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QUESTION NO: 1

A 28-year-old man presents with a 2 hours' history of rapid palpitations. He feels a little light headed but is other exam: pulse=170 bpm and regular, BP=100/68 mmHg. He has had 2 similar episodes in the past.

What is the most disturbance?

A. SVT

B. VF

C. A-fibrillation

D. VT

E. Ventricular-ectopic

ANSWER: A

Explanation:

SVT is the most likely rhythm disturbance. The presentation is characteristic of paroxysmal supraventricular tachycardia: a young adult has recurrent, abrupt episodes of a rapid, regular palpitation, with a pulse rate of approximately 170 beats per minute. SVT commonly begins and ends suddenly and is often caused by a re-entry circuit involving the atrioventricular node or an accessory pathway. Patients may experience light-headedness because the rapid rate reduces ventricular filling time and can transiently lower cardiac output. His blood pressure is maintained and there is no description of collapse, chest pain, or acute heart failure, supporting a haemodynamically stable episode. In clinical practice, a 12-lead ECG obtained during symptoms is needed to establish the precise tachycardia mechanism and to guide management. For a stable regular narrow-complex tachycardia, initial management typically includes vagal manoeuvres, followed by adenosine when appropriate and when no contraindication is present. Recurrent symptomatic episodes merit assessment for definitive treatment, including catheter ablation where indicated. The European Society of Cardiology guideline provides a detailed approach to diagnosis and treatment of supraventricular tachycardias: ESC Guidelines for supraventricular tachycardia. Additional clinical guidance is available from StatPearls: Supraventricular Tachycardia.

QUESTION NO: 2

A 41-year-old woman awoke from a nap with severe pain in her index finger and found it to be flexed while all other fingers were extended. When she tried to pull it free she heard a loud popping sound and the pain subsided. The following day she comes to her doctor’s office concerned about the sound and pain.

What is the most appropriate next stop in the management of this patient?

A. Steroid injection

B. Admit to the hospital.

C. NSAID therapy

D. Amputate the finger

E. Rehabilitate the finger

ANSWER: A

Explanation:

Steroid injection is the appropriate next step because this presentation is characteristic of trigger finger, also called stenosing tenosynovitis. In this condition, inflammation and thickening around the flexor tendon and its pulley create a mechanical mismatch: the tendon may catch as the digit moves, producing painful locking in flexion followed by a sudden release or “pop.” The fact that the index finger was transiently locked and then released is particularly consistent with this mechanism. Management is generally guided by symptoms and functional limitation, and a local corticosteroid injection into the flexor tendon sheath is a well-established first-line nonsurgical treatment. It reduces local inflammation, improves tendon gliding, and has a meaningful chance of relieving triggering without an operation. The patient should also receive follow-up advice to

return if locking recurs, pain persists, or finger motion becomes limited. If appropriately administered injections do not provide durable relief, surgical release of the affected pulley can be considered. This approach is consistent with guidance from the American Academy of Orthopaedic Surgeons and the clinical review in StatPearls: Trigger Finger.

QUESTION NO: 3

A 42-year-old man presents with a target shaped rash that has developed over the last several days. He was on a camping trip in the woods last week in Maine.

What is the next best step in management?

A. Western blot

B. Doxycycline

C. ELISA

D. Serology for IgM

ANSWER: B

Explanation:

Doxycycline is the appropriate next step because the described expanding target-shaped lesion following woodland exposure in Maine is classic for erythema migrans, the characteristic early cutaneous manifestation of Lyme disease. In a patient with a compatible lesion and likely exposure in a Lyme-endemic area, erythema migrans is diagnosed clinically and treatment should begin promptly; laboratory testing is not required before therapy. Early in infection, antibody-based tests may still be negative because a detectable immune response has not yet developed, so testing does not improve immediate management when the rash is characteristic.

For an adult without a stated contraindication, oral doxycycline is a recommended first-line regimen for erythema migrans. CDC guidance lists doxycycline 100 mg orally twice daily for 10 days as an effective treatment course for adults. Timely treatment eradicates *Borrelia burgdorferi* infection and helps prevent later neurologic, cardiac, and joint manifestations. The clinical setting and rash morphology therefore support initiating doxycycline now. See the CDC guidance on erythema migrans and the CDC treatment recommendations for Lyme disease.

QUESTION NO: 4

At what CD4 count should anti-retroviral treatment commence in asymptomatic HIV patients?

