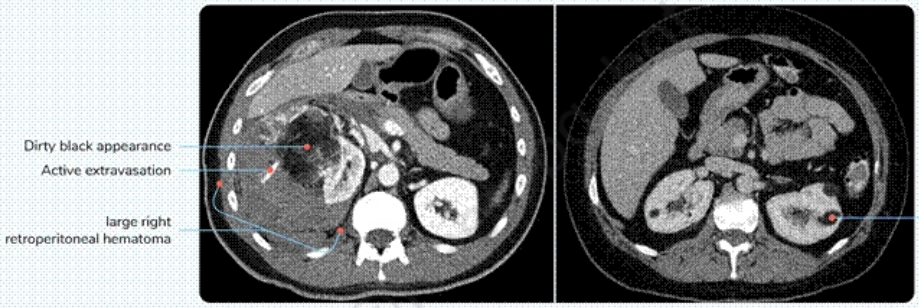


Correct Answer: C. Renal angiomyolipoma

Explanation: The presence of hematuria and a neovascular mass in the left kidney on a CT scan suggests a benign renal tumor, likely Renal Angiomyolipoma (AML) . Arise from Perivascular epithelioid cells Types Sporadic AMLs: Present in the 4th-6th decades, typically small, solitary, and slow-growing. TSC-associated AMLs: Present earlier (3rd-4th decades), larger, multiple, bilateral, and tend to grow. Symptoms Abdominal or flank pain, hematuria, hypertension, anemia. Impaired kidney function, usually due to hemorrhage (severe complication). Wunderlich syndrome : Nontraumatic kidney hemorrhage. Risk Factors for AML Complications Pregnancy:

Increased risk of hemorrhage TSC-associated AMLs: Higher risk of CKD and ESKD Epithelioid AMLs: Potential for malignant transformation, metastasis, and local recurrence. Risk factors for hemorrhage: AML size (>6 cm) Increased vascularity Large intralesional aneurysms (>5 mm) Exophytic growth pattern. Histology Circular blood vessels, muscles, and fat; perivascular epithelioid cells with dense eosinophilic cytoplasm and mitotic figures. {{caption_text}} Diagnosis CT: (Investigation of choice) Presence of intralesional fat and neovascular mass. {{caption_text}} USG: Appears as hyperechoic Immunocytochemical analysis: Differentiates AML from RCC, using markers like HMB-45 and melan-A . Treatment Observation (tumors <4 cm) Nephron-Sparing Surgery(Partial nephrectomy) (larger tumors or those with a high risk of bleeding) Angioembolization (acute hemorrhage). Medications (mTOR inhibitors like everolimus and sirolimus). Renal cell carcinoma (RCC) (Option A) is a malignant tumor of the kidney that appears as a solid, heterogeneous mass with irregular borders and necrosis. While it shows neovascularization, it lacks the fat component and distinct vascular pattern of angiomyolipomas (AMLs). The presence of these benign features suggests AML, not RCC. {{caption_text}} {{caption_text}} Renal oncocytoma (Option B) is a benign tumor that typically appears as a well-defined, solid mass with homogeneous enhancement and sometimes a central scar on CT or MRI. It lacks the neovascular pattern and fat component seen in AMLs. Oncocytomas have less vascularity, making them unlikely in this case. {{caption_text}} Renal cysts (Option D) is a fluid-filled, non-enhancing structure with smooth walls on imaging. It lacks vascularity and neovascularization. A renal cyst doesn't cause hematuria or present as a neovascular mass, making it unlikely in this case. {{caption_text}}





Angiomyolipoma

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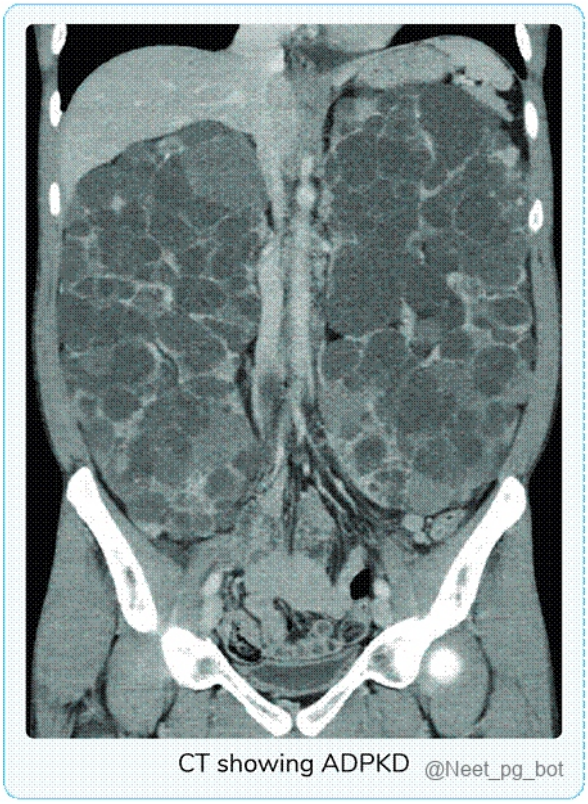
Axial unenhanced CT scan

A. Shows and expansile mass involving the right kidney. Postcontrast axial CT in corticomedullary phase.
B. Shows heterogeneous and intense enhancement of the mass. Delayed-phase image (90 seconds).
C. Shows contrast washout in the mass. This pattern of enhancement and contrast washout is typical of clear cell renal cell carcinoma.

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References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page, 1482.

↑ *Back to this question in Part A*

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Q34: Which lymph node is most commonly involved in prostate cancer? (Q857794)

A. Deep inguinal

B. Retroperitoneal

C. Superficial inguinal

D. Pelvic

Correct Answer: D. Pelvic

Explanation: Prostate Cancer primarily spreads to regional pelvic lymph nodes, including the external and internal iliac nodes, before metastasizing to other areas. Most common malignant tumor in men over the age of 65 years. Most common among Afro-American Risk factor Advanced age High-fat diet Protective factors (Mnemonic: LESA) L ycopene Vitamin E S elenium Vitamin A Pathology Most common site- peripheral zone (75%) > transitional zone (15%) > central zone (10%) Most common histological type is adenocarcinoma Most common genetic alteration seen in CA prostate- hypermethylation of GSTP1 (Glutathione transferase promoter region 1) located on chromosome 11. 70-80% of the cases. Microscopy: small, crowded, absent basal layer, lack of branching Clinical features Commonly asymptomatic. Bladder outlet obstruction. Haematuria Pelvic pain, back pain, arthritic pain in sacroiliac joint-features of secondaries On per rectal examination: hard, nodular, irregular often with loss of median groove. Routes of spread Most common route of spread- haematogenous (skeletal metastases: pelvic bones and the lower lumbar vertebrae) Lymphatic: Internal iliac, external iliac lymph nodes, retroperitoneal lymph nodes, mediastinal nodes and occasionally the supraclavicular nodes. Investigations DRE (Digital Rectal Exam): Physical examination; detects nodules but limited in early-stage PSA (prostate-specific antigen) Test: Measures PSA levels; elevated levels suggest cancer TRUS (Transrectal Ultrasound): Imaging with rectal probe; detects abnormalities mpMRI (Multiparametric MRI): Advanced imaging; superior for staging and capsular spread Prostate Biopsy: Gold standard for diagnosis; tissue sampling for cancer cells Management Active Surveillance: For low-risk cases; regular monitoring Radical Prostatectomy: Surgery for localized cancer; potentially curative Radiation Therapy: High-energy rays; external or brachytherapy Hormone Therapy: Reduces/block testosterone; for advanced/metastatic cases Chemotherapy: Systemic drug treatment; for advanced/metastatic cases

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1531-1533.

SRB’s Manual of Surgery, 6th Edition, Page 1037-1039.

↑ *Back to this question in Part A*

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Q35: Which of the following statements is false about the following image? (Q857795)

A. Staphylococcus aureus is the causative organism

B. Common in diabetic patients

C. High mortality

D. The testes remain unaffected



Correct Answer: A. Staphylococcus aureus is the causative organism

Explanation: The given image depicts Fournier's Gangrene , which results from a polymicrobial infection involving both aerobic and anaerobic bacteria, rather than solely Staphylococcus aureus Fournier's Gangrene Definition Necrotizing infection of the soft tissues in the perineum, external genitalia, and perianal region, akin to necrotizing fasciitis. Causative Organisms Mixed infection of aerobic and anaerobic bacteria in a fulminating inflammation of the subcutaneous tissues. (Option A) Clinical Presentation Symptoms: Intense pain in the genitalia, progressing through five phases: Prodromal Phase: Fever and lethargy. Early Pain Phase: Intense pain, possible edema, pruritus. Progressive Phase: Increased pain, erythema. Crepitation Phase: Dusky skin with subcutaneous crepitation. Gangrene Phase: Gangrene with purulent discharge. Pain may decrease as gangrene progresses. Severity ranges from localized tenderness to septic shock. Risk Factors Peripheral vascular disease Diabetes mellitus (Option B ruled out) Malnutrition Alcoholism Immunocompromised states. Diagnosis Clinical presentation supported by imaging or lab findings. Management Initial Treatment: Fluid resuscitation. Broad-spectrum antibiotics. Surgical debridement of necrotic tissue. Additional Measures: Daily rounds (high

rates mortality and morbidity) (Option C ruled out) Urinary and fecal diversion to prevent wound contamination. Intensive monitoring for sepsis. Wound review and vacuum-assisted dressing. Skin grafting post-infection control. The testes remain unaffected (Option D) in this condition as they have the dual blood supply.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page, 1573-1574.

Sabiston Textbook of Surgery, 21st Edition, Page, 1372.

↑ *Back to this question in Part A*

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Q36: What type of hernia is a funicular hernia? (Q857796)

A. Direct inguinal hernia

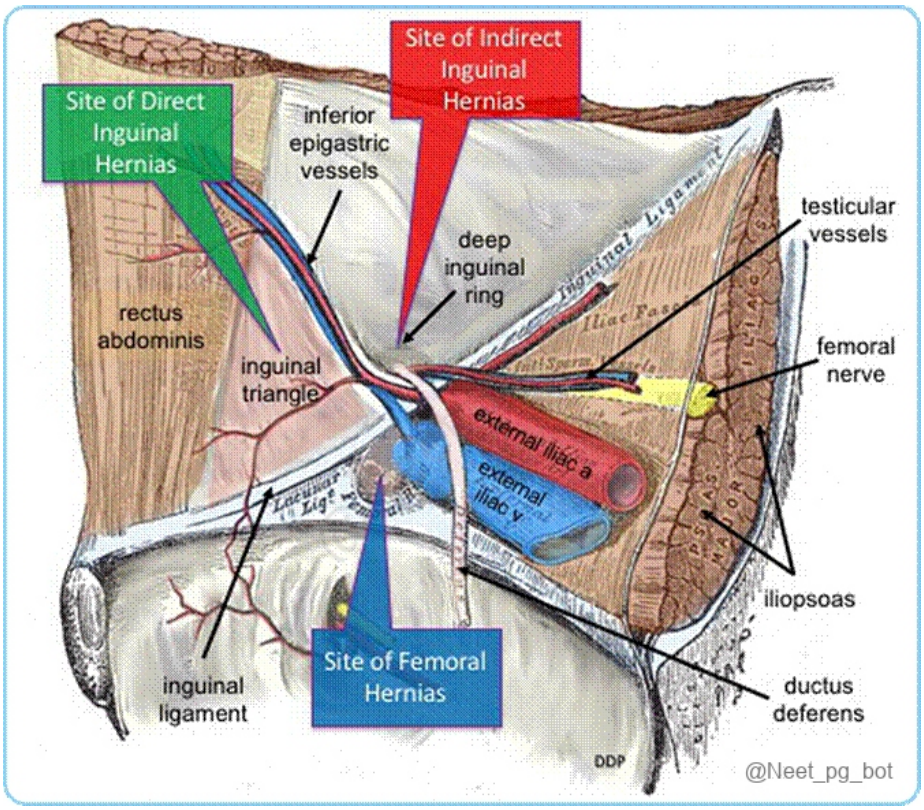
B. Indirect inguinal hernia

C. Femoral hernia

D. Umbilical hernia

Correct Answer: B. Indirect inguinal hernia

Explanation: Funicular hernia is a type of indirect Inguinal Hernia . Feature Indirect Inguinal Hernia Direct Inguinal Hernia (Option A ruled out) Common in Young adults Elderly Course It enters through the deep inguinal ring, traverses the inguinal canal, and exits via the superficial inguinal ring. Protrudes directly through Hesselbach's triangle Relation to Spermatic Cord Anterolateral to the spermatic cord Posterior to the spermatic cord Location of Neck of Sac Above and medial to the pubic tubercle. Lies within the Hesselbach's triangle. Relation to Inferior Epigastric vessels Lateral to the inferior epigastric vessels. Medial to the inferior epigastric vessels. Relation to Scrotum Descends into the scrotum Does not Descend Types Bubonocele: Confined to inguinal canal Funicular: Processus vaginalis closed above epididymis, hernia content distinct from testis (Option B) Complete/Scrotal: Testis in the lower part of the hernia — {{caption_text}} Femoral hernia (Option C) occurs when abdominal contents push through the femoral canal, located below the inguinal ligament, and is more common in women due to a wider pelvis. It differs from funicular or inguinal hernias as it is not associated with the inguinal canal and carries a higher risk of complications like incarceration or strangulation. Umbilical hernia (Option D) occurs when part of the intestine or abdominal tissue protrudes near the navel. It is more common in infants but can affect adults, often due to obesity or increased intra-abdominal pressure. Unlike inguinal hernias, it is not related to the inguinal canal or processus vaginalis.



References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1065-1066.

↑ *Back to this question in Part A*

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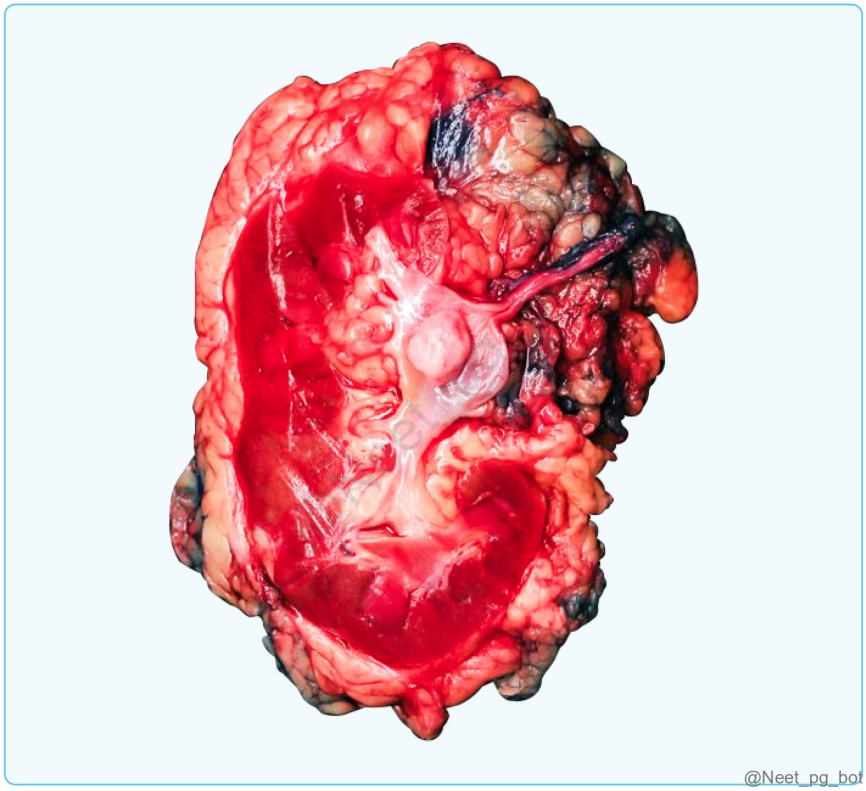
Q37: A 50-year-old male patient came to the outpatient department with complaints of hematuria. A 2x2 cm bladder mass is seen which is low-grade transitional cell carcinoma. Which among the following is the ideal management? (Q857799)

A. Transurethral resection of the tumor

B. Resection with ileal conduit

C. Partial cystectomy with bladder reconstruction

D. Neoadjuvant chemotherapy



Correct Answer: A. Transurethral resection of the tumor

Explanation: In the case of a 2x2 cm bladder mass indicative of low-grade transitional cell carcinoma, the preferred initial treatment is Transurethral Resection of Bladder Tumor (TURBT) . It is the initial management of bladder tumours for accurate staging. (Option A) It is performed using a cystoscope inserted through the urethra to remove the tumor from the bladder. It allows for both diagnostic and therapeutic purposes (tumor is removed and sent for histopathological examination). Large tumours: Standard fractionated resection of the entire tumour (tumour base with deep muscle). Small tumors (<3 cm): En bloc resection of the entire tumour (solitary tumor) The following details should be recorded to enable accurate risk stratification: Size of the primary tumour Number of tumours Nodular or papillary features Presence of CIS Completeness of visual resection. Mapping biopsies (if CIS suspected): Taken from trigone, bladder dome and the right, left, anterior and posterior bladder wall. Tumor Stage Tis (Carcinoma in situ) TURBT (Transurethral Resection of Bladder Tumor) May be used for initial diagnosis and tumor resection if not already performed Intravesical BCG Induction: Weekly for 6 weeks Maintenance: Weekly for 3 weeks at months 3, 6, 12, 18, 24, 30, and 36 Continue BCG Maintenance Therapy Up to 3 years Ta (Non-muscle invasive) TURBT Complete resection of tumor Low-risk: Single Instillation (SI) of Intravesical Chemotherapy (e.g., gemcitabine, mitomycin) SI within 24 hours of TURBT Alternative: Continuous saline bladder irrigation Intermediate-risk: Intravesical Chemotherapy (e.g., gemcitabine) Induction: 6 weekly courses Maintenance: Up to 1 year T1 (Muscle invasive) TURBT - For initial diagnosis and tumor debulking High-risk: Intravesical BCG Induction: Weekly for 6 weeks Maintenance: Up to 3 years Consider Cystectomy If BCG is not tolerated or ineffective- Alternative: Trimodality therapy (TURBT + Chemoradiation) T2 (Muscle invasive) TURBT - May be used for tumor resection and staging Initial Treatment: Consider Cystectomy Alternatively, Trimodality therapy (TURBT + Chemoradiation) Adjuvant Therapy: Depending on response and tumor characteristics T3 (Advanced muscle invasive) Initial Treatment: Cystectomy with possible neoadjuvant chemotherapy TURBT - Often not performed if cystectomy is planned Adjuvant Therapy: Based on pathology and staging Neoadjuvant therapy may continue T4 (Locally advanced) Initial Treatment: Cystectomy Neoadjuvant

Chemotherapy, if not yet administered TURBT - Typically avoided if cystectomy and neoadjuvant therapy are planned Adjuvant Therapy: Additional chemotherapy or radiation based on residual disease and staging Resection with ileal conduit (Option B) involves removing the entire bladder and creating a urinary diversion using the ileum. It is typically reserved for invasive or high-grade bladder cancer, not low-grade transitional cell carcinoma, where transurethral resection is the ideal treatment. Partial cystectomy with bladder reconstruction (Option C) is typically reserved for invasive bladder cancer or select cases of localized low-grade tumors in favorable locations. However, for most low-grade, non-muscle invasive bladder cancers, transurethral resection (TURBT) is the preferred initial treatment. Neoadjuvant chemotherapy (Option D) , given before the main treatment, is typically used for muscle-invasive bladder cancer or high-risk cases. For low-grade, non-muscle invasive tumors, TURBT is the initial treatment, with chemotherapy considered only if there is recurrence or progression.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1517.

↑ *Back to this question in Part A*

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Q38: Which of the following will have unilateral hydronephrosis? (Q857801)

A. Urethral atresia

B. Posterior urethral valves

C. Benign Prostatic Hyperplasia

D. Retrocaval ureter

Correct Answer: D. Retrocaval ureter

Explanation: Retrocaval ureter is one of the causes of unilateral Hydronephrosis (HN) . It is an aseptic dilatation of pelvicalyceal system due to partial or intermittent obstruction to the outflow of urine. Causes: Unilateral Hydronephrosis Bilateral Hydronephrosis Extramural Causes: Advanced Malignancies Colorectal cancer Carcinoma cervix Carcinoma Prostate Retroperitoneal fibrosis Retrocaval Ureter (Option D) Congenital Causes: Posterior Urethral Valve (Option B ruled out) Urethral atresia (Option A ruled out) Intramural Causes: PUJ Obstruction Ureterocele Ureteric Stricture Urothelial tumor Acquired Causes: Bladder neck stenosis BPH (Benign Prostatic Hyperplasia) (Option C ruled out) CA Prostate Urethral strictures Intraluminal Causes: Stone Papillary Slough Due to: Analgesic nephropathy Sickle cell anemia Clinical features: Unilateral Hydronephrosis Bilateral Hydronephrosis Congenital PUJ obstruction and calculus are the most common causes Male to Female ratio 2:1 Right side kidney is affected more commonly From lower urinary tract obstruction: Loin pain Features of bladder outlet obstruction—frequency, hesitancy, poor stream Kidneys are not palpable if renal failure develops early Dull aching loin pain with dragging sensation or heaviness Mass in the loin which moves with respiration Dietl's crisis (Intermittent Hydronephrosis) : Swelling in the loin after acute renal colic, disappears after passing a large volume of urine Dysuria, haematuria. If infected, fever and tenderness in the renal angle From bilateral upper urinary tract obstruction: Loin pain, mass in the loin, attacks of renal colic In severe cases, features of renal failure like oliguria,

edema, and hiccoughs may be present

References:

SRB Manual of Surgery, 6th Edition, Page, 1000-1002.

↑ *Back to this question in Part A*

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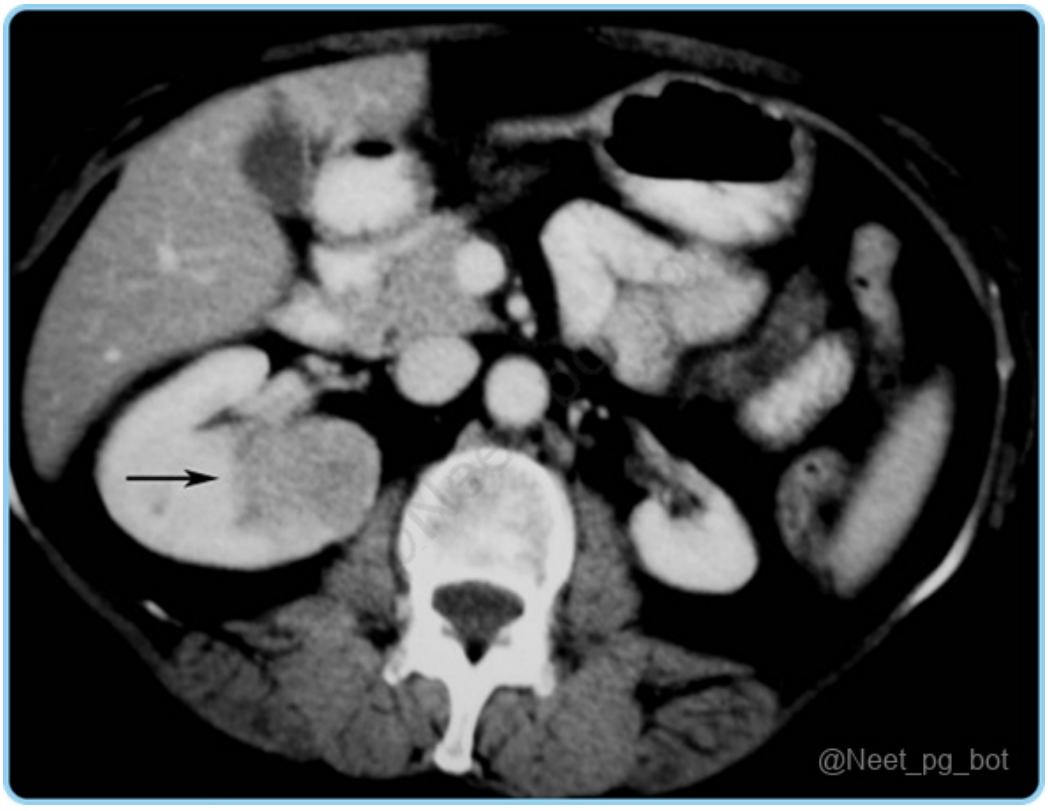
Q39: A 44-year-old female presents with an incidentally discovered 4 cm solid, hyper-enhancing mass in the lower pole of the right kidney on CT imaging. The contralateral kidney is normal, and there is no evidence of lymphadenopathy or distant metastasis. What is the most appropriate management for this patient? (Q857802)

A. Partial nephrectomy

B. Partial nephrectomy + Neoadjuvant chemotherapy

C. Radical nephrectomy

D. Radical nephrectomy + Postoperative radiotherapy



Correct Answer: A. Partial nephrectomy

Explanation: A 4 cm solid, hyper-enhancing renal mass is classified as clinical Stage T1a . According to current urological guidelines (AUA/EAU 2026), Partial Nephrectomy (Nephron-Sparing Surgery) is the treatment of choice for T1a tumors because it provides oncological outcomes equivalent to radical surgery while preserving renal function and reducing long-term cardiovascular risk. It involves the complete removal of the tumor with a margin of healthy tissue, sparing the rest of the kidney. It is indicated for small tumors, solitary kidneys, or bilateral renal masses. Partial nephrectomy + Neoadjuvant chemotherapy (Option B): Localized RCC is highly resistant to conventional chemotherapy. Neoadjuvant therapy is not indicated for T1a disease and does not provide any survival benefit in this setting. Radical nephrectomy (Option C): This involves removing the entire kidney, Gerota's fascia, and the adrenal gland. While effective, it is considered "over-treatment" for a 4 cm localized mass that is technically amenable to a partial resection. Radical nephrectomy + Postoperative radiotherapy (Option D): RCC is largely radio-resistant. Radiotherapy is primarily used for the palliation of bone or brain metastases and has no role as an adjuvant treatment for localized T1a disease.

References:

Sabiston Textbook of Surgery, 21st Edition, Page 2091-2092.

↑ *Back to this question in Part A*

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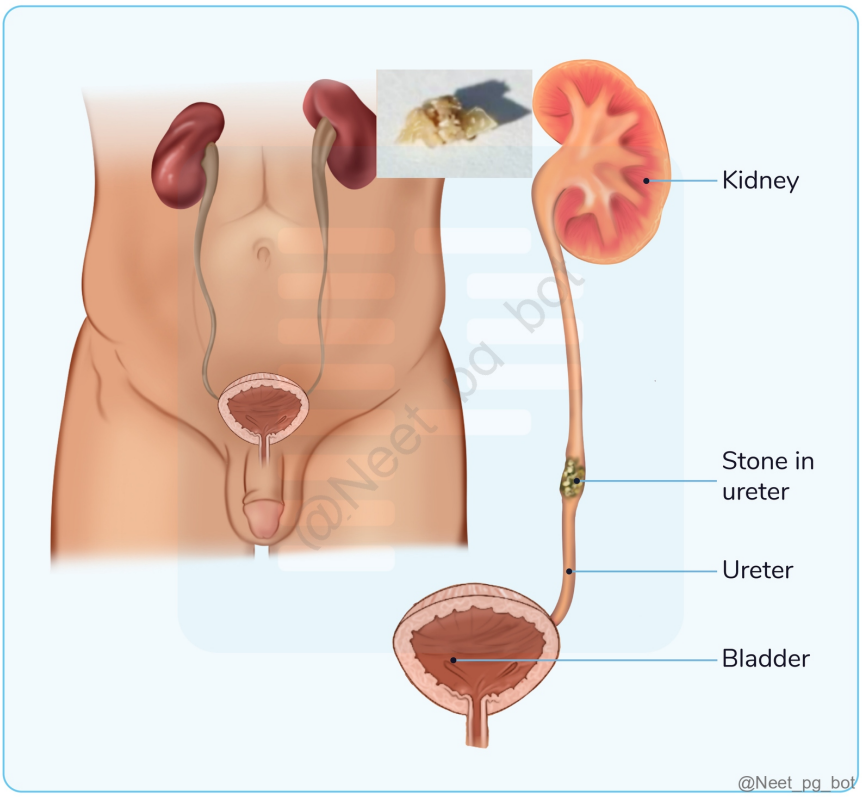
Q40: Which of the following is the recommended treatment for the condition shown in the image, where the size of the stone is 1.5 cm? (Q857820)

A. Percutaneous nephrolithotomy

B. Ureteroscopy

C. ESWL

D. Wait and watch



Correct Answer: B. Ureteroscopy

Explanation: A 2 mm stone in the ureter is managed by ureteroscopy, a minimally invasive procedure that uses a flexible tube inserted through the urethra and bladder to remove or fragment stones smaller than 2 cm. Conservative management of Renal Stones: Indications Upto 5 mm in size Non dilated ureter Stone located in the lower third of the ureter Progressive downward movement on repeated scan Increased fluid intake to promote diuresis and stone passage Medical expulsive therapy (MET) Involves the use of alpha-blocker medications (e.g., tamsulosin) or calcium channel blockers (e.g., nifedipine) Helps to relax the ureter smooth muscle, facilitating the spontaneous passage of the stone Typically recommended for stones up to 10 mm in size. Intervention (if the stone fails to pass or symptoms worsen) Ureteroscopic stone extraction (Option B) It allows fragmentation and removal of stones smaller than 2 cm from the ureter or kidney. Avoided in <5 years ESWL (Extracorporeal Shock Wave Lithotripsy) (Option C ruled out) Radiolucent or radiopaque renal or ureteric stones less than 2 cm in diameter Stones located in the renal pelvis, upper, or middle ureter Patients with normal renal function and no severe hydronephrosis Percutaneous nephrolithotomy (PCNL) (Option A ruled out) To extract stones from the kidney through a dilated tract. For stones larger than 2 cm. Regular follow-up with imaging to monitor stone location and size ESWL (Option C): ESWL can be considered for renal or proximal ureteric stones <2 cm , its effectiveness drops as the stone approaches 1.5 cm and especially in mid/distal ureter where targeting is more difficult. Wait and Watch (Option D) can be appropriate for stones smaller than 5 mm that are not causing significant symptoms, ureteroscopy is recommended when a stone is causing discomfort or complications. A 2 cm stone can be removed or fragmented quickly through ureteroscopy, making it a more proactive and effective treatment option.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Pg, 280, 1476.

↑ *Back to this question in Part A*

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Q41: What is the initial management approach for urinary symptoms in a patient with benign prostatic hyperplasia (BPH)? (Q857822)

A. TURP: Transurethral resection of prostate

B. Tamsulosin

C. Finasteride

D. Observation

Correct Answer: B. Tamsulosin

Explanation: The initial treatment for a patient with Benign Prostatic Hyperplasia (BPH) is Tamsulosin, an α-1 blocker. Management Medical Management 1st line management: ■ 1 Blocker Prazosin Terazosin Silodosin Most commonly used: Tamsulosin (■ 1A selective Blocker) (Option B) 2nd line: 5 ■ Reductase inhibitors Finasteride (Option C ruled out) Dutasteride Triptorelin pamoate Combination treatment with ■ 1 Blocker and 5 ■ Reductase inhibitors are used in large prostate. Surgical Management Indications: No improvement in medical management. Acute retention of urine Chronic urinary retention with residual urine of more than 200 ml. Complications like hydroureter, hydronephrosis, stone formation, recurrent infection, and gross haematuria Surgeries: Gold standard-TURP (Trans urethral resection of prostate). (Option A ruled out) Trans urethral incision of prostate (TUIP) Open prostatectomy procedures Acute management in urinary retention: urethral catheterization and if it fails - suprapubic cystostomy (SPC). Observation (Option D) may be suitable for mild, asymptomatic BPH cases that don't significantly affect quality of life, with regular monitoring and lifestyle changes. However, if symptoms worsen, medications like Tamsulosin are typically recommended, as observation alone is not the standard initial treatment for urinary symptoms.

References:

Bailey and Love's Short Practice of Surgery, 28th Edition, Page 1526-1529

↑ *Back to this question in Part A*

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Q42: Which of the following are true about nephroblastoma except: (Q857825)

A. Treatment is chemotherapy followed by surgery

B. Lung metastasis is common

C. Hematogenous spread

D. Most common intra-abdominal malignancy in children

Correct Answer: D. Most common intra-abdominal malignancy in children

Explanation: Nephroblastoma, or Wilms Tumor, is the most common primary renal malignancy in childhood and the 2nd most common intraabdominal malignancy (neuroblastoma being the most common) in children, typically affecting those aged 2 to 5 years. Cause Caused by mutations in WT1 and WT2 genes on chromosome 11. Associated syndromes Denys-Drash Syndrome (DDS): A rare genetic disorder caused by mutations in the WT1 gene, characterized by a triad of Wilms' tumor, nephrotic syndrome due to diffuse mesangial sclerosis, and male pseudohermaphroditism WAGR Syndrome: A rare genetic condition caused by a deletion on chromosome 11p13, leading to a combination of Wilms' tumor, aniridia (absence of the iris), genitourinary abnormalities, and intellectual disability. Beckwith-Wiedemann Syndrome (BWS): A genetic disorder characterized by overgrowth, increased tumor risk, macroglossia, abdominal wall defects, and hemihyperplasia, often due to abnormalities on chromosome 11p15.5. Perlman Syndrome: A rare genetic disorder characterized by overgrowth, developmental delay, intellectual disability, distinctive facial features, and an increased risk of Wilms' tumor, often caused by mutations in the DIS3L2 gene. Clinical Presentation Most common malignant pediatric renal tumor. Triad: Asymptomatic abdominal mass (MC presentation) Fever (disappears after tumor resection) Hematuria (Gross/Microscopic) Rarely : Pain Investigations USG- Primary investigation CECT- Investigation of choice. MRI - For better soft tissue visualization. Treatment Chemotherapy followed by surgery. (Option A ruled out) Multimodal approach Surgery : Radical nephrectomy or nephron-sparing surgery Chemotherapy : VCD regimen Vincristine, Cyclophosphamide, Dactinomycin/Doxorubicin Radiation therapy : For higher stages or unfavorable histology Staging I. Disease confined to the kidney and completely resectable II . Tumor extends beyond the kidney but can be excised completely Ill . Residual disease after resection with positive lymph nodes and massive spillage IV . Blood-borne metastasis V . Bilateral disease Prognosis Most important Prognostic Factor - Histology > Stage Metastasis Mainly through a hematogenous route into: (Option C ruled out) Lungs (MC) (Option B ruled out) Liver Bones (Rarely)

References:

SRB Manual of Surgery, 6th Edition, Page, 1012-1013.

↑ *Back to this question in Part A*

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Q43: A 25-year-old patient presents to the surgical OPD with a painless left inguinal reducible mass. On examination cough impulse is positive. After further investigations, the patient is diagnosed with an inguinal hernia. What is the surgical management of this patient? (Q857831)

A. Herniotomy

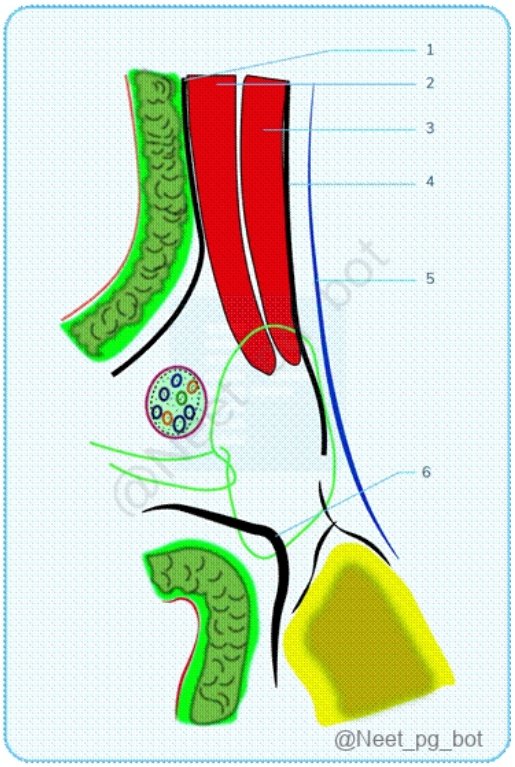
B. Hernioplasty

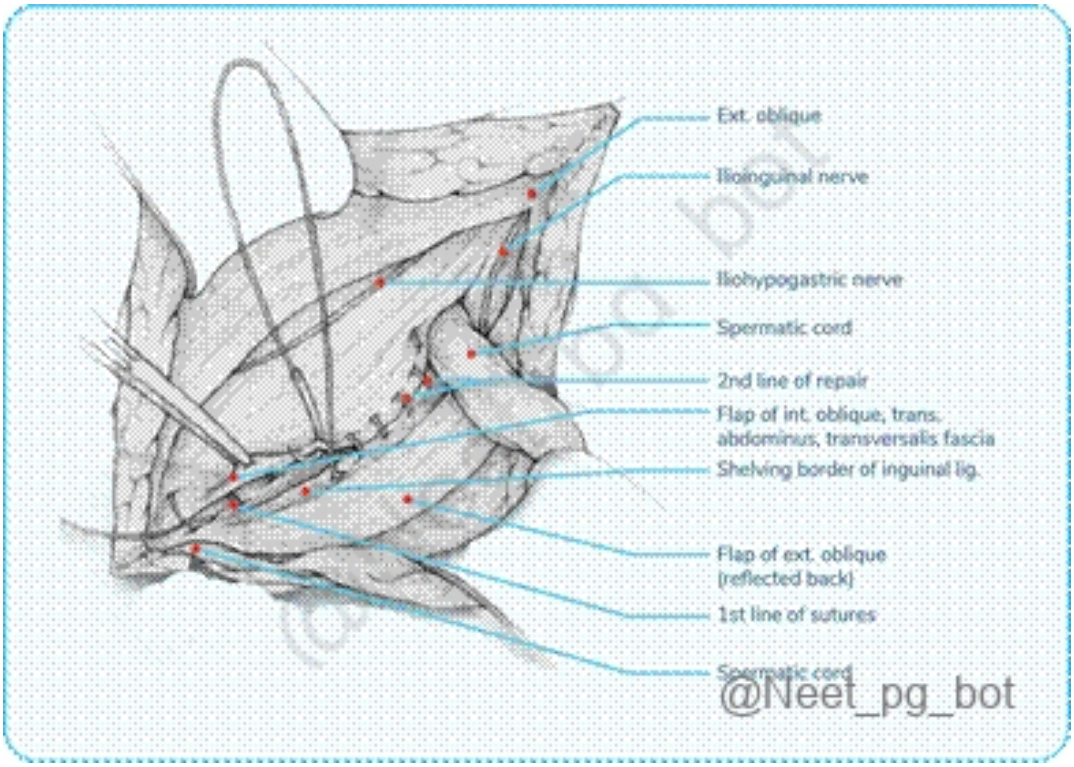
C. Wait and watch

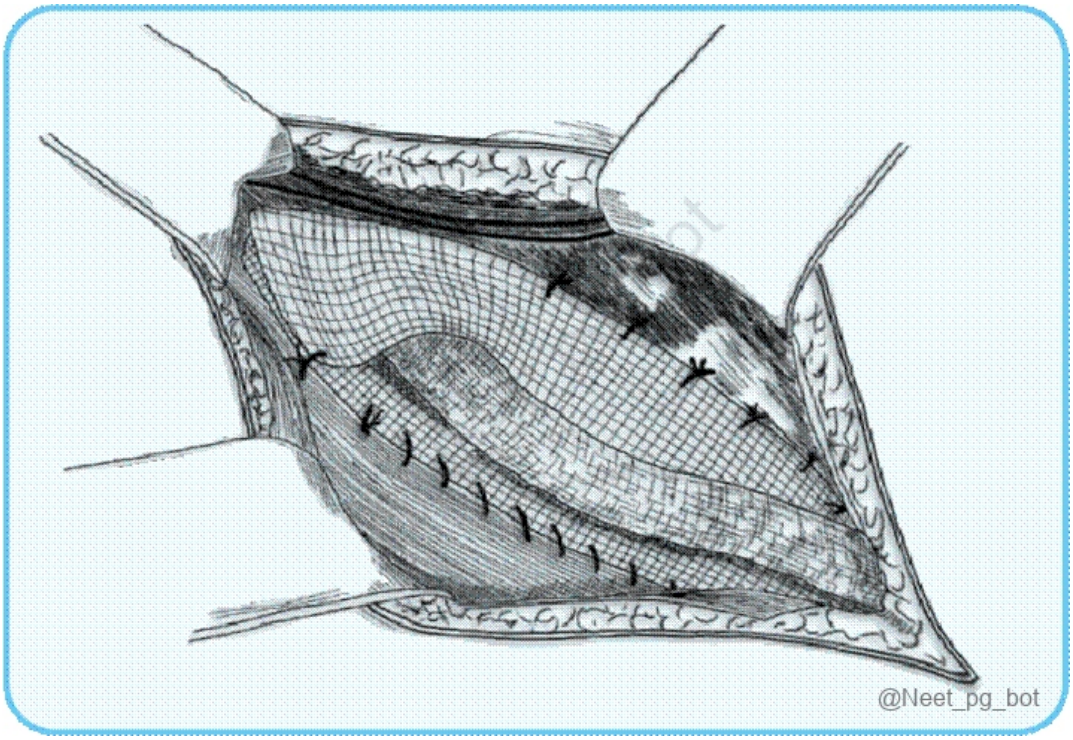
D. Emergency laparotomy

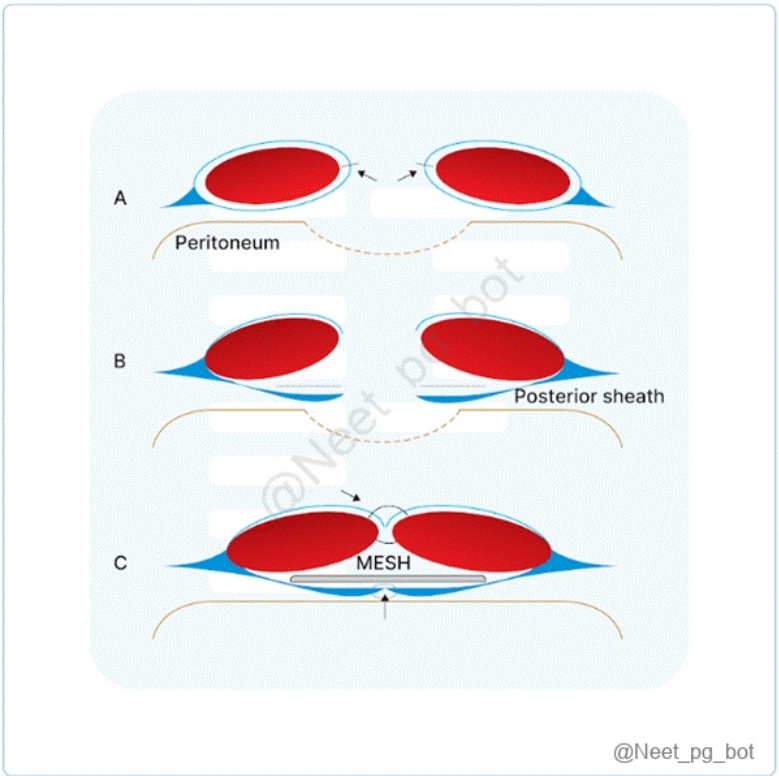
Correct Answer: B. Hernioplasty

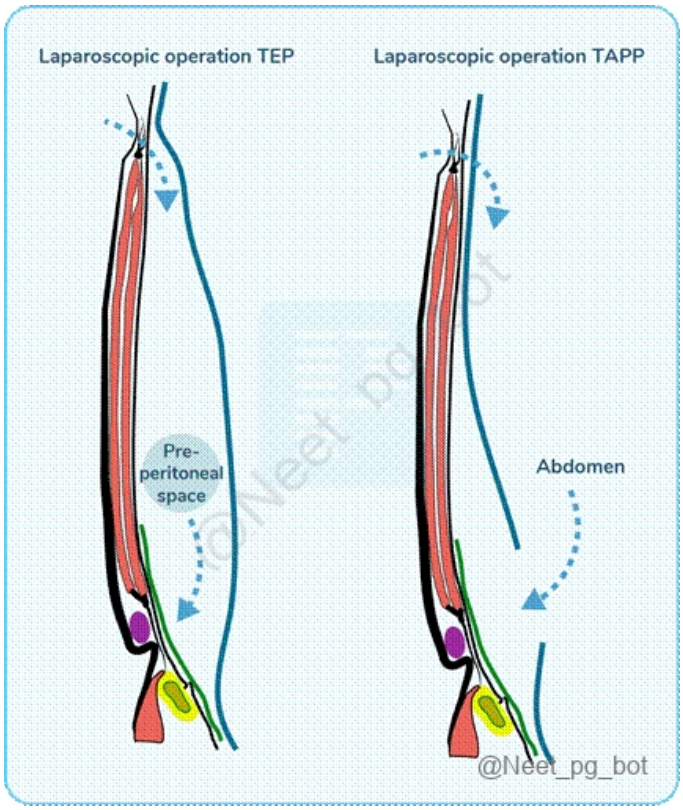
Explanation: Hernioplasty is the preferred surgical approach for Inguinal Hernia in adults, involving the repair of the hernia with synthetic mesh to strengthen the abdominal wall and prevent recurrence. Management of Inguinal Hernia Surgical Approaches: Herniotomy : It involves excising and closing the hernia sac Primarily used in children with lateral hernias and congenital hydrocele. In adults, herniotomy alone is insufficient due to high recurrence rates. (Option A ruled out) Hernioplasty : Includes herniotomy plus inguinal floor reconstruction with mesh (preferred in adults). (Option B) Indications: Direct hernia Recurrent hernia, Re-recurrent hernia lncisional hernia Old age Hernia with weak abdominal muscle tone Sliding hernia. Herniorrhaphy : Includes herniotomy plus reconstruction of the inguinal floor with sutures Techniques: Bassini's Repair: Involves suturing the internal oblique, transversus abdominis, and fascia transversalis to the inguinal ligament. Known as a triple-layer repair. Higher recurrence rates. {{caption_text}} Shouldice Repair: involves a four-layer repair (double breasting of fascia transversalis), resulting in lower recurrence rates compared to Bassini's. {{caption_text}} Modified Shouldice : A six-layer repair, including additional layers for reinforcement. Anterior Tension-Free Repair: Lichtenstein Repair : Utilizes a mesh to reinforce the inguinal floor, which is considered the gold standard due to lower recurrence rates and faster recovery. It is a a tension-free, simple, fat, polypropylene mesh repair for inguinal hernia. (Option A) {{caption_text}} Open Preperitoneal Repair: Stoppa Repair : Uses a mesh to reinforce the area behind the peritoneum Done in Recurrent inguinal hernia Laparoscopic Hernia Repair: Totally Extraperitoneal (TEP) Repair Transabdominal Preperitoneal (TAPP) Repair {{caption_text}} Wait and watch (Option C) may be considered for small, asymptomatic hernias in low-risk patients, but in this case, surgical intervention is recommended to prevent complications like incarceration or strangulation, as inguinal hernias do not resolve on their own. Emergency laparotomy (Option D) is reserved for incarcerated or strangulated hernias with compromised blood supply or bowel obstruction, not necessary for this reducible and painless hernia.


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2
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Ext. oblique
Ilioinguinal nerve
Iliohypogastric nerve
Spermatic cord
2nd line of repair
Flap of int. oblique, trans. abdominus, transversalis fascia
Shelving border of inguinal lig.
Flap of ext. oblique (reflected back)
1st line of sutures
Spermatic cord
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A
Peritoneum
B
Posterior sheath
C
MESH
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References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1068.

↑ *Back to this question in Part A*

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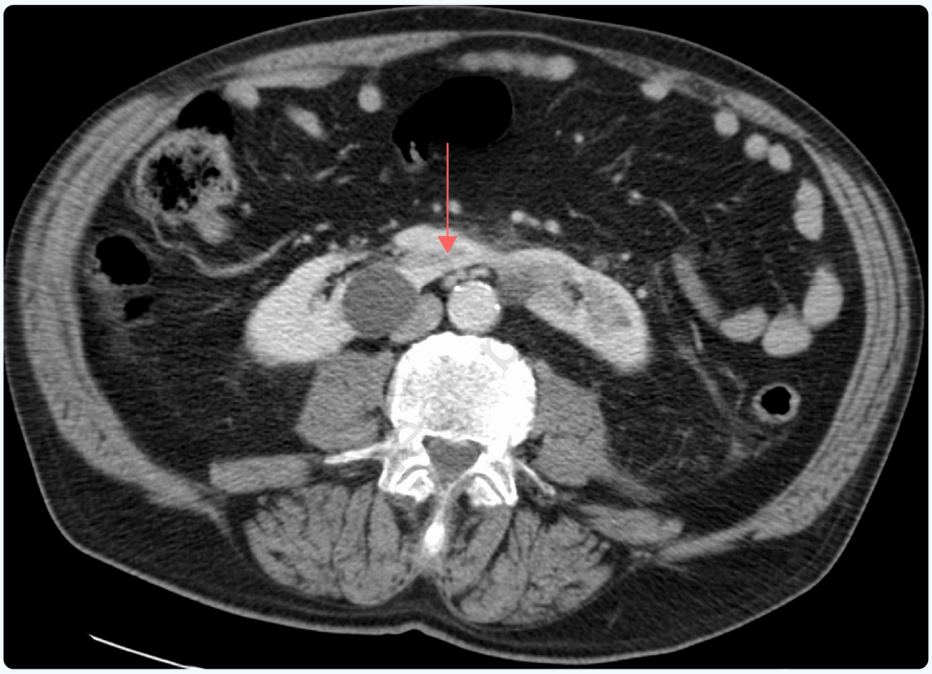
Q44: A male patient presented with complaints of hematuria and recurrent urinary tract infection. You notice the following finding in his CT. What is the likely condition indicated by the arrow in the image? (Q857867)

A. Polycystic kidney disease

B. Horseshoe kidney

C. Hydronephrosis

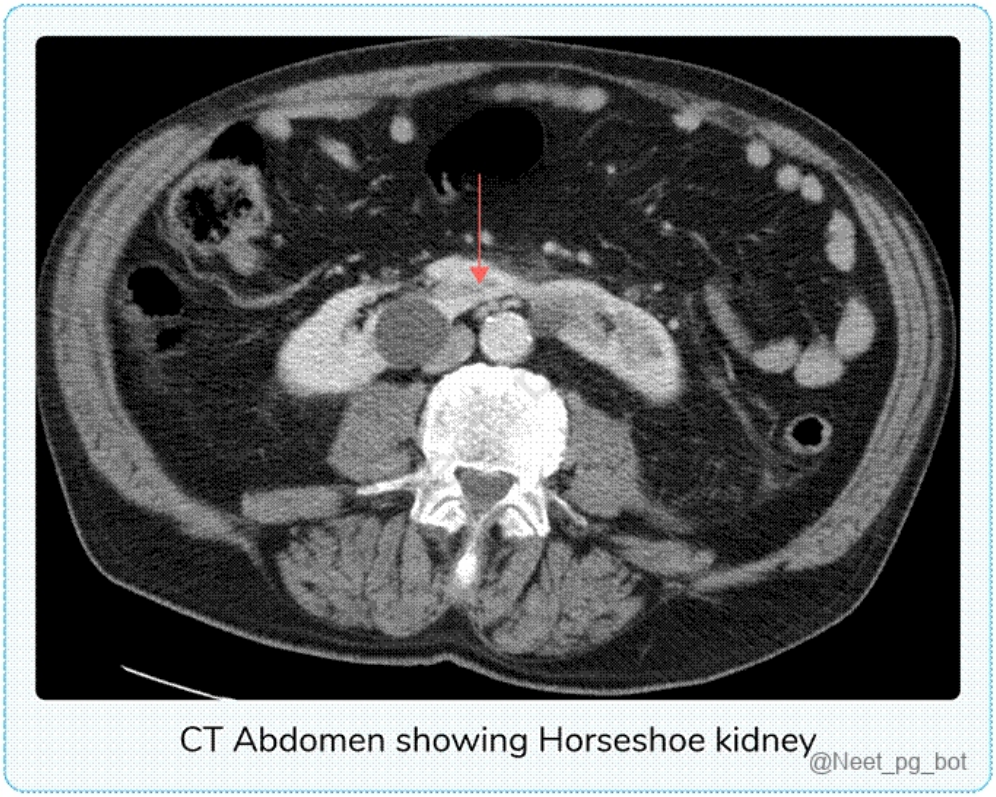
D. Pancake kidney

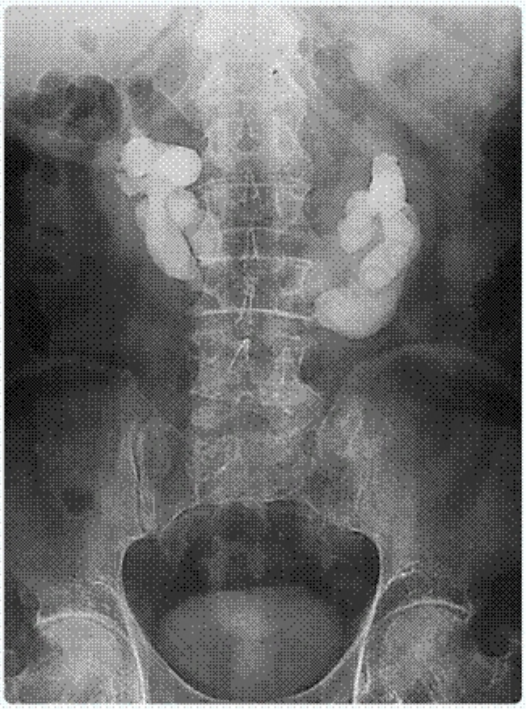


Correct Answer: B. Horseshoe kidney

Explanation: The patient, who presents with hematuria and recurrent urinary tract infections, is diagnosed with Horseshoe Kidney , as indicated by a CT abdomen revealing the fusion of the two kidneys at their lower ends, forming a U-shaped structure. Horseshoe Kidney It is a congenital condition in which the two kidneys are fused at the lower ends, forming a U-shaped structure. Cause During fetal development the kidneys fuse at their lower poles, forming a U-shaped structure. This fusion results in the inferior mesenteric artery preventing the ascent of the isthmus of the kidney to its normal position in the abdomen, leading to an abnormal location lower in the abdomen. Clinical Features Mostly asymptomatic. Pain: due to obstruction or renal stones. Recurrent urinary tract infections (UTIs) Hydronephrosis Hematuria Rovsing's syndrome: Hyperextension of the spine- nausea, vomiting, abdominal pain. Investigation CT Angiography (CT Angio): This is the investigation of choice for diagnosing a horseshoe kidney, as it allows for detailed visualization of the renal anatomy, the abnormal vascular supply, and associated complications. {{caption_text}} CT Abdomen showing Horseshoe kidney Contrast-Enhanced CT (CECT): Used when CT Angio is not available Intravenous Pyelogram (IVP) - characteristic findings include : Medial Orientation of Calyces: Referred to as the " Hand Joining Sign ." High Insertion of Ureters with Anterior Transposition: This creates a "Flower Vase" appearance of the ureters. {{caption_text}} {{caption_text}} Management Asymptomatic Patients: Typically do not require treatment, but should be monitored periodically. Symptomatic Patients: UPJ Obstruction: Surgical intervention such as pyeloplasty Kidney Stones: Management may include conservative measures like increased fluid intake, medical therapy, or surgical removal UTIs: Treated with antibiotics, and preventive measures may be considered if infections are recurrent. Isthmus Management: The isthmus of the horseshoe kidney should not be divided surgically as it contains functional renal tissue. Pregnancy Considerations: A horseshoe kidney can lead to dystocia (difficult labor) due to the kidney's abnormal position. Polycystic kidney disease (Option A) is a genetic disorder with multiple fluid-filled cysts causing kidney enlargement. CT imaging shows round or oval cysts, but no kidney fusion. The CT scan in this case, showing fused kidneys, is inconsistent with PKD. {{caption_text}} Hydronephrosis (Option C) is caused by urinary tract

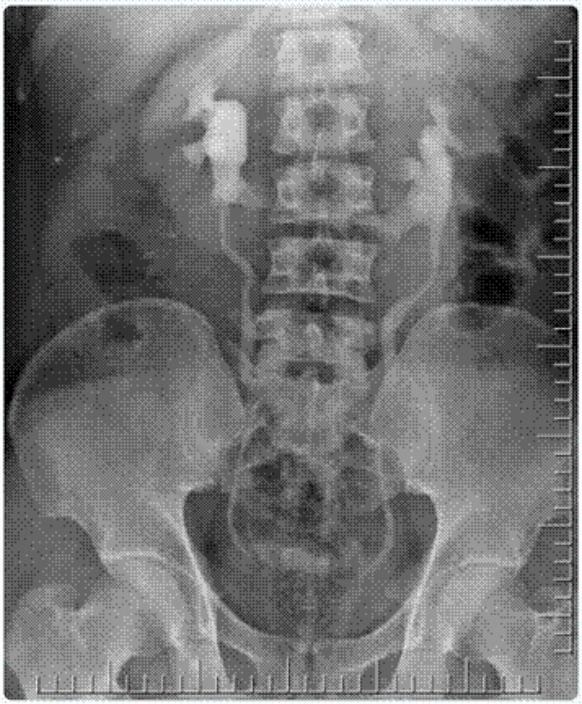
blockage, leading to kidney swelling. CT shows dilated renal pelvis and calyces, but no kidney fusion. The CT scan here shows fused kidneys, indicating horseshoe kidney, not hydronephrosis. {{caption_text}} Pancake kidney (Option D) is a rare congenital anomaly where the kidneys fuse into a flattened, disc-like shape. On CT, it appears as a flattened mass lower in the abdomen, unlike the U-shaped fusion seen in horseshoe kidney. This case shows a U-shaped fusion, indicating horseshoe kidney, not pancake kidney. {{caption_text}}





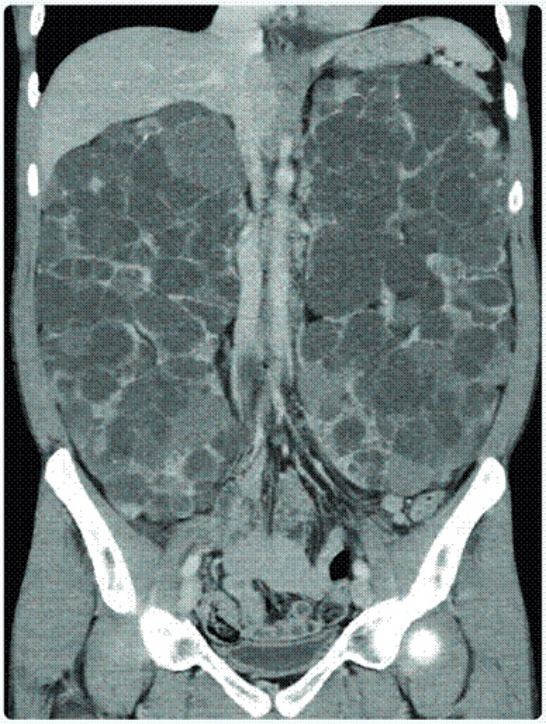
Hand joining sign

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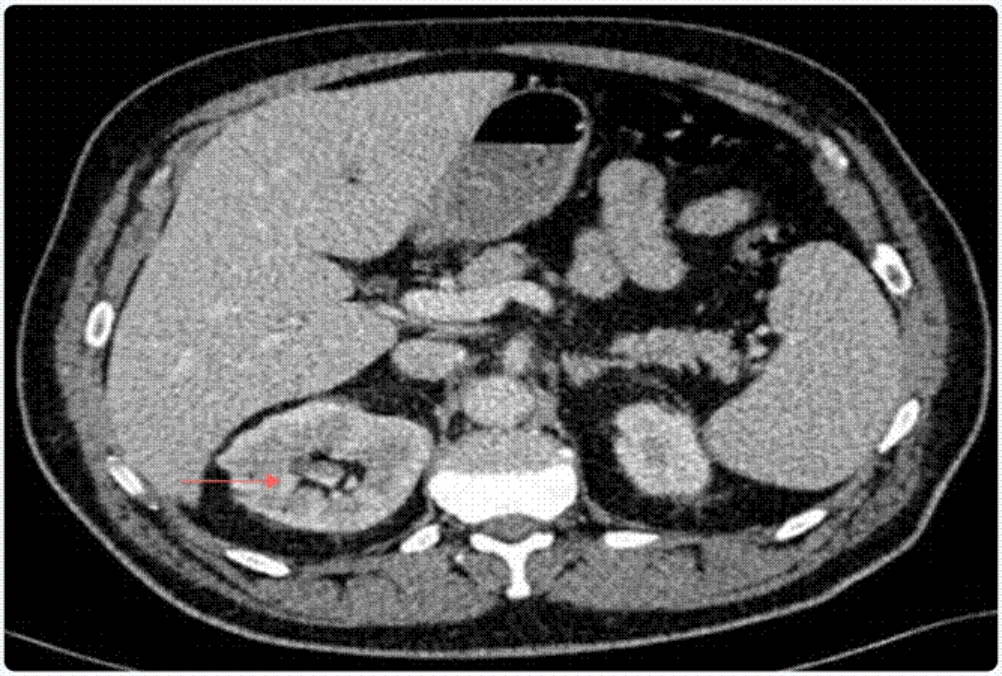


Flower vase appearence of ureter

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CT showing ADPKD@Neet_pg_bot



CT image showing hydronephrosis in the right kidney (Arrow)
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References:

Bailey and Love's Short Practice of Surgery, 28th Edition, Page 1466.

Grainger and Allison's Textbook of Diagnostic Radiology, 7th Edition, Page 776.

↑ *Back to this question in Part A*

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Q45: Which is the correct sequence for the correction of hypospadias? Urethroplasty Penile de-gloving Orthoplasty Glanuloplasty (Q855696)

A. 1,3,2,4

B. 2,3,1,4

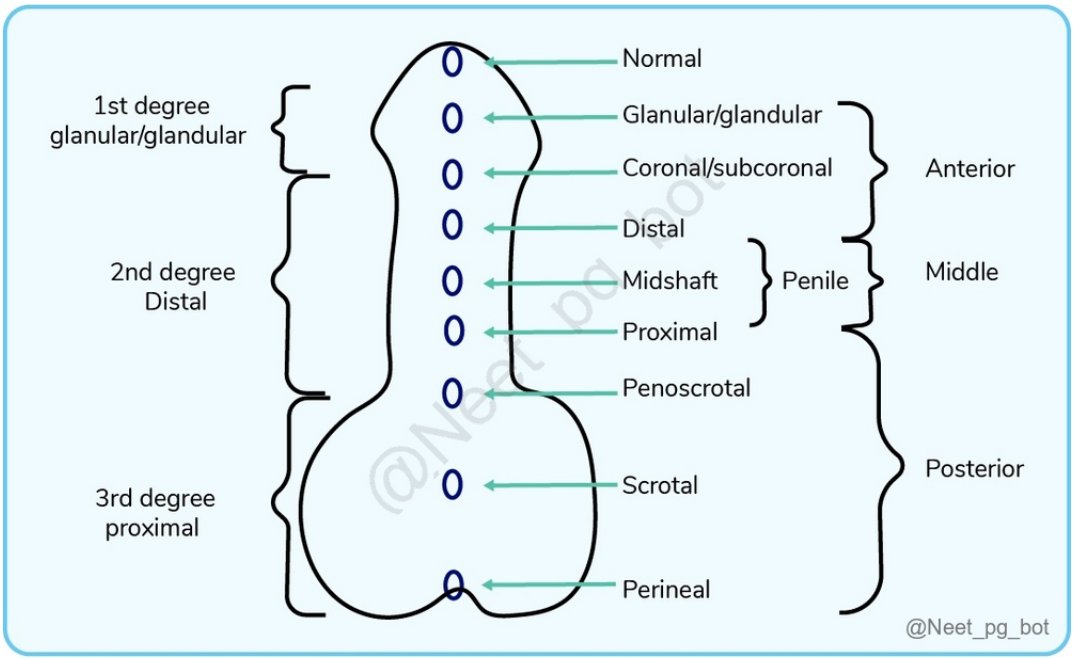
C. 3,1,4,2

D. 1,3,4,2

Correct Answer: B. 2,3,1,4

Explanation: The correct sequence for the correction of Hypospadias is 2,3,1,4 Caused by failure of fusion of urethral folds- meatus in ventral aspect Affects about 1 in 300 male live births, The most common congenital abnormality of the urethra. Characterized by: Ectopic ventrally located urethral meatus, Ventral penile curvature (chordee), Incomplete dorsal hood prepuce. Classification/Types: Glanular Hypospadias: Most common type Coronal Hypospadias Penile Hypospadias Penoscrotal Hypospadias Perineal Hypospadias Scrotal Hypospadias Distal penile Hypospadias {{caption_text}} Hypospadias Repair Steps De-gloving → Orthoplasty → Urethroplasty → Meatoplasty → Glanuloplasty → Penoplasty → Scrotoplasty Degloving : Removal of the penile skin to expose the underlying structures. (Statement 2) Orthoplasty : Correction of penile curvature and any

associated penile shaft issues. This step involves mobilising and repositioning the urethral plate if necessary. (Statement 3) Urethroplasty : Creation or reconstruction of the neourethra using tissue flaps or grafts to form a functional urethra. (Statement 1) Providing vascularised coverage for the urethroplasty. Glanuloplasty : Reconstruction of the glans penis, focusing on creating a normal appearance and aligning the meatus. (Statement 4) Penoplasty : Reconstruction of the penile shaft to restore or enhance its normal appearance and function. This may involve skin flaps or grafts. Scrotoplasty : Correction or reconstruction of the scrotum, which may be necessary if there are associated anomalies or for cosmetic reasons.



References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1539-1540. Steps

↑ *Back to this question in Part A*

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Q46: A 30-year-old male patient presents with a pelvic fracture following blunt abdominal trauma. No blood is seen at the meatus. Catheterisation does not produce significant urine output. The radiological image is given below. What is the next step in management? (Q855183)

A. Suprapubic cystostomy

B. Per Urethral catheterisation

C. Laparotomy

D. Pelvic packing along with B/L percutaneous nephrostomy



Correct Answer: C. Laparotomy

Explanation: The patient’s pelvic fracture, absence of blood at the meatus, and minimal urine output on catheterisation, along with radiological findings suggestive of Intraperitoneal Bladder Rupture , indicate that immediate laparotomy is required. Intraperitoneal Bladder Rupture Involves a tear or injury to the peritoneum over the bladder, and urine leaks into the peritoneal cavity in males. Causes Often occurs in a fully distended bladder, usually due to trauma or injury Clinical Features Sudden, severe pain in the suprapubic region. Signs of shock and syncope. Diffuse abdominal pain with later features of peritonitis. Abdominal distension. Haematuria Absence of desire to urinate Diagnosis Plain X-ray: It may show a ground glass appearance. Peritoneal Tap: Used to collect urine from the abdominal cavity. Cystography: Iodine dye is injected via a catheter to visualise bladder tears and the dye entry into the peritoneal cavity. The contrast outlines the bowel loops. Ultrasound: To assess other abdominal injuries. {{caption_text}} Treatment Emergency Laparotomy is required. (Option C) . Bladder tear is sutured with polylactic acid (vicryl) in two layers. Peritoneal wash to clean out the peritoneal cavity. Separate drainage for prevesical space and peritoneal cavity. Administration of specific antibiotics to prevent sepsis. Catheterisation: Malecot’s catheter is placed suprapubically. Foley's catheter passed urethrally. Complications Cystitis /and pyelonephritis. Peritonitis. Pelvic abscess. Fistula formation (vesicovaginal or rectovesical). Paralytic ileus. Hemorrhage. Suprapubic cystostomy (Option A) is used to divert urine in cases of bladder injuries, but it’s typically considered when there is a lower urinary tract injury, such as bladder rupture without peritoneal involvement. Per Urethral catheterisation (Option B) is performed to assess for urethral injury or urinary retention. However, in cases of pelvic fractures with suspected bladder rupture (especially intraperitoneal), catheterisation may exacerbate the injury or is not helpful. Pelvic packing along with B/L percutaneous nephrostomy (Option D) is typically used for severe hemorrhagic shock and pelvic fractures with significant bleeding, often in cases of pelvic vascular injuries.



CT showing intra-peritoneal bladder rupture

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References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1520. Textbook of SRB’s Surgical Operations, 6th Edition, Page, 224-225.

↑ *Back to this question in Part A*

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Q47: What is the most likely diagnosis for a young girl who presents with continuous dribbling of urine despite voiding normally, as reported by her parents, who mention her never being completely dry since birth? (Q857151)

A. Ectopic ureter

B. Ureterocele

C. Congenital megaureter

D. Vesicoureteric reflux

Correct Answer: A. Ectopic ureter

Explanation: In females, an ectopic ureter opens below the sphincter into the urethra or vagina. It presents as continuous urinary dribbling despite normal voiding. Diagnosis is based on history and confirmed by excretory urography. An intravenous dye, such as indigo carmine, can help visualise the ectopic orifice. Ureterocele (Option B) Would present with recurrent UTIs, voiding difficulty , and bladder outlet obstruction rather than continuous dribbling. Congenital megaureter (Option C) Typically presents with hydronephrosis and recurrent UTIs , not continuous dribbling. Vesicoureteric reflux (Option D) Causes recurrent UTIs and hydronephrosis but does not cause continuous dribbling from birth.

References:

Bailey and Love Short Practice of Surgery, 28th Edition, Page 1467

↑ *Back to this question in Part A*

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Q48: A 1-month-old child is brought to the OPD for consultation regarding an empty scrotal sac. On examination B/L inguinal masses are palpable. What is the next step of management for this child? (Q857163)

A. Perform karyotyping

B. Surgical exploration within the next 2 weeks

C. Perform orchidopexy now

D. Wait and watch for spontaneous descent within the next 6 months.

Correct Answer: D. Wait and watch for spontaneous descent within the next 6 months.

Explanation: A palpable bilateral (B/L) inguinal mass in a 1-month-old with an empty scrotal sac suggests undescended testes (cryptorchidism). The inguinal masses are likely the testes themselves In most cases, these testes will descend spontaneously within the first few months of life. It's recommended to wait for at least 6 months before considering further intervention. Perform karyotyping (Option A): Karyotyping is generally not the first step for a palpable undescended testis. It's usually reserved for cases of non-palpable testes , particularly when associated with other genital anomalies , as it may suggest a disorder of sexual development . Surgical exploration within the next 2 weeks (Option B) & Perform orchidopexy now (Option C): Early surgical intervention is not recommended. The spontaneous descent rate is high in the first 6 months. Surgical exploration and orchidopexy are typically performed if the testes have not descended on their own by 6-12 months of age. Operating on a very young infant is also associated with a higher risk of anesthetic complications.

References:

Bailey & Love's Short Practice of Surgery (28th Edition), Page 1559 -1561.

Schwartz's Principles of Surgery (11th Edition), Page 1777.

SRB's Manual of Surgery (6th Edition), Page 1065 -1068.

↑ *Back to this question in Part A*

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Q49: Which of the following is the most common type of radiolucent renal stone? (Q857202)

A. Calcium Oxalate Stones

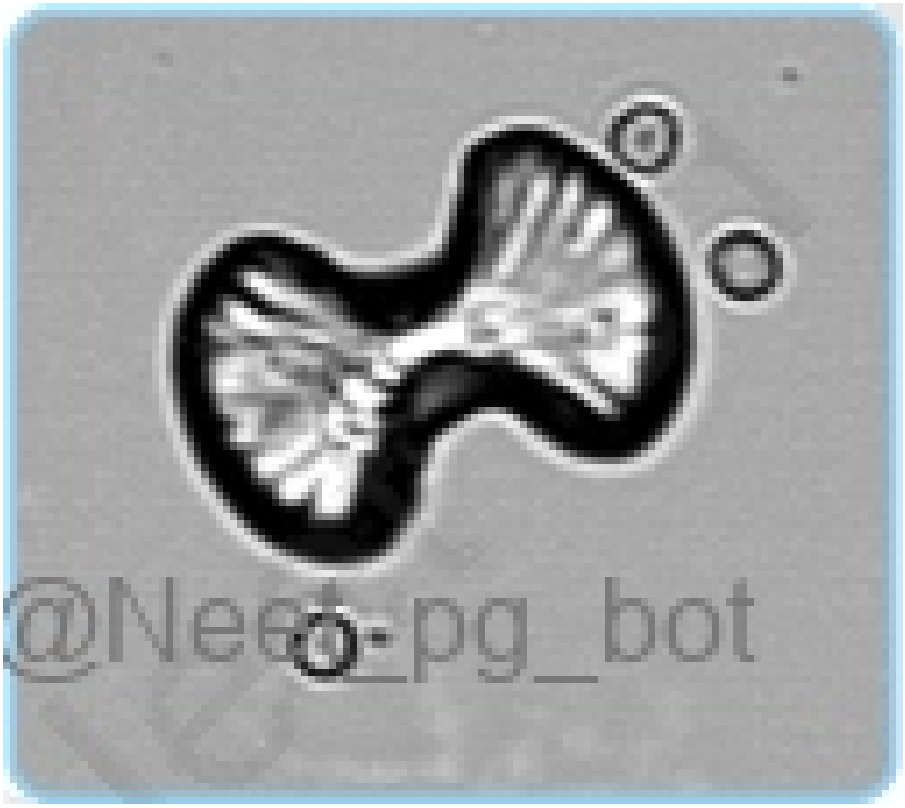
B. Uric Acid Stones

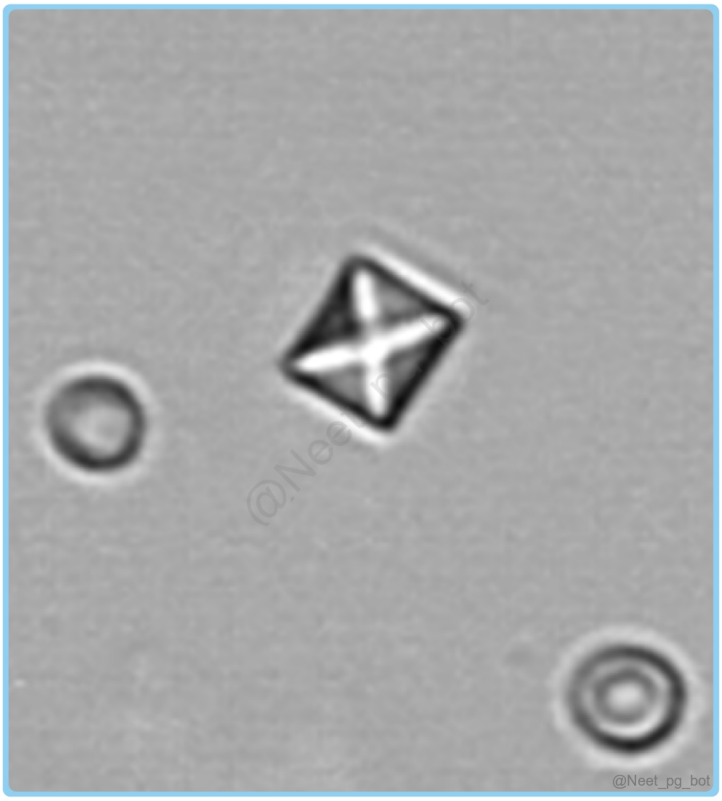
C. Cystine Stones

D. Xanthine Stones

Correct Answer: B. Uric Acid Stones

Explanation: Radiopaque stones: Calcium Oxalate Stones (Option A ruled out) Calcium Phosphate Stones Struvite Stones Cystine stones are also mildly radiopaque (Option C ruled out) Radiolucent stones include: Uric acid stones (most common) (Option B) Xanthine stones (rarely seen, mainly in patients with xanthinuria) (Option D ruled out) Stone Type Features Image Calcium Oxalate The most common type of stone (60–85% of all stones) ; Radiopaque Associated with hypercalciuria, hypercalcaemia, hyperoxaluria, hyperuricosuria, and hypocitraturia Types: monohydrate (dumbbell-shaped) , dihydrate (envelope shaped) ■ {{caption_text}} ■ ■■ {{caption_text}} ■ ■ Calcium Phosphate Pure calcium phosphate stones are rare Types include apatite and brushite stones Apatite stones are seen with infection; brushite stones are associated with distal renal tubular acidosis. ■ {{caption_text}} ■■ Struvite Aka staghorn calculi / Triple phosphate stone (Ca, Mg, NH4+, Phosphate) Radiopaque Infection stones that form in alkaline urine due to urease-producing bacteria (e.g., Proteus, Klebsiella, Serratia, Enterobacter) ■■ {{caption_text}} ■ ■ ■■ Cystine Radiopaque , Constitute approximately 1% of stones Result from cystinuria , an autosomal recessive inherited disease that causes decreased reabsorption of cystine. Very hard stones due to disulfide bonds {{caption_text}} Uric Acid Radiolucent Promoted by hyperuricosuria, which can be caused by conditions like gout and myeloproliferative disorders Precipitates in acidic urine and remains soluble in alkaline urine. ■ {{caption_text}}

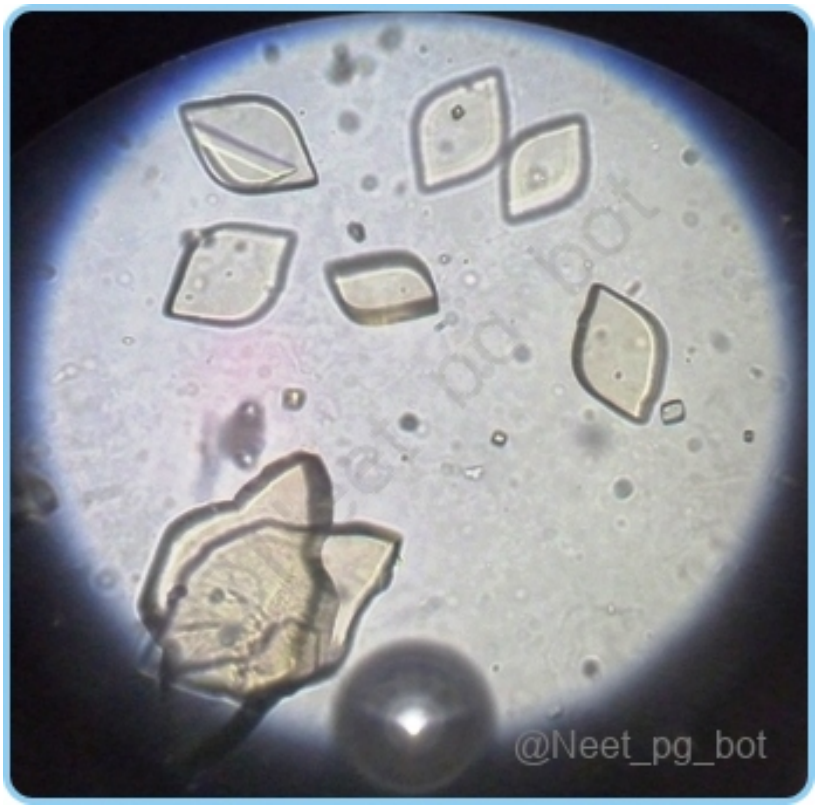

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References:

Bailey and Love's Short Practice of Surgery, 28th Edition, Page 1474-1475

↑ *Back to this question in Part A*

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Q50: For which of the following conditions is the Whitaker test recommended? (Q857211)

A. Hydronephrosis

B. Posterior urethral valve

C. Urethral atresia

D. Urethral stricture

Correct Answer: A. Hydronephrosis

Explanation: Whitaker test Feature Details Definition A urodynamic test that measures the pressure gradient between the renal pelvis and bladder to assess upper urinary tract obstruction. Indications Equivocal cases of upper urinary tract obstruction, PUJ obstruction, post-pyeloplasty evaluation, distinguishing true obstruction from hydronephrosis. Procedure 1. Percutaneous nephrostomy placed in the renal pelvis. 2. Bladder catheter inserted for pressure measurement. 3. Fluid infusion into renal pelvis at 10 ml/min. 4. Pressure difference between renal pelvis & bladder recorded. Interpretation <15 cm H■O → No obstruction. 15–22 cm H■O → Indeterminate (needs further evaluation). >22 cm H■O → Significant obstruction present. Advantages Helps differentiate true obstruction vs. non-obstructive dilation. Useful in post-surgical cases. Limitations Invasive (rarely used due to modern imaging). Replaced by diuretic renal scan (DTPA/EC scan) & MR Urography. Posterior urethral valve (Option B) PUV is a lower urinary tract obstruction (at the urethra), and the Whitaker test assesses upper tract obstruction . Best Test: Voiding Cystourethrogram (VCUG). Urethral atresia Congenital absence of urethral patency (Option C) is usually diagnosed prenatally or at birth. Whitaker test is not needed , as the condition is identified early with fetal ultrasound . Urethral stricture (Option D) Affects the lower urinary tract, while the Whitaker test evaluates upper urinary tract obstruction. Best Test: Retrograde Urethrogram (RUG) or Uroflowmetry.

References:

https://pubmed.ncbi.nlm.nih.gov/25015627/

↑ *Back to this question in Part A*

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Q51: A 33-year-old man was referred to the surgery OPD from the infertility clinic. On palpation, a bag of worms sensation was felt with dilated veins. What is the most likely diagnosis? (Q857251)

A. Hydrocele

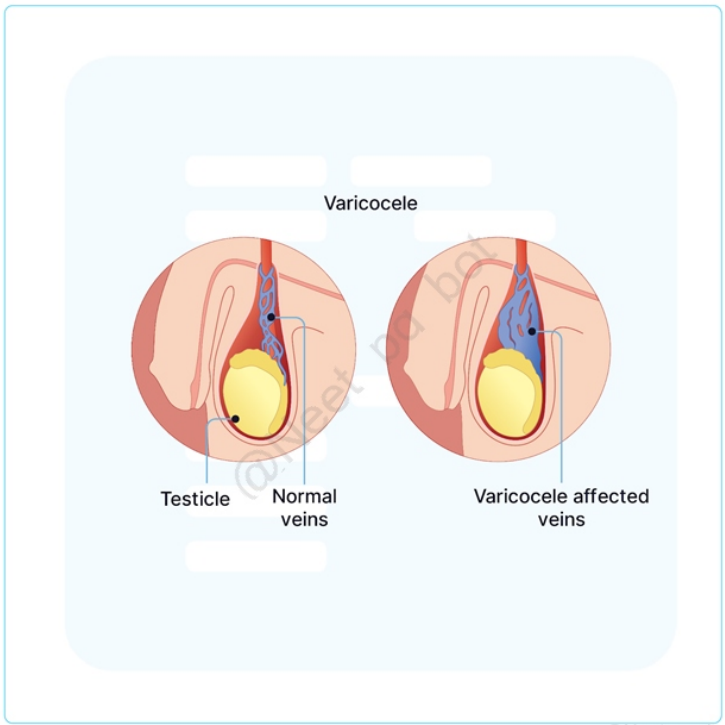
B. Varicocele

C. Testicular torsion

D. Epididymo Orchitis

Correct Answer: B. Varicocele

Explanation: Varicocele : Dilatation and tortuosity of the pampiniform plexus of veins and testicular veins. Varicocele Common Occurrence More common in tall, thin young men More frequent on the left side but can be bilateral Causes Idiopathic Absence or incompetent valve at the junction of the left testicular vein and left renal vein Perpendicular entry of the left testicular vein into the left renal vein Left-sided renal cell carcinoma causing blockage of the left testicular vein Effects Increased temperature in the scrotum, depressing spermatogenesis and causing infertility Symptoms Swelling at the root of the scrotum Dragging pain in the groin and scrotum "Bag of worms" feeling Impulse on coughing Swelling reduces on lying down (except in renal cell carcinoma) Investigations Venous Doppler of the scrotum and groin Ultrasound of the abdomen to check for kidney tumours Semen analysis Treatment Palomo's Operation: Suprainguinal extraperitoneal ligation of the testicular vein Ligation of veins Excision of veins Hydrocele (Option A) is an abnormal collection of serous fluid in some part of the processus vaginalis, usually the tunica. Testicular torsion (Option C) is seen in a teenager or young adult male. It is easily missed. Pain can be referred to the right iliac fossa, and appendicitis will be suspected unless the scrotum is examined. Epididymo Orchitis (Option D) is intrascrotal swelling, most common among intra-scrotal swelling. It is usually caused as a result of the retrograde ascent of Pathogens.



References:

SRB Manual of Surgery, 6th Edition, Pages 1063-1064

↑ *Back to this question in Part A*

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Q52: What would be the best treatment option for a patient who has been diagnosed with renal cell carcinoma and has a tumour measuring 10 cm in size, located at the lower part of the kidney, and has negative regional lymph nodes? (Q857266)

A. Radical nephrectomy

B. Partial nephrectomy

C. Radiotherapy

D. Chemotherapy

Correct Answer: A. Radical nephrectomy

Explanation: Tumor size: The tumour is 10 cm, which classifies it as T2 RCC (T2a if 7–10 cm, T2b if >10 cm but still confined to the kidney). Location: Since the tumour is large and located in the lower part of the kidney, a partial nephrectomy is not feasible due to a high risk of incomplete resection or complications. No lymph node involvement: There is no evidence of metastasis (N0M0), making surgery the best option. Partial nephrectomy (Option B) Indicated for tumours <7 cm (T1) when feasible. A 10 cm tumour is too large for nephron-sparing surgery. Radiotherapy (Option C) RCC is chemo-resistant . Systemic therapy is considered only for metastatic disease (stage IV). Chemotherapy (Option D) Chemotherapy isn't generally advised for renal cell carcinoma.

References:

Sabiston Textbook of Surgery, 21st Edition, Page 2091, 2092

↑ *Back to this question in Part A*

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Q53: What is the most likely diagnosis for a patient who has a scrotal mass on the left side that is hard in texture, has uneven edges, does not decrease in size when lying down or manipulated, does not have a cough impulse, but shows enlargement in the para-aortic lymph nodes? (Q857268)

A. Hydrocele

B. Direct inguinal hernia

C. Indirect inguinal hernia

D. Metastasising testicular tumor

Correct Answer: D. Metastasising testicular tumor

Explanation: Scrotal mass on the left side → indicate a testicular pathology. Hard texture with uneven edges → Indicative of a solid tumor , likely testicular cancer (e.g., seminoma or non-seminomatous germ cell tumor). Does not decrease in size when lying down or manipulated → Rules out conditions like hydrocele or hernia . No cough impulse → Further rules out an inguinal hernia . Enlarged para-aortic lymph nodes → Strongly indicates metastatic spread from a testicular malignancy , as testicular tumors typically metastasize to retroperitoneal (para-aortic) lymph nodes . Hydrocele (Option A) Soft, cystic , transilluminates, and size decreases on lying down . No involvement of para-aortic lymph nodes . Direct Inguinal Hernia (Option B) Usually reducible , with a positive cough impulse . Does not cause para-aortic lymph node enlargement. Indirect Inguinal Hernia (Option C) Often soft, reducible , and may extend into the scrotum . Positive cough impulse . Does not cause para-aortic lymph node enlargement.

References:

https://www.ncbi.nlm.nih.gov/books/NBK563159/?utm_source

↑ *Back to this question in Part A*

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Q54: A 10-month-old male baby presented with an empty scrotum. Ultrasonography revealed that the right testis was found in the right inguinal canal, while the left testis was found in the perineum. Comment on the diagnosis of this baby. (Q857500)

A. Bilateral undescended testis

B. Bilateral ectopic testis

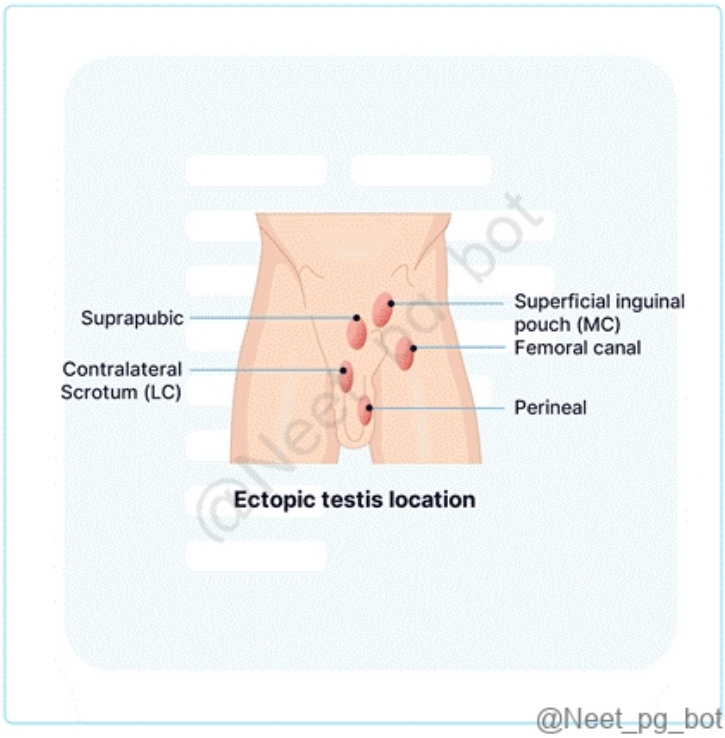
C. Right-side undescended testis and left-sided ectopic testis

D. Right side ectopic testis and left side undescended testis

Correct Answer: C. Right-side undescended testis and left-sided ectopic testis

Explanation: In the case of undescended testis the testis is usually found in the route at which it descends, such as the inguinal canal. In the above patient, the right testis was found in the inguinal canal. In ectopic testis, the testis is found in places other than the route of descent of the testis, as in this case, the left testis is seen in the perineum. Hence, the correct choice is Right-side undescended testis and left-sided ectopic testis. Bilateral undescended testis

(Option A) The left testis is found in the perineum, which is indicative of ectopic testis. Bilateral ectopic testis (Option B) The right testis is found in the inguinal canal, which is indicative of an undescended testis. Right side ectopic testis and left side undescended testis (Option D) The right testis is found in the inguinal canal and is indicative of undescended testi,s whereas the left side is found in the perineum which is indicative of ectopic testis. Ectopic testis An ectopic testis is when a testicle fails to descend into the scrotum and lies outside the normal descent tract, typically due to abnormalities in the gubernaculum {{caption_text}} Management: Surgical Correction (Orchidopexy): To reposition the testis into the scrotum. Complications: Infertility Increased risk of testicular cancer



References:

SRB's Manual of Surgery, 6th Edition, Page 1068.

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1559 -1561.

↑ *Back to this question in Part A*

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Q55: What is the most probable diagnosis for a 14-year-old boy who is experiencing sudden scrotal pain, where physical examination reveals a swollen and red scrotum with the right testes being retracted, absent cremasteric reflex, and negative Prehn's sign? (Q857504)

A. Right-sided hydrocele

B. Strangulated inguinal hernia

C. Right testicular torsion

D. Right epididymo orchitis

Correct Answer: C. Right testicular torsion

Explanation: In the case of torsion of the testis, the testicular clinical features include an empty, swollen scrotum, which is edematous on the side of the lesion. Tender lump at the external abdominal ring. Elevation of the scrotum increases pain. Right-sided hydrocele (Option A) Hydrocele presents with a painless swelling. No sudden pain is seen in the right-sided hydrocele. Hence, it is not the correct choice. Strangulated inguinal hernia (Option B) In the case of a strangulated inguinal hernia, the scrotum will show ischemic changes but will not be edematous. Right epididymo orchitis (Option D) It is an inflammation of the epididymis. It is caused by a bacterial infection and presents as a swelling on the posterior aspect of the epididymis.

References:

SRB Manual of Surgery, 6th Edition, Pages 1068-1070

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Q56: What is the likely diagnosis for an elderly male patient who has come to the hospital with lower back pain, a movable mass in the lower back that becomes more prominent when breathing in and a general feeling of weakness? The lab tests show the presence of red blood cells in the urine, with no sign of pus cells. (Q857531)

A. Polycystic kidney disease

B. Hydronephrosis

C. Renal cell carcinoma

D. Chronic pyelonephritis

Correct Answer: C. Renal cell carcinoma

Explanation: Renal cell carcinoma is a type of kidney cancer that originates in the cells of the kidney tubules. It commonly presents with symptoms such as persistent back pain, a palpable mass in the lumbar region, fatigue, and hematuria. The presence of RBCs in the urine without pus cells, along with lumbar pain and a ballotable mass, is consistent with renal cell carcinoma. Polycystic kidney disease (Option A) Polycystic kidney disease (PKD) is a genetic disorder characterized by the growth of multiple cysts in the kidneys. It typically presents with symptoms

such as abdominal or flank pain, hypertension, and enlarged kidneys. While PKD can cause hematuria (blood in the urine), the presence of a ballotable mass and lumbar pain during inspiration is not commonly associated with PKD. Hydronephrosis (Option B) Hydronephrosis refers to the swelling or enlargement of the kidney due to the buildup of urine caused by an obstruction in the urinary tract. It can result from conditions such as kidney stones, tumours, or structural abnormalities. While hydronephrosis can cause lumbar pain and a ballotable mass in the affected area, the presence of RBCs in the urine without pus cells suggests an alternative diagnosis. Chronic pyelonephritis (Option D) Chronic pyelonephritis is a long-term inflammation of the kidney resulting from recurrent urinary tract infections. It may cause symptoms such as flank pain, fever, frequent urination, and the presence of pus cells in the urine. However, the absence of pus cells and the presence of RBCs in the urine, along with the presence of a ballotable mass, are not typical for chronic pyelonephritis.

References:

Bailey & Love's Short Practice of Surgery, 28th edition, Page - 1483 to 1485

↑ *Back to this question in Part A*

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Q57: What is the likely diagnosis for a 60-year-old male who is experiencing lower back pain and has sclerotic lesions in the vertebrae? (Q857532)

A. Carcinoma prostate

B. Tuberculosis

C. Renal cell carcinoma

D. Carcinoma colon

Correct Answer: A. Carcinoma prostate

Explanation: The most likely primary cancer site associated with sclerotic lesions in the vertebrae in a 60-year-old male is carcinoma prostate. Prostate cancer commonly metastasizes to the bones, including the vertebrae, leading to sclerotic (hardened) lesions. Carcinoma Prostate with Bone Metastases: Aspect Details Pathophysiology Prostate cancer spreads hematogenously to bones , commonly affecting the spine, pelvis, ribs, and femur . Metastases are osteoblastic (sclerotic) due to increased osteoblast activity. Common Symptoms Lower back pain , pathological fractures, urinary symptoms (hesitancy, frequency), and neurological deficits if spinal cord compression occurs . Laboratory Findings PSA – Elevated , ALP – Elevated (bone involvement), Serum Calcium – Normal/mildly elevated (osteoblastic metastases do not cause severe hypercalcemia). X-ray Findings Sclerotic (osteoblastic) lesions in vertebrae, pelvis, and long bones. Bone Scan (Tc-99m) Shows increased radiotracer uptake in metastatic sites (best for early detection). MRI Spine Detects spinal cord compression marrow infiltration . CT Pelvis/Spine Defines bone metastases and local spread . Confirmatory Test TRUS-guided prostate biopsy (Transrectal Ultrasound Biopsy). Treatment Androgen Deprivation Therapy (ADT) (GnRH agonists like Leuprolide), Bisphosphonates for bone health , Radiation for spinal metastases , and Surgical decompression if cord compression occurs . Tuberculosis (Option B) Tuberculosis (TB) typically affects the lungs, but it can also

involve other organs, including the spine. Spinal tuberculosis, known as Pott's disease, can cause vertebral destruction and collapse, leading to back pain. Renal cell carcinoma (Option C) Renal cell carcinoma (RCC) is a type of kidney cancer. While it can metastasize to the bones, including the vertebrae, it typically presents with lytic (destructive) lesions rather than sclerotic lesions. Carcinoma colon (Option D) Colorectal cancer can metastasize to the bones, including the Vertebrae.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1531-1534

↑ *Back to this question in Part A*

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Q58: A patient with a history of trauma has a ruptured bulbar urethra. What is the location for the accumulation of urine? (Q857534)

A. Superficial pouch

B. Deep pouch

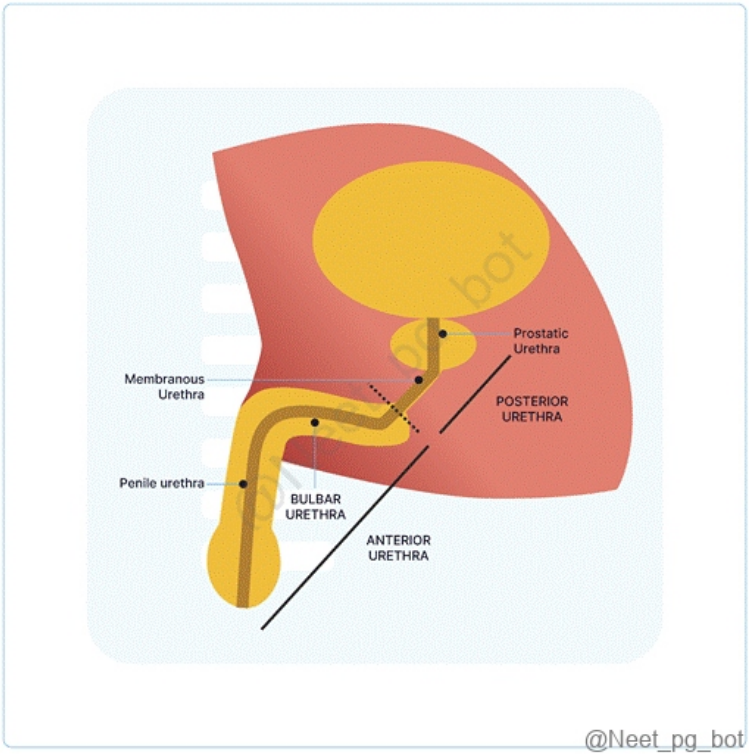
C. Rectouterine pouch

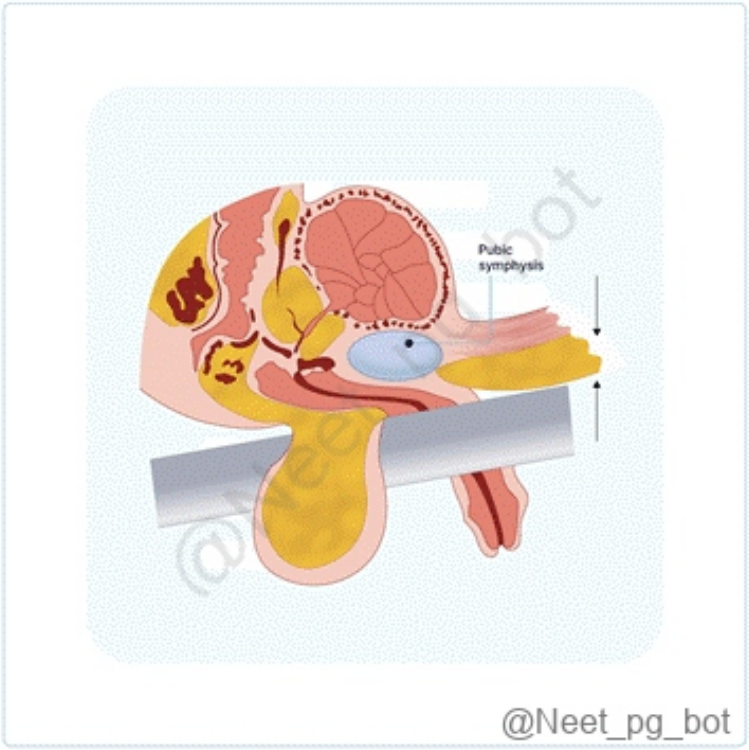
D. Uterovesical pouch

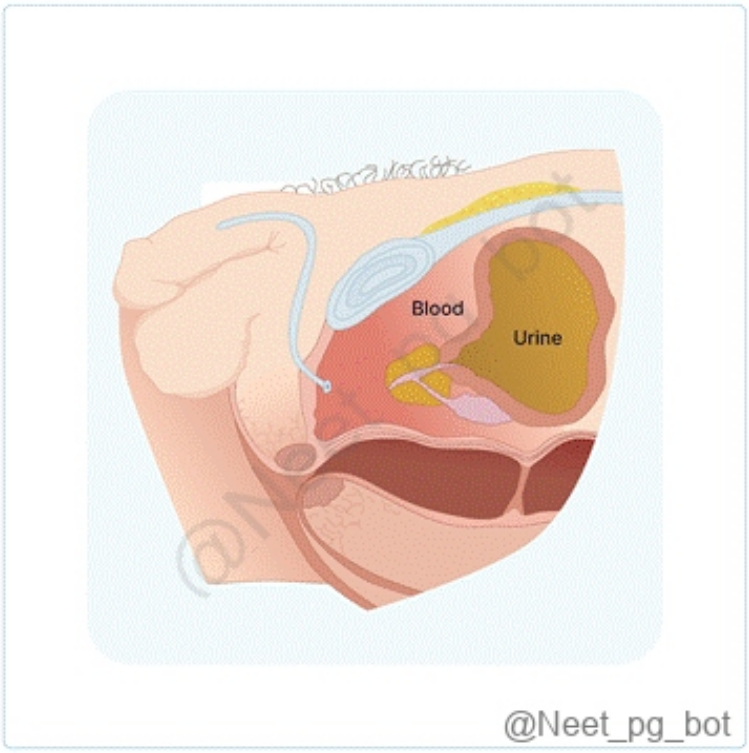
Correct Answer: A. Superficial pouch

Explanation: The superficial pouch, also known as the superficial perineal space or superficial perineal compartment, is an anatomical space located between the perineal membrane and the superficial fascia. It contains various structures, including the root of the penis, the bulb of the penis (which includes the bulbar urethra in males), and associated muscles. If the bulbar urethra is ruptured, urine can potentially leak into the superficial pouch and accumulate there. Deep pouch (Option A) The deep pouch (Space of Retzius) , also known as the space of Retzius, is an extraperitoneal space located between the pubic symphysis and the anterior bladder wall. It is situated in the lower abdomen and is not directly involved in the accumulation of urine in the case of a ruptured bulbar urethra. Rectouterine pouch (Option C) The rectouterine pouch (Pouch of Douglas) , also referred to as the pouch of Douglas, is a peritoneal space located between the posterior wall of the uterus (in females) or the bladder (in males) and the anterior wall of the rectum. Uterovesical pouch (Option D) The uterovesical pouch (Vesicouterine pouch) , also called the vesicouterine pouch, is a peritoneal space located between the uterus and the bladder in females. Urethral injury Urethral injuries refer to damage to the urethra, the tube that carries urine from the bladder to the outside of the body. {{caption_text}} Anterior vs. Posterior Urethral Injuries Feature Anterior Urethral Injury Posterior Urethral Injury Location Bulbar urethra (most common) Penile urethra {{caption_text}} Membranous urethra (bulbomembranous junction most common) Prostatic urethra {{caption_text}} Common Causes Straddle injuries Direct trauma Iatrogenic injuries (catheterization, cystoscopy) Penetrating trauma (stab/gunshot wounds) Pelvic fractures (often due to motor vehicle accidents) Blunt trauma Clinical Features Hematuria (blood in urine) Penile/perineal bruising (butterfly-shaped hematoma) Perineal pain Urinary retention or difficulty voiding Possible swelling of the penis or scrotum due to hematoma Blood at the

meatus Inability to void High-riding prostate on rectal exam Perineal or suprapubic pain Pelvic hematoma associated with pelvic fractures Possible concomitant bladder injury Investigations Retrograde Urethrography (RGU) : Gold standard, shows the extent and location of the injury Voiding Cystourethrography (VCUG): Used to assess urethral patency post-repair Ultrasound: Can detect hematoma or associated injuries Retrograde Urethrography (RGU): Gold standard for initial assessment CT Urethrography: Useful in evaluating complex injuries Pelvic CT Scan: Important for associated pelvic fractures Cystoscopy: Sometimes performed for further evaluation If injury at Prostatomembranous junction - High lying prostate → On IVP- Pie in-sky appearance







References:

Bailey and Love's Short Practice of Surgery, 28th Edition, Page 1541,1542.

Schwartz's Principles of Surgery, 11th Edition, Page 1767.

SRB's Manual of Surgery, 6th Edition, Pages 1040-1042.

↑ *Back to this question in Part A*

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Q59: In a newborn male with an undeveloped scrotum, the testis was observed to be located near the peritoneum. Which of the following factors aids in the descent of the testis into the scrotum? (Q857536)

A. GnRH Analogues

B. Testosterone

C. Cold Compressions

D. Manually bring the testis down to the bottom of scrotum.

Correct Answer: A. GnRH Analogues

Explanation: GnRH analogue increases the level of gonadotropin,s which further increases the level of androgens that help in testicular descent as it is an androgen-dependent process. Testosterone (Option B) GnRH analogue is preferred over testosterone as neonatal gonadotropin therapy can increase the testosterone levels without fear of inducing spermatogenesis or negatively affecting an ultimate number of Sertoli cells (an important determinant of fertility). Cold Compressions (Option C) Cold compresses or ice application is not a recognised method to assist testicular descent in newborns. Manually bring the testis down to the bottom of the scrotum (Option D). This option describes a manual technique called orchidopexy or surgical orchiopexy. It involves surgically bringing the undescended testis down to the scrotum. It is a definitive treatment for undescended testis, but it is typically performed by a healthcare professional and not manually by parents or Caregivers.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1559 -1561.

Schwartz's Principles of Surgery, 11th Edition, Page 1777.

SRB's Manual of Surgery, 6th Edition, Page 1065 -1068.

↑ *Back to this question in Part A*

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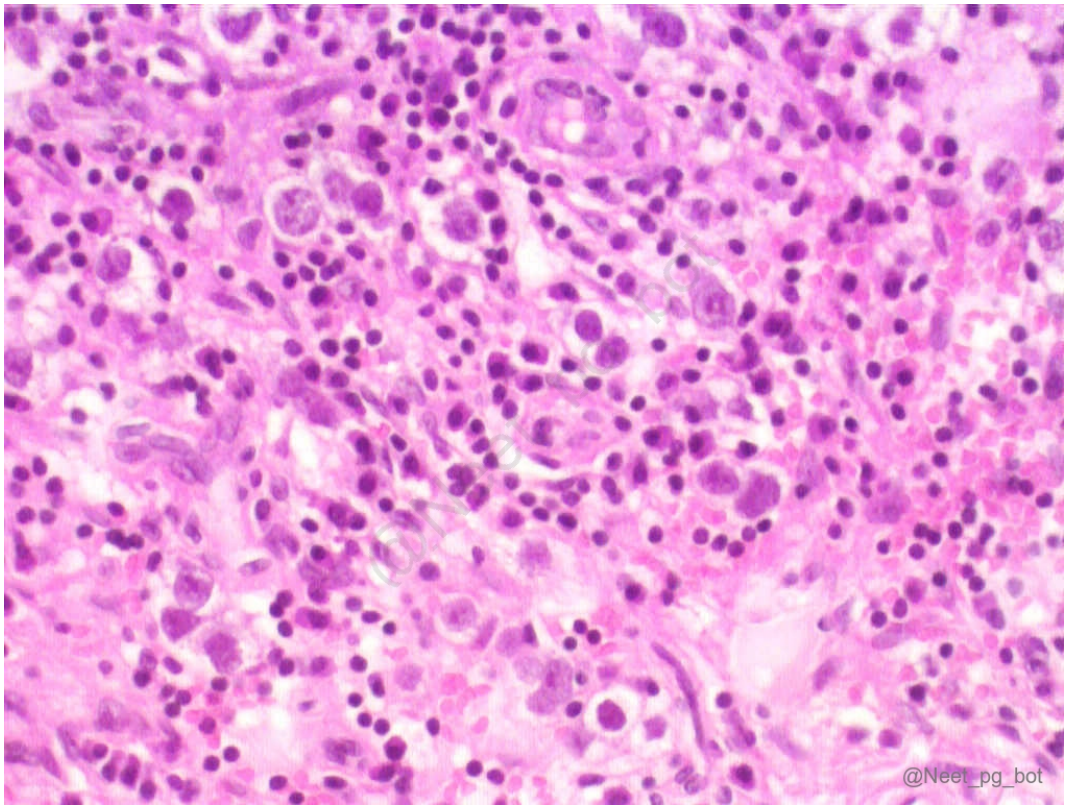
Q60: A 35-year-old man presents with scrotal enlargement. His LDH levels are notably elevated, while HCG and alpha-fetoprotein levels remain within normal ranges. Upon histopathological examination, the findings are as shown below. What is the most probable diagnosis? (Q857537)

A. Leydig cell tumor

B. Embryonal carcinoma

C. Seminoma

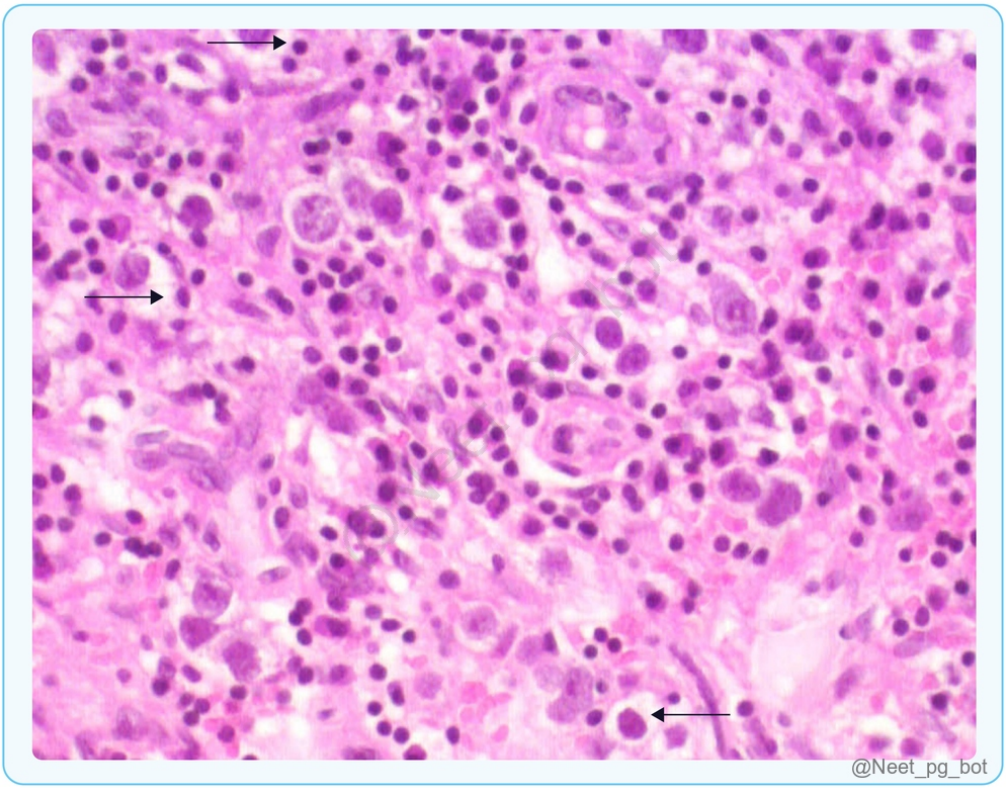
D. Teratoma



Correct Answer: C. Seminoma

Explanation: Seminoma Feature Details Tumor Type Seminoma, the most common pure testicular germ cell tumour in men aged 25-45 Origin Germinal epithelium of the seminiferous tubules Clinical Features Painless, firm swelling or mass in the testicle, typically unilateral. Accounts for 50% of all testicular germ cell tumors. 10% have secondary hydrocele, 5% have gynecomastia Diagnostic Markers AFP: Normal hCG: Normal or mildly elevated LDH: Elevated Investigation Ultrasound: Homogeneous, hypoechoic mass Histology: Sheets of oval cells with clear cytoplasm, large nuclei with prominent acidophilic nucleoli {{caption_text}} FNAC: Contraindicated due to the risk of tumour cell seeding and lymph node metastasis Treatment Primary: High Inguinal Radical Orchidectomy Adjuvant: Radiation therapy or chemotherapy for positive lymph nodes Leydig cell tumour (Option A) : Benign testicular tumour that typically occurs in adults aged 30-60. While it presents as a painless testicular

mass, Leydig cell tumours don't typically elevate beta-hCG. Embryonal carcinoma (Option B) : Aggressive germ cell tumour that often occurs in young men. However, it typically presents with both elevated AFP and beta-hCG, not just beta-hCG alone. It's also usually more heterogeneous on ultrasound. Teratoma (Option D): Typically occurs in young men and usually presents with normal tumour markers (both beta-hCG and AFP). On ultrasound, it appears heterogeneous with both cystic and solid components.



References:

Bailey & Love Short Practice of Surgery, 28th Edition, Page1569,1572

Seminoma

↑ *Back to this question in Part A*

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Q61: A young male underwent lumbar sympathectomy, and bilateral L1 ganglions were removed. What will be the most common side effect? (Q857538)

A. Impotence

B. Retrograde ejaculation

C. Bladder dysfunction

D. Incontinence

Correct Answer: B. Retrograde ejaculation

Explanation: Lumbar sympathectomy can disrupt the sympathetic innervation responsible for controlling the closure of the bladder neck during ejaculation. This disruption can lead to retrograde ejaculation, where semen enters the bladder instead of being expelled through the penis during ejaculation. Retrograde ejaculation is a known and frequently reported side effect of lumbar sympathectomy. Impotence (Erectile Dysfunction) (Option A) Erection is mainly parasympathetically mediated (S2-S4, pelvic splanchnic nerves), not lumbar sympathetic nerves. Sympathectomy may affect ejaculation but does not typically cause impotence. Bladder Dysfunction (Option C) The main control of bladder function (detrusor contraction, micturition reflex) is via S2-S4 parasympathetic fibers , not L1 sympathetic nerves. Some mild urinary dysfunction may occur , but retrograde ejaculation is more common. Incontinence (Option D) Urinary continence is maintained by external urethral sphincter control (somatic, pudendal nerve - S2-S4) , which remains intact after L1 sympathectomy.

References:

sympathectomy

↑ *Back to this question in Part A*

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Q62: All the following are features of polycystic disease of kidneys except: (Q857543)

A. Hematuria

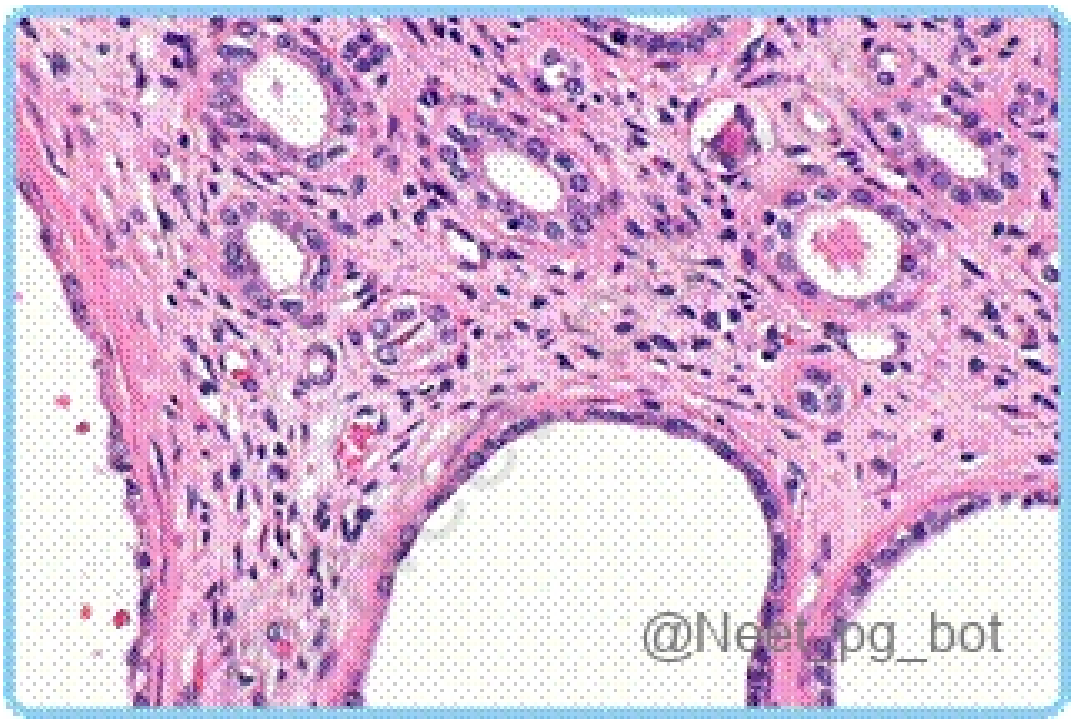
B. Hypertension

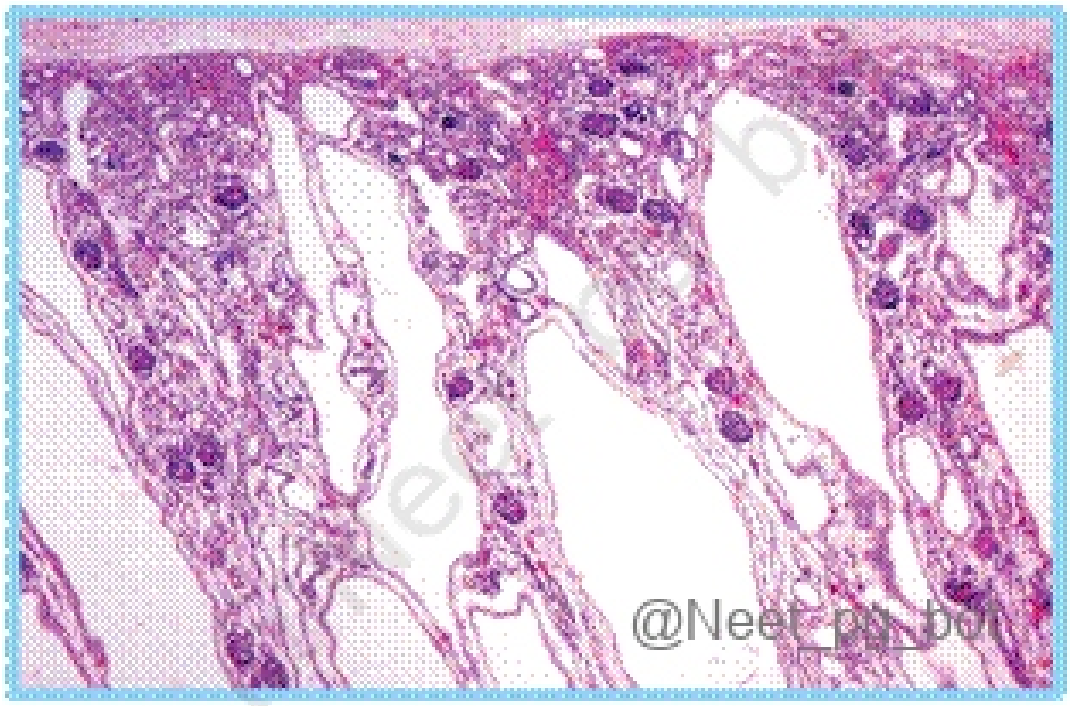
C. Renal failure

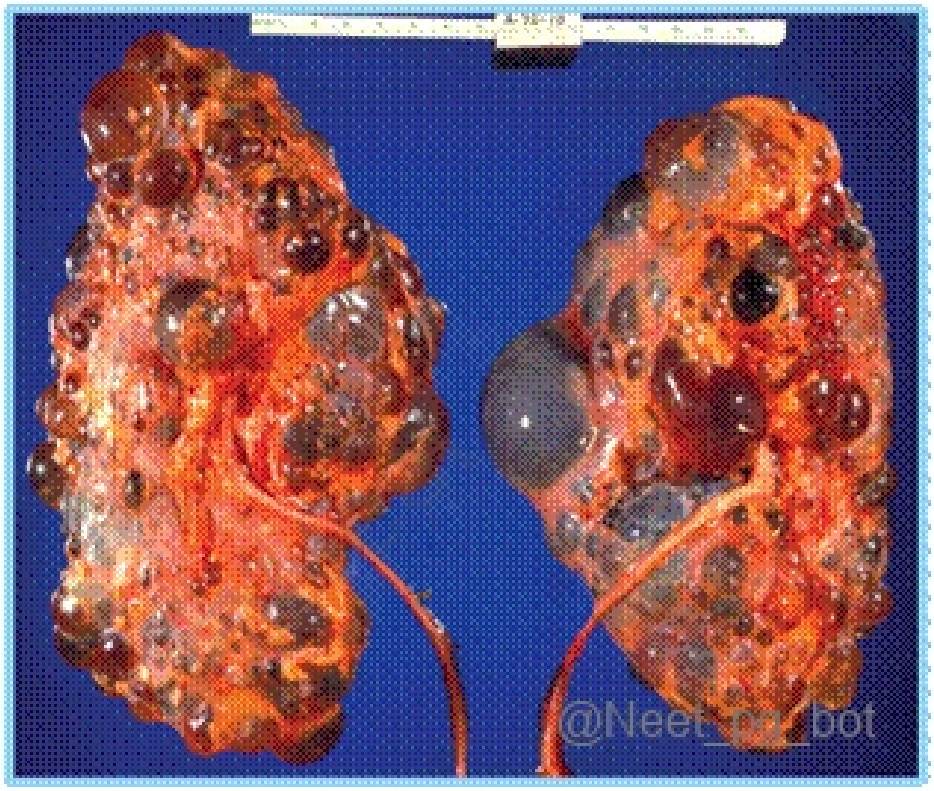
D. Erythrocytosis

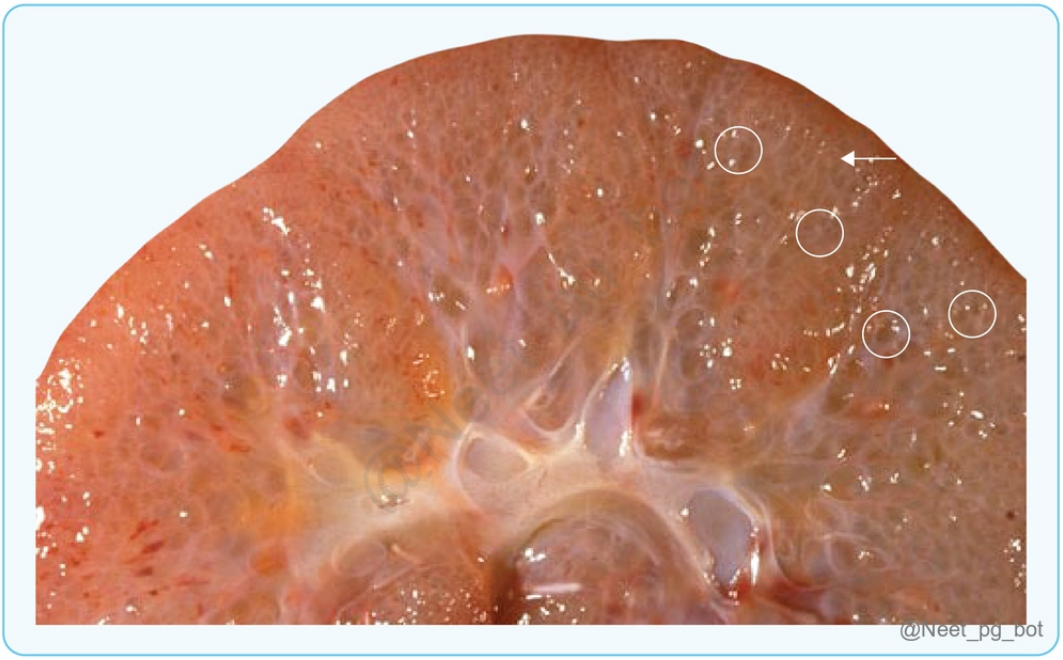
Correct Answer: D. Erythrocytosis

Explanation: Polycystic kidney disease (PKD) is characterized by multiple renal cysts , leading to progressive renal failure . The key clinical features include hematuria, hypertension, and renal failure . However, erythrocytosis (increased RBC count) is not a typical feature because PKD often leads to chronic kidney disease (CKD) , which is associated with anemia rather than polycythemia. Polycystic Kidney Disease (PKD) Feature


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References:

Robbins and Cotran, Pathologic Basis of Disease, 10th edition, Page no. 941-944A

SRB Manual of Surgery, 6th Edition, Page 994, 995

↑ *Back to this question in Part A*

@Neet_pg_bot

Q63: A 26 year old male presented with a painless large round firm right testicular swelling, with a dragging sensation. The left testis was normal. AFP was around 3000U. What is the next best step in the management? (Q858337)

A. FNAC

B. Scrotal true cut biopsy

C. High inguinal orchidectomy

D. Repeat tumor markers

Correct Answer: C. High inguinal orchidectomy

Explanation: The next best step in the management of a painless large round firm right testicular swelling with an elevated AFP level is high inguinal orchidectomy as these findings are suggestive of testicular tumor probably non seminomatous germ cell tumor due to raised AFP levels. An inguinal orchidectomy is commonlyperformed as a treatment for testicular cancer or for other conditions such as testicular torsion or certain cases of transgender surgery. FNAC (Option A) is not recommended in the management of testicular masses. Scrotal true cut biopsy (Option B) A high inguinal orchidectomy is the preferred approach for the management of suspected testicular malignancies. Repeat tumor markers (Option D) An elevated AFP level in the context of a testicular mass requires further evaluation and definitive management rather than repeating tumor markers.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1569- 1572

↑ *Back to this question in Part A*

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Q64: A 20-year-old was brought to the ER after falling off his bicycle. His vitals were stable, but he had a bruise over the perineum, and he had not passed urine yet. Blood was seen at the meatus and the bladder was not palpable. How do you manage him? (Q858339)

A. Wait and send him home

B. Immediate insertion of a Foley catheter

C. Suprapubic aspiration of urine

D. Wait for bladder to fill and urge to urinate

Correct Answer: D. Wait for bladder to fill and urge to urinate

Explanation: In a patient who fell off a bicycle, has blood at the meatus, perineal bruising, and no palpable bladder, the management would be to wait for the bladder to fill and for the patient to have an urge to urinate. This is done to ensure the urethral integrity. Wait and send him home (Option A) there are indications of potential urethral injury, and therefore, the patient should be managed actively rather than being sent home without intervention. Immediate insertion of Foley's catheter (Option B) inserting a Foley catheter without assessing urethral integrity can lead to further complications. Suprapubic aspiration of urine (Option C) is not the initial management approach in this scenario. The bladder needs to be filled and the urge to urinate needs to be assessed before considering invasive measures.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, pages 1540- 1542

↑ *Back to this question in Part A*

@Neet_pg_bot

Q65: What is the primary reason for bladder outlet obstruction in male children? (Q858352)

A. Posterior urethral valve

B. Urethral atresia

C. Anterior urethral valve

D. Ureterocele

Correct Answer: A. Posterior urethral valve

Explanation: Posterior urethral valve (PUV) is the most common cause of bladder outlet obstruction in male children. PUV is an abnormal fold of tissue within the urethra that obstructs the flow of urine. It is a congenital condition that occurs during foetal development. PUV can cause various urinary symptoms, such as difficulty urinating, weak urinary stream, urinary tract infections, and urinary retention. It is more commonly seen in male infants. Urethral atresia (Option B) is a rare condition in which the urethra is completely closed or absent. It is a congenital anomaly and can lead to urinary retention and other urinary complications. While urethral atresia can cause bladder outlet obstruction, it is not as common as the posterior urethral valve in male children. Anterior urethral valve (Option C) is a less common condition compared to the posterior urethral valve. It is characterised by abnormal tissue folds or membranes in the anterior portion of the urethra. Anterior urethral valve can cause urinary obstruction and other urinary symptoms, but it is not the most common cause of bladder outlet obstruction in male children. Ureterocele (Option D) is a bulging of the ureter into the bladder. It can obstruct the flow of urine

from the affected kidney. While ureterocele can lead to urinary obstruction, it primarily affects the upper urinary tract rather than the bladder outlet.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 282 - 283

↑ *Back to this question in Part A*

@Neet_pg_bot

Q66: A 3-year-old boy is brought by his mother with right-sided abdominal swelling noticed during bathing. He had a history of hematuria 2 weeks ago, which resolved spontaneously. On examination, a right-sided reniform, ballotable mass is palpable. What is the investigation of choice for confirming the diagnosis? (Q856530)

A. CECT abdomen

B. PET-CT

C. 24-hour urinary VMA

D. FNAC

Correct Answer: A. CECT abdomen

Explanation: The child is 3 years old and presents with a reniform, ballotable abdominal mass and a recent history of hematuria. Most likely diagnosis: Wilms tumor (nephroblastoma) - the most common renal malignancy in children aged 2–5 years. Reniform (kidney-shaped) mass points to renal origin, helping distinguish from other abdominal tumors like neuroblastoma. CECT (Contrast-enhanced CT) abdomen is the investigation of choice in suspected Wilms tumor. CECT abdomen confirms: Renal origin of the mass Tumor size and extent Involvement of renal vessels and surrounding structures Contralateral kidney assessment for staging It is first-line and safest initial investigation for suspected Wilms tumor. Incorrect Options: Option B) PET-CT: Not used as a routine initial investigation for Wilms tumor. May be used in select cases for detecting metastases, but it is not first-line. Expensive and involves unnecessary radiation exposure. Option C) 24-hour urinary VMA : Useful for neuroblastoma, not Wilms tumor. VMA is a catecholamine metabolite; normal in Wilms tumor. Option D) FNAC: Contraindicated in suspected Wilms tumor. Risk of tumor spillage, which can worsen prognosis. Histopathological confirmation is obtained after nephrectomy.

References:

Bailey & Love’s Short Practice of Surgery (28th Edition) page 674- 678

↑ *Back to this question in Part A*

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Q67: A 50-year-old male patient came to the outpatient department with complaints of hematuria. A 2x2 cm bladder mass is seen which is low grade transitional cell carcinoma. Which among the following is the ideal management? (Q856567)

A. Transurethral resection of the tumor

B. Resection with ileal conduit

C. Partial cystectomy with bladder reconstruction

D. Neoadjuvant chemotherapy

Correct Answer: A. Transurethral resection of the tumor

Explanation: Transurethral resection of the tumour (TURBT) is the initial standard treatment for low-grade transitional cell carcinoma (TCC) of the bladder. This procedure is performed using a cystoscope inserted through the urethra to remove the tumor from the bladder. TURBT allows for both diagnostic and therapeutic purposes, as the tumor is removed and sent for histopathological examination to confirm the diagnosis and assess the stage and grade of the tumor. Resection with ileal conduit (Option B) is not the ideal management for low-grade transitional cell carcinoma of the bladder. It is typically reserved for cases of invasive or high-grade bladder cancer that cannot be adequately treated with transurethral resection alone. Partial cystectomy with bladder reconstruction (Option C) may be considered particularly if the tumour is in a favourable location and can be completely excised while preserving bladder function. However, transurethral resection is generally the preferred initial treatment for most cases of low-grade bladder cancer. Neoadjuvant chemotherapy (Option D) It is typically used for muscle-invasive bladder cancer or cases with a high risk of progression. Tumor Stage Tis (Carcinoma in situ) TURBT (Transurethral Resection of Bladder Tumor) May be used for initial diagnosis and tumor resection if not already performed Intravesical BCG Induction: Weekly for 6 weeks Maintenance: Weekly for 3 weeks at months 3, 6, 12, 18, 24, 30, and 36 Continue BCG Maintenance Therapy Up to 3 years Ta (Non-muscle invasive) TURBT Complete resection of tumor Low-risk: Single Instillation (SI) of Intravesical Chemotherapy (e.g., gemcitabine, mitomycin) SI within 24 hours of TURBT Alternative: Continuous saline bladder irrigation Intermediate-risk: Intravesical Chemotherapy (e.g., gemcitabine) Induction: 6 weekly courses Maintenance: Up to 1 year T1 (Muscle invasive) TURBT - For initial diagnosis and tumor debulking High-risk: Intravesical BCG Induction: Weekly for 6 weeks Maintenance: Up to 3 years Consider Cystectomy If BCG is not tolerated or ineffective- Alternative: Trimodality therapy (TURBT + Chemoradiation) T2 (Muscle invasive) TURBT - May be used for tumor resection and staging Initial Treatment: Consider Cystectomy Alternatively, Trimodality therapy (TURBT + Chemoradiation) Adjuvant Therapy: Depending on response and tumor characteristics T3 (Advanced muscle invasive) Initial Treatment: Cystectomy with possible neoadjuvant chemotherapy TURBT - Often not performed if cystectomy is planned Adjuvant Therapy: Based on pathology and staging Neoadjuvant therapy may continue T4 (Locally advanced) Initial Treatment: Cystectomy Neoadjuvant Chemotherapy, if not yet administered TURBT - Typically avoided if cystectomy and neoadjuvant therapy are planned Adjuvant Therapy: Additional chemotherapy or radiation based on residual disease and staging

References:

https://www.uptodate.com/contents/treatment-of-primary-non-muscle-invasive-urothelial-carcinoma-of-the-bladder?search=bladder%20cancer&sectionRank=1&usage_type=default&anchor=H3412363&source=machineLearni

ng&selectedTitle=7~150&display_rank=7#H3412363

↑ *Back to this question in Part A*

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Q68: Which of the following statements is true regarding the condition mentioned below? {{caption_text}} (Q856203)

A. Patient must be started on anti-gas gangrene serum therapy

B. It is a mixed flora aerobic and anaerobic infection

C. Bilateral orchiectomy is generally performed

D. Compulsory urinary diversion is performed



Correct Answer: B. It is a mixed flora aerobic and anaerobic infection

Explanation: The given image depicts Fournier's Gangrene , a severe, progressive infection of the genitalia and perineum caused by a mixed aerobic and anaerobic bacterial flora. Definition Necrotizing infection of the soft tissues in the perineum, external genitalia, and perianal region, akin to necrotizing fasciitis. Cause It is usually caused by mixed bacterial fora (Escherichia coli, Bacteroides spp., Streptococcus pyogenes, Staphylococcus aureus). (Option B) Clinical Presentation Symptoms: Intense pain in the genitalia, progressing through five phases:

Prodromal Phase: Fever and lethargy. Early Pain Phase: Intense pain, possible oedema, pruritus. Progressive Phase: Increased pain, and erythema. Crepitation Phase: Dusky skin with subcutaneous crepitation. Gangrene Phase: Gangrene with purulent discharge. Pain may decrease as gangrene progresses. Severity ranges from localised tenderness to septic shock. Risk Factors Peripheral vascular disease, diabetes mellitus, malnutrition, alcoholism, immunocompromised states. Diagnosis Clinical presentation supported by imaging or lab findings. Management Initial Treatment: Fluid resuscitation. Broad-spectrum antibiotics. Surgical debridement of necrotic tissue. Additional Measures: Urinary and fecal diversion to prevent wound contamination. Intensive monitoring for sepsis. Wound review and vacuum-assisted dressing. Skin grafting post-infection control. Patient must be started on anti-gas gangrene serum therapy (Option A), which is an incorrect statement as it is not required in Fournier gangrene. Bilateral orchiectomy is generally performed (Option C) is an incorrect statement as Bilateral orchiectomy is generally not required in this condition, and testis is unaffected. Compulsory urinary diversion is performed (Option D) is an incorrect statement as the urinary system is unaffected in this condition.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1573-1574.

Sabiston Textbook of Surgery, 21st Edition, Page 1372.

↑ *Back to this question in Part A*

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Q69: In a patient with abdominal pain and sterile pyuria, what is the finding shown in the image given? (Q856205)

A. Putty kidney

B. Nephrocalcinosis

C. Staghorn calculus

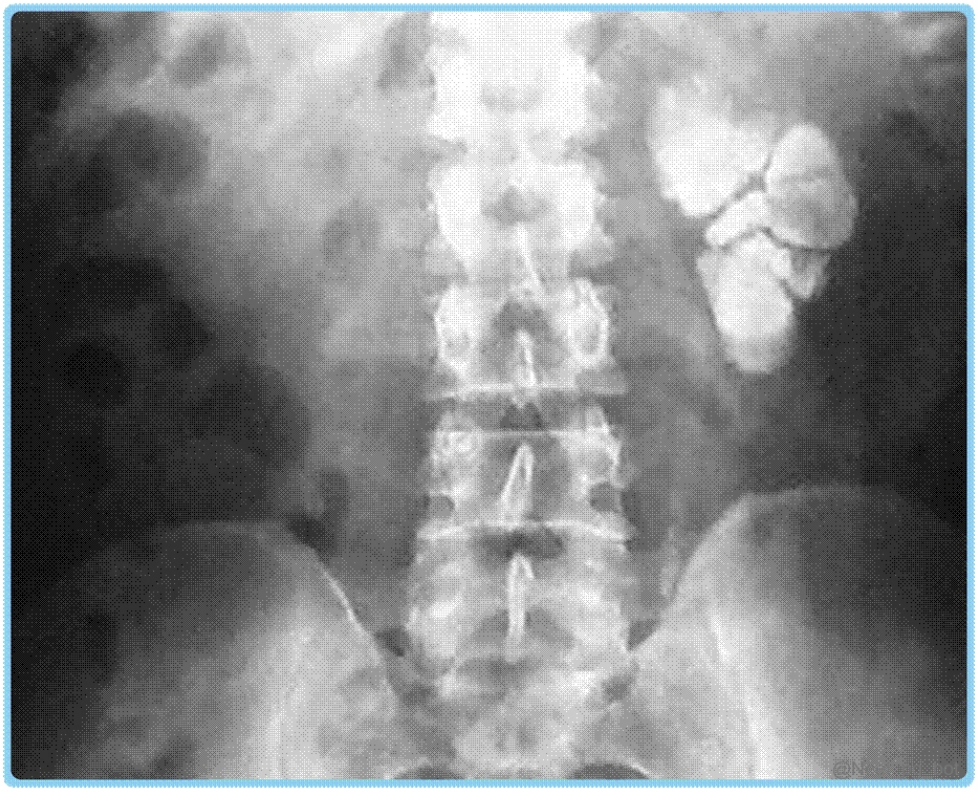
D. Psoas calcification

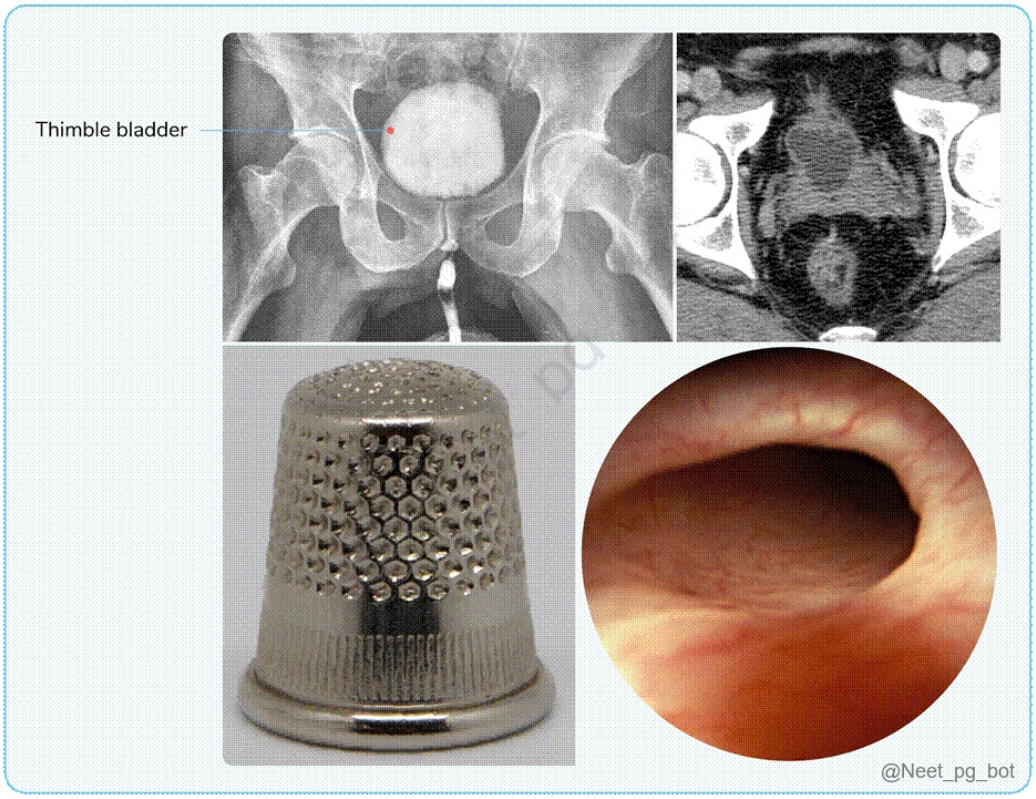


Correct Answer: A. Putty kidney

Explanation: In a patient with abdominal pain and sterile pyuria, the finding shown in the image is likely Putty kidney, a late stage of Genitourinary Tuberculosis (GUTB) , characterised by widespread calcification of non-functioning renal tissue, resulting in kidney failure. {{caption_text}} Bladder TB: Infection Progression: The infection spreads from the ureter into the bladder, with an early sign observable during cystoscopy being pallor around the ureteric orifice in the bladder. Chronic Inflammation: This inflammation leads to the formation of tubercles in the bladder, followed by fibrosis. Bladder Changes: The fibrosis results in a small, contracted bladder with significantly reduced capacity, often referred to as a "thimble bladder." Advanced TB: In advanced cases, where the bladder is contracted, the ureteric orifices may appear as "golf hole" shapes. {{caption_text}} GUTB involving the prostate: Calcification: The affected area becomes calcified, resulting in a hard and nodular texture. Testis: The testis is usually spared in cases of genitourinary tuberculosis. Characteristic Feature: A distinctive feature of tuberculosis is the "beaded" appearance of the vas deferens, often accompanied by multiple discharging sinuses through the scrotum. Investigations: Urine routine and microscopy-pyuria with or without hematuria Urine culture-sterile pyuria IVU clearly shows the effects of GUTB on the urinary tract, such as: The fuzzy or moth-eaten appearance of the calyces due to ulceration. (Earliest sign of renal TB) Strictures in the ureters cause narrowing or blockage. Hydronephrosis A small, shrunken bladder ("thimble bladder") due to fibrosis Gold standard for early genitourinary tuberculosis CECT Retrograde pyelograms (RGP)-visualisation of ureteral abnormalities and strictures Treatment: Antituberculous Therapy (ATT) : The primary treatment for GUTB is a course of ATT (a short course regimen). Nephrocalcinosis (Option B) is the widespread deposition of calcium salts in the kidney tissue, often associated with metabolic disorders like hypercalcemia or chronic kidney disease. While nephrocalcinosis may present with calcifications, it typically does not present in the same "putty" pattern seen in putty kidneys and is often more diffuse. {{caption_text}} Staghorn calculus (Option C) is a large, branching kidney stone that takes the shape of the renal pelvis and calyces. It usually results from chronic urinary tract infections, often with organisms like Proteus species. While a staghorn calculus may be visible on imaging, it is

not associated with the extensive calcification and kidney destruction seen in putty kidneys. {{caption_text}}
Psoas calcification (Option D) refers to calcification of the psoas muscle, which could occur due to past infections, trauma, or other inflammation causes. Psoas calcifications would not be related to kidney tissue and are not indicative of the changes in putty kidneys. {{caption_text}}




Thimble bladder
@Neet_pg_bot


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X Ray showing right staghorn calculi



References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 89, 1472.

↑ *Back to this question in Part A*

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Q70: A 75-year-old man with prostate carcinoma presents to you with a PSA of 9 ng/mL with a small tumour focus. His Gleason score is 6. What will be your most likely management? (Q856232)

A. Radical prostatectomy

B. External beam radiation

C. Brachytherapy

D. Active surveillance

Correct Answer: D. Active surveillance

Explanation: Active surveillance is the recommended management for a patient with prostate carcinoma presenting with a PSA of 9 ng/mL, a small tumour focus, and a Gleason Score of 6. Purpose: Predicts cancer aggressiveness and potential for spread. Important for prognosis and treatment planning. Scoring System: Ranges from 6 to 10, based on gland appearance and differentiation. Two most common patterns in the biopsy are graded and summed for the final score. Gleason Score Grade Components Cancer Grade Description 6 3 + 3 Low-grade Cells resemble healthy tissue; low likelihood of growth and spread. 7 3 + 4 or 4 + 3 Intermediate-grade Cells show more variation and moderate risk of growth and spread. 8 4 + 4, 3 + 5, or 5 + 3 High-grade Cells look very different; higher likelihood of rapid growth and spread. 9 or 10 4 + 5, 5 + 4, or 5 + 5 Very high-grade Cells are highly aggressive and very likely to grow and spread quickly. CA Prostate Management: Management Strategy Key Points Active Surveillance (Option D) For low-risk cases, regular monitoring Radical Prostatectomy (Option A ruled out) Surgery for localized cancer; potentially curative Radiation Therapy (Option B, C ruled out) High-energy rays; external or brachytherapy Hormone Therapy Reduces/block testosterone; for advanced/metastatic cases Chemotherapy Systemic drug treatment; for advanced/metastatic cases

References:

Bailey & Love’s Short Practice of Surgery, 28th Edition, Page 1451 , 1533-1536.

↑ *Back to this question in Part A*

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Q71: A patient arrives after being involved in a motorcycle road traffic accident. The patient does not report any pain or injury. Upon examination, there is evidence of blood at the urethral meatus. What would be your subsequent course of action in

terms of managing this patient? (Q856251)

A. Foley’s catheterization

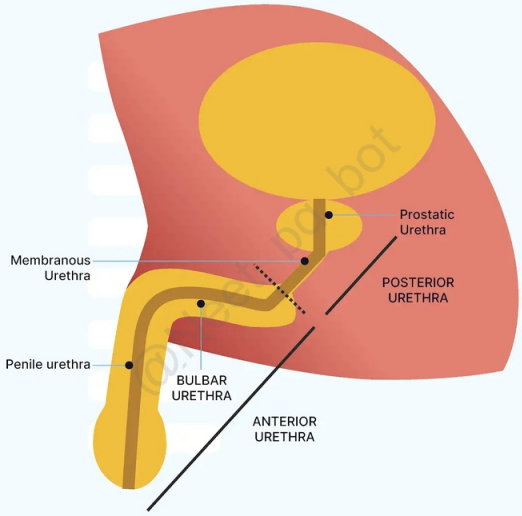
B. Wait and watch

C. Nephrogram

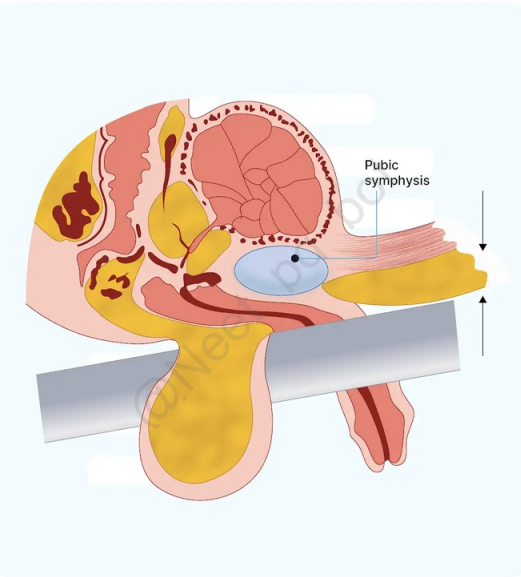
D. Suprapubic cystostomy

Correct Answer: B. Wait and watch

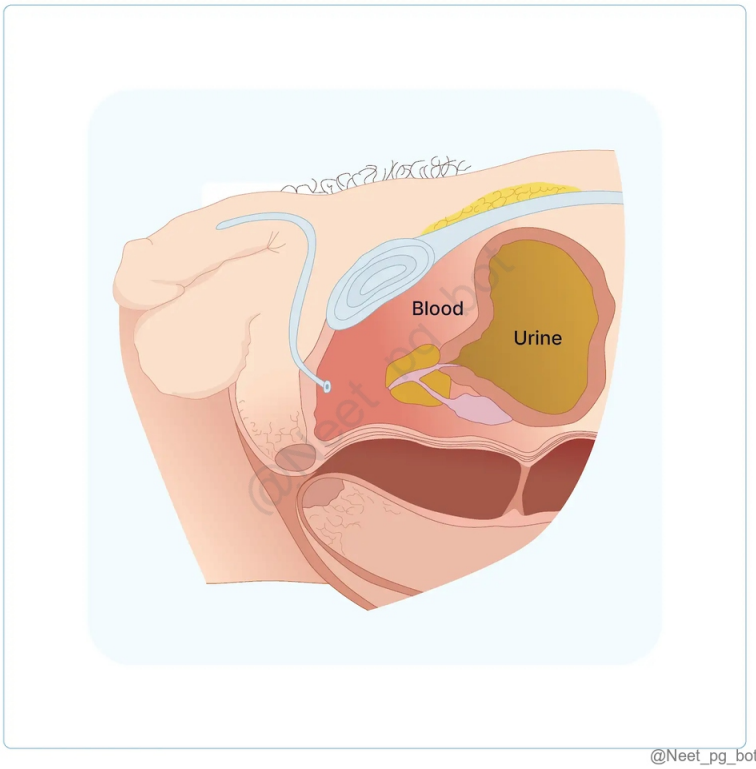
Explanation: Blood at the tip of the urethral meatus suggests a posterior Urethral Injury , for which suprapubic cystostomy is a definitive treatment, but the initial management is conservative unless there are symptoms of urinary retention or significant pelvic hematoma. It refers to damage to the urethra, the tube that carries urine from the bladder to the outside of the body. Feature Anterior Urethral Injury Posterior Urethral Injury Location Bulbar urethra (most common) Penile urethra Membranous urethra (bulbomembranous junction most common) Prostatic urethra Common Causes Straddle injuries Direct trauma Iatrogenic injuries (catheterisation, cystoscopy) Penetrating trauma (stab/gunshot wounds) Pelvic fractures (often due to motor vehicle accidents) Blunt trauma Clinical Features Hematuria Penile/perineal bruising (butterfly-shaped hematoma) Perineal pain Urinary retention or difficulty voiding Possible swelling of the penis or scrotum due to hematoma Blood at the meatus Inability to void High-riding prostate on rectal exam Perineal or suprapubic pain Pelvic hematoma associated with pelvic fractures Possible concomitant bladder injury Investigations Retrograde Urethrography (RGU) : Gold standard, shows the extent and location of the injury Voiding Cystourethrography (VCUG): Used to assess urethral patency post-repair Ultrasound: Can detect hematoma or associated injuries Retrograde Urethrography (RGU): Gold standard for initial assessment CT Urethrography: Useful in evaluating complex injuries Pelvic CT Scan: Important for associated pelvic fractures Cystoscopy: Sometimes performed for further evaluation If injury at Prostatomembranous junction - High lying prostate → On IVP- Pie in-sky appearance. Management Minor Injuries: Managed conservatively with catheterisation or suprapubic catheter if severe bruising Severe Injuries: Surgical intervention like primary repair, urethroplasty, or end-to-end anastomosis Antibiotics: To prevent infection Initial Management: Suprapubic catheterization for urinary diversion Delayed Urethroplasty (Definitive management): 3-6 months post-injury after inflammation and fibrosis have subsided Primary Realignment: Occasionally attempted if conditions permit Endoscopic Realignment: For selected cases, though often reserved for acute management Complications Urethral stricture (risk of recurrence) Erectile dysfunction (especially if injury near the penile base) Urinary incontinence (less common) Infection (urethritis or abscess formation) Bladder neck contracture Chronic pelvic syndrome Foley’s catheterization (Option A) insertion is avoided in the presence of blood at the urethral meatus, as it may worsen a posterior urethral injury and should be delayed until imaging confirms urethral integrity. Nephrogram (Option C) is not the immediate step for managing urethral injury. Imaging, like a retrograde urethrogram, is important, but the initial evaluation should be followed to stabilise the patient and ensure proper drainage without causing further harm. Suprapubic Cystoscopy (Option D) is for significant urethral injury, retention, or obstruction, but if the injury is mild or unconfirmed, a conservative wait-and-watch approach is preferred to avoid unnecessary procedures. It is reserved for severe cases or when other drainage methods are unsafe.



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References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page, 1541-1542.

Schwartz's Principles of Surgery, 11th Edition, Page, 1767.

SRB's Manual of Surgery, 6th Edition, Page, 1040-1042.

↑ *Back to this question in Part A*

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Q72: What is the probable diagnosis for a girl who has experienced continuous urinary dribbling and persistent bladder fullness since birth? (Q856227)

A. Stress incontinence

B. Ureterocele

C. Ectopic ureter

D. Vesicovaginal fistula

Correct Answer: C. Ectopic ureter

Explanation: Continuous urinary dribbling and persistent bladder fullness since birth are classic symptoms of an ectopic ureter. Ectopic ureter Etiology It results from abnormal embryological development, often associated with ureteral duplication. Pathology Ectopic ureters drain to sites other than the bladder, which is commonly associated with duplication of the ureter. Pathophysiology In females, ectopic ureters open below the urethral sphincter or into the vagina, leading to incontinence . In males, ectopic ureters usually open above the external urethral sphincter, maintaining continence. Types Bilateral ectopic ureters (10% of cases). Unilateral ectopic ureters. Clinical Features Females: Continuous urinary incontinence despite normal voiding. Males: Typically asymptomatic or continent due to ureter opening above the sphincter. Diagnosis Computed Tomo-Urography (CTU). Magnetic Resonance Urography (MRU). Lab Investigations Primarily imaging-based diagnostics (CTU or MRU). Complications Persistent incontinence in females. Potential recurrent urinary tract infections. Differential Diagnosis Vesicoureteral Reflux Urethral Stricture: Difficulty in urination and weak stream, not continuous incontinence. Neurogenic Bladder Treatment Surgical correction: Reposition it into the bladder to restore normal continence. Stress incontinence (Option A) is the involuntary leakage of urine that occurs when there is increased pressure on the bladder, such as during coughing, sneezing, or exercise. It is more common in adults, especially in women, after childbirth or menopause. Ureterocele (Option B) is the congenital dilation of the distal ureter, which forms a cyst-like structure in the bladder wall. This can obstruct urine flow , potentially causing hydronephrosis or recurrent urinary tract infections (UTIs). Vesicovaginal fistula (Option D) is an abnormal communication between the bladder and vagina, typically caused by prolonged obstructed labour. This leads to tissue breakdown and formation of a fistula, resulting in continuous leakage of urine through the vagina.

References:

Bailey and Love’s Short Practice of Surgery, 28th Edition, page 1467

↑ *Back to this question in Part A*

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Q73: Identify the investigation and the lesion depicted in the image given below: (Q854923)

A. Retrograde cystourethrogram with membranous urethra stricture

B. Retrograde cystourethrogram with penile urethral stricture

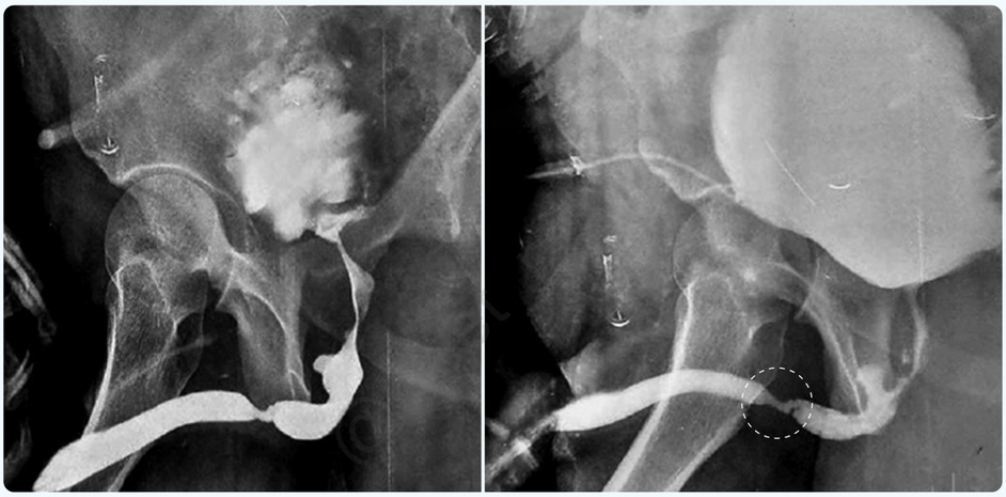
C. Micturating cystourethrography with bulbar stricture

D. Micturating cystourethrography with prostatic urethra stricture



Correct Answer: B. Retrograde cystourethrogram with penile urethral stricture

Explanation: auses Trauma (Most common): Pelvic fractures, falls, accidents, or iatrogenic trauma from prolonged catheterization. Infections: STIs like gonorrhoea and chlamydia cause urethritis. Medical Procedures : Urethral surgeries or radiation for pelvic cancers. Inflammatory Conditions: Chronic inflammation from conditions like lichen sclerosus. Investigations Posterior Urethral Stricture: Micturating Cystourethrogram (MCU) to visualize the posterior urethra and bladder during voiding. (Option C & D ruled out) {{caption_text}} Anterior Urethral Stricture: Retrograde Urethrogram (RGU). {{caption_text}} Emergency Evaluation: Both RGU and MCU may be used in trauma cases or acute urinary retention. Management Urethral Dilation: Temporary relief with dilators, often leading to recurrence. Optical Internal Urethrotomy (OIU): Endoscopic incision at the 12 o'clock position; effective for short bulbar strictures (<2 cm). Urethroplasty: Surgical excision and reconstruction; the gold standard for recurrent or complex strictures Strictures up to 2 cm: Excision with end-to-end anastomosis. Strictures >2 cm: Excision and reconstruction with buccal mucosa, bladder mucosa, or penile skin. Retrograde cystourethrogram with membranous urethra stricture (Option A): Membranous urethral strictures are located in the part of the urethra that passes through the pelvic floor. While RUG can identify strictures in this area, the presentation described in the options fits a more distal site. ■ {{caption_text}}

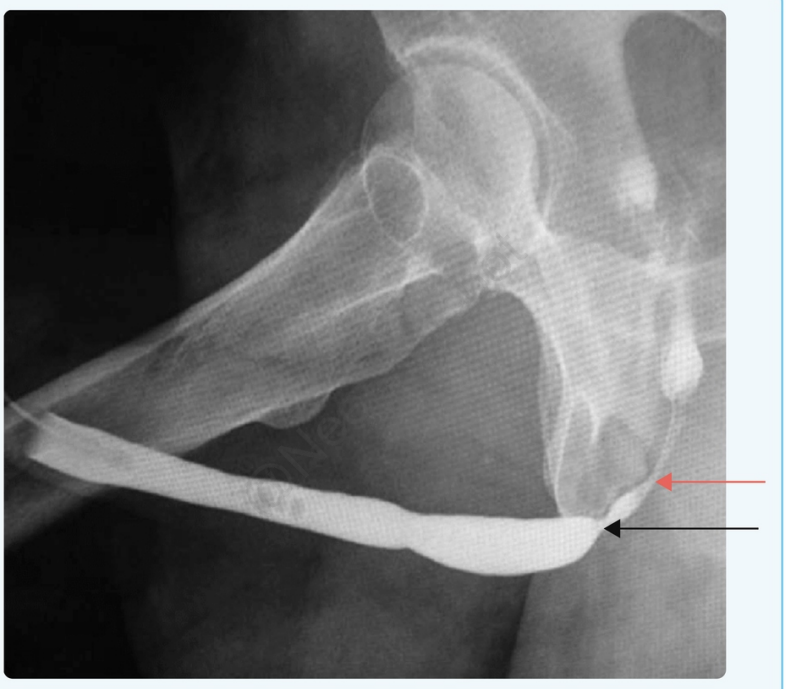


RGU MCU

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Membranous urethral (red arrow) and bulbar stricture (black arrow).

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References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1542-1545. SRB's Manual of Surgery, 6th Edition, Page 1042-1044.

↑ *Back to this question in Part A*

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Q74: A male patient was brought to the emergency department following a fall into a manhole, resulting in injury to his perineum. He experiences a strong urge to urinate but is unable to do so. During examination, blood is observed at the opening of the urethra, and there is swelling of the penis and scrotum. Which specific area is affected by the injury? (Q854961)

A. Membranous urethra rupture

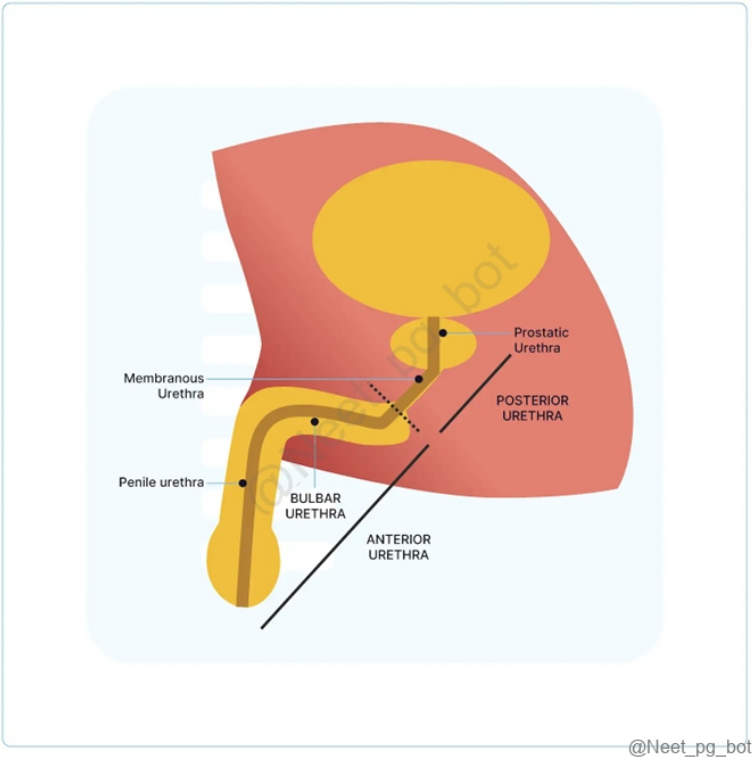
B. Bulbar urethra injury

C. Prostatic urethra injury

D. Urinary bladder rupture

Correct Answer: B. Bulbar urethra injury

Explanation: Bulbar urethra injury occurs due to trauma to the perineum, especially in cases like falls onto the perineum (e.g., falling into a manhole). The bulbar urethra is the part of the urethra that passes through the perineum, and it is the most commonly injured part in straddle/perineal trauma (anterior injury). Blood at the urethral meatus, along with swelling of the scrotum and penis, points toward this injury. Feature Anterior Urethral Injury Location Bulbar urethra (most common) Penile urethra Common Causes Straddle injuries Direct trauma Iatrogenic injuries (catheterization, cystoscopy) Penetrating trauma (stab/gunshot wounds) Clinical Features Hematuria (blood in urine) Penile/perineal bruising (butterfly-shaped hematoma) Perineal pain Urinary retention or difficulty voiding Possible swelling of the penis or scrotum due to hematoma Investigations Retrograde Urethrography (RGU) : Gold standard , shows the extent and location of injury Voiding Cystourethrography (VCUG): Used to assess urethral patency post-repair Ultrasound: Can detect hematoma or associated injuries Membranous urethra rupture (Option A) is usually identified by a high-riding prostate on digital rectal examination and difficulty voiding. However, the presence of blood at the urethral meatus and swelling of the penis and scrotum, in this case, points to a more distal injury, making membranous rupture unlikely. The membranous urethra is most commonly injured in pelvic fractures (posterior injury). Prostatic urethra (Option C) injury is uncommon and usually results from high-energy trauma, often involving significant pelvic fractures. The symptoms would be less likely to involve external swelling and blood at the meatus, which suggests of a distal injury. Urinary bladder rupture (Option D) presents with abdominal pain, tenderness, hematuria and inability to pass urine. Blood at the urethral meatus and swelling of the external genitalia are not typical findings for bladder rupture.



References:

Bailey and Love’s Short Practice of Surgery, 28th Edition, Pages 1541,1542

↑ *Back to this question in Part A*

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Q75: Which of the following should be the treatment of choice for renal cell carcinoma with a tumour less than 4 cm in size? (Q854970)

A. Partial nephrectomy

B. Partial nephrectomy + Neoadjuvant chemotherapy

C. Radical nephrectomy

D. Radical nephrectomy + Postoperative radiotherapy

Correct Answer: A. Partial nephrectomy

Explanation: For renal cell carcinoma (RCC) with a tumour size of less than 4 cm, the treatment of choice is partial nephrectomy. This approach preserves kidney function while removing the tumour, making it the preferred method for small tumours. Treatment of RCC: RCCs are radio and chemo-resistant (Option B & D ruled out) Surgical Management: Partial Nephrectomy (Option A): Involves removing only the tumour while preserving the remainder of the kidney. Indications: T1 Disease(<7cm) Restricted to poles RCC in solitary functioning kidney Radical Nephrectomy: Involves removal of the kidney with Gerota's fascia, para-aortic nodes, and ureter up to the pelvic brim. Indications: Larger tumours or when partial nephrectomy is not feasible (Option C ruled out) Ablative Techniques Radiofrequency Ablation (RFA) and Cryoablation involve destroying the tumour using extreme temperatures. Indications: Patients who are not surgical candidates Patients with small tumours (T1a lesions) (usually <4 cm). Systemic Therapy (For advanced/ metastatic disease) Targeted Therapy Tyrosine kinase inhibitors (e.g., sunitinib, pazopanib) mTOR inhibitors (e.g., everolimus) Immunotherapy: Immune checkpoint inhibitors (e.g., nivolumab)

References:

Sabiston, Text Book of Surgery, 21st Edition, Pages 2091, 2092.

↑ *Back to this question in Part A*

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Q76: A 65-year-old man presented to his primary care physician with a 3-month history of increasing urinary frequency without burning and nocturia four times each day. He has limited his fluid consumption and caffeine intake in the evening without much benefit. On prostate examination, the swelling was palpated with a smooth surface, and a firm, non-tender rubber-like consistency was found. The physician

thinks of benign prostate hypertrophy. All are characteristic features of benign prostate hypertrophy except: (Q859601)

A. Increased trabeculations in the bladder

B. J-shaped/ fish hook proximal ureter

C. J-shaped/ fish hook distal ureters

D. Bilateral hydronephrosis

Correct Answer: B. J-shaped/ fish hook proximal ureter

Explanation: Benign Prostatic Hypertrophy (BPH) causes bladder outlet obstruction, leading to a cascade of changes in the urinary tract. These changes are visible on imaging and are characteristic features of the condition. Trabeculations in the Urinary Bladder: These are muscular ridges formed from the bladder wall hypertrophying to push urine past the prostate. (Option A) Bilateral Hydroureter and Hydronephrosis: This occurs when chronic obstruction causes urine to back up, dilating both the ureters and kidneys. (Option D) J-shaped / Fish Hook Distal Ureter: This deformity is caused by the enlarged prostate elevating the bladder base, which pulls the end of the ureter upwards. (Option C) A J-shaped proximal ureter is not seen in BPH but is the characteristic sign of a retrocaval ureter.

References:

Bailey and Love's Short Practice of Surgery, 28th Edition, Pages 1522, 1523,

SRB's Manual of Surgery, 6th Edition, Page 1033, 1034

↑ *Back to this question in Part A*

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Q77: A 68-year-old man presents to OPD with a low backache. His PSA level is 100 ng/ml. Which of the following drugs is indicated for treatment? (Q859617)

A. Somatostatin

B. Terlipressin

C. Goserelin

D. Testosterone

Correct Answer: C. Goserelin

Explanation: The given condition with low back pain and an elevated PSA level of 100 ng/ml is suggestive of prostate cancer , and Goserelin is the correct drug for this patient. Goserelin is a hormonal therapy medication that is a GnRH agonist that works by reducing the levels of testosterone in the body and can help in slowing down the growth of prostate cancer cells. Prostate cancer is testosterone-dependent , and reducing testosterone levels is a critical part of managing advanced or metastatic prostate cancer. CA Prostate Management Strategy Key Points Active Surveillance For low-risk cases; regular monitoring Radical Prostatectomy Surgery for localized cancer; potentially curative Radiation Therapy High-energy rays; external or brachytherapy Hormone Therapy Reduces/block testosterone; for advanced/metastatic cases Chemotherapy Systemic drug treatment; for advanced/metastatic cases Somatostatin (Option A) analogues such as octreotide and lanreotide are used in treating conditions like acromegaly , carcinoid tumours , and neuroendocrine tumours , but they are not effective for treating prostate cancer . Terlipressin (Option B) is a synthetic analogue of vasopressin and is primarily used for the management of variceal bleeding (e.g., in cirrhosis with portal hypertension) but is not used in prostate cancer treatment. Testosterone (Option D) is the hormone that is often implicated in the growth of prostate cancer. Administering testosterone would exacerbate prostate cancer nand ot help in treating it.

References:

Bailey & Love’s Short Practice of Surgery, 28th Edition, Pages 1451 , 1533, 1534, 1535, 1536

↑ *Back to this question in Part A*

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Q78: A 25-year-old morbidly obese male patient presented with complaints of severe abdominal pain and urinary disturbances. His urine microscopy shows the following type of crystals, and an ultrasound of the kidney revealed a renal stone of size 2.5 cm. What is the treatment of choice? (Q859621)

A. Extracorporeal shockwave lithotripsy (ESWL)

B. Percutaneous nephrolithotomy (PCNL

C. Open surgery

D. Ureteroscopy-assisted removal



Correct Answer: B. Percutaneous nephrolithotomy (PCNL

Explanation: Percutaneous nephrolithotomy (PCNL) is the most suitable option for a 2.5 cm cystine stone (given in the image), especially in a morbidly obese patient where ESWL and ureteroscopy may be less effective. The given image shows hexagonal-shaped crystals that suggest cystine stones , typical of cystinuria . PCNL involves the creation of a small percutaneous tract through the skin, directly accessing the renal collecting system and is indicated for the treatment of renal stones larger than 2 cm in diameter or stones resistant to ESWL. Typically, this procedure is done in the prone position. Fluoroscopy or ultrasound is used for localisation. The posterolateral calyx is commonly chosen for entry. Management of renal stones Medical management Surgical Management Analgesics like diclofenac, ketorolac, tramadol Fluid therapy: IVF (intravenous fluids) are administered to prevent dehydration Alpha 1 blocker: Tamsulosin (relaxes ureter and expels the stone). Extracorporeal shock wave lithotripsy (ESWL): Indicated if the size of the calculi <2 cm . (Contraindicated in pregnancy and bleeding diathesis) . (Option A ruled out) PCNL (Percutaneous nephrolithotomy): If the size is >2 cm . (Option B) Ureteroscopy Retrograde intrarenal surgery Pyelolithotomy and nephrolithotomy (rarely used). Open surgery (Option C) is rarely necessary these days and is typically reserved for complex cases or when other treatments have failed. Given the effectiveness of PCNL for large stones, open surgery would not be the first option. Ureteroscopy-assisted removal (Option D) involves inserting a thin tube (ureteroscope) through the urethra and bladder to access stones in the ureter or kidney. While it is effective for smaller stones, a 2.5 cm stone in the kidney may be challenging to remove entirely using ureteroscopy alone.

References:

Harrison’s Principles of Internal Medicine, 21st Edition, Volume I, Page 2372, 2373

↑ *Back to this question in Part A*

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Q79: According to Weigert Meyer’s rule of duplication of the ureter, the lower pole ureter in the urinary bladder is: (Q859624)

A. Lateral and cephalad to the upper pole ureter

B. Lateral and caudal to the upper pole ureter

C. Medial and cephalad to the upper pole ureter

D. Medial and caudal to the upper pole ureter

Correct Answer: A. Lateral and cephalad to the upper pole ureter

Explanation: Weigert Meyer's rule states that in incomplete duplication of the ureter, the upper pole ureter is caudal and medial compared to the lower pole ureter. Hence, the statement “lower pole ureter is positioned laterally and cephalad in relation to the upper pole ureter” corresponds with the expected anatomical configuration as per Weigert Meyer's rule. Weigert Meyer's rule

References:

Bailey & Love’s Short Practice of Surgery, 28th Edition, Pages 278,1469.

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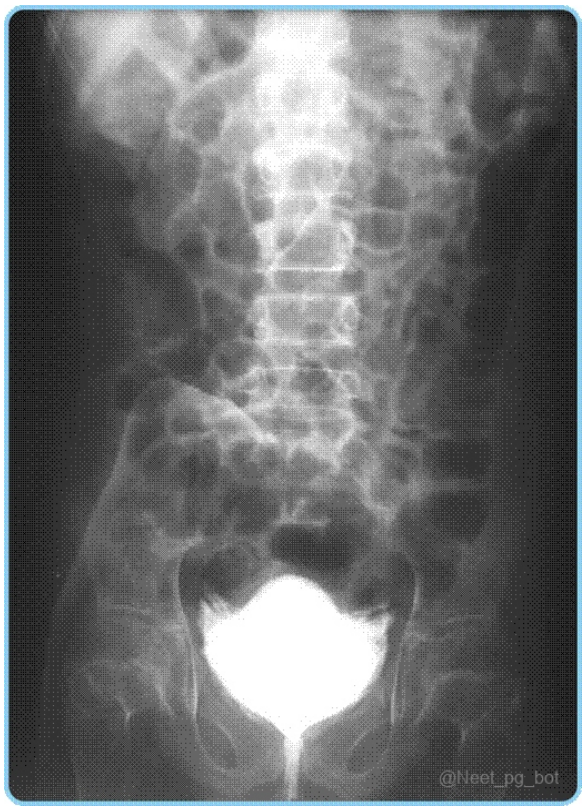
Q80: A 35-year-old male presents to the emergency department after a motor vehicle accident with a pelvic fracture and gross hematuria. The CT cystogram showed the following characteristic findings. Which of the following statements regarding the diagnosis of this patient is incorrect? (Q859625)

A. Retrograde cystography demonstrates extravasation of contrast limited to the perivesical space.

B. Catheter drainage for 10-14 days is the treatment of choice for uncomplicated cases.

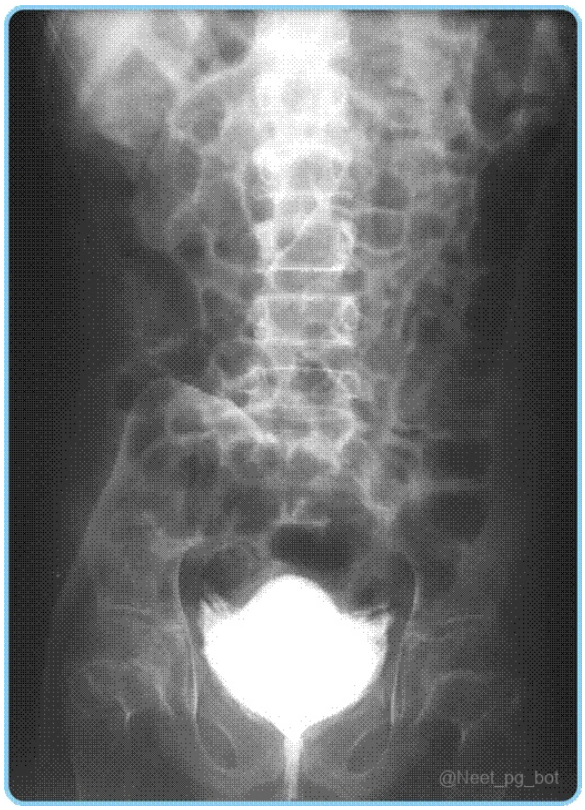
C. Immediate surgical repair in cases of bladder neck injury.

D. Both urethral and suprapubic catheters are recommended in all cases.



Correct Answer: D. Both urethral and suprapubic catheters are recommended in all cases.

Explanation: The contrast extravasation seen on CT cystography is confined to the perivesical space , giving a characteristic flame-shaped appearance , which is seen in Extraperitoneal bladder rupture. While the use of both urethral and suprapubic catheters might be considered in complex cases, it is not universally recommended. Routine use of both types of catheters can increase morbidity and delay hospital discharge. The American Urological Association (AUA) guidelines recommend against the routine placement of a suprapubic catheter following bladder injury repair. Extra peritoneal bladder rupture Definition It occurs when the bladder wall is disrupted, but the peritoneal lining remains intact, often due to trauma. Investigations CT cystography reveals characteristic features like a flame-shaped appearance, pear sign & teardrop appearance. {{caption_text}} Retrograde cystography (Option A) is the imaging modality of choice for diagnosing bladder ruptures, including extraperitoneal injuries. Extravasation of contrast limited to the perivesical space is a key finding that helps differentiate extraperitoneal from intraperitoneal ruptures, where contrast would outline bowel loops. Management Initial management (Option B): Urethral catheterisation with free bladder drainage for 10-14 days. Followed by a cystogram to confirm healing before catheter removal. If the injury is iatrogenic: Repair during the same procedure (open or laparoscopic). Repair done in two layers using 2/0 vicryl absorbable sutures Bladder injury with pelvic fracture: The bladder should be repaired at the same time during the surgery for pelvic fracture. Immediate surgical repair is indicated (Option C) in cases where there are complicating factors like intravesical bone spicules, bladder neck injuries , or associated vaginal or rectal lacerations. Laparoscopy can be used in the management of bladder rupture, particularly in cases where less invasive approaches are preferred.



References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1520

↑ *Back to this question in Part A*

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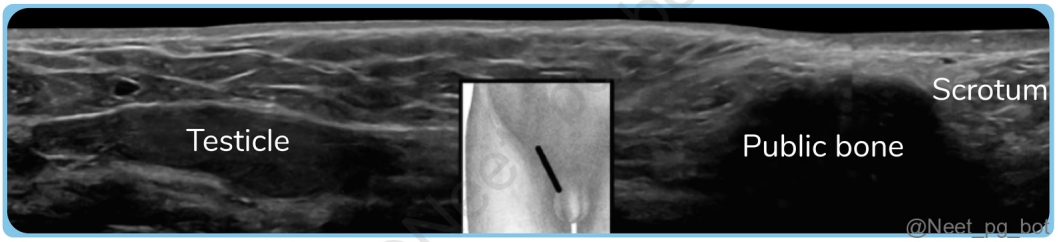
Q81: An 11-month-old boy had a recent urinary tract infection that was resolved with antibiotics. Vital signs are within normal limits. Physical examination revealed an empty scrotum on the right side with normal left testis. However, a mass was palpable on the right inguinal canal. The USG revealed the right testicle under the subcutaneous fat near the right inguinal canal, as shown in the image below. What is the next best step in management? (Q859626)

A. Observation

B. Hormonal therapy with hCG

C. Orchidopexy

D. Diagnostic laparoscopy



Correct Answer: C. Orchidopexy

Explanation: The testis is palpable in the inguinal canal (not intra-abdominal) → palpable undescended testis . Age >6 months: spontaneous descent is unlikely. Orchidopexy is recommended between 6–18 months of age to preserve fertility potential and reduce the risk of malignancy and torsion. Observation (Option A): Appropriate only if <6 months, as spontaneous descent may still occur. Hormonal therapy (Option B): Low success rate and not recommended for palpable testes. Diagnostic laparoscopy (Option D): Indicated only for nonpalpable or impalpable testes (to locate intra-abdominal or absent testis).

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Pages 1559 -1561.

SRB's Manual of Surgery, 6th Edition, Pages 1065 - 1068.

↑ *Back to this question in Part A*

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Q82: A 65-year-old male presents with a low backache and weight loss. He has progressive difficulty in urination and had an episode of urinary retention two days back, which was relieved by catheterisation. PSA was done, which was 5.2 ng/ml, and an x-ray of the LS spine showed osteoblastic changes. What is the clinical diagnosis? (Q859832)

A. Benign prostatic hypertrophy

B. Carcinoma bladder

C. Prostate cancer

D. Renal cell cancer

Correct Answer: C. Prostate cancer

Explanation: The combination of urinary symptoms , elevated PSA , and osteoblastic changes on the x-ray strongly points to prostate cancer. Osteoblastic changes in the lumbar spine are a characteristic feature that suggests bone metastasis, which is common in prostate cancer, as it frequently metastasises to bone. Investigations

for Prostate Cancer DRE Physical examination detects nodules but is limited in early-stage PSA Test Measures PSA levels; elevated levels suggest cancer TRUS Imaging with the rectal probe detects abnormalities mpMRI Advanced imaging; superior for staging and capsular spread Prostate Biopsy The gold standard for diagnosis; tissue sampling for cancer cells Benign prostatic hypertrophy (Option A) can also cause urinary symptoms like difficulty urinating and urinary retention , but it does not cause weight loss or osteoblastic bone changes on an x-ray. Additionally, the PSA in BPH is usually mildly elevated but not to the degree seen in prostate cancer. Carcinoma bladder (Option B) can cause urinary symptoms like hematuria, dysuria, or obstructive voiding symptoms, but it is less likely to cause osteoblastic changes in the bones, and the PSA elevation is also not characteristic of bladder cancer. Renal cell cancer (Option D) presents with symptoms such as hematuria, flank pain, and a palpable abdominal mass. The symptoms described by the patient, along with the elevated PSA level and osteoblastic changes on the X-ray, are not characteristic of renal cell cancer.

References:

Bailey and Love's Short Practice of Surgery, 28th Edition, Page 1451 , 1533-1536

↑ *Back to this question in Part A*

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Q83: What should be the initial course of action for a patient who has presented with a pelvic fracture and a rupture in the membranous urethra? (Q859840)

A. A suprapubic catheter should be inserted as soon as possible

B. IVP should be done

C. Immediate urethroplasty

D. MCU should be done

Correct Answer: A. A suprapubic catheter should be inserted as soon as possible

Explanation: The initial course of action for a patient with a pelvic fracture and ruptured membranous urethra is to insert a suprapubic catheter for urinary diversion. By placing a suprapubic catheter, urine can be diverted from the injured urethra, ensuring proper bladder drainage. This helps prevent urinary retention, minimises the risk of urinary extravasation, and reduces further damage to the urethra. Suprapubic catheterisation is considered a temporary solution to manage urine drainage until definitive treatment, such as urethral repair, can be performed. Membranous urethral rupture is a type of Posterior Urethral Injury. The posterior urethra consists of the prostatic urethra and membranous urethra , and injuries in this region are often caused by pelvic fractures , particularly from high-energy trauma like motor vehicle accidents. Investigations, Management & Complications of Posterior Urethral Injuries Investigations Retrograde Urethrography (RGU): Gold standard for initial assessment CT Urethrography : Useful in evaluating complex injuries Pelvic CT Scan: Important for associated pelvic fractures Cystoscopy: Sometimes performed for further evaluation If injury at Prostatomembranous junction - High lying prostate → On IVP- Pie in-sky appearance Management Initial Management: Suprapubic catheterisation for urinary diversion Delayed Urethroplasty (Definitive management): 3-6 months post-injury after inflammation and

fibrosis have subsided (Option B ruled out) Primary Realignment: Occasionally attempted if conditions permit Endoscopic Realignment: For selected cases, though often reserved for acute management Complications Urethral stricture (most common long-term complication) Urinary incontinence (due to sphincter damage) Erectile dysfunction (common due to injury near neurovascular structures) Bladder neck contracture Chronic pelvic syndrome IVP (Option B) can be useful for evaluating the urinary tract, but it is not the initial step in the management of a ruptured urethra . The patient should be stabilised first, with urinary diversion (via suprapubic catheter), before any imaging studies are done. MCU should be done (Option D): Micturating Cystourethrogram is an imaging study that evaluates the urethra and bladder during voiding. While it may be helpful in assessing the extent of a urethral injury, it is not the first step in management. The priority is to manage the patient's urinary diversion and stabilise them before any imaging studies are performed.

References:

Bailey and Love’s Short Practice of Surgery, 28th Edition, Page 1541,1542,

SRB's Manual of Surgery, 6th Edition, Pages 1040-1042

↑ *Back to this question in Part A*

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Q84: What is the cause of the following appearance in IVP? (Q859841)

A. Horseshoe kidney

B. Ureterocoele

C. Bladder tumour

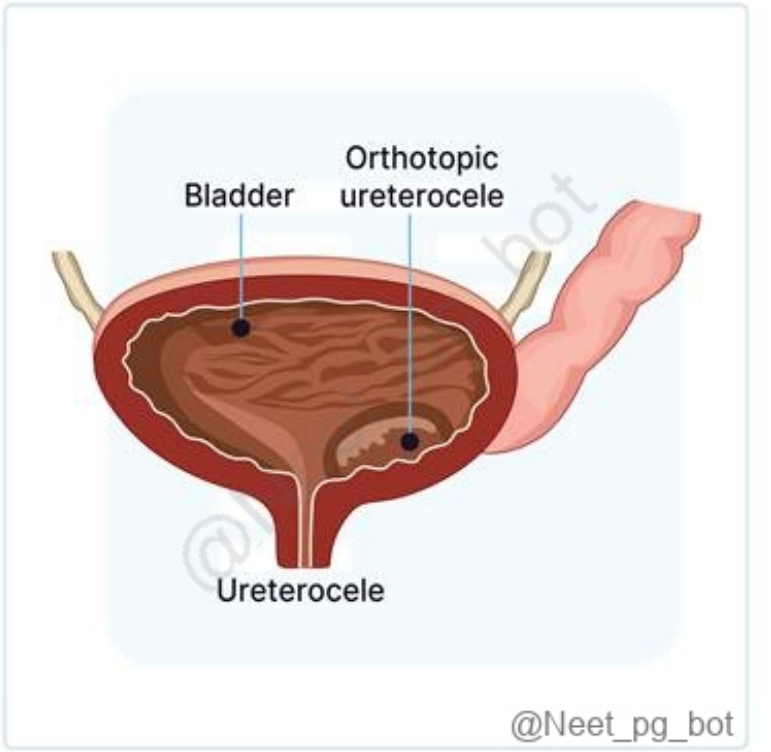
D. Posterior urethral valve

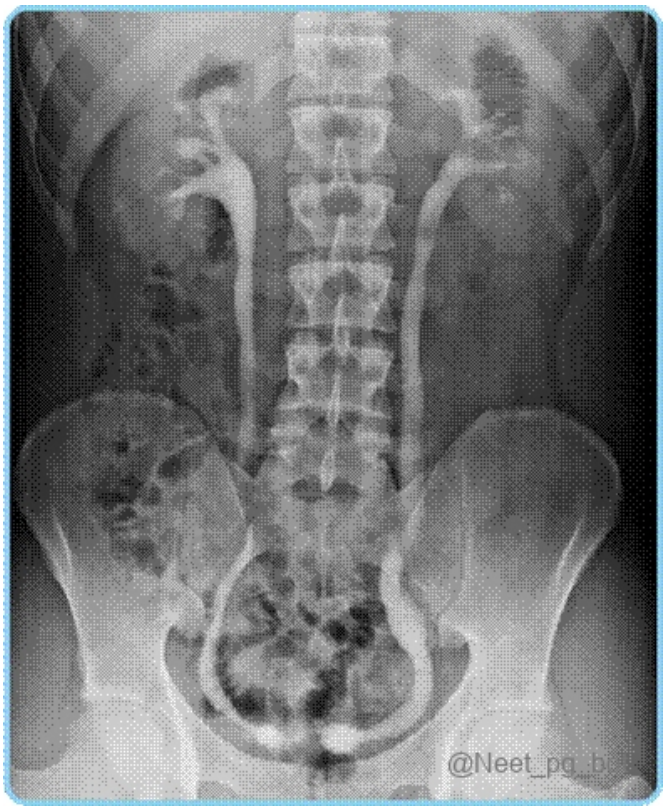


Correct Answer: B. Ureterocoele

Explanation: The cobra head appearance in IVP is most characteristic of ureterocoele , where there is a cystic dilation of the distal ureter at its insertion into the bladder. Ureterocele is the congenital dilation of the distal ureter within the bladder wall. It can obstruct urine flow, leading to recurrent UTIs and hydronephrosis. Treatment often involves surgical correction to relieve the obstruction. Ureterocoele Types Simple Ureterocele (Intravesical - 20%): Found entirely within the bladder and associated with a single ureter. It is less complex and easier to manage. Ectopic Ureterocele (80%) : Extends beyond the bladder and often involves a duplicated ureter. This is more complicated due to its location, which may involve the bladder, neck, or urethra. Etiology Congenital anomaly is caused by an obstruction in the development of the distal ureter during fetal growth, leading to cystic dilation at the ureteral orifice. Clinical Features Recurrent Urinary Tract Infections (UTIs)/ Urosepsis. Unilateral Hydroureteronephrosis. Palpable Abdominal Mass: Particularly in children, where a distended bladder or large ureterocele might be felt as a mass. Investigations Ultrasound (USG): The first-line imaging modality revealing hydroureteronephrosis and a cystic structure in the bladder. Micturating Cystourethrogram (MCU): Demonstrates a filling defect in the bladder caused by the ureterocele. Cystoscopy: Allows direct visualisation of the ureterocele as a cystic structure that enlarges and collapses with urine flow in the bladder. Intravenous Pyelogram (IVP): The investigation of choice (IOC) for diagnosing ureterocele, showing the characteristic "adder head" or "cobra head" appearance due to the dilated ureter within the bladder. {{caption_text}} Cobra head or adder head appearance Treatment The treatment approach depends on the type of ureterocele: Intravesical Ureterocele: Typically managed with an incision over the cyst wall to allow free flow of urine into the bladder, relieving the obstruction. Ectopic Ureterocele: More complex, often requiring surgical excision of the ureterocele and reimplantation of the ureter into the bladder to correct the abnormal anatomy. Associated Congenital Abnormalities The most common congenital abnormality of the upper urinary tract is ureteral duplication , which can be associated with ureterocele. Vesicoureteric reflux (VUR) , another common congenital abnormality, may occur in conjunction with ureterocele, particularly in cases involving ureteral duplication. Horseshoe kidney (Option A) refers to a

congenital fusion of the lower poles of the kidneys, forming a U-shape. IVP here shows characteristic findings, which include medial orientation of calyces (Hand Joining Sign) and high insertion of ureters with anterior transposition ("Flower Vase" appearance of the ureters) . {{caption_text}} {{caption_text}} Bladder tumour (Option C) may cause various structural changes in the bladder, but it normally does not result in the distinct cobra head appearance seen in the ureterocoele. Bladder tumours are more likely to show mass-like lesions or irregularities in the bladder contour. Posterior urethral valve (Option D) Posterior urethral valves are a congenital abnormality in males where there is a flap-like obstruction in the posterior urethra. This condition is typically diagnosed in infancy or childhood. While an IVP may show associated findings, such as bladder distention or bilateral hydronephrosis, it does not typically cause the cobra head appearance seen in the ureterocoele .







Flower vase appearence of ureter

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References:

Bailey and Love's Short Practice of Surgery, 28th Edition, Page 1467

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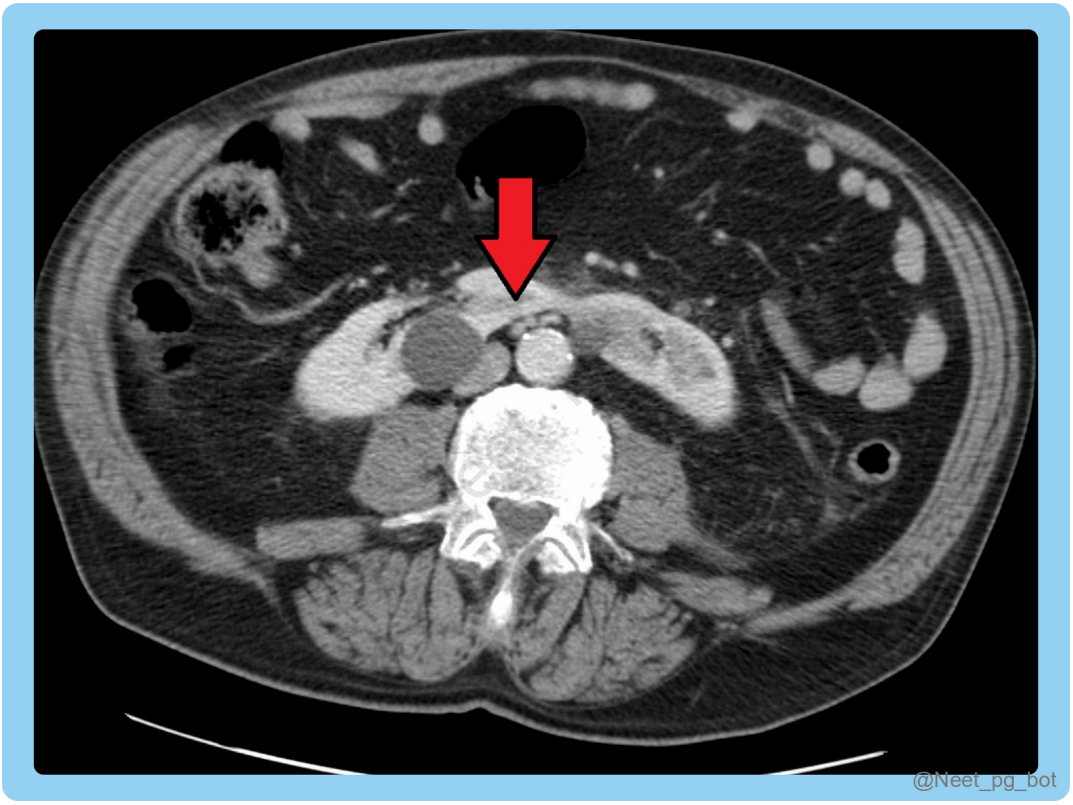
Q85: A 30-year-old man developed abdominal pain for which he was being evaluated. You notice the following in his CECT. What is the likely condition indicated by the arrow in the image? (Q859842)

A. Appendicitis

B. Horseshoe kidney

C. Wilms tumor

D. Abdominal aortic aneurysm



Correct Answer: B. Horseshoe kidney

Explanation: The most likely condition, based on the provided options and typical CT findings, is Horseshoe kidney . It is a congenital anomaly where the two kidneys are fused at their lower poles, forming a “U” or "horseshoe" shape. Horseshoe kidney Causes During fetal development, the kidneys fuse at their lower poles, forming a U-shaped structure. This fusion results in the inferior mesenteric artery preventing the ascent of the isthmus of the kidney to its normal position in the abdomen, leading to an abnormal location lower in the abdomen. Clinical features Mostly asymptomatic. Pain: due to obstruction or renal stones. Recurrent urinary tract infections (UTIs). Hydronephrosis. Hematuria Rovsing's syndrome: Hyperextension of the spine- nausea, vomiting, abdominal pain. Investigations CT Angiography (CT Angio): This is the investigation of choice for diagnosing a horseshoe kidney, as it allows for detailed visualisation of the renal anatomy, the abnormal vascular supply, and associated complications. Contrast-Enhanced CT (CECT): Used when CT Angio is not available Intravenous Pyelogram (IVP) - characteristic findings include : Medial Orientation of Calyces: Referred to as the " Hand Joining Sign." High Insertion of Ureters with Anterior Transposition: This creates a "Flower Vase" appearance of the ureters. {{caption_text}} {{caption_text}} Treatment Treatment depends on the presence and severity of symptoms: Asymptomatic Patients: Typically do not require treatment but should be monitored periodically. Symptomatic Patients: UPJ Obstruction: Surgical intervention such as pyeloplasty Kidney Stones: Management may include conservative measures like increased fluid intake, medical therapy, or surgical removal UTIs: Treated with antibiotics, and preventive measures may be considered if infections are recurrent. Isthmus Management: The isthmus of the horseshoe kidney should not be divided surgically as it contains functional renal tissue. Pregnancy Considerations: A horseshoe kidney can lead to dystocia (difficult labour) due to the kidney's abnormal position. Appendicitis (Option A) often presents with right lower quadrant abdominal pain, and in CT, it typically shows a dilated, inflamed appendix. It wouldn't have a horseshoe-shaped mass as seen in the CT scan, making this option unlikely in the given context. {{caption_text}} Wilms tumour (Option C) is a pediatric malignancy of the kidney, and it would present as a mass in the kidney, often seen as well-defined & lobulated.

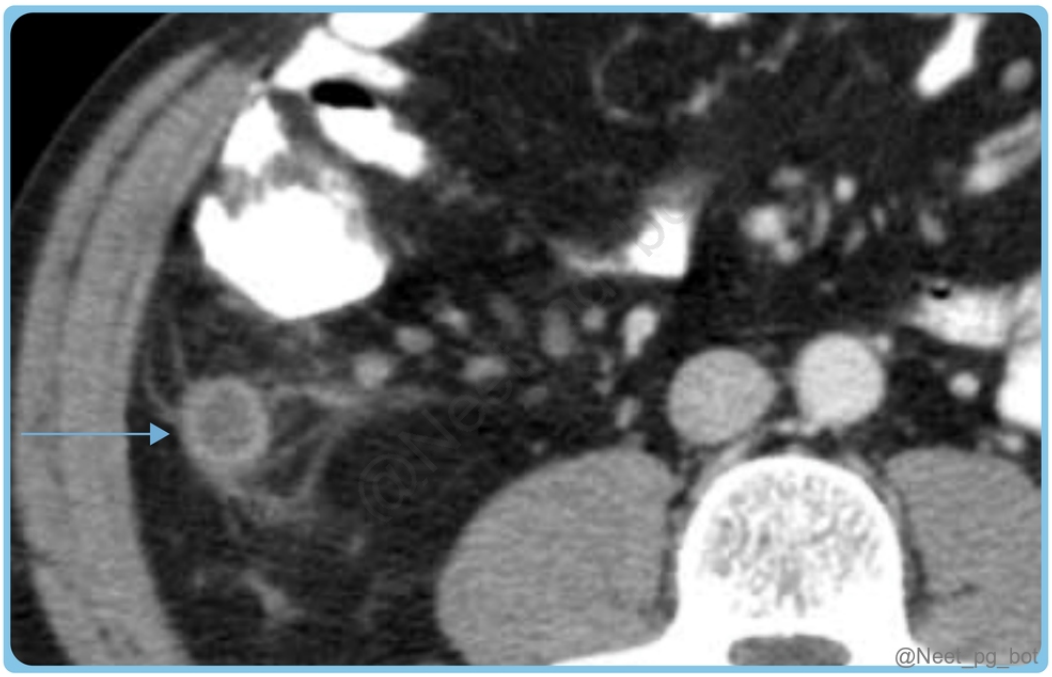
While it can be seen in adults, it’s far more common in children. The tumour's presentation wouldn't usually show a horseshoe shape, and it would commonly be isolated in one kidney. {{caption_text}} Abdominal aortic aneurysm (Option D) appears as a focal dilation of the abdominal aorta, often seen in the midline of the abdomen. It can cause abdominal pain, but it would not present as a kidney-shaped mass or with the characteristic "horseshoe" shape. {{caption_text}}



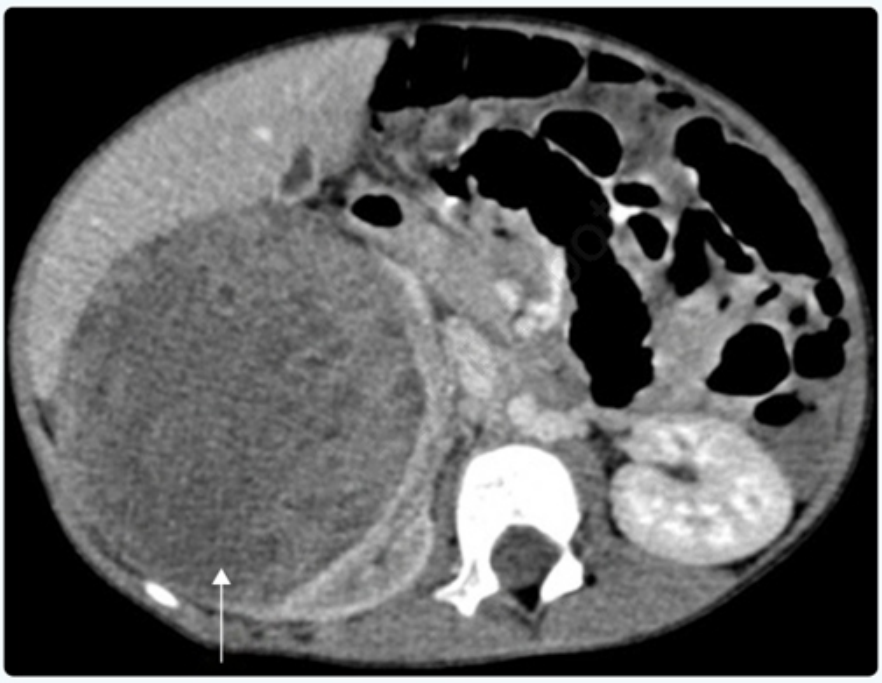


Hand joining sign

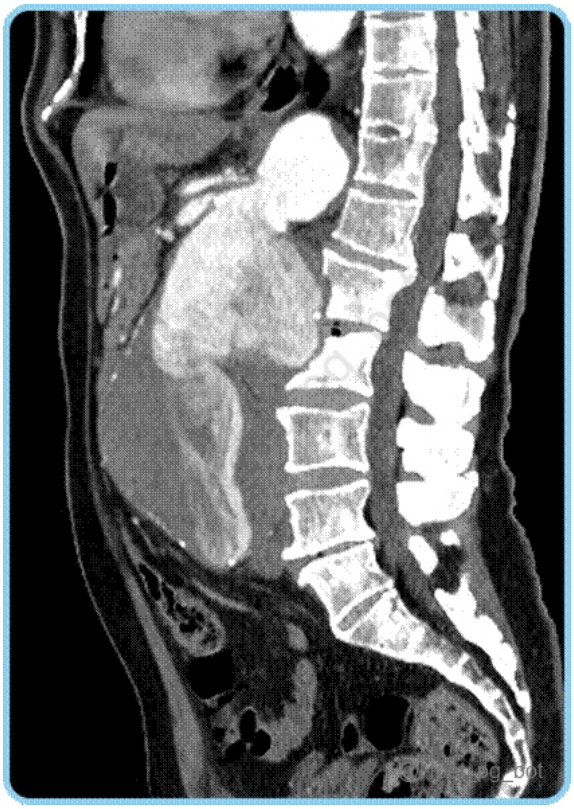
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CT showing Wilms tumour @Neet_pg_bot



References:

Bailey and Love's Short Practice of Surgery, 28th Edition, Page 1466

↑ *Back to this question in Part A*

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Q86: What is the likely diagnosis for a patient who visited the outpatient department (OPD) experiencing intense pain during erection and a deviated penis for the past half-year? (Q859845)

A. Peyronie’s disease

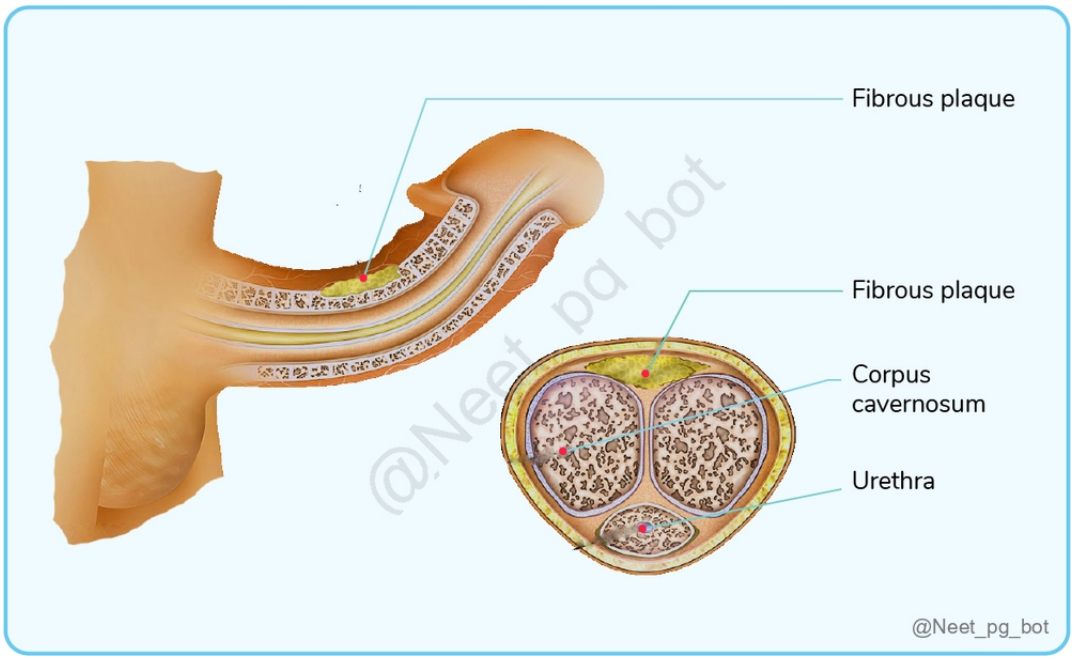
B. Priapism

C. Marion’s disease

D. Erectile dysfunction

Correct Answer: A. Peyronie’s disease

Explanation: The patient described in the scenario, experiencing intense pain during erection and a deviated penis for the past six months, is most likely suffering from Peyronie’s disease . Peyronie’s disease Definition It is characterised by fibrous plaques in the tunica albuginea of the penis, causing abnormal curvature during erections. Characteristics Plaque Location: Typically on the dorsolateral aspect of the penis. Curvature: Resulting from plaque contraction. {{caption_text}} Causes Trauma/Injury: Repeated minor trauma to the penis. Genetic Factors: Possible genetic predisposition. Connective Tissue Disorders: Associated with conditions like Dupuytren’s contracture. Associated Conditions Galezia’s Triad: Dupuytren’s Contracture: Thickening and shortening of connective tissue in fingers. Retroperitoneal Fibrosis: Fibrosis in the retroperitoneal space. Peyronie’s Disease Clinical Features Painful Erection Erectile Dysfunction Penile Curvature Palpable Plaques Impotence & Infertility (in severe cases) Treatment Observation: Spontaneous Resolution: Often improves without treatment. Medical Management: Oral Medications: Pentoxifylline, colchicine, vitamin E (efficacy varies). Surgical Intervention (If Spontaneous Resolution Does Not Occur): Nesbit Operation: Placement of a non-absorbable suture opposite the plaque to correct the curvature. Plication Surgery: Shortens the longer side of the penis. Plaque Excision and Grafting: Removes plaque and replaces it with graft material. Penile Prosthesis: For severe cases. Priapism (Option B) is a condition where a prolonged and often painful erection occurs unrelated to sexual stimulation. It is typically unrelated to penile curvature and is caused by abnormal blood flow in the penis, leading to stagnant blood in the erectile tissues. It is considered a urological emergency and requires immediate medical attention. Marion’s disease (Option C) is also known as bladder neck stenosis or primary bladder neck obstruction (PBNO). Marion described diseases affecting the bladder and neck as causing urinary disturbances resembling those caused by prostate enlargement. However, these disturbances result from changes in the bladder neck itself, without any visible abnormalities. Erectile dysfunction (Option D) is the inability to achieve or maintain an erection sufficient for sexual intercourse. It is not associated with pain or penile curvature. In some cases, pain or discomfort may accompany an erection, but it is not the primary symptom of ED.



References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1550,

SRB's Manual of Surgery, 6th Edition, Page 1051.

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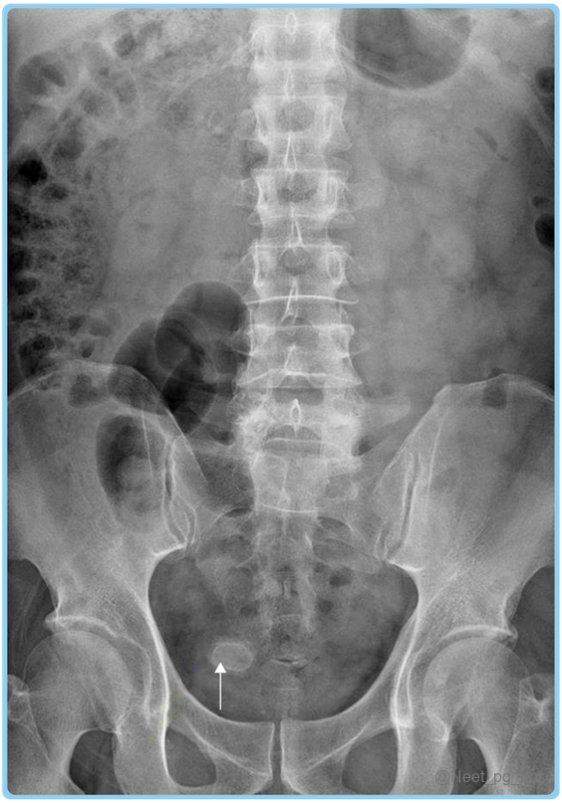
Q87: What is the diagnosis based on the X-ray given below? {{caption_text}} (Q859858)

A. Renal calculi

B. Bladder calculi

C. Schistosomiasis

D. Ureteric calculi



Correct Answer: B. Bladder calculi

Explanation: The X-ray image shows radio-opaque shadows within the pelvis, which are consistent with bladder calculi. Bladder stones can be classified into primary and secondary types based on their underlying causes. Type Primary Bladder Stones Secondary Bladder Stones Causes Nutritional deficiency (Vitamins A, B6, magnesium, protein-carbohydrate imbalance) Bladder outlet obstruction, infection, foreign body presence Common Composition Ammonium urate, calcium oxalate Uric acid, struvite (infection-related) Common Population Children in developing countries Adults with urinary tract dysfunction or infection Clinical Presentation May be asymptomatic or present with dysuria, hematuria Hematuria, dysuria, frequency and urgency, Investigations A simple X-ray, renal tract ultrasound or CT scan Renal calculi (Option A) are typically found in the renal pelvis or kidney . Though they can cause similar symptoms, they are located in the upper urinary tract so that they would be seen above the bladder, not within it. Schistosomiasis (Option C) is a parasitic infection caused by Schistosoma species, which can affect the bladder and cause hematuria , bladder fibrosis , and calcification . The infection can result in bladder wall calcifications , and the radiograph shows the classic appearance of the calcified bladder, which resembles a fetal head in the pelvis, but these would not appear as radio-opaque stones in the bladder. Ureteric calculi (Option D) are stones located in the ureters , which are the tubes that carry urine from the kidneys to the bladder. These stones can cause intense flank pain , hematuria, and urinary obstruction. However, they are usually not seen within the bladder , and the X-ray shows radio-opaque shadows specifically in the bladder , not along the ureter.

References:

Bailey & Love’s Short Practice of Surgery, 28th Edition, Page 1509

↑ *Back to this question in Part A*

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Q88: A 60-year-old patient undergoes TURP, and after 3 days, the patient develops altered sensitiveness and drowsiness. The most probable diagnosis is: (Q859864)

A. Hypernatremia

B. Hyponatremia

C. Stroke

D. Meningitis due to spinal anaesthesia

Correct Answer: B. Hyponatremia

Explanation: The patient is experiencing altered sensitivity and drowsiness 3 days after undergoing TURP (Transurethral Resection of the Prostate) , raising suspicion for hyponatremia as the most likely diagnosis. TURP Syndrome is a complication that can occur after a TURP procedure, which results from excessive absorption of irrigating fluids during the surgery, leading to hyponatremia , fluid overload , and a variety of systemic symptoms. TURP Syndrome Pathophysiology It is because fluid is absorbed intravascularly due to high volumes of hypotonic irrigation fluid used during the resection, causing dilutional hyponatremia and various neurologic symptoms. Risk factors Size of prostate > 75g Duration of surgery > 90 minutes Pre-existing hyponatremia Renal failure Clinical presentation Confusion, Agitation, Nervousness, Nausea, Hemolysis, Visual disturbances, Coma and shock. Treatment Drug of choice: IV furosemide. Mild to moderate cases: IV furosemide and normal saline Severe or symptomatic patients: IV 3% Saline Fluid restriction: Useful after initial stabilisation and correction of severe hyponatremia to prevent further fluid overload. Hypernatremia (Option A) symptoms include thirst , muscle twitching , muscle weakness, seizures and confusion . It is less likely in this case since the patient is experiencing drowsiness , which is more characteristic of hyponatremia . Stroke (Option C) can present with altered consciousness or neurological deficits such as hemiparesis or aphasia . However, stroke symptoms typically present suddenly and are not typically related to a postoperative time frame of 3 days. The timing of the symptoms makes a stroke less likely unless there is a specific underlying vascular issue. Hyponatremia is a more common cause of these symptoms after TURP. Meningitis due to spinal anaesthesia (Option D) is a rare complication, with symptoms including fever , headache , neck stiffness, nausea, vomiting and photophobia . The timing of the symptoms (3 days after surgery) is not typical for spinal meningitis . Also, the given symptoms align more with hyponatremia .

References:

Bailey and Love’s Short Practice of Surgery, 28th Edition, Page 1530

↑ *Back to this question in Part A*

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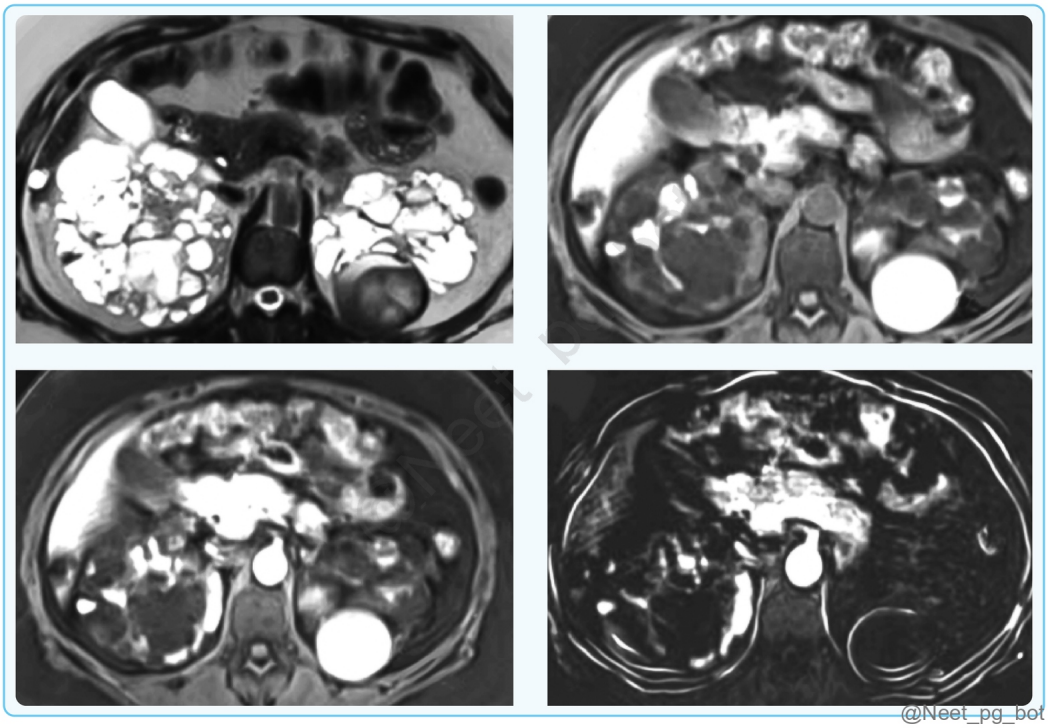
Q89: A 40-year-old man with a known case of hypertension presented with multiple episodes of hematuria and loin pain. His elder brother passed away due to a stroke at the age of 40. The CT abdomen is shown below. What is the probable diagnosis? (Q855565)

A. Renal cell carcinoma

B. Autosomal dominant polycystic kidney disease

C. Tuberculosis of the kidney

D. Autosomal recessive polycystic kidney disease



Correct Answer: B. Autosomal dominant polycystic kidney disease

Explanation: The CT scan shows bilaterally enlarged kidneys with multiple cysts of varying sizes, a classic feature of ADPKD. The patient has hypertension, which is a common early manifestation of ADPKD due to cyst-induced renal ischemia. Recurrent hematuria and loin pain occur from cyst rupture, infection, or stones. A strong family history is present- his brother died of a stroke at 40, suggesting a ruptured berry aneurysm, which is strongly associated with ADPKD. ADPKD is the most common hereditary kidney disease and typically presents in adulthood (30–50 years). The combination of clinical findings + imaging + family history makes ADPKD the most likely diagnosis. Incorrect Options: Renal cell carcinoma (Option A) can present with hematuria as a common feature; it typically presents with a mass or a solitary tumour, not multiple cysts on CT. Tuberculosis of the kidney (Option C) usually presents with symptoms like hematuria, dysuria, fever, and flank pain and would not show cystic lesions on CT. Putty kidney refers to the appearance of the kidney in advanced renal tuberculosis, characterised by a pale, nodular surface due to caseous necrosis. {{caption_text}} Autosomal recessive polycystic

kidney disease (Option D) typically presents in childhood with liver involvement and more severe kidney dysfunction, whereas the patient's age and presentation point more toward ADPKD.



References:

SRB’s Manual of Surgery, 6th Edition, Pages 994, 995

↑ *Back to this question in Part A*

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Q90: What is the probable diagnosis for an elderly male patient who experienced scrotal pain and discharge, as indicated in the provided image? (Q855763)

A. Torsion of testis

B. Acute epididymo-orchitis

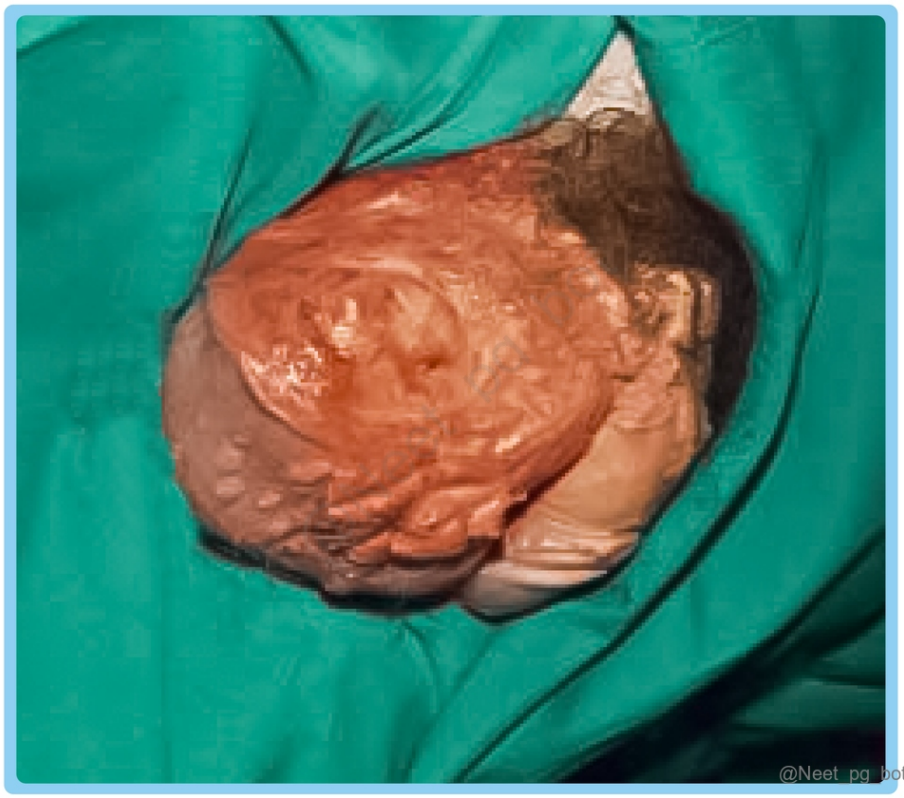
C. Scrotal carcinoma

D. Fournier’s gangrene



Correct Answer: D. Fournier’s gangrene

Explanation: The given image and the symptoms are suggestive of Fournier’s gangrene. Fournier's Gangrene Definition Necrotizing infection of the soft tissues in the perineum, external genitalia, and perianal region, akin to necrotizing fasciitis. Clinical Presentation Symptoms: Intense pain in the genitalia, progressing through five phases: Prodromal Phase : Fever and lethargy. Early Pain Phase : Intense pain, possible edema, pruritus. Progressive Phase: Increased pain and erythema. Crepitation Phase: Dusky skin with subcutaneous crepitation. Gangrene Phase: Gangrene with purulent discharge. Pain may decrease as gangrene progresses. Severity ranges from localised tenderness to septic shock. Risk Factors Peripheral vascular disease, diabetes mellitus, malnutrition, alcoholism, immunocompromised states. Diagnosis Clinical presentation supported by imaging or lab findings. Management Initial Treatment: Fluid resuscitation. Broad-spectrum antibiotics. Surgical debridement of necrotic tissue. Additional Measures: Urinary and fecal diversion to prevent wound contamination. Intensive monitoring for sepsis. Wound review and vacuum-assisted dressing. Skin grafting post-infection control. Torsion of the testis (Option A) is an emergency condition where the testis twists on its axis, compromising blood supply and potentially leading to gangrene within 12-24 hours. It presents with a sudden onset of severe scrotal pain and swelling but without the extensive tissue necrosis and discharge seen in Fournier’s gangrene. Acute epididymo-orchitis (Option B) is an inflammation of the epididymis and testis , typically caused by bacterial infections. It causes painful swelling of the scrotum and is usually accompanied by fever and urinary symptoms, but it doesn’t cause necrotic tissue or the severe systemic toxicity seen in Fournier’s gangrene. Scrotal carcinoma (Option C) usually presents as a painless mass or ulcerated lesion with everted edges and indurated base. It is not typically associated with acute pain, discharge, or the rapid onset of a severe infection, as seen in Fournier’s gangrene. {{caption_text}}



References:

Sabiston, Text Book of Surgery, 21st edition, page 1372

↑ *Back to this question in Part A*

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Q91: A patient presents with prostate carcinoma, which has now spread to the vertebra. What is the route of spread to the lumbar vertebra? (Q855766)

A. Batson's plexus

B. Transcoelomic spread

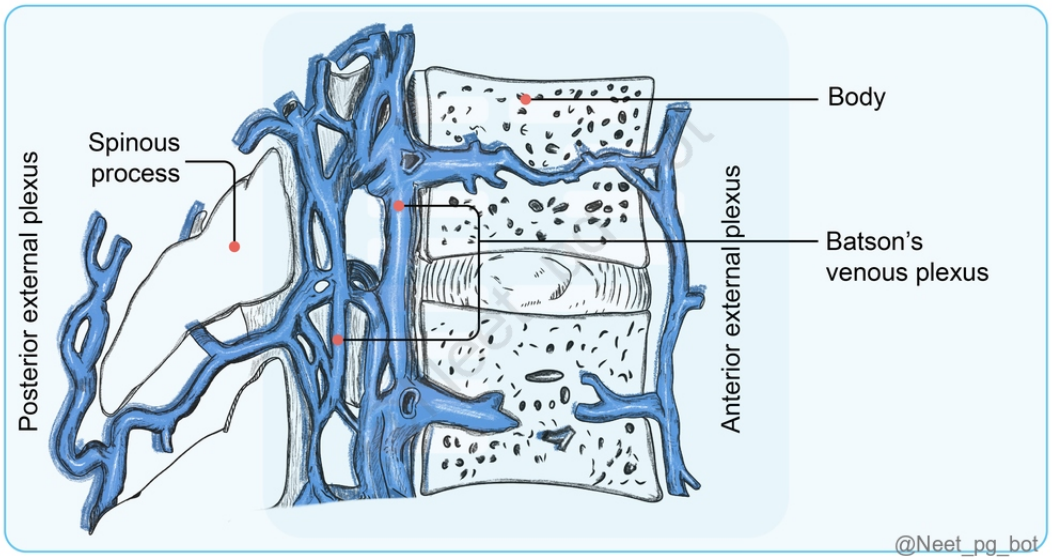
C. Inferior vesical vein

D. Internal iliac vein

Correct Answer: A. Batson's plexus

Explanation: The most likely route of spread to the lumbar vertebra is through Batson's plexus . Batson's plexus , or the vertebral venous plexus , is a network of veins that connects the pelvic venous system to the spinal venous

system. This plexus is valveless , allowing for retrograde blood flow, meaning that prostate cancer cells can travel upwards and spread directly to the vertebrae. Routes of the spread of prostate cancer: Most common route of spread- haematogenous (skeletal metastases: pelvic bones and the lower lumbar vertebrae) (through Batson's plexus) Other routes- local, lymphatic {{caption_text}} Transcoelomic spread (Option B) refers to the spread of cancer cells through the peritoneum, but it is not a typical route for prostate cancer to reach the lumbar vertebrae. Inferior vesical vein (Option C) drains the prostate and bladder but does not provide a direct route to the lumbar vertebrae. It drains into the internal iliac vein , which does not facilitate metastatic spread to the vertebrae. Internal iliac vein (Option D) drains the pelvic organs, including the prostate, but it does not directly connect to the spinal venous system where prostate cancer metastasis occurs to the vertebrae.



References:

Bailey and Love's Short Practice of Surgery, 28th Edition, Pages 1531 - 1534

↑ *Back to this question in Part A*

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Q92: A 6-year-old boy came with a history of recurrent urinary tract infections. Imaging was done and is shown below. What is the diagnosis? (Q855781)

A. Vesicoureteric reflux

B. Urinary bladder diverticulum

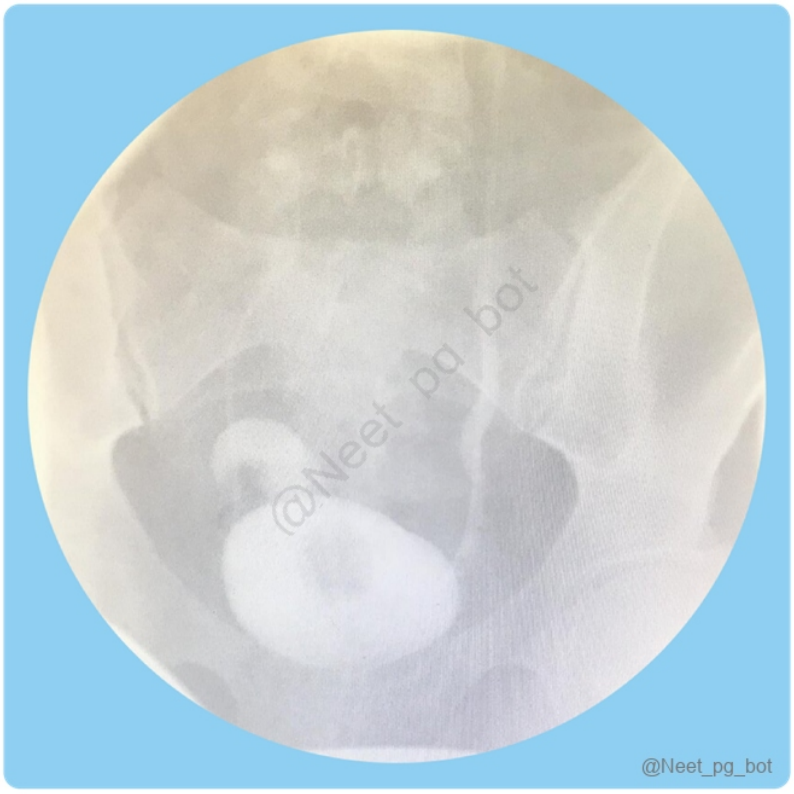
C. Urinary bladder hernia

D. Vesicocolic fistula



Correct Answer: A. Vesicoureteric reflux

Explanation: The history of recurrent urinary tract infections (UTIs) in a 6-year-old boy, along with the imaging findings, strongly suggests vesicoureteric reflux (VUR). The imaging shown in the question is a voiding cystourethrogram, which is a test that helps diagnose VUR. In this test, a catheter is placed in the bladder, and a special dye is inserted through the catheter. X-ray images are taken while the child urinates, showing whether the dye flows backwards into the ureters or kidneys. Vesicoureteric reflux Causes Congenital: Commonly associated with posterior urethral valve Acquired: Trauma due to surgery or intervention Clinical Features Recurrent UTI and Pyelonephritis Palpable mass in the loin Renal failure in bilateral cases Complications Renal scarring, if not managed in symptomatic patients Investigations Micturating cystourethrogram (IOC) Intravenous urography Urine microscopy and C/S Blood urea and serum creatinine Treatment Grade I to III- Antibiotic Prophylaxis as it resolves spontaneously in most patients. Grade IV to V- Antibiotics + Surgery Only symptomatic patients require surgical correction via ureteric reimplantation. Surgery: Ureterovesicoplasty Ureteric reimplantation (Lich-Gregoir technique) STING Operation (Endoscopic) Severe cases may require nephrectomy and renal transplantation. Urinary bladder diverticulum (Option B) is an outpouching of the bladder wall, which can occur due to increased bladder pressure or congenital weakness. It is not typically associated with the backward flow of urine into the ureters. {{caption_text}} Cystogram showing bladder outpouching Urinary bladder hernia (Option C) is a rare condition where part of the bladder herniates through the weakness in the abdominal wall. This condition is not associated with reflux of urine into the kidneys. Vesicocolic fistula (Option D) is an abnormal connection between the bladder and the colon, usually caused by diverticulitis or carcinoma. It can lead to symptoms like fecaluria and recurrent UTIs . However, the imaging would show an abnormal connection between the bladder and colon, which is inconsistent with VUR.



References:

SRB's Manual of Surgery, 6th Edition, Page 1028, 1029

↑ *Back to this question in Part A*

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Q93: A young male patient with a history of a motor vehicle accident cannot pass urine. Blood is seen at the meatus. What is the most likely site of urethral injury? (Q855797)

A. Bulbar urethra

B. Spongy urethra

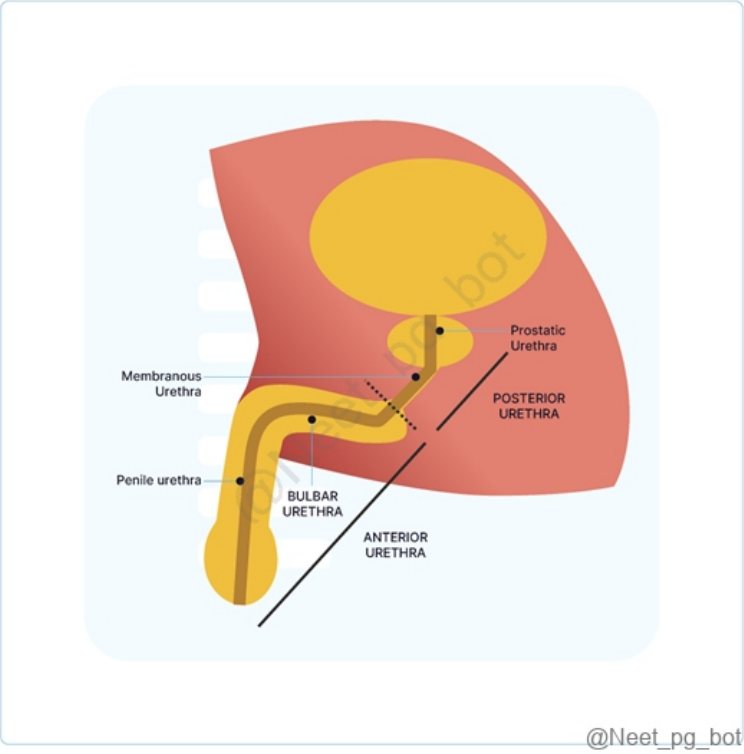
C. Membranous urethra

D. Penile urethra



Correct Answer: C. Membranous urethra

Explanation: The most likely site of urethral injury in a young male with the inability to urinate , blood at the meatus , and a history of motor vehicle accidents is the membranous urethra . In the picture, a retrograde urethrogram is shown to assess for extravasation, and the leak is noted proximal to the bulbar urethra , indicating injury to the membranous urethra Feature Membranous urethra Location Membranous urethra (bulbomembranous junction most common) Common Causes Pelvic fractures (often due to motor vehicle accidents) Blunt trauma Clinical Features Blood at the meatus Inability to void High-riding prostate on rectal exam Perineal or suprapubic pain Pelvic hematoma associated with pelvic fractures Possible concomitant bladder injury Investigations Retrograde Urethrography (RGU): Gold standard for initial assessment CT Urethrography: Useful in evaluating complex injuries Pelvic CT Scan: Important for associated pelvic fractures Cystoscopy: Sometimes performed for further evaluation If injury at Prostatomembranous junction - High lying prostate → On IVP- Pie in sky appearance Bulbar urethra (Option A) is located in the penile shaft and is more flexible than the membranous urethra. It is more typically associated with straddle injuries or direct blows to the perineum rather than motor vehicle accidents Spongy urethra (Option B) is also known as the penile urethra . It is the part of the urethra that runs along the shaft of the penis . Penile fractures or direct blows to the penis can cause injuries to the penile urethra, but motor vehicle accidents typically cause pelvic fractures that affect the membranous urethra. Penile urethra (Option D) is the part of the urethra that runs along the shaft of the penis . Penile fractures or direct blows to the penis can cause injuries to the penile urethra, but motor vehicle accidents typically cause p elvic fractures that affect the membranous urethra.



References:

Bailey and Love's Short Practice of Surgery, 28th Edition, Pages 1541,1542.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q94: A delayed intravenous urogram of a patient is given below. What is the likely diagnosis? (Q855803)

A. Pelviureteric junction obstruction

B. Putty kidney

C. Staghorn calculus

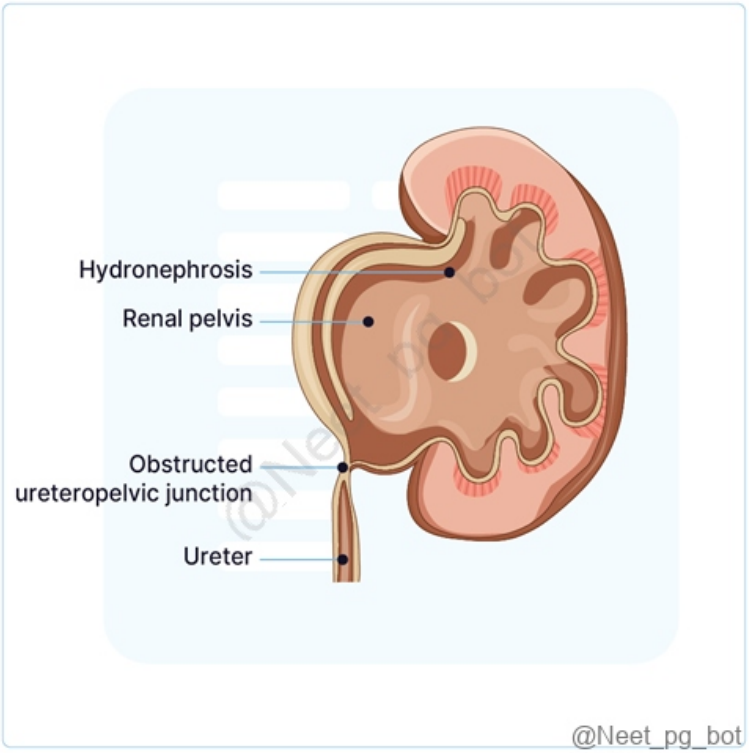
D. Cystic kidney



Correct Answer: A. Pelviureteric junction obstruction

Explanation: In a delayed intravenous urogram (IVU), the delayed contrast uptake seen in the right kidney suggests an obstruction at the pelvic ureteric junction (PUJ) Pelviureteric Junction (PUJ) obstruction is a condition where the flow of urine from the renal pelvis into the ureter is impeded due to a narrowing or blockage at the junction between the renal pelvis and the ureter. Key radiologic features include (for this case): Dilated renal pelvis and calyces (hydronephrosis) on right side Delayed contrast excretion on affected side Abrupt cut-off/narrowing at the pelviureteric junction Normal left kidney with prompt contrast excretion No contrast in right ureter - indicates obstruction at PUJ level Ballooning of renal pelvis with dilated calyces Pelviureteric junction obstruction Causes Congenital Atresia/stenosis - Developmental anomaly that leads to an intrinsic narrowing Aberrant left renal artery - The presence of an abnormal blood vessel compressing the junction externally Acquired Scarring from previous infections Kidney stones (most common) Surgery - stricture formation Clinical Features Intermittent Flank Pain - increased fluid intake or diuresis, which increases urine production and pressure at the obstruction site. Hematuria - if there are associated kidney stones. Recurrent Urinary Tract Infections Hydronephrosis - may be asymptomatic in the early stages. Investigations Ultrasound Diuretic Renal Scan (DTPA Scan) - Investigation of choice Whittaker’s Test: This is an invasive pressure-flow study used if the DTPA Scan is equivocal, to differentiate between true obstruction and non-obstructive hydronephrosis by measuring the pressure gradient across the PUJ. Magnetic Resonance Urography (MRU): Helps to pinpoint the location and cause of the obstruction. Putty kidney (Option B) is a sequela of genitourinary tuberculosis (GUTB) characterised by "extensive dystrophic calcification involving all or most of the kidney, seen as calcified non-functioning renal tissue. " It is the end stage of renal tuberculosis , which causes the kidney to malfunction. Staghorn calculus (Option C) is a large kidney stone that fills the renal pelvis and branches out into the calyces , forming a shape resembling a stag’s antlers. It is also known as triple phosphate stone (MgNH4Po4), which is caused by recurrent UTI and is associated with urea-splitting organisms. Cystic kidney (Option D) is a condition in which the kidneys contain numerous fluid-filled sacs or cysts. This can cause enlargement of the kidneys and

impair their function, but it does not cause obstruction or delay of contrast dye uptake, as seen in the image provided.



References:

Bailey and Love's Short Practice of Surgery, 28th Edition, Pages 1468, 1469.

↑ *Back to this question in Part A*

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Q95: What is the initial management approach for urinary symptoms in a patient with benign prostatic hyperplasia (BPH) ? (Q794786)

A. TURP: Transurethral resection of prostate

B. Tamsulosin

C. Finasteride

D. Observation

Correct Answer: B. Tamsulosin

Explanation: Correct Option B - Tamsulosin: Tamsulosin is used to treat the symptoms of an enlarged prostate (benign prostatic hyperplasia or BPH) in which which include difficulty urinating (hesitation, dribbling, weak stream, and incomplete bladder emptying), painful urination, and urinary frequency and urgency. Incorrect Options: Option A - TURP (Transurethral resection of prostate): TURP is a surgical procedure performed to treat moderate to severe urinary symptoms caused by BPH. TURP is not typically used in the initial stage of BPH when the symptoms are mild. It is usually considered when conservative measures and medication have not provided adequate relief or when there are complications associated with BPH. Option C - Finasteride: Finasteride works by inhibiting the conversion of testosterone to dihydrotestosterone (DHT). While finasteride is effective in managing BPH symptoms and can provide long-term benefits, it is not typically the initial choice for managing urinary symptoms in the early stages of BPH. It may be considered for patients with larger prostate volumes or those at a higher risk of disease progression. Option D - Observation: Observation may be an option for patients with mild urinary symptoms that do not significantly affect their quality of life. In such cases, regular monitoring, lifestyle modifications (such as limiting fluid intake before bedtime), and periodic follow-up with a healthcare provider may be recommended. However, if the symptoms worsen or become bothersome, medical intervention with medication, such as tamsulosin, is usually recommended. Observation alone is not considered the standard initial management strategy for urinary symptoms caused by BPH.

References:

Prepladder Notes

↑ *Back to this question in Part A*

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Q96: A 50-year-old male patient came to the outpatient department with complaints of hematuria . A 2x2 cm bladder mass is seen which is low grade transitional cell carcinoma . Which among the following is the ideal management? (Q802848)

A. Transurethral resection of the tumor

B. Resection with ileal conduit

C. Partial cystectomy with bladder reconstruction

D. Neoadjuvant chemotherapy



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Correct Answer: A. Transurethral resection of the tumor

Explanation: Correct option A - Transurethral resection of the tumour: Transurethral resection of the tumour (TURBT) is the initial standard treatment for low-grade transitional cell carcinoma (TCC) of the bladder. This procedure is performed using a cystoscope inserted through the urethra to remove the tumor from the bladder. TURBT allows for both diagnostic and therapeutic purposes, as the tumor is removed and sent for histopathological examination to confirm the diagnosis and assess the stage and grade of the tumor. Incorrect Options: Option B - Resection with ileal conduit: Resection with ileal conduit is not the ideal management for low-grade transitional cell carcinoma of the bladder. This procedure involves the removal of the entire bladder and the diversion of urine through a surgically created ileal conduit (urinary diversion). It is typically reserved for cases of invasive or high-grade bladder cancer that cannot be adequately treated with transurethral resection alone. Option C - Partial cystectomy with bladder reconstruction: Partial cystectomy with bladder reconstruction may be considered for select cases of localised low-grade bladder cancer, particularly if the tumour is in a favourable location and can be completely excised while preserving bladder function. However, transurethral resection is generally the preferred initial treatment for most cases of low-grade bladder cancer. Option D - Neoadjuvant chemotherapy: Neoadjuvant chemotherapy refers to the administration of chemotherapy before the main treatment. It is typically used for muscle-invasive bladder cancer or cases with a high risk of progression.

References:

Prepladder Notes

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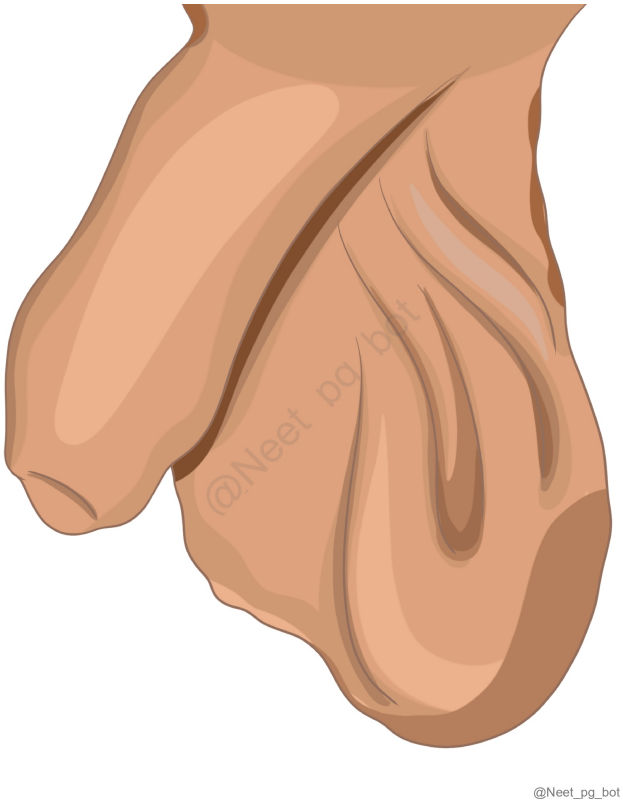
Q97: A 33-year-old man was referred to the surgery OPD from the infertility clinic . On inspection, the scrotum appeared as in the image. On palpation, a bag of worm sensation was felt . What is the most likely diagnosis? (Q793368)

A. Hydrocele

B. Varicocele

C. Testicular torsion

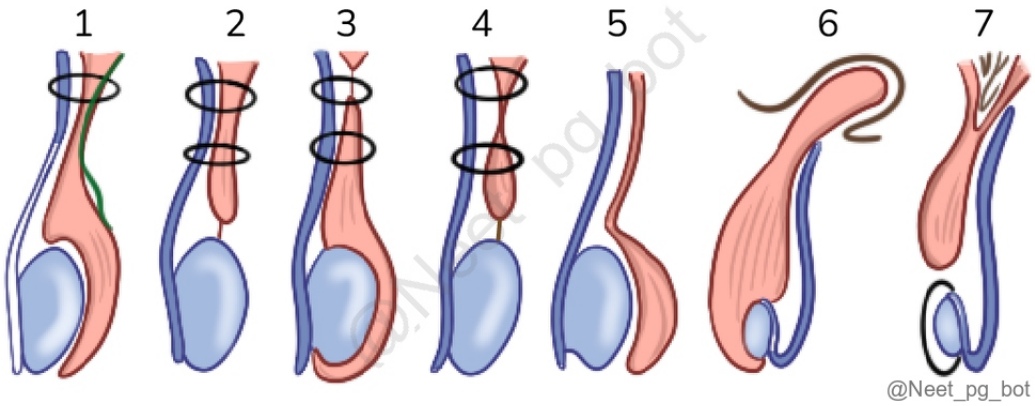
D. Epididymo Orchitis

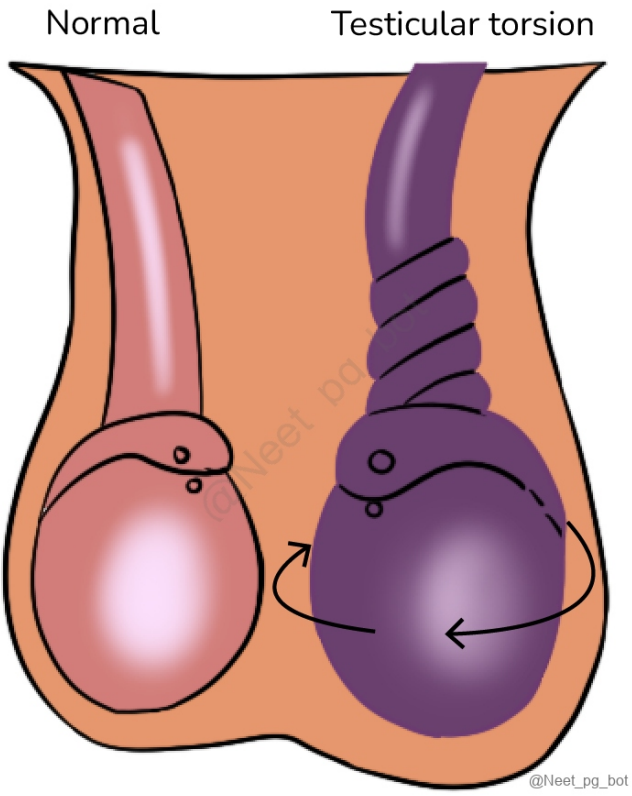


Correct Answer: B. Varicocele

Explanation: Correct Option B - Varicocele: The most likely diagnosis for this presentation is Varicocele. A varicocele is an enlargement of the veins within the scrotum, similar to varicose veins that occur in the legs. It is a common cause of male infertility. The typical presentation of a varicocele is an asymptomatic painless swelling of the scrotum, which may be described as a "bag of worms" sensation on palpation. The swelling is typically more prominent when the patient is standing and may decrease when the patient is lying down. Incorrect Options: Option A - Hydrocele: Hydrocele is a collection of fluid within the tunica vaginalis (the membrane that covers the testis) that leads to scrotal swelling. It is typically painless and feels like a smooth, round mass on palpation. Unlike varicocele, hydrocele is not typically associated with male infertility. Option C - Testicular torsion: Testicular torsion is a medical emergency that occurs when the spermatic cord (the bundle of blood vessels and

nerves that supports the testis) becomes twisted, cutting off the blood supply to the testis. If not treated promptly, this can lead to severe pain, swelling, and a high risk of testicular loss. Unlike varicocele, testicular torsion is typically associated with severe pain. Option D - Epididymo Orchitis: Epididymo-orchitis is an inflammation of the epididymis (a coiled tube located at the back of the testis that stores and carries sperm) and/or the testis. It is typically associated with pain, swelling, and tenderness of the scrotum, as well as fever and other signs of infection. Unlike varicocele, epididymo-orchitis is typically associated with pain and tenderness.





References:

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Q98: Which of the following are s torage symptoms of benign prostatic hyperplasia ? 1. Urgency 2. Enuresis 3. Hesitancy 4. Frequency 5. Dribbling (Q793417)

A. 1, 3, 4

B. 2 and 5

C. 1, 2, 4, 5

D. 1, 2, 4

Correct Answer: D. 1, 2, 4

Explanation: Correct Option D - 1, 2, 4: Benign prostatic hyperplasia (BPH) is a noncancerous enlargement of the prostate gland that occurs commonly in men as they age. BPH can cause a range of lower urinary tract symptoms, including both voiding and storage symptoms. Storage symptoms refer to the symptoms related to the bladder's storage capacity and include the following: Urgency: A sudden and strong urge to urinate that may be difficult to suppress. Enuresis: Involuntary leakage of urine that occurs during sleep. Frequency : The need to urinate frequently, often more than 8 times a day. Nocturia - is the complaint that the individual needs to wake at night at least once to void. Urge incontinence (UI) is involuntary urinary leakage, often large volume, immediately preceded by the sensation of urgency. Urgency and episodes of urge incontinence are often associated with an overactive bladder or bladder neuropathy. Voiding symptoms refer to the symptoms related to the emptying of bladder and include the following : Hesitancy: Difficulty initiating urination, often characterized by a delay in the start of the urinary stream Dribbling: A continued leakage of urine after the urinary stream has stopped. Intermittency is the term used when the individual describes urine flow which stops and starts, on one or more occasions, during micturition. Poor flow Incomplete emptying is the sensation that at the end of micturition bladder fullness persists. Therefore, the correct answer is option d, as it includes all the storage symptoms of BPH. Incorrect Options: Option A - 1, 3, 4: Urgency, hesitancy, and frequency are incorrect. Option B - 2 and 5: Enuresis and dribbling are incorrect. Option C - 1, 2, 4, 5: All except dribbling is incorrect, as dribbling is not a storage symptom but a voiding symptom.

References:

Prepladder Notes

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Q99: What diagnosis would you suggest for a 10-month-old male baby who presented with an empty scrotum , wherein ultrasonography showed the right testis located in

the right inguinal canal and the left testis located in the perineum? (Q793435)

A. Bilateral undescended testis

B. Bilateral ectopic testis

C. Right side undescended testis and left sided ectopic testis

D. Right side ectopic testis and left side undescended testis

Correct Answer: C. Right side undescended testis and left sided ectopic testis

Explanation: Correct Option C - Right side undescended testis and left sided ectopic testis: The 10-month-old male baby has been diagnosed with one undescended testis on the right side and one ectopic testis on the left side. An ectopic testis is when a testis deviates from its normal descent pathway and is found outside the scrotum. During fetal development, testes typically descend from the abdomen into the scrotum through the inguinal canal. However, in some cases, one or both testes fail to complete this descent, a condition known as undescended testis or cryptorchidism. In this baby's case, the right testis remains in the right inguinal canal, classified as undescended. The left testis not only fails to descend but also follows an abnormal pathway, ending up in the perineum, classified as ectopic. Incorrect Options: Option A - Bilateral undescended testis: Bilateral undescended testis refers to the situation where both testes have failed to descend into the scrotum. Option B - Bilateral ectopic testis: Bilateral ectopic testis refers to the situation where both testes have followed abnormal pathways and are located outside of the scrotum. Option D - Right side undescended testis and left sided ectopic testis : Right side undescended testis and left-sided ectopic testis would be an incorrect diagnosis for this baby since only one testis is undescended, and the other one is ectopic.

References:

Prepladder Notes

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Q100: Identify the investigation and the lesion depicted in the image given below. (Q793492)

A. Retrograde cystourethrogram with membranous urethra stricture

B. Retrograde cystourethrogram with penile urethral stricture

C. Micturating cystourethrography with bulbar stricture

D. Micturating cystourethrography with psoriatic urethra stricture



Correct Answer: B. Retrograde cystourethrogram with penile urethral stricture

Explanation: Correct Option B - Retrograde cystourethrogram with penile urethral stricture: The image is showing a radiographic view of the male urethra, which is being filled with contrast material from a retrograde cystourethrogram. This is a diagnostic test used to evaluate the urethra, bladder, and sometimes the kidneys. During the test, a catheter is inserted into the urethra and contrast material is injected, followed by X-ray imaging. The stricture is a narrowing of the urethral lumen, which can occur at any point along the urethra, from the bladder neck to the external urethral meatus. In this case, the stricture is located in the penile urethra, which is the portion of the urethra that runs through the penis. Thus the image shows retrograde cystourethrogram with penile urethral stricture. Incorrect Options: Option A - Retrograde cystourethrogram with membranous urethral stricture: The stricture is not located in the membranous portion of the urethra, which is located between the prostate gland and the bulbous urethra. Option C - Micturating cystourethrography with bulbar stricture: A micturating cystourethrogram (MCU) is a different type of test used to evaluate the bladder and urethra during urination. A bulbar stricture refers to a narrowing in the bulbar portion of the urethra, which is located between the bulbous urethra and the membranous urethra. Option D - Micturating cystourethrography with psoriatic urethral stricture: Psoriasis is a skin condition and does not directly affect the urethra.

References:

Prepladder Notes

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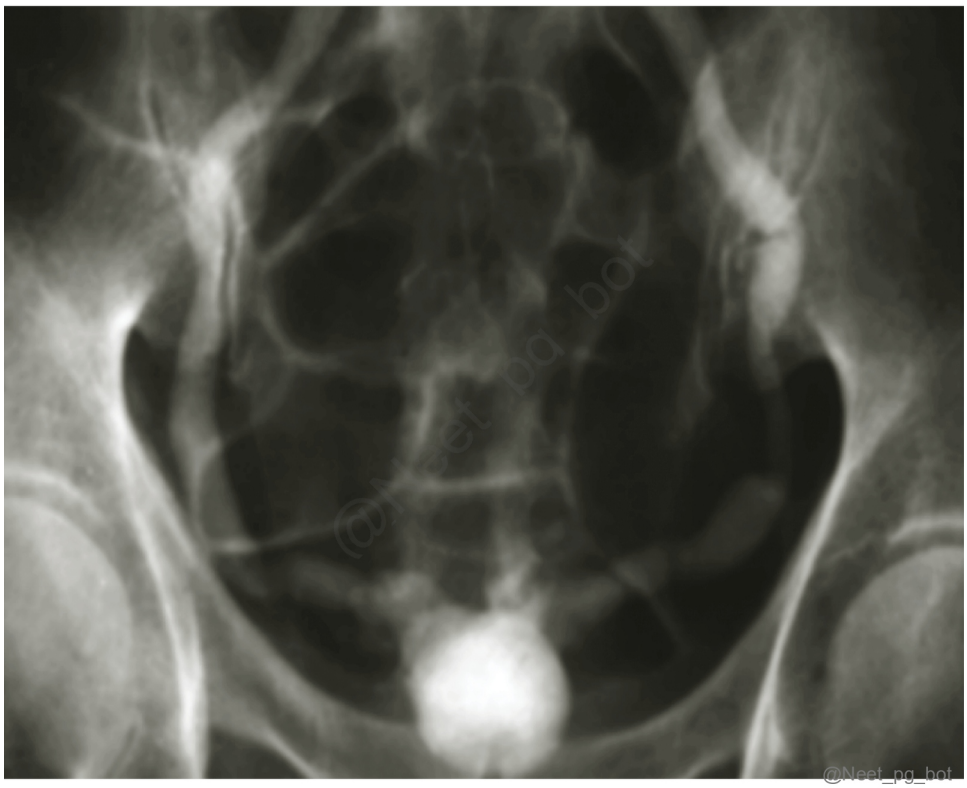
Q101: A patient presented to the hospital with a history of increased frequency of micturition . On cystoscopy, a pale ureteric orifice was seen. The patient's KUB x-ray is given below. What is the most probable diagnosis? (Q793507)

A. Bladder carcinoma

B. Schistosomiasis

C. Bladder tuberculosis

D. Papilloma of urinary bladder



Correct Answer: C. Bladder tuberculosis

Explanation: Correct Option C - Bladder tuberculosis: The most probable diagnosis based on the given history, cystoscopic findings, and KUB x-ray is "Bladder tuberculosis." Bladder tuberculosis is a chronic bacterial infection caused by Mycobacterium tuberculosis that affects the urinary bladder. The most common symptoms of bladder tuberculosis are increased frequency of micturition, dysuria, and hematuria. In advanced cases, patients may also experience suprapubic pain, urinary incontinence, and bladder dysfunction. The pale ureteric orifice seen on cystoscopy is a typical finding in patients with bladder tuberculosis, indicating that the mucosa around the orifice is inflamed and edematous. The KUB x-ray may show calcification in the bladder wall, which is a characteristic finding in bladder tuberculosis. Incorrect Options: Option A - Bladder carcinoma: Bladder carcinoma is a malignant tumor that arises from the epithelial cells lining the urinary bladder. It can also present with similar symptoms, such as hematuria and urinary frequency. However, the pale ureteric orifice seen on cystoscopy is not a typical finding in these conditions. Option B - Schistosomiasis : Schistosomiasis is a parasitic

infection caused by Schistosoma haematobium that can affect the urinary tract and cause bladder inflammation and fibrosis. It can also present with similar symptoms, such as hematuria and urinary frequency. However, the pale ureteric orifice seen on cystoscopy is not a typical finding in these conditions. Option D - Papilloma of urinary bladder: Papilloma of the urinary bladder is a benign tumor that arises from the urothelium lining the bladder. It can also present with similar symptoms, such as hematuria and urinary frequency. However, the pale ureteric orifice seen on cystoscopy is not a typical finding in these conditions.

References:

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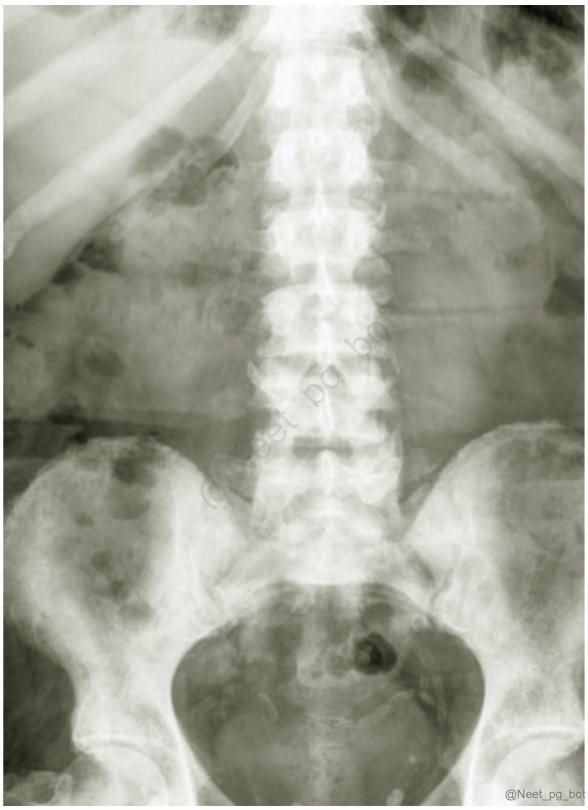
Q102: A 77-year-old man presented with worsening hip and back pain . He also reports weight loss and loss of appetite . His PSA levels are elevated. What is the most likely diagnosis here? (Q793512)

A. Ankylosing spondylitis

B. Osteosarcoma

C. Osteoclastoma

D. Prostate cancer



Correct Answer: D. Prostate cancer

Explanation: Option D - Prostate cancer: The most likely diagnosis in this case is prostate cancer. Prostate cancer typically presents with symptoms such as urinary frequency, urgency, and difficulty urinating. However, in advanced cases, it can cause hip and back pain, weight loss, and loss of appetite. Elevated levels of PSA (prostate-specific antigen) in the blood are also a common finding in prostate cancer. Therefore, given the presentation of worsening hip and back pain, weight loss, loss of appetite, and elevated PSA levels, prostate cancer is the most likely diagnosis in this case. Incorrect Options: Option A - Ankylosing spondylitis: Ankylosing spondylitis is a chronic inflammatory condition that affects the joints of the spine and the sacroiliac joint. It typically presents with back pain and stiffness, especially in the morning or after prolonged periods of inactivity. However, ankylosing spondylitis does not typically cause weight loss or elevated PSA levels, so it is an unlikely diagnosis in this case. Option B - Osteosarcoma: Osteosarcoma is a type of bone cancer that typically affects children and young adults. It can occur in any bone, but it most commonly affects the long bones of the arms and legs. Osteosarcoma typically presents with bone pain, swelling, and tenderness, but it is unlikely to cause weight loss or elevated PSA levels. Therefore, osteosarcoma is an unlikely diagnosis in this case. Option C - Osteoclastoma: Osteoclastoma, also known as giant cell tumor of bone, is a rare type of bone tumor that typically affects the long bones of the arms and legs. It can cause bone pain, swelling, and tenderness, but it is unlikely to cause weight loss or elevated PSA levels. Therefore, osteoclastoma is an unlikely diagnosis in this case.

References:

Prepladder Notes

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Q103: A 50-year-old male patient presents with palpitations, episodic headaches , and sweating episodes . Workup shows a small left-sided suprarenal mass . Which of the following would be done for confirmation? (Q793850)

A. Urinary vanillyl mandelic acid levels

B. Blood 5-HIAA levels

C. Urine myoglobin

D. Stool trypsin levels

Correct Answer: A. Urinary vanillyl mandelic acid levels

Explanation: Correct Option A - Urinary vanillyl mandelic acid levels: The given symptoms of palpitations, episodic headache, sweating episodes, and a small left-sided suprarenal mass suggest a possible diagnosis of pheochromocytoma. Pheochromocytoma is a rare tumor of the adrenal gland tumor that produces excessive amounts of catecholamines (epinephrine, norepinephrine, and dopamine), which can cause symptoms such as hypertension, headache, and sweating. Among the various blood and urine tests, measuring urinary vanillyl mandelic acid (VMA) levels is a commonly used and highly sensitive test for pheochromocytoma. Incorrect Options: Option B - Blood 5-HIAA levels: 5-HIAA (5-5-hydroxy indole acetic acid) is a breakdown product of serotonin produced by carcinoid tumors. While carcinoid tumors can also produce catecholamines, they are much less common than pheochromocytomas. Thus, measuring blood 5-HIAA levels is not useful for confirming the diagnosis of pheochromocytoma. Option C - Urine myoglobin: Myoglobin is a protein found in muscle tissue, and its presence in urine can indicate muscle damage or injury. However, urine myoglobin levels are not specific for pheochromocytoma and do not help confirm the diagnosis. Option D - Stool trypsin levels: Stool trypsin levels can be used to diagnose pancreatic insufficiency, a condition where the pancreas does not produce enough enzymes to digest food properly. However, this test is not relevant for diagnosing pheochromocytoma.

References:

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Q104: If radiotherapy is administered along with chemotherapy for bladder cancer, which drug's dosage should be decreased? (Q793872)

A. Cisplatin

B. Gemcitabine

C. Paclitaxel

D. Ifosfamide

Correct Answer: B. Gemcitabine

Explanation: Correct Option B - Gemcitabine: Gemcitabine is a chemotherapy drug commonly used to treat bladder cancer. If a patient receives chemotherapy and radiation therapy, the dose of gemcitabine may need to be reduced to avoid increased toxicity. This is because radiation therapy can affect the body's ability to metabolize and eliminate the chemotherapy drug. Radiation can increase the levels of gemcitabine in the body, leading to increased side effects such as low white blood cell counts, nausea, and fatigue. Therefore, the dose of gemcitabine may need to be reduced with radiation therapy. Incorrect Options: Option A - Cisplatin: Cisplatin is another chemotherapy drug used to treat bladder cancer. While it can also cause toxicity when given radiation therapy, the question specifically asks about the drug for which the dose should be reduced, and the correct answer is gemcitabine. Option C - Paclitaxel: Paclitaxel is a chemotherapy drug used to treat various cancers but not commonly used to treat bladder cancer. Additionally, no evidence suggests that the paclitaxel dose should be reduced with radiation therapy. Option D - Ifosfamide: Ifosfamide is another chemotherapy drug used to treat bladder cancer. While it can cause toxicity when given radiation therapy, the question specifically asks about the drug for which the dose should be reduced, and the correct answer is gemcitabine.

References:

Prepladder Notes

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Q105: Which of the following is used for prostate cancer ? (Q793878)

A. Gleason score

B. Bethesda score

C. Alvarado score

D. Nottingham score

Correct Answer: A. Gleason score

Explanation: Correct Option A - Gleason score: The Gleason score is a grading system used to assess the aggressiveness of prostate cancer. It is determined by examining prostate tissue samples obtained through a biopsy. The pathologist assigns a grade to the two most common patterns of cancer cells observed in the tissue sample. The grades are added together to create a total Gleason score ranging from 6 to 10. Higher scores indicate a more aggressive cancer. Incorrect Options: Option B - Bethesda score: The Bethesda score is a classification

system for interpreting thyroid biopsies. It is used to assess the likelihood of a thyroid nodule being malignant. Option C - Alvarado score: The Alvarado score is a scoring system used to diagnose acute appendicitis. It combines clinical symptoms and laboratory values to assess the patient's likelihood of acute appendicitis. Option D - Nottingham score: The Nottingham score is a grading system used to assess the aggressiveness of breast cancer. It is determined by examining breast tissue samples obtained through a biopsy.

References:

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Q1: A 45-year-old woman has a painless, firm breast lump and enlarged lymph nodes in the armpit. Which imaging technique is most sensitive for detecting cancer, especially in dense breast tissue? (Q880445)

A. 2D mammography

B. Digital mammography

C. Tomosynthesis with conventional mammography

D. Full-field digital mammography

Correct Answer: C. Tomosynthesis with conventional mammography

Explanation: Tomosynthesis (3D mammography): Acquires multiple low-dose images at different angles → reconstructs a 3D image of the breast; best sensitivity and specificity, especially for dense breasts and detecting small/hidden lesions. Incorrect Options: 2D mammography (Option A): Standard screening tool, but sensitivity is limited in dense breasts and overlapping tissue. Digital mammography (Option B): Improves image capture and contrast but still suffers from tissue overlap. Full-field digital mammography(Option D): A digital replacement of film mammography, better than conventional film but inferior to tomosynthesis in sensitivity.

References:

Sabiston’s principles of surgery, 21st Edition, Page no.818

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Q2: During the luteal phase of the menstrual cycle, which hormone is mainly responsible for promoting lobular and alveolar development of the mammary glands? (Q880421)

A. Estrogen

B. Progesterone

C. Both A and B

D. Prolactin

Correct Answer: B. Progesterone

Explanation: Progesterone primarily stimulates lobular and alveolar development of the breast, especially during the luteal phase of the menstrual cycle and pregnancy. Incorrect Options: Estrogen (Option A) promotes ductal growth, not lobular development. Both estrogen and progesterone (Option C): While estrogen supports ductal growth, lobular development is mainly driven by progesterone. Prolactin (Option D) is responsible for milk production, not the structural development of lobules.

References:

Schwartz's Principles of Surgery, 11th Edition, Page 547.

↑ *Back to this question in Part A*

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Q3: During a routine third-trimester checkup, a pregnant woman is found to have additional nipples along the embryonic milk line. What is the proper medical term for this condition? (Q880423)

A. Polymastia

B. Polythelia

C. Accessory mammary tissue

D. Mammary hypertrophy

Correct Answer: B. Polythelia

Explanation: Polythelia refers to the presence of extra nipples along the milk line, usually without additional glandular breast tissue. Incorrect Options: Polymastia (Option A) refers to accessory or supernumerary breast tissue that includes glandular tissue, sometimes with a nipple-areolar complex. Accessory mammary tissue

(Option C) is a descriptive term but not the precise medical term. Mammary hypertrophy (Option D) refers to enlargement of the normal breasts, not extra nipples.

References:

Schwartz's Principles of Surgery, 11th Edition, Page 543-544

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Q4: A 28-year-old woman is noted to have extra glandular tissue in her axilla that becomes tender during her menstrual cycle. Regarding accessory breast tissue, which of the following statements is incorrect? (Q880425)

A. It can respond to hormonal changes such as menstruation or pregnancy

B. It is synonymous with supernumerary nipples

C. It can rarely be found along the chest wall or abdomen

D. Surgical removal may be considered for cosmetic or symptomatic reasons

Correct Answer: B. It is synonymous with supernumerary nipples

Explanation: Accessory breast tissue (also called ectopic breast tissue) differs from polythelia (supernumerary nipples), which are extra nipples that may lack glandular tissue. It consists of additional glandular tissue that forms due to incomplete regression of the embryonic milk line. It can respond to hormonal changes such as menstruation or pregnancy (Option A ruled out) It may appear along the chest or abdominal wall (Option C ruled out) It can be surgically removed for cosmetic or symptomatic relief (Option D ruled out) .

References:

Schwartz's Principles of Surgery, 11th Edition, Page 543-544

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Q5: Congenital absence of the breast (amazia) is most commonly associated with which syndrome? (Q880427)

A. Turner syndrome

B. Poland’s syndrome

C. Klinefelter syndrome

D. Marfan syndrome

Correct Answer: B. Poland’s syndrome

Explanation: Amazia - Congenital absence of one or both breasts often occurs with Poland’s syndrome. Poland’s Syndrome: Absence of the sternal portion of pectoralis major. Symbrachydactyly (short, webbed fingers) on the same side. Management: Breast reconstruction using the latissimus dorsi muscle flap and silicone breast implant. Incorrect Options: Turner syndrome (Option A): Causes gonadal dysgenesis and delayed puberty, but not congenital absence of breast tissue. Klinefelter syndrome (Option C): Often presents with gynecomastia (excess breast tissue in males), not breast absence. Marfan syndrome (Option D): A connective tissue disorder affecting the skeleton, eyes, and heart, with no link to breast development anomalies.



References:

Bailey & Love Short Practice of Surgery, 28th Edition, Page. 1146.

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Q6: Which of the following is a typical clinical feature of Poland syndrome? (Q880430)

A. Absence of the sternal portion of pectoralis major

B. Short, webbed fingers (symbrachydactyly)

C. Unilateral breast hypoplasia or aplasia

D. All of the above

Correct Answer: D. All of the above

Explanation: Poland Syndrome is a congenital condition characterized by chest wall and hand abnormalities, usually on the same side. Clinical features: Absence of the sternal portion of pectoralis major. (Option A, C ruled out) Symbrachydactyly (short, webbed fingers) on the same side. (Option B ruled out)





References:

Bailey & Love Short Practice of Surgery, 28th Edition, Page. 1146

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Q7: A 41-year-old woman presents with a painful, cord-like structure on the anterior chest wall extending over her breast. She denies trauma, infection, or fever. On examination, a tender, subcutaneous cord is palpable, fixed to the overlying skin. When she raises her arm, a narrow groove alongside the cord becomes visible. What is the most likely diagnosis? (Q880431)

A. Mastitis

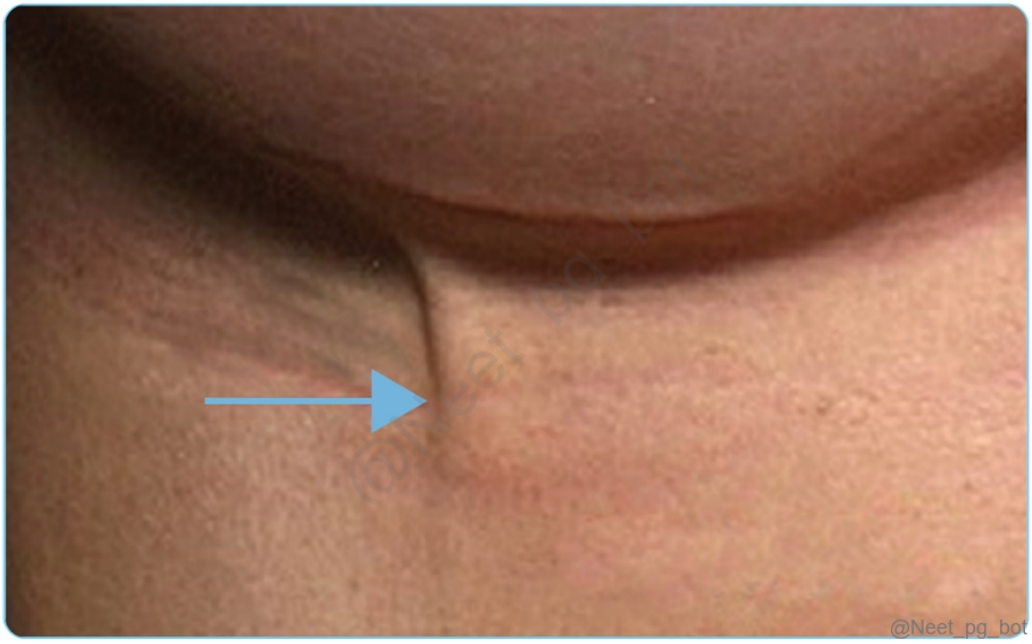
B. Mondor's disease

C. Inflammatory breast carcinoma

D. Lymphangitis

Correct Answer: B. Mondor's disease

Explanation: Mondor's Disease is thrombophlebitis of the superficial veins of the breast and anterior chest wall. Pathognomonic feature → Tender, thrombosed subcutaneous cord attached to the skin, often becoming more visible when the arm is raised. It usually resolves spontaneously within a few months without recurrence or complications. Mastitis (Option A): Typically presents with erythema, warmth, and systemic signs of infection, not a discrete subcutaneous cord. Inflammatory breast carcinoma (Option C): Presents with peau d'orange, diffuse induration, and often a palpable mass, not a superficial cord. Lymphangitis (Option D): Characterized by red streaks, tenderness, and systemic symptoms, not a tender subcutaneous cord.



References:

Bailey & Love Short Practice of Surgery, 28th Edition, Page. 930

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Q8: A 48-year-old woman with mammary duct ectasia presents with persistent periareolar swelling, recurrent nipple discharge, and discomfort despite conservative management and antibiotics. Which surgical procedure is most appropriate in this scenario? (Q880432)

A. Microdochectomy

B. Hadfield's procedure

C. Axillary lymph node dissection

D. Excision of breast tissue related to the affected duct

Correct Answer: B. Hadfield's procedure

Explanation: Hadfield's procedure is the most appropriate choice because: Persistent symptoms (swelling, discharge, discomfort) from mammary duct ectasia. Conservative treatment has failed. Involves the removal of all major ducts behind the nipple (total duct excision), which effectively treats multiduct disease like duct ectasia. Microdochectomy (Option A): Removes a single duct, suitable for isolated duct pathology, not effective in multiduct ectasia. Axillary lymph node dissection (Option C): Used in breast cancer for staging or treatment, not for benign conditions like duct ectasia. Excision of breast tissue related to the affected duct (Option D): Vague and not a standard procedure; does not ensure complete resolution of multiduct disease.

References:

Mammary Duct Ectasia - StatPearls - NCBI Bookshelf

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Q9: A 42-year-old woman presents with a single-duct, bloody nipple discharge from her right breast. She has no palpable lumps, and her mammogram and ultrasound are normal. She is concerned about the possibility of cancer. Which of the following is the most appropriate next step in management? (Q880433)

A. Simple reassurance and annual imaging follow-up

B. Microdochectomy of the affected duct

C. Hadfield’s major mammary duct excision

D. Start empirical antibiotics and observe

Correct Answer: B. Microdochectomy of the affected duct

Explanation: Nipple discharge: Non-bloody discharge: reassurance may be sufficient. (Option A ruled out) Profuse discharge causing social embarrassment: Microdochectomy or major duct excision. (Option B) Bloody or serous discharge: <40 years: reassure if triple assessment is normal. (Option A ruled out) ≥40 years: single-duct discharge → microdochectomy; multiduct discharge → Hadfield’s excision. (Option C ruled out) Microdochectomy removes a 1.5–2 cm segment of the affected duct. Start empirical antibiotics and observe (Option D): Infection is not suspected; antibiotics are unnecessary in the absence of mastitis or systemic signs.

References:

Bailey & Love Short Practice of Surgery, 28th edition, Page. 925

↑ *Back to this question in Part A*

@Neet_pg_bot

Q10: At what age is routine screening mammography generally recommended for asymptomatic women without high-risk factors? (Q880441)

A. After 30 years

B. After 35 years

C. After 40 years

D. After 50 years

Correct Answer: C. After 40 years

Explanation: Routine screening mammography is generally done after 40 years in asymptomatic women Early screening → Indicated in women with a family history of breast cancer or histological risk factors Mammography before 35 years → Usually not performed unless there is a suspicious lump or strong family history. (Option B ruled out)

References:

SRB’s Manual of Surgery, 6th Edition, Page. 507

↑ *Back to this question in Part A*

@Neet_pg_bot

Q11: Which of the following is correct regarding screening mammography? (Q880442)

A. Performed in symptomatic women and requires only a single view of each breast

B. Two standard views, mediolateral oblique and craniocaudal, are obtained for each breast in asymptomatic women

C. Not performed in women older than 40 years

D. Diagnostic mammography and screening mammography are identical in technique and timing

Correct Answer: B. Two standard views, mediolateral oblique and craniocaudal, are obtained for each breast in asymptomatic women

Explanation: Screening Mammography is performed in asymptomatic women to detect occult breast cancer Two views per breast: mediolateral oblique (MLO) and craniocaudal (CC) The breast is compressed between plates to improve image quality and resolution Diagnostic mammography → Performed for evaluation of abnormalities, read immediately, and may include additional views (magnification or compression) Incorrect Options: Performed in symptomatic women and requires only a single view of each breast (Option A): Screening is for asymptomatic women, and standard views include MLO and CC Not performed in women older than 40 years (Option C): Screening is recommended after 40 years. Diagnostic mammography and screening mammography are identical in technique and timing (Option D): Diagnostic mammography may include extra views and is read immediately

References:

Sabiston Textbook of Surgery: The Biological Basis of Modern Surgical Practice, 21st Edition, Page. 817-818.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q12: A 65-year-old patient undergoes a screening mammogram. The radiologist identifies a cluster of calcifications and a discrete mass. Which of the following radiological descriptors in the mammography report would be the least concerning for malignancy? (Q880443)

A. Irregular mass

B. Wide halo

C. Macrocalcification

D. Spiculated margins

Correct Answer: C. Macrocalcification

Explanation: In mammography, certain descriptors suggest a higher or lower risk of malignancy: Irregular mass – Usually suspicious; irregular shapes are more likely to be malignant. Concerning (Option A ruled out) Wide halo – Can indicate a benign cyst or fibroadenoma; less specific but generally less worrisome than spiculated margins. (Option B ruled out) Macrocalcification – Large, coarse calcifications, often bilateral and diffuse, are typically benign and associated with aging or degenerative changes. Least concerning (Option C) Spiculated margins – Highly suspicious; spiculations suggest invasive carcinoma. (Option D ruled out)

References:

Bailey & Love Short Practice of Surgery, 28th Edition, Page no.917

↑ *Back to this question in Part A*

@Neet_pg_bot

Q13: Match the following findings with the associated condition: Type of calcification Disease A. Popcorn calcification i) Fibrocystic disease B. Lead-pipe calcification ii) Duct ectasia C. Broken needle calcification iii) Traumatic fat necrosis D. Tea cup calcification iv) Fibroadenoma (Q880444)

A. A-iii, B-ii, C-i, D-iv

B. A-iv, B-iii, C-ii, D-i

C. A-i, B-iii, C-ii, D-iv

D. A-ii, B-iv, C-iii, D-i

Correct Answer: B. A-iv, B-iii, C-ii, D-i

Explanation: Popcorn calcification → Fibroadenoma Coarse, “popcorn-like” calcifications are typical of involuting fibroadenomas. Lead-pipe calcification → Traumatic fat necrosis Linear or laminar calcifications resembling a lead pipe can develop in areas of fat necrosis after trauma. Broken needle calcification → Duct ectasia Calcifications within dilated ducts can appear as fragmented or “broken needle” patterns, seen in duct ectasia. Tea-cup calcification → Fibrocystic disease Curved, crescent-shaped (“tea-cup”) calcifications are often associated with fibrocystic changes in the breast.

References:

SRB’s Manual of Surgery, 6th Edition, Page no.509.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q14: Which of the following describes the basal type of breast malignancy? (Q848861)

A. ER +, PR -, and HER2 +

B. ER -, PR -, and HER2 -

C. ER +, PR +, and HER2 +

D. ER -, PR -, and HER2 +

Correct Answer: B. ER -, PR -, and HER2 -

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Molecular classification of breast cancer: Subtype ER Status PR Status HER2 Status Ki-67 Status Characteristics Luminal A + + - Low Generally low grade, better prognosis, responsive to hormonal therapy. Luminal B + + or - + or - High Higher grade, poor prognosis compared to Luminal A, may require targeted HER2 therapy following status. HER2-enriched - - + High Aggressive, higher grade, poor prognosis, requires targeted HER2 therapy. Basal-like - - - High Includes triple-negative breast cancer (TNBC), highly aggressive, no targeted hormonal therapy. Claudin-low - - + or - Often High Often associated with poor prognosis and aggressive behavior, typically lacks response to hormonal therapy.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 931

SRB's Manual of Surgery, 6th Edition, Page 533

↑ *Back to this question in Part A*

@Neet_pg_bot

Q15: A 45-year-old woman diagnosed with early-stage breast cancer opts for surgery that involves the removal of the entire breast, including the nipple and areola, but not the axillary lymph nodes. Which type of mastectomy is she likely undergoing? (Q848864)

A. Total (Simple) Mastectomy

B. Modified Radical Mastectomy

C. Radical Mastectomy

D. Extended Mastectomy

Correct Answer: A. Total (Simple) Mastectomy

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Mastectomy: Surgical procedure to remove one or both breasts, typically to treat or prevent breast cancer. Types of Mastectomy Types Structures removed Simple/Total mastectomy (Option A) En bloc removal of Nipple Areola Breast mass Skin Extended mastectomy (Total Mastectomy with Axillary Dissection) (Option D) Simple mastectomy + removal of level I axillary lymph nodes Halsted/Radical mastectomy (Option C) Simple mastectomy + removal of level I, II, III axillary lymph nodes + excision of pectoralis major and minor muscle. Modified Radical Mastectomy(MRM) (Option B) Simple mastectomy + removal of level I, II axillary lymph nodes Variants : Auchincloss modification : MRM Patey's modification : MRM + excision of pectoralis minor Scanlons modification : MRM + division of pectoralis minor(removal and resuturing)

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Pages 935, 937.

SRB's Manual of Surgery, 6th Edition, Pages 538-542.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q16: Which of the following conditions is not an absolute contraindication for breast-conserving surgery (BCS)? (Q848863)

A. Prior radiation therapy to the chest wall or breast

B. Diffuse malignant microcalcifications

C. Stage IIB breast cancer

D. Pregnancy

Correct Answer: C. Stage IIB breast cancer

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Breast-conserving surgery (BCS), also known as lumpectomy, involves removing a breast tumor along with a small margin of surrounding healthy tissue while preserving the majority of the breast. The goal is to remove the cancerous cells while maintaining the breast's appearance and function. Performed for early invasive breast cancer (Stage I, IIA, IIB) Absolute Contraindications for breast-conserving surgery (BCS): ■■ Pregnancy (Option D ruled out) because after BCS postop radiotherapy will be necessary which is not possible in case pregnancy. Multicentric Disease Diffuse malignant microcalcifications on mammogram suggests widespread disease, making complete excision with clear margins unlikely (Option B ruled out) Prior Radiation Therapy to the Chest Wall or Breast cannot give radiation again, which is essential after BCS (Option A ruled out) Extensive Positive Pathological Margins

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Pages 935, 936.

Schwartz's Principles of Surgery, 11th Edition, Page 591.

Sabiston Textbook of Surgery, 21st Edition, Pages 843, 844.

https://www.ncbi.nlm.nih.gov/books/NBK547708

↑ *Back to this question in Part A*

@Neet_pg_bot

Q17: Which of the following are components of the Van Nuys Prognostic Index (VNPI) for DCIS? Tumor size Margin status Histological grade Patient age (Q848862)

A. 1 & 2

B. 1 & 3

C. 1, 2 & 3

D. 1, 2, 3 & 4

Correct Answer: D. 1, 2, 3 & 4

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: "Micro Swag" Mnemonic for the components of VPNI Micro - Microcalcification S -Size W -Width of margin A -Age G -Grade Van Nuys Prognostic Index (VNPI) for Ductal Carcinoma In Situ (DCIS) Factor Score 1 Score 2 Score 3 Tumor Size ≤ 15 mm 16-40 mm >40 mm Margin Status >10 mm 1-9 mm <1 mm Histological Grade Grade I/II Well-differentiated Necrosis absent Grade I/II Moderately differentiated Necrosis present Grade III Poorly differentiated Necrosis present Patient Age > 61 years 40-60 years < 39 years VNPI Score Calculation The VNPI score is the sum of points from all four factors. The total score is used to stratify the risk and guide treatment decisions Total Score 4-6: Low risk Total Score 7-9: Intermediate risk Total Score 10-12:

High risk

References:

SRB's Manual of Surgery, 6th Edition, Page 524.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q18: Arrange the following in decreasing order of frequency of metastasis in breast cancer (Q848853)

A. Lumbar vertebrae> femur> thoracic vertebrae> ribs> skull

B. Lumbar vertebrae> thoracic vertebrae> ribs> skull> femur

C. Thoracic vertebrae>lumbar vertebrae> ribs> skull> femur

D. Thoracic vertebrae> femur> lumbar vertebrae> ribs> skull

Correct Answer: A. Lumbar vertebrae> femur> thoracic vertebrae> ribs> skull

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: LFT RISK- mnemonic L umbar vertebrae> f emur> t horacic vertebrae> ri bs> sk ull Spread of breast cancer Local Invasion Tumors invade nearby tissues (skin, chest wall). Lymphatic Spread Cancer cells spread to nearby lymph nodes Hematogenous Spread Cancer cells enter the bloodstream indicating stage IV cancer. Metastasising to distant organs in frequency : Bones> lungs> liver> brain Among bones frequency: Lumbar vertebrae> femur> thoracic vertebrae> ribs> skull (Option A) Multifocal Growth Cancers may appear as multiple independent foci within the same breast or different quadrants Common in invasive lobular carcinoma.

References:

Sabiston Textbook of Surgery, 21st Edition, Pages 810 ,832

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 932

Schwartz's Principles of Surgery, 11th Edition, Page 563

↑ *Back to this question in Part A*

@Neet_pg_bot

Q19: What is the primary arterial supply to the superior part of the breast? (Q848845)

A. Internal thoracic artery

B. Lateral thoracic artery

C. Thoracoacromial artery

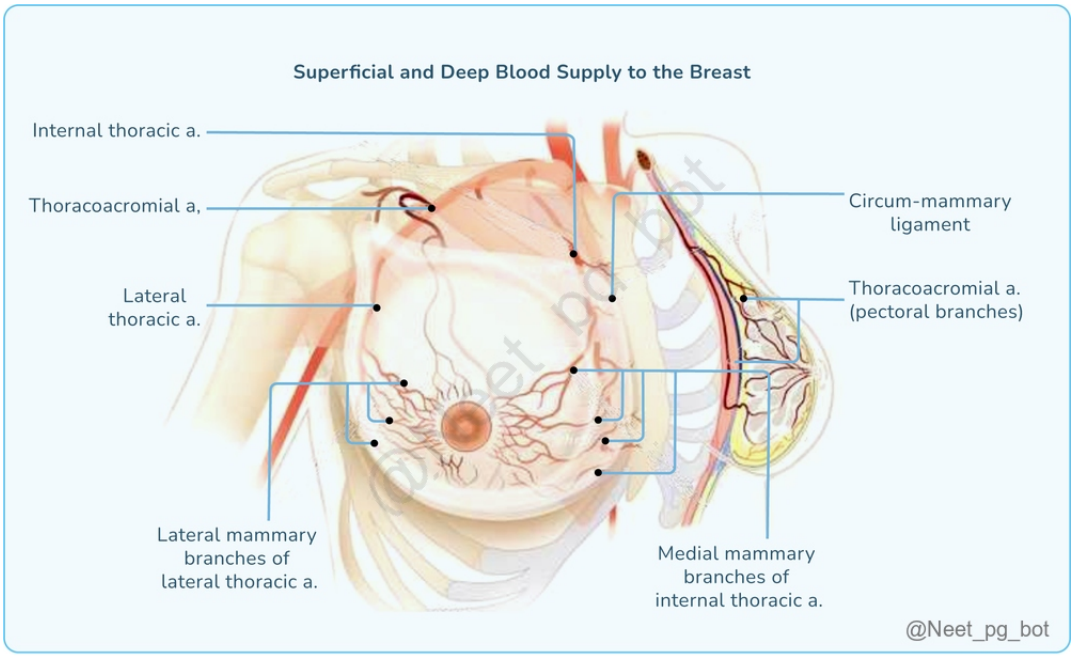
D. Intercostal artery

Correct Answer: C. Thoracoacromial artery

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Artery Areas Supplied Internal thoracic artery (Option A) Medial and central parts of the breast Lateral thoracic artery (Option B) Lateral aspect of the breast Thoracoacromial artery (Option C) Superior part of the breast Posterior intercostal arteries (Option D) Lateral and posterior aspects of the breast Superior thoracic artery Upper part of the breast (limited supply) Subscapular artery Lower part of the breast {{caption_text}}



References:

Gray’s Anatomy, 42nd Edition, Pages 1014, 1015.

SRB's Manual of Surgery, 6th Edition, Page 506.

https://www.ncbi.nlm.nih.gov/books/NBK519575/

↑ *Back to this question in Part A*

@Neet_pg_bot

Q20: Which of the following is the most common cause of bloody nipple discharge? (Q848846)

A. Breast cancer

B. Fibroadenoma

C. Intraductal papilloma

D. Duct Ectasia

Correct Answer: C. Intraductal papilloma

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Nipple Discharge Type of Nipple Discharge Causes Bloody Intraductal Papilloma (Most Common) Breast Carcinoma Duct Ectasia Serous Fibrocystic Disease (Most Common) Breast Carcinoma Duct Ectasia Greenish/Blackish Duct Ectasia Milk (Galactorrhea) Physiological (e.g., Pregnancy, Lactation) Hyperprolactinemia (e.g., Pituitary Adenoma, Hypothyroidism) Medications (e.g., Antipsychotics, Antidepressants, Oral Contraceptives) Purulent Breast Abscess Mastitis

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 924.

SRB's Manual of Surgery, 6th Edition, Page 556.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q21: Which of the following statements about breast cancer risk factors is true? (Q848847)

A. The median age of breast cancer presentation is 60 years in India

B. The relative risk of Papillomatosis is 8-10

C. Relative Risk for breast cancer in 1st-degree relative is 3

D. Early onset of menstruation increases breast cancer risk.

Correct Answer: D. Early onset of menstruation increases breast cancer risk.

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Non-modifiable risk factors for breast cancer Age: Median age at presentation is 60 years in the West(UK,USA) While it is around 48 years in low/middle-income nations such as India. (Option A ruled out) Family history of breast cancer: 1 first-degree relative RR= 2 (Option C ruled out) Early Menarche(<12years): Increases by around 5% for each year earlier menstruation begins RR=1.19 (Option D ruled out) High-risk breast lesions Complex fibroadenoma RR=3 Papillomatosis RR=3(Option B) Ductal and lobular hyperplasia RR= 5 Lobular carcinoma in situ RR= 8-10

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Pages 930, 931.

Schwartz's Principles of Surgery, 11th Edition, Pages 555, 556.

SRB's Manual of Surgery, 6th Edition, Page 523.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q22: Which of the following is the most common model used for breast cancer risk assessment? (Q848848)

A. Gail Model

B. Framingham Risk Score

C. ASCVD Risk Estimator

D. QRISK3

Correct Answer: A. Gail Model

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Risk assessment models of breast carcinoma Two main models are used Gail model Clause model Gail model Clause model Most commonly used (Option A) More information about family history Absolute risk estimation Relative risk estimation It is assessed with Age at menarche Number of 1st°relatives with breast carcinoma Age at first life birth Number of breast biopsies It is assessed with 1st° and 2nd° relatives with breast cancer Age of diagnosis of relatives Framingham Risk Score (Option B): Primarily used for assessing the risk of cardiovascular disease, not breast cancer. ASCVD Risk Estimator (Option C): Used to assess the risk of atherosclerotic cardiovascular disease, not breast cancer. QRISK3 (Option D): Model used to predict the risk of

cardiovascular disease, not breast cancer.

References:

Sabiston Textbook of Surgery, 21st Edition, Pages 823, 824.

Schwartz's Principles of Surgery, 11th Edition, Page 555.

SRB's Manual of Surgery, 6th Edition, Page 523.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q23: All of the following are invasive carcinomas except: (Q848849)

A. Ductal carcinoma

B. Lobular carcinoma

C. Tubular carcinoma

D. Fibroadenoma

Correct Answer: D. Fibroadenoma

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Classification of breast cancer Invasive Carcinomas Invasive Carcinoma of No Special Type (NST) Special Subtypes of Invasive Carcinoma: Invasive Ductal carcinoma (Option A) Invasive Lobular Carcinoma: Classic, solid, alveolar, pleomorphic, and tubulolobular variants. (Option B) Tubular Carcinoma (Option C) Cribriform Carcinoma Mucinous Carcinoma: Characterized by mucin production, good prognosis Medullary Carcinoma: Lymphoplasmacytic infiltrate, associated with BRCA1 mutations Metaplastic Carcinoma Invasive Micropapillary Carcinoma Carcinomas with Apocrine Differentiation Benign Epithelial Proliferations Fibroadenomas (Option D) Phyllodes Tumors

References:

Sabiston Textbook of Surgery, 21st Edition, Page 828

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 931

Schwartz's Principles of Surgery, 11th Edition, Page 566

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www.ncbi.nlm.nih.gov/pmc/articles/PMC8797705/

↑ *Back to this question in Part A*

@Neet_pg_bot

Q24: A 52-year-old woman undergoes a routine mammogram, which reveals clustered calcifications in her left breast. Further investigation confirms the diagnosis of ductal carcinoma in situ (DCIS). The lesion is small, low-grade, and has clear margins. The patient expresses a strong desire to preserve her breast if possible. What is the most appropriate initial treatment approach? (Q848850)

A. Hormonal therapy alone

B. Lumpectomy with radiation therapy

C. Lumpectomy alone

D. Systemic chemotherapy

Correct Answer: C. Lumpectomy alone

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Given that the DCIS is small, low-grade, and has clear margins, the scenario describes a low-risk case. Considering the patient's desire for breast preservation, breast-conserving surgery (Lumpectomy) alone is appropriate. Ductal Carcinoma in situ (DCIS) Malignant proliferation of ductal epithelial cells confined within ducts True pre-invasive carcinoma Pathology Types: Comedo (most aggressive) Cribriform, papillary, solid Central necrosis → calcifications Clinical Features Usually detected on mammography Microcalcifications (hallmark) May present as: Lump (rare) Nipple discharge Risk High risk of progression to invasive ductal carcinoma Treatment Mastectomy Near-certain cure rate (98-99% survival) 1-2% lifetime risk of local recurrence Breast-conserving surgery (lumpectomy) with radiation Reduces recurrence risk compared to lumpectomy alone (Option B) Oncotype DX DCIS score: Estimates the risk of local recurrence in ductal carcinoma in situ and helps guide the need for radiotherapy after breast-conserving surgery (lumpectomy). Breast-conserving surgery alone For specific low-risk cases (Option C) Adjuvant Therapies Hormonal therapy (e.g., Tamoxifen) (Option A) Sentinel lymph node biopsy (SLNB) Recommended for mastectomy patients Considered in specific breast-conserving surgery cases

References:

Sabiston Textbook of Surgery, 21st Edition, Pages 827, 828

Schwartz's Principles of Surgery, 11th Edition, Pages 564, 565

SRB's Manual of Surgery, 6th Edition, Page 52

↑ *Back to this question in Part A*

@Neet_pg_bot

Q25: A 38-year-old premenopausal woman is diagnosed with Lobular Carcinoma In Situ (LCIS) after a breast biopsy. She opts for chemoprevention as her management strategy. Her doctor discusses various medication options with her. Which of the following statements about chemoprevention for LCIS is correct? (Q848851)

A. Chemoprevention eliminates the risk of developing breast cancer

B. Tamoxifen reduces breast cancer risk by 25% over 5 years

C. Chemoprevention is only effective for the ipsilateral breast

D. Tamoxifen reduces breast cancer risk by 56% over 5 years

Correct Answer: D. Tamoxifen reduces breast cancer risk by 56% over 5 years

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Lobular Carcinoma In Situ (LCIS) Proliferation of malignant cells in lobules without breaching basement membrane Considered more of a risk marker than a true cancer Pathology : Cells are: Small, uniform, discohesive Loss of E-cadherin (key feature) Often bilateral & multicentric Clinical Features Asymptomatic Usually incidental finding on biopsy Not visible on mammography (no calcifications) Risk Increases risk of: Both breasts Both ductal & lobular carcinoma Management Close observation Chemoprevention Medications: Tamoxifen, Raloxifene, or Arimidex Tamoxifen reduces risk by 56% over 5 years Surgical: Bilateral mastectomy (if surgery chosen prophylactically)

References:

Sabiston Textbook of Surgery, 21st Edition, Pages 821, 827, 828

Schwartz's Principles of Surgery, 11th Edition, Pages 563, 564

SRB's Manual of Surgery, 6th Edition, Page 526

↑ *Back to this question in Part A*

@Neet_pg_bot

Q26: A 55-year-old woman is diagnosed with breast cancer. The pathology report shows a 2.5 cm tumor with positive lymph nodes. The tumor is ER-positive, PR-positive, and HER2-negative. Which of the following statements is most accurate regarding her prognosis and treatment? (Q848852)

A. The tumor size and lymph node status suggest a favorable prognosis

B. The hormone receptor status indicates the tumor will not respond to endocrine therapy

C. The absence of HER2 overexpression means targeted therapies are the primary treatment option

D. The ER-positive status suggests a better prognosis and responsiveness to endocrine therapy

Correct Answer: D. The ER-positive status suggests a better prognosis and responsiveness to endocrine therapy

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Disease factors that influence prognosis Tumour Size & Lymph Node Pathologic staging (tumour size, lymph nodes) guides prognosis and treatment. Larger tumours and positive lymph nodes = worse prognosis. (Option A) Molecular Markers Hormone Receptors (ER, PR): ER-positive = better prognosis (Option D) , responsive to endocrine therapy. (Option B) HER-2 Status: HER-2 positive = aggressive but treatable with targeted therapies. (Option C)

References:

Sabiston Textbook of Surgery, 21st Edition, Pages 828, 829, 831, 832, 835, 839, 847, 851

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 942

↑ *Back to this question in Part A*

@Neet_pg_bot

Q27: Which of the following statements about lymphatic drainage of the breast is true? (Q848844)

A. Level III lymph nodes are located lateral to the pectoralis minor muscle.

B. Lymphatic drainage from the breast is directed to the subclavian lymph nodes.

C. Level I lymph nodes are also known as Rotter’s nodes.

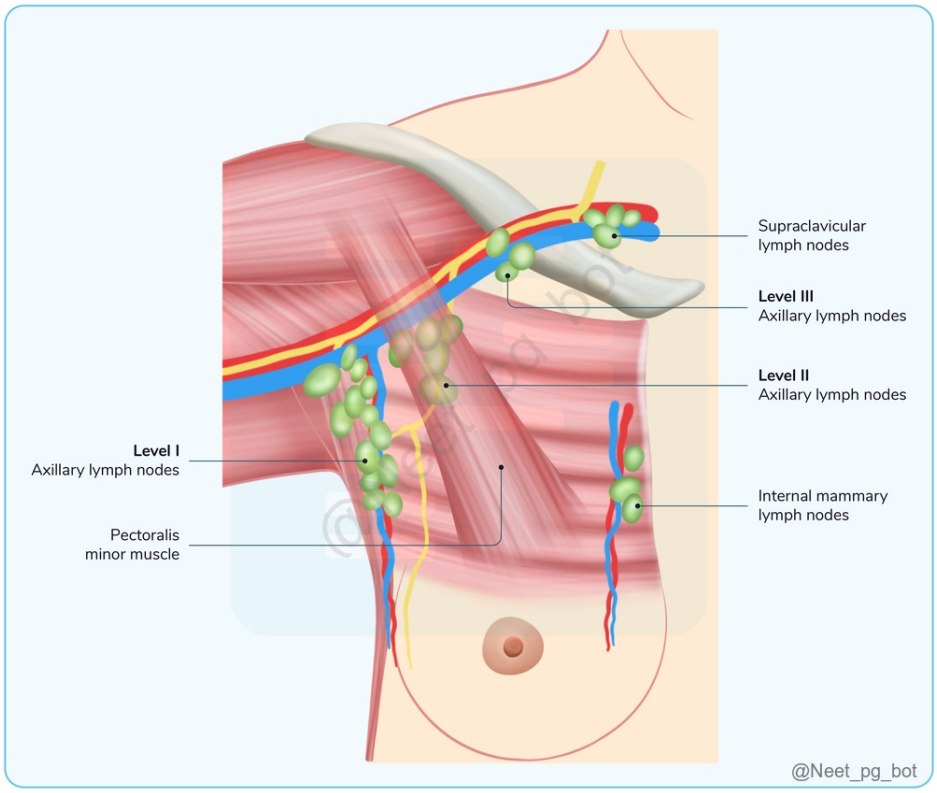
D. Level II lymph nodes are located posterior to the pectoralis major

Correct Answer: D. Level II lymph nodes are located posterior to the pectoralis major

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Axillary lymph nodes are categorised into three anatomical levels based on their relationship to the pectoralis minor muscle. Level of node Location Level I Lateral and below to the lateral border of pectoralis minor Level II(Rotter/Interpectoral nodes) Anterior as well as posterior to the pectoralis minor and posterior to the pectoralis major. Level III Medial and above to the pectoralis minor muscle and include subclavicular nodes {{caption_text}}



References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 915.

