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Question: 1

A 65-year-old female with a history of diabetes, hypercholesterolemia, and systemic lupus erythematosus presents to your clinic for evaluation of a change in her vision. You note that she is taking simvastatin, hydroxychloroquine, and prednisone daily. She states that very slowly, over a period of many months, she feels that her vision has decreased in both of her eyes. She complains of mild diplopia, blurriness, excessive glare, and reduced color perception. Her physical exam reveals a translucent, yellow discoloration of the lens, and examination of her red reflex shows a dark defect against a red background.

All the following are risk factors for this patient's problem except:

- A. her use of prednisone (Deltasone)
- B. her history of diabetes
- C. her use of simvastatin (Zocor)
- D. her use of hydroxychloroquine (Plaquenil)

Answer: D

Explanation:

This patient has cataracts, an opacity of the natural lens of the eye due to a progressive increase in the proportion of insoluble protein. Cataracts may involve a small part of the lens or the entire lens. They can be caused by age (senile), trauma, congenital causes, systemic disease, or medications. Hydroxychloroquine is a disease-modifying antirheumatic drug (DMARD) used to treat autoimmune conditions such as systemic lupus erythematosus. It is known to cause ocular toxicity, which manifests as changes in the retina, cornea, and ciliary body, but not the lens (i.e. cataracts).

Long-term prednisone use has been associated with the formation of cataracts.

The statin family of lipid-lowering drugs has been associated with the increased risk of cataracts.

Having diabetes, even a well-controlled disease, can be a risk factor for the development of cataracts.

Question: 2

You see a patient with an elevated adjusted serum calcium level and a low parathyroid hormone (PTH) level. Which of the following causes should you suspect?

- A. Parathyroid gland hyperplasia
- B. Parathyroid carcinoma
- C. Benign parathyroid gland adenoma
- D. Multiple myeloma

Answer: D

Explanation:

To screen for hypercalcemia, you must always calculate the adjusted total calcium. It is measured by: the measured serum calcium (mg/dL) + [0.8 X (4.0 - serum albumin [g/dL])]. Elevated adjusted serum calcium with an elevated parathyroid hormone (PTH) level indicates a primary disorder. However, elevated adjusted serum calcium with a low PTH level indicates a secondary disorder such as a malignancy. Multiple myeloma, head-neck-lung cancers, and Hodgkin's lymphoma are common malignancies that trigger hypercalcemia.

Benign parathyroid gland adenoma is a primary cause of hypercalcemia and is responsible for 85% of primary hyperparathyroidism cases. PTH levels will be normal.

Parathyroid gland hyperplasia is also a primary cause of hypercalcemia and accounts for 15% of primary hyperparathyroidism. PTH levels will likely be normal.

Parathyroid carcinoma is a rare, primary cause of hypercalcemia accounting for just 3% of all primary hyperparathyroidism. In these patients, PTH levels will be elevated as well.

Question: 3

A patient with tuberculosis develops progressive kyphosis. This condition is known as:

- A. Scheuermann disease
- B. Pott's disease
- C. Osgood-Schlatter disease
- D. Volkmann ischemic contracture

Answer: B

Explanation:

Tuberculosis of the spine is the most common extrapulmonary location of tuberculosis after the lymph nodes and causes progressive kyphosis, which is an increased convex curvature of the thoracic spine. It is known as Pott's disease.

Scheuermann disease is idiopathic osteochondrosis of the thoracic spine and is also known as juvenile kyphosis.

Volkmann ischemic contracture is a complication of a supracondylar humerus fracture due to a concurrent injury to the brachial artery.

Osgood-Schlatter disease is apophysitis of the tibial tubercle caused by trauma or overuse.

Question: 4

A 37-year-old female presents to your office for evaluation of her legs. She states that over the past several weeks she has been awakened during her sleep by her legs jerking. She states that she also sometimes has a feeling of itching and crawling on her legs when she is trying to go to sleep.

All the following are appropriate screening tests for secondary causes to this disorder except:

- A. Fasting glucose
- B. Fasting triglycerides

- C. Urine HCG
- D. CBC with ferritin levels

Answer: B

Explanation:

This patient is describing classic symptoms of restless leg syndrome (RLS). RLS affects approximately 10% of adults. Patients feel a subjective need to move the legs and often have abnormal sensations including tingling, creeping or crawling sensations, itching, heaviness, burning, coldness, or tension. Symptoms occur during periods of inactivity or rest. Sleep disturbance is common as patients typically will also have frequent involuntary movements during sleep or while at rest. Most cases are primary, but RLS may occur secondary to peripheral neuropathy, uremia, pregnancy, or iron deficiency.

Question: 5

A 13-year-old male comes to your office with the complaint of acne. On his exam, you find multiple open and closed comedones with only a few scattered inflammatory papules on his face. His trunk and shoulders are clear. What is the most appropriate treatment for this patient's acne at this time?