A. Below 500/mm3

B. Below 100/mm3

C. Below 50/mm3

D. Below 200/mm3

E. Regardless of CD4 count

ANSWER: E

Explanation:

Regardless of CD4 count is correct. Current HIV treatment guidance recommends initiating antiretroviral therapy for every person diagnosed with HIV as soon as possible after diagnosis, including people who are asymptomatic and those with high CD4 cell counts. This approach is commonly termed rapid initiation or treatment for all. The purpose is not merely to wait until immune deficiency becomes measurable; early, sustained viral suppression protects immune function, reduces HIV-related illness and mortality, and prevents sexual transmission when viral load is durably suppressed. CD4 testing remains clinically important at baseline, particularly for identifying advanced HIV disease and determining the need for prophylaxis against opportunistic infections, but it should not delay the decision to start treatment. The World Health Organization

recommends lifelong ART for all people living with HIV regardless of clinical stage or CD4 cell count. Similarly, United States guidelines recommend ART for all individuals with HIV to reduce morbidity, mortality, and transmission risk. See the World Health Organization consolidated HIV guidelines and the NIH guidance on initiating antiretroviral therapy.

QUESTION NO: 5

A 43-years-old man is brought to the emergency department after a motor vehicle accident involving ahead He mentioned that he is having headache and dizziness. During his overnight admission for observation, his serum sodium level rises to 151 meq/L.

All of the following tests are indicated EXCEPT:

A. Measurement of morning cortisol level and plasma and urine osmolality

B. Measurement of response to desmopressin

C. MRI scan of the head

D. Overnight dehydration test

ANSWER: D

Explanation:

Overnight dehydration test is the exception because this patient already has hypernatremia following head trauma, a pattern that raises urgent concern for diabetes insipidus, particularly central diabetes insipidus due to traumatic hypothalamic or pituitary injury. Water deprivation testing depends on controlled withholding of fluids while monitoring weight, serum sodium, plasma osmolality, urine output, and urine osmolality. It is not appropriate when significant hypernatremia or volume depletion is already present, since further water restriction can worsen hyperosmolality, dehydration, and neurologic risk. In this setting, immediate paired plasma and urine osmolality testing helps establish whether inappropriately dilute urine is accompanying the hypernatremia. Desmopressin response can then help confirm impaired antidiuretic hormone action and characterize the disorder. Assessment of pituitary function, including morning cortisol where clinically appropriate, and pituitary-hypothalamic imaging are also relevant after traumatic brain injury because central diabetes insipidus may coexist with other pituitary hormone deficiencies or structural injury. Diagnostic evaluation should proceed alongside prompt fluid replacement and close monitoring of sodium correction. See Endotext: Diagnostic Tests for Diabetes Insipidus and Endotext: Diabetes Insipidus.

QUESTION NO: 6

A 58-year-old woman has a chronic ulcer above the medial malleolus. The surrounding skin is hyperpigmented and there are visible varicose veins. Her ankle-brachial pressure index is 1.0.

What is the most appropriate management?

A. Compression bandaging

B. Oral flucloxacillin

C. High-dose corticosteroids

D. Immediate skin biopsy

E. Below-knee amputation

ANSWER: A

Explanation:

Compression bandaging is the most appropriate management for a venous leg ulcer when arterial supply is adequate. The ulcer location in the gaiter area, haemosiderin skin staining, and varicose veins are typical of chronic venous insufficiency. An ankle-brachial pressure index of 1.0 indicates that significant peripheral arterial disease is unlikely.

Graduated compression improves venous return, reduces oedema, and promotes ulcer healing. The patient should also receive wound care, pain management, exercise and mobility advice, and assessment for treatment of superficial venous reflux where indicated. High compression should not be used without assessment of arterial circulation. See NICE guidance on varicose veins.

QUESTION NO: 7

Cervical cancer diagnostic test:

A. Cone biopsy

B. Punch biopsy

C. FNAC

D. Pap smear

ANSWER: A

Explanation:

Cone biopsy is correct because it provides a definitive histopathologic tissue specimen for diagnosing cervical precancer and early cervical cancer. In this procedure, a cone-shaped section of the cervix is excised, including the transformation zone and part of the endocervical canal. This is particularly valuable when an abnormal screening result or colposcopic assessment suggests a high-grade lesion, when the lesion extends into the canal, or when prior smaller samples do not adequately exclude invasive disease. A pathologist can examine the excised tissue to identify the lesion type, determine whether invasion is present, and assess the margins of excision. These findings establish the diagnosis and help guide subsequent management. Cone biopsy may be performed with a loop electrosurgical excision procedure or with a cold-knife technique. It can serve both diagnostic and therapeutic purposes, since complete excision of a precancerous lesion or selected very early cancers may be achieved at the same time. The National Cancer Institute describes cone biopsy as removal of a cone-shaped piece of tissue from the cervix for examination and notes its role in diagnosis and treatment of cervical abnormalities. See the National Cancer Institute definition of cone biopsy and the American Cancer Society guidance on cervical cancer diagnosis.