Sabiston Textbook of Surgery, 21st Edition, Pages 810, 811.

SRB's Manual of Surgery, 6th Edition, Page 507.

Grays Anatomy, 42nd Edition, Page 1015.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q28: A 52-year-old female presents with a two-month history of persistent itching, redness, and scaling of the right nipple, unresponsive to moisturizing creams. Physical examination reveals erythema and crusting of the nipple and areola without palpable breast lumps. The image of her right breast is given below. What is the most probable diagnosis? {{caption_text}} (Q848854)

A. Paget disease of the nipple

B. Scirrhous tumor

C. Ductal papilloma

D. Inflammatory carcinoma



Correct Answer: A. Paget disease of the nipple

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The given case scenario is that of Paget's disease of the nipple Finding Description Possible Cause Nipple discharge {{caption_text}} Discharge from a single duct orifice Papilloma (Option C) or other underlying ductal disease Paget disease of the nipple {{caption_text}} Appears as a psoriatic rash starting on the nipple and spreading to the areola and breast skin. Paget disease Skin dimpling {{caption_text}} Traction on Cooper ligaments by a scirrhous tumor Best seen with angled indirect lighting during the abduction of the arms upward. Scirrhous tumor (Option B) Peau d'orange (skin of the orange) {{caption_text}} Edema of the breast skin

Inflammatory carcinoma (Option D) Lymphatic blockage Mastitis









References:

Sabiston Textbook of Surgery, 21st Edition, Page 815

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 924.

SRB's Manual of Surgery, 6th Edition, Pages 525, 526.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q29: A 45-year-old female presents with a painless lump in her right breast, noticed during a self-examination two weeks ago. Which of the following tests has the maximum accuracy? (Q848855)

A. FNAC

B. Core biopsy

C. Mammography

D. Triple assessment

Correct Answer: D. Triple assessment

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Triple assessment is a combination of assessments used for breast cancer screening and diagnosis Triple Assessment of Breast Examination 1. Clinical Examination Objective: Identify lumps, skin changes, nipple discharge, or lymphadenopathy. Procedure: Palpation of breasts and lymph nodes. 2. Imaging Methods: Mammography: Preferred for women over 40. Ultrasound: Used in younger women or for further evaluation. 3. Biopsy Types: FNAC: Minimally invasive; used for cystic lesions. Core Needle: Preferred for solid masses. Excisional: Removes lump for examination.

References:

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7188022/

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 915.

SRB's Manual of Surgery, 6th Edition, Page 538.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q30: A lesion was found in a routine mammogram of a 52-year-old asymptomatic woman. Which of the following statements regarding mammogram findings is false? (Q848856)

A. If the density of the lesion is high, it is mostly malignant

B. Architectural distortion is usually present in benign lesions

C. Calcification in benign lesions is diffuse

D. Margins are well-circumscribed in benign lesions

Correct Answer: B. Architectural distortion is usually present in benign lesions

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Architectural distortion is usually present in malignant lesions, not benign lesions Mammography findings Feature Benign Lesions Malignant Lesions Shape Round, oval, lobular Irregular Margins Circumscribed Microlobulated, obscured, indistinct, spiculated Density Low to intermediate Intermediate to high Distribution of Calcifications Randomly distributed, diffuse Grouped, clustered, fine linear, branching, segmental Architectural Distortion Usually absent Often present Mammography Purpose of Screening Detect occult breast cancer in asymptomatic women Benefits Early detection Reduced mortality High sensitivity and specificity in older women (fatty breast tissue) Disadvantages Screening expenses False positives Additional workups Anxiety (USPSTF) Recommendations Biennial screening for women 50-74 years Recommended against screening for women 40-49 years and >75 years. American Cancer Society Recommendations Annual screening for women >40 years in good health MRI screening for younger women with high risk (20% lifetime risk)

References:

https://www.ncbi.nlm.nih.gov/books/NBK12642/

Sabiston Textbook of Surgery, 21st Edition, Pages 817, 818.

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 916, 917.

SRB's Manual of Surgery, 6th Edition, Pages 533, 534.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q31: A 48-year-old female underwent a lumpectomy for a 2 cm invasive ductal carcinoma in her right breast. Post-surgery pathology revealed positive margins, indicating residual cancerous tissue. Which of the following investigations is most suitable to check for residual cancer tissues? (Q848857)

A. MRI

B. USG

C. Mammography

D. Repeat the biopsy

Correct Answer: A. MRI

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: MRI is preferred for checking for residual disease after lumpectomy with positive margins. Magnetic Resonance Imaging (MRI) in breast cancer Indications: Tumors in patients with axillary lymph node metastases and no mammographic evidence Paget disease of the nipple without radiographic evidence of a primary tumor The extent of the primary tumor, especially in young women with dense breast tissue Residual disease after lumpectomy with positive margins Screening the contralateral breast Invasive lobular cancers After neoadjuvant chemotherapy Assessing implant rupture or evaluating the breast after silicone injection.

References:

Sabiston Textbook of Surgery, 21st Edition, Pages 818-819

Bailey & Love's Short Practice of Surgery, 28th Edition, Pages 915, 916, 917.

SRB's Manual of Surgery, 6th Edition, Pages 534, 537.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q32: Match the following: Biopsy Feature 1. FNAC a. Evaluation of cellular fibroadenoma 2. Core-needle biopsy b. Assessment of suspicious lymph nodes 3. Excisional biopsy c. Sampling solid masses, calcifications, and densities identified on imaging (Q848858)

A. 1-b,2-c,3-a

B. 1-a,2-b,3-c

C. 1-c,2-b,3-a

D. 1-b,2-a,3-c

Correct Answer: A. 1-b,2-c,3-a

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Biopsy Type Correct Feature Reason v Fine-needle aspiration Cytology (FNAC) b. Assessment of suspicious lymph nodes Gives cytology only (cells, no architecture) Best for rapid, minimally invasive evaluation , especially lymph nodes Core Needle Biopsy (CNB) c. Sampling solid masses, calcifications, densities on imaging Provides tissue architecture Gold standard for breast lump evaluation , especially image-guided lesions Excisional Biopsy a. Evaluation of cellular fibroadenoma Entire lesion removed It is used when the diagnosis is uncertain or borderline lesions (ADH, phyllodes, cellular fibroadenoma) Options B, C, and D are incorrectly matched.

References:

Sabiston Textbook of Surgery, 21st Edition, Pages 816, 817

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 918

SRB's Manual of Surgery, 6th Edition, Pages 534, 535

↑ *Back to this question in Part A*

@Neet_pg_bot

Q33: A 45-year-old woman presents for her routine mammogram. She has no family history of breast cancer and no previous history of breast issues. A mammogram reveals a well-circumscribed, homogeneous lesion with characteristic benign features, such as a simple cyst with no suspicious calcifications or architectural distortions. Based on these findings, What is the appropriate BI-RADS category for this lesion? (Q848859)

A. BI-RADS 1

B. BI-RADS 2

C. BI-RADS 3

D. BI-RADS 4

Correct Answer: B. BI-RADS 2

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The scenario describes a well-circumscribed, homogeneous lesion with characteristic benign features, such as a simple cyst with no suspicious calcifications or architectural distortions. This suggests lesion is Benign and so BIRADS 2 is the appropriate score for this situation. BI-RADS Score: BI-RADS Category Description Management Likelihood of Malignancy 0 Incomplete Need additional imaging evaluation N/A 1

Negative Routine screening Essentially 0% 2 Benign Routine screening Essentially 0% 3 Probably Benign Short-term follow-up (6 months) < 2% 4 Suspicious of Malignancy Biopsy should be considered 4A Suspicious: Low _ > 2% to ≤ 10% 4B Suspicious: Moderate _ > 10% to ≤ 50% 4C Suspicious: High _ > 50% to ≤ 95% 5 Highly Suggestive of Malignancy Appropriate action should be taken > 95% 6 Known Biopsy-Proven Malignancy Appropriate action should be taken 100%

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 917.

Sabiston Textbook of Surgery, 21st Edition, Page 821

SRB's Manual of Surgery, 6th Edition, Page 507.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q34: A 55-year-old woman presents with a palpable breast lump. After imaging studies and a biopsy, the results show a tumor measuring 3.5 cm in the breast. The patient also has involvement of ipsilateral internal mammary lymph nodes, but no distant metastases are detected. Based on the TNM staging system, what is the appropriate stage for this breast cancer? (Q848860)

A. T1 N2

B. T2 N1

C. T2 N2

D. T3 N1

Correct Answer: C. T2 N2

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: (T2 N2) The tumor size of 3.5 cm fits the T2 category (tumor > 2.0 cm but ≤ 5.0 cm). The involvement of ipsilateral internal mammary lymph nodes is classified as N2, and no distant metastases (M0) are present. TNM staging for breast cancer: T (Tumor) N (Nodes) M (Metastasis) Tx – Tumor not assessed Nx – Nodes not assessed M0 – No metastasis T0 – No tumor N0 – No nodal metastasis M1 – Distant metastasis Tis – In situ (DCIS/LCIS/Paget's) N0(i+) – Isolated tumor cells T1 – ≤ 2 cm N1 – 1–3 axillary nodes T1mi – ≤1 mm T1a – 1–5 mm T1b – 5–10 mm T1c – 10–20 mm T2 – 2–5 cm N2 – 4–9 axillary / IM nodes T3 – >5 cm N3 – ≥10 / infraclavicular / supraclavicular T4 – Chest wall / skin involvement N3a – ≥10 axillary T4a – Chest wall N3b – IM + axillary T4b – Skin (peau d'orange, ulcer) N3c – Supraclavicular T4c – Both T4d – Inflammatory carcinoma Stage Grouping: Stage TNM Combination Stage 0 Tis N0 M0 Stage IA T1 / T1mi N0 M0 Stage IB T0 N1mi M0

T1 / T1mi N1mi M0 Stage IIA T0 N1 M0 T1 N1 M0 T2 N0 M0 Stage IIB T2 N1 M0 T3 N0 M0 Stage IIIA T0 N2 M0 T1 N2 M0 T2 N2 M0 T3 N1 M0 Stage IIIB T3 N2 M0 Stage IIIC T4 N0 M0 T4 N1 M0 T4 N2 M0 Any T N3 M0 Stage IV Any T Any N M1

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 934

Sabiston Textbook of Surgery, 21st Edition, Page 833

SRB's Manual of Surgery, 6th Edition, Page 532

↑ *Back to this question in Part A*

@Neet_pg_bot

• [07_Endocrine Surgery] 042 Breast-Ii

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[07_Endocrine Surgery] 042 Breast-Ii — Quick Jump

Q1 (p. 2787)	*Q2 (p. 2787)*	*Q3 (p. 2788)*	*Q4 (p. 2789)*	*Q5 (p. 2790)*	*Q6 (p. 2790)*
Q7 (p. 2791)	*Q8 (p. 2792)*	*Q9 (p. 2793)*	*Q10 (p. 2793)*	*Q11 (p. 2795)*	*Q12 (p. 2796)*
Q13 (p. 2796)	*Q14 (p. 2798)*	*Q15 (p. 2799)*	*Q16 (p. 2799)*	*Q17 (p. 2800)*	*Q18 (p. 2801)*
Q19 (p. 2802)	*Q20 (p. 2803)*	*Q21 (p. 2804)*	*Q22 (p. 2805)*	*Q23 (p. 2807)*	*Q24 (p. 2808)*
Q25 (p. 2809)	*Q26 (p. 2809)*	*Q27 (p. 2810)*			

Q1: What is the approximate risk of malignancy associated with a lesion classified as BI-RADS 4A? (Q880446)

A. 2–10%

B. 10–50%

C. 50–95%

D. ≥95%

Correct Answer: A. 2–10%

Explanation: Breast Imaging Reporting and Database System (BI-RADS) BI-RADS Assessment Probability of malignancy Follow-up recommendation 0 Assessment is incomplete Not applicable Need for additional imaging evaluation and/or prior mammograms for comparison 1 Negative Essentially 0% Routine annual screening mammography (for women over age 40) 2 Benign fnding(s) 3 Probably benign fnding >0% but ≤2% Initial short-term follow-up (usually 6 months) 4 4a: Findings needing intervention with a >2 to ≤10% low suspicion for malignancy >2 to ≤10% (Option A) Biopsy should be considered 4b: Intermediate suspicion of malignancy >10% to ≤50% >10% to ≤50% (Option B ruled out) 4c: Findings of moderate concern, with >50% to <95% high suspicion for malignancy >50% to <95% (Option C ruled out) 5 Highly suggestive of malignancy ≥95% (Option D ruled out) Requires biopsy or surgical treatment 6 Known biopsy-proven malignancy Not applicable Category reserved for lesions identified on imaging study with biopsy proof of malignancy before definitive therapy

References:

Bailey & Love Short Practice of Surgery, 28th Edition, Page no.917

↑ *Back to this question in Part A*

@Neet_pg_bot

Q2: A 38-year-old woman presents with localized, non-cyclical medial breast pain. Examination and imaging are normal. Pain is maximal at a specific point, and musculoskeletal causes have been excluded. Which of the following is the most appropriate management? (Q880439)

A. Reassurance only

B. Oral NSAIDs for 1 week

C. Local injection of corticosteroid plus lidocaine

D. Empirical antibiotics

Correct Answer: C. Local injection of corticosteroid plus lidocaine

Explanation: Non-cyclical pain may be due to trigger points or musculoskeletal causes Local injection of a long-acting corticosteroid (e.g., triamcinolone) with lidocaine at the point of maximal tenderness can relieve trigger point pain Repeated injections may be performed until pain is controlled Incorrect Options: Reassurance only (Option A): Appropriate for cyclical or generalized pain, not localized trigger point pain. Oral NSAIDs (Option B): May provide temporary relief, but are often insufficient for trigger point pain. Empirical antibiotics (Option D): No infection is present

References:

Bailey & Love Short Practice of Surgery, 28th Edition, Pages 919-921

↑ *Back to this question in Part A*

@Neet_pg_bot

Q3: Which of the following are indications for adjuvant chemotherapy in breast cancer? Post-surgery eradication of microscopic residual disease in high-risk patients Inflammatory breast cancer. HER2-positive breast cancer in combination with HER2-targeted therapy Triple-negative breast cancer Enabling breast-conserving surgery by reducing tumor size. (Q848826)

A. 1, 3, and 5 are correct

B. 2, 3, and 5 are correct

C. 2, 4, and 5 are correct

D. 1, 3, and 4 are correct

Correct Answer: D. 1, 3, and 4 are correct

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Indications for Chemotherapy in Breast Cancer : Neoadjuvant Therapy Treatment given before surgery to shrink tumors and make surgery easier. Tumor downstaging before surgery, especially for large or near chest wall/skin tumors. Adjuvant Therapy Treatment given after surgery to eradicate microscopic residual disease and reduce the risk of recurrence. Post-surgery eradication of microscopic residual disease in high-risk patients. Node-positive disease. High-risk node-negative disease based on tumor characteristics. Tumors greater than 2 cm with additional risk factors. High-grade tumors. HER2-positive breast cancer in combination with HER2-targeted therapy. Triple-negative breast cancer. Genomic assays indicating benefit of chemotherapy in early-stage breast cancer.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Pages 940,941.

Schwartz's Principles of Surgery, 11th Edition, Pages 594-596.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q4: Physiological gynecomastia is not typically seen in which of the following age groups? (Q880438)

A. Neonates

B. Pubertal boys

C. Men over 50 years

D. Men aged 30–40 years

Correct Answer: D. Men aged 30–40 years

Explanation: Gynecomastia in men aged 30–40 years is usually pathological rather than physiological Physiological Gynecomastia occurs in: Neonates due to maternal estrogen (Option A ruled out) Pubertal boys due to a transient hormonal imbalance (Option B ruled out) Elderly men (>50 years) due to senescent changes (Option C ruled out)

References:

Sabiston Textbook of Surgery: The Biological Basis of Modern Surgical Practice, 21st Edition, Page. 814

↑ *Back to this question in Part A*

@Neet_pg_bot

Q5: Which of the following statements regarding phyllodes tumours is true? (Q880437)

A. Most commonly seen in women aged 15–25 years

B. True mixed neoplasms comprising both epithelial and mesenchymal elements

C. Rarely require wide local excision due to low recurrence risk

D. Frequently infiltrate the skin early in their course

Correct Answer: B. True mixed neoplasms comprising both epithelial and mesenchymal elements

Explanation: Phyllodes Tumor: Occur usually in women >30 years, occasionally younger (Option A ruled out) Present as large, mobile, bosselated breast lumps Rarely infiltrate skin early (Option D ruled out) High local recurrence risk → wide local excision with 2-cm margin required (Option C ruled out) True mixed neoplasm: Both epithelial and mesenchymal elements (Option B)

References:

Bailey & Love Short Practice of Surgery, 28th Edition, Page. 922-923

↑ *Back to this question in Part A*

@Neet_pg_bot

Q6: A 16-year-old girl presents with a rapidly enlarging breast lump. On examination, the lump is firm, well-circumscribed, and measures more than 5 cm in diameter. Which of the following terms best describes this fibroadenoma? (Q880436)

A. Simple fibroadenoma

B. Giant fibroadenoma

C. Complex fibroadenoma

D. Phyllodes tumor

Correct Answer: B. Giant fibroadenoma

Explanation: Giant Fibroadenomas occasionally occur during puberty. They are defined as fibroadenomas measuring over 5 cm in diameter, often rapidly growing, and can be enucleated through a submammary incision.

These differ from simple fibroadenomas, which are usually 2–3 cm in size. Incorrect Options: Simple fibroadenoma (Option A): Typically 2–3 cm, slow-growing, well-circumscribed, and often observed without biopsy. Complex fibroadenoma (Option C): Has histological features such as epithelial hyperplasia, sclerosing adenosis, or cysts; associated with a slightly increased cancer risk. Phyllodes tumor (Option D): Rare, can be large and rapidly growing, but histologically distinct from fibroadenoma and may be malignant.

References:

Bailey & Love Short Practice of Surgery, 28th Edition, Page. 922

↑ *Back to this question in Part A*

@Neet_pg_bot

Q7: Regarding breast carcinoma, which of the following statements is incorrect? (Q880435)

A. Inflammatory carcinoma produces cutaneous oedema due to obstruction of subdermal lymphatics by tumour cells

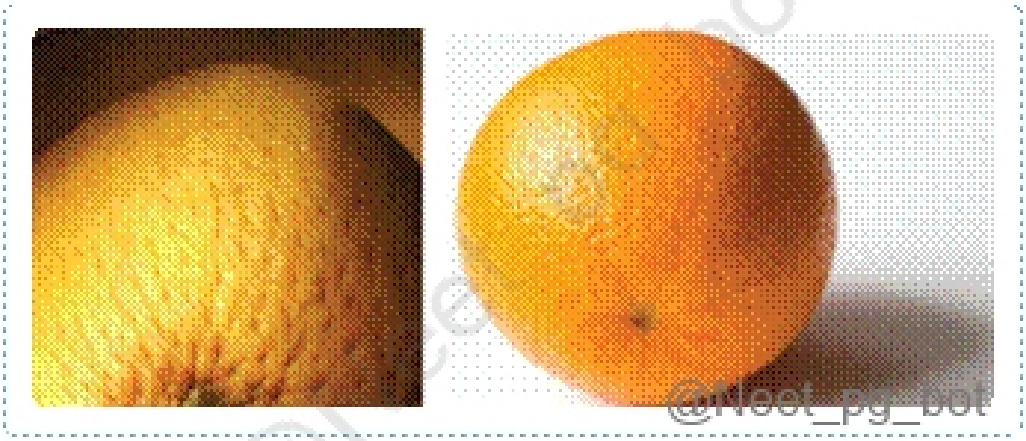
B. Mucinous carcinomas are typically hormone receptor–negative

C. Ductal carcinoma in situ often shows associated calcifications

D. Lobular carcinoma in situ tends to be multicentric and bilateral

Correct Answer: B. Mucinous carcinomas are typically hormone receptor–negative

Explanation: Mucinous (colloid) carcinomas of the breast are generally hormone receptor–positive (estrogen and progesterone receptors positive), which is linked to a better prognosis and response to hormonal therapy. Inflammatory carcinoma produces cutaneous oedema due to obstruction of subdermal lymphatics by tumour cells (Option A): This is a classic feature of inflammatory breast carcinoma. Tumour emboli obstruct the dermal lymphatics, causing characteristic skin changes such as oedema, redness, and peau d’orange (orange peel appearance). Ductal carcinoma in situ often shows associated calcifications (Option C): DCIS frequently presents on mammography with microcalcifications, which aid early detection. Lobular carcinoma in situ tends to be multicentric and bilateral (Option D): LCIS commonly involves multiple foci within the same breast (multicentric) and often affects both breasts (bilateral).



References:

Bailey & Love Short Practice of Surgery, 28th Edition, Page 931.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q8: A 22-year-old woman presents with a firm, mobile, well-circumscribed breast lump measuring 2.5 cm. Ultrasound confirms a typical fibroadenoma. She has no family history of breast cancer. Which of the following best describes the underlying pathological process in fibroadenoma? (Q880434)

A. Hyperplasia of a breast lobule

B. Malignant transformation of ductal epithelium

C. Cystic degeneration of breast stroma

D. Inflammatory infiltration of breast tissue

Correct Answer: A. Hyperplasia of a breast lobule

Explanation: The given scenario is of a Fibroadenoma, → most common breast lump in women aged 15–25 years. It arises from hyperplasia of a lobule and is usually surrounded by a well-defined capsule. Incorrect Options: Malignant transformation of ductal epithelium (Option B): Fibroadenomas are benign; malignant change is rare. Cystic degeneration of breast stroma (Option C): Not a feature of fibroadenoma; cystic changes may occur in other benign conditions. Inflammatory infiltration of breast tissue (Option D): Not seen in fibroadenoma; there is no infection or inflammation involved.

References:

Bailey & Love Short Practice of Surgery, 28th Edition, Page. 922

↑ *Back to this question in Part A*

@Neet_pg_bot

Q9: A 28-year-old lactating mother presents with fever, breast pain, swelling, and a tender, erythematous area on her left breast. Ultrasonography confirms the presence of a pus-filled cavity. What would be the initial treatment in this scenario? (Q848841)

A. Close Observation

B. Antibiotics and breast emptying

C. Hormonal therapy

D. Surgical excision

Correct Answer: B. Antibiotics and breast emptying

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The given clinical history of a lactating mother with painful, tender breasts with ultrasound findings of a pus-filled cavity is suggestive of lactational abscess. The preferred treatment would be antibiotics and breast emptying. Treatment for Breast Abscess Lactational Mastitis: Antibiotics: Anti-staphylococcal (e.g., cloxacillin, flucloxacillin, erythromycin). Breast emptying: Frequent breastfeeding or pumping. Support: Breast support garment, cold compresses, analgesia. Drainage: Ultrasound-guided preferred over surgical incision. Follow-up: Regular clinical and ultrasonographic reviews, culture-based antibiotic modification. Non-Lactational Mastitis: Broad-spectrum antibiotics for subareolar infections. Needle aspiration for abscess drainage. Major milk duct excision for complications like sepsis or fistula.

References:

Sabiston Textbook of Surgery, 21st Edition, Pages 826,827

Bailey & Love's Short Practice of Surgery, 28th Edition, Pages 927,928

Schwartz's Principles of Surgery, 11th Edition, Pages 550-553, 601, 602

↑ *Back to this question in Part A*

@Neet_pg_bot

Q10: A 55-year-old menopausal woman presents with a unilateral, scaly, and erythematous lesion on her nipple, initially resembling eczema but without itching. She was diagnosed with Paget's disease of the nipple. Which of the following cancers is most commonly associated with Paget's disease? {{caption_text}} (Q848836)

A. Invasive ductal carcinoma

B. Invasive lobular carcinoma

C. Ductal carcinoma in situ

D. Lobular carcinoma in situ



Correct Answer: C. Ductal carcinoma in situ

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: In Paget disease, malignant ductal cells (Paget cells) originate from underlying DCIS. These cells migrate along lactiferous ducts and spread into the epidermis of the nipple. Importantly, they remain intraepidermal (do not cross basement membrane) → hence linked to DCIS. Invasive Ductal Carcinoma (Option A): Although Invasive ductal carcinoma is the most common associated underlying malignancy overall, but for paget's disease; the epidermal lesion is due to spread of DCIS cells. Invasive lobular carcinoma (ILC) (Option B) : It is rarely associated with Paget's disease. ILC spreads diffusely and does not typically involve the nipple epidermis. Lobular carcinoma in situ (LCIS) (Option D) : LCIS is usually an incidental finding and not linked to

Paget's disease.

References:

Robbins & Cotran Pathologic Basis of Disease, 10th Edition, Page 1044-1045

SRB's Manual of Surgery, 6th Edition, Page 526

↑ *Back to this question in Part A*

@Neet_pg_bot

Q11: A 45-year-old woman with a family history of breast cancer undergoes genetic testing and is found to have a BRCA1 mutation. What are the implications of this mutation regarding the cancer risks and potential associated cancers? (Q848843)

A. Increased risk of breast cancer with well-differentiated hormone receptor-positive tumors.

B. Increased risk of breast cancer, typically high-grade and triple-negative, along with higher risks of colon and ovarian cancers.

C. Increased risk of breast cancer and higher risk of endometrial cancer.

D. Increased risk of ovarian cancer with no significant increase in breast cancer risk.

Correct Answer: B. Increased risk of breast cancer, typically high-grade and triple-negative, along with higher risks of colon and ovarian cancers.

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: BRCA1 mutations greatly increase the risk of high-grade, triple-negative breast cancers and also raise the risk of ovarian and colon cancer . They also increase prostate (in male carriers) cancer risks. Category BRCA1 BRCA2 Breast Cancer Characteristics High grade, hormone receptor-negative Often triple-negative (ER-negative, PR-negative, HER2-negative) (Option B) Basal phenotype Typically, invasive ductal carcinomas More likely hormone receptor-positive (Option A) Well-differentiated Associated Cancers Increased risk of O varian , C olon and P rostate cancers (OCP - Mnemonic) Broader spectrum: prostate, colon, pancreatic, gallbladder, bile duct, stomach cancers and melanoma

References:

Sabiston Textbook of Surgery, 21st Edition, Pages 822-824

Bailey & Love's Short Practice of Surgery, 28th Edition, Pages 931, 935, 940, 941

Schwartz's Principles of Surgery, 11th Edition, Pages 558, 559

↑ *Back to this question in Part A*

@Neet_pg_bot

Q12: A 35-year-old woman presents with cyclical breast pain and palpable lumps in her breasts. She reports that the pain increases just before her menstrual period. Physical examination reveals dense breast tissue without any nipple discharge or skin involvement. What is the most likely diagnosis? (Q848842)

A. Mucinous carcinoma

B. Fibrocystic Changes

C. Medullary Carcinoma

D. Ductal carcinoma

Correct Answer: B. Fibrocystic Changes

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The history of cyclical breast pain with palpable lumps is suggestive of fibrocystic changes of the breast. Fibrocystic changes Causes Believed to result from an exaggerated response to hormonal fluctuations , particularly estrogen. Involves hypertrophy and altered morphology rather than hyperplasia. Symptoms Common: Breast pain (mastalgia) , either cyclical (linked to menstrual cycle) or non-cyclical . The breast may feel lumpy or dense . Palpable cysts may develop. Diagnosis Patient history: Age, menstrual history, and previous breast biopsies. Physical examination: Visual inspection, palpation of breast tissue and lymph nodes Imaging tests: Mammography : Detects dense tissue or cysts. Ultrasound : Differentiates cysts from solid masses. Biopsy: To rule out malignancy or evaluate suspicious findings. Treatment No treatment is needed for mild symptoms. Symptomatic relief Cyst aspiration : Draining fluid from large or painful cysts. Hormonal therapy : Medications like danocrine, lupron, or tamoxifen in some cases (not typically first-line treatment due to potential side effects). Feature Fibrocystic Changes (Option B) Mucinous Carcinoma (Option A) Medullary Carcinoma (Option C) Ductal Carcinoma (Option D) Age 30–50 yrs Elderly Younger >40 yrs Pain Cyclical No No No/late Lump Diffuse, bilateral Soft, single Well-defined Hard, irregular Cycle relation Present Absent Absent Absent Skin changes Absent Absent Rare Common Nature Benign Malignant Malignant Malignant

References:

Sabiston Textbook of Surgery, 21st Edition, Pages 813, 814

Bailey & Love's Short Practice of Surgery, 28th Edition, Pages 914-919

↑ *Back to this question in Part A*

@Neet_pg_bot

Q13: A 35-year-old woman presents with a tender, thrombosed subcutaneous cord on her right breast, which becomes more pronounced when she raises her arm. She reports no recent trauma or infections. What is the most likely diagnosis? (Q848839)

A. Ductal carcinoma in situ

B. Mondor's Disease

C. Mastitis

D. Fibrocystic Changes

Correct Answer: B. Mondor's Disease

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Mondor’s disease Cause Unknown; can be due to injury or infection. Affected Veins: Lateral thoracic, thoracoepigastric, and superficial epigastric veins. Clinical features Tender, thrombosed subcutaneous cord attached to the skin (string phlebitis) A narrow, shallow subcutaneous groove appears on the arm raise. Treatment Limit arm movement Anti-inflammatory medications Warm compresses Biopsy- if the diagnosis is uncertain or a mass is present near the cord. Prognosis Symptoms usually resolve in 4 to 6 weeks without recurrence or complications. {{caption_text}}



References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Pages 930

Schwartz's Principles of Surgery, 11th Edition, Page 550

↑ *Back to this question in Part A*

@Neet_pg_bot

Q14: A 20-year-old woman presents with a painless, firm, mobile lump in her breast. On physical examination, the lump is approximately 1 cm in diameter, firm, well-circumscribed, and freely mobile. Ultrasound confirms a well-defined, solid, homogeneous mass with smooth margins and no signs of calcifications. What is the most likely diagnosis and management plan? (Q848838)

A. Cyst; surgical excision.

B. Fibroadenoma; conservative management with regular monitoring.

C. Giant fibroadenoma; immediate surgical removal.

D. Inflammatory carcinoma; urgent biopsy and treatment.

Correct Answer: B. Fibroadenoma; conservative management with regular monitoring.

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Fibroadenoma Definition Benign tumours arising from the proliferation of glandular tissue in the breast Prevalence Most common in women aged 15-25 years Aetiology Believed to be influenced by hormonal fluctuations during reproductive years Clinical Presentation Painless, firm, rubbery, and mobile lumps Described as feeling like a "marble in the breast" Diagnosis Triple Assessment : Clinical examination, radiological imaging (ultrasound), tissue sampling (core-needle biopsy) Ultrasound: Helps distinguish fibroadenomas from cysts Core-Needle Biopsy: Provides definitive diagnosis Treatment Conservative Management: Watchful waiting, regular monitoring (Option B) Giant Fibroadenomas: Over 5 cm, may require excision through submammary incision (Option C)

References:

Sabiston Textbook of Surgery, 21st Edition, Pages 816,817, 826

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 922

Schwartz's Principles of Surgery, 11th Edition, Pages 551-554

↑ *Back to this question in Part A*

@Neet_pg_bot

Q15: Which of the following statements regarding phyllodes tumor are correct? Statements: Tumors of mixed connective tissue and epithelium Classified as benign, intermediate, and malignant Discrete structure with cystic spaces in USG Excisional biopsy is the definitive diagnostic method (Q848837)

A. 1,3

B. 4

C. 3,4

D. 1,2,3,4

Correct Answer: D. 1,2,3,4

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: All 4 statements are correct Phyllodes tumor: Characteristic Details Description Tumors of mixed connective tissue and epithelium Classification Benign Phyllodes Tumors Intermediate (Borderline) Phyllodes Tumors Malignant Phyllodes Tumors Imaging Mammography: Round densities with smooth borders, indistinguishable from fibroadenomas Ultrasound: Discrete structure with cystic spaces Diagnosis Core needle biopsy (CNB) preferred Excisional biopsy is definitive Treatment Benign: Local excision Intermediate: Excision with negative margins (at least 1 cm) Malignant: Complete surgical excision; total mastectomy if large; possible adjuvant radiation therapy if margins are concerning

References:

Sabiston Textbook of Surgery, 21st Edition, Pages 831-832

↑ *Back to this question in Part A*

@Neet_pg_bot

Q16: A 45-year-old woman presents with a palpable mass in her left breast. On examination, the mass is 3 cm in diameter, and there is no evidence of skin or chest wall involvement. An ultrasound reveals a single enlarged axillary lymph node. Biopsy confirms invasive ductal carcinoma, ER/PR positive, HER2 negative, shows no distant metastasis. What is the most appropriate management approach? (Q848823)

A. Total mastectomy with sentinel lymph node biopsy (SLNB)

B. Breast-conserving surgery (BCS) with SLNB followed by radiotherapy (RT)

C. Neoadjuvant chemotherapy followed by mastectomy

D. BCS with axillary lymph node dissection (ALND) without radiotherapy

Correct Answer: B. Breast-conserving surgery (BCS) with SLNB followed by radiotherapy (RT)

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The tumour is classified as T2 due to its 3 cm size, N1 because of a single enlarged axillary lymph node, and M0 as there is no distant metastasis, placing it in Stage IIB. Management of Early Invasive Breast Cancer Stages Involved: I, IIA and IIB Breast Conservation Surgery (BCS): Preferred for suitable candidates to preserve breast tissue. Post-Operative Radiotherapy (RT): Given after BCS to prevent recurrence. Sentinel Lymph Node Biopsy (SLNB): Performed with BCS to assess lymph node involvement. BCS + SLNB + RT is the standard approach for most early-stage invasive breast cancer cases. Other options: Option A: Total mastectomy with SLNB Mastectomy is not mandatory for a 3-cm operable tumour without skin/chest wall invasion. Breast-conserving approaches provide equivalent survival when combined with radiotherapy. Therefore, mastectomy would be overtreatment. Option C: Neoadjuvant chemotherapy followed by mastectomy Neoadjuvant chemotherapy is recommended for triple-negative or HER2-positive tumours, or when downstaging is needed. This patient has luminal (ER/PR+) disease, and is already operable. Option D: BCS with ALND without radiotherapy Radiotherapy is mandatory after BCS. ALND is not first-line; SLNB is performed initially unless nodes are proven metastatic preoperatively or >2 nodes are positive.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Pages 935-939.

Schwartz's Principles of Surgery, 11th Edition, Pages 582-585.

SRB's Manual of Surgery, 6th Edition, Pages 547,548.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q17: A 65-year-old man presents with a hard, unilateral breast lump and nipple retraction. Clinical examination reveals skin dimpling and axillary lymphadenopathy. A biopsy confirms breast cancer. Which of the following is wrong about his diagnosis? (Q848835)

A. Associated with BRCA2 mutation

B. Most common in 4th decade of life

C. Poorer prognosis compared to carcinoma breast in females

D. Infiltrating duct carcinoma is the most common type

Correct Answer: B. Most common in 4th decade of life

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Male breast cancer is more common in the 60s than in the 40s Male breast cancer: Characteristic Details Mean Age 65 years Risk Factors BRCA2 gene mutation Radiation Excess estrogen Cirrhosis Klinefelter's syndrome Liver schistosomiasis Family history Testicular disease Infertility Obesity Common Type Infiltrating duct carcinoma (90%) , Ductal carcinoma in situ (10%) Prognosis Poorer prognosis compared to breast carcinoma in females

References:

SRB's Manual of Surgery, 6th Edition, Pages 551-552

↑ *Back to this question in Part A*

@Neet_pg_bot

Q18: A 25-year-old was diagnosed with invasive ductal carcinoma in her 5th week of gestation. Her axillary lymph node biopsy has come back positive. What is the most appropriate management along with modified radical mastectomy? (Q848834)

A. Termination of pregnancy

B. Chemotherapy

C. Radiation therapy

D. Termination of pregnancy and chemotherapy

Correct Answer: D. Termination of pregnancy and chemotherapy

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: For this patient at 5 weeks gestation (first trimester) with invasive ductal carcinoma and positive axillary lymph nodes, termination of pregnancy followed by chemotherapy is the most appropriate management. Node-Positive Breast Cancer Requires Urgent Systemic Therapy: Positive axillary nodes = high-risk disease requiring adjuvant chemotherapy Invasive ductal carcinoma with nodal involvement has significant metastatic potential Delay in chemotherapy by 6-8 months (waiting for 2nd/3rd trimester) can adversely affect outcomes First Trimester - Critical Organogenesis Period: Weeks 3-8: Period of maximum teratogenic risk Major organ formation occurring (heart, CNS, limbs, eyes) Chemotherapy in 1st trimester causes: Spontaneous abortion (high risk), Major congenital malformations, Growth restriction, and Fetal death Absolute contraindication for chemotherapy 1st

trimester 2nd trimester 3rd trimester Modified radical mastectomy Modified radical mastectomy Modified radical mastectomy Termination and chemotherapy if the axillary lymph node is positive Careful chemotherapy After delivery - chemotherapy (lactation is contraindicated) Other options: Option A: Termination of pregnancy (alone) Termination alone does NOT treat the cancer Node-positive disease requires systemic chemotherapy Simply terminating pregnancy without chemotherapy leaves the cancer untreated Option B: Chemotherapy (continuing pregnancy) Highly teratogenic in 1st trimester: Contraindicated in 1st trimester (weeks 1-12) Period of organogenesis - maximum fetal vulnerability Option C: Radiation therapy Contraindicated throughout pregnancy, especially 1st trimester Does NOT provide systemic therapy - node-positive disease needs systemic treatment Radiation is local/regional therapy only Insufficient treatment for node-positive breast cancer

References:

SRB's Manual of Surgery, 6th Edition, Page 552

↑ *Back to this question in Part A*

@Neet_pg_bot

Q19: A 35-year-old lactating woman presents with a rapidly progressing, painful, and warm swelling involving her entire left breast. She was diagnosed with inflammatory breast cancer. Which of the following statements are correct regarding her condition? {{caption_text}} (Q848833)

A. The prognosis is bad

B. Stage III B carcinoma (T4d)

C. Can be mistaken for acute mastitis

D. All are true



Correct Answer: D. All are true

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Inflammatory breast cancer: Characteristic Details Nature Most aggressive Rapidly progressive Worst prognosis Short duration Rapidly metastasizes to chest wall, bone, and lungs Always stage III B carcinoma (T4d) Common in lactating women or pregnancy Differential Diagnosis Acute mastitis (total count is increased in acute mastitis and normal in inflammatory breast cancer)

References:

SRB's Manual of Surgery, 6th Edition, Page 525

↑ *Back to this question in Part A*

@Neet_pg_bot

Q20: What is the primary purpose of a sentinel lymph node biopsy in the management of cancer, and how does it help guide treatment decisions? (Q848832)

A. To determine the exact stage of the cancer by identifying all affected lymph nodes.

B. To assess whether cancer has spread to the lymph nodes.

C. To completely remove all lymph nodes to prevent cancer recurrence.

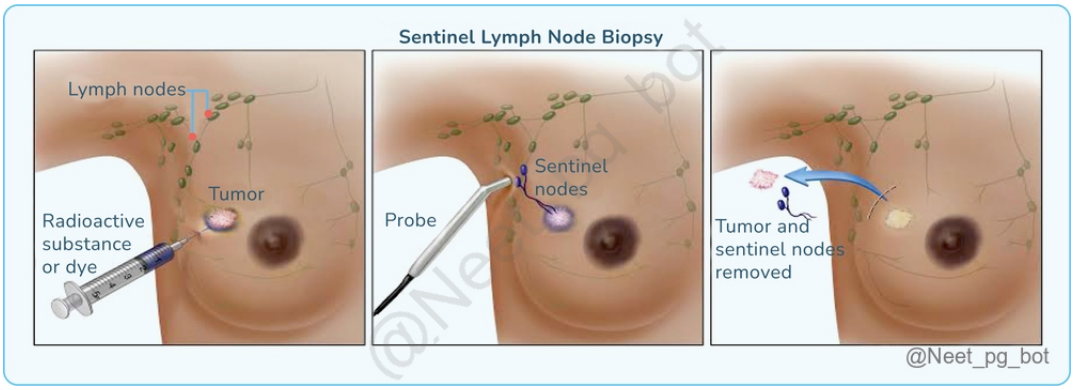
D. To evaluate the effectiveness of chemotherapy before surgery.

Correct Answer: B. To assess whether cancer has spread to the lymph nodes.

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Sentinel Lymph Node Biopsy The sentinel lymph node/Gatekeeper node is the first lymph node that receives lymph directly from the tumour. It is used to assess whether cancer has spread to the lymph nodes, which helps in staging the disease and deciding on the need for additional treatments. It is used in case of - Carcinoma breast Carcinoma penis Head and neck malignancies Carcinoma vulva Malignant melanoma



References:

Sabiston Textbook of Surgery, 21st Edition, Pages 840, 841

Biopsy image

↑ *Back to this question in Part A*

@Neet_pg_bot

Q21: Which of the following components is not evaluated in the Bloom-Richardson grading system? (Q848831)

A. Tubule formation

B. Nuclear pleomorphism

C. Mitotic count

D. Tumor size

Correct Answer: D. Tumor size

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The Bloom-Richardson grading system, also known as the Nottingham grading system, assigns points to three histological features of breast cancer. Features Score Tubule Formation: Percentage of the tumor that forms normal duct structures Score 1 : >75% of tumor area forms tubules Score 2 : 10-75% of tumor area forms tubules Score 3 : <10% of tumor area forms tubules Nuclear Pleomorphism: Variation in size and shape of the tumor cell nuclei Score 1 : Small, uniform nuclei Score 2 : Moderate increase in size and variability Score 3 : Marked variation in size and shape, large and bizarre nuclei Mitotic Count: Number of mitoses per 10 high-power fields Score 1 : 0-9 mitoses per 10 high-power fields Score 2 : 10-19 mitoses per 10 high-power fields Score 3 : 20 or more mitoses per 10 high-power fields

References:

pubmed.ncbi.nlm.nih.gov/15920556/

↑ *Back to this question in Part A*

@Neet_pg_bot

Q22: Which of the following statements about the TRAM flap is true? (Q848830)

A. The TRAM flap uses only skin and fat from the abdomen, preserving the abdominal muscle.

B. The TRAM flap relies on tissue from the back, including skin and muscle, for reconstruction.

C. The TRAM flap involves using tissue from the abdomen, including both skin and muscle, for breast reconstruction.

D. The TRAM flap uses tissue from the thigh, including skin and fat, to reconstruct the breast.

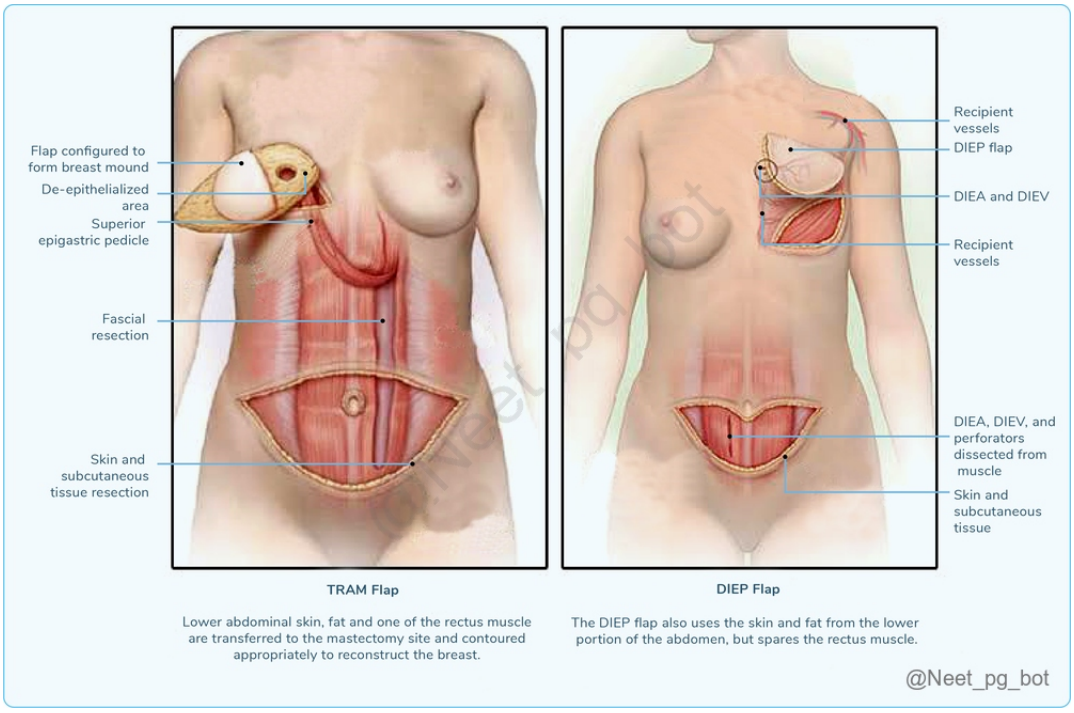
Correct Answer: C. The TRAM flap involves using tissue from the abdomen, including both skin and muscle, for breast reconstruction.

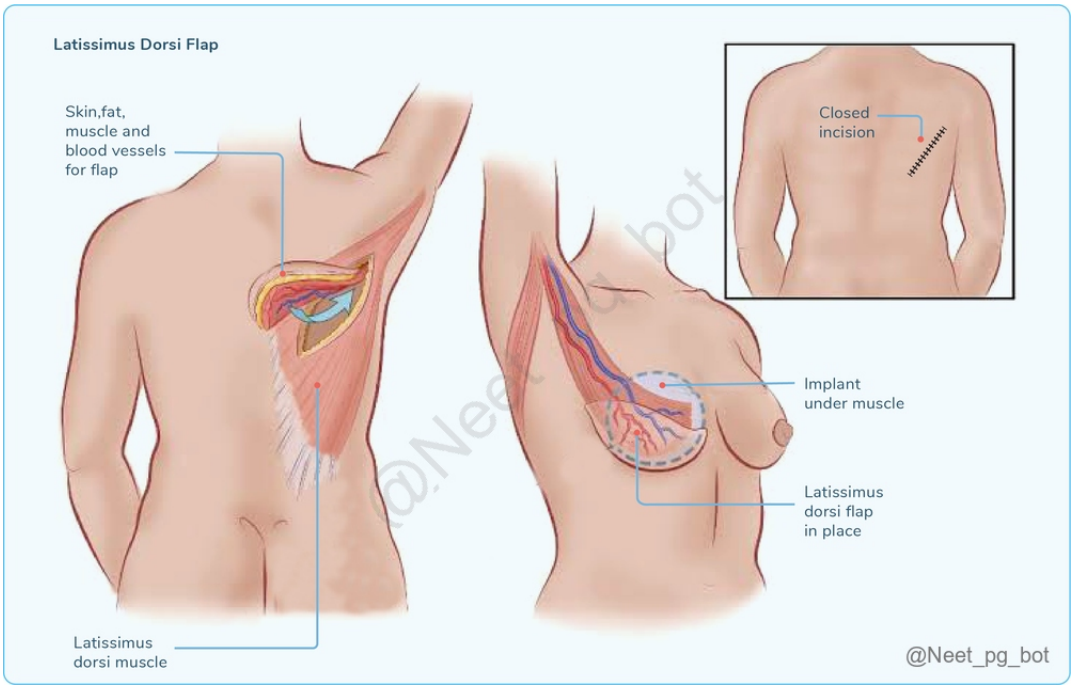
■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Breast Reconstruction Flaps Flaps Clinical Correlation Transverse Rectus Abdominis Muscle Flap (TRAM) Free flap involves using tissue from the abdomen, including both skin and muscle Most commonly used flap but not the best flap It is based on inferior epigastric vessels Disadvantage: causes weakness in infra umbilical region Deep Inferior Epigastric Artery Perforator flap (DIEP) Flap which uses skin and fat from the lower abdomen, but spares the abdominal muscles Innervation of the flap depends on dermatomes from the 11 and 12th intercostal nerves, with some contribution from the iliohypogastric and the ilioinguinal nerves The blood supply to the skin and fat from the lower abdominal wall, which will constitute the flap, arises from the external iliac artery and runs from lateral to medial under the rectus muscle Best flap for breast reconstruction as there is no risk of hernia and muscle weakness Also, useful in the reconstruction of the head and neck, in particular, in resections leaving a large defect, such as in total glossectomy and facial dysmorphisms such as Romberg's disease. Latissimus Dorsi Flap Flap which uses Latissimus dorsi muscle, skin and fat It is a type of subcutaneous flap based

on thoracodorsal vessels. SIEA Flap SIEA provides the same abdominal tissue for breast reconstruction as the DIEP flap, but no incision must be made in the abdominal fascia, and no vessel dissection is performed through the rectus abdominis muscle Veins are only inconsistently present on a sufficient caliber to reliably support sufficient tissue for breast reconstruction, hence less preferred GAP Flap Gluteal artery perforator (GAP) flaps allow the transfer of tissue from the buttock and are based on perforators from either the superior or inferior gluteal artery. Profunda Artery Perforator Flap It uses posterior thigh soft tissue based on profunda artery perforators The posterior thigh tissue is bounded by the iliotibial tract and adductor muscles horizontally, and the gluteal fold and popliteal fossa vertically. The profunda femoris artery enters the posterior compartment of the thigh to give three main perforators. Ideal for patients with a small to medium breast size and excess tissue in the posterior thigh.





References:

Sabiston Textbook of Surgery, 21st Edition, Pages 861- 862

https://www.ncbi.nlm.nih.gov/books/NBK565866/

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 690

↑ *Back to this question in Part A*

@Neet_pg_bot

Q23: A patient develops a painful, swollen area in the axillary region two weeks after mastectomy. What is the most likely diagnosis? (Q848829)

A. Seroma

B. Lymphedema

C. Hematoma

D. Axillary lymphadenopathy

Correct Answer: A. Seroma

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: s Lymphedema (option B) Swelling caused by the accumulation of lymph fluid in the arm or chest wall due to the removal of lymph nodes.(After MRM and axillary dissection) Wound infection/Flap necrosis Postoperative infections where blackening of suture line is seen (flap necrosis), if necrosed site note removed, leads to wound infection Post-Mastectomy Pain Syndrome Chronic pain in the chest or upper arm due to nerve damage or scar tissue formation. Nerve Injuries Long thoracic nerve- injury leads to winging of scapula Thoracodorsal nerve Lymphangiosarcoma Stewart-treves syndrome - Cancerous growth in the lymphatic vessels, often associated with long-standing lymphedema. After an average of 10.5 years following MRM and radiotherapy, patient develops angiosarcoma Hematoma (Option C) : A hematoma is a collection of blood in the tissue and can cause swelling and discomfort. However, it usually presents sooner after surgery (within days) and may be associated with more severe pain. Axillary Lymphadenopathy (Option D) : Enlargement of the lymph nodes in the axilla can occur, but it usually indicates a reactive or malignant process rather than an immediate postoperative issue. It might present with a firm, discrete mass rather than diffuse swelling.

References:

Sabiston Textbook of Surgery, 21st Edition, Page 832

SRB's Manual of Surgery, 6th Edition, Pages 25 & 26

Complications

↑ *Back to this question in Part A*

@Neet_pg_bot

Q24: Match the following hormonal therapy drugs with their primary use: 1.Tamoxifen a. Pre-menopausal hormone receptor-positive breast cancer 2.Anastrozole b. Post-menopausal hormone receptor-positive breast cancer 3.Fulvestrant c. HER2-positive breast cancer 4.Trastuzumab d. Hormone receptor-positive metastatic breast cancer (Q848828)

A. 1-a, 2-b, 3-d, 4-c

B. 1-b, 2-c, 3-d, 4-a

C. 1-a, 2,d, 3-b, 4-c

D. 1-c, 2-a, 3-b, 4-d

Correct Answer: A. 1-a, 2-b, 3-d, 4-c

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Hormonal therapy for breast cancer Drug Given for Clinical Correlation Tamoxifen Pre-menopausal hormone receptor-positive breast cancer Selective estrogen receptor modulator (SERM) works by blocking estrogen receptors on breast cancer cells, which can slow or stop the growth of tumors that require estrogen to grow. Anastrozole Post-menopausal hormone receptor-positive breast cancer Aromatase inhibitors that reduce the production of estrogen in the body by blocking the enzyme aromatase, which converts androgens into estrogen in postmenopausal women. Fulvestrant Hormone receptor-positive metastatic breast cancer Estrogen receptor antagonists work by binding to estrogen receptors and degrading them, which helps to reduce the growth of estrogen-dependent cancer cells. Trastuzumab HER2-positive breast cancer Monoclonal antibodies that target the HER2 receptor inhibit the growth of cancer cells and can also recruit the body's immune system to destroy these cells.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Pages 940, 941

Sabiston Textbook of Surgery, 21st Edition, Pages 848, 849

↑ *Back to this question in Part A*

@Neet_pg_bot

Q25: Which of the following types of breast carcinoma is most likely to respond best to radiation therapy? (Q848827)

A. Invasive ductal carcinoma

B. Inflammatory breast cancer

C. Ductal carcinoma in situ (DCIS)

D. Triple-negative breast cancer

Correct Answer: C. Ductal carcinoma in situ (DCIS)

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Ductal carcinoma in situ (DCIS) (Option C) is non-invasive, with cancer cells confined to the breast ducts. Radiation therapy is highly effective, especially after lumpectomy, significantly reducing recurrence risk. DCIS responds exceptionally well to radiation, making it the most responsive among these options. Radiotherapy: Indications: Breast-Conserving Surgery (BCS): To reduce local recurrence. Post-Mastectomy: For large tumors or positive lymph nodes. Locally Advanced Disease: To shrink tumors preoperatively. Metastatic Disease: For symptom relief. Positive Lymph Nodes: To reduce regional recurrence. High-Risk Features: To lower recurrence risk. Ductal Carcinoma In Situ (DCIS): Responds exceptionally well to radiation and prevents local recurrence post-surgery. Invasive ductal carcinoma (IDC) (Option A) is the most common type of breast cancer. It can spread beyond the breast, requiring multimodal treatment including surgery, chemotherapy, and radiation therapy. Inflammatory breast cancer (IBC) (Option B): Treatment includes chemotherapy, surgery, and radiation therapy. Triple-negative breast cancer (TNBC) (Option D) lacks estrogen, progesterone receptors, and HER2 protein, limiting treatment options. It often requires chemotherapy and may include radiation for local control post-surgery. However, due to its aggressive nature and lack of specific targets, TNBC's response to radiation alone is not as pronounced as DCIS.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Pages 939,940.

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5161063/

↑ *Back to this question in Part A*

@Neet_pg_bot

Q26: A 55-year-old woman with Stage IV HER2-positive metastatic breast cancer presents with fungation of the breast, multiple metastases to the liver and bones. Which of the following treatment strategies is most appropriate for her condition?

(Q848825)

A. Trastuzumab + Chemotherapy + Palliative mastectomy

B. Tamoxifen + Radiation Therapy + Bone-targeted therapy

C. Hormonal Therapy alone

D. Surgical Resection of Metastases + Radiotherapy

Correct Answer: A. Trastuzumab + Chemotherapy + Palliative mastectomy

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Management of Stage IV HER2-Positive Metastatic Breast Cancer Type Description Treatment Systemic Therapy Targeted Therapy: Specific for HER2-positive cancers Trastuzumab, Pertuzumab, Lapatinib Chemotherapy: Addresses systemic disease Taxanes, Anthracyclines, Capecitabine Hormonal Therapy: For hormone receptor-positive cases (not standalone for HER2-positive) Tamoxifen, Aromatase Inhibitors (if combined) Local Therapy Palliative Surgery: Relieves significant symptoms from the primary tumour growth Mastectomy Radiotherapy: Controls localised symptoms, especially bone metastases _ Bone-targeted Therapy Manages bone metastases and reduces skeletal-related events Bisphosphonates, Denosumab

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 941.

Schwartz's Principles of Surgery, 11th Edition, Page 587.

SRB's Manual of Surgery, 6th Edition, Pages 549, 550.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q27: A 52-year-old woman presents with Stage III B breast cancer. Her diagnostic workup includes imaging studies and biopsy, revealing a locally advanced tumor with involvement of regional lymph nodes. The tumor is hormone receptor-positive and HER2-positive. What would be the most appropriate management approach for this patient? (Q848824)

A. Neoadjuvant chemotherapy followed by modified radical mastectomy and adjuvant radiotherapy

B. Immediate modified radical mastectomy followed by adjuvant chemotherapy and endocrine therapy

C. Primary endocrine therapy followed by adjuvant chemotherapy and radiotherapy

D. Neoadjuvant chemotherapy followed by lumpectomy and adjuvant radiotherapy

Correct Answer: A. Neoadjuvant chemotherapy followed by modified radical mastectomy and adjuvant radiotherapy

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Management of Locally Advanced Breast Cancer (LABC) Stages Involved: Stage IIIA , IIIB and IIIC Neoadjuvant Chemotherapy (NACT): Administered before surgery to shrink the tumor, making it operable and allowing for breast conservation if possible. This also helps assess the tumor's response to treatment. Modified Radical Mastectomy (MRM) : Performed after neoadjuvant chemotherapy to remove the breast tissue and axillary lymph nodes. The surgery aims to achieve local control and address regional disease. Post-Surgery Radiotherapy (RT): Administered after MRM to reduce the risk of local recurrence and ensure any remaining microscopic disease is treated. NACT + MRM + RT is the standard approach for LABC to ensure comprehensive treatment. This sequence allows for effective tumor reduction, surgical resection, and post-operative control to prevent a recurrence.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Pages 939-941.

Schwartz's Principles of Surgery, 11th Edition, Pages 582-585.

SRB's Manual of Surgery, 6th Edition, Pages 548, 549.

↑ *Back to this question in Part A*

@Neet_pg_bot

• [07_Endocrine Surgery] 043 Thyroid-I

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[07_Endocrine Surgery] 043 Thyroid-I — Quick Jump

Q1 (p. 2812)	*Q2 (p. 2813)*	*Q3 (p. 2815)*	*Q4 (p. 2816)*	*Q5 (p. 2817)*	*Q6 (p. 2818)*
Q7 (p. 2819)	*Q8 (p. 2820)*	*Q9 (p. 2821)*	*Q10 (p. 2823)*	*Q11 (p. 2823)*	*Q12 (p. 2824)*
Q13 (p. 2825)	*Q14 (p. 2826)*	*Q15 (p. 2827)*	*Q16 (p. 2828)*	*Q17 (p. 2829)*	*Q18 (p. 2830)*
Q19 (p. 2831)	*Q20 (p. 2835)*	*Q21 (p. 2841)*			

Q1: A 12-year-old child presents with congenital sensorineural hearing loss, recurrent episodes of vertigo, and a palpable thyroid gland. The child's mother has a similar history. What is the most likely diagnosis? (Q848948)

A. Alport syndrome

B. Pendred syndrome

C. Usher syndrome

D. Perrault syndrome

Correct Answer: B. Pendred syndrome

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Pendred syndrome is characterized by a combination of congenital sensorineural hearing loss, recurrent vertigo, and the presence of a palpable thyroid gland. The family history of similar symptoms in the mother further supports this diagnosis, indicating autosomal recessive inheritance caused by the SLC26A4 gene mutation. Clinical Features of Pendred syndrome: Sensorineural Hearing Loss: Typically congenital and can be progressive. Vertigo: Recurrent episodes due to vestibular dysfunction. Euthyroid Goiter: A goiter present with normal thyroid function (Euthyroidism). Metabolic Alkalosis: Sometimes observed due to associated acid-base balance abnormalities. Other options: Option A: Alport syndrome Characterized by progressive SNHL, hematuria, renal failure, and ocular abnormalities. No thyroid involvement and no episodic vertigo. Hence, it does not match the clinical picture. Option C: Usher syndrome Features SNHL + retinitis pigmentosa + vestibular areflexia. Patients eventually show night blindness and visual field loss, which are absent here. Thyroid involvement is not seen. Option D: Perrault syndrome Seen in females with SNHL + gonadal dysgenesis. No thyroid enlargement, and usually does not cause vertigo. Also occurs mainly in females (infertility), making it unlikely here.

References:

https://www.ncbi.nlm.nih.gov/books/NBK549839/

↑ *Back to this question in Part A*

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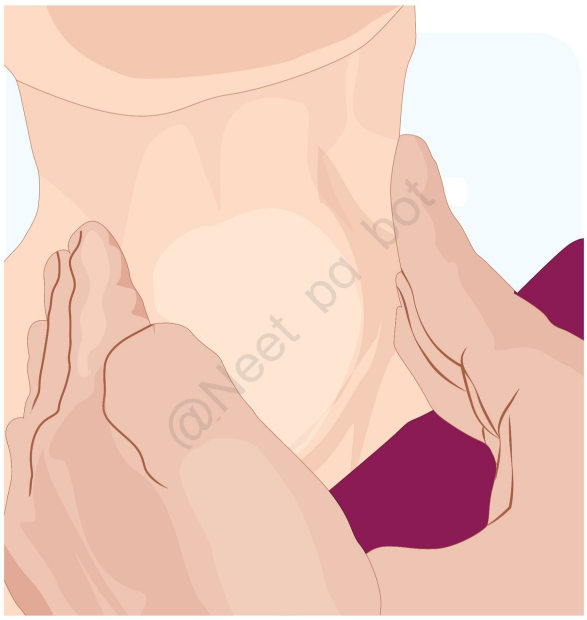
Q2: Identify the below technique used during the examination of the thyroid gland. (Q848947)

A. Kocher's method

B. Lahey’s method

C. Crile’s method

D. Pizillo’s method



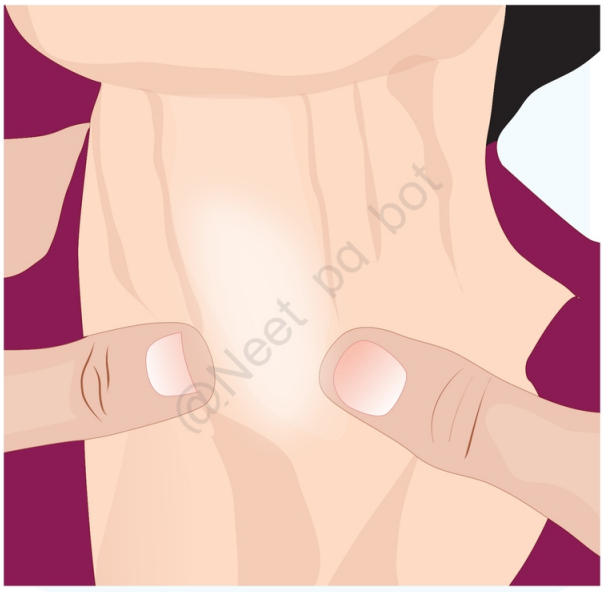
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Correct Answer: B. Lahey’s method

- *Listen (English)*
- *Listen (Hindi)*

Explanation: In Lahey's method, the examiner places the fingers of one hand on the patient’s neck to support the thyroid gland, while the other hand palpates the gland’s surface to assess its size, texture, and any nodules. This technique helps in assessing the consistency and mobility of the thyroid gland, which are important for diagnosing conditions like goiter or thyroid nodules. In Kocher’s method, slight pressure is applied to the lateral lobes of the

thyroid gland to evaluate the impact of thyroid swelling on the trachea. A positive test indicates that thyroid swelling is compressing the trachea, leading to stridor (Option A) In Crile's method, the examiner places a thumb on the swelling and asks the patient to swallow. This technique is used to assess the nodularity of the thyroid swelling. As the patient swallows, the movement of the thyroid gland can help in evaluating the presence and extent of nodules (Option C) Pizillo's method is used in patients with an obese or short neck where visual inspection of the thyroid gland is difficult. The patient places their hand behind their head and pushes backwards against the clasped hands on the occiput, improving the visibility and accessibility of the thyroid gland for examination (Option D)



@Neet_pg_bot



References:

https://pubmed.ncbi.nlm.nih.gov/35800594/
https://clinipedia.wordpress.com/2016/03/28/kochers-test-for-stridor-in-a-goiter/

↑ *Back to this question in Part A*

@Neet_pg_bot

Q3: A 44-year-old woman presents with a solitary thyroid swelling. On examination, a 3 cm non-tender thyroid nodule is noted, and her thyroid function tests are normal. What is the next step in the investigation of this thyroid swelling? (Q848935)

A. Fine Needle Aspiration Cytology

B. USG of thyroid

C. Core biopsy

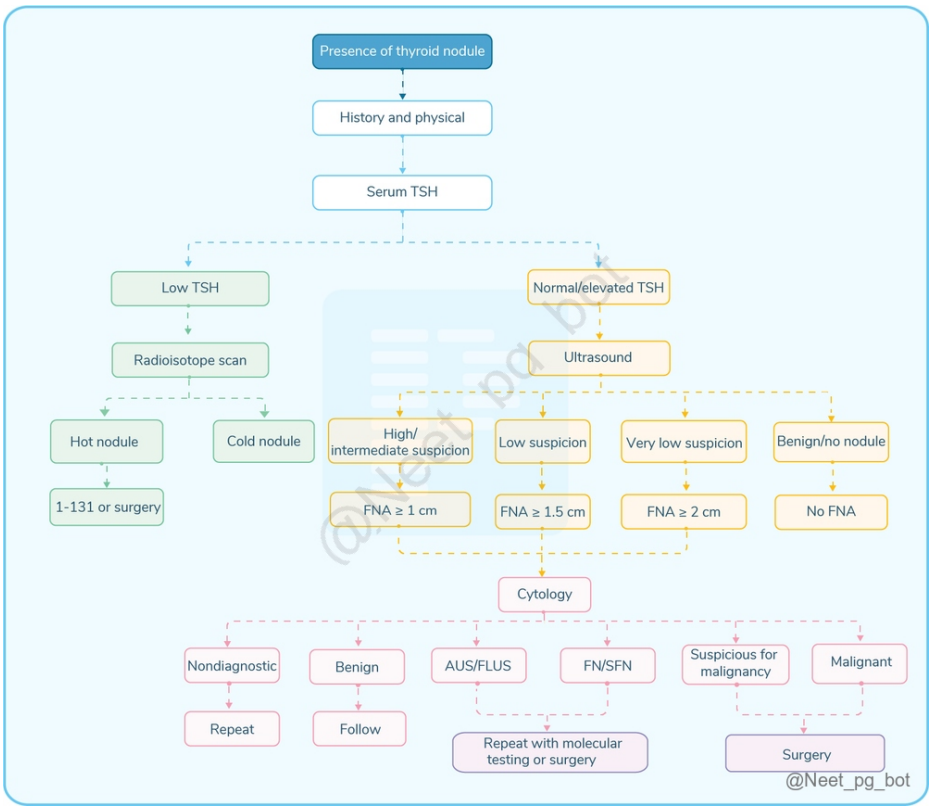
D. CT neck

Correct Answer: B. USG of thyroid

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Ultrasound (USG) is the initial investigation of choice for any solitary thyroid nodule. It identifies whether the nodule is solid or cystic, evaluates suspicious ultrasound features, assesses lymph nodes, and determines the need for USG-guided FNAC . FNAC is performed after USG, not before. Fine Needle Aspiration Cytology (Option A): Not the first investigation. FNAC is guided by USG findings and is done only if the nodule meets size or risk criteria. Core biopsy (Option C): Not routinely used. Reserved for suspected lymphoma, anaplastic carcinoma, or repeatedly nondiagnostic FNAC. CT neck (Option D): Not used for initial evaluation. Used only for large retrosternal goiters, tracheal compression, or staging after confirmed malignancy. Management of solitary thyroid nodule: Benign nodule For a Cystic nodule : Aspiration first If recurrent → hemithyroidectomy For a solid nodule: Surgery (hemithyroidectomy) only if: Large size Compressive symptoms Cosmetic concern Patient preference Malignancy Near / Total thyroidectomy



References:

Sabiston’s Textbook of Surgery, 21st edition, Page 892

Bailey & Love’s Short Practice of Surgery, 28th edition, Page 858, 859

↑ *Back to this question in Part A*

@Neet_pg_bot

Q4: Which of the following conditions is a contraindication for radioactive iodine therapy? (Q848945)

A. Medullary thyroid carcinoma

B. Papillary thyroid carcinoma

C. Hurthle cell carcinoma

D. Tumor size > 2cm + distant metastasis

Correct Answer: A. Medullary thyroid carcinoma

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: In medullary thyroid carcinoma (TSH independent tumor) , the thyroid follicular cells don't take up iodine and hence radioactive iodine has no role. Radioactive iodine therapy can serve three primary roles: Remnant Ablation: Destruction of any remaining benign thyroid tissue following a total or subtotal thyroidectomy. Adjuvant Therapy: Additional treatment post-surgery to reduce the risk of cancer recurrence. Treatment of Known Disease: Targeting and destroying residual cancer cells or recurrent structural or biochemical disease. Indications Contraindications Differentiated thyroid cancers E.g., Papillary thyroid carcinoma (Option B) Follicular thyroid carcinoma Hurthle cell carcinoma (Option C) Tumor size > 2 cm (Option D) One or more risk factors Obvious extrathyroidal extension > 45 years of age Lymph node and distant metastasis (Option D) Poorly differentiated thyroid cancers E.g., Medullary thyroid carcinoma Anaplastic thyroid carcinoma Pregnancy & Breastfeeding (Absolute contraindications) Vomiting & Diarrhea (Relative contraindications)

References:

Sabiston’s textbook of surgery , 21st Edition, Page 905. https://www.ncbi.nlm.nih.gov/books/NBK580567/ SRB’s Manual of Surgery, 6th Edition, Page 476.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q5: A 27-year-old female presents with symptoms of weight loss, palpitations and eye protrusion. Lab tests reveal ■ TSH and ■ T3, T4 values. What is the most likely diagnosis and the primary target of this condition? (Q848938)

A. Toxic multinodular goiter,TSH receptor

B. Graves disease, TSH receptor

C. Hashimoto's Thyroiditis, TPO

D. Subacute Thyroiditis, Thyroglobulin

Correct Answer: B. Graves disease, TSH receptor

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Symptoms such as weight loss, palpitations, and eye protrusion, combined with low TSH and elevated T3 and T4 levels, indicate Graves disease , an autoimmune disorder. In this condition, antibodies (long acting thyroid stimulator (LATS) target and bind to the TSH receptor . Toxic multinodular goitre causes hyperthyroidism due to autonomously functioning nodules; the primary target is not the TSH receptor (Option A) Hashimoto's Thyroiditis is an autoimmune hypothyroid condition targeting TPO (thyroid peroxidase), presenting with high TSH and low T3/T4 (Option C) Subacute Thyroiditis f ollows a viral infection, causing transient hyperthyroidism with elevated thyroglobulin; not associated with eye protrusion (Option D)



References:

1. Sabiston’s Textbook of Surgery, 21st edition, Page 886, 887. 2. SRB’s Manual of Surgery, 6th Edition, Page 460.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q6: A 50-year-old woman with Graves disease has been receiving medical management for 6 months but continues to have significant symptoms and persistent ophthalmopathy. The goitre remains large. Considering her ongoing symptoms, what is the most appropriate next step in her treatment? (Q848940)

A. Thyroidectomy

B. Radioactive iodine ablation

C. Antithyroid medications and beta-blockers.

D. External beam radiotherapy

Correct Answer: A. Thyroidectomy

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Thyroidectomy is a suitable next step for patients with persistent symptoms and a large goiter not responding adequately to medical management. Radioactive Iodine (RAI) Ablation is contraindicated in: Pregnancy, Lactation, Patient with eye signs (worsens Ophthalmopathy) (Option B) Antithyroid medications and beta-blockers (Option C) : Given the patient's persistent symptoms despite six months of treatment, continuing these medications is unlikely to resolve the issue effectively. External Beam Radiotherapy is not typically used as the primary treatment of thyrotoxicosis (Option D)

References:

Bailey & Love’s Short Practice of Surgery, 28th edition, Page 862

↑ *Back to this question in Part A*

@Neet_pg_bot

Q7: A 45-year-old man presents with neck pain, fever, and fatigue. His physical examination shows a tender, swollen thyroid gland. Lab reports revealed elevated inflammatory markers and low radioactive iodine uptake, and he is HLA B35 positive. What is the most appropriate initial treatment step for this patient? (Q848942)

A. NSAIDs

B. Start Levothyroxine and continue throughout

C. Start antithyroid drugs

D. Thyroidectomy

Correct Answer: A. NSAIDs

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The clinical presentation and diagnostic findings strongly indicate De Quervain's thyroiditis (subacute or granulomatous thyroiditis), in which NSAIDs are used as first-line treatment. De Quervain's Thyroiditis/Viral thyroiditis/ Granulomatous thyroiditis: Often follows a viral upper respiratory tract infection. Initial Brief Hyperthyroidism due to follicular destruction followed by Hypothyroidism, which returns to an Euthyroid state in a few months. (Self Limiting) Associated with HLA B35 IOC : FNAC Clinical Features: Neck Pain and Tenderness. Symptoms of Hyperthyroidism and Hypothyroidism depend upon stage. Diagnosis: Raised inflammatory markers Radioiodine uptake low: Due to follicle destruction. Management: Self Limiting Condition NSAIDs: First-line treatment to control pain and inflammation. Steroids: Used if NSAIDs are ineffective Levothyroxine: Given only during the Hypothyroid phase (Option B is ruled out)

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 872.

↑ *Back to this question in Part A*

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Q8: A 40-year-old woman with a known history of Graves' disease presents with signs of thyroid storm i.e., fever, delirium, tachycardia, and restlessness. In addition to beta-blockers and antithyroid drugs, she is started on glucocorticoids. What is the primary rationale for administering glucocorticoids in the management of thyroid storm? (Q848950)

A. To block the conversion of T4 to T3

B. To suppress the synthesis of thyroid hormones

C. To reduce the effects of catecholamines

D. To block the release of T4 and T3

Correct Answer: A. To block the conversion of T4 to T3

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Glucocorticoids act by inhibiting the conversion of T4 to T3 , thus reducing the metabolic effects of excess thyroid hormone and offering adrenal support during the crisis. Thyroid storm is a life-threatening exacerbation of hyperthyroidism that requires urgent hospital management due to its high mortality risk. Management of Thyroid storm Oxygen supplementation IV fluids (with continuous monitoring with central

venous catheter) Stop IV fluids/blood transfusion in case of CHF or arrhythmias Propylthiouracil This is the drug of choice It acts by blocking the thyroid hormone synthesis & inhibiting peripheral conversion of T4 to T3 (Option B) ROA: NG Tube, rectal route Methimazole can be used as an alternative option instead of Propylthiouracil Beta-blockers Propranolol is commonly used It reduces the heart rate & the effects of catecholamines (Option C) Esmolol is used in case of heart failure as Propranolol should be avoided in such conditions Glucocorticoids Hydrocortisone is preferred It acts by inhibiting the conversion of T4 to T3 It helps in preventing adrenal crisis Lugol solution It blocks the release of T3 and T4 and to reduce the vascularity of the thyroid (Option D) It is also used preoperatively to prevent thyroid storms by inducing the Wolff-Chaikoff effect. Cholestyramine It is used to help sequester thyroid hormones. Chlorpromazine Used to induce sedation. Plasmapheresis, charcoal plasma perfusion, or exchange transfusion are reserved for refractory cases that do not respond to standard treatment within 24 to 48 hours.

References:

Sabiston, Textbook of Surgery, 21st edition, Page 260, 261.

↑ *Back to this question in Part A*

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Q9: A 20-year-old male presents with a painless midline neck swelling that has been present since childhood and has gradually increased in size. The swelling moves upward on protrusion of the tongue. Ultrasound shows a cystic midline lesion .Which of the following is the correct statement regarding this condition? (Q848929)

A. High risk of developing squamous cell carcinoma

B. Removal of the cyst along with the tract and part of the hyoid bone is done

C. Most commonly seen in the suprahyoid region

D. Incision and Drainage are the preferred management



Correct Answer: B. Removal of the cyst along with the tract and part of the hyoid bone is done

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The clinical presentation and image classically suggest a Thyroglossal cyst, which is managed by removing the cyst along with the tract up to the base of the tongue and part of the hyoid bone (SISTRUNK Procedure) to minimize the recurrence. A congenital neck mass resulting from the persistence of the thyroglossal duct, an embryological structure (can also be present in adulthood). The cyst represents a remnant of this duct and can be found anywhere along the midline from the base of the tongue to the thyroid isthmus. It presents as midline swelling that moves with deglutition and protrusion of the tongue. Most Common Site: Subhyoid (Option C ruled out) Differential Diagnosis: ■■ Condition Location Movement with Swallowing Movement with Tongue Protrusion Other Distinguishing Features Thyroglossal cyst Midline Yes Yes Cystic, below hyoid, may get infected Dermoid cyst Midline (submental) No No Soft, doughy, does not move Thyroid swelling (Goiter) Midline Yes No Moves only on swallowing, not tongue Lymphadenopathy Usually lateral No No Firm, may be tender, multiple nodes Branchial cyst Lateral neck (anterior to SCM) No No Seen along anterior border of SCM Laryngocele Lateral / upper neck No No Increases on coughing/straining , air-filled Cystic hygroma Posterior triangle No No Soft, compressible, transilluminant Ectopic thyroid Midline Yes No May be only functioning thyroid tissue Lipoma Anywhere No No Soft, lobulated, “slip sign” present Treatment: Sistrunk Procedure: Complete surgical excision of the cyst and its tract up to the base of the tongue, as well as a portion of the hyoid bone, to prevent recurrence. Incision and drainage are never done (Option D ruled out) as they lead to the formation of a Thyroglossal fistula. (also forms if an inflamed cyst ruptures) - Always Acquired. Long-standing thyroglossal cyst - > Risk of developing into Papillary thyroid carcinoma. (Option A ruled out)

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 806.

↑ *Back to this question in Part A*

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Q10: A 64-year-old man with multinodular goitre is being treated with a large dose of iodine. Subsequently, his thyroid function tests show significantly elevated TSH and low free T4 levels, but he is asymptomatic. What is the most likely finding? (Q848949)

A. Jod- Basedow effect

B. Wolff-Chaikoff effect

C. Amiodarone- induced thyrotoxicosis

D. Thyroid storm

Correct Answer: B. Wolff-Chaikoff effect

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The above case, showing raised TSH and reduced T4 levels, is suggestive of hypothyroidism . In this patient, despite adequate iodine intake, hypothyroidism has developed due to iodine-induced suppression of thyroid hormone synthesis , a phenomenon known as the Wolff–Chaikoff effect . The Wolff-Chaikoff effect is characterized by temporary inhibition of thyroid hormone synthesis in response to excess iodine. In individuals with preexisting thyroid conditions, such as multinodular goiter, a high dose of iodine can lead to reduced synthesis of thyroid hormones, causing elevated TSH levels and low free T4 levels, even in the absence of symptoms. Jod- Basedow effect occurs when excess iodine induces hyperthyroidism in individuals with pre existing thyroid disease, typically causing elevated thyroid hormones (Option A)

References:

Sabiston's textbook of surgery, 21st Edition, Page 887, 889.

↑ *Back to this question in Part A*

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Q11: A 31-year-old female with Graves' disease who underwent total thyroidectomy now presents with hoarseness of voice and stridor due to recurrent laryngeal nerve injury. What is the most common site of injury to the recurrent laryngeal nerve? (Q848946)

A. Through the carotid sheath

B. At the level of the zuckerkandl tubercle

C. At the level of the cricothyroid muscle

D. Near the inferior thyroid artery

Correct Answer: D. Near the inferior thyroid artery

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Even though Berry's ligament is the anatomical point where the recurrent laryngeal nerve is most prone to injury, the best choice among the provided options is near the inferior thyroid artery , because this is the area routinely dissected and ligated during thyroidectomy and therefore carries significant risk. The recurrent laryngeal nerve, a branch of the vagus nerve, divides into the right and left recurrent laryngeal nerves. It originates from the sixth branchial arches, below the sixth aortic arches. Left Recurrent Laryngeal Nerve: Loops around the ligamentum arteriosum and travels along the tracheoesophageal groove to reach the thyroid gland. Right Recurrent Laryngeal Nerve: Loops under the right subclavian artery (4th arch derivative) because the right 6th arch regresses. Injury to the RLN can result in hoarseness, aphonia, stridor, and aspiration. However, anatomically, the true most common site of RLN injury is at the Ligament of Berry , where the nerve is tightly adherent as it enters the larynx.

References:

Sabiston's textbook of surgery , 21st Edition, Page 877. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9638796/

↑ *Back to this question in Part A*

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Q12: A 60-year-old man presents with worsening shortness of breath and difficulty swallowing. On physical examination, a large, firm, and non-tender neck swelling is noted. The lower limit of the swelling cannot be palpated, and raising his arms above his head results in the finding shown in the image. Given these clinical findings, which of the following is the Investigation of choice? (Q848944)

A. Ultrasound of the Neck

B. CT Scan of the Neck and Chest

C. MRI of the Neck

D. Radioactive Iodine Uptake Test



Correct Answer: B. CT Scan of the Neck and Chest

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The clinical scenario, along with a neck swelling whose lower limit cannot be palpated along with a positive Pemberton Sign, points towards Retrosternal Goiter in which Computed Tomography (CT) Scan of the Neck and Chest is the Investigation of choice (IOC). Retrosternal Goiter: A thyroid gland enlargement that extends into the mediastinum behind the Sternum (>50% of thyroid tissue located below thoracic cavity). Types: Primary: Ectopic thyroid tissue in the mediastinum (10%) Secondary: Starts from neck and extends retrosternally (90%) Clinical Features: Neck Swelling with Compression Symptoms: Difficulty breathing (tracheal compression) and swallowing (esophageal compression). Pemberton Sign: Facial flushing and increased difficulty breathing when raising the arms due to thoracic inlet compression. Diagnosis: Physical examination: Limited palpation of the lower border of the thyroid swelling. Imaging: Computed Tomography (CT) Scan of the Neck and Chest is IOC to assess the extent of mediastinal involvement and to evaluate compression of surrounding structures. Management: Surgical intervention and the approaches are Primary / Recurrent / Large Malignant Retrosternal Goiter - Median Sternotomy Secondary Retrosternal Goiter - Cervical / Neck Incision

References:

Bailey & Love’s Short Practice of Surgery, 28th Edition, Page 860.

↑ *Back to this question in Part A*

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Q13: A 60-year-old woman with a large multinodular goitre is scheduled for a total thyroidectomy. To prepare her for the surgery and reduce the risk of complications, her endocrinologist prescribed Lugol's iodine. Which of the following statements are

true regarding Lugol's iodine? It is used to reduce thyroid vascularity before thyroid surgery It works by inhibiting the synthesis of thyroid hormones in the thyroid gland It increases the uptake of radioactive iodine It is not commonly indicated in the management of toxic multinodular goiter It is not indicated in case of a thyroid storm (Q848943)

A. 1,2,5

B. 2,3,4

C. 3,4,5

D. 1,2,4

Correct Answer: D. 1,2,4

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The primary role of Lugol's iodine in the pre-operative management of a patient with a goitre is to reduce thyroid gland vascularity. (Statement 1) Lugol's Iodine is a Saturated Potassium Iodide Solution (5% iodine + 10% potassium iodide) Dose : 3 drops TID for 7-10 days. Role of Lugol's Iodine: Reduce Vascularity: Used pre-operatively to reduce the vascularity of the thyroid gland. This helps in minimizing bleeding during surgery and prevents complications. Prevent Thyroid Storm: By decreasing vascularity, it also helps prevent thyroid storms, which can occur if there is an excessive release of thyroid hormones during or after surgery. (Statement 5) Iodine's Effect: Iodine has a transient effect on thyroid function by inhibiting the release of thyroid hormones from the thyroid gland (Statement 2) . This phenomenon is known as the Wolff-Chaikoff effect . In Toxic Multinodular Goiter , Lugol's iodine may not achieve the goal of temporary euthyroidism, and instead may exacerbate hyperthyroidism due to the Jod-Basedow phenomenon. (Statement 4) It increases the uptake of radioactive iodine (Statement 3): Lugol's iodine does not increase radioactive iodine uptake; rather, it prepares the thyroid gland for surgery by reducing vascularity.

References:

Sabiston's Textbook of Surgery, 21st Edition, Page 888

SRB's Manual of Surgery, 6th Edition, Page 464

↑ *Back to this question in Part A*

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Q14: A 55-year-old woman presents with an enlarging, hard, and fixed thyroid mass, neck discomfort, and difficulty swallowing. On examination, the thyroid gland feels rock-hard with no tenderness. Ultrasound of the thyroid shows extensive fibrosis.

What is the most likely diagnosis? (Q848941)

A. Riedel’s Thyroiditis

B. Hashimoto’s Thyroiditis

C. De Quervain’s Thyroiditis

D. Silent Thyroiditis

Correct Answer: A. Riedel’s Thyroiditis

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Riedel’s thyroiditis (Fibrosing Thyroiditis) is the most likely diagnosis, given the hard/woody thyroid, fixed thyroid mass, absence of tenderness, and ultrasound findings of extensive fibrosis. Riedel’s Thyroiditis (Fibrosing Thyroiditis): Replacement of thyroid tissue with fibrous tissue. There is both intrathyroidal as well as extrathyroidal fibrosis. Clinical Features: Permanent hypothyroidism and hypoparathyroidism. Stridor, with positive Berry's sign (absence/impalpable carotid pulsation). Hard, woody thyroid gland compresses midline structures: Trachea: Causes dyspnea. Esophagus: Causes dysphagia. Recurrent laryngeal nerve: Causes hoarseness of voice. Features Hashimoto Thyroiditis (Option B) De Quervain’s Thyroiditis (Option C) Riedel’s Thyroiditis Also Known As Struma Lymphomatosa Viral Thyroiditis, Granulomatous Thyroiditis Fibrosing Thyroiditis Riedel struma Etiology Autoimmune Anti-TPO antibodies HLA-B8/DR3 Viral infection, Granulomatous inflammation HLA-B35 Autoimmune or a part of systemic fibrosing disorder Clinical Features Initial Hyperthyroidism followed by Prolonged Hypothyroidism Brief Hyperthyroidism followed by Hypothyroidism and returns to Euthyroid state in 3 - 4 months Permanent hypothyroidism and hypoparathyroidism. Management Levothyroxine Total thyroidectomy if malignancy is suspected. NSAIDs (first-line) Steroids (if NSAIDs are ineffective) >90% spontaneous resolution Corticosteroids and tamoxifen Life long management with Levothyroxine Calcium & vitamin D in case of hypoparathyroidism Silent thyroiditis is a form of subacute thyroiditis that is usually painless. It presents with transient thyroid dysfunction (hyperthyroidism followed by hypothyroidism) and is generally less associated with a hard and fixed thyroid mass (Option D)

References:

1. Bailey & Love’s Short Practice of Surgery, 28th edition, Page 871, 872. 2. SRB’s Manual of Surgery, 6th Edition, Page 478.

↑ *Back to this question in Part A*

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Q15: A 30-year-old pregnant woman in her first trimester is diagnosed with Graves disease. What is the most appropriate first-line treatment for her condition? (Q848939)

A. Propylthiouracil

B. Methimazole

C. Levothyroxine

D. Propranolol

Correct Answer: A. Propylthiouracil

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Propylthiouracil (PTU) is the drug of choice during the first trimester of pregnancy for treating hyperthyroidism due to its safety profile in early pregnancy. Drug Preferred Age Group Clinical consideration Propylthiouracil Pregnant women (first trimester), children Safe in the first trimester and for children; risk of liver toxicity. Methimazole Adults, pregnant women (second and third trimesters) Higher efficacy; not used in the first trimester due to teratogenic effects. Carbimazole Adults, children (in some regions) Converts to methimazole. Beta Blockers (e.g., Propranolol) Adults Manages adrenergic symptoms; used as adjunctive therapy.

References:

Bailey & Love's Short Practice of Surgery, 28th edition, Page 861, 862.
https://www.ncbi.nlm.nih.gov/books/NBK279107/

↑ *Back to this question in Part A*

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Q16: A 23-year-old female visited the clinician with a solitary thyroid nodule and was advised for thyroid function tests where Tsh level is 27.3mU/L, T3 is 1.24 ng/ml, and T4 is 4.87 microgram/ml. Which of the following manifestations is true regarding the condition? (Q848937)

A. Heat intolerance

B. Tachycardia

C. Diarrhea

D. Weight gain

Correct Answer: D. Weight gain

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The patient’s thyroid function tests show elevated TSH with normal T3 and T4 levels, indicating primary hypothyroidism. Weight Gain is consistent with hypothyroidism due to reduced metabolic rate. Heat Intolerance (Option A) , Tachycardia (Option B), and Diarrhea (Option C) are more common in hyperthyroidism , not hypothyroidism. Hypothyroidism Hyperthyroidism Decreased metabolic rate Increased metabolic rate Weight gain, puffiness, dry skin Weight loss Decreased appetite Increased appetite Bradycardia Tachycardia Cold intolerance Heat intolerance Constipation Diarrhea Menorrhagia Amenorrhea, infertility Cardiomegaly, pericardial effusion Cardiovascular complications such as atrial fibrillation, cardiomyopathy, congestive heart failure Altered mental status, coma -

References:

Sabiston’s Textbook of Surgery, 21st Edition, Page 884, 886.

↑ *Back to this question in Part A*

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Q17: A 36-year-old woman presents with a solid, hypoechoic thyroid nodule. She undergoes Fine Needle Aspiration Cytology (FNAC), which confirms the nodule is benign. What is the most appropriate Bethesda classification and its management for this benign thyroid nodule? (Q848936)

A. Bethesda I; Repeat FNA

B. Bethesda II; Clinical and sonographic follow-up

C. Bethesda III; Near total thyroidectomy

D. Bethesda VI; Repeat FNA, molecular testing or lobectomy

Correct Answer: B. Bethesda II; Clinical and sonographic follow-up

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Benign nodules are Bethesda II, and the management is Clinical and sonographic follow-up Class Diagnostic category Management Bethesda I (Option A) Non-diagnostic or unsatisfactory Repeat FNA with ultrasound guidance Bethesda II (Option B) Benign Clinical and sonographic follow-up Bethesda III (Option C) Atypia of undermined significance or follicular lesion of undermined significance Repeat FNA, molecular testing or lobectomy Bethesda IV Suspicion for follicular neoplasm Molecular testing and lobectomy Bethesda V Suspicion for malignancy Near total thyroidectomy or lobectomy Bethesda VI (Option D) Malignancy

References:

Sabiston’s Textbook of Surgery, 21 edition, Page 897

↑ *Back to this question in Part A*

Q18: A 65-year-old woman presents with a thyroid mass and normal thyroid function tests. Fine Needle Aspiration Cytology (FNAC) is planned to evaluate the mass. Which of the following conditions is FNAC effective in diagnosing? (Q848934)

A. Follicular Neoplasm

B. Riedel’s Thyroiditis

C. Thyroid Lymphoma

D. Solitary Thyroid Nodule

Correct Answer: D. Solitary Thyroid Nodule

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: FNAC is the investigation of choice for Solitary thyroid nodules. Indications of FNAC: Lymph Nodes Tubercular lymphadenitis Reactive lymphadenopathy Metastatic deposits Suspected lymphoma (screening) Thyroid Investigation of choice for thyroid nodules Colloid goiter Thyroiditis Suspected malignancy Breast Palpable breast lump Differentiate: Cyst vs fibroadenoma vs carcinoma Axillary lymph node evaluation (staging) Salivary Glands Parotid/submandibular swelling Pleomorphic adenoma vs carcinoma Soft Tissue & Skin Lesions Lipoma Epidermoid cyst Suspicious soft tissue tumors Cystic Lesions Breast cyst Abscess Diagnostic + therapeutic aspiration Intra-abdominal Lesions (Image-guided) Liver masses (HCC, metastasis) Pancreatic lesions Thoracic Lesions Lung mass (CT-guided FNAC) Pleural lesions Recurrent/Metastatic Disease Detect recurrence of cancer Evaluate metastatic deposits Limitations of FNAC: Follicular Neoplasms: FNAC cannot differentiate between follicular adenoma and follicular carcinoma because it does not provide information about the capsule or vascular invasion. Further biopsy is needed for a definitive diagnosis. (Option A) Riedel’s Thyroiditis: In this, the thyroid gland is replaced by fibrous tissue, which can result in a poor yield of cells, reducing the effectiveness of FNAC. (Option B) Thyroid Lymphoma: FNAC may not provide sufficient information to diagnose thyroid lymphoma accurately. A biopsy is required to obtain tissue samples for specific markers and a more comprehensive diagnosis. (Option C) Classification of FNAC reports: Thy 1 Non diagnostic Thy 1c Non diagnostic cystic Thy 2 Non neoplastic Thy 3 Follicular Thy 4 Suspicion of malignancy Thy 5 Malignant

References:

Bailey & Love’s Short Practice of Surgery, 28th Edition, Page 866

SRB’s Manual of Surgery, 6th Edition, Page 449

↑ *Back to this question in Part A*

Q19: A 45-year-old patient with a history of multinodular goitre is being considered for thyroid surgery. The surgical team decides to perform a procedure that removes the majority of the thyroid gland, leaving a small amount of tissue in one of the lobes and removing the isthmus. Which of the following best describes this procedure? (Q848932)

A. Total Thyroidectomy

B. Lobectomy

C. Dunhill Procedure

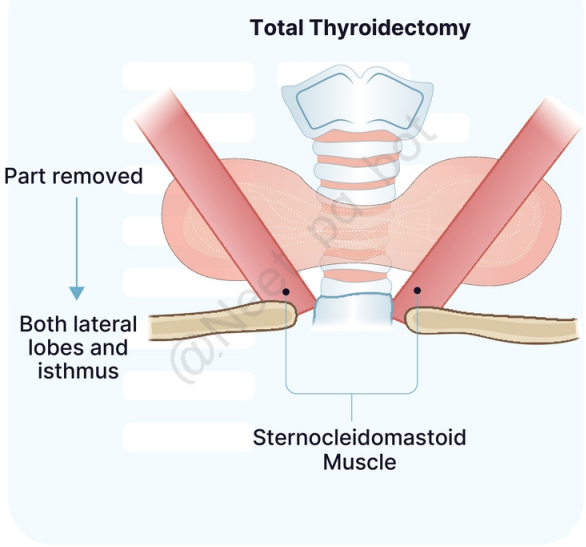
D. Subtotal Thyroidectomy

Correct Answer: C. Dunhill Procedure

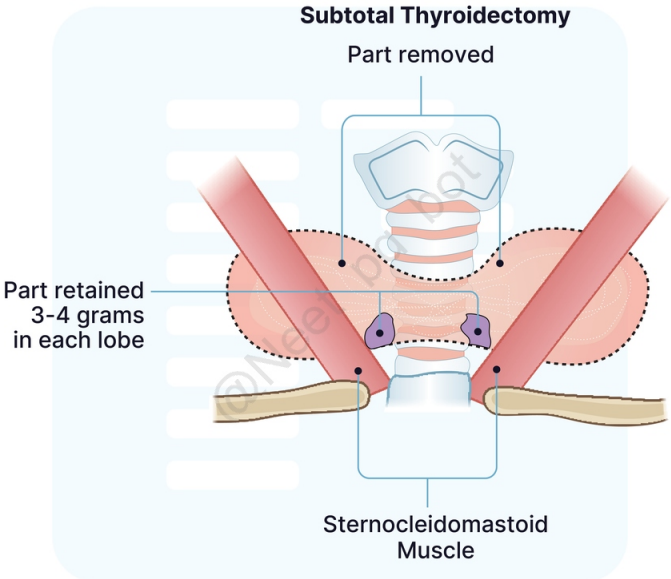
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■ *Listen (Hindi)*

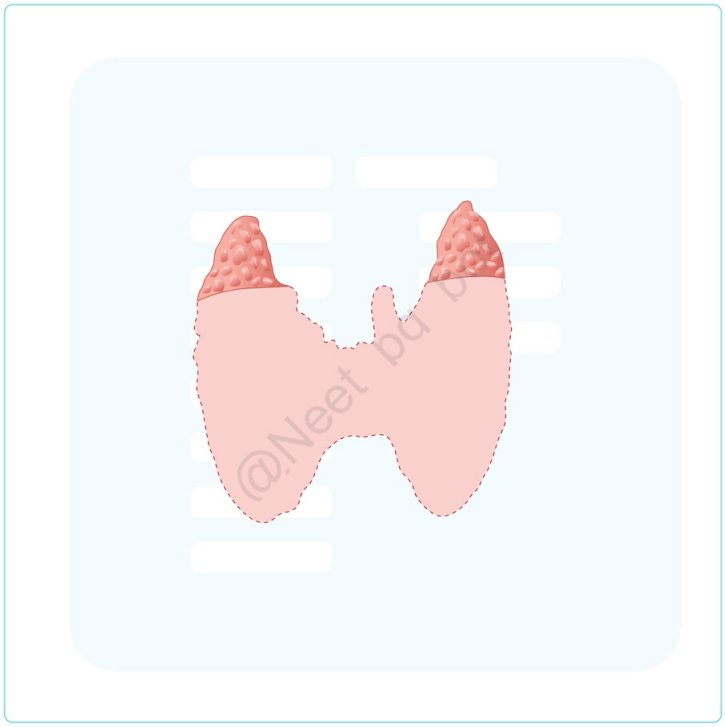
Explanation: The procedure described fits the description of the Dunhill procedure, also known as Near-Total Thyroidectomy, which involves: Total/Near-total thyroidectomy on one side Subtotal resection on the opposite side, leaving a small remnant Removal of the isthmus This is a modification of subtotal thyroidectomy. Types of Thyroidectomy: Total Thyroidectomy (Option A) All visible thyroid tissue is removed Subtotal Thyroidectomy (Option D) 3-4 grams of thyroid tissue is left in each lobe Only Indication - MNG in Elderly Near-Total Thyroidectomy (Dunhill Procedure) 4-6 grams of thyroid is left in one lobe + Subtotal Lobectomy Lobectomy (Hemithyroidectomy) (Option B) Removal of one lobe of the thyroid gland + Isthmus



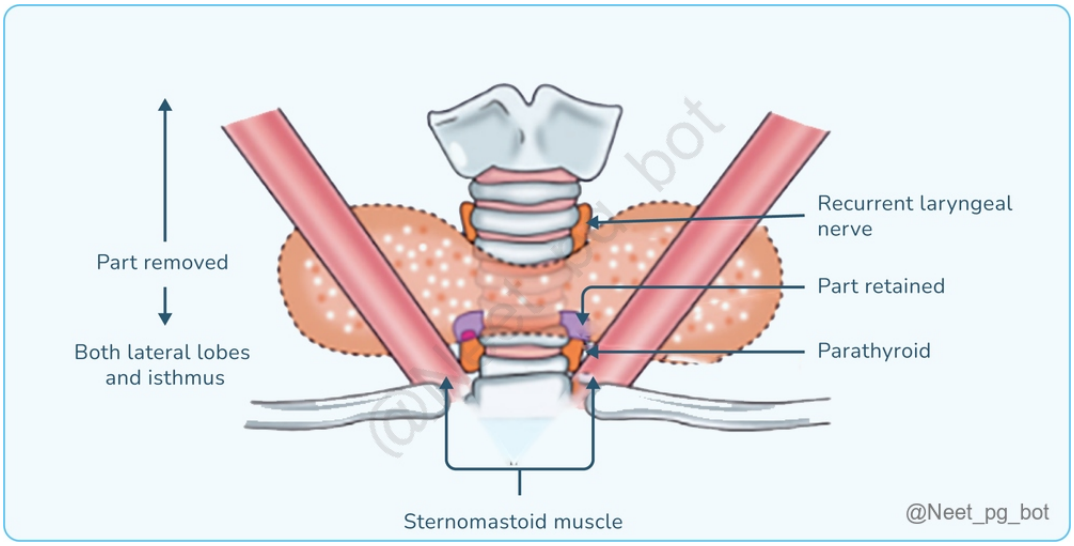
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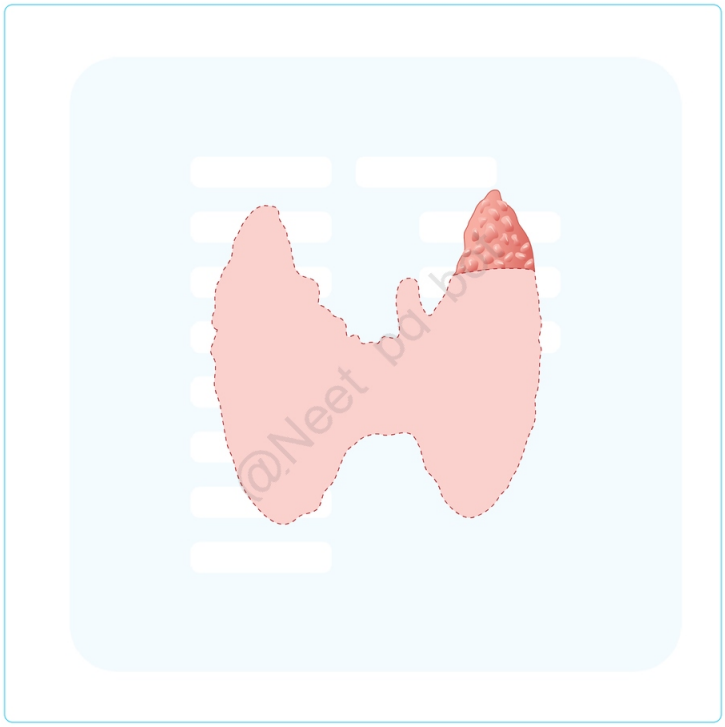


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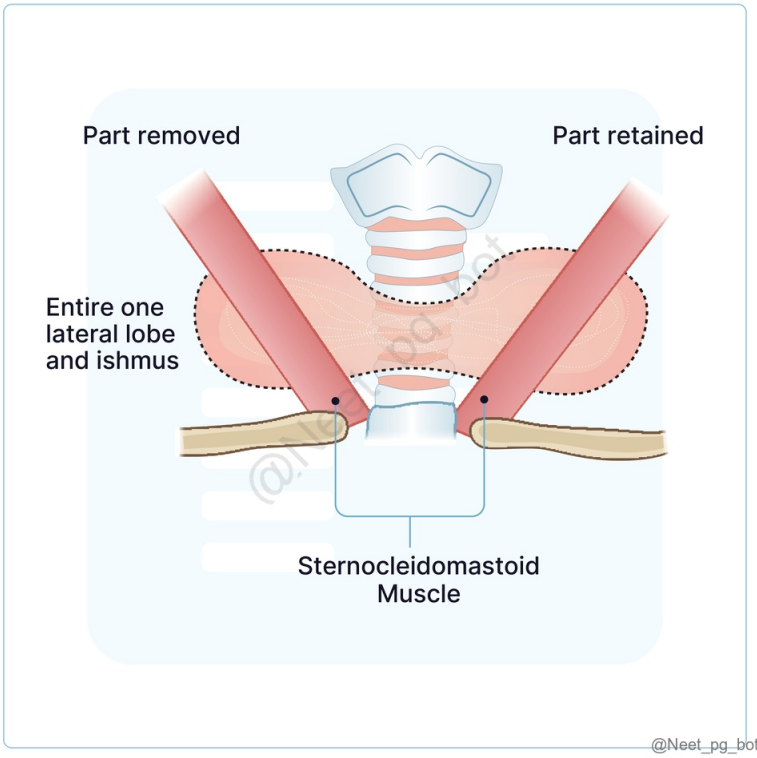


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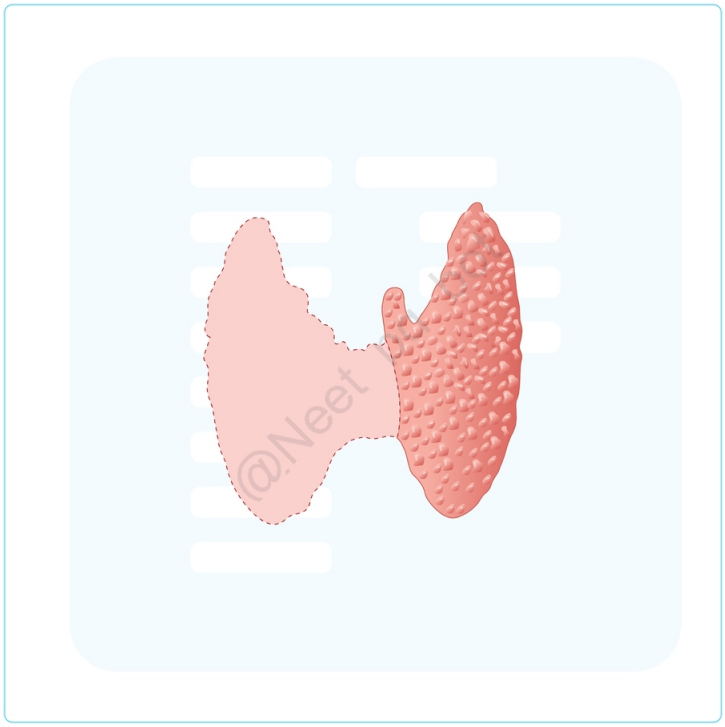

Part removed
Both lateral lobes and isthmus
Recurrent laryngeal nerve
Part retained
Parathyroid
Sternomastoid muscle
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References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 860.

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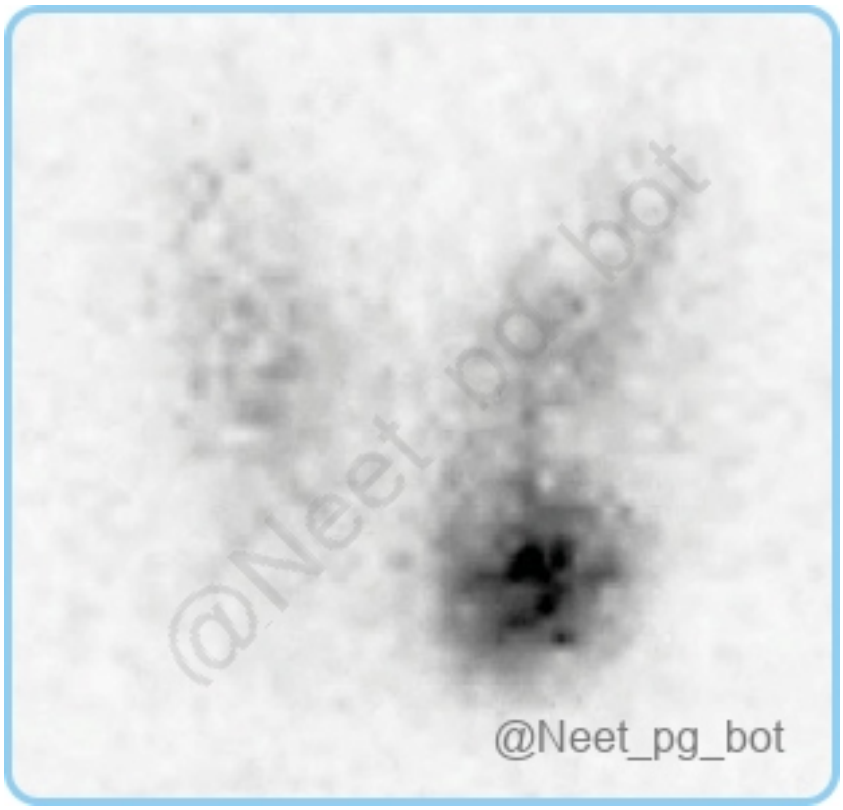
Q20: Match the following Thyroid scan images with respective conditions: 1. A. Graves Disease 2. B. Cold nodule 3. C. Hot Nodule 4. D. Toxic Multinodular Goiter (Q848931)

A. 1-C, 2-A, 3-D, 4-B

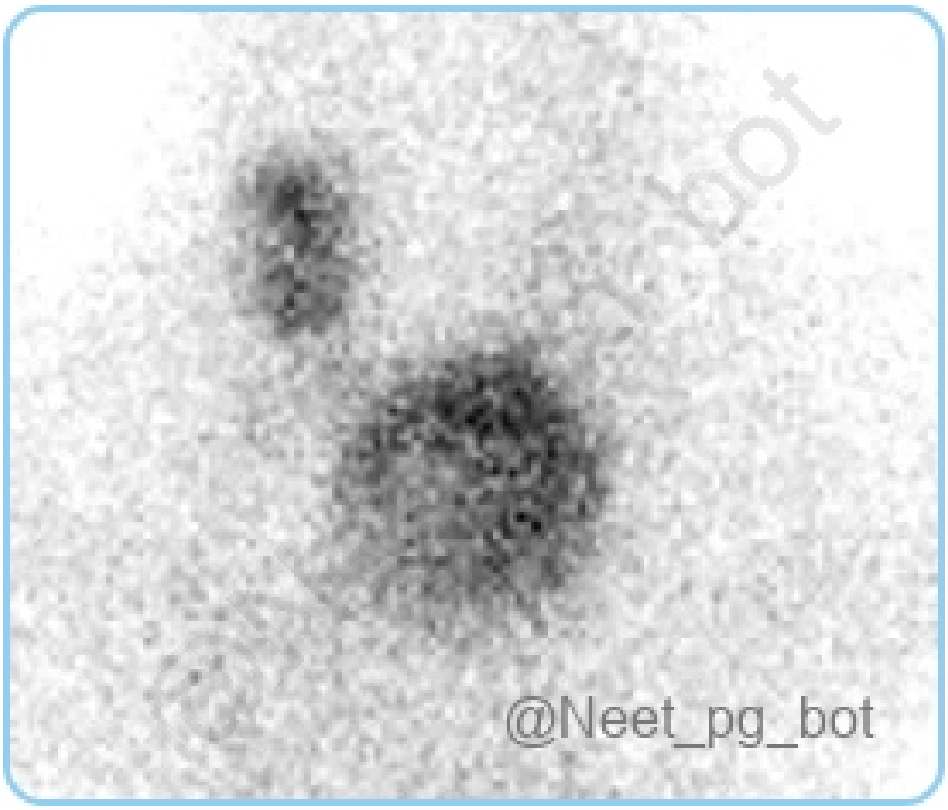
B. 1-A, 2-C, 3-B, 4-D

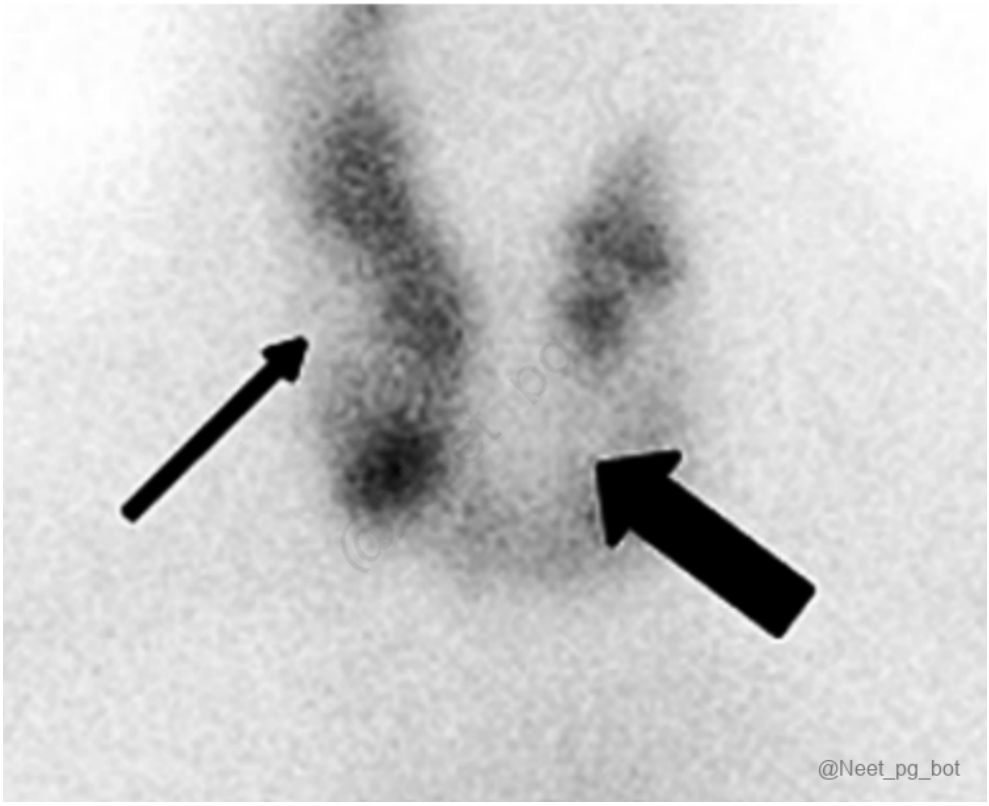
C. 1-B, 2-D, 3-A, 4-C

D. 1-C, 2-D, 3-A, 4-B


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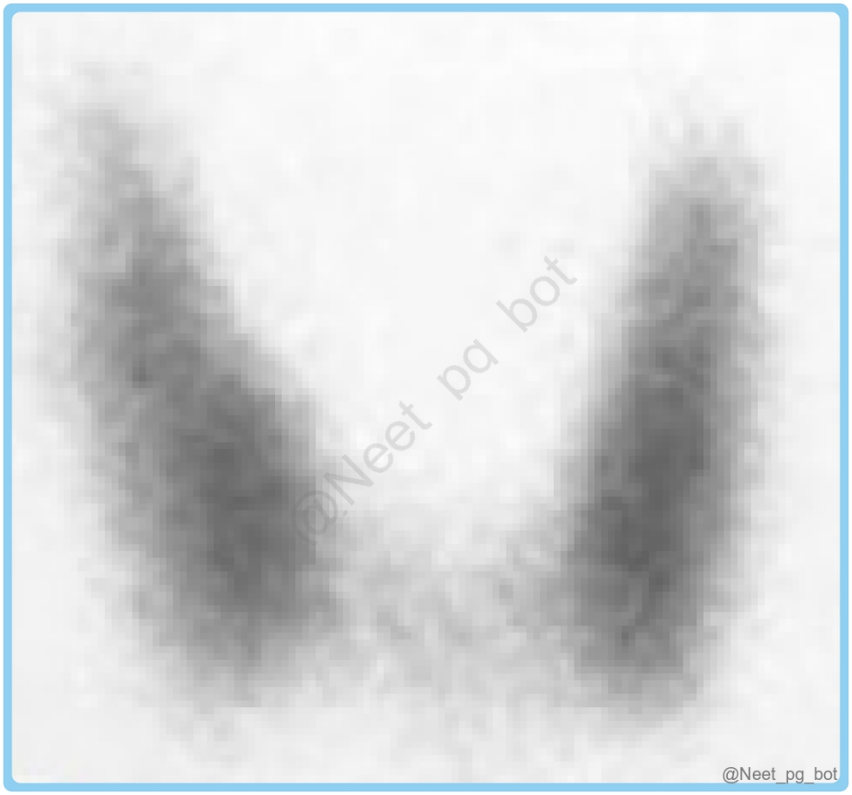


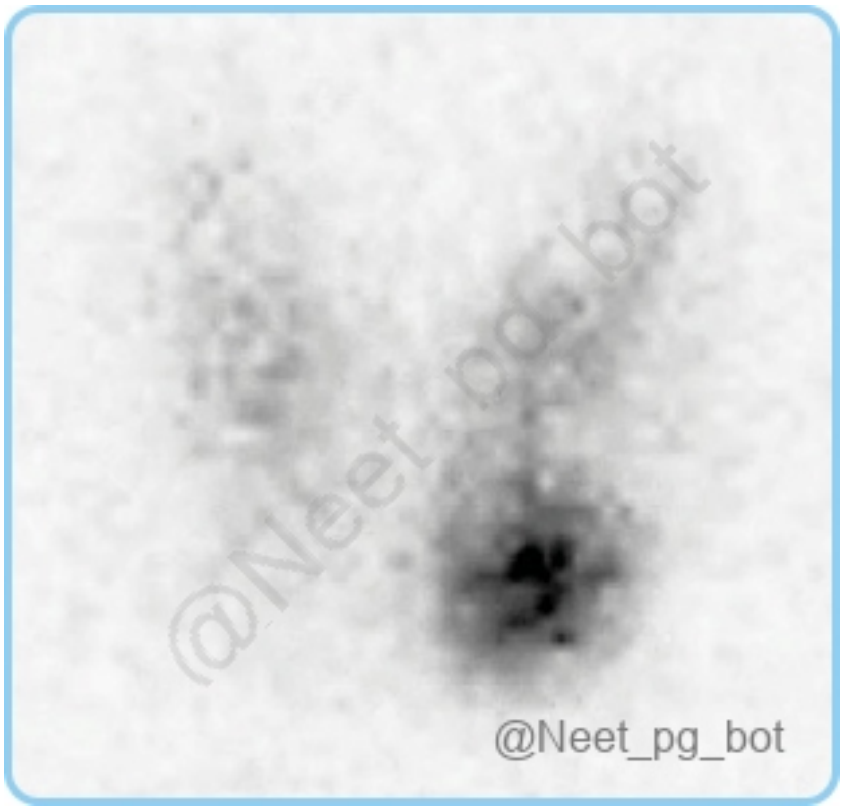
Correct Answer: A. 1-C, 2-A, 3-D, 4-B

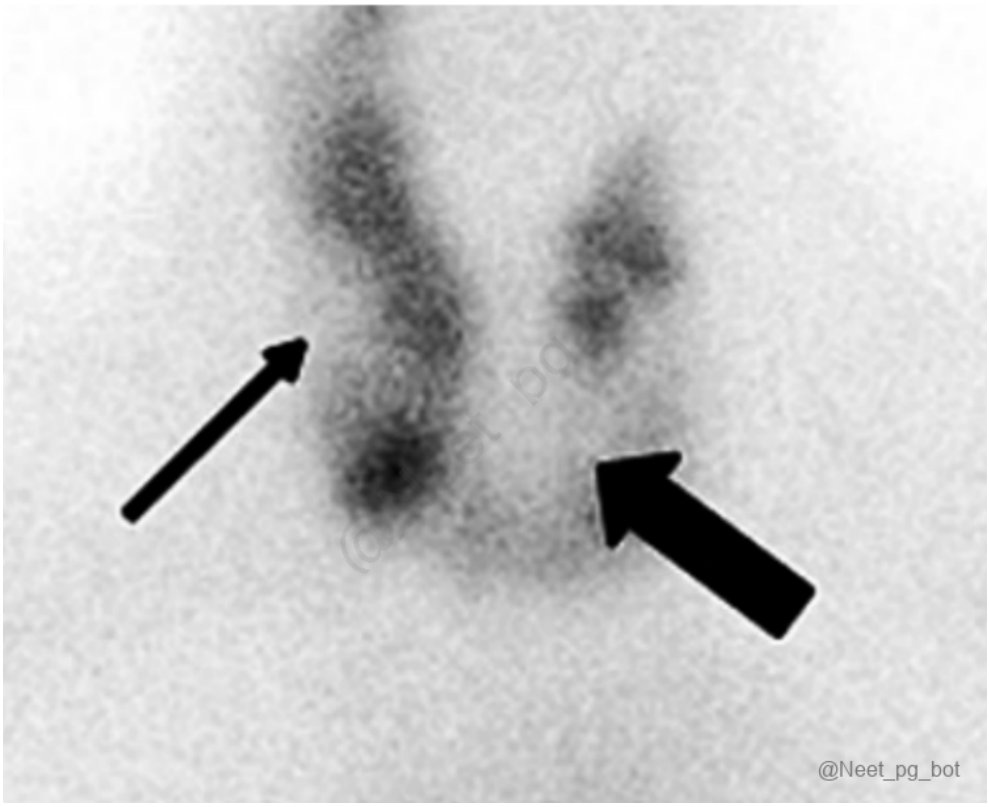
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■ *Listen (Hindi)*

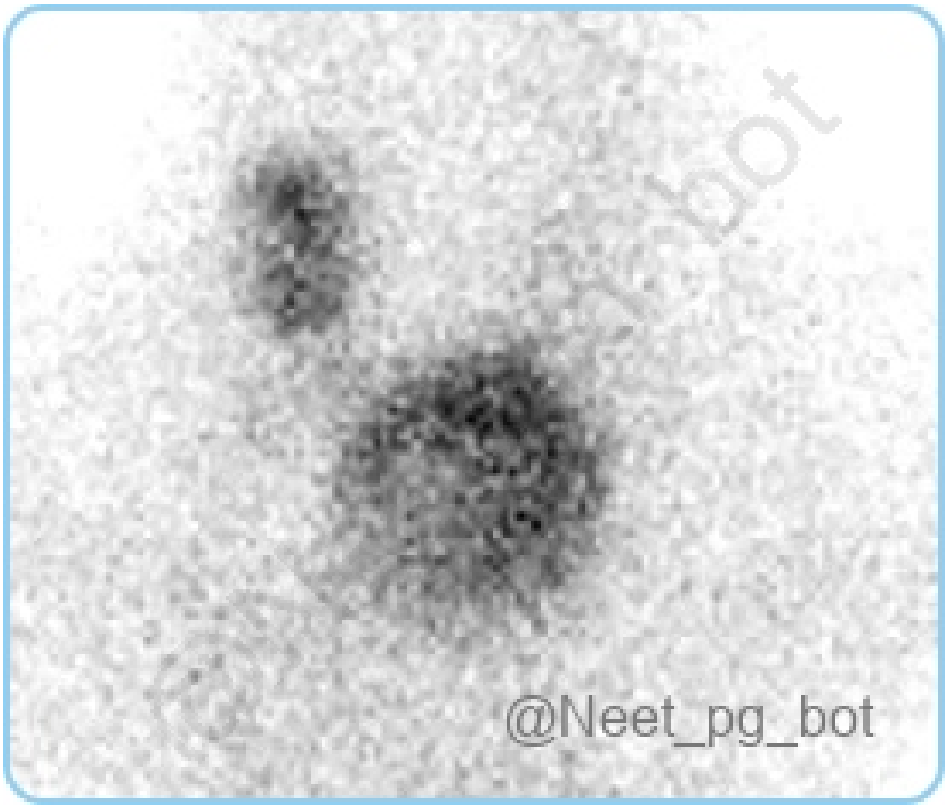
Explanation: Normal Thyroid: Uniform uptake Hot Nodules (Image 1): Increased uptake in specific areas Often benign and indicate hyperfunctioning tissue. Risk of Malignancy: 1-3% Cold Nodules (Image 4) : Reduced uptake in specific areas Risk of Malignancy: 17-20% Grave's Disease (Image 2): Increased uptake throughout the thyroid gland, showing heightened overall activity (Diffuse goiter) Toxic Multinodular Goiter (Image 3): Multiple areas of varying uptake Some nodules might show increased activity (Hot Nodules) Some might show decreased activity (Cold Nodules) Thyroiditis (Inflammation of the Thyroid): Decreased uptake throughout the areas of inflammation due to follicular destruction.

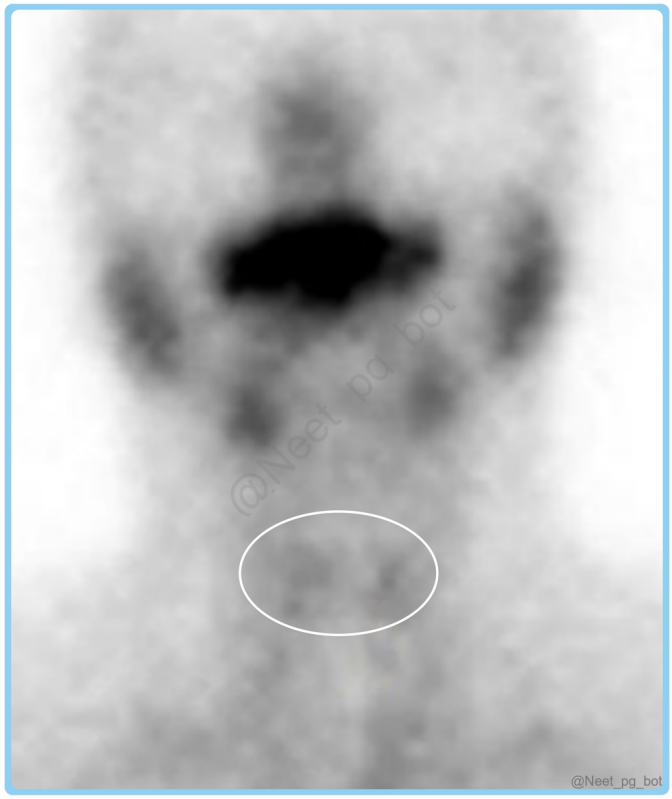



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References:

SRB's Manual of Surgery 6th Edition Page 466, 463. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3354842/ https://www.ncbi.nlm.nih.gov/books/NBK559283/ https://www.google.com/url?sa=i&url=https%3A%2F%2Fimaginglily.com%2Fblog-what-to-expect-from-technetium-thyroid-scan.html&psig=AOvVaw2ReNWmoSkc7AEs8ks_XL79&ust=1722609829782000&source=images&cd=vfe&opi=89978449&ved=0CBEQjRxqFwoTCJiSt4GE1IcDFQAAAAAdAAAAABAE

↑ *Back to this question in Part A*

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Q21: A 45-year-old woman with differentiated thyroid cancer has undergone a total thyroidectomy. To target any residual thyroid tissue or cancer cells, she is scheduled for radioactive iodine ablation therapy. Which of the following isotopes of iodine is used for this therapeutic procedure? (Q848930)

A. Iodine-123 (I-123)

B. Iodine-125 (I-125)

C. Iodine-131 (I-131)

D. Iodine-132 (I-132)

Correct Answer: C. Iodine-131 (I-131)

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: In a patient with well differentiated thyroid cancer who has undergone total thyroidectomy, to target any residual thyroid tissue or cancer cells, R adioactive Iodine Ablation (RAI) therapy is done. The isotope of choice is Iodine-131 as it provides both the therapeutic beta radiation and the gamma rays necessary for imaging and monitoring. It also has long half life (8 days). RADIOACTIVE ISOTOPES USED IN THYROID: ISOTOPES ROUTE OF ADMINISTRATION HALF-LIFE TYPES OF RAYS USE I-123 (Option A) Oral 13 hours ■-rays For diagnostic purposes I-124 PET scan in thyroid cancer 4 days - - I-125 (Option B) Oral 60 days ■-rays Diagnostic purposes and, in some cases, for brachytherapy I-131 Oral 8 days ■ and ■-rays Radioactive iodine ablation therapy I-132 (Option D) Oral 2.3 hours - Used in research Tc-99 scan IV 6 hours - Technetium is better at identifying non-functioning secondaries.

References:

Sabiston’s Textbook of Surgery, 21 Edition Page 905 SRB’s Manual of Surgery 6th Edition Page 466,467

↑ *Back to this question in Part A*

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• [07_Endocrine Surgery] 044 Thyroid-Ii

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[07_Endocrine Surgery] 044 Thyroid-Ii — Quick Jump

Q1 (p. 2843)	*Q2 (p. 2843)*	*Q3 (p. 2844)*	*Q4 (p. 2845)*	*Q5 (p. 2846)*	*Q6 (p. 2847)*
Q7 (p. 2849)	*Q8 (p. 2851)*	*Q9 (p. 2853)*	*Q10 (p. 2854)*	*Q11 (p. 2855)*	*Q12 (p. 2856)*
Q13 (p. 2858)	*Q14 (p. 2859)*	*Q15 (p. 2861)*	*Q16 (p. 2862)*	*Q17 (p. 2863)*	*Q18 (p. 2865)*
Q19 (p. 2866)	*Q20 (p. 2867)*	*Q21 (p. 2868)*			

Q1: What is the best investigation to check for extra thyroid spread of thyroid gland neoplasm ? (Q882181)

A. USG

B. MRI

C. PET scan

D. Iodine scan

Correct Answer: B. MRI

Explanation: Correct option B. MRI Best modality for: Extrathyroidal extension Soft tissue invasion (muscles, trachea, esophagus) Advantage: Superior soft-tissue resolution Investigation of choice Incorrect Options: A. USG (Ultrasound) Best for: Thyroid nodules Cervical lymph nodes Limitation: Poor assessment of deep tissue planes and invasion into surrounding structures Not ideal for evaluating extra-thyroid spread C. PET scan Used for: Poorly differentiated or recurrent thyroid cancer Non-iodine-avid metastases Limitation: Not first-line for local invasion Not the best test for extra-thyroid spread D . Iodine scan Used for: Functioning thyroid tissue Distant iodine-avid metastases Limitation: Does not show local anatomical spread Not useful for extra-thyroid extension

↑ *Back to this question in Part A*

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Q2: A 30-year-old patient presents with hypertension, sweating, and frequent headaches. Imaging reveals a thyroid nodule, and tests show elevated serum calcitonin. The family history includes similar early-onset cases. What condition is most likely associated with these findings? (Q848961)

A. MEN 1

B. MEN 2A

C. Cowden syndrome

D. Familial medullary thyroid carcinoma

Correct Answer: B. MEN 2A

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: A history of hypertension, sweating, and recurrent headaches in a young male is suggestive of pheochromocytoma . The presence of a thyroid nodule with elevated serum calcitonin indicates medullary carcinoma of the thyroid . A positive family history of similar early-onset cases supports the diagnosis of Multiple Endocrine Neoplasia type 2A (MEN 2A) . MEN 2A (Multiple Endocrine Neoplasia Type 2A) is an autosomal dominant syndrome. Occurs due to gain of function mutation of RET proto-oncogene Urinary catecholamines testing is the screening test that should be done pre-operatively. Syndromes associated with Thyroid carcinoma: Syndrome Key Features Genetic Mutation MEN 2A Medullary Thyroid Carcinoma (MTC) Pheochromocytoma Primary Hyperparathyroidism RET proto-oncogene gain of function - elevated tyrosine kinase MEN 2B Medullary Thyroid Carcinoma (MTC) (more aggressive) Pheochromocytoma Mucosal Neuromas Marfanoid Habitus RET proto-oncogene gain of function - elevated tyrosine kinase Familial Medullary Thyroid Carcinoma (FMTC) (Option D) Medullary Thyroid Carcinoma (MTC) only RET proto-oncogene gain of function Cowden Syndrome (Option C) Thyroid Carcinoma (often follicular) Benign Tumors (e.g., skin lesions) Increased risk of breast and endometrial cancers. Tumor suppressor PTEN gene Loss of function Werner syndrome Follicular/ Papillary/Anaplastic Thyroid Carcinoma Premature aging WRN gene loss of function Gardner Syndrome Papillary Thyroid Carcinoma Multiple colorectal polyps Osteomas and soft tissue tumours APC gene loss of function MEN 1 syndrome is not associated with Thyroid carcinoma MEN 1 (Option A) Primary hyperparathyroidism Endocrine tumors Gastrinoma Insulinoma / VIPoma Pituitary adenoma Carcinoid tumor MEN 1 gene on Chr . 11 Altered menin expression

References:

Bailey & Love’s Short Practice of Surgery, 28th Edition, Page 870.

https://www.ncbi.nlm.nih.gov/books/NBK568728/

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Q3: A 72-year-old male presents with a rapidly growing thyroid mass accompanied by severe pain and hoarseness of voice. Imaging shows the direct invasion of surrounding structures, including the trachea and oesophagus. The diagnosis of anaplastic thyroid carcinoma is confirmed. In managing this condition, which of the following is not typically included? (Q848972)

A. Radioactive iodine

B. Tumor debulking

C. Doxorubicin

D. Trametinib

Correct Answer: A. Radioactive iodine

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Radioactive Iodine is not typically used for anaplastic thyroid carcinoma due to the lack of iodine uptake in this aggressive form of thyroid cancer. Management of Anaplastic carcinoma: Resectable Tumors (restricted to Thyroid): Total thyroidectomy + Central Neck Dissection + Modified Radical Neck Dissection Unresectable Tumors: Palliative care with tracheostomy for airway obstruction Chemotherapy: Doxorubicin (Option C) Tyrosine Kinase Inhibitors : Dabrafenib, Trametinib (Option D) Tumour Debulking : Isthmusectomy done if pressure over the Trachea. (Option B)

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 870.

↑ *Back to this question in Part A*

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Q4: A 45-year-old female recently underwent total thyroidectomy for papillary thyroid carcinoma. Which of the following is not part of her post-surgical management? (Q848970)

A. Immediately start high-dose thyroxine (T4) to prevent hypothyroidism.

B. Stop thyroxine (T4) for 6 weeks before a whole-body scan.

C. Administer recombinant TSH if stopping thyroxine (T4) is intolerable.

D. PET scan if thyroglobulin rises despite normal neck USG and chest X-ray.

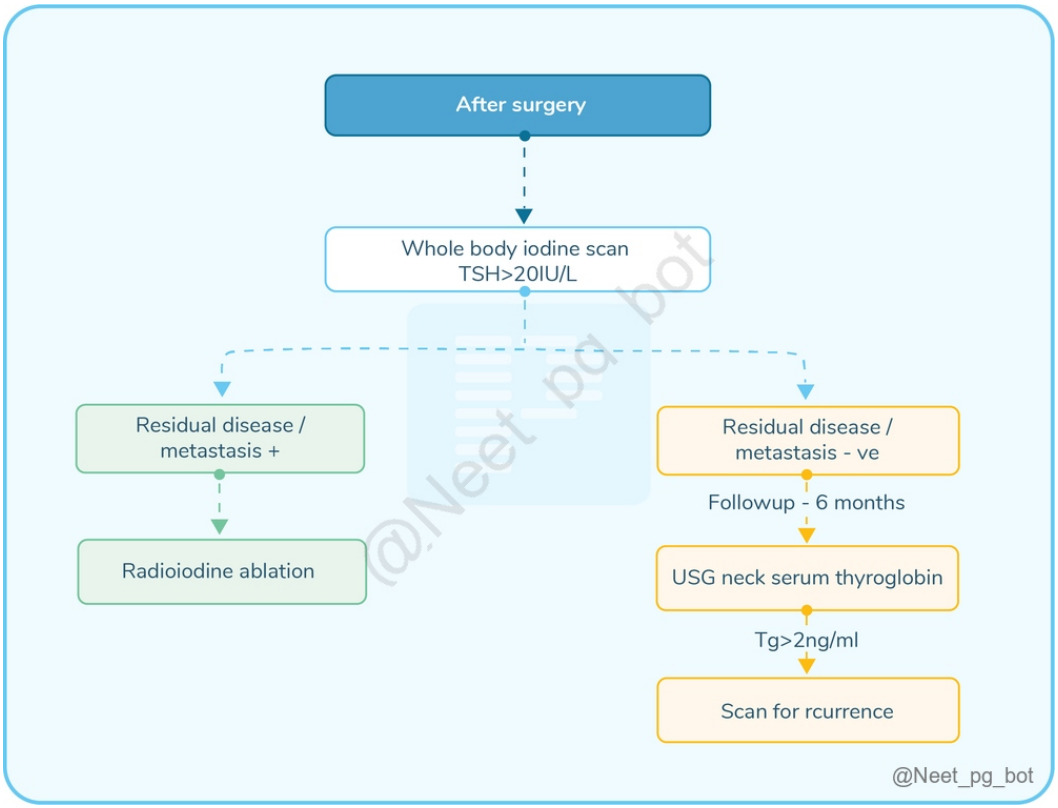
Correct Answer: A. Immediately start high-dose thyroxine (T4) to prevent hypothyroidism.

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: High-dose thyroxine (T4) is started to prevent proliferation of thyroid tissue (to prevent cancer recurrence). Post-Surgical Management of Thyroid Cancers: Thyroxine Therapy: High-Risk Patients: Thyroxine is

used to suppress TSH to prevent cancer recurrence. TSH was maintained at a lower normal limit. Low-Risk Patients: Thyroxine is given at physiological levels to maintain normal thyroid function. Radioiodine Therapy: Stop Thyroxine (T4): Discontinue thyroxine for 6 weeks to increase TSH levels (Option B) , enhancing iodine uptake. If intolerable, switch to triiodothyronine (T3) for 2 weeks or use recombinant TSH. (Option C) Whole-Body Scan: Performed to detect and ablate any residual thyroid tissue or cancer cells. Radioactive iodine (RAI) has no role in Medullary carcinoma Imaging and follow-up: Ultrasound Neck and Chest X-ray. To detect recurrence: Thyroglobulin Levels: Monitored as a marker for cancer recurrence. PET Scan has maximum sensitivity for detecting recurrence and is indicated if thyroglobulin levels rise despite normal ultrasound and chest X-ray (Option D). RAI ablation can be repeated if cancer recurs .



References:

Bailey & Love's Short Practice of Surgery, 28th edition, Page 870,871

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Q5: A 45-year-old patient undergoes a total thyroidectomy for a large multinodular goitre. Postoperatively, the patient is monitored for complications. Which of the following is least likely to occur? (Q848969)

A. Tension Hematoma

B. Horner's syndrome

C. RLN Palsy

D. Hypercalcemia

Correct Answer: D. Hypercalcemia

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Hypercalcemia is not a typical complication following thyroidectomy. Instead, parathyroid insufficiency is more common, which can lead to hypocalcemia (low calcium levels). Complications of Thyroidectomy: Hemorrhage: Bleeding from muscular arteries or slippage of ligature from superior thyroid vessels. Complication: Tension hematoma causing respiratory distress. (Option A) Management: Immediate re-operation, open sutures, control bleeding, drain hematoma, and close the wound. Respiratory Obstruction: Primary Cause: Laryngeal edema from extubation injury. (Most Common Complication) Other Causes: RLN palsy and tension hematoma. Nerve Injury: Commonly Injured Nerve: External branch of the superior laryngeal nerve. Other Injuries: RLN Injury causing palsy (Option C) and cervical sympathetic trunk causing Horner's syndrome . (Option B) Parathyroid Insufficiency: Ligating the inferior thyroid artery away from the thyroid leads to parathyroid vascular infarction. Causes hypocalcemia (low calcium levels) presenting 2–5 days post-surgery. Thyroid Insufficiency: Total thyroidectomy leads to hypothyroidism and requires lifelong levothyroxine replacement. Thyrotoxic Crisis: Inadequate preoperative preparation in hyperthyroid patients, leading to the release of thyroid hormones during surgery.

References:

Bailey & Love’s Short Practice of Surgery, 28th edition, Page 865

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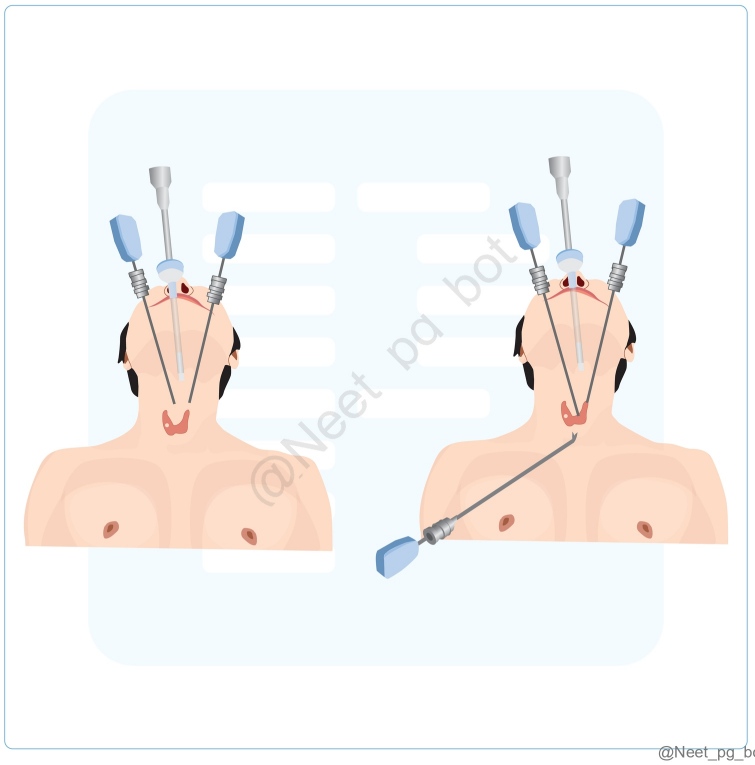
Q6: A 45-year-old woman with a thyroid pathology is being considered for the procedure shown in the image. Which of the following conditions is a contraindication for this procedure? (Q848983)

A. Hashimoto's thyroiditis

B. Benign thyroid nodule 2 cm

C. T1 Papillary carcinoma

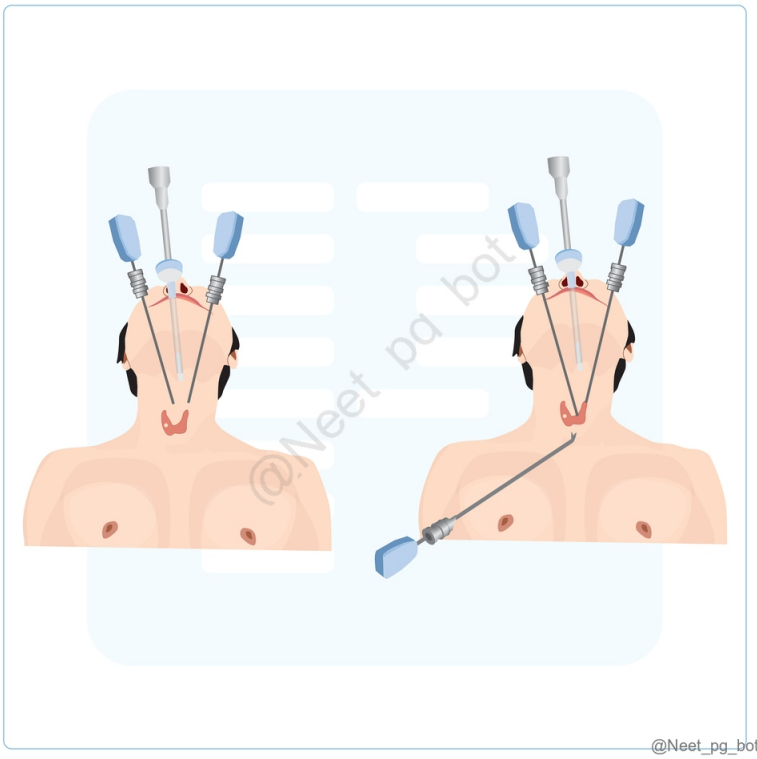
D. Thyroid adenoma 2.5 cm



Correct Answer: A. Hashimoto's thyroiditis

- *Listen (English)*
- *Listen (Hindi)*

Explanation: The Procedure in the given image is Minimally Invasive Video-Assisted Thyroidectomy (MIVAT), and Thyroiditis is contraindicated for this procedure. Minimally Invasive Video-Assisted Thyroidectomy (MIVAT): MIVAT is a surgical technique for thyroidectomy using endoscopic assistance through small incisions. Most common approach is through the axilla (Others: Transoral, retro auricular, Nipples) Indications: Benign Thyroid swelling: Size < 3 cm; typically requires hemithyroidectomy. (Option B) Papillary Carcinoma: Size should be < 2 cm; usually involves total thyroidectomy. (Option C) Contraindications: Thyroiditis Advantages: Cosmetic Benefit: Smaller incisions result in less scarring. Recovery: Generally associated with quicker recovery and less postoperative discomfort than traditional open surgery.



References:

Bailey & Love's Short Practice of Surgery, 28th edition, Page 865
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6995905/

↑ *Back to this question in Part A*

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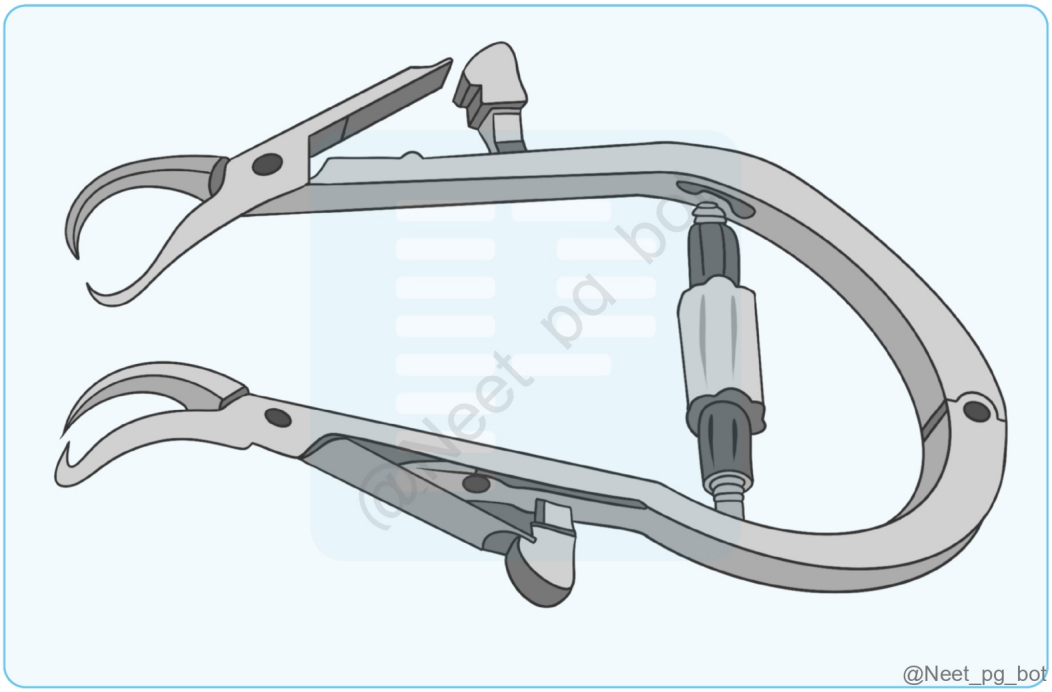
Q7: A 55-year-old patient is undergoing a thyroidectomy, and the surgical team uses a specialized retractor to improve exposure and facilitate the operation. Identify the retractor. (Q848981)

A. Deaver's retractor

B. Joll's retractor

C. Richardson retractor

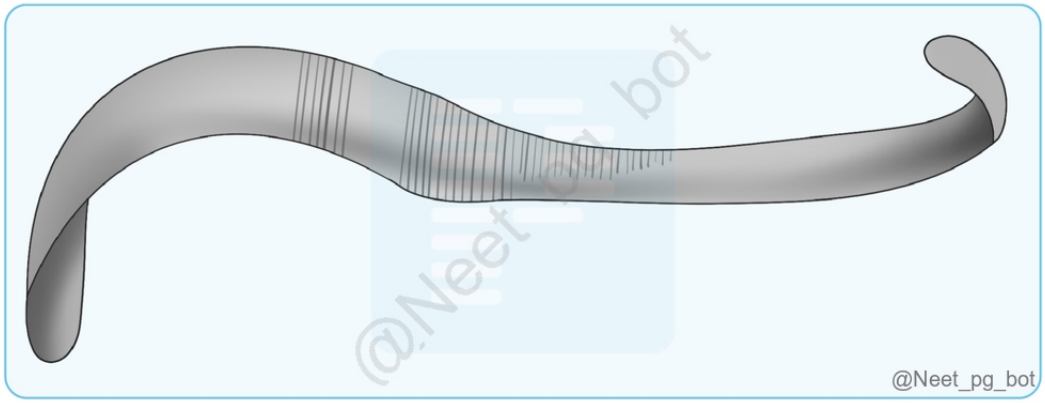
D. Volkmann retractor

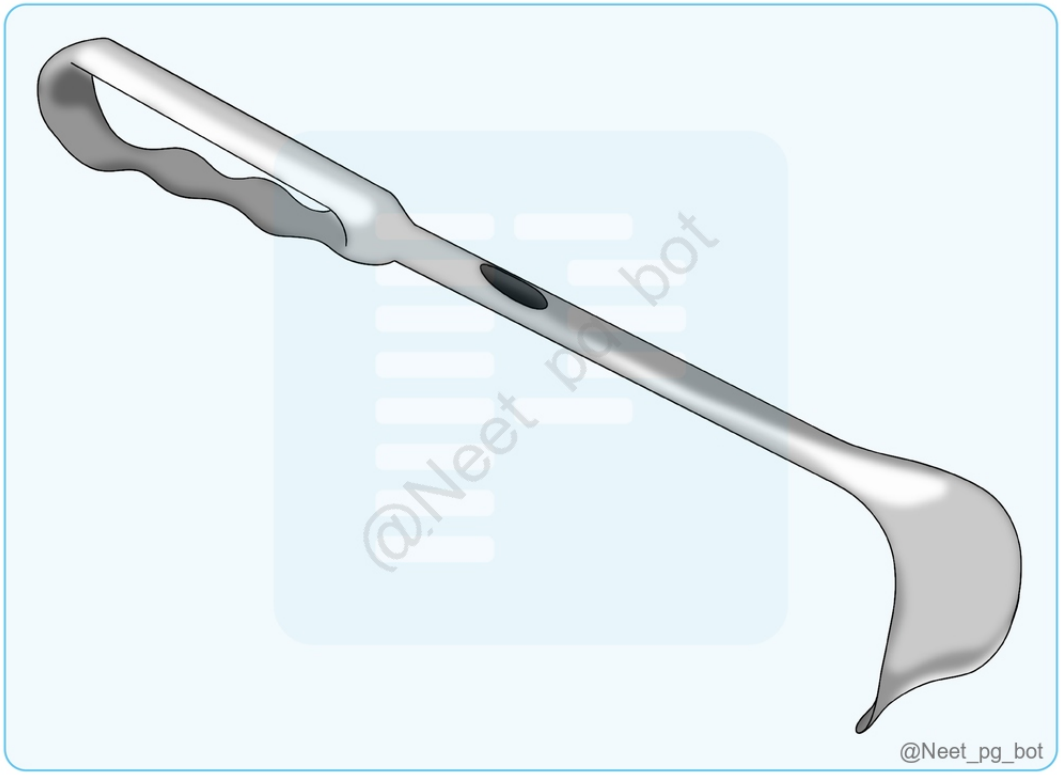


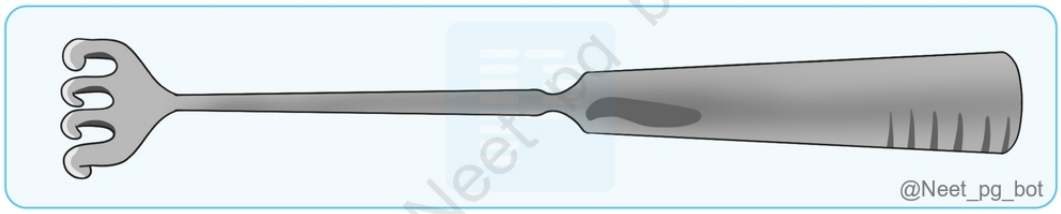
Correct Answer: B. Joll’s retractor

- *Listen (English)*
- *Listen (Hindi)*

Explanation: Joll’s retractor is a self-retaining retractor specifically designed for thyroid surgery, providing excellent exposure by effectively retracting the thyroid gland and surrounding structures. Deaver’s Retractor (Option A): A General-purpose retractor used in various abdominal and thoracic surgeries Richardson Retractor (Option C) : Commonly used in abdominal surgery for abdominal wall retraction. Volkmann Retractor (Option D): Often used in orthopaedic surgery, particularly for retracting soft tissues, but not specifically designed for thyroid surgery.







References:

SRB Manual of Surgery, 6th Edition, Page 1150

↑ *Back to this question in Part A*

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Q8: A 60-year-old woman presents with symptoms of hyperthyroidism, including weight loss, palpitations, and tremors. A large thyroid nodule is noted on examination, and laboratory tests reveal elevated thyroid hormones with suppressed thyroid-stimulating hormone (TSH) levels. An ultrasound shows multiple nodules in the thyroid gland. Which of the following management strategies is most appropriate for this patient? (Q848980)

A. Antithyroid drugs followed by total thyroidectomy

B. Radioactive iodine therapy

C. Thyroid hormone replacement therapy

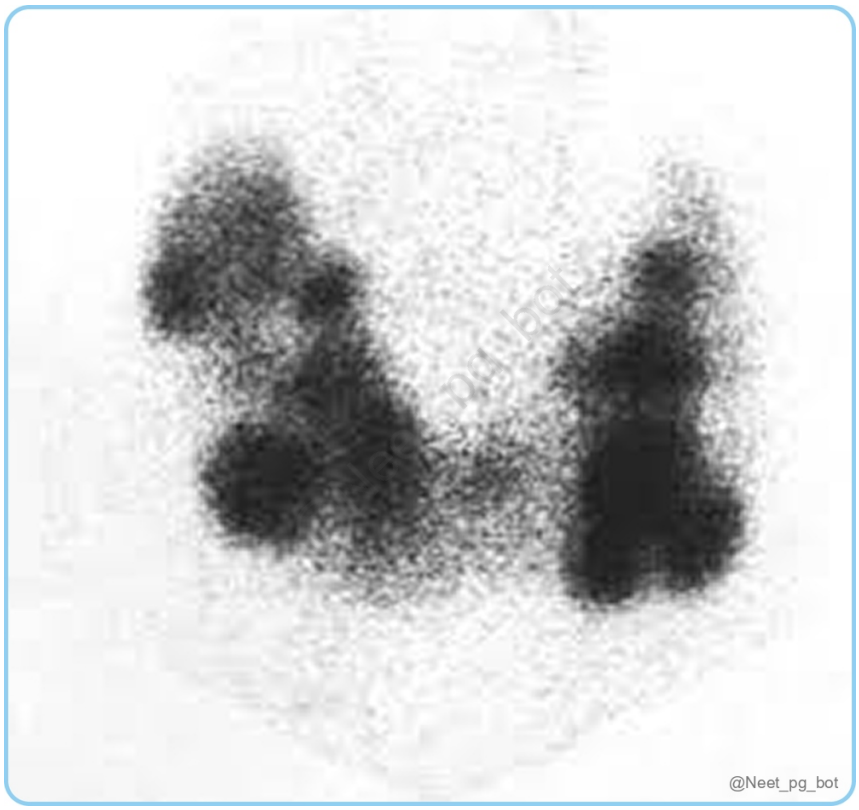
D. Treat with lugol iodine followed by surgery

Correct Answer: A. Antithyroid drugs followed by total thyroidectomy

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The patient has toxic multinodular goitre , also known as Plummer’s disease, characterized by multiple overactive thyroid nodules causing hyperthyroidism. It is more common in females and is the second most common cause of hyperthyroidism. Toxic multinodular goitre Also known as Plummer’s disease, characterized by multiple overactive thyroid nodules causing hyperthyroidism. Epidemiology More common in females and occurs often after 60 years of age Second most common cause of hyperthyroidism More prevalent in Iodine deficient region Pathophysiology Chronic iodine deficiency or thyroid dysfunction → reduced hormone production → increased hypothalamic TRH secretion → persistent TSH stimulation of the thyroid gland → hyperplasia of thyroid nodules Multiple somatic mutations of TSH receptor occur in long-standing goiters (> 60% of cases) → autonomous functioning of nodules (toxic MNG) → hyperthyroidism Clinical features Painless goiter with multiple palpable nodules Symptoms of thyrotoxicosis Lab investigations ↑ T3 and ↓ TSH Neck USG - multiple nodules within the thyroid parenchyma Increased radioiodine uptake by multiple hyperfunctioning (hot) nodules Decreased uptake by the rest of the gland Hypofunctioning or cold nodules may also be present in the multinodular gland. Management Antithyroid drugs followed by Total Thyroidectomy are preferred. Antithyroid drugs (Carbimazole, Methimazole) are to make the patient euthyroid and stabilize the patient before surgery. Total thyroidectomy is to remove the toxic nodules and resolve the underlying problem. Radioactive Iodine Therapy: Add - “(Iodine-131)” Alternative or adjunctive treatment to destroy overactive thyroid tissue, especially useful if surgery is not feasible or desired (Option B) Given in high doses as uptake is less compared to graves . Hence, it is not preferred before surgery. Thyroid hormone replacement therapy (Option C) is not used for treating hyperthyroidism; it is used for managing hypothyroidism. Treatment with lugol iodine followed by surgery (Option D) can lead to the Jod-Basedow phenomenon , where excessive iodine can exacerbate hyperthyroidism , particularly in patients with multinodular goitre. Hence, it is avoided.



References:

1. Sabiston’s Textbook of Surgery, 21st Edition, Page 888, 889. 2. Radioactive Iodine Therapy - StatPearls - NCBI Bookshelf

↑ *Back to this question in Part A*

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Q9: A 72-year-old woman with a history of Hashimoto's thyroiditis presents with a rapidly growing thyroid mass, dysphagia, dyspnea, and hoarseness. Biopsy confirms diffuse large B-cell lymphoma. Which of the following is most appropriate for treating this patient? (Q848979)

A. Surgical resection alone

B. External beam radiotherapy combined with chemotherapy

C. Expectant management with hormone replacement

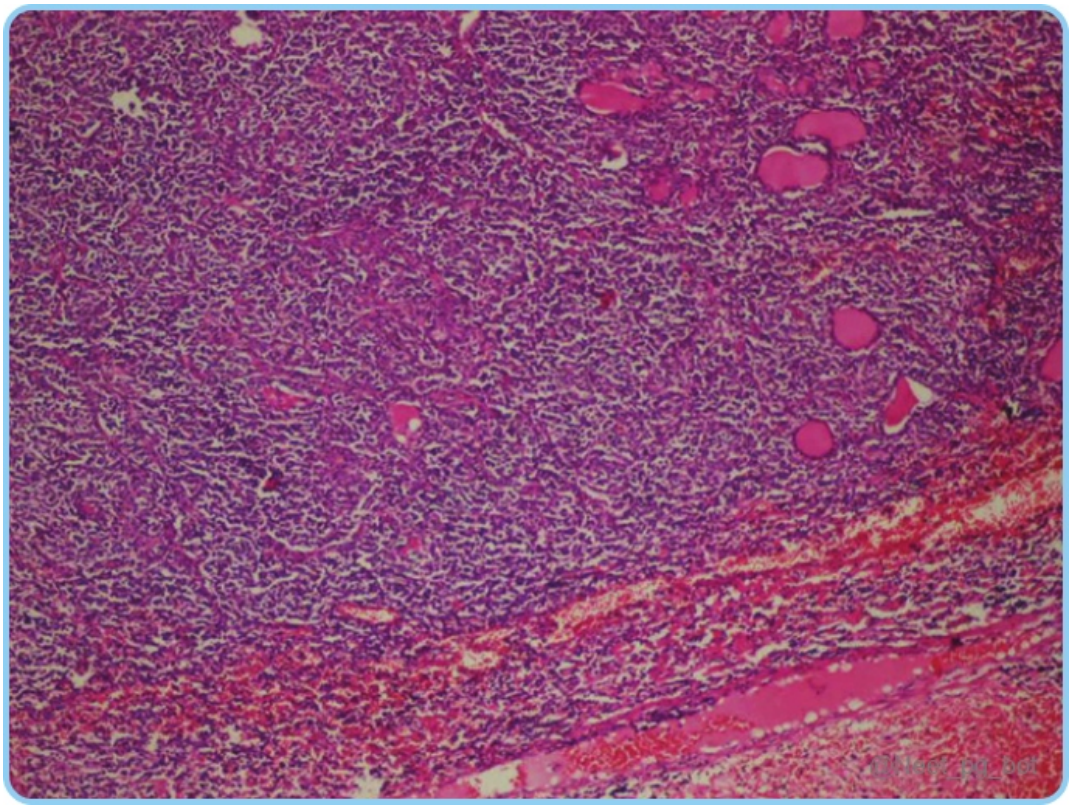
D. Chemotherapy followed by thyroidectomy

Correct Answer: B. External beam radiotherapy combined with chemotherapy

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The patient has thyroid lymphoma , specifically diffuse large B-cell lymphoma, which is a rare form of extranodal non-Hodgkin lymphoma in which External Beam Radiotherapy (EBRT) and Chemotherapy (R-CHOP regimen) are the standard treatment approaches Management: First-line Treatment: External Beam Radiotherapy (EBRT) combined with Chemotherapy, R-CHOP regimen which includes: R - Rituximab C - Cyclophosphamide H - Hydroxydaunorubicin (Doxorubicin) O - Oncovin (Vincristine) P - Prednisone In cases of residual or recurrent disease: Surgical intervention Other options: Option A: Surgical resection alone Thyroid lymphoma is not treated surgically, as it responds dramatically to chemoradiation. Surgery does not improve outcomes and is avoided due to risk of complications in an inflamed, infiltrated gland. Option C: Expectant management with hormone replacement Not appropriate; this is an aggressive malignancy requiring immediate therapy. Hormone therapy has no role in the treatment of lymphoma. Option D: Chemotherapy followed by thyroidectomy Thyroidectomy is not part of the standard treatment protocol for lymphoma. Resection offers no additional benefit after chemo.



References:

Bailey & Love’s Short Practice of Surgery, 28th Edition, Page 868, 871.

↑ *Back to this question in Part A*

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Q10: A 62-year-old woman has recently undergone surgery for papillary thyroid carcinoma (PTC). Postoperative pathology reports indicate: Tumour Size: 3.8 cm Extrathyroidal Invasion: Present No lymph node involvement No distant metastases Complete surgical resection Which of the following scoring systems is specifically used to assess the prognosis in the postoperative setting? (Q848977)

A. AGES Scoring System

B. AMES Scoring System

C. MACIS Scoring System

D. TNM Staging System

Correct Answer: C. MACIS Scoring System

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The MACIS Scoring System is designed for postoperative use, as it considers the completeness of surgical resection, unlike other scoring systems that are used preoperatively. Used to evaluate the risk of recurrence and survival after initial treatment. Prognostic Indicators of Thyroid cancers: AGES System AMES System MACIS A ge Histologic G rade E xtrathyroidal invasion S ize A ge M etastasis E xtrathyroidal invasion S ize M etastasis A ge C ompleteness of original surgical resection E xtrathyroidal invasion S ize Used for differentiated thyroid carcinomas to assess survival rates and identify high-risk patients. A prognostic index which categorizes patients of differentiated thyroid carcinoma into Low and High risk Used to evaluate the risk of recurrence and survival after initial treatment.

References:

Schwartz’s Principles of Surgery, 11th edition, Page 1648

↑ *Back to this question in Part A*

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Q11: A 40-year-old patient presents with midline neck swelling, persistent diarrhoea, and elevated serum calcitonin. Imaging shows the tumour confined to the thyroid without lymph node involvement. Histopathology reveals amyloid stroma. Which of the following is most appropriate for managing this condition? (Q848975)

A. Radioactive iodine therapy

B. Total thyroidectomy with modified radical neck dissection

C. Tyrosine kinase inhibitors and radiotherapy

D. Total thyroidectomy with central neck dissection

Correct Answer: D. Total thyroidectomy with central neck dissection

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The clinical presentation and histopathological examination, showing amyloid-rich stroma and elevated calcitonin, indicate Medullary Thyroid Carcinoma. Total thyroidectomy with central neck dissection is appropriate for managing tumors confined to the thyroid. Modified radical neck dissection is indicated if only there is significant lymph node involvement. (Option B ruled out) Management of Medullary thyroid carcinoma (MTC): MTC is a TSH-independent tumor, so Radioactive Iodine (RAI) therapy is ineffective. (Option A ruled out) Surgical Management: If restricted to the thyroid: T otal Thyroidectomy (TT) + Central Neck Dissection (CND). If there is the involvement of Level 6 Nodes or other nodes: T otal Thyroidectomy (TT) + Central Neck Dissection (CND) + Modified Radical Neck Dissection (MRND) If Calcitonin levels >200 pg/mL: Consider Prophylactic Neck Dissection. Radiotherapy: Used primarily for local symptoms. Metastatic MTC: Managed with Tyrosine Kinase Inhibitors. Preoperative Considerations: Always rule out pheochromocytoma and hyperparathyroidism. Monitoring and Follow-Up: Calcitonin Doubling time (sensitive marker) CEA Radioactive iodine therapy (Option A) is ineffective for medullary thyroid carcinoma as it is TSH-independent. Tyrosine kinase inhibitors and radiotherapy (Option C) are generally used for metastatic cases or symptomatic control, not initial management.

References:

Bailey & Love’s Short Practice of Surgery, 28th Edition, Page 870, 871.

↑ *Back to this question in Part A*

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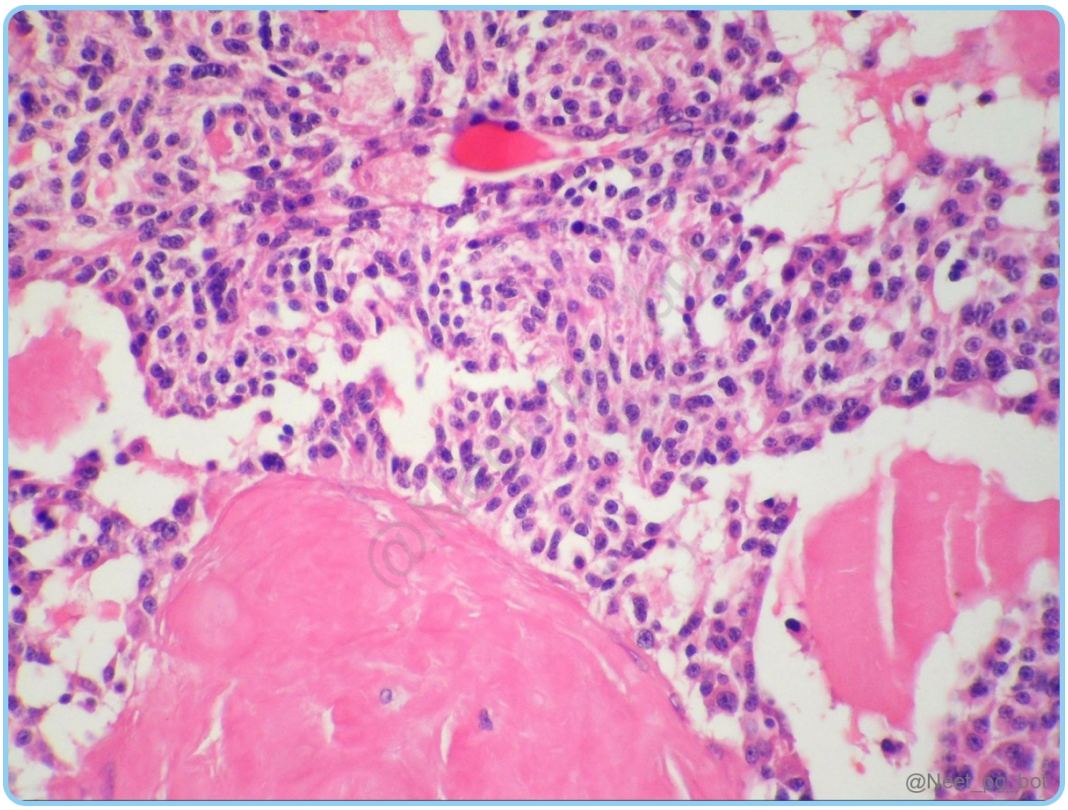
Q12: A 45-year-old with midline neck swelling and persistent diarrhoea has an enlarged thyroid gland. The family history includes pheochromocytoma and hyperparathyroidism. The image shows a histopathological examination of the thyroid. Which marker is most valuable for monitoring this condition? (Q848973)

A. Serum TSH

B. Serum Calcitonin

C. Serum Thyroglobulin

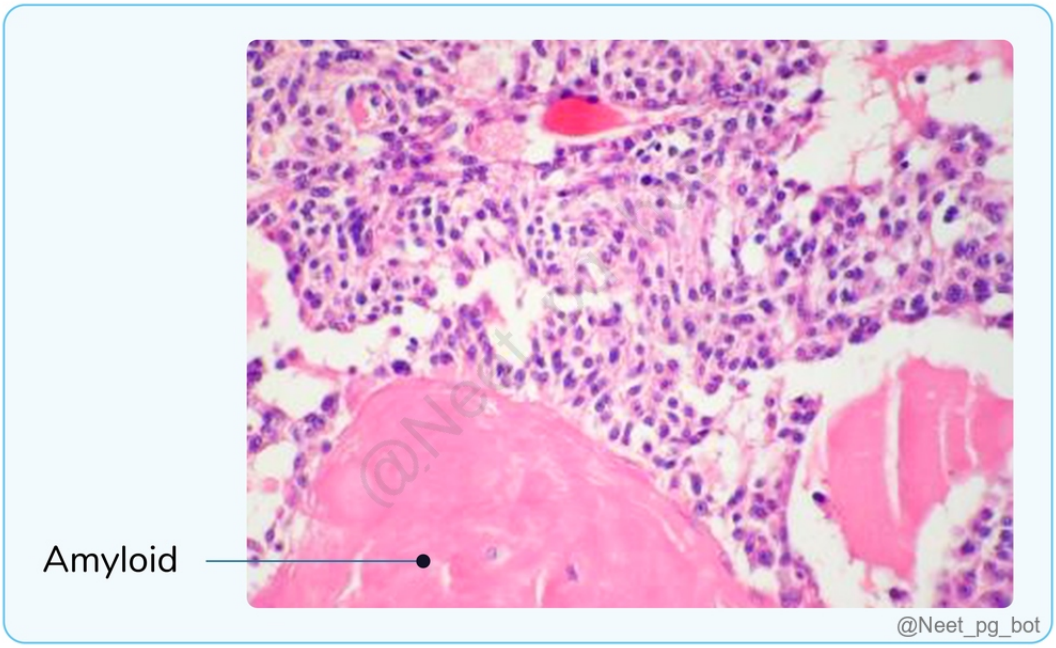
D. Serum PTH



Correct Answer: B. Serum Calcitonin

- *Listen (English)*
- *Listen (Hindi)*

Explanation: The clinical scenario with diarrhoea, enlarged thyroid with a family history of pheochromocytoma and hyperparathyroidism (MEN 2A syndrome), and HPE showing amyloid-rich stroma points towards Medullary carcinoma of the Thyroid (MTC). Arises from parafollicular C cells (C cells) in the thyroid, derived from the neural crest. Associated with MEN 2A and MEN 2B (RET Mutations). Clinical Features: Midline neck swelling, persistent diarrhea (due to serotonin), and flushing (due to histamine). Metastasis: Lymphatic and hematogenous spread, commonly to the liver. The tumor produces calcitonin, carcinoembryonic antigen (CEA), and chromogranin A. Serum calcitonin , a critical biomarker secreted by parafollicular cells , is used for diagnosis and monitoring; levels drop after surgery but rise with recurrence. Fine Needle Aspiration Cytology (FNAC) is the investigation of choice for diagnosis, characterized by an amyloid-rich stroma.



References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 870, 871

↑ *Back to this question in Part A*

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Q13: A 48-year-old female presents with a midline neck swelling which moves upwards when she swallows. On examination, the swelling is suspected to be related to the thyroid gland. What is the most likely anatomical structure responsible for this movement, and what is the clinical significance of this feature? (Q848954)

A. Prevertebral fascia - distinguishing thyroid masses from parathyroid masses

B. Pretracheal fascia - causes thyroid masses to move with swallowing

C. Investing layer of the deep cervical fascia - encloses both the thyroid and trachea

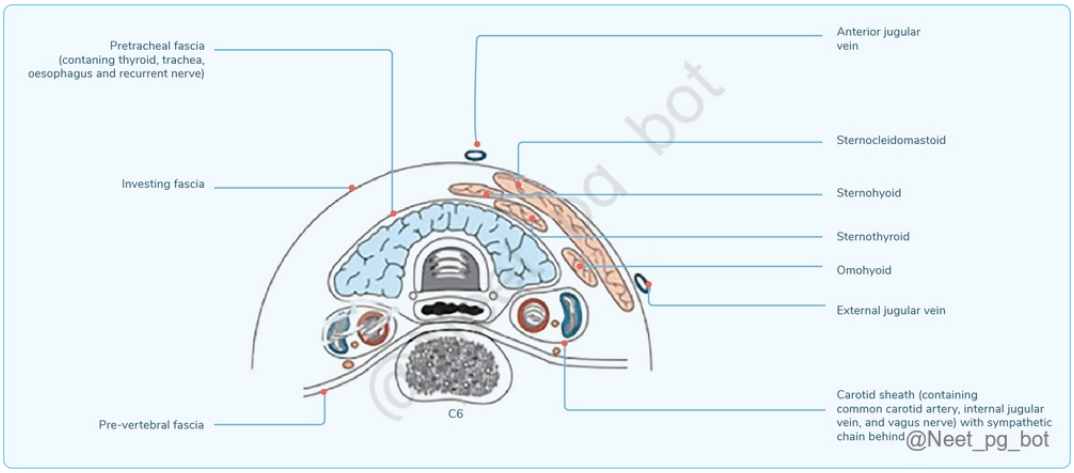
D. Superficial fascia - supports the thyroid gland's position in the neck

Correct Answer: B. Pretracheal fascia - causes thyroid masses to move with swallowing

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The pretracheal layer of deep cervical fascia : Encloses: Thyroid gland Trachea Esophagus Extends from: Hyoid bone → down into superior mediastinum Pretracheal fascia causes thyroid masses to move with swallowing It encloses the thyroid gland and allows it to move with the trachea during swallowing Berry's ligament also firmly connects the thyroid gland to the trachea, ensuring the gland moves with the trachea during swallowing. This anatomical relationship is useful in physical examinations to distinguish thyroid masses from other cervical masses. The prevertebral fascia (Option A) is a part of the deep cervical fascia that covers the prevertebral muscles and surrounds the vertebral column. It is located posteriorly in the neck, behind the pharynx, esophagus, and trachea. The investing layer of the deep cervical fascia (Option C) surrounds the entire neck and encloses the trapezius and sternocleidomastoid muscles. It provides a general covering for the deeper structures but does not explicitly enclose the thyroid gland. Superficial fascia (Option D) is a thin layer of connective tissue beneath the skin containing fat and superficial vessels. It does not enclose the thyroid gland or affect the movement of deeper structures like it.



References:

Bailey & Love’s Short Practice of Surgery, 28th edition, Page 785, 786

↑ *Back to this question in Part A*

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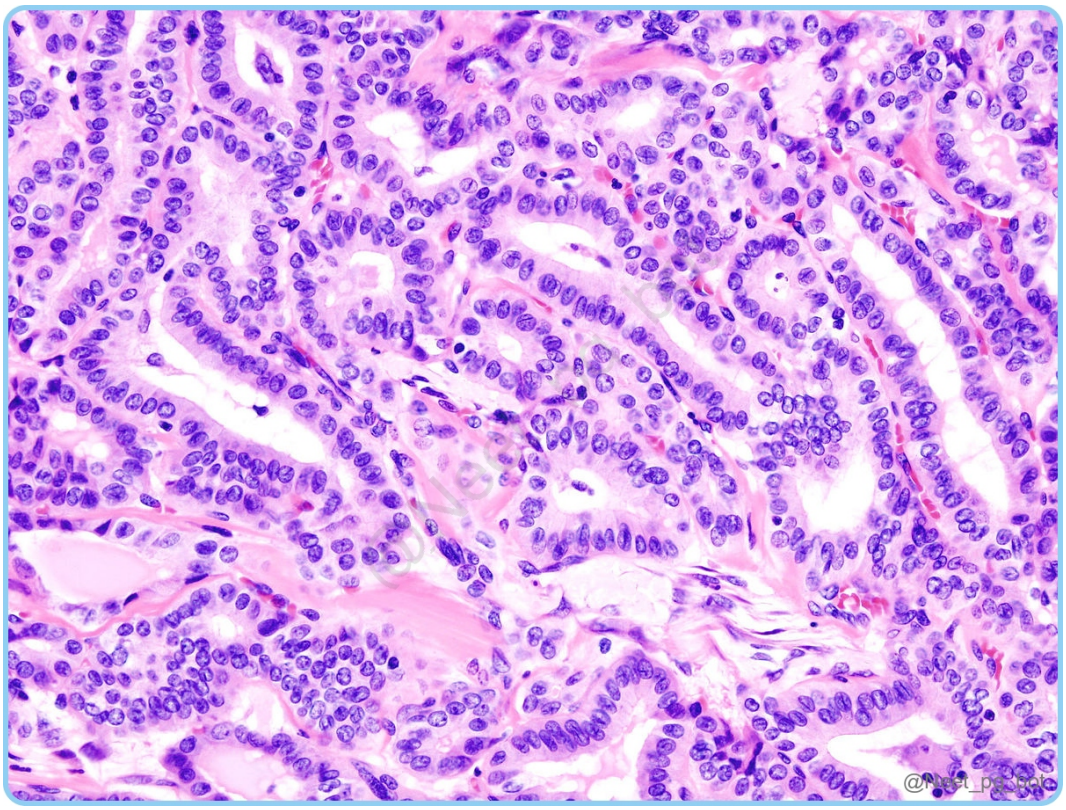
Q14: A 32 year old female patient presented with complaints of midline swelling in neck without any palpable lymph nodes. FNAC and biopsy revealed the image below. Which of the following should be the management of this condition ? (Q848968)

A. Thyroidectomy + Removal of enlarged lymph nodes

B. Thyroidectomy + Removal of enlarged lymph nodes + MRND

C. MRND

D. Thyroidectomy



Correct Answer: D. Thyroidectomy

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The given scenario is suggestive of Papillary thyroid carcinoma (PTC) without any enlarged lymph nodes, the treatment of choice should be thyroidectomy . If lymph node enlargement or metastasis is present, then total thyroidectomy along with the removal of enlarged group of lymph nodes with or without ipsilateral modified radical neck dissection (MRND) is done. (Option A, B, C) If no lymph node enlargement, or no metastasis is present, then, only thyroidectomy is done. Thyroidectomy Position: Rose position ("barking dog" position). Types : Total - entire gland is removed Near total -a small cuff of thyroid tissue is left behind Subtotal - a large cuff of thyroid tissue is left behind Lobectomy - only one lobe is removed Hemothyroidectomy - one lobe with isthmus is removed Incision: Kocher's transverse cervical collar incision. Sub-platysma Flap Elevation: Raised superiorly to the thyroid cartilage and inferiorly to the suprasternal notch. Exposure: Strap muscles are incised in the midline and retracted laterally to expose the thyroid gland. Nerve and Parathyroid Preservation: Identify and preserve the recurrent laryngeal nerve, superior laryngeal nerve, and parathyroid glands. Gland Mobilization by dividing superior, middle, and inferior thyroid vessels. Resection: Perform total or partial thyroidectomy as indicated. Hemostasis and Closure: Ensure hemostasis, place a drain if necessary, and close the wound in layers.

References:

Bailey & Love’s Short Practice of Surgery, 28th edition, Page 869, 870.

↑ *Back to this question in Part A*

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Q15: Which type of incision is typically used for thyroidectomy? (Q848966)

A. Killian’s incision

B. Gridiron incision

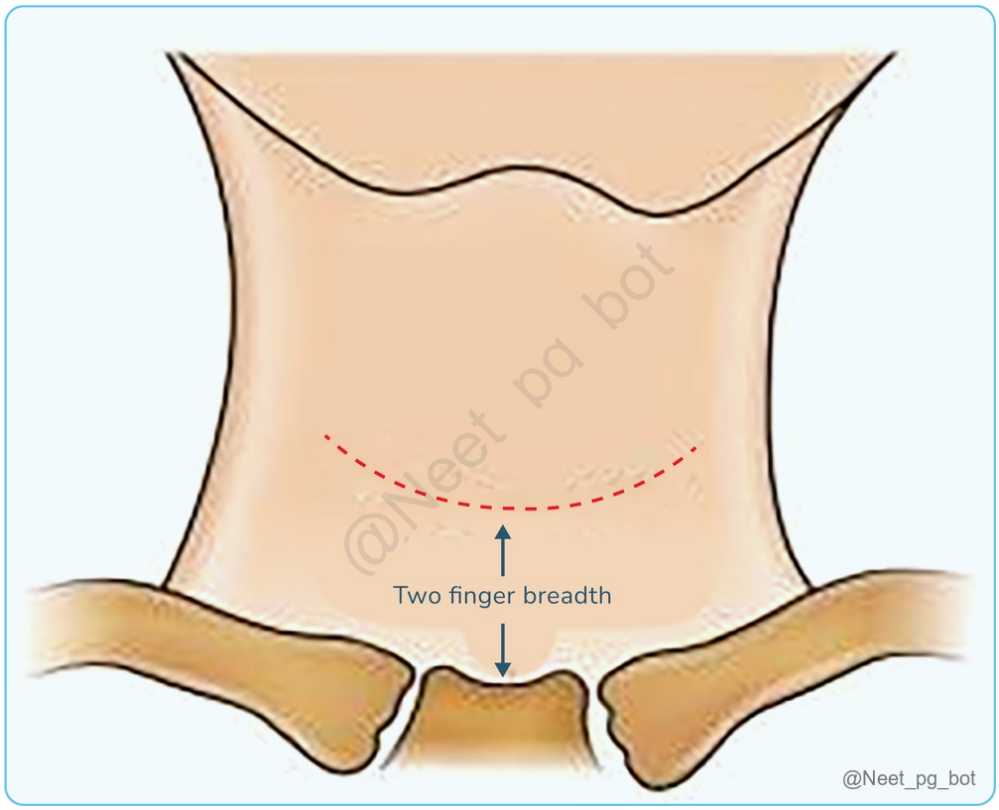
C. Lanz crease incision

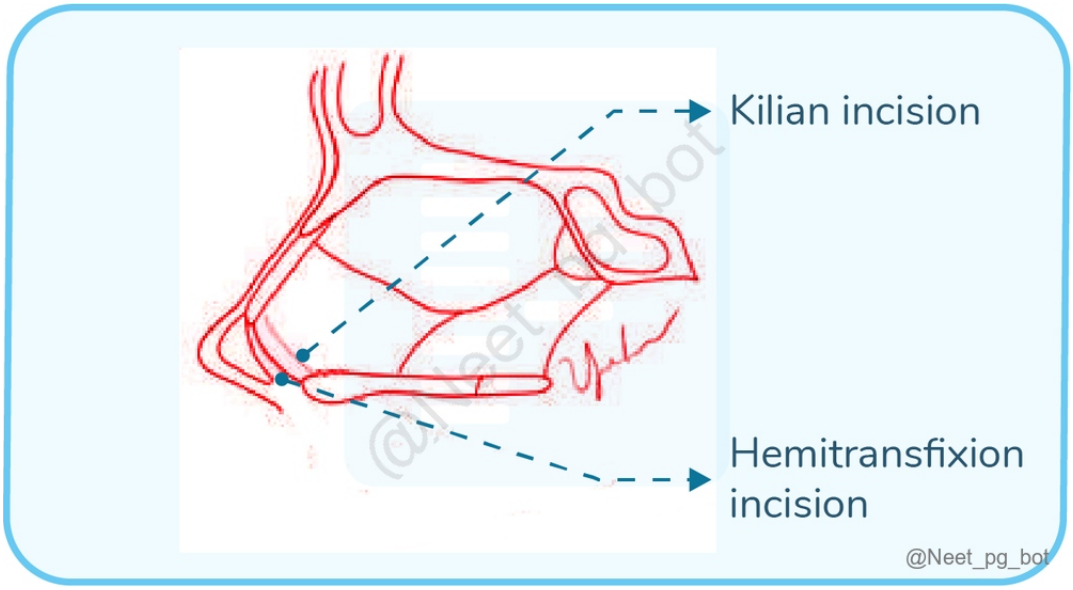
D. Kocher’s collar incision

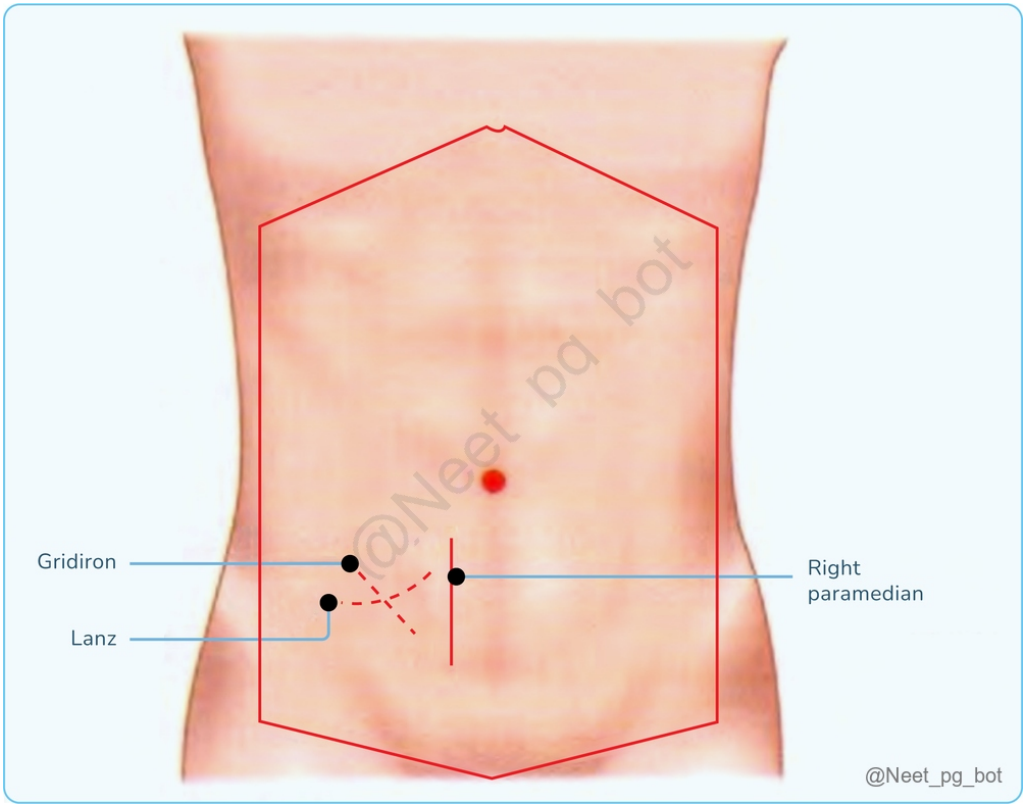
Correct Answer: D. Kocher’s collar incision

- *Listen (English)*
- *Listen (Hindi)*

Explanation: Kocher’s transverse cervical collar incision is made in thyroidectomy. It is a transverse incision made about 2 cm above the clavicles, extending across the front of the neck. This approach provides excellent access to the thyroid gland while minimising visible scarring. Killian’s incision (Option A): In septoplasty for a deviated septum, a curvilinear incision is made 2-3 mm above the caudal end of the septal cartilage on the concave side. Gridiron incision (Option B): In an appendectomy, Gridiron incision is made perpendicular to the right spinoumbilical line at the McBurney’s point. Lanz crease incision (Option C) is made centering at McBurney’s point, as shown above. It is also used in appendectomy and is cosmetically better than other incisions.







References:

Bailey & Love's Short Practice of Surgery, 28th edition, Page 98.

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Q16: A 56-year-old female patient with a history of long-standing goiter, presented with complaints of sudden, painless increase in the size of swelling of the neck. Biopsy revealed the presence of follicles suggestive of carcinoma. What is the most common site and route of metastasis in this condition? (Q848964)

A. Lungs, lymphatic

B. Liver, lymphatic

C. Bones, hematogenous

D. Liver, hematogenous

Correct Answer: C. Bones, hematogenous

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The history of long standing goiter, sudden, painless increase in size of swelling, biopsy showing follicles is suggestive of follicular carcinoma , in which the most common site of metastasis is bone, and the route is hematogenous. Lymphatic spread is not seen. Bone metastases are typically osteolytic. Most common sites: Flat bones, Vertebra (Thoracic vertebra) Thyroglobulin levels can be used to monitor patients for recurrence. Follicular thyroid carcinoma typically has a mortality rate about twice that of papillary thyroid carcinoma.

References:

Bailey & Love's Short Practice of Surgery, 28th edition Page 868, 869

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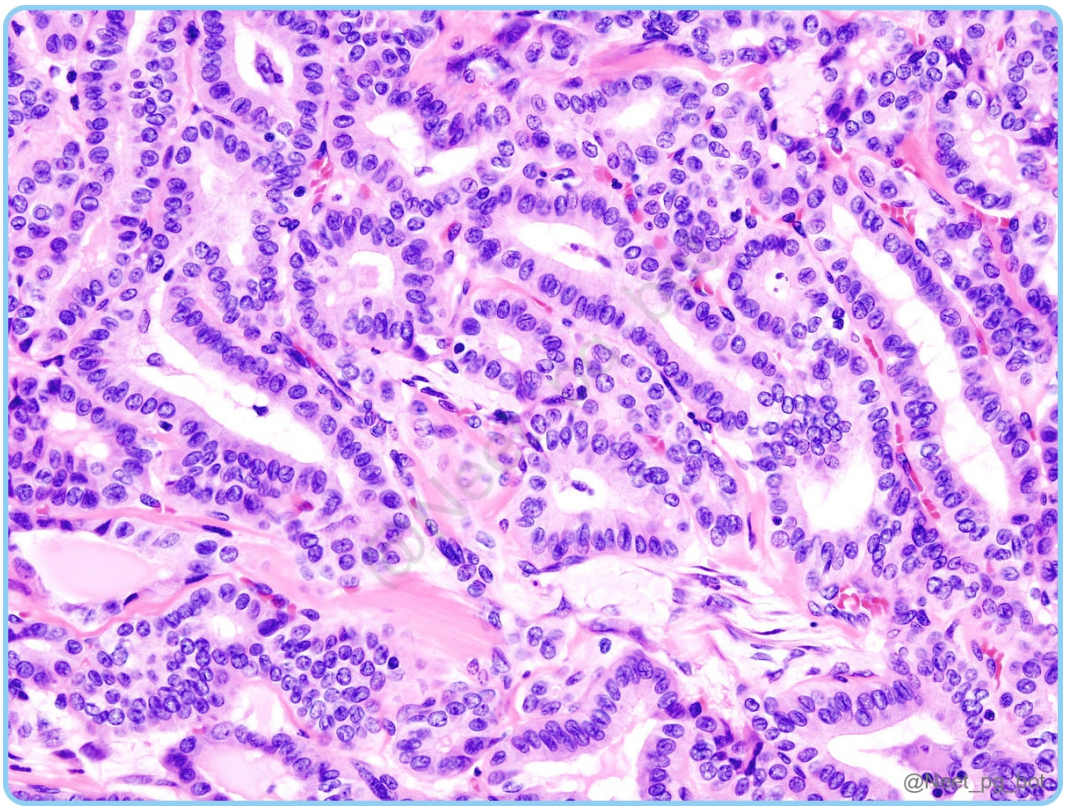
Q17: A 34-year-old female presents with neck swelling and a history of childhood neck irradiation for Hodgkin's lymphoma. On examination, a hard mass is found in the neck. FNAC confirms thyroid carcinoma with HPE image given below, what is the most likely diagnosis? (Q848963)

A. Follicular thyroid carcinoma

B. Medullary thyroid carcinoma

C. Anaplastic thyroid carcinoma

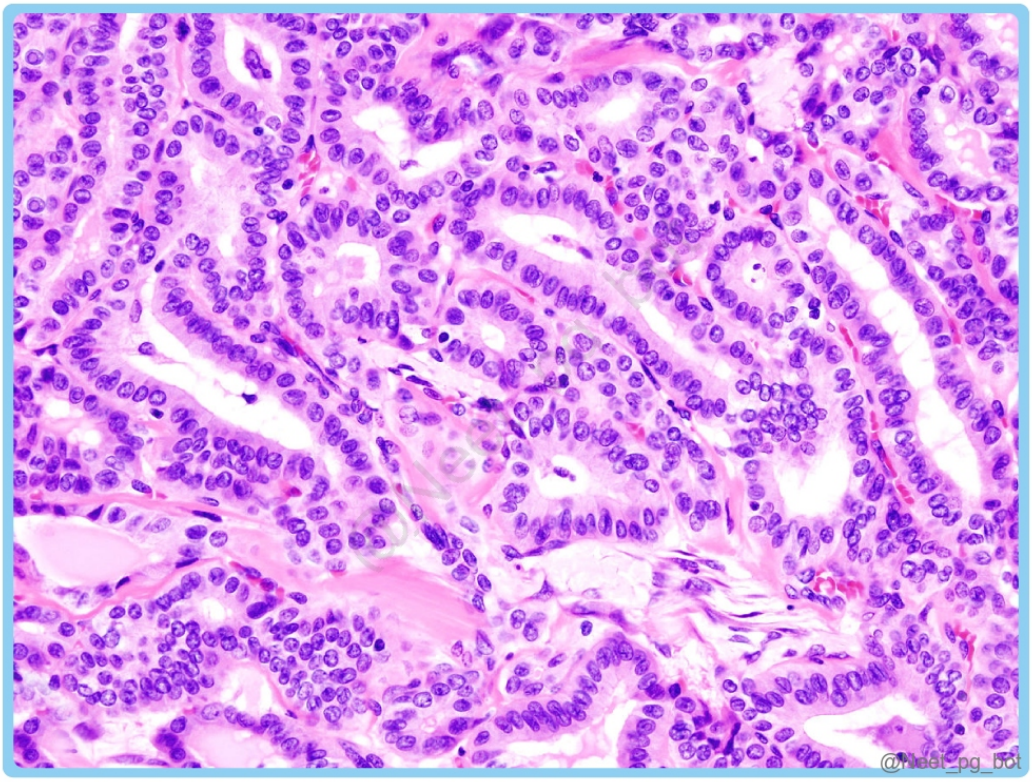
D. Papillary thyroid carcinoma



Correct Answer: D. Papillary thyroid carcinoma

- *Listen (English)*
- *Listen (Hindi)*

Explanation: The clinical scenario suggests P apillary Thyroid Carcinoma , which is common in the 3rd to 4th decade and often follows childhood irradiation. Origin: Follicular cells Genetics: BRAF, RET-PTC Risk factors: Radiation Thyroglossal cyst Hashimoto's thyroiditis Clinical Manifestations: Seen in the 3rd to 4th decade. Midline swelling in the anterior part of the neck Occasionally, lateral aberrant thyroid is seen. Metastasis: Lymphatic Characteristic histological features include: Papillary projections Optically clear nuclei (Orphan Annie eye nuclei) Pseudo-inclusion bodies Psammoma bodies (Dystrophic calcification). Follicular thyroid carcinoma (Option A): Less associated with radiation exposure and spreads hematogenously; HPE shows follicular cell architecture with capsular and/or vascular invasion, but lacks the nuclear features of papillary carcinoma. Medullary thyroid carcinoma (Option B): Arises from parafollicular C-cells, not follicular cells, and is associated with MEN 2 and elevated calcitonin; HPE shows nests or sheets of polygonal cells with amyloid stroma (Congo red positive). Anaplastic thyroid carcinoma (Option C): Highly aggressive tumor seen in the elderly, not young adults; HPE shows undifferentiated pleomorphic giant cells and spindle cells with high mitotic activity and necrosis, lacking any features of differentiated thyroid cancer.



References:

Bailey & Love's Short Practice of Surgery, 28th edition, Page 866-871.

↑ *Back to this question in Part A*

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Q18: A 58-year-old woman has a 5 cm thyroid tumour with extrathyroidal extension, cervical lymphadenopathy, and no distant metastasis. Based on the TNM staging system, what is the most accurate classification for this patient? (Q848959)

A. T3b N1 M0

B. T4 N1 M1

C. T4 N1 M0

D. T2 N0 M0

Correct Answer: C. T4 N1 M0

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: T4 indicates extensive extrathyroidal extension , N1 signifies regional lymph node involvement , and M0 denotes no distant metastasis. TNM Staging of Thyroid Carcinoma Category Description T (Primary Tumor) T1 Tumor ≤ 2 cm, limited to the thyroid. Tumor ≤ 1 cm, limited to the thyroid. Tumor > 1 cm but ≤ 2 cm, limited to the thyroid. T2 Tumor > 2 cm but ≤ 4 cm, limited to the thyroid. T3 Tumor > 4 cm, limited to the thyroid or minimal extrathyroidal extension. Tumor > 4 cm, limited to the thyroid. Tumor with minimal extrathyroidal extension (e.g., strap muscles). T4 Tumor of any size with extensive extrathyroidal extension. T4a Tumor invades subcutaneous soft tissues, larynx, trachea, oesophagus, or recurrent laryngeal nerve. T4b Tumor invades prevertebral fascia or encases carotid artery or mediastinal vessels. N (Regional Lymph Nodes) N0 No regional lymph node metastasis. N1 Regional lymph node metastasis. N1a Metastasis to level VI or VII lymph nodes (pre-tracheal, paratracheal, and prelaryngeal). N1b Metastasis to unilateral, bilateral, or contralateral cervical or superior mediastinal lymph nodes. M (Distant Metastasis) M0 No distant metastasis. M1 Distant metastasis present.

References:

Sabiston’s Textbook of Surgery, 21st Edition, Page 902, 903.
https://www.researchgate.net/figure/3-TNM-Staging-for-Thyroid-Neoplasms_tbl2_260267435

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@Neet_pg_bot

Q19: All the following forms the boundaries of Beahrs' triangle except? (Q848958)

A. Common Carotid Artery

B. Inferior Thyroid Artery

C. Recurrent Laryngeal Nerve

D. Superior Thyroid Artery

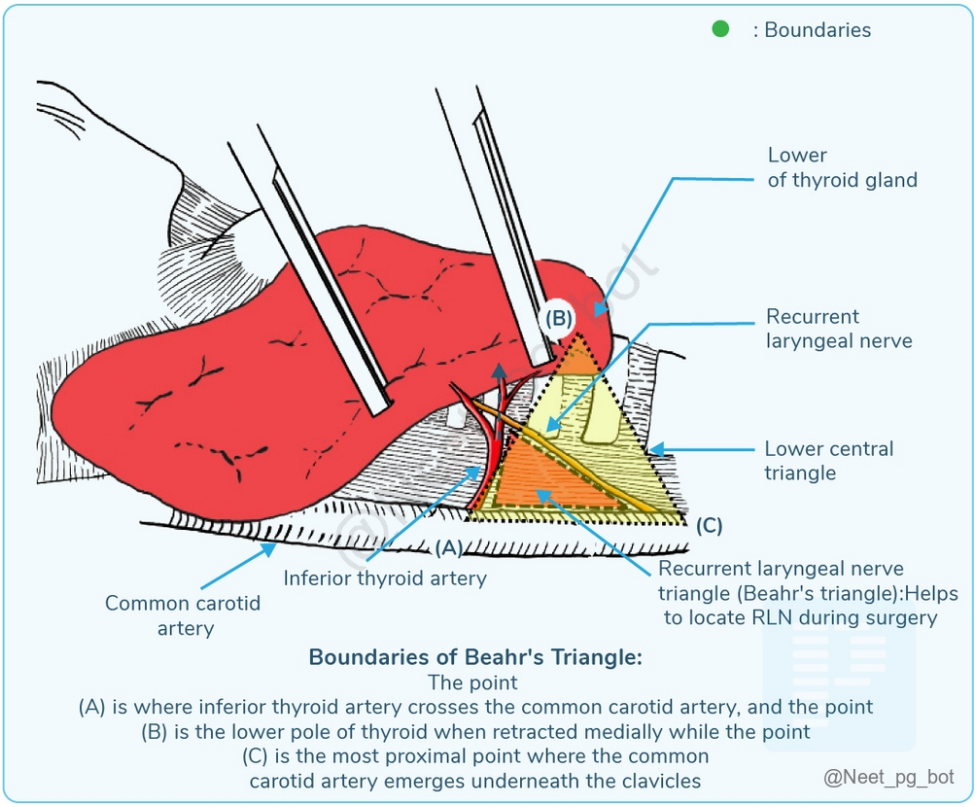
Correct Answer: D. Superior Thyroid Artery

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The superior thyroid artery does not form the boundary of the Beahr triangle. Beahrs' triangle: Boundaries : Medially: Recurrent laryngeal nerve (RLN) Ascends in the tracheoesophageal groove Closely related to the inferior thyroid artery Enters the larynx at the cricothyroid joint Injury leads to hoarseness, vocal cord paralysis Laterally: Common carotid artery Lies lateral to the trachea and thyroid gland Enclosed within the carotid sheath No branches in the neck (till bifurcation) Serves as an important lateral landmark in neck surgery Superiorly: Inferior thyroid artery Branch of thyrocervical trunk (from subclavian artery) Runs horizontally and then medially towards the thyroid Crosses behind the carotid sheath Closely related to RLN Supplies the inferior pole of the thyroid and parathyroids Significance : It helps surgeons avoid injury to critical structures, particularly the recurrent laryngeal nerve (RLN), during thyroid and parathyroid surgeries Superior Thyroid Artery (Option D)

is a branch of the external carotid artery and supplies the upper pole of the thyroid. It is closely related to the external laryngeal nerve, and it is not a part of Beahrs' triangle boundary



References:

Bailey & Love's Short Practice of Surgery 28th Edition Page 852

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Q20: A 60-year-old male undergoes a total thyroidectomy for a large multinodular goitre. Postoperatively, he experiences hoarseness and difficulty speaking. Which anatomical site is most commonly associated with this nerve injury during thyroidectomy? (Q848957)

A. Right subclavian artery

B. Arch of the aorta

C. Berry's ligament

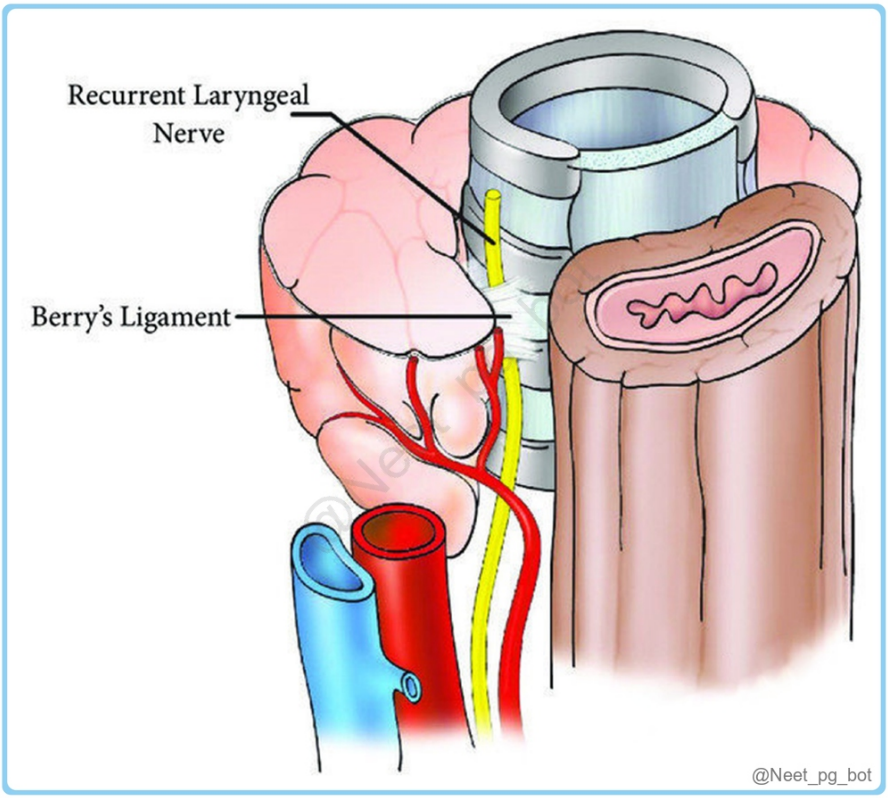
D. Tubercle of Zuckerkandl

Correct Answer: C. Berry’s ligament

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: One of the most commonly nerve injured during thyroidectomy is the Recurrent laryngeal nerve (RLN), a branch of the vagus nerve. Berry’s ligament is the most common site of RLN injury during thyroidectomy because the nerve is directly associated with this region as it enters the larynx. The RLN provides motor innervation to all intrinsic muscles of the larynx (except the cricothyroid muscle , which is innervated by the external branch of the superior laryngeal nerve). It controls the vocal cords, playing a crucial role in voice production and airway protection. The RLN loops around the right subclavian artery, but this is generally not the site of most common RLN injuries during thyroid surgery (Option A) The left RLN loops under the arch of the aorta before ascending to the larynx. Injury to this nerve can occur with excessive manipulation or dissection around the aortic arch, but it is less common than injury at the level of Berry's ligament (Option B)



References:

Bailey & Love’s Short Practice of Surgery, 28th Edition, Page 865.

↑ *Back to this question in Part A*

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Q21: During thyroid surgery on a patient, significant bleeding occurs near the superior pole of the thyroid gland. Which vessel branches from the artery supplying this region? (Q848955)

A. Common carotid artery

B. Subclavian artery

C. External carotid artery

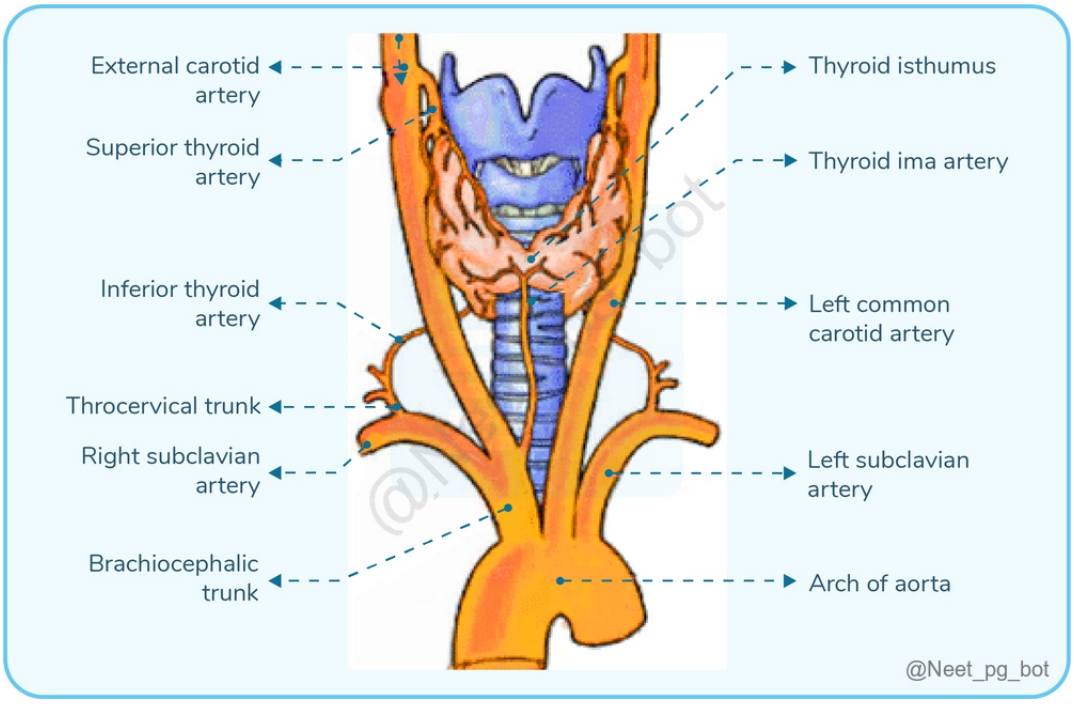
D. Brachiocephalic trunk

Correct Answer: C. External carotid artery

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The superior pole of the thyroid is supplied by the Superior thyroid artery , a branch of the External carotid artery. Arterial supply of thyroid gland : Artery Origin Supply Superior Thyroid Artery External carotid artery The superior pole of the thyroid gland, thyroid isthmus, larynx, and surrounding tissues Inferior Thyroid Artery Thyrocervical trunk (branch of the subclavian artery) Inferior pole of the thyroid gland Thyroidea Ima Artery Variable (may arise from the brachiocephalic trunk, common carotid artery, or aortic arch) Provides additional blood supply to the thyroid gland.



References:

Bailey & Love’s Short Practice of Surgery, 28th Edition, Page 850, 851.

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• [07_Endocrine Surgery] 045 Parathyroid And Adrenal Glands - I

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[07_Endocrine Surgery] 045 Parathyroid And Adrenal Glands - I — Quick Jump

Q1 (p. 2871)	*Q2 (p. 2872)*	*Q3 (p. 2873)*	*Q4 (p. 2873)*	*Q5 (p. 2874)*	*Q6 (p. 2875)*
Q7 (p. 2876)	*Q8 (p. 2878)*	*Q9 (p. 2878)*	*Q10 (p. 2879)*	*Q11 (p. 2880)*	*Q12 (p. 2881)*
Q13 (p. 2882)	*Q14 (p. 2884)*	*Q15 (p. 2885)*	*Q16 (p. 2886)*	*Q17 (p. 2887)*	*Q18 (p. 2888)*
Q19 (p. 2889)	*Q20 (p. 2891)*	*Q21 (p. 2893)*			

Q1: A 45-year-old woman presents with a large adrenal mass discovered incidentally on imaging. The tumor measures 12 cm and shows irregular borders with central necrosis. She exhibits symptoms of Cushing syndrome. What is the most likely diagnosis for this adrenal mass? (Q848874)

A. Benign Cortical Adenoma

B. Adrenal Myelolipoma

C. Adrenocortical Carcinoma

D. Aldosterone-Producing Adenoma

Correct Answer: C. Adrenocortical Carcinoma

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Adrenocortical Carcinoma: Characterized by large tumor size (typically >9 cm), irregular borders, and the presence of central necrosis, which matches the clinical scenario. Adrenocortical carcinoma often presents with hormone overproduction and significant local invasion or metastases. Common presentations include Cushing syndrome (M/C) and virilization. Adrenocortical tumor arises from the retroperitoneum. Whenever there is a retroperitoneal mass or pathology involved, the IOC is CECT. CT shows a heterogeneous mass with irregular borders, central necrosis, and invasion of adjacent structures. Possible metastases to lymph nodes, liver, and lungs.



References:

Sabiston Textbook of surgery, 21st edition, Pg 980-981

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@Neet_pg_bot

Q2: Which of the following is not an indication for surgery in an asymptomatic patient with primary hyperparathyroidism? (Q848886)

A. Serum calcium level 0.25 mmol/L above the upper limit of normal

B. DEXA T score of -2.5 at the lumbar spine

C. Creatinine clearance <60 mL/min

D. Age >60 years

Correct Answer: D. Age >60 years

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Indications of surgery in an asymptomatic case with primary hyperparathyroidism are: Serum calcium 0.25 mmol/L (1.0 mg/dL) above the upper limit of normal (Option A) Bone mineral density (BMD) by DEXA; T score –2.5 at lumbar spine (Option B) , total hip, femoral neck, or distal one-third of radius Vertebral fracture Creatinine clearance <60 mL/min (Option C) 24-hour urinary calcium >10 mmol/dL (>400 mg/day) or increased risk of stone formation by risk analysis Age <50 years (Option D) When medical therapy is not possible

References:

Bailey & Love's Short Practice of Surgery, 28th edition, pg: 876, 879. SRBs Manual of Surgery, 6th edition, pg: 493. https://www.ncbi.nlm.nih.gov/books/NBK563274/ https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6935782/

↑ *Back to this question in Part A*

@Neet_pg_bot

Q3: Which of the following statements is TRUE regarding olfactory neuroblastoma? (Q848885)

A. Benign tumor arising from the squamous epithelium of the nasal cavity.

B. Presents as a bilateral mass in the lower nasal cavity.

C. Causes anosmia and nasal obstruction due to a unilateral polypoidal mass.

D. Treated with chemotherapy alone, with no surgical excision.

Correct Answer: C. Causes anosmia and nasal obstruction due to a unilateral polypoidal mass.

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: It is a rare malignant neoplasm of the sinonasal tract that arises from the olfactory neuroepithelium with neuroblastic differentiation (Option A) Most often present in the superior nasal cavity . (Option B) Olfactory neuroblastoma or esthesioneuroblastoma causes a unilateral nasal obstruction and anosmia as it causes a unilateral polypoidal mass . (Option C) Treatment : Surgical excision followed by radiotherapy (Option D)

References:

https://www.ncbi.nlm.nih.gov/books/NBK539694/

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@Neet_pg_bot

Q4: A mother brought her 2-year-old child as she noticed he is unable to completely open his eyes and that there is a limp in his walk. On examination, there is a mass in the abdomen and miosis and anhidrosis in the eyes. A biopsy confirms neuroblastoma. What would be the laboratory findings in this case? (Q848884)

A. Raised 24 hr urinary catecholamines

B. Low serum LDH

C. Low neuron specific enolase

D. Thrombocytopenia

Correct Answer: A. Raised 24 hr urinary catecholamines

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Neuroblastoma secretes catecholamines which increases the excretion and hence can be seen raised in the 24 hour urine sample Laboratory evaluation includes: CBC: thrombocytosis (Option D) 24-hour urinary sample: Raised catecholamines (Option A) Renal function Liver function Electrolytes LDH: high (Option B) CT scan of abdomen & pelvis: calcification and metastasis MRI spine: for Horner's syndrome or cord compression Skeletal surveys Baseline ECG and echocardiogram Increased Neuron-specific enolase (Option C) Biopsy and histology: Small round pale blue cells, known as Homer-Wright pseudorosettes, are seen.

References:

Sabiston textbook of surgery, 21st edition, pg: 1637. Baile & Love's short practice of surgery, 28th edition, pg:902. https://www.ncbi.nlm.nih.gov/books/NBK448111/

↑ *Back to this question in Part A*

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Q5: A child of 2 years is brought to the hospital with an abdominal mass that has grown from the right to the center of the abdomen for a few months. The child has urinary symptoms and bluish-purple discoloration around the eyes. What is the most probable diagnosis? (Q848883)

A. Pheochromocytoma

B. Adrenocortical carcinoma

C. Paraganglioma

D. Neuroblastoma

Correct Answer: D. Neuroblastoma

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: A 2-year-old child presenting with a progressively enlarging abdominal mass that crosses the midline , along with urinary symptoms and bluish-purple discoloration around the eyes (raccoon eyes) , is highly suggestive of neuroblastoma . Neuroblastoma is the most common extracranial solid tumor in children , arising

from neural crest cells of the sympathetic nervous system , most commonly from the adrenal medulla . The abdominal mass in neuroblastoma is typically irregular, firm, and crosses the midline , which helps differentiate it from other pediatric abdominal tumors. The presence of periorbital ecchymosis (raccoon eyes) indicates metastasis to the orbit , which is a classical and high-yield feature. Urinary symptoms occur due to compression of adjacent structures . On investigation, neuroblastoma shows elevated urinary catecholamine metabolites (VMA and HVA) , which are important diagnostic markers. Prognosis depends on factors such as age (better if <1 year) and N-MYC amplification (poor prognosis) . Pheochromocytoma (Option A) is a tumor of the adrenal medulla that presents with hypertension, headache, sweating, and palpitations due to catecholamine excess. It is more common in adults and does not present with large abdominal masses crossing midline or raccoon eyes . Adrenocortical carcinoma (Option B) arises from the adrenal cortex and typically presents with hormonal manifestations such as Cushing's syndrome or virilization . It does not cause periorbital ecchymosis and is less likely to present with these classical features in a young child. Paraganglioma (Option C) is an extra-adrenal catecholamine-secreting tumor , presenting with symptoms similar to pheochromocytoma . It does not present with abdominal mass crossing midline or orbital metastasis (raccoon eyes) .



References:

Sabiston textbook of surgery, 21st Edition, Pages 981,1871.

Baile & Love's short practice of surgery, 28th Edition, Pages 898, 902

https://www.ncbi.nlm.nih.gov/books/NBK448111/

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Q6: A 55-year-old patient is diagnosed with malignant pheochromocytoma after presenting with persistent hypertension and elevated plasma metanephrines. Imaging

reveals metastasis to various sites. Which of the following is not a common site for metastasis? (Q848881)

A. Liver

B. Brain

C. Lungs

D. Kidney

Correct Answer: B. Brain

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Brain is not a common site for metastasis in malignant pheochromocytoma. Malignant Pheochromocytoma Tumors that have undergone metastasis to Lymph-node (or) Distant site (Biochemically same as Pheochromocytoma) Survival Rate 5-year survival ranges from 20% to 45%. Criteria of Malignancy Malignancy is defined by the development of metastases Common Sites of Metastasis Axial skeleton, lymph nodes, liver, lung, and kidney. (Option A,C,D) Diagnosis MIBG & Gallium Dotate is Best for Diagnosis Biopsy & FNAC are avoided in Malignant Pheochromocytoma Confirmed by the presence of metastases in locations where neuroectodermal tissues are not normally found. This is the primary criterion distinguishing malignant pheochromocytomas from benign ones, as histopathologic features alone are not reliable in predicting malignancy. Histopathologic Criteria No histopathologic criteria can accurately predict the clinical course of malignancy. Primary Treatment Surgical resection, even if not curative, can offer significant palliative benefits by managing mass effects and reducing catecholamine excess. Response to Radiotherapy/Chemotherapy Minimal response to radiotherapy and chemotherapy. Liver (Option A) is one of the most common metastatic sites for malignant pheochromocytoma. Hematogenous spread to liver is frequently observed. Lungs (Option C): Pulmonary metastases are also very common due to hematogenous dissemination and are often found during staging. Kidney (Option D) involvement may occur by local extension or metastasis, and while not the most common, it is still more frequent compared to brain involvement.

References:

Bailey & Love Short practice of surgery, 28th Edition, Page 902

Sabiston Textbook of Surgery, 21st Edition, Page 986

www.sciencedirect.com/topics/immunology-and-microbiology/neuroectoderm#

www.ncbi.nlm.nih.gov/pmc/articles/PMC8175409/

↑ *Back to this question in Part A*

@Neet_pg_bot

Q7: A 30-year-old woman in her 24th week of pregnancy presents with severe headaches, palpitations, and paroxysmal hypertension. Laboratory investigations reveal elevated plasma metanephrines, and imaging confirms the presence of a pheochromocytoma. Which of the following is the most appropriate management strategy for this patient? (Q848880)

A. Use phenoxybenzamine and plan laparoscopic adrenalectomy in the second trimester.

B. Wait until the third trimester, use Labetalol to control BP, and perform a C-section followed by adrenalectomy.

C. Use calcium channel blockers and plan for surgical resection postpartum.

D. Perform immediate open adrenalectomy.

Correct Answer: A. Use phenoxybenzamine and plan laparoscopic adrenalectomy in the second trimester.

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: For pregnant patients diagnosed with pheochromocytoma, it is essential to initiate α-blockade with phenoxybenzamine to control hypertension and reduce catecholamine excess. Laparoscopic adrenalectomy is typically recommended during the second trimester as it minimizes the risks to both the mother and fetus. Management of Pheochromocytoma Biochemical Diagnosis Identify pheochromocytoma using biochemical tests and imaging for localization. Preoperative Preparation Start with an α-adrenoceptor blocker like phenoxybenzamine. Adjust the dose to 100-160 mg/day to achieve postural hypotension. Add β-blockers if necessary after α-blockade to manage tachycardia. Other regimens include α-blockade with doxazosin or prazosin, with and without β-blockers, calcium channel blockers alone, and using catecholamine synthesis blocker metyrosine in cardiac failure. Surgery Laparoscopic Adrenalectomy : Preferred for PCC unless tumor >10 cm or malignant signs are present. Open Surgery : Recommended for large tumors or those along the sympathetic chain. Postoperative Care Monitor for hypovolemia and hypoglycemia for 24 hrs post-surgery. Conduct annual biochemical tests for recurrence. Malignant Pheochromocytoma Perform surgical excision , possibly with en bloc resection for invasive tumors. Consider adjuvant therapies like radiolabeled MIBG and octreotide. Pheochromocytoma in Pregnancy First/Second Trimester : Implement α-blockade, then proceed with laparoscopic adrenalectomy. Third Trimester : Plan for an elective C-section followed by adrenalectomy 6 weeks later. Other options: Option B: Wait until the third trimester and use labetalol, then perform C-section + adrenalectomy Deferring surgery until the third trimester increases maternal mortality from uncontrolled catecholamine surges. Labetalol alone is inadequate because β-blockade without prior α-blockade can worsen hypertension (“unopposed α-stimulation”). C-section first, adrenalectomy later is considered only if tumor is diagnosed very late in pregnancy or second-trimester surgery is not feasible. Option C: Use calcium channel blockers and operate postpartum Calcium channel blockers may be adjuncts, not definitive therapy. Postponing adrenalectomy until postpartum exposes the mother and fetus to dangerous hypertensive crises. Option D: Immediate open adrenalectomy Not indicated unless hemodynamic instability persists despite optimal α-blockade. Emergency open adrenalectomy carries very high fetal risk. Controlled α-blockade first is essential.

References:

Bailey & Love’s Short Practice of surgery, 28th Edition, Page 901

↑ *Back to this question in Part A*

@Neet_pg_bot

Q8: A 33-year-old man presents with a history of paroxysmal hypertension, palpitations, headaches, and sweating. Initial plasma-free metanephrine testing returns positive results. What is the most appropriate next step in the investigation of this patient's condition to confirm the diagnosis? (Q848878)

A. Performing an MIBG (metaiodobenzylguanidine) scan

B. Performing a 24-hour urine collection for metanephrines

C. Conducting a clonidine suppression test

D. Ordering a CT/MRI scan of the abdomen

Correct Answer: D. Ordering a CT/MRI scan of the abdomen

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: This patient’s symptoms (paroxysmal hypertension, palpitations, headaches, sweating) and positive plasma-free metanephrines indicate a strong biochemical suspicion for pheochromocytoma . Once plasma metanephrines are clearly positive , the biochemical diagnosis is considered confirmed , and the appropriate next step is localization of the tumor . The first-line imaging modality is CT or MRI of the abdomen to identify an adrenal or extra-adrenal mass. Performing an MIBG scan (Option A): MIBG scanning is reserved for cases where CT/MRI is inconclusive , extra-adrenal disease is suspected, or metastatic disease needs evaluation. Performing a 24-hour urine collection for metanephrines (Option B): Urinary metanephrines are an alternative initial test , not required once plasma metanephrines are already positive. Conducting a clonidine suppression test (Option C): Clonidine suppression is used only when plasma metanephrine levels are borderline or equivocal, not when results are already clearly positive.

References:

Sabiston Surgery Textbook of Surgery, 21st Edition Page no: 982

↑ *Back to this question in Part A*

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Q9: A 35-year-old woman presents with episodes of severe headaches, palpitations, and sweating. Imaging reveals a large adrenal mass and biochemical tests confirm elevated plasma metanephrines. Further genetic testing shows a mutation in the SDHB gene. Which of the following genetic syndromes is most likely associated with her condition? (Q848877)

A. MEN 2 Syndrome

B. Hereditary Paraganglioma-Pheochromocytoma Syndrome (HPPS)

C. Von Hippel–Lindau Disease (VHL)

D. Neurofibromatosis Type 1 (NF1)

Correct Answer: B. Hereditary Paraganglioma-Pheochromocytoma Syndrome (HPPS)

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The presence of an SDHB gene mutation, along with symptoms of severe headaches, palpitations, sweating, imaging showing a large adrenal mass, and elevated plasma metanephrines, is most consistent with Hereditary Paraganglioma-Pheochromocytoma Syndrome (HPPS). It encompasses germline mutations in several genes, including SDH subunits. SDHB mutations are particularly noted for their association with high rates of malignant pheochromocytomas and extra-adrenal tumors. These mutations lead to the accumulation of Krebs cycle intermediates, promoting tumorigenesis. Patients with SDHB mutations are at high risk for malignant extra-adrenal (abdominal or thoracic) tumors , making it the most likely syndrome in this clinical scenario.

References:

Bailey & Love Short practice of surgery, 28th Edition Page no: 899 Sabiston Textbook of Surgery, 21st Edition Page no: 986

↑ *Back to this question in Part A*

@Neet_pg_bot

Q10: A 52-year-old patient presents with intermittent episodes of hypertension, headache, and sweating. After conducting a series of tests, the diagnosis points toward an extra-adrenal pheochromocytoma. What is the most common site for an extra-adrenal pheochromocytoma? (Q848876)

A. Adrenal medulla

B. Organ of Zuckerkandl

C. Parotid gland

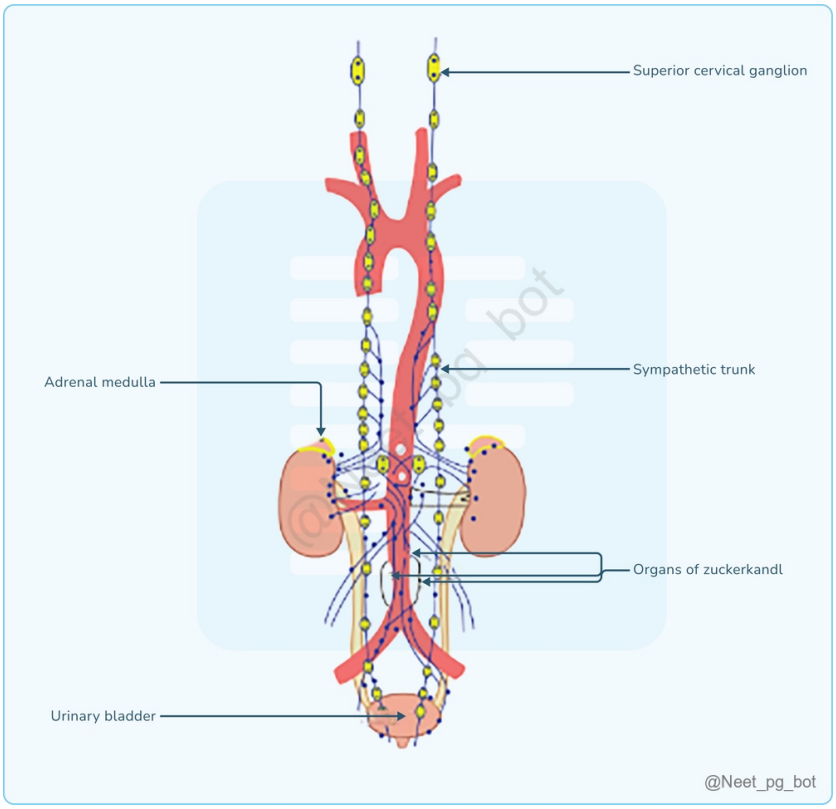
D. Pancreas

Correct Answer: B. Organ of Zuckerkandl

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The Organ of Zuckerkandl is the m/c site for extra-adrenal pheochromocytomas and sympathetic paragangliomas. It is located near the aortic bifurcation or close to the origin of the inferior mesenteric artery and often serves as a site for these tumors outside the adrenal glands. M/c site of parasympathetic paraganglioma is the carotid body.



References:

Sabiston Textbook of Surgery, 21st Edition Page no: 984,985 Bailey & Love Short practice of surgery, 28th Edition Page no: 852;889;899 https://www.ncbi.nlm.nih.gov/books/NBK549834/

↑ *Back to this question in Part A*

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Q11: A 48-year-old man presents with episodic symptoms of severe headache, palpitations, and profuse sweating. His laboratory tests reveal elevated plasma metanephrines, and a CT scan identifies a vascular adrenal mass. Which of the following statements accurately describes the nature of this adrenal mass? (Q848875)

A. Primarily secretes ACTH, causing continuous hypertension.

B. It intermittently releases catecholamines, leading to episodes of headache, palpitations, and sweating.

C. Presents with chronic, steady symptoms without significant paroxysms.

D. Usually non-vascular and causes minimal clinical symptoms.

Correct Answer: B. It intermittently releases catecholamines, leading to episodes of headache, palpitations, and sweating.

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Pheochromocytomas cause episodic symptoms due to intermittent bursts of catecholamines, Adrenaline and Noradrenaline , classically resulting in paroxysms of headache, palpitations, and sweating, aligning with the patient's presentation . Pathophysiology of Pheochromocytomas: Catecholamine Production: Tyrosine is converted to dihydroxyphenylalanine (DOPA) by tyrosine hydroxylase, then to dopamine, norepinephrine, and finally epinephrine, with PNMT (phenylethanolamine-N-methyltransferase) catalyzing the final step. (Option A) Storage: Catecholamines are stored in vesicles and released into circulation. Release: Pheochromocytomas release catecholamines in paroxysmal, continuous, or mixed patterns, leading to persistent hypertension (norepinephrine) or tachyarrhythmias (epinephrine). (Option C) Epinephrine and Norepinephrine bind to adrenoceptors with varying affinities. Pheochromocytomas are highly vascular and are associated with significant clinical symptoms due to the excessive production of catecholamines. (Option D)

References:

Bailey & Love Short practice of surgery, 28th Edition Page no: 900 Sabiston Textbook of Surgery, 21st Edition Page no: 981 https://www.ncbi.nlm.nih.gov/books/NBK589700/

↑ *Back to this question in Part A*

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Q12: A 45-year-old patient with h/o chronic kidney disease is found to have elevated serum calcium levels. Which of the following actions of parathyroid hormone (PTH) is most directly responsible for increasing serum calcium levels? (Q848840)

A. Inhibition of calcium reabsorption in the kidneys.

B. Stimulation of 1,25-dihydroxyvitamin D production.

C. Decreased intestinal calcium absorption.

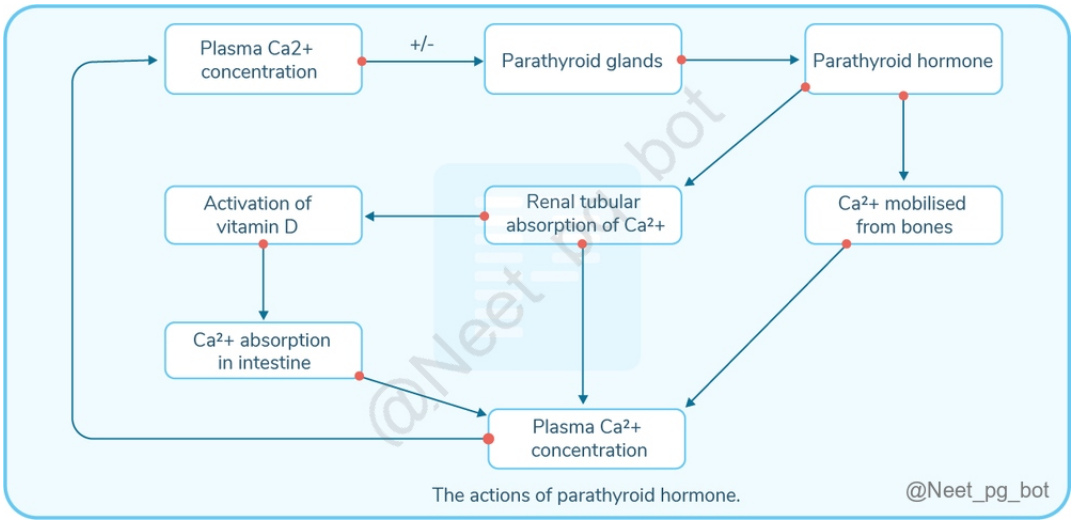
D. Promotion of bone mineralization.

Correct Answer: B. Stimulation of 1,25-dihydroxyvitamin D production.

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Parathyroid hormone (PTH) stimulates the production of 1,25-dihydroxyvitamin D (active vitamin D) in the kidneys, which enhances intestinal calcium absorption, thereby increasing serum calcium levels. Role of Parathyroid Glands : Regulate serum calcium levels through parathyroid hormone (PTH). PTH Secretion : Triggered by low calcium or high magnesium levels . Initially cleaved in the liver yielding an active N-terminal fragment, that has a 3-5 minute half-life. PTH Action : Kidneys: Increases serum calcium by increasing resorption from renal tubules (Option A) and by activating 25-hydroxyvitamin D to 1,25-dihydroxy vitamin D (active form). (Option B) Bone : Stimulates osteoblasts and osteoclasts to increase bone turnover , thereby increasing serum calcium. (Option D) GI Tract: Enhances calcium absorption through active vitamin D. (Option C)



The actions of parathyroid hormone.

References:

Bailey & Love Short practice of surgery, Edition 28, page no:873-875 Schwartz’s principles of surgery, Edition 11, page no:1164

↑ *Back to this question in Part A*

@Neet_pg_bot

Q13: A 55-year-old woman undergoes a routine abdominal CT scan for an unrelated issue. The scan reveals a 2.5 cm mass in the left adrenal gland. The patient has no

history of adrenal disorders but reports occasional episodes of sweating and palpitations. Her blood pressure is elevated. Based on these findings, what condition should be primarily ruled out in the diagnostic workup? (Q848873)

A. Subclinical Cushing syndrome

B. Adrenocortical carcinoma

C. Pheochromocytoma

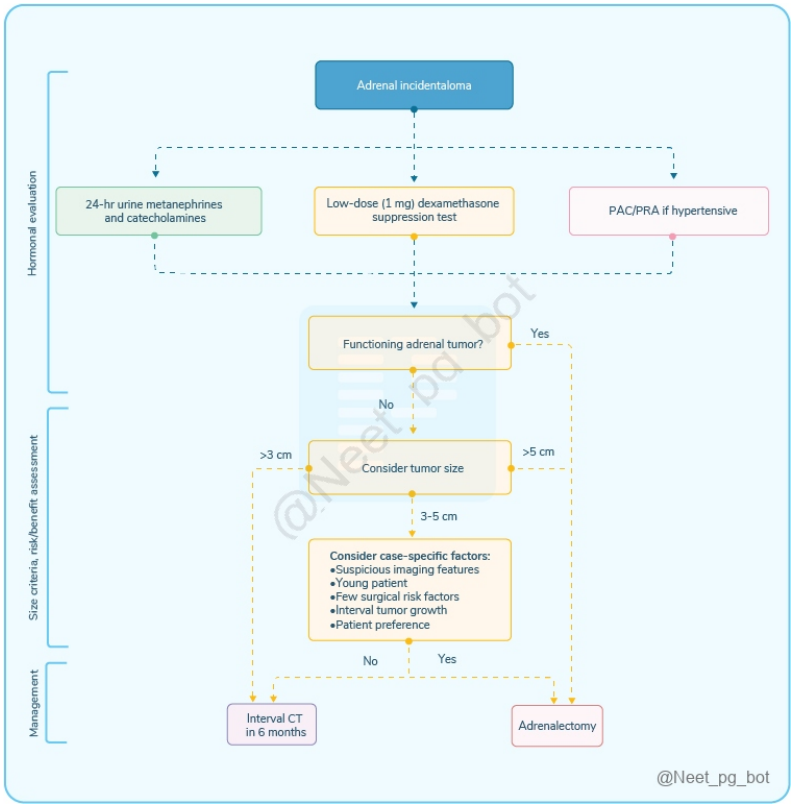
D. Aldosteronoma

Correct Answer: C. Pheochromocytoma

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Pheochromocytoma should be ruled out in patients with adrenal incidentalomas presenting with symptoms such as sweating and palpitations, particularly if the unenhanced CT attenuation is >10 HU. This condition can cause significant cardiovascular complications if left untreated. Evaluation of incidentaloma: Imaging All patients with adrenal incidentalomas should be assessed for malignancy based on the size and imaging characteristics of the mass. CT differentiates benign cortical adenoma from adrenal carcinoma or metastasis. FNAC Fine-needle aspiration differentiates adrenal tumors from metastatic tumors. Biopsy is avoided in suspected pheochromocytomas due to the risk of crisis. FNAC is to be done only after ruling out Pheochromocytoma Hormonal Evaluation All patients with adrenal incidentalomas should be assessed for subclinical hormonal hyperfunction. Pheochromocytoma 24-hour urinary fractionated metanephrines, catecholamines, or plasma fractionated metanephrines Subclinical Cushing Syndrome Measure dehydroepiandrosterone sulfate (DHEAS) and perform 1 mg overnight dexamethasone suppression test (DST) Primary Aldosteronism Measure plasma aldosterone and plasma renin activity (if hypertension or hypokalemia is present)



References:

Sabiston Textbook of Surgery, 21st edition, Pg 987 https://www.uptodate.com/contents/evaluation-and-management-of-the-adrenal-incidentaloma?search=adrenal%20incidentaloma&sectionRank=3&usage_type=default&anchor=H28&source=machineLearning&selectedTitle=1~25&display_rank=1#H28

↑ *Back to this question in Part A*

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Q14: A 50-year-old patient presents with elevated serum calcium levels and a neck mass. After further evaluation, the diagnosis of parathyroid carcinoma is confirmed. The patient is scheduled for surgery. What is the standard surgical treatment for this case to minimize the risk of local recurrence? (Q848872)

A. Total thyroidectomy

B. En bloc resection

C. Lymph node dissection

D. Total parathyroidectomy

Correct Answer: B. En bloc resection

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: En-bloc resection involves removing the tumor and any adjacent structures it has invaded as a single mass, which helps reduce the risk of spilling tumor cells and local recurrence. Management of Parathyroid Carcinoma En-Bloc Resection (Option B) Includes removal of adjacent invaded tissues; performed in 12.5% of cases Resectable Parathyroid Carcinoma (Local or regional recurrence of parathyroid carcinoma) En-bloc resection is standard for initial and recurrent disease, involving the removal of the tumor along with any invaded structures. Lymph Node Dissection: Performed only if lymph node involvement is confirmed. (Option C) CDC73/HRPT2 Variant Carriers: Bilateral exploration or selective resection of abnormal glands. Total parathyroidectomy is not favored. (Option D) Metastasis: Spreads locally, invading adjacent structures in the neck such as the thyroid gland and strap muscles. Surgical resection of metastasis for palliation of hypercalcemia Post-op Serum Calcium Monitoring: Essential for managing "hungry bone syndrome". Medical Therapy for Unresectable Parathyroid Carcinoma (When parathyroid carcinoma is not resectable due to widespread dissemination) Managed with hypercalcemia control and palliative care. Bisphosphonates: Intravenous zoledronic acid or pamidronate. Calcimimetics: Cinacalcet is used if bisphosphonates are ineffective. It works on the calcium-sensing receptor (CASR) of the parathyroid gland and controls the parathyroid hormone. Denosumab: For hypercalcemia, refractory to bisphosphonates and cinacalcet. Biotherapy Emerging therapies include parafibromin inhibitors, telomerase inhibitors, and immune therapies.

References:

Bailey and Love Short practice of surgery, 28 edition, Pg 886 Sabiston Textbook of Surgery 21st edition, Pg 937 https://www.uptodate.com/contents/parathyroid-carcinoma?search=parathyroid%20carcinoma&sectionRank=2&usage_type=default&anchor=H6&source=machineLearning&selectedTitle=1~43&display_rank=1#H6 https://www.ncbi.nlm.nih.gov/books/NBK519038/

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Q15: A 45-year-old woman undergoes a total thyroidectomy for the treatment of Graves' disease. Two days postoperatively, she presents with numbness and tingling around her mouth and in her fingers. She also complains of muscle cramps and mild weakness. Laboratory tests reveal decreased serum calcium levels. What is the most likely cause of her symptoms following the surgery? (Q848871)

A. Postoperative hypophosphatemia

B. Hypocalcemia due to damage to the parathyroid glands

C. Infection at the surgical site

D. Postoperative bleeding leading to hypovolemia

Correct Answer: B. Hypocalcemia due to damage to the parathyroid glands

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The patient's symptoms of numbness, tingling, muscle cramps, and decreased serum calcium levels indicate hypocalcemia. The most common cause of hypocalcemia following thyroid surgery is damage to the parathyroid glands or their blood supply. HYPOPARATHYROIDISM Common Causes: Thyroid Surgery Most frequent cause is damage to the parathyroid glands or their blood supply. (Option B) Risk Factors: Bilateral neck exploration, Extensive central neck dissection, Revision surgery, Thyroidectomy for Graves' disease, Pediatric patients. Autoimmune Disorders Autoimmune polyendocrine syndrome type 1 (APS-1). Genetic Conditions DiGeorge syndrome , autosomal dominant hypocalcemia. Radiation Therapy Radiation to the neck area can damage parathyroid glands. Medications Lithium, and some chemotherapeutic agents (Pembrolizumab).

References:

Bailey and Love Short practice of surgery, 28th edition, Pg 866. Sabiston Textbook of surgery 21st edition, Pg 913,915. https://pubmed.ncbi.nlm.nih.gov/23084333/ https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7924152/#

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@Neet_pg_bot

Q16: A 62-year-old woman with a history of tertiary hyperparathyroidism undergoes total parathyroidectomy. Three days later, she presents with carpopedal spasms and numbness around her mouth. Her serum calcium level is 6.9 mg/dL. What is the most likely diagnosis? (Q848870)

A. Pseudohypoparathyroidism

B. Hungry bone syndrome

C. Persistent hyperparathyroidism

D. Recurrent hyperparathyroidism

Correct Answer: B. Hungry bone syndrome

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Hungry Bone Syndrome (HBS): It is a state of profound hypocalcemia that persists for prolonged periods following parathyroidectomy or after thyroidectomy and can also be seen in metastatic prostate cancer. Pathophysiology : Rapid calcium uptake by bones after removal of excess hormone (PTH). Symptoms: Seizures Tetany Paresthesia Carpopedal spasms Arrhythmias Laryngospasm Management: Oral Supplements : Calcium carbonate or calcium citrate. Indications for IV Calcium : Serum calcium <7.6 mg/dL, symptomatic patients, or

EKG changes. IV Calcium: Calcium gluconate (preferred) or calcium chloride. Pseudohypoparathyroidism (Option A) is due to end-organ resistance to PTH , not post-surgical change. It presents with high PTH levels with hypocalcemia and is usually a chronic genetic condition (Albright hereditary osteodystrophy) . It does not occur acutely after parathyroidectomy . Persistent Hyperparathyroidism (Option B) signifies that hypercalcemia continues even after surgery due to incomplete removal of parathyroid tissue. This patient has hypocalcemia , not hypercalcemia. Recurrent Hyperparathyroidism (Option C) occurs months to years after surgery , not within a few days. It again presents with elevated calcium levels , whereas this patient has low calcium .

References:

Bailey & Love, 28th Edition, Pages 885-887

www.ncbi.nlm.nih.gov/books/NBK549880/

www.ncbi.nlm.nih.gov/books/NBK547709/

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@Neet_pg_bot

Q17: A 57-year-old patient with chronic renal failure is found to have elevated parathyroid hormone levels, but his serum calcium level is in the normal range. What is the diagnosis? (Q848869)

A. Primary hyperparathyroidism

B. Tertiary hyperparathyroidism

C. Secondary hyperparathyroidism

D. Calciphylaxis

Correct Answer: C. Secondary hyperparathyroidism

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: A raised parathyroid hormone with a normal or low serum calcium level points to the diagnosis of secondary hyperparathyroidism. Feature Primary Hyperparathyroidism (Option A) Secondary Hyperparathyroidism (Option C) Tertiary Hyperparathyroidism (Option B) Basic defect Autonomous ↑ PTH secretion Compensatory ↑ PTH due to hypocalcemia Autonomous PTH secretion after long-standing secondary HPT Common cause Parathyroid adenoma (most common) Chronic renal failure: ■ phosphate excretion ■ serum phosphate binds to serum calcium & ■ free serum calcium levels. ■ 1-hydroxylase activity in the kidney ➜ ■ 1,25 (OH)2 vitamin D formation ➜ ■ intestinal absorption of calcium. This results in increased secretion of parathyroid hormone. Vitamin D deficiency Intestinal calcium malabsorption/ steatorrhoea Long-standing CKD (post-secondary), impaired graft function, non-suppressible PTH, slow gland involution, insufficient calcitriol conversion. Serum PTH Raised Raised Very high Serum Calcium Hypercalcemia Reduced/normal Hypercalcemia

develops Serum Phosphate Low Increased in CKD Increased Vitamin D Normal /Decreased Decreased (impaired activation in kidney) Decreased Bone changes Osteitis fibrosa cystica Renal osteodystrophy Severe bone disease Renal effects Stones, nephrocalcinosis CKD-related changes Often already on dialysis Clinical features " Bones, stones, groans, psychic overtones " Features of CKD + bone pain Mixed features + hypercalcemia symptoms Gland status Single adenoma (most) Diffuse hyperplasia Autonomous hyperplasia Treatment Parathyroidectomy Phosphate intake should be reduced, and phosphate binders should be used to manage excess phosphate. Vitamin D and calcium supplementation. Parathyroidectomy should be considered if secretion remains abnormal. Patients with Chronic renal failure: High Calcium, low aluminium dialysis bath. Surgical intervention : Mainstay of treatment: Subtotal or total parathyroidectomy with autotransplantation of parathyroid gland

References:

Sabiston Textbook of Surgery, 21st Edition, Pages 935, 936

Bailey & Love Short Practice of Surgery, 28th Edition, Pages 885, 886

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Q18: A 40-year-old lady comes to the emergency department with muscle weakness, fatigue, and abdominal pain, and on evaluation, has some memory loss. Her lab reports show elevated serum calcium levels (13mg%), and she is diagnosed with primary hyperparathyroidism. Which of the following is the preferred treatment in this scenario? (Q848868)

A. Selective estrogen receptor modulators

B. Bisphosphonates

C. Parathyroidectomy

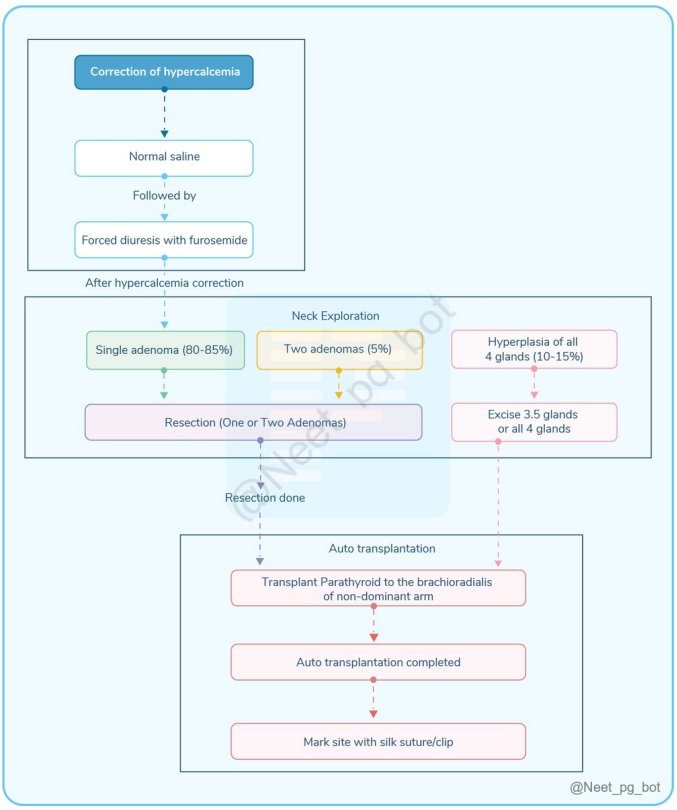
D. Calcimimetic drugs

Correct Answer: C. Parathyroidectomy

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: In severely symptomatic primary hyperparathyroidism (PHPT), the most preferred mode of management is surgical management . The main modality of treatment is as follows:



References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Pages 876, 879

SRBs Manual of Surgery, 6th Edition, Page 493

https://www.ncbi.nlm.nih.gov/books/NBK563274/

www.ncbi.nlm.nih.gov/pmc/articles/PMC6935782/

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Q19: Which of the following is the most accurate investigation to localize the lesion in a case of primary hyperparathyroidism? (Q848867)

A. Ultrasonography

B. Sestamibi scan

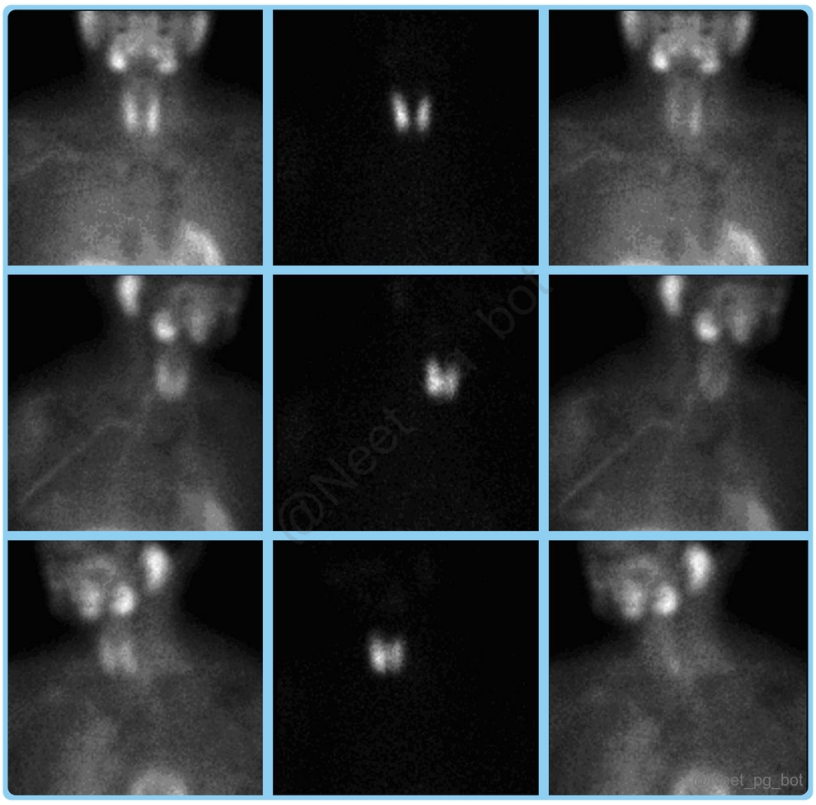
C. 4D computed tomography

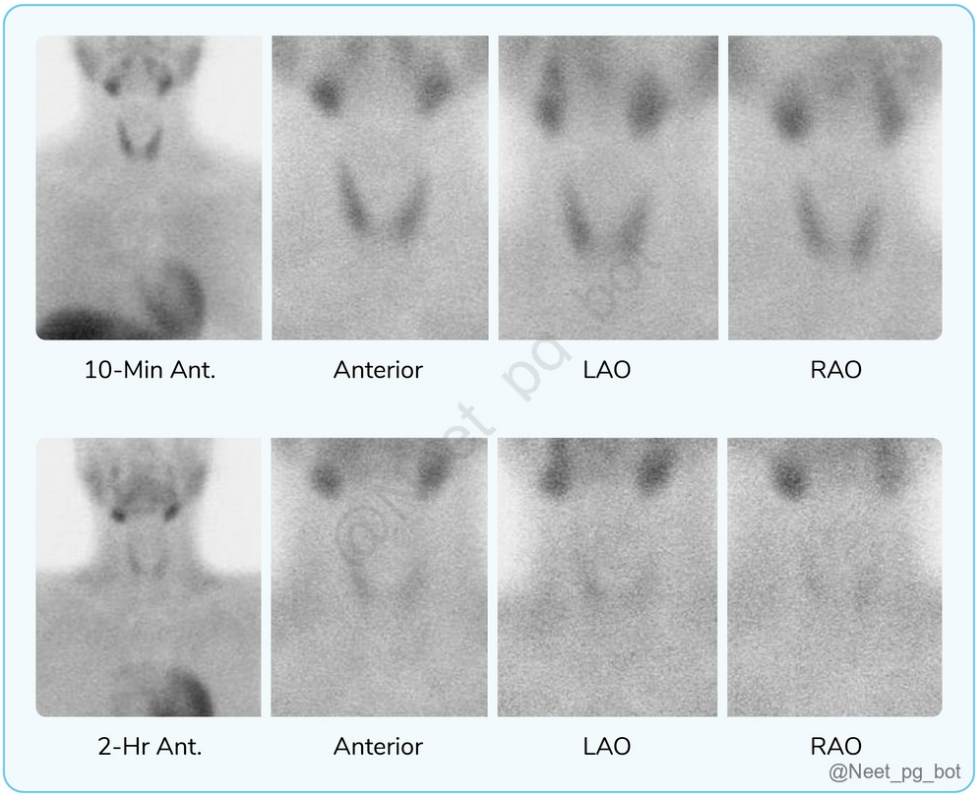
D. MRI

Correct Answer: B. Sestamibi scan

- *Listen (English)*
- *Listen (Hindi)*

Explanation: Sestamibi scan is a type of nuclear medicine-based study that is most accurate for parathyroid lesion localization. It is safe and reproducible . It has a sensitivity and specificity similar to ultrasound but may detect glands in ectopic positions better. Sestamibi accumulates in the mitochondria and hence the rates at which it washes out differs as per the number of mitochondria in different tissues. Parathyroid adenoma is rich in oxyphilic cells with a high concentration of mitochondria and hence has a lower washout than the thyroid gland. False positives are rare and the sensitivity and specificity are 79% and 90% respectively. Addition of a thyroid specific radioactive-tracer eliminates the chance of false positives.





References:

Bailey & Love's Short Practice of Surgery, 28th edition, pg: 877,878. SRB's Manual of Surgery, 6th edition, pg: 491. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4607146/

↑ *Back to this question in Part A*

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Q20: A 55-year-old postmenopausal woman presents with a fracture of the radius. She is found to have some mild memory impairment on questioning and her X-ray shows osteoporosis. On further evaluation, her serum calcium levels are elevated. Which of the following is not a common manifestation of this condition? (Q848866)

A. Nephrolithiasis

B. Salt and pepper skull

C. Neck mass

D. Brown tumors

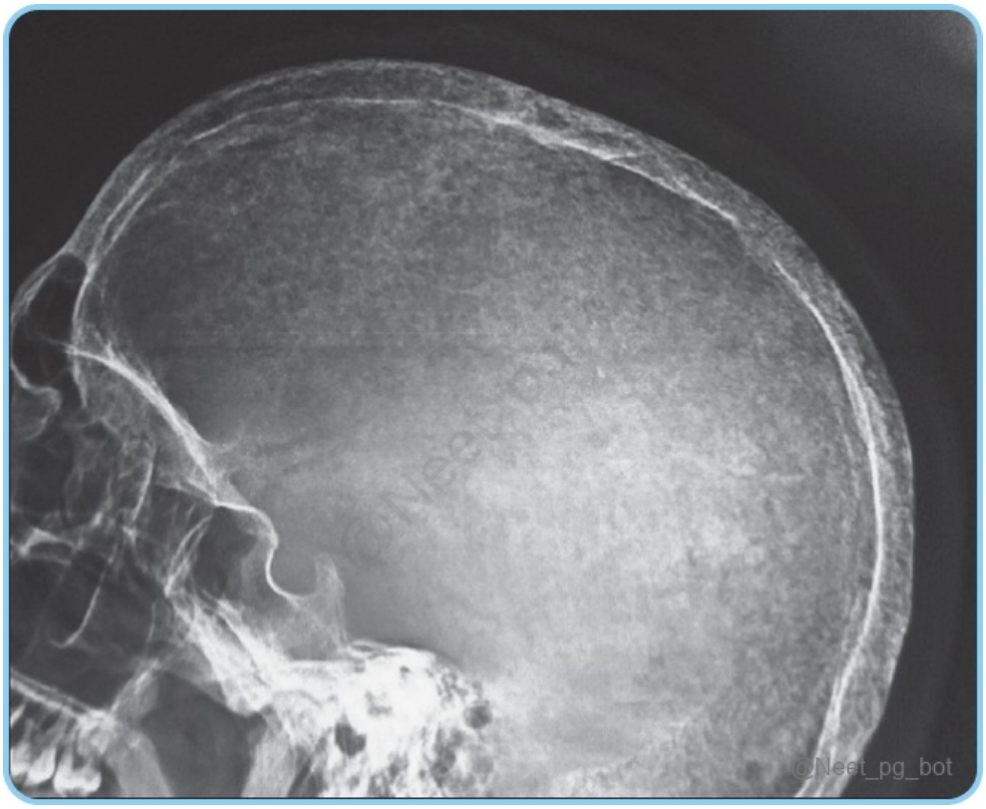
Correct Answer: C. Neck mass

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The diagnosis here points to primary hyperparathyroidism. A neck mass is an uncommon finding in cases of hyperparathyroidism. The abnormality in the parathyroid gland leads to the increased secretion of parathyroid hormone. Causes of primary hyperparathyroidism : The most common cause of primary hyperparathyroidism is a solitary parathyroid adenoma (most common on the inferior lobe of the right parathyroid). Manifestations of PHPT: System Manifestations Reason Renal system (stones) Hypercalciuria Nephrocalcinosis Nephrolithiasis (Option A) Polydipsia, polyuria, nocturia Excretion of excess serum calcium Calcium deposition in renal parenchyma Precipitation of calcium with phosphate or oxalate Inhibition of ADH due to ■ serum calcium. Skeletal system Osteoporosis Subperiosteal resorption(radial aspect) Tufting of distal phalanx Brown tumor/ osteitis fibrosa cystica (OptionD) Salt and pepper skull (Option B) Chondrocalcinosis Pseudo gout Joint pain Calcium resorption Deposition of hemosiderin in the lesion. Abdomen (abdominal groans) Nausea Vomiting Constipation Peptic ulcer disease: abdominal groans Inhibitory effect of hypercalcemia on gastrointestinal (GI) smooth muscle contraction. Spasm of sphincters Increased gastrin CNS (psychiatric moans) Confusion Anxiety Depression Psychosis: psychic moans Some mild memory loss Depression of nervous system Muscular system Weakness Fatigue overtones Decreased muscle activity.





References:

Bailey & Love's Short Practice of Surgery, 28th edition, pg: 875,876.

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Q21: A 45-year-old woman presents with recurrent kidney stones. Lab tests showed elevated calcium and parathyroid hormone levels. Imaging reveals pituitary adenoma and pancreatic neuroendocrine tumors. Her father had similar issues. What is the most likely diagnosis? (Q848865)

A. Wermer syndrome

B. Werner syndrome

C. MEN 4

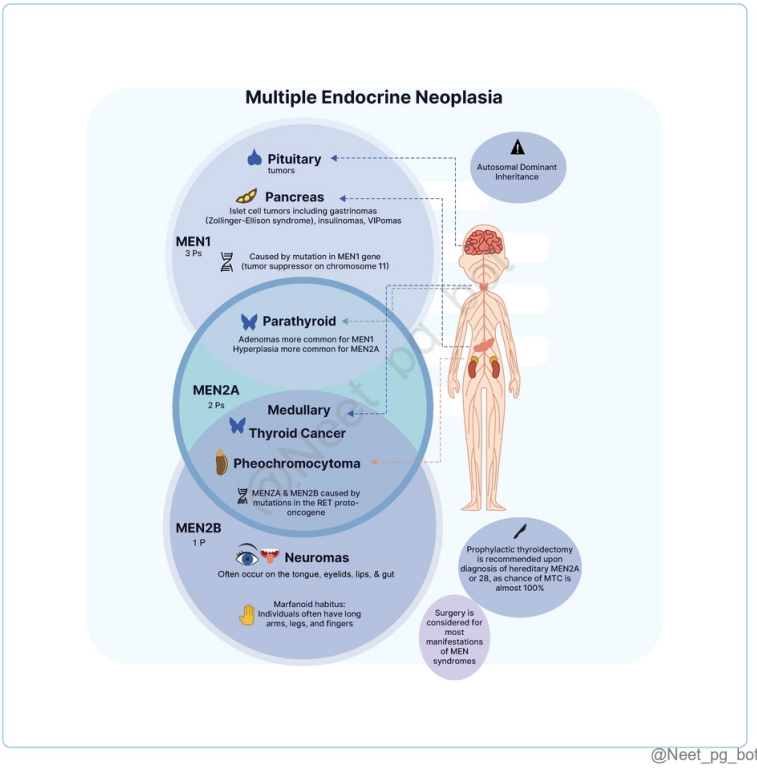
D. Sipple syndrome

Correct Answer: A. Wermer syndrome

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: MEN 1 syndrome presents with Parathyroid tumors (Hyperparathyroidism and hypercalcemia) , pituitary adenoma, and pancreatic neuroendocrine tumors. Wermer syndrome is also known as Multiple Endocrine Neoplasia Type 1 (MEN 1) MEN 1/ Wermer Syndrome: Autosomal dominant. Mutation of the MEN-1 gene, located on chromosome 11, affects tumor suppressor protein menin. Involves: Parathyroid tumors Pituitary tumors Pancreatic neuroendocrine tumors



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References:

Bailey & Love Short practice of surgery, Edition 28, page no:911-913 Sabiston textbook of surgery, Edition 21, page no:998-1006

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Q7 (p. 2901)	*Q8 (p. 2902)*	*Q9 (p. 2902)*	*Q10 (p. 2903)*	*Q11 (p. 2904)*	*Q12 (p. 2905)*
Q13 (p. 2905)	*Q14 (p. 2906)*	*Q15 (p. 2907)*	*Q16 (p. 2908)*	*Q17 (p. 2909)*	*Q18 (p. 2909)*
Q19 (p. 2910)	*Q20 (p. 2912)*	*Q21 (p. 2914)*	*Q22 (p. 2915)*	*Q23 (p. 2917)*	*Q24 (p. 2919)*
Q25 (p. 2920)	*Q26 (p. 2921)*	*Q27 (p. 2923)*	*Q28 (p. 2924)*	*Q29 (p. 2925)*	*Q30 (p. 2925)*
Q31 (p. 2927)	*Q32 (p. 2928)*	*Q33 (p. 2929)*	*Q34 (p. 2930)*	*Q35 (p. 2930)*	*Q36 (p. 2934)*
Q37 (p. 2935)	*Q38 (p. 2936)*	*Q39 (p. 2938)*	*Q40 (p. 2939)*	*Q41 (p. 2941)*	*Q42 (p. 2942)*
Q43 (p. 2943)	*Q44 (p. 2944)*	*Q45 (p. 2944)*	*Q46 (p. 2946)*	*Q47 (p. 2947)*	*Q48 (p. 2948)*
Q49 (p. 2949)	*Q50 (p. 2949)*	*Q51 (p. 2950)*	*Q52 (p. 2951)*	*Q53 (p. 2952)*	*Q54 (p. 2953)*
Q55 (p. 2954)	*Q56 (p. 2955)*	*Q57 (p. 2956)*	*Q58 (p. 2957)*	*Q59 (p. 2958)*	*Q60 (p. 2959)*
Q61 (p. 2959)	*Q62 (p. 2960)*	*Q63 (p. 2963)*	*Q64 (p. 2964)*	*Q65 (p. 2965)*	*Q66 (p. 2966)*
Q67 (p. 2967)	*Q68 (p. 2968)*	*Q69 (p. 2969)*	*Q70 (p. 2969)*	*Q71 (p. 2970)*	

Q1: A 30-year-old lactating mother presents with pain in her left breast and a fever. On examination of the affected side, there is localized erythema, warmth, and point tenderness, the fluctuation test is positive. There is mild axillary lymphadenopathy on the affected side and the contralateral breast is normal. Repeated aspirations under antibiotic cover were unsuccessful. A USG done showed fluid collection. What is the management plan for this patient? (Q857135)

A. Incision and drainage

B. Broad spectrum antibiotics only

C. Breast conservation surgery

D. Punch biopsy

Correct Answer: A. Incision and drainage

Explanation: Breast Abscess Definition Pus-filled cavity within the breast tissue. Types Lactational Abscess: Associated with breastfeeding. Non-Lactational Abscess: Occurs in non-lactating women, e.g., periductal mastitis. Causes and Risk Factors Lactation: Incidence: 3% to 20% in lactating mothers. Common pathogen: Staphylococcus aureus (methicillin-resistant strains in hospital settings). Entry points: Cracked/retracted nipple, blocked lactiferous ducts. Non-Lactation: Often in nulliparous women or post-lactation. Conditions: Periductal

mastitis, idiopathic granulomatous mastitis, tubercular mastitis. Smoking and diabetes as risk factors. Signs and symptoms Fever, leukocytosis, erythema, pain and tenderness, swelling, malaise, difficulty feeding, enlarged and tender axillary nodes Diagnosis Ultrasonography: Detects cellulitis, and liquefaction necrosis. Confirms abscess size, location, and loculation. Treatment Lactational Mastitis: Antibiotics: Anti-staphylococcal (e.g., cloxacillin, flucloxacillin, erythromycin). Breast emptying: Frequent breastfeeding or pumping. Support: Breast support garment, cold compresses, analgesia. Drainage: Ultrasound-guided is preferred over surgical incision. (Option A) Follow-up: Regular clinical and ultrasonographic reviews of culture-based antibiotic modification.
Non-Lactational Mastitis: Broad-spectrum antibiotics for subareolar infections. Needle aspiration for abscess drainage. Major milk duct excision for complications like sepsis or fistula. Broad-spectrum antibiotics only (Option B) Antibiotics alone are not sufficient for an established abscess. Breast conservation surgery (Option C) is not required, as it is an infective condition, not malignancy. Punch biopsy (Option D) Not necessary unless malignancy is suspected (which is unlikely in a lactating mother with classical abscess signs).

References:

Sabiston Textbook of Surgery, 21st Edition, Pages 826,827

Bailey & Love's Short Practice of Surgery, 28th Edition, Pages 927,928

Schwartz's Principles of Surgery, 11th Edition, Pages 550-553, 601, 602

↑ *Back to this question in Part A*

@Neet_pg_bot

Q2: Fluorescence in-situ hybridization (FISH) is required in which of the following interpretations of HER2/NEU? (Q856565)

A. 1+

B. 2+

C. 3+

D. All of the above

Correct Answer: B. 2+

Explanation: HER2/NEU 2+ in immunohistochemistry (IHC) requires fluorescence in-situ hybridization (FISH) for interpretation. FISH confirms HER2/NEU gene amplification in cases with equivocal IHC scores (2+), indicating neither definitively negative nor positive. FISH determines HER2/NEU overexpression, rendering the test positive. 1+ (Option A) IHC score suggests low HER2/NEU expression, usually considered negative, not requiring FISH. 3+ (Option C) IHC score indicates strong HER2/NEU overexpression, typically positive, not necessitating FISH. All of the above (Option D) FISH is essential only for 2+ IHC results to confirm positivity; it's not needed for 1+ or 3+ scores.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, pages 197

↑ *Back to this question in Part A*

@Neet_pg_bot

Q3: What would be the appropriate next step in the management of a 55-year-old female patient who has a 4x3 cm lump in the right upper outer quadrant, with no involvement of axillary lymph nodes, and a BIRADS 4b staging on mammography? The patient underwent breast conservation surgery, and the final histopathology examination (HPE) report indicated high nuclear-grade ductal carcinoma in situ (DCIS) with necrosis and a 10mm margin clearance. (Q856541)

A. Adjuvant radiotherapy

B. Adjuvant chemotherapy

C. Follow up 6 monthly for 2 years and then yearly follow up

D. Trastuzumab therapy

Correct Answer: A. Adjuvant radiotherapy

Explanation: After breast conservation surgery for high nuclear-grade DCIS with necrosis and margin clearance, adjuvant radiotherapy is the appropriate choice. DCIS, a non-invasive breast cancer type, involves abnormal cells within breast ducts but not spreading outside. High nuclear grade DCIS with necrosis signifies a more aggressive form. Margin clearance of 10mm confirms absence of cancer cells around the tumor, lowering local recurrence risk. Adjuvant radiotherapy targets any remaining cancer cells in breast tissue, further reducing recurrence risk, notably ipsilateral. Adjuvant Chemotherapy (Option B) Not typically recommended for DCIS, reserved for invasive breast cancer. Follow up 6 monthly for 2 years and then yearly follow up (Option C) While follow-ups are crucial post-treatment, adjuvant radiotherapy is necessary here to minimize recurrence risk. Trastuzumab Therapy (Option D) Targeted for HER2-positive invasive breast cancer, not typically indicated for HER2-negative DCIS. Reserved for cases with HER2 overexpression, typically invasive cancers.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Pages 933, 939,940.

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5161063/

↑ *Back to this question in Part A*

@Neet_pg_bot

Q4: In the surgical procedure for breast carcinoma, a frozen section was performed. This technique has benefits for all individuals, with the exception of: (Q858358)

A. To assess sentinel lymph node

B. To know margin positivity

C. To know metastasis

D. To confirm definitive diagnosis immediately in all cases

Correct Answer: D. To confirm definitive diagnosis immediately in all cases

Explanation: Frozen section is not always reliable for final diagnosis because it lacks the precision of permanent histopathology. Special tests like ER, PR, and HER2/neu receptor studies require formalin-fixed tissue, making frozen section unsuitable for definitive diagnosis in all cases To assess sentinel lymph node involvement (Option B) Frozen section is commonly used during breast cancer surgery to assess sentinel lymph nodes . If metastases are found, further axillary dissection may be performed in the same surgery. To know margin positivity (Option C) Frozen section helps determine tumor margin involvement intraoperatively , allowing surgeons to achieve clear margins during breast-conserving surgery. To know metastasis (Option D) Frozen section can detect regional or distant metastases , especially in lymph nodes, but micrometastases may be missed .

References:

Robbins and Cotran Pathologic basis of disease, 10th edition, Page 331

↑ *Back to this question in Part A*

@Neet_pg_bot

Q5: Which patient has better prognosis in breast cancer? (Q857556)

A. Her2+

B. Triple negative

C. Luminal B

D. Luminal A

Correct Answer: D. Luminal A

Explanation: Among the molecular subtypes of breast cancer, Luminal A has the best prognosis due to its hormone receptor positivity , low proliferation index , and good response to endocrine therapy . Molecular Subtypes of Breast Cancer Subtype Receptor Status Prognosis Treatment Response Luminal A ER+, PR+, HER2- Best prognosis Good response to endocrine therapy (Tamoxifen, Aromatase inhibitors) Luminal B ER+, PR±, HER2±

Intermediate Responds to endocrine therapy but has higher proliferation than Luminal A HER2+ (non-luminal) ER-, PR-, HER2+ Poorer prognosis Requires Trastuzumab (Herceptin) Triple-negative (Basal-like) ER-, PR-, HER2- Worst prognosis Chemotherapy is the only option; high recurrence HER2+ (Option A): Incorrect because HER2+ cancers tend to be aggressive, though targeted therapy (Trastuzumab) has improved survival. Triple negative (Option B): Incorrect because triple-negative breast cancer (TNBC) has the worst prognosis due to aggressive nature and lack of targeted therapy. Luminal B (Option C): Incorrect because Luminal B has a worse prognosis than Luminal A due to a higher proliferation rate.

References:

Robbins and Cotran, Pathologic basis of Disease, 10th edition. Page 1049, 1056-1058)

Bailey and Love, Short Practice of Surgery, 28th edition, Page 931

↑ *Back to this question in Part A*

@Neet_pg_bot

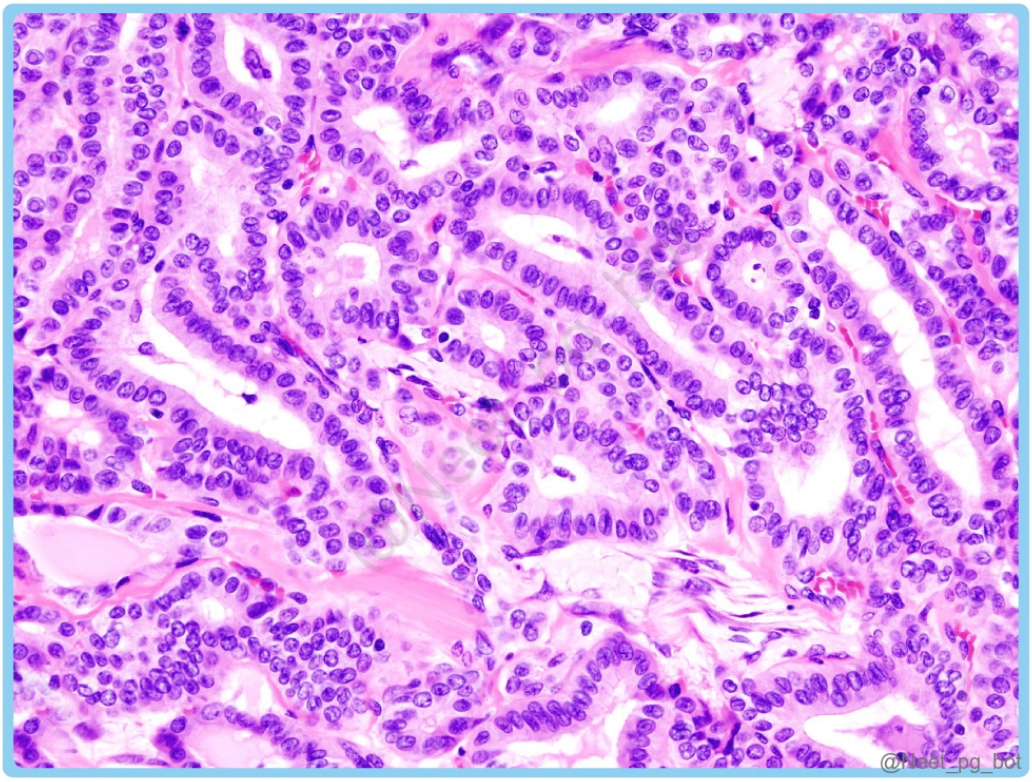
Q6: A 45-year-old lady presented with a swelling in her neck. She had an exposure to radiation in the past. Identify the type of disease, image of FNAC is given below: (Q857495)

A. Papillary carcinoma

B. Follicular carcinoma

C. Medullary carcinoma

D. Anaplastic carcinoma



Correct Answer: A. Papillary carcinoma

Explanation: Papillary Carcinoma of the Thyroid Feature Details Definition Most common thyroid malignancy (80–85%) with excellent prognosis. Risk Factors Childhood radiation exposure, BRAF & RET/PTC mutations, family history. Spread Lymphatic spread (cervical lymph nodes commonly affected). Clinical Features Painless thyroid nodule, cervical lymphadenopathy, euthyroid state. Histopathology Orphan Annie eye nuclei, Psammoma bodies, Nuclear grooves, Papillary structures with fibrovascular cores. Diagnosis 1. Ultrasound – Microcalcifications, hypoechoic nodule, irregular margins. 2. FNAC – First-line test. Treatment 1. Total thyroidectomy (>1 cm, multifocal, lymph node involvement). 2. Lobectomy (<1 cm, no metastasis). 3. RAI therapy (for residual disease or metastasis). 4. TSH suppression therapy (Levothyroxine). Prognosis Excellent (>95% 10-year survival). Worse with older age, distant metastasis, large tumor size, BRAF mutation. Follicular Carcinoma (Option B) Hematogenous spread (not lymphatic like PTC) FNAC cannot differentiate follicular adenoma vs. carcinoma (requires capsular/vascular invasion assessment on histology). Medullary Carcinoma (Option C) Derived from parafollicular C cells (calcitonin-secreting). FNAC shows amyloid deposits (Congo red positive) and polygonal/spindle cells. Associated with MEN 2A/2B mutations (RET oncogene). Anaplastic Carcinoma (Option D) Highly aggressive with rapid growth, dysphagia, and hoarseness. FNAC shows pleomorphic giant cells, mitotic figures, and necrosis.

References:

Harrison's principles of internal medicine, 21st Edition, Page: 2951

↑ *Back to this question in Part A*

@Neet_pg_bot

Q7: A 30-year-old lactating mother presents with pain in her left breast and a fever. On examination of the affected side, there is localised erythema, warmth, and point tenderness, and the fluctuation test is positive. Mild axillary lymphadenopathy is on the affected side, and the contralateral breast is normal. What is the most likely diagnosis for this patient? (Q857494)

A. Lactational mastitis

B. Breast carcinoma

C. Breast abscess

D. Fibroadenoma

Correct Answer: C. Breast abscess

Explanation: Correct answer C) Breast abscess A lactating woman with fever, localized breast pain, erythema, and a positive fluctuation test most likely has a breast abscess . Breast Abscess Definition Pus-filled cavity within the breast tissue. Types Lactational Abscess: Associated with breastfeeding. Non-Lactational Abscess: Occurs in non-lactating women, e.g., periductal mastitis. Causes and Risk Factors Lactation: Incidence: 3% to 20% in lactating mothers. Common pathogen: Staphylococcus aureus (methicillin-resistant strains in hospital settings). Entry points: Cracked/retracted nipple, blocked lactiferous ducts. Non-Lactation: Often in nulliparous women or post-lactation. Conditions: Periductal mastitis, idiopathic granulomatous mastitis, tubercular mastitis. Smoking and diabetes as risk factors. Signs and symptoms Fever, leukocytosis, erythema, pain and tenderness, swelling, malaise, difficulty feeding, enlarged and tender axillary nodes Diagnosis Ultrasonography: Detects cellulitis, and liquefaction necrosis. Confirms abscess size, location, and loculation. Treatment Lactational Mastitis: Antibiotics: Anti-staphylococcal (e.g., cloxacillin, flucloxacillin, erythromycin). Breast emptying: Frequent breastfeeding or pumping. Support: Breast support garment, cold compresses, analgesia. Drainage: Ultrasound-guided is preferred over surgical incision. Follow-up: Regular clinical and ultrasonographic reviews, and culture-based antibiotic modification. Non-Lactational Mastitis: Broad-spectrum antibiotics for subareolar infections. Needle aspiration for abscess drainage. Major milk duct excision for complications like sepsis or fistula. Lactational mastitis (Option A): In Lactational mastitis, a cracked nipple is a predisposing factor. It presents with engorgement of lactational ducts and the presence of clumps of milk. It does not cause fluctuance. Breast carcinoma (Option B) In the case of carcinoma of the breast, we see a fixed lump, ulcerated nipple and peu d orange. The swelling is not fluctuate. Fibroadenoma (Option D) Fibroadenoma is a benign, painless well defined firm mobile mass which does not show fluctuance.

References:

Sabiston Textbook of Surgery, 21st Edition, Pages 826,827

Bailey & Love's Short Practice of Surgery, 28th Edition, Pages 927,928

Schwartz's Principles of Surgery, 11th Edition, Pages 550-553, 601, 602

↑ *Back to this question in Part A*

@Neet_pg_bot

Q8: Best prognosis among the following breast cancer subtypes is for: (Q857269)

A. Luminal A

B. Luminal B

C. ER negative

D. Basal like

Correct Answer: A. Luminal A

Explanation: Molecular classification of breast cancer: Subtype ER Status PR Status HER2 Status Ki-67 Status Characteristics Luminal A + + - Low Generally, it is low grade, has a better prognosis, and is responsive to hormonal therapy. Luminal B + + or - + or - High Higher grade, poor prognosis compared to Luminal A, may require targeted HER2 therapy following status. (Option B ruled out) HER2-enriched - - + High Aggressive, higher grade, poor prognosis, requires targeted HER2 therapy. (Option C ruled out) Basal-like - - - High Includes triple-negative breast cancer (TNBC), highly aggressive, no targeted hormonal therapy. (Option D ruled out) Claudin-low - - + or - Often High Often associated with poor prognosis and aggressive behaviour, typically lacks response to hormonal therapy.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 931. SRB's Manual of Surgery, 6th Edition, Page 533.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q9: A 23-year-old woman presents to the surgery out-patient with a left-sided breast lump, which she noticed on a self-breast examination 3 weeks ago. She has no other complaints. On palpation, the lump seems to be mobile and firm. FNAC is characterized by stromal and epithelial elements with no signs of malignancy. What is the best next step in management? (Q857141)

A. Mammography

B. Reassurance and follow-up

C. Surgical excision

D. Start Tamoxifen

Correct Answer: B. Reassurance and follow-up

Explanation: In a young woman with a mobile, firm breast lump and FNAC ruling out malignancy, the best approach is reassurance and regular follow-up, as fibroadenoma is the most likely diagnosis. Common ANDI by age group: 15–25 years: Fibroadenoma 25–40 years: Fibroadenosis >40 years: Fibroadenosis, followed by duct ectasia Fibroadenoma Definition Benign tumors arising from the proliferation of glandular tissue in the breast Prevalence Most common in women aged 15-25 years Aetiology Believed to be influenced by hormonal fluctuations during reproductive years Clinical Presentation Painless, firm, rubbery, and mobile lumps Described as feeling like a "marble in the breast" Diagnosis Triple Assessment: Clinical examination, radiological imaging (ultrasound), tissue sampling (core-needle biopsy) Ultrasound: Helps distinguish fibroadenomas from cysts Core-Needle Biopsy: Provides definitive diagnosis Treatment Conservative Management: Watchful waiting, regular monitoring Surgical Excision: For larger fibroadenomas, those causing symptoms, or uncertain diagnosis Giant Fibroadenomas: Over 5 cm, may require excision through submammary incision Prognosis Benign , do not increase risk of breast cancer Growth can vary, influenced by hormonal changes Recurrence is uncommon Relationship to ANDI Categorised according to ANDI as: Normal: Small fibroadenomas (≤1 cm) Disorder: Larger fibroadenomas (≤3 cm) Disease: Giant fibroadenomas (>3 cm), multiple fibroadenomas Mammography (Option A) is not the first-line imaging in young women due to dense breast tissue , making it less sensitive; ultrasound is preferred . Surgical Excision (Option C) is only indicated if the fibroadenoma is >5 cm, rapidly growing, painful, or causing significant anxiety ; otherwise, conservative management is preferred . Start Tamoxifen (Option D) is not used for fibroadenomas, as they are benign tumors , and Tamoxifen is reserved for hormone receptor-positive breast cancers .

References:

Sabiston Textbook of Surgery, 21st Edition, Pages 816,817, 826

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 922

Schwartz's Principles of Surgery, 11th Edition, Pages 551-554

↑ *Back to this question in Part A*

@Neet_pg_bot

Q10: Which of the following statements are true? 1. Due to increasing mammography there occurs over diagnosis of breast carcinoma 2. Colon cancer screening is done by digital rectal examination 3. Oral cancer screening is done by visual inspection 4. Cervix cancer screening is done by a pap smear (Q856570)

A. 2, 3, 4

B. 1, 2, 3, 4

C. 4 only

D. 1, 3, 4

Correct Answer: D. 1, 3, 4

Explanation:

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, page 916, 1358- 1361

cervical cancer , cdc

nationalcancersociety

↑ *Back to this question in Part A*

@Neet_pg_bot

Q11: For a patient presenting with a new breast lump, which of the following investigations is the LEAST appropriate for the initial diagnosis? (Q855288)

A. Radiological investigations

B. PET scan

C. Clinical examination

D. Histology and cytology

Correct Answer: B. PET scan

Explanation: A PET scan is not typically used as a first-line test for evaluating breast lumps, as it is more commonly employed in other cancers, like lung or colorectal, to detect metastases or assess disease extent. Triple Assessment is a combination of assessments used for breast cancer screening and diagnosis. 1. Clinical Examination (Option C ruled out) Objective: Identify lumps, skin changes, nipple discharge, or lymphadenopathy. Procedure: Palpation of breasts and lymph nodes. 2. Imaging (Option A ruled out) Methods: Mammography: Preferred for women over 40. Ultrasound: Used in younger women or for further evaluation. 3. Biopsy (Option D ruled out) Types: FNA: Minimally invasive; used for cystic lesions. Core Needle: Preferred for solid masses. Excisional: Removes lump for examination. Triple assessment yields more accurate results than individual assessment.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 915. SRB's Manual of Surgery, 6th Edition, Page 538. Triple Assessment of Breast Lump: Should We Perform Core Biopsy for Every Patient? - PMC

↑ *Back to this question in Part A*

@Neet_pg_bot

Q12: A 25-year-old woman presents with a breast lump, no skin changes, and no indurations. In histology, fibroadenoma appeared. Which of the following categories does it fall under? (Q855202)

A. BI-RADS 1

B. BI-RADS 2

C. BI-RADS 3

D. BI-RADS 4

Correct Answer: B. BI-RADS 2

Explanation: A fibroadenoma, with its characteristic appearance and benign nature, falls under BIRADS 2, representing benign findings on imaging. BI-RADS (Breast Imaging Reporting and Data System (BI-RADS) Score: BI-RADS Category Description Management Likelihood of Malignancy 0 Incomplete Need additional imaging evaluation N/A 1 (Option A ruled out) Negative Routine screening Essentially 0% 2 (Option B) Benign Routine screening Essentially 0% 3 (Option C ruled out) Probably Benign Short-term follow-up (6 months) < 2% 4 (Option D ruled out) Suspicious of Malignancy Biopsy should be considered. 4A Suspicious: Low _ > 2% to ≤ 10% 4B Suspicious: Moderate _ > 10% to ≤ 50% 4C Suspicious: High _ > 50% to ≤ 95% 5 Highly Suggestive of Malignancy Appropriate action should be taken > 95% 6 Known Biopsy-Proven Malignancy Appropriate action should be taken 100%

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 917. Sabiston Textbook of Surgery, 21st Edition, Page 821. SRB's Manual of Surgery, 6th Edition, Page 507

↑ *Back to this question in Part A*

@Neet_pg_bot

Q13: What is the appropriate next step in managing a 37-year-old unmarried woman who has never given birth, is sexually active, and is currently taking oral contraceptive pills, considering that her mother was diagnosed with breast cancer at the age of 60 and her older sister was diagnosed with ovarian cancer at 40? (Q855690)

A. Genetic counseling and screening for BRCA

B. Routine mammography

C. Stop taking oral and contraceptive pills

D. Prophylactic surgery

Correct Answer: A. Genetic counseling and screening for BRCA

Explanation: Given the patient's family history of breast and ovarian cancer, along with her being a 37-year-old unmarried, sexually active woman who has never given birth and is taking oral contraceptive pills, the next step in management would be genetic counselling and BRCA mutation screening. Risk factors for breast cancer Modifiable risk factors Non-modifiable risk factors Obesity: BMI > 30 (RR= 1.29) Age Median age at presentation is 60 years in the West(UK, USA), While it is around 48 years in low/middle-income nations such as India. Nulliparous women or first pregnancy after 35 years Sex Female sex is a risk factor Male sex accounts for 0.5-1% of all breast cancer Breastfeeding is a protective factor Ethnicity American white, African-American Parsi in India Use of Hormonal Replacement Therapy (HRT) >10 years (RR= 1.2) Family history of breast cancer 1 first-degree relative RR= 2 2 first-degree relative RR= 3 Tobacco use (RR=1.07-1.14) Genetic predisposition BRCA1 and BRCA2 mutations account for 70% of hereditary breast cancers Alcohol Consumption (RR = 1.05-1.32) Early Menarche(<12years) Increases by around 5% for each year earlier menstruation begins RR=1.19 Radiation exposure (RR=6) Late Menopause(>55years) Increases by about 3% for each year later menopause begins RR=1.12 Age at first child <20years - Less risk >35years - High risk High-risk breast lesions Complex fibroadenoma RR=3 Papillomatosis RR=3 Ductal and lobular hyperplasia RR= 5 Lobular carcinoma in situ RR= 8-10 Routine mammography (Option B) is not recommended at age 37 as it is typically for women 40 and older and focuses on screening, not genetic risk assessment. Stop taking oral contraceptive pills (Option C) should be based on a broader risk assessment, not just family history. Prophylactic surgery (Option D) is an extreme measure and is typically considered only after genetic testing confirms a significant genetic risk.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 930-931. Schwartz's Principles of Surgery, 11th Edition, Page 555-556. SRB's Manual of Surgery, 6th Edition, Page 523.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q14: Which of the following is not a relative contraindication for breast conservative surgery? (Q855688)

A. Tumor size <4 cm

B. Li-Fraumeni Syndrome

C. Prior radiation to the chest

D. Genetic Predisposition to Breast Cancer

Correct Answer: A. Tumor size <4 cm

Explanation: Tumor size less than 4 cm is not a relative contraindication for Breast-conserving surgery (BCS), also known as Lumpectomy . It involves removing a breast tumour along with a small margin of surrounding healthy tissue while preserving the majority of the breast. The goal is to remove the cancerous cells while maintaining the breast's appearance and function. Contraindications of Breast-conserving surgery (BCS): Absolute Contraindications First-trimester Pregnancy Multicentric Disease Diffuse Suspicious microcalcifications on mammogram Extensive DCIS Inflammatory Breast Cancer Tumors for which Clear Margins are Unobtainable with Lumpectomy Homozygous for ATM Mutation Relative Contraindications Prior Radiation Therapy to the Chest Wall or Breast (Option C ruled out) Active Connective Tissue Disease Involving the Skin (e.g., Scleroderma) Extensive Positive Pathological Margins Large Tumor Size Relative to Breast Size or Tumors >5 cm (Option A) Known or Suspected Li-Fraumeni Syndrome (p53 Mutation) (Option B ruled out) Known or Suspected Genetic Predisposition to Breast Cancer (e.g., BRCA1, BRCA2) (Option D ruled out)

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Pages 935-936. Sabiston Textbook of Surgery, 21st Edition, Pages 843-844.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q15: A 49-year-old female presents with a breast lump. Which of the following findings is in accordance with basal cell type breast cancer? (Q855676)

A. ER +ve, PR +ve, HER2 -ve

B. ER +ve, PR -ve, HER2 -ve

C. ER -ve, PR -ve, HER2 -ve

D. ER -ve, PR -ve, HER2 +ve

Correct Answer: C. ER -ve, PR -ve, HER2 -ve

Explanation: Basal cell carcinoma, according to Molecular Classification of Breast Cancer, is characterised by estrogen receptor-negative (ER-negative), progesterone receptor-negative (PR-negative), and human epidermal growth factor receptor 2-negative (HER2-negative) status. Classification Hormone receptor HER2/Neu Others Luminal A (Option A, and B ruled out) Positive (either or both ER/PR) Negative Ki-67 low Luminal B (Option A and B ruled out) Positive (either or both ER/PR) Negative Ki-67 high Basal type (triple -ve) (Option C) Negative Negative Ki-67 usually high HER2/neu enriched (Option D ruled out) Negative Positive Ki-67 high Claudin low Negative Negative Claudin low

References:

Bailey and Love, Short Practice of Surgery, 28th Edition, Page 931. Robbins and Cotran, Pathologic basis of Disease, 10th Edition, Page 1049, 1056-1058.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q16: What preoperative intervention can be administered to minimise intraoperative bleeding in a 32-year-old female patient diagnosed with Grave's disease, presenting with eye symptoms and an enlarged thyroid, who is scheduled to undergo a total thyroidectomy? (Q855665)

A. Potassium iodide

B. Propranolol

C. Propylthiouracil

D. Betamethasone

Correct Answer: A. Potassium iodide

Explanation: The most appropriate preoperative intervention to minimise intraoperative bleeding in a patient with Grave's disease scheduled for a total thyroidectomy is Potassium Iodide . It reduces thyroid vascularity and size, helping minimise bleeding during surgery. Mechanism: It inhibits thyroid hormone synthesis and decreases the thyroid gland's vascularity. Lugol’s Iodine It is a Saturated Potassium Iodide Solution (5% iodine + 10% potassium iodide) Dose : 3 drops TID for 7-10 days. Role: Reduce Vascularity: Used pre-operatively to reduce the vascularity of the thyroid gland. This helps in minimising bleeding during surgery and prevents complications. (Option A) Prevent Thyroid Storm: Decreasing vascularity also helps prevent thyroid storms, which can occur if there is an excessive release of thyroid hormones during or after surgery. Iodine's Effect: Iodine has a transient effect on thyroid function by inhibiting the release of thyroid hormones from the thyroid gland. This phenomenon is known as the Wolff-Chaikoff effect . In Toxic Multinodular Goiter , Lugol's iodine may not achieve the goal of temporary euthyroidism and instead may exacerbate hyperthyroidism due to the Jod-Basedow phenomenon. Propranolol (Option B) is a beta-blocker that can be used to manage the symptoms of hyperthyroidism, such as tremors, palpitations, and anxiety. It does not affect thyroid vascularity or directly reduce intraoperative bleeding. Propylthiouracil (PTU) (Option C) is an anti-thyroid medication used in the management of hyperthyroidism (by inhibiting thyroid hormone production) but does not reduce thyroid vascularity or intraoperative bleeding. Betamethasone (Option D) is a corticosteroid that has anti-inflammatory and immunosuppressive properties. It can be used for inflammation and immune suppression but does not reduce thyroid vascularity or intraoperative bleeding in thyroid surgery.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 863. Sabiston’s Textbook of Surgery, 21st Edition, Page 888. SRB’s Manual of Surgery, 6th Edition, Page 464.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q17: What is the probable diagnosis for a 30-year-old woman who complains of a painless mass in her left breast that can be felt? The mass is highly movable, measures 3 x 3 cm, and has a rubbery texture. (Q793449)

A. Breast abscess

B. Phyllodes tumor

C. Fibroadenoma

D. Invasive ductal carcinoma

Correct Answer: C. Fibroadenoma

Explanation: The most likely diagnosis, in this case, is fibroadenoma. Fibroadenomas are benign (non-cancerous) breast tumors that are common in women between the ages of 20 and 40. They are made up of glandular and connective tissue and are often hormone-responsive, meaning they can change in size with hormonal fluctuations. On examination, fibroadenomas typically present as a well-circumscribed, mobile, and painless mass in the breast. They are usually rubbery or firm in consistency and can vary in size. Incorrect Choices: Option a: Breast abscesses, on the other hand, are typically associated with redness, warmth, and tenderness in the breast, as well as fever and other signs of infection. Option b: Phyllodes tumors are another type of breast tumor that can be mistaken for a fibroadenoma, but they tend to be larger in size and have a more irregular shape. Option d: : IDC often presents as a breast lump, which may feel hard or have an irregular shape, but it is typically not as mobile or well-circumscribed as a fibroadenoma. IDC may cause the nipple to become inverted or to produce discharge. Invasive ductal carcinoma is not typically associated with redness, warmth, or tenderness in the breast

↑ *Back to this question in Part A*

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Q18: Which of the following carries the lowest risk of developing invasive ductal carcinoma? (Q793425)

A. Florid epithelial hyperplasia

B. Papilloma with fibrovascular core

C. Atypical hyperplasia

D. Squamous metaplasia

Correct Answer: D. Squamous metaplasia

Explanation: Correct choice : Option 4 :Invasive ductal carcinoma (IDC) is the most common type of breast cancer, accounting for around 70-80% of all cases. It develops from the cells that line the milk ducts and can invade surrounding tissues. Squamous metaplasia is a benign breast condition that is characterized by a change in the normal breast tissue cells to a squamous cell type. Squamous metaplasia is not considered a risk factor for developing breast cancer. Incorrect Choices: Option a: Florid epithelial hyperplasia is a benign breast condition that is characterized by an overgrowth of cells in the ducts and lobules of the breast. While florid epithelial hyperplasia is not cancerous, it can be a risk factor for developing breast cancer. Option b: Papilloma with fibrovascular core is a benign growth that develops in the ducts of the breast. It is usually small and does not cause any symptoms, but in some cases, it can cause nipple discharge. Like florid epithelial hyperplasia, a papilloma can be a risk factor for developing breast cancer. Option c: atypical hyperplasia is a benign breast condition that is characterized by abnormal growth of cells in the ducts and lobules of the breast. Atypical hyperplasia is considered a high-risk lesion and is associated with an increased risk of developing breast cancer.