- A. Oral tetracycline
- B. Topical clindamycin (Clindacin)
- C. Topical retinoids (Retin-A)
- D. Oral trimethoprim-sulfamethoxazole (Sulfatrim, Bactrim)

Answer: C

Explanation:

This patient's presentation is consistent with mild acne. He has predominantly comedones and few inflammatory lesions. Topical retinoids work very well in this type of acne. Other acceptable topical medications are azelaic acid and salicylic acid.

Topical clindamycin is a medication for inflammatory acne lesions such as papules, pustules, nodules, or cysts. It does not work on mild, comedonal acne.

Oral tetracycline is a systemic medication that is appropriate for cystic acne and more severe forms of inflammatory acne that also involve the trunk and shoulders.

Oral trimethoprim-sulfamethoxazole may be used as a second-line systemic medication, but again, should be used only in more severe cases of cystic acne or inflammatory acne of the trunk and shoulders.

Question: 6

A patient who has dysphagia with or without intermittent chest pain that may or may not be associated with eating likely has which of the following esophageal motility disorders?

- A. Esophageal stenosis

- B. Achalasia
- C. Diffuse esophageal spasm
- D. Neurogenic dysphagia

Answer: C

Explanation:

While dysphagia is a symptom common to all esophageal motility disorders, the presentation can help determine the underlying cause. Diffuse esophageal spasm is characterized by dysphagia or intermittent chest pain that may or may not be associated with eating.

Achalasia presents as slowly progressive dysphagia with episodic regurgitation and chest pain. It is a global esophageal motor disorder in which peristalsis is decreased and lower esophageal sphincter tone is increased.

Esophageal stenosis causes dysphagia for solid foods. Slow progression indicates a more benign process (webs or rings) whereas rapid progression is indicative of malignancy.

Neurogenic dysphagia causes dysphagia with both liquids and solids and is associated with an injury or disease of the brain stem or cranial nerves IX and X.

Question: 7

All of the following types of seizures involve an impairment of consciousness except:

- A. generalized absence
- B. grand mal
- C. focal seizure without cognitive impairment
- D. focal seizure with cognitive impairment

Answer: C

Explanation:

Seizures are transient disturbances of cerebral function caused by abnormal paroxysmal neuronal discharges in the brain. A focal seizure without cognitive impairment is not accompanied by a loss of consciousness. It typically begins as a unilateral, isolated tonic or clonic activity in a limb or a transient altered sensory perception which may then spread to the entire area or side of the body in a "Jacksonian march."

In focal seizures with cognitive impairment, also known as temporal lobe seizures, there is usually an aura (transient abnormal sensation, perception, emotion, or memory) followed by impaired consciousness, nausea, vomiting, focal sensory perceptions, and/or focal tonic or clonic activity.

A generalized non-convulsive (absence) seizure is characterized by a sudden loss of consciousness and only minor motor activity, such as blinking or facial twitching.

A grand mal seizure is also known as a generalized convulsive or tonic-clonic seizure. There is a sudden loss of consciousness followed by tonic-clonic motor activity, postictal obtundation, and confusion lasting minutes or hours.

Question: 8

Chronic tamoxifen use is a risk factor for which of the following types of cancer?

- A. Endometrial cancer
- B. Ovarian cancer
- C. Vulvar cancer
- D. Cervical cancer

Answer: A

Explanation:

Endometrial cancer is the most common gynecologic cancer, and it is the fourth common malignancy in women in the U.S. It is usually a diagnosis made in those who are postmenopausal—they comprise 75% of cases. Adenocarcinomas make up 75% of all cancer cell types. In addition to chronic tamoxifen use, risk factors include obesity, nulliparity, infertility, late menopause, diabetes mellitus, unopposed estrogen stimulation, hypertension, and gallbladder disease.

Risk factors for cervical cancer include human papillomavirus (HPV) infection (especially types 16, 18, 31, and 33). Over 90% of invasive cervical carcinomas show the presence of HPV. However, it alone is probably not sufficient for the development of CIN. Other cofactors include early age at first intercourse, early childbearing, multiple sexual partners or a high-risk sex partner, history of a sexually transmitted disease, low socioeconomic status, and cigarette smoking.

Risk factors for ovarian cancer include age (mean age is 69), nulliparity, Caucasian descent, and a positive family history of ovarian or endometrial cancer. It is the second most common gynecologic malignancy, the fifth most common cancer in American women, and it has the highest mortality rate of any gynecologic cancer, which is 60% within five years of diagnosis.

Most vulvar malignancies are squamous cell carcinomas. Risk factors include age (mean age is 65 at diagnosis), obesity, hypertension, diabetes mellitus, arteriosclerosis, and a history of chronic vulvar itching. Vulvar cancer in younger women is associated with human papillomavirus (HPV) infection, smoking, and cervical cancer; 25% of patients have co-existing cervical carcinoma.