QUESTION NO: 8

A young man comes up with a headache, which he describes that this headache is the most severe headache in his life.

Which of the following will be less useful?

A. Lumbar Puncture

B. Do MRI or CT scan

C. Skull X ray

D. Asking more details about headache

ANSWER: C

Explanation:

Skull X ray is the least useful investigation for a young person presenting with a sudden, “most severe headache of life,” a description that is concerning for thunderclap headache and possible subarachnoid haemorrhage. Plain skull radiographs show bony skull structures and may demonstrate only limited, indirect abnormalities; they do not visualise acute intracranial bleeding, the subarachnoid space, brain parenchyma, or cerebral blood vessels adequately. Consequently, they do not provide the urgent diagnostic information required in this presentation and should not delay an evidence-based acute-headache assessment.

Modern evaluation focuses on rapidly detecting or excluding dangerous intracranial causes with appropriate neuroimaging, particularly non-contrast head CT in the acute setting, followed by further testing when clinically indicated. Clinical history

remains essential to establish onset, timing, associated neurological symptoms, and relevant risk factors. Major emergency-medicine guidance addresses acute headache and use of non-contrast CT and subsequent testing for patients at risk of subarachnoid haemorrhage. See the American College of Emergency Physicians acute headache clinical policy and the NICE guideline on subarachnoid haemorrhage caused by a ruptured aneurysm.

QUESTION NO: 9

An 8-week baby boy is noted to be jaundiced. He is breast-feeding well and has gained 300g since birth. His s and his urine is pale straw colored.

What is the most likely diagnosis?

A. Breast milk jaundice

B. G6PD deficiency

C. Galactosemia

D. Congenital viral infection

E. Biliary atresia

ANSWER: A

Explanation:

Breast milk jaundice is the most likely diagnosis because this is a well, breast-fed infant with persistent jaundice at 8 weeks of age and no stated features of illness or biliary obstruction. Breast milk jaundice typically emerges after the first few days of life, often becoming apparent during the second week, and can persist for 8–12 weeks or occasionally longer. Affected infants generally feed well and otherwise appear healthy. It is an unconjugated hyperbilirubinaemia thought to result from factors in breast milk that increase intestinal bilirubin reabsorption and/or reduce bilirubin conjugation.

Clinical assessment should still confirm that the infant has normal stool and urine colour and obtain fractionated bilirubin, because prolonged neonatal jaundice requires evaluation for conjugated hyperbilirubinaemia and other underlying disease. In a thriving infant with normal-coloured urine and stools, the overall pattern is consistent with breast milk jaundice. The American Academy of Pediatrics discusses prolonged jaundice and the need to measure total and direct-reacting bilirubin in its hyperbilirubinaemia guideline. Additional clinical guidance on recognising prolonged jaundice is available from NICE.

QUESTION NO: 10

A 32-year-old man with schizophrenia and a history of violence and distressing auditory hallucinations was a ward with aggressive behavior and has already smashed his room. He is refusing any oral meds.

What is the s appropriate injection?

A. Flupenthixol

B. Risperidone

C. Haloperidol

D. Fluphenazine

ANSWER: C

Explanation:

Haloperidol is the appropriate choice from the listed injections for urgent pharmacological management of severe psychotic agitation when a patient refuses oral medication and poses an immediate risk through violent behaviour. Haloperidol is a potent antipsychotic available as an intramuscular preparation and has established use in rapid tranquillisation for acute

behavioural disturbance associated with psychosis. It directly treats the likely psychotic driver of the aggression, including distressing hallucinations and severe agitation.

In current UK rapid-tranquillisation guidance, intramuscular haloperidol should generally be administered with intramuscular promethazine, particularly when intramuscular treatment is needed and lorazepam alone is not selected. The combination helps provide sedation and reduces the risk of acute extrapyramidal adverse effects. Before giving haloperidol, clinicians should consider cardiovascular risk, including QT-interval prolongation, and use appropriate physical observations after administration. De-escalation, assessment of capacity, and the least restrictive safe intervention remain important, but the described immediate violence and refusal of oral treatment justify urgent intramuscular medication. See NICE guidance on violence and aggression: short-term management and the haloperidol injection prescribing information.

QUESTION NO: 11

A young girl presented to gynecologist for assessment with lower abdominal pain and per vaginal bleedin of hysterosalpingograph as a part of her infertility treatment. Observation: BP=90/50mmHg, pulse-120bpm, and revealed rigid abdomen.

What is the most appropriate next investigation?