References:

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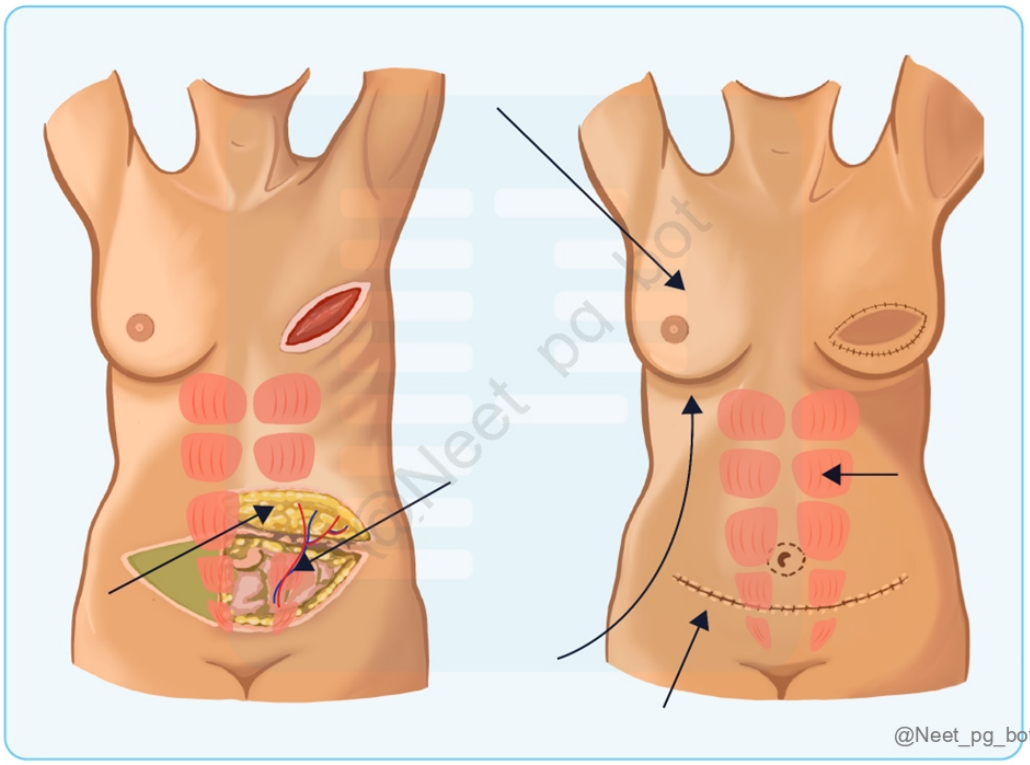
Q19: Which of the following is true about the flap given in the image? (Q858485)

A. Pedicled TRAM based on superior epigastric artery

B. Free TRAM based on superior and inferior epigastric artery

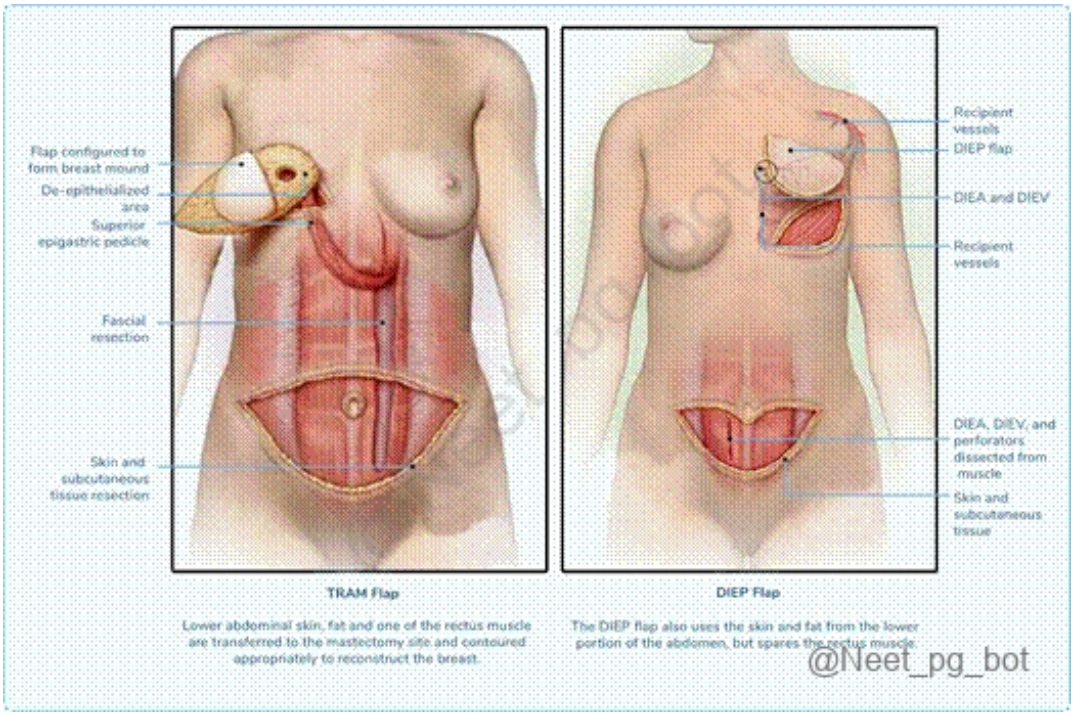
C. DIEP based on deep inferior epigastric artery

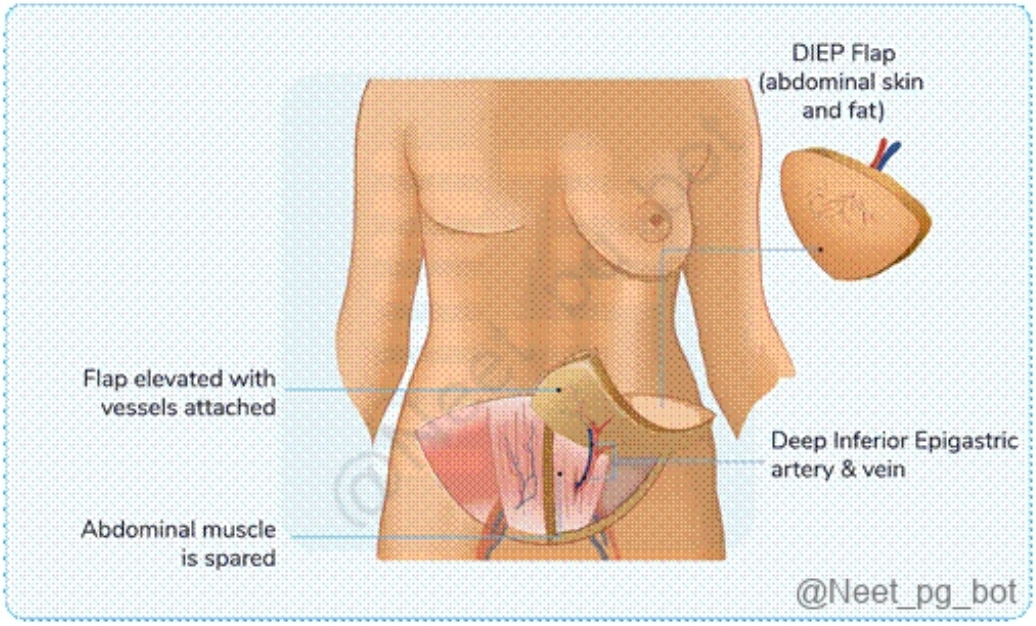
D. Lower abdominal fat-based inferior epigastric vessels



Correct Answer: C. DIEP based on deep inferior epigastric artery

Explanation: The flap given is DIEP (Deep Inferior Epigastric Perforator Flap), which involves harvesting tissue from the lower abdomen without taking the muscle. The flap relies on the deep inferior epigastric artery for blood supply, making it a muscle-sparing option for breast reconstruction or other soft tissue reconstructions. It is the best flap for breast reconstruction as there is no risk of hernia and muscle weakness. Breast Reconstruction Flaps Flaps Clinical Correlation Transverse Rectus Abdominis Muscle Flap (TRAM) Free flap involves using tissue from the abdomen, including both skin and muscle (Option A ruled out) Most commonly used flap but not the best flap It is based on inferior epigastric vessels Disadvantage: causes weakness in infra umbilical region Deep Inferior Epigastric Artery Perforator flap (DIEP) Flap which uses skin and fat from lower abdomen, but spares abdominal muscles Best flap for breast reconstruction as there is no risk of hernia and muscle weakness Latissimus Dorsi Flap Flap, which uses Latissimus dorsi muscle, skin and fat It is a type of subcutaneous flap based on thoracodorsal vessels. Pedicled TRAM based on the superior epigastric artery (Option A): A pedicled TRAM flap involves using the skin, muscle, fat and blood vessels, but the image does not depict a Pedicled TRAM flap ; the image actually shows a DIEP flap. Lower abdominal fat-based inferior epigastric vessels (Option D) The image does not depict lower abdominal fat based on inferior epigastric vessels; the image actually shows a DIEP flap.





References:

Sabiston's Text Book of Surgery, 21st Edition, Pages 861, 862

↑ *Back to this question in Part A*

@Neet_pg_bot

Q20: A woman presented with the following findings in the left breast for 3 months and pain for 2 months. What is the management plan for the following? (Q879127)

A. Simple mastectomy followed by management of complications

B. Neoadjuvant chemotherapy followed by radical mastectomy

C. Radical mastectomy with Axillary Lymph node dissection

D. Neoadjuvant chemotherapy followed by MRM and RT



Correct Answer: D. Neoadjuvant chemotherapy followed by MRM and RT

Explanation: Correct Option D - Neoadjuvant chemotherapy followed by MRM and RT: Inflammatory breast cancer (IBC) is a locally advanced , highly aggressive cancer. The standard of care is: Neoadjuvant chemotherapy (anthracycline + taxane regimen) Modified radical mastectomy (MRM) (not radical mastectomy) Post-mastectomy radiotherapy (mandatory due to high recurrence risk) Management of Locally Advanced Breast Cancer (LABC) (Stages Involved: Stage IIIA, IIIB and IIIC) Neoadjuvant Chemotherapy (NACT) Administered before surgery to shrink the tumor, making it operable and allowing for breast conservation if possible (also assess the response to treatment). Modified Radical Mastectomy (MRM) Performed after neoadjuvant chemotherapy to remove the breast tissue and axillary lymph nodes (local control; address regional disease). Post-Surgery Radiotherapy (RT) Administered after MRM to reduce the risk of local recurrence and ensure any remaining microscopic disease is treated. NACT + MRM + RT is the standard approach for LABC to ensure comprehensive treatment. This sequence allows for effective tumor reduction, surgical resection, and post-operative control to prevent a recurrence. Incorrect Options: Simple mastectomy followed by management of complications (Option A): Simple

mastectomy does not address nodal disease or achieve proper local control in locally advanced breast cancer. Neoadjuvant chemotherapy followed by radical mastectomy (Option B): Radical mastectomy is obsolete and offers no survival benefit over MRM while causing greater morbidity. Radical mastectomy with axillary lymph node dissection (Option C): Performing an upfront radical mastectomy without neoadjuvant therapy is inappropriate in locally advanced disease where tumor downstaging is required first.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Pages 939-941.

Schwartz's Principles of Surgery, 11th Edition, Pages 582-585.

SRB's Manual of Surgery, 6th Edition, Pages 548, 549.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q21: Identify the wrong statement about late dumping syndrome from the following? (Q879109)

A. Symptoms start after 2 hours of food intake

B. Symptoms worsen with physical activity

C. Symptoms are relieved on lying down

D. Clinical features include tremors, dizziness and palpitations

Correct Answer: C. Symptoms are relieved on lying down

Explanation: Correct Option C - Symptoms are relieved on lying down: Late dumping causes post-prandial hypoglycemia 1.5–3 hours after eating; lying down helps early dumping but not the hypoglycemic symptoms of late dumping. Clinical features of Dumping Syndrome: GI symptoms : Abdominal pain, early satiety, nausea, vomiting, diarrhoea, bloating Vasomotor systemic symptoms (Option D ruled out) : Diaphoresis, tachycardia, palpitations, headache, syncope Early Dumping Late Dumping It is seen within 30 minutes of meals Worsens with food intake Relieved by lying down (Option C) Rapid passage of high osmolar food from the stomach into the small intestine ↓ Rapid shift of extracellular fluid into the intestine ↓ Distension of the small intestine ↓ Symptoms begin It is seen after 1-3 hours of meals (Option A ruled out) Less common Worsens with exercise (Option B ruled out) Relieved by food Rapid dumping of carbohydrates into the small intestine. ↓ Rapid absorption and hyperglycemia ↓ Increased release of insulin ↓ Leading to Reactive Hypoglycemia ↓ Activates the adrenal gland ↓ Catecholamines released: diaphoresis, tremulousness, light-headedness, tachycardia, and confusion. Treatment: Intravenous fluids Treatment: Oral glucose is given

References:

Sabiston Textbook of Surgery, 21st Edition, Page 1217

↑ *Back to this question in Part A*

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Q22: A 59-year-old lady presents with a progressive, painless lump in the breast. What is the cause for the following skin change? (Q855834)

A. Infiltration of subdermal lymphatics

B. Infiltration of the lactiferous duct

C. Involvement of Cooper’s ligament

D. Spread of the tumour to the anterior chest wall



Correct Answer: A. Infiltration of subdermal lymphatics

Explanation: In a patient with progressive, painless breast lump and skin changes, the most likely cause of the skin changes is infiltration of subdermal lymphatics. In breast cancer, the tumour cells can spread to the lymphatic system, which can lead to obstruction of the lymphatic drainage of the skin. This obstruction can cause skin changes such as peau d’orange (skin that appears dimpled or like orange peel) due to fluid accumulation and swelling in the dermis. {{caption_text}} {{caption_text}} Infiltration of the lactiferous duct (Option B) could cause a nipple discharge , but it is not the primary cause of skin changes like peau d’orange. Involvement of

Cooper’s ligament (Option C) can cause retraction or deformity of the breast , leading to a pulled-in appearance of the skin; it does not directly lead to the skin changes. Spread of the tumour to the anterior chest wall (Option D) involves the deeper tissues of the muscle and rib cage and may cause fixation of the breast or a palpable mass that is immobile . This is less likely to cause the specific skin changes associated with lymphatic obstruction.





References:

Robbins and Cotran, Pathologic Basis of Disease, 10th Edition, Page 1058

↑ *Back to this question in Part A*

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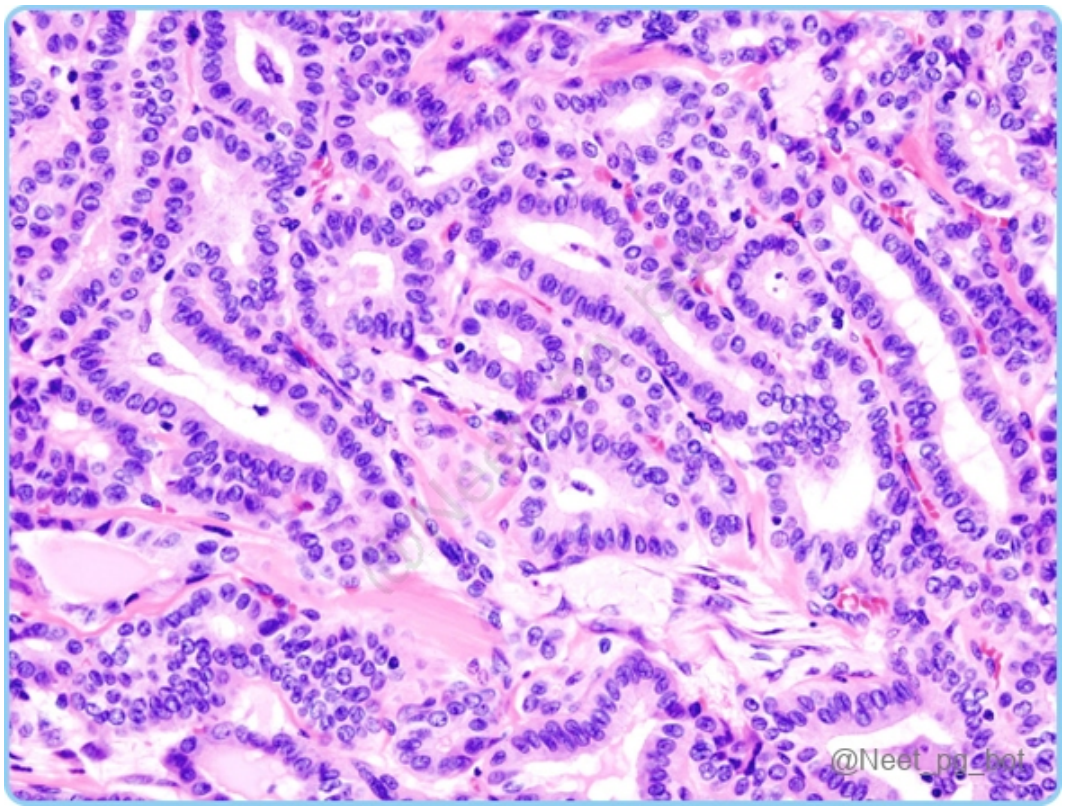
Q23: A male patient presented with midline neck swelling. He later developed cervical node enlargement. The histopathology of the lesion is shown below. Which of the following statements is false about this condition? (Q855784)

A. Excellent prognosis is associated with this condition

B. It spreads quickly via lymphatics

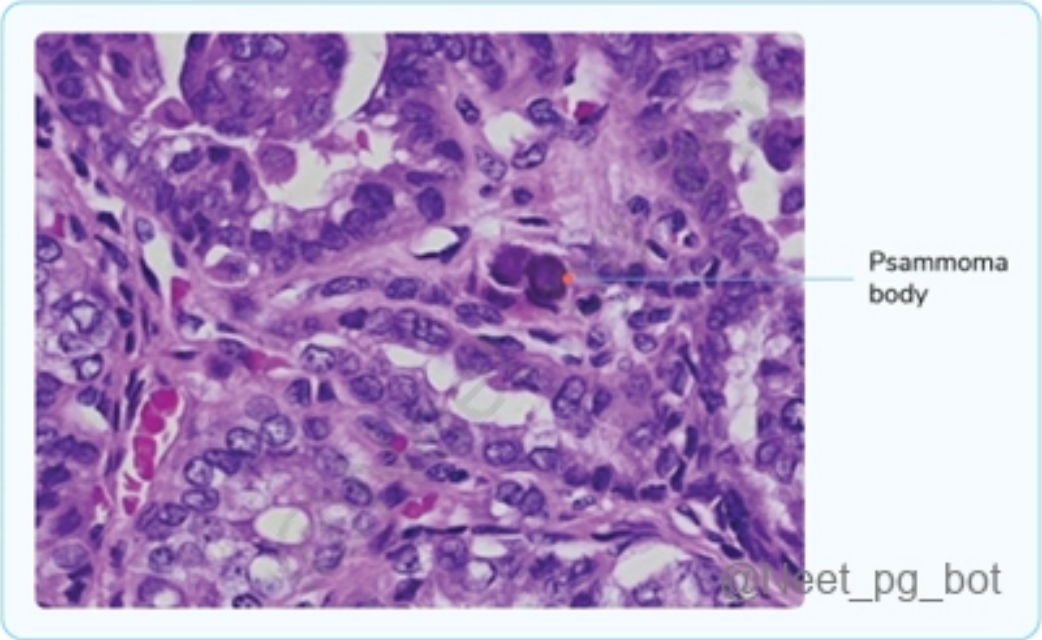
C. Nuclear characteristics are used for the identification

D. Fine needle aspiration cytology (FNAC) is not diagnostic



Correct Answer: D. Fine needle aspiration cytology (FNAC) is not diagnostic

Explanation: The patient’s presentation of midline neck swelling , cervical node enlargement , and histopathological findings strongly suggest a diagnosis of Papillary Thyroid Carcinoma (PTC) FNAC is a minimally invasive diagnostic procedure and is the gold standard in diagnosing thyroid nodules, including PTC , as it can reveal characteristic cytological features. PTC is the most common type of thyroid cancer and is characterised by lymphatic spread. Papillary cell carcinoma Origin Follicular cells Risk factors Radiation Thyroglossal cyst Hashimoto’s thyroiditis Genetics BRAF, RET-PTC Clinical Manifestations Seen in the 3rd to 4th decade. Midline swelling in the anterior part of the neck Occasionally, lateral aberrant thyroid is seen. Metastasis Lymphatic (Option B ruled out) Histopathology (Option C ruled out) Papillary projections Optically clear nuclei (Orphan Annie eye nuclei) Pseudo-inclusion bodies Psammoma bodies (Dystrophic calcification) {{caption_text}} These characteristic histological features help for identification. Prognosis Excellent (Option A ruled out)



References:

Bailey and Love's Short Practice of Surgery, 28th edition, Pages 866 - 877

↑ *Back to this question in Part A*

@Neet_pg_bot

Q24: Grey-Turner's sign is seen in: (Q859891)

A. Acute appendicitis

B. Acute pancreatitis

C. Acute cholecystitis

D. Acute hepatitis

Correct Answer: B. Acute pancreatitis

Explanation: Grey-Turner's sign refers to bluish discolouration or bruising of the flanks (the sides of the abdomen), which can be seen in severe acute pancreatitis . It is a sign of retroperitoneal hemorrhage , which occurs when pancreatic inflammation spreads from the anterior pararenal space to the lateral edge of the quadratus lumborum muscle, causing bruising on the flanks. {{caption_text}} Acute appendicitis (Option A) generally presents with right lower abdominal pain, fever, and nausea. It does not usually cause retroperitoneal haemorrhage or bruising, so Grey-Turner's sign is not associated with it. Acute cholecystitis (Option C) involves inflammation of the gallbladder, usually causing right upper quadrant pain. While it may cause jaundice or tenderness, Grey-Turner's sign is not typically seen. Acute hepatitis (Option D) involves liver inflammation, often caused by viral infections

or drug-induced liver injury, which can cause jaundice, but Grey-Turner's sign is not characteristic of hepatitis.



References:

Bailey & Love’s Short Practice of Surgery, 28th Edition, Page 1055.

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Q25: Best way to localise extra-adrenal pheochromocytoma: (Q859889)

A. X-ray

B. Nucleotide scan

C. VMA excretion

D. Clinical examination

Correct Answer: B. Nucleotide scan

Explanation: The best method to localise extra-adrenal pheochromocytomas is through a Nucleotide scan (such as MIBG or PET scan), which allows for accurate identification of the tumour's location. MIBG is a radiopharmaceutical that is selectively absorbed by neuroendocrine tumours, such as pheochromocytomas. When radioactive iodine-labelled MIBG is administered intravenously, the tumour cells take it up due to their affinity for norepinephrine. Once the MIBG is taken up by the tumour, a whole-body scan is performed using a gamma camera , allowing for the precise localization of pheochromocytomas, including extra-adrenal tumours . X-ray (Option A) is not suitable for visualising soft tissue tumours like pheochromocytomas or detecting abnormal growths. It is better suited for visualising bones or detecting larger, more obvious structural abnormalities. VMA excretion (Option C) is a metabolite of catecholamines and can be measured in urine to help diagnose pheochromocytoma . However, while increased VMA (Vanillyl mandelic acid) excretion is suggestive of pheochromocytoma, it does not help localise the tumor . Clinical examination (Option D) can reveal signs and symptoms of pheochromocytoma, but it is not reliable for localising an extra-adrenal pheochromocytoma. Symptoms like hypertension, sweating, and tachycardia suggest the presence of pheochromocytoma, but further imaging studies (like the nucleotide scan) are required for accurate localisation.

References:

Grainger and Allison’s Diagnostic Radiology, 7th Edition, Page 950.

Bailey & Love’s Short Practice of Surgery, 28th Edition, Pages 900, 901.

↑ *Back to this question in Part A*

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Q26: What kind of thyroid cancer is frequently linked to prior radiation exposure, elevated RET/PTC rearrangements, and BRAF mutations? (Q859619)

A. Follicular carcinoma

B. Papillary carcinoma

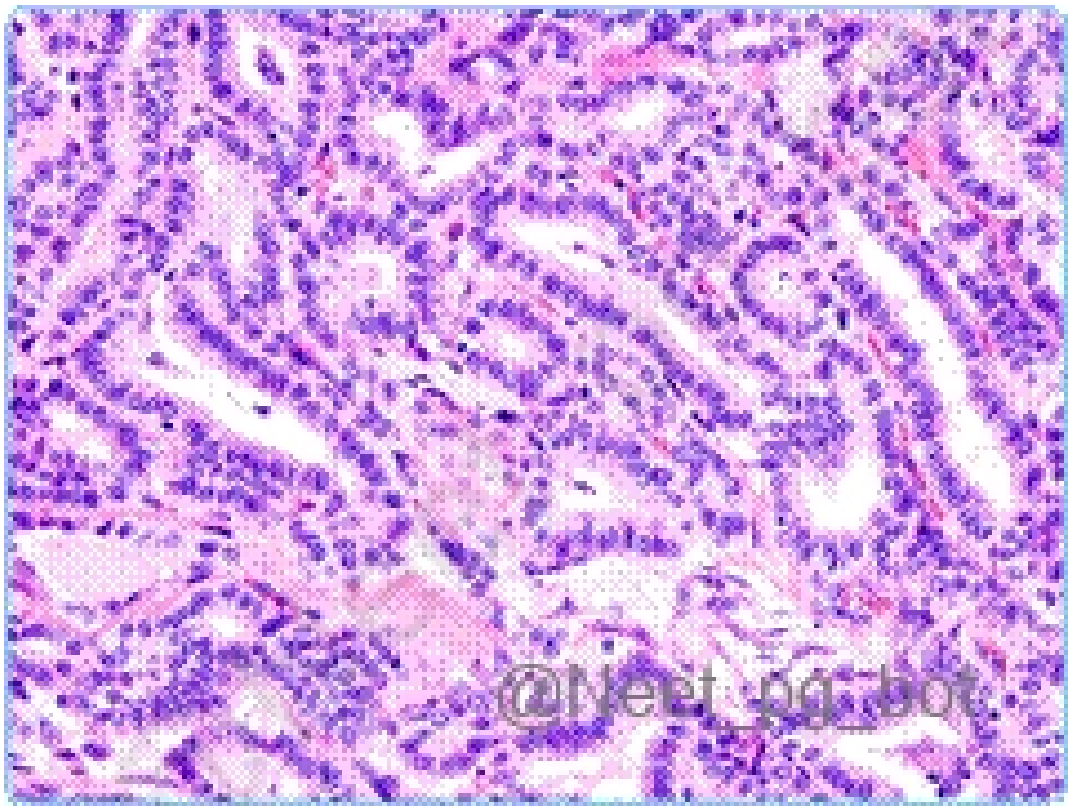
C. Anaplastic carcinoma

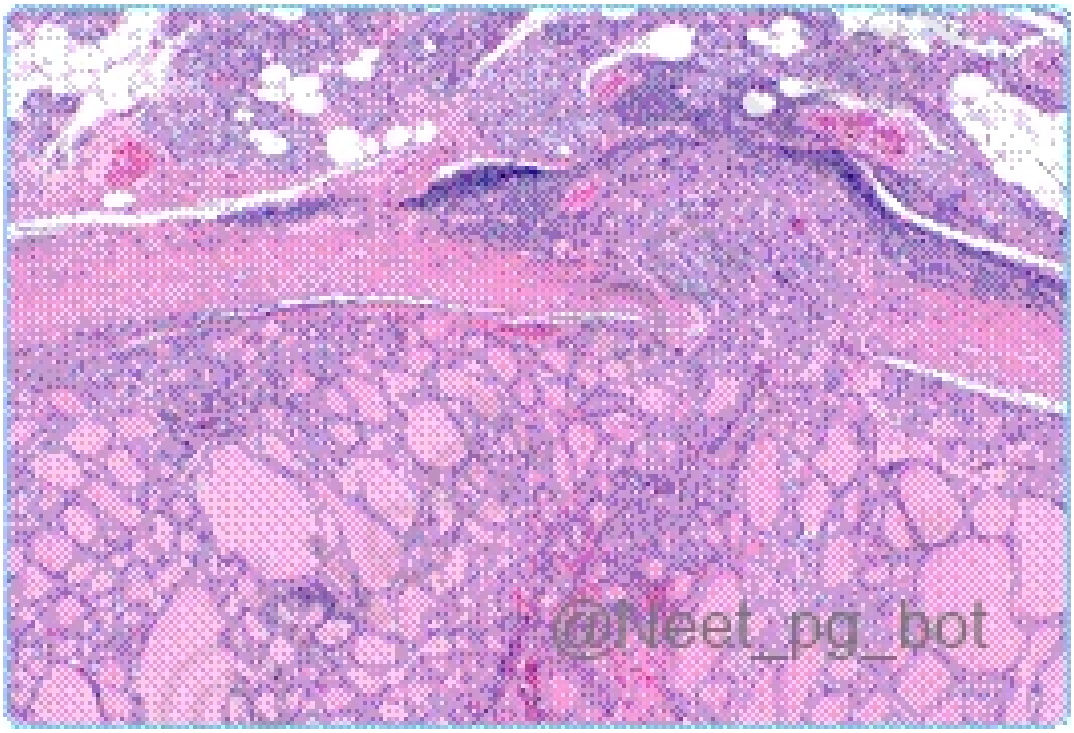
D. Medullary carcinoma

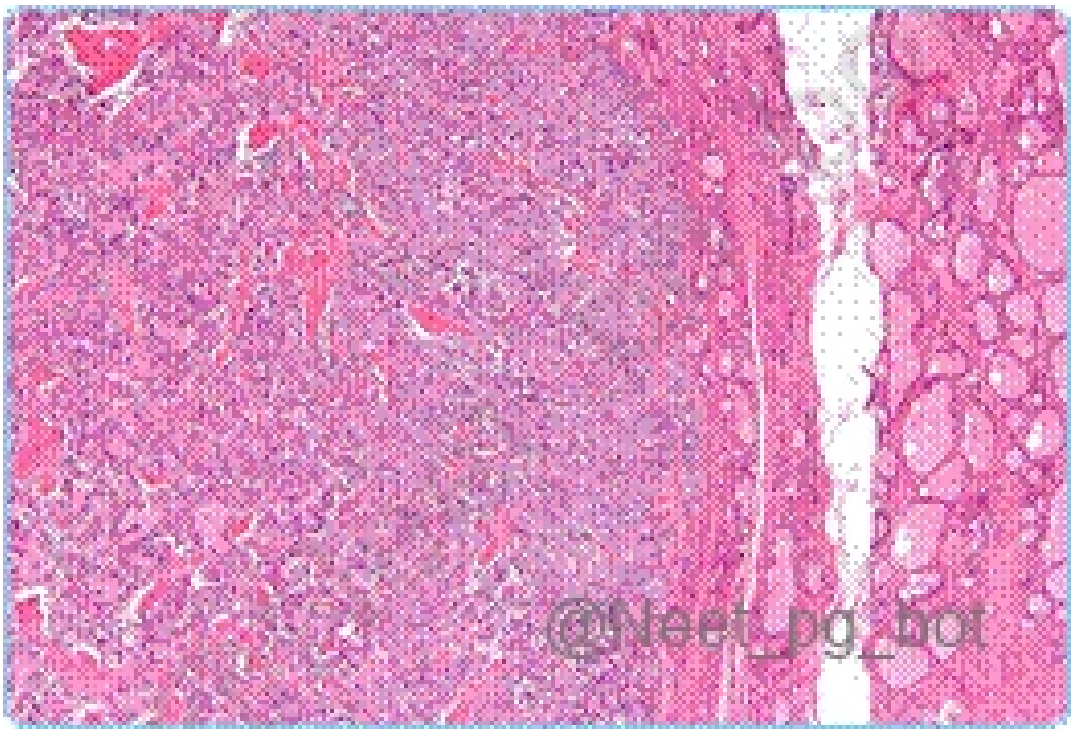
Correct Answer: B. Papillary carcinoma

Explanation: Papillary thyroid carcinoma (PTC) is the most common type of thyroid cancer and is frequently linked to prior radiation exposure . It is also associated with RET/PTC rearrangements and BRAF mutations , both of which are genetic alterations commonly found in this type of cancer. Papillary (Option B) Follicular (Option A ruled out) Medullary (Option D ruled out) Anaplastic (Option C ruled out) Origin Follicular cells Follicular cells Para follicular cells Follicular cells Risk factors Radiation Thyroglossal cyst Hashimoto’s thyroiditis Iodine deficiency Multinodular goitre - - Genetics BRAF, RET-PTC PAX-8,/PPAR-1, PTEN, P-53, RAS RET, MEN II P53 Clinical Manifestations Seen in the 3rd to 4th decade. Midline swelling in the anterior part of the neck Occasionally, lateral aberrant thyroid is seen. Seen in the 5th to 6th decade. A sudden increase in the size of the

swelling Minimal or no pain Raised calcitonin. History of diarrhoea Family history of pheochromocytoma or hyperparathyroidism Metastasis Lymphatic Hematogenous Both Both and Direct invasion. Histopathology Optically clear nuclei (Orphan Annie eye nuclei) Dystrophic calcification (Psammoma bodies) {{caption_text}} Follicles (multiple foci are seen) {{caption_text}} Amyloid deposition {{caption_text}} Highly pleomorphic cells, spindle cells, giant cells, often areas of necrosis and mitotic figures.







References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Pages 866 - 871

↑ *Back to this question in Part A*

@Neet_pg_bot

Q27: A 15-year-old boy undergoes bilateral adrenalectomy for phaeochromocytoma. On the third postoperative day, the boy feels lethargic and tired. Blood pressure is 80/60 mm Hg; there is no sign of bleeding. What could be the cause of this? (Q858492)

A. Addisonian crisis

B. SIADH

C. Diabetes insipidus

D. Cerebral salt wasting disease

Correct Answer: A. Addisonian crisis

Explanation: The most likely cause of the patient's lethargy , fatigue , and hypotension (with no sign of bleeding) is an Addisonian crisis (also known as an adrenal crisis) due to adrenal insufficiency after bilateral adrenalectomy . It occurs when there is a sudden, severe deficiency of cortisol and aldosterone . It leads to hypotension ,

electrolyte imbalances , and symptoms like lethargy and fatigue . It is managed by IV hydrocortisone. SIADH (Option B) results in hyponatremia due to excessive ADH secretion, but it does not explain the low blood pressure and fatigue in this patient, as the Addisonian crisis does. Diabetes insipidus (Option C) involves a deficiency of ADH or kidney resistance to it, leading to excessive urination and thirst . It would not typically present with the hypotension and lethargy seen in this patient. Cerebral salt wasting disease (Option D) can potentially cause increased urinary loss of sodium, hyponatremia and hypovolemia due to CNS conditions, while adrenal crisis shows low sodium alongside other symptoms related to low cortisol and aldosterone levels, requiring immediate hormone replacement therapy.

References:

Davidson's Principles and Practice of Medicine, 24th Edition, Pages 672-673

↑ *Back to this question in Part A*

@Neet_pg_bot

Q28: A 28-year-old lactating mother presents with pain in her left breast. Which of the following is the most likely cause of acute mastitis? (Q857792)

A. Breast engorgement

B. Hormonal influence

C. Absence of lactation

D. Crack in the nipple

Correct Answer: D. Crack in the nipple

Explanation: The most likely cause of Acute Mastitis is crack in the nipple. It refers to infammation of the breast tissue. It can occur in lactating (more common) as well as non-lactating women. It occurs during the first month of breastfeeding. It is caused by a local infection (due to cracks and fissures in the nipples). Organisms: Staphylococcus aureus (more common), Streptococci Clinical features: Erythematous and painful breast Fever Single or multiple abscesses (Staphylococci) Cellulitis (Streptococci) Management: Antibiotics Continued milk expression from the breast. Breast engorgement (Option A) causes swelling and discomfort but doesn’t lead to infection or mastitis unless complications like blocked ducts or nipple damage occur. It also lacks the fever and redness seen in mastitis. Hormonal influence (Option B) , such as those during pregnancy or menstruation, can cause breast tenderness and swelling, but they don't directly lead to acute mastitis. While hormonal fluctuations may contribute to conditions like engorgement, they don't cause the infection or inflammation seen in mastitis. Absence of lactation (Option C) , or insufficient milk supply, may cause discomfort or engorgement but is not linked to acute mastitis. Mastitis usually occurs in breastfeeding women due to milk stasis, blocked ducts, or nipple trauma, which allow bacteria to enter. If a mother isn't lactating, mastitis is unlikely unless there's an unrelated infection.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 927.

Robbins & Cotran Pathologic Basis of Disease, 10th Edition, Page 1040.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q29: Which of the following nerves is least injured during thyroid surgery? (Q856287)

A. Recurrent laryngeal nerve

B. Cervical sympathetic trunk

C. External laryngeal nerve

D. Marginal mandibular nerve

Correct Answer: D. Marginal mandibular nerve

Explanation: The marginal mandibular nerve innervates the muscles of the lower lip and is the least at risk during thyroid surgery. It is not directly involved or at risk during thyroid surgery, as it is not in close proximity to the thyroid gland. Complications of Thyroidectomy Hemorrhage Bleeding from muscular arteries or slippage of ligature from superior thyroid vessels. Complication: Tension hematom a causing respiratory distress. Management: Immediate re-operation, open sutures, control bleeding, drain hematoma, and close the wound. Respiratory Obstruction Primary Cause: Laryngeal edema from extubation injury. (Most Common Complication) Other Causes: RLN palsy and tension hematoma. Nerve Injury Commonly Injured Nerve: External branch of the superior laryngeal nerve. Other Injuries: RLN Injury causing palsy and Cervical sympathetic trunk causing Horner's syndrome. (Options A & B ruled out) Parathyroid Insufficiency Ligating the inferior thyroid artery away from the thyroid leads to parathyroid vascular infarction. Causes hypocalcemia (low calcium levels) presenting 2–5 days post-surgery. Thyroid Insufficiency Total thyroidectomy leads to hypothyroidism and requires lifelong levothyroxine replacement. Thyrotoxic Crisis Inadequate preoperative preparation in hyperthyroid patients leads to the release of thyroid hormones during surgery. The external laryngeal nerve (Option C) is a branch of the superior laryngeal nerve that innervates the cricothyroid muscle, and it can be injured during thyroidectomy.

References:

Bailey & Love’s Short Practice of Surgery, 28th edition, Page 865

↑ *Back to this question in Part A*

@Neet_pg_bot

Q30: A 40-year-old woman presents with complaints of swelling of the right breast over the past 15 days. On examination, there was a local rise in temperature, and the

lump was mobile over the chest wall. What is the likely diagnosis? (Q856239)

A. Inflammatory carcinoma

B. Giant fibroadenoma

C. Phyllodes tumour

D. Galactocele



Correct Answer: A. Inflammatory carcinoma

Explanation: The presentation of the patient, along with redness and swelling of the right breast with a mobile lump, is suggestive of Inflammatory breast carcinoma. It is a rare but aggressive form of breast cancer characterised by pain, redness, swelling , and warmth of the breast. In I nflammatory breast carcinoma, edematous skin is tethered to the breast by Cooper ligaments and mimics orange peel or peau d'orange. {{caption_text}} Microscopy shows: No inflammation is present. Diffuse lymphovascular space plugging with carcinoma cells in dermal lymphatics. The presentation can be confused with a breast infection, leading to delayed diagnosis. The stage of Inflammatory Breast Cancer (IBC) is always T4d, which corresponds to at least stage III breast cancer. This indicates locally advanced disease with a poor prognosis, though it may be stage IV if distant metastases are present. Giant fibroadenoma (Option B) is a benign breast tumour that can grow large but is usually firm and mobile . It is not associated with warmth in the breast and is unlikely to cause signs of inflammation, as seen in inflammatory carcinoma. Phyllodes tumours (Option C), also called cystosarcoma phyllodes are stromal tumours developing from the connective tissue of the breast. Most of them are benign, but a small number can be borderline or malignant. They do not generally cause the redness and skin changes seen in inflammatory breast cancer. Galactocele (Option D) is a benign lump, which is a milk retention cyst, and it usually occurs in lactating women.

It presents as a moderately firm, painless mass that may gradually or rapidly enlarge, with size fluctuations throughout the day. While they are generally painless and non-inflammatory, complications can occasionally lead to infection.



References:

Robbins and Cotran Pathologic Basis of Disease, 10th Edition, Page 1058

↑ *Back to this question in Part A*

@Neet_pg_bot

Q31: What will be the most likely associated condition with increased TSH and low T4 levels? (Q856211)

A. Hypoparathyroidism

B. Pituitary Adenoma

C. Grave's disease

D. Hashimoto's thyroiditis

Correct Answer: D. Hashimoto's thyroiditis

Explanation: Hashimoto's Thyroiditis is an autoimmune hypothyroid condition presenting with high TSH and low T3/T4. In Hashimoto's thyroiditis, the immune system mistakenly targets the thyroid gland, leading to chronic inflammation and damage. Antibodies play a crucial role in this process, Anti-Thyroid Peroxidase (TPO) Antibodies: Target an enzyme called thyroid peroxidase, which helps synthesise thyroid hormones. They are a hallmark of Hashimoto's thyroiditis and are frequently elevated in affected individuals. Anti-Thyroglobulin(Tg) Antibodies: Thyroglobulin is a protein involved in thyroid hormone production. Antibodies against thyroglobulin can disrupt hormone synthesis and contribute to thyroid gland damage. These antibodies and other immune cells contribute to the characteristic features of Hashimoto's thyroiditis, including thyroid gland enlargement, decreased thyroid hormone production, and symptoms of hypothyroidism. Hypoparathyroidism (Option A) is a condition where there is an underproduction of parathyroid hormone (PTH), leading to low blood calcium levels. It involves low PTH levels and affects calcium balance, but it is not related to thyroid hormone levels. Pituitary Adenoma (Option B) is a benign tumour of the pituitary gland that can affect its ability to produce hormones, including TSH. It can cause secondary hypothyroidism by not secreting enough TSH, but the given scenario is suggestive of primary hypothyroidism, not secondary (also called central hypothyroidism: Low TSH, T3, and T4 levels). Grave's disease (Option C) is an autoimmune disorder that causes hyperthyroidism, which leads to elevated T4 and suppressed TSH , not low T4 and high TSH. Therefore, this is the opposite of what is presented in the question.

References:

Harrison’s principle of Internal Medicine, 21st Edition, Page 2934.

Sabiston, Text Book of Surgery, 21st Edition, Pages 884, 886.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q32: What risks are associated with the initiation of tamoxifen in a patient diagnosed with unilateral breast cancer? (Q856774)

A. Ovarian cancer

B. Endometrial cancer

C. Breast cancer, on the other side

D. Cervical cancer

Correct Answer: B. Endometrial cancer

Explanation: Tamoxifen is a selective estrogen receptor modulator (SERM) used in the treatment of breast cancer, which has a potential risk for endometrial cancer. While it is effective at preventing estrogen from binding to receptors in breast tissue, it can act as an estrogen agonist in the endometrium. Prolonged use of Tamoxifen leads to endometrial hyperplasia , which is a significant risk factor for developing endometrial cancer. Ovarian cancer (Option A): Tamoxifen does not significantly increase the risk of ovarian cancer. Breast cancer on the other side (Option C): Tamoxifen reduces the risk of contralateral breast cancer by blocking estrogen receptors in the breast

tissue, hence lowering the risk. Cervical cancer (Option D): There is no direct association between tamoxifen use and an increased risk of cervical cancer.

References:

William's Gynaecology, 4th Edition, Page 699.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q33: Which of the following statements is correct regarding adequate thyroid FNAC sampling? (Q856768)

A. 6 follicular clusters each with 10 cells each

B. 3 follicular clusters with 10-15 cells each

C. 10 follicular cell clusters with 6-8 cells each

D. 12 follicular cell clusters with 10-12 cells each

Correct Answer: A. 6 follicular clusters each with 10 cells each

Explanation: For adequate thyroid FNAC sampling , the recommended guideline is typically 6 follicular clusters , each containing at least 10 cells . This ensures accurate results and reduces the risk of false-negative findings. Thyroid FNAC is a procedure to collect cells for cytology, and adequate sampling is essential for reliable results. The Bethesda System for Reporting Thyroid Cytopathology (TBSRTC) is a standardised reporting system designed to classify thyroid Fine-Needle Aspiration Cytology (FNAC) biopsy results. The system includes six diagnostic categories, ranging from non-diagnostic/unsatisfactory to malignant. The Bethesda System for Reporting Thyroid Cytopathology Diagnostic category Risk of malignancy (%) Usual management Non-diagnostic 5-20 Repeat FNAC with ultrasound guidance Benign 2-7 Clinical and sonographic follow-up Atypia of undetermined significance 13-30 Repeat FNAC, molecular testing, diagnostic lobectomy, or surveillance Follicular neoplasm 23-34 Molecular testing, diagnostic lobectomy Suspicious for malignancy 67-83 Molecular testing, lobectomy, or near-total thyroidectomy Malignant 97-100 Lobectomy or near-total thyroidectomy Other options B, C & D do not meet the recommended criteria for an adequate thyroid FNAC sample.

References:

NIHLink

The Bethesda System for Reporting Thyroid Cytopathology, 3rd Edition, Page 4

↑ *Back to this question in Part A*

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Q34: A 50-year-old female presents with a 4 x 3 cm irregular mass in the upper outer quadrant of the right breast, which is not fixed to the skin or the chest wall. A 2 cm lymph node is palpated in the right axilla. No mass is noted in the opposite breast. Which of the following investigations would you perform in this patient? Bilateral Mammography PET Scan Biopsy of the breast mass USG guided biopsy of the lymph node (Q856729)

A. 1, 2, 3 & 4

B. 1, 2 & 3

C. 1, 3 & 4

D. 1 & 3

Correct Answer: C. 1, 3 & 4

Explanation: This patient presents with a palpable breast lump and axillary lymphadenopathy — both suggestive of breast carcinoma . Following investigations needs to be done: Mammography (1): It is the gold standard for evaluating suspicious breast masses. In this case, it helps assess the mass's characteristics (e.g., shape, edges, density) and detect any other lesions in the contralateral breast, which is important given the patient's age and increased breast cancer risk. Biopsy of the breast mass (3): It is crucial to determine if the mass is malignant or benign (FNA or core needle). It provides tissue for histopathological examination, which guides treatment decisions based on tumour type, grade, and receptor status. USG-guided biopsy of the lymph node (4): To determine if the enlarged axillary lymph node represents metastatic spread; ultrasound guidance increases accuracy of sampling.■ Triple Assessment of Breast Examination 1. Clinical Examination Objective: Identify lumps, skin changes, nipple discharge, or lymphadenopathy. Procedure: Palpation of breasts and lymph nodes. 2. Imaging Methods: (Mammography ± Ultrasound) Mammography: Preferred for women over 40. Ultrasound: Used in younger women or for further evaluation. 3. Biopsy Types: FNA: Minimally invasive; used for cystic lesions. Core Needle: Preferred for solid masses. Excisional: Removes lump for examination. Triple assessment yields more accurate results than individual assessment. PET Scan (2) is generally used for staging or detecting distant metastasis after a diagnosis of breast cancer is confirmed. It is not normally employed in the initial workup of a palpable breast mass.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 915

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Q35: A patient underwent surgery for breast carcinoma. She now presents with painless swelling involving the arm, as shown in the image below. What is the most likely diagnosis? (Q856226)

A. Lymphedema

B. Lymphangiosarcoma

C. Venous thrombosis

D. Cellulitis



Correct Answer: A. Lymphedema

Explanation: The most likely diagnosis is Lymphedema , a common complication after breast cancer surgery, especially when lymph nodes are removed or damaged, leading to painless arm swelling from lymph fluid buildup. It is a frequent complication post-mastectomy or axillary lymph node dissection. Risk factors after breast cancer surgery include the extent of surgery, radiation, obesity, infection, and pre-existing lymphatic issues. Complications of Mastectomy: Lymphedema (Option A) Swelling is caused by the accumulation of lymph fluid in the arm or chest wall due to the removal of lymph nodes. (After MRM and axillary dissection). Clinical features: Square toes due to lymphatic fluid causing uniform swelling of digits. Stemmer's sign : Skin over the dorsum of the foot cannot be pinched because of subcutaneous fibrosis. {{caption_text}} {{caption_text}} {{caption_text}} Wound infection/Flap necrosis Postoperative infections where blackening of suture line is seen (flap necrosis), if necrosed site note removed, leads to wound infection Post-Mastectomy Pain Syndrome Chronic pain in the chest or upper arm due to nerve damage or scar tissue formation. Nerve Injuries Long thoracic nerve (winging of the

scapula) Thoracodorsal nerve (weakened shoulder adduction) Intercostobrachial nerve (dysaesthesia over medial aspect or upper arm) Medial pectoral nerve (pectoralis muscle atrophy, loss of chest wall contour) Lymphangiosarcoma (Option B ruled out) Stewart-Treves syndrome - Cancerous growth in the lymphatic vessels, often associated with long-standing lymphedema. After an average of 10.5 years following MRM and radiotherapy, the patient develops angiosarcoma. Hematoma formation Axillary vein injury or thrombosis (Option C ruled out) Seroma Shoulder dysfunction Pain and numbness Axillary hyperesthesia Cellulitis (Option D) causes swelling, warmth, redness, pain, and fever, which are not described in this case. {{caption_text}}




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References:

Sabiston Textbook of Surgery, 21st Edition, Page 832.

Textbook of SRB's Surgical Operations, 6th Edition, Page 25-26.

↑ *Back to this question in Part A*

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Q36: Which of the following is the most common cause of bloody nipple discharge? (Q852700)

A. Breast cancer

B. Fibroadenoma

C. Intraductal papilloma

D. Duct Ectasia

Correct Answer: C. Intraductal papilloma

Explanation: Intraductal papilloma: A benign tumor that forms in a milk duct in the breast. It is the most common cause of bloody nipple discharge. Symptoms : The most common cause of Nipple discharge (often clear or bloody), a palpable lump near the nipple. Causes : Age (35-55 years) Longtime exposure to estrogen Family history of breast cancer Diagnosis : Clinical breast examination Imaging: Mammography and ultrasound Biopsy to rule out malignancy. Treatment : Surgical removal of the papilloma and the affected duct and monitoring for any signs of recurrence. Incorrect Options: Breast cancer (Option A): Both ductal carcinoma in situ (DCIS) and invasive ductal carcinoma can present with bloody discharge. However, this is not the most common cause as compared to intraductal papilloma. Fibroadenoma (Option B): Benign breast tumors that are most common in

young women. They are usually painless, firm, and mobile lumps within the breast. Fibroadenomas do not typically cause bloody nipple discharge Duct ectasia (Option D): Inflammation and dilation of the ducts, which can sometimes cause bloody discharge. However, this is not the most common cause as compared to intraductal papilloma.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 924.

SRB's Manual of Surgery, 6th Edition, Page 556.

↑ *Back to this question in Part A*

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Q37: A patient presents with polyuria, polydipsia, lethargy, and abdominal pain. She also has a history of mood disorders and recurrent kidney stones. Which of the following investigations would not be useful in arriving at the diagnosis? (Q860481)

A. Nuclear sestamibi scan

B. USG neck

C. Dual-energy radiographic absorptiometry (DEXA)

D. Angiography of renal arteries

Correct Answer: D. Angiography of renal arteries

Explanation: The patient’s symptoms, including polyuria , polydipsia , lethargy , abdominal pain , and a history of recurrent kidney stones , strongly suggest a diagnosis of primary hyperparathyroidism , which can result in hypercalcemia . The most likely cause of primary hyperparathyroidism is a parathyroid adenoma. Angiography of renal arteries is typically used to evaluate the renal vasculature in cases of renal artery stenosis or other vascular abnormalities. However, it does not provide useful information for diagnosing primary hyperparathyroidism, which is the most likely diagnosis in this patient. Incorrect Options: Nuclear sestamibi scan (Option A) is used to identify parathyroid adenomas . It is a key investigation in the diagnosis of primary hyperparathyroidism , especially in localising the adenoma. USG neck (Option B) can also help in visualising parathyroid glands and is commonly used for parathyroid adenomas . Dual energy radiographic absorptiometry (DEXA) (Option C) is a test used to assess bone density and is often ordered to evaluate for osteoporosis , which is common in primary hyperparathyroidism due to bone resorption from elevated calcium.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 877, 878

SRB's Manual of Surgery, 6th Edition, Page 491

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4607146/

↑ *Back to this question in Part A*

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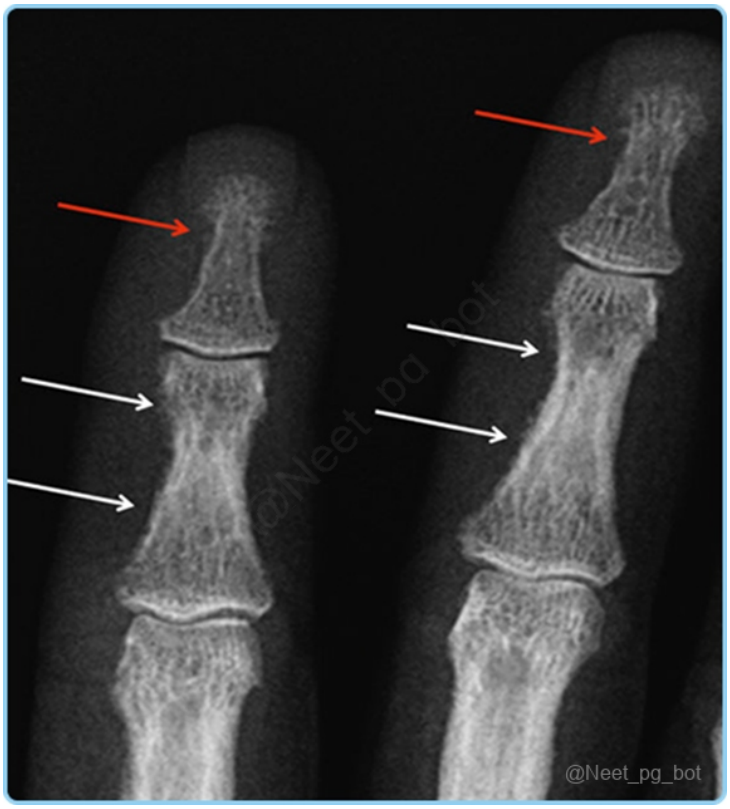
Q38: A middle-aged man with a history of renal calculi presents with bone pain and abdominal cramps. X-ray shows subperiosteal resorption of the 2nd and 3rd metacarpals and phalanges. Serum calcium and PTH are raised, and phosphate levels are decreased. Which of the following investigations will help localise the pathology? (Q860470)

A. 99Tc radiolabelled sestamibi scan

B. MRI scan

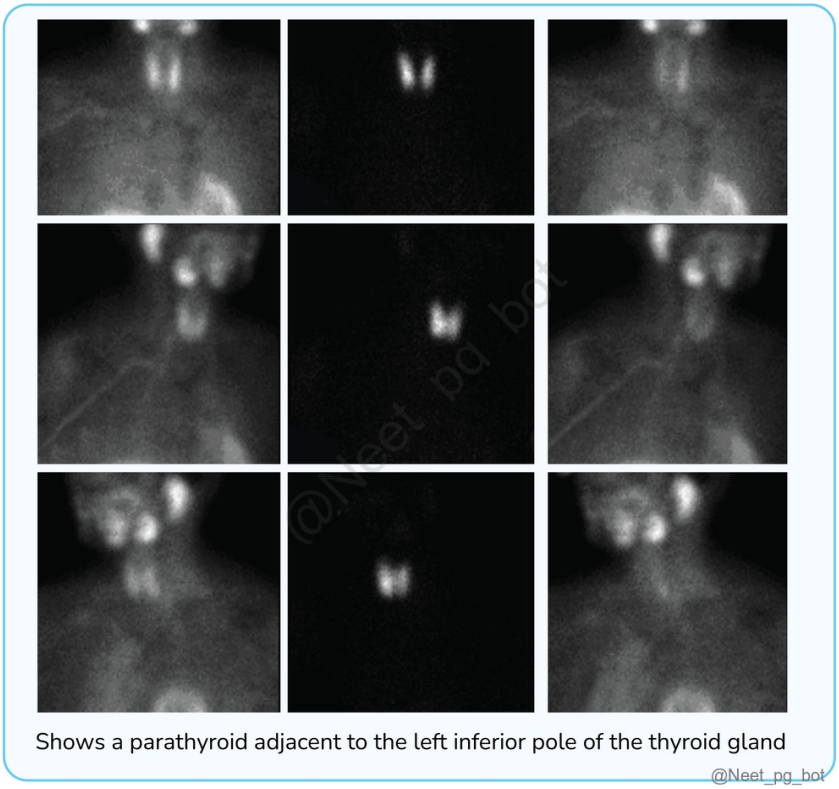
C. USG

D. CT scan



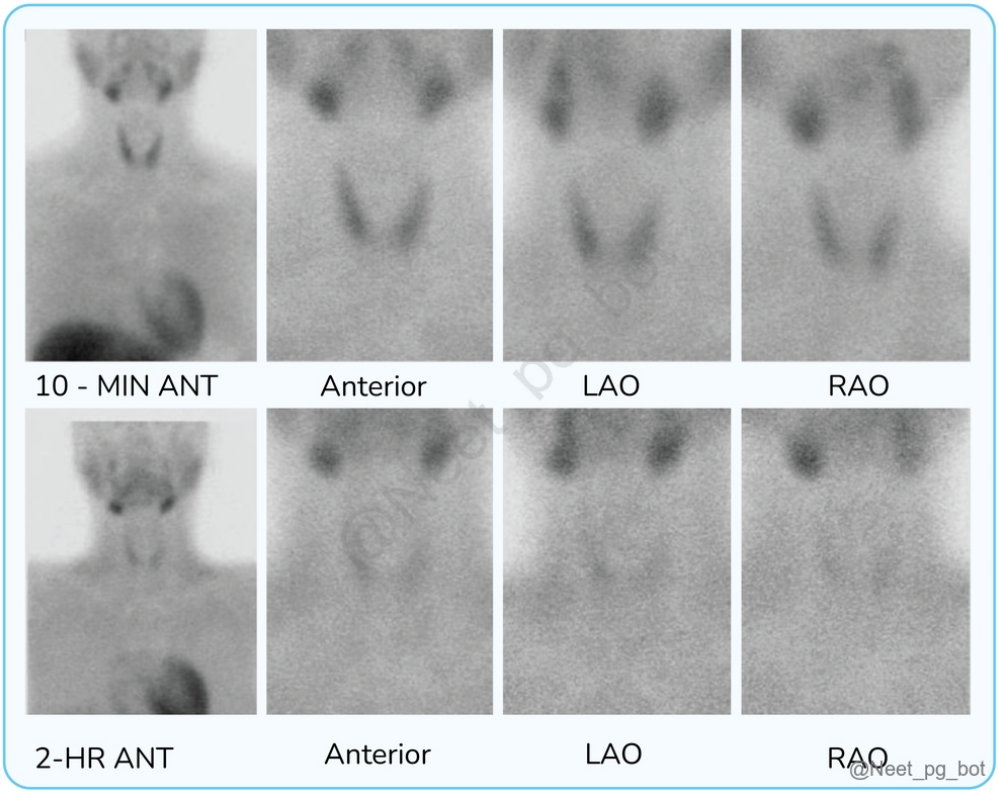
Correct Answer: A. 99Tc radiolabelled sestamibi scan

Explanation: This patient's presentation is highly suggestive of primary hyperparathyroidism . The most common cause of primary hyperparathyroidism is a solitary parathyroid adenoma . The characteristic findings of subperiosteal resorption on X-ray, along with elevated calcium and PTH levels and low phosphate , point towards this diagnosis. To localise the pathology (typically a parathyroid adenoma), the most appropriate imaging test is a 99Tc radiolabelled sestamibi scan . Sestamibi scan is a type of nuclear medicine-based study that is most accurate for parathyroid lesion localisation. It is safe and reproducible . It has a sensitivity and specificity similar to ultrasound but may detect glands in ectopic positions better. Sestamibi accumulates in the mitochondria, and henc,e the rates at which it washes out differ as per the number of mitochondria in different tissues. Parathyroid adenoma is rich in oxyphilic cells with a high concentration of mitochondria and, hence has a lower washout than the thyroid gland. False positives are rare, and the sensitivity and specificity are 79% and 90,% respectively. Addition of a thyroid specific radioactive tracer eliminates the chance of false positives. {{caption_text}} {{caption_text}} Other investigations: Parathyroid angiography and venous sampling for parathyroid hormone. Biochemical analysis is always to be done. Incorrect Options: Ultrasonography (Option C): Parathyroid adenoma is identified as an oval/ elongated, bi or multiloculated hypoechoic structure. Advantage: Can identify and facilitate biopsy of any concomitant thyroid pathology. Disadvantage : Adenomas in retro-oesophageal, retrosternal, or retro-tracheal areas can be missed. CT (Option D): Rapid uptake and washout allow hyperfunctioning glands to be differentiated from lymph nodes that demonstrate a progressive enhancement pattern. Disadvantage: Higher radiation dose than traditional imaging. Hence, it is not preferred. MRI (Option B): It is not commonly used, but it is helpful for preoperative cases or mediastinal adenomas. It has poor resolution for small glands/adenomas <5 mm, and it is difficult to localise superior glands. Biochemical tests: (Hyperparathyroidism) Serum calcium levels High Intact PTH Low or inappropriately high Serum phosphate Low 24-hour urinary calcium High Chloride to phosphate ratio High 1,25- hydroxy Vitamin D Normal or raised



Shows a parathyroid adjacent to the left inferior pole of the thyroid gland

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References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 877,878

SRB's Manual of Surgery, 6th Edition, Page 491

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4607146/

↑ *Back to this question in Part A*

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Q39: Which of the following is not an indication for parathyroidectomy in a patient with primary hyperparathyroidism? (Q860451)

A. Serum calcium > 1 mg/dL above the upper limit of normal

B. 24-hour urine calcium > 400 mg/d

C. Age < 50 years

D. Creatinine clearance < 90 mL/min

Correct Answer: D. Creatinine clearance < 90 mL/min

Explanation: Creatinine clearance < 90 mL/min is not an indication for parathyroidectomy. Indications for Parathyroidectomy: Serum calcium > 0.25 mmol/L (1.0 mg/dL) above the upper limit of normal. (Option A) Bone Mineral Density (BMD) by DEXA: T-score ≤ -2.5 at the lumbar spine, total hip, femoral neck, or distal one-third of radius. Vertebral fracture. Creatinine clearance < 60 mL/min. 24-hour urinary calcium > 10 mmol/dL (>400 mg/day) (Option B) or increased risk of stone formation Age < 50 years (Option C)

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 879

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Q40: A patient presents with a swelling in the thyroid region that moves with deglutination and protrusion of the tongue. The swelling has ruptured, resulting in pus discharge. What is the preferred treatment? (Q860404)

A. Sistrunk procedure

B. Antibiotics

C. Incision and drainage

D. None of the above



Correct Answer: A. Sistrunk procedure

Explanation: The clinical presentation and image classically suggest a Thyroglossal cyst, which is managed by removing the cyst along with the tract up to the base of the tongue and part of the hyoid bone (SISTRUNK Procedure) Thyroglossal Cyst: It is a congenital neck mass resulting from the persistence of the thyroglossal duct, an embryological structure. It can also be present in adulthood. The cyst represents a remnant of this duct and can be found anywhere along the midline from the base of the tongue to the thyroid isthmus. {{caption_text}} It presents as midline swelling that moves with deglutition and protrusion of the tongue. Most Common Site: Subhyoid (can also be seen on the floor of the mouth, Suprahyoid, near thyroid cartilage and foramen caecum) Treatment: Sistrunk Procedure : Complete surgical excision of the cyst and its tract up to the base of the tongue, as well as a portion of the hyoid bone, to prevent recurrence. Incision and drainage (Option C) are never done as they lead to the formation of a Thyroglossal fistula. (It also forms if an inflamed cyst ruptures.)—Always Acquired. Long-standing thyroglossal cyst - - - > Risk of developing into Papillary thyroid carcinoma. Antibiotics (Option B) might be used as adjunctive therapy to treat infection, but they are not the definitive treatment.



References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 806

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Q41: A female presented with 1x 1 cm thyroid swelling. What is next best step in management? (Q844302)

A. I 131

B. TSH

C. TSH and T4

D. T3 and T4

Correct Answer: C. TSH and T4

Explanation: Correct Option C - TSH and T4: The initial evaluation of thyroid swelling should include testing for thyroid function, which involves measuring TSH and T4 levels. This approach helps determine whether the

thyroid gland is functioning normally or if there are abnormalities, such as hyperthyroidism or hypothyroidism, that could influence the management plan for the thyroid nodule. This information is crucial for deciding whether additional diagnostic procedures, such as a thyroid ultrasound or fine needle aspiration Incorrect Options: Option A - I-131 (Radioactive Iodine Therapy): I-131 is used primarily for treating hyperthyroidism or thyroid cancer, not for initial evaluation of a thyroid swelling. It is not appropriate for the initial assessment of a thyroid nodule. Option B - TSH (Thyroid-Stimulating Hormone) Test: TSH is a crucial initial test for evaluating thyroid function. It helps determine if the thyroid is underactive (hypothyroidism) or overactive (hyperthyroidism). However, TSH alone does not provide information about thyroid hormone levels or nodule characteristics, which are also important. Option D - T3 (Triiodothyronine) and T4 (Thyroxine) Test: T3 and T4 levels measure thyroid hormone levels, but TSH is more useful for assessing overall thyroid function. T3 levels are less commonly measured unless specifically indicated, as TSH and T4 are typically sufficient for initial evaluation.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 851, 858

↑ *Back to this question in Part A*

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Q42: A patient presents to the outpatient department with an ulcerated breast tumor and liver metastasis. What is the appropriate management? (Q844324)

A. Simple mastectomy

B. Modified Radical Mastectomy (MRM)

C. Radical mastectomy

D. Neoadjuvant chemotherapy followed by surgery

Correct Answer: A. Simple mastectomy

Explanation: The patient has an ulcerated breast tumor with liver metastasis, indicating Stage IV metastatic breast cancer . In Stage IV disease, the primary goal is systemic therapy , not curative surgery. However, when the breast tumor is ulcerated or fungating, palliative local surgery is performed for symptom relief. A simple mastectomy (toilet mastectomy) is the appropriate palliative procedure for local control. Modified Radical Mastectomy (Option B): A curative procedure involving axillary clearance; not indicated in Stage IV disease. Radical Mastectomy (Option C): An obsolete, excessively morbid surgery; no role in metastatic breast cancer. Neoadjuvant Chemotherapy Followed by Surgery (Option D): Used for Stage III locally advanced cancer, not Stage IV; surgery does not improve survival in metastatic disease.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 934,935

↑ *Back to this question in Part A*

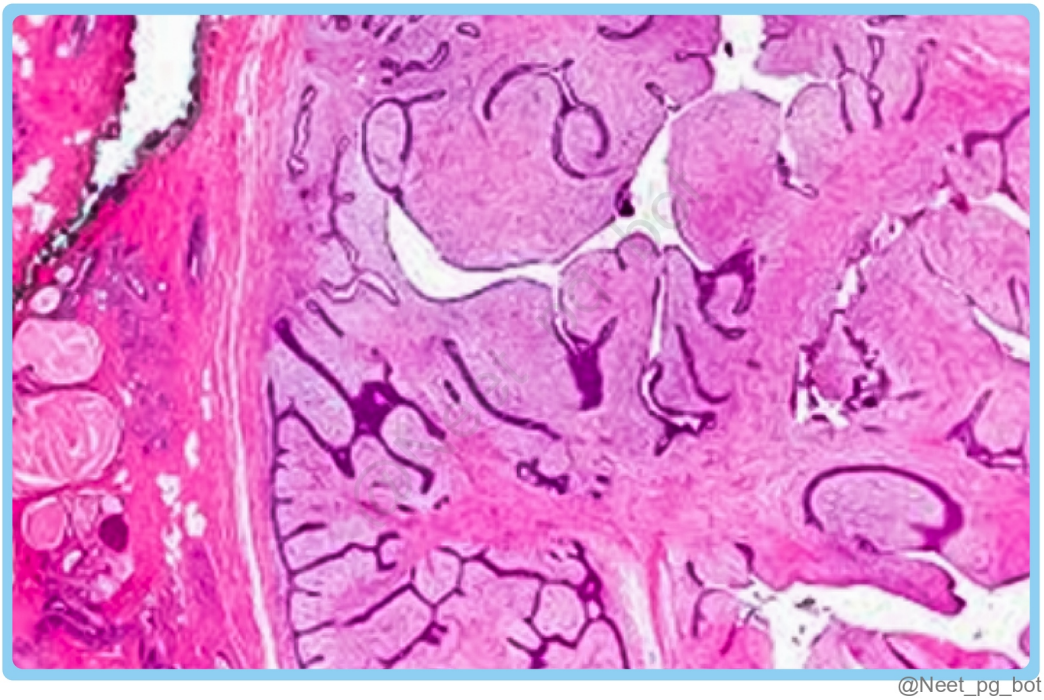
Q43: A 40-year-old female presents with an irregular 5 x 6 cm mass in the right breast. Histopathological examination reveals findings consistent with which of the following diagnoses? (Q844306)

A. Phyllodes tumor

B. Fibroadenoma

C. Mastitis

D. Grade 2 breast tumor



Correct Answer: A. Phyllodes tumor

Explanation: Histopathology image shows a biphasic tumor with both epithelial and stromal elements. The stroma is hypercellular, more prominent than in a fibroadenoma. The characteristic “leaf-like” (phyllodal) architecture is visible- cleft-like spaces lined by epithelium. This “leaf” pattern is a hallmark feature of phyllodes tumors. They arise from periductal stroma and can be benign, borderline, or malignant. Clinically, they present as rapidly enlarging, large breast masses in middle-aged women. Incorrect Options: Fibroadenoma: Stroma is less cellular and lacks the leaf-like pattern; more uniform and benign. Mastitis: Shows inflammatory cells (neutrophils), not a solid stromal-epithelial tumor. Grade 2 breast carcinoma: Pure epithelial malignancy, not biphasic and not showing leaf-like architecture.

References:

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Q44: A 23-year-old female visited the clinician with a solitary thyroid nodule and was advised for thyroid function tests where Tsh level is 27.3mU/L, T3 is 1.24 ng/ml, and T4 is 4.87 microgram/ml. Which of the following manifestations is true regarding the condition? (Q852701)

A. Heat intolerance

B. Tachycardia

C. Diarrhea

D. Weight gain

Correct Answer: D. Weight gain

Explanation: The patient's thyroid function tests show elevated TSH with normal T3 and T4 levels, indicating primary hypothyroidism. Weight Gain is consistent with hypothyroidism due to reduced metabolic rate. Heat Intolerance (Option A) , Tachycardia (Option B), and Diarrhea (Option C) are more common in hyperthyroidism , not hypothyroidism. Hypothyroidism Hyperthyroidism Decreased metabolic rate Increased metabolic rate Weight gain, puffiness, dry skin Weight loss Decreased appetite Increased appetite Bradycardia Tachycardia Cold intolerance Heat intolerance Constipation Diarrhea Menorrhagia Amenorrhea, infertility Cardiomegaly, pericardial effusion. Cardiovascular complications such as atrial fibrillation, cardiomyopathy, and Congestive heart failure. Altered mental status, coma -

References:

Sabiston's Textbook of Surgery, 21st Edition, Pages 884, 886

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Q45: What is the preferred treatment for a benign tumour of the superficial parathyroid gland? (Q860494)

A. Enucleation

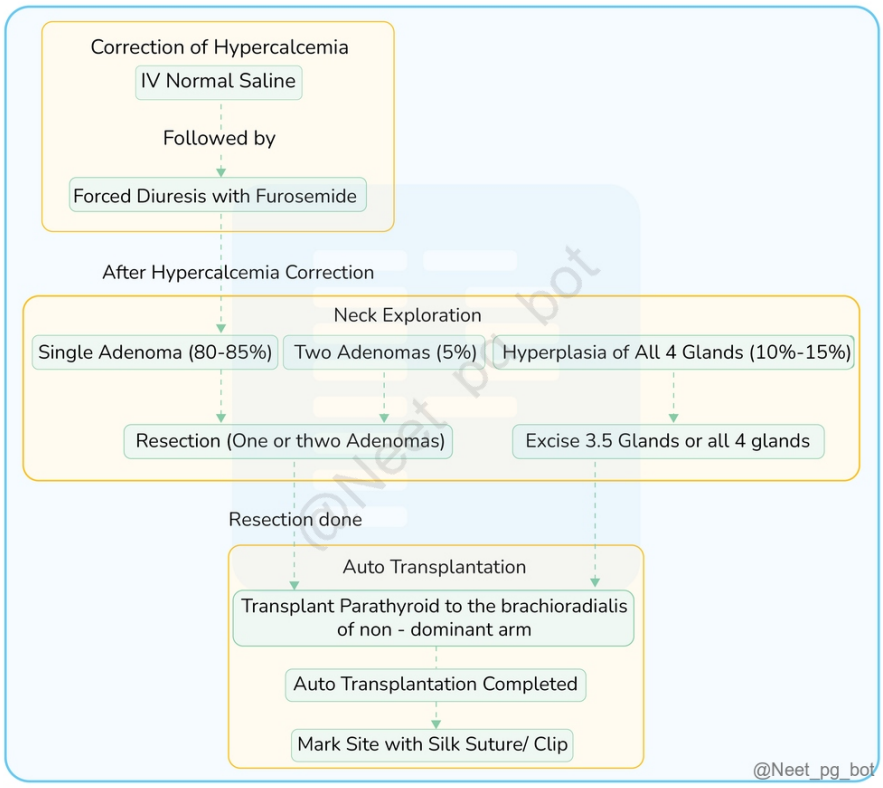
B. Surgical resection

C. Chemotherapy

D. Radiation therapy

Correct Answer: B. Surgical resection

Explanation: The preferred treatment for a benign tumour of the superficial parathyroid gland is surgical resection, which involves removing the tumour to avoid complications. Since benign parathyroid tumours (often referred to as adenomas) can lead to conditions like hypercalcemia, surgery is usually the most effective and curative treatment. The main modality of treatment is as follows: Indications of parathyroidectomy: Severe symptoms Young age Markedly reduced bone density Serum calcium more than 11mg% Urinary calculi Neuromuscular symptoms Urinary calcium more than 400mg/24 hours Indications of surgery in an asymptomatic case are: Serum calcium 0.25 mmol/L (1.0 mg/dL) above the upper limit of normal Bone mineral density (BMD) by DEXA; T score –2.5 at lumbar spine, total hip, femoral neck, or distal one-third of radius Vertebral fracture Creatinine clearance <60 mL/min 24-hour urinary calcium >10 mmol/dL (>400 mg/day) or increased risk of stone formation by risk analysis Age <50 years When medical therapy is not possible Miami Protocol: An intraoperative PTH is measured If it has reduced by more than 50% than the preoperative value, it indicates surgical removal. Casanova test: It is to differentiate the recurrence site after Removal of all 4 Parathyroid gland and auto transplant of it. PTH measurements are taken from the neck vein & brachial vessel. A positive Casanova test is if 20 times higher concentration in the brachial vessel Contraindications of surgery: Absolute contraindication: familial hypercalciuric hypercalcemia Here, elevated calcium and PTH level but 24 hr urinary calcium and calcium to creatinine clearance are low. Parathyroidectomy does not cure hypercalcemia due to FHH syndrome. Relative contraindications: Controlateral recurrent laryngeal nerve injury. Vocal cord dysfunction.



References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 876, 879

SRB's Manual of Surgery, 6th Edition, Page 493

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6935782/

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Q46: Which is the most lethal nerve injury during thyroid surgery? (Q853037)

A. U/L RLN (partial)

B. B/L RLN (partial)

C. U/L RLN (complete)

D. B/L RLN (complete)

Correct Answer: D. B/L RLN (complete)

Explanation: The recurrent laryngeal nerve (RLN) is a crucial structure in thyroid surgery because it innervates the laryngeal muscles , which control vocal cord function. Bilateral complete injury to the RLN is the most lethal nerve injury during thyroid surgery as it can cause paralysis of both vocal cords , leading to stridor, voice changes, breathing difficulties, and, in severe cases, airway obstruction. Unilateral injury is generally less dangerous than bilateral injury because the contralateral vocal cord can compensate to a significant degree. (Options A & C ruled out) The individual may experience hoarseness or aspiration of fluids through the glottis. Partial injury typically does not lead to significant airway compromise. (Option B ruled out) Reference:

References:

Dhingra's Diseases Of Ear, Nose And Throat, & Head and Neck Surgery, 8th Edition, Page 350

Bailey & Love’s Short Practice of Surgery, 28th Edition, Page 865

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Q47: A 20-year-old male presents with occasional palpitations, high blood pressure, and headache. He is diagnosed with pheochromocytoma. What is the preferred initial investigation? (Q853036)

A. USG-abdomen

B. MRI - abdomen

C. MIBG

D. 24 hours urine metanephrines

Correct Answer: D. 24 hours urine metanephrines

Explanation: The preferred initial investigation in a patient suspected of having pheochromocytoma is a 24-hour urine collection for metanephrines , as it is a sensitive and specific test for detecting catecholamine-secreting tumours. Pheochromocytoma Definition A catecholamine-secreting tumour that arises from the chromaffin cells of the abdominal sympathetic chain/ adrenal medulla Co-exist with neurofibromatosis, VHL syndrome, MEN syndrome Clinical features Classical triad: Headache (most common), profuse sweating, palpitation and tachycardia Hypertension (sustained or intermittent) Anxiety, panic attacks Hyperglycemia and Hypercalcemia Pallor (due to alpha-1 mediated vasoconstriction) Polyuria and polydipsia Orthostatic hypotension Dilated cardiomyopathy Erythrocytosis Constipation Abdominal pain Weakness Weight Loss The rule of 10 10% are bilateral 10% are extra-adrenal 10% are malignant 25-33% are inherited Symptomatic patients do not follow the Rule of 10’s Diagnosis Measurement of the plasma fractionated metanephrines is the most sensitive screening test; hence, the initial investigation is preferred. Increase 24 hour urinary VMA(Vanillyl mandelic acid) and metanephrines (Option D) MRI is the investigation of choice. (Option B ruled out) Biopsy and CT contrast scans are contraindicated in order to avoid hypertensive crises Treatment Adrenalectomy is the treatment of choice Size<5cm- Laparoscopic adrenalectomy Preop Alpha-blockers should be given Mitotane should be started as

adjuvant or palliative treatment USG-abdomen (Option A) may sometimes be used to assess abdominal masses, it is not the preferred initial investigation for pheochromocytoma, as it may not detect smaller tumours or those located in less accessible areas, such as the adrenal glands or retroperitoneal space. MIBG (Option C) is specialised imaging studies used for further evaluation, especially in metastatic or multifocal cases, and are not used for initial biochemical confirmation after plasma testing.

References:

Sabiston's Text Book of Surgery, 21st Edition, Page 987

OP Ghai Essentials of Pediatrics, 10th Edition, Pages 545, 546

↑ *Back to this question in Part A*

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Q48: Which of the following is not a component of MEN2B syndrome? (Q853035)

A. Medullary thyroid carcinoma

B. Mucosal ganglioneuromatosis

C. Marfanoid habitus

D. Parathyroid hyperplasia

Correct Answer: D. Parathyroid hyperplasia

Explanation: Parathyroid hyperplasia is associated with MEN2A , not MEN2B. MEN is a group of genetic syndromes (Autosomal Dominant) characterised by the development of tumours in multiple endocrine glands. Diagnostic criteria for MEN is Clinical features of 2 or more associated tumours. Notable Family history Confirmation by genetic analysis. MEN2B is also called as MEN type 3. Types of Multiple Endocrine Neoplasia MEN Type I MEN Type II MEN Type III MEN Type IV Cause Defect of chromosome 11q13 causing MEN 1 gene mutation Also called Wermer's syndrome Defect of chr.10 leading to mutation of RET gene Also called Sipple's syndrome Also called MEN II B , it is a variant of Type 2 MEN Defect of chr.12 causing CDKN1B gene Tumors Included Parathyroid adenoma (most common) It presents with primary hyperparathyroidism (↑ PTH and ↑ Ca) All the four glands can be included. Rx: Total/subtotal parathyroid resection Parathyroid adenoma (most common, and calcium can be normal) Medullary carcinoma thyroid (most common) (Option A ruled out) Parathyroid adenoma (Presents as hypercalcemia) Pancreatic adenoma Presents as Gastrinoma or Zollinger-Ellison syndrome This leads to peptic ulcer disease in the duodenum, which is the leading cause of death in this type. Pheochromocytoma . Pheochromocytoma (Most important criterion for both MEN 2 and MEN 3): Presents with elevated blood pressure. Pituitary adenoma: Prolactinoma Pituitary adenoma: Prolactinoma, causing amenorrhea and Infertility Medullary thyroid carcinoma Calcitonin is the tumor marker present Cold nodules are seen on the thyroid scan Metastasis can be traced with PET scan Visible neck mass, causing dysphagia Rx - Prophylactic thyroidectomy Reproductive tract tumors Testicular tumours Neuroendocrine tumor (Cervix) Associated conditions Angio■broma Collagenoma Adrenocortical tumor Carcinoid tumors/Argenta■noma Pheochromocytoma (only in 1%) Congenital aganglionosis, Hirschsprung disease Marfanoid habitus (Option C

ruled out) Medullated corneal nerve ■bers Mucosal neuromas (Option B ruled out) Megacolon and Multiple diverticulae Occasionally with Renal tumour Adrenal tumour

References:

Harrison’s Principle of Internal Medicine, 21st Edition, Pages 2983 - 2990

Davidson’s Principles and Practice of Medicine, 24th Edition, Pages 868, 869

↑ *Back to this question in Part A*

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Q49: A 40-year-old patient with a history of Hodgkin’s lymphoma and prior radiation therapy presents with a right-sided thyroid swelling. Fine needle aspiration cytology (FNAC) confirms papillary carcinoma with no evidence of lymph node involvement. What is the next step in management? (Q853034)

A. Hemi-thyroidectomy with modified radical neck dissection

B. Total thyroidectomy

C. Total thyroidectomy with modified radical neck dissection

D. Hemi-thyroidectomy

Correct Answer: B. Total thyroidectomy

Explanation: The next step in the management of papillary thyroid carcinoma, especially in a patient with a history of radiation exposure, is Total thyroidectomy. If lymph node enlargement or metastasis is present, then total thyroidectomy, along with the removal of an enlarged group of lymph nodes with or without ipsilateral modified radical neck dissection (MRND), is done. (Option C ruled out) Hemithyroidectomy involves the removal of one lobe of the thyroid gland and isthmus; it would not be sufficient in this scenario due to the higher risk of multifocal disease and recurrence. (Options A & D ruled out) A total thyroidectomy ensures that there is no residual thyroid tissue, making these post-surgical follow-up strategies more reliable.

References:

Bailey & Love’s Short Practice of Surgery, 28th Edition, Pages 869, 870.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q50: A 34-year-old male presents with a serum calcium level of 12.8 mg/dL (normal range: 8.5–10.25 mg/dL) along with elevated parathyroid hormone (PTH) levels. Ultrasound imaging reveals a 1.5 x 1.5 cm mass in the right lower lobe of the thyroid gland. Which of the following statements is correct regarding this condition? (Q853033)

A. MIBI followed by focussed parathyroidectomy to be done

B. Normal DEXA scan rules out the need for surgery

C. Only observation, no need for surgery

D. Creatinine clearance > 80 ml/min mandates the surgery

Correct Answer: A. MIBI followed by focussed parathyroidectomy to be done

Explanation: MIBI scan followed by focused parathyroidectomy is the recommended course of action for this patient. This scenario suggests primary hyperparathyroidism, likely due to a parathyroid adenoma, given the elevated calcium and PTH levels, along with the thyroid mass that could be related to a parathyroid lesion. Sestamibi scan is a type of nuclear medicine-based study that is most accurate for parathyroid lesion localisation. Indications of parathyroidectomy include: (Option C ruled out) Severe symptoms Young age Markedly reduced bone density Serum calcium more than 11mg% Urinary calculi Neuromuscular symptoms Urinary calcium more than 400mg/24 hour Normal DEXA scan rules out the need for surgery (Option B) is not true because even if bone density is normal, elevated calcium and PTH levels indicate that the parathyroid adenoma should be addressed surgically. Creatinine clearance > 80 ml/min mandates the surgery (Option D) : Surgical intervention is primarily indicated based on the diagnosis of primary hyperparathyroidism and the presence of complications or symptoms, not just creatinine clearance.

References:

Bailey & Love’s Short Practice of Surgery, 28th Edition, Pages 876, 879

↑ *Back to this question in Part A*

@Neet_pg_bot

Q51: A neonate is diagnosed with congenital hypothyroidism. Thyroid ultrasound shows normal gland in-situ, but radioiodine uptake scan shows no uptake. What is the diagnosis? (Q866458)

A. Absent thyroid gland

B. Thyroid dyshormogenesis

C. Iodine deficiency

D. Defective thyroid uptake

Correct Answer: D. Defective thyroid uptake

Explanation: The correct answer is Defective thyroid uptake because the presence of a normal thyroid gland on ultrasound rules out agenesis (absent gland), and absent uptake on a radioiodine scan despite normal anatomy indicates a defect in the iodide transport mechanism into the gland - i.e., a defective sodium-iodide symporter function . Absent thyroid gland (Option A): Ultrasound clearly shows a normal gland, so agenesis is excluded. Thyroid dyshormogenesis (Option B): Usually presents with normal or increased uptake because the gland traps iodine but cannot synthesize hormone efficiently. Iodine deficiency (Option C): The gland would usually have increased uptake due to upregulated TSH activity.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q52: A 43 year old female present to OPD due changes in breast changes in breast and a lump in breast as given below, what is the diagnosis? (Q866420)

A. T4d

B. T4a

C. T1c

D. T3



Correct Answer: A. T4d

Explanation: The given image depicts Peau d orange appearance & redness > 1/3rd of breast which corresponds to T4d. In TNM staging for breast cancer: T4d: Inflammatory carcinoma, peau d'orange and redness involving >1/3rd of the surface of the breast with or without a breast lump. TNM staging for breast cancer Stage Description Tumor size (T) TX Primary tumor cannot be assessed T0 No evidence of primary tumor Tis Carcinoma in situ (DCIS, LCIS, or Paget's disease) T1 Tumor ≤ 2 cm T1mi Tumor ≤ 1 mm T1a Tumor > 1 mm but ≤ 5 mm T1b Tumor > 5 mm but ≤ 10 mm T1c Tumor > 10 mm but ≤ 20 mm T2 Tumor > 2 cm but ≤ 5 cm T3 Tumor > 5 cm T4 Tumor of any size with direct extension to chest wall or skin T4a Extension to chest wall T4b Ulceration or skin nodules or Peau d orange T4c Both T4a and T4b T4d Inflammatory breast cancer, peau d'orange and redness involving >1/3rd of the surface of the breast with or without a breast lump Node (N) NX Regional lymph nodes cannot be assessed N0 No regional lymph node metastasis N1 Metastases to movable ipsilateral level I, II axillary lymph nodes N2 Metastasis to axillary lymph nodes or clinically apparent internal mammary nodes N2a Metastasis to axillary lymph nodes that are clinically fixed or matted N2b Metastasis to internal mammary nodes without axillary lymph node involvement N3 Metastasis to axillary lymph nodes or infraclavicular nodes, or to supraclavicular nodes N3a Metastasis to infraclavicular nodes N3b Metastasis to internal mammary nodes N3c Metastasis to supraclavicular nodes Metastasis (M) MX Distant metastasis cannot be assessed M0 No distant metastasis M1 Distant metastasis present Stage Grouping Stage 0: Tis N0 M0 Stage IA: T1/T1mi N0 M0 Stage IB: T0 N1mi M0; T1/T1mi N1mi M0 Stage IIA: T0 N1 M0; T1 N1 M0; T2 N0 M0 Stage IIB: T2 N1 M0; T3 N0 M0 Stage IIIA: T0 N2 M0; T1 N2 M0; T2 N2 M0; T3 N1 M0 Stage IIIB: T3 N2 M0 Stage IIIC: T4 N0 M0; T4 N1 M0; T4 N2 M0; Any T N3 M0 Stage IV: Any T Any N M1

References:

Bailey and Love Surgery, 28th edition. Page 934

↑ *Back to this question in Part A*

@Neet_pg_bot

Q53: A 45-year-old woman with a history of multinodular goitre undergoes a CT angiogram with iodinated contrast for suspected pulmonary embolism. Two weeks later, she presents with palpitations, heat intolerance, and weight loss. Her thyroid function tests show suppressed TSH and elevated T3 and T4. Which of the following best explains this patient's current condition? (Q865430)

A. Wolff-Chaikoff effect

B. Jod-Basedow effect

C. Thyroid storm

D. Hashitoxicosis

Correct Answer: B. Jod-Basedow effect

Explanation: The patient shows features of hyperthyroidism, which occurred after receiving iodinated contrast during a CT angiogram. This Iodine-induced hyperthyroidism is called the Jod-Basedow effect, which occurs due to increased iodine trapping leading to Increased T4, T3 production. Wolff Chaikoff effect & Jod Basedow effect Feature Wolff-Chaikoff Effect Job-Basedow Effect Definition Temporary inhibition of thyroid hormone synthesis in response to high iodine exposure Iodine-induced hyperthyroidism Mechanism High iodine levels inhibit thyroid peroxidase, reducing T3 and T4 production Excess iodine stimulates autonomous thyroid hormone production in susceptible individuals Duration Temporary (usually resolves in 1-2 weeks) Can persist until treated Thyroid Function Tests Initially decreased T3 and T4, increased TSH Increased T3 and T4, decreased TSH At-risk Population Normal thyroid glands Pre-existing thyroid disease (e.g., multinodular goiter, Graves' disease) Clinical Presentation Usually asymptomatic or mild hypothyroid symptoms Symptoms of hyperthyroidism (e.g., palpitations, heat intolerance, weight loss)

References:

Davidson’s Principle and Practice of Medicine, 24th Edition, Page 647

↑ *Back to this question in Part A*

@Neet_pg_bot

Q54: A 52-year-old female patient presents with HER-2-positive breast cancer that has become resistant to trastuzumab treatment. The oncologist is considering the next line of treatment. Which of the following options would be the most appropriate choice? (Q854756)

A. Lapatinib

B. Sorafenib

C. Vemurafenib

D. Erlotinib

Correct Answer: A. Lapatinib

Explanation: Lapatinib is a dual tyrosine kinase inhibitor that targets both HER-2 and EGFR receptors, and it is commonly used in patients with HER-2-positive breast cancer that is resistant to trastuzumab. It works by blocking the signalling pathways that promote tumour growth. Management of Stage IV HER2-Positive Metastatic Breast Cancer Type Description Treatment Systemic Therapy Targeted Therapy: Specific for HER2-positive cancers Trastuzumab, Pertuzumab, Lapatinib Chemotherapy: Addresses systemic disease Taxanes, Anthracyclines, Capecitabine Hormonal Therapy: For hormone receptor-positive cases (not standalone for HER2-positive) Tamoxifen, Aromatase Inhibitors (if combined) Local Therapy Palliative Surgery: Relieves significant symptoms from primary tumour growth Mastectomy Radiotherapy: Controls localised symptoms, especially bone metastases _ Bone-targeted Therapy Manages bone metastases and reduces skeletal-related events Bisphosphonates,

Denosumab Incorrect Options: Sorafenib (Option B) is a multikinase inhibitor that targets angiogenesis pathways involved in tumour growth. However, it lacks specificity for HER-2 positive breast cancer or trastuzumab resistance, making it ineffective for this condition. Vemurafenib (Option C) is primarily used in melanoma with a BRAF V600E mutation; this drug is not suitable for HER-2-positive breast cancer and is not indicated in this case. Erlotinib (Option D) : Although effective in non-small cell lung cancer with EGFR mutations, erlotinib's activity in HER-2-positive breast cancer is limited, making it an inappropriate treatment choice for this patient.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 941

SRB's Manual of Surgery, 6th Edition, Page 549, 550

↑ *Back to this question in Part A*

@Neet_pg_bot

Q55: A 50-year-old woman after thyroidectomy comes to you for a 2 nd opinion for further treatment of papillary thyroid cancer. What would you recommend for this patient? (Q857779)

A. Radiotherapy

B. Chemotherapy

C. Radioiodine scan

D. Wait and watch

Correct Answer: C. Radioiodine scan

Explanation: After thyroidectomy for papillary thyroid cancer, a radioiodine scan (I-131) is recommended to detect any remaining thyroid tissue or metastasis, as papillary thyroid cancer is often Radioactive Iodine (RAI) -avid (capable of absorbing and concentrating radioactive iodine). Roles: Remnant Ablation: Destruction of any remaining benign thyroid tissue following a total or subtotal thyroidectomy. Adjuvant Therapy: Additional treatment post-surgery to reduce the risk of cancer recurrence. Treatment of Known Disease: Targeting and destroying residual cancer cells or recurrent structural or biochemical disease. Radioactive Iodine Ablation (RAI): Isotope Used : Iodine-131 (Half-Life: 8 Days) Emission: Beta Rays : 90% of emissions; targeted treatment of the thyroid gland while sparing surrounding tissues. Gamma Rays: 10% of emissions; used for imaging and also responsible for side effects. Applications: Primarily for Differentiated Thyroid Cancer (DTC) like Papillary Thyroid Carcinoma (PTC) and Follicular Thyroid Carcinoma (FTC). Side Effects : (Dose-Dependent): Sialadenitis, nasolacrimal duct obstruction, transient swelling, infertility, secondary malignancies (e.g., leukemia) Indications Contraindications Differentiated thyroid cancers E.g., Papillary thyroid carcinoma Follicular thyroid carcinoma Hurthle cell carcinoma Tumor size >2cm One or more risk factors Obvious extrathyroidal extension >45 years of age Lymph node and distant metastasis Poorly differentiated thyroid cancers E.g., Medullary thyroid carcinoma Anaplastic thyroid carcinoma Pregnancy & Breastfeeding (Absolute contraindications) Vomiting &

Diarrhea (Relative contraindications) Radiotherapy (Option A) is not the standard follow-up after thyroidectomy for papillary thyroid cancer (PTC). RAI therapy is preferred as it targets thyroid tissue, while radiotherapy is reserved for advanced cases or metastasis. RAI is more effective than radiotherapy for treating remaining thyroid cells or metastasis. Chemotherapy (Option B): Papillary thyroid cancer (PTC) is not treated with chemotherapy, as it doesn't respond well. RAI is the standard treatment, while chemotherapy is used for more aggressive cancers like anaplastic thyroid cancer. Wait and watch (Option D) approach may be used in low-risk cases of papillary thyroid cancer (PTC) if the tumor is small, localized, and has been fully removed. However, after thyroidectomy, a radioiodine scan (RAI) is typically done to check for remaining tissue or metastases, even in low-risk cases.

References:

Sabiston's Textbook of Surgery,21st Edition, Page 905.

SRB's Manual of Surgery, 6th Edition, Page 476.

Radioactive Iodine Therapy for Thyroid Malignancies - StatPearls - NCBI Bookshelf

↑ *Back to this question in Part A*

@Neet_pg_bot

Q56: Genetic testing for BRCA 1/BRCA 2 is indicated for all of the following except: (Q857771)

A. Breast cancer diagnosed in a postmenopausal female >50 years of age

B. Male breast cancer

C. Two breast cancer primaries

D. TNBC diagnosed age 60 years

Correct Answer: A. Breast cancer diagnosed in a postmenopausal female >50 years of age

Explanation: Genetic Testing for BRCA1/BRCA2 Mutations is generally not routinely indicated for women who are diagnosed with breast cancer after the age of 50. Indications An individual at any age with a known pathogenic/likely pathogenic variant in a cancer susceptibility gene within the family Breast cancer diagnosed age ≤50 years TNBC (Triple-Negative Breast Cancer) diagnosed age ≤60 years (Option D ruled out) Two breast cancer primaries (Option C ruled out) Breast cancer at any age with one or more relative with breast cancer diagnosed ≤50 years, invasive ovarian cancer, male breast cancer, pancreatic cancer, high-grade or metastatic prostate cancer Breast cancer at any age with two or more affected relatives Male breast cancer (Option B ruled out) An individual with a personal or family history of ≥3 of the following: Breast cancer, sarcoma, adrenocortical carcinoma, brain tumour, leukaemia Colon cancer, endometrial cancer, thyroid cancer, kidney cancer, dermatological manifestations, macrocephaly or hamartomatous polyps of the gastrointestinal tract Lobular breast cancer, diffuse gastric cancer Breast cancer, gastrointestinal cancer or hamartomatous polyps, ovarian sex chord tumours, pancreatic cancer, testicular Sertoli cell tumours or childhood skin pigmentation.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 942.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q57: A 51-year-old woman is evaluated for a right breast mass. Physical examination reveals a 6 cm firm tumor. Palpable, mobile lymph nodes are also noted in the right axilla. A core biopsy confirms invasive ductal carcinoma, and a subsequent workup for distant disease is negative. According to the AJCC TNM staging system, what is the clinical stage of her cancer? (Q857767)

A. cT3N1M0

B. cT4N0M0

C. cT4N1M0

D. cT3N0M0

Correct Answer: A. cT3N1M0

Explanation: According to the TNM Staging of Breast Cancer , the staging in the given case is cT3N1M0. cT3: Clinically, the tumor is greater than 5 cm. N1: Ipsilateral mobile axillary lymph nodes are involved. M0: No evidence of distant metastasis. Stage Description Tumor size (T) TX Primary tumor cannot be assessed T0 No evidence of primary tumor Tis Carcinoma in situ (DCIS, LCIS, or Paget's disease) T1 Tumor ≤ 2 cm T1mi Tumor ≤ 1 mm T1a Tumor > 1 mm but ≤ 5 mm T1b Tumor > 5 mm but ≤ 10 mm T1c Tumor > 10 mm but ≤ 20 mm T2 Tumor > 2 cm but ≤ 5 cm T3 Tumor > 5 cm T4 Tumor of any size with direct extension to chest wall or skin T4a Extension to the chest wall T4b Ulceration or skin nodules T4c Both T4a and T4b T4d Inflammatory breast cancer Node (N) NX Regional lymph nodes cannot be assessed N0 No regional lymph node metastasis N1 Metastases to movable ipsilateral level I, II axillary lymph nodes N2 Metastasis to axillary lymph nodes or clinically apparent internal mammary nodes N2a Metastasis to axillary lymph nodes that are clinically fixed or matted N2b Metastasis to internal mammary nodes without axillary lymph node involvement N3 Metastasis to axillary lymph nodes or infraclavicular nodes, or to supraclavicular nodes N3a Metastasis to infraclavicular nodes N3b Metastasis to internal mammary nodes N3c Metastasis to supraclavicular nodes Metastasis (M) MX Distant metastasis cannot be assessed M0 No distant metastasis M1 Distant metastasis present Stage Grouping Stage 0: Tis N0 M0 Stage IA: T1/T1mi N0 M0 Stage IB: T0 N1mi M0; T1/T1mi N1mi M0 Stage IIA: T0 N1 M0; T1 N1 M0; T2 N0 M0 Stage IIB: T2 N1 M0; T3 N0 M0 Stage IIIA: T0 N2 M0; T1 N2 M0; T2 N2 M0; T3 N1 M0 Stage IIIB: T3 N2 M0 Stage IIIC: T4 N0 M0; T4 N1 M0; T4 N2 M0; Any T N3 M0 Stage IV: Any T Any N M1

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 934.

Sabiston Textbook of Surgery, 21st Edition, Page 833.

SRB's Manual of Surgery, 6th Edition, Page 532.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q58: A woman presents with a BIRADS-5 breast lesion. Which of the following is a good prognostic factor for this lesion? (Q855191)

A. BRCA-1 positive

B. p53 positive

C. ER positive

D. High Ki-67

Correct Answer: C. ER positive

Explanation: A BIRADS-5 lesion is highly suspicious for malignancy, and the prognostic factors depend on tumour biology. ER, (Estrogen Receptor) positivity is associated with a better prognosis as it indicates that the tumor is likely to respond to hormonal therapy. Disease factors that influence prognosis Histologic Subtypes Invasive Ductal Carcinoma (IDC): Prognosis varies by grade and molecular markers. Invasive Lobular Carcinoma (ILC): Intermediate prognosis. Tubular and Mucinous Carcinomas: Best prognosis. Basal-like Breast Cancer: Aggressive, triple-negative, no targeted treatments. Other Subtypes: Medullary, cribriform, papillary, adenoid cystic, and metaplastic carcinomas vary in prognosis. Tumor Size & Lymph Node Pathologic staging (tumour size, lymph nodes) guides prognosis and treatment. Larger tumours and positive lymph nodes = worse prognosis. Molecular Markers Hormone Receptors (ER, PR) : ER-positive = better prognosis , responsive to endocrine therapy. HER-2 Status: HER-2 positive = aggressive but treatable with targeted therapies. Patient factors that influence prognosis Age Younger, particularly premenopausal women, may have higher local recurrence rates post-surgery, but radiation therapy can reduce this risk. BRCA Mutation (Option A) Generally more aggressive and associated with poorer prognosis. Family History A strong family history may indicate inherited susceptibility and potentially a worse prognosis. Prior Breast Cancer History Previous breast cancer can negatively influence the prognosis of a new diagnosis. Lifestyle Factors Obesity and inactivity are linked to increased recurrence risk and may affect overall prognosis. Treatment Adherence Non-compliance can worsen prognosis. p53 positive (Option B): Mutations in the p53 gene are commonly observed in various cancers, including breast cancer. p53 positivity generally indicates a more aggressive form of the disease, making it a poor prognostic factor. High Ki-67 (Option D): Ki-67 is a protein expressed in proliferating cells. A high Ki-67 index suggests a rapid rate of cell division, which is typically associated with more aggressive tumours and, therefore, a worse prognosis.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 942

Sabiston Textbook of Surgery, 21st Edition, Page 828-832, 835, 839, 847, 851

↑ *Back to this question in Part A*

@Neet_pg_bot

Q59: What is the primary prognostic factor that significantly influences the outcome of breast cancer? (Q854789)

A. Lymph node

B. Distant metastasis

C. Size

D. Hormone receptors

Correct Answer: A. Lymph node

Explanation: The involvement of lymph nodes, particularly axillary lymph nodes , is the most important prognostic factor for breast cancer and significantly influences treatment decisions and overall survival. In breast cancer , the status of the axillary lymph nodes is the most significant prognostic factor. In metastatic breast cancer , the most important prognostic factor is the status of estrogen receptors (ER) and progesterone receptors (PR). Disease factors that influence prognosis Histologic Subtypes Invasive Ductal Carcinoma (IDC): Prognosis varies by grade and molecular markers. Invasive Lobular Carcinoma (ILC): Intermediate prognosis. Tubular and Mucinous Carcinomas: Best prognosis. Basal-like Breast Cancer: Aggressive, triple-negative, no targeted treatments. Other Subtypes: Medullary, cribriform, papillary, adenoid cystic, and metaplastic carcinomas vary in prognosis. Tumor Size & Lymph Node Pathologic staging (tumour size, lymph nodes) guides prognosis and treatment. Larger tumours and positive lymph nodes = worse prognosis Molecular Markers Hormone Receptors (ER, PR): ER-positive = better prognosis, responsive to endocrine therapy. HER-2 Status: HER-2 positive = aggressive but treatable with targeted therapies. Patient factors that influence prognosis Age Younger, particularly premenopausal women, may have higher local recurrence rates post-surgery, but radiation therapy can reduce this risk. BRCA Mutation Generally more aggressive and associated with poorer prognosis. Family History A strong family history may indicate inherited susceptibility and potentially a worse prognosis. Prior Breast Cancer History Previous breast cancer can negatively influence the prognosis of a new diagnosis. Lifestyle Factors Obesity and inactivity are linked to increased recurrence risk and may affect overall prognosis. Treatment Adherence Non-compliance can worsen prognosis. Other options: Option B: Distant metastasis Although presence of metastasis dramatically worsens prognosis, it is considered a stage-defining feature, not the primary prognostic factor in potentially curable early breast cancer. Among local-regional factors, lymph node status still remains the strongest. Option C: Size Tumor size is important but secondary to nodal involvement. Small tumors with multiple positive nodes have worse prognosis than large tumors without nodal spread. Option D: Hormone receptors ER/PR positivity has prognostic and therapeutic implications but is not as strong a survival predictor as nodal stage. Even ER-positive tumors behave aggressively when nodes are positive.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 942

Sabiston Textbook of Surgery, 21st Edition, Page 828 - 832, 835, 839, 847, 851

↑ *Back to this question in Part A*

@Neet_pg_bot

Q60: A 55-year-old female presents with a breast lump and is seeking medical evaluation. On examination, a palpable mass is detected in the breast. Which of the following conditions is not associated with the development of breast cancer? (Q854764)

A. Alcohol intake

B. Late menopause

C. Hormone replacement therapy

D. Multiparity

Correct Answer: D. Multiparity

Explanation: Multiparity is not a risk factor for breast carcinoma. Risk factors for breast carcinoma: Risk factors Relative risk Female gender. Increasing age. Germline mutations of high penetrance. Strong family history (>1 first-degree relative, young age, multiple cancers). Personal history of breast cancer. High breast density. >4.0 Germline mutations of moderate penetrance. High-dose radiation to the chest at a young age. Family history (1 first-degree relative). 2.1-4.0 Early menarche (age <12 years) Late menopause (age >55 years) (Option B) Late first pregnancy (age >35 years). Nulliparity. Absence of breastfeeding. Exogenous hormone therapy (Option C) Postmenopausal obesity. Physical inactivity. High alcohol consumption (Option A) 1.1-2.0 Relative risk is the likelihood of developing invasive carcinoma compared to women without any risk factors.

References:

Robbins & Cotran Pathologic Basis of Disease, 10th Edition, Page 1047

↑ *Back to this question in Part A*

@Neet_pg_bot

Q61: Which of the following are typically done in breast conservation therapy? Wide local excision Axillary node dissection Frozen section during surgery Optional: Post-operative radiotherapy (Q854762)

A. 1, 2, 3

B. 1, 3, 4

C. 1, 2

D. 2, 3

Correct Answer: A. 1, 2, 3

Explanation: In the context of Breast Conservation Therapy (BCT) , Radiotherapy (RT) is not optional but a necessary treatment component. Breast Conservation Therapy (BCT) combines BCS and post-operative radiotherapy (RT). All patients undergoing BCS will receive radiotherapy, which is integral to the treatment. The equation for this therapy is BCS + RT = BCT. Breast-conserving surgery (BCS) , also known as lumpectomy, involves removing a breast tumour along with a small margin of surrounding healthy tissue while preserving the majority of the breast. The goal is to remove the cancerous cells while maintaining the breast's appearance and function. Contraindications for Breast-Conserving Surgery (BCS): Absolute Contraindications First-trimester Pregnancy Multicentric Disease Diffuse Suspicious microcalcifications on mammogram Extensive DCIS Inflammatory Breast Cancer Tumors for which Clear Margins are Unobtainable with Lumpectomy Homozygous for ATM Mutation Relative Contraindications Prior Radiation Therapy to the Chest Wall or Breast Active Connective Tissue Disease Involving the Skin (e.g., Scleroderma) Extensive Positive Pathological Margins Large Tumor Size Relative to Breast Size or Tumors Greater Than 5 cm Known or Suspected Li-Fraumeni Syndrome (p53 Mutation) Known or Suspected Genetic Predisposition to Breast Cancer (e.g., BRCA1, BRCA2)

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 935

Schwartz's Principles of Surgery, 11th Edition, Page 591

Sabiston Textbook of Surgery, 21st Edition, Page 843,844

↑ *Back to this question in Part A*

@Neet_pg_bot

Q62: A 50-year-old woman presents with a slowly enlarging, painless thyroid nodule. She has no history of radiation exposure. On examination, the nodule is firm and mobile. Thyroid function tests are within normal limits. Ultrasound shows a solitary, solid lesion in the right lobe of the thyroid. Fine-needle aspiration cytology (FNAC) is performed, but is inconclusive. A hemithyroidectomy is done, and histopathology reveals capsular and vascular invasion. What is the most likely diagnosis? (Q865363)

A. Papillary thyroid carcinoma

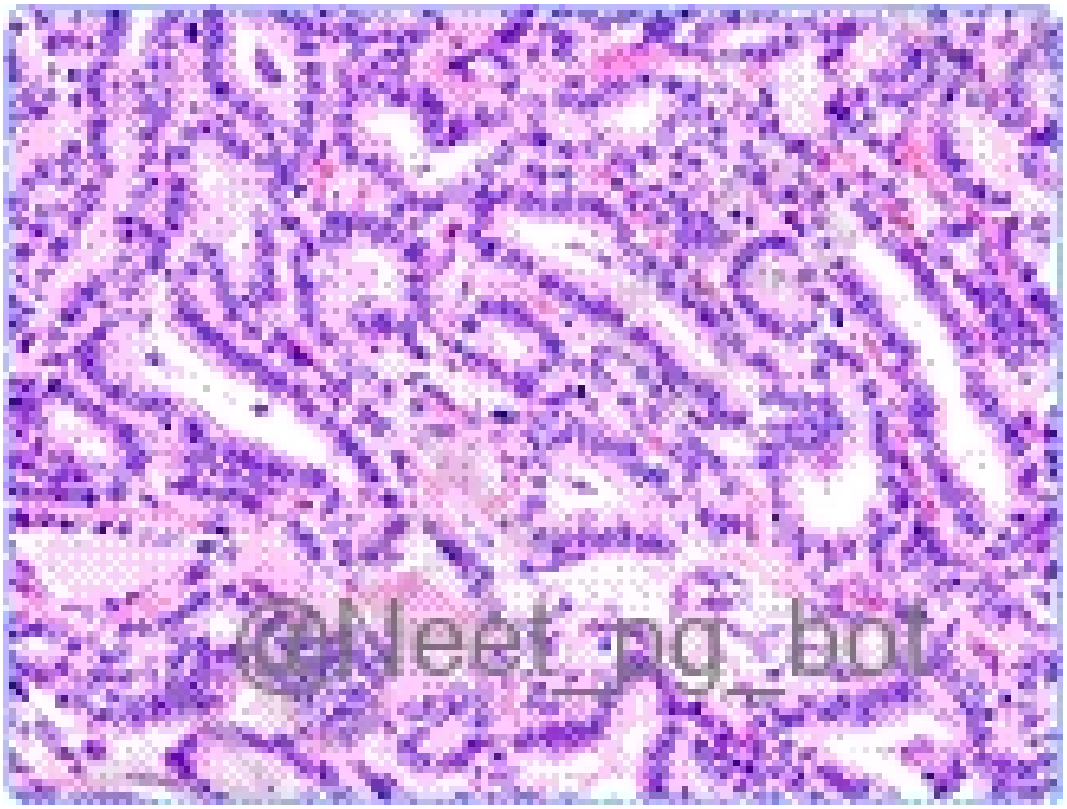
B. Follicular adenoma

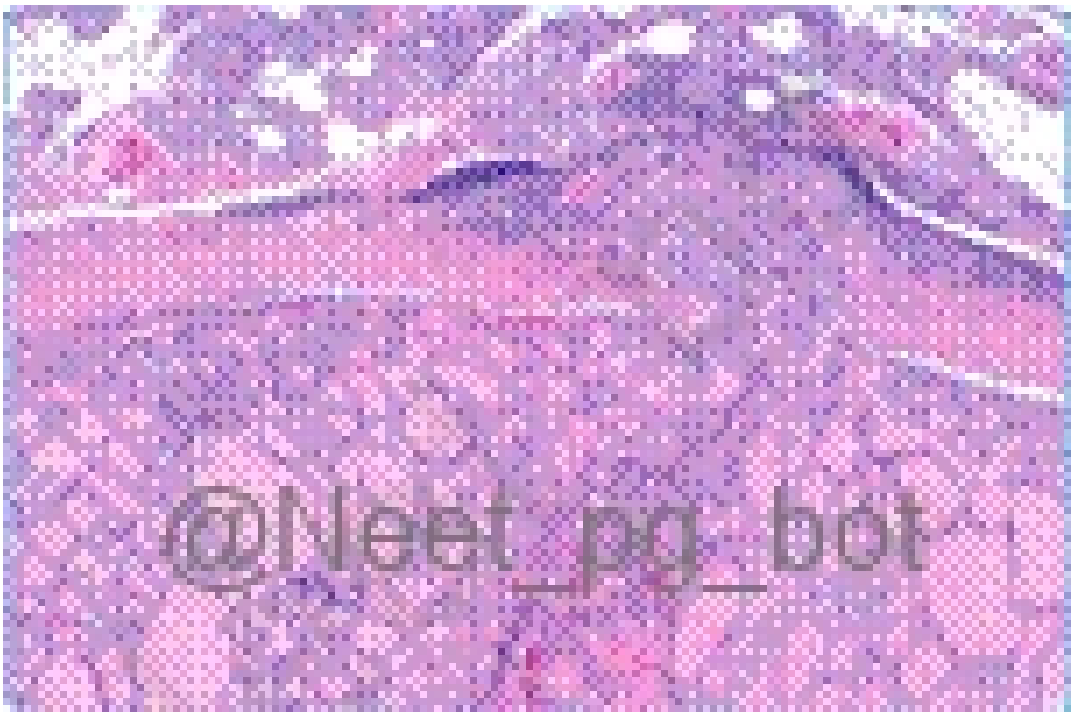
C. Follicular thyroid carcinoma

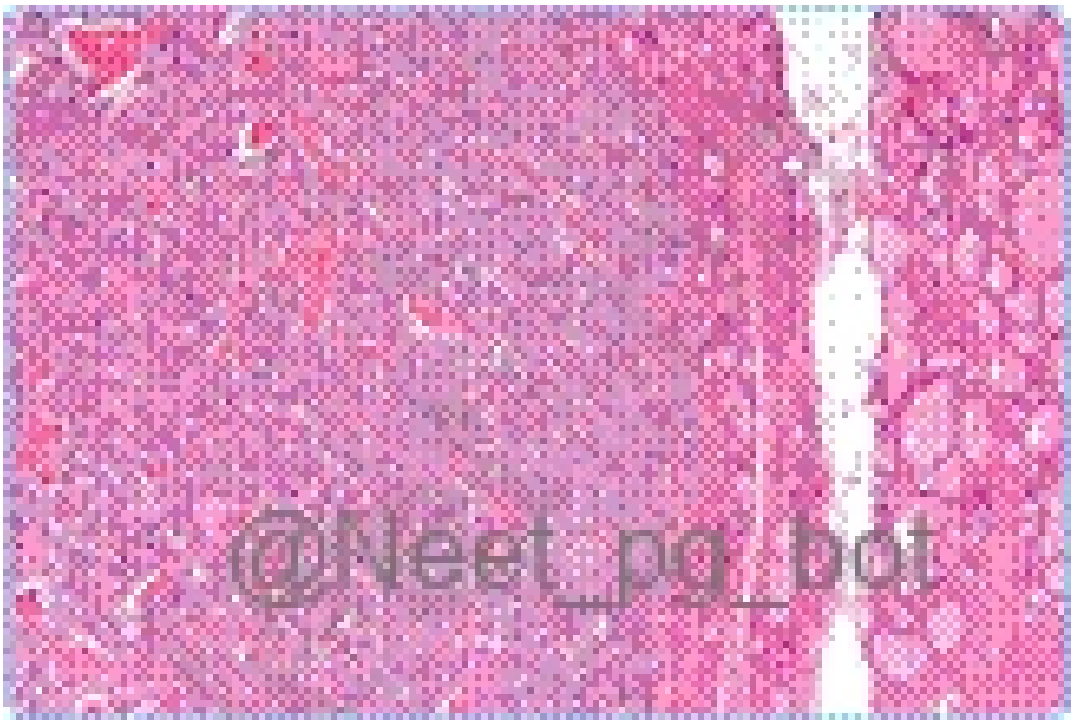
D. Medullary thyroid carcinoma

Correct Answer: C. Follicular thyroid carcinoma

Explanation: Follicular thyroid carcinoma is a malignant tumour of follicular cells that cannot be diagnosed on FNAC alone , because cytology cannot normally distinguish between follicular adenoma and carcinoma . (Option B) It is diagnosed on histopathology when capsular and/or vascular invasion is seen The Follicular thyroid carcinoma is known for its metastasis to bone, through the hematogenous spread. Pulsatile secondaries are osteolytic, vascular metastases due to increased vascularity of the deposits. They are seen in renal cell carcinoma (RCC) and follicular thyroid carcinoma. Types of thyroid carcinomas: Papillary (Option A) Follicular Medullary (Option C) Anaplastic Origin Follicular cells Follicular cells Para follicular cells Follicular cells Risk factors Radiation Thyroglossal cyst Hashimoto's thyroiditis Iodine deficiency Multinodular goitre - - Genetics BRAF, RET-PTC PAX-8,/PPAR-1, PTEN, P-53, RAS RET, MEN II P53 Clinical Manifestations Seen in the 3rd to 4th decade. Midline swelling in the anterior part of the neck Occasionally, lateral aberrant thyroid is seen. Seen in the 5th to 6th decade. A sudden increase in the size of the swelling Minimal or no pain Raised calcitonin. History of diarrhoea Family history of pheochromocytoma or hyperparathyroidism Metastasis Lymphatic Hematogenous Both Both and Direct invasion. Histopathology Optically clear nuclei (Orphan Annie eye nuclei) Dystrophic calcification (Psammoma bodies) Follicles (multiple foci are seen) Amyloid deposition Highly pleomorphic cells, spindle cells, giant cells, often areas of necrosis and mitotic figures.







References:

Bailey & Love’s Short Practice of Surgery, 28th Edition, Page 866 - 871

↑ *Back to this question in Part A*

@Neet_pg_bot

Q63: Which of the following condition is depicted in the given CT image ? (Q820159)

A. Cirrhosis

B. HCC

C. Congenital Adrenal Hyperplasia

D. Hepatitis



Correct Answer: C. Congenital Adrenal Hyperplasia

Explanation: Correct Option C - Congenital Adrenal Hyperplasia Congenital adrenal hyperplasia is a genetic disorder that affects the adrenal glands, leading to problems with hormone production. CAH is often diagnosed through newborn screening programs, which aim to detect hormone imbalances shortly after birth. Genetic testing and hormone level assessments are also used for diagnosis. Incorrect Options: Option A - Cirrhosis: Cirrhosis is a late stage of scarring (fibrosis) of the liver caused by many forms of liver diseases and conditions, such as hepatitis and chronic alcoholism. It can lead to various structural changes in the liver, but these changes might not be directly visible on a single CT image. Option B - HCC (Hepatocellular Carcinoma): Hepatocellular carcinoma is the most common type of primary liver cancer. It often occurs in the context of chronic liver disease and cirrhosis. On a CT scan, HCC may appear as a mass or a lesion within the liver. The appearance can vary, but it might have characteristics like enhancing in the arterial phase and washout in the delayed phase on contrast-enhanced scans. Option D - Hepatitis: Hepatitis is an inflammation of the liver, often caused by viral infections. On a CT scan, the liver might appear enlarged and have altered density due to inflammation, but specific visual characteristics might not be definitive for a hepatitis diagnosis. Other diagnostic methods, such as blood tests and clinical history, are usually necessary

References:

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↑ *Back to this question in Part A*

@Neet_pg_bot

Q64: A patient with a known history of rheumatoid arthritis is brought to the ER due to dizziness. Her blood pressure is 90/60 mmHg. She stopped taking a medication prescribed by her local doctor. Her blood sugar is low, and serum potassium is 6 mEq/L. Which of the following drugs should be given to her next? (Q857303)

A. IV Saline

B. Hydrocortisone

C. Dopamine infusion

D. Sodium bicarbonate

Correct Answer: B. Hydrocortisone

Explanation: The patient likely has adrenal insufficiency due to the sudden discontinuation of corticosteroids, prescribed for rheumatoid arthritis. This can precipitate an adrenal crisis, presenting with hypotension, dizziness, hypoglycemia, and hyperkalemia. The treatment of choice for adrenal crisis is Hydrocortisone , which is a corticosteroid that replaces the deficient hormones and helps in stabilising the patient's condition. Addison's disease / primary adrenocortical failure: Clinical features Glucocorticoid insufficiency: Weight loss, anorexia, malaise, weakness, nausea, vomiting, diarrhoea or constipation, postural hypotension, shock, hypoglycemia, hyponatremia (dilutional), hypercalcemia Mineralocorticoid insufficiency Hypotension, shock, hyponatremia, hyperkalemia ACTH excess: Pigmentation Adrenal androgen insufficiency: Decreased body hair and loss of libido, especially in females Investigations Random plasma cortisol measurement (values >500 nmol/L exclude adrenal insufficiency) Short ACTH stimulation test- if random cortisol levels are between 100-500, 1 microgram ACTH, serum cortisol levels of <500 is considered confirmatory for adrenal insufficiency. Plasma renin and aldosterone (high renin with low/lower part of the reference range aldosterone in mineralocorticoid deficiency) Dehydroepiandrosterone sulfate (DHEAS) and androstenedione in women Adrenal autoantibodies for autoimmune causes; imaging (CT/MRI) if antibodies are negative. Management Glucocorticoid Replacement: Oral hydrocortisone is preferred, and Prednisolone and dexamethasone may also be used. Mineralocorticoid Replacement: Fludrocortisone Addisonian crisis An Addisonian crisis is a life-threatening medical emergency that occurs when there is a severe deficiency of cortisol and aldosterone. It is most commonly seen in people with Addison's disease (primary adrenal insufficiency), especially when their hormone replacement therapy is inadequate or missed or during periods of extreme stress (e.g., illness, trauma, or surgery). Management: IV Hydrocortisone

References:

Davidson's Principles and Practice of Medicine, 24th Edition, Pages 671-673

↑ *Back to this question in Part A*

@Neet_pg_bot

Q65: Which of the following is the best method to conclusively localize a parathyroid adenoma? (Q857302)

A. SPECT Sestamibi

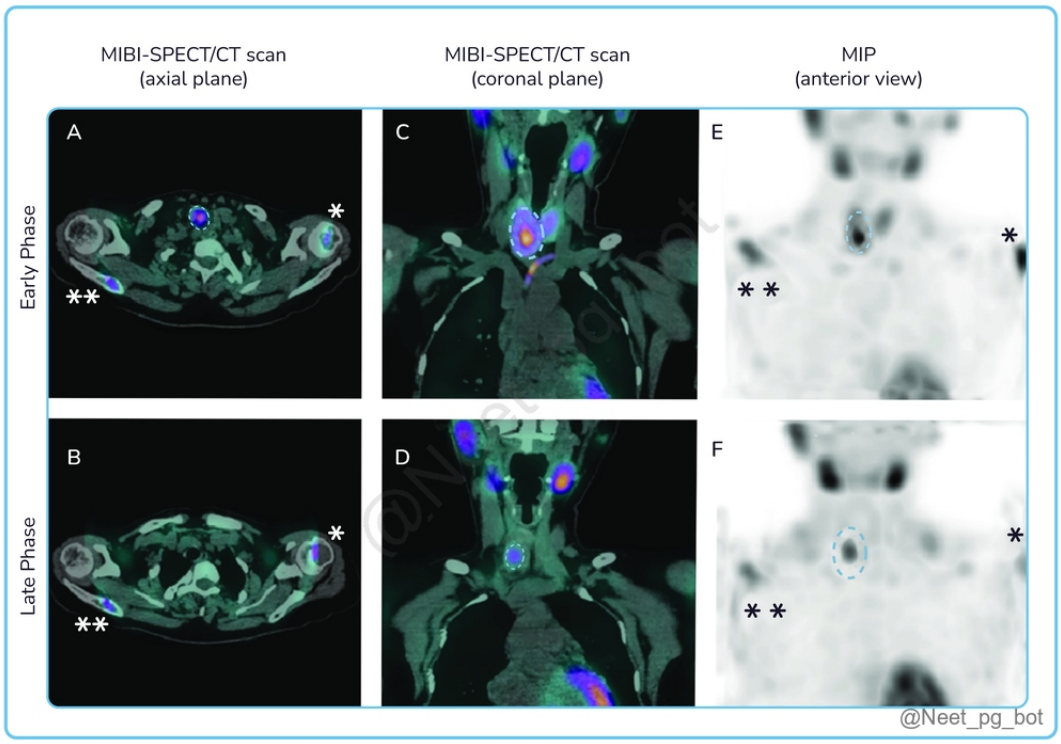
B. Tc99 Sestamibi Scan

C. USG Neck

D. MRI

Correct Answer: A. SPECT Sestamibi

Explanation: The best method to conclusively localise a parathyroid adenoma would be SPECT Sestamibi . SPECT Sestamibi : Sestamibi scintigraphy is a common and effective technique for parathyroid imaging. It works by utilising a radiotracer that is preferentially taken up by hyperfunctioning parathyroid glands. SPECT (Single Photon Emission Computed Tomography) is a more advanced form of imaging, offering three-dimensional (3D) imaging, which significantly improves the accuracy of localising parathyroid adenomas. {{caption_text}} Sensitivity : The sensitivity of sestamibi-SPECT is 79% for localising a parathyroid adenoma and provides more anatomical detail compared to other methods. While its sensitivity for multi-gland disease is lower (44%), it is still the best available method for localising single parathyroid adenomas. Tc99m sestamibi scan (Option B) refers to the standard two-phase imaging of parathyroid glands. While effective for identifying parathyroid adenomas, it lacks the 3D imaging capabilities of SPECT , thus making it slightly less accurate than SPECT Sestamibi in providing detailed localisation. Ultrasound (USG) (Option C) is commonly used for initial imaging and is non-invasive, inexpensive, and widely available. However, its sensitivity for localising multi-gland disease is only about 35%, and it has limitations in detecting ectopic parathyroid glands (e.g., in the mediastinum or retroesophageal locations). Therefore, while useful as an initial screening tool, it is not the best option for conclusive localisation of parathyroid adenomas. MRI (Option D) has a relatively low sensitivity (43%–94%) for parathyroid adenomas and is used only as a second or third-line modality. It is typically reserved for challenging or reoperative cases and is not the best method for the initial localisation of parathyroid adenomas.



References:

Sabiston Textbook of Surgery, 21st Edition, Page 936

↑ *Back to this question in Part A*

@Neet_pg_bot

Q66: Which of the following drugs are not used for thyrotoxic crisis management? (Q857301)

A. Acetaminophen

B. Aspirin

C. Lugol's iodine

D. Propranolol

Correct Answer: B. Aspirin

Explanation: Aspirin is not recommended in thyrotoxic crisis. It can interfere with the effectiveness of iodine therapy by displacing thyroid hormones from protein binding sites, potentially worsening the condition. Thyroid Storm About A thyroid storm, or thyrotoxic crisis, is an acute, life-threatening complication of hyperthyroidism. It presents with multisystem involvement and has a mortality rate of 8 to 25% despite advancements in treatment.

Management Initial Supportive Measures: IV fluids, oxygen, cooling blankets, and acetaminophen (Option A) . Beta-blocker Therapy: Start with propranolol (Option D) immediately (40-80 mg every 4-6 hours) to control adrenergic tone. Thionamide Therapy: Administer propylthiouracil (500-1000 mg loading, then 250 mg every 4 hours) or methimazole (20 mg every 4-6 hours). This reduces thyroid hormone synthesis. Iodine Solution (Option C): Give SSKI (5 drops every 6 hours) after thionamide to reduce the release of thyroid hormone Glucocorticoids: Hydrocortisone (100 mg IV every 8 hours) or dexamethasone (2 mg every 6 hours). Therapy to block peripheral conversion of T4 to T3 : Iodinated radiocontrast agent, glucocorticoid, PTU, propranolol Cholestyramine (Bile acid sequestrant) : 4 grams orally 4 times daily for severe cases to reduce enterohepatic recycling of thyroid hormone. Monitoring: Admit to ICU with close cardiac monitoring and ventilatory support if needed. Alternative Medications: Esmolol as a short-acting beta-blocker; diltiazem if beta-blockers are contraindicated. Surgery: Thyroidectomy for patients with contraindications to thionamides after pre-treatment. Definitive Treatment: Recommend radioiodine therapy or surgery for hyperthyroidism once stabilized.

References:

Harrison Principles of Internal Medicine, 21st Edition, Page 2941

Davidson’s Principles and Practice of Medicine, 24th Edition, Page 639

https://www.ncbi.nlm.nih.gov/books/NBK448095/

↑ *Back to this question in Part A*

@Neet_pg_bot

Q67: Identify the most common pancreatic islet tumor associated with MEN-1 syndrome. (Q860303)

A. VIPoma

B. Gastrinoma

C. Insulinoma

D. Lipoma

Correct Answer: B. Gastrinoma

Explanation: Gastrinoma is the most common pancreatic islet tumor associated with MEN-1 syndrome (Multiple Endocrine Neoplasia type 1). Gastrinomas are typically found in the pancreas or duodenum and cause Zollinger-Ellison syndrome, which is characterized by severe peptic ulcers due to excessive gastrin secretion. Types of Multiple Endocrine Neoplasia MEN Type I MEN Type II MEN Type III MEN Type IV Cause Defect of chromosome 11q13 causing MEN 1 gene mutation Also called Wermer’s syndrome Defect of chr.10 leading to mutation of RET gene Also called Sipple’s syndrome Also called MEN II B , it is a variant of Type 2 MEN Defect of chr.12 causing CDKN1B gene Tumors Included Parathyroid adenoma (most common) It presents with primary hyperparathyroidism (↑ PTH and ↑ Ca) All the 4 glands can be included. Rx: Total/subtotal parathyroid resection Parathyroid adenoma (most common, and calcium can be normal) Medullary carcinoma thyroid (most common)

Parathyroid adenoma (Presents as hypercalcemia) Pancreatic adenoma Presents as Gastrinoma or Zollinger-Ellison syndrome This leads to peptic ulcer disease in the duodenum, which is the leading cause of death in this type. Pheochromocytoma . Pheochromocytoma (Most important criterion for both MEN 2 and MEN 3): Presents with elevated blood pressure. Pituitary adenoma: Prolactinoma Pituitary adenoma: Prolactinoma, causing amenorrhea and Infertility Medullary thyroid carcinoma Calcitonin is the tumor marker present Cold nodules are seen on the thyroid scan Metastasis can be traced with PET scan Visible neck mass, causing dysphagia Rx - Prophylactic thyroidectomy Reproductive tract tumors Testicular tumors Neuroendocrine tumor (Cervix) Associated conditions Angio■broma Collagenoma Adrenocortical tumor Carcinoid tumors/Argenta■noma Pheochromocytoma (only in 1%) Congenital aganglionosis, Hirschsprung disease Marfanoid habitus Medullated corneal nerve ■bers Mucosal neuromas Megacolon and Multiple diverticulae Occasionally with Renal tumor Adrenal tumor

References:

Harrison’s Principle of Internal Medicine, 21st Edition, Page 2983-2990

Davidson’s Principles and Practice of Medicine, 24th Edition, Page 868,869

↑ *Back to this question in Part A*

@Neet_pg_bot

Q68: Which of the following will not result in hoarseness of voice after a thyroid surgery? (Q840046)

A. Dissecting/retracting strap muscles

B. Exploring Beahrs triangle

C. Tubercle of zuckerkandl dissection

D. Ligating inferior thyroid vessels

Correct Answer: A. Dissecting/retracting strap muscles

Explanation: Hoarseness after thyroid surgery is mainly due to injury or irritation of the recurrent laryngeal nerve or the external branch of the superior laryngeal nerve, which control vocal cord movement and tension. Dissecting or retracting the strap muscles is a superficial procedure and does not directly affect the laryngeal nerves, so they do not cause hoarseness. Exploring Beahr’s triangle (Option B): RLN forms one side of Beahrs' triangle. Therefore, exploring this area is a high-risk step for RLN injury and can cause hoarseness. Tubercle of Zuckerkandl dissection (Option C): The recurrent laryngeal nerve lies close behind it and may be damaged. Ligating inferior thyroid vessels (Option D): The inferior thyroid artery as one of the boundaries of Beahrs' triangle, is in immediate proximity to the RLN.

References:

Bailey & Love's Short Practice of Surgery- 28th Edition, Page 851, 852

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@Neet_pg_bot

Q69: A 52-year-old woman is diagnosed with invasive ductal carcinoma of the left breast. On examination, there is skin ulceration overlying the tumor, localized edema and redness, but no diffuse inflammatory changes. Nipple retraction is present. No axillary lymphadenopathy is noted, and imaging shows no distant metastasis. What is the T-stage of this tumor? (Q840029)

A. T2

B. T3

C. T4a

D. T4b

Correct Answer: D. T4b

Explanation: The TNM staging system for breast cancer defines the "T" (tumor) stage based on its size and local invasion. While T1, T2, and T3 are defined by tumor size, the T4 stage is determined by direct extension of the tumor to the chest wall or skin, regardless of size. T4a: Extension to the chest wall. (Option C ruled out) T4b: Edema (including peau d'orange) or ulceration of the skin of the breast , or satellite skin nodules confined to the same breast. T4c: Both T4a and T4b are present. T4d: Inflammatory carcinoma (characterized by diffuse redness and swelling involving a third or more of the breast). T2 (Option A): Ruled out because T2 tumors are 2–5 cm in size without skin or chest wall involvement . T3 (Option B): Ruled out because T3 tumors are >5 cm without skin or chest wall involvement .

References:

Bailey and Love’s Short Practice of Surgery, 28th Edition, Page 934

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@Neet_pg_bot

Q70: ER positivity is used as which of the following in the context of breast carcinoma? (Q840015)

A. Diagnostic marker

B. Prognostic marker

C. Surrogate molecular marker

D. Treatment

Correct Answer: B. Prognostic marker

Explanation: Correct option B - Prognostic marker: Estrogen sensitive receptors, which are cytosolic, glycoprotein present in the breast and tumor tissue. It is an important indicator of prognosis of carcinoma breast. If the value is more than 10 units (f/mols) per n gram of tissue it is called ER +ve status. ER positivity is common in postmenopausal women (60%) compared to premeno- pausal women (30%). If the value is less than 10 units per gram of tissue it is called ER-ve status. ER +ve status ER -ve status Prognosis is good. Hormone therapy including tamoxifen is more beneficial. Response to treatment is better. Prognosis is poor. Hormone therapy is not very beneficial (but used) as compared to ER +ve patients. Response to treatment is not good. Incorrect Options: Options A - Diagnostic marker: AFP, and CA153 are tumour markers used in the diagnosis of breast cancer. Option C - Surrogate molecular marker: Surrogate molecular marker, based on immunohistochemical markers identifies different subtypes of breast carcinoma. Option D - Treatment: Treatment is based on the TNM staging of breast cancer.

References:

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@Neet_pg_bot

Q71: What is the term used to describe the signs and symptoms caused by hormones released from tumor tissue, which cannot be explained by the tumor's anatomical distribution? (Q793543)

A. Pretumor syndrome

B. Paraneoplastic syndrome

C. Paratumour syndrome

D. Autocrine phenomenon

Correct Answer: B. Paraneoplastic syndrome

Explanation: Correct Option B - Paraneoplastic syndrome: Paraneoplastic syndrome refers to a group of signs and symptoms that occur because of hormones or other substances produced by tumor cells but are not related to the primary tumor's location or direct invasion of surrounding tissues. These symptoms may be the first indication of an underlying malignancy and may even precede the diagnosis of cancer. Characteristics: Paraneoplastic syndromes can affect various organ systems. They often manifest as neurologic, endocrine, dermatologic, rheumatologic, or hematologic abnormalities. These syndromes may precede the diagnosis of cancer, occur

simultaneously, or follow the diagnosis. Incorrect Options: Option A - Pretumor syndrome: Pretumor syndrome is not a recognized medical term, and there is no established definition or diagnostic criteria. Option C - Para tumor syndrome: Para tumor syndrome is also not a recognized medical term and has no defined meaning. Option D - Autocrine phenomenon: Autocrine phenomenon refers to the production and secretion of a hormone or other signaling molecule by a cell, which then acts on the same cell or nearby cells through specific receptors. This term is not specific to cancer and can occur in various physiological and pathological contexts.

References:

Prepladder Notes

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@Neet_pg_bot

• [08_Plastic Surgery] 047 Burns

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[08_Plastic Surgery] 047 Burns — Quick Jump

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Q7 (p. 2979)	*Q8 (p. 2982)*	*Q9 (p. 2983)*	*Q10 (p. 2984)*	*Q11 (p. 2984)*	*Q12 (p. 2986)*
Q13 (p. 2986)	*Q14 (p. 2987)*	*Q15 (p. 2988)*	*Q16 (p. 2989)*	*Q17 (p. 2990)*	*Q18 (p. 2991)*
Q19 (p. 2992)	*Q20 (p. 2993)*				

Q1: A 35 year old industrial worker presents to the ED with severe pain and burns on his right hand after exposure to hydrofluoric acid. The burns are superficial, with erythema and blistering. What is the most appropriate initial management step? (Q849515)

A. Immediate surgical debridement

B. Topical application of calcium gluconate gel

C. Intravenous calcium gluconate

D. Bier's block with calcium gluconate 10%

Correct Answer: B. Topical application of calcium gluconate gel

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Hydrofluoric acid is commonly used in industrial areas. It is the strongest inorganic acid that can produce corrosion and dehydration. Though hydrofluoric acid (HF) is a weak acid, it can chelate calcium and magnesium in tissues, causing both local and systemic effects. Management: Initial Management : Applying calcium gluconate gel directly to the burn site (Option B) helps neutralize the acid and provide calcium, which counters the acid's chelating effects and prevents hypocalcemia. Immediate surgical debridement (Option A) is indicated only for burns with HF concentrations above 50% to prevent hypocalcemia and arrhythmias. IV calcium (Option C) is used if there are systemic symptoms of hypocalcemia, but it is not the first step for localized burns. Bier's block with calcium gluconate 10% (Option D) is used for severe or extensive burns, not as the initial management. Chemical burns: These injuries involve two aspects: Physical destruction of the skin. Systemic poisoning due to absorption. Initial management steps: Determine if the chemical is a solid powder or a liquid. Solid powders, such as phosphorus and elemental sodium, should be removed with forceps and not irrigated with water to prevent further reactions. Liquids can generally be washed off with water. Acids and alkalis are the most common causes of chemical burns. Alkalis are often more destructive than acids, especially dangerous to the eyes.

References:

Bailey and love's Short practice of Surgery, 28th edition, Page 680.

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@Neet_pg_bot

Q2: A 40-year-old man suffered burns from a wildfire affecting his entire right upper limb and the front of his torso. What is the total percentage of body surface area that has been burned? (Q849512)

A. 27%

B. 18%

C. 36%

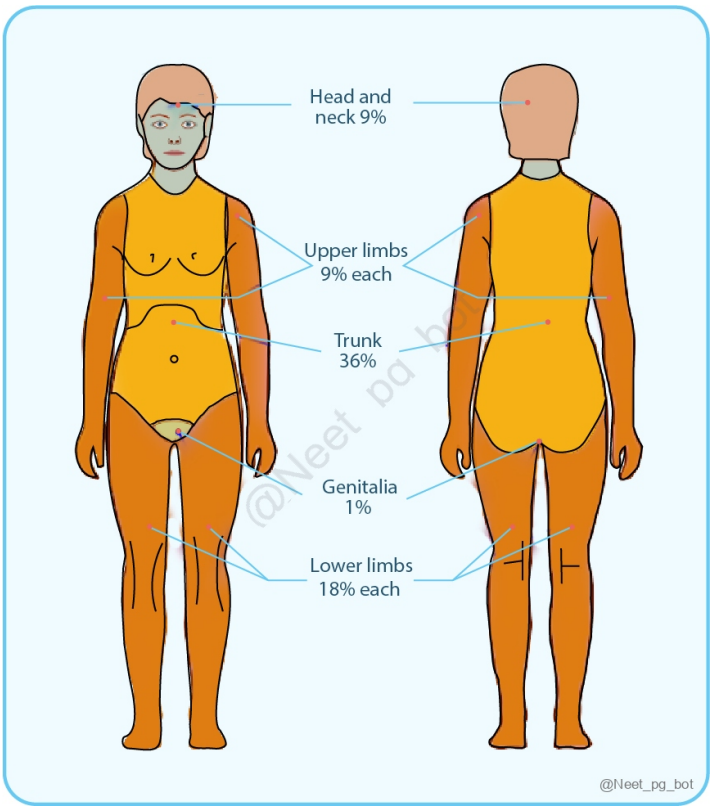
D. 32%

Correct Answer: A. 27%

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: According to the Wallace rule of 9, this is how the area burned is calculated: Adults Children Infants Head & neck 9% 18% 20% Front of chest & abdominal wall 9 x 2 = 18% 18% 10 x 2 = 20% Back of chest & abdominal wall 9 x 2 = 18% 18% 10 x 2 = 20% Lower limb 18 x 2 = 36% 13.5 x 2 = 27% 10 x 2 = 20% Upper limb 9 x 2 = 18% 18% 10 x 2 = 20% Perineum 1% 1% Since the patient in the scenario is an adult, Burned area% = entire right upper limb (9%) + front of his torso (18%) , which is 27%



References:

SRB's Manual of Surgery, 6th Edition, Page 122.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q3: A 29-year-old woman sustained severe burns following a spillage of boiling water in the kitchen by accident. She requires colloid resuscitation after the first 24 hours of crystalloid resuscitation. Which of the following can be used to calculate colloid fluid volume? (Q849510)

A. Parkland formula

B. Muir and Barclay regime

C. Evan’s formula

D. Galveston regime

Correct Answer: B. Muir and Barclay regime

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: All of the options are formulas for the calculation of fluid volume for resuscitation following burns Muir and Barclay regime calculates the colloid fluid volume specifically. Muir and Barclay regime: For colloid after 12-24 hours ½ (% Burns x Body weight in kg) = 1 Ration 3 Rations in the first 12 hours 2 Rations in the second 12 hours 1 Ration in the third 12 hours Fluid resuscitation in burns: Fluid Management in the First 24 Hours Only crystalloids should be given (e.g., saline, dextrose saline, Ringer lactate-fluid of choice) Fluid Management After 24 Hours (Up to 30-48 Hours) Colloids should be given to compensate for plasma loss (Plasma, Haemaccel (gelatin), Dextrans, Hetastarch) Human albumin is considered the ideal colloid Blood is transfused later (after 48 hours) The Parkland formula, Evan's formula, and the Galveston regime (Options A, B, and C) are all based on crystalloid resuscitation.

References:

SRB's Manual of Surgery, 6th Edition, Page 127.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q4: A 24-year-old boy sustained burns in an accident. He has 20% burns and is of 60 kg. What is the total fluid requirement for a day according to the Parkland regime? (Q849508)

A. 4800 mL

B. 5000 mL

C. 4000 mL

D. 3800 mL

Correct Answer: A. 4800 mL

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Parkland regime: Fluid requirement in 24 hours in mL = 4 X % burn X Body Weight in kg Substituting the values, 4 x 20 x 60 = 4800 mL in 24 hours. Half the volume is given in the first 8 hours, and the rest half is given in the next 16 hours In children, maintenance fluid must also be given. This is normally dextrose saline given as follows: 100 mL/kg for 24 hours for the first 10 kg 50 mL/kg for the next 10 kg 20 mL/kg for 24 hours for each kilogram over 20 kg body weight.

References:

Bailey & Love’s Short Practice of Surgery, 28th Edition, Page 671 SRB's Manual of Surgery, 6th Edition, Page 127.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q5: A 25-year-old female is brought to the emergency department after being found unconscious during a thunderstorm. On examination, she has fern-like marks on his neck (as shown in the image below). After regaining consciousness, she complains of weakness and numbness in her lower limbs. What is the most likely diagnosis of her condition? (Q849517)

A. Compartment syndrome

B. Keraunoparalysis

C. Hypokalemic periodic paralysis

D. Transient ischemic attack



Correct Answer: B. Keraunoparalysis

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Fern-like marks (Lichtenberg figures): These are pathognomonic (unique) to lightning strikes. They are not true burns but rather an inflammatory reaction caused by the transmission of static electricity through the skin's superficial vasculature. They usually appear within hours and disappear within 24 hours. Weakness and numbness in lower limbs: This describes Keraunoparalysis , a temporary state of paralysis specific to lightning strikes. It is characterized by: Autonomic instability (vasospasm). Sensory loss and motor paralysis (usually affecting the lower limbs more than the upper). Limbs that appear cold, pulseless, and pale (due to extreme vasospasm). Spontaneous resolution, typically within a few hours. Pathophysiology of Lichtenberg Figures: The high-voltage surge of a lightning strike causes a massive, instantaneous dielectric breakdown of the skin. This leads to: Vascular Damage: The intense electrical energy causes sudden, severe damage to the capillary walls. Blood Extravasation: Because the capillaries are compromised, red blood cells are forced out into the surrounding subcutaneous tissue (extravasation). The "Fern" Pattern: The electricity follows the path of least resistance, which often mirrors the branching patterns of the vasculature or moisture on the skin. The resulting "burn" is essentially a transient tracking of red blood cell leakage along these dendritic paths. Compartment syndrome (Option A): While this can occur after electrical burns due to deep tissue swelling, it wouldn't explain the "fern-like" marks or the immediate, widespread limb weakness that resolves quickly. Hypokalemic periodic paralysis (Option C): This causes muscle weakness related to low potassium levels, but it is unrelated to thunderstorms or the specific skin markings described. Transient ischemic attack (Option D): A TIA involves temporary neurological deficits due to brain ischemia. It would not cause Lichtenberg figures and typically presents with focal deficits (like one-sided weakness) rather than bilateral lower limb paralysis following environmental trauma.



References:

www.uptodate.com/contents/electrical-injuries-and-lightning-strikes-evaluation-and-management/print

↑ *Back to this question in Part A*

@Neet_pg_bot

Q6: A 35-year-old electrician is brought to the emergency department after sustaining an electrical injury while working on a faulty high-voltage switchboard. On examination, he is noted to have an entry wound on his left hand and an exit wound on his right foot and dark urine in the Foley catheter bag. Laboratory tests show the following results: Serum creatinine: 2.5 mg/dL Potassium: 5.8 mEq/L Creatine kinase (CK): 25,000 U/L What is the most appropriate next step in the management of this patient? (Q849516)

A. Initiate intravenous fluid resuscitation and monitor urine output

B. Immediate surgical debridement of the entry and exit wounds

C. Administer calcium gluconate for hyperkalemia

D. Start hemodialysis immediately

Correct Answer: A. Initiate intravenous fluid resuscitation and monitor urine output

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: This scenario describes a patient with an electrical burn who shows signs of rhabdomyolysis, as evidenced by dark urine and extremely elevated CK levels. The elevated serum creatinine and hyperkalemia indicate that the patient is at risk of acute kidney injury (AKI) due to myoglobinuria. The first and most critical step in managing rhabdomyolysis is aggressive intravenous fluid resuscitation to ensure adequate urine output and prevent renal failure. This helps flush out myoglobin and other cellular debris from the kidneys, reducing the risk of AKI. Monitoring urine output ensures that the patient responds to the fluid therapy and aids in assessing the need for further intervention. After the patient is stabilized, immediate surgical debridement of the entry and exit wounds (Option B) can be performed. While hyperkalemia is present, the immediate priority is fluid resuscitation. Calcium gluconate (Option C) can be given if the patient shows signs of cardiac instability. Hemodialysis (Option D) is considered if the patient does not respond to initial management or has severe electrolyte abnormalities unresponsive to other treatments.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 679

↑ *Back to this question in Part A*

@Neet_pg_bot

Q7: A 32 year old male arrives at the emergency department with severe facial burns after being involved in a car accident. The patient's facial burns are extensive, covering the entire face and neck region, and have caused significant swelling. He is conscious and in pain, but his airway is patent. Which method of dressing should be chosen for this patient's facial burns, and why? (Q849514)

A. Exposure Method – To allow continuous monitoring of the facial burns and prevent airway compromise.

B. Closed Method – To reduce the risk of infection by providing a protective barrier over the burned area.

C. Exposure Method – To facilitate a moist environment that promotes healing in the facial area.

D. Closed Method – To minimize fluid loss from the burned area and aid in preventing dehydration.

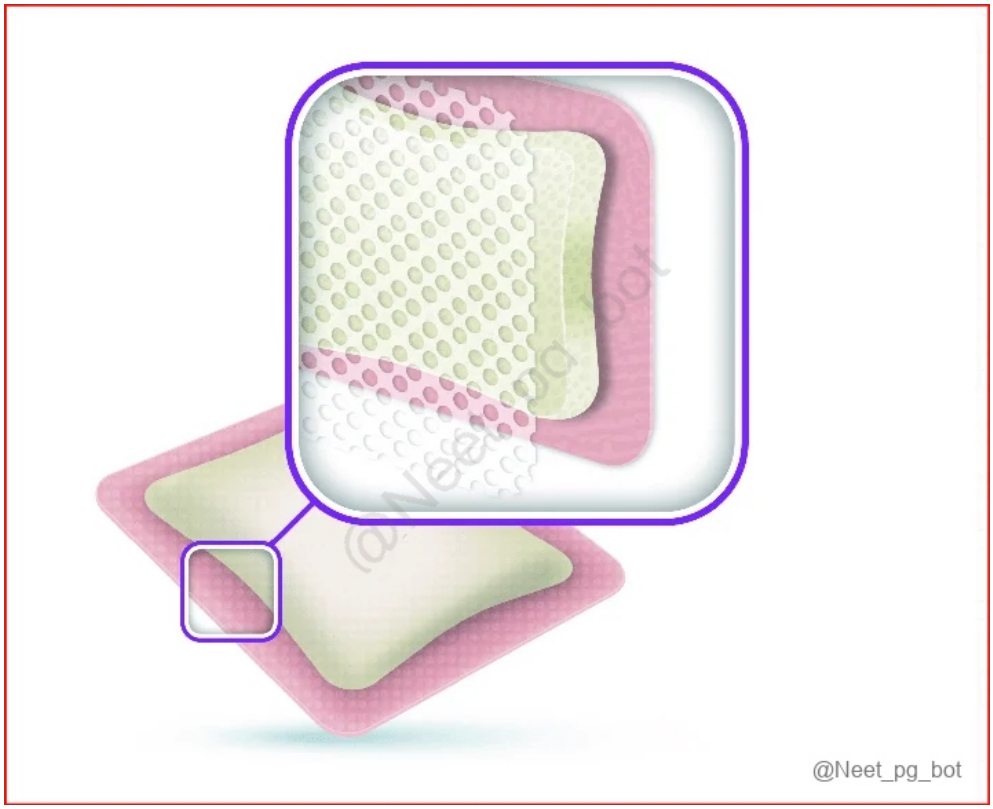
Correct Answer: A. Exposure Method – To allow continuous monitoring of the facial burns and prevent airway compromise.

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The exposure method is chosen in cases of facial burns because it allows healthcare providers to closely monitor the patient's airway and facial swelling. This method ensures that any signs of airway obstruction can be addressed promptly, which is crucial for patient safety in the case of severe facial burns. Types of methods used for burns wound care: Exposure method Closed method No dressing is done. Antimicrobials are given 2-3 times/day. They are used for burns involving the face & the head. Disadvantages: Increased pain & heat loss. Increased risk of cross-contamination. Occlusive dressing is applied over the antimicrobial agent. The dressing is changed twice daily. Advantages: Decreased pain & heat loss. Decreased risk of cross-contamination. Disadvantages: Increased risk of bacterial growth if the dressing is not changed twice daily. Wound Dressings: Alginate Foam Hydrocolloid Hydrogel Transparent Film Absorptive, but nonadherent Used in high drainage wounds Absorptive hence used for high drainage wounds Contraindicated in non-draining wounds Autolytic debridement Used for bedsores & stasis ulcers. Not used in high drainage wounds Rehydrates the wound bed Used for dry wounds needing moisture May cause wound macerate Not absorptive Nonabsorptive Autolytic debridement Not used in high drainage wounds


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References:

SRB's Manual of Surgery, Page 127

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@Neet_pg_bot

Q8: A 36 year old male is admitted to the hospital with severe second and third-degree burns. On the fourth day, the patient develops a fever, increased pain in the burned area, and a malodorous discharge from the wound. The burn wound appears to have significant eschar formation. Wound cultures reveal heavy growth of Pseudomonas aeruginosa. Which of the following topical agents would be most appropriate for this patient? (Q849513)

A. Silver sulfadiazine (1%)

B. Sulfamylon (Mafenide acetate) (5%/11%)

C. Silver nitrate (0.5%)

D. Povidone iodine (5%)

Correct Answer: B. Sulfamylon (Mafenide acetate) (5%/11%)

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Sulfamylon: Good antipseudomonal agent Good eschar penetration Topical agents Advantages Disadvantages/ Side effects Silver sulfadiazine (1 %) (Option A) Effective against Pseudomonas and gram negative bacteria Does not cause pain Neutropenia Does not penetrate effectively into eschars Should be avoided in pregnancy, nursing mothers and infants below 2yrs of age Sulfamylon (5%/11 %) (Mafenide acetate) (Option B) Good antipseudomonal agent Good eschar penetration Painful Can cause acidosis Silver nitrate (0.5%) (Option C) Also has anti Pseudomonal activity Stains burnt area Povidone iodine (5%) (Option D) Used over granulation tissue after eschar separation. Irritant Silver sulphadiazine and cerium nitrate Boosts cell-mediated immunity (immunomodulator) Expensive 0.025% sodium hypochlorite (Dakin's solution) Effective against gram positive organisms Inhibits epithelialization In this scenario, though silver sulfadiazine (Option A) and silver nitrate (Option C) have antipseudomonal activity, they do not penetrate into eschar, hence not the most appropriate topical antibiotic of choice.

References:

SRB’s Manual of Surgery, Page 128

↑ *Back to this question in Part A*

@Neet_pg_bot

Q9: A 24-year-old burns patient is receiving fluid resuscitation and is being closely monitored. What should his ideal urine output be? (Q849511)

A. 1 mL/kg/hr

B. 3 mL/kg/hr

C. 5 mL/kg/hr

D. 2 mL/kg/hr

Correct Answer: A. 1 mL/kg/hr

Explanation: During fluid resuscitation, burns patients should be closely monitored The main aspect of monitoring is urine output. A urinary output of 0.5 mL/kg/hr in adults and 1 mL/kg/hr in children should always be maintained to prevent over and under-perfusion. Patient Group Target Urine Output Adults ≥ 0.5 mL/kg/hr Children 1–2 mL/kg/hr

References:

Sabiston Textbook of Surgery, 21st Edition, Page 492.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q10: A 10-year-old boy contracted burns and is in need of fluid resuscitation. Which of the following formulas can be used to measure the fluid volume? (Q849509)

A. Parkland formula

B. Modified Brooke formula

C. Evan’s formula

D. Galveston formula

Correct Answer: D. Galveston formula

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: All of the options are formulas for calculating the resuscitation fluid volume but for the pediatric age group, the Galveston formula is used.. Galveston Formula: Galveston formula gives the volume of crystalloid fluid for fluid resuscitation in the pediatric group 5000 mL/m 2 of Total Burnt surface area + 2000 ml/m 2 (Maintenance) of Total Body surface area 50% of calculated fluid is given in 1st 8 hours Rest 50% of calculated fluid is given in next 16 hours Parkland Formula (Option A): 24 hours fluid requirement in ml = 4 × body weight (kg) × % of Burnt surface area 50% of calculated fluid is given in 1st 8 hours Rest 50% of calculated fluid is given in next 16 hours Maximum fluid given is according to 50% burns Timing is calculated since the time of burn First-degree burns are not included 2nd day fluid requirement: 40 - 60% of 1st day fluid requirement Modified Brooke formula (Option B): A more "conservative" version of the Parkland formula. 2 mL × Body Weight (kg) × % TBSA burned It uses a lower volume of crystalloid in the first 24 hours to avoid "fluid creep" (over-resuscitation and excessive swelling). It is rarely used as the primary choice for pediatric patients because children require more aggressive fluid support to maintain cardiac output. Evan’s formula (Option C): 1 mL/kg/TBSA of Colloids + 1 mL/kg/TBSA of Electrolytes + 2000 mL of 5% Dextrose in water (for maintenance). It was unique because it included colloids (like albumin or saline) in the first 24 hours. Mostly obsolete today, as most modern protocols (like Parkland) avoid colloids in the first 24 hours because the "leaky" capillaries in a fresh burn allow the large proteins to leak into the tissue, potentially worsening edema.

References:

SRB's Manual of Surgery, 6th Edition, Page 127.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q11: A 70-year-old woman presents to the emergency department after a house fire. She has burns involving parts of her face, neck, and both hands. The total body surface area (TBSA) affected is approximately 12%. After emergency management using ATLS guidelines, What is the most appropriate next step in management? (Q849498)

A. Discharge with outpatient follow-up for wound care and pain management

B. Admit to the general medical floor for observation and supportive care

C. Refer to a burn center for specialized treatment

D. Manage in the emergency department with fluids and dressings, then discharge

Correct Answer: C. Refer to a burn center for specialized treatment

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The patient has significant burns involving critical areas (face, neck, and hands) and is elderly, which increases the risk of complications. Referral to a burn center for specialized treatment is the most appropriate step. Indications of referral to burns center Suspected airway injury Burns on face/neck, hoarseness, stridor, singed facial/nasal hair Burns needing fluid resuscitation >15% TBSA in adults >10% in children/elderly Burns requiring surgery Deep partial-thickness (deep dermis damage) Full-thickness (entire dermis destroyed) Circumferential full-thickness (restricted movement) Significant burns Burns on hands, face, feet and perineum Psychiatric/social concerns Mental health issues, substance abuse and unstable living conditions Suspected non-accidental injury Delayed presentation, inconsistent history and unexplained injuries Extremes of age Infants, elderly with thinner skin and higher risk of complications Burns with serious sequelae High-tension electrical burns, hydrofluoric acid burns, etc. Definitive Management of Such Burns: Once the patient is transferred to a burn center, management shifts from acute stabilization (ATLS) to definitive care: 1. Airway and Pulmonary Hygiene: If inhalation injury is confirmed via bronchoscopy, management involves aggressive pulmonary toilet, humidified oxygen, and potentially mechanical ventilation with lung-protective strategies. 2. Wound Management and Surgery: Early Escharotomy: If neck or hand burns are circumferential and full-thickness, an escharotomy may be performed to prevent respiratory distress or compartment syndrome in the limbs. Debridement and Grafting: For deep partial or full-thickness burns, early excision and skin grafting (autografting) is the definitive treatment to reduce infection risk and promote functional recovery. Specialized Dressings: Use of antimicrobial silver-impregnated dressings or biosynthetic skin substitutes to maintain a moist environment and prevent "burn wound sepsis." 3. Rehabilitation (The "Functional" Management): Positioning and Splinting: Especially for the hands and neck, "the position of comfort is the position of contracture." Specialists use customized splints to maintain the hands in a functional position and prevent the neck from healing in a flexed (downward) position. Early Physical Therapy: Crucial to maintain range of motion in the joints of the hands.

References:

Bailey & Love’s Short Practice of Surgery, 28th Edition, Pages 665-673.

Sabiston Textbook of Surgery, 28th Edition, Page 485.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q12: What is the most commonly used fluid for initial resuscitation in burn patients? (Q849507)

A. Hypertonic saline

B. Ringer lactate

C. 5% Dextrose

D. Albumin

Correct Answer: B. Ringer lactate

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Fluid resuscitation: Intravenous resuscitation is appropriate for any adult with burns greater than 15% TBSA and children with burns greater than 10% TBSA. The ideal site is veins of the hand and antecubital fossa. Long saphenous vein is preferred in case of edema due to burns. Three main fluids are used in the resuscitation stage: Crystalloid, Colloid and Hypertonic saline. The fluid of choice in burns is Ringer lactate (Crystalloid), as it closely replicates the osmolality of plasma. The lactate content helps correct metabolic acidosis, which is common in burns patients. The maintenance fluid of choice in children with burns is DNS as children have lesser glycogen. Other fluids used are Hypertonic saline, Normal saline, and Human albumin. Hypertonic saline is used in patients with shock due to burn injury. Human albumin (Colloid) (Option D) is avoided during first 24 hours of burn injury as it causes edema .

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 670-671.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q13: Which of the following complications in a patient with an airway burn most at risk? (Q849506)

A. Chronic bronchitis

B. Pulmonary embolism

C. Acute airway obstruction

D. Pleural effusion

Correct Answer: C. Acute airway obstruction

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Airway burns Burned airways can swell and cause acute airway obstruction. Danger signs include singed nasal hair, Hoarseness of voice, Carbonaceous deposits in sputum, and History of burns in a closed room. Symptoms of laryngeal oedema include voice changes, stridor, anxiety, and respiratory difficulty. Treatment involves securing the airway with an endotracheal tube until the swelling subsides (usually about 48 hours). Early intubation is preferred for suspected airway burns. Intubation can be difficult or impossible due to swelling(Laryngeal edema), so cricothyroidotomy is done. Time from burn to airway occlusion is typically 4-24 hours .

References:

Bailey & Love's Short practice of Surgery, 28th Edition, Page 667.

www.ncbi.nlm.nih.gov/pmc/articles/PMC5446904/

↑ *Back to this question in Part A*

@Neet_pg_bot

Q14: What is the most common cause of death in the first 24 hours after sustaining severe burns? (Q849505)

A. Septicemia

B. Hypovolemic shock

C. Acute respiratory distress syndrome (ARDS)

D. Renal failure

Correct Answer: B. Hypovolemic shock

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Hypovolemic shock is the most common cause of death in the first 24 hours due to massive fluid loss from burn wounds. M/C cause of death at the site of accident Asphyxia M/C cause of early death in burns Hypovolemic shock M/C cause of late death in burns Sepsis (M/C organism- Pseudomonas Other causes of death in burns : Acute respiratory distress syndrome (ARDS) Brain death Upper alimentary tract hemorrhaging

Multiorgan failure Septicemia (Option A) : Occurs later in burn injuries, typically after 48 hours, not within the first 24 hours. Acute respiratory distress syndrome (ARDS) (Option C) : Serious lung condition that usually develops later, not typically in the first 24 hours. Renal failure (Option D) : Complication that usually occurs after the first 24 hours due to prolonged shock.

References:

Bailey&Love's Short practice of Surgery, 28th Edition, Pages 665 & 666.

www.ncbi.nlm.nih.gov/pmc/articles/PMC2811947/

↑ *Back to this question in Part A*

@Neet_pg_bot

Q15: A 35-year-old male presents to the emergency department with complaints of extensive burns on his back, chest, and legs. On examination, the affected areas are dry, leathery, and charred black with no blister formation.What is the most likely type of burn? (Q849504)

A. Second-degree burn

B. First-degree burn

C. Third-degree burn

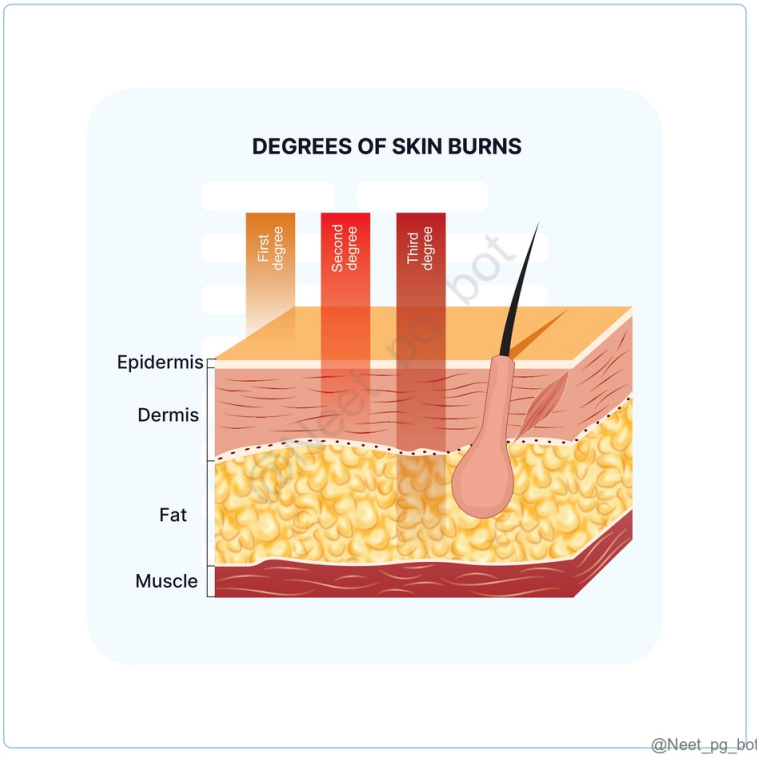
D. Fourth-degree burn

Correct Answer: C. Third-degree burn

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Third-degree burns/Full thickness burn Extends through the full thickness of the skin, involving the epidermis, dermis, and subcutaneous tissue. The burned area appears charred black , leathery, or waxy with a dry texture. Typically painless due to the destruction of nerve endings, although the surrounding areas may be painful. Characteristic features: No pain, No blisters and No prickpin sensation Initial Management: Prioritize airway management if the burn involves the face or neck, followed by aggressive fluid resuscitation and wound care. Treatment : If the eschar is circumferential, then Escharotomy is done and excision of burned skin with skin grafting. Second-degree burn (Option A) presents with moist, painful, blistering lesions , which is different from the dry, leathery appearance described in the case. First-degree burn (Option B) involves only the epidermis and appears as red, painful skin without charring , which does not match the findings here. Fourth-degree burn (Option D) extends into deeper tissues such as muscle, fascia, or bone , often exposing underlying structures, which is not described in this scenario.



References:

Bailey & Love's Short Practice of Surgery, 28th Edition, page 670, 673.

www.ncbi.nlm.nih.gov/books/NBK430741/

↑ *Back to this question in Part A*

@Neet_pg_bot

Q16: Match the type of burn with its corresponding characteristic: Type of Burn Characteristics 1. First-degree burn A. Blistering, partial-thickness damage 2. Second-degree burn B. Charring, full-thickness skin damage 3. Third-degree burn C. Redness, Epidermal burn 4. Fourth-degree burn D. Involvement of muscles and bones (Q849503)

A. 1-C, 2-A, 3-B, 4-D

B. 1-A, 2-B, 3-D, 4-C

C. 1-C, 2-B, 3-A, 4-D

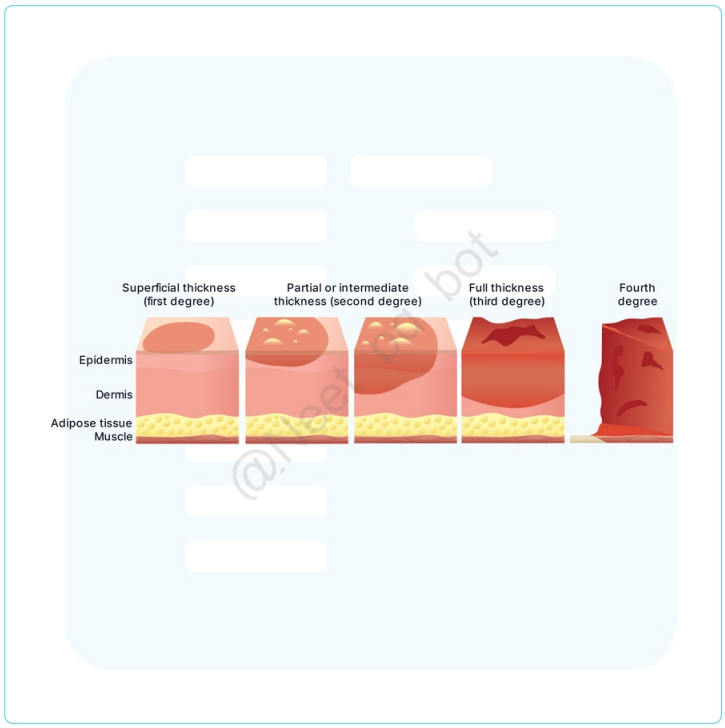
D. 1-D, 2-C, 3-A, 4-B

Correct Answer: A. 1-C, 2-A, 3-B, 4-D

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Burns are classified based on depth and extent of tissue damage: Type of Burn Characteristics First-degree burn Redness, Epidermal burn Involves only epidermis Painful and erythematous with no blisters. Healing time: 5-10 days Second-degree burn Blistering, partial-thickness skin damage Superficial partial thickness burn- Epidermis + Papillary dermis Deep partial thickness burn- Epidermis + reticular dermis Healing time: 2-3 weeks Third-degree burn Charring, full-thickness skin damage Involvement of epidermis + dermis + subcutaneous fat Fourth-degree burn Involvement of skin and underlying muscles and bones



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References:

Bailey & Love’s Short Practice of Surgery, 28th Edition, Page 669, 670.

↑ *Back to this question in Part A*

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Q17: Which of the following best differentiates deep partial-thickness burns from superficial partial-thickness burns? (Q849502)

A. Involvement of the epidermis and papillary dermis with visible capillary refill.

B. Blistering and loss of epidermis with pink and moist dermis.

C. Healing within 2 weeks without scarring.

D. Reduced sensation, fixed capillary staining and no blanching with pressure.

Correct Answer: D. Reduced sensation, fixed capillary staining and no blanching with pressure.

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Deep partial-thickness burns extend into the reticular dermis, often presenting with reduced sensation, fixed capillary staining, and no blanching with pressure. These features distinguish them from superficial partial-thickness burns. Characteristic Superficial Partial-Thickness Burns Deep Partial-Thickness Burns Affected Area Epidermis and papillary dermis. Epidermis and reticular dermis. Clinical Features Loss of epidermis Blistering Pink and moist dermis Normal sensation Visible capillary refill Loss of epidermis Less moist dermis Fixed capillary staining Reduced sensation No blanching with pressure Healing Heals within 2 weeks without scarring. Takes 3+ weeks: often leads to scarring. Treatment Supportive care, wound protection, and pain management May require surgical intervention (e.g., skin grafting)

References:

Bailey & Love’s Short Practice of Surgery, Edition 28, Page 669,670

↑ *Back to this question in Part A*

@Neet_pg_bot

Q18: In burn injuries, which zone is characterized by necrotic tissue and irreversible cell damage at the time of injury? (Q849501)

A. Zone of Hyperemia

B. Zone of Stasis

C. Zone of Coagulation

D. Zone of Inflammation

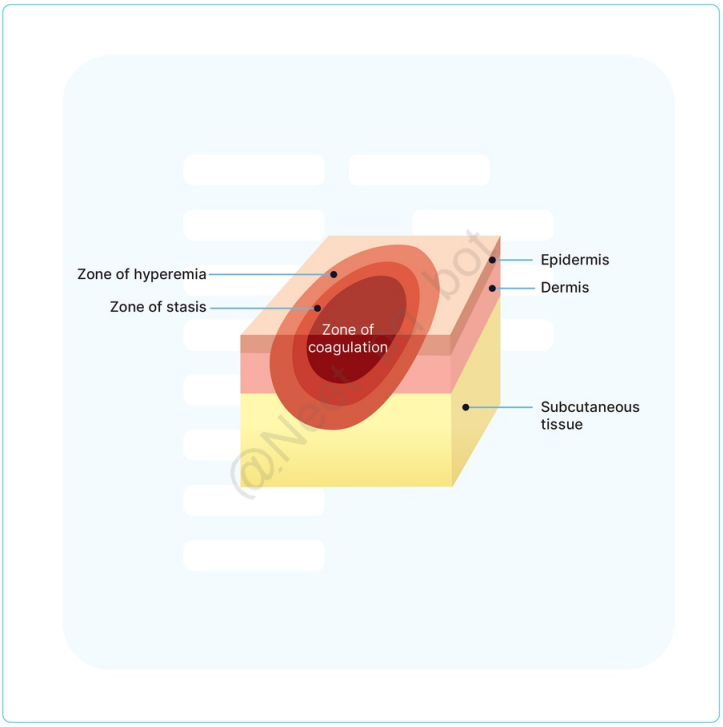
Correct Answer: C. Zone of Coagulation

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Zones of Cutaneous Injury : Zone of Coagulation : Area with necrotic tissue and irreversible cell damage at the time of injury. (Option C) Zone of Stasis : Surrounds the coagulation zone, with reduced perfusion

and potential for either recovery or progression to necrosis. Zone of Hyperemia : Outermost zone with vasodilation and viable tissue, not at risk for further necrosis.



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References:

Sabiston Textbook of Surgery, 21st Edition, Page 486.

↑ *Back to this question in Part A*

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Q19: A 55-year-old male with a history of a recent traumatic brain injury presents with sudden epigastric pain, vomiting of blood, and black stools. He is diagnosed with a Cushing ulcer. Despite initial management with IV fluids and proton pump inhibitors (PPIs), the patient continues to bleed. What is the most appropriate next step in management? (Q849500)

A. Increase the dose of IV PPIs and observe for improvement.

B. Perform an urgent endoscopy to control the bleeding.

C. Schedule the patient for a planned surgical vagotomy and pyloroplasty.

D. Refer the patient for immediate angiography with embolization.

Correct Answer: B. Perform an urgent endoscopy to control the bleeding.

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Urgent endoscopy is the first-line intervention for controlling gastrointestinal bleeding in patients with Cushing ulcers. It is effective even though there is a high risk of re-bleeding. Cushing Ulcer Pathophysiology Cushing's ulcer is a gastro-duodenal ulcer caused by increased intracranial pressure (ICP), commonly due to brain tumors, head injuries or other intracranial conditions. Vagal Stimulation : Overstimulation of the vagus nerve due to elevated ICP leads to increased gastric acid secretion. Sympathetic Paralysis : Disruption in sympathetic pathways may exacerbate the imbalance in gastric secretions, contributing to ulcer formation. Clinical Presentation Epigastric pain Nausea and vomiting. Gastrointestinal bleeding, presenting as hematemesis (vomiting blood) or melena (black stools). Potential complications include ulcer perforation and peritonitis, which are life-threatening if untreated. Initial Management Prophylaxis may fail. Resuscitation: Begins with crystalloids and early use of balanced blood products. Coagulopathy Correction: FFP or platelet transfusions are needed for coagulopathy or antiplatelet drug use. Nasogastric Tube: Key for lavage and decompression in hemorrhagic stress gastritis. Antisecretory Agents: IV PPIs are preferred over H2 antagonists for bleeding control. Endoscopy: First-line for GI bleeding, effective despite high rebleed risk. Angiography: For failed endoscopy, involves embolization or vasopressin infusion. Surgical Indications For unresponsive, recurrent bleeding or perforations. Surgical Approach A staged approach starting with bleeding control is safer. Initial Surgery: Long midline incision for exploration; anterior gastrotomy. Stable Patients: Vagotomy and pyloroplasty after bleeding control; abdominal closure. Unstable Patients: Leave the abdomen open for resuscitation; second surgery for vagotomy and pyloroplasty when stable. Rare Procedures: Due to the high risks, gastric resection, subtotal or total gastrectomy, and gastric devascularization are rarely performed.

References:

https://www.uptodate.com/contents/management-of-stress-ulcers?search=Cushings%20ulcer&source=search_result&selectedTitle=1~16&usage_type=default&display_rank=1#H2132097936

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4421974/

↑ *Back to this question in Part A*

@Neet_pg_bot

Q20: Which among the following statements about the body responses to severe burns are true? A) Hypermetabolism after a burn increases oxygen consumption and leads to muscle wasting. B) The zone of coagulation is a reversible area of tissue damage in burns. C) Cardiopulmonary effects in severe burns can result in reduced cardiac output. D) Immune suppression following a burn increases the risk of infection. E) Inflammation and edema in burn injuries cause increased vascular permeability and fluid loss. (Q849499)

A. All except A and C

B. All except A and B

C. All except B

D. All are correct

Correct Answer: C. All except B

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: PATHOPHYSIOLOGY OF BURNS Local responses: Skin Damage Burns cause cell membrane disruption and necrosis due to rapid temperature changes. The depth of injury depends on temperature, exposure duration, and thermal conductivity (e.g., oil burns are deeper than water burns). Jackson Levels Zone of Coagulation : Irreversible tissue damage with cell destruction. (Statement B) Zone of Stasis: Moderate damage with reduced perfusion; survival depends on timely intervention. Zone of Hyperemia: Vasodilation around the wound; generally remains viable and aids healing. Systemic Responses: Inflammation & Edema Burns trigger widespread inflammation, increasing vascular permeability, leading to fluid loss, edema, and decreased plasma volume. (Statement E) Cardiopulmonary Effects Microvascular changes reduce cardiac output, potentially leading to ventricular dysfunction despite fluid resuscitation. (Statement C) Renal System Decreased blood volume affects renal blood flow, risking acute tubular necrosis if not managed promptly. Immune Suppression Burns impair immune function, increasing infection risk due to compromised neutrophils, macrophages, and T lymphocytes. (Statement D) Hypermetabolism Burns induce a hypermetabolic state, leading to increased oxygen consumption, protein/fat breakdown, and muscle wasting. The liver plays a key role in gluconeogenesis and fatty acid processing. (Statement A) Ebb and Flow Phases Post-injury, the body undergoes an initial low metabolic rate (ebb phase) followed by a hypermetabolic state (flow phase). Complications: Infection : Early excision and grafting of burns are crucial to prevent infections. Organ Failure : Severe burns can lead to multiple organ failure due to a systemic inflammatory response.

References:

Bailey & Love’s Short Practice of Surgery, 28th Edition, Pages 665, 666.

Sabiston surgery, 21st Edition, Pages 485-490.

↑ *Back to this question in Part A*

@Neet_pg_bot

• [08_Plastic Surgery] 048 Plastic Surgery And Skin Lesions

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[08_Plastic Surgery] 048 Plastic Surgery And Skin Lesions — Quick Jump

Q1 (p. 2995)	*Q2 (p. 2995)*	*Q3 (p. 2996)*	*Q4 (p. 2997)*	*Q5 (p. 2997)*	*Q6 (p. 2999)*
Q7 (p. 3001)	*Q8 (p. 3002)*	*Q9 (p. 3004)*	*Q10 (p. 3005)*	*Q11 (p. 3006)*	*Q12 (p. 3009)*
Q13 (p. 3012)	*Q14 (p. 3013)*	*Q15 (p. 3014)*	*Q16 (p. 3016)*	*Q17 (p. 3016)*	*Q18 (p. 3017)*
Q19 (p. 3021)	*Q20 (p. 3022)*	*Q21 (p. 3023)*	*Q22 (p. 3025)*	*Q23 (p. 3027)*	*Q24 (p. 3029)*
Q25 (p. 3030)	*Q26 (p. 3031)*	*Q27 (p. 3034)*	*Q28 (p. 3034)*	*Q29 (p. 3036)*	*Q30 (p. 3040)*

Q1: The following are good prognostic factors for melanoma except (Q849574)

A. No or very few mitoses (<1 per mm sq)

B. Lack of ulceration

C. Absence of Regression

D. Thinner tumor growth

Correct Answer: C. Absence of Regression

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Regression is defined as the partial or complete disappearance of a previously present tumor in the absence of therapeutic interventions or physical trauma. Microscopically it is characterized by the replacement of melanoma cells by dense inflammatory cell infiltrate or dermal fibrosis. Favorable prognostic factors of Malignant melanoma are: Thinner tumor growth (Option D ruled out) No or very few mitoses (Option A ruled out) Regression Lack of ulceration (Option B ruled out) Absence of metastasis in the sentinel lymph node A brisk tumor-infiltrating lymphocyte response

References:

SRB’s Manual of Surgery, 6th Edition, Page 287-289

↑ *Back to this question in Part A*

@Neet_pg_bot

Q2: After a skin graft procedure in a burn patient, regeneration of the epidermis occurs from resident stem cells in the basal layer. These regenerative cells belong to which category of stem cell potency? (Q882386)

A. Multipotent

B. Pluripotent

C. Totipotent

D. Unipotent

Correct Answer: A. Multipotent

Explanation: The epidermis regenerates from basal layer stem cells and hair follicle bulge stem cells These stem cells can differentiate into multiple cell types within a specific tissue lineage (keratinocytes, adnexal structures) They cannot form cells of all three germ layers Hence they are classified as multipotent stem cells Pluripotent (Option B): Can form cells of all three germ layers (e.g., embryonic stem cells, iPSCs) — not the case in normal skin repair Totipotent (Option C): Can form an entire organism including placenta (zygote, early blastomeres) Unipotent (Option D): Can form only one cell type; epidermal stem cells can produce multiple epithelial lineages

References:

https://www.mdpi.com/2076-3417/11/7/3000#

↑ *Back to this question in Part A*

@Neet_pg_bot

Q3: Which of the following is true regarding basal cell carcinoma? (Q849639)

A. Superficial BCC typically appears with a thin pearly border

B. Nodular is the least common type of BCC

C. Morpheaform variant is the most common type of BCC

D. The prognosis is very poor for all cases

Correct Answer: A. Superficial BCC typically appears with a thin pearly border

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: BCC has various types such as: Nodular- Most common type (Option B ruled out) Small, slow-growing pearly nodules, with telangiectatic vessels on the surface. Variants: The morpheaform variant is

uncommon and is the most aggressive form. (Option C ruled out) Pigmented variant of BCC. Infiltrative BCC Superficial BCC typically appears on the trunk as a pink or erythematous plaque with a thin pearly border. Fibroepithelioma of Pinkus Nodulocystic variant of BCC Patients with BCC show excellent prognosis with 100% survival rates for cases that have not spread to other sites. (Option D ruled out)

References:

SRB's Manual of Surgery, 6th Edition, Page 284, 285

↑ *Back to this question in Part A*

@Neet_pg_bot

Q4: All of these are used for flap monitoring except: (Q849638)

A. Clinical assessment

B. Color Doppler sonography

C. Microdialysis

D. None of the above

Correct Answer: D. None of the above

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Monitoring of flap failure: Clinical assessment (Option A ruled out) (gold standard)- By checking for flap skin color, turgor, surface temperature, rate of bleeding with pin-prick, and capillary refill time. Handheld Doppler (best method) - It is widely available and can be used as an adjunct to clinical methods. But it is influenced by nearby vessels and can give false results USG Color Doppler (Option B ruled out) - To assess velocity and rate of flow. Pinprick method - Flap pricked to check for perfusion (bleeding) Microdialysis (Option C ruled out) - Insertion of small catheters into subcutaneous tissue to measure metabolites such as glucose, lactate, and pyruvate at intervals. Low glucose and high lactate levels are a warning sign. Color change is one of the first signs of flap failure.

References:

www.jprasurg.com/article/S1748-6815(24)00249-3/abstract

↑ *Back to this question in Part A*

@Neet_pg_bot

Q5: Which of the following types do osteomyocutaneous flaps belong to? (Q849637)

A. Conjoined flaps

B. Chimeric flaps

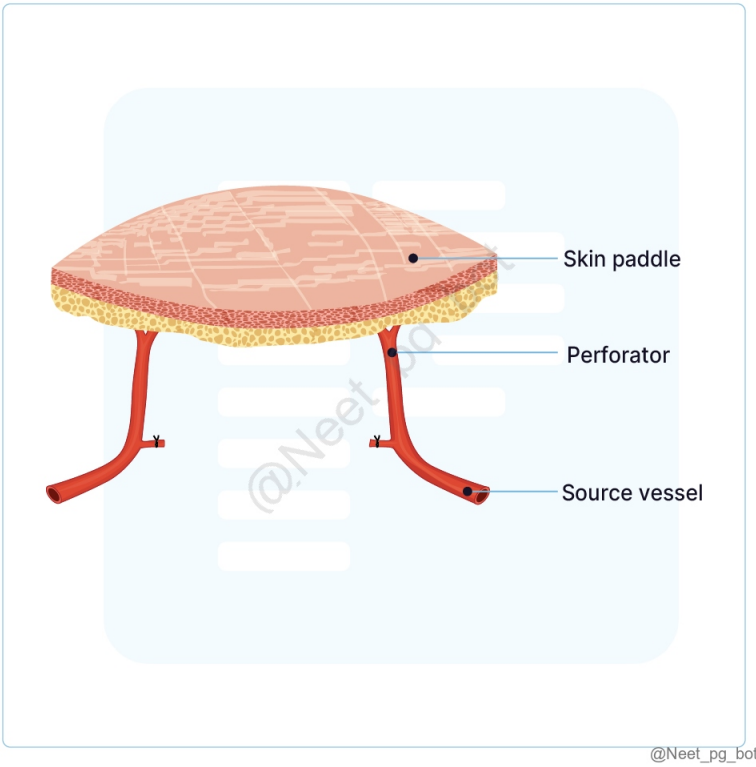
C. Composite flaps

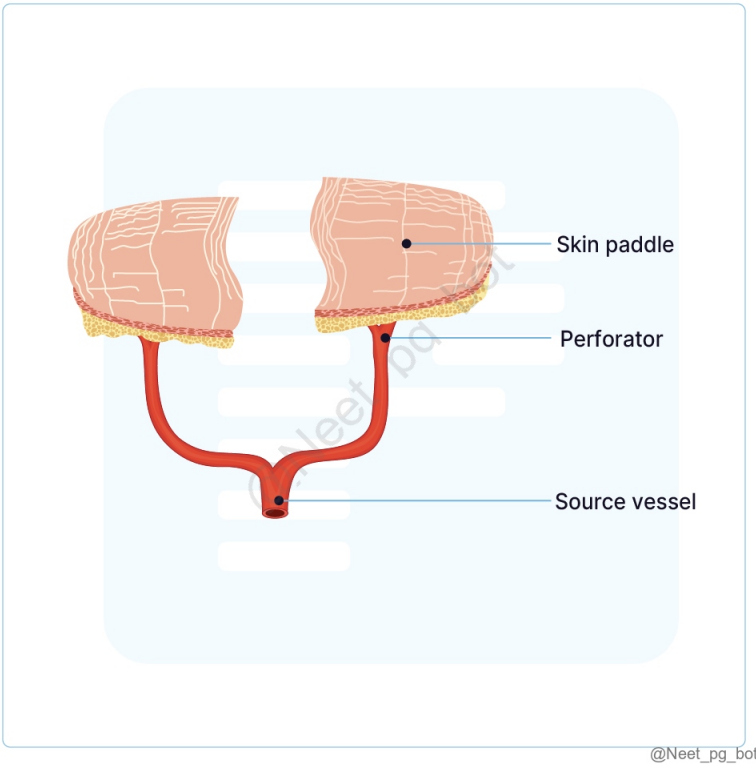
D. None of the above

Correct Answer: C. Composite flaps

- *Listen (English)*
- *Listen (Hindi)*

Explanation: Composite flaps are defined as multiple tissue components all served by the same single vascular supply, and thereby consisting of dependent parts. Osteomyocutaneous flaps include flaps that combine bone, muscle, and skin. Examples are the radius flap with the brachioradialis muscle and skin, and the rib flap with intercostal muscles and skin, which are types of composite flaps. Conjoined flaps (Option A) are composed of several distinct, mobile segments, each with its own independent blood supply from a major branch. They are joined together through a larger common vascular source . Chimeric flaps (Option B) are several separate flaps, each with its distinct blood supply, which are connected through microanastomosis, creating a linked sequence similar to the links of a chain.





References:

SRB's Manual of Surgery, 6th Edition, Page 320

pubmed.ncbi.nlm.nih.gov/16772903/

↑ *Back to this question in Part A*

@Neet_pg_bot

Q6: Which of the following is an example of a free flap? (Q849636)

A. Z-Plasty

B. Pectoralis major myocutaneous flap

C. Radial artery forearm flap

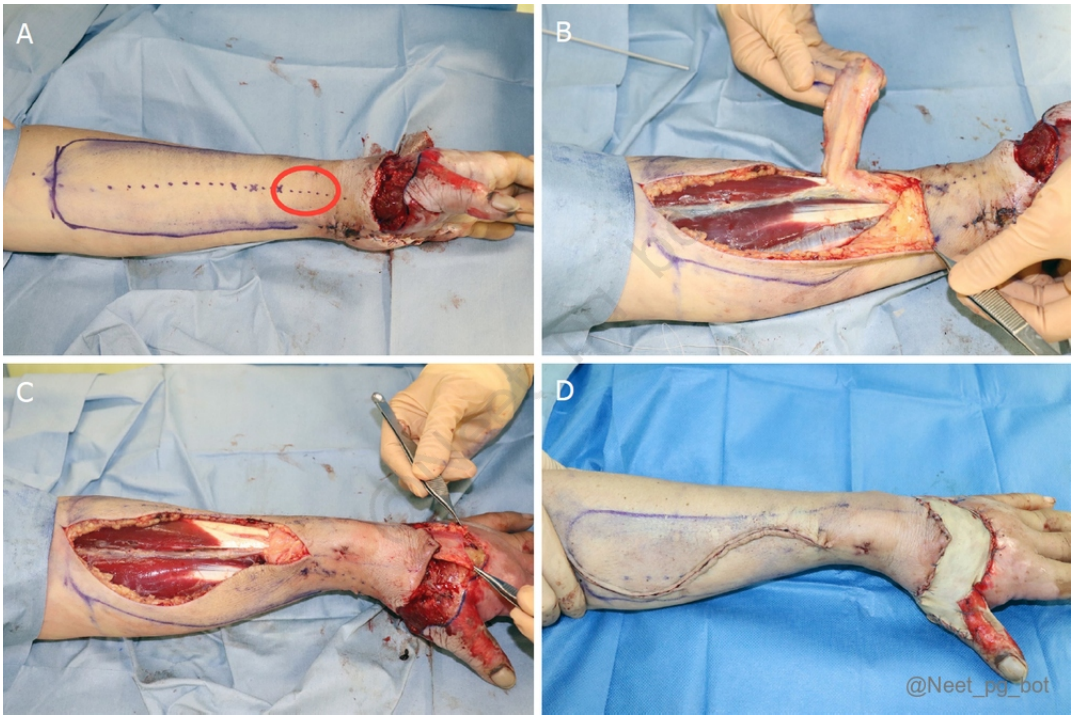
D. Deltopectoral flap

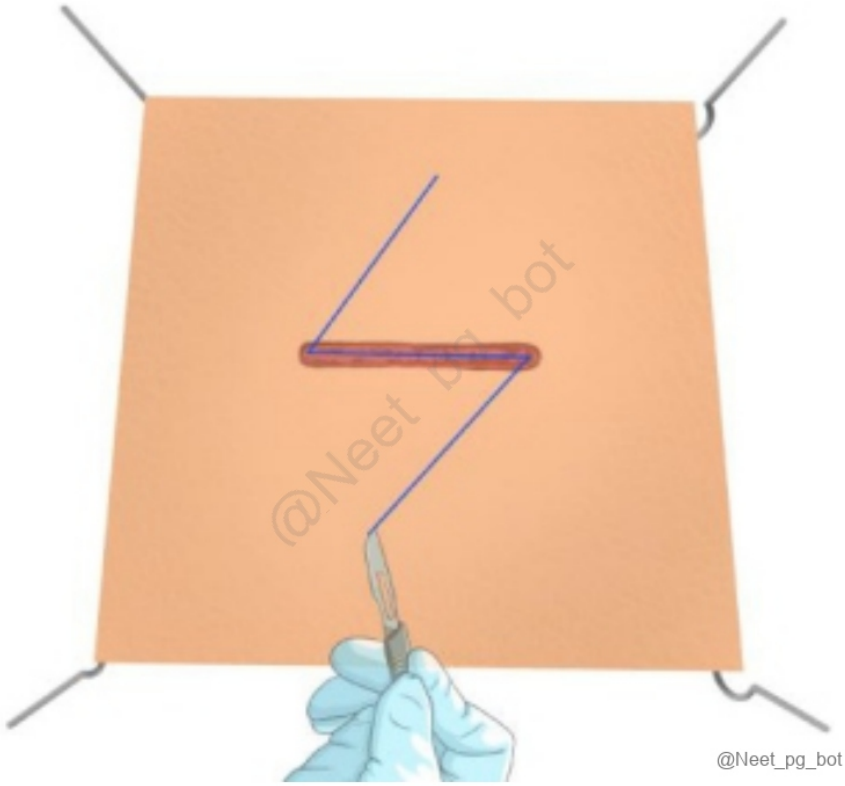
Correct Answer: C. Radial artery forearm flap

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Radial Forearm flap is an example of a free flap . Free flaps are a surgical technique allowing for the transfer of tissues like skin, muscle, bone, and fat to repair significant defects in various body parts. Free flaps involve transferring donor tissue with its blood supply (through a pedicle) to the recipient area. This contrasts with grafts, which lack their blood supply. Free flaps are suitable for: Large, deep wounds Covering exposed bone, tendon, or cartilage Cases where skin grafts have repeatedly failed Radial Forearm Free Flap uses tissue from the forearm, supplied by radial vessels. It commonly reconstructs mandible (jawbone) defects. The procedure involves meticulously dissecting the skin, a segment of the radius bone, and the brachioradialis muscle, all while preserving the radial nerve. Z-Plasty (Option A) is an example of a random flap that involves the transposition of two interdigitating triangular flaps. Pectoralis major myocutaneous flap and Deltopectoral flap (Options B and D) are examples of axial flaps.





References:

SRB's Manual of Surgery, 6th Edition, Page 319, 321-325

↑ *Back to this question in Part A*

@Neet_pg_bot

Q7: A 45-year-old man presents with a large soft tissue defect on his lower leg following a motorcycle accident. The wound measures 10 cm x 15 cm and involves exposure of the tibia. The plastic surgeon is considering an axial flap for reconstruction. Which of the following statements is incorrect regarding the usage of an axial flap? (Q849635)

A. Axial pattern flaps derive their blood supply directly from a fasciocutaneous artery that runs beneath the flap's longitudinal axis.

B. It allows for a larger flap design compared to random pattern flaps and delivers better cosmetic results

C. Deltopectoral flap is a type of axial flap

D. Due to larger size, axial flaps require a high complexity, multi-step method for reconstruction of defects

Correct Answer: D. Due to larger size, axial flaps require a high complexity, multi-step method for reconstruction of defects

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Axial flaps can provide a low complexity, one-step method for reconstruction for defects that are larger in area. An axial pattern flap incorporates an anatomically named vascular pedicle. Axial pattern flaps derive their blood supply directly from this fasciocutaneous artery that runs beneath the flap's longitudinal axis. (Option A ruled out) These arteries ensure blood supply to the subdermal plexus and guarantee blood supply to the flap. It allows for a larger flap design compared to random pattern flaps and delivers better cosmetic results (Option B ruled out) Examples of axial flaps include: Deltopectoral flap (Option C ruled out) Nasolabial flap off of the angular vessels Paramedian forehead flap off of the supratrochlear vessels Facial artery musculo-mucosal flap Melolabial flap

References:

SRB’s Manual of General Surgery, 6th Edition, Page 320, 321

www.ncbi.nlm.nih.gov/books/NBK563191/

↑ *Back to this question in Part A*

@Neet_pg_bot

Q8: Regarding the use of random flaps in grafting, which of the following statements is incorrect? (Q849634)

A. V-Y Plasty is a random flap used for fingertips and extremities

B. Random flaps rely on perfusion from the subdermal vascular plexus which is a low-pressure system

C. Z-Plasty is used for lengthening of tissue and scars.

D. Due to the tenuous blood supply, a minimum length-width ratio of 3:1 is required

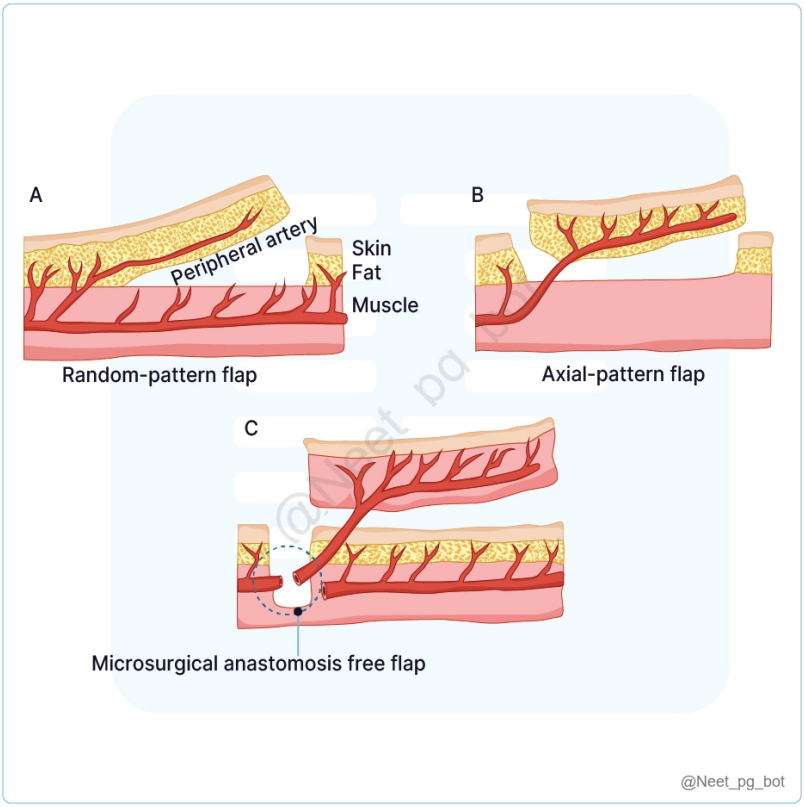
Correct Answer: D. Due to the tenuous blood supply, a minimum length-width ratio of 3:1 is required

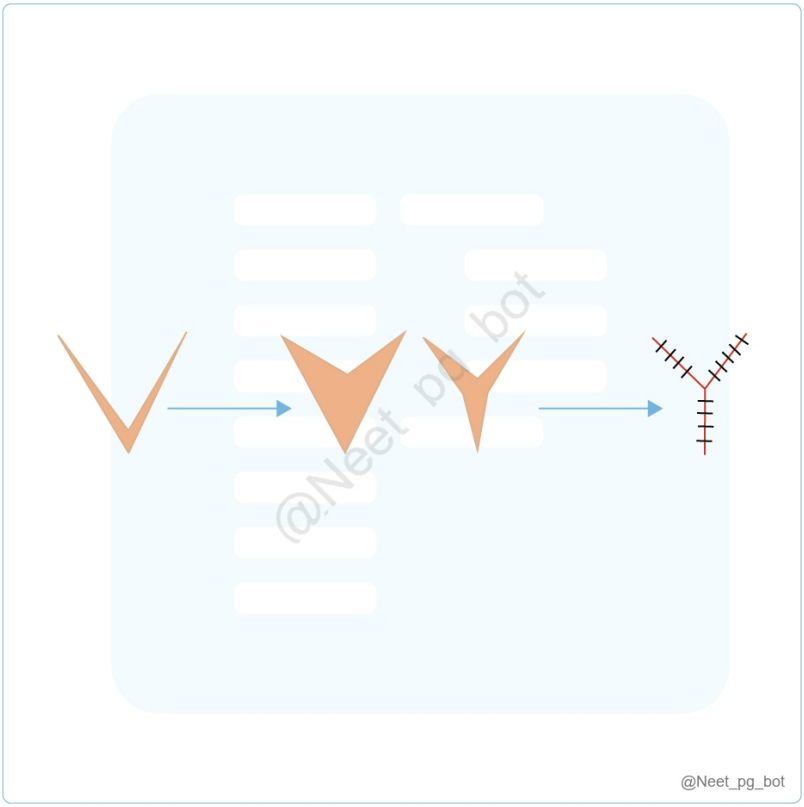
■ *Listen (English)*

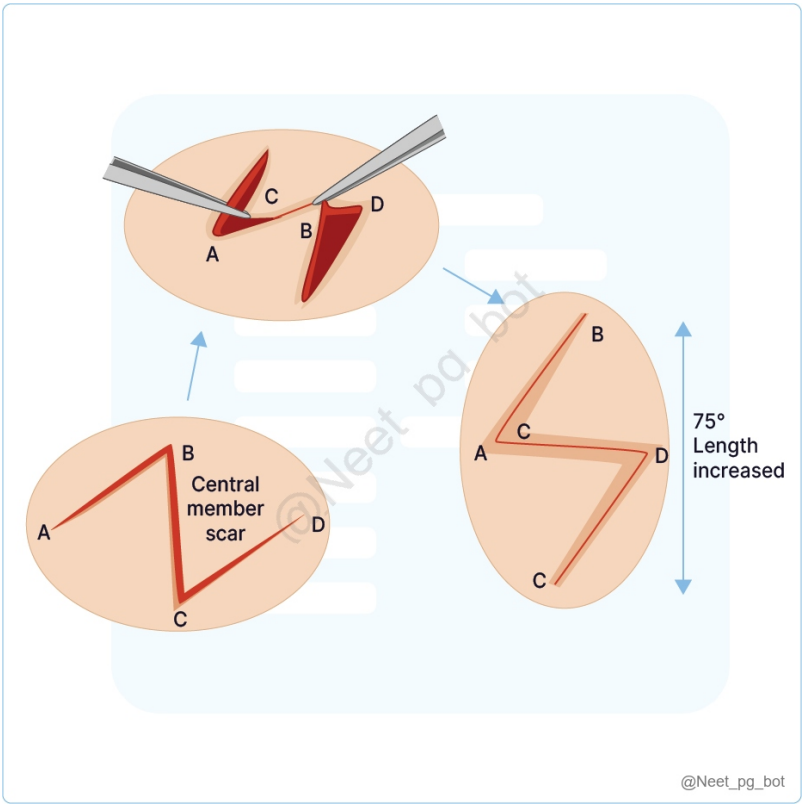
■ *Listen (Hindi)*

Explanation: Random flaps have a tenuous blood supply. Due to this reason, designing these flaps with a length-width ratio not exceeding 3:1 is advisable. Random pattern blood supply flaps rely on perfusion from the subdermal vascular plexus, a low-pressure system vulnerable to compromise under excessive twisting or

stretching. (Option B ruled out) There are 2 types of random flaps used for grafting purposes: V-Y Plasty Z-Plasty Used for fingertips and extremities. (Option A ruled out) Used for lengthening of tissue and scars (Option C ruled out)







References:

SRB Manual of General Surgery, 6th Edition, Page 320, 321

www.ncbi.nlm.nih.gov/books/NBK563252/

↑ *Back to this question in Part A*

@Neet_pg_bot

Q9: A 48-year-old man presents with a progressively enlarging, painless mass in his groin. A biopsy confirms a diagnosis of soft tissue sarcoma. Which of the following characteristics would most likely increase the probability of lymph node involvement in this patient? (Q849633)

A. Tumor Size >5 cm

B. High-grade histology

C. Rhabdomyosarcoma histotype

D. Deep location relative to fascia

Correct Answer: C. Rhabdomyosarcoma histotype

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Rhabdomyosarcoma histotype: Rhabdomyosarcoma is one of the few soft tissue sarcomas with a predilection for lymphatic spread, making this histotype particularly important when considering lymph node involvement. Spread of Sarcomas: Soft tissue sarcomas typically spread hematogenously to distant organs such as the lungs. However, lymphatic spread, although uncommon, is seen more frequently in certain sarcoma subtypes and under specific conditions. Sarcomas which are known to potentially spread through the lymphatic system: Rhabdomyosarcoma Synovial Sarcoma Undifferentiated Pleomorphic Liposarcoma (MFH) Angiosarcoma Epithelioid Sarcoma Clear Cell Sarcoma Liposarcoma Tumor Size >5 cm (Option A): While large size increases the overall risk of metastasis, it does not specifically predispose to lymph node involvement. High-grade histology (Option B): Similar to tumor size, high-grade tumors are more likely to metastasize, but this typically occurs via the bloodstream. Deep location relative to fascia (Option D): This factor primarily influences the potential for local invasion and hematogenous spread rather than lymphatic dissemination.

References:

Sabiston Textbook of Surgery, 21st Edition, Page 740

↑ *Back to this question in Part A*

@Neet_pg_bot

Q10: A 35-year-old woman with a family history of multiple cancers presents with a soft tissue mass. Genetic testing reveals a TP53 mutation. Which of the following is the most likely clinical course associated with her condition? (Q849632)

A. Development of multiple benign lipomas

B. Increased risk of developing gastrointestinal stromal tumors (GIST)

C. High likelihood of developing soft tissue sarcomas, breast cancer, and brain tumors

D. Predominantly risk of osteosarcoma and leukemia

Correct Answer: C. High likelihood of developing soft tissue sarcomas, breast cancer, and brain tumors

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Li-Fraumeni syndrome is characterized by a mutation in the TP53 gene , significantly increasing the risk of various malignancies, particularly soft tissue sarcomas, breast cancer, brain tumors, and adrenocortical carcinoma. This syndrome leads to a broad spectrum of cancer risks, often manifesting at a young age. Soft tissue sarcomas are a diverse group of malignancies originating from mesenchymal tissues. Associated Syndromes with

Soft Tissue Sarcomas: Syndrome Mutated Gene(s) Clinical Features Li-Fraumeni Syndrome TP53 High risk of soft tissue sarcomas, breast cancer, brain tumors, osteosarcoma, adrenocortical carcinoma, and other early-onset cancers. Neurofibromatosis Type 1 (NF1) NF1 Development of multiple neurofibromas, café-au-lait spots, and malignant peripheral nerve sheath tumors. Gardner's Syndrome APC Associated with familial adenomatous polyposis (FAP), desmoid tumors (a type of aggressive fibromatosis), and colorectal cancer. Hereditary Retinoblastoma RB1 Increased risk of retinoblastoma, osteosarcoma, and other soft tissue sarcomas; typically present in childhood. Werner Syndrome WRN Premature aging, increased risk of various cancers including soft tissue sarcomas, especially in older adults. Gorlin Syndrome (NBCCS) PTCH1 Increased risk of basal cell carcinomas, jaw cysts, medulloblastomas, and rare occurrences of soft tissue sarcomas like rhabdomyosarcoma.

References:

Sabiston Textbook of Surgery, 21st Edition, Page 734, 735

↑ *Back to this question in Part A*

@Neet_pg_bot

Q11: A 5-year-old boy is brought to the OPD by his mother with complaints of swelling on her nape. On examination, a hard, freely mobile, and slow-growing mass is seen. A photograph of the lesion is shown below. Which of the following is the most appropriate clinical diagnosis for this patient? (Q849631)

A. Cock’s Peculiar Tumor

B. Pott’s Puffy Tumor

C. Pilomatrixoma

D. Cylindroma



Correct Answer: C. Pilomatrixoma

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: A benign, non-cancerous, skin lesion of the hair follicle characterizes Pilomatrixoma. The clinical features include a rugged, freely mobile, and slow-growing mass. The treatment of choice is surgical excision. Cock’s Peculiar tumor (Option A): This is a sebaceous cyst (trichilemmal cyst) that has ulcerated and grown rapidly, mimicking a Squamous Cell Carcinoma. It is usually found on the scalp of elderly patients , not in a 5-year-old. Pott’s Puffy tumor (Option B): This is not a skin tumor at all; it is a clinical emergency involving frontal bone osteomyelitis with an associated subperiosteal abscess. It usually follows a bout of frontal sinusitis and presents with a "doughy" (pitting) swelling on the forehead, not a hard mobile mass. Cylindroma (Option D): Also known as a "Turban tumor" when multiple. These are usually seen in adults (often inherited via the CYLD gene) and present as smooth, firm, pink nodules on the scalp. They are less common in young children and typically aren't "stony hard" like a pilomatrixoma.


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References:

SRB's Manual of Surgery, 6th Edition, Page 286

↑ *Back to this question in Part A*

@Neet_pg_bot

Q12: All of the following conditions resolve spontaneously in an infant except (Q849578)

A. Port wine stain

B. Strawberry angioma

C. Salmon patch

D. Cock's peculiar tumor

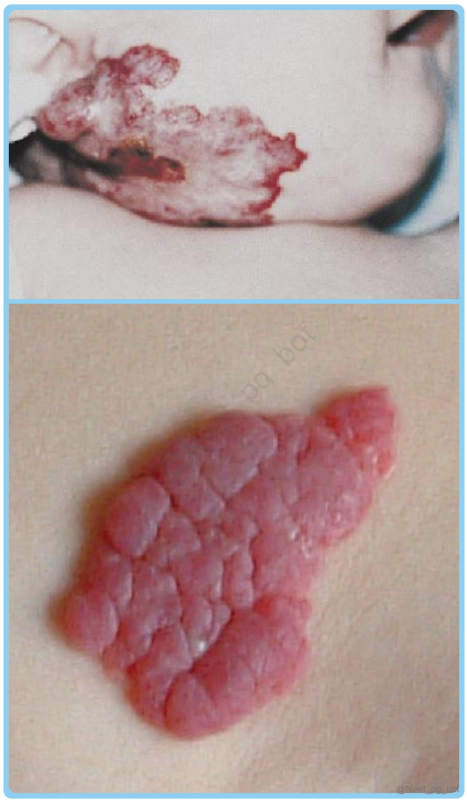
Correct Answer: A. Port wine stain

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Port wine stain appears at birth. It represents progressive ectasia of the superficial vascular plexus mostly involving the face. It grows along with the child and persists throughout life. A 585 nm pulsed dye laser is usually used to treat it. Strawberry angioma (Option B) is a type of capillary hemangioma. it appears 1-3 weeks after birth and spontaneously regresses by 9 years of age. Salmon patch (Option C) also known as stroke bite is present since birth, which develops due to vascular ectasia and disappears by the age of 1 year. Cock's peculiar tumor(Option D) is an infected cyst of the scalp and usually resolves on it's own without the need for any intervention.







References:

SRB’s Manual of Surgery, 6th Edition, Page 205-209

↑ *Back to this question in Part A*

@Neet_pg_bot

Q13: A 28-year-old female patient came to OPD complaining of swelling on the side of her face. On examination, the swelling was painless, smooth, soft, and non-tender. A CT scan was done to rule out dural attachment and a diagnosis of angular dermoid was made. How will you manage the case? (Q849577)

A. Surgical excision

B. Wait and watch

C. Wide local excision with a 2 cm margin

D. Laser ablation



Correct Answer: A. Surgical excision

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Angular dermoid is a type of dermoid cyst that commonly occurs as a smooth, non-tender, soft swelling at the fronto-zygomatic suture. The formation of an angular dermoid is due to the sequestration of ectodermal tissue during embryonic development, which gives rise to a cyst containing dermal elements like hair follicles, sebaceous glands, and sweat glands. Angular dermoids are most often located near the lateral canthus , which is the outer corner of the eye where the upper and lower eyelids meet. They may also occur near suture lines of the skull. They are usually asymptomatic unless they become large enough to cause pressure effects on adjacent structures or become infected. Diagnosis and Treatment: Imaging: Ultrasound or CT scans may be used to evaluate the extent of the cyst, especially if deep or orbital involvement is suspected. Surgical Excision: Complete surgical excision is the treatment of choice , especially if the cyst is causing cosmetic concerns or other symptoms. Careful dissection is required to ensure that the cyst is fully removed and to avoid recurrence. If left untreated, angular dermoids sometimes undergo resorption or indentation of the underlying base. CT is done to rule out dural attachments.

References:

SRB’s Manual of Surgery, 6th Edition, Page 72

↑ *Back to this question in Part A*

@Neet_pg_bot

Q14: A 64-year-old male patient came to the OPD with complaints of swelling on the back of the neck. O/E the swelling is soft and doughy to the touch and non-tender. A diagnosis of lipoma is made. What is the definitive management of this condition? (Q849576)

A. Surgical excision

B. Wide local excision with sentinel node biopsy

C. Excision of the cyst with the wall

D. Incision and drainage followed by excision



Correct Answer: A. Surgical excision

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: A lipoma is a benign tumor composed of mature adipocytes (fat cells) and is the most common soft tissue tumor. Warning signs - soft-tissue tumour: Larger than 5 cm Increasing in size Painful Deep to the fascia Recurrence after previous excision Management: Most lipomas do not require treatment unless they become symptomatic, grow rapidly, or cause cosmetic concerns. Surgical excision is the definitive treatment and is usually curative. Liposuction may also be an option for larger lipomas, but complete excision is preferred to prevent recurrence.

References:

SRB's Manual of Surgery, 6th Edition, Page 68-69

↑ *Back to this question in Part A*

@Neet_pg_bot

Q15: A patient came with complaints of a painful swelling present on the trunk. On examination, tenderness and pus discharge present with a black-colored punctum seen. A provisional diagnosis of an infected sebaceous cyst is made. Identify the incorrect statement about this condition. (Q849575)

A. It contains sebum.

B. It is a type of retention cyst

C. Black colored punctum is present on the cyst

D. There is the proliferation of epidermal cells



Correct Answer: A. It contains sebum.

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Sebaceous cyst is a type of retention cyst. (Option B ruled out) It's a misnomer, it does not originate from sebaceous glands, it occurs due to the proliferation of epidermal cells. (Option D ruled out) Black colored punctum is present on the center of the cyst. (Option C ruled out) Content: white creamy material (desquamated epithelial cells and keratin) Management: Infected cyst - Incision and drainage followed by excision of the cyst with the wall.

References:

SRB’s Manual of Surgery, 6th Edition, Page 75-77

↑ *Back to this question in Part A*

@Neet_pg_bot

Q16: A patient with a skin graft is experiencing mild swelling and oozing at the graft site 24 hours after surgery. Which phase of graft take is most likely occurring? (Q849551)

A. Imbibition

B. Inflammation

C. Revascularization

D. Maturation

Correct Answer: A. Imbibition

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: During the imbibition phase , which occurs within the first 24-48 hours, the graft survives through the diffusion of nutrients and plasma from the recipient bed. The process of skin graft healing is called “Skin graft Take.” The phases of graft take involve a series of 3 steps critical for the successful integration of a graft into the recipient site. These phases are Serum Imbibition (Plasmatic Circulation): In the first 48 hours, the graft is sustained by plasma exudate from the capillaries in the host bed. Revascularization (Option C ruled out) : After 48 hours, two key processes commence. Neovascularization , where new blood vessels grow from the recipient site into the graft, and inosculation , where graft and host vessels form direct connections. Organization: This phase begins immediately after grafting, with a fibrin layer forming at the graft-bed interface to stabilize the graft. By day 7, this layer is replaced by fibroblasts, and by days 10 to 14, the graft is typically well-adhered to the underlying bed.

References:

Sabiston Textbook of Surgery, 21st Edition, Page 1917

↑ *Back to this question in Part A*

@Neet_pg_bot

Q17: Which of the following Clark levels indicates that malignant melanoma has invaded the subcutaneous tissue? (Q849573)

A. Level II

B. Level III

C. Level IV

D. Level V

Correct Answer: D. Level V

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Level V indicates that the melanoma has penetrated through the dermis into the subcutaneous tissue, which is the deepest level according to Clark's classification Clark Staging- Clark Level Skin Layer Involved Level I Epidermis Level II (Option A ruled out) Papillary Dermis Level III (Option B ruled out) Junction of Papillary and Reticular Dermis Level IV (Option C ruled out) Reticular Dermis Level V (Option D) Subcutaneous Tissue



References:

training.seer.cancer.gov/melanoma/abstract-code-stage/staging.html

Sabiston Textbook of Surgery, 21st Edition, Page 711-713

https://radiopaedia.org/articles/melanoma-staging

↑ *Back to this question in Part A*

@Neet_pg_bot

Q18: Which of the following statements is true about malignant melanoma? (Q849572)

A. CK-20 is a positive marker for malignant melanoma

B. Lentigo Maligna is the most malignant type of malignant melanoma

C. Lymphatic spread is the common route of metastasis

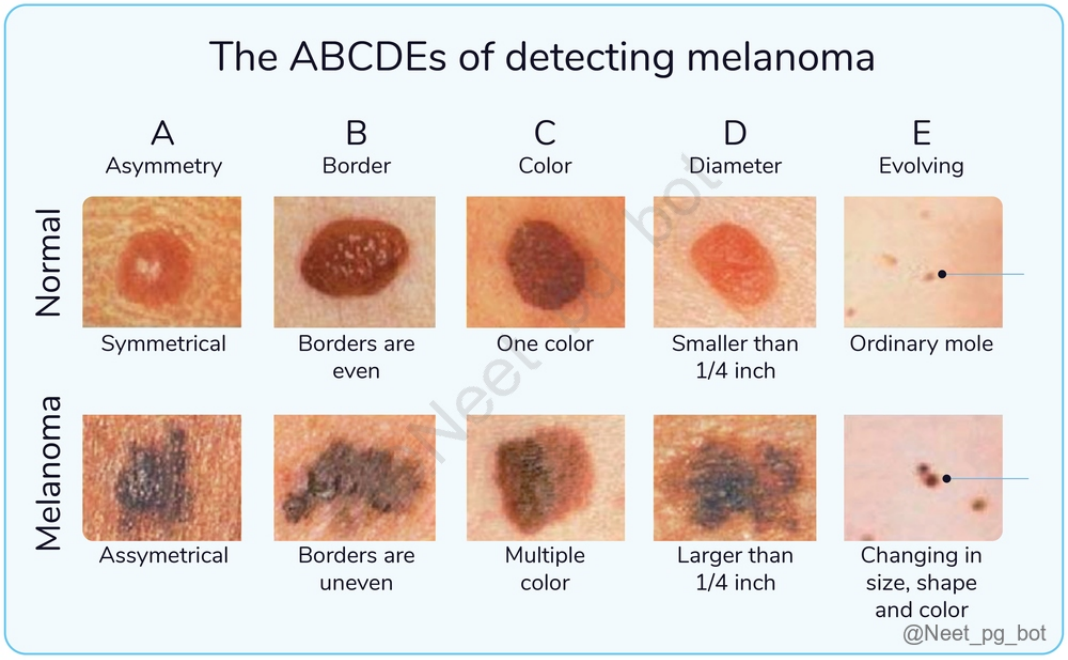
D. Most common site of metastasis is the Lymph Node

Correct Answer: C. Lymphatic spread is the common route of metastasis

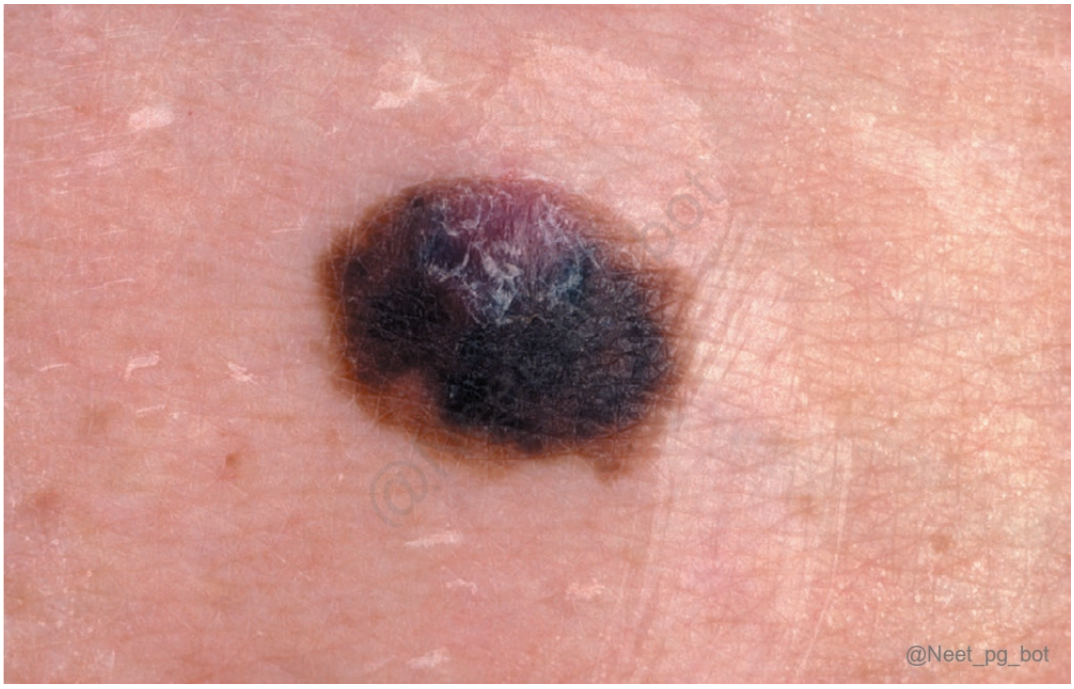
■ *Listen (English)*

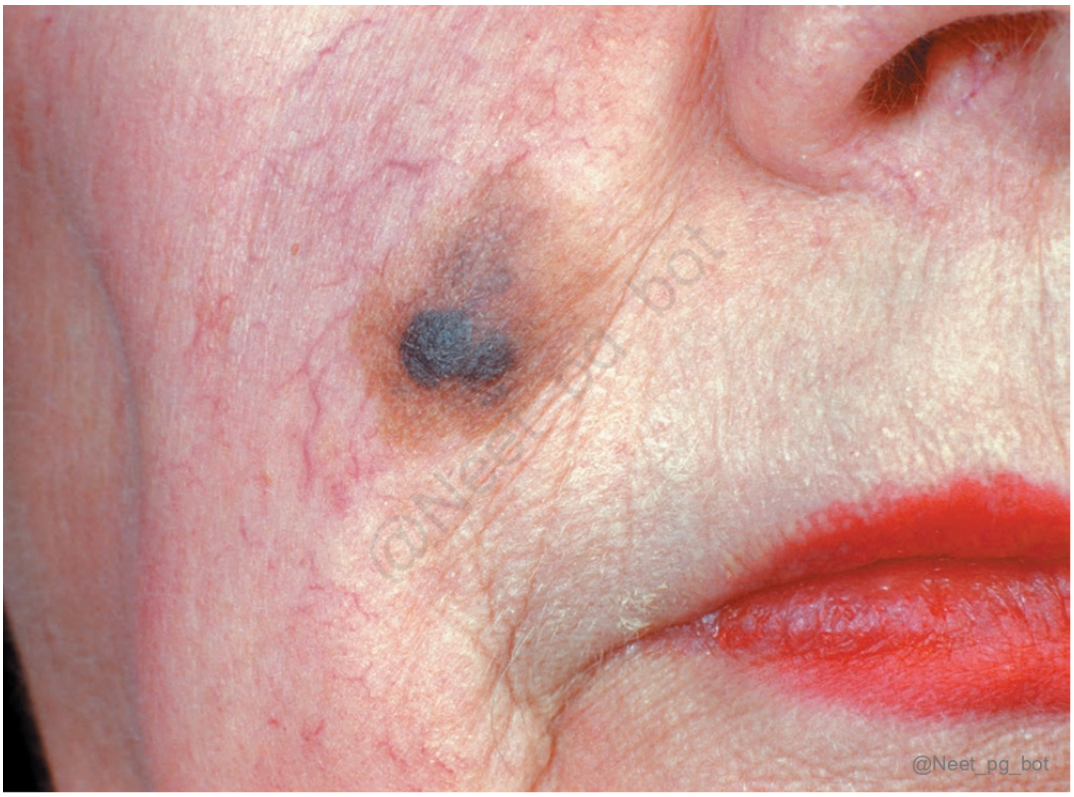
■ *Listen (Hindi)*

Explanation: Characteristic features of malignant melanoma Most common route of spread: Lymphatic Most common site of metastasis: Liver (Option D ruled out) Malignant melanoma arises from the malignant transformation of junctional melanocytes, situated at the dermo-epidermal junction. Positive markers for malignant melanoma: S-100 HMB 45 Vimentin Negative marker for malignant melanoma: CK-20 (Option A ruled out) Types of Malignant Melanoma: Superficial Spreading: Most prevalent type Most commonly found on the torso Nodular: Second most common type Most aggressive form Exhibits only vertical growth Typically occurs on the head and neck Lentigo Maligna: Least malignant form (Option B ruled out) Common in elderly individuals Primarily found on the face (sun-exposed areas) Acral Lentiginous: Least frequent type Has the worst prognosis Most often located on the sole of the foot (under the great toenail)




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References:

Sabiston Textbook of Surgery, 21st Edition, Pages 705-711

Bailey & Love's Short Practice of Surgery, 28th Edition, Pages 656-657

↑ *Back to this question in Part A*

@Neet_pg_bot

Q19: A 70-year-old male presents with a large, aggressive squamous cell carcinoma on his lower lip. After initial treatment attempts, the tumor remains persistent. Which of the following treatment options is most appropriate to ensure complete removal of the tumor while minimizing damage to surrounding healthy tissue? (Q849571)

A. Cryotherapy

B. Electrodesiccation and Curettage

C. Wide Local Excision

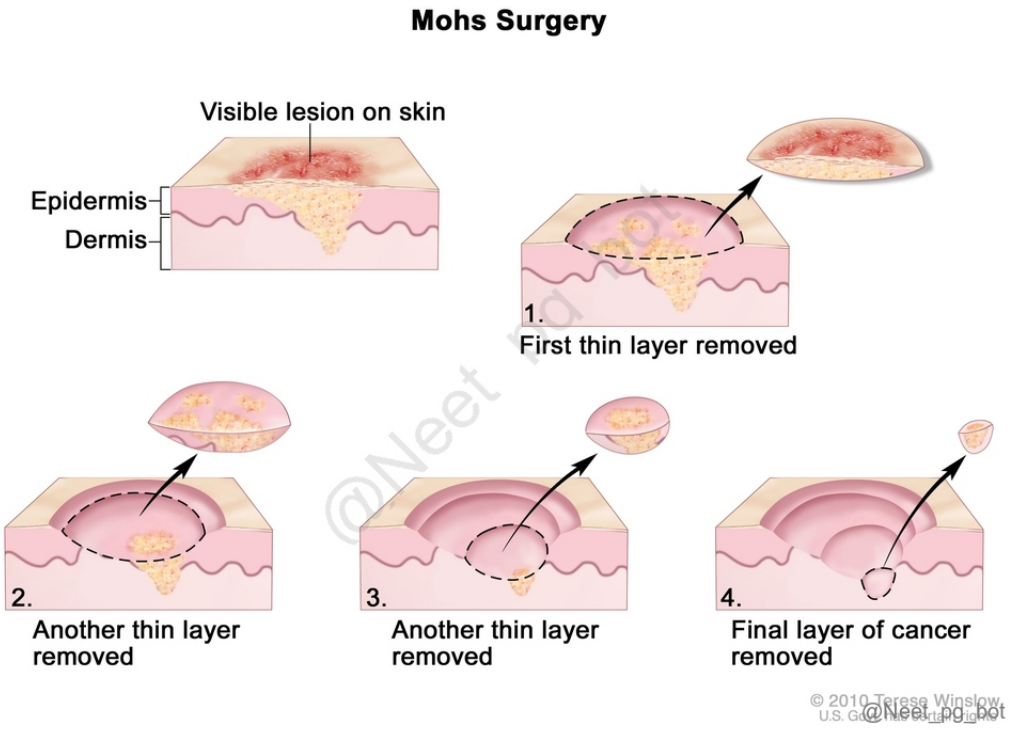
D. Mohs Micrographic Surgery

Correct Answer: D. Mohs Micrographic Surgery

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Mohs Micrographic Surgery is a specialized surgical technique used for treating large, aggressive, or recurrent SCCs. It involves the serial excision of the tumor in small increments with immediate microscopic analysis of each layer to ensure complete removal of cancerous tissue. Treatment of SCC: For Small or Non-invasive SCCs: Wide local excision , typically with a 2 cm margin (Option C) For Large, Aggressive, or Recurrent Tumors, or those in Vital/Cosmetic Areas: Mohs Micrographic Surgery



References:

SRB's Manual of Surgery, 6th Edition, Page 281-283

↑ *Back to this question in Part A*

@Neet_pg_bot

Q20: A 65-year-old farmer presents with a persistent, scaly lesion on his ear. The lesion has irregular, everted edges and has been gradually growing as shown below. Which of the following is the most common causative factor for his condition? (Q849567)

A. Tobacco Use

B. Arsenic Exposure

C. Sunlight Exposure

D. Radiation Exposure



Correct Answer: C. Sunlight Exposure

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Sunlight exposure is the most common and significant cause of squamous cell carcinoma of the skin. UV radiation from the sun causes direct DNA damage to skin cells, leading to mutations and increased risk of developing SCC. Squamous Cell Carcinoma (SCC) The most commonly involved areas are (parts exposed to sunlight): Ears, Cheeks, Lower lip, and back of hands. Predisposing Factors: Actinic keratosis (senile keratosis) Prolonged sunlight exposure Radiation exposure (Option D ruled out) Infection with Human Papillomavirus (HPV) Immunosuppression or HIV Exposure to arsenic (Option B ruled out) Bowen’s disease Tobacco use (Option A ruled out) Xeroderma pigmentosa

References:

SRB's Manual of Surgery , 6th Edition, Page 281-282

↑ *Back to this question in Part A*

@Neet_pg_bot

Q21: A 62-year-old male presents with a slow-growing, pearly nodule on his nose. The lesion shows telangiectatic vessels on its surface and has a central depression. Which of the following is the most appropriate diagnostic method to confirm the diagnosis of

this skin lesion? (Q849566)

A. Punch Biopsy

B. Wedge Biopsy

C. Excisional Biopsy

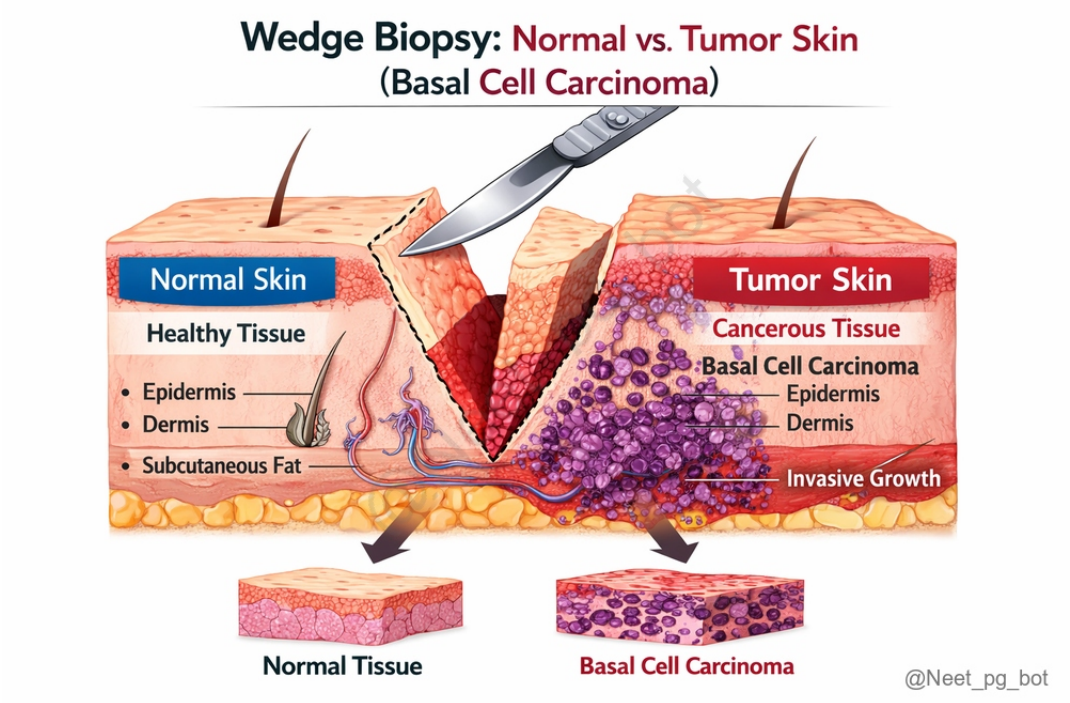
D. None of the above

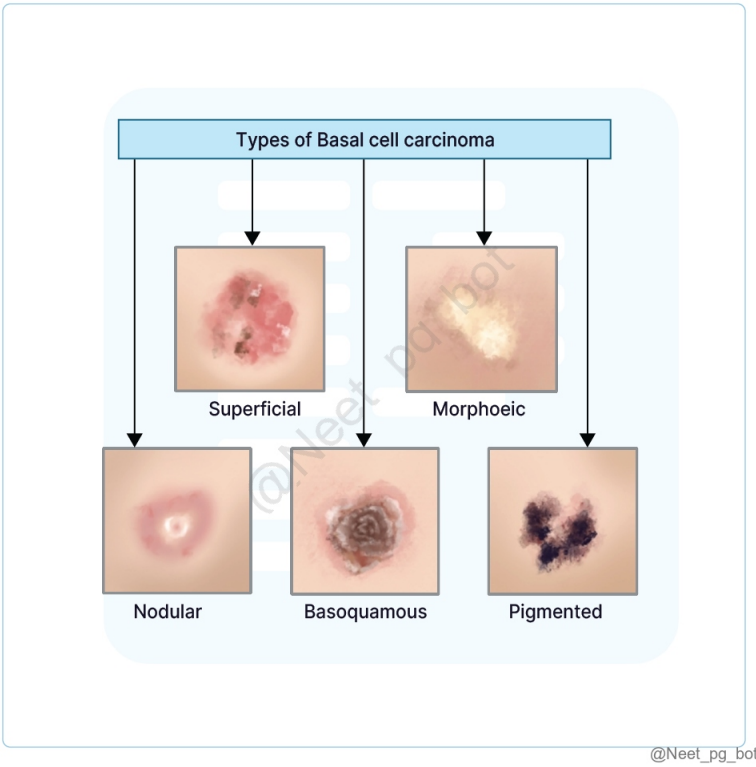
Correct Answer: B. Wedge Biopsy

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: A wedge biopsy is the preferred method for diagnosing basal cell carcinoma because it allows examination of the edges where the cancer is likely to be most active, providing a more comprehensive assessment of the lesion's extent and ensuring that the entire affected area is evaluated. Management: For non-aggressive tumors on the trunk or extremities, wide local excision with a 2 cm margin is usually sufficient. For large, aggressive tumors affecting vital or cosmetic areas, or recurrent tumors, Mohs micrographic surgery is recommended.





References:

SRB's Manual of Surgery, 6th Edition, Page 284-286

↑ *Back to this question in Part A*

@Neet_pg_bot

Q22: A 65-year-old man presents with a non-healing ulcer on the popliteal surface of his leg that has been present for several months. The ulcer developed at the site of a burn scar he sustained 30 years ago. On examination, the ulcer is painless, slow-growing, and has irregular borders as shown in the image? What is the most appropriate initial management for this patient? (Q849560)

A. Cryotherapy and regular dressing changes

B. Wide local excision followed by flap cover

C. Wide local excision followed by flap cover and radiotherapy

D. Observation and follow-up in 6 months



Correct Answer: B. Wide local excision followed by flap cover

- *Listen (English)*
- *Listen (Hindi)*

Explanation: The clinical scenario and image suggest that the patient has Marjolin’s ulcer. Management of Marjolin’s ulcer consists of wide local excision followed by flap cover . Radiotherapy should be avoided as it is radio-resistant and also to prevent obliterative endarteritis. Marjolin’s Ulcer Definition Low-grade Squamous Cell Carcinoma (SCC) Common Sites of Development Post-burn scar Long-standing venous ulcer Chronic ulcer due to trauma Chronic discharging osteomyelitis sinus Post-radiation ulcer Pathophysiology Develops in scar tissue due to chronic irritation Characteristic Features Painless (no nerves in scar tissues) Slow growing No regional LN metastasis (no lymphatics in scar tissue) Investigation of Choice Biopsy Management Wide local excision followed by flap cover Radiotherapy should be avoided (as it is radio-resistant and also to prevent obliterative end arteritis) (Option C ruled out)



References:

SRB’s Manual of Surgery, 6th Edition, Pages 283, 284

Pubmed

↑ *Back to this question in Part A*

@Neet_pg_bot

Q23: A 55-year-old man with a history of diabetes presents with a chronic wound on his lower leg. On examination, you observe a well-defined lesion with the following characteristics: The deepest part of the lesion shows exposed muscle tissue. The exposed surface appears red and moist with some granulation tissue. There is a distinct boundary between healthy skin and the wound. A narrow area surrounds the wound where the skin appears different from both the healthy skin and the wound itself. Based on this clinical scenario, which of the following correctly matches the described features with the parts of an ulcer? (Q849558)

A. Exposed muscle - Floor; Red, moist surface with granulation - Base; Boundary of healthy skin - Edge; Narrow surrounding area - Margin

B. Exposed muscle - Base; Red, moist surface with granulation - Floor; Boundary of healthy skin - Margin; Narrow surrounding area - Edge

C. Exposed muscle - Floor; Red, moist surface with granulation - Base; Boundary of healthy skin - Margin; Narrow surrounding area - Edge

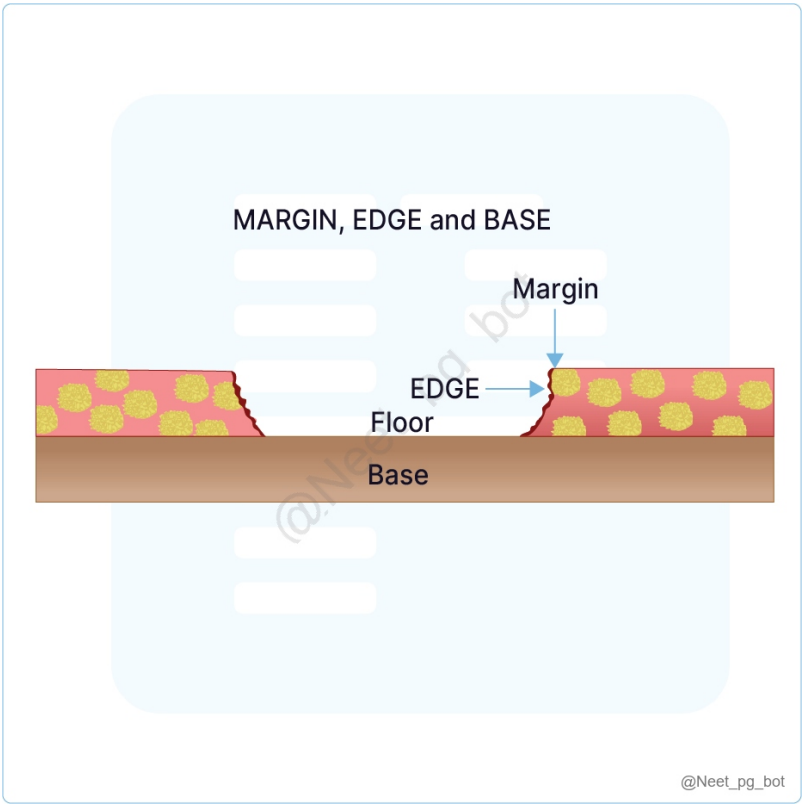
D. Exposed muscle - Base; Red, moist surface with granulation - Edge; Boundary of healthy skin - Floor; Narrow surrounding area - Margin

Correct Answer: B. Exposed muscle - Base; Red, moist surface with granulation - Floor; Boundary of healthy skin - Margin; Narrow surrounding area - Edge

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The given lesion with history of diabetes mellitus is suggestive of a diabetic ulcer. Morphologically, an ulcer has 4 parts: Base: Surface on which ulcer rests (usually underlying muscles/bones) Floor: Exposed surface of ulcer (usually seen as purulent discharge/granulation tissue/red and moist) Margin: Junction between normal epithelium & ulcer Edge: Area between margin & floor



References:

SRB's Manual of Surgery, 6th Edition, Page 15

↑ *Back to this question in Part A*

@Neet_pg_bot

Q24: Which of the following is not a type of fasciocutaneous flap? (Q849557)

A. Radial forearm flap

B. Groin flap

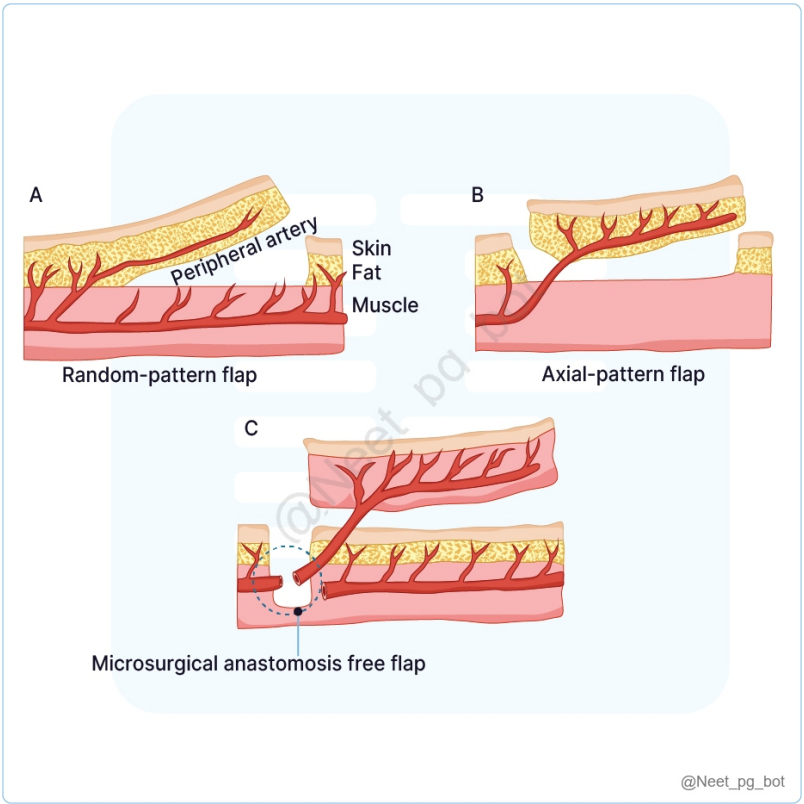
C. Tensor fascia lata flap

D. Scapular flap

Correct Answer: C. Tensor fascia lata flap

- *Listen (English)*
- *Listen (Hindi)*

Explanation: The tensor fascia lata flap is a type of muscle flap. Types of flap based on the type of tissue and source of blood supply are listed in the table below: Anatomical types based on type of tissue Cutaneous flap Forehead flap, Deltopectoral flap Fasciocutaneous flap Radial forearm flap, Scapular flap, Lateral arm flap, Groin flap (Option A, B & D ruled out) Muscle flap Gluteus maximus muscle flap, Gracilis flap, Tensor fascia lata muscle flap Myocutaneous flap Pectoralis major myocutaneous flap, Latissimus dorsi flap—composite flap Osteomyocutaneous flaps Radius with brachioradialis and skin—composite flap, Rib with intercostal muscles and skin—composite flap Anatomical types based on the source of vascular supply Random Pattern Flap Rely on low pressure found in subdermal plexus Used to reconstruct small but full-thickness defect Not amenable to skin grafting Axial Flap Based on the named vessel If the axial flap remains attached to its proximal blood supply & transferred to a defect known as pedicle flap Free Flap Autogenous transplant of vascularized tissues There is devascularization from donor site & revascularization at recipient bed



References:

SRB's Manual of Surgery, 6th Edition, Page 319-320

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↑ *Back to this question in Part A*

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Q25: Which of the following is not an absolute indication for flap surgery? (Q849556)

A. Post-burn contractures

B. Exposed bony prominences in the joint area

C. Radiated vessel

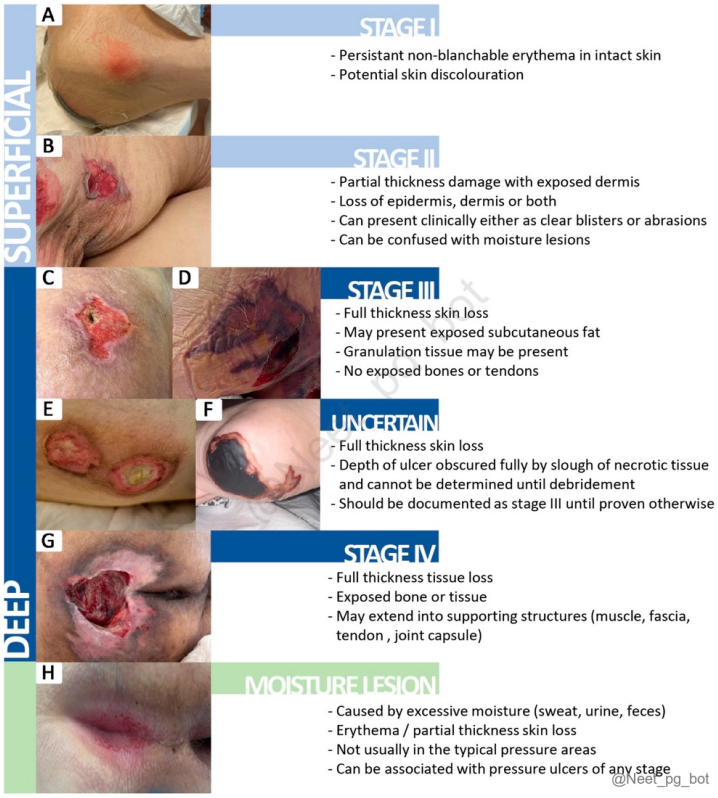
D. Stage III bedsores

Correct Answer: D. Stage III bedsores

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Stage III bedsores are primarily managed by Debridement and dressing with Vacuum-assisted closure, also known as negative pressure dressing. There is no requirement for flap surgery. However, Stage IV bedsores require flap reconstruction with the help of Tensor fascia lata flap . Absolute indications of flap reconstruction are mentioned below: Exposed bone Exposed brain Post-burn contractures (Option A) Radiated vessel (Option C) Pressure sore at bony prominence (Stage IV) Open joints or non-biological implant materials (Option B)



References:

SRB's Manual of Surgery, 6th Edition, Page 319-322

www.etb-bislife.org/docs/casestudy-Glyaderm.pdf

↑ *Back to this question in Part A*

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Q26: A 30-year-old patient with extensive third-degree burns requires skin grafting. The surgical team opts for a meshed split-thickness skin graft (STSG). Which of the following is a key benefit of using a meshed skin graft in this scenario? (Q849555)

A. Enhanced cosmetic appearance

B. Coverage of a large area with minimal donor skin

C. Reduced risk of secondary contraction

D. Decreased need for vascularization

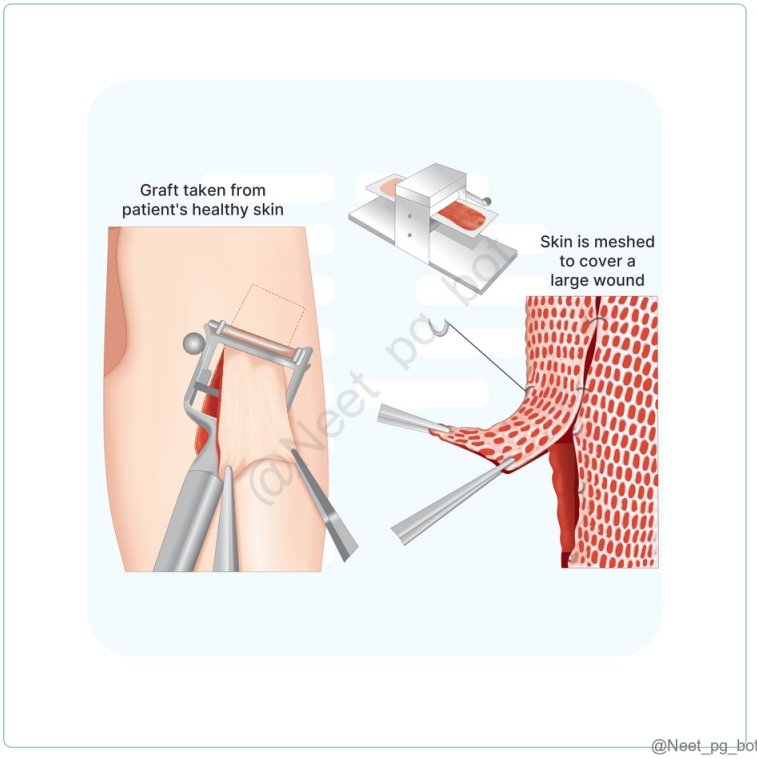
Correct Answer: B. Coverage of a large area with minimal donor skin

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: A meshed split-thickness skin graft (STSG) is particularly advantageous in cases of extensive burns because it allows for the expansion of the graft over a larger surface area with limited donor skin. By creating tiny splits in the graft, the skin can be stretched, enabling it to cover more extensive areas, which is critical in managing large burn wounds. These splits also facilitate fluid egress, which helps the graft conform to the wound bed, ensuring better contour matching. The ideal meshing ratio typically ranges from 1:1.5 to 1:6 , depending on the area that needs coverage. Despite its utility, the meshed skin graft has some drawbacks, including a less favorable cosmetic appearance due to the visible mesh pattern and a higher degree of secondary contraction , which can lead to scarring .







References:

Sabiston Textbook of Surgery, 21st Edition, Page 1917

↑ *Back to this question in Part A*

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Q27: A 45-year-old male undergoes a split-thickness skin graft for a large wound on his leg. Three days postoperatively, the graft appears swollen with fluid accumulating underneath it. Which of the following complications is most likely? (Q849554)

A. Graft failure

B. Hematoma or seroma formation

C. Infection

D. Poor cosmetic outcome

Correct Answer: B. Hematoma or seroma formation

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: In this scenario, the accumulation of fluid beneath the graft is indicative of hematoma or seroma formation. This complication can prevent proper adherence of the graft to the wound bed, leading to graft failure if not addressed promptly. Hematomas are collections of blood, while seromas are accumulations of clear fluid. Both can occur when there is inadequate hemostasis or when there is excessive movement or pressure on the graft site post-operatively. Complications of Skin Grafting: Graft Failure (Option A ruled out) : This occurs when the graft does not survive or integrate with the recipient site, due to poor vascularization or improper placement. It is not characterized by fluid accumulation beneath the graft. It can be prevented by ensuring good contact between the graft and the wound bed and avoiding movement or pressure on the graft. Infection (Option C ruled out) : Infection typically presents with redness, warmth, and pus rather than just fluid accumulation. Strict sterile techniques during surgery and the use of prophylactic antibiotics can help prevent infections. Hematoma or Seroma Formation (Option B) : Occur when blood or fluid collects under the graft. Proper hemostasis during surgery and the use of drains can prevent this issue. Poor Cosmetic Outcome (Option D ruled out) : If the graft does not match the recipient site's skin texture or thickness, or if it is not placed correctly, the cosmetic result may be unsatisfactory. Careful selection of graft thickness and meticulous placement can help achieve a better aesthetic outcome.

References:

Sabiston Textbook of Surgery, 21st Edition, Page 1917

↑ *Back to this question in Part A*

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Q28: A patient needs a graft to cover a small, non-weight-bearing area that is prone to contraction. Which type of graft would be most appropriate to minimize the risk of contraction? (Q849553)

A. Thiersch graft, due to its minimal contraction

B. Wolfe graft, due to its full-thickness nature

C. Split-thickness graft, because it can cover larger areas

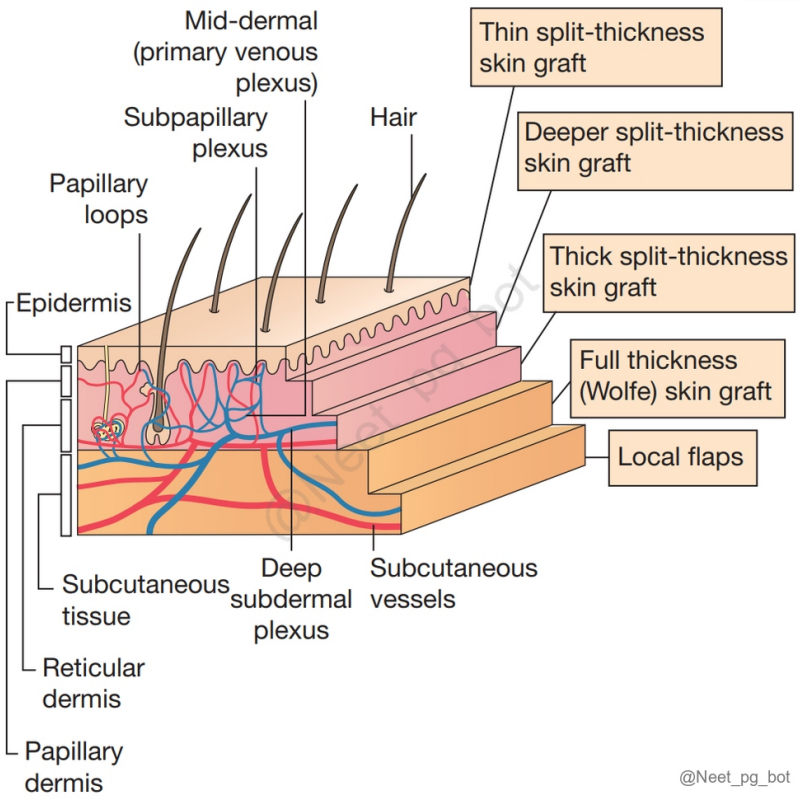
D. Composite graft, because it includes skin and underlying tissue

Correct Answer: B. Wolfe graft, due to its full-thickness nature

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: A Wolfe graft is a full-thickness skin graft that is less prone to contraction compared to split-thickness grafts like the Thiersch graft. This makes it more suitable for areas where minimizing contraction is important. Feature Thiersch Graft (Split-Thickness Skin Graft) Wolfe Graft (Full-Thickness Skin Graft) Type of Skin Grafting Split-thickness Full-thickness Composition Epidermis + part of dermis Epidermis + full thickness of dermis Graft Size Large grafts can be taken Only small grafts can be taken Graft Survival Easier More difficult Donor Site Healing Heals spontaneously, allowing repeated grafts Permanent defect develops, preventing repeated grafts Graft Contraction Significant contraction, leading to poor cosmetic appearance Lesser contraction, better cosmetic appearance Common Donor Sites Inner thigh, upper arm, flexor aspect of forearm, abdominal wall Upper eyelid, retro auricular skin, supraclavicular skin, antecubital skin, inframammary skin, inguinal skin, genital skin, gluteal skin Donor Site Exclusions None Axilla is not used as a donor site Advantages of Harvesting Allows calibration of thickness and large area coverage Calibration of thickness for small but thick grafts



References:

Sabiston Textbook of Surgery, 21st Edition, Page 1917

www.sciencedirect.com/science/article/abs/pii/S030541791730030X

↑ *Back to this question in Part A*

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Q29: During a skin grafting procedure, the surgeon opts for a tool that can precisely control the thickness of the graft to ensure uniformity. Which of the following instruments is most appropriate for this task? (Q849552)

A. Surgical scissors

B. Dermabrader

C. Ferris-Smith forceps

D. Electric dermatome

Correct Answer: D. Electric dermatome

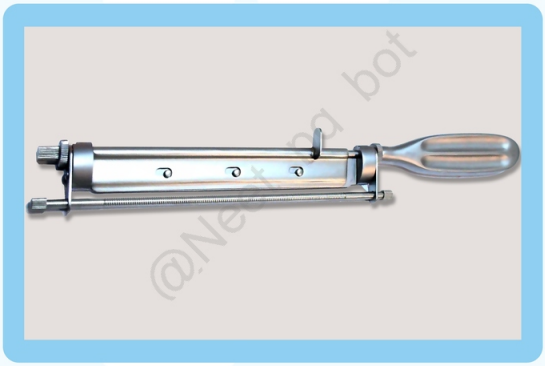
■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: An electric dermatome allows for precise control over the thickness of the skin graft, producing a uniform graft that is ideal for transplantation. Humby's knife is another specialized surgical instrument designed for harvesting thin, uniform skin grafts with precision. Skin graft mesher is another instrument used in grafting. It helps to increase the surface area of smaller grafts. It is used for large wounds. Surgical scissors (Option A): Not suitable for harvesting grafts as they lack the precision and uniformity needed. Dermabrader (Option B): Used for removing superficial layers, not for harvesting grafts. Ferris-Smith forceps (Option C): These are used for tissue manipulation, not for graft harvesting.



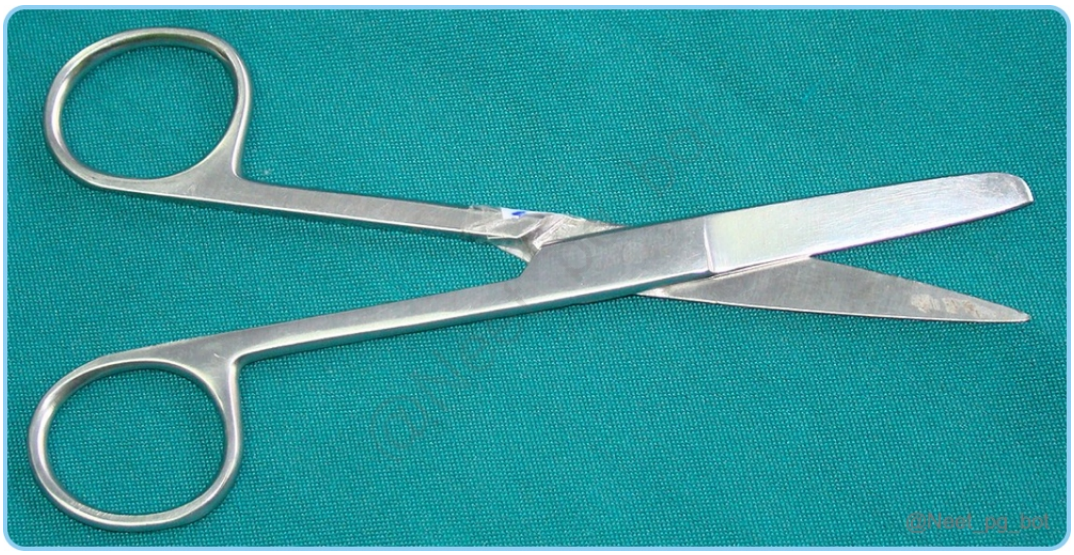
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References:

www.ncbi.nlm.nih.gov/books/NBK551561/

www.ncbi.nlm.nih.gov/pmc/articles/PMC3745118/

↑ *Back to this question in Part A*

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Q30: Match the following types of ulcers with their characteristic edge appearance: Conditions Edges 1. Healing Ulcer a. Punched-out edges 2. Ischaemic Ulcer b. Undermined edges 3. Tubercular Ulcer c. Sloping edges 4. Basal Cell Carcinoma d. Everted edges 5. Squamous Cell Carcinoma e. Rolled or Pearly white edges (Q849559)

A. 1-c, 2-a, 3-b, 4-d, 5-e

B. 1-b, 2-c, 3-a, 4-d, 5-e

C. 1-c, 2-a, 3-b, 4-e, 5-d

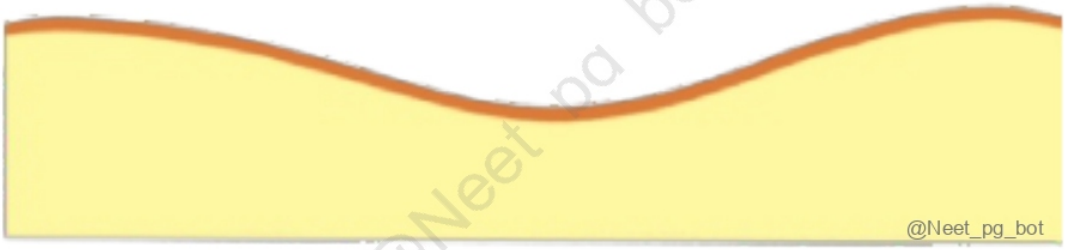
D. 1-b, 2-c, 3-a, 4-e, 5-d

Correct Answer: C. 1-c, 2-a, 3-b, 4-e, 5-d

■ *Listen (English)*

■ *Listen (Hindi)*

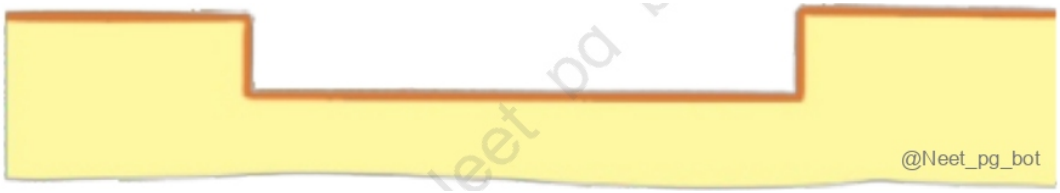
Explanation: The type of ulcer edges seen in various clinical conditions is listed in the table below: Type of edges Clinical conditions Details Sloping edge Healing ulcer Varicose ulcer Inner part: Red (healthy granulation tissue) Middle part: Blue (epithelial proliferation) Outer part: White (scar/fibrous tissue) Undermined edge Tubercular ulcers Disease process advances in the deeper plane (subcutaneous tissue) whereas (skin) epidermis proliferates inwards Punched out edge Arterial / Ischemic ulcers Gummatous (syphilitic) ulcer Trophic ulcer Due to endarteritis Rolled / Pearly white beaded edges Rodent ulcer- Basal cell carcinoma Beads are due to proliferating active cells Pearly white in appearance Everted edge / Rolled out edge Squamous cell carcinoma Due to the spill of proliferating malignant tissue over the normal skin



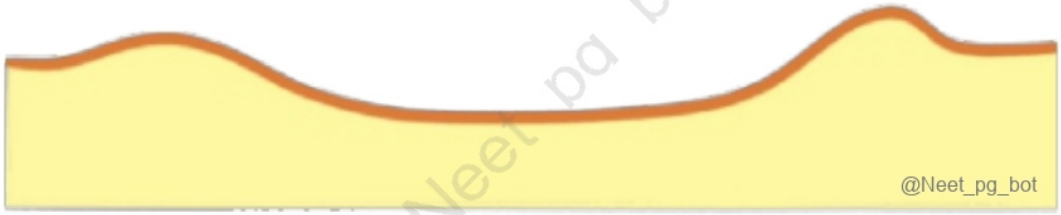



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References:

SRB’s Manual of Surgery, 6th Edition, Page 15

www.ncbi.nlm.nih.gov/pmc/articles/PMC1360405/

↑ *Back to this question in Part A*

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• [08_Plastic Surgery] 049 Wound Healing

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[08_Plastic Surgery] 049 Wound Healing — Quick Jump

Q1 (p. 3045) *Q2 (p. 3047)* *Q3 (p. 3048)* *Q4 (p. 3050)* *Q5 (p. 3051)* *Q6 (p. 3052)*
Q7 (p. 3053) *Q8 (p. 3054)* *Q9 (p. 3056)* *Q10 (p. 3057)* *Q11 (p. 3059)* *Q12 (p. 3061)*
Q13 (p. 3062)

Q1: A 75-year-old bedridden patient is admitted to the hospital with pneumonia. During routine care, the nurse notices an area of redness and tissue breakdown over the patient's sacrum. The patient has been immobile for several days due to weakness. Which of the following statements is incorrect regarding pressure sores? (Q849533)

A. Pressure sores occur when external pressure exceeds capillary occlusive pressure of 30 mm Hg

B. Malnutrition and neurological deficits are contributing factors to pressure sore development

C. The most common site for pressure sores is the greater trochanter

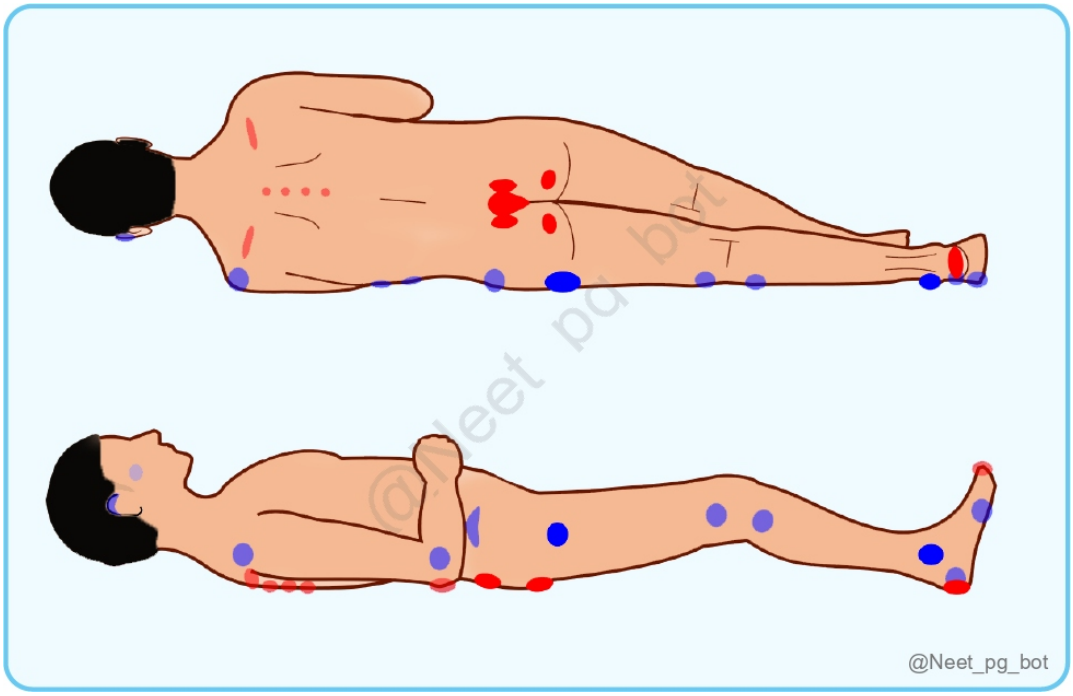
D. In case of pressure sores on Malleolus, lateral is more commonly affected than medial

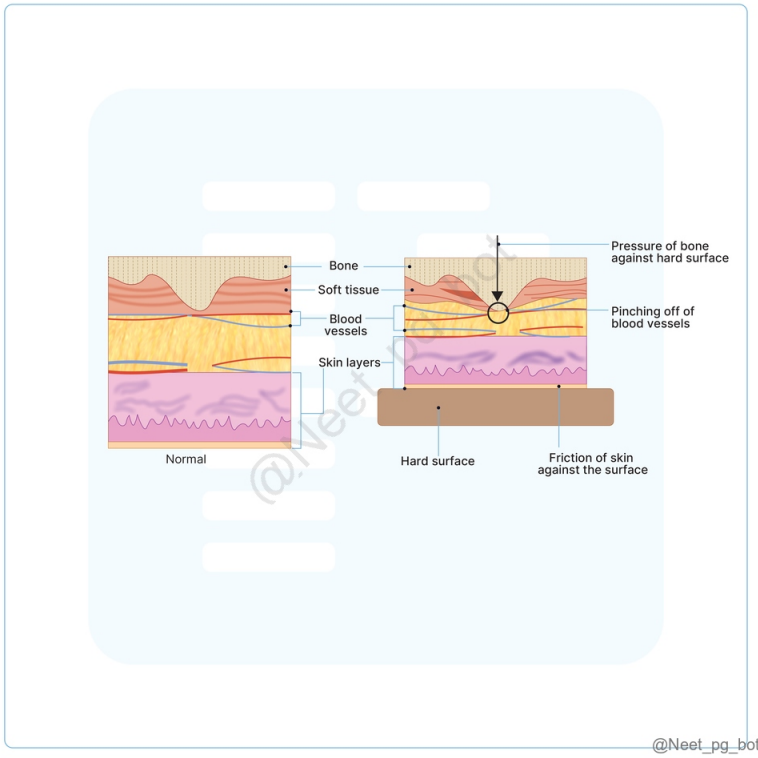
Correct Answer: C. The most common site for pressure sores is the greater trochanter

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The most common site for pressure sores is Ischium. Pressure sores Tissue necrosis & ulceration due to prolonged pressure Other names: Bedsore Decubitus ulcer Trophic ulcer Penetrating ulcer Pathophysiology: External pressure exceeds capillary occlusive pressure (>30 mm Hg) (Option A) Stoppage of perfusion leading to ischemia Leads to necrosis and ulceration Other contributing mechanisms: Malnutrition (Option B) Neurological deficit Sites: Ischium (Most common site) Greater trochanter Sacrum Heel Malleolus (lateral > medial) (Option D) Occiput





References:

SRB's Manual of Surgery, 8th Edition, Page 22, 23

↑ *Back to this question in Part A*

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Q2: A 75-year-old bedridden patient in a long-term care facility is found to have a pressure sore on his sacral area during a routine skin assessment. Upon examination, the nurse notices a deep, crater-like wound extending through the dermis into the subcutaneous tissue. The base of the wound appears red, and there is no visible bone, tendon, or muscle. Based on the staging system for pressure sores, how would this be classified? (Q849536)

A. Stage IV

B. Stage II

C. Stage III

D. Stage I

Correct Answer: C. Stage III

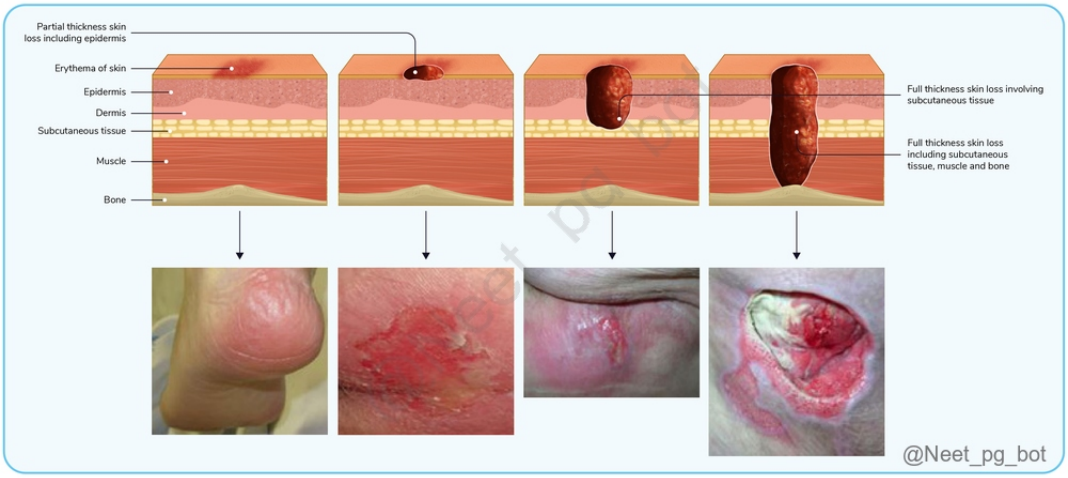
■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: According to the staging system for pressure sores, a Stage III pressure sore is characterized by full-thickness skin loss involving the subcutaneous tissues but not extending to the underlying fascia, muscle, or bone. 5. Unstageable: The depth is unknown because slough or eschar obscures the extent of tissue damage. Stage Description Key Management Strategy Stage I Red, intact skin Frequent repositioning (every 2 hours); pressure-redistribution surfaces (air mattresses); keep skin clean/dry. Stage II Blister or shallow crater Hydrocolloid or occlusive dressings to maintain a moist healing environment; protect from friction. Stage III Deep crater (into fat) Debridement of necrotic tissue; moisture-retentive dressings; possible topical antibiotics; nutritional support (protein/Vitamin C). Stage IV Exposed bone/muscle Surgical consultation for debridement or skin flaps; specialized low-air-loss beds; systemic antibiotics if infected. Unstageable Obscured by slough/eschar Debridement (unless on heels) to visualize the wound bed; enzymatic or sharp debridement by a specialist. Management: Preventable by: Good skincare: Avoid over/under hydration Pressure dispersion cushions/foams Low air loss & air fluidized beds Urinary & fecal diversion: If required Bedridden patients: patients should be turned at least every 2 hourly Wheelchair-bound patients: Patients should lift themselves off their seats every 10 minutes for 10 seconds Surgical treatment: For patients with no improvement after conservative management Surgical options: Adequate debridement: Slough/Necrotic tissue Vaccum-assisted closure/Negative pressure wound therapy Flap closure: Large myocutaneous flap with intact sensory innervation Extensor fascia lata flap with lateral cutaneous nerve of thigh (M/c) Vacuum-Assisted closure/ Negative pressure wound therapy (NPWT): Applies a vacuum through a specially sealed dressing -125 mmHg pressure is applied 2-3 times a week Promotes wound healing by: Draws out excess fluid Increases blood flow to the area Vacuum can be applied continuously or intermittently

Stage I	Stage II	Stage III	Stage IV
Non blanchable erythema of skin without breach in epidermis	Partial thickness less including epidermis + dermis.	Full thickness skin loss involving subcutaneous tissues but not through underlying fasica.	Full thickness skin loss involving subcutaneous tissue, muscle bone, joints or tendon.
Early superficial ulcer	Late superficial ulcer	Early deep ulcer	Late deep ulcer

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References:

SRB's Manual of Surgery, 8th Edition, Page 22, 23

https://www.ncbi.nlm.nih.gov/books/NBK553107/

↑ *Back to this question in Part A*

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Q3: A 25-year-old woman presents with a raised, firm, reddish-purple lesion extending beyond the margins of a surgical scar on her chest. The scar is from a surgery performed 8 months ago. The lesion is pruritic and occasionally painful. Which of the following is the most likely diagnosis? (Q849542)

A. Hypertrophic scar

B. Keloid

C. Dermatofibroma

D. Malignant transformation of the scar

Correct Answer: B. Keloid

- *Listen (English)*
- *Listen (Hindi)*

Explanation: The patient's scar extending beyond the original wound margins, continuing growth after 8 months, and symptoms of pruritus and pain are all consistent with a keloid scar. Key features that distinguish keloids from hypertrophic scars and other conditions include: Keloid Hypertrophic scar (Option A) Extends beyond the original wound margins Continues to grow over time More common in darker skin types Often appears on chest, shoulders, earlobes May be pruritic or painful Does not regress spontaneously Collagen Type: Primarily Type I and Type III collagen. The collagen fibers are large, thick, and disorganized (Haphazard / Whorled bundles) Remains within the boundaries of the original wound Develops within weeks of injury May regress over time (usually within a year) More common than keloids Can occur in any skin type May be red, raised, and firm Collagen Type: Mostly Type III collagen. The collagen fibers are organized parallel to the surface of the epithelium. Dermatofibroma (Option C) is incorrect as dermatofibromas are typically small, firm nodules that don't arise from surgical scars. Malignant transformation (Option D) is incorrect as malignant transformation of scars is rare and would present differently, typically with ulcération or rapid growth.





References:

Sabiston Textbook of Surgery, 21st Edition, Page 130-132

↑ *Back to this question in Part A*

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Q4: Which of the following best describes the proliferative phase of wound healing? (Q849523)

A. Vasoconstriction and thrombus formation

B. Fibroblast activity and collagen production

C. Maturation of collagen

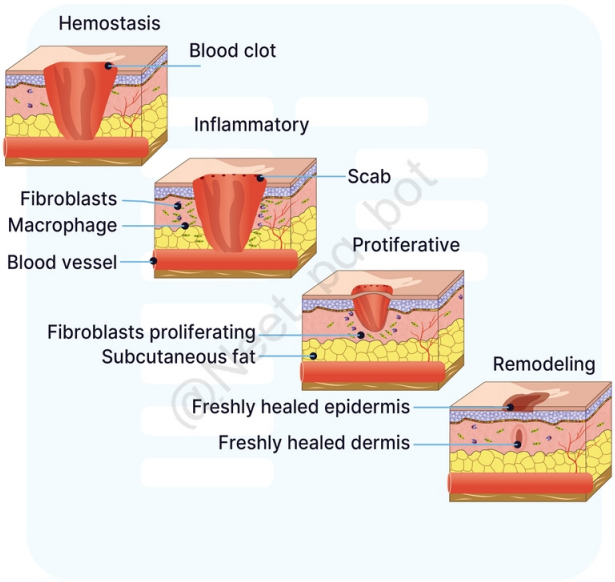
D. Recruitment of neutrophils and macrophages

Correct Answer: B. Fibroblast activity and collagen production

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The wound-healing process consists of four overlapping phases: Hemostasis: Immediately after injury, platelets aggregate and form a fibrin clot to stop bleeding. Inflammatory phase : Neutrophils and macrophages infiltrate the wound, removing debris and bacteria. Proliferative phase: This phase is characterized by collagen deposition, angiogenesis (formation of new blood vessels), and granulation tissue formation. Remodeling phase: The final phase involves collagen reorganization and wound contraction.



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References:

Sabiston Textbook of Surgery, 21st Edition, Page120

↑ *Back to this question in Part A*

@Neet_pg_bot

Q5: Which of the following factors is most likely to adversely affect wound healing? (Q849524)

A. Proper oxygenation

B. Vitamin A supplementation

C. Ionizing radiation

D. Normal body temperature

Correct Answer: C. Ionizing radiation

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Ionizing radiation impairs wound healing by causing obliterating endarteritis and decreasing vascularity. Several factors can adversely affect wound healing: Local factors Systemic factors Infection Ischemia Foreign body Hematoma Movement Mechanical stress Presence of necrotic tissues Diabetes mellitus Ionizing radiation (impairs wound healing by causing obliterating endarteritis and decreasing vascularity) Immunocompromised state Advancing age Malnutrition Vitamin A & C deficiency Zinc & Iron deficiency Drugs (e.g., steroids, doxorubicin) Jaundice Uremia Malignancy

References:

Sabiston Textbook of Surgery, 21st Edition, Page 131

↑ *Back to this question in Part A*

@Neet_pg_bot

Q6: A 50-year-old woman undergoes an elective cholecystectomy. How would you classify this surgical wound? (Q849525)

A. Class I

B. Class II

C. Class III

D. Class IV

Correct Answer: B. Class II

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Cholecystectomy will be categorized under Class II (clean-contaminated wound) as it is an operative wound involving the gastrointestinal tract under controlled conditions. The surgical classification of wounds includes four categories: Class I (Option A)- Clean: Uninfected operative wounds without inflammation. Respiratory, alimentary, genital, or urinary tracts are not entered. Examples: Inguinal hernia operation, mastectomy, thyroidectomy. Class II (Option B)- Clean-contaminated: Operative wounds in which the respiratory tract, gastrointestinal tract, or genitourinary tract are entered under controlled conditions without unusual contamination. Examples: Cholecystectomy, elective GI surgery. Class III (Option C)- Contaminated: Open, fresh accidental wounds, operations with major breaks in sterile techniques or gross spillage from the GIT, and incisions with acute, non-purulent inflammation. Examples: Appendicular perforation, gastric perforation. Class IV (Option

D)- Dirty: Old traumatic wounds with retained devitalized tissue, wounds with clinical infection, or perforated viscera. Examples: Perforated diverticulitis, fecal peritonitis. Wound Class Infection Rate (No Antibiotics) Infection Rate (With Antibiotics) Class I: Clean 1% – 5% < 1% – 2% Class II: Clean-Contaminated 10% – 15% 3% – 5% Class III: Contaminated 15% – 30% 10% – 15% Class IV: Dirty-Infected 30% – 60% ~25%

References:

Sabiston Textbook of Surgery, 21st Edition, Page 225

↑ *Back to this question in Part A*

@Neet_pg_bot

Q7: All of the following measures help prevent surgical site infections except: (Q849526)

A. Minimizing postoperative hospital stay

B. Proper hand hygiene and surgical scrubbing

C. Prolonged use of postoperative drains

D. Administering pre-operative antibiotics at induction

Correct Answer: C. Prolonged use of postoperative drains

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Prolonged use of postoperative drains can actually increase the risk of SSIs by providing a potential route for bacterial entry. Surgical site infections (SSIs) are a significant cause of postoperative morbidity. Prevention strategies include: Preoperative measures: Chlorhexidine showers, proper hair removal (clipping instead of shaving), and optimizing patient factors (e.g., glycemic control). Intraoperative measures: Proper hand hygiene and surgical scrubbing, appropriate skin preparation, maintaining normothermia, and proper surgical technique. Antibiotic prophylaxis: Administering appropriate antibiotics within 60 minutes before incision and redosing for long procedures. Postoperative care: Early removal of urinary catheters and proper wound care. Several specific measures that can help prevent surgical site infections: Staff should follow hand washing between patients (Option B) Length of hospital stay should be kept minimum (Option A) (to prevent hospital-acquired infections) Preoperative shaving should be avoided if possible to minimize minor cuts Antibiotic skin preparation should be standardized Bowel preparation for intra-abdominal surgery should be followed Best time to give preoperative antibiotics (Option D) : At the time of induction via IV route or 1 hour before surgery Attention to theater technique & discipline Avoid hypothermia pre-operatively Monofilament sutures should be preferred over polyfilament sutures (Increased risk of infection in polyfilament) Proper apposition of the wound during suturing Prevention of dead space & hematoma. The Role of ERAS: ERAS is a multimodal perioperative care pathway designed to achieve early recovery after major surgery. Regarding infection control, ERAS emphasizes: Antimicrobial Prophylaxis: Strict adherence to timing (at induction) and stopping antibiotics within 24 hours post-op. Normothermia: Keeping the patient warm, as hypothermia causes vasoconstriction and impairs immune

response. Glycemic Control: Maintaining stable blood glucose levels (even in non-diabetics) to prevent impaired wound healing. Drains and Tubes: Minimizing the use of urinary catheters and wound drains to prevent ascending infections.

References:

Sabiston Textbook of Surgery, 21st Edition, Page 224

↑ *Back to this question in Part A*

@Neet_pg_bot

Q8: A patient presents with a large, open wound on the lower leg that has been left to heal naturally without surgical closure. This type of healing is best described as: (Q849527)

A. Healing by primary intention

B. Healing by secondary intention

C. Healing by tertiary intention

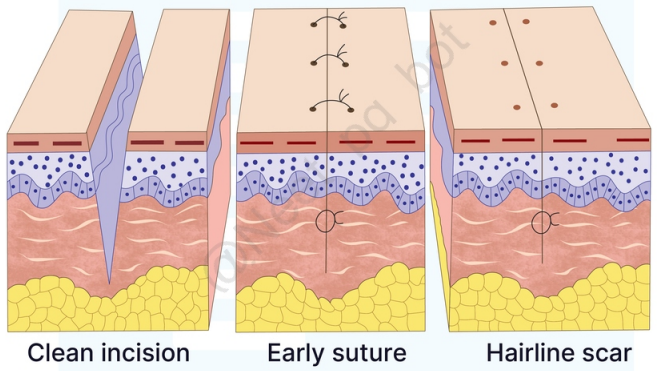
D. Delayed primary closure

Correct Answer: B. Healing by secondary intention

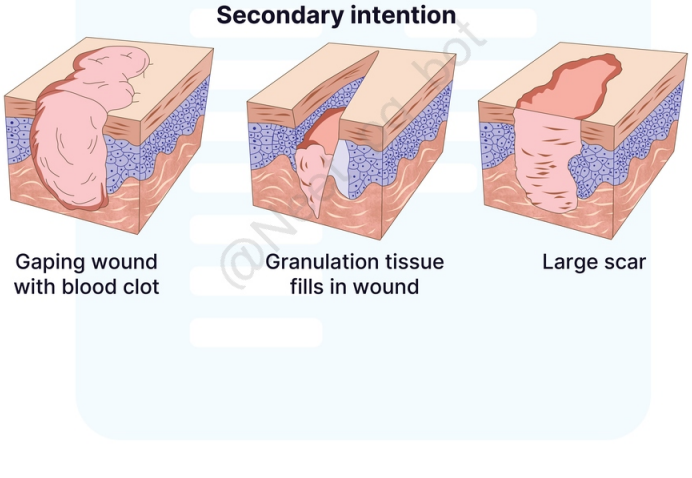
■ *Listen (English)*

■ *Listen (Hindi)*

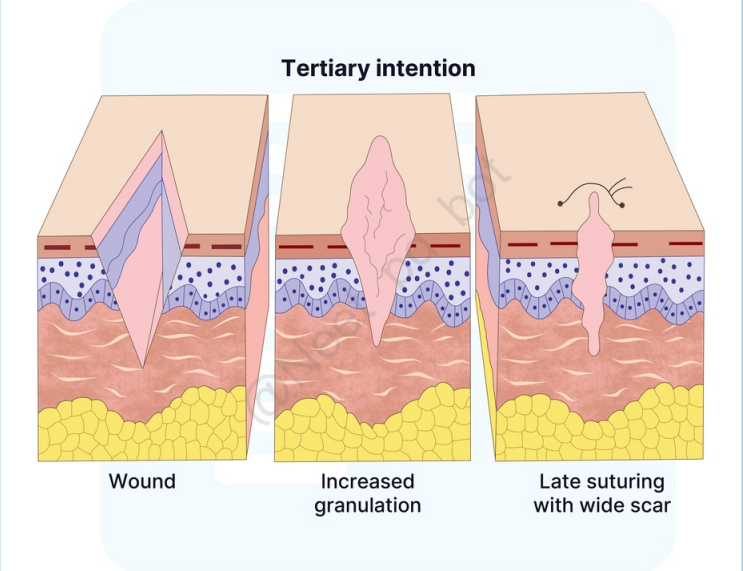
Explanation: In the given scenario, the large, open wound left to heal naturally without surgical closure is healing by secondary intention. Wound healing can occur by different mechanisms: 1. Healing by primary intention or first intention (Option A) : Edges of a clean wound are brought together and secured with sutures, staples, or adhesives. Minimal scarring occurs. 2. Healing by secondary intention (Option B) : The wound is left open to heal by granulation, contraction, and epithelialization. This is common in wounds with significant tissue loss or contamination. 3. Healing by tertiary intention (delayed primary closure) (Option C & D) : The wound is initially left open and then closed surgically after several days when it's clean and granulating. This is used for contaminated wounds to prevent infection.



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References:

Sabiston Textbook of Surgery, 21st Edition, Page 215

↑ *Back to this question in Part A*

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Q9: A 68-year-old diabetic patient presents with a non-healing ulcer on their heel that has persisted for 4 months despite regular dressing changes and offloading. The image showing the wound is given below. Based on this clinical scenario, which of the following statements is incorrect? (Q849530)

A. Chronic wound is a wound that persists beyond 4-12 weeks from its first appearance

B. Delay in healing most commonly occurs due to prolonged inflammatory phase

C. Pain is initially severe, but disappears with time due to nociceptor damage

D. Examples of chronic wounds include vascular ulcers, diabetic ulcers, and pressure sores



Correct Answer: C. Pain is initially severe, but disappears with time due to nociceptor damage

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Chronic wounds commonly present with sharp chronic pain which increases with time. In fact, pain is one of the factors in deciding the treatment protocol. Chronic wound Definition Any wound which persists beyond 4-12 weeks (Option A) despite conservative treatment (dressing) Pathophysiology Wounds that fail to progress through normal stages of wound healing Most commonly prolonged phase is the Inflammatory phase (Option B) Formation of microbial biofilms on wound Treatment Conservative treatment- Tried first, though mostly requires aggressive treatment (surgical) Surgical treatment- Debridement, control of infection and inflammation Surgical treatment is done when the patient suffers from intractable pain Examples Vascular ulcers (Option D) Diabetic ulcers Pressure sores

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 34

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Q10: A 35-year-old factory worker presents to the emergency department with a severe injury to his right forearm after it was caught in a machine, as shown in the picture below. Which of the following statements is incorrect with respect to the injury? (Q849531)

A. It occurs due to shearing force between tissue planes, usually between subcutaneous tissue and deep fascia or between muscle and bone.

B. Skin viability is assessed using Fluorescein injection under anesthesia

C. Characteristic Morel-Lavallée lesion can be seen due to edema of surrounding viable tissue around the wound

D. Treatment primarily involves a multidisciplinary approach which may require amputation



Correct Answer: C. Characteristic Morel-Lavallée lesion can be seen due to edema of surrounding viable tissue around the wound

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The clinical scenario according to the presentation and image is indicative of Degloving Injury. Morel-Lavallée lesion, seen in degloving injury, occurs due to disruption of perforating vascular and lymphatic vessels causing hemo-lymphatic collection between the fascial planes. Degloving Injury Definition Degloving injuries are serious traumatic injuries occuring due to shearing force between tissue planes, usually between subcutaneous tissue and deep fascia or between muscle and bone. Pathophysiology Avulsion due to shearing force strips off the superficial tissues exposing the neurovascular bundle, muscles, tendons, and bone . Diagnosis Diagnosis is mainly based on clinical appearance of the wound Tissue viability is assessed by injecting Fluorescein intravenously. Treatment Wound excision and scar revision with revascularization Flap coverage by skin grafting Amputation may be required. Blood transfusion in heavy blood loss Clinical Assessment of Tissue Viability: Feature Signs of Viability Signs of Non-Viability (Necrosis) Color Pink or pale (blanchable) Cyanotic (blue/purple) or marbled white Capillary Refill Present (< 2 seconds) Absent or sluggish Dermal Bleeding Bright red bleeding upon bright prick Absent or dark, sluggish oozing Temperature Warm to the touch Cold Sensation May be preserved Usually anesthetic (numb)



References:

SRB's Manual of Surgery, 8th Edition, Page 12

www.ncbi.nlm.nih.gov/books/NBK557707/

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Q11: A 25-year-old man is brought to the emergency department following a motorcycle accident. He has a closed fracture of the right tibia and complains of severe pain in his right lower leg. On examination, there is pain on passive stretching of the affected limb and distal sensory disturbances are noted. The emergency physician suspects compartment syndrome. Which of the following is the most applicable next step in an ideal clinical setting in the management of the patient? (Q849532)

A. Immediate fasciotomy without further investigation

B. Measurement of compartment pressure

C. Application of a compression bandage to reduce swelling

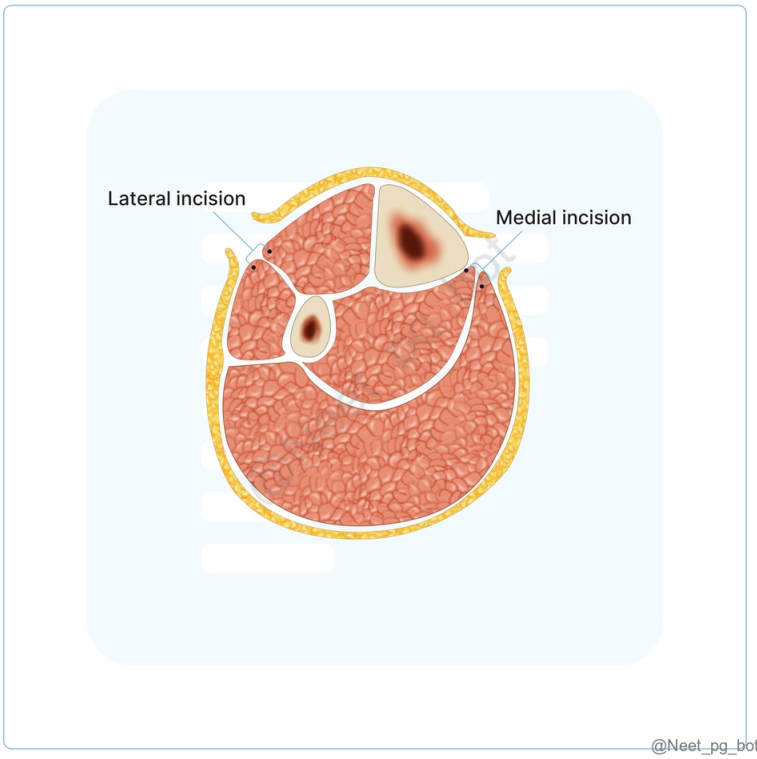
D. Administration of intravenous antibiotics

Correct Answer: B. Measurement of compartment pressure

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The most applicable next step in an ideal clinical setting in the management after suspecting compartment syndrome in the given patient, is to measure the compartment pressure by using a pressure monitor and catheter inserted into the muscle compartment. If pressure is greater than 30 mm Hg then diagnosis of compartment syndrome is confirmed, warranting further measures. Compartment Syndrome Definition • Common in the anterior compartment of the leg and in front of the forearm. • Because of the closed compartment, pressure increases following fracture, haematoma develops which compresses over the vessel. • Leads to blockade of vessels causing acute ischaemia of the limb presenting with severe pain, pallor, pulselessness. Clinical Features • Severe pain • Pain on passive stretching of affected limb • Distal sensory disturbances • Absence of distal pulses (late sign) Investigation • Compartment pressure is measured • Pressure monitor & catheter inserted into muscle compartment • Diagnosis confirmed if pressure is greater than 30 mm Hg Treatment Fasciotomy: • Indication: If compartment pressure is > 30 mmHg • Clinical signs and symptoms of compartment syndrome Procedure • Two longitudinal incisions should be given – one on the medial and the other on the lateral side • Incised layers are: Skin Subcutaneous fat Fascia • After incision, the muscle should be bulging through the fascia Immediate fasciotomy without further investigation (Option A): While the clinical signs are suggestive, the diagnosis should be confirmed by measuring compartment pressure before proceeding to surgery. In most hospitals, due to unavailability of equipment to measure the compartment pressure, we do immediate fasciotomy while suspecting compartment syndrome Applying a compression bandage (Option C) could potentially worsen compartment syndrome by increasing pressure within the compartment. While antibiotics (Option D) might be considered for an open fracture, they are not the primary management for compartment syndrome, and the scenario describes a closed fracture.





References:

SRB's Manual of Surgery, 8th Edition, Page 184

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Q12: A 65-year-old bedridden patient presents with a stage III pressure sore on the sacrum. Which of the following is the most appropriate initial management approach? (Q849537)

A. Immediate surgical debridement

B. Application of hydrocolloid dressing

C. Negative pressure wound therapy

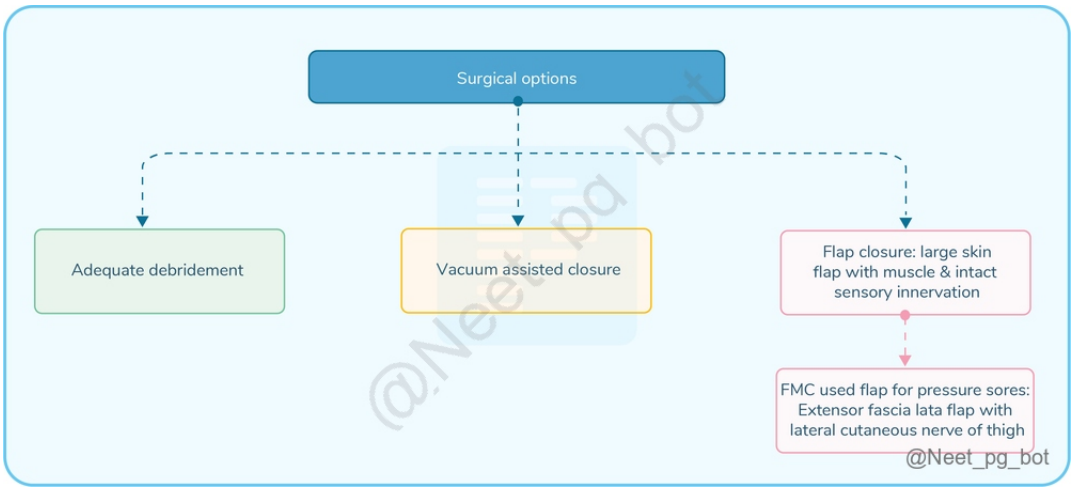
D. Flap reconstruction

Correct Answer: B. Application of hydrocolloid dressing

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The management of pressure sores depends on the stage and severity of the wound. For a stage III pressure sore, conservative management is typically the initial approach, with surgery reserved for more advanced cases or when conservative measures fail. Conservative management includes: 1. Pressure relief: Repositioning the patient every 2-3 hours 2. Wound care: Cleaning and dressing the wound 3. Nutritional support: Ensuring adequate protein and calorie intake 4. Hydrocolloid dressings: These maintain a moist environment, promote autolytic debridement, and protect the wound Surgical management is considered for: 1. Stage III and IV pressure sores that fail to heal with conservative measures 2. Exposed bone, tendon, or joint 3. Undermining, tunneling, or sinus tract formation Surgical options include: Immediate surgical debridement (Option A) is incorrect as it's too aggressive for initial management. Negative pressure wound therapy (Option C) is typically used after debridement and is not the first-line treatment. Flap reconstruction (Option D) is a surgical option reserved for more advanced cases or when conservative measures fail.