Question: 9

A multiparous woman who has delivered all her children vaginally presents with the complaint of feeling that she is "sitting on a ball." Examination reveals a moderate uterine prolapse. Which of the following is true regarding uterine prolapse?

- A. Uterine prolapse is more common in African-American women.
- B. Pelvic muscle exercises can help manage uterine prolapse.
- C. Uterine prolapse is graded as 0 to 5.
- D. Menopausal women have a decreased risk of uterine prolapse.

Answer: B

Explanation:

Pelvic organ prolapse refers to the protrusion of the pelvic organs into or out of the vagina. Prolapse may result from excessive stretching of the pelvic fascia, ligaments, and muscles during pregnancy, labor, and delivery; from increased intra-abdominal pressure; or from iatrogenic factors. The risk of uterine prolapse increases up to 50% after menopause. Anterior vaginal prolapse includes cystoceles or cystourethroceles, and posterior vaginal prolapse includes enteroceles and rectoceles.

Uterine prolapse is more common in Hispanic and white women when compared to Asian- and African-American women.

The grading of a prolapse ranges from 0 (no descent) to 4 (through the hymen). Pelvic muscle exercises (often called Kegel exercises) are a non-surgical management approach. Additional non-surgical management includes weight reduction, smoking cessation, and vaginal pessary use. If non-surgical management fails, a hysterectomy may be considered.

Question: 10

Which of the following physical exam findings would you expect to find in a patient with cardiac tamponade?

- A. Hypertension
- B. Bradycardia
- C. A widened pulse pressure
- D. Pulsus paradoxus

Answer: D

Explanation:

Cardiac tamponade occurs when fluid compromises cardiac filling and impairs cardiac output. It may occur in the setting of acute pericarditis that develops into a cardiac effusion or cardiac effusion due to uremia or cardiac trauma. It may be a cause of obstructive shock and produce the clinical symptoms of tachycardia, tachypnea, narrow pulse pressure, hypotension, jugular venous distention, and pulsus paradoxus.

Question: 11

Which of the following statements regarding acute respiratory distress syndrome (ARDS) is false?

- A. ARDS typically presents as a rapid onset of dyspnea 12 to 24 hours after a precipitating event and is characterized by cyanosis and hypoxia that is refractory to administered oxygen,
- B. The single most important clinical setting in which ARDS occurs, accounting for a majority of cases, is multiple transfusions,
- C. The chest radiograph is generally normal at first. Pulmonary capillary wedge pressure is normal.
- D. One-third of deaths occur within three days of the onset of symptoms and the rest occur within two weeks due to infection and multiple organ failure,

Answer: B

Explanation:

The underlying abnormality in ARDS is increased permeability of the alveolar-capillary membranes; this leads to the development of protein-rich pulmonary edema. Three clinical settings account for 75% of ARDS cases: sepsis syndrome, multiple trauma, and aspiration of the gastric contents. Of these, sepsis syndrome is the single most important. Other causes include shock, toxic inhalation, multiple transfusions, and near-drowning. Treatment includes identification and specific treatment of the underlying precipitating event as well as any secondary conditions. To compensate for the severe respiratory dysfunction, oxygen should be delivered via endotracheal intubation with positive pressure ventilation and low levels of positive end-expiratory pressure (PEEP). The hypoxia is often refractory to treatment and, therefore, the mortality rate of ARDS is high.

Question: 12

A 25-year-old HIV positive male presents to your clinic with the complaint of right-sided ear pain that has worsened over the past several days. His exam shows a right external auditory canal that is erythematous and edematous with a purulent exudate. He states that the pain is exacerbated as you palpate and move the auricle and tragus.

Based on your suspected diagnosis, prompt treatment is necessary to prevent which of the following potential complications in this patient?

- A. Chronic otitis media
- B. Sensorineural hearing loss
- C. Malignant otitis externa
- D. Rupture of the TM

Answer: C

Explanation:

Malignant otitis externa may develop in a patient who is immunocompromised or diabetic as a result of a rapid or untreated otitis externa, which is what you would suspect given this patient's clinical findings. Malignant otitis externa is a necrotizing infection that extends into the blood vessels, bone, and cartilage and requires hospitalization and parenteral antibiotics for treatment.

This patient has classic findings of otitis externa. There is no middle ear infection; therefore, rupture of the TM is unlikely.

Chronic otitis media results from repeated episodes of acute otitis media, trauma, or cholesteatoma. The main physical exam findings include a perforated TM with discharge. There may or may not be pain. Sensorineural hearing loss occurs as a result of damage or impairment of the inner ear (cochlea) or neural pathways. Therefore, it is not a complication of otitis externa.

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