A. Coagulation profile

B. Chest X ray

C. Ultrasound abdomen

D. X-ray erect and supine

E. CT SCAN

ANSWER: C

Explanation:

Ultrasound abdomen is the most appropriate immediate investigation because the combination of acute lower abdominal pain, vaginal bleeding, hypotension, marked tachycardia, and abdominal rigidity indicates a potentially life-threatening intra-abdominal or pelvic bleeding event. In this setting, urgent ultrasound—ideally performed as a focused transabdominal and pelvic examination—can rapidly identify free intraperitoneal fluid consistent with haemoperitoneum, assess the uterus and adnexa, and help identify a possible tubal or uterine source of bleeding. It is rapid, non-invasive, available at the bedside, and does not expose an unstable patient to ionising radiation or delay urgent resuscitation and gynaecological/surgical management. A pregnancy test and blood tests, including full blood count and group-and-save/crossmatch, would also be undertaken during resuscitation, but ultrasound is the best answer among the listed investigations for promptly evaluating suspected intra-abdominal bleeding. Guidance on acute pelvic pain and suspected ectopic pregnancy supports urgent ultrasound assessment in clinically concerning presentations. See NICE guideline NG126: Ectopic pregnancy and miscarriage and ACOG: Ectopic Pregnancy.

QUESTION NO: 12

A pregnant lady comes at 37 weeks with 3+ proteinuria, confusion and Blood pressure 170/110 mmhg.

What is the best step in her management?

A. Admit and monitor / mgso4 E-Send home

B. Hydralazine

C. Deliver the baby immediately

D. C-section

E. Stabilize with magnesium sulfate and antihypertensive treatment, then proceed to prompt delivery

ANSWER: E

Explanation:

Stabilize the mother with magnesium sulfate and urgent blood-pressure control, then proceed to prompt delivery is the best management. This presentation is pre-eclampsia with severe features: severe-range hypertension (170/110 mmHg), marked proteinuria, and neurological dysfunction (confusion). Confusion is particularly concerning because it indicates central nervous system involvement and a high risk of eclampsia, stroke, and other serious maternal complications. Magnesium sulfate should be given for seizure prophylaxis. Severe hypertension requires urgent treatment with an appropriate rapid-acting antihypertensive, such as intravenous hydralazine, intravenous labetalol, or immediate-release oral nifedipine, to reduce the risk of maternal intracranial hemorrhage and other end-organ injury. At 37 weeks, delivery is indicated after maternal stabilization because it is the definitive treatment for pre-eclampsia; the route of delivery should be selected according to obstetric circumstances, fetal status, cervical findings, and urgency, rather than automatically requiring cesarean delivery. This sequence avoids delaying essential maternal resuscitation while ensuring timely birth. Guidance from NICE: Hypertension in pregnancy and ACOG: Gestational Hypertension and Preeclampsia supports stabilization, magnesium sulfate for severe disease, treatment of acute severe hypertension, and delivery at this gestation.

QUESTION NO: 13

A 26-year-old political refugee has sought asylum in the UK and complains of poor concentration. He keeps his family whom he saw killed in a political coup. He is unable to sleep and feels hopeless about his survival. But he is afraid to go out.

What is the most likely diagnosis?

A. PTSD

B. Acute stress disorder

C. OCD

D. Social phobia

E. GAD

ANSWER: A

Explanation:

PTSD is the most likely diagnosis because the patient has experienced a severely traumatic event—witnessing the violent death of family members during a political coup—and now has a characteristic trauma-related symptom pattern. The description indicates persistent distressing recollections of the event, expressed as repeatedly thinking about or mentally reliving what happened to his family. His insomnia and poor concentration fit the heightened arousal and reactivity symptoms commonly seen after trauma. Being afraid to go out is consistent with avoidance of situations, places, or cues that may feel unsafe or remind him of the traumatic circumstances. Feelings of hopelessness may also occur alongside the negative mood and cognition changes associated with PTSD. In a clinical assessment, the clinician should establish symptom duration, functional impact, comorbid depression or anxiety, suicide risk, and immediate social and safeguarding needs, particularly given his refugee status and profound bereavement. PTSD is diagnosed from the overall syndrome of trauma exposure followed by intrusion, avoidance, negative changes in mood or thinking, and arousal symptoms. The NHS overview of PTSD is available at NHS: Post-traumatic stress disorder. Diagnostic symptom criteria are also summarized by the U.S. Department of Veterans Affairs National Center for PTSD.

QUESTION NO: 14

A 28-weeks pregnant woman presents with uterine bleeding after sexual intercourse. What is the most appropriate diagnosis?