References:

Bailey and Love’s Short Practice of Surgery, 28th Edition, Page 34, 35

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Q13: What is the maximum tensile strength that a mature scar can achieve compared to normal skin? (Q849540)

A. 20-30%

B. 40-50%

C. 70-80%

D. 90-100%

Correct Answer: C. 70-80%

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The final tensile strength of a mature scar is typically 70-80% of normal skin Scar formation is a complex process that occurs in several stages: 1. Immature scar (0-3 months): Red, sometimes raised and firm May be painful or itchy Actively producing collagen 2. Mature scar (3 months to 1-2 years): Flat and pale No pain or itching Collagen remodeling continues Changes from immature to mature scar : Color changes from red to pale Flattening of the raised scar Decrease in vascularity Realignment of collagen fibers The maximum tensile strength of a scar is an important characteristic: At 3 weeks post-injury, the scar has about 20% of normal skin strength By 3 months, it reaches about 80% of normal skin strength The final tensile strength of a mature scar is typically 70-80% of normal skin

References:

www.ncbi.nlm.nih.gov/books/NBK586057/

www.ncbi.nlm.nih.gov/pmc/articles/PMC4961501/

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• [08_Plastic Surgery] 050 Previous Year Questions

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[08_Plastic Surgery] 050 Previous Year Questions — Quick Jump

Q1 (p. 3064)	*Q2 (p. 3065)*	*Q3 (p. 3067)*	*Q4 (p. 3068)*	*Q5 (p. 3070)*	*Q6 (p. 3071)*
Q7 (p. 3074)	*Q8 (p. 3075)*	*Q9 (p. 3076)*	*Q10 (p. 3077)*	*Q11 (p. 3078)*	*Q12 (p. 3079)*
Q13 (p. 3080)	*Q14 (p. 3080)*	*Q15 (p. 3081)*	*Q16 (p. 3083)*	*Q17 (p. 3084)*	*Q18 (p. 3085)*
Q19 (p. 3086)	*Q20 (p. 3087)*	*Q21 (p. 3088)*	*Q22 (p. 3088)*	*Q23 (p. 3091)*	*Q24 (p. 3091)*

Q1: A 7-year-old boy is brought to the emergency department 6 hours after sustaining burns involving 22% of total body surface area (TBSA). On examination, he has cool extremities, blood pressure 92/50 mmHg, pulse rate 56/min, and urine output <0.5 mL/kg/hour since the burn. What is the most appropriate next step in management? (Q866923)

A. Administer a crystalloid bolus of 10–20 mL/kg (Ringer's lactate)

B. Start colloid infusion for volume expansion

C. Proceed with surgical intervention for burn wound management

D. Initiate fluid resuscitation at 30 mL/kg/hour

Correct Answer: A. Administer a crystalloid bolus of 10–20 mL/kg (Ringer's lactate)

Explanation: The child has established burn shock , as evidenced by: Significant burns (>15% TBSA in children) Hypotension Bradycardia (a late sign of shock in children) Cool extremities Oliguria (<0.5 mL/kg/hour) The immediate priority is restoration of intravascular volume . According to ATLS / PALS guidelines , pediatric burn shock should be treated initially with a rapid isotonic crystalloid bolus (10–20 mL/kg of Ringer's lactate) , followed by reassessment and then calculation of ongoing burn resuscitation fluids (e.g., Parkland formula). Incorrect Options: B. Colloid infusion: Avoided in the first 24 hours due to increased capillary permeability, causing leakage into interstitial spaces and worsening edema. C. Surgical intervention: Definitive burn management is delayed until hemodynamic stabilization is achieved. D. Fluid at 30 mL/kg/hour: Not a standard recommendation and may lead to fluid overload, pulmonary edema, and abdominal compartment syndrome .

References:

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↑ *Back to this question in Part A*

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Q2: A patient presented with a 0.3 cm nodule on the left nasolabial fold. It was excised, and a pathological examination was done. What is the diagnosis? (Q855808)

A. Basal cell carcinoma

B. Melanoma

C. Squamous cell carcinoma

D. Nevus



Correct Answer: A. Basal cell carcinoma

Explanation: A 0.3 cm nodule on the left nasolabial fold is most likely to represent a Basal Cell Carcinoma (BCC) , especially given the location on the nasolabial fold , which is a common site for BCC. Basal cell carcinoma Also known as Rodent Ulcer . Locally invasive , meaning it destroys surrounding tissues. Referred to as Tear Cancer, it occurs typically above a line drawn from the ear lobule to the corner of the mouth. Originates from the basal layer of the epidermis . The most common site is the nose, with the inner canthus being another frequent location. Types Nodular: The most common type. Appears as small, slow-growing pearly nodules. Characterised by telangiectatic vessels on the surface. Notable for a central depression called umbilication It can also be pigmented. {{caption_text}} {{caption_text}} Cystic Superficial Management For non-aggressive tumours on the trunk or extremities, wide local excision with a 2 cm margin is usually sufficient. For large, aggressive tumours affecting vital or cosmetic areas or recurrent tumours, Mohs micrographic surgery is recommended. Melanoma (Option B) is a malignant skin tumour that arises from melanocytes , the pigment-producing cells of the skin. Melanoma appears as a dark, irregularly shaped nodule or lesion and is less likely to present as a small nodule of 0.3 cm in

size, especially on the nasolabial fold. Squamous cell carcinoma (Option C) is another type of skin cancer but is less common than BCC . SCC typically presents as a firm, scaly nodule or plaque with a tendency to become ulcerated . SCC has a higher likelihood of metastasising compared to BCC. Nevus (Option D) is a benign growth of melanocytes , typically presenting as a small, well-circumscribed brown or black lesion. While nevi can appear anywhere on the skin, including the face, they are usually flat or slightly elevated and not typically a firm, pearly nodule like a BCC.





References:

SRB’s Manual of Surgery, 6th Edition, Pages 284 - 286

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Q3: A 4-year-old child presents with burn injuries after accidental contact with a hot metal surface. Examination shows burns involving the entire posterior trunk, the upper half of the anterior trunk, and the anterior and posterior surfaces of both arms. Using the pediatric Lund and Browder chart, estimate the total body surface area (TBSA) burned. (Q855773)

A. 15-20%

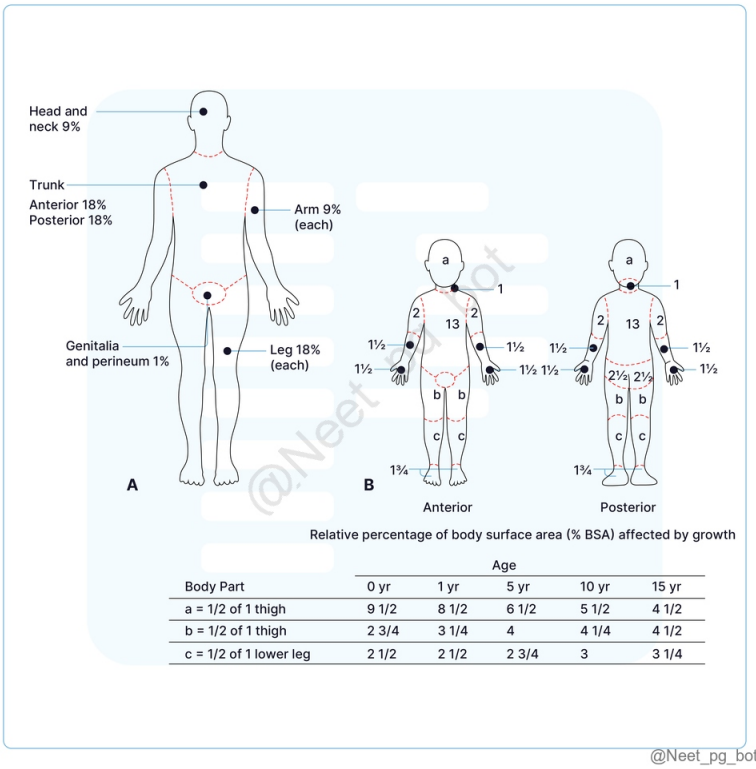
B. 25-30%

C. 35-40%

D. 10-15%

Correct Answer: B. 25-30%

Explanation: Using the Modified Lund & Browder chart for children: Entire posterior trunk = 13% Upper half of the anterior trunk ≈ 6–7% Anterior + posterior surfaces of both arms (bilaterally) ≈ 8% total Adding these areas: = 27–28% TBSA



Relative percentage of body surface area (% BSA) affected by growth

	Age				
Body Part	0 yr	1 yr	5 yr	10 yr	15 yr
a = 1/2 of 1 thigh	9 1/2	8 1/2	6 1/2	5 1/2	4 1/2
b = 1/2 of 1 thigh	2 3/4	3 1/4	4	4 1/4	4 1/2
c = 1/2 of 1 lower leg	2 1/2	2 1/2	2 3/4	3	3 1/4

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References:

SRB's Manual of Surgery, 6th Edition, Page 122

↑ *Back to this question in Part A*

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Q4: The image below shows a pressure sore. Which stage does this belong to? (Q855758)

A. Stage 1

B. Stage 2

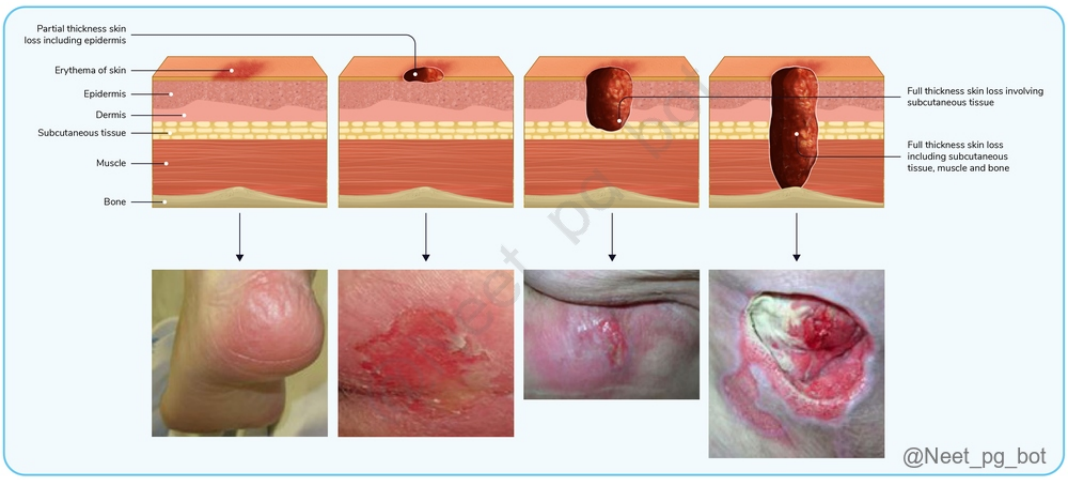
C. Stage 3

D. Stage 4



Correct Answer: D. Stage 4

Explanation: The image given is of Stage 4 pressure sores; they are the most severe type of pressure ulcers, involving extensive tissue damage that extends through the skin to underlying structures, such as muscles, tendons, and bone . Pressure sore stages Stage I (Option A ruled out) Early superficial ulcer Non blanchable erythema of the skin, without breach in the epidermis Stage II (Option B ruled out) Late superficial ulcer Partial thickness, less including epidermis + dermis Stage III (Option C ruled out) Early deep ulcer Full-thickness skin loss involving subcutaneous tissues but not through underlying fascia Stage IV (Option D) Late deep ulcer Full-thickness skin loss involving subcutaneous tissue, muscle, bone, joints or tendon. {{caption_text}}



References:

SRB’s Manual of Surgery, 6th Edition, Pages 22, 23

↑ *Back to this question in Part A*

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Q5: What is the preferred management of the condition in the image below? (Q859868)

A. Surgical excision

B. Radiotherapy

C. Antibiotics

D. Intralesional steroids



Correct Answer: A. Surgical excision

Explanation: The given image suggests an Angular dermoid cyst ,and the preferred management for this is surgical excision , as it completely removes the cyst and prevents recurrence. Angular Dermoid Presentation It commonly occurs as a smooth, non-tender, soft swelling at the fronto-zygomatic suture. Location They are most often located near the lateral canthus , which is the outer corner of the eye where the upper and lower eyelids meet. They may also occur near suture lines of the skull. Symptoms They are usually asymptomatic unless they become large

enough to cause pressure effects on adjacent structures or become infected. Diagnosis Ultrasound or CT scans may be used to evaluate the extent of the cyst, especially if deep or orbital involvement is suspected. Management (Option A) Surgical Excision: Complete surgical excision is the treatment of choice , especially if the cyst is causing cosmetic concerns or other symptoms. Careful dissection is required to ensure the cyst is fully removed and avoid recurrence. If left untreated, angular dermoids sometimes undergo resorption or indentation of the underlying base. CT is done to rule out dural attachments. Radiotherapy (Option B) is not a standard treatment for dermoid cysts . It is typically used for malignant tumours or conditions such as cancer and is not indicated for benign lesions like dermoid cysts. Antibiotics (Option C) are used for bacterial infections. They are not the treatment of choice for an uncomplicated dermoid cyst as it is non-infectious. They are only needed if the cyst becomes infected. Intralesional steroids (Option D) are typically used for conditions like keloids or hypertrophic scars and are not effective in treating dermoid cysts . The goal for dermoid cysts is to remove the cyst hence, surgical excision is the appropriate approach.

References:

SRB’s Manual of Surgery, 6th Edition, Page 72

↑ *Back to this question in Part A*

@Neet_pg_bot

Q6: What is the probable diagnosis for the lesion developed by a patient after 6 months of undergoing a surgery, as depicted below? (Q859844)

A. Hypertrophic scar

B. Atrophic scar

C. Keloid scar

D. Contracture



Correct Answer: C. Keloid scar

Explanation: The most probable diagnosis based on the image and the lesion that developed 6 months after a surgery is a keloid scar . It is characterized by abnormal and excessive growth of scar tissue that grows beyond the boundaries of the original wound and does not regress. It typically appears firm, raised, and extends beyond the margins of the initial injury. Keloid formation seems to be an individual predisposition, and it is more common in African Americans. Treatment can be done by i ntralesional injection of steroids like Triamcinolone. Hypertrophic scars (Option A) are also raised, they typically remain within the boundaries of the original injury. They may regress over time and are less likely to recur after treatment compared to keloids. {{caption_text}} Atrophic scars (Option B) are pale, flat, and depressed scars that appear sunken or as indentations in the skin due to loss of tissue or collagen. Contracture (Option D) occurs when scar tissue forms and tightens , leading to restricted movement of nearby joints or tissues. They typically occur in case of burns or deep wounds . Contractures may result in deformity and functional impairment. {{caption_text}}





References:

Robbins and Cotran’s Pathologic Basis of Disease, 10th Edition, Page 110

↑ *Back to this question in Part A*

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Q7: A 23-year-old man presented with a burn injury. He is covered with burns on his head & neck, both upper limbs, front and back of the chest. Calculate the percentage of burns. (Q856257)

A. 27%

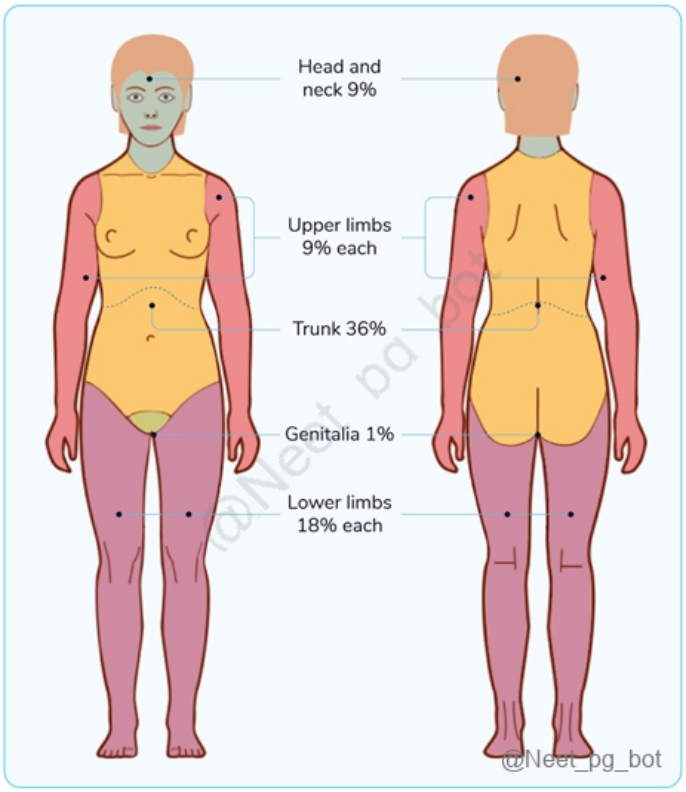
B. 36%

C. 45%

D. 18%

Correct Answer: C. 45%

Explanation: The correct answer in the given condition is 45% based on the rule of 9. To calculate the percentage of burns , we can use the Rule of Nines , a system commonly used to estimate the body surface area (BSA) affected by burns. Since the patient in the scenario is an adult, Burned area% = Head & neck (9%) + Both upper limbs (18%) + Front & back of the chest (18%) = 45% Rule of Nines Adults Children Infants Head & neck 9% 18% 20% Front of chest & abdominal wall 9 x 2 = 18% 18% 10 x 2 = 20% Back of chest & abdominal wall 9 x 2 = 18% 18% 10 x 2 = 20% Lower limb 18 x 2 = 36% 13.5 x 2 = 27% 10 x 2 = 20% Upper limb 9 x 2 = 18% 18% 10 x 2 = 20% Perineum 1% 1%



References:

SRB's Manual of Surgery, 6th Edition, Page 122

↑ *Back to this question in Part A*

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Q8: Which of the following statements regarding Marjolin's ulcer is not true? (Q857471)

A. It is seen in sites of chronic wounds or scars

B. It rapidly progresses to malignancy

C. It can progress to squamous cell carcinoma

D. It is radioresistant due to avascularity

Correct Answer: B. It rapidly progresses to malignancy

Explanation: A marjolin's ulcer usually occurs on long-standing chronic wound scars. It presents as a non-healing ulcer with elevated margins that grow rapidly. In some cases, it can become malignant and progress to squamous

cell carcinoma. It is usually treated by surgical excision using Mohs surgery, where the lesion, along with a 1-2 cm margin is removed. It is seen in the site of chronic wounds or scars (Option A). This statement regarding Marjolin's ulcer is true. It can progress to squamous cell carcinoma (Option C) It has a greater chance of progressing to squamous cell carcinoma rather than basal cell carcinoma. It is radioresistant due to avascularity (Option D). This statement is also true as Marjolin's ulcer has less vascularity and can be radioresistant.

References:

SRB Manual of Surgery, 6th Edition, Page 283, 284

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↑ *Back to this question in Part A*

@Neet_pg_bot

Q9: A 65-year-old man who has the following lesion over the face. He complains of bleeding while itching. The most likely diagnosis is (Q857457)

A. Dermatofibrosarcoma

B. Marjolin's ulcer

C. Basal cell carcinoma

D. Naevus



Correct Answer: C. Basal cell carcinoma

Explanation: Basal cell carcinoma, a slow-growing malignant tumor, invades locally and primarily affects the pilosebaceous skin. It's mainly categorised into localized and generalized forms, with nodular and nodulocystic variants comprising 90% of cases. Typically, it appears as a pink, pearly papule with telangiectasias, rolled borders, and central crusty ulcerations. Dermatofibrosarcoma (Option A) It is a soft tissue sarcoma that presents as a reddish-brown plaque that does not have rolled borders as seen in the image. Marjolin's ulcer (Option B) Marjolin's ulcer can develop into squamous cell carcinoma. It occurs on a previously long-standing scar. The image shown is not marjolin's ulcer. Nevus (Option D) It is a benign skin growth that occurs due to the accumulation of melanocytes. The image shown is not a nevus.

References:

SRB's Manual of Surgery, 6th Edition, Page 284-286

↑ *Back to this question in Part A*

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Q10: Pressure greater than __ mm of Hg causes pressure sores.: (Q857264)

A. 33

B. 45

C. 54

D. 67

Correct Answer: A. 33

Explanation: Pressure sores (also called decubitus ulcers or pressure ulcers) occur due to prolonged pressure on the skin , leading to ischemia and tissue necrosis . The critical pressure threshold that exceeds capillary perfusion pressure and causes ischemia is greater than 33 mmHg . Normal capillary pressure is around 25–32 mmHg , so pressure exceeding 33 mmHg leads to inadequate blood supply and tissue damage. 45 mmHg, 54 mmHg, 67 mmHg (Option B, C and D) While higher pressures can accelerate tissue necrosis, ischemia begins at pressures just above 33 mmHg. Higher pressures are often seen in bony prominences (e.g., sacrum, heels), but even lower sustained pressure over time can lead to ulcers.

References:

Bailey and Love's Short Practice of Surgery, 28th Edition, Pages 325, 326

↑ *Back to this question in Part A*

@Neet_pg_bot

Q11: A patient who underwent surgery for a lipoma 5 weeks ago now presents with a scar at the incision site that is limited to the original wound boundaries. What is the most likely diagnosis? (Q857170)

A. Keloid

B. Exuberant granulation

C. Hypertrophic scar

D. Granulation tissue

Correct Answer: C. Hypertrophic scar

Explanation: Comparison of Hypertrophic Scar, Keloid, Exuberant Granulation, and Granulation Tissue Feature Hypertrophic Scar Keloid Exuberant Granulation ("Proud Flesh") Granulation Tissue Definition Excess collagen deposition leading to a raised scar within wound boundaries. (Option D ruled out) Excess collagen deposition extending beyond the wound. (Option A ruled out) Overgrowth of granulation tissue above skin level. (Option B ruled out) Early vascularized tissue forming during wound healing. (Option C) Wound Boundaries Confined to the original wound. Extends beyond the wound margins. Protrudes beyond the skin level. Confined to wound, but not raised. Onset Weeks after injury. Months after injury. Early post-injury phase. Forms within days of injury. Resolution May regress over time. Persists and grows continuously. Requires treatment (cauterization or excision). Normal component of healing. Common Locations Areas of high tension (joints, chest, back). Earlobes, shoulders, chest, upper arms. Open wounds, surgical sites. Any healing wound. Histology Collagen organized parallel to skin

surface. Disorganized, excessive collagen deposition. Excess granulation tissue, rich in capillaries. Fibroblasts, capillaries, and inflammatory cells. Treatment Pressure therapy, steroids, laser therapy (if symptomatic). Intralesional steroids, cryotherapy, excision (high recurrence). Silver nitrate cautery, surgical trimming. No treatment needed (normal part of healing).

References:

Bailey and Love Short Practice of Surgery, 28th Edition, Pages 24, 25, 684, 685

↑ *Back to this question in Part A*

@Neet_pg_bot

Q12: What is the preferred management of angular dermoid cyst? (Q857146)

A. Surgical excision

B. Wait and watch

C. Wide local excision with a 2 cm margin

D. Laser ablation

Correct Answer: A. Surgical excision

Explanation: Angular dermoid is a type of dermoid cyst that commonly occurs as a smooth, non-tender, soft swelling at the fronto-zygomatic suture. The formation of an angular dermoid is due to the sequestration of ectodermal tissue during embryonic development, which gives rise to a cyst containing dermal elements like hair follicles, sebaceous glands, and sweat glands. Angular dermoids are most often located near the lateral canthus , which is the outer corner of the eye where the upper and lower eyelids meet. They may also occur near suture lines of the skull. They are usually asymptomatic unless they become large enough to cause pressure effects on adjacent structures or become infected. Diagnosis and Treatment: Imaging: Ultrasound or CT scans may be used to evaluate the extent of the cyst, especially if deep or orbital involvement is suspected. Surgical Excision: Complete surgical excision is the treatment of choice , especially if the cyst is causing cosmetic concerns or other symptoms. Careful dissection is required to ensure that the cyst is fully removed and to avoid recurrence. If left untreated, angular dermoids sometimes undergo resorption or indentation of the underlying base. CT is done to rule out dural attachments. Wait and watch (Option B) This is not recommended for angular dermoids, as they can grow or become infected. Surgical excision is the definitive treatment. Wide local excision with a 2 cm margin (Option C) A wide excision is unnecessary. Angular dermoids are benign, so simple surgical excision without wide margins is sufficient. Laser ablation (Option D) is inappropriate for treating angular dermoids. Surgical excision ensures complete removal of the cyst, preventing recurrence.

References:

SRB’s Manual of Surgery, 6th Edition, Page 72

↑ *Back to this question in Part A*

Q13: In the case of a woman who has suffered third and fourth degree burns on her back, what would be the appropriate sequence of steps in her treatment? (Q793406)

A. Resuscitation – reconstruction – debridement

B. Resuscitation – debridement – allograft or autograft

C. Debridement – resuscitation – autograft

D. Debridement – reconstruction – resuscitation

Correct Answer: B. Resuscitation – debridement – allograft or autograft

Explanation: Third-degree burns affect the full thickness of the skin and can cause damage to underlying tissue, while fourth-degree burns extend into the muscle, bone, or internal organs. Both types of burns require prompt and aggressive treatment to prevent complications such as infection, hypovolemia, and shock. The most appropriate order of sequence in the management of a woman who has sustained third and fourth-degree burns on her back is as follows: Resuscitation: The first step in the management of severe burns is resuscitation. This involves assessing and stabilizing the patient's airway, breathing, and circulation. Intravenous fluids and electrolytes are administered to prevent hypovolemia and maintain hemodynamic stability. Debridement: Once the patient is stabilized, the next step is debridement. Debridement involves removing all necrotic tissue and debris from the wound to prevent infection and promote healing. Surgical or non-surgical methods can do debridement. Allograft or autograft: After debridement, the wound is covered with either an allograft or autograft. Allografts are skin grafts taken from another person, while autografts are skin grafts taken from the patient's own body. Both types of grafts can provide temporary coverage to the wound and promote wound healing. Therefore, the correct option would be Resuscitation – Debridement – Allograft or Autograft. Incorrect Choices: Option a. Resuscitation – reconstruction – debridement is incorrect because Ressuscitation – Debridement – Allograft or Autograft is the correct sequence. Option c: Debridement – resuscitation – autograft is incorrect because Resuscitation – Debridement – Allograft or Autograft is the correct sequence. Option d: Reconstruction is not an appropriate step in the initial management of third and fourth-degree burns, as the focus should be on stabilizing the patient and preventing complications. Reconstruction is typically done later in the treatment process once the wound has healed. Thus, Resuscitation – Debridement – Allograft or Autograft is the correct sequence.

References:

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↑ *Back to this question in Part A*

Q14: What type of graft is used when a patient undergoes skin grafting following a road traffic accident in which the graft is harvested from the patient's own body? (Q857870)

A. Autograft

B. Xenograft

C. Allograft

D. Isograft



Correct Answer: A. Autograft

Explanation: The graft harvested from the patient's own body is called an autograft. Types of Grafts Graft Type Source Advantages Disadvantages Autograft (Option A) Tissue from one site to another on the same individual No risk of immune rejection; high success rate Requires a donor site, additional morbidity Allograft (Option C ruled out) Tissue from another individual of the same species Availability of larger tissue amounts Risk of immune rejection; needs immunosuppression Xenograft (Option B ruled out) Tissue from a different species (e.g., pig to human) Readily available; used as temporary grafts High risk of immune rejection; often temporary Isograft (Option D ruled out) Tissue between genetically identical individuals No risk of immune rejection due to genetic identity Limited availability; specific to identical twins Concordant Xenograft: Xenograft between closely related species. Compatibility: Better immune compatibility; lower risk of hyperacute rejection. Example: Primate to human (e.g., baboon to human). Discordant Xenograft: Xenograft between distantly related species. Compatibility: Poor immune compatibility; high risk of hyperacute rejection. Example: Pig to human.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 688.

Classic and Current Opinions in Human Organ and Tissue Transplantation - PMC

↑ *Back to this question in Part A*

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Q15: A 56-year-old female was treated for a burn wound in the lower limb 5 years ago. Now she has developed an ulcer in the burn scar as shown in the image below. What is the most probable diagnosis ? (Q820097)

A. Marjolin’s ulcer

B. Venous ulcer

C. Arterial ulcer

D. Cellulitis



Correct Answer: A. Marjolin’s ulcer

Explanation: Correct option A - Marjolin’s ulcer: Marjolin's ulcer is a type of skin cancer that arises from chronic non-healing wounds, scars, or ulcers, usually after a prolonged period of time (years). It is most commonly associated with burn wounds. The appearance of a chronic ulcer following a burn injury is a classic indication of Marjolin's ulcer. Incorrect options: Option B - Venous ulcer: Venous ulcers typically occur due to chronic venous insufficiency. They usually appear around the ankles and lower legs and are characterized by shallow, irregularly shaped ulcers with a red or yellowish base. They are often associated with edema, varicose veins, and skin discoloration. Option C - Arterial ulcer: Arterial ulcers are a result of inadequate blood supply to the tissue, usually due to underlying arterial disease such as peripheral arterial disease (PAD). These ulcers often occur on the feet, toes, or lower legs and are characterized by a "punched out" appearance with well-defined edges. The base may appear pale or necrotic. Option D - Cellulitis: Cellulitis is a bacterial skin infection that typically presents as redness, swelling, warmth, and pain at the affected site. While cellulitis can occur at sites of wounds or breaks in

the skin, it does not typically present as a chronic ulcer.

↑ *Back to this question in Part A*

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Q16: Estimate the extent of injury for a patient with burns involving front of the chest & abdomen, right upper limb, and right thigh(Anterior). (Q857246)

A. 45%

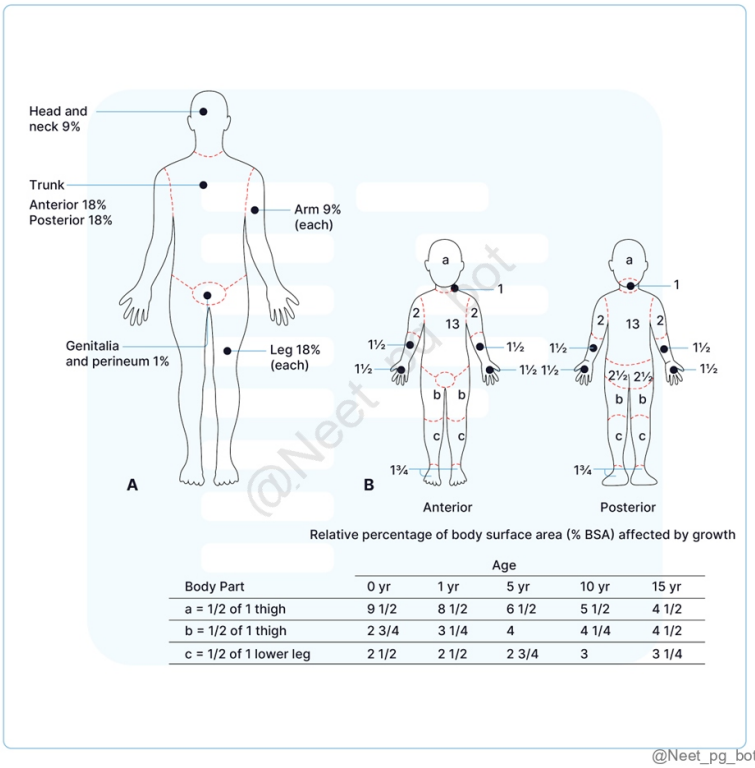
B. 27%

C. 36%

D. 31.5%

Correct Answer: C. 36%

Explanation: According to Wallace's rule of 9 Front of chest and abdomen = 18% Right upper limb = 9% Right thigh (Anterior) = 9% (Total =18+9+9= 36) According to the Wallace rule of 9, the area burned is calculated as : Adults Children Infants Head & neck 9% 18% 20% Front of chest & abdominal wall 9 x 2 = 18% 18% 10 x 2 = 20% Back of chest & abdominal wall 9 x 2 = 18% 18% 10 x 2 = 20% Lower limb 18 x 2 = 36% 13.5 x 2 = 27% 10 x 2 = 20% Upper limb 9 x 2 = 18% 18% 10 x 2 = 20% Perineum 1% 1%



Relative percentage of body surface area (% BSA) affected by growth

	Age				
Body Part	0 yr	1 yr	5 yr	10 yr	15 yr
a = 1/2 of 1 thigh	9 1/2	8 1/2	6 1/2	5 1/2	4 1/2
b = 1/2 of 1 thigh	2 3/4	3 1/4	4	4 1/4	4 1/2
c = 1/2 of 1 lower leg	2 1/2	2 1/2	2 3/4	3	3 1/4

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References:

SRB's Manual of Surgery, 6th Edition, Page 122

↑ *Back to this question in Part A*

@Neet_pg_bot

Q17: How does the graft get nutrition on day 3? (Q844293)

A. Imbibition

B. Inosculation

C. Neovascularization

D. None

Correct Answer: B. Inosculation

Explanation: On day 3 , inosculation starts in which graft and host vessels form anastomosis. This means capillary buds from the recipient bed begin to connect with the graft’s vessels , allowing some blood flow and nutrient delivery. Day Nutritional Mechanism 0–2 Plasmatic imbibition (diffusion) (Option A) ~3 Inosculation (capillary connections form) 4–7 Neovascularization (new vessels grow in) (Option C)

References:

Sabiston Textbook of Surgery, 21st Edition, Page 1917

↑ *Back to this question in Part A*

@Neet_pg_bot

Q18: What type of dressing is used to cover this post burn wound? (Q844314)

A. Split thickness skin graft

B. Full thickness skin graft

C. VAC dressing

D. Normal sumag dressing



Correct Answer: A. Split thickness skin graft

Explanation: Correct Option A - Split-thickness skin graft: A Split-Thickness Skin Graft (STSG) is a thin sheet of skin, containing the epidermis and a partial layer of the dermis, harvested from a healthy donor site on the patient. The graft is often meshed to expand its size, allowing it to cover a wound much larger than the donor area. It is placed over the prepared burn wound where it develops a new blood supply, providing a permanent, living layer of skin for definitive closure. Incorrect Options: Option B - Full-Thickness Skin Graft : A full-thickness skin graft consists of the entire epidermis and dermis, requiring the donor site to be surgically sutured closed. It provides better cosmetic results with less contraction and is used for smaller wounds on critical areas like the face or hands. Option C - VAC Dressing : A VAC dressing is a therapy that uses a sealed sponge and negative pressure to prepare a wound for definitive closure. It promotes healing by removing fluid and increasing blood flow but is a temporary measure used before a skin graft is applied. Option D - Normal Sumag Dressing: A normal saline

dressing is a basic, temporary wound cover using gauze soaked in a sterile saline solution.Its purpose is to keep the wound moist and clean between more definitive treatments, but it offers no permanent coverage.

References:

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↑ *Back to this question in Part A*

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Q19: A 30 year old female was brought to EMR after fire on examination of lower limb full-thickness burns and deep partial-thickness burns were present involving it Circumferentially, procedure was performed as given below, identify the procedure? (Q866414)

A. Escharotomy

B. Debridement

C. Excised to healthy tissue fat/fascia

D. Early skin grafting



Correct Answer: A. Escharotomy

Explanation: The appropriatet answer is escharotomy because circumferential full-thickness burns produce a tough, leathery, non-elastic eschar . This can restrict circulation and ventilation (if on chest) due to swelling beneath the eschar. Escharotomy is an emergency procedure where the eschar is incised longitudinally to relieve pressure, restore distal circulation, and prevent compartment syndrome. It is performed along the medial and lateral aspects of the limb, avoiding neurovascular bundles. Debridement (Option B): Removal of necrotic tissue, usually done during wound care, not the immediate emergency procedure for circumferential burns with vascular compromise. Excised to healthy tissue fat/fascia (Option C): Refers to tangential or fascial excision in burn surgery, typically performed in planned operative settings, not as an emergency decompression. Early skin grafting (Option D): Performed after excision of burn tissue to cover wounds and promote healing; not indicated as the first step in this emergency.

References:

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↑ *Back to this question in Part A*

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Q20: Which of the following is correct regarding nerve grafts: Nerve graft is used for peripheral nerves It is used for surgical repair of facial nerve palsy Most common nerve grafts are saphenous nerve and anterior interosseous nerve Nerve graft can be reconstructed only with fibrin glue (Q865378)

A. 2, 3

B. 1, 3, 4

C. 1, 2

D. 1, 2, 3

Correct Answer: C. 1, 2

Explanation: Nerve grafting is performed when a segmental defect in a peripheral nerve prevents direct end-to-end repair. It is mainly used for peripheral nerves such as median, ulnar, radial, and sciatic nerves. In cases of facial nerve palsy with a nerve gap, autologous nerve grafts (e.g., sural nerve) can restore continuity. The most commonly harvested nerves for grafts are the sural nerve (leg) and medial antebrachial cutaneous nerve (forearm). The anterior interosseous nerve is rarely used and is not a standard graft source. Nerve grafts can be repaired using microsutures, fibrin glue, or a combination, depending on the surgeon’s preference. Fibrin glue alone is not mandatory, though it can help reduce tension at the repair site. Therefore, statements 1 and 2 are correct, while 3 and 4 are incorrect.

References:

Bailey and Love Short Practice of Surgery, 28th Edition, Page 687.

↑ *Back to this question in Part A*

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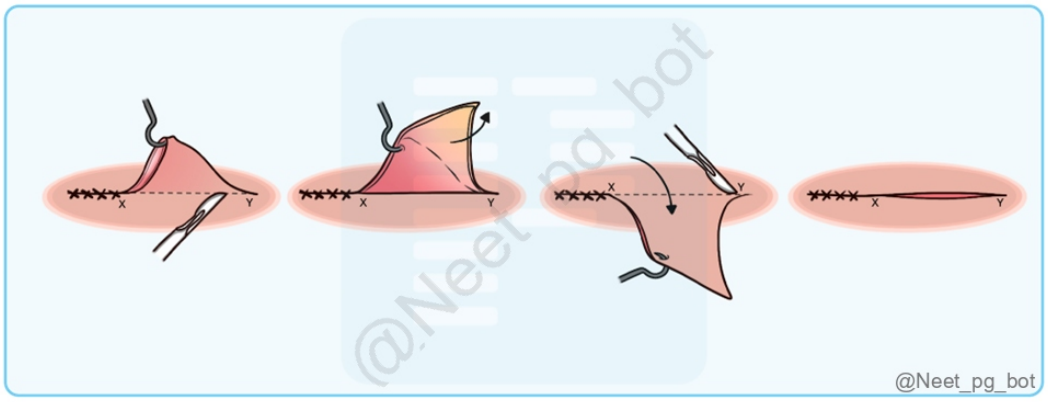
Q21: The following approach is used in: (Q865375)

A. Keloid excision

B. Abscess Drainage

C. Correcting Dog ear

D. Split thickness skin graft



Correct Answer: C. Correcting Dog ear

Explanation: Dog's ear refers to a puckered or folded deformity at the end of a wound or incision, often occurring after elliptical excisions or closures under tension. The approach used to correct a dog's ear involves triangular excision and re-approximation to flatten the skin and ensure a smooth closure. Keloid excision (Option A) - Typically involves wider excision and adjunct therapies (e.g., steroids, radiation). Abscess Drainage (Option B) - Requires incision and drainage, not dog-ear correction. Split thickness skin graft (Option D) - Skin grafts are used to achieve wound closure in situations where the skin defects are too large for primary closure and healing by secondary intention may be inappropriate or lead to an unreasonable delay in complete healing such as burns.

References:

Bailey and Love Short Practice of Surgery, 28th Edition, Page 99

↑ *Back to this question in Part A*

@Neet_pg_bot

Q22: Identify the procedure given below in the image? (Q865299)

A. Transposition flap is used for scar revision

B. Split-thickness skin grafting

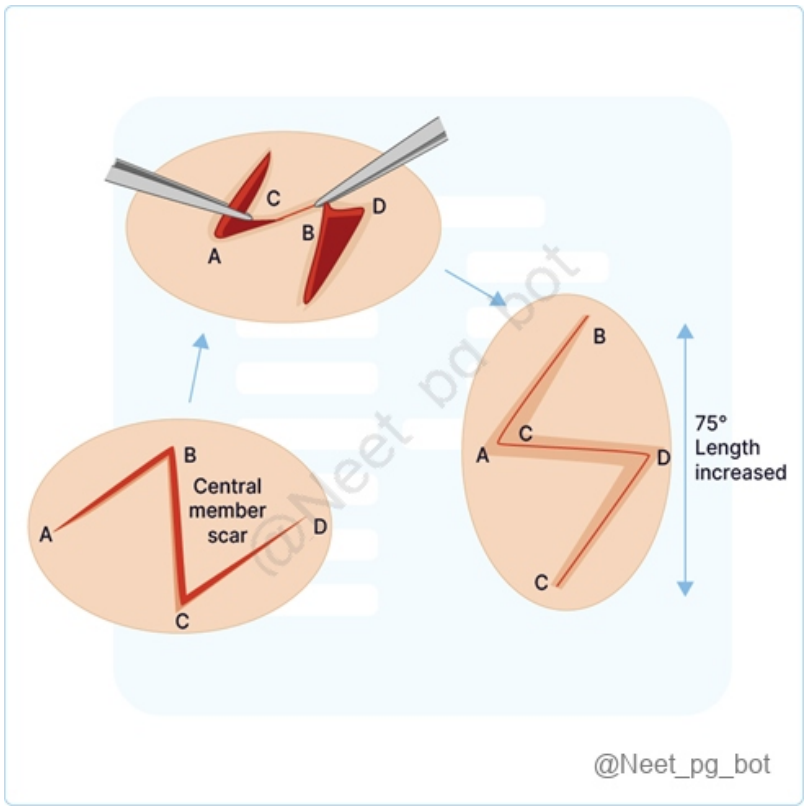
C. Repositioning flap without transposition

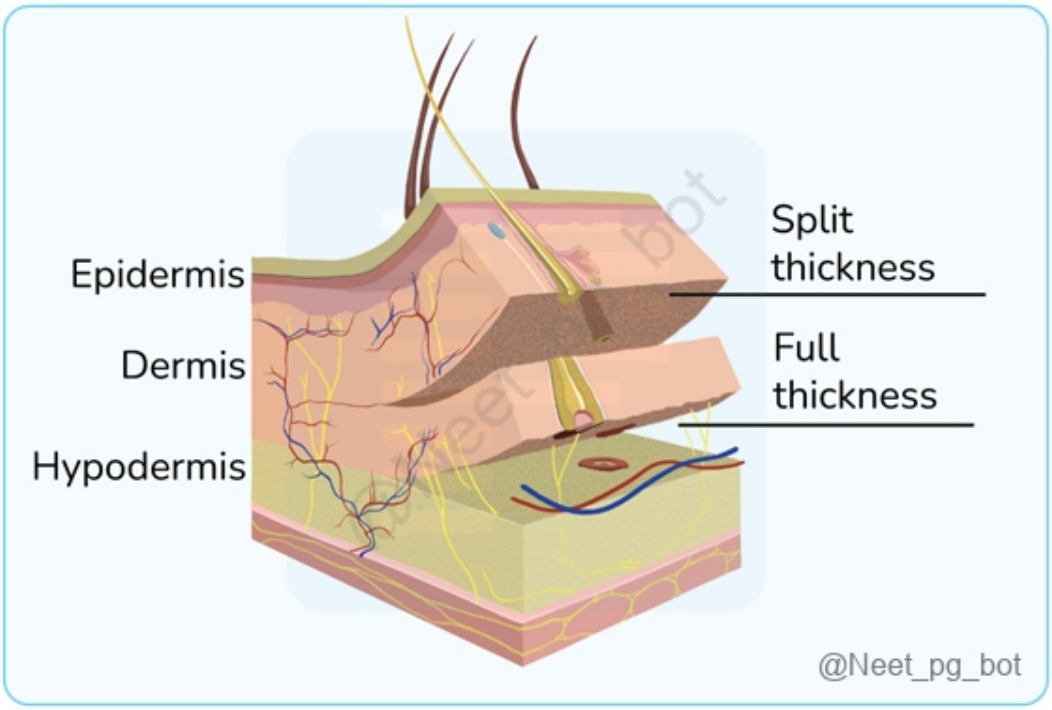
D. Tissue transplantation



Correct Answer: A. Transposition flap is used for scar revision

Explanation: The given image is that of Z-plasty, a surgical technique used to realign scars with natural skin folds or relaxed tension lines and to lengthen contracted scars . It involves creating two triangular flaps of equal size , which are then transposed to redirect and release the scar. Z-plasty is a type of random flap used for grafting purposes, and the other type of random flap is V-Y plasty. Split-thickness skin grafting (Option B) is a surgical technique used to repair skin defects by transferring a thin layer of skin from a donor site to the recipient site. The graft includes the epidermis and a variable thickness of the underlying dermis. It is not a random flap technique. Repositioning flap without transposition (Option C) involves moving a flap directly forward to cover a defect, without rotating or pivoting it across adjacent tissue, but Z-plasty requires transposition. Tissue transplantation (Option D) is a procedure that involves replacing damaged or missing tissues or organs with healthy ones from a donor. The types of grafts used can be an Autograft, Allograft, Xenograft or Isograft.





References:

SRB Manual of General Surgery, 6th Edition, Page 320, 321

Basic Flap Design PubMed

Z-plasty

↑ *Back to this question in Part A*

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Q23: A patient underwent split-thickness skin grafting for a burn injury on the arm. On post-operative day 6, he develops stiffness of the arm during physiotherapy. What is the most appropriate next step in management? (Q866899)

A. Surgical excision of contracture

B. Passive extension of the joint under direct visualization of the graft

C. Continue physiotherapy without intervention

D. Remove the graft and regraft the area

Correct Answer: B. Passive extension of the joint under direct visualization of the graft

Explanation: By post-operative day 6, the split-thickness skin graft is in the fibrovascular ingrowth and early maturation phase. If stiffness develops during physiotherapy, Passive extension of the joint under direct visualization of the graft is the most appropriate step. Early stiffness after a graft (post-op day 6) is usually due to immobility or edema, not established contracture. Gentle, controlled movements protect the graft while restoring range of motion. Aggressive or blind manipulation may damage the fragile graft in the early post-op period. Incorrect Options: Surgical excision of contracture (Option A): Contracture release is indicated in long-standing, mature scars , not within the first week after grafting. Continue physiotherapy without intervention (Option C): Risk of damaging the graft if stiffness is due to early adhesion or improper graft placement; should first ensure graft safety. Remove the graft and regraft the area (Option D): Not necessary unless the graft has failed; stiffness alone at day 6 is not an indication for regrafting.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q24: What does the inclusion of a split-thickness skin graft in wound closure on the thigh entail? (Q793440)

A. Epidermis and full dermis

B. Epidermis and variable part of the dermis

C. Epidermis, dermis and fat

D. Epidermis only

Correct Answer: B. Epidermis and variable part of the dermis

Explanation: of correct option.

References:

Prepladder Notes

↑ *Back to this question in Part A*

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• [09_Oncology] 051 Oncology

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[09_Oncology] 051 Oncology — Quick Jump

Q1 (p. 3093) *Q2 (p. 3094)* *Q3 (p. 3095)* *Q4 (p. 3096)* *Q5 (p. 3097)* *Q6 (p. 3098)*
Q7 (p. 3099) *Q8 (p. 3102)* *Q9 (p. 3103)* *Q10 (p. 3104)* *Q11 (p. 3105)* *Q12 (p. 3106)*
Q13 (p. 3107)

Q1: Which of the following is the most common type of soft tissue sarcoma in adults? (Q849395)

A. Leiomyosarcoma

B. Liposarcoma

C. Rhabdomyosarcoma

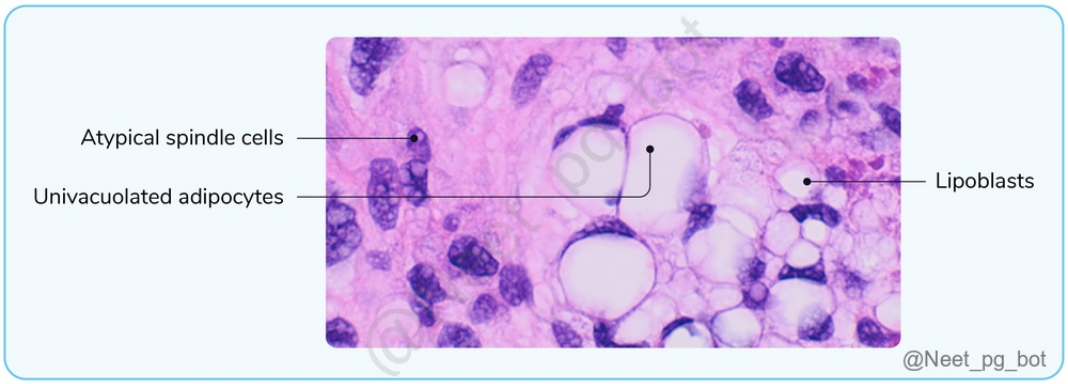
D. Angiosarcoma

Correct Answer: B. Liposarcoma

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Liposarcoma is the most commo n soft tissue sarcoma in adults followed by Leiomyosarcoma. Rhabdomyosarcoma is the most common soft tissue sarcoma in children . Malignant fibrous histiocytoma is the most common soft tissue sarcoma in extremities . Liposarcoma Origin: A malignant tumour arises from adipocytes or fat cells. Characteristics: Liposarcomas are typically large at the time of diagnosis, often because they grow in the retroperitoneum or other deep tissues where they can expand without causing early symptoms. They can vary from well-differentiated to poorly differentiated, with the latter being more aggressive. Presentation: Patients may present with a painless, enlarging mass. In the retroperitoneum, symptoms may be related to the compression of nearby organs. HPE reveals a tumour composed of adipocytes with atypical spindle cells.



References:

Bailey & Love's Short Practice of Surgery, 28th edition

↑ *Back to this question in Part A*

@Neet_pg_bot

Q2: A 60-year-old male presents with a rapidly enlarging mass in the retroperitoneal area. Imaging reveals a large, heterogeneous mass with areas of necrosis. A biopsy confirms the diagnosis of dedifferentiated liposarcoma . What is the most common cause of death in patients with this condition? (Q849396)

A. Hemorrhage due to tumour rupture

B. Metastasis to lungs

C. Infection secondary to immunosuppression

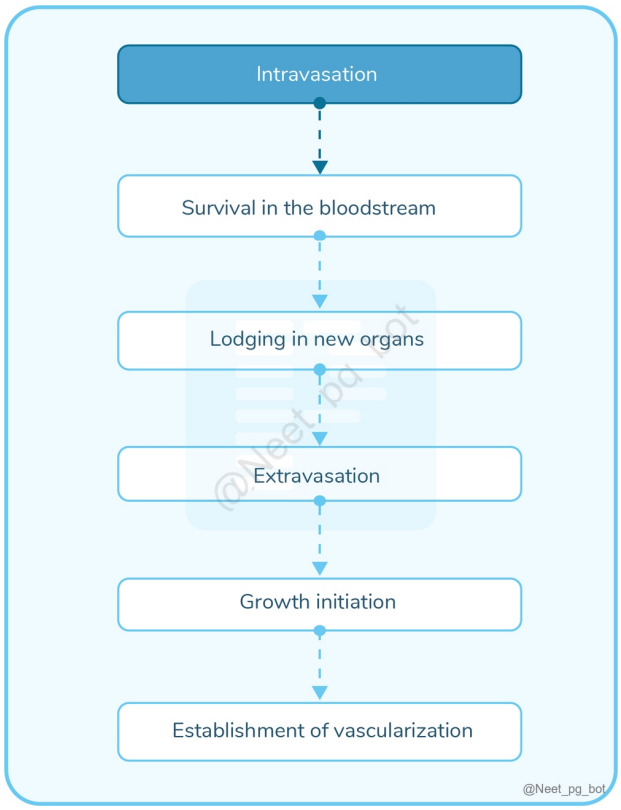
D. Local recurrence leading to organ failure

Correct Answer: B. Metastasis to lungs

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Metastasis is the most common cause of death in patients with high-grade soft tissue sarcomas, including dedifferentiated liposarcoma. Soft tissue sarcomas often invade nearby blood vessels, allowing cancer cells to enter the circulatory system. Vascular invasion is a significant prognostic indicator, suggesting a higher likelihood of hematogenous spread. The most common site of metastasis in soft tissue sarcoma is Lung . Metastasis typically indicates a poorer prognosis and may require systemic treatments and local management and local management. Process of metastasis



References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Pages 589-591.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q3: Which of the following malignant tumours is known for spreading through both hematogenous and lymphatic routes? (Q849397)

A. Liposarcoma

B. Leiomyosarcoma

C. Angiosarcoma

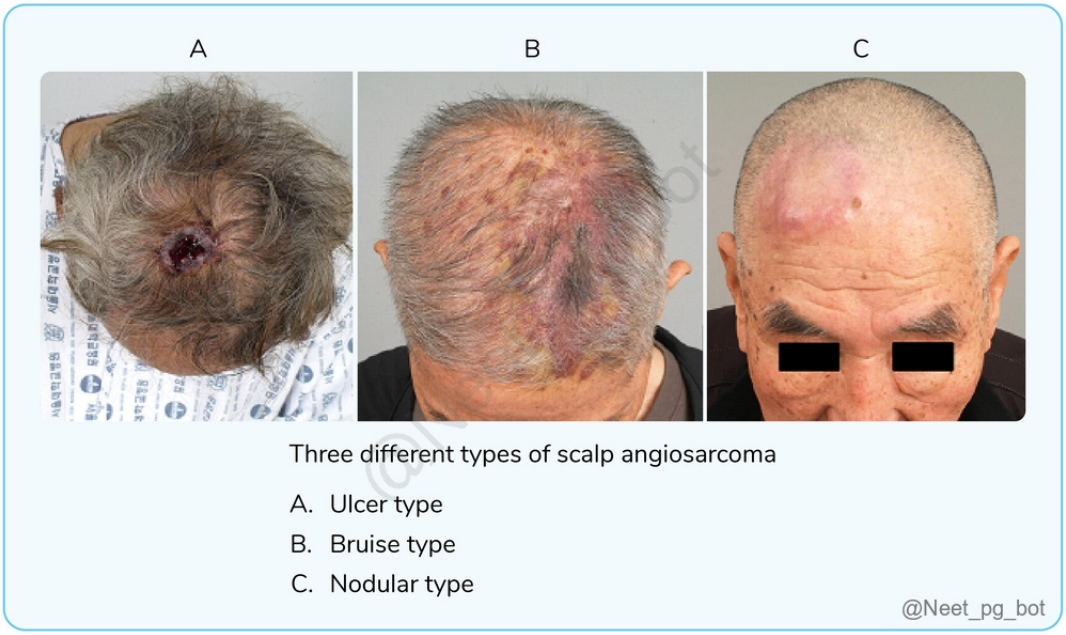
D. Rhabdomyosarcoma

Correct Answer: C. Angiosarcoma

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Angiosarcoma is a malignant tumour that arises from the endothelial cells lining blood vessels. It has a higher propensity to metastasise via the lymphatic system than other sarcomas. History of radiation therapy is a significant risk factor. Clinically, it presents as a red-brown, indurated, and ulcerated skin lesion . It can spread through lymphatic and hematogenous routes , but due to the tumour's vascular nature, hematogenous spread (via blood vessels) is more common. The liver and lungs are common sites of metastasis, reflecting the tumour's aggressive nature. The majority of soft tissue sarcomas spread via the hematogenous route; however, some exceptions primarily spread through the lymphatic system, including: Clear cell sarcoma Rhabdomyosarcoma Epithelioid sarcoma Angiosarcoma Malignant fibrous histiocytoma Synovial sarcoma



References:

Bailey & Love’s Short Practice of Surgery, 28th Edition, Pages 661-662.

↑ *Back to this question in Part A*

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Q4: A 45-year-old male presents with a rapidly enlarging, painless mass in his right thigh, which has been growing over a few months. The mass is firm, deep-seated, and non-tender on examination. Which of the following is the most appropriate next step to establish a definitive diagnosis? (Q849398)

A. Contrast-Enhanced CT (CECT)

B. MRI

C. Tru-cut biopsy

D. PET-CT

Correct Answer: C. Tru-cut biopsy

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The clinical presentation is characteristic of Liposarcoma, a malignant tumour arising from adipocytes (fat cells). The definitive diagnosis is made via histopathological examination, often through a tru-cut biopsy. Tru-cut biopsy Aspect Details Purpose A minimally invasive procedure to obtain a tissue sample from a suspicious mass or tumour for histopathological examination is often used to diagnose soft tissue sarcomas. Procedure A needle is inserted into the mass under imaging guidance (e.g., ultrasound, CT) to retrieve a core of tissue for microscopic analysis to determine the nature and characteristics of the tumour. Advantages Minimally invasive compared to surgical biopsy. Provides sufficient tissue for accurate histological diagnosis. Outpatient procedure with minimal recovery time. Limitations The sample size is relatively small, potentially not representing the entire tumour if it is heterogeneous. Risk of sampling error leading to potential misdiagnosis.
Contrast-Enhanced CT (CECT) (Option A): Excellent for vascularity, necrosis, and lung metastasis screening, but lacks MRI's soft tissue detail; not definitive. MRI (Option B): The best initial imaging to see the tumor's size and relationship to nerves/vessels. However, imaging can only suggest malignancy; it cannot provide the cellular proof needed for a final diagnosis. PET-CT (Option D): Assesses metabolic activity for staging distant spread after tissue confirmation; misses histologic specificity.

References:

Bailey & Love’s Short Practice of Surgery, 28th Edition, Pages 589-591.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q5: A 60-year-old male presents with a rapidly growing, painless mass in the upper arm. Imaging shows that the mass is located deep in the fascia, and biopsy results indicate poorly differentiated pleomorphic cells with high mitotic activity. What is the most important prognostic factor for this patient's soft tissue sarcoma? (Q849400)

A. Tumor Size

B. Presence of Necrosis

C. Depth of Tumor

D. Histological Grade

Correct Answer: D. Histological Grade

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The histological grade is the most crucial prognostic factor in soft tissue sarcomas, as it directly reflects the tumour's biological behaviour, aggressiveness, and potential response to therapy. Prognostic factors for soft tissue sarcoma Prognostic Factor Importance Histological Grade Comprehensive assessment of tumour aggressiveness; Depth of Tumor Tumours deep into the fascia are more likely to be malignant and have a poorer prognosis. (Option C) Size of Tumor Larger tumours (>5 cm) are more likely to be malignant and associated with a worse prognosis. (Option A) Presence of Necrosis Indicates high-grade tumours with aggressive behaviour. (Option B) Vascular Invasion Associated with a higher risk of metastasis and worse prognosis Perineural Invasion Suggests aggressive behaviour and the potential for local spread Positive Resection Margins Higher risk of recurrence if cancer cells remain at the edges of surgical resection

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Pages 589-591.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q6: In the surgical management of soft tissue sarcoma, which of the following criteria is most appropriate for achieving optimal outcomes? (Q849402)

A. Wide local excision with a 1 cm margin

B. Radical excision with removal of adjacent muscle groups

C. Wide local excision with a 2 cm margin

D. Radical excision with lymph node removal

Correct Answer: C. Wide local excision with a 2 cm margin

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Wide local excision with a 2 cm margin ensures complete tumour removal while preserving function and minimising tissue loss. This approach effectively reduces the risk of local recurrence. Wide local excision with a 1 cm margin (Option A) may be inadequate for many soft tissue sarcomas, potentially leading to higher rates of local recurrence. Radical excision with removal of adjacent muscle groups (Option B): It is often overly aggressive and can lead to unnecessary functional impairment without significantly improving outcomes in most cases. Radical excision with lymph node removal (Option D) is generally not necessary for most soft tissue sarcomas, as they typically spread hematogenously rather than through lymphatics, and routine lymph node dissection is not standard practice unless there is evidence of lymph node involvement.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Pages 589-590.

↑ *Back to this question in Part A*

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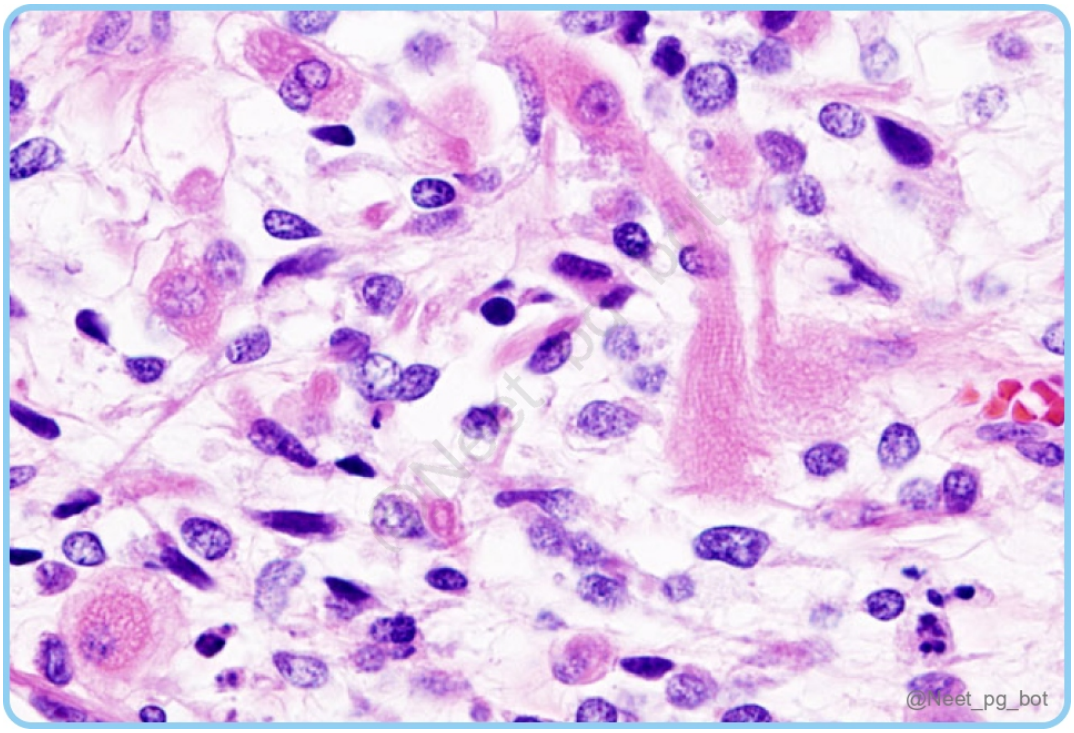
Q7: A 6-year-old boy has a rapidly growing 3 cm mass in his right cheek. Biopsy shows small round blue cells, alveolar patterns, eosinophilic cytoplasm with cross-striations, and positive immunochemistry for desmin and myogenin. What is the most likely diagnosis? (Q849403)

A. Ewing sarcoma

B. Neuroblastoma

C. Rhabdomyosarcoma

D. Lymphoma



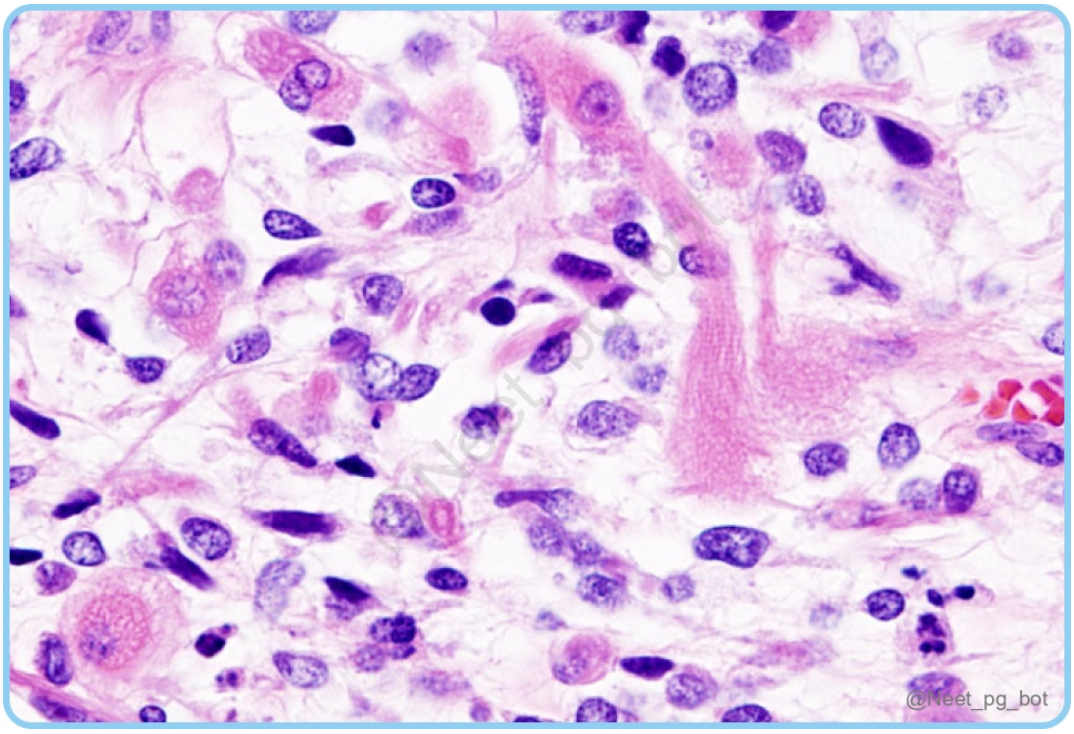
Correct Answer: C. Rhabdomyosarcoma

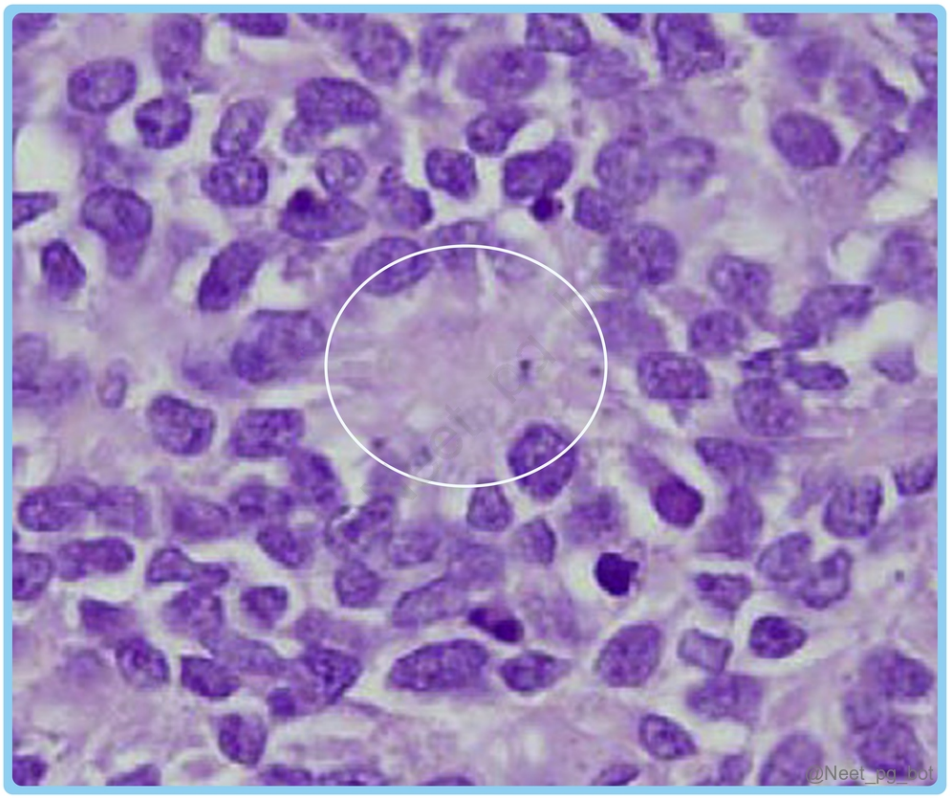
■ *Listen (English)*

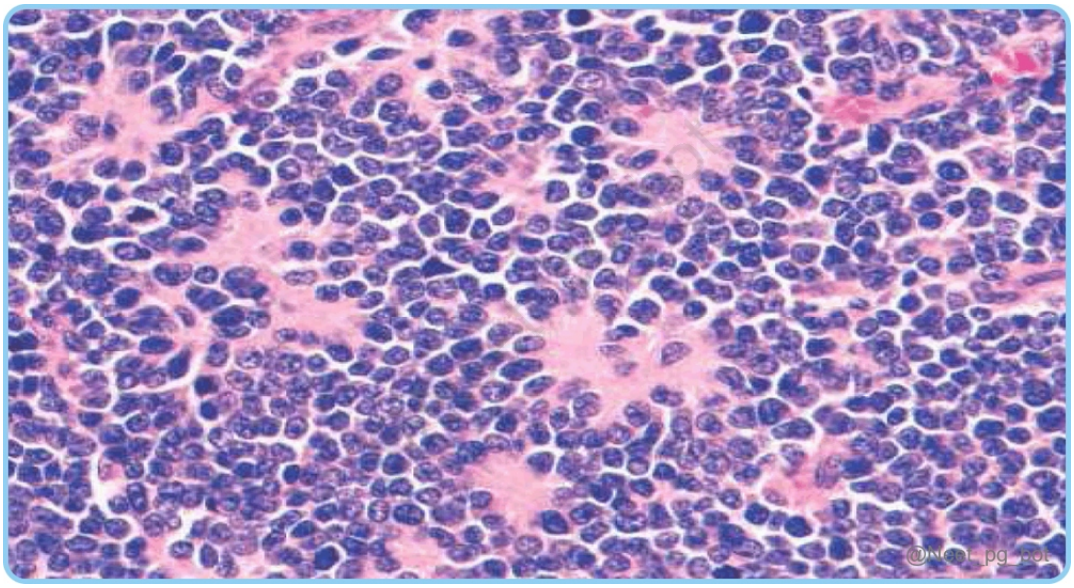
■ *Listen (Hindi)*

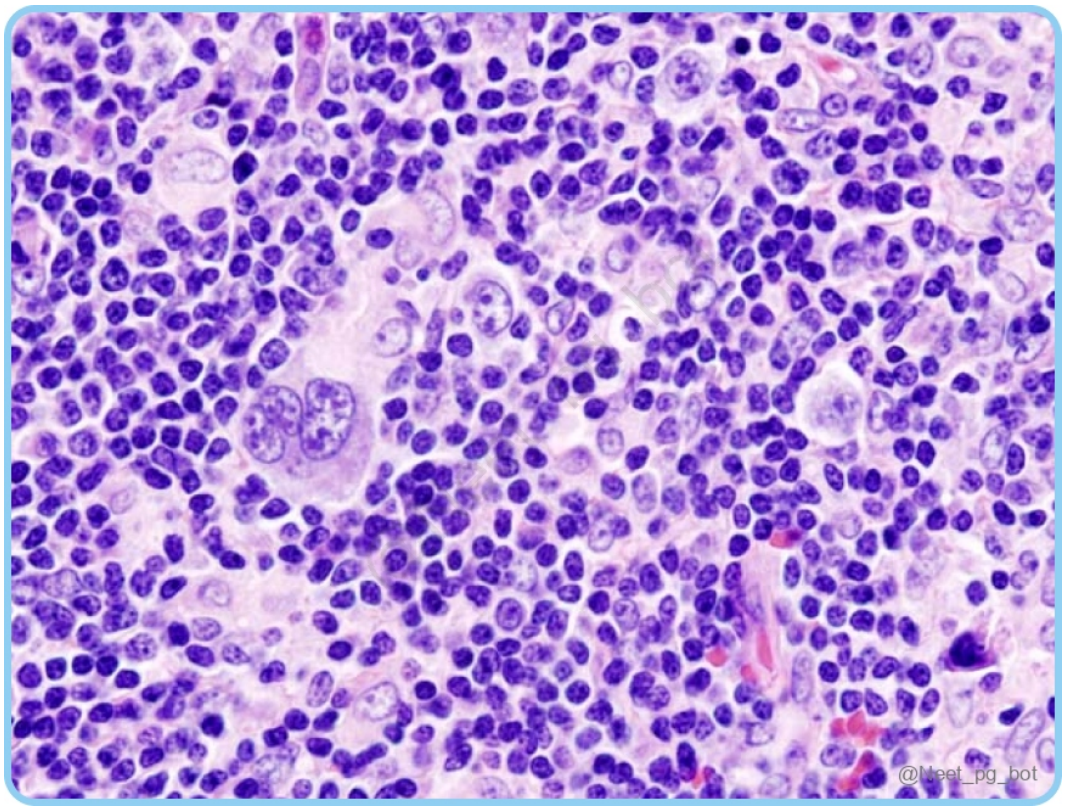
Explanation: The clinical presentation and histopathology features suggest Rhabdomyosarcoma , a malignant tumour that arises from primitive mesenchymal cells committed to the skeletal muscle lineage. It is the most common soft tissue sarcoma in children and adolescents. It can occur anywhere in the body, but common sites

include the head and neck, genitourinary tract, and extremities. It typically presents as a painless, rapidly growing mass, often in the head and neck region. Histopathology reveals small round blue cells with features of skeletal muscle differentiation. Immunohistochemistry confirms the diagnosis with positive for muscle markers like desmin, myogenin, and MyoD1. Treatment involves a multimodal approach, including surgery, chemotherapy, and often radiation therapy. Prognosis varies widely depending on subtype, location, stage, and age at diagnosis.
Ewing Sarcoma (Option A) typically presents with small, round blue cells with scant cytoplasm lacking muscle differentiation. It commonly affects bone or soft tissue in children and young adults and is often associated with the EWSR1-FLI1 fusion gene. Neuroblastoma (Option B) usually originates from the adrenal gland or sympathetic ganglia in young children. Histology reveals small, round blue cells with Homer Wright rosettes and neurite-like processes, positive for synaptophysin and chromogranin. Lymphoma (Option D) typically shows monomorphic lymphoid cells and is identified by markers like CD20, CD3, or CD45. The presence of alveolar patterns, cross-striations, and muscle markers (desmin, myogenin) points to rhabdomyosarcoma, not lymphoma.




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References:

Sabiston’s Textbook of Surgery, 21st Edition, Pages 1874, 1875, 797.

↑ *Back to this question in Part A*

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Q8: A 58-year-old woman is diagnosed with a high-grade retroperitoneal liposarcoma. After treatment, her oncologist monitors for metastases. What's the most common site of metastasis for retroperitoneal sarcomas? (Q849414)

A. Lungs

B. Liver

C. Bone

D. Brain

Correct Answer: B. Liver

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Retroperitoneal sarcomas, including liposarcomas, spreads primarily via the portal veain , and the liver > Lungs is the most common site of metastasis. Retroperitoneal Sarcomas are rare, aggressive tumours often diagnosed late due to non-specific symptoms. Subtypes include liposarcoma, leiomyosarcoma, and malignant fibrous histiocytoma. Treatment: Surgery is the mainstay, often followed by radiation or chemotherapy. Prognosis: Depending on size, grade, and resectability, local recurrence is common.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1105.

Sabiston's Textbook of Surgery, 21st Edition, Pages 1101-1102.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q9: In unresectable or metastatic Dermatofibrosarcoma Protuberans (DFSP), which targeted therapy is considered the drug of choice? (Q849416)

A. Vemurafenib

B. Imatinib

C. Pembrolizumab

D. Dabrafenib

Correct Answer: B. Imatinib

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Imatinib , a tyrosine kinase inhibitor, is the drug of choice for unresectable or metastatic Dermatofibrosarcoma Protuberans (DFSP) when surgery is not feasible. Targets the COL1A1-PDGFB fusion protein present in most DFSP cases. Effectively inhibits tumour growth. Shown significant efficacy in clinical trials for unresectable or metastatic DFSP. Dermatofibrosarcoma Protuberans (DFSP): It is a rare, low-grade sarcoma of the dermis. It is characterised by slow growth and local aggressiveness but rarely metastasises. Clinical features: It presents as a firm, painless plaque or nodule on the trunk or extremities, often mistaken for a benign lesion initially. Pathology: Translocation resulting in COL1A1-PDGFB fusion. Treatment: Surgery with wide local excision or Mohs micrographic surgery is the primary treatment. Targeted therapy with imatinib is used for unresectable or metastatic cases.



References:

Sabiston’s Textbook of Surgery, 21st Edition, Page 731.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q10: Which of the following is NOT a critical metabolic derangement typically observed in tumour lysis syndrome? (Q849417)

A. Hyperkalemia

B. Hyperuricemia

C. Hypercalcemia

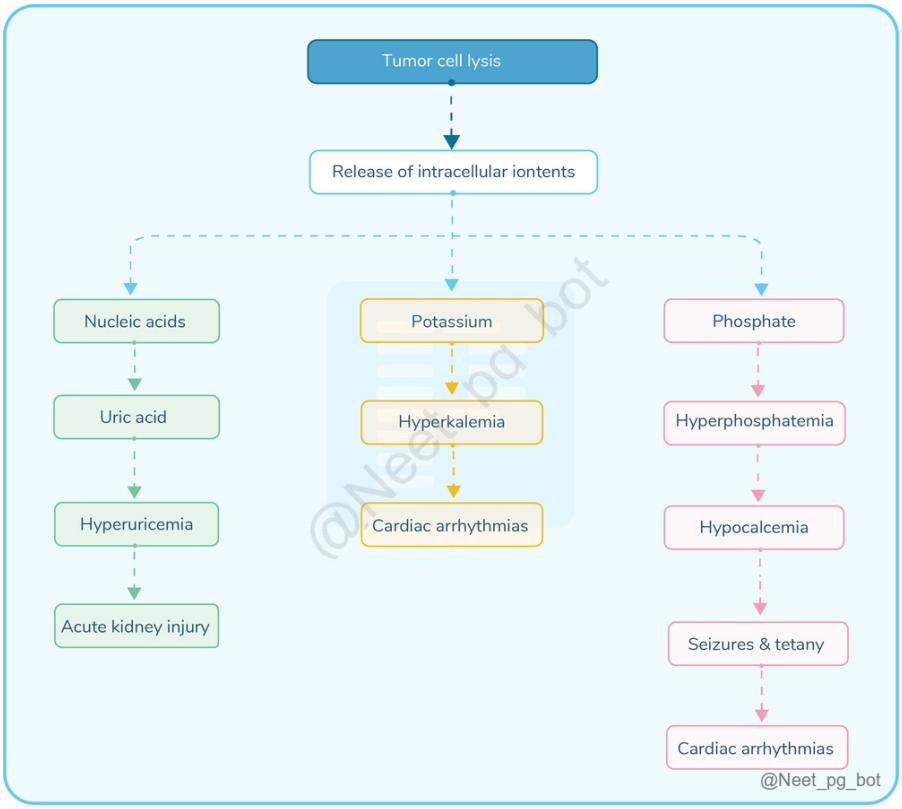
D. Hyperphosphatemia

Correct Answer: C. Hypercalcemia

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Tumor lysis syndrome (TLS) is a potentially life-threatening oncological emergency occurring when large numbers of cancer cells are rapidly destroyed. It results in several metabolic derangements, but hypercalcemia is not typically observed. Metabolic derangements associated with Tumor Lysis Syndrome: Hyperuricemia Hyperkalemia Hyperphosphatemia Hypocalcemia



References:

Sabiston’s Textbook of Surgery, 21st Edition, Pages 88-89.

Schwartz’s Principles of Surgery, 11th Edition, Page 99.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q11: A 50-year-old male who has been taking chemotherapy for chronic leukaemia for 2 years was having shortness of breath, dizziness, and flank pain for 3 days. His investigations revealed elevated serum uric acid, phosphate and potassium levels and decreased calcium levels. Which of the following is not the management of this condition? (Q849419)

A. Aggressive hydration

B. Allopurinol

C. Bisphosphonates

D. Hemodialysis

Correct Answer: C. Bisphosphonates

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The given clinical scenario suggests an oncological emergency known as Tumor lysis syndrome, in which bisphosphonates are not used for management. Tumor Lysis Syndrome An oncological emergency which results when the release of intracellular metabolites overwhelms the kidney's excretory capacity during cancer treatment. Due to tumour cell lysis, there is the release of uric acid, potassium and phosphorus, leading to hyperuricemia, hyperkalemia and hyperphosphatemia, respectively, which in turn leads to hypocalcemia and acute renal failure. This condition is commonly seen in poorly differentiated lymphomas (high-grade lymphoma, Burkitt's lymphoma) and leukaemias (chronic leukaemia, ALL-acute lymphoblastic leukaemia). Management includes, Aggressive hydration to correct plasma volume (Option A) Correction of lactic acidosis by Sodium bicarbonate) Correction of hyperuricemia by Allopurinol, Rasburicase, etc. (Option B) Hemodialysis is also done in case of renal failure. (Option D)

References:

Schwartz's Principles of Surgery, 11th Edition, Pages 99-100.

↑ *Back to this question in Part A*

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Q12: A 48-year-old male with small cell carcinoma of the lung presents with cyanosis of the neck and face, epistaxis, headache, dizziness and swelling over the face, neck and upper chest. He is irregular regarding chemotherapy sessions. Chest x-ray revealed a widening of the superior mediastinum. What is the investigation of choice in this condition? (Q849420)

A. Chest x-ray

B. MRI

C. Ultrasound

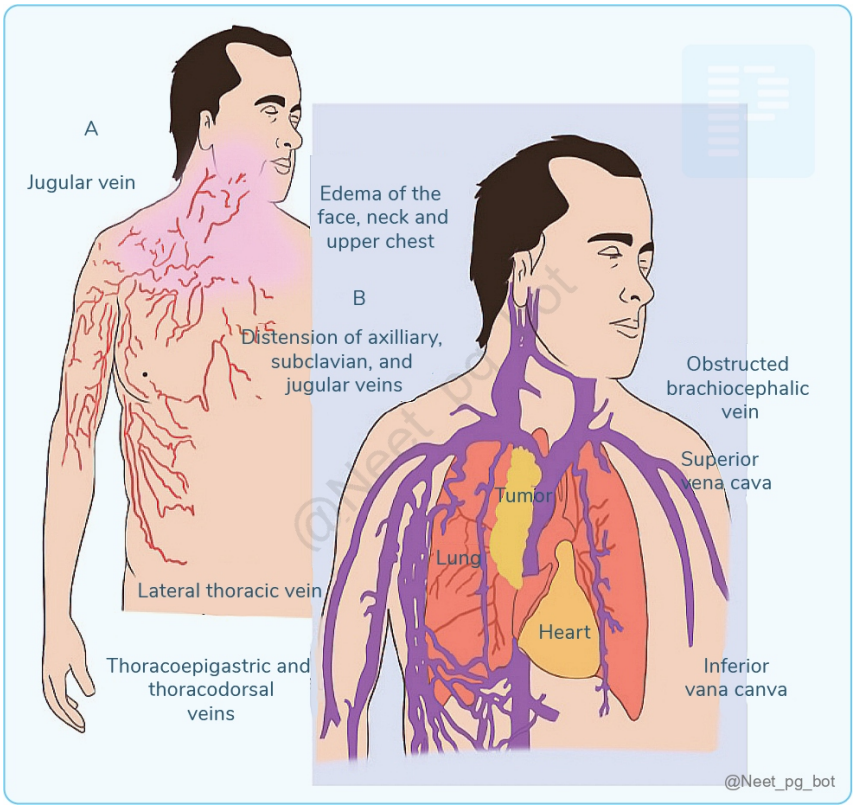
D. CT scan

Correct Answer: D. CT scan

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The given scenario suggests superior vena cava syndrome (SVC) , and a CT scan is the investigation choice for this conditio n. Superior Vena Cava (SVC) syndrome: It occurs when the superior vena cava is obstructed, often due to bulky mediastinal lymph nodes or a right upper lobe tumour compressing or invading the vessel. This obstruction severely reduces venous return from the head, neck, and upper extremities, leading to clinical manifestations such as: Variable degrees of swelling of head, neck and arms along with cyanosis. Headache, conjunctival oedema, dizziness, and syncope can be seen Some other features, such as nasal stuffiness, epistaxis, and tongue swelling, may also be seen. Dyspnea, dysphagia, cough and hoarseness of voice can also be seen in case of compression of mediastinal structures. Chest X-ray suggests a widening of superior mediastinum (Option A). The investigation of choice is CT scan (Option D) . MRI (Option B) and ultrasound (Option C) are not the investigations of choice, though mediastinal mass can be seen and diagnosed. Management of this syndrome depends on the cause. In cases of tracheal obstruction, a tracheostomy might be done.



References:

Schwartz’s Principles of Surgery, 11th Edition, Page 681.

↑ *Back to this question in Part A*

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Q13: Which of the following statements regarding desmoid tumours is NOT true? (Q849421)

A. It is often associated with FAP (familial adenomatous polyposis)

B. It arises in musculoaponeurotic structures

C. It is more common in females than males

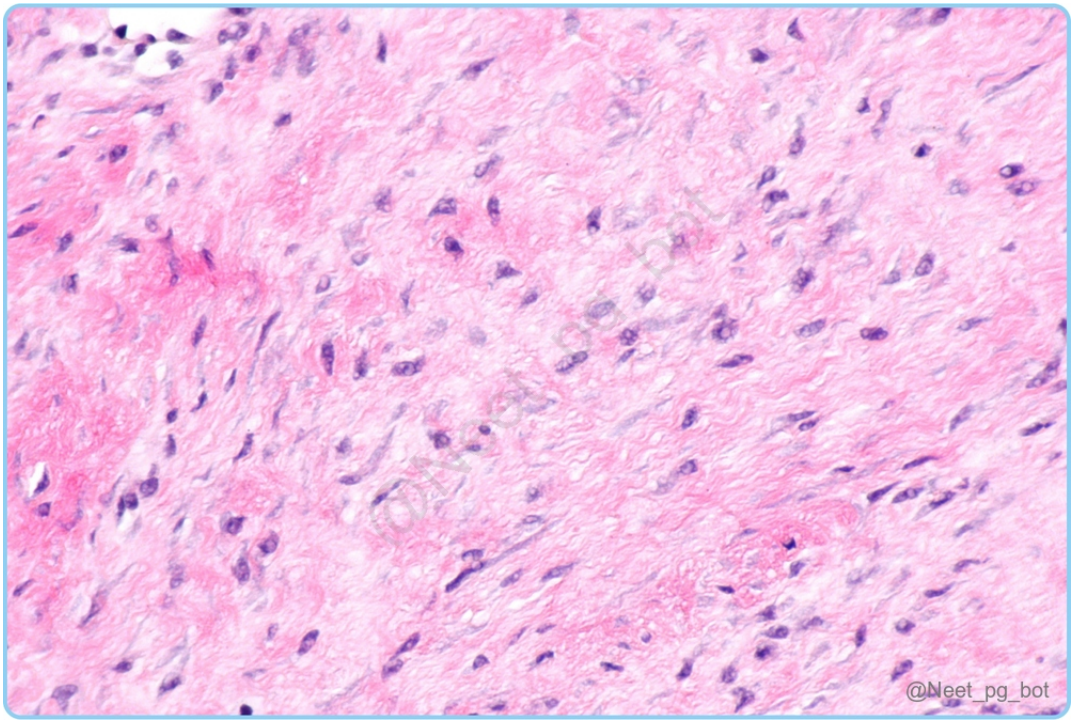
D. Estrogen inhibits its growth

Correct Answer: D. Estrogen inhibits its growth

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Desmoid tumour's growth is stimulated by estrogen. Desmoid tumour Also known as aggressive fibromatosis, it is a rare fibroblastic neoplasm with aggressive infiltrative behaviour but no metastatic potential. Generally, it arises in musculoaponeurotic structures (Option B) in the abdominal wall. This tumour can occur anywhere in the body but is more common in the abdominal wall. Predisposing risk factors include, History of surgical incision/trauma. Estrogen stimulates its growth (Option D) It is more commonly seen in females (Option C) It is often associated with FAP (familial adenosis polyposis) (Option A) and Gardner's syndrome. Biopsy is the investigation of choice which shows multinucleated plasmodial giant cells. Below is the histopathological image showing fibromatosis infiltrating skeletal muscles.



References:

Schwartz's Principles of Surgery, 11th Edition, Page 1557.

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1082.

Robbins & Cotran Pathologic Basis of Disease, 10th Edition, Page 1211.

↑ *Back to this question in Part A*

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• [09_Oncology] 052 Previous Year Questions

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[09_Oncology] 052 Previous Year Questions — Quick Jump

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Q7 (p. 3119)	*Q8 (p. 3120)*	*Q9 (p. 3120)*	*Q10 (p. 3121)*	*Q11 (p. 3122)*	*Q12 (p. 3123)*
Q13 (p. 3123)	*Q14 (p. 3124)*	*Q15 (p. 3124)*	*Q16 (p. 3125)*	*Q17 (p. 3126)*	

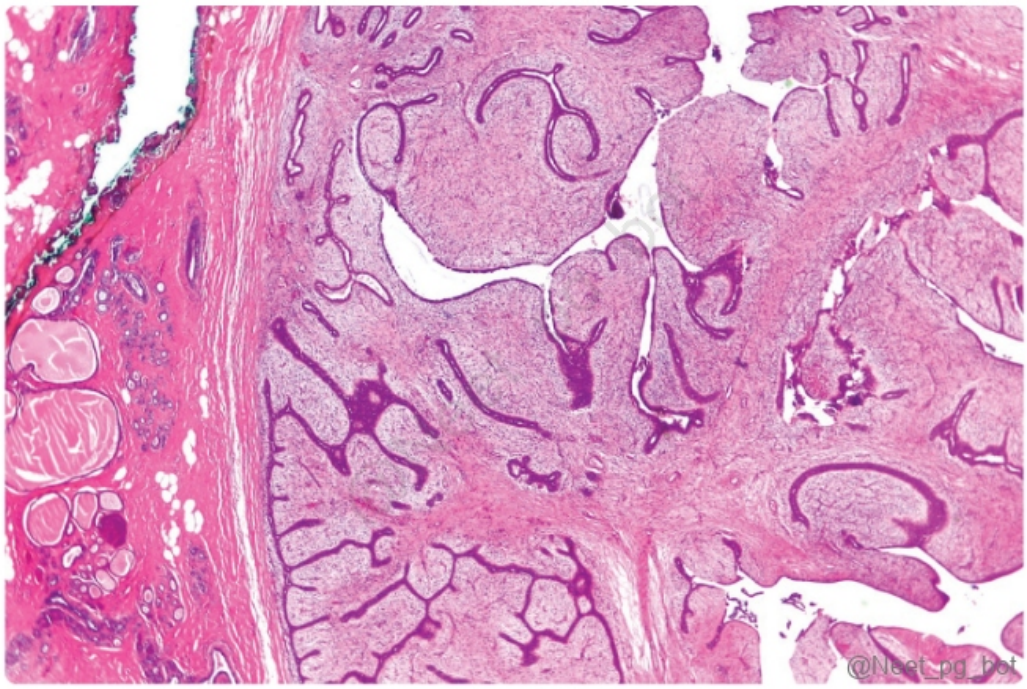
Q1: A 30-year-old female presents to the OPD with a 3 cm breast lump in the upper medial quadrant . The lump has an uneven, bosselated surface , and the overlying skin is mildly ulcerated . Microscopic examination reveals the given findings. What is the most likely diagnosis? (Q852716)

A. Phyllodes tumor

B. Galactocele

C. Fibroadenoma

D. Paget's disease



Correct Answer: A. Phyllodes tumor

Explanation: Phyllodes tumors are fibroepithelial breast tumors that exhibit stromal overgrowth and a leaf-like architecture on histology. They often present as large, bosselated (lobulated) masses with rapid growth . Ulceration of overlying skin suggests an aggressive nature, which is common in borderline or malignant phyllodes tumors . Histopathology confirms the diagnosis by showing stromal hypercellularity and cleft-like spaces resembling leaf-like structures . Phyllodes Tumor Feature Description Age Group 30-50 years Growth Rapid, large lobulated mass Surface Uneven, bosselated Histology Stromal overgrowth, leaf-like pattern Treatment Wide local excision / mastectomy Galactocele (Option B): Incorrect because it occurs in lactating women due to ductal obstruction , presenting as a smooth, cystic mass without ulceration. Fibroadenoma (Option C): Incorrect because it is a well-defined, mobile mass with smooth surface , lacking ulceration and stromal overgrowth. Paget's Disease (Option D): Incorrect because it involves the nipple-areolar complex , with eczematous changes , and is associated with underlying ductal carcinoma .

References:

Robbins & Cotran Pathologic Basis of Disease, 10th Edition, Page No.1062-63.

↑ *Back to this question in Part A*

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Q2: A patient present with abdominal pain on evaluation patient has raised mucin and CEA levels and normal amylase what might be the diagnosis? (Q879136)

A. Serous cystadenoma of pancreas

B. Pseudocyst of pancreas

C. Mucinous cystic neoplasm of pancreas

D. Intraductal papilloma of pancreas

Correct Answer: C. Mucinous cystic neoplasm of pancreas

Explanation: Correct Option C - Mucinous cystic neoplasm of pancreas: Mucinous Cystic Neoplasms (MCNs) characteristically show high mucin content and high CEA levels with normal or low amylase because they do not communicate with the pancreatic duct. Factor MCNs (Option C) Adenomas Pseudocysts (Option B ruled out) Serous cystadenoma (Option A ruled out) Seen in Perimenopausal women Varied History of pancreatitis Older woman Location Pancreatic body or tail Ampulla of Vater Anywhere in the pancreas Tail of pancreas Features Multilocular cysts, thick walls Polypoid submucosal masses Cysts with elevated amylase Lobular, hypodense lesion with multiple small cysts Diagnosis CEA levels (>400 ng/mL) Endoscopy History, imaging, amylase levels CECT: Central stellate scar, central sunburst calcification Intraductal papilloma (IPMN) (Option D) usually have high amylase because they communicate with the duct. Although CEA may be elevated, the normal amylase makes IPMN unlikely .

References:

Bailey & Love’s Short Practice of Surgery, 28th Edition, Page 1276,1281,1282.

↑ *Back to this question in Part A*

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Q3: A 40-year-old man presents with a lesion over his left ear. It slowly grew in size over the past 3 months, and he is a chronic smoker with 20 pack years. Vitals are within normal limits, and his physical examination is otherwise unremarkable. The histopathologic evaluation shows keratin pearls. What is the most likely diagnosis for this patient? (Q859628)

A. Nodular melanoma

B. Basal cell carcinoma

C. Squamous cell carcinoma

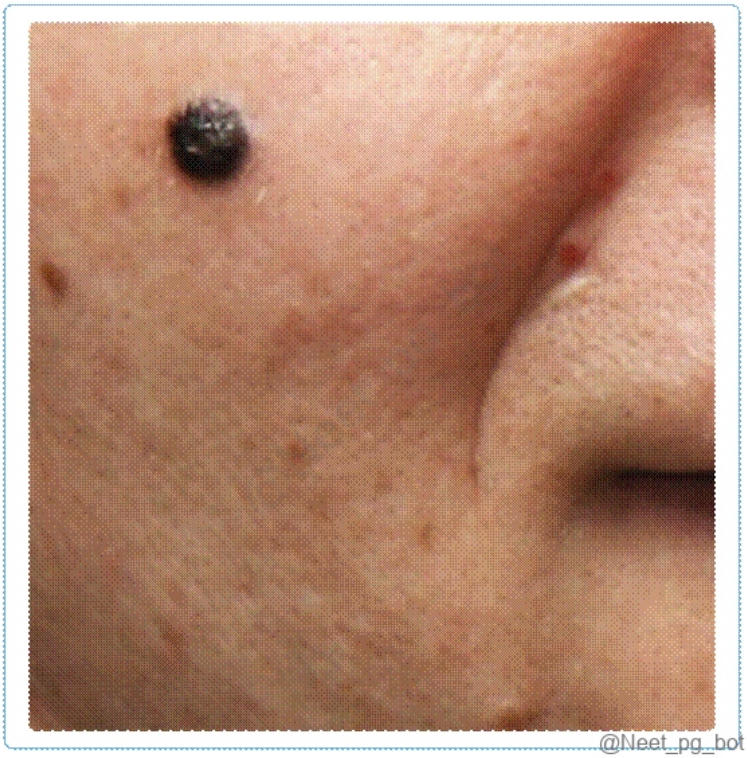
D. Malignant melanom



Correct Answer: C. Squamous cell carcinoma

Explanation: Based on the information provided, the most likely diagnosis for the lesion over the left ear in the 40-year-old chronic smoker with histopathologic evaluation showing keratin pearls is Squamous Cell Carcinoma. Squamous cell carcinoma Definition It is a type of skin cancer that arises from the squamous cells, which are the flat cells found in the epidermis, mucous membranes & tissues lining your organs. It is the second most common type of skin cancer after basal cell carcinoma. Risk factors High sunlight exposure Arsenic exposure. Immunosuppression (organ transplant, HIV) Chronic lymphocytic leukemia Human papilloma virus. Presentation It commonly presents as papules, nodules, or plaques with induration and signs of photodamage like crusting and scaling. {{caption_text}} Diagnosis It involves physical examination and biopsy Histopathology Reveals characteristic keratin pearls. Treatment Primary treatment involves wide surgical excision with margins. Mohs micrographic surgery (MMS) aids in intraoperative histopathological examination. Advanced cases may require radiation or chemotherapy. Nodular melanoma (Option A) is a type of melanoma that is a malignant skin cancer originating from melanocytes. It typically appears as a darkly pigmented, elevated nodule with irregular borders. It often has a different histopathological appearance, with atypical melanocytes rather than keratinisation. {{caption_text}} Basal cell carcinoma (Option B) is the most common type of skin cancer, which commonly presents with non-healing ulcers, pearly or translucent papules or nodules with rolled borders, often associated with telangiectasias. Histologically, BCC arises from basal cells of the epidermis. {{caption_text}} Malignant melanoma (Option D) is a malignant tumour arising from melanocytes at the epidermal-dermal junction. It presents as a pigmented lesion that enlarges, ulcerates, or bleeds. They generally have abnormal melanocytes and lack keratinisation. {{caption_text}}




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References:

Rook’s Textbook of Dermatology, 9th Edition, Page 142.10

↑ *Back to this question in Part A*

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Q4: A 50-year-old lady presented with a 1.5 cm pigmented lesion on her face that was growing rapidly in size and associated with itching. The lesion is shown below. Which of the following is likely the diagnosis? (Q859627)

A. Dysplastic nevus

B. Congenital melanocytic nevus

C. Acquired melanocytic nevus

D. Malignant melanoma



Correct Answer: D. Malignant melanoma

Explanation: Given the rapid growth, pigmentation, and associated itching, the most likely diagnosis is Malignant melanoma. Malignant melanoma Definition Melanoma is a malignant tumour arising from melanocytes at the epidermal-dermal junction. Though it is a rare skin cancer, it has a high mortality rate. It presents as a pigmented lesion that enlarges, ulcerates, or bleeds. Risk factors Positive family history. Fair skin. Genetics: CDKN2A (chromosome 9p21), MC1R, and TYR genes. Nevus: Congenital melanocytic nevi. Junctional nevi. Atypical nevi. Dysplastic nevi. Diagnostic criteria (P neumonic : ABCDE) Asymmetry: Irregular shapes. Border: Irregular. Colour: Various colours present or uneven distribution. Diameter: > 6 mm . Evolution: Changes in lesion over time (size, shape, itching, or bleeding) Investigations Clinical examination. Dermoscopy. Biopsy. Immunohistochemistry: The markers are S-100, HMB-45 (the most specific), Melan-A (MART-1), and MITF. CT scan. Management Wide local excision (with margins measured before excision and determined by Breslow depth, sentinel lymph node biopsy indicated for tumours with a depth of >1.0 mm). If the tumour is aggressive: Immunotherapy. Chemotherapy. Targeted therapy. Interferon-■ is the only adjuvant treatment that has documented beneficial effects on overall survival. Dysplastic nevus (Option A), also called as atypical moles, are abnormal moles that have irregular borders, varied pigmentation, and larger size and are at higher risk of developing into melanoma. However, they typically grow slowly and don’t cause rapid enlargement or significant itching. Congenital melanocytic nevus (Option B) are present at birth and are usually large, pigmented moles. They generally grow slowly over time. They don't usually grow rapidly in adulthood or cause itching, unlike the lesion described in this case. They also have a higher risk of developing melanoma. Acquired melanocytic nevus (Option C) , also commonly called moles, is a benign, small, symmetrical, and well-defined lesions that develop during childhood or adolescence. They grow slowly and do not typically cause rapid changes or itching. This is in contrast to the features described in the patient’s presentation. {{caption_text}}



References:

Rook’s Textbook of Dermatology, 9th Edition, Pages 143.7 - 143.28

Harrison’s Principles of Internal Medicine, 21st Edition, Pages 587

↑ *Back to this question in Part A*

@Neet_pg_bot

Q5: Most common primary source of metastasis to the brain is: (Q859618)

A. Thyroid

B. Lung

C. Liver

D. Breast

Correct Answer: B. Lung

Explanation: The most common primary source of metastasis to the brain is lung cancer with approximately 47% of patients with non-small cell lung cancer (NSCLC) showing brain involvement. This high prevalence is due to

the vascular nature of the brain and the tendency of lung cancer cells to spread hematogenous Ca lung is the most common primary for metastasis to: (Pneumonic- KEPABS) K– Kidney E– Esophagus P– Pancreas A– Adrenal B– Brain S– Skin Thyroid (Option A) can metastasise to the brain, but it is not as common compared to lung cancer. Thyroid cancer more commonly spreads to the bones and lungs. Liver (Option C) cancer, particularly hepatocellular carcinoma, does not commonly metastasise to the brain. It usually spreads to the lungs and other abdominal organs. Breast (Option D) cancer is also a common cause of brain metastases, but it is not as common as lung cancer. However, it remains a significant cause, particularly in cases of advanced-stage breast cancer.

References:

Sabiston's Text Book of Surgery, 21st Edition, Page 1585

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↑ *Back to this question in Part A*

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Q6: A factory worker working in a plastic pipe factory presented to the OPD with weight loss and right upper quadrant abdominal pain for 6 months duration. He had hepatomegaly. Further investigation revealed that most of the liver was replaced by a hemorrhagic tumour with extensive necrosis. What can be the likely diagnosis in this case? (Q859608)

A. Cavernous hemangioma

B. Metastatic carcinoma of the liver

C. Angiosarcoma of the liver

D. Primary hepatocellular carcinoma

Correct Answer: C. Angiosarcoma of the liver

Explanation: The patient's occupation, history of weight loss , abdominal pain , and hepatomegaly , coupled with the imaging findings of extensive haemorrhage and necrosis , strongly point to Angiosarcoma of the liver as the likely diagnosis. Hepatic Angiosarcoma Definition It is a high-grade vascular malignancy that arises from the endothelial cells lining blood vessels or lymphatic channels. It is the most common sarcoma arising in the liver, especially in those with significant exposure to Vinyl chloride. Common in Men and elderly Risk Factors Arsenic, Radiation, Thorium dioxide (Thorotrast) Metastasis It can spread through lymphatic and hematogenous routes , but due to the tumour's vascular nature, hematogenous spread (via blood vessels) is more common. The liver and lungs are common sites of metastasis, reflecting the tumour's aggressive nature Clinical presentation It presents as a red-brown, indurated, and ulcerated skin lesion. Cavernous hemangioma (Option A) is the most common benign liver tumour. It appears as a discrete red-blue, soft nodule less than 2 cm in diameter, commonly located in a subcapsular location. It does not explain the severe symptoms or the findings of tumour necrosis and haemorrhage in this case. Metastatic carcinoma of the liver (Option B) refers to the spread of cancer from other sites to the liver.

While it can cause hepatomegaly and liver involvement, the description of extensive necrosis and hemorrhage is more suggestive of a primary malignant tumour. Primary hepatocellular carcinoma (Option D) is the most common primary malignancy of the liver. It typically presents with symptoms like hepatomegaly , weight loss , and abdominal pain . However, the extensive necrosis and hemorrhage described in this case are more characteristic of angiosarcoma rather than HCC .

References:

Robbins and Cotran's Pathologic Basis of Disease, 10th Edition, Page 522

Bailey & Love's Short Practice of Surgery, 28th Edition, pages 661, 662

↑ *Back to this question in Part A*

@Neet_pg_bot

Q7: Which of the following is the most commonly seen tumour in the retroperitoneal space? (Q856278)

A. Liposarcoma

B. Rhabdomyosarcoma

C. Synovial sarcoma

D. Neurofibroma

Correct Answer: A. Liposarcoma

Explanation: Liposarcoma is the most commonly seen malignant tumour of the retroperitoneum, accounting for a significant portion of retroperitoneal tumours. They are the most common adult sarcoma and commonly occur in the sixth and seventh decades. Three subtypes are: Well-differentiated: chromosome 12 amplification, including p53 inhibitor MDM2. Myxoid: t(12;16) translocation. Pleomorphic Rhabdomyosarcoma (Option B) is a malignant tumour arising from skeletal muscle progenitors. It is the most common soft tissue sarcoma in children and adolescents, and it commonly presents in the extremities, not the retroperitoneum. Synovial sarcoma (Option C) is a rare, slow-growing cancer that affects the soft tissues. It is commonly found in the arm, leg, or foot, and joints such as the wrist or ankle but it is not very common in retroperitoneum. Neurofibroma (Option D) is a benign nerve sheath tumour often associated with neurofibromatosis. While it can occur in the retroperitoneum, it is not as common as liposarcoma in that region.

References:

Bailey and Love's Short Practice of Surgery, 28th Edition, Page 1105

↑ *Back to this question in Part A*

@Neet_pg_bot

Q8: What is the most likely primary site of origin for metastatic liver adenocarcinoma with CK 7 (-), CK 20 (+), and CDX-1 (+) IHC markers? (Q856231)

A. Colon carcinoma

B. Breast carcinoma

C. Pancreatic carcinoma

D. Ovarian carcinoma

Correct Answer: A. Colon carcinoma

Explanation: The immunohistochemical (IHC) markers provided - CK 7 (-), CK 20 (+), and CDX-1 (+), suggest a colorectal origin for the metastatic liver adenocarcinoma. Cytokeratin 20 (CK 20) is a marker of epithelial origin expressed in colon cancer. CDX-1 is a transcription factor that is typically expressed in the nuclei of normal intestinal epithelium and is highly specific for colorectal carcinomas. CK7 CK20 CDX1 Colon cancer (-) ve (+) ve (+) ve Breast cancer (Option B ruled out) (+) ve (-) ve (-) ve Pancreatic cancer (Option C ruled out) (+) ve (+) ve (-) ve Ovarian cancer (Option D ruled out) (+) ve (-) ve (-) ve

References:

Robbins and Cotran, Pathological Basis of Disease, 10th Edition, Pages 993, 719, 593, 1056, 718.

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Q9: Match the following: A. Marjolin ulcer over the dorsum of foot measuring 3cm x 2cm 1. Excision biopsy B. 1.5 cm cervical lymph node in the neck 2. Core needle biopsy C. Soft tissue sarcoma over mid-thigh 3. USG guided FNAC D. Solitary thyroid nodule 4. Wedge biopsy (Q855301)

A. A-1, B-2, C-3, D-4

B. A-4, B-1, C-2, D-3

C. A-3, B-2, C-1, D-4

D. A-4, B-3, C-2, D-1

Correct Answer: B. A-4, B-1, C-2, D-3

Explanation: Correct answer B) A-4, B-1, C-2, D-3 Condition Investigations Marjolin ulcer over the dorsum of foot measuring 3cm x 2cm Wedge biopsy (removing a small wedge-shaped tissue sample from the nodule) is commonly performed on a Marjolin ulcer (a malignant transformation in a chronic non-healing wound). 1.5 cm cervical lymph node in the neck Excision biopsy is commonly used to evaluate a lymph node. Soft tissue sarcoma over mid-thigh Core needle biopsy involves obtaining a small cylindrical core of tissue from the lymph node for pathological examination. Solitary thyroid nodule USG guided FNAC is used to evaluate a solitary thyroid nodule by guiding a needle into the tumour to collect cells for cytological analysis.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 179, 842, 866.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q10: What is the meaning of neoadjuvant chemotherapy in the context of a 54-year-old woman diagnosed with stage 2A cervical cancer? (Q855282)

A. Chemotherapy is given along with radiation.

B. Chemotherapy is given during surgery.

C. Chemotherapy is given before radical surgery to reduce the bulk of the tumour.

D. Chemotherapy is given after radical surgery for micrometastases.

Correct Answer: C. Chemotherapy is given before radical surgery to reduce the bulk of the tumour.

Explanation: Neoadjuvant chemotherapy refers to chemotherapy given before surgery to reduce the tumor size, making the surgery more effective and improving outcomes. Neoadjuvant Systemic Therapy (NAST) refers to treatments like neoadjuvant chemotherapy (NACT), targeted therapy, or hormonal therapy administered before surgery. The goal is to shrink the tumour and assess its in vivo response to therapy. Indications for Neoadjuvant Chemotherapy (NACT): Locally advanced breast cancer (T3, T4, N2, N3): To reduce tumor size. Select cases of early breast cancer : To downsize the tumour for breast conservation surgery (BCS). HER2/neu-positive tumors . Triple-negative breast cancer (TNBC). Premenopausal women (age <50 years). Patients with axillary node metastasis . Neoadjuvant Targeted Therapy: Administered for HER2/neu-positive tumours >5 mm in size, using trastuzumab and pertuzumab . Neoadjuvant Hormonal Therapy: Offered to elderly or frail women with ER and/or PR-positive advanced tumours who are unfit for chemotherapy. This therapy takes longer (3-6 months) for a clinical response to become evident. Other options: Option A: Chemotherapy is given along with radiation - This describes concurrent chemoradiation, not neoadjuvant therapy. It is the standard of care for stage IIB–IVA disease. Option B: Chemotherapy is given during surgery - There is no intra-operative chemotherapy used in cervical cancer (HIPEC is for peritoneal cancers—unrelated here). Option D: Chemotherapy is given after radical surgery for micrometastases - This defines adjuvant chemotherapy, not neoadjuvant.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 933

↑ *Back to this question in Part A*

@Neet_pg_bot

Q11: A patient with a known case of HTN came in with complaints of headaches for five days. All classical signs, increased metanephrine levels, and other investigations indicate pheochromocytoma. What is the best imaging modality for this patient? (Q820147)

A. CECT Chest and Abdomen

B. Sestamibi scan

C. MIBG

D. USG

Correct Answer: C. MIBG

Explanation: Correct Option C - MIBG MIBG scintigraphy helps locate and visualize pheochromocytomas or paragangliomas, even in cases where these tumors may not be easily seen with other imaging methods. It is particularly valuable for detecting extra-adrenal (paragangliomas) and metastatic lesions. It is valuable for confirming the diagnosis of pheochromocytoma, assessing the extent of disease (staging), and identifying the presence of metastases to other areas of the body. Incorrect Options: Option A - CECT (Contrast-Enhanced Computed Tomography) Chest and Abdomen: CECT provides detailed cross-sectional images of the chest and abdomen, allowing visualization of the adrenal glands and any potential tumors. It can help determine the size, location, and characteristics of the tumor, as well as its potential involvement with nearby structures. But it is not IOC for pheochromocytoma Option B - Sestamibi Scan: Sestamibi scans are typically used for parathyroid imaging and localizing certain types of tumors. They are not the most appropriate imaging modality for pheochromocytoma evaluation. Option D - USG (Ultrasound): Ultrasound may be used as an initial screening tool for certain abdominal conditions, but it is not the preferred imaging modality for diagnosing or localizing pheochromocytoma. This may not provide the level of detail needed to assess the adrenal glands and surrounding structures

References:

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↑ *Back to this question in Part A*

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Q12: A 45-year-old female presents with redness and a Peau d'orange appearance involving more than 2/3 of her breast, without any palpable lump in the breast. On further evaluation, it is found that the skin involvement extends to the chest wall and is suggestive of inflammatory carcinoma . What is the appropriate TNM staging for this patient? (Q820110)

A. T4a

B. T4b

C. T3

D. T4d

Correct Answer: D. T4d

Explanation: of correct answer.

↑ *Back to this question in Part A*

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Q13: A female presents with a non-palpable lump in the breast. The biopsy and IHC results reveal Luminal A. What characteristics are included under Luminal A? (Q857277)

A. ER positive, PR positive, Her2 neu positive

B. ER positive, PR positive, Her2 neu negative with low proliferation

C. ER positive, PR positive, Her2 neu negative with high proliferation

D. Triple-negative

Correct Answer: B. ER positive, PR positive, Her2 neu negative with low proliferation

Explanation: Luminal A is characterised by being ER positive, PR positive, and Her2 neu negative. It is the most common breast cancer subtype, characterised by low cell proliferation activity and the best prognosis among all subtypes. Molecular classification of breast cancer: Subtype ER Status PR Status HER2 Status Ki-67 Status Characteristics Luminal A + + - Low Generally, it is low grade, has a better prognosis, and is responsive to hormonal therapy. Luminal B + + or - + or - High Higher grade, poor prognosis compared to Luminal A, may require targeted HER2 therapy following status. HER2-enriched - - + High Aggressive, higher grade, poor prognosis, requires targeted HER2 therapy. Basal-like - - - High Includes triple-negative breast cancer (TNBC),

highly aggressive, no targeted hormonal therapy. Claudin-low - - + or - Often High Often associated with poor prognosis and aggressive behaviour, typically lacks response to hormonal therapy.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 931

SRB's Manual of Surgery, 6th Edition, Page 533

↑ *Back to this question in Part A*

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Q14: Spread of prostate cancer to lumbar vertebra is via? (Q852720)

A. Arterial spread

B. Local spread

C. Lymphatic spread

D. Venous spread

Correct Answer: D. Venous spread

Explanation: Prostate cancer commonly metastasizes to bones, especially the lumbar vertebrae. Batson’s venous plexus (valveless vertebral venous system) connects the prostatic venous plexus to the vertebral column , providing a direct route for metastasis. This system allows retrograde venous flow , especially in conditions of increased intra-abdominal pressure, facilitating spread to the lumbar spine . Spread of Prostate Cancer Route Mechanism & Common Sites Local spread Direct extension into the seminal vesicles, bladder, or rectum Lymphatic spread Obturator, internal & external iliac nodes are commonly involved Hematogenous spread Via Batson’s venous plexus → lumbar vertebrae, pelvis, femur, ribs Arterial spread Rare, usually occurs late in disease progression Arterial spread (Option A): Incorrect because arterial dissemination is rare in early prostate cancer and occurs mainly in advanced cases. Local spread (Option B): Incorrect because local invasion affects seminal vesicles, bladder, and rectum , but does not explain vertebral metastasis . Lymphatic spread (Option C): Incorrect because lymphatic metastasis affects pelvic nodes first (obturator, iliac) before distant sites.

References:

Bailey and Love’s Short Practice of Surgery, 28th Edition, Page 940, 941, 1531-1534

https://www.ncbi.nlm.nih.gov/books/NBK563248/

↑ *Back to this question in Part A*

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Q15: In a follow-up case of prostate cancer, what do we need to check? (Q852724)

A. Alkaline phosphatase

B. PSA

C. Testosterone

D. Acid phosphatase

Correct Answer: B. PSA

Explanation: Prostate-Specific Antigen (PSA): PSA is the most sensitive marker for monitoring prostate cancer progression and recurrence. Serial PSA measurements help assess treatment response and early detection of relapse . Role in Follow-Up: After radical prostatectomy: A rising PSA suggests biochemical recurrence . During androgen deprivation therapy (ADT): Persistent or rising PSA indicates treatment resistance . Post-radiotherapy: A gradual PSA rise may suggest local or metastatic progression . Follow-Up in Prostate Cancer Parameter Significance in Prostate Cancer Follow-Up PSA (Prostate-Specific Antigen) Most important marker; rising levels indicate recurrence or metastasis Alkaline Phosphatase (ALP) Marker for bone metastases , but not routinely used for follow-up Acid Phosphatase (PAP) Older marker, now largely replaced by PSA Testosterone Checked in hormone-sensitive cases on ADT to confirm castrate levels Alkaline Phosphatase (Option A): Incorrect because it is primarily used to detect bone metastases , not routine follow-up. Testosterone (Option C): Incorrect because it is only relevant in patients on androgen deprivation therapy (ADT) to confirm castration levels. Acid Phosphatase (Option D): Incorrect because Prostatic Acid Phosphatase (PAP) is an outdated marker, now replaced by PSA.

References:

Bailey and Love Short practice of surgery,28e, pg 1532, 1533, 1534, 1535.

↑ *Back to this question in Part A*

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Q16: What is the T stage for this tumour in the oral cavity? (Q853071)

A. T3

B. ■■■T4a

C. T2

D. ■■■T4b



Correct Answer: B. ■■■T4a

Explanation: The T stage is part of the TNM system to classify tumour extent. The image shows cancer involving both the lip and floor of the mouth , indicating invasion of adjacent structures, which is characteristic of T4a . Staging of Oral Cavity Cancer (AJCC 8th Edition): T (Primary Tumor): Tx Primary tumor cannot be assessed. Tis Carcinoma in situ. T1 Tumor ≤2 cm, ≤5 mm depth of invasion (DOI). T2 Tumor ≤2 cm, DOI >5 mm and ≤10 mm; or tumor >2 cm but ≤4 cm, and ≤10 mm DOI. (Option C ruled out) T3 Tumor >4 cm; or any tumor >10 mm DOI. (Option A ruled out) T4a Moderately advanced local disease - Invades through cortical bone, deep/ extrinsic muscle of tongue, maxillary sinus, or skin of the face. T4b Very advanced local disease - Invades masticator space, pterygoid plates, skull base, or encases internal carotid artery. (Option D ruled out) N (Regional Lymph Nodes): Nx Regional lymph nodes cannot be assessed. N0 No regional lymph node metastasis. N1 Metastasis in a single ipsilateral lymph node, ≤3 cm in greatest dimension. N2 N2a: Metastasis in a single ipsilateral node, >3 cm but ≤6 cm in greatest dimension. N2b: Metastasis in multiple ipsilateral nodes, all ≤6 cm). N2c: Metastasis in bilateral or contralateral lymph nodes, all ≤6 cm. N3 N3a: Metastasis in a lymph node >6 cm in greatest dimension, ENE(-). N3b: Metastasis in any node(s) with clinically overt ENE(+). M (Distant Metastasis): M0 No distant metastasis M1 Distant metastasis

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Pages 816, 817.

↑ *Back to this question in Part A*

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Q17: Which of the following drugs is preferred for lowering uric acid to prevent renal damage in tumor lysis syndrome ? (Q793897)

A. Furosemide

B. Rasburicase

C. Corticosteroids

D. Febuxostat

Correct Answer: B. Rasburicase

Explanation: Option B - Rasburicase: Rasburicase is the preferred treatment for reducing uric acid levels to prevent kidney damage in tumor lysis syndrome (TLS). TLS is a dangerous complication of cancer treatment where cancer cells release their contents into the bloodstream, causing a buildup of uric acid that can harm the kidneys. Rasburicase, an enzyme, converts uric acid into a less harmful compound, reducing the risk of kidney damage. Incorrect Options: Option A - Furosemide : Rasburicase is a loop diuretic used to treat fluid retention and edema caused by various medical conditions such as heart failure, liver cirrhosis, and kidney disease. Option C - Corticosteroids : This is incorrect, as corticosteroids have no renal protective role in tumor lysis syndrome. Option D - Febuxostat: Febuxostat is another xanthine oxidase inhibitor used to lower uric acid levels in patients with gout. It is similar to allopurinol in its mechanism of action and is not the preferred drug for preventing renal damage in tumor lysis syndrome.

References:

Prepladder Notes

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[10_Others] 053 Previous Year Questions — Quick Jump

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Q7 (p. 3137)	*Q8 (p. 3138)*	*Q9 (p. 3138)*	*Q10 (p. 3139)*	*Q11 (p. 3140)*	*Q12 (p. 3140)*
Q13 (p. 3141)	*Q14 (p. 3143)*	*Q15 (p. 3143)*	*Q16 (p. 3144)*	*Q17 (p. 3146)*	*Q18 (p. 3150)*
Q19 (p. 3151)	*Q20 (p. 3152)*	*Q21 (p. 3156)*	*Q22 (p. 3158)*	*Q23 (p. 3158)*	*Q24 (p. 3159)*
Q25 (p. 3160)	*Q26 (p. 3161)*	*Q27 (p. 3162)*	*Q28 (p. 3162)*	*Q29 (p. 3163)*	*Q30 (p. 3164)*
Q31 (p. 3166)	*Q32 (p. 3167)*	*Q33 (p. 3168)*	*Q34 (p. 3169)*	*Q35 (p. 3170)*	*Q36 (p. 3170)*
Q37 (p. 3172)	*Q38 (p. 3172)*	*Q39 (p. 3173)*	*Q40 (p. 3175)*	*Q41 (p. 3175)*	*Q42 (p. 3176)*
Q43 (p. 3177)	*Q44 (p. 3177)*	*Q45 (p. 3178)*	*Q46 (p. 3180)*	*Q47 (p. 3180)*	*Q48 (p. 3181)*
Q49 (p. 3183)	*Q50 (p. 3184)*	*Q51 (p. 3184)*	*Q52 (p. 3185)*	*Q53 (p. 3186)*	*Q54 (p. 3189)*
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Q67 (p. 3203)	*Q68 (p. 3203)*	*Q69 (p. 3204)*	*Q70 (p. 3205)*	*Q71 (p. 3205)*	*Q72 (p. 3206)*
Q73 (p. 3207)					

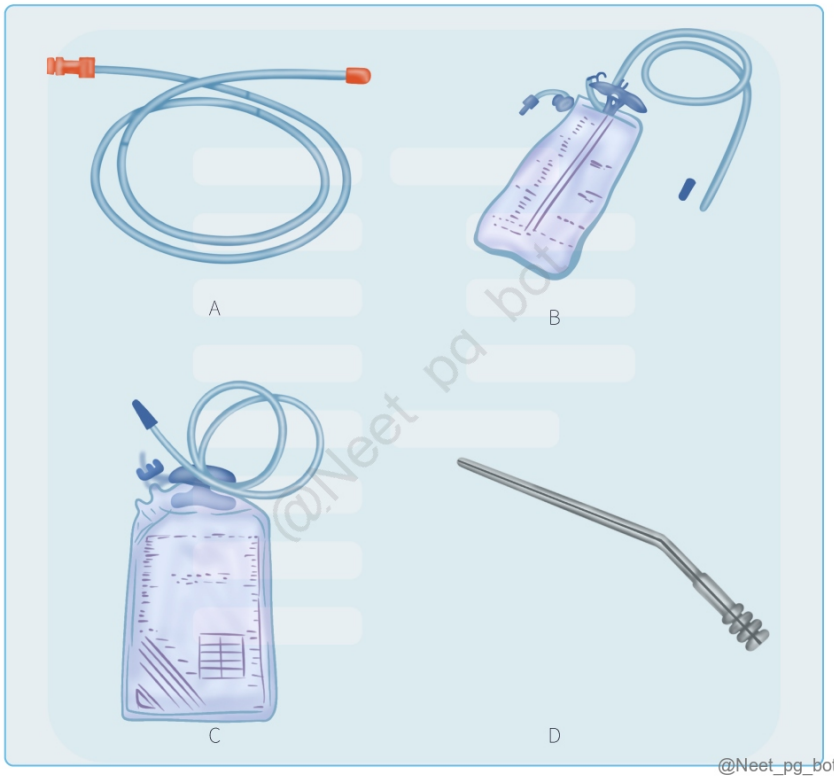
Q1: Match the following 1. Urine Bag 2. Nasogastric Tube 3. Underwater seal bag 4. Suction cannula (Q856303)

A. 1-D, 2-C, 3-A, 4-B

B. 1-C, 2-A, 3-B, 4-D

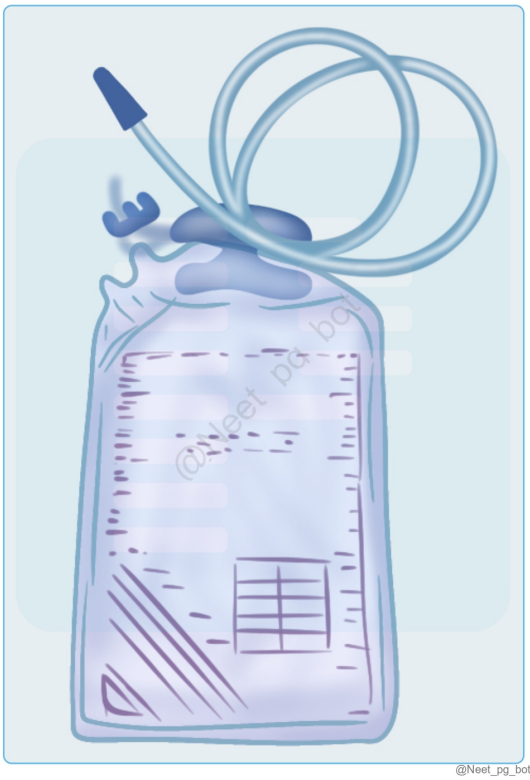
C. 1-D, 2-A, 3-C, 4-B

D. 1-B, 2-A, 3-C, 4-D



Correct Answer: B. 1-C, 2-A, 3-B, 4-D

Explanation: 1. Urine Bag It is a collection bag attached to a catheter inserted into the urinary bladder to collect and measure urine 2. Nasogastric Tube It is flexible tube inserted through the nose and down into the stomach for various diagnostic or therapeutic purposes. 3. Underwater seal bag A device used in chest drainage systems to maintain a seal and prevent air from entering the pleural space 4. Suction cannula {{caption_text}} It is a hollow tube used for the removal of fluid or secretions through suction.


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References:

Sabiston Text Book of Surgery, 21st Edition, Pages 112, 113

↑ *Back to this question in Part A*

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Q2: What steps should be taken to manage the case of a 24-year-old male who was hit by a motorbike while crossing the road, leading to abdominal injuries and bruising, with a blood pressure of 88/60 and IV fluids already administered, along with a positive FAST examination? (Q857115)

A. Abdominal CT scan

B. Abdominal MRI scan

C. Exploratory laparotomy

D. Diagnostic peritoneal lavage

Correct Answer: C. Exploratory laparotomy

Explanation: Exploratory laparotomy indicated in patients with a positive FAST assessment to avoid further bleeding in the abdomen. Hemodynamically unstable patients (BP <90 mmHg , signs of shock) with positive FAST should undergo emergency exploratory laparotomy to identify and control the source of bleeding. CT scan (Abdominal/Pelvic) (Option A) is indicated only for hemodynamically stable patients. Since this patient is unstable, CT is not appropriate . Abdominal MRI scan (Option B) MRIs are usually preferred for investigation of Soft tissue pathology, bone pathology, and head trauma. Diagnostic Peritoneal Lavage (DPL) (Option D) is rarely used now, as FAST is the preferred modality for detecting intra-abdominal bleeding.

References:

Sabiston’s Principles of Surgery, 21st Edition, Page 394.

↑ *Back to this question in Part A*

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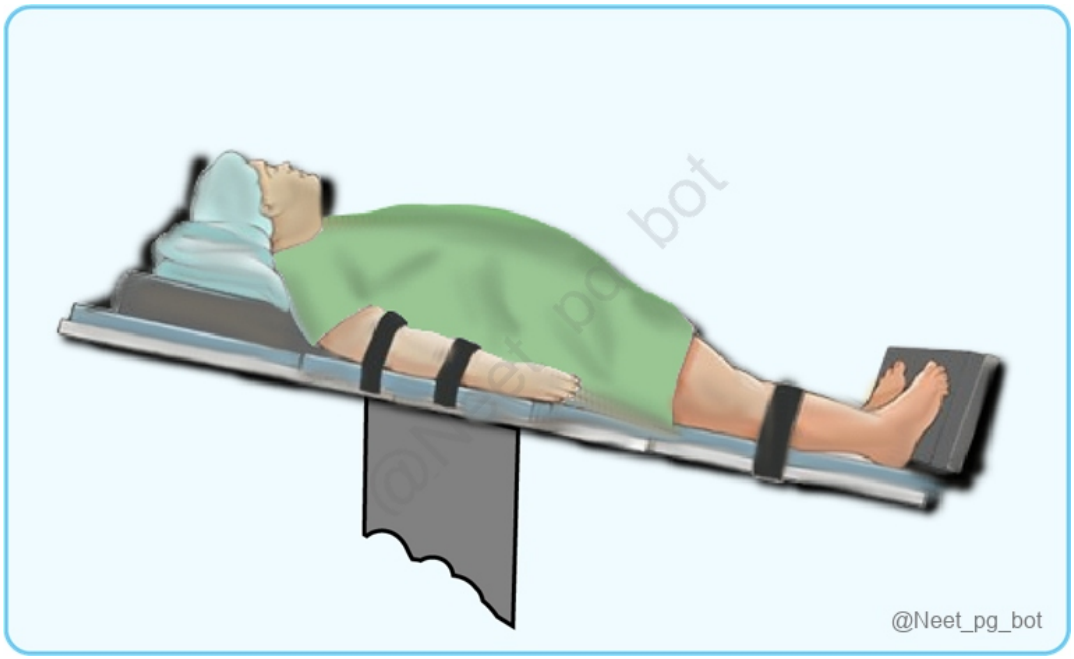
Q3: The position of the patient in the image shown below is known as: (Q856730)

A. Lloyd Davis position

B. Jack knife position

C. Trendelenburg position

D. Reverse Trendelenburg position



Correct Answer: D. Reverse Trendelenburg position

Explanation: The position of the patient shown in the image is known as the Reverse Trendelenburg position. The patient is placed with the head elevated above the level of the head and the feet lowered than the head. This position is often used during upper abdominal surgeries. Positioning on the Operating Table Position Description Uses and Complications Supine Position Most common position for general surgical procedures. Modifications of Supine position: Rose’s position Shoulder and Arm Extended Trendelenburg Position Reverse Trendelenburg Position Fowler's Position General surgeries. Rose's Position Supine with slight neck extension. Head and neck surgery. Shoulder and Arm Extended Supine with shoulder and arm extended. Axillary and breast surgery. Trendelenburg Position (Option C) Head end tilted down, knees slightly flexed. Pelvic procedures, resuscitating patients in shock. Reverse Trendelenburg Position The head end tilted upward, placing the head higher than the feet. Upper abdominal surgeries. Complication: Right shoulder pain due to CO2 collected under the right dome of the diaphragm during laparoscopic cholecystectomy Fowler's Position Semi-sitting with the trunk raised at 40° and knees bent. Neurosurgery, shoulder surgeries, patients with heart or respiratory failure. Complication: Increased risk of air embolism. Prone Position The patient is intubated and log-rolled onto the operating bed with help. Spinal surgery, extra levator abdominoperineal excision for rectal cancer. Jackknife Position (Option B) (Prone Position Modification) Chest supported, abdomen relaxed by flexing at the hips. Provides excellent access to the perineum. Complication: Positional asphyxia Lateral Decubitus or Kidney Position Lower leg flexed, pillow between legs, upper leg flexed in an exaggerated position. Draining abscesses, lateral thoracotomy, urological and retroperitoneal procedures. Complication: Increased risk of brachial plexus injury due to hyperextension Lithotomy Position Supine with hips and knees flexed, legs in stirrups, hips flexed to 90°. Gynecological, perineal, and urological procedures. Complication: Common peroneal nerve injury if legs are not supported properly Lloyd-Davies Position (Option A) (Lithotomy Modification) Supine with hips minimally flexed (~15°) and a 30° head-down tilt. Gynecological, perineal, and urological procedures.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Pages 94 - 96.

↑ *Back to this question in Part A*

Q4: Which of the following methods is accurate for measuring the nasogastric tube? (Q856572)

A. Tip of nose to ear lobule to xiphisternum

B. Angle of mouth to tragus to xiphisternum

C. Ala of nose to angle of mandible to xiphisternum

D. Angle of mouth to ear lobule to umbilicus

Correct Answer: A. Tip of nose to ear lobule to xiphisternum

Explanation: The correct method for measuring a nasogastric tube involves measuring the distance from the tip of the patient's nose to the ear lobule and then down to the xiphisternum, which is the lower end of the sternum. This measurement helps determine the appropriate length of the nasogastric tube that needs to be inserted. Nasogastric (NG) Tubes: Inserted through the nose and passed into the stomach Larger in diameter (typically 14-18 French) Common markings: Measurement markings in centimeters to indicate the insertion depth 'STOMACH' printed on the tube to confirm correct placement Indications: Decompression of the stomach (e.g., in intestinal obstruction) Enteral feeding in adults and older children Medication administration {{caption_text}}



References:

Bailey & Love's Short Practice of Surgery, 28th Edition, page 115,116

↑ *Back to this question in Part A*

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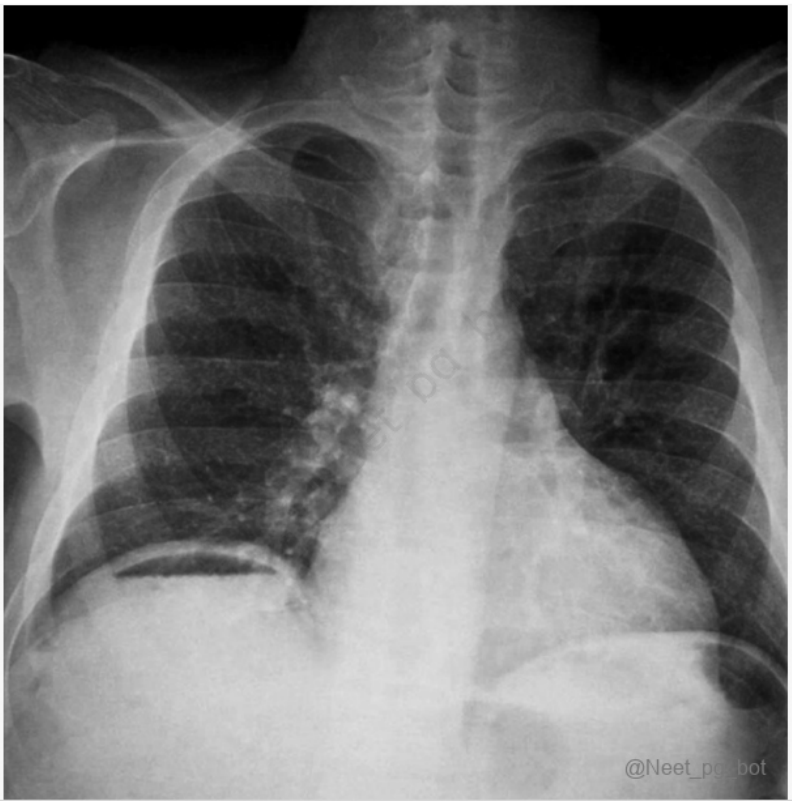
Q5: What might you suspect as the diagnosis for a 26-year-old male patient who arrives at the emergency department complaining of abdominal pain and constipation persisting for the last three days? The patient recalls being struck in the abdomen by a bull three days ago. Could yo u examine the provided X-ray to aid in your assessment? (Q856561)

A. Hemothorax

B. Hollow viscus perforation

C. Pneumothorax

D. Intestinal obstruction



Correct Answer: B. Hollow viscus perforation

Explanation: Hollow viscus perforation refers to the rupture or perforation of a hollow organ within the abdominal cavity. In this case, the patient's symptoms of abdominal pain and obstipation, along with a history of abdominal trauma from a bull gore, raise suspicion for a hollow viscus injury. The X-ray suggestive of perforation, such as free air under the diaphragm Hemothorax (Option A) Accumulation of blood in the pleural cavity due to trauma, does not match the patient's symptoms of abdominal pain and obstipation resulting from a bull gore injury. Pneumothorax (Option C) Air in the pleural cavity causing lung collapse, doesn't align with the patient's symptoms of abdominal pain and obstipation due to bull gore injury. Pneumothorax typically presents with sudden chest pain, breathing difficulty, and decreased breath sounds. Intestinal obstruction (Option D) Blockage of intestinal flow, partially fits the patient's presentation but doesn't explain the bull gore injury and X-ray findings of perforation.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, pages 373

↑ *Back to this question in Part A*

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Q6: What is the needle placement angle when using the interrupted suturing technique to suture a laceration in the ER? (Q856559)

A. 60 degrees

B. 70 degrees

C. 80 degrees

D. 90 degrees

Correct Answer: D. 90 degrees

Explanation: When using the interrupted suturing technique, the needle should be placed perpendicular to the skin surface, creating a 90-degree angle. This angle allows for proper penetration and closure of the wound edges. By inserting the needle at a right angle to the skin, the sutures can adequately hold the tissues together and provide optimal wound closure and healing. 60 degrees (Option A) would be too shallow for proper needle placement during interrupted suturing. 70 degrees (Option B) is also too shallow for interrupted suturing. 80 degrees (Option C) is closer to the correct angle of 90 degrees but is still not ideal for interrupted suturing.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Pages 95, 107, 108, 109.

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↑ *Back to this question in Part A*

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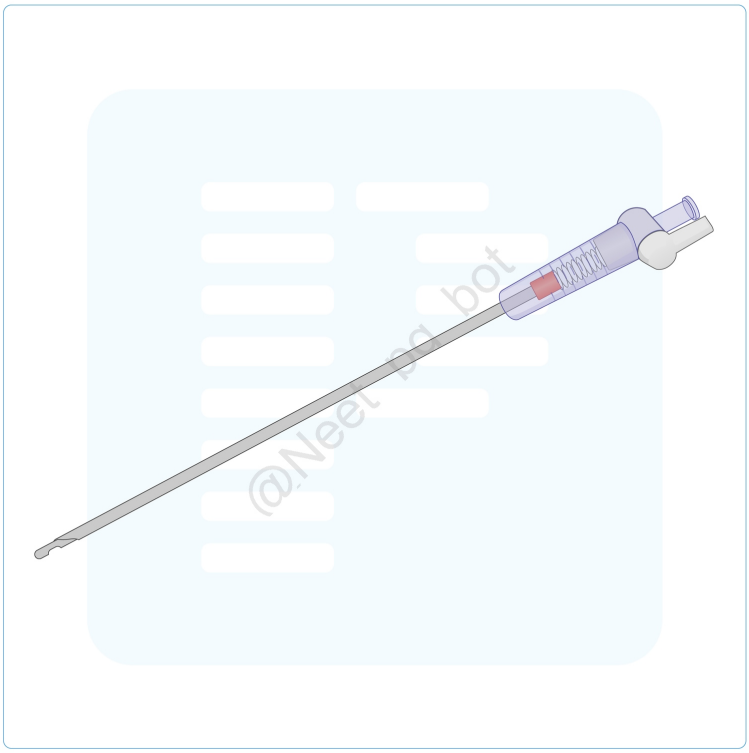
Q7: What is the name of the instrument depicted below, which is utilized for the creation of a pneumoperitoneum? (Q856535)

A. Veress needle

B. Morris' needle

C. Yankauer suction tip

D. Von Graefe needle



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Correct Answer: A. Veress needle

Explanation: The Veress needle is a surgical instrument used to create a pneumoperitoneum, which is the insufflation of carbon dioxide gas into the peritoneal cavity to create a working space during laparoscopic procedures. The Veress needle is inserted through a small incision or through the umbilicus, and its tip is equipped with a spring-loaded mechanism that allows for controlled penetration of the abdominal wall. Once inserted, carbon dioxide gas is introduced through the needle to inflate the peritoneal cavity. Morris' needle (Option B) Not commonly used for pneumoperitoneum; it is mainly used in general surgical procedures for drainage or infiltration. Yankauer suction tip (Option C) A rigid suction device used primarily in oropharyngeal and surgical suctioning , not for insufflation. Von Graefe needle (Option D) A specialized needle used in ophthalmic surgery , particularly for cataract procedures , unrelated to laparoscopic surgery

References:

Bailey & Love's Short Practice of Surgery (28th Edition) page 102, 103

↑ *Back to this question in Part A*

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Q8: What is triage for? (Q856526)

A. To prepare for a disaster

B. To assess the impact of a disaster

C. To classify the priority of treatment

D. To rehabilitate following a disaster

Correct Answer: C. To classify the priority of treatment

Explanation: Triage is the process of classifying patients based on the severity of their condition and the priority of treatment required. It is commonly used in emergencies or mass casualty incidents with limited resources. Triage helps in efficiently allocating resources by prioritising patients based on the urgency of their condition. To prepare for a disaster (Option A) is incorrect because the purpose of triage is not to prepare for a disaster but rather to assess and prioritise patients during a disaster or emergency situation. To assess the impact of a disaster (Option B) is incorrect because while triage is a part of disaster response, its main objective is not to assess the overall impact of a disaster but to categorise patients based on the severity of their injuries or illnesses. To rehabilitate following a disaster (Option D) triage is not involved in the rehabilitation process after a disaster. Triage focuses on initial assessment and prioritisation of patients during the acute phase of a disaster.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 449-452

↑ *Back to this question in Part A*

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Q9: Match the correct answer related to the nerve injuries in various surgeries: A. Breast surgery 1. External Laryngeal nerve B. Thyroid surgery 2. Hypoglossal nerve C. Submandibular excision 3. Phrenic nerve D. Thymectomy 4. Long Thoracic Nerve (Q856314)

A. A-1, B-2, C-3, D-4

B. A-2, B-3, C-4, D-1

C. A-3, B-4, C-1, D-2

D. A-4, B-1, C-2, D-3

Correct Answer: D. A-4, B-1, C-2, D-3

Explanation: A. Breast surgery 4. Long Thoracic Nerve This nerve is commonly injured during breast surgery, leading to a "winged scapula". Breast surgery can also lead to Thoracodorsal nerve injury. B. Thyroid surgery 1. External Laryngeal nerve It is a branch of the superior laryngeal nerve and innervates the cricothyroid muscle; it can be injured during thyroidectomy. It leads to hoarseness and difficulty in pitch modulation. C. Submandibular excision 2. Hypoglossal nerve It supplies motor innervation to the muscles of the tongue. It runs near the submandibular gland and can be injured during its excision, leading to deviation of the tongue towards the affected side. D. Thymectomy 3. Phrenic nerve The phrenic nerve may be injured during thymectomy, leading to diaphragm paralysis.

References:

Sabiston, Text Book of Surgery, 21st Edition, Page832,

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 865,

SRB's Manual of Surgery, 6th Edition, Page 441.

↑ *Back to this question in Part A*

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Q10: The components of qSOFA scoring include: A. Mental status B. Blood pressure C. Respiratory rate D. Heart rate (Q856309)

A. A & B

B. C & D

C. A, B & C

D. A, B, C & D

Correct Answer: C. A, B & C

Explanation: qSOFA is quick Sequential Organ Failure Assessment scoring, and it uses 3 components, i.e.; Respiratory rate (≥ 22 breaths per minute) Altered mental status (GCS ≤ 15) Low systolic blood pressure (≤ 100) qSOFA is a bedside score that helps identify patients at risk of death from a suspected infection. Heart rate is not included in the qSOFA score. (Statement D ruled out)

References:

qSOFA Link .

↑ *Back to this question in Part A*

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Q11: In a patient with liver cirrhosis, what is the primary cause of mortality when esophageal varices are present? (Q857119)

A. Hypovolemic shock

B. Cardiogenic shock

C. Obstructive shock

D. Distributive shock

Correct Answer: A. Hypovolemic shock

Explanation: Hypovolemic shock is circulatory failure due to loss of intravascular volume by variceal bleed. This loss of intravascular volume loss will lead to tissue hypoperfusion and tissue hypoxia. In cirrhosis, the blood flow to the liver is cut down, leading to more flow of blood through the veins of the oesophagus, leading to haemorrhage. Cardiogenic shock (Option B) is characterised by the impaired ability of the heart to pump blood. (especially by the left ventricle) Obstructive shock (Option C) is a condition wherein blood and oxygen fail to reach the organs. Examples include blood clots, collapsed lungs, tension pneumothorax, and pericardial Tamponade. Distributive shock (Option D) This leads to poor tissue perfusion due to excessive vasodilation and poor distribution of blood flow to the heart, brain, and kidneys.

References:

SRB’s Manual of Surgery 6th Edition, Page 105-107

Bailey & Love's Short Practice of Surgery 28th Edition, Page number 12.

↑ *Back to this question in Part A*

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Q12: A 32-year-old woman has been declared brain dead, and her family has chosen to donate her organs. Who would be the most suitable recipient of her organs? (Q856294)

A. 14-year-old child with multi-organ dysfunction syndrome

B. 50-year alcoholic man with liver cirrhosis with 1 month abstinence

C. 70-year-old woman with end-stage renal disease

D. 32-year-old woman with renal failure

Correct Answer: D. 32-year-old woman with renal failure

Explanation: A 32-year-old woman with renal failure is the most suitable recipient for the donor's organs as the age match between the donor and the recipient increases the likelihood of a successful transplant. When it comes to organ donation, the primary considerations for choosing the recipient include matching the donor's organ characteristics such as size, blood type, and tissue compatibility, as well as the recipient's health status and likelihood of receiving benefit from the transplant. Optimal transplantation involves choosing donors and recipients of similar age , among other factors, to minimise compatibility challenges 14-year-old child with multi-organ dysfunction syndrome (Option A): A 14-year-old child with multi-organ dysfunction syndrome is likely to have a more complicated prognosis, and the organs of a 32-year-old woman may not be the best match for a pediatric recipient. 50-year alcoholic man with liver cirrhosis with 1-month abstinence (Option B): Even though he has been abstinent for a month, liver transplant eligibility often requires a longer period of sobriety, as relapse can occur and impact the success of the transplant. Additionally, liver transplants are often prioritized for individuals with urgent needs or a better prognosis. 70-year-old woman with end-stage renal disease (Option C): The 70-year-old woman's potential benefit from a kidney transplant needs careful consideration of her age and associated comorbidities.

References:

Oxford academicLink,

NIHLink.

↑ *Back to this question in Part A*

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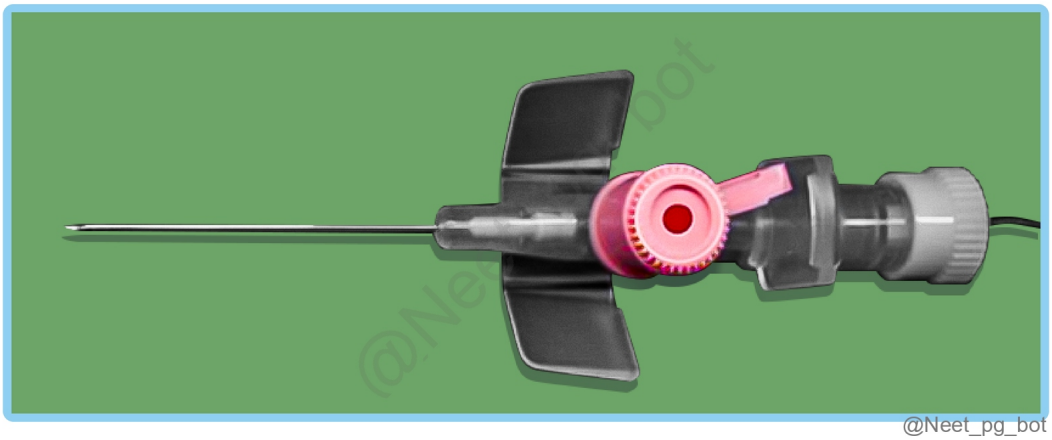
Q13: What is the size of the cannula shown in the below image? (Q856292)

A. 16 G

B. 18 G

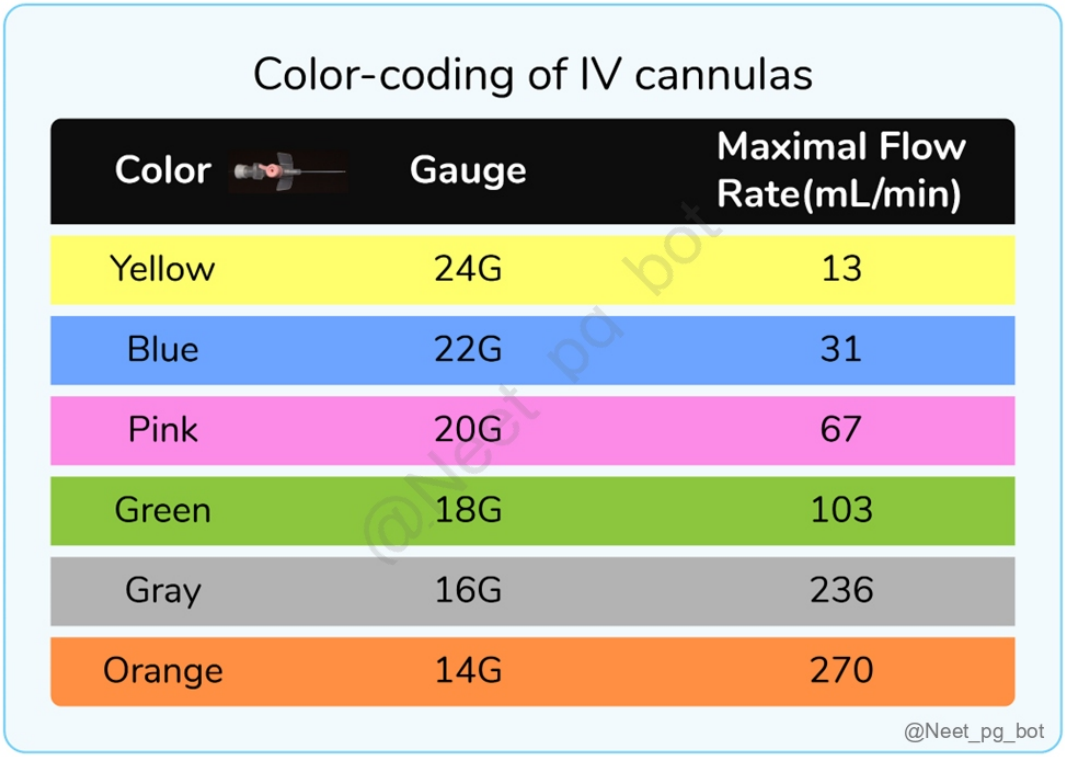
C. 20 G

D. 22 G



Correct Answer: C. 20 G

Explanation: The pink-coloured cannula refers to a cannula with a gauge size of 20. The pink cannula is used for rapid fluid replacement & routine blood transfusions. Colour code Gauge Flow rate (ml/min) Indications Orange 14 240 Used in surgical procedures and trauma Grey (Option A ruled out) 16 180 Used in surgical procedures and trauma Green (Option B ruled out) 18 90 In Trauma and quick blood transfusions Pink (Option C) 20 60 In IV fluids & blood transfusions Blue (Option D ruled out) 22 36 Used in children and older adults Yellow 24 20 Used in neonates and children Violet 26 13 Used in neonates



References:

Medscape Link

↑ *Back to this question in Part A*

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Q14: FAST stands for (Q856255)

A. First assessment with sonography in trauma

B. Focussed assessment with sonography in trauma

C. First abdominal sonography in trauma

D. Focussed abdominal sonography in trauma

Correct Answer: B. Focussed assessment with sonography in trauma

Explanation: Focussed assessment with sonography in trauma is the correct full form of FAST . It is a rapid, non-invasive ultrasound examination used primarily in trauma settings to detect free fluid (such as blood) in the abdomen or Thorax. It can be used to assess the hepatorenal, splenorenal, and pelvis spaces for fluid that is considered to be blood in a trauma case. It is a valuable tool in the early management of trauma patients as it helps identify life-threatening conditions, such as internal bleeding, which may require immediate surgical intervention. Other options A, C & D are not correct.

References:

Bailey and Love’s Short Practice of Surgery, 28th Edition, Page 373

↑ *Back to this question in Part A*

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Q15: A patient, after a road traffic accident, presented with pain in the abdomen. The resident examined the child and found that vitals were stable, and tenderness was present in the left lumbar region. Which is the best investigation of choice? (Q856254)

A. Contrast-enhanced CT scan

B. Retrograde urethrogram

C. Wait and watch

D. Emergency laparotomy

Correct Answer: A. Contrast-enhanced CT scan

Explanation: A CT scan is a non-invasive tool that provides detailed images of abdominal organs and can identify injuries, bleeding, or fractures in patients with abdominal pain after a road traffic accident. The most commonly injured organ in: Blunt trauma abdomen is the spleen > liver. Penetrating trauma is the liver. Gunshot injury is the small intestine > large bowel > liver > intra-abdominal vasculature. The most commonly injured part of the bowel in blunt trauma abdomen is the jejunum and the ileum. The most commonly injured structure in seat belt injury is the mesentery. First investigation done in blunt trauma abdomen: FAST (Focused Assessment with Sonography for Trauma). Investigation of choice for stable blunt trauma abdomen: CECT (Contrast-Enhanced CT scan). (Option A) Retrograde urethrogram (Option B) is used to assess urethral injuries, especially with pelvic fractures or blood at the meatus, but it isn't the best initial test for abdominal pain with left lumbar tenderness. Wait and watch (Option C) may be considered if the patient is stable with no immediate concern, but in trauma with abdominal pain and tenderness, proper investigation is crucial to rule out serious injuries. Emergency laparotomy (Option D) is a major surgery and should be done only if there's clear evidence of a life-threatening condition, like active bleeding or peritonitis. It's not the first choice for investigation here.

References:

Textbook of SRB’s Surgical Operations, 6th Edition, Page 139.

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 381, 382.

↑ *Back to this question in Part A*

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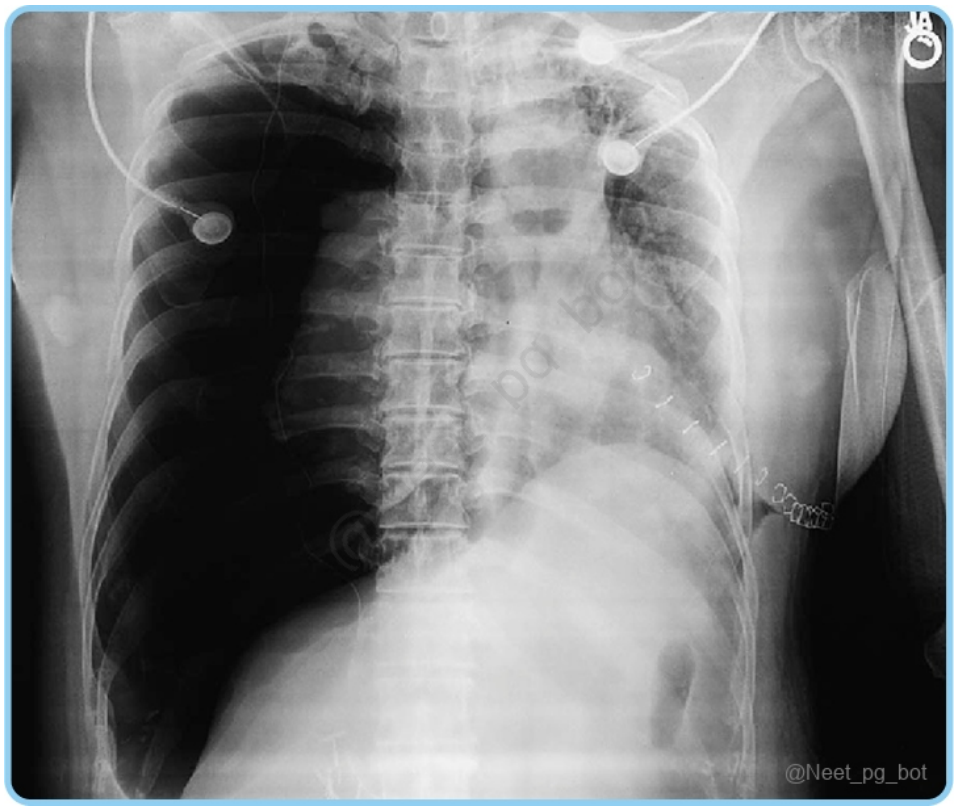
Q16: A patient following a road traffic accident presented with subcutaneous emphysema. On auscultation, there was no air entry on the right side. Vitals were unstable. What will be your immediate management? (Q856246)

A. Insertion of wide bore needle in the 2nd intercostal space

B. Wide bore needle decompression and IV fluids

C. Intubation and positive pressure ventilation

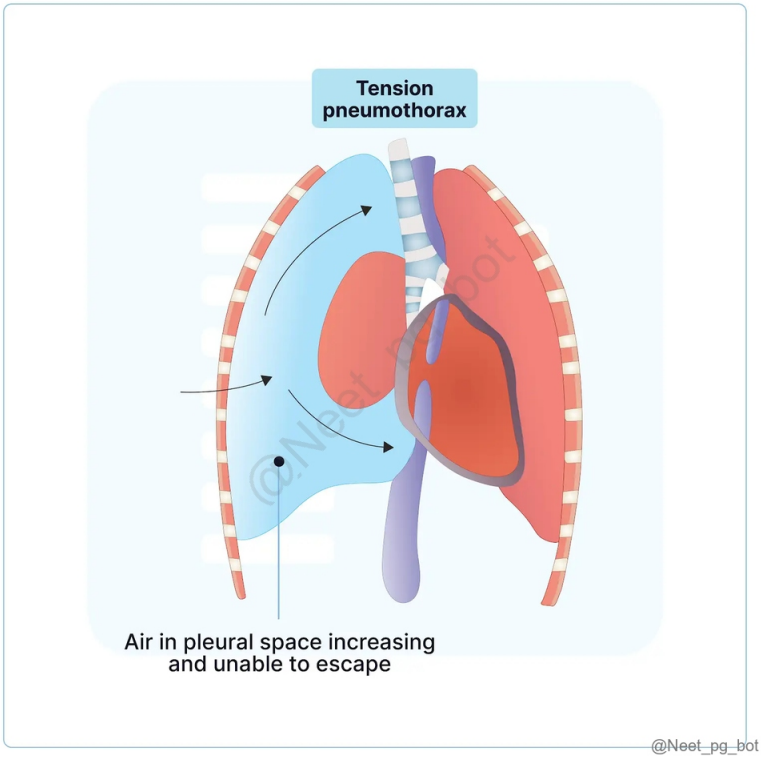
D. e-FAST



Correct Answer: A. Insertion of wide bore needle in the 2nd intercostal space

Explanation: The patient's clinical findings and X-ray confirm a right-sided Tension Pneumothorax and immediate management involves decompressing the pleural space by inserting a wide-bore needle in the 2nd intercostal space (since the age of the patient is not mentioned and we can assume the patient is a child and the options give in 2nd ICS). It is a life-threatening condition where air accumulates in the pleural cavity under pressure, causing lung collapse on the affected side, mediastinal shift , and severe impairment of cardiovascular function. Pathology: It occurs when air enters the pleural cavity through a "one-way valve" mechanism, leading to lung collapse and mediastinal shift towards the opposite side. ↑Pleural pressure→ Opposite lung compression→ ↓venous return→ ↓cardiac output and potentially sudden death . Aetiology: Penetrating chest trauma. Blunt chest trauma with parenchymal lung injury. Iatrogenic lung injury (e.g., central venous catheterisation), and mechanical positive-pressure ventilation. Clinical Features: Restlessness, tachypnea, dyspnea, tachycardia, and chest pain. Distended neck veins, hyper-resonance, and decreased or absent breath sound on the affected side. Late findings may include tracheal deviation and cyanosis. Hypotension and severe mediastinal/tracheal shift are also common. Management: Immediate decompression with a large-bore needle in the 2nd intercostal space at the midclavicular line or the "safe triangle" via needle thoracostomy or finger thoracostomy. (Option A) Followed by intercostal chest tube (ICT) placement in the 5th intercostal space in the anterior axillary line. Provide oxygen, analgesics, antibiotics, and ventilator support if necessary. Wide bore needle decompression and IV fluids (Option B): While needle decompression is the correct initial management for tension pneumothorax, IV fluids are secondary and do not directly address the life-threatening issue of air accumulation in the pleural space. The priority is to relieve the pressure with a needle insertion, followed by stabilization with fluids. Intubation and positive pressure ventilation (Option C) are important for managing respiratory failure or compromised airways, but in the case of a tension pneumothorax, these could worsen the condition by increasing the pressure in the chest. The first step should always be to decompress the pleural space to relieve pressure. e-FAST (Extended Focused Assessment with Sonography for Trauma) (Option D) exam is useful for detecting pneumothorax, hemothorax, or internal bleeding,

but in this case, the patient’s clinical signs strongly suggest a tension pneumothorax. Immediate decompression is needed before further diagnostic imaging.



References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 374.

Textbook of SRB’s Surgical Operations, 6th Edition, Page, 1101-1102.

↑ *Back to this question in Part A*

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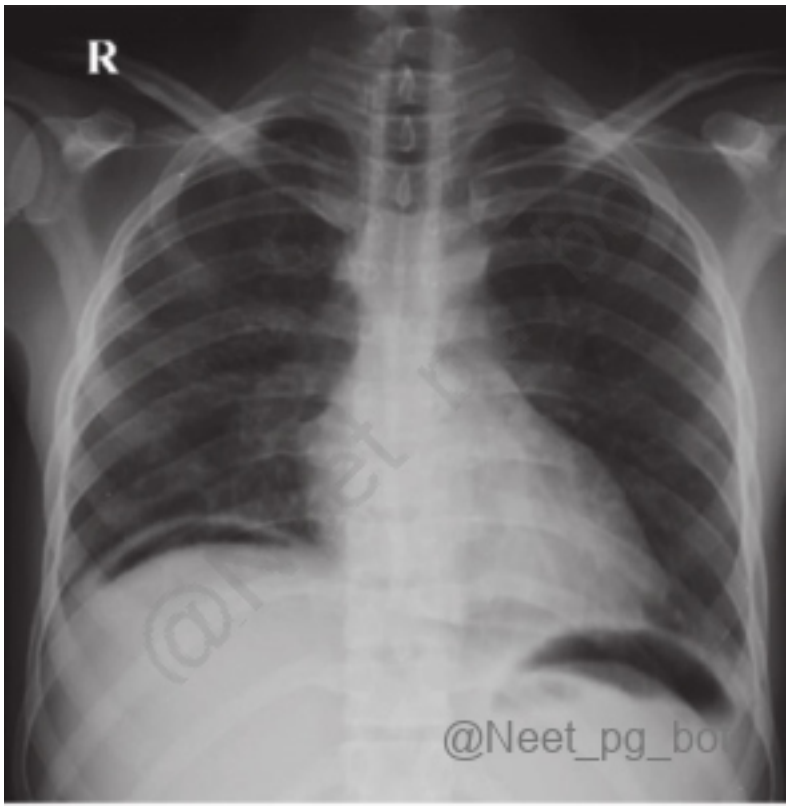
Q17: What is the most probable diagnosis for a 25-year-old patient who has been experiencing abdominal pain and fever for the past three days, based on the provided chest X-ray taken in an upright position? (Q856206)

A. Hollow viscus perforation

B. Gastric volvulus

C. Liver abscess

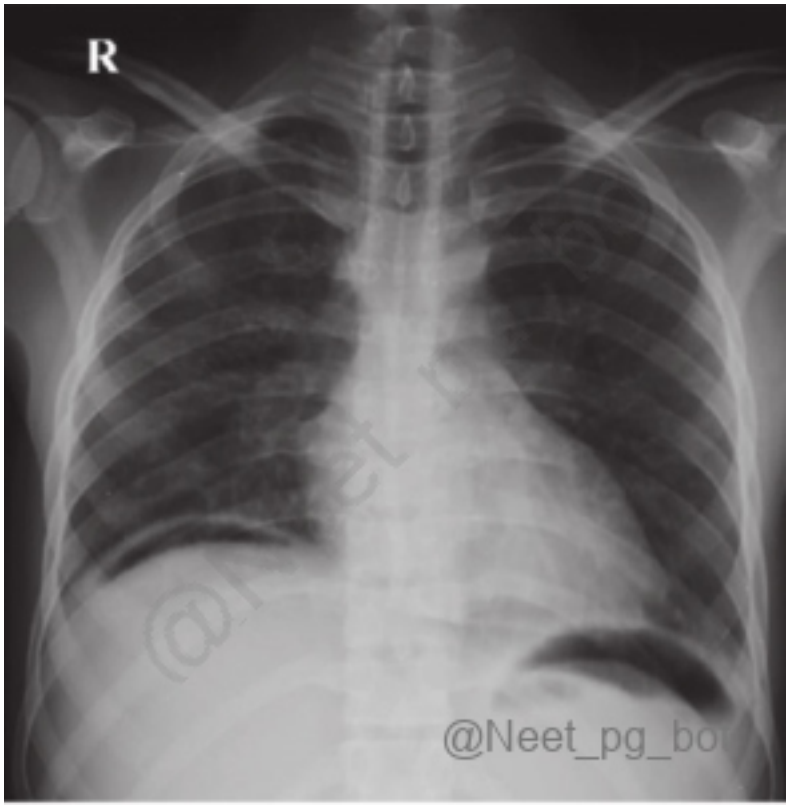
D. Empyema thoracis

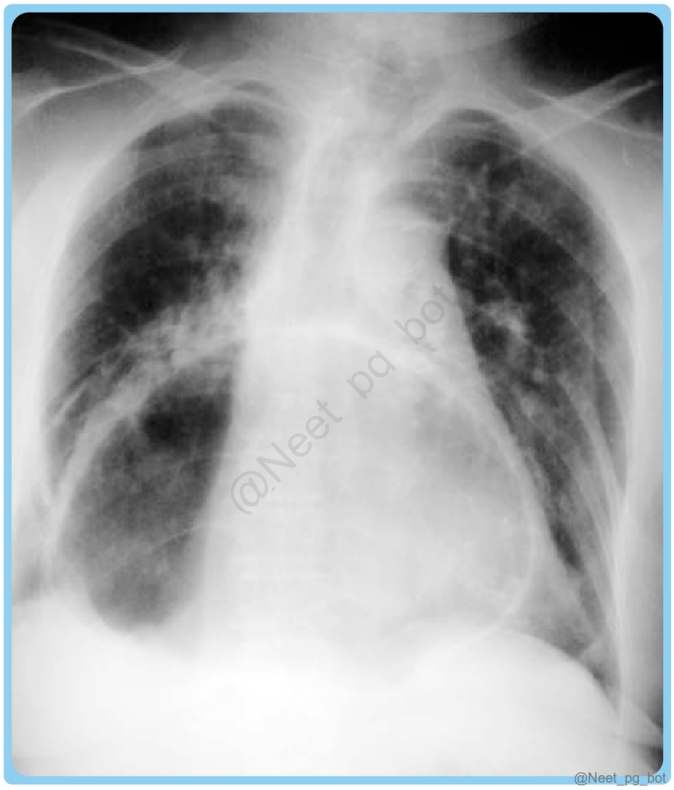


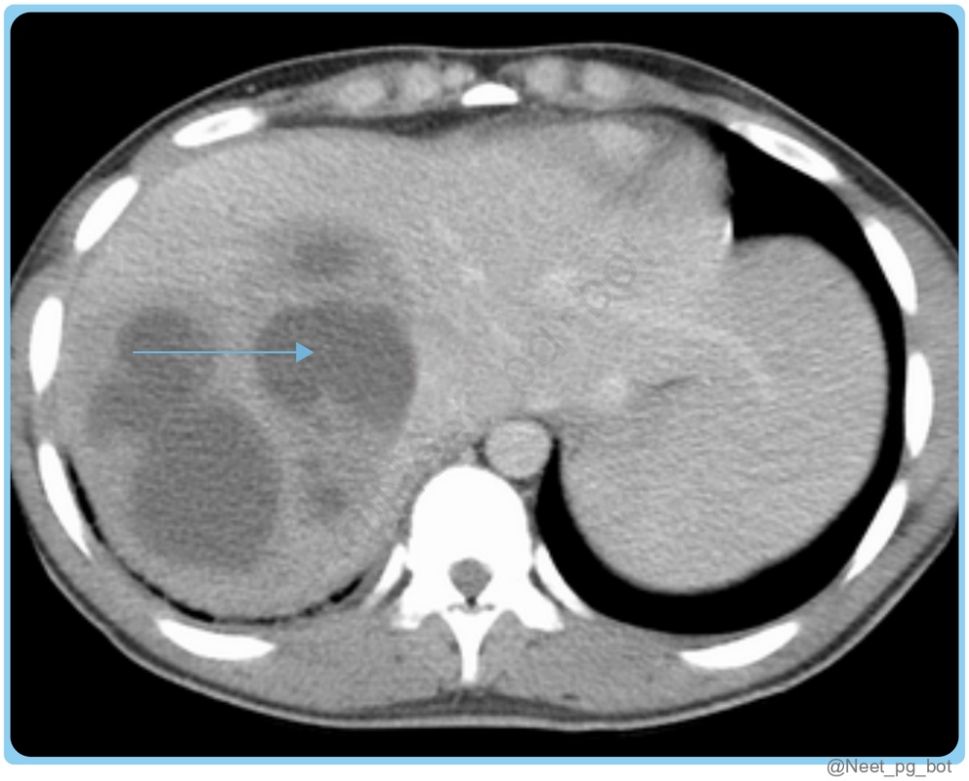
Correct Answer: A. Hollow viscus perforation

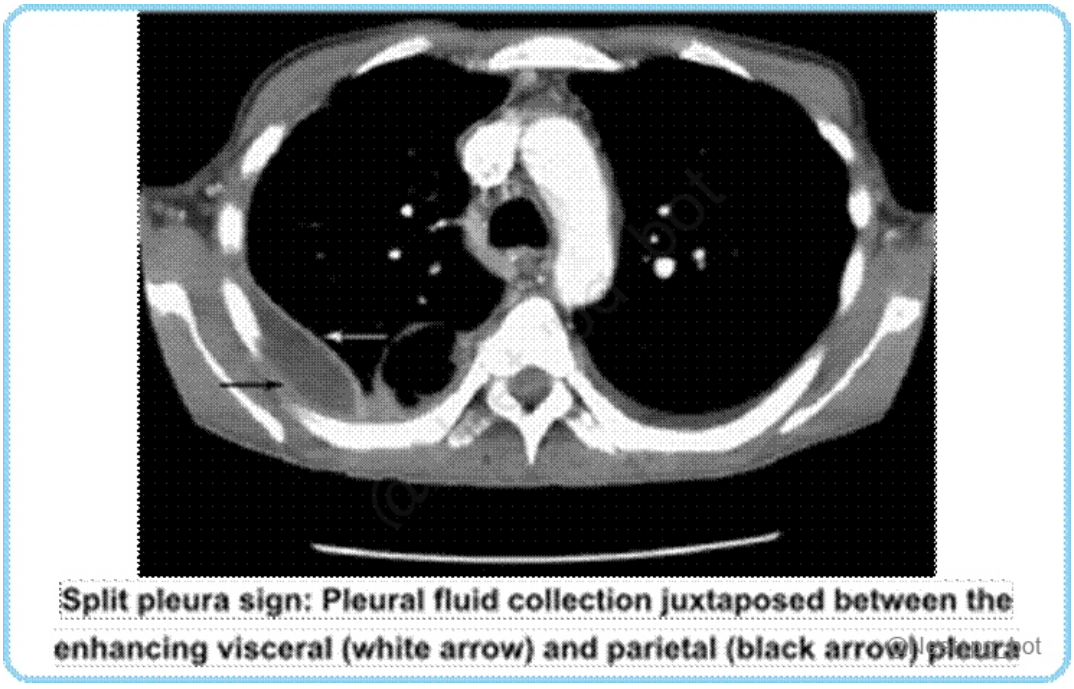
Explanation: The case of abdominal pain, fever, and an upright X-ray showing free air under the diaphragm is most likely diagnosed as hollow viscus perforation . The contents of the organ, including digestive juices and bacteria, can leak into the surrounding tissues or abdominal cavity, leading to a serious condition known as peritonitis. Diagnosis: Free air under the diaphragm (upright plain film taken at the level of the diaphragm). (Option A) Pneumoperitoneum Pneumoperitoneum refers to the presence of free gas in the peritoneal cavity, typically indicating a perforated viscus (e.g., perforated peptic ulcer). Causes: Common: Perforated peptic ulcers, bowel obstruction, inflammatory conditions, ischemia, injury during colonoscopy. Other causes without peritonitis: Postoperative (up to 7 days), peritoneal dialysis, sealed perforation, and tracking from pneumomediastinum. Diagnosis on Imaging: Erect CXR: Free gas is seen under the right hemidiaphragm (cupola sign) , but it is difficult to differentiate on the left due to gastric or colonic gas. Supine AXR: Right upper quadrant gas in the perihepatic, subhepatic space, Morrison's pouch, and ligament visualisation (e.g., falciform ligament). Rigler's Sign: Visualization of both sides of the bowel wall due to surrounding gas. CT Scan: Most sensitive; small volumes of gas seen in the liver or peritoneal recesses, often using broad window settings. Gastric volvulus (Option: B) occurs when the stomach twists around its axis, leading to obstruction and preventing the passage of food and fluids. It typically causes symptoms like vomiting, nausea, and distension, but not free air under the diaphragm, as seen in hollow viscus perforation. Imaging, such as X-rays or CT scans, may reveal an abnormal stomach position, often showing twisted loops. {{caption_text}} Liver abscess (Option C) appears as a well-defined dark area on ultrasound and a hypodense lesion with a defined rim on CT. It may cause fever and abdominal pain but doesn't cause free air under the diaphragm. Diagnosis is typically made with ultrasound or CT, which shows localised fluid collections. {{caption_text}} Empyema thoracis (Option D) is an infection in the pleural space, causing fever, cough, and pleuritic chest pain. It doesn't cause free air under the diaphragm. On X-ray, it shows a loculated pleural effusion, with possible diaphragm elevation. CT reveals thickened pleura and

fluid collections, while ultrasound aids in detecting and draining fluid. {{caption_text}}









References:

Sabiston Textbook of Surgery, 21st Edition, Page 1140

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↑ *Back to this question in Part A*

Q18: A patient presented with blunt trauma to the abdomen. On evaluation, liver injury was noted, for which primary repair was done. Coagulation function was monitored intraoperatively using the method shown below. What is the method used? (Q855836)

A. Thromboelastography

B. Plethysmography

C. Sonography

D. Elastography



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Correct Answer: A. Thromboelastography

Explanation: The method used for monitoring coagulation function in this patient undergoing primary repair for liver injury is thromboelastography (TEG). TEG is a test that studies the ability of blood to form a clot by studying its viscoelastic properties. Stages of Thromboelastogram Definition Normal value Problem it indicates Treatment Reaction time Time taken for the clot to start forming 7.5-15 mins Increased: Deficiency in clotting factors Decreased: Hypercoagulable states Fresh frozen plasma K time- clot firmness Time for the clot to reach fixed

strength 3-6 mins Fibrinogen dysfunction Cryoprecipitate Alpha angle Fibrin linking speed 45° and 55° Fibrinogen dysfunction Cryoprecipitate Maximum amplitude The highest vertical amplitude of TEG 50-60 mm Platelets (most often) Clotting factors Platelets Lysis in 30 mins Percentage of amplitude reduction 30 minutes after maximum amplitude 0-8% A high value indicates excess lysis of the clot Tranexamic acid Plethysmography (Option B) is a test used to measure changes in the volume of an organ or body part, often used for assessing lung function . It does not assess coagulation or blood clotting function. Sonography (Option C) or ultrasound is an imaging technique that uses sound waves to visualise internal structures. It can be used for assessing injuries (such as liver damage) but is not a tool for coagulation monitoring. Elastography (Option D) is an imaging technique that evaluates the elasticity or stiffness of tissues. It is used mainly to assess liver fibrosis but is not involved in coagulation monitoring.

References:

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Q19: A patient with an incident of being stabbed in the front part of the abdomen is brought to the emergency. The patient's vital signs are stable. What will be the next step in managing this case? (Q855832)

A. Emergency laparotomy

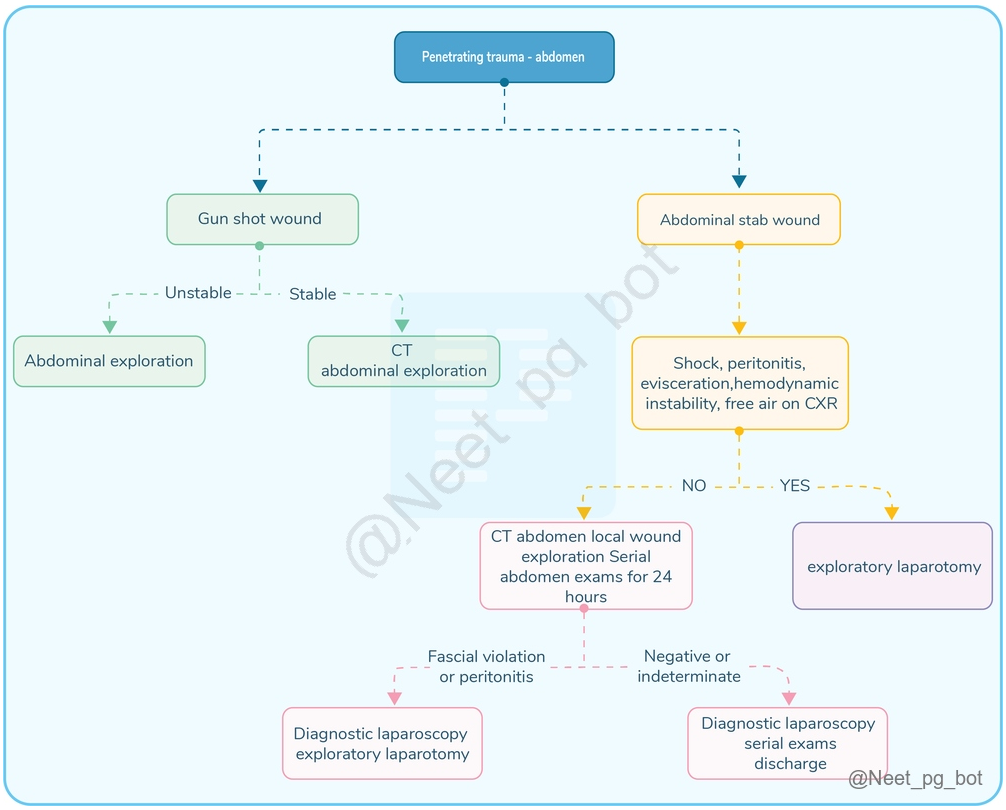
B. Observation

C. Intravenous hydration

D. Further investigation

Correct Answer: D. Further investigation

Explanation: The next step in this case is to investigate further to evaluate the extent of the injury and make a decision regarding whether surgical intervention is necessary. The patient is hemodynamically stable , which means they are not in shock or showing signs of severe internal injury at this point. In such cases, the management should focus on evaluating the injury more thoroughly, as penetrating abdominal trauma may sometimes cause delayed complications or injuries that aren't immediately apparent. Emergency laparotomy is generally indicated only if the patient shows signs of peritonitis , active bleeding , or deterioration in their clinical status. (Option A ruled out) For stable patients, imaging first allows them to make a more informed decision about whether surgery is immediately necessary or if observation and further management are sufficient. (Option B ruled out) Intravenous hydration (Option C) can be important to maintain circulation, especially in trauma cases. However, it is not the primary next step in managing abdominal stab wounds. The focus in this case is on determining the extent of injury using imaging before considering any surgical intervention or supportive measures.



References:

NIH Link

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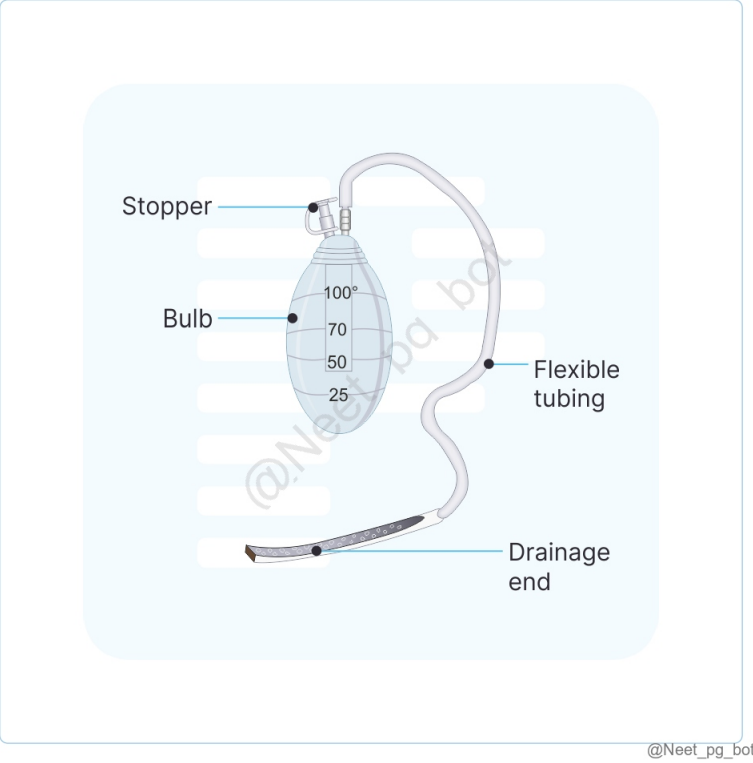
Q20: A 45-year-old patient undergoes a mastectomy for breast cancer. Post-operatively, the surgeon decides to use a closed suction drain. Which of the following drain types is shown in the image below? (Q858365)

A. Penrose drain

B. Jackson Pratt drain

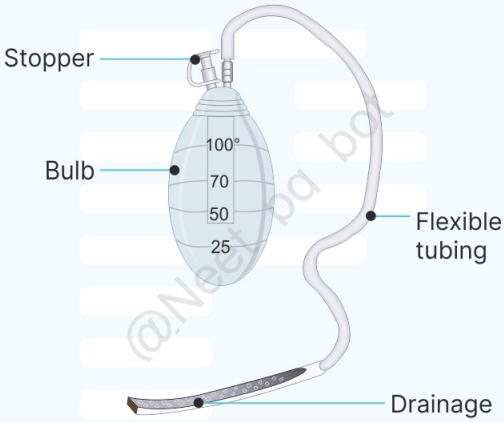
C. Romovac suction drain

D. Hemovac drain



Correct Answer: B. Jackson Pratt drain

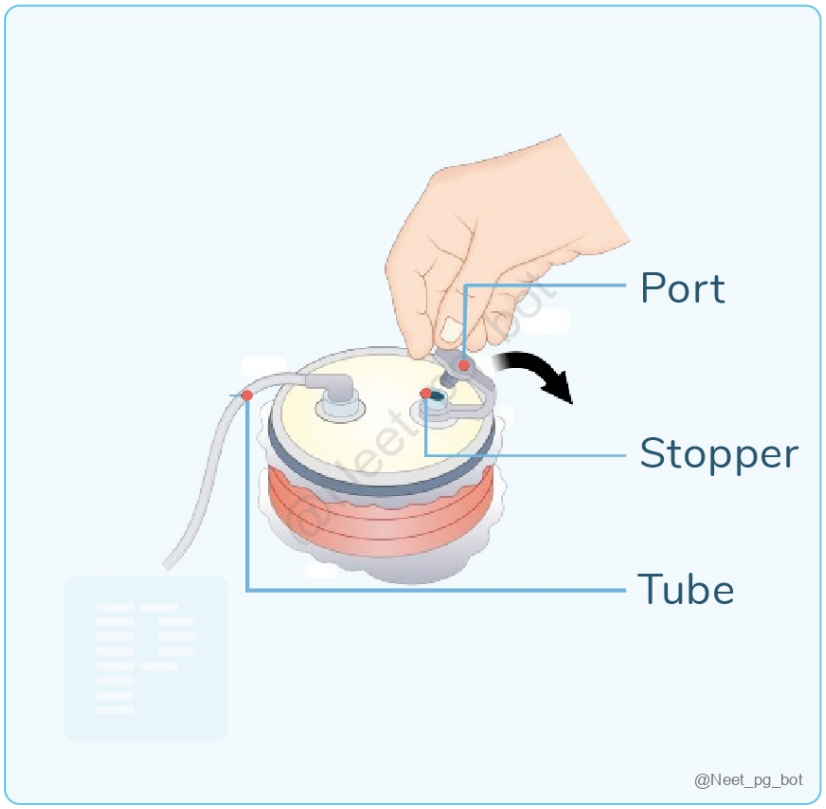
Explanation: The image shows a Jackson Pratt (JP) drain , which is a type of closed suction drain commonly used in various surgical procedures, including mastectomies. Jackson Pratt drain: Consists of a soft, flattened silicone tube connected to a soft plastic bulb The bulb can be compressed to create negative pressure Typically clear or translucent, allowing easy visualization of drainage Suitable for various surgeries, including breast, plastic, and abdominal procedures Easy to empty and maintain by patients {{caption_text}} Penrose drain (Option A) This is an open, passive drain consisting of a soft rubber tube. It relies on gravity and capillary action for drainage. {{caption_text}} Jackson-pratt drain (Option B) Consists of a soft, flattened silicone tube connected to a soft plastic bulb The bulb can be compressed to create negative pressure Suitable for various surgeries, including breast, plastic, and abdominal procedures {{caption_text}} Romovac suction drain (Option C) Another type of closed suction drain Uses a spring-loaded mechanism to create constant negative pressure Often used in orthopedic surgeries and joint replacements {{caption_text}} Hemovac drain (Option D) This is another brand of closed suction drain, similar in principle to the JP drain. However, Hemovac drains typically have a larger, more rigid collection chamber compared to the soft, compressible bulb of the JP {{caption_text}}


Stopper
Bulb
100°
70
50
25
Flexible tubing
Drainage end

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References:

https://www.saintjohnscancer.org/melanoma/patient-resources/jackson-pratt-jp-drain/

↑ *Back to this question in Part A*

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Q21: Which among the following are incorrect about tension pneumothorax? Occurs due to improper dressing of open wound Blunt trauma with simple pneumothorax can never convert to tension pneumothorax Most common cause is due to positive pressure in mechanical ventilation Can be caused due to spinal injury (Q865398)

A. 1, 4

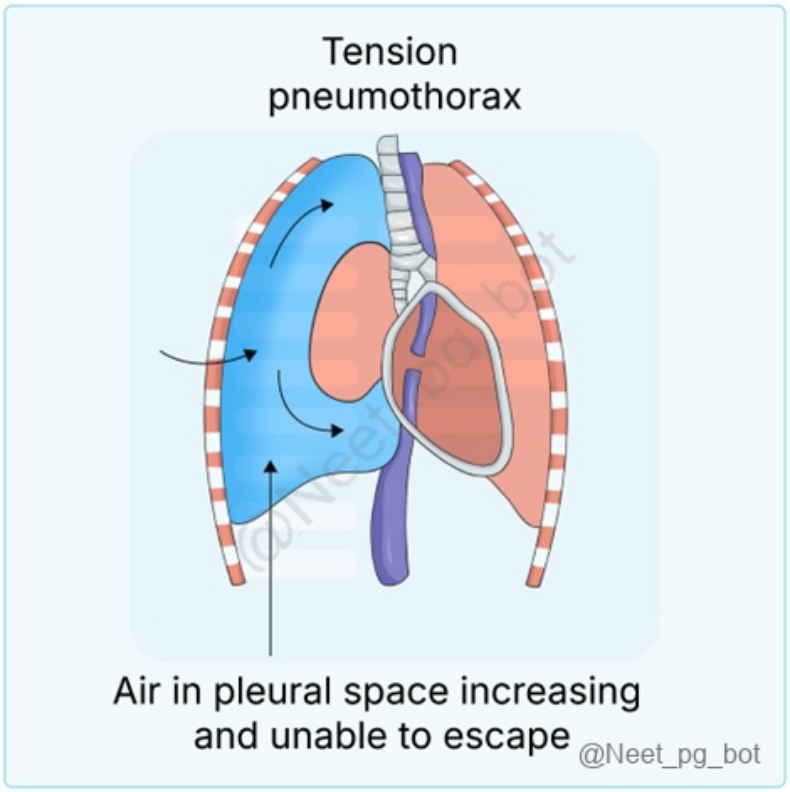
B. 2,3,4

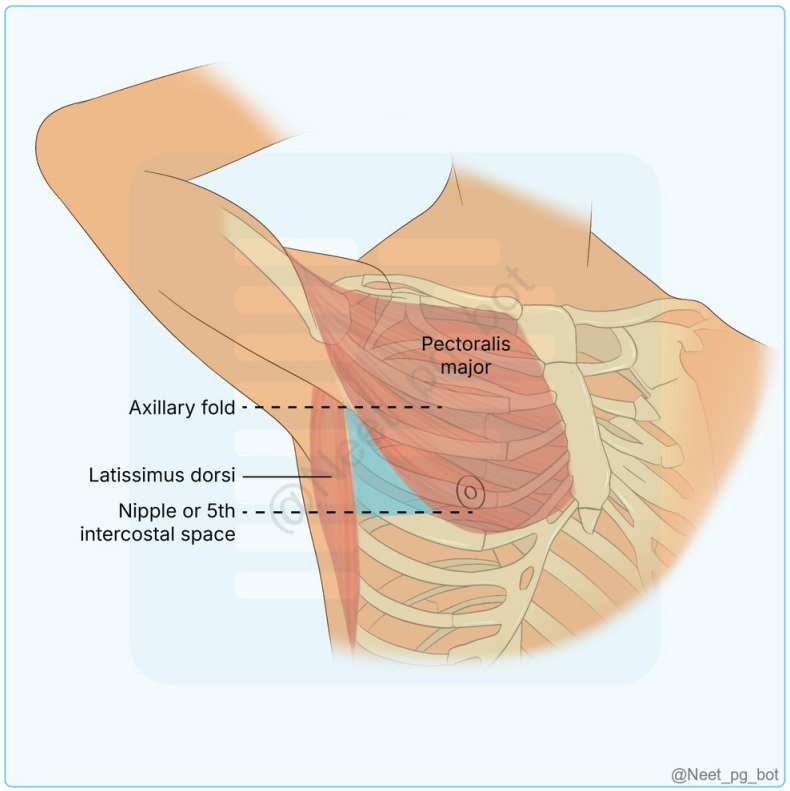
C. 1,2,4

D. 2,3

Correct Answer: D. 2,3

Explanation: Statements 2 and 3 are incorrect while 1 and 4 are correct. A tension pneumothorax develops when a ‘one-way valve’ air leak occurs either from the lung or through the chest wall. Open (sucking) chest wounds can act as a one-way valve when improperly dressed. Air enters during inspiration but cannot exit during expiration, causing a valve mechanism , leading to tension pneumothorax . (Statement 1) High cervical spinal injuries may result in diaphragmatic paralysis or respiratory failure, predisposing to pneumothorax due to barotrauma from mechanical ventilation or reduced clearance. Though indirect, spinal injury can be associated with tension pneumothorax. (Statement 4) TENSION PNEUMOTHORAX Pathophysiology D/t ‘one-way valve’ air leaks from the lung or chest wall. Air is sucked into the thoracic cavity without any escape, collapsing and compressing the affected lung. The mediastinum shifts to the opposite side, reducing venous return and compressing the opposite lung, leading to decreased cardiac output and function. This can result in sudden death. Causes Penetrating Chest Trauma. Blunt Chest Trauma with parenchymal lung injury and persistent air leak. (Statement 2) Iatrogenic Lung Injury (e.g., central venepuncture) Mechanical Positive-Pressure Ventilation. (Statement 3) Clinical Features Tachypnea and Tachycardia Hyper-resonance and Decreased/Absent Breath Sounds Resonant Percussion with severe mediastinal/tracheal shift Cyanosis and Hypotension Chest Pain Distended Neck Veins Emergency Management Tension pneumothorax is a clinical diagnosis, and treatment should never be delayed by waiting for radiological confirmation. Immediate Thoracocentesis (needle): Wide bore needle (typically a 20- or 22-gauge) in the 5th intercostal space in the safety triangle. Decompression should be performed in the "safe triangle." Safe Triangle Boundaries : Posterior: Latissimus dorsi Anterior: Lateral border of the pectoralis major Inferior: A line drawn perpendicularly from the nipple to the back, just anterior to the mid-axillary line. In critical situations, a finger thoracostomy can be done in the same location. Nasal Oxygen for support. Intercostal Tube Placement (ICT) once stable and confirmed by chest X-ray. Additional Care Antibiotics and analgesics for treatment. Ventilator Support with IPPV in severe cases.





References:

Bailey and Love Surgery, 28th edition. Pg. 374

Sabiston Textbook of Surgery, 21st edition, Pg. 404, 405, 1632

Tension Pneumothorax - StatPearls - NCBI Bookshelf.

↑ *Back to this question in Part A*

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Q22: All of the following is a contraindication to Breast Conservation surgery except ? (Q865393)

A. Previous history of radiation to the chest

B. Tumor involving single quadrant

C. Scleroderma

D. Persistent positive margins even after resection

Correct Answer: B. Tumor involving single quadrant

Explanation: Breast conservation surgery (BCS), also known as lumpectomy or wide local excision (WLE), is contraindicated in certain conditions where it may compromise oncological safety or cosmetic outcomes. BCS is feasible if the tumor is confined to a single quadrant and is aimed at removing the tumour along with a 1-cm margin of normal breast tissue. All patients with BCS receive radiotherapy. BCS together with radiotherapy is called breast conservation therapy (BCT): BCS + RT = BCT BCS is avoided in patients with: Multicentric tumour Diffuse microcalcifications on a mammogram Large tumour-to-breast ratio Two times positive surgical margins after re-excision History of previous breast or chest wall radiation Systemic lupus erythematosus or other collagen vascular disease (these patients have a high risk of a radiation reaction), or ankylosing spondylitis Severe orthopnea (as the patient cannot lie on the radiation table) Previous history of radiation to the chest (Option A) Prior radiation to the chest (e.g., for Hodgkin's lymphoma) increases the risk of radiation-induced toxicity and poor wound healing, making BCS unsafe. Scleroderma (Option C) Scleroderma (a connective tissue disorder) impairs wound healing and increases radiation toxicity, making BCS + radiotherapy risky. Persistent positive margins even after resection (Option D) Patients with involved margins will have to undergo a revision of margins called a 'cavity shave'.

References:

Sabiston Textbook of Surgery, 21st Edition, Page 853.

Bailey & Love's Short Practice of Surgery, 28th edition, Pages 935.

↑ *Back to this question in Part A*

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Q23: A 40-year-old male presents to the emergency department with severe respiratory distress, BP: 70/59 mmHg, tracheal deviation to the right, distended neck veins, and absent breath sounds on the left side. These findings are suggestive of a tension pneumothorax. What is the most appropriate immediate next step in management? (Q865354)

A. Perform needle thoracostomy immediately

B. CT Chest

C. Airway, breathing, and circulation (ABC) assessment

D. Chest tube insertion

Correct Answer: A. Perform needle thoracostomy immediately

Explanation: This patient has classic signs of a tension pneumothorax - severe respiratory distress, tracheal deviation to the opposite side, distended neck veins, absent breath sounds on one side, and hypotension. This is a life-threatening emergency that requires immediate decompression by needle thoracostomy , even before imaging or confirmation. Procedure: Insert a wide-bore (14–16 gauge) needle Site: 2nd intercostal space, midclavicular line , on the affected side This releases trapped air, converting the tension pneumothorax into a simple pneumothorax and rapidly restoring venous return. CT Chest (Option B): Imaging wastes critical time; diagnosis is clinical . ABC assessment (Option C): Already implied - once tension pneumothorax is identified, decompression is the airway–breathing management step. Chest tube insertion (Option D): Definitive treatment, but performed after needle decompression. Attempting it first delays lifesaving decompression.

References:

Sabiston’s principles of surgery, 21st Edition, Page 391, 392

↑ *Back to this question in Part A*

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Q24: A 65-year-old patient is on mechanical ventilation for acute respiratory distress syndrome (ARDS). Suddenly, the patient becomes hypotensive, tachycardic, and shows absent breath sounds on the left side with tracheal deviation to the right. What is the most common cause of this in patients receiving mechanical ventilation? (Q865348)

A. High tidal volume

B. Barotrauma due to high airway pressure

C. Endotracheal tube malposition

D. Oxygen toxicity

Correct Answer: B. Barotrauma due to high airway pressure

Explanation: Patients with ARDS often require high airway pressures during mechanical ventilation to maintain oxygenation. This increases the risk of barotrauma , leads to alveolar rupture and air leakage into extra-alveolar spaces , causing complications such as pneumothorax, pneumomediastinum , or subcutaneous emphysema . Ventilator factors that increase the risk: High plateau pressure (>30–35 cm H■O) High peak inspiratory pressures High tidal volumes Auto-PEEP from inadequate exhalation Prevention: Plateau pressure is limited to ≤30 cm H■O to minimize the risk of barotrauma and pneumothorax. High tidal volume (Option A) can contribute to barotrauma but they are not the direct cause of sudden hemodynamic collapse and tracheal deviation. Endotracheal tube malposition (Option C) usually leads to unilateral ventilation (e.g., right main bronchus intubation), causing decreased breath sounds on the left but it does not explain the tracheal shift or hemodynamic instability. Oxygen toxicity (Option D) develops gradually over prolonged exposure to high FiO■ in ARDS. It does not cause sudden collapse or tracheal deviation.

↑ *Back to this question in Part A*

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Q25: A patient presents with a breast lump, and imaging (X-ray mammography) along with histopathology confirms a diagnosis of breast cancer. She has a family history of breast cancer involving two relatives and has a 29-year-old daughter. Which gene should be tested to assess hereditary breast cancer risk in this patient? (Q865316)

A. BRCA1

B. TP53

C. BRCA2

D. STK11

Correct Answer: A. BRCA1

Explanation: Women with BRCA1 mutations and a family history of breast cancer have a higher lifetime risk of developing breast cancer compared to those with BRCA2 mutations. BRCA1 mutations are associated with high-grade, triple-negative breast cancers and increased risks of colon and prostate cancers. Mutations seen in Breast Cancer High penetrance mutations (>4-fold risk, 3-7% of breast cancers) Gene % of single-cell cancers Associated tumours BRCA1 (Option A) 55% Breast, ovarian (~20%–40%), fallopian tube, pancreas, and prostate. BRCA2 (Option C) 35% Breast, ovarian (~10%–20%), pancreas, and prostate. Associated with male breast cancer. TP53 (Option B) <1% Breast, sarcoma, leukaemia, and brain tumours. PTEN Breast, thyroid, and endometrium. STK11 (Option D) Breast, ovarian, colon, and pancreas. CDH1 (Option C) Breast, gastric signet ring cell carcinoma, and colon. PALPB2 Breast, pancreas, and prostate. Moderate penetrance germline mutations (2- to

4-fold increased risk; 5-10% of breast cancers) ATM 5% CHEK2 (Option D) Prostate, thyroid, colon, and kidney.

References:

Robbins Pathology, 10th edition , 10th Edition, Page 1049

↑ *Back to this question in Part A*

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Q26: Which of the following is not a component of TNM stage T4b breast cancer? (Q865312)

A. Ulceration

B. Peau d'orange

C. Inflammatory carcinoma

D. Ipsilateral macroscopic satellite nodules

Correct Answer: C. Inflammatory carcinoma

Explanation: Inflammatory carcinoma is classified separately as T4d in the TNM staging, but not stage T4b. TNM staging for breast cancer Stage Description Tumor size (T) TX Primary tumor cannot be assessed T0 No evidence of primary tumor Tis Carcinoma in situ (DCIS, LCIS, or Paget's disease) T1 Tumor ≤ 2 cm T1mi Tumor ≤ 1 mm T1a Tumor > 1 mm but ≤ 5 mm T1b Tumor > 5 mm but ≤ 10 mm T1c Tumor > 10 mm but ≤ 20 mm T2 Tumor > 2 cm but ≤ 5 cm T3 Tumor > 5 cm T4 Tumor of any size with direct extension to chest wall or skin T4a Extension to chest wall T4b Ulceration or skin nodules (Option A, B & D) T4c Both T4a and T4b T4d Inflammatory breast cancer (Option C) Node (N) NX Regional lymph nodes cannot be assessed N0 No regional lymph node metastasis N1 Metastases to movable ipsilateral level I, II axillary lymph nodes N2 Metastasis to axillary lymph nodes or clinically apparent internal mammary nodes N2a Metastasis to axillary lymph nodes that are clinically fixed or matted N2b Metastasis to internal mammary nodes without axillary lymph node involvement N3 Metastasis to axillary lymph nodes or infraclavicular nodes, or to supraclavicular nodes N3a Metastasis to infraclavicular nodes N3b Metastasis to internal mammary nodes N3c Metastasis to supraclavicular nodes Metastasis (M) MX Distant metastasis cannot be assessed M0 No distant metastasis M1 Distant metastasis present Stage Grouping Stage 0: Tis N0 M0 Stage IA: T1/T1mi N0 M0 Stage IB: T0 N1mi M0; T1/T1mi N1mi M0 Stage IIA: T0 N1 M0; T1 N1 M0; T2 N0 M0 Stage IIB: T2 N1 M0; T3 N0 M0 Stage IIIA: T0 N2 M0; T1 N2 M0; T2 N2 M0; T3 N1 M0 Stage IIIB: T3 N2 M0 Stage IIIC: T4 N0 M0; T4 N1 M0; T4 N2 M0; Any T N3 M0 Stage IV: Any T Any N M1

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 934.

Sabiston Textbook of Surgery, 21st Edition, Page 833.

SRB's Manual of Surgery, 6th Edition, Page 532

↑ *Back to this question in Part A*

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Q27: A 38-year-old man was brought to the emergency department after sustaining an RTA and injury to the lower chest. On presentation, the patient is stable, and vitals are normal. Chest radiography showed clear lung fields. What is the next step in management? (Q858483)

A. eFAST

B. Tube thoracostomy

C. CECT chest

D. CECT abdomen

Correct Answer: A. eFAST

Explanation: According to ATLS trauma protocol , eFAST is an adjunct to the primary survey and should be performed in all significant blunt trauma patients , regardless of hemodynamic stability. Injury to the lower chest raises suspicion for upper abdominal organ injury (liver, spleen, diaphragm) even if the chest X-ray is normal. Therefore, the next immediate step is eFAST , which quickly detects: Intraperitoneal free fluid (hemoperitoneum) Pericardial effusion Occult pneumothorax or pleural fluid not visible on X-ray This bedside scan is rapid, non-invasive, and ensures there is no internal bleeding before sending the patient for CT. Tube thoracostomy (Option B): Not indicated, as the chest X-ray shows no pneumothorax or hemothorax . CECT chest (Option C): Not part of the primary survey and unnecessary when CXR is normal. CECT abdomen (Option D): This is performed later during the secondary survey , after eFAST, if the patient remains stable.

References:

Bailey and Love’s Short Practice of Surgery, 28th Edition, Page 373

↑ *Back to this question in Part A*

@Neet_pg_bot

Q28: What could be the most likely reason for a patient presenting with chronic non-pitting edema in the lower extremities? (Q858480)

A. Lymphedema

B. Arterial Disorders

C. Venous Disorders

D. Coronary heart disease

Correct Answer: A. Lymphedema

Explanation: Lymphedema refers to the accumulation of lymph fluid in the interstitial tissue, typically resulting in chronic non-pitting edema . In this type of edema, when pressure is applied to the swollen area, the indentation doesn't remain. Causes of Primary Lymphedema Congenital Lymphedema Lymphedema Praecox Lymphedema Tarda Age: Seen in < 1 year of age Present at birth. Lower limb, genitalia, and face are involved. Usually, B/L and multiple limbs are involved. Familial version of congenital lymphedema – known as Milroy's disease. M/C type of primary lymphedema (>90% of cases). Age: 1 to 35 years. M/C seen in females. Usually U/L. Involves calf and foot Familial version of lymphedema praecox - known as Meig's disease. Age: Usually seen in > 35 years age group It is a rare disease. Secondary Lymphedema Filariasis MC overall cause of lymphedema worldwide MC secondary cause of lymphedema Lymphoedema due to Lymphatic obstruction Surgery Axillary block dissection- MC cause of secondary lymphedema in the USA MC iatrogenic cause of secondary lymphedema Inguinal block dissection Lymphedema due to Lymphatic disruption Infections Tuberculosis Syphilis Fungal and Bacterial infections Other causes: Trauma Malignancy Radiotherapy Arterial Disorders (Option B) like peripheral artery disease (PAD) generally present with claudication and other signs of ischemia , such as cold extremities , pale skin , and ulcers . Eedema is not a common finding here. Venous Disorders (Option C) can cause oedema in the lower extremities. However, in venous disorders, the oedema is due to venous stasis , and it's generally pitting rather than non-pitting . Signs like varicose veins or venous ulcers are also present. Coronary heart disease (Option D) mainly affects the coronary arteries and leads to symptoms such as chest pain , shortness of breath , and possibly heart attacks . While heart failure (due to CHD) can cause edema in the legs, which is usually pitting because it results from fluid retention and venous congestion due to impaired cardiac function .

References:

SRB's Manual of Surgery, 6th Edition, Page 242

↑ *Back to this question in Part A*

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Q29: Identify the fluid shown below on the basis of composition: Sodium (Na+) 131 millimoles per liter Chloride (Cl-) 111 millimoles per liter Lactate 29 millimoles per liter Potassium (K+) 5 millimoles per liter Calcium (Ca2+) 2 millimoles per liter Total osmolarity 279 millimoles per liter (Q855761)

A. Haemaccel

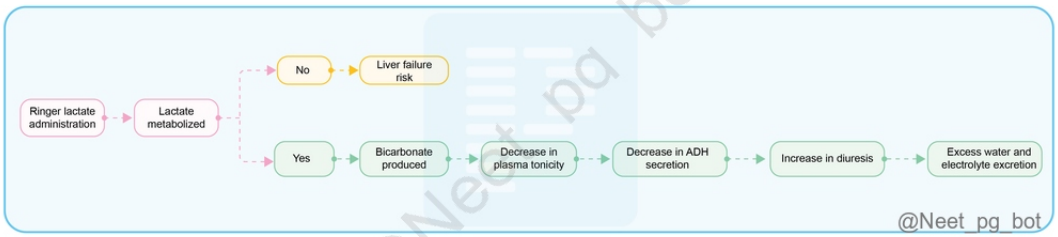
B. Ringer lactate

C. Isolyte

D. Isolyte M

Correct Answer: B. Ringer lactate

Explanation: The composition provided matches Ringer's lactate , a commonly used intravenous (IV) fluid in clinical settings for fluid resuscitation and electrolyte correction . It is also called at Hartmann’s solution Ringer's Lactate (Balanced Crystalloid) Usage : Maintenance fluid during surgery. Advantage : Prevents hyperchloremic metabolic acidosis, unlike normal saline. Excretion : Rapid elimination is due to the suppression of ADH secretion, which promotes diuresis. Buffer : Lactate is metabolised to bicarbonate, maintaining or slightly increasing HCO3 levels and preventing acidosis. Haemaccel (Option A) is a colloidal plasma expander used to restore blood volume, and it does not contain the same electrolyte composition as Ringer’s lactate. Haemaccel consists of sodium chloride, potassium chloride and calcium chloride. Isolyte (Option C) , with a pH of 7.4, is isosmotic and used for hydration and electrolyte replacement. It provides essential electrolytes, including sodium (a major cation in the solution), and helps correct fluid deficits, promoting urinary output. It typically has concentrations different from Ringer’s lactate. Isolyte M (Option D) is another type of intravenous fluid used for hydration and electrolyte correction, but it also has a different electrolyte profile from Ringer's lactate .



References:

Miller’s Anaesthesia, 9th Edition, Pages 1492, 1495, 1503, 1513, 1514, 1518

↑ *Back to this question in Part A*

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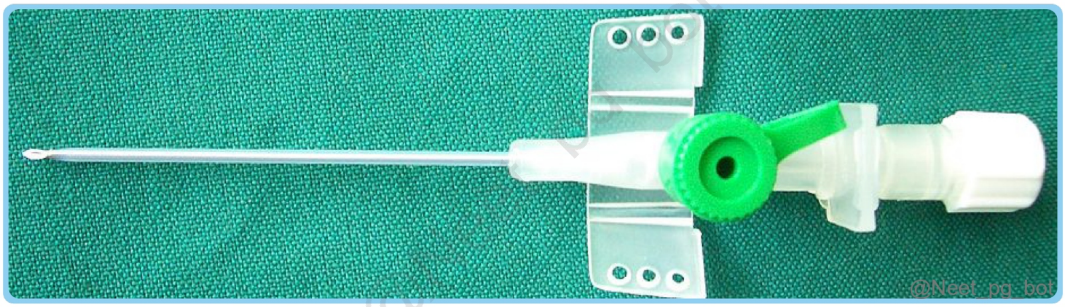
Q30: A patient was received in the casualty following a road traffic accident. His BP was 90/60 mmHg and his pulse rate was 120/min. The emergency room physician asked you to replace the fluid loss in this patient. What is the flow rate of fluid with the IV cannula given in the image? (Q858350)

A. 86ml/min

B. 96ml/min

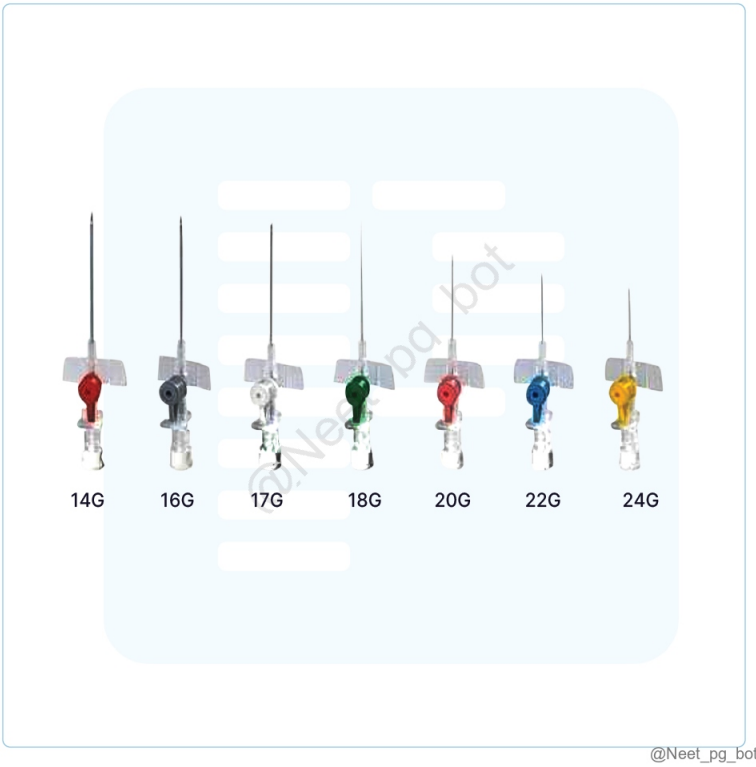
C. 90 ml/min

D. 63ml/min



Correct Answer: C. 90 ml/min

Explanation: To calculate the maximum flow rate of fluid with a specific IV cannula, we need to consider the size of the cannula, which is given as 18G (green). Intravenous (IV) Cannula Sizes, Colors, and Uses: Cannula Gauge (G) Outer Diameter (mm) Color Flow Rate (mL/min) Common Uses 14G 2.1 mm Orange 240 mL/min Massive transfusion, trauma, rapid fluid resuscitation 16G 1.8 mm Grey 180 mL/min Major surgery, large fluid replacement, blood transfusion 18G (Option C) 1.3 mm Green ~90 mL/min Routine blood transfusion, IV fluids, medications 20G 1.1 mm Pink 55-65 mL/min IV fluids, antibiotics, minor procedures 22G 0.9 mm Blue 33-36 mL/min IV medications, pediatric & elderly patients 24G 0.7 mm Yellow 20-22 mL/min Neonates, small veins, slow infusions 26G 0.6 mm Purple 13-15 mL/min Rarely used, for neonates & fragile veins Sizes of Cannula: {{caption_text}}



References:

https://emedicine.medscape.com/article/1998177-periprocedure?form=fpf

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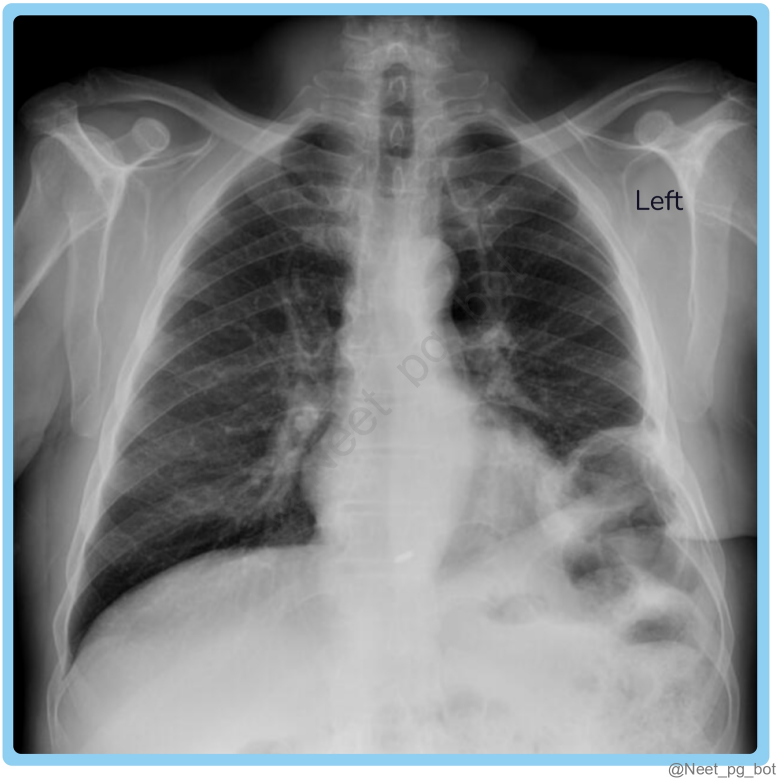
Q31: A 24-year-old male patient was brought to the emergency department following a road traffic accident. His heart rate was 100/min, respiratory rate was 24/min, and his chest X ray is given below. Which of the following is contraindicated in him? (Q858348)

A. Nasogastric tube insertion

B. Chest tube insertion

C. Log roll

D. Epidural anaesthesia



Correct Answer: B. Chest tube insertion

Explanation: Xray findings: Parts of bowel loops , including splenic flexure of the colon, are herniated into the thorax through a defect in the lateral aspect of the left hemidiaphragm, causing mild left lung base collapse. The anterior arch of the left 5th and 6th ribs shows evidence of prior fracture. A small metallic foreign body is also noted posterior to the cardiac shadow. There are mild peribronchial opacities in the central segments of both lungs. Chest tube insertion is generally contraindicated in patients with isolated rib fractures without associated

pneumothorax or hemothorax . Chest tube insertion is primarily performed to drain air or fluid from the pleural space when there is a pneumothorax or hemothorax. Nasogastric tube insertion (Option A) is not directly contraindicated in a patient with diaphragmatic hernia. Nasogastric tube insertion is a common procedure performed in emergency departments to decompress the stomach and remove gastric contents. Log rol l (Option C) trauma precautions are generally recommended in trauma patients to minimise movement of the spine and reduce the risk of spinal cord injury. Epidural anaesthesia (Option D) is a regional anesthesia technique commonly used for pain management during surgical procedures. Diaphragmatic hernia is not directly contraindication for epidural anesthesia.

References:

https://emedicine.medscape.com/article/80678-overview?form=fpf

↑ *Back to this question in Part A*

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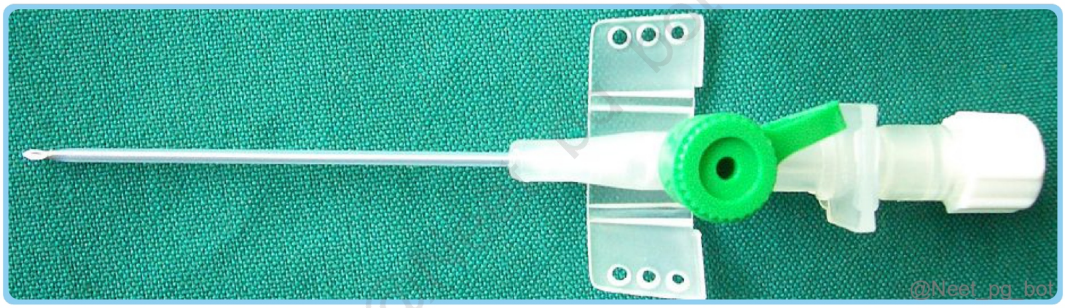
Q32: What is the size of the cannula gauge used in this picture? (Q858341)

A. 14

B. 16

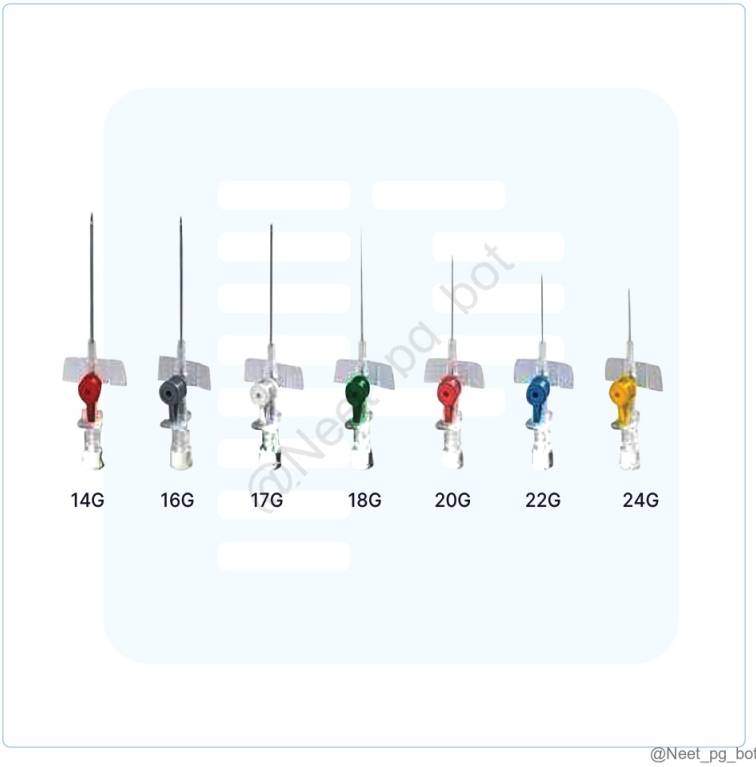
C. 18

D. 20



Correct Answer: C. 18

Explanation: The gauge size of the cannula shown in the image is 18. Intravenous (IV) Cannula Sizes, Colors, and Uses: Cannula Gauge (G) Outer Diameter (mm) Color Flow Rate (mL/min) Common Uses 14G (Option A ruled out) 2.1 mm Orange 240 mL/min Massive transfusion, trauma, rapid fluid resuscitation 16G (Option B ruled out) 1.8 mm Grey 180 mL/min Major surgery, large fluid replacement, blood transfusion 18G (Option C) 1.3 mm Green 90-105 mL/min Routine blood transfusion, IV fluids, medications 20G (Option D ruled out) 1.1 mm Pink 55-65 mL/min IV fluids, antibiotics, minor procedures 22G 0.9 mm Blue 33-36 mL/min IV medications, pediatric & elderly patients 24G 0.7 mm Yellow 20-22 mL/min Neonates, small veins, slow infusions 26G 0.6 mm Purple 13-15 mL/min Rarely used, for neonates & fragile veins Sizes of Cannula: {{caption_text}}



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References:

https://emedicine.medscape.com/article/1998177-periprocedure?form=fpf

↑ *Back to this question in Part A*

@Neet_pg_bot

Q33: In all types of shock, which of the following is observed? (Q857889)

A. Reduced tissue perfusion

B. Increased peripheral resistance

C. Decreased respiratory rate

D. Cold clammy skin

Correct Answer: A. Reduced tissue perfusion

Explanation: Reduced tissue perfusion, a hallmark of all Shock types, results in inadequate oxygen and nutrient delivery, leading to organ dysfunction. It is defined as a systemic state of low tissue perfusion which is inadequate for normal cellular respiration. (Option A) Classification Type of Shock Mechanism Examples Hypovolemic Shock Reduced circulating blood volume Hemorrhage, Dehydration Cardiogenic Shock Failure of the cardiac

pump Myocardial Infarction, Cardiac Dysrhythmias Obstructive Shock Mechanical obstruction of cardiac filling Cardiac Tamponade, Tension Pneumothorax Distributive Shock Systemic vasodilation leading to organ hypoperfusion Septic Shock, Anaphylactic Shock Endocrine Shock Combination of hypovolemic, cardiogenic, or distributive shock mechanisms Addisonian Crisis, Myxedema Coma Increased peripheral resistance (Option B) may occur in some shock types (e.g., hypovolemic, cardiogenic) as compensation to maintain blood pressure, but it's not universal. In septic shock, peripheral resistance is often decreased due to vasodilation. Decreased respiratory rate (Option C) may occur in certain shock types (e.g., neurogenic, severe hypovolemic), but increased respiratory rate (tachypnea) is more common as the body compensates for low oxygen levels, making it not universal in all shock types. Cold clammy skin (Option D) occurs in some shock types (e.g., hypovolemic, cardiogenic) due to vasoconstriction, but not in all. In septic shock, skin may be warm and flushed due to vasodilation.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 11-12.

SRB’s Manual of Surgery, 6th Edition, Page 104-105.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q34: Among the options provided, which pairing correctly matches the trauma patients brought to the casualty? (Q857835)

A. Extradural hemorrhage (EDH) - Pin point pupil

B. Penetrating injury to eustachian tube - CSF otorrhea

C. Penetrating injury to eye - Battle sign

D. Gaze palsy - Mid brain lesion

Correct Answer: D. Gaze palsy - Mid brain lesion

Explanation: Gaze palsy, a difficulty in eye movement, can result from damage to structures in the midbrain, such as the third cranial nerve nucleus and paramedian pontine reticular formation. Extradural hemorrhage (EDH) - Pin point pupil (Option A) : EDH causes a dilated, non-reactive pupil due to pressure on the oculomotor nerve (CN III), while pinpoint pupils are more associated with opioid overdose or pontine lesions. Penetrating injury to eustachian tube - CSF otorrhea (Option B): Penetrating injury to the eustachian tube may cause complications but not CSF otorrhea, which is typically linked to basilar skull fractures and injury to the temporal bone. Penetrating injury to eye - Battle sign (Option C): Battle sign, bruising behind the ear, is associated with basilar skull fractures, not penetrating eye injuries, which present with hyphema, corneal damage, or visual disturbances.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 364.

↑ *Back to this question in Part A*

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Q35: Which of the following is not included in the qSOFA score components? (Q857805)

A. Respiratory rate >22

B. Lactate dehydrogenase

C. Altered mental status

D. Systolic blood pressure <100 mmHg

Correct Answer: B. Lactate dehydrogenase

Explanation: Lactate dehydrogenase (LDH) is not part of the components used in the qSOFA (quick Sequential Organ Failure Assessment) Score . It is a simplified, rapid assessment scale developed as an easier alternative to the more complex SOFA score, which requires laboratory tests. The Third International Consensus Definition of Sepsis recommends using qSOFA to identify patients with sepsis (higher risk of death, prolonged ICU stay, and increased need for ICU admission). Components: Respiratory rate ≥22 (Option A ruled out) Altered mental status (Option C ruled out) Systolic blood pressure ≤100 mm Hg. (Option D ruled out) Interpretation: qSOFA ≥2 (with a concern for infection) is associated with a significantly greater risk of death or prolonged ICU stay.

References:

Sabiston Textbook of Surgery, 21st Edition, Page 62-63.

Harrison’s Priniciples of Internal Medicine, 21st Edition, Page 2238.

↑ *Back to this question in Part A*

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Q36: A 38-year-old man was brought to the emergency department after sustaining an RTA and injury to the lower chest. On presentation, the patient is stable, and vitals are normal. Chest radiography showed clear lung fields. What is the next step in management? (Q857798)

A. eFAST

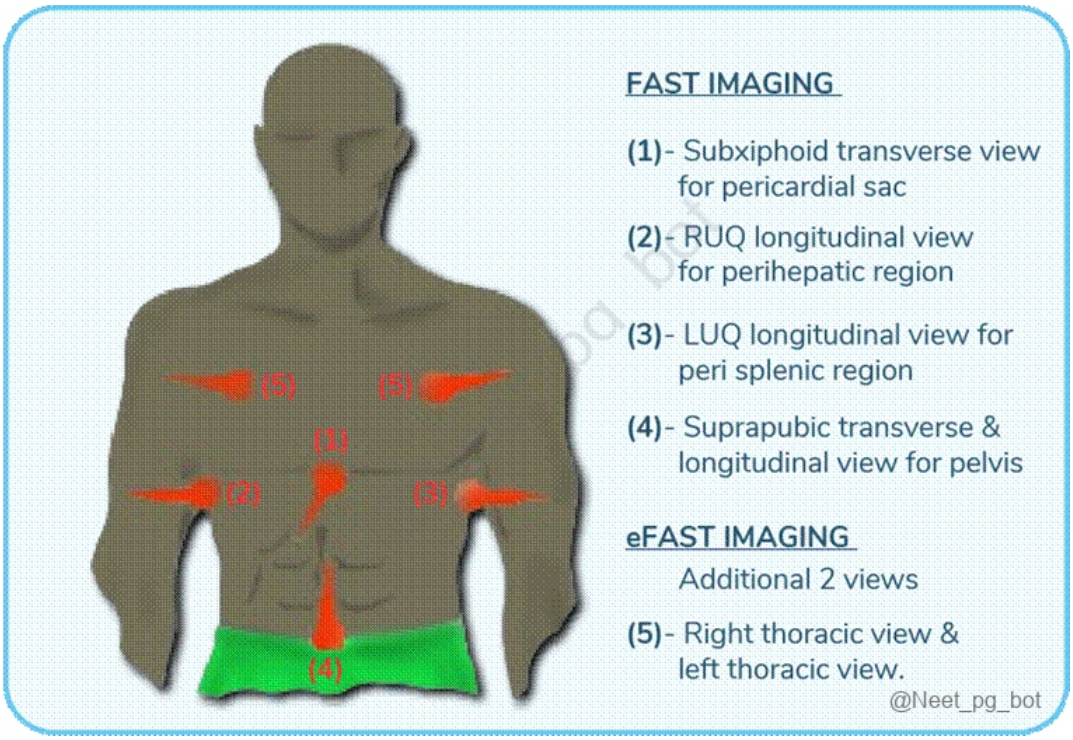
B. Tube thoracostomy

C. CECT chest

D. CECT abdomen

Correct Answer: A. eFAST

Explanation: In the scenario of an RTA with a stable patient, normal vitals, and clear lung fields, the most appropriate next step would be an extended Focused Assessment with Sonography in Trauma (eFAST) . It is a rapid bedside ultrasound to detect life-threatening injuries in trauma patients, focusing on the chest and abdomen. It assesses the pericardium, pleural spaces, and abdominal cavity for air or fluid. If clear lung fields rule out pneumothorax or hemothorax, eFAST helps detect other bleeding sources, like intraperitoneal bleeding. FAST (Focused Abdominal Sonography for Trauma) and eFAST (Extended FAST) Purpose : Assess for free fluid in the abdominal cavity, thoracic cavities, and pericardium. (Option A) Nature of Injury : Not used to determine the specific nature or extent of injury. Advantages : (Option A) Rapid, reproducible, portable, and non-invasive bedside test. Can be performed simultaneously with resuscitation. Accurate at detecting >100 mL of free blood. Limitations : Operator-dependent and may be unreliable in obese patients or when the bowel is full of gas. Low sensitivity (29–35%) for detecting hollow viscus or solid organ injuries without haemoperitoneum. Unreliable for excluding injuries in penetrating trauma. Requires repeat or supplementary investigations if needed. Unreliable for assessing retroperitoneum. {{caption_text}} Tube thoracostomy (Option B) is used for pneumothorax or hemothorax, but since the chest radiography shows clear lung fields, it’s not needed at this point. CECT chest (Option C) and abdomen (Option D) are more invasive imaging options. Since the chest radiography is clear and the patient is stable, eFAST is a quicker, non-invasive first step to assess for other injuries, such as abdominal or retroperitoneal bleeding, before considering further imaging.



References:

Bailey and Love’s Short Practice of Surgery, 28th Edition, Page 378-379.

SRB’s Manual of Surgery, 6th Edition, Page 139-140.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q37: Which class of hypovolemic shock, according to Advanced Trauma Life Support (ATLS) guidelines, is characterised by the absence of urine output? (Q857765)

A. Class I

B. Class II

C. Class III

D. Class IV

Correct Answer: D. Class IV

Explanation: According to the Advanced Trauma Life Support (ATLS) , in the classes of hypovolemic shock , class IV is characterised by the absence of urine output. Parameter Class I (Option A ruled out) Class II (Option B ruled out) Class III (Option C ruled out) Class IV (Option D) Blood loss (%) 0-15% 15-30% 30-40% > 40% Central Nervous System (CNS) Slightly anxious Mildly anxious Anxious or confused Confused or lethargic Pulse (beats/min) < 100 > 100 > 120 > 140 Blood pressure Normal Normal Decreased Decreased Pulse pressure Normal Decreased Decreased Decreased Respiratory rate (breaths/min) 14-20 20-30 30-40 > 35 Urine output (mL/hr) > 30 20-30 5-15 Negligible/Nil Fluid requirement Crystalloid Crystalloid Crystalloid + Blood Crystalloid + Blood Base deficit (mEq/L) 0 to -2 -2 to -6 -6 to -10 -10 or less

References:

SRB’s Manual of Surgery, 6th Edition, Page 105-107.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q38: Among the options provided, which one is NOT acknowledged as a potential complication resulting from a significant blood transfusion? (Q854760)

A. Hypocalcemia

B. Hypokalemia

C. Hypothermia

D. Hypernatremia

Correct Answer: D. Hypernatremia

Explanation: Hypernatremia is not typically a complication of blood transfusion. Complications of massive blood transfusion: Hypocalcemia : (Option A) Packed red blood cells (PRBCs) and other blood products are preserved with citrate , an anticoagulant. Citrate binds to ionised calcium (Ca^{2}■) in the recipient's blood, reducing the free calcium level - hypocalcemia. Presents as muscle spasms, cardiac arrhythmias, and decreased myocardial contractility. Metabolic Alkalosis : Citrate is metabolised in the liver to bicarbonate (HCO■■) . Rapid transfusion of citrate-containing blood products can overwhelm the liver’s ability to metabolise citrate, leading to an increase in bicarbonate levels. This results in metabolic alkalosis Hyperkalemia : Stored blood undergoes hemolysis over time, releasing potassium from red blood cells into the plasma. Transfusion of large volumes of stored blood can introduce a significant potassium load, causing hyperkalemia . Presents with cardiac arrhythmias, especially in patients with pre-existing kidney dysfunction. Hypothermia : (Option C) Rapid transfusion of cold-stored blood products (typically kept at 1–6°C) can lower the patient’s core body temperature. Coagulopathy : Massive transfusion dilutes clotting factors and platelets, leading to dilutional coagulopathy . Hypothermia and hypocalcemia exacerbate this by impairing the function of coagulation enzymes and platelets. Hypokalemia : (Option B) Post-transfusion, potassium that had leaked out of stored red blood cells can re-enter the cells in vivo. This shift can lead to hypokalemia , especially if the patient has a strong cellular uptake of potassium.

References:

Harmening, D. M. (2012). Modern Blood Banking & Transfusion Practices, 6th Edition.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q39: A patient arrives at the emergency department after being involved in a car accident. The patient is experiencing difficulty breathing and their neck veins appear dilated. The x-ray reveals a significant amount of air on the left side. What is the most appropriate course of action for treatment? (Q793363)

A. Wide bore needle insertion in the 5th intercostal space

B. Endotracheal intubation

C. Tracheostomy

D. Pericardiocentesis



Correct Answer: A. Wide bore needle insertion in the 5th intercostal space

Explanation: Correct Option A: This scenario's next best management step is the wide bore needle insertion in the 5th intercostal space. This is indicative of a tension pneumothorax, which is a medical emergency that requires immediate treatment. A tension pneumothorax occurs when air enters the pleural space (between the lungs and the chest wall) and becomes trapped. As more air accumulates, it can cause a shift in the position of the mediastinum (the area in the chest between the lungs that contains the heart, great vessels, and other structures), leading to compression of the lungs and blood vessels. This can result in respiratory distress, hypoxemia (low oxygen levels in the blood), and cardiovascular collapse. Treating of a tension pneumothorax involves relieving the pressure in the pleural space by inserting a needle or catheter into the chest cavity to allow the trapped air to escape. The insertion site is typically in the 5th intercostal space in the midclavicular line (i.e., the space between the fifth and sixth ribs, in line with the middle of the collarbone). This procedure is known as needle decompression or thoracostomy. Incorrect Options: Option B: Endotracheal intubation involves placing a tube through the mouth or nose into the trachea to provide mechanical ventilation and oxygenation. While this may be necessary in some cases of respiratory distress, it does not address the underlying problem of a tension pneumothorax. Option C: Tracheostomy is a surgical procedure that involves creating a small opening in the neck and inserting a tube directly into the trachea. This is typically done in upper airway obstruction or long-term mechanical ventilation cases. Again, this does not address the underlying problem of a tension pneumothorax. Option D: Pericardiocentesis involves inserting a needle into the pericardial sac (the membrane surrounding the heart) to drain fluid or blood that may be compressing the heart. While this can be a life-saving procedure in cases of cardiac tamponade (heart compression due to fluid or blood in the pericardial sac), it is not indicated in a tension pneumothorax.

References:

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↑ *Back to this question in Part A*

@Neet_pg_bot

Q40: A patient sustained a crush injury on their right arm. He was taken to the hospital and on examination, his arm was pulseless, swollen, and dark red. What would be the best way to manage this case? (Q793385)

A. Intraosseous administration of fluids

B. Acidification of urine

C. Fasciotomy

D. Hemodialysis

Correct Answer: C. Fasciotomy

Explanation: The best way to manage a patient with a crush injury to the arm that presents with a pulseless, swollen, and dark red arm is fasciotomy. A crush injury can result in a significant amount of tissue damage, which can lead to the development of compartment syndrome. Compartment syndrome occurs when there is increased pressure within a muscle compartment, which can result in tissue damage, nerve injury, and even loss of limb function. In this case, the patient's pulseless, swollen, and dark red arm is likely indicative of compartment syndrome, which is a medical emergency that requires immediate intervention to prevent irreversible tissue damage. Fasciotomy is a surgical procedure that involves making an incision into the affected compartment to relieve pressure and improve blood flow to the affected tissues. It is the recommended treatment for compartment syndrome in cases where conservative measures, such as elevation and pain management, are ineffective. Incorrect Choices: Option a: Intraosseous administration of fluids is a method of delivering fluids and medications directly into the bone marrow, bypassing the need for venous access. While this may be useful in certain situations, such as when venous access is difficult to obtain, it is not the appropriate treatment for compartment syndrome. Option b: Acidification of urine may be used in the management of certain types of poisoning, such as aspirin overdose, but it is not indicated in the treatment of a crush injury. Option d: Hemodialysis is a treatment for kidney failure and is not indicated in the treatment of a crush injury.

References:

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↑ *Back to this question in Part A*

@Neet_pg_bot

Q41: During a complicated delivery, a mother died. Which of the following is the most common Direct cause of maternal death? (Q820108)

A. Embolism

B. Heart Disease

C. Hemorrhage

D. Anemia

Correct Answer: C. Hemorrhage

Explanation: Correct Option C - Hemorrhage Hemorrhage, is the most common Direct cause of maternal death during complicated delivery Incorrect Options: Option A - Embolism: An embolism refers to the sudden blockage of a blood vessel by a clot (embolus), which can potentially lead to serious complications. Pulmonary embolism, where a blood clot travels to the lungs, is a known cause of maternal mortality. It can occur during pregnancy, childbirth, or the postpartum period. An embolism can obstruct blood flow and lead to respiratory distress, shock, and even death. While embolism can be a cause of maternal death, but is not the most common direct cause. Option B - Heart Disease: Pre-existing heart disease in a pregnant woman can increase the risk of complications during childbirth. Cardiac events, such as heart failure, myocardial infarction (heart attack), or arrhythmias, can contribute to maternal death. However, but is not the most common direct cause. Option D - Anemia: Anemia is most common indirect cause of death.

References:

.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q42: Which fluid is administered most commonly during intraoperative blood loss? (Q820149)

A. Isolyte P

B. Crystalloids

C. Blood

D. Colloids

Correct Answer: B. Crystalloids

Explanation: Correct option B - Crystalloids: Crystalloids are the most commonly administered fluid for intraoperative fluid administration, especially in minor surgical procedures. Crystalloids are cost-effective, readily available, and generally safe. Incorrect options: Option A, C and D are incorrect.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q43: A 39-year-old female presented in the OPD with bloody discharge from the nipple . On examination, it was found to be from a single lactiferous duct . What is the treatment for bloody nipple discharge with single duct involvement? (Q820183)

A. Microdochectomy

B. Hadfield’s procedure

C. Microdiscectomy

D. IV antibiotics + Incision

Correct Answer: A. Microdochectomy

Explanation: Correct option A - Microdochectomy Microdochectomy involves the surgical removal of the affected lactiferous duct. It is the treatment of choice for cases of bloody nipple discharge originating from a single duct. Incorrect options: Option B - Hadfield’s procedure : Hadfield's procedure is an obsolete surgical procedure used in the past for the treatment of mammary duct ectasia. It is not used for bloody nipple discharge from a single duct. Option C - Microdiscectomy: Microdiscectomy is a surgical procedure used to treat herniated spinal discs that are pressing on nerves. Option D - IV antibiotics + Incision: It is considered in cases of infection-related symptoms or abscesses in the breast and is not the primary treatment for bloody nipple discharge with single duct involvement.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q44: Which of the following is not correct for the device depicted below: (Q820185)

A. Based on infrared emitted from RBCs

B. Localizes calcified plaque

C. Checks blood flow

D. Checks thickness of artery and vein



Correct Answer: A. Based on infrared emitted from RBCs

Explanation: Correct option A - Based on infrared emitted from RBCs: The device depicted is a Doppler ultrasound machine, which uses sound waves and not infrared emitted from RBCs, to create images of blood flow. Doppler ultrasound works by measuring the frequency shift of sound waves reflected off moving red blood cells. This shift in frequency, known as the Doppler effect, helps in visualizing blood flow direction and velocity. Incorrect options: Option B - Localizes calcified plaque: Doppler ultrasound can identify areas of calcified plaque within blood vessels. However, it might not provide as detailed information about the plaque compared to other imaging techniques like CT scans or angiography. Option C - Checks blood flow : Doppler ultrasound is primarily used for assessing blood flow and vascular conditions. Option D - Checks thickness of artery and vein: Doppler ultrasound can be used to measure the thickness of arteries and veins, as well as assess their overall structure and condition. It is particularly useful for evaluating conditions like atherosclerosis, where arteries might become thicker due to plaque buildup.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q45: A 35-year-old male sustained a head injury following a motorcycle accident. He experienced a brief loss of consciousness at the scene. Upon regaining consciousness, he developed a severe headache and began to feel drowsy. A CT scan of the head is performed. Which of the following should be the management for this patient?

(Q840033)

A. Anticoagulants

B. Immediate surgical decompression

C. Observation in ICU

D. Mannitol administration



Correct Answer: B. Immediate surgical decompression

Explanation: Correct Option B - Immediate surgical decompression: The above CT scan shows Biconvex or lenticular or lens shaped hyperdense lesion which is characteristic of Extradural hemorrhage. Patient complains of severe headache and drowsiness. Delaying treatment can lead to increase in ICP which can cause uncal herniation and 3rd nerve palsy. This patient requires immediate surgical decompression by Burr hole or craniotomy. Incorrect Options: Option A - Anticoagulants: Anticoagulants are not used in the treatment as it increases the risk of bleeding or exacerbate the current bleeding. Option C - Observation in ICU: Observation in ICU is not recommended as the patient already exhibits lucid interval and delaying surgery can lead to increased ICP. Option D - Mannitol administration: Mannitol administration is contraindicated in EDH as it increases the mass of the lesion due to water loss.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q46: Which of the following is not done in the primary survey of trauma? (Q840042)

A. NCCT head

B. CXR

C. Intubation

D. ICD drainage

Correct Answer: A. NCCT head

Explanation: Correct Option A - NCCT head: NCCT head is not an adjunct of primary survey in trauma cases. NCCT head is only done after stabilizing the patient as part of tertiary survey, which includes comprehensive evaluation of the patient by physical examination, radiographic imaging. Incorrect Options: Option B - CXR: Chest X-rays is an adjunct of primary survey and it is performed to rule out thoracic blood loss (to rule out hemothorax, pneumothorax, and perforation peritonitis). Option C - Intubation: Endotracheal intubation is performed in case of limited respiratory efforts or dyspnea or low GCS. Option D - ICD drainage: ICD drainage is performed in cases of massive hemothorax, tension pneumothorax and it is an adjunct of primary survey.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q47: Mount fuji sign on CT is seen in which of the following? (Q840051)

A. Pneumocephalus

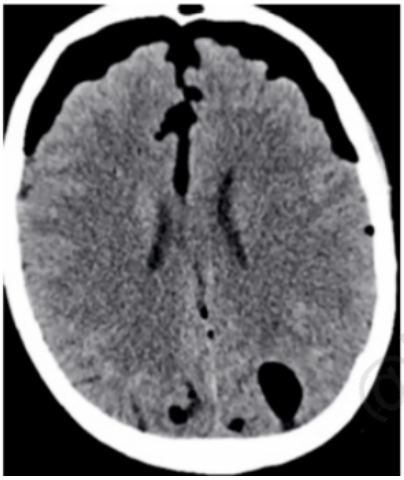
B. Pneumoperitoneum

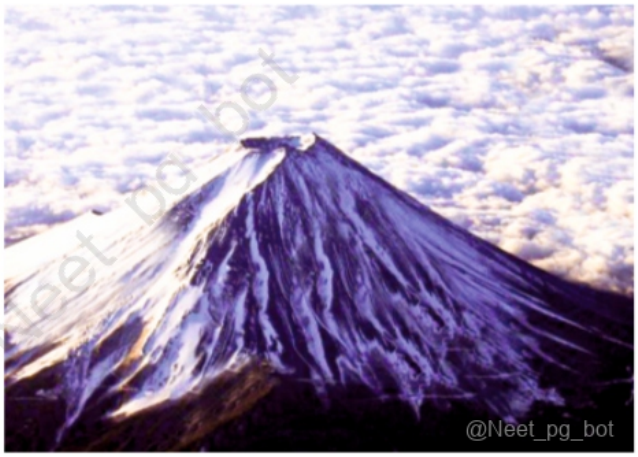
C. Pneumomediastinum

D. Pneumothorax

Correct Answer: A. Pneumocephalus

Explanation: Correct Option A - Pneumocephalus: Mount Fuji sign is seen in tension pneumocephalus. The black area in the T represents air, that is collection of air in the frontal region. Incorrect Options: Option B - Pneumoperitoneum: Pneumoperitoneum on CT shows gas anteriorly and gas in the bowel loops. Option C - Pneumomediastinum: Pneumomediastinum could show ring around artery sign, continuous diaphragm sign, extrapleural sign, and Naclerio V sign. Option D - Pneumothorax: Pneumothorax shows gas around the edges of the lung.





↑ *Back to this question in Part A*

@Neet_pg_bot

Q48: Which of the following is a complication usually associated with the procedure shown in the image below? (Q854753)

A. Aspiration

B. Torticollis

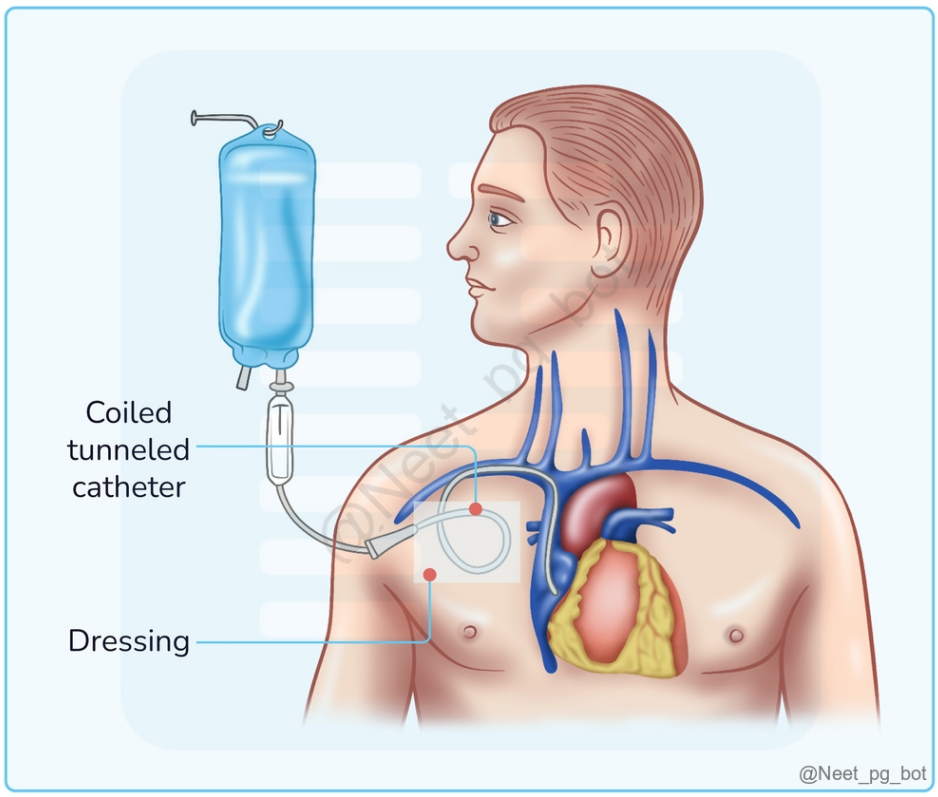
C. Pneumothorax

D. Recurrent laryngeal nerve paralysis



Correct Answer: C. Pneumothorax

Explanation: The procedure shown in the image is central line placement. A potential complication of this procedure is pneumothorax , which occurs when air enters the pleural space, leading to the partial or complete collapse of the lung. This can happen when the central line needle or catheter is inserted into the subclavian or jugular veins. The central venous catheter is used for fluid, medication, and nutrition administration. The tip is located in the superior vena cava. Order of preference: Subclavian vein > Internal jugular vein > Femoral vein Inside OT: Internal jugular vein Outside OT: Subclavian vein. Complications: Catheter-related sepsis, pneumothorax. Incorrect Options: Aspiration (Option A) involves inhaling stomach contents or foreign material into the lungs. Although it can occur in various clinical situations, it is not typically associated with central line placement. Torticollis (Option B) , or wry neck, is a condition where the neck muscles involuntarily contract, causing the neck to twist to one side. This is not a complication directly related to central line placement. Recurrent laryngeal nerve paralysis (Option D) is a complication typically associated with surgeries or procedures involving the neck or chest, such as thyroid or thoracic surgery. It is not commonly linked to central line placement.



References:

https://www.ncbi.nlm.nih.gov/books/NBK557798/

↑ *Back to this question in Part A*

@Neet_pg_bot

Q49: For the purpose of preventing surgical site infection, what is the recommended technique and optimal timing for hair removal prior to surgery? (Q793358)

A. On the OT table with electric hair clippers

B. With a razor 24 hours before surgery

C. With a hair removal cream on the previous day

D. On the OT table with a razor

Correct Answer: A. On the OT table with electric hair clippers

Explanation: Correct Option A: On the OT table with electric hair clippers The ideal time and method of removing hair before surgery to avoid surgical site infection are on the OT table with electric hair clippers. This method is

preferred over the other options because it is considered to be the safest and most effective method for hair removal. Electric clippers are less likely to cause nicks, cuts, or skin irritation than a razor or hair removal cream. Moreover, electric clippers are designed to cut the hair close to the skin without causing any damage to the skin itself. Incorrect Options: Option B: Removing hair with a razor 24 hours before surgery is not recommended because it can cause microscopic cuts on the skin, increasing the risk of infection. Option C: Hair removal creams can cause skin irritation, which can also increase the risk of infection. Option D: Removing hair on the OT table with a razor is not a recommended method because it increases the risk of infection due to the fact that it is more difficult to maintain a sterile environment in the operating room when using a razor.

References:

Sabiston & Bailey

↑ *Back to this question in Part A*

@Neet_pg_bot

Q50: What is the minimum platelet count necessary for most surgical procedures? (Q854782)

A. 20,000 (10^9/L)

B. 30,000 (10^9/L)

C. 40,000 (10^9/L)

D. 50,000 (10^9/L)

Correct Answer: D. 50,000 (10^9/L)

Explanation: A platelet count of at least 50,000 (10^9/L) is generally considered the minimum for performing most surgical procedures safely, as it helps minimise the risk of bleeding. National Institute for Health and Care Excellence (NICE) Guidelines (2015): For invasive procedures or surgery: Platelet counts should be increased above 50,000/µL. For patients at high risk of bleeding: A platelet count of 50,000-75,000/µL is considered appropriate. For surgery at critical sites: A platelet count of > 100,000/µL is recommended.

References:

https://pmc.ncbi.nlm.nih.gov/articles/PMC9988645/

↑ *Back to this question in Part A*

@Neet_pg_bot

Q51: Which one of the following is excluded from the primary survey? (Q854940)

A. Measuring blood pressure

B. Removing clothes to inspect for wounds

C. Taking CT scan of the patient

D. Checking airway patency

Correct Answer: C. Taking CT scan of the patient

Explanation: Taking a CT scan is not part of the primary survey because it is a diagnostic tool used in the secondary survey . ATLS protocol/ Advanced Trauma Life Support protocol: Primary survey: It includes the airway, breathing, circulation, disability or neurologic condition, and exposure and environmental control, which is known by the mnemonic ABCDE. The airway is assessed immediately by a verbal response, and if it is not clear, needful intervention is carried out. (Option D ruled out) Breathing is evaluated by chest movements, breath sounds and saturation and assisted ventilation is provided if needed. Circulation assessment includes ruling out shock . Assessment of circulatory status (e.g., blood pressure, pulses, bleeding), maintaining IV access and immediate fluid resuscitation are recommended according to the ATLS in case of shock. (Option A ruled out) Neurological assessment is done to assess any traumatic brain or spinal injury and neurogenic shock. The GCS score is evaluated. Environmental control: The patient's clothes should be removed for a thorough examination, and hypothermia should be prevented (warm IV fluids, raised room temperature, body warmers). (Option B ruled out) Secondary survey: This includes a complete patient history and a thorough head-to-toe assessment. It is done almost immediately in stable patients and includes radiological investigations. The AMPLE history mnemonic is used to gather key details (A llergies, M edications, P ast medical history, L ast meal, E vents/ E nvironment related to the injury). Face deformities, posterior neck injuries, the torso, a per rectal examination for GI bleed, and prostate location are all included in this step. A thorough neurological examination and evaluation of superficial injuries are done. The complete physical examination and use of imaging are now included in the tertiary survey.

References:

Sabiston’s Text Book of Surgery, 21st Edition, Pages 391, 392

↑ *Back to this question in Part A*

@Neet_pg_bot

Q52: Which of the following is not taken into consideration in ASEPSIS wound scoring? (Q854951)

A. Wound swab from the site

B. Serous discharge

C. Erythema

D. Induration

Correct Answer: D. Induration

Explanation: The Asepsis scoring system evaluates infection based on visible signs like erythema, exudate type, and laboratory investigations , but induration is not directly taken into account. Asepsis wound score: Parameters Score A dditional treatment: Antibiotics Pus drainage Wound debridement 10 5 10 S erous discharge - For 5 days of the first 7 days of wound infection (Option B ruled out) 0-5 Daily E rythema - For 5 days of first 7 days of wound infection (Option C ruled out) 0-5 Daily P urulent fluid - For 5 days of the first 7 days of wound infection 0-10 Daily S eparation of deep tissues - For 5 days of the first 7 days of wound infection 0-10 Daily I solation of bacteria (Option A ruled out) 10 S tay in the hospital (in-patient) >14 days due to infection 5 Asepsis scores are grouped into the following categories: Satisfactory healing: 0-10 Disturbance of healing:11-20 Minor SSI: 21-30 Moderate SSI: 31-40 Severe SSI: >40

References:

SRB's Manual of Surgery, 6th Edition, Page 62. NIH Link .

↑ *Back to this question in Part A*

@Neet_pg_bot

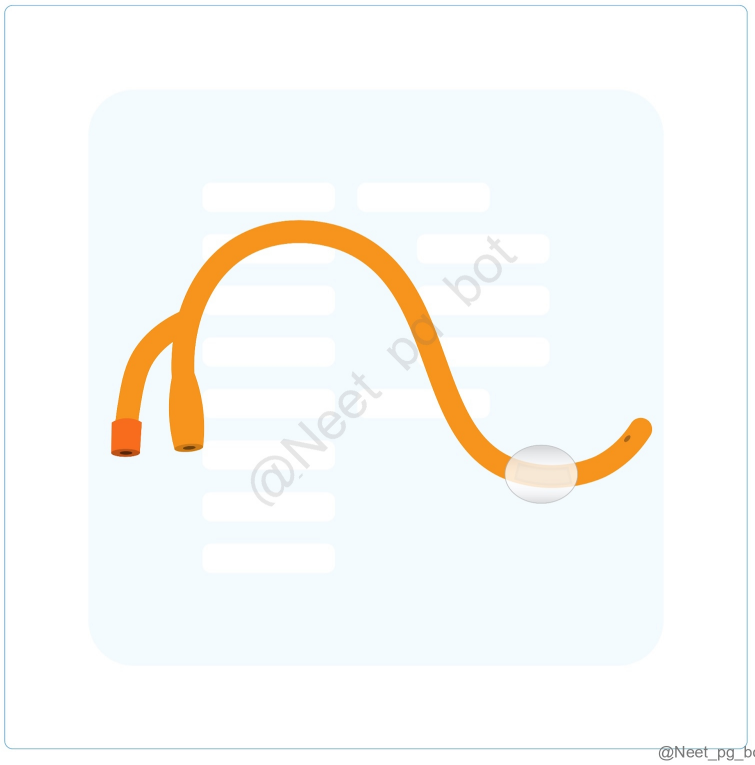
Q53: What does the number (14Fr) marked on the Foley catheter correspond to? (Q855673)

A. Inner lumen diameter

B. Length of the tube

C. Outer tube diameter

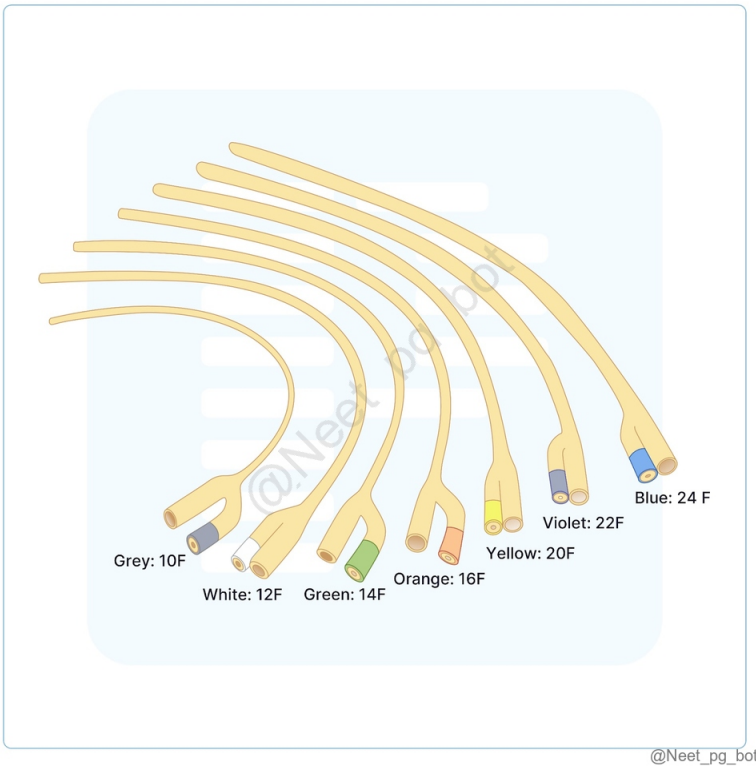
D. Bulb size



Correct Answer: C. Outer tube diameter

Explanation: The number (14Fr) marked on the Foley’s Catheter indicates its outer tube diameter, measured in French (Fr) units, where 1 French equals 0.33 mm. {{caption_text}} Material LATEX - Less irritation & crust formation Silicone Coating- for Prolonged use (up to 3 months) Types 2-way Foley catheter 3-way Foley catheter Channels 2-way Foley catheter: Main channel: For drainage of urine Small channel: For inflating balloon 3-way Foley catheter: Main channel: for drainage of urine Additional channel for irrigation Balloon Inflation 20-30 ml saline for self-retaining 30-50 ml of saline for a hemostatic compression effect Sizes (French scale) Pediatric patients : 4, 6, 8, 10 Adult patients: 12, 14, 16, 18 Size Calculation Outer diameter of catheter in mm = Fr/3 (Fr - French units) E.g., if the size of the catheter is 18 French, then diameter = 18/3 = 6mm Uses To relieve urinary retention To measure urine output For administration of intravesical chemotherapy 3 ways catheter - for Irrigation after TURP May be used for supra-pubic cystostomy Inner lumen diameter (Option A) : The marked number refers to the outer diameter, not the inner lumen diameter, which impacts flow rate but is not indicated by the French size. Length of the tube (Option B) : The French size does not represent the catheter's length, which is usually marked separately and unrelated to the outer diameter measurement. Bulb size (Option D) : The French size does not indicate the balloon or bulb size, which is specified separately and unrelated to the outer tube diameter.





References:

SRBs Manual of Surgery, 8th Edition, Page 990-991.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q54: Which of the following statements are true regarding central venous access and peripheral venous access? Phlebitis is the most common complication in peripheral venous access. Isotonic saline and heparin are flushed to retain patency If an arteriovenous fistula is present in a limb, avoid peripheral venous access in the same limb. Vasopressors for septic shock are given in the central line to avoid limb ischemia. (Q855686)

A. 1, 3, 4

B. 2, 3, 4

C. 1, 2, 3, 4

D. 1, 2, 3

Correct Answer: C. 1, 2, 3, 4

Explanation: All four statements regarding central venous access and peripheral venous access are true. Phlebitis is the most common complication in peripheral venous access It refers to inflammation of the vein It is a common complication of peripheral venous access. It can occur due to various factors, such as chemical irritation, mechanical irritation, or infection. Isotonic saline and heparin are flushed to retain patency: To maintain the patency of central venous access devices (such as central venous catheters or central lines), periodic flushing with isotonic saline and heparin is commonly performed. This helps prevent clot formation and maintain the functionality of the line. If an arteriovenous fistula is present in a limb, avoid peripheral venous access in the same limb. An arteriovenous fistula (AVF) is a surgically created connection between an artery and a vein, typically used for hemodialysis. When an AVF is present in a limb, it is generally recommended to avoid peripheral venous access in the same limb to prevent damage to the AVF and maintain its functionality. Vasopressors for septic shock are given in the central line to avoid limb ischemia. Vasopressors for septic shock can be administered through either central venous access or peripheral venous access, depending on the clinical situation and availability of access. The choice of access depends on factors such as the stability of peripheral veins, the need for continuous infusion, and the urgency of treatment. Limb ischemia is a potential complication of vasopressor administration, but it is not exclusive to peripheral venous access.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 18, 338-340. Study on incidence of phlebitis following the use of pherpheral intravenous catheter - PMC Heparin flush vs. normal saline flush to maintain the patency of central venous catheter among adult patients: A systematic review and meta-analysis - PMC

↑ *Back to this question in Part A*

@Neet_pg_bot

Q55: Which of the following statements is accurate concerning split-thickness and full-thickness skin grafts? Primary contractures are more in split skin grafts Secondary contractures are more in split skin grafts Primary contractures are more in full-thickness grafts Secondary contractures are more in full-thickness grafts (Q855680)

A. 2 and 3

B. 2 and 4

C. 1 and 3

D. 1 and 4

Correct Answer: A. 2 and 3

Explanation: Primary contraction is the initial recoil of the skin graft, which is more pronounced in full-thickness grafts. Secondary contraction occurs after the healing process and is commonly seen in split-thickness grafts. Feature Split-Thickness Skin Graft Full-Thickness Skin Graft Composition Epidermis + part of dermis Epidermis + full thickness of dermis Graft Size Large grafts can be taken Only small grafts can be taken Graft Survival Easier More difficult Donor Site Healing Heals spontaneously, allowing repeated grafts Permanent defect develops, preventing repeated grafts Graft Contraction (Option A) Secondary contracture is more significant Primary contracture is more significant Common Donor Sites Inner thigh, upper arm, flexor aspect of forearm, abdominal wall Upper eyelid, retro auricular skin, supraclavicular skin, antecubital skin, inframammary skin, inguinal skin, genital skin, gluteal skin Donor Site Exclusions None Axilla is not used as a donor site Advantages of Harvesting Allows calibration of thickness and large area coverage Calibration of thickness for small but thick grafts

References:

Sabiston Textbook of Surgery, 21st Edition, Page 1917. https://www.ncbi.nlm.nih.gov/books/NBK551561/

↑ *Back to this question in Part A*

@Neet_pg_bot

Q56: Which of the following options does not represent one of the boundaries of the triangle of safety for the insertion of an ICD in a patient with a chest x-ray showing pneumothorax? (Q855678)

A. Lateral edge of the pectoralis major

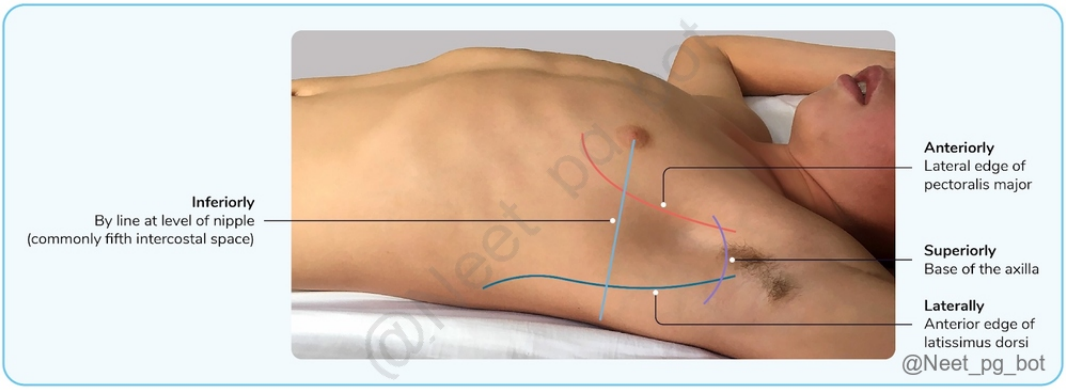
B. Mid-clavicular line

C. 5th intercostal space

D. Lateral border of latissimus dorsi

Correct Answer: B. Mid-clavicular line

Explanation: The mid-clavicular line is a vertical line through the clavicle and does not define the boundaries of the Triangle of Safety . It is an anatomical region in the axilla that guides the safe position for intercostal catheter (ICC) placement. With the arm abducted, the apex is the axilla, and the triangle is formed by the following: The lateral border of the pectoralis major - anteriorly. (Option A ruled out) The lateral border of the latissimus dorsi - posteriorly. (Option D ruled out) Inferiorly, by a horizontal line from the nipple (commonly the 5th intercostal space). (Option B ruled out) {{caption_text}} Triangle of safety



References:

Bailey and Love Short Practice of Surgery, 28th Edition, Page 981. Triangle of safety

↑ *Back to this question in Part A*

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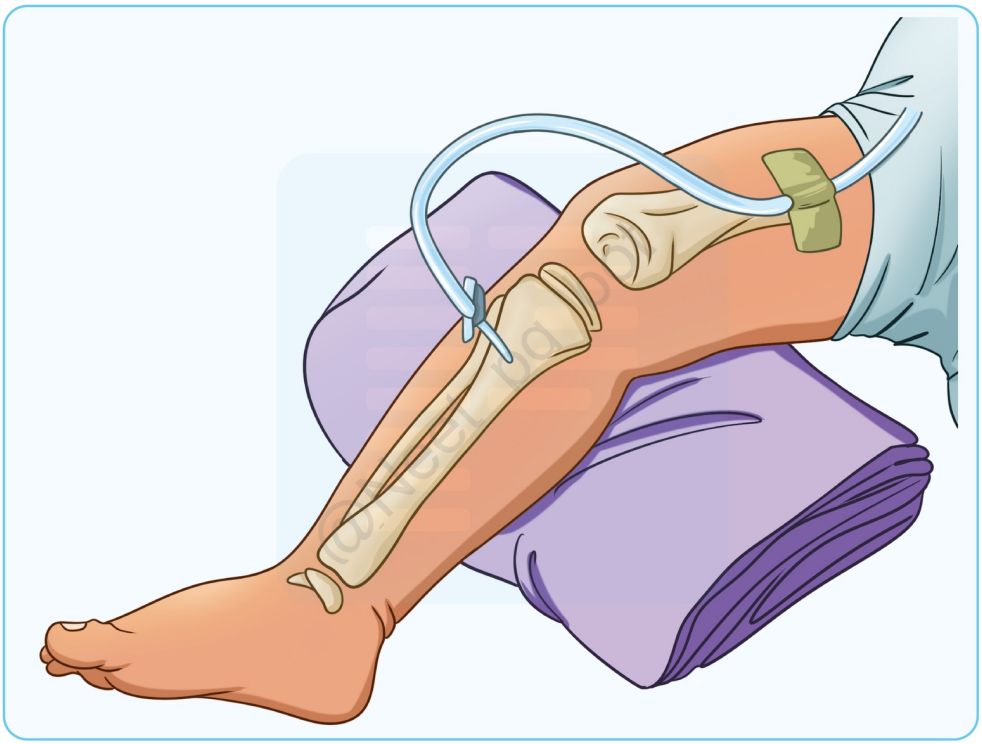
Q57: Identify the procedure being performed in the image given below. (Q855166)

A. Intraosseous cannula for pain relief

B. Bone marrow aspiration

C. Intraosseous route access for giving IV fluids

D. Bone marrow biopsy



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Correct Answer: C. Intraosseous route access for giving IV fluids

Explanation: The image likely depicts a procedure for establishing an intraosseous route to administer IV fluids. This technique is commonly used when IV access is difficult or not possible. Intraosseous infusion (IO) involves injecting drugs, fluids, or blood products directly into the medullary cavity of the bone, providing a non-collapsible entry point into the systemic venous system. IO route is an alternative to the IV route in the transfusion of fluids in shock. The marrow of long bones has a rich network of vessels that drain into the central venous canal, emissary veins, and ultimately to central circulation. So, bone marrow functions as a non-collapsible venous access route. Intraosseous cannulation: Intraosseous cannulation is a widely accepted technique for both children and adults. The EZ-IO® system is commonly used in the UK. A hand-held electric drill is used to insert a cannula through the tibia or humeral head into the marrow cavity. The response time for drug administration is similar to intravenous (IV) access. Entire resuscitations , including anaesthetic drugs and fluids, can be performed through intraosseous cannulae. Due to resistance to flow , fluids should be given as boluses using a 50 mL syringe . Other options: Option A: Intraosseous cannula for pain relief IO access is not used for analgesia. It is used only for emergency vascular access. Option B: Bone marrow aspiration This is done with a different needle, usually at the iliac crest, and not used for administering fluids. Option D: Bone marrow biopsy This is a therapeutic/diagnostic procedure for hematologic evaluation, not for vascular access or resuscitation.

References:

Apley and Solomon’s System of Orthopaedics and Trauma, 10th Edition, Page 682

↑ *Back to this question in Part A*

@Neet_pg_bot

Q58: In the case of a patient arriving at the emergency department with a road traffic accident (RTA), what is the appropriate order of steps in their management? Cervial spine stabilisation Intubation IV cannulation CECT (Q855671)

A. 1, 3, 2, 4

B. 1, 2, 3, 4

C. 2, 1, 3, 4

D. 2, 1, 4, 3

Correct Answer: B. 1, 2, 3, 4

Explanation: The proper sequence of Trauma Care management for a patient presenting with an RTA (road traffic accident) is 1, 2, 3, 4. Primary Survey It aims to identify and manage the most immediately life-threatening pathologies first and follows cABCDE. c: Exsanguinating external haemorrhage The exsanguinating external haemorrhage from massive arterial bleeding needs to be controlled even before the airway is managed. A: Airway with cervical spine control Cervical spine stabilisation. (Statement 1) Assessment of the patient's airway. Compromised airway requires a stepwise progression: Clearing the airway by suctioning secretions or blood. Simple airway manoeuvres (jaw thrust, chin lift and insertion of an oropharyngeal or nasopharyngeal airway). Advanced airway manoeuvres (intubation). (Statement 2) B: Breathing and ventilation High-flow oxygen. Assess bilateral chest raise. Assess breath sounds Use pulse oximetry Life-threatening chest pathology (tension pneumothorax, massive haemothorax and fail segment) should be diagnosed and managed. C: Circulation and haemorrhage control Monitor vitals. Heart sounds ECG Intravenous (IV) access with at least two large-bore IV cannulae (central, peripheral). (Statement 3) Blood was taken for cross-match and laboratory assessment. Treatment of shock. Control of external bleeding. D: Disability Neurological examination. Use required tubes like catheters, Ryle's tube. E: Exposure Undress the patient Hypothermia assessment. Assess injuries (imaging like USG, CT scan, MRI). (Statement 4) Examine joints, bones, abdomen, and other systems. Look for identification marks. Secondary Survey: Detailed top-to-toe examinations after life-threatening injuries have been identified and managed during the primary survey. Patients may be intubated and unresponsive at this point, limiting the accuracy of clinical examination. Tertiary survey After extubation, identify any missed 'minor' injuries (scaphoid fracture in the wrist or a rotator cuff tear in the shoulder). These injuries have the potential to cause significant long-term disability.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 355-357. SRB's Surgical Operations, 6th Edition, Page 203.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q59: Hand rub can be utilised in accordance with the standard hand hygiene protocol in all locations listed below, with the exception of: (Q855667)

A. If the hands are visibly soiled

B. While moving from a contaminated site to a clean site during patient care

C. After removing sterile gloves

D. During direct patient contact

Correct Answer: A. If the hands are visibly soiled

Explanation: As per the WHO Standard Hand Hygiene Protocol , hand rub is not suitable for visibly soiled hands, and handwashing with soap and water is required to remove dirt and contaminants. Indications: Wash hands with soap and water when visibly dirty or visibly soiled with blood or other body fluids or after using the toilet. (Option A) If exposure to potential spore-forming pathogens is strongly suspected or proven, including outbreaks of Clostridium difficile , hand washing with soap and water is the preferred means. Use an alcohol-based hand rub as the preferred means for routine hand antisepsis in clinical situations if hands are not visibly soiled. (Option A) If alcohol-based hand rub is not obtainable, wash hands with soap and water. Perform hand hygiene: Before and after touching the patient. (Option D ruled out) Before handling an invasive device for patient care, regardless of whether or not gloves are used After contact with body fluids or excretions, mucous membranes, non-intact skin, or wound dressings If moving from a contaminated body site to another body site during the care of the same patient (Option B ruled out) After contact with inanimate surfaces and objects (including medical equipment) in the immediate vicinity of the patient. After removing sterile or non-sterile gloves. (Option C ruled out) Before handling medication or preparing food, perform hand hygiene using an alcohol-based hand rub or wash hands with either plain or antimicrobial soap and water. Soap and alcohol-based hand rubs should not be used concomitantly. Technique: Apply a palmful of alcohol-based hand rub and cover all surfaces of the hands. Rub hands until dry. When washing hands with soap and water, Wet hands with water and apply the amount of product necessary to cover all surfaces. Rinse hands with water and dry thoroughly with a single-use towel. Use clean, running water whenever possible. Avoid using hot water, as repeated exposure to hot water may increase the risk of dermatitis. Use towel to turn off the tap/faucet. Dry hands thoroughly using a method that does not recontaminate hands. Make sure towels are not used multiple times or by multiple people. Liquid, bar, leaf or powdered forms of soap are acceptable. When bar soap is used, small bars of soap in racks that facilitate drainage should be used to allow the bars to dry.



References:

CONSENSUS RECOMMENDATIONS - WHO Guidelines on Hand Hygiene in Health Care - NCBI Bookshelf

↑ *Back to this question in Part A*

@Neet_pg_bot

Q60: Which of these is the most life-threatening injury that can be identified by assessing the breathing component of the patient? (Q855661)

A. Cervical spine injury

B. Tension pneumothorax

C. Blunt cardiac injury

D. Laryngotracheal injury

Correct Answer: B. Tension pneumothorax

Explanation: Tension Pneumothorax is the most life-threatening injury that can be identified by assessing the patient's breathing component. It occurs when air accumulates in the pleural space, increasing pressure on the

lungs and heart, leading to lung collapse and impaired blood flow. It can rapidly cause cardiovascular collapse and is fatal without prompt decompression. Life-threatening Injuries These can be remembered as the ‘ deadly dozen’ . Six Immediately life-threatening injuries were managed during the primary survey. Six Potentially life-threatening injuries were detected during the secondary survey. Immediately life-threatening injuries Potentially life-threatening injuries Airway obstruction Tension pneumothorax Pericardial tamponade Open pneumothorax Massive haemothorax Flail chest Aortic injuries Tracheobronchial injuries Myocardial contusion Rupture of the diaphragm Oesophageal injuries Pulmonary contusion Cervical spine injury (Option A) can cause neurological complications, but it doesn’t directly compromise breathing, making it less life-threatening compared to other injuries in this context. Blunt cardiac injury (Option C) primarily affects the heart, potentially leading to arrhythmias or cardiac rupture. While it can be life-threatening, it does not directly compromise breathing, unlike other injuries. Laryngotracheal injury (Option D) can cause airway obstruction and breathing difficulties, but tension pneumothorax is more immediately life-threatening, rapidly leading to respiratory and cardiovascular collapse if untreated.

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Q61: According to triage, which of the following categories of patients comes under green? (Q855552)

A. Ambulatory patients

B. Moderate priority

C. High Priority

D. Dead patients

Correct Answer: A. Ambulatory patients

Explanation: In triage, patients are categorised based on the urgency of their medical needs, and the green category is for ambulatory patients , meaning those who are able to walk and have non-life-threatening injuries. Colour Priority Medical Need Clinical Status Examples Red First Immediate Critical, but likely to survive if treatment is given early Severe facial trauma Tension pneumothorax Profuse external bleeding Haemothorax Flail chest Major intra-abdominal bleed Extradural haematomas Yellow Second Urgent Critical, but likely to survive if treatment is given within hours Compound fractures Degloving injuries Ruptured abdominal viscus Pelvic fracture Spinal injuries Green Third Non-Urgent Stable, likely to survive even if treatment is delayed for hours to days Simple fractures Sprains Minor lacerations Black Last Unsalvageable Not breathing, pulseless, so severely injured that no medical care is likely to help. Severe brain damage Very extensive burns Major disruption/ loss of chest or abdominal wall structures Moderate priority (Option B) can be classified as yellow in triage. These patients have conditions that are serious but not immediately life-threatening. They may require medical attention, but they can still wait for a period without their condition deteriorating rapidly. High priority (Option C) is generally categorised as red in triage, indicating immediate care is required . These patients have life-threatening injuries or conditions and need immediate medical intervention. Dead patients (Option D) are not part of the triage process, as they are not classified for further care. Triage prioritises patients based on the severity of their condition to allocate

resources effectively, focusing on those who can be saved or treated.

References:

Sabiston’s Text Book of Surgery, 21st Edition, Pages 560, 561

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Q62: A patient presents with multiple stab injuries to the chest. On examination, there is reduced chest movement on the right side and tracheal deviation to the left side. Additionally, the neck veins are distended. What is the next best step in the management of this patient? (Q855325)

A. Resuscitative thoracotomy

B. ICD placement

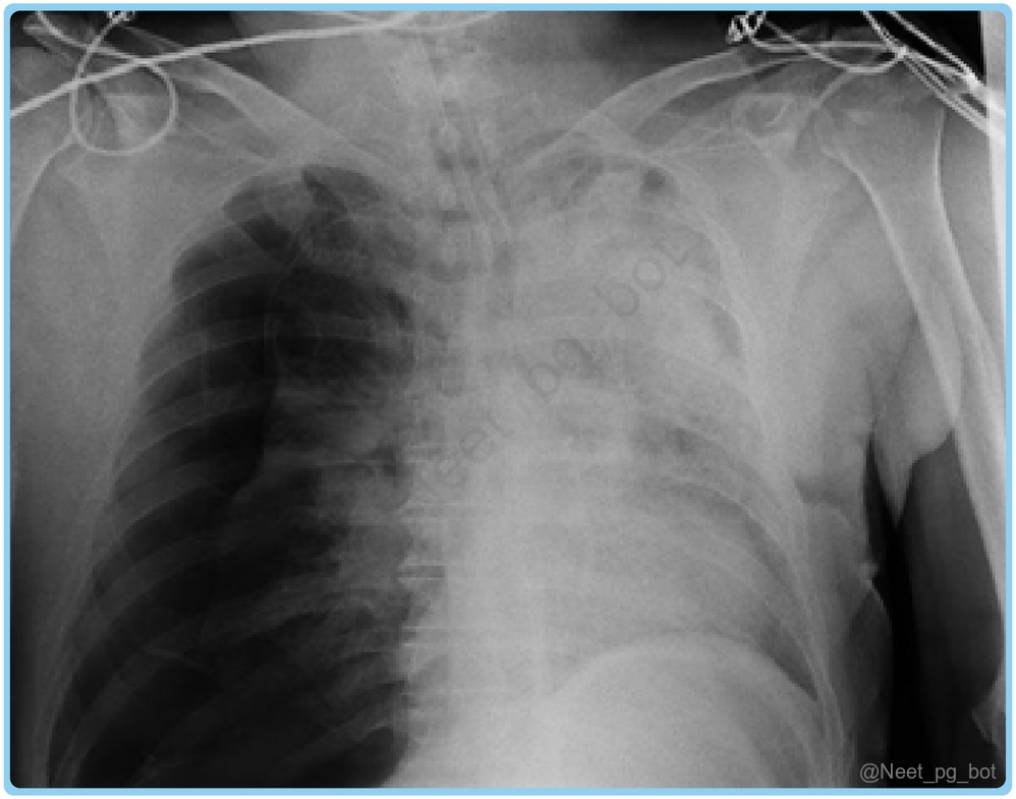
C. Needle thoracocentesis

D. Finger thoracotomy

Correct Answer: C. Needle thoracocentesis

Explanation: Needle thoracocentesis The signs of reduced chest movement, tracheal deviation, and distended neck veins suggest a Tension Pneumothorax , which requires immediate decompression with needle thoracocentesis to relieve pressure and stabilise the patient before further interventions. Tension Pneumothorax It is a life-threatening condition where air accumulates in the pleural cavity under pressure, causing lung collapse on the affected side, mediastinal shift , and severe impairment of cardiovascular function. Pathology It occurs when air enters the pleural cavity through a "one-way valve" mechanism, leading to lung collapse and mediastinal shift towards the opposite side. ↑Pleural pressure→ Opposite lung compression→ ↓venous return→ ↓cardiac output and potentially sudden death. Aetiology Penetrating chest trauma. Blunt chest trauma with parenchymal lung injury. Iatrogenic lung injury (e.g., central venous catheterisation) and mechanical positive-pressure ventilation. Clinical Features Restlessness, tachypnea, dyspnea, tachycardia, and chest pain. Distended neck veins, hyper-resonance, and decreased or absent breath sound on the affected side. Late findings may include tracheal deviation and cyanosis. Hypotension and severe mediastinal/tracheal shift are also common. Management Needle Thoracocentesis : Immediate decompression with a large-bore needle in the 2nd intercostal space at the midclavicular line, or the "safe triangle". Followed by intercostal chest tube (ICT) placement in the 5th intercostal space in the anterior axillary line. Provide oxygen, analgesics, antibiotics, and ventilator support if necessary. {{caption_text}} Resuscitative thoracotomy (Option A) is used in traumatic cardiac arrest or severe haemorrhage, not for tension pneumothorax. Tension pneumothorax is urgent but not immediately fatal and should be treated with needle thoracocentesis. ICD placement (Option B) is not the immediate treatment for tension pneumothorax, as it doesn't quickly relieve pressure. Needle thoracocentesis should be performed first, with ICD placement done afterwards for ongoing drainage. Finger thoracotomy (Option D) is used for cardiac tamponade, not tension pneumothorax. Needle thoracocentesis is the preferred initial intervention for rapid decompression, while finger thoracotomy is

reserved for later stages if needed.



References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 374. Textbook of SRB’s Surgical Operations, 6th Edition, Page 1101-1102.

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@Neet_pg_bot

Q63: Which of the following is true regarding shock? (Q855318)

A. Anaerobic respiration produces carbon dioxide

B. Hypovolaemic shock—most common type

C. Stage of compensatory shock is also called stage 2 of shock

D. Anaphylactic shock—is due to a Type 2 hypersensitivity reaction

Correct Answer: B. Hypovolaemic shock—most common type

Explanation: Hypovolaemic Shock is the most common type of shock. It is due to a reduced circulating volume. Cause: Haemorrhagic Injury to the liver, spleen, and bone fractures Haemothorax Vascular injury Severe bleeding on the table during surgeries Nonhaemorrhagic Poor fluid intake (dehydration) Excessive fluid loss due to vomiting, diarrhoea, urinary loss (e.g. diabetes) Evaporation or 'thirdspacing', where fluid is lost into the gastrointestinal tract and interstitial spaces (bowel obstruction or pancreatitis). Clinical features: Cold and clammy skin - due to inadequate tissue perfusion. Reduced renal blood flow and GFR lead to oliguria, which may lead to anuria. Cerebral blood flow is reduced, leading to drowsiness and confusion. Tachypnoea - due to lactic acidosis Tachycardia Weak thready pulse Sweating Classification: Parameter Class I (Compensated Shock) Class II (Hypoxemia) Class III Class IV (Refractory Shock) Blood Loss Up to 15% 15-30% 30-40% More than 40% Mechanism Compensatory mechanisms maintain cardiac output. Generalised vasoconstriction. Decompensated shock. Refractory shock. Heart Rate <100/min 100-120/min 120-140/min >140/min Blood Pressure Normal Hypotension Marked hypotension Profound hypotension Respiratory Rate Normal Tachypnea Tachypnea Tachypnea Urine Output >30 ml/hour 20-30 ml/hour 5-15 ml/hour No urine output Mental Status Alert, normal Anxious, mildly agitated Confused, altered mental status Comatose, lethargic Anaerobic respiration produces carbon dioxide (Option A) : Anaerobic respiration occurs in the absence of oxygen and results in the production of lactic acid, not carbon dioxide. Stage of compensatory shock is also called stage 2 of shock (Option C) : Class I refers to hypovolemic shock with up to 15% blood loss, where compensatory mechanisms sustain cardiac output, also known as Compensated Hypovolemic Shock. Anaphylactic shock is due to Type 2 hypersensitivity reaction (Option D) : Anaphylactic shocks due to Type 1 hypersensitivity reaction.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 12-14.

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@Neet_pg_bot

Q64: Which one of the options listed below does not belong to the category of damage control surgery? (Q855279)

A. Control of hemorrhage

B. Resuscitation

C. Decontamination

D. Vascular anastomosis

Correct Answer: D. Vascular anastomosis

Explanation: Vascular anastomosis is not typically performed during Damage Control Surgery , as the focus is on resuscitation, hemorrhage control, and stabilisation, with definitive repairs done later when the patient is stable. Phases of Damage Control Surgery Phase Intervention Steps 1 Recognition and Decision-making Intubation, early rewarming, and prompt movement to operation theatre 2 Immediate Laparotomy Control of bleeding, abdominal packing, and temporary abdominal closure 3 Intensive Care Unit Ongoing resuscitation and normalisation of

physiological and biochemical parameters 4 Re-Exploration Definitive repair of all injuries Stages of Damage Control Surgery Stage Intervention 1 Patient Selection 2 Control of haemorrhage and contamination (Option A, C ruled out) 3 Resuscitation in ICU (Option B ruled out) 4 Definitive Surgery 5 Abdomen closure

References:

Bailey and Love's Short Practice of Surgery, 28th Edition, Page 385-386, 463-464. Schwartz's Principles of Surgery, 11th Edition, Page 215.

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Q65: A young patient presents with a 5-day fever history and signs of hypotension, tachycardia, tachypnea, and altered mental status. Lab results show elevated white blood cell count, neutrophil proportion, and serum creatinine. The intern doctor plans to assess the quick Sequential Organ Failure Assessment (qSOFA) score for prognosis prediction and hospitalisation duration. Which elements are part of the qSOFA score? (Q855275)

A. BP, RR, and CBC

B. Creatinine, PR, and BP

C. RR, Body temperature, and PR

D. SBP, RR, and GCS score

Correct Answer: D. SBP, RR, and GCS score

Explanation: The qSOFA score includes three components: Systolic Blood Pressure (SBP) less than 100 mmHg Respiratory Rate (RR) greater than or equal to 22 breaths per minute Glasgow Coma Scale (GCS) score. These components help in the assessment of organ failure and sepsis prognosis. Sepsis & q SOFA: Sepsis is now defined as an increase of 2 or more points in the Sequential Organ Failure Assessment (SOFA) score from baseline. However, calculating the full SOFA score can be complex and requires lab results, so a simpler tool, the quick SOFA (qSOFA) score, was introduced for bedside use. qSOFA Criteria: qSOFA involves evaluating three key signs: Respiratory rate ≥ 22 breaths per minute Altered mental status (GCS score) Systolic blood pressure ≤ 100 mmHg (hypotension) If a patient meets at least 2 of the 3 qSOFA criteria and is at risk for sepsis (e.g., has an infection), further evaluation should be conducted to identify the source of infection and initiate appropriate treatment.

References:

Sabiston Textbook of Surgery, 21st Edition, Page 62, 63

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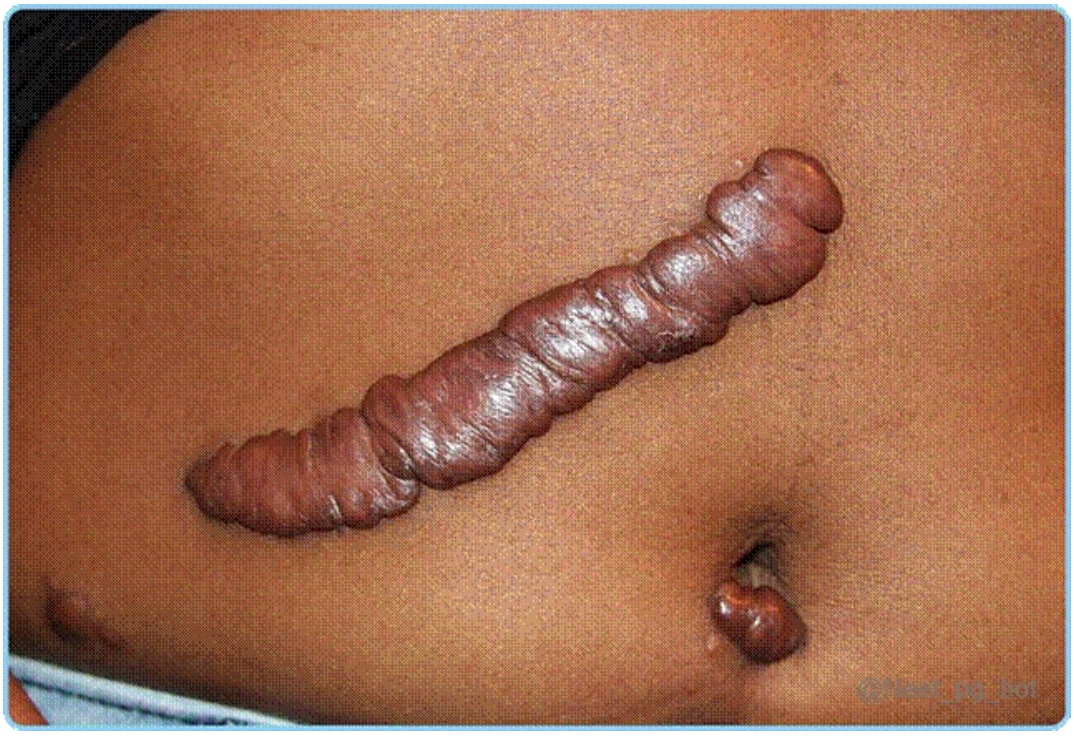
Q66: A patient presents to the clinic with a lesion as shown in the image. He had a traumatic injury to the chest one year ago, and the scar has grown beyond the boundary of the initial injury. What is the most likely diagnosis? (Q855177)

A. Hemangioma

B. Hypertrophic scar

C. Keloid

D. Neurofibroma



Correct Answer: C. Keloid

Explanation: Keloid: The lesion described is most consistent with a keloid that is characterised by the excessive growth of scar tissue beyond the boundaries of the original injury, and it often develops after trauma or surgery. They are known for being raised, thick, and sometimes itchy. Doesn't regress. More common among African Americans. Develops after deep dermal injuries. {{caption_text}} Hemangiomas (Option A) are benign tumours of blood vessels, usually present at birth or appearing in early childhood. They do not develop as a result of trauma. Hypertrophic scar: (Option B) {{caption_text}} Confined to the original wound boundaries, unlike keloids that extend beyond the wound area. Raised scar with excess collagen. It grows rapidly and contains myofibroblasts. It tends to regress over time (months) and recur less compared to keloid Neurofibromas (Option

D) are benign nerve sheath tumours, commonly associated with genetic conditions like neurofibromatosis rather than trauma.





References:

Robbins & Cotran Pathologic Basis of Disease, 10th Edition, Page 110,111

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 28

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Q67: A 38-year-old man was brought to the emergency department after sustaining an RTA and injury to the lower chest. On presentation, the patient is stable, and vitals are normal . Chest radiography showed clear lung fields. What is the next step in management? (Q801160)

A. eFAST

B. Tube thoracostomy

C. CECT chest

D. CECT abdomen

Correct Answer: A. eFAST

Explanation: Correct Option A - eFAST: eFAST (extended Focused Assessment with Sonography for Trauma) is a rapid bedside ultrasound to detect life-threatening injuries in trauma patients, focusing on the chest and abdomen. It assesses the pericardium, pleural spaces, and abdominal cavity for air or fluid. If a pneumothorax or hemothorax is ruled out by clear lung fields on chest radiography, eFAST helps identify other bleeding sources, like intraperitoneal bleeding, guiding further management. Incorrect Options: Option B - Tube thoracostomy: Inserting a chest tube treats pneumothorax or hemothorax, but since lung fields are clear, it's not the immediate step. Options C and D - CECT chest and abdomen: While valuable, immediate CECT can delay addressing the cause. It's better for later detailed imaging.

References:

Prepladder Notes

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@Neet_pg_bot

Q68: Which of the following tests is not conducted before a blood transfusion for a person with RTA, when a family member is volunteering for blood donation? (Q793932)

A. Hepatitis A

B. Hepatitis B

C. Hepatitis C

D. HIV 1 & 2

Correct Answer: A. Hepatitis A

Explanation: Correct Option A - Hepatitis A: Hepatitis A virus is usually transmitted through contaminated food or water and is not typically transmitted through blood transfusions. Therefore, testing for Hepatitis A is not routinely performed before blood transfusion. Incorrect Options: Options B, C & D: these are incorrect as can be transmitted through blood and other bodily fluids and need to be screened before transfusion.

References:

Prepladder Notes

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@Neet_pg_bot

Q69: What guidance would you provide to the female patient prior to undergoing laparoscopic surgery? (Q793926)

A. Eat full before surgery.

B. Drink plenty of water before surgery.

C. Enema on the night before surgery

D. NPO for specific hours before surgery

Correct Answer: D. NPO for specific hours before surgery

Explanation: Correct Option D - NPO for specific hours before surgery: Laparoscopic surgery is a minimally invasive surgical procedure During laparoscopic surgery, the patient is under general anesthesia, which can cause nausea and vomiting if the stomach is not empty. To reduce the risk of aspiration , it is recommended that patients undergoing laparoscopic surgery follow NPO guidelines. The specific NPO guidelines may vary depending on the type of surgery and the individual patient's medical history, but generally, patients are advised not to eat or drink anything for several hours before the surgery. Incorrect Options: Option A - Eat full before surgery: Eating a full meal before surgery is not recommended as it can increase the risk of aspiration and may cause delays in the surgery. Option B - Drink plenty of water before surgery: Drinking water before surgery can increase the risk of aspiration and delay the procedure. Patients are typically allowed to drink clear liquids up to two hours before the surgery. Option C - Enema in the night before surgery . Enema in the night before surgery", may be recommended

for certain types of surgeries or patients, but it is not a standard recommendation for laparoscopic surgery.

References:

Prepladder Notes

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@Neet_pg_bot

Q70: Which of the following is not included in the AAST grading system for splenic trauma? (Q793921)

A. Parenchymal destruction

B. Vascular involvement

C. Adjacent organ involvement

D. Hematoma

Correct Answer: C. Adjacent organ involvement

Explanation: of correct answer.

References:

Sabiston & Bailey

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Q71: What is the likely reason behind the occurrence of surgical emphysema in the patient following an emergency tracheostomy performed outside of the hospital? (Q793917)

A. Puncture of posterior wall

B. High tracheostomy

C. Blockage of the tube

D. Tight suture

Correct Answer: D. Tight suture

Explanation: Correct Option D - Tight suture: Surgical emphysema (subcutaneous emphysema) occurs when air gets trapped in the soft tissues around the surgical site, causing swelling and discomfort. In the case of a tracheostomy, a common cause of surgical emphysema is improper technique during the procedure. Tight suturing around the tracheostomy site can lead to air leakage into the surrounding tissues. When sutures are placed too tightly, they can tear the tissues or fail to adequately seal the surgical site, allowing air to escape and become trapped in the subcutaneous tissues, resulting in surgical emphysema. Incorrect Options: Option A - Puncture of posterior wall: Puncture of the posterior wall of the trachea during a tracheostomy can indeed cause air to leak into the surrounding tissues, leading to surgical emphysema. However, it is less common than issues related to suturing technique. This situation could lead to more severe complications, including mediastinal emphysema. Option B - High tracheostomy: A high tracheostomy (placing the tracheostomy tube above the second or third tracheal ring) can cause complications, but it is not typically associated with surgical emphysema. More common issues include difficulty in stabilizing the tracheostomy tube and increased risk of subglottic stenosis. Option C - Blockage of the tube: Blockage of the tracheostomy tube can cause respiratory distress or hypoxia but is not typically associated with surgical emphysema. Air trapping in the soft tissues around the tracheostomy site is not a direct result of tube blockage.

References:

Prepladder Notes

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Q72: What would be the subsequent course of action for this injury depicted in the image after a three-day period following a Road Traffic Accident (RTA)? (Q793911)

A. Debridement of necrotic tissue with primary closure

B. Debridement of necrotic tissue and hyperbaric oxygen

C. Amputation

D. Clean and close with rotation flap



Correct Answer: B. Debridement of necrotic tissue and hyperbaric oxygen

Explanation: Correct Option B - Debridement of necrotic tissue and hyperbaric oxygen: The injury in question involves tissue necrosis, possibly due to a traumatic event such as a road traffic accident (RTA). Debridement of necrotic tissue involves the removal of dead or damaged tissue to prevent infection and promote healing. Hyperbaric oxygen therapy (HBOT) treats various conditions, including tissue necrosis, by increasing the amount of oxygen that reaches the damaged tissues. The high pressure helps dissolve more oxygen in the blood, stimulating the growth of new blood vessels and promoting tissue regeneration. The combination of debridement and hyperbaric oxygen therapy can be particularly effective in tissue necrosis caused by ischemia, as it helps restore blood flow and oxygenation to the affected area. Incorrect Choices: Incorrect Options: Option A - Debridement of necrotic tissue with primary closure: Debridement of necrotic tissue with primary closurecan trap bacteria and other debris inside the wound, increasing the risk of infection and delaying healing. Option C - Amputation: Amputation may be necessary in severe cases of tissue necrosis that cannot be treated by other means. However, amputation is a last resort Option D - Clean and close with rotation flap: In cases of tissue necrosis, a rotation flap alongside cleaning may be suitable for small affected areas with healthy surrounding tissue, but it's less likely to be suitable for extensive damage, where debridement and HBOT are preferable.

References:

Prepladder Notes

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@Neet_pg_bot

Q73: Which of the following CT findings is not an indication to perform angiography in a splenic trauma patient under conservative management? (Q793370)

A. Subcapsular hematoma covering 40% surface area.

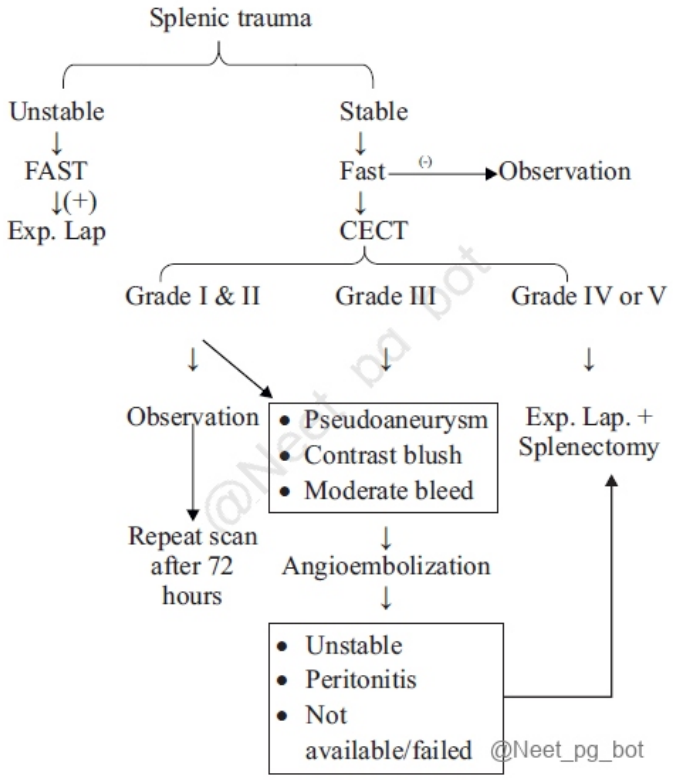
B. Significant hemoperitoneum

C. Presence of pseudoaneurysm

D. Contrast extravasation

Correct Answer: A. Subcapsular hematoma covering 40% surface area.

Explanation: Correct Option A - Subcapsular hematoma covering 40% surface area: Subcapsular hematoma covering 40% surface area alone is not an indication for performing angiography in a splenic trauma patient under conservative management. This is because, according to the AAST grading system provided, a subcapsular hematoma covering 40% of the surface area falls under Grade II, which is considered stable for conservative management. Incorrect Options: Option B - Significant hemoperitoneum: Hemoperitoneum indicates bleeding into the peritoneal cavity, which can result from splenic trauma, among other causes. Option C - Presence of pseudoaneurysm: In the context of splenic trauma, the presence of a pseudoaneurysm indicates ongoing arterial bleeding and is a potential indication for angiography. Option D - Contrast extravasation: In the context of splenic trauma, the presence of contrast extravasation on CT imaging suggests ongoing arterial bleeding and is an indication for further evaluation and intervention.



References:

Prepladder Notes

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Q13 (p. 3225)	*Q14 (p. 3225)*	*Q15 (p. 3229)*	*Q16 (p. 3231)*	*Q17 (p. 3233)*	*Q18 (p. 3234)*
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Q37 (p. 3255)	*Q38 (p. 3256)*	*Q39 (p. 3257)*	*Q40 (p. 3258)*	*Q41 (p. 3261)*	*Q42 (p. 3261)*
Q43 (p. 3263)	*Q44 (p. 3266)*	*Q45 (p. 3269)*	*Q46 (p. 3270)*	*Q47 (p. 3271)*	*Q48 (p. 3273)*
Q49 (p. 3275)	*Q50 (p. 3277)*				

Q1: Identify the type of ulcer shown in the image below: (Q860399)

A. Venous ulcer

B. Malignant ulcer

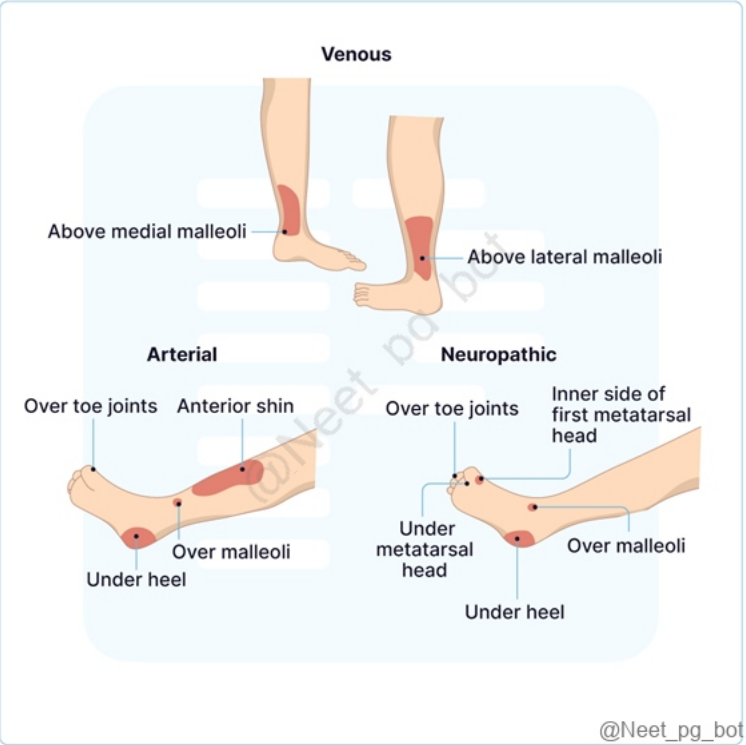
C. Arterial ulcer

D. Trophic ulcer



Correct Answer: D. Trophic ulcer

Explanation: Trophic ulcers, also referred to as neuropathic ulcers occur due to a loss of sensation and an impaired ability to protect the skin, often resulting from conditions like peripheral neuropathy or poor circulation. These ulcers are usually present with well-defined borders and a pale or pink wound bed, commonly located in weight-bearing areas where pressure or friction is frequent. Type of Ulcer: Type History Lesion Characteristics Pain Ischemic/Arterial Smoking, intermittent claudication Irregular edges, poor granulation tissue, dry necrotic base; round or punched-out with sharp demarcation Severe, particularly at night; relieved by dependency Venous Varicose veins, DVT, trauma, surgery, multiple pregnancies Shallow, irregular/shaggy shape, granulating base, fibrinous material with moderate to heavy exudate Mild; relieved by elevation Neurotrophic Numbness, paresthesias, burning, loss of sensation in the foot, DM Punched-out, deep sinus, variable depth partial thickness to severe, involving the tendon, fascia, joint capsule, or bone None Malignant Ulcer History of skin cancer (e.g., basal or squamous cell carcinoma) Irregular, raised borders, ulcerating tumor with hard, indurated tissue Often painful, can be associated with bleeding or foul odor



References:

https://pmc.ncbi.nlm.nih.gov/articles/PMC3036466/

↑ *Back to this question in Part A*

@Neet_pg_bot

Q2: A 35-year-old woman, 10 years after mastectomy, notices gradual swelling and heaviness in her right upper limb without pain. On examination, bluish nodules on the skin with no infections are noted. What is the most likely cause of her symptoms? (Q860167)

A. Lymphangiosarcoma

B. Thoracic outlet syndrome

C. Chronic venous insufficiency

D. Recurrent breast cancer

Correct Answer: A. Lymphangiosarcoma

Explanation: Lymphangiosarcoma is the most likely cause of these symptoms, especially in a patient with a history of mastectomy. This condition, also known as Stewart-Treves syndrome , can develop years after mastectomy due to long-standing lymphedema, which is a consequence of lymphatic obstruction. Complications of mastectomy: Complications

References:

Sabiston Textbook of Surgery, 21st Edition, Page 832.

SRB's Manual of Surgery, 6th Edition, Page 25, 26.

https://www.ncbi.nlm.nih.gov/books/NBK538212/#:~:text=Patients%20tolerate%20mastectomy%20well%20in,breakdown%20or%20necrosis,%20and%20lymphedema.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q3: A patient presents to the emergency room after a road traffic accident with shock and hypotension. The extended focused assessment with sonography for trauma (eFAST) is negative, the X-ray is normal, and the ECG shows bradycardia. The patient's SpO2 is 93%, blood pressure is 80/60 mmHg, and pulse rate is 40/min. Based on this information, what type of shock is most likely? (Q860219)

A. Septic shock

B. Hemorrhagic shock

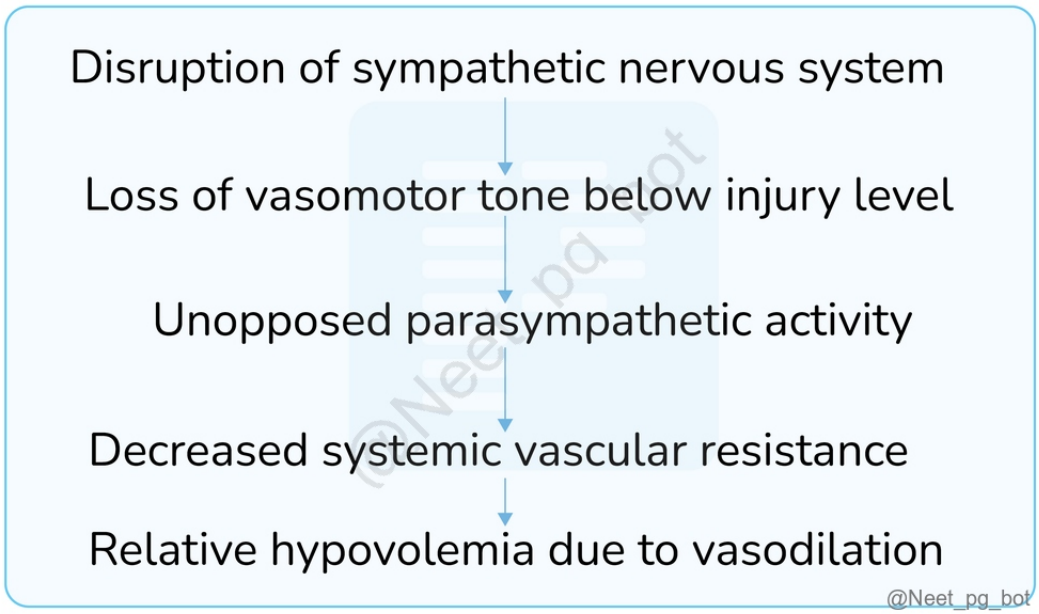
C. Cardiogenic shock

D. Neurogenic shock

Correct Answer: D. Neurogenic shock

Explanation: Neurogenic shock is characterized by hypotension, bradycardia, and normal or slightly reduced SpO2. The absence of trauma to solid organs, negative eFAST, and normal X-rays help rule out hemorrhagic or cardiogenic shock. The bradycardia (pulse of 40/min) is due to a loss of sympathetic tone following spinal cord injury or severe trauma, leading to vasodilation and bradycardia. Neurogenic shock: In neurogenic shock, there is a loss of sympathetic tone, leading to vasodilation of the peripheral vasculature, resulting in decreased peripheral vascular resistance and hypotension. This is the primary mechanism underlying neurogenic shock. Causes: Neurogenic shock is a critical condition that results from the dysregulation of the autonomic nervous system following spinal cord injury, especially in the cervical and upper thoracic vertebrae above the T6 level, as a result of traumatic events. The dysregulation arises due to the lack of sympathetic tone and decreased peripheral vascular resistance. The decline in sympathetic tone prompts the dilation of capacitance blood vessels in the lower extremities. This, in turn, results in decreased cardiac filling, leading to hypotension and shock. Reduced sympathetic control over the heart leads to a situation where unopposed vagal cardiac influence causes

bradycardia. Patients with neurogenic shock may also exhibit pink and warm skin due to the dilation of subcutaneous blood vessels. Severe brain injury. Certain anaesthetics. Pathophysiology Clinical Manifestations: Hypotension Bradycardia (unlike other forms of shock) Warm, dry skin below injury level Priapism in males Respiratory compromise (if high cervical injury) Poikilothermia (inability to regulate body temperature) Physiological Hemodynamic Characteristics of Shock Type of Shock Cardiac Output Systemic Vascular Resistance Central Venous Pressure Mean Arterial Pressure Hypovolemic ↓ ↑ ↓ ↓ Cardiogenic ↓ ↑ ↑ ↓ Distributive(Septic, anaphylactic, neurogenic) ↑ or ↓ ↓ ↓ or N ↓ Obstructive (pulmonary embolism, cardiac tamponade, tension pneumothorax) ↓ ↑ ↑ ↓



References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 12

SRB's Manual of Surgery, 6th Edition, Page 106

Sabiston Textbook of Surgery, 21st Edition, Page 526

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@Neet_pg_bot

Q4: In patients at risk of refeeding syndrome, which of the following electrolyte imbalances is typically not associated with this condition? (Q860221)

A. Hypokalemia

B. Hyperkalemia

C. Hypocalcemia

D. Hypophosphatemia

Correct Answer: B. Hyperkalemia

Explanation: Refeeding syndrome occurs when a malnourished patient is rapidly reintroduced to nutrition, especially carbohydrates. Insulin release shifts potassium, phosphate, and magnesium into cells, causing: Hypophosphatemia (most characteristic) Hypokalemia Hypomagnesemia Hypocalcemia (secondary to hypomagnesemia) Hyperkalemia does not occur because total body potassium is already depleted, and insulin drives it into cells. Incorrect Options: Option A) Hypokalemia: Common due to cellular shift during refeeding. Option C) Hypocalcemia: Can occur secondarily to hypomagnesemia. Option D) Hypophosphatemia: The hallmark of refeeding syndrome, due to increased cellular uptake of phosphate.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 340

↑ *Back to this question in Part A*

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Q5: Identify the edges of the lesion given in the image: (Q860254)

A. Everted

B. Rolled out

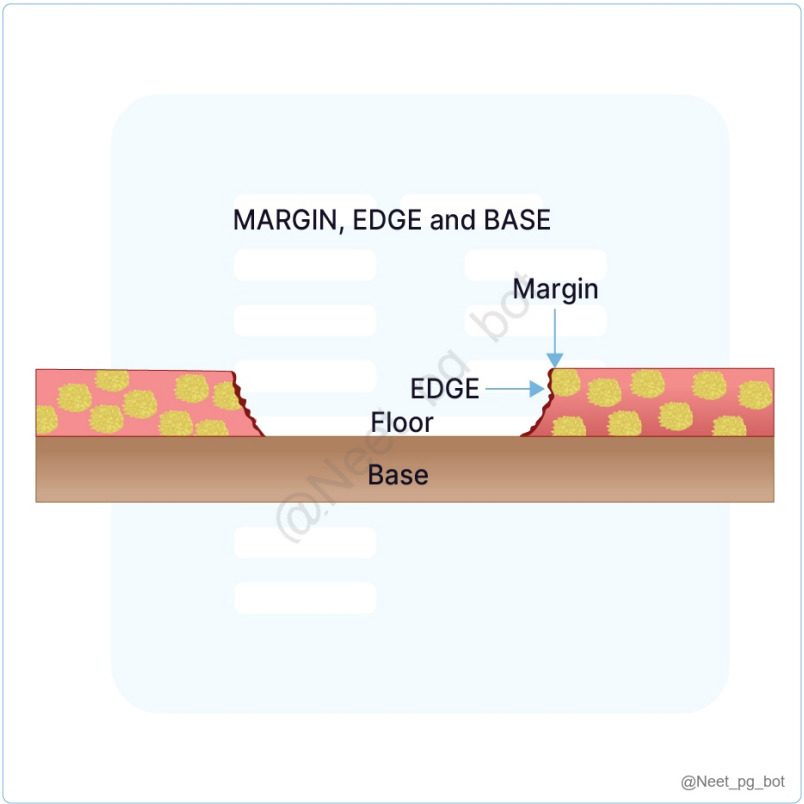
C. Sloping

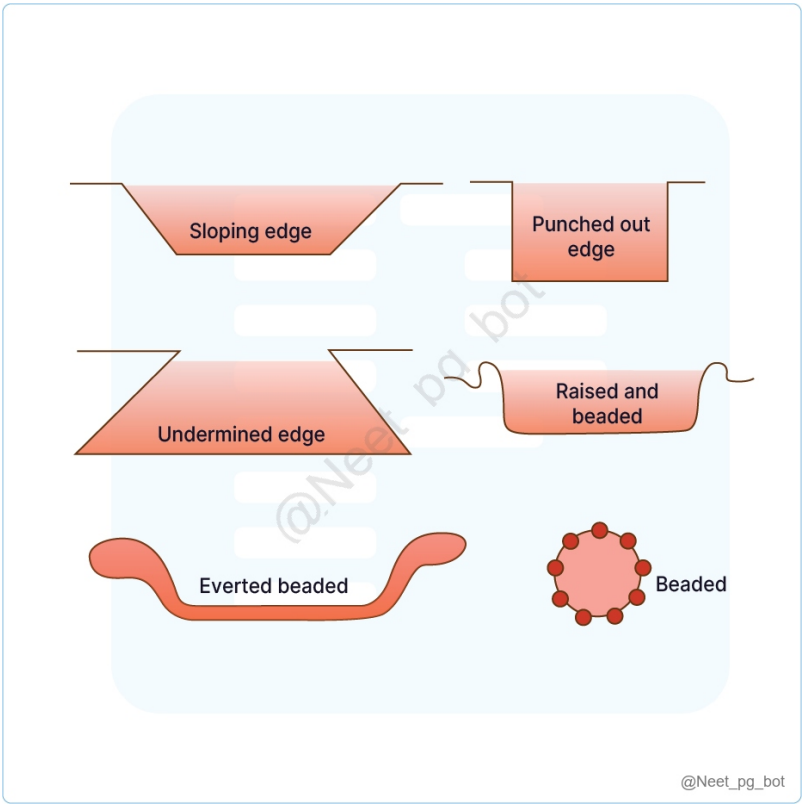
D. Punched out



Correct Answer: B. Rolled out

Explanation: The given image shows rolled-out edges suggesting Basal cell carcinoma. Morphologically, an ulcer has 4 parts: Base: Surface on which ulcer rests (usually underlying muscles/bones) Floor: Exposed surface of ulcer (usually seen as purulent discharge/granulation tissue/red and moist) Margin: Junction between normal epithelium & ulcer Edge: Area between margin & floor Type of edges Clinical conditions Details Sloping edge Healing ulcer Varicose ulcer Inner part: Red (healthy granulation tissue) Middle part: Blue (epithelial proliferation) Outer part: White (scar/fibrous tissue) Undermined edge Tubercular ulcers Disease process advances in the deeper plane (subcutaneous tissue), whereas (skin) epidermis proliferates inwards Punched out edge Arterial / Ischemic ulcers Gummatous (syphilitic) ulcer Trophic ulcer Due to endarteritis Raised & beaded edge Rolled out / Pearly white edge Rodent ulcer- Basal cell carcinoma Beads are due to proliferating active cells Pearly white in appearance Everted edge / Rolled out edge Squamous cell carcinoma Due to the spill of proliferating malignant tissue over the normal skin





References:

SRB's Manual of Surgery, 6th Edition, Page 15

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1360405/

↑ *Back to this question in Part A*

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Q6: A patient following a road traffic accident (RTA) with a crush injury presents with crepitus and a reddish-brown wound within 3 days after amputation. What is the most likely condition? (Q860260)

A. Gas gangrene

B. Impetigo

C. Tetanus

D. Cellulitis

Correct Answer: A. Gas gangrene

Explanation: Gas gangrene is caused by Clostridium species, typically after traumatic injuries, especially with crush wounds or amputation. It is characterized by crepitus (gas production), reddish-brown discoloration of the wound, and rapid progression within days. Gas Gangrene A rapidly progressive, potentially fatal condition characterized by widespread necrosis of muscles and soft-tissue destruction, often due to late-presenting missile wounds or crushing injuries. Cause Clostridium perfringens Incubation period <24 hours but ranges from 1 hour to 6 weeks Sources and predisposing factors Contaminated soil and feces. Wounds with necrotic or foreign material. Crush wounds, road traffic accidents, amputations. Anaerobic environments in the wound. Common sites of infection Adductor region of the lower limb and buttocks. Subscapular region in the upper limb. Clinical features Severe pain with limb swelling rapidly increases in severity. Serosanguineous discharge. Skin turns brown to blue-black with hemorrhagic bullae. Sweet, sticky odor & Soft-tissue crepitus. Complication Septicaemia, toxemia, renal failure, liver failure. Circulatory failure, DIC, secondary infections. Death occurs in critically ill patients. Investigation X-ray: Gas in soft tissues. Gram stain & blood culture: Large Gram-positive bacilli without neutrophils. Biochemical profile: Metabolic acidosis, renal failure. Peripheral blood smear: Haemolysis. CT scan for chest or abdominal wounds. Treatment High-dose intravenous penicillin and clindamycin, along with 3rd generation cephalosporins, are given intravenously. Polyvalent antiserums given intravenously. All dead tissues are excised, and debridement is performed until healthy tissue bleeds. Amputation done in severe cases Hyperbaric oxygen therapy. Prevention Proper debridement of devitalized crushed wounds. Devitalized wounds should not be sutured. Adequate cleaning of wounds with H■O■ and normal saline. Penicillin - As a prophylactic antibiotic. Image {{caption_text}} Incorrect Options: Impetigo (Option B) is a superficial skin infection caused by Streptococcus or Staphylococcus bacteria, presenting as honey-colored crusts, but does not typically cause crepitus or involve deep tissue. Tetanus (Option C) results from infection with Clostridium tetani , leading to muscle stiffness and spasms. While it follows a traumatic injury, it doesn’t typically present with crepitus or reddish-brown wound discoloration. Cellulitis (Option D) is a bacterial skin infection that causes redness, swelling, and warmth, but it does not produce crepitus or reddish-brown wounds and typically develops over a longer period.



References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 57,457,643

SRB's Manual of Surgery, 6th Edition, Page 44, 50-52,1056

↑ *Back to this question in Part A*

@Neet_pg_bot

Q7: Arrange the stages of wound healing in the correct sequence: (Q860267)

A. Proliferation, hemostasis, inflammation, remodeling

B. Inflammation, remodeling, hemostasis, proliferation

C. Hemostasis, inflammation, proliferation, remodeling

D. Remodeling, proliferation, hemostasis, inflammation

Correct Answer: C. Hemostasis, inflammation, proliferation, remodeling

Explanation: Wound healing occurs in four stages : hemostasis , inflammation , proliferation , and remodeling . Hemostasis: Occurs immediately after injury: vasoconstriction, platelet aggregation, and clot formation. Platelets release growth factors (e.g., TGF-β , PDGF , VEGF) that promote matrix deposition, chemotaxis, and angiogenesis. Coagulation cascade leads to thrombin formation, stabilizing the platelet plug. Inflammation: Early Phase (Days 1-2): Neutrophils clear debris and fight infection. Vasoactive amines increase vascular permeability.

Late Phase (Days 2-3): Macrophages debride the wound, release growth factors, and promote fibroblast and angiogenesis. Cardinal signs: rubor (redness), tumor (swelling), calor (heat), dolor (pain). Proliferation: Days 3-14: Fibroblasts produce collagen and extracellular matrix. Granulation tissue forms, and angiogenesis occurs. Myofibroblasts help contract the wound and bring edges together. Remodelling: Weeks to months: Type III collagen is replaced by stronger type I collagen . The wound reaches about 80% of normal skin strength by 12 weeks and continues to mature for up to a year.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 25,26

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Q8: Which of the following is considered a “sure sign” of abdominal wound dehiscence in a post-operative hypotensive patient? (Q860272)

A. Increased bowel sounds

B. Persistent abdominal pain

C. Serosanguinous drainage from the wound

D. Widening of the abdominal scar with palpable edges

Correct Answer: C. Serosanguinous drainage from the wound

Explanation: Serosanguinous drainage from the wound is considered a "sure sign" of abdominal wound dehiscence in a post-operative hypotensive patient (Salmon fluid sign) Wound dehiscence is the disruption of any or all layers of a wound. It occurs in up to 3% of abdominal wounds and is associated with an increased risk of postoperative mortality. Timing and Presentation: Wound dehiscence typically occurs 5 to 8 days postoperatively when the strength of the wound is at its weakest. It often presents with serosanguinous discharge and may be preceded by a popping sensation felt by the patient, particularly during activities like straining or coughing. The dehiscence may also indicate an underlying abscess. Risk factors: Poor wound closure or closure under tension Infection , hematoma , or seroma at the wound site Increased intra-abdominal pressure , e.g., in postoperative patients with chronic obstructive pulmonary disease (COPD) or excessive coughing Malnourishment Diabetes Obesity Renal failure Jaundice Sepsis Cancer Steroid use Emergency surgery Management: Full-thickness dehiscence generally requires the patient to return to the operating room for resuturing. In cases of infected tissues, poor-quality tissue, or wounds under excessive tension, the wound may be left open and managed with dressings or vacuum-assisted closure (VAC) .

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 325

↑ *Back to this question in Part A*

@Neet_pg_bot

Q9: An elderly chronic smoker male is diagnosed with squamous cell carcinoma of the lower lip with no lymph node involvement. What is the treatment of choice? (Q860276)

A. Radiotherapy

B. Combined chemoradiotherapy

C. Wide local excision with negative borders

D. Wide local excision with frozen section

Correct Answer: D. Wide local excision with frozen section

Explanation: Wide local excision with frozen section is the treatment of choice for early-stage squamous cell carcinoma of the lower lip in patients with no lymph node involvement. This technique ensures that the excision margins are clear in real-time, reducing the risk of recurrence. Cutaneous Squamous Cell Carcinoma (SCC): SCC is a malignant tumor of keratinising cells in the epidermis, commonly arising from the stratum basalis. It is the second most common skin cancer, more prevalent in fair-skinned individuals with chronic sun exposure. Risk factors: UV radiation , chronic inflammation, immunosuppression , chemical carcinogens (e.g., arsenic), and HPV infection (types 5 and 16). Tobacco use doubles the risk. Precursor lesions: Actinic Keratosis (AK) : Dysplastic lesions from sun damage; 20% progress to SCC. Keratin Horns : Raised keratinous surface from AK, 10% may have underlying SCC. Keratoacanthomas : Rapidly growing, nodular tumors that resemble SCC and should be excised. Clinical features: SCC presents as nodular, verrucous, or ulcerating lesions with an everted edge and surrounding induration. Differential diagnosis : AK, BCC, pyoderma gangrenosum, and warts. Microscopic features: Irregular squamous epithelium invading the dermis, positive for cytokeratins 1 and 10 . Broders' grading assesses tumor differentiation. Management: The primary treatment for SCC is surgical excision , which provides accurate histological diagnosis and clear margins . The size of the SCC influences the required margin: <2 cm SCC : 4 mm margin >2 cm SCC : 1 cm margin The recurrence rate is approximately 20% . Surgical excision is the only reliable method for ensuring clear margins. Mohs’ micrographic surgery may be indicated for difficult-to-resect tumours or those with recurrent SCC.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 652-655

↑ *Back to this question in Part A*

@Neet_pg_bot

Q10: In a triage setting, which of the following categories requires the highest priority intervention? (Q860294)

A. Red

B. Yellow

C. Green

D. Black

Correct Answer: A. Red

Explanation: In triage, the Red category represents patients who have life-threatening injuries or conditions but can survive with immediate medical intervention. These patients are prioritised for treatment and intervention to prevent imminent death. Triage colour coding systems: Colour Priority Medical Need Clinical Status Examples Red First Immediate Critical, but likely to survive if treatment is given early Severe facial trauma Tension pneumothorax Profuse external bleeding Haemothorax Flail chest Major intra-abdominal bleed Extradural haematomas Yellow (Option B) Second Urgent Critical, but likely to survive if treatment is given within hours Compound fractures Degloving injuries Ruptured abdominal viscus Pelvic fracture Spinal injuries Green (Option C) Third Non-Urgent Stable, likely to survive even if treatment is delayed for hours to days Simple fractures Sprains Minor lacerations Black (Option D) Last Unsalvageable Not breathing, pulseless, so severely injured that no medical care is likely to help. Severe brain damage Very extensive burns Major disruption/ loss of chest or abdominal wall structures

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 449

Sabiston Textbook of Surgery, 21st Edition, Page 560, 561

https://www.ncbi.nlm.nih.gov/books/NBK557583/

↑ *Back to this question in Part A*

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Q11: What type of skin graft is used in the image shown? (Q860305)

A. Split thickness

B. Full thickness

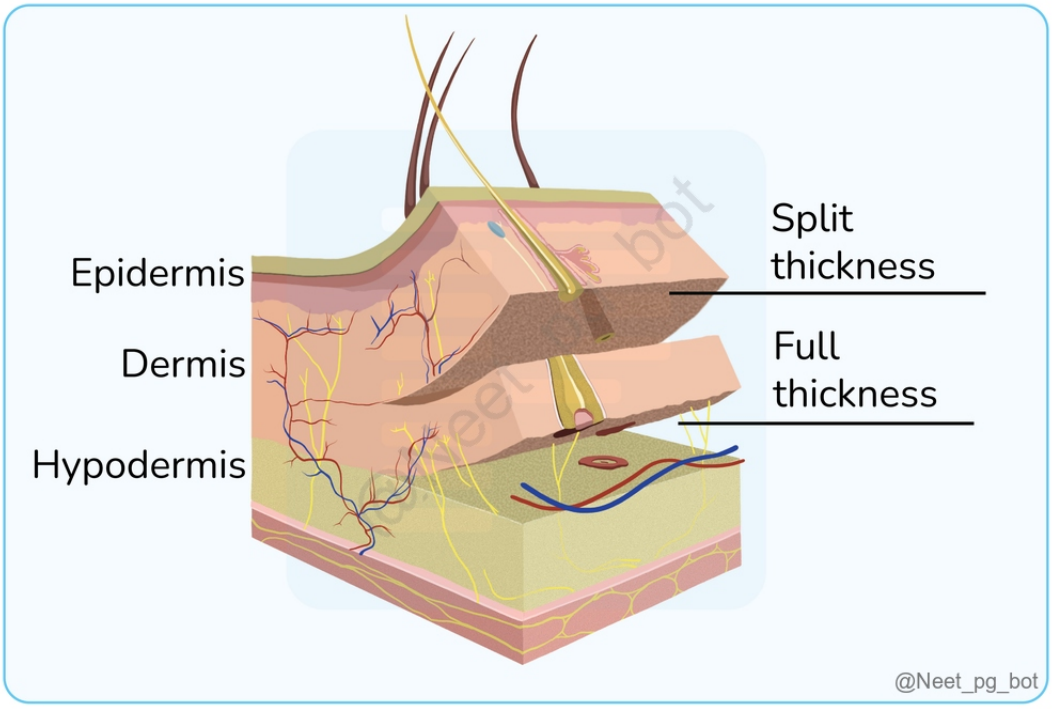
C. Wolfe graft

D. Local flap



Correct Answer: A. Split thickness

Explanation: The image in question depicts a split-thickness skin graft (STSG), which consists of the epidermis and a portion of the dermis. These grafts are typically harvested from areas such as the inner thigh. Due to their ease of harvesting and ability to cover larger wounds, split-thickness grafts are commonly used for extensive skin coverage. Feature Thiersch Graft (Split-Thickness Skin Graft) Wolfe Graft (Full-Thickness Skin Graft) Type of Skin Grafting Split-thickness Full-thickness Composition Epidermis + part of dermis Epidermis + full thickness of dermis Graft Size Large grafts can be taken Only small grafts can be taken Graft Survival Easier More difficult Donor Site Healing Heals spontaneously, allowing repeated grafts Permanent defect develops, preventing repeated grafts Graft Contraction Significant contraction, leading to poor cosmetic appearance Lesser contraction, better cosmetic appearance Common Donor Sites Inner thigh, upper arm, flexor aspect of forearm, abdominal wall Upper eyelid, retro auricular skin, supraclavicular skin, antecubital skin, inframammary skin, inguinal skin, genital skin, gluteal skin Donor Site Exclusions None Axilla is not used as a donor site Advantages of Harvesting Allows calibration of thickness and large area coverage Calibration of thickness for small but thick grafts



References:

SRB's Manual of Surgery, 6th Edition, Page 316, 317, 319

↑ *Back to this question in Part A*

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Q12: A female patient presents to the outpatient department 10 days postpartum with complaints of a fluctuant breast mass with tenderness, high-grade fever, and cracked nipples. What is the most probable diagnosis? (Q860324)

A. Breast engorgement

B. Breast abscess

C. Acute mastitis

D. Fibroadenoma

Correct Answer: B. Breast abscess

Explanation: A breast abscess is a localized collection of pus within the breast tissue, most commonly seen in lactating women. The patient's clinical presentation, including a fluctuant mass, high fever, and localized tenderness, strongly suggests this diagnosis. Breast Abscess Definition Pus-filled cavity within breast tissue. Types Lactational Abscess: Associated with breastfeeding. Non-Lactational Abscess: Occurs in non-lactating women, e.g., periductal mastitis. Causes and Risk Factors Lactation: Incidence: 3% to 20% in lactating mothers. Common pathogen: Staphylococcus aureus (methicillin-resistant strains in hospital settings). Entry points: Cracked/retracted nipple, blocked lactiferous ducts. Non-Lactation: Often in nulliparous women or post-lactation. Conditions: Periductal mastitis, idiopathic granulomatous mastitis, tubercular mastitis. Smoking and diabetes as risk factors. Signs and symptoms Fever, leukocytosis, erythema, pain and tenderness, swelling, malaise, difficulty feeding, enlarged and tender axillary nodes Diagnosis Ultrasonography: Detects cellulitis, liquefaction necrosis. Confirms abscess size, location, and loculation. Treatment Lactational Mastitis: Antibiotics: Anti-staphylococcal (e.g., cloxacillin, flucloxacillin, erythromycin). Breast emptying: Frequent breastfeeding or pumping. Support: Breast support garment, cold compresses, analgesia. Drainage: Ultrasound-guided preferred over surgical incision. Follow-up: Regular clinical and ultrasonographic reviews, culture-based antibiotic modification. Non-Lactational Mastitis: Broad-spectrum antibiotics for subareolar infections. Needle aspiration for abscess drainage. Major milk duct excision for complications like sepsis or fistula. Incorrect Options: Breast engorgement (Option A) is not associated with a fluctuant mass, high fever, or localized pain. Acute mastitis (Option C) can cause breast pain and swelling, but it typically does not present as a fluctuant mass. Fibroadenoma (Option D) does not present with a fluctuant mass, high fever, or localized pain.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 927, 928

Sabiston Textbook of Surgery, 21st Edition, Pages 826, 827

Schwartz's Principles of Surgery, 11th Edition, Pages 550-553, 601, 602

↑ *Back to this question in Part A*

@Neet_pg_bot

Q13: Which of the following is characteristic of hypovolemic shock? (Q860374)

A. Increase in cardiac output

B. High vascular resistance

C. Increase in venous pressure

D. Increased mixed venous saturation

Correct Answer: B. High vascular resistance

Explanation: In Hypovolemic shock, as the body tries to compensate for the reduced blood volume, the blood vessels constrict (vasoconstriction) to preserve blood pressure and redirect blood flow to vital organs like the heart and brain. This results in increased vascular resistance. Decreased cardiac output (Option A) : Since there's less blood to pump, the heart cannot maintain a normal cardiac output. This is opposite to what happens in some other types of shock (e.g., septic shock), where cardiac output may initially increase. Decreased venous pressure (Option C) : Lower blood volume means less blood returning to the heart, leading to reduced venous pressure. Decreased mixed venous saturation (Option D) : In hypovolemic shock, oxygen delivery is impaired, and the blood returning to the heart has a lower oxygen saturation, which is reflected in a lower mixed venous oxygen saturation. Physiological Hemodynamic Characteristics of Shock Type of Shock Cardiac Output Systemic Vascular Resistance Central Venous Pressure Mean Arterial Pressure Hypovolemic ↓ ↑ ↓ ↓ Cardiogenic ↓ ↑ ↑ ↓ Distributive(Septic, anaphylactic, neurogenic) ↑ or ↓ ↓ ↓ or N ↓ Obstructive (pulmonary embolism, cardiac tamponade, tension pneumothorax) ↓ ↑ ↑ ↓

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 12

↑ *Back to this question in Part A*

@Neet_pg_bot

Q14: What is the diagnosis based on the image below? (Q859893)

A. Botryomycosis

B. Erysipelas

C. Ecthyma

D. Carbuncle



Correct Answer: D. Carbuncle

Explanation: The carbuncle is the most likely diagnosis in this case due to the pus-filled masses with necrotic tissue and a yellow centre seen in the image, which is characteristic of this type of deep skin infection. These are composed of two or more furuncles. They classically have multiple pustules, or "heads," originating from the underlying abscess. Carbuncle Definition Infection of hair follicles extending into surrounding and subcutaneous tissue. Cause Staphylococcus aureus. Common Sites Nape of neck, back. Symptoms Red, painful nodule; tender, fluctuant lesion; multiple draining sinuses; fever, lymphadenopathy. Complications Septicemia, abscess, necrosis, requiring possible excision or skin graft. Treatment Control of diabetes; antibiotics; drainage, debridement, possible excision. {{caption_text}} Botryomycosis (Option A) is a chronic bacterial infection, commonly affecting the skin and rarely the soft tissues, often mistaken for an abscess. It is commonly caused by Staphylococcus aureus, or other bacteria, but it presents more as granulomatous lesions rather than the typical pus-filled carbuncle . {{caption_text}} Erysipelas (Option B) is a localised cutaneous sharply demarcated infection to the upper layers of the dermis, usually associated with broken skin. It is caused by beta-hemolytic Streptococcus pyogenes. It appears to be a red, swollen, and shiny rash , not a deep abscess with pus or necrotic tissue. {{caption_text}} Ecthyma (Option C) is a deeper form of impetigo caused by bacteria (usually Streptococcus), which presents as ulcerative lesions with a crusted appearance , not as a deep abscess with dead tissue and a yellow centre. {{caption_text}}





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References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 643.

↑ *Back to this question in Part A*

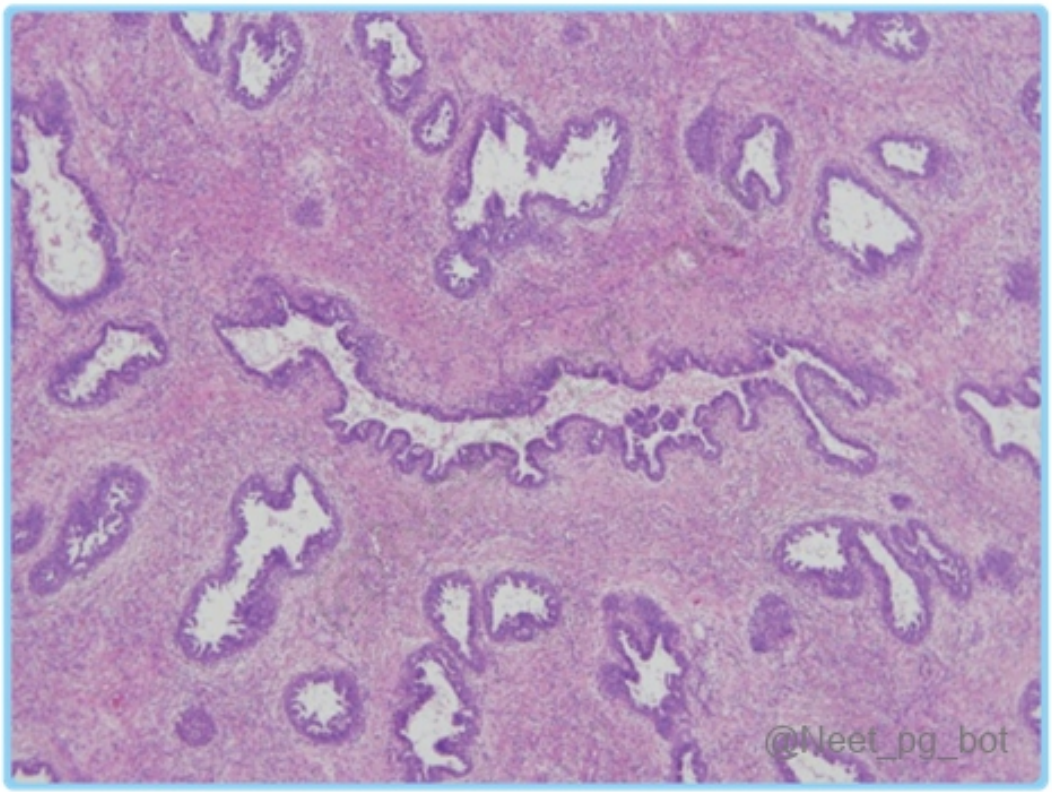
Q15: A 30-year-old female who is receiving cyclosporine A following renal transplantation develops multiple and bilateral breast lumps that regress after cessation of the treatment. Biopsy image is given below. What is the most likely diagnosis? (Q860452)

A. Fat necrosis

B. Phyllodes tumour

C. Fibroadenoma

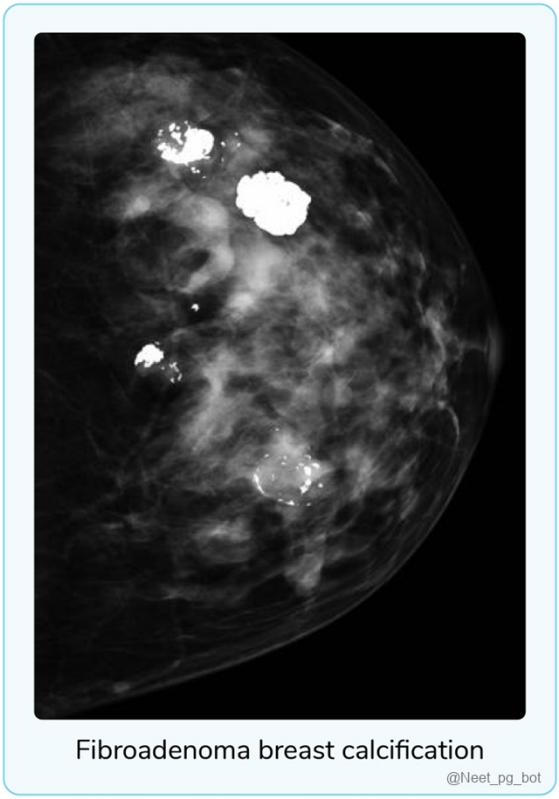
D. Carcinoma breast



Correct Answer: C. Fibroadenoma

Explanation: The biopsy image shows a proliferation of ducts arranged in both intracanalicular and pericanalicular patterns, surrounded by fibromyxoid stroma, suggesting Fibroadenoma. These tumours are common in young women, and hormonal changes may influence their growth. Cyclosporine A, which has hormonal effects, could contribute to the development of fibroadenoma. Fibroadenoma: It is the most common benign breast tumour, typically found in women aged 15-35. Characteristics: Spherical masses measuring 1-10 cm, firm, non-tender,

well-circumscribed, mobile and often single . The lump is mobile and slippery and hence called breast mouse. Estrogen sensitivity: Can increase in size during pregnancy, lactation, or estrogen therapy and usually regress after menopause. HPE: Well-defined borders due to a fibrous capsule , with proliferating stroma potentially compressing and distorting glandular components. Popcorn calcification on mammogram. {{caption_text}} Ageing effect: Epithelium atrophies with age, and the stroma becomes more hyalinised. Molecular alteration: Alterations in MED12 gene Drug associated with bilateral fibroadenomas: Cyclosporine The histological features of a fibroadenoma include: Fibroepithelial tumours are composed of benign-appearing cellular or myxoid stroma encircling epithelium-lined glands and cystic spaces. Staghorn clusters of cells - Ductal cells arranged in a deer horn-like pattern Bare nuclei - cytoplasm is stripped of,f and only nuclei are visible in blue colour. {{caption_text}} Incorrect Options: Fat necrosis (Option A) typically presents with firm, tender breast lumps following trauma or surgery and shows fatty tissue changes on biopsy, not ductal proliferation. Phyllodes tumour (Option B) can have similar histological features with ductal proliferation but is typically more cellular and can have a leaf-like architecture. It also tends to grow rapidly and is more common in older women. Carcinoma breast (Option D) would be expected to present with more aggressive histological features, such as invasion of surrounding tissue and atypical cells, rather than benign ductal proliferation.





References:

Robbins & Cotran Pathologic Basis of Disease, 10th Edition, Page 1062

https://karger.com/acy/article/58/6/533/8975/Liquid-Based-Cytology-in-Fine-Needle-Aspiration-of

↑ *Back to this question in Part A*

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Q16: A 65-year-old male presents to the outpatient department with a swelling in the back of his neck that has been present for almost a year. The swelling has not increased in size. On examination, it is non-pulsatile, and the slip sign is positive, with the swelling measuring 3x3 cm. Which of the following statements is most likely true? (Q860457)

A. High chances of malignant transformation

B. FNAC necessary for diagnosis

C. PET scan necessary for staging

D. Excision can be done if the patient requests it



Correct Answer: D. Excision can be done if the patient requests it

Explanation: Based on the clinical features (non-pulsatile, stable size, and positive slip sign), this is most likely a lipoma , which is a benign tumour of fatty tissue. If the patient requests excision, and if there are no concerns about malignancy, excision can be performed to remove the lipoma for cosmetic or symptomatic reasons. Lipoma: A lipoma is a benign tumour composed of mature adipocytes (fat cells) and is the most common soft tissue tumor. These tumors are generally soft, mobile, and painless masses found beneath the skin. Most frequently found on the trunk, shoulders, neck, and arms. Histologically, lipomas consist of mature fat cells that are identical to normal adipose tissue but are encapsulated by a thin fibrous capsule , distinguishing them from the surrounding tissue. Lipomas are typically slow-growing, soft, and non-tender. They are usually asymptomatic but can cause discomfort if they compress nearby structures or are located in a site prone to friction or pressure. On physical examination, lipomas are well-circumscribed, mobile masses that can vary in size from a few millimetres to several centimetres. Slip sign: Positive Very low risk of malignant transformation into liposarcoma. (Option A) Management: Most lipomas do not require treatment unless they become symptomatic, grow rapidly, or cause cosmetic concerns. Surgical excision is the definitive treatment and is usually curative. Liposuction may also be an option for larger lipomas, but complete excision is preferred to prevent recurrence. While FNAC can be used for diagnosing soft tissue masses, it is not always required if the lesion's clinical presentation is typical of a lipoma. In many cases, a clinical diagnosis based on history and examination (such as soft, mobile, non-tender mass) is sufficient. (Option B) PET scans are generally used for staging known malignancies, such as lymphoma or other aggressive cancers. In this case, there is no indication that this is a malignant lesion, so a PET scan is unnecessary. (Option C)

References:

SRB’s Manual of Surgery, 6th Edition, Page 68, 69

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Q17: A 47-year-old man presents with a chronic non-healing painless ulcer over his scalp for 8 years. He has a history of electric burns to the scalp 8 years ago. The examination findings are shown below. Which of the following statements is true? (Q860461)

A. Radiotherapy is useful

B. It can progress to squamous cell carcinoma

C. No lymphatic spread

D. Long-duration antibiotics will improve the condition.



Correct Answer: B. It can progress to squamous cell carcinoma

Explanation: Chronic non-healing ulcers , especially those resulting from burn injuries or other trauma, are at high risk of malignant transformation , most commonly to squamous cell carcinoma (SCC) . This is known as Marjolin's ulcer , which can develop in areas of chronic injury or scar tissue. Marjolin’s Ulcer Definition Low-grade Squamous Cell Carcinoma (SCC) Common Sites of Development Post-burn scar Long-standing

venous ulcer Chronic ulcer due to trauma Chronic discharging osteomyelitis sinus Post-radiation ulcer Pathophysiology Develops in scar tissue due to chronic irritation Characteristic Features Painless (no nerves in scar tissues) Slow growing No regional LN metastasis (no lymphatics in scar tissue) Investigation of Choice Biopsy Management Wide local excision followed by a flap cover Radiotherapy should be avoided (Option A) (as it is radio-resistant and also to prevent obliterative end arteritis) {{caption_text}} Malignant lesions like squamous cell carcinoma can spread via lymphatic channels (Option C) , particularly if left untreated. While antibiotics may help treat an infected ulcer , a chronic non-healing ulcer with a history of burn injury is unlikely to respond to antibiotics alone (Option D) .



References:

SRB's Manual of Surgery, 6th Edition, Page 283, 284

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Q18: A 25-year-old woman presents with severe pain and swelling in her right hand, which is increasing in size and severity. She had a prick injury in the garden 5 days ago. On examination, she cries out in pain when her hand is extended and when the palmar aspect is palpated passively. Which of the following statements is true about the condition? (Q860463)

A. More common in the dorsal aspect of the hand

B. X-ray imaging will aid in the location of the foreign body in all patients

C. It requires incision and drainage

D. Oral analgesics are the mainstay of treatment



Correct Answer: C. It requires incision and drainage

Explanation: The patient likely has a deep palmar abscess secondary to a foreign body, and incision and drainage (I&D) is required to relieve pressure, remove the foreign body, and treat the infection. Deep Palmar Infection: These infections begin in the palm and may be confined to a web space initially. As the infection progresses, the entire hand becomes swollen and tender due to the accumulation of pus on either side of the septum. Management: The treatment involves incision and drainage (I&D) with a thorough washout of the wound. It's essential to open all affected deep spaces. In some cases, incisions may be needed on both the dorsal and volar sides of the hand. If the extent of the infection is unclear, imaging techniques like ultrasound or MRI can be used to delineate the spread within the deep palmar spaces. Incorrect Options: More common in the dorsal aspect of the hand (Option A) : Infections or abscesses caused by foreign bodies are more common in the palmar aspect due to the tighter fascial compartments. X-ray imaging will aid in the location of the foreign body in all patients (Option B) : X-rays are not always helpful, especially for non-radio-opaque foreign bodies (wood), so other imaging like ultrasound might be more useful. Oral analgesics (Option D) may help manage pain, but they are not sufficient for treating the underlying infection/abscess , which requires I&D .

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 543

↑ *Back to this question in Part A*

@Neet_pg_bot

Q19: A patient fell from a train onto the railway track and injured both his legs severely. He was urgently taken to the hospital, and the following procedure was performed (image shown below). What is the rationale for performing this procedure? (Q860466)

A. Better fit for prosthesis

B. Life-saving procedure

C. Reduces risk of cancer

D. Good cosmetic outcomes



Correct Answer: B. Life-saving procedure

Explanation: In cases of severe trauma , such as being run over or falling on railway tracks, injuries can be so extensive that amputation is necessary to prevent massive blood loss , gangrene , or infection , which can lead to

death. The decision for a bilateral below-knee amputation is usually made as a life-saving measure when there is irreversible damage to the legs. Indications for Amputation: Dead Limb: Gangrene Deadly Limb Wet gangrene Spreading cellulitis Arteriovenous fistula Malignancy (e.g., sarcoma) Dead loss of limb: Severe rest pain due to irreversible critical leg ischemia Paralysis Severe contracture Trauma (irreparable damage) Local Amputation : For small-vessel disease (e.g., diabetes) : Gangrene of toes may require local amputation. If the metatarsophalangeal joint is involved, ray excision may be necessary. Major Amputation: Below-knee Amputation : Preserves knee joint, offering better prosthetic use. Above-knee Amputation : For poor circulation or non-mobilizing patients. Knee Disarticulation : Preserves femur and patella for better prosthetic function. Post-operative care: Pain Management : Regular opiate use. Limb Care : Prevent pressure ulcers on the remaining limb. Exercise : Prevent deformities, build strength, and improve mobility. Complications: Early : Hemorrhage, infection, gas gangrene, and wound dehiscence. Late : Phantom limb pain, stump ulceration, DVT, and pulmonary embolism Other options: Option A: Better fit for prosthesis This may be relevant in elective or planned amputations (e.g., vascular disease), but in acute traumatic crush injuries, survival takes priority. Prosthetic fitting is considered later. Option C: Reduces risk of cancer There is no cancer-related indication in traumatic amputations. This option is irrelevant to the clinical context. Option D: Good cosmetic outcomes Cosmesis is not a priority in emergency traumatic amputations. Such procedures are typically disarticulations or guillotine amputations for source control.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1014,1015

↑ *Back to this question in Part A*

@Neet_pg_bot

Q20: In solid organ transplantation, which of the following organs is associated with a higher incidence of rejection? (Q860491)

A. Lungs

B. Intestine

C. Kidney

D. Liver

Correct Answer: A. Lungs

Explanation: Survival after lung transplantation continues to improve over time; however, the rates remain lower compared to other solid organ transplants. Around 50% of lung transplant recipients will face at least one episode of acute rejection within the first year . Furthermore, by five years post-transplant , roughly half of recipients will have developed chronic rejection . Incorrect Options: Kidney transplantation: (Option C) Graft rejection rate for kidney transplants is quite low after the first year. Specifically, with living-donor kidneys , the 1-year survival rate is 98% , and with deceased-donor kidneys , the 1-year survival rate is 93% . At 5 years, the graft survival rate for living-donor kidneys is 85%, and for deceased-donor kidneys, it is 75% . By 10 years, the survival rates drop to

65% for living-donor kidneys and 48% for deceased-donor kidneys, indicating a gradual decline due to chronic processes rather than acute rejection episodes. Liver transplantation (Option D): Chronic rejection occurs in about 13-17% of recipients Intestinal transplantation (Option B): Chronic rejection occurs in about 10% of recipients.

References:

Harrison's Principle of Internal Medicine, 21st Edition, Page 2213, 2325, 2326

https://pmc.ncbi.nlm.nih.gov/articles/PMC5715482/#:~:text=Clinical%20Features%20and%20Diagnosis%20of%20Chronic%20Rejection&text=CR%20occurs%20in%203%E2%80%9317,to%20earlier%20Cyclosporin%20based%20studies.

https://pubmed.ncbi.nlm.nih.gov/29327261/

↑ *Back to this question in Part A*

@Neet_pg_bot

Q21: A 55-year-old female patient with chronic pancreatitis undergoes a Puestow procedure. What is the most preferred route for supplementary nutrition in this patient? (Q860504)

A. TPN (Total Parenteral Nutrition)

B. Oral feeding

C. Feeding gastrostomy

D. Feeding jejunostomy

Correct Answer: D. Feeding jejunostomy

Explanation: After major pancreatic surgery (including Puestow), the stomach and duodenum frequently develop postoperative ileus, making early oral or gastric feeding unreliable. Feeding jejunostomy (FJ) delivers nutrition directly into the jejunum, bypassing the non-functioning upper GI tract. Enteral feeding through a jejunostomy is safer than gastric feeding, reduces aspiration risk, and is preferred over TPN because it maintains gut mucosal integrity and lowers infection risk. Hence, FJ is the most appropriate supplementary feeding route. Incorrect Options: Option A) TPN : Only used when enteral feeding is impossible. Higher risks: line infections, metabolic complications. Enteral > parenteral whenever feasible. Option B) Oral feeding : Usually delayed due to postoperative ileus , nausea, and vomiting. Not dependable for immediate nutritional needs. Option C) Feeding gastrostomy : Stomach often has poor motility post-pancreatic surgery; higher aspiration risk. Not recommended for early postoperative feeding.

References:

SRB's Manual of Surgery, 6th Edition, Page 693.

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 338, 339.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q22: A 30-year-old female presents to the emergency department with burn injuries sustained from a stove explosion. She has burns involving the face with singeing of eyelashes, both upper limbs entirely, and the anterior chest. The burns are partial-thickness, involving the epidermis and part of the dermis. Based on the rule of Nines, what is the approximate total body surface area (TBSA) affected by burns? (Q865330)

A. 33-36%

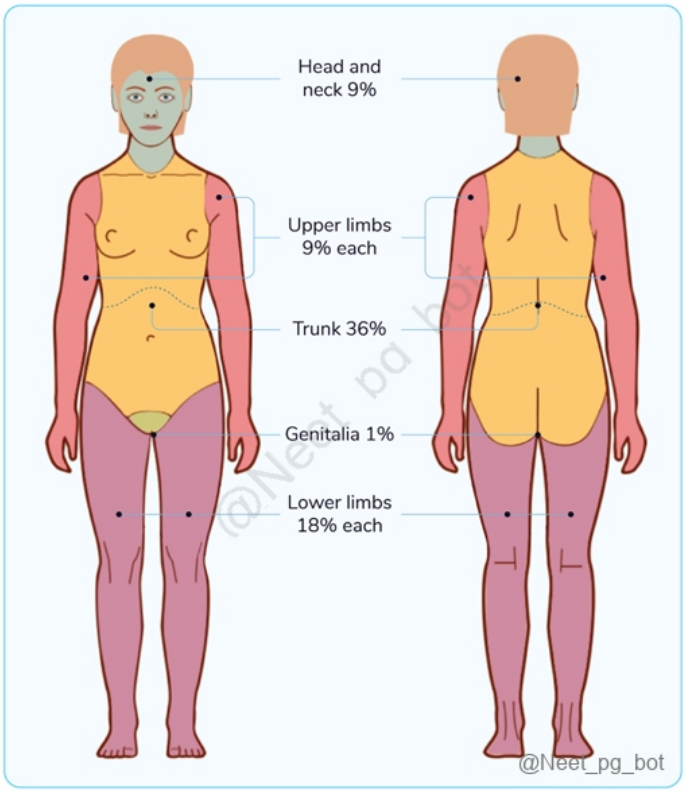
B. 40-45%

C. 25-28%

D. 50-55%

Correct Answer: A. 33-36%

Explanation: According to the Wallace rule of 9 , Face is 9% (head and neck). Both upper limbs: Each upper limb = 9%, so both = 18% . The entire anterior trunk (chest + abdomen) = 18%. The anterior chest alone (without abdomen) is approximately 9% (half of the anterior trunk). TBSA = 9 + 18 + 9 = 36%, hence it is 33 - 36% Wallace rule of 9 Adults Children Infants Head & neck 9% 18% 20% Front of chest & abdominal wall 9 x 2 = 18% 18% 10 x 2 = 20% Back of chest & abdominal wall 9 x 2 = 18% 18% 10 x 2 = 20% Lower limb 18 x 2 = 36% 13.5 x 2 = 27% 10 x 2 = 20% Upper limb 9 x 2 = 18% 18% 10 x 2 = 20% Perineum 1% 1%



References:

SRB's Manual of Surgery, 6th Edition, Page 122

↑ *Back to this question in Part A*

@Neet_pg_bot

Q23: Which of the following is incorrect regarding the following dressing? (Q865340)

A. Redressing is done after 4 - 7 days

B. Negative pressure 10-20 mmHg

C. Increase proliferation and protein matrix synthesis

D. Can be continuous & intermittent



Correct Answer: B. Negative pressure 10-20 mmHg

Explanation: The image shows a Vacuum-assisted closure, also known as negative pressure wound therapy and, the usual therapeutic negative pressure range used in NPWT is -125 mmHg , not 10–20 mmHg. NPWT stimulates cell proliferation, angiogenesis, and extracellular matrix (ECM) production, thereby enhancing healing. It promotes formation of granulation tissue. (Option C) NPWT can be delivered in either continuous or intermittent modes (Option D) They are typically changed every 48–72 hours , but can be left for up to 5–7 days in clean wounds. Dressing changes are done more frequently if infection is suspected. (Option A) Indications of NPWT: Acute wounds: Open fractures, burns, degloving injuries, fasciotomies. Chronic wounds: Diabetic foot ulcers, pressure sores. Surgical wounds: Dehisced incisions, grafts/flaps, closed incisions at high risk of dehiscence

References:

Negative pressure wound dressing

Barash Clinical Anesthesiology, 9th Edition, Page 4841- 4846

↑ *Back to this question in Part A*

@Neet_pg_bot

Q24: Which of the following cancers is NOT related to obesity? (Q865421)

A. Meningioma

B. Gastric carcinoma

C. Pancreatic carcinoma

D. Multiple myeloma

Correct Answer: A. Meningioma

Explanation: Meningiomas are typically benign central nervous system tumors arising from the meninges. Although some observational studies have noted a possible link between obesity and meningioma (particularly in women), this association is not considered well established or causal. Obesity is a well-established risk factor for numerous malignancies , particularly those influenced by chronic inflammation , insulin resistance , and hormonal imbalances . The cancers most strongly linked to obesity include: Endometrial Breast (postmenopausal) Colorectal Esophageal (adenocarcinoma) Pancreatic (Option C) Renal cell carcinoma Gallbladder Liver Gastric (cardia type) (Option B) Multiple myeloma (Option D) These associations are supported by robust epidemiological data and acknowledged by major health organizations (e.g., IARC, WHO, CDC).

References:

Harrison's Principles of Internal Medicine, 21st edition, Page 679-680, 702, 901.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q25: A 30-year-old lactating mother presents with pain in her left breast and a fever. On examination, the left breast appears as shown in the image below. There is mild axillary lymphadenopathy on the affected side and the contralateral breast is normal. Repeated aspirations under antibiotic cover were unsuccessful. A USG done showed fluid collection. What is the next best step in the management of this patient? (Q865425)

A. Incision and drainage

B. Broad-spectrum antibiotics only

C. Breast conservation surgery

D. Punch biopsy



Correct Answer: A. Incision and drainage

Explanation: The clinical scenario described suggests that the patient may have developed a breast abscess. Breast abscesses are typically caused by bacterial infection and are more common in lactating women due to the increased risk of bacterial colonization of the breast ducts. The presence of fever, pain, and fluid collection seen on ultrasound are also consistent with a breast abscess. Repeated aspirations under antibiotic cover have been unsuccessful, suggesting that the abscess is not resolving with conservative management alone. Therefore, the next best step in the management of this patient would be incision and drainage of the abscess. Incision and drainage is the most effective way to treat a breast abscess, as it allows for the complete removal of the infected material and helps to prevent recurrence. Breast Abscess Definition Pus-filled cavity within breast tissue. Types Lactational Abscess: Associated with breastfeeding. Non-Lactational Abscess: Occurs in non-lactating women, e.g., periductal mastitis. Causes and Risk Factors Lactation: Incidence: 3% to 20% in lactating mothers. Common pathogen: Staphylococcus aureus (methicillin-resistant strains in hospital settings). Entry points: Cracked/retracted nipple, blocked lactiferous ducts. Non-Lactation: Often in nulliparous women or post-lactation. Conditions: Periductal mastitis, idiopathic granulomatous mastitis, tubercular mastitis. Smoking and diabetes as risk factors. Signs and symptoms Fever, leukocytosis, erythema, pain and tenderness, swelling, malaise, difficulty feeding, enlarged and tender axillary nodes Diagnosis Ultrasonography: Detects cellulitis, liquefaction necrosis. Confirms abscess size, location, and loculation. Treatment Lactational Mastitis: Antibiotics: Anti-staphylococcal (e.g., cloxacillin, flucloxacillin, erythromycin). Breast emptying: Frequent breastfeeding or pumping. Support: Breast support garment, cold compresses, analgesia. Drainage: Ultrasound-guided preferred over surgical incision. Follow-up: Regular clinical and ultrasonographic reviews, culture-based antibiotic modification. Non-Lactational Mastitis: Broad-spectrum antibiotics for subareolar infections. Needle aspiration for abscess drainage. Major milk duct excision for complications like sepsis or fistula. Broad-spectrum antibiotics (Option B) may be used in conjunction with incision and drainage to treat the infection, but antibiotics alone are not sufficient for the management of a Breast abscess. Breast conservation surgery (Option C) typically involves the removal of a breast lump or tumor.

Thus, breast conservation surgery is not appropriate management option for a breast abscess. Punch biopsy (Option C) is a diagnostic procedure used to obtain a tissue sample for analysis.

References:

Sabiston Textbook of Surgery, 21st Edition, Page 826, 827

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 927, 928

Schwartz textbook of Surgery, 11th Edition, Page 550-553, 601, 602

↑ *Back to this question in Part A*

@Neet_pg_bot

Q26: An 84-year-old man who had a stroke 2 years ago and has been on extended bed rest, develops a pressure ulcer with partial skin thickness loss and a clean base. What is the grade of his pressure sore? (Q853066)

A. 1

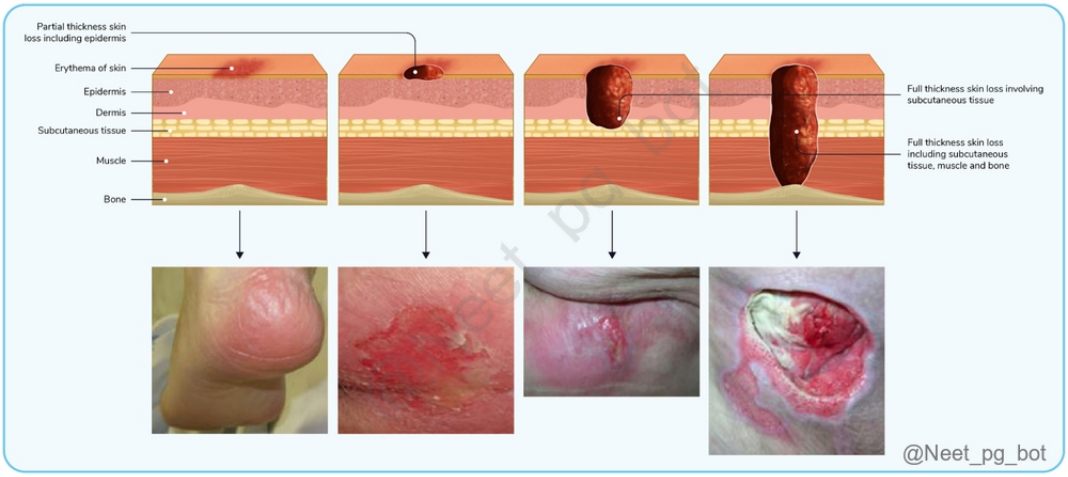
B. 2

C. 3

D. 4

Correct Answer: B. 2

Explanation: The pressure ulcer described in the scenario has partial skin thickness loss with a clean base , characteristic of a Grade 2 pressure sore. Pressure sore stages Stage I (Option A ruled out) Early superficial ulcer Non blanchable erythema of the skin, without breach in the epidermis Stage II (Option B) Late superficial ulcer Partial thickness, less including epidermis + dermis Stage III (Option C ruled out) Early deep ulcer Full-thickness skin loss involving subcutaneous tissues but not through underlying fascia Stage IV (Option D ruled out) Late deep ulcer Full-thickness skin loss involving subcutaneous tissue, muscle, bone, joints or tendon.



References:

SRB's Manual of Surgery, 6th Edition, Pages 22, 23

↑ *Back to this question in Part A*

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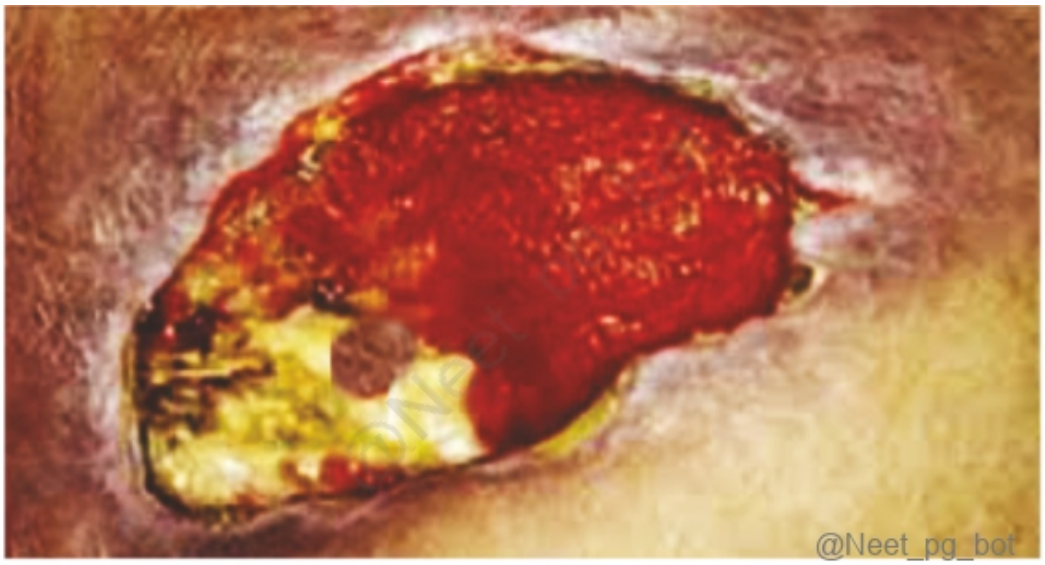
Q27: Identify the grade of the condition given in the image below ? (Q844279)

A. Grade 1

B. Grade 2

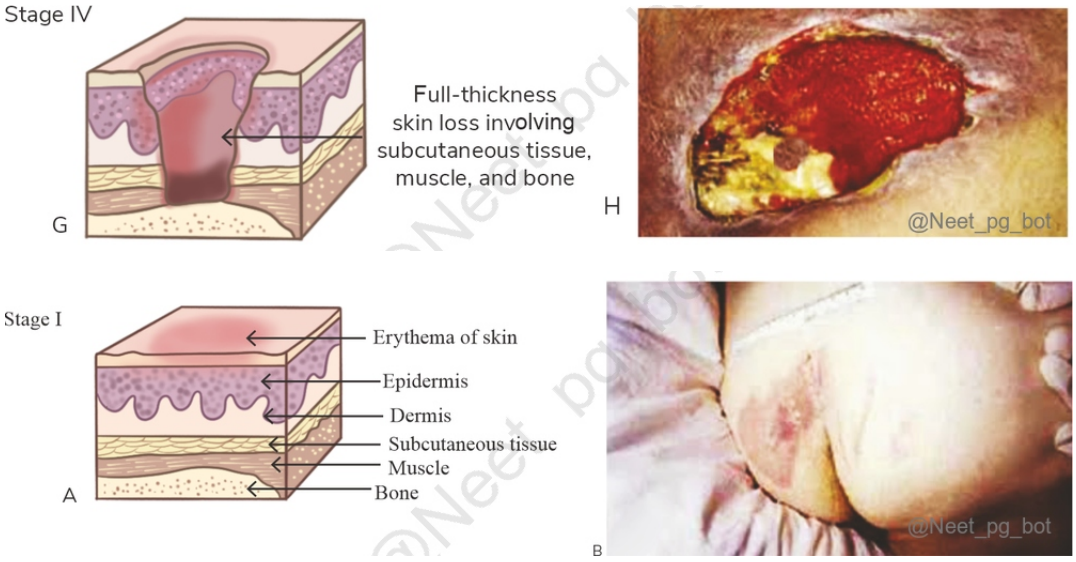
C. Grade 3

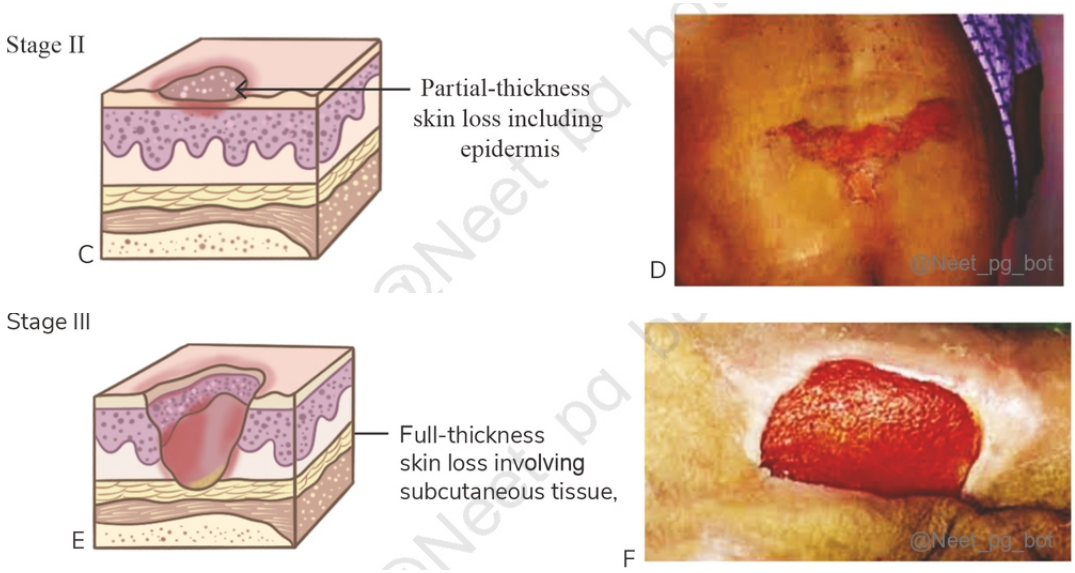
D. Grade 4



Correct Answer: D. Grade 4

Explanation: Correct Option D - Grade 4: The image shows a deep ulcer with exposed bone, muscle, or tendon, characteristic of a Grade 4 pressure sore, the most severe level of pressure-induced tissue damage. Incorrect Options: Option A - Grade 1: This is the earliest stage of a pressure sore where damage is limited to superficial layers of the skin. Option B - Grade 2: This stage involves damage beyond the epidermis into the dermis, often resembling an abrasion, blister, or shallow crater. Option C - Grade 3: The ulcer has extended deeper into the tissue but has not yet reached the muscle or bone.





References:

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↑ *Back to this question in Part A*

@Neet_pg_bot

Q28: A 20-year-old chronic alcoholic presents with severe hematemesis. An ultrasound (USG) shows distention of the portal vein, and the liver appears hyperechoic. Pantoprazole has been administered. What is the next appropriate step in management? (Q844303)

A. Initiate a course of broad-spectrum antibiotics

B. Order a liver biopsy to assess for fibrosis

C. Administer intravenous fluids and electrolyte replacement

D. Perform an endoscopy to look for varices

Correct Answer: C. Administer intravenous fluids and electrolyte replacement

Explanation: Correct Option C - Administer intravenous fluids and electrolyte replacement: The patient is presenting with severe hematemesis, which suggests significant blood loss. The immediate priority is stabilizing the patient by administering intravenous fluids to maintain blood pressure, replace lost fluids, and correct electrolyte imbalances. Incorrect Options: Option A - Initiate a course of broad-spectrum antibiotics: While antibiotics may be needed later in managing a patient with suspected variceal bleeding and cirrhosis (to prevent infections like spontaneous bacterial peritonitis), it is not the immediate next step. The priority is to stabilize the

patient first. Option B - Order a liver biopsy to assess for fibrosis: A liver biopsy is useful for diagnosing the extent of liver fibrosis or cirrhosis. However, in the acute setting of severe hematemesis, it is inappropriate as the immediate next step. The patient needs urgent stabilization, not an invasive diagnostic procedure. Option D - Perform an endoscopy to look for varices: Endoscopy is essential for diagnosing and managing variceal bleeding, particularly in a patient with portal hypertension secondary to chronic alcohol use. However, it should be performed after initial stabilization, including fluid resuscitation and hemodynamic support.

References:

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↑ *Back to this question in Part A*

@Neet_pg_bot

Q29: Which of the following is a complication of Total Parenteral Nutrition (TPN) in a sepsis patient in the ICU? (Q844304)

A. Hyperlipidemia

B. Hyperglycemia

C. Hyperglyceridemia

D. Hypoglycemia

Correct Answer: B. Hyperglycemia

Explanation: Correct Option B - Hyperglycemia: The biochemical abnormality most consistent with early TPN complications (TPN-induced hyperglycemia) This is a frequent complication of TPN, particularly in critically ill patients, such as those with sepsis (metabolic disorders). The high glucose content of TPN, combined with insulin resistance often seen in sepsis, increased catecholamines, and impaired glucose utilization can lead to significant elevations in blood glucose levels. Incorrect Options: Option A - Hyperlipidemia: TPN can sometimes lead to elevated lipid levels, especially if the lipid component is administered in excess. However, this is less common in the acute setting of a septic patient compared to hyperglycemia. Option C - Hyperglyceridemia: While TPN contains lipids that can elevate glyceride levels, hyperglyceridemia is not as common or clinically significant as hyperglycemia in the acute management of sepsis. Option D - Hypoglycemia: Although hypoglycemia can occur if TPN is suddenly stopped or if there is an insulin overdose, it is not a common complication during the administration of TPN, especially in a septic patient where hyperglycemia is more likely.

References:

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↑ *Back to this question in Part A*

@Neet_pg_bot

Q30: What is the ideal pressure setting for vacuum-assisted closure (VAC) therapy? (Q844308)

A. -125 mm Hg

B. 60 to 80 mm Hg

C. 130 mm Hg

D. 80 to 100 mm Hg

Correct Answer: A. -125 mm Hg

Explanation: Correct Option A - 125 mm Hg: This is the most commonly recommended and studied pressure setting for VAC therapy. It is considered ideal for promoting wound healing, reducing edema, and enhancing blood flow while minimizing tissue damage. Most clinical guidelines and studies support this pressure as the optimal setting for standard VAC therapy. It has been observed that pressures above 125 mmHg may compromise microcirculatory blood flow. Incorrect Options: Option B - 60 to 80 mm Hg: This lower pressure range may be used in specific situations, such as when treating wounds over sensitive or delicate areas where higher pressures might cause discomfort or tissue damage. However, it is generally not considered the ideal setting for most VAC applications. Option C - 130 mm Hg : Although close to the recommended pressure, this slightly higher setting may increase the risk of tissue damage and discomfort, making it less ideal compared to the 125 mm Hg setting. Option D - 80 to 100 mm Hg: This range may be used for certain wounds where a lower pressure is needed, such as in patients with compromised circulation or delicate tissues. However, it is not the standard pressure setting for VAC therapy in most cases.

References:

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↑ *Back to this question in Part A*

@Neet_pg_bot

Q31: During laparoscopic port placement, injury to which abdominal wall vessels must be avoided while inserting the trocar?During laparoscopic surgery, where shouldn't the trocar be inserted? (Q852687)

A. Superior epigastric artery

B. Inferior epigastric artery

C. Abdominal aorta

D. Both A and B

Correct Answer: D. Both A and B

Explanation: Trocar placement during laparoscopic surgery requires careful consideration to avoid injury to major blood vessels, including both the superior and inferior epigastric arteries . Inferior epigastric artery (IEA): Located on the posterior aspect of the rectus sheath, arising from the external iliac artery , it is at risk when inserting trocars in the lower abdominal wall. Superior epigastric artery (SEA): A continuation of the internal thoracic artery , it supplies the upper abdominal wall and is at risk in upper trocar insertions . Both arteries run within the rectus sheath , making them relevant in trocar placement at different levels of the anterior abdominal wall. Trocar Placement & Epigastric Arteries: Trocar Site At Risk Artery Precautions Umbilical (Primary) Minimal risk Insert at linea alba Supraumbilical (Upper Trocar) Superior Epigastric Artery Avoid midline rectus sheath Infraumbilical/Midclavicular Inferior Epigastric Artery Insert lateral to rectus muscle Palmar's Point (LUQ Trocar) Minimal risk Used in difficult access cases Superior Epigastric Artery (Option A): Incorrect alone because it is only at risk in upper abdominal trocar placement . Inferior Epigastric Artery (Option B): Incorrect alone because both superior and inferior epigastric arteries are at risk depending on trocar position . Abdominal Aorta (Option C): Incorrect because the aorta is a deep retroperitoneal structure, not directly relevant to trocar insertion .

References:

Bailey & Love's Short Practice of Surgery, Ed 28, Pg 102, 103

SRB's Surgical Operations, Text and Atlas, Edition 1, Pg. 550,551

https://pmc.ncbi.nlm.nih.gov/articles/PMC4664217/

https://pmc.ncbi.nlm.nih.gov/articles/PMC5206834/

↑ *Back to this question in Part A*

@Neet_pg_bot

Q32: A 45-year-old male patient was brought to the emergency department following a road traffic accident.O/E, he had multiple injuries all over his body and was found to be in class III hemorrhagic shock. The percentage of blood loss would be between: (Q852705)

A. 5-15%

B. 30-40%

C. >40%

D. 15-30%

Correct Answer: B. 30-40%

Explanation: The percentage of blood loss in class III hemorrhagic shock is 30-40%. Parameter Class I (Compensated Shock) Class II (Hypoxemia) Class III Class IV (Refractory Shock) Blood Loss Up to 15% (Option A) 15-30% (Option D) 30-40% (Option B) More than 40% (Option C) Mechanism Compensatory mechanisms maintain cardiac output. Generalized vasoconstriction. Decompensated shock. Refractory shock. Heart Rate <100/min 100-120/min 120-140/min >140/min Blood Pressure Normal Hypotension Marked hypotension Profound hypotension Respiratory Rate Normal Tachypnea Tachypnea Tachypnea Urine Output >30 ml/hour 20-30 ml/hour 5-15 ml/hour No urine output Mental Status Alert, normal Anxious, mildly agitated Confused, altered mental status Comatose, lethargic

References:

SRB’s Manual of Surgery, 6th Edition, Pages 105, 106, 107

Bailey & Love's Short Practice of Surgery, 28th Edition, Pages 13, 14

↑ *Back to this question in Part A*

@Neet_pg_bot

Q33: A 45-year-old man is found unconscious after a fall from a ladder. In the emergency department, his eyes do not open even in response to pain; he is making incomprehensible sounds, and he exhibits abnormal flexion in response to painful stimuli. What is his Glasgow Coma Scale (GCS) score? (Q852706)

A. 5

B. 6

C. 7

D. 8

Correct Answer: B. 6

Explanation: The Glasgow Coma Scale (GCS) is a tool used to assess a patient’s level of consciousness based on three parameters: eye-opening , verbal response , and motor response . Each parameter is scored, and the total GCS score ranges from 3 (deep coma) to 15 (fully awake). Eye response : The patient's eyes do not open, even in response to pain, corresponding to a score of 1 . Verbal response : The patient makes incomprehensible sounds, corresponding to a score of 2 . Motor response : The patient exhibits abnormal flexion (decorticate posturing) in response to pain, corresponding to a score of 3 . Thus, the GCS score for this patient is: 1 (Eye) + 2 (Verbal) + 3 (Motor) = 6 Simplified Glasgow Coma Scale (GCS) Table Category Response Score Eye Opening (E) Spontaneous 4 To speech 3 To pain 2 None 1 Verbal Response (V) Oriented 5 Confused conversation 4 Inappropriate words 3 Incomprehensible sounds 2 None 1 Motor Response (M) Obeys commands 6 Localizes to pain 5 Withdraws from pain 4 Abnormal flexion (decorticate) 3 Abnormal extension (decerebrate) 2 No response 1

Head Injury Severity: Clinical Classification Minor head injury GCS 15 with no LOC (loss of consciousness) Mild head injury GCS 14 or 15 with LOC Moderate head injury GCS 9 - 13 Severe head injury GCS 3 - 8 The GCS-P score is calculated by subtracting the Pupil Reactivity Score (PRS) from the Glasgow Coma Scale (GCS) total score: GCS-P = GCS - PRS. Pupils Unreactive to Light Pupil Reactivity Score Both Pupils 2 One Pupil 1 Neither Pupil 0 GCS-P score can range from 1 to 15 GCS-P score values between one and 8 denote a severe injury

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Pages 357, 361

https://www.glasgowcomascale.org/what-is-gcs-p/

https://www.ncbi.nlm.nih.gov/books/NBK513298/

↑ *Back to this question in Part A*

@Neet_pg_bot

Q34: A 20-year-old male presents to the outpatient department with a swelling on his wrist. He reports fluctuation in size , mild numbness in the hand , and occasional pain . What is the most likely diagnosis? (Q852713)

A. Lipoma

B. Ganglion cyst

C. Dermoid cyst

D. Hematoma



Correct Answer: B. Ganglion cyst

Explanation: The clinical presentation and image are characteristic of a ganglion cyst , which is the most common soft tissue swelling of the wrist. Supporting features: Location : Commonly over the dorsal aspect of the wrist (as seen in image) Fluctuation in size : Classic feature due to cyst fluid dynamics Mild numbness : Can occur if the cyst compresses nearby nerves Occasional pain : Especially with wrist movement or pressure Differentiating Wrist Masses: Condition Characteristics Pain Fluctuation in Size Numbness Lipoma Soft, mobile, subcutaneous fat mass No No No Ganglion cyst Fluid-filled, over joint or tendon sheath, translucent Occasional Yes Rare Dermoid cyst Congenital, contains ectodermal elements (hair/sebum) Rare Rare Yes Hematoma Post-trauma, discoloured, self-resolving Yes (initially) No No Lipoma (Option A): Typically soft, non-fluctuant, and slow-growing; not commonly associated with wrist joints or changes in size with activity. Dermoid cyst (Option C): Usually congenital, midline, and more common in children; contains ectodermal elements, and rarely found over the wrist joint. Hematoma (Option D): Usually follows trauma, appears bruised or discoloured, and resolves over time; not fluctuant or recurrent like this.

References:

https://www.ncbi.nlm.nih.gov/books/NBK470168/

https://www.ncbi.nlm.nih.gov/books/NBK507906/

https://pmc.ncbi.nlm.nih.gov/articles/PMC6258973/

https://www.ncbi.nlm.nih.gov/medgen/5484

↑ *Back to this question in Part A*

@Neet_pg_bot

Q35: A woman, a few weeks after delivery, complains of bloody discharge from nipple and fever. On examination, diffuse lump under areola. What is the diagnosis? (Q852719)

A. Galactocele

B. Lactational mastitis

C. Mondor disease

D. Fibrocystic disease

Correct Answer: B. Lactational mastitis

Explanation: Recent postpartum status → Lactating women are at high risk of mastitis due to milk stasis and bacterial infection. Bloody nipple discharge and fever → Suggests infection and inflammation , which are characteristic of lactational mastitis . Diffuse lump under the areola → Likely represents engorgement or inflammatory induration due to stasis or bacterial invasion (commonly Staphylococcus aureus). Lactational Mastitis Feature Lactational Mastitis Etiology Bacterial infection due to milk stasis (commonly Staphylococcus aureus) Risk Factors Breastfeeding, nipple trauma (cracks), poor latch, prolonged engorgement Symptoms Fever, malaise, painful swollen breast , erythema, bloody or purulent discharge Examination Tender indurated mass , warmth, erythema over the affected breast Complications Breast abscess (if untreated) Management Frequent breastfeeding, warm compress, analgesics, antibiotics (dicloxacillin, cephalexin) Galactocele (Option A): Incorrect because it presents as a painless cystic swelling due to milk retention , without fever, tenderness, or bloody discharge . Mondor disease (Option C): Incorrect because it is thrombophlebitis of the superficial veins of the breast , presenting as a palpable cord-like structure , not a diffuse lump or fever . Fibrocystic disease (Option D): Incorrect because it causes cyclic breast pain and nodularity, typically worsening before menstruation, not postpartum infection .

References:

Robbins 10th Ed. Pg 1040

↑ *Back to this question in Part A*

@Neet_pg_bot

Q36: A patient with dilated tortuous veins of the leg presented to the OPD and is diagnosed with varicose vein of grade C4a. What is the best preferred treatment? (Q852721)

A. Compression

B. Endothermal ablation

C. Non endothermal non tumescent ablation

D. Open surgery

Correct Answer: B. Endothermal ablation

Explanation: Grade C4a varicose veins (as per CEAP classification) indicate skin changes such as pigmentation or eczema due to chronic venous insufficiency. Endothermal ablation (radiofrequency or laser) is the first-line treatment for symptomatic varicose veins. It is minimally invasive, effective, and has faster recovery compared to open surgery . CEAP Classification & Treatment of Varicose Veins CEAP Class Clinical Features Preferred Treatment C0 No visible/palpable signs No treatment needed C1 Telangiectasias or reticular veins Conservative (compression) C2 Varicose veins Compression, ablation, or surgery C3 Edema Endothermal ablation C4a Pigmentation/eczema Endothermal ablation C4b Lipodermatosclerosis or atrophie blanche Endothermal or open surgery C5 Healed venous ulcer Endothermal ablation + ulcer care C6 Active venous ulcer Multimodal therapy Compression (Option A): Incorrect because while compression stockings help relieve symptoms, they do not treat the underlying venous reflux . Non-endothermal non-tumescent ablation (Option C): Incorrect because options like cyanoacrylate glue or mechanochemical ablation are alternative treatments but not first-line . Open surgery (Option D): Incorrect because surgical vein stripping is now reserved for cases where endothermal ablation is not feasible .

References:

Sabiston Textbook of Surgery, 21st Edition, Page 1814

Bailey and Love’s Short Practice of Surgery, 28th Edition, Page 1030

CEAP

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Q37: The ureter is safe in which type of hysterectomy? (Q852722)

A. Open laparotomy

B. Laparoscopy

C. Robotic

D. Vaginal

Correct Answer: D. Vaginal

Explanation: In vaginal hysterectomy , the ureter is least at risk of injury because: The procedure is performed entirely through the vaginal route without significant dissection near the ureter. There is less manipulation of pelvic structures compared to other approaches. Other methods like open, laparoscopic, and robotic hysterectomy involve greater ureteric handling, increasing the risk of thermal injury, ligation, or transection . Ureteric Safety in Hysterectomy Types Hysterectomy Type Ureteric Injury Risk Reasons Open laparotomy Moderate Direct ureteric handling, risk during ligation Laparoscopic High Increased risk due to thermal and traction injuries Robotic Moderate to high Similar to laparoscopic but better visualization Vaginal Lowest Minimal ureteric dissection, lower risk of injury Open laparotomy (Option A): Incorrect because ureteric injury can occur during ligation of uterine vessels or parametrial dissection . Laparoscopy (Option B): Incorrect as ureteric injury is common due to thermal damage from electrocautery . Robotic (Option C): Incorrect since it has a similar risk as laparoscopic hysterectomy .

References:

https://pmc.ncbi.nlm.nih.gov/articles/PMC5385136/

https://pmc.ncbi.nlm.nih.gov/articles/PMC7363243/

↑ *Back to this question in Part A*

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Q38: A 25-year-old male with a history of a road traffic accident presents to the emergency department. His GCS is 8/15, oxygen saturation is 85%, blood pressure is 100/60 mmHg and heart rate is 60 beats per minute. On examination, breath sounds are absent on the right side. What is the next step in management? (Q853038)

A. Start IV fluids, give atropine and secure airway

B. Secure airway, give oxygen, insert ICD, secure IV line

C. Evaluate for head injury and do CT-head

D. ■■■Administer IV dextrose followed by NCCT head

Correct Answer: B. Secure airway, give oxygen, insert ICD, secure IV line

Explanation: The patient has GCS 8/15 , indicating a severe head injury and possible impaired consciousness . Therefore, securing the airway is the priority to prevent further deterioration. Oxygen should be administered to address the low oxygen saturation (85%). The absence of breath sounds on the right side raises concern for tension pneumothorax or large pneumothorax , which can lead to respiratory failure . In this case, the next step is to insert an intercostal chest drain (ICD) to relieve any pneumothorax and re-expand the lung. IV access should be secured for fluid resuscitation or medication administration, but airway and breathing take precedence. We will follow a primary survey of A, B, C, D, and E to manage this patient, where A is securing the airway, B is giving oxygen and inserting ICD, and C includes IV line. Start IV fluids, give atropine and secure airway (Option A) : Securing the airway is important, but giving atropine is not the priority here because the patient has a heart rate of 60 bpm ,

which is not significantly low and does not require atropine at this stage. Evaluate for head injury and do CT-head (Option C) : The immediate concern is the airway and respiratory distress . The absence of breath sounds on the right side suggests a life-threatening thoracic injury that should be managed first, with a CT scan of the head being considered later once the patient is stabilised. Administer IV dextrose followed by NCCT head (Option D) : There is no indication that the patient is hypoglycemic or in need of IV dextrose at this moment. The priority should be stabilising the airway and managing the potential pneumothorax . The NCCT head can be done later if head injury is suspected after stabilizing the patient.

References:

Sabiston, Text Book of Surgery, 21st edition, Pages 391, 392

↑ *Back to this question in Part A*

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Q39: What should be the next course of action in the management of a 30-year-old breastfeeding mother who is experiencing pain and fever in her left breast? The left breast appears abnormal as depicted in the provided image. There is slight swelling of the lymph nodes in the armpit on the affected side, while the opposite breast appears normal. Despite multiple attempts at draining the fluid with the use of antibiotics, it was unsuccessful. An ultrasound examination revealed the presence of fluid collection. (Q793402)

A. Incision an drainage

B. Broad spectrum antibiotics only

C. Breast conservation surgery

D. Punch biopsy



Correct Answer: A. Incision an drainage

Explanation: Correct choice : Option a :The clinical scenario described suggests that the patient may have developed a breast abscess. Breast abscesses are typically caused by bacterial infection and are more common in lactating women due to the increased risk of bacterial colonization of the breast ducts. The presence of fever, pain, and fluid collection seen on ultrasound are also consistent with a breast abscess. Repeated aspirations under antibiotic cover have been unsuccessful, suggesting that the abscess is not resolving with conservative management alone. Therefore, the next best step in the management of this patient would be incision and drainage of the abscess . Incision and drainage is the most effective way to treat a breast abscess, as it allows for the complete removal of the infected material and helps to prevent recurrence. Incorrect Choices: Option b: Broad-spectrum antibiotics may be used in conjunction with incision and drainage to treat the infection, but antibiotics alone are not sufficient for the management of a breast abscess. Option c: Breast conservation surgery typically involves the removal of a breast lump or tumor. Thus, breast conservation surgery is not appropriate management option for a breast abscess. Option d: Punch biopsy is a diagnostic procedure used to obtain a tissue sample for analysis. Thus, punch biopsy is not appropriate management option for a breast abscess.

References:

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Q40: A 35-year-old male had surgery for an ileal perforation. Due to significant contamination, only the sheath was sutured, leaving the wound open. Daily wound irrigation was carried out, and the wound was closed on postoperative day 5. What type of wound-healing mechanism is occurring in this scenario? (Q853067)

A. Primary intention

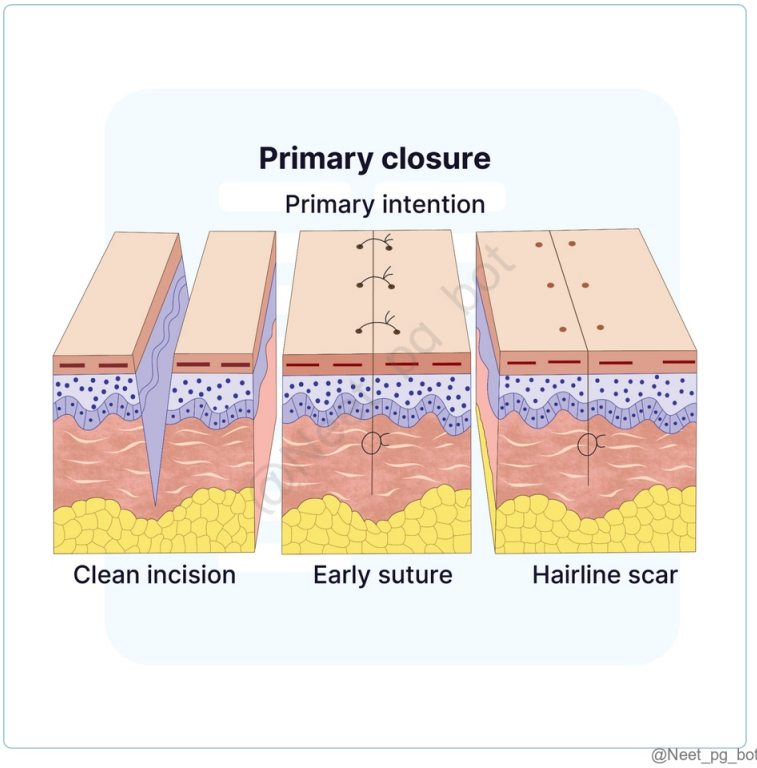
B. Secondary intention

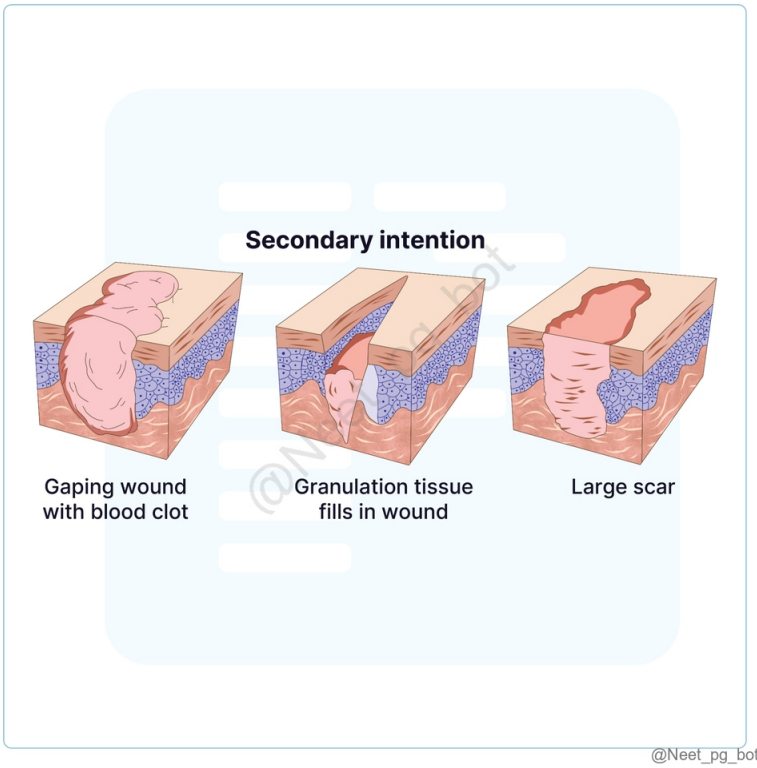
C. Tertiary intention

D. Quaternary intention

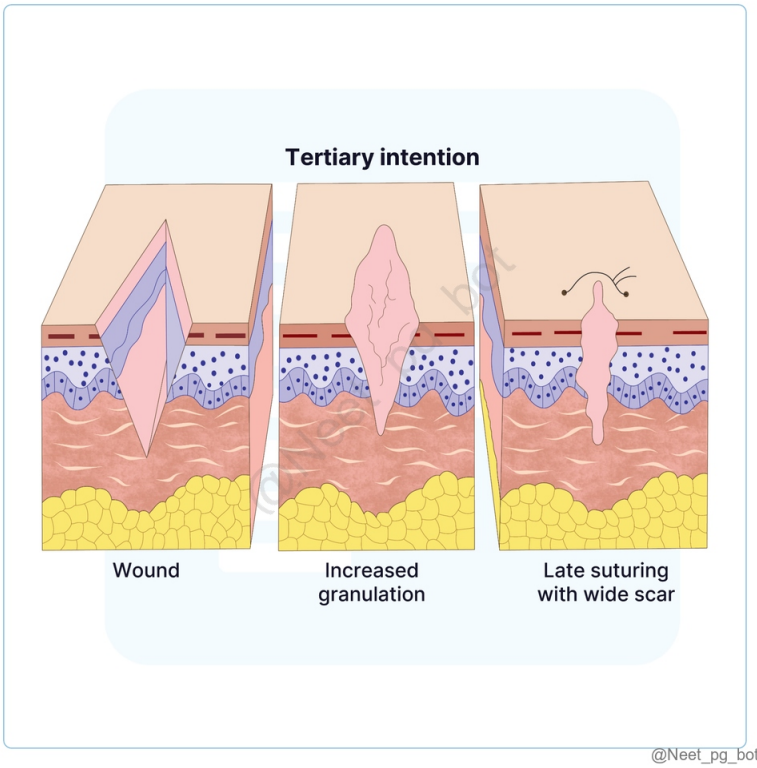
Correct Answer: C. Tertiary intention

Explanation: The type of wound healing mechanism described in this scenario is tertiary intention (also known as (delayed primary closure). Wound healing Healing by primary intention (Option A ruled out) It occurs when the edges of a clean wound are brought together and secured with sutures, staples, or adhesives. Minimal scarring occurs. Healing by secondary intention (Option B ruled out) The wound is left open to heal by granulation, contraction, and epithelialisation. This is common in wounds with significant tissue loss or contamination. Healing by tertiary intention (delayed primary closure) (Option C) The wound is initially left open and then closed surgically after several days when it's clean and granulating. This is used for contaminated wounds to prevent infection. Quaternary intention (Option D) is not a recognised term in wound healing. The proper classification includes primary, secondary, and tertiary intention.





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References:

Sabiston’s Text Book of Surgery, 21st Edition, Page 215

↑ *Back to this question in Part A*

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Q41: A friend of yours is teaching you about enhanced recovery after surgery. Which of the following statements he makes is inaccurate? (Q853068)

A. ■■■Prolonged fasting is necessary

B. Epidural anaesthesia recommended in laparoscopic surgery for pain control

C. Reduction of hospital stay by 2-3 weeks

D. Beta-blockers are given after major surgery done under general anaesthesia to improve the outcome

Correct Answer: A. ■■■Prolonged fasting is necessary

Explanation: ERAS protocols emphasise reducing fasting times before surgery. It allows a light meal up to six hours before surgery and clear fluids up to two hours prior. It also includes carbohydrate-rich drinks up to two hours before the procedure as it helps reduce postoperative insulin resistance, preserve muscle mass, minimize protein loss, and alleviate preoperative thirst, hunger, and anxiety. ERAS is a set of evidence-based guidelines aimed at improving recovery after surgery. It focuses on optimising preoperative, intraoperative, and postoperative care to speed up recovery, reduce complications, and shorten hospital stays. Epidural anaesthesia recommended in laparoscopic surgery for pain control (Option B) is true because it is one of the main component of ERAS and it can be used for effective pain control in many types of surgery, including laparoscopic surgery. However, its use may depend on the type of surgery and the patient's condition. Reduction of hospital stay by 2-3 weeks (Option C) is correct as one of the key goals of ERAS is to reduce the length of hospital stay. Beta-blockers are given after major surgery done under general anaesthesia to improve outcome (Option D) is true and is mainly given to improve cardiovascular outcome. Reference:

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page10.

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Q42: What kind of wound is an open cardiac massage? (Q857262)

A. Clean

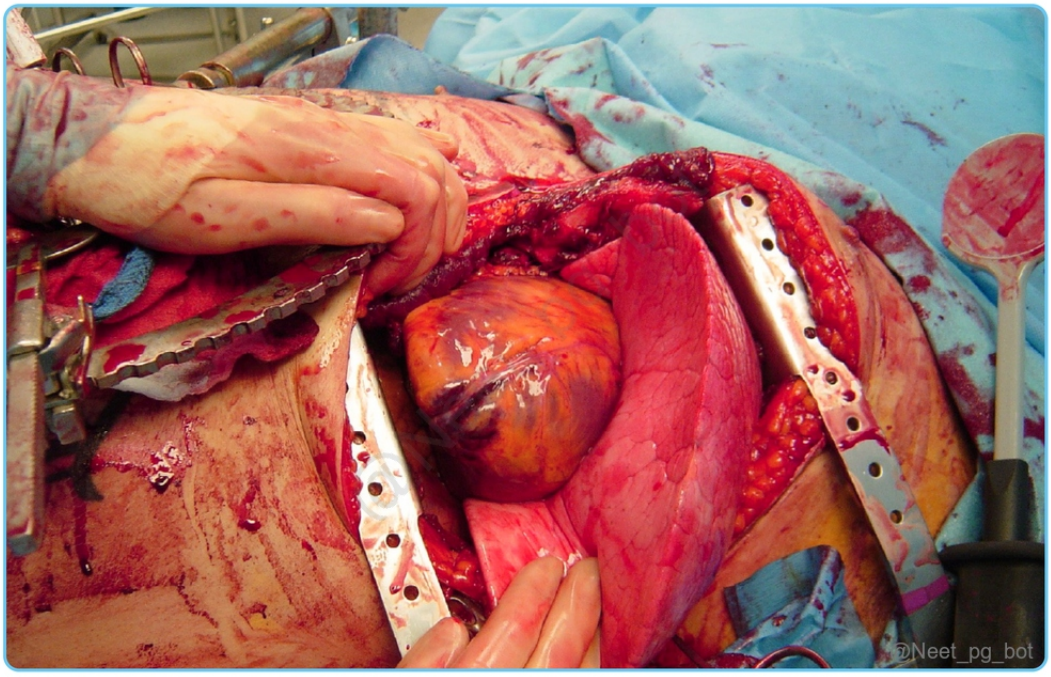
B. Contaminated

C. Dirty

D. Clean Contaminated

Correct Answer: B. Contaminated

Explanation: Open cardiac massage is classified as Category 3 due to a significant breach in sterile technique. It is generally performed in situations of inadequate cardiac output, following emergency thoracotomy for penetrating chest trauma, during pericardial tamponade, or in cases of cardiac arrest after recent chest surgery. {{caption_text}} Classification of Wounds: Classification Description Class I Clean An uninfected operative wound with no inflammation and no entry into the respiratory, alimentary, genital, or uninfected urinary tracts. Wounds are primarily closed, and drainage is closed if needed. Class II Clean-Contaminated An operative wound where the respiratory, alimentary, genital, or urinary tracts are entered under controlled conditions without unusual contamination. Includes operations like biliary tract, appendix, vagina, and oropharynx. Class III Contaminated Open, fresh accidental wounds or operations with major breaks in sterile technique (open cardiac massage) or gross spillage from the gastrointestinal tract , with acute non-purulent inflammation. Class IV Dirty-Infected Old traumatic wounds with retained devitalized tissue, clinical infection, or perforated viscera. The organisms causing postoperative infection were already present in the operative field before the operation.



References:

Sabiston Textbook of Surgery, 21st Edition, Page 225

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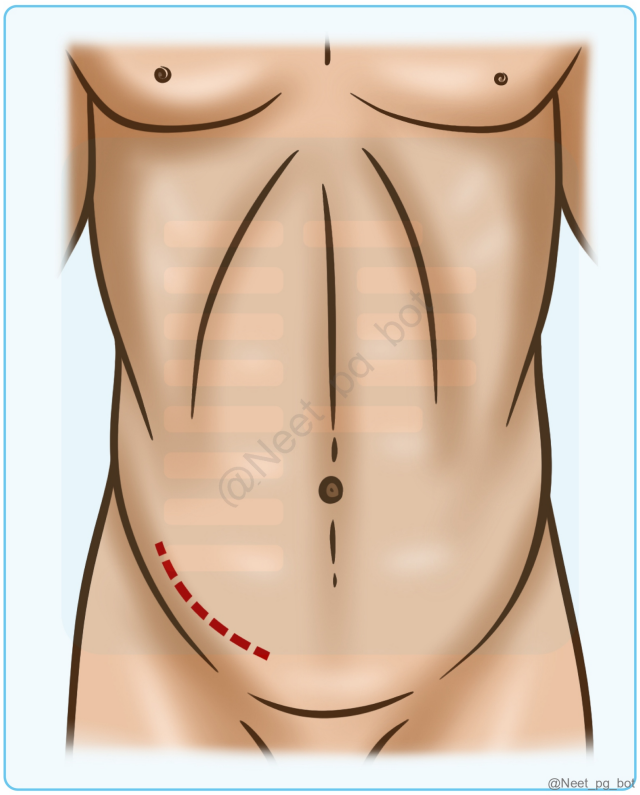
Q43: Identify the incision made and marked in the image. (Q857292)

A. Robson

B. Maylard

C. Gibson Abernathy

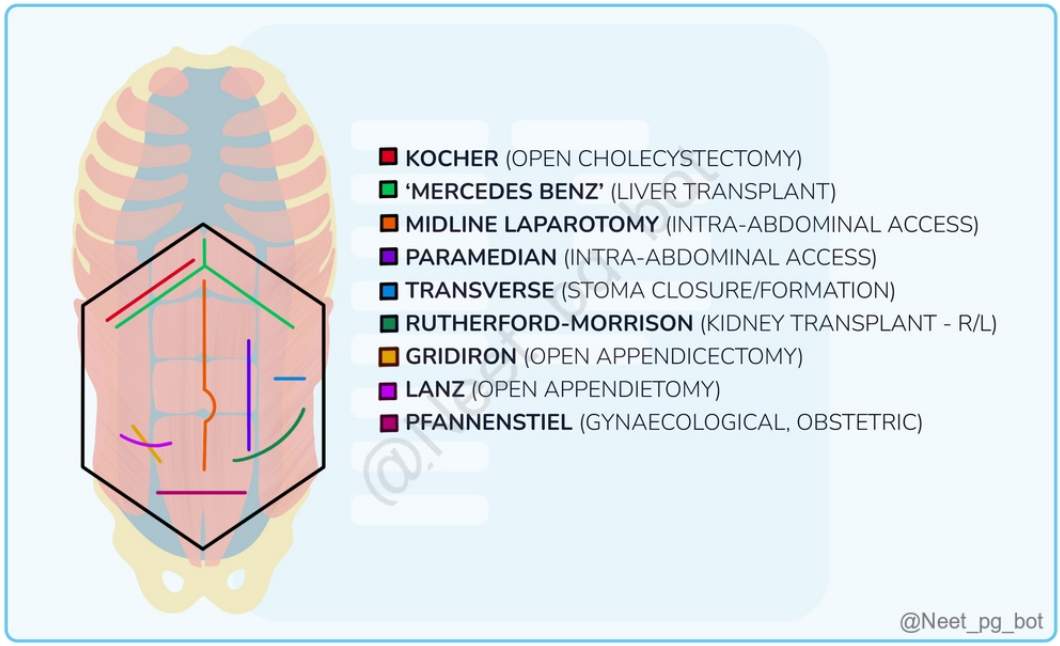
D. Kocher's

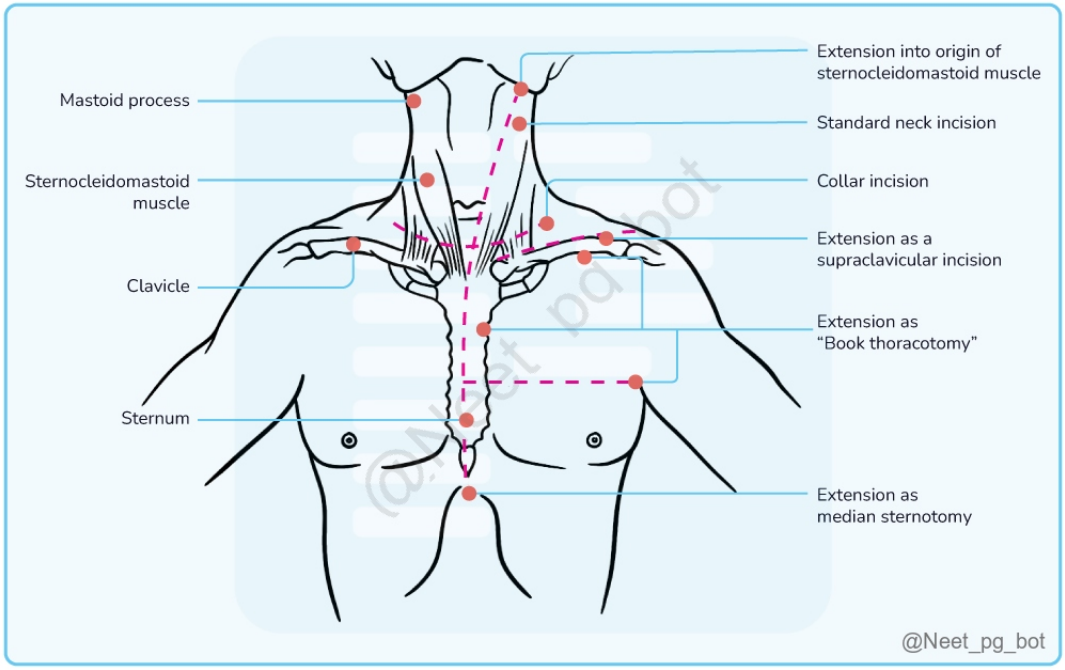


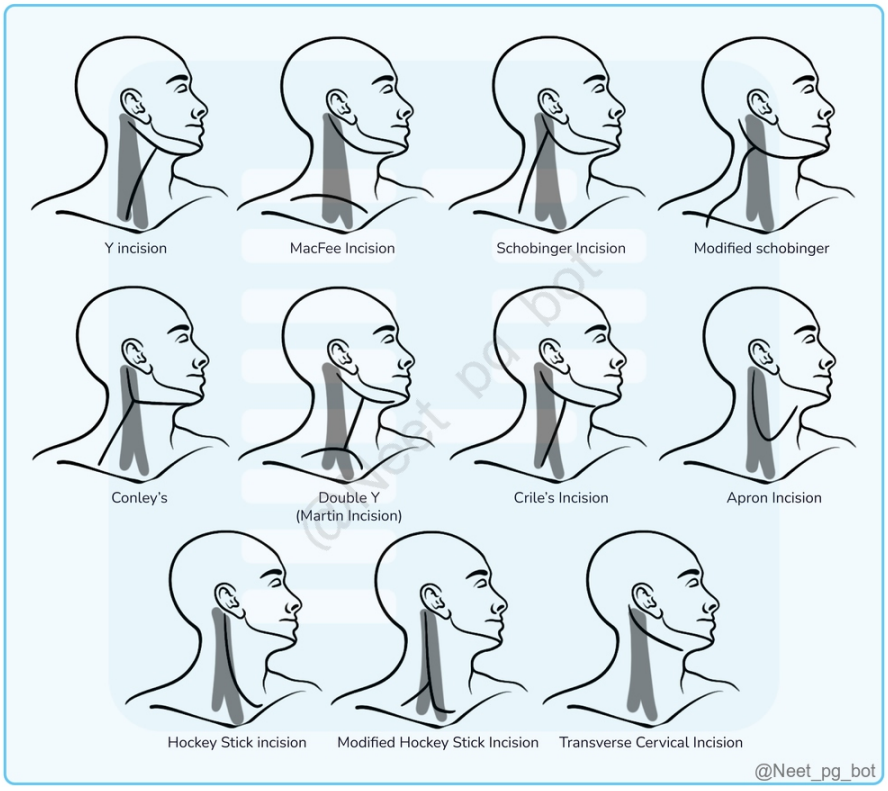
Correct Answer: C. Gibson Abernathy

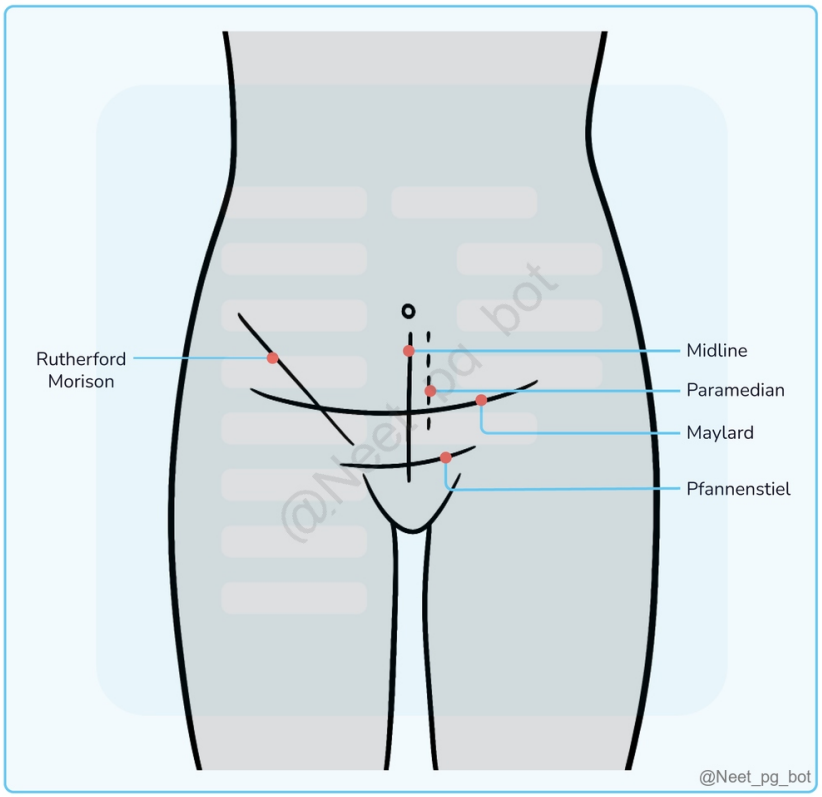
Explanation: The given image shows Gibson Abernathy's incision. Gibson Abernathy incision: Primary Use: Provides access to the lower/distal part of the ureter. Procedure Steps: The patient is placed in a supine position. The incision is made 1 inch medial to the anterior superior iliac spine (ASIS), extending 1 inch above the inguinal ligament toward the pubic symphysis. Indications: Renal transplant offers less trauma and convenient access to the iliac fossa and bladder. Laparoscopic surgery is used as access for the non-dominant hand. Open nephroureterectomy, facilitates splitting the rectus fascia and developing the space of Retzius for distal ureterectomy. Kidney excision and removal of the renal specimen from the entrapment sac. Incision Type Description Common Uses Abdominal Incisions Midline Longitudinal cut through the linea alba, bloodless access Exploratory laparotomy, trauma surgery, emergency surgeries Periumbilical Incisions around the umbilicus, avoiding the umbilical stalk Laparoscopy, umbilical hernia repairs, postpartum tubal ligation Pararectus Along the semilunar line, lateral to the rectus abdominis Abdominal wall hernia repairs, stoma creation, pelvic surgeries Paramedian Lateral to the linea alba, access to lateral viscera Lateral abdominal structures, Reduced hernia risk

Kocher/Subcostal Inferior and parallel to the costal margin, access to upper abdomen structures Gallbladder, biliary tree, pancreas, liver transplants, epigastric surgeries Gridiron/ McBurney/ Lanz Lower abdomen incisions, typically for appendectomy Appendectomy (right side), sigmoid diverticulitis (left side), cosmetic appendectomy Thoracoabdominal From 7th intercostal space to the umbilicus, exposes thoracic and abdominal organs Retroperitoneal masses, pleural space, distal oesophagus, abdominal organs Thoracic Incisions Thoracotomy Access to thoracic structures, various approaches Lung transplants, cardiac surgeries, trauma Median Sternotomy Vertical incision dividing the sternum, wide access to the mediastinum Open-heart surgery, anterior mediastinal tumour resection Trapdoor Complex incision, supraclavicular, sternal, and thoracotomy components Penetrating trauma, aortic arch aneurysms, complex cardiovascular access Infraclavicular A transverse incision just below the clavicle for subclavian vessel access Thoracic outlet syndrome, subclavian vessel surgeries Supraclavicular Superior to the clavicle, providing access to the subclavian vessels Trauma, thoracic outlet syndrome Neck Incisions Collar Incision above the sternal notch for thyroid surgeries Thyroid surgery, mid-neck structures Traumatic Neck Along the sternocleidomastoid muscle for trauma Vascular or traumatic neck injuries Tracheostomy Vertical/horizontal incision superior to the thyroid for tracheostomy Airway management in patients needing long-term ventilation Pelvic Incisions Pfannenstiel Transverse incision above the pubic symphysis Cesarean section, pelvic, urologic, and orthopaedic surgeries Maylard/Cherney Above pubic tubercle provides access to pelvic structures Hysterectomy, pelvic lymph node dissection, lower pelvis surgeries Inguinal Above and parallel to the inguinal ligament Inguinal hernia repair, urologic surgeries (cryptorchidism, varicocele) McEvedy Vertical incision for femoral hernia repair Femoral hernia repair (obsolete now due to high hernia recurrence rate) Gibson Above inguinal ligament, arc to the lateral rectus sheath Kidney transplantation, retroperitoneal access (iliac vessels, ureter)




Mastoid process
Sternocleidomastoid muscle
Clavicle
Sternum
Extension into origin of sternocleidomastoid muscle
Standard neck incision
Collar incision
Extension as a supraclavicular incision
Extension as "Book thoracotomy"
Extension as median sternotomy
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Y incision
MacFee Incision
Schobinger Incision
Modified schobinger
Conley's
Double Y (Martin Incision)
Crile's Incision
Apron Incision
Hockey Stick incision
Modified Hockey Stick Incision
Transverse Cervical Incision
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References:

https://www.ncbi.nlm.nih.gov/books/NBK541018/

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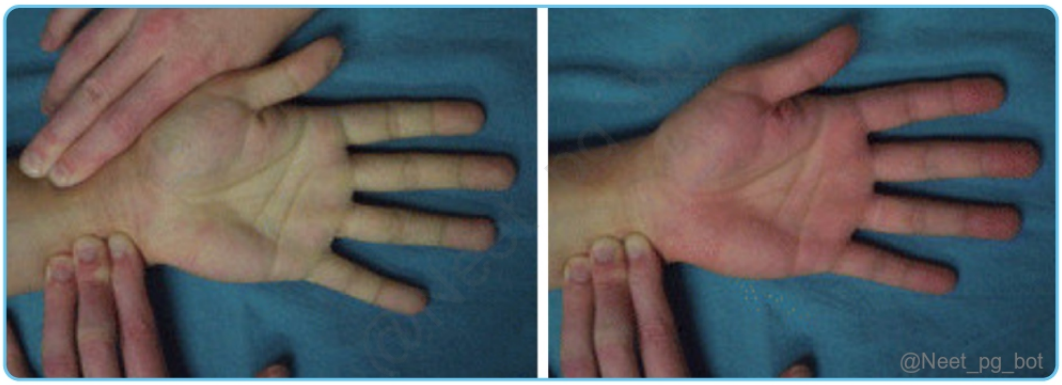
Q44: Identify the test provided in the image below. (Q857294)

A. Allen’s test

B. Adson’s test

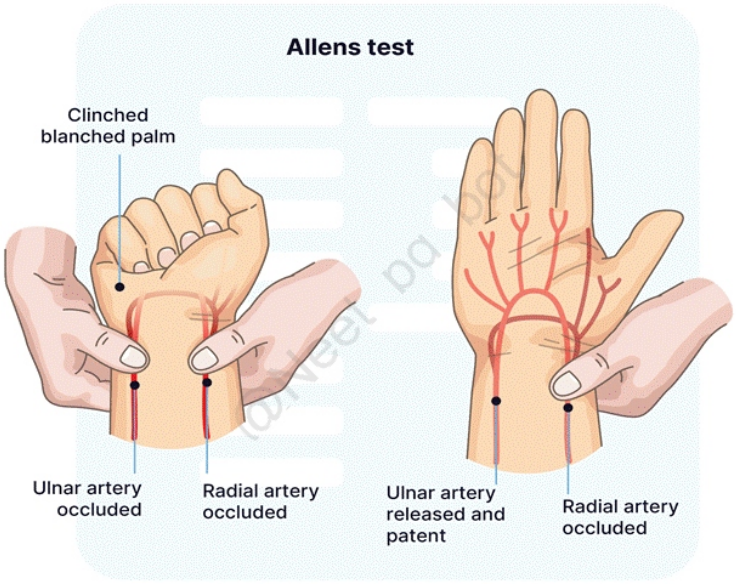
C. Elevated arm stress test

D. Nicoladoni’s test

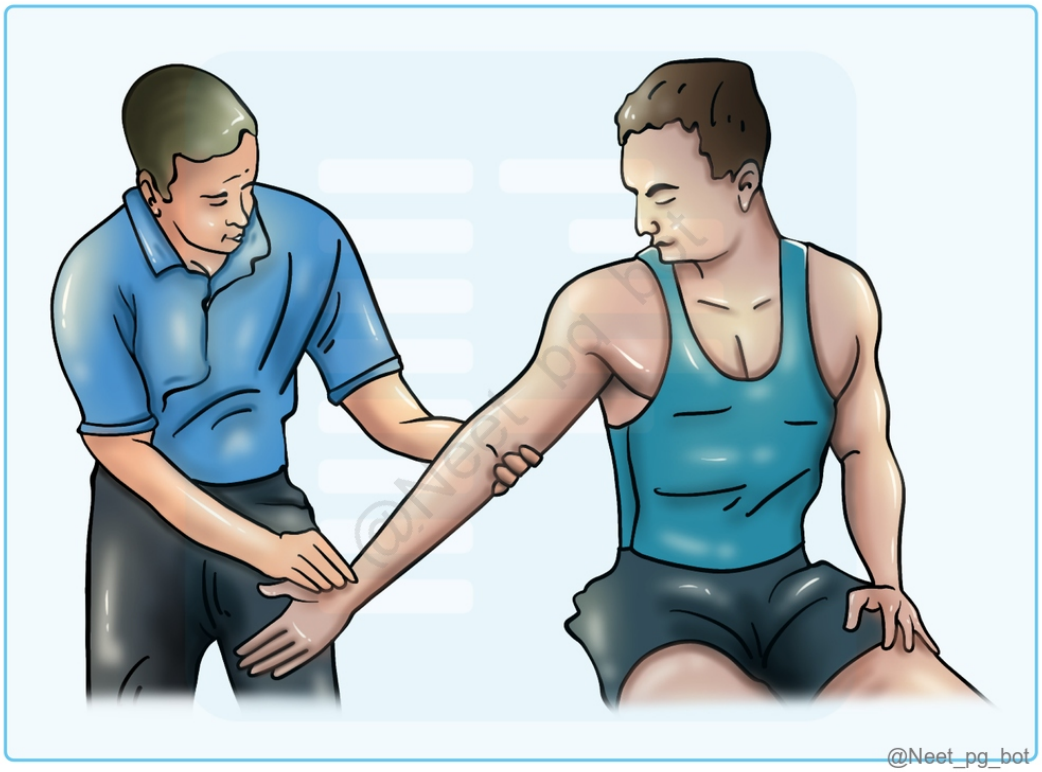


Correct Answer: A. Allen’s test

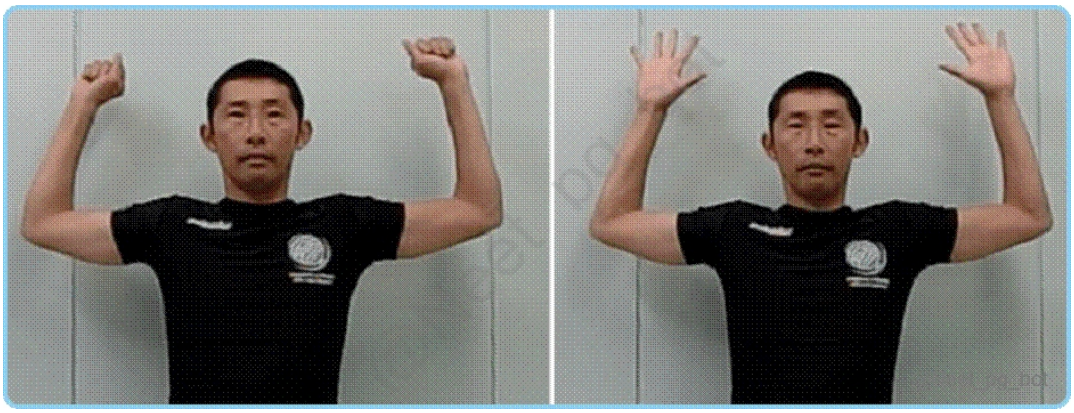
Explanation: The given image shows Allen’s test. Allen's Test is a clinical manoeuvre used to assess the blood flow to the hand, specifically evaluating the patency of the radial and ulnar arteries. It is commonly used before procedures like inserting an arterial line or taking a blood sample from the radial artery. Procedure: The patient is asked to make a fist, compressing the radial and ulnar arteries simultaneously. The patient is then asked to open their hand (which should appear pale). Once the hand is open, the examiner releases one of the arteries (usually the ulnar artery). The test is positive if normal colour returns to the hand quickly (within 5-10 seconds), indicating adequate collateral circulation. If there is a delay in the colour return or no return, this may suggest compromised blood flow through the released artery, which could indicate arterial occlusion & the radial artery should not be pricked. Adson's test (Option B) is used to diagnose thoracic outlet syndrome (TOS), which occurs due to compression of the brachial plexus or subclavian artery in the thoracic outlet. The patient is instructed to extend their neck and turn their head toward the arm being tested while the examiner palpates the radial pulse. The patient then takes a deep breath. A positive test is indicated by a reduction or disappearance of the radial pulse, suggesting compression in the thoracic outlet. Elevated Arm Stress Test (Option C) evaluates thoracic outlet syndrome by assessing the compression of neurovascular structures in the thoracic outlet. The patient’s arms are raised above the head and held for 1-2 minutes. A positive test occurs if the patient experiences symptoms of numbness, tingling, or a decrease in the radial pulse, which indicates compression of the neurovascular bundle in the thoracic outlet. {{caption_text}} Nicoladoni's test (Option D) is used to assess for increased intracranial pressure (ICP) or brainstem compression . The test is positive if the patient exhibits a sudden drop in pulse or blood pressure when their head is tilted backwards (in a hyperextended position).



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References:

Harrison Principles of Internal Medicine, 21st Edition, Page 1818

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Q45: Smoking increases the risk of which of the following diseases? Duct ectasia Fibroadenoma Mondor disease Breast carcinoma (Q857295)

A. 2, 3

B. 1, 4

C. 2, 3, 4

D. 1, 3, 4

Correct Answer: D. 1, 3, 4

Explanation: Smoking is not directly associated with an increased risk of fibroadenomas, which are benign breast tumours often occurring in younger women. Smoking increases the risk of duct ectasia , Mondor disease , and breast carcinoma , but not fibroadenoma . Duct ectasia refers to the dilation or enlargement of the milk ducts in the breast, often leading to inflammation and possible discharge. It is often seen in older women, particularly during menopause. Smoking is considered a risk factor for this condition as it contributes to vascular changes and may affect the ducts. Mondor's disease is a rare condition that involves thrombophlebitis (inflammation of veins caused by blood clots) of the superficial veins in the breast or chest area. Smoking has been linked to vascular changes, which may increase the likelihood of developing Mondor’s disease. Smoking is a well-established risk factor for breast cancer, especially in postmenopausal women. Risk factors for breast cancer Modifiable risk factors Non-modifiable risk factors Obesity: BMI > 30 (RR= 1.29) Age Median age at presentation is 60 years in the West(UK, USA), While it is around 48 years in low/middle-income nations such as India. Nulliparous women or first pregnancy after 35 years Sex Female sex is a risk factor Male sex accounts for 0.5-1% of all breast cancer Breastfeeding is a protective factor Ethnicity American white, African-American Parsi in India Use of Hormonal

Replacement Therapy (HRT) >10 years (RR= 1.2) Family history of breast cancer 1 first-degree relative RR= 2 2 first-degree relative RR= 3 Tobacco use (RR=1.07-1.14) Genetic predisposition BRCA1 and BRCA2 mutations account for 70% of hereditary breast cancers Alcohol Consumption (RR = 1.05-1.32) Early Menarche(<12years) Increases by around 5% for each year earlier menstruation begins RR=1.19 Radiation exposure (RR=6) Late Menopause(>55years) Increases by about 3% for each year later menopause begins RR=1.12 Age at first child <20years - Less risk >35years - High risk High-risk breast lesions Complex fibroadenoma RR=3 Papillomatosis RR=3 Ductal and lobular hyperplasia RR= 5 Lobular carcinoma in situ RR= 8-10

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 922,930,931

Sabiston Textbook of Surgery, 21st Edition, Page 826

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Q46: A 25-year-old male patient is brought to the casualty after a road traffic accident (RTA) with suspected pelvic fractures. On examination, he is found to be in hypovolemic shock. What is the earliest treatment for control of haemorrhage in this case? (Q857297)

A. Immediate internal fixation

B. Multiple blood transfusions

C. Use bedsheets to compress the pelvis

D. Emergency external fixation

Correct Answer: C. Use bedsheets to compress the pelvis

Explanation: In the case of pelvic fractures with suspected haemorrhage and hypovolemic shock, pelvic compression is a critical step to control bleeding and stabilise the patient. Using bedsheets (or a pelvic binder) to compress the pelvis helps reduce the volume of the pelvic cavity, which in turn minimises bleeding from the fractured vessels and improves hemodynamic stability. Management of Pelvic fractures: The primary goal in managing pelvic fractures with bleeding is to stop the bleeding, as these injuries pose a significant threat to circulation. Initial management: The first step is applying a compression binder or sheet around the true pelvis at the level of the greater trochanters to reduce pelvic volume. This life-saving procedure should be performed in the emergency department immediately. Bleeding sources: Venous Bleeding (85% of cases): Most bleeding originates from veins, which can be controlled non-operatively using pelvic compression (via binding or external fixators). Another technique is extraperitoneal pelvic packing, where the space between the bony pelvis and the peritoneum is packed to compress veins. Arterial Bleeding: If bleeding is arterial in origin, angiographic embolisation becomes the next choice for controlling haemorrhage. Techniques such as compression, packing, fixation, and angiography may be used together, as they can complement one another. If bleeding persists after packing, angiography or other

interventions may be necessary. If the source of bleeding is unclear, or if diagnostic imaging (FAST/CT) shows significant blood in the peritoneal cavity, an exploratory laparotomy is warranted to rule out or address concurrent intra-abdominal injuries.



References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 384

↑ *Back to this question in Part A*

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Q47: A soldier arrives at a referral hospital 24 hours after experiencing a shrapnel injury to his right thigh caused by a high-speed projectile. He expresses significant discomfort at the site of the wound. Upon examination, there is evidence of crepitus. Which of the following microorganisms is the probable culprit behind his current state? (Q857804)

A. Clostridium septicum

B. Clostridium difficile

C. Clostridium novyi

D. Clostridium perfringens

Correct Answer: D. Clostridium perfringens

Explanation: The soldier's shrapnel injury to his right thigh, accompanied by significant discomfort, crepitus (presence of gas in the tissues), suggests Gas Gangrene caused by Clostridium perfringens. A rapidly progressive, potentially fatal condition characterized by widespread necrosis of muscles and soft-tissue destruction, often due to late-presenting missile wounds or crushing injuries. Cause Clostridium perfringens (Option D) Incubation period <24 hours but ranges from 1 hour to 6 weeks Sources and predisposing factors Contaminated soil and feces. Wounds with necrotic or foreign material. Crush wounds, road traffic accidents, amputations. Anaerobic environments in the wound. Common sites of infection Adductor region of the lower limb and buttocks. Subscapular region in the upper limb. Clinical features Severe pain with limb swelling rapidly increases in severity. Serosanguineous discharge. Skin turns brown to blue-black with hemorrhagic bullae. Sweet, sticky odor & Soft-tissue crepitus (presence of gas in the tissues). Complication Septicaemia, toxemia, renal failure, liver failure. Circulatory failure, DIC, secondary infections. Death occurs in critically ill patients. Investigation X-ray: Gas in soft tissues. Gram stain & blood culture: Large Gram-positive bacilli without neutrophils. Biochemical profile: Metabolic acidosis, renal failure. Peripheral blood smear: Haemolysis. CT scan for chest or abdominal wounds. Treatment High-dose intravenous penicillin and clindamycin, along with 3rd generation cephalosporins, are given intravenously. Polyvalent antiserums given intravenously. All dead tissues are excised, and debridement is performed until healthy tissue bleeds. Amputation done in severe cases Hyperbaric oxygen therapy. Prevention Proper debridement of devitalized crushed wounds. Devitalized wounds should not be sutured. Adequate cleaning of wounds with H■O■ and normal saline. Penicillin - As a prophylactic antibiotic. Image {{caption_text}} Clostridium septicum (Option A) causes spontaneous, non-traumatic gas gangrene and is associated with conditions like colorectal cancer or immunocompromised states, whereas Clostridium perfringens is more commonly linked to gas gangrene in traumatic injuries. Clostridioides difficile (Option B) is primarily linked to antibiotic-associated diarrhea and colitis, not gas gangrene, and does not produce the gas or tissue necrosis seen in traumatic injuries. Clostridium novyi (Option C) is a less common cause of gas gangrene, typically associated with specific conditions like soil or animal-related injuries, and is unlikely to be the cause of a shrapnel wound.



References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 57, 457, 643.

SRB's Manual of Surgery, 6th Edition, Page, 44, 50-52, 1056.

↑ *Back to this question in Part A*

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Q48: A 32-year-old female undergoes emergency laparotomy for perforation peritonitis. Which of the following is the surest sign of wound dehiscence? (Q857853)

A. Copious sero-sanguinous discharge

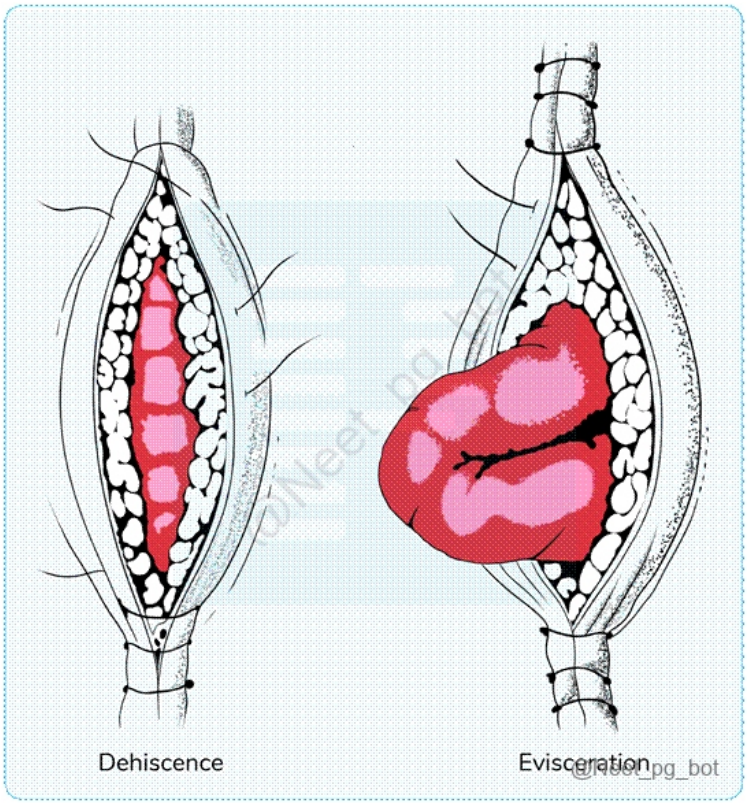
B. Rebound tenderness

C. Hemorrhage

D. Hypotension

Correct Answer: A. Copious sero-sanguinous discharge

Explanation: The surest sign of Wound Dehiscence following emergency laparotomy is copious serosanguinous discharge, typically occurring around day 6 post-op, indicating a burst abdomen and requiring urgent laparotomy management. Definition Disruption of any or all of the layers in a wound. Occurrence Up to 3% of abdominal wounds; most commonly occurs between the 5th and 8th postoperative days. Types Partial dehiscence: Involves only the skin and subcutaneous fat. Complete dehiscence: Involves the fascial layer and may include evisceration (extrusion of abdominal viscera). Risk Factors General: Malnourishment Diabetes Obesity Renal failure Jaundice Sepsis Cancer Treatment with steroids Emergency surgery Local: Inadequate or poor closure of wound or closure of a wound under tension Poor local wound healing Increased intra-abdominal pressure Clinical Presentation Pinkish serosanguinous discharge (salmon-coloured fluid), (Option A) Possible evisceration, Popping sensation during straining or coughing. Treatment Partial dehiscence (without evisceration): Prompt reclosure of the fascia is generally advised. Complete dehiscence with evisceration: Requires urgent reoperation. Tension suturing is done. Protect eviscerated bowel with moist towels; handle carefully to prevent injury. Antibiotic therapy; fluid management. Rebound tenderness (Option B) refers to pain that is felt when pressure is released from the abdomen, often indicating peritoneal irritation or inflammation, typically seen in conditions like peritonitis. While rebound tenderness could suggest a complication (such as ongoing infection or intra-abdominal issues), it is not specific to wound dehiscence. Hemorrhage (Option C) : Although significant bleeding can occur after surgery, hemorrhage is not a typical feature of wound dehiscence. Hemorrhage can be caused by vessel injury, clotting issues, or inadequate hemostasis at the surgical site, but it's not directly linked to the reopening of the wound itself. Hypotension (Option D) may occur due to various factors like shock, blood loss, or infection. While hypotension can be a result of complications following surgery, it is a general sign of systemic distress rather than a specific sign of wound dehiscence. The cause of hypotension needs to be identified through further clinical investigation.



References:

Bailey & Love’s Short Practice of Surgery, 28th Edition, Page 325.

Sabiston Textbook of Surgery, 21st Edition, Page 240-241.

SRB’s Manual of Surgery, 6th Edition, Pages 732-733.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q49: A barber aged 42 years presented with a healed ulcer as below, over the lower medial aspect of the right leg. On examination, he has varicose veins on both his legs. What is the most likely type of ulcer he had? (Q859836)

A. Neuropathic ulcer

B. Arterial ulcer

C. Venous ulcer

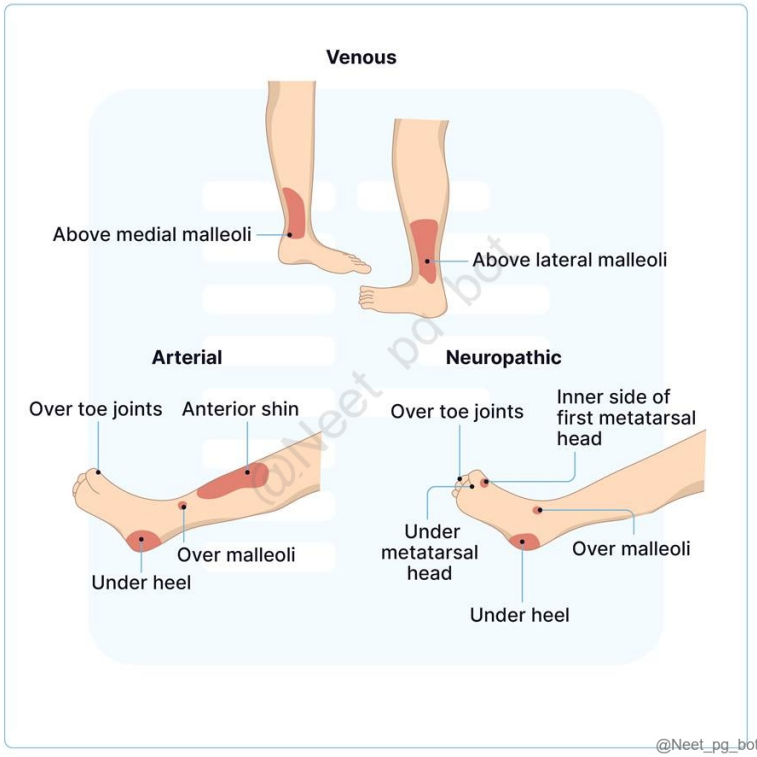
D. Tubercular ulcer



Correct Answer: C. Venous ulcer

Explanation: The most likely diagnosis is venous ulcer , given the ulcer's location on the medial aspect of the leg and the presence of varicose veins , which are indicative of venous insufficiency. These ulcers commonly occur in

areas of chronic venous insufficiency , often associated with varicose veins . Venous ulcer (Option C) Arterial ulcer (Option B) Neuropathic ulcer (Option A) Pressure ulcer Site Gaiter's area (area between malleolus and calf) At distal ends of limbs, such as toes, feet and legs. Over toe joints, under the heel, over malleoli, under the metatarsal head, etc Seen over pressure points, most common are ischium, greater trochanter, sacrum, hee, malleolus, occiput, etc Appearance Vertically oval with a sloping edge and will not penetrate deep fascia. Punched-out edges are seen in this type of ulcer. Ulcers can be associated with gangrene and abscesses; osteomyelitis can be seen here. Punched out ulcer with bone as a base. Cause Caused by ambulatory chronic venous hypertension due to varicose veins. This occurs due to severe arterial insufficiency of digital and medium-sized arteries, leading to ischemia and tissue death in the region. It is caused due to repeated trauma and ischemia due to microangiopathy in diabetic patients . It is tissue necrosis and ulceration due to prolonged pressure on any part of the body. Characteristics It is initially painful, then chronically becomes painless. It heals on rest and treatment but reforms again. It is intensely painful, and distal pulses are not palpable, and associated with shiny skin, brittle nails and loss of hair over the region. It is also known as diabetic ulcer since it is seen in diabetic patients. It is common in bedridden patients with head injuries, neurological deficits, and comatose and stroke-ridden patients. Tuberculous ulcer (Option D) occurs when tuberculosis affecting the lungs spreads to the skin . This type of ulcer is relatively uncommon but can develop in individuals with advanced or untreated TB. These ulcers typically have distinct characteristics like an undermined edge and necrotic base and may show signs like scarring or lymphadenopathy.



References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Pages 998, 999.

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@Neet_pg_bot

Q50: False regarding deep second-degree burns: (Q859883)

A. Heal by scar deposition

B. No blanching

C. Damage to the deeper dermis

D. Completely painless

Correct Answer: D. Completely painless

Explanation: Deep second-degree (deep partial-thickness) burns extend into the reticular dermis , damaging most skin appendages and vascular structures. Pain is reduced but not completely absent , as some nerve endings remain intact. Only full-thickness (third-degree) burns are truly painless due to total nerve destruction. Deep Partial-Thickness Burns Affected Area Epidermis and reticular dermis (bottom layer of dermis) (Option C ruled out). Clinical Features Sensation is reduced, not absent. Loss of epidermis Less moist dermis Fixed capillary staining Reduced sensation No blanching with pressure (Option B ruled out) Healing Takes 3+ weeks : often leads to scarring (Option A ruled out) Treatment May require surgical intervention (e.g., skin grafting)

References:

Bailey & Love’s Short Practice of Surgery, 28th Edition, Pages 669, 670

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@Neet_pg_bot

• [12_Miscellaneous] 055 Trauma Atls Protocol

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[12_Miscellaneous] 055 Trauma Atls Protocol — Quick Jump

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Q7 (p. 3282)	*Q8 (p. 3282)*	*Q9 (p. 3283)*	*Q10 (p. 3284)*	*Q11 (p. 3284)*	*Q12 (p. 3285)*
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Q19 (p. 3291)	*Q20 (p. 3292)*	*Q21 (p. 3293)*	*Q22 (p. 3293)*	*Q23 (p. 3295)*	*Q24 (p. 3296)*
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Q1: A 35-year-old male arrives in the emergency department after a motor vehicle collision with unstable vitals and multiple injuries. Which trauma severity score is most appropriate for predicting his likelihood of survival? (Q849616)

A. Injury Severity Score (ISS)

B. Revised Trauma Score (RTS)

C. Trauma and Injury Severity Score (TRISS)

D. Mangled Extremity Severity Score (MESS)

Correct Answer: C. Trauma and Injury Severity Score (TRISS)

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: TRISS (Trauma and Injury Severity Score) is designed to predict the probability of survival in trauma patients by combining the physiological aspects of trauma (Revised trauma score/RTS), anatomical aspects (Injury severity score/ISS), and patient age. It is widely used in trauma settings for patients with multiple injuries, as in this scenario. TRISS is calculated using a logistic regression formula and has been validated as one of the most accurate predictors of survival in trauma patients. The ISS (Injury Severity Score)(Option A) quantifies the overall injury burden by summing up the square of the highest Abbreviated Injury Scale (AIS) scores in different body regions. It is useful in determining the severity of the injury but does not take into account physiological responses like the TRISS score does, making it less useful for predicting survival. RTS (Revised Trauma Score) (Option B) focuses on the physiological status of the patient, assessing respiratory rate, systolic blood pressure, and Glasgow Coma Scale (GCS). While it helps in triaging trauma patients, RTS alone is less comprehensive than TRISS, as it does not account for anatomical injury severity. The MESS (Mangled Extremity Severity Score)(Option D) is specific to assessing the severity of limb injuries and predicting the need for amputation. While useful for patients with severe extremity trauma, it is not appropriate for assessing the overall survival probability in patients with multiple systemic injuries. Score Key Parameters Application ISS Anatomical injury in body regions (AIS system) Measures overall injury severity RTS GCS, Respiratory Rate, Systolic BP

Physiological response to trauma TRISS Combination of ISS, RTS, and Age Predicts survival probability in trauma MESS Limb ischemia, shock, age, and energy of injury Predicts need for amputation in limb trauma

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Pages 342, 453.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q2: In the context of severely injured trauma patients, which of the following is not classically included in the “lethal triad” that worsens outcomes? (Q880420)

A. Hypothermia

B. Shock

C. Acidosis

D. Coagulopathy

Correct Answer: B. Shock

Explanation: The lethal triad includes: Hypothermia Acidosis Progressive coagulopathy. These three factors worsen each other in a vicious cycle during major trauma. Shock (usually hemorrhagic) is the precipitating cause but is not part of the triad itself.

References:

SRB’s manual of surgery, 6th Edition, Page. 114

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@Neet_pg_bot

Q3: Which of the following best describes the principle of balanced resuscitation in trauma patients? (Q880418)

A. Maintaining airway, breathing, and circulation

B. Allowing permissive hypotension

C. Maintaining pH by correcting acid–base balance

D. Fluid resuscitation with both colloids and crystalloids

Correct Answer: B. Allowing permissive hypotension

Explanation: Balanced resuscitation Avoids excessive crystalloids. Uses blood products in a balanced ratio (PRBC:FFP: Platelets ≈ 1:1:1). Includes permissive hypotension (target SBP 80–90 mmHg until bleeding controlled) to prevent clot dislodgement and worsening hemorrhage. ABC (Option A): Initial trauma assessment, not balanced resuscitation. pH correction (Option C) Supportive care, not the definition of balanced resuscitation. Colloids and crystalloids (Option D). Old approach: excessive fluids worsen coagulopathy, acidosis, and hypothermia (lethal triad).

References:

Balanced Resuscitation in Trauma Management - PubMed

↑ *Back to this question in Part A*

@Neet_pg_bot

Q4: A 28-year-old man with head trauma is on mechanical ventilation. On examination, he opens his eyes spontaneously and shows purposeful movements in all four limbs. What is his GCS? (Q880417)

A. Eyes – 4, Verbal – 1, Motor – 5

B. Eyes – 4, Verbal – NT, Motor – 5

C. Eyes – 4, Verbal – 1, Motor – 6

D. Eyes – 4, Verbal – NT, Motor – 6

Correct Answer: D. Eyes – 4, Verbal – NT, Motor – 6

Explanation: Eye response (E): Opens eyes spontaneously → E = 4 Verbal response (V): Patient is intubated → verbal score not testable (NT). In exam papers, some sources mark this as 1 (lowest possible), but the recommended notation is V = NT. Motor response (M): Purposeful movement (obeys commands / spontaneous normal movement) → M = 6 GCS (Glasgow Coma Scale) - Scored out of 15. 1. Eye Opening (E) - /4 4: Spontaneous 3: To speech 2: To pain 1: None 2. Verbal Response (V) - /5 5: Oriented 4: Confused conversation 3: Inappropriate words 2: Incomprehensible sounds 1: None 3. Motor Response (M) - /6 6: Obeys commands 5: Localizes pain 4: Withdraws from pain 3: Flexion to pain (decorticate) 2: Extension to pain (decerebrate) 1: None

References:

Bailey & Love Short Practice of Surgery, 28th Edition, Page. 357

↑ *Back to this question in Part A*

@Neet_pg_bot

Q5: A 40-year-old comatose patient on ventilatory support is being assessed for brainstem death. Which of the following findings may falsely suggest preserved brainstem activity, and therefore should not be taken as evidence of brainstem function? 1. Babinski reflex 2. Decorticate/decerebrate posturing 3. Tachycardia 4. Normal systolic BP >100 mmHg 5. Presence of oculocephalic reflex (Q880416)

A. 2, 4, and 5

B. 1, 2, and 3

C. 2, 3 and 5

D. 1, 3 and 4

Correct Answer: B. 1, 2, and 3

Explanation: Oculocephalic reflex (Doll's eye reflex): True brainstem reflex; its presence indicates an intact brainstem. Babinski reflex: Spinal reflex, does not require the brainstem, and can persist after brainstem death. Decorticate/decerebrate posturing: Generated at the subcortical or spinal level, not proof of intact brainstem. Tachycardia / BP >100 mmHg: Due to circulating catecholamines, not reliable for brainstem activity. Therefore, 1 (Babinski), 2 (Posturing), and 3 (Tachycardia) may be misinterpreted, but do not indicate normal brainstem function.

References:

Sabiston's principles of surgery, 21st Edition, Page. 1885

Guidelines for the Diagnosis of Brain Death

↑ *Back to this question in Part A*

@Neet_pg_bot

Q6: A young male presents with a severely mangled lower limb following a road traffic accident. The surgeon plans to calculate the Mangled Extremity Severity Score (MESS) to guide the decision on amputation versus salvage. Which one of the following factors is not a component of the MESS scoring system? (Q880410)

A. Age of the patient

B. Ischemia

C. Neurogenic injury

D. Energy of injury

Correct Answer: C. Neurogenic injury

Explanation: Neurogenic (nerve) injury is not a component of the Mangled Extremity Severity Score (MESS). MESS includes four parameters: Age - Younger patients score lower. Ischemia - Duration and severity of limb ischemia. Energy of injury - High-energy injuries (e.g., crush, blast) score higher. Shock - Based on systolic blood pressure and response to resuscitation. A score of 7 or higher consistently predicted the need for amputation, whereas all limbs with initial scores of 6 or less remained viable in the long term.

References:

Sabiston's principles of surgery, 21st Edition, Page.460

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@Neet_pg_bot

Q7: Which of the following parameters are included in calculating the Revised Trauma Score (RTS)? 1. Glasgow Coma Scale 2. Respiratory rate 3. Pulse rate 4. Systolic blood pressure 5. Mechanism of injury (Q880409)

A. 2, 4, and 5

B. 1, 3, and 5

C. 2, 3, and 4

D. 1, 2, and 4

Correct Answer: D. 1, 2, and 4

Explanation: The Revised Trauma Score (RTS) is calculated using: Glasgow Coma Scale (GCS) - assesses neurological status Respiratory Rate (RR) - reflects respiratory function Systolic Blood Pressure (SBP) – indicates circulatory status It does not include pulse rate or mechanism of injury.

References:

SRB's manual of surgery, 6th Edition, Page. 135

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@Neet_pg_bot

Q8: In a disaster scenario, assign the appropriate triage color code to the following patients: Patient Triage Color Code 1. An unconscious patient with massive head trauma and no spontaneous respiration A. Black 2. A patient with an open femur fracture and active bleeding B. Red 3. A patient with stable vitals but multiple rib fractures C. Yellow 4. A patient with a sprained ankle is walking around D. Green (Q880405)

A. 1-A, 2-B, 3-C, 4-D

B. 1-B, 2-A, 3-D, 4-C

C. 1-C, 2-A, 3-D, 4-B

D. 1-D, 2-C, 3-B, 4-A

Correct Answer: A. 1-A, 2-B, 3-C, 4-D

Explanation: Correct Option A: 1-A, 2-B, 3-C, 4-D A patient with massive head trauma who has no spontaneous respiration is classified as Black , which means expectant. A patient with an open femur fracture accompanied by active bleeding is classified as Red , which means immediate priority. A patient who is hemodynamically stable but has multiple rib fractures is classified as Yellow , which means delayed priority. A patient with a minor ankle sprain who can walk is classified as Green , which means minimal priority.

References:

Bailey & Love Short Practice of Surgery, 28th Edition, Page. 447.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q9: Which of the following does not typically rise as part of the acute neuroendocrine response to surgical stress or trauma? (Q880404)

A. ACTH

B. TNF-α

C. Growth hormone

D. Insulin

Correct Answer: D. Insulin

Explanation: Insulin decreases during stress, since counter-regulatory hormones dominate, resulting in stress-induced hyperglycemia. Incorrect Options: ACTH (Option A) increases and stimulates the adrenal cortex, leading to an increase in cortisol for stress adaptation. TNF-alpha(Option B) increases, being released by macrophages to initiate the inflammatory and acute phase response. Growth hormone (Option C) increases, promoting lipolysis, gluconeogenesis, and protein conservation as a counter-regulatory hormone to insulin.

References:

Bailey & Love Short Practice of Surgery, 28th Edition, Page. 3, 4.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q10: A 60-year-old man taking medication to prevent blood clots suddenly suffers severe bleeding after an accident. Which treatment option is most effective for quickly reversing the blood-thinning effects and controlling the bleeding? (Q880268)

A. Cryoprecipitate

B. Prothrombin complex concentrate

C. Fresh-frozen plasma

D. Platelets

Correct Answer: B. Prothrombin complex concentrate

Explanation: Prothrombin Complex Concentrates (PCC) are purified products derived from pooled plasma, containing coagulation factors II, VII, IX, and X. They are primarily used for the urgent reversal of warfarin therapy in patients with uncontrolled bleeding. Incorrect Options: Cryoprecipitate (Option A): Used primarily for fibrinogen replacement and is not effective in reversing warfarin anticoagulation. Fresh-frozen plasma (Option C) is an alternative but takes longer to infuse and has more volume load, making it less preferable for rapid reversal. Platelets (Option D) are used for thrombocytopenia or platelet dysfunction, not for warfarin reversal.

References:

Bailey & Love Short Practice of Surgery, 28th Edition, Page. 21

↑ *Back to this question in Part A*

@Neet_pg_bot

Q11: A person experiencing significant internal bleeding needs to have their blood levels restored to a safe range. Experts recommend not aiming too high to avoid complications. Based on current best practices, which of the following target values is considered appropriate for restoring blood levels in such a situation? (Q880266)

A. 12 g/dL

B. 6 g/dL

C. 10 g/dL

D. 8 g/dL

Correct Answer: D. 8 g/dL

Explanation: A restrictive transfusion strategy targeting a hemoglobin level of 7–8 g/dL (70-80 g/L) is recommended in cases of significant internal bleeding. Levels >8 g/dL → increase the risk of rebleeding Levels <7 g/dL → lead to hypoperfusion and ischemia.

References:

Schwartz's Principles of Surgery, 11th Edition, Page. 144

↑ *Back to this question in Part A*

@Neet_pg_bot

Q12: Based on the shelf life of the various blood components, which should be utilized first to minimize the risk of wastage due to expiry? (Q880256)

A. Packed RBCs

B. Fresh frozen plasma

C. Cryoprecipitate

D. Platelets

Correct Answer: D. Platelets

Explanation: Platelets are stored on a special agitator at 20–24°C and have a shelf life of only 5 days. Incorrect Options: Packed RBCs (Option A) are stored in a SAGM (saline-adenine-glucose-mannitol) solution to increase shelf life to 5 weeks at 2–6°C. Fresh frozen plasma (FFP) (Option B) is stored at –40°C to –50°C with a 2 year shelf life. Cryoprecipitate (Option C) is stored at –30°C with a 2 year shelf life.

References:

Bailey & Love Short Practice of Surgery, 28th Edition, Page. 21

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@Neet_pg_bot

Q13: With respect to the Enhanced Recovery After Surgery (ERAS) protocol, which of the following statements is incorrect? (Q880233)

A. Early initiation of physiotherapy and mobilisation is recommended

B. ERAS protocols are applicable in colorectal surgical procedures

C. Oral feeding is delayed for one week postoperatively

D. Discharge planning begins before hospital admission

Correct Answer: C. Oral feeding is delayed for one week postoperatively

Explanation: ERAS emphasises early oral feeding, often within hours of surgery, to promote gut function recovery and reduce postoperative ileus. Incorrect Options: Early initiation of physiotherapy and mobilisation is recommended (Option A): Early mobilisation reduces complications, including thromboembolism, muscle wasting, and helps quicker return of normal function. It is a core component of ERAS. ERAS protocols are applicable in colorectal surgical procedures (Option B): ERAS was originally developed and widely validated in colorectal surgery and is now extended to many surgical specialities. Discharge planning begins before hospital admission (Option D): ERAS protocols involve comprehensive preoperative planning, including discharge planning to facilitate smooth transition and reduce length of stay.

References:

Bailey & Love Short Practice of Surgery, 28th Edition, Pages 990, 1142.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q14: A 40-year-old male is admitted to the hospital after a major traumatic injury. On the third day post-trauma, his oxygen consumption and metabolic rate have increased significantly, and he exhibits elevated catecholamine levels. Which phase of the metabolic response is this patient most likely in? (Q849617)

A. Ebb phase

B. Flow phase

C. Anabolic phase

D. Recovery phase

Correct Answer: B. Flow phase

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The patient is in the Flow phase or catabolic phase , typically occurring 2–7 days post-trauma , characterized by increased metabolic rate, higher oxygen consumption, and tissue catabolism. Catecholamines, such as adrenaline, drive this hypermetabolic response as the body uses energy substrates for repair and organ function maintenance. Phases of Metabolic Response to Trauma Phase Timing Key Features Ebb Phase (Option A) First 24–48 hours ↓ Metabolic rate, ↓ Energy expenditure, ↓ Nitrogen excretion, Hemodynamic stability Flow Phase or Catabolic phase 2–7 days post-trauma ↑ Metabolic rate, ↑ Oxygen consumption, Catabolism, ↑ Catecholamines Anabolic Phase (Option C) Weeks post-trauma Positive nitrogen balance, Protein synthesis, Restoration of tissue mass The Recovery phase (Option D) refers to the period when the metabolic response returns to normal, with stabilization of energy requirements and cessation of catabolism, which happens after the Anabolic phase has run its course.

References:

Sabiston Textbook of Surgery, 21st Edition, Pages 108, 109.

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4379844/

↑ *Back to this question in Part A*

@Neet_pg_bot

Q15: A road traffic accident has occurred, and the first response team has arrived at the scene. Which of the following is not a key priority in prehospital care? (Q849595)

A. Evaluate the scene

B. Perform an initial assessment

C. Make triage-transport decision

D. Transport immediately and delay interventions

Correct Answer: D. Transport immediately and delay interventions

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The initial critical intervention is done, and the patient is transported. Initial life-saving critical interventions are not delayed and are immediately done at the site; only then is the patient transferred. Initial approach to an injured patient in the prehospital setting include 4 key priorities: Evaluates the scene Perform an initial assessment Make triage-transport decision Initial critical interventions and transport the patient Initial assessment: It is done rapidly and includes the identification of life-threatening situations that need immediate intervention. The a irway, b reathing, and c irculation are assessed. Once the spine is secured, the airway is secured, and assisted ventilation can be given as necessary. External bleeding is identified and immediately controlled, and resuscitation is initiated. Triage-transport decision: Rapid critical intervention is essential, but triaging and quick transport are equally important for optimal outcomes. The goal is to minimize the time from injury to definitive care, ideally keeping on-scene time under 15 minutes. The “load-and-go” approach enables critical interventions during transport, saving valuable time and improving hospital outcomes. Trauma patients with prehospital hypotension (<90 mm Hg), GCS ≤8, or non-extremity firearm injuries have higher mortality with prolonged prehospital time. Any previous comorbidities should be identified and communicated to the hospital for effective treatment and expedited care.

References:

Sabiston’s principles of surgery, 21st edition, pg: 389, 391.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q16: A 30-year-old woman with mid-facial trauma from a car accident is stabilized and the secondary survey begins. Which of the following is not an appropriate step in the secondary survey? (Q849615)

A. Obtaining a detailed history

B. Digital rectal examination for spinal injury

C. Nasogastric tube in a patient with mid-facial fractures

D. Repeat FAST examination for abdominal injury

Correct Answer: C. Nasogastric tube in a patient with mid-facial fractures

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Insertion of a nasogastric tube is contraindicated in patients with mid-facial fractures due to the risk of intracranial placement. Instead, an orogastric tube should be used if necessary. Steps of Secondary Survey in Trauma Management Step Description Prerequisites Primary survey must be completed. Resuscitation initiated. All life-threatening conditions identified and addressed. Normalization of vital signs should have begun. Obtain AMPLE History (Option A) A focused history covering: A llergies, M edications, P revious medical history/illness or Pregnancy, L ast meal, E vents/environment related to the injury. This guides ongoing care and anticipates

complications. Complete Physical Examination Systematic head-to-toe exam including front, back, sides, and hidden areas (scalp, axillae, perineum). Reassess airway and lung function. Vital Signs Assessment Monitor vital signs regularly. Narrow pulse pressure and tachycardia suggest hypovolemic shock. Be cautious with delayed hemodynamic changes in the elderly. Head and Face Examination Check for scalp hematomas, skull depression, facial fractures, septal hematomas, raccoon eyes, or Battle's sign. Avoid nasogastric tube insertion if facial trauma is present. Neck Examination Immobilize and palpate the neck. Rule out cervical spine injury with imaging or clinical criteria.. Chest Examination Palpate for tenderness, crepitus, and fractures. Inspect for seatbelt bruising and assess respiratory and heart sounds. Abdomen Examination Look for distension, bruising, tenderness, and marks. Assess for peritoneal injury. Pelvic and Rectal Examination Check for pelvic instability and perineal injury. Perform digital rectal exam if there is suspicion of rectal or urethral injury, especially in spinal cord injury, pelvic fractures or gunshot wounds to the pelvis. Genital Examination Vaginal examination in women with pelvic fractures or lacerations. Assess for signs of vaginal trauma or pregnancy-related complications. Extremities Examination Evaluate for fractures, tenderness, deformities, neurovascular status, and signs of compartment syndrome. Neurological Examination Reassess Glasgow Coma Scale Evaluate sensory and motor functions, pupillary response, and signs of head injury. FAST Use Focused Abdominal Sonography for Trauma (FAST) to check for internal bleeding in abdominal injury or unexplained blood loss. Special Considerations Update tetanus status. Assess urine output. Remove dressings to reassess injuries. Remove cervical collar briefly to evaluate the neck while maintaining immobilization. Diagnostic Tests and Consultations Obtain additional imaging or lab tests as needed and request specialist consultations. Tertiary Survey Conducted within 24 hours for multisystem trauma patients to identify missed injuries from primary and secondary surveys.

References:

Schwartz Textbook of Surgery, Edition 11, Page 195.

https://www.ncbi.nlm.nih.gov/books/NBK441902/

↑ *Back to this question in Part A*

@Neet_pg_bot

Q17: A 25-year-old male involved in a high-speed motor vehicle accident is brought to the emergency department. After completing the primary survey and stabilizing the patient, the trauma team begins the secondary survey. Which of the following steps is not a part of the secondary survey? (Q849614)

A. Identifying external hemorrhage

B. Full neurological examination

C. Thorough head-to-toe examination

D. Obtaining a detailed patient history

Correct Answer: A. Identifying external hemorrhage

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Identifying and controlling external hemorrhage is a step in the primary survey , not the secondary survey. During the primary survey, life-threatening conditions such as external hemorrhage are identified and managed immediately as part of the "C" (Circulation) in the ABCDE approach of trauma care Secondary Survey: Obtain AMPLE history of presenting complaint: A: A llergies M: M edication - about anticoagulant and antiplatelet therapies, corticosteroid use, and any possible immunosuppressive treatment P: P ast medical and surgical history - about anesthetic in the past, and were there any complications L: L ast time - something to eat or drink E: E vents - events that led to the injury Top-to-toe examination by a systemic approach to the injured extremity: Look Feel Move (active and passive) Special tests Special investigations Neurovascular examination A full neurological examination (Option B) , including the Glasgow Coma Scale (GCS), pupil response, and motor function, is crucial in the secondary survey. While GCS is assessed in the primary survey, the secondary survey provides a more detailed evaluation of non-life-threatening but significant injuries. A complete head-to-toe physical examination (Option C) is essential in the secondary survey to identify injuries not obvious during the primary survey, such as soft tissue injuries, fractures, or subtle internal injuries. Obtaining a detailed patient history (Option D) is also part of the secondary survey. The AMPLE mnemonic (Allergies, Medications, Past medical history, Last meal, Events leading to injury) offers key information quickly.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Pages 416, 417.,418

Sabiston Textbook of Surgery, 21st Edition, Page 395.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q18: A 45-year-old man is found unconscious after a fall from a ladder. In the emergency department, his eyes do not open even in response to pain; he is making incomprehensible sounds, and he exhibits abnormal flexion in response to painful stimuli. What is his Glasgow Coma Scale (GCS) score? (Q849613)

A. 5

B. 6

C. 7

D. 8

Correct Answer: B. 6

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The Glasgow Coma Scale (GCS) is a tool used to assess a patient’s level of consciousness based on three parameters: eye-opening , verbal response , and motor response . Each parameter is scored, and the total GCS score ranges from 3 (deep coma) to 15 (fully awake). Eye response : The patient's eyes do not open, even in response to pain, corresponding to a score of 1 . Verbal response : The patient makes incomprehensible sounds, corresponding to a score of 2 . Motor response : The patient exhibits abnormal flexion (decorticate posturing) in response to pain, corresponding to a score of 3 . Thus, the GCS score for this patient is: 1 (Eye) + 2 (Verbal) + 3 (Motor) = 6 Simplified Glasgow Coma Scale (GCS) Table Category Response Score Eye Opening (E) Spontaneous 4 To speech 3 To pain 2 None 1 Verbal Response (V) Oriented 5 Confused conversation 4 Inappropriate words 3 Incomprehensible sounds 2 None 1 Motor Response (M) Obeys commands 6 Localizes to pain 5 Withdraws from pain 4 Abnormal flexion (decorticate) 3 Abnormal extension (decerebrate) 2 No response 1 Head Injury Severity: Clinical Classification Minor head injury GCS 15 with no LOC (loss of consciousness) Mild head injury GCS 14 or 15 with LOC Moderate head injury GCS 9 - 13 Severe head injury GCS 3 - 8 The GCS-P score is calculated by subtracting the Pupil Reactivity Score (PRS) from the Glasgow Coma Scale (GCS) total score: GCS-P = GCS - PRS. Pupils Unreactive to Light Pupil Reactivity Score Both Pupils 2 One Pupil 1 Neither Pupil 0 GCS-P score can range from 1 to 15 GCS-P score values between one and 8 denote a severe injury

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 357,361

https://www.glasgowcomascale.org/what-is-gcs-p/

https://www.ncbi.nlm.nih.gov/books/NBK513298/

↑ *Back to this question in Part A*

@Neet_pg_bot

Q19: During the primary survey of a trauma patient in the emergency department, which of the following injuries is not classified as life-threatening under the category of “breathing” problems? (Q849604)

A. Flail chest

B. Hemothorax

C. Bronchial rupture

D. Expanding hematoma

Correct Answer: D. Expanding hematoma

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Expanding hematoma is a life-threatening injury of the airway rather than breathing. The components of ATLS include the evaluation of: Airway Breathing Circulation Disability Exposure/Environmental Control

Life-threatening injuries during the primary survey (ATLS 2018 Update): Airway: Expanding hematoma Foreign bodies embedded in the soft tissue Perioral and perinasal burns or soot Any pathology that can occlude the trachea Breathing: Rib fractures Flail chest (Option A) Tension pneumothorax Diaphragmatic rupture Bronchial rupture (Option C) Damaged lung parenchyma leading to pulmonary contusion Hemothorax (Option B) Circulation: Vessel disruptions that cause haemorrhage Myocardial contusion Cardiac tamponade Compartment syndrome Tension pneumothorax Hemorrhage

References:

https://www.ncbi.nlm.nih.gov/books/NBK547757/

↑ *Back to this question in Part A*

@Neet_pg_bot

Q20: Which of the following statements is true regarding the CRASH-2 trial in trauma? (TXA= Tranexamic acid) (Q849603)

A. TXA is more effective when given after 3 hours of trauma.

B. TXA reduced all-cause mortality versus placebo.

C. TXA in children worsens pulmonary and neurological outcomes.

D. CRASH-2 showed TXA is ineffective in trauma.

Correct Answer: B. TXA reduced all-cause mortality versus placebo.

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: According to the CRASH-2 trial, tranexamic acid reduced all-cause mortality in hemorrhagic patients compared with a placebo. Tranexamic acid is a synthetic analogue of the amino acid lysine and an effective antifibrinolytic agent that competitively inhibits plasminogen activation to plasmin . It prevents the breakdown of fibrin that forms blood clots, thereby helping to form clots. The Clinical Randomization of an Antifibrinolytic in Significant Hemorrhage (CRASH-2) Trial: This is a multicenter randomized controlled civilian trial of 20,211 patients . It showed that tranexamic acid (TXA) reduced all-cause mortality versus placebo (14.5% vs. 16%). The risk of death caused by bleeding was also reduced (4.9% vs. 5.7%). The study found that administering tranexamic acid within 3 hours of injury improved survival rates. A dose of 1 gram is usually given over 10 minutes in the field, followed by another 1 gram given over 8 hours. CRASH-2 suggested that TXA was less effective and could even be harmful if treatment was delayed more than 3 hours after admission (Option A) . The PED-TRAX study also suggests that TXA administration was associated with decreased mortality and improved neurologic and pulmonary outcomes (Option C) . The drug is inexpensive and easy to use with minimal side effects. The key is dosing, timing, and patient selection. CRASH-3 trial is currently being done to assess the effect of TXA on the risk of death or disability in patients with TBI.

References:

Sabiston’s Principles of Surgery, 21st edition, Page 57.

↑ *Back to this question in Part A*

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Q21: A 35-year-old male is brought in after a fall from height and is found to be in hypovolemic shock. According to ATLS protocol, which of the following investigations is not recommended during the primary survey to identify the cause of the life-threatening bleed? (Q849602)

A. FAST scan

B. Chest X-Ray

C. Pelvic radiograph

D. CT scan

Correct Answer: D. CT scan

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: A CT scan is not preferred in the primary survey for assessment of the cause of hemorrhage in trauma. The major locations that lead to extensive blood loss are: Chest Abdomen Retroperitoneum Pelvis / long bone fractures Hence, an effective investigative plan to focus on each source is made. The following investigations are done: X-ray examinations: Chest radiograph to rule out a hemothorax (Option B) Pelvic radiograph to rule out fractures (Option C) Ultrasound: Focused Abdominal Sonography in Trauma (FAST) (Option A) is a rapidly available ultrasound examination done to find intraperitoneal fluid. It can be used to assess the hepatorenal, splenorenal, and pelvis spaces for fluid that is considered to be blood in a trauma case. A CT scan is done later, not immediately, as in the primary assessment. Diagnostic peritoneal lavage (DPL): This invasive procedure detects intraperitoneal hemorrhage, particularly in hemodynamically unstable patients. Computed tomography (CT): A CT scan can provide more detailed information about organ injury and hemorrhage. CTs of the head, chest, abdomen, and spine may be necessary to identify the source of bleeding. Angiography: This study helps evaluate and manage bleeding from pelvic fractures.

References:

https://pmc.ncbi.nlm.nih.gov/articles/PMC1914302/

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Q22: A road accident patient, stabilized with no severe external injuries, suddenly develops tachycardia, weak pulses, hypotension, and tachypnoea. Which ATLS primary assessment component is most likely causing these symptoms? (Q849601)

A. Airway

B. Circulation

C. Neurological

D. Hypothermia

Correct Answer: B. Circulation

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The symptoms here point to the diagnosis of shock, which is a part of the assessment of circulation . Shock refers clinically to evidence of end-organ hypoperfusion present on physical examination. The major reason for shock in trauma patients is hypovolemia due to hemorrhage . Even though there are no major external injuries, hypovolemic shock can still be caused due to internal hemorrhages that may not be identified at first. The primary goal of cardiovascular assessment is to determine the presence or absence of shock. Clinical features of shock: Agitation or confusion Tachycardia Tachypnoea Diaphoresis Cool, mottled extremities Weak distal pulses Decreased pulse pressure Decreased urine output Hypotension As soon as shock is recognized, the following procedures are to be followed as per ATLS: IV access should be established with two large-bore peripheral catheters or an interosseous needle or central venous catheter. Initial resuscitation should involve 1L of warm crystalloid solution. Product-based resuscitation should be administered if fluid resuscitation fails. >1.5 L of crystalloids should be avoided as it increases the risk of death. Rapid screening should be conducted to identify the cause of life-threatening blood loss. Urine output is the best indicator of tissue perfusion, and central venous pressure is the best indicator of resuscitation needs. Patients are monitored for the progress of shock or its resolution. If it resolves, a comprehensive evaluation for all injuries is done. If not, then, Blood and blood product transfusions , Emergency laparotomy (abdominal bleed), Pelvic binder or sheet followed by surgery or angiographic treatment for embolization of artery (for pelvic fracture and increases pelvic volume), Thoracotomy (continued bleeding after chest tube placement) might be needed. The major locations that lead to extensive blood loss are: Chest Abdomen Retroperitoneum Pelvis / long bone fractures During this initial assessment, the cause of blood loss and any fracture is identified and immediately managed with Immediate direct pressure Fracture splinting Airway (Option A) issues are assessed by a simple verbal response and any difficulty is identified immediately and presents with different clinical signs. Neurological (Option C) deficits present with low GCS score and issues with mobility of extremities. Hypothermia (Option D) is evaluated and presents with a low core body temperature, and immediate measures to increase the same are done.

References:

Sabiston’s Principles of Surgery, 21st edition, pg: 394, 395.

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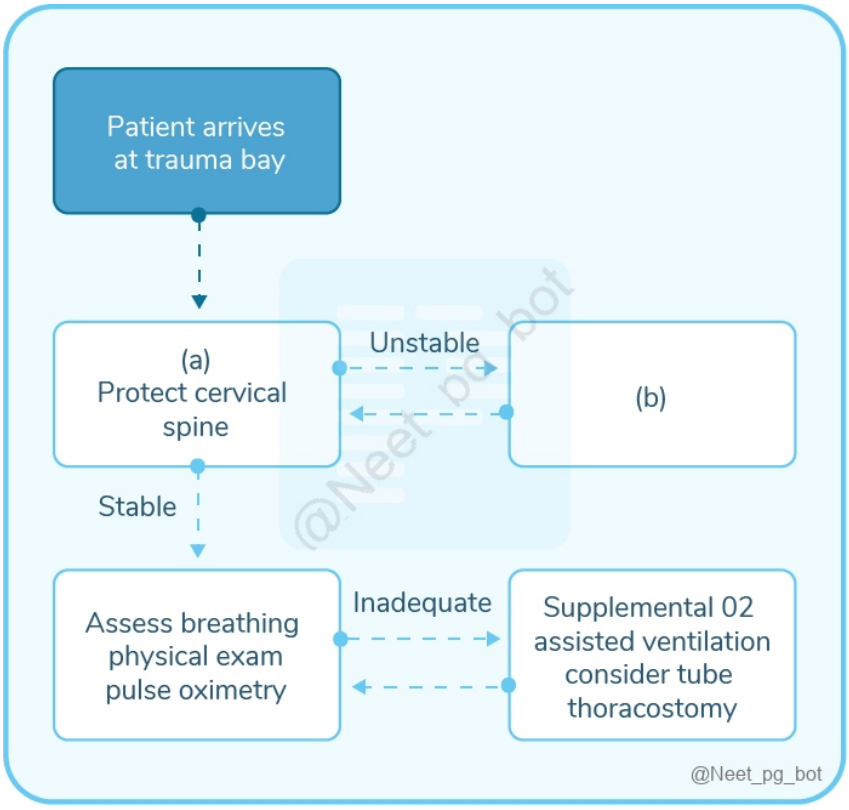
Q23: A critically injured patient is brought to the emergency department. The primary assessment is started. In the following algorithm identify the missing step (a) and action (b). (Q849600)

A. a- Assess airway, b- Establish stable airway

B. a- Assess circulation, b- Prevent shock

C. a- Establish airway, b- Assess circulation

D. a- Assess airway, b- Assess circulation



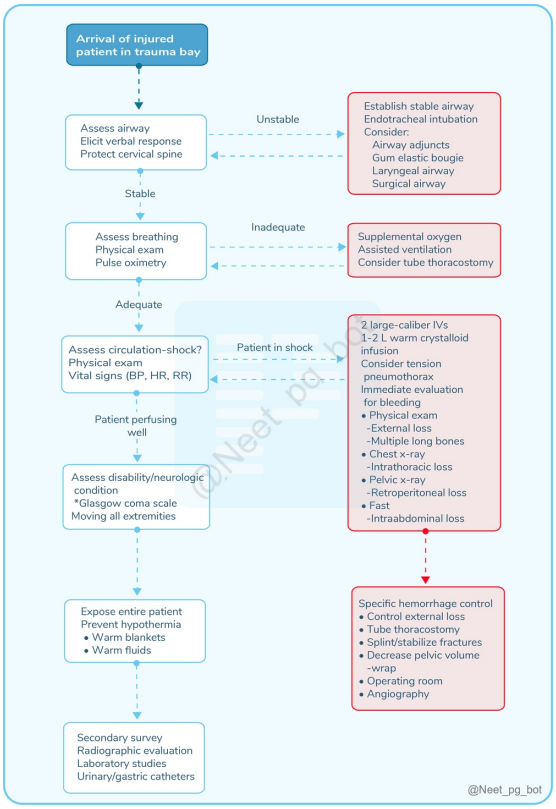
Correct Answer: A. a- Assess airway, b- Establish stable airway

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The algorithm given here is of the primary assessment of a trauma patient and the missing steps here are to assess the airway and establish a stable airway if there isn't one. The first and foremost step in the primary assessment, as soon as the patient arrives in the hospital, according to the ATLS protocol, is to assess the airway while the cervical spine is stabilized and protected. The airway is assessed by eliciting a verbal response . The next step is to establish a clear airway. If one is absent, then go on to assess the circulation . The complete algorithm of

primary assessment is as follows:



References:

Sabiston’s Principles of Surgery, 21st edition, Page 392.

↑ *Back to this question in Part A*

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Q24: A 34-year-old patient arrives at the emergency department after a motor vehicle collision. The ED physician is assessing whether to order spinal imaging. Which of the following findings does not indicate that spinal imaging is necessary? (Q849599)

A. No focal neurological deficit

B. Patient is intoxicated

C. Altered level of consciousness

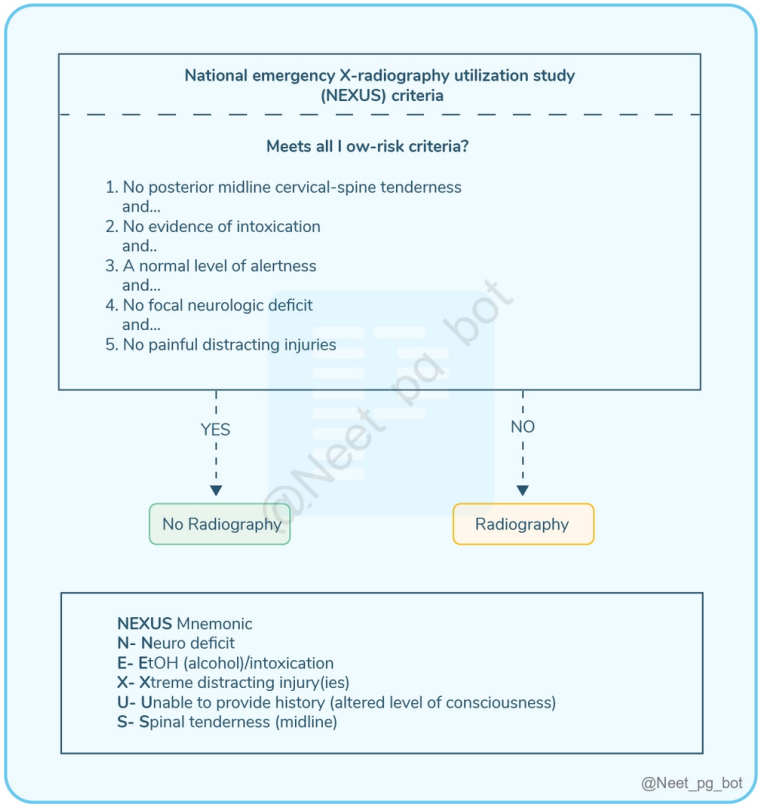
D. Presence of midline spinal tenderness

Correct Answer: A. No focal neurological deficit

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: According to the NEXUS criteria, the absence of focal neurological deficits alone does not indicate that spinal imaging is unnecessary, while other factors like midline spinal tenderness, altered level of consciousness, and intoxication do suggest imaging may be required. The NEXUS criteria: The National Emergency X-Radiography Utilization Study (NEXUS) criteria are a clinical decision tool for cervical spine evaluation. The criteria are used to determine which patients with blunt trauma require radiographic evaluation of the cervical spine. If a patient meets all of the low-risk criteria, radiography is not required. The signs that show a trauma patient does not need spinal imaging are: Alert and stable No focal neurological deficits No altered level of consciousness Not intoxicated No midline spinal tenderness No distracting injury



References:

https://pubmed.ncbi.nlm.nih.gov/29232770/

https://radiopaedia.org/articles/nexus-criteria

↑ *Back to this question in Part A*

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Q25: In an emergency situation in the casualty, the ATLS protocol is followed after a patient who was in a road traffic accident is brought to the hospital. Which of the

following is not a component in the primary evaluation of the patient? (Q849598)

A. Detailed history of the patient

B. Airway assessment

C. Rule out shock

D. Check for neurological disability

Correct Answer: A. Detailed history of the patient

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The detailed history is part of the secondary assessment according to the ATLS protocol. ATLS protocol/ Advanced Trauma Life Support protocol: Primary survey: It includes the airway, breathing, circulation, disability or neurologic condition, and exposure and environmental control, which is known by the mnemonic ABCDE. The airway is assessed (Option B) immediately by a verbal response, and if it is not clear, needful intervention is carried out. Breathing is evaluated by chest movements, breath sounds and saturation and assisted ventilation is provided if needed. Circulation assessment includes ruling out shock (Option C) . IV access and immediate fluid resuscitation are recommended according to the ATLS in case of shock. Neurological assessment (Option D) is done to assess any traumatic brain or spinal injury and neurogenic shock. The GCS score is evaluated. Environmental control: The patient's clothes should be removed for a thorough examination, and hypothermia should be prevented (warm IV fluids, raised room temperature, body warmers). Secondary survey: This includes a complete patient history and a thorough head-to-toe assessment. It is done almost immediately in stable patients and includes radiological investigations. The AMPLE history mnemonic is used to gather key details (A llergies, M edications, P ast medical history, L ast meal, E vents/ E nvironment related to the injury). Face deformities, posterior neck injuries, the torso, a per rectal examination for GI bleed, and prostate location are all included in this step. A thorough neurological examination and evaluation of superficial injuries are done. The complete physical examination and use of imaging are now included in the tertiary survey.

References:

Sabiston’s principles of surgery, 21st edition, pg: 391, 392.

https://www.acls.net/images/algo-arrest.pdf

https://www.aclsmedicaltraining.com/adult-bls/

↑ *Back to this question in Part A*

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Q26: After a major earthquake, a patient presents with a compound fracture and spinal injuries. Considering the severity of these injuries and the urgency of treatment, which triage color code is most appropriate for this patient? (Q849597)

A. Black

B. Red

C. Green

D. Yellow

Correct Answer: D. Yellow

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: This patient's condition comes under the category that needs urgent intervention and hence is coded yellow. The North Atlantic Treaty Organization triage categorization system is used here. Triage is used in healthcare to categorize patients by the severity of their injuries, determining the priority and timing of their care and monitoring. Triage color coding systems: Colour Priority Medical Need Clinical Status Examples Red (Option B) First Immediate Critical, but likely to survive if treatment given early Severe facial trauma Tension pneumothorax Profuse external bleeding Haemothorax Flail chest Major intra-abdominal bleed Extradural haematomas Yellow (Option D) Second Urgent Critical, but likely to survive if treatment given within hours Compound fractures Degloving injuries Ruptured abdominal viscus Pelvic fracture Spinal injuries Green (Option C) Third Non-Urgent Stable, likely to survive even if treatment is delayed for hours to days Simple fractures Sprains Minor lacerations Black (Option A) Last Unsalvageable Not breathing, pulseless, so severely injured that no medical care is likely to help Severe brain damage Very extensive burns Major disruption/ loss of chest or abdominal wall structures

References:

Sabiston’s principles of surgery, 21st edition, pg: 560, 561

https://www.ncbi.nlm.nih.gov/books/NBK557583/

Bailey & Love Short Practice of Surgery, 28th edition, pg:449

↑ *Back to this question in Part A*

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Q27: After a high-speed road traffic accident, a trauma team arrives to find multiple critically injured patients. According to the trimodal mortality model, which statement is correct? (Q849596)

A. Immediate deaths occur days after the injury

B. Early deaths occur within hours of reaching the hospital

C. Majority of deaths are due to cardiac causes

D. Late deaths are mostly due to internal hemorrhage

Correct Answer: B. Early deaths occur within hours of reaching the hospital

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Early deaths occur within a few hours of reaching the hospital . The trimodal mortality model for trauma proposes that deaths following injury typically cluster around three distinct periods: immediate death, early death, and late death. The majority of deaths in traumatic injuries are due to brain injury (50%) (Option C) . Causes: Immediate death Early death Late death This peak occurs seconds to minutes after the injury. (Option A) Due to the extreme nature of these injuries, very few patients in this category can be saved, and prevention remains the most effective way to address this peak. This peak occurs within minutes to several hours post-injury. The "golden hour" of trauma care, characterized by a need for rapid assessment and resuscitation, is crucial in managing these patients. This peak emerges days to weeks after the initial injury. Severe and nonsurvivable injury Irreversible brain injury Hemorrhages of organs like: Heart Aorta Liver Lungs Pelvic fracture Intracranial hemorrhage/ brain lacerations/ contusions Hemorrhage of respiratory or abdominal organs. Multiple small injuries causing major blood loss. Infection/sepsis or Multiorgan failure (MODS) (80% cases) (Option D) Brain injury Hemorrhage With this model, a few conclusions can be made: The immediate and early deaths are fairly unchanged. Late deaths have decreased drastically. Causes of death remain unchanged.

References:

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3603725/

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• [12_Miscellaneous] 056 General Surgery Robotic Laparoscopic And Bariatric Surgeries

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[12_Miscellaneous] 056 General Surgery Robotic Laparoscopic And Bariatric Surgeries — Quick Jump

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Q7 (p. 3309)	*Q8 (p. 3311)*	*Q9 (p. 3312)*	*Q10 (p. 3313)*	*Q11 (p. 3314)*	*Q12 (p. 3315)*
Q13 (p. 3316)	*Q14 (p. 3317)*	*Q15 (p. 3318)*	*Q16 (p. 3318)*	*Q17 (p. 3319)*	*Q18 (p. 3321)*
Q19 (p. 3321)	*Q20 (p. 3323)*	*Q21 (p. 3323)*	*Q22 (p. 3328)*	*Q23 (p. 3329)*	*Q24 (p. 3330)*
Q25 (p. 3331)	*Q26 (p. 3332)*	*Q27 (p. 3334)*	*Q28 (p. 3334)*	*Q29 (p. 3336)*	*Q30 (p. 3337)*

Q1: During a laparoscopic intra-abdominal surgery, the surgeon has to insufflate the peritoneal cavity. Which of the following statements is true regarding the Veress needle technique? (Q849681)

A. It is an open technique for creating pneumoperitoneum

B. The positioning of the needle is confirmed by a laparoscopic camera

C. Veress needle is a spring-loaded needle

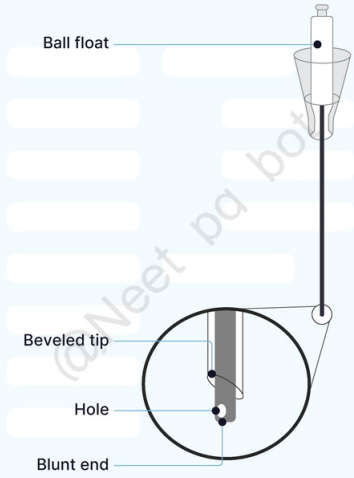
D. It has a sharp inner stylet that deploys in the peritoneal cavity

Correct Answer: C. Veress needle is a spring-loaded needle

■ *Listen (English)*

■ *Listen (Hindi)*

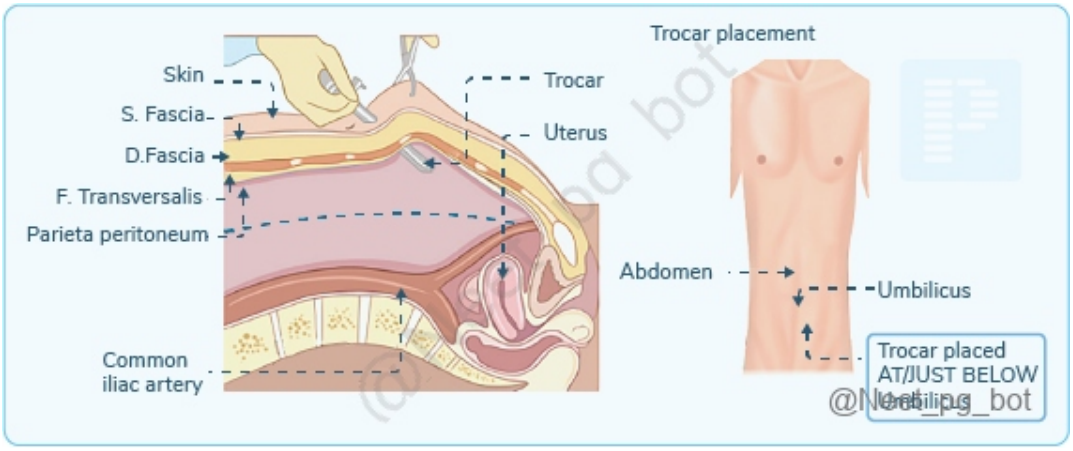
Explanation: Veress needle is a spring-loaded needle used to create a pneumoperitoneum. Methods of creating pneumoperitoneum. Closed technique Open technique Veress needle and/or visual entry trocar (Option A) The Veress needle is a spring-loaded needle (Option C) . It has: An outer sharp bevel that cuts. A spring-loaded blunt inner stylet (Option D) deploys once it enters the peritoneum and protects from injuries to the bowel and vessels. Inserted at the umbilical region or other sites like Palmer’s point. Once position is confirmed (by the hanging drop method or abdominal pressure reading of <10mmHg), CO2 insufflation is started slowly until a pressure of 12-15mmHg is reached. The needle is then removed, and an optical primary port is placed. Veress needle: Hasson’s or modified Hasson’s Umbilicus is the preferred site for a 10-12mm initial port placement. A blunt-tipped 10 to 12-mm trocar is pushed through an incision made through the decussation inferior to the cicatrix of the umbilicus. The laparoscopic camera is used to confirm the successful placement. (Option B) Then CO2 gas insufflation is started at low flow (1-4 litres per minute) Increased to a maximum pressure of 15 mmHg with a maximum flow rate of 20L/min . Trocar:



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References:

Bailey and Love's Short Practice of Surgery, 28th edition, Pages 102,103.

↑ *Back to this question in Part A*

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Q2: A patient who has undergone gastric banding is being advised on postoperative nutritional guidelines. Which of the following supplements is specifically recommended for this patient to prevent deficiency? (Q849695)

A. Selenium

B. Folic acid

C. Zinc

D. Vitamin D

Correct Answer: D. Vitamin D

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Nutritional guidelines post-bariatric surgery: After gastric banding Multivitamin Mineral supplement Thiamine if vomiting Vitamin D (Option D) Iron. After sleeve gastrectomy, forms of gastric bypass, biliopancreatic diversion/duodenal switch (BPD/DS), single-anastomosis duodenoileal bypass with sleeve gastrectomy (SADI-S) As for gastric banding + Selenium (Option A) Copper Zinc (Option C) Folic acid (Option B) Vitamins B12, A, E, K. (BPD/DS, SADI-S may require higher doses)

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1190

↑ *Back to this question in Part A*

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Q3: A 45-year-old patient undergoes bariatric surgery and is at risk for postoperative complications. What is the most common cause of 30-day mortality following bariatric surgery? (Q849694)

A. Cardiac failure

B. Pulmonary embolism

C. Anastomotic leak

D. Respiratory failure

Correct Answer: B. Pulmonary embolism

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Perioperative Mortality of Bariatric Surgery: Overall mortality rates Perioperative mortality for bariatric surgery is low (<0.5%) and declining but can reach 2.0% or higher in some patient groups. Common causes of 30-day mortality after bariatric surgery Pulmonary embolism (38%) (Option B) Cardiac failure (18%) (Option A) Anastomotic leak (18%) (Option C) Respiratory failure (12%) (Option D) Most dreaded complication Anastomotic leak with overall morbidity of 61% and mortality of 15%. Maximum risk of anastomotic leak Gastrojejunal anastomosis (60-80%)

References:

Schwartz Principles of Surgery, 11th edition, Pages 1203,1204

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3249614/

https://tsaco.bmj.com/content/3/1/e000219

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Q4: A 45-year-old patient with a BMI of 38 kg/m² is considering weight loss surgery. The surgeon suggests a procedure that involves placing a band around the stomach just below the cardia to create a small gastric pouch. Which procedure is being recommended? (Q849693)

A. Sleeve gastrectomy

B. Roux-en-Y gastric bypass

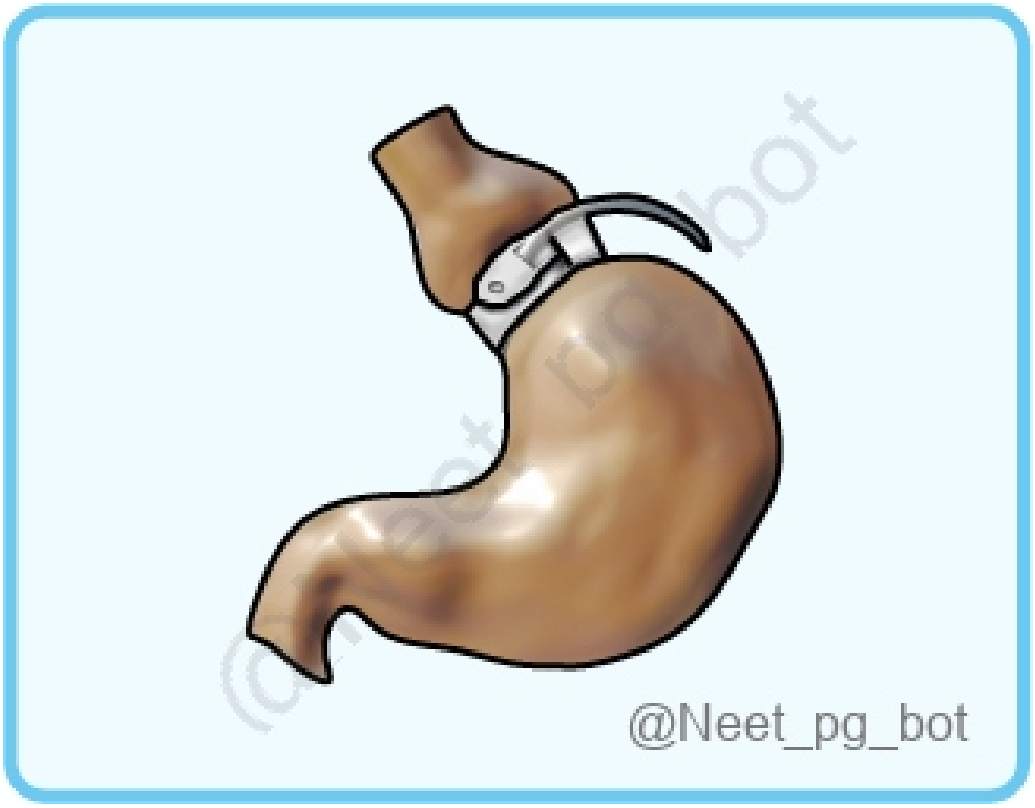
C. Intragastric balloon placement

D. Laparoscopic adjustable gastric banding

Correct Answer: D. Laparoscopic adjustable gastric banding

- *Listen (English)*
- *Listen (Hindi)*

Explanation: Laparoscopic adjustable gastric banding (Option D): Popularity decline Due to long-term results and alternatives. Procedure Uses the pars flaccida technique through the window of the lesser omentum. Band Placement: Positioned just below the esophagogastric junction to create a small virtual gastric pouch. Band Fixation: Sutured anteriorly with gastrogastric tunneling sutures to prevent slippage. Access Port: Sutured to the rectus sheath in the upper abdomen for easy access by a non-coring, Huber needle for adjustments. Types of adjustable bands Lapband (silicon) SAGB Image {{caption_text}} Mechanism of action Purely restrictive bariatric procedure. Reduces hunger, likely through vagal mediation. Treatment approach Initial Placement: Marks the start of treatment, requiring ongoing management. Band Adjustments: Involves specialist consultations to assess eating habits and then perform adjustments with injection or aspiration of saline to achieve optimal appetite control. Challenges Requires frequent adjustments, associated with patient frustration and lower compliance, impacting long-term weight loss. Follow up Monthly visits are recommended for the first year, with full multidisciplinary team (MDT) support. Complications Early: Access port infection (1%) Deep vein thrombosis(DVT)/ Pulmonary embolism (PE)(<0.1%) Late: Band infection Tubing leak Slippage Erosion into stomach Band intolerance Failure to lose weight/weight regain



References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Pages 1186,1187,1189

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1356846/

https://www.ncbi.nlm.nih.gov/books/NBK526062/

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4917609/

https://www.ncbi.nlm.nih.gov/books/NBK578184/

↑ *Back to this question in Part A*

@Neet_pg_bot

Q5: A 38-year-old woman with a BMI of 40 kg/m² undergoes sleeve gastrectomy. Post-surgery, she asks how the procedure helps her lose weight. What is the primary mechanism by which sleeve gastrectomy leads to weight loss? (Q849692)

A. Reduced stomach size and hormonal changes.

B. Complete removal of the stomach.

C. Reduced appetite with no hormonal impact.

D. Nutrient malabsorption due to intestinal bypass.

Correct Answer: A. Reduced stomach size and hormonal changes.

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Sleeve gastrectomy A recent, safe and effective surgical technique and a leading method in metabolic surgery for treating obesity with higher survival rates. Procedure Involves resection of a large part of the stomach, which regulates appetite. Does not require gastrointestinal anastomosis or intestinal bypass. Minimally invasive and less technically challenging. Image {{caption_text}} Mechanism of weight loss (Option A) Weight loss is achieved through both mechanical restriction (reduction of stomach size) and hormonal modulation (affecting hunger hormones such as ghrelin). Uses Weight Loss Reduce mental health problems Clinical Markers: Improve serum lipid profile, biochemical, histological, hematological and inflammatory markers. Obesity-related disease resolution: Better control of Type 2 diabetes, non-alcoholic fatty liver disease, cardiovascular risk, obstructive sleep apnea and stroke risk. Non-obesity related disease remission: Reduced gout attacks, musculoskeletal pain, improved fertility and reduced pregnancy complications and lower cancer incidence. Complications Early Leak at angle of His (1-2%) Intra-abdominal bleed (2-3%) Deep vein thrombosis(DVT)/ Pulmonary embolism (PE)(<1%) Late Nutritional: Iron, vitamin B12, calcium,vitamin D deficiency Gastro-oesophageal reflux Barrett's esophagus Weight regain



References:

Bailey & Love’s Short Practice of Surgery, 28th Edition, Pages 1186,1189

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7052082/

↑ *Back to this question in Part A*

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Q6: A 52-year-old woman is recovering from a recent Roux-en-Y gastric bypass surgery. She has been informed about the possible complications that can arise post-surgery. Which of the following is least likely to be a complication of her bypass surgery? (Q849691)

A. Anastomotic leak

B. Internal hernia

C. Pancreatitis

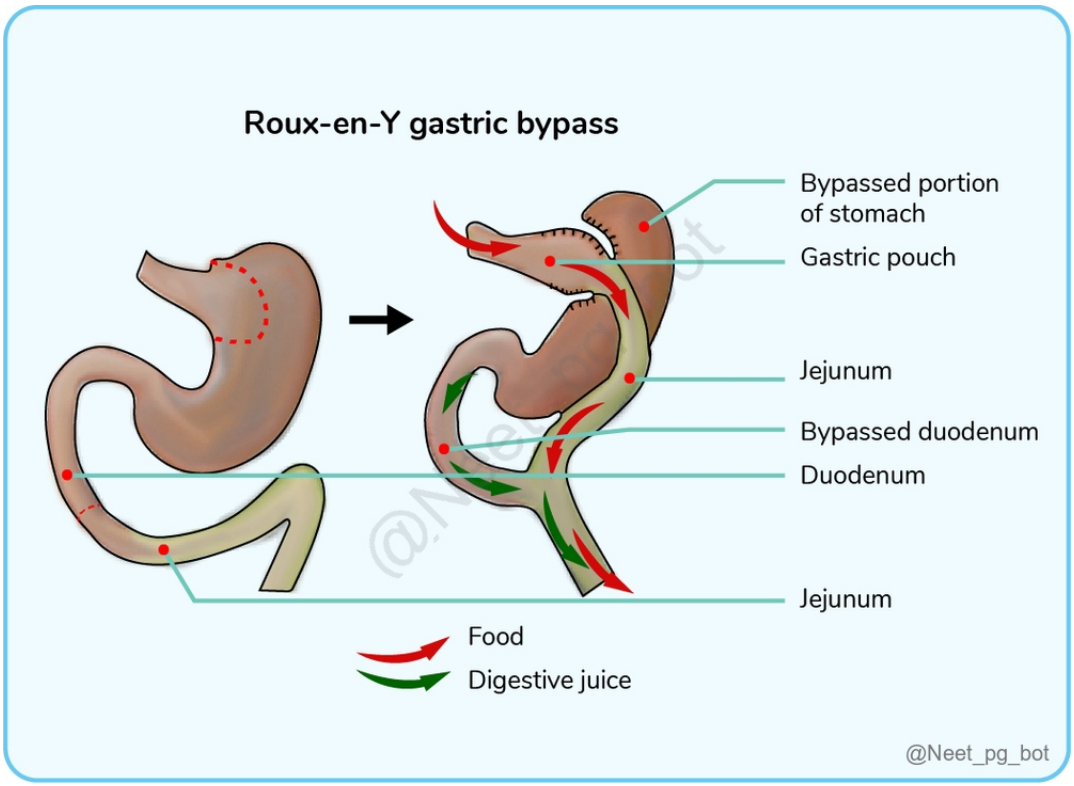
D. Deep vein thrombosis

Correct Answer: C. Pancreatitis

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Pancreatitis directly following bariatric surgery is uncommon but can be fatal. Roux-en-Y Gastric Bypass Involves the creation of a small gastric pouch from the proximal end of the stomach, which is then connected with the distal jejunum. Roux limb is varied between 100-150 cm. {{caption_text}} Complications: Early: Anastomotic leak (<1 %) (Option A) Intra-abdominal bleed (2-3%) Unspecified obstruction (1-2%) Deep vein thrombosis(DVT)/ Pulmonary embolism (PE) (<1%) (Option D) Late: Internal hernia (Option B) Chronic abdominal pain Malnutrition if long limb bypass; Iron deficiency anemia; Vitamin B12 deficiency; Calcium deficiency Anastomotic ulcer/ stricture



References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Pages 1186,1187,1189

SRB's Manual of Surgery, 6th Edition, Page 101

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9889439/

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6612182/

↑ *Back to this question in Part A*

@Neet_pg_bot

Q7: A 40-year-old obese male visits the surgical OPD. He is advised to undergo a biliopancreatic diversion and duodenal switch (BPD-DS) surgery. What would not be a possible indication for BPD-DS? (Q849690)

A. Higher BMIs

B. Failed another operation for weight loss

C. Failed surgery for metabolic control

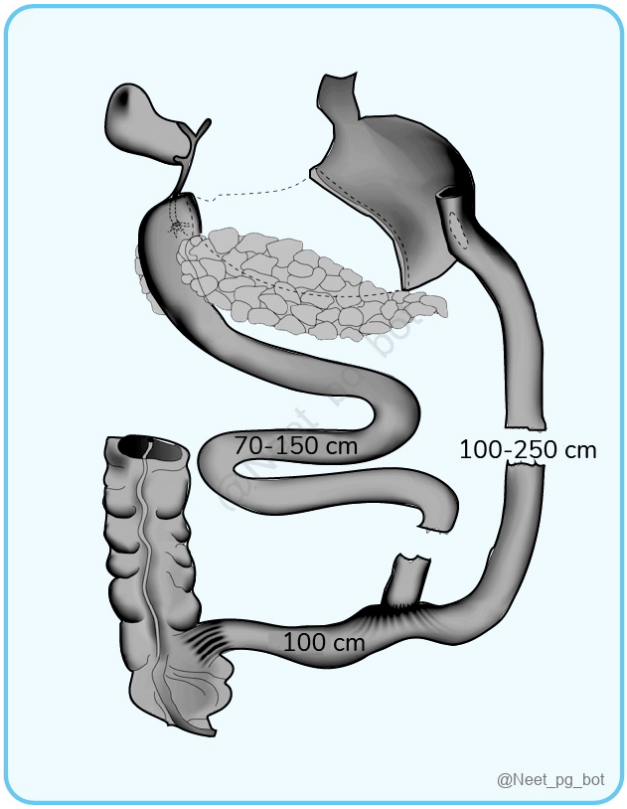
D. Preexisting iron deficiency

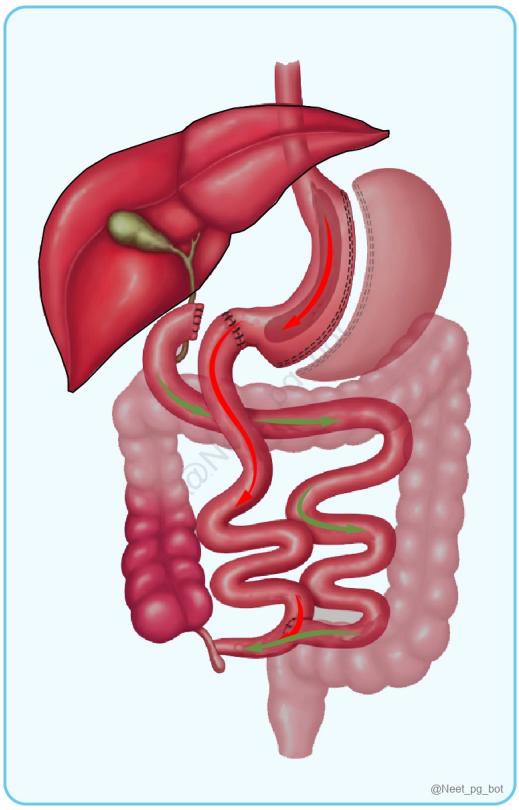
Correct Answer: D. Preexisting iron deficiency

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: A preexisting anemia is a contraindication for BPD-DS. Biliopancreatic diversion: It begins with a distal subtotal gastrectomy with a residual 200mL gastric pouch. The terminal ileum is divided 250 cm proximal to the ileocecal valve. The distal end is then divided and anastomosed to the stomach. A 2 to 3-cm stoma is created. Proximal end of the ileum is anastomosed side-to-side to the terminal ileum. Cholecystectomy is done prophylactically due to the high incidence of gallstone formation with malabsorption of bile salts. {{caption_text}} Duodenal switch: The only difference is that instead of a distal gastrectomy, resection of all the stomach except for a narrow lesser curvature of the stomach is performed. The duodenum is then divided in its first portion. The end of the duodenum is anastomosed to the distal 250 cm of ileum. Distal bowel configuration and cholecystectomy are similar to BPD. {{caption_text}} Indications: Higher BMIs ((BMI >50 kg/m ²) (Option A). Failed another operation for weight loss or metabolic control (Option B & C). Type 2 DM with poor metabolic control. Non-alcoholic steatohepatitis (NASH). Contraindications: Geographic distance from the surgeon. Lack of financial means to afford supplements. Preexisting calcium, iron or other nutrient deficiencies (Option D). Severe esophageal reflux (GERD). Preexisting severe malabsorption (IBS/Crohn's). Inability to comply with lifelong vitamin/mineral supplementation. Patients with high surgical risk (ASA IV).





References:

Schwartz Principles of Surgery, 11th edition, Pages 1189,1190.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q8: In the preoperative assessment for obesity surgery, which of the following factors does NOT contribute to the obesity surgery mortality risk score? (Q849689)

A. BMI >50 kg/m²

B. Female gender

C. Age >45 years

D. Hypertension

Correct Answer: B. Female gender

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The obesity surgery mortality risk score includes factors such as BMI greater than 50 kg/m², male gender (not female), age greater than 45 years, hypertension, and risk factors for pulmonary thromboembolism. Obesity Surgery Mortality Risk Score (OS-MRS): It is used to estimate the likelihood of mortality following bariatric surgery Risk factor Points BMI >50 kg/m 2 1 Male gender 1 Age >45 years 1 Hypertension 1 Risk factors for pulmonary thromboembolism 1 Risk group Score Postoperative mortality Low risk 0-1 0.3 Moderate risk 2-3 1.7 High risk 4-5 3.2

References:

https://www.researchgate.net/publication/361425833_Preoperative_preparation_and_premedication_of_bariatric_surgical_patient

↑ *Back to this question in Part A*

@Neet_pg_bot

Q9: A patient is evaluated for obesity in the hospital for bariatric surgery. Which of the following would not be an indication for the surgery? (Q849688)

A. BMI ≥ 40kg/m2 with no comorbidities

B. BMI ≥ 35kg/m2 with no comorbidities

C. Failure of previous nonsurgical attempts

D. BMI ≥ 37.5kg/m2 in Asian population with/without comorbidities

Correct Answer: B. BMI ≥ 35kg/m2 with no comorbidities

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: BMI ≥ 35kg/m2 with comorbidities is an indication of surgery and not without comorbidities. Indications for bariatric surgery: International Population Asian Population (metabolic surgery) BMI ≥ 40kg/m2 with/without comorbidities (Option A) BMI ≥ 35kg/m2 with comorbidities (Option B) BMI ≥ 37.5kg/m2 with/without comorbidities (Option D) BMI ≥ 32.5kg/m2 with comorbidities Failure of previous nonsurgical attempts at weight loss (Option C). A patient who is committed to postoperative care, follow-ups, medical management, and instructions for any tests and procedures.

References:

Schwartz Principles of Surgery, 11th edition, Pages 1173,1175.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q10: In which of the following situations is robotic surgery not suitable? (Q849687)

A. Limited space/visualization

B. Surgeon suffers from tremors in hands

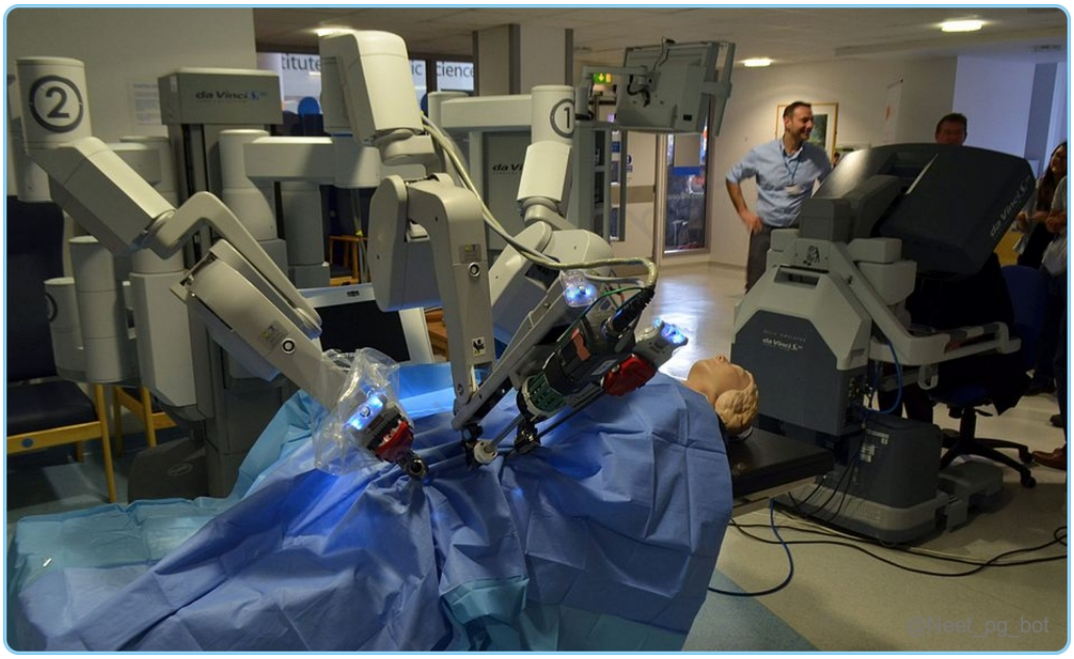
C. Gynecological operations

D. Low-budget surgical setup

Correct Answer: D. Low-budget surgical setup

- *Listen (English)*
- *Listen (Hindi)*

Explanation: Robotic surgery is very expensive, so it is not suitable in a low-budget setup. It operates on a "master-slave" principle, with the surgeon (master) controlling the robot (slave) through hand movements. The robot's wristed instruments replicate these movements precisely, avoiding the fulcrum issue of laparoscopic tools. This precision allows for fine motor skills in confined spaces. (Option A ruled out) Additionally, the robotic system includes filters to counteract tremors and can translate large movements into smaller, precise ones. (Option B ruled out) Remote operation is possible, making telesurgery feasible for hostile environments such as military, space missions, deep-sea exploration, and polar expeditions. Degrees of Freedom (DOF): Robotic instruments provide 7 degrees of freedom , mimicking the human wrist inside the abdomen. This overcomes the fulcrum effect of standard laparoscopy where tools are restricted to 4 degrees of freedom, allowing for precise suturing and dissection in confined spaces. {{caption_text}} Applied in: Prostatic surgery Gynecological surgeries (Option C ruled out) Some cardiac surgeries Urologic surgeries Endocrine surgery



References:

Sabiston’s Textbook of Surgery, 21st edition, Pages 353, 354.

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1356187/

↑ *Back to this question in Part A*

@Neet_pg_bot

Q11: Which of the following statements about per-oral endoscopic myotomy is false? (Q849686)

A. It is a modification of NOTES surgery

B. A flexible endoscope is used to create a submucosal tunnel

C. It is a good surgical technique for achalasia cardia

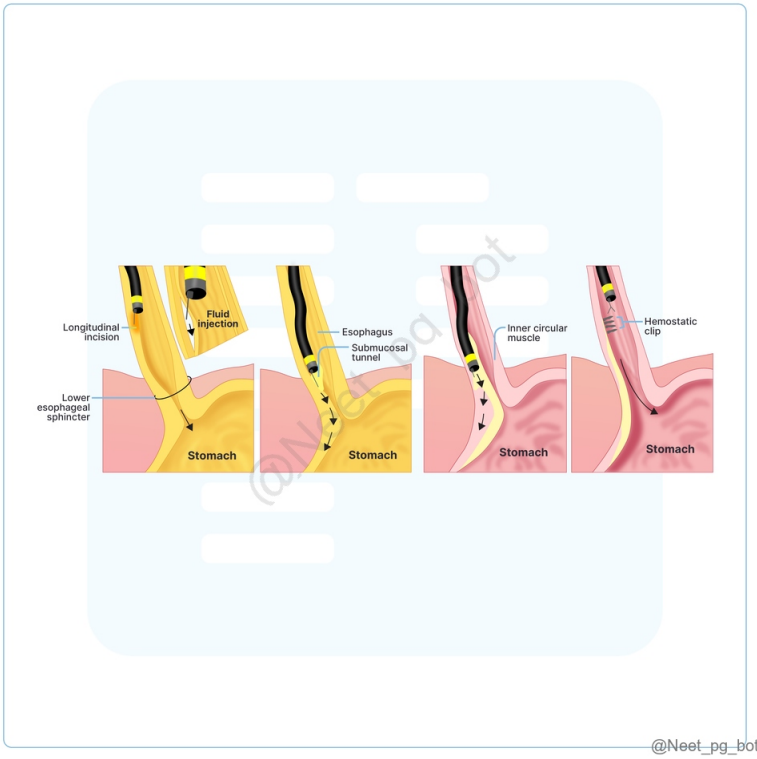
D. The procedure involves the division of longitudinal muscles

Correct Answer: D. The procedure involves the division of longitudinal muscles

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Per-oral endoscopic myotomy (POEM) involves the division of the circular muscles of the esophagus. It is a modification of the NOTES procedure (Option A) . This is a natural orifice procedure. It is used for achalasia cardia (Option C) and is being tried for gastric outlet obstruction. Procedure: A flexible endoscope (Option B) is inserted into the esophagus and a long esophageal myotomy is created. Fluid is injected, and a submucosal tunnel is created. Then, the circular muscle fibres (Option D) are divided Once the procedure is completed, hemostatic clips are applied at the incision site.



References:

Sabiston's Textbook of Surgery, 21st edition, Page 352.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q12: A 20-year-old female comes to the OPD for an elective abdominal surgery. She is worried about developing a scar and enquires about a scarless procedure. Which among the following surgical procedures gives a scarless result? (Q849685)

A. Laparoscopic abdominal surgery

B. Laparotomy

C. Natural orifice transluminal endoscopic surgery

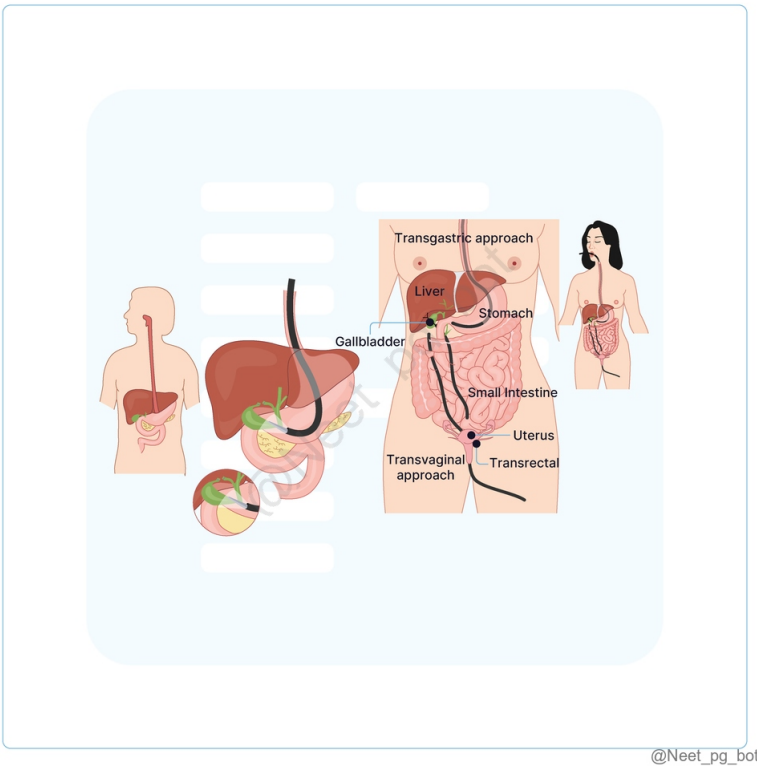
D. Hand-assisted laparoscopic surgery

Correct Answer: C. Natural orifice transluminal endoscopic surgery

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The Natural orifice transluminal endoscopic surgery (NOTES) surgery is scarless as it is done via the natural body orifices (rectum, mouth, vagina). This technique can be applied to the pelvis , abdomen, and thorax . Closure of the visceral puncture site is a major issue that has prevented the uptake of this method. Transgastric, trans colonic closure of peritoneal entry sites in a safe way remains a problem. Significant cost and training implications have also limited more widespread adoption. Appendectomy and cholecystectomy are done with this method. Staging of intra-abdominal malignancy, segmental colectomy, and gastro-jejunostomy are also performed this way. Advantages : Complications like hernias and wound infections are also eliminated. Usage of a flexible endoscope used in NOTES allows access to remote areas of the peritoneal cavity more easily and quickly.



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References:

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3099337/

Bailey and Love's Short Practice of Surgery, 28th edition, Page 163.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q13: A 25-year-old female who underwent a simple mastectomy was admitted in the hospital and discharged on the same day after the procedure. What type of surgery is this? (Q849684)

A. Daycare surgery

B. Fast track surgery

C. Overnight stay surgery

D. Short stay surgery

Correct Answer: A. Daycare surgery

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Day surgery or daycare (Option A) surgery is the admission of selected patients to a hospital for a planned surgical procedure, returning home on the same day. “True day surgery” patients are those who need full operating theatre facilities and/or a general anesthetic, and any day cases are not included as outpatients or undergoing endoscopy. Fast-track surgery (Option B) is a multimodal approach. It uses a combination of several evidence-based peri-operative interventions to improve recovery after surgery. If a surgery requires a 23-hour stay with an overnight stay it is an overnight stay surgery (Option C) and the patient is discharged early morning. In short-stay surgeries (Option D) , the patient is admitted for 72 hours.

References:

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4173620/

↑ *Back to this question in Part A*

@Neet_pg_bot

Q14: A laparoscopic surgery was done on a patient for cholecystitis, and he later complained of shoulder pain. What would be the most possible cause for this? (Q849683)

A. Intrabdominal abscess

B. Mesenteric bleeding

C. Perforation of esophagus

D. Splenic trauma

Correct Answer: D. Splenic trauma

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Splenic trauma leads to bleeding, and this causes a collection of blood under the diaphragm (Kehr's sign). This leads to the irritation of the diaphragm and referred pain via the phrenic nerve , hence the shoulder pain . This can also be due to CO2 used for insufflation that irritates the diaphragm.

References:

https://www.ncbi.nlm.nih.gov/books/NBK6923/

↑ *Back to this question in Part A*

@Neet_pg_bot

Q15: A 45-year-old patient is about to undergo a cholecystectomy. He has no other comorbidities and wants a minimally invasive surgery; hence, the surgeon suggests a laparoscopic cholecystectomy. Which of the following gases is most widely used for creating a pneumoperitoneum? (Q849682)

A. Room air

B. O2 (oxygen)

C. CO2 (carbon dioxide)

D. He (helium)

Correct Answer: C. CO2 (carbon dioxide)

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Carbon dioxide is the most frequently used gas for pneumoperitoneum, considering its inert quality and non-inflammable characteristics. CO2 insufflation is started slowly until an abdominal pressure of 12-15mmHg is reached. Although carbon dioxide meets most of the requirements for pneumoperitoneum, the absorption of CO2 may be associated with adverse events like cardiopulmonary complications and adverse events in people with high anesthetic risk which is avoided by hyperventilation.

References:

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6481852/

↑ *Back to this question in Part A*

@Neet_pg_bot

Q16: A diabetic patient with severe sepsis develops a persistent urinary tract infection (UTI) despite antibiotic treatment. The infection control team suspects a multidrug-resistant pathogen. Which of the following is true about nosocomial infections? (Q849664)

A. Staphylococcus aureus is the most common cause of hospital-acquired respiratory infections.

B. Klebsiella is a frequent cause of drug-resistant hospital-acquired UTIs.

C. Nosocomial infections are not typically transmitted between patients.

D. Patients with artificial prostheses are less prone to nosocomial infections than those with indwelling devices.

Correct Answer: B. Klebsiella is a frequent cause of drug-resistant hospital-acquired UTIs.

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Klebsiella is indeed a frequent pathogen responsible for hospital-acquired urinary tract infections and is notably resistant to multiple drugs, making it a major concern in nosocomial infections. (Option B) Staphylococcus aureus is commonly associated with hospital-acquired wound infections, not respiratory infections . (Option A) Nosocomial infections can and do spread between patients. Transmission can occur through direct patient contact or contaminated equipment. (Option C) Patients with artificial prostheses are actually at increased risk for nosocomial infections compared to those with indwelling devices, due to the potential for infection at the site of the prosthesis and the complexity of managing such infections. (Option D) Hospital Acquired Infections: Acquired infections after 48 hours of hospital admission that were neither present nor incubating at the time of admission. Spread by healthcare workers or between patients if aseptic measures are not followed. Common Pathogens Wound infection: Staphylococcus aureus (most common), Pseudomonas, Klebsiella, E.coli, Proteus. Respiratory tract infections: Streptococcus pneumoniae, Haemophilus, Herpes, Varicella, Aspergillus, Pneumocystis carinii. UTIs: Klebsiella (most common). Antibiotic-associated diarrhea: Clostridium difficile.

References:

SRB’s Manual of Surgery, 6th Edition, Pages 59, 60

↑ *Back to this question in Part A*

@Neet_pg_bot

Q17: A 55-year-old woman, 4 days post-abdominal surgery, reports a sudden feeling of popping at her surgical site followed by the drainage of pinkish fluid. On examination, there is partial wound dehiscence with no visible bowel protrusion. What is the next best step in management? (Q849680)

A. Prompt reclosure of the fascia

B. Apply a wound vacuum system and monitor

C. Prescribe oral antibiotics and discharge

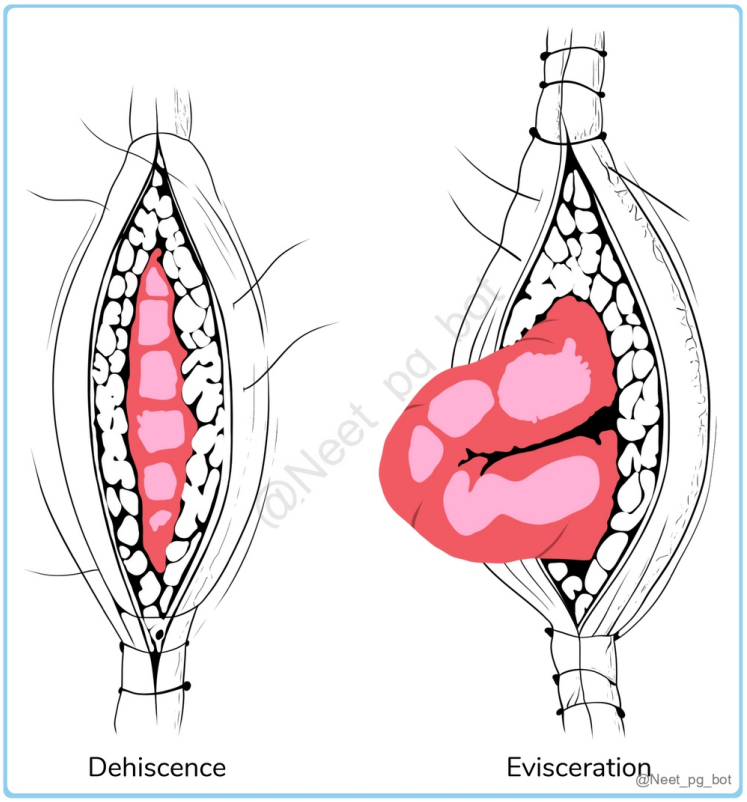
D. Place an abdominal binder and observe

Correct Answer: A. Prompt reclosure of the fascia

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Wound Dehiscence Disruption of any or all of the layers in a wound. Types Partial dehiscence: Involves only the skin and subcutaneous fat. Complete dehiscence: Involves the fascial layer and may include evisceration (extrusion of abdominal viscera). Clinical Presentation Pinkish serosanguinous discharge (salmon-coloured fluid), Possible evisceration, Popping sensation during straining or coughing. Treatment Partial dehiscence (without evisceration): Prompt reclosure of the fascia is generally advised. (Option A) Complete dehiscence with evisceration: Requires urgent reoperation. Tension suturing is done. Protect eviscerated bowel with moist towels; handle carefully to prevent injury. Antibiotic therapy; fluid management.



References:

Bailey & Love’s Short Practice of Surgery, 28th Edition, Page 325

Sabiston Textbook of Surgery, 21st edition, Pages 240,241

SRB’s Manual of Surgery, 6th Edition, Pages 732, 733

↑ *Back to this question in Part A*

@Neet_pg_bot

Q18: A 68-year-old man develops a fever of 101.5°F on postoperative day 5 after total hip replacement. He also has localized pain and swelling in his left calf. The chest X-ray is normal, and there are no respiratory symptoms. What is the most likely cause of his fever? (Q849679)

A. Pulmonary embolism

B. Thrombophlebitis

C. Deep infections

D. Gas gangrene of wound

Correct Answer: B. Thrombophlebitis

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Causes of Postoperative Fever Immediate Fever: Fever occurs immediately after surgery or within hours on postoperative days (POD) 0 or 1. Malignant Hyperthermia Bacteremia Gas gangrene of the wound (Option D) Febrile non-hemolytic transfusion reaction Acute Fever: Fever occurs in the first week (POD 1 to 7). POD 1: Pyretic response to surgery POD 3: Unresolved atelectasis resulting in pneumonia; development of urinary tract infection (UTI) POD 5: Thrombophlebitis (Option B) POD 7: Pulmonary embolism (Option A) POD 7 (5 to 10): Wound infection Subacute Fever: Fever occurs between postoperative weeks 1 and 4. POD 10: Deep infections (Option C) Drugs reactions Delayed Fever: Fever after >4 weeks. Skin and soft tissue infection (SSTI) Viral infections

References:

https://www.ncbi.nlm.nih.gov/books/NBK482299/

↑ *Back to this question in Part A*

@Neet_pg_bot

Q19: In the operating room, the surgical team is completing the WHO Surgical Safety Checklist. They are focused on final checks before closing the incision. Which of the following is not a standard checklist item at this stage? (Q849678)

A. Confirm patient identity.

B. Verify surgical team roles.

C. Reviewing anesthesia concerns.

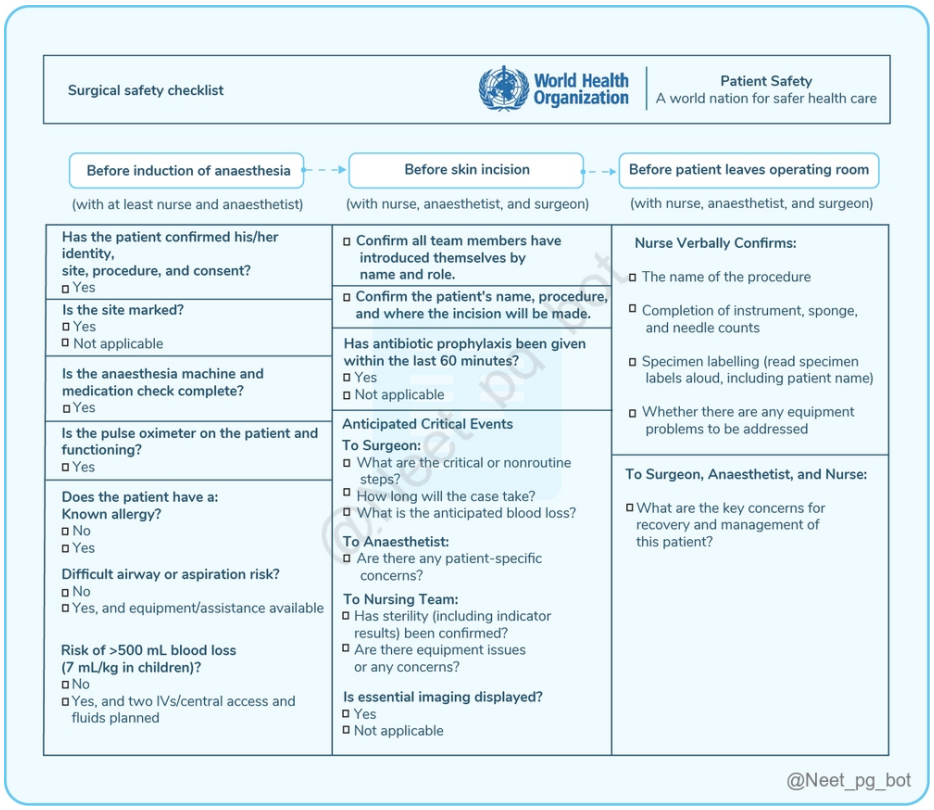
D. Checking the patient's COVID-19 status.

Correct Answer: D. Checking the patient's COVID-19 status.

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The WHO Surgical Safety Checklist focuses on critical safety measures directly related to the surgical procedure, and checking the patient's COVID-19 status is not part of the standard checklist items during final checks before closing the incision. WHO Surgical Safety Checklist:



References:

Bailey & Love’s Short Practice of Surgery, 28th Edition, Page 240

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5885453/

↑ *Back to this question in Part A*

@Neet_pg_bot

Q20: A 50-year-old man develops sudden respiratory distress, altered consciousness and hypotension during a craniotomy surgery. The anesthesiologist hears a mill-wheel murmur and suspects an air embolism. What is the most appropriate immediate action? (Q849677)

A. Administer a diuretic.

B. Perform CPR.

C. Place in Trendelenburg position.

D. Administer epinephrine.

Correct Answer: C. Place in Trendelenburg position.

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Air Embolism Occurs when air enters accidentally into the vascular system. The external jugular vein (EJV) is a superficial, thin-walled vein without valves in its terminal part. When it is injured, negative intrathoracic pressure during inspiration can suck air into the venous system. Even a small volume of air entering the central circulation can obstruct right heart outflow → air embolism → sudden cardiac arrest and death. Commonly iatrogenic via interventional procedures, but also from trauma, diving, childbirth, and other circumstances. Treatment Positioning: Trendelenburg position: Keeps air bubbles away from coronary arteries. (Option C) Left lateral decubitus position: Helps trap air in the non-dependent segment of the right ventricle, preventing it from entering the pulmonary artery. Hyperbaric oxygen therapy: Useful in both venous and arterial air embolism as it reduces ischemia, bubble size; in arterial embolism it removes nitrogen from bubbles to improve perfusion and oxygenation. Aspiration: Air should be aspirated from the right ventricle with a needle. Open Thoracotomy: Life-saving procedure required to aspirate excess air causing the block.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1014

SRB's Manual of Surgery, 6th Edition, Pages 188, 189

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3665124/

↑ *Back to this question in Part A*

@Neet_pg_bot

Q21: A 55-year-old female patient is scheduled for lateral thoracotomy. The surgical team prepares to position her on the operating table. Which position should the

patient be placed in for optimal access to the thorax? (Q849676)

A. Jackknife Position

B. Lateral Decubitus Position

C. Lithotomy Position

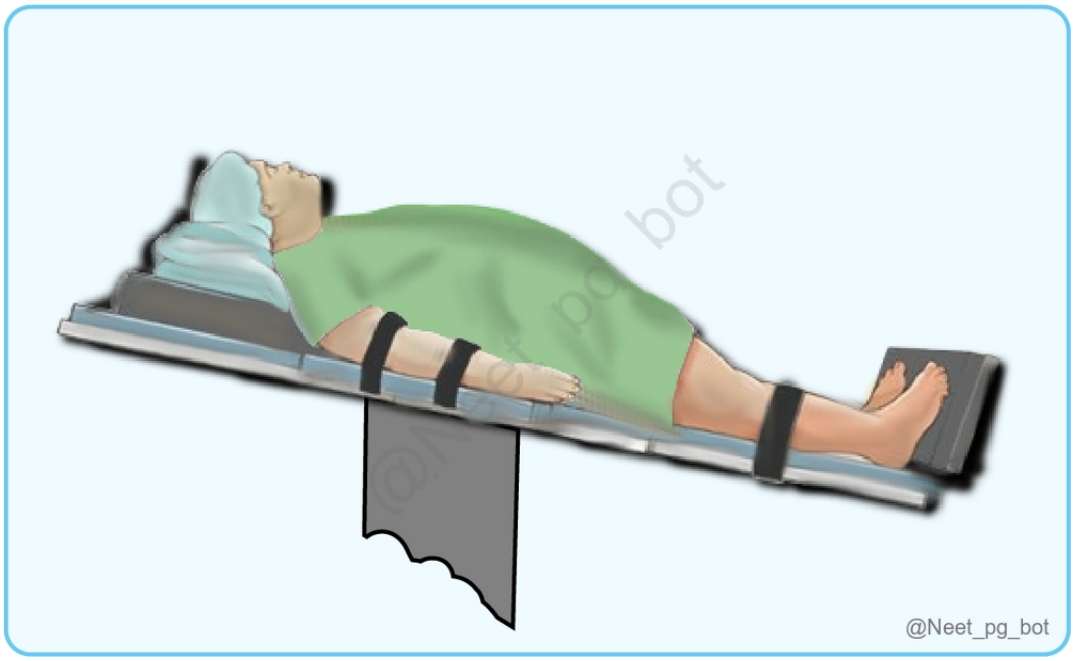
D. Trendelenburg Position

Correct Answer: B. Lateral Decubitus Position

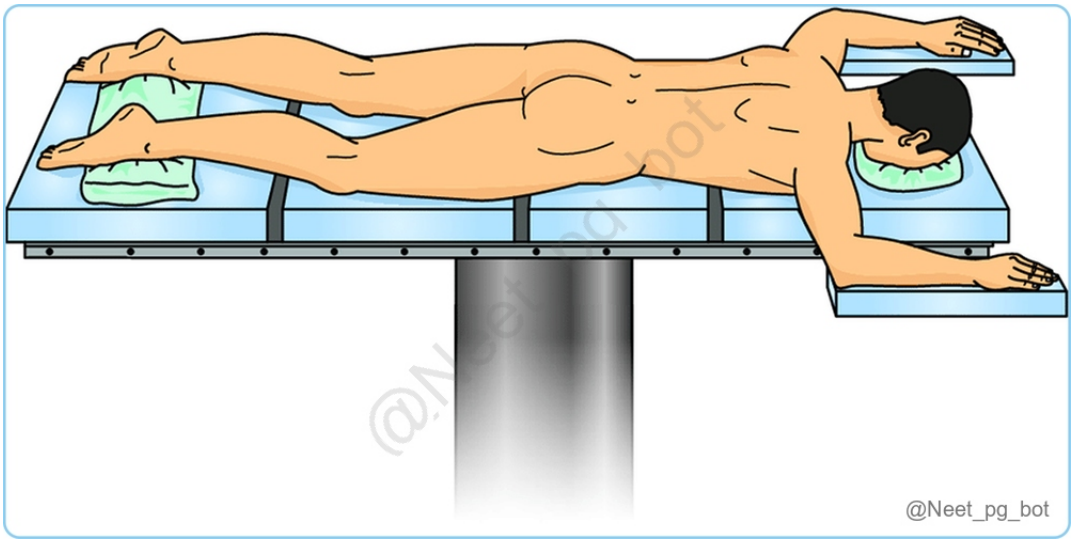
- *Listen (English)*
- *Listen (Hindi)*

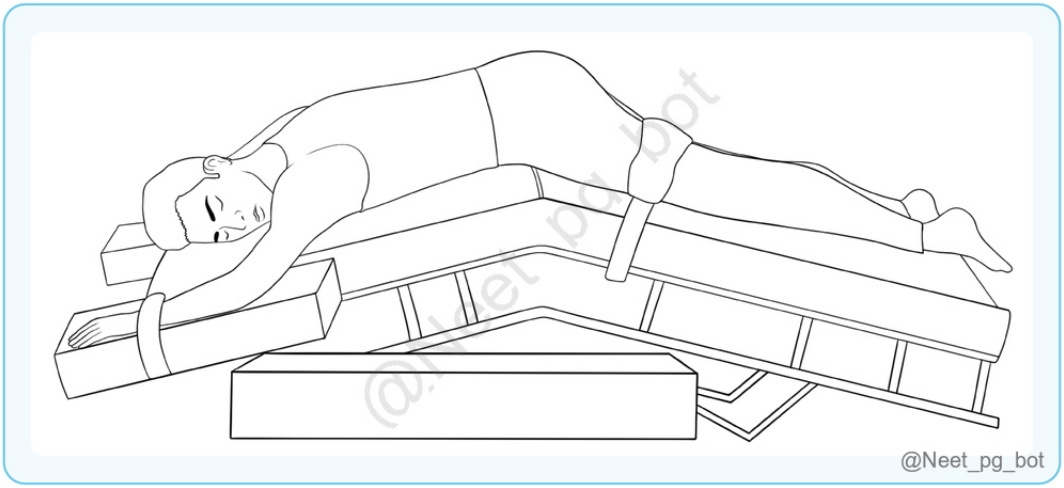
Explanation: For a lateral thoracotomy , the patient is placed in the lateral decubitus position , which provides optimal exposure to the thoracic cavity, lungs, pleura, and ribs. Positioning on Operating Table: Position Description Uses and Complications Supine Position Most common position for general surgical procedures. Modifications of Supine position: Rose’s position Shoulder and Arm Extended Trendelenburg Position Reverse Trendelenburg Position Fowler's Position General surgeries. Rose's Position Supine with slight neck extension. Head and neck surgery. Shoulder and Arm Extended Supine with shoulder and arm extended. Axillary and breast surgery. Trendelenburg Position (Option D) Head end tilted down, knees slightly flexed. Pelvic procedures, resuscitating patients in shock. Reverse Trendelenburg Position Head end tilted upward, placing the head higher than the feet. Upper abdominal surgeries. Complication: Right shoulder pain due to CO2 collected under the right dome of diaphragm during laparoscopic cholecystectomy Fowler's Position Semi-sitting with trunk raised at 40° and knees bent. Neurosurgery, shoulder surgeries, patients with heart or respiratory failure. Complication: Increased risk of air embolism. Prone Position Patient is intubated and log-rolled onto the operating bed with help. Spinal surgery, extra levator abdominoperineal excision for rectal cancer. Jackknife Position (Option A) (Prone Position Modification) Chest supported, abdomen relaxed by flexing at the hips. Provides excellent access to the perineum. Complication: Positional asphyxia Lateral Decubitus or Kidney Position (Option B) Lower leg flexed, pillow between legs, upper leg flexed in an exaggerated position. Draining abscesses, lateral thoracotomy, urological and retroperitoneal procedures. Complication: Increased risk of brachial plexus injury due to hyperextension Lithotomy Position (Option C) Supine with hips and knees flexed, legs in stirrups, hips flexed to 90°. Gynecological, perineal, and urological procedures. Complication: Common peroneal nerve injury if legs are not supported properly Lloyd-Davies Position (Lithotomy Modification) Supine with hips minimally flexed (~15°) and a 30° head-down tilt. Gynecological, perineal, and urological procedures. Trendelenburg Position: {{caption_text}} Reverse Trendelenburg Position: {{caption_text}} Fowler's Position: {{caption_text}} Prone Position: {{caption_text}} Jackknife Position: {{caption_text}} Lateral decubitus or Kidney Position: {{caption_text}} Lithotomy Position: {{caption_text}} Lloyd-Davies: {{caption_text}}

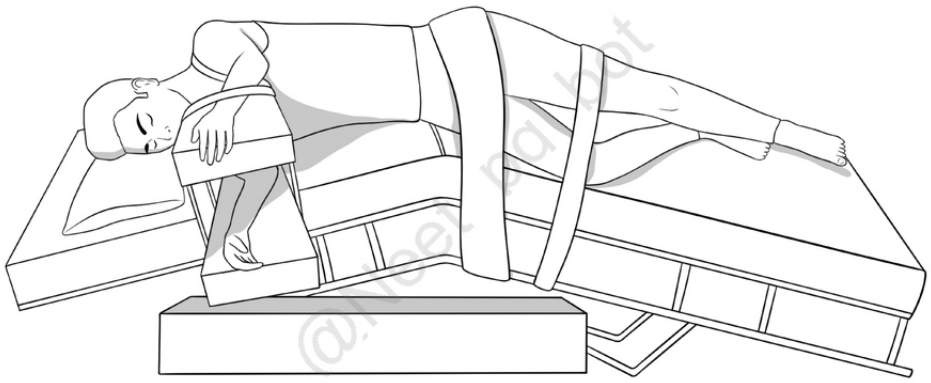

Hill-Rom


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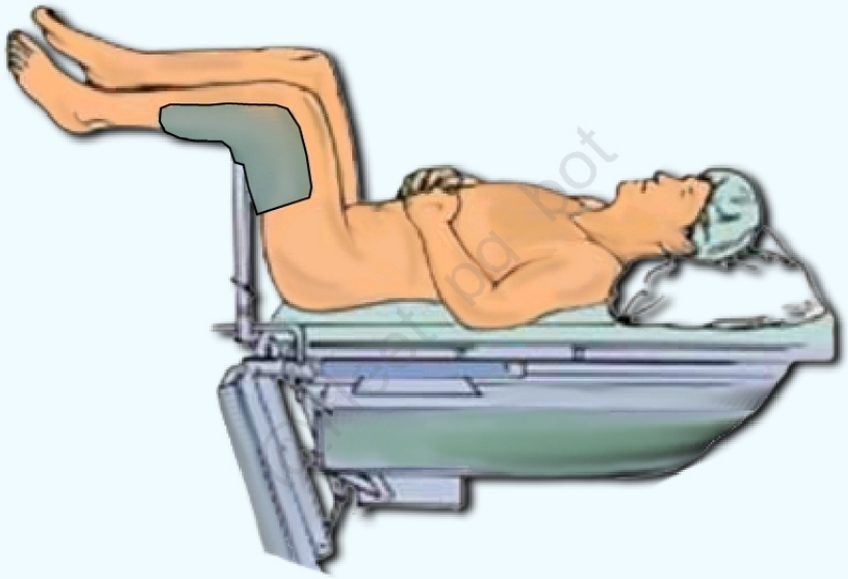

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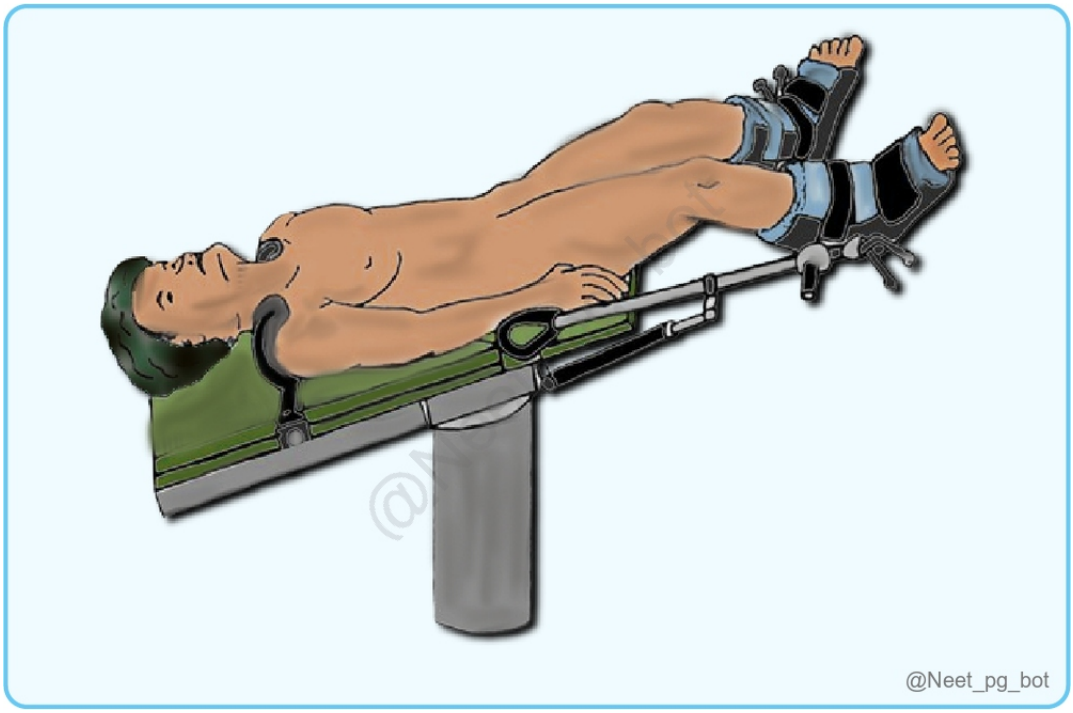

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References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Pages 94-96

https://journals.lww.com/wjcs/fulltext/2018/07010/

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10152920/

↑ *Back to this question in Part A*

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Q22: A patient's wound, evaluated on postoperative day 7, shows signs of erythema, pain and swelling with no discharge and deep tissue involvement. What is the likely Southampton wound grading? (Q849675)

A. Grade I

B. Grade II

C. Grade III

D. Grade IV

Correct Answer: B. Grade II

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The patient shows erythema and signs of inflammation with no discharge, so according to Southampton wound grading, it is classified as Grade II. Southampton wound grading system Grade Appearance Subtypes 0 Normal healing I (Option A) Normal healing with mild bruising or erythema A: Some bruising B: Considerable bruising C: Mild erythema II (Option B) Erythema plus other signs of inflammation A: At 1 point B: Around sutures C: Along wound D: Around wound III (Option C) Clear or haemoserous discharge A: At 1 point only (<2 cm) B: Along wound (>2 cm) C: Large volume D: Prolonged (>3 days) IV (Option D) Pus A: At 1 point only (<2 cm) B: Along wound (>2 cm) V Deep or severe infection with or without tissue breakdown; haematoma requiring aspiration

References:

SRB's Manual of Surgery, 6th Edition, Pages 34,62

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6505358/

↑ *Back to this question in Part A*

@Neet_pg_bot

Q23: Which of the following correctly matches the zone in an OT (Operating Theatre) complex with its primary function? (Q849673)

A. Protective zone: Includes the sterile operation rooms.

B. Clean zone: Primarily contains the change rooms for medical and paramedical staff.

C. Aseptic zone: Contains the sterile operating rooms.

D. Disposal zone: Connected directly to the aseptic zone and contains the patient transfer bay.

Correct Answer: C. Aseptic zone: Contains the sterile operating rooms.

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The Aseptic zone (Option C) includes the sterile operating rooms where surgeries are performed, and maintaining a high degree of cleanliness is critical. The protective zone (Option A) includes areas such as change rooms, transfer bays, and pre/post-operative rooms, but it does not contain the sterile operating rooms. The Clean zone (Option B) connects the protective zone to the aseptic zone. It typically contains: Clean rooms for preparation Storage for surgical instruments Areas for surveillance and maintenance Emergency exit routes The Disposal zone (Option D) is where waste from the operating rooms is collected and managed, but it is not directly connected to the patient transfer bay, which is part of the protective zone.

References:

https://journals.lww.com/ijaweb/fulltext/2007/51030/designing_an_ideal_operating_room_complex.5.aspx

↑ *Back to this question in Part A*

@Neet_pg_bot

Q24: Which of the following strategies is most effective in preventing surgical site infections (SSIs) during an operation? (Q849672)

A. Administering prophylactic antibiotics before the first incision and maintaining positive pressure in the operating room (OR).

B. Using concentric circles for antisepsis application and maintaining the OR temperature at 18 ± 3°C.

C. Administering antibiotics after the operation and maintaining a negative pressure differential in the OR.

D. Avoiding alcohol-based antiseptic solutions and using antibiotics with a short tissue half-life.

Correct Answer: A. Administering prophylactic antibiotics before the first incision and maintaining positive pressure in the operating room (OR).

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Administering prophylactic antibiotics before the first incision ensures that maximal antibiotic levels are present in the tissues when the incision is made, reducing the risk of bacterial contamination during surgery. Maintaining a positive pressure differential in the OR helps keep outside air from entering the sterile environment, which is crucial for preventing airborne contamination and thus reducing SSIs. (Option A) Prophylactic Considerations Details Prophylactic Antibiotics Administered before the first incision to ensure maximal antibiotic levels are present in tissues at the time of incision, reducing the risk of bacterial contamination. (Option C) Operating Room (OR) Air Pressure Positive pressure differential in the OR is essential to keep outside air from entering, preventing airborne contamination and reducing the risk of Surgical Site Infections (SSIs). (Option C) Antisepsis Application Technique Concentric circles are often used, but WHO guidelines state that the specific pattern (concentric circles, horizontal or vertical) does not significantly impact SSI prevention. (Option B) Operating Room Temperature Recommended OR temperature is 21 ± 3°C. A temperature of 18°C is too low, potentially causing hypothermia in patients, negatively affecting wound healing and outcomes. (Option B) Skin Antisepsis Solution Alcohol-based solutions like chlorhexidine alcohol are recommended for skin antisepsis because of their effectiveness in reducing transient organisms and preventing SSIs. (Option D) Antibiotic Selection Antibiotics with a short half-life might not maintain adequate tissue levels throughout surgery. Long-acting antibiotics or those that can be re-dosed during long surgeries are preferred. (Option D) Glucose Control Tight perioperative glycemic control (target <180 mg/dL) significantly reduces SSI risk; hyperglycemia impairs neutrophil function and wound healing.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 61.

https://www.nabh.co/Images/PDF/Operation-Theatre-Guidelines.pdf

↑ *Back to this question in Part A*

@Neet_pg_bot

Q25: A 62-year-old man with hypovolemic shock requires rapid fluid resuscitation. Which of the following IV catheters would be most appropriate for this situation? (Q849671)

A. 22G yellow catheter

B. 18G green catheter

C. 14G orange catheter

D. 24G blue catheter

Correct Answer: C. 14G orange catheter

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The 14G orange catheter is the most appropriate for rapid fluid resuscitation in hypovolemic shock. Larger gauge (smaller number) catheters allow for higher flow rates, which is crucial in emergencies requiring rapid volume replacement. IV Catheter Gauge, Color, and Flow Rates Gauge Color Flow Rate (mL/min) Typical Use 14 Orange 270 Rapid transfusion, trauma, Large volume replacement 16 Gray 236 Large volume infusion, blood transfusions 18 Green 103 Blood products, contrast study, surgery 20 Pink 67 General IV access 22 Blue 42 Small, fragile veins 24 Yellow 20 Pediatric use



References:

Equipment in Anaesthesia and Critical Care, 1st Edition, Page 264.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q26: A 28-year-old man from a resource-poor area presents with a 3-week history of fever, abdominal pain, and altered bowel habits. Abdominal examination reveals a doughy feel and a mass in the right iliac fossa. Which finding would most likely distinguish intestinal tuberculosis from typhoid fever in this patient? (Q849670)

A. Evening rise in temperature

B. Positive blood culture for Salmonella Typhi

C. Multiple longitudinal ulcers in the terminal ileum

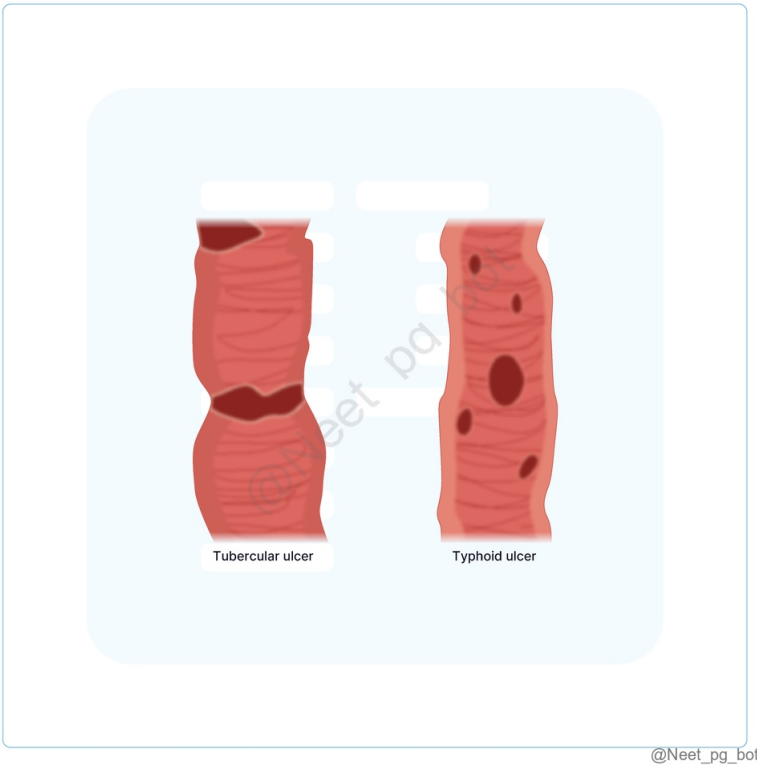
D. Caseating granulomas on intestinal biopsy

Correct Answer: D. Caseating granulomas on intestinal biopsy

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Caseating granulomas on intestinal biopsy are characteristic of intestinal tuberculosis and would distinguish it from typhoid fever. In tuberculosis, Histology shows caseating granuloma with giant cells. This finding is not seen in typhoid fever and is highly suggestive of tuberculosis. Features of Intestinal TB vs Typhoid: Feature Intestinal Tuberculosis Typhoid (Enteric Fever) Causative Organism Mycobacterium tuberculosis Salmonella typhi Mode of Transmission Ingestion of food contaminated with tubercle bacilli Fecal-oral route Gross Appearance (Ulcer Description) Ulcers are transverse, often circumferential, forming a "girdle" shape. Typically multiple ulcers. Located mostly in the Ileocaecal region. Ulcers are longitudinal, multiple and arranged in a parallel and antimesenteric pattern. Often occur in the terminal ileum and Peyer's patches. Ulcers can perforate, leading to peritonitis. Microscopic Features Presence of granulomas with caseating necrosis. Epithelioid cells and Langhans giant cells are common. Lymphoid hypertrophy is noted. Neutropenia and splenomegaly may also be observed. Clinical Presentation Dull, colicky abdominal pain, often in the right iliac fossa. Weight loss, fever, and anemia are common. Mass may be felt in the right iliac fossa (indicating ileocaecal involvement). Presents initially with fever, chills, and abdominal pain. Severe diarrhea, relative bradycardia, and abdominal tenderness are common. Complications Intestinal obstruction due to stricture formation. Risk of bowel perforation and fistula formation. Intestinal hemorrhage. Perforation leading to faecal peritonitis. Paralytic ileus is a common complication. Diagnostic Features Histology: Granulomas, Langhans giant cells and caseating necrosis are diagnostic. IFN-γ release assays Widal test, blood cultures positive for S. typhi. PCR assay for typhoid is also useful. X-ray may show gas under the diaphragm if perforation is present. Treatment Anti-tubercular therapy Antibiotics (e.g., cephalosporins)



References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Pages 88, 89, 91.

SRB’s Manual of Surgery, 6th Edition, Pages 573, 574, 858, 859.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q27: A 48-year-old male immigrant presents with a painless, fluctuating mass in the neck that has been gradually enlarging over 2 months, along with an evening rise in temperature and weight loss. On examination, there is a 3 cm soft, non-tender swelling in the left posterior triangle of the neck without signs of inflammation. Which of the following is the most appropriate next step in management? (Q849669)

A. Incision and drainage

B. Fine needle aspiration cytology

C. Excisional biopsy

D. Empiric antitubercular therapy

Correct Answer: C. Excisional biopsy

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The patient presents with classic features of tuberculous cervical lymphadenitis : Painless, soft, non-tender lymph node Posterior triangle involvement Evening rise of temperature Weight loss No signs of acute inflammation I n the early stages of adenitis , before cold abscess formation or sinus development, the investigation of choice is an excisional biopsy . A portion of the lymph node must be sent fresh for histopathology and culture to confirm tuberculous lymphadenitis . Treatment Antitubercular Drugs: Rifampicin, INH, Ethambutol, Pyrazinamide (for 6-9 months) Aspiration: Cold abscess is aspirated to prevent sinus formation Anti-tubercular therapy (ATT): If abscess recurs Surgical Removal: Indicated if there is no response to drugs or sinus persists

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Pages 86, 87.

SRB’s Manual of Surgery, 6th Edition, Pages 431, 432, 433.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q28: A 56-year-old diabetic male presents with severe leg pain, swelling, dusky discoloration, and bullae, 24 hours after a minor cut. The leg is edematous with crepitus, and the patient is febrile and tachycardic, showing signs of septic shock. What is the most appropriate next step? (Q849668)

A. Monitor and observe

B. Immediate surgical debridement

C. IV fluids and pain management

D. Oral antibiotics

Correct Answer: B. Immediate surgical debridement

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The patient in the scenario presents with symptoms strongly indicative of necrotizing fasciitis , a rapidly progressing and life-threatening soft tissue infection. Therefore, the most appropriate management method is immediate surgical debridement. Signs and Symptoms Local: Unusual pain, Erythema, edema, warmth, Crepitus, Blisters, bullae, Grayish drainage (dishwasher pus), Fixed staining, Necrosis, gangrene. Systemic: Fever, tachycardia, tachypnea, Shock, Coagulopathy, Multiorgan failure. Management Immediate ICU admission with monitoring of volume status and cardiac function. Administer oxygen; intubate if necessary. High-dose IV penicillin G and broad-spectrum antibiotics (e.g., third-generation cephalosporins, metronidazole). (Option D ruled out) Immediate, aggressive surgical excision with daily dressing changes. Multiple debridements may be needed. Large wounds may require skin grafting or flap coverage. Vacuum-assisted dressings and early skin grafting aid healing and minimize fluid loss. Hyperbaric oxygen therapy can reduce mortality. Image {{caption_text}}



References:

Bailey & Love’s Short Practice of Surgery, 28th Edition, Pages 33, 34, 456, 457, 644

↑ *Back to this question in Part A*

@Neet_pg_bot

Q29: A 45-year-old man presents with severe muscle pain and swelling in his leg following a gunshot wound. The wound has a foul-smelling, brown discharge and shows signs of crepitus. X-rays reveal gas in the soft tissues. What is the most likely diagnosis? (Q849667)

A. Hidradenitis Suppurativa

B. Fournier’s Gangrene

C. Gas Gangrene

D. Cellulitis

Correct Answer: C. Gas Gangrene

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Gas Gangrene A rapidly progressive, potentially fatal condition characterized by widespread necrosis of muscles and soft-tissue destruction, often due to late-presenting missile wounds or crushing injuries. Cause Clostridium perfringens Sources and predisposing factors Contaminated soil and feces. Wounds with necrotic or foreign material. Crush wounds, road traffic accidents, amputations. Anaerobic environments in the wound. Clinical features Severe pain with limb swelling rapidly increases in severity. Serosanguineous discharge. Skin turns brown to blue-black with hemorrhagic bullae. Sweet, sticky odor & Soft-tissue crepitus. Investigation X-ray: Gas in soft tissues. Gram stain & blood culture: Large Gram-positive bacilli without neutrophils. Biochemical profile: Metabolic acidosis, renal failure. Peripheral blood smear: Haemolysis. CT scan for chest or abdominal wounds. Treatment High-dose intravenous penicillin and clindamycin, along with 3rd generation cephalosporins, are given intravenously. Polyvalent antiserums given intravenously. All dead tissues are excised, and debridement is performed until healthy tissue bleeds. Amputation done in severe cases Hyperbaric oxygen therapy. Image {{caption_text}}



References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Pages 57, 457, 643

SRB's Manual of Surgery, 6th Edition, Pages 44, 50-52,1056

↑ *Back to this question in Part A*

@Neet_pg_bot

Q30: A 55-year-old diabetic male presents with a 2-day history of increasing redness, warmth, and swelling in his left leg and also has fever and chills. The erythema is rapidly expanding, with no clear demarcation. What is the most likely diagnosis? (Q849666)

A. Carbuncle

B. Cellulitis

C. Erysipelas

D. Necrotizing fasciitis

Correct Answer: B. Cellulitis

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Feature Erysipelas (Option C) Cellulitis (Option B) Carbuncle (Option A) Definition Localized, sharply demarcated infection of upper dermis, often with broken skin. Generalized deeper infection affecting dermis and subcutaneous tissue. Infection of hair follicles extending into surrounding and subcutaneous tissue. Cause Beta-hemolytic Streptococcus pyogenes . Streptococcus pyogenes , Staphylococcus aureus . Staphylococcus aureus . Common Sites Lower limb, face, ear lobule, orbit. Lower limb, upper limb, face, scrotum. Nape of neck, back. Symptoms Erythematous, edematous rash; fever, leukocytosis, toxemia; raised rash with sharp margins; serous discharge; Milian's ear sign. Diffuse expanding erythema, painful, swelling; fever, malaise, toxicity; lymphangitis; no clear edge or limit to infection. Red, painful nodule; tender, fluctuant lesion; multiple

draining sinuses; fever, lymphadenopathy. Complications Septicemia, localized gangrene, abscess, pneumonia, meningitis, lymphedema, recurrence (20%). Pyogenic abscess, bacteremia, septicemia, local gangrene, necrotizing fasciitis. Septicemia, abscess, necrosis, requiring possible excision or skin graft. Treatment Broad-spectrum antibiotics; penicillins, clindamycin; long-term penicillin for recurrence. Broad-spectrum IV antibiotics; elevation, glycerine-magnesium sulfate dressing. Control of diabetes; antibiotics; drainage, debridement, possible excision. Image {{caption_text}} {{caption_text}} {{caption_text}}







References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 643

Schwartz Textbook of Surgery, 11th edition, Page 524

SRB's Manual of Surgery, 6th Edition, Pages 34, 35, 45, 60

https://www.ncbi.nlm.nih.gov/books/NBK303996/

https://www.ncbi.nlm.nih.gov/books/NBK554459/

↑ *Back to this question in Part A*

@Neet_pg_bot

• [12_Miscellaneous] 057 Injuries To The Head Neck And Thorax

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[12_Miscellaneous] 057 Injuries To The Head Neck And Thorax — Quick Jump

Q1 (p. 3340)	*Q2 (p. 3341)*	*Q3 (p. 3342)*	*Q4 (p. 3343)*	*Q5 (p. 3343)*	*Q6 (p. 3344)*
Q7 (p. 3344)	*Q8 (p. 3345)*	*Q9 (p. 3346)*	*Q10 (p. 3346)*	*Q11 (p. 3347)*	*Q12 (p. 3348)*
Q13 (p. 3348)	*Q14 (p. 3350)*	*Q15 (p. 3350)*	*Q16 (p. 3351)*	*Q17 (p. 3352)*	*Q18 (p. 3353)*
Q19 (p. 3354)	*Q20 (p. 3355)*	*Q21 (p. 3357)*	*Q22 (p. 3358)*	*Q23 (p. 3360)*	*Q24 (p. 3363)*
Q25 (p. 3364)	*Q26 (p. 3365)*	*Q27 (p. 3366)*	*Q28 (p. 3367)*	*Q29 (p. 3368)*	*Q30 (p. 3369)*
Q31 (p. 3370)	*Q32 (p. 3371)*	*Q33 (p. 3373)*			

Q1: A 45 y/o male is brought to the emergency room after a car accident with a penetrating injury to the left chest. An eFAST reveals fluid accumulation in the pericardial sac. Which of the following is not a component of Beck's triad, a classic finding in pericardial tamponade? (Q849790)

A. Hypotension

B. Jugular venous distension

C. Bradycardia

D. Muffled heart sounds

Correct Answer: C. Bradycardia

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Bradycardia is not part of Beck's triad; in fact, patients with pericardial tamponade typically present with tachycardia as a compensatory response to hypotension. Becks Triad Hypotension (Option A ruled out) : A key component of Beck's triad, indicating reduced cardiac output due to heart compression. Jugular venous distension (Option B ruled out) : Due to increased venous pressure from impaired venous return. Muffled heart sounds (Option D ruled out) : Caused by the fluid in the pericardial sac dampening the heart sounds.

References:

Bailey & Love’s Short Practice of Surgery, 28th Edition, Page 374

Sabiston Textbook of Surgery, 21st edition, Page 409

↑ *Back to this question in Part A*

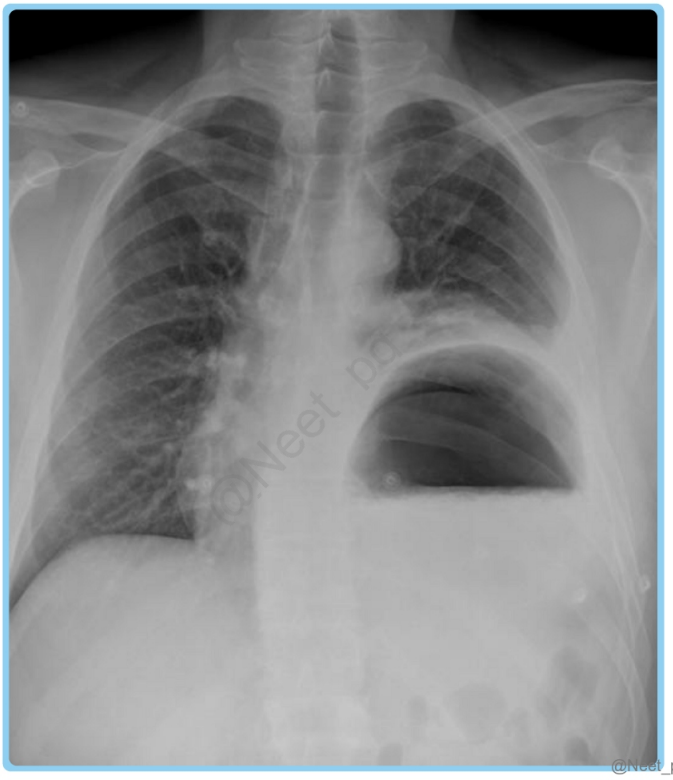
Q2: An elderly lady presents to the trauma care center following a motor vehicle collision. She complains of chest pain and abdominal pain. On examination, breath sounds are decreased on the left side. X-ray chest shows loops of bowel in the left hemithorax. Which of the following statements is false regarding the management of this patient's likely condition? (Q880429)

A. The most accurate evaluation of the condition in stable patients may be achieved by a CT scan

B. Operative repair is indicated in all symptomatic or diagnosed cases to prevent delayed complications

C. In the setting of an acute penetrating injury, repair can often be achieved via a thoracic incision

D. The defect is typically closed with non-absorbable sutures, such as polypropylene, placed in an interrupted fashion



Correct Answer: C. In the setting of an acute penetrating injury, repair can often be achieved via a thoracic incision

Explanation: This patient's presentation and imaging suggest a high likelihood of Traumatic Diaphragmatic Rupture (TDR) with herniation of abdominal contents (bowel) into the chest cavity, The preferred surgical approach for acute traumatic diaphragmatic rupture (TDR) , whether from blunt or penetrating injury, is generally the abdominal (laparotomy) incision because it allows for: Mandatory exploration and repair of associated intra-abdominal injuries (e.g., spleen, liver, bowel), which are highly prevalent. Reduction of herniated abdominal contents from the chest cavity. Direct repair of the diaphragmatic defect. The thoracic (thoracotomy) incision is reserved for: Chronic or delayed TDR (due to dense adhesions). Acute TDR where an overwhelming thoracic injury (e.g., major chest hemorrhage) is the primary concern. Most accurate evaluation is by CT scan (Option A). CT with multiplanar reconstruction is the best modality in stable patients for confirming diaphragmatic rupture and associated injuries. Operative repair is indicated in all cases (Option B) : All traumatic diaphragmatic ruptures, even small or asymptomatic ones, require surgery to prevent delayed herniation, strangulation, or obstruction. Defect closed with polypropylene sutures (Option D): Repair is done with non-absorbable sutures (polypropylene) in an interrupted/simple continuous fashion for strong, durable closure

References:

Bailey & Love Short Practice of Surgery, 28th Edition, Page. 377

↑ *Back to this question in Part A*

@Neet_pg_bot

Q3: A 35-year-old man presents to the casualty after being stabbed in the precordial region. He is in shock, with elevated jugular venous pressure and muffled heart sounds. Which of the following statements is incorrect? (Q880389)

A. Cardiac tamponade is the most likely diagnosis

B. If an open pneumothorax is suspected, the chest wound should be sealed completely on all four sides with an occlusive dressing

C. eFAST can identify fluid around the heart

D. Needle pericardiocentesis is not routinely recommended

Correct Answer: B. If an open pneumothorax is suspected, the chest wound should be sealed completely on all four sides with an occlusive dressing

Explanation: The combination of hypotension, jugular venous distension, and muffled heart sounds is known as Beck’s triad, which is strongly suggestive of cardiac tamponade. (Option A) Open pneumothorax wounds must be sealed on 3 sides only (to allow air to escape but prevent entry). Sealing on all 4 sides risks creating a tension pneumothorax The extended FAST (eFAST) examination can identify pericardial effusion or hemopericardium and helps confirm the diagnosis of tamponade . (Option C) Needle pericardiocentesis is no longer recommended as a routine treatment. Instead, emergency thoracotomy or creation of a pericardial window is the preferred approach . (Option D)

References:

SRB’s manual of surgery, 6th Edition, Page. 1113

↑ *Back to this question in Part A*

@Neet_pg_bot

Q4: A patient with blunt chest trauma undergoes tube thoracostomy. Which of the following best confirms that the intercostal drain is functioning properly? (Q880388)

A. Continuous air bubbles in the underwater seal

B. Oscillation of the water column in the tube

C. Chest X-ray

D. Auscultation

Correct Answer: B. Oscillation of the water column in the tube

Explanation: Proper functioning of an ICD is indicated by oscillation (swinging) of the water column in the underwater seal with respiration. Continuous air bubbling (Option A) suggests an air leak (bronchopleural fistula or tube not sealed). Chest X-ray shows tube position, but not its function. (Option C) Auscultation can detect lung expansion but is not reliable for ICD function (Option D)

References:

SRB’s manual of surgery, 6th Edition, Page. 1106

↑ *Back to this question in Part A*

@Neet_pg_bot

Q5: A 10-year-old child is brought to the emergency department after a road traffic accident. He is in severe respiratory distress with hypotension, tracheal deviation to the left, and absent breath sounds on the right side. What is the first-line management? (Q880387)

A. Insert a wide-bore needle in the 5th ICS anterior to the mid-axillary line

B. Insert a wide-bore needle in the 5th ICS in the mid-clavicular line

C. Insert a wide-bore needle in the 2nd ICS in the mid-axillary line

D. Insert a wide-bore needle in the 2nd ICS in the mid-clavicular line

Correct Answer: D. Insert a wide-bore needle in the 2nd ICS in the mid-clavicular line

Explanation: Tension pneumothorax (post-blunt chest trauma) presents with respiratory distress, hypotension, tracheal deviation, hyper-resonance, and absent breath sounds. Treatment consists of immediate decompression. Rapid insertion of a large-bore cannula into the second intercostal space in the mid-clavicular line of the affected side, followed by insertion of a chest tube through the fifth intercostal space in the anterior axillary line.

References:

Bailey & Love Short Practice of Surgery, 28th Edition, Page. 374

↑ *Back to this question in Part A*

@Neet_pg_bot

Q6: A 28-year-old man presents with pain and tenderness over the right upper chest after a fall from a motorcycle. Chest X-ray reveals a fracture of the right 3rd rib. Which of the following is not recommended in the management of an isolated rib fracture? (Q880386)

A. Provide opioid analgesia

B. Advise deep breathing

C. Advise frequent coughing

D. Strapping over the affected rib

Correct Answer: D. Strapping over the affected rib

Explanation: Rib fractures are usually managed conservatively with adequate analgesia, chest physiotherapy, incentive spirometry, and encouraging deep breathing/coughing to prevent atelectasis and pneumonia. Strapping or binding the chest is not recommended, as it restricts chest expansion and worsens pulmonary complications. Adequate pain relief (often opioids or NSAIDs) allows effective breathing and coughing.

References:

Sabiston’s principles of surgery, 21st Edition, Page. 407

↑ *Back to this question in Part A*

@Neet_pg_bot

Q7: A 35-year-old man suffers severe blunt chest trauma in a high-speed motorcycle accident. On arrival, he is tachycardic and hypotensive with unequal blood pressures in both upper limbs. Chest X-ray demonstrates mediastinal widening without evidence of lung injury. Which investigation is the most appropriate to confirm the diagnosis? (Q880383)

A. Transoesophageal echocardiography

B. CT angiography

C. MR angiography

D. Transthoracic echocardiography

Correct Answer: A. Transoesophageal echocardiography

Explanation: Transesophageal echocardiography (TEE/TOE) is preferred in unstable patients who cannot be shifted to CT because it can be done bedside with high sensitivity and specificity. CT angiography (Option B) is the gold standard and investigation of choice in hemodynamically stable patients. MR angiography (Option C): Highly sensitive, but impractical in the emergency setting—takes longer, not suitable for unstable trauma patients. Transthoracic echocardiography (Option D) is limited in evaluating the descending thoracic aorta due to poor acoustic windows; it is not reliable for diagnosing traumatic aortic injury.

References:

Sabiston’s principles of surgery, 21st Edition, Page. 406

↑ *Back to this question in Part A*

@Neet_pg_bot

Q8: A 38-year-old man arrives in the emergency department after sustaining a stab injury to the lower chest. He is bradycardic and hypotensive, not improving with IV fluids. Chest X-ray shows clear lung fields. What is the most appropriate next step in management? (Q880382)

A. eFAST

B. Tube thoracostomy

C. CECT chest

D. CECT abdomen

Correct Answer: A. eFAST

Explanation: In stab injuries to the lower chest, both cardiac tamponade and intra-abdominal bleeding must be suspected. Tube thoracostomy is indicated for hemothorax or pneumothorax . In this case, Clear lung fields on X-ray rule out major hemothorax/pneumothorax. (Option B) With persistent shock, the immediate next step is eFAST to assess for pericardial or peritoneal fluid. CT/ CECT is avoided in unstable patients (Option C & D)

References:

SRB's manual of surgery, 6th Edition, Page. 1098

↑ *Back to this question in Part A*

@Neet_pg_bot

Q9: A 32-year-old male arrives at the trauma bay with multiple penetrating injuries to the anterior and lateral neck following an assault. Which of the following would not warrant immediate surgical exploration? (Q880378)

A. Pulsatile bleeding

B. Respiratory distress

C. Fluid-responsive hemorrhagic shock

D. Air bubbling from penetrating injury

Correct Answer: C. Fluid-responsive hemorrhagic shock

Explanation: Fluid-responsive hemorrhagic shock can often be stabilized first; it is not by itself an indication for immediate surgery. Indications for neck exploration in injuries: Expanding haematoma; Uncontrolled external haemorrhage; Decreased carotid pulse; Strider, hoarseness, dysphonia, haemoptysis; Severe dysphagia, odynophagia; Blood in oropharynx. Pulsatile bleeding suggests arterial injury. (Option A) Respiratory distress suggests airway compromise . (Option B) Air bubbling from the wound suggests tracheal/airway breach . (Option D)

References:

SRB's manual of surgery, 6th Edition, Page. 137

↑ *Back to this question in Part A*

@Neet_pg_bot

Q10: Which of the following regarding acute spinal cord injury is incorrect? (Q880376)

A. Hypotension occurs due to loss of parasympathetic tone

B. Immediate respiratory compromise may result from phrenic nerve involvement

C. The Canadian C-Spine rule and NEXUS are used to assess the need for cervical spine imaging

D. Patients with neurological deficits should be shifted off the backboard as early as possible

Correct Answer: A. Hypotension occurs due to loss of parasympathetic tone

Explanation: In acute spinal cord injury, hypotension is due to loss of sympathetic tone, not parasympathetic tone. High cervical cord injury can involve the phrenic nerve (C3–C5), causing immediate respiratory compromise . (Option B) The Canadian C-spine rule and NEXUS are validated tools to decide the need for cervical spine radiographs/CT . (Option C) Patients with neurological deficits should be removed from the backboard early to prevent pressure sores and complications. (Option D)

References:

Sabiston’s principles of surgery, 21st Edition, Page. 526

↑ *Back to this question in Part A*

@Neet_pg_bot

Q11: A 30-year-old man is rescued after a road traffic accident with suspected cervical spine injury. The team decides to log roll him for safe transfer. According to ATLS guidelines, what is the minimum number of people required for this maneuver? (Q880375)

A. 3

B. 4

C. 5

D. 6

Correct Answer: B. 4

Explanation: Log-rolling in suspected spinal injury requires at least 4 people – one to stabilize the head and neck, and three to control the shoulders, pelvis, and legs. This ensures spinal alignment and prevents secondary injury.

References:

Bailey & Love Short Practice of Surgery, 28th Edition, Page. 391

↑ *Back to this question in Part A*

@Neet_pg_bot

Q12: While transferring a conscious patient with multiple injuries following a road accident, which of the following methods of transport is inappropriate? (Q880371)

A. Securing the thorax, abdomen, and lower limbs with straps on a stretcher

B. Positioning the patient prone to reduce aspiration risk

C. Shifting the patient in the lateral position for immediate transfer

D. Rolling the patient carefully onto a rigid spine board

Correct Answer: C. Shifting the patient in the lateral position for immediate transfer

Explanation: Every trauma patient should be treated as if they have a spinal injury until proven otherwise. Do not immediately shift a polytrauma patient to their side. This uncontrolled movement is extremely dangerous and risks causing further, potentially irreversible damage to the spinal cord. Spinal immobilization is the top priority to prevent paralysis. Strapping a patient to a rigid backboard secures the torso and limbs, stopping any movement during transport . (Option A) Placing the patient prone is a last resort to protect the airway from aspiration if a patient cannot be intubated, but it's done with great care to maintain spinal alignment (Option B) The log roll is a key technique for safely moving a patient with suspected spinal injuries onto a board while keeping the spine perfectly aligned . (Option D)

References:

Bailey & Love Short Practice of Surgery, 28th Edition, Page. 390

↑ *Back to this question in Part A*

@Neet_pg_bot

Q13: A 45-year-old male with a large right-sided pneumothorax and decreased breath sounds requires an intercostal chest drain (ICD). What is the most appropriate insertion site for the ICD? (Q849794)

A. 5th intercostal space, midclavicular line

B. 2nd intercostal space, midaxillary line

C. 5th intercostal space, anterior axillary line

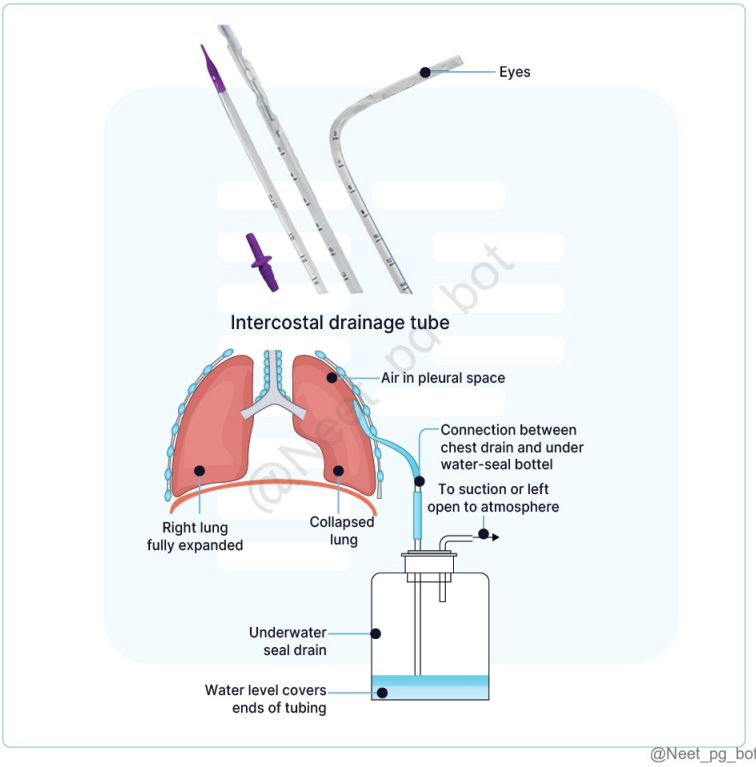
D. 2nd intercostal space, posterior axillary line

Correct Answer: C. 5th intercostal space, anterior axillary line

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: 5th intercostal space in the anterior axillary line is the safest and most common site for chest drain insertion. It lies within the “triangle of safety,” minimizing the risk of injury to vital structures. Safe Insertion Site: Triangle of Safety Anterior to mid-axillary line Above nipple level Below and lateral to pectoralis major Typically at the 5th intercostal space. Technique: Local Anaesthesia: Adequate to include pleura. Dissection: Sharp dissection: Skin only. Blunt dissection: Use artery forceps through muscle layers, particularly the serratus anterior, creating a short tunnel to reduce air entry. Drain Direction: Pneumothorax/Haemothorax: Towards lung apex. Pleural Effusion/Empyema: Near lung base. Avoid Neurovascular Bundle: Pass drain over the upper edge of the lower rib. Stitches: Secure retaining stitch, but don’t obstruct the drain. Vertical mattress suture: For pneumothorax Post-Insertion: Connect to an underwater seal device (one-way valve). Verify with a chest radiograph. Suction Consideration: Suction is not always necessary and can worsen air leaks in fragile lungs or shift the mediastinum. Avoid clamping a bubbling drain unless necessary.



References:

Bailey & Love’s Short Practice of Surgery, 28th Edition, Pages 980, 981

↑ *Back to this question in Part A*

Q14: A 25 y/o male is brought to the ED after an explosion at a construction site. He was close to the blast and submerged in water. He has severe abdominal pain, difficulty hearing, shortness of breath, unstable vitals, and ruptured tympanic membranes on examination. Which organ is most severely damaged in this scenario? (Q849793)

A. Lungs

B. Limbs

C. Gastrointestinal tract

D. Brain

Correct Answer: C. Gastrointestinal tract

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Underwater blasts cause more significant damage to the gastrointestinal tract due to the pressure impact on hollow organs, making it the most severely affected organ in this scenario. Blast injuries primarily damage air-containing organs because rapid pressure changes disrupt tissues at air–tissue interfaces. Underwater blasts particularly injure the gastrointestinal tract , as pressure waves affect hollow organs, causing perforations (especially in the colon). Most vulnerable: Eardrum (tympanic membrane): ruptures easily. Lungs: prone to barotrauma (contusion, hemorrhage, pneumothorax). GI tract: hollow organs are severely affected. Least affected: Solid organs like the liver and spleen , which resist pressure due to the absence of air–tissue interfaces. Lungs (Option A) are commonly injured in air blast injuries Limbs and Brain (Option B & D): While the limbs and brain can be affected in blast injuries, they are not the most severely injured organs in underwater blasts.

References:

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www.msdmanuals.com/en-in/professional/injuries-poisoning/

www.ncbi.nlm.nih.gov/pmc/articles/PMC4659630/

↑ *Back to this question in Part A*

Q15: A 32 y/o male presents after a car accident with severe chest and abdominal pain. O/E there are decreased breath sounds on the left side and abdominal tenderness. Chest X-ray reveals bowel gas patterns in the left thoracic cavity. A nasogastric tube is placed, and its tip is seen in the thoracic cavity. What is the most appropriate next step in management? (Q849792)

A. Initiate conservative management and observe the patient.

B. Emergency laparotomy.

C. Order a CT scan of the chest and abdomen for further evaluation.

D. Schedule an elective surgery.

Correct Answer: B. Emergency laparotomy.

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The presence of bowel gas patterns in the thoracic cavity and the nasogastric tube in the chest are clear indicators of diaphragmatic rupture with herniation of abdominal contents into the chest cavity. Emergency laparotomy is necessary to repair the diaphragm and reduce the risk of complications like strangulation. Initiate conservative management and observe the patient (Option A): Diaphragmatic injuries, especially with herniation of abdominal contents into the chest, require operative repair due to the risk of strangulation and other complications. Conservative management is not appropriate in this scenario. Order a CT scan of the chest and abdomen for further evaluation (Option C): Although a CT scan can provide additional information, the diagnosis of diaphragmatic rupture with herniation is already clear from the chest X-ray and nasogastric tube findings. Schedule an elective surgery (Option D): Elective surgery is not appropriate in the presence of acute diaphragmatic injury with herniation of abdominal contents. Immediate surgical intervention is required to prevent complications.

References:

Bailey & Love’s Short Practice of Surgery, 28th Edition, Page 377

Sabiston Textbook of Surgery, 21st Edition, Page 411

↑ *Back to this question in Part A*

@Neet_pg_bot

Q16: A 45 y/o male presents to the emergency department after a motor vehicle accident. He is tachypneic, has severe chest pain, and paradoxical chest wall movement is noted on physical examination. His oxygen saturation is 85% on room air. A chest X-ray shows multiple rib fractures on the left side. What is the most appropriate initial management for this patient? (Q849791)

A. Tracheostomy

B. Intercostal tube drainage

C. Positive pressure ventilation

D. Thoracotomy

Correct Answer: C. Positive pressure ventilation

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The patient’s trauma history, followed by the examination findings points towards the diagnosis of a flail chest . Positive pressure ventilation is the appropriate initial management in such cases. Tracheostomy (Option A) if support exceeds 10 days. Intercostal tube drainage (Option B) is used for pneumothorax or hemothorax, which may accompany the flail chest. However, without these complications, immediate airway management and stabilization are more crucial given the severity of the respiratory distress. Thoracotomy (Option D) is reserved for massive hemothorax, persistent air leaks, or severe thoracic injuries that cannot be managed conservatively. It is not the initial treatment for flail chest with respiratory distress unless other severe complications are present.

References:

SRB’s Manual of Surgery, 6th Edition, Pages 1100, 1101

Bailey and Love’s Short Practice of Surgery, 28th edition, Page 375

↑ *Back to this question in Part A*

@Neet_pg_bot

Q17: In a patient with raised intracranial pressure (ICP) that remains elevated despite initial management, which of the following strategies is considered a second-tier therapy for refractory cases? (Q849783)

A. Elevate the head end of the bed to 30°.

B. Administer mannitol to maintain serum osmolality < 320 mOsm/kg.

C. Perform a decompressive craniectomy.

D. Start therapeutic hyperventilation.

Correct Answer: C. Perform a decompressive craniectomy.

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Decompressive craniectomy is categorized as a second-tier therapy for managing refractory elevated ICP, used when initial treatments fail to control the pressure. This surgical intervention involves removing part of the skull to allow the brain to expand and decrease ICP. Management Strategies: Positioning : Elevate the head end of the bed to 30°: Promotes cerebral venous drainage and decreases ICP. (Option A ruled out) Osmotherapy : Mannitol: Maintain serum osmolality < 320 mOsm/kg to draw fluid out of the brain. (Option B ruled out) 2.5% Saline: Hypertonic saline solution to reduce cerebral oedema. Hyperventilation : Therapeutic Hyperventilation: Used only for short periods to decrease CO■ levels and reduce ICP. (Option D ruled out) Second-Tier Therapies (for refractory elevated ICP) : Decompressive Craniectomy : Surgical removal of a portion of the skull to allow brain expansion and reduce ICP. High-Dose Barbiturate Therapy : Reduces neuronal metabolism and increases neuron longevity

References:

www.ncbi.nlm.nih.gov/pmc/articles/PMC4923559/

www.researchgate.net/publication/283895411

Bailey and Love Short Practice of Surgery, 28th Edition, Page 368

Schwartz Textbook of Surgery, 11th edition, Page 218

↑ *Back to this question in Part A*

@Neet_pg_bot

Q18: A 35 y/o man with a head injury, scalp laceration, headache, skull depression, and CT showing an intracranial hematoma and frontal sinus involvement presents to the emergency department. What is the most appropriate management? (Q849775)

A. Monitor and allow spontaneous healing with no immediate intervention.

B. Order a follow-up CT scan in 24 hours to reassess the extent of the injuries.

C. Perform operative debridement and repair the scalp, and consider craniotomy

D. Administer antibiotics and provide supportive care without any surgical intervention.

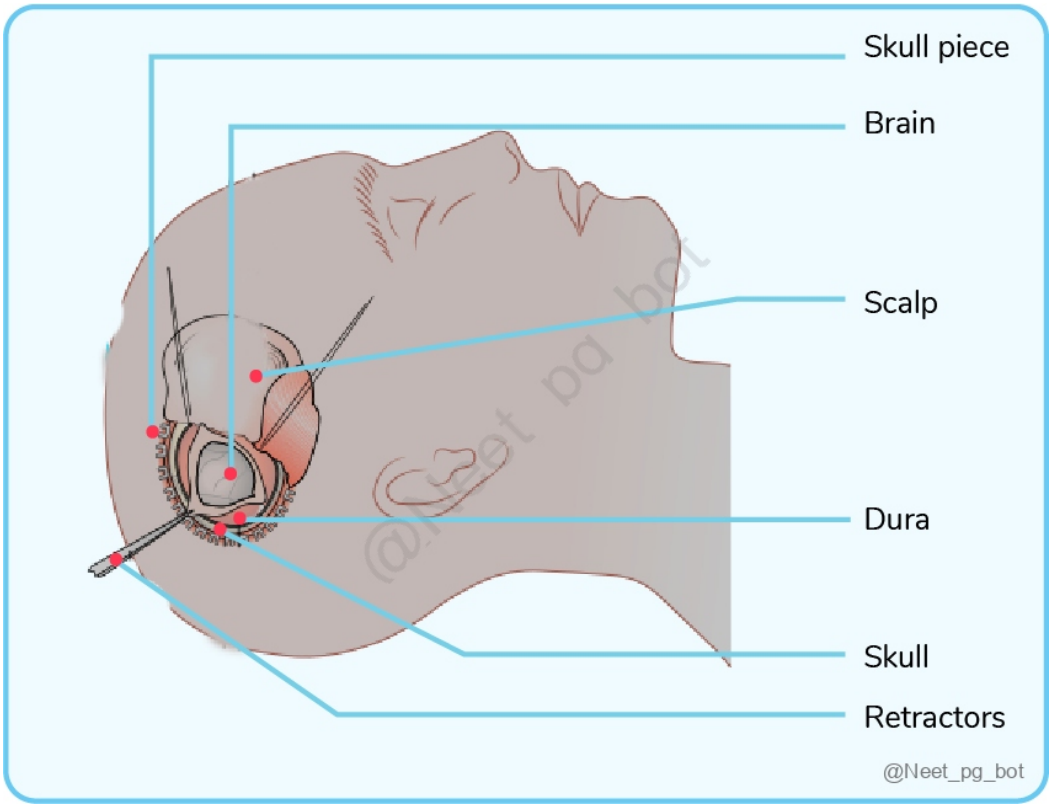
Correct Answer: C. Perform operative debridement and repair the scalp, and consider craniotomy

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: For open skull fractures with scalp disruption, operative debridement and repair are crucial to prevent infection. Additionally, a craniotomy is indicated to address the depressed skull fracture and intracranial hematoma, which can create pressure on the brain and lead to serious complications. Monitor and allow spontaneous healing with no immediate intervention (Option A): This option is more appropriate for closed skull

fractures where the skin remains intact, and there is no exposure to the brain. Order a follow-up CT scan in 24 hours to reassess the extent of the injuries (Option B): Although follow-up imaging may be useful in some cases, it is not the immediate priority here. Administer antibiotics and provide supportive care without any surgical intervention (Option D): Antibiotics and supportive care are essential components of treatment but are not sufficient alone for an open skull fracture with associated complications like depression and hematoma.