A. Placental abruption

B. Missed abortion

C. Placental previa

D. Ectropion

ANSWER: C

Explanation:

Placental previa is the most appropriate diagnosis because bleeding in the late second or third trimester that is painless and may follow sexual intercourse is a classic presentation of a low-lying placenta or placenta covering the cervical opening. As the lower uterine segment develops and the cervix is disturbed, placental vessels near the internal cervical os can bleed. The stem specifies uterine bleeding at 28 weeks and identifies intercourse as the precipitating event, which strongly supports antepartum haemorrhage related to placental previa. This presentation should prompt urgent obstetric assessment, including maternal and fetal evaluation and ultrasound to establish placental location. A digital vaginal examination must not be performed until placenta previa has been excluded by imaging, because it can provoke severe haemorrhage. The Royal College of Obstetricians and Gynaecologists describes placenta previa as an important cause of painless vaginal bleeding after 20 weeks, and its guideline addresses assessment and management of bleeding with a low-lying placenta. Further information is available from the RCOG patient information on placenta praevia and the RCOG guideline on placenta praevia and placenta accreta.

QUESTION NO: 15

A 27-year-old lady after C-section developed epigastric pain after 8h.

What is the appropriate investigations?

A. Liver enzyme

B. Liver biopsy

C. ABG

D. Coagulation

ANSWER: A

Explanation:

Liver enzyme testing is the best available answer because new epigastric or right-upper-quadrant pain in the immediate postpartum period is a concerning symptom of pre-eclampsia with severe features and HELLP syndrome (haemolysis, elevated liver enzymes, and low platelet count). HELLP can first become clinically apparent after delivery, including after a caesarean birth, so postpartum onset does not exclude this diagnosis. Measurement of serum aminotransferases, particularly AST and ALT, assesses hepatic involvement and can identify the “elevated liver enzymes” component promptly. In clinical practice, liver enzyme testing should be obtained urgently as part of a broader HELLP evaluation that includes a full blood count with platelet count, markers of haemolysis such as LDH and bilirubin, renal function, and assessment of blood pressure and proteinuria. Early recognition is important because significant hepatic injury and other severe maternal complications may develop rapidly. ACOG identifies persistent right upper-quadrant or epigastric pain as a severe feature that warrants maternal laboratory evaluation, including liver transaminases. See ACOG guidance on gestational hypertension and pre-eclampsia and StatPearls: HELLP Syndrome.

QUESTION NO: 16

65 years old male with hypertension, congestive heart failure and peptic ulcer disease came to your office for his regular blood pressure check. Although his blood pressure is now under control, he complains of an inability to maintain an erection. He currently is taking propranolol, verapamil, hydrochlorothiazide, and r pressure is 125/76 mmHg. His pulse is 56 and regular. The rest of the cardiovascular examination and the rest of the physical examination are normal.

Which of the following generally considered the MOST common cause of sexual dysfunction?

A. Panic disorder

B. Major depressive disorder

C. Generalized anxiety disorder

D. Dysthymic disorder

E. pharmacological agents

ANSWER: E

Explanation:

Pharmacological agents are the best answer in this clinical context because medication-related erectile dysfunction is common and should be actively assessed in a patient who develops difficulty maintaining an erection while receiving treatment for cardiovascular disease. In particular, propranolol, a nonselective beta-blocker, and hydrochlorothiazide, a thiazide diuretic, are well-recognized antihypertensive drugs associated with sexual adverse effects. These medicines can reduce erectile function through effects on vascular blood flow, autonomic responses, and, in some patients, fatigue or reduced libido. The temporal relationship between treatment exposure and the reported symptom makes a medication review an essential part of the evaluation. Management includes confirming the medication history, assessing other cardiovascular and metabolic contributors, and considering a safer alternative when clinically appropriate; antihypertensive treatment should not be stopped abruptly. The American Urological Association recommends a comprehensive medical and medication assessment for erectile dysfunction, including identification of potentially contributory prescription drugs. The American Academy of Family Physicians likewise identifies antihypertensive medications among recognized causes that should be reviewed during evaluation. See the American Urological Association erectile dysfunction guideline and the American Academy of Family Physicians review of erectile dysfunction.

QUESTION NO: 17

Ophthalmoplegic migraine is best characterised as?