References:

pubmed.ncbi.nlm.nih.gov/16540744/

my.clevelandclinic.org/health/diseases/skull-fracture

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↑ *Back to this question in Part A*

@Neet_pg_bot

Q19: A 25 y/o male presents to the emergency department after being struck on the head by a small, high-velocity object. He is conscious but reports a severe headache. A CT scan reveals a depressed skull fracture with evidence of intracranial air. Which of the following is the most appropriate next step in management? (Q849776)

A. Conservative management with observation.

B. Surgical exploration and elevation of the depressed fracture.

C. Intravenous antibiotics without surgery.

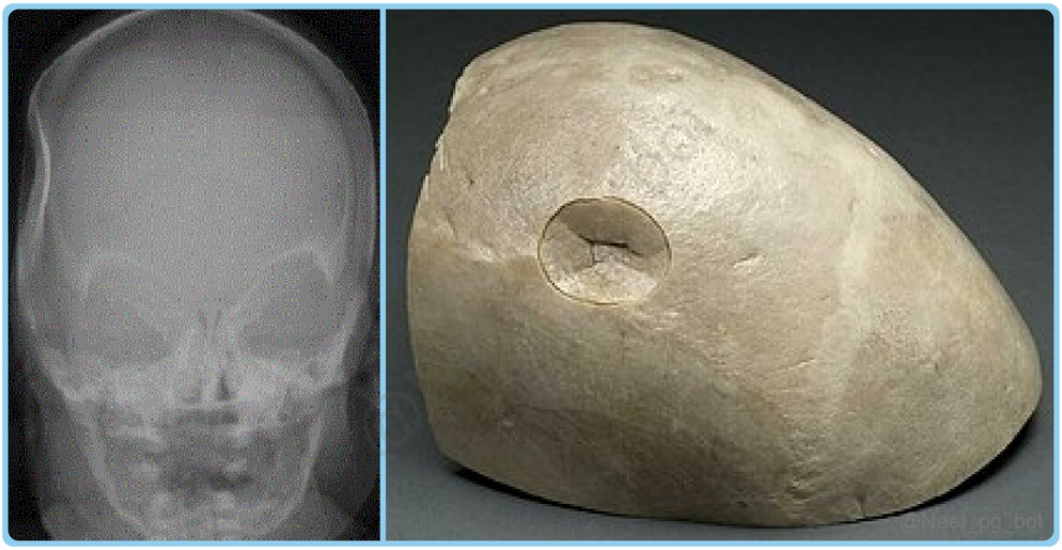
D. Application of a pressure dressing to the fracture site.

Correct Answer: B. Surgical exploration and elevation of the depressed fracture.

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Depressed skull fractures involve the inward displacement of a bone fragment by at least the thickness of the skull. The recommended management for these is surgical exploration and elevation, particularly when intracranial air indicates a dural breach. Surgery helps to reduce the risk of infection, address neurological damage, and correct the deformity. Management Require surgical exploration and elevation. Intracranial air (indicating a dural breach) necessitates surgery. Open fractures (e.g., involving air sinuses) are managed with surgical exploration and broad-spectrum antibiotics. Conservative management with observation (Option A): This is not appropriate for a depressed skull fracture, especially with intracranial air. Intravenous antibiotics without surgery (Option C): Intravenous antibiotics alone are insufficient; surgical intervention is necessary for a depressed fracture with intracranial air. Application of a pressure dressing to the fracture site (Option D) is inappropriate as it does not address the need for surgical elevation or potential dural breach.



References:

Bailey & Love’s Short Practice of Surgery, 28th Edition, Pages 364, 365

↑ *Back to this question in Part A*

@Neet_pg_bot

Q20: A 32 y/o male presents to the emergency department after a high-impact motor vehicle accident. He complains of a severe headache, difficulty smelling, and clear fluid dripping from his nose. O/E, there is no external evidence of trauma, but the patient has a subconjunctival haemorrhage in the right eye. What is the most likely location of his skull fracture? (Q849777)

A. Anterior cranial fossa

B. Middle cranial fossa

C. Posterior cranial fossa

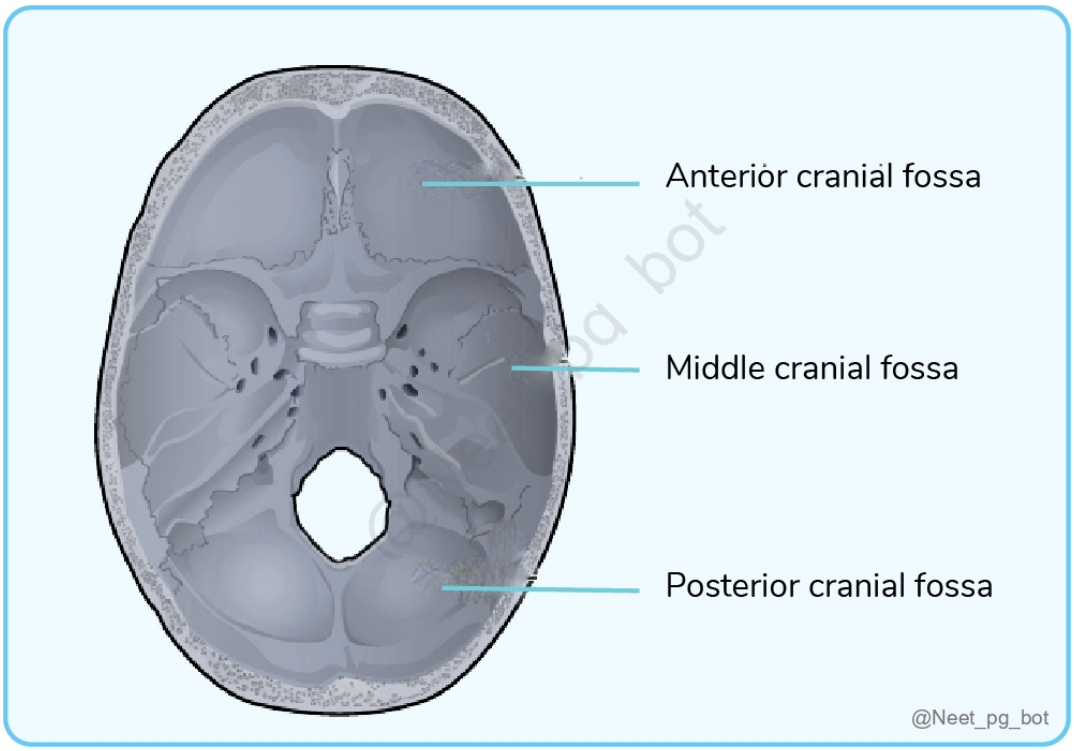
D. Occipital bone

Correct Answer: A. Anterior cranial fossa

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: This is the most likely location of the fracture (Fx), given the patient's symptoms of anosmia (loss of smell), CSF rhinorrhea (clear fluid leaking from the nose), and subconjunctival haemorrhage . These are hallmark signs of an anterior cranial fossa fracture, which often involves the cribriform plate and can affect the olfactory and optic nerves. Cranial Fossa Fractures: Fracture locations: Anterior Cranial Fossa Middle Cranial Fossa (Option B ruled out) Posterior Cranial Fossa (Option C ruled out) About Fx of cribriform plate. Fx of maxillary, sphenoid, or other sinus cavities. Less common. Clinical features CSF rhinorrhea Subconjunctival hemorrhage. Cranial nerve damage leading to: Anosmia (CN I damage) Partial or complete blindness (CN II or III damage) CSF otorrhea Epistaxis Cranial nerve damage leading to: Inward deviation of the eye (CN VI damage). Facial muscle weakness (CN VII damage). Hearing loss, vertigo (CN VIII damage). Boggy swelling at the nape of the neck. Cranial nerve damage leading to: Difficulty swallowing, hoarseness, and muscle weakness (CN XI, X. XI damage). Management: Conservative management: For fractures without significant intracranial injury or those near dural venous sinuses. Craniotomy and elevation: Surgical intervention to elevate depressed bone fragments and address underlying injuries. Occipital bone (Option D): Fractures of the occipital bone are usually associated with trauma to the back of the head and can lead to issues like visual disturbances or cervical spine injuries. The symptoms in this patient do not suggest an occipital bone fracture.



References:

SRB's Manual of Surgery, 6th Edition, Page 1084

↑ *Back to this question in Part A*

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Q21: A 68 y/o male on warfarin therapy presents to the emergency department after a fall from a ladder. He is fully conscious with a Glasgow Coma Scale (GCS) score of 15. He reports no loss of consciousness but is unable to recall events that happened before the fall. According to NICE guidelines, what is the most appropriate timing for a CT head scan in this patient? (Q849778)

A. Immediate CT scan within 1 hour

B. CT scan within 8 hours

C. CT scan within 24 hours

D. No need for a CT scan; observation only

Correct Answer: B. CT scan within 8 hours

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: According to NICE guidelines , a CT scan should be performed within 8 hours If the patient is older than 65, Has a coagulopathy (e.g., on warfarin therapy), Has experienced a dangerous mechanism of injury (such as a fall from a height), Has retrograde amnesia(inability to recall events before the amnesia-causing event) lasting more than 30 minutes. This patient meets multiple criteria, making a CT scan within 8 hours the appropriate management. Neurological Observation and NICE Guidelines for CT Head Imaging: Aspect Details Neurological Observation in TBI (Traumatic Brain Injury) Crucial for managing moderate to severe TBI. Key Assessments: Glasgow Coma Scale (GCS) score and pupil responses. Note the extent of retrograde and anterograde amnesia. Initial: Half-hourly for 2 hours. Follow-up: Hourly for 4 hours, then every 2 hours. If Deterioration: Return to half-hourly and resume the original schedule. NICE Guidelines for CT Head Imaging in Adults CT within 1 Hour: (Option A ruled out) GCS < 13 at any time. GCS < 15 at 2 hours post-injury. Focal neurological deficit. Suspicion of open, depressed, or basal skull fracture. Multiple vomiting episodes. Post-traumatic seizure. CT within 8 Hours: Age > 65. Coagulopathy (e.g., aspirin, warfarin use). Dangerous mechanism of injury. Retrograde amnesia > 30 minutes. NICE Guidelines for CT Head Imaging in Children Immediate CT: Suspicion of non-accidental injury. First seizure. GCS < 14, or < 15 in children < 1 year old. Signs of skull base fracture. Focal neurological deficit. Bruising, swelling, or laceration > 5 cm in children < 1 year old. Additional Criteria (If Multiple Present): Loss of consciousness > 5 minutes. Abnormal drowsiness. ≥4 vomiting episodes. Dangerous mechanism of injury. Amnesia > 5 minutes. Additional Notes These lists are not exhaustive; clinical judgment should be used in deciding whether to order a CT scan. CT scan within 24 hours (Option C): There is no recommendation in the NICE guidelines for a CT scan within 24 hours.

References:

Bailey & Love’s Short Practice of Surgery, 28th Edition, Pages 362, 363, 369

NICE guidelines for neurological observation

↑ *Back to this question in Part A*

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Q22: A 20 y/o male footballer sustains a blow to the head during a match. He did not lose consciousness but appeared confused and had difficulty recalling events before the impact. O/E, he is slow to respond and exhibits slight incoordination while walking. It is determined that he has suffered a concussion. Which of the following statements is most appropriate regarding his management? (Q849779)

A. He should be allowed to return to play if he feels better after 15 minutes.

B. An immediate CT scan is required to rule out a cerebral contusion.

C. He should be monitored for second-impact syndrome if he returns to play prematurely.

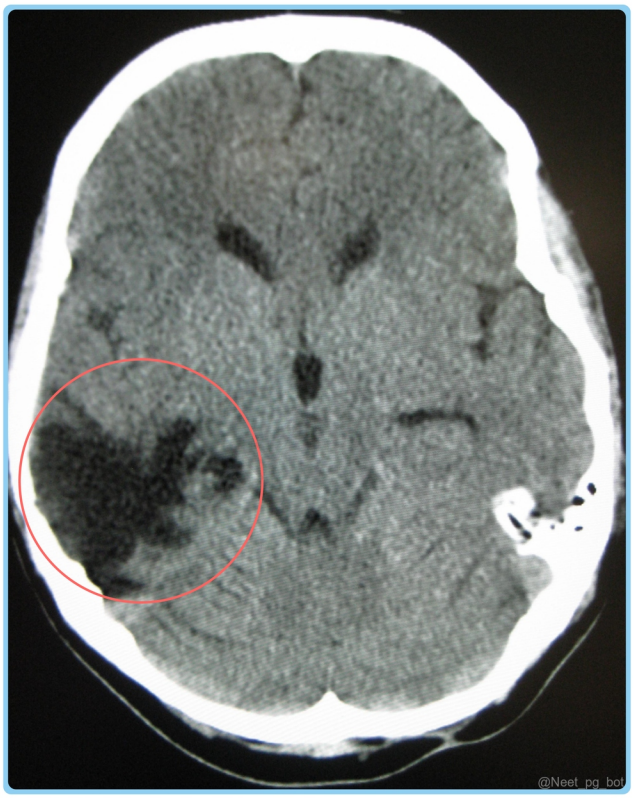
D. A diagnosis of concussion is unlikely since there was no loss of consciousness.

Correct Answer: C. He should be monitored for second-impact syndrome if he returns to play prematurely.

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Second impact syndrome is a rare but serious condition that can occur if a person sustains a second head injury before fully recovering from a concussion. Therefore, it is crucial to monitor for this and advise the patient to avoid returning to play until asymptomatic . (Option A ruled out) Concussion and Cerebral Contusions: Aspect Details Concussion Defined as an alteration of consciousness due to a closed head injury, typically without imaging abnormalities. Confusion, amnesia, lethargy, distractibility, forgetfulness, slow interaction, emotional lability, gait disturbance, and incoordination. Loss of consciousness is not required for diagnosis. Cerebral Autoregulation: May be impaired, increasing vulnerability to repeat impacts. Second Impact Syndrome A rare but potentially fatal condition involving malignant brain swelling after a trivial repeat injury in someone with a recent concussion (fatal). Advisory: Individuals, especially athletes, should avoid returning to play until fully asymptomatic. Postconcussive Syndrome A set of long-term symptoms following a concussion. Somatic Symptoms: Headache, dizziness, hearing and vision disorders. Neurocognitive/Neuropsychological Symptoms: Difficulty with concentration and recall, insomnia, emotional lability, fatigue, depression, and personality changes. Cerebral Contusions Commonly occur where the brain contacts the skull (eg., inferior frontal lobes, temporal poles). Can occur distant from the impact site due to brain movement (coup-contrecoup injury). CT Appearance: Heterogeneous, due to mixed injured brain matter and blood. Management: Rarely require surgery but may be evacuated to reduce the mass effect. An immediate CT scan is required to rule out a cerebral contusion (Option B): While CT scans can be useful, they aren’t always necessary for concussions unless there are red flags like worsening neurological symptoms, focal deficits, or significant mechanism of injury. A diagnosis of concussion is unlikely since there was no loss of consciousness (Option D): A concussion can occur without any loss of consciousness. The presence of confusion, amnesia, and other symptoms like incoordination are key indicators of concussion.



References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Pages 362, 367

↑ *Back to this question in Part A*

@Neet_pg_bot

Q23: A 45 y/o male presents to the ED after a head injury sustained in a motor vehicle accident. He briefly lost consciousness at the scene but was alert and oriented upon arrival. A few hours later, he becomes progressively drowsy, and his right pupil is dilated. A CT scan shows the following findings. What is the most likely diagnosis? (Q849780)

A. Subdural Hematoma (SDH)

B. Epidural Hematoma (EDH)

C. Intracerebral Haemorrhage (ICH)

D. Cerebral Contusion

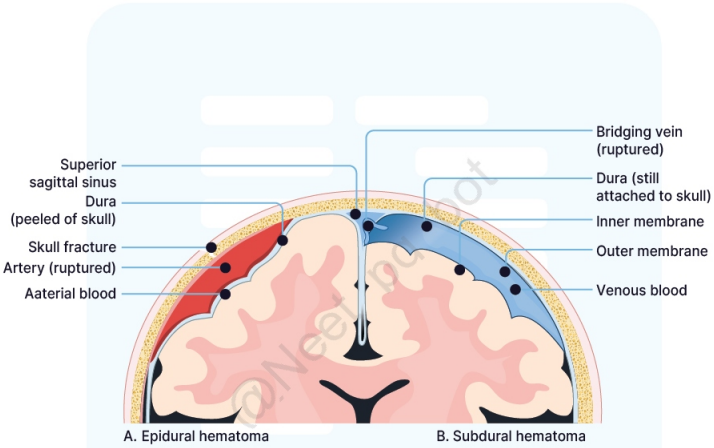


Correct Answer: B. Epidural Hematoma (EDH)

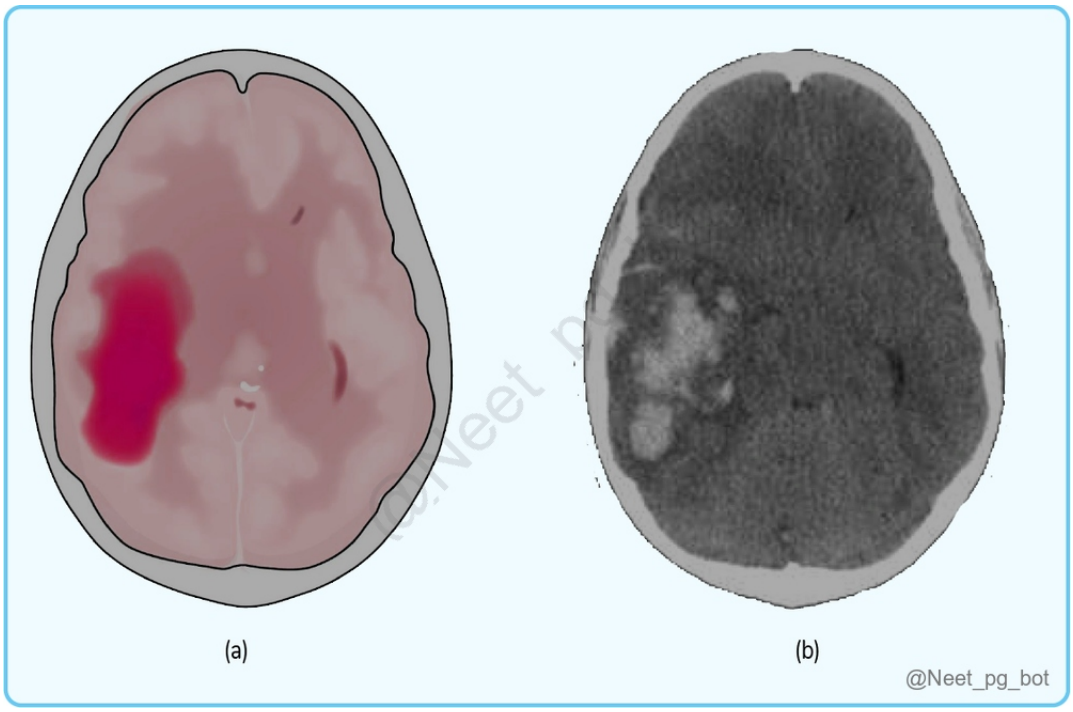
- *Listen (English)*
- *Listen (Hindi)*

Explanation: EDH is classically associated with a transient loss of consciousness followed by a lucid interval and then rapid neurological deterioration, as seen in this patient. The CT image shows a biconvex (lens-shaped) hyperdense lesion that is characteristic of EDH, usually due to arterial bleeding, often from the middle meningeal artery. Subdural hematoma Intracerebral Haemorrhage (ICH) (Option C): ICH typically presents with sudden-onset focal deficits and is usually associated with hypertension or trauma. The CT appearance is a hyperdense lesion within the brain parenchyma, not the biconvex shape described here. This makes ICH less likely in this context. Cerebral Contusion (Option D): Contusions appear as heterogeneous areas of mixed density on CT, reflecting injured brain tissue and blood. They are typically linked to coup-contrecoup injuries and lack the lucid interval and rapid deterioration seen in epidural hematomas (EDH).


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Superior sagittal sinus
Dura (peeled of skull)
Skull fracture
Artery (ruptured)
Aaterial blood
Bridging vein (ruptured)
Dura (still attached to skull)
Inner membrane
Outer membrane
Venous blood
A. Epidural hematoma
B. Subdural hematoma

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References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Pages 365, 366, 367, 711

↑ *Back to this question in Part A*

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Q24: A 60 y/o male suddenly experiences an intense headache, described as the worst headache of his life, followed by vomiting and photophobia. O/E he has neck stiffness and a dilated pupil on the right side. A CT scan reveals bleeding in the subarachnoid space. Which of the following is the most common cause of this condition? (Q849781)

A. Hypertension

B. Intracranial aneurysm

C. Arteriovenous malformation (AVM)

D. Brain tumour

Correct Answer: B. Intracranial aneurysm

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The clinical scenario described is highly indicative of a subarachnoid haemorrhage (SAH), which is characterized by the sudden onset of a severe headache, vomiting, photophobia, neck stiffness, and neurological signs such as a dilated pupil. The most common cause of subarachnoid haemorrhage (SAH) is the rupture of an intracranial aneurysm , responsible for about 50% of cases. Most Common Cause Overall: Trauma (Head injury).

References:

SRB's Manual of surgery, 6th edition, Pages 1083,1084

Bailey and Love Short manual of surgery, 28th Edition, Pages 708-711

↑ *Back to this question in Part A*

@Neet_pg_bot

Q25: A 35-year-old male in a high-speed crash presents with sudden loss of consciousness and remains comatose with neurological deficits, despite normal CT findings. What is the most likely diagnosis? (Q849782)

A. Contusion

B. Subdural hematoma

C. Diffuse axonal injury (DAI)

D. Epidural hematoma

Correct Answer: C. Diffuse axonal injury (DAI)

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Diffuse axonal injury (DAI) is consistent with the clinical presentation of a coma and persistent neurological deficits despite normal CT findings. DAI is caused by rotational forces and is often not well-visualized on CT but can be detected on MRI, making it the most likely diagnosis in this scenario. Contusions (Option A) are localized brain injuries resulting from direct impacts, which typically show visible haemorrhages and bruising on CT. The scenario describes a lack of clear findings on CT, making contusion less likely. Subdural hematomas (Option B) are typically associated with venous bleeding and can be visible on CT, often presenting with a crescent-shaped haemorrhage. Epidural hematomas (Option D) typically present as a lens-shaped haemorrhage on CT, usually associated with a skull fracture and more acute changes in consciousness.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 368

Schwartz Textbook of Surgery, 11th edition, Page 1837

↑ *Back to this question in Part A*

Q26: Match each description with the correct layer of the scalp: 1. Pericranium a) Richly vascularized 2. Aponeurosis b) Periosteum 3. Skin c) Danger zone 4. Connective Tissue d) Connects scalp muscles 5. Loose Areolar Connective Tissue e) Sebaceous glands (Q849665)

A. 1-d, 2-e, 3-c, 4-b, 5-a

B. 1-c, 2-d, 3-b, 4-d, 5-a

C. 1-e, 2-b, 3-a, 4-d, 5-c

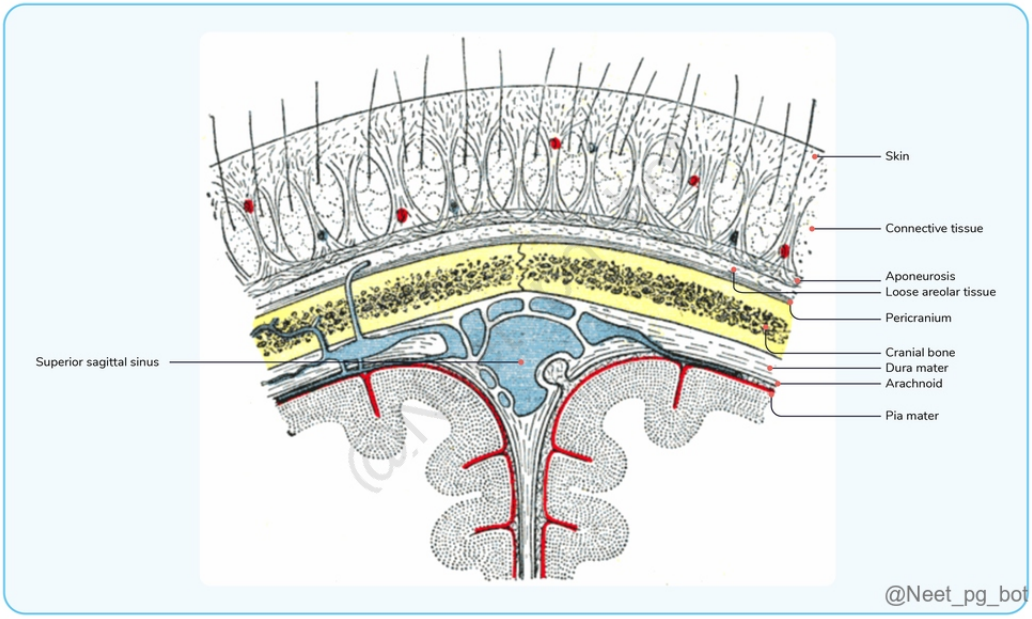
D. 1-b, 2-d, 3-e, 4-a, 5-c

Correct Answer: D. 1-b, 2-d, 3-e, 4-a, 5-c

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Layer Description Skin The outermost layer; contains hair follicles and sebaceous glands that produce sebum for lubrication and protection. Connective Tissue Dense layer with blood vessels, nerves, and fat; richly vascularized , leading to significant bleeding from injuries. Aponeurosis A tough fibrous layer (epicranial aponeurosis or galea aponeurotica); connects frontalis and occipitalis muscles for scalp movement. Loose Areolar Connective Tissue It allows mobility between the upper layers and the pericranium; it is considered a "danger zone" due to the potential for infection to spread via the emissary veins (from the scalp to the meninges). Pericranium The innermost layer; the periosteum of the skull bones; provides nourishment and protection to the skull.



References:

emedicine.medscape.com/article/834808

www.ncbi.nlm.nih.gov/books/NBK540961/

↑ *Back to this question in Part A*

@Neet_pg_bot

Q27: A 30 y/o woman sustains a stab wound in the neck that is located just above the cricoid cartilage but below the angle of the mandible. The injury is causing severe bleeding, and there is concern about the potential involvement of vital neck structures. Which neck zone is most relevant for assessing potential injury to major blood vessels and the trachea in this patient? (Q849784)

A. Zone I

B. Zone II

C. Zone III

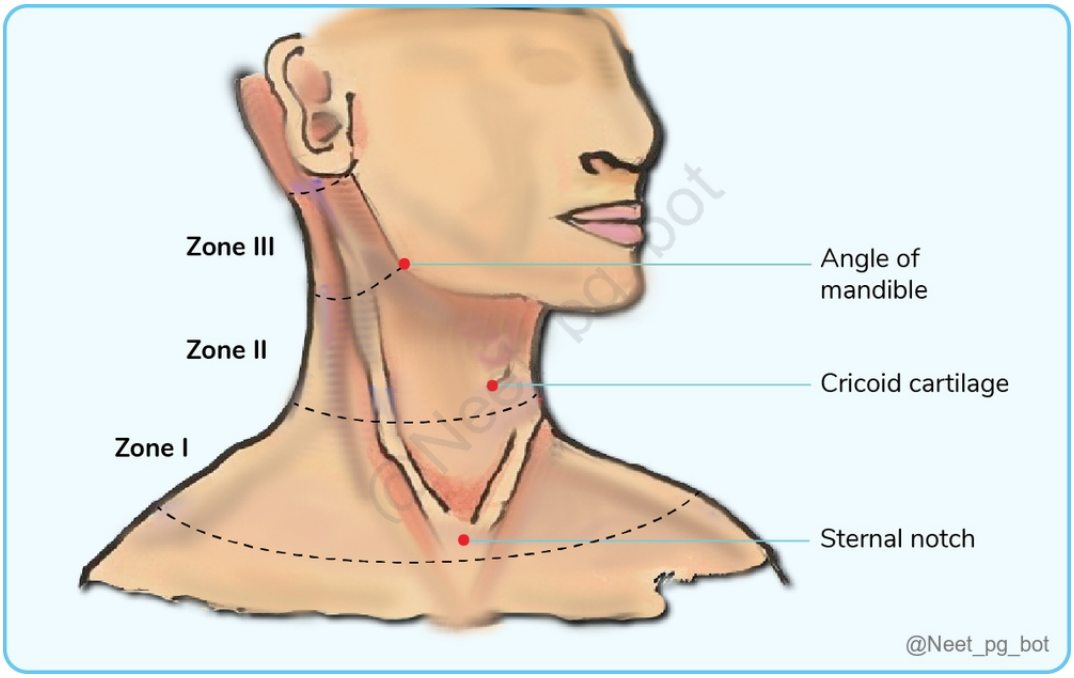
D. Zone IV

Correct Answer: B. Zone II

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The described injury location, between the cricoid cartilage and the angle of the mandible, corresponds to Zone II. Zones of Neck Injuries Zone of Neck Location Contents Features Zone II Between the cricoid cartilage and the angle of the mandible. Carotid and vertebral arteries Internal jugular veins Trachea Esophagus Largest zone Most commonly injured Relatively easy access for clinical examination and surgical exploration.



References:

www.ncbi.nlm.nih.gov/books/NBK470422/

↑ *Back to this question in Part A*

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Q28: A 67 y/o man collapses and requires cardiopulmonary resuscitation (CPR) in the emergency department. After successful resuscitation, imaging reveals a rib fracture. Which rib is most commonly fractured during CPR? (Q849785)

A. 1st rib

B. 2nd rib

C. 5th rib

D. 11th rib

Correct Answer: C. 5th rib

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The 5th rib is most commonly fractured during CPR due to its location in the middle of the ribcage where chest compressions are applied with significant force. Rib Fractures (Fx) Rib fractures can be traumatic or atraumatic. Most rib fractures are due to direct penetrating or blunt trauma to the chest. Fx of ribs 1-3: Occurs due to high-energy trauma. (Options A & B) Fx of ribs 4-10: Most common. Fx of ribs 11,12: Difficult, since they are very mobile. (Option D)

References:

radiopaedia.org/articles/rib-fractures

www.physio-pedia.com/Rib_Fracture

↑ *Back to this question in Part A*

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Q29: A 55 y/o female was involved in a motor vehicle collision and now complains of severe anterior chest pain. O/E, she has point tenderness over the sternum and visible ecchymosis. What is the most likely associated injury that should be evaluated in a patient with a sternal fracture? (Q849786)

A. Rib fractures

B. Pulmonary contusion

C. Myocardial contusion

D. Pneumothorax

Correct Answer: C. Myocardial contusion

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Sternal fractures, especially those caused by high-impact trauma such as motor vehicle collisions, are often associated with other significant injuries due to the force required to cause the fracture. Myocardial contusion is a common and serious associated injury, given the proximity of the sternum to the heart. This makes it a critical condition to assess for in patients with sternal fractures. While rib fractures (Option A ruled out) , pulmonary contusions (Option B ruled out) , and pneumothorax (Option D ruled out) are also possible, myocardial contusion is particularly concerning due to its potential impact on cardiac function and its association with blunt chest trauma.

References:

Sternal fractures

Bailey and Love Short Practice of surgery, 28th edition, Page 400

Schwartz Textbook of Surgery, 11th edition, Page 1304

↑ *Back to this question in Part A*

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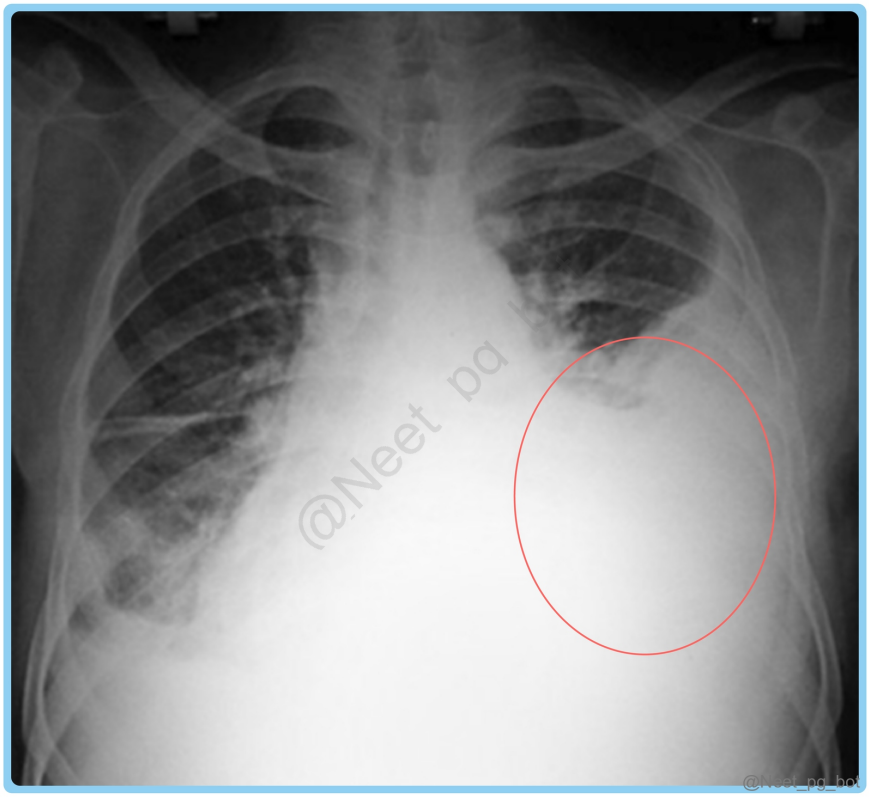
Q30: A 34 y/o male presents to the ER after a high-speed car collision. He complains of severe shortness of breath, and physical examination reveals absent breath sounds on the lower left side with a dull note on percussion. The chest X-ray is given below. Which of the following is the most appropriate next step in management? (Q849787)

A. Needle thoracostomy

B. ICD (Intercostal Drain) insertion

C. Immediate thoracotomy

D. Observation and serial chest X-rays

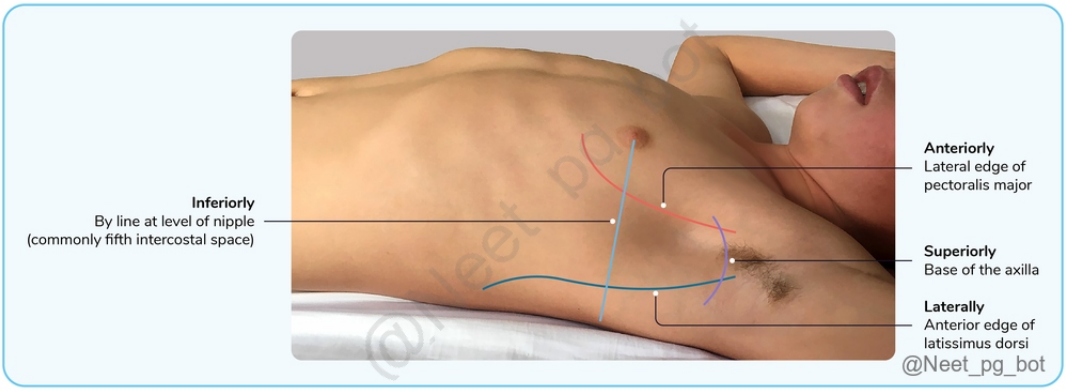


Correct Answer: B. ICD (Intercostal Drain) insertion

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The combination of trauma + dyspnea + dullness on percussion + absent breath sounds + CXR showing opaque hemithorax with mediastinal shift is classic for left hemothorax. First-line management in a hemodynamically stable or borderline-stable patient is immediate tube thoracostomy (ICD), both for therapeutic drainage and for quantifying blood loss. ICD allows assessment of: Immediate drain output (>1500 mL suggests need for thoracotomy) Rate of ongoing bleeding (>200–250 mL/h for 3 hours also indicates thoracotomy) Management ICD (Intercostal drain) insertion in the 5 th intercostal space in the anterior axillary line. Needle thoracostomy (Option A) is primarily used for tension pneumothorax, not indicated in this scenario. Immediate thoracotomy (Option C) is reserved for massive bleeding or unstable patients after initial drainage efforts. Observation and serial chest X-rays (Option D) are inadequate for a potentially serious pleural abnormality that requires immediate intervention.



References:

Hemothorax

Triangle of safety

Bailey and Love Short manual of surgery, 28th Edition, Page 981

↑ *Back to this question in Part A*

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Q31: A 45 y/o male presents with severe chest trauma following a motor vehicle accident. After inserting a chest tube, the initial drainage is 1600 ml of blood, and he continues to drain over 200 ml/hour for the next three hours despite stabilization efforts. What is the most appropriate next step in management? (Q849788)

A. Increase the suction on the chest tube

B. Administer intravenous fluids and continue observation

C. Perform an urgent thoracotomy

D. Insert a second chest tube

Correct Answer: C. Perform an urgent thoracotomy

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: An urgent thoracotomy is indicated for initial tube drainage >1500 ml in blunt trauma or persistent drainage >200 ml/hour for 3 consecutive hours as seen in this patient. Indications for thoracotomy Initial tube thoracostomy drainage > 1000 ml in Penetrating trauma > 1500 ml in Blunt trauma Persistent tube thoracostomy drainage More than 200 ml/hour for 3 consecutive hours in non-coagulopathic patients (In clotted hemothorax- first the clot is liquified, then thoracotomy is performed) Increase the suction on the chest tube (Option A): Suction adjustment won't address ongoing massive bleeding. Administer intravenous fluids and continue observation (Option B): Observation is inadequate given the significant ongoing blood loss. Insert a second chest tube (Option D): Not appropriate for controlling ongoing massive haemorrhage that requires surgical intervention.

References:

emedicine.medscape.com/article/82584

www.ncbi.nlm.nih.gov/books/NBK557600/

SRB’s Manual of Surgery, 6th Edition, Page 1102

SRB’s Surgical Operations, Page 205

Bailey and Love Short manual of surgery, 28th Edition, Page 987

↑ *Back to this question in Part A*

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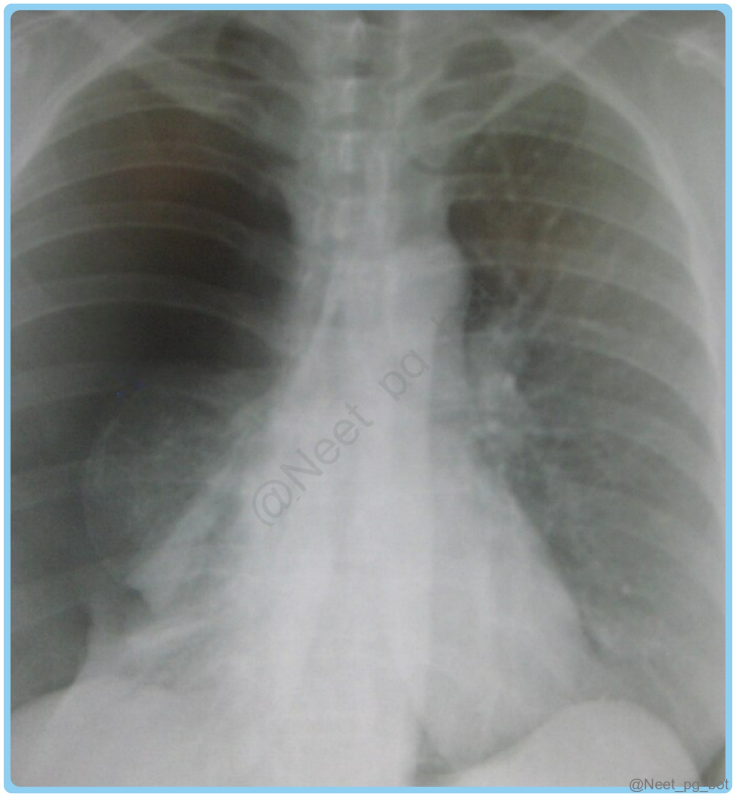
Q32: A 45 y/o man presents to the ED after a fall from a height. He is in severe respiratory distress, with rapid breathing. An x-ray film was taken of the chest which revealed the following. His blood pressure is rapidly dropping. Which of the following findings is least likely to be associated with this patient's condition? (Q849789)

A. Hyper-resonance on the affected side

B. Tracheal deviation towards the opposite side

C. Bilateral equal breath sounds

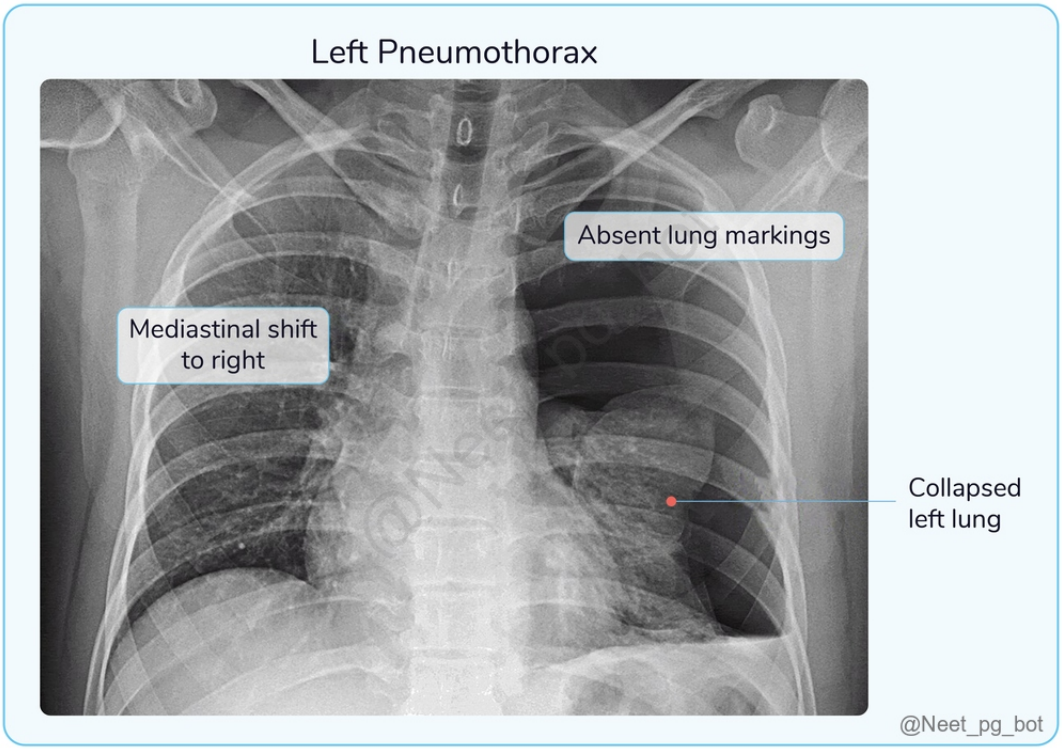
D. Distended neck veins



Correct Answer: C. Bilateral equal breath sounds

- *Listen (English)*
- *Listen (Hindi)*

Explanation: The patient’s clinical findings and the X-ray image confirm the diagnosis of tension pneumothorax on the right side. Breath sounds are usually absent on the affected side. Tension Pneumothorax A tension pneumothorax is a life-threatening condition where air accumulates in the pleural cavity under pressure, causing lung collapse on the affected side, mediastinal shift, and severe impairment of cardiovascular function. Clinical Features: (Options A, B & D ruled out) Restlessness, tachypnea, dyspnea, tachycardia, and chest pain. Distended neck veins, hyper-resonance, and decreased or absent breath sound on the affected side. Late findings may include tracheal deviation and cyanosis. Hypotension and severe mediastinal/tracheal shift are also common.



References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 374

SRB's Manual of Surgery, 6th edition, Page 1101,1102

↑ *Back to this question in Part A*

@Neet_pg_bot

Q33: A 30-year-old male is brought in after a road traffic accident. He has quadriplegia, urinary retention, and cervical spine tenderness on examination. What is the most appropriate advice regarding radiographic evaluation in this patient? (Q880374)

A. Patient should not be moved; obtain a portable X-ray after stabilizing the neck

B. Ask the radiographer to take cervical and chest X-rays

C. Obtain AP and lateral cervical X-rays without cervical support

D. Order a cervical X-ray and allow the patient to shift himself from the trolley

Correct Answer: A. Patient should not be moved; obtain a portable X-ray after stabilizing the neck

Explanation: Suspected cervical spine injury must be handled with strict spinal precautions. Neck stabilization is mandatory before any imaging is performed. Portable X-rays are preferred to avoid unnecessary patient movement. Allowing the patient to move or imaging without support is unsafe.

References:

Bailey & Love Short Practice of Surgery, 28th Edition, Page. 364

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@Neet_pg_bot

• [12_Miscellaneous] 058 Abdominal Trauma

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[12_Miscellaneous] 058 Abdominal Trauma — Quick Jump

Q1 (p. 3375)	*Q2 (p. 3375)*	*Q3 (p. 3376)*	*Q4 (p. 3377)*	*Q5 (p. 3377)*	*Q6 (p. 3378)*
Q7 (p. 3379)	*Q8 (p. 3379)*	*Q9 (p. 3380)*	*Q10 (p. 3381)*	*Q11 (p. 3381)*	*Q12 (p. 3382)*
Q13 (p. 3383)	*Q14 (p. 3383)*	*Q15 (p. 3384)*	*Q16 (p. 3386)*	*Q17 (p. 3387)*	*Q18 (p. 3388)*
Q19 (p. 3389)	*Q20 (p. 3390)*	*Q21 (p. 3392)*	*Q22 (p. 3392)*	*Q23 (p. 3394)*	*Q24 (p. 3395)*
Q25 (p. 3396)	*Q26 (p. 3397)*				

Q1: Which of the following statements about abdominal trauma is true? (Q880392)

A. The most commonly injured organ in blunt trauma is the liver

B. The spleen is the most commonly injured organ in penetrating trauma

C. In gunshot injuries, the stomach is the most commonly injured organ

D. The jejunum is the most commonly injured part of the bowel in blunt trauma

Correct Answer: D. The jejunum is the most commonly injured part of the bowel in blunt trauma

Explanation: In blunt abdominal trauma, the spleen is most commonly injured (not the liver). In penetrating trauma, the liver is the most commonly injured organ. In gunshot injuries, the small intestine (jejunum/ileum) is most commonly injured (not the stomach). In blunt bowel trauma, the jejunum is the most commonly affected part.

References:

SRB’s manual of surgery, 6th Edition, Page. 139, 586

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@Neet_pg_bot

Q2: A 19-year-old male is brought to the emergency department after a high-speed car crash. He is hypotensive (SBP 65 mmHg), and a FAST scan is positive. At laparotomy, heavy bleeding is noted from the area behind the liver along with a hollow-viscus perforation. A Pringle manoeuvre does not control the bleeding. Laparotomy packs are placed, slowing the haemorrhage. Despite resuscitation, his blood pressure remains low. Arterial pH is 7.05, and core temperature is 34°C. What

is the next best step in management? (Q880428)

A. Ligation of the hepatic arteries

B. Hepatectomy

C. Hepatic artery embolization

D. Shift the patient to ICU for resuscitation

Correct Answer: D. Shift the patient to ICU for resuscitation

Explanation: This patient has ongoing haemorrhage, severe acidosis (pH ~7.05), hypothermia (34°C), and shock - classic lethal triad of trauma (coagulopathy, acidosis, hypothermia). Definitive procedures like hepatectomy or hepatic artery ligation/ embolization are not tolerated in this physiologic state. The correct approach is Damage Control Surgery (DCS) - temporary packing, control contamination, and rapid transfer to ICU for correction of physiology (warming, correction of acidosis/coagulopathy, continued resuscitation). Definitive surgery is performed later once stabilized. Ligation of hepatic arteries (Option A) causes massive hepatic necrosis and is the only last resort. Hepatectomy (Option B) has high mortality in unstable patients, not done in a damage control setting. Hepatic artery embolization (Option C) requires hemodynamic stability to tolerate IR transfer, not feasible here.

References:

Bailey & Love Short Practice of Surgery, 28th Edition, Page. 16,17

↑ *Back to this question in Part A*

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Q3: A 10-year-old boy is brought to the emergency department after a bicycle handlebar injury to the abdomen. Ultrasound reveals a Grade II splenic laceration. The child is hemodynamically stable with no signs of ongoing bleeding. What is the most appropriate management in this case? (Q880426)

A. Conservative management

B. Splenectomy

C. Embolization

D. Splenorrhaphy

Correct Answer: A. Conservative management

Explanation: Splenic injuries in children are managed non-operatively in most cases if the child is hemodynamically stable, regardless of the grade (I–III). Grade II splenic injury (subcapsular hematoma or superficial laceration <3 cm depth) without active bleeding is best managed conservatively. Conservative management includes: Monitoring vitals in ICU/HDU. Serial hemoglobin/hematocrit. Bed rest. Blood transfusion if required. Surgical management is done whenever the patient is haemodynamically not stable or there is associated injuries or hilar or shattered grade V injuries.

References:

Bailey & Love Short Practice of Surgery, 28th Edition, Page. 1224

SRB's manual of surgery, 6th Edition, Page. 663,664

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@Neet_pg_bot

Q4: During an emergency laparotomy for a patient with blunt abdominal trauma, the surgeon encounters a perirenal hematoma around the left kidney. The patient remains hemodynamically unstable.What is the next best step in management? (Q880424)

A. Single-shot intravenous pyelography

B. Contrast-enhanced computed tomography

C. Ultrasonography of the abdomen

D. Direct renal exploration

Correct Answer: D. Direct renal exploration

Explanation: In unstable trauma patients undergoing laparotomy, if a perirenal hematoma is seen: Expanding or non-contained hematoma → proceed with direct renal exploration (do not delay for imaging). Contained, stable hematoma → may be left undisturbed if the patient is stable. CECT or Ultrasound are for stable patients . (Option B, C) Single-shot IVP is rarely used, only if renal function/contralateral kidney status is unknown before nephrectomy . (Option A)

References:

Bailey & Love Short Practice of Surgery, 28th Edition, Page. 1478

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@Neet_pg_bot

Q5: A young man sustains a renal injury following a road traffic accident and is initially managed conservatively. A few days later, he develops a flank swelling and imaging reveals a urinoma. What is the next best step in management? (Q880422)

A. Ureteral stenting

B. Surgical repair and exploration

C. Observation

D. Percutaneous drainage

Correct Answer: A. Ureteral stenting

Explanation: Most urinomas after renal trauma occur due to persistent urinary extravasation from the collecting system. First-line treatment → internal drainage with retrograde ureteral stenting. Percutaneous drainage (Option D) is used if the urinoma is large, infected, or not resolving. Surgical exploration (Option B) is rarely needed unless stenting/drainage fails. Observation (Option C) is not preferred, as ongoing leakage can lead to infection, abscess, or fibrosis.

↑ *Back to this question in Part A*

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Q6: A 25-year-old male presents after a high-velocity road traffic accident. He is hypotensive (BP 85/60 mmHg) and tachycardic (HR 100/min). Imaging suggests a pelvic fracture with retroperitoneal bleeding. Regarding the principles of damage control surgery (DCS), which of the following statements is correct? (Q880419)

A. Coagulopathy is corrected in Phase II of DCS

B. Definitive repair of injuries is done 12–24 hours after Phase III

C. Internal iliac artery ligation is done in Phase II

D. Hypothermia and acidosis are corrected in Phase I

Correct Answer: A. Coagulopathy is corrected in Phase II of DCS

Explanation: Damage Control Surgery Phases: Phase I: Initial abbreviated surgery: bleeding control (packing, vessel ligation, temporary closure). No correction of physiology here. Phase II: Critical care resuscitation in ICU: correction of coagulopathy, hypothermia, and acidosis. Phase III: Definitive surgery: performed after 24–48 hours, once physiology is normalized.

References:

Bailey & Love Short Practice of Surgery, 28th Edition, Page. 277

↑ *Back to this question in Part A*

@Neet_pg_bot

Q7: A trauma patient is undergoing diagnostic peritoneal lavage (DPL) to evaluate for intra-abdominal bleeding. Which one of the following statements regarding the interpretation of DPL results is incorrect? (Q880415)

A. More than 100,000 red blood cells per mm^3 is considered positive

B. More than 200 white blood cells per mm^3 is considered positive

C. Aspiration of 10 mL or more of gross blood is an indication for laparotomy

D. Amylase level greater than 175 units/dL is considered positive

Correct Answer: B. More than 200 white blood cells per mm^3 is considered positive

Explanation: The white blood cell cutoff is 500 cells/mm^3, not 200 cells/mm^3. Diagnostic peritoneal lavage (DPL) is a test used to detect the presence of blood or other contaminants in the abdominal cavity following trauma. A finding of more than 100,000 red blood cells/mm^3 in the lavage fluid is considered positive. The white blood cell cutoff is 500 cells/mm^3 . Aspiration of at least 10 mL of gross blood during the procedure is taken as a direct indication for laparotomy. Amylase levels greater than 175 units/dL suggest injury to a hollow viscus or the pancreas.

References:

Bailey & Love Short Practice of Surgery, 28th Edition, Page. 379

↑ *Back to this question in Part A*

@Neet_pg_bot

Q8: A 12-year-old boy presents after a fall from a height with abdominal pain. He is hemodynamically stable on examination, with tenderness in the left flank region. Urinalysis reveals 50 RBC/hpf.What is the investigation of choice for this patient? (Q880400)

A. Contrast-enhanced CT scan

B. Retrograde urethrogram

C. Wait and watch

D. Emergency laparotomy

Correct Answer: A. Contrast-enhanced CT scan

Explanation: In a hemodynamically stable child with suspected renal injury (hematuria + flank tenderness), the investigation of choice is CECT abdomen with urography. Retrograde urethrogram (RUG) (Option B) is used if urethral injury is suspected (blood at the meatus, high-riding prostate). Wait and watch (Option C) management approach, not investigation. Emergency laparotomy (Option D) is indicated only if the patient is unstable with ongoing hemorrhage.

References:

Bailey & Love Short Practice of Surgery, 28th Edition, Page. 382,1478

↑ *Back to this question in Part A*

@Neet_pg_bot

Q9: A 40-year-old man is admitted to the ICU following blunt abdominal trauma. On monitoring, his intra-abdominal pressure is measured as 24 mmHg.What is the grade of intra-abdominal hypertension in this patient? (Q880399)

A. Grade I

B. Grade II

C. Grade III

D. Grade IV

Correct Answer: C. Grade III

Explanation: Abdominal Compartment Syndrome (ACS) is diagnosed when this pressure exceeds 12 mmHg, causing various complications across multiple organ systems. Burch Grading System of Intra-abdominal Pressure Grade Pressure (mm Hg) Management 1 12-15 It does not require decompression 2 16-20 Close monitoring (Option A ruled out) 3 21-25 Most require decompression 4 >25 All require immediate decompression

References:

Schwartz’s Principles of Surgery, 11th Edition, Page. 238, 239 SRB’s Manual of Surgery, 6th Edition, Page. 144, 145

↑ *Back to this question in Part A*

@Neet_pg_bot

Q10: A 35-year-old woman with 35% total body surface area (TBSA) deep burns over the abdomen and lower limbs is admitted to the burns ICU. She had received 9 litres of Ringer's lactate at a peripheral hospital. On arrival, she is hypotensive (BP 86/52 mmHg), tachycardic (HR 120 bpm), and her urine output has been less than 15 mL over the past 2 hours. On examination, there are tight circumferential eschars over the abdomen. The ventilator shows peak airway pressures of 40 cm H■O. What is the most appropriate next step? (Q880396)

A. Administration of dobutamine

B. Measurement of bladder pressure

C. Diuresis with furosemide

D. Increase PEEP

Correct Answer: B. Measurement of bladder pressure

Explanation: This patient has burn resuscitation + tense abdominal wall + oliguria + hypotension + high peak airway pressures → suspected abdominal compartment syndrome (ACS). The first step in diagnosis is measuring intra-abdominal pressure, most commonly via bladder pressure monitoring. Dobutamine is not useful until the diagnosis is confirmed . (Option A) Furosemide - inappropriate; oliguria here is due to intra-abdominal hypertension, not fluid overload . (Option C) Increasing PEEP worsens venous return and hypotension . (Option D)

References:

Sabiston's principles of surgery, 21st Edition, Page. 1141

↑ *Back to this question in Part A*

@Neet_pg_bot

Q11: A critically ill patient on mechanical ventilation develops rising airway pressures, hypotension, and oliguria. Abdominal compartment syndrome is suspected. Which of the following statements is false regarding this condition? (Q880395)

A. Hypercarbia and respiratory acidosis

B. Hypoxia due to increased peak inspiratory pressure

C. Hypotension due to a decrease in venous return

D. Oliguria due to ureter obstruction

Correct Answer: D. Oliguria due to ureter obstruction

Explanation: In abdominal compartment syndrome, oliguria is due to reduced renal perfusion from decreased renal blood flow and raised renal vein pressure, not from ureteric obstruction. Hypercarbia and respiratory acidosis (Option A): Raised intra-abdominal pressure pushes the diaphragm upwards → reduced lung compliance → hypoventilation → CO■ retention → respiratory acidosis. Hypoxia due to increased peak inspiratory pressure (Option B): Elevated abdominal pressure impairs diaphragmatic excursion, increases airway pressures, and decreases oxygenation. Hypotension due to decreased venous return (Option C): Compression of IVC → reduced preload → decreased cardiac output → hypotension.

References:

Bailey & Love Short Practice of Surgery, 28th Edition, Page. 386

↑ *Back to this question in Part A*

@Neet_pg_bot

Q12: A 35-year-old man sustained a penetrating abdominal injury during a street altercation. At laparotomy, the cecum was found to be extensively damaged and non-salvageable. What is the most appropriate management for this patient? (Q880394)

A. Catheter tube cecostomy

B. Right hemicolectomy with ileocolostomy

C. Transverse colostomy

D. End loop sigmoid colostomy

Correct Answer: B. Right hemicolectomy with ileocolostomy

Explanation: The cecum is thin-walled and prone to leak, so severe injury requires resection. Right hemicolectomy is the standard, safe option for non-salvageable cecal trauma. A small wound over the right-sided colon can be sutured primarily. Ileostomy alone or ileostomy with ilea-transverse anastomosis or right hemicolectomy with ileostomy is indicated in following situations: Extensive peritoneal contamination Colonic vascular injuries Haemodynamically unstable patients Long-term hypotension after trauma. Cecostomy (Option A) causes high leak/ abscess risk and is not advised. Transverse colostomy (Option C) for left-sided/multiple injuries. Sigmoid colostomy (Option D) for distal colon/rectum, not cecum.

References:

SRB’s manual of surgery, 6th Edition, Page. 144

↑ *Back to this question in Part A*

@Neet_pg_bot

Q13: Regarding abdominal trauma, which of the following is correct? 1. The mesentery is the most commonly injured structure in seat belt injuries. 2. The first investigation in blunt abdominal trauma is CT scan. 3. FAST (Focused Assessment with Sonography for Trauma) is the initial investigation of choice. 4. CECT is the investigation of choice in a hemodynamically stable patient. (Q880393)

A. 1,3,4

B. 1,2,3

C. 2,3,4

D. 2,4

Correct Answer: A. 1,3,4

Explanation: Seat belt injuries commonly cause mesenteric tears. The first investigation in blunt abdominal trauma is FAST, not CT. CECT is the gold standard in hemodynamically stable patients with blunt trauma. FAST (Focused Assessment with Sonography for Trauma) is the initial investigation of choice in a case of abdominal trauma.

References:

SRB’s manual of surgery, 6th Edition, Page. 571

↑ *Back to this question in Part A*

@Neet_pg_bot

Q14: Which of the following statements is true? The most commonly injured organ in blunt trauma to the abdomen is the liver. The liver is the most commonly injured organ in penetrating abdominal trauma. In gunshot injuries to the abdomen, the stomach is the most commonly injured organ. The jejunum is the most commonly injured part of the bowel in blunt trauma to the abdomen. The mesentery is the most commonly injured structure in seat belt injuries. The first investigation done on a patient with blunt abdominal trauma is a CT scan. CECT is the investigation of choice

for a stable patient with blunt abdominal trauma. (Q849659)

A. 1, 2, 3, 6, 7

B. 3, 4, 5, 6

C. 2, 4, 5, 7

D. 1, 2, 5, 7

Correct Answer: C. 2, 4, 5, 7

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The most commonly injured organ in blunt trauma abdomen is the spleen > liver. The most commonly injured organ in penetrating trauma is the liver The most commonly injured organ in gunshot injury is the small intestine > large bowel > liver > intra-abdominal vasculature The most commonly injured part of the bowel in blunt trauma abdomen is the jejunum and the ileum . The most commonly injured structure in seat belt injury is the mesentery. First investigation done in blunt trauma abdomen: FAST (Focused Assessment with Sonography for Trauma). Investigation of choice for stable blunt trauma abdomen: CECT (Contrast-Enhanced CT scan).

References:

SRB's Manual of Surgery (6th Edition) page 139

Bailey and Love's Short Practice of Surgery (28th Edition) page 381

www.msdmanuals.com/en-in/professional/injuries-poisoning/abdominal-trauma/.

emedicine.medscape.com/article/370508.

www.ncbi.nlm.nih.gov/pmc/articles/PMC4818312/.

www.ncbi.nlm.nih.gov/books/NBK564335/

www.ncbi.nlm.nih.gov/pmc/articles/PMC6082438/

↑ *Back to this question in Part A*

@Neet_pg_bot

Q15: A 35 y/o male presents to the ER after a high-speed motor vehicle accident. He is hemodynamically stable but complains of left-sided abdominal pain. He has hematuria & his CECT shows a 3 cm laceration extending into the renal cortex and medulla without involvement of the collecting system. No evidence of vascular injury

is noted. What is the most appropriate grade of renal trauma based on the findings? (Q849746)

A. Grade I Renal Trauma

B. Grade II Renal Trauma

C. Grade III Renal Trauma

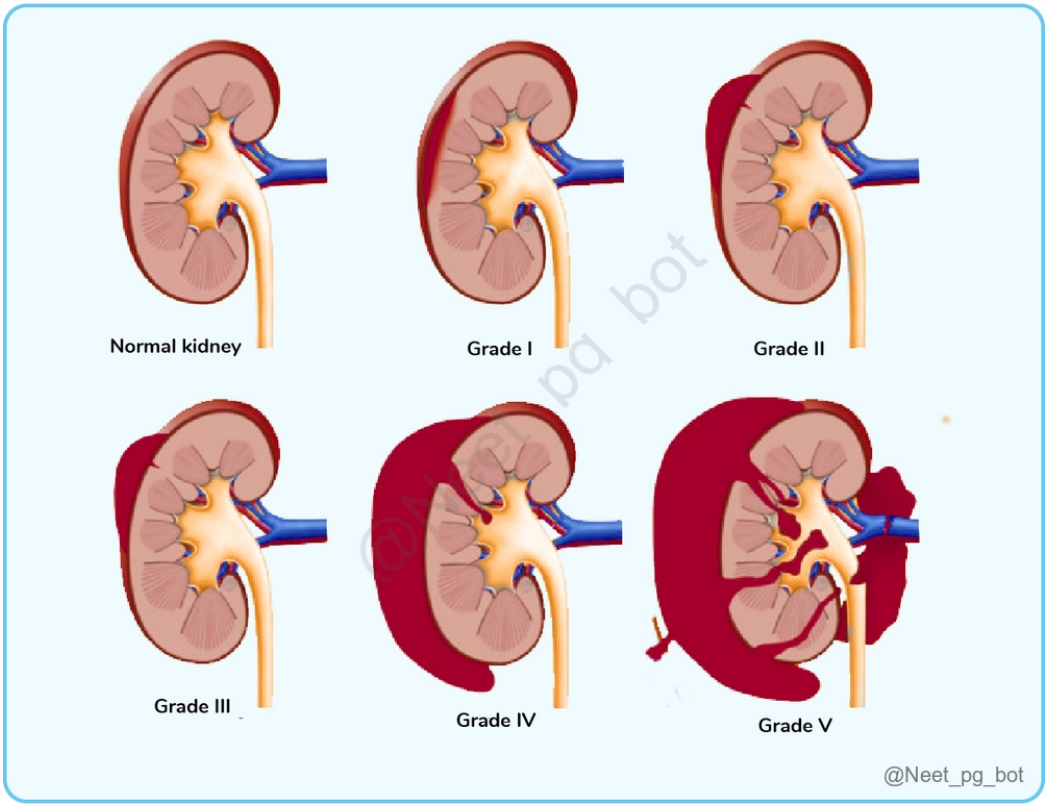
D. Grade IV Renal Trauma

Correct Answer: C. Grade III Renal Trauma

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The patient's CECT scan shows a 3 cm laceration extending into the renal cortex and medulla without vascular injury. According to the AAST grading, this is a Grade III injury (laceration >1 cm deep without vascular involvement). AAST GRADING OF RENAL TRAUMA Grade I Subcapsular hematoma and/or parenchymal contusion without laceration. (Option A ruled out) Grade II Perirenal hematoma. Laceration < 1 cm deep without urinary extravasation. (Option B ruled out) Grade III Laceration > 1 cm deep or renal pedicle injury without urinary extravasation or vascular injury. (Option C) Grade IV Parenchymal laceration extends into the collecting system with urinary extravasation. Segmental renal vein or artery injury. (Option D ruled out) Grade V Main renal artery or vein laceration or avulsion of the hilum. Completely shattered kidney or renal avulsion.



References:

Renal trauma: the current best practice - PMC (nih.gov)

AAST grading- Kidney trauma

Sabiston Textbook of Surgery, 21st edition, Pages 423, 424

↑ *Back to this question in Part A*

@Neet_pg_bot

Q16: A 40 y/o male presents to the ER after being involved in a motorcycle collision. His vital signs are stable, and a CT scan reveals an expanding hematoma confined to the lateral retroperitoneum with no active bleeding. What is the most appropriate management approach for this patient? (Q849738)

A. Immediate surgical exploration

B. Extraperitoneal packing

C. Diagnostic peritoneal lavage (DPL)

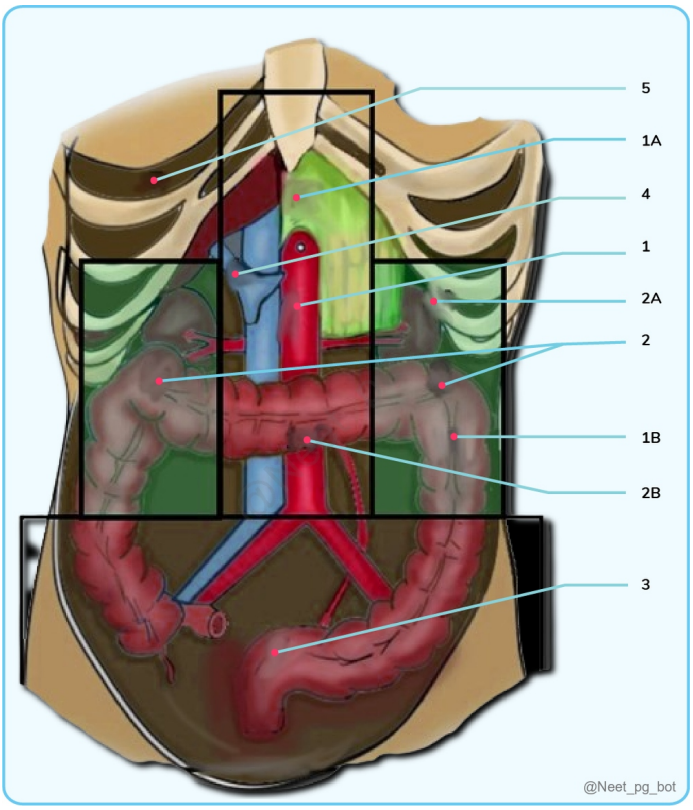
D. Angioembolization

Correct Answer: D. Angioembolization

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Angioembolization is a minimally invasive procedure that involves the selective occlusion of bleeding vessels. In Zone 2 expanding hematoma confined to the lateral retroperitoneum without active bleeding and hemodynamically stable patient angioembolization is a suitable option to prevent or control bleeding while avoiding the risks associated with open surgery. The retroperitoneum is divided into three zones for intraoperative management in blunt trauma: Zone I – Central Zone 2 - Lateral Zone 3 - Pelvic Associated with injuries of The aorta & its proximal branches Inferior vena cava & its proximal tributaries Structures located - Distal renal vessels Confined to the retroperitoneal zone of the pelvis Structures located - Iliac vessels Management: Central hematoma - exploration with proximal & distal vascular control (Option A ruled out) . Management: Lateral hematoma (renal in origin) - managed nonoperatively (angioembolization) (Option D) . Pulsatile hematoma or penetrating injury present - exploration. Management: Pelvic hematoma is exceptionally difficult to control. Usually, it should not be opened. It is managed by packing/angioembolization (Option B ruled out) . Explored only if there is expanding or pulsatile or penetrating injury present. Diagnostic peritoneal lavage (Option C): Assesses intraperitoneal bleeding, not retroperitoneal.



References:

Sabiston Textbook of Surgery (21st edition) page 423

Bailey and Love's Short Practice of Surgery (28th Edition) page 382, 383

↑ *Back to this question in Part A*

@Neet_pg_bot

Q17: A 45 y/o male patient presents with abdominal distension, decreased urine output, and difficulty breathing following abdominal surgery. His intra-abdominal pressure (IAP) is measured at 28 cm H■O. Which of the following is the most appropriate next step in management? (Q849734)

A. Close monitoring in the ICU

B. Aggressive fluid resuscitation

C. Surgical decompression

D. Administration of diuretics

Correct Answer: C. Surgical decompression

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Surgical decompression is indicated for patients with an IAP of 28 cmH■O, which corresponds to Grade III of the Burch Grading System of Intra-abdominal Pressure. This step is necessary to relieve the pressure within the abdominal cavity, preventing further deterioration of organ function and avoiding potentially fatal complications. Abdominal Compartment Syndrome (ACS) is diagnosed when this pressure exceeds 12 mmHg, causing various complications across multiple organ systems. Burch Grading System of Intra-abdominal Pressure Grade Pressure (cm of H 2 O) Pressure (mm Hg) Management 1 10-15 12-15 It does not require decompression 2 16-25 16-20 Close monitoring (Option A ruled out) 3 26-35 21-25 Most require decompression 4 >35 >25 All require immediate decompression Hemodynamic changes: ↑ Central venous pressure (CVP) due to compression of IVC. ↑ Systemic vascular resistance (SVR) from reduced venous return and vasoconstriction. ↑ Heart rate (tachycardia) as a compensatory response. ↓ Cardiac output decreases because preload and venous return fall despite raised CVP. Renal/GI effects: ↓ Glomerular filtration rate (GFR) is decreased due to renal vein compression and decreased renal perfusion. ↓ Urine output (oliguria/anuria). Gut ischemia can occur.

References:

Schwartz's Principles of Surgery (11th Edition) page 238, 239

SRB's Manual of Surgery (6th Edition) page 144, 145

↑ *Back to this question in Part A*

@Neet_pg_bot

Q18: A 45 y/o male is undergoing damage control surgery after sustaining severe abdominal injuries in a construction accident. After rapid haemorrhage control, he is moved to the ICU for further resuscitation. What is the main focus during the ICU stage of damage control surgery? (Q849733)

A. Definitive Closure of the Abdomen

B. Ongoing Resuscitation and Stabilization

C. Repair of Organ Injuries

D. Selection of the Next Surgical Procedure

Correct Answer: B. Ongoing Resuscitation and Stabilization

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: During the ICU stage of damage control surgery , the main focus is on continuing resuscitation efforts, such as correcting hypothermia, coagulopathy, and acidosis (lethal triad) . The patient is closely monitored, and organ function is supported to ensure they are stable enough for further surgical intervention. Phases of Damage Control Surgery Phase Intervention Steps 1 Recognition and Decision-making Intubation, early rewarming, and prompt movement to operation theatre 2 Immediate Laparotomy Control of bleeding, abdominal packing, and temporary abdominal closure 3 Intensive Care Unit Ongoing resuscitation and normalization of physiological and biochemical parameters (Option B) 4 Re-Exploration Definitive repair of all injuries (Options A & C ruled out)

References:

Bailey and Love's Short Practice of Surgery (28th Edition) page 385, 386, 463, 464

Schwartz's Principles of Surgery (11th Edition) page 215

↑ *Back to this question in Part A*

@Neet_pg_bot

Q19: A 29 y/o male presents to the emergency following a high-speed car crash. He was wearing a seat belt and had a clear seat belt sign across his lower abdomen. He reports increasing abdominal pain and tenderness. Which structure is commonly injured in this scenario? (Q849732)

A. Mesentery

B. Liver

C. Spleen

D. Bladder

Correct Answer: A. Mesentery

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The mesentery , a fold of tissue that attaches the intestines to the posterior abdominal wall, is particularly vulnerable in seat belt injuries due to the compressive force of the belt across the abdomen. This can lead to mesenteric tears, avulsions, or hematomas, resulting in internal bleeding or ischemia which often require surgical intervention to prevent complications like bowel necrosis. The classical seat belt sign refers to a distinctive pattern of bruising or contusion across the abdomen and chest, resulting from the force of a seat belt during a car accident. This visible mark is a significant indicator of potential underlying injuries, including damage to internal organs like the mesentery, small intestine, or spine.



References:

SRB's Manual of Surgery, 6th Edition, Pg.145

Schwartz's Principles of Surgery, 11th Edition, Pg.244

www.ncbi.nlm.nih.gov/books/NBK470262/

www.ncbi.nlm.nih.gov/pmc/articles/PMC5357874/.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q20: A 28 y/o male suffers a stab wound to the abdomen. During surgery, an injury to the head of the pancreas is discovered, with the involvement of both the main pancreatic duct and the intrapancreatic bile duct. Which surgical procedure is most appropriate for this injury? (Q849731)

A. Distal pancreatectomy

B. Whipple procedure

C. External drainage alone

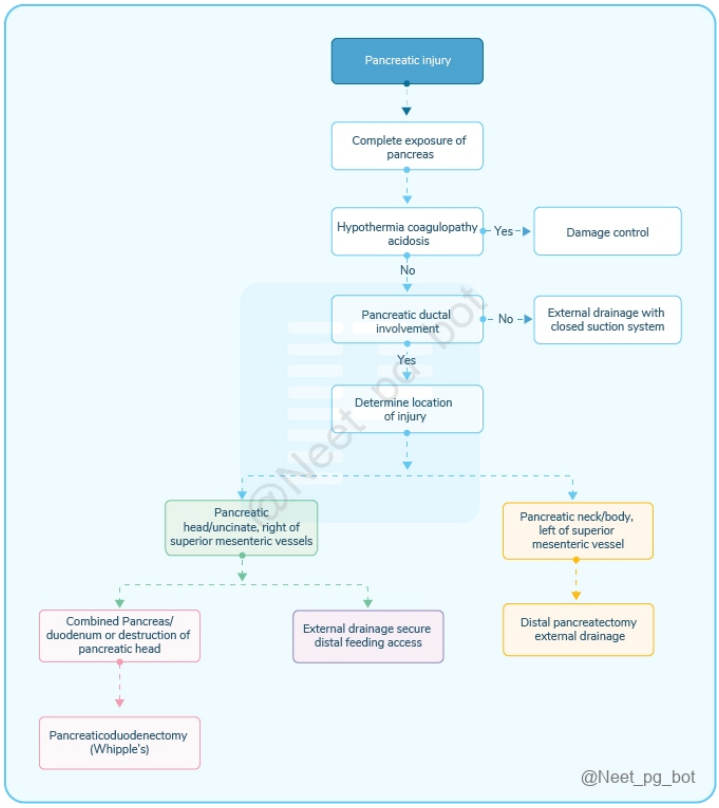
D. Repair of the pancreatic duct without resection

Correct Answer: B. Whipple procedure

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: A Whipple procedure (pancreaticoduodenectomy) is the appropriate surgical approach for extensive injuries to the head of the pancreas, particularly when both the main pancreatic duct and the intrapancreatic bile duct are involved. This procedure involves the removal of the head of the pancreas along with parts of the stomach, duodenum, and bile duct, addressing the complex injury. It is a definitive surgical option that ensures the damaged pancreatic tissue and associated structures are adequately managed, reducing the risk of severe complications such as fistulas, abscesses, or pancreatitis.



References:

Sabiston Textbook of Surgery (21st edition) page 420, 421

Schwartz’s Principles of Surgery (11th Edition) page 229

Bailey and Love’s Short Practice of Surgery (28th Edition) page 381

radiopaedia.org/articles/pancreatic-trauma-injury-grading

↑ *Back to this question in Part A*

@Neet_pg_bot

Q21: A 40 y/o male presents to the emergency after a high-speed motorcycle collision. He is hemodynamically stable but reports severe, diffuse abdominal pain. On examination, there is significant tenderness in the upper abdomen, but no guarding or rebound tenderness is noted. Which of the following findings on the CT scan would most strongly suggest a duodenal injury? (Q849730)

A. Free air in the retroperitoneum

B. Liver laceration with intra-abdominal free fluid

C. Large splenic hematoma with peri splenic fluid collection

D. Moderate free fluid in the pelvis without solid organ injury

Correct Answer: A. Free air in the retroperitoneum

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Free air in the retroperitoneum is the most direct and specific indicator of duodenal injury, typically resulting from a perforation in the duodenum. Any gas or fluid collection in the periduodenal tissue is suggestive of injury to the duodenum. Duodenal wall thickening and contrast extravasation are also findings of duodenal injury. Anatomical Localization of Perforation: Retroperitoneal Air: Classic finding in perforation of the D2 and D3 (retroperitoneal) segments of the duodenum. Intraperitoneal Air: More common in D1 and D4 (intraperitoneal) segments; these segments are mobile and surrounded by peritoneum, mimicking a typical peptic ulcer perforation.

References:

Sabiston Textbook of Surgery, 21st edition, Pg.419,420

Bailey and Love’s Short Practice of Surgery, 28th Edition, Pg.381

↑ *Back to this question in Part A*

@Neet_pg_bot

Q22: During liver trauma surgery, the Pringle manoeuvre is performed to control bleeding. Which of the following structures is occluded during this manoeuvre? (Q849674)

A. Hepatic artery

B. Portal vein

C. Both the hepatic artery and portal vein

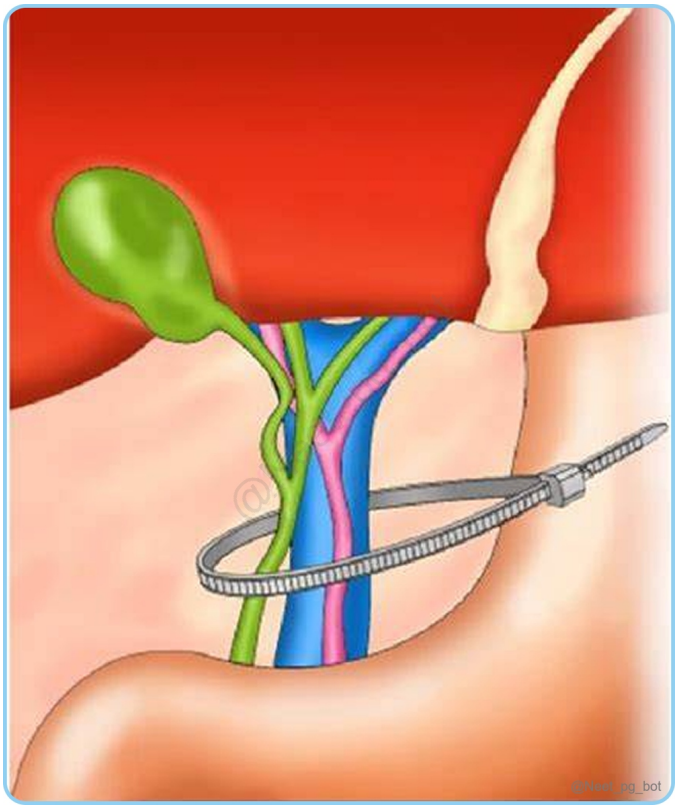
D. Bile duct

Correct Answer: C. Both the hepatic artery and portal vein

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Pringle maneuver is the quickest temporary method for controlling active liver bleeding. It involves clamping the hepatoduodenal ligament (porta hepatis), which contains the portal vein, hepatic artery, and common bile duct . This maneuver temporarily interrupts hepatic inflow by occluding the hepatic artery and portal vein. If bleeding stops, the source is the portal triad vessels (hepatic inflow). If bleeding continues, the source is hepatic veins or retrohepatic IVC (not controlled by clamp). Procedural Safety & Duration: Safe Duration: In a normothermic patient, the hepatic inflow can be occluded safely for up to 20–30 minutes . Intermittent Occlusion: If prolonged control is required, use cycles of 20 minutes of clamping followed by 5 minutes of reperfusion to mitigate ischemic injury to the liver parenchyma. Contraindication: Do not exceed safe limits, especially in patients with pre-existing cirrhosis or steatosis, as they have significantly reduced ischemic tolerance.



References:

Sabiston Textbook of Surgery (21st edition) page 416, 417, 418

Bailey and Love's Short Practice of Surgery (28th Edition) page 380, 1200

SRB's Manual of Surgery (6th Edition) page 588

www.ncbi.nlm.nih.gov/books/NBK513236/

↑ *Back to this question in Part A*

@Neet_pg_bot

Q23: A 35 y/o male presents to the emergency following a motor vehicle accident. He is hemodynamically stable with left upper quadrant tenderness. A FAST exam reveals free fluid in the abdomen. The CT scan shows a minor splenic injury. What is the most appropriate next step in management? (Q849663)

A. Immediate splenectomy

B. Non-operative management with close monitoring in ICU

C. Exploratory laparotomy

D. Angiography with embolization

Correct Answer: B. Non-operative management with close monitoring in ICU

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: For hemodynamically stable patients with minor splenic injuries , non-operative management (NOM) is the preferred approach. This involves admission to the ICU for close monitoring, with repeated clinical assessments and possibly serial imaging to ensure there is no progression of injury or delayed bleeding. The goal is to preserve the spleen, thus avoiding the complications associated with splenectomy, such as OPSI (Overwhelming post-splenectomy infection) Immediate splenectomy (Option A): Reserved for hemodynamically unstable patients or those where non-operative management fails. Exploratory laparotomy (Option C): This approach is usually reserved for patients who are hemodynamically unstable despite resuscitation or those who have ongoing signs of internal bleeding that cannot be controlled non-operatively. Angiography with embolization (Option D): It is often used in conjunction with non-operative management. It is not indicated as the immediate next step in a stable patient without signs of active bleeding or vascular injury on the initial CT scan.

References:

Sabiston Textbook of Surgery, 21st edition, Pg.414,415

Schwartz's Principles of Surgery, 11th Edition, Pg.227,228

Bailey and Love's Short Practice of Surgery, 28th Edition, Pg.1224,1231

↑ *Back to this question in Part A*

Q24: A 34 y/o man presents with a gunshot wound to the abdomen. He is hemodynamically unstable with a blood pressure of 90/60 mmHg and a heart rate of 130 bpm. On examination, there is significant abdominal tenderness with guarding and rigidity. What is the best initial management step? (Q849662)

A. Perform a FAST scan

B. Start fluid resuscitation and obtain an abdominal X-ray

C. Urgent exploratory laparotomy

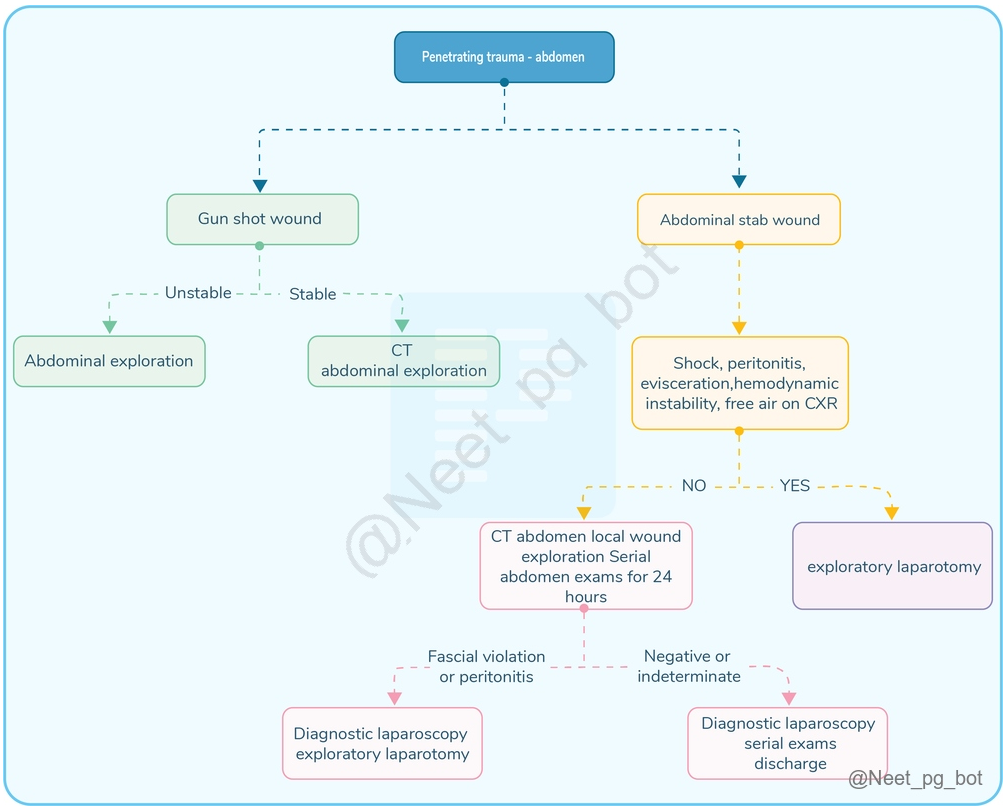
D. Obtain a CT scan with IV contrast

Correct Answer: C. Urgent exploratory laparotomy

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: In cases of penetrating abdominal trauma , especially in a patient who is hemodynamically unstable with clinical signs of peritonitis, immediate exploratory laparotomy is the most appropriate step. Surgery allows for direct visualisation and control of any haemorrhage, repair of organ injuries, and management of contamination from gastrointestinal perforations. Perform a FAST scan (Option A): FAST is helpful only when diagnosis is unclear . This patient already has peritonitis + instability → straight to OR , no time for FAST. Start fluid resuscitation and obtain abdominal X-ray (Option B) : Fluids may be started, but X-ray is unnecessary and delays definitive management . Obtain a CT scan with IV contrast (Option D) CT is only for stable patients. Unstable patients with a gunshot wound and signs of peritonitis go directly to surgery .



References:

Sabiston Textbook of Surgery (21st edition) page 412, 413, 414

SRB's Manual of Surgery (6th Edition) page 136

↑ *Back to this question in Part A*

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Q25: Which of the following is the most accurate diagnostic tool for evaluating blunt abdominal trauma in a hemodynamically stable patient? (Q849661)

A. FAST (Focused Assessment with Sonography for Trauma)

B. Diagnostic Peritoneal Lavage (DPL)

C. CT scan with IV contrast

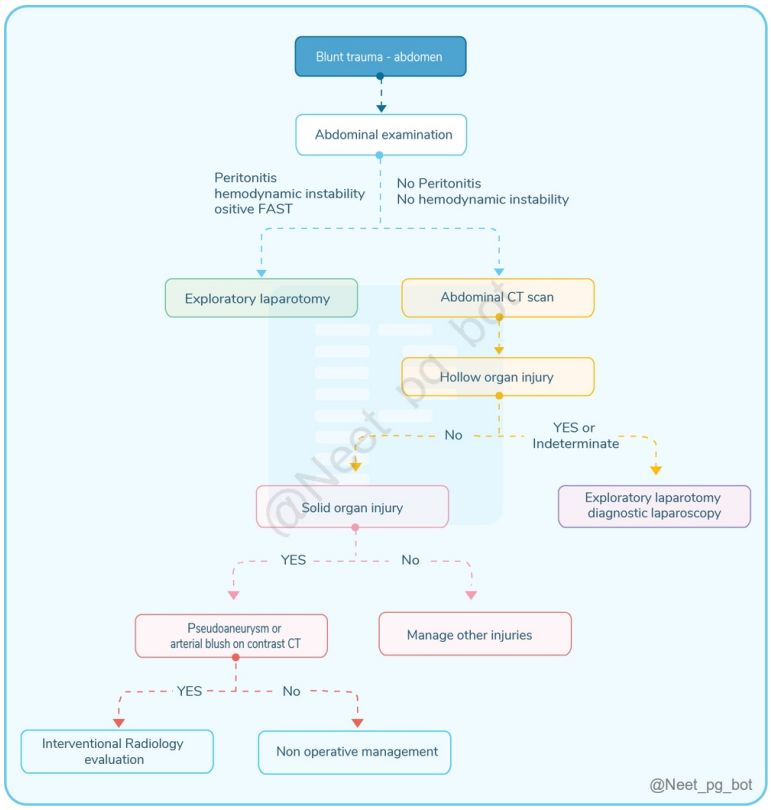
D. Plain abdominal X-ray

Correct Answer: C. CT scan with IV contrast

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: CT scan with IV contrast is a detailed imaging modality that provides high-resolution images of abdominal organs and blood vessels. It is considered the gold standard for diagnosing blunt abdominal trauma in stable patients, and accurately identifying organ injuries, active bleeding, and other critical conditions.
Management protocol for blunt trauma abdomen:



References:

Sabiston Textbook of Surgery (21st edition) page 412, 413

Bailey and Love's Short Practice of Surgery (28th Edition) page 379

SRB's Manual of Surgery (6th Edition) page 139, 142

↑ *Back to this question in Part A*

@Neet_pg_bot

Q26: A 30 y/o male is admitted after a motorcycle accident with abdominal trauma. The doctor decides to perform initial imaging tests. Which statement about FAST, eFAST, and DPL is incorrect? (Q849660)

A. eFAST can detect >100 mL of free blood in the abdomen and thoracic cavities.

B. FAST is reliable for assessing retroperitoneum and detecting injuries to hollow viscus.

C. DPL is valuable in resource-limited settings and detects blood or contaminants in the abdomen.

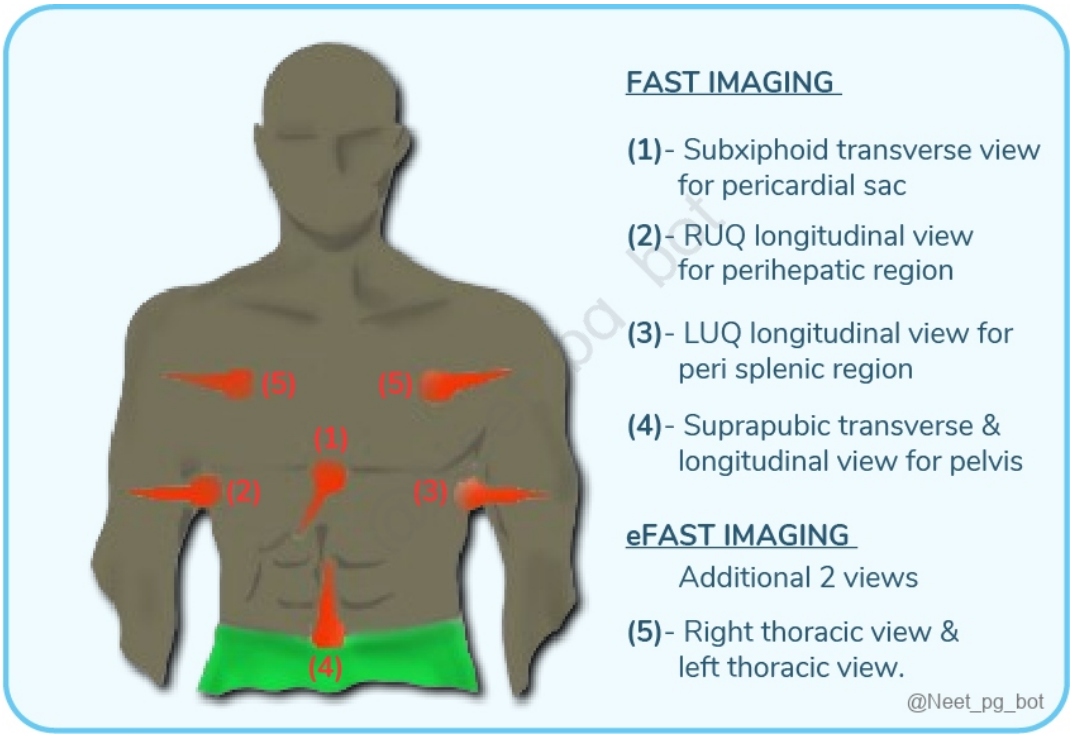
D. FAST and eFAST do not determine the specific nature or extent of injuries.

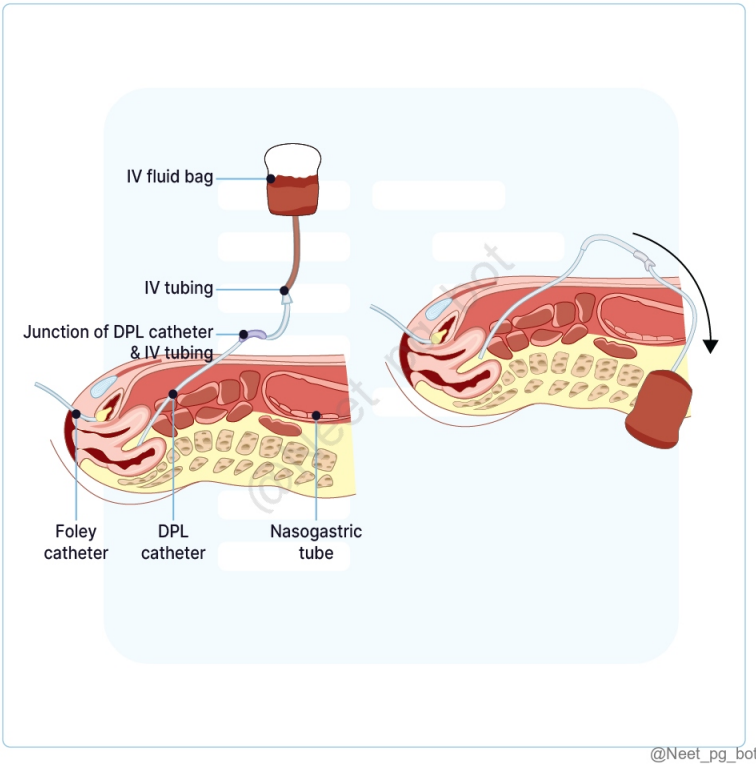
Correct Answer: B. FAST is reliable for assessing retroperitoneum and detecting injuries to hollow viscus.

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: FAST is not reliable for assessing the retroperitoneum or accurately detecting injuries to hollow viscus and solid organs. FAST (Focused Abdominal Sonography for Trauma) and eFAST (Extended FAST) : Assess for free fluid in the abdominal cavity, thoracic cavities, and pericardium. Not used to determine the specific nature or extent of injury. (Option D ruled out) Advantages : Rapid, reproducible, portable, and non-invasive bedside test. Can be performed simultaneously with resuscitation. Accurate at detecting >100 mL of free blood. (Option A ruled out) Diagnostic Peritoneal Lavage (DPL): Assess for the presence of blood or contaminants in the abdomen, valuable in resource-limited settings. (Option C ruled out) The positive result is if Frank blood or contaminants are present, or If laboratory results show >100,000 red cells/µL or >500 white cells/µL or Amylase levels in the fluid of more than 175 IU/dl. Drainage of lavage fluid via a chest drain indicates diaphragm penetration.





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References:

Bailey and Love's Short Practice of Surgery (28th Edition) page 378, 379

SRB's Manual of Surgery (6th Edition) page 139, 140

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@Neet_pg_bot

• [12_Miscellaneous] 059 Transplantation

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[12_Miscellaneous] 059 Transplantation — Quick Jump

Q1 (p. 3400)	*Q2 (p. 3400)*	*Q3 (p. 3401)*	*Q4 (p. 3402)*	*Q5 (p. 3403)*	*Q6 (p. 3404)*
Q7 (p. 3405)	*Q8 (p. 3406)*	*Q9 (p. 3407)*	*Q10 (p. 3408)*	*Q11 (p. 3409)*	*Q12 (p. 3410)*
Q13 (p. 3411)	*Q14 (p. 3412)*	*Q15 (p. 3413)*	*Q16 (p. 3414)*	*Q17 (p. 3415)*	*Q18 (p. 3416)*
Q19 (p. 3416)	*Q20 (p. 3417)*	*Q21 (p. 3418)*	*Q22 (p. 3419)*	*Q23 (p. 3419)*	*Q24 (p. 3420)*
Q25 (p. 3421)	*Q26 (p. 3422)*	*Q27 (p. 3422)*	*Q28 (p. 3423)*		

Q1: An elderly man with diabetes presents with progressive weight loss and poor appetite. You decide to assess his nutritional status using the Malnutrition Universal Screening Tool (MUST) . Which of the following factors are included in this assessment? 1. Body Mass Index (BMI) 2. Age 3. Recent weight loss 4. Current nutritional intake 5. Acute illness (Q880220)

A. 1,3,4,5

B. 1,2,3,4

C. 2,3,4,5

D. 1,2,3,5

Correct Answer: A. 1,3,4,5

Explanation: The Malnutrition Universal Screening Tool (MUST) assesses an individual's risk of malnutrition based on five steps: Step 1: BMI (Option 1) Step 2: recent weight loss (Option 3) Step 3: effect of acute illness on current nutritional intake (Options 4 and 5) Step 4: overall risk score, Step 5: management plan. It does not include age as a formal scoring component. (Option 2 ruled out)

References:

Bailey & Love Short Practice of Surgery, 28th Edition, Page 332.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q2: A patient with long-standing Crohn's disease is found to have several skip lesions in the small intestine. If surgical excision includes the segment primarily responsible for bile salt absorption, the patient is most likely to develop steatorrhea. Which segment is this? (Q880219)

A. Duodenum

B. Ileum

C. Jejunum

D. Caecum

Correct Answer: B. Ileum

Explanation: The ileum is the primary site for active absorption of conjugated bile salts via specialised transporters. It reabsorbs about 95% of the bile salts to recycle them back to the liver (enterohepatic circulation). Surgical removal or disease involvement of the ileum leads to bile salt loss in the stool, causing fat malabsorption and steatorrhea. Incorrect Options: Duodenum (Option A): The duodenum is the first segment of the small intestine, mainly involved in neutralising stomach acid and starting nutrient absorption, especially iron and calcium. It does not specialise in bile salt absorption. Jejunum (Option C): Jejunum mainly absorbs carbohydrates, proteins, and lipids, but does not specifically reabsorb bile salts efficiently Caecum (Option D): The caecum is part of the large intestine and does not absorb bile salts.

References:

Bailey & Love Short Practice of Surgery, 28th Edition, Page 1327.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q3: Following an emergency laparotomy for a penetrating abdominal injury, a patient is left with less than 100 cm of jejunum and a jejunostomy is created. Which of the following statements regarding management of this condition is incorrect? (Q880218)

A. The patient behaves as a net secretor

B. Oral water intake should be restricted to less than 1 L per day

C. Resuscitation is best achieved with hypotonic intravenous fluids

D. Use of antisecretory agents is recommended

Correct Answer: C. Resuscitation is best achieved with hypotonic intravenous fluids

Explanation: Resuscitation requires isotonic or near-isotonic fluids like normal saline to replenish sodium and water losses. Hypotonic fluids would worsen hyponatremia and cellular swelling. Incorrect Options: The patient behaves as a net secretor (Option A): Patients with less than 100 cm of jejunum and a jejunostomy lose more fluid and sodium than they absorb orally, causing high stomal output, dehydration, and electrolyte imbalances. Oral water intake should be restricted to less than 1 L per day (Option B): Excess oral hypotonic fluids worsen sodium losses and dehydration. Restricting oral intake and supplementation with oral glucose-saline solutions helps reduce stomal output. Use of antisecretory agents is recommended (Option D): Drugs like proton pump inhibitors or octreotide reduce gastric acid secretion and intestinal secretions, lowering stomal output and aiding fluid/electrolyte balance.

References:

Bailey & Love Short Practice of Surgery, 28th Edition, Pages 335, 1316.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q4: Which of the following parameters is NOT included in the MELD (Model for End-Stage Liver Disease) score? (Q849882)

A. Bilirubin

B. Creatinine

C. International Normalized Ratio (INR)

D. Albumin

Correct Answer: D. Albumin

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Albumin is included in the calculation of the PELD (Pediatric End-Stage Liver Disease) and not the MELD (Model for End-Stage Liver Disease) score. 1. MELD (Model for End-Stage Liver Disease) score: Used for adult transplant prioritization C reatinine (Option B) B ilirubin (Option A) I NR (Option C) 2. PELD (Pediatric End-Stage Liver Disease) Score: Used to determine priority for children awaiting liver transplantation N utrition A ge B ilirubin I NR A lbumin (Option D) 3. Child-Pugh Score: Used for prognosis/staging in cirrhosis Bilirubin Albumin INR (PT) Ascites Encephalopathy.

References:

https://pubmed.ncbi.nlm.nih.gov/12151728/

Bailey & Love's, Short Practice of Surgery, 28th Edition, Page 1620

Sabiston Textbook of Surgery, The Biological Basis of Modern Surgical Practice, 21st Edition, Page 618, 619

↑ *Back to this question in Part A*

@Neet_pg_bot

Q5: A 55 y/o male with advanced idiopathic pulmonary fibrosis (IPF) is evaluated for lung transplantation. He has significant dyspnea on minimal exertion, and his forced vital capacity (FVC) is 42% of the predicted value. His pre-transplant workup is normal, and he is listed for a single lung transplant. Which of the following conditions is most likely to benefit from single lung transplantation? (Q849892)

A. Cystic fibrosis

B. Pulmonary arterial hypertension

C. Idiopathic pulmonary fibrosis

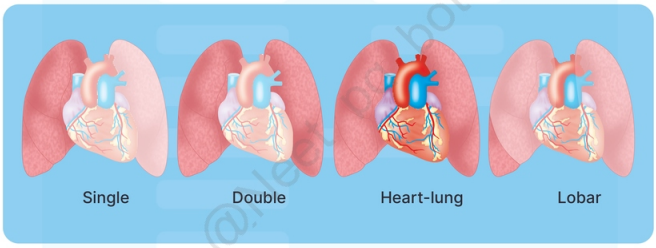
D. Bronchiectasis

Correct Answer: C. Idiopathic pulmonary fibrosis

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Idiopathic pulmonary fibrosis (IPF) is a common indication for single lung transplantation , as it primarily affects the lungs without the risk of cross-contamination In diseases like cystic fibrosis (Option A) or bronchiectasis (Option D) , double lung transplantation is required because of the risk of cross-contamination. Pulmonary Arterial Hypertension (Option B) is generally managed with double lung or heart-lung transplantation Types of Transplant: Type of Transplant Indications Single Lung Transplant Idiopathic Pulmonary Fibrosis Alpha-1 Antitrypsin Deficiency Older patients Double Lung Transplant Cystic Fibrosis Bronchiectasis Pulmonary Arterial Hypertension Younger patients



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References:

Bailey and Love Short Practice of Surgery, 28th Edition, Page 1645, 1646.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q6: A 55 y/o male who underwent heart transplantation 10 years ago presents with exertional dyspnea and fatigue for a few weeks. His initial post-transplant course was uneventful, and he has been compliant with his immunosuppressive regimen. What is the most common cause of late mortality in heart transplant recipients that should be considered in this patient? (Q849891)

A. Graft rejection

B. Infection

C. Cardiac allograft vasculopathy (CAV)

D. Renal failure

Correct Answer: C. Cardiac allograft vasculopathy (CAV)

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Cardiac Allograft Vasculopathy (CAV): The most common cause of late mortality in heart transplant recipients is cardiac allograft vasculopathy (CAV). It is a form of chronic rejection characterized by diffuse, progressive narrowing of the coronary arteries in the transplanted heart, leading to ischemic heart disease. CAV often presents with nonspecific symptoms like exertional dyspnea or fatigue due to the denervation of the transplanted heart , which can mask typical angina. Causes of Mortality Graft failure Myocardial infarction (often silent due to denervation) Arrhythmias Sudden cardiac death Heart failure Complications of Heart Transplantation: Primary Graft Dysfunction (PGD) Right Ventricular Failure Rejection (Option A): Hyperacute Rejection/Acute Cellular Rejection/Antibody-Mediated Rejection (AMR) Chronic Allograft Vasculopathy (CAV) Infection (Option B) Malignancy: EBV-associated Post-Transplant Lymphoproliferative Disorder (PTLD) due to chronic immunosuppression. Renal Dysfunction (Option D) Diabetes and Hyperlipidemia

References:

Bailey and Love's Short Practice of Surgery, 28th Edition, Page 1640.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q7: A 45-year-old male with end-stage heart failure secondary to ischemic cardiomyopathy is being evaluated for orthotopic heart transplantation. After confirming the indications for transplantation, the surgical team begins the procedure. Which of the following represents the correct sequence of anastomoses typically performed? (Q849890)

A. Pulmonary artery → Left atrium → Aorta → Right atrium

B. Left atrium → Right atrium → Pulmonary artery → Aorta

C. Aorta → Pulmonary artery → Left atrium → Right atrium

D. Right atrium → Aorta → Pulmonary artery → Left atrium

Correct Answer: B. Left atrium → Right atrium → Pulmonary artery → Aorta

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The Sequence of Anastomosis In Heart transplantation: Left Atrium: The first anastomosis is performed on the left atrium to restore pulmonary venous return, which is vital for maintaining adequate oxygenated blood flow from the lungs to the heart. Right Atrium: The next step is the anastomosis of the right

atrium, establishing venous return from the body through the superior and inferior vena cavae. Pulmonary Artery: This is followed by the pulmonary artery anastomosis to allow deoxygenated blood to flow from the right ventricle to the lungs for oxygenation. Aorta: Finally, the aorta is connected to facilitate the distribution of oxygenated blood from the left ventricle to the systemic circulation. This sequence ensures a stepwise reestablishment of circulation, reducing ischemic time for the donor heart and allowing for efficient restoration of heart function post-transplantation. Indications for Heart Transplantation: 1. End-stage heart failure unresponsive to maximal medical therapy. 2. Multiple hospitalizations due to decompensated heart failure. 3. Severe reduction in ejection fraction (EF < 20%) indicating poor heart function.

References:

Bailey and Love's Short Practice of Surgery, 28th Edition, Page 1639

↑ *Back to this question in Part A*

@Neet_pg_bot

Q8: In isolated intestine transplantation, the venous outflow from the allograft is typically established by anastomosis of which of the following? (Q849889)

A. Donor SMV to the recipient superior vena cava

B. Donor SMV to the recipient portal vein or inferior vena cava

C. Donor SMA to the recipient portal vein

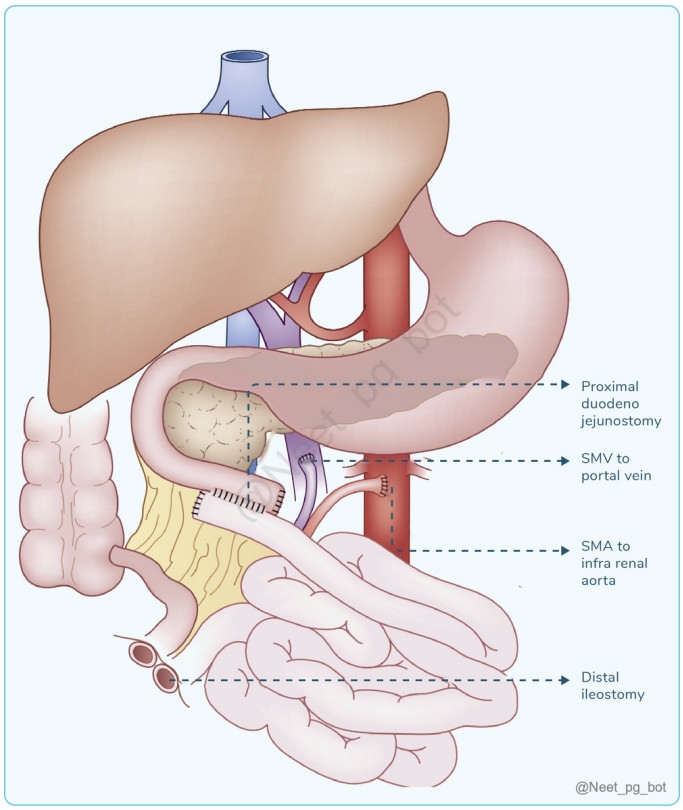
D. Donor SMV to the recipient splenic vein

Correct Answer: B. Donor SMV to the recipient portal vein or inferior vena cava

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Venous outflow in isolated intestine transplantation is typically established by anastomosis of the donor superior mesenteric vein (SMV) to either the recipient's portal vein or inferior vena cava . Isolated Intestine Allografts: Typically include the entire jejunum and ileum with the associated vasculature (SMA and SMV).



References:

Sabiston Textbook of Surgery, 21st Edition, Page 647.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q9: A transplant team is evaluating potential cadaveric donors for a small bowel transplant. Criteria for donor selection include compatible blood type, size of the donor relative to the recipient, and viral serologic testing. Which of the following is NOT a criterion for donor selection in small bowel transplantation? (Q849888)

A. Blood type compatibility

B. Donor body weight 50% to 75% of the recipient’s weight

C. Maximum cold ischemia time of 10 to 12 hours

D. Donor's minimal vasopressor requirement

Correct Answer: C. Maximum cold ischemia time of 10 to 12 hours

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The correct cold ischemia time for small bowel transplantation is 6 to 8 hours . A cold ischemia time of 10 to 12 hours exceeds the recommended duration and may lead to complications such as loss of mucosal integrity, bacterial translocation, or intestinal perforation. Criteria for donor selection in small bowel transplantation: 1. Blood Type: Donor selection is based on compatible blood type. (Option A) 2. Size Compatibility: Size is crucial due to loss of abdominal domain in recipients. Ideal donor body weight: 50% to 75% of the recipient's weight. (Option B) 3. Abdominal Surgical History: Extensive abdominal surgical history in the donor may preclude procurement. 4. Cold Ischemia Time: Intestinal allografts are sensitive to cold ischemia due to their highly vascularized and metabolically active mucosa. Maximum cold ischemia time advised: 6 to 8 hours. Hence, Donors should be hemodynamically stable, require minimal vasopressor support, and be geographically close to the transplant center. (Option D) 5. Viral Serologic Testing: Testing for Epstein-Barr virus (EBV) and cytomegalovirus (CMV) is crucial to avoid risks such as post-transplant lymphoproliferative disorder (PTLD) and severe enteritis.

References:

Sabiston Textbook of Surgery, 21st Edition, Page 646

↑ *Back to this question in Part A*

@Neet_pg_bot

Q10: A 50-year-old female with a history of type 1 diabetes mellitus presents with recurrent severe hypoglycemia with decreased awareness. He is scheduled for islet cell transplantation. Which immunosuppressive regimen is most commonly used to prevent immune rejection of the transplanted islet cells? (Q849887)

A. Cyclosporine + azathioprine + prednisolone

B. Methotrexate + mycophenolate mofetil + hydrocortisone

C. Cyclophosphamide + etanercept + rituximab

D. Daclizumab + sirolimus + tacrolimus

Correct Answer: D. Daclizumab + sirolimus + tacrolimus

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Edmonton regimen : Induction therapy with Daclizumab + Maintenance therapy with sirolimus and tacrolimus is given for immunosuppression after islet cell transplantation. Cyclosporine + azathioprine + prednisolone (Option A): Traditional in solid organ transplants, but less favoured for islet transplantation due to beta-cell toxicity and less specific immunomodulation. Methotrexate + mycophenolate mofetil + hydrocortisone

(Option B): Not standard for islet transplantation. Methotrexate is not typically used in this context. Cyclophosphamide + etanercept + rituximab (Option C): More commonly used in autoimmune conditions or bone marrow transplant conditioning , not routine for islet cell transplant.

References:

ttps://www.ncbi.nlm.nih.gov/books/NBK562272/

Sabiston Textbook of Surgery, 21st Edition, Page 640, 641

https://pubmed.ncbi.nlm.nih.gov/17005949/#:~:text=Conclusions%3A%20Islet%20transplantation%20with%20the,independence%20is%20usually%20not%20sustainable

↑ *Back to this question in Part A*

@Neet_pg_bot

Q11: A 45-year-old male with a history of type 1 diabetes mellitus undergoes a pancreas transplantation. On postoperative day 3, he develops sudden-onset severe abdominal pain, and doppler ultrasound reveals no blood flow to the pancreas graft. What is the most common cause of pancreatic graft failure in this scenario? (Q849886)

A. Vascular thrombosis

B. Anastomotic leak

C. Pancreatitis

D. Bleeding

Correct Answer: A. Vascular thrombosis

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Vascular thrombosis is the most common non-immunologic cause of pancreatic graft failure. Complications of pancreatic transplantation: Leak: (Option B) Enteric leak - needs surgical intervention Bladder leak - small leak is managed with foley’s catheter Vascular Complications: Bleeding : (Option D) Immediate posttransplantation bleeding: From the pancreatic parenchyma Delayed gastrointestinal bleeding: From the en enteric anastomosis Late gastrointestinal bleeding: CMV infection, duodenal ulcers of the duodenal stump from ischemia, pseudoaneurysm development. Thrombosis: Majority of graft thrombosis occur early. Infection Pancreatitis: (Option C) Early pancreatitis is likely due to reperfusion injury to the graft Most cases are self-limited Bowel obstruction Procedure Description: The donor pancreas (with its attached duodenal segment) is placed in the iliac fossa (extra-peritoneal or intra-peritoneal). Vascular Anastomosis: The donor portal vein (or splenic vein) is anastomosed to the recipient's iliac vein (Systemic drainage). The donor arterial supply (usually a Y-graft of donor iliac artery attached to the splenic and superior mesenteric arteries) is anastomosed to the recipient’s common or external iliac artery . Exocrine Drainage: Enteric Drainage (Preferred): The donor duodenal segment is

anastomosed to the recipient’s small bowel (jejunum) . This is the physiological gold standard. Bladder Drainage (Historical): Donor duodenum anastomosed to the bladder (used to monitor amylase as a marker for rejection, but now mostly abandoned due to complications like cystitis and metabolic acidosis). Indications: Type 1 Diabetes Mellitus: Indicated for patients with brittle diabetes, severe hypoglycemia unawareness, or concurrent End-Stage Renal Disease (ESRD) requiring a Simultaneous Pancreas-Kidney (SPK) transplant . Insulin Reserve: Patients must have exhausted other therapeutic options and, in specific Type 2 cases, must demonstrate low C-peptide levels indicating insulin deficiency.

References:

Sabiston Textbook of surgery, 21st Edition, Page 639, 640

↑ *Back to this question in Part A*

@Neet_pg_bot

Q12: Which of the following statements is/are true regarding pancreas transplantation? Type-2 DM with clear c-peptide deficiency is not an indication for pancreas transplantation. End-to-end anastomosis is done between the internal iliac artery and splenic artery Systemic venous drainage is preferred over portal venous drainage Enteric drainage of endocrine secretion is preferred (Q849885)

A. Only 2

B. 1, 2, and 4

C. 2 and 3

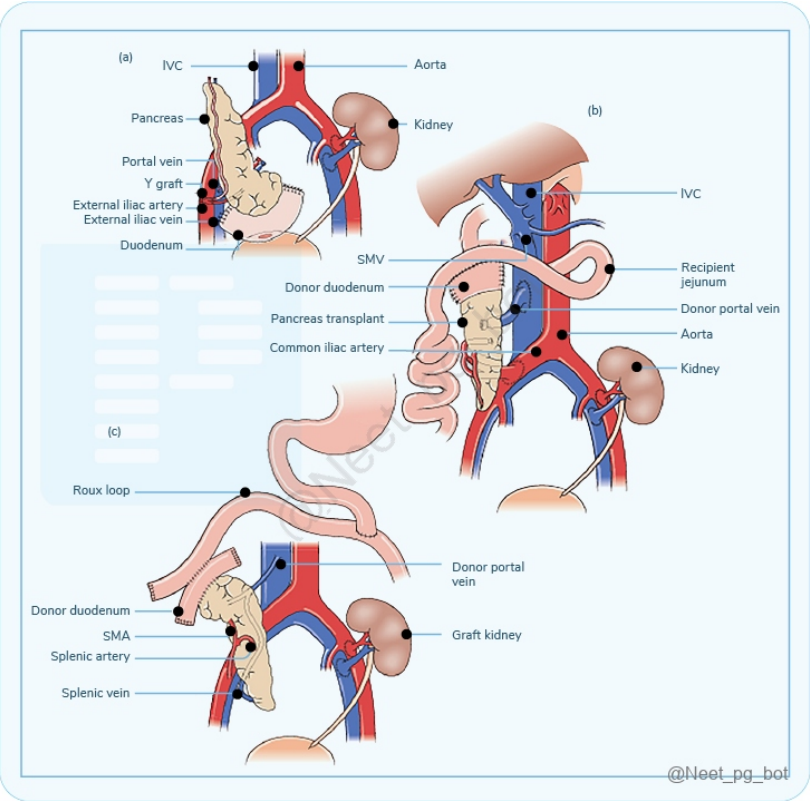
D. All of the above

Correct Answer: C. 2 and 3

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Indications of pancreas transplantation: Type 2 DM with clear c-peptide deficiency Anastomosis: Internal iliac → splenic artery, External iliac → SMA. Venous drainage: systemic (IVC/iliac vein) preferred . Exocrine secretions are drained enterically , not endocrine



References:

Bailey and Love's Short Practice of Surgery, 28th Edition, Page 1623-1626

Sabiston Textbook of Surgery, 21st Edition, Page 637-639

↑ *Back to this question in Part A*

@Neet_pg_bot

Q13: Which of the following statements is NOT true regarding contraindications and complications of renal transplantation? (Q849884)

A. Renal vein thrombosis post-surgery is managed conservatively with anticoagulants

B. Active IV drug abuse is a contraindication for the transplant

C. Lymphocele can cause ureteric obstruction

D. Renal artery stenosis post-transplant is best treated by angioplasty

Correct Answer: A. Renal vein thrombosis post-surgery is managed conservatively with anticoagulants

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Renal vein thrombosis post-surgery is an emergency and needs urgent surgical exploration. Complications of renal transplantation Complication Key Feature Management Urinary retention (donor) Most common donor complication Catheterization Ileus (donor) Postoperative bowel inactivity Conservative (NG tube, fluids, early mobilization) Hemorrhage Early postoperative bleeding Resuscitation ± surgical exploration Renal artery thrombosis (<1%) Sudden graft loss, anuria Urgent thrombectomy (often graft loss) Renal vein thrombosis (1–5%) Painful graft swelling, hematuria Surgical exploration ± graft nephrectomy Renal artery stenosis (Option D) Late complication, hypertension Angioplasty ± stenting Urinary leak Due to distal ureter ischemia Drainage + ureteric stenting/reimplantation Ureteric obstruction Hydronephrosis, ↓ urine output Stenting or surgical revision Lymphocele (Option C) May compress ureter → obstruction Aspiration or surgical drainage (marsupialization) Acute allograft dysfunction Rejection, ATN, drug toxicity Depends on cause (e.g., steroids for rejection) Chronic allograft dysfunction Fibrosis, chronic rejection Optimize immunosuppression, supportive care Contraindications of renal transplant: Active malignant disease Active infection Unreconstructable peripheral vascular disease Severe cardiac or pulmonary disease Active intravenous drug abuse (Option B) Significant psychosocial barriers

References:

Bailey and Love's Short Practice of Surgery, 28th edition, Page 1605-1607

Sabiston Textbook of Surgery, 21st edition, Page 628

↑ *Back to this question in Part A*

@Neet_pg_bot

Q14: A 45-year-old male with end-stage renal disease due to polycystic kidney disease is scheduled for a renal transplant, with his brother serving as the donor. During the transplant procedure, where is the donor kidney typically placed, and to which vessel is its renal artery anastomosed? (Q849883)

A. Right hypochondrium and aorta

B. Left hypochondrium and external iliac artery

C. Iliac fossa and Internal iliac artery

D. Lumbar region and Inferior vena cava

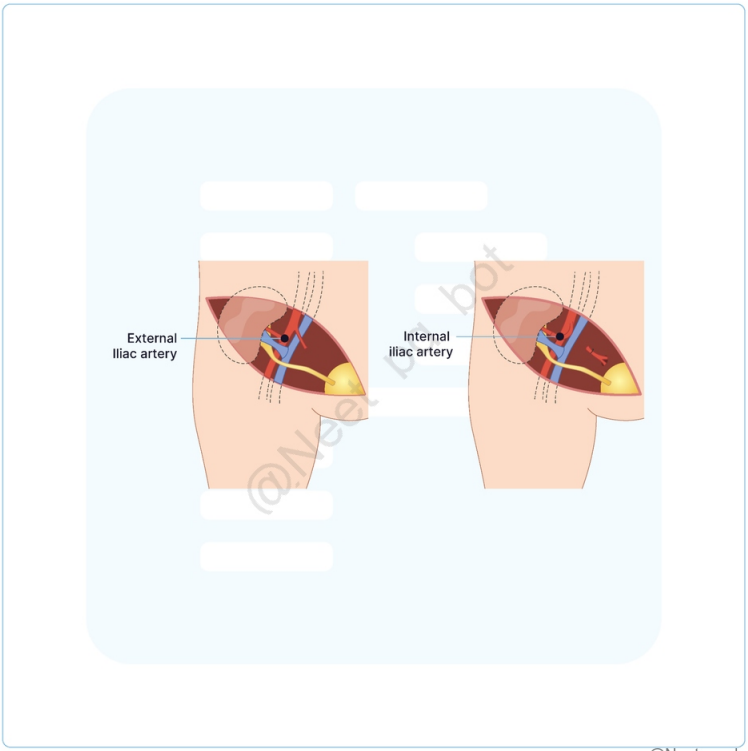
Correct Answer: C. Iliac fossa and Internal iliac artery

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: In living donors, the donor renal artery is anastomosed to the internal iliac artery and the renal graft is placed in the iliac fossa. Renal transplant procedure: The donor kidney is transplanted into one of the iliac fossae

(Option C) (retroperitoneal location) leaving the native kidney in situ. Hence, a total of 3 kidneys in the recipient. The donor renal vein is anastomosed end to side to the external or common iliac vein. In a cadaveric donor, the renal artery is anastomosed end to side to the external or common iliac artery. In live donors, end-to-end anastomosis to the divided internal iliac artery is used more commonly due to the lack of an aortic patch (Carrel's patch) .



References:

Bailey and Love's Short Practice of Surgery, 28th Edition, Page 1602-1604

↑ *Back to this question in Part A*

@Neet_pg_bot

Q15: Which of the following best describes the definition of a "deceased person" according to the Transplantation of Human Organs Act? (Q849795)

A. A person who has been unconscious for more than 24 hours.

B. A person who has a permanent cessation of all evidence of life.

C. A person who has been declared clinically dead but with potential for revival.

D. A person who has undergone a major surgery with no sign of life for 6 hours.

Correct Answer: B. A person who has a permanent cessation of all evidence of life.

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: According to the Act, a "deceased person" is defined as one who has experienced a permanent cessation of all signs of life , which is crucial for determining organ donation eligibility. This definition ensures that the donor is truly deceased and prevents confusion with conditions like clinical death or severe unconsciousness. Transplantation of Human Organs Act, India (1994) Purpose : Regulate organ transplantation and ensure ethical organ donation practices, particularly for deceased donors.

References:

https://pubmed.ncbi.nlm.nih.gov/22728294/ https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9067489/

↑ *Back to this question in Part A*

@Neet_pg_bot

Q16: A 55-year-old patient with end-stage liver disease receives a liver from a donor with familial amyloid polyneuropathy (FAP) as part of a domino liver transplantation. Which of the following statements is incorrect? (Q849881)

A. It can use a liver from a patient with familial amyloid polyneuropathy (FAP).

B. FAP symptoms appear immediately after transplantation.

C. If the recipient later develops FAP symptoms, they can undergo a retransplantation without risk of malignancy recurrence.

D. The recipient is less likely to develop or be significantly affected by the metabolic syndrome

Correct Answer: B. FAP symptoms appear immediately after transplantation.

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: FAP symptoms develop 10-20 years after transplantation, not immediately. Domino Liver Transplantation Definition : Transplanting a liver from a patient with a metabolic disease into a patient with end-stage liver disease. Rationale : The donor’s liver has a normal structure and function, but would eventually cause systemic disease in the donor. The recipient is less likely to develop or be significantly affected by the metabolic syndrome. (Option D) Key Benefit : If the recipient does not develop malignancy recurrence and later becomes symptomatic from the metabolic disease, they can receive a re-transplant without the risk of malignancy recurrence. (Option C) Suitable Metabolic Diseases : Familial amyloid polyneuropathy (FAP) (Option A) Maple syrup urine disease Familial hypercholesterolemia

References:

Bailey & Love's Short Practice of surgery, 28th Edition, Page 1615

↑ *Back to this question in Part A*

@Neet_pg_bot

Q17: A 52-year-old woman, who underwent a liver transplant 2 months ago, presents with jaundice and bile leakage from the surgical site. Imaging studies suggest narrowing of the bile ducts. What is the most likely complication she is experiencing, and what could be the potential need for management? (Q849880)

A. Acute cellular rejection- Increase immunosuppressants

B. Chronic rejection- Continue monitoring

C. Ischemic-type biliary lesion (ITBL)- Consider retransplantation

D. Hepatic artery thrombosis- Start anticoagulation therapy

Correct Answer: C. Ischemic-type biliary lesion (ITBL)- Consider retransplantation

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Ischemic-type biliary lesion (ITBL) is a severe form of biliary stricture that can occur after liver transplantation, often leading to bile leaks and jaundice. In severe cases, it may necessitate re-transplantation. Pathophysiology of ITBL: The biliary tree has a dual blood supply (hepatic artery branches). In liver transplants, the bile duct is dependent entirely on the donor hepatic artery. Mechanism: If there is a delay in reperfusion, arterial thrombosis, or prolonged cold ischemia, the peribiliary vascular plexus is damaged → ischemic necrosis of the biliary epithelium → stricture/dilatation. Complications and Indications for Re-transplantation Complication Description Re-transplant Indication Primary Non-function (PNF) Transplanted liver fails to function. Often required. Hemorrhage Bleeding due to portal hypertension or coagulopathy. Not usually indicated unless severe. Hepatic Artery Thrombosis (Option D) Blockage of the hepatic artery. Often required, especially if early onset. Biliary Complications Bile leaks, strictures, or ischemic-type biliary lesions. Required in severe cases like ITBLs. Acute Cellular Rejection (Option A) The immune system attacks the liver. Usually managed with medication. Chronic Rejection (Option B) Gradual loss of graft function over time. May eventually require retransplant.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1617, 1618.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q18: A 40-year-old male with end-stage liver disease due to chronic hepatitis C is being evaluated for a liver transplant. During the evaluation, it was noted that his 38-year-old sister is willing to donate a portion of her liver. Which of the following liver transplant options is most appropriate for this patient? (Q849879)

A. Deceased Donor Liver Transplantation (DDLT)

B. Domino Liver Transplantation

C. Living Donor Liver Transplantation (LDLT)

D. Split Liver Transplantation

Correct Answer: C. Living Donor Liver Transplantation (LDLT)

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Living Donor Liver Transplantation (LDLT) involves transplanting a portion of the liver from a living donor, making it an appropriate option when a suitable living donor, such as the patient's sister, is available. Liver Transplant Types Deceased Donor Liver Transplantation (DDLT): (Option A) Source: Donors after brain death (DBD) or circulatory death (DCD). Note: DCD livers are at higher risk of damage but increase organ availability. Living Donor Liver Transplantation (LDLT) Source: A portion of the liver from a living donor. Application: Common where deceased donor organs are scarce. Split Liver Transplantation: (Option D) Procedure: Divide a deceased donor's liver into two parts. Recipients: Pediatric (left lateral segment) and adult (extended right lobe). Reduced-size Liver Transplantation Procedure: Resect a portion of a full-size liver to fit a smaller recipient. Use: Urgent cases, no additional graft generated. Auxiliary Liver Transplantation Procedure: Graft implanted while preserving native liver (e.g., APOLT). Application: Bridge to native liver regeneration in acute liver failure. Domino Liver Transplantation (Option B) Source: Donor with metabolic liver disease. Note: Recipients may develop metabolic syndrome later. Paired-exchange Programs Method: Incompatible donor-recipient pairs exchange livers for compatibility.

References:

Bailey & Love’s Short Practice of Surgery, 28th Edition, Page 1596, 1602, 1608, 1609, 1612, 1613, 1614, 1615, 1637.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q19: Which of the following methods is currently considered the gold standard for preserving the pancreas before transplantation? (Q849878)

A. Hypothermic machine perfusion (HMP)

B. Normothermic machine perfusion (NMP)

C. Static cold storage (SCS) with University of Wisconsin (UW) solution

D. Normothermic regional perfusion (NRP)

Correct Answer: C. Static cold storage (SCS) with University of Wisconsin (UW) solution

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Static cold storage (SCS) with University of Wisconsin (UW) solution: This is the most commonly used and considered the gold standard for organ preservation, especially for the pancreas. The UW solution contains hydroxyethyl starch (HES), which is crucial for reducing metabolic activity and preserving the pancreas during cold storage. Methods of Organ Preservation Method Description Advantages/Limitations Static Cold Storage (SCS) (Option C) Cooling the organ to 4°C with a preservation solution to reduce metabolism. The most common method. Uses the University of Wisconsin (UW) solution Hypothermic Machine Perfusion (HMP) (Option A) Continuously pumps cooled preservation solution through the organ's vasculature. Promising in experimental settings. Normothermic Machine Perfusion (NMP) (Option B) Circulates warm, oxygenated, red blood cell-based perfusate through the organ. Creates a physiological environment ex vivo . Used in other organs (heart, lung, liver, kidney). Less successful for the pancreas due to organ injury from high autolytic enzyme concentrations. Normothermic Regional Perfusion (NRP) (Option D) Warm, oxygenated blood is pumped back through abdominal organs after circulatory arrest. Beneficial for liver preservation. Efficacy for pancreas transplantation remains inconclusive.

References:

Bailey & Love’s Short Practice of Surgery, 28th Edition, Page 1598, 1619, 1623, 1624, 1643.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q20: A 45-year-old male is declared legally dead due to irreversible brainstem function loss following a severe head injury. He is considered for organ donation. Which of the following statements is true regarding Donation After Brainstem Death (DBD)? (Q849877)

A. In DBD complications like graft dysfunction, especially with the liver and pancreas, are expected.

B. A 5-minute "no-touch" period is observed in the case of DBD.

C. In DBD, organs are perfused with oxygenated blood at the time of procurement.

D. Warm ischemia is seen in DBD.

Correct Answer: C. In DBD, organs are perfused with oxygenated blood at the time of procurement.

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: In Donation After Brainstem Death (DBD,) organs remain perfused with oxygenated blood until retrieval, generally ensuring better viability and outcomes. Differences Between DBD and DCD Donors Feature DBD (Donation After Brainstem Death) DCD (Donation After Circulatory Death) Terminology Heart-beating donors Asystolic or Non-heart-beating donors Organ Condition Perfused with oxygenated blood at the time of procurement (Option C) Warm but not perfused with oxygenated blood; risk of warm ischemia (Option D) Procedure Timing Organ retrieval after brainstem death declaration Controlled DCD: Retrieval after a 5-minute "no-touch" period post-arrest. (Option B) Uncontrolled DCD : Retrieval following failed resuscitation in the ICU or ED. Viability & Outcomes Generally good, with organs in better condition due to oxygenation Variable quality; higher risk of complications like graft dysfunction. Outcomes can improve with machine perfusion and careful organ selection. (Option A)

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1595, 1596, 1612, 1613.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q21: A 52-year-old female who received a multi-visceral transplant presents with unexplained fever, night sweats, and significant weight loss. Her laboratory results show persistent Epstein–Barr virus (EBV) viremia. Which of the following transplant recipients is at the highest risk of developing post-transplant lymphoproliferative disorder (PTLD)? (Q849803)

A. Kidney transplant recipient

B. Liver transplant recipient

C. Intestinal transplant recipient

D. Heart transplant recipient

Correct Answer: C. Intestinal transplant recipient

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Intestinal transplant recipients have the highest risk of developing PTLD, with an incidence of up to 17%, due to the high level of immunosuppression and the large amount of lymphoid tissue in the graft. Post-Transplant Lymphoproliferative Disorder (PTLD) Symptoms and Diagnosis: Persistent Epstein–Barr virus

(EBV) viremia or B symptoms (night sweats, unexplained fevers, weight loss) should prompt consideration of PTLD. Treatment Approach: First-Line Treatment: Rituximab and careful reduction of immunosuppression. Caution Required: Especially in multi-visceral/intestinal transplants to avoid rejection.

References:

Bailey & Love's Short Practice of Surgery, 28th edition, Page 1635

↑ *Back to this question in Part A*

@Neet_pg_bot

Q22: In transplant recipients, which of the following is the most common cause of viral infection within the first 6 months post-transplant? (Q849802)

A. Herpes Simplex Virus (HSV)

B. Cytomegalovirus (CMV)

C. Epstein-Barr Virus (EBV)

D. BK Virus

Correct Answer: B. Cytomegalovirus (CMV)

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Cytomegalovirus (CMV) is the most common cause of viral infection in transplant recipients within the first 6 months after transplantation. CMV often reactivates in immunosuppressed patients, leading to systemic and organ-specific complications. Clinical Manifestations: Typically manifests within the first 6 months (30-50 days) post-transplant. Systemic Symptoms: Fever, fatigue, and malaise. Organ-Specific Involvement: Can affect various organs including the lungs (pneumonitis), gastrointestinal tract(colitis), liver(hepatitis), and eyes(retinitis). Treatment: IV Ganciclovir (main treatment) Also used for chemoprophylaxis Most common cause of transplant rejection >6 months: BK virus.

References:

https://www.ncbi.nlm.nih.gov/books/NBK459185/

↑ *Back to this question in Part A*

@Neet_pg_bot

Q23: Which intervention has been shown to reduce the risk of graft loss in kidney transplant recipients with BK virus nephropathy? (Q849801)

A. Increasing the dosage of calcineurin inhibitors

B. Administering antiviral therapy as a first-line treatment

C. Timely reduction of immunosuppressive therapy

D. Routine use of corticosteroids

Correct Answer: C. Timely reduction of immunosuppressive therapy

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Timely reduction of immunosuppressive therapy has been proven to significantly reduce graft loss in kidney transplant recipients with BK virus nephropathy, lowering the risk from 90% to 10%. BK Virus: Belongs to the Polyomavirus family. Infection in Transplant Recipients : Reactivation : Can reactivate in immunocompromised patients, particularly in kidney transplant recipients. Timing : 1-4 months after transplantation. Increasing the dosage of calcineurin inhibitors (Option A): Increasing the dosage of calcineurin inhibitors can exacerbate BK virus nephropathy by further suppressing the immune system. Administering antiviral therapy as a first-line treatment (Option B): While antiviral therapy may be used in severe cases, the primary strategy for reducing graft loss is to manage immunosuppression. Routine use of corticosteroids (Option D): Routine use of corticosteroids is not specific to managing BK virus nephropathy and can contribute to further complications.

References:

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5084638/

↑ *Back to this question in Part A*

@Neet_pg_bot

Q24: Which of the following is the most common malignancy in transplant recipients? (Q849800)

A. Kaposi Sarcoma

B. Post-transplant lymphoproliferative Disorder (PTLD)

C. Squamous Cell Carcinoma

D. Cytomegalovirus-Associated Tumors

Correct Answer: C. Squamous Cell Carcinoma

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Squamous Cell Carcinoma is the most common malignancy in transplant recipients. Due to the long-term immunosuppression required to prevent organ rejection, transplant recipients have an increased risk of developing skin cancer, with squamous cell carcinoma being particularly prevalent. Although Post-transplant lymphoproliferative disorder (Option B) , Kaposi Sarcoma (Option A) is seen among transplant recipients, it is not the most common Viral Infections- Cytomegalovirus (CMV) (Option D) : Peak within the first 6 months post-transplantation.

References:

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7152453/

↑ *Back to this question in Part A*

@Neet_pg_bot

Q25: Which of the following drugs works by inhibiting T-cell activation through the blockage of calcineurin, ultimately reducing IL-2 production? (Q849799)

A. Azathioprine

B. Prednisone

C. Tacrolimus

D. Sirolimus

Correct Answer: C. Tacrolimus

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Tacrolimus is a calcineurin inhibitor that works by blocking the enzyme calcineurin, leading to a reduction in IL-2 production and subsequent T-cell activation. Class Examples Mechanism of Action Calcineurin Inhibitors Cyclosporine, Tacrolimus Inhibit T-cell activation by blocking calcineurin, reducing IL-2 production Antimetabolites Azathioprine (Option A), Mycophenolate mofetil Inhibit nucleotide synthesis, suppressing lymphocyte proliferation mTOR Inhibitors Sirolimus (Option D) , Everolimus Inhibit the mTOR pathway, blocking cell cycle progression in T-cells Corticosteroids Prednisone (Option B), Methylprednisolone Broad anti-inflammatory effects; reduce cytokine production Monoclonal Antibodies Basiliximab, Rituximab, Belatacept Target specific immune cells or cytokines to inhibit immune responses Anti-thymocyte Globulin (ATG) - Polyclonal antibodies that deplete T-cells, reducing immune response

References:

Bailey and Love's Short Practice of Surgery, 27th Edition, Page 601, 602
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8987166/

↑ *Back to this question in Part A*

@Neet_pg_bot

Q26: Which type of graft involves tissue transplantation between genetically identical individuals, such as identical twins? (Q849798)

A. Autograft

B. Allograft

C. Isograft

D. Xenograft

Correct Answer: C. Isograft

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: An isograft involves tissue transplantation between genetically identical individuals, such as identical twins. Graft Type Source Advantages Autograft (Option A) Tissue from one site to another on the same individual No risk of immune rejection; high success rate Allograft (Option B) Tissue from another individual of the same species Availability of larger tissue amounts Xenograft (Option D) Tissue from a different species (e.g., pig to human) Readily available; used as temporary grafts Isograft (Option C) Tissue between genetically identical individuals No risk of immune rejection due to genetic identity

References:

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9624478/ https://www.ncbi.nlm.nih.gov/books/NBK45531/

↑ *Back to this question in Part A*

@Neet_pg_bot

Q27: A 45-year-old patient requires a kidney transplant. Which statement about HLA matching is most accurate for this transplant? (Q849797)

A. Mismatches at the HLA-B locus have a more significant impact on transplant outcomes than mismatches at the HLA-DR locus.

B. HLA typing is typically performed using DNA sequencing to assess compatibility.

C. HLA Class I molecules are categorized into HLA-DP, HLA-DQ, and HLA-DR.

D. Tissue typing in transplantation includes HLA-B, HLA-C, and HLA-DP loci.

Correct Answer: B. HLA typing is typically performed using DNA sequencing to assess compatibility.

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: HLA typing for compatibility is performed using DNA sequencing. HLA Matching in Transplantation Definition: HLA (Human Leukocyte Antigen) matching is essential in organ transplantation to reduce the risk of graft rejection. HLA molecules, also known as MHC (Major Histocompatibility Complex) antigens, help the immune system distinguish between self and foreign tissues. HLA Classes Class HLA Molecules Characteristics Class I (Option C) HLA-A, HLA-B, HLA-C Present on most cells, involved in immune response. Class II HLA-DP, HLA-DQ, HLA-DR Found on antigen-presenting cells, critical for immune recognition. DR locus mismatches have the greatest impact on transplant outcomes. (Option A) , B locus mismatches are more significant than A locus mismatches. Tissue typing in transplantation includes HLA-A, HLA-B, and HLA-DR loci (Option D) .

References:

SRB's Manual of Surgery, 6th Edition, Page 327, 330, 331.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q28: A 45-year-old male patient undergoes a kidney transplant. Shortly after the procedure, he experiences a rapid onset of graft dysfunction characterized by the destruction of the graft's vascularization. Which type of rejection does this patient most likely have? (Q849796)

A. Hyperacute Rejection

B. Acute Cellular Rejection

C. Acute Humoral Rejection

D. Chronic Rejection

Correct Answer: A. Hyperacute Rejection

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Hyperacute Rejection is correct as it occurs within minutes to hours of transplantation and is characterized by rapid destruction of vascularization due to pre-existing antibodies against the graft. This type of graft rejection is primarily antibody-mediated and is most commonly associated with pre-existing antibodies against the graft. Types of Rejection Type of Rejection Timing Mechanism Characteristics Clinical Presentation Hyperacute (Option A) Minutes to hours Antibody-mediated (preformed antibodies) Rapid vascular thrombosis and graft necrosis Immediate graft failure, no urine output (kidney), mottled/cyanotic graft Acute (Option B & D) Within 6 months Cellular (T-cell) ± Humoral (antibody) Lymphocytic infiltration, endothelial injury Fever, graft tenderness, ↓ organ function (e.g., rising creatinine in kidney) Chronic (Option D) Months to years Mixed (cellular + antibody-mediated) Progressive fibrosis, vascular narrowing Gradual graft dysfunction, hypertension, proteinuria (kidney)

References:

SRB’s Manual of Surgery, 6th Edition, Page 328, 32.

↑ *Back to this question in Part A*

@Neet_pg_bot

• [12_Miscellaneous] 060 Nutrition Sutures And Anastomosis

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[12_Miscellaneous] 060 Nutrition Sutures And Anastomosis — Quick Jump

Q1 (p. 3425)	*Q2 (p. 3426)*	*Q3 (p. 3427)*	*Q4 (p. 3428)*	*Q5 (p. 3428)*	*Q6 (p. 3429)*
Q7 (p. 3430)	*Q8 (p. 3430)*	*Q9 (p. 3431)*	*Q10 (p. 3432)*	*Q11 (p. 3432)*	*Q12 (p. 3434)*
Q13 (p. 3438)	*Q14 (p. 3439)*	*Q15 (p. 3441)*	*Q16 (p. 3442)*	*Q17 (p. 3443)*	*Q18 (p. 3444)*
Q19 (p. 3445)	*Q20 (p. 3446)*	*Q21 (p. 3447)*	*Q22 (p. 3448)*	*Q23 (p. 3449)*	*Q24 (p. 3450)*
Q25 (p. 3451)					

Q1: Which of the following is the recommended knot for securing the final stitch in a continuous suture technique during surgery? (Q849771)

A. Reef knot

B. Aberdeen knot

C. Surgeon’s knot

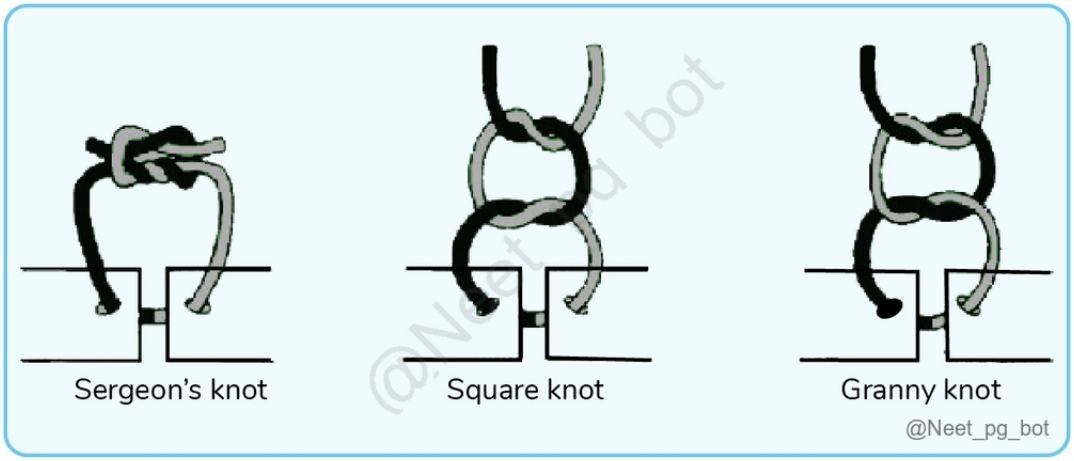
D. Buried knot

Correct Answer: B. Aberdeen knot

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Aberdeen knot is specifically used to secure the final stitch in continuous suture techniques. Continuous sutures involve using a single length of suture material to create multiple stitches, and the Aberdeen knot is effective at securing the end of this continuous line of sutures. It provides a secure closure and is particularly useful for finishing a continuous suture , ensuring the stitches remain tight and secure. Square/ Reef knot (Option A) : It is a standard knot with an extra throw for security. Surgeon’s Knot (Option C) : Extra security, prevents slippage (two-throw knot). Buried Knot (Option D) : Used to secure the ends of absorbable sutures when a subcuticular suture technique is used to close the skin.





References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Pages 95, 107, 108, 109.

www.ncbi.nlm.nih.gov/pmc/articles/PMC5991013/

↑ *Back to this question in Part A*

@Neet_pg_bot

Q2: In a patient suffering from acute pancreatitis, which electrolyte disturbance is most commonly observed? (Q880229)

A. Hypercalcemia

B. Hypocalcemia

C. Hypernatremia

D. Hyperkalemia

Correct Answer: B. Hypocalcemia

Explanation: Hypocalcemia is common in acute pancreatitis due to saponification, where free fatty acids released by pancreatic lipase bind calcium, forming calcium soaps that precipitate in necrotic fat tissues. This reduces serum calcium levels. Incorrect Options: Hypercalcemia (Option A): Hypercalcemia is a rare cause, not a result, of acute pancreatitis Hypernatremia (Option C): Not a typical finding; sodium may be normal or low depending on fluid status and resuscitation. Hyperkalemia (Option D): Not typically seen; in fact, hypokalemia is more common due to vomiting or fluid shifts.

References:

Bailey & Love Short Practice of Surgery, 28th Edition, Page 1274.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q3: All of the following are recognised causes of hypokalemia except: (Q880228)

A. Hyperaldosteronism

B. Diarrhoea

C. High nasogastric output

D. Metabolic acidosis

Correct Answer: D. Metabolic acidosis

Explanation: Metabolic acidosis is typically associated with hyperkalemia rather than hypokalemia. In acidosis, hydrogen ions shift into cells and potassium shifts out into the serum, raising potassium levels. Incorrect Options: Hyperaldosteronism (Option A) causes hypokalemia by increasing renal potassium excretion as aldosterone promotes sodium retention and potassium loss in the distal tubules. Diarrhoea (Option B) leads to potassium loss via the gastrointestinal tract and is a common cause of hypokalemia. High nasogastric output (Option C): Nasogastric suction removes gastric fluids that contain potassium, leading to hypokalemia.

References:

Bailey & Love Short Practice of Surgery, 28th Edition, Page 1169.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q4: In a post-surgical patient, which of the following is typically the first clinical indication of fluid overload? (Q880227)

A. Distended neck veins

B. Peripheral edema

C. Weight gain

D. Increased cardiac output

Correct Answer: C. Weight gain

Explanation: Weight gain is the earliest and most sensitive clinical indicator of fluid overload. Weight changes reflect fluid accumulation before visible edema or vascular changes. Incorrect Options: Distended neck veins (Option A): Occur later in fluid overload with sufficient volume to cause elevated central venous pressure. Peripheral edema (Option B): Usually appears after interstitial fluid accumulates due to prolonged or significant volume overload. Increased cardiac output (Option D): Cardiac output initially may increase to compensate for volume overload, but it is not a direct clinical sign and varies widely.

References:

Bailey & Love Short Practice of Surgery, 28th Edition, Page 339.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q5: Long-term dependence on total parenteral nutrition without adequate supplementation can most commonly lead to deficiency of which of the following? (Q880226)

A. Vitamin B12

B. Folic acid

C. Amino acids

D. Zinc

Correct Answer: D. Zinc

Explanation: Zinc deficiency is a well-recognised complication in patients on prolonged TPN if not supplemented properly. Zinc plays a key role in wound healing, immune function, and enzymatic processes, and its deficiency can cause dermatitis, alopecia, impaired taste, and poor wound healing. Incorrect Options: Vitamin B12 (Option A) deficiency is uncommon because B12 stores are large and the liver stores can last for years; also, B12 can be supplemented parenterally. Folic acid (Option B) deficiency can occur, but it is less common if TPN is properly formulated, as folate is water-soluble and routinely included in the solution. Amino acids (Option C) are important components of TP, N and deficiency is generally avoided with adequate formulation.

References:

Bailey & Love Short Practice of Surgery, 28th Edition, Page 338.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q6: A patient has been receiving total parenteral nutrition (TPN) through a central venous line for more than a month. Which of the following is not routinely recommended as part of monitoring during TPN therapy? (Q880225)

A. Regular assessment for new-onset glucose intolerance

B. Checking serum electrolytes every 2–3 days

C. Weekly monitoring of liver function tests and blood urea nitrogen

D. Scheduled replacement of the central venous catheter every two weeks

Correct Answer: D. Scheduled replacement of the central venous catheter every two weeks

Explanation: Routine catheter replacement every two weeks is not advised, as repeated manipulation increases the risk of infection. Instead, catheters should be changed only when clinically necessary, such as in cases of catheter-related bloodstream infection or malfunction. Incorrect Options: Regular assessment for new-onset glucose intolerance (Option A): Monitoring blood glucose regularly is important since TPN formulations are rich in dextrose, and hyperglycemia is a common complication. Checking serum electrolytes every 2–3 days (Option B): Electrolytes such as sodium, potassium, magnesium, phosphate, and calcium require frequent monitoring (often daily or every 2–3 days) to detect imbalances early. Weekly monitoring of liver function tests and blood urea nitrogen (Option C): Liver function tests (LFTs) and renal function, including blood urea nitrogen (BUN), are monitored regularly, typically at least weekly during long-term TPN to detect liver dysfunction and renal complications.

References:

Bailey & Love Short Practice of Surgery, 28th Edition, Pages 336, 808.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q7: A patient is started on total parenteral nutrition through a peripherally inserted central catheter. After placement, a chest radiograph is obtained to confirm the line's position. The catheter tip should ideally terminate in which vessel? (Q880223)

A. Subclavian vein

B. Internal jugular vein

C. Superior vena cava

D. Inferior vena cava

Correct Answer: C. Superior vena cava

Explanation: The ideal location is the lower third of the superior vena cava (SVC), near the cavo-atrial junction (CAJ). This provides fast blood flow to rapidly dilute the infusate, minimising irritation of the vascular endothelium and risk of thrombosis or vessel wall damage. Correct tip placement reduces complications such as thrombophlebitis, catheter occlusion, and cardiac arrhythmias. Incorrect Options: Subclavian vein (Option A): The subclavian vein is a common access site for central lines, but the catheter tip should not be left here because blood flow is slower and the risk of thrombosis and complications is higher. Internal jugular vein (Option B): The catheter tip should advance beyond this point into a larger vessel for optimal dilution and to reduce complications. Inferior vena cava (Option D): This is anatomically too low and is the venous drainage of the lower body.

References:

Bailey & Love Short Practice of Surgery, 28th Edition, Pages 338-339.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q8: While inserting a Ryle's tube in a conscious patient, which position is considered most appropriate to facilitate the smooth passage of the tube? (Q880221)

A. Supine with neck flexion

B. Supine with neck extension

C. Sitting with neck flexion

D. Sitting with neck extension

Correct Answer: C. Sitting with neck flexion

Explanation: The sitting position facilitates swallowing by using gravity, while flexing the neck in a "chin tuck" posture helps close the trachea and open the oesophagus, ensuring smoother passage of the tube into the oesophagus and stomach. Incorrect Options: Supine with neck flexion (Option A): Neck flexion facilitates oesophageal entry by aligning the tube with the pharynx, but the supine position increases the risk of aspiration and is less comfortable for conscious patients. Supine with neck extension (Option B): Neck extension predisposes to entry into the larynx and increases risk of tube passing into the trachea; not recommended for safe nasogastric tube placement. Sitting with neck extension (Option D): Neck extension risks misdirection of the tube into the airway, increasing the risk of coughing and aspiration .

References:

Bailey & Love Short Practice of Surgery, 28th Edition, Page 336.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q9: Which of the following contributes to the generation of endogenous water within the body? (Q880217)

A. Ingested fluids

B. Breakdown of solid food

C. Oxidation of solid foodstuffs

D. Both A and C

Correct Answer: C. Oxidation of solid foodstuffs

Explanation: Endogenous or metabolic water is produced primarily during the oxidation of nutrients such as carbohydrates, fats, and proteins inside cells. This metabolic water contributes to the body's water balance. Incorrect Options: Ingested fluids (Option A): These are external water sources consumed through drinking and food, not produced within the body, so not considered endogenous water. Breakdown of solid food (Option B): Digestion breaks down food into absorbable nutrients but does not itself generate water.

References:

Bailey & Love Short Practice of Surgery, 28th Edition, Page 331.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q10: During morning rounds, an intern is asked how to recognise inadequate perfusion in a burns patient receiving fluid therapy. The resident explains that a fluid bolus of 10 mL/kg should be given if certain warning signs appear. Which of the following is not an indication for administering a fluid bolus?: (Q880215)

A. Tachycardia

B. Low hematocrit

C. Restlessness

D. Cool peripheries

Correct Answer: B. Low hematocrit

Explanation: A low hematocrit typically indicates anemia. In burn patients, hematocrit may be low due to fluid resuscitation and hemodilution, but it is not a direct indication of hypovolemia or inadequate perfusion. Hence, it is not an indication for a fluid bolus. Incorrect Options: Tachycardia (Option A): Tachycardia is a warning sign of inadequate perfusion and hypovolemia. It often occurs as the body tries to compensate for decreased circulating volume. Restlessness (Option C): Restlessness can signify poor cerebral perfusion and hypoxia, which may result from inadequate circulating volume, making a fluid bolus appropriate. Cool peripheries (Option D): Cool extremities suggest peripheral vasoconstriction due to poor perfusion and hypovolemia, and are a sign that fluid resuscitation might be necessary.

References:

Bailey & Love Short Practice of Surgery, 28th Edition, Page 671.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q11: A 60-year-old patient is undergoing ileostomy closure and the surgeon opts for a hand-sewn anastomosis technique. Which of the following accurately describes the single-layer hand-sewn anastomosis technique? (Q849774)

A. It includes an inner continuous suture layer and an outer layer of interrupted sutures.

B. It uses a continuous suture line through all layers of the bowel wall, except the mucosa.

C. It uses a continuous suture line through all layers of the bowel wall.

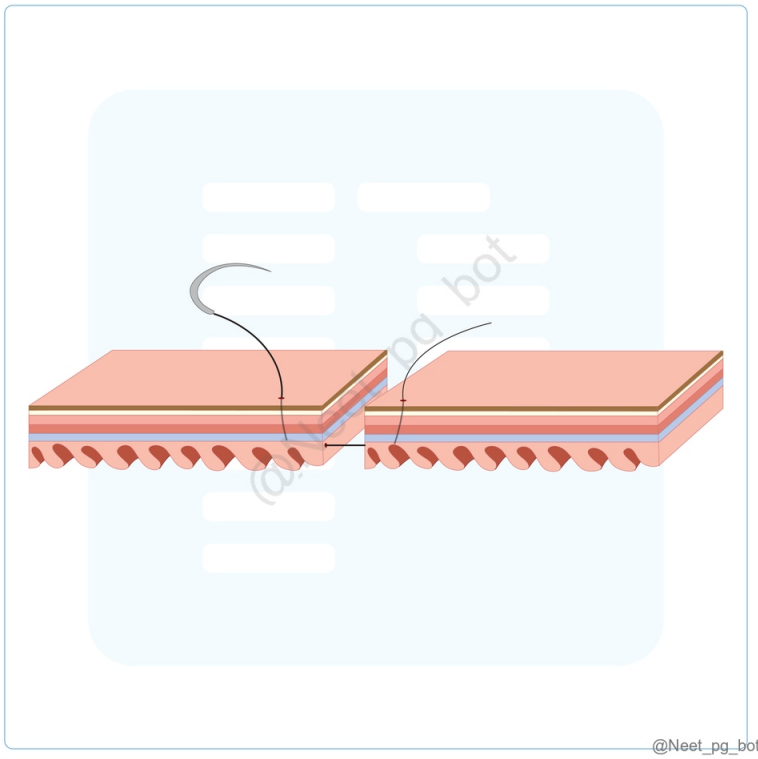
D. It involves placing a purse-string suture on the distal stump and stapling the anastomosis.

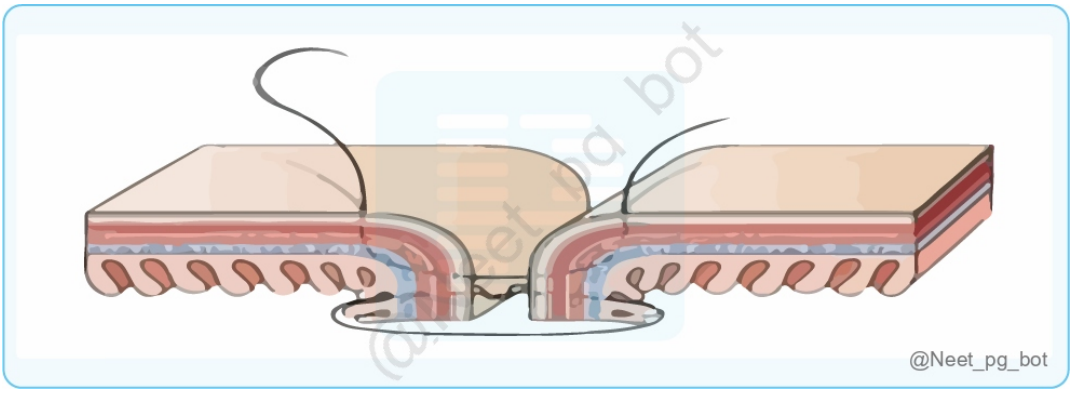
Correct Answer: B. It uses a continuous suture line through all layers of the bowel wall, except the mucosa.

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The single-layer hand-sewn anastomosis involves using a continuous suture line that spans through all layers of the bowel wall except the mucosa . This technique is chosen for its simplicity and potentially lower risk of leakage due to fewer suture lines. Hand-Sewn Anastomosis Technique Description Material Used Advantages and Risks Single layer Anastomosis Continuous suture line, all layers except mucosa (Option B) (Option A & C ruled out) Monofilament absorbable Or Vicryl. Quicker procedure Potentially lower risk of leakage Double Layer Anastomosis Inner continuous layer (Albert layer) + outer interrupted sutures (Lembert layer) Inner layer: Vicryl Outer layer: Silk Traditional method with additional support from the outer layer. Risk: Potential for stricture formation.





References:

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8610634/

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5138069/

↑ *Back to this question in Part A*

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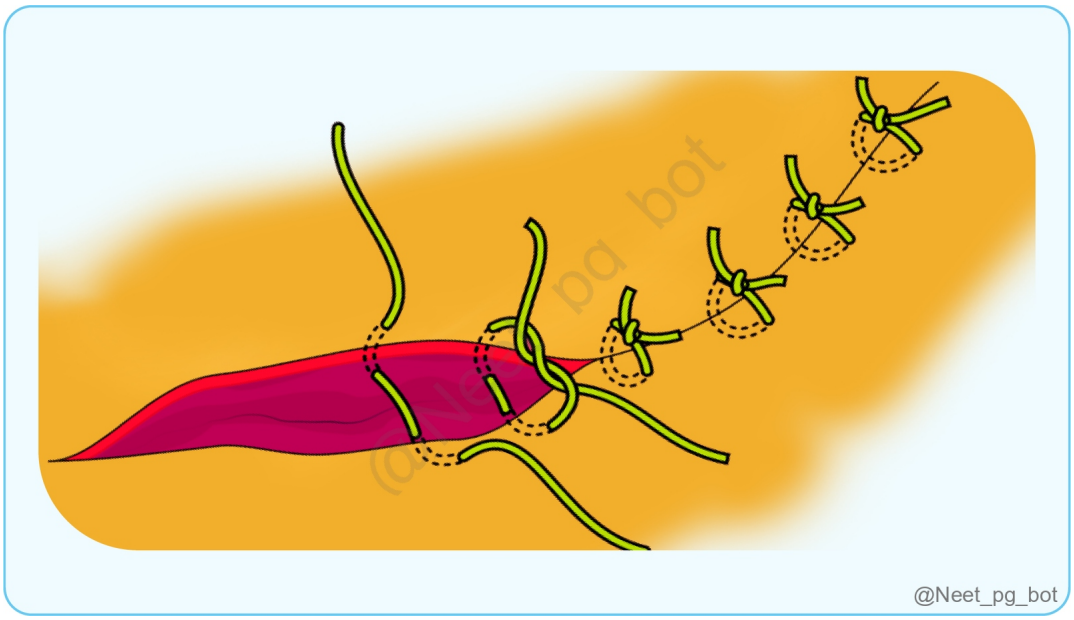
Q12: Identify the type of suturing technique used in the image given below. (Q849773)

A. Interrupted sutures

B. Continuous sutures

C. Mattress sutures

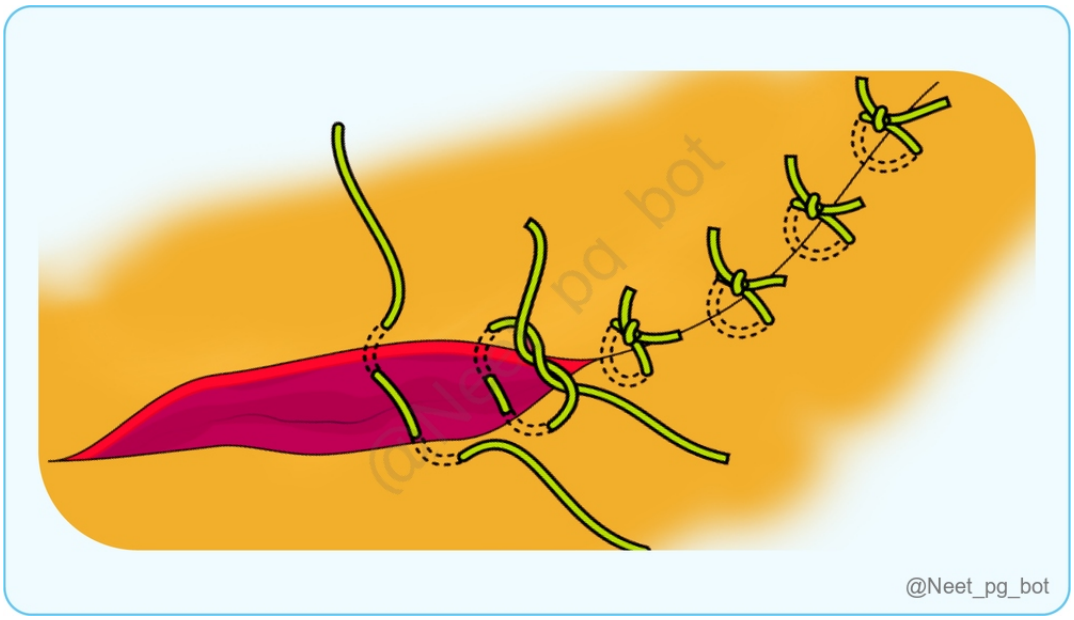
D. Subcuticular sutures

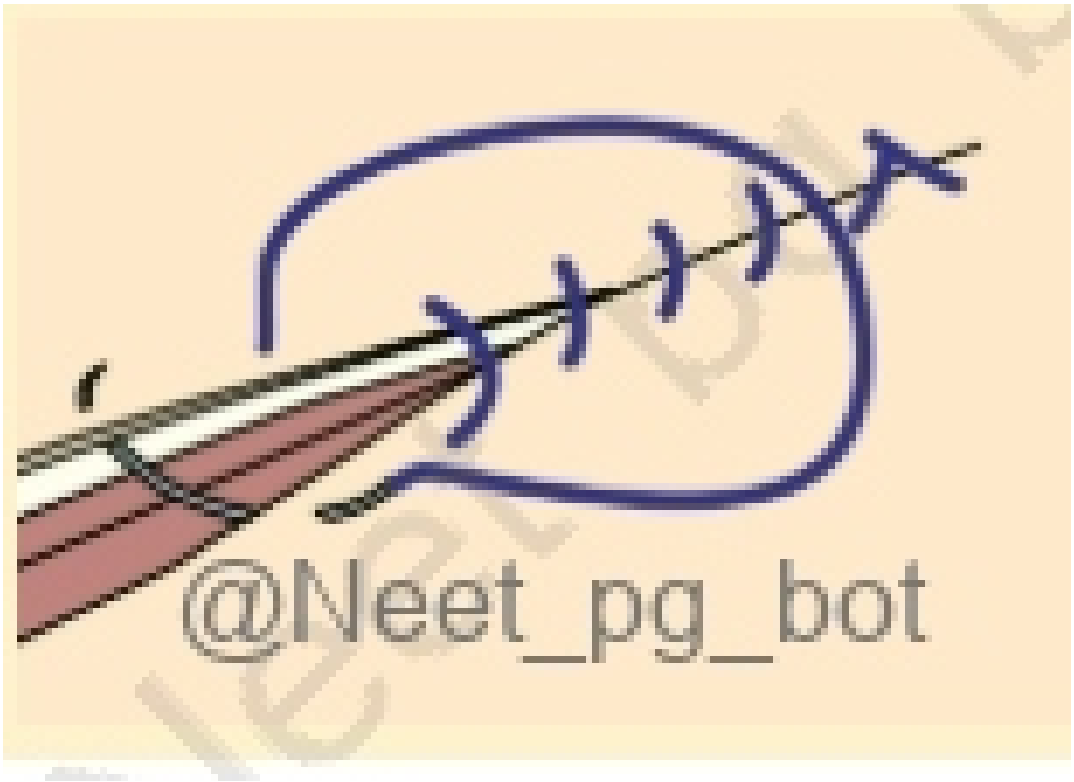


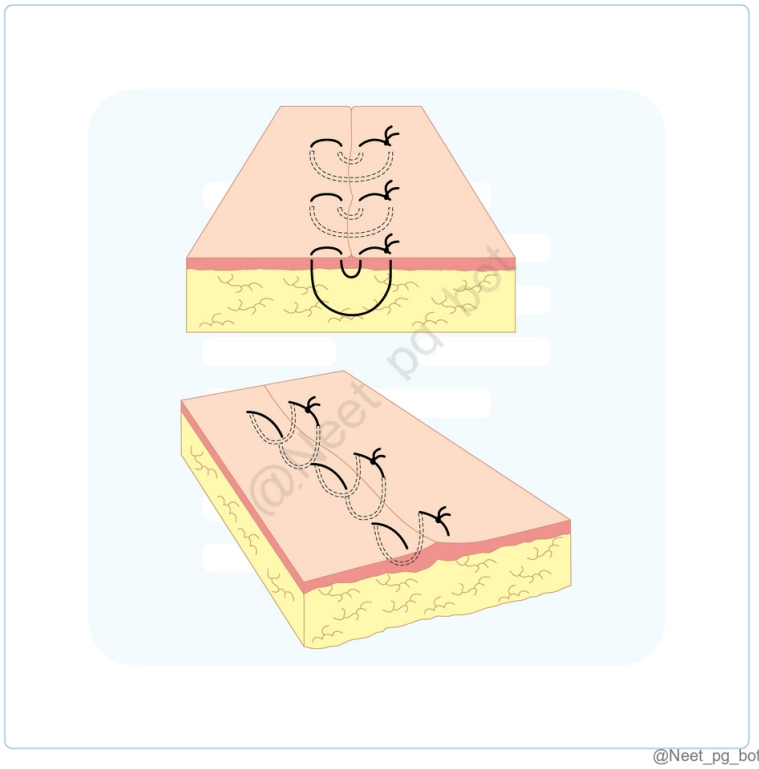
Correct Answer: A. Interrupted sutures

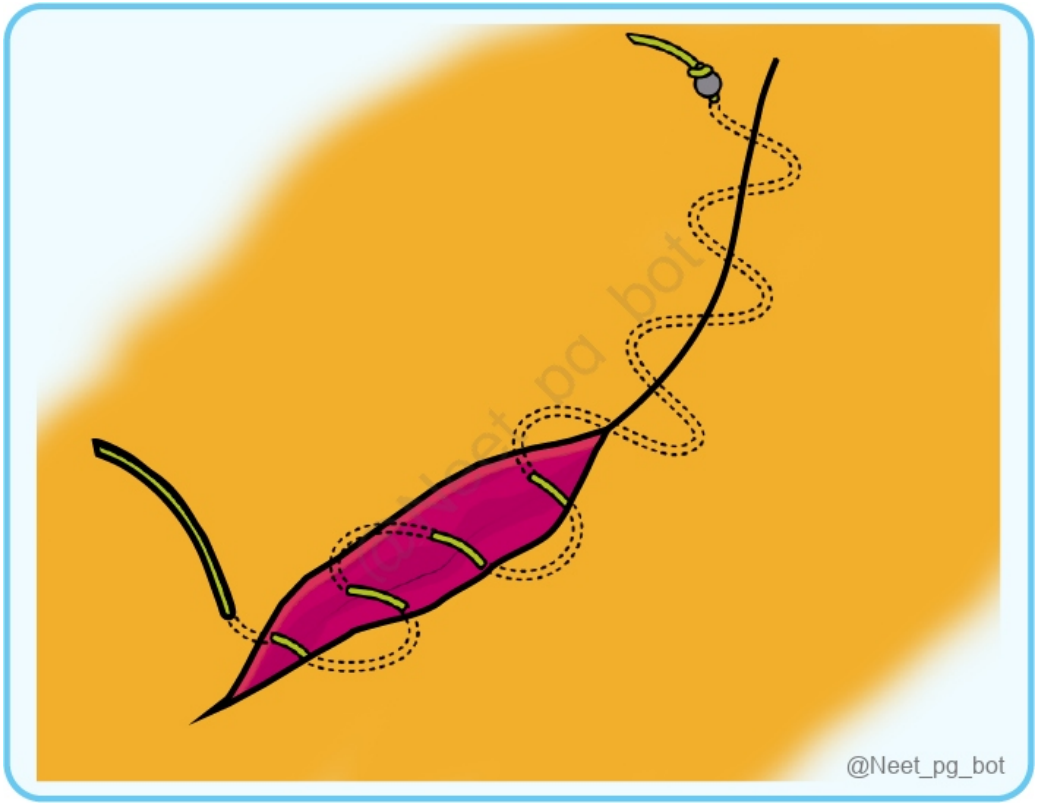
- *Listen (English)*
- *Listen (Hindi)*

Explanation: Each stitch is a separate piece of suture material , allowing for individual control over each stitch. Therefore, the suturing technique depicted in the given image is that of interrupted sutures . Suturing Techniques: Technique Image Description Suture Placement Interrupted Sutures (Option A) Needle inserted at 90-degree angle, passed through both sides of wound Distance = tissue thickness, each suture twice as far from edge as previous Continuous Sutures (Option B ruled out) Continuous placement after initial start, with suture appearing diagonal Maintain proper tension, secure end with Aberdeen knot or final suture loop Mattress Sutures (Option C ruled out) Vertical or horizontal, used to align wound edges Passed through both sides, either vertically or horizontally Subcuticular Sutures (Option D ruled out) Aesthetic closure with small bites of tissue, edges easily approximated Absorbable or non-absorbable, secured with collar and bead or buried knot


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References:

Bailey & Love's Short Practice of Surgery (28th Edition), Page 107, 108.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q13: Which of the following types of surgical needles is most appropriate for suturing tough or dense tissue such as skin and fascia? (Q849772)

A. Round-bodied needle

B. Triangular needle

C. Blunt-ended needle

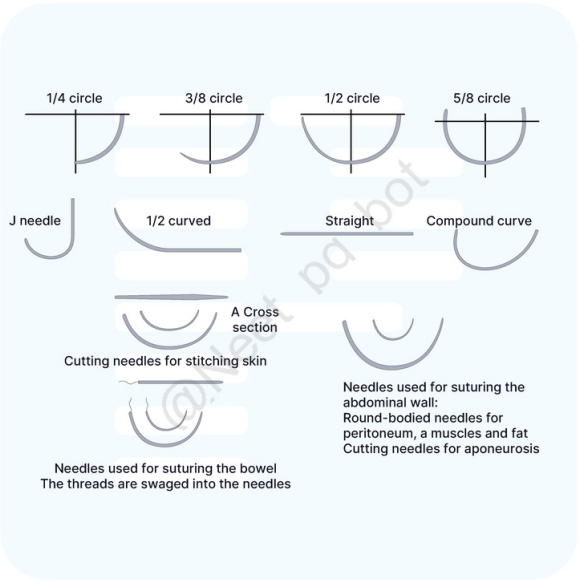
D. J-shaped needle

Correct Answer: B. Triangular needle

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Triangular needles have cutting edges along all three sides, making them suitable for penetrating tough or dense tissues like skin and fascia. Needle Types: Shape/Type Function/Usage Round-bodied (Option A ruled out) Separates tissue fibers, used in intestinal and cardiovascular surgery Triangular (Option B) Cuts through tough or dense tissue like skin and fascia Blunt-ended (Option C ruled out) Minimizes needlestick injuries, used in abdominal wall closure J-shaped (Option D ruled out) Laparoscopic port site closure Needle Size & Curvature Chart: Needle selection is determined by the needle length (arc length) and curvature (arc of a circle). Curvature Typical Usage 1/4 Circle Microsurgery, Ophthalmic surgery. 3/8 Circle Most common; used for skin, vascular, and superficial structures. 1/2 Circle Deep cavity/body wall closure (e.g., abdomen, peritoneum). 5/8 Circle Deep, tight spaces like the pelvic floor or anal canal. Needle Size Notation: Needles are classified by the length of the needle arc (e.g., 10mm, 20mm, 35mm). As a rule, use the smallest needle that can effectively hold the tissue to minimize trauma.



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References:

Bailey & Love's Short Practice of Surgery (28th Edition), Page 104.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q14: A 45 y/o male patient is admitted to the ICU following a major road traffic accident, resulting in multiple fractures and abdominal injuries. The patient is currently unable to take oral nutrition. He is expected to require enteral feeding for more than 3 weeks. Imaging studies reveal delayed gastric emptying and significant gastric distension. What is the most appropriate route for enteral nutrition in this patient? (Q849754)

A. Nasogastric tube

B. Ryles tube

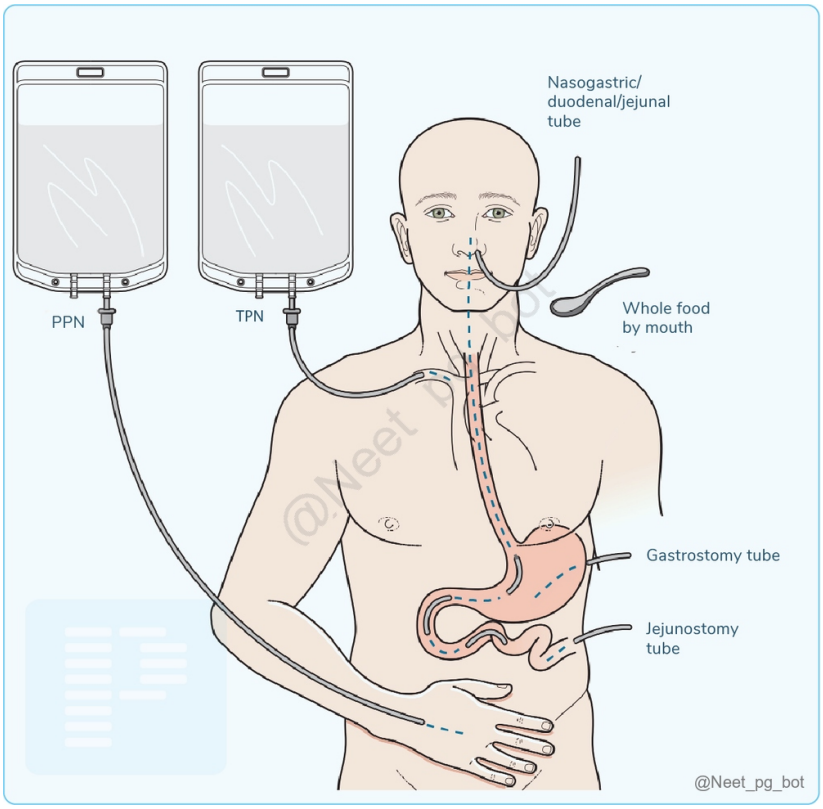
C. Feeding gastrostomy

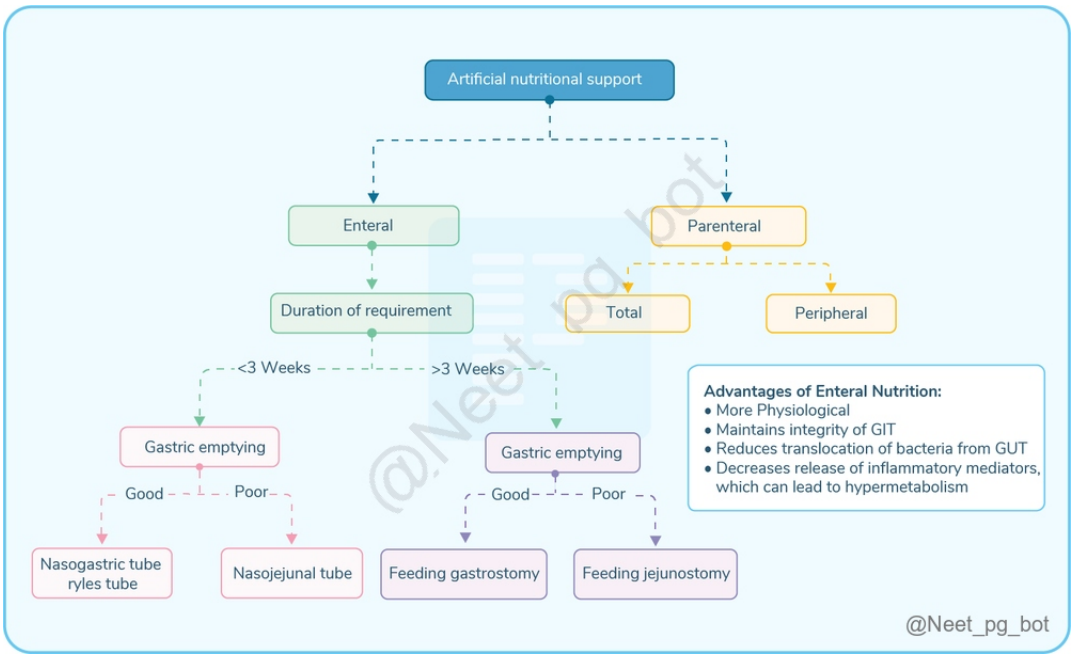
D. Feeding jejunostomy

Correct Answer: D. Feeding jejunostomy

■ *Listen to Audio 1*

Explanation: This trauma patient has delayed gastric emptying with significant gastric distension and requires long-term enteral nutrition for more than 3 weeks . Therefore, feeding jejunostomy is the most appropriate route as it bypasses the stomach, thereby reducing the risk of complications such as aspiration and further gastric distension. Types of Artificial nutritional supports:





References:

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↑ *Back to this question in Part A*

@Neet_pg_bot

Q15: Which of the following best describes Jenkins's rule in the context of abdominal wound closure? (Q849770)

A. Use of interrupted sutures with bites 2 cm apart to reduce wound tension.

B. Continuous suturing with bites 1 cm apart, avoiding suture locking to create a "spring coil" effect.

C. Continuous suturing with locking sutures, with bites placed 1 cm from the wound edge

D. Use of mattress sutures to maximize the tension across the wound during healing

Correct Answer: B. Continuous suturing with bites 1 cm apart, avoiding suture locking to create a "spring coil" effect.

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Jenkins's rule involves continuous suturing with bites that are 1 cm apart and no more than 1 cm from the previous bite, without locking the sutures to allow for a "spring coil" effect that manages wound tension during

healing. Jenkins's Rule in Abdominal Wound Closure: Purpose : Optimizes healing and manages wound distension post-midline laparotomies. Physiological Basis : Collagen Focus : Targets type I collagen, abundant around 1 cm from the rectus sheath edge. Healing Enhancement : Leverages the natural properties of tissue for improved wound closure.

References:

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5991013/

↑ *Back to this question in Part A*

@Neet_pg_bot

Q16: A 60-year-old woman with a history of peripheral artery disease presents with critical limb ischemia. She is scheduled for a femoral-popliteal bypass surgery to restore blood flow to her lower extremity. Which suture is preferred for vascular anastomosis? (Q849769)

A. Prolene

B. Silk

C. Vicryl

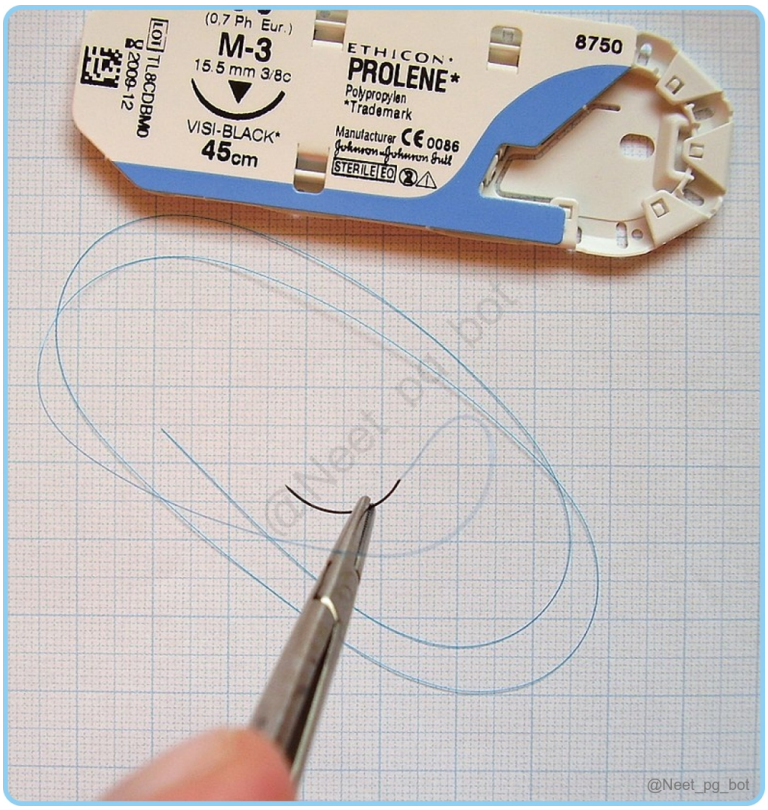
D. Nylon

Correct Answer: A. Prolene

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Prolene is the least thrombogenic suture material and is often used in vascular surgery. Prolene (Polypropylene) : Raw material: Polymer of propylene Monofilament. Low tissue reaction Tensile strength: Infinite (>1 year) Least thrombogenic suture material Uses: Cardiovascular surgery- vascular anastomosis (Option A) , plastic surgery, rectus sheath, ophthalmic, surgery, general surgical subcuticular skin closure. Silk (Option B): Skin suturing Vicryl (Option C): CBD, ureter and bladder Nylon (Option D): Tendon repair



References:

Bailey & Love's Short Practice of Surgery, 28th edition, pg 105-106

ScienceDirect - Prolene

↑ *Back to this question in Part A*

@Neet_pg_bot

Q17: A 45-year-old female undergoes an abdominal hysterectomy. The surgeon chooses to close the rectus sheath using PDS (polydioxanone) sutures due to their prolonged tensile strength. What is the expected time frame for the complete absorption of the polydioxanone sutures in this patient? (Q849763)

A. 60 - 90 days

B. 180 days

C. 90 - 120 days

D. 7 - 10 days

Correct Answer: B. 180 days

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Complete absorption of polydioxanone sutures occurs in 180 days. Polydioxanone (PDS): Raw material: Para-dioxanone polymer Monofilament Absorption rate: Complete absorption at 180 days (Option B) Mild tissue reaction Uses: Instances where slightly longer wound support is required Lowest affinity for adherence to E.coli and staph. aureus Complete absorption of vicryl sutures occurs in 60–90 days (Option A) . Polyglycaprone is completely absorbed in 90 - 120 days (Option C) . Catgut undergoes enzymatic degradation within 7 to 10 days (Option D) .



References:

Bailey and Love Short practice of surgery,28th edition, page 106.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q18: A 28-year-old male undergoes repair of a laceration on his forearm following a minor accident. The surgeon chooses monocryl for the subcutaneous layer and polyglycolic acid sutures for the deep dermal layer. Which of the following statements is/are true regarding these sutures in this case? Poliglecaprone is not preferred for subcuticular suturing Monocryl is a polymer of glycolide and caprolactone Polyglycolic acid exhibits highest affinity for adherence to E.coli and staph. aureus Patient is informed that monocryl will be completely absorbed in 180 days (Q849762)

A. Only 2

B. 2 and 3

C. 1, 2 and 4

D. All the statements

Correct Answer: B. 2 and 3

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Monocryl suture (Poliglecaprone) Polyglycolic acid suture (DEXON) Raw material: Copolymer of glycolite and caprolactone . (Statement 2) Monofilament Absorption rate: 90–120 days (Statement 4 ruled out). Tensile strength retention in vivo: 21 days maximum Mild tissue reaction Uses: Subcuticular in skin (most commonly used (Statement 1 ruled out)), ligation, gastrointestinal, and muscle surgery. It is a polymer of glycolic acid Polyfilament suture Absorbed by hydrolysis Maintain sufficient tension over the first 2 weeks Exhibits highest affinity for adherence to E.coli and staph. aureus (Statement 3) .



References:

https://www.sciencedirect.com/topics/nursing-and-health-professions/polyglycolic-acid-suture

https://pubmed.ncbi.nlm.nih.gov/6364858/.

Bailey & Love's Short Practice of Surgery (28th Edition), Page 106.

SRB's Manual of Surgery (6th Edition), Page 1154.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q19: A 30-year-old female undergoes an elective laparoscopic cholecystectomy, during which the surgeon uses Vicryl sutures to close the internal fascial layers. Postoperatively, the patient expresses concern about how long the sutures will remain in her body before being fully absorbed. What is the expected time frame for complete

absorption of the Vicryl sutures in this case? (Q849761)

A. 60 - 90 days

B. 180 days

C. 90 - 120 days

D. 7 - 10 days

Correct Answer: A. 60 - 90 days

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Complete absorption of vicryl sutures occurs in 60–90 days. Vicryl suture (Polyglactin) : Braided, multifilament and absorbable suture. Absorption rate: By hydrolysis Complete absorption 60–90 days (Option A) Polydioxanone suture is completely absorbed in 180 days. (Option B) Poliglecaprone is completely absorbed in 90 - 120 days. (Option C) Catgut undergoes enzymatic degradation within 7 to 10 days. (Option D)

References:

Bailey and Love Short practice of surgery,28th edition, page 106.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q20: A 30-year-old man undergoes an open appendectomy, and plain catgut sutures are used for closing the muscle layer. Which of the following statements regarding these sutures is most accurate? (Q849760)

A. Non-absorbable and provide long-term tensile strength

B. Made from synthetic materials and are highly resistant to enzymatic degradation

C. Primarily absorbed by enzymatic proteolysis and has variable tensile strength

D. Causes minimal tissue reaction and are preferred for patients with suture allergies

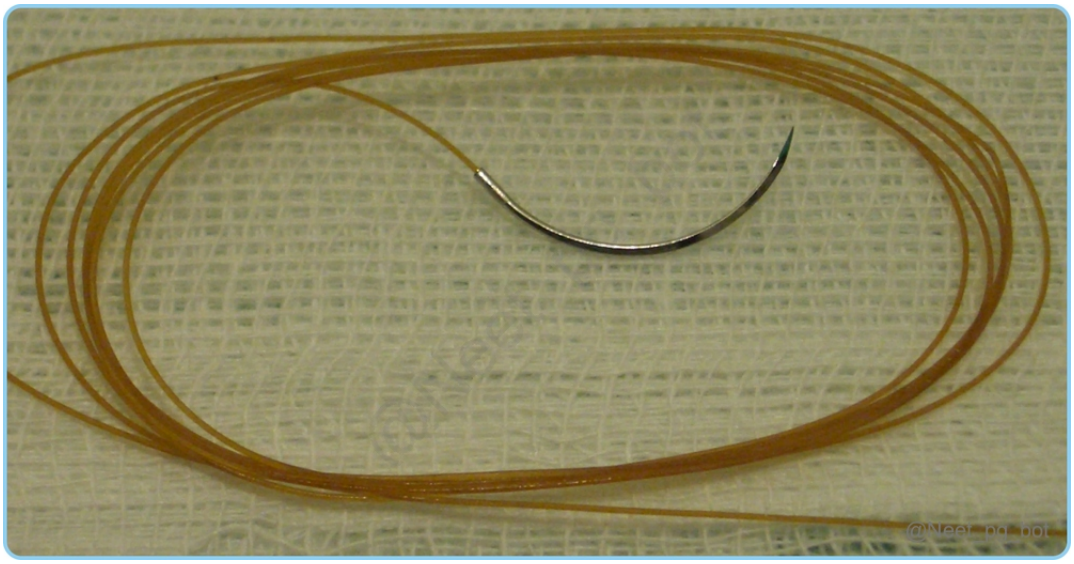
Correct Answer: C. Primarily absorbed by enzymatic proteolysis and has variable tensile strength

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Absorption of catgut is by phagocytosis and enzymatic degradation. Absorption Mechanisms: Enzymatic Proteolysis: Used by Natural Absorbable sutures (e.g., Plain/Chromic Catgut). This involves

phagocytic digestion of collagen, which is unpredictable and induces significant inflammation. Hydrolysis: Used by Synthetic Absorbable sutures (e.g., Vicryl, Monocryl, PDS). Water molecules break the polymer chains, resulting in a predictable, uniform absorption rate with minimal tissue reaction. Suture Plain Catgut Frequent uses Superficial vessels ligation Subcutaneous tissues suturing Stomas and other tissues that heal rapidly Contraindications Tissues that heal slowly and require prolonged support. Tissue reaction High (Option D ruled out) Absorption rate Phagocytosis and enzymatic degradation within 7–10 days. (Option C) (Option A ruled out) Tensile strength retention in vivo Lost within 7–10 days Marked patient variability and unpredictable (Option C) (Option A ruled out) Raw material Collagen derived from the submucosa of sheep small intestine. (Option B ruled out)



References:

Bailey & Love's Short Practice of Surgery (28th Edition), Page 106.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q21: A 30-year-old male undergoes abdominal surgery, and the surgeon plans to use a non-absorbable monofilament suture for skin closure to minimize tissue reaction and ensure long-term wound support. Which of the following sutures should be selected? (Q849759)

A. Polyglactin 910 (Vicryl)

B. Polydioxanone (PDS)

C. Nylon

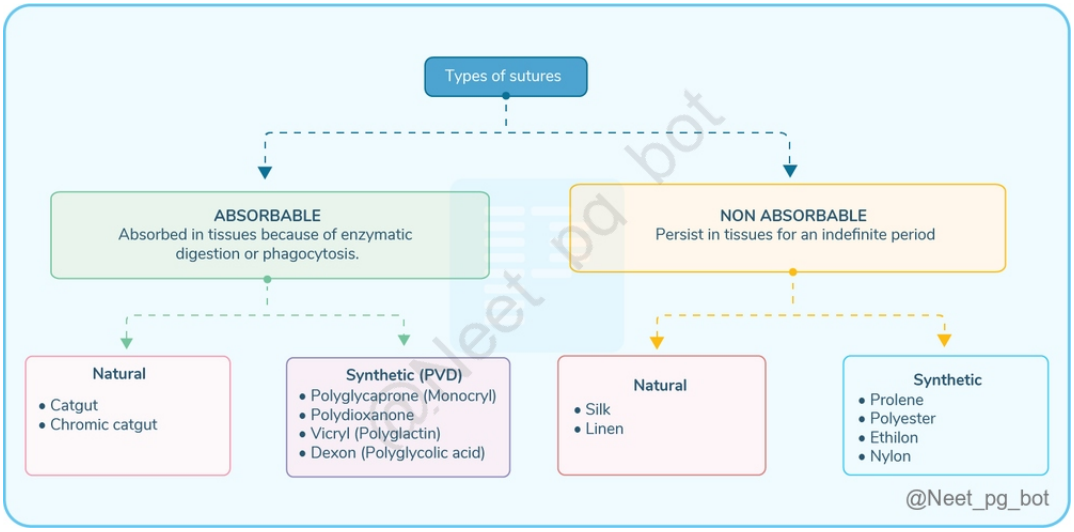
D. Polyglycolic acid (Dexon)

Correct Answer: C. Nylon

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Nylon is a non-absorbable monofilament suture frequently used for skin closure due to its strength, durability, and minimal tissue reactivity. Types of sutures:



References:

Bailey and Love's Short Practice of Surgery, 28th edition, page 106.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q22: A 45 year old male severely malnourished patient with a history of chronic alcoholism and recent weight loss is admitted in the hospital. After stabilization, he is started on a high-calorie enteral feeding regimen to address his nutritional deficiencies. Within 48 hours of initiating feeding, he begins to have muscle weakness, difficulty in breathing and is confused. Which of the following electrolyte abnormalities in the blood is least likely to be associated with his current condition? (Q849758)

A. Hypophosphatemia

B. Hypokalemia

C. Hypomagnesemia

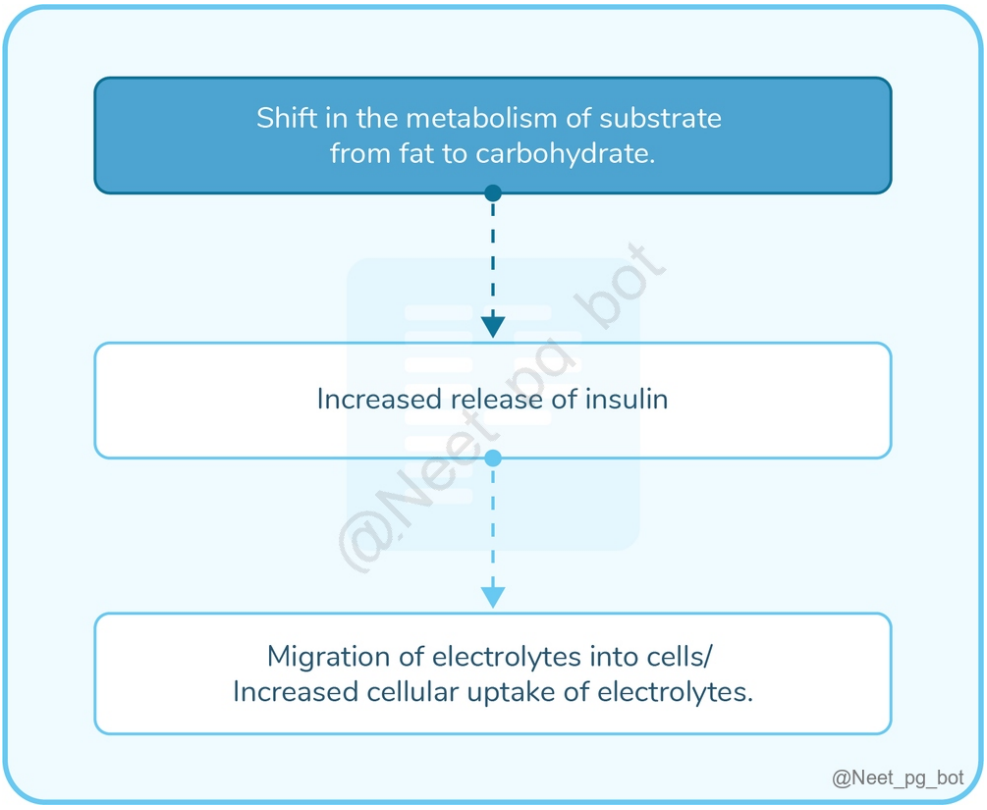
D. Hypernatremia

Correct Answer: D. Hypernatremia

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: In this scenario, the likely diagnosis is refeeding Syndrome , which can cause shifts in electrolytes as the body transitions from a catabolic to an anabolic state. Hence, hypernatremia is not commonly associated with refeeding syndrome. Mechanism of Refeeding Syndrome: Electrolyte abnormalities: Hypophosphatemia, (Option A ruled out) Hypomagnesemia, (Option C ruled out) Hypokalemia, (Option B ruled out) Hypocalcemia Lead to arrhythmia, confusion, and respiratory failure, ultimately leading to death.



References:

https://pmc.ncbi.nlm.nih.gov/articles/PMC2440847

↑ *Back to this question in Part A*

@Neet_pg_bot

Q23: A 72-year-old male with severe pancreatitis is initiated on total parenteral nutrition (TPN) due to his inability to tolerate enteral feeding. Shortly after the central venous catheter is inserted, he complains of sudden onset shortness of breath and pleuritic chest pain. On examination, his breath sounds are decreased on the same side of the catheter insertion. What is the most likely complication that has occurred? (Q849757)

A. Catheter-related sepsis

B. Catheter related thrombosis

C. Dyselectrolytemia

D. Pneumothorax

Correct Answer: D. Pneumothorax

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Sudden onset of symptoms after central venous catheter insertion for TPN with decreased breath sounds on the same side of insertion site are pointing towards pneumothorax. Complications of Total Parenteral Nutrition (TPN) Line Insertion Complications Pneumothorax (most dangerous) Misplacement of catheter Line-Related Complications Sepsis (most common) Thrombosis (more common with long-term catheter use) Electrolyte imbalances (e.g., refeeding syndrome) Metabolic Complications Blood sugar derangements (hyperglycemia, hypoglycemia) Liver dysfunction Metabolic bone disease Vitamin deficiencies

References:

Bailey and love Short practice of surgery, edition 28, page 339.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q24: A 45-year-old male recovering from gastrointestinal surgery is on total parenteral nutrition (TPN). Initially, he was receiving a 2-in-1 TPN formulation. Due to ongoing nutritional needs, the medical team switches him to a 3-in-1 TPN formulation. Which component is newly included in the 3-in-1 formulation that was not in the 2-in-1? (Q849756)

A. Amino acids

B. Dextrose

C. Lipids

D. Fiber

Correct Answer: C. Lipids

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: In a 3-in-1 TPN, lipids are included along with dextrose and amino acids, which are present in 2-in-1 TPN. TPN Formulations: 3 in 1 formulation 2 in 1 formulation 60/20/20 60% by dextrose 20% by amino acids 20% by fat. 75/25 75% by dextrose (Option B ruled out) 25% by amino acids (Option A ruled out) No lipids used (Option C) Fiber is absent in both the formulations (Option D ruled out)

References:

Bailey and Love's Short Practice of Surgery, 28th edition, page 338.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q25: A 38-year-old male involved in a motor vehicle accident has been in the ICU for several days with multiple injuries including head and abdominal trauma. The ICU team is considering starting enteral feeding. Which of the following findings would most likely contraindicate the initiation of enteral nutrition in this patient? (Q849755)

A. Inflammatory bowel disease

B. Distal low-output enterocutaneous fistula

C. Proximal small intestinal fistula

D. Constipation

Correct Answer: C. Proximal small intestinal fistula

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Proximal small intestinal fistula Explanantion: Enteral feeding should be avoided in proximal small intestinal fistula as it can lead to increased fistula output, worsening fluid and electrolyte imbalances. Enteral Nutrition: Indications Contraindications Protein-energy malnutrition with inadequate oral intake Small bowel obstruction or ileus Dysphagia except for liquids Severe diarrhea Major trauma or surgery when returning to dietary intake is prolonged Proximal small intestinal fistula (Option C) Inflammatory bowel disease (Option A ruled out) Severe Pancreatitis (the food particles stimulate the release of pancreatic enzymes, ultimately

worsening the symptoms.) Distal low-output enterocutaneous fistula (Option B ruled out) GI bleed

References:

Bailey and love Short practice of surgery, ed.28, page 336, 337, 338

SRB’s Manual of Surgery 6e, pg no 96, 97

↑ *Back to this question in Part A*

@Neet_pg_bot

• [12_Miscellaneous] 061 Shock

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[12_Miscellaneous] 061 Shock — Quick Jump

Q1 (p. 3453)	*Q2 (p. 3454)*	*Q3 (p. 3455)*	*Q4 (p. 3456)*	*Q5 (p. 3457)*	*Q6 (p. 3458)*
Q7 (p. 3459)	*Q8 (p. 3460)*	*Q9 (p. 3461)*	*Q10 (p. 3462)*	*Q11 (p. 3463)*	*Q12 (p. 3463)*
Q13 (p. 3464)	*Q14 (p. 3465)*	*Q15 (p. 3466)*	*Q16 (p. 3466)*		

Q1: A 56-year-old man is brought to the emergency department after a road traffic accident. He is confused, has a heart rate of 132/min, blood pressure 78/50 mmHg, cool clammy extremities, and a capillary refill time of >4 seconds. Arterial blood gas shows metabolic acidosis with elevated lactate.Which statement best explains the underlying pathophysiology in this patient's condition? (Q849579)

A. Decreased tissue perfusion leading to impaired oxygen delivery and utilization at the cellular level.

B. Low arterial pressure alone, irrespective of oxygen delivery.

C. Fluid loss without impact on cellular respiration.

D. Inflammatory cytokine release causing organ failure in all patients with trauma.

Correct Answer: A. Decreased tissue perfusion leading to impaired oxygen delivery and utilization at the cellular level.

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Shock is fundamentally defined as a state of circulatory failure resulting in inadequate tissue perfusion . This leads to a mismatch between oxygen delivery and oxygen consumption, impairing cellular respiration and shifting metabolism towards anaerobic pathways, reflected by elevated lactate and metabolic acidosis in this patient. Low arterial pressure alone (Option B): Hypotension often accompanies shock but is not always present. For example, in early septic shock, tissue hypoperfusion may exist even with preserved or elevated blood pressure due to vasodilation. Fluid loss without impact on respiration (Option C): Although hemorrhage or dehydration may cause shock, the definition is not restricted to fluid loss. Inflammatory cytokine release in all trauma patients (Option D): Cytokine release is a key mechanism in septic shock or systemic inflammatory states, but not all trauma patients develop it. The unifying definition across all types of shock (hypovolemic, cardiogenic, obstructive, distributive) is inadequate tissue perfusion, not inflammation alone.

References:

https://www.ncbi.nlm.nih.gov/books/NBK531492/

↑ *Back to this question in Part A*

@Neet_pg_bot

Q2: A 25-year-old male patient was brought with multiple injuries on his body following a road traffic accident. O/E patient was drowsy and confused, extremities were cold and clammy, weak thready pulse noted. On auscultation, tachypnoea and tachycardia observed. Identify the type of shock seen in this patient. (Q849580)

A. Hypovolemic shock

B. Distributive shock

C. Neurogenic shock

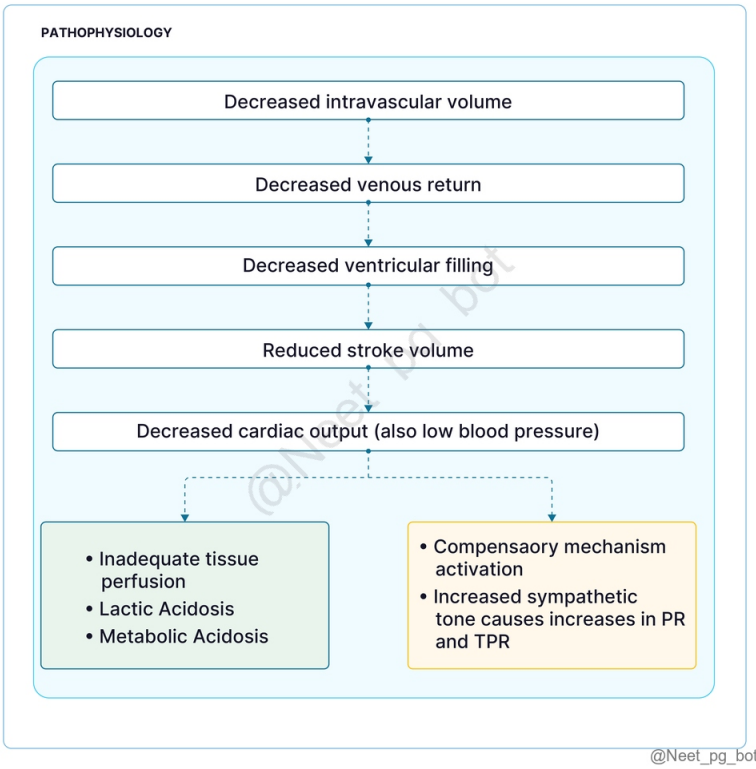
D. Cardiogenic shock

Correct Answer: A. Hypovolemic shock

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Hypovolemic shock is likely to be seen in this patient due to hemorrhage (Option A)
Pathophysiology:



References:

https://www.ncbi.nlm.nih.gov/books/NBK513297/

↑ *Back to this question in Part A*

@Neet_pg_bot

Q3: A 45-year-old male patient was brought to the emergency department following a road traffic accident. O/E, he had multiple injuries all over his body and was found to be in class III hemorrhagic shock. The percentage of blood loss would be between: (Q849581)

A. 5-15%

B. 30-40%

C. >40%

D. 15-30%

Correct Answer: B. 30-40%

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The percentage of blood loss in class III hemorrhagic shock is 30-40%. Parameter Class I (Compensated Shock) Class II (Hypoxemia) Class III Class IV (Refractory Shock) Blood Loss Up to 15% (Option A) 15-30% (Option D) 30-40% (Option B) More than 40% (Option C) Mechanism Compensatory mechanisms maintain cardiac output. Generalized vasoconstriction. Decompensated shock. Refractory shock. Heart Rate <100/min 100-120/min 120-140/min >140/min Blood Pressure Normal Hypotension Marked hypotension Profound hypotension Respiratory Rate Normal Tachypnea Tachypnea Tachypnea Urine Output >30 ml/hour 20-30 ml/hour 5-15 ml/hour No urine output Mental Status Alert, normal Anxious, mildly agitated Confused, altered mental status Comatose, lethargic Base Deficit (mEq/L) 0 to -2 -2 to -6 -6 to -10 >-10

References:

SRB’s Manual of Surgery 6th edition page number 105,106.-107

Bailey & Love's Short Practice of Surgery 28th Edition, Page number 13,14

↑ *Back to this question in Part A*

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Q4: Following a road traffic accident, a 23-year-old man presents with multiple injuries on his body and the percentage of blood loss is <15%. Identify which class of ATLS classification it belongs to. (Q849582)

A. Class 1

B. Class 2

C. Class 3

D. Class 4

Correct Answer: A. Class 1

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: In ATLS Class 1 , the percentage of blood loss is less than 15% . In this stage, the patient's BP will be normal, urine output >30 mL/hr, and the patient will be in a slightly anxious state. Advanced Trauma Life Support (ATLS) Classes of Hypovolemic Shock Parameter Class I Class II Class III Class IV Blood loss (%) 0-15% 15-30% 30-40% > 40% Central Nervous System (CNS) Slightly anxious Mildly anxious Anxious or confused Confused or lethargic Pulse (beats/min) < 100 > 100 > 120 > 140 Blood pressure Normal Normal Decreased Decreased Pulse pressure Normal Decreased Decreased Decreased Respiratory rate (breaths/min) 14-20 20-30 30-40 > 35 Urine output (mL/hr) > 30 20-30 5-15 Negligible/Nil Fluid requirement Crystalloid Crystalloid Crystalloid + Blood Crystalloid + Blood Base deficit (mEq/L) 0 to -2 -2 to -6 -6 to -10 -10 or less

References:

SRB’s Manual of Surgery 6th edition page number 105-107

↑ *Back to this question in Part A*

@Neet_pg_bot

Q5: A 62-year-old male with a history of hypertension and type 2 diabetes presents with chest pain. His ECG shows ST-segment elevation in the anterior leads. Despite initial treatment, his condition deteriorates with low blood pressure, rapid heart rate, and difficulty breathing. Examination reveals elevated jugular venous pressure (JVP) and crackles on lung auscultation. What type of shock is this patient most likely experiencing? (Q849583)

A. Cardiogenic shock

B. Obstructive shock

C. Hypovolemic shock

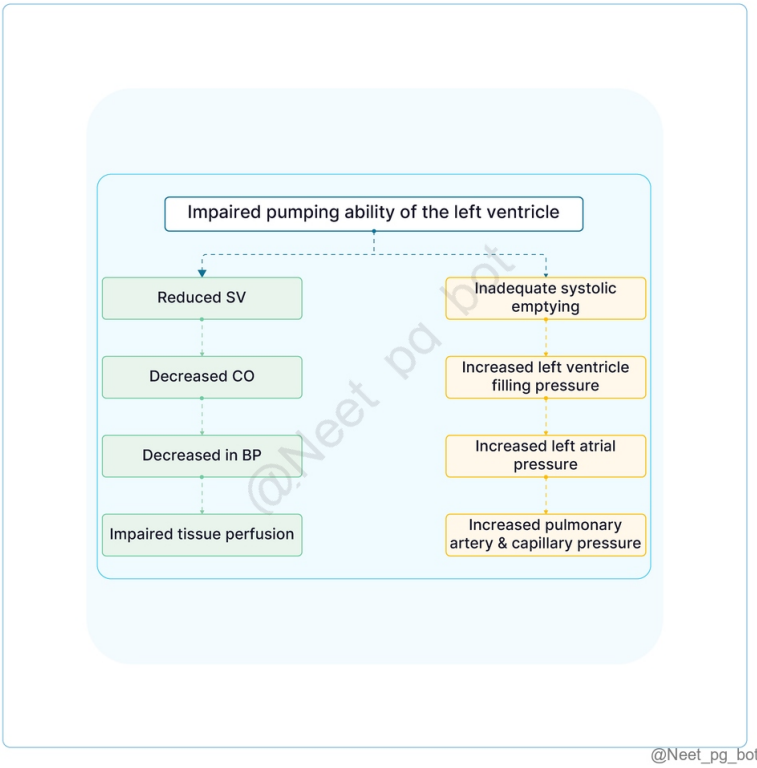
D. Septic shock

Correct Answer: A. Cardiogenic shock

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Cardiogenic shock is seen in myocardial depression as a result of infarction. The patient is most likely experiencing Cardiogenic shock . The ECG findings of an anterior STEMI indicate extensive damage to the heart's main pumping chamber, the left ventricle. This pump failure leads to low blood pressure and organ hypoperfusion. The elevated JVP and crackles in the lungs are classic signs of backward failure, where blood congests in the venous system and lungs because the damaged heart cannot effectively pump it forward Obstructive shock (Option B) is caused by a physical blockage outside the heart muscle (like a pulmonary embolism or cardiac tamponade). The ECG findings of a STEMI point to a primary heart muscle problem, not an obstruction. Hypovolemic shock (Option C) is due to a loss of blood or fluid volume → ↓ venous return → ↓ CO → ↓ sympathetic activity. In this case, the JVP would be flat (low), and the lungs would be clear, which is the opposite of this patient's presentation. Septic shock (Option D) is caused by a widespread infection leading to massive vasodilation → ↓ systemic vascular resistance → venous pooling → tissue hypoxia. There are no signs of infection (like fever) in this patient



References:

SRB's Manual of Surgery 6th Edition, Page number 106

Bailey & Love's Short Practice of Surgery 28th Edition, Page number 12.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q6: A patient admitted to the hospital with a urinary tract infection develops oliguria and lightheadedness on the third day of admission. His peripheries are warm, capillary refill is brisk, and his blood pressure is noted to be 86/56 mmHg despite fluid resuscitation. What type of shock is this patient likely experiencing? (Q849584)

A. Hypovolemic shock

B. Septic shock

C. Obstructive shock

D. Cardiogenic shock

Correct Answer: B. Septic shock

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The given presentation is seen in septic shock. Sepsis + hypotension for at least 1 hour, despite adequate fluid resuscitation (SBP<90 mmHg/40mmhg less than normal BP) In septic shock, the extremities are warm, and capillary refill will be brisk. Pathophysiology of Septic Shock Infection (insult/injury) ↓ Release of inflammatory mediators ↓ Systemic inflammatory response ↓ Diffuse endothelial injury, vasodilation, and increased capillary permeability ↓ Progressive vasodilation and maldistribution of blood flow ↓ Organ hypoperfusion ↓ Multiple organ dysfunction syndrome (MODS) Clinical Features: Fever. Chills and rigor. Evidence of local infection at the site. Hypotension. Rapid capillary filling. Bounding pulse. Vasodilation - leads to warm peripheries.

References:

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↑ *Back to this question in Part A*

@Neet_pg_bot

Q7: A 42-year-old man is brought after a high-impact motor vehicle accident. On examination, he has a spinal cord injury at the level of T6 with flaccid paralysis of the lower extremities. His vital signs show hypotension, bradycardia, and warm, flushed skin. Which of the following is the most likely underlying pathophysiologic mechanism for his shock state? (Q849585)

A. Decreased cardiac output

B. Decreased blood volume

C. Increased vascular permeability

D. Decreased peripheral vascular resistance

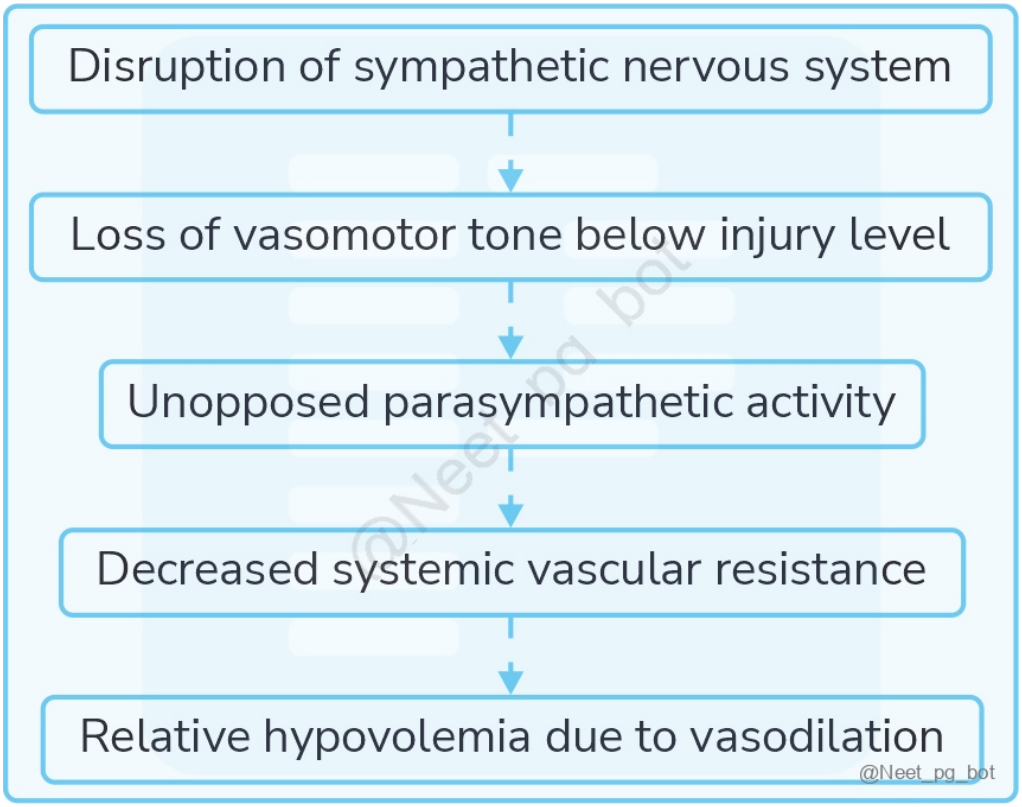
Correct Answer: D. Decreased peripheral vascular resistance

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: In neurogenic shock , there is a loss of sympathetic tone leading to vasodilation of the peripheral vasculature, resulting in decreased peripheral vascular resistance and hypotension. This is the primary mechanism underlying neurogenic shock. Clinical Manifestations: Hypotension Bradycardia (unlike other forms of shock) Warm, dry skin below injury level Priapism in males Respiratory compromise (if high cervical injury) Poikilothermia (inability to regulate body temperature) Decreased cardiac output (Option A) : Cardiac output may

fall secondarily due to hypotension + bradycardia, but the primary mechanism is loss of SVR , not pump failure. Decreased blood volume (Option B) : Neurogenic shock is not associated with decreased blood volume, unlike hypovolemic shock. Increased vascular permeability (Option C) : More characteristic of distributive shock like septic shock, not neurogenic shock.



References:

Sabiston Textbook of Surgery, 21st Edition, Page 526

SRB's Manual of Surgery 6th Edition, Page 106.

https://www.ncbi.nlm.nih.gov/books/NBK459361/

↑ *Back to this question in Part A*

@Neet_pg_bot

Q8: A 28-year-old male presents with a sudden onset of severe fatigue, weakness, nausea, vomiting, and abdominal pain. On examination, he is hypotensive (BP 75/45 mmHg), tachycardic (HR 115 bpm), and has noticeable diffuse skin hyperpigmentation, especially in sun-exposed areas and palmar creases. Laboratory results reveal: Sodium: 128 mEq/L Potassium: 5.8 mEq/L Glucose: 58 mg/dL What is the most likely diagnosis? (Q849586)

A. Diabetic ketoacidosis

B. Septic shock

C. Addison's disease

D. Panhypopituitarism

Correct Answer: C. Addison's disease

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Addison's disease , or primary adrenal insufficiency , is characterized by the destruction of the adrenal cortex, leading to deficient production of cortisol and aldosterone. In an acute crisis, patients present with severe hypotension, electrolyte imbalances (low sodium, high potassium), hypoglycemia, and dehydration, which are all seen in this patient. Diffuse skin hyperpigmentation occurs due to increased ACTH levels stimulating melanocytes, which is a hallmark of Addison's disease. Diabetic ketoacidosis (Option A) typically presents with hyperglycemia, not hypoglycemia. The electrolyte pattern and skin hyperpigmentation are not consistent with DKA. Septic shock (Option B) can cause hypotension and tachycardia, but doesn't explain electrolyte abnormalities, or skin hyperpigmentation. Septic shock typically causes hyperglycemia, not hypoglycemia. Panhypopituitarism (Option D) can cause secondary adrenal insufficiency, but it wouldn't result in skin hyperpigmentation (due to low ACTH levels). Also, the electrolyte abnormalities are typically less severe in secondary adrenal insufficiency because aldosterone production is usually preserved.

References:

https://www.ncbi.nlm.nih.gov/books/NBK499968/

↑ *Back to this question in Part A*

@Neet_pg_bot

Q9: A 55-year-old patient is brought to the emergency department with severe abdominal pain, tachycardia, and hypotension. Examination reveals pale, cool, and clammy skin with delayed capillary refill. The patient has oliguria. Which of the following hemodynamic profiles is most characteristic of this patient's condition? (Q849587)

A. SVR - ↓ ; CO - ↑ ; CVP - Normal or ↑

B. SVR - ↑ ; CO - ↓ ; CVP - ↓

C. SVR - ↓ ; CO - ↓ ; CVP - ↑

D. SVR - ↑ ; CO - ↑ ; CVP - ↑

Correct Answer: B. SVR - ↑ ; CO - ↓ ; CVP - ↓

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The clinical presentation of tachycardia, hypotension, pale and cool skin, and oliguria is characteristic of hypovolemic shock . In this condition, there is an increase in systemic vascular resistance as a compensatory mechanism to maintain blood pressure, but a decreased cardiac output due to the reduced intravascular volume. The central venous pressure is typically decreased due to the hypovolemic state. Physiological Hemodynamic Characteristics of Shock Type of Shock Cardiac Output Systemic Vascular Resistance Central Venous Pressure Mean Arterial Pressure Hypovolemic ↓ ↑ ↓ ↓ Cardiogenic ↓ ↑ ↑ ↓ Distributive (Septic, anaphylactic, neurogenic) ↑ or ↓ ↓ ↓ or N ↓ Obstructive (pulmonary embolism, cardiac tamponade, tension pneumothorax) ↓ ↑ ↑ ↓

References:

Bailey & Love's Short Practice of Surgery, 28th edition, Page number 12

↑ *Back to this question in Part A*

@Neet_pg_bot

Q10: A 65-year-old patient presents with sudden onset of shortness of breath, tachycardia, and hypotension. Examination reveals cool, clammy skin, and delayed capillary refill. The most appropriate initial management strategy for this patient's condition would be : (Q849588)

A. Fluid resuscitation with normal saline and initiation of norepinephrine

B. Fluid resuscitation with Ringer's lactate and initiation of dobutamine

C. Fluid resuscitation with normal saline and initiation of dopamine

D. Fluid resuscitation with Ringer's lactate and initiation of epinephrine

Correct Answer: A. Fluid resuscitation with normal saline and initiation of norepinephrine

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Based on the clinical presentation of tachycardia, hypotension, and poor peripheral perfusion, this patient is likely in hypovolemic or distributive shock. The initial management should focus on fluid resuscitation with normal saline, as it is the preferred crystalloid for volume replacement in shock. Type of Shock Drug of Choice (DOC) Rationale Secondary Options Hypovolemic Shock Intravenous fluids (crystalloids or colloids) Restore intravascular volume Blood products if hemorrhagic shock Cardiogenic Shock Inotropes (e.g.,

Dobutamine) Improve cardiac contractility Vasopressors (e.g., Norepinephrine) if hypotension persists Distributive Shock Vasopressors (e.g., Norepinephrine) Counteract vasodilation and increase systemic vascular resistance Vasopressin as a second-line agent Obstructive Shock Treat underlying cause (e.g., thrombolysis for pulmonary embolism, pericardiocentesis for cardiac tamponade) Address the cause of obstruction Intravenous fluids and vasopressors as needed Anaphylactic Shock Epinephrine Potent vasoconstrictor and bronchodilator Antihistamines, corticosteroids

References:

Bailey & Love's Short Practice of Surgery, 28th edition, Page number 17, 18.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q11: Among the different types of shock, which one is most common? (Q880237)

A. Hypovolemic

B. Cardiogenic

C. Obstructive

D. Distributive

Correct Answer: A. Hypovolemic

Explanation: Hypovolemic Shock , the most common type of shock, occurs due to severe blood or fluid loss. It is caused by hemorrhage, vomiting, diarrhea, or burns, resulting in decreased venous return, reduced cardiac output, and impaired tissue perfusion. Incorrect Options: Cardiogenic (Option B) shock results from the heart's inability to pump effectively, commonly due to myocardial infarction, severe heart failure, or arrhythmias. Obstructive (Option C) shock occurs due to a physical blockage of blood flow into or out of the heart, such as cardiac tamponade, tension pneumothorax, or pulmonary embolism. Distributive (Option D) shock is characterized by abnormal distribution of blood flow due to vasodilation, commonly caused by sepsis, anaphylaxis, or neurogenic injury.

References:

Bailey & Love Short Practice of Surgery, 28th Edition, Page. 12

↑ *Back to this question in Part A*

@Neet_pg_bot

Q12: A 24-year-old man is brought to the emergency department after sustaining multiple injuries in a motorcycle crash. He is hypotensive and tachycardic, and physical examination shows cool extremities and delayed capillary refill. His body initiates compensatory mechanisms to maintain perfusion to vital organs. Which of the following tissues is least likely to maintain adequate blood flow during this compensatory response? (Q880242)

A. Brain

B. Heart

C. Kidneys

D. GI tract

Correct Answer: D. GI tract

Explanation: In this scenario, a man presents to the emergency department after a motorcycle accident with hypotension, tachycardia, cool extremities, and delayed capillary refill - clinical signs indicative of Hypovolemic Shock . Perfusion to vital organs (brain, heart, and kidneys) is preserved → Triggering peripheral vasoconstriction to redirect blood flow. (Option A, B, C ruled out) Perfusion to less critical tissues (skin, gastrointestinal tract, and skeletal muscles) is significantly reduced early in shock. (Option D) Renal perfusion → Initially maintained but may decline if the shock is severe or prolonged.

References:

Bailey & Love Short Practice of Surgery, 28th Edition, Page 13-14

↑ *Back to this question in Part A*

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Q13: Which type of shock is associated with cardiac tamponade? (Q880246)

A. Hypovolemic shock

B. Cardiogenic shock

C. Obstructive shock

D. Distributive shock

Correct Answer: C. Obstructive shock

Explanation: Obstructive Shock is linked to cardiac tamponade . Classic signs, known as Beck's triad , include hypotension, distended neck veins, and muffled heart sounds . Fluid accumulates in the pericardial sac → compresses the heart → restricts ventricular filling → leads to obstructive shock by physically blocking blood flow. Hypovolemic shock (Option A) is caused by loss of blood or fluids. Cardiogenic shock (Option B) results from heart pump failure, such as in myocardial infarction. Distributive shock (Option D) occurs due to abnormal distribution of blood flow, as seen in septic or anaphylactic shock.

References:

Schwartz's Principles of Surgery, 11th Edition, Page. 150

↑ *Back to this question in Part A*

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Q14: Which of the following equations correctly represents the calculation of the modified shock index? (Q880252)

A. Heart Rate divided by Systolic Blood Pressure (HR/SBP)

B. Heart Rate divided by Diastolic Blood Pressure (HR/DBP)

C. Heart Rate divided by Mean Arterial Pressure (HR/MAP)

D. Pulse Rate divided by Systolic Blood Pressure (PR/SBP)

Correct Answer: C. Heart Rate divided by Mean Arterial Pressure (HR/MAP)

Explanation: Modified Shock Index (MSI) is defined as Heart Rate (HR) divided by Mean Arterial Pressure (MAP). MSI rises → indicates a low stroke volume and low systemic vascular resistance (hypodynamic circulation). Low MSI → indicates a hyperdynamic state.

$$\text{MSI} = \frac{\text{Heart Rate (HR)}}{\text{Mean Arterial Pressure (MAP)}}$$

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References:

Sabiston Textbook of Surgery, 21st Edition, Page. 51.

↑ *Back to this question in Part A*

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Q15: Which of the following are included in the quick Sequential Organ Failure Assessment (qSOFA) criteria? 1. Respiratory rate ≥ 22 breaths per minute 2. Systolic blood pressure ≤ 100 mmHg 3. Altered mental status (Glasgow Coma Scale < 15) 4. Heart rate ≥ 120 beats per minute 5. Fever ≥ 38°C (Q880270)

A. 1, 2, 3

B. 2, 3, 4

C. 3, 4, 5

D. 1, 2, 4

Correct Answer: A. 1, 2, 3

Explanation: The quick Sequential Organ Failure Assessment (qSOFA) suggests potentially life-threatening sepsis when at least two of the following parameters are met : Altered mental status (Option 3) Systolic blood pressure ≤ 100 mmHg (Option 2) Respiratory rate ≥ 22 breaths/minute (Option 1)

References:

Schwartz's Principles of Surgery, 11th Edition, Page 161

↑ *Back to this question in Part A*

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Q16: Which of the following are not included in the Systemic Inflammatory Response Syndrome (SIRS) criteria? 1. Body temperature > 38°C or < 36°C 2. Heart rate > 90 beats per minute 3. Respiratory rate > 20 breaths per minute or PaCO■ < 32 mmHg 4. White blood cell count > 12,000/mm³ or < 4,000/mm³ or > 10% immature forms (bands) 5. Systolic blood pressure < 90 mmHg (Q880272)

A. 1 only

B. 2 and 3

C. 5 only

D. 1 and 4

Correct Answer: C. 5 only

Explanation: Systemic Inflammatory Response Syndrome (SIRS) is diagnosed when at least two of the following criteria are present: Temperature ≥38°C (100.4°F) or ≤36°C (96.8°F) (Option 1) Heart rate ≥90 beats per minute (Option 2) Respiratory rate ≥20 breaths per minute or Paco2 ≤ 32 mmHg or mechanical ventilation (Option 3) Abnormal white blood cell count (≥12,000/µL or ≤4000/µL or ≥10% immature band forms) (Option 4)

References:

Schwartz's Principles of Surgery, 11th edition, pg. 29

↑ *Back to this question in Part A*

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• [12_Miscellaneous] 062 Tubes Catheters And Drains

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[12_Miscellaneous] 062 Tubes Catheters And Drains — Quick Jump

Q1 (p. 3468) *Q2 (p. 3469)* *Q3 (p. 3473)* *Q4 (p. 3474)* *Q5 (p. 3475)* *Q6 (p. 3477)*
Q7 (p. 3479) *Q8 (p. 3482)* *Q9 (p. 3487)* *Q10 (p. 3488)* *Q11 (p. 3489)*

Q1: A 45-year-old patient undergoes a mastectomy for breast cancer. Post-operatively, the surgeon decides to use a closed suction drain. Which of the following drain types is shown in the image below? (Q849748)

A. Penrose drain

B. Jackson Pratt drain

C. Romovac suction drain

D. Hemovac drain

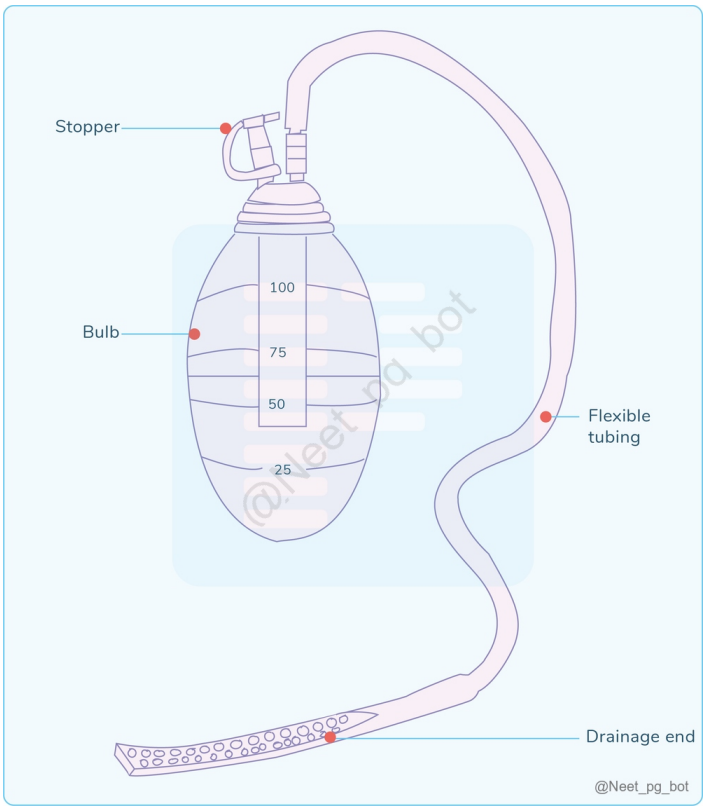


Correct Answer: B. Jackson Pratt drain

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The image shows a Jackson Pratt (JP) drain , which is a type of closed suction drain commonly used in various surgical procedures, including mastectomies. Jackson Pratt drain: Consists of a soft, flattened silicone tube connected to a soft plastic bulb The bulb can be compressed to create negative pressure Typically clear or translucent, allowing easy visualization of drainage Suitable for various surgeries, including breast, plastic, and abdominal procedures Easy to empty and maintain by patients Other options: Option A: Penrose drain A passive, open drainage system Made of soft, flat rubber tubing (looks like a rubber band stretched into a tube) No reservoir or collection system attached Option C: Romovac suction drain A variant of closed suction drains Less commonly used Option D: Hemovac drain A closed suction drainage system Larger, more spherical/round bulbs (often described as "grenade-shaped") Higher capacity - can hold more fluid (typically 400-600 mL vs JP's 100 mL) Bulbs are more rigid when empty Larger drainage tubes (wider bore)



References:

www.saintjohnscancer.org/melanoma/patient-resources/jackson-pratt-jp-drain/

↑ *Back to this question in Part A*

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Q2: A 6-month-old infant is admitted with severe vomiting and requires placement of a gastric tube. The nurse sets up the feeding equipment as shown in the image. Which

of the following tubes is correctly depicted in the image? (Q849749)

A. Nasogastric tube

B. Infant feeding tube

C. Orogastric tube

D. Jejunal feeding tube



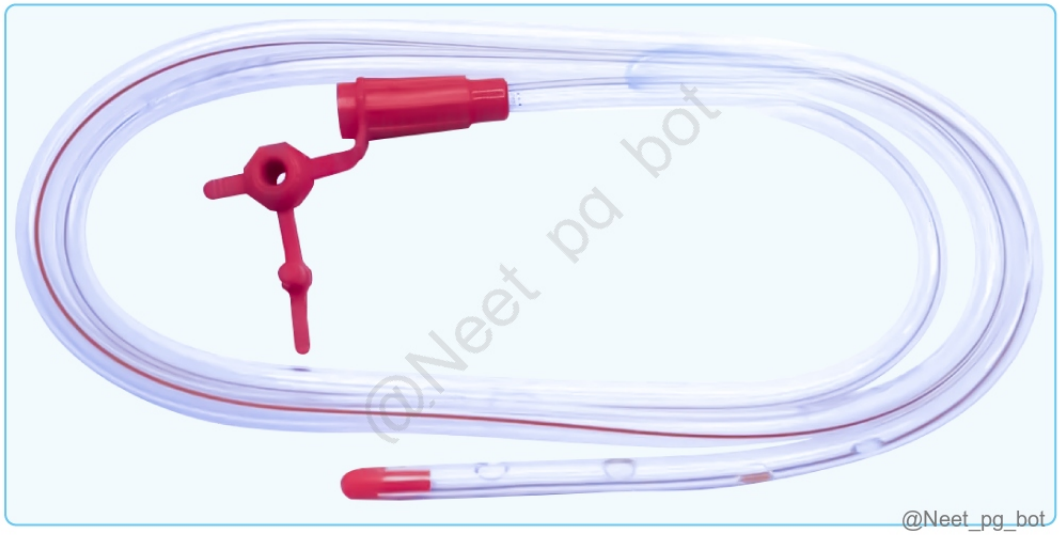
Correct Answer: B. Infant feeding tube

- *Listen (English)*
- *Listen (Hindi)*

Explanation: The tube depicted in the image is an infant feeding tube, which is smaller in diameter and more flexible compared to a standard nasogastric (NG) tube. Infant feeding tubes are specifically designed for use in newborns and young infants due to their smaller anatomy and inability to tolerate a larger NG tube. Infant Feeding Tubes (Option B): Smaller in diameter (typically 5-8 French) and more flexible Suitable for newborns and young infants due to their smaller anatomy and inability to tolerate a larger NG tube. No specific markings on the tube Indications: Enteral feeding in newborns and infants Gastric decompression in infants Medication administration in infants Other options: Option A: Nasogastric tube Inserted nasogastrically, the term "nasogastric tube" typically refers to adult/larger pediatric tubes (10-18 Fr). The question is asking for the specific type shown, which is an infant feeding tube. Option C: Orogastric tube This would be inserted through the mouth (oro-) rather than nose. While the tube itself might look similar, orogastric placement is typically used for: Neonates (especially premature infants who are obligate nose breathers) Short-term use The question context suggests nasal placement for a

6-month-old Option D: Jejunal feeding tube This is a longer tube that passes beyond the stomach into the jejunum Usually weighted at the tip Much longer length Used for post-pyloric feeding Not the first choice for simple gastric decompression/feeding









References:

Sabiston's Textbook of Surgery, 21st Edition, Page 112-113.

↑ *Back to this question in Part A*

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Q3: A 45-year-old patient undergoes a choledochotomy for the removal of common bile duct stones. The surgeon decides to use the given tube during the procedure. Which of the following statements best describes its correct use and function in this scenario? (Q849750)

A. It is inserted to provide long-term biliary drainage and should be left in place for several months.

B. It acts as a stent and is retained for 4-6 weeks in the distal filling defect.

C. It is used to create a biliary-enteric anastomosis and is removed immediately after surgery.

D. It is placed to perform intraoperative cholangiography and is removed before closing the incision.



Correct Answer: B. It acts as a stent and is retained for 4-6 weeks in the distal filling defect.

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The given image is of Kehr's T-tube, used in bile duct surgeries, especially after Choledochotomy. After the longitudinal incision in choledochotomy, the T-tube is inserted to act as a stent. (Option B) T-tube has a horizontal part which is placed in the CBD and vertical part which is allowed to come out, to drain bile. Amount of bile draining daily is measured. Before removal of the T-tube, patency of CBD should be confirmed. T-tube is retained for 4-6 weeks in a distal filling defect. (Option A ruled out) The tube is not used for creating a

biliary-enteric anastomosis; it is for temporary drainage and is not removed immediately after surgery (Option C ruled out) . Although the tube can assist in intraoperative cholangiography, it is not removed before closing the incision; it stays in place for postoperative monitoring and drainage (Option D ruled out) .



References:

SRB's Manual of Surgery, 8th Edition, Page, 1153.

↑ *Back to this question in Part A*

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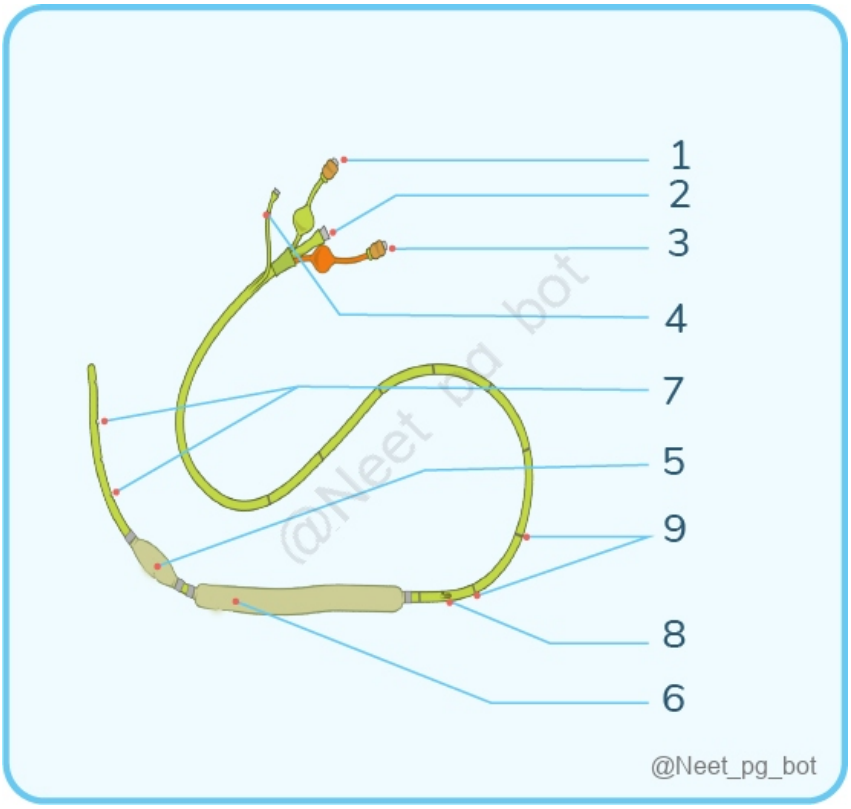
Q4: A 45-year-old patient with a history of cirrhosis presents to the emergency department with massive hematemesis. The physician uses an instrument given in the picture below. Which of the following statements is correct with respect to use of this device? (Q849751)

A. This instrument is commonly used if variceal bleeding does not stop by banding/sclerotherapy/gluing.

B. The esophageal balloon is inflated first with 30-40 mmHg pressure, followed by gastric balloon inflation with 400 mL of air.

C. It is a definitive treatment and does not require further procedures like banding or sclerotherapy.

D. The most common complication associated with its use is pressure necrosis of esophageal mucosa.



Correct Answer: A. This instrument is commonly used if variceal bleeding does not stop by banding/sclerotherapy/gluing.

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The Sengstaken-Blakemore tube is a temporary balloon tamponade device used to control severe esophageal variceal bleeding when initial endoscopic treatments fail. It acts as a bridge to definitive therapy (like band ligation, sclerotherapy, or TIPS). (Option C) Balloon inflation is done in sequence: gastric balloon first (250-300 mL air/saline), then esophageal balloon (20-40 mmHg) . (Option B) Common complications include aspiration pneumonia , mucosal ulceration, and esophageal rupture. (Option D)

References:

SRB's Manual of Surgery, 8th Edition, Page, 614.

↑ *Back to this question in Part A*

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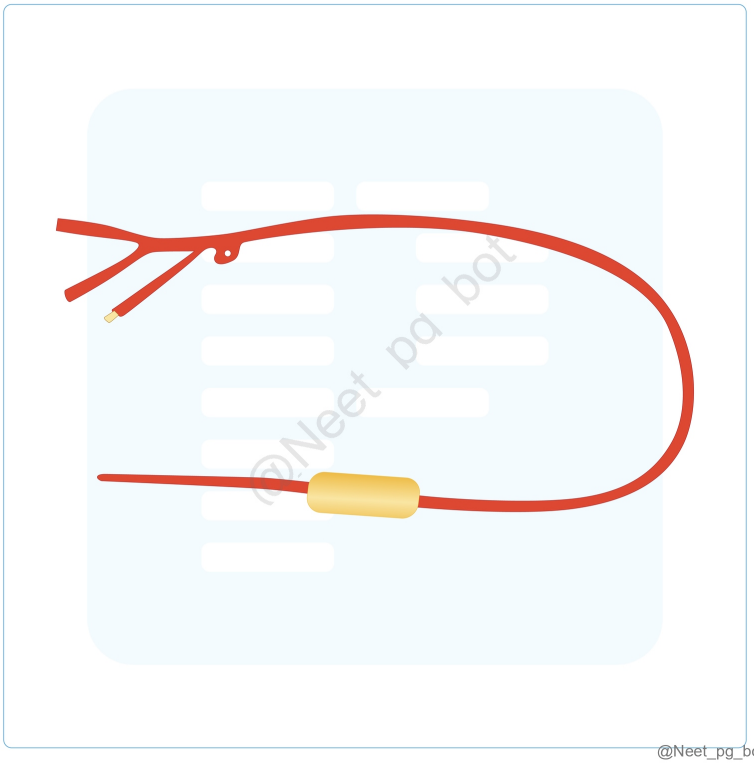
Q5: A 60-year-old man with a history of alcoholic cirrhosis presents to the emergency department with massive hematemesis. After initial stabilization, the decision is made to use the following device, as given in the picture below, for temporary management of suspected bleeding gastric varices. Which of the following statements about the device is INCORRECT? (Q849752)

A. The device shown in the picture is Sengstaken-Blakemore tube

B. It contains three lumens consisting of Esophageal and gastric aspiration port, and a port for balloon inflation

C. It has a single gastric balloon with capacity 500-600cc

D. It is used for temporary management of bleeding gastric varices

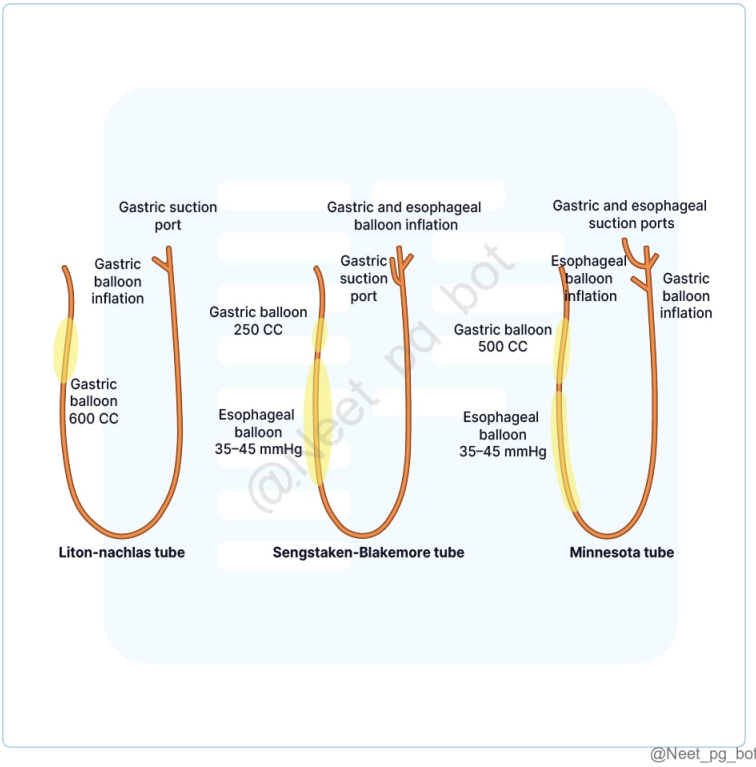


Correct Answer: A. The device shown in the picture is Sengstaken-Blakemore tube

- *Listen (English)*
- *Listen (Hindi)*

Explanation: The image shows a Linton–Nachlas tube , which is used mainly for bleeding gastric varices and is recognized by having: One large gastric balloon Three lumens (gastric suction + balloon inflation + esophageal suction) A large single balloon capacity of ~500–600 cc In contrast: Sengstaken–Blakemore tube has TWO balloons One gastric balloon One esophageal balloon Balloon capacities: Gastric: 250–300 cc Esophageal: 100–150 cc Gastroesophageal Balloon Tamponade Devices Device Number of Lumens Components Special

Feature Primary Use Sengstaken–Blakemore (SB) Tube 3 Gastric balloon, Esophageal balloon, Gastric suction port Standard tamponade device Esophageal variceal bleeding Minnesota Tube 4 Gastric balloon, Esophageal balloon, Gastric suction, Esophageal suction Extra esophageal suction prevents aspiration Esophageal variceal bleeding (safer than SB) Linton–Nachlas Tube 2 Large gastric balloon, Gastric suction No esophageal balloon Gastric variceal bleeding



References:

emedicine.medscape.com/article/81020

www.sciencedirect.com/topics/medicine-and-dentistry

↑ *Back to this question in Part A*

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Q6: Which of the following statements about the following instrument in the image is incorrect? (Q849753)

A. The catheter is coated with silicone to minimize irritation during prolonged use.

B. For self-retaining purposes, the balloon is inflated with 20-30 ml of saline.

C. It can be used for administration of intravesical chemotherapy

D. 2-way foley’s catheter can be used for bladder irrigation following TURP

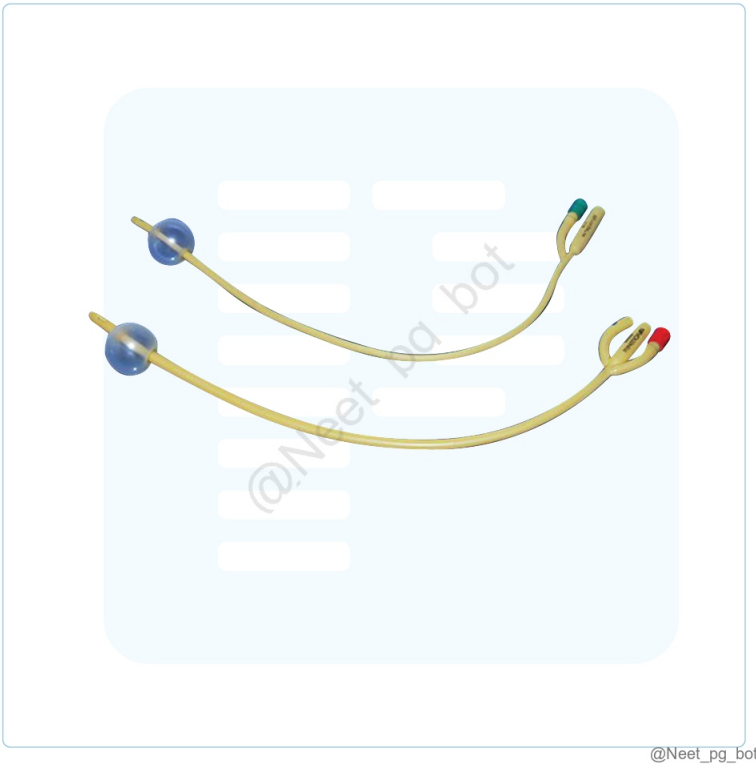


Correct Answer: D. 2-way foley’s catheter can be used for bladder irrigation following TURP

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: For bladder irrigation following TURP, 3-way Foley’s is used. The additional channel in the 3-way catheter is used for draining clots in patients with haematuria and clot retention, following transurethral prostate or bladder surgery. Material LATEX - Less irritation & crust formation Silicone Coating- For Prolonged use (upto 3 months) (Option A) Channels 2-way Foley catheter: Main channel: For drainage of urine Small channel: For inflating balloon 3-way Foley catheter: Main channel: for drainage of urine Additional channel for irrigation Balloon Inflation 20-30 ml saline for self-retaining (Option B) 30-50 ml of saline for hemostatic compression effect Uses To relieve urinary retention To measure urine output For administration of intravesical chemotherapy (Option C) 3 ways catheter - for Irrigation after TURP May be used for supra-pubic cystostomy



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References:

SRB Manual of Surgery, 8th Edition, Page 990-991

↑ *Back to this question in Part A*

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Q7: A 58-year-old patient is rushed to the emergency department with symptoms of acute limb ischemia. The vascular surgeon diagnoses an arterial embolism and decides to perform an embolectomy. Which of the following catheters is specifically designed and most appropriate for this procedure? (Q849764)

A. Swan-Ganz catheter

B. Fogarty Catheter

C. De-Pezzer Catheter

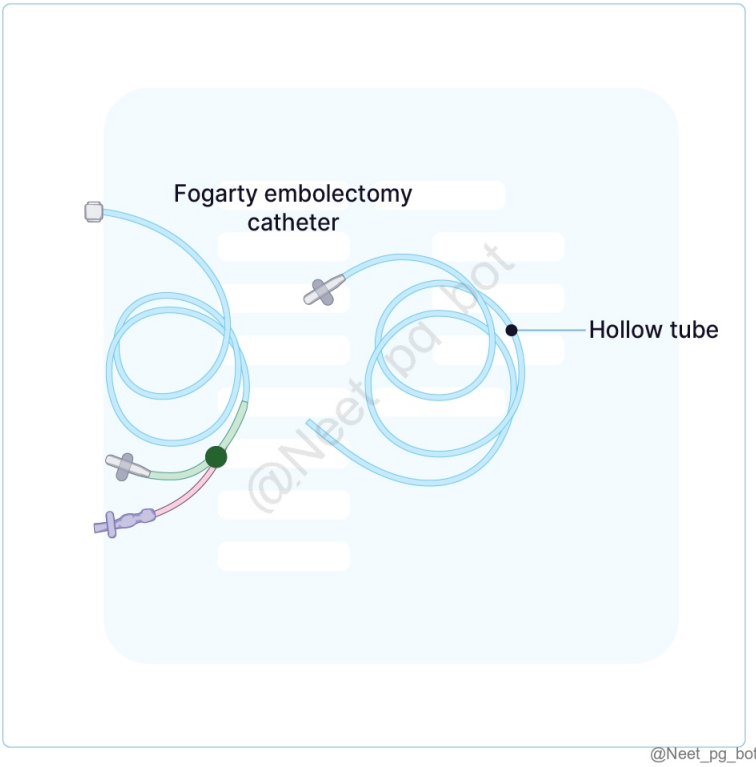
D. Malecot’s Catheter

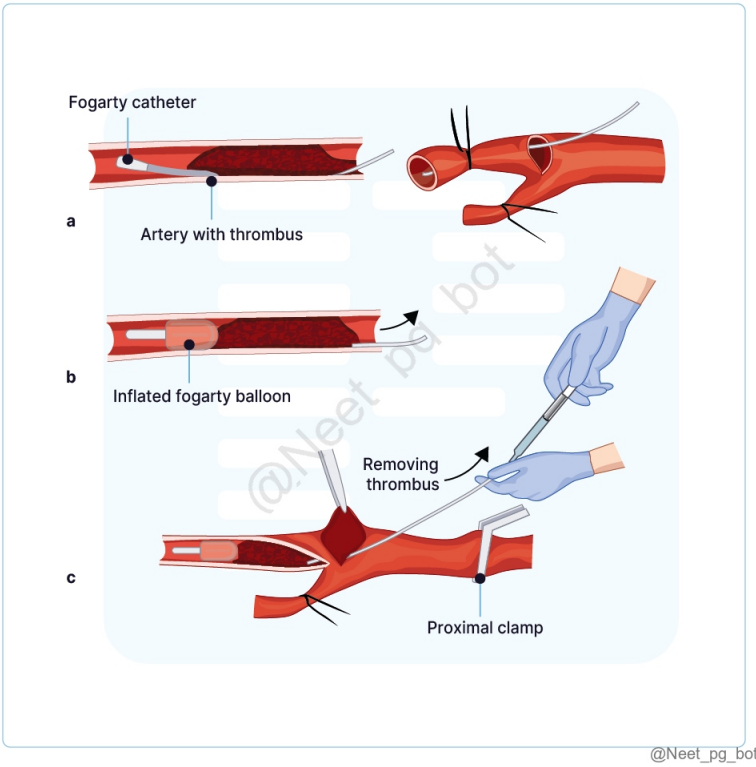
Correct Answer: B. Fogarty Catheter

■ *Listen (English)*

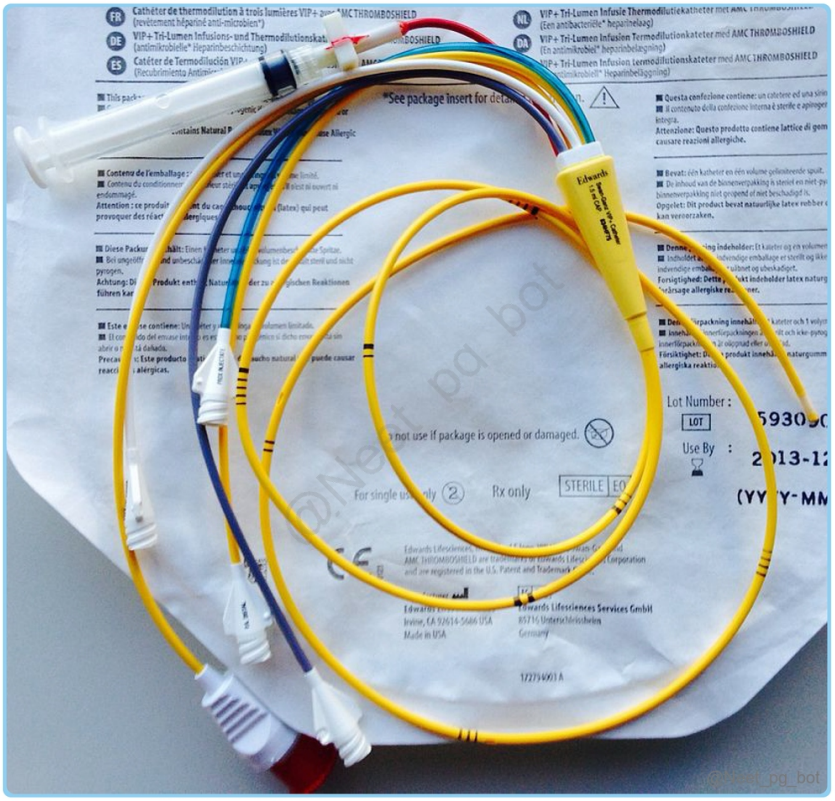
■ *Listen (Hindi)*

Explanation: Fogarty Embolectomy Catheter is used in embolectomy to treat arterial or venous thrombus/emboli in blood vessels. Swan-Ganz catheter (Option A) is used for hemodynamic monitoring using pulmonary artery catheterization, not for embolectomy. De-Pezzer Self-Retaining Catheter (Option C) & Malecot Catheter (Option D) are used for urinary drainage and related procedures, not for vascular embolectomy.





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References:

SRB Manual of Surgery, 8th Edition, Page 187, 990.

↑ *Back to this question in Part A*

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Q8: Match the following: a. Foley’s catheter 1. b. Nelaton’s catheter 2. c. Malecot’s catheter 3. d. Red-rubber catheter 4. (Q849765)

A. a-3, b-4, c-1,d-2

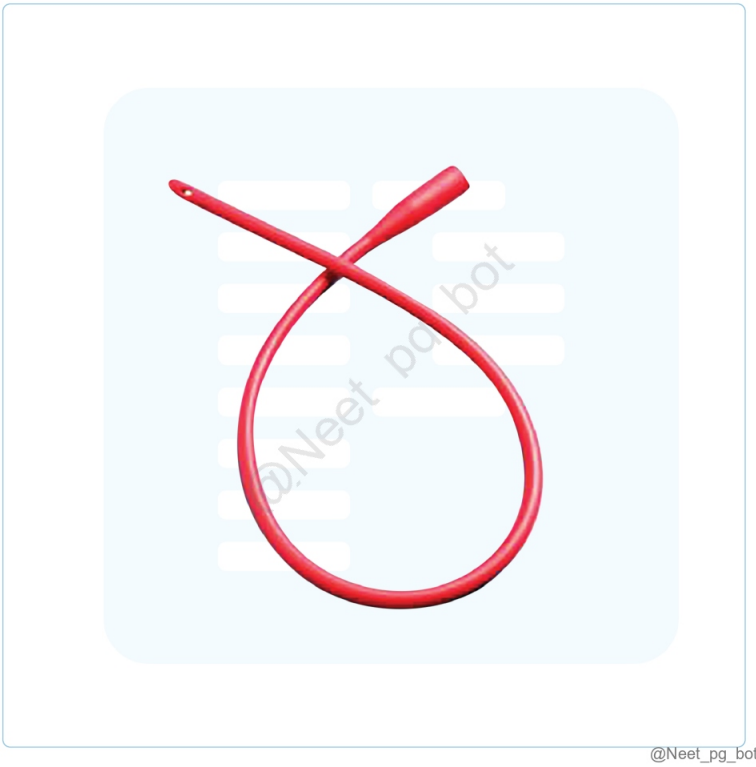
B. a-4, b-3, c-2, d-1

C. a-1, b-2, c-3, d-4

D. a-2, b-1, c-4, d-3



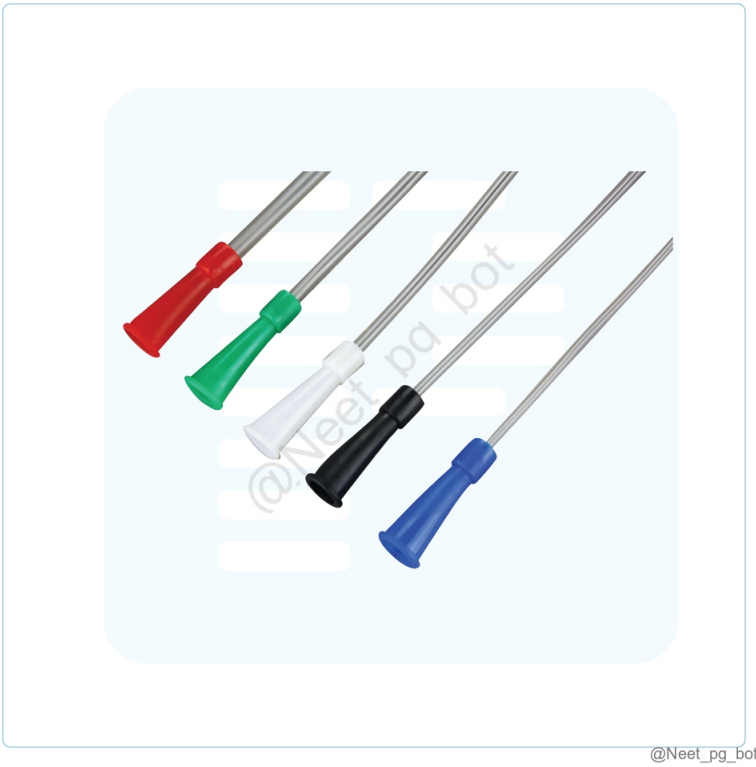
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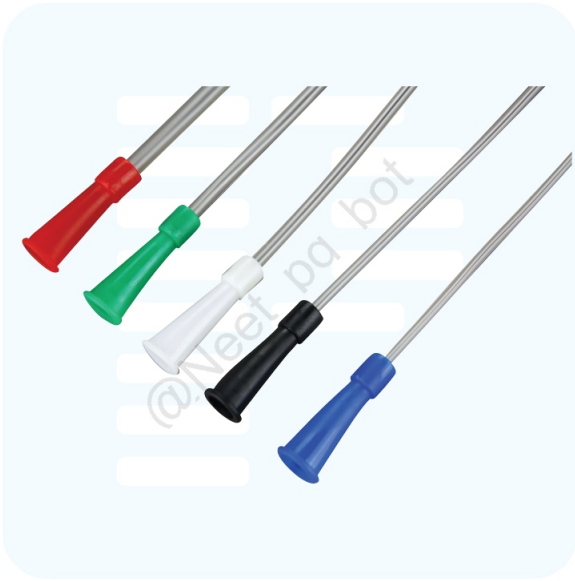
Correct Answer: A. a-3, b-4, c-1,d-2

- *Listen (English)*
- *Listen (Hindi)*

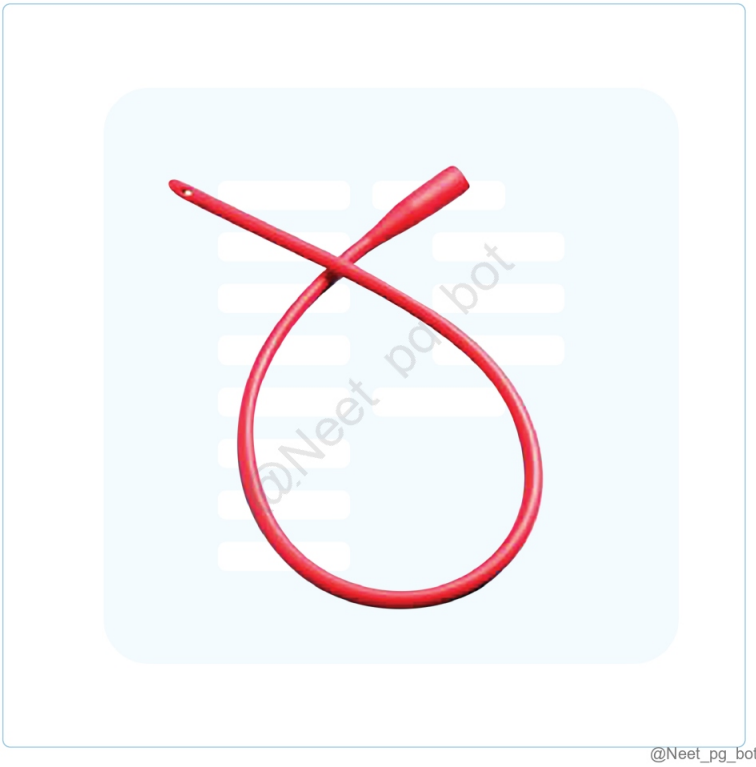
Explanation: Various catheters used in surgery- A Malecot catheter is a self-retaining catheter with an umbrella or flower tip. I Uses: Suprapubic cystostomy Perinephric abscess Amoebic liver abscess Subphrenic abscess Cholecystostomy Fig: Malecot catheter A Nelaton catheter is used for one-time emptying of the bladder during or after surgery. Fig. Nelaton catheter A red-rubber catheter is a non-self-retaining urinary catheter (has no balloon) Tip: rounded and blunt Uses: Temporarily used to drain urine from the bladder Used to estimate the residual urine Fig: Red -Rubber catheter A Foley's catheter is a thin, sterile tube inserted into the bladder to drain urine. It is also known as an indwelling catheter as it can be left in place in the bladder for a period of time. Fig: Foley's catheter



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References:

SRB’s Manual of Surgery, 6th Edition, Page 999-1001

↑ *Back to this question in Part A*

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Q9: All of the following are true statements regarding central venous catheters except- (Q849766)

A. The tip of the catheter is situated in the inferior vena cava

B. The most dangerous complication is pneumothorax

C. Inside OT, the Internal jugular vein is the preferred vein

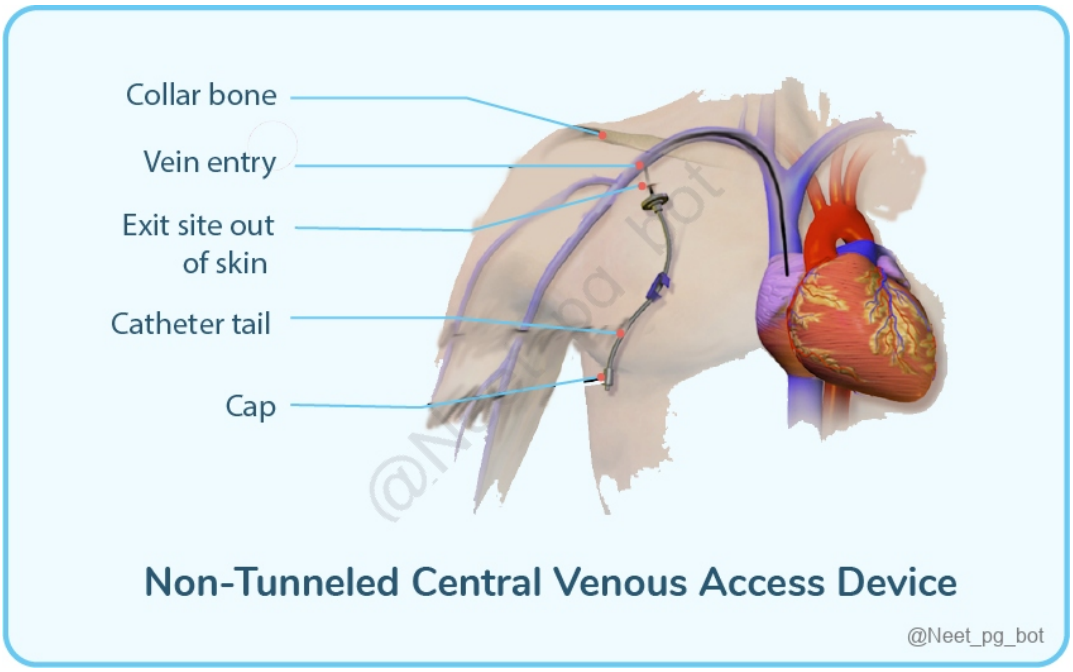
D. In acutely injured, critically ill patients Femoral vein is the preferred vein

Correct Answer: A. The tip of the catheter is situated in the inferior vena cava

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The tip of the central venous catheter is situated in the superior vena cava, not on the inferior vena cava. The central venous catheter is used for fluid, medication, and nutrition administration. The tip is located in the superior vena cava Order of preference: Subclavian vein > Internal jugular vein > Femoral vein (Option D) Inside OT: Internal jugular vein (Option C) Outside OT: Subclavian vein Complications: Catheter-related sepsis, pneumothorax (Option B)



References:

www.ncbi.nlm.nih.gov/books/NBK557798/

↑ *Back to this question in Part A*

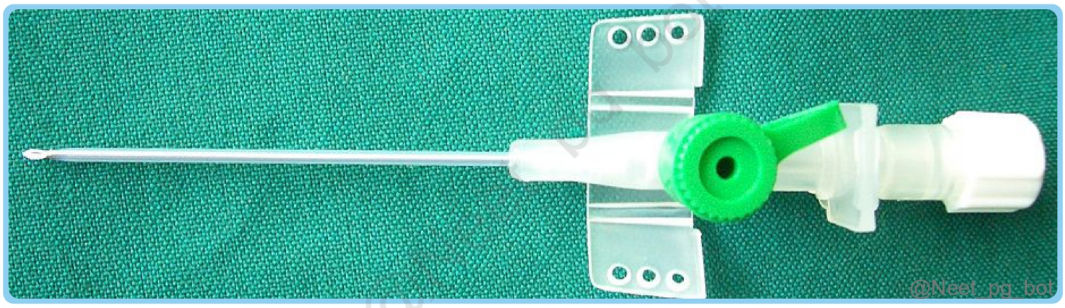
Q10: What is the size of the cannula shown in the below image? (Q849767)

A. 18G

B. 20G

C. 24G

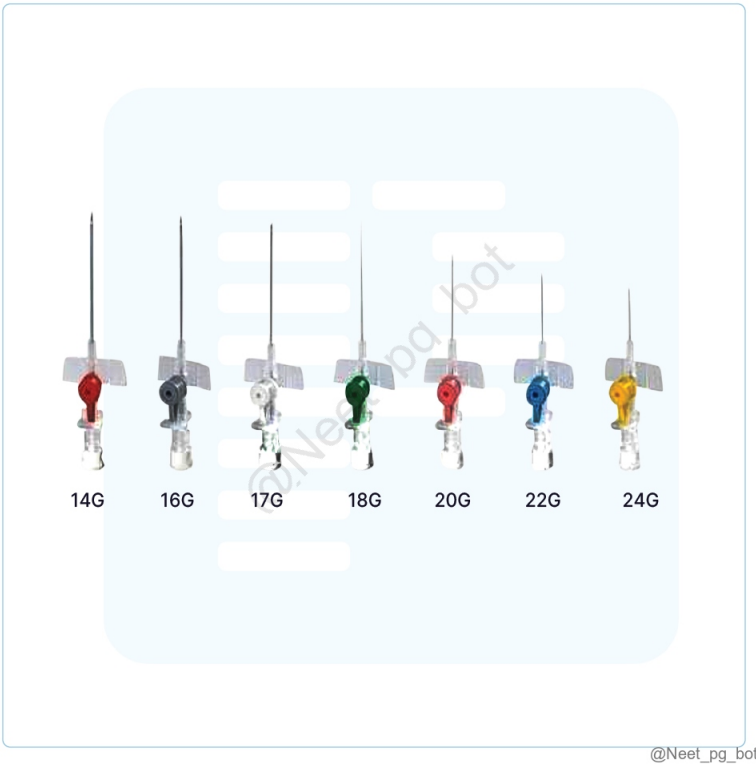
D. 26G



Correct Answer: A. 18G

- *Listen (English)*
- *Listen (Hindi)*

Explanation: The given cannula is an 18G IV cannula and its color code is green The green cannula has a flow rate of 90 ml/min and it is used for administering blood products, irritant medications, in major surgery, contrast study Sizes of Cannula:



References:

https://emedicine.medscape.com/article/1998177-periprocedure?form=fpf

↑ *Back to this question in Part A*

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Q11: All of the following about chemo-port is true, except (Q849768)

A. Retained for 5 years

B. Used for chemotherapy administration

C. The catheter is placed beneath the skin

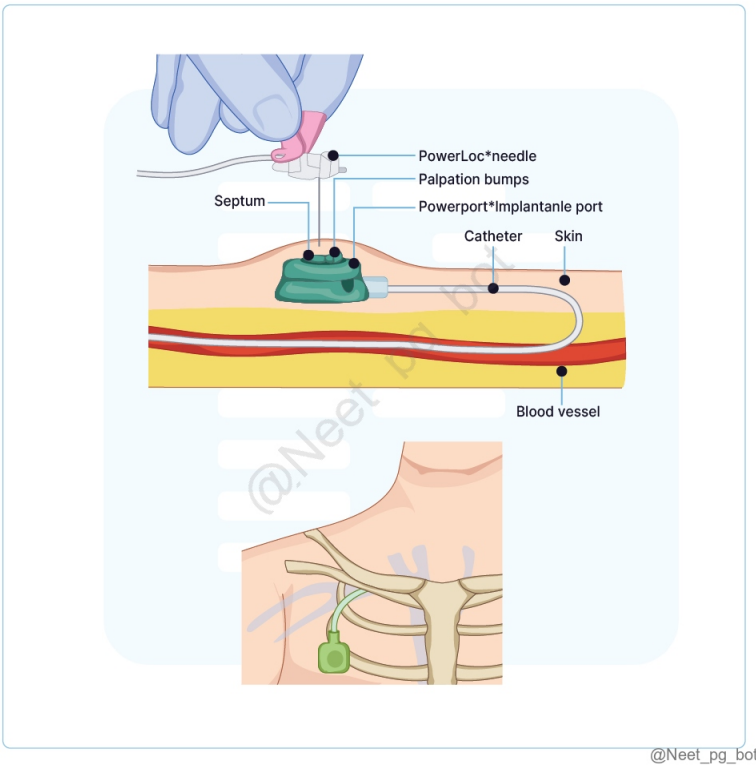
D. The veins used are the internal jugular and subclavian veins.

Correct Answer: A. Retained for 5 years

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Chemoport is an implantable venous access device which is placed beneath the skin. (Option C) It is retained for 1-2 years. The veins used are the internal jugular vein and the subclavian vein. (Option D) Used for chemotherapy administration. (Option B) In the chemo port, there are palpation pumps with which we can feel the presence of the septum. Complications- catheter embolization, port occlusion, vascular thrombosis.



References:

https://www.moffitt.org/treatments/chemotherapy/what-is-a-chemo-port/

↑ *Back to this question in Part A*

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• [12_Miscellaneous] 063 Instruments

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[12_Miscellaneous] 063 Instruments — Quick Jump

Q1 (p. 3491)	*Q2 (p. 3492)*	*Q3 (p. 3493)*	*Q4 (p. 3494)*	*Q5 (p. 3495)*	*Q6 (p. 3497)*
Q7 (p. 3499)	*Q8 (p. 3500)*	*Q9 (p. 3500)*	*Q10 (p. 3501)*	*Q11 (p. 3504)*	*Q12 (p. 3506)*
Q13 (p. 3506)	*Q14 (p. 3507)*	*Q15 (p. 3508)*	*Q16 (p. 3510)*	*Q17 (p. 3513)*	*Q18 (p. 3516)*
Q19 (p. 3519)	*Q20 (p. 3520)*	*Q21 (p. 3521)*	*Q22 (p. 3523)*	*Q23 (p. 3526)*	*Q24 (p. 3529)*
Q25 (p. 3530)	*Q26 (p. 3534)*	*Q27 (p. 3536)*	*Q28 (p. 3541)*	*Q29 (p. 3542)*	*Q30 (p. 3543)*
Q31 (p. 3547)	*Q32 (p. 3549)*				

Q1: The surgical instrument displayed in the image is not typically used for which of the following purposes? (Q880283)

A. Blunt dissection of soft tissues in pelvic surgery

B. Deep tissue dissection during vagotomy

C. Cutting sutures on the skin surface

D. Dissection during laparoscopic cholecystectomy



Correct Answer: C. Cutting sutures on the skin surface

Explanation: The image shows blunt Metzenbaum scissors , which are characterized by long, slender blades relative to the shaft , designed for blunt and sharp dissection of soft tissues in deep surgical areas . They are commonly used in procedures such as vagotomy, cholecystectomy, pelvic surgeries, etc. (Option A, B, D ruled out) They are for deep tissue dissection rather than surface use; Mayo scissors or suture scissors are more appropriate for this purpose. (Option C)

References:

SRBs Surgical Operations, 1st Edition, Page 91.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q2: Which of the following is an advantage of robotic-assisted surgery over conventional laparoscopy? (Q880402)

A. Completely eliminates the need for trained surgical assistance

B. Offers fully autonomous operation without surgeon input

C. Provides motion scaling and tremor suppression for enhanced precision

D. Has lower cost compared to laparoscopic surgery

Correct Answer: C. Provides motion scaling and tremor suppression for enhanced precision

Explanation: A major advantage of Robotic Surgery is that it enhances precision through motion scaling and tremor suppression, translating large hand movements into smaller, controlled instrument actions for more stable and accurate performance, especially in delicate procedures. Advantages Disadvantages 3D HD vision with depth perception Camera angulation and wristed instruments Enhanced dexterity (7 degrees of freedom) Motion scaling and tremor filtering (Option C) Improved ergonomics with seated console operation Reduces surgeon strain and distractions Potential for motion compensation in moving organs. Higher cost due to expensive equipment and consumables (Option D ruled out) Limited proven benefit over laparoscopy in outcomes or hospital stay Longer operating times, especially initially Steep, variable learning curve Shared use limits access, slowing skill development. Completely eliminates the need for trained surgical assistance (Option A): Robotic surgery still requires skilled surgical assistants for tasks like instrument changes and patient management. Offers fully autonomous operation without surgeon input (Option B): Robots are controlled by surgeons in real-time and do not operate independently or autonomously.

References:

Bailey and Love’s Textbook of Surgery, 28th Edition, Pages 167-168.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q3: Flexible sigmoidoscopy is a diagnostic procedure commonly used to evaluate the lower gastrointestinal tract. Up to which part of the colon can a flexible sigmoidoscope typically reach? (Q880401)

A. Ascending colon

B. Hepatic flexure

C. Splenic flexure

D. Sigmoid colon

Correct Answer: C. Splenic flexure

Explanation: A flexible sigmoidoscope typically reaches up to the splenic flexure , allowing visualization of the rectum , sigmoid colon , and descending colon up to that point. Incorrect Options: It does not usually reach the hepatic flexure or ascending colon - a full colonoscopy is required. (Option A, B ruled out) Sigmoid colon (Option D): While the sigmoid colon is visualized during flexible sigmoidoscopy, it is not the upper limit; the scope typically advances further to the splenic flexure.



References:

Bailey and Love’s Textbook of Surgery, 28th Edition, Page 1395-1396.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q4: Which of the following best explains the mechanism of action of the wound management technique shown in the image? (Q880398)

A. Application of negative pressure to promote wound healing

B. Application of positive pressure to increase tissue perfusion

C. Use of foam dressing to provide antimicrobial action

D. Use of sponge material to mechanically debride the wound



Correct Answer: A. Application of negative pressure to promote wound healing

Explanation: The procedure shown is Negative Pressure Wound Therapy (NPWT) , also known as vacuum-assisted closure (VAC) . It involves placing a foam dressing into the wound, sealing it with an adhesive drape, and applying controlled negative pressure via a suction device. Negative pressure helps draw the wound edges together, remove exudate, reduce oedema and promote granulation tissue formation. Use: Chronic, non-healing wounds, pressure ulcers, and post-surgical wound dehiscence. It is not recommended in the setting of

exposed vessels, malignancy, untreated osteomyelitis, necrotic tissue or non-enteric and unexplored fistulae. Incorrect Options: Application of positive pressure to increase tissue perfusion (Option B): Positive pressure is not used in wound healing therapies like this; it can actually impair perfusion and is not a principle used in modern wound care. Use of foam dressing to provide antimicrobial action (Option C): While foam dressings are used in NPWT, their primary function is to distribute negative pressure evenly, not to provide antimicrobial action unless specifically impregnated with antimicrobial agents (which is not shown here). Use of sponge material to mechanically debride the wound (Option D): Mechanical debridement involves physically removing necrotic tissue. The sponge in NPWT aids in pressure distribution and exudate removal, not mechanical debridement.

References:

Bailey and Love's Textbook of Surgery, 28th Edition, Page 32.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q5: Which of the following statements about the device shown in the image is true? (Q880397)

A. The electrical current passes between two closely placed electrodes on the surgical site

B. It does not require a grounding pad since the circuit is closed within the instrument

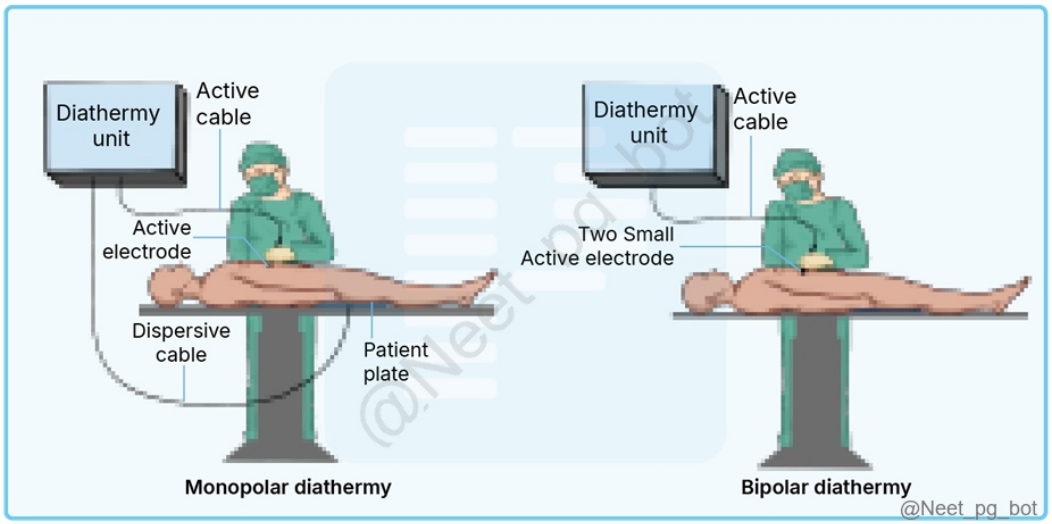
C. Unipolar cautery has a lower risk of electrical burns compared to bipolar cautery

D. The current enters the patient through the active electrode and exits via a dispersive electrode



Correct Answer: D. The current enters the patient through the active electrode and exits via a dispersive electrode

Explanation: Unipolar cautery (as shown in the image) uses an active electrode (the tip) to deliver electrical current to the tissue. The current then passes through the patient's body and exits via a dispersive grounding pad, completing the electrical circuit. The electrical current passes between two closely placed electrodes on the surgical site (Option A): This describes bipolar cautery, where current flows between two electrodes on the device itself. It does not require a grounding pad since the circuit is closed within the instrument (Option B): This is incorrect because unipolar cautery requires a grounding pad to return the current safely. Unipolar cautery has a lower risk of electrical burns compared to bipolar cautery (Option C): Unipolar cautery actually carries a higher risk of burns compared to bipolar cautery.



References:

Bailey and Love's Textbook of Surgery, 28th Edition, Page 110-111.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q6: Which of the following features is most characteristic of coagulation mode in electrosurgical diathermy? (Q880391)

A. Continuous low-voltage current with rapid heating and tissue vaporization

B. Energy concentrated over a small area with minimal lateral thermal spread

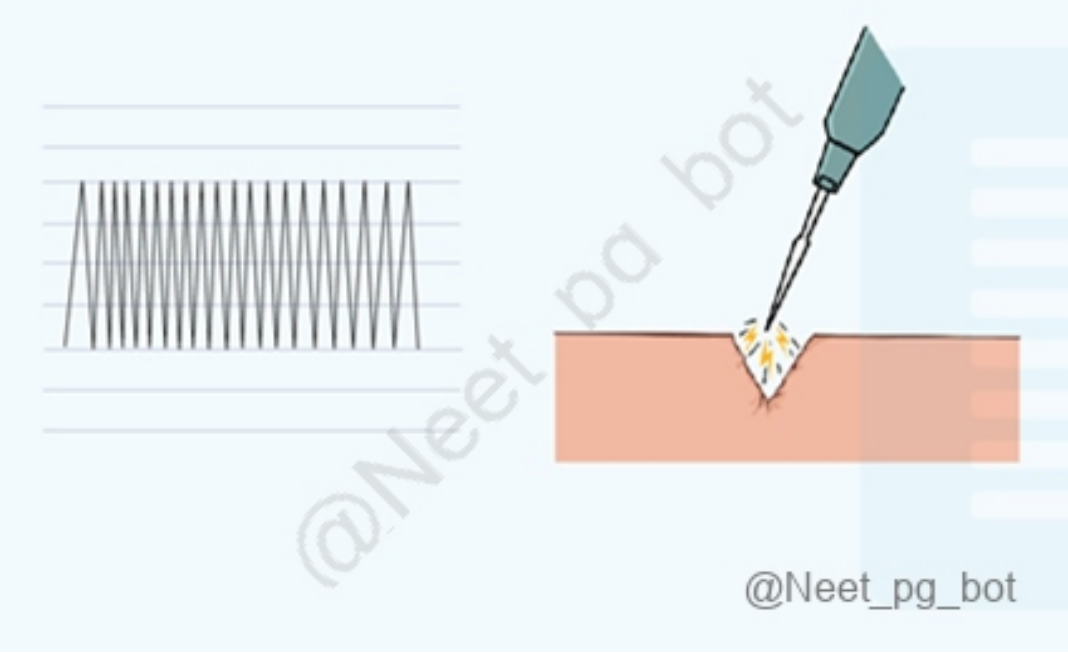
C. Intermittent high-voltage current causing tissue dehydration and protein denaturation

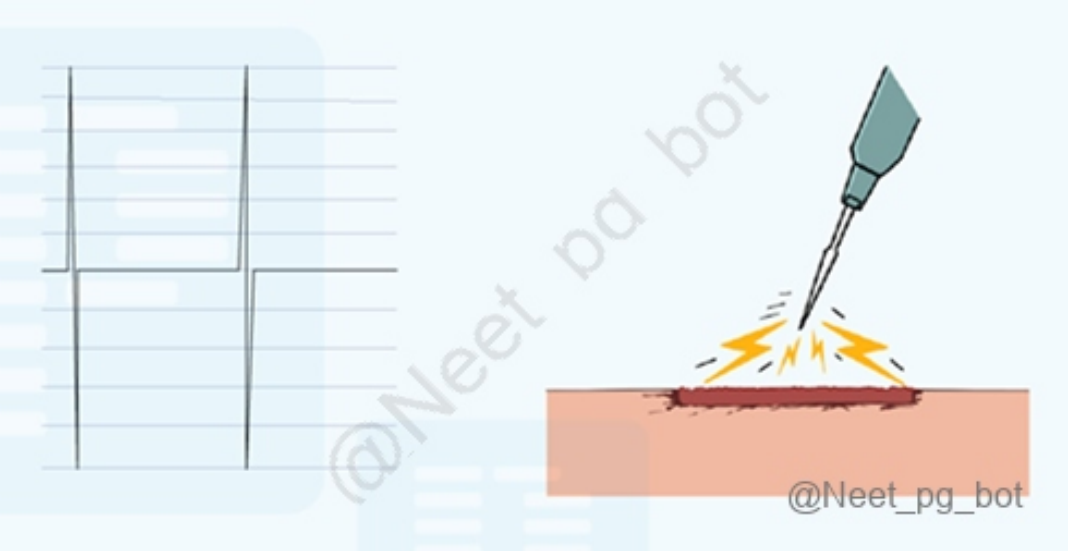
D. Generation of sparks used primarily for precise tissue dissection

Correct Answer: C. Intermittent high-voltage current causing tissue dehydration and protein denaturation

Explanation: Coagulation mode uses interrupted high-voltage current that slowly heats tissue, causing dehydration and protein coagulation, making it ideal for hemostasis. Comparison of cutting and coagulation of tissue using diathermy Cutting Coagulation Lower voltage current (Option A ruled out) Higher voltage current (Option C) Continuous (current is 'on' 100% of the time) (Option A ruled out) Interrupted (current flows 6% of the time and is off for the remaining 94%) (Option C) Energy concentrated over a small area (Option B ruled out) Energy is dispersed over a large area Rapid, high-temperature heating causes tissue vaporization, resulting in cutting. Modulated current slows tissue heating, causing dehydration and protein denaturation, leading to coagulation ideal for hemostasis by sealing vessels and promoting clotting (Option C) Minimal lateral spread and collateral damage

Extensive lateral spread Cutting divides tissue by arcing sparks, most effective when the tip is held just above the tissue (Option D ruled out) Similar to cutting, it works best with no or minimal contact just above the tissue Used for clean tissue cutting, dissection, and division also along with skin incisions. Uses: Coagulation and achieving haemostasis





References:

SRBs Surgical Operations, 1st Edition, Page 568.

Bailey’s and Love Textbook of Surgery, 28th Edition, Page 111-112

↑ *Back to this question in Part A*

@Neet_pg_bot

Q7: What is the primary use of the instrument shown in the image below? (Q880390)

A. Measuring oral temperature

B. Measuring rectal temperature

C. Measuring tympanic temperature

D. Measuring axillary temperature



Correct Answer: B. Measuring rectal temperature

Explanation: The image shows a Rectal Temperature Probe , which is specifically designed to measure core body temperature accurately via the rectum. This method provides a more reliable reflection of the body's true internal temperature compared to oral or axillary measurements. It is commonly used in critical care and situations requiring precise temperature monitoring.

References:

Procedure of rectal temperature measurement affects brain, muscle, skin and body temperatures and modulates the effects of intravenous cocaine

Temperature management : rectal temperature (PCCU) | NHSGGC

↑ *Back to this question in Part A*

@Neet_pg_bot

Q8: In adult males, which Foley catheter size is generally preferred to minimize urethral trauma while ensuring adequate drainage? (Q880385)

A. 8 French

B. 12 French

C. 16 French

D. 20 French

Correct Answer: C. 16 French

Explanation: The French (Fr) scale refers to the external diameter of the catheter, where 1 Fr equals 0.3 mm in diameter. The standard catheter size for uncomplicated urethral catheterization is 12-14 Fr in women and 16 Fr in men (balances adequate urinary drainage with minimizing urethral trauma). Smaller catheters (8-12 Fr) may be used in patients with urethral strictures , while larger sizes such as 22 Fr are reserved for cases like haematuria with clot retention to help drain thick clots.

References:

Bailey’s and Love Textbook of Surgery, 28th Edition, Page 1508.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q9: Identify the medical device shown in the image below: (Q880384)

A. Central venous catheter

B. Pigtail catheter

C. Foley catheter

D. Nasogastric tube



Correct Answer: B. Pigtail catheter

Explanation: A Pigtail Catheter is a small-bore, flexible, self-retaining catheter with a curled tip that prevents dislodgement and minimizes tissue trauma. It is commonly used for minimally invasive drainage of pleural effusions, pneumothorax, and liver abscesses. Incorrect Options: Central venous catheter (Option A) is used for vascular access, not for drainage of fluid collections. Foley catheter (Option C) is designed for urinary bladder drainage via the urethra and not for fluid drainage in the chest or abdomen. Nasogastric tube (Option D) is used for gastric decompression or feeding, not for draining pleural or abdominal fluid collections.

References:

The pigtail catheter for pleural drainage: a less invasive alternative to tube thoracostomy - PubMed

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 68-69

↑ *Back to this question in Part A*

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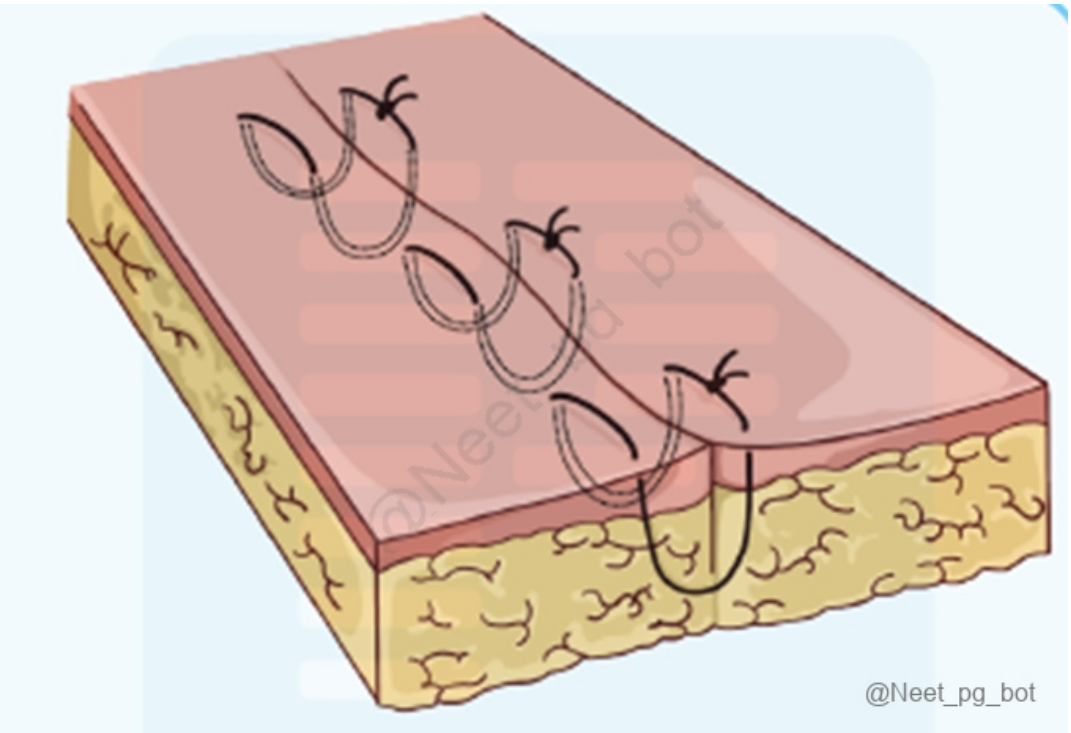
Q10: Identify the suturing technique demonstrated in the accompanying image. (Q880381)

A. Interrupted sutures

B. Continuous sutures

C. Mattress sutures

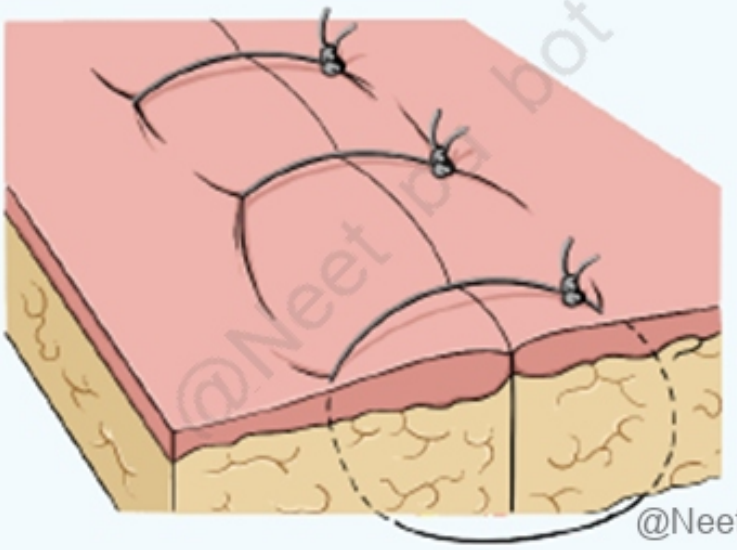
D. Subcuticular sutures



Correct Answer: C. Mattress sutures

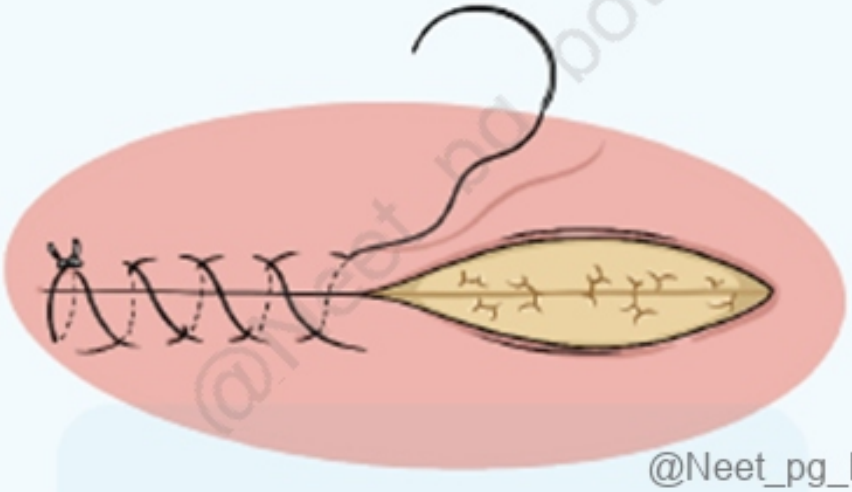
Explanation: Mattress sutures, either vertical or horizontal, pass through wound edges twice to precisely approximate and evert or invert irregular wound edges, promoting better healing. This differs from continuous sutures, which run uninterrupted along the wound, and subcuticular sutures, placed just beneath the skin surface for cosmetic closure. Types of Suture Techniques Individual stitches placed separately at right angles to the wound, allowing precise tension control and easy removal of single sutures if needed. (Option A ruled out) A single thread passed continuously along the wound edge, providing quick closure but with less tension control compared to interrupted sutures. (Option B ruled out) Sutures that pass through the wound edges twice in either a vertical or horizontal direction to evert or invert wound edges for better healing. (Option C) Fine sutures placed just beneath the skin surface in the dermis, providing a cosmetic closure with minimal scarring and no external stitches visible. (Option D ruled out)

Interrupted Sutures

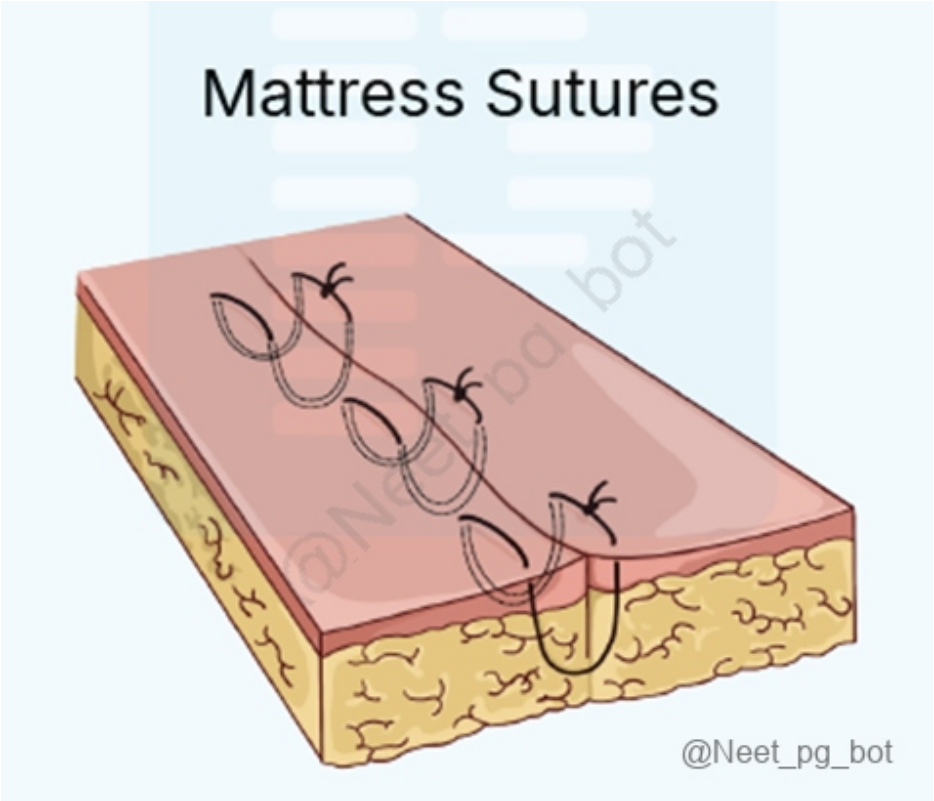


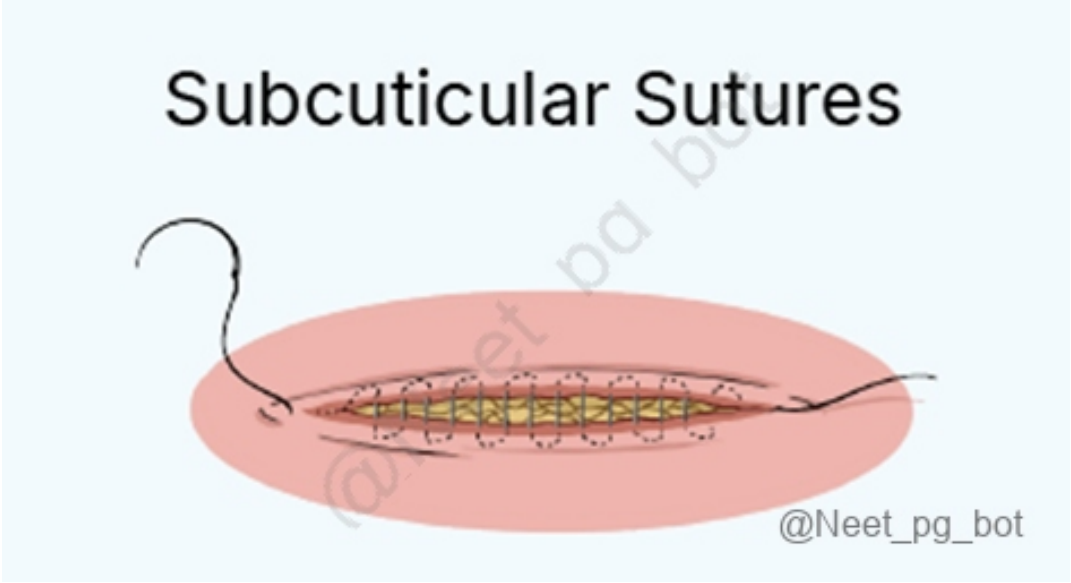
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Continuous Sutures



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References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 107-108

↑ *Back to this question in Part A*

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Q11: Which of the following statements about surgical knots is correct? (Q880380)

A. A square knot provides more security than a granny knot due to equal tension in both throws

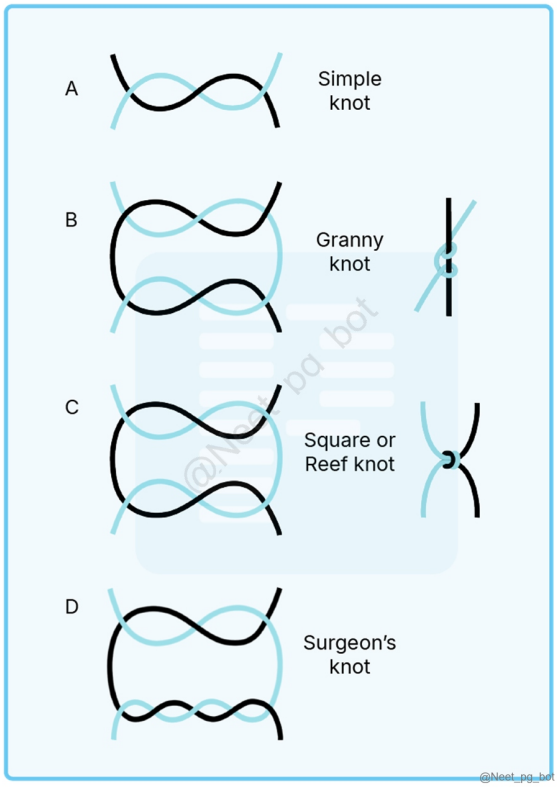
B. A granny knot is preferred over a square knot for ligating blood vessels because it tightens more securely

C. A surgeon's knot involves a single throw followed by multiple throws to reduce slippage in high-tension areas

D. The slip knot is used to permanently secure sutures as it does not loosen over time.

Correct Answer: A. A square knot provides more security than a granny knot due to equal tension in both throws

Explanation: The square knot (reef knot) is the standard surgical knot, formed by two opposing throws that create equal tension and prevent slipping, making it secure and reliable. Granny knot is a mis-tied knot where the throws are made in the same direction; it tends to slip and is less secure, so it is not preferred for ligating blood vessels. (Option B ruled out) Surgeon's knot involves a double first throw (two loops) followed by a single or more throws, which increases friction and reduces slippage, especially useful in high-tension tissues. (Option C ruled out) Slip knot is a temporary knot used to adjust tension or position but loosens easily and is not used for permanent ligation. (Option D ruled out)



References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 108-109.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q12: The eye present at the tip of Kocher's thyroid dissector is used for: (Q880379)

A. Passing ligatures through it to tie the superior pedicle

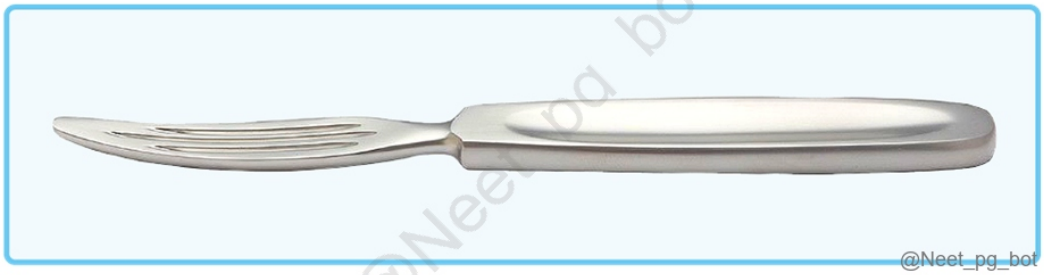
B. Fixation to the thyroid capsule

C. Holding the inferior thyroid artery

D. Injecting local anesthetic

Correct Answer: A. Passing ligatures through it to tie the superior pedicle

Explanation: Kocher's thyroid dissector has a small eye (a hole) at its tip, which is specifically designed to allow the passage of ligatures. During thyroidectomy, when the superior thyroid vessels (superior pedicle) need to be tied off to control bleeding, a ligature (surgical thread) can be passed through this eye to facilitate secure and precise ligation. (Option B, C, D ruled out) This feature helps surgeons maintain control and precision while cutting and tying the superior pedicle.



References:

SRBs Surgical Operations, 1st Edition, Page 79.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q13: A surgeon is performing an inguinal hernia repair and needs an instrument to retract the skin, fascia, and muscle superficially. Which retractor is most appropriate for this purpose? (Q880377)

A. Deaver retractor

B. Langenbeck retractor

C. Kocher’s intestinal clamp

D. Lahey’s thyroid tenaculum

Correct Answer: B. Langenbeck retractor

Explanation: The Langenbeck retractor , with its long handle and small solid blade, is ideal for gentle superficial retraction of skin, fascia, and muscle, commonly used in hernia and other superficial surgeries. Incorrect Options: Deaver retractor (Option A): Used for deep retraction of abdominal and thoracic organs, not superficial tissues. Kocher’s intestinal clamp (Option C): A toothed clamp designed to grasp intestinal tissue, not a retractor. Lahey’s thyroid tenaculum (Option D): Has sharp hooks to hold thyroid tissue firmly, not used for superficial retraction.



References:

SRBs Surgical Operations, 1st Edition, Page 81.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q14: The primary function of the instrument depicted is to, (Q880373)

A. Retracting the abdominal wall and deep viscera like liver and spleen

B. Levering tissues atraumatically to provide adequate surgical exposure

C. Clamping and holding intestinal tissue firmly during bowel surgery

D. Assisting in major abdominal surgeries such as cholecystectomy



Correct Answer: C. Clamping and holding intestinal tissue firmly during bowel surgery

Explanation: The image shows Deaver's Retractor - a stout, atraumatic instrument shaped like a question mark (?) with a broad, gently curved, long blade and a strong handle. Works by levering tissues (not pushing or pulling) and requires moist mops underneath during use. (Option B ruled out) Use: Retract the abdominal wall and viscera, like the liver and spleen, providing good exposure in major abdominal surgeries. (Option A, D ruled out)

References:

SRBs Surgical Operations, 1st Edition, Page 82.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q15: Which of the following statements correctly describes the Morris retractor? (Q880372)

A. Self-retaining, used in oral surgery

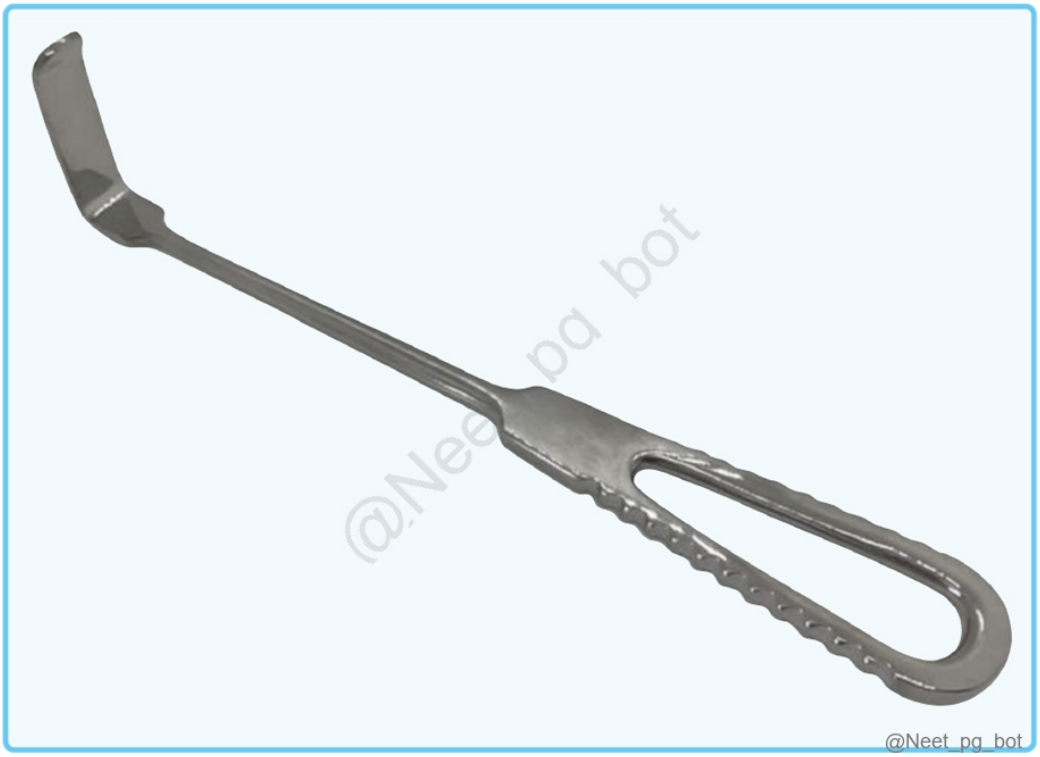
B. Flat curved blade with blunt ridge

C. Sharp hooks for thyroid tissue

D. Toothed clamp for intestines

Correct Answer: B. Flat curved blade with blunt ridge

Explanation: The Morris Retractor (manual retractor) has a single or double flat, transversely curved blade with a blunt projecting ridge and backward curve for better grip. It is used to retract deep wounds like abdominal wall, loin, or subcostal incisions. The beak end prevents slipping, holding the wound edges securely. Self-retaining, used in oral surgery (Option A): This describes instruments like the Doyen's mouth gag, not the Morris retractor, which is manual and used for deep wounds. Sharp hooks for thyroid tissue (Option C): This fits the Lahey's thyroid tenaculum, which is designed to grasp thyroid tissue, unlike the Morris retractor. Toothed clamp for intestines (Option D): This describes Kocher's intestinal clamp, used to hold intestinal tissue, unlike the flat-bladed Morris retractor.



References:

SRBs Surgical Operations, 1st Edition, Page 82.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q16: Which surgical instrument is depicted in the image provided below? (Q880288)

A. Langenbeck retractor

B. Kocher’s intestinal clamp

C. Doyen’s mouth gag

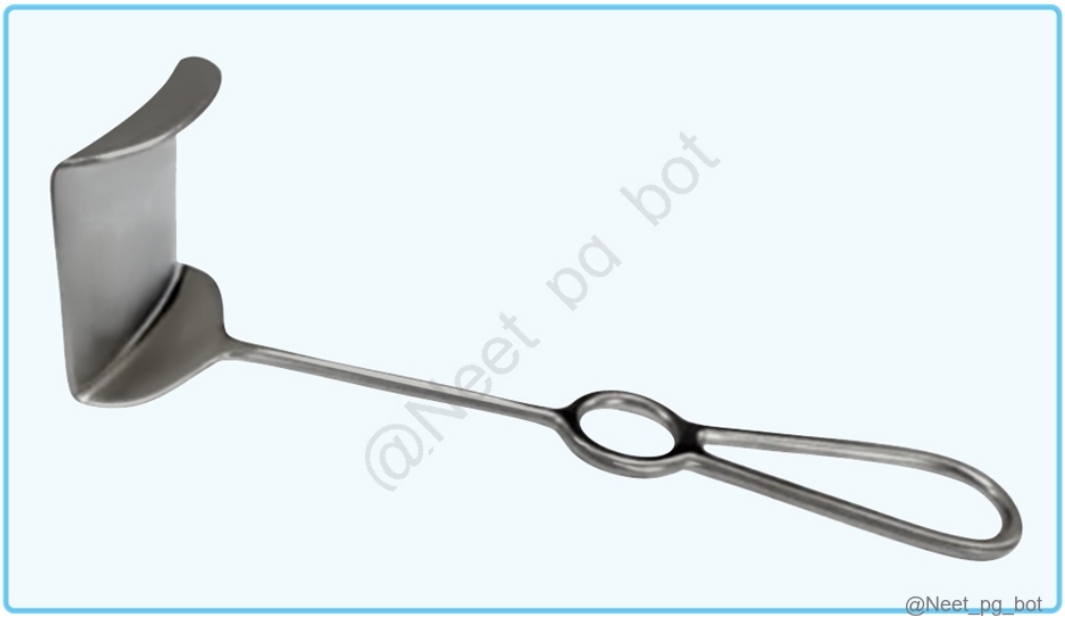
D. Lahey’s thyroid tenaculum



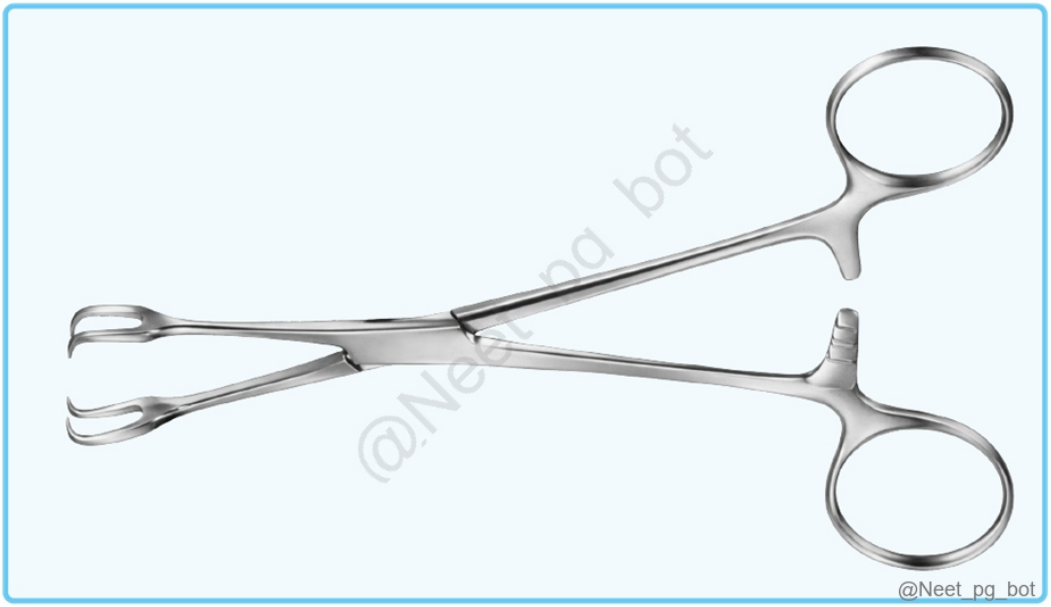
Correct Answer: C. Doyen’s mouth gag

Explanation: The given image shows Doyen’s mouth gag , an instrument featuring flat, broad, and strong curved distal blades with serrations on the outer surface to ensure a secure grip on the teeth. The blades are covered with rubber tubing to protect the enamel from injury. Use: Biopsies of the oral cavity, dental extractions, tonsillectomy, and excision of small lesions within the oral cavity. Langenbeck retractor (Option A): Has a flat, curved blade used to hold back soft tissues during surgery. Kocher’s intestinal clamp (Option B): Has strong, toothed jaws designed to firmly grasp intestinal tissue. Lahey’s thyroid tenaculum (Option D): Features sharp, pointed hooks for grasping thyroid tissue securely.


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References:

SRBs Surgical Operations, 1st Edition, Page 114.

↑ *Back to this question in Part A*

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Q17: Which of the given instrument's tip resembles the given image? (Q849835)

A. Mayo's Towel Clip

B. Rampley's Sponge Holding Forceps

C. Moynihan's Tetra-Towel Clip

D. Doyen's Towel Clip



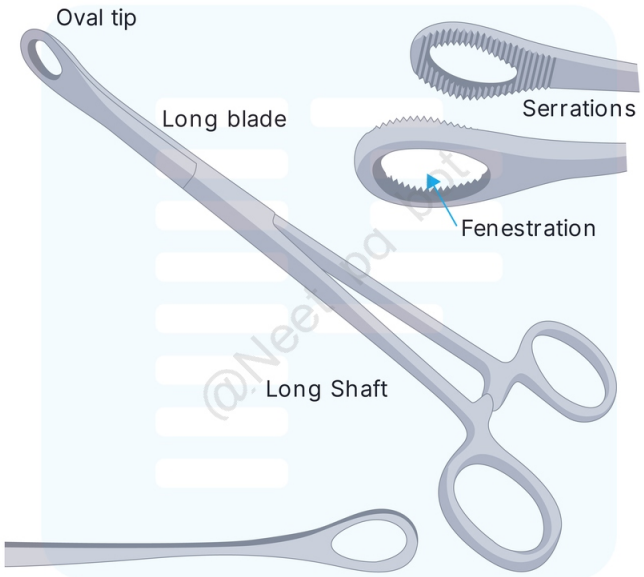
Correct Answer: B. Rampley's Sponge Holding Forceps

■ *Listen (English)*

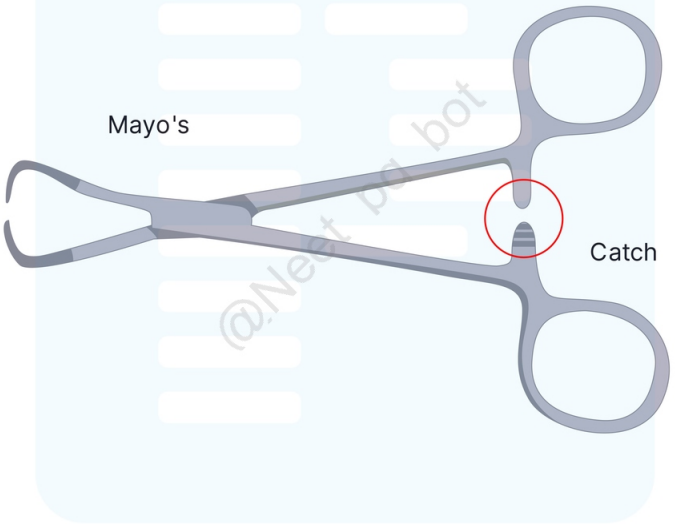
■ *Listen (Hindi)*

Explanation: The given image has oval tip with serrations and fenestrations which is seen in Rampley's Sponge Holding Forceps. Uses: Handle gauze or sponges. To hold gall bladder/cervix/tongue, etc. during operative procedures. Mayo's Towel Clip (Option A) : Cross-action tip: no approximation. Used to secure drapes in the surgical area, attach suction tubes, diathermy wires, and laparoscopic cables to the operating table and to stabilize ribs in cases of flail chest. Doyen's Towel Clip (Option D) : A short instrument with curved ends with sharp points. The handles connect at the proximal ends. Moynihan's Tetra-Towel clip (Option C) ■: Has two teeth on each blade. Attaches cut edges of a skin incision to the corners of draped tetra towels to isolate the surgical area.

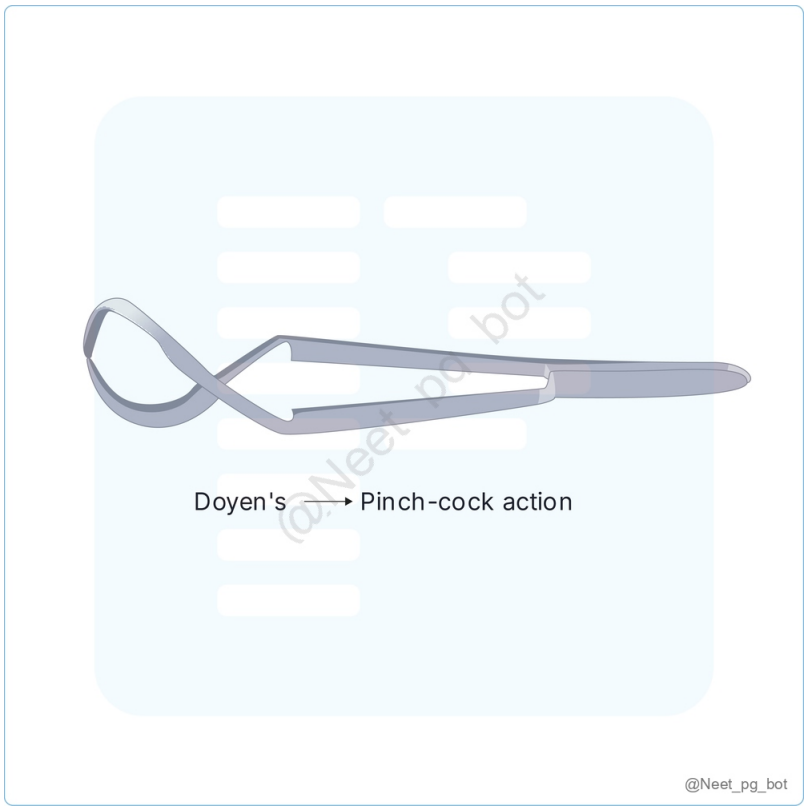
Rampley's sponge holding forceps

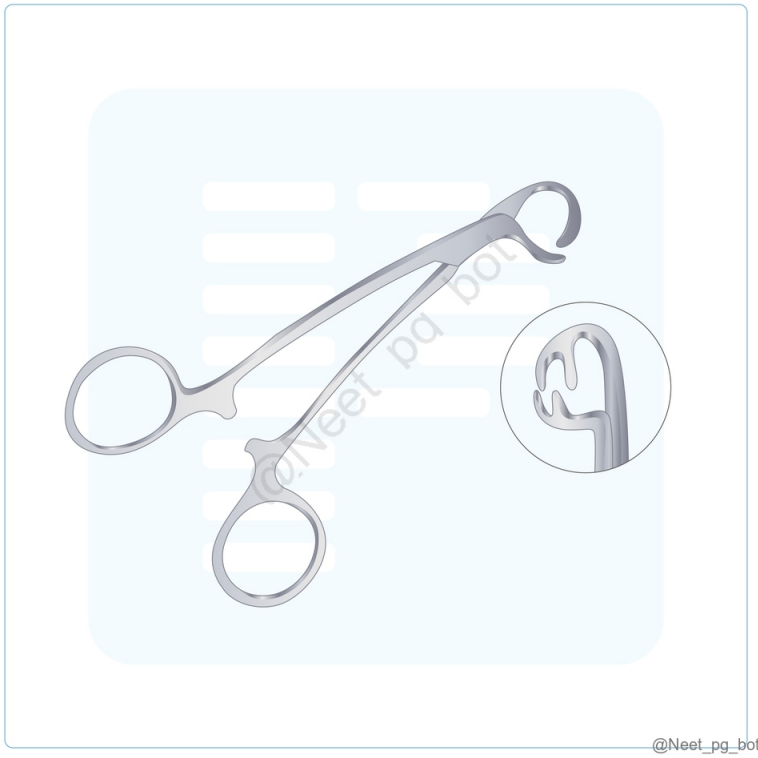


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References:

SRB’s Surgical Operations, Text and Atlas, 1st Edition, Page 71-73.

SRB’s Manual of Surgery, 6th Edition, Page, 1146

Rampley forceps

↑ *Back to this question in Part A*

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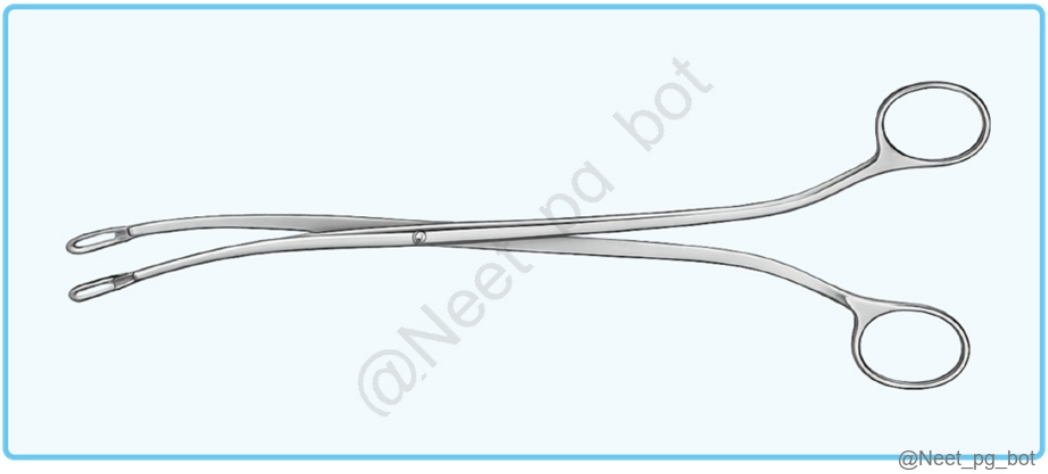
Q18: What is the name of the instrument shown below that is used for gallstone removal? (Q880278)

A. Sponge holding forceps

B. Desjardin’s choledocholithotomy forceps

C. Blakemore’s gallstone forceps

D. Tischler forceps

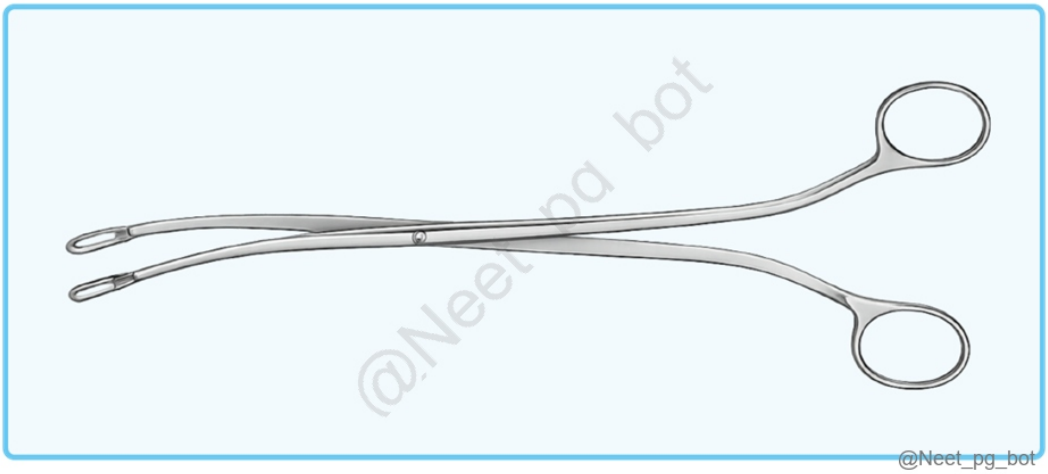


Correct Answer: B. Desjardin’s choledocholithotomy forceps

Explanation: The instrument displayed is Desjardin’s choledocholithotomy forceps. Instrument Use Image Sponge holding forceps (Option A ruled out) For holding surgical sponges Desjardin’s choledocholithotomy forceps (Option B) Removes gallstones from the common bile duct (choledocholithotomy) and, gallbladder. Remove stones in the ureter and kidney. Blakemore’s gallstone forceps (Option C ruled out) For manipulating delicate tissues without causing damage. Tischler forceps (Option D ruled out) Used to take small tissue samples (biopsies) from the cervix, most commonly during a colposcopy procedure, to diagnose cervical cancer and other conditions.



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References:

SRBs Surgical Operations, 1st Edition, Page 92.

↑ *Back to this question in Part A*

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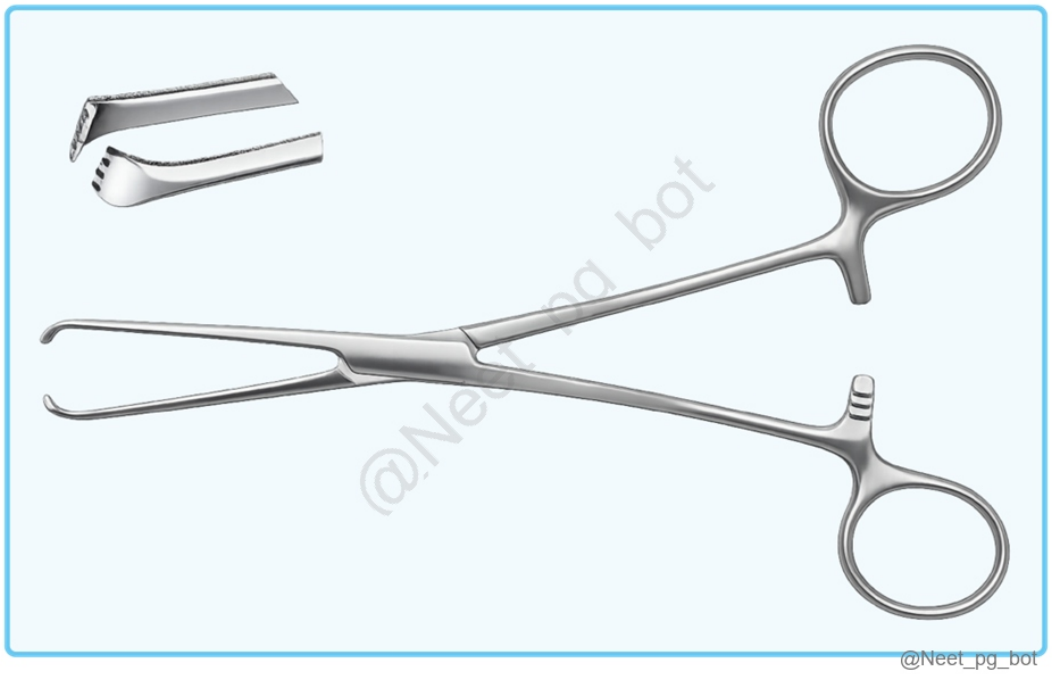
Q19: Which of the following is not a typical application of the instrument shown in the image below? (Q880275)

A. Holding the margins of vaginal flaps during a colporrhaphy operation

B. Grasping the rectus sheath during abdominal wall repair

C. Retracting bowel loops during a laparotomy

D. Holding the anterior lip of the cervix during a D&C procedure



Correct Answer: C. Retracting bowel loops during a laparotomy

Explanation: Allis Tissue Forceps (as shown in the image) are used for grasping tough tissues, not delicate structures like bowel loops, which can be damaged by their toothed jaws. A metallic forceps with handle and catch on one end and toothed blades on the other. Uses: Hold vaginal flaps (colporrhaphy) (Option A ruled out) Grasp the peritoneum or the rectus sheath (abdominal wall repair) (Option B ruled out) Hold vaginal margins (abdominal hysterectomy) Grasp the cervix in D&C (Option D ruled out) Catch sphincter ends in CPT repair Remove small polyps Retrieve tissue after wedge biopsy

References:

DC Dutta's Textbook of Gynaecology, 8th Edition, Page 535.

↑ *Back to this question in Part A*

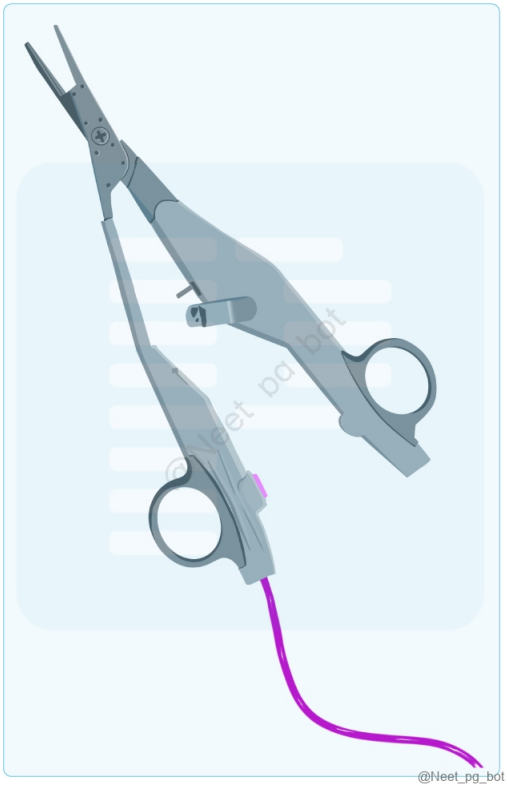
Q20: Which of the following statements is false regarding the given instrument? (Q849848)

A. Uses pressure and continuous bipolar energy for vessel sealing.

B. Achieves burst pressures over three times the normal systolic blood pressure.

C. Sealing time is 8-10 seconds.

D. Denatures collagen and elastin in vessel walls, forming a solid tissue seal.



Correct Answer: C. Sealing time is 8-10 seconds.

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The given image is that of Ligasure. The sealing time is 2 to 4 seconds per seal. LigaSure: Technology: Uses pressure and continuous bipolar energy for vessel sealing. (Option A) Mechanism: Applies high mechanical compression and adjusts energy delivery. Denatures collagen and elastin in vessel walls, forming a solid tissue seal upon cooling. (Option D) Efficiency: Sealing time: Quick - 2 to 4 seconds per seal. Achieves burst pressures over three times the normal systolic blood pressure. (Option B) Enhances reliability and consistency in

surgical procedures. Advantages: Significantly decreases operative blood loss and procedure time compared to traditional sutures and clips.



References:

LigaSure

Ligasure sealing system

SRB's Surgical Operations, Text and Atlas, 1st Edition, Page, 571.

↑ *Back to this question in Part A*

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Q21: Which of the following best describes the safety protocols for electrosurgery using diathermy? (Q849847)

A. Always use the maximum current setting to ensure effectiveness and minimize burns.

B. Bipolar diathermy is preferred in patients with implants.

C. Monopolar diathermy is preferred near vital & sensitive structures.

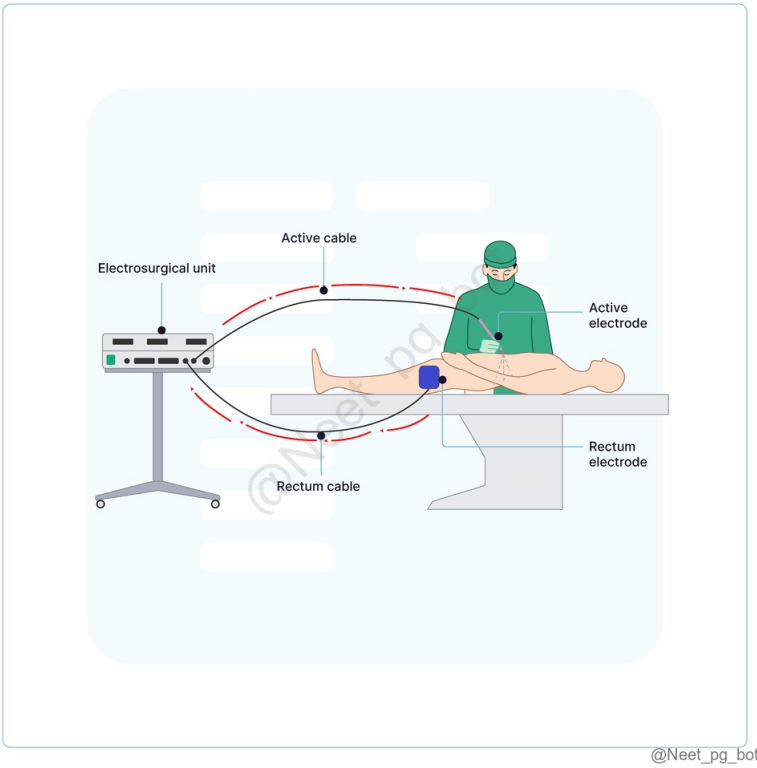
D. There is no need to use smoke extractors as the risk of exposure to surgical smoke is minimal.

Correct Answer: B. Bipolar diathermy is preferred in patients with implants.

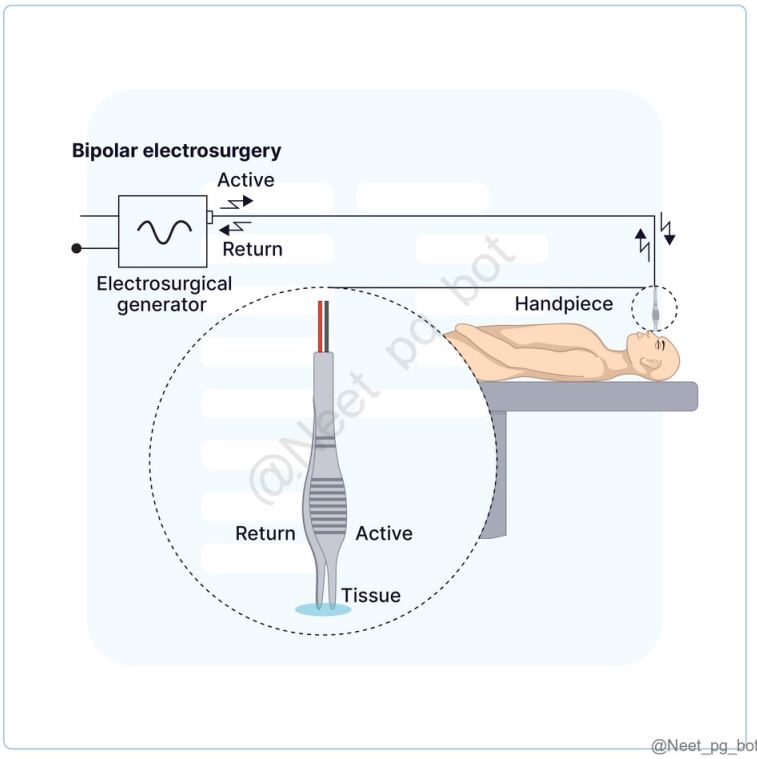
■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Bipolar diathermy is preferred in sensitive areas and for patients with implanted devices because it limits the current flow to the tissue between the two active electrodes, thus reducing the risk of unintended burns and ensuring a more controlled application. Monopolar Diathermy Mechanism: Electrical current flows from a single electrode (diathermy pencil) through the target tissue and returns via a large surface plate (indifferent electrode). Applications: Used for cutting and coagulation in various surgeries. Hazards : Inadequate Contact : Poor contact with the indifferent electrode can cause burns. Bipolar Diathermy: Mechanism: Uses two active electrodes (forceps, scissors) with current flowing between them, heating only the tissue between the tips. No indifferent electrode is needed. Applications: Ideal for operating near vital structures and for patients with implanted devices. (Option C) Advantages: Enhanced safety by localizing current and reducing the risk of unintended burns. Key Considerations for Safe Electrosurgery Equipment Check: Verify settings before use. Lowest Effective Setting : Use minimal current necessary. (Option A) Caution with Metal Objects : Be careful near other metal instruments. Intermittent Use : Apply in short, controlled bursts. Bipolar Preference: Prefer bipolar in sensitive areas or for patients with implants. Smoke Evacuation: Use smoke extractors to reduce exposure to surgical smoke. (Option D)



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References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page, 110-113.

↑ *Back to this question in Part A*

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Q22: Which laparoscopic instrument is used to establish pneumoperitoneum in the closed approach? (Q849846)

A. Hasson Cannula/Trocar

B. Veress Needle

C. Laparoscopic Camera

D. Secondary Trocar

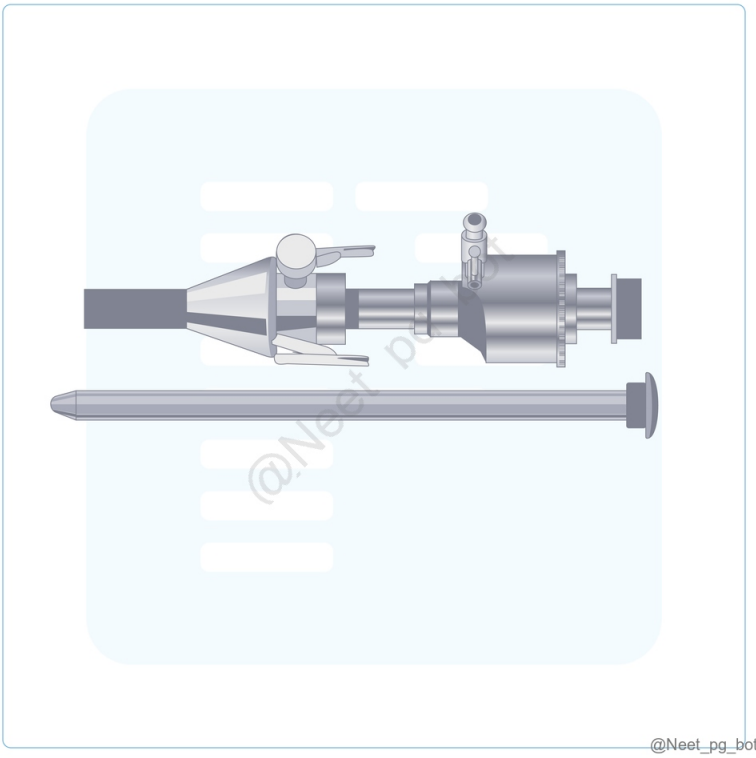
Correct Answer: B. Veress Needle

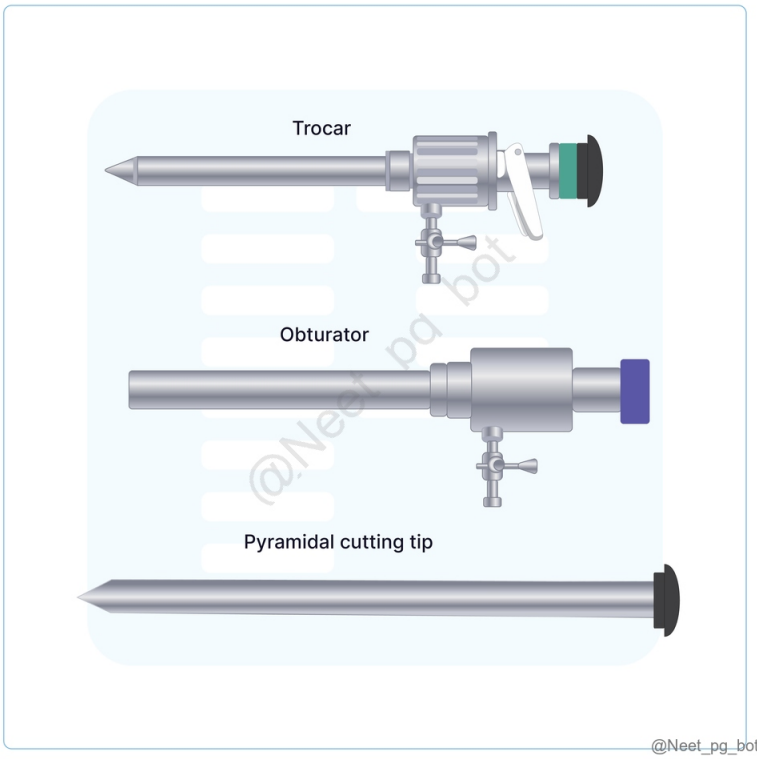
■ *Listen (English)*

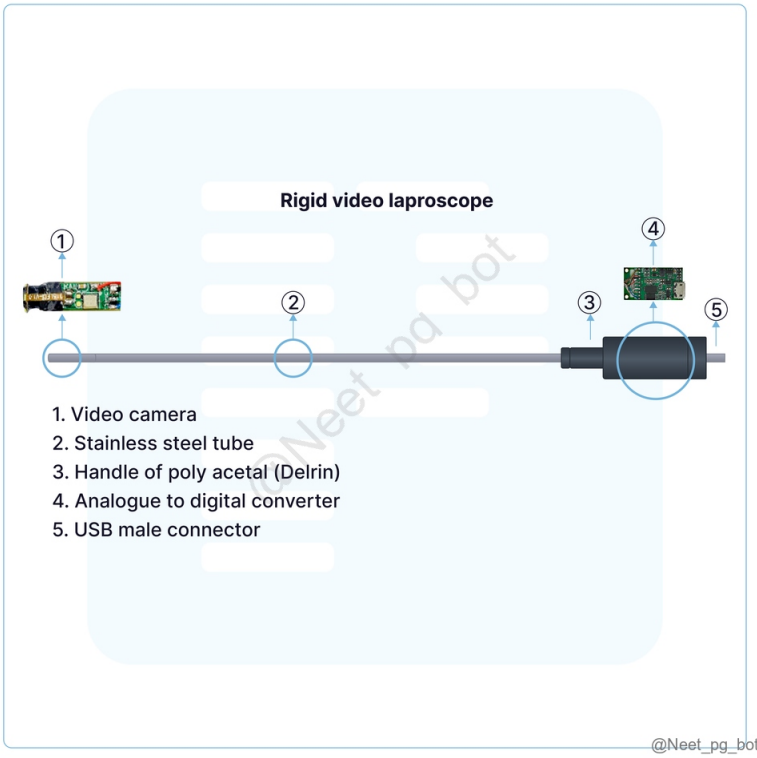
■ *Listen (Hindi)*

Explanation: The Veress needle is specifically designed to establish pneumoperitoneum by creating a space in the abdominal cavity for laparoscopic procedures. It uses a sharp outer bevel to penetrate the abdominal wall and a blunt inner stylet to prevent injury to internal organs. Laparoscopic Instruments: Instrument Description Primary Use Veress Needle Spring-loaded with a sharp outer bevel and blunt inner stylet. Inserted at Palmer's point (3 cm below the left costal margin). Establishes pneumoperitoneum for laparoscopic procedures. Hasson Cannula/Trocar (Option A) A blunt-tipped trocar is inserted through a surgically created opening, typically at the umbilicus. Used for open technique access in laparoscopy. Trocar (Secondary) (Option D) Inserted under direct laparoscopic vision after pneumoperitoneum is established. Smaller diameters are preferred. Allows insertion of additional instruments. Laparoscopic Camera (Option C) Provides a magnified, real-time view of the surgical field. Visualises the surgical field during laparoscopic surgery.









References:

Bailey & Love’s Short Practice of Surgery, 28th Edition, Page, 102, 103

SRB’s Surgical Operations, Text and Atlas, 1st Edition, Page, 550-551

↑ *Back to this question in Part A*

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Q23: Which of the following instruments is used to assess the patency of CBD? (Q849845)

A. Bakes Dilator

B. Tracheal Dilator

C. Urethral Dilator

D. Filiform Bougies

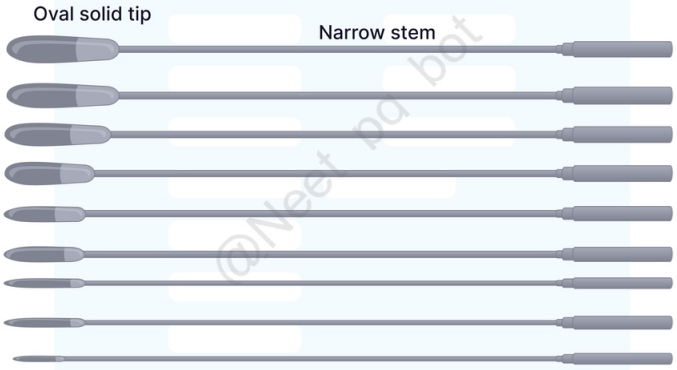
Correct Answer: A. Bakes Dilator

■ *Listen (English)*

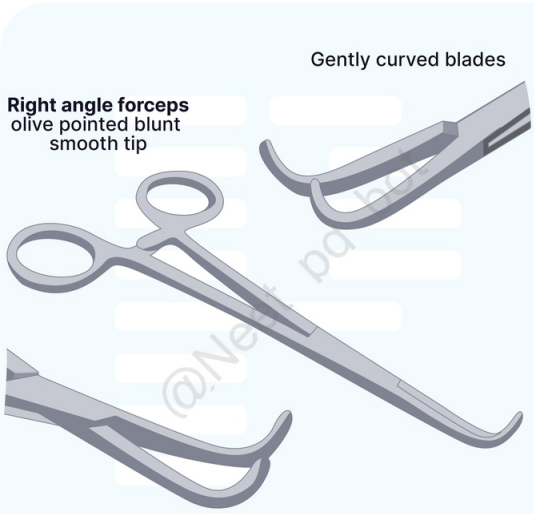
■ *Listen (Hindi)*

Explanation: Dilation Instruments: Instrument Description Primary Use Bakes Dilator / Bakes bile duct dilator A long, malleable, metallic instrument with a club-shaped tip. Assessing patency/blockage of the CBD and duodenal papilla. Tracheal Dilator (Option B) Used to widen the tracheal opening during tracheostomy. Facilitates insertion of a tracheostomy tube. Urethral Dilator (Option C) A long, curved, metallic instrument with a blunt tip. Urethral dilation. Filiform Bougies (Option D) : These are thin, cylindrical instruments used for navigating strictures and do not have a club-shaped tip.

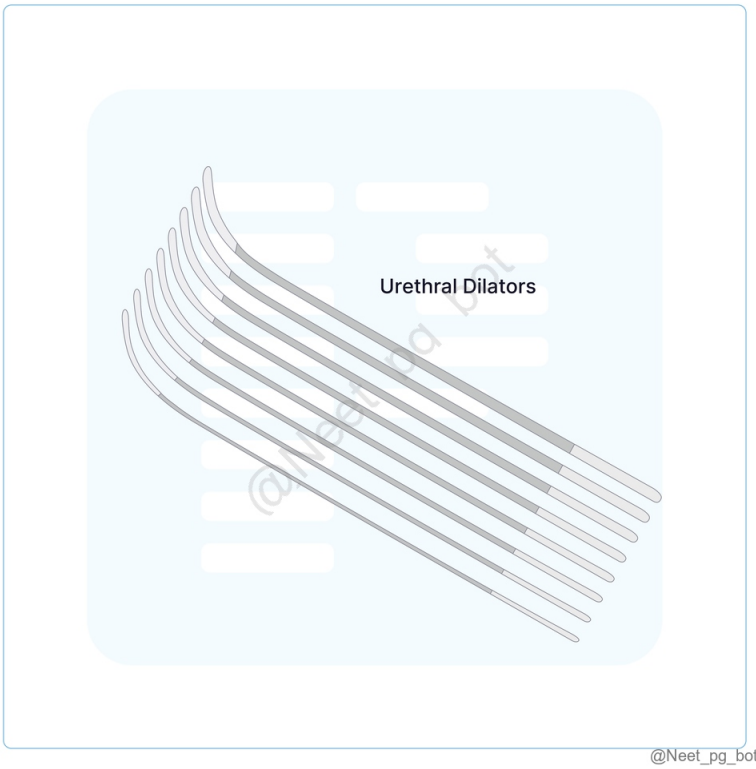
Bakes bile duct dilator

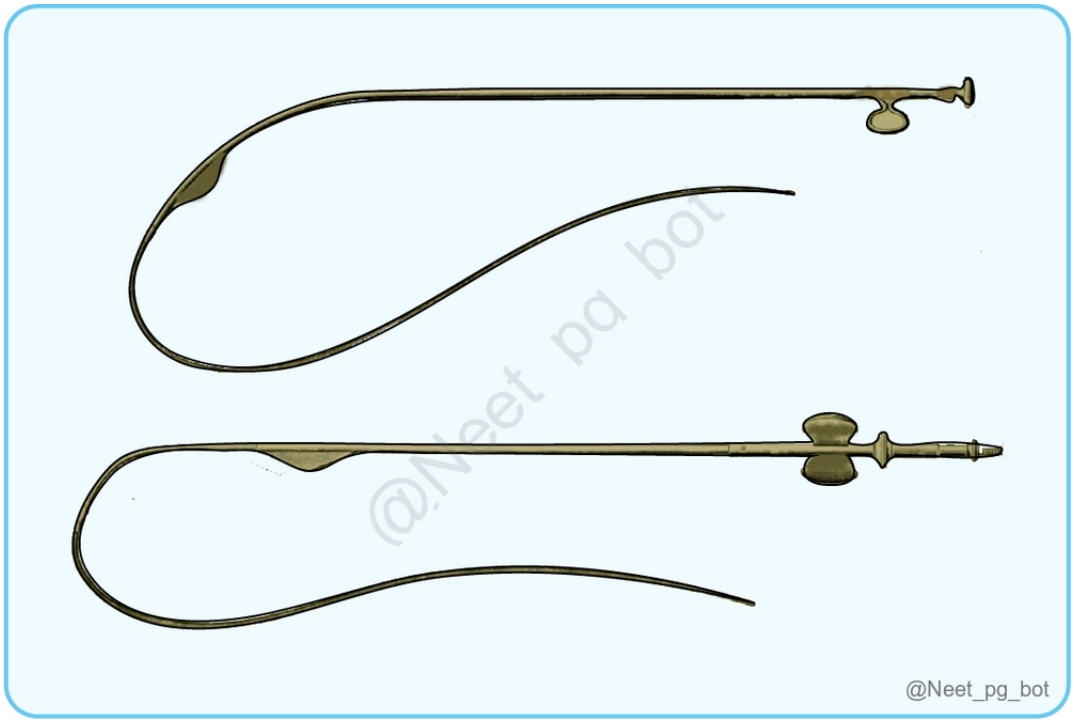


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References:

SRB’s Surgical Operations, Text and Atlas, 1st Edition, Page, 93, 95, 96, 105.

↑ *Back to this question in Part A*

Q24: Which of the following statements correctly differentiates Mayo scissors from Metzenbaum scissors? (Q849844)

A. Mayo scissors are designed for delicate dissection while Metzenbaum scissors are sturdy and suited for cutting dense tissues.

B. Mayo scissors are sturdy and suitable for cutting dense tissues, while Metzenbaum scissors are ideal for blunt dissection and fine tissue work.

C. Metzenbaum scissors are used for cutting dense tissues, while Mayo scissors are for blunt dissection in thoracic surgeries.

D. Metzenbaum scissors are suitable for cutting sutures and are sturdy, whereas Mayo scissors are delicate and used for blunt dissection

Correct Answer: B. Mayo scissors are sturdy and suitable for cutting dense tissues, while Metzenbaum scissors are ideal for blunt dissection and fine tissue work.

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Mayo scissors are designed to handle dense and tough tissues, making them suitable for procedures like appendectomy and mastectomy. Metzenbaum scissors, on the other hand, are designed for more delicate tasks such as blunt dissection and cutting fine tissues. Scissors Type Design Mayo Scissors (suture scissors) Metzenbaum Scissors (Metz or Lahey forceps)





References:

www.germedusa.com/blog/metzenbaum-vs-mayo-scissors

www.germedusa.com/blog/commonly-used-nursing-scissors

journals.sagepub.com/doi/10.1177/01455613231215169.

↑ *Back to this question in Part A*

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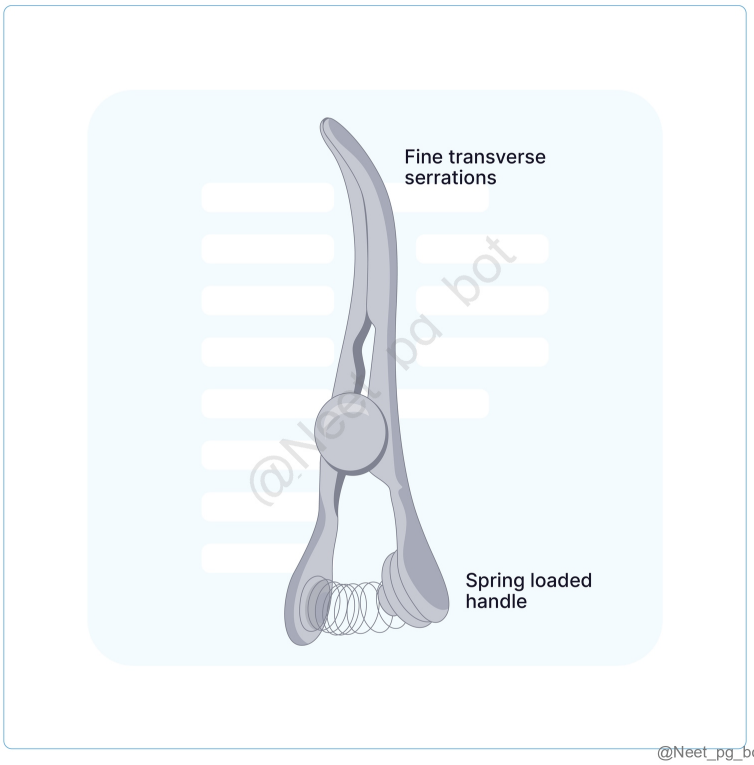
Q25: Identify the following instrument: (Q849843)

A. Payr’s gastric occlusion clamp

B. Potts bulldog clamp

C. Doyens intestinal occlusion clamp

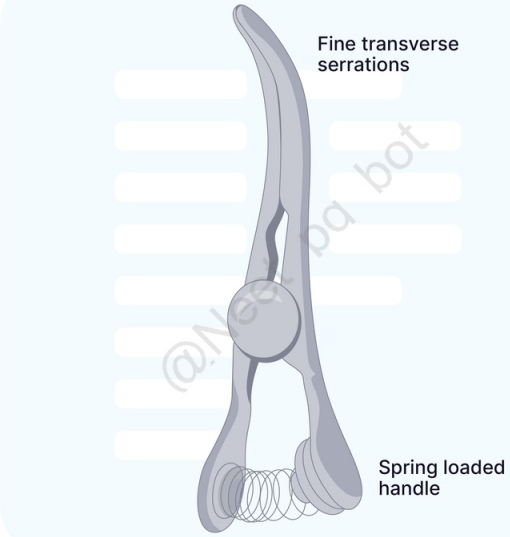
D. Lights bulldog clamp



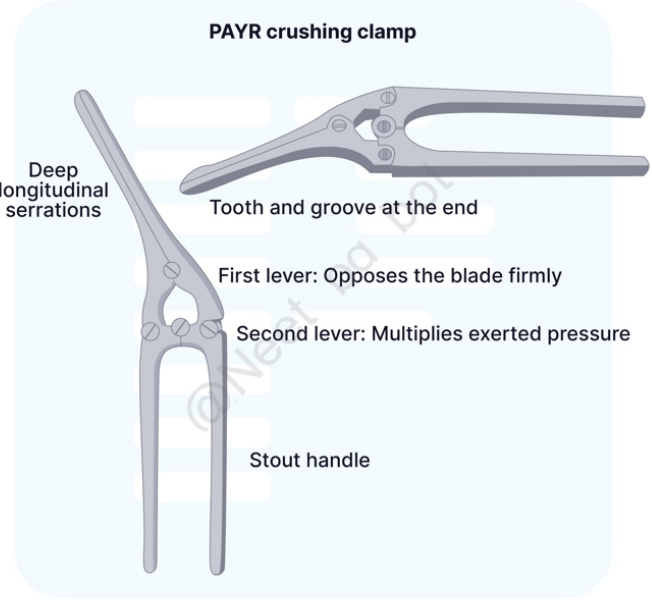
Correct Answer: B. Potts bulldog clamp

- *Listen (English)*
- *Listen (Hindi)*

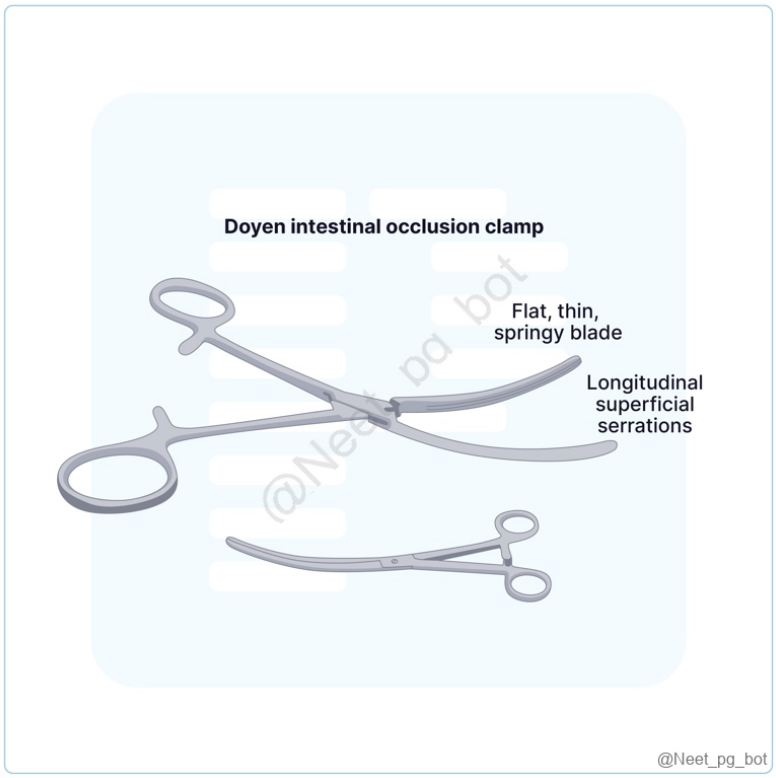
Explanation: Potts bulldog clamp resembles a paper clip with strong jaws and serrations, equipped with a spring-loaded handle for a secure vessel grip. Uses : Clamps vessels during vascular anastomosis (e.g., creating AV fistula in renal failure patients). Payr's gastric occlusion clamp (Option A): It has longitudinal serrations on the inner surface of the blades with several ball-like projections along the sides which interlock each other of the opposite blade to have a firm grip on the stomach/bowel while using. Doyen's intestinal occlusion clamp (Option C): Have diagonal serrations with opposing blades. Used to grasp and enclose delicate structures such as the intestines. Light's Bulldog clamp (Option D): Operates with a pinch cock mechanism to open and close. Features fine transverse serrations on the blades. Used to clamp vessels during vascular anastomosis, such as in AV fistula creation

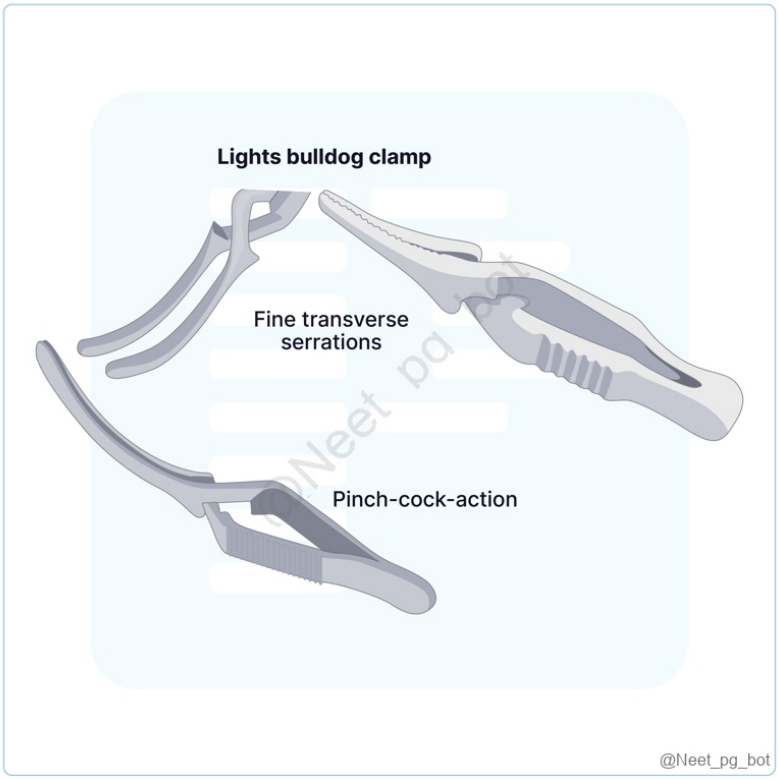


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References:

Doyens clamp

SRB’s Surgical Operations: Text and Atlas, 1st Edition, Page 75, 92

↑ *Back to this question in Part A*

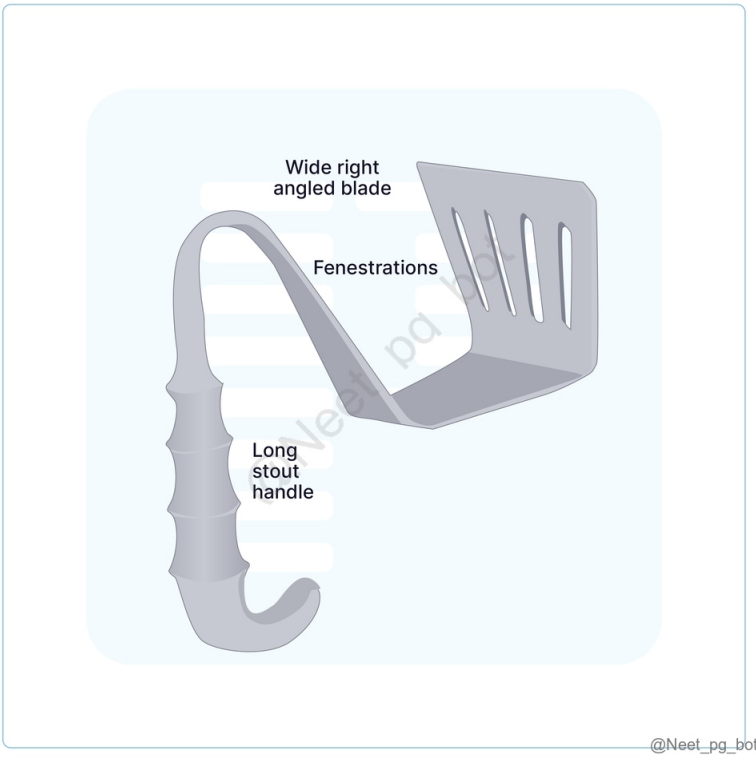
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Q26: Which of the following is used to retract the scapula during thoracotomy? (Q849842)

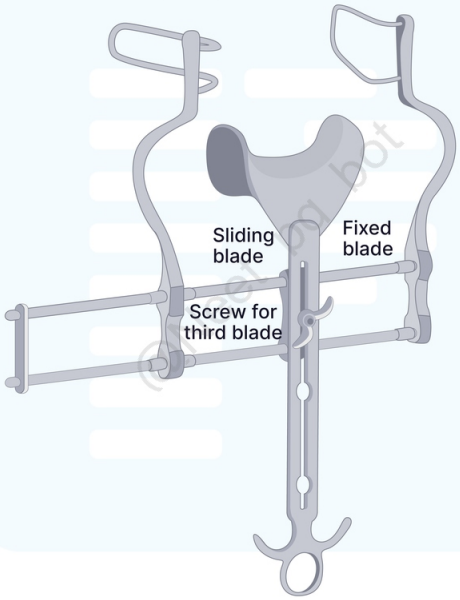
Correct Answer: Unknown

- *Listen (English)*
- *Listen (Hindi)*

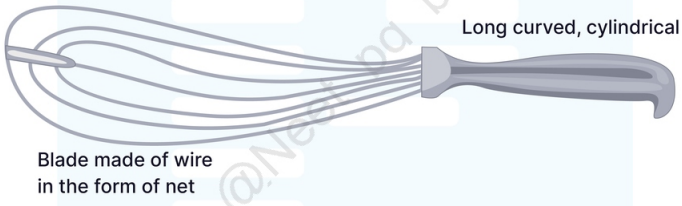
Explanation: This instrument is known as a scapula retractor. It has got a long stout handle with a broad right-angled blade with serrations. It is used to retract scapula during thoracotomy Balfour self-retaining retractor (Option A): Adjustable blades for retracting the abdominal wall and tissues during surgery. Allison Lung retractor (Option C): Long handle with light blade. The blade is made up of wires. The blade is at right angle to the handle. It is used to retract the lungs. Beckman Weitlaner retractor (Option D): F inger ring handles along with a self-locking mechanism. It is most commonly used during spinal and hip surgeries.



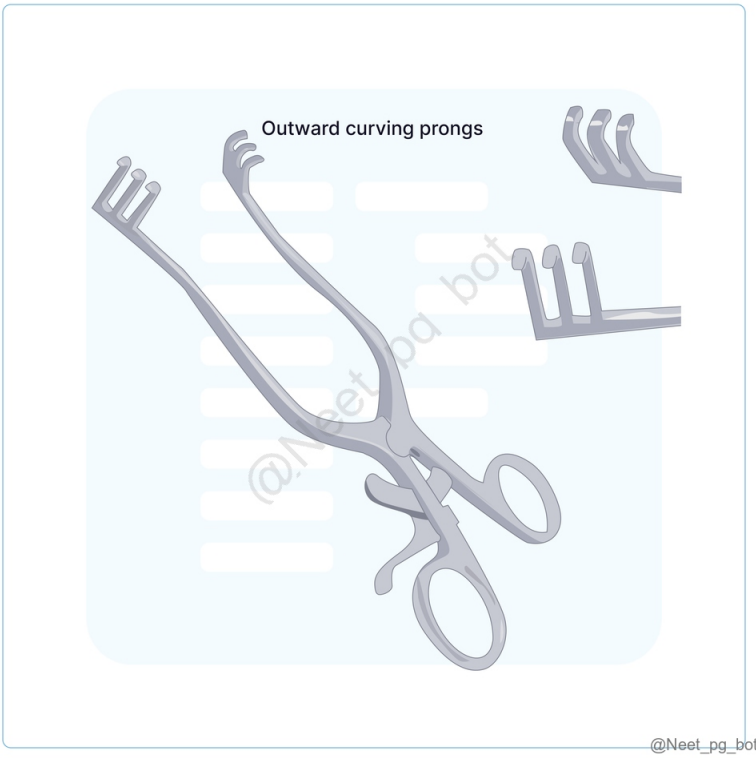
Balfour self-retaining abdominal wall retractor



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References:

SRB’s Surgical Operations: Text and Atlas, 1st Edition, Page, 83-85.

Beckmann

↑ *Back to this question in Part A*

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Q27: Match the following instruments with their respective images: 1. Kocher’s forceps A) 2. Mosquito forceps B) 3. Allis forceps C) 4. Babcock’s forceps D) (Q849841)

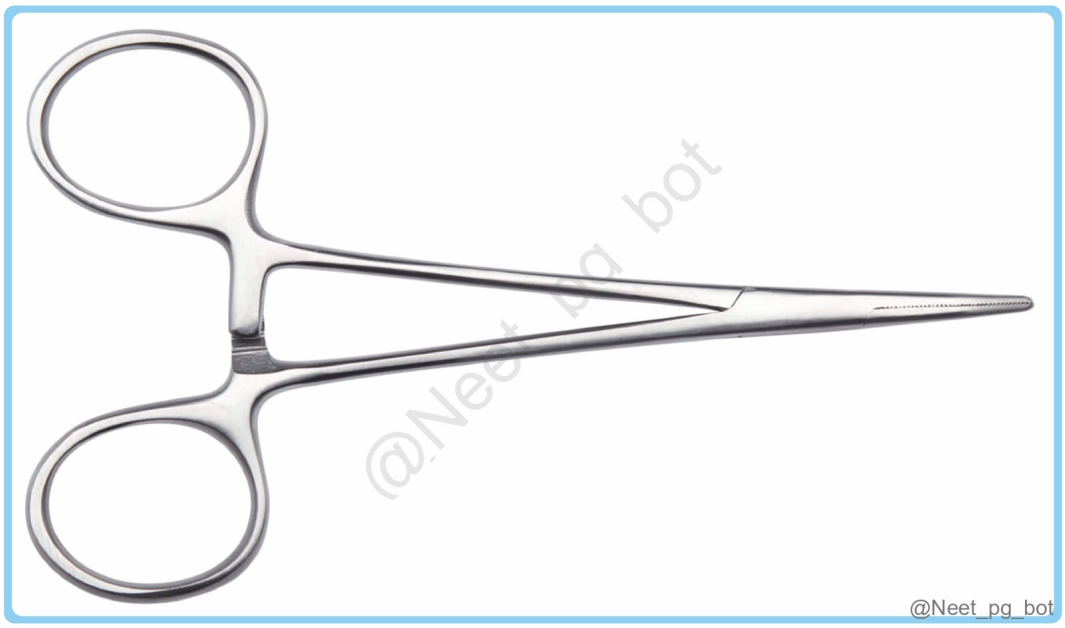
A. 1-A,2-B,3-C,4-D

B. 1-B,2-C,3-A,4-D

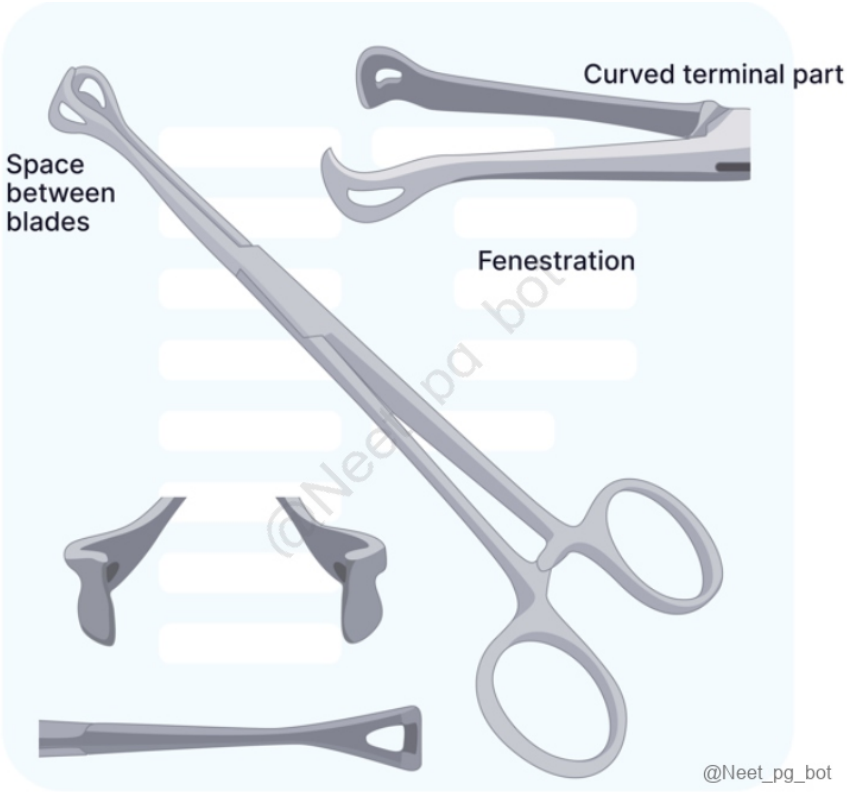
C. 1-C,2-B,3-1,4-D

D. 1-D,2-A,3-B,4-C


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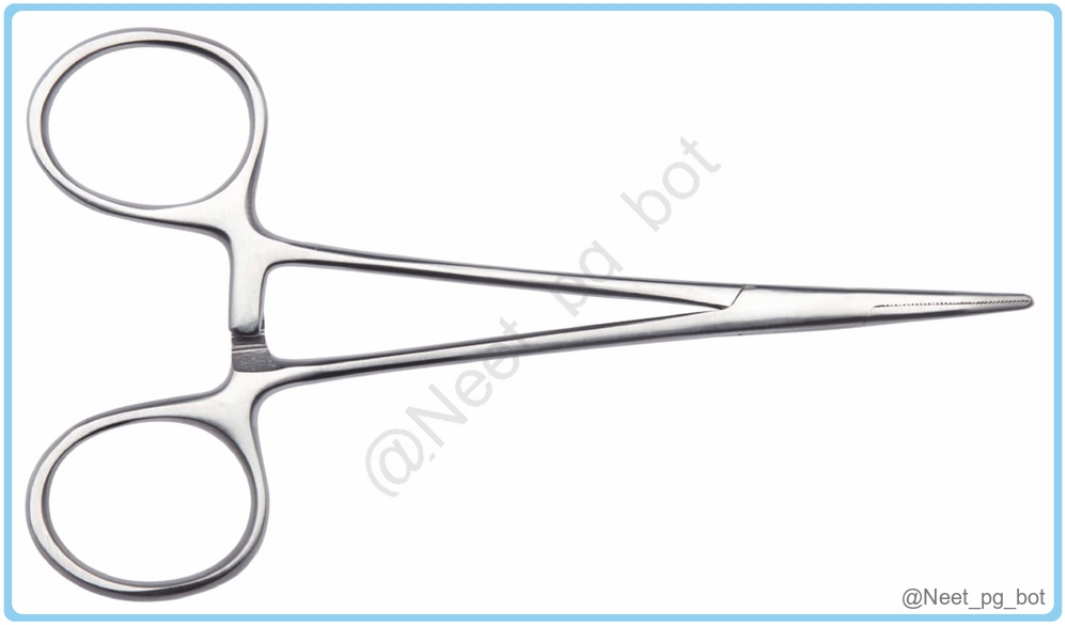
Correct Answer: A. 1-A,2-B,3-C,4-D

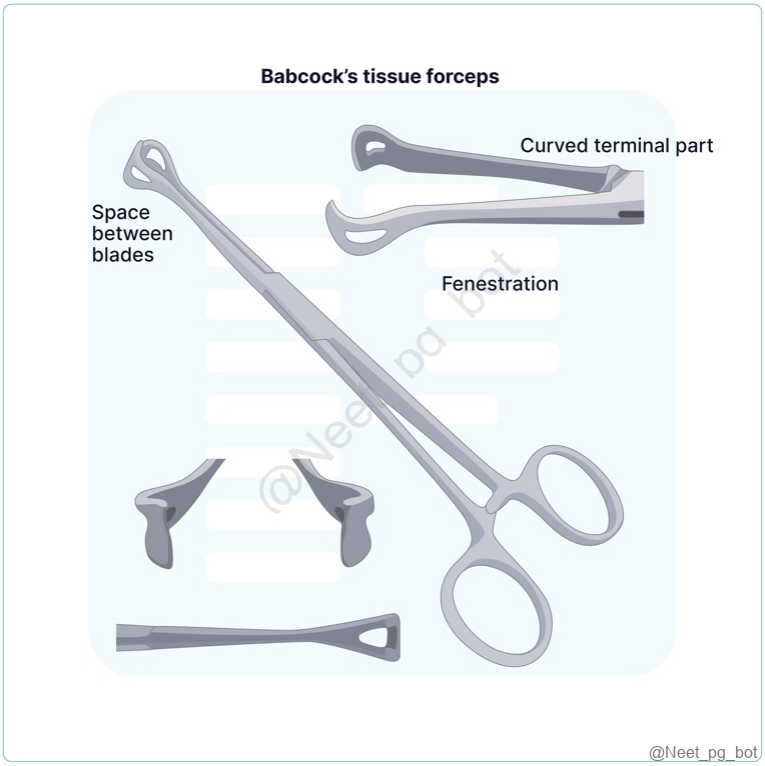
- *Listen (English)*
- *Listen (Hindi)*

Explanation: Kocher's Forceps: Serrations in the distal blades with an opposing tooth at the tip. Holds tissues or pedicles securely, preventing slippage and retraction of vessels or bleeders. Mosquito Forceps: Distal blades have transverse serrations for a firm grip. Babcock's Forceps: Distal blades are curved with triangular fenestra, allowing

soft tissues to bulge out. Non-traumatic tip with transverse serrations and a ratchet mechanism. Alli’s tissue-holding forceps: Distal blades do not oppose each other; the tip has opposing teeth in each straight blade. Not recommended for holding delicate structures like bowel or vessel walls.









References:

SRB's Surgical Operations: Text and Atlas, 1st Edition, Page, 73,76,77.

↑ *Back to this question in Part A*

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Q28: A 45 year old woman undergoes surgery for varicose veins involving the stripping of the long saphenous vein using a Mayo vein stripper. Post-operatively, she complains of pain and tingling along the medial aspect of her leg. Which nerve is most commonly damaged during the stripping of the long saphenous vein? (Q849840)

A. Sciatic nerve

B. Tibial nerve

C. Saphenous nerve

D. Femoral nerve

Correct Answer: C. Saphenous nerve

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The saphenous nerve runs along the path of the long saphenous vein and is susceptible to injury during stripping procedures, leading to saphenous neuralgia. Sciatic nerve (Option A) : Unlikely to be damaged as it runs posteriorly in the thigh, far from the saphenous vein. Tibial nerve (Option B) : Unlikely to be affected since it is located in the posterior compartment of the leg, not near the saphenous vein. Femoral nerve (Option D) : Unlikely to be damaged during this procedure as it is located in the groin and anterior thigh, away from the path of the saphenous vein.



References:

Nerve injury

Procedure

Endothermal ablatio

Endothermal ablation procedure

↑ *Back to this question in Part A*

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Q29: A 60 year old male presents with rectal bleeding and a history of hemorrhoids. His physician decides to perform a proctoscopy using Kelly's rectal speculum to assess the cause of the bleeding. Which of the following is NOT an indication of the use of Kelly's rectal speculum? (Q849839)

A. Diagnosing piles

B. Treating partial rectal prolapse

C. Treating acute anal fissure

D. Assessing rectal carcinoma

Correct Answer: C. Treating acute anal fissure

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Kelly's rectal speculum is contraindicated in cases of acute anal fissure due to the potential for exacerbating the patient's pain and causing further injury. Indications: Diagnostic : Piles (Option A) Fissure in ano Polyps Stricture Internal opening in fistula Carcinoma or any rectal bleeding (Option D) Therapeutic : Injection therapy for partial prolapse or piles (Option B) Cryotherapy for piles Banding for piles Polypectomy Biopsy for carcinoma rectum or anorectum.



References:

SRB’s Surgical Operations: Text and Atlas, 1st Edition, Page, 108, 109

↑ *Back to this question in Part A*

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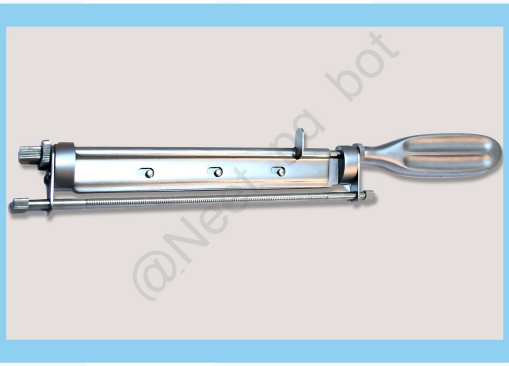
Q30: Match the following instruments with their corresponding images: 1) a) Bone nibbler 2) b) Humby's Knife 3) c) Rib Shear 4) d) Bone Cutter (Q849838)

A. 1-a. 2-d, 3-c, 4-b

B. 1-b, 2-c, 3-d, 4-a

C. 1-b, 2-a, 3-d, 4-c

D. 1-c, 2-a, 3-d, 4-b



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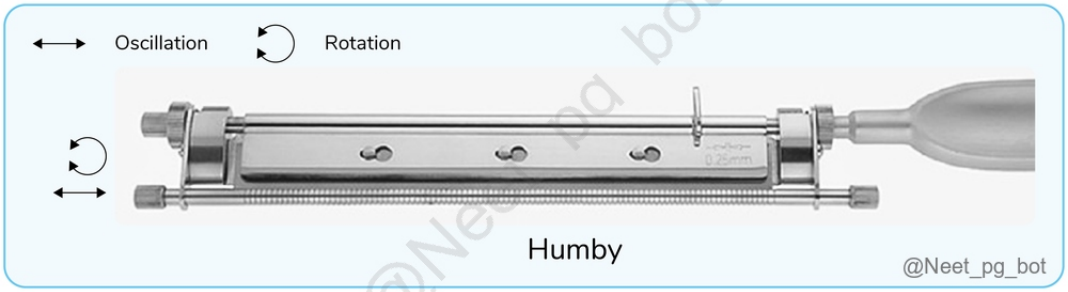


Correct Answer: B. 1-b, 2-c, 3-d, 4-a

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: INSTRUMENT DESCRIPTION HUMBY'S KNIFE Used for harvesting split skin grafts, usually from the thigh. Parts: Stout handle with two flat blades, one fixed and one rotatable. RIB SHEAR One blade is blunt with grooves and serrations, used as a protector for adjacent tissues. The other blade is sharp and cuts the rib. BONE / RIB CUTTER Short blades with sharp, firm cutting edges for cutting bones. BONE NIBBLER Sharp edges at the tip with concave blades. Used to nibble bone into pieces.


Oscillation
Rotation
Humby
@Neet_pg_bot


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References:

SRB's Surgical Operations: Text and Atlas, 1st Edition, Page, 86, 115, 116

↑ *Back to this question in Part A*

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Q31: Which of the following statements is FALSE? (Q849837)

A. The needle holder is sterilized by an autoclave.

B. Toothed dissecting forceps are used to hold delicate structures like nerves and vessels.

C. Curved needle holders provide better maneuverability in deep areas like the pelvis.

D. Plain non-toothed dissecting forceps are used to hold friable structures like peritoneum and tendons.

Correct Answer: B. Toothed dissecting forceps are used to hold delicate structures like nerves and vessels.

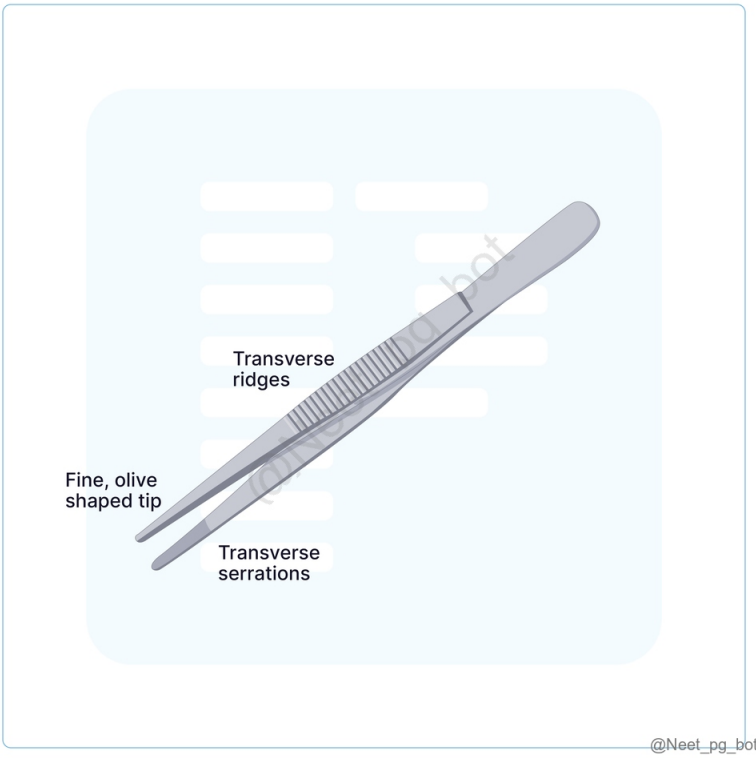
■ *Listen (English)*

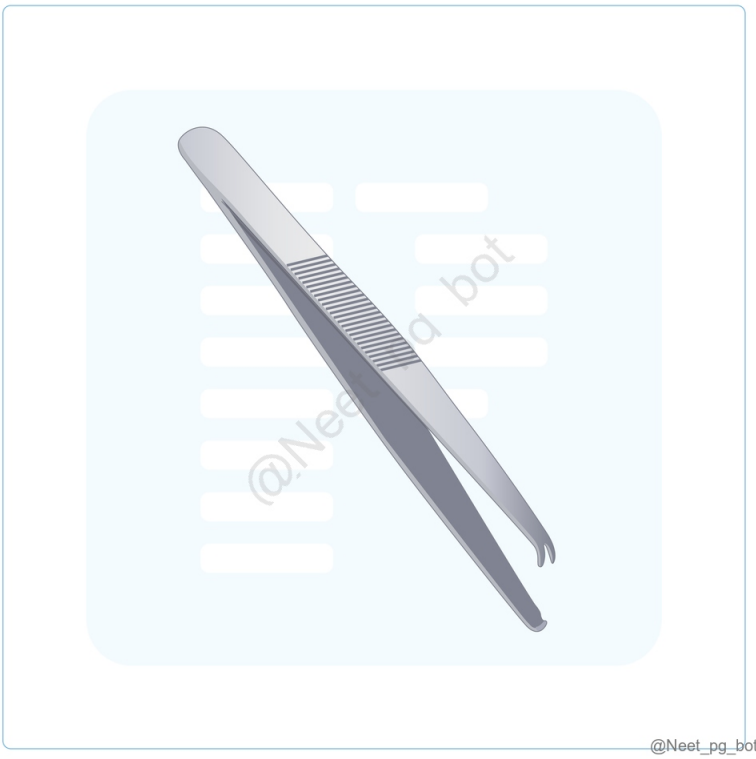
■ *Listen (Hindi)*

Explanation: INSTRUMENT DESCRIPTION NEEDLE HOLDER FORCEPS Small distal blades with criss-cross serrations and a groove for grip. Length of handle: Blade Ratio : 4:1. Types : Straight or curved Needle Positioning : Needle held at the junction of proximal 2/3 and distal 1/3 for control. Handling : Held between thumb and ring finger. Curved Holders : For better maneuverability in deep areas (pelvis, thorax). (Option C) Sterilization : Autoclave. (Option A) PLAIN DISSECTING FORCEPS Used to hold delicate, soft, and friable structures like peritoneum, vessels, bowel, nerves, and tendons. (Option D) Not suitable for holding skin or tough structures. Hold, fix, steady, or stretch tissues. Hold and cauterize small bleeding vessels. TOOTHED FORCEPS Used to hold skin and tough structures like fascia and aponeurosis. Not used for delicate structures like the bowel, vessels,

or nerves.


RS-Vetcon
@Neet_pg_bot


Transverse ridges
Fine, olive shaped tip
Transverse serrations
@Neet_pg_bot



References:

SRB’s Surgical Operations: Text and Atlas, Ed 1, Pg. 88, 79

↑ *Back to this question in Part A*

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Q32: Match the following Blade numbers with their uses given. 1. No. 11 a) Skin incisions in major surgeries 2. No. 12 b) Used in plastic surgery 3. No. 15 c) Incision and drainage of abscesses 4. No. 22 d) Used for tonsillectomy (Q849836)

A. 1-d, 2-c, 3-a, 4-b

B. 1-a, 2-b, 3-d, 4-c

C. 1-c, 2-a, 3-b, 4-d

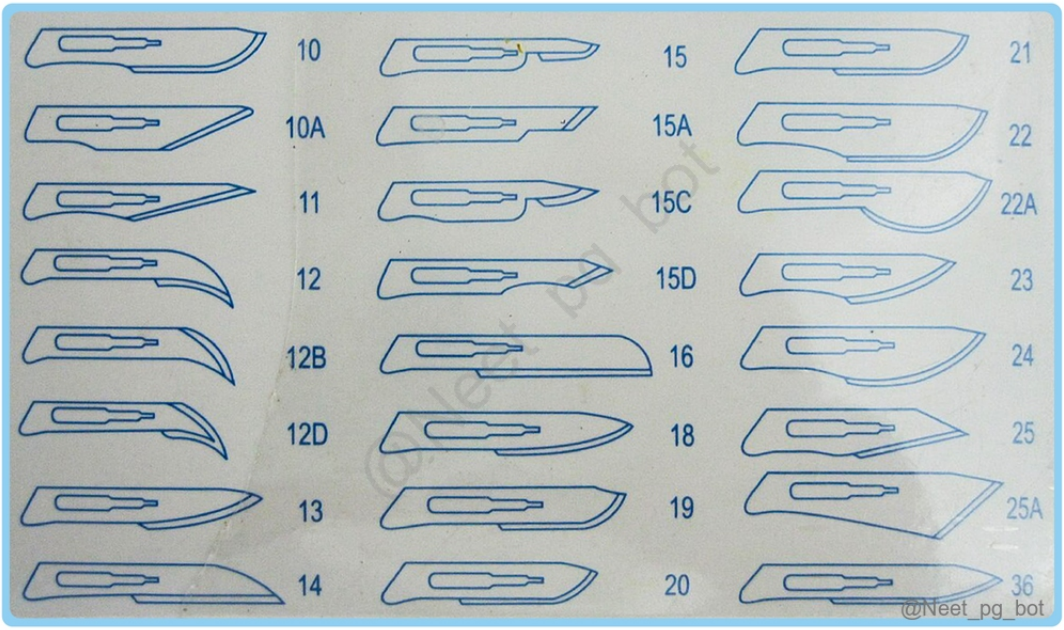
D. 1-c, 2-d, 3-b, 4-a

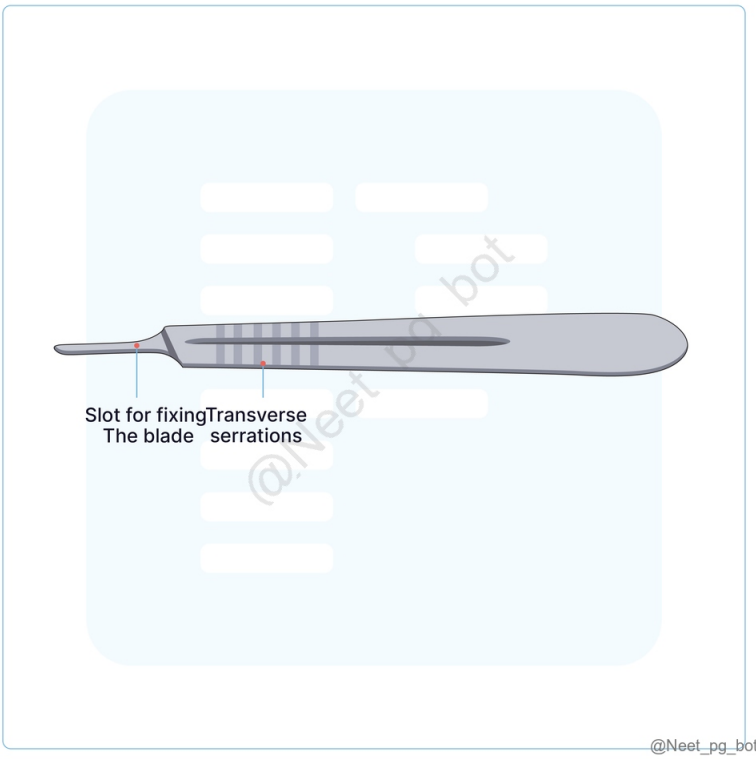
Correct Answer: D. 1-c, 2-d, 3-b, 4-a

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Blade Number Use No. 11 Stab knife, used for incision and drainage of abscesses, and small incisions (e.g., drains). No. 12 Curved blade, used for tonsillectomy and suture removal in delicate procedures; cutting edge faces the surgeon. No. 15 Used in plastic surgery, head and neck surgeries, and facial surgeries. Nos. 20, 22, 24 Used for skin incisions in major surgeries like laparotomy, thoracotomy, craniotomy, and limb surgeries. The Bard-Parker (BP) handle is a flat stainless steel instrument with slots on both sides for attaching scalpel blades. The BP handle is sterilized using an autoclave. For each patient, a new blade is inserted into the handle to ensure sharpness.





References:

SRB’s Surgical Operations: Text and Atlas, 1st Edition, Page 88-89

Bailey & Love’s Short Practice of Surgery, 28th Edition, Page, 98

↑ *Back to this question in Part A*

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• [12_Miscellaneous] 064 Pediatric Surgery

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[12_Miscellaneous] 064 Pediatric Surgery — Quick Jump

Q1 (p. 3552)	*Q2 (p. 3553)*	*Q3 (p. 3554)*	*Q4 (p. 3554)*	*Q5 (p. 3556)*	*Q6 (p. 3557)*
Q7 (p. 3558)	*Q8 (p. 3559)*	*Q9 (p. 3561)*	*Q10 (p. 3562)*	*Q11 (p. 3564)*	*Q12 (p. 3565)*
Q13 (p. 3566)	*Q14 (p. 3567)*	*Q15 (p. 3568)*	*Q16 (p. 3569)*	*Q17 (p. 3570)*	*Q18 (p. 3572)*
Q19 (p. 3574)	*Q20 (p. 3575)*	*Q21 (p. 3576)*	*Q22 (p. 3577)*	*Q23 (p. 3578)*	*Q24 (p. 3580)*
Q25 (p. 3581)					

Q1: At 2 days of life, a male newborn becomes irritable and inconsolable. He is noted to have abdominal distension. He failed to pass meconium since being born. A follow-up barium enema shows microcolon and terminal ileum with meconium. What is the most probable diagnosis? (Q849737)

A. Sigmoid volvulus

B. Hirschsprung disease

C. Duodenal atresia

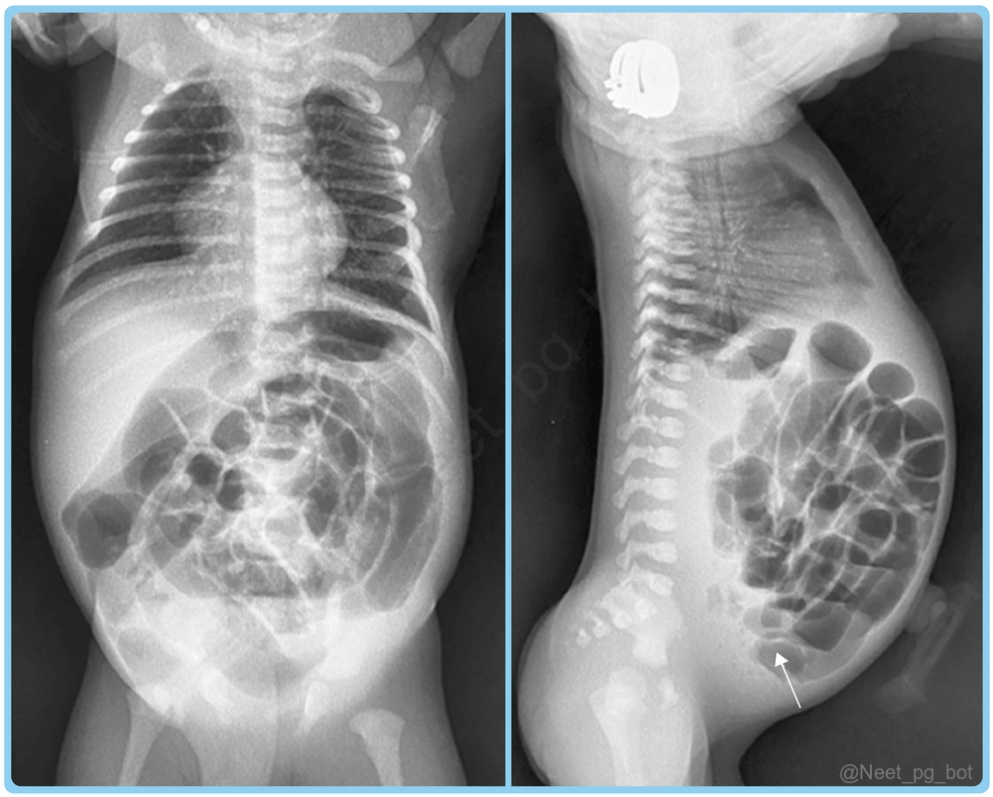
D. Meconium ileus

Correct Answer: D. Meconium ileus

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: In the given scenario, the child presented with abdominal distension and failed to pass meconium since birth. Additionally, barium enema showing microcolon and terminal ileum with meconium is suggestive of meconium ileus. Clinical features: Generalized abdominal distension Bilious vomiting Failure of passage of meconium Diagnosis: On X-ray: Dilated bowel loops are present, and air-fluid levels are absent Mass of meconium on the right side of the abdomen is mixed with gas – Soap bubble / Ground glass appearance (Characteristic appearance) Investigation of choice: Water-soluble contrast enema Management: Simple evacuation of meconium with irrigation of proximal and distal bowel with normal saline or 4% acetylcysteine. Named surgeries: Paul Mikulicz Double barrel ileostomy Bishop-Koop's distal chimney ileostomy Santulli's proximal chimney ileostomy Sigmoid volvulus (Option A): X-ray abdomen shows a coffee bean appearance of bowel loops . Hirschsprung disease (Option B): The baby presents with bilious vomiting, failure to pass meconium in the first 48 hours of life, abdominal distention, and no stool in the rectal vault. Plain x-ray shows small bowel obstruction. Duodenal atresia (Option C) : The baby will present with bilious vomiting, the X-ray abdomen shows a double bubble sign .



References:

SRB's Manual of Surgery, 6th Edition, Page 918-919.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q2: A 14-year-old boy presents with pain in the right lower abdomen and lower back. On clinical examination, there is discomfort in the right hip during passive extension, along with a palpable swelling in the right lumbar area extending towards the groin. What is the most likely diagnosis? (Q880413)

A. Pyelonephritis

B. Psoas abscess

C. Appendicitis

D. Torsion of the right undescended testis

Correct Answer: B. Psoas abscess

Explanation: Psoas abscess presents with back, flank, or hip pain and a positive psoas sign, often with fever, limp, or restricted hip movements. A lumbar or groin swelling may be seen if it extends below the inguinal ligament, and it arises from hematogenous spread or nearby infections like spine or urinary tract disease. Incorrect Options: Pyelonephritis (Option A) usually causes flank pain and fever, but no palpable lumbar swelling or hip pain with position changes. Appendicitis (Option C) commonly causes right lower quadrant pain but not lumbar swelling or hip pain on extension. Torsion of the right undescended testis (Option D) causes groin or lower abdominal pain, but not a palpable lumbar swelling or hip discomfort on extension.

References:

Bailey & Love Short Practice of Surgery, 28th Edition, Page 1104.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q3: Which of the following is the most frequently encountered extracranial solid malignancy in the pediatric age group? (Q880412)

A. Neuroblastoma

B. Nephroblastoma

C. Medulloblastoma

D. Rhabdomyosarcoma

Correct Answer: A. Neuroblastoma

Explanation: Neuroblastoma is the most common extracranial solid tumour in children, particularly infants. It arises from neural crest cells of the sympathetic nervous system, most commonly in the adrenal glands. It may present with an abdominal mass, systemic symptoms, or metastases. Prognosis varies based on tumour behaviour and genetic factors such as MYCN amplification. Incorrect Options: Nephroblastoma (Option B) (Wilms tumour) is a common pediatric renal cancer, but less frequent than neuroblastoma overall. Medulloblastoma (Option C) is a common pediatric brain tumour, but intracranial, not extracranial. Rhabdomyosarcoma (Option D) is a soft tissue malignancy, but less common than neuroblastoma.

References:

Bailey & Love Short Practice of Surgery, 28th Edition, Page 902.

↑ *Back to this question in Part A*

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Q4: A pediatric surgery resident evaluates a newborn presenting with an abdominal wall malformation. Which of the following statements about this condition is incorrect? (Q880408)

A. The central abdominal wall defect can exceed 4 cm in size

B. This malformation typically occurs without any associated congenital anomalies

C. The covering sac consists of amnion and peritoneum

D. This defect forms part of Cantrell's pentalogy



Correct Answer: B. This malformation typically occurs without any associated congenital anomalies

Explanation: Omphalocele/Exomphalos: Omphalocele is frequently associated with other major congenital anomalies, including cardiac, chromosomal, and genitourinary defects. (Option B) Incorrect Options: Omphalocele defects often exceed 4 cm in diameter, especially when multiple organs are involved. (Option A) The sac covering an omphalocele consists of amnion (outer layer) and peritoneum (inner layer). (Option C) Omphalocele is a key feature of Cantrell's pentalogy, which also includes sternal, diaphragmatic, pericardial, and cardiac defects. (Option D)

References:

Bailey & Love Short Practice of Surgery, 28th Edition, Pages 270-271.

↑ *Back to this question in Part A*

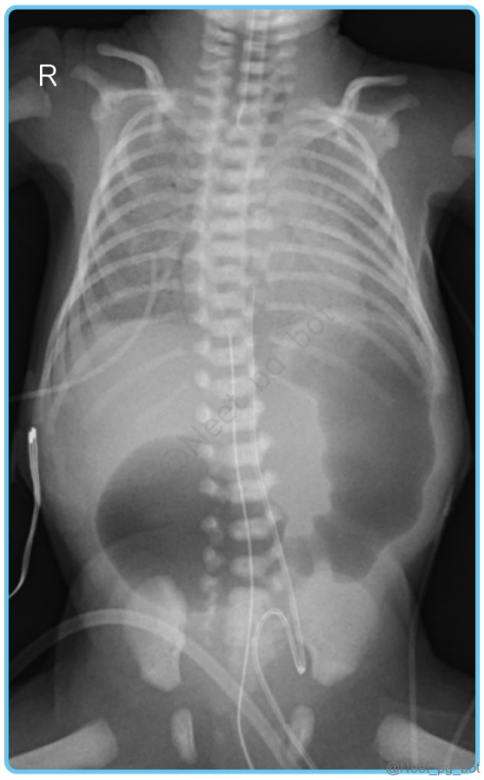
Q5: A newborn, 3 days old, has repeated episodes of bilious vomiting. The erect abdominal X-ray is shown. What should be the immediate next step in management? (Q880407)

A. CT scan of the abdomen

B. Gastrograffin follow-through

C. Abdominal ultrasound

D. Exploratory laparotomy



Correct Answer: B. Gastrograffin follow-through

Explanation: In a newborn with repeated bilious vomiting, duodenal obstruction is suspected. An erect abdominal X■ray is the first step, but the next best investigation is a Gastrografin follow■through, which confirms the diagnosis, defines the level of obstruction, and excludes malrotation or volvulus requiring urgent surgery. Incorrect Options: CT scan of the abdomen (Option A): Not preferred initially in neonates due to radiation exposure and need for sedation; reserved for complicated or unclear cases. Abdominal ultrasound (Option C): Useful for evaluating other causes or complications, but limited in defining the precise site of obstruction or malrotation

Exploratory laparotomy (Option D): Definitive treatment after imaging confirms obstruction; immediate surgery without imaging risks unnecessary intervention.

References:

Bailey & Love Short Practice of Surgery, 28th Edition, Page 266.

↑ *Back to this question in Part A*

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Q6: Among all the types of gastrointestinal atresias, which one occurs most frequently? (Q880406)

A. Duodenal atresia

B. Colonic atresia

C. Ileal atresia

D. Jejunal atresia

Correct Answer: A. Duodenal atresia

Explanation: Duodenal atresia is the most common intestinal atresia, often associated with Down syndrome and congenital heart defects. It results from failed duodenal recanalisation, causing obstruction that presents in newborns with vomiting and the classic “double bubble” sign on X■ray. Definitive treatment is surgical, with excellent outcomes. Incorrect Options: Colonic atresia (Option B): Rare obstruction of the colon, causing bowel distension and delayed passage of stool. Ileal atresia (Option C): Blockage in the ileum, part of the small intestine, leads to abdominal distension and vomiting. Jejunal atresia (Option D): Obstruction in the jejunum; similar symptoms to ileal atresia with vomiting and distension.



References:

Bailey & Love Short Practice of Surgery, 28th Edition, Pages 264, 1388.

↑ *Back to this question in Part A*

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Q7: A 10-day-old female baby was brought to the OPD with the following findings as shown in the image given below. On examination there is no cough impulse in the swelling. X-ray examination shows the erosion of the coccyx. The most likely clinical diagnosis would be: (Q849745)

A. Spina bifida

B. Myelomeningocele

C. Sacrococcygeal teratoma

D. Sacral agenesis



Correct Answer: C. Sacrococcygeal teratoma

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The given image showing a large mass in the sacrococcygeal region (lower back, near the tailbone) along with the X-ray showing erosion of the coccyx points toward the diagnosis of sacrococcygeal teratoma. Teratomas mostly occur during the neonatal period and most of them are benign Most common site- Sacrococcygeal region Females > males The risk of malignancy increases with age It is thought to be derivative of the primitive streak Clinical features: External presacral mass with minimal intrapelvic presacral component Symptoms include weakness, paralysis, and bladder or bowel dysfunction Currarino Triad: Anorectal malformations + sacrococcygeal osseous defect + presacral mass Diagnosis: Clinical diagnosis CT/MRI is done to detect intra-abdominal and intra-pelvic components. Treatment: Complete surgical excision of the tumor should be done To avoid local recurrence - resection of the coccyx is done Spina bifida (Option A) : Typically presents with a midline defect in the spine but without erosion of the coccyx or a prominent cough impulse. Myelomeningocele (Option B) : Involves herniation of the meninges and spinal cord, usually in the lumbosacral region, but is not characterized by coccygeal erosion or a teratoma-like mass. Sacral agenesis (Option D): A developmental disorder characterized by the absence of parts of the sacrum but not typically associated with a mass or erosion of the coccyx.

References:

SRB’s Manual Of Surgery, 6th Edition, Page 987

↑ *Back to this question in Part A*

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Q8: How will you manage a case of anorectal malformation with no visible fistula in a female patient with cross-table lateral X-ray showing rectum below the coccyx? (Q849744)

A. Protective colostomy followed by posterior sagittal anorectoplasty

B. Anoplasty

C. Colostomy

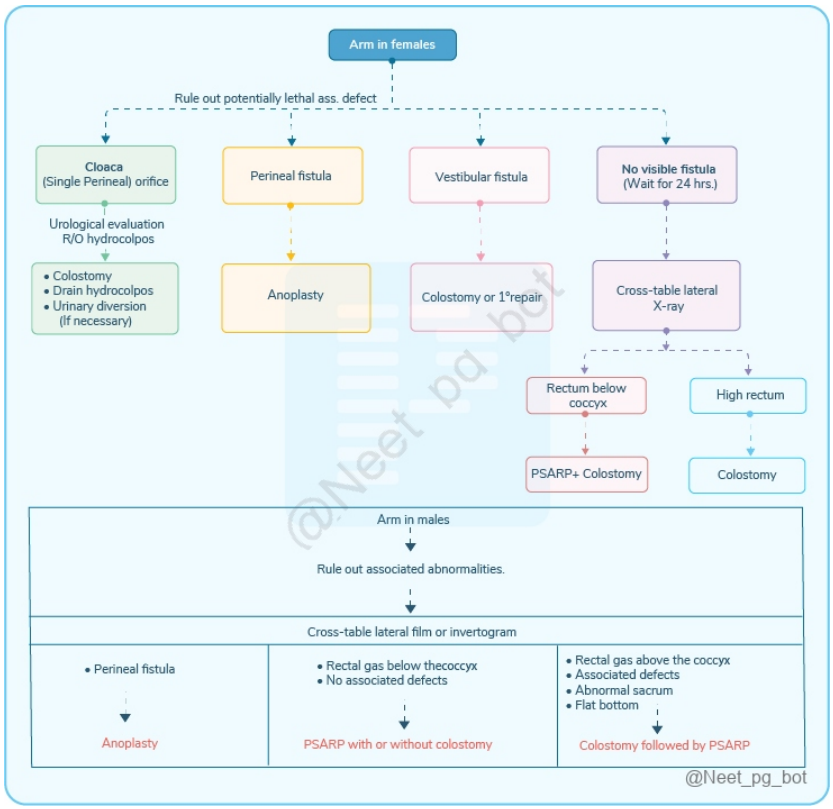
D. None of the above

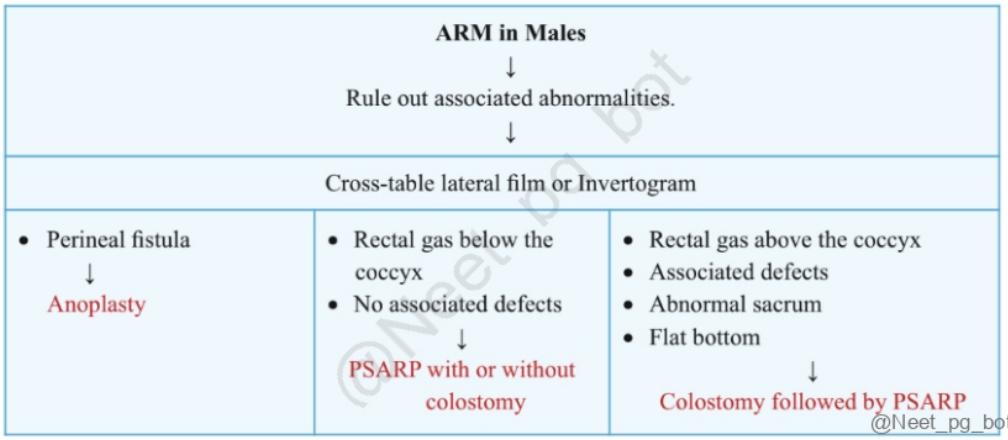
Correct Answer: A. Protective colostomy followed by posterior sagittal anorectoplasty

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The management of anorectal malformation varies based on sex and whether the lesion is high or low. For High lesions- Protective colostomy followed by Posterior Sagittal Anorectoplasty (PSARP) after 4-8 weeks. For Low lesions- Only perineal anoplasty is performed Management protocol of ARM in males and females: Anoplasty (Option B) is the treatment of choice in perineal fistula Colostomy (Option C) In cases of no visible fistulae with cross-table lateral X-ray suggestive of high rectum, colostomy is the treatment of choice.





References:

SRB's Manual Of Surgery, 6th Edition, Page 965, 967

↑ *Back to this question in Part A*

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Q9: Which of the following diagnostic methods is used to differentiate between a high and low lesion in anorectal malformation, and how does it determine the location of the rectum? (Q849743)

A. Abdominal ultrasound; identifies the rectal location by imaging the entire pelvic cavity.

B. MRI of the pelvis; differentiates based on the presence of anatomical anomalies in the pelvic floor

C. Invertogram; assesses the rectal termination by the rise of gas in relation to the pelvic floor.

D. X-ray of the pelvis; determines rectal termination based on bone structures and distance from the pelvic floor.

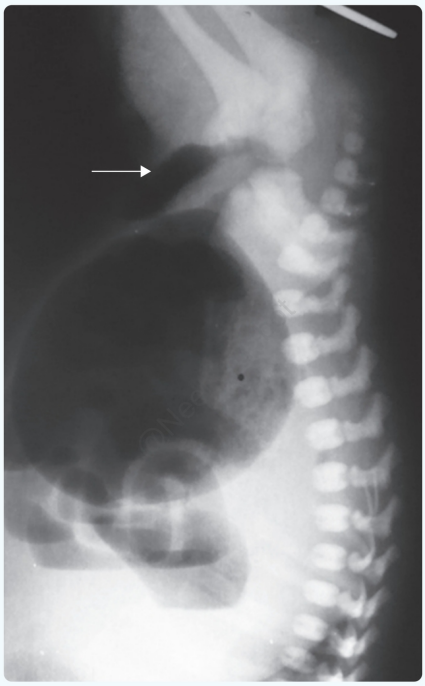
Correct Answer: C. Invertogram; assesses the rectal termination by the rise of gas in relation to the pelvic floor.

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: An invertogram is the diagnostic method used to differentiate between high and low lesions in anorectal malformation. Invertogram is used to determine the rectal termination relative to the pelvic floor. This test is typically performed 6-12 hours after birth. A coin is placed at the location where the anus is expected, and the baby is positioned upside down for at least 3 minutes. The gas is going to rise at the distal part of the large intestine. High Lesion: The rectum ends above the Levator ani complex. Low Lesion: The rectum ends below the Levator ani complex. Abdominal ultrasound (Option A) does not specifically differentiate high vs. low lesions

based on rectal termination relative to the pelvic floor. MRI of the pelvis (Option B) is not typically used for this specific diagnostic purpose in anorectal malformation. X-ray of the pelvis (Option D) does not accurately determine the rectal termination in relation to the pelvic floor.



Invertogram showing a big gas shadow in the abdomen

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References:

SRB's Manual of Surgery, 6th Edition, Page 957

↑ *Back to this question in Part A*

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Q10: Which of the following accurately describes a component and a step involved in the LADD's operation for managing intestinal malrotation? (Q849742)

A. Appendectomy; Division of LADD’s bands near the medial aspect of the duodenum

B. Reduction of volvulus; Widening of the mesenteric base by mobilizing the duodenum

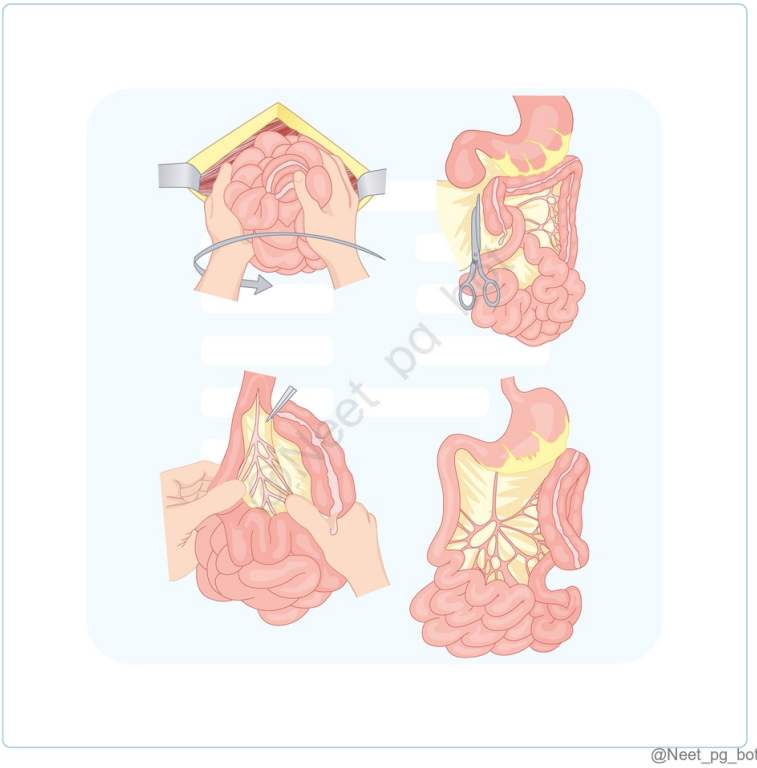
C. Bowel repositioning; Resection of viable bowel wrapped in warm, moist sponges

D. Division of LADD’s bands; Placement of the duodenum and proximal jejunum on the left side of the abdomen

Correct Answer: B. Reduction of volvulus; Widening of the mesenteric base by mobilizing the duodenum

- *Listen (English)*
- *Listen (Hindi)*

Explanation: Reduction of Volvulus : This is a key component of the LADD's operation, which involves correcting the twisted bowel. Widening of the Mesenteric Base : During the procedure, the duodenum is mobilized and straightened by dividing the abnormal ligament of Treitz and LADD's bands to prevent future volvulus. LADD's Operation Components : Reduction of Volvulus : Correcting the twisted bowel. Division of LADD's Bands : Cutting the fibrous bands that may cause obstruction. Appendectomy : Removing the appendix to prevent future diagnostic confusion. Positioning of the Intestine : Adjusting the placement of the intestines, with or without fixation. Steps : RUQ Transverse Incision : Making an incision across the right upper quadrant. Counter-Clockwise Rotation : Correcting the volvulus by rotating the bowel counter-clockwise. Bowel with Uncertain Viability : Wrapping potentially viable bowel in warm, moist sponges for at least 15 minutes. Resection of Gangrenous Bowel : Removing any necrotic bowel sections. Division of LADD's Bands : Cutting the bands near the lateral side of the duodenum. Widening of the Mesenteric Base : Mobilizing and straightening the duodenum by dividing the abnormal ligament of Treitz and LADD's bands. Appendectomy : Performing an appendectomy to avoid future diagnostic issues. Final Bowel Position : Duodenum and Proximal Jejunum : Positioned on the right side of the abdomen. Terminal Ileum and Cecum : Positioned on the left side of the abdomen. (A) Bowel is assessed and, if volvulus is present, gently detorsed in a counterclockwise direction (arrow). (B) Ladd bands attaching the colon to the liver, gallbladder, or retroperitoneum are divided sharply or with electrocautery. (C) Adhesions to the mesentery are divided (arrows) and the mesenteric pedicle widened, allowing the colon to be placed on the left side of the patient and the small bowel with a straightened duodenum on the right. (D) Final position of the bowel contents at the completion of the Ladd procedure.



References:

SRB's Manual of Surgery, 6th Edition, Page, 916, 918.

↑ *Back to this question in Part A*

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Q11: A 3-week-old infant presents with sudden-onset bilious vomiting and lethargy. The baby has been experiencing intermittent abdominal pain and has not been gaining weight as expected. On examination, the infant shows signs of poor perfusion and decreased urine output. Which of the following is the most likely diagnosis, and what should be the primary investigation to confirm it? (Q849741)

A. Intestinal Malrotation with Midgut Volvulus; Upper GI Contrast Study

B. Pyloric Stenosis; Upper GI Contrast Study

C. Intestinal Malrotation with Midgut Volvulus; Barium Swallow Study

D. Pyloric Stenosis; Barium Swallow Study

Correct Answer: A. Intestinal Malrotation with Midgut Volvulus; Upper GI Contrast Study

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The infant’s presentation with sudden-onset bilious vomiting, lethargy, and signs of poor perfusion and metabolic acidosis suggests midgut volvulus , a serious complication of malrotation. Upper GI Contrast Study is the primary investigation to confirm malrotation. It allows visualization of the positioning of the duodenum and the ligament of Treitz and can identify midgut volvulus. Clinical Features of malrotation: Asymptomatic Cases : Malrotation can be discovered incidentally through radiological exams or during an autopsy when no symptoms are present. Symptomatic Cases : Without Volvulus : Symptoms include persistent abdominal pain, bilious vomiting, and failure to thrive (inadequate weight gain). With Volvulus (Emergency Situation) : The primary symptom may be bilious vomiting, which can sometimes be the sole indication of midgut volvulus. Lethargy due to inadequate blood flow. Decreased urine output . Metabolic acidosis . Investigations: Laboratory Findings : Metabolic acidosis Thrombocytopenia Leucopenia Gold Standard for Diagnosis : The Upper GI Contrast Study is the preferred method for diagnosing malrotation. Barium Swallow : This test is not typically used for diagnosing malrotation because it does not effectively rule out malrotation. Pyloric stenosis presents in infants between 3-6 weeks of age and the vomiting is non-bilious because the obstruction is proximal to the duodenum. Additionally, the imaging investigation for pyloric stenosis is ultrasound , not an upper GI contrast study. An ultrasound would show the characteristic "olive sign" and pyloric muscle hypertrophy. Management For Acutely Ill Children with Peritonitis: Exploratory Laparotomy is performed as an emergency procedure. For Symptomatic Volvulus: Administer IV fluids and IV antibiotics. Decompress the proximal stomach. Proceed with emergency surgery. For Chronic Symptoms or Symptom-Free Patients: Plan for elective correction. The standard surgical approach is the

LADD's procedure.

References:

https://www.ncbi.nlm.nih.gov/books/NBK560888/

↑ *Back to this question in Part A*

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Q12: Which of the following statements is true about hyper-rotation of intestines? (Q849740)

A. The cecum is located in the left hypochondrium

B. The cecum is in the midline inferior to the pylorus

C. Arrested counter-clockwise rotation around 180°

D. The presence of Ladd's bands is noticed

Correct Answer: A. The cecum is located in the left hypochondrium

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Hyper-rotation occurs when there is excessive counter-clockwise rotation of the midgut beyond the 270° rotation. Due to this excessive rotation, the cecum, which normally ends up in the right lower quadrant of the abdomen, may be displaced to the left upper quadrant (left hypochondrium) . This abnormal positioning is a direct result of the excessive rotation of the midgut. Types of rotational abnormalities: Rotational Abnormalit Description Abnormalities Non-Rotation Most common rotational abnormality. Failure of counter-clockwise rotation after return of midgut to the abdominal cavity. Duodenum (C-loop), Ligament of Treitz, and small intestine are on the right side. Cecum and large intestine are on the left side. Proximal jejunum and ascending colon fused as one pedicle. Incomplete Rotation Most common type of malrotation. Arrested counter-clockwise rotation around 180° (Option C) . Small intestine lies on the right side. DJ flexure located on the right side of the vertebral column. Duodenum may have a corkscrew configuration. Major part of the large intestine on the left side. Cecum is close to midline. Right colon located more medially. Failure of fixation of ascending colon in right hypochondrium, leading to narrow intestinal mesentery and presence of Ladd's bands. (Option D) Reverse Rotation Rotation occurs in a clockwise direction around the SMA. Duodenum is anterior to the superior mesenteric artery. Transverse colon is posterior to the superior mesenteric artery. Hyper-Rotation Counter-clockwise rotation greater than 270°. Cecum is located in the left hypochondrium (Option A) . Mixed Rotation Intestine does not rotate as it enters the abdomen after a physiological hernia. Cecum is located in the midline, inferior to the pylorus (Option B) . Increased risk of volvulus.

References:

SRB's Manual of Surgery, 6th Edition, Page, 917.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q13: A 3-day-old male baby is brought with complaints of irritable crying. Mother gave the history of not passing meconium in the first 48 hours of life. On examination, abdominal distension was seen with rebound tenderness and reduced bowel sounds. Identify the condition. (Q849739)

A. Complicated meconium ileus

B. Sigmoid volvulus

C. Duodenal atresia

D. Midgut volvulus

Correct Answer: A. Complicated meconium ileus

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Meconium ileus is complicated by perforation in utero or just after birth. This leads to peritonitis. This results in: Dense inflammatory adhesions Calcification (snowstorm appearance in USG) Clinical features: Meconium pseudocyst Adhesive peritonitis with or without bacterial infection Ascites Diagnosis: X-ray Specks of calcification Dilated bowel loops Mass Effect On USG: Snowstorm appearance(characteristic finding) Management: For uncomplicated cases - Non-operative treatment like enemas with Gastrografin, N-acetylcysteine 10% solution for irrigation per-rectum, or via NG tube. In more severe or unresponsive cases, surgery is required. The standard surgical approach involves: Enterotomy (making an incision into the bowel) and irrigation with warm saline or 4% N-acetylcysteine to flush out meconium pellets. The bowel is then closed after complete evacuation of the meconium. If necessary, meconium pellets may be manually pushed into the large bowel. Sigmoid volvulus (Option B) occurs in older children, adolescents, or adults. It generally causes progressive abdominal distension, vomiting, and constipation, but it is not associated with the failure to pass meconium within the first 48 hours of life. Duodenal atresia (Option C) typically presents with bilious vomiting within the first few hours after birth, often associated with conditions like Down syndrome. Obstruction occurs proximally in the duodenum and is not associated with delayed meconium passage. Midgut volvulus (Option D) usually presents with bilious vomiting , abdominal pain, and signs of bowel ischemia. The hallmark of midgut volvulus is bilious vomiting rather than failure to pass stool and presents with more acute symptoms.



References:

SRB's Manual of Surgery, 6th Edition, Page, 918-919.

↑ *Back to this question in Part A*

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Q14: A 35-year-old man presents with recurrent chest infections and dyspnea. Chest CT reveals a 5 cm, well-defined, fluid-filled cystic lesion in the right paratracheal region. What is the most likely diagnosis? (Q849720)

A. Pulmonary sequestration

B. Bronchogenic cyst

C. Pericardial cyst

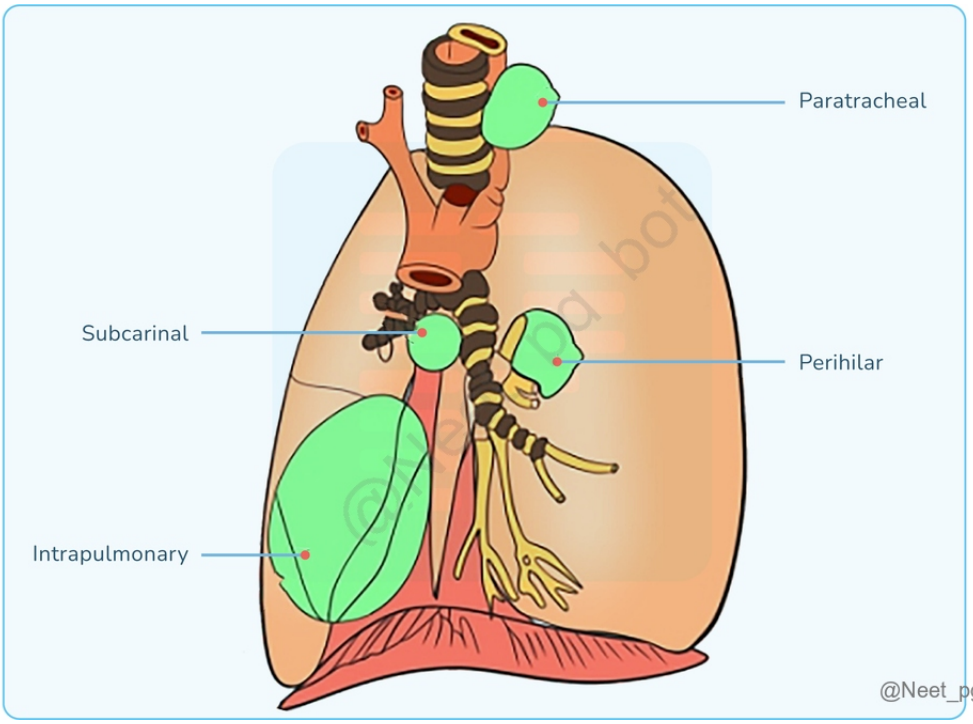
D. Hydatid cyst

Correct Answer: B. Bronchogenic cyst

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The patient's presentation with recurrent chest infections and dyspnea, along with the CT findings of a well-defined, fluid-filled cystic lesion in the paratracheal region, strongly suggests a bronchogenic cyst . Key features of bronchogenic cysts: Congenital malformation arising from abnormal budding of the tracheobronchial tree Usually located in the mediastinum (65-90%), particularly in the paratracheal or carinal region Can also occur within the lung parenchyma (15-20%) Typically filled with mucoid material Often asymptomatic, but can cause symptoms due to compression of surrounding structures Symptoms may include cough, dyspnea, chest pain, or recurrent infections On CT, appear as well-defined, fluid-filled cystic lesions Pulmonary sequestration (Option A) is incorrect as sequestrations typically present as solid masses with their own blood supply, not as fluid-filled cysts. Pericardial cyst (Option C) is incorrect as these are typically located in the right cardiophrenic angle and are less likely to cause recurrent infections. Hydatid cyst (Option D) is incorrect as these are parasitic cysts, usually found in the liver or lung parenchyma, and would have a different appearance on CT.



References:

Sabiston's Textbook of Surgery, 21st Edition, Page, 1591.

↑ *Back to this question in Part A*

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Q15: Which of the following statements about the meconium plug are false? (Q849736)

A. Associated with hypothyroidism and cystic fibrosis

B. X-ray of the abdomen shows the corkscrew's appearance

C. Water-soluble contrast enema is used for diagnosis and therapeutic purposes.

D. It is mostly seen in preterm infants.

Correct Answer: B. X-ray of the abdomen shows the corkscrew's appearance

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: X-ray of the abdomen - the meconium plug normally presents as dilated bowel loops. Corkscrew appearance on X-ray is usually seen in midgut volvulus. Meconium plug: It is a manifestation of Meconium syndrome It leads to large bowel obstruction Most commonly seen in preterm infants. Generalized abdominal distension Associated with: Maternal diabetes, hypothyroidism, cystic fibrosis . Diagnosis: On abdominal X-ray - Dilated bowel loops can be observed. Water soluble contrast enema- contrast is hypertonic, and it attracts water in the lumen, as a result of which the patient passes the plug. Hence, the investigation is both diagnostic & therapeutic. Water-soluble contrast enema → Passage of meconium plug → Relief of obstruction.

References:

SRB’s Manual of Surgery, 6th Edition, Page 918.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q16: All of the following are true about small bowel duplication except? (Q849735)

A. These are submucosa-lined structures in continuity with the GI tract

B. The most common site is the ileum

C. Cystic duplication is the most common type

D. Located along the mesenteric border

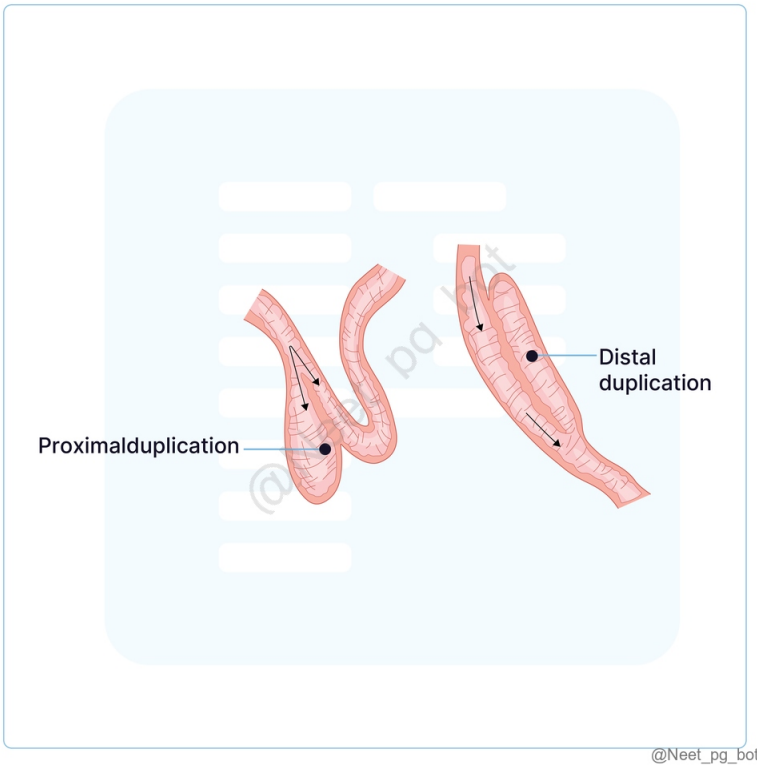
Correct Answer: A. These are submucosa-lined structures in continuity with the GI tract

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Duplication of the small bowel are mucosa-lined structures in continuity with the GI tract. Small Intestinal Duplication: These are mucosa -lined structures in continuity with the GI tract (Option A) . Most common site - ileum (Option B) Contains all 3 layers Shares the common wall and vascular supply Located along the mesenteric border (Option D) Types of small bowel duplication: Cystic duplication: Tubular duplication: Most common - 75% cases (Option C) It does not communicate with the lumen of the small intestine Partial small bowel

obstruction leads to: Recurrent abdominal pain Vomiting 25% cases Communicates with the lumen of the small intestine If the proximal part communicates: Proximal duplication . If the distal part communicates: Distal duplication . Presence of ectopic gastric mucosa (ileal ulcer) → acid production → ulcer → bleeding → hematochezia. Treatment : For short segment duplication: Resection and anastomosis For long segment duplication: Multiple enterotomy with stripping of mucosa Division of common wall by stapler.



References:

https://pubs.rsna.org/doi/10.1148/radiographics.13.5.8210590

SRB's Manual of Surgery, 6th Edition, Page, 918.

↑ *Back to this question in Part A*

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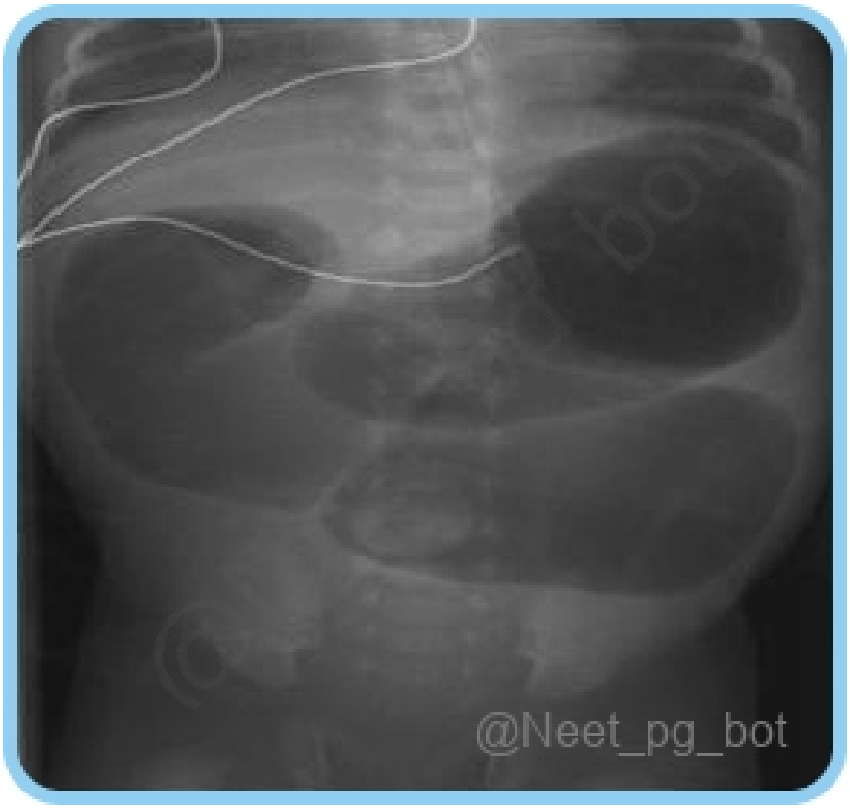
Q17: A 3-day-old neonate presents with abdominal distension and bilious vomiting. An erect X-ray of the abdomen is done, as shown below. What is the most probable diagnosis you suspect? (Q849729)

A. Jejunoileal atresia

B. Congenital diaphragmatic hernia

C. Sigmoid volvulus

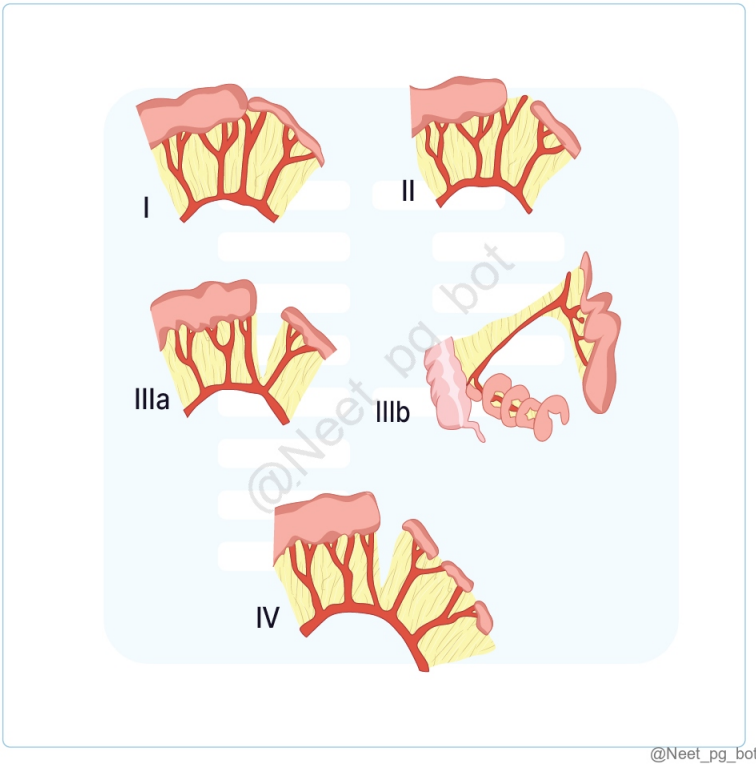
D. Duodenal atresia



Correct Answer: A. Jejunoileal atresia

- *Listen (English)*
- *Listen (Hindi)*

Explanation: The given image shows a triple-bubble appearance which is suggestive of jejunoileal atresia. Clinical features: Bilious vomiting within the first day of life. Vomiting is more prominent in proximal obstruction. Abdominal distension is more common in distal obstruction. Management: IV fluids and IV antibiotics Proximal nasogastric decompression Exploratory laparotomy- resection of atretic segment+anastomosis Classification & Management of jejunoileal atresia: Type Feature Management Strategy Type 1 Membranous atresia with intact bowel mesentery Resection of the atretic site + Primary end-to-end anastomosis. Type 2 With an atretic cord between two blind ends of the bowel with intact mesentery Resection of atretic cord + Primary end-to-end anastomosis. Type 3a Complete separation of the blind ends of the bowel by a V-shaped mesenteric gap Resection + Anastomosis; may require a larger resection. Type 3b An apple peel or Christmas tree deformity with a large mesenteric gap Requires tapering enteroplasty of the dilated proximal segment to prevent dysmotility before anastomosis. Type 4 Multiple atresias, with a string of sausage appearance Multiple anastomoses; highest risk of Short Bowel Syndrome Congenital diaphragmatic hernia (Option B) : Herniation of abdominal contents into the thoracic cavity, ipsilateral lung hypoplasia with mediastinal shift Sigmoid volvulus (Option C) : Coffee bean sign Duodenal atresia (Option D) : Double bubble sign



References:

SRB's Manual of Surgery, 6th Edition, Page 916-917.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q18: On observing the following finding in the X-ray of a baby with a history of Down's syndrome, what is the most likely diagnosis you would suspect? (Q849728)

A. Duodenal atresia

B. Ileal atresia

C. Jejunal atresia

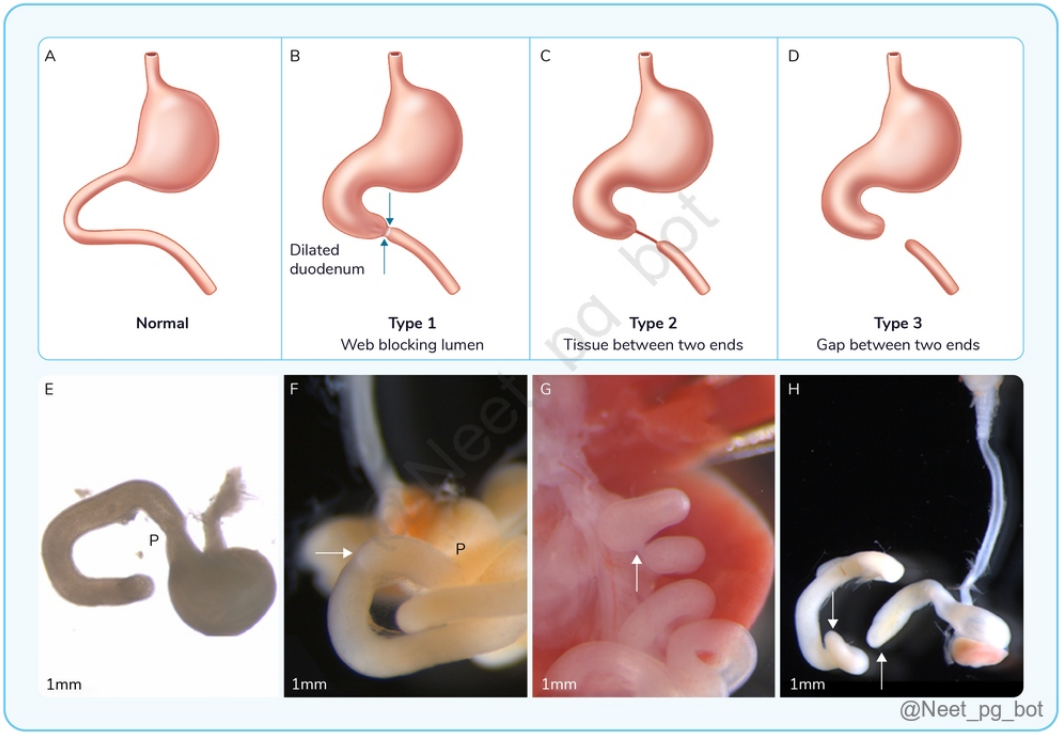
D. Congenital hypertrophic pyloric stenosis



Correct Answer: A. Duodenal atresia

- *Listen (English)*
- *Listen (Hindi)*

Explanation: The presence of a double-bubble sign on a plain abdominal radiograph is suggestive of duodenal atresia. Duodenal atresia occurs due to failure of recanalization of the intestinal lumen during gestation. The hallmark of duodenal obstruction is bilious vomiting without abdominal distension, usually present within the 1st day of life. Conditions associated with duodenal atresia are Down syndrome, Annular pancreas, malrotation, biliary atresia, polyhydramnios, and prematurity. Types of duodenal atresia: Type 1: There is the presence of a duodenal diaphragm/mucosal web (Windsock deformity) Type 2: The two ends are separated by fibrous cords Type 3: Complete separation of 2 ends Diagnosis : On X-ray abdomen - double bubble sign Treatment: The initial treatment of infants with duodenal atresia includes nasogastric or orogastric decompression and intravenous fluid replacement. Treatment of choice is surgical repair - Duodenoduodenostomy Jejunal and ileal atresia (Option B, C): Multiple air-fluid levels on plain erect X-ray abdomen presenting as a Triple bubble sign is seen. Congenital hypertrophic pyloric stenosis (Option D) : A single bubble sign is seen .



References:

SRB's Manual of Surgery, 6th Edition, Page 915-916

↑ *Back to this question in Part A*

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Q19: An 8-week-old infant is diagnosed with type 3 biliary atresia. The surgical team is planning the most appropriate intervention for this patient. Which of the following describes the preferred surgical approach for this patient? (Q849727)

A. Liver transplantation

B. Kasai porto-enterostomy

C. Choledochoenterostomy

D. Conservative management with ursodeoxycholic acid

Correct Answer: B. Kasai porto-enterostomy

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: Treatment of choice for biliary atresia, specifically for type 2 or above is, Kasai porto-enterostomy. Biliary atresia Treatment Exploratory laparotomy Intra-operative Cholecysto-cholangiogram To confirm the diagnosis, Demonstrate fibrotic biliary remnant Define absent proximal & distal bile duct patency For Type 1- Roux-en-Y jejunal anastomosis For Type 2 and above- Kasai Porto-enterostomy (TOC) Liver transplantation may be required after 3 months. Kasai portoenterostomy Removal of gallbladder and bile duct in case of progressive obliteration Division of jejunum, distal part taken, and proximal part anastomosed into the side of the jejunum Postoperative drug therapy UDCA (Facilitates bile flow) Methylprednisolone (anti-inflammatory agent) TMP-SMX (For antimicrobial prophylaxis) Postoperative Complications Most common: Cholangitis Prognosis No medical treatment can reverse the process of biliary atresia If Surgery is not performed, death occurs within 2 years Surgery should be done within 60 days of birth for better outcomes and survival 30% of patients undergoing Portoenterostomy before 60 days of age have long-term successful survival & don't require liver transplantation Liver Transplantation (Option A): While liver transplantation may eventually be necessary for some patients, it is not the first-line treatment, especially within the first 3 months of life. Choledochoenterostomy (Option C): Choledochoenterostomy is not a suitable treatment option for optimal outcomes. Conservative management with ursodeoxycholic acid (Option D): While UDCA is mentioned as part of postoperative management, it is not a substitute for surgical intervention.

References:

SRB Manual of Surgery, 8th Edition, Page, 630-631.

Bailey & Love Short Practice of Surgery, 28th Edition, Page 1241

↑ *Back to this question in Part A*

@Neet_pg_bot

Q20: A 3-week-old infant is brought to the pediatrician with persistent jaundice and pale, clay-colored stools. The parents report that the baby is not gaining weight as expected. On physical examination, the infant appears jaundiced and the liver is palpable 2 cm below the right costal margin. Which of the following diagnostic tests would be most specific for confirming the suspected diagnosis? (Q849726)

A. Abdominal ultrasound

B. CECT

C. Hepatobiliary scintigraphy

D. Intraoperative cholangiogram

Correct Answer: D. Intraoperative cholangiogram

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The given clinical history of persistent jaundice in an infant with clay-coloured stools with palpable hepatomegaly is suggestive of biliary atresia . The gold standard test for the diagnosis of Biliary atresia in pediatric patients is intraoperative cholangiogram/ peroperative cholangiogram. Clinical Features and Diagnostic Modalities for Biliary Atresia Clinical Features Obstructive Jaundice at birth or some days after birth Passage of acholic pale grey stools (due to obstructed bile flow) Failure to thrive Signs and symptoms of portal hypertension & hepatic failure (if diagnosis or treatment is delayed) In 25% of cases - Associated malformations (Polysplenia, Malrotation, Preduodenal Portal Vein, Intrahepatic vena cava) Pathological Hallmarks Bile duct proliferation Severe cholestasis with plugging Inflammatory cell infiltrate Diagnosis Gold standard: Intraoperative/perioperative cholangiogram / cholecystocholangiogram (Option D) USG Findings (Option A): Gallbladder is shrunken, CBD is not visible USG Signs: Gallbladder Ghost triad, triangular cord sign Hepatobiliary scintigraphy (Option C): Uptake into the liver without any flow into the duodenum/excretion of radiotracer into the intestine CECT (Option B) is not the primary imaging modality used for the diagnosis of biliary atresia.

References:

www.ncbi.nlm.nih.gov/pmc/articles/PMC6392153/

↑ *Back to this question in Part A*

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Q21: A 6-week-old infant presents with persistent jaundice and acholic stools. After initial workup, a congenital hepatobiliary disorder is suspected. Intraoperative cholangiography reveals complete obliteration of the common bile duct, cystic duct, and hepatic duct up to the porta hepatis. Based on the Kasai Classification, which type of this condition does this infant have? (Q849725)

A. Type 1

B. Type 2A

C. Type 2B

D. Type 3

Correct Answer: D. Type 3

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The infant's age, persistent jaundice, acholic stools, and the cholangiographic findings of complete biliary obstruction up to the porta hepatis all point to the diagnosis of biliary atresia. Definition Progressive obliteration of both intrahepatic & extrahepatic bile ducts Incidence 1:1000 live births Clinical Significance Most common indication of pediatric liver transplantation Pathological Hallmarks Bile duct proliferation Severe cholestasis with plugging Inflammatory cell infiltrate Disease Progression Progresses to: Cirrhosis Portal

hypertension Hepatic failure Kasai Classification Type 1(Option A): Common bile duct (CBD) is obliterated with patent proximal bile duct & cystic duct Type 2A (Option B): Characterized by atresia of Common hepatic duct (CHD) with patent cystic duct & CBD Type 2B (Option C): Characterized by obliteration of CHD, Cystic duct & CBD Type 3 (MC type) (Option D): Atresia of CBD, cystic duct & hepatic duct up to Porta hepatis (responsible > 90% of the cases)

References:

SRB Manual of Surgery, 8th Edition, Page, 630-631

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Q22: A newborn is diagnosed with Type A Tracheoesophageal fistula (TEF). The surgical team is discussing treatment options based on the gap between the proximal and distal ends of the esophagus. On further investigations, the gap is considerably larger. Which of the following will be the correct management for this patient? (Q849724)

A. Tension-free Esophago-Esophagostomy

B. Feeding gastrostomy followed by tension free Esophago-Esophagostomy

C. Excision of fistula tract + Tension-free esophago-esophagostomy.

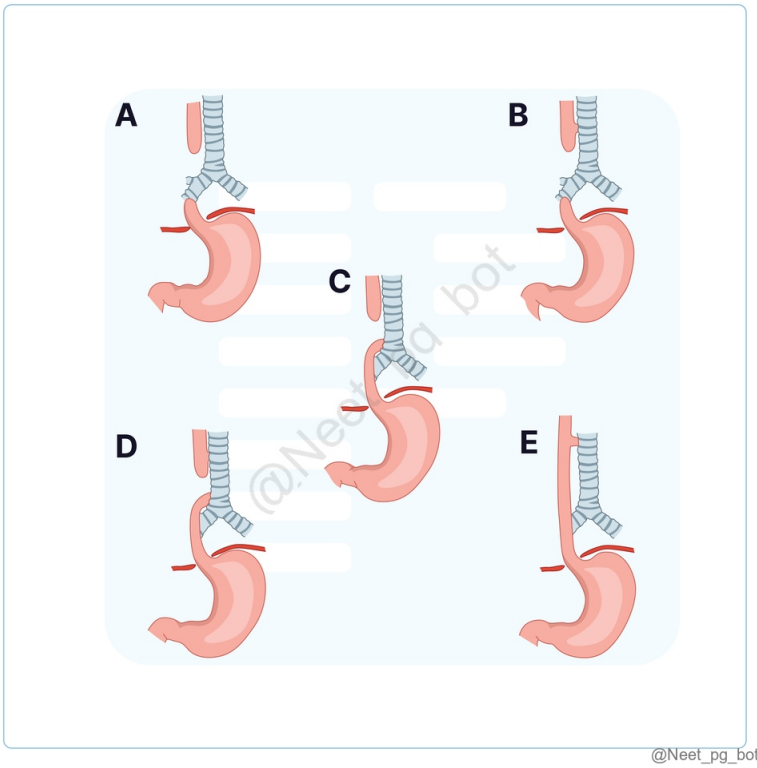
D. Excision of fistula tract + repair of the defect.

Correct Answer: B. Feeding gastrostomy followed by tension free Esophago-Esophagostomy

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The management of Type A TEF depends on the size of the gap between the proximal and distal ends of the esophagus. If the gap is large, feeding gastrostomy followed by tension-free Esophago-Esophagostomy is done. Tracheoesophageal Fistula (TEF) Treatment Protocol A: Esophageal atresia (EA) without tracheoesophageal fistula (TEF); B: Proximal TEF with distal EA; C: Distal TEF with proximal EA; D: Proximal and distal TEF; E: TEF without EA ″ H"-type TEF. Surgical Management For Type A TEF (Isolated esophageal atresia without TEF): a. For small gap: (Option A) Perform tension-free Esophago-Esophagostomy Suture proximal and distal ends b. For large gap: Perform feeding gastrostomy Follow with delayed tension-free Esophago-Esophagostomy For Types B, C, and D TEF (TEF with esophageal atresia): (Option C) Excision of fistula tract Perform tension-free esophago-esophagostomy For Type E TEF (TEF without esophageal atresia): (Option D) Excision of fistula tract Repair of the defect



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References:

SRB Manual of Surgery, 8th Edition, Page, 793-794

www.ncbi.nlm.nih.gov/books/NBK535376/

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Q23: A newborn male presents with continuous drooling of saliva from the mouth and regurgitation of feeds given orally. When attempting to pass a nasogastric tube, the physician notices that it coils in the esophagus and cannot be passed into the stomach. X-ray reveals the presence of gas in the gastrointestinal tract below the diaphragm. Further evaluation reports the presence of cardiovascular abnormality. Which of the following cardiac abnormalities is most likely to be seen? (Q849723)

A. Ventricular septal defect (VSD)

B. Patent ductus arteriosus (PDA)

C. Tetralogy of Fallot (TOF)

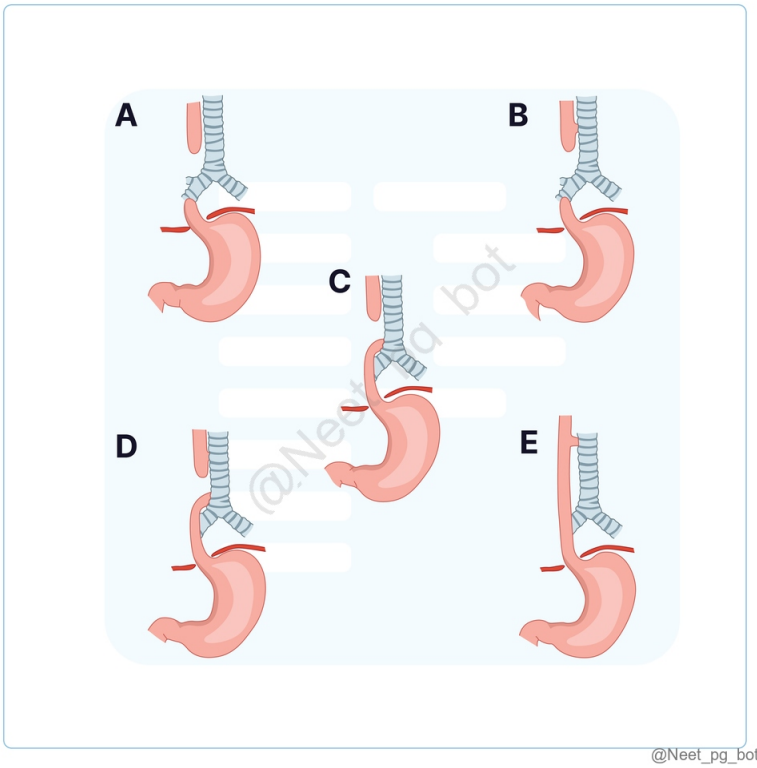
D. Atrial septal defect (ASD)

Correct Answer: A. Ventricular septal defect (VSD)

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The clinical scenario likely suggests the presence of a tracheo-esophageal fistula . The associated abnormalities are called VACTERL abnormalities, among which VSD is the most common cardiac abnormality. Tracheoesophageal fistula Type A: Isolated esophageal atresia without TEF Type B: Esophageal atresia with proximal TEF Type C: Esophageal atresia with distal tracheoesophageal fistula (Most common type) Type D: Esophageal atresia with both proximal + distal esophageal fistula (Least common type) Type E: TEF without esophageal atresia or H-shaped fistula Clinical Features Continuous drooling of saliva from the mouth Regurgitation of feeds given orally If food or saliva enters the trachea: Choking Coughing Cyanosis Dyspnea Associated Abnormalities (VACTERL) V ertebral body segmentation defect A nal atresia C ardiovascular anomalies (VSD, PDA): M/C anomaly. Ventricular septal defect (VSD): M/C among cardiovascular defects TE F R enal abnormality (Unilateral renal agenesis) L imb anomalies (Radial ray hypoplasia)



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References:

SRB Manual of Surgery (8th Edition) page 793, 794

Pubmed

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Q24: A 45-year-old man presents with progressive dyspnea on exertion. Chest X-ray shows an elevated left hemidiaphragm. Further imaging reveals thinning and upward displacement of the left hemidiaphragm without any defect. What is the most appropriate management? (Q849722)

A. Observation and follow-up

B. Plication of the diaphragm

C. Mesh repair

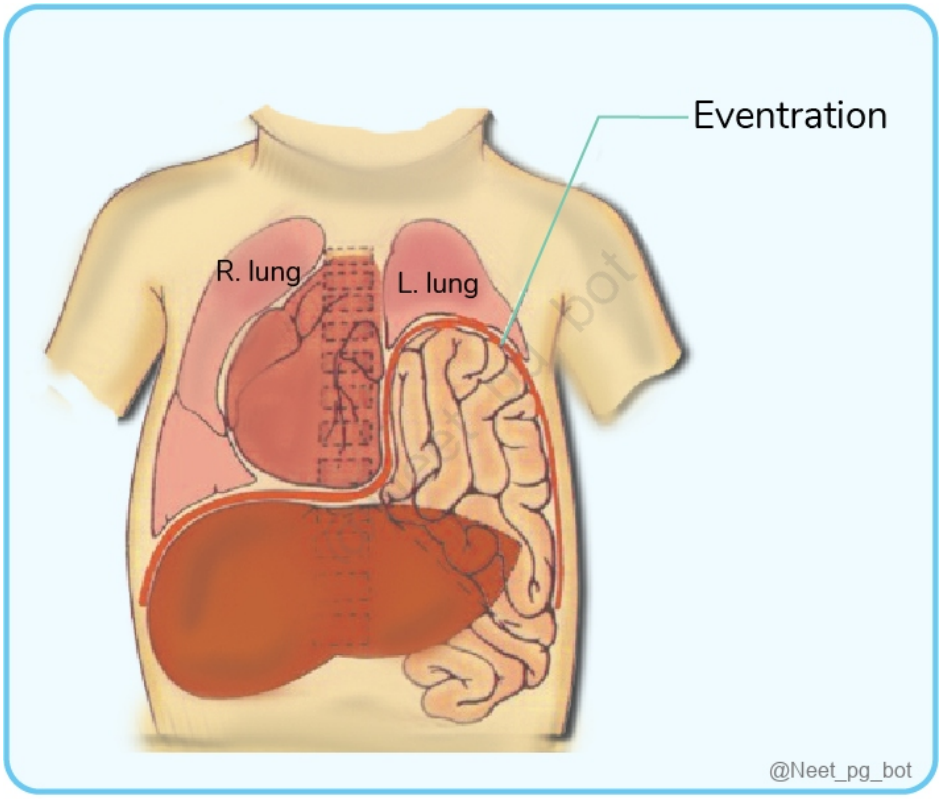
D. Pneumoperitoneum induction

Correct Answer: B. Plication of the diaphragm

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: The clinical scenario describes eventration of the diaphragm , a condition characterized by abnormal elevation of part or all of the diaphragm due to thinning or absence of muscle fibers . In this case, the patient is symptomatic with progressive dyspnea, indicating the need for surgical intervention. Plication of the diaphragm is the most appropriate management. Types of eventration: 1. Congenital: Present at birth, often due to incomplete muscularization 2. Acquired: Secondary to phrenic nerve injury, neuromuscular disorders, or trauma Treatment depends on the severity of symptoms: Asymptomatic cases: Observation and follow-up Symptomatic cases: Surgical intervention Surgical options: Plication of the diaphragm: The most common surgical approach Involves folding and suturing the thinned diaphragm to reduce its surface area and lower its position Can be done via open thoracotomy or minimally invasive techniques (thoracoscopy or laparoscopy) Mesh reinforcement: Used in cases with severe thinning or small defects Observation and follow-up (Option A) is incorrect as the patient is symptomatic and requires intervention. Mesh repair (Option C) is incorrect as there is no defect mentioned, only thinning and displacement. Pneumoperitoneum (Option D) induction is incorrect as this is not a standard treatment for diaphragmatic eventration.



References:

Sabiston's Textbook of Surgery, 21st Edition, Page, 1850

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Q25: A 20-year-old female presents with recurrent hemoptysis. CT angiography reveals a dense lesion in the left lower lobe with arterial supply from the descending thoracic aorta. Which of the following is the most likely diagnosis? (Q849721)

A. Intralobar pulmonary sequestration

B. Extralobar pulmonary sequestration

C. Bronchogenic cyst

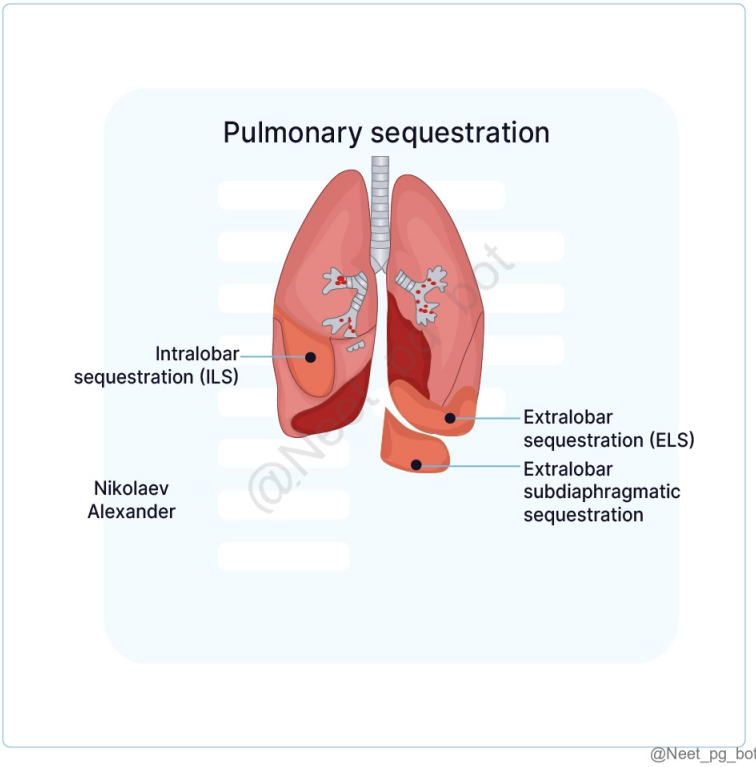
D. Congenital cystic adenomatoid malformation

Correct Answer: A. Intralobar pulmonary sequestration

■ *Listen (English)*

■ *Listen (Hindi)*

Explanation: In this case, the patient's age (20 years), presentation with hemoptysis, and CT findings of a lesion within the lung parenchyma with systemic arterial supply are all consistent with intralobar pulmonary sequestration . Pulmonary sequestration is a congenital malformation where a segment of lung tissue is separated from the normal bronchial tree and receives its blood supply from systemic circulation, typically the descending thoracic aorta . There are two types of pulmonary sequestration: Intralobar sequestration (ILS) Extralobar sequestration (ELS) More common (75-90% of cases) Located within normal lung tissue Shares pleural covering with the normal lung Usually diagnosed in adolescents or young adults Common symptoms: recurrent pneumonia, hemoptysis Venous drainage is typically to the pulmonary veins Less common (10-25% of cases) Separate from normal lung tissue with its own pleural covering Usually diagnosed in infancy or early childhood Often associated with other congenital anomalies Venous drainage is typically to the systemic veins (Azygos, Hemiazygos vein, Venacava) Extralobar pulmonary sequestration (Option B) is incorrect as ELS is usually diagnosed earlier in life and is less likely to present with hemoptysis. Bronchogenic cyst (Option C) is incorrect as these are fluid-filled cysts without systemic arterial supply. Congenital cystic adenomatoid malformation (Option D) is incorrect as these typically do not have a systemic arterial supply and present differently on imaging.



References:

Sabiston's Textbook of Surgery, 21st Edition, Page, 1591.

https://www.sciencedirect.com/topics/medicine-and-dentistry/pulmonary-sequestration

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Q55 (p. 3644)	*Q56 (p. 3645)*	*Q57 (p. 3646)*	*Q58 (p. 3648)*	*Q59 (p. 3652)*	*Q60 (p. 3652)*
Q61 (p. 3653)	*Q62 (p. 3654)*	*Q63 (p. 3655)*	*Q64 (p. 3657)*	*Q65 (p. 3660)*	*Q66 (p. 3662)*
Q67 (p. 3663)	*Q68 (p. 3665)*	*Q69 (p. 3665)*	*Q70 (p. 3667)*	*Q71 (p. 3667)*	*Q72 (p. 3671)*
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Q79 (p. 3676)	*Q80 (p. 3677)*	*Q81 (p. 3678)*	*Q82 (p. 3680)*	*Q83 (p. 3683)*	*Q84 (p. 3684)*
Q85 (p. 3686)	*Q86 (p. 3687)*	*Q87 (p. 3687)*	*Q88 (p. 3688)*	*Q89 (p. 3690)*	*Q90 (p. 3691)*
Q91 (p. 3692)	*Q92 (p. 3693)*	*Q93 (p. 3694)*	*Q94 (p. 3695)*	*Q95 (p. 3697)*	*Q96 (p. 3698)*
Q97 (p. 3699)	*Q98 (p. 3701)*	*Q99 (p. 3702)*	*Q100 (p. 3703)*	*Q101 (p. 3704)*	*Q102 (p. 3705)*
Q103 (p. 3706)	*Q104 (p. 3707)*	*Q105 (p. 3708)*	*Q106 (p. 3708)*	*Q107 (p. 3710)*	*Q108 (p. 3711)*
Q109 (p. 3712)	*Q110 (p. 3712)*	*Q111 (p. 3713)*	*Q112 (p. 3715)*	*Q113 (p. 3718)*	*Q114 (p. 3719)*
Q115 (p. 3721)	*Q116 (p. 3722)*	*Q117 (p. 3724)*	*Q118 (p. 3725)*	*Q119 (p. 3725)*	*Q120 (p. 3726)*
Q121 (p. 3728)	*Q122 (p. 3728)*	*Q123 (p. 3731)*	*Q124 (p. 3732)*	*Q125 (p. 3733)*	*Q126 (p. 3734)*
Q127 (p. 3734)	*Q128 (p. 3735)*	*Q129 (p. 3737)*	*Q130 (p. 3738)*	*Q131 (p. 3739)*	*Q132 (p. 3743)*
Q133 (p. 3745)	*Q134 (p. 3746)*	*Q135 (p. 3747)*	*Q136 (p. 3749)*	*Q137 (p. 3751)*	*Q138 (p. 3752)*
Q139 (p. 3754)	*Q140 (p. 3755)*	*Q141 (p. 3759)*	*Q142 (p. 3761)*	*Q143 (p. 3764)*	*Q144 (p. 3768)*
Q145 (p. 3769)	*Q146 (p. 3770)*	*Q147 (p. 3772)*	*Q148 (p. 3772)*	*Q149 (p. 3773)*	*Q150 (p. 3774)*

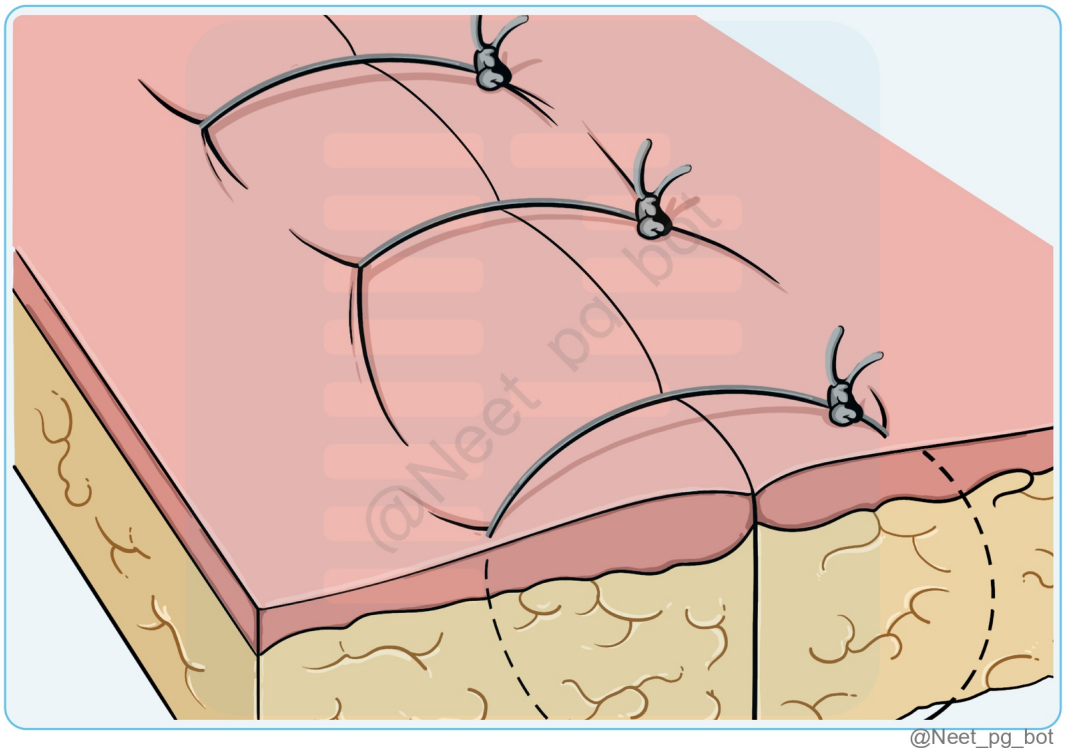
Q1: Identify the types of sutures? (Q866904)

A. Vertical Mattress

B. Horizontal mattress

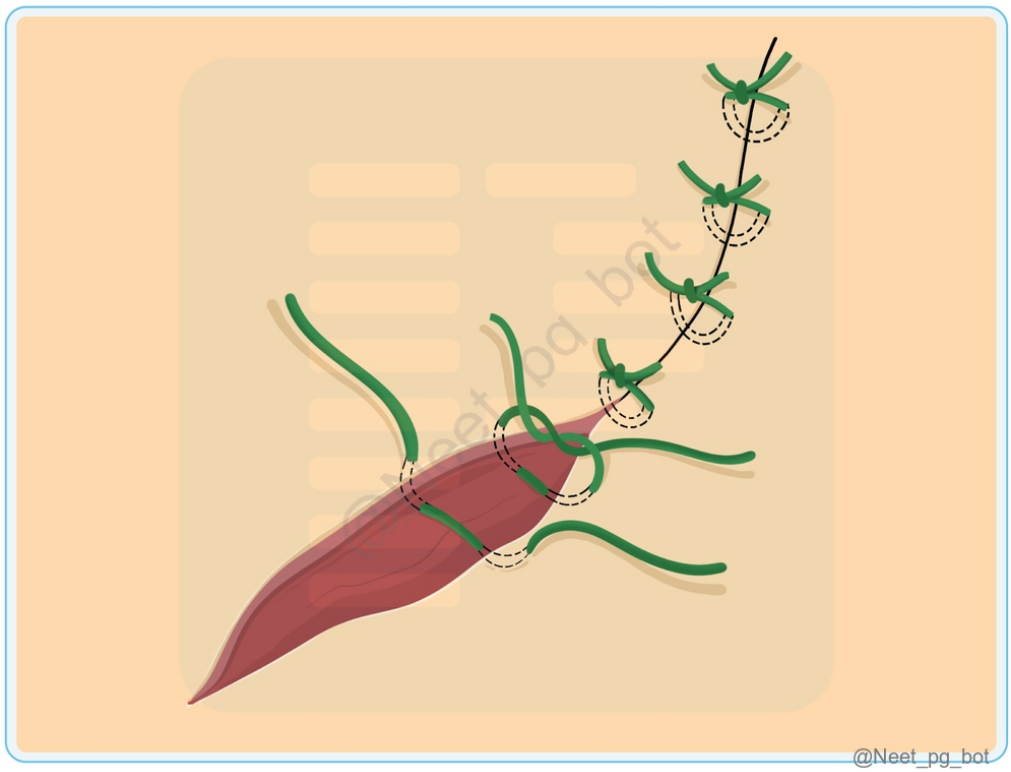
C. Subcuticular suture

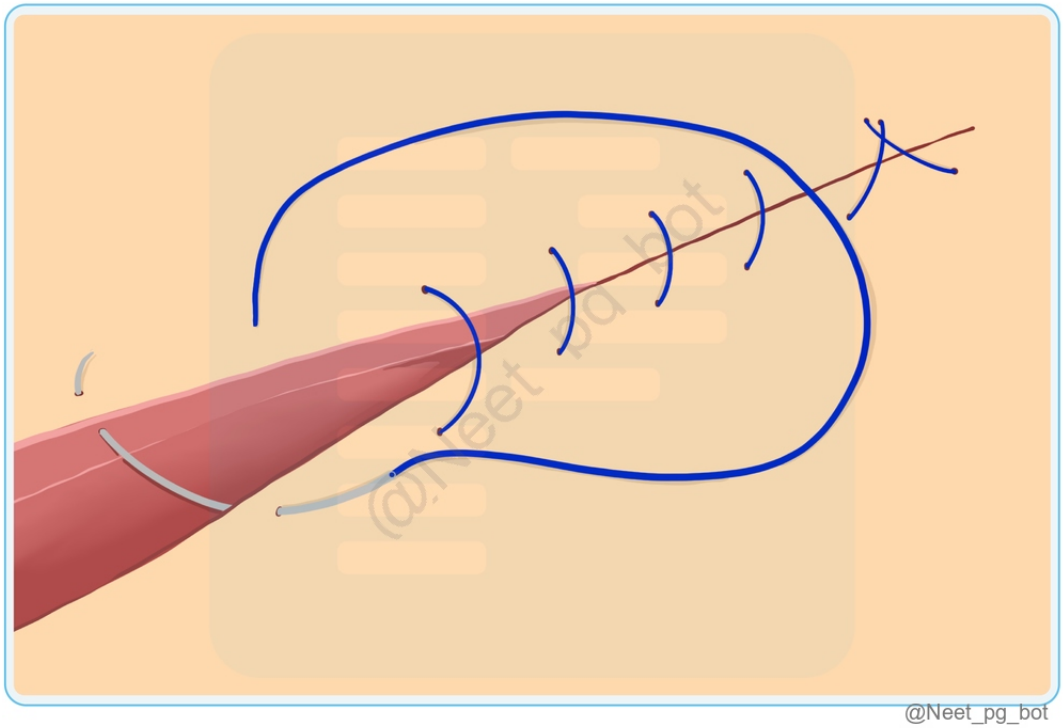
D. Simple Interrupted suture

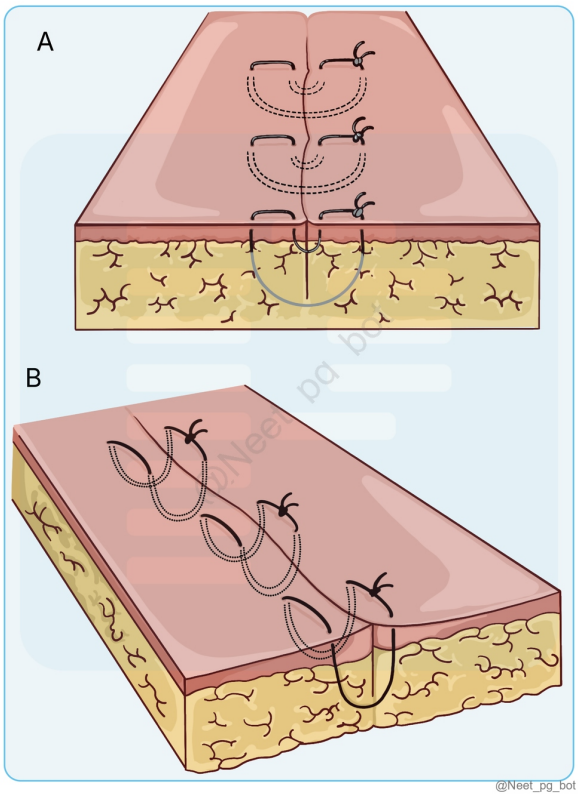


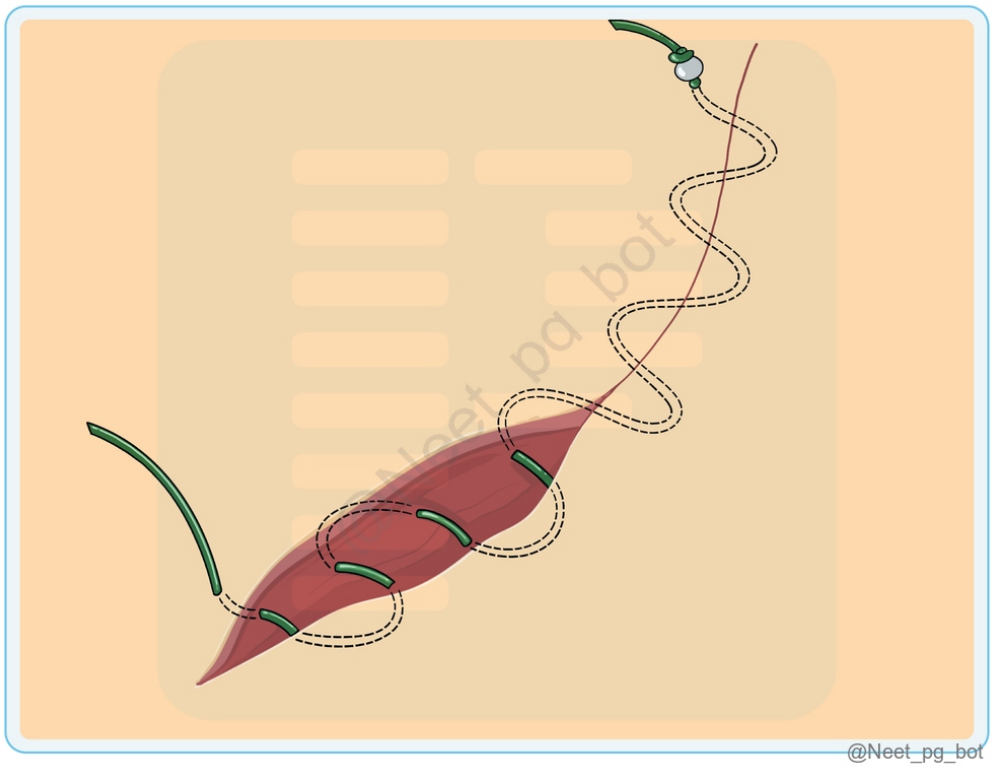
Correct Answer: D. Simple Interrupted suture

Explanation: The image depicts Simple interrupted suture. Suturing Techniques: Technique Image Description Suture Placement Interrupted Sutures Needle inserted at 90-degree angle, passed through both sides of wound Distance = tissue thickness, each suture twice as far from edge as previous Continuous Sutures Continuous placement after initial start, with suture appearing diagonal Maintain proper tension, secure end with Aberdeen knot or final suture loop Mattress Sutures (Option A & B) Vertical or horizontal, used to align wound edges Passed through both sides, either vertically or horizontally Subcuticular Sutures (Option C) Aesthetic closure with small bites of tissue, edges easily approximated Absorbable or non-absorbable, secured with collar and bead or buried knot


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References:

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↑ *Back to this question in Part A*

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Q2: Given below what is the correct sequence of Damage control surgery? 1. Patient selection 2. Primary exploration 3. ICU care 4. Secondary exploration (Q866908)

A. 1,2,3,4

B. 2,1,4,3

C. 3,1,2,4

D. 1,3,2,4

Correct Answer: A. 1,2,3,4

Explanation: Damage Control Surgery (DCS) is performed in critically ill or severely injured patients to quickly control bleeding and contamination, then allow physiological stabilization before definitive repair. Sequence: Patient selection – Identify patients who are unstable (acidosis, hypothermia, coagulopathy) and unlikely to survive prolonged surgery. Primary exploration – Abbreviated laparotomy to control hemorrhage (packing, vessel ligation) and contamination (bowel stapling, temporary closure). ICU care – Aggressive resuscitation and correction of acidosis, coagulopathy, and hypothermia. Secondary exploration – Definitive surgical repair after stabilization, usually within 24–48 hours.

↑ *Back to this question in Part A*

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Q3: After an RTA patient has severe Maxillofacial trauma with SpO2 80% at room air, and the patient cannot be intubated or ventilated, what should be your immediate step for this? (Q866924)

A. Cricothyrotomy

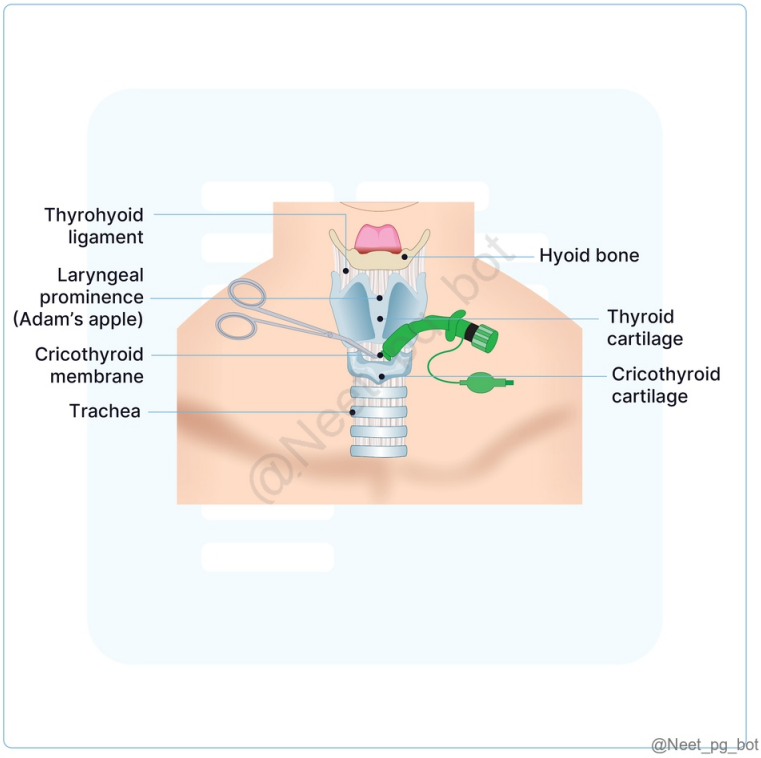
B. Tracheostomy

C. ICD insertion

D. Do suction and again try intubation

Correct Answer: A. Cricothyrotomy

Explanation: In this patient, in whom intubation and ventilation are not possible is known as a “cannot intubate, cannot ventilate” (CICV) scenario → this is a surgical airway emergency. Severe maxillofacial trauma often distorts airway anatomy, making both oral and nasal intubation impossible. In CICV, the fastest and most accessible surgical airway is emergency cricothyrotomy. Although tracheostomy provides a definitive airway, it takes longer and requires a more stable patient; not suitable for immediate life-threatening hypoxia. Cricothyrotomy allows rapid oxygenation within 30–60 seconds. Cricothyrotomy: Indications: CICV situations Severe facial trauma Upper airway obstruction Massive facial burns/swelling Landmarks: Thyroid cartilage Cricothyroid membrane (between thyroid & cricoid cartilage) Procedure: Palpate the cricothyroid membrane. Make a vertical skin incision, a horizontal membrane incision. Insert a tracheostomy or endotracheal tube. Advantages: Quick, minimal equipment, bypasses upper airway obstruction. Limitations: Should be converted to tracheostomy within 24–72 hrs to prevent subglottic stenosis. Other surgical airway options in emergencies: Needle cricothyrotomy with jet ventilation: In children <12 years or where surgical cricothyrotomy is risky. Tracheostomy: elective or semi-urgent, not first-line in hypoxic arrest situations. Tracheostomy (Option B) – Too time-consuming in a rapidly desaturating patient. ICD insertion (Option C) – For chest trauma/pneumothorax, not airway obstruction. Do suction and again try intubation (Option D) – Wastes critical seconds; patient already in CICV state.



↑ *Back to this question in Part A*

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Q4: A child comes after a train accident with stable vitals but a big laceration on the leg. Which triage category does the patient come under? (Q866932)

A. Red

B. Yellow

C. Green

D. Black

Correct Answer: B. Yellow

Explanation: In disaster triage , the Yellow category means the patient is “Delayed” — they have serious injuries but are not in immediate danger of death and can tolerate some delay before definitive treatment. Stable vitals → no immediate threat to airway, breathing, or circulation. Big laceration on the leg → significant injury requiring medical attention, but not life-threatening right now. The child can be managed after Red category (Immediate) patients are stabilized. Triage Color Codes: Red - Immediate (Option A) Life-threatening but treatable injuries needing urgent attention. Examples: airway obstruction, severe bleeding, shock. Yellow - Delayed (Option B) Serious injuries but stable; treatment can be delayed. Examples: large lacerations, stable fractures, moderate burns. Green - Minor Walking wounded; minor injuries. Examples: small cuts, abrasions, sprains. Black - Expectant / Deceased (Option D) No signs of life or injuries incompatible with survival even with care.

↑ *Back to this question in Part A*

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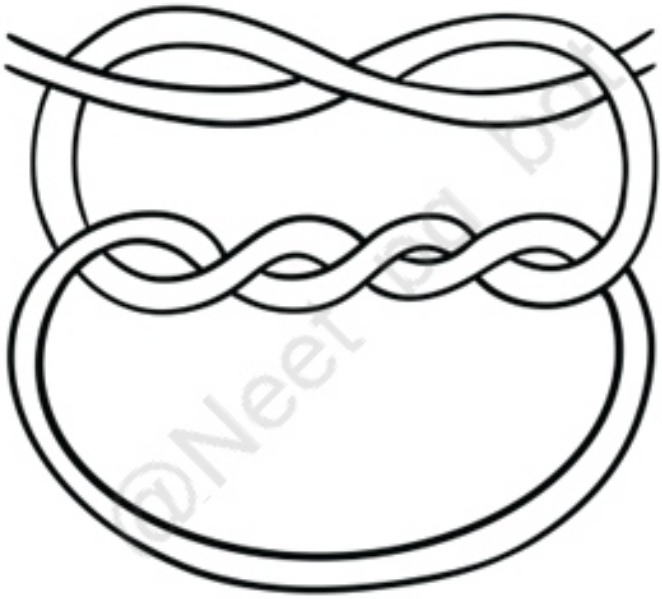
Q5: Identify the knot? (Q866418)

A. Granny’s knot

B. Reef knot

C. Double Knot

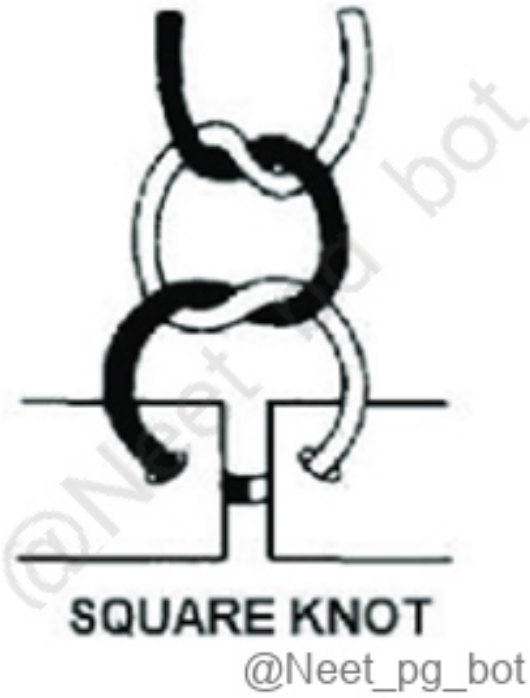
D. Surgeons knot

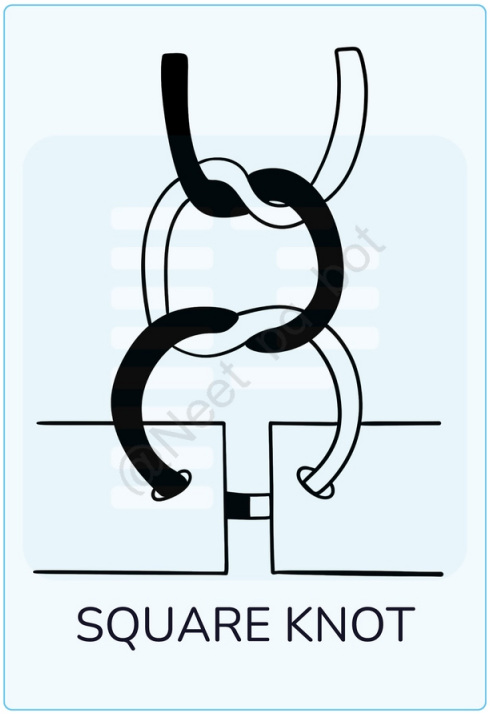


Correct Answer: D. Surgeons knot

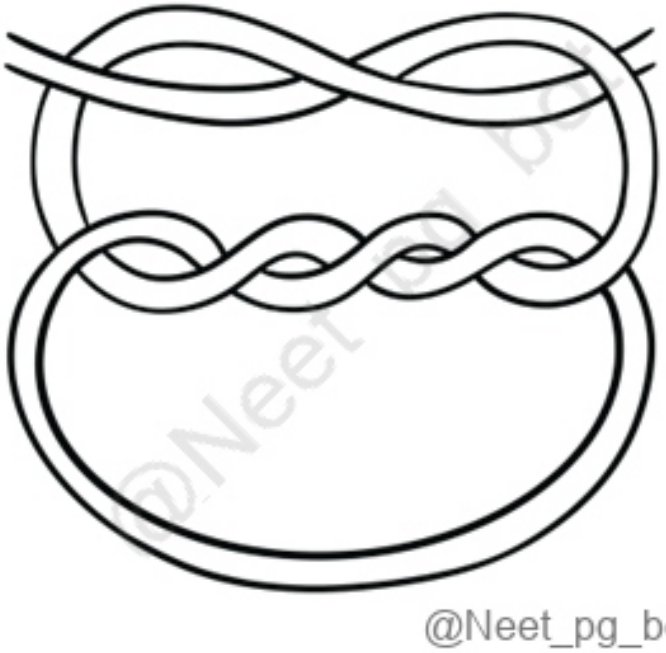
Explanation: The given image depicts a surgeon’s knot. Knotting techniques: Granny/ Slip Knots : A knot used to fasten a rope or line around an object, often deemed less dependable than the reef knot. Square/ Reef knot : It is a standard knot with an extra throw for security. Surgeon’s Knot : Extra security, prevents slippage (two-throw knot). Aberdeen Knot : Secures final knot in continuous sutures. Buried Knot : Used to secure the ends of absorbable sutures when a subcuticular suture technique is used to close the skin. Monofilament Sutures : Require six throws for secure tying; leave 1–2 mm ends to prevent unraveling.


GRANNY KNOT
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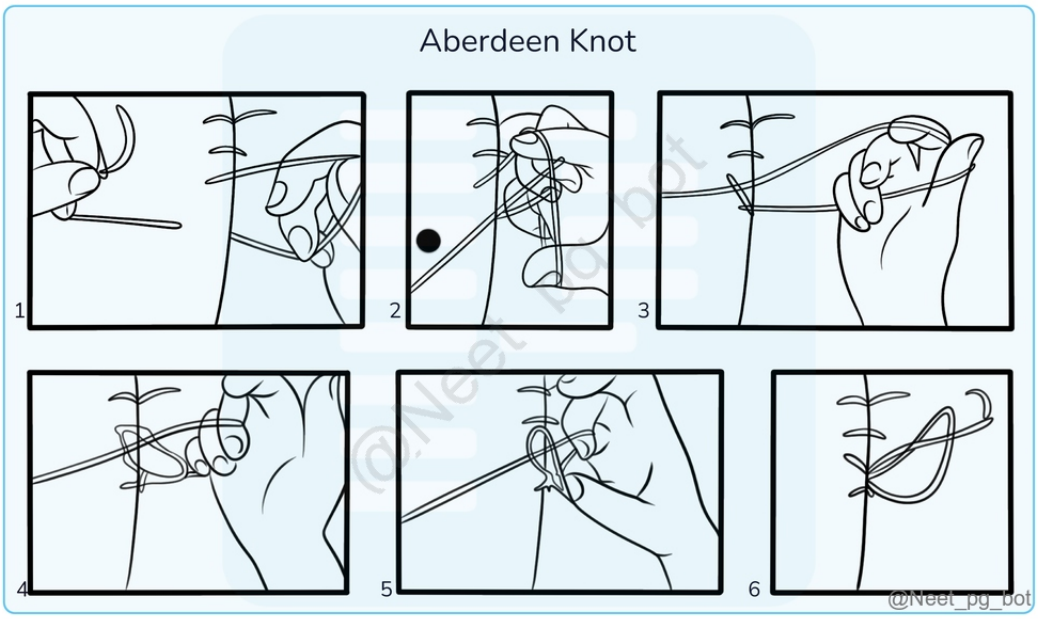

SQUARE KNOT
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↑ *Back to this question in Part A*

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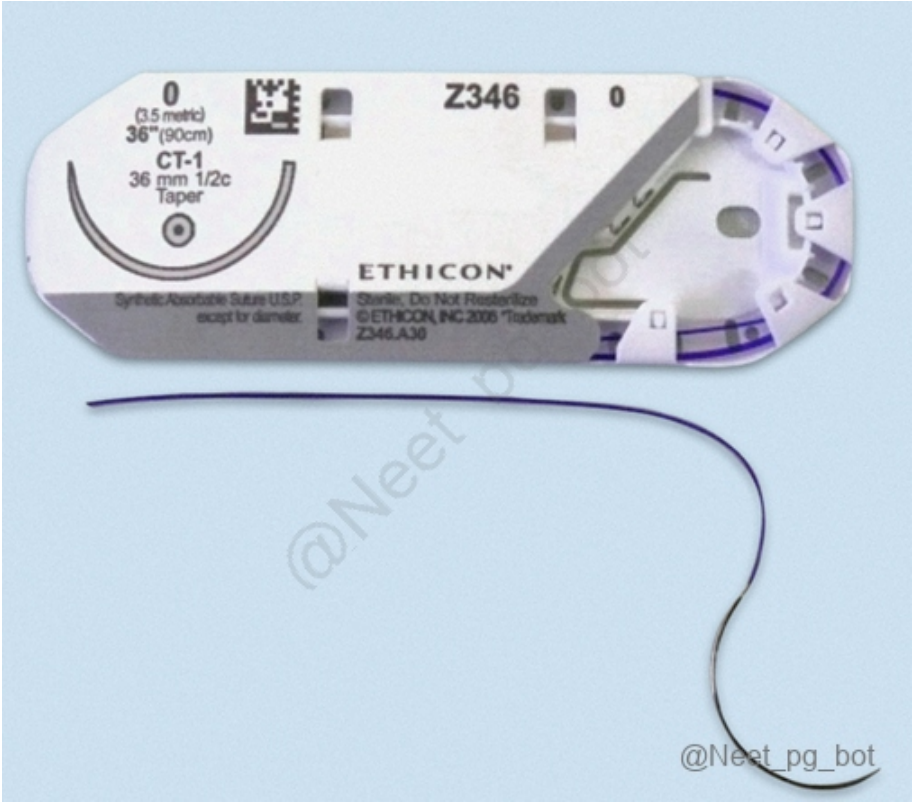
Q6: What is correct regarding this suture ? (Q866449)

A. Non absorbable

B. Monofilament

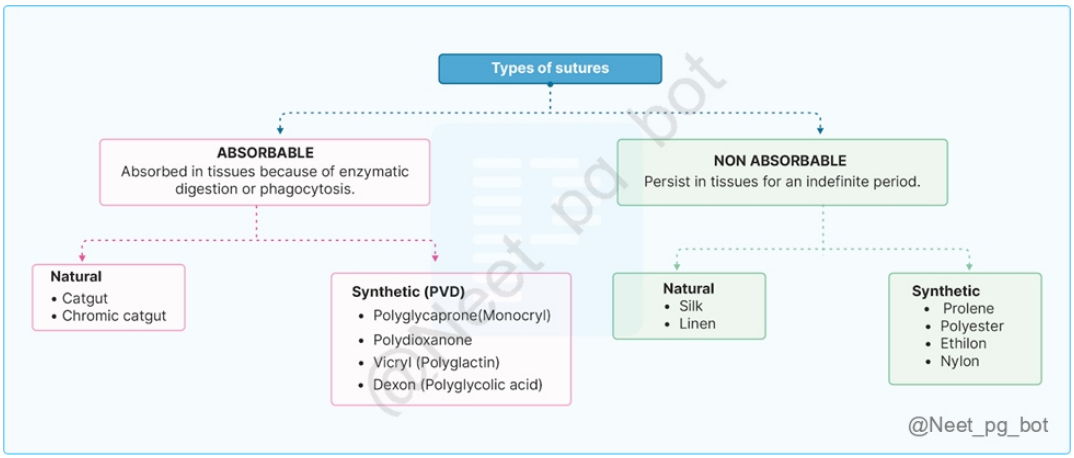
C. Braided multiflament

D. Collagen derived



Correct Answer: B. Monofilament

Explanation: The image depicts Polydioxanone suture and most appropriate answer would be monofilament suture. Polydioxanone (PDS): Raw material: Para-dioxanone polymer (Synthetic) Monofilament Absorption rate: Complete absorption at 180 days Mild tissue reaction Tensile strength retention in vivo: 70% remains at 2 weeks 50% remains at 4 weeks 14% remains at 8 weeks Uses: Instances where slightly longer wound support is required Lowest affinity for adherence to E.coli and staph. aureus Types of sutures: Based on the number of strands : Monofilament Polyfilament Single strand of fiber Multiple strands braided together Smooth & strong Easier to handle Decreased chance of bacterial infection Increased risk of infection due to the lodging of bacteria in crevices Knots tied may become loose (6-8 knots) Knots are stable (3-4 knots) E.g.: Prolene Ethilon Nylon PDS E.g.: Silk Linen Polyglycolic acid (Dexon) Polyglactin 910 (Vicryl) is an absorbable polyfilament suture. Polyglycolic acid (Dexon) is an absorbable polyfilament suture.



References:

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↑ *Back to this question in Part A*

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Q7: A patient arrives at the emergency room with a penetrating injury and low blood pressure (hypotension). What is the most appropriate next step in managing this patient? (Q866481)

A. Emergency laparotomy

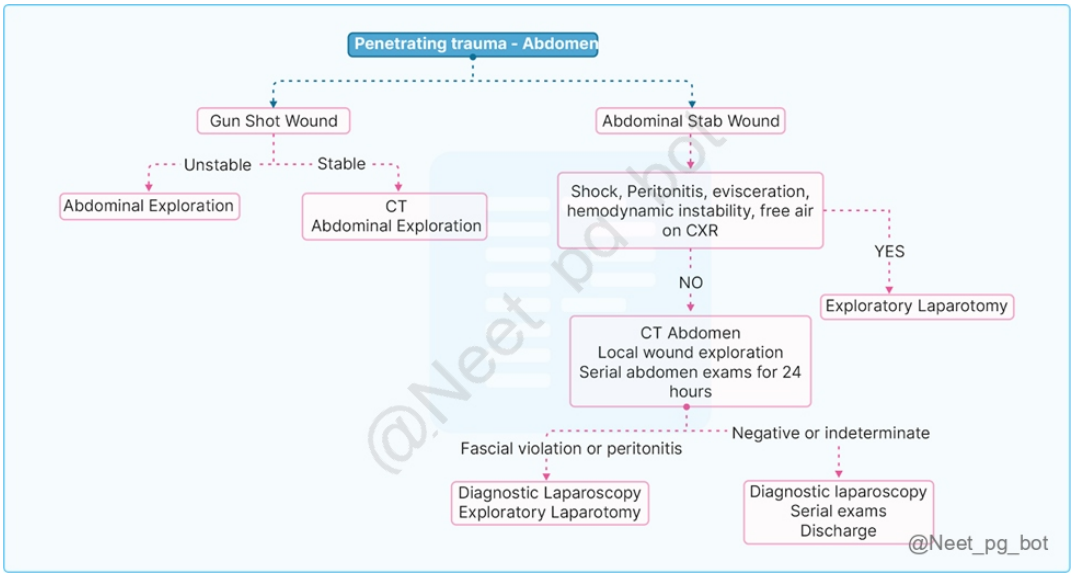
B. Computed Tomography (CT) scan

C. Diagnostic Peritoneal Lavage (DPL)

D. Ultrasonography (USG) of the abdomen

Correct Answer: A. Emergency laparotomy

Explanation: A penetrating injury accompanied by hypotension indicates likely internal bleeding or significant intra-abdominal injury, making urgent surgical exploration the priority, with emergency laparotomy being the gold standard treatment for hemodynamically unstable patients. Incorrect Options: Computed Tomography (CT) scan (Option B): Requires the patient to be stable and takes time; not suitable in unstable patients with hypotension. Diagnostic Peritoneal Lavage (DPL) (Option C): Useful in stable or borderline cases, but invasive and less commonly used now due to FAST ultrasound. Still, it can be considered if FAST is unavailable. Ultrasonography (USG) of the abdomen (Option D): FAST scan is helpful for rapid assessment, but it is a diagnostic tool and does not replace the need for urgent surgery in unstable patients.



↑ *Back to this question in Part A*

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Q8: Apart from the abdominal cavity, which body part is included in e-FAST? (Q856756)

A. Pelvic Cavity

B. Peripheral vessels

C. Thoracic cavity

D. Dural and subdural spaces

Correct Answer: C. Thoracic cavity

Explanation: The e-FAST is a rapid, non-invasive ultrasound examination used primarily in trauma settings to detect free fluid (such as blood) in the abdomen or Thorax. If clear lung fields on the chest radiography rule out pneumothorax or hemothorax, eFAST can help detect other sources of bleeding, such as intraperitoneal haemorrhage, to guide further management. It can be used to assess the hepatorenal, splenorenal, and pelvis spaces for fluid that is considered to be blood in a trauma case. Pelvic Cavity (Option A) can be assessed in e-FAST, but the question is about extrabdominal cavities assessed in e-FAST. Peripheral vessels (Option B) are not normally evaluated with e-FAST. Dural and subdural spaces (Option D) are assessed by neuroimaging but not by e-FAST.

References:

Bailey and Love’s Short Practice of Surgery, 28th Edition, Page 373

↑ *Back to this question in Part A*

@Neet_pg_bot

Q9: According to GCS, a verbal score of 1 indicates: (Q859598)

A. No Verbal response

B. Inappropriate words

C. Incomprehensible sounds

D. Oriented response

Correct Answer: A. No Verbal response

Explanation: A verbal score of 1 on the Glasgow Coma Scale (GCS) means no verbal response from the patient, indicating the most severe level of impairment in verbal communication. The Glasgow Coma Scale (GCS) is a tool used to assess a patient's level of consciousness based on three parameters: eye-opening , verbal response , and motor response . Each parameter is scored, and the total GCS score ranges from 3 (deep coma) to 15 (fully awake). Simplified Glasgow Coma Scale (GCS) Category Response Score Eye Opening (E) Spontaneous 4 To speech 3 To pain 2 None 1 Verbal Response (V) Oriented 5 (Option D ruled out) Confused conversation 4 Inappropriate words 3 (Option B ruled out) Incomprehensible sounds 2 (Option C ruled out) None 1 Motor Response (M) Obeys commands 6 Localizes to pain 5 Withdraws from pain 4 Abnormal flexion (decorticate) 3 Abnormal extension (decerebrate) 2 No response 1

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Pages 357, 361

↑ *Back to this question in Part A*

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Q10: Most common site of peripheral aneurysm? (Q859603)

A. Brachial artery

B. Popliteal artery

C. Radial artery

D. Femoral artery

Correct Answer: B. Popliteal artery

Explanation: The popliteal artery is the most common site for a peripheral aneurysm . Aneurysms in this location are more frequent due to the anatomical structure of the popliteal artery and its exposure to mechanical stress in the knee area. Popliteal artery aneurysms are often associated with degenerative changes in the arterial wall, such as atherosclerosis. These aneurysms can lead to the development of a pulsatile mass behind the knee and may increase the risk of complications such as thrombosis or embolism. Brachial artery (Option A) is located in the upper arm and is responsible for supplying blood to the arm. However, aneurysms in the brachial artery are not as common compared to other popliteal artery aneurysms. Radial artery (Option C) is located in the forearm and is a major artery responsible for supplying blood to the hand. While aneurysms can occur in the radial artery, they are rare compared to other sites. Femoral artery (Option D) aneurysms are uncommon compared to those in the popliteal artery but can still occur.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Pages 1005, 1017-1024.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q11: Which one of the following is absent in cases of massive blood transfusion? (Q859604)

A. DIC

B. Febrile transfusion reaction

C. Hypercalcemia

D. Thrombocytopenia

Correct Answer: C. Hypercalcemia

Explanation: Massive blood transfusion involves replacement of >1–1.5 blood volumes or >10 units of PRBCs. Complications arise due to dilutional effects, citrate toxicity, and stored blood changes. Citrate in stored blood binds calcium, leading to hypocalcemia, not hypercalcemia. Other metabolic disturbances include hypokalemia or hyperkalemia depending on storage. Hypercalcemia is not a feature of massive transfusion. Recognition is important to prevent mismanagement of electrolyte imbalances. Symptomatic hypocalcemia may require calcium supplementation during transfusion. Therefore, hypercalcemia is absent, while the other complications are common. Incorrect Options: Option A) DIC : Can occur due to consumption and dilution of clotting factors. Option B) Febrile transfusion reaction : Caused by recipient antibodies against donor leukocytes, common in massive transfusion. Option D) Thrombocytopenia : Results from dilution of platelets during large-volume transfusion.

References:

Harrison's Principles of Internal Medicine, 21st Edition, Pages 888 - 896,

Davidson's Principles and Practice of Medicine, 24th Edition, Pages 931 - 934,

NIHLink.

↑ *Back to this question in Part A*

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Q12: Which of the following statements about ranula is FALSE? (Q859629)

A. Mucus extravasation cyst

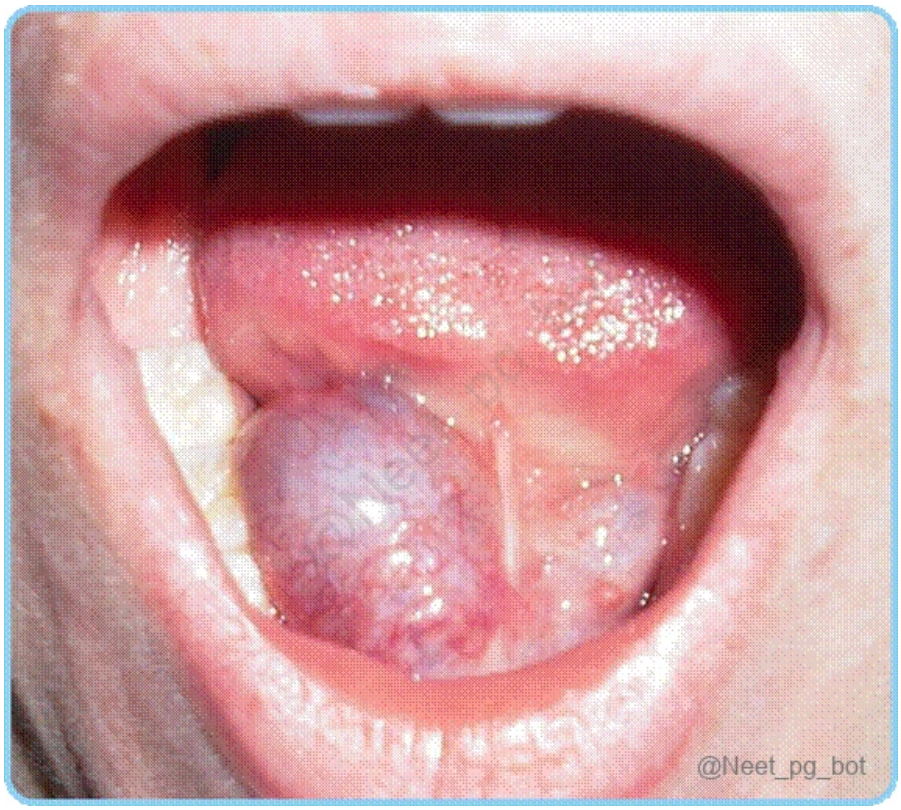
B. Arises from submandibular salivary gland

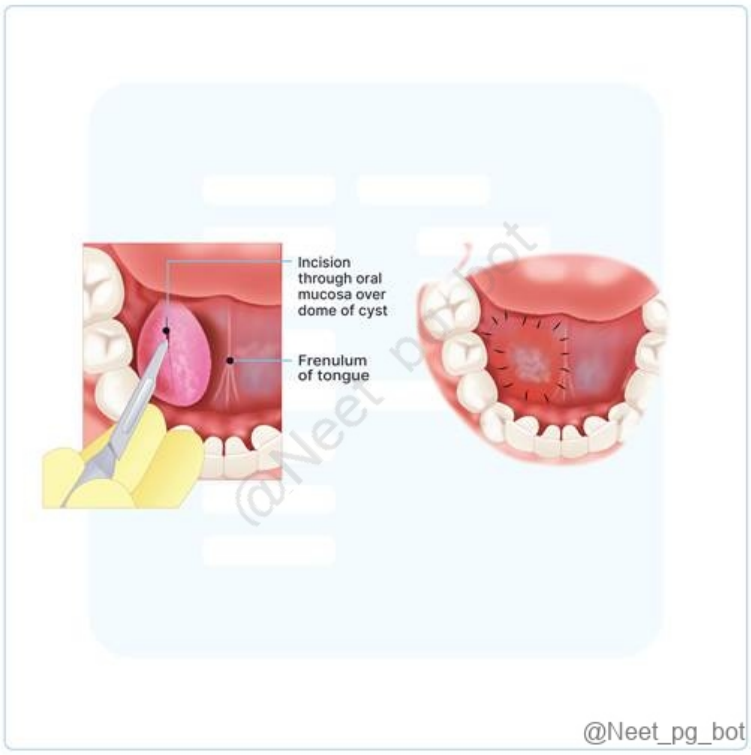
C. Bluish, translucent cystic swelling on the floor of the mouth

D. Marsupialization or excision is the treatment

Correct Answer: B. Arises from submandibular salivary gland

Explanation: A ranula is a mucus extravasation cyst, which most commonly arises from the sublingual salivary gland, not the submandibular salivary gland. Ranula Definition (Options A & C ruled out) Ranulas are a type of extravasation mucocele , caused by the rupture of the main duct or obstructed acini of the sublingual gland . They appear as bluish, translucent, cystic swelling on the floor of the mouth and resemble the belly of a frog. {{caption_text}} Location Commonly found in the anterior floor of the mouth. When it extends through the mylohyoid muscle, it presents as a submental swelling known as a "plunging ranula." Symptoms Typically soft, fluctuant, and painless unless infected. Diagnosis Confirmed through Magnetic Resonance Imaging (MRI) Ultrasound Aspiration of thick, sticky saliva differentiates it from a lymphangioma. Treatment (Option D ruled out) Excision of the sublingual gland is preferred. Incision, drainage, and marsupialisation have low success rates. Although marsupialisation is often adequate, it has a higher recurrence rate compared to sublingual gland excision. OK-432 injection Botulinum toxin injections {{caption_text}}





References:

Bailey and Love's Short Practice of Surgery, 28th Edition, Page 834

SRB's Manual of Surgery, 6th Edition, Page 357

↑ *Back to this question in Part A*

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Q13: What is the probable diagnosis for a patient who is taking steroids for psoriasis and is experiencing a low-grade fever only at night, weight loss, and an ulcer on her neck with undermined edges, as depicted in the provided image? (Q859630)

A. Psoriasis flare-up

B. Tubercular lymphadenitis

C. Lymphosarcoma

D. Syphilis



Correct Answer: B. Tubercular lymphadenitis

Explanation: The patient’s symptoms of night sweats, weight loss, and the ulcer with undermined edges indicate Tubercular lymphadenitis. It is a common manifestation of tuberculosis, especially in immunosuppressed patients, such as those taking steroids. Steroids can weaken the immune system, increasing susceptibility to infections like tuberculosis. Lymph Node TB (Tuberculous Lymphadenitis) Most common extrapulmonary TB presentation. Risk Groups HIV-positive individuals, Immunosuppressive individuals, children, and non-Caucasian women. Causative Organism Previously M. bovis; now mainly M. tuberculosis. Clinical Presentation Painless swelling in lymph nodes, usually posterior cervical or supraclavicular (historically called scrofula). Early disease: Discrete nodes Advanced disease: Matted, nontender mass, possible fistula draining caseous material. Pulmonary disease in <50% of cases. Systemic symptoms are uncommon except in HIV-positive patients. Non-specific reaction → Matting → Cold Abscess → Collar stud abscess → Sinus formation Diagnosis Fine-needle aspiration biopsy (80% yield) or surgical excision biopsy. Granulomatous lesions may or may not contain AFBs. Cultures are positive in 70–80% of cases. HIV-positive patients: Poorly organised or absent granulomas; higher bacterial loads increase diagnostic yield. Differential Diagnosis Infectious diseases Lymphomas Metastatic carcinomas Rare disorders: Kikuchi’s disease, Kimura’s disease, Castleman’s disease. Psoriasis flare-up (Option A) presents red, scaly patches on the skin and is unlikely to cause the ulcer and systemic symptoms described. {{caption_text}} Lymphosarcoma (Option C) can present with lymphadenopathy , but it doesn’t typically cause the characteristic ulcer with undermined edges seen in tubercular lymphadenitis. Syphilis (Option D) can cause ulcers (chancre) , but it doesn't typically present with the described systemic symptoms like night fever and weight loss in this context.



References:

Harrison’s Principles of Internal Medicine, 21st Edition, Page 1364

↑ *Back to this question in Part A*

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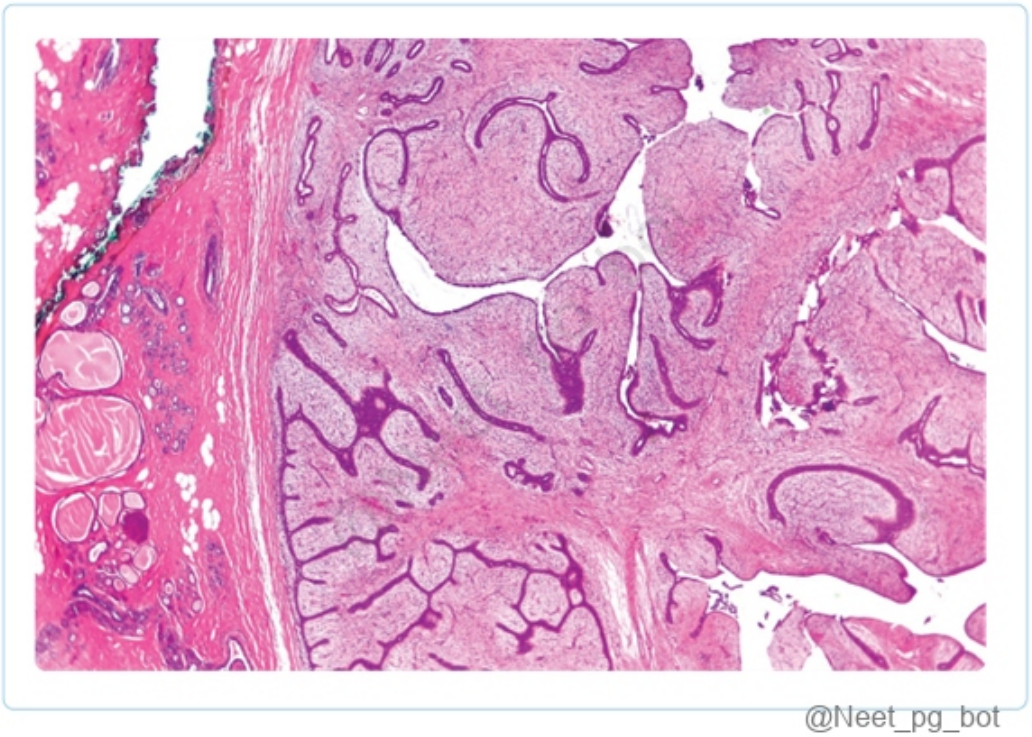
Q14: A 45-year-old woman comes to the OPD with a history of a lump in the left breast. On clinical examination, the size of the lump in the left breast is 9x10 cm with the following appearance and no axillary lymphadenopathy. The histopathology of the biopsy from the lump shows increased stromal cellularity and typical leaflike architecture. What is your likely diagnosis? (Q859852)

A. Phyllodes tumour

B. Giant fibroadenoma

C. Inflammatory carcinoma

D. Ductal carcinoma



Correct Answer: A. Phyllodes tumour

Explanation: The clinical features and HPE show increased stromal cellularity and overgrowth, giving rise to the typical leaf-like architecture, suggesting phyllodes tumour. Phyllodes tumours, also called cystosarcoma phyllodes, are stromal tumours developing from the breast's connective tissue. It occurs in middle-aged women (40 - 50 years). Most phyllodes tumours are benign (noncancerous) , but a small number (about 10% to 15%) can be borderline or malignant (cancerous). They present as a lump in the breast, which may be firm, smooth, and well-defined. It may also grow quickly from a few centimetres to massive lesions involving the entire breast. Phyllodes tumour is differentiated from fibroadenoma based on its overgrowth of stroma, increased mitotic activity and cellularity, and nuclear pleomorphism. (Option B ruled out) Inflammatory carcinoma (Option C) presents with redness, swelling, warmth, and often skin changes (such as peau d'orange). It also presents with more aggressive symptoms like axillary lymphadenopathy and is often accompanied by pain. Ductal carcinoma (Option D) usually presents with irregular masses , skin changes , and often axillary lymphadenopathy . Histologically, it is characterised by the proliferation of malignant epithelial cells in the ducts, not the stromal cellularity and leaflike pattern seen in phyllodes tumours.

References:

Robbins & Cotran Pathologic Basis of Disease, 10th Edition, Pages 1062 - 1063

↑ *Back to this question in Part A*

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Q15: What is the diagnosis from the given abdominal x-ray? (Q859880)

A. Ureterocoele

B. Pelvic bone fracture

C. Rectal foreign body

D. Bladder stone



Correct Answer: C. Rectal foreign body

Explanation: The correct diagnosis based on the abdominal x-ray given is a rectal foreign body. It refers to an object that has been accidentally or intentionally inserted into the rectum and is typically visible on abdominal X-rays . These are serious injuries and generally require surgical intervention. Temporary colostomy may be necessary for recovery. There's a risk of developing necrotising fasciitis , so broad-spectrum antibiotics are crucial. Bladder or urethral damage can also be associated with these injuries. Ureterocoele (Option A) is a congenital dilation of the distal ureter that occurs at the ureterovesical junction . It is usually identified on IVU with a "cobra head" appearance, which is a hallmark of a ureterocele, but it would not be visible as a foreign object in the rectal area on an abdominal x-ray. Pelvic bone fracture (Option B) would be visible on an x-ray, but it would involve fractures of the pelvic bones but not a foreign body in the rectum. Bladder stone (Option D) would be visible on an abdominal x-ray as a radio-opaque mass in the bladder, but the given image is suggestive of a rectal foreign body.

References:

Bailey and Love's Short Practice of Surgery, 28th Edition, Page 1396

↑ *Back to this question in Part A*

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Q16: Which of the following is not a component of TNM stage T4b breast cancer? (Q865312)

A. Ulceration

B. Peau d'orange

C. Inflammatory carcinoma

D. Ipsilateral macroscopic satellite nodules

Correct Answer: C. Inflammatory carcinoma

Explanation: Inflammatory carcinoma is classified separately as T4d in the TNM staging, but not stage T4b. TNM staging for breast cancer Stage Description Tumor size (T) TX Primary tumor cannot be assessed T0 No evidence of primary tumor Tis Carcinoma in situ (DCIS, LCIS, or Paget's disease) T1 Tumor ≤ 2 cm T1mi Tumor ≤ 1 mm T1a Tumor > 1 mm but ≤ 5 mm T1b Tumor > 5 mm but ≤ 10 mm T1c Tumor > 10 mm but ≤ 20 mm T2 Tumor > 2 cm but ≤ 5 cm T3 Tumor > 5 cm T4 Tumor of any size with direct extension to chest wall or skin T4a Extension to chest wall T4b Ulceration or skin nodules (Option A, B & D) T4c Both T4a and T4b T4d Inflammatory breast cancer (Option C) Node (N) NX Regional lymph nodes cannot be assessed N0 No regional lymph node metastasis N1 Metastases to movable ipsilateral level I, II axillary lymph nodes N2 Metastasis to axillary lymph nodes or clinically apparent internal mammary nodes N2a Metastasis to axillary lymph nodes that are clinically fixed or matted N2b Metastasis to internal mammary nodes without axillary lymph node involvement N3 Metastasis to axillary lymph nodes or infraclavicular nodes, or to supraclavicular nodes N3a Metastasis to infraclavicular nodes N3b Metastasis to internal mammary nodes N3c Metastasis to supraclavicular nodes Metastasis (M) MX Distant metastasis cannot be assessed M0 No distant metastasis M1 Distant metastasis present Stage Grouping Stage 0: Tis N0 M0 Stage IA: T1/T1mi N0 M0 Stage IB: T0 N1mi M0; T1/T1mi N1mi M0 Stage IIA: T0 N1 M0; T1 N1 M0; T2 N0 M0 Stage IIB: T2 N1 M0; T3 N0 M0 Stage IIIA: T0 N2 M0; T1 N2 M0; T2 N2 M0; T3 N1 M0 Stage IIIB: T3 N2 M0 Stage IIIC: T4 N0 M0; T4 N1 M0; T4 N2 M0; Any T N3 M0 Stage IV: Any T Any N M1

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 934.

Sabiston Textbook of Surgery, 21st Edition, Page 833.

SRB's Manual of Surgery, 6th Edition, Page 532

↑ *Back to this question in Part A*

@Neet_pg_bot

Q17: A patient presents with a breast lump, and imaging (X-ray mammography) along with histopathology confirms a diagnosis of breast cancer. She has a family history of breast cancer involving two relatives and has a 29-year-old daughter. Which gene should be tested to assess hereditary breast cancer risk in this patient? (Q865316)

A. BRCA1

B. TP53

C. BRCA2

D. STK11

Correct Answer: A. BRCA1

Explanation: Women with BRCA1 mutations and a family history of breast cancer have a higher lifetime risk of developing breast cancer compared to those with BRCA2 mutations. BRCA1 mutations are associated with high-grade, triple-negative breast cancers and increased risks of colon and prostate cancers. Mutations seen in Breast Cancer High penetrance mutations (>4-fold risk, 3-7% of breast cancers) Gene % of single-cell cancers Associated tumours BRCA1 (Option A) 55% Breast, ovarian (~20%–40%), fallopian tube, pancreas, and prostate. BRCA2 (Option C) 35% Breast, ovarian (~10%–20%), pancreas, and prostate. Associated with male breast cancer. TP53 (Option B) <1% Breast, sarcoma, leukaemia, and brain tumours. PTEN Breast, thyroid, and endometrium. STK11 (Option D) Breast, ovarian, colon, and pancreas. CDH1 (Option C) Breast, gastric signet ring cell carcinoma, and colon. PALPB2 Breast, pancreas, and prostate. Moderate penetrance germline mutations (2- to 4-fold increased risk; 5-10% of breast cancers) ATM 5% CHEK2 (Option D) Prostate, thyroid, colon, and kidney.

References:

Robbins Pathology, 10th edition , 10th Edition, Page 1049

↑ *Back to this question in Part A*

@Neet_pg_bot

Q18: A 65-year-old patient is on mechanical ventilation for acute respiratory distress syndrome (ARDS). Suddenly, the patient becomes hypotensive, tachycardic, and shows absent breath sounds on the left side with tracheal deviation to the right. What is the most common cause of this in patients receiving mechanical ventilation? (Q865348)

A. High tidal volume

B. Barotrauma due to high airway pressure

C. Endotracheal tube malposition

D. Oxygen toxicity

Correct Answer: B. Barotrauma due to high airway pressure

Explanation: Patients with ARDS often require high airway pressures during mechanical ventilation to maintain oxygenation. This increases the risk of barotrauma , leads to alveolar rupture and air leakage into extra-alveolar spaces , causing complications such as pneumothorax, pneumomediastinum , or subcutaneous emphysema . Ventilator factors that increase the risk: High plateau pressure (>30–35 cm H■O) High peak inspiratory pressures High tidal volumes Auto-PEEP from inadequate exhalation Prevention: Plateau pressure is limited to ≤30 cm H■O to minimize the risk of barotrauma and pneumothorax. High tidal volume (Option A) can contribute to barotrauma but they are not the direct cause of sudden hemodynamic collapse and tracheal deviation. Endotracheal tube malposition (Option C) usually leads to unilateral ventilation (e.g., right main bronchus intubation), causing decreased breath sounds on the left but it does not explain the tracheal shift or hemodynamic instability. Oxygen toxicity (Option D) develops gradually over prolonged exposure to high FiO■ in ARDS. It does not cause sudden collapse or tracheal deviation.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q19: A 40-year-old male presents to the emergency department with severe respiratory distress, BP: 70/59 mmHg, tracheal deviation to the right, distended neck veins, and absent breath sounds on the left side. These findings are suggestive of a tension pneumothorax. What is the most appropriate immediate next step in management? (Q865354)

A. Perform needle thoracostomy immediately

B. CT Chest

C. Airway, breathing, and circulation (ABC) assessment

D. Chest tube insertion

Correct Answer: A. Perform needle thoracostomy immediately

Explanation: This patient has classic signs of a tension pneumothorax - severe respiratory distress, tracheal deviation to the opposite side, distended neck veins, absent breath sounds on one side, and hypotension. This is a life-threatening emergency that requires immediate decompression by needle thoracostomy , even before imaging or confirmation. Procedure: Insert a wide-bore (14–16 gauge) needle Site: 2nd intercostal space, midclavicular line , on the affected side This releases trapped air, converting the tension pneumothorax into a simple pneumothorax

and rapidly restoring venous return. CT Chest (Option B): Imaging wastes critical time; diagnosis is clinical . ABC assessment (Option C): Already implied - once tension pneumothorax is identified, decompression is the airway–breathing management step. Chest tube insertion (Option D): Definitive treatment, but performed after needle decompression. Attempting it first delays lifesaving decompression.

References:

Sabiston's principles of surgery, 21st Edition, Page 391, 392

↑ *Back to this question in Part A*

@Neet_pg_bot

Q20: All of the following is a contraindication to Breast Conservation surgery except ? (Q865393)

A. Previous history of radiation to the chest

B. Tumor involving single quadrant

C. Scleroderma

D. Persistent positive margins even after resection

Correct Answer: B. Tumor involving single quadrant

Explanation: Breast conservation surgery (BCS), also known as lumpectomy or wide local excision (WLE), is contraindicated in certain conditions where it may compromise oncological safety or cosmetic outcomes. BCS is feasible if the tumor is confined to a single quadrant and is aimed at removing the tumour along with a 1-cm margin of normal breast tissue. All patients with BCS receive radiotherapy. BCS together with radiotherapy is called breast conservation therapy (BCT): BCS + RT = BCT BCS is avoided in patients with: Multicentric tumour Diffuse microcalcifications on a mammogram Large tumour-to-breast ratio Two times positive surgical margins after re-excision History of previous breast or chest wall radiation Systemic lupus erythematosus or other collagen vascular disease (these patients have a high risk of a radiation reaction), or ankylosing spondylitis Severe orthopnea (as the patient cannot lie on the radiation table) Previous history of radiation to the chest (Option A) Prior radiation to the chest (e.g., for Hodgkin's lymphoma) increases the risk of radiation-induced toxicity and poor wound healing, making BCS unsafe. Scleroderma (Option C) Scleroderma (a connective tissue disorder) impairs wound healing and increases radiation toxicity, making BCS + radiotherapy risky. Persistent positive margins even after resection (Option D) Patients with involved margins will have to undergo a revision of margins called a 'cavity shave'.

References:

Sabiston Textbook of Surgery, 21st Edition, Page 853.

Bailey & Love's Short Practice of Surgery, 28th edition, Pages 935.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q21: Which among the following are incorrect about tension pneumothorax? Occurs due to improper dressing of open wound Blunt trauma with simple pneumothorax can never convert to tension pneumothorax Most common cause is due to positive pressure in mechanical ventilation Can be caused due to spinal injury (Q865398)

A. 1, 4

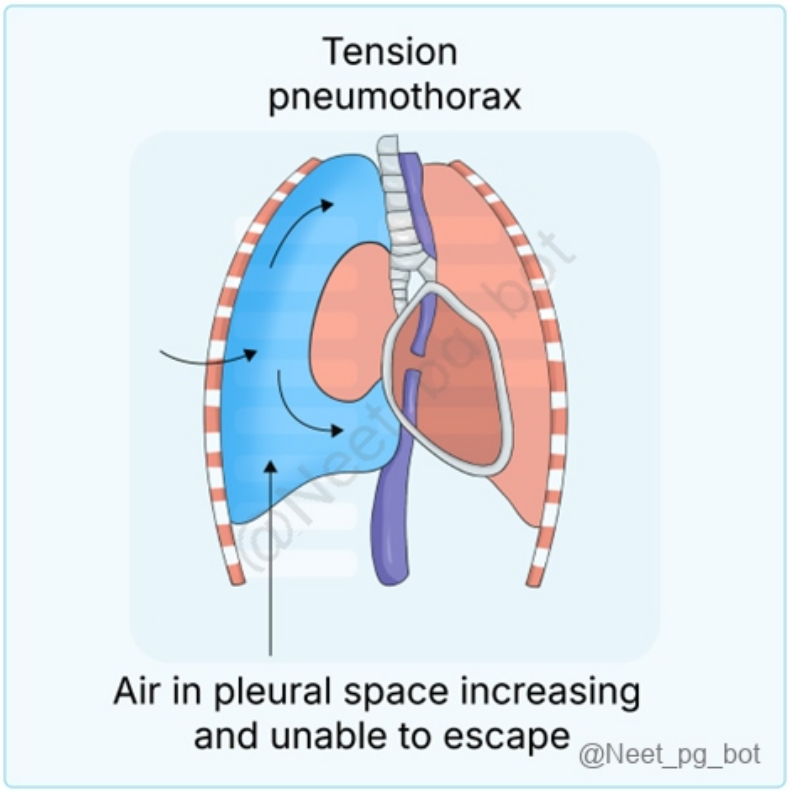
B. 2,3,4

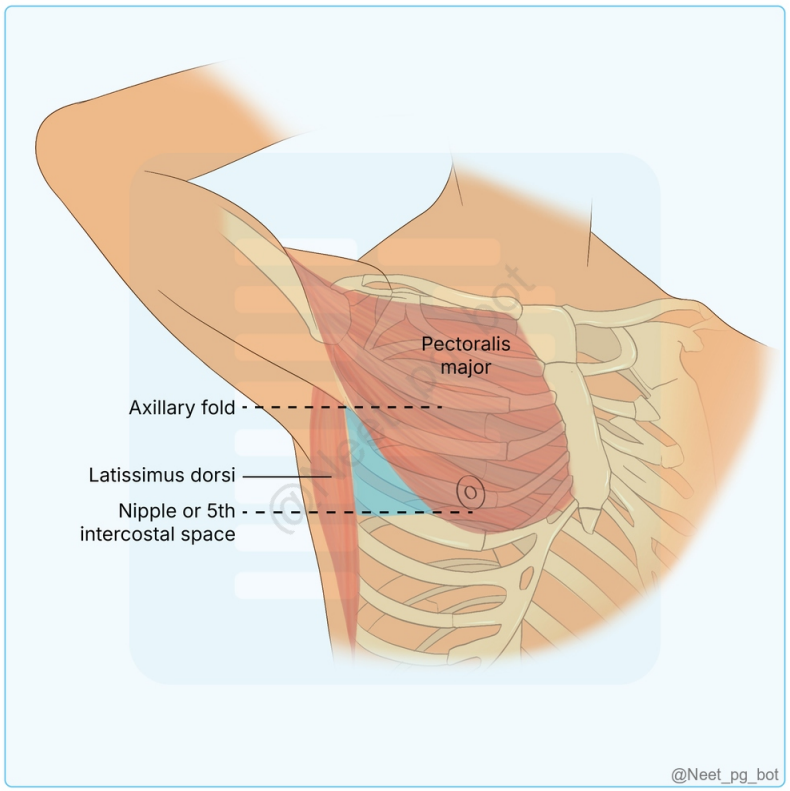
C. 1,2,4

D. 2,3

Correct Answer: D. 2,3

Explanation: Statements 2 and 3 are incorrect while 1 and 4 are correct. A tension pneumothorax develops when a ‘one-way valve’ air leak occurs either from the lung or through the chest wall. Open (sucking) chest wounds can act as a one-way valve when improperly dressed. Air enters during inspiration but cannot exit during expiration, causing a valve mechanism , leading to tension pneumothorax . (Statement 1) High cervical spinal injuries may result in diaphragmatic paralysis or respiratory failure, predisposing to pneumothorax due to barotrauma from mechanical ventilation or reduced clearance. Though indirect, spinal injury can be associated with tension pneumothorax. (Statement 4) TENSION PNEUMOTHORAX Pathophysiology D/t ‘one-way valve’ air leaks from the lung or chest wall. Air is sucked into the thoracic cavity without any escape, collapsing and compressing the affected lung. The mediastinum shifts to the opposite side, reducing venous return and compressing the opposite lung, leading to decreased cardiac output and function. This can result in sudden death. Causes Penetrating Chest Trauma. Blunt Chest Trauma with parenchymal lung injury and persistent air leak. (Statement 2) Iatrogenic Lung Injury (e.g., central venepuncture) Mechanical Positive-Pressure Ventilation. (Statement 3) Clinical Features Tachypnea and Tachycardia Hyper-resonance and Decreased/Absent Breath Sounds Resonant Percussion with severe mediastinal/tracheal shift Cyanosis and Hypotension Chest Pain Distended Neck Veins Emergency Management Tension pneumothorax is a clinical diagnosis, and treatment should never be delayed by waiting for radiological confirmation. Immediate Thoracocentesis (needle): Wide bore needle (typically a 20- or 22-gauge) in the 5th intercostal space in the safety triangle. Decompression should be performed in the "safe triangle." Safe Triangle Boundaries : Posterior: Latissimus dorsi Anterior: Lateral border of the pectoralis major Inferior: A line drawn perpendicularly from the nipple to the back, just anterior to the mid-axillary line. In critical situations, a finger thoracostomy can be done in the same location. Nasal Oxygen for support. Intercostal Tube Placement (ICT) once stable and confirmed by chest X-ray. Additional Care Antibiotics and analgesics for treatment. Ventilator Support with IPPV in severe cases.





References:

Bailey and Love Surgery, 28th edition. Pg. 374

Sabiston Textbook of Surgery, 21st edition, Pg. 404, 405, 1632

Tension Pneumothorax - StatPearls - NCBI Bookshelf.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q22: A 35-year-old male sustained a head injury following a motorcycle accident. He experienced a brief loss of consciousness at the scene. Upon regaining consciousness, he developed a severe headache and began to feel drowsy. A CT scan of the head is performed. Which of the following should be the management for this patient? (Q840033)

A. Anticoagulants

B. Immediate surgical decompression

C. Observation in ICU

D. Mannitol administration



Correct Answer: B. Immediate surgical decompression

Explanation: Correct Option B - Immediate surgical decompression: The above CT scan shows Biconvex or lenticular or lens shaped hyperdense lesion which is characteristic of Extradural hemorrhage. Patient complains of severe headache and drowsiness. Delaying treatment can lead to increase in ICP which can cause uncal herniation and 3rd nerve palsy. This patient requires immediate surgical decompression by Burr hole or craniotomy. Incorrect Options: Option A - Anticoagulants: Anticoagulants are not used in the treatment as it increases the risk of bleeding or exacerbate the current bleeding. Option C - Observation in ICU: Observation in ICU is not recommended as the patient already exhibits lucid interval and delaying surgery can lead to increased ICP. Option D - Mannitol administration: Mannitol administration is contraindicated in EDH as it increases the mass of the lesion due to water loss.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q23: Which of the following is not done in the primary survey of trauma? (Q840042)

A. NCCT head

B. CXR

C. Intubation

D. ICD drainage

Correct Answer: A. NCCT head

Explanation: Correct Option A - NCCT head: NCCT head is not an adjunct of primary survey in trauma cases. NCCT head is only done after stabilizing the patient as part of tertiary survey, which includes comprehensive evaluation of the patient by physical examination, radiographic imaging. Incorrect Options: Option B - CXR: Chest X-rays is an adjunct of primary survey and it is performed to rule out thoracic blood loss (to rule out hemothorax, pneumothorax, and perforation peritonitis). Option C - Intubation: Endotracheal intubation is performed in case of limited respiratory efforts or dyspnea or low GCS. Option D - ICD drainage: ICD drainage is performed in cases of massive hemothorax, tension pneumothorax and it is an adjunct of primary survey.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q24: Mount fuji sign on CT is seen in which of the following? (Q840051)

A. Pneumocephalus

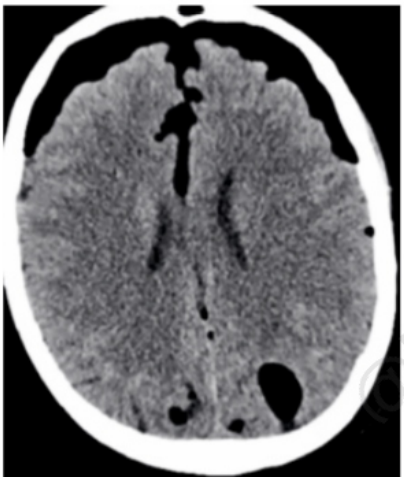
B. Pneumoperitoneum

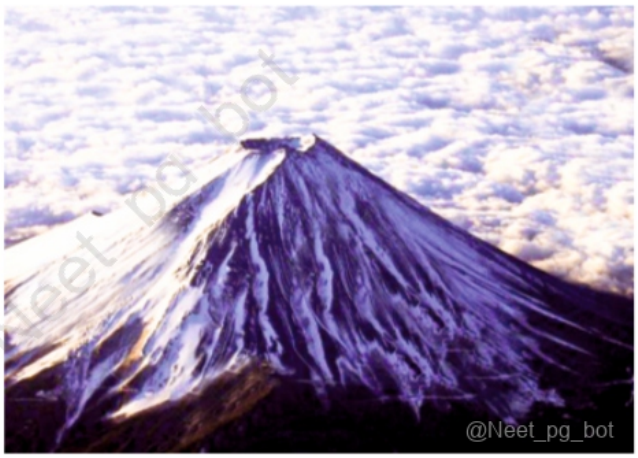
C. Pneumomediastinum

D. Pneumothorax

Correct Answer: A. Pneumocephalus

Explanation: Correct Option A - Pneumocephalus: Mount Fuji sign is seen in tension pneumocephalus. The black area in the T represents air, that is collection of air in the frontal region. Incorrect Options: Option B - Pneumoperitoneum: Pneumoperitoneum on CT shows gas anteriorly and gas in the bowel loops. Option C - Pneumomediastinum: Pneumomediastinum could show ring around artery sign, continuous diaphragm sign, extrapleural sign, and Naclerio V sign. Option D - Pneumothorax: Pneumothorax shows gas around the edges of the lung.





↑ *Back to this question in Part A*

@Neet_pg_bot

Q25: During a complicated delivery, a mother died. Which of the following is the most common Direct cause of maternal death? (Q820108)

A. Embolism

B. Heart Disease

C. Hemorrhage

D. Anemia

Correct Answer: C. Hemorrhage

Explanation: Correct Option C - Hemorrhage Hemorrhage, is the most common Direct cause of maternal death during complicated delivery Incorrect Options: Option A - Embolism: An embolism refers to the sudden blockage

of a blood vessel by a clot (embolus), which can potentially lead to serious complications. Pulmonary embolism, where a blood clot travels to the lungs, is a known cause of maternal mortality. It can occur during pregnancy, childbirth, or the postpartum period. An embolism can obstruct blood flow and lead to respiratory distress, shock, and even death. While embolism can be a cause of maternal death, but is not the most common direct cause. Option B - Heart Disease: Pre-existing heart disease in a pregnant woman can increase the risk of complications during childbirth. Cardiac events, such as heart failure, myocardial infarction (heart attack), or arrhythmias, can contribute to maternal death. However, but is not the most common direct cause. Option D - Anemia: Anemia is most common indirect cause of death.

References:

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↑ *Back to this question in Part A*

@Neet_pg_bot

Q26: Which fluid is administered most commonly during intraoperative blood loss? (Q820149)

A. Isolyte P

B. Crystalloids

C. Blood

D. Colloids

Correct Answer: B. Crystalloids

Explanation: Correct option B - Crystalloids: Crystalloids are the most commonly administered fluid for intraoperative fluid administration, especially in minor surgical procedures. Crystalloids are cost-effective, readily available, and generally safe. Incorrect options: Option A, C and D are incorrect.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q27: A 39-year-old female presented in the OPD with bloody discharge from the nipple . On examination, it was found to be from a single lactiferous duct . What is the treatment for bloody nipple discharge with single duct involvement? (Q820183)

A. Microdochectomy

B. Hadfield’s procedure

C. Microdiscectomy

D. IV antibiotics + Incision

Correct Answer: A. Microdochectomy

Explanation: Correct option A - Microdochectomy Microdochectomy involves the surgical removal of the affected lactiferous duct. It is the treatment of choice for cases of bloody nipple discharge originating from a single duct. Incorrect options: Option B - Hadfield’s procedure : Hadfield's procedure is an obsolete surgical procedure used in the past for the treatment of mammary duct ectasia. It is not used for bloody nipple discharge from a single duct. Option C - Microdiscectomy: Microdiscectomy is a surgical procedure used to treat herniated spinal discs that are pressing on nerves. Option D - IV antibiotics + Incision: It is considered in cases of infection-related symptoms or abscesses in the breast and is not the primary treatment for bloody nipple discharge with single duct involvement.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q28: Which of the following is not correct for the device depicted below: (Q820185)

A. Based on infrared emitted from RBCs

B. Localizes calcified plaque

C. Checks blood flow

D. Checks thickness of artery and vein



Correct Answer: A. Based on infrared emitted from RBCs

Explanation: Correct option A - Based on infrared emitted from RBCs: The device depicted is a Doppler ultrasound machine, which uses sound waves and not infrared emitted from RBCs, to create images of blood flow. Doppler ultrasound works by measuring the frequency shift of sound waves reflected off moving red blood cells. This shift in frequency, known as the Doppler effect, helps in visualizing blood flow direction and velocity. Incorrect options: Option B - Localizes calcified plaque: Doppler ultrasound can identify areas of calcified plaque within blood vessels. However, it might not provide as detailed information about the plaque compared to other imaging techniques like CT scans or angiography. Option C - Checks blood flow : Doppler ultrasound is primarily used for assessing blood flow and vascular conditions. Option D - Checks thickness of artery and vein: Doppler ultrasound can be used to measure the thickness of arteries and veins, as well as assess their overall structure and condition. It is particularly useful for evaluating conditions like atherosclerosis, where arteries might become thicker due to plaque buildup.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q29: Which of the following is a complication usually associated with the procedure shown in the image below? (Q854753)

A. Aspiration

B. Torticollis

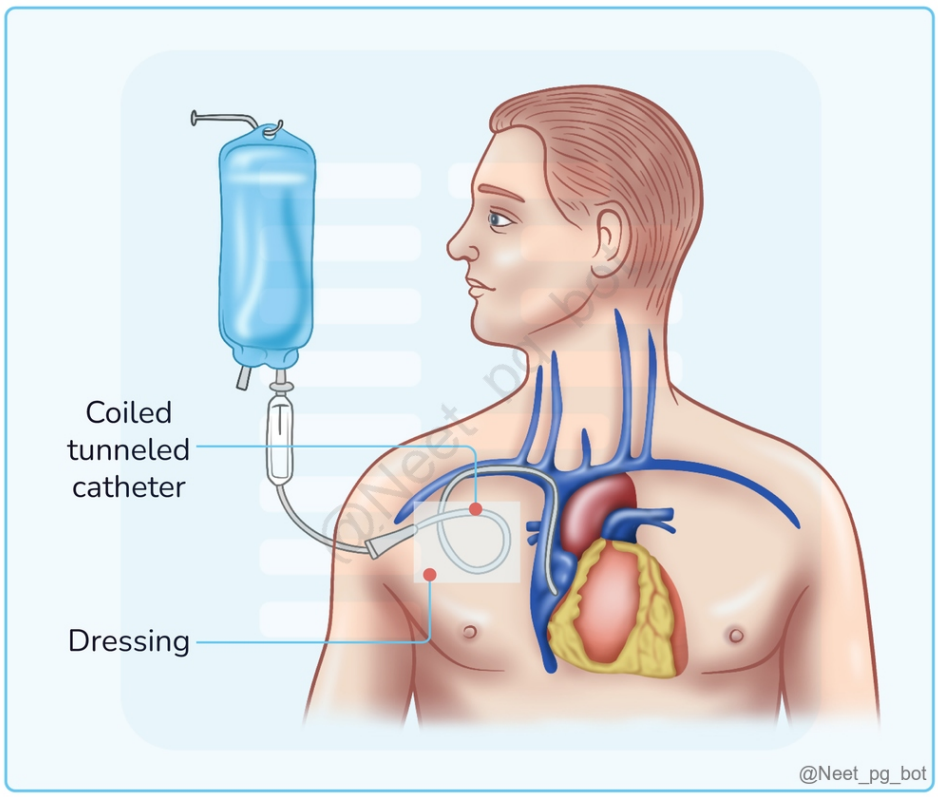
C. Pneumothorax

D. Recurrent laryngeal nerve paralysis



Correct Answer: C. Pneumothorax

Explanation: The procedure shown in the image is central line placement. A potential complication of this procedure is pneumothorax , which occurs when air enters the pleural space, leading to the partial or complete collapse of the lung. This can happen when the central line needle or catheter is inserted into the subclavian or jugular veins. The central venous catheter is used for fluid, medication, and nutrition administration. The tip is located in the superior vena cava. Order of preference: Subclavian vein > Internal jugular vein > Femoral vein Inside OT: Internal jugular vein Outside OT: Subclavian vein. Complications: Catheter-related sepsis, pneumothorax. Incorrect Options: Aspiration (Option A) involves inhaling stomach contents or foreign material into the lungs. Although it can occur in various clinical situations, it is not typically associated with central line placement. Torticollis (Option B) , or wry neck, is a condition where the neck muscles involuntarily contract, causing the neck to twist to one side. This is not a complication directly related to central line placement. Recurrent laryngeal nerve paralysis (Option D) is a complication typically associated with surgeries or procedures involving the neck or chest, such as thyroid or thoracic surgery. It is not commonly linked to central line placement.



References:

https://www.ncbi.nlm.nih.gov/books/NBK557798/

↑ *Back to this question in Part A*

@Neet_pg_bot

Q30: Among the options provided, which one is NOT acknowledged as a potential complication resulting from a significant blood transfusion? (Q854760)

A. Hypocalcemia

B. Hypokalemia

C. Hypothermia

D. Hypernatremia

Correct Answer: D. Hypernatremia

Explanation: Hypernatremia is not typically a complication of blood transfusion. Complications of massive blood transfusion: Hypocalcemia : (Option A) Packed red blood cells (PRBCs) and other blood products are preserved

with citrate , an anticoagulant. Citrate binds to ionised calcium (Ca^{2}■) in the recipient's blood, reducing the free calcium level - hypocalcemia. Presents as muscle spasms, cardiac arrhythmias, and decreased myocardial contractility. Metabolic Alkalosis : Citrate is metabolised in the liver to bicarbonate (HCO■■) . Rapid transfusion of citrate-containing blood products can overwhelm the liver’s ability to metabolise citrate, leading to an increase in bicarbonate levels. This results in metabolic alkalosis Hyperkalemia : Stored blood undergoes hemolysis over time, releasing potassium from red blood cells into the plasma. Transfusion of large volumes of stored blood can introduce a significant potassium load, causing hyperkalemia . Presents with cardiac arrhythmias, especially in patients with pre-existing kidney dysfunction. Hypothermia : (Option C) Rapid transfusion of cold-stored blood products (typically kept at 1–6°C) can lower the patient’s core body temperature. Coagulopathy : Massive transfusion dilutes clotting factors and platelets, leading to dilutional coagulopathy . Hypothermia and hypocalcemia exacerbate this by impairing the function of coagulation enzymes and platelets. Hypokalemia : (Option B) Post-transfusion, potassium that had leaked out of stored red blood cells can re-enter the cells in vivo. This shift can lead to hypokalemia , especially if the patient has a strong cellular uptake of potassium.

References:

Harmening, D. M. (2012). Modern Blood Banking & Transfusion Practices, 6th Edition.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q31: What is the minimum platelet count necessary for most surgical procedures? (Q854782)

A. 20,000 (10^9/L)

B. 30,000 (10^9/L)

C. 40,000 (10^9/L)

D. 50,000 (10^9/L)

Correct Answer: D. 50,000 (10^9/L)

Explanation: A platelet count of at least 50,000 (10^9/L) is generally considered the minimum for performing most surgical procedures safely, as it helps minimise the risk of bleeding. National Institute for Health and Care Excellence (NICE) Guidelines (2015): For invasive procedures or surgery: Platelet counts should be increased above 50,000/µL. For patients at high risk of bleeding: A platelet count of 50,000-75,000/µL is considered appropriate. For surgery at critical sites: A platelet count of > 100,000/µL is recommended.

References:

https://pmc.ncbi.nlm.nih.gov/articles/PMC9988645/

↑ *Back to this question in Part A*

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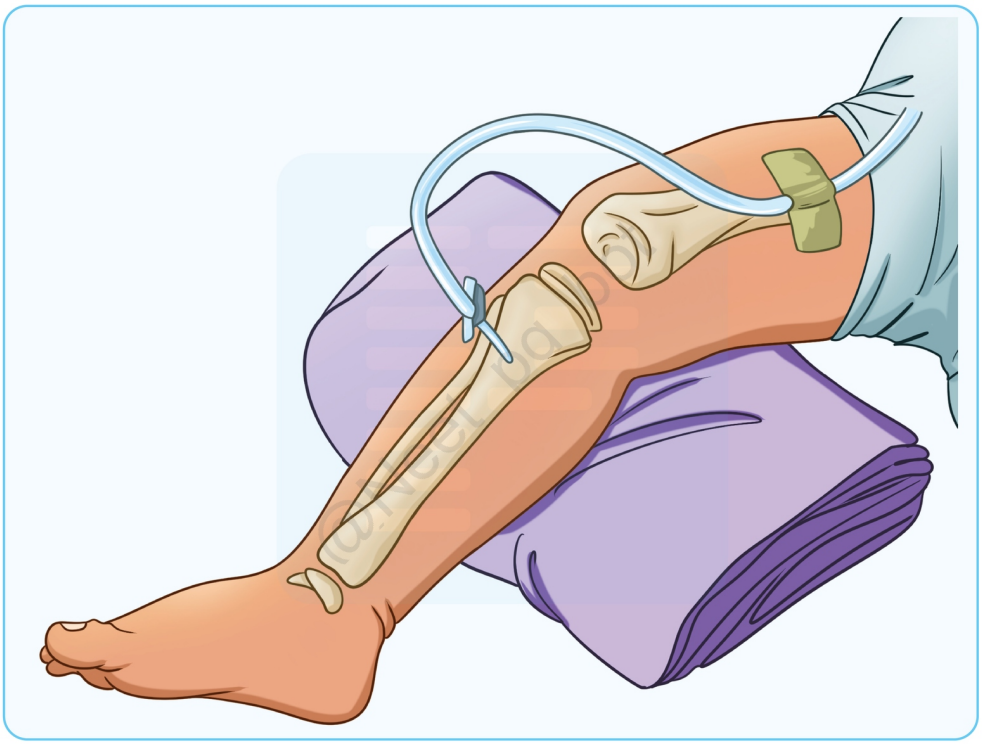
Q32: Identify the procedure being performed in the image given below. (Q855166)

A. Intraosseous cannula for pain relief

B. Bone marrow aspiration

C. Intraosseous route access for giving IV fluids

D. Bone marrow biopsy



Correct Answer: C. Intraosseous route access for giving IV fluids

Explanation: The image likely depicts a procedure for establishing an intraosseous route to administer IV fluids. This technique is commonly used when IV access is difficult or not possible. Intraosseous infusion (IO) involves injecting drugs, fluids, or blood products directly into the medullary cavity of the bone, providing a non-collapsible entry point into the systemic venous system. IO route is an alternative to the IV route in the transfusion of fluids in shock. The marrow of long bones has a rich network of vessels that drain into the central venous canal, emissary veins, and ultimately to central circulation. So, bone marrow functions as a non-collapsible venous access route. Intraosseous cannulation: Intraosseous cannulation is a widely accepted technique for both children and adults. The EZ-IO® system is commonly used in the UK. A hand-held electric drill is used to insert a cannula through the tibia or humeral head into the marrow cavity. The response time for drug administration is similar to intravenous (IV) access. Entire resuscitations , including anaesthetic drugs and fluids, can be performed

through intraosseous cannulae. Due to resistance to flow , fluids should be given as boluses using a 50 mL syringe . Other options: Option A: Intraosseous cannula for pain relief IO access is not used for analgesia. It is used only for emergency vascular access. Option B: Bone marrow aspiration This is done with a different needle, usually at the iliac crest, and not used for administering fluids. Option D: Bone marrow biopsy This is a therapeutic/diagnostic procedure for hematologic evaluation, not for vascular access or resuscitation.

References:

Apley and Solomon’s System of Orthopaedics and Trauma, 10th Edition, Page 682

↑ *Back to this question in Part A*

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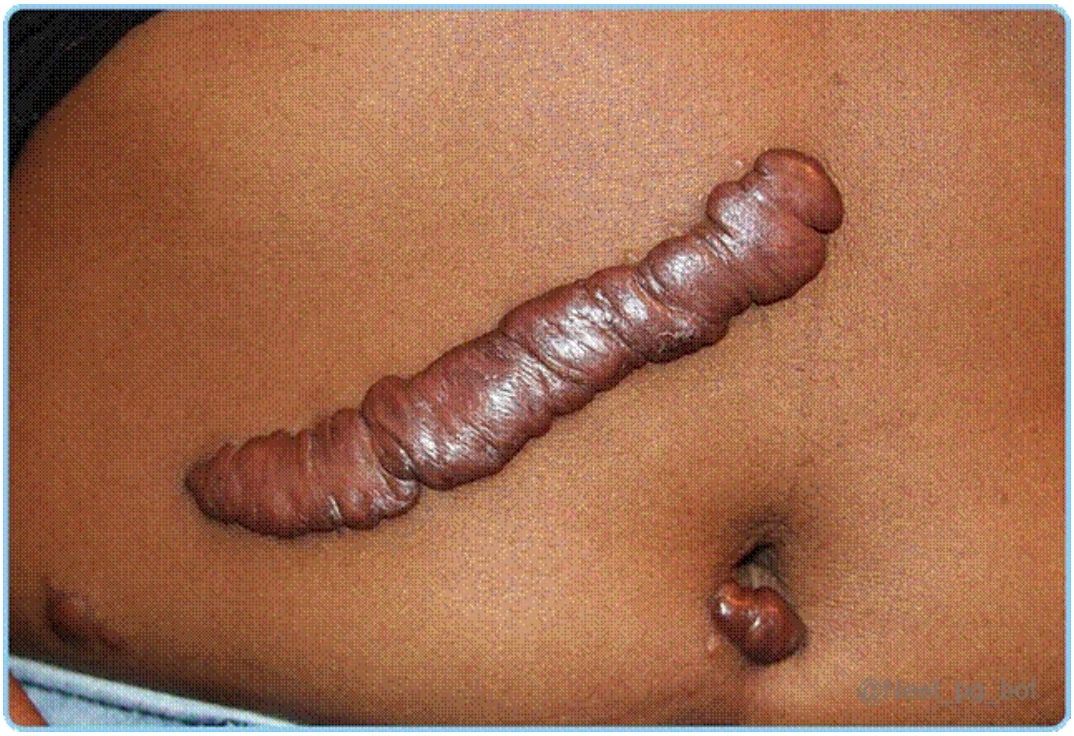
Q33: A patient presents to the clinic with a lesion as shown in the image. He had a traumatic injury to the chest one year ago, and the scar has grown beyond the boundary of the initial injury. What is the most likely diagnosis? (Q855177)

A. Hemangioma

B. Hypertrophic scar

C. Keloid

D. Neurofibroma



Correct Answer: C. Keloid

Explanation: Keloid: The lesion described is most consistent with a keloid that is characterised by the excessive growth of scar tissue beyond the boundaries of the original injury, and it often develops after trauma or surgery. They are known for being raised, thick, and sometimes itchy. Doesn't regress. More common among African Americans. Develops after deep dermal injuries. {{caption_text}} Hemangiomas (Option A) are benign tumours of blood vessels, usually present at birth or appearing in early childhood. They do not develop as a result of trauma. Hypertrophic scar: (Option B) {{caption_text}} Confined to the original wound boundaries, unlike keloids that extend beyond the wound area. Raised scar with excess collagen. It grows rapidly and contains myofibroblasts. It tends to regress over time (months) and recur less compared to keloid Neurofibromas (Option D) are benign nerve sheath tumours, commonly associated with genetic conditions like neurofibromatosis rather than trauma.





References:

Robbins & Cotran Pathologic Basis of Disease, 10th Edition, Page 110,111

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 28

↑ *Back to this question in Part A*

@Neet_pg_bot

Q34: A young patient presents with a 5-day fever history and signs of hypotension, tachycardia, tachypnea, and altered mental status. Lab results show elevated white blood cell count, neutrophil proportion, and serum creatinine. The intern doctor plans to assess the quick Sequential Organ Failure Assessment (qSOFA) score for prognosis prediction and hospitalisation duration. Which elements are part of the qSOFA score? (Q855275)

A. BP, RR, and CBC

B. Creatinine, PR, and BP

C. RR, Body temperature, and PR

D. SBP, RR, and GCS score

Correct Answer: D. SBP, RR, and GCS score

Explanation: The qSOFA score includes three components: Systolic Blood Pressure (SBP) less than 100 mmHg Respiratory Rate (RR) greater than or equal to 22 breaths per minute Glasgow Coma Scale (GCS) score. These components help in the assessment of organ failure and sepsis prognosis. Sepsis & q SOFA: Sepsis is now defined as an increase of 2 or more points in the Sequential Organ Failure Assessment (SOFA) score from baseline. However, calculating the full SOFA score can be complex and requires lab results, so a simpler tool, the quick SOFA (qSOFA) score, was introduced for bedside use. qSOFA Criteria: qSOFA involves evaluating three key signs: Respiratory rate ≥ 22 breaths per minute Altered mental status (GCS score) Systolic blood pressure ≤ 100 mmHg (hypotension) If a patient meets at least 2 of the 3 qSOFA criteria and is at risk for sepsis (e.g., has an infection), further evaluation should be conducted to identify the source of infection and initiate appropriate treatment.

References:

Sabiston Textbook of Surgery, 21st Edition, Page 62, 63

↑ *Back to this question in Part A*

@Neet_pg_bot

Q35: Which class of hypovolemic shock, according to Advanced Trauma Life Support (ATLS) guidelines, is characterised by the absence of urine output? (Q857765)

A. Class I

B. Class II

C. Class III

D. Class IV

Correct Answer: D. Class IV

Explanation: According to the Advanced Trauma Life Support (ATLS) , in the classes of hypovolemic shock , class IV is characterised by the absence of urine output. Parameter Class I (Option A ruled out) Class II (Option B ruled out) Class III (Option C ruled out) Class IV (Option D) Blood loss (%) 0-15% 15-30% 30-40% > 40% Central Nervous System (CNS) Slightly anxious Mildly anxious Anxious or confused Confused or lethargic Pulse (beats/min) < 100 > 100 > 120 > 140 Blood pressure Normal Normal Decreased Decreased Pulse pressure Normal Decreased Decreased Decreased Respiratory rate (breaths/min) 14-20 20-30 30-40 > 35 Urine output (mL/hr) > 30 20-30 5-15 Negligible/Nil Fluid requirement Crystalloid Crystalloid Crystalloid + Blood Crystalloid + Blood Base deficit (mEq/L) 0 to -2 -2 to -6 -6 to -10 -10 or less

References:

SRB’s Manual of Surgery, 6th Edition, Page 105-107.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q36: A 38-year-old man was brought to the emergency department after sustaining an RTA and injury to the lower chest. On presentation, the patient is stable, and vitals are normal. Chest radiography showed clear lung fields. What is the next step in management? (Q857798)

A. eFAST

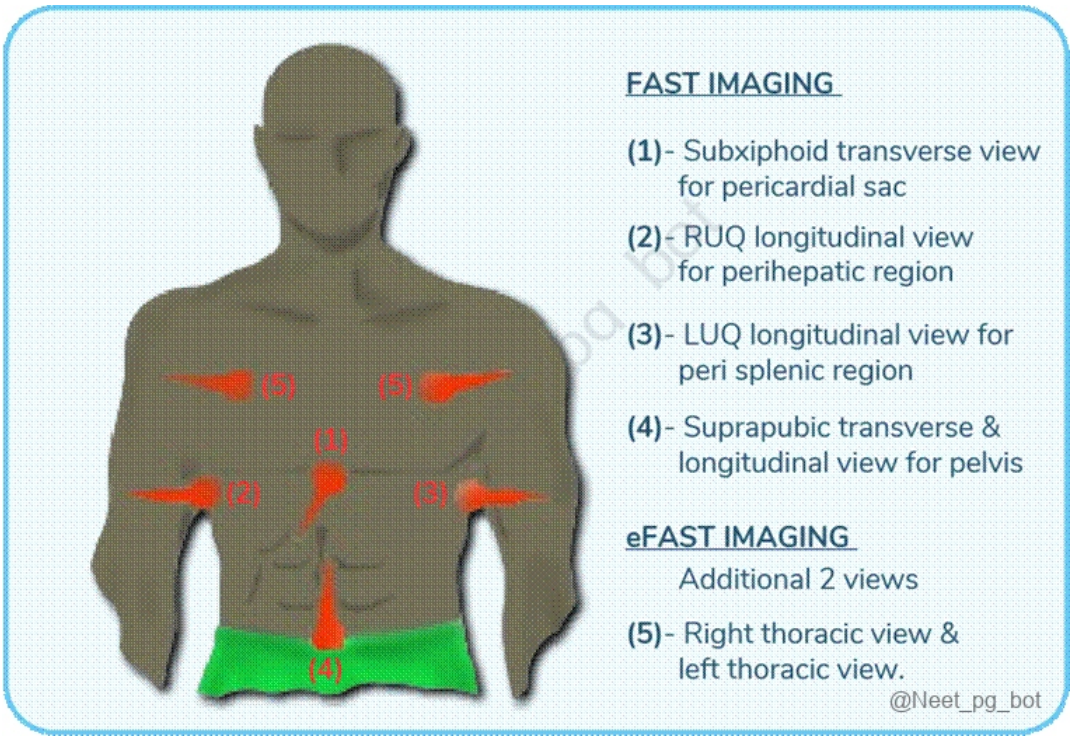
B. Tube thoracostomy

C. CECT chest

D. CECT abdomen

Correct Answer: A. eFAST

Explanation: In the scenario of an RTA with a stable patient, normal vitals, and clear lung fields, the most appropriate next step would be an extended Focused Assessment with Sonography in Trauma (eFAST) . It is a rapid bedside ultrasound to detect life-threatening injuries in trauma patients, focusing on the chest and abdomen. It assesses the pericardium, pleural spaces, and abdominal cavity for air or fluid. If clear lung fields rule out pneumothorax or hemothorax, eFAST helps detect other bleeding sources, like intraperitoneal bleeding. FAST (Focused Abdominal Sonography for Trauma) and eFAST (Extended FAST) Purpose : Assess for free fluid in the abdominal cavity, thoracic cavities, and pericardium. (Option A) Nature of Injury : Not used to determine the specific nature or extent of injury. Advantages : (Option A) Rapid, reproducible, portable, and non-invasive bedside test. Can be performed simultaneously with resuscitation. Accurate at detecting >100 mL of free blood. Limitations : Operator-dependent and may be unreliable in obese patients or when the bowel is full of gas. Low sensitivity (29–35%) for detecting hollow viscus or solid organ injuries without haemoperitoneum. Unreliable for excluding injuries in penetrating trauma. Requires repeat or supplementary investigations if needed. Unreliable for assessing retroperitoneum. {{caption_text}} Tube thoracostomy (Option B) is used for pneumothorax or hemothorax, but since the chest radiography shows clear lung fields, it’s not needed at this point. CECT chest (Option C) and abdomen (Option D) are more invasive imaging options. Since the chest radiography is clear and the patient is stable, eFAST is a quicker, non-invasive first step to assess for other injuries, such as abdominal or retroperitoneal bleeding, before considering further imaging.



References:

Bailey and Love's Short Practice of Surgery, 28th Edition, Page 378-379.

SRB's Manual of Surgery, 6th Edition, Page 139-140.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q37: Which of the following is not included in the qSOFA score components? (Q857805)

A. Respiratory rate >22

B. Lactate dehydrogenase

C. Altered mental status

D. Systolic blood pressure <100 mmHg

Correct Answer: B. Lactate dehydrogenase

Explanation: Lactate dehydrogenase (LDH) is not part of the components used in the qSOFA (quick Sequential Organ Failure Assessment) Score . It is a simplified, rapid assessment scale developed as an easier alternative to the more complex SOFA score, which requires laboratory tests. The Third International Consensus Definition of

Sepsis recommends using qSOFA to identify patients with sepsis (higher risk of death, prolonged ICU stay, and increased need for ICU admission). Components: Respiratory rate ≥22 (Option A ruled out) Altered mental status (Option C ruled out) Systolic blood pressure ≤100 mm Hg. (Option D ruled out) Interpretation: qSOFA ≥2 (with a concern for infection) is associated with a significantly greater risk of death or prolonged ICU stay.

References:

Sabiston Textbook of Surgery, 21st Edition, Page 62-63.

Harrison's Priniciples of Internal Medicine, 21st Edition, Page 2238.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q38: Among the options provided, which pairing correctly matches the trauma patients brought to the casualty? (Q857835)

A. Extradural hemorrhage (EDH) - Pin point pupil

B. Penetrating injury to eustachian tube - CSF otorrhea

C. Penetrating injury to eye - Battle sign

D. Gaze palsy - Mid brain lesion

Correct Answer: D. Gaze palsy - Mid brain lesion

Explanation: Gaze palsy, a difficulty in eye movement, can result from damage to structures in the midbrain, such as the third cranial nerve nucleus and paramedian pontine reticular formation. Extradural hemorrhage (EDH) - Pin point pupil (Option A) : EDH causes a dilated, non-reactive pupil due to pressure on the oculomotor nerve (CN III), while pinpoint pupils are more associated with opioid overdose or pontine lesions. Penetrating injury to eustachian tube - CSF otorrhea (Option B): Penetrating injury to the eustachian tube may cause complications but not CSF otorrhea, which is typically linked to basilar skull fractures and injury to the temporal bone. Penetrating injury to eye - Battle sign (Option C): Battle sign, bruising behind the ear, is associated with basilar skull fractures, not penetrating eye injuries, which present with hyphema, corneal damage, or visual disturbances.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 364.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q39: In all types of shock, which of the following is observed? (Q857889)

A. Reduced tissue perfusion

B. Increased peripheral resistance

C. Decreased respiratory rate

D. Cold clammy skin

Correct Answer: A. Reduced tissue perfusion

Explanation: Reduced tissue perfusion, a hallmark of all Shock types, results in inadequate oxygen and nutrient delivery, leading to organ dysfunction. It is defined as a systemic state of low tissue perfusion which is inadequate for normal cellular respiration. (Option A) Classification Type of Shock Mechanism Examples Hypovolemic Shock Reduced circulating blood volume Hemorrhage, Dehydration Cardiogenic Shock Failure of the cardiac pump Myocardial Infarction, Cardiac Dysrhythmias Obstructive Shock Mechanical obstruction of cardiac filling Cardiac Tamponade, Tension Pneumothorax Distributive Shock Systemic vasodilation leading to organ hypoperfusion Septic Shock, Anaphylactic Shock Endocrine Shock Combination of hypovolemic, cardiogenic, or distributive shock mechanisms Addisonian Crisis, Myxedema Coma Increased peripheral resistance (Option B) may occur in some shock types (e.g., hypovolemic, cardiogenic) as compensation to maintain blood pressure, but it's not universal. In septic shock, peripheral resistance is often decreased due to vasodilation. Decreased respiratory rate (Option C) may occur in certain shock types (e.g., neurogenic, severe hypovolemic), but increased respiratory rate (tachypnea) is more common as the body compensates for low oxygen levels, making it not universal in all shock types. Cold clammy skin (Option D) occurs in some shock types (e.g., hypovolemic, cardiogenic) due to vasoconstriction, but not in all. In septic shock, skin may be warm and flushed due to vasodilation.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 11-12.

SRB’s Manual of Surgery, 6th Edition, Page 104-105.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q40: For the purpose of preventing surgical site infection, what is the recommended technique and optimal timing for hair removal prior to surgery? (Q793358)

A. On the OT table with electric hair clippers

B. With a razor 24 hours before surgery

C. With a hair removal cream on the previous day

D. On the OT table with a razor

Correct Answer: A. On the OT table with electric hair clippers

Explanation: Correct Option A: On the OT table with electric hair clippers The ideal time and method of removing hair before surgery to avoid surgical site infection are on the OT table with electric hair clippers. This method is preferred over the other options because it is considered to be the safest and most effective method for hair removal. Electric clippers are less likely to cause nicks, cuts, or skin irritation than a razor or hair removal cream. Moreover, electric clippers are designed to cut the hair close to the skin without causing any damage to the skin itself. Incorrect Options: Option B: Removing hair with a razor 24 hours before surgery is not recommended because it can cause microscopic cuts on the skin, increasing the risk of infection. Option C: Hair removal creams can cause skin irritation, which can also increase the risk of infection. Option D: Removing hair on the OT table with a razor is not a recommended method because it increases the risk of infection due to the fact that it is more difficult to maintain a sterile environment in the operating room when using a razor.

References:

Sabiston & Bailey

↑ *Back to this question in Part A*

@Neet_pg_bot

Q41: A patient arrives at the emergency department after being involved in a car accident. The patient is experiencing difficulty breathing and their neck veins appear dilated. The x-ray reveals a significant amount of air on the left side. What is the most appropriate course of action for treatment? (Q793363)

A. Wide bore needle insertion in the 5th intercostal space

B. Endotracheal intubation

C. Tracheostomy

D. Pericardiocentesis



Correct Answer: A. Wide bore needle insertion in the 5th intercostal space

Explanation: Correct Option A: This scenario's next best management step is the wide bore needle insertion in the 5th intercostal space. This is indicative of a tension pneumothorax, which is a medical emergency that requires immediate treatment. A tension pneumothorax occurs when air enters the pleural space (between the lungs and the chest wall) and becomes trapped. As more air accumulates, it can cause a shift in the position of the mediastinum (the area in the chest between the lungs that contains the heart, great vessels, and other structures), leading to compression of the lungs and blood vessels. This can result in respiratory distress, hypoxemia (low oxygen levels in the blood), and cardiovascular collapse. Treating of a tension pneumothorax involves relieving the pressure in the pleural space by inserting a needle or catheter into the chest cavity to allow the trapped air to escape. The insertion site is typically in the 5th intercostal space in the midclavicular line (i.e., the space between the fifth and sixth ribs, in line with the middle of the collarbone). This procedure is known as needle decompression or thoracostomy. Incorrect Options: Option B: Endotracheal intubation involves placing a tube through the mouth or nose into the trachea to provide mechanical ventilation and oxygenation. While this may be necessary in some cases of respiratory distress, it does not address the underlying problem of a tension pneumothorax. Option C: Tracheostomy is a surgical procedure that involves creating a small opening in the neck and inserting a tube directly into the trachea. This is typically done in upper airway obstruction or long-term mechanical ventilation cases. Again, this does not address the underlying problem of a tension pneumothorax. Option D: Pericardiocentesis involves inserting a needle into the pericardial sac (the membrane surrounding the heart) to drain fluid or blood that may be compressing the heart. While this can be a life-saving procedure in cases of cardiac tamponade (heart compression due to fluid or blood in the pericardial sac), it is not indicated in a tension pneumothorax.

References:

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↑ *Back to this question in Part A*

@Neet_pg_bot

Q42: A patient sustained a crush injury on their right arm. He was taken to the hospital and on examination, his arm was pulseless, swollen, and dark red. What would be the best way to manage this case? (Q793385)

A. Intraosseous administration of fluids

B. Acidification of urine

C. Fasciotomy

D. Hemodialysis

Correct Answer: C. Fasciotomy

Explanation: The best way to manage a patient with a crush injury to the arm that presents with a pulseless, swollen, and dark red arm is fasciotomy. A crush injury can result in a significant amount of tissue damage, which can lead to the development of compartment syndrome. Compartment syndrome occurs when there is increased pressure within a muscle compartment, which can result in tissue damage, nerve injury, and even loss of limb function. In this case, the patient's pulseless, swollen, and dark red arm is likely indicative of compartment syndrome, which is a medical emergency that requires immediate intervention to prevent irreversible tissue damage. Fasciotomy is a surgical procedure that involves making an incision into the affected compartment to relieve pressure and improve blood flow to the affected tissues. It is the recommended treatment for compartment syndrome in cases where conservative measures, such as elevation and pain management, are ineffective. Incorrect Choices: Option a: Intraosseous administration of fluids is a method of delivering fluids and medications directly into the bone marrow, bypassing the need for venous access. While this may be useful in certain situations, such as when venous access is difficult to obtain, it is not the appropriate treatment for compartment syndrome. Option b: Acidification of urine may be used in the management of certain types of poisoning, such as aspirin overdose, but it is not indicated in the treatment of a crush injury. Option d: Hemodialysis is a treatment for kidney failure and is not indicated in the treatment of a crush injury.

References:

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↑ *Back to this question in Part A*

@Neet_pg_bot

Q43: Which of these is the most life-threatening injury that can be identified by assessing the breathing component of the patient? (Q855661)

A. Cervical spine injury

B. Tension pneumothorax

C. Blunt cardiac injury

D. Laryngotracheal injury

Correct Answer: B. Tension pneumothorax

Explanation: Tension Pneumothorax is the most life-threatening injury that can be identified by assessing the patient's breathing component. It occurs when air accumulates in the pleural space, increasing pressure on the lungs and heart, leading to lung collapse and impaired blood flow. It can rapidly cause cardiovascular collapse and is fatal without prompt decompression. Life-threatening Injuries These can be remembered as the ‘ deadly dozen’ . Six Immediately life-threatening injuries were managed during the primary survey. Six Potentially life-threatening injuries were detected during the secondary survey. Immediately life-threatening injuries Potentially life-threatening injuries Airway obstruction Tension pneumothorax Pericardial tamponade Open pneumothorax Massive haemothorax Flail chest Aortic injuries Tracheobronchial injuries Myocardial contusion Rupture of the diaphragm Oesophageal injuries Pulmonary contusion Cervical spine injury (Option A) can cause neurological complications, but it doesn’t directly compromise breathing, making it less life-threatening compared to other injuries in this context. Blunt cardiac injury (Option C) primarily affects the heart, potentially leading to arrhythmias or cardiac rupture. While it can be life-threatening, it does not directly compromise breathing, unlike other injuries. Laryngotracheal injury (Option D) can cause airway obstruction and breathing difficulties, but tension pneumothorax is more immediately life-threatening, rapidly leading to respiratory and cardiovascular collapse if untreated.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q44: Hand rub can be utilised in accordance with the standard hand hygiene protocol in all locations listed below, with the exception of: (Q855667)

A. If the hands are visibly soiled

B. While moving from a contaminated site to a clean site during patient care

C. After removing sterile gloves

D. During direct patient contact

Correct Answer: A. If the hands are visibly soiled

Explanation: As per the WHO Standard Hand Hygiene Protocol , hand rub is not suitable for visibly soiled hands, and handwashing with soap and water is required to remove dirt and contaminants. Indications: Wash hands with soap and water when visibly dirty or visibly soiled with blood or other body fluids or after using the toilet. (Option

A) If exposure to potential spore-forming pathogens is strongly suspected or proven, including outbreaks of Clostridium difficile , hand washing with soap and water is the preferred means. Use an alcohol-based hand rub as the preferred means for routine hand antisepsis in clinical situations if hands are not visibly soiled. (Option A) If alcohol-based hand rub is not obtainable, wash hands with soap and water. Perform hand hygiene: Before and after touching the patient. (Option D ruled out) Before handling an invasive device for patient care, regardless of whether or not gloves are used After contact with body fluids or excretions, mucous membranes, non-intact skin, or wound dressings If moving from a contaminated body site to another body site during the care of the same patient (Option B ruled out) After contact with inanimate surfaces and objects (including medical equipment) in the immediate vicinity of the patient. After removing sterile or non-sterile gloves. (Option C ruled out) Before handling medication or preparing food, perform hand hygiene using an alcohol-based hand rub or wash hands with either plain or antimicrobial soap and water. Soap and alcohol-based hand rubs should not be used concomitantly. Technique: Apply a palmful of alcohol-based hand rub and cover all surfaces of the hands. Rub hands until dry. When washing hands with soap and water, Wet hands with water and apply the amount of product necessary to cover all surfaces. Rinse hands with water and dry thoroughly with a single-use towel. Use clean, running water whenever possible. Avoid using hot water, as repeated exposure to hot water may increase the risk of dermatitis. Use towel to turn off the tap/faucet. Dry hands thoroughly using a method that does not recontaminate hands. Make sure towels are not used multiple times or by multiple people. Liquid, bar, leaf or powdered forms of soap are acceptable. When bar soap is used, small bars of soap in racks that facilitate drainage should be used to allow the bars to dry.



References:

CONSENSUS RECOMMENDATIONS - WHO Guidelines on Hand Hygiene in Health Care - NCBI Bookshelf

↑ *Back to this question in Part A*

Q45: In the case of a patient arriving at the emergency department with a road traffic accident (RTA), what is the appropriate order of steps in their management? Cervial spine stabilisation Intubation IV cannulation CECT (Q855671)

A. 1, 3, 2, 4

B. 1, 2, 3, 4

C. 2, 1, 3, 4

D. 2, 1, 4, 3

Correct Answer: B. 1, 2, 3, 4

Explanation: The proper sequence of Trauma Care management for a patient presenting with an RTA (road traffic accident) is 1, 2, 3, 4. Primary Survey It aims to identify and manage the most immediately life-threatening pathologies first and follows cABCDE. c: Exsanguinating external haemorrhage The exsanguinating external haemorrhage from massive arterial bleeding needs to be controlled even before the airway is managed. A: Airway with cervical spine control Cervical spine stabilisation. (Statement 1) Assessment of the patient's airway. Compromised airway requires a stepwise progression: Clearing the airway by suctioning secretions or blood. Simple airway manoeuvres (jaw thrust, chin lift and insertion of an oropharyngeal or nasopharyngeal airway). Advanced airway manoeuvres (intubation). (Statement 2) B: Breathing and ventilation High-flow oxygen. Assess bilateral chest raise. Assess breath sounds Use pulse oximetry Life-threatening chest pathology (tension pneumothorax, massive haemothorax and fail segment) should be diagnosed and managed. C: Circulation and haemorrhage control Monitor vitals. Heart sounds ECG Intravenous (IV) access with at least two large-bore IV cannulae (central, peripheral). (Statement 3) Blood was taken for cross-match and laboratory assessment. Treatment of shock. Control of external bleeding. D: Disability Neurological examination. Use required tubes like catheters, Ryle's tube. E: Exposure Undress the patient Hypothermia assessment. Assess injuries (imaging like USG, CT scan, MRI). (Statement 4) Examine joints, bones, abdomen, and other systems. Look for identification marks. Secondary Survey: Detailed top-to-toe examinations after life-threatening injuries have been identified and managed during the primary survey. Patients may be intubated and unresponsive at this point, limiting the accuracy of clinical examination. Tertiary survey After extubation, identify any missed 'minor' injuries (scaphoid fracture in the wrist or a rotator cuff tear in the shoulder). These injuries have the potential to cause significant long-term disability.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 355-357. SRB's Surgical Operations, 6th Edition, Page 203.

↑ *Back to this question in Part A*

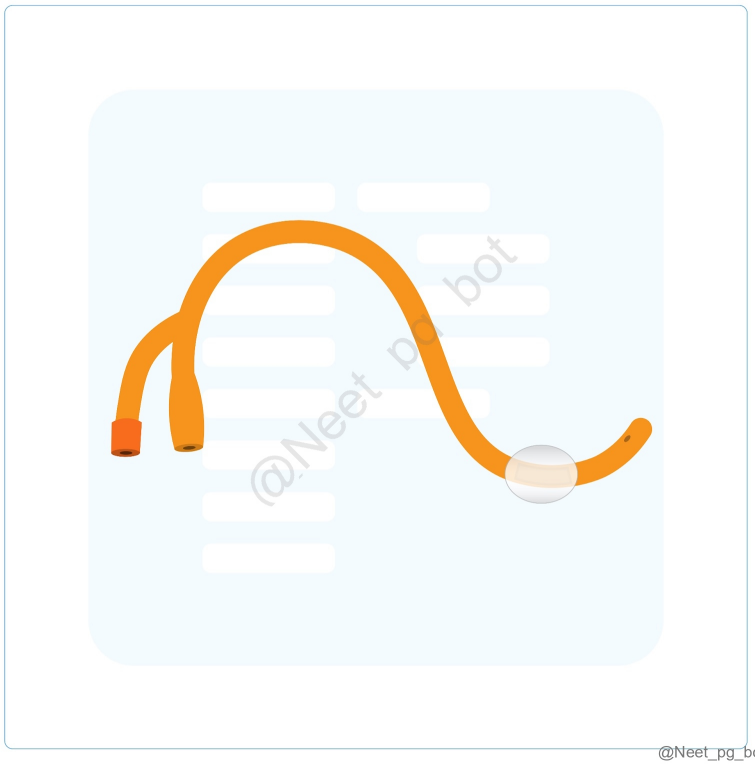
Q46: What does the number (14Fr) marked on the Foley catheter correspond to? (Q855673)

A. Inner lumen diameter

B. Length of the tube

C. Outer tube diameter

D. Bulb size

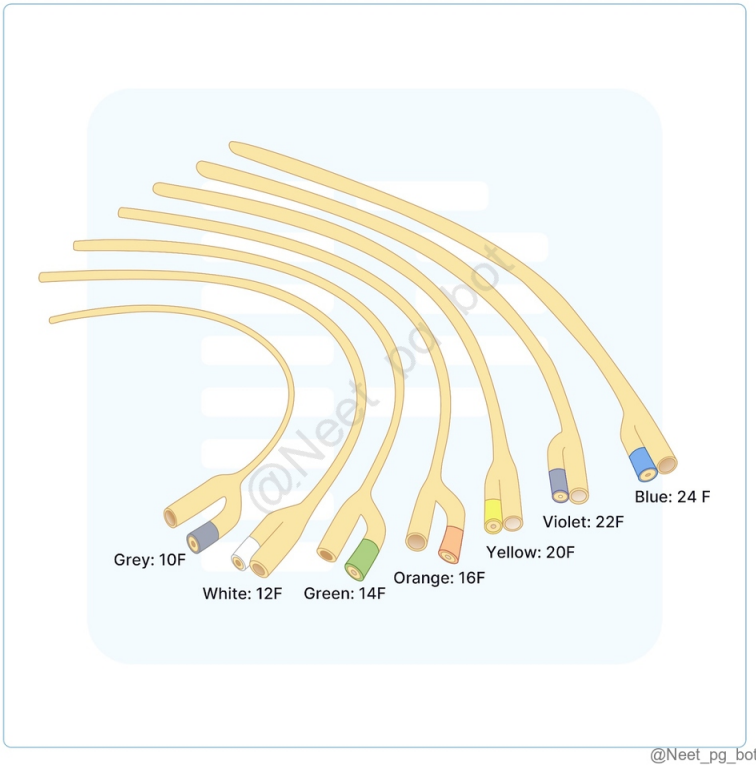


Correct Answer: C. Outer tube diameter

Explanation: The number (14Fr) marked on the Foley's Catheter indicates its outer tube diameter, measured in French (Fr) units, where 1 French equals 0.33 mm. {{caption_text}} Material LATEX - Less irritation & crust formation Silicone Coating- for Prolonged use (up to 3 months) Types 2-way Foley catheter 3-way Foley catheter Channels 2-way Foley catheter: Main channel: For drainage of urine Small channel: For inflating balloon 3-way Foley catheter: Main channel: for drainage of urine Additional channel for irrigation Balloon Inflation 20-30 ml saline for self-retaining 30-50 ml of saline for a hemostatic compression effect Sizes (French scale) Pediatric patients : 4, 6, 8, 10 Adult patients: 12, 14, 16, 18 Size Calculation Outer diameter of catheter in mm = Fr/3 (Fr - French units) E.g., if the size of the catheter is 18 French, then diameter = 18/3 = 6mm Uses To relieve urinary retention To measure urine output For administration of intravesical chemotherapy 3 ways catheter - for Irrigation after TURP May be used for supra-pubic cystostomy Inner lumen diameter (Option A) : The marked number

refers to the outer diameter, not the inner lumen diameter, which impacts flow rate but is not indicated by the French size. Length of the tube (Option B) : The French size does not represent the catheter's length, which is usually marked separately and unrelated to the outer diameter measurement. Bulb size (Option D) : The French size does not indicate the balloon or bulb size, which is specified separately and unrelated to the outer tube diameter.





References:

SRBs Manual of Surgery, 8th Edition, Page 990-991.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q47: Which of the following options does not represent one of the boundaries of the triangle of safety for the insertion of an ICD in a patient with a chest x-ray showing pneumothorax? (Q855678)

A. Lateral edge of the pectoralis major

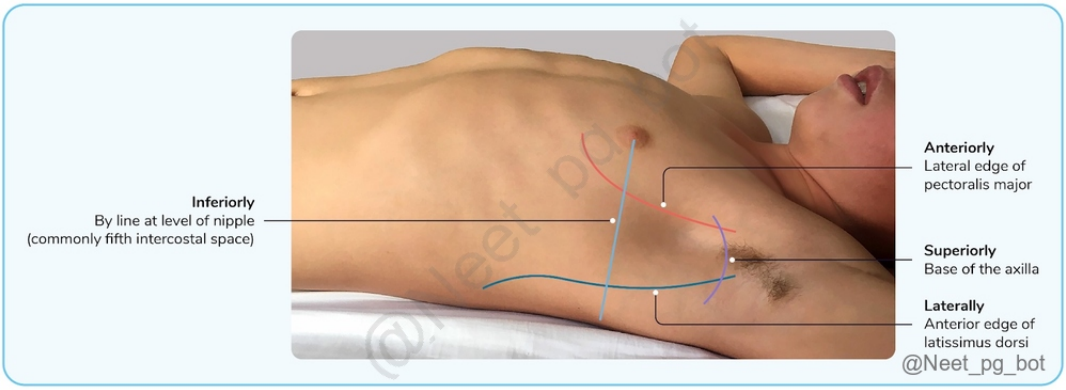
B. Mid-clavicular line

C. 5th intercostal space

D. Lateral border of latissimus dorsi

Correct Answer: B. Mid-clavicular line

Explanation: The mid-clavicular line is a vertical line through the clavicle and does not define the boundaries of the Triangle of Safety . It is an anatomical region in the axilla that guides the safe position for intercostal catheter (ICC) placement. With the arm abducted, the apex is the axilla, and the triangle is formed by the following: The lateral border of the pectoralis major - anteriorly. (Option A ruled out) The lateral border of the latissimus dorsi - posteriorly. (Option D ruled out) Inferiorly, by a horizontal line from the nipple (commonly the 5th intercostal space). (Option B ruled out) {{caption_text}} Triangle of safety



References:

Bailey and Love Short Practice of Surgery, 28th Edition, Page 981. Triangle of safety

↑ *Back to this question in Part A*

@Neet_pg_bot

Q48: Which of the following statements is accurate concerning split-thickness and full-thickness skin grafts? Primary contractures are more in split skin grafts Secondary contractures are more in split skin grafts Primary contractures are more in full-thickness grafts Secondary contractures are more in full-thickness grafts (Q855680)

A. 2 and 3

B. 2 and 4

C. 1 and 3

D. 1 and 4

Correct Answer: A. 2 and 3

Explanation: Primary contraction is the initial recoil of the skin graft, which is more pronounced in full-thickness grafts. Secondary contraction occurs after the healing process and is commonly seen in split-thickness grafts. Feature Split-Thickness Skin Graft Full-Thickness Skin Graft Composition Epidermis + part of dermis Epidermis + full thickness of dermis Graft Size Large grafts can be taken Only small grafts can be taken Graft Survival Easier More difficult Donor Site Healing Heals spontaneously, allowing repeated grafts Permanent defect develops, preventing repeated grafts Graft Contraction (Option A) Secondary contracture is more significant Primary contracture is more significant Common Donor Sites Inner thigh, upper arm, flexor aspect of forearm, abdominal wall Upper eyelid, retro auricular skin, supraclavicular skin, antecubital skin, inframammary skin, inguinal skin, genital skin, gluteal skin Donor Site Exclusions None Axilla is not used as a donor site Advantages of Harvesting Allows calibration of thickness and large area coverage Calibration of thickness for small but thick grafts

References:

Sabiston Textbook of Surgery, 21st Edition, Page 1917. https://www.ncbi.nlm.nih.gov/books/NBK551561/

↑ *Back to this question in Part A*

@Neet_pg_bot

Q49: Which of the following statements are true regarding central venous access and peripheral venous access? Phlebitis is the most common complication in peripheral venous access. Isotonic saline and heparin are flushed to retain patency If an arteriovenous fistula is present in a limb, avoid peripheral venous access in the same limb. Vasopressors for septic shock are given in the central line to avoid limb ischemia. (Q855686)

A. 1, 3, 4

B. 2, 3, 4

C. 1, 2, 3, 4

D. 1, 2, 3

Correct Answer: C. 1, 2, 3, 4

Explanation: All four statements regarding central venous access and peripheral venous access are true. Phlebitis is the most common complication in peripheral venous access It refers to inflammation of the vein It is a common complication of peripheral venous access. It can occur due to various factors, such as chemical irritation, mechanical irritation, or infection. Isotonic saline and heparin are flushed to retain patency: To maintain the patency of central venous access devices (such as central venous catheters or central lines), periodic flushing with isotonic saline and heparin is commonly performed. This helps prevent clot formation and maintain the functionality of the line. If an arteriovenous fistula is present in a limb, avoid peripheral venous access in the same limb. An arteriovenous fistula (AVF) is a surgically created connection between an artery and a vein, typically used for hemodialysis. When an AVF is present in a limb, it is generally recommended to avoid peripheral venous access in the same limb to prevent damage to the AVF and maintain its functionality. Vasopressors for septic shock are given in the central line to avoid limb ischemia. Vasopressors for septic shock can be administered through either central venous access or peripheral venous access, depending on the clinical situation and availability of access. The choice of access depends on factors such as the stability of peripheral veins, the need for continuous infusion, and the urgency of treatment. Limb ischemia is a potential complication of vasopressor administration, but it is not exclusive to peripheral venous access.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 18, 338-340. Study on incidence of phlebitis following the use of pherpheral intravenous catheter - PMC Heparin flush vs. normal saline flush to maintain the patency of central venous catheter among adult patients: A systematic review and meta-analysis - PMC

↑ *Back to this question in Part A*

@Neet_pg_bot

Q50: Which one of the options listed below does not belong to the category of damage control surgery? (Q855279)

A. Control of hemorrhage

B. Resuscitation

C. Decontamination

D. Vascular anastomosis

Correct Answer: D. Vascular anastomosis

Explanation: Vascular anastomosis is not typically performed during Damage Control Surgery , as the focus is on resuscitation, hemorrhage control, and stabilisation, with definitive repairs done later when the patient is stable. Phases of Damage Control Surgery Phase Intervention Steps 1 Recognition and Decision-making Intubation, early rewarming, and prompt movement to operation theatre 2 Immediate Laparotomy Control of bleeding, abdominal packing, and temporary abdominal closure 3 Intensive Care Unit Ongoing resuscitation and normalisation of physiological and biochemical parameters 4 Re-Exploration Definitive repair of all injuries Stages of Damage Control Surgery Stage Intervention 1 Patient Selection 2 Control of haemorrhage and contamination (Option A, C ruled out) 3 Resuscitation in ICU (Option B ruled out) 4 Definitive Surgery 5 Abdomen closure

References:

Bailey and Love's Short Practice of Surgery, 28th Edition, Page 385-386, 463-464. Schwartz's Principles of Surgery, 11th Edition, Page 215.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q51: Which of the following is true regarding shock? (Q855318)

A. Anaerobic respiration produces carbon dioxide

B. Hypovolaemic shock—most common type

C. Stage of compensatory shock is also called stage 2 of shock

D. Anaphylactic shock—is due to a Type 2 hypersensitivity reaction

Correct Answer: B. Hypovolaemic shock—most common type

Explanation: Hypovolaemic Shock is the most common type of shock. It is due to a reduced circulating volume. Cause: Haemorrhagic Injury to the liver, spleen, and bone fractures Haemothorax Vascular injury Severe bleeding on the table during surgeries Nonhaemorrhagic Poor fluid intake (dehydration) Excessive fluid loss due to vomiting, diarrhoea, urinary loss (e.g. diabetes) Evaporation or 'thirdspacing', where fluid is lost into the gastrointestinal tract and interstitial spaces (bowel obstruction or pancreatitis). Clinical features: Cold and clammy skin - due to inadequate tissue perfusion. Reduced renal blood flow and GFR lead to oliguria, which may lead to anuria. Cerebral blood flow is reduced, leading to drowsiness and confusion. Tachypnoea - due to lactic acidosis Tachycardia Weak thready pulse Sweating Classification: Parameter Class I (Compensated Shock) Class II (Hypoxemia) Class III Class IV (Refractory Shock) Blood Loss Up to 15% 15-30% 30-40% More than 40% Mechanism Compensatory mechanisms maintain cardiac output. Generalised vasoconstriction. Decompensated shock. Refractory shock. Heart Rate <100/min 100-120/min 120-140/min >140/min Blood Pressure Normal Hypotension Marked hypotension Profound hypotension Respiratory Rate Normal Tachypnea Tachypnea Tachypnea Urine Output >30 ml/hour 20-30 ml/hour 5-15 ml/hour No urine output Mental Status Alert, normal Anxious, mildly agitated Confused, altered mental status Comatose, lethargic Anaerobic respiration produces carbon dioxide (Option A) : Anaerobic respiration occurs in the absence of oxygen and results in the production of

lactic acid, not carbon dioxide. Stage of compensatory shock is also called stage 2 of shock (Option C) : Class I refers to hypovolemic shock with up to 15% blood loss, where compensatory mechanisms sustain cardiac output, also known as Compensated Hypovolemic Shock. Anaphylactic shock is due to Type 2 hypersensitivity reaction (Option D) : Anaphylactic shocks due to Type 1 hypersensitivity reaction.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 12-14.