A. Headache associated with irreversible palsy of 3rd nerve

B. Headache with optic neuritis

C. Recurrent headache with transient palsy of 3, 4 and / or 6th cranial nerves

ANSWER: C

Explanation:

“Recurrent headache with transient palsy of 3, 4 and / or 6th cranial nerves

” is correct because the defining clinical pattern is repeated attacks of headache associated with paresis of one or more ocular motor cranial nerves. These nerves control eye movements: the oculomotor nerve, trochlear nerve, and abducens nerve. Their temporary dysfunction produces ophthalmoplegia, which may cause diplopia, ptosis, impaired eye movements, or pupillary abnormalities depending on the nerve involved. The headache may have migraine-like features and can precede, accompany, or follow the ocular motor deficit. Although the older term “ophthalmoplegic migraine” is still commonly encountered in examinations and clinical discussion, the current International Classification of Headache Disorders uses the term recurrent painful ophthalmoplegic neuropathy. This reflects evidence that the disorder is more consistent with a recurrent inflammatory cranial neuropathy than with migraine itself. Establishing the diagnosis requires that relevant structural, vascular, orbital, parasellar, and other causes of painful ocular motor palsy have been appropriately excluded, usually with neuroimaging when clinically indicated. The International Headache Society diagnostic description is available in the ICHD-3 classification; an overview is also provided by StatPearls.

QUESTION NO: 18

A 62-year-old man diagnosed with T2DM with BMI=33. Lifestyle modifications have failed to control blood. Labs: urea=3.6mmol/l, creatinine=89mmol/l.

What is the next appropriate management?

A. Sulfonylurea receptor binder

B. Glitazone

C. Biguanide

D. Sulfonylurea

ANSWER: C

Explanation:

Biguanide is the appropriate next management, specifically metformin, because this patient has type 2 diabetes inadequately controlled with lifestyle measures and obesity (BMI 33 kg/m²). Metformin is generally the preferred initial glucose-lowering medicine in this setting because it effectively lowers HbA1c, has a low intrinsic risk of hypoglycaemia, and is weight-neutral or may produce modest weight loss. These characteristics are particularly helpful where excess weight contributes to insulin resistance and cardiometabolic risk. The reported renal indices do not suggest an evident contraindication, although prescribing should be based on a calculated estimated glomerular filtration rate (eGFR), rather than serum creatinine alone. Renal function should be checked before starting therapy and monitored subsequently; metformin dose adjustment or discontinuation may be needed if eGFR declines. Metformin should also be introduced alongside continued nutrition, physical-activity, and weight-management support, rather than replacing those measures. Contemporary diabetes guidance further emphasizes individualizing treatment according to cardiovascular, kidney, and weight-related risks, but metformin remains an appropriate foundational treatment for an obese person with type 2 diabetes when no relevant contraindication is present. See the NICE guideline on type 2 diabetes in adults and the KDIGO guideline on diabetes management in chronic kidney disease.

QUESTION NO: 19

A 6-year-old boy fell in the playground and has been holding his forearm complaining of pain. Exam: no sign swelling. However, there is minimal tenderness on exam.

What is the diagnosis?

A. Green stick fx of distal radius

B. Fracture neck of humerus

C. Fracture mid ulnar

D. Fracture mid radius

ANSWER: A

Explanation:

Green stick fx of distal radius is the most likely diagnosis. Greenstick fractures are incomplete fractures that occur predominantly in children because their bones are relatively flexible and have a thicker, more resilient periosteum than adult bones. Following a fall, often onto an outstretched hand, the distal radius is a common site of injury. One side of the bone cortex breaks while the opposite side bends, analogous to bending a fresh green branch. This injury can therefore produce comparatively subtle physical findings: the child may guard the forearm and report pain, yet have little or no visible swelling, deformity, or bruising. Localized distal forearm tenderness may likewise be mild, particularly when displacement is minimal. In a child with this mechanism and presentation, careful examination of the wrist and distal forearm, followed by plain radiographs when clinical suspicion persists, is appropriate. Radiographs may show cortical disruption or angulation on only one side, supporting the diagnosis. Prompt recognition matters because these fractures generally require immobilization and assessment of alignment to promote uncomplicated healing. See the Royal Children's Hospital guideline on distal radius fractures and StatPearls: Greenstick Fracture.

QUESTION NO: 20

60-year-old male complains of decreased libido, decreased ejaculation, FBS= 6.5 mmol, increased prolactin, normal FSH and LH.

What is the next step?

A. Testosterone level

B. DM

C. MRI of the pituitary (sellar MRI)

D. NL FBG

ANSWER: C

Explanation:

MRI of the pituitary (sellar MRI) is the appropriate next diagnostic step in a man with clinically significant hyperprolactinemia and symptoms of hypogonadism, including reduced libido and reduced ejaculation. Prolactin excess can suppress hypothalamic gonadotropin-releasing hormone activity, impairing the gonadal axis and causing sexual symptoms even when measured follicle-stimulating hormone and luteinizing hormone values are within their reference ranges. Once hyperprolactinemia has been identified and clinically correlated, dedicated pituitary imaging is needed to evaluate for a prolactin-secreting pituitary adenoma and to define its size and local extension. MRI provides substantially better visualization of the pituitary gland, stalk, and surrounding sellar structures than CT, particularly for small lesions. Identifying a pituitary lesion is important because lesion size affects assessment for mass effects, such as optic pathway involvement, and guides endocrine referral and treatment planning. In clinical practice, reversible contributors to raised prolactin, including medications, hypothyroidism, and renal impairment, should also be reviewed; however, among the available actions, dedicated pituitary MRI best addresses the likely structural cause of this patient's symptomatic prolactin elevation. See the Endotext review of prolactinoma management and the American College of Radiology guidance on pituitary imaging.

QUESTION NO: 21

The best test for diagnosis of adenomyosis:

A. Ultrasound

B. Laparoscopy

C. Hysteroscopy

D. MRI

ANSWER: D

Explanation:

MRI is the best test for diagnosing adenomyosis when a definitive noninvasive imaging assessment is needed. Adenomyosis consists of ectopic endometrial glands and stroma within the myometrium, producing characteristic changes in the uterine muscle and at the endometrial–myometrial junction. Pelvic MRI, especially high-resolution T2-weighted imaging, depicts these changes clearly. A thickened or irregular junctional zone, commonly assessed in the appropriate clinical and imaging context, along with small high-signal-intensity myometrial foci and areas of heterogeneous myometrium, supports the diagnosis. MRI also helps determine whether disease is focal or diffuse and distinguishes adenomyosis from coexisting leiomyomas, information that can guide counseling and treatment planning. Although transvaginal ultrasound is commonly used as the initial imaging study in routine practice, MRI offers superior tissue contrast and is particularly valuable when ultrasound findings are indeterminate or when accurate mapping is clinically important. Histopathology after hysterectomy remains the traditional definitive confirmation, but it is not an appropriate routine diagnostic test for a condition often managed conservatively. Evidence reviews find MRI to have high diagnostic accuracy for adenomyosis and support its role as the preferred problem-solving imaging modality. See StatPearls: Adenomyosis and the diagnostic-accuracy review indexed at PubMed.

QUESTION NO: 22

Patient came with pitting edema grade 1, where fluid is will accumulate.

A. Veniole

B. Arteriole

C. Interstitial

D. Capillary

ANSWER: C

Explanation:

Interstitial is correct because pitting edema represents an abnormal accumulation of excess fluid in the interstitial space: the compartment between tissue cells and the vascular system. Normally, capillary filtration and reabsorption, together with lymphatic drainage, maintain a small, regulated amount of interstitial fluid. When filtration from the circulation exceeds reabsorption and lymphatic removal—for example, because of increased hydrostatic pressure, reduced plasma oncotic pressure, sodium and water retention, increased capillary permeability, or impaired lymphatic drainage—fluid expands within this tissue space.

In grade 1 pitting edema, gentle pressure displaces this mobile interstitial fluid and leaves a shallow indentation that resolves quickly. The grade describes the clinical depth and persistence of the indentation; it does not change the anatomical location of the accumulated fluid. This distinction is important clinically: edema fluid is outside blood vessels and outside cells, within the extracellular interstitial compartment. Standard physiology references describe edema as excess fluid in tissue interstitial spaces and relate its formation to the balance of capillary and lymphatic fluid exchange. See the NCBI StatPearls overview of peripheral edema and Merck Manual's discussion of edema.

QUESTION NO: 23

A 64-year-old man complains of increasing dyspnea and cough for the past 18months. He coughs up a Table mucopurulent sputum with occasional specks of blood.

What is the most likely underlying cause?

A. Acute bronchitis

B. Bronchiectasis

C. Chronic bronchitis

D. Lung cancer

E. Pneumonia

ANSWER: C

Explanation:

Chronic bronchitis is the most likely diagnosis because the presentation is of a persistent, gradually progressive productive cough with worsening breathlessness in an older adult. Chronic bronchitis is a clinical phenotype of chronic obstructive pulmonary disease in which ongoing airway inflammation and mucus hypersecretion produce regular sputum expectoration. During exacerbations or more active airway inflammation, sputum may become mucopurulent. Small blood specks can occur when inflamed bronchial mucosa is irritated by repeated coughing; this does not by itself establish a separate diagnosis.

The relatively modest sputum volume described is also consistent with chronic bronchitis. The key clinical pattern is chronic productive cough accompanied by progressive dyspnea, reflecting chronic airflow limitation and mucus-producing airway disease. In formal epidemiologic definitions, chronic bronchitis requires productive cough for at least three months in each of two consecutive years; however, this vignette's intended clinical diagnosis is chronic bronchitis based on its prolonged, progressive symptom pattern and sputum characteristics. Smoking history, spirometry, and assessment for acute exacerbation would help confirm chronic obstructive airway disease and guide management. See the Merck Manual overview of chronic obstructive pulmonary disease and NICE guidance on chronic obstructive pulmonary disease.

QUESTION NO: 24

65years man had a bowel resection 5days ago. He is anuric and breathless. His

BP=150/110mmHg.He has lung bases and sacral edema. Bloods: K+=6.8mmol/l, urea=58mmol/l, creatinine=600umol/l.

What is the single immediate management?

A. Bolus of 20U insulin

B. 5% dextrose infusion

C. Calcium resonium enema

D. 10U insulin, 50ml of 50% dextrose infusion

E. Dextrose-saline infusion

ANSWER: D

Explanation:

10U insulin, 50ml of 50% dextrose infusion is the appropriate immediate treatment for this severe hyperkalaemia. A potassium concentration of 6.8 mmol/L in an anuric patient with marked acute kidney injury is a medical emergency because extracellular potassium can rapidly cause life-threatening cardiac conduction abnormalities and arrhythmias. Intravenous soluble insulin promptly shifts potassium from the extracellular space into cells by stimulating cellular sodium-potassium ATPase activity. The concurrent 50 mL of 50% dextrose supplies 25 g glucose, reducing the substantial risk of insulin-induced hypoglycaemia. This treatment begins lowering serum potassium within approximately 15–30 minutes, so it is an essential temporising intervention while cardiac monitoring, repeat potassium and glucose measurements, and definitive management are arranged. The patient's anuria, pulmonary congestion, oedema, and severe biochemical renal failure also make urgent specialist assessment for renal replacement therapy highly likely, as dialysis removes potassium and excess fluid. Guidance on emergency hyperkalaemia management is available from the UK Kidney Association and the Resuscitation Council UK.

QUESTION NO: 25

Which vitamin has a protective effect against colon cancer?

A. Vitamin C

B. Vitamin D

C. Folic acid

D. Vitamin K

ANSWER: B

Explanation:

Vitamin D is the best answer because adequate vitamin D status has been associated with a lower risk of colorectal cancer in observational research. Vitamin D is involved in calcium absorption and has biologically plausible actions in colonic tissue, including regulation of cell growth, differentiation, and apoptosis. These mechanisms support the possibility that it contributes to protection against malignant transformation in the bowel. Its relationship with calcium is particularly relevant: vitamin D helps maintain calcium balance, and higher combined intakes or status of vitamin D and calcium have been investigated in relation to colorectal neoplasia. The National Cancer Institute notes that studies have examined vitamin D in relation to colorectal cancer risk, while also emphasizing that research findings and the benefit of supplementation alone have not been fully consistent. Thus, in the context of this single-best-answer question, vitamin D is the vitamin classically associated with a protective effect against colon cancer. This should be understood as an association supported by nutritional and epidemiologic evidence rather than a recommendation to use high-dose supplements for cancer prevention. Prevention also depends on established measures such as screening, healthy body weight, physical activity, and dietary patterns. See the National Cancer Institute vitamin D fact sheet and the World Cancer Research Fund colorectal cancer evidence.

QUESTION NO: 26

50 year's old male complained of right iliac fossa dull aching pain. Exam showed that he had right iliac fossa mass with positive cough impulse. The examining doctor found a bluish tinge on the mass surface & the percussion tab was positive.

The most likely diagnosis is:

A. Saphena Varix

B. Right femoral hernia

C. Right vaginal Hydrocele

D. Cysts of Morgagni

E. Right inguinal hernia

ANSWER: A

Explanation:

Saphena Varix is the most likely diagnosis. A saphena varix is a localized dilatation of the terminal great saphenous vein at, or immediately adjacent to, its junction with the femoral vein in the groin. It classically presents as a soft, compressible groin swelling that may have a bluish discoloration because it is a superficial venous lesion. The swelling can become more apparent with standing or raised intra-abdominal pressure and may demonstrate a cough impulse, which is why it can be mistaken clinically for a groin hernia.

The described positive percussion tap is also compatible with a venous swelling: transmitted venous impulse can be elicited when the varix communicates with the saphenofemoral junction. In an older patient with a dull ache and a blue-tinged, cough-impulsive swelling in the groin region, these combined venous features strongly support saphena varix. Clinical examination should include assessment while standing and supine, and duplex ultrasonography can confirm venous communication and evaluate associated venous reflux. Further clinical details are available from Patient.info: Saphena varix and Radiopaedia: Saphena varix.