↑ *Back to this question in Part A*

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Q52: A patient presents with multiple stab injuries to the chest. On examination, there is reduced chest movement on the right side and tracheal deviation to the left side. Additionally, the neck veins are distended. What is the next best step in the management of this patient? (Q855325)

A. Resuscitative thoracotomy

B. ICD placement

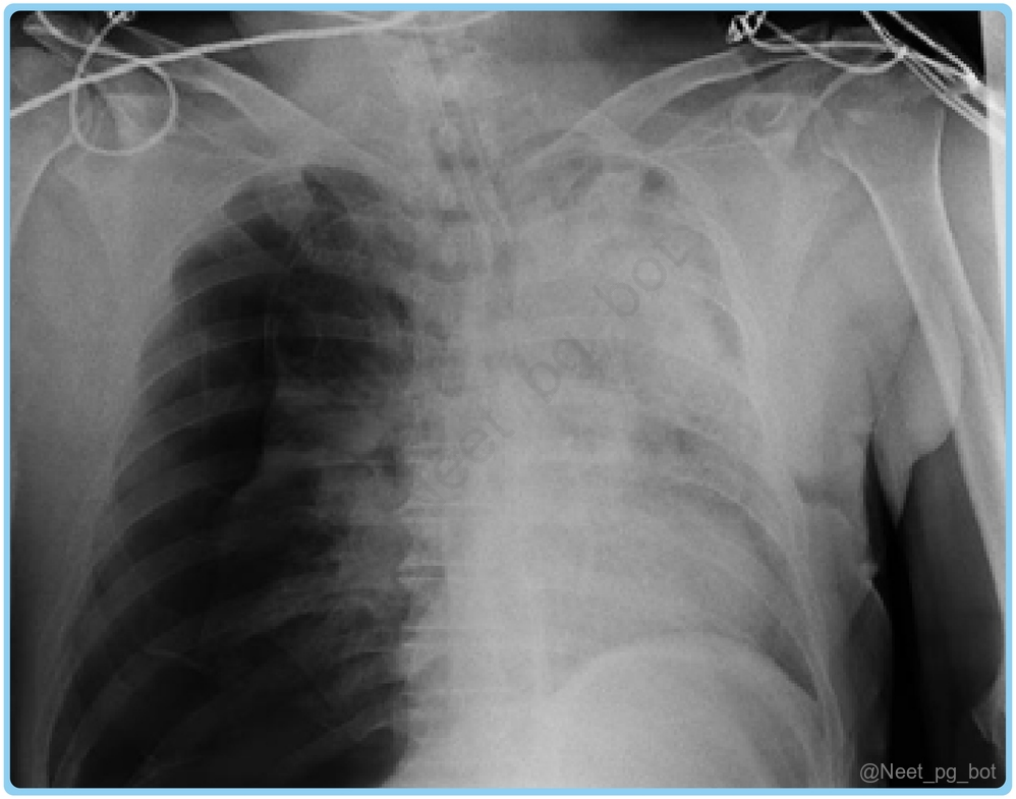
C. Needle thoracocentesis

D. Finger thoracotomy

Correct Answer: C. Needle thoracocentesis

Explanation: Needle thoracocentesis The signs of reduced chest movement, tracheal deviation, and distended neck veins suggest a Tension Pneumothorax , which requires immediate decompression with needle thoracocentesis to relieve pressure and stabilise the patient before further interventions. Tension Pneumothorax It is a life-threatening condition where air accumulates in the pleural cavity under pressure, causing lung collapse on the affected side, mediastinal shift , and severe impairment of cardiovascular function. Pathology It occurs when air enters the pleural cavity through a "one-way valve" mechanism, leading to lung collapse and mediastinal shift towards the opposite side. ↑Pleural pressure→ Opposite lung compression→ ↓venous return→ ↓cardiac output and potentially sudden death. Aetiology Penetrating chest trauma. Blunt chest trauma with parenchymal lung injury. Iatrogenic lung injury (e.g., central venous catheterisation) and mechanical positive-pressure ventilation. Clinical Features Restlessness, tachypnea, dyspnea, tachycardia, and chest pain. Distended neck veins, hyper-resonance, and decreased or absent breath sound on the affected side. Late findings may include tracheal deviation and cyanosis. Hypotension and severe mediastinal/tracheal shift are also common. Management Needle Thoracocentesis : Immediate decompression with a large-bore needle in the 2nd intercostal space at the midclavicular line, or the "safe triangle". Followed by intercostal chest tube (ICT) placement in the 5th intercostal space in the anterior axillary line. Provide oxygen, analgesics, antibiotics, and ventilator support if necessary. {{caption_text}} Resuscitative thoracotomy (Option A) is used in traumatic cardiac arrest or severe haemorrhage, not for tension pneumothorax. Tension pneumothorax is urgent but not immediately fatal and should be treated with needle thoracocentesis. ICD placement (Option B) is not the immediate treatment for tension pneumothorax, as it doesn't

quickly relieve pressure. Needle thoracocentesis should be performed first, with ICD placement done afterwards for ongoing drainage. Finger thoracotomy (Option D) is used for cardiac tamponade, not tension pneumothorax. Needle thoracocentesis is the preferred initial intervention for rapid decompression, while finger thoracotomy is reserved for later stages if needed.



References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 374. Textbook of SRB’s Surgical Operations, 6th Edition, Page 1101-1102.

↑ *Back to this question in Part A*

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Q53: What steps should be taken to manage the case of a 24-year-old male who was hit by a motorbike while crossing the road, leading to abdominal injuries and bruising, with a blood pressure of 88/60 and IV fluids already administered, along with a positive FAST examination? (Q857115)

A. Abdominal CT scan

B. Abdominal MRI scan

C. Exploratory laparotomy

D. Diagnostic peritoneal lavage

Correct Answer: C. Exploratory laparotomy

Explanation: Exploratory laparotomy indicated in patients with a positive FAST assessment to avoid further bleeding in the abdomen. Hemodynamically unstable patients (BP <90 mmHg , signs of shock) with positive FAST should undergo emergency exploratory laparotomy to identify and control the source of bleeding. CT scan (Abdominal/Pelvic) (Option A) is indicated only for hemodynamically stable patients. Since this patient is unstable, CT is not appropriate . Abdominal MRI scan (Option B) MRIs are usually preferred for investigation of Soft tissue pathology, bone pathology, and head trauma. Diagnostic Peritoneal Lavage (DPL) (Option D) is rarely used now, as FAST is the preferred modality for detecting intra-abdominal bleeding.

References:

Sabiston's Principles of Surgery, 21st Edition, Page 394.

↑ *Back to this question in Part A*

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Q54: In a patient with liver cirrhosis, what is the primary cause of mortality when esophageal varices are present? (Q857119)

A. Hypovolemic shock

B. Cardiogenic shock

C. Obstructive shock

D. Distributive shock

Correct Answer: A. Hypovolemic shock

Explanation: Hypovolemic shock is circulatory failure due to loss of intravascular volume by variceal bleed. This loss of intravascular volume loss will lead to tissue hypoperfusion and tissue hypoxia. In cirrhosis, the blood flow to the liver is cut down, leading to more flow of blood through the veins of the oesophagus, leading to haemorrhage. Cardiogenic shock (Option B) is characterised by the impaired ability of the heart to pump blood. (especially by the left ventricle) Obstructive shock (Option C) is a condition wherein blood and oxygen fail to reach the organs. Examples include blood clots, collapsed lungs, tension pneumothorax, and pericardial Tamponade. Distributive shock (Option D) This leads to poor tissue perfusion due to excessive vasodilation and poor distribution of blood flow to the heart, brain, and kidneys.

References:

SRB's Manual of Surgery 6th Edition, Page 105-107

Bailey & Love's Short Practice of Surgery 28th Edition, Page number 12.

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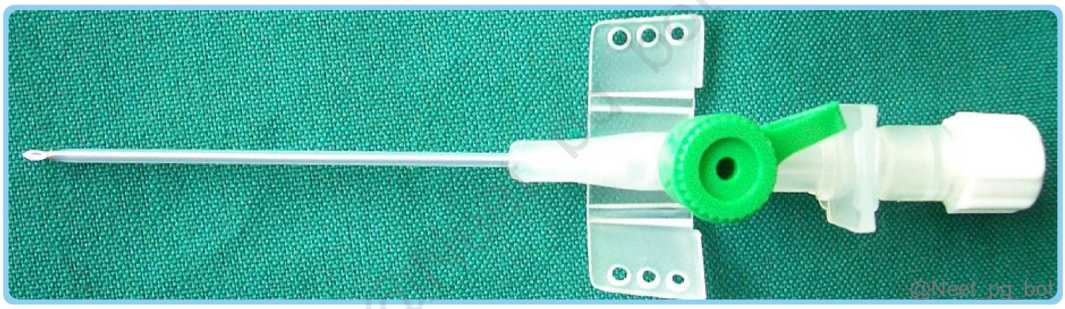
Q55: What is the size of the cannula gauge used in this picture? (Q858341)

A. 14

B. 16

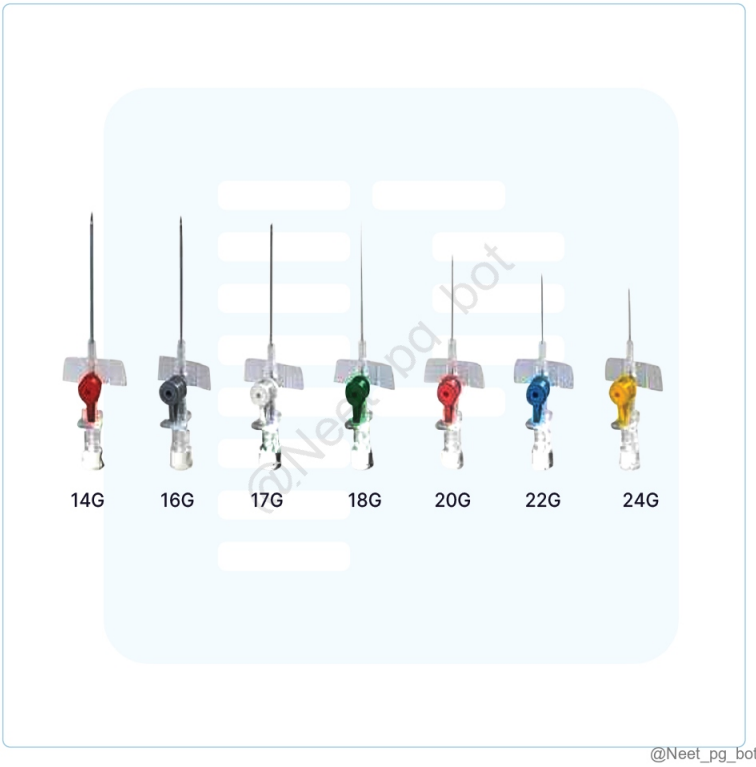
C. 18

D. 20



Correct Answer: C. 18

Explanation: The gauge size of the cannula shown in the image is 18. Intravenous (IV) Cannula Sizes, Colors, and Uses: Cannula Gauge (G) Outer Diameter (mm) Color Flow Rate (mL/min) Common Uses 14G (Option A ruled out) 2.1 mm Orange 240 mL/min Massive transfusion, trauma, rapid fluid resuscitation 16G (Option B ruled out) 1.8 mm Grey 180 mL/min Major surgery, large fluid replacement, blood transfusion 18G (Option C) 1.3 mm Green 90-105 mL/min Routine blood transfusion, IV fluids, medications 20G (Option D ruled out) 1.1 mm Pink 55-65 mL/min IV fluids, antibiotics, minor procedures 22G 0.9 mm Blue 33-36 mL/min IV medications, pediatric & elderly patients 24G 0.7 mm Yellow 20-22 mL/min Neonates, small veins, slow infusions 26G 0.6 mm Purple 13-15 mL/min Rarely used, for neonates & fragile veins Sizes of Cannula: {{caption_text}}



References:

https://emedicine.medscape.com/article/1998177-periprocedure?form=fpf

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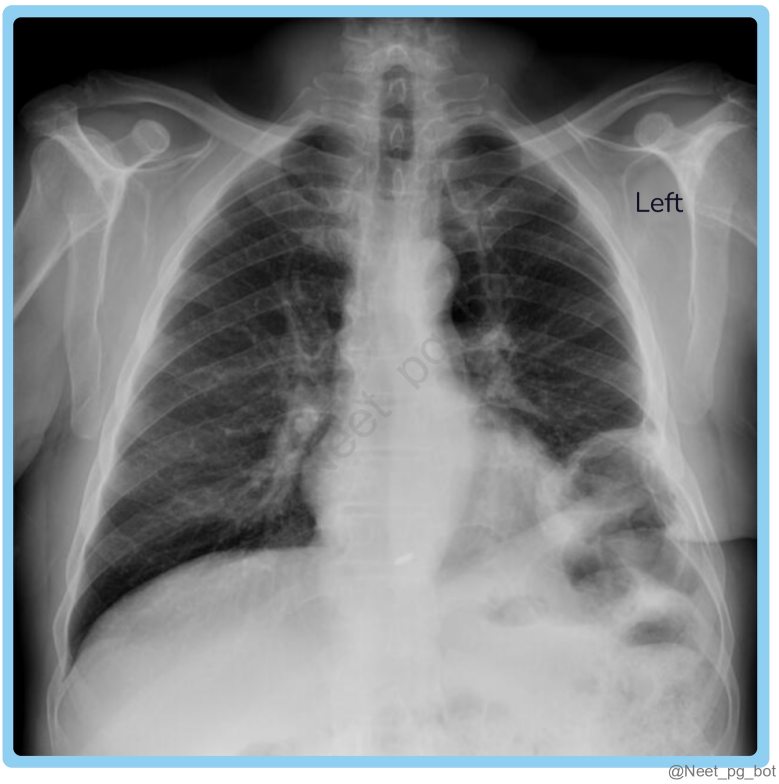
Q56: A 24-year-old male patient was brought to the emergency department following a road traffic accident. His heart rate was 100/min, respiratory rate was 24/min, and his chest X ray is given below. Which of the following is contraindicated in him? (Q858348)

A. Nasogastric tube insertion

B. Chest tube insertion

C. Log roll

D. Epidural anaesthesia



Correct Answer: B. Chest tube insertion

Explanation: Xray findings: Parts of bowel loops , including splenic flexure of the colon, are herniated into the thorax through a defect in the lateral aspect of the left hemidiaphragm, causing mild left lung base collapse. The anterior arch of the left 5th and 6th ribs shows evidence of prior fracture. A small metallic foreign body is also noted posterior to the cardiac shadow. There are mild peribronchial opacities in the central segments of both lungs. Chest tube insertion is generally contraindicated in patients with isolated rib fractures without associated pneumothorax or hemothorax . Chest tube insertion is primarily performed to drain air or fluid from the pleural space when there is a pneumothorax or hemothorax. Nasogastric tube insertion (Option A) is not directly contraindicated in a patient with diaphragmatic hernia. Nasogastric tube insertion is a common procedure performed in emergency departments to decompress the stomach and remove gastric contents. Log rol l (Option C) trauma precautions are generally recommended in trauma patients to minimise movement of the spine and reduce the risk of spinal cord injury. Epidural anaesthesia (Option D) is a regional anesthesia technique commonly used for pain management during surgical procedures. Diaphragmatic hernia is not directly contraindication for epidural anesthesia.

References:

https://emedicine.medscape.com/article/80678-overview?form=fpf

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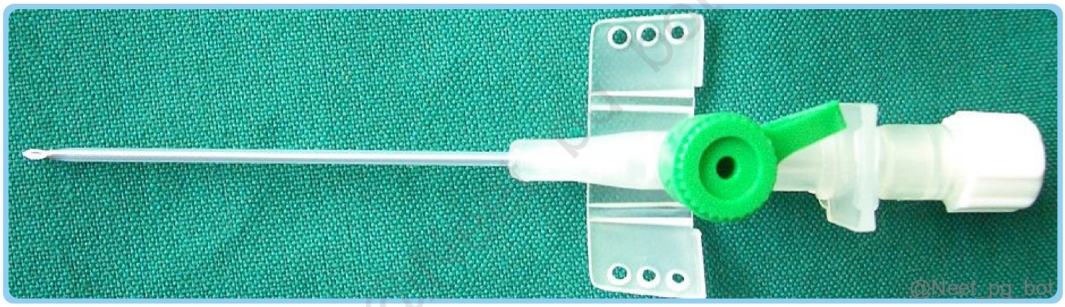
Q57: A patient was received in the casualty following a road traffic accident. His BP was 90/60 mmHg and his pulse rate was 120/min. The emergency room physician asked you to replace the fluid loss in this patient. What is the flow rate of fluid with the IV cannula given in the image? (Q858350)

A. 86ml/min

B. 96ml/min

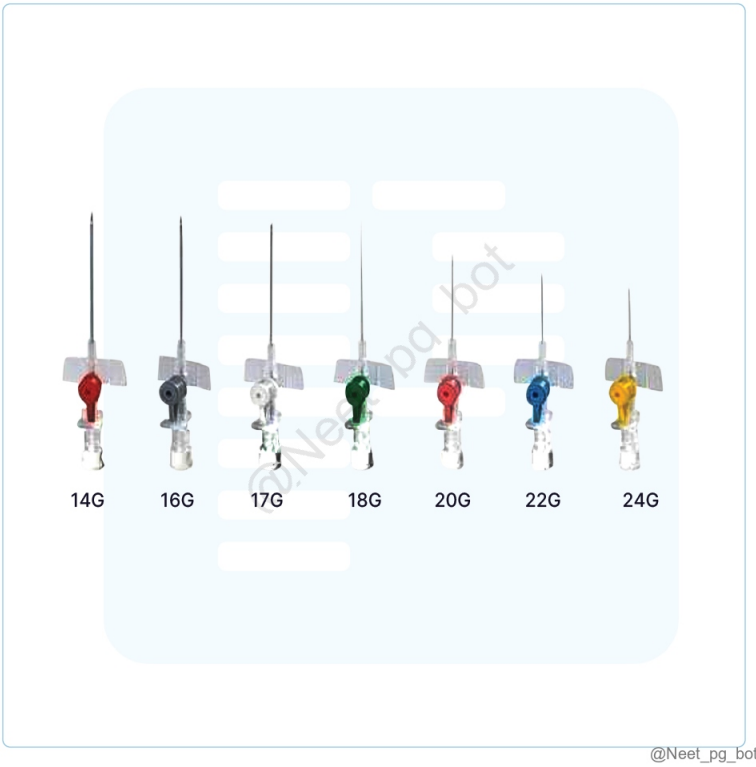
C. 90 ml/min

D. 63ml/min



Correct Answer: C. 90 ml/min

Explanation: To calculate the maximum flow rate of fluid with a specific IV cannula, we need to consider the size of the cannula, which is given as 18G (green). Intravenous (IV) Cannula Sizes, Colors, and Uses: Cannula Gauge (G) Outer Diameter (mm) Color Flow Rate (mL/min) Common Uses 14G 2.1 mm Orange 240 mL/min Massive transfusion, trauma, rapid fluid resuscitation 16G 1.8 mm Grey 180 mL/min Major surgery, large fluid replacement, blood transfusion 18G (Option C) 1.3 mm Green ~90 mL/min Routine blood transfusion, IV fluids, medications 20G 1.1 mm Pink 55-65 mL/min IV fluids, antibiotics, minor procedures 22G 0.9 mm Blue 33-36 mL/min IV medications, pediatric & elderly patients 24G 0.7 mm Yellow 20-22 mL/min Neonates, small veins, slow infusions 26G 0.6 mm Purple 13-15 mL/min Rarely used, for neonates & fragile veins Sizes of Cannula: {{caption_text}}



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References:

https://emedicine.medscape.com/article/1998177-periprocedure?form=fpf

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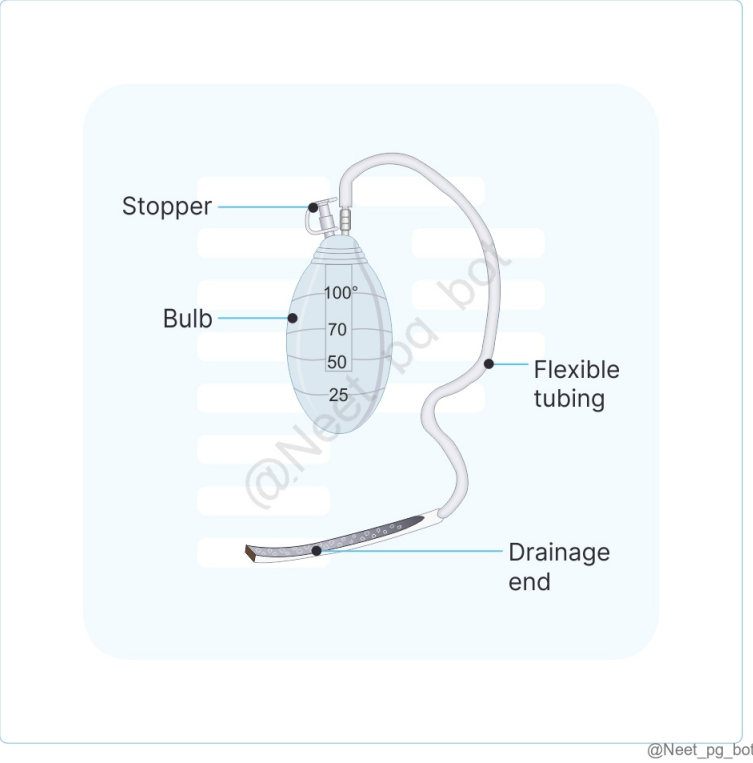
Q58: A 45-year-old patient undergoes a mastectomy for breast cancer. Post-operatively, the surgeon decides to use a closed suction drain. Which of the following drain types is shown in the image below? (Q858365)

A. Penrose drain

B. Jackson Pratt drain

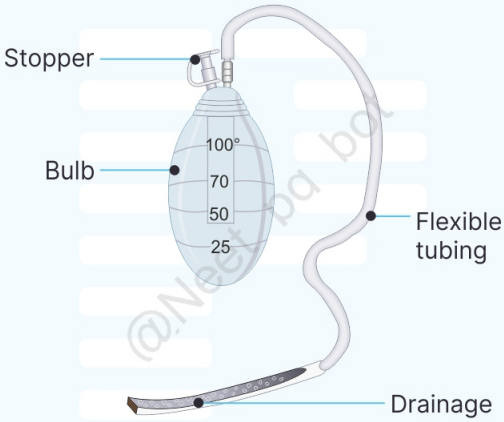
C. Romovac suction drain

D. Hemovac drain



Correct Answer: B. Jackson Pratt drain

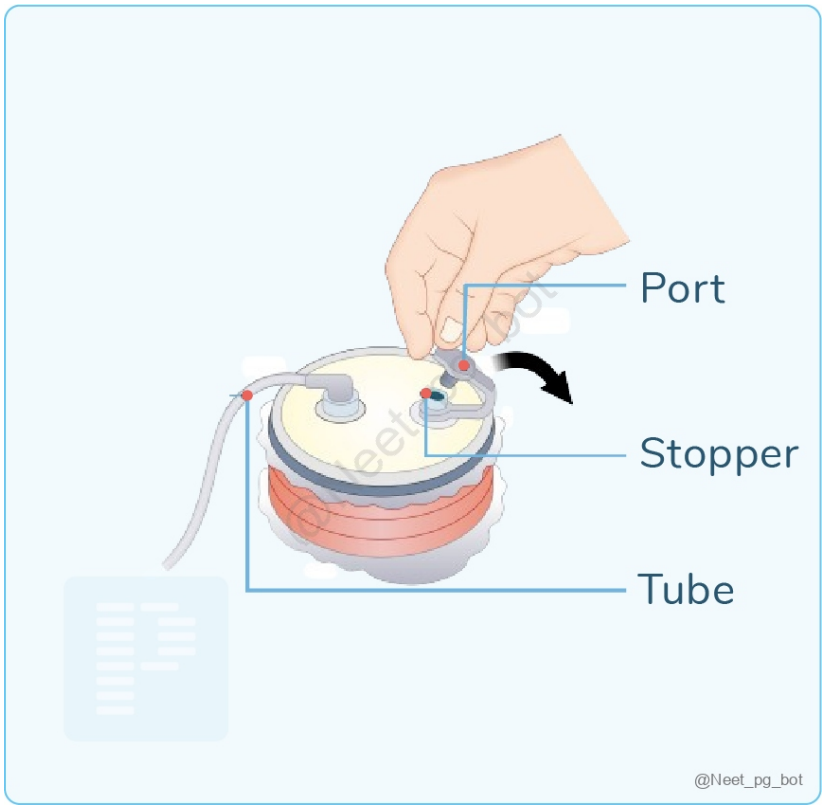
Explanation: The image shows a Jackson Pratt (JP) drain , which is a type of closed suction drain commonly used in various surgical procedures, including mastectomies. Jackson Pratt drain: Consists of a soft, flattened silicone tube connected to a soft plastic bulb The bulb can be compressed to create negative pressure Typically clear or translucent, allowing easy visualization of drainage Suitable for various surgeries, including breast, plastic, and abdominal procedures Easy to empty and maintain by patients {{caption_text}} Penrose drain (Option A) This is an open, passive drain consisting of a soft rubber tube. It relies on gravity and capillary action for drainage. {{caption_text}} Jackson-pratt drain (Option B) Consists of a soft, flattened silicone tube connected to a soft plastic bulb The bulb can be compressed to create negative pressure Suitable for various surgeries, including breast, plastic, and abdominal procedures {{caption_text}} Romovac suction drain (Option C) Another type of closed suction drain Uses a spring-loaded mechanism to create constant negative pressure Often used in orthopedic surgeries and joint replacements {{caption_text}} Hemovac drain (Option D) This is another brand of closed suction drain, similar in principle to the JP drain. However, Hemovac drains typically have a larger, more rigid collection chamber compared to the soft, compressible bulb of the JP {{caption_text}}


Stopper
Bulb
100°
70
50
25
Flexible tubing
Drainage end

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References:

https://www.saintjohnscancer.org/melanoma/patient-resources/jackson-pratt-jp-drain/

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Q59: What is triage for? (Q856526)

A. To prepare for a disaster

B. To assess the impact of a disaster

C. To classify the priority of treatment

D. To rehabilitate following a disaster

Correct Answer: C. To classify the priority of treatment

Explanation: Triage is the process of classifying patients based on the severity of their condition and the priority of treatment required. It is commonly used in emergencies or mass casualty incidents with limited resources. Triage helps in efficiently allocating resources by prioritising patients based on the urgency of their condition. To prepare for a disaster (Option A) is incorrect because the purpose of triage is not to prepare for a disaster but rather to assess and prioritise patients during a disaster or emergency situation. To assess the impact of a disaster (Option B) is incorrect because while triage is a part of disaster response, its main objective is not to assess the overall impact of a disaster but to categorise patients based on the severity of their injuries or illnesses. To rehabilitate following a disaster (Option D) triage is not involved in the rehabilitation process after a disaster. Triage focuses on initial assessment and prioritisation of patients during the acute phase of a disaster.

References:

Bailey & Love’s Short Practice of Surgery, 28th Edition, Page 449-452

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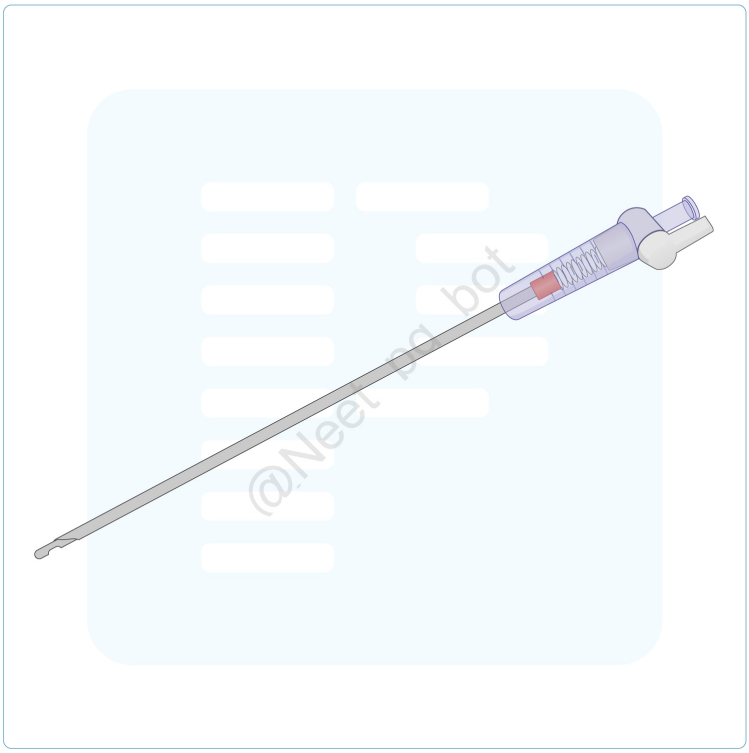
Q60: What is the name of the instrument depicted below, which is utilized for the creation of a pneumoperitoneum? (Q856535)

A. Veress needle

B. Morris' needle

C. Yankauer suction tip

D. Von Graefe needle



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Correct Answer: A. Veress needle

Explanation: The Veress needle is a surgical instrument used to create a pneumoperitoneum, which is the insufflation of carbon dioxide gas into the peritoneal cavity to create a working space during laparoscopic procedures. The Veress needle is inserted through a small incision or through the umbilicus, and its tip is equipped with a spring-loaded mechanism that allows for controlled penetration of the abdominal wall. Once inserted, carbon dioxide gas is introduced through the needle to inflate the peritoneal cavity. Morris' needle (Option B) Not commonly used for pneumoperitoneum; it is mainly used in general surgical procedures for drainage or infiltration. Yankauer suction tip (Option C) A rigid suction device used primarily in oropharyngeal and surgical suctioning , not for insufflation. Von Graefe needle (Option D) A specialized needle used in ophthalmic surgery , particularly for cataract procedures , unrelated to laparoscopic surgery

References:

Bailey & Love’s Short Practice of Surgery (28th Edition) page 102, 103

↑ *Back to this question in Part A*

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Q61: What is the needle placement angle when using the interrupted suturing technique to suture a laceration in the ER? (Q856559)

A. 60 degrees

B. 70 degrees

C. 80 degrees

D. 90 degrees

Correct Answer: D. 90 degrees

Explanation: When using the interrupted suturing technique, the needle should be placed perpendicular to the skin surface, creating a 90-degree angle. This angle allows for proper penetration and closure of the wound edges. By inserting the needle at a right angle to the skin, the sutures can adequately hold the tissues together and provide optimal wound closure and healing. 60 degrees (Option A) would be too shallow for proper needle placement during interrupted suturing. 70 degrees (Option B) is also too shallow for interrupted suturing. 80 degrees (Option C) is closer to the correct angle of 90 degrees but is still not ideal for interrupted suturing.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Pages 95, 107, 108, 109.

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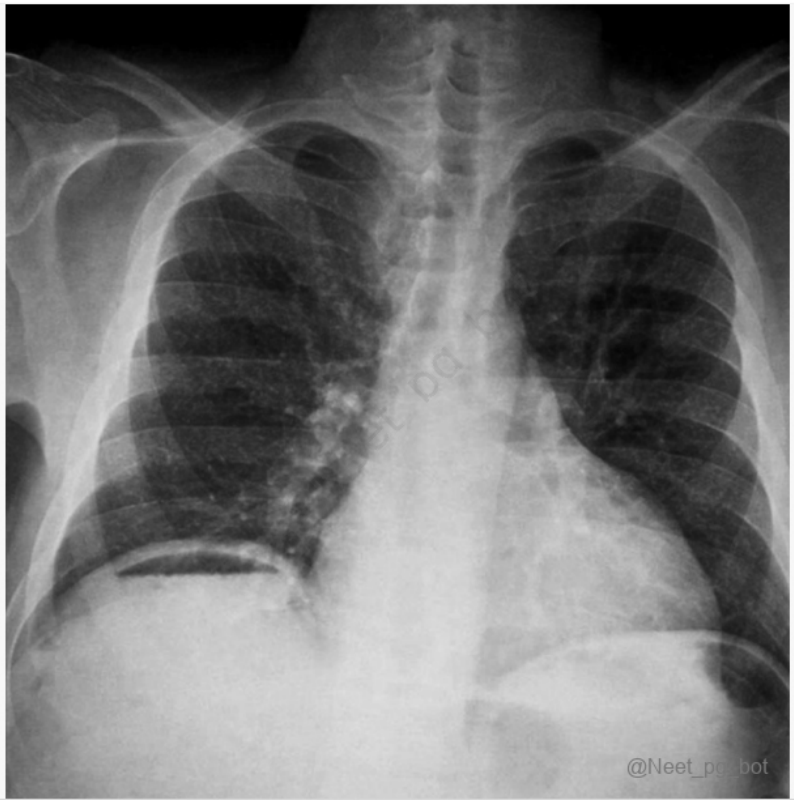
Q62: What might you suspect as the diagnosis for a 26-year-old male patient who arrives at the emergency department complaining of abdominal pain and constipation persisting for the last three days? The patient recalls being struck in the abdomen by a bull three days ago. Could yo u examine the provided X-ray to aid in your assessment? (Q856561)

A. Hemothorax

B. Hollow viscus perforation

C. Pneumothorax

D. Intestinal obstruction



Correct Answer: B. Hollow viscus perforation

Explanation: Hollow viscus perforation refers to the rupture or perforation of a hollow organ within the abdominal cavity. In this case, the patient's symptoms of abdominal pain and obstipation, along with a history of abdominal trauma from a bull gore, raise suspicion for a hollow viscus injury. The X-ray suggestive of perforation, such as free air under the diaphragm Hemothorax (Option A) Accumulation of blood in the pleural cavity due to trauma, does not match the patient's symptoms of abdominal pain and obstipation resulting from a bull gore injury. Pneumothorax (Option C) Air in the pleural cavity causing lung collapse, doesn't align with the patient's symptoms of abdominal pain and obstipation due to bull gore injury. Pneumothorax typically presents with sudden chest pain, breathing difficulty, and decreased breath sounds. Intestinal obstruction (Option D) Blockage of intestinal flow, partially fits the patient's presentation but doesn't explain the bull gore injury and X-ray findings of perforation.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, pages 373

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Q63: Which of the following methods is accurate for measuring the nasogastric tube? (Q856572)

A. Tip of nose to ear lobule to xiphisternum

B. Angle of mouth to tragus to xiphisternum

C. Ala of nose to angle of mandible to xiphisternum

D. Angle of mouth to ear lobule to umbilicus

Correct Answer: A. Tip of nose to ear lobule to xiphisternum

Explanation: The correct method for measuring a nasogastric tube involves measuring the distance from the tip of the patient's nose to the ear lobule and then down to the xiphisternum, which is the lower end of the sternum. This measurement helps determine the appropriate length of the nasogastric tube that needs to be inserted. Nasogastric (NG) Tubes: Inserted through the nose and passed into the stomach Larger in diameter (typically 14-18 French) Common markings: Measurement markings in centimeters to indicate the insertion depth 'STOMACH' printed on the tube to confirm correct placement Indications: Decompression of the stomach (e.g., in intestinal obstruction) Enteral feeding in adults and older children Medication administration {{caption_text}}



References:

Bailey & Love's Short Practice of Surgery, 28th Edition, page 115,116

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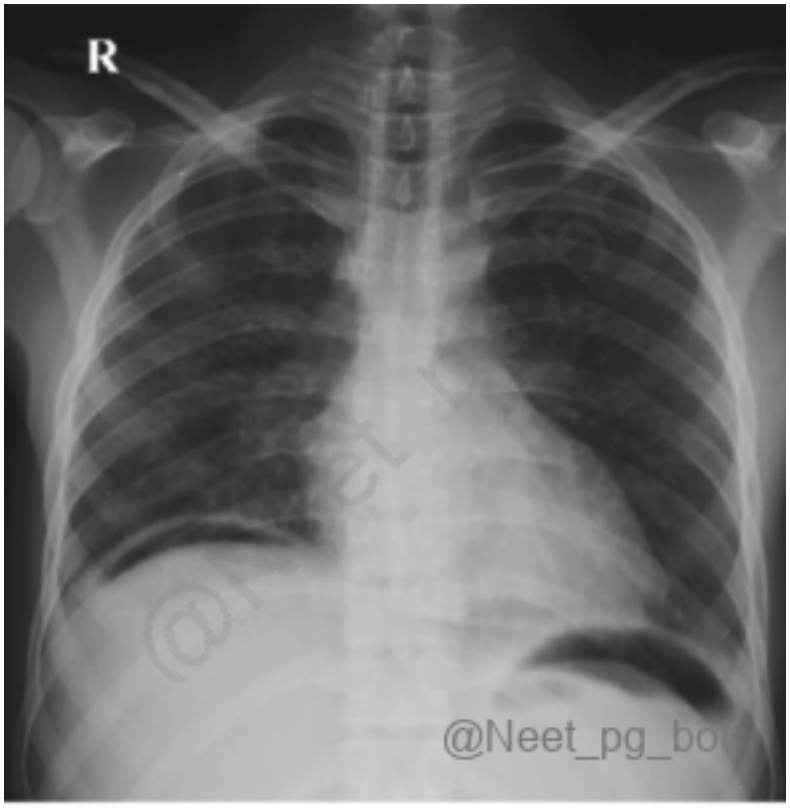
Q64: What is the most probable diagnosis for a 25-year-old patient who has been experiencing abdominal pain and fever for the past three days, based on the provided chest X-ray taken in an upright position? (Q856206)

A. Hollow viscus perforation

B. Gastric volvulus

C. Liver abscess

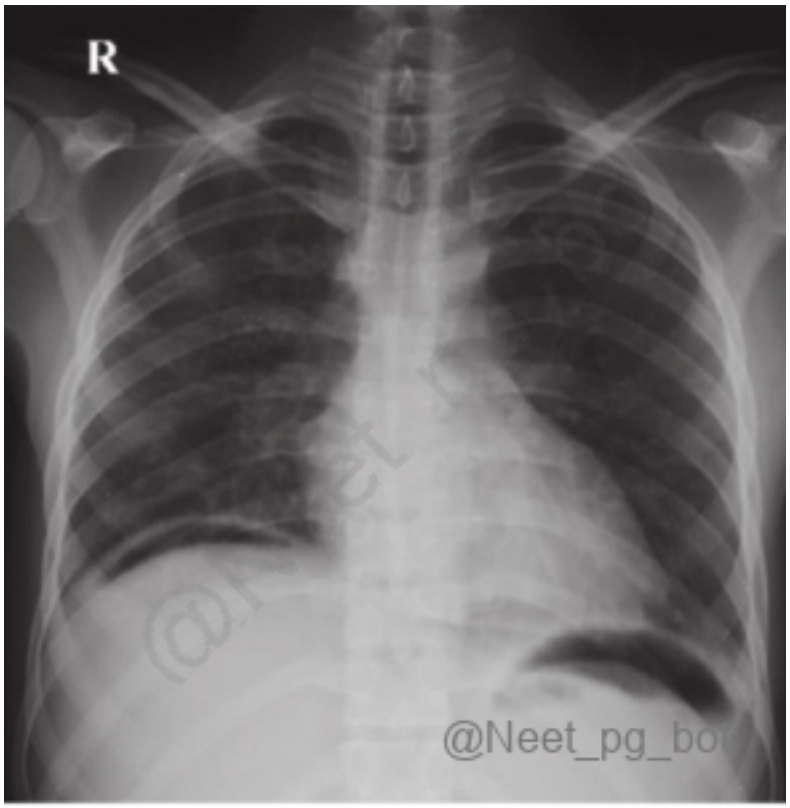
D. Empyema thoracis

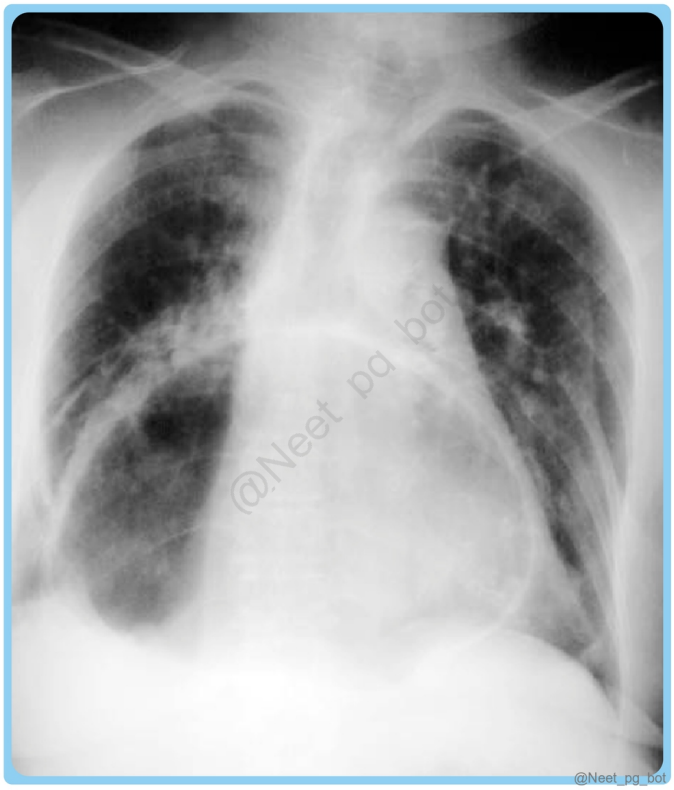


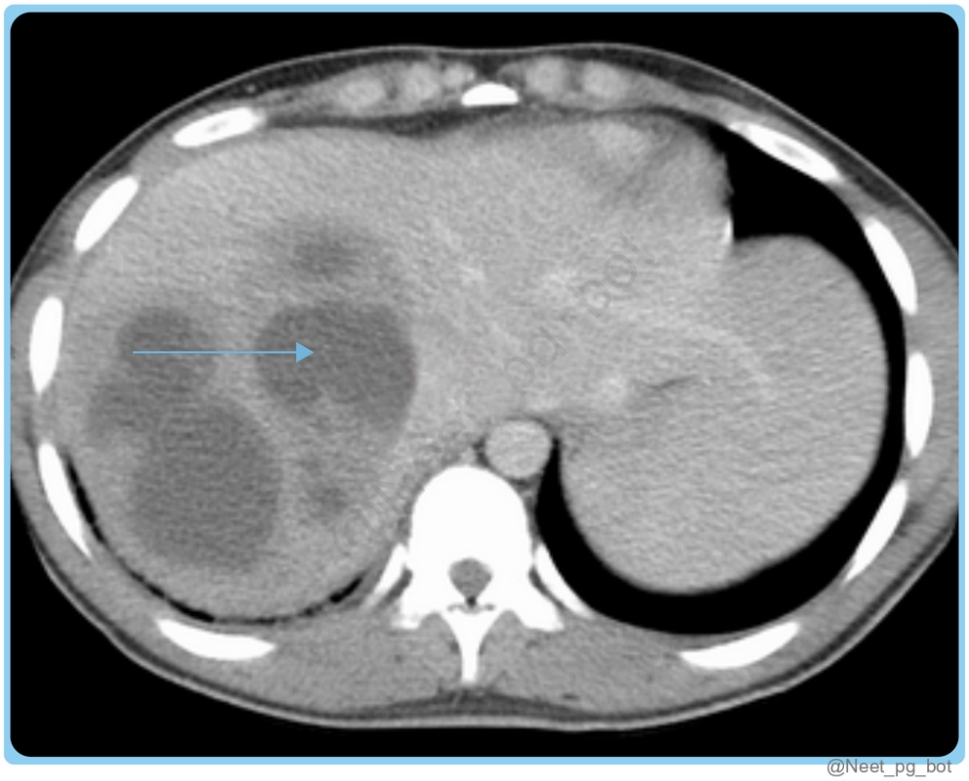
Correct Answer: A. Hollow viscus perforation

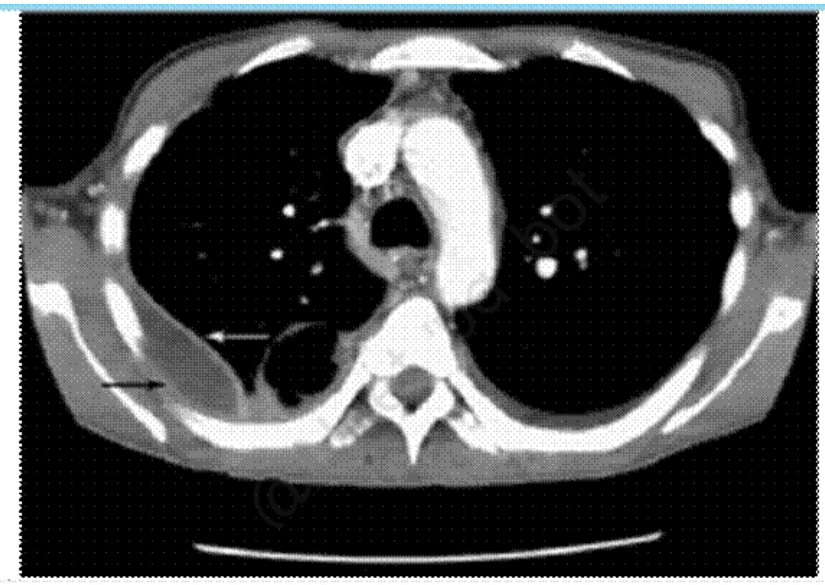
Explanation: The case of abdominal pain, fever, and an upright X-ray showing free air under the diaphragm is most likely diagnosed as hollow viscus perforation . The contents of the organ, including digestive juices and bacteria, can leak into the surrounding tissues or abdominal cavity, leading to a serious condition known as peritonitis. Diagnosis: Free air under the diaphragm (upright plain film taken at the level of the diaphragm). (Option A) Pneumoperitoneum Pneumoperitoneum refers to the presence of free gas in the peritoneal cavity, typically indicating a perforated viscus (e.g., perforated peptic ulcer). Causes: Common: Perforated peptic ulcers, bowel obstruction, inflammatory conditions, ischemia, injury during colonoscopy. Other causes without peritonitis: Postoperative (up to 7 days), peritoneal dialysis, sealed perforation, and tracking from pneumomediastinum. Diagnosis on Imaging: Erect CXR: Free gas is seen under the right hemidiaphragm (cupola

sign) , but it is difficult to differentiate on the left due to gastric or colonic gas. Supine AXR: Right upper quadrant gas in the perihepatic, subhepatic space, Morrison’s pouch, and ligament visualisation (e.g., falciform ligament). Rigler’s Sign: Visualization of both sides of the bowel wall due to surrounding gas. CT Scan: Most sensitive; small volumes of gas seen in the liver or peritoneal recesses, often using broad window settings. Gastric volvulus (Option: B) occurs when the stomach twists around its axis, leading to obstruction and preventing the passage of food and fluids. It typically causes symptoms like vomiting, nausea, and distension, but not free air under the diaphragm, as seen in hollow viscus perforation. Imaging, such as X-rays or CT scans, may reveal an abnormal stomach position, often showing twisted loops. {{caption_text}} Liver abscess (Option C) appears as a well-defined dark area on ultrasound and a hypodense lesion with a defined rim on CT. It may cause fever and abdominal pain but doesn’t cause free air under the diaphragm. Diagnosis is typically made with ultrasound or CT, which shows localised fluid collections. {{caption_text}} Empyema thoracis (Option D) is an infection in the pleural space, causing fever, cough, and pleuritic chest pain. It doesn’t cause free air under the diaphragm. On X-ray, it shows a loculated pleural effusion, with possible diaphragm elevation. CT reveals thickened pleura and fluid collections, while ultrasound aids in detecting and draining fluid. {{caption_text}}




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Split pleura sign: Pleural fluid collection juxtaposed between the enhancing visceral (white arrow) and parietal (black arrow) pleura

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References:

Sabiston Textbook of Surgery, 21st Edition, Page 1140

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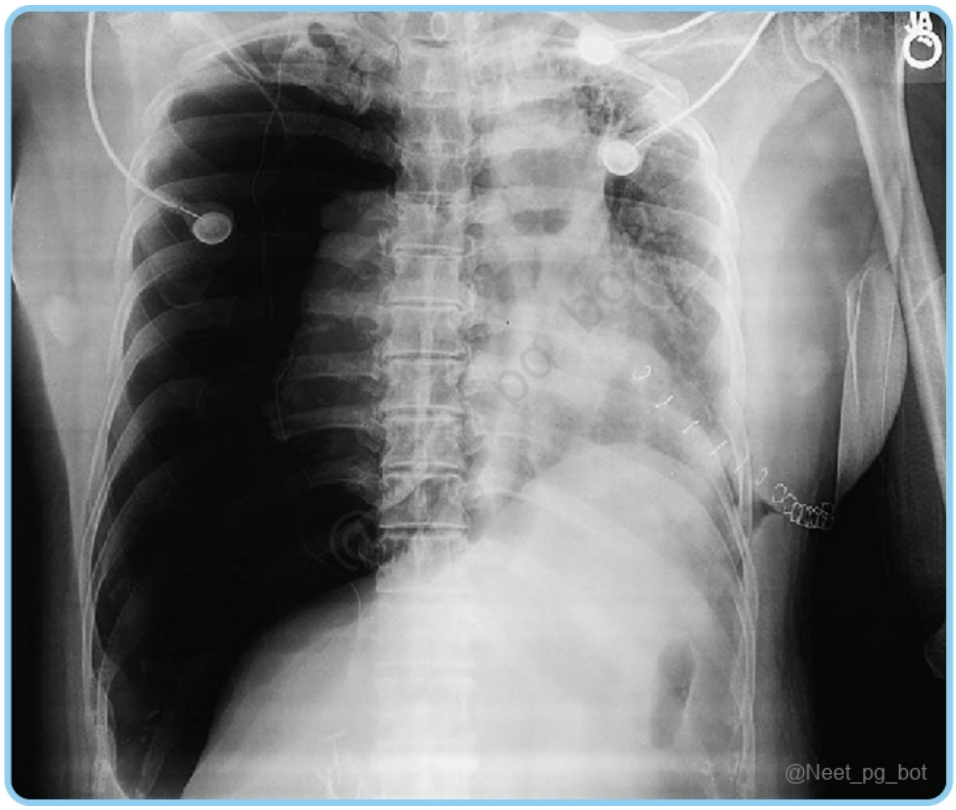
Q65: A patient following a road traffic accident presented with subcutaneous emphysema. On auscultation, there was no air entry on the right side. Vitals were unstable. What will be your immediate management? (Q856246)

A. Insertion of wide bore needle in the 2nd intercostal space

B. Wide bore needle decompression and IV fluids

C. Intubation and positive pressure ventilation

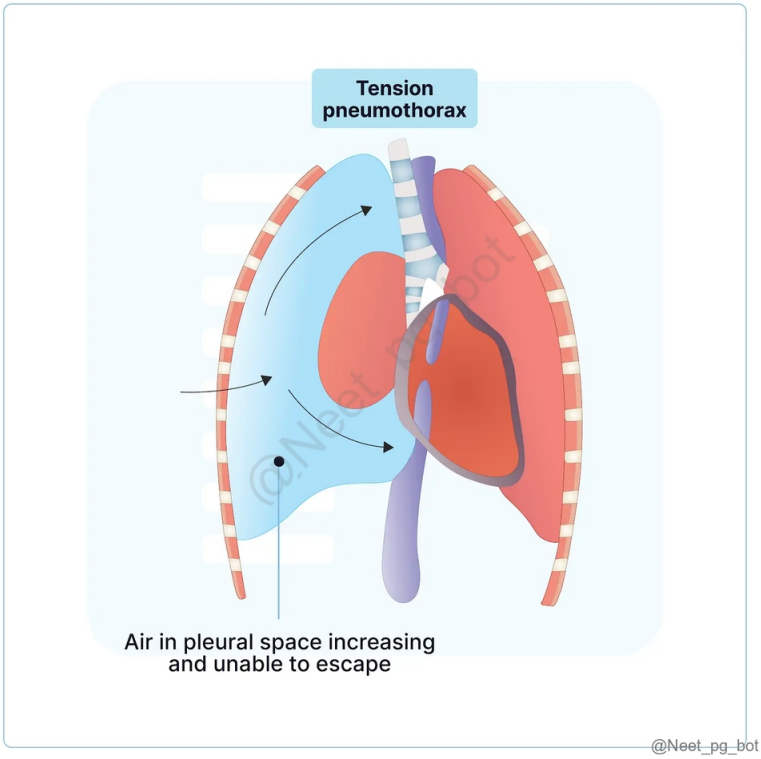
D. e-FAST



Correct Answer: A. Insertion of wide bore needle in the 2nd intercostal space

Explanation: The patient's clinical findings and X-ray confirm a right-sided Tension Pneumothorax and immediate management involves decompressing the pleural space by inserting a wide-bore needle in the 2nd intercostal space (since the age of the patient is not mentioned and we can assume the patient is a child and the options give in 2nd ICS). It is a life-threatening condition where air accumulates in the pleural cavity under pressure, causing lung collapse on the affected side, mediastinal shift , and severe impairment of cardiovascular function. Pathology: It occurs when air enters the pleural cavity through a "one-way valve" mechanism, leading to lung collapse and mediastinal shift towards the opposite side. ↑Pleural pressure→ Opposite lung compression→ ↓venous return→ ↓cardiac output and potentially sudden death . Aetiology: Penetrating chest trauma. Blunt chest trauma with parenchymal lung injury. Iatrogenic lung injury (e.g., central venous catheterisation), and mechanical positive-pressure ventilation. Clinical Features: Restlessness, tachypnea, dyspnea, tachycardia, and chest pain. Distended neck veins, hyper-resonance, and decreased or absent breath sound on the affected side. Late findings may include tracheal deviation and cyanosis. Hypotension and severe mediastinal/tracheal shift are also common. Management: Immediate decompression with a large-bore needle in the 2nd intercostal space at the midclavicular line or the "safe triangle" via needle thoracostomy or finger thoracostomy. (Option A) Followed by intercostal chest tube (ICT) placement in the 5th intercostal space in the anterior axillary line. Provide oxygen, analgesics, antibiotics, and ventilator support if necessary. Wide bore needle decompression and IV fluids (Option B): While needle decompression is the correct initial management for tension pneumothorax, IV fluids are secondary and do not directly address the life-threatening issue of air accumulation in the pleural space. The priority is to relieve the pressure with a needle insertion, followed by stabilization with fluids. Intubation and positive pressure ventilation (Option C) are important for managing respiratory failure or compromised airways, but in the case of a tension pneumothorax, these could worsen the condition by increasing the pressure in the chest. The first step should always be to decompress the pleural space to relieve pressure. e-FAST (Extended Focused Assessment with Sonography for Trauma) (Option D) exam is useful for detecting pneumothorax, hemothorax, or internal bleeding,

but in this case, the patient’s clinical signs strongly suggest a tension pneumothorax. Immediate decompression is needed before further diagnostic imaging.



References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 374.

Textbook of SRB’s Surgical Operations, 6th Edition, Page, 1101-1102.

↑ *Back to this question in Part A*

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Q66: A patient, after a road traffic accident, presented with pain in the abdomen. The resident examined the child and found that vitals were stable, and tenderness was present in the left lumbar region. Which is the best investigation of choice? (Q856254)

A. Contrast-enhanced CT scan

B. Retrograde urethrogram

C. Wait and watch

D. Emergency laparotomy

Correct Answer: A. Contrast-enhanced CT scan

Explanation: A CT scan is a non-invasive tool that provides detailed images of abdominal organs and can identify injuries, bleeding, or fractures in patients with abdominal pain after a road traffic accident. The most commonly injured organ in: Blunt trauma abdomen is the spleen > liver. Penetrating trauma is the liver. Gunshot injury is the small intestine > large bowel > liver > intra-abdominal vasculature. The most commonly injured part of the bowel in blunt trauma abdomen is the jejunum and the ileum. The most commonly injured structure in seat belt injury is the mesentery. First investigation done in blunt trauma abdomen: FAST (Focused Assessment with Sonography for Trauma). Investigation of choice for stable blunt trauma abdomen: CECT (Contrast-Enhanced CT scan). (Option A) Retrograde urethrogram (Option B) is used to assess urethral injuries, especially with pelvic fractures or blood at the meatus, but it isn't the best initial test for abdominal pain with left lumbar tenderness. Wait and watch (Option C) may be considered if the patient is stable with no immediate concern, but in trauma with abdominal pain and tenderness, proper investigation is crucial to rule out serious injuries. Emergency laparotomy (Option D) is a major surgery and should be done only if there's clear evidence of a life-threatening condition, like active bleeding or peritonitis. It's not the first choice for investigation here.

References:

Textbook of SRB’s Surgical Operations, 6th Edition, Page 139.

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 381, 382.

↑ *Back to this question in Part A*

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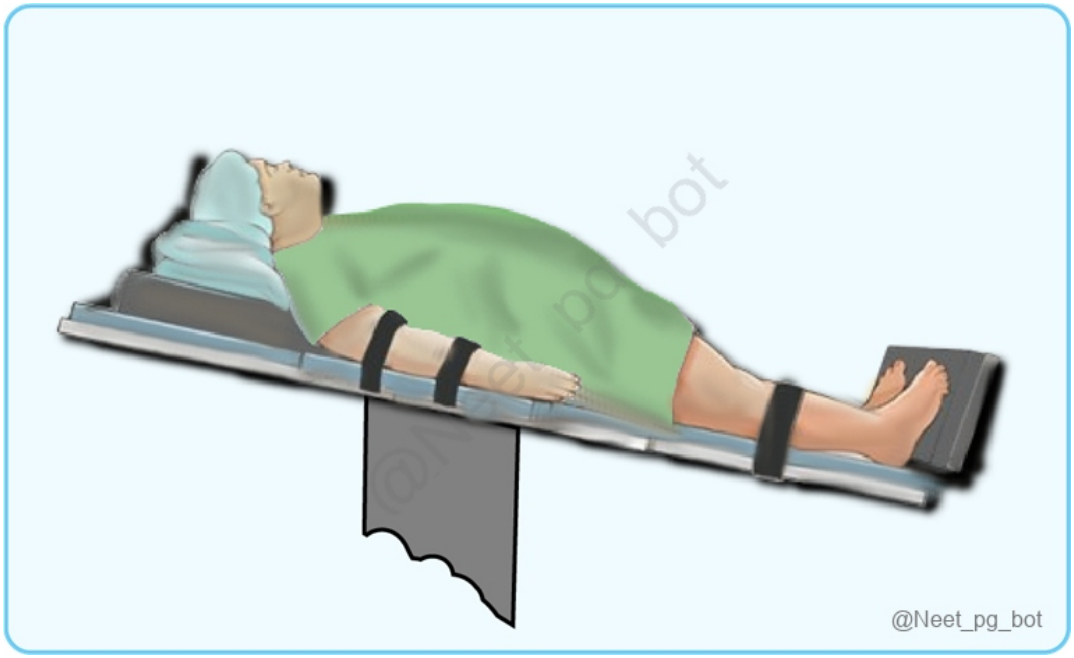
Q67: The position of the patient in the image shown below is known as: (Q856730)

A. Lloyd Davis position

B. Jack knife position

C. Trendelenburg position

D. Reverse Trendelenburg position



Correct Answer: D. Reverse Trendelenburg position

Explanation: The position of the patient shown in the image is known as the Reverse Trendelenburg position. The patient is placed with the head elevated above the level of the head and the feet lowered than the head. This position is often used during upper abdominal surgeries. Positioning on the Operating Table Position Description Uses and Complications Supine Position Most common position for general surgical procedures. Modifications of Supine position: Rose’s position Shoulder and Arm Extended Trendelenburg Position Reverse Trendelenburg Position Fowler's Position General surgeries. Rose's Position Supine with slight neck extension. Head and neck surgery. Shoulder and Arm Extended Supine with shoulder and arm extended. Axillary and breast surgery. Trendelenburg Position (Option C) Head end tilted down, knees slightly flexed. Pelvic procedures, resuscitating patients in shock. Reverse Trendelenburg Position The head end tilted upward, placing the head higher than the feet. Upper abdominal surgeries. Complication: Right shoulder pain due to CO2 collected under the right dome of the diaphragm during laparoscopic cholecystectomy Fowler's Position Semi-sitting with the trunk raised at 40° and knees bent. Neurosurgery, shoulder surgeries, patients with heart or respiratory failure. Complication: Increased risk of air embolism. Prone Position The patient is intubated and log-rolled onto the operating bed with help. Spinal surgery, extra levator abdominoperineal excision for rectal cancer. Jackknife Position (Option B) (Prone Position Modification) Chest supported, abdomen relaxed by flexing at the hips. Provides excellent access to the perineum. Complication: Positional asphyxia Lateral Decubitus or Kidney Position Lower leg flexed, pillow between legs, upper leg flexed in an exaggerated position. Draining abscesses, lateral thoracotomy, urological and retroperitoneal procedures. Complication: Increased risk of brachial plexus injury due to hyperextension Lithotomy Position Supine with hips and knees flexed, legs in stirrups, hips flexed to 90°. Gynecological, perineal, and urological procedures. Complication: Common peroneal nerve injury if legs are not supported properly Lloyd-Davies Position (Option A) (Lithotomy Modification) Supine with hips minimally flexed (~15°) and a 30° head-down tilt. Gynecological, perineal, and urological procedures.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Pages 94 - 96.

↑ *Back to this question in Part A*

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Q68: FAST stands for (Q856255)

A. First assessment with sonography in trauma

B. Focussed assessment with sonography in trauma

C. First abdominal sonography in trauma

D. Focussed abdominal sonography in trauma

Correct Answer: B. Focussed assessment with sonography in trauma

Explanation: Focussed assessment with sonography in trauma is the correct full form of FAST . It is a rapid, non-invasive ultrasound examination used primarily in trauma settings to detect free fluid (such as blood) in the abdomen or Thorax. It can be used to assess the hepatorenal, splenorenal, and pelvis spaces for fluid that is considered to be blood in a trauma case. It is a valuable tool in the early management of trauma patients as it helps identify life-threatening conditions, such as internal bleeding, which may require immediate surgical intervention. Other options A, C & D are not correct.

References:

Bailey and Love’s Short Practice of Surgery, 28th Edition, Page 373

↑ *Back to this question in Part A*

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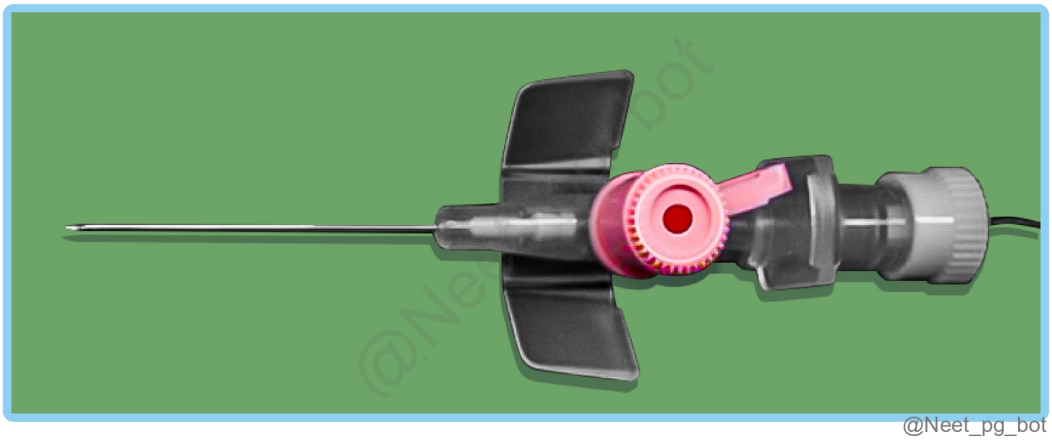
Q69: What is the size of the cannula shown in the below image? (Q856292)

A. 16 G

B. 18 G

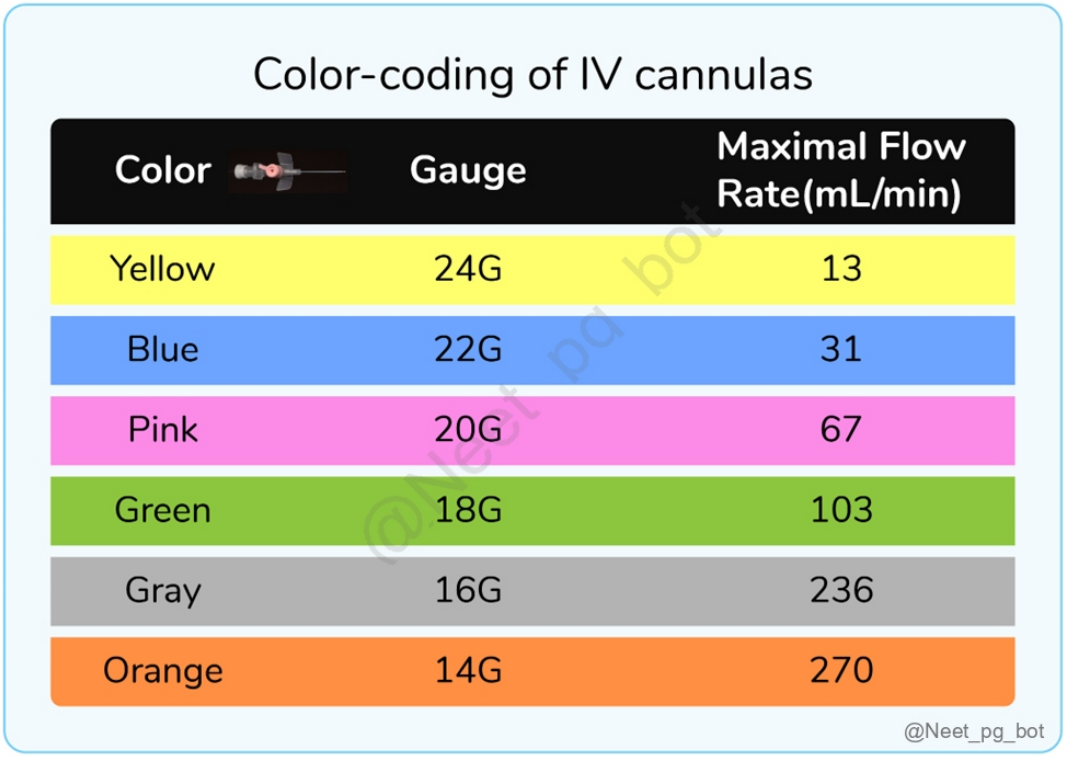
C. 20 G

D. 22 G



Correct Answer: C. 20 G

Explanation: The pink-coloured cannula refers to a cannula with a gauge size of 20. The pink cannula is used for rapid fluid replacement & routine blood transfusions. Colour code Gauge Flow rate (ml/min) Indications Orange 14 240 Used in surgical procedures and trauma Grey (Option A ruled out) 16 180 Used in surgical procedures and trauma Green (Option B ruled out) 18 90 In Trauma and quick blood transfusions Pink (Option C) 20 60 In IV fluids & blood transfusions Blue (Option D ruled out) 22 36 Used in children and older adults Yellow 24 20 Used in neonates and children Violet 26 13 Used in neonates



References:

Medscape Link

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Q70: A 32-year-old woman has been declared brain dead, and her family has chosen to donate her organs. Who would be the most suitable recipient of her organs? (Q856294)

A. 14-year-old child with multi-organ dysfunction syndrome

B. 50-year alcoholic man with liver cirrhosis with 1 month abstinence

C. 70-year-old woman with end-stage renal disease

D. 32-year-old woman with renal failure

Correct Answer: D. 32-year-old woman with renal failure

Explanation: A 32-year-old woman with renal failure is the most suitable recipient for the donor's organs as the age match between the donor and the recipient increases the likelihood of a successful transplant. When it comes to organ donation, the primary considerations for choosing the recipient include matching the donor's organ characteristics such as size, blood type, and tissue compatibility, as well as the recipient's health status and likelihood of receiving benefit from the transplant. Optimal transplantation involves choosing donors and recipients of similar age , among other factors, to minimise compatibility challenges 14-year-old child with multi-organ dysfunction syndrome (Option A): A 14-year-old child with multi-organ dysfunction syndrome is likely to have a more complicated prognosis, and the organs of a 32-year-old woman may not be the best match for a pediatric recipient. 50-year alcoholic man with liver cirrhosis with 1-month abstinence (Option B): Even though he has been abstinent for a month, liver transplant eligibility often requires a longer period of sobriety, as relapse can occur and impact the success of the transplant. Additionally, liver transplants are often prioritized for individuals with urgent needs or a better prognosis. 70-year-old woman with end-stage renal disease (Option C): The 70-year-old woman's potential benefit from a kidney transplant needs careful consideration of her age and associated comorbidities.

References:

Oxford academicLink,

NIHLink.

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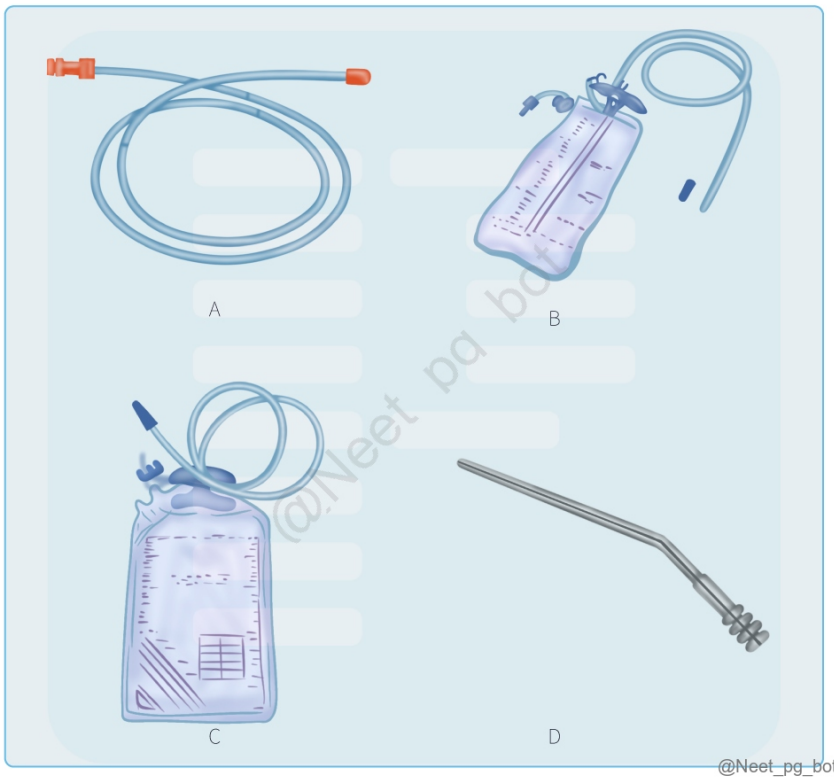
Q71: Match the following 1. Urine Bag 2. Nasogastric Tube 3. Underwater seal bag 4. Suction cannula (Q856303)

A. 1-D, 2-C, 3-A, 4-B

B. 1-C, 2-A, 3-B, 4-D

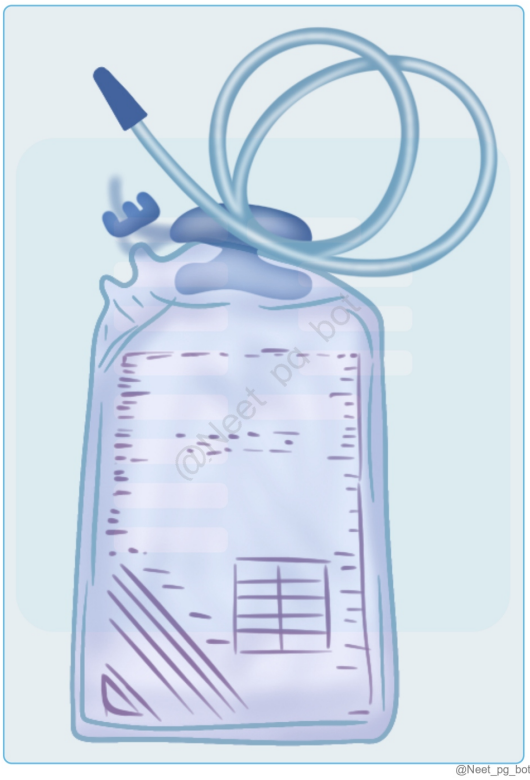
C. 1-D, 2-A, 3-C, 4-B

D. 1-B, 2-A, 3-C, 4-D



Correct Answer: B. 1-C, 2-A, 3-B, 4-D

Explanation: 1. Urine Bag It is a collection bag attached to a catheter inserted into the urinary bladder to collect and measure urine 2. Nasogastric Tube It is flexible tube inserted through the nose and down into the stomach for various diagnostic or therapeutic purposes. 3. Underwater seal bag A device used in chest drainage systems to maintain a seal and prevent air from entering the pleural space 4. Suction cannula {{caption_text}} It is a hollow tube used for the removal of fluid or secretions through suction.


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References:

Sabiston Text Book of Surgery, 21st Edition, Pages 112, 113

↑ *Back to this question in Part A*

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Q72: The components of qSOFA scoring include: A. Mental status B. Blood pressure C. Respiratory rate D. Heart rate (Q856309)

A. A & B

B. C & D

C. A, B & C

D. A, B, C & D

Correct Answer: C. A, B & C

Explanation: qSOFA is quick Sequential Organ Failure Assessment scoring, and it uses 3 components, i.e.; Respiratory rate (≥ 22 breaths per minute) Altered mental status (GCS ≤ 15) Low systolic blood pressure (≤ 100) qSOFA is a bedside score that helps identify patients at risk of death from a suspected infection. Heart rate is not included in the qSOFA score. (Statement D ruled out)

References:

qSOFA Link .

↑ *Back to this question in Part A*

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Q73: Match the correct answer related to the nerve injuries in various surgeries: A. Breast surgery 1. External Laryngeal nerve B. Thyroid surgery 2. Hypoglossal nerve C. Submandibular excision 3. Phrenic nerve D. Thymectomy 4. Long Thoracic Nerve (Q856314)

A. A-1, B-2, C-3, D-4

B. A-2, B-3, C-4, D-1

C. A-3, B-4, C-1, D-2

D. A-4, B-1, C-2, D-3

Correct Answer: D. A-4, B-1, C-2, D-3

Explanation: A. Breast surgery 4. Long Thoracic Nerve This nerve is commonly injured during breast surgery, leading to a "winged scapula". Breast surgery can also lead to Thoracodorsal nerve injury. B. Thyroid surgery 1. External Laryngeal nerve It is a branch of the superior laryngeal nerve and innervates the cricothyroid muscle; it can be injured during thyroidectomy. It leads to hoarseness and difficulty in pitch modulation. C. Submandibular excision 2. Hypoglossal nerve It supplies motor innervation to the muscles of the tongue. It runs near the submandibular gland and can be injured during its excision, leading to deviation of the tongue towards the affected side. D. Thymectomy 3. Phrenic nerve The phrenic nerve may be injured during thymectomy, leading to diaphragm paralysis.

References:

Sabiston, Text Book of Surgery, 21st Edition, Page832,

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 865,

SRB's Manual of Surgery, 6th Edition, Page 441.

↑ *Back to this question in Part A*

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Q74: Which one of the following is excluded from the primary survey? (Q854940)

A. Measuring blood pressure

B. Removing clothes to inspect for wounds

C. Taking CT scan of the patient

D. Checking airway patency

Correct Answer: C. Taking CT scan of the patient

Explanation: Taking a CT scan is not part of the primary survey because it is a diagnostic tool used in the secondary survey . ATLS protocol/ Advanced Trauma Life Support protocol: Primary survey: It includes the airway, breathing, circulation, disability or neurologic condition, and exposure and environmental control, which is known by the mnemonic ABCDE. The airway is assessed immediately by a verbal response, and if it is not clear, needful intervention is carried out. (Option D ruled out) Breathing is evaluated by chest movements, breath sounds and saturation and assisted ventilation is provided if needed. Circulation assessment includes ruling out shock . Assessment of circulatory status (e.g., blood pressure, pulses, bleeding), maintaining IV access and immediate fluid resuscitation are recommended according to the ATLS in case of shock. (Option A ruled out) Neurological assessment is done to assess any traumatic brain or spinal injury and neurogenic shock. The GCS score is evaluated. Environmental control: The patient's clothes should be removed for a thorough examination, and hypothermia should be prevented (warm IV fluids, raised room temperature, body warmers). (Option B ruled out) Secondary survey: This includes a complete patient history and a thorough head-to-toe assessment. It is done

almost immediately in stable patients and includes radiological investigations. The AMPLE history mnemonic is used to gather key details (A llergies, M edications, P ast medical history, L ast meal, E vents/ E nvironment related to the injury). Face deformities, posterior neck injuries, the torso, a per rectal examination for GI bleed, and prostate location are all included in this step. A thorough neurological examination and evaluation of superficial injuries are done. The complete physical examination and use of imaging are now included in the tertiary survey.

References:

Sabiston's Text Book of Surgery, 21st Edition, Pages 391, 392

↑ *Back to this question in Part A*

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Q75: Which of the following is not taken into consideration in ASEPSIS wound scoring? (Q854951)

A. Wound swab from the site

B. Serous discharge

C. Erythema

D. Induration

Correct Answer: D. Induration

Explanation: The Asepsis scoring system evaluates infection based on visible signs like erythema, exudate type, and laboratory investigations , but induration is not directly taken into account. Asepsis wound score: Parameters Score A dditional treatment: Antibiotics Pus drainage Wound debridement 10 5 10 S erous discharge - For 5 days of the first 7 days of wound infection (Option B ruled out) 0-5 Daily E rythema - For 5 days of first 7 days of wound infection (Option C ruled out) 0-5 Daily P urulent fluid - For 5 days of the first 7 days of wound infection 0-10 Daily S eparation of deep tissues - For 5 days of the first 7 days of wound infection 0-10 Daily I solation of bacteria (Option A ruled out) 10 S tay in the hospital (in-patient) >14 days due to infection 5 Asepsis scores are grouped into the following categories: Satisfactory healing: 0-10 Disturbance of healing:11-20 Minor SSI: 21-30 Moderate SSI: 31-40 Severe SSI: >40

References:

SRB's Manual of Surgery, 6th Edition, Page 62. NIH Link .

↑ *Back to this question in Part A*

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Q76: What could be the most likely reason for a patient presenting with chronic non-pitting edema in the lower extremities? (Q858480)

A. Lymphedema

B. Arterial Disorders

C. Venous Disorders

D. Coronary heart disease

Correct Answer: A. Lymphedema

Explanation: Lymphedema refers to the accumulation of lymph fluid in the interstitial tissue, typically resulting in chronic non-pitting edema . In this type of edema, when pressure is applied to the swollen area, the indentation doesn't remain. Causes of Primary Lymphedema Congenital Lymphedema Lymphedema Praecox Lymphedema Tarda Age: Seen in < 1 year of age Present at birth. Lower limb, genitalia, and face are involved. Usually, B/L and multiple limbs are involved. Familial version of congenital lymphedema – known as Milroy's disease. M/C type of primary lymphedema (>90% of cases). Age: 1 to 35 years. M/C seen in females. Usually U/L. Involves calf and foot Familial version of lymphedema praecox - known as Meig's disease. Age: Usually seen in > 35 years age group It is a rare disease. Secondary Lymphedema Filariasis MC overall cause of lymphedema worldwide MC secondary cause of lymphedema Lymphoedema due to Lymphatic obstruction Surgery Axillary block dissection- MC cause of secondary lymphedema in the USA MC iatrogenic cause of secondary lymphedema Inguinal block dissection Lymphedema due to Lymphatic disruption Infections Tuberculosis Syphilis Fungal and Bacterial infections Other causes: Trauma Malignancy Radiotherapy Arterial Disorders (Option B) like peripheral artery disease (PAD) generally present with claudication and other signs of ischemia , such as cold extremities , pale skin , and ulcers . Eedema is not a common finding here. Venous Disorders (Option C) can cause oedema in the lower extremities. However, in venous disorders, the oedema is due to venous stasis , and it's generally pitting rather than non-pitting . Signs like varicose veins or venous ulcers are also present. Coronary heart disease (Option D) mainly affects the coronary arteries and leads to symptoms such as chest pain , shortness of breath , and possibly heart attacks . While heart failure (due to CHD) can cause edema in the legs, which is usually pitting because it results from fluid retention and venous congestion due to impaired cardiac function .

References:

SRB's Manual of Surgery, 6th Edition, Page 242

↑ *Back to this question in Part A*

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Q77: A 38-year-old man was brought to the emergency department after sustaining an RTA and injury to the lower chest. On presentation, the patient is stable, and vitals are normal. Chest radiography showed clear lung fields. What is the next step in management? (Q858483)

A. eFAST

B. Tube thoracostomy

C. CECT chest

D. CECT abdomen

Correct Answer: A. eFAST

Explanation: According to ATLS trauma protocol , eFAST is an adjunct to the primary survey and should be performed in all significant blunt trauma patients , regardless of hemodynamic stability. Injury to the lower chest raises suspicion for upper abdominal organ injury (liver, spleen, diaphragm) even if the chest X-ray is normal. Therefore, the next immediate step is eFAST , which quickly detects: Intraperitoneal free fluid (hemoperitoneum) Pericardial effusion Occult pneumothorax or pleural fluid not visible on X-ray This bedside scan is rapid, non-invasive, and ensures there is no internal bleeding before sending the patient for CT. Tube thoracostomy (Option B): Not indicated, as the chest X-ray shows no pneumothorax or hemothorax . CECT chest (Option C): Not part of the primary survey and unnecessary when CXR is normal. CECT abdomen (Option D): This is performed later during the secondary survey , after eFAST, if the patient remains stable.

References:

Bailey and Love's Short Practice of Surgery, 28th Edition, Page 373

↑ *Back to this question in Part A*

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Q78: According to triage, which of the following categories of patients comes under green? (Q855552)

A. Ambulatory patients

B. Moderate priority

C. High Priority

D. Dead patients

Correct Answer: A. Ambulatory patients

Explanation: In triage, patients are categorised based on the urgency of their medical needs, and the green category is for ambulatory patients , meaning those who are able to walk and have non-life-threatening injuries. Colour Priority Medical Need Clinical Status Examples Red First Immediate Critical, but likely to survive if treatment is given early Severe facial trauma Tension pneumothorax Profuse external bleeding Haemothorax Flail chest Major intra-abdominal bleed Extradural haematomas Yellow Second Urgent Critical, but likely to survive if treatment is

given within hours Compound fractures Degloving injuries Ruptured abdominal viscus Pelvic fracture Spinal injuries Green Third Non-Urgent Stable, likely to survive even if treatment is delayed for hours to days Simple fractures Sprains Minor lacerations Black Last Unsalvageable Not breathing, pulseless, so severely injured that no medical care is likely to help. Severe brain damage Very extensive burns Major disruption/ loss of chest or abdominal wall structures Moderate priority (Option B) can be classified as yellow in triage. These patients have conditions that are serious but not immediately life-threatening. They may require medical attention, but they can still wait for a period without their condition deteriorating rapidly. High priority (Option C) is generally categorised as red in triage, indicating immediate care is required . These patients have life-threatening injuries or conditions and need immediate medical intervention. Dead patients (Option D) are not part of the triage process, as they are not classified for further care. Triage prioritises patients based on the severity of their condition to allocate resources effectively, focusing on those who can be saved or treated.

References:

Sabiston's Text Book of Surgery, 21st Edition, Pages 560, 561

↑ *Back to this question in Part A*

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Q79: Identify the fluid shown below on the basis of composition: Sodium (Na+) 131 millimoles per liter Chloride (Cl-) 111 millimoles per liter Lactate 29 millimoles per liter Potassium (K+) 5 millimoles per liter Calcium (Ca2+) 2 millimoles per liter Total osmolarity 279 millimoles per liter (Q855761)

A. Haemaccel

B. Ringer lactate

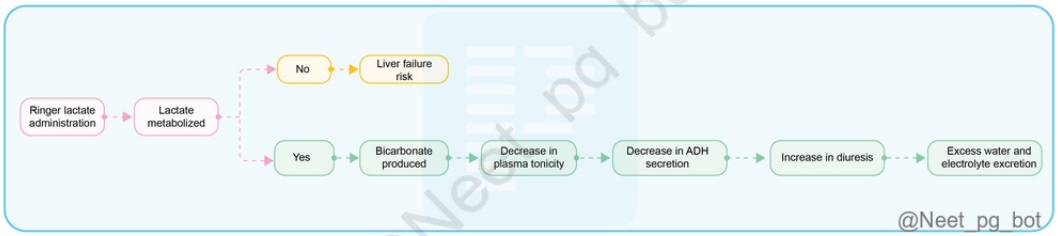
C. Isolyte

D. Isolyte M

Correct Answer: B. Ringer lactate

Explanation: The composition provided matches Ringer's lactate , a commonly used intravenous (IV) fluid in clinical settings for fluid resuscitation and electrolyte correction . It is also called at Hartmann's solution Ringer's Lactate (Balanced Crystalloid) Usage : Maintenance fluid during surgery. Advantage : Prevents hyperchloremic metabolic acidosis, unlike normal saline. Excretion : Rapid elimination is due to the suppression of ADH secretion, which promotes diuresis. Buffer : Lactate is metabolised to bicarbonate, maintaining or slightly increasing HCO3 levels and preventing acidosis. Haemaccel (Option A) is a colloidal plasma expander used to restore blood volume, and it does not contain the same electrolyte composition as Ringer's lactate. Haemaccel consists of sodium chloride, potassium chloride and calcium chloride. Isolyte (Option C) , with a pH of 7.4, is isosmotic and used for hydration and electrolyte replacement. It provides essential electrolytes, including sodium (a major cation in the solution), and helps correct fluid deficits, promoting urinary output. It typically has concentrations different from Ringer's lactate. Isolyte M (Option D) is another type of intravenous fluid used for

hydration and electrolyte correction, but it also has a different electrolyte profile from Ringer's lactate .



References:

Miller’s Anaesthesia, 9th Edition, Pages 1492, 1495, 1503, 1513, 1514, 1518

↑ *Back to this question in Part A*

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Q80: A patient with an incident of being stabbed in the front part of the abdomen is brought to the emergency. The patient’s vital signs are stable. What will be the next step in managing this case? (Q855832)

A. Emergency laparotomy

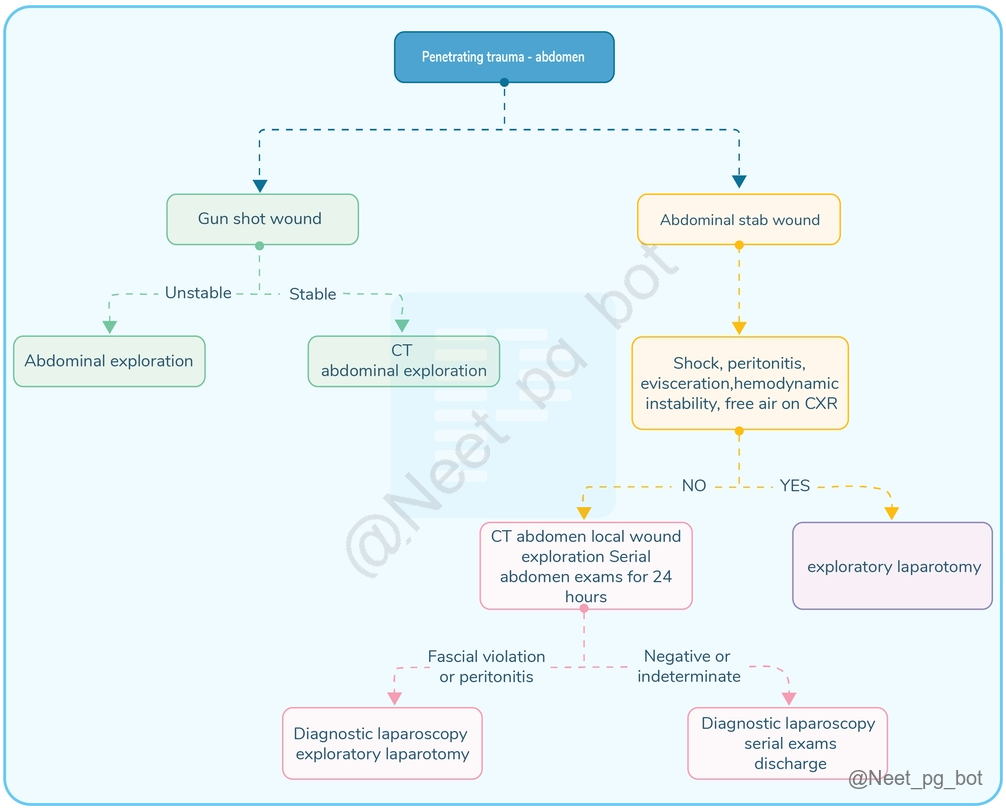
B. Observation

C. Intravenous hydration

D. Further investigation

Correct Answer: D. Further investigation

Explanation: The next step in this case is to investigate further to evaluate the extent of the injury and make a decision regarding whether surgical intervention is necessary. The patient is hemodynamically stable , which means they are not in shock or showing signs of severe internal injury at this point. In such cases, the management should focus on evaluating the injury more thoroughly, as penetrating abdominal trauma may sometimes cause delayed complications or injuries that aren't immediately apparent. Emergency laparotomy is generally indicated only if the patient shows signs of peritonitis , active bleeding , or deterioration in their clinical status. (Option A ruled out) For stable patients, imaging first allows them to make a more informed decision about whether surgery is immediately necessary or if observation and further management are sufficient. (Option B ruled out) Intravenous hydration (Option C) can be important to maintain circulation, especially in trauma cases. However, it is not the primary next step in managing abdominal stab wounds. The focus in this case is on determining the extent of injury using imaging before considering any surgical intervention or supportive measures.



References:

NIH Link

↑ *Back to this question in Part A*

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Q81: A patient presented with blunt trauma to the abdomen. On evaluation, liver injury was noted, for which primary repair was done. Coagulation function was monitored intraoperatively using the method shown below. What is the method used? (Q855836)

A. Thromboelastography

B. Plethysmography

C. Sonography

D. Elastography



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Correct Answer: A. Thromboelastography

Explanation: The method used for monitoring coagulation function in this patient undergoing primary repair for liver injury is thromboelastography (TEG). TEG is a test that studies the ability of blood to form a clot by studying its viscoelastic properties. Stages of Thromboelastogram Definition Normal value Problem it indicates Treatment Reaction time Time taken for the clot to start forming 7.5-15 mins Increased: Deficiency in clotting factors Decreased: Hypercoagulable states Fresh frozen plasma K time- clot firmness Time for the clot to reach fixed strength 3-6 mins Fibrinogen dysfunction Cryoprecipitate Alpha angle Fibrin linking speed 45° and 55° Fibrinogen dysfunction Cryoprecipitate Maximum amplitude The highest vertical amplitude of TEG 50-60 mm Platelets (most often) Clotting factors Platelets Lysis in 30 mins Percentage of amplitude reduction 30 minutes after maximum amplitude 0-8% A high value indicates excess lysis of the clot Tranexamic acid Plethysmography (Option B) is a test used to measure changes in the volume of an organ or body part, often used for assessing lung function . It does not assess coagulation or blood clotting function. Sonography (Option C) or ultrasound is an imaging technique that uses sound waves to visualise internal structures. It can be used for assessing injuries (such as liver damage) but is not a tool for coagulation monitoring. Elastography (Option D) is an imaging technique that evaluates the elasticity or stiffness of tissues. It is used mainly to assess liver fibrosis but is not involved in coagulation monitoring.

References:

NIH Link

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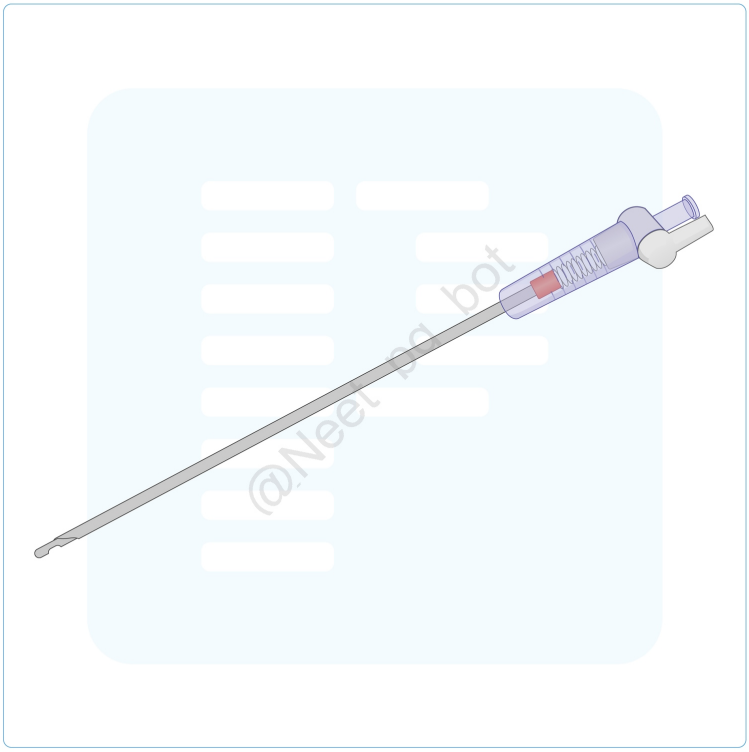
Q82: Identify the given instrument. (Q852678)

A. Veress needle

B. Hasson's cannula

C. Jamshidi needle

D. 3 mm Trocar

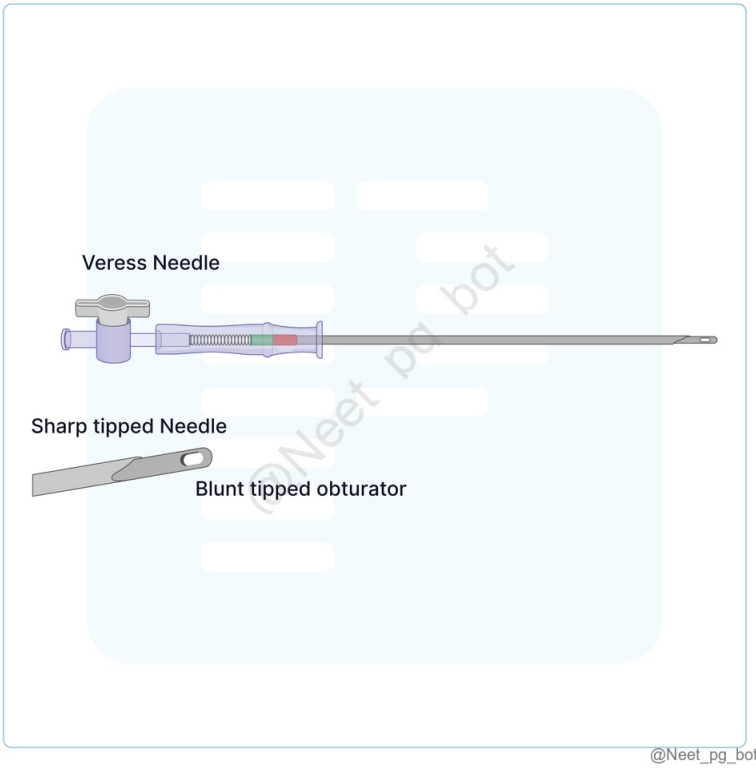


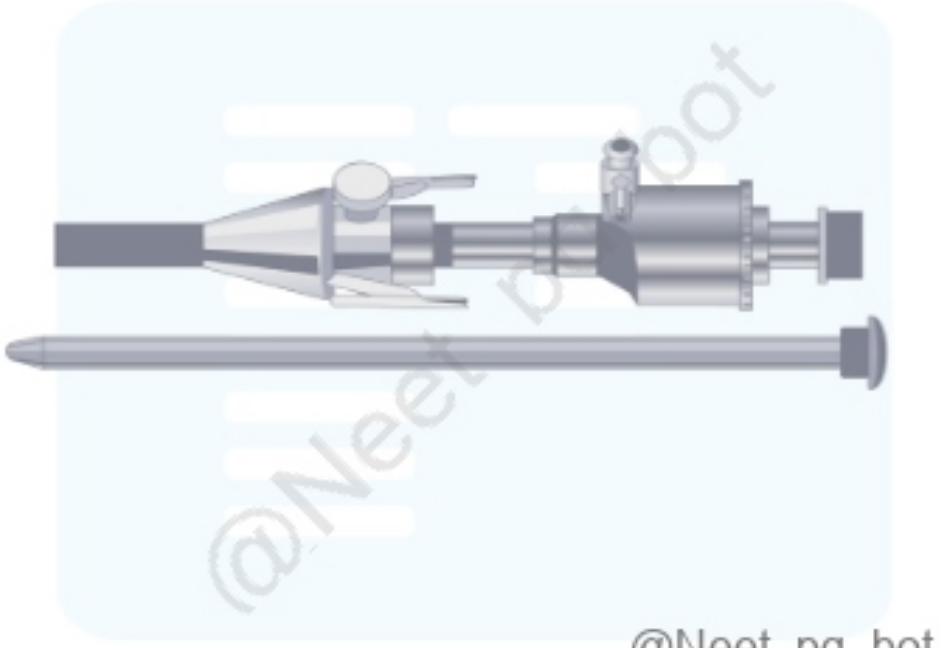
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Correct Answer: A. Veress needle

Explanation: Function: The Veress needle is used for creating pneumoperitoneum in laparoscopic surgery. Structure: It has a spring-loaded blunt stylet that retracts upon entering the peritoneal cavity. Use: It allows insufflation of CO■ for laparoscopic procedures. Alternative Methods: Hasson’s technique is used for open laparoscopy instead. Veress Needle Feature Description Purpose Creates pneumoperitoneum for laparoscopy Mechanism Spring-loaded blunt stylet for safety Insertion Site Commonly at the umbilicus Alternative Hasson’s open technique Pneumoperitoneum in Laparoscopy Aspect Details Definition Artificial creation of gas insufflation in the peritoneal cavity to facilitate laparoscopic surgery. Common Gas Used Carbon dioxide (CO■) due to its rapid absorption, non-combustibility, and high solubility in blood. Techniques Closed technique : Uses Veress needle for insufflation. Open technique : Uses Hasson’s cannula without prior insufflation. Insufflation Pressure 10-15 mmHg (optimal for maintaining surgical space while minimizing complications). Complications Gas-related : Hypercapnia, acidosis, gas embolism. Entry-related : Bowel injury, vascular injury, preperitoneal insufflation. Prevention of Complications Correct needle placement confirmation (aspiration test, saline drop test).

Slow controlled insufflation. Monitoring end-tidal CO■ levels. Hasson’s cannula (Option B): Incorrect because it is used in the open technique of laparoscopy, not for closed insufflation. Jamshidi needle (Option C): Incorrect because it is used for bone marrow aspiration, not laparoscopic entry. 3 mm Trocar (Option D): Incorrect because it is a port for inserting laparoscopic instruments, not for initial insufflation.

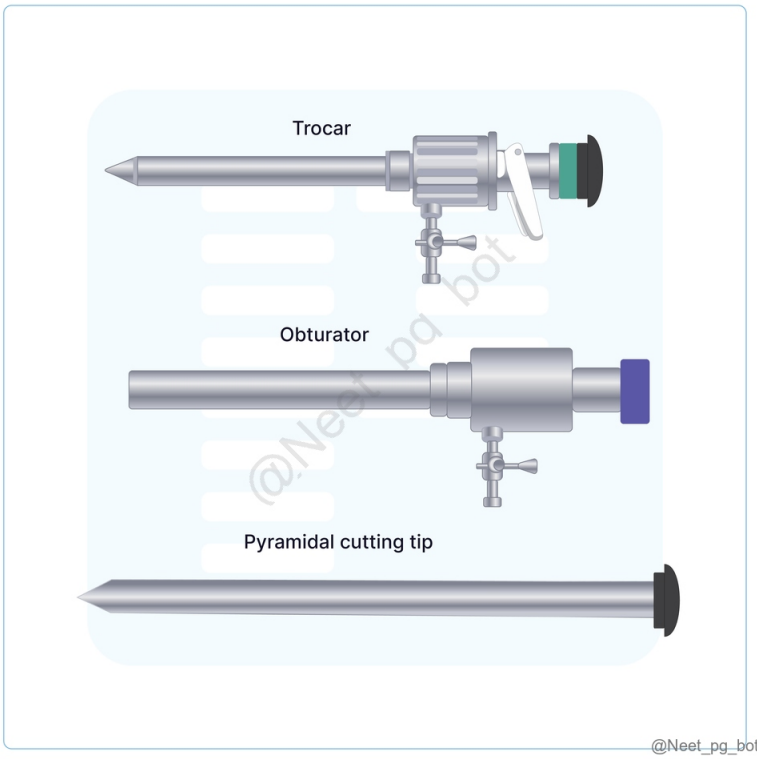




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References:

Bailey & Love's Short Practice of Surgery, Ed 28, Pg 102, 103

SRB's Surgical Operations, Text and Atlas, Edition 1, Pg. 550,551

https://pmc.ncbi.nlm.nih.gov/articles/PMC7881279/

↑ *Back to this question in Part A*

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Q83: A patient presents with burn injuries involving the anterior and posterior torso, both upper limbs, and the perineum. The face and lower limbs are spared. According to the Rule of Nines, what is the total body surface area (TBSA) burned? (Q852680)

A. 5-10%

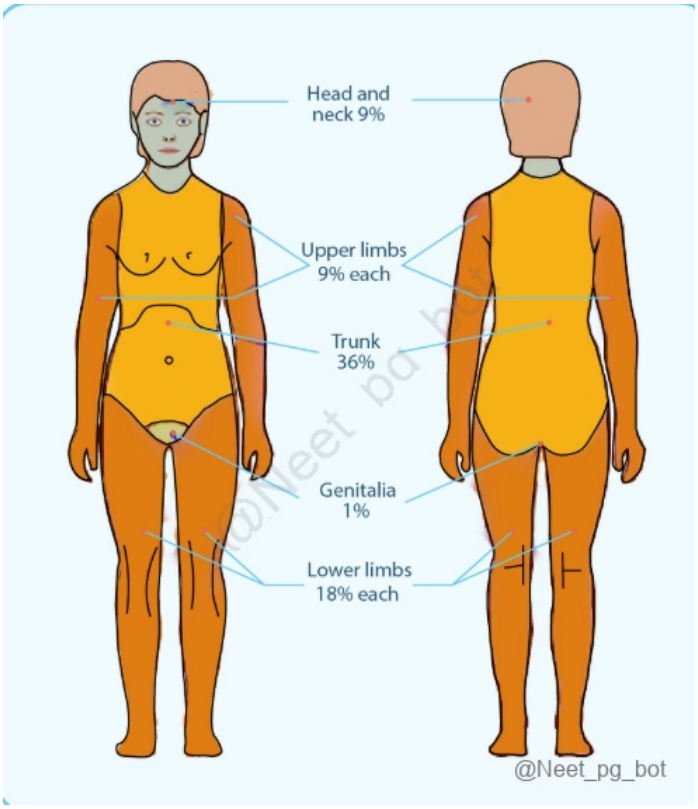
B. 20-30%

C. 10-15%

D. 40-50%

Correct Answer: D. 40-50%

Explanation: Face & Lower Limbs are Spared → These are not included in the burn calculation. Burned Areas : Anterior Torso : 18% Posterior Torso : 18% Both Arms : 9% (each arm is 9%, but if only the front or back is affected, it would be 4.5% per arm) Perineum : 1% Total Burn Area Calculation : Anterior Torso (18%) + Posterior Torso (18%) + Both Arms (9%) + Perineum (1%) = 46% TBSA According to the Wallace rule of 9 , this is how the area burned is calculated: Adults Children Infants Head & neck 9% 18% 20% Front of chest & abdominal wall 9 x 2 = 18% 18% 10 x 2 = 20% Back of chest & abdominal wall 9 x 2 = 18% 18% 10 x 2 = 20% Lower limb 18 x 2 = 36% 13.5 x 2 = 27% 10 x 2 = 20% Upper limb 9 x 2 = 18% 18% 10 x 2 = 20% Perineum 1% 1%



References:

Sabiston Textbook of Surgery, 21st Edition- Page 486

SRB's Manual of Surgery, 6th Edition- Page 122

↑ *Back to this question in Part A*

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Q84: Identify the procedure? (Q852684)

A. Retrograde pyelogram

B. Combined Retrograde Pyelogram and Ureteroscopy

C. Intravenous Pyelogram

D. Antegrade pyelography



Correct Answer: C. Intravenous Pyelogram

Explanation: VP is a radiographic study of the urinary tract using intravenous contrast. The contrast is injected intravenously, filtered by the kidneys, and visualizes the renal calyces, pelvis, ureters, and bladder in sequential X-ray images. The characteristic findings in IVP include contrast-filled renal collecting systems, ureters, and bladder , differentiating it from other contrast-based urinary tract studies. Urinary Tract Imaging Techniques Procedure Method Indications Key Features Intravenous Pyelogram (IVP) IV contrast injection Suspected urinary obstruction, nephrolithiasis, tumors Contrast seen in kidneys, ureters, and bladder on sequential films Retrograde Pyelogram (RGP) (Option A ruled out) Contrast injected via cystoscopy into ureters Suspected ureteral obstruction, non-visualization on IVP Contrast opacifies the ureter and renal pelvis without nephrogram Antegrade Pyelography (Option D ruled out) Contrast injected percutaneously into the renal pelvis Upper urinary tract obstruction, post-surgical assessment Contrast fills renal pelvis and ureters from above Combined RGP & Ureteroscopy (Option B ruled out) Ureteroscope inserted via cystoscopy + contrast study Ureteric stones, strictures, or tumors Direct visualization of ureter along with contrast study

References:

Grainger & Allison's Diagnostic Radiology 7th edition • Page no: 758, 760

Bailey & Love's Short Practice of Surgery - 28th Edition • Page no: 1467

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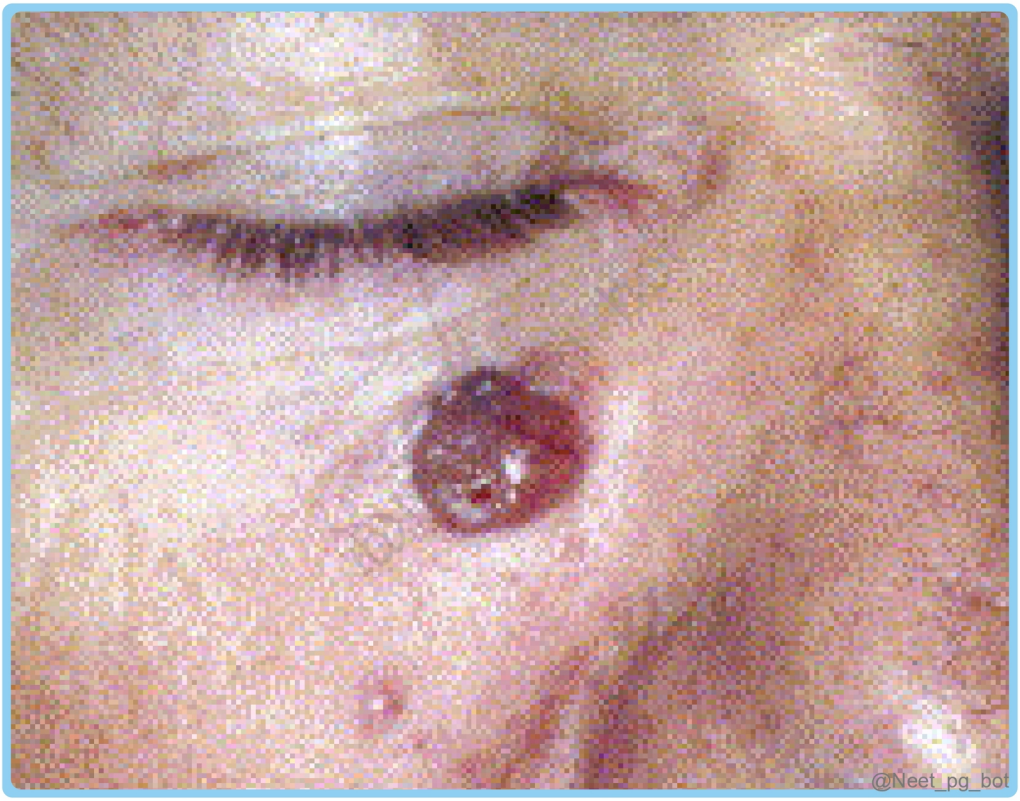
Q85: Which of the following is not related to disease progression? (Q852689)

A. Duration

B. Depth

C. Site

D. Stage of Cancer



Correct Answer: A. Duration

Explanation: Basal Cell Carcinoma (BCC) is a slow-growing skin cancer that rarely metastasizes. Disease progression in BCC depends on: Depth of invasion (deeper tumors are more aggressive). Site (high-risk areas like the nose, periorbital region, and ears have a higher recurrence risk). Stage of cancer (advanced stages indicate deeper tissue involvement). Duration alone does not determine progression , as BCC can remain localized for years without significant spread. Factors Affecting BCC Progression Factor Effect on Progression

References:

Robbin’s Pathology, 10th edition, pg 292, 1147-1149

↑ *Back to this question in Part A*

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Q86: A patient with diffuse severely contaminated peritonitis underwent laparotomy and was left open after surgery. Which of the following might help? (Q852688)

A. VAC

B. Normal saline soaked gauze

C. Prefer closure after laparotomy

D. Antibiotic soaked gauze

Correct Answer: A. VAC

Explanation: Vacuum-Assisted Closure (VAC) is an effective method for managing open abdomen cases after laparotomy in severe, contaminated peritonitis . It helps by: Reducing edema and improving perfusion. Removing infectious material through negative pressure therapy. Facilitating faster wound healing by promoting granulation tissue formation. Preventing abdominal compartment syndrome , which can occur if primary closure is forced in a swollen abdomen. Open Abdomen Management in Contaminated Peritonitis Management Option Effectiveness in Open Abdomen Key Considerations VAC Therapy Highly effective Reduces infection, removes fluids, aids healing Normal Saline Soaked Gauze Temporary benefit Keeps wound moist but does not actively remove exudates Primary Closure After Laparotomy Not preferred in contamination Risk of abdominal compartment syndrome & infection Antibiotic-Soaked Gauze Limited benefit Does not provide negative pressure drainage Normal Saline Soaked Gauze (Option B): Incorrect because it only provides a moist environment but does not actively help with infection control or wound healing. Prefer Closure After Laparotomy (Option C): Incorrect because immediate closure is not ideal in diffuse contamination , as it increases the risk of abdominal compartment syndrome and sepsis . Antibiotic Soaked Gauze (Option D): Incorrect because while it may help prevent infection, it does not provide negative pressure therapy needed for wound contraction and fluid removal.

References:

SRB’s Manual of Surgery, 6th Edition, Page 319-322

https://pubmed.ncbi.nlm.nih.gov/30949740/

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Q87: A patient presents to the emergency department with confusion. On examination, he opens his eyes to pain, shows abnormal flexion to pain, and is disoriented in speech. What is his Glasgow Coma Scale (GCS) score? (Q852690)

A. 11

B. 12

C. 10

D. 9

Correct Answer: D. 9

Explanation: The Glasgow Coma Scale (GCS) is calculated based on three components : Response Category Patient's Response Score Eye Opening (E) To pain 2 Verbal Response (V) Confused 4 Motor Response (M) Abnormal Flexion to pain 3 Total GCS Score 2 + 4 + 3 = 9 Glasgow Coma Scale (GCS) Components Category Score Description Eye Opening (E) 4 Spontaneous 3 To voice 2 To pain 1 None Verbal Response (V) 5 Oriented 4 Confused 3 Inappropriate words 2 Incomprehensible sounds 1 None Motor Response (M) 6 Obeys commands 5 Localizes pain 4 Withdraws from pain 3 Flexion (abnormal) 2 Extension (abnormal) 1 None

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 357,361

https://www.glasgowcomascale.org/what-is-gcs-p/

https://www.ncbi.nlm.nih.gov/books/NBK513298/

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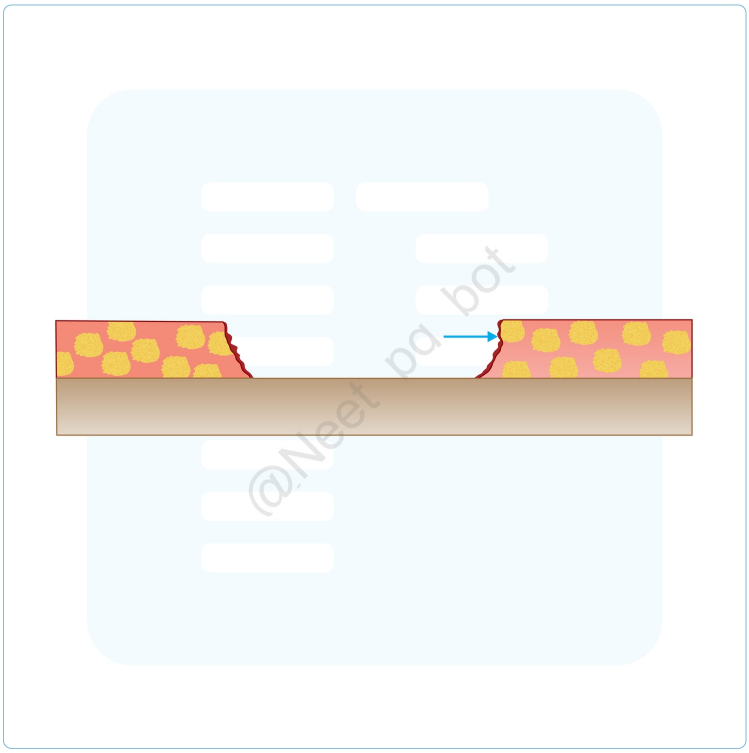
Q88: The given image is of an ulcer, identify the marked structure? (Q852682)

A. Margin

B. Edge

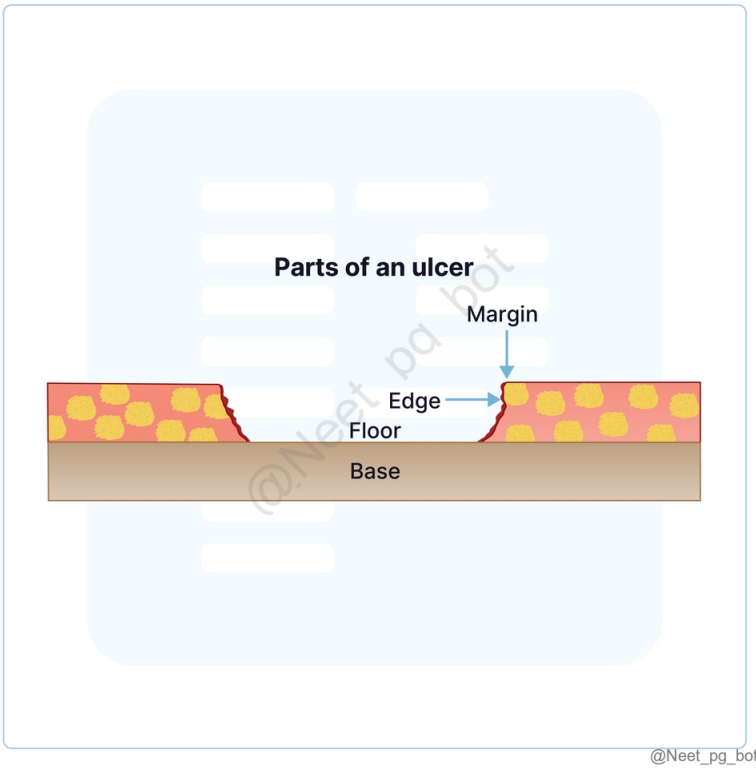
C. Floor

D. Base



Correct Answer: B. Edge

Explanation: Ulcers have distinct anatomical parts: margin, edge, floor, and base . The edge is the transition zone between the margin and the floor of the ulcer. If the image shows a raised, rolled, undermined, or punched-out border , it indicates the edge of the ulcer. Parts of an Ulcer Part Description Margin (Option A ruled out) Outer limit of the ulcer, usually blending into the surrounding skin/mucosa. Edge The border between the margin and the ulcer floor, may be raised (malignant), undermined (tuberculous), or punched-out (syphilitic). Floor (Option C ruled out) The exposed surface inside the ulcer, may contain slough, granulation tissue, or necrosis. Base (Option D ruled out) The structure beneath the ulcer, which can be soft tissue, bone, or a vessel.



References:

SRB's Manual of Surgery, 6th Edition, Page 15

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Q89: In a patient experiencing excessive bleeding, with limbs displaying low temperature and reduced central venous pressure (CVP), what type of shock is observed? (Q859602)

A. Cardiogenic shock

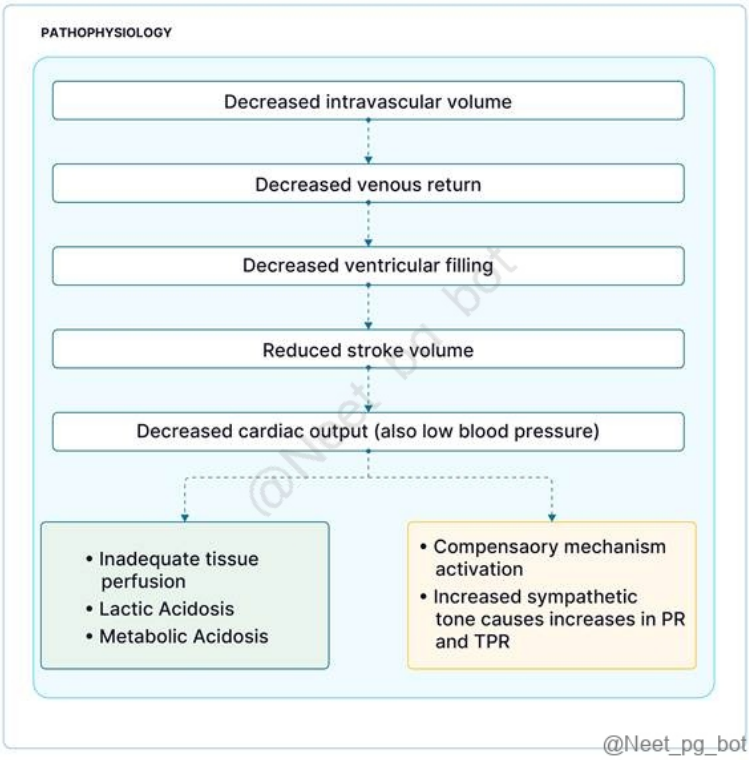
B. Hypovolemic shock

C. Obstructive shock

D. Hypo adrenal shock

Correct Answer: B. Hypovolemic shock

Explanation: The type of shock seen in a patient with profuse bleeding, cold extremities, and decreased central venous pressure (CVP) is "Hypovolemic shock." It occurs due to a significant loss of blood or fluid volume, leading to insufficient circulation and oxygen delivery to tissues. Pathophysiology of Hypovolemic shock {{caption_text}} The decreased cardiac output leads to Inadequate tissue perfusion, lactic acidosis, metabolic acidosis along with Compensatory mechanism activation & increased sympathetic tone cause an increase in PR & TPR. Cardiogenic shock (Option A) is due to the primary failure of the heart to pump blood. It may be due to myocardial infarction, cardiomyopathy, or blunt myocardial injury. Obstructive shock (Option C) is characterised by a reduction in preload due to mechanical obstruction of the cardiac filling of the left and/or right side of the heart, which in turn leads to a fall in cardiac output. Hypoadrenal shock (Option D) stems from inadequate cortisol release during stress, illness, or trauma, often due to chronic glucocorticoid use or adrenal insufficiency related to metastatic disease, amyloidosis, bilateral adrenal haemorrhage, etomidate, TB, or idiopathic atrophy. SU752



References:

SRB’s Manual of Surgery, 6th Edition, Pages 105 -107.

Bailey & Love's Short Practice of Surgery 28th Edition, Page 12.

↑ *Back to this question in Part A*

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Q90: In a hypotensive patient with a head injury, which of the subsequent fluids should be avoided? (Q859606)

A. 0.9% NS

B. 5% Dextrose

C. Ringer lactate

D. 3% saline

Correct Answer: B. 5% Dextrose

Explanation: In a hypotensive patient with a head injury, 5% dextrose should be avoided because it is a hypotonic solution, and its administration can lead to cerebral oedema and ICP by reducing serum sodium. The aim of fluid resuscitation in such cases is to improve circulation without worsening intracranial pressure or causing cerebral oedema. Isotonic crystalloids like 0.9% NS are preferred for fluid resuscitation in head injuries (Option A ruled out) Ringer Lactate (Option C) is an isotonic solution mainly used in aggressive volume resuscitation from blood loss or burn injuries. Its osmolarity of 273 mOsm/L is slightly lower than plasma but still within an isotonic range; it could increase intracellular space volume, leading to an increase in intracranial pressure in brain-injured trauma patients. 3% saline (Option D) is a hypertonic solution that is a preferred treatment for head injuries that involve increased intracranial pressure (ICP). It helps reduce brain oedema by drawing fluid out of the brain cells into the bloodstream. They also support circulatory stability by increasing blood pressure and cardiac output .

References:

Morgan and Mikhail’s Clinical Anaesthesia, 7th Edition, Page 2262,

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Q91: A 30-year-old female presents to the emergency department with burn injuries sustained from a stove explosion. She has burns involving the face with singeing of eyelashes, both upper limbs entirely, and the anterior chest. The burns are partial-thickness, involving the epidermis and part of the dermis. Based on the rule of Nines, what is the approximate total body surface area (TBSA) affected by burns? (Q865330)

A. 33-36%

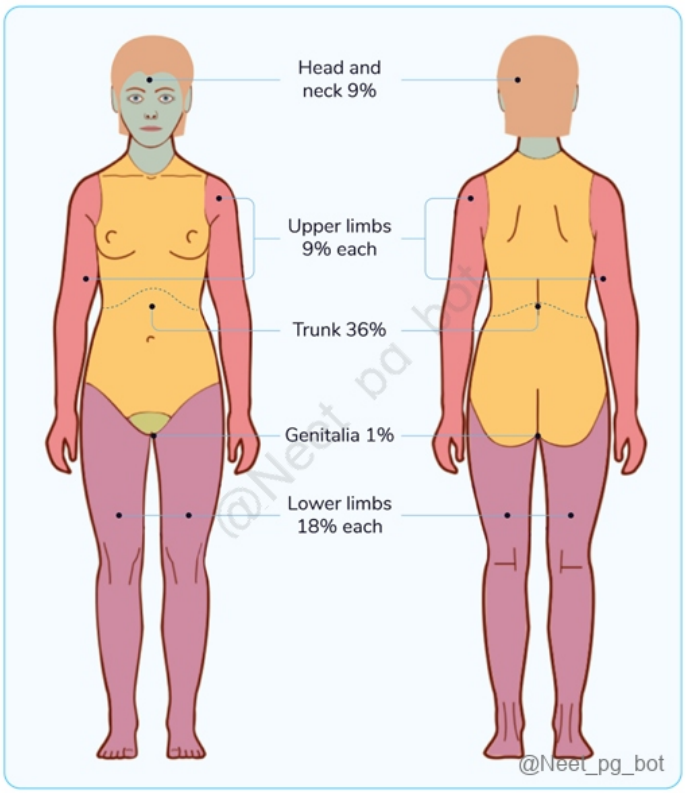
B. 40-45%

C. 25-28%

D. 50-55%

Correct Answer: A. 33-36%

Explanation: According to the Wallace rule of 9 , Face is 9% (head and neck). Both upper limbs: Each upper limb = 9%, so both = 18% . The entire anterior trunk (chest + abdomen) = 18%. The anterior chest alone (without abdomen) is approximately 9% (half of the anterior trunk). TBSA = 9 + 18 + 9 = 36%, hence it is 33 - 36% Wallace rule of 9 Adults Children Infants Head & neck 9% 18% 20% Front of chest & abdominal wall 9 x 2 = 18% 18% 10 x 2 = 20% Back of chest & abdominal wall 9 x 2 = 18% 18% 10 x 2 = 20% Lower limb 18 x 2 = 36% 13.5 x 2 = 27% 10 x 2 = 20% Upper limb 9 x 2 = 18% 18% 10 x 2 = 20% Perineum 1% 1%



References:

SRB's Manual of Surgery, 6th Edition, Page 122

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Q92: Which of the following is incorrect regarding the following dressing? (Q865340)

A. Redressing is done after 4 - 7 days

B. Negative pressure 10-20 mmHg

C. Increase proliferation and protein matrix synthesis

D. Can be continuous & intermittent



Correct Answer: B. Negative pressure 10-20 mmHg

Explanation: The image shows a Vacuum-assisted closure, also known as negative pressure wound therapy and, the usual therapeutic negative pressure range used in NPWT is -125 mmHg , not 10–20 mmHg. NPWT stimulates cell proliferation, angiogenesis, and extracellular matrix (ECM) production, thereby enhancing healing. It promotes formation of granulation tissue. (Option C) NPWT can be delivered in either continuous or intermittent modes (Option D) They are typically changed every 48–72 hours , but can be left for up to 5–7 days in clean wounds. Dressing changes are done more frequently if infection is suspected. (Option A) Indications of NPWT: Acute wounds: Open fractures, burns, degloving injuries, fasciotomies. Chronic wounds: Diabetic foot ulcers, pressure sores. Surgical wounds: Dehisced incisions, grafts/flaps, closed incisions at high risk of dehiscence

References:

Negative pressure wound dressing

Barash Clinical Anesthesiology, 9th Edition, Page 4841- 4846

↑ *Back to this question in Part A*

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Q93: Which of the following cancers is NOT related to obesity? (Q865421)

A. Meningioma

B. Gastric carcinoma

C. Pancreatic carcinoma

D. Multiple myeloma

Correct Answer: A. Meningioma

Explanation: Meningiomas are typically benign central nervous system tumors arising from the meninges. Although some observational studies have noted a possible link between obesity and meningioma (particularly in women), this association is not considered well established or causal. Obesity is a well-established risk factor for numerous malignancies , particularly those influenced by chronic inflammation , insulin resistance , and hormonal imbalances . The cancers most strongly linked to obesity include: Endometrial Breast (postmenopausal) Colorectal Esophageal (adenocarcinoma) Pancreatic (Option C) Renal cell carcinoma Gallbladder Liver Gastric (cardia type) (Option B) Multiple myeloma (Option D) These associations are supported by robust epidemiological data and acknowledged by major health organizations (e.g., IARC, WHO, CDC).

References:

Harrison's Principles of Internal Medicine, 21st edition, Page 679-680, 702, 901.

↑ *Back to this question in Part A*

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Q94: A 30-year-old lactating mother presents with pain in her left breast and a fever. On examination, the left breast appears as shown in the image below. There is mild axillary lymphadenopathy on the affected side and the contralateral breast is normal. Repeated aspirations under antibiotic cover were unsuccessful. A USG done showed fluid collection. What is the next best step in the management of this patient? (Q865425)

A. Incision and drainage

B. Broad-spectrum antibiotics only

C. Breast conservation surgery

D. Punch biopsy



Correct Answer: A. Incision and drainage

Explanation: The clinical scenario described suggests that the patient may have developed a breast abscess. Breast abscesses are typically caused by bacterial infection and are more common in lactating women due to the increased risk of bacterial colonization of the breast ducts. The presence of fever, pain, and fluid collection seen on ultrasound are also consistent with a breast abscess. Repeated aspirations under antibiotic cover have been unsuccessful, suggesting that the abscess is not resolving with conservative management alone. Therefore, the next best step in the management of this patient would be incision and drainage of the abscess. Incision and drainage is the most effective way to treat a breast abscess, as it allows for the complete removal of the infected material and helps to prevent recurrence. Breast Abscess Definition Pus-filled cavity within breast tissue. Types Lactational Abscess: Associated with breastfeeding. Non-Lactational Abscess: Occurs in non-lactating women, e.g., periductal mastitis. Causes and Risk Factors Lactation: Incidence: 3% to 20% in lactating mothers. Common pathogen: Staphylococcus aureus (methicillin-resistant strains in hospital settings). Entry points: Cracked/retracted nipple, blocked lactiferous ducts. Non-Lactation: Often in nulliparous women or post-lactation. Conditions: Periductal mastitis, idiopathic granulomatous mastitis, tubercular mastitis. Smoking and diabetes as risk factors. Signs and symptoms Fever, leukocytosis, erythema, pain and tenderness, swelling, malaise, difficulty feeding, enlarged and tender axillary nodes Diagnosis Ultrasonography: Detects cellulitis, liquefaction necrosis. Confirms abscess size, location, and loculation. Treatment Lactational Mastitis: Antibiotics: Anti-staphylococcal (e.g., cloxacillin, flucloxacillin, erythromycin). Breast emptying: Frequent breastfeeding or pumping. Support: Breast support garment, cold compresses, analgesia. Drainage: Ultrasound-guided preferred over surgical incision. Follow-up: Regular clinical and ultrasonographic reviews, culture-based antibiotic modification. Non-Lactational Mastitis: Broad-spectrum antibiotics for subareolar infections. Needle aspiration for abscess drainage. Major milk duct excision for complications like sepsis or fistula. Broad-spectrum antibiotics (Option B) may be used in conjunction with incision and drainage to treat the infection, but antibiotics alone are not sufficient for the management of a Breast abscess. Breast conservation surgery (Option C) typically involves the removal of a breast lump or tumor.

Thus, breast conservation surgery is not appropriate management option for a breast abscess. Punch biopsy (Option C) is a diagnostic procedure used to obtain a tissue sample for analysis.

References:

Sabiston Textbook of Surgery, 21st Edition, Page 826, 827

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 927, 928

Schwartz textbook of Surgery, 11th Edition, Page 550-553, 601, 602

↑ *Back to this question in Part A*

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Q95: A 25-year-old male with a history of a road traffic accident presents to the emergency department. His GCS is 8/15, oxygen saturation is 85%, blood pressure is 100/60 mmHg and heart rate is 60 beats per minute. On examination, breath sounds are absent on the right side. What is the next step in management? (Q853038)

A. Start IV fluids, give atropine and secure airway

B. Secure airway, give oxygen, insert ICD, secure IV line

C. Evaluate for head injury and do CT-head

D. ■■■Administer IV dextrose followed by NCCT head

Correct Answer: B. Secure airway, give oxygen, insert ICD, secure IV line

Explanation: The patient has GCS 8/15 , indicating a severe head injury and possible impaired consciousness . Therefore, securing the airway is the priority to prevent further deterioration. Oxygen should be administered to address the low oxygen saturation (85%). The absence of breath sounds on the right side raises concern for tension pneumothorax or large pneumothorax , which can lead to respiratory failure . In this case, the next step is to insert an intercostal chest drain (ICD) to relieve any pneumothorax and re-expand the lung. IV access should be secured for fluid resuscitation or medication administration, but airway and breathing take precedence. We will follow a primary survey of A, B, C, D, and E to manage this patient, where A is securing the airway, B is giving oxygen and inserting ICD, and C includes IV line. Start IV fluids, give atropine and secure airway (Option A) : Securing the airway is important, but giving atropine is not the priority here because the patient has a heart rate of 60 bpm , which is not significantly low and does not require atropine at this stage. Evaluate for head injury and do CT-head (Option C) : The immediate concern is the airway and respiratory distress . The absence of breath sounds on the right side suggests a life-threatening thoracic injury that should be managed first, with a CT scan of the head being considered later once the patient is stabilised. Administer IV dextrose followed by NCCT head (Option D) : There is no indication that the patient is hypoglycemic or in need of IV dextrose at this moment. The priority should be stabilising the airway and managing the potential pneumothorax . The NCCT head can be done later if head injury is suspected after stabilizing the patient.

References:

Sabiston, Text Book of Surgery, 21st edition, Pages 391, 392

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Q96: An 84-year-old man who had a stroke 2 years ago and has been on extended bed rest, develops a pressure ulcer with partial skin thickness loss and a clean base. What is the grade of his pressure sore? (Q853066)

A. 1

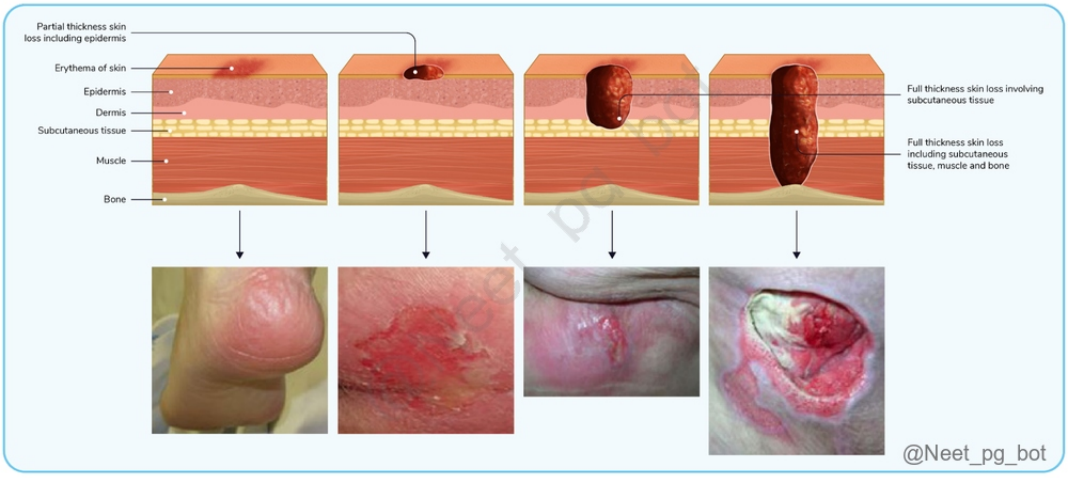
B. 2

C. 3

D. 4

Correct Answer: B. 2

Explanation: The pressure ulcer described in the scenario has partial skin thickness loss with a clean base , characteristic of a Grade 2 pressure sore. Pressure sore stages Stage I (Option A ruled out) Early superficial ulcer Non blanchable erythema of the skin, without breach in the epidermis Stage II (Option B) Late superficial ulcer Partial thickness, less including epidermis + dermis Stage III (Option C ruled out) Early deep ulcer Full-thickness skin loss involving subcutaneous tissues but not through underlying fascia Stage IV (Option D ruled out) Late deep ulcer Full-thickness skin loss involving subcutaneous tissue, muscle, bone, joints or tendon.



References:

SRB’s Manual of Surgery, 6th Edition, Pages 22, 23

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Q97: A 35-year-old male had surgery for an ileal perforation. Due to significant contamination, only the sheath was sutured, leaving the wound open. Daily wound irrigation was carried out, and the wound was closed on postoperative day 5. What type of wound-healing mechanism is occurring in this scenario? (Q853067)

A. Primary intention

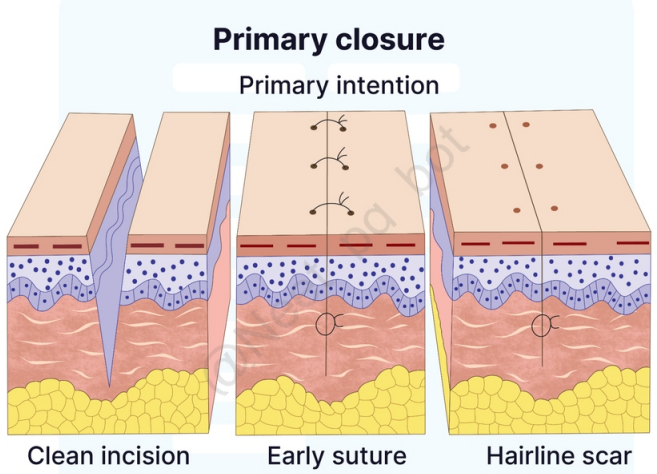
B. Secondary intention

C. Tertiary intention

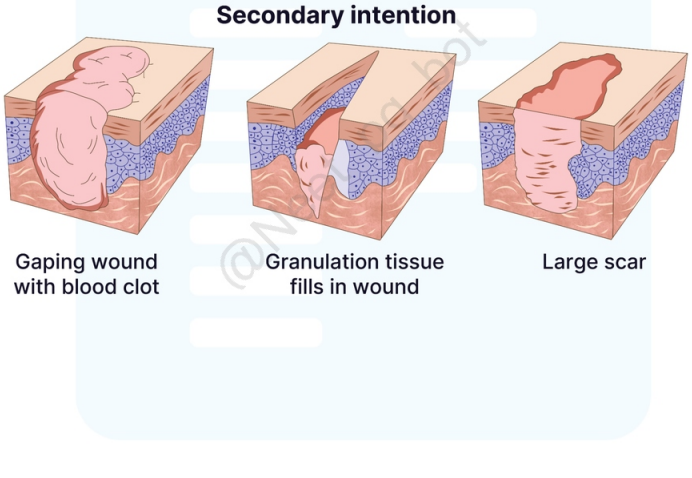
D. Quaternary intention

Correct Answer: C. Tertiary intention

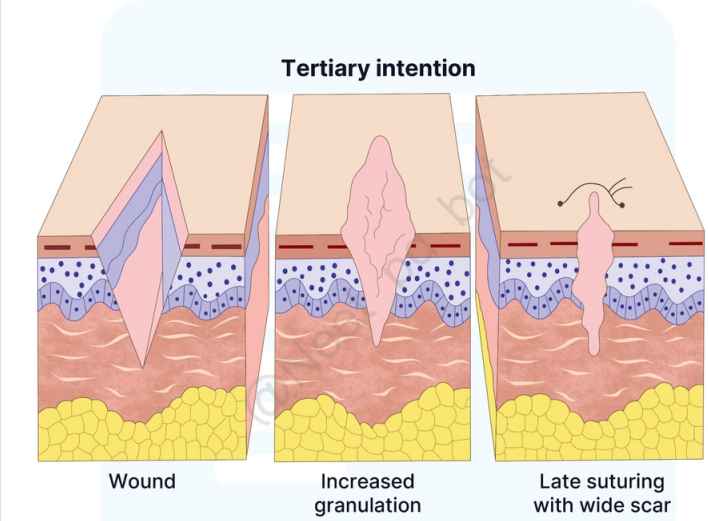
Explanation: The type of wound healing mechanism described in this scenario is tertiary intention (also known as (delayed primary closure). Wound healing Healing by primary intention (Option A ruled out) It occurs when the edges of a clean wound are brought together and secured with sutures, staples, or adhesives. Minimal scarring occurs. Healing by secondary intention (Option B ruled out) The wound is left open to heal by granulation, contraction, and epithelialisation. This is common in wounds with significant tissue loss or contamination. Healing by tertiary intention (delayed primary closure) (Option C) The wound is initially left open and then closed surgically after several days when it's clean and granulating. This is used for contaminated wounds to prevent infection. Quaternary intention (Option D) is not a recognised term in wound healing. The proper classification includes primary, secondary, and tertiary intention.



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References:

Sabiston's Text Book of Surgery, 21st Edition, Page 215

↑ *Back to this question in Part A*

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Q98: A friend of yours is teaching you about enhanced recovery after surgery. Which of the following statements he makes is inaccurate? (Q853068)

A. ■■■Prolonged fasting is necessary

B. Epidural anaesthesia recommended in laparoscopic surgery for pain control

C. Reduction of hospital stay by 2-3 weeks

D. Beta-blockers are given after major surgery done under general anaesthesia to improve the outcome

Correct Answer: A. ■■■Prolonged fasting is necessary

Explanation: ERAS protocols emphasise reducing fasting times before surgery. It allows a light meal up to six hours before surgery and clear fluids up to two hours prior. It also includes carbohydrate-rich drinks up to two

hours before the procedure as it helps reduce postoperative insulin resistance, preserve muscle mass, minimize protein loss, and alleviate preoperative thirst, hunger, and anxiety. ERAS is a set of evidence-based guidelines aimed at improving recovery after surgery. It focuses on optimising preoperative, intraoperative, and postoperative care to speed up recovery, reduce complications, and shorten hospital stays. Epidural anaesthesia recommended in laparoscopic surgery for pain control (Option B) is true because it is one of the main component of ERAS and it can be used for effective pain control in many types of surgery, including laparoscopic surgery. However, its use may depend on the type of surgery and the patient's condition. Reduction of hospital stay by 2-3 weeks (Option C) is correct as one of the key goals of ERAS is to reduce the length of hospital stay. Beta-blockers are given after major surgery done under general anaesthesia to improve outcome (Option D) is true and is mainly given to improve cardiovascular outcome. Reference:

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page10.

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↑ *Back to this question in Part A*

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Q99: During laparoscopic port placement, injury to which abdominal wall vessels must be avoided while inserting the trocar?During laparoscopic surgery, where shouldn't the trocar be inserted? (Q852687)

A. Superior epigastric artery

B. Inferior epigastric artery

C. Abdominal aorta

D. Both A and B

Correct Answer: D. Both A and B

Explanation: Trocar placement during laparoscopic surgery requires careful consideration to avoid injury to major blood vessels, including both the superior and inferior epigastric arteries . Inferior epigastric artery (IEA): Located on the posterior aspect of the rectus sheath, arising from the external iliac artery , it is at risk when inserting trocars in the lower abdominal wall. Superior epigastric artery (SEA): A continuation of the internal thoracic artery , it supplies the upper abdominal wall and is at risk in upper trocar insertions . Both arteries run within the rectus sheath , making them relevant in trocar placement at different levels of the anterior abdominal wall. Trocar Placement & Epigastric Arteries: Trocar Site At Risk Artery Precautions Umbilical (Primary) Minimal risk Insert at linea alba Supraumbilical (Upper Trocar) Superior Epigastric Artery Avoid midline rectus sheath Infraumbilical/Midclavicular Inferior Epigastric Artery Insert lateral to rectus muscle Palmar's Point (LUQ Trocar) Minimal risk Used in difficult access cases Superior Epigastric Artery (Option A): Incorrect alone because it is only at risk in upper abdominal trocar placement . Inferior Epigastric Artery (Option B): Incorrect alone

because both superior and inferior epigastric arteries are at risk depending on trocar position . Abdominal Aorta (Option C): Incorrect because the aorta is a deep retroperitoneal structure, not directly relevant to trocar insertion .

References:

Bailey & Love's Short Practice of Surgery, Ed 28, Pg 102, 103

SRB's Surgical Operations, Text and Atlas, Edition 1, Pg. 550,551

https://pmc.ncbi.nlm.nih.gov/articles/PMC4664217/

https://pmc.ncbi.nlm.nih.gov/articles/PMC5206834/

↑ *Back to this question in Part A*

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Q100: A 45-year-old male patient was brought to the emergency department following a road traffic accident.O/E, he had multiple injuries all over his body and was found to be in class III hemorrhagic shock. The percentage of blood loss would be between: (Q852705)

A. 5-15%

B. 30-40%

C. >40%

D. 15-30%

Correct Answer: B. 30-40%

Explanation: The percentage of blood loss in class III hemorrhagic shock is 30-40%. Parameter Class I (Compensated Shock) Class II (Hypoxemia) Class III Class IV (Refractory Shock) Blood Loss Up to 15% (Option A) 15-30% (Option D) 30-40% (Option B) More than 40% (Option C) Mechanism Compensatory mechanisms maintain cardiac output. Generalized vasoconstriction. Decompensated shock. Refractory shock. Heart Rate <100/min 100-120/min 120-140/min >140/min Blood Pressure Normal Hypotension Marked hypotension Profound hypotension Respiratory Rate Normal Tachypnea Tachypnea Tachypnea Urine Output >30 ml/hour 20-30 ml/hour 5-15 ml/hour No urine output Mental Status Alert, normal Anxious, mildly agitated Confused, altered mental status Comatose, lethargic

References:

SRB's Manual of Surgery, 6th Edition, Pages 105, 106, 107

Bailey & Love's Short Practice of Surgery, 28th Edition, Pages 13, 14

↑ *Back to this question in Part A*

Q101: A 20-year-old male presents to the outpatient department with a swelling on his wrist. He reports fluctuation in size , mild numbness in the hand , and occasional pain . What is the most likely diagnosis? (Q852713)

A. Lipoma

B. Ganglion cyst

C. Dermoid cyst

D. Hematoma



Correct Answer: B. Ganglion cyst

Explanation: The clinical presentation and image are characteristic of a ganglion cyst , which is the most common soft tissue swelling of the wrist. Supporting features: Location : Commonly over the dorsal aspect of the wrist (as seen in image) Fluctuation in size : Classic feature due to cyst fluid dynamics Mild numbness : Can occur if the cyst compresses nearby nerves Occasional pain : Especially with wrist movement or pressure Differentiating Wrist Masses: Condition Characteristics Pain Fluctuation in Size Numbness Lipoma Soft, mobile, subcutaneous fat mass No No No Ganglion cyst Fluid-filled, over joint or tendon sheath, translucent Occasional Yes Rare Dermoid cyst

Congenital, contains ectodermal elements (hair/sebum) Rare Rare Yes Hematoma Post-trauma, discoloured, self-resolving Yes (initially) No No Lipoma (Option A): Typically soft, non-fluctuant, and slow-growing; not commonly associated with wrist joints or changes in size with activity. Dermoid cyst (Option C): Usually congenital, midline, and more common in children; contains ectodermal elements, and rarely found over the wrist joint. Hematoma (Option D): Usually follows trauma, appears bruised or discoloured, and resolves over time; not fluctuant or recurrent like this.

References:

https://www.ncbi.nlm.nih.gov/books/NBK470168/

https://www.ncbi.nlm.nih.gov/books/NBK507906/

https://pmc.ncbi.nlm.nih.gov/articles/PMC6258973/

https://www.ncbi.nlm.nih.gov/medgen/5484

↑ *Back to this question in Part A*

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Q102: A patient with dilated tortuous veins of the leg presented to the OPD and is diagnosed with varicose vein of grade C4a. What is the best preferred treatment? (Q852721)

A. Compression

B. Endothermal ablation

C. Non endothermal non tumescent ablation

D. Open surgery

Correct Answer: B. Endothermal ablation

Explanation: Grade C4a varicose veins (as per CEAP classification) indicate skin changes such as pigmentation or eczema due to chronic venous insufficiency. Endothermal ablation (radiofrequency or laser) is the first-line treatment for symptomatic varicose veins. It is minimally invasive, effective, and has faster recovery compared to open surgery . CEAP Classification & Treatment of Varicose Veins CEAP Class Clinical Features Preferred Treatment C0 No visible/palpable signs No treatment needed C1 Telangiectasias or reticular veins Conservative (compression) C2 Varicose veins Compression, ablation, or surgery C3 Edema Endothermal ablation C4a Pigmentation/eczema Endothermal ablation C4b Lipodermatosclerosis or atrophie blanche Endothermal or open surgery C5 Healed venous ulcer Endothermal ablation + ulcer care C6 Active venous ulcer Multimodal therapy Compression (Option A): Incorrect because while compression stockings help relieve symptoms, they do not treat the underlying venous reflux . Non-endothermal non-tumescent ablation (Option C): Incorrect because options like cyanoacrylate glue or mechanochemical ablation are alternative treatments but not first-line . Open surgery (Option D): Incorrect because surgical vein stripping is now reserved for cases where endothermal ablation is not

feasible .

References:

Sabiston Textbook of Surgery, 21st Edition, Page 1814

Bailey and Love’s Short Practice of Surgery, 28th Edition, Page 1030

CEAP

↑ *Back to this question in Part A*

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Q103: A 45-year-old man is found unconscious after a fall from a ladder. In the emergency department, his eyes do not open even in response to pain; he is making incomprehensible sounds, and he exhibits abnormal flexion in response to painful stimuli. What is his Glasgow Coma Scale (GCS) score? (Q852706)

A. 5

B. 6

C. 7

D. 8

Correct Answer: B. 6

Explanation: The Glasgow Coma Scale (GCS) is a tool used to assess a patient’s level of consciousness based on three parameters: eye-opening , verbal response , and motor response . Each parameter is scored, and the total GCS score ranges from 3 (deep coma) to 15 (fully awake). Eye response : The patient's eyes do not open, even in response to pain, corresponding to a score of 1 . Verbal response : The patient makes incomprehensible sounds, corresponding to a score of 2 . Motor response : The patient exhibits abnormal flexion (decorticate posturing) in response to pain, corresponding to a score of 3 . Thus, the GCS score for this patient is: 1 (Eye) + 2 (Verbal) + 3 (Motor) = 6 Simplified Glasgow Coma Scale (GCS) Table Category Response Score Eye Opening (E) Spontaneous 4 To speech 3 To pain 2 None 1 Verbal Response (V) Oriented 5 Confused conversation 4 Inappropriate words 3 Incomprehensible sounds 2 None 1 Motor Response (M) Obeys commands 6 Localizes to pain 5 Withdraws from pain 4 Abnormal flexion (decorticate) 3 Abnormal extension (decerebrate) 2 No response 1 Head Injury Severity: Clinical Classification Minor head injury GCS 15 with no LOC (loss of consciousness) Mild head injury GCS 14 or 15 with LOC Moderate head injury GCS 9 - 13 Severe head injury GCS 3 - 8 The GCS-P score is calculated by subtracting the Pupil Reactivity Score (PRS) from the Glasgow Coma Scale (GCS) total score: GCS-P = GCS - PRS. Pupils Unreactive to Light Pupil Reactivity Score Both Pupils 2 One Pupil 1 Neither Pupil 0 GCS-P score can range from 1 to 15 GCS-P score values between one and 8 denote a severe injury

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Pages 357, 361

https://www.glasgowcomascale.org/what-is-gcs-p/

https://www.ncbi.nlm.nih.gov/books/NBK513298/

↑ *Back to this question in Part A*

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Q104: A woman, a few weeks after delivery, complains of bloody discharge from nipple and fever. On examination, diffuse lump under areola. What is the diagnosis? (Q852719)

A. Galactocele

B. Lactational mastitis

C. Mondor disease

D. Fibrocystic disease

Correct Answer: B. Lactational mastitis

Explanation: Recent postpartum status → Lactating women are at high risk of mastitis due to milk stasis and bacterial infection. Bloody nipple discharge and fever → Suggests infection and inflammation , which are characteristic of lactational mastitis . Diffuse lump under the areola → Likely represents engorgement or inflammatory induration due to stasis or bacterial invasion (commonly Staphylococcus aureus). Lactational Mastitis Feature Lactational Mastitis Etiology Bacterial infection due to milk stasis (commonly Staphylococcus aureus) Risk Factors Breastfeeding, nipple trauma (cracks), poor latch, prolonged engorgement Symptoms Fever, malaise, painful swollen breast , erythema, bloody or purulent discharge Examination Tender indurated mass , warmth, erythema over the affected breast Complications Breast abscess (if untreated) Management Frequent breastfeeding, warm compress, analgesics, antibiotics (dicloxacillin, cephalexin) Galactocele (Option A): Incorrect because it presents as a painless cystic swelling due to milk retention , without fever, tenderness, or bloody discharge . Mondor disease (Option C): Incorrect because it is thrombophlebitis of the superficial veins of the breast , presenting as a palpable cord-like structure , not a diffuse lump or fever . Fibrocystic disease (Option D): Incorrect because it causes cyclic breast pain and nodularity, typically worsening before menstruation, not postpartum infection .

References:

Robbins 10th Ed. Pg 1040

↑ *Back to this question in Part A*

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Q105: The ureter is safe in which type of hysterectomy? (Q852722)

A. Open laparotomy

B. Laparoscopy

C. Robotic

D. Vaginal

Correct Answer: D. Vaginal

Explanation: In vaginal hysterectomy , the ureter is least at risk of injury because: The procedure is performed entirely through the vaginal route without significant dissection near the ureter. There is less manipulation of pelvic structures compared to other approaches. Other methods like open, laparoscopic, and robotic hysterectomy involve greater ureteric handling, increasing the risk of thermal injury, ligation, or transection . Ureteric Safety in Hysterectomy Types Hysterectomy Type Ureteric Injury Risk Reasons Open laparotomy Moderate Direct ureteric handling, risk during ligation Laparoscopic High Increased risk due to thermal and traction injuries Robotic Moderate to high Similar to laparoscopic but better visualization Vaginal Lowest Minimal ureteric dissection, lower risk of injury Open laparotomy (Option A): Incorrect because ureteric injury can occur during ligation of uterine vessels or parametrial dissection . Laparoscopy (Option B): Incorrect as ureteric injury is common due to thermal damage from electrocautery . Robotic (Option C): Incorrect since it has a similar risk as laparoscopic hysterectomy .

References:

https://pmc.ncbi.nlm.nih.gov/articles/PMC5385136/

https://pmc.ncbi.nlm.nih.gov/articles/PMC7363243/

↑ *Back to this question in Part A*

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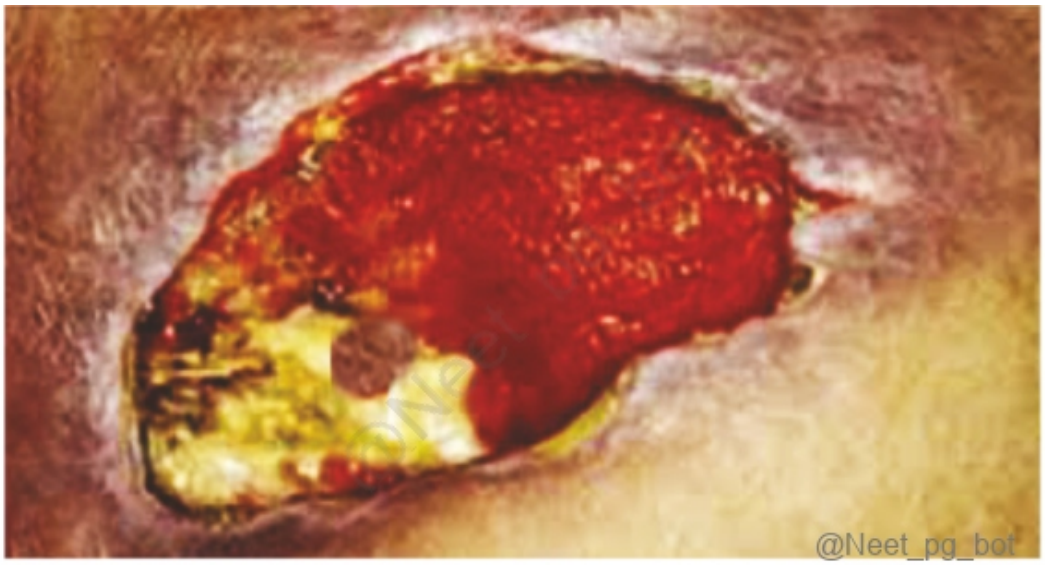
Q106: Identify the grade of the condition given in the image below ? (Q844279)

A. Grade 1

B. Grade 2

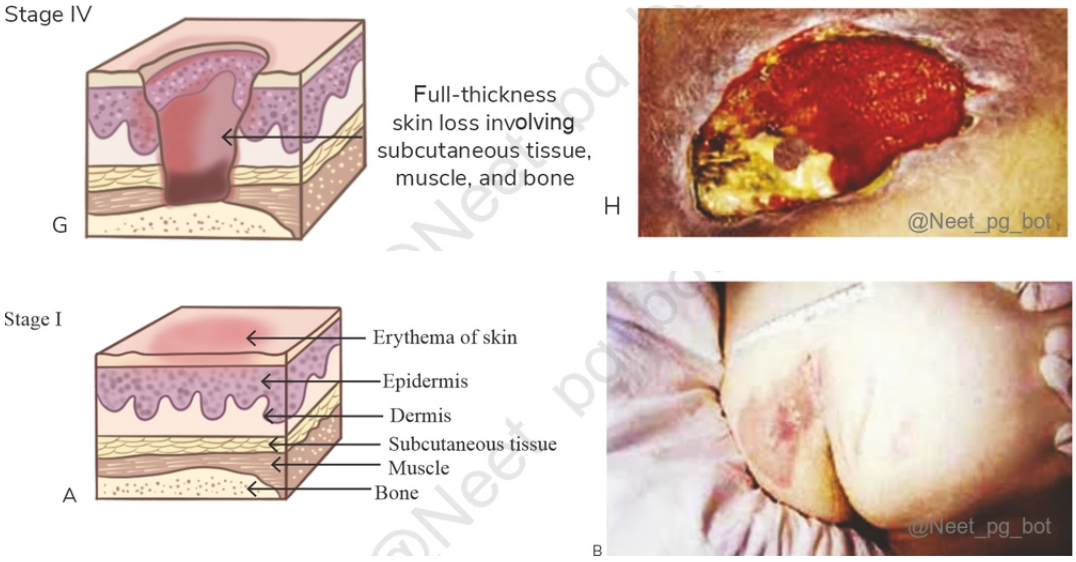
C. Grade 3

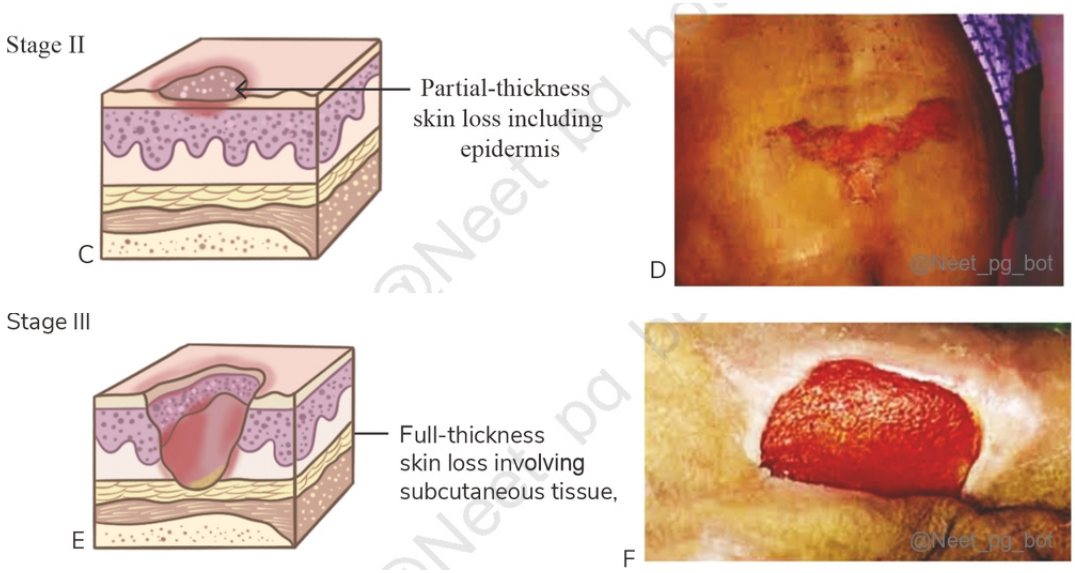
D. Grade 4



Correct Answer: D. Grade 4

Explanation: Correct Option D - Grade 4: The image shows a deep ulcer with exposed bone, muscle, or tendon, characteristic of a Grade 4 pressure sore, the most severe level of pressure-induced tissue damage. Incorrect Options: Option A - Grade 1: This is the earliest stage of a pressure sore where damage is limited to superficial layers of the skin. Option B - Grade 2: This stage involves damage beyond the epidermis into the dermis, often resembling an abrasion, blister, or shallow crater. Option C - Grade 3: The ulcer has extended deeper into the tissue but has not yet reached the muscle or bone.





References:

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↑ *Back to this question in Part A*

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Q107: What is the ideal pressure setting for vacuum-assisted closure (VAC) therapy? (Q844308)

A. -125 mm Hg

B. 60 to 80 mm Hg

C. 130 mm Hg

D. 80 to 100 mm Hg

Correct Answer: A. -125 mm Hg

Explanation: Correct Option A - 125 mm Hg: This is the most commonly recommended and studied pressure setting for VAC therapy. It is considered ideal for promoting wound healing, reducing edema, and enhancing blood flow while minimizing tissue damage. Most clinical guidelines and studies support this pressure as the optimal setting for standard VAC therapy. It has been observed that pressures above 125 mmHg may compromise microcirculatory blood flow. Incorrect Options: Option B - 60 to 80 mm Hg: This lower pressure range may be used in specific situations, such as when treating wounds over sensitive or delicate areas where higher pressures might cause discomfort or tissue damage. However, it is generally not considered the ideal setting for most VAC applications. Option C - 130 mm Hg : Although close to the recommended pressure, this slightly higher setting may increase the risk of tissue damage and discomfort, making it less ideal compared to the 125 mm Hg setting.

Option D - 80 to 100 mm Hg: This range may be used for certain wounds where a lower pressure is needed, such as in patients with compromised circulation or delicate tissues. However, it is not the standard pressure setting for VAC therapy in most cases.

References:

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↑ *Back to this question in Part A*

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Q108: A 20-year-old chronic alcoholic presents with severe hematemesis. An ultrasound (USG) shows distention of the portal vein, and the liver appears hyperechoic. Pantoprazole has been administered. What is the next appropriate step in management? (Q844303)

A. Initiate a course of broad-spectrum antibiotics

B. Order a liver biopsy to assess for fibrosis

C. Administer intravenous fluids and electrolyte replacement

D. Perform an endoscopy to look for varices

Correct Answer: C. Administer intravenous fluids and electrolyte replacement

Explanation: Correct Option C - Administer intravenous fluids and electrolyte replacement: The patient is presenting with severe hematemesis, which suggests significant blood loss. The immediate priority is stabilizing the patient by administering intravenous fluids to maintain blood pressure, replace lost fluids, and correct electrolyte imbalances. Incorrect Options: Option A - Initiate a course of broad-spectrum antibiotics: While antibiotics may be needed later in managing a patient with suspected variceal bleeding and cirrhosis (to prevent infections like spontaneous bacterial peritonitis), it is not the immediate next step. The priority is to stabilize the patient first. Option B - Order a liver biopsy to assess for fibrosis: A liver biopsy is useful for diagnosing the extent of liver fibrosis or cirrhosis. However, in the acute setting of severe hematemesis, it is inappropriate as the immediate next step. The patient needs urgent stabilization, not an invasive diagnostic procedure. Option D - Perform an endoscopy to look for varices: Endoscopy is essential for diagnosing and managing variceal bleeding, particularly in a patient with portal hypertension secondary to chronic alcohol use. However, it should be performed after initial stabilization, including fluid resuscitation and hemodynamic support.

References:

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↑ *Back to this question in Part A*

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Q109: Which of the following is a complication of Total Parenteral Nutrition (TPN) in a sepsis patient in the ICU? (Q844304)

A. Hyperlipidemia

B. Hyperglycemia

C. Hyperglyceridemia

D. Hypoglycemia

Correct Answer: B. Hyperglycemia

Explanation: Correct Option B - Hyperglycemia: The biochemical abnormality most consistent with early TPN complications (TPN-induced hyperglycemia) This is a frequent complication of TPN, particularly in critically ill patients, such as those with sepsis (metabolic disorders). The high glucose content of TPN, combined with insulin resistance often seen in sepsis, increased catecholamines, and impaired glucose utilization can lead to significant elevations in blood glucose levels. Incorrect Options: Option A - Hyperlipidemia: TPN can sometimes lead to elevated lipid levels, especially if the lipid component is administered in excess. However, this is less common in the acute setting of a septic patient compared to hyperglycemia. Option C - Hyperglyceridemia: While TPN contains lipids that can elevate glyceride levels, hyperglyceridemia is not as common or clinically significant as hyperglycemia in the acute management of sepsis. Option D - Hypoglycemia: Although hypoglycemia can occur if TPN is suddenly stopped or if there is an insulin overdose, it is not a common complication during the administration of TPN, especially in a septic patient where hyperglycemia is more likely.

References:

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↑ *Back to this question in Part A*

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Q110: Which of the following is characteristic of hypovolemic shock? (Q860374)

A. Increase in cardiac output

B. High vascular resistance

C. Increase in venous pressure

D. Increased mixed venous saturation

Correct Answer: B. High vascular resistance

Explanation: In Hypovolemic shock, as the body tries to compensate for the reduced blood volume, the blood vessels constrict (vasoconstriction) to preserve blood pressure and redirect blood flow to vital organs like the heart and brain. This results in increased vascular resistance. Decreased cardiac output (Option A) : Since there's less blood to pump, the heart cannot maintain a normal cardiac output. This is opposite to what happens in some other types of shock (e.g., septic shock), where cardiac output may initially increase. Decreased venous pressure (Option C) : Lower blood volume means less blood returning to the heart, leading to reduced venous pressure. Decreased mixed venous saturation (Option D) : In hypovolemic shock, oxygen delivery is impaired, and the blood returning to the heart has a lower oxygen saturation, which is reflected in a lower mixed venous oxygen saturation. Physiological Hemodynamic Characteristics of Shock Type of Shock Cardiac Output Systemic Vascular Resistance Central Venous Pressure Mean Arterial Pressure Hypovolemic ↓ ↑ ↓ ↓ Cardiogenic ↓ ↑ ↑ ↓ Distributive(Septic, anaphylactic, neurogenic) ↑ or ↓ ↓ ↓ or N ↓ Obstructive (pulmonary embolism, cardiac tamponade, tension pneumothorax) ↓ ↑ ↑ ↓

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 12

↑ *Back to this question in Part A*

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Q111: Identify the type of ulcer shown in the image below: (Q860399)

A. Venous ulcer

B. Malignant ulcer

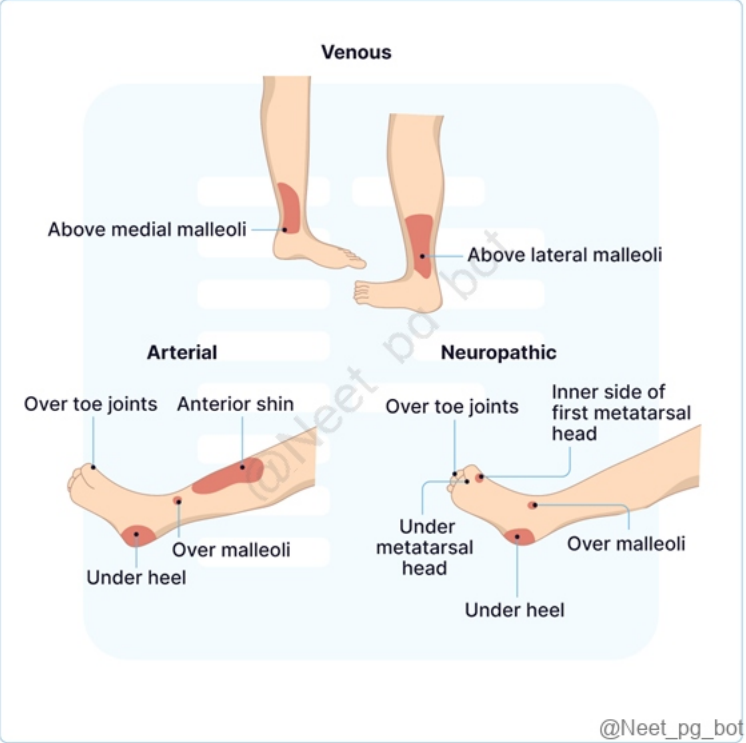
C. Arterial ulcer

D. Trophic ulcer



Correct Answer: D. Trophic ulcer

Explanation: Trophic ulcers, also referred to as neuropathic ulcers occur due to a loss of sensation and an impaired ability to protect the skin, often resulting from conditions like peripheral neuropathy or poor circulation. These ulcers are usually present with well-defined borders and a pale or pink wound bed, commonly located in weight-bearing areas where pressure or friction is frequent. Type of Ulcer: Type History Lesion Characteristics Pain Ischemic/Arterial Smoking, intermittent claudication Irregular edges, poor granulation tissue, dry necrotic base; round or punched-out with sharp demarcation Severe, particularly at night; relieved by dependency Venous Varicose veins, DVT, trauma, surgery, multiple pregnancies Shallow, irregular/shaggy shape, granulating base, fibrinous material with moderate to heavy exudate Mild; relieved by elevation Neurotrophic Numbness, paresthesias, burning, loss of sensation in the foot, DM Punched-out, deep sinus, variable depth partial thickness to severe, involving the tendon, fascia, joint capsule, or bone None Malignant Ulcer History of skin cancer (e.g., basal or squamous cell carcinoma) Irregular, raised borders, ulcerating tumor with hard, indurated tissue Often painful, can be associated with bleeding or foul odor



References:

https://pmc.ncbi.nlm.nih.gov/articles/PMC3036466/

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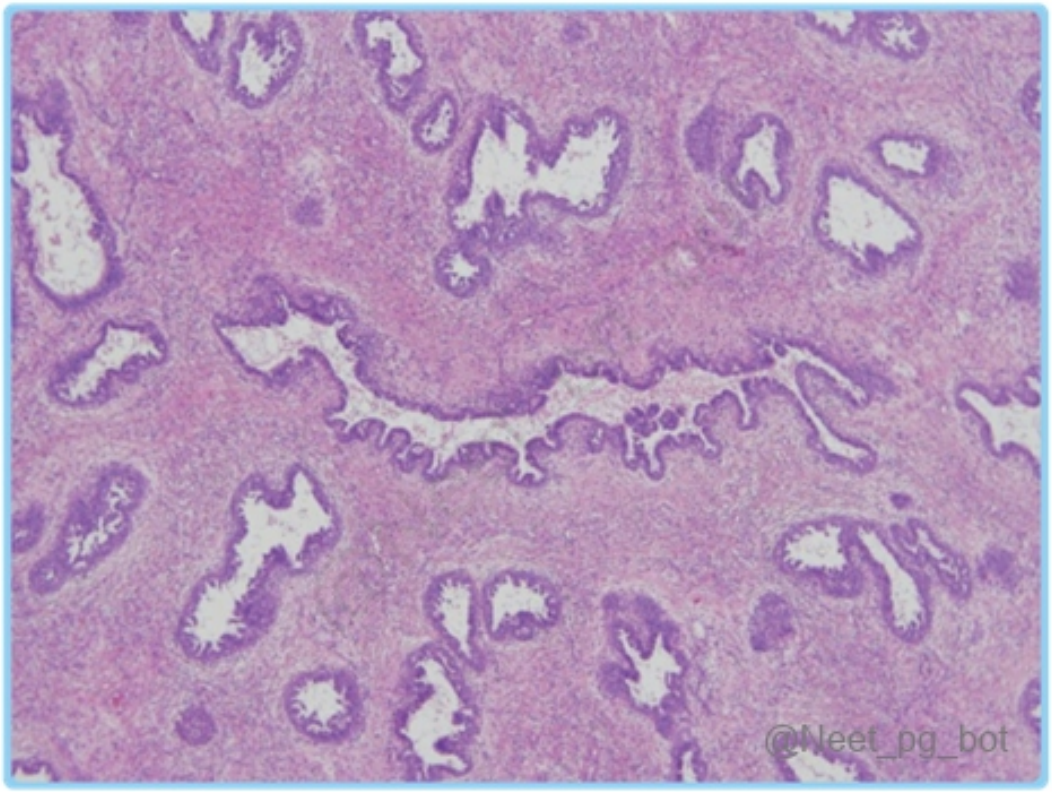
Q112: A 30-year-old female who is receiving cyclosporine A following renal transplantation develops multiple and bilateral breast lumps that regress after cessation of the treatment. Biopsy image is given below. What is the most likely diagnosis? (Q860452)

A. Fat necrosis

B. Phyllodes tumour

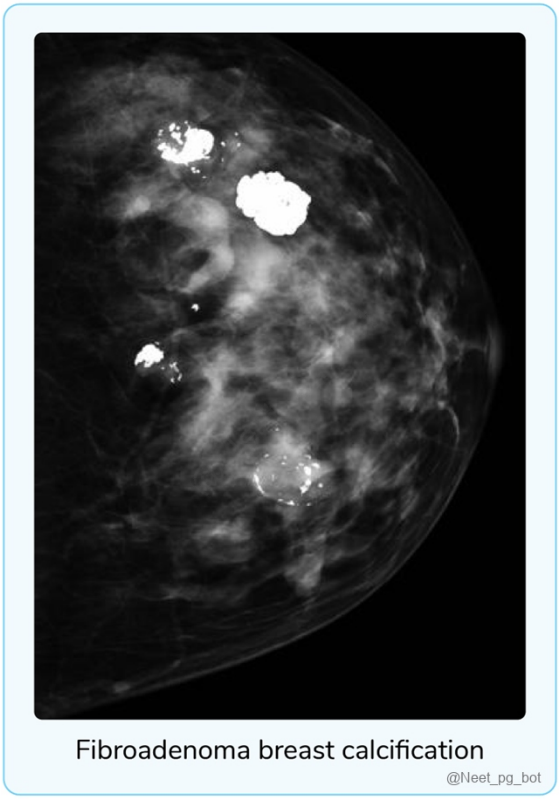
C. Fibroadenoma

D. Carcinoma breast



Correct Answer: C. Fibroadenoma

Explanation: The biopsy image shows a proliferation of ducts arranged in both intracanalicular and pericanalicular patterns, surrounded by fibromyxoid stroma, suggesting Fibroadenoma. These tumours are common in young women, and hormonal changes may influence their growth. Cyclosporine A, which has hormonal effects, could contribute to the development of fibroadenoma. Fibroadenoma: It is the most common benign breast tumour, typically found in women aged 15-35. Characteristics: Spherical masses measuring 1-10 cm, firm, non-tender, well-circumscribed, mobile and often single . The lump is mobile and slippery and hence called breast mouse. Estrogen sensitivity: Can increase in size during pregnancy, lactation, or estrogen therapy and usually regress after menopause. HPE: Well-defined borders due to a fibrous capsule , with proliferating stroma potentially compressing and distorting glandular components. Popcorn calcification on mammogram. {{caption_text}} Ageing effect: Epithelium atrophies with age, and the stroma becomes more hyalinised. Molecular alteration: Alterations in MED12 gene Drug associated with bilateral fibroadenomas: Cyclosporine The histological features of a fibroadenoma include: Fibroepithelial tumours are composed of benign-appearing cellular or myxoid stroma encircling epithelium-lined glands and cystic spaces. Staghorn clusters of cells - Ductal cells arranged in a deer horn-like pattern Bare nuclei - cytoplasm is stripped of,f and only nuclei are visible in blue colour. {{caption_text}} Incorrect Options: Fat necrosis (Option A) typically presents with firm, tender breast lumps following trauma or surgery and shows fatty tissue changes on biopsy, not ductal proliferation. Phyllodes tumour (Option B) can have similar histological features with ductal proliferation but is typically more cellular and can have a leaf-like architecture. It also tends to grow rapidly and is more common in older women. Carcinoma breast (Option D) would be expected to present with more aggressive histological features, such as invasion of surrounding tissue and atypical cells, rather than benign ductal proliferation.





References:

Robbins & Cotran Pathologic Basis of Disease, 10th Edition, Page 1062

https://karger.com/acy/article/58/6/533/8975/Liquid-Based-Cytology-in-Fine-Needle-Aspiration-of

↑ *Back to this question in Part A*

Q113: A 65-year-old male presents to the outpatient department with a swelling in the back of his neck that has been present for almost a year. The swelling has not increased in size. On examination, it is non-pulsatile, and the slip sign is positive, with the swelling measuring 3x3 cm. Which of the following statements is most likely true? (Q860457)

A. High chances of malignant transformation

B. FNAC necessary for diagnosis

C. PET scan necessary for staging

D. Excision can be done if the patient requests it



Correct Answer: D. Excision can be done if the patient requests it

Explanation: Based on the clinical features (non-pulsatile, stable size, and positive slip sign), this is most likely a lipoma , which is a benign tumour of fatty tissue. If the patient requests excision, and if there are no concerns about malignancy, excision can be performed to remove the lipoma for cosmetic or symptomatic reasons. Lipoma: A lipoma is a benign tumour composed of mature adipocytes (fat cells) and is the most common soft tissue tumor.

These tumors are generally soft, mobile, and painless masses found beneath the skin. Most frequently found on the trunk, shoulders, neck, and arms. Histologically, lipomas consist of mature fat cells that are identical to normal adipose tissue but are encapsulated by a thin fibrous capsule , distinguishing them from the surrounding tissue. Lipomas are typically slow-growing, soft, and non-tender. They are usually asymptomatic but can cause discomfort if they compress nearby structures or are located in a site prone to friction or pressure. On physical examination, lipomas are well-circumscribed, mobile masses that can vary in size from a few millimetres to several centimetres. Slip sign: Positive Very low risk of malignant transformation into liposarcoma. (Option A) Management: Most lipomas do not require treatment unless they become symptomatic, grow rapidly, or cause cosmetic concerns. Surgical excision is the definitive treatment and is usually curative. Liposuction may also be an option for larger lipomas, but complete excision is preferred to prevent recurrence. While FNAC can be used for diagnosing soft tissue masses, it is not always required if the lesion's clinical presentation is typical of a lipoma. In many cases, a clinical diagnosis based on history and examination (such as soft, mobile, non-tender mass) is sufficient. (Option B) PET scans are generally used for staging known malignancies, such as lymphoma or other aggressive cancers. In this case, there is no indication that this is a malignant lesion, so a PET scan is unnecessary. (Option C)

References:

SRB’s Manual of Surgery, 6th Edition, Page 68, 69

↑ *Back to this question in Part A*

@Neet_pg_bot

Q114: A 47-year-old man presents with a chronic non-healing painless ulcer over his scalp for 8 years. He has a history of electric burns to the scalp 8 years ago. The examination findings are shown below. Which of the following statements is true? (Q860461)

A. Radiotherapy is useful

B. It can progress to squamous cell carcinoma

C. No lymphatic spread

D. Long-duration antibiotics will improve the condition.



Correct Answer: B. It can progress to squamous cell carcinoma

Explanation: Chronic non-healing ulcers , especially those resulting from burn injuries or other trauma, are at high risk of malignant transformation , most commonly to squamous cell carcinoma (SCC) . This is known as Marjolin's ulcer , which can develop in areas of chronic injury or scar tissue. Marjolin’s Ulcer Definition Low-grade Squamous Cell Carcinoma (SCC) Common Sites of Development Post-burn scar Long-standing venous ulcer Chronic ulcer due to trauma Chronic discharging osteomyelitis sinus Post-radiation ulcer Pathophysiology Develops in scar tissue due to chronic irritation Characteristic Features Painless (no nerves in scar tissues) Slow growing No regional LN metastasis (no lymphatics in scar tissue) Investigation of Choice Biopsy Management Wide local excision followed by a flap cover Radiotherapy should be avoided (Option A) (as it is radio-resistant and also to prevent obliterative end arteritis) {{caption_text}} Malignant lesions like squamous cell carcinoma can spread via lymphatic channels (Option C) , particularly if left untreated. While antibiotics may help treat an infected ulcer , a chronic non-healing ulcer with a history of burn injury is unlikely to respond to antibiotics alone (Option D) .



References:

SRB's Manual of Surgery, 6th Edition, Page 283, 284

↑ *Back to this question in Part A*

@Neet_pg_bot

Q115: A 25-year-old woman presents with severe pain and swelling in her right hand, which is increasing in size and severity. She had a prick injury in the garden 5 days ago. On examination, she cries out in pain when her hand is extended and when the palmar aspect is palpated passively. Which of the following statements is true about the condition? (Q860463)

A. More common in the dorsal aspect of the hand

B. X-ray imaging will aid in the location of the foreign body in all patients

C. It requires incision and drainage

D. Oral analgesics are the mainstay of treatment



Correct Answer: C. It requires incision and drainage

Explanation: The patient likely has a deep palmar abscess secondary to a foreign body, and incision and drainage (I&D) is required to relieve pressure, remove the foreign body, and treat the infection. Deep Palmar Infection: These infections begin in the palm and may be confined to a web space initially. As the infection progresses, the entire hand becomes swollen and tender due to the accumulation of pus on either side of the septum. Management: The treatment involves incision and drainage (I&D) with a thorough washout of the wound. It's essential to open all affected deep spaces. In some cases, incisions may be needed on both the dorsal and volar sides of the hand. If the extent of the infection is unclear, imaging techniques like ultrasound or MRI can be used to delineate the spread within the deep palmar spaces. Incorrect Options: More common in the dorsal aspect of the hand (Option A) : Infections or abscesses caused by foreign bodies are more common in the palmar aspect due to the tighter fascial compartments. X-ray imaging will aid in the location of the foreign body in all patients (Option B) : X-rays are not always helpful, especially for non-radio-opaque foreign bodies (wood), so other imaging like ultrasound might be more useful. Oral analgesics (Option D) may help manage pain, but they are not sufficient for treating the underlying infection/abscess , which requires I&D .

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 543

↑ *Back to this question in Part A*

@Neet_pg_bot

Q116: A patient fell from a train onto the railway track and injured both his legs severely. He was urgently taken to the hospital, and the following procedure was performed (image shown below). What is the rationale for performing this procedure? (Q860466)

A. Better fit for prosthesis

B. Life-saving procedure

C. Reduces risk of cancer

D. Good cosmetic outcomes



Correct Answer: B. Life-saving procedure

Explanation: In cases of severe trauma , such as being run over or falling on railway tracks, injuries can be so extensive that amputation is necessary to prevent massive blood loss , gangrene , or infection , which can lead to death. The decision for a bilateral below-knee amputation is usually made as a life-saving measure when there is irreversible damage to the legs. Indications for Amputation: Dead Limb: Gangrene Deadly Limb Wet gangrene Spreading cellulitis Arteriovenous fistula Malignancy (e.g., sarcoma) Dead loss of limb: Severe rest pain due to irreversible critical leg ischemia Paralysis Severe contracture Trauma (irreparable damage) Local Amputation : For small-vessel disease (e.g., diabetes) : Gangrene of toes may require local amputation. If the metatarsophalangeal joint is involved, ray excision may be necessary. Major Amputation: Below-knee Amputation : Preserves knee joint, offering better prosthetic use. Above-knee Amputation : For poor circulation or

non-mobilizing patients. Knee Disarticulation : Preserves femur and patella for better prosthetic function. Post-operative care: Pain Management : Regular opiate use. Limb Care : Prevent pressure ulcers on the remaining limb. Exercise : Prevent deformities, build strength, and improve mobility. Complications: Early : Hemorrhage, infection, gas gangrene, and wound dehiscence. Late : Phantom limb pain, stump ulceration, DVT, and pulmonary embolism Other options: Option A: Better fit for prosthesis This may be relevant in elective or planned amputations (e.g., vascular disease), but in acute traumatic crush injuries, survival takes priority. Prosthetic fitting is considered later. Option C: Reduces risk of cancer There is no cancer-related indication in traumatic amputations. This option is irrelevant to the clinical context. Option D: Good cosmetic outcomes Cosmesis is not a priority in emergency traumatic amputations. Such procedures are typically disarticulations or guillotine amputations for source control.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 1014,1015

↑ *Back to this question in Part A*

@Neet_pg_bot

Q117: In solid organ transplantation, which of the following organs is associated with a higher incidence of rejection? (Q860491)

A. Lungs

B. Intestine

C. Kidney

D. Liver

Correct Answer: A. Lungs

Explanation: Survival after lung transplantation continues to improve over time; however, the rates remain lower compared to other solid organ transplants. Around 50% of lung transplant recipients will face at least one episode of acute rejection within the first year . Furthermore, by five years post-transplant , roughly half of recipients will have developed chronic rejection . Incorrect Options: Kidney transplantation: (Option C) Graft rejection rate for kidney transplants is quite low after the first year. Specifically, with living-donor kidneys , the 1-year survival rate is 98% , and with deceased-donor kidneys , the 1-year survival rate is 93% . At 5 years, the graft survival rate for living-donor kidneys is 85%, and for deceased-donor kidneys, it is 75% . By 10 years, the survival rates drop to 65% for living-donor kidneys and 48% for deceased-donor kidneys, indicating a gradual decline due to chronic processes rather than acute rejection episodes. Liver transplantation (Option D): Chronic rejection occurs in about 13-17% of recipients Intestinal transplantation (Option B): Chronic rejection occurs in about 10% of recipients.

References:

Harrison’s Principle of Internal Medicine, 21st Edition, Page 2213, 2325, 2326

https://pmc.ncbi.nlm.nih.gov/articles/PMC5715482/#:~:text=Clinical%20Features%20and%20Diagnosis%20of%20Chronic%20Rejection&text=CR%20occurs%20in%203%E2%80%9317,to%20earlier%20Cyclosporin%20based%20studies.

https://pubmed.ncbi.nlm.nih.gov/29327261/

↑ *Back to this question in Part A*

@Neet_pg_bot

Q118: A 55-year-old female patient with chronic pancreatitis undergoes a Puestow procedure. What is the most preferred route for supplementary nutrition in this patient? (Q860504)

A. TPN (Total Parenteral Nutrition)

B. Oral feeding

C. Feeding gastrostomy

D. Feeding jejunostomy

Correct Answer: D. Feeding jejunostomy

Explanation: After major pancreatic surgery (including Puestow), the stomach and duodenum frequently develop postoperative ileus, making early oral or gastric feeding unreliable. Feeding jejunostomy (FJ) delivers nutrition directly into the jejunum, bypassing the non-functioning upper GI tract. Enteral feeding through a jejunostomy is safer than gastric feeding, reduces aspiration risk, and is preferred over TPN because it maintains gut mucosal integrity and lowers infection risk. Hence, FJ is the most appropriate supplementary feeding route. Incorrect Options: Option A) TPN : Only used when enteral feeding is impossible. Higher risks: line infections, metabolic complications. Enteral > parenteral whenever feasible. Option B) Oral feeding : Usually delayed due to postoperative ileus , nausea, and vomiting. Not dependable for immediate nutritional needs. Option C) Feeding gastrostomy : Stomach often has poor motility post-pancreatic surgery; higher aspiration risk. Not recommended for early postoperative feeding.

References:

SRB's Manual of Surgery, 6th Edition, Page 693.

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 338, 339.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q119: A 35-year-old woman, 10 years after mastectomy, notices gradual swelling and heaviness in her right upper limb without pain. On examination, bluish nodules on the skin with no infections are noted. What is the most likely cause of her symptoms? (Q860167)

A. Lymphangiosarcoma

B. Thoracic outlet syndrome

C. Chronic venous insufficiency

D. Recurrent breast cancer

Correct Answer: A. Lymphangiosarcoma

Explanation: Lymphangiosarcoma is the most likely cause of these symptoms, especially in a patient with a history of mastectomy. This condition, also known as Stewart-Treves syndrome , can develop years after mastectomy due to long-standing lymphedema, which is a consequence of lymphatic obstruction. Complications of mastectomy: Complications

References:

Sabiston Textbook of Surgery, 21st Edition, Page 832.

SRB's Manual of Surgery, 6th Edition, Page 25, 26.

https://www.ncbi.nlm.nih.gov/books/NBK538212/#:~:text=Patients%20tolerate%20mastectomy%20well%20in,breakdown%20or%20necrosis,%20and%20lymphedema.

↑ *Back to this question in Part A*

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Q120: A patient presents to the emergency room after a road traffic accident with shock and hypotension. The extended focused assessment with sonography for trauma (eFAST) is negative, the X-ray is normal, and the ECG shows bradycardia. The patient's SpO2 is 93%, blood pressure is 80/60 mmHg, and pulse rate is 40/min. Based on this information, what type of shock is most likely? (Q860219)

A. Septic shock

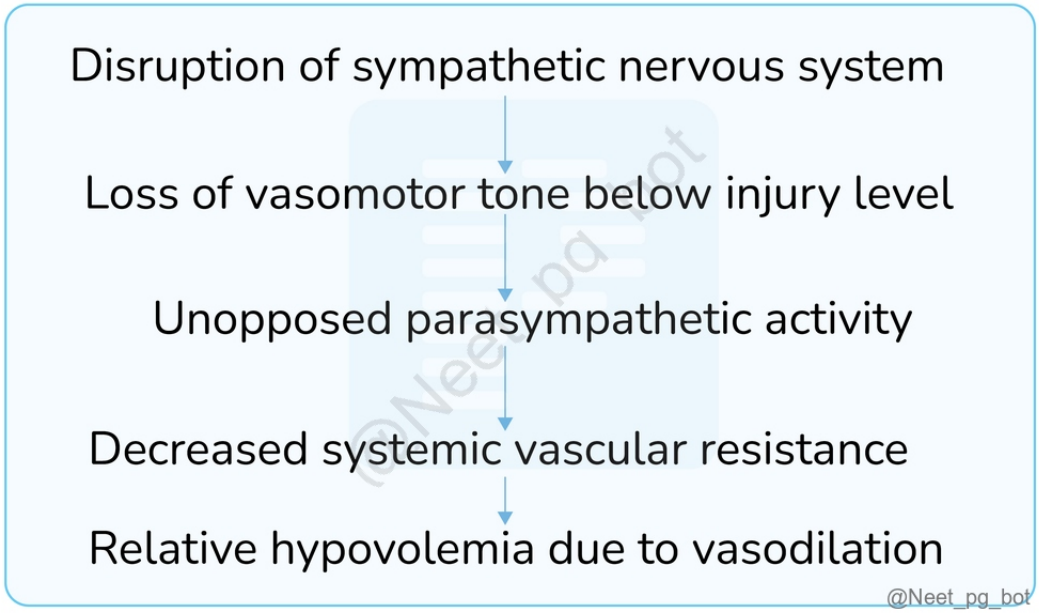
B. Hemorrhagic shock

C. Cardiogenic shock

D. Neurogenic shock

Correct Answer: D. Neurogenic shock

Explanation: Neurogenic shock is characterized by hypotension, bradycardia, and normal or slightly reduced SpO2. The absence of trauma to solid organs, negative eFAST, and normal X-rays help rule out hemorrhagic or cardiogenic shock. The bradycardia (pulse of 40/min) is due to a loss of sympathetic tone following spinal cord injury or severe trauma, leading to vasodilation and bradycardia. Neurogenic shock: In neurogenic shock, there is a loss of sympathetic tone, leading to vasodilation of the peripheral vasculature, resulting in decreased peripheral vascular resistance and hypotension. This is the primary mechanism underlying neurogenic shock. Causes: Neurogenic shock is a critical condition that results from the dysregulation of the autonomic nervous system following spinal cord injury, especially in the cervical and upper thoracic vertebrae above the T6 level, as a result of traumatic events. The dysregulation arises due to the lack of sympathetic tone and decreased peripheral vascular resistance. The decline in sympathetic tone prompts the dilation of capacitance blood vessels in the lower extremities. This, in turn, results in decreased cardiac filling, leading to hypotension and shock. Reduced sympathetic control over the heart leads to a situation where unopposed vagal cardiac influence causes bradycardia. Patients with neurogenic shock may also exhibit pink and warm skin due to the dilation of subcutaneous blood vessels. Severe brain injury. Certain anaesthetics. Pathophysiology Clinical Manifestations: Hypotension Bradycardia (unlike other forms of shock) Warm, dry skin below injury level Priapism in males Respiratory compromise (if high cervical injury) Poikilothermia (inability to regulate body temperature) Physiological Hemodynamic Characteristics of Shock Type of Shock Cardiac Output Systemic Vascular Resistance Central Venous Pressure Mean Arterial Pressure Hypovolemic ↓ ↑ ↓ ↓ Cardiogenic ↓ ↑ ↑ ↓ Distributive(Septic, anaphylactic, neurogenic) ↑ or ↓ ↓ ↓ or N ↓ Obstructive (pulmonary embolism, cardiac tamponade, tension pneumothorax) ↓ ↑ ↑ ↓



References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 12

SRB's Manual of Surgery, 6th Edition, Page 106

Sabiston Textbook of Surgery, 21st Edition, Page 526

↑ *Back to this question in Part A*

@Neet_pg_bot

Q121: In patients at risk of refeeding syndrome, which of the following electrolyte imbalances is typically not associated with this condition? (Q860221)

A. Hypokalemia

B. Hyperkalemia

C. Hypocalcemia

D. Hypophosphatemia

Correct Answer: B. Hyperkalemia

Explanation: Refeeding syndrome occurs when a malnourished patient is rapidly reintroduced to nutrition, especially carbohydrates. Insulin release shifts potassium, phosphate, and magnesium into cells, causing: Hypophosphatemia (most characteristic) Hypokalemia Hypomagnesemia Hypocalcemia (secondary to hypomagnesemia) Hyperkalemia does not occur because total body potassium is already depleted, and insulin drives it into cells. Incorrect Options: Option A) Hypokalemia: Common due to cellular shift during refeeding. Option C) Hypocalcemia: Can occur secondarily to hypomagnesemia. Option D) Hypophosphatemia: The hallmark of refeeding syndrome, due to increased cellular uptake of phosphate.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 340

↑ *Back to this question in Part A*

@Neet_pg_bot

Q122: Identify the edges of the lesion given in the image: (Q860254)

A. Everted

B. Rolled out

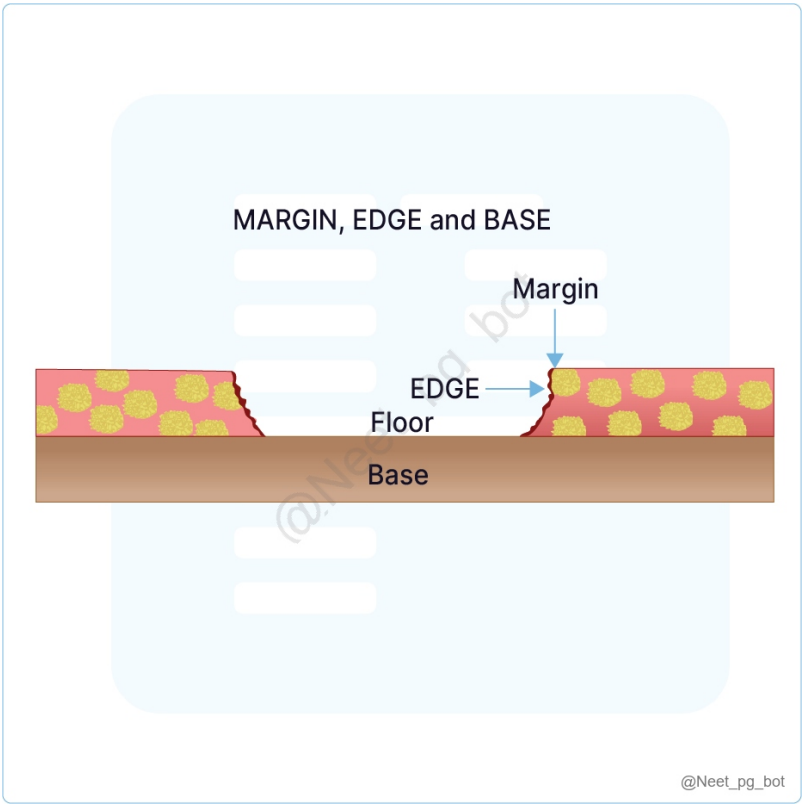
C. Sloping

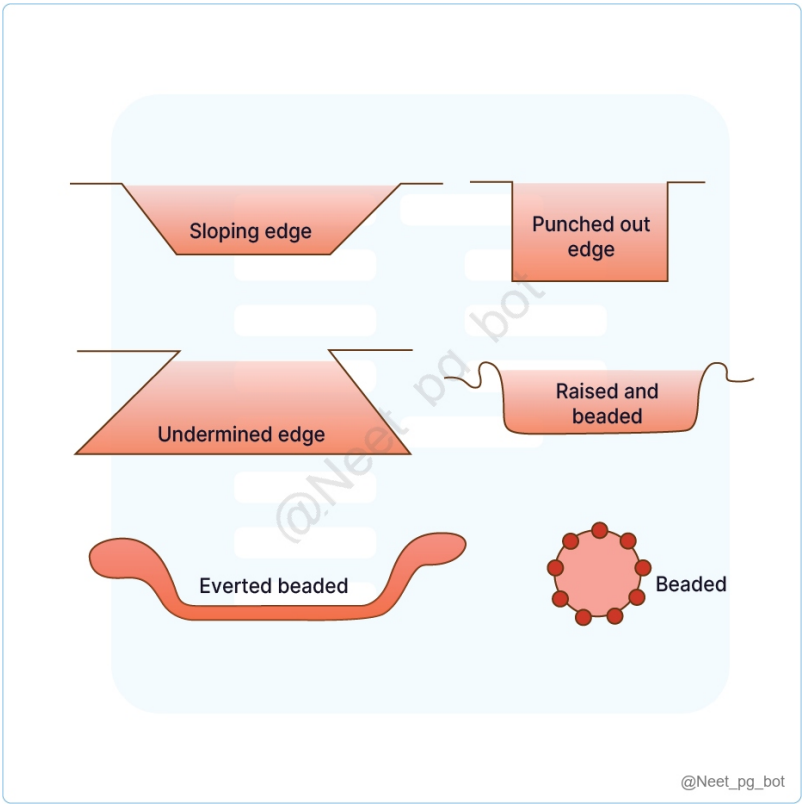
D. Punched out



Correct Answer: B. Rolled out

Explanation: The given image shows rolled-out edges suggesting Basal cell carcinoma. Morphologically, an ulcer has 4 parts: Base: Surface on which ulcer rests (usually underlying muscles/bones) Floor: Exposed surface of ulcer (usually seen as purulent discharge/granulation tissue/red and moist) Margin: Junction between normal epithelium & ulcer Edge: Area between margin & floor Type of edges Clinical conditions Details Sloping edge Healing ulcer Varicose ulcer Inner part: Red (healthy granulation tissue) Middle part: Blue (epithelial proliferation) Outer part: White (scar/fibrous tissue) Undermined edge Tubercular ulcers Disease process advances in the deeper plane (subcutaneous tissue), whereas (skin) epidermis proliferates inwards Punched out edge Arterial / Ischemic ulcers Gummatous (syphilitic) ulcer Trophic ulcer Due to endarteritis Raised & beaded edge Rolled out / Pearly white edge Rodent ulcer- Basal cell carcinoma Beads are due to proliferating active cells Pearly white in appearance Everted edge / Rolled out edge Squamous cell carcinoma Due to the spill of proliferating malignant tissue over the normal skin





References:

SRB's Manual of Surgery, 6th Edition, Page 15

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1360405/

↑ *Back to this question in Part A*

@Neet_pg_bot

Q123: A patient following a road traffic accident (RTA) with a crush injury presents with crepitus and a reddish-brown wound within 3 days after amputation. What is the most likely condition? (Q860260)

A. Gas gangrene

B. Impetigo

C. Tetanus

D. Cellulitis

Correct Answer: A. Gas gangrene

Explanation: Gas gangrene is caused by Clostridium species, typically after traumatic injuries, especially with crush wounds or amputation. It is characterized by crepitus (gas production), reddish-brown discoloration of the wound, and rapid progression within days. Gas Gangrene A rapidly progressive, potentially fatal condition characterized by widespread necrosis of muscles and soft-tissue destruction, often due to late-presenting missile wounds or crushing injuries. Cause Clostridium perfringens Incubation period <24 hours but ranges from 1 hour to 6 weeks Sources and predisposing factors Contaminated soil and feces. Wounds with necrotic or foreign material. Crush wounds, road traffic accidents, amputations. Anaerobic environments in the wound. Common sites of infection Adductor region of the lower limb and buttocks. Subscapular region in the upper limb. Clinical features Severe pain with limb swelling rapidly increases in severity. Serosanguineous discharge. Skin turns brown to blue-black with hemorrhagic bullae. Sweet, sticky odor & Soft-tissue crepitus. Complication Septicaemia, toxemia, renal failure, liver failure. Circulatory failure, DIC, secondary infections. Death occurs in critically ill patients. Investigation X-ray: Gas in soft tissues. Gram stain & blood culture: Large Gram-positive bacilli without neutrophils. Biochemical profile: Metabolic acidosis, renal failure. Peripheral blood smear: Haemolysis. CT scan for chest or abdominal wounds. Treatment High-dose intravenous penicillin and clindamycin, along with 3rd generation cephalosporins, are given intravenously. Polyvalent antiserums given intravenously. All dead tissues are excised, and debridement is performed until healthy tissue bleeds. Amputation done in severe cases Hyperbaric oxygen therapy. Prevention Proper debridement of devitalized crushed wounds. Devitalized wounds should not be sutured. Adequate cleaning of wounds with H■O■ and normal saline. Penicillin - As a prophylactic antibiotic. Image {{caption_text}} Incorrect Options: Impetigo (Option B) is a superficial skin infection caused by Streptococcus or Staphylococcus bacteria, presenting as honey-colored crusts, but does not typically cause crepitus or involve deep tissue. Tetanus (Option C) results from infection with Clostridium tetani , leading to muscle stiffness and spasms. While it follows a traumatic injury, it doesn’t typically present with crepitus or reddish-brown wound discoloration. Cellulitis (Option D) is a bacterial skin infection that causes redness, swelling, and warmth, but it does not produce crepitus or reddish-brown wounds and typically develops over a longer period.



References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 57,457,643

SRB's Manual of Surgery, 6th Edition, Page 44, 50-52,1056

↑ *Back to this question in Part A*

@Neet_pg_bot

Q124: Arrange the stages of wound healing in the correct sequence: (Q860267)

A. Proliferation, hemostasis, inflammation, remodeling

B. Inflammation, remodeling, hemostasis, proliferation

C. Hemostasis, inflammation, proliferation, remodeling

D. Remodeling, proliferation, hemostasis, inflammation

Correct Answer: C. Hemostasis, inflammation, proliferation, remodeling

Explanation: Wound healing occurs in four stages : hemostasis , inflammation , proliferation , and remodeling . Hemostasis: Occurs immediately after injury: vasoconstriction, platelet aggregation, and clot formation. Platelets release growth factors (e.g., TGF-β , PDGF , VEGF) that promote matrix deposition, chemotaxis, and angiogenesis. Coagulation cascade leads to thrombin formation, stabilizing the platelet plug. Inflammation: Early Phase (Days 1-2): Neutrophils clear debris and fight infection. Vasoactive amines increase vascular permeability.

Late Phase (Days 2-3): Macrophages debride the wound, release growth factors, and promote fibroblast and angiogenesis. Cardinal signs: rubor (redness), tumor (swelling), calor (heat), dolor (pain). Proliferation: Days 3-14: Fibroblasts produce collagen and extracellular matrix. Granulation tissue forms, and angiogenesis occurs. Myofibroblasts help contract the wound and bring edges together. Remodelling: Weeks to months: Type III collagen is replaced by stronger type I collagen . The wound reaches about 80% of normal skin strength by 12 weeks and continues to mature for up to a year.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 25,26

↑ *Back to this question in Part A*

@Neet_pg_bot

Q125: Which of the following is considered a “sure sign” of abdominal wound dehiscence in a post-operative hypotensive patient? (Q860272)

A. Increased bowel sounds

B. Persistent abdominal pain

C. Serosanguinous drainage from the wound

D. Widening of the abdominal scar with palpable edges

Correct Answer: C. Serosanguinous drainage from the wound

Explanation: Serosanguinous drainage from the wound is considered a "sure sign" of abdominal wound dehiscence in a post-operative hypotensive patient (Salmon fluid sign) Wound dehiscence is the disruption of any or all layers of a wound. It occurs in up to 3% of abdominal wounds and is associated with an increased risk of postoperative mortality. Timing and Presentation: Wound dehiscence typically occurs 5 to 8 days postoperatively when the strength of the wound is at its weakest. It often presents with serosanguinous discharge and may be preceded by a popping sensation felt by the patient, particularly during activities like straining or coughing. The dehiscence may also indicate an underlying abscess. Risk factors: Poor wound closure or closure under tension Infection , hematoma , or seroma at the wound site Increased intra-abdominal pressure , e.g., in postoperative patients with chronic obstructive pulmonary disease (COPD) or excessive coughing Malnourishment Diabetes Obesity Renal failure Jaundice Sepsis Cancer Steroid use Emergency surgery Management: Full-thickness dehiscence generally requires the patient to return to the operating room for resuturing. In cases of infected tissues, poor-quality tissue, or wounds under excessive tension, the wound may be left open and managed with dressings or vacuum-assisted closure (VAC) .

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 325

↑ *Back to this question in Part A*

@Neet_pg_bot

Q126: An elderly chronic smoker male is diagnosed with squamous cell carcinoma of the lower lip with no lymph node involvement. What is the treatment of choice? (Q860276)

A. Radiotherapy

B. Combined chemoradiotherapy

C. Wide local excision with negative borders

D. Wide local excision with frozen section

Correct Answer: D. Wide local excision with frozen section

Explanation: Wide local excision with frozen section is the treatment of choice for early-stage squamous cell carcinoma of the lower lip in patients with no lymph node involvement. This technique ensures that the excision margins are clear in real-time, reducing the risk of recurrence. Cutaneous Squamous Cell Carcinoma (SCC): SCC is a malignant tumor of keratinising cells in the epidermis, commonly arising from the stratum basalis. It is the second most common skin cancer, more prevalent in fair-skinned individuals with chronic sun exposure. Risk factors: UV radiation , chronic inflammation, immunosuppression , chemical carcinogens (e.g., arsenic), and HPV infection (types 5 and 16). Tobacco use doubles the risk. Precursor lesions: Actinic Keratosis (AK) : Dysplastic lesions from sun damage; 20% progress to SCC. Keratin Horns : Raised keratinous surface from AK, 10% may have underlying SCC. Keratoacanthomas : Rapidly growing, nodular tumors that resemble SCC and should be excised. Clinical features: SCC presents as nodular, verrucous, or ulcerating lesions with an everted edge and surrounding induration. Differential diagnosis : AK, BCC, pyoderma gangrenosum, and warts. Microscopic features: Irregular squamous epithelium invading the dermis, positive for cytokeratins 1 and 10 . Broders' grading assesses tumor differentiation. Management: The primary treatment for SCC is surgical excision , which provides accurate histological diagnosis and clear margins . The size of the SCC influences the required margin: <2 cm SCC : 4 mm margin >2 cm SCC : 1 cm margin The recurrence rate is approximately 20% . Surgical excision is the only reliable method for ensuring clear margins. Mohs’ micrographic surgery may be indicated for difficult-to-resect tumours or those with recurrent SCC.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 652-655

↑ *Back to this question in Part A*

@Neet_pg_bot

Q127: In a triage setting, which of the following categories requires the highest priority intervention? (Q860294)

A. Red

B. Yellow

C. Green

D. Black

Correct Answer: A. Red

Explanation: In triage, the Red category represents patients who have life-threatening injuries or conditions but can survive with immediate medical intervention. These patients are prioritised for treatment and intervention to prevent imminent death. Triage colour coding systems: Colour Priority Medical Need Clinical Status Examples Red First Immediate Critical, but likely to survive if treatment is given early Severe facial trauma Tension pneumothorax Profuse external bleeding Haemothorax Flail chest Major intra-abdominal bleed Extradural haematomas Yellow (Option B) Second Urgent Critical, but likely to survive if treatment is given within hours Compound fractures Degloving injuries Ruptured abdominal viscus Pelvic fracture Spinal injuries Green (Option C) Third Non-Urgent Stable, likely to survive even if treatment is delayed for hours to days Simple fractures Sprains Minor lacerations Black (Option D) Last Unsalvageable Not breathing, pulseless, so severely injured that no medical care is likely to help. Severe brain damage Very extensive burns Major disruption/ loss of chest or abdominal wall structures

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 449

Sabiston Textbook of Surgery, 21st Edition, Page 560, 561

https://www.ncbi.nlm.nih.gov/books/NBK557583/

↑ *Back to this question in Part A*

@Neet_pg_bot

Q128: What type of skin graft is used in the image shown? (Q860305)

A. Split thickness

B. Full thickness

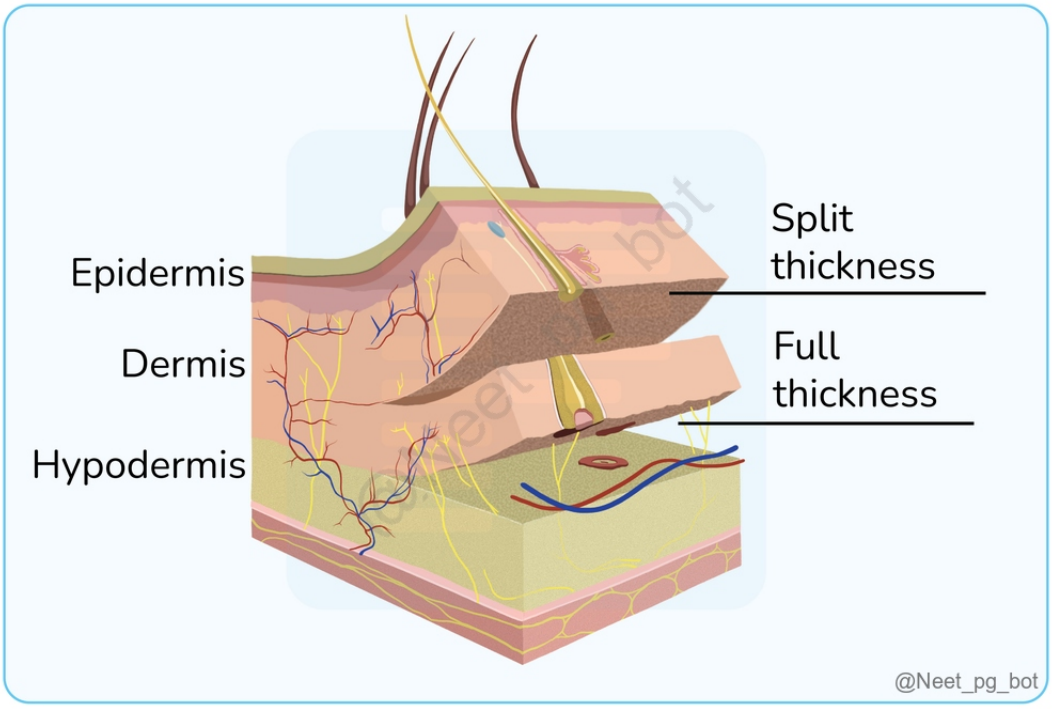
C. Wolfe graft

D. Local flap



Correct Answer: A. Split thickness

Explanation: The image in question depicts a split-thickness skin graft (STSG), which consists of the epidermis and a portion of the dermis. These grafts are typically harvested from areas such as the inner thigh. Due to their ease of harvesting and ability to cover larger wounds, split-thickness grafts are commonly used for extensive skin coverage. Feature Thiersch Graft (Split-Thickness Skin Graft) Wolfe Graft (Full-Thickness Skin Graft) Type of Skin Grafting Split-thickness Full-thickness Composition Epidermis + part of dermis Epidermis + full thickness of dermis Graft Size Large grafts can be taken Only small grafts can be taken Graft Survival Easier More difficult Donor Site Healing Heals spontaneously, allowing repeated grafts Permanent defect develops, preventing repeated grafts Graft Contraction Significant contraction, leading to poor cosmetic appearance Lesser contraction, better cosmetic appearance Common Donor Sites Inner thigh, upper arm, flexor aspect of forearm, abdominal wall Upper eyelid, retro auricular skin, supraclavicular skin, antecubital skin, inframammary skin, inguinal skin, genital skin, gluteal skin Donor Site Exclusions None Axilla is not used as a donor site Advantages of Harvesting Allows calibration of thickness and large area coverage Calibration of thickness for small but thick grafts



References:

SRB's Manual of Surgery, 6th Edition, Page 316, 317, 319

↑ *Back to this question in Part A*

@Neet_pg_bot

Q129: A female patient presents to the outpatient department 10 days postpartum with complaints of a fluctuant breast mass with tenderness, high-grade fever, and cracked nipples. What is the most probable diagnosis? (Q860324)

A. Breast engorgement

B. Breast abscess

C. Acute mastitis

D. Fibroadenoma

Correct Answer: B. Breast abscess

Explanation: A breast abscess is a localized collection of pus within the breast tissue, most commonly seen in lactating women. The patient's clinical presentation, including a fluctuant mass, high fever, and localized tenderness, strongly suggests this diagnosis. Breast Abscess Definition Pus-filled cavity within breast tissue. Types Lactational Abscess: Associated with breastfeeding. Non-Lactational Abscess: Occurs in non-lactating women, e.g., periductal mastitis. Causes and Risk Factors Lactation: Incidence: 3% to 20% in lactating mothers. Common pathogen: Staphylococcus aureus (methicillin-resistant strains in hospital settings). Entry points: Cracked/retracted nipple, blocked lactiferous ducts. Non-Lactation: Often in nulliparous women or post-lactation. Conditions: Periductal mastitis, idiopathic granulomatous mastitis, tubercular mastitis. Smoking and diabetes as risk factors. Signs and symptoms Fever, leukocytosis, erythema, pain and tenderness, swelling, malaise, difficulty feeding, enlarged and tender axillary nodes Diagnosis Ultrasonography: Detects cellulitis, liquefaction necrosis. Confirms abscess size, location, and loculation. Treatment Lactational Mastitis: Antibiotics: Anti-staphylococcal (e.g., cloxacillin, flucloxacillin, erythromycin). Breast emptying: Frequent breastfeeding or pumping. Support: Breast support garment, cold compresses, analgesia. Drainage: Ultrasound-guided preferred over surgical incision. Follow-up: Regular clinical and ultrasonographic reviews, culture-based antibiotic modification. Non-Lactational Mastitis: Broad-spectrum antibiotics for subareolar infections. Needle aspiration for abscess drainage. Major milk duct excision for complications like sepsis or fistula. Incorrect Options: Breast engorgement (Option A) is not associated with a fluctuant mass, high fever, or localized pain. Acute mastitis (Option C) can cause breast pain and swelling, but it typically does not present as a fluctuant mass. Fibroadenoma (Option D) does not present with a fluctuant mass, high fever, or localized pain.

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 927, 928

Sabiston Textbook of Surgery, 21st Edition, Pages 826, 827

Schwartz's Principles of Surgery, 11th Edition, Pages 550-553, 601, 602

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Q130: What kind of wound is an open cardiac massage? (Q857262)

A. Clean

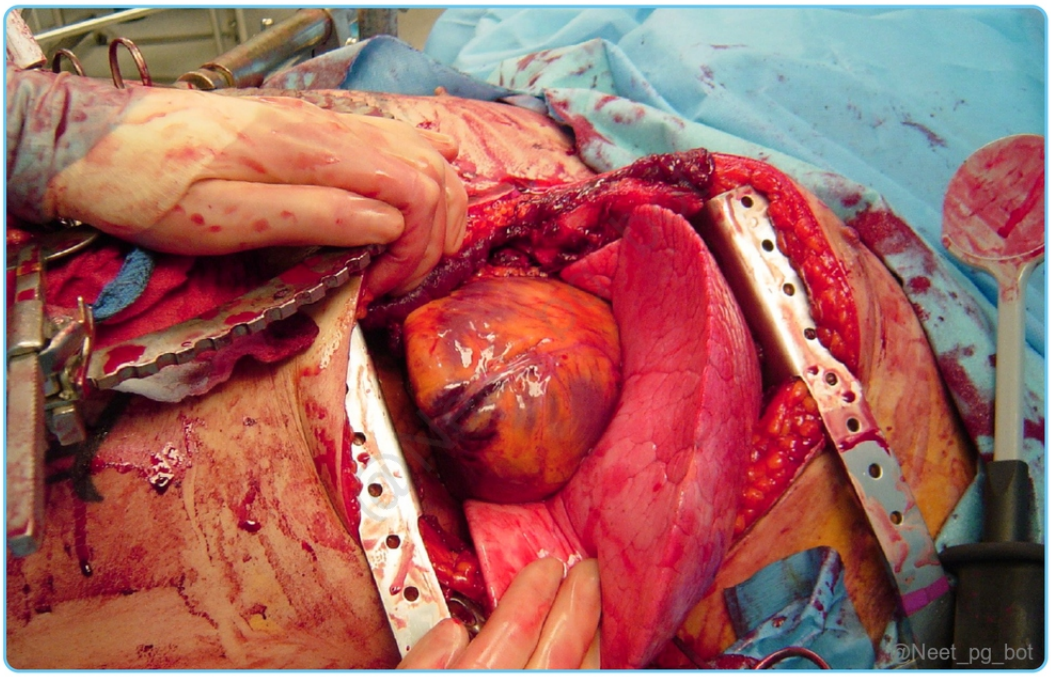
B. Contaminated

C. Dirty

D. Clean Contaminated

Correct Answer: B. Contaminated

Explanation: Open cardiac massage is classified as Category 3 due to a significant breach in sterile technique. It is generally performed in situations of inadequate cardiac output, following emergency thoracotomy for penetrating chest trauma, during pericardial tamponade, or in cases of cardiac arrest after recent chest surgery. {{caption_text}} Classification of Wounds: Classification Description Class I Clean An uninfected operative wound with no inflammation and no entry into the respiratory, alimentary, genital, or uninfected urinary tracts. Wounds are primarily closed, and drainage is closed if needed. Class II Clean-Contaminated An operative wound where the respiratory, alimentary, genital, or urinary tracts are entered under controlled conditions without unusual contamination. Includes operations like biliary tract, appendix, vagina, and oropharynx. Class III Contaminated Open, fresh accidental wounds or operations with major breaks in sterile technique (open cardiac massage) or gross spillage from the gastrointestinal tract , with acute non-purulent inflammation. Class IV Dirty-Infected Old traumatic wounds with retained devitalized tissue, clinical infection, or perforated viscera. The organisms causing postoperative infection were already present in the operative field before the operation.



References:

Sabiston Textbook of Surgery, 21st Edition, Page 225

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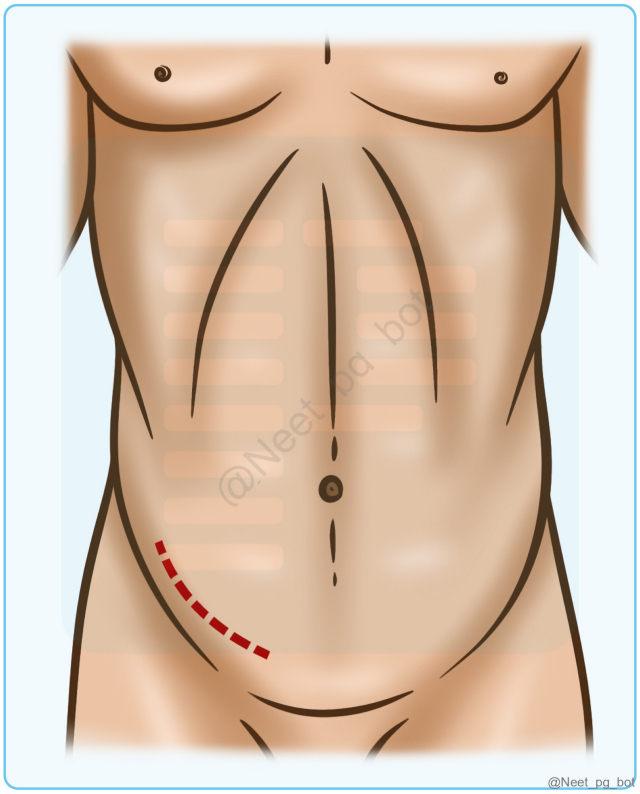
Q131: Identify the incision made and marked in the image. (Q857292)

A. Robson

B. Maylard

C. Gibson Abernathy

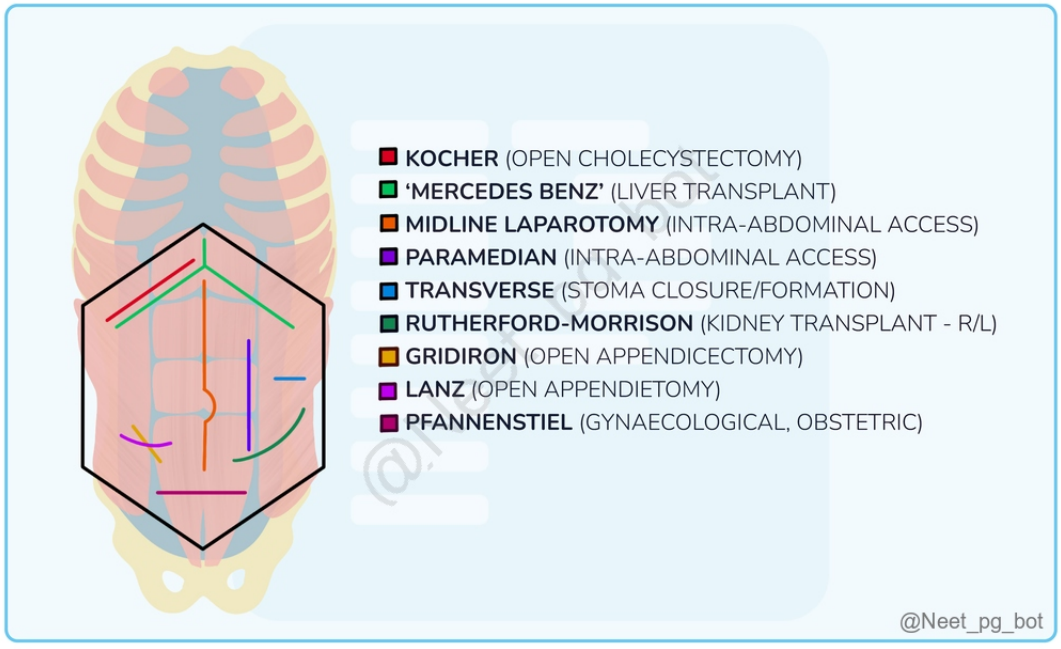
D. Kocher's

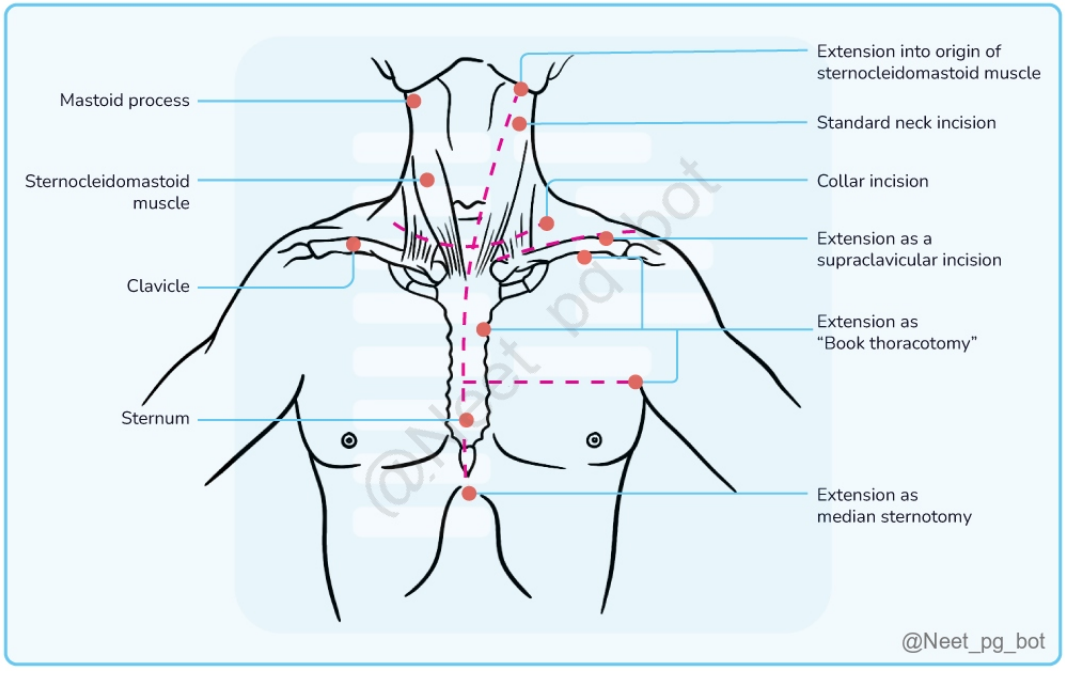


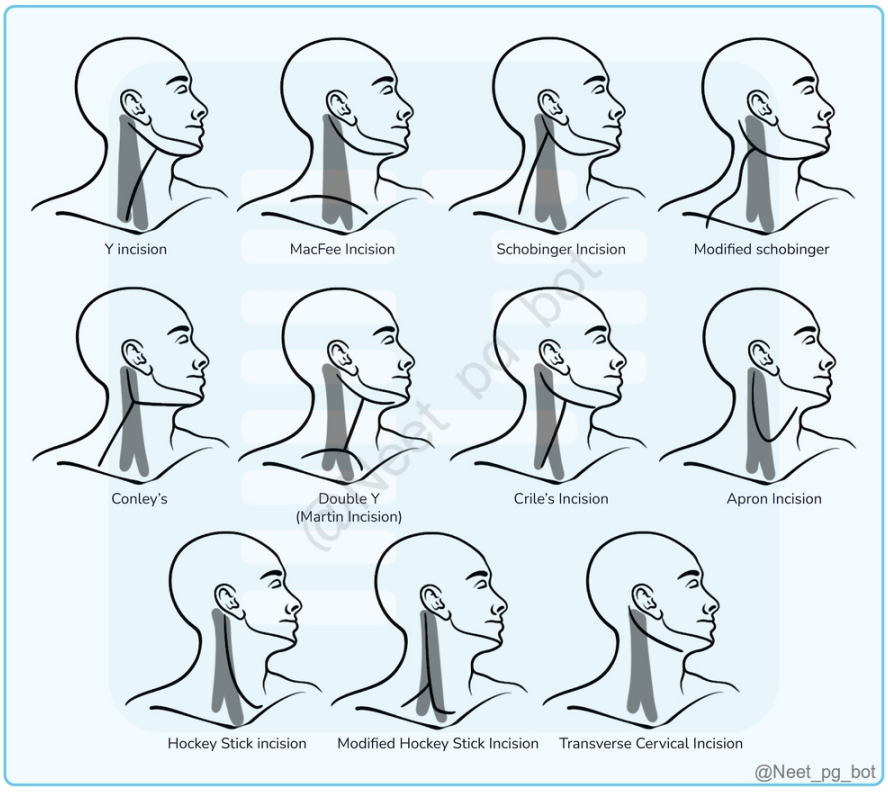
Correct Answer: C. Gibson Abernathy

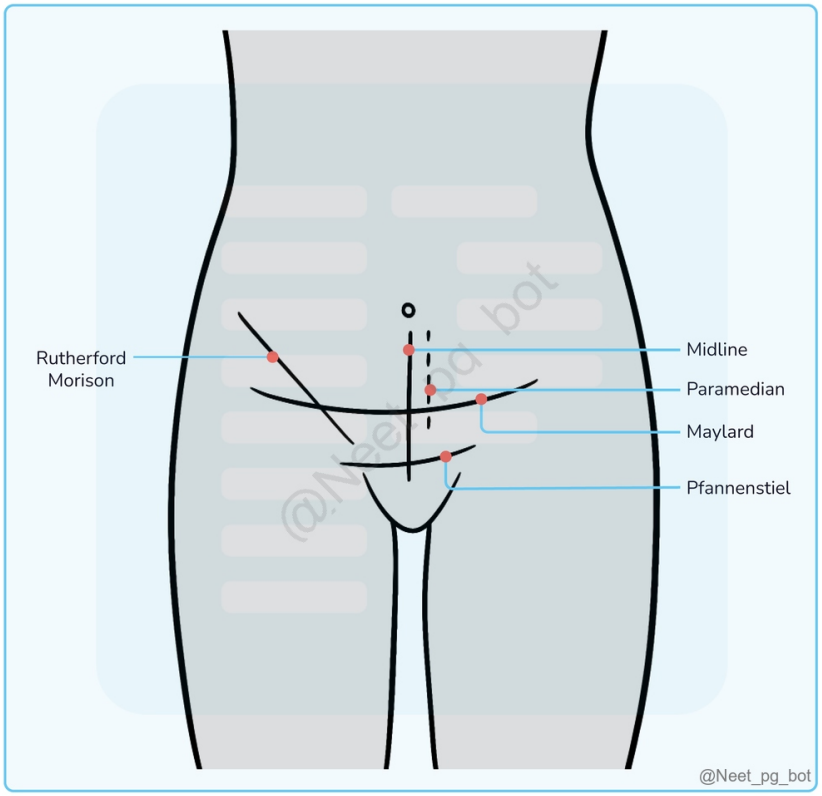
Explanation: The given image shows Gibson Abernathy's incision. Gibson Abernathy incision: Primary Use: Provides access to the lower/distal part of the ureter. Procedure Steps: The patient is placed in a supine position. The incision is made 1 inch medial to the anterior superior iliac spine (ASIS), extending 1 inch above the inguinal ligament toward the pubic symphysis. Indications: Renal transplant offers less trauma and convenient access to the iliac fossa and bladder. Laparoscopic surgery is used as access for the non-dominant hand. Open nephroureterectomy, facilitates splitting the rectus fascia and developing the space of Retzius for distal ureterectomy. Kidney excision and removal of the renal specimen from the entrapment sac. Incision Type Description Common Uses Abdominal Incisions Midline Longitudinal cut through the linea alba, bloodless access Exploratory laparotomy, trauma surgery, emergency surgeries Periumbilical Incisions around the umbilicus, avoiding the umbilical stalk Laparoscopy, umbilical hernia repairs, postpartum tubal ligation Pararectus Along the semilunar line, lateral to the rectus abdominis Abdominal wall hernia repairs, stoma creation, pelvic surgeries Paramedian Lateral to the linea alba, access to lateral viscera Lateral abdominal structures, Reduced hernia risk Kocher/Subcostal Inferior and parallel to the costal margin, access to upper abdomen structures Gallbladder, biliary tree, pancreas, liver transplants, epigastric surgeries Gridiron/ McBurney/ Lanz Lower abdomen incisions, typically for appendectomy Appendectomy (right side), sigmoid diverticulitis (left side), cosmetic appendectomy Thoracoabdominal From 7th intercostal space to the umbilicus, exposes thoracic and abdominal organs Retroperitoneal masses, pleural space, distal oesophagus, abdominal organs Thoracic Incisions Thoracotomy Access to thoracic structures, various approaches Lung transplants, cardiac surgeries, trauma Median Sternotomy Vertical incision dividing the sternum, wide access to the mediastinum Open-heart surgery, anterior mediastinal tumour resection Trapdoor Complex incision, supraclavicular, sternal, and thoracotomy components Penetrating trauma, aortic arch aneurysms, complex cardiovascular access Infraclavicular A transverse incision just below the clavicle for subclavian vessel access Thoracic outlet syndrome, subclavian vessel surgeries Supraclavicular Superior to the clavicle, providing access to the subclavian vessels Trauma, thoracic outlet syndrome Neck

Incisions Collar Incision above the sternal notch for thyroid surgeries Thyroid surgery, mid-neck structures Traumatic Neck Along the sternocleidomastoid muscle for trauma Vascular or traumatic neck injuries Tracheostomy Vertical/horizontal incision superior to the thyroid for tracheostomy Airway management in patients needing long-term ventilation Pelvic Incisions Pfannenstiel Transverse incision above the pubic symphysis Cesarean section, pelvic, urologic, and orthopaedic surgeries Maylard/Cherney Above pubic tubercle provides access to pelvic structures Hysterectomy, pelvic lymph node dissection, lower pelvis surgeries Inguinal Above and parallel to the inguinal ligament Inguinal hernia repair, urologic surgeries (cryptorchidism, varicocele) McEvedy Vertical incision for femoral hernia repair Femoral hernia repair (obsolete now due to high hernia recurrence rate) Gibson Above inguinal ligament, arc to the lateral rectus sheath Kidney transplantation, retroperitoneal access (iliac vessels, ureter)









References:

https://www.ncbi.nlm.nih.gov/books/NBK541018/

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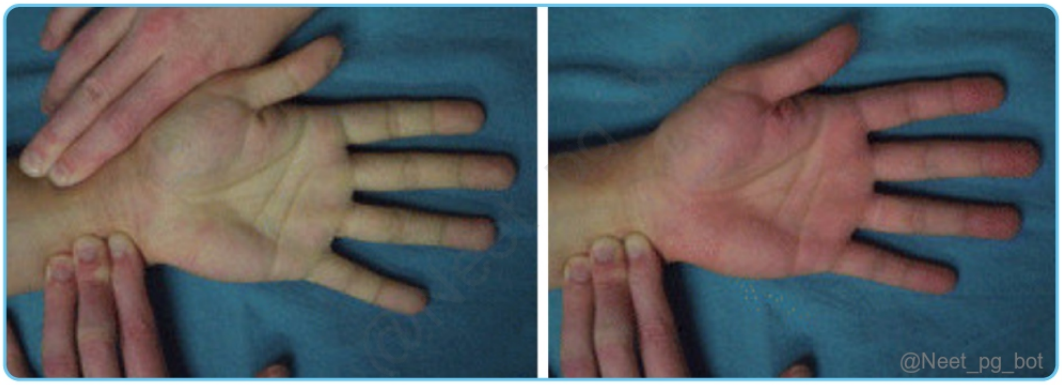
Q132: Identify the test provided in the image below. (Q857294)

A. Allen’s test

B. Adson’s test

C. Elevated arm stress test

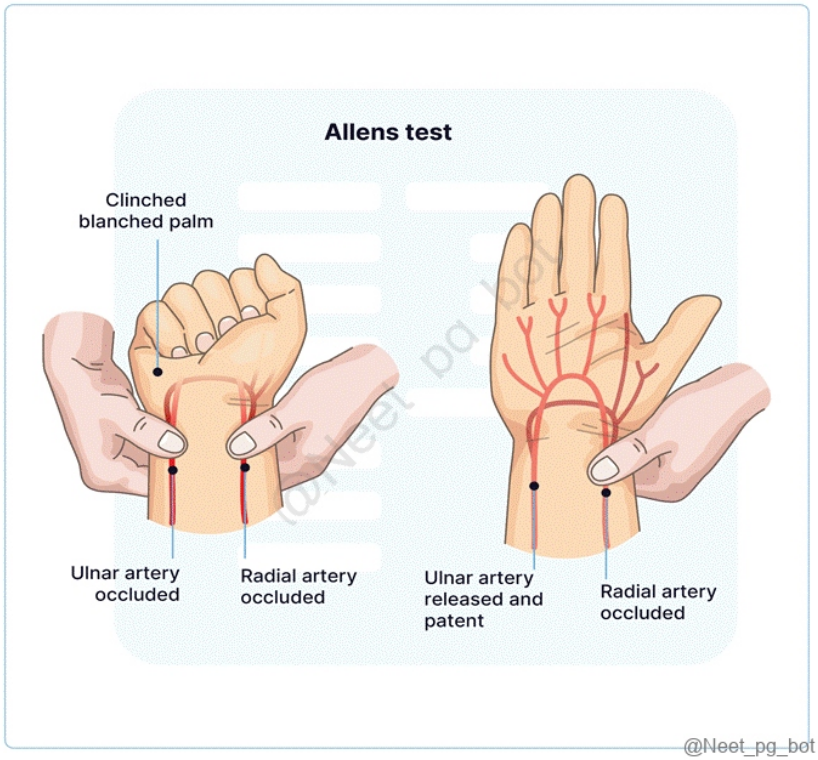
D. Nicoladoni’s test

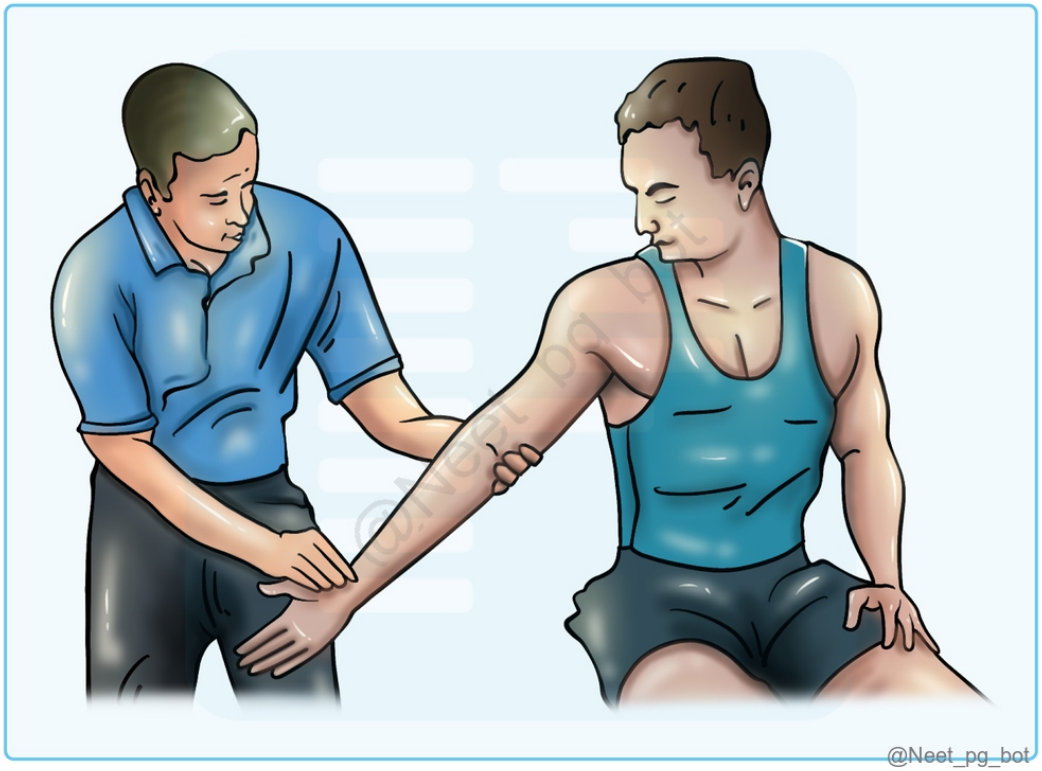


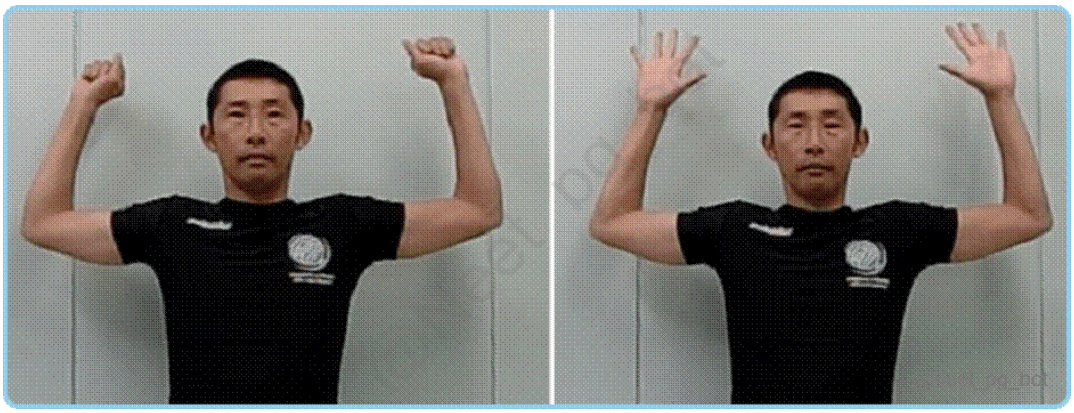
Correct Answer: A. Allen’s test

Explanation: The given image shows Allen’s test. Allen's Test is a clinical manoeuvre used to assess the blood flow to the hand, specifically evaluating the patency of the radial and ulnar arteries. It is commonly used before procedures like inserting an arterial line or taking a blood sample from the radial artery. Procedure: The patient is asked to make a fist, compressing the radial and ulnar arteries simultaneously. The patient is then asked to open their hand (which should appear pale). Once the hand is open, the examiner releases one of the arteries (usually the ulnar artery). The test is positive if normal colour returns to the hand quickly (within 5-10 seconds), indicating adequate collateral circulation. If there is a delay in the colour return or no return, this may suggest compromised blood flow through the released artery, which could indicate arterial occlusion & the radial artery should not be pricked. Adson's test (Option B) is used to diagnose thoracic outlet syndrome (TOS), which occurs due to compression of the brachial plexus or subclavian artery in the thoracic outlet. The patient is instructed to extend their neck and turn their head toward the arm being tested while the examiner palpates the radial pulse. The patient then takes a deep breath. A positive test is indicated by a reduction or disappearance of the radial pulse, suggesting compression in the thoracic outlet. Elevated Arm Stress Test (Option C) evaluates thoracic outlet syndrome by assessing the compression of neurovascular structures in the thoracic outlet. The patient’s arms are raised above the head and held for 1-2 minutes. A positive test occurs if the patient experiences symptoms of numbness, tingling, or a decrease in the radial pulse, which indicates compression of the neurovascular bundle in the thoracic outlet. {{caption_text}} Nicoladoni's test (Option D) is used to assess for increased intracranial pressure (ICP) or brainstem compression . The test is positive if the patient exhibits a sudden drop in pulse or blood pressure when

their head is tilted backwards (in a hyperextended position).







References:

Harrison Principles of Internal Medicine, 21st Edition, Page 1818

↑ *Back to this question in Part A*

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Q133: Smoking increases the risk of which of the following diseases? Duct ectasia Fibroadenoma Mondor disease Breast carcinoma (Q857295)

A. 2, 3

B. 1, 4

C. 2, 3, 4

D. 1, 3, 4

Correct Answer: D. 1, 3, 4

Explanation: Smoking is not directly associated with an increased risk of fibroadenomas, which are benign breast tumours often occurring in younger women. Smoking increases the risk of duct ectasia , Mondor disease , and breast carcinoma , but not fibroadenoma . Duct ectasia refers to the dilation or enlargement of the milk ducts in the breast, often leading to inflammation and possible discharge. It is often seen in older women, particularly during menopause. Smoking is considered a risk factor for this condition as it contributes to vascular changes and may affect the ducts. Mondor's disease is a rare condition that involves thrombophlebitis (inflammation of veins caused by blood clots) of the superficial veins in the breast or chest area. Smoking has been linked to vascular changes, which may increase the likelihood of developing Mondor’s disease. Smoking is a well-established risk factor for breast cancer, especially in postmenopausal women. Risk factors for breast cancer Modifiable risk factors Non-modifiable risk factors Obesity: BMI > 30 (RR= 1.29) Age Median age at presentation is 60 years in the West(UK, USA), While it is around 48 years in low/middle-income nations such as India. Nulliparous women or first pregnancy after 35 years Sex Female sex is a risk factor Male sex accounts for 0.5-1% of all breast cancer Breastfeeding is a protective factor Ethnicity American white, African-American Parsi in India Use of Hormonal

Replacement Therapy (HRT) >10 years (RR= 1.2) Family history of breast cancer 1 first-degree relative RR= 2 2 first-degree relative RR= 3 Tobacco use (RR=1.07-1.14) Genetic predisposition BRCA1 and BRCA2 mutations account for 70% of hereditary breast cancers Alcohol Consumption (RR = 1.05-1.32) Early Menarche(<12years) Increases by around 5% for each year earlier menstruation begins RR=1.19 Radiation exposure (RR=6) Late Menopause(>55years) Increases by about 3% for each year later menopause begins RR=1.12 Age at first child <20years - Less risk >35years - High risk High-risk breast lesions Complex fibroadenoma RR=3 Papillomatosis RR=3 Ductal and lobular hyperplasia RR= 5 Lobular carcinoma in situ RR= 8-10

References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 922,930,931

Sabiston Textbook of Surgery, 21st Edition, Page 826

↑ *Back to this question in Part A*

@Neet_pg_bot

Q134: A 25-year-old male patient is brought to the casualty after a road traffic accident (RTA) with suspected pelvic fractures. On examination, he is found to be in hypovolemic shock. What is the earliest treatment for control of haemorrhage in this case? (Q857297)

A. Immediate internal fixation

B. Multiple blood transfusions

C. Use bedsheets to compress the pelvis

D. Emergency external fixation

Correct Answer: C. Use bedsheets to compress the pelvis

Explanation: In the case of pelvic fractures with suspected haemorrhage and hypovolemic shock, pelvic compression is a critical step to control bleeding and stabilise the patient. Using bedsheets (or a pelvic binder) to compress the pelvis helps reduce the volume of the pelvic cavity, which in turn minimises bleeding from the fractured vessels and improves hemodynamic stability. Management of Pelvic fractures: The primary goal in managing pelvic fractures with bleeding is to stop the bleeding, as these injuries pose a significant threat to circulation. Initial management: The first step is applying a compression binder or sheet around the true pelvis at the level of the greater trochanters to reduce pelvic volume. This life-saving procedure should be performed in the emergency department immediately. Bleeding sources: Venous Bleeding (85% of cases): Most bleeding originates from veins, which can be controlled non-operatively using pelvic compression (via binding or external fixators). Another technique is extraperitoneal pelvic packing, where the space between the bony pelvis and the peritoneum is packed to compress veins. Arterial Bleeding: If bleeding is arterial in origin, angiographic embolisation becomes the next choice for controlling haemorrhage. Techniques such as compression, packing, fixation, and angiography may be used together, as they can complement one another. If bleeding persists after packing, angiography or other

interventions may be necessary. If the source of bleeding is unclear, or if diagnostic imaging (FAST/CT) shows significant blood in the peritoneal cavity, an exploratory laparotomy is warranted to rule out or address concurrent intra-abdominal injuries.



References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 384

↑ *Back to this question in Part A*

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Q135: A soldier arrives at a referral hospital 24 hours after experiencing a shrapnel injury to his right thigh caused by a high-speed projectile. He expresses significant discomfort at the site of the wound. Upon examination, there is evidence of crepitus. Which of the following microorganisms is the probable culprit behind his current state? (Q857804)

A. Clostridium septicum

B. Clostridium difficile

C. Clostridium novyi

D. Clostridium perfringens

Correct Answer: D. Clostridium perfringens

Explanation: The soldier's shrapnel injury to his right thigh, accompanied by significant discomfort, crepitus (presence of gas in the tissues), suggests Gas Gangrene caused by Clostridium perfringens. A rapidly progressive, potentially fatal condition characterized by widespread necrosis of muscles and soft-tissue destruction, often due to late-presenting missile wounds or crushing injuries. Cause Clostridium perfringens (Option D) Incubation period <24 hours but ranges from 1 hour to 6 weeks Sources and predisposing factors Contaminated soil and feces. Wounds with necrotic or foreign material. Crush wounds, road traffic accidents, amputations. Anaerobic environments in the wound. Common sites of infection Adductor region of the lower limb and buttocks. Subscapular region in the upper limb. Clinical features Severe pain with limb swelling rapidly increases in severity. Serosanguineous discharge. Skin turns brown to blue-black with hemorrhagic bullae. Sweet, sticky odor & Soft-tissue crepitus (presence of gas in the tissues). Complication Septicaemia, toxemia, renal failure, liver failure. Circulatory failure, DIC, secondary infections. Death occurs in critically ill patients. Investigation X-ray: Gas in soft tissues. Gram stain & blood culture: Large Gram-positive bacilli without neutrophils. Biochemical profile: Metabolic acidosis, renal failure. Peripheral blood smear: Haemolysis. CT scan for chest or abdominal wounds. Treatment High-dose intravenous penicillin and clindamycin, along with 3rd generation cephalosporins, are given intravenously. Polyvalent antiserums given intravenously. All dead tissues are excised, and debridement is performed until healthy tissue bleeds. Amputation done in severe cases Hyperbaric oxygen therapy. Prevention Proper debridement of devitalized crushed wounds. Devitalized wounds should not be sutured. Adequate cleaning of wounds with H■O■ and normal saline. Penicillin - As a prophylactic antibiotic. Image {{caption_text}} Clostridium septicum (Option A) causes spontaneous, non-traumatic gas gangrene and is associated with conditions like colorectal cancer or immunocompromised states, whereas Clostridium perfringens is more commonly linked to gas gangrene in traumatic injuries. Clostridioides difficile (Option B) is primarily linked to antibiotic-associated diarrhea and colitis, not gas gangrene, and does not produce the gas or tissue necrosis seen in traumatic injuries. Clostridium novyi (Option C) is a less common cause of gas gangrene, typically associated with specific conditions like soil or animal-related injuries, and is unlikely to be the cause of a shrapnel wound.



References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 57, 457, 643.

SRB's Manual of Surgery, 6th Edition, Page, 44, 50-52, 1056.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q136: A 32-year-old female undergoes emergency laparotomy for perforation peritonitis. Which of the following is the surest sign of wound dehiscence? (Q857853)

A. Copious sero-sanguinous discharge

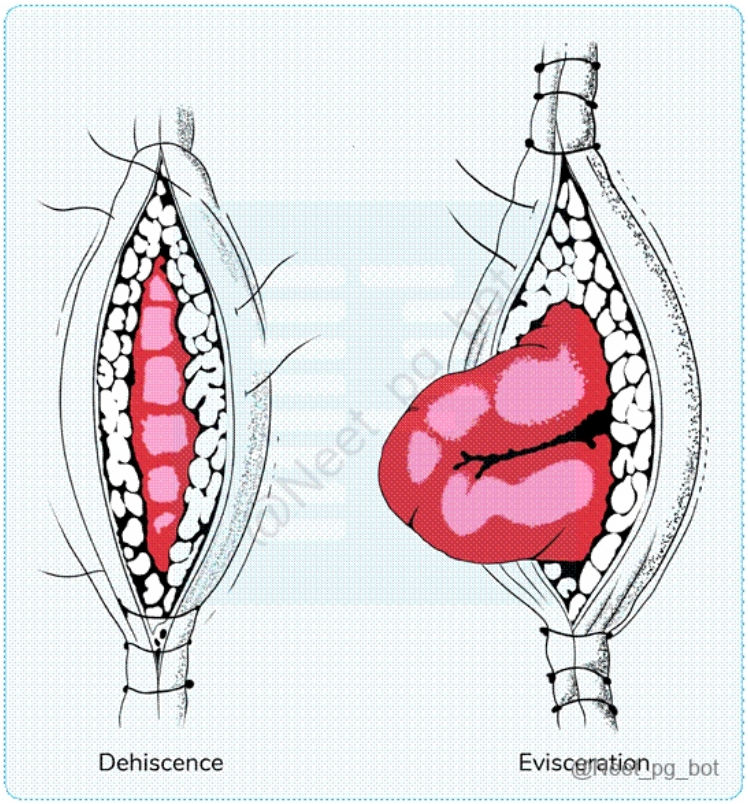
B. Rebound tenderness

C. Hemorrhage

D. Hypotension

Correct Answer: A. Copious sero-sanguinous discharge

Explanation: The surest sign of Wound Dehiscence following emergency laparotomy is copious serosanguinous discharge, typically occurring around day 6 post-op, indicating a burst abdomen and requiring urgent laparotomy management. Definition Disruption of any or all of the layers in a wound. Occurrence Up to 3% of abdominal wounds; most commonly occurs between the 5th and 8th postoperative days. Types Partial dehiscence: Involves only the skin and subcutaneous fat. Complete dehiscence: Involves the fascial layer and may include evisceration (extrusion of abdominal viscera). Risk Factors General: Malnourishment Diabetes Obesity Renal failure Jaundice Sepsis Cancer Treatment with steroids Emergency surgery Local: Inadequate or poor closure of wound or closure of a wound under tension Poor local wound healing Increased intra-abdominal pressure Clinical Presentation Pinkish serosanguinous discharge (salmon-coloured fluid), (Option A) Possible evisceration, Popping sensation during straining or coughing. Treatment Partial dehiscence (without evisceration): Prompt reclosure of the fascia is generally advised. Complete dehiscence with evisceration: Requires urgent reoperation. Tension suturing is done. Protect eviscerated bowel with moist towels; handle carefully to prevent injury. Antibiotic therapy; fluid management. Rebound tenderness (Option B) refers to pain that is felt when pressure is released from the abdomen, often indicating peritoneal irritation or inflammation, typically seen in conditions like peritonitis. While rebound tenderness could suggest a complication (such as ongoing infection or intra-abdominal issues), it is not specific to wound dehiscence. Hemorrhage (Option C) : Although significant bleeding can occur after surgery, hemorrhage is not a typical feature of wound dehiscence. Hemorrhage can be caused by vessel injury, clotting issues, or inadequate hemostasis at the surgical site, but it's not directly linked to the reopening of the wound itself. Hypotension (Option D) may occur due to various factors like shock, blood loss, or infection. While hypotension can be a result of complications following surgery, it is a general sign of systemic distress rather than a specific sign of wound dehiscence. The cause of hypotension needs to be identified through further clinical investigation.



References:

Bailey & Love’s Short Practice of Surgery, 28th Edition, Page 325.

Sabiston Textbook of Surgery, 21st Edition, Page 240-241.

SRB’s Manual of Surgery, 6th Edition, Pages 732-733.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q137: What should be the next course of action in the management of a 30-year-old breastfeeding mother who is experiencing pain and fever in her left breast? The left breast appears abnormal as depicted in the provided image. There is slight swelling of the lymph nodes in the armpit on the affected side, while the opposite breast appears normal. Despite multiple attempts at draining the fluid with the use of antibiotics, it was unsuccessful. An ultrasound examination revealed the presence of fluid collection. (Q793402)

A. Incision an drainage

B. Broad spectrum antibiotics only

C. Breast conservation surgery

D. Punch biopsy



Correct Answer: A. Incision an drainage

Explanation: Correct choice : Option a :The clinical scenario described suggests that the patient may have developed a breast abscess. Breast abscesses are typically caused by bacterial infection and are more common in lactating women due to the increased risk of bacterial colonization of the breast ducts. The presence of fever, pain, and fluid collection seen on ultrasound are also consistent with a breast abscess. Repeated aspirations under antibiotic cover have been unsuccessful, suggesting that the abscess is not resolving with conservative management alone. Therefore, the next best step in the management of this patient would be incision and drainage of the abscess . Incision and drainage is the most effective way to treat a breast abscess, as it allows for the complete removal of the infected material and helps to prevent recurrence. Incorrect Choices: Option b: Broad-spectrum antibiotics may be used in conjunction with incision and drainage to treat the infection, but antibiotics alone are not sufficient for the management of a breast abscess. Option c: Breast conservation surgery typically involves the removal of a breast lump or tumor. Thus, breast conservation surgery is not appropriate management option for a breast abscess. Option d: Punch biopsy is a diagnostic procedure used to obtain a tissue sample for analysis. Thus, punch biopsy is not appropriate management option for a breast abscess.

References:

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↑ *Back to this question in Part A*

@Neet_pg_bot

Q138: A barber aged 42 years presented with a healed ulcer as below, over the lower medial aspect of the right leg. On examination, he has varicose veins on both his legs. What is the most likely type of ulcer he had? (Q859836)

A. Neuropathic ulcer

B. Arterial ulcer

C. Venous ulcer

D. Tubercular ulcer



Correct Answer: C. Venous ulcer

Explanation: The most likely diagnosis is venous ulcer , given the ulcer's location on the medial aspect of the leg and the presence of varicose veins , which are indicative of venous insufficiency. These ulcers commonly occur in areas of chronic venous insufficiency , often associated with varicose veins . Venous ulcer (Option C) Arterial ulcer (Option B) Neuropathic ulcer (Option A) Pressure ulcer Site Gaiter’s area (area between malleolus and calf) At distal ends of limbs, such as toes, feet and legs. Over toe joints, under the heel, over malleoli, under the metatarsal head, etc Seen over pressure points, most common are ischium, greater trochanter, sacrum, hee, malleolus, occiput, etc Appearance Vertically oval with a sloping edge and will not penetrate deep fascia. Punched-out edges are seen in this type of ulcer. Ulcers can be associated with gangrene and abscesses; osteomyelitis can be seen here. Punched out ulcer with bone as a base. Cause Caused by ambulatory chronic venous hypertension due to varicose veins. This occurs due to severe arterial insufficiency of digital and medium-sized arteries, leading to ischemia and tissue death in the region. It is caused due to repeated trauma and

ischemia due to microangiopathy in diabetic patients . It is tissue necrosis and ulceration due to prolonged pressure on any part of the body. Characteristics It is initially painful, then chronically becomes painless. It heals on rest and treatment but reforms again. It is intensely painful, and distal pulses are not palpable, and associated with shiny skin, brittle nails and loss of hair over the region. It is also known as diabetic ulcer since it is seen in diabetic patients. It is common in bedridden patients with head injuries, neurological deficits, and comatose and stroke-ridden patients. Tuberculous ulcer (Option D) occurs when tuberculosis affecting the lungs spreads to the skin . This type of ulcer is relatively uncommon but can develop in individuals with advanced or untreated TB. These ulcers typically have distinct characteristics like an undermined edge and necrotic base and may show signs like scarring or lymphadenopathy.



References:

Bailey & Love’s Short Practice of Surgery, 28th Edition, Pages 998, 999.

↑ *Back to this question in Part A*

@Neet_pg_bot

Q139: False regarding deep second-degree burns: (Q859883)

A. Heal by scar deposition

B. No blanching

C. Damage to the deeper dermis

D. Completely painless

Correct Answer: D. Completely painless

Explanation: Deep second-degree (deep partial-thickness) burns extend into the reticular dermis , damaging most skin appendages and vascular structures. Pain is reduced but not completely absent , as some nerve endings remain intact. Only full-thickness (third-degree) burns are truly painless due to total nerve destruction. Deep Partial-Thickness Burns Affected Area Epidermis and reticular dermis (bottom layer of dermis) (Option C ruled out). Clinical Features Sensation is reduced, not absent. Loss of epidermis Less moist dermis Fixed capillary staining Reduced sensation No blanching with pressure (Option B ruled out) Healing Takes 3+ weeks : often leads to scarring (Option A ruled out) Treatment May require surgical intervention (e.g., skin grafting)

References:

Bailey & Love’s Short Practice of Surgery, 28th Edition, Pages 669, 670

↑ *Back to this question in Part A*

@Neet_pg_bot

Q140: What is the diagnosis based on the image below? (Q859893)

A. Botryomycosis

B. Erysipelas

C. Ecthyma

D. Carbuncle



Correct Answer: D. Carbuncle

Explanation: The carbuncle is the most likely diagnosis in this case due to the pus-filled masses with necrotic tissue and a yellow centre seen in the image, which is characteristic of this type of deep skin infection. These are composed of two or more furuncles. They classically have multiple pustules, or "heads," originating from the underlying abscess. Carbuncle Definition Infection of hair follicles extending into surrounding and subcutaneous tissue. Cause Staphylococcus aureus. Common Sites Nape of neck, back. Symptoms Red, painful nodule; tender, fluctuant lesion; multiple draining sinuses; fever, lymphadenopathy. Complications Septicemia, abscess, necrosis, requiring possible excision or skin graft. Treatment Control of diabetes; antibiotics; drainage, debridement, possible excision. {{caption_text}} Botryomycosis (Option A) is a chronic bacterial infection, commonly affecting the skin and rarely the soft tissues, often mistaken for an abscess. It is commonly caused by Staphylococcus aureus, or other bacteria, but it presents more as granulomatous lesions rather than the typical pus-filled carbuncle . {{caption_text}} Erysipelas (Option B) is a localised cutaneous sharply demarcated infection to the upper layers of the dermis, usually associated with broken skin. It is caused by beta-hemolytic Streptococcus pyogenes. It appears to be a red, swollen, and shiny rash , not a deep abscess with pus or necrotic tissue. {{caption_text}} Ecthyma (Option C) is a deeper form of impetigo caused by bacteria (usually Streptococcus), which presents as ulcerative lesions with a crusted appearance , not as a deep abscess with dead tissue and a yellow centre. {{caption_text}}





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References:

Bailey & Love's Short Practice of Surgery, 28th Edition, Page 643.

↑ *Back to this question in Part A*

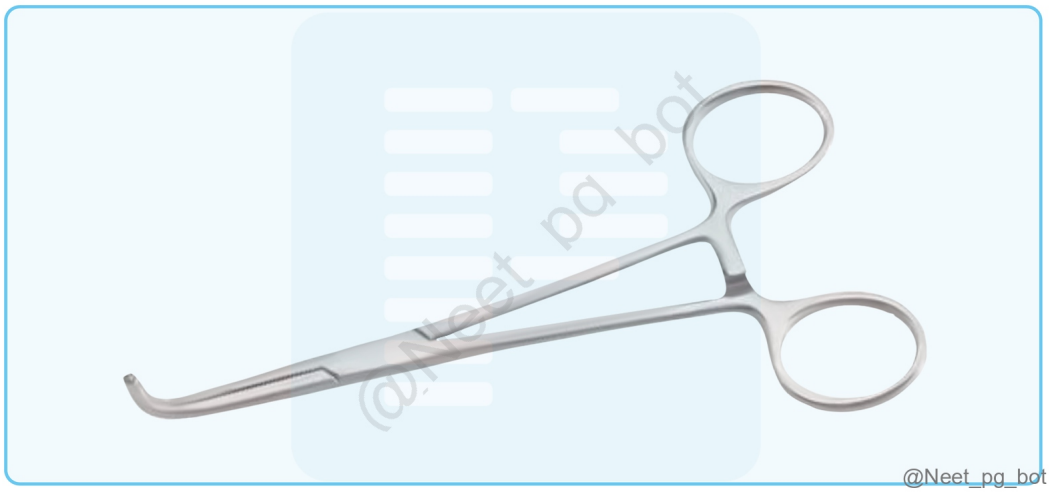
Q141: Identify the surgical instrument depicted in the provided image. (Q854778)

A. Mixter Forceps

B. Rampley Forceps

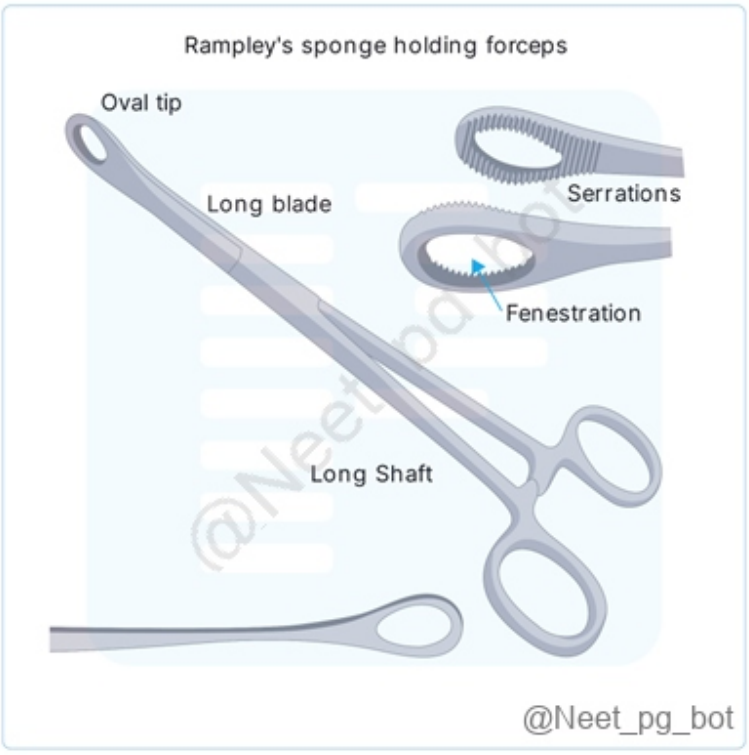
C. Kocher Forceps

D. Adson Forceps

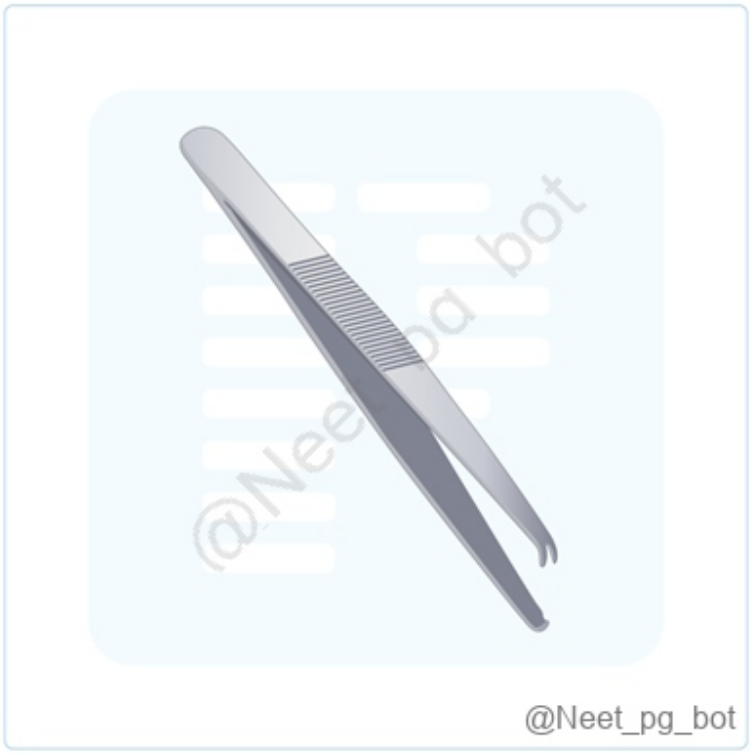


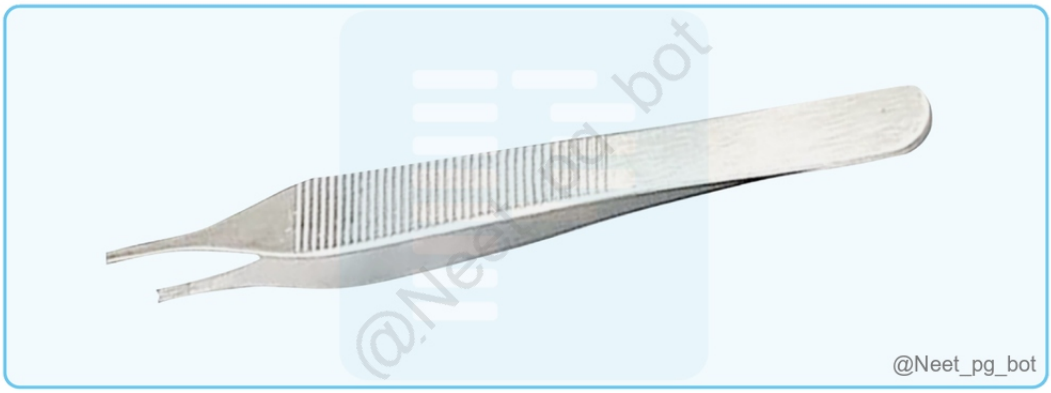
Correct Answer: A. Mixter Forceps

Explanation: The instrument shown in the image is a Mixter forceps , frequently used in surgical procedures for grasping and handling delicate tissues. Mixter forceps are particularly useful for achieving hemostasis during surgery. They feature a distinct curved design and serrated jaws with cross grooves, which ensure a firm grip on tissues while being manipulated during surgery. Instrument Image Description Rampley's Sponge Holding Forceps (Option B) Designed in a scissor-like configuration, featuring ratcheted handles with serrated looped jaws . Used to handle gauze or sponges. Used to hold gall bladder/cervix/tongue etc., during operative procedures. Kocher’s Forceps (Option C) {{caption_text}} Serrations in the distal blades with an opposing tooth at the tip. Holds tissues or pedicles securely, preventing slippage and retraction of vessels or bleeders. Types: Straight/Curved. Small/medium/large. Used in thyroidectomy, hemorrhoidectomy, mastectomy, polypectomy, and hysterectomy . Used to secure tough or fibrous tissues in areas like the palms, soles, and scalp to prevent vessel retraction during surgery. Holds gauze and gauze pellets. Toothed Forceps Used to hold skin and tough structures like fascia and aponeurosis. Not used for delicate structures like the bowel, vessels, or nerves. May have one-in-two or two-in-three teeth. Adson’s Forceps (Option D) : Small, fine forceps for delicate work; can be toothed or non-toothed. Victor–Bonney’s Forceps : Heavy-toothed dissecting forceps.


Rampley's sponge holding forceps
Oval tip
Long blade
Serrations
Fenestration
Long Shaft
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References:

SRB’s Surgical Operations, Text and Atlas, Edition 1, Page 88, 79

https://andersencaledonia.com/what-are-rampley-forceps/

↑ *Back to this question in Part A*

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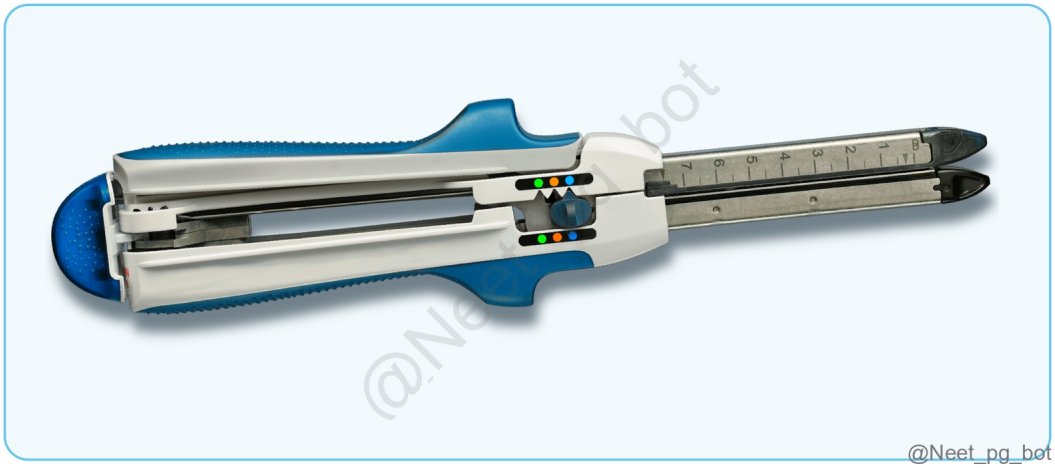
Q142: Please determine the instrument provided. (Q857871)

A. Linear stapler

B. Skin stapler

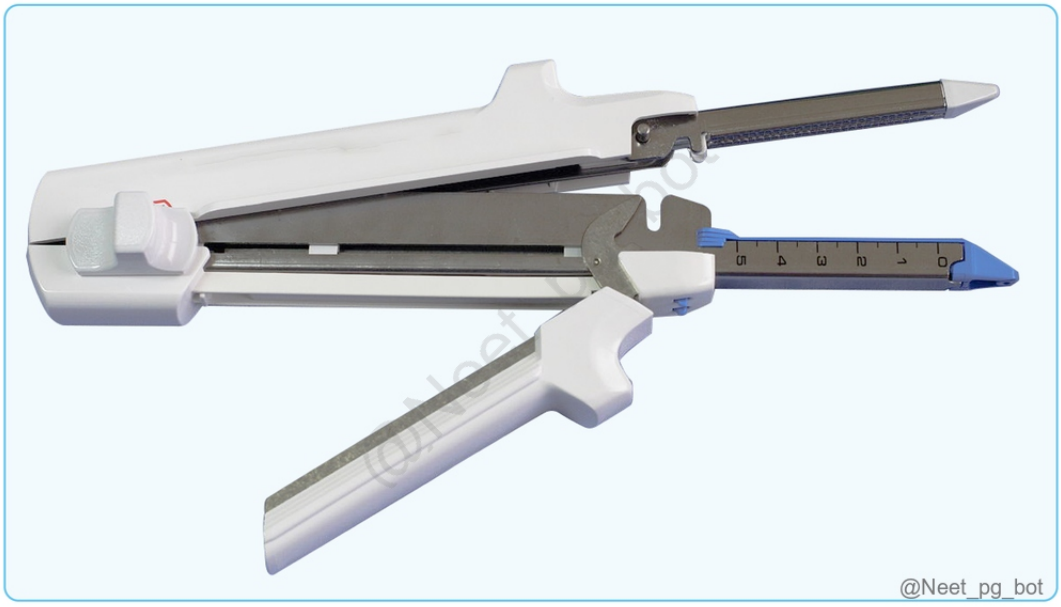
C. Circular stapler

D. Curved stapler

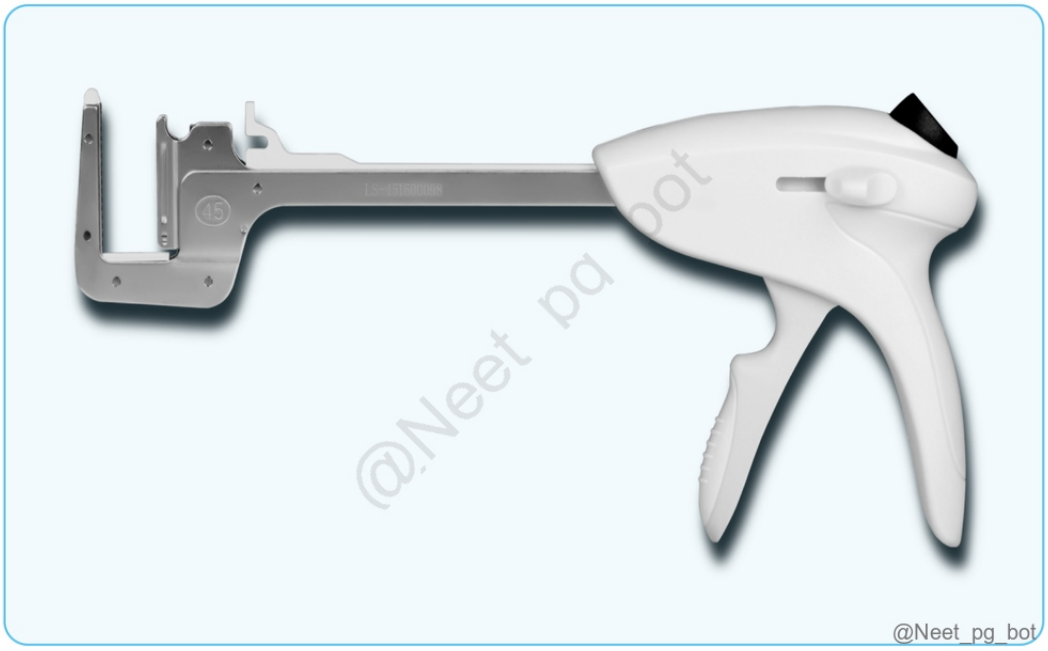


Correct Answer: A. Linear stapler

Explanation: The instrument shown in the image is a Linear Stapler . It consists of a handle, shaft, anvil, and stapling cartridge. Uses: Side to side anastomoses. Ends are closed by transverse staple. To close the bowel either completely or partially. {{caption_text}} Skin stapler (Option B) is used for closing skin wounds, not internal tissues, and does not create the straight-line closure typical of a linear stapler. {{caption_text}} Circular stapler, also called EEA stapler (End to End Anastomosis) (Option C) is used for anastomosis of tubular structures like the bowel or blood vessels, creating a circular stapling line. It is not suitable for straight-line stapling, which is the function of a linear stapler. Curved stapler (Option D) is used for hard-to-reach areas, typically in the gastrointestinal tract, but like the circular stapler, it does not create a straight-line closure, which is the purpose of a linear stapler.


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References:

SRB's Manual of Surgery, 6th Edition, Page 1160.

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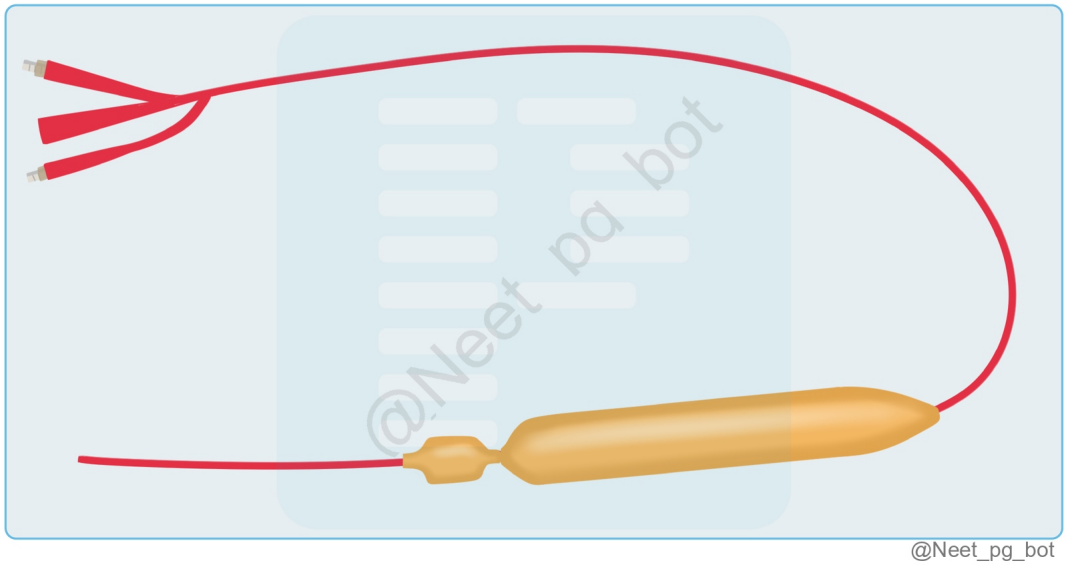
Q143: Which of the following are used to stop oesophagal variceal bleeding? A. B. C. D. (Q856236)

A. A, B & C

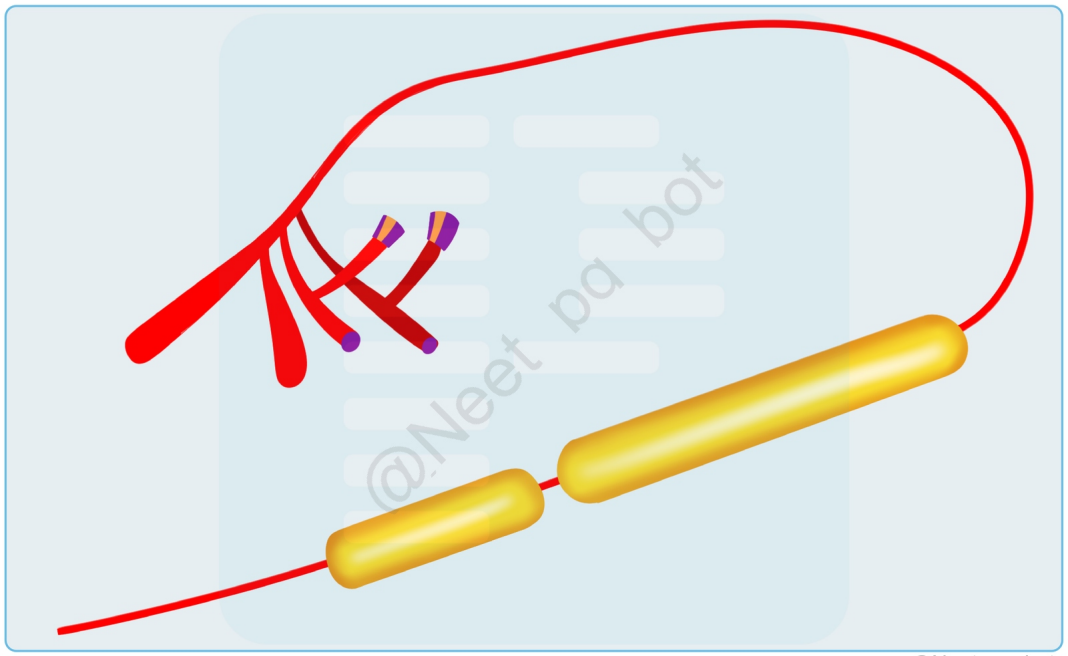
B. A and B only

C. B and C

D. A, B and D



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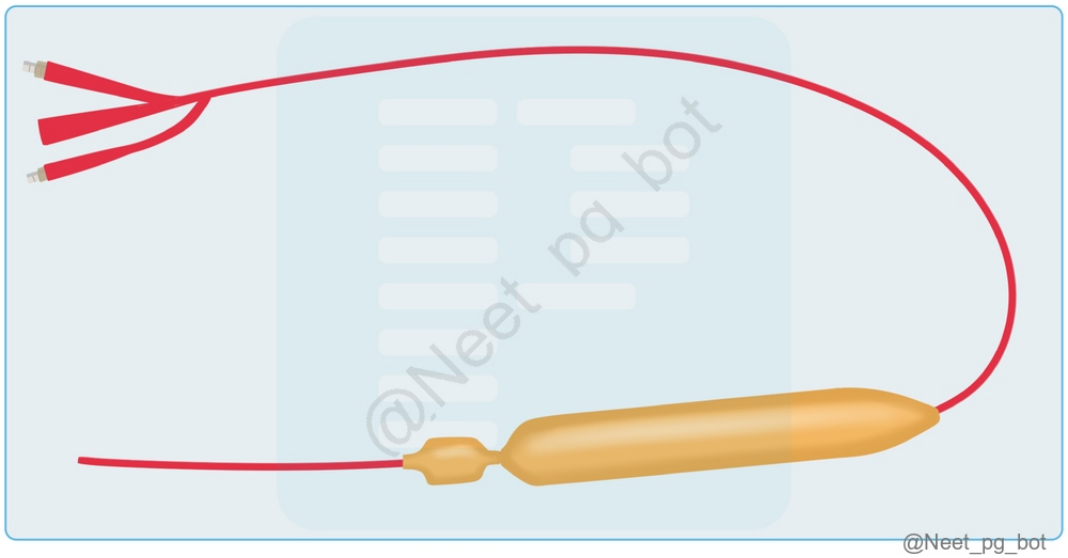


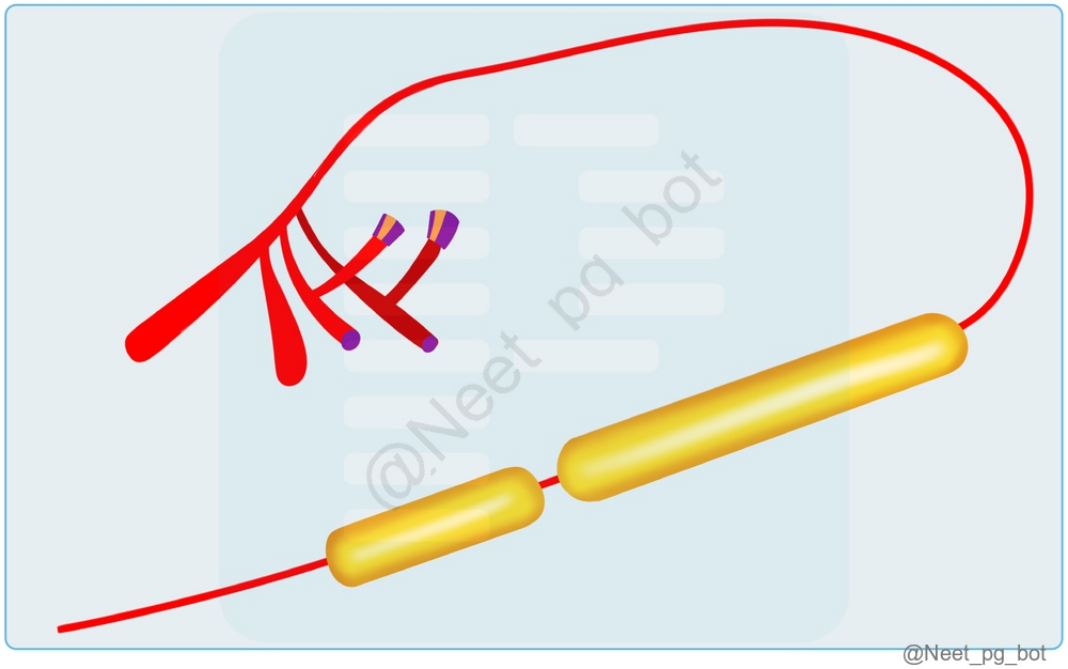


Correct Answer: A. A, B & C

Explanation: Sengstaken Blakemore Tube (A): Its primary use is Balloon tamponade for controlling variceal bleeding in the oesophagus and stomach. It is also called a four-lumen Minnesota tube or Linton's tube or Modified 4 lumen Pitcher tube. It contains a gastric balloon, esophageal balloon, gastric aspiration port and esophageal aspiration port. Minnesota tube (B): It is similar to the Sengstaken-Blakemore tube and is used to control upper GI bleeding, including oesophageal varices, by balloon tamponade. Upper GI endoscopy (C): It is a crucial tool in managing oesophagal variceal bleeding. While it doesn't directly stop the bleeding, it allows for visualisation of the varices and enables interventions such as band ligation or sclerotherapy to control the bleeding. {{caption_text}} Ryle’s tube (D): A nasogastric feeding or decompression tube , not used for variceal bleeding. A

nasogastric tube used for gastric aspiration, lavage, or feeding.









References:

Bailey and Love's Short Practice of Surgery, 28th Edition, Pages 1204, 1206

↑ *Back to this question in Part A*

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Q144: A 38-year-old man was brought to the emergency department after sustaining an RTA and injury to the lower chest. On presentation, the patient is stable, and vitals are normal . Chest radiography showed clear lung fields. What is the next step in management? (Q801160)

A. eFAST

B. Tube thoracostomy

C. CECT chest

D. CECT abdomen

Correct Answer: A. eFAST

Explanation: Correct Option A - eFAST: eFAST (extended Focused Assessment with Sonography for Trauma) is a rapid bedside ultrasound to detect life-threatening injuries in trauma patients, focusing on the chest and abdomen. It assesses the pericardium, pleural spaces, and abdominal cavity for air or fluid. If a pneumothorax or hemothorax is ruled out by clear lung fields on chest radiography, eFAST helps identify other bleeding sources, like intraperitoneal bleeding, guiding further management. Incorrect Options: Option B - Tube thoracostomy: Inserting a chest tube treats pneumothorax or hemothorax, but since lung fields are clear, it's not the immediate step. Options C and D - CECT chest and abdomen: While valuable, immediate CECT can delay addressing the cause. It's better for later detailed imaging.

References:

Prepladder Notes

↑ *Back to this question in Part A*

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Q145: Which of the following CT findings is not an indication to perform angiography in a splenic trauma patient under conservative management? (Q793370)

A. Subcapsular hematoma covering 40% surface area.

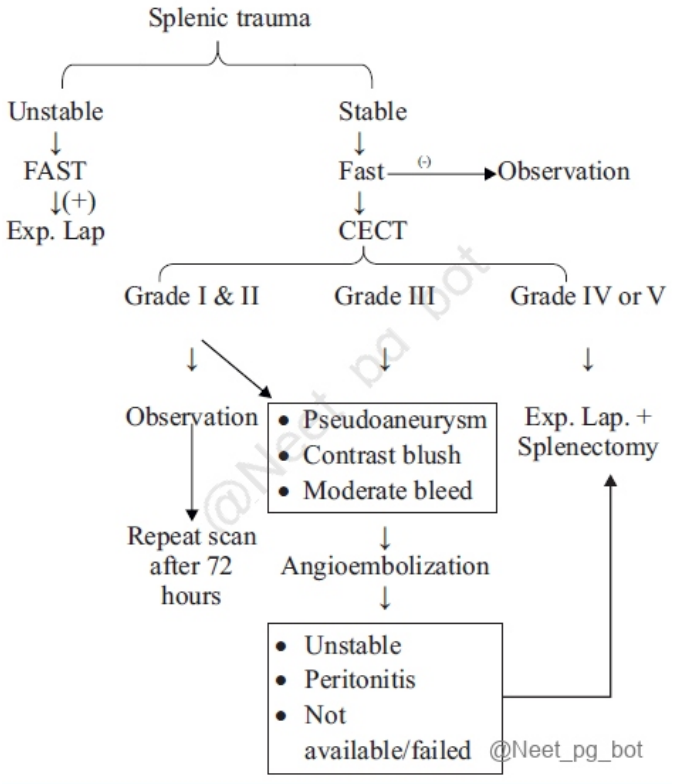
B. Significant hemoperitoneum

C. Presence of pseudoaneurysm

D. Contrast extravasation

Correct Answer: A. Subcapsular hematoma covering 40% surface area.

Explanation: Correct Option A - Subcapsular hematoma covering 40% surface area: Subcapsular hematoma covering 40% surface area alone is not an indication for performing angiography in a splenic trauma patient under conservative management. This is because, according to the AAST grading system provided, a subcapsular hematoma covering 40% of the surface area falls under Grade II, which is considered stable for conservative management. Incorrect Options: Option B - Significant hemoperitoneum: Hemoperitoneum indicates bleeding into the peritoneal cavity, which can result from splenic trauma, among other causes. Option C - Presence of pseudoaneurysm: In the context of splenic trauma, the presence of a pseudoaneurysm indicates ongoing arterial bleeding and is a potential indication for angiography. Option D - Contrast extravasation: In the context of splenic trauma, the presence of contrast extravasation on CT imaging suggests ongoing arterial bleeding and is an indication for further evaluation and intervention.



References:

Prepladder Notes

↑ *Back to this question in Part A*

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Q146: What would be the subsequent course of action for this injury depicted in the image after a three-day period following a Road Traffic Accident (RTA)? (Q793911)

A. Debridement of necrotic tissue with primary closure

B. Debridement of necrotic tissue and hyperbaric oxygen

C. Amputation

D. Clean and close with rotation flap



Correct Answer: B. Debridement of necrotic tissue and hyperbaric oxygen

Explanation: Correct Option B - Debridement of necrotic tissue and hyperbaric oxygen: The injury in question involves tissue necrosis, possibly due to a traumatic event such as a road traffic accident (RTA). Debridement of necrotic tissue involves the removal of dead or damaged tissue to prevent infection and promote healing. Hyperbaric oxygen therapy (HBOT) treats various conditions, including tissue necrosis, by increasing the amount of oxygen that reaches the damaged tissues. The high pressure helps dissolve more oxygen in the blood, stimulating the growth of new blood vessels and promoting tissue regeneration. The combination of debridement and hyperbaric oxygen therapy can be particularly effective in tissue necrosis caused by ischemia, as it helps restore blood flow and oxygenation to the affected area. Incorrect Choices: Incorrect Options: Option A - Debridement of necrotic tissue with primary closure: Debridement of necrotic tissue with primary closurecan trap bacteria and other debris inside the wound, increasing the risk of infection and delaying healing. Option C - Amputation: Amputation may be necessary in severe cases of tissue necrosis that cannot be treated by other means. However, amputation is a last resort Option D - Clean and close with rotation flap: In cases of tissue necrosis, a rotation flap alongside cleaning may be suitable for small affected areas with healthy surrounding tissue, but it's less likely to be suitable for extensive damage, where debridement and HBOT are preferable.

References:

Prepladder Notes

↑ *Back to this question in Part A*

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Q147: What is the likely reason behind the occurrence of surgical emphysema in the patient following an emergency tracheostomy performed outside of the hospital? (Q793917)

A. Puncture of posterior wall

B. High tracheostomy

C. Blockage of the tube

D. Tight suture

Correct Answer: D. Tight suture

Explanation: Correct Option D - Tight suture: Surgical emphysema (subcutaneous emphysema) occurs when air gets trapped in the soft tissues around the surgical site, causing swelling and discomfort. In the case of a tracheostomy, a common cause of surgical emphysema is improper technique during the procedure. Tight suturing around the tracheostomy site can lead to air leakage into the surrounding tissues. When sutures are placed too tightly, they can tear the tissues or fail to adequately seal the surgical site, allowing air to escape and become trapped in the subcutaneous tissues, resulting in surgical emphysema. Incorrect Options: Option A - Puncture of posterior wall: Puncture of the posterior wall of the trachea during a tracheostomy can indeed cause air to leak into the surrounding tissues, leading to surgical emphysema. However, it is less common than issues related to suturing technique. This situation could lead to more severe complications, including mediastinal emphysema. Option B - High tracheostomy: A high tracheostomy (placing the tracheostomy tube above the second or third tracheal ring) can cause complications, but it is not typically associated with surgical emphysema. More common issues include difficulty in stabilizing the tracheostomy tube and increased risk of subglottic stenosis. Option C - Blockage of the tube: Blockage of the tracheostomy tube can cause respiratory distress or hypoxia but is not typically associated with surgical emphysema. Air trapping in the soft tissues around the tracheostomy site is not a direct result of tube blockage.

References:

Prepladder Notes

↑ *Back to this question in Part A*

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Q148: Which of the following is not included in the AAST grading system for splenic trauma? (Q793921)

A. Parenchymal destruction

B. Vascular involvement

C. Adjacent organ involvement

D. Hematoma

Correct Answer: C. Adjacent organ involvement

Explanation: of correct answer.

References:

Sabiston & Bailey

↑ *Back to this question in Part A*

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Q149: What guidance would you provide to the female patient prior to undergoing laparoscopic surgery? (Q793926)

A. Eat full before surgery.

B. Drink plenty of water before surgery.

C. Enema on the night before surgery

D. NPO for specific hours before surgery

Correct Answer: D. NPO for specific hours before surgery

Explanation: Correct Option D - NPO for specific hours before surgery: Laparoscopic surgery is a minimally invasive surgical procedure During laparoscopic surgery, the patient is under general anesthesia, which can cause nausea and vomiting if the stomach is not empty. To reduce the risk of aspiration , it is recommended that patients undergoing laparoscopic surgery follow NPO guidelines. The specific NPO guidelines may vary depending on the type of surgery and the individual patient's medical history, but generally, patients are advised not to eat or drink anything for several hours before the surgery. Incorrect Options: Option A - Eat full before surgery: Eating a full meal before surgery is not recommended as it can increase the risk of aspiration and may cause delays in the surgery. Option B - Drink plenty of water before surgery: Drinking water before surgery can increase the risk of aspiration and delay the procedure. Patients are typically allowed to drink clear liquids up to two hours before the surgery. Option C - Enema in the night before surgery . Enema in the night before surgery", may be recommended for certain types of surgeries or patients, but it is not a standard recommendation for laparoscopic surgery.

References:

Prepladder Notes

↑ *Back to this question in Part A*

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Q150: Which of the following tests is not conducted before a blood transfusion for a person with RTA, when a family member is volunteering for blood donation? (Q793932)

A. Hepatitis A

B. Hepatitis B

C. Hepatitis C

D. HIV 1 & 2

Correct Answer: A. Hepatitis A

Explanation: Correct Option A - Hepatitis A: Hepatitis A virus is usually transmitted through contaminated food or water and is not typically transmitted through blood transfusions. Therefore, testing for Hepatitis A is not routinely performed before blood transfusion. Incorrect Options: Options B, C & D: these are incorrect as can be transmitted through blood and other bodily fluids and need to be screened before transfusion.

References:

Prepladder Notes

↑ *Back to this question in Part A*